

## TRUST BOARD MEETING

Formal meeting, which is open to members of the public (to observe). Please note that questions from members of the public should be asked at the end of the meeting, and relate to one of the agenda items

**10am – c.12.30pm THURSDAY 24<sup>TH</sup> MAY 2018**

**PENTECOST/SOUTH ROOMS, THE ACADEMIC CENTRE,  
MAIDSTONE HOSPITAL**

### A G E N D A – P A R T 1

Ref.	Item	Lead presenter	Attachment
5-1	To receive apologies for absence	Chair of the Trust Board	Verbal
5-2	To declare interests relevant to agenda items	Chair of the Trust Board	Verbal
5-3	Minutes of the Part 1 meeting of 26 <sup>th</sup> April 2018	Chair of the Trust Board	1
5-4	To note progress with previous actions	Chair of the Trust Board	2
5-5	Safety moment	Chief Nurse	Verbal
5-6	Report from the Chair of the Trust Board	Chair of the Trust Board	Verbal
5-7	Report from the Chief Executive	Chief Executive	3
<b>Staff experience</b>			
5-8	The “End PJ Paralysis” campaign	Chief Nurse / End PJ Paralysis Team	Presentation
5-9	Board Assurance Framework (BAF): Agreement of key objectives for 2018/19	Trust Secretary	4 (to follow)
5-10	Integrated Performance Report for April 2018 <ul style="list-style-type: none"><li>Effectiveness / Responsiveness</li><li>Safe / Effectiveness / Caring</li><li>Safe / Effectiveness (incl. mortality)</li><li>Safe (infection control)</li><li>Well-Led (finance)</li><li>Well-Led (workforce)</li></ul>	Chief Executive Chief Operating Officer Chief Nurse Medical Director Dir. of Infect. Prev. & Control Director of Finance Director of Workforce	5
5-11	Planned and actual ward staffing for April 2018	Chief Nurse	6
5-12	Winter review 2017/18 (incl. CQC letter on winter pressures in Emergency Departments)	Chief Operating Officer	7
5-13	Update from the Best Care Programme Board	Chief Executive	8 (to follow)
<b>Quality items</b>			
5-14	Approval of progress report against the Clinical Negligence Scheme for Trusts (CNST) incentive scheme maternity safety actions	Chief Nurse	9 (N.B. The full document has been issued as a supplement to the main reports)
<b>Planning and strategy</b>			
5-15	Approval of the Outline Business Case for an Electronic Patient Record (EPR)	Chief Operating Officer / Interim Director of Health Informatics / Chief Clinical Information Officer	10
<b>Assurance and policy</b>			
5-16	NHS Provider licence: Self-certification for 2017/18	Trust Secretary	11
<b>Reports from Trust Board sub-committees (and the Trust Management Executive)</b>			
5-17	Audit and Governance Committee, 02/05/18 & 24/05/18 (incl. Audit & Governance Committee Annual Report for 2017/18)	Committee Chair	12
5-18	Trust Management Executive (TME), 16/05/18	Committee Chair	13
5-19	Finance and Performance Committee, 22/05/18 (incl. quarterly progress update on Procurement Transformation Plan, and approval of proposed amendments to Terms of Reference)	Committee Chair	14, 15 & 16 (to follow)
<b>Annual Report and Accounts</b>			
5-20	Approval of Annual Report, 2017/18 (incl. Annual Governance Statement)	Chair of Audit and Governance Committee	17
5-21	Approval of Annual Accounts 2017/18		18 (to follow)
5-22	Approval of Management Representation Letter, 2017/18		19 (to follow)
5-23	<b>To consider any other business</b>		
5-24	<b>To receive any questions from members of the public</b>		
5-25	To approve the motion (to enable the Trust Board to convene its ‘Part 2’ meeting) that in pursuance of Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest	Chair of the Trust Board	Verbal
<b>Date of next meeting:</b> 28 <sup>th</sup> June 2018, 10am, Education Centre, Tunbridge Wells Hospital			

**David Highton,**  
Chair of the Trust Board

**MINUTES OF THE TRUST BOARD MEETING ('PART 1') HELD ON THURSDAY  
26<sup>TH</sup> APRIL 2018, 10A.M, AT MAIDSTONE HOSPITAL**



**FOR APPROVAL**

Present:	David Highton	Chair of the Trust Board	(DH)
	Maureen Choong	Non-Executive Director	(MC)
	Angela Gallagher	Chief Operating Officer	(AG)
	Nazeya Hussain	Non-Executive Director	(NH)
	Peter Maskell	Medical Director	(PM)
	Claire O'Brien	Chief Nurse	(COB)
	Steve Orpin	Director of Finance	(SO)
	Steve Phoenix	Non-Executive Director	(SP)
	Miles Scott	Chief Executive	(MS)
In attendance:	Simon Hart	Director of Workforce	(SH)
	Jim Lusby	Deputy Chief Executive	(JL)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Kevin Rowan	Trust Secretary	(KR)
	Jenny Anderson	Acting General Manager, Cancer	(JA)
	Neil Bedford	General Manager, Radiology	(NB)
	Stephen Duck	Director of Medical Physics	(SD)
	Henry Taylor	Clinical Director, Cancer, Haematology and Radiology	(HT)
	Charlotte Wadey	Lead Matron, Cancer, Haematology and Radiology	(CW)
Observing:	Hannah Alland	Digital Communications Officer	(HA)
	Richard Flood	Staff Side representative (from item 4-2)	(RF)
	Annemieke Koper	Staff Side representative	(AKo)
	Debbie O'Reilly	Staff Side representative	(DOR)
	Caitlin Webb	Member of the press (KM)	(CWe)

**4-1 To receive apologies for absence**

Apologies were received from Sarah Dunnett (SDu), Non-Executive Director (NED); and Tim Livett (TL), NED. DH also noted that it was NH's first Trust Board meeting since being appointed as a substantive NED, whilst it was also JL's last Board meeting before leaving the Trust.

DH added that it was AKo's last Trust Board meeting, as she was leaving the Trust on 26/04/18, after 27 years.

**4-2 To declare interests relevant to agenda items**

No interests were declared.

**4-3 Minutes of the 'Part 1' meeting of 29<sup>th</sup> March 2018**

The minutes were approved as a true and accurate record of the meeting subject to the following amendments:

- Item 3-8, page 4 of 12: Replace "...staff may need to ask patients to supplement the scant knowledge they may have" with "staff may need to ask patients to supplement the non-specialised knowledge they may have"
- Item 3-24, page 12 of 12: Remove "and PM had been able to train himself in its use"

**Action: Amend the minutes of the 'Part 1' Trust Board meeting held on 29/03/18 (Trust Secretary, April 2018)**

**4-4 To note progress with previous actions**

The circulated report (Attachment 2) was noted. The following actions were discussed in detail:

- 1-8 ("Circulate, to Trust Board Members, a report responding to the specific points and general themes arising from the "A patient's experiences of the Trust's services" item at**

**the Trust Board meeting on 25/01/18”).** COB stated that the report was almost complete, and she would aim to send the report within the next week.

- **2-10b (“Publicise the steps the Trust was taking to ensure the safety of its services, in the context of the recent media coverage regarding increased demand and treatment delays across the NHS”).** JL reported that he had discussed the issue with the Head of Communications, to ensure this was addressed. DH noted that the review of the winter plan 2017/18 had been considered at the Trust Management Executive (TME) on 25/04/18, and suggested it would perhaps be beneficial if a briefer version was circulated. JL agreed this would be beneficial. It was agreed to close the action.
- **2-10c (“Review the Trust’s current policy regarding the start and end dates of the staff Annual Leave year, taking into account other NHS provider organisations’ policies”).** SH stated that a report should be ready for consideration by the next Trust Board meeting.

*[Post-meeting note: It has since been determined that the report reviewing the Trust’s current policy regarding the start and end dates of the staff Annual Leave year should be considered by the Workforce Committee (in May 2018) before being considered by the Trust Board]*

#### **4-5 Safety moment**

COB reported that the theme for April was infection prevention and control, and the focus had been on 3 areas: peripheral cannula related infections, learning from MRSA-related incidents, and ensuring mattresses were clean. SM added some further points.

DH observed that the issues raised by COB and SM emphasised the importance of documentation, noting that this had been the subject of a previous safety moment. COB agreed, and stated that it was intended to apply the Listening into Action (LiA) approach to documentation, to help improve the consistency, and accessibility, of documentation in clinical areas. PM added that he aimed to address similar concerns in relation to Medical documentation.

#### **4-6 Report from the Chair of the Trust Board**

DH referred to the circulated report and highlighted the following points:

- MC and NH had both now been appointed as substantive NEDs, so DH was therefore seeking to appoint up to 2 Associate NEDs
- The NeXT Director placement had now been agreed, and it was hoped that the documentation would be completed to enable the individual to start in time for the May 2018 Trust Board meeting. The placement would be supernumerary, and would last for at least 6 months, but most likely 12 months
- The appointment of a successor to JL was underway
- The only Advisory Appointments Committee (AAC) meeting that had been held since the last Trust Board meeting had not resulted in an appointment
- DH wanted to thank the Executive Team, at year-end, for all the hard work during the year and the improvements that had been made

#### **4-7 Report from the Chief Executive**

MS referred to the circulated report and highlighted that he also wished to also acknowledge the work undertaken in 2017/18, particularly in relation to patient flow, and added that there was a strong sense of optimism for the future now that the highest levels of activity pressure had abated. MS continued that staff pressures did however remain, and the 2 biomedical scientists who had participated in a Royal College of Pathologists pilot training scheme to achieve an Advanced Specialist Diploma in Histopathology was an important example of the alternative approach required to address such pressures.

#### **Presentation from a Clinical Directorate**

#### **4-8 Cancer and Haematology**

DH welcomed JA, NB, SD, HT and CW to the meeting, and noted that this was the last of the current round of presentations from Clinical Directorates. HT then gave a presentation highlighting the following points:

- The Directorate was complex in that it served a population of over 1.8 million across Kent, Medway and parts of East Sussex
- The Directorate's annual budget was £51m
- The oncology service was a high-volume, Consultant-led service
- The Directorate oversaw the Trust's Cancer waiting time target performance, which was currently fragile, as significant improvements were seen one month, but issues may occur that meant performance declined the following month. A skin cancer service, which had a quicker time to treatment, was not provided by the Cancer Centre, and although this was not an excuse for the Trust's poor performance, it was part of the explanation

DH asked whether the percentage of Medical oncology patients was lower at the Trust than at non-District General Hospital-based Cancer Centres. HT confirmed that the overall percentage of Medical oncology patients was lower at the Trust than some other Cancer Centres. HT then continued, and highlighted the following points:

- Cancer care was prioritised towards urgent and emergency cases, and benchmark data showed that the Trust performed comparatively better on such cases, despite its overall average performance comparing adversely
- The Trust did however perform comparatively well on Clinical Governance measures
- The Directorate's vision was "To be the Kent & Medway Cancer Centre of excellence for all patients throughout their cancer pathway from effective timely diagnosis to living with and beyond cancer"
- Current risks included strained capital funding, which could have an adverse impact on replacement of equipment
- Challenges included the need to ensure compliance with all national cancer performance targets, and to recruit and retain staff across all services
- Opportunities included increasing research; working closely with the newly-announced Kent and Medway Medical School; and exploring partnership arrangements with the Independent Sector, to provide additional, and replace existing, Radiology imaging equipment
- Strengths included the CHKS revalidation, innovation, and having a good local reputation
- Future improvements included developing the Trust's strategy for the delivery of all Cancer services and treatments through other models of delivery

PM asked how engaged the Directorate's clinicians were. HT replied that overall, the Directorate performed better on engagement than other hospital groups, and elaborated that Oncologists had an outward perspective, which reflected the fact that they worked at other Trusts. HT added that work was however required to improve engagement and communication with other staff groups. NB added that for Radiology, work was needed to improve the provision of cross-cover across both main hospital sites, as this was currently a challenge.

MS noted that workforce challenges were often discussed, and asked for a comment on the development of new roles and new approaches. NB pointed out that the Trust had a high number of Radiographers undertaking reporting, and all virtual colonoscopies at the Trust were performed by Radiographers. CW added further details.

DH thanked JA, NB, SD, HT and CW for the presentation.

#### **4-9 Year-end review of the Board Assurance Framework, 2017/18**

KR referred to Attachment 5 and highlighted the following points:

- The report was submitted to the Trust Board each year in April, to formally close down the Board Assurance Framework (BAF) for the previous year
- The summary position was provided on page 1, whilst further details on the rationale for the year-end rating was contained on successive pages
- The year-end ratings should not be unexpected, given the oversight that had been applied to each objective in 2017/18
- The key objectives to feature in the 2018/19 BAF would be subject to further discussion, following the submission of the Trust's final plans for 2018/19, and would then be submitted to the Trust Board, for approval, hopefully at the May 2018 Trust Board meeting

DH agreed that the content of the report should not be unexpected. MS concurred, but stated that there should be reflection of the fact that only 1 of the Trust's key objectives was met for the year, and he did not want to be in the same position in April 2019. DH acknowledged the point, and the need to ensure the Trust delivered its key objectives for 2018/19.

#### **4-10 Integrated Performance Report for March 2018**

MS referred to Attachment 6 and highlighted the following points:

- There had been a detailed discussion at the Finance and Performance Committee on 24/04/18, and a number of actions had been agreed, including in relation to performance against the 62-day Cancer waiting time and Referral to Treatment (RTT) targets
- The improvement in A&E 4-hour waiting time target performance was based on systematic changes that had been made

#### **Effectiveness / Responsiveness (incl. DTOCs)**

AG then highlighted the following points:

- The A&E 4-hour waiting time target improvements were based on the application of best practice, but it was important to continue to maintain such improvements
- Performance on Cancer pathways and RTT would now be the main area of focus. Best practice was not as well developed for these areas as for the A&E 4-hour waiting time target, but the Intensive Support Team (IST), who would revisit the Trust in May 2018, would be used to apply whatever best practice was in place at other organisations

DH asked for a comment on the Cancer 2 week waiting time target performance. AG explained the Trust's plans regarding this, and the expected role of the Trust Cancer Committee.

#### **Safe / Effectiveness / Caring**

COB highlighted the following points:

- The falls target rate had been achieved for 2017/18, although there had been some falls-related Serious Incidents (SIs). There would be no complacency
- An internal review regarding pressure ulcers had raised some issues, but a response had been developed. The Trust was also currently recruiting a second Tissue Viability Nurse, although the responsibility for the prevention of pressure ulcers went beyond that of individuals
- Friends and Family Test (FFT) response rates had improved since the previous month
- There had been some mixed accommodation breaches, which related to operational pressures on the Acute Medical Unit (AMU)
- Complaints responses were a significant challenge, and performance was only at 52%, compared with the internal target of 75%. Meetings would be held with all parties at the end of May 2018 (i.e. after the May Board meeting) to understand the issues affecting performance

DH asked for further details of the challenges affecting complaints response performance. COB provided the further details. DH remarked that it was important to prevent initial complaints from escalating more formally, and appealed for support to ensure staff understood that this was part of their role. COB agreed, and explained this would form part of the aforementioned discussions at the end of May. DH asked for confirmation that the situation required a more complex solution than just allocating short-term financial resources. COB confirmed she believed this was the case.

MC then asked for a comment on the Patient Advice & Liaison Service (PALS) issues that had been raised in relation to Ophthalmology appointments. COB noted that the PALS had been able to resolve the issues for the patients who had contacted them, but challenges in the underlying system remained. AG explained the nature of the issues, and the action being taken to try and address these.

COB then reported that the Trust had now appointed a Learning Disability Nurse, who was proving to be very beneficial; and added that Venous Thromboembolism (VTE) SIs would in future be added as a separate line on the monthly performance dashboard, but there had been 13 such SIs in 2017/18 compared to 8 in 2016/17.

### **Safe / Effectiveness (incl. Mortality)**

PM reported there had been an improvement in the completion of mortality reviews.

### **Safe (infection control)**

SM highlighted the following points:

- 2017/18 was the first year that SM had been able to report that there had been no cases of MRSA bacteraemia for the entire financial year
- The Clostridium difficile trajectory for 2017/18 had been achieved, as there had been 25 cases against a trajectory of 27. The trajectory for 2018/19 was 26.
- MC and SM would be attending a Board assurance meeting w/c 30/04/18 regarding gram-negative infections
- There had been 37 cases of influenza in March 2018. A total of 14 cases had been admitted to the ICU, which equated to 191 bed days, and which resulted in considerable pressure on ICU

### **Well-Led (finance)**

SO highlighted the following points:

- The figures in Attachment 6 were out of date because a final Sustainability and Transformation Fund (STF) payment of £3m was received after the report had been issued. The Trust's reported 2017/18 out-turn was therefore a deficit of £10.918m, which was exactly the same as the 2016/17 out-turn. All of the other figures were however unchanged
- The Trust had significantly improved its underlying deficit. The original control total for 2017/18 had not been achieved, but the revised forecast was achieved
- Temporary staffing expenditure had increased, for Nursing Agency and Medical Locum and Agency staff, and such expenditure had increased in the last 3 months of the year in particular. Some of this arose from vacancies and winter pressures, and well as sickness absence. However, the requirements for temporary staffing had begun to reduce, in accordance with the de-escalation of inpatient capacity
- The plan for 2018/19 would be discussed under item 4-14

### **Well-led (workforce)**

SH then reported the following points:

- Long-term sickness absence had reduced, so short-term sickness absence was now the main concern. Some progress had been made in certain areas, including Women's and Children's, but more work was required, via engagement with staff networks
- Staff turnover continued to reduce
- The Trust had joined cohort 3 of NHS Improvement's (NHSI's) staff retention programme, and had been asked to undertake a 3 month diagnostic exercise, before setting a target
- Vacancies remained a concern, and although there had been some improvement in recruitment, further improvements were required. A report regarding this had been discussed at the TME meeting on 25/04/18
- The importance of appraisals would increase if the current national pay award was implemented, and a review was underway to ensure the Trust's appraisal process was robust

NH referred to Estates and Facilities having high levels of both sickness absence and turnover, so asked whether this was an area of focus. SH replied that the aforementioned NHSI programme was primarily aimed at clinical areas, but there was no reason why the same approach could not be applied to Estates and Facilities.

NH then referred to appraisal compliance, and noted that the Care Quality Commission (CQC) inspection had emphasised the importance of ensuring appraisals were of a certain quality, rather than just focusing on compliance with undertaking such appraisals. SH acknowledged the point.

### **4-11 Update from the Best Care Programme Board**

MS referred to Attachment 7 referred to the circulated report and highlighted the following points:

- The overall programme structure was now in place, and the Best Care Programme Board was the key forum. SO would take over the oversight of the Programme from JL

- It was important to ensure there was appropriate capability and capacity in the individual workstreams, and further discussion regarding resourcing, in terms of internal secondments, Project Management Office (PMO) support and potential external funding, was underway
- Clarity was required on the specific Key Performance Indicators (KPIs) to be used to judge whether performance was as expected
- Clarity was also needed regarding communications and branding of the programme, and although MS felt that the knowledge of those engaged directly was sufficient, the awareness of other staff needed to increase
- The Best Care programme was more than just the Cost Improvement Programme (CIP), and was the Trust's transformation programme. In this context, although the Best Safety programme did not currently have any savings values allocated, no apologies should be made for this, as the work of that programme was important

SO commented further on the work being undertaken to ensure there was sufficient capacity and capability to support the programme.

NH remarked that it was important that some key messages were relayed to staff to ensure that the Best Care programme was regarded as a long-term approach to improvement and transformation, rather than just another short-term initiative. SP added that the key issue for him was being able to explain how the Best Care programme related to other current initiatives. DH emphasised the importance of the transformational aspects of programme being implemented earlier, to enable future benefit to be optimised. The points were acknowledged.

### **Quality Items**

#### **4-12 Planned and actual ward staffing for March 2018**

COB referred to Attachment 8 and highlighted the following points:

- The ratings for the Nurse-sensitive indicators on Ward 20 related to patient falls, but the area had responded, including seeking advice from the Dementia Clinical Nurse Specialist. More work was however still required
- It was hoped that the Quality, Effectiveness & Safety Trigger (QuEST) tool would be able to be included in the report submitted to the May 2018 Trust Board meeting
- There was also a desire to use the eRoster IT system, to automate the production of the reports, which were currently carried out manually by the Deputy Chief Nurse. The report would therefore change in subsequent months

#### **4-13 Board members' Quality Walkarounds**

KR referred to Attachment 9 and invited questions or comments. NH noted that she had undertaken some visits that were not listed, but she would ensure these were recorded in future.

### **Planning and strategy**

#### **4-14 Final review of the planning submissions for 2018/19 (incl. operating plan)**

SO referred to Attachment 10 and highlighted that the control total required for 2018/19 was now a £1m deficit, inclusive of Provider Sustainability Fund (PSF) monies. DH remarked that the new control total represented a de-risking of the Trust's position.

SO then continued, and highlighted the following points:

- The CIP target was £21.4m, which was similar to that achieved in recent years. However, the Trust still required £7.4m (not the £10.4m stated in the report) of non-recurrent benefit to achieve the plan
- Mitigations were being developed in the event of performance varying from the plan
- The national and local planning assumptions were described in Attachment 10, along with a 'top-down' view of clinical income. However, more detailed analysis of the latter would be presented at the Trust Board Seminar scheduled for later that day

- It was important for Trust Board Members to understand the key risks, and in this regard, the 2 most significant risks were the impact of non-elective activity being above planned levels, and the delivery of the full value of the aforementioned non-recurrent benefit
- The capital programme for 2018/19 would be challenging, as the Trust did not have as much capital funding as it would have liked. The Linear Accelerator (LinAc) replacement programme and aging equipment were significant factors. The Trust was therefore exploring the potential for loans and/or Independent Sector funding
- An assumption had been made that the Trust's cash would be used to repay a previous working capital loan, but discussions would be held with NHSI regarding this, as the Trust needed to ensure it had the appropriate financial balance

DH emphasised the importance of making a conscious decision regarding the control total, adding that the Finance and Performance Committee meeting on 24/04/18, which involved TL and SDu, had recommended that the Trust Board should agree to the control total. MS added that the Committee had also noted the importance of understanding how the A&E 4-hour waiting time target aspect of the PSF would be paid, as achieving the control total required the receipt of the full amount of available PSF monies. MS stated that he therefore recommended that the control total be agreed, on the understanding that this meant that the A&E 4-hour waiting time target needed to be achieved. The point was acknowledged.

The Trust Board approved the plan for 2018/19, including the control total.

#### **4-15 Review of engagement strategy**

SH referred to Attachment 11 and highlighted the following points:

- The Strategy been discussed with Staff Side, the TME, the Workforce Committee and others
- Engagement was important in relation to recruitment, retention and quality
- The Trust wanted its staff to recognise the Trust as an organisation that engaged with staff
- A range of actions would be undertaken to embed an organisational culture of trust and transparency, so that all staff felt safe and able to participate in the transformation and improvement of the Trust
- Many of the actions would overlap with the aforementioned NHSI retention programme, and it was intended to establish a joint group to oversee both

#### **Assurance and policy**

#### **4-16 Approval of statement of compliance with the 2017/18 Data Security Protection Requirements**

COB referred to Attachment 12 and highlighted the following points:

- The report had been drafted by the Trust's Head of Information Governance
- The standards had arisen from recommendations from the National Data Guardian
- Some of the standards were listed as partially compliant, and COB had asked for details of the timescales for full compliance. However, some of this was challenging, and related to the implementation of the forthcoming General Data Protection Regulation (GDPR)

NH referred to Requirement 9 ("On-site cyber and data security assessments"), and stated that it was not clear from the report whether there were any concerns in relation to cyber security risks. COB replied that she did not believe any concerns had been raised. KR added that he understood that the specific condition for Requirement 9 was for the Trust to have undertaken an on-site cyber and data security assessment, if requested to do so by NHS Digital, and the Trust had not been asked to undertake such an assessment. DH therefore proposed that the statement of compliance be approved as circulated, but that clarification be obtained as to whether the Trust was able to ask NHS Digital to undertake such an assessment (and if so, to request that such an assessment be undertaken). This was agreed.

**Action: Clarify whether the Trust was able to ask NHS Digital to undertake an on-site cyber and data security assessment (and if so, to request that such an assessment be undertaken) (Chief Nurse (as Senior Information Risk Owner), April 2018 onwards)**



The Trust Board therefore approved the statement of compliance with the 2017/18 Data Security Protection Requirements as circulated, subject to the requested clarification.

#### **4-17 Annual approval of the Sustainable Development Management Plan (SDMP)**

AG referred to Attachment 13 and highlighted the key points therein, which included the carbon reduction target. DH commended the introduction of LED lighting.

NH asked whether had been any guidance and/or thought given to reducing the Trust's use of plastics. AG replied that guidance was awaited guidance before acting, but confirmed that thought had been given to the issue. SO added that the Procurement team had also given consideration to reducing packaging.

The Trust Board approved the Sustainable Development Management Plan as circulated.

#### **4-18 Freedom to Speak Up Guardian arrangements**

SH referred to Attachment 14 and highlighted the key points therein. SP stated that he supported the arrangements, but emphasised the importance of maintaining the NED link, and recommended that the Chair of the Workforce Committee be available to listen to any concerns. DH concurred. SH acknowledged the points.

#### **Reports from Trust Board sub-committees (and the Trust Management Executive)**

#### **4-19 Workforce Committee, 29/03/18 (incl. the findings of the national NHS staff survey 2017)**

SP referred to Attachment 15 and drew attention to the NHS Staff Survey 2017 and Gender Pay Gap reports which had been included as appendices. SP continued that the Workforce Committee had expressed concerns regarding the sample size of the Staff Survey, and had also asked for further analysis of the Gender Pay Gap reporting, which included the application of the Clinical Excellence Awards. SP added that he had also suggested that a female Task Force review the issue in more detail, noting that the Director of Workforce, Medical Director and Chair of the Workforce Committee were all middle-aged white males.

DH asked for comments on the proposed approach. MS challenged the benefit of undertaking multiple reviews of different aspects of diversity, rather than an overall review of equality and diversity. SP acknowledged the point, but suggested that the proposed focus be maintained for the time being. MS elaborated that his remarks related specifically to the intended review of the Clinical Excellence Awards, in that he believed it would not be appropriate for the review to only consider gender. SH clarified that the review intended to consider all protected characteristics.

NH highlighted the importance of the establishment of the Task Force, and suggested that NEDs be included. The suggestion was acknowledged.

#### **4-20 Quality Committee, 10/04/18**

In SDu's absence, SP referred to Attachment 16 and invited questions or comments. DH remarked that the review of the quality of care provided under inpatient escalation had been excellent.

#### **4-21 Finance and Performance Committee, 24/04/18**

DH referred to Attachment 17 and invited questions or comments. None were received.

#### **4-22 Trust Management Executive (TME), 25/04/18**

MS reported that the only issue worthy of reporting was that the membership of the TME had been broadened to include the Chief Clinical Information Officer (CCIO), who now joined the Director of Medical Education (DME) and Clinical Lead for Research as members.

**4-23 To approve revised Terms of Reference for the Remuneration & Appointments Committee**

The revised Terms of Reference for the Remuneration and Appointments Committee were approved as circulated.

**4-24 To consider any other business**

There was no other business.

**4-25 To receive any questions from members of the public**

AKo thanked the Trust Board for its support and introduced RF and DOR, who would replace AKo in her Staff Side role. AKo added that she was optimistic of a step-change improvement in staff engagement, and appealed for the LiA to not be forgotten. DH thanked AKo for her contribution to the Trust.

**4-26 To approve the motion (to enable the Trust Board to convene its 'Part 2' meeting) that in pursuance of Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest**

The motion was approved, which enabled the 'Part 2' Trust Board meeting to be convened.

## Trust Board Meeting – May 2018

**5-4 Log of outstanding actions from previous meetings**
**Chair of the Trust Board**
**Actions due and still ‘open’**

Ref.	Action	Person responsible	Original timescale	Progress <sup>1</sup>
2-10c (Feb 18)	Review the Trust’s current policy regarding the start and end dates of the staff Annual Leave year, taking into account other NHS provider organisations’ policies	Director of Workforce	March 2018 onwards	<div style="background-color: green; height: 10px; width: 100%;"></div> The report of the requested review will be considered by the Workforce Committee (in May 2018) before being considered by the Trust Board (in June 2018)
4-16 (April 18)	Clarify whether the Trust was able to ask NHS Digital to undertake an on-site cyber and data security assessment (and if so, to request that such an assessment be undertaken)	Chief Nurse (as Senior Information Risk Owner)	April 2018 onwards	<div style="background-color: green; height: 10px; width: 100%;"></div> The requested clarification is being sought. The Trust Board will be informed of the outcome, once this is confirmed.

**Actions due and ‘closed’**

Ref.	Action	Person responsible	Date completed	Action taken to ‘close’
1-8 (Jan 18)	Circulate, to Trust Board Members, a report responding to the specific points and general themes arising from the “A patient’s experiences of the Trust’s services” item at the Trust Board meeting on 25/01/18	Chief Nurse	May 2018	A report was circulated to Trust Board Members, and sent to the patient’s relative, on 16/05/18
4-3 (April 18)	Amend the minutes of the ‘Part 1’ Trust Board meeting held on 29/03/18	Trust Secretary	April 2018	The minutes were amended prior to being signed by the Chair of the Trust Board

**Actions not yet due (and still ‘open’)**

Ref.	Action	Person responsible	Original timescale	Progress
7-14 (July 17)	Arrange for details of the length of the Trust’s backlog maintenance programme to be included in future Estates and Facilities Annual Reports	Chief Operating Officer	July 2018	<div style="background-color: green; height: 10px; width: 100%;"></div> The Director of Estates and Facilities has been notified of the request, and been asked to ensure the information is included in the 2017/18 Annual Report, which is scheduled to be considered by the Trust Board in July 2018

1

Not started

On track

Issue / delay

Decision required

## Trust Board meeting – May 2018

5-7	Report from the Chief Executive	Chief Executive
	<p>I wish to draw the points detailed below to the attention of the Board:</p> <ol style="list-style-type: none"> <li>Our annual plan for 2018/19 puts us within touching distance of becoming a strong independent Trust again that can make more of our long-held aspirations for our services, patient care and everyday working lives a reality.</li> <li>This year's plan moves us to within 12 months of securing long-term financial sustainability for MTW and has the potential to create enormous investment opportunity along the way.</li> <li>Over the last two years, we have managed to get our underlying deficit down from £37 million to £18 million, and we want to eradicate that over this year and next. Consequently, this year, we will be delivering a savings programme of £24 million – an amount similar to the savings we delivered last year.</li> <li>By achieving this year's plan, we will:               <ul style="list-style-type: none"> <li>Move out of Financial Special Measures and be considerably closer to achieving long-term underlying financial sustainability at MTW.</li> <li>Be able to earn £12 million in additional funding from the NHS Provider Sustainability Fund to spend in 2019/20. This will provide more cash for us to invest in capital improvements in future years.</li> <li>Have our lowest ever underlying deficit to tackle in 2019/20, so we can regain our autonomy and authority to make significant change for the better.</li> </ul> </li> </ol> <p>It is taking a huge amount of effort on a daily basis from everyone across the Trust to meet our challenges - but it's vital that we work smarter, not just harder. We must all support the whole of the Trust's plan, not just the financial aspects of the changes we know we must make.</p> <p>The Best Care programme, which I have mentioned before, will help us to do exactly that and to reap the rewards. The programme has five workstreams: Best Safety, Best Quality, Best Patient Flow, Best Workforce and Best Use of Resources.</p> <p>I have stressed to our staff that it is important for us all to make a commitment to this programme, as we all have a part to play in improving our patient and staff experience this year. The key, as always, is about us all working together to help make MTW the great place we all want it to be.</p>	<ol style="list-style-type: none"> <li>I accompanied a team of clinicians from MTW on a fact-finding visit to Northumbria Healthcare NHS Foundation Trust, one of the top-performing NHS trusts in the country.</li> </ol> <p>There is clearly much for us to be proud of at MTW and it is realistic for us to match Northumbria's Outstanding rating and clinical, operational and financial performance over the next couple of years.</p> <p>Northumbria has a lot of great practice that we can emulate and I look forward to working with our clinical teams over the coming weeks and months to develop further improvement initiatives at MTW that continue to enhance our patient and staff experience.</p> <ol style="list-style-type: none"> <li>We reached out to over 40,000 people through social media earlier this month as part of the publicity we generated around our latest achievements and celebration of our staff endeavour.</li> </ol> <p>We have taken a great deal of pride this month in celebrating International Midwives' Day,</p>

International Nurses' Day and National Operating Department Practitioners' (ODP) Day. Staff from our wards and departments sent in photos of their teams that we posted on social media as part of our celebrations. They have gained thousands of likes and many positive comments.

Many improvements are being made within multiple areas of our hospitals, which are having a positive impact on patient outcomes, patient and staff experience and performance targets. Major programmes such as the Best Care Programme, the LIA Programme, as well as the recent CQC report have succeeded in demonstrating what positive work is being undertaken across our Trust.

It is so important for us all to recognise, publicise and celebrate these achievements and our exceptional staff. To do this, we are submitting information and nominations around much of this fantastic work to national awards panels.

I was delighted to hear that one of our midwifery volunteers from Crowborough Birth Centre, Kay Sutherland, was nominated for an NHS Lifetime Achievement Award and appeared on BBC's One Show this month as part of a special programme to celebrate 70 years of the NHS. We have also had a number of nominations put forward by our local MPs for the NHS70 Parliamentary Awards. Staff who have been put forward for national recognition include:

- The Cancer Survivorship Programme Team (Excellence in Cancer Care)
- The Frailty Unit at Maidstone Hospital (Excellence in Urgent and Emergency Care)
- Matrons Kate Holmes and Glenda Sonquit (Care and Compassion)
- Retired Clinical Nurse Specialist Jane Elliott (Lifetime Achievement)
- The Oncology Centre breast cancer team's partnership working with the Living With Secondary Breast Cancer Service (Excellence in Cancer Care)

7. Generous donations from charities Maidstone Hospital League of Friends, Prostate Cancer Support Association Kent and Malling Lions, has helped MTW set up a pioneering prostate biopsy clinical – one of only two clinics running in England.

The money has funded the purchase of some specialist equipment that allows our clinical team to undertake prostate biopsies using local anaesthetic, avoiding the risks of sepsis associated with biopsy whilst maintaining the accuracy of diagnosis. The new procedure greatly benefits patients as it takes just 12 minutes to carry out, with only an hour's recovery time, meaning patients have a less invasive procedure and can leave hospital sooner.

Our strong links with the local community continued in May with the Mayor of Maidstone, Cllr Malcolm Greer, officially opening our new Kent Lung Awareness wellbeing garden at Maidstone Hospital. The garden has been funded through Cllr Greer's charitable work and this great new space will benefit our patients and their families.

#### **Which Committees have reviewed the information prior to Board submission?**

- N/A

#### **Reason for receipt at the Board (decision, discussion, information, assurance etc.)<sup>1</sup>**

Information and assurance

<sup>1</sup> All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

## Trust Board Meeting – May 2018

**5-9 Board Assurance Framework: Agreement of 2018/19 key objectives Trust Secretary****Background**

The Board Assurance Framework (BAF) is the document through which the Trust Board identifies the principal risks to the Trust meeting its key objectives, and to ensure adequate controls and measures are in place to manage those risks. The ultimate aim of the BAF is to help ensure that the key objectives agreed by the Board are met. The BAF differs from the Risk Register as the BAF only contains the risks posing a direct threat to the achievement of the Trust's objectives

The BAF for 2017/18 and 2016/17 was based on the principle of focusing on a deliberately small number of higher-level objectives to act as proxy indicators (i.e. a 'litmus test') for broader performance. For example, the 62-day Cancer waiting time target was selected because achieving this was likely to result in the achievement of the other Cancer waiting time targets; whilst the A&E 4-hour waiting time target is selected because it provides an overall indication of patient flow.

**Approach and format for the BAF document**

The 'litmus test' approach to the key objectives within the BAF is proposed to remain unchanged for 2018/19, on the basis that this enables clarity on priorities (which may be adversely affected by approaches (which the Trust has used in the past) that include a larger number of objectives).

The BAF is considered at the Trust Board, Audit and Governance Committee, Trust Management Executive (TME), and Finance and Performance Committee (for the relevant objectives only) and the same reporting frequency applied in 2017/18 is also proposed. The format of the BAF document/reports is also proposed to remain primarily unchanged for 2018/19, as this accords with the accepted best practice for BAFs, and has not been subject to any negative feedback from either the Trust Board, Audit and Governance Committee, Finance and Performance Committee or the TME. The Audit and Governance Committee did however ask that the BAF incorporate assurances on the data quality of performance information, whilst the Finance and Performance Committee asked that external factors were included within the "What could prevent this objective being achieved?" section, so these aspects will be included in the first populated BAF.

**Draft key objectives for 2018/19**

The proposed key objectives are listed below. All the objectives are intended to address the underlying risk that the Trust is unable to demonstrate clinical operational or financial sustainability. The objectives have been informed by the Trust's "Operational Plan 2017/18- 2018/19", that was submitted to NHS Improvement on 30/04/18. However, the operational plan does not contain a specific list of objectives that can be directly reflected in the BAF.

	<b>Draft objective</b>	<b>Lead</b>
1	To deliver the trajectory agreed with NHS Improvement for the A&E 4 hour waiting time target	Chief Operating Officer
2	To deliver the trajectory agreed with NHS Improvement for the 62-day Cancer waiting time target	Chief Operating Officer
3	To deliver the Referral to Treatment (RTT) trajectory agreed with NHS Improvement for patients on an 'incomplete' pathway	Chief Operating Officer
4	To deliver the financial plan for 2018/19	Director of Finance
5	To ensure a falls rate of no more than 6.0 per 1000 occupied bed days	Chief Nurse
6	To ensure a pressure ulcer rate of no more than 3.0 per 1000 admissions	Chief Nurse
7	To deliver the agreed 'lessons learned' plan for 2018/19	Medical Director
8	To deliver the agreed medical productivity plan for 2018/19	Medical Director
9	To deliver a vacancy rate of no more than 8.5%	Director of Workforce
10	To deliver a staff turnover rate of less than 10%	Director of Workforce

**Which Committees have reviewed the information prior to Board submission?**

- N/A

**Reason for receipt at the Board (decision, discussion, information, assurance etc.)<sup>1</sup>**













To agree the key objectives to feature in the Board Assurance Framework (BAF) for 2018/19

<sup>1</sup> All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

## Appendix 1: Extract of the Board Assurance Framework (BAF) for 2017/18 (to illustrate the proposed format and approach for 2018/19)

### Board Assurance Framework 2017/18



<b>What does the Trust want to achieve? (i.e. the key objective)<sup>2</sup></b>		<i>Key objective</i>	
1 To reduce mortality (HSMR) in line with the national average			
<b>Relevant CQC domain/s:</b>		Safe <input checked="" type="checkbox"/>	Effective <input checked="" type="checkbox"/>
		Caring <input checked="" type="checkbox"/>	Responsive <input type="checkbox"/>
		Well-led <input checked="" type="checkbox"/>	
<b>What could prevent this objective being achieved?</b>		<i>Risks to key objective</i>	
1. If the issue is not afforded appropriate priority		3. If there is failure to follow best practice in response	
2. If there is insufficient analytical support to understand the data		4. If there is lack of ownership by Clinical Directorates	
<b>What actions have been taken in response to the above issues? (number/s in bracket refers to points above)</b>		<i>Controls</i>	
a. The issue has a high profile at the Trust Board and Quality Committee, and the response has been led by the Medical Director. One of the new Deputy Medical Directors will also be asked to take the lead on this (although responsibility will remain with the Medical Director) (1)		d. The Clinical Coding department restructure is underway, which is expected to result in improvements via closer working between clinical staff and Clinical Coders (3)	
b. The Assistant Director of Business Intelligence is directly involved in the analysis to understand the situation, & there is close liaison with Dr Foster (2)		e. The Trust is adapting its process of detailed Mortality Reviews to comply with the latest guidance/recommendations from the National Quality Board (as is expected by NHS Improvement) (3)	
c. The Trust is following the investigation pathway recommended by Dr Foster (i.e. checking coding, casemix, structure, process, individuals & teams) (3)		f. 'Deep dive' reviews were undertaken into some of the 'red flag' alerts identified by Dr Foster, but the Trust's approach to such alerts has developed, and these are now first considered within the Mortality Surveillance Group before considering whether a more detailed review is required	
<b>Where can assurance be obtained on the actions taken to date?</b>		<i>Sources of assurance</i>	
1. Written reports to the 'main' Quality Committee (May and July 2017) and Quality Committee 'deep dive' meeting (Jan, Feb & June 2017)		2. Monthly verbal reports to the Trust Board (Feb 2017 onwards)	
		3. Monthly Performance Dashboard reports to Trust Board (which reports the latest HSMR)	
<b>Do we have all the data needed to judge performance?</b>		Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
<b>If "No", what other data is needed?</b>		<i>Gaps in assurance</i>	
1. N/A			
<b>Risk owner/s:</b> Medical Director	<b>Responsible Director:</b> Medical Director	<b>Main committee/s responsible for oversight:</b> Trust Clinical Governance Committee / Quality Committee / Trust Board	
<b>How confident is the Responsible Director that the objective will be achieved by the end of 2017/18?<sup>3</sup></b>			
July 2017	September 2017	November 2017	February 2018
  	  	  	  
<b>Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):</b>			
<ul style="list-style-type: none"> <li>At month 10, the 12-month rolling average HSMR was 106.0 (the baseline/expected rate is 100), which continues the recent downward trend, and the 1-month HSMR was 99.4</li> </ul>			

<sup>2</sup> In July 2016, the Board approved the proposal to focus on a deliberately small number of higher-level objectives to act as proxy indicators (a 'litmus test') for broader performance. The Board approved the key objectives for 2017/18 on 26/04 & 19/07/17. This objective is intended to manage the broad risk that "The Trust fails to improve key aspects of clinical care and safety"

<sup>3</sup> "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

## Trust Board meeting – May 2018



5-10 Integrated Performance Report, April 2018	Chief Executive / Members of the Executive Team
<p>The enclosed report includes:</p> <ul style="list-style-type: none"> <li>▪ The 'story of the month' for April 2018 (including Emergency Performance (4 hour standard); Delayed Transfers of Care (DTOCs); Cancer 62 day First Definitive Treatment) and Referral to Treatment (RTT)</li> <li>▪ A Quality and Safety Report</li> <li>▪ An Infection Prevention and Control Report</li> <li>▪ A financial commentary</li> <li>▪ A workforce commentary</li> <li>▪ The Trust performance dashboard</li> <li>▪ An explanation of the Statistical Process Control charts which are featured in the "Integrated performance charts" section</li> <li>▪ Integrated performance charts</li> <li>▪ The Board finance pack</li> </ul>	
<p><b>Which Committees have reviewed the information prior to Board submission?</b></p> <ul style="list-style-type: none"> <li>▪ Finance &amp; Performance Committee (in part)</li> </ul>	
<p><b>Reason for receipt at the Board (decision, discussion, information, assurance etc.) <sup>1</sup></b></p> <p>Review and discussion</p>	

<sup>1</sup> All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

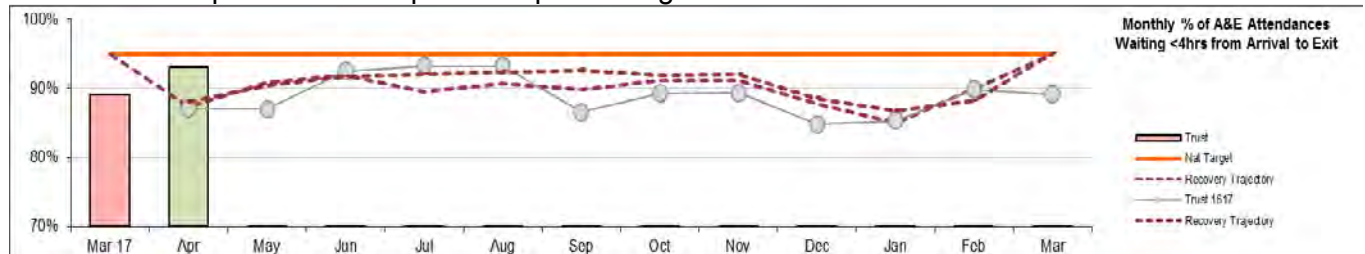


## The 'story of the month' for April 2018

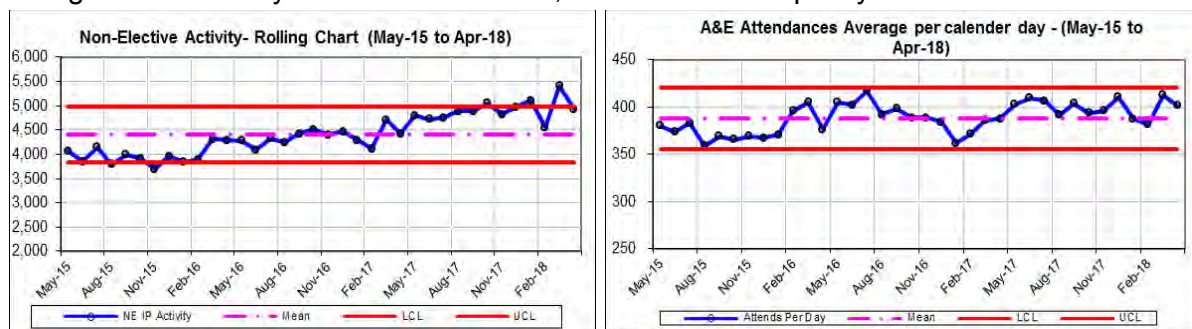
### OPERATIONAL PERFORMANCE REPORT FOR APRIL -18

The Trust delivered significantly above the expected trajectory in April, scoring 93.1% against a target of 88.0%. For the year 1718 we scored 89.1%, compared to 87.12% in 1617.

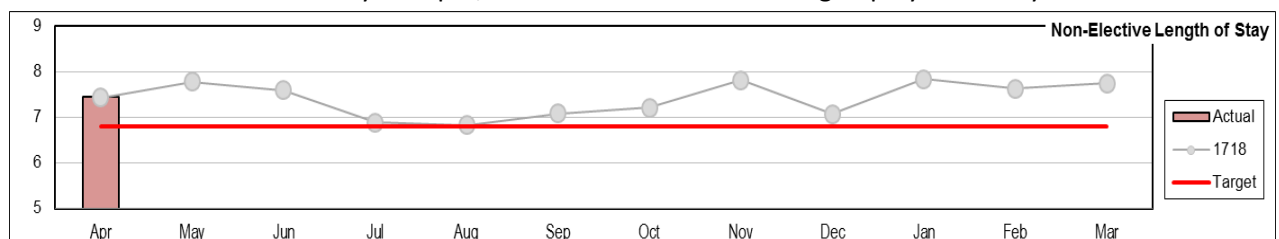
We continue to perform significantly better than the national average on the 4 hour standard. In the past 3 months, we have scored at least 9 percentage points higher than the national average, and have been placed in the top 20% of performing trusts.



- A&E Attendances continue to increase. 1718 attendance (excluding Crowborough MIU) was 3.2% up on the previous year, and there was a significant increase in attendances between mid-November and early January which had no clear reason. April's attendances were 3.5% less than modelled and 1.1% less than the TDA trajectory, but 3.4% higher than Apr-17 (excluding Crowborough MIU)
- Non-Elective Activity (excluding Maternity) was 4.7% above plan & 14.0% higher than last April at 4,395 discharges. NE activity has been steadily increasing since early 2016, increasing by 25-30% since then. Much of this is driven by increased ED demand and our improved flow-through of ambulatory / assessment wards, and increased capacity in CDU.



Non-Elective LOS was 7.46 days in April, vs 7.41 in 1718. It tends to go up by half a day or so in winter



- The average occupied bed days dropped sharply 729 per day, down from its record 868 in Feb. For the whole of 1718 it was 764.

The intensive focus on managing capacity and flow remains in place with daily oversight at senior management and clinical level on the front door pathways and especially on reducing length of stay on the wards. The urgent care division are working collaboratively with system partners to address and change longstanding issues affecting patient transfers and discharges. The most effective changes to date have been:

- Increased focus on AEC with twice daily board rounds on AMUs
- Frail Elderly Unit at Maidstone, with a frailty manager in place from 14-May
- Tunbridge Wells Acute Frailty Unit opened 21<sup>st</sup> March 2018 as planned on Ward 2 in 2 rooms
- Focus on SAFER to achieve an improved length of stay.

- Weekly review of the KPI dashboard to monitor improvements
- Daily breach analysis & RCA reviews as appropriate
- Winter "Capacity Huddles" commenced chaired by the COO
- Implementation of Live Data dashboards to give an understanding of the current position
- Continuing to work on the areas of improvement identified by 2020 Productivity – AEC, GP Streaming, Frailty and LOS.

## 1. Delayed Transfers of Care

The percentage occupied bed-days due to DToC deteriorated slightly from 4.26% in March to 4.58% in Apr. Despite the small upward movement, Apr-18 is the sixth consecutive month that the DToC percentage has been below 5%, and we ended the year on 4.95%. On average, 36 beds per day were lost to these patients. We have experienced a greater focus from external partners on the exit routes from the hospital and have now rolled out Pathway 1, 2 & 3 of the Home First initiative in full. The Frail Elderly unit at Maidstone is operating effectively and the TWH Frailty Unit opened on 21<sup>st</sup> March 2018 on Ward 2, in 2 rooms.

Category	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	Rolling 12 Month
A : Awaiting Assessment	13	11	7	2	2	7	6	2	5	2	1	2	60
B : Awaiting Public Funding	3	3	3	2	0	2	1	0	1	5	1	2	23
C : Awaiting Further Non-Acute NHS Care	21	27	11	8	21	15	10	18	21	9	21	12	194
Di : Awaiting Residential Home	8	16	16	23	32	21	19	18	24	18	40	15	250
Dii : Awaiting Nursing Home	70	94	53	63	42	46	54	38	37	47	54	53	651
E : Awaiting Care Package	39	43	27	27	32	24	36	14	18	20	28	20	328
F : Awaiting Community Adaptations	8	7	15	8	5	10	12	4	12	10	7	15	113
G : Patient or Family Choice	10	8	10	13	14	28	38	13	11	5	10	3	163
H : Disputes	1	2	0	1	0	0	1	0	0	0	0	1	6
I : Housing	3	5	6	8	2	2	1	2	3	3	2	6	43
<b>Grand Total</b>	<b>176</b>	<b>216</b>	<b>148</b>	<b>155</b>	<b>150</b>	<b>155</b>	<b>178</b>	<b>109</b>	<b>132</b>	<b>119</b>	<b>164</b>	<b>129</b>	<b>1,831</b>
<b>Rate</b>	<b>6.03%</b>	<b>6.24%</b>	<b>5.41%</b>	<b>4.54%</b>	<b>5.32%</b>	<b>5.36%</b>	<b>4.84%</b>	<b>3.73%</b>	<b>4.27%</b>	<b>3.89%</b>	<b>4.26%</b>	<b>4.56%</b>	<b>4.87%</b>

## 2. Cancer 62 Day First Definitive Treatment

62 day performance for March was 68.0%, with 1718 Q4 ending on 67.8% and the year on 70.4%. The current forecast 62 day position for April is 56.7% (which is undergoing validation), 60% for MTW to MTW only.

The delivery plan remains focused both on patients in the 40 -62 day category and those who have already breached to bring them in for treatment sooner to help reduce the backlog. The backlog at the end of March was 61. 34 of these were MTW patients

The key improvement initiative for the cancer services is the daily huddle where the focus is on the next event for individual patients (outpatient appt, test, result review, date for treatment) that is needed to pull them through the pathway, with any delays or blocks being actioned on the same day.

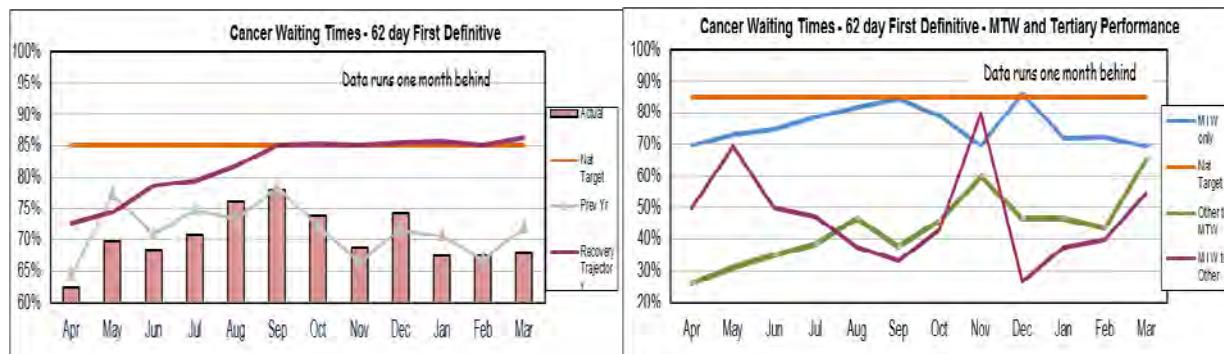
The Oncology PTL is taking place weekly to replicate the main PTL meeting in order to progress radiotherapy and chemotherapy treatments and oncology are calling in to the daily huddle as well.

Tumour site action plans are being collated in conjunction with the clinical teams and a recovery plan will be presented to TME in May and Finance and Performance Committee in June. In addition, straight to test triage clinics are now well established for colorectal and lung referrals. This is reducing the overall length of pathways for these patients and has significantly improved the performance of lower GI.

The process and approach used by MTW to track, monitor and manage patients who have been referred with a possible cancer diagnosis was reviewed in February by NHSI, using a critical friend approach. We have received positive feedback overall and we have agreed to work with them to further improve our approach to demand and capacity and specifically the urology pathway.

## Cancer 2 week waits

The surgical team are reviewing how to increase their capacity longer term as it is known that demand is in excess of capacity. In breast care, the implementation of a new model of sending letters to patients on annual follow up rather than bringing them back to clinic will release around 3,000 appointments per year and so this can be reused for new patients. The new process is expected to go live for patients from May.



62 Day Performance : All				62 Day Performance : MTW Only			
Tumour	Tot	Brch	Score	Tumour	Tot	Brch	Score
Brain / CNS	-	-	#DIV/0!	Brain / CNS	-	-	#DIV/0!
Breast	20.5	4.0	80.5%	Breast	19.0	4.0	78.9%
Gynae	8.0	-	100.0%	Gynae	5.0	-	100.0%
Haematology	6.0	5.0	16.7%	Haematology	6.0	4.0	33.3%
Head & neck	2.5	2.0	20.0%	Head & neck	1.0	-	100.0%
Lower GI	18.0	4.0	77.8%	Lower GI	15.0	4.0	73.3%
Lung	13.0	2.5	80.8%	Lung	7.0	1.0	85.7%
Other	2.0	1.0	50.0%	Other	2.0	1.0	50.0%
Sarcoma	1.0	-	100.0%	Sarcoma	1.0	-	100.0%
Skin	-	-	#DIV/0!	Skin	-	-	#DIV/0!
Upper GI	11.0	4.5	59.1%	Upper GI	10.0	4.0	60.0%
Urology	27.5	12.0	56.4%	Urology	25.0	10.0	60.0%
<b>TOTAL</b>	<b>109.5</b>	<b>35.0</b>	<b>68.0%</b>	<b>TOTAL</b>	<b>91.0</b>	<b>28.0</b>	<b>69.2%</b>

### 3. Referral To Treatment – 18 weeks

April performance shows the Trust continues to forecast non-compliance with the Incomplete RTT standards at an aggregate level – 79.4% which is a decrease since last month. Our trajectory required us to achieve 79.77% by the end of April 18.

The Trust is investigating some 52wk breaches which have been highlighted but these have not been concluded currently. The key issues contributing to the low performance and increased backlog remain:

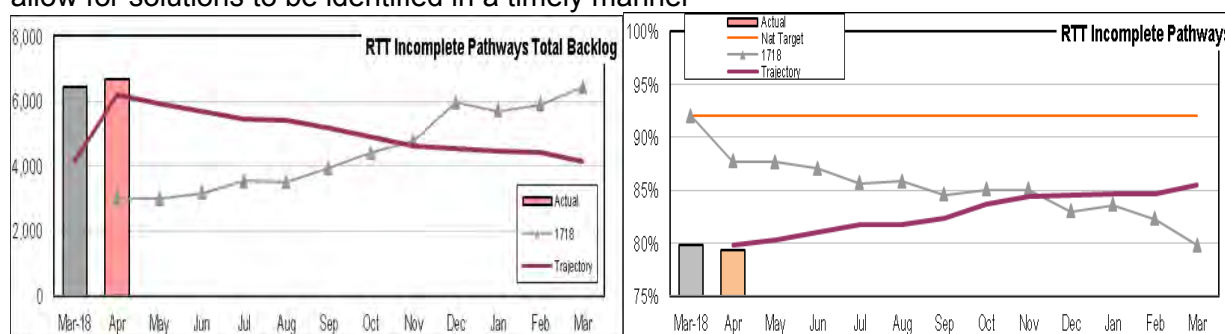
- The inability to do a sufficient level of elective work caused by the increased non-elective activity
- Cessation of outsourcing to IS providers
- Planned reduction of activity during PAS implementation, prolonged by on-going data and admin issues post go-live.
- Key vacancies in consultant and trainee posts in a variety of specialties (GS, Urology, Neurology & Endocrinology)
- Reduced activity in January to support NEL flow and further reduction in February due to snow.

The majority of the backlog continues to be concentrated in T&O, Gynae, ENT, General Surgery, Ophthalmology and Neurology-all of which are being carefully monitored against trajectories and action plans on a weekly basis.

	Apr-18	Apr -18 Trajectory	Variance from trajectory
RTT Backlog Incomplete	6675	6186	489
RTT Waiting List	32,512	30,573	1939
RTT Incomplete performance %	79.38%	79.77%	-0.39%

Further validation of the waiting list especially the backlog continues. Duplicate pathways are still an issue particularly in Ophthalmology and General Surgery which has caused the waiting list size to grow again. Further training is being given in these areas and internal teams are focusing on these as well. Operational teams are continuing their plans to increase elective activity and arrange extra clinics to ensure backlog does not grow further.

- Continue to ensure achievement of Incomplete targets month on month at an aggregate level by reducing RTT backlog for Incompletes through implementation of speciality plans
- Monitor weekly all Non-Admitted patients at 11wks or over without an OPA and all Admitted patients at 18wks or over without a TCI
- Ensure backlog patients are booked chronologically to avoid long waits/52 wk breaches
- Outsourcing to continue for Neurology in order to support Backlog reduction. Locum's being appointed in Endocrinology
- Reviewing the validation team resources to support further validation of the backlog following go live of Allscripts PAS including recruitment of dedicated Patient Admin Transformation manager who will assist in supporting training for 18 weeks and PAS
- Intense training on PTL management has been instigated and rolled out to each CAU which should be completed by end of March
- Increase clinic/theatre capacity/activity on weekends to improve income, activity and incomplete performance
- Continue weekly PTL/RTT performance monitoring to maintain overall performance
- Ensure robust management of Diagnostic waiting lists to ensure problems identified early to allow for solutions to be identified in a timely manner



## Quality and Safety (April data)

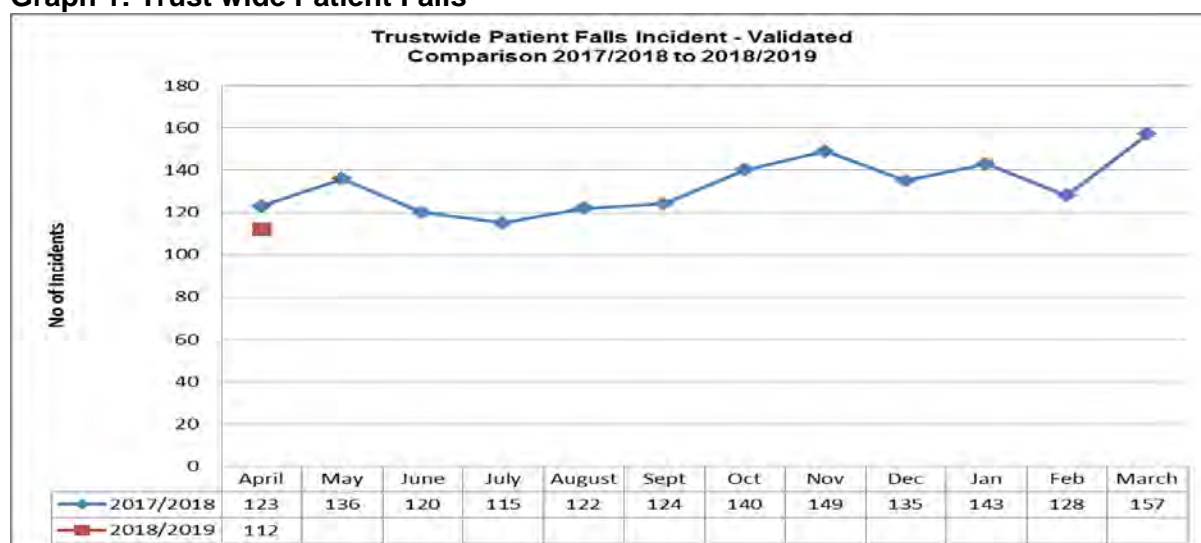
### Patient Falls incidents

There were 112 falls reported for the month of April, compared to 157 for March 2018. The comparison against April 2017 at 123 can be seen in Graph 1 which provides a comparison for the same period on the previous year. The breakdown of incidents by site equates to 41 falls at Maidstone and 71 at Tunbridge Wells.

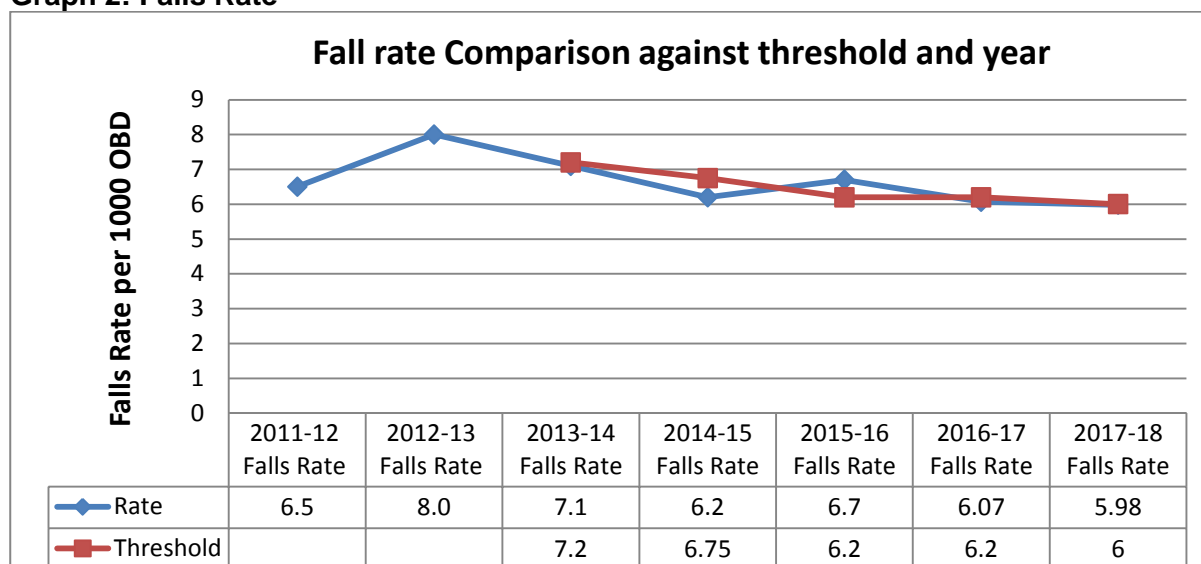
The rate per 1000 occupied bed days is 5.27 for the month of April. (Rate for 2017/18 was 5.98 per 1000 occupied bed days). Comparison of year end falls rate per 1000 occupied bed days for previous years is shown in graph 2.

There was 1 Serious Incident declared in April 2018.

**Graph 1: Trust wide Patient Falls**



**Graph 2: Falls Rate**



### Pressure Ulcers:

The incidence of confirmed Hospital acquired Pressure Ulcers for April 2018 is 9.

The rate (per 1000 admissions) for April is 1.66 compared to 2.24 for the same month last year. The incidence rate for the year is 1.66 against a threshold of 3.0.

The recruitment of a 2<sup>nd</sup> TVN is ongoing, support is being provided from the Professional Standards Team with a suitably qualified RN providing 0.8 WTE cover to the service.



## Friends and Family test

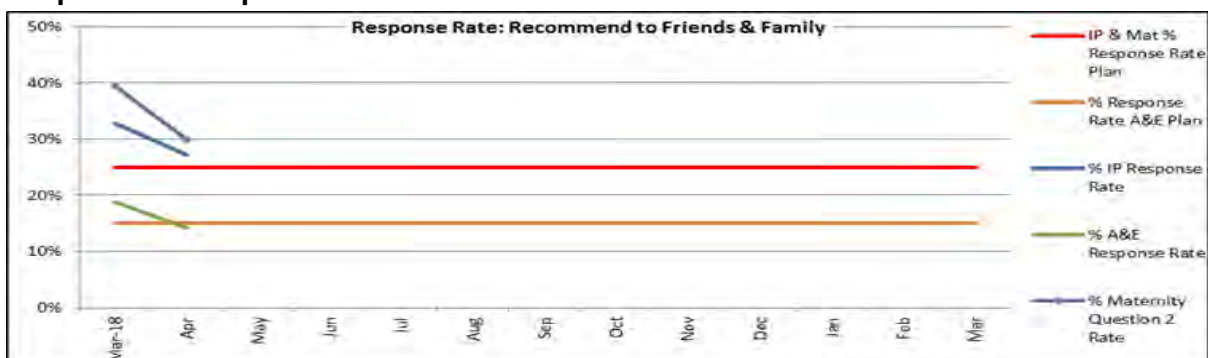
Overall response rates for April have seen a decrease compared to March. This is likely attributable to a damaged package of FFT forms being returned to the Trust. The forms were unable to be processed due to a risk that some forms might have fallen out during transit. In addition, for Accident & Emergency an ordering issue was reported for the friends and family cards during the month leading to photocopies being used. 198 forms were subsequently rejected as the photocopies with QR codes could not be uploaded. There will be an attempt to manually process these by the company but the data will not register until May's report.

Positive response rates compared to March are: Inpatients 27.2% compared to 32.7% in March, A&E 14.2% compared to 18.8% in March and Maternity 29.8% compared to 39.4% in March.

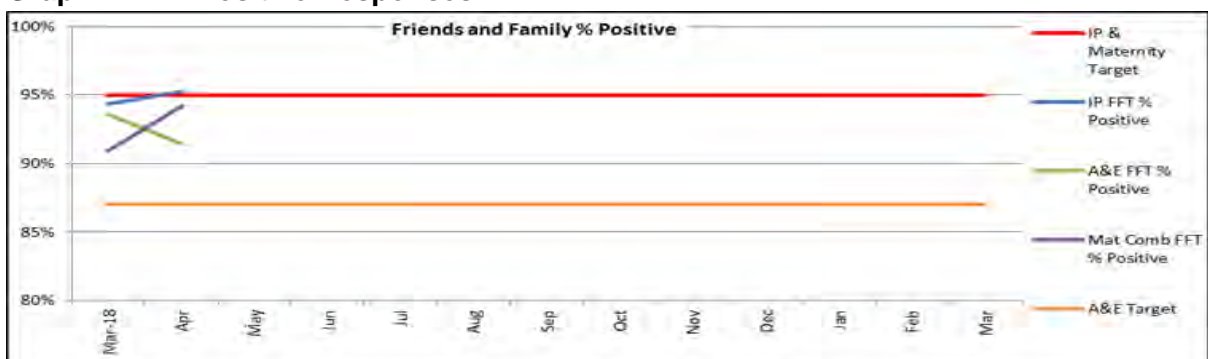
The positive responses stayed broadly the same however there has been a slight decrease seen for the % Positive for April; inpatients decreased slightly from 94.4% last month down to 93.3% and are below target of 95.8%. A&E decreased from 93.6% last month to 91.2% but remain above target of 85.5% and Maternity (all 4 combined) increased from 90.9% last month to 94.9% (slightly below the 95.6% target).

Outpatient responses were expected to increase due to the overnight file transfers being reinstated. April increased to 5684 compared to 2719 in March.

**Graph 3 FFT Response Rates**



**Graph 4: FFT Positive Responses**



## Single Sex Compliance:

There were zero incidences of mixed sex accommodation reported during the month of April which is comparable to April 2017.

## Complaints

There were 47 new complaints reported for April which equates to a rate of 2.21 new complaints per 1,000 occupied bed days. This is a decrease compared to 2.38 for March. There were 148 open complaints at the end of April compared to 173 in March.

65.9% of complaints were responded to within deadline compared to a target of 75%.

The available data has been analysed by the date of the event being complained about, rather than when the complaint itself was received. It is hoped that this will give a truer picture of the current issues affecting our patients and service users. However, it should be noted that although the majority of complaints are raised within a month or two of the event occurring, there will be a degree of time delay. As a result, there will be less data available for the current and preceding month, than there will be for earlier months. The charts/graphs below will therefore be updated each month and may show variations (if compared retrospectively) for this reason.

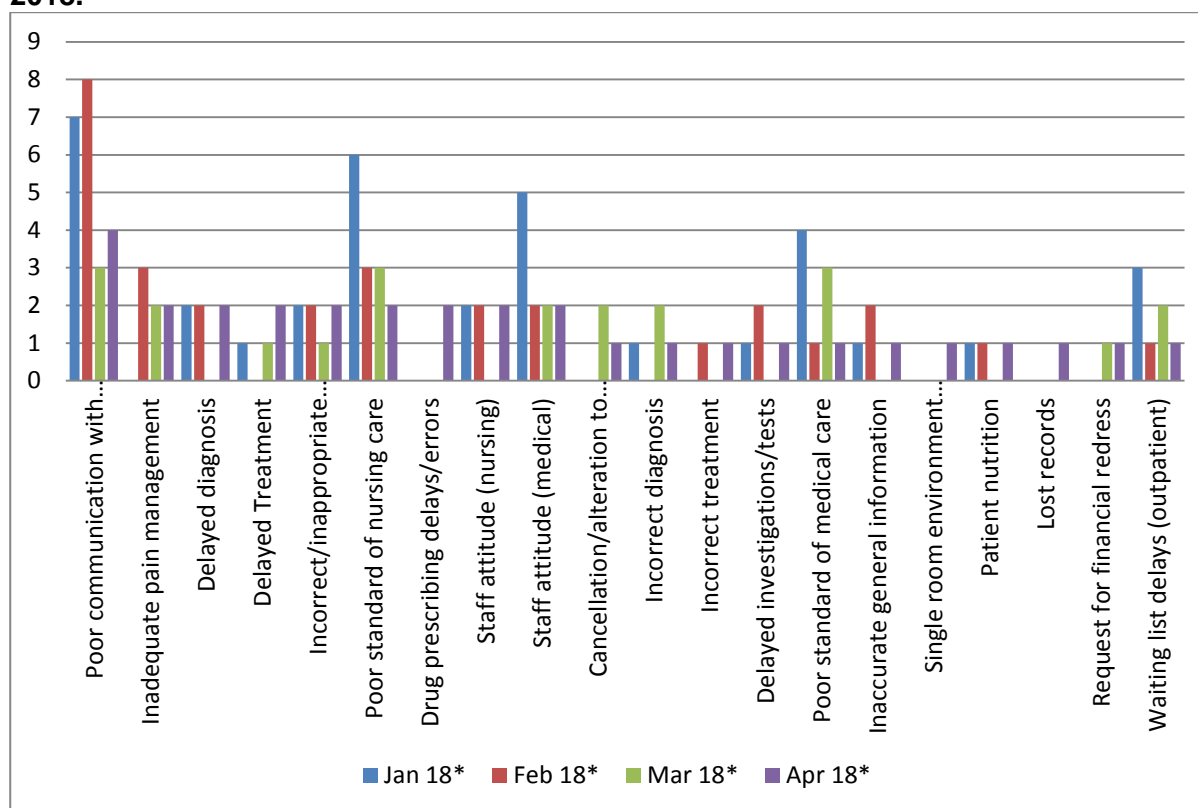
**Graph 5: Complaints by Sub-subject – most frequently raised in April 2018**

	Jan 18*	Feb 18*	Mar 18*	Apr 18*	Trend (Jan-Apr)
Poor communication with patient/relative	7	8	3	4	↓
Inadequate pain management	0	3	2	2	↑
Delayed diagnosis	2	2	0	2	↓
Delayed Treatment	1	0	1	2	↑
Incorrect/inappropriate clinical advice	2	2	1	2	→
Poor standard of nursing care	6	3	3	2	↓
Drug prescribing delays/errors	0	0	0	2	↑
Staff attitude (nursing)	2	2	0	2	↓
Staff attitude (medical)	5	2	2	2	↓

\*reflects the date of the event being complained about

The following graph (Graph 6) shows an expanded view of the themes of complaints that occurred in April 2018.

**Graph 6: All themes/subjects raised in complaints made about events that occurred in April 2018.**



It is clear that consistently, communication with patients/relatives remains a key theme within complaints. Between January and April, this has remained one of the most frequently raised subjects in new complaints.

Looking at emerging issues, there has been a rising trend of complaints about:

- Inadequate pain management
- Delayed treatment
- Drug prescribing delays/errors

All other areas show stable or slightly reducing trends, with the most significant reduction in complaints about poor standards of nursing care and poor communication (despite this remaining a frequently raised issue).

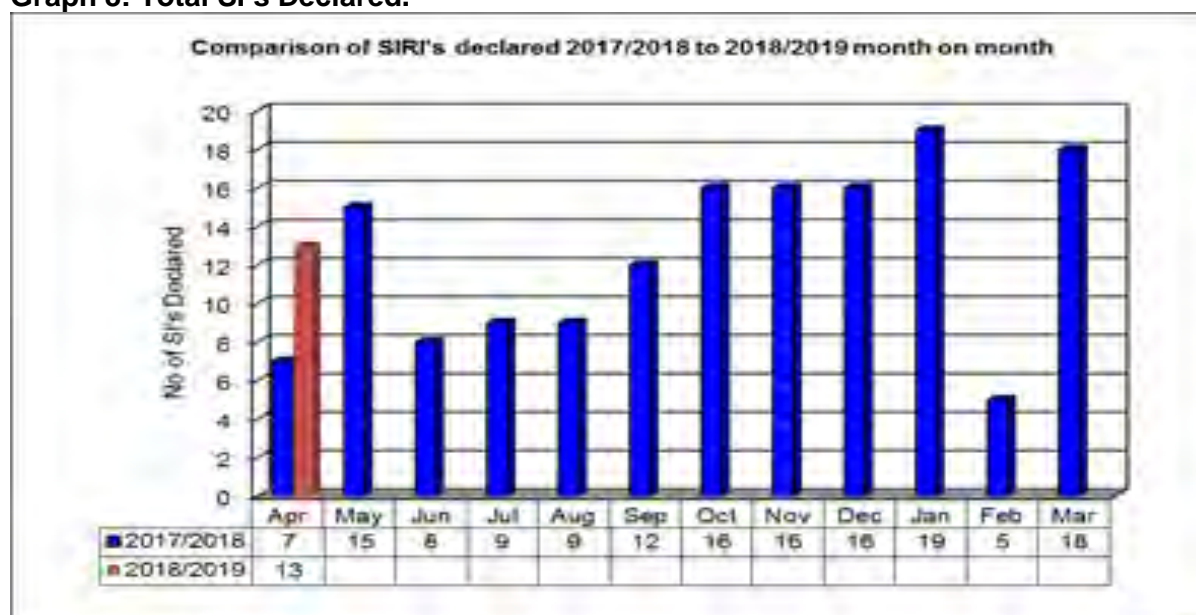
Complaint case studies are published in the Governance Gazette to highlight key themes and trends seen coming through complaints and the learning taken from complaint investigations.

### Serious Incidents (SI's)

There were 13 Serious Incident's reported in April:-

- 1 fall resulting in a fractured hip in Specialist Medicine
- 1 Pressure damage – category 3 in Specialist Medicine
- 1 Safeguarding (consent and allegation of assault) in Surgery
- 10 Main SI's spanning 5 divisions
  - 5 in Women's
  - 2 in Specialist Medicine
  - 1 each in Surgery / Acute & Emergency / Corporate.

**Graph 8: Total SI's Declared.**



During the month of April we have closed 7 SI's, these included two patient falls and one hospital acquired VTE.

The learning from the fall's panel included ensuring that risk assessments were timely and that documentation is fully completed. In addition it is evident that the wards were challenged in ensuring that enhanced care needs are met with 1:1 supervision at all times.

Learning from the VTE panel concluded that the assessment had been incorrectly completed and demonstrated that the pre-assessment had identified a family history of DVT which the surgical team on admission did not recognise. Communication re escalation is being reviewed.



## **Infection Prevention and Control**

### **MRSA**

One new case of post 48hour MRSA bloodstream infection was seen in April. The patient was a neonate with co-morbidities. A Serious Incident has been declared and the investigation is ongoing.

**C. difficile** - There were no cases of post-72 hour *C. difficile* infection in April against a monthly limit of three cases.

The objective for 2018/19 has been set at **26** cases.

### **Methicillin sensitive *Staphylococcus aureus* bacteraemia**

2 cases of hospital attributable MSSA blood stream infection were seen in April 2018. Root cause analysis is being carried out on both cases and they will be reviewed at the *C. difficile* panel

### **Gram negative bacteraemia**

Seven cases of hospital attributable gram negative blood stream infection were seen in April. Three cases due to *E. coli*, three due to *Klebsiella* species and one due to *Pseudomonas* species

We are working with community colleagues to improve continuity of catheter care across health and social care. An updated version of the catheter passport will be launched over the summer.

Hydration (or lack of) is recognised as a risk factor for UTI in hospital and in care homes. A focussed piece of work on hydration of patients has been very successful in preventing admission to hospital in a study carried out in care homes. We are looking at the potential to extend this study to patients in hospital where it may help to reduce length of stay and avoid infections.

### **Infection Prevention and Control Workplan**

The annual work plan for the infection prevention team was reviewed at the Infection Prevention and Control Committee in April together with the annual audit plan. Progress against the plan will be monitored throughout the year and reported up to Trust Clinical Governance Committee and the Quality Committee

## Financial commentary

- The Trust's deficit including PSF was £2.2m in April which was on plan, the Trust was £0.2m adverse against the CIP plan which was offset by non-recurrent underspends associated with 2017/18 accrual reversals.
- In April the Trust operated with an EBITDA surplus of £0.4m which was on plan.
- The Trust's normalised pre PSF run rate in April was a deficit of £3m. The main normalised adjustments in April related to: £0.1m Minor Injury Unit charges relating to month 1 paid in 2017/18 and £0.1m DTOC income relating to 2017/18 reported in April.
- The key variances in the month are as follows:
  - Total income was £0.3m adverse in the month; Clinical Income excluding HCDs was £0.2m adverse in April. The key adverse variances in April Elective & Day Cases (£0.5m), and Excess Bed Days (£0.4m) offset by a favourable adjustment of £0.7m relating to the aligned incentive contract. PSF income was on plan due to delivery of the financial control target and A&E trajectory in April. Other Operating Income is breakeven to plan although after accounting for pass-through adjustments the revised variance was £0.1m adverse. The main adverse items relate to Commercial income (£41k adverse) due to slippage relating to Car Parking and Catering and £40k slippage in Pathology income mainly relating to Medway Histopathology income.
  - Pay was £0.1m adverse in the month, mainly due to CIP slippage (£ 0.1m) relating to the standardisation of medical STP agency rates. Total Pay costs in April reduced between months by £0.6m but remained at the higher quarter 4 (2017/18) levels at £22m per month compared to quarter 3 (2017/18) levels of £21.6m per month. Overspends within Medical Staffing (£0.1m), and Nursing (£0.1m) partly offset by underspends within STT staffing (£0.1m) and Admin and Clerical. The Urgent Care Division overspent by £350k in April, £80k due to CIP slippage (mainly due to STP medical rates) and £270k adverse associated with other budget pressures. Womens, Childrens and Sexual Health (£52k) are the only other division adverse in April mainly caused by Nursing overspend (£33k). Divisions have been tasked to complete a forecast for all temporary staffing by 25<sup>th</sup> May.
  - Non Pay was underspent by £0.4m in April this was mainly due to underspends within drugs (£0.4m net of pass through costs) and a non recurrent benefit of £0.1m due to April MIU costs reported in 2017/18 . The Trust was adverse to plan by £0.1m relating to out sourcing expenditure, this overspend was mainly within T&O (£60k) and Diagnostics (£30k).
- The Trust achieved £0.8m savings in April which was £0.2m adverse to plan, this is mainly due to STP Medical rate slippage (£0.1m) and Outsourcing reduction slippage (£0.1m).
- The Trust held £12.9m of cash at the end of April which is lower than the plan of £16.8m. The Trust continues to proactively engage with NHS organisations trying to collect all agreed values and organising "like for like" arrangements to reduce both debtor and creditor balances
- The Trust has an approved Capital Plan of £14.5m, which is financed by Capital resources of £13.5m depreciation; proposed asset sales of £2.4m (Maidstone Residences); donated assets of £0.7m; planned bid for national funding for the next replacement Linac of £1.75m (LA5); a proposed Capital Investment Loan for critical imaging equipment of £2.5m; a proposed Salix loan of £1.2m for the additional Energy Infrastructure work; less £7.6m of existing loan repayments. The business case for Estates Backlog Maintenance programme of works has been approved and schemes are underway, with other Estates projects and renewals being prioritised by the Estates Department. A major scheme for the Energy Infrastructure will be dependent on the successful application for a Salix loan and agreement from DH to provide the necessary Capital resource cover. The ICT schemes have been prioritised and approved by the ISG in principle but will require IAG Business case sign off. The equipment schemes are being prioritised and the final list will go to Execs for approval subject to individual Business case preparation as required. Linac 4 replacement at Maidstone was delivered in early May and commissioning the equipment will begin and be ready for clinical use by Oct 18. The donated equipment is mainly made up of the remaining Cardiology legacies, and a large donation for Urology/Oncology equipment.

## Workforce Commentary

As at the end of April 2018, the Trust employed 5022.0 whole time equivalent substantive staff, a 2.5 WTE increase from the previous month. Agency use is higher than planned, in line with the higher than anticipated vacancy levels.

Sickness absence in the month (March) decreased by 0.28% to 3.73%, 0.43% over target but continuing the downward movement over recent months. Directorates demonstrating the highest sickness rates include Patient Administration (9.61%), Facilities (6.96%) and Children's Services (6.02%) with rates having increased in two of the three areas since last month. At a divisional level, Planned Care has a lower combined sickness absence rate (2.88%) than Urgent Care (3.76%) or Women, Children and Sexual Health (5.10%) but with the former two areas decreasing from the previous month. At a trust level, the breakdown in December is 52.15% short-term, 47.85% long term, constituting a modest shift from short-term to long-term absence. Effective sickness absence management remains a key area of focus for the HR and operational management teams, particularly targeting long term sickness in outlying areas.

Statutory and mandatory training compliance has increased marginally by 0.54% to 87.88%, and remains above the target percentage. In general, corporate areas demonstrate a higher level of training compliance, in line with the more limited range of training needs that are required. Directorates with lower overall compliance include Trauma and Orthopaedic (80.58%), General Surgery (81.76%) and Children's Services (84.99%), all having decreased from the previous month.

Turnover has decreased since last month to 10.90%, higher than target with outliers in Estates (20.66%) and Clinical Governance (19.30%). It should be noted that due to the 12 month rolling calculation, turnover figures typically move more slowly and incorporate historic data as well as the most recent month. HR Business Partners continue to work closely with divisional operational management teams in order to address areas which have a high turnover.

Appraisal compliance is not formally reported during the first three months of the year, while within the appraisal window.

Trust Performance Dashboard

Position as at:30 April 2018

	Safe	Latest Month		Year to Date		YTD Variance		Year End		Bench Mark
		Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/ Limit	Forecast	
1-01	*Rate C-Diff (Hospital only)	9.48	0.0	9.5	0.0	-9.5	- 14.1	11.5	8.7	
1-02	Number of cases C.Difficile (Hospital)	2	0	2	0	-2	- 3	26	23	
1-03	Number of cases MRSA (Hospital)	0	1	0	1	1	1	0	1	
1-04	Elective MRSA Screening	98.0%	99.5%	98.0%	99.5%	1.5%	1.5%	98.0%	99.5%	
1-05	% Non-Elective MRSA Screening	96.5%	No data	96.5%	No data			95.0%	No data	
1-06	**Rate of Hospital Pressure Ulcers	2.24	1.66	2.24	1.66	- 0.58	- 1.35	3.01	1.65	3.00
1-07	***Rate of Total Patient Falls	5.59	5.27	5.59	5.27	- 0.32	- 0.73	6.00	5.08	
1-08	***Rate of Total Patient Falls Maidstone	4.95	4.93	4.95	4.93	- 0.02			4.77	
1-09	***Rate of Total Patient Falls TWells	6.04	5.49	6.04	5.49	- 0.54			5.28	
1-10	Falls - SIs in month	1	1	1	1	-				
1-11	VTE - SIs in month	0	0	0	0	-				
1-11	Number of Never Events	0	0	0	0	0	0	0	0	
1-12	Total No of SIs Open with MTW	27	59			32				
1-13	Number of New SIs in month	7	13	7	13	6	3			
1-14	***Serious Incidents rate	0.33	0.61	0.33	0.61	0.28	0.55	0.0084 - 0.6078	0.61	0.0084 - 0.6078
1-15	Rate of Patient Safety Incidents - harmful	0.87	1.46	0.87	1.46	0.59	0.23	0 - 1.23	1.23	0 - 1.23
1-16	Number of CAS Alerts Overdue	0	0			0	0	0		
1-17	VTE Risk Assessment - month behind	96.3%	95.6%	96.3%	95.6%	-0.7%	0.6%	95.0%	95.6%	95.0%
1-18	Safety Thermometer % of Harm Free Care	96.0%	97.2%	96.6%	97.2%	0.5%	2.2%	95.0%		93.4%
1-19	Safety Thermometer % of New Harms	3.64%	2.66%	3.64%	2.66%	-0.98%	-0.3%	3.00%	2.66%	
1-20	C-Section Rate (non-elective)	12.8%	13.1%	13.7%	13.1%	-0.56%	-1.9%	15.0%	13.1%	

	Effectiveness	Latest Month		Year to Date		YTD Variance		Year End		Bench Mark
		Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/ Limit	Forecast	
2-01	Hospital-level Mortality Indicator (SHMI)*****	Prev Yr: July 14 to June 15		1.0762	1.0440	- 0.0	0.0	Band 2	Band 2	1.0
2-02	Standardised Mortality HSMR	Prev Yr: Apr 15 to Mar 16		110.0	103.7	- 6.3	3.7	Lower confidence limit to be <100		100.0
2-03	Crude Mortality	1.4%	0.9%	1.0%	0.9%	-0.1%				
2-04	****Readmissions <30 days: Emergency	12.2%	11.0%	11.7%	12.9%	1.2%	-0.7%	13.6%	12.9%	14.1%
2-05	****Readmissions <30 days: All	11.4%	10.5%	11.0%	12.3%	1.3%	-2.4%	14.7%	12.3%	14.7%
2-06	Average LOS Elective	2.55	2.94	2.55	2.94	0.38	- 0.27	3.20	2.94	
2-07	Average LOS Non-Elective	7.43	7.45	7.43	7.45	0.01	0.65	6.80	6.80	
2-22	NE Discharges - Percent zero LoS	28.6%	34.0%	30.9%	37.2%	6.3%			37.2%	
2-08	*****FollowUp : New Ratio	1.77	1.50	1.77	1.50	- 0.27	- 0.02	1.52	1.50	
2-09	Day Case Rates	88.0%	87.3%	88.0%	87.3%	-0.8%	7.3%	80.0%	87.3%	82.2%
2-10	Primary Referrals	8,225	9,698	8,225	9,698	17.9%	6.3%	121,638	122,680	
2-11	Cons to Cons Referrals	4,452	4,159	4,452	4,159	-6.6%	-7.2%	56,704	52,611	
2-12	First OP Activity (adjusted for uncashed)	14,431	17,321	14,431	17,321	20.0%	6.9%	208,349	219,113	
2-13	Subsequent OP Activity (adjusted for uncashed)	26,912	24,055	26,912	24,055	-10.6%	-18.9%	382,157	382,157	
2-14	Elective IP Activity	482	476	482	476	-1.2%	-12.5%	7,674	7,674	
2-15	Elective DC Activity	3,490	3,262	3,490	3,262	-6.5%	-5.7%	44,403	44,403	
2-16	**Non-Elective Activity	4,426	4,935	4,426	4,935	11.5%	3.0%	58,582	58,582	
2-17	A&E Attendances (Calendar Mth) Excl Crowboro	13,552	14,008	13,552	14,008	3.4%	-1.9%	174,428	174,428	
2-18	Oncology Fractions	4,858	5,624	4,858	5,624	15.8%	4.8%	67,890	67,890	
2-19	No of Births (Mothers Delivered)	470	457	470	457	-2.8%	-8.2%	5,977	5,977	
2-20	% Mothers initiating breastfeeding	80.8%	82.5%	80.8%	82.5%	1.7%	4.5%	78.0%	82.5%	
2-21	% Stillbirths Rate	0.4%	0.00%	0.42%	0.00%	-0.4%	-0.5%	0.47%	0.00%	0.47%

	Caring	Latest Month		Year to Date		YTD Variance		Year End		Bench Mark
		Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/ Limit	Forecast	
3-01	Single Sex Accommodation Breaches	0	0	0	0	0	0	0	0	
3-02	*****Rate of New Complaints	1.37	2.21	2.67	2.21	-0.5	0.90	1.318-3.92	2.13	
3-03	% complaints responded to within target	93.8%	65.9%	74.3%	65.9%	-8.5%	-9.1%	75.0%	75.0%	
3-04	****Staff Friends & Family (FFT) % rec care	76.0%	66.7%	76.0%	66.7%	-9.4%	-12.3%	79.0%	79.0%	
3-05	*****IP Friends & Family (FFT) % Positive	95.3%	93.3%	95.3%	93.3%	-1.9%	-1.7%	95.0%	95.0%	95.8%
3-06	A&E Friends & Family (FFT) % Positive	91.4%	91.2%	91.4%	91.2%	-0.2%	4.2%	87.0%	91.2%	85.5%
3-07	Maternity Combined FFT % Positive	94.2%	94.9%	93.6%	94.9%	1.3%	-0.1%	95.0%	95.0%	95.6%
3-08	OP Friends & Family (FFT) % Positive	83.9%		83.0%	83.2%	0.2%			83.2%	

\* Rate of C.Difficile per 100,000 Bed days, \*\* Rate of Pressure Sores per 1,000 admissions (excl Day Case), \*\*\* Rate of Falls per 1,000 Occupied Beddays, \*\*\*\* Readmissions run one month behind, \*\*\*\*\* Rate of Complaints per 1,000 occupied beddays.

\*\*\*\*\* New :FU Ratio is now both consultant and non-consultant led for all specialties -plan still being agreed so currently last year plan

Delivering or Exceeding Target			Please note a change in the layout of this Dashboard to the Five CQC/TDA Domains							
Underachieving Target			*****A&E 4hr Wait monthly plan is Trust Recovery Trajectory							
Failing Target										
	Responsiveness	Latest Month		Year/Qtr to Date		YTD Variance		Year End		Bench Mark
		Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/ Limit	Forecast	
4-01	*****Emergency A&E 4hr Wait	87.1%	93.09%	87.1%	93.09%	6.0%	5.5%	90.8%	89.7%	76.9%
4-02	Emergency A&E >12hr to Admission	0	0	0	0	0	0	0	0	
4-03	Ambulance Handover Delays >30mins	248	290	248	290	42			290	
4-04	Ambulance Handover Delays >60mins	19	44	19	44	25			44	
4-05	RTT Incomplete Admitted Backlog	2,298	2,631	2,298	2,631	333	- 15	2,151	2,151	
4-06	RTT Incomplete Non-Admitted Backlog	718	4,044	718	4,044	3,326	504	1,995	1,995	
4-07	RTT Incomplete Pathway	87.7%	79.4%	87.7%	79.4%	-8.3%	-0.4%	85.5%	85.5%	
4-08	RTT 52 Week Waiters (new in month)	0	2	0	2	2	2	0	2	
4-09	RTT Incomplete Total Backlog	3,016	6,675	3,016	6,675	3,659	489	4,146	4,146	
4-10	% Diagnostics Tests WTimes <6wks	99.82%	99.1%	99.8%	99.1%	-0.7%	0.1%	99.0%	99.0%	
4-11	*Cancer WTimes - Indicators achieved	3	3	3	3	-	- 6	9	1	Data runs one month behind so Forecast is year end 1718
4-12	*Cancer two week wait	83.0%	83.0%	89.1%	85.2%	-3.9%	-7.8%	93.0%	89.1%	
4-13	*Cancer two week wait-Breast Symptoms	69.1%	69.1%	83.9%	80.3%	-3.6%	-12.7%	93.0%	83.9%	
4-14	*Cancer 31 day wait - First Treatment	97.2%	97.2%	95.7%	96.4%	0.7%	0.4%	96.0%	95.7%	
4-15	*Cancer 62 day wait - First Definitive	68.0%	68.0%	70.4%	67.8%	-2.7%	-14.4%	85.0%	70.4%	
4-16	*Cancer 62 day wait - First Definitive - MTW	71.7%	69.2%	71.7%	71.3%	-0.5%		85.0%		
4-17	*Cancer 104 Day wait Accountable	11.0	15.5	101.0	88.5	-12.5	88.5	0	88.5	
4-18	*Cancer 62 Day Backlog with Diagnosis	78	99	78	99	21				
4-19	*Cancer 62 Day Backlog with Diagnosis - MTW	63	90	63	90	27				
4-20	Delayed Transfers of Care	5.72%	4.56%	5.72%	4.56%	-1.17%	1.06%	3.50%	3.50%	
4-21	% TIA with high risk treated <24hrs	77.8%	66.7%	81.7%	66.7%	-15.0%	6.7%	60%	66.7%	
4-22	***** spending 90% time on Stroke Ward	86.7%	91.7%	88.5%	91.7%	3.1%	11.7%	80%	91.7%	
4-23	*****Stroke:% to Stroke Unit <4hrs	64.9%	43.3%	64.9%	39.5%	-25.3%	-20.5%	60.0%	60.0%	
4-24	*****Stroke: % scanned <1hr of arrival	62.2%	53.7%	62.2%	51.2%	-11.0%	3.2%	48.0%	51.2%	
4-25	*****Stroke:% assessed by Cons <24hrs	76.5%	81.0%	76.5%	81.0%	4.5%	1.0%	80.0%	81.0%	
4-26	Urgent Ops Cancelled for 2nd time	0	0	0	0	0	0	0	0	
4-27	Patients not treated <28 days of cancellation	5	3	5	3	-2	3	0	3	

RTT Incomplete Pathway Monthly Plan is Trust Recovery Trajectory

\*CWT run one mth behind, YTD is Quarter to date, Monthly Plan for 62 Day Wait First Definitive is Trust Recovery Trajectory

\*\*\* Contracted not worked includes Maternity /Long Term Sick

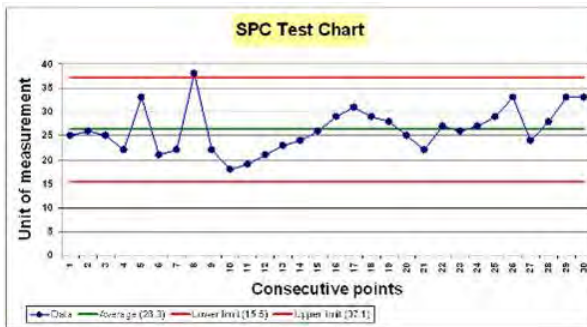
\*\*\*\* Staff FFT is Quarterly therefore data is latest Quarter

Well-Led	Latest Month		Year to Date		YTD Variance		Year End		Bench Mark
	Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/ Limit	Forecast	
Income	36,968	35,863	36,968	35,863	-3.0%	-0.8%	466,224	466,224	
EBITDA	1,307	358	1,307	358	-72.6%	-4.4%	38,910	38,910	
Surplus (Deficit) against B/E Duty	(1,229)	(2,160)	(1,229)	(2,160)			11,691	11,691	
CIP Savings	1,042	794	1,042	794	-23.8%	-20.3%	24,111	24,111	
Cash Balance	13,564	12,872	13,564	12,872			1,000	1,000	
Capital Expenditure	37	214	37	214			13,762	13,762	
Establishment WTE	5,605.4	5,588.6	5,605.4	5,588.6	-0.3%	0.0%	5,588.6	5,588.6	
Contracted WTE	5,090.3	5,024.5	5,090.3	5,024.5	-1.3%	0.2%	5,014.8	5,014.8	
Vacancies WTE	515.1	564.1	515.1	564.1	9.5%	-1.7%	573.8	573.8	
Vacancy Rate (%)	9.2%	10.1%	9.2%	10.1%	0.9%	-0.2%	10.3%	10.3%	
Substantive Staff Used	4,932.9	4,885.2	4,932.9	4,885.2	-1.0%	-1.9%	4,980.3	4,980.3	
Bank Staff Used	384.7	358.6	384.7	358.6	-6.8%	-1.9%	365	365.4	
Agency Staff Used	169.5	293.6	169.5	293.6	73.2%	20.9%	242.9	242.9	
Overtime Used	41.7	58.6	41.7	58.6	40.7%				
Worked WTE	5,528.8	5,595.9	5,528.8	5,595.9		0.1%	5,588.6	5,588.6	
Nurse Agency Spend	(608)	(829)	(608)	(829)	36.2%				
Medical Locum & Agency Spend	(1,365)	(1,420)	(1,365)	(1,420)	4.0%				
Temp costs & overtime as % of total pay bill	15.2%	16.7%	16.9%	16.7%	-0.2%				
Staff Turnover Rate	11.5%	10.9%		10.9%	-0.6%	0.4%	10.5%	10.5%	11.05%
Sickness Absence	3.8%	3.7%		3.7%	-0.1%	0.4%	3.3%	3.3%	4.3%
Statutory and Mandatory Training	86.8%	87.9%		87.9%	1.1%	2.9%	85.0%	87.9%	
Appraisal Completeness	Data not shown for Quarter 1							90.0%	
Overall Safe staffing fill rate	98.2%	98.2%	98.2%	98.2%	0.0%		93.5%	98.2%	
****Staff FFT % recommended work	50.9%	61%	50.9%	61%	9.7%	-1.4%	62.0%	62%	
***Staff Friends & Family -Number Responses	701	33	701	33	-668				
*****IP Resp Rate Recmd to Friends & Family	23.7%	27.2%	23.7%	27.2%	3.5%	2.2%	25.0%	27.2%	25.7%
A&E Resp Rate Recmd to Friends & Family	21.4%	14.2%	21.4%	14.2%	-7.3%	-0.8%	15.0%	15.0%	12.7%
Mat Resp Rate Recmd to Friends & Family	44.7%	29.8%	44.7%	29.8%	-14.9%	4.8%	25.0%	29.8%	24.0%



## Explanation of Statistical Process Control (SPC) Charts

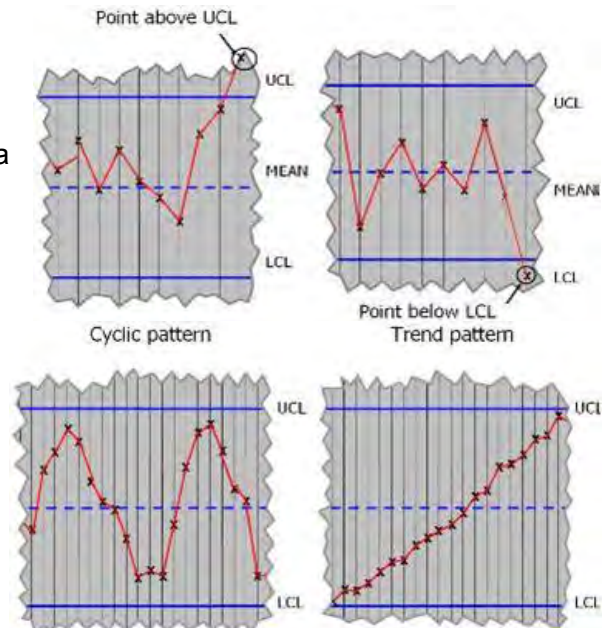
In order to better understand how performance is changing over time, data on the Trusts performance reports are often displayed as SPC Charts. An SPC chart looks like this:



SPC is a type of charting that shows the variation that exists in the systems that are being measured. When interpreting SPC charts there are 4 rules that help to identify what the system is doing. If one of the rules has been broken, this means that 'special cause' variation is present in the system. It is also perfectly normal for a process to show no signs of special cause. This means that only 'common cause' variation is present.

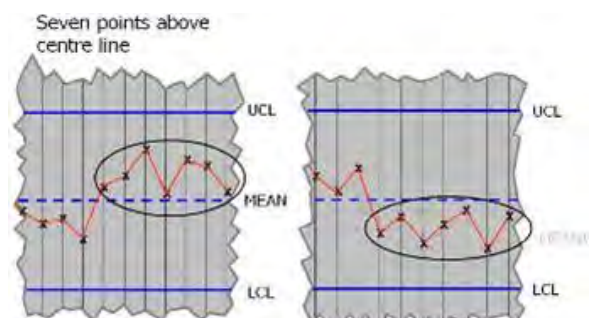
**Rule 1:** Any point outside one of the control limits. Typically this will be some form of significant event, for example unusually severe weather. However if the data points continue outside of the control limits then that significant change is permanent. When we are aware of a significant change to a service such as Tunbridge Wells Hospital opening, then we will recalculate the centre and control lines. This is called a step change.

**Rule 2:** Any unusual pattern or trends within the control limits. The most obvious example of a cyclical pattern is seasonality but we also see it when looking at daily discharges where the weekends have low numbers. To qualify as a trend there must be at least 6 points in a row. This is one of the key reasons we use SPC charts as it helps us differentiate between natural variation & variation due to some action we have taken.

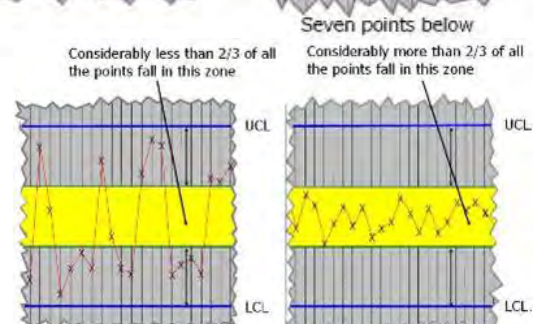


Rules 1 and 2 are the main reason for displaying SPC charts on our performance reports as it makes abnormally high or low values and trends immediately obvious. However there are two other rules that are also used to interpret the graphs.

**Rule 3:** A run of seven points all above or all below the centre line, or all increasing or decreasing. This shows some longer term change in the process such as a new piece of equipment that allows us to perform a procedure in an outpatient setting rather than admitting them. However alternating runs of points above the line then points below the line can also invoke rule 3.

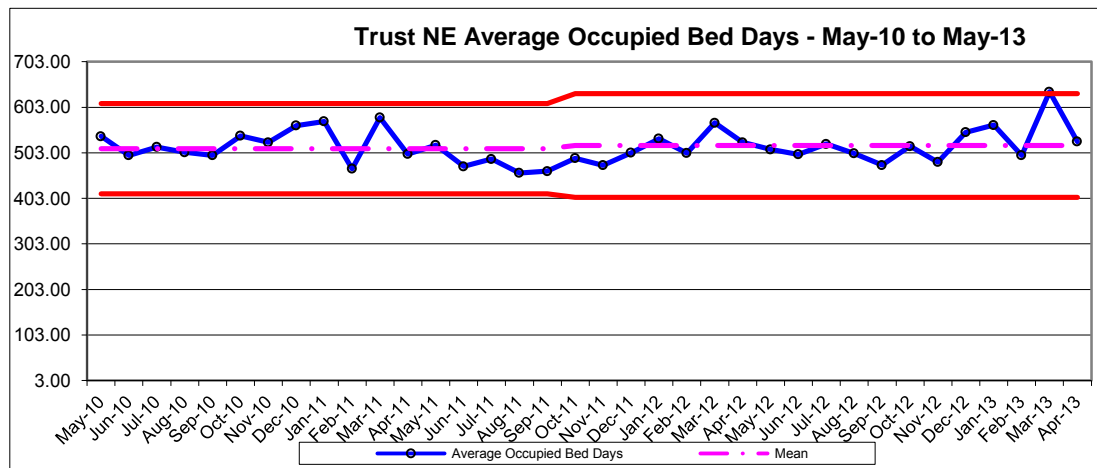


**Rule 4:** The number of points within the middle third of the region between the control limits differs markedly from two-thirds of the total number of points. This gives an indication of how stable a process is. If controlled variation (common cause) is displayed in the SPC chart, the process is stable and predictable, which means that the variation is inherent in the process. To change performance you will have to change the entire system.

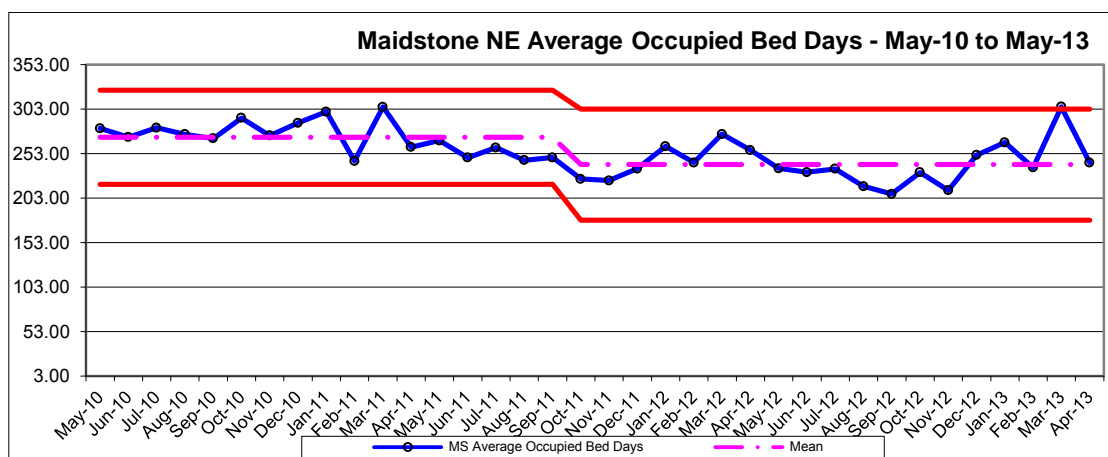
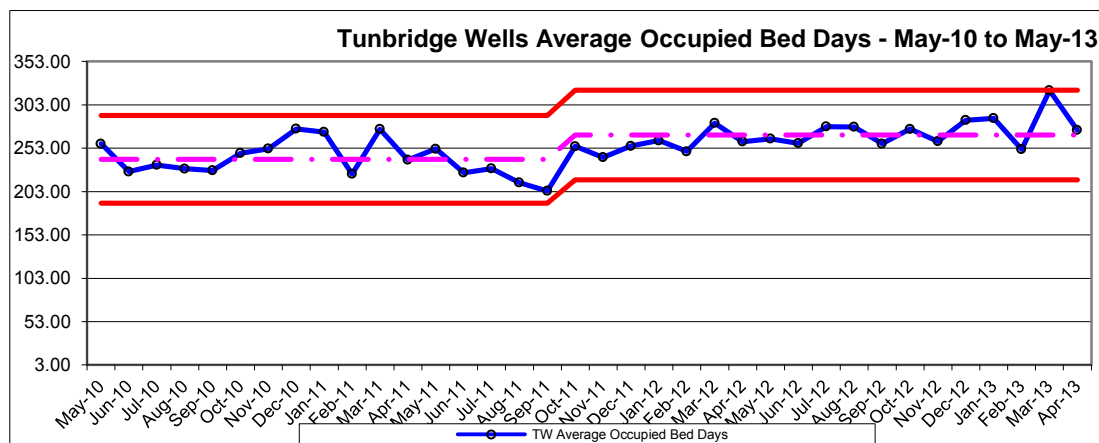


## Changes to Control Lines

When there are known changes to the services we provide we reset the calculations as at the date of that change. For example you will see in the graph below that we have re-calculated the control lines from October 2011 onwards. This is to reflect the move of services to the new Tunbridge Wells Hospital in late September.



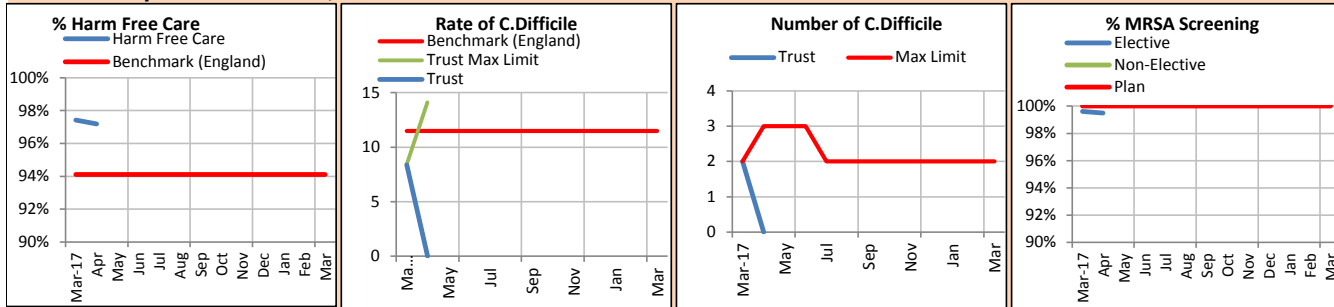
The change is not immediately obvious in the graph above if you look at just the blue line, but we know there were major changes to our inpatient beds. Looking at site level the change is more obvious:



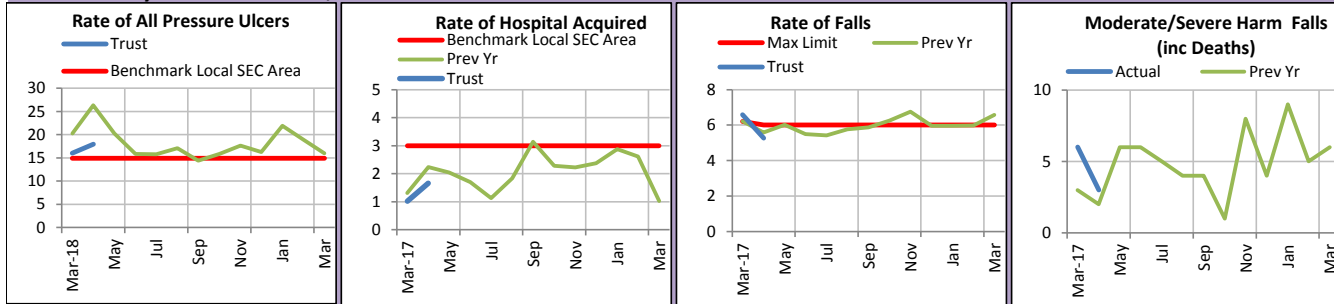
So in the examples given we have calculated a mean and control limits based on the data for May 2010 to September 2011 and then calculated them based on the period October 2011 to April 2013. The lines are all a result of the SPC calculations, only the date of the change is decided by the Information team based on a real life changes in process or service.

# INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

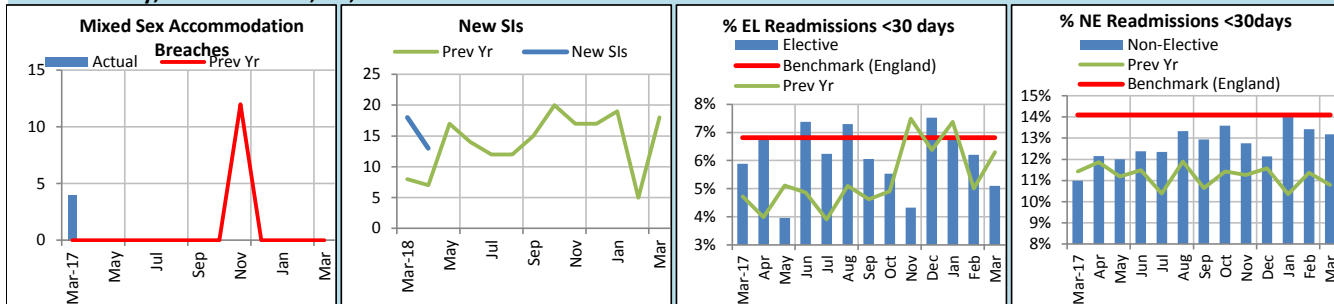
## Patient Safety - Harm Free Care, Infection Control



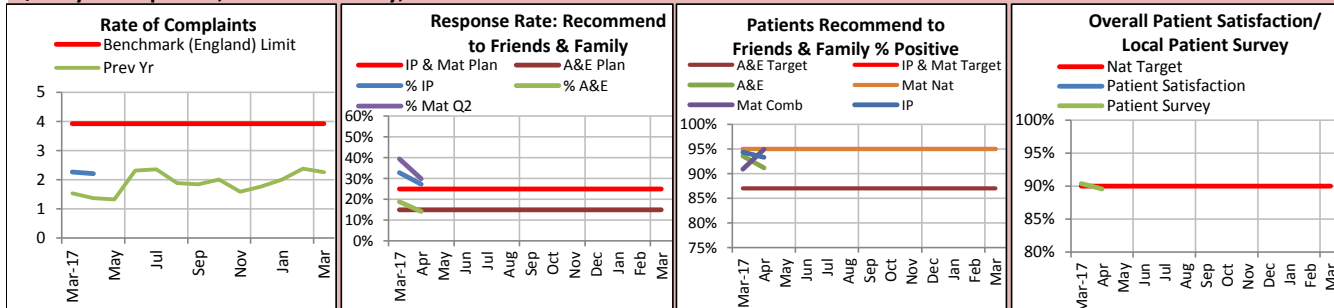
## Patient Safety - Pressure Ulcers, Falls



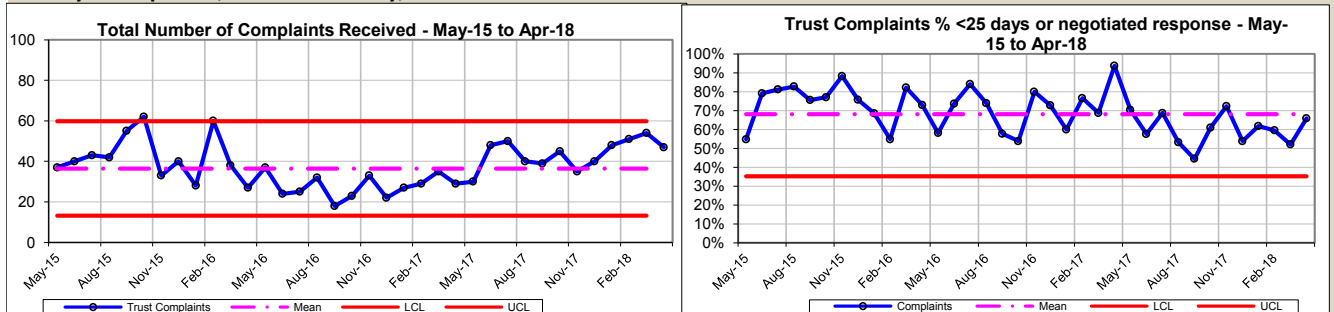
## Patient Safety, MSA Breaches, SIs, Readmissions



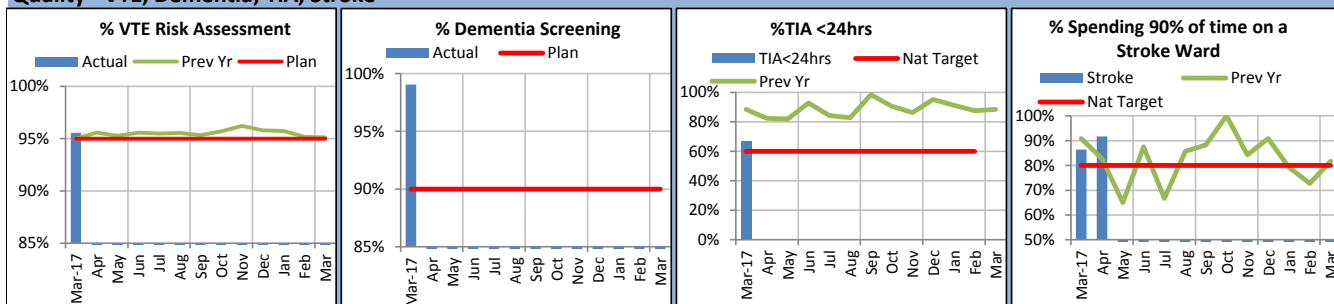
## Quality - Complaints, Friends & Family, Patient Satisfaction



## Quality - Complaints, Friends & Family, Patient Satisfaction

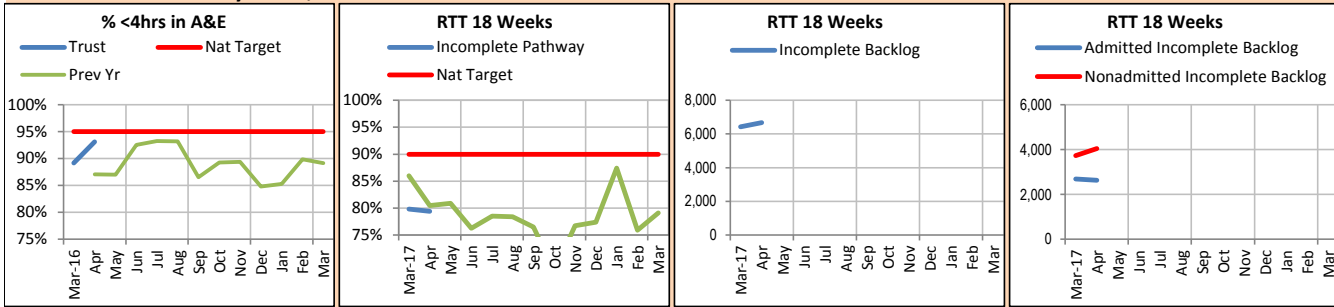


## Quality - VTE, Dementia, TIA, Stroke

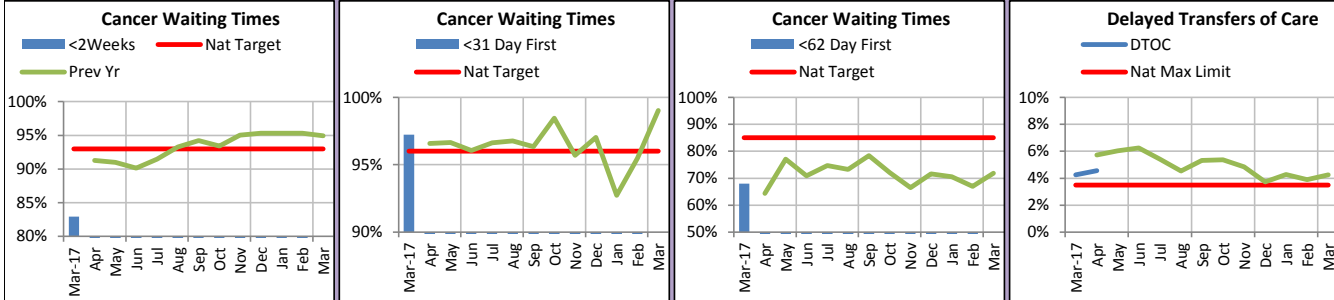


# INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

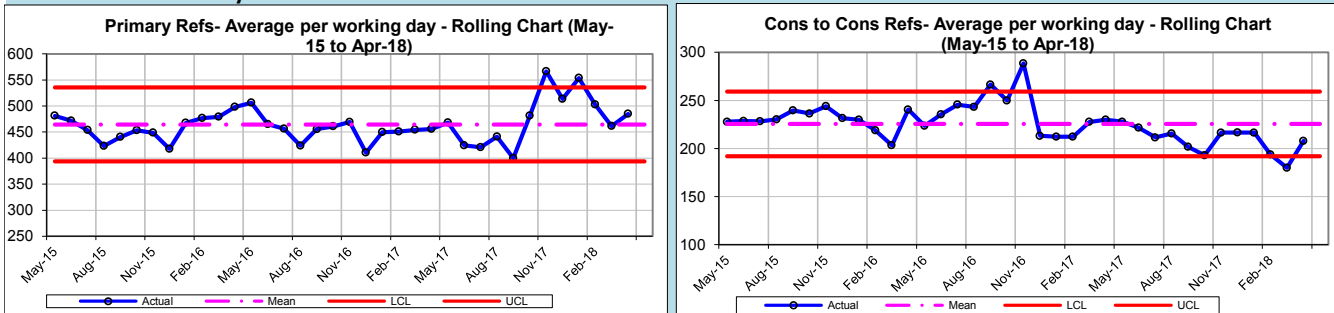
## Performance & Activity - A&E, 18 Weeks



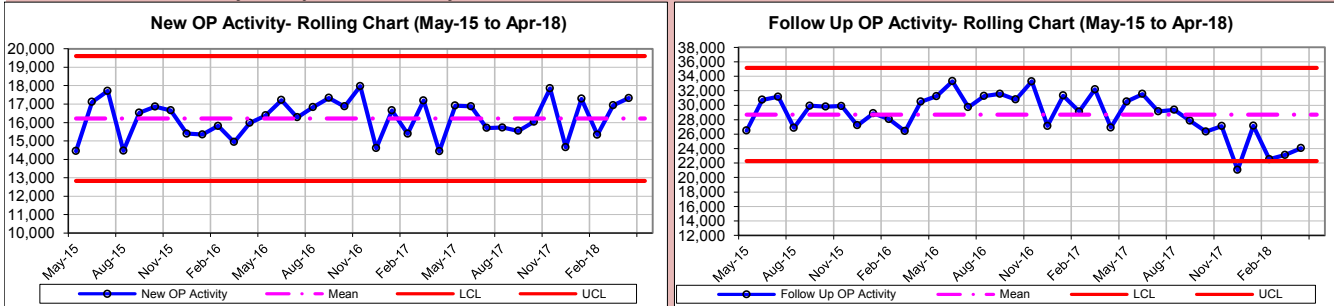
## Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care



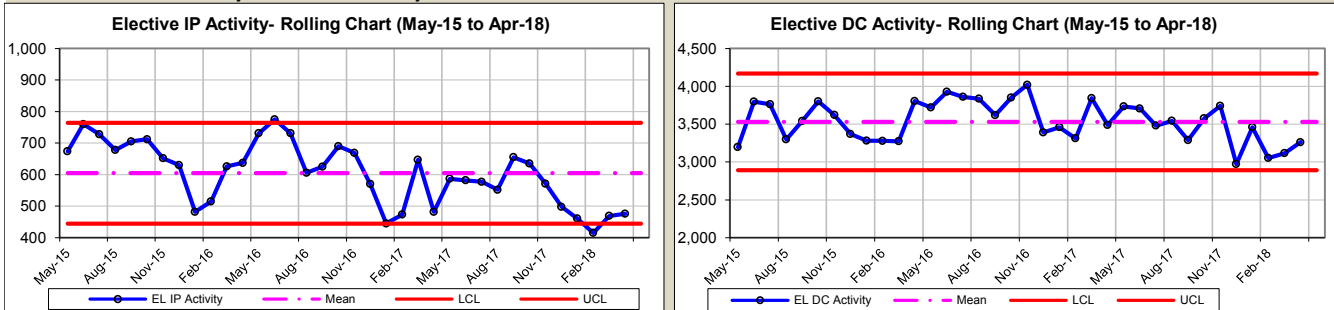
## Performance & Activity - Referrals



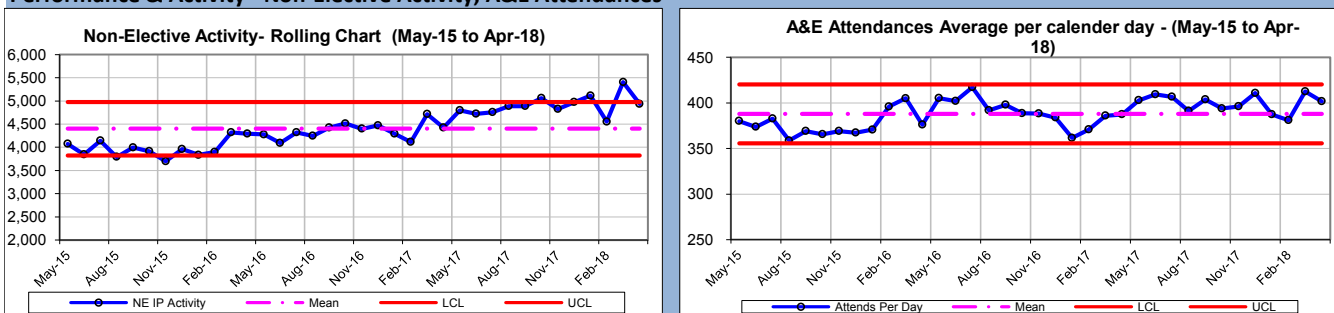
## Performance & Activity - Outpatient Activity



## Performance & Activity - Elective Activity



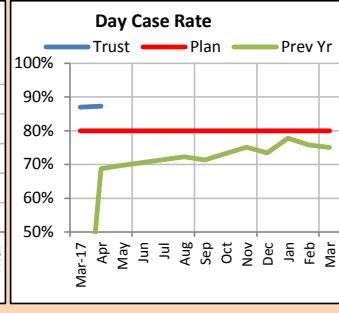
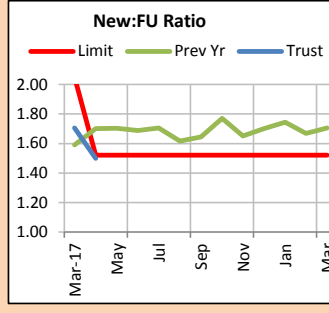
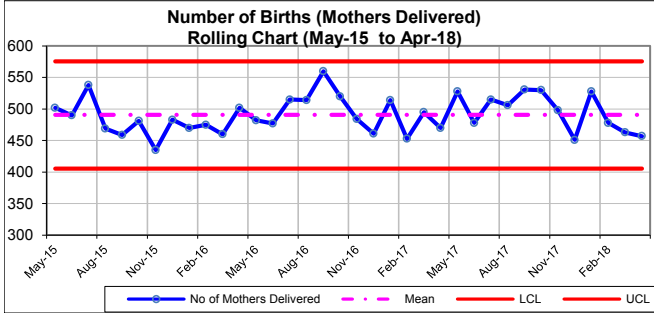
## Performance & Activity - Non-Elective Activity, A&E Attendances



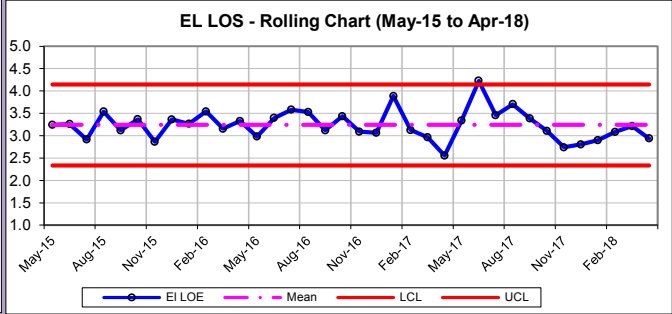
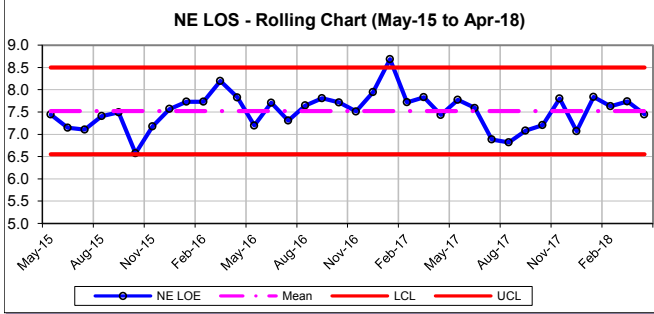


# INTEGRATED PERFORMANCE REPORT ANALYSIS - FINANCE, EFFICIENCY & WORKFORCE

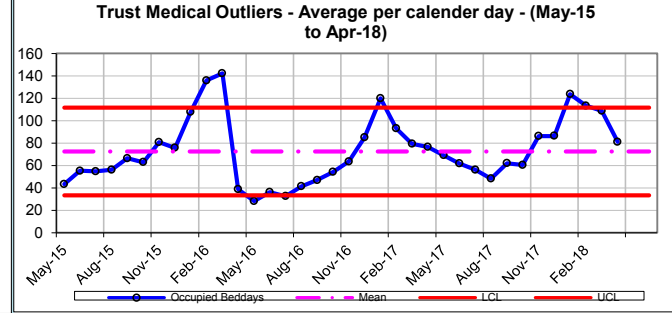
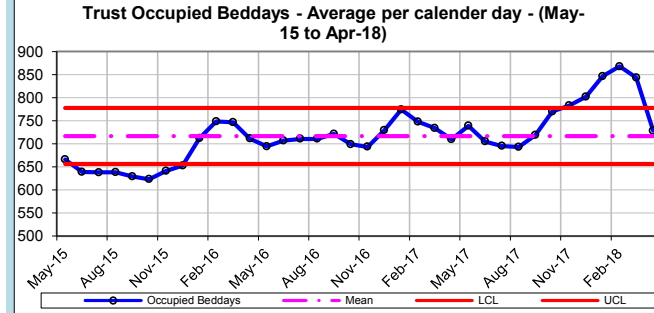
## Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates



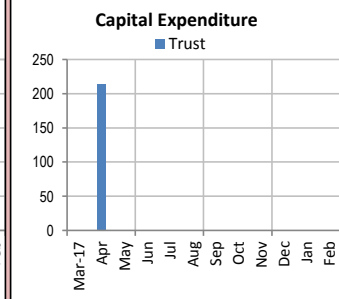
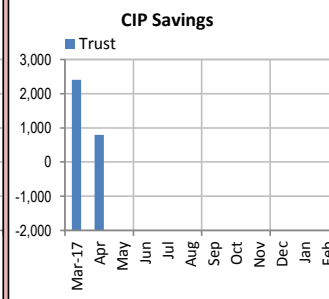
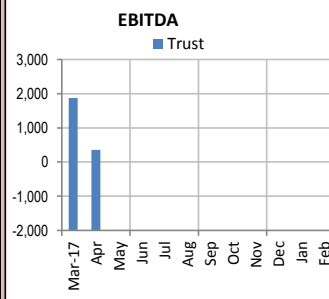
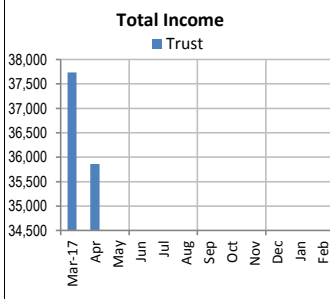
## Finance, Efficiency & Workforce - Length of Stay (LOS)



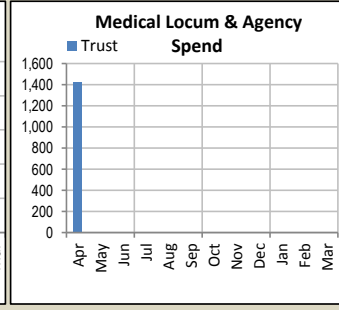
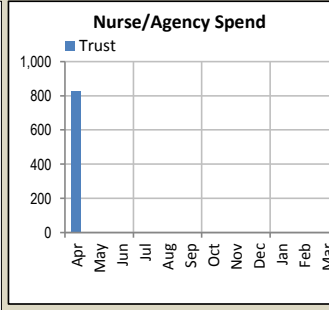
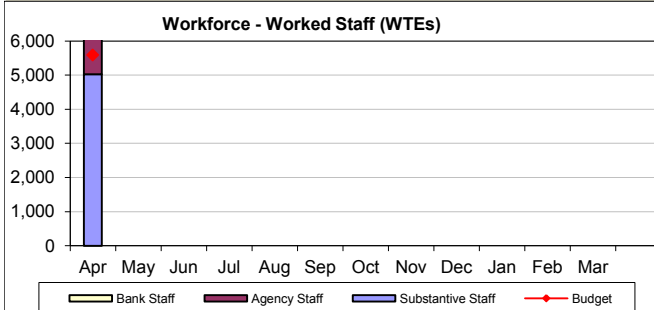
## Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers



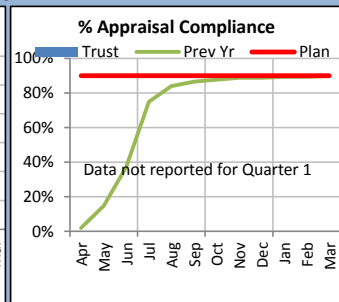
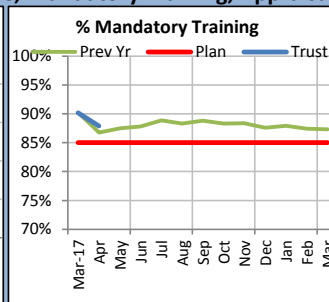
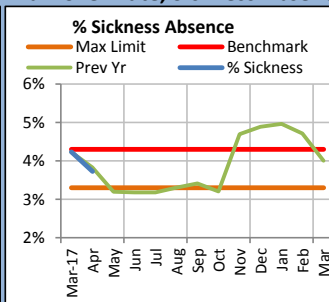
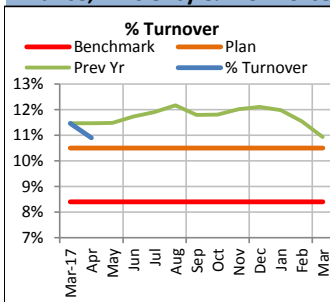
## Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure



## Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend



## Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals



# Trust Board Finance Pack

**Month 1  
2018/19**

# Content

## Trust Board Finance Pack for April 2018

### 1. Executive Summary

- a. Executive Summary
- b. Executive Summary KPI's

### 2. Financial Performance

- a. Consolidated I&E

### 3. Expenditure and WTE Analysis

- a. Run Rate Analysis £

### 4. Cost Improvement Programme / Financial Recovery Plan

- a. Current Month Savings by Directorate
- b. Forecast Savings by Directorate

### 5. Balance Sheet

- a. Balance Sheet
- b. Cash Flow

### 6. Capital

- a. Capital Plan

# 1.Executive Summary

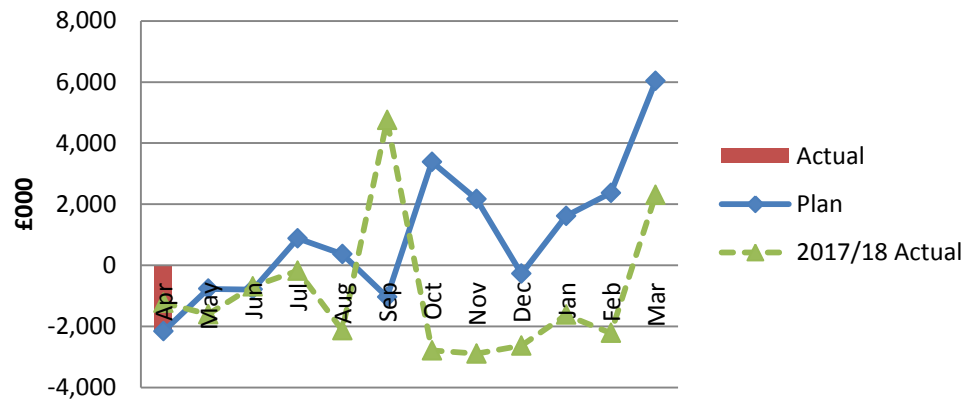
## 1a. Executive Summary April 2018

### Key Variances £m

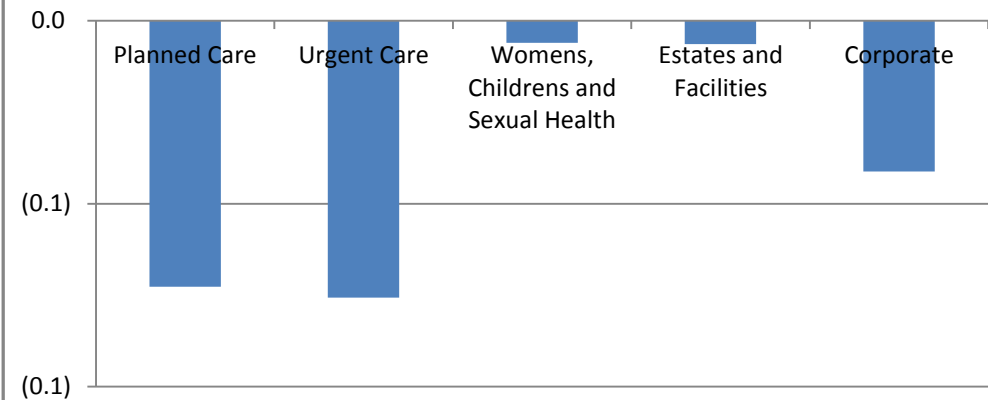
	April	YTD		Headlines
Total Surplus (+) / Deficit (-)	0.0	0.0	Favourable	The Trusts deficit including PSF was £2.2m in April which was on plan, the Trust was £0.2m adverse against the CIP plan which was offset by non recurrent underspends associated with 2017/18 accrual reversals.
Clinical Income	(0.2)	(0.2)	Favourable	Clinical Income excluding HCDs was £0.2m adverse to plan in April. The key adverse variances in April were Elective & Day Cases (£0.5m), and Excess Bed Days (£0.4m) offset by a favourable adjustment of £0.7m relating to the aligned incentive contract.
Elective IP and DC	(0.5)	(0.5)	Adverse	Elective and Day Case activity is adverse to plan in month by £0.5m in month.
Provider Sustainability Fund	0	0	Favourable	The Trust achieved the financial performance and A&E trajectory in April therefore was eligible for PSF income.
Other Operating Income	(0.0)	(0.0)	Favourable	Other Operating Income is breakeven to plan although after accounting for pass-through adjustments the revised variances is £0.1m adverse. The main adverse items relate to Commercial income (£41k adverse) due to slippage relating to Car Parking and Catering and £40k slippage in Pathology income mainly relating to Medway Histopathology income.
Pay	(0.1)	(0.1)	Adverse	Pay was £0.1m adverse in the month, mainly due to CIP slippage (£0.1m) relating to the standardisation of medical STP agency rates. Pay costs in April reduced between months by £0.6m but remained at the higher quarter 4 (2017/18) levels at £22m per month compared to quarter 3 (2017/18) levels of £21.6m per month. Overspends within Medical Staffing (£0.1m), and Nursing (£0.1m) partly offset by underspends within STT staffing (£0.1m) and Admin and Clerical. The Urgent Care Division overspent by £350k in April, £80k due to CIP slippage (mainly due to STP medical rates) and £270k adverse associated with other budget pressures. Womens, Childrens and Sexual Health (£52k) are the only other division adverse in April mainly caused by Nursing overspend (£33k). Divisions have been tasked to complete a forecast for all temporary staffing by 25th May.
Non Pay	0.4	0.4	Favourable	Non Pay was underspent by £0.4m in April this was mainly due to underspends within drugs (£0.4m net of pass through costs) and a non recurrent benefit of £0.1m within Services from NHS bodies due to April MIU costs reported in 2017/18. The Trust was adverse to plan by £0.1m relating to out sourcing expenditure, this overspend was mainly within T&O (£60k) and Diagnostics (£30k).
Other Finance Costs	(0.0)	(0.0)	Favourable	Other Finance Costs were on plan in April.
CIP / FRP	(0.2)	(0.2)	Adverse	The Trust achieved £0.8m savings in April which was £0.2m adverse to plan mainly due to slippage relating to STP Medical rates (£0.1m) and Outsourcing reductions (£0.1m).

## 1b. Executive Summary KPI's April 2018

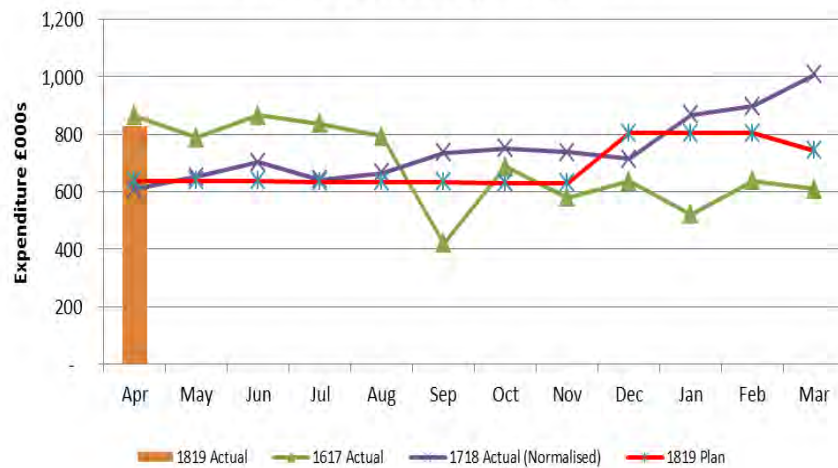
### Monthly Surplus / Deficit (-)



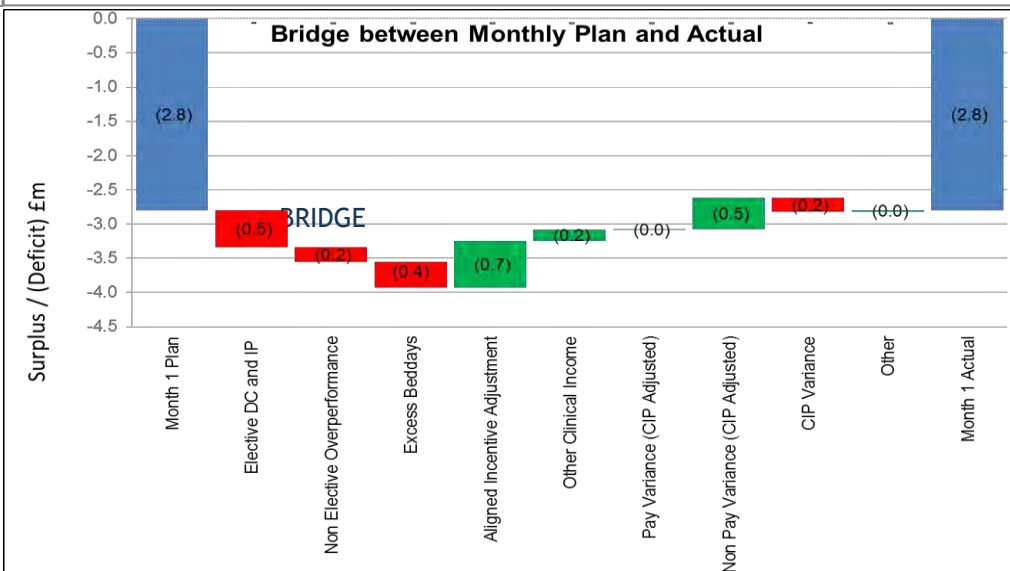
### YTD CIP Variance £m



### Agency Nurse Expenditure



### Bridge between Monthly Plan and Actual



## 2. Income and Expenditure

### 2a. Income & Expenditure

Income &amp; Expenditure April 2018/19

	Current Month					Annual Forecast		
	Actual £m	Plan £m	Variance £m	Pass- through £m	Revised Variance £m	Actual £m	Plan £m	Variance £m
<b>Revenue</b>								
Clinical Income	27.3	27.5	(0.2)	(0.0)	(0.2)	351.5	351.5	0.0
High Cost Drugs	3.4	3.5	(0.1)	(0.1)	(0.0)	43.3	43.3	0.0
<b>Total Clinical Income</b>	<b>30.7</b>	<b>31.0</b>	<b>(0.3)</b>	<b>(0.1)</b>	<b>(0.2)</b>	<b>394.8</b>	<b>394.8</b>	<b>0.0</b>
PSF	0.6	0.6	0.0	0.0	0.0	12.7	12.7	0
Other Operating Income	4.5	4.5	(0.0)	0.1	(0.1)	58.7	58.7	0.0
<b>Total Revenue</b>	<b>35.9</b>	<b>36.2</b>	<b>(0.3)</b>	<b>0.0</b>	<b>(0.3)</b>	<b>466.2</b>	<b>466.2</b>	<b>0.0</b>
<b>Expenditure</b>								
Substantive	(18.3)	(18.5)	0.3	(0.0)	0.3	(221.7)	(221.7)	0
Bank	(1.0)	(1.0)	(0.1)	0.0	(0.1)	(12.0)	(12.0)	0
Locum	(0.5)	(0.4)	(0.0)	0.0	(0.0)	(5.5)	(5.5)	0
Agency	(2.0)	(1.7)	(0.3)	(0.0)	(0.3)	(22.1)	(22.1)	0
Pay Reserves	(0.2)	(0.2)	0.0	0.0	0.0	(2.3)	(2.3)	0
<b>Total Pay</b>	<b>(22.0)</b>	<b>(21.9)</b>	<b>(0.1)</b>	<b>(0.0)</b>	<b>(0.1)</b>	<b>(263.6)</b>	<b>(263.6)</b>	<b>0</b>
						0.0		
Drugs & Medical Gases	(4.2)	(4.6)	0.5	0.1	0.4	(52.9)	(52.9)	0
Blood	(0.2)	(0.2)	0.0	0.0	0.0	(2.4)	(2.4)	0
Supplies & Services - Clinical	(2.6)	(2.6)	0.0	0.0	(0.0)	(31.3)	(31.3)	0
Supplies & Services - General	(0.4)	(0.5)	0.0	0.0	0.0	(5.0)	(5.0)	0
Services from Other NHS Bodies	(0.6)	(0.8)	0.2	0.0	0.1	(9.6)	(9.6)	0
Purchase of Healthcare from Non-NHS	(0.3)	(0.2)	(0.1)	(0.0)	(0.1)	(5.3)	(5.3)	0
Clinical Negligence	(1.6)	(1.6)	0.0	0.0	0.0	(19.0)	(19.0)	0
Establishment	(0.3)	(0.3)	(0.0)	(0.0)	0.0	(3.5)	(3.5)	0
Premises	(1.9)	(1.9)	0.0	0.0	0.0	(21.1)	(21.1)	0
Transport	(0.2)	(0.1)	(0.0)	0.0	(0.0)	(1.3)	(1.3)	0
Other Non-Pay Costs	(1.0)	(0.8)	(0.2)	(0.1)	(0.1)	(9.8)	(9.8)	0
Non-Pay Reserves	(0.2)	(0.2)	0.0	0.0	0.0	(2.3)	(2.3)	0
<b>Total Non Pay</b>	<b>(13.5)</b>	<b>(13.9)</b>	<b>0.4</b>	<b>(0.0)</b>	<b>0.4</b>	<b>(163.8)</b>	<b>(163.8)</b>	<b>0</b>
<b>Total Expenditure</b>	<b>(35.5)</b>	<b>(35.8)</b>	<b>0.3</b>	<b>(0.0)</b>	<b>0.3</b>	<b>(427.3)</b>	<b>(427.3)</b>	<b>0</b>
<b>EBITDA</b>	<b>0.4</b>	<b>0.4</b>	<b>(0.0)</b>	<b>(0.0)</b>	<b>(0.0)</b>	<b>38.9</b>	<b>38.9</b>	<b>0</b>
	0.0	0.0	0.0	%		8.3%	8.3%	
<b>Other Finance Costs</b>								
Depreciation	(1.1)	(1.1)	(0.0)	0	(0.0)	(13.5)	(13.5)	0
Interest	(0.1)	(0.1)	(0.0)	0	(0.0)	(1.6)	(1.6)	0
Dividend	(0.1)	(0.1)	0.0	0	0	(1.3)	(1.3)	0
PFI and Impairments	(1.2)	(1.2)	(0.0)	0	(0.0)	(11.9)	(11.9)	0
<b>Total Finance Costs</b>	<b>(2.5)</b>	<b>(2.5)</b>	<b>(0.0)</b>	<b>0.0</b>	<b>(0.0)</b>	<b>(28.2)</b>	<b>(28.2)</b>	<b>0</b>
<b>Net Surplus / Deficit (-)</b>	<b>(2.2)</b>	<b>(2.2)</b>	<b>(0.0)</b>	<b>(0.0)</b>	<b>(0.0)</b>	<b>10.7</b>	<b>10.7</b>	<b>0.0</b>
<b>Technical Adjustments</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>(0.0)</b>	<b>0.0</b>	<b>1.0</b>	<b>1.0</b>	<b>0.0</b>
<b>Surplus/ Deficit (-) to B/E Duty</b>	<b>(2.2)</b>	<b>(2.2)</b>	<b>0.0</b>	<b>(0.0)</b>	<b>0.0</b>	<b>11.7</b>	<b>11.7</b>	<b>0.0</b>
<b>Surplus/ Deficit (-) to B/E Duty Excl PSF</b>	<b>(2.8)</b>	<b>(2.8)</b>	<b>0.0</b>	<b>(0.0)</b>	<b>0.0</b>	<b>(1.0)</b>	<b>(1.0)</b>	<b>0.0</b>

#### Commentary

The Trusts deficit including PSF was £2.2m in April which was on plan, the Trust was £0.2m adverse against the CIP plan which was offset by non recurrent underspends associated with 2017/18 accrual reversals.

The Trust's normalised pre PSF run rate in April was a deficit of £3m. The main normalised adjustments in April related to: £0.1m Minor Injury Unit charges relating to month 1 paid in 2017/18, and £0.1m DTOC income relating to 2017/18 reported in April.

Pass-through adjustments have been applied to account for: High Cost Drugs and devices, STP associated costs, Education and Training costs associated with PSF and CPD funding, Sexual Health outsourced pass-through tests and PAS AllScripts.

Clinical Income excluding HCDs was £0.2m adverse to plan in April. The key adverse variances in April were Elective & Day Cases (£0.5m), and Excess Bed Days (£0.4m) offset by a favourable adjustment of £0.7m relating to the aligned incentive contract.

The Trust achieved the full PSF income in April due to the delivery of the financial control total and A&E trajectory.

Other Operating Income is breakeven to plan although after accounting for pass-through adjustments the revised variances is £0.1m adverse. The main adverse items relate to Commercial income (£41k adverse) due to slippage relating to Car Parking and Catering and £40k slippage in Pathology income mainly relating to Medway Histopathology income.

Pay was £0.1m adverse in the month, mainly due to CIP slippage (£0.1m) relating to the standardisation of medical STP agency rates. Pay costs in April reduced between months by £0.6m but remained at the higher quarter 4 (2017/18) levels at £22m per month compared to quarter 3 (2017/18) levels of £21.6m per month. Overspends within Medical Staffing (£0.1m), and Nursing (£0.1m) partly offset by underspends within STT staffing (£0.1m) and Admin and Clerical. The Urgent Care Division overspent by £350k in April, £80k due to CIP slippage (mainly due to STP medical rates) and £270k adverse associated with other budget pressures. Womens, Childrens and Sexual Health (£52k) are the only other division adverse in April mainly caused by Nursing overspend (£33k). Divisions have been tasked to complete a forecast for all temporary staffing by 25th May.

Non Pay was underspent by £0.4m in April this was mainly due to underspends within drugs (£0.4m net of pass through costs) and a non recurrent benefit of £0.1m within Services from NHS bodies due to April MIU costs reported in 2017/18. The Trust was adverse to plan by £0.1m relating to out sourcing expenditure, this overspend was mainly within T&O (£60k) and Diagnostics (£30k).

The Trust is forecasting to deliver the planned Surplus including PSF of £11.7m.

### 3. Expenditure Analysis

#### 3a. Run Rate Analysis

Analysis of 13 Monthly Performance (£m's)

		Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	Change between Months
Revenue	Clinical Income	31.9	31.8	32.3	32.1	31.2	32.6	31.3	31.2	31.7	32.0	31.2	33.8	30.7	(3.1)
	STF	0.4	0.4	0.6	0.3	0.0	2.2	0.0	0.0	0.0	0.0	0.0	3.0	0.6	(2.4)
	High Cost Drugs	(0.1)	(0.0)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Other Operating Income	4.7	4.6	3.5	4.3	4.5	4.1	3.8	3.4	3.8	4.0	5.7	3.9	4.5	0.6
	<b>Total Revenue</b>	<b>37.0</b>	<b>36.8</b>	<b>36.5</b>	<b>36.7</b>	<b>35.7</b>	<b>38.9</b>	<b>35.0</b>	<b>34.5</b>	<b>35.5</b>	<b>36.0</b>	<b>36.9</b>	<b>40.8</b>	<b>35.9</b>	<b>(4.9)</b>
Expenditure	Substantive	(17.9)	(18.0)	(18.1)	(17.8)	(17.7)	(17.8)	(17.9)	(18.0)	(17.8)	(17.9)	(17.5)	(17.9)	(18.3)	(0.4)
	Bank	(0.9)	(0.9)	(0.9)	(0.9)	(0.7)	(1.2)	(1.0)	(0.9)	(1.2)	(1.2)	(1.1)	(1.3)	(1.0)	0.2
	Locum	(0.6)	(0.5)	(0.1)	(0.4)	(0.5)	(0.5)	(0.5)	(0.6)	(0.5)	(0.5)	(0.6)	(0.7)	(0.5)	0.2
	Agency	(1.7)	(1.3)	(1.8)	(1.4)	(1.7)	(1.9)	(2.0)	(1.8)	(1.9)	(2.3)	(1.8)	(2.6)	(2.0)	0.5
	Pay Reserves	(0.2)	(0.2)	(0.2)	(0.2)	(0.1)	1.5	(0.2)	(0.2)	(0.2)	(0.2)	(0.3)	(0.2)	(0.2)	(0.0)
	<b>Total Pay</b>	<b>(21.3)</b>	<b>(21.0)</b>	<b>(21.1)</b>	<b>(20.8)</b>	<b>(20.8)</b>	<b>(20.0)</b>	<b>(21.6)</b>	<b>(21.6)</b>	<b>(21.6)</b>	<b>(22.2)</b>	<b>(21.3)</b>	<b>(22.7)</b>	<b>(22.0)</b>	<b>0.6</b>
Non-Pay	Drugs & Medical Gases	(4.2)	(4.6)	(4.6)	(4.2)	(4.8)	(4.1)	(4.4)	(4.5)	(4.2)	(4.5)	(4.3)	(4.5)	(4.2)	0.3
	Blood	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.1)	(0.2)	(0.2)	(0.0)
	Supplies & Services - Clinical	(2.6)	(2.8)	(2.7)	(2.7)	(2.7)	(2.2)	(2.5)	(2.6)	(2.5)	(2.6)	(2.5)	(2.1)	(2.6)	(0.5)
	Supplies & Services - General	(0.4)	(0.5)	(0.5)	(0.5)	(0.3)	(0.5)	(0.5)	(0.5)	(0.5)	(0.4)	(0.5)	(0.6)	(0.4)	0.1
	Services from Other NHS Bodies	(0.8)	(0.7)	(0.6)	(0.7)	(0.7)	(0.7)	(0.6)	(1.3)	(0.9)	(0.7)	(0.7)	(0.3)	(0.6)	(0.4)
	Purchase of Healthcare from Non-NHS	(0.5)	(0.5)	(0.2)	(0.3)	(0.3)	(0.3)	(0.4)	(0.4)	(0.4)	(0.2)	(0.2)	(0.3)	(0.3)	(0.0)
	Clinical Negligence	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.6)	0.1
	Establishment	(0.3)	(0.3)	(0.3)	(0.3)	(0.2)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.1)
	Premises	(2.0)	(2.3)	(1.6)	(1.7)	(1.9)	(1.5)	(1.8)	(1.8)	(2.2)	(1.8)	(3.8)	(3.0)	(1.9)	1.1
	Transport	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.2)	(0.1)	(0.1)	(0.2)	(0.1)	(0.2)	(0.2)	0.0
	Other Non-Pay Costs	(1.5)	(1.1)	(0.7)	(1.4)	(1.6)	(0.5)	(1.5)	(0.0)	(1.0)	(1.1)	(1.1)	(0.2)	(1.0)	(0.8)
	Non-Pay Reserves	(0.1)	(0.1)	(0.1)	0.2	0.0	0.3	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.2)	(0.2)
	<b>Total Non Pay</b>	<b>(14.4)</b>	<b>(14.9)</b>	<b>(13.5)</b>	<b>(13.6)</b>	<b>(14.4)</b>	<b>(11.7)</b>	<b>(14.1)</b>	<b>(13.4)</b>	<b>(14.2)</b>	<b>(13.7)</b>	<b>(15.4)</b>	<b>(13.2)</b>	<b>(13.5)</b>	<b>(0.3)</b>
	<b>Total Expenditure</b>	<b>(35.7)</b>	<b>(35.9)</b>	<b>(34.6)</b>	<b>(34.3)</b>	<b>(35.2)</b>	<b>(31.6)</b>	<b>(35.7)</b>	<b>(35.0)</b>	<b>(35.8)</b>	<b>(35.8)</b>	<b>(36.7)</b>	<b>(35.9)</b>	<b>(35.5)</b>	<b>0.4</b>
	<b>EBITDA</b>	<b>1.3</b>	<b>0.9</b>	<b>1.9</b>	<b>2.4</b>	<b>0.4</b>	<b>7.3</b>	<b>(0.6)</b>	<b>(0.5)</b>	<b>(0.3)</b>	<b>0.2</b>	<b>0.2</b>	<b>4.9</b>	<b>0.4</b>	<b>(4.6)</b>
Other Finance Costs	4%	2%	5%	6%	1%	19%	-2%	-1%	-1%	1%	1%	12%	1%		
	Depreciation	(1.2)	(1.2)	(1.2)	(1.2)	(1.2)	(1.2)	(0.8)	(1.1)	(1.0)	(1.2)	(1.1)	(1.2)	(1.1)	0.1
	Interest	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	0.0
	Dividend	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	0.5	(0.1)	0.2	(0.1)	(0.3)
	PFI and Impairments	(1.2)	(1.2)	(1.2)	(1.2)	(1.1)	(1.1)	(1.1)	(1.2)	(5.2)	(1.1)	(1.2)	17.5	(1.2)	(18.7)
	<b>Total Other Finance Costs</b>	<b>(2.6)</b>	<b>(2.5)</b>	<b>(2.6)</b>	<b>(2.6)</b>	<b>(2.6)</b>	<b>(2.6)</b>	<b>(2.2)</b>	<b>(2.5)</b>	<b>(6.4)</b>	<b>(1.9)</b>	<b>(2.5)</b>	<b>16.3</b>	<b>(2.5)</b>	<b>(18.9)</b>
Net Surplus / Deficit (-)	Net Surplus / Deficit (-)	(1.3)	(1.6)	(0.7)	(0.2)	(2.2)	4.7	(2.8)	(2.9)	(6.7)	(1.7)	(2.2)	21.2	(2.2)	(23.4)
Technical Adjustments	Technical Adjustments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Surplus/ Deficit (-) to B/E Duty Incl STF	Surplus/ Deficit (-) to B/E Duty	(1.2)	(1.6)	(0.7)	(0.2)	(2.2)	4.7	(2.8)	(2.9)	(6.7)	(1.7)	(2.2)	21.2	(2.2)	(23.4)
Surplus/ Deficit (-) to B/E Duty Excl STF	Surplus/ Deficit (-) to B/E Duty	(1.6)	(2.0)	(1.4)	(0.5)	(2.2)	2.5	(2.8)	(2.9)	(6.7)	(1.7)	(2.2)	18.2	(2.8)	(21.0)

## 4. Cost Improvement Programme

### 4a. Current Month Savings by Directorate

	Current Month		
	Actual	Original Plan	Variance
	£m	£m	£m
Cancer	0.1	0.1	(0.0)
Critical Care	0.2	0.2	0.0
Diagnostics	0.1	0.0	0.0
Head and Neck	0.0	0.0	(0.0)
Surgery	0.0	0.1	(0.0)
T&O	0.2	0.2	(0.0)
Patient Admin	0.0	0.0	(0.0)
Private Patient Unit	0.0	0.0	0.0
<b>Planned Care</b>	<b>0.5</b>	<b>0.6</b>	<b>(0.1)</b>
Urgent Care	0.1	0.2	(0.1)
Womens, Childrens and Sexual Health	0.1	0.1	(0.0)
Estates and Facilities	0.1	0.1	(0.0)
Corporate	0.1	0.1	(0.0)
<b>Total</b>	<b>0.8</b>	<b>1.0</b>	<b>(0.2)</b>

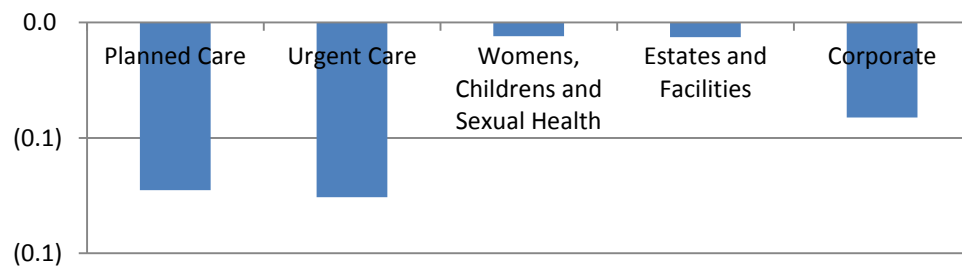
#### Comment

The Trust achieved £0.8m savings in April which was £0.2m adverse to plan., this is mainly due to STP Medical rate slippage (£0.1m) and Outsourcing reduction slippage (£0.1m).

**Planned Care:** £0.1m adverse compared to the CIP plan this is mainly due to STP Medical rate slippage (£41k), £25k slippage relating to outsourcing reduction within T&O and £13k associated with reduction in Surgery Medical locums.

**Urgent Care:** £0.1m adverse compared to the CIP plan this is mainly due to STP Medical rate slippage (£68k).

#### Current Month Variance £m





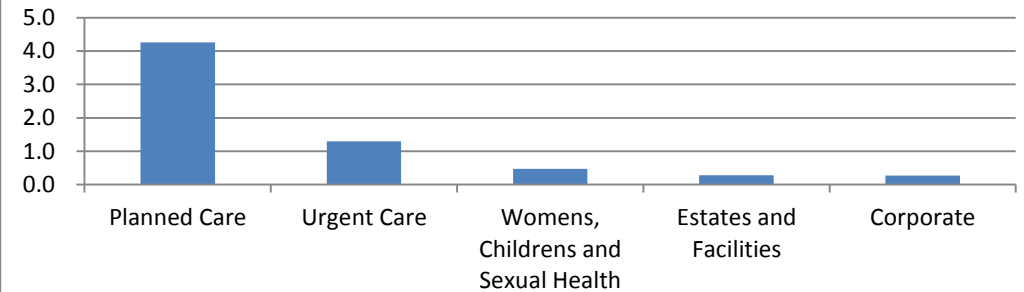
## 4b. Forecast savings by Directorate

### Directorate Performance

	Forecast Savings			
	Risk Adjusted Forecast	Unidentified (Risk Adjusted)	Plan	% Unidentified
	£m	£m	£m	
Cancer	0.8	0.5	1.3	35%
Critical Care	1.7	0.6	2.3	26%
Diagnostics	0.6	0.2	0.7	23%
Head and Neck	0.9	0.7	1.6	46%
Surgery	1.1	0.5	1.6	34%
T&O	4.6	1.2	5.8	21%
Patient Admin	0.0	0.1	0.1	100%
Private Patient Unit	0.5	0.5	1.0	50%
<b>Planned Care</b>	<b>10.1</b>	<b>4.3</b>	<b>14.4</b>	<b>30%</b>
<b>Urgent Care</b>	<b>2.2</b>	<b>1.3</b>	<b>3.5</b>	<b>37%</b>
<b>Womens, Childrens and Sexual Health</b>	<b>1.6</b>	<b>0.5</b>	<b>2.1</b>	<b>23%</b>
<b>Estates and Facilities</b>	<b>2.9</b>	<b>0.3</b>	<b>3.1</b>	<b>9%</b>
<b>Corporate</b>	<b>0.7</b>	<b>0.3</b>	<b>1.0</b>	<b>27%</b>
<b>Total</b>	<b>17.5</b>	<b>6.6</b>	<b>24.1</b>	<b>27%</b>

Savings as per 10th May

### Unidentified CIP £m



The Trust has a £24.1m CIP plan for 2018/19 which has been fully identified however the current forecasted risk adjusted savings is a shortfall of £6.1m (25%).

**Planned Care Division** have a risk adjusted shortfall of £4.1m (29%).

**Urgent Care Division** have a risk adjusted shortfall of £0.9m (26%).

**Womens, Childrens and Sexual Health Division** have a risk adjusted shortfall of £0.5m (21%).

**Estates and Facilities** have a risk adjusted shortfall of £0.3m (9%) however the subsidiary (£1.75m) is rated as green therefore forecasting full delivery under the risk adjusted method.

**Corporate directorates** have a risk adjusted shortfall of £0.3m (27%)

## 5a. Balance Sheet and Liquidity

### 5a. Balance Sheet

April 2018

The Trust Balance Sheet is produced on a monthly basis and reflects changes in the asset values, as well as movement in liabilities.

£m's	April			March Reported
	Reported	Plan	Variance	
Property, Plant and Equipment (Fixed Assets)	293.3	293.3	0.0	294.0
Intangibles	2.5	2.4	0.1	2.6
PFI Lifecycle	0.0	0.0	0.0	0.0
Debtors Long Term	1.2	1.2	0.0	1.2
<b>Total Non-Current Assets</b>	<b>297.0</b>	<b>296.9</b>	<b>0.1</b>	<b>297.8</b>
<b>Current Assets</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>
Inventory (Stock)	7.8	8.0	(0.2)	7.8
Receivables (Debtors) - NHS	29.0	28.0	1.0	27.9
Receivables (Debtors) - Non-NHS	16.3	14.0	2.3	9.5
Cash	12.9	16.8	(3.9)	1.5
Assets Held For Sale	0.0	0.0	0.0	0.0
<b>Total Current Assets</b>	<b>66.0</b>	<b>66.8</b>	<b>(0.8)</b>	<b>46.7</b>
<b>Current Liabilities</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>
Payables (Creditors) - NHS	(6.2)	(8.5)	2.3	(8.8)
Payables (Creditors) - Non-NHS	(37.2)	(37.5)	0.3	(35.1)
Deferred Income	(24.4)	(22.5)	(1.9)	(2.6)
Capital Loan	(2.2)	(2.2)	0.0	(2.2)
Working Capital Loan	(16.9)	(16.9)	0.0	(16.9)
Other loans	(0.1)	(0.1)	0.0	(0.1)
Borrowings - PFI	(5.0)	(5.0)	(0.0)	(5.3)
Provisions for Liabilities and Charges	(1.8)	(1.8)	0.0	(1.7)
<b>Total Current Liabilities</b>	<b>(93.8)</b>	<b>(94.5)</b>	<b>0.7</b>	<b>(72.7)</b>
<b>Net Current Assets</b>	<b>(27.8)</b>	<b>(27.7)</b>	<b>(0.1)</b>	<b>(26.0)</b>
Borrowings - PFI > 1yr	(192.7)	(192.7)	0.0	(193.2)
Capital Loans	(10.1)	(10.1)	0.0	(10.1)
Working Capital Facility & Revenue loans	(26.1)	(26.1)	0.0	(26.1)
Other loans	(0.6)	(0.6)	0.0	(0.6)
Provisions for Liabilities and Charges- Long term	(1.1)	(1.1)	0.0	(1.1)
<b>Total Assets Employed</b>	<b>38.6</b>	<b>38.6</b>	<b>0.0</b>	<b>40.8</b>
Financed By:	0.0	0.0	0.0	0.0
Capital & Reserves	0.0	0.0	0.0	0.0
Public dividend capital	207.3	207.3	0.0	207.3
Revaluation reserve	29.8	29.8	0.0	29.9
Retained Earnings Reserve	(198.5)	(198.5)	0.0	(196.4)

#### Commentary:

The month 1 balance sheet position is consistent with the plan that was submitted in April. The overall working capital within the month results in slightly higher debtors than planned and a reduction in creditors compared to the plan, both of these result in a lower cash balance held at the end of the month.

#### Non-Current Assets -

Capital additions of £14.5m are planned for 18/19 and £0.7m on donated assets. The planned depreciation for the year is £13.5m. The month 1 capital spend is £0.2m against a plan of £0.4m.

#### Current Assets -

Inventory of £7.8m is a small reduction from the planned value. The main stock balances are pharmacy £2.8m, TWH theatres £1.5m, Materials Management £1.1m and Cardiology £1m. NHS Receivables have increased since the year end by £1.1m. Of the £29m reported balance, £23m relates to invoiced debt of which £3.8m is aged debt over 90 days. Invoiced debt over 90 days has increased by £0.9m compared with the March reported position. The remaining £6m relates to uninvoiced accrued income including work in progress partially completed spells. Due to the cash pressures of many neighbouring NHS bodies regular communication is continuing and arrangements are being put in place to help reduce the level of debt.

Non NHS Receivables have increased by £6.8m compared with the March reported position. Included within this balance is trade invoiced debt of £3.1m and private patient invoiced debt of £0.8m. Prepayments and accrued income totalling £9.8m. Prepayments primarily relate to rates & annual service maintenance contracts, which will reduce throughout the year as they are expensed.

The cash balance of £12.9m is lower than plan due to the increase in debtors and decrease in creditors.

#### Current Liabilities -

NHS payables have decreased from March's reported position by £2.6m. Non-NHS trade payables have increased since March by £2.1m.

Of the £43.4m combined payables balances, £19.4m relates to actual invoices and £24m relates to uninvoiced accruals. The accruals include expected values for tax, NI, Superannuation and PDC payments.

Deferred income of £24.4m primarily is in relation to c£20m double block SLA received from WK CCG in April, which reduces over the remaining 11 months.

£16.9m working capital loan is repayable in February 2019

Other loans for both current and non current liabilities relate to the Salix loan which has been taken out to improve the energy efficiency of the Trust.

#### Long term Liabilities-

The PFI liability reduces each month as the Unitary Charge includes financing repayments.

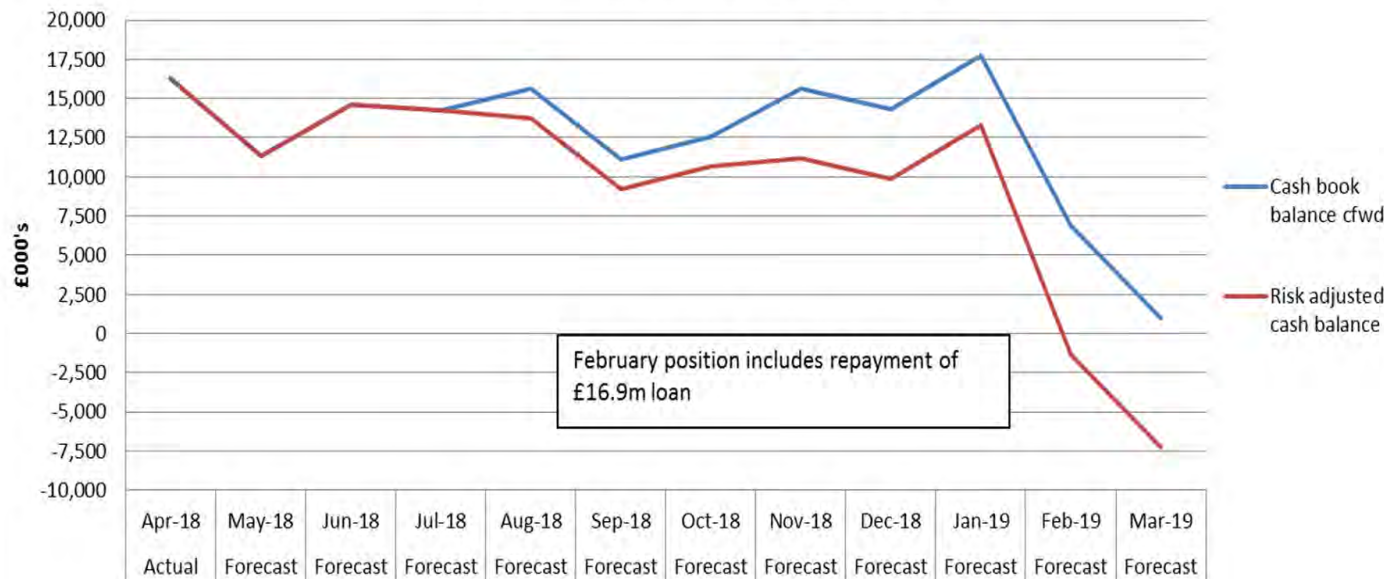
The working capital and revenue loans relate to - £12.132m repayable in October 20, the remaining balance is a combination of 3 working capital loans totalling £13.990 taken out in 2017/18 and are repayable in 2020/21.

#### Capital and Reserves-

For each area within this element for month 1 are consistent with the plan

## 5b. | Cash Flow

### Risk adjusted cash flow 2018/19



#### Commentary

The blue line shows the Trust's cash position for 2018/19 and the red risk adjusted line shows the position if the relevant risk items are not received.

The Trust's cash flow is based on the Income & Expenditure (I&E) plan and working capital adjustments from the Balance sheet. If the I&E starts to move away from the plan, this will effect the Trust's cash position.

In April the Trust received advance contract payment from WK CCG of c£19m. The rest of the contract balance is paid over the remaining 11 months.

The Trust received notification in April regarding additional STF funding for 2017/18 of £3m, this has been forecast for receipt in June within the 2018/19 cash flow.

The risk adjusted items relate to: PSF funding (previously STF) which is received if certain targets are met. The cashflow has three quarters included as the income is received in arrears. Quarter 4 will be included within 2019/20 cash flow.

The Trust has asset sales planned for January of £2.4m, if these are not achieved the associated capital expenditure will also not happen.

Also within quarter 4 the Trust has external loan capital financing of £2.5m, if the funding is not received the capital expenditure will not be spent.

The Trust has planned to receive PDC funding of £1.8m in March as part of the Linac replacement programme. If the funding is not received the Linac will not be purchased.

The Trust needs to repay the Single currency interim loan of £16.9m in February in order to repay this the Trust will need to request a further working capital financing of £6m.

## 6. Capital

### 6a. Capital Programme

#### Capital Projects/Schemes

	Year to Date			Annual		
	<i>Actual</i>	<i>Plan</i>	<i>Variance</i>	<i>Plan</i>	<i>Forecast</i>	<i>Variance</i>
	£000	£000	£000	£000	£000	£m
Estates	30	80	50	5,788	5,788	0
ICT	78	83	5	1,002	1,002	0
Equipment	105	217	112	6,501	6,501	0
PFI Lifecycle (IFRIC 12)	0	0	0	471	471	0
Donated Assets	0	42	42	700	700	0
<b>Total</b>	<b>214</b>	<b>422</b>	<b>208</b>	<b>14,462</b>	<b>14,462</b>	<b>0</b>
Less donated assets	0	-42	-42	-700	-700	0
Asset Sales (net book value)	0	0	0	-2,402	-2,402	0
Contingency Against Non-Disposal	0	0	0	0	0	0
<b>Adjusted Total</b>	<b>214</b>	<b>380</b>	<b>166</b>	<b>11,360</b>	<b>11,360</b>	<b>0</b>

The Trust has an approved Capital Plan of £14.5m, which is financed by Capital resources of £13.5m depreciation; proposed asset sales of £2.4m (Maidstone Residences); donated assets of £0.7m; planned bid for national funding for the next replacement Linac of £1.75m (LA5); a proposed Capital Investment Loan for critical imaging equipment of £2.5m; a proposed Salix loan of £1.2m for the additional Energy Infrastructure work; less £7.6m of existing loan repayments.

The business case for Estates Backlog Maintenance programme of works has been approved and schemes are underway, with other Estates projects and renewals being prioritised by the Estates Department. A major scheme for the Energy Infrastructure will be dependent on the successful application for a Salix loan and agreement from DH to provide the necessary Capital resource cover. The ICT schemes have been prioritised and approved by the ISG in principle but will require IAG Business case sign off. The equipment schemes are being prioritised and the final list will go to Execs for approval subject to individual Business case preparation as required. Linac 4 replacement at Maidstone was delivered in early May and commissioning the equipment will begin and be ready for clinical use by Oct 18. The donated equipment is mainly made up of the remaining Cardiology legacies, and a large donation for Urology/Oncology equipment.

## Trust Board Meeting – May 2018

## 5-11 Staffing (planned and actual ward staffing for April 2018)

Chief Nurse

The attached paper shows the planned v actual nursing staffing as uploaded to UNIFY for April 2018. This data is also published via the NHS Choices website and the Trust website as directed by NHS England and the National Quality Board.

**Wards of note this month include:**

**Acute Stroke Unit (Maidstone): sustained Improvement:** Reduction in incidence of falls has been maintained.

**John Day:** RN: CSW ratio shift. An accepted risk to ensure sufficient staff available to provide fundamental aspects of care. No change in nurse sensitive indicators noted in month.

**Chaucer:** High fill rate due to escalation of frailty assessment unit overnight for 14 nights.

**Edith Cavell:** Increased staffing requirements at night to support a number of patients under DoLS.

**Maidstone UMAU:** Escalated overnight,

**Ward 22/ASU:** Low RN fill rate, due to an inability to fill from Bank/Agency.

**CCU (TWH):** Low RN fill rate, due to an inability to fill from Bank/Agency

**Ward 32:** RN: CSW ratio shift accepted risk, as additional CSW required to support enhanced care needs (number of patients at risk of falls); fall rate 2 above agreed threshold.

**Ward 10:** RN: CSW ratio shift to ensure sufficient staff on ward to provide fundamental aspects of care and maintain a 'line of sight' level of observation. Ratio shift an accepted risk as unable to fill some RN shifts with temporary cover.

**Ward 12:** RN fill rate due to inability of bank or agency to fill requests. Falls rate 4 above agreed threshold.

**Ward 20:** Increased CSW requirement to support cohort care for patients with cognitive impairment and/or risk of falls. **Improvements** seen in falls, with 6 compared to 30 last month. This is below the agreed threshold of 7.

**Ward 2:** RN fill rate due to inability of bank or agency to fill requests. Falls rate 5 above agreed threshold.

**Planned vs. Actual**

The fill rate percentage is the actual hours used compared to the hours set in the budgeted establishment. That is, the budgeted establishment sets out the numbers of Registered Nurses and Clinical Support Workers based on an average acuity and dependency (or planned case mix for elective units). When units are faced with increased acuity and/or dependency, in escalation or undergo a service change that is not currently reflected in the budget, this is represented by an 'overfill'. Financial and key nurse-sensitive indicators have also been included as an aid to triangulation of both efficient and effective use of staff.

When the fill rate is only marginally over 100% by +/- 5% this is normally related to working patterns which required staff to work an additional shift periodically as long shifts result in a staff member either working over or under their contracted hours in any given month. The RAG rating for the fill rate is rated as:

Green: Greater than 90% but less than 110%

Amber Less than 90% OR greater than 110%

Red Less than 80% OR greater than 130%

The principle being that any shortfall below 90% may have some level of impact on the delivery of care. However this is dependent on both acuity and dependency. Acuity is the term used to describe the clinical needs of a patient or group of patients, whilst dependency refers to the support a patient or group of patients may need with activities such as eating, drinking, or washing.

High fill rates (those greater than 110%) would indicate significant changes in acuity and dependency. This results in the need for short notice additional staff and as a consequence may have a detrimental impact on the quality of patient care.

The exception reporting rationale is overall RAG rated according to professional judgement against the following expectations:

- The ward maintained a nurse to patient ratio of 1:5 – 1:7
- Acuity and dependency within expected tolerances

- Workforce issues such as significant vacancy
- Quality & safety data
- Overall staffing levels
- Risks posed to patients as a result of the above

**QuESTT:**

As reported last month, the 'overall RAG' ratings are being replaced with a more objective approach to the safety and effectiveness of a ward. The RAG ratings considered only nurse sensitive indicators which did not reflect other aspects of good leadership and multi-professional engagement with care.

The Quality, Effectiveness & Safety Trigger Tool (QuESTT) collection tool is now available to all wards. 60% of wards have now completed the QuESTT assessment and the scores are noted on the safe staffing dashboard.

The tool has 16 statements that are answered true or false (Table 1). The questions cover a range of domains including leadership, staff support, user feedback and incidence. Each question is weighted with a score between 1 and 3. Any ward or department scoring above 12 would give rise to further enquiry. The aim of the tool is to identify wards that may need additional support or intervention before any adverse impact on the clinical care and outcomes.

**Table 1**

QuESTT: <u>Q</u> uality, <u>E</u> ffectiveness and <u>S</u> afety <u>T</u> rigger <u>T</u> ool		Score if True		
Name of person completing review:		Date of Review:		
<b>Section One:</b> The content of this completed tool should be used to form the basis of a <i>monthly</i> multi-disciplinary review of the key quality indicators within a clinical area. The assessment should be made by the team leader and then validated by the members of the review group discussing the results. Section One acts as a trigger or early warning tool and must be assessed and completed each month. <i>Instructions: If the statement is true, insert a X in the cell (the score will be calculated automatically). If it is not true, leave blank.</i>				
Indicators	True?	1	2	3
New or no line manager in post (within last 6 months)				
Vacancy rate higher than 3%				
Unfilled shifts is higher than 6%				
Sickness absence rate higher than 3.5%				
<u>No</u> monthly review of key quality indicators by peers, e.g. peer review or governance team meeting				
Planned annual appraisals <u>not</u> performed				
<u>No</u> involvement in Trust-wide multi-disciplinary meetings				
<u>No</u> formal feedback obtained from patients during the month, e.g. questionnaires or surveys				
2 or more formal complaints in a month (Wards) or 3 or more (A&E or OPD) or 1 or more (CCU & IC)				
<u>No</u> evidence of resolution to recurring themes				
Unusual demands on service exceeding capacity to deliver, e.g. national targets, outbreak				
Hand hygiene audits <u>not</u> performed				
Cleanliness audits <u>not</u> performed				
Ward/Department appears untidy				
<u>No</u> evidence of <i>effective</i> multi-disciplinary/multi-professional team working				
Ongoing investigation or disciplinary investigation (including RCA's & infection control RCA's)				
<b>Overall Score:</b>				
Insert comments below (if appropriate):				

**Which Committees have reviewed the information prior to Board submission?**

- N/A

**Reason for receipt at the Board (decision, discussion, information, assurance etc.)<sup>1</sup>**

Assurance

<sup>1</sup> All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

April '18		Day		Night		Overall Care Hours per pt day	Nurse Sensitive Indicators						Financial review		
Hospital Site name	Ward name	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)		FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	QuESTT Score	Comments	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Acute Stroke	94.7%	89.2%	97.5%	100.0%	7.3	74.2%	91.3%	3	0	NS	RN fill rate due to inability to fill with bank / agency cover.	136,633	136,510	123
MAIDSTONE	Cornwallis (on Foster)	113.3%	116.7%	98.9%	104.5%	7.7	34.6%	97.2%	1	0	5	Area escalated for 2/7	89,447	73,005	16,442
MAIDSTONE	Coronary Care Unit (CCU)	98.3%	93.3%	100.0%	N/A	11.0	121.4%	100.0%	0	0	0		107,155	128,017	-20,862
MAIDSTONE	Culpepper	100.0%	95.0%	100.0%	100.0%	6.8	110.3%	100.0%	1	0	0				
MAIDSTONE	John Day	82.0%	118.5%	98.7%	96.7%	6.4	56.1%	90.6%	5	0	NS	RN:CSW ratio due to inability to fill RN shifts (vacancy and lack of temp staffing)	126,238	127,177	(939)
MAIDSTONE	Intensive Treatment Unit (ITU)	93.8%	105.0%	91.3%	N/A	48.9			0	0	3		155,506	167,462	(11,956)
MAIDSTONE	Pye Oliver	99.1%	89.5%	101.1%	100.0%	5.5	73.3%	90.9%	6	1	8	RN fill rate due to inability to fill with temporary staffing. Falls 1 above threshold	113,849	109,846	4,003
MAIDSTONE	Chaucer	115.8%	91.0%	141.7%	106.7%	9.5	17.1%	95.7%	3	0	8	Escalation of frailty unit on 14 nights and enhanced care requirements for 10/7	115,628	104,776	10,852
MAIDSTONE	Lord North	96.0%	123.3%	98.9%	96.7%	6.9	73.7%	96.4%	3	0	6	Chemotherapy trained nurse requirement Falls 1 above threshold	100,372	104,250	(3,878)
MAIDSTONE	Mercer	106.7%	96.7%	100.0%	101.7%	6.1	59.5%	81.8%	2	1	2		103,678	97,290	6,388
MAIDSTONE	Edith Cavell	99.1%	110.5%	98.9%	120.0%	6.1	129.4%	86.4%	4	0	0	Fill rate due to enhanced care requirements and supporting supernumerary CSW apprentice	69,757	72,374	(2,617)
MAIDSTONE	Urgent Medical Ambulatory Unit (UMAU)	87.4%	93.6%	125.6%	190.0%	10.7	8.5%	100.0%	2	0	4	RN fill rate due to inability to fill with temporary staffing. Area escalated at night	129,135	118,698	10,437
TWH	Stroke/W22	85.6%	100.7%	98.0%	97.8%	10.6	257.1%	94.4%	5	0	NS	RN fill rate due to inability to fill with temporary staffing.	147,193	141,743	5,450
TWH	Coronary Care Unit (CCU)	88.2%	86.7%	97.8%	N/A	10.7	79.3%	100.0%	1	0	0	RN fill rate due to inability to fill with temporary staffing. Enhanced care requirements reported on 3/7 Falls 1 above threshold	66,907	81,763	(14,856)
TWH	Gynaecology/ Ward 33	94.2%	96.7%	100.0%	100.0%	7.9	21.2%	93.5%	0	0	NS		77,920	74,468	3,452
TWH	Intensive Treatment Unit (ITU)	99.2%	96.7%	99.2%	103.3%	34.4	0.0%	-	0	0	5		184,533	192,073	(7,540)
TWH	Medical Assessment Unit	91.1%	95.8%	118.7%	100.0%	7.7	28.4%	92.6%	9	0	8	Escalation area Falls 3 above threshold	186,019	182,380	3,639
TWH	SAU	98.9%	96.7%	100.0%	96.7%	8.7			0	0	NS		60,652	62,179	(1,527)
TWH	Ward 32	82.8%	121.1%	98.9%	126.7%	7.1	48.2%	92.6%	8	2	8	RN fill rate due to inability to fill with temporary staffing. Enhanced care requirements on 23/7 Falls 2 above threshold	136,521	135,319	1,202
TWH	Ward 10	96.0%	99.2%	75.0%	160.0%	8.7	15.1%	100.0%	3	0	NS	RN:CSW ratio shift to maintain sufficient staff numbers to delivery fundamental aspects of care. Falls 1 above threshold	117,435	113,461	3,974
TWH	Ward 11	100.0%	107.8%	96.7%	106.7%	6.8	0.0%	0.0%	4	0	NS		123,751	126,799	(3,048)
TWH	Ward 12	80.1%	109.2%	100.0%	100.0%	6.6	24.6%	100.0%	10	2	NS	RN fill rate due to inability to fill with temporary staffing. Falls 4 above threshold	118,597	127,646	(9,049)
TWH	Ward 20	88.9%	120.8%	100.0%	121.7%	6.5	75.7%	53.6%	6	0	9	RN fill rate due to inability to fill with temporary staffing. Enhanced care requirements on a daily basis through the entire month	115,008	136,033	(21,025)
TWH	Ward 21	86.1%	120.0%	100.0%	118.3%	6.7	39.6%	95.2%	5	1	8	RN fill rate due to inability to fill with temporary staffing. CSW increase due to increased dependency and enhanced care requirements.	131,980	140,009	(8,029)
TWH	Ward 2	88.3%	101.3%	100.0%	98.3%	7.5	59.6%	87.1%	11	0	3	Reduced RNs due to both inability to fill with temporary staff, and 4 rooms closed for building works. Falls 5 above threshold	133,780	133,762	18
TWH	Ward 30	89.9%	103.7%	103.3%	91.1%	0.0	0.0%	0.0%	4	0	NS	RN fill rate due to inability to fill with temporary staffing	120,058	105,682	14,376
TWH	Ward 31	90.0%	105.0%	97.5%	96.7%	0.0	45.0%	92.6%	5	2	5		137,102	121,319	15,783
Crowborough	Birth Centre	93.3%	96.7%	96.7%	100.0%		29.8%	94.9%	0	0	NS		69,998	72,166	(2,168)
TWH	Ante-Natal	93.5%	93.5%	93.5%	71.0%	8.1			0	0	NS	MSW fill rate due to inability to cover speciality	670,000	652,270	17,730
TWH	Delivery Suite	98.1%	98.3%	93.3%	85.0%	28.8			0	0	NS				
TWH	Post-Natal	97.2%	95.6%	98.3%	67.8%	5.4			0	0	NS				
TWH	Gynae Triage	98.5%	100.0%	95.0%	93.3%				0	0	NS		9,190	11,977	(2,787)
TWH	Hedgehog	98.3%	60.0%	98.0%	80.0%	8.0	24.7%	95.7%	0	0	NS		179,806	197,921	(18,115)
MAIDSTONE	Birth Centre	98.3%	96.7%	100.0%	100.0%				0	0	NS		61,580	64,135	(2,555)
TWH	Neonatal Unit	108.3%	66.7%	103.3%	86.7%	10.7			0	0	NS		176,176	182,778	(6,602)
MAIDSTONE	MSSU	114.7%	95.5%	105.0%	N/A		21.7%	97.3%	1	0	NS	RN fill rate to meet increased acuity and activity; as increase in elective activity. Escalated 3/7	41,043	44,466	(3,423)
MAIDSTONE	Peale	113.3%	88.2%	100.0%	126.7%	8.9	20.0%	100.0%	1	0	2	Enhanced care required for 7/7	73,146	76,144	(2,998)
TWH	SSSU	100.0%	100.0%	100.0%	100.0%				0	0	10		118,751	138,438	(19,687)
MAIDSTONE	Whatman	94.5%	95.8%	101.1%	141.7%	5.7	116.7%	90.5%	8	0	NS	Additional CSW requirements to support enhanced care needs Falls 2 above threshold	97,360	105,234	(7,874)
MAIDSTONE	A&E	98.4%	82.0%	99.1%	96.7%		4.6%	91.7%	1	0	NS		193,788	222,584	(28,796)
TWH	A&E	101.4%	92.8%	103.1%	91.7%		23.5%	91.1%	4	0	NS		295,467	363,212	(67,745)
Total Establishment Wards												5,091,159	5,245,361	(154,202)	
Additional Capacity beds												36,003	33,655	2,348	
Other associated nursing costs												2,636,036	2,598,433	37,603	
Total												7,763,198	7,877,449	(114,251)	

RAG Key

Under fill

Over fill

## Trust Board meeting - May 2018



5-12	Winter review 2017/18 (incl. CQC letter on winter pressures in Emergency Departments)	Chief Operating Officer
	<p><b>Summary / Key points</b></p> <p>The Winter Review 2017/18 (enclosed) was circulated for discussion at the TME meeting on 25<sup>th</sup> April 2018 and further comments received on what worked well and what might be done differently next winter. The enclosed letter (Appendix 1) received from the CQC concerning winter pressures in Emergency Departments was discussed at the TME on 16<sup>th</sup> May 2018. Feedback from all of these sources will be considered in the planning process for the winter plan for 2018/19.</p> <p>The Winter Review 2017/18 (as circulated to the TME on 25<sup>th</sup> April) offers a comprehensive critical review of our winter plans for 2017/18, with an indication of the benefits realised from the initiatives we had in place. It has assessed:</p> <ul style="list-style-type: none"> <li>• the activity which we experienced,</li> <li>• the initiatives and plans themselves within each of the directorates to identify if they had the beneficial effect we intended</li> <li>• feedback from the winter debrief event which was held at the end of March.</li> </ul> <p>The lessons learnt from this review will be used in the planning process for the winter plan for 18/19. The review answers the questions :</p> <ol style="list-style-type: none"> <li><u>What challenges did we experience this winter ?</u> - 01-Dec-17 and 28-Feb-18 were 6.9% higher than the equivalent period last year. For most of the year (April to November) followed the previous year extremely closely, but the winter has been significantly higher than either the model or last year.</li> <li><u>Did our plans work as we thought across all directorates</u> – The assessment show that the majority of the schemes worked well, and some can be further developed to maximize their benefit, which will be taken forward within the winter planning process . The daily huddles with clinicians clearly allowed improved ownership and understanding of the daily pressures across the trust and risk for the next 24hrs., planning to reduce elective work to generate capacity was beneficial, along with the development of capacity in the community to reduce delayed discharges</li> <li><u>What should be our focus in planning for the 2018/19 winter.</u>- the same as this year, with the need to further improvement in patient flow, through the 'Best Care delivery programme'. To embed a clear understanding throughout the organisation of what staff can do when the organisation moves from Opel 3 to Opel 4 level. Secure more capacity in the community to allow the flow of patients out of secondary care when medically fit. Develop a digitalised approach to information to allow improved availability and access to up to date information to assist in decision making.</li> </ol>	
	<p><b>Which Committees have reviewed the information prior to Board submission?</b></p> <ul style="list-style-type: none"> <li>▪ TME, 25/04/18 and 16/05/18 (CQC letter)</li> </ul>	
	<p><b>Reason for receipt at the Board (decision, discussion, information, assurance etc.)<sup>1</sup></b></p> <p>Review</p>	

<sup>1</sup> All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance



## **Winter review 2017/18**

### **1.0 Introduction**

1.1 This paper offers a comprehensive and critical review of our winter plans for 2017/18, with an indication of the benefits realised from the initiatives we had in place. It has assessed the activity which we experienced, the initiatives and plans themselves within each of the directorates to identify if they had the beneficial effect we intended and feedback from the winter debrief event which was held at the end of March. The lessons learnt from this review will then be used in the planning process for the winter plan for 18/19

1.2 It answers the questions :

- d. What challenges did we experience this winter ?
- e. Did our plans work as we thought ?– what went well , what not so well and still need improvement?
- f. What should be our focus in planning for the 2018/19 winter

1.3 The planning for winter 2017/18 started in April 2017 and was managed through the Winter Planning and resilience group chaired by the COO with representatives from each of the Clinical Divisions and Estates & Facilities, HR and IT . Their objective was to ensure that the plans developed would deliver operational resilience for the winter period 2017/18. The aim of the plan was :

- a. To ensure that there are plans in place to manage the modelled increased activity scenarios and likely impact on bed capacity.
- b. Adopt and implement evidence based best practice, to reduce the number of non-elective medical admissions by a combination of the extended use of ambulatory care pathways, the establishment of an acute frailty service on both sites and reduced MFFD patients and to ensure internal processes and systems are fit for purpose and resilient to meet the anticipated level of demand,
- c. Maintain and optimise patient flow through the hospitals to provide safe emergency and elective care.
- d. To ensure that all support services have plans to meet the demand scenarios concerning increased activity throughout the hospital
- e. To ensure that there is appropriate, safe escalation plans in places which reduce the risk of medical outliers and negative impact on elective activity in surgery especially when escalation occurs in the theatre recovery areas.

### **1.4 Original Planning parameters**

1.4.1 For Winter 17/18 the following predictions had been identified

1) Total A&E attendances : The model was predicting total weekly attendances of 2,600 to 2,800 per week between Nov-17 and Feb-18, rising to 2,900 a week by the end of March – around 5% higher than the winter of 16-17.

- a. For Maidstone, the projection is 1,200 to 1,300 between Nov-17 and Feb-18, rising to 1,350 by the end of Mar
- b. For TWH, it's 1,400 to 1,500 per week, rising to 1,550.

Note that individual weeks can be up to 10% above or below projections

2) Ambulance arrivals were expected to be around 750-850 per week

- a. For Maidstone, we would expect 250-300 per week
- b. For TW, we would expect 500-550

These numbers will be higher if there is a protracted period of cold weather in the winter

3) Emergency admissions are more difficult to predict, as these no longer have a seasonal pattern. Emergency admissions were currently running at all time high of 900-950 per week, and this has been gradually rising from a low of 700-800 per week in late 2015. If the medium-term trend continues, then emergency admissions of 950-1,050 per week will be seen over the winter.

a. For Maidstone, it's currently around 325-375 a week, up from 250-300 per week in late 2015. If this continues, we could see 375-425 per week in the coming winter

b. For TW, it's currently 525-575 a week, up from 450-500 in late 2015. This could rise to 575-625 if the trend continues.

Current levels would probably be the low estimate, and the trend continuing would represent the high estimate

4) Non-elective LoS (excluding zero) had been fairly constant at 7.0 days for the last 2 years, with a tendency to rise by half a day or so in the depths of winter. This effect is usually only seen in Jan & Feb

5) Non Elective Bed Occupancy – bed occupancy modelled, with 85<sup>th</sup> percentile figures equals 679 beds occupied by non-elective patients. 384 at TWH and 295 at Maidstone based on last year (679 Total).

a. If the non-elective activity trends continued, then winter admissions could be 5-10% higher than they were in October.

b. If the usual 10% increase in NE LoS manifests at the same time, then they increase to 442 and 339 – a total of 781

1.4.2 The overall impact on beds means that we needed 339 at Maidstone and 442 at TWH. This means that we would be 36 short at Maidstone and 61 short at TW as a 'bad-case' scenario. Our plans were needed to cover this scenario but also contingency plans if activity began to rise considerably above our projections in autumn and beyond.

1.4.3 A worst case scenario, due to a few weeks of cold weather or a minor flu epidemic would raise this shortfall considerably to 45 at Maidstone and 68 at TWH.

1.4.4 If NE activity flattened off, then we would be 7 short at Maidstone and 29 short at TW. This could be considered a best (or at least better) case scenario.

Additional beds were not available and therefore the focus was on ensuring that there was improved flow of patients through our available bed stock and use of appropriate escalation of areas. The escalation policy was being revised as part of winter planning process.

## 1.5 Areas of focus

1.5.1 It was recognised early in the year that there were four consistent themes, where improvement in delivery and planning would make a significant difference in helping to manage the increased flow of urgent patients during the winter period:

- Activity
- Pathways
- Workforce
- Sustainability

### a. Activity planning

- *Non elective activity* : As in subsequent years it is likely that the trend of increased numbers of non-elective patients attending our A.E units would continue to rise,. The age profile of the patients is also increasing bringing added complexity to their treatment and subsequent discharge arrangements.

- *Elective activity* : The ability to undertake elective activity in previous winters was compromised when considering the parameters associated with the new Aligned Incentive contract, consideration should be made to profiling our contracted activity differently

b. *Improved Pathways*- Particularly for non-elective activity which focuses on the delivery of:

- Ambulatory pathways for all specialties
- Specialty units e.g. Frail elderly
- Acute assessment units

c. *Workforce*- This is a key issue each year, as with higher demands we have to secure increased staffing to support escalated areas often with significant financial cost, particularly if we need to use agencies

d. *Sustainability* - This falls into how best we can deliver our services and the configuration of our resources to achieve it the ever growing demands e.g.

- *Bed reconfiguration, escalation and de-escalation plans* to see how to best align non elective bed requirements with those of elective activity.

- *Bed stock and Future Use of space and facilities:*

National best practice concerning elderly frail units, larger multispecialty assessment units and engaging the GP service in our front of house flow of E.D patients will be developed and implemented in a phased way across our sites.

- *The change of use of theatres at TWH*

- *Patient flow*

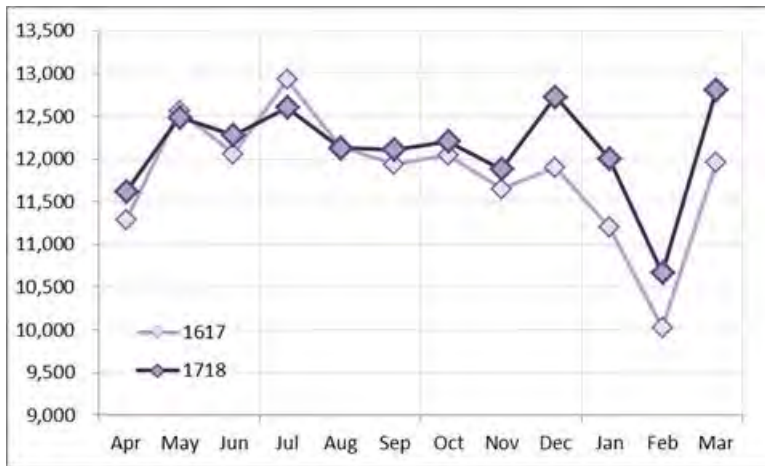
Each site will need to secure the correct number of discharges a day to cope with the numbers of admissions. This can only be achieved through continued improvement in operational ways of working in terms of *admission avoidance schemes* reducing LOS through 'SAFER' and securing maximum benefit in the *Home first programme*, developing increased capacity and use of pathway 3 beds in community

The review will reflect back on these core areas.

## **2.0 What did we experience in terms of demand ?**

2.1 We have a detailed model of expected activity across a number of areas and had used the historical activity to best model growth and likely activity during the winter period particularly for non- elective activity .

**2.2 Type 1 A&E attendances** between 01-Dec-17 and 28-Feb-18 were 6.9% higher than the equivalent period last year. For most of the year (April to November) followed the previous year extremely closely, but the winter has been significantly higher than either the model or last year.

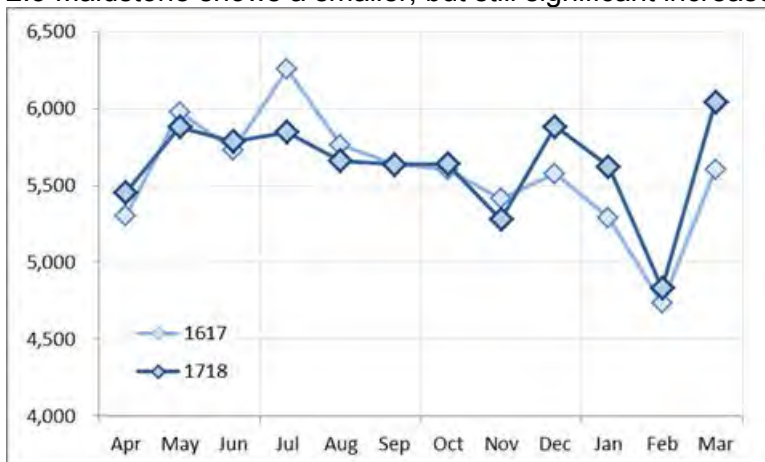


2.3 Splitting this to site level, the increase has mainly been at the TW site, with an increase of 8.8% over the winter compared to last year.

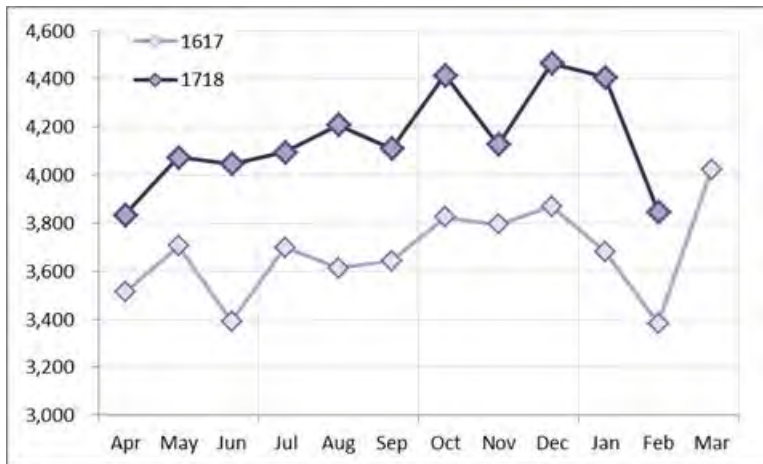


2.4 The step-up in activity at TW actually began in mid-November, with the week ending 26-Nov-17 logging the second highest attendances ever recorded at TW.

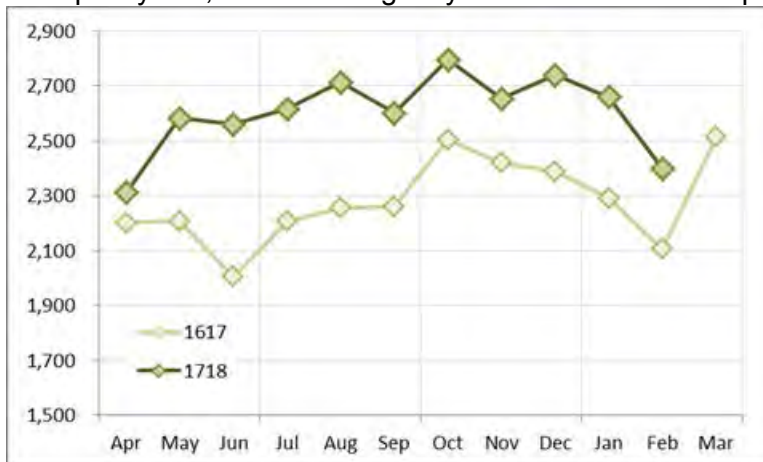
2.5 Maidstone shows a smaller, but still significant increase of 4.8%



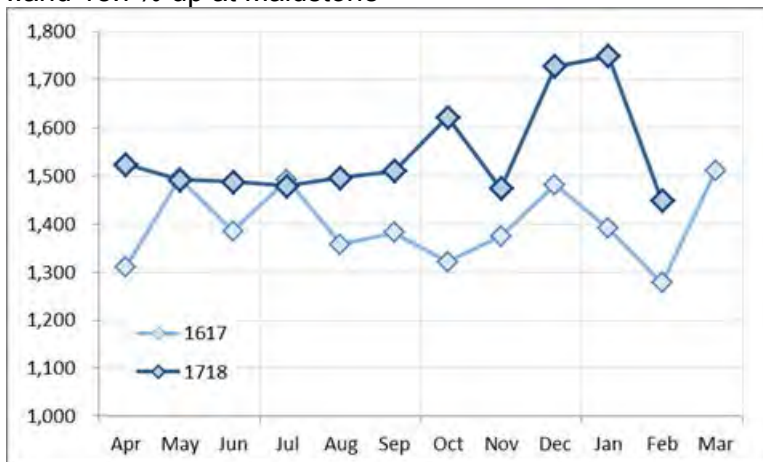
**2.6 Emergency Admissions** (not including maternity) are showing an even larger increase over last year, with a 12.8% increase on last year between April & November, and a 16.4% increase over the 3 winter months (Dec, Jan & Feb)



2.7 Split by site, Winter emergency admits were 14.9% up on last winter at TWH



..and 18.7% up at Maidstone



2.8 This increase is largely due to the increased use of Assessment & Frailty units, and increased capacity in CDU. Counting only the emergency admissions with LoS >0, we see around a 4.0% increase on admissions Trust wide. This demonstrates that benefits were delivered through the implementation of best practice

2.8 Age profiling is also an important aspect in understanding and managing demand . The age profile – splitting patients into 10year age bands

2.10 The total number of Emergency Admissions is up around 16%. Four bands are significantly different.

- 1) Patients under 18 are only up 2%
- 2) Patients in their 50s are up 25%
- 3) Patients in their 60s are up 10%
- 4) Patient in their 70s are up 27%

All the other age bands are not significantly different.

2.11 An increase in elderly patients would be expected thanks to the frailty unit – but interestingly it's only the 70-79 band that is up above base

2.12 The smaller than expected increase in the 60s band is only just significant, so it may be nothing.

2.13 The larger than expected spike in the 50s group has a higher significance & no obvious explanation

2.14 In summary – we had planned for higher levels of non-elective activity over the winter period but had to manage significantly high volumes than expected.

2.15 As part of the winter planning process, this data will be broken down further into HRG and disease types to see where the greatest clinical pressures lay. This will enable better understanding as to local pressure on these particular specialties and allow planning of resourcing to be in place for 2018/19

### **3.0 What did our Divisional plans include and how successful were they ?**

#### **3.1 Urgent care**

Initiative	Explanation of what it involves	The likely benefit	Did this take place? Measurable benefit – e.g. how many . add comment
1. <i>Extending hours of Discharge Lounge at TW to close at 20.00hr</i>	<i>Staff consultation underway. Looking at staffing requirements and cost but expecting to be able to do this without additional resources by staggering start/finish times.</i>	<i>More patients will be able to be transferred to the Discharge Lounge later in the afternoon which frees up beds on the wards to support better flow.</i>	Staff consultation was completed and the discharge lounge opened for extended hours within their staffing establishment by staggering shift times. Staff long term sickness resulted in extended opening hours being stopped in mid-December as bank unable to back fill. Use of the lounge was minimal from 16;00 and audited by Band 7 (report to be attached when received). Wards and patients unhappy to use lounge later during winter relating to the weather and pharmacy supplies.
2. <i>Reducing OP clinics over the weeks of 18<sup>th</sup> Dec, 27<sup>th</sup> Dec and 2<sup>nd</sup> Jan and allocating consultants and Regs to wards for additional ward rounds.</i>	<i>This has been agreed by Site Leads. Clinics being cancelled.</i>	<i>Improved discharge profile on the key weeks leading up to and after the Xmas/New year period to support flow and safety</i>	Outpatient clinics were reduced by approximately 1/3 <sup>rd</sup> over this period. Reduction of outpatient activity allowed senior daily ward rounds. Gastro team led the medical outliers team ensuring that medical outliers were seen in a timely manner Directorate non-elective LoS

Initiative	Explanation of what it involves	The likely benefit	Did this take place? Measurable benefit – e.g. how many . add comment
			reduced from 13.1 days (16/17) to 11.6 days (17/18) Area of biggest reduction was Elderly Care with a reduction from 13.0 days (16/17) – 11.4 days (17/18)
3. <i>Consultants to provide their leave requests for the 3 week period from 18<sup>th</sup> Dec to 5<sup>th</sup> Jan to be submitted by October</i>	<i>Asking consultants to comply with this request (officially only need to give 6 weeks' notice)</i>	<i>Will allow us to roster senior decision makers to each ward as described in point 2.</i>	Yes – significant majority of Consultants complied with this request however there were some outliers that did not submit requests by requested deadline despite repeated requests
4. <i>'Outlier' medical team to support winter resilience. Supported by both site leads and CD and management team.</i>	<i>Suggested team consisting of: 1 consultant 1 reg/ staff grade 2 Juniors 1 senior nurse 1 pharmacist</i>	<i>Better continuity in reviewing the patients by the same team would improve flow by reducing the LOS of the medical outliers</i>	Yes, Medical outlier team was assembled through temporary agency/bank staff. This time backfilled the Gastro team to allow gastro team to take lead on seeing medical outliers in a timely and responsive manner. This was deemed to be very successful and something that will continue to be part of the plan next year. Whilst LoS is not measured in isolation for medical outliers they are included in the Spec Med non-elective LoS figures as above and despite seeing a 5% increase on attendances/admissions overall the length of stay reduced due to measures that were put in place.
5. <i>Senior nurse to be seconded to support the medical Post Take Ward Round each morning in ED/AMU</i>	<i>CSP has agreed to a 6/12 secondment to undertake this role, starting from 1<sup>st</sup> November</i>	<i>Improved patient flow and reduction in Stranded Patients</i>	Band 8A took on this role over the winter period. Was deemed successful and full evaluation being completed. Supported prompt start of medical PTWR each morning, discharge of DTA's in ED whenever possible by enhanced communication across internal and external partners. Supported safe identification of patients fit to Board as per policy, worked closely with the CSM's to ensure 12hour breaches were placed within correct timeframe. Improved relationships with medical teams.
6. <i>ED improvement -is securing Internal</i>	<i>Improve timeliness of 1<sup>st</sup></i>	<i>Improved reaction time to patients</i>	Yes, benefit difficult to ascertain but complaints from ED team



Initiative	Explanation of what it involves	The likely benefit	Did this take place? Measurable benefit – e.g. how many . add comment
professional standards concerning appropriate and safe reaction time and decision making to support patient flow through the department. This is supported by a newly developed breach report	clinical assessment Breach report circulated to all specialties highlighting breach reasons on a daily basis Review of handover delays Improvement in real time tracking	needed specialist review within E.D	regarding long waits for specialty referrals have anecdotally improved
7. Implementation of the front-door GP streaming model,	A&E departments are then free to treat for the most urgent patients. This includes the estates changes to support this pathway following a successful capital bid	The timely review of the most urgent patient within E.D. by diverting patients away from minors	Yes, measurement period from 12 <sup>th</sup> Jan to 31 <sup>st</sup> March: TW use of GP has increased from 0.7 pts/hr to 2 pts/hr MH use of GP has increased from 1.2 pts / hr to 2 pts/hr. Positive impact on ED has been masked by increased level of attendances
8. Improving flow- Embedding of SAFER and implementing a review process of the stranded patients	Review of wards against new CUR (Clinical Utilisation Review) data identifying themes/ action plans for stranded patients. A key to improving this is the process to identify stranded patients which can now occur through the Clinical Utilisation Review (CUR) software initiative . The Stranded Patient metric is be implemented, putting a focus on all patients with a LOS of 7 days and	Secure appropriate but well planned patient discharges in a timely way	Partially CUR implementation not yet fully embedded however good process has been made. Accurate and timely data inputting has been negatively impacted by staffing shortages. Plan in place to ensure this data is collected (Flow Co-ordinators) from summer. Stranded Patient report now received daily and reviewed by matrons and senior managers. Numbers have reduced since 1 <sup>st</sup> Feb for both Stranded and Super Stranded cohorts.  Electronic Day Before actions not implemented  EDN pilot – not aware of outcome of pilot

Initiative	Explanation of what it involves	The likely benefit	Did this take place? Measurable benefit – e.g. how many . add comment
	over EDN project group working with Telelogic on final simplified EDN to be piloted on 4 wards. Rollout of electronic Day Before Actions forms on 2 wards		
9. <i>Go Green for Winter</i>	<i>Red and green days will be introduced as a visual management system to improve flow and identify where patients are delayed. A Red Day is a day of no added value to the patient. A Green day is a day of value to the patient where a patient receives active medical treatment or diagnostics on the day that they have been requested. These will be monitored on a daily basis through the site meetings</i>	<i>To ensure that patients are identified and then receive timely treatment to reduce their LOS</i>	No, following discussion with senior team it was felt that the winter period was not the right time to bring in a new initiative without proper education and training. ECIP supporting trust with developing this concept within the organisation.
10. <i>Implementation of Home First in Full (pathways 1 &amp; 2 already in place)</i>	<i>A model for Pathway 3 has now been identified and a Standing Operating Procedure has been developed as a guide to the processes to be used through proof of concept.</i>	<i>Ability to move 30 MFFD patients from acute beds into a community setting awaiting further assessment of their future needs. This will generate physical bed capacity within the acute hospital setting</i>	Yes, an average of 30 places has been used to support pathway 3. Evaluation of Home First undertaken and presented to the Home First Programme Board. In discussion with partners and CCG regarding ongoing funding.

Initiative	Explanation of what it involves	The likely benefit	Did this take place? Measurable benefit – e.g. how many . add comment
	<i>This guide will be updated as the model develops through the proof of concept phase.</i>		
11. The escalation and de-escalation policy been reviewed	<p>These reflect the changes in bed availability this year compared to last year and ensure that the escalation ladder reflects the operational objectives, needs and priorities of the organisation. To also ensure that that agreed policies such as patient 'ward boarding' are understood and implemented</p> <p>Current available escalation capacity is Foster Clark at Maidstone, however, the use of this ward for transferred elective work from TWH would mean that Peale ward could close and then be available for escalation for non-elective activity if required, recognising that patients (possibly MFFD) would need to move between sites</p>	A comprehensive plan / policy which educates the organisation as to how, where and when escalation can take place. Also what it means to staff in terms of additional actions required	<p>Yes, escalation policy approved though all appropriate levels and on Q Pulse.</p> <p>Boarding policy used more widely this winter than previously but with no patient harm caused. OPEL escalation used more effectively this winter and the notice boards were a positive addition to ensure staff were kept updated although further work needed to spread this across whole organisation.</p> <p>Foster Clark used successfully to support additional capacity and closed within planned timeframe.</p> <p>Between Dec and Feb on average there were 57 beds escalated , of which Maidstone at 22 and TWH at 35 .</p> <p>The escalation and de- escalation plans worked well , within the limitations of theatre recovery areas which had to be used . Pre identified Over flow Areas with E.D at TWH also had to be used in peak pressure periods .</p>

Initiative	Explanation of what it involves	The likely benefit	Did this take place? Measurable benefit – e.g. how many . add comment
<i>12. Workforce – reduce the risk of Flu outbreaks affecting both staffing and patients</i>	<i>–to secure 70% + inoculation rates amongst our staff and encourage risk patients to have their injections</i>	<i>Reduced risk of high staff sickness rates over the acute winter period</i>	Compliance for Urgent Care 41% This could be better, particularly for key front line staff. Vaccinations were available throughout the winter period and as more acutely unwell flu patients were admitted, staff uptake improved. Challenge for next winter is how we improve uptake across the trust.

3.1.1 The provision of on average 40 beds purchased in the community, has significantly helped in the flow of patients waiting for social services support and pathway 3 type patients (22 beds are occupied under the Pathway 3 scheme and a further 24 patients are being managed through the commercial bed scheme) It is recognised that this level of addition capacity is required through the year and to be enhanced over the winter periods. Securing access to this level of community bed capacity will be central to our ongoing planning process.

3.1.2 Debrief group feedback :

- The instigation of winter huddles proved very successful especially in engaging medical staff in understanding the pressures on the health system.
- The CCG must review the G4S contract as this undoubtedly caused significant delays and extra costs to the trust. The service provided was ineffective and almost non-existent during the bad weather. A further review of NRS for equipment needs to be carried out.

### 3.2 Planned care

Initiative / Plan Planned care	Explanation of what it involves	The likely benefit	Did this take place - Measurable benefit – e.g. how many . add comments
Maintaining elective activity at Maidstone	<p>All Theatre lists will run as normal in Main theatres, EMU and MSSU – except lists cancelled due to AL</p> <p>MOU will be run 10 sessions per week and will not feature as part of escalation – this will involve elective Orthopaedic lists being moved in addition to those currently allocated to MOU to ensure it is fully utilised and maximum elective activity is maintained</p>	Ensure elective activity will continue at Maidstone at normal levels and so help maintain cancer performance	<p>Cornwallis ward moved to Foster Clarke ward on the 2nd December which enabled an extra 9 beds to be opened to accommodate the ENT and Gynae elective activity being moved out of TWH</p> <p>Whilst the extra beds on Foster Clarke were also used at times for Medical outliers, no elective activity was cancelled at Maidstone compared with last year and MSSU had no medical outliers at all.</p> <p>In addition at the end of Feb the Four eyes programme to improve theatre capacity commenced and so additional cases were being added to Theatre lists at Maidstone. In order to help accommodate extra activity the Orthopaedic lists going through MSSU the patients were sent back to MOU post operatively and this will continue.</p> <p>MOU and MSSU were all closed when possible over the Christmas period and up until March when activity was low to help staffing levels and</p> <p>Trauma cases were added to the MOU lists although this had to be carefully managed due to equipment resource. This can be repeated throughout the year although the organisation and communication between all parties concerned needs to be more robust.</p>
Moving elective activity from TW to MH	As many lists as possible will be moved across to Maidstone. Consultants are being asked to provide advance notice of leave now	To maximise as much elective activity as possible to sustain the RTT position as achieved	Cornwallis ward moved to Foster Clarke ward on the 2nd December which enabled an extra 9 beds to be opened on the 11 December to accommodate the ENT and Gynae elective activity being moved out of TWH

Initiative / Plan Planned care	Explanation of what it involves	The likely benefit	Did this take place - Measurable benefit – e.g. how many . add comments																				
	<p>rather than 6 weeks ahead to ensure this is planned well in advance in order to protect as much elective activity as possible</p> <p>Plan for moving as much of gynaecology and ENT elective activity from TWH to Maidstone over the winter period to be examined and implemented if feasible</p>	<p>at the end of Dec throughout Jan / Feb rather than worsen by 500 patients as has occurred in the last 2 years through cancellations.</p>	<p>A staff consultation had to be performed before the moves could take place.</p> <p>In 2017 379 patients were cancelled for surgery in the same period in 2018 29 patients were cancelled.</p> <p>A total of 71 theatre sessions which took 13,353 minutes were moved from TWH to MS, an additional 172 patients were treated in these sessions.</p> <p>These sessions were split over the following specialties:</p> <table><tr><td>General Surgery</td><td>1</td></tr><tr><td>Vascular</td><td>1</td></tr><tr><td>Paediatrics</td><td>2</td></tr><tr><td>Urology</td><td>3</td></tr><tr><td>LGI</td><td>5</td></tr><tr><td>Ophthalmology</td><td>5</td></tr><tr><td>Breast Surgery</td><td>6</td></tr><tr><td>T&amp;O</td><td>6</td></tr><tr><td>ENT</td><td>11</td></tr><tr><td>Gynae</td><td>31</td></tr></table> <p>This compares to 137 ENT and 244 Gynae patients identified in the feasibility proposal. However if these were not moved it would have been highly likely that these patients would have been cancelled.</p>	General Surgery	1	Vascular	1	Paediatrics	2	Urology	3	LGI	5	Ophthalmology	5	Breast Surgery	6	T&O	6	ENT	11	Gynae	31
General Surgery	1																						
Vascular	1																						
Paediatrics	2																						
Urology	3																						
LGI	5																						
Ophthalmology	5																						
Breast Surgery	6																						
T&O	6																						
ENT	11																						
Gynae	31																						
Escalation plan for MH involving surgery	Up to 6 IP beds will be offered towards winter escalation for Urgent care to use as part of the wider	To provide medical bed space without impacting on surgical activity to	Surgical beds were utilised for medical patients as predicted although this did not stop the elective activity going through the surgical bed base.																				

Initiative / Plan Planned care	Explanation of what it involves	The likely benefit	Did this take place - Measurable benefit – e.g. how many . add comments
	Escalation plan	support A&E performance as part of escalation plan	At Maidstone on average 21 beds were escalated each day – range 0 – 46 Total 2,594. Unfortunately this data is not collated by speciality so we are not able to tell how many of the escalated beds for medicine were on Foster Clarke.  There were on average 53 MFFD patients on site, a total of 6425 bed days “lost” during the winter.
Implementation of either Plan A or B (between 23 <sup>rd</sup> Dec and 19 <sup>th</sup> Feb) at Tunbridge Wells for elective care based on progress of Urgent care schemes – final decision to be taken at end of October	<p><b>Plan B</b> - If SSSU remains fully escalated and it is likely that the site needs to use Recovery 1 or 2 for escalation then only 4 theatres will be open – 3 used for emergency work and the remaining one allocated to ENT, Gynae, Ortho for cancer work or 52 week breaches. TW Orthopaedic Unit would be reallocated in full to NEL beds</p> <p>In both options above SSU will also be staffed to operate an admissions lounge process which again will help flow of any elective activity that does take place.</p>	<p>Ensure elective activity can continue at TWH for those specialities with the highest RTT backlogs to maintain position as at start of winter (i.e. does not worsen) as well as maintain cancer performance.</p> <p>This also increases capacity for NEL patients especially for surgery by ensuring extra emergency theatre is in place, thus reducing pre-operative LOS</p>	<p>SSSU and Recovery 1 were escalated for at least 16 weeks and Recovery 2 for 12 weeks. This was managed in a more controlled manner which worked well enabling good communication between SSSU staff, theatre staff and management</p> <p>Escalation guidelines were written and ratified to support the escalation process.</p> <p>SAU remained constantly escalated which inhibited the non-elective surgical flow.</p> <p>SSSU and SAU were however completely de-escalated just before Christmas</p> <p>Having non-clinical staff volunteer to assist in the escalation areas was a huge benefit. They made beds, performed tea/coffee rounds and helped with meal times.</p> <p>At TWH an average 35 beds were escalated each day – range 10-69 Total 4,224</p> <p>There were on average 65 MFFD patients on site, a total of 7514 bed days “lost” during the winter period.</p>



Initiative / Plan Planned care	Explanation of what it involves	The likely benefit	Did this take place - Measurable benefit – e.g. how many . add comments
			<p>Having both Recoveries and Holding bay escalated did mean that flow through emergency theatres was restricted at times especially when emergency recovery was also blocked by patients waiting to get to ITU.</p> <p>The exact number of cases performed across both sites can be found in Appendix 1. Overall there were 1,000 elective cases done in the same period when compared to Winter 16/17. The only speciality that did more cases was T&amp;O. There are a number of reasons why the number of cases were lower which included snow (which did not occur in Q4 2016/17), reduction in General Surgery cases at MH following NHSE instruction to cancel all non-urgent cases in Jan (these were not expected to happen as part of Project ICE) and there were less cases that could safely be moved across to MH from TW.</p> <p>382 trauma lists occurred during the winter period, operating at an average of 106% utilisation and 92 sessions operating at more than 12% utilisation.</p> <p>During the winter period NE LOS at TWH was:</p> <ul style="list-style-type: none"> <li>• T&amp;O reduced from 10.39 to 9.96</li> <li>• General Surgery increased from 4.95 to 5.65</li> <li>• ENT reduced from 3.06 to 2.36</li> </ul> <p>The reduction in LOS for Trauma was attributed to more patients having access to Theatre much earlier as in Feb 90% of #NOFs were operated on within 36 hours of admission</p>

Initiative / Plan Planned care	Explanation of what it involves	The likely benefit	Did this take place - Measurable benefit – e.g. how many . add comments
			<p>Plans:</p> <ul style="list-style-type: none"> <li>• Revisit the escalation process guidelines for all these areas.</li> <li>• Trigger points to be implemented when the Trust is in OPEL 3 &amp; 4 so that extra catering and linen are automatically provided to escalation areas.</li> <li>• Review the CEPOD Theatre capacity for General Surgery</li> <li>• Lack of toilet and washing facilities were a huge problem and in full escalation there are only 7 toilets for 42 patients.</li> <li>• No patient chairs, patient trolleys, commodes and TV's for patients in the escalation areas.</li> <li>• Admission lounge to be implemented for all admissions via SSSU</li> </ul>
Ambulatory care pathways for I&D and orthopaedic cellulitis/sepsis	<p>Develop ambulatory pathways so they are agreed, documented and circulated to the appropriate staff.</p> <p>Explore other possible ambulatory pathways for implementation.</p>	These pathways will assist in reducing surgical admissions and length of stay.	<p>I&amp;D abscess ambulatory pathway implemented which only worked when there was no escalation in SSSU and SAU. This pathway has been reviewed and a new process is being submitted for agreement and start date.</p> <p>Extension of orthopaedic block lists, worked well when could be staffed properly. One block list per week, added an extra two lists per month with an average of 5-7 patients on each list who went through without needing beds</p>
Cancelled operating lists between 23 <sup>rd</sup> Dec and 19 <sup>th</sup> Feb	<ul style="list-style-type: none"> <li>• Surgeons who have their lists cancelled in a planned way will be asked to undertake clinics instead to ensure activity and waiting times are reduced here.</li> <li>• Those who still have their lists cancelled on the day will be asked to support the emergency</li> </ul>	As above but focus more towards maintain OPD activity and reducing waiting times here	<p>Anecdotal evidence is that conversion from theatre lists to OP was patchy.</p> <ul style="list-style-type: none"> <li>• Surgery used the 2 displaced surgeons as “surgeon of the day” in Tunbridge Wells.</li> <li>• Orthopaedics – 9 theatre sessions were converted into Out-Patient Clinics</li> <li>• Head and Neck – provided additional adhoc work</li> </ul>

Initiative / Plan Planned care	Explanation of what it involves	The likely benefit	Did this take place - Measurable benefit – e.g. how many . add comments
	<p>teams in undertaking ward rounds, operating etc.</p> <ul style="list-style-type: none"> <li>In some areas it may be possible to allocate more surgeons / anaesthetist annual leave during this period than normal, as long as services are covered.</li> </ul>		
Increasing elective activity before 23 <sup>rd</sup> Dec across both sites	In run up to December extra activity at weekends and ensuring all existing sessions are fully utilised within theatres will be pushed as much as possible to mitigate any loss of activity in Q4.	Improve RTT position and reduce waiting times before head into Winter as part of plan to return to 92% aggregate by end of November	From October 2017 there was a decline in RTT performance with a significant increase in the backlog. This was following unforeseen complications prior to go live of the new PAS. This resulted in the Trust being non-compliant at a speciality level for almost all specialties, however the majority of the backlog is still concentrated in three specialties of ENT, T&O and Gynaecology. Further non urgent elective activity was cancelled in January particularly in specialist medicine to cope with higher than planned NEL winter pressures but despite this the Trust reported an aggregate performance of 83.6% which is slight improvement from December.
Implement a Non-elective Matron for TWH only from 1 November – 31 March 2018	Matron to support all surgical specialties to optimise patients and assist with the stranded patients on a daily basis	Optimise discharges within surgery and assist with the push/pull of patients from A&E	<p>Non-elective Flow co-ordinator implemented from 11 December 2017 - 1 May 2018 to concentrate on the push-pull of patients from A&amp;E, SAU and the wards, Red/Green days and the stranded patients across all surgical specialties</p> <p>KPI's implemented which demonstrate some improvement. The role will discontinue on 28 April and an evaluation paper written.</p> <p>Plan: Not to implement this role for next year but to implement a discharge facilitator linked to IDT to work between ward 30 and 31</p>

Initiative / Plan Planned care	Explanation of what it involves	The likely benefit	Did this take place - Measurable benefit – e.g. how many . add comments
Critical care capacity to meet peaks in demand within the Trust and within the local network.	<p>Escalation for physical Critical Care Capacity and patient dependency occurs on both the Tunbridge Wells and Maidstone sites during peak demand periods. Whilst Maidstone ICU is currently staffed for a dependency of 7, 14 physical bed spaces are available within the ICU to admit patients. At Tunbridge Wells Hospital the ICU is currently staffed for a dependency of 7 although there are 9 physical bed spaces and with the colocation of Non Elective Recovery provides the use of a maximum 2 further bed spaces, an ICU bedside workstation is in place to facilitate this.</p> <p>Both Intensive Care Units submit twice daily updates to the National NHS Directory of Services (DOS) online Critical Care bed capacity system and daily to the Emergency Bed Service.</p> <p>At TWH there are 3 extra wte posts to help facilitate escalation into Recovery by providing a good core staff base to enable a critical care “staff bank” to function and cover when we need to escalate.</p>	All escalation is dependent on a suitably trained workforce and staff are utilised flexibly across site on a daily basis to accommodate patient need. This may be supported by the Critical Care Outreach Service if required	<p>ITU at TWH remained escalated most of the time with 1-2 patients also in emergency recovery. Issues were lack of staffing and for patients in recovery these were nursed by the outreach team which encroached on the service daily.</p> <p>Due to patients conditions TWH ran out of ventilators and had to share with MDGH</p> <p>Plan:</p> <ul style="list-style-type: none"> <li>• Revisit escalation plan for ITU and review equipment resource.</li> <li>• Review staffing and outreach facility.</li> </ul>

**Appendix 1 - Elective Activity through both sites during Dec – March (2 years compared)**

	ENT	GENERAL SURGERY	GYNAE	OPHTH	TRAUMA & ORTHO	UROLOGY	GYNAE ONCOLOGY	Grand Total
17/18	359	3324	512	1620	899	618	127	7459
16/17	488	3863	607	1803	879	759	141	8540
Variance	129	539	95	183	-20	141	14	1081

**3.3 Radiology , Pharmacy , Pathology**

<b>Diagnostics and Clinical Support</b>	<b>Explanation of what it involves</b>	<b>The likely benefit</b>	<b>Did this take place - Measurable benefit – e.g. how many . add comments</b>
1. 7 day pharmacy service will be provided	The main challenge concerns staffing levels , however these are currently being improved prior to winter	Allow improved discharge arrangements over the weekend	Seven day services were maintained over the winter period. EDN turnaround times on both sites were below the national average
2. Outsource CT Scan capacity	This will be for routine tests in run up to winter to ensure internal capacity free for NEL patients	To ensure 6 week diagnostic target maintained throughout winter for CT	Measure was specific to this winter as CT waiting time had increased.
3. Increased phlebotomy service	To increase staffing x 1 per day on both sites	To ensure capacity increased to meet demand and assist in improving flow for NEL patients	Anecdotal evidence for additional Phlebotomy support was well received. We are considering way of providing this all year rather than just in winter.
4. Increase mortuary capacity	To increase mortuary capacity internally and by working with partner organisations	To increase mortuary capacity by 100 for the winter period to cope with potential increase in demand	Mortuary – capacity was severely tested in November and December. Business continuity plan was fully employed but we came very close to running out of capacity. All other Trusts around us experienced high volumes of deceased and so we could not transfer bodies between sites (also a legal issue if paperwork not completed/family consented). Business continuity actions included:

Diagnostics and Clinical Support	Explanation of what it involves	The likely benefit	Did this take place - Measurable benefit – e.g. how many . add comments
			<ul style="list-style-type: none"> <li>• Additional capacity brought in at start of November (Nutwells)</li> <li>• Sharing storage for two deceased (minimised as much as possible)</li> <li>• Contacting funeral directors and crematoriums to take bodies sooner where possible</li> </ul> <p>Visibility of capacity issues was addressed with a twice daily report being sent out to COO and to me.</p> <p>Business case has been submitted to increase racking in mortuary for additional capacity and estates were reviewing adding in another power point in TWH to allow additional temporary storage to be brought in for the winter..</p>

## Debrief comments -

- During the winter NHS England required Trusts to cancel non urgent activity to allow staff and resources to concentrate on the non-elective flow. The trust had already considered this by reviewing activity and moving to Maidstone to free up capacity at Tunbridge. The pre-emptive cancellation and movement of elective patients to the Maidstone site was very successful in reducing last minute cancellations and allowing planning of beds on both sites.
- In particular areas such as theatres felt that the level of pre planning meant that they knew how and what to staff and led to improved safety in what and when recovery and holding bays were escalated.

### 3.4 Women's and children

Initiative	Action	Benefit	Did this take place - Measurable benefit – eg how many . add comment
<i>Maintain elective activity RTT performance</i>	<ul style="list-style-type: none"> <li>• <i>Continue with waiting list sessions</i></li> <li>• <i>Move DC and IP gynaecology to Maidstone (as theatre capacity allows)</i></li> <li>• <i>Ensure compliance with ambulatory pathways</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>Ensure elective activity will continue to maintain RTT performance</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>Able to do some elective activity at Maidstone</i></li> <li>• <i>Need to plan better, refine the criteria for which cases can be done at Maidstone</i></li> </ul> <p><i>so able to do more , if have clear sessions rather than ad hoc depending on annual leave gaps in other services eg a set day each week</i></p>
<i>Preserving elective activity – linked with implementation of either Plan A or B as part of Planned Care initiatives outlined in section 4.0</i>	<ul style="list-style-type: none"> <li>• <i>As per planned care</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>As per planned care</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>Agree annual leave rules for all staff groups so have enough staff for peak activities</i></li> <li>• <i>Switch ward 33 for the 'A&amp;B' side of the level 3 ward – draft plans in progress- have protected beds in the 'summer' months so able to do more elective work , then switch when winter pressures increase</i></li> </ul>
<i>Cancel operating lists between 23<sup>rd</sup> Dec and 19<sup>th</sup> Feb</i>	<ul style="list-style-type: none"> <li>• <i>Surgeons who have their lists cancelled in a planned way will be asked to undertake clinics instead to ensure activity and waiting times are reduced here.</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>As above but focus more towards maintain OPD activity and reducing waiting times here</i></li> <li>• <i>Improve RTT position and</i></li> </ul>	<ul style="list-style-type: none"> <li>•</li> </ul>



Initiative	Action	Benefit	Did this take place - Measurable benefit – eg how many . add comment
	<ul style="list-style-type: none"> <li>Those who still have their lists cancelled on the day will be asked to support the emergency obstetric teams in undertaking ward rounds, operating etc.</li> <li>In run up to December extra activity at weekends and ensuring all existing sessions are fully utilised within theatres will be pushed as much as possible to mitigate any loss of activity in Q4.</li> <li>Allocate registrar to review all women on ward 33 to start discharge processes</li> </ul>	<p>reduce waiting times before head into Winter as part of plan to return to 92% aggregate by end of November</p>	
Emergency gynaecology	<ul style="list-style-type: none"> <li>To extend the opening hours of EGAU to 8 pm dependant on staffing availability when in OPAL 3/4?.</li> </ul>	<ul style="list-style-type: none"> <li>Help to manage the flow of these patients when the trust is experiencing high demand</li> </ul>	<ul style="list-style-type: none"> <li>Possibility of extending to 10 pm if have bank staff to cover the work</li> <li>Look to convert maternity and ward 33 nurse money into a combined nurse post so able to work between both maternity (elective c./section) and ward 33, mat attract more staff, shared post</li> </ul>
1. Emergency Paediatrics	<ul style="list-style-type: none"> <li>5 escalation beds on Hedgehog ward will be escalated from Nov 1st. There is an escalation policy in place.</li> <li>Once Hedgehog is full then further escalation occurs in Woodlands dependant on staffing.</li> <li>Making woodlands a staff 'B&amp;B' when snow came, kept staff safe and able to work consecutive shifts</li> </ul>	<ul style="list-style-type: none"> <li>To manage peaks in demands</li> <li>Check policy shows clear actions to be taken , so able to flex when needed</li> </ul>	<ul style="list-style-type: none"> <li>Planned closure of woodlands and Riverbank to help wood and Ed areas- close over Christmas &amp; New Year</li> </ul>

Initiative	Action	Benefit	Did this take place - Measurable benefit – eg how many . add comment
2. Maternity flows	<ul style="list-style-type: none"> <li>Upgrade discharge lounge on post-natal ward to encourage early vacated beds</li> <li>Increase ward clerk hours on delivery suite 1400-2000hrs to ensure no patient flow delays due to paperwork</li> <li>Follow escalation policy on Q pulse</li> <li>This includes network divert on a case by case basis if needed- depends on everyone else's status</li> <li>Working with IT to get possible forecast of clinical numbers for maternity so able to predict activity</li> </ul>	<p>Did not happen as more women discharged directly from delivery suite</p> <ul style="list-style-type: none"> <li>Recruited to</li> <li>Daily 'staff huddles' to review clinical activity and agree plans to ensure flow through maternity</li> </ul>	<p>Review possibility of employing nurse to do 'flu' clinics for women, they can also help to vaccinate staff – more staff took up the vaccine if the y service came to them</p>

### 3.5 E&F management

#### E&F winter plan review

Initiative / Plan	Explanation of what it involves	The likely benefit	Did this take place - Measurable benefit – eg how many . add comment
1. Internal Facilities Staff bank	Increase staff bank pool across Facilities. Employees can work multi/cross disciplinary. Better bank provision reduces need for overtime and agency. Recruitment and retention remains a challenge in FM.	Savings. Multi skilled workforce. Improved morale/lower stress at busy times. Quicker response to shortages.	Directorate Workforce committee formed as sub-group of Directorate Board with representatives from directorate and HR. Cross service cover now implemented between cleaning, portering, catering and decontamination and positive feedback received from staff.

			Early signs of success with internal appointments to vacant posts.
2. Non Emergency Patient transport	Provision of self managed discharge and transfer service.	Better patient experience. Faster patient discharges and moves.	Tender process due to commence. Private resources retained for winter period and increased where necessary to support clinical demand and performance failures of CCG contractor. Issues and failures with CCG contractor reported as appropriate.
3. Catering - emergency food provision	Additional stock of frozen meals to be held in case of inclement weather/delivery failures	Ensure continuity of catering provision to staff and patients.	Works were completed to equipment at Maidstone to increase onsite freezer capacity. No issues throughout period
4. Inter-departmental management working and support incl daily/weekly duty manager and supervisor.	Management provision takes responsibility across the full range of Hotel Services. I.e. Zone managers now support catering and portering as well as domestics. Daily nominated lead for default 'goes to' lead, to avoid confusion.	Increased management input across services and better resilience through winter when staffing comes under pressure and weather can impede staff attendance.	Implemented. Positive feedback received from Winter debrief. Some difficulty during extreme weather conditions due to a number of vacancies. These posts are now being advertised.
4 x 4 driver training	General Transport drivers to receive 4 x 4 training	Readily available driver pool for driving 4 x 4 vehicles in inclement weather. Keep staff coming to work and maintain discharges of patients etc.	Implemented.

Winter Snow and Ice Procedure	The purpose of this document is to identify who is responsible for managing, implementing and carrying out the various aspects of maintaining the roads and pathways for the safe passage of patients, visitors and staff during periods of forecasted or unpredicted inclement weather i.e. frost, icy conditions and snow	Ensure safe access in and around the sites.	Winter clearance Operating Procedures developed and implemented effectively. Positive feedback received from staff.
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3.6 Cleaning - . Even with the new UV cleaning equipment , high levels of fogging still took place which meant that rooms were out of use for up to 4hrs . A review of the lasts cleaning system will help reduce this down time period, prior to next winter..

### 3.7 Debrief feedback comments –

- The work done by Estates to pre plan gritting & snow clearance worked well at MGH although for the next winter discussion about how to clear bays effectively could be considered
- Snow clearance at MGH was the best it has ever been with very few justifiable complaints –there were some concerns about the speed of snow ploughing at Tunbridge Wells which would benefit from post winter review.
- All those present agreed that the pre planning for the winter was better and more successful than in previous years. A core winter group met from April onwards to consider the planning required and this paid dividends. In particular the inclusion of finance and Information on this group meant decisions were based on improved forecasts.
- It was pointed out that estates & facilities responded quickly and effectively to sudden escalation of areas.

#### 4.0 Overall performance indicators

The key patient rated performance indications demonstrates that even with increased pressure year on year, the trust demonstrated improved patient management when compared to the previous year.

Key indicators	16/17	17/18
Incidents reported Nov – March	Same	
Falls and falls SI Nov – March	869 with 18 SIs	850 with 14 SIs
Boarding incidents Nov – March	6	4 (with increased boarding in 17/18)
Boarding numbers	Unavailable	Approx. 38 occasions with 77 patients
Pressure damage - Nov – March	172	170
DTOC – December data	8.1 5	3.7%
ED performance Q4	83%	88.6% withy 5.7 more attendances.
Staffing incidents	120	130 staffing incidents 5x higher at TW

##### 4.1 OPEL (Operational Pressures Escalation Level) -

- The Operational Pressures Escalation Level (OPEL) framework was published by NHS England in October 2016 to provide national consistency in declaring a change in escalation level and what actions should be considered.
- There are 4 levels – level 4 being the worst (black status)

##### 4.2 The trust did operate in level 4 on 10 occasions over the winter period which was triggered by :

- No capacity across the Trust
- Severe ambulance handover delays
- Emergency care pathway significantly compromised
- Unable to offload ambulances within 120 minutes
- Unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow is at a level that compromises service provision / patient safety

4.3 The number of times in which Opel 4 was initiated, offers an insight into how the pressure the trust was under during the winter period and how the winter plans helped manage the high flows flow of patients.

4.4 It was recognised that there was a need to outline exactly what was required from staff groups when in Opel 3 and 4. This would range from cancelling all meetings to securing pre-arranged volunteers to support front line staff . This would be laid out more clearly and embedded into the organisation as part of the planning process for 2018/19

##### 4.5 winter debrief group feedback

- During escalation it was felt that even when every bed space in the hospital was full and the trust was at OPEL 4 that patient safety was constantly reviewed and kept safe. There was no increase in serious incidents or other risk markers. In ED sepsis screening and other important patient safety assessments were all completed.
- It was highlighted that the Operations Centre could be used better when in OPEL 4 by redeploying admin staff and a manager to keep this open – all communications via this

room would allow Clinical Site Managers to get on around the hospital more effectively. This will be taken forward in our plans.

**4.6 A.E performance** - Performance for the Trust for the calendar month of February increased to 90.33% (including MIU and Crowborough), achieving the Trust recovery plan of 90.0% for Feb. We are 89.0% YTD. 1617 came in at 87.1%. This year, we will be judged against a new set of targets, where Q1, Q2 and Q3 must score 90% or above, then 95% in March. This also indicates that our winter plans concerning the management of the patient flow during this critical winter period have worked. There is still a need and opportunity for further improvement and this is being addressed as part of the new best patient flow programme

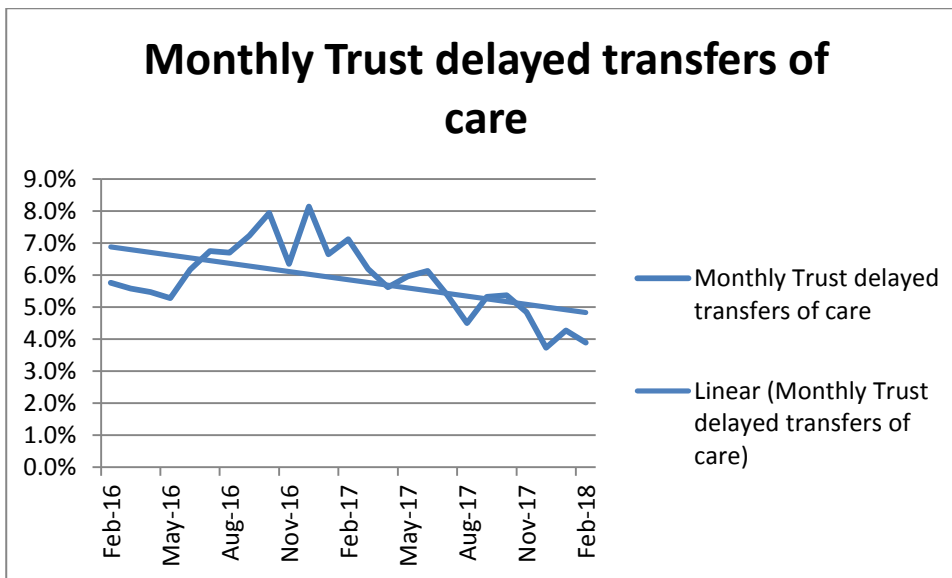
**4.7 Infection rates** - The Influenza epidemic over the winter months placed an additional burden on services not seen in recent years. Flu cases were seen in high numbers during January, reaching a peak in February and decreasing slightly in March, mirroring the national picture. In total 114 inpatients were diagnosed (January to March) with Influenza compared to just 12 cases for the same period in 2017. Of these, 14 required ITU admission with an average length of stay in ITU of 13.6 days. Isolation of suspected cases was challenging on the Maidstone site and two wards saw probable hospital acquired cases where index cases were not recognised and isolated effectively. Sickness levels amongst staff were higher than the previous year reaching 5.0% absence in January and 4.7% in February. March levels returned to a more usual level of 4.0%. Influenza vaccine uptake was just over 70%. There is no data on Influenza cases amongst staff. We vaccinated 3,458 staff in total which equates to 61% of all staff and we vaccinated 3,188 frontline workers equating to 71.1% of frontline workers. Other hospital acquired infections remained at baseline levels with 4 cases of C. difficile infection seen over the Q4 period, despite an increase in antibiotic use across the Trust

**4.8 Debrief feedback :**

- *The rise in flu cases was dealt with well although more training in the correct PPE and the establishment of onsite testing will help.*

**4.9 LOS** - 7.59 days reported for the Non-elective Length of Stay for Feb-18 discharges against the Trust phased target of 6.8 days. The LOS has previously risen by 1 day over the winter period, which has not occurred this year as it has been managed better through the patient flow initiatives identified within the plan. 7.37 YTD against 7.72 for 1617.

**4.10 Percentage delayed of occupied bed-days** eased back from 4.27% in Jan to 3.98% in Feb. The number of bed days dropped increased from 1,023 in Jan to 833 in Feb, the lowest volume for several years. For 1617, there were 17,781 bed days lost equating to a rate of 6.67% compared to 6.19% on 1516. 1718 is currently 5.02% YTD



4.10 The trust did need to implement its Boarding policy 38 times- (A patient residing on a ward without an allocated bed space) to help in the flow of patient out from ED. The triggers for this included :

- No space to safely care for patients in ED
- Overflow into ED corridor
- Trust in OPEL level 3 or 4
- More than 20 unplaced patients waiting for beds
- 3 or more ambulances being held for more than 45 mins

4.11 Winter debrief comment -

- *The capacity and escalation plan was robustly tested this winter and on the whole worked well. The boarding policy that supported it was also used and found to be a helpful tool in creating rapid capacity.*

4.12 **Complaints:** 54 new complaints were received in Mar 18, and compliance with 25 days or negotiated response date was 52.1% for March. 60.2% for 1718 against 74.3% for 1617. The rate of complaints per 1,000 occupied bed-days was 2.26 in March and 1.93 for 1718 compared to 2.57 for

## 5.0 Communications

### 5.1 Debrief feedback:

- Through the national perspective the winter period was characterised by significant media interest with high profile Headlines and need for good communication and continuous assurance concerning patient safety and patient flow issues throughout the local and national health economy .
- 5.2 E Mails are not an effective way of communicating. A more effective way of communicating must be found. Even in OPEL 4 global e mails were going out about things that could have been stopped. Its important that communications are considered in the escalation policy to stop all no urgent e mail traffic.
- 5.3 It is important that Communications consider how we get 24 hour communications out to staff proactively when they need it. This is especially important when in OPEL 4
- 5.4 There is a need to consider how and what we tell the public and staff before winter starts and when actions like cancellation of appointments is carried out.



- 5.5 There was considerable national interest in how the NHS coped with the winter – how do we ensure patients, staff and public understand what is going on locally.
- When incidents occur like the loss of heating how do we communicate effectively?
- 5.6 Liaison with SECAMB locally was good however there was no consistency in decision making at a Silver Level and Business Continuity Incidents appeared to be declared regularly without warning. In addition a clear flowchart from the CCG detailing what SECAMB are contracted to do – especially transfers needs to be provided to avoid unhelpful conversations.

5.8 The above points of learning will be taken forward in our plans

## **6.0 Adverse Weather**

Debrief group feedback and lessons learnt for next winter :

- 6.1 This winter severe weather warnings were issued for extreme cold, snow and ice on numerous occasions. In general these warnings have become very accurate and therefore the trust can be more secure in making decisions based on them.
- 6.2 A heating failure at Maidstone proved challenging during the coldest part of the winter. Estates purchased heaters but more robust contracts are required to be able to procure this type of emergency purchase. Estates worked hard to ensure patient safety during this time despite some unrealistic expectations placed upon them by staff.
- 6.3 Accommodation was sourced easily at Maidstone however it was slightly more challenging to get numbers at TWH as the Doctors accommodation has not been used for emergency accommodation before. An emergency accommodation SOP needs to be created to include how to book purchase hotel accommodation.
- 6.4 A review of 4WD drive vehicles needs to be undertaken. The 4WD MOU is only for use once the trust has exhausted all business continuity plans. These plans include the provision of at least two internal 4WD with drivers by estates. It may be that a full external contract is a better way of delivering this essential business continuity. A separate plan to ensure the integrity of the 6X service needs to be considered especially clear early morning communications to staff – especially those waiting in freezing conditions.
- 6.5 Pre cancelling Outpatients and other activity due to the amber weather warning was the right thing to do by reducing traffic on the sites and potential for slips trips and falls.
- 6.6 The post freeze water disruption also presented challenges especially in discharging patients to areas without water. The trust plans and liaison with South East Water proved very effective.

## **7.0 Staffing & Staff Welfare**

Debrief feedback which will be considered as part of our planning process for next winter :

- 7.1 An urgent review of HR policies needs to take place to ensure a consistent message about staff moving between sites and wards. A number of staff threatened to walk out if made to move wards and others just refused to do so. A review of bank staff needs to take place to identify those who simply don't turn up or walk out if asked to move wards and their bank contracts suspended. This needs HR support to ensure patient care can be provided across the trust in extremis.

- 7.2 During times of extreme pressure the trust needs to pre plan for staffing for pre and post RAP.
- 7.3 During OPEL 4 there needs to be a clear plan for managers to work shifts so the burden does not fall on the on call managers. For example if both sites were covered 0700 – 2200 the on call manager would only cover the 9 hours over night. A review of the welfare of the on call manager needs consideration.
- 7.4 Staffing was generally poor across the sites particularly at Tunbridge Wells
- 7.5 It was felt that Nurse Bank needs to be more in line with the Operations Centres with better communications with the CSMs
- 7.6 During adverse weather some staff just decide not to attend work – a more robust approach needs to be taken by managers on personal preparedness for adverse weather.
- 7.7 The creation of a team of non-clinical staff to support wards was very successful and HR should with the corporate nursing team create a team from HR , finance and other nonclinical staff to be ready to be automatically called upon in OPEL 4.
- 7.8 How do we look after staff in terms of provision of food and drink in OPEL 4 or bad weather? Could the trust invest in discounts at Costa or ensure canteens can stay open longer to provide hot food until 2000hrs even if this was only beans on toast.
- 7.9 The trust needs to consider how it helps staff especially staff new to the trust cope with the intense pressure of OPEL 4 and how all divisions and staff contribute to that pressure. There must be recognition that the extreme pressure experienced is very difficult emotionally and physically for some staff.
- 7.10 Procurement needs to create an easy emergency purchase system for use out of hours especially for hotels. Effective pre planning to negotiate good rates and discounts should be carried out in advance.

## 8.0 Financial impact

**8.1** Winter spend analysis (November 2017 to March 2018) shows that of the initial budget allocation of £800 K. The actual expenditure for the period was £1,809K. Next year appropriate budget allocation needs to be made to cover winter periods in order to reduce risk to the to year end position  
The table showing the areas of winter spend summarised by month and expenditure type.

			Nov	Dec	Jan	Feb	Mar	Total
Area	Pay / Non Pay	Additional Information	£	£	£	£	£	£
Pathology - Phlebotomy	Pay	Overtime		929	929	929		2,786
Pathology - Mortuary	Non Pay	Temporary Storage costs		5,250	5,250	5,250	5,250	21,000
Short stay Surgical Ward Escalation	Pay	Agency Nursing	88,000	88,000	88,000	88,000	88,000	440,000
Ward 32 - Urgent Care CIP	Pay / Non Pay	Original CIP plan factored in closure	86,000	86,000	86,000	86,000	86,000	430,000
Move Cornwallis Ward to Foster Clarke	Pay	Nurse Agency	4,300	4,300	4,300	4,300	4,300	21,500
Move Cornwallis Ward to Foster Clarke	Pay	Nurse Bank	4,300	4,300	4,300	4,300	4,300	21,500
Open Escalation of Cornwallis Ward	Pay	Nurse Agency			103,000	103,000	103,000	309,000
Open Escalation of Cornwallis Ward	Pay	Nurse Bank			34,333	34,333	34,334	103,000
Hire of Extra beds	Non Pay	20 beds		8,273	8,273	8,273		24,820
Hire of Extra Mattresses	Non Pay	20 mattresses		5,513	5,513	5,513		16,539
Additional Medical Team - Urgent Care (TWH)	Pay	Medical Agency		63,667	63,667	63,667	33,000	224,000
Additional Patient Transport (TWH to Maidstone)	Non Pay		15,000	45,000	45,000	45,000	45,000	195,000
			<b>197,600</b>	<b>311,232</b>	<b>448,565</b>	<b>448,565</b>	<b>403,184</b>	<b>1,809,145</b>

Plan **800,000**

Adverse to plan **-1,009,145**

## **9.0 What are the key themes will be taking forward in our plans for next winter**

9.1 Operational Initiatives which work well to manage flow & patient safety during the Winter 2017-18 and which will be included in the plans for 2018/19 :

- Daily safety huddle with good clinical engagement
- Dedicated “outlier “medical teams
- Post-take senior nurse reviews
- Consistent approach to site management
- Pre-emptive cancellation of elective work & moved some of TWH elective work to Maidstone
- AEC established at TW.
- surgical flow coordinator to support surgical flow & oversee escalation areas
- Increased establishment in ED to manage periods of overcrowding
- Secure the capacity in the community to allow the flow of patients out of secondary care when medically fit e.g. Increased pathway 3 bed capacity
- further improvement in patient flow , through the ‘Best delivery programme’
- To embed a clear understanding through the organisation of what all staff should do, when the organisation moves from Opel 3 to Opel 4 level.
- Develop a digitalised approach to information to allow improved availability and access to up to date information to assist in decision making.
- Secure necessary staffing and reduction in vacancy levels.
- Secure improved flow of patients into and out from the available ITU capacity
- Work with colleagues in other units to secure an improved flow of patients to and from tertiary centres

## **10 . Conclusion**

10.1 Despite record breaking attendances, intense and sustained pressures, national expectations the trust managed the flow of patients well and kept patients safe. The proven delivery of the effective plans carried out this year provides the solid basis for this coming winter , where lessons learnt will become a key component of next year’s plans.



Via Email

**Care Quality Commission**  
151 Buckingham Palace Road  
London  
SW1W 9SZ  
Telephone: 03000 616161  
Fax: 03000 616172  
[www.cqc.org.uk](http://www.cqc.org.uk)

16 March 2018

Dear Chief Executive

In September we wrote to you sharing the findings from a workshop CQC held with frontline staff. This letter and our report *Sharing best practice from clinical leaders in emergency departments* identified key areas where patients could be at risk, and shared best practice from clinical staff on addressing these risk areas, in order to support local quality improvements.

As you will be all too aware, the demand on emergency departments in winter 2017/18 was and continues to be unprecedented. On our inspections, we have seen many examples of staff going to extraordinary lengths to mitigate the risks this demand presents to patient safety.

We are writing to you now to let you know that yesterday we again brought together over 40 senior clinicians from 24 trusts to discuss the key challenges they are facing right now, to share practical solutions to tackling these problems and to consider preparation strategies for future surges in demand. We will be publishing a full report based on the findings of this workshop, and of our inspections of emergency departments over the winter period in a few weeks.

Recent CQC inspections and our Local System Reviews have demonstrated the importance of the eight key themes to ensure patient safety in departments working under pressure that we outlined in the letter of 29 September 2017. At yesterday's workshop clinicians reaffirmed their importance. They told us that where they had successfully implemented action to address these issues, this was critically dependent on strong leadership, engagement and support by the board and executive team of the trust.

It is important that in all trusts working under pressure in this current environment there is strong leadership from the board to ensure that patient safety is secured at all times. The clinicians stressed the importance of a trust wide, not a purely ED-focused approach to the management of clinical risk. The support of other clinical services in ensuring that crowding in the emergency department is dealt with effectively when there are surges of activity is also vital.

We often pick up a perception that we expect standard staffing ratios that prevents trusts from flexibly staffing the hospital at times of high demand. We would like to take this opportunity to clarify CQC's position on staffing. Boards should assure themselves that they have the right information to make appropriate local staffing decisions. These decisions may require balancing clinical demand in emergency departments with that across the rest of the hospital, but must always be based on

the needs of their patients, using patient acuity and dependency data alongside throughput, and the skills and experience of the wider multi-professional team. When CQC inspect, we look for evidence that boards have made such decisions based upon objective criteria that include both and an appropriate assessment of clinical risk and an assessment of the impact on patient experience.

CQC does not endorse patients being cared for in inappropriate environments and clinicians stressed the importance of this. Trusts must take a trust-wide assessment of where the safest place to care for any patient is, taking into account the physical environment but also the staffing available. It is unacceptable for patients to be cared for in unsuitable spaces such as ED corridors, or in ambulances on the hospital forecourt. Ambulances must be unloaded in a timely way. Clinicians told us that patient flow often proved challenging and they needed the full commitment and support of their boards to ensure they do not care for patients in inappropriate places. This is what clinicians want and what patients and families expect. Trusts must not normalise unacceptable practices.

While all trusts had escalation plans, clinicians told us that these were not always effectively implemented. It is essential that boards ensure that trust-wide escalation plans are thoroughly risk assessed to ensure they manage increased activity effectively and safely. These plans must be owned across the organisation they are not solely the responsibility of the emergency department.

Our recent inspections and yesterday's workshop have demonstrated to us more than ever the heroic efforts clinical staff are making to continue to provide good safe care in an increasingly pressurised environment – and, in many cases, the significant toll that this is taking on them. We will support the system as much as possible, while balancing this with our responsibility to ensure that increased pressure doesn't result in deterioration in the quality of care patients receive by continuing to monitor performance very closely and acting to protect people if necessary.

Finally, it's important to reiterate that these pressures do not originate with and are not restricted to emergency departments, or to NHS acute trusts. This is a whole system issue, which demands a whole system response. The long-term solution must be for health and care providers and commissioners to collaborate to provide health and social care services that meet the needs of their local population, with a stronger focus on keeping people well and helping them stay out of hospital, and on reducing variation that can inhibit people's access to and choice of services.

Yours sincerely,



**Sir David Behan**  
**Chief Executive**



**Professor Edward Baker**  
**Chief Inspector of Hospitals**

**Trust Board meeting - May 2018**



**5-13 Update from the Best Care Programme Board**

**Chief Executive**

Enclosed is an update from the Best Care Programme Board

**Which Committees have reviewed the information prior to Board submission?**

▪ -

**Reason for receipt at the Board (decision, discussion, information, assurance etc.) <sup>1</sup>**

Information

<sup>1</sup> All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance



# Best Care Programme

## Trust Board Report

MAY 2018

### Best Care Workstreams

There are several projects supporting the Best Care Workstreams, the key projects are noted below.

Best Patient Flow	<p><u>Non-Elective Key Projects</u></p> <ul style="list-style-type: none"> <li>• Frailty Pathway (Extend Maidstone Frailty Unit/Implement TWH Frailty Unit (5 day Service)/Reduce unnecessary inpatient admission)</li> <li>• Ambulatory Pathway (Increase Ambulatory Pathway / Hybrid Doctor/Nurse led AEC model)</li> <li>• Reduction of LOS (Fully embed SAFER at ward level / Implement R2G Process / CUR)</li> <li>• Out of Hospital (Fully embed &amp; roll out a full assessment of home first service / Roll out of DTA model / Reduce number of super stranded patients)</li> </ul> <p><u>Elective Key Projects</u></p> <ul style="list-style-type: none"> <li>• Prime Provider (Successful bidder to become prime provider for elective activity WKCCG)</li> <li>• Theatre Productivity (Increase utilisation to 85%/Undertake 2500 additional cases / Reduce late starts/Improve scheduling / Improve POA utilisation)</li> <li>• Outpatient Productivity (Reduce cancellations on the day/Improve scheduling/Improving POA utilisation)</li> <li>• Outpatients Transformation(eReferral /Partnership working with CCG/GPs/MTW)</li> </ul>
Best Workforce	<ul style="list-style-type: none"> <li>• Medical Productivity</li> <li>• Temporary Staffing</li> <li>• New Roles &amp; Apprenticeship</li> </ul>
Best Quality	<ul style="list-style-type: none"> <li>• Complex Needs</li> <li>• Quality Improvement</li> <li>• Staff Experience &amp; Engagement</li> <li>• Effectiveness &amp; Excellence</li> </ul>
Best Safety	<ul style="list-style-type: none"> <li>• 7 Day Services</li> <li>• Mortality</li> <li>• Preventing Harm</li> <li>• Learning Lessons</li> </ul>
Best Use of Resources	<ul style="list-style-type: none"> <li>• Medicines Management</li> <li>• Diagnostics</li> <li>• Procurement</li> <li>• E&amp;F Projects</li> </ul>

The Non-Elective projects are enablers for the Elective projects, in terms of Prime Provider.

### CIP Month 1 Position

The Trust achieved £0.8m savings in Month 1, which was £0.2m adverse to plan. This slippage was due to not achieving STP Medical rate (£0.1m) and outsourcing reduction (£0.1m).

A review of outsourcing reduction has seen an improvement during month 2, so assured that month 2 will be achieved.

A recovery plan for Temporary Staffing (STP Medical rate) has been produced and is currently being reviewed to provide greater assurance to achieve the CIP target.

## Best Care Programme Planning Status

The Planning RAG rating requires the following to report a Green status;

- Project Plan
  - o Detailed Project Plan
  - o Baseline Plan
  - o Critical Path identified
- KPIs
  - o Identified
  - o Monitoring in place
- QIA
  - o Approved by Clinical Lead
  - o Approved by Chief Nurse and Medical Director
- Financial Methodology
  - o Agreed
  - o Critical path aligned to Financial opportunity

## Best Safety

Best Safety	
Projects	Planning RAG Status
7 Day Services	Amber
Mortality	Amber
Preventing Harm	Red
MTW Quality Mark	Red
Learning Lessons	Red

Amber Projects – KPIs identified outstanding

Red Projects – KPIs identified and detailed project plan outstanding

## Best Quality

Best Quality	
Projects	
	Planning RAG Status
Complex Needs: Paediatric Transition	Amber
Complex Needs: Dementia (and Delirium)	Amber
Complex Needs: MCA & DOLS	Amber
Quality Improvement Committee	Amber
Patient Experience & Engagement and Public Engagement	Amber
Staff Experience and Engagement	Amber
Effectiveness & Excellence: Maternity Better Births / CNST	Green
Effectiveness & Excellence: Crowborough Birthing Centre	Amber
Effectiveness & Excellence: CQUINS	Amber
Effectiveness & Excellence: #EndPJPparalysis	Red
Effectiveness & Excellence: Criteria Led Discharge	Red

Amber Projects – KPIs identified outstanding

Red Projects – KPIs identified and detailed project plan outstanding

## Best Workforce

BEST WORKFORCE	
Projects	
	Planning RAG Status
Directorate Schemes	
Medical Productivity	
Temporary Staffing	

## Best Patient Flow

Best Patient Flow	
Projects	Planning RAG Status
Non Elective: Frailty Project	Amber
Non Elective: AEC & Ambulatory	Amber
Non Elective: Reducing Length of Stay	Amber
Non Elective: Out of Hospital Capacity	Amber
Non Elective: Therapies	Amber
Elective: E-Referral	Green
AIC T&O MSK	Green
Elective: AIC Outpatient Transformation Programme (3 detailed plans OPT Steering Group/Sub Group/Cardiology Sprint)	Green
Elective: Theatre Productivity Programme	Green
Elective: Outpatient Productivity Programme	Green
Elective: Private Patients	Red
Elective: Prime Provider	Green
Elective: CAU Effectiveness	Green
Elective: AIC Outpatient Transformation Programme	Green
Elective: E-Referral	Green
Endoscopy - Bowel Income	Red
WLI - Endoscopy Decrease	Red

Amber Projects – QIA approval outstanding

Red Projects – QIA and detailed project plan outstanding

## Best Use of Resources

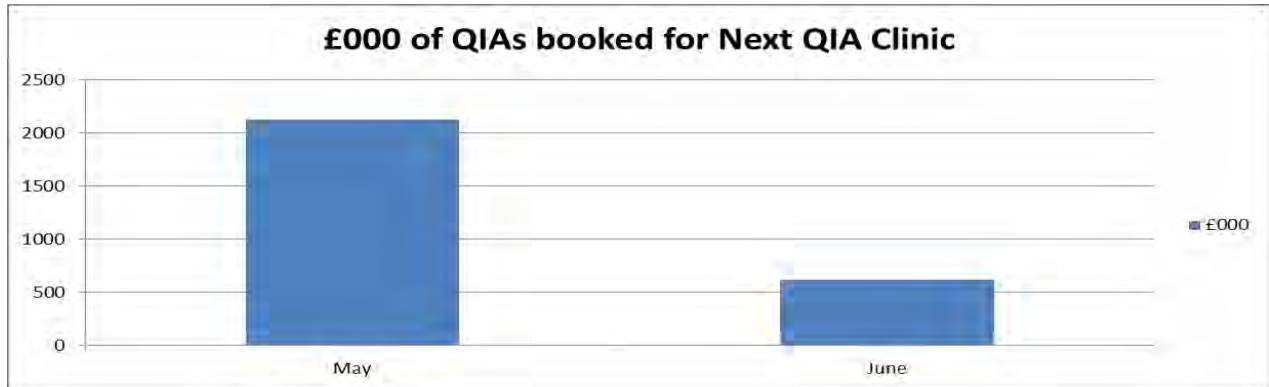
Best use of resources	
Projects	Planning RAG Status
ICT - Data Centre Charges	
ICT - Excess Travel Payments for KMHIS staff - 1819	
ICT - PAS support contract - NHS England	
E&F - E&F Change	
E&F - Energy Efficiencies	
E&F - Biomass	
E&F - NHS Property Services ISTC / Psychiatric Liason	
E&F - Patient Transport -	
Procurement - General Tenders & Trials	
Procurement - STP	
AIC - Medicine Management Implement Biosimilars Roll out of current Biosimilars	
AIC - Medicines Management Joint Strategy for interface formulary	
AIC - Medicines Management Medicines Optimisationm initiatives	
AIC - Medicines Management - Avastin	
AIC - Diagnostics - Pathology	
STP - Pathology	
AIC - Diagnostics - Radiology	
AIC - Diabetes	
NHS SLA Contracts	

Amber Projects – KPIs identified outstanding and QIA approval

Red Project – Awaiting for judicial review which starts in July 2018 till Sept 2018, plan to be developed in preparation for go live.

## Quality Impact Assessments (QIA)

There are 12 QIAs scheduled for the May QIA Clinic and 10 QIAs scheduled for the June Clinic, with a total financial opportunity of £2.7m. Subject to approval, all projects will then convert to Green RAG planning status. Detail of schemes listed in table below



Workstream	Scheme	Enabler/Financial Opportunity	£000	QIA Date
PatientFlow	Fraility Unit	Prime Provider	0	21/05/2018
PatientFlow	Ambulatory Pathways	Prime Provider	0	21/05/2018
PatientFlow	LOS Reduction	Prime Provider	0	21/05/2018
PatientFlow	Out of Hospital Capacity	Prime Provider	0	21/05/2018
PatientFlow	Therapies	Prime Provider	0	21/05/2018
PatientFlow	Virtual OCT	Outpatients	0	11/06/2018
PatientFlow	Gastro IBD	Outpatients	0	11/06/2018
PatientFlow	Haem-Ambulatory	Outpatients	0	11/06/2018
PatientFlow	Hyperemesis	Outpatients	0	11/06/2018
PatientFlow	Prime Provider - Elective	Financial Opportunity	492	21/05/2018
PatientFlow	Private Patients	Financial Opportunity	1000	21/05/2018
PatientFlow	Bowel Screening	Financial Opportunity	250	21/05/2018
PatientFlow	Reduce WLI	Financial Opportunity	250	21/05/2018
Use of Resources	Biosimilars - Transnuzimab	Financial Opportunity	98	21/05/2018
Workforce	ITU/Theatre	Financial Opportunity	26	21/05/2018
Workforce	Replace JCF	Financial Opportunity	12	21/05/2018
Use of Resources	Patient Transport	Financial Opportunity	300	15/06/2018
Use of Resources	Drugs Contract Change	Financial Opportunity	150	15/06/2018
Use of Resources	Pathology Sendaway	Financial Opportunity	30	15/06/2018
Use of Resources	Anti D Savings	Financial Opportunity	6	15/06/2018
Use of Resources	Vision Screening	Financial Opportunity	68	15/06/2018
Use of Resources	DTOC	Financial Opportunity	67	15/06/2018

## Trust Board meeting – May 2018

5-14	<b>Approval of progress report against the Clinical Negligence Scheme for Trusts (CNST) incentive scheme maternity safety actions</b>	<b>Chief Nurse</b>
	<p>As part of DH's Maternity Safety Strategy, the CNST incentive scheme seeks to reward providers of maternity services who improve maternity safety. The CNST incentive scheme identifies 10 maternity safety actions against which Trusts are invited to evidence progress and compliance.</p> <p>The "Q&amp;A regarding Maternity Safety Strategy actions and Clinical Negligence Scheme for Trusts (CNST) incentive scheme" states that "Trusts will be expected to provide a report to their Board demonstrating progress (with evidence) against each of the 10 actions using the template Board report for result submission... Completed reports need to be signed off by the Board, discussed with your commissioner and then submitted to NHS Resolution (with all relevant supporting documentation) by Friday 29 June 2018 for review by the National Maternity Safety Champions and the Steering group."</p> <p>This report has been prepared using the template specified by NHS Resolution. Trust Boards are tasked with assessment and self-certification of the evidence provided.</p> <p>Further information about the CNST incentive scheme is provided in Appendix A and detail about each of the 10 NHS Resolution criteria is provided in Appendix B.</p> <p>A number of embedded documents are included within the report as evidence of compliance, and these have been combined and circulated as a supplementary report to the formal 'pack' of Board reports.</p>	
	<b>Which Committees have reviewed the information prior to Board submission?</b> <ul style="list-style-type: none"> <li>▪ N/A</li> </ul>	
	<b>Reason for receipt at the Board (decision, discussion, information, assurance etc.) <sup>1</sup></b> <p>The Board is invited to sign off and self-certify the report to NHS Resolution that will be submitted by 29/06/18</p>	

<sup>1</sup> All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance





## Board report on Maidstone & Tunbridge Wells NHS Trust progress against the Clinical Negligence Scheme for Trusts (CNST) incentive scheme maternity safety actions









Date: May 2018










### SECTION A: Evidence of Trust's progress against 10 safety actions:





Please note that trusts with multiple sites will need to provide evidence of each individual site's performance against the required standard.















Safety action – please see the guidance for the detail required for each action	Evidence of Trust's progress	Action met? (Y/N)
1). Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths?	<p><i>Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document.</i></p> <p><i>NHS Resolution will also use data from MBRRACE to verify the Trust's progress against this action.</i></p> <div style="display: flex; justify-content: space-around; align-items: center;">   </div> <p>PMRT Letter to maternity safety chair      Safety Action 1.docx</p> <p><i>2 staff have authorised access to use the tool, this will become an integrated part of the RCA process for qualifying cases, so will be filled in promptly</i></p>	yes



Safety action – please see the guidance for the detail required for each action	Evidence of Trust's progress	Action met? (Y/N)
<p>2). Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?</p>	<p><i>Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document.</i></p> <p><i>NHS Resolution will also use data from NHS Digital to verify the Trust's progress against this action.</i></p> <div data-bbox="752 644 819 708" data-label="Image"> </div> <p>CNST Criteria - October, November 2</p> <p>Have submitted January / February 2018 data, there are currently IT issue with the submission of the March data, working with the IT company Euroking to resolve - <b><i>we are confident this will be resolved within the date for submission</i></b></p>	<p><b>yes</b></p>
<p>3). Can you demonstrate that you have transitional care facilities that are in place and operational to support the implementation of the ATAIN</p>	<p><i>Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document.</i></p> <p><i>NHS Resolution will cross-check trusts' self-reporting with Neonatal Operational Delivery Networks to verify the Trust's progress against this</i></p>	<p><b>yes</b></p>











Safety action – please see the guidance for the detail required for each action	Evidence of Trust's progress	Action met? (Y/N)
<p><b>Programme?</b></p>	<p><i>action.</i></p> <p>At MTW we have Transitional Care Facilities on the Post Natal Ward</p> <p>We have a Band 7 Transitional Care Lead</p> <p>ATAIN meetings are multidisciplinary and meet monthly</p> <p>Staff also represent the Trust at Regional Neonatal meetings</p> <div style="display: flex; justify-content: space-around; align-items: flex-end;"> <div style="text-align: center;">   MATERNITY - TRANSITIONAL CARE </div> <div style="text-align: center;">   ATAIN data Q3.pdf </div> <div style="text-align: center;">   ATAIN minutes 23March18.docx </div> <div style="text-align: center;">   ATAIN slides SEC 0218 MTW.pptx </div> <div style="text-align: center;">   Meeting Attendance Neonatal 080218.pdf </div> </div> <div style="display: flex; justify-content: space-around; align-items: flex-end; margin-top: 20px;"> <div style="text-align: center;">   ATAIN terms of ref MTW.doc </div> <div style="text-align: center;">   SEC Neonatal Governance Group nc </div> </div>	
<p><b>4). Can you demonstrate an effective system of medical workforce planning?</b></p>	<p><i>Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document. This should include reference to the Royal College of Obstetricians and Gynaecologists (RCOG) workforce monitoring tool template</i></p> <div style="text-align: center; margin-top: 20px;">   Copy of CNST Report - Middle Grade </div>	<p><b>yes</b></p>

Safety action – please see the guidance for the detail required for each action	Evidence of Trust's progress	Action met? (Y/N)
<b>5). Can you demonstrate an effective system of midwifery workforce planning?</b>	<p><i>Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance slides.</i></p> <div style="display: flex; justify-content: space-around; align-items: center;">   </div> <div style="display: flex; justify-content: space-around; align-items: center;"> <span>MTW Midwifery Staffing Report 2018</span> <span>MIDWIFERY WORKFORCE REVIEW</span> </div>	<b>yes</b>
<b>6). Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives (SBL) care bundle?</b>	<p><i>Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document.</i></p> <p><i>NHS Resolution will cross-check trusts' self-reporting with NHS England.</i></p> <p><i>4 parts:</i></p> <p>Copy of MTW Stillbirth Bundle survey admission</p> <p>Stillbirth Bundle is discussed at the Trust Maternity Board meetings</p> <div style="display: flex; justify-content: space-around; align-items: center;">      </div> <div style="display: flex; justify-content: space-around; align-items: center;"> <span>Copy of Maidstone and Tunbridge Wells I</span> <span>Maternity Board Minutes 01Sept17.do</span> <span>Maternity Board Minutes 03Nov17 ap</span> <span>Maternity Board Minutes 12May2017</span> <span>Maternity Board Minutes 14July2017.c</span> </div> <div style="display: flex; justify-content: space-around; align-items: center; margin-top: 20px;">   </div> <div style="display: flex; justify-content: space-around; align-items: center;"> <span>Maternity Safety &amp; Innovation Board dat</span> <span>Maternity Board Minutes 20April18 - D</span> </div>	<b>yesyes</b>


Safety action – please see the guidance for the detail required for each action	Evidence of Trust's progress	Action met? (Y/N)
	<p><i>1 Carbon monoxide monitoring:</i></p> <p> MATERNITY - SMOKING CESSATION</p> <p><i>2/ Fetal growth monitoring</i></p> <p>  G&amp;G Competency form.docx      GAP Grow guideline.doc</p> <p><i>3/ fetal movements</i></p> <p> fetal movement guideline.doc</p> <p><i>4/ Staff awareness –</i></p> <p>Band 7 co-ordinator free to be 'fresh eyes' for women on CTG monitoring</p> <p>K2 package purchased in Autumn 2017 , part of NHS Safety Funds- staff are being asked to do various parts of the package</p>	

Safety action – please see the guidance for the detail required for each action	Evidence of Trust's progress	Action met? (Y/N)
	 CTG 6 month letter.doc  fetal monitoring guideline.doc  Training Needs Analysis.doc	
<b>7). Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback?</b>	<p><i>Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document.</i></p>  National Maternity Survey.doc  Birth Voices minutes 28 April 17.doc  MTW MVP minutes 11 September 17.doc  MTW MVP minutes 8 January 2018.doc  Baby Cafe feedback action plan January 2	<b>yes</b>
<b>8). Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?</b>	<p><i>Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document. This should include completion of a local training record form.</i></p>  Copy of Copy of MTCompliance All (26  New Large Programme 2018-13tl  Training Dates 2017.docx  TRAINING DATES 2018.docx  Overview Plan for Community Training C   Training Strategy-draft 2018 19.doc	<b>No</b>

Safety action – please see the guidance for the detail required for each action	Evidence of Trust's progress	Action met? (Y/N)
	<div data-bbox="777 355 862 438"></div> <div data-bbox="676 440 956 510">MTW PROMPT Training Record 2017</div> <div data-bbox="1079 355 1167 438"></div> <div data-bbox="983 440 1263 510">Copy of CNST Training Spreadsheet</div> <p>From April 2017 MTW had a 75% target for maternity mandatory training This CNST incentive scheme raised the required standard to 90% standard in February 2018. Our mandatory training compliance system does an overall percentage- see compliance list attached. Using this system we have reached over 90% in emergency and CTG training for the total staff group</p> <p>The Emergency Maternity Training day does not include CTG up , this is held as a separate training event</p> <p><b>CTG training</b></p> <p>Part of the National Safety money was spent on buying the e learning K2 package for staff to do their CTG up date</p> <p>Staff also have the option to attend weekly face to face meetings and midwives have a session in their Day 3 training day.</p> <p>Community Meetings</p> <p>Delivery suite sessions</p>	

Safety action – please see the guidance for the detail required for each action	Evidence of Trust's progress	Action met? (Y/N)
	<p>Weekly Risk Meetings</p> <p>Some Clinical Governance meetings have CTG training as an agenda item</p> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">  <p>CG agenda 13Feb18.docx</p> </div> <div style="text-align: center;">  <p>Attendance 13Feb18.pdf</p> </div> </div>	
<p><b>9). Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?</b></p>	<p><i>Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document.</i></p> <div style="display: flex; flex-wrap: wrap; justify-content: space-around;"> <div style="text-align: center; margin: 5px;">  <p>Maternity Board Minutes 01Sept17.doc</p> </div> <div style="text-align: center; margin: 5px;">  <p>Maternity Board Minutes 14July2017.doc</p> </div> <div style="text-align: center; margin: 5px;">  <p>Maternity Board Minutes 03Nov17 app</p> </div> <div style="text-align: center; margin: 5px;">  <p>Maternity Board Minutes 12May2017 ε</p> </div> <div style="text-align: center; margin: 5px;">  <p>Maternity Board Minutes 16 February</p> </div> <div style="text-align: center; margin: 5px;">  <p>Audit of meeting attendance in 2017 o</p> </div> <div style="text-align: center; margin: 5px;">  <p>Trust Safety Champion Meeting 11</p> </div> <div style="text-align: center; margin: 5px;">  <p>Maternity Board TOR updated July 2017v2</p> </div> </div>	<p><b>yes</b></p>



Safety action – please see the guidance for the detail required for each action	Evidence of Trust's progress	Action met? (Y/N)
	 <p>Maternity Board Minutes 20April18 - D</p>	
<b>10). Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme?</b>	<p><i>Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document.</i></p> <p><i>NHS Resolution will also use data from the National Neonatal Research Database to verify the Trust's progress against this action.</i></p> <p>Trusts will meet the required standard by reporting all qualifying 2017/18 incidents to NHS Resolution, regardless of whether or not these were submitted within the required timescales</p> <p>Did not report from 1/4/17 within the set time frame</p> <p>Have 18 cases that qualify for this</p> <p>All women will have received a duty of candour letter and all cases will be on the system</p> <p>Key staff have attended workshops to understand this new process and what it entails</p> <p>Process agreed between the Trust Legal and Maternity Governance Team</p>	<b>Yes</b>

## **SECTION B: Further action required:**

*If the Trust is unable to demonstrate the required progress against any of the 10 actions, please use this section to set out a detailed plan for how the Trust intends to achieve the required progress and over what time period. Where possible, please also include an estimate of the additional costs of delivering this.*

*The National Maternity Safety Champions and Steering group will review these details and NHS Resolution, at its absolute discretion, will agree whether any reimbursement of CNST contributions is to be made to the Trust. Any such payments would be at a much lower level than for those trusts able to demonstrate the required progress against the 10 actions and the 10% of the maternity contribution used to create the fund. If made, any such reimbursement must be used by the Trust for making progress against one or more of the 10 actions.*

### **Area for Improvement**

#### **8/ Staff training**

Capture staff training per staff group

Mandatory training is part of the Appraisal process and staff are unable to apply for additional training if they are not compliant with their mandatory training

#### **10. NHS Resolution Early Notification**

The 18 cases will be reported to NHS Resolution once the families have been informed of this requirement in time for the formal submission of this report. In future, this will be part of the Trust Duty of Candour Process and will be done within the set time limit.

The Trust Legal team and Maternity Governance have agreed the process for future cases as part of the RCA/ SI process -Cost implications- no costs predicted as will be part of RCA/SI process.

**SECTION C: Sign-off**

.....

**For and on behalf of the Board of Maidstone & Tunbridge Wells NHS Trust confirming that:**

- **The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards and that the self-certification is accurate.**
- **The content of this report has been shared with the commissioner(s) of the Trust’s maternity services**
- **If applicable, the Board agrees that any reimbursement of CNST funds will be used to deliver the action(s) referred to in Section B**

**Position:** .....

**Date:** .....

**We expect trust Boards to self-certify the Trust’s declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group escalate to the appropriate arm’s length body/NHS System leader.**

.....

**SECTION D: Appendices**

Please list and attach copies of all relevant evidential appendices:

## Q&A regarding Maternity Safety Strategy actions and Clinical Negligence Scheme for Trusts (CNST) incentive scheme

### Q1) What are the aims of the CNST incentive scheme and why maternity?

The Maternity Safety Strategy set out the Department of Health's ambition to reward those who have taken action to improve maternity safety. We are very happy to support this work by trialling the CNST incentive scheme for 2018/19. The scheme is absolutely discretionary and subject to available funds. Using CNST to incentivise safer care received strong support from respondents to our [2016 CNST consultation](#) where 93% of respondents wanted incentives under CNST to fund safety initiatives. This is also directly aligned to the Intervention objective in our [Five year strategy: Delivering fair resolution and learning from harm](#).

Maternity safety is an important issue for all CNST members as obstetric claims represent the scheme's biggest area of spend (c£500m in 2016/17). Of the clinical negligence claims notified to us in 2016/17, obstetric claims represented 10% of the volume and 50% of the value. These figures do not take into account the recent change to the Personal Injury Discount Rate.

It is important to remember that trusts that improve their maternity safety will be saving the NHS money, allowing more money to be made available for frontline care.

### Q2) What are the 10 maternity safety actions?

The actions are as follows:

1. Are you using the National Perinatal Mortality Review Tool to review perinatal deaths?
2. Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?
3. Can you demonstrate that you have transitional care facilities that are in place and operational to support the implementation of the ATAIN Programme?
4. Can you demonstrate an effective system of medical workforce planning?
5. Can you demonstrate an effective system of midwifery workforce planning?
6. Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?
7. Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback?



## Resolution

8. Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?
9. Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?
10. Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme?

The precise detail for exactly what is required under each action and how this should be evidenced can be found [here](#).

### **Q3) How many of the actions will the trust need to meet in order to qualify for the CNST incentive payment?**

The expectation is that trusts will be able to demonstrate the required progress against **all 10** of the actions in order to qualify for a minimum rebate of their contribution to the incentive fund (calculated at 10% of their maternity premia).

### **Q4) Why have these actions been chosen?**

These actions were agreed by the National Maternity Safety Champions as reflecting best practice in maternity safety improvement which could be evidenced to demonstrate progress against them. Implementing these actions should deliver a qualitative difference in trusts' performance on improving maternity safety and by doing this, trusts would be expected to reduce incidents of harm that lead to clinical negligence claims. The scheme will therefore reward those trusts who have implemented the **10 maternity safety actions**.

### **Q5) Who else has been involved in designing the scheme?**

The National Maternity Safety Champions were advised by a group of system experts including representatives from:

- NHS England
- NHS Improvement
- NHS Digital
- MBRRACE UK
- Royal College of Obstetricians and Gynaecologists
- Royal College of Midwives
- Care Quality Commission
- Department of Health
- NHS Resolution
- Clinical obstetric, midwifery and neonatal staff

We will shortly be agreeing terms of reference to create a Steering group which will be responsible for confirming the final results as well as evaluating the scheme itself.

**Q6) Who does the scheme apply to?**

The scheme will only apply to acute trusts in 2018/19. However, we want to support the improvement of maternity services in all settings so, if the scheme is successful, we will look at how we can extend it in future years.

**Q7) How will trusts be assessed against the actions and by when?**

Trusts will be expected to provide a report to their Board demonstrating progress (with evidence) against each of the 10 actions using the [template Board report for result submission](#).

Completed reports need to be signed off by the Board, discussed with your commissioner and then submitted to NHS Resolution (with all relevant supporting documentation) **by Friday 29 June 2018** for review by the National Maternity Safety Champions and the Steering group.

Please note that:

- NHS Resolution will be accessing external data sources to validate some of the trust's responses.
- Completed reports should be sent to NHS Resolution at [contributions@resolution.nhs.uk](mailto:contributions@resolution.nhs.uk)
- If a completed report is not returned to NHS Resolution by **Friday 29 June 2018**, NHS Resolution will treat that as a nil response and no incentive payment will be made

The proposed timescale is as follows:

Step	Date
Completed Board reports with Board sign-off submitted to NHS Resolution	By end June 2018
National Maternity Safety Champions and Steering group to confirm final results	By end July 2018
Evaluation of scheme and confirmation of approach for 2019/20	By end July 2018
NHS Resolution to confirm and pay discounts	By end Aug 2018

**Q8) What if my trust has multiple sites providing maternity services**

Multi-site providers will need to demonstrate the necessary progress for each individual site. The Board final report template should therefore include evidence of progress overall and at each site level.



## Resolution

### **Q9) How and when will trusts get their discount?**

Discounts are expected to be confirmed and paid by the end of August 2018. NHS Resolution will do this by:

1. Confirming the value of the credit to be made to members; and
2. Issuing a credit note and making the payment.

Please note that any direct debit payments set up on the basis of the original contribution level will not be subsequently adjusted

### **Q10) What if my trust is unable to demonstrate the required progress against all 10 actions?**

If your trust is unable to demonstrate the required progress against all of the 10 actions, the Board report should set out a detailed plan for how the trust intends to achieve the required progress and over what time period. Where possible, this should also include an estimate of the additional costs of delivering this.

The National Maternity Safety Champions and Steering group will review these details and NHS Resolution, at its absolute discretion, will agree whether any reimbursement of CNST contributions is to be made to the trust. Any such payments would be at a much lower level than for those trusts able to demonstrate the required progress against the 10 actions and the 10% of the maternity contribution used to create the fund. If made, any such reimbursement must be used by the trust for making progress against one or more of the 10 actions.

### **Q11) What if the trust self-certifies as having met the required progress against all 10 actions but subsequent verification suggests otherwise?**

We expect trust Boards to self-certify declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of Board governance which the steering group will escalate within the system for further exploration. We will also take steps to recover in full any incentive payment that has been made under the scheme.



### **Q12) How will the impact of the scheme be evaluated?**

It is important to make sure we evaluate the scheme to understand whether it has been successful in incentivising sustainable improvement(s) in maternity safety.

We will make a short online survey available in June to capture feedback on key points, such as:

- Whether the scheme has had a positive impact on your ability to deliver safer maternity care?
- Whether the scheme has supported discussions with Commissioners around the delivery of safer maternity care?
- What other areas do you think it would be useful to incentivise through CNST contributions?
- Whether there have been any unintended consequences as a result of the process?
- How the scheme could be improved in future years – e.g. improvements to the verification process?
- Any other thoughts/comments on the scheme

The National Maternity Safety Champions and the Steering group will use this feedback, as well as third party data sources to review whether the scheme has been successful. If so, we will look at how the scheme could be extended and developed in future years to continue to drive improvements in safety. Future developments could include things like specific neonatal workforce measures or other suggestions put forward during the evaluation process.

### **Q13) What should trusts do if they have any queries regarding the scheme?**

Please submit queries to [contributions@resolution.nhs.uk](mailto:contributions@resolution.nhs.uk). This mailbox will be periodically monitored and queries answered as quickly as possible.

# 1. Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths?



## Resolution

<b>Required standard and minimum evidential requirement</b>	Ability to demonstrate use of the NPMRT to review perinatal deaths <b>between January 2018 – April 2018</b> . This would include using the NPMRT to review perinatal deaths that pre-date the NPMRT's launch.
<b>Validation process</b>	<p>Self-certification report to Board using template report.</p> <p>Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) data will be used to cross-reference against Trust self-certification.</p>



## Resolution

## 2. Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

### Required standard and minimum evidential requirement

**NB/ The text in green was amended on 14 February 2018**

Able to demonstrate progress on at least 8 out of the following 10 criteria:

- Submitted MSDS in all of the last three months (**i.e. data relating to January - March 2018**)
- Latest submission contained booking appointments in the month
- Latest submission contained method of delivery for at least 80% of births
- Latest submission contained at least 80% of HES births expectation (unless reason understood)
- Latest submission contained all of the tables 501, 502, 404, 409
- Latest submission contained all the tables 401,406,408,508,602 (unless justifiably blank)
- Latest submission contained valid\* smoking at booking for at least 80% of bookings
- Latest submission contained valid baby's first feed for at least 80% of births
- Latest submission contained valid in days gestational age **for at least** 80% of births
- Latest submission contained valid\* presentation at onset for at least 80% of deliveries where onset of labour recorded

*\* valid excludes not known and missing*

Where the criteria assesses the quality of booking, delivery or births data and no data of that type are submitted, the criteria is not met.

### Validation process

Self-certification report to Board using template report.

NHS Digital data will be used to cross-reference against Trust self-certification.

Trusts assessed against the required standard for March 2018 submitted by the end of May 2018 - (this will be at provider level data rather than site level data).

### Support available

Please see the general guidance available on the NHS Digital website.

### 3. Can you demonstrate that you have transitional care facilities in place and operational to support the implementation of the ATAIN Programme?



## Resolution

<b>Required standard and minimum evidential requirement</b>	<p>Provision of a service delivery model where care, <i>additional to normal infant care</i>, is provided in a postnatal clinical setting or in a bespoke transitional care unit with the mother as primary care giver, supported by appropriately trained healthcare professionals. Additional care requirements may include: care for late preterm infants, provision of intravenous antibiotics, provision of complementary nasogastric tube feed.</p> <p>Trusts should be assessing their transitional care provision <b>as at end April 2018</b>.</p>
<b>Validation process</b>	<p>Self-certification report to Board using template report.</p> <p>NHS Resolution will cross-check trusts' self-reporting with Neonatal Operational Delivery Networks to verify the Trust's progress against this action.</p>
<b>Support available</b>	<ul style="list-style-type: none"> <li>• <a href="https://www.e-lfh.org.uk/programmes/avoiding-term-admissions-into-neonatal-units/">https://www.e-lfh.org.uk/programmes/avoiding-term-admissions-into-neonatal-units/</a></li> <li>• <a href="https://improvement.nhs.uk/resources/">https://improvement.nhs.uk/resources/</a></li> <li>• <a href="https://improvement.nhs.uk/resources/preventing-avoidable-admissions-full-term-babies/">https://improvement.nhs.uk/resources/preventing-avoidable-admissions-full-term-babies/</a></li> </ul>



## Resolution

### 4. Can you demonstrate an effective system of medical workforce planning?

<b>Required standard and minimum evidential requirement</b>	<p>No more than 20% of middle grade sessions on labour ward filled by consultants acting down from other sessions.</p> <p>Trusts to self-assess against <b>any consecutive 4 week period in March or April</b> using the Royal College of Obstetricians and Gynaecologists (RCOG) workforce monitoring tool (to follow in late January/early February).</p>
<b>Validation process</b>	<p>Self-certification report to Board using report template and completed RCOG workforce monitoring tool.</p>



## Resolution

### 5. Can you demonstrate an effective system of midwifery workforce planning?

<p><b>Required standard and evidential requirement</b></p>	<ol style="list-style-type: none"> <li>1. Evidence of a systematic, <b>evidence-based</b> process to calculate midwifery staffing establishment;</li> <li>2. Trust policy demonstrating that, as standard, midwifery labour ward shifts are rostered in a way that allows the labour ward coordinator to have supernumerary status (defined as having no case load of their own during that shift); and</li> <li>3. Good practice includes neonatal workforce within work force plans.</li> </ol> <p>Trusts should be evidencing the position <b>as at end April 2018</b>. Evidence for item 1 could include Board minutes or evidence of a full audit or table-top exercise using a tool such as Birthrate+</p>
<p><b>Validation process</b></p>	<p>Self-certification report to Board using template report.</p>

## 6. Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives (SBL) care bundle?



### Resolution

<b>Required standard and minimum evidential requirement</b>	<p>Ability to demonstrate Board level consideration of the SBL care bundle in a way that supports the delivery of safer maternity services.</p> <p>Board minutes demonstrating that each element of the SBL care bundle has been implemented or that an alternative intervention put in place to deliver against element(s).</p> <p>Trusts should be evidencing the position <b>as at end April 2018</b>.</p>
<b>Validation process</b>	<p>Self-certification report to Board using template report.</p> <p>NHS Resolution to cross-check Trusts' self-reporting with NHS England.</p>
<b>Support available</b>	<p>SBL Care bundle and guidance: <a href="https://www.england.nhs.uk/wp-content/uploads/2016/03/saving-babies-lives-car-bundl.pdf">https://www.england.nhs.uk/wp-content/uploads/2016/03/saving-babies-lives-car-bundl.pdf</a></p>

**7. Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership (MVP) Forum, and that you regularly act on feedback?**



**Resolution**

<p><b>Required standard and minimum evidential requirement</b></p>	<p>This action is self-explanatory.</p> <p>Evidence would include minutes of regular MVP meetings demonstrating their business.</p> <p>Trusts should be evidencing the position <b>as at end April 2018</b>.</p>
<p><b>Validation process</b></p>	<p>Self-certification report to Board using template report.</p>



## 8. Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?



### Resolution

<b>Required standard</b>	<p>Training should include fetal monitoring in labour and integrated team-working with relevant simulated emergencies and/or hands on workshops. The training syllabus should be based on current evidence, national guidelines/ recommendations, any relevant local audit findings, risk issues and case review feedback, and include the use of local charts, emergency boxes, algorithms and pro-formas. There should also be feedback on local maternal and neonatal outcomes.</p> <p>Maternity staff attendees should include: obstetricians (including Consultants, staff grades and trainees); obstetric anaesthetic staff (Consultants and relevant trainees); midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and stand alone birth centres) and bank midwives); maternity theatre and critical care staff; health care assistants (to be included in the maternity skill drills as a minimum) and other relevant clinical members of the maternity team.</p> <p>Trusts should be evidencing the position <b>as at end April 2018</b>.</p>
<b>Minimum evidential requirement</b>	<p>Completion of the '<b>CNST local training record</b>' form following each training day, including details of the programme used as well as entering all attendees on their local training database to ensure they can demonstrate the percentage attendance for each staff group.</p>
<b>Validation process</b>	<p>Self-certification report to Board using template report.</p>

## 9. Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?



### Resolution

<p><b>Required standard and minimum evidential requirement</b></p>	<p>Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?</p> <p>Evidence of bi-monthly meetings through meeting agendas, minutes etc. demonstrating reviews of published national reports (such as Each Baby Counts and MBRRACE-UK), reviews of locally collected clinical measures, inspection reports and feedback from women and families.</p> <p>Trusts should be evidencing the position <b>as at end April 2018</b>.</p>
<p><b>Validation process</b></p>	<p>Self-certification report to Board using template report.</p>

## 10. Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme?



<b>Required standard and minimum evidential requirement</b>	<p>Reporting of all qualifying <b>incidents that occurred in the 2017/18 financial year</b> to NHS Resolution under the Early Notification scheme reporting criteria.</p> <p>Trusts should be evidencing the position <b>as at end March 2018</b>.</p>
<b>Validation process</b>	<p>Self-certification report to Board using template report with Commissioner sign-off.</p> <p>NHS Resolution to cross reference Trust report against the National Neonatal Research Database (NRRD) data.</p>
<b>Support available</b>	<p>Early Notification scheme guidance already circulated to NHS Resolution maternity contacts.</p> <p>Please contact <a href="mailto:ENTeam@resolution.nhs.uk">ENTeam@resolution.nhs.uk</a> to request further copies of the same.</p>

## Trust Board meeting - May 2018

5-15	Approval of the Outline Business Case for an Electronic Patient Record	Chief Operating Officer / Interim Director of Health Informatics
<p>Enclosed is the business case for an Electronic Patient Record (EPR). The Appendices to the document have not been circulated due to their large size and to the fact that their content is included within the business case circulated.</p> <p>The business case was reviewed and broadly supported by the TME at its meeting on 16th May 2018. At that meeting, it was noted that the project costs relating to 2018/19 had not been included in the plan that had recently been submitted to NHS Improvement (NHSI), and that there were currently further cost pressures in 2019/20 and 2020/21 before benefits would exceed costs later in the project's life. It is hoped that central funding will be available to make a significant contribution to these costs and, although it is hoped to confirm such funding before developing the case, the Memorandum of Understanding with Allscripts requires a decision to be made by the end of June 2018. TME agreed that, should the central funding not become available, the additional costs would need to be covered by increased savings from the Divisions. Further work is also ongoing on the quantification of benefits to be derived from the project.</p> <p>The business case is now circulated for consideration of approval by the Trust Board, subject to review first by the Finance and Performance Committee on 22<sup>nd</sup> May 2018. The Trust Board is also asked to consider the level of scrutiny it feels appropriate prior to this decision, e.g. whether it wishes to review the full business case prior to agreement – in the recent past, the Finance and Performance Committee and Trust Board have reviewed similar business cases at the point at which funding was committed, i.e. at the current stage of the process.</p>		
<p><b>Which Committees have reviewed the information prior to Board submission?</b></p> <ul style="list-style-type: none"> <li>Finance and Performance, 22/05/18</li> </ul>		
<p><b>Reason for receipt at the Board (decision, discussion, information, assurance etc.)<sup>1</sup></b></p> <p>Review and consideration for approval</p>		

<sup>1</sup> All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

## Summary

Following the go-live of the Allscripts PAS in October 2017 and the approval to enter into a Memorandum of Understanding (MOU) with Allscripts in December 2017, an Outline Business Case (OBC) was commissioned and requires Trust Board approval to move to the next stage.

The OBC highlights a funding requirement of **£3m** capital over the next 4 years which currently **£3.6m** allocated to IT over the same period in the capital plan.

The case demonstrates revenue saving of **£5.7m** over a 10-year investment period, with further savings still being identified. However, the initial 3 years of the project would place a **£3.78m** cost pressure on the Trust, prior to the benefits are able to be realised.

This paper outlines the key points made in the OBC, discusses the processes to be undertaken to meet the timescales laid down in the MOU, whilst ensuring the proposal continues to represent value for money.

## Outline Business Case

### *Strategic Case*

The Trust Strategy may be enabled through better implementation and utilisation of informatics. The current distributed model for data and best of breed systems does not support the Trust in delivering its strategic goals or used to drive the operational efficiencies required.

The case for change has been made based upon local clinical requirements, the need to reduce risk and the provision of efficiency gains. In meeting these local needs, the investment also addresses national drivers and objectives.

### *Economic Case*

Long list options were considered using the Treasury Green Book Model categories. The options were developed through presentations workshops, meetings with clinical and operational staff and consultations with partner organisations. The options were analysed against Trust strategic objectives and critical success factors, to identify the shortlist of options: -

1. Do Nothing
2. Best of Breed EPR – Capital and Revenue Model
3. Single Supplier EPR – Capital and Revenue Model
4. Single Supplier EPR – Fully Managed Service Model
5. Kent Wide EPR – Fully Managed Service Model

**Option 4** is preferred at this stage due to the benefits identified.

### *Commercial Case*

The systems and services considered, based on Trust needs and planned approach: -

- Phase 1 – Preparation of Existing Systems
- Phase 2 – Implement Foundation Systems and Preparation
- Phase 3 – Implement EPR Core Systems
- Phase 4 – Implement Departmental Systems

The procurement plan to achieve dates specified in MOU: -

Finalise Specification	14th May 2018
Final Contract Review	18th & 19th June 2018
Evaluation	29th June 2018
Executable Contract Agreed	30th June 2018
Contract Signed	30 September 2018

## Financial Case

## 10 Year I&amp;E Summary: -

Maidstone & Tunbridge Wells NHS Trust	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Total
INCOME & EXPENDITURE SUMMARY	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	
<b>COSTS</b>												
Revenue payments	335	1,481	1,963	783	801	820	839	858	878	899	940	10,597
Non-recoverable VAT on revenue	0	0	0	0	0	0	0	0	0	0	0	0
Depreciation (non-cash flow item)	29	214	321	330	333	339	348	359	377	396	53	3,100
Rate of return (non-cash flow item)	5	35	70	75	65	54	43	32	20	8	1	408
<b>Grand total costs</b>	<b>369</b>	<b>1,730</b>	<b>2,354</b>	<b>1,188</b>	<b>1,200</b>	<b>1,213</b>	<b>1,230</b>	<b>1,250</b>	<b>1,276</b>	<b>1,302</b>	<b>993</b>	<b>14,104</b>
<b>FUNDING</b>												
Cash releasing benefits	0	0	673	1,655	2,087	2,310	2,358	2,408	2,458	2,510	2,514	18,972
Other (specify details)									397	403	54	855
<b>Grand total funding</b>	<b>0</b>	<b>0</b>	<b>673</b>	<b>1,655</b>	<b>2,087</b>	<b>2,310</b>	<b>2,358</b>	<b>2,408</b>	<b>2,855</b>	<b>2,913</b>	<b>2,568</b>	<b>19,827</b>
<b>NET COST TO REVENUE SOURCES</b>	<b>369</b>	<b>1,730</b>	<b>1,682</b>	<b>-468</b>	<b>-887</b>	<b>-1,097</b>	<b>-1,128</b>	<b>-1,158</b>	<b>-1,580</b>	<b>-1,611</b>	<b>-1,575</b>	<b>-5,722</b>

## Year Cashflow Summary, including Optimum Bias and Contingency: -

Maidstone & Tunbridge Wells NHS Trust	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Total
CASH FLOW SUMMARY £000	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	
<b>CASH OUT</b>												
Capital payments - Maidstone & Tunbridge	287	1,389	694	22	0	0	0	0	0	0	0	2,392
Capital payments - optimism bias uplift *	5	22	11	0	0	0	0	0	0	0	0	38
Capital contingency **	29	181	123	34	23	29	35	36	37	20	20	567
<b>Capital payments - total</b>	<b>320</b>	<b>1,591</b>	<b>827</b>	<b>57</b>	<b>23</b>	<b>29</b>	<b>35</b>	<b>36</b>	<b>37</b>	<b>20</b>	<b>20</b>	<b>2,997</b>
Revenue payments - Maidstone & Tunbridg	300	1,294	1,721	694	709	724	739	755	771	787	788	9,281
Revenue payments - optimism bias uplift *	5	21	28	11	11	12	12	12	12	13	13	149
Revenue contingency **	30	166	214	78	81	84	88	92	95	99	139	1,167
<b>Revenue payments - total</b>	<b>335</b>	<b>1,481</b>	<b>1,963</b>	<b>783</b>	<b>801</b>	<b>820</b>	<b>839</b>	<b>858</b>	<b>878</b>	<b>899</b>	<b>940</b>	<b>10,597</b>
VAT	117	532	474	126	124	127	129	132	135	138	138	2,172
Cash releasing benefits	0	0	-673	-1,655	-2,087	-2,310	-2,358	-2,408	-2,458	-2,510	-2,514	-18,972
<b>Total cash out</b>	<b>772</b>	<b>3,604</b>	<b>2,592</b>	<b>-689</b>	<b>-1,138</b>	<b>-1,334</b>	<b>-1,355</b>	<b>-1,381</b>	<b>-1,408</b>	<b>-1,453</b>	<b>-1,416</b>	<b>-3,206</b>
<b>CASH IN</b>												
Recovered VAT	117	471	433	126	124	127	129	132	135	138	138	2,070
Other (specify details)												0
<b>Total cash in</b>	<b>117</b>	<b>471</b>	<b>433</b>	<b>126</b>	<b>124</b>	<b>127</b>	<b>129</b>	<b>132</b>	<b>135</b>	<b>138</b>	<b>138</b>	<b>2,070</b>
<b>NET CASHFLOW</b>												
<b>Net cashflow</b>	<b>655</b>	<b>3,133</b>	<b>2,159</b>	<b>-815</b>	<b>-1,262</b>	<b>-1,461</b>	<b>-1,484</b>	<b>-1,513</b>	<b>-1,543</b>	<b>-1,591</b>	<b>-1,554</b>	<b>-5,276</b>
Brought forward	0	655	3,789	5,947	5,132	3,870	2,410	926	-587	-2,131	-3,722	
Carried forward	655	3,789	5,947	5,132	3,870	2,410	926	-587	-2,131	-3,722	-5,276	
<b>Element of payments in 'cash out' that comprises inflation</b>												
Capital	0	32	33	3	2	3	4	5	5	4	4	96
Revenue	-0	29	78	47	64	80	98	116	134	152	161	959

Whole Life Costs, tested for the NHSi £15m freshhold: -

Whole Life Costs	Yr 0 2018/19	Yr 1 2019/20	Yr 2 2020/21	Yr 3 2021/22	Yr 4 2022/23	Yr 5 2023/24	Yr 6 2024/25	Yr 7 2025/26	Yr 8 2026/27	Yr 9 2027/28	Yr 10 2028/29	Total
Capital Costs	£ -	£ 300	£ 200	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ 500
Project Management	£ 287	£ 1,061	£ 466	£ 21	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ 1,835
Optimism Bias (Capital)	£ 5	£ 22	£ 11	£ 0	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ 37
<b>Total Capital</b>	<b>£ 292</b>	<b>£ 1,383</b>	<b>£ 677</b>	<b>£ 21</b>	<b>£ -</b>	<b>£ -</b>	<b>£ -</b>	<b>£ -</b>	<b>£ -</b>	<b>£ -</b>	<b>£ -</b>	<b>£ 2,372</b>
Running Costs	£ 300	£ 1,268	£ 1,510	£ 576	£ 576	£ 576	£ 576	£ 576	£ 576	£ 576	£ 576	£ 7,686
Training	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -
Optimism Bias (Revenue)	£ 5	£ 20	£ 24	£ 9	£ 9	£ 9	£ 9	£ 9	£ 9	£ 9	£ 9	£ 123
<b>Total Revenue</b>	<b>£ 300</b>	<b>£ 1,268</b>	<b>£ 1,510</b>	<b>£ 576</b>	<b>£ 576</b>	<b>£ 576</b>	<b>£ 576</b>	<b>£ 576</b>	<b>£ 576</b>	<b>£ 576</b>	<b>£ 576</b>	<b>£ 7,686</b>
<b>Total Whole Life Cost</b>	<b>£ 592</b>	<b>£ 2,651</b>	<b>£ 2,187</b>	<b>£ 597</b>	<b>£ 576</b>	<b>£ 576</b>	<b>£ 576</b>	<b>£ 576</b>	<b>£ 576</b>	<b>£ 576</b>	<b>£ 576</b>	<b>£ 10,058</b>

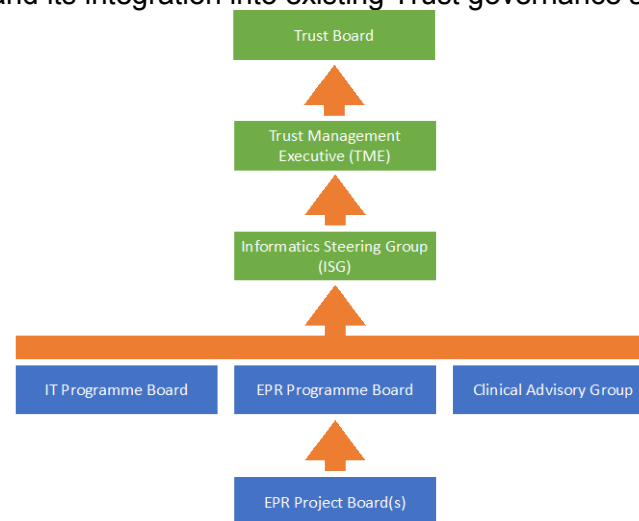
External Funding Options: -

The Trust is currently pursuing opportunities for NHS England funding to support the financing of the project. However it is unlikely this either of the 2 available funding streams will be awarded prior to the end of the June 2018. The Trust may therefore may need to consider both the managed service and capital options at the FBC stage.

#### Management Case

The Programme will be managed under PProjects IN Controlled Environments, version 2 (PRINCE2) and Managing Successful Programmes (MSP) methodology.

The proposed structure for the EPR Programme and its integration into existing Trust governance structures is: -



## **Next Steps**

The business case has identified that there are sufficient benefits and savings to be made for procuring an EPR and associated services. The recommendation is: -

- Finalisation and Board approval of IT Strategy Vision;
- Finalise the EPR specification and undertake the procurement phase, including contract preparation. This stage is anticipated to require an investment of £25k;
- Decide enabling systems to be progressed;
- Develop the detailed benefits plan, once the final configuration and systems are known;
- Prepare the FBC for approval by the Trust Board.



# Outline Business Case

## Electronic Health Record

**Amendment History**

Version	Date	Amendment History
0.1	28/12/2017	First Draft
0.2	05/04/2018	Reviewed and updated
0.3	20/04/2018	Clinical Systems Strategy Update
0.4	02/05/2018	Reviewed and updated inc Financial Models
0.5	03/05/2018	Strategy update, benefits added
0.6	10/05/2018	Updates following feedback
1.0	11/05/2018	Final

**Previous Reviews**

Version	Date	Comments
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**Forecast Changes**

Anticipated Changes	Schedule
Benefits Updated	May 18
Finance Update	May 18

**Reviewers**

This document must be reviewed by the following:

Name	Title / Responsibility	Date	Version
Michael Beckett			
Nick Baber			
Stuart Doyle			

**Approvals**

Name	Title / Responsibility	Date	Version
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## Document Status

This is a controlled document.

Whilst this document may be printed, the electronic version maintained in Q:\IT Programmes\EPR\OBC is the controlled copy. Any printed copies of the document are not controlled.

## Related Documents

These documents will provide additional information.

Ref No.	Doc Ref No.	Document Title	Version
1	Appendices	OBC Appendices	0.5

## Glossary

The following table presents a glossary of specific terms used in this business case that are in many cases important with regard to precise definitions of the content of the business case.

Term	Abbreviation	Definition
Accountable Care System	ACS	In an ACS, NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve
Absolute Value for Money Ratio	AVFM	An economic measure used to calculate the Absolute Value for Money ratio of benefits vs. net cost of an investment in discounted terms for external comparison purposes to demonstrate Value for Money.
Cash Releasing Benefits	CRB	Benefits that directly release cash back into the organisation.
Clinical Commissioning Group	CCG	The local Clinical Commissioning Group (West Kent CCG)
Clinical digital maturity index	CDMI	A model for assessing the maturity of information systems.
Commissioning for Quality and Innovation	CQUIN	
Consumer Price Index	CPI	Used for calculating inflation. The CPI is taken from quarterly forecasts prepared by HM Treasury.
Cost Improvement Programme	CIP	Trusts programme looking into cost savings within the Trust
Critical Success Factor	CSF	
Did Not Attend	DNA	
Electronic Health Record	EPR	The central electronic based record holding patient data (both clinical and administrative), also often referred to as Electronic Patient Record (EPR).

Term	Abbreviation	Definition
Electronic Document Management	EDM	The Viper system has patients' medical record scanned into for ease of access to patient's notes, this is known as e-notes.
Electronic Medical Record Adoption Model	EMRAN	A model for assessing the adoption of clinical of information systems
Electronic Prescribing and Medicine Administration	ePMA	
Full Business Case	FBC	The business case presented following detailed work up of the case for change to the processes and technology related to delivery of the Electronic Patient Record for MTW
Health and Information Management Systems Society	HIMMS	
Health and Social Care Information Centre	HSCIC	
Information and Communication Technology	ICT	
Information Management and Technology	IMT	
Information Technology	IT	
Investment Objectives	IO	
Invitation to participate in competitive dialogue	IPCD	The first stage of dialogue in the procurement process
Invitation to Submit Final tender	ISFT	The final stage of dialogue in the procurement process
Invitation to Tender	ITT	
Laboratory information Management System	LIMS	
Managing Successful Programmes	MSP	A recommended programme management best practice framework.
Non-Cash Releasing Benefits	NCRB	Benefits to the NHS that are measurable but do not release cash.
Maidstone and Tunbridge Wells NHS Trust	MTW	
NHS Improvement	NHSi	
Office of Government Commerce	OGC	
Official Journal of European Union	OJEU	Where adverts for new work are placed for public bodies
Order Communications Systems	OCS	The system used to request tests and receive results back from areas including pathology and radiology, also often referred to as Order Communication, Results and Reporting (OCRR)
Outline Business Case	OBC	The business case setting out options and high level costs for approach to Electronic Patient Record, the approval of which authorised further detailed work up on the preferred options and initiation of the

Term	Abbreviation	Definition
Patient Administration System	PAS	procurement exercise Core central system for managing the hospital patients systems
Patient Master Index	PMI	The main source of patient demographic data
Patient Tracking Lists	PTL	How patients waiting for operations and appointments are tracked
Picture Archiving and Communication System	PACS	System for managing digital x-rays
Post Implementation Review	PIR	Review of the programme undertaken after the systems have been deployed
Projects IN Controlled Environments, version 2	PRINCE2	A recommended project management best practice framework.
Quality, Innovation, Productivity and Prevention	QIPP	
Radiology Information System	RIS	
Senior Responsible Owner	SRO	Executive in charge of the programme
Societal Benefits	SB	
Strategic Outline Case	SOC	
Sustainability & Transformation Partnership	STP	
The Public Contracts Regulations 2015	PCR15	Legislation introduced on 26 <sup>th</sup> February 2015 related to UK public sector procurement and implementing the 2014 EU Public Sector Procurement Directive.
Transfer under Protection of Earnings	TUPE	Rules for transfer staff between employers at start or end of contract
User Acceptance Testing	UAT	
Value for Money	VFM	A term used to describe the economic return on investment. In general, an investment that produces a Net Present Value (NPV) i.e. cumulative benefits exceed cumulative costs is considered to be VFM. The HM Treasury Green Book recommends the preferred option to be the option with the highest NPV, which represent best Value For Money.

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## 1. Executive Summary

### 1.1. Introduction

This document comprises the Outline Business Case (OBC) for the procurement of systems and services that would form the Electronic Patient Record (EPR) for Maidstone and Tunbridge Wells NHS Trust (MTW). The required investment will depend upon the preferred option; initial estimates for investment for a 10-year contract range from, a managed service contract, with a capital investment of **£3.1m** and revenue of **£10.60m** over 10 years (excluding non-recoverable VAT) and a purchase and support contract with a capital investment of **£8.24m** and revenue of **£5.03m** over 10 years (excluding non-recoverable VAT).

The OBC follows the approved format of the Five Case Model, which comprises the following key components:

- **The strategic case.** This section sets out the case for change, together with the supporting investment objectives for the scheme.
- **The economic case.** This section demonstrates that the organisation has selected the most economically advantageous offer, which best meets the existing and future needs of the service and optimises value for money (VFM).
- **The commercial case.** This section sets out the content of the proposed deal.
- **The financial case.** This section confirms funding arrangements, affordability and the effect on the balance sheet of the organisation.
- **The management case.** This section details the plans for the successful delivery of the scheme to cost, time and quality targets and tolerances.

### 1.2. Approvals Process

The process for approval of this OBC is as follow:

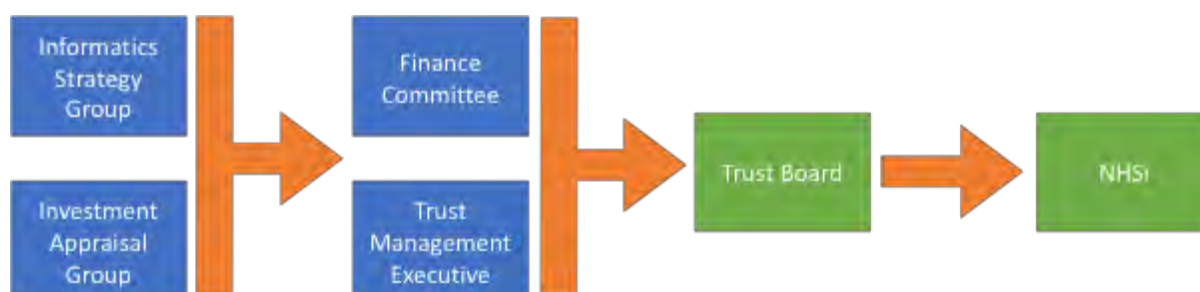


Figure 1: Approvals Process

### 1.3. Context

#### 1.3.1. What is the Nature of the Proposed Investment?

The proposed investment is for the procurement and implementation of a new trust wide EPR. The primary constituents of the EPR are a revised and embedded working practices across the organisation supported by the technologies and systems that enable the new working practices.

Over recent years the Trust has undertaken several reviews of the strategic direction regarding informatics and IT. A number of IT Strategies have been produced by the Trust in 2009, 2014 and 2018. Each documented strategy outlined substantial changes in approach, reflecting both national and local Trust imperatives for informatics, in particular the need to align with the National Programme for IT (NPfIT), along with the innate expectation that this would deliver EPR functionality via nationally contracted Local Service Providers. As a result, the Trust's investment in IT and

informatics has been sporadic and often focussed on tactical solutions. Without the delivery of NPfIT EPR systems, this has resulted in the Trust being left with a mixed estate of isolated specialist departmental systems. Central funding has recently enabled the implementation of the Allscripts PAS which provides the strategic basis for developing a full EPR solution. However, this does not fully address the needs of a fully integrated patient record, such as ePrescribing functionality.

As noted in the Trust's Annual Report 2016/17, over the year MTW has seen significant increases in its workload, with increases of approximately 18,000 Accident and Emergency (A&E) attendances and 4,000 hospital admissions over the previous year, which adversely affected elective activity and placed tremendous strain on Trust staff and resources.

In combination with the financial challenges set out in the annual report, including the reported deficit of £10.9m and the continuation of being placed in Financial Special Measures (FSM), the Trust faces substantial, on-going challenges in the provision of its services.

The current financial pressures within the NHS, along with the specific challenges facing MTW noted above, require efficiency and productivity gains that can only be achieved through embedding changes to processes. This in turn requires staff in all areas of the organisation to have access to the required information when and where they need it.

An EPR system could be delivered as a single solution or a mix of a core systems plus optional departmental systems with rigorous, automated integration. The strategic approach to achieve the EPR technology is a key decision point for the Trust, as this will help to define the programme and investment profiles for both the technology implementation and the surrounding business change programme.

As part of work undertaken by the Trust the following investment objectives have been identified to support the investment:

Ref	Investment Objective Description
IO1	Provide a system that can support improved clinical outcomes through a single source of patient data for staff;
IO2	Provide a system that can improve patient safety through ensuring the clinical teams have the information they require where and when needed;
IO3	Provide a system that can improve productivity and efficiency through delivery of benefits that reduce time wasted on administrative processes in the patient workflow;
IO4	Provide a system that will support the engagement between MTW and its regional partners, in particular, engagement with the Trusts STP partners.
IO5	Provide a clinical system that allows patient involvement and engagement in their care;
IO6	Realisation of benefits mapped to objectives in the Trust's Strategy;
IO7	Demonstrates Value for Money through the procurement process as a measurable outcome; to confirm affordability of preferred option.
IO8	Demonstrable Return on Investment through the business case financial assessment;
IO9	Demonstrate alignment to and delivery of MTW Trust Strategy and achievement of national drivers.
IO10	Provide a system that can support service transformation and integration through delivery of a single source of data for clinical teams across the care settings;
IO11	Provide a system that both populates and utilises a centralised repository of data for research.
IO12	Provide a system that can support improved clinical outcomes through a single source of patient data for staff;

Figure 2: Investment Objectives Table

**1.3.2. What is the Purpose of this Business Case?**

This document will:

- Present the outcomes of the recent review of organisation drivers; and
- Identify and confirm the Trust's objectives that have led to this investigation of EPR; and
- Set out and appraise the options available to the Trust to achieve these objectives.

Authority is sought for the preferred option to commence to the procurement phase along with the development of the Full Business Case.

**1.4. Strategic Case - Why Is It Needed?****1.4.1. The Strategic Context**

Maidstone and Tunbridge Wells NHS Trust is a large acute hospital trust in the south east of England. It provides a full range of general hospital services to around 590,000 people living in West Kent and East Sussex. The Trust also provides some aspects of specialist care to a wider population.

The Trust employs a team of over 5000 staff. It operates from two main sites but also has services at Canterbury and Crowborough hospitals as well as outpatient provision at several community locations. It has over 800,000 patient visits a year, 150,000 of these coming through our Emergency Departments, accessible on the main sites. Maidstone Hospital has 325 overnight beds and Tunbridge Wells Hospital 475 overnight beds.

The current financial pressures within the NHS generally, and some of the specific challenges facing MTW, require efficiency and productivity gains that can only be made through providing staff in all areas with the information required, first time, when and where they need it. This acts as a catalyst to drive further cost savings throughout the organisation.

MTW is a financially challenged Trust which has recognised the need to drive major strategic change to secure clinical, operational and financial sustainability. With the health system undergoing significant change, due to increasing pressure on health and social services and the need for improved sustainability, MTW is looking to adapt to meet local and regional health needs, in order to maintain high levels of service. This will involve further supporting community based services and collaborating more closely with neighbouring secondary care trusts and other health providers

This proposed programme recognises that informatics and a new EPR are key drivers, providing the ability to deliver the required changes and through this further efficiencies and savings. This programme case has not sought to pre-judge the outcomes of the national and local reviews but has focused on identifying a solution that can flex to meet current and future national framework requirements, which the Trust will need to address in its clinical, operational and financial performance.

### 1.4.2. The Case for Change

The organisation has recently published its Trust Strategy. Building upon the Trust's vision, *to deliver kind, compassionate and sustainable services for our community, through being improvement driven and responsive to the needs of our patients and staff, making MTW a great Trust to visit and work.* The below diagram sets out “clear organising principles to provide a framework for service developments and improvements”.



Figure 3: Trust Strategy

MTW recognises that each of the focus areas set out in its Trust Strategy may be enabled through better implementation and utilisation of informatics. However, it is not believed that the current distributed model for data and best of breed systems can support the Trust in delivering its strategic goals, nor can it be used to drive forward the operational efficiencies required by the Trust.

The impact of this is that in some cases the ageing applications and lack of integration is now causing day to day difficulties for end users. The challenge of integrating data between so many systems is inhibiting the achievement of a patient-focussed approach and care delivery, this alone could justify the need for investment in an EPR.

The Trust also acknowledges that the current applications do not provide the functionality required to meet the needs of national drivers, such as the Lord Carter Report and the NHS 5 Year Forward View. Where a key enabler is the delivery of an electronic patient record and in particular electronic prescribing.

During the development of the OBC an array of clinical, nursing, management and administrative staff have developed a working group to understand the current challenges faced and how investment in new systems could benefit patients and staff. A summary of the issues identifies:

- The Trust maintains a significant operational overhead as a result of manual duplication of data between a significant number of existing systems. Paper based processes flowing across the organisation are replicated within electronic systems, meaning that data is often transposed from paper to electronic and back to paper multiple times as the processes are enacted.
- Data processes within MTW are generally perceived to be inefficient and very “manual” requiring significant administrative overhead to operate.
- Although a wealth of information is contained within the Trust’s disparate systems, it is difficult for end-users to access without the further development required to deliver performance dashboards which provide a rapid view of key indicators and the ability for users to drill down into the analytics without recourse to an overstretching information team.
- The Trust’s multiple clinical systems and paper records make it increasingly difficult for health workers and clinicians to access the full content of a patient’s electronic record where information has been recorded digitally. The Trust remains largely a paper-driven organisation.
- The lack of a full ePMA results in prescribing errors resulting in drug wastage and clinical errors.
- Delays and errors caused by repeated signing in and out of clinical systems generates a negative response from clinicians who feel the process is ‘clunky’ and more time consuming than the traditional pen and paper approach.
- The Trust has taken a best of breed approach to procuring clinical systems, however, the Trust is operating a number of legacy systems which are not adequately interfaced. Support and sustainability of this setup is an increasing challenge for the Trust and represents a risk to the organisation and its patients.
- With an ongoing programme of work under way with the CCG and now a wider driver from the STP, MTW’s aspiration for a continuous electronic patient pathway across the Trust, community and GP systems is not achievable with current Trust systems, yet it is essential in providing the best possible care for patients.
- There is currently no clinical decision support in place with the current clinical systems, to reduce errors and ensure best practice is followed.

- There is a general recognition that the additional resource required to implement and deliver the change to MTW will be a challenge to the current team and additional resources will be needed.

The case for change has been made based upon local clinical requirements, the need to reduce risk and the provision of efficiency gains, following a period of underinvestment. In meeting these local needs, the investment also addresses national drivers and objectives.

### 1.4.3. Key Stakeholder Support

The support for the investment in new information systems (EPR) has been reviewed in workshops and meetings with three key stakeholder groups:

- Service users – including clinical and administrative staff
- Senior managers and clinical leaders
- Executive team

## 1.5. Economic Case - Options Appraisal

### 1.5.1. OBC Longlist and Shortlist

The OBC has built a set of long list options (See Appendix A) which were constructed based on a range of categories using the Treasury Green Book Model. These options were developed through presentations workshops, along with meetings with clinical and operational staff and consultations with partner organisations. The options were further analysed against Trust strategic objectives and critical success factors, to identify the shortlist of options.

The following table shows the shortlisted options that are recommended to be taken forward for further assessment at Full Business Case (FBC) stage.

Shortlist Option Number	Option Elements	Description
1	Do Nothing	This is the baseline option and only shows replacing the PAS, which is the highest risk, therefore the 'do nothing' option doesn't exist.
2	Best of Breed EPR - Capital and Revenue model	A best of breed EPR based upon core systems from a single provider (i.e. PAS, Order Comms), integrated with the best available departmental systems. Purchased as a capital and revenue model
3	EPR Module - Capital and Revenue model	Purchase additional EPR module providing almost all required functionality. Purchased as a capital and revenue model
4	EPR Module - Managed Service model	Purchase additional EPR module providing almost all required functionality. Purchased as a managed service model
5	Kent Wide EPR solution	A single supplier EPR providing almost all aspects of required functionality provided as part of Kent wide deployment across Kent acute Trusts.

Figure 4: Shortlisted Options

### 1.5.2. Key findings

From the further analysis undertaken at an economic level the following undiscounted table was produced:



Summary - undiscounted (all financial figures £000 exc VAT)	Option 1 - Do Nothing	Option 2 - Best of Breed Solution (Capital Programme)	Option 3 - EPR Solution (Capital Programme)	Option 4 - EPR Solution (Managed Service)	Option 5 - Kent Wide EPR
Capital expenditure exc VAT	(1,520)	(5,347)	(6,825)	(2,335)	(5,219)
Capital expenditure optimism bias uplift	0	(86)	(130)	(37)	(99)
Revenue expenditure exc VAT	0	(5,318)	(3,517)	(8,444)	(5,107)
Revenue expenditure optimism bias uplift	0	(85)	(73)	(135)	(97)
<b>Total expenditure exc VAT</b>	<b>(1,520)</b>	<b>(10,836)</b>	<b>(10,544)</b>	<b>(10,951)</b>	<b>(10,522)</b>
Plus cost of risk retained	(1,360)	(1,310)	(1,265)	(1,265)	(1,324)
Less cash releasing benefits	0	9,385	16,623	16,623	13,623
Less non-cash releasing benefits	0	11,545	14,497	14,497	12,954
Less societal benefits	0	0	0	0	0
<b>Total - undiscounted (highest +ve figure = best)</b>	<b>(2,880)</b>	<b>8,784</b>	<b>10,011</b>	<b>10,904</b>	<b>14,731</b>
<b>Risk Score</b>	<b>608</b>	<b>490</b>	<b>467</b>	<b>467</b>	<b>479</b>
<b>Quality benefits score</b>	<b>0</b>	<b>182</b>	<b>211</b>	<b>211</b>	<b>223</b>

Figure 5: Undiscounted economic cost by option

This demonstrates at the economic level all the options for delivering the change to the Trust, all identified savings and all efficiency improvements, with Options 2,3,4 and 5 showing positive net savings. The economic variation shows that an EPR (delivered via either Capital and Revenue or Fully Managed Service models) provides a lower risk and higher benefits return than the Best of Breed approach. The FBC will further consider the Capital/Revenue model versus the Managed Service model, which will be assessed through the procurement stage to better understand the additional benefits and risk analysis of each option.

The following table shows a similar comparison of the options at financial level:

Summary - discounted (all financial figures £000 exc VAT)	Option 1 - Do Nothing	Option 2 - Best of Breed Solution (Capital Programme)	Option 3 - EPR Solution (Capital Programme)	Option 4 - EPR Solution (Managed Service)	Option 5 - Kent Wide EPR
Capital expenditure exc VAT	(1,303)	(5,007)	(6,581)	(2,243)	(4,964)
Capital expenditure optimism bias uplift	0	(80)	(125)	(36)	(94)
Revenue expenditure exc VAT	0	(4,379)	(3,130)	(7,272)	(4,362)
Revenue expenditure optimism bias uplift	0	(70)	(59)	(116)	(83)
<b>Total expenditure exc VAT</b>	<b>(1,303)</b>	<b>(9,526)</b>	<b>(9,895)</b>	<b>(9,667)</b>	<b>(9,503)</b>
Plus cost of risk retained	(1,148)	(1,121)	(1,083)	(1,083)	(1,137)
Less cash releasing benefits	0	7,457	13,402	13,402	10,778
Less non-cash releasing benefits	0	9,218	11,576	11,576	10,168
Less societal benefits	0	0	0	0	0
<b>Total - discounted - (highest +ve figure = best)</b>	<b>(2,452)</b>	<b>6,019</b>	<b>14,000</b>	<b>14,228</b>	<b>10,304</b>
<b>Risk Score</b>	<b>608</b>	<b>490</b>	<b>467</b>	<b>467</b>	<b>479</b>
<b>Quality benefits score</b>	<b>0</b>	<b>182</b>	<b>211</b>	<b>211</b>	<b>223</b>

Figure 6: Discounted economic cost by option including PDC and VAT impact

## 1.6. Commercial Case

### 1.6.1. Agreed Products and Services

The following products and services are being considered through this OBC, based upon Trust needs and planned approach:

#### Phase 1 – Preparation of Existing Systems

- Upgrade roadmap for those systems that are allocated to later replacement phases.
- Review and upgrade roadmap for those systems that require data quality improvements prior to moving into EPR.
- Confirm Infrastructure and Data Centre are fit for purpose.

#### Phase 2 – Foundation systems and preparation:

- Data Warehouse integration reviewed and prepared
- Electronic Document Management (EDM) reviewed and prepared for integration
- Investment in the preparation of hardware and PCs to support the programme

### Phase 3 – EPR Core Systems including

- Order Entry and Result Reporting with the ability to configure orders that drive worklists (task scheduling) and orders that drive flowsheet charting;
- Clinical documentation using flowsheets, structured notes, and clinical summary tiles;
- Patient Timeline View
- Patient information, patient lists, patient orders and results
- Interoperability – access to external systems and information
- Integration to third party systems.
- Bed and Ward Management
- Emergency Department
- Clinical Documentation / e-Noting
- ePrescribing
- Rules Engine: Alert escalation, Allergy checking, Dosage range checking, Dosage calculations, Duplicate order checking, Duplicate task checking, Expert dosing, Panic results and conflicting medications;
- Community Services Integration
- Interoperability standards to allow information flows across the region.

### Phase 4 - Departmental Systems including:

- Critical Care
- Diabetes
- Voice Recognition integration
- Anaesthetics Record and Pre-Assessment
- Tracking Boards
- Secure Messaging for clinicians
- Mobile EPR
- eObservations

*With the exception of option 1 – Do nothing, all phases have been included within the costs of this EPR outline business case.*

### 1.6.2. Procurement approach

The options review has recommended that the procurement be broken down into the following phases:

Phase	Procurement Route	Description
Phase 1 and 2	System Updates	Covered under existing contracts.
Phase 3 and 4	National Frameworks	Use existing National Frameworks to procure systems reducing costs and timescales to begin implementation of services.

*Figure 7: Procurement Approach*

### 1.6.3. Procurement plans and timescales

The following tables show the current plans for the procurement:



Stage	Date
Finalise Specification	14 <sup>th</sup> May 2018
Issue ITT through SBS framework	15 <sup>th</sup> May 2018
Clarification Session	21 <sup>st</sup> & 22 <sup>nd</sup> May 2018
Deadline for Supplier clarifications to be received	5 <sup>th</sup> June 2018
Deadline for Trust responses to clarifications	12 <sup>th</sup> June 2018
Final contract review	18 <sup>th</sup> & 19 <sup>th</sup> June 2018
Deadline for submission of bid	26 <sup>th</sup> June 2018
Final Business Case (FBC) Approval	28 <sup>th</sup> June 2018
Evaluation	29 <sup>th</sup> June 2018
Executable Contract Agreed	30 <sup>th</sup> June 2018
Contract Signed	30 September 2018

Figure 8: Procurement Plan

### 1.7. Finance Case - How Much Will It Cost?

Maidstone & Tunbridge Wells NHS Trust	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Total
CASH FLOW SUMMARY £000	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	
<b>CASH OUT</b>												
Capital payments - Maidstone & Tunbridge	287	1,369	694	22	0	0	0	0	0	0	0	2,392
Capital payments - optimism bias uplift *	5	22	11	0	0	0	0	0	0	0	0	38
Capital contingency **	29	181	123	34	23	29	35	36	37	20	20	567
<b>Capital payments - total</b>	<b>320</b>	<b>1,591</b>	<b>827</b>	<b>57</b>	<b>23</b>	<b>29</b>	<b>35</b>	<b>36</b>	<b>37</b>	<b>20</b>	<b>20</b>	<b>2,997</b>
Revenue payments - Maidstone & Tunbridge	300	1,294	1,721	694	709	724	739	755	771	787	788	9,281
Revenue payments - optimism bias uplift *	5	21	28	11	11	12	12	12	12	13	13	149
Revenue contingency **	30	166	214	78	81	84	88	92	95	99	139	1,167
<b>Revenue payments - total</b>	<b>335</b>	<b>1,481</b>	<b>1,963</b>	<b>783</b>	<b>801</b>	<b>820</b>	<b>839</b>	<b>858</b>	<b>878</b>	<b>899</b>	<b>940</b>	<b>10,597</b>
VAT	117	532	474	126	124	127	129	132	135	138	138	2,172
Cash releasing benefits	0	0	-673	-1,655	-2,087	-2,310	-2,358	-2,408	-2,458	-2,510	-2,514	-18,072
<b>Total cash out</b>	<b>772</b>	<b>3,604</b>	<b>2,592</b>	<b>-689</b>	<b>-1,138</b>	<b>-1,334</b>	<b>-1,355</b>	<b>-1,381</b>	<b>-1,408</b>	<b>-1,453</b>	<b>-1,416</b>	<b>-3,206</b>
<b>CASH IN</b>												
Recovered VAT	117	471	433	126	124	127	129	132	135	138	138	2,070
Other (specify details)												0
<b>Total cash in</b>	<b>117</b>	<b>471</b>	<b>433</b>	<b>126</b>	<b>124</b>	<b>127</b>	<b>129</b>	<b>132</b>	<b>135</b>	<b>138</b>	<b>138</b>	<b>2,070</b>
<b>NET CASHFLOW</b>												
Net cashflow	655	3,133	2,159	-815	-1,262	-1,461	-1,484	-1,513	-1,543	-1,581	-1,554	-5,276
Brought forward	0	655	3,789	5,947	5,132	3,870	2,410	926	-687	-2,131	-3,722	
Carried forward	655	3,789	5,947	5,132	3,870	2,410	926	-687	-2,131	-3,722	-5,276	
<b>Element of payments in 'cash out' that comprises inflation</b>												
Capital	0	32	33	3	2	3	4	5	5	4	4	96
Revenue	-2	29	78	47	64	80	98	116	134	152	161	959

Figure 9: Cashflow Summary

Note: Positive Values represent cash-out and Negative Values represent cash-in

The Cashflow Summary for the preferred Option 4 of a Single Supplier Fully Managed EPR Service shows the year on year investment required to deliver the efficiency, safety and quality benefits for patients and staff.

Maidstone & Tunbridge Wells NHS Trust	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Total
INCOME & EXPENDITURE SUMMARY	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	
<b>COSTS</b>												
Revenue payments	335	1,481	1,963	783	801	820	839	858	878	899	940	10,597
Non-recoverable VAT on revenue	0	0	0	0	0	0	0	0	0	0	0	0
Depreciation (non-cash flow item)	29	214	321	330	333	339	348	359	377	396	53	3,100
Rate of return (non-cash flow item)	5	35	70	75	65	54	43	32	20	8	1	408
<b>Grand total costs</b>	<b>369</b>	<b>1,730</b>	<b>2,354</b>	<b>1,188</b>	<b>1,200</b>	<b>1,213</b>	<b>1,230</b>	<b>1,250</b>	<b>1,276</b>	<b>1,302</b>	<b>993</b>	<b>14,104</b>
<b>FUNDING</b>												
Cash releasing benefits	0	0	673	1,655	2,087	2,310	2,358	2,408	2,458	2,510	2,514	18,972
Other (specify details)												0
<b>Grand total funding</b>	<b>0</b>	<b>0</b>	<b>673</b>	<b>1,655</b>	<b>2,087</b>	<b>2,310</b>	<b>2,358</b>	<b>2,408</b>	<b>2,458</b>	<b>2,513</b>	<b>2,568</b>	<b>19,827</b>
<b>NET COST TO REVENUE SOURCES</b>	<b>369</b>	<b>1,730</b>	<b>1,682</b>	<b>-468</b>	<b>-887</b>	<b>-1,097</b>	<b>-1,128</b>	<b>-1,158</b>	<b>-1,580</b>	<b>-1,611</b>	<b>-1,575</b>	<b>-5,722</b>

Figure 10: Income &amp; Expenditure Summary

Note: Positive Values represent cash-out and Negative Values represent cash-in

The Income & Expenditure Summary demonstrates the Revenue Impact of the preferred Option 4. A closer analysis will be undertaken during the FBC stage to establish whether the Capital and Revenue model provides a better option for the Trust.

The required funding to deliver the initial 3 years of the EPR Programme currently sits outside of the Capital Plan. IT Capital funding of £2.9m has been identified and allocated to the EPR Programme.

## 1.8. Management Case

### 1.8.1. Programme Management Arrangements

The following diagram shows the proposed structure of the EPR Programme alongside the additional governance structures recommended for interrelated change and operational work. It reflects the need to represent the organisation, end users, suppliers and provision of external quality assurance roles.

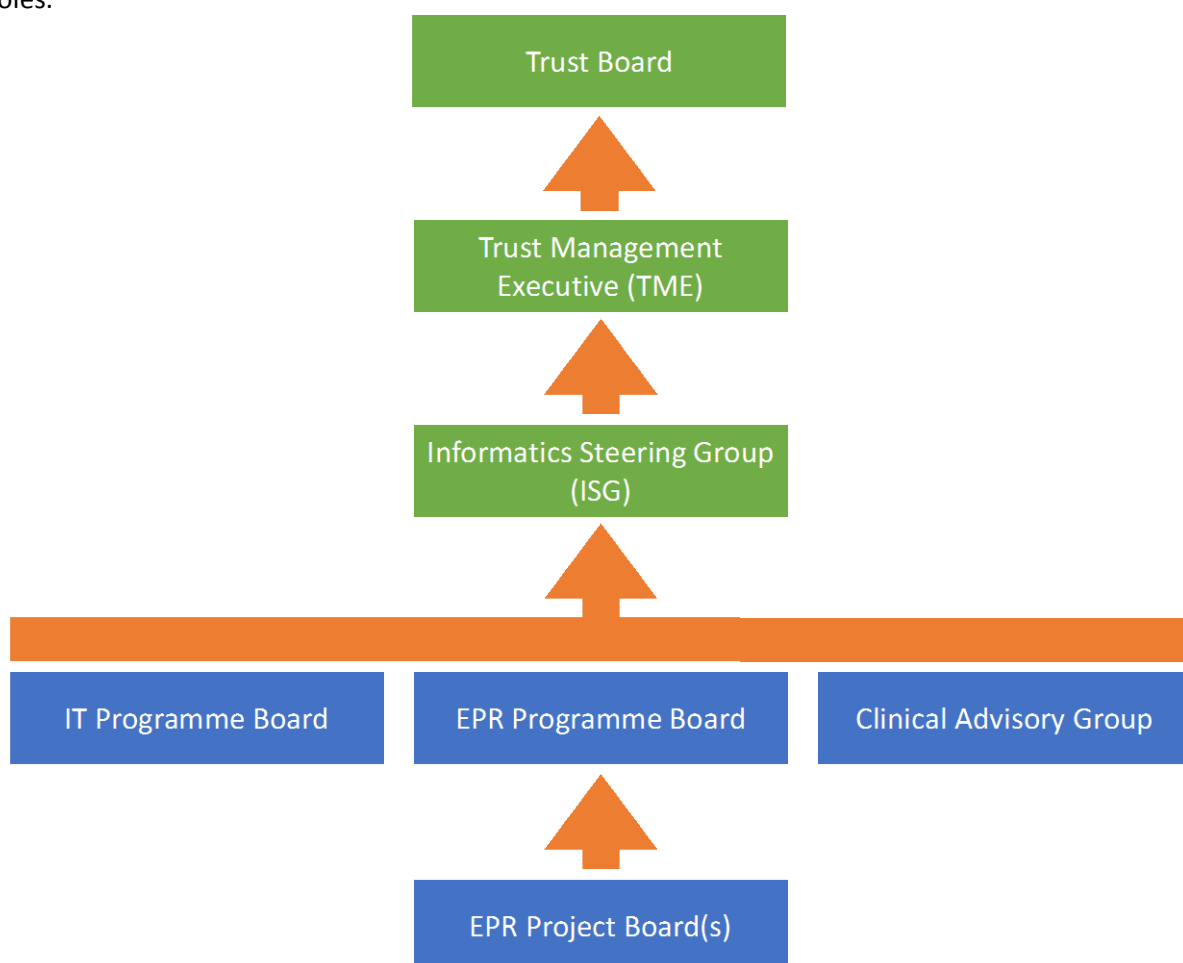


Figure 11: Proposed Overarching Governance Structure

### 1.8.2. Informatics Steering Group

The Informatics Steering Group is to be formed reporting to the Trust Management Executive. The group will set the direction of travel and ensure that the Trust Board and other key stakeholders are kept informed of the progress to date. The group will provide the governance structure for both informatics projects and operational performance ensuring that all Informatics development is coordinated to meet the needs of the organisation.

**1.8.3. EPR Programme Board**

The EPR Programme Board will provide the overall direction to the EPR programme according to the Programme Vision. It has responsibility to formally agree proposals and commit resources and is the authority that signs off the completion of each stage as well as authorising the start of the next stage. The EPR Programme Board will commission projects to deliver the programme requirements and will delegate to reporting Project Boards.

**1.8.4. Clinical Advisory Group (CAG)**

The CAG will aid the clinical engagement with the programme, ensuring that at all stages clinical sign off is provided. The chair of the CAG will sit on the EPR programme board as senior user, with CAG members acting as senior users on EPR project boards and working groups, to ensure clinical engagement at all levels.

**1.8.5. Resources**

It is recognised that a programme of work of this size will require a considerable investment in people, as well as technology, to deliver the vision and benefits. The case acknowledges that this will apply additional pressures to the IT team and business users, and where required additional costs have been included for external / backfill support.

**1.8.6. Benefits Realisation and Risk Management**

At this stage, only indicative work has been undertaken to identify benefits to support the investment and they have been assessed against the following criteria:

- Cash releasing benefits
- Non-cash releasing benefits
- Quality benefits

The benefits have been identified from discussions with the EPR Working Group and workshops held with key stakeholders, along with data gathered from previous business cases and published data. For each benefit there is clear description of the improvement and the functionality that delivers the benefit, along with a financial value, where possible. Appendix B contains the benefits plan, which includes the detail tracker for each benefit. It is recommended that a detailed benefits plan, localised to MTW, should be developed once the final solution is known for the FBC.

A robust and structured risk management strategy will be developed as one of the early deliverables of the EPR Programme Board; the initial risks associated with the successful delivery of this programme will be assessed in detail and are incorporated within a Programme Risk Register. The risk management approach recommended builds upon best practice described within Management of Risk (MoR) as well as the HM Treasury Orange Book.

**1.8.7. Arrangements for Post Programme and Project Evaluation**

The arrangements for a post implementation review (PIR) and a project evaluation review (PER) will be established by the EPR Programme Board in accordance with best practice and are recommended to incorporate the following:

- Post Implementation Review (PIR)
- Programme Evaluation Review (PgER)
- Project Evaluation Reviews (PjER)

**1.9. Recommendation**

The outline business case has confirmed that there are sufficient benefits and savings to be made from procuring an EPR and associated services for MTW. The recommendation is:

- The Trust confirm their intention to invest in an EPR solution from a single supplier.
- The next stage of the EPR specification commences to finalise the required functionality.
- That the procurement phase commences (including contract preparation). This stage is anticipated to require an investment cost of £25k;
- The detailed benefit is developed, once the final configuration and systems are known to support the FBC;
- Prepare the FBC to present to the Trust Board for final approval, that shows the full costs and benefits, once the preferred supplier is identified;
- The decision is made on which enabling systems will be progressed

Signed:

Date:

**Senior Responsible Owner**

## 2. Strategic Case

### 2.1. Introduction

This Outline Business Case (OBC) identifies the investment required to procure and implement an Electronic Health Record for the Maidstone and Tunbridge Wells NHS Trust (MTW).

### 2.2. The strategic context

#### 2.2.1. Organisational overview

Maidstone and Tunbridge Wells NHS Trust is a large acute hospital trust in the south east of England. It provides a full range of general hospital services to around 590,000 people living in West Kent and East Sussex. The Trust also provides some aspects of specialist care to a wider population.

The Trusts' vision is, to be more responsive and focused on improvement, fulfil its potential and be the high performing organisation its patients and staff deserve. The aim is to be a Trust where, patients choose to be treated and the best people aspire to work.

The health system is changing around MTW due to the increasing pressure on health and social services and the need for improved sustainability. MTW must be ready to adapt to meet local and regional health needs, in order to maintain high levels of service. This will involve further supporting community based services and collaborating more closely with neighbouring secondary care trusts and other health providers.

The Trust aims to deliver the vision, through its values:

- Patient First - We keep the patient at the heart of everything we do.
- Respect – We respect and value our patients, visitors and staff
- Innovation – We take every opportunity to improve services
- Delivery – We aim to deliver high standards of quality and efficiency in everything we do
- Excellence – We take every opportunity to enhance our reputation

The Trust employs a team of over 5000 staff. It operates from two main sites but also has services at Canterbury and Crowborough hospitals and outpatient provision at several community locations. It has over 800,000 patient visits a year, 150,000 of these coming through our Emergency Departments which are accessible on the main sites. Maidstone Hospital has 325 overnight beds and Tunbridge Wells Hospital 475 overnight beds.

Tunbridge Wells Hospital is a Private Finance Initiative (PFI) hospital, providing mainly single bedded, en-suite accommodation for inpatients in a modern, state of the art environment. It is a designated Trauma Unit, undertakes the Trust's emergency surgery and is the main site for Women & Children and Orthopaedic services.

Maidstone Hospital benefits from its central county location. It hosts the Kent Oncology Centre providing specialist cancer services to around 2 million people across Kent and East Sussex, the fourth largest oncology service in the country. The Trust offers PET CT services in a new, dedicated building and has a rolling programme to upgrade its Linear Accelerator radiotherapy machines.

The Maidstone site also has a state of the art birth centre, a new £3 million dedicated ward for respiratory services and an impressive academic centre with a 200 seat auditorium. With the academic centre at Tunbridge Wells, and its full resuscitation simulation suite, the Trust is able to offer excellent clinical training. The Trust has strong clinical, academic and research links with

London hospitals, including joint appointments and a growing research capability. Many staff are also nationally recognised for excellence in their fields.

The Trust also forms part of the Kent and Medway Sustainability & Transformation Plan (STP). This aims for all organisations within the STP to work together on planning how health and social care services will be transformed to meet the changing needs of local people. MTW are a key and active partner in this process which will result in the creation of an accountable care system (ACS) across Kent and Medway.

### 2.3. National drivers

The following tables provide a summary of the National Drivers and Initiatives that MTW need to meet:

#### Lord Carter Report

February 16	Operational Productivity and performance in the NHS Acute Hospitals The review identified: <ul style="list-style-type: none"> <li>• The provision of high quality clinical care and good resource management go hand-in-hand. All trusts should therefore grasp the use of their resources more effectively</li> <li>• A single reporting framework should be adopted across all trusts, which pulls together clinical quality and resource performance data and compares it to the 'best in class'</li> <li>• Delayed transfers of care for patients out of the acute hospital setting affects nearly all trusts A significant proportion of the £5bn efficiency target cannot be unlocked unless delays in transfer are managed more effectively</li> </ul>
Implication for MTW	The introduction of a new EPR would support MTW meeting the recommendations in the Lord Carter report.

#### The NHS Five year forward view:

October 2014	This 'Forward View' sets out a clear direction for the NHS – showing why change is needed and what it will look like which has resulted in the development of the STP's. Section 4 of the Five Year Forward View defines: "How we will get there" and includes the following requirement, as part of its commitment to 'exploit the information revolution':  "Fully interoperable electronic health records, so that patients' records are largely paperless. Patients will have full access to these records and be able to write into them. They will retain the right to opt out of their record being shared electronically".
Implication for MTW	The introduction of interoperable systems would enable MTW to begin the journey to deliver the outcomes of the Five-year forward view. Currently, there are many systems being used within the trust that do not 'talk' to one another. There is also the requirement to understand how data can be shared with surrounding organisations.

**Sustainability and Transformation Plans:**

December 15 The NHS shared planning guidance 16/17 – 20/21 outlined a new approach to help ensure that health and care services are built around the needs of local populations. To do this, every health and care system in England will produce a multi-year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency. MTW is part of the Kent and Medway STP formed of local commissioners, providers and social care partners.

Implication for MTW IT has a significant role to play in sustainability and transformation. Any major system implementation needs to take into account the benefits it will also provide to the wider STP vision.

**Dalton Review**

January 15 The review identifies 5 important themes:

- One size does not fit all
- Quicker transformational and transactional change is required
- Ambitious organisations with a proven track record should be encouraged to expand their reach and have greater impact
- Overall sustainability for the provider sector is a priority
- A dedicated implementation programme is needed to make change happen

Implication for MTW The introduction of an EPR would be a key catalyst for delivering the outcomes of the Dalton Review.

**Improving Transparency in the NHS**

January 15 The MyNHS website enables health and care organisations, as well as the public, to compare the performance of services over a range of measures, at both local and national level.

The Department of Health, NHS England, Care Quality Commission, Public Health England and the Health and Social Care Information Centre are working together on how this site can be improved and are keen to hear suggestions about how to develop it and help make it as useful as possible.

The site aims to drive improvement in health and care by encouraging organisations and professional teams to compare their performance and see where they can improve.

Implication for MTW MTW can only really compare if they have systems that can accurately and efficiently capture the data needed. The new EPR would allow this.

**NHS Constitution**

March 2013 – updated February 2015 Seven key principles guide the NHS in all it does. They are underpinned by core NHS values, which have been derived from extensive discussions with staff, patients and the public. These values are:-

- The NHS provides a comprehensive service, available to all.
- Access to NHS services is based on clinical need, not an individual's

ability to pay.

- The NHS aspires to the highest standards of excellence and professionalism.
- The NHS aspires to put patients at the heart of everything it does.
- The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population.
- The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.
- The NHS is accountable to the public, communities and patients that it serves.

Implication for  
MTW

MTW can only meet these principles if it has systems that allow it to, for example, share data across boundaries to support patient flows, which is only possible if systems can talk to each other.

### **Personalised Health and Care 2020**

November 2014

Better use of data and technology has the power to improve health, transform quality and reduce the cost of health and care services.

It can:

- give patients and citizens more control over their health and wellbeing
- empower carers
- reduce the administrative burden on care professionals
- support the development of new medicines and treatments

This framework has been developed based on evidence from many sources, including civil society and patient organisations, as well as directly from service users. This is not a strategy in the conventional sense. It is not a national plan, but a framework for action that will support frontline staff, patients and citizens to better take advantage of the digital opportunity.

The National Information Board will report annually on progress made against the priorities detailed in this framework and review them each year to reflect changing technology and accommodate new requirements from the public and staff. The proposals in this framework are not comprehensive, but represent the core and immediate priorities for delivery of modern digital health and care services.

Implication for  
MTW

MTW can only meet this policy if the systems are there to support them. The new EPR would allow such sharing.

### **DH digital strategy update: 2014 to 2015**

October 2014

The digital strategy for 2014 to 2015 is to deliver work around 5 themes:

- Openness
- Simplicity
- Evidence
- Mainstream
- Efficiency

Implication for  
MTW

MTW can only meet this policy if the systems are there to support them. The new EPR would support the digital strategy.

### **The Power of Information: giving people control of the health and care information they need**



October 2014	This strategy sets out plans for using information and technology to improve health, care and support – to improve the experience, quality and outcomes of health and care services, putting people truly at the heart of care
Implication for MTW	MTW can only meet this strategy if the systems are there to support them. The new EPR would support the digital strategy.

### 2.3.1. Local business strategies

Maidstone and Tunbridge Wells NHS Trust is a large acute hospital trust in the south east of England. It provides a full range of general hospital services to around 590,000 people living in West Kent and East Sussex. The Trust also provides some aspects of specialist care to a wider population.

The current financial pressures within the NHS generally and some of the specific challenges facing MTW require efficiency and productivity gains that can only be made through providing staff in all areas with the information they need, first time, when and where they require it. This would be a catalyst to drive further savings throughout the organisation.

MTW is a financially challenged Trust and has recognised the need to drive major strategic change to secure clinical, operational and financial sustainability. With the health system changing around MTW due to the increasing pressure on health and social services and the need for sustainability, MTW is looking to adapt to meet local and regional health needs in order to maintain high levels of service. This will involve further supporting community based services and collaborating more closely with neighbouring secondary care trusts and other health providers.

This proposed Programme recognises that informatics and a new EPR are key drivers and catalysts for providing the ability to deliver organisational change and further efficiencies and savings. This programme case has not sought to pre-judge the outcomes of the national and local reviews but has focused on identifying a solution that can flex to meet the current and future national frameworks and requirements that the Trust need to address its clinical, operational and financial challenges.

### 2.3.2. Current Local Strategy

The Trust's recently published Trust Strategy 2016-21.

#### Our values – we take 'PRIDE' in everything we do...

Our staff worked together to develop our values. They define, as a Trust, who we are, what we believe and how we will work to fulfil our vision and meet our strategic objectives.



#### Patient First

At MTW we put the patient first and at the centre of what we do. Patient safety is our top priority and we are kind, courteous and friendly, keeping our patients and their carers informed. We introduce ourselves, ask how people are and offer help to those who may need it.

#### Respect

At MTW we respect and value our patients, visitors and each other. We are one team, collaborating and helping each other to provide the best service we can as a Trust. We are open, honest and polite whilst acting with discretion. We respect the opinion of others and take time to explain our own views.

#### Innovation

At MTW we take every opportunity to improve our services, reviewing the way we do things and sharing ideas for improvement. Looking for good ideas from elsewhere, we identify better approaches and implement them. We then share our successes and learnings with others.

#### Delivery

At MTW we aim to deliver high quality standards and productivity in everything we do. We work hard to meet objectives and targets and follow agreed policy and good practice. We manage our own time effectively and address poor performance.

#### Excellence

At MTW we take every opportunity to aim for excellence and celebrate great practice. We always do our best, acting positively to feedback and self-develop, and adopt high standards of conduct and integrity.

Figure 12: Trust Strategic Values

The focus areas the Trust has set for the 2016 to 2021 period are set out below. It is expected that an EPR will be a key enabler for many of these strategically driven changes.



Figure 13: Trust Objectives

MTW's overriding aim is to provide high quality patient care, *"to deliver kind, compassionate and sustainable services for our community, through being improvement driven and responsive to the needs of our patients and staff, making MTW a great Trust to visit and work"*.

## 2.4. Current IT Clinical Systems Strategy

The aim of the IT Strategy is to ensure that the organisation delivers the ambitions set locally and nationally. As a result, the Trust aims to deliver the following:

**Ensure that IT solutions support our users in their work** - Provide IT solutions which support staff to reduce data entry requirements, support operational management, manage patient pathways, improve patient safety, provide decision support and intelligent alerting, allowing staff to spend more time with patients, focused of the services they provide.

**IT System availability** - Provide an end to end solution which offers access to data and tools which are easy to use, quick and readily available, replicating the ease of use of technology that staff are used to using at home.

**Support multidisciplinary teams working across organisations** - With continued collaborative working across NHS and social care organisations, ensure system integration is in place to provide a complete care record, both within the Trust and partner organisations.

**Provide a single electronic health record** - The availability of a full electronic health record will enable our staff to have rapid access to the right patient data at the right time wherever they are; ensuring that information and applications support staff in providing patients with the best possible care within the Trust.

**Comprehensive data reporting and analysis** - Either through the clinical applications or the Trusts' Business Intelligence solution, ensure the Trust is capable of analysing clinical information to aid operational management and support service improvement.

**Patient Access** - Provide patients with access to their clinical information, to improve engagement with patients and their carers, promote data quality and provide additional opportunities to improve patient care.

**Secure** - All solutions must proactively prevent cyber-attacks, which could either affect the services the Trust provides or result in the loss or exposure of patient data.

### 2.4.1. EPR

#### What is an EPR

An Electronic Patient Record (EPR) is an electronic version of a patients medical history, that is maintained by an organisation over time, and may include all of the key administrative clinical data relevant to that persons care under an organisation, including demographics, clinical notes, activity, medication, vital signs, past medical history, diagnostic reports and scheduling.



Combined with improved infrastructure, the aim of an EPR is to help treat patients more effectively by giving healthcare staff easier access to a single version of up-to-date information, it will also use this information to improve care through decision support tools, giving healthcare staff the functionality and data needed to be safer and more efficient.

An electronic patient record also opens opportunities for the sharing of patient data across boundaries, to improve care where services are provided but different teams across organisations.

### Why we need an EPR

The aim of the IT strategy should be to ensure that the organisation delivers the ambitions set locally and nationally, key to this is the implementation of a full EPR. Below are just some of the key reasons for the introduction of the solution at the Trust:

- **Clinician access to patient information**

The availability of an electronic full patient record will enable our staff to have rapid access to the right patient data at the right time wherever they are; ensuring that information and information technology supports staff in providing patients with the best possible care within the Trust.

- **A single version of the truth**

Currently data can be held on many different IT systems and on paper notes. There is a requirement to reduce duplication of data input and interrogation; improving data quality from both reliability and accuracy perspectives.

- **Deployment of supporting administrative and reporting systems**

The provision of a unified view across all Trust operations, combined with dashboard reporting that gives the ability to “drill down” into areas of interest will provide streamlined administration and reporting.

- **Reduce clinician’s administration requirements**

Provide IT solutions which support clinical staff to reduce data entry requirements and allow staff to spend more time with patients. This includes functionality such as decision support, system integration and process automation.

- **Paper-lite patient records**

Provide electronic data capture solutions, both hardware and software solutions to reduce the paper record within the Trust.

- **Meet national requirements**

In February 2016, the Lord Carter report on hospital inefficiency focused on improved efficiencies across the NHS. Of the 15 recommendations two are relevant to IT; the Pharmacy Transformation Programme focusing on the introduction of e-Prescribing by April 2020; and the need for key digital information systems to be in place and utilised. These include patient level costing, e-catalogue and inventory management, and EPR.

## 2.4.2. Meeting the Trusts Strategic Aims

To meet the vision, strategic aims and many challenges, the Trust will need to deploy modern, dependable IT systems, resilient infrastructure and IT support services to deliver the information required to provide quality, safe patient care, transform services and ways of working by improving productivity and efficiency.

The table below shows how the IT strategy will support the delivery of the Trust's objectives.

Strategic Aims	IT Strategic Aims
<b>Our patients and their carers</b>	
High quality, kind and compassionate care is pivotal to our vision and is at the centre of what we do at MTW. It is a motivation for our staff.	IT solutions which support not hinder staff in providing services to our patients. Ensuring the information is available in the right place at the right time through the implementation of an EPR and end-user devices. IT should support our staff in providing the best possible care to our patients.
<b>Our staff</b>	
Attract the best people to work at MTW by ensuring our staff feel fully supported and highly valued in their roles. Respect for all colleagues will be championed at all times.	IT Solutions which replicate usability of systems used at home and support staff to effectively perform their roles.
<b>Our partners and community</b>	
Continue to work closely with NHS and social care colleagues as well as our local community to maximise quality of care and address health inequalities.	With continued collaborative working across NHS and social care organisations and part of the STP, we will ensure system integration is in place to provide a complete care record both within the Trust and partner organisations. There will be a continued drive towards a regional care record, which the Trust aim to provide by integration with its EPR.



Strategic Aims	IT Strategic Aims
<b>Configuration of our services</b>	
<p>Work to enhance local care and ensure our acute services are run as effectively as possible with neighbouring acute providers.</p>	<p>IT Solutions deployed within the Trust must support the ability to interoperate with neighbouring health providers and be flexible enough to accommodate the reconfiguration of local health service provision.</p>
<b>Productivity of our services</b>	
<p>Continue work to maximise the flow of patients through our hospitals and ensure key facilities such as theatres, outpatients, imaging and information technology are used to best effect.</p>	<p>IT Solutions should link together, making information and tools available to support an improved patient flow throughout the Trust.</p>
<b>Cost of delivering our services</b>	
<p>Continue to identify ways in which costs to the organisation can be minimised through working with MTW and wider NHS colleagues and using benchmarking.</p>	<p>IT Solutions should enable the collection of Data and provision of Reporting and Data Dashboards to enable the optimisation of patient pathways.</p>
<b>Engaging &amp; empowering our staff</b>	
<p>Actively strengthen staff engagement in the running of the Trust and provide ways in which staff can</p>	<p>IT Solutions must empower staff by providing the right information at the right time, with the use of an electronic patient record and mobile technology.</p>
<p>their services.</p>	
<b>One team with one plan</b>	
<p>Provide a clear annual plan and priorities for the Trust, aligned with the strategy, so staff can work more easily across the organisation as a team, being clear about the most important improvements to be achieved.</p>	<p>IT Solutions should enable staff to work easily across the organisation as a team with one single view of the patient journey.</p>
<b>Increasing clinical leadership</b>	
<p>Encourage clinical engagement across the organisation at all levels to ensure we are delivering the most successful improvements for our patients and staff.</p>	<p>IT Solutions will be deployed to meet the strategic clinical direction of the Trust, supported by the Chief Clinical Informatics Officer (CCIO) and the newly formed Clinical Advisory Group (CAG).</p>

Figure 14: IT Strategic Aims

### 2.4.3. Delivery

The following timescales have been identified to achieve the delivery of this strategy by 2020:

#### IT Strategy Roadmap – Key

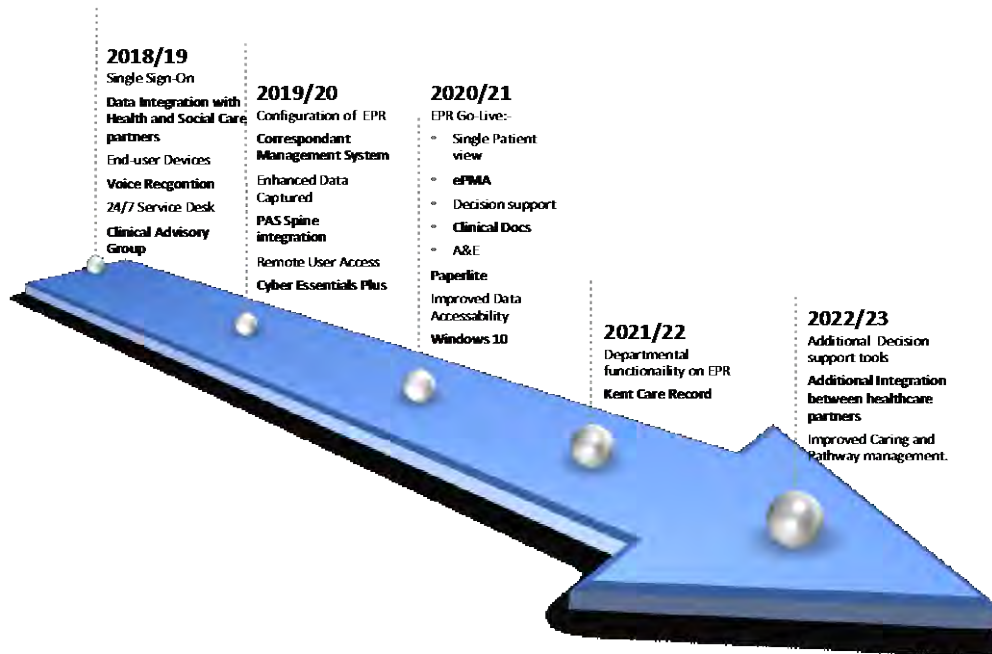


Figure 15: IT Strategic IT Plan

### 2.5. Local Health Economy

Kent and Medway, like other parts of England, have the challenge of balancing significantly increasing demand, the need to improve quality of care and improve access, all within the financial constraints of taxpayer affordability over the next five years. As a result, health and social care, with partners, have come together to develop this Sustainability and Transformation Plan.

The Kent and Medway STP is made up of 21 organisations, containing 8 CCGs, 7 NHS providers and 2 local authorities. MTW are a key and active partner in this process, which will result in the creation of an accountable care system (ACS) across Kent and Medway. The first changes are expected from April 2018 and will have an impact on the way services are provided across Kent.

One of the key enablers for the STP is the availability of patient records in one place 24 hours a day. Therefore, it is paramount that patient records are completely electronic and capable of integrating with other organisations to meet this objective.



## 2.6. The Case for Change

The case for change could be made purely on the basis that current systems do not share information or do not exist. This presents a unique opportunity to consider the scope and scale of the requirements for the Trust and local community, over the next 10 years and should not be missed, as the case for change is potentially wider and is summarised in the following tables. The case for change is therefore presented from both the internal and external community facing viewpoints:

### Internal Drivers

#### 2.6.1. Need for Improved Strategic Fit for Services

Factor	Current Problems Faced
Out of date systems	<ul style="list-style-type: none"> <li>The current IT systems are mainly stand alone with little connectivity, resulting in multiple data entry of patient data with increased risk of transcription errors and mistakes being made. This also creates delays in patient care being delivered and patients being discharged.</li> <li>There are separate systems and notes for medical, nurse and pharmacy, which all need to be known in order for a patient to be discharged.</li> <li>Many staff groups, including therapy specialists, keep paper records that have to be manually re-entered for statistical purposes, which are not maintained as part of the medical record.</li> </ul>

#### 2.6.2. Need to Meet National, Regional, and Local Policy Imperatives

Factor	Current Problems Faced
National drivers including: Health and Social Care Bill 2012. The Power of Information May 2012. Francis Report. The Digital Challenge - Paperless by 2018. Lord Carter Report.	<ul style="list-style-type: none"> <li>The Trust will need to work within the new framework for commissioning; the EPR will need to deliver the information that commissioners require and support wider initiatives such as CQUINS</li> <li>In May 2012 DH issued the report “The Power of Information: putting all of us in control of the health and care information we need”. The strategy set a ten-year framework for transforming information for health and care and stated ambitions that could only be delivered via a comprehensive EPR</li> <li>The Francis Report emphasised the need for and impact of not having access to real-time information to support clinical services - the EPR will enable this across the entire organisation</li> <li>Digital First is a Department of Health initiative, which aims to reduce unnecessary face-to-face contact between patients and healthcare professionals by incorporating technology into these interactions – the EPR will provide the foundations to meet the challenge.</li> </ul>

**2.6.3. Need for Better Access to Services**

Factor	Current Problems Faced
Increasing patient activity	<ul style="list-style-type: none"> <li>The trust has seen year on year growth in patient numbers. This will have a significant increase in patient record management and information flows. The current multiple systems result in duplicate patient records with split clinical history. This increases clinical risk and wastes considerable time in managing patients and seeking relevant information.</li> </ul>
Patients	<p>The patients experience is impacted by the inability of the clinical staff to quickly locate and utilise the information held about them</p> <p>In the near future patients will expect to be able to access their record themselves – ‘online’</p>

**2.6.4. Need for Improved Clinical Quality of Services**

Factor	Current Problems Faced
Data management	<ul style="list-style-type: none"> <li>MTW needs to have a single view of patient data to support Clinical Commissioning Groups (CCGs) and patient pathways across all aspect of the care pathway (some of which are outside of MTW – i.e. primary care).</li> <li>MTW needs to be able to capture and report on activity and performance in real time from a single source.</li> <li>MTW needs to be able to support research activity from all aspects of its activity.</li> </ul>
Clarity and all information captured	<ul style="list-style-type: none"> <li>MTW needs to ensure staff capture the depth and breadth of information required to support clinical change</li> <li>Mapping of patient pathways and data capture.</li> <li>Sharing with the health and service community, in the best interest of the patient</li> </ul>
Reduced clinical harm and risks through accurate clinical support	<ul style="list-style-type: none"> <li>Without a single view of all relevant clinical data, there is a risk that the professional treating the patient will not have all necessary information to provide the best patient outcome.</li> <li>The use of eObservations systems to capture nurse observations would reduce patient risks.</li> </ul>
Improved patient safety	<ul style="list-style-type: none"> <li>If systems can be joined up, such as ePrescribing, patient safety can be improved through avoidance of prescribing and administration errors</li> </ul>
Reduced patient risks	<ul style="list-style-type: none"> <li>During the development of the OBC (November 17 to February 18), there were 78 new Datix risks raised for patient clinical risks, based upon a lack of information available when needed.</li> </ul>

**2.6.5. Need for Development of Existing Services and/or Provision of New Services**

Factor	Current Problems Faced
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Community services	<ul style="list-style-type: none"> <li>The challenge of providing joined up community services with system(s) supporting the care pathway. The current systems are disjointed and do not support the needs of patients or staff.</li> </ul>
Unable to map patient flows to new service	<ul style="list-style-type: none"> <li>Unable to track patients across service provision in detail, as different systems are being used, which are not connected.</li> </ul>

### 2.6.6. For improved Environmental Quality of Services

Factor	Current Problems Faced
Environmental costs	<ul style="list-style-type: none"> <li>The current paper based systems are not environmentally efficient and a new electronic based system would reduce the environmental impact on the delivery of services, through less paper and potentially less travel</li> </ul>

### 2.6.7. Need to Make More Effective Use of Resources

Factor	Current Problems Faced
Manage growing expectation with existing resources	<ul style="list-style-type: none"> <li>The new commissioning structure will require patient level costing and activity – to achieve this MTW needs a single view of patient data.</li> <li>Additional pressure for change will come through the CQUIN programme – MTW will need a system that can deliver on the CQUINS objectives and targets.</li> <li>The ability to connect and share data between MTW and GPs and other third-party care providers is going to form a key part of the patient record</li> </ul>
Staff required to support manual processes	<ul style="list-style-type: none"> <li>The current paper based processes and lack of connectivity results in departments having to manually complete tasks such as: <ul style="list-style-type: none"> <li>Staff manually entering data and recording activity on excel forms, often with manual duplication to multiple alternative systems.</li> <li>Additional staff employed to manage paper based medical records.</li> <li>Additional staff employed solely to duplicate data entry between systems.</li> <li>Multiple extra steps added to each process, as it is paper driven, with much time lost from chasing lost or mislaid results.</li> </ul> </li> </ul>
Financial savings	<ul style="list-style-type: none"> <li>There would be savings expected from the current departmental contracts, that would come from implementation of single EPR systems.</li> </ul>
Catalyst for change	<ul style="list-style-type: none"> <li>A joined up electronic system could act as a catalyst for change to be delivered in the clinical divisions, which will release substantial productivity benefits.</li> </ul>
Avoiding charges and penalties	<ul style="list-style-type: none"> <li>Without joined up systems and accurate data the Trust is exposed to penalties and charges, through failure to</li> </ul>

meet CCG targets.

### External Community Drivers

#### **2.6.8. Need for Improved Strategic Fit for Services**

Factor	Current Problems Faced
Joint working across the community	<ul style="list-style-type: none"> <li>The Trust is seeking to work collaboratively across both the local community and across the wider STP partners, in providing a seamless pathway of care. The current systems do not easily support data sharing or flexibility to adapt quickly and easily to meet the needs of the organisation</li> </ul>

#### **2.6.9. Need to Meet National, Regional, and Local Policy Imperatives**

Factor	Current Problems Faced
Increased exchange of data across the care pathways 5 year look forward	<ul style="list-style-type: none"> <li>There is a clear need for information and data to flow from primary care, through acute, tertiary and community services as the patient pathways change to reflect new models of service delivery.</li> <li>The Trust has identified expected changes to services such as care pathways straddling acute and community services, the informatics system must be capable of supporting these new and patient centric workflows.</li> </ul>

#### **2.6.10. Need for Development of Existing Services and/or Provision of New Services**

Factor	Current Problems Faced
Sharing of Data with community, primary care and social care	<ul style="list-style-type: none"> <li>As the current systems cannot exchange data they are unable to work cohesively with the wider health and social settings. This increases paperwork, delays care and inconveniences the patient. This also does not support the objectives of the Kent and Medway STP.</li> </ul>

#### **2.6.11. To Meet Training, Teaching and Research Needs**

Factor	Current Problems Faced
Provision of data to support teaching, training and research.	<ul style="list-style-type: none"> <li>As clinical data is recorded either on paper or across multiple IT systems it becomes difficult providing meaningful clinical data across all areas to support training, teaching and research needs.</li> </ul>

**2.6.12. Future Service Trends**

Factor	Current Problems Faced
Collaborative working	The health service is in a constant flux of change; the current systems do not easily allow the transfer of data (patient clinical or administrative). MTW need to be able to adapt quickly and easily to changing trends and a new modern standards based solution would support this need.

Through separating the internal and external drivers the Trust can procure a solution that focuses on its internal needs, but also recognises the system must have the ability to support and interact with the wider community. These drivers will be resolved through the use of open standard data sharing models based upon the international standard for Health Information Exchange.

## 2.7. Investment objectives

Investment objectives align with the Trust 5-year Strategy and Trust IT Strategy. Following a series of workshops and meetings the following SMART investment objectives were developed:

Ref	Investment Objective Description
IO1	Provide a system that can support improved clinical outcomes through a single source of patient data for staff;
IO2	Provide a system that can improve patient safety through ensuring the clinical teams have the information they require were and when needed;
IO3	Provide a system that can improve productivity and efficiency through delivery of benefits that reduce time wasted on administrative processes in the patient workflow;
IO4	Provide a system that will support the engagement between MTW and its regional partners, in particular, engagement with the Trusts STP partners.
IO5	Provide a clinical system that allows patient involvement and engagement in their care;
IO6	Realisation of benefits mapped to objectives in the Trust's Strategy;
IO7	Demonstrates Value for Money through the procurement process as a measurable outcome; to confirm affordability of preferred option
IO8	Demonstrable Return on Investment through the business case financial assessment;
IO9	Demonstrate alignment to and delivery of MTW Trust Strategy and achievement of national drivers.
IO10	Provide a system that can support service transformation and integration through delivery of a single source of data for clinical teams across the care settings;
IO11	Provide a system that both populates and utilises a centralised repository of data for research.
IO12	Provide a system that can support improved clinical outcomes through a single source of patient data for staff;

Figure 16: Investment Objectives Table

### 2.7.1. Existing arrangements

The existing arrangements are the based upon the following disconnected systems:

System	Supplier	Function
Patient Administration System	Allscripts PAS	Patient administrative management including: <ul style="list-style-type: none"> <li>• Patient master index</li> <li>• Patient waiting list</li> <li>• Inpatient and some outpatient management slots</li> <li>• Patient tracking</li> </ul>
Intensive Care Management System		Used in ITU and burns to manage patient workflow and records
PACS	GE	Image management system
Infection Control	ICNet	Management of Infection Control Management and Alerting.
RIS	GE	Radiology information management system
LIMS	CSC Telepath	Laboratory information management system
Pharmacy	JAC	Pharmacy management system
Cardiology information system	Tomcat	Cardiology / vascular data

System	Supplier	Function
Diabetes	Diabeta 3	management Diabetes management and workflow system
Accident and Emergency	EMIS Symphony	A&E information management system
Orthopaedic	OpenEyes	Stand-alone system for supporting orthopaedics patient management and scheduling
Theatres	TheatreMan	Stand-alone system for supporting workflow in theatres
Maternity	Euroking	Maternity information management system
Electronic order system	Allscripts PAS	Order Communications for requesting diagnostic tests, therapy services and viewing results
Electronic Documents Management	EHI Viper	Scan deceased and dormant patient notes
Gastroenterology	Endoscribe	Stand-alone system for supporting workflow in Gastroenterology

Figure 17: Table of Existing Major Systems

### 2.7.2. Main benefits criteria

Satisfying the potential scope of this investment will deliver the following high-level strategic and operational benefits. These benefits have been identified and financially assessed at OBC stage based upon Treasury Green Book model of estimations, driven by:

- Workshops, interviews and EPR Working Group sessions.
- Identified themes and areas are further analysed, either from local information, such as current expenditure, or, where this is not viable for the OBC stage, against baseline evidence from areas such as the Public Accounts Committee report on EPR benefits, NHS Digital guidance or HSCIC original Lorenzo report
- The modelling of the benefits realisation is phased over multiple years, against an estimated delivery plan and this is seen in the finance model Appendix C.

These benefits are presented below by investment objectives (IO):

Investment Objective	Investment Description	Benefit Reference	Benefit Description	Benefit Type
IO1	Provide a system that can support improved	B32	Eliminating misplacing of drug cards and significantly improving the clarity of prescribing, drug round times can be significantly reduced	NCRB

Investment Objective	Investment Description	Benefit Reference	Benefit Description	Benefit Type
	clinical outcomes through a single source of patient data for staff;	B46	The new integrated workflow from EPR will allow for improved turnaround of discharges, improved bed management through the centralised electronic system and greater use of the clinical workflow by junior doctors	NCRB
		B19	Single solution to access all clinical data across the organisation.	Q
		B47	New integrated EPR and workflow system	Q
		B53	Theatre utilisation and improved use of clinical time	Q
		B54	Interfaces with other local providers provides improved patient information which is accessible to end-users	Q
IO2	Provide a system that can improve patient safety through ensuring the clinical teams have the information they require where and when needed;	B31	e-Prescribing can improve medicines reconciliation because of increased accessibility of the drug chart resulting in cost savings	CRB
		B16	Single solution to access all clinical data across the organisation.	NCRB
		B27	Excess bed days are avoided by the reduction of drug errors and avoidable adverse drug reactions	NCRB
		B28	Improved efficiency of the discharge prescribing process through selecting and copying forward medicines from the inpatient prescription to the TTO/TTA	NCRB
		B45	The new integrated EPR will not require multiple log-ons to different systems to support clinical workflow for A&E, order comms, clinical notes, bed management and discharges	NCRB
		B46	The new integrated workflow from EPR will allow for improved turnaround of discharges and improved bed management	NCRB



Investment Objective	Investment Description	Benefit Reference	Benefit Description	Benefit Type
		B24	Provides decision support to users when placing orders for patients	Q
		B35	Improved access to information, more complete and better quality of data to support mandatory reporting.	Q
		B38	Improved patient care through patients having the right medication at the right time.	Q
		B39		Q
		B42	The EPR system will aid the clinician in making decisions with regard to patient care	Q
		B43	Greater capacity and capability to audit the use of drugs. Better management of patients on antibiotics and controlled drugs.	Q
		B51	Improvement monitoring of infections across the Trust due to integrated infection control solution.	Q
		B53	Theatre utilisation and improved use of clinical time	Q
IO3	Provide a system that can improve productivity and efficiency through delivery of the benefits that reduce time wasted on administrative processes in the patient workflow;	B14	New application would manage functionality of existing system.	CRB
		B30	Agreed local drug formulary to reduce diversity of prescribing practice	CRB
		B31	e-Prescribing can improve medicines reconciliation because of increased accessibility of the drug chart	CRB
		B13	Integrated document managed and voice recognition reduces admin time.	NCRB
		B21	Centralisation and full digitalisation of diabetes process.	NCRB
		B23	ePrescribing and EDN process combined within the EPR	NCRB
		B25	Integrated system will allow for electronic results to be made available to clinicians.	NCRB

Investment Objective	Investment Description	Benefit Reference	Benefit Description	Benefit Type
		B28	Improved efficiency of the discharge prescribing process through selecting and copying forward medicines from the inpatient prescription to the TTO/TTA	NCRB
		B29	In this case e-Prescribing will impact on Drs/Prescribers Prescribing in all clinical areas	NCRB
		B33	Increased availability of pharmacy staff time for clinical checks, patient and staff drug education etc. due to increased availability of prescriptions chart	NCRB
		B34	Saving of staff time due to significant reduction in time spent collating data from various paper sources for audit purposes	NCRB
		B40	Reduction in staff time to transport paper drug chart between patient locations.	NCRB
		B41	EPR will provide a means of capturing the referral and the treatment/care given to the patient, enabling the follow up care to be viewed by all clinicians managing the patient.	NCRB
		B44	The new integrated EPR will not require multiple log-ons to different systems to support clinical workflow for A&E, order comms, clinical notes, bed management and discharges	NCRB
		B45		
		B22	New functionality within the application will allow for voice recognition. Which can be used for updating of notes and letters.	Q

Investment Objective	Investment Description	Benefit Reference	Benefit Description	Benefit Type
		B55	This will result in a reduction of Health Records staff needed to pull records. This will result in a 10% reduction in health records staff. With 103 staff within the current team at an average at a band 3. Only 80% of this benefit would be realised for option 2 due to the reduced integration.	CRB
		B56	The current managed print contract costs will reduce by 10%.	CRB
IO4	Provide a system that will support the engagement between MTW and its regional partners.	B18	Improved multi-disciplinary team working	Q
		B54	Interfaces with other local providers provides improved patient information which is accessible to end-users	Q
IO5	Provide a clinical system that allows patient involvement and engagement in their care;	B17	Single solution across all Acute Trusts in Kent.	NCRB
		B44	The new integrated EPR will not require multiple log-ons to different systems to support clinical workflow for A&E, order comms, clinical notes, bed management and discharges	NCRB
		B45		NCRB
IO6	Realisation of benefits mapped to trust objectives;	B35	Improved access to information, more complete and better quality of data to support mandatory reporting.	Q
		B36		Q
		B38		Q
IO7	Demonstrates Value for Money through the procurement process as a measurable outcome;	B01	New application would manage functionality of existing system.	CRB
		B02		
		B03		
		B05		
		B06		
		B07		
		B08		
		B09		
		B10		
		B11		
		B20	Reduction in costs associated with ordering printed order forms	CRB

Investment Objective	Investment Description	Benefit Reference	Benefit Description	Benefit Type
		B26	New electronic system for charting would be in place.	CRB
		B30	Agreed local drug formulary to reduce diversity of prescribing practice	CRB
IO8	Demonstrable Return on Investment through the business case financial assessment;	B12	New application would replace functionality of existing system.	CRB
		B04	New application would replace functionality of existing system.	NCRB
		B37	Reduced bed costs through the reduction in readmission as a consequence of drug errors	NCRB
IO9	Demonstrate alignment to and Delivery of MTW Strategic Objectives and national drivers	B20	Reduction in costs associated with ordering printed order forms	CRB
		B30	Agreed local drug formulary to reduce diversity of prescribing practice	CRB
		B27	Excess bed days are avoided by the reduction of drug errors and avoidable adverse drug reactions	NCRB
		B44	The new integrated EPR will not require multiple log-ons to different systems to support clinical workflow for A&E, order comms, clinical notes, bed management and discharges	NCRB
		B45		
		B51	Improvement monitoring of infections across the Trust due to integrated infection control solution.	Q
IO10	Provide a system that can support service transformation and integration through delivery of a single source of data for clinical teams across the care settings;	B16	Single solution to access all clinical data across the organisation.	NCRB
		B19		Q
		B43	Greater capacity and capability to audit the use of drugs.	Q

Investment Objective	Investment Description	Benefit Reference	Benefit Description	Benefit Type
IO11	Provide a system that both populates and utilises a centralised repository of data for research.	B35	Improved access to information, more complete and better quality of data to support mandatory reporting.	Q
IO12	Provide a system that can support improved clinical outcomes through a single source of patient data for staff;	B32	y eliminating misplacing of drug cards and significantly improving the clarity of prescribing, drug round times can be significantly reduced	NCRB
		B35	Improved access to information, more complete and better quality of data to support mandatory reporting.	Q

Figure 18: Investment Objectives and Mapped Associated Benefits

The Trust recognises that at this stage the benefits associated with the programme have been identified at a very high level and these are based upon work at other EPR implementations. Further work is required with the preferred suppliers to provide the next level of detail and to map out the comprehensive benefits realisation plan beyond the level known today.

In addition, where possible the quality benefits will be monitored and assessed through patient and staff surveys and 360 reviews. A model for tracking benefits has been added to Appendix B as the basis for the delivery of the benefits. This will be completed at FBC stage when a firm solution and implementation plan has been developed.

### 2.7.3. Main Dis-benefits

Whilst the main dis-benefit of a new system is often the change and the associated training, this will be minimised through the transfer of the training and migration to the contractor, through the procurement process. This will minimise exposure to the Trust, with any remaining risks identified within the risk register and financial risks assessed.

### 2.7.4. Main Risks

The main risks are summarised below. Further details please see the attached risk register in the finance model Appendix C

Title	Description	Implication(s)	Mitigating Action Description	Probability	Impact	Time Pressures
MTW is unable to secure appropriate funding	Due to competing financial pressures the MTW is unable to fund the business case cost.  Compounded by the financial challenges	If suitable funding is not available, then the timetable for procurement and implementation will need to be revised or put on hold.	1. The scope of the programme will need to be reduced 2. Alternative sources of funding will need to be considered 3. Revised timescales will need to be considered that spreads cost over different financial years.	Medium	High	Near
Changes in MTW priorities results in reduced support for programme	Changes in the wider health economy causes the Trust to review its strategic objectives – i.e. estates move	Changes in MTW priorities or strategic direction may result in delay to the timelines, reduced scope, re-evaluation of the programme principles	1. Ensure that programme is fully imbedded in the strategic objectives 2. Engage and integrate programme with clinical priorities 3. Develop a flexible deployment plan that allows for changes in scope, direction and commitment	Medium	High	Medium
Non-availability of relevant IT, clinical & managerial staff	All relevant staff identified through discussions with Clinical and Business Areas may not be available at all workshops	To deliver to a defined timeframe all-necessary staff required to input into the decisions being made on the programme are available to attend planned review sessions. If there are areas in which this cannot be achieved, then the impact will be to increase the amount of time required to make the required decisions.	Relevant staff identified through early discussions  Provide relevant staff with advanced notice. 6-8 weeks' notice required to free up medical staff.  Deputies for relevant staff identified to attend sessions if core clinical members cannot attend.  Additional costs included in business case for external support.	Medium	High	Medium
There is a risk that the scale of change expected will not happen unless sponsored and driven through by senior executives.	Senior management ownership of the programme	The programme change process must be owned and driven by MTW and have clear engagement from end users. It is therefore imperative that the clinical and operational managers are involved. A lack of involvement will significantly increase the risk of failure of the programme.	Ensure that a senior executive act as SRO and sponsors the programme.  Clinical lead identified and appointed, and CAG established  Users involved at all levels of this change.  Clear Governance to manage change	Low	High	Far
On-going support	The new system will require additional on-going support to a greater level of capability than currently available in MTW	The current team will not be able to provide the full range of support services required	Consider options for either enhancing current team or seeking external help for on-going support	High	High	Far

Figure 19: Main Risks and Countermeasures

## **2.8. Constraints and Dependencies**

### **2.8.1. Constraints**

The project is subject to following constraints:

- Allscripts MOU pricing, if they become preferred EPR supplier;
- Tendering EPR suppliers' ability to work with existing PAS system;
- Contract Terms of current system suppliers and exit strategy for data migration;
- Health and Social Care service partners ability to integrate systems.

### **2.8.2. Dependencies**

The project is subject to the following dependencies that will be carefully monitored and managed throughout the lifespan of the scheme:

- IT Programme Board
- PC Replacement Programme;
- Cyber-security Improvement;
- Recruitment of CCIO and establishment of CAG;
- Finances commitments being made available over multiple budgetary cycles.

### 3. Economic Case

#### 3.1. Introduction

In accordance with the Capital Investment Manual and requirements of HM Treasury's Green Book (A Guide to Investment Appraisal in the Public Sector), this section of the OBC explores and assesses a series of options for delivering the investment objectives, resulting in the identification of the best value for money option, that is subsequently carried forward into the affordability analysis within the Affordability Section.

In accordance with the Department of Health '5-case' guidelines for IM&T business cases, the process adopted was as follows:

- Step 1: generate a list of critical success factors (CSFs) against which the options will be assessed.
- Step 2: identify and evaluate against the CSFs a 'long list' of potential options for satisfying the investment objectives.
- Step 3 – create a shortlist by forming composite options from the individual options that emerged from each category in the previous step.
- Step 4: undertake a full value for money appraisal of these shortlisted options in order to identify a preferred option that forms the basis of the remainder of the business case.

This can be seen as:

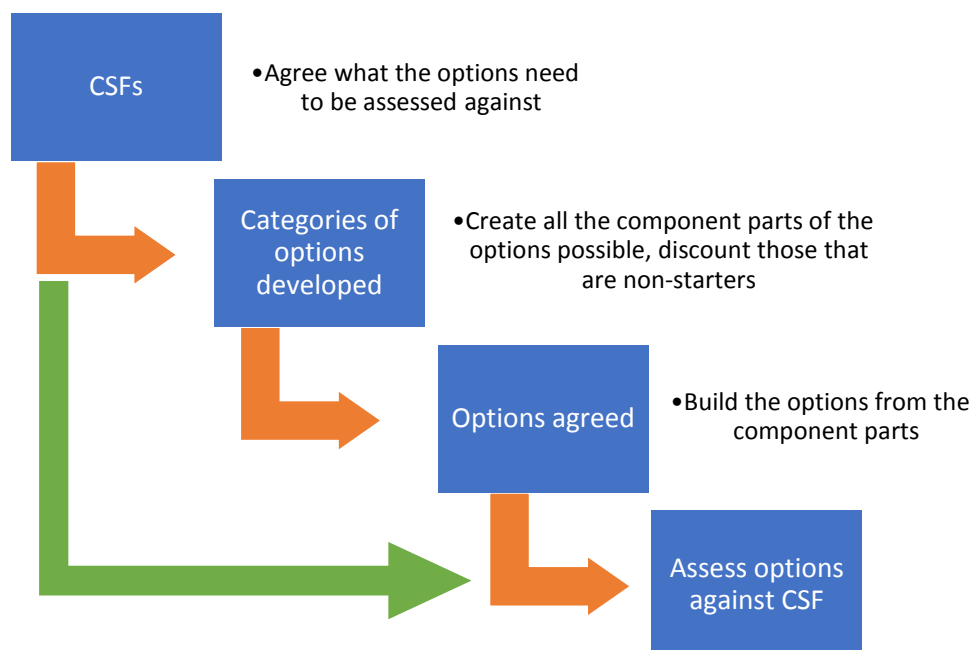


Figure 20: Option Development Process

The outcomes of this process will be described further in this document.

#### 3.2. Step 1 - Critical Success Factors

The following is a set of critical success factors that could be applied and have been generated through reference to the Treasury IM&T guidelines:

Critical Success Factors	How To Evaluate?
CSF1: strategic fit	<ul style="list-style-type: none"> <li>• Degree to which proposed options meet MTW</li> </ul>



Critical Success Factors	How To Evaluate?
	policy targets.
CSF2: investment objectives	<ul style="list-style-type: none"> <li>How well the proposed options support the strategy.</li> <li>Degree to which proposed options are compatible with other MTW corporate initiatives.</li> <li>How well the proposed options integrate with other MTW developments.</li> <li>Degree to which proposed options meet investment objectives.</li> </ul>
CSF3: value for money	<ul style="list-style-type: none"> <li>Extent to which lifetime costs and risks are minimised and benefits are maximised.</li> <li>Capability of supplier to undertake and deliver the programme.</li> </ul>
CSF4: supplier feasibility	<ul style="list-style-type: none"> <li>Capacity of supplier to supply services within the agreed timescales.</li> </ul>
CSF5: potential affordability	<ul style="list-style-type: none"> <li>Ability of the MTW to meet the required total capital and revenue costs, including any anticipated cash releasing benefits and new financial contributions.</li> <li>Capacity and capability of MTW Informatics programme and project management to deliver the required services, within planned timescales.</li> </ul>
CSF6: organisational achievability	<ul style="list-style-type: none"> <li>Capacity and capability of the service users to assimilate, adapt and respond to the required changes enabled by the preferred solution, within the planned timescales.</li> <li>Capacity and capability of MTW staff to support the new service after implementation.</li> </ul>

Figure 21: Critical Success Factors

### 3.3. Step 2 – Identify and Evaluate Long list

With such a project there are several approaches to viewing the different options. Options could vary according to the scope, funding, solution and implementation approach/timescale.

To develop the review, which takes into account these various options, the approaches have been sub-divided into the following categories and a long list of options considered within the framework set out below. This is consistent with the Treasury Green Book and NHS Guidance:

- Service Solution Scope options – considering the various levels of technical and functional solution which could be adopted.
- Service Scale options – considering how the system requirements could be scaled.
- Service Delivery options – considering the options for delivery of the solution within the NHS.
- Implementation options – considering the options for different timescales and incremental approaches to implementation of the solution.
- Procurement options – considering the possible procurement routes.
- Funding options – considering the available methods of finance.

For each category, the options within each category and their assessment against the CSFs where:

‘✓’ indicates a poor match against the critical success factor.

‘✓✓’ indicates a medium match against the critical success factor.

‘✓✓✓’ indicates a good match against the critical success factor.

Appendix A contains the details of the assessment for each category and the long list options developed. Each was reviewed and assessed for either discounting at this stage or being carried forward to form the shortlist.

### 3.4. Step 3 - Option Shortlist Development

The options were then developed through two stages:

#### 3.4.1. Stage 1 – Discount Long List Options

The first stage focused on eliminating options that were non-starters. The following options were eliminated without further evaluation:

Stage	Option	Reason for Rejection
Scope	A4	This does not fit with the long term strategic vision of the Trust.
Scale	B4	The trust needs a solution that spans more than just acute. At this stage a joint procurement was not seen as viable. Intend to leave the option for other Trusts to join at a later date.
Service Delivery	C4	The use of an in-house team to develop the solution was not seen as viable
Procurement	D1 D3	Trust to use SBS EPR Framework process
Implementation	E1 E3	Approach will follow a Big Bang for Core Systems with other systems following fast behind
Funding	F3	A risk / reward contract was deemed challenging to achieve at this stage of the process

Figure 22: Discounted Long List

#### 3.4.2. Short List Development

This next step involves creating a short list by forming composite options from the individual options that emerged from each category above. As a consequence, the following composite short-listed options have been devised ready for further analysis.

Not all of the initial options are retained as standalone elements, and some are not differentiators at this stage (such as deployment).

## A: Scope

## B: Scale

## C: Service Delivery

## D: Procurement

## E: Implementation

## F: Funding

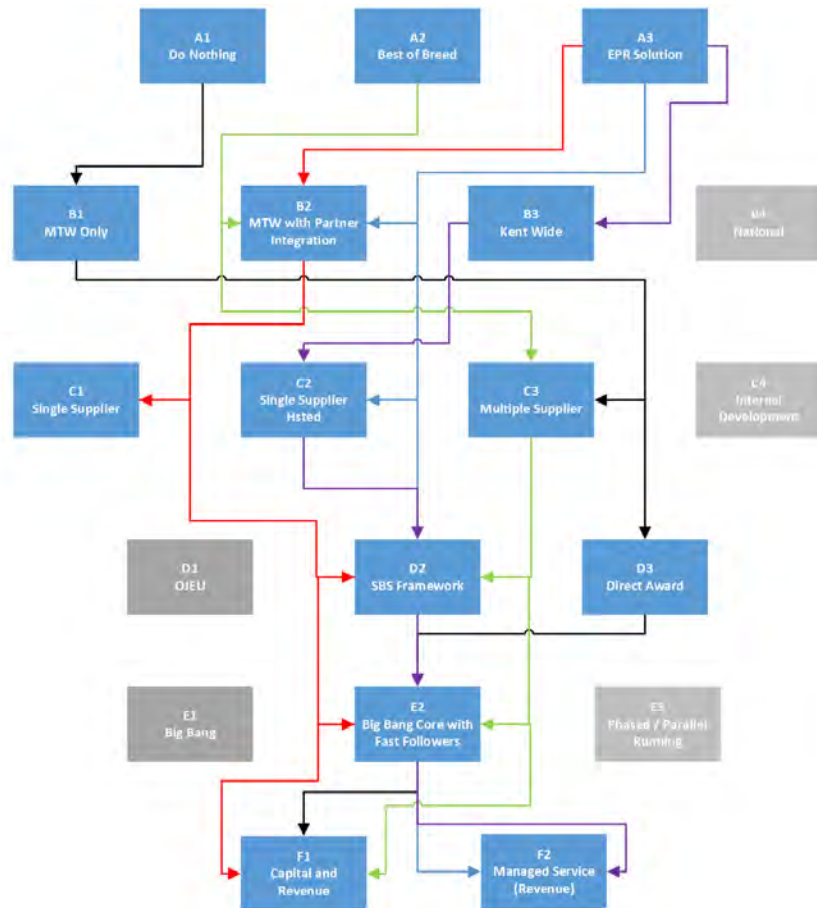


Figure 23: Shortlist Formation

The diagram shows how each option has been built up, for example:

- Option 4 – is made up of A3, B2, C2, D2, E2, F2

As the above diagram indicates some of the long list options could not be separated and analysed at this stage. These will be reviewed at FBC Stage, as required, following completion of the procurement phase.

### 3.4.3. Short-listed options

The short-listed options that were derived from the long listing exercise are:

Shortlist Option Number	Option Elements	Description
1	Do Nothing	This is the baseline option and only shows replacing the PAS, which is the highest risk, therefore the 'do nothing' option doesn't exist.
2	A Best of Breed EPR - Capital and Revenue model	A best of breed EPR based upon a set of core systems from a single provider (i.e. PAS, Order Comms), with the best available departmental system. Purchased as a capital and revenue model
3	EPR - Capital and Revenue model	A single supplier providing all aspects of an EPR. Purchased as a capital and revenue model
4	EPR - Managed Service model	A single supplier providing all aspects of an EPR.

Shortlist Option Number	Option Elements	Description
5	Kent Wide EPR	Purchased as a managed service model. A single supplier providing all aspects of an EPR, with the solution covering all local Kent acute Trusts.

Figure 24: Shortlist of Options

The deployment option was not differentiated at the OBC stage, as this will be reviewed and agreed with the supplier through the procurement process.

### 3.5. Economic appraisal

#### 3.5.1. Introduction

This final step involved undertaking a full value for money appraisal of the shortlisted options. This was done by assessing the costs, benefits and risks of each option and then comparing the combined results in order to identify which option has the best combination of risk-adjusted net present value and quality benefits score.

#### 3.5.2. Overall Approach

The methodology used to undertake the value for money assessment is consistent with the HM Treasury Green Book, whereby:

1. Possible benefits and risks have been assigned monetary values. Where this has not been possible benefits and risks have been assessed by a process of weighting and scoring.
2. Options have been compared using discounted cash flow, discounting at 3.5%.
3. VAT has been ignored, as from a value for money perspective it represents a financial transfer within the public sector.
4. The analysis is in real terms - i.e. the general effect of inflation on costs and benefits has been ignored.

Public expenditure which has already taken place, or which cannot be avoided has been treated as a 'sunk cost' and does not enter into the economic appraisal.

#### 3.5.3. Specific Assumptions

The following specific assumptions underpin the value for money assessment:

- That the procurement will be complete by the end of June 2018;
- That the Trust will begin to deploy the system in 2018/19 financial year and complete in 2020/21;
- That the finance model assumes inflation.

#### 3.5.4. Estimating costs

The costs of each option, based on the different bidders, has been calculated to enable comparison.

##### 3.5.4.1. Costing Methodology

The costs have been built on the following basis with information gathered from early market engagement with potential suppliers, business cases from other trusts and known costs. The costs are shown as capital and annual support, the actual finance model will be agreed at the FBC stage.

Maidstone & Tunbridge Wells NHS Trust	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Total
CASH FLOW SUMMARY £000	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	
<b>CASH OUT</b>												
Capital payments - Maidstone & Tunbridge	287	1,389	684	22	0	0	0	0	0	0	0	2,392
Capital payments - optimism bias uplift *	5	22	11	0	0	0	0	0	0	0	0	38
Capital contingency **	29	181	123	34	23	29	35	36	37	20	20	587
<b>Capital payments - total</b>	<b>320</b>	<b>1,591</b>	<b>827</b>	<b>57</b>	<b>23</b>	<b>29</b>	<b>35</b>	<b>36</b>	<b>37</b>	<b>20</b>	<b>20</b>	<b>2,997</b>
Revenue payments - Maidstone & Tunbridg	300	1,294	1,721	694	709	724	739	755	771	787	788	9,281
Revenue payments - optimism bias uplift *	5	21	28	11	11	12	12	12	12	13	13	149
Revenue contingency **	30	166	214	78	81	84	88	92	95	99	139	1,167
<b>Revenue payments - total</b>	<b>335</b>	<b>1,481</b>	<b>1,963</b>	<b>783</b>	<b>801</b>	<b>820</b>	<b>839</b>	<b>858</b>	<b>878</b>	<b>899</b>	<b>940</b>	<b>10,597</b>
VAT	117	532	474	126	124	127	129	132	135	138	138	2,172
Cash releasing benefits	0	0	-673	-1,655	-2,067	-2,310	-2,358	-2,408	-2,458	-2,510	-2,514	-18,072
<b>Total cash out</b>	<b>772</b>	<b>3,604</b>	<b>2,592</b>	<b>-689</b>	<b>-1,138</b>	<b>-1,334</b>	<b>-1,355</b>	<b>-1,381</b>	<b>-1,408</b>	<b>-1,453</b>	<b>-1,416</b>	<b>-3,206</b>
<b>CASH IN</b>												
Recovered VAT	117	471	433	126	124	127	129	132	135	138	138	2,070
Other (specify details)												0
<b>Total cash in</b>	<b>117</b>	<b>471</b>	<b>433</b>	<b>126</b>	<b>124</b>	<b>127</b>	<b>129</b>	<b>132</b>	<b>135</b>	<b>138</b>	<b>138</b>	<b>2,070</b>
<b>NET CASHFLOW</b>												
Net cashflow	655	3,133	2,159	-815	-1,262	-1,461	-1,484	-1,513	-1,543	-1,591	-1,554	-5,276
Brought forward	0	655	3,789	5,947	5,132	3,870	2,410	926	-587	-2,131	-3,722	
Carried forward	655	3,789	5,947	5,132	3,870	2,410	926	-587	-2,131	-3,722	-5,276	
<b>Element of payments in 'cash out' that comprises inflation</b>												
Capital	0	32	33	3	2	3	4	5	5	4	4	96
Revenue	-5	29	78	47	64	80	98	116	134	152	161	959

Figure 25: Costing Methodology

Note: Positive Values represent cash-out and Negative Values represent cash-in

The approach taken to cover the cutover and double running has been phased to release the benefits of the current system maintenance costs over an extended period, so that the cost of having both systems running and being paid for is clear. This can be observed in the finance model (appendix B). The average double running period is 1 year with a 50% reduction in the last 6 months.



The following table shows the estimated costs by option:

Costs (£000 exc VAT)		2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	Total	% of highest cost	Rank
Option 1 - Do Nothing	Capital	£0	£0	£670	£0	£0	£500	£0	£0	£0	£350	£0	£1,520	14%	1
	Revenue	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0		
	Total	£0	£0	£670	£0	£0	£500	£0	£0	£0	£350	£0	£1,520		
Option 2 - Best of Breed Solution (Capital Programme)	Capital	£200	£2,001	£2,156	£470	£0	£500	£0	£20	£0	£0	£0	£5,347	99%	4
	Revenue	£0	£155	£504	£563	£563	£598	£563	£683	£563	£563	£563	£5,318		
	Total	£200	£2,156	£2,660	£1,033	£563	£1,098	£563	£703	£563	£563	£563	£10,665		
Option 3 - EPR Solution (Capital Programme)	Capital	£2,278	£2,361	£1,965	£21	£0	£200	£0	£0	£0	£0	£0	£6,825	99%	3
	Revenue	£0	£50	£383	£423	£423	£423	£423	£423	£423	£423	£423	£3,817		
	Total	£2,278	£2,411	£2,348	£444	£423	£623	£423	£423	£423	£423	£423	£10,642		
Option 4 - EPR Solution (Managed Service)	Capital	£287	£1,361	£866	£21	£0	£0	£0	£0	£0	£0	£0	£2,335	100%	5
	Revenue	£300	£1,268	£1,652	£653	£653	£653	£653	£653	£653	£653	£653	£8,444		
	Total	£587	£2,629	£2,518	£674	£653	£653	£653	£653	£653	£653	£653	£10,779		
Option 5 - Kent Wide EPR	Capital	£390	£2,320	£2,299	£160	£0	£50	£0	£0	£0	£0	£0	£5,219	96%	2
	Revenue	£120	£302	£635	£675	£675	£675	£675	£675	£675	£0	£0	£5,107		
	Total	£510	£2,622	£2,934	£835	£675	£725	£675	£675	£675	£0	£0	£10,326		

Figure 26: Cost by Option

### 3.5.5. Benefits Methodology

At this stage the benefits have been built from interviews with key staff, workshops across the trust and also reference to benefits work from similar systems published by NHS Digital and HSCIC Lorenzo modelling. At FBC stage a full detailed time and motion study will be undertaken to fully map the benefits to the preferred option with a benefits tracker developed to monitor the benefit realisation. For quality benefits the scores and weightings were established through trust based workshops with key stakeholders.

The following table's shows the summary for each type of quantified benefit classified by Cash-Releasing, Non-cash releasing and Societal, for which the detailed modelling can be found in Appendix B.

Cash releasing benefits (£000)		2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	Total	% of highest benefit	Rank
Option 1 - Do Nothing		£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	0%	5
Option 2 - Best of Breed Solution (Capital Programme)		£0	£0	£329	£676	£769	£941	£1,016	£1,317	£1,446	£1,446	£1,446	£9,385	56%	4
Option 3 - EPR Solution (Capital Programme)		£0	£0	£646	£1,557	£1,922	£2,083	£2,083	£2,083	£2,083	£2,083	£2,083	£16,623	100%	1
Option 4 - EPR Solution (Managed Service)		£0	£0	£646	£1,557	£1,922	£2,083	£2,083	£2,083	£2,083	£2,083	£2,083	£16,623	100%	1
Option 5 - Kent Wide EPR		£0	£0	£91	£387	£1,284	£1,977	£1,977	£1,977	£1,977	£1,977	£1,977	£13,623	82%	3

Figure 27: Cash Releasing Benefits

## EPR Outline Business Case – ID545

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Non-cash releasing benefits (£000)	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	Total	% of highest benefit	Rank
Option 1 - Do Nothing	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	0%	5
Option 2 - Best of Breed Solution (Capital Programme)	£0	£0	£0	£770	£1,539	£1,539	£1,539	£1,539	£1,539	£1,539	£1,539	£11,545	80%	4
Option 3 - EPR Solution (Capital Programme)	£0	£0	£0	£966	£1,933	£1,933	£1,933	£1,933	£1,933	£1,933	£1,933	£14,497	100%	1
Option 4 - EPR Solution (Managed Service)	£0	£0	£0	£966	£1,933	£1,933	£1,933	£1,933	£1,933	£1,933	£1,933	£14,497	100%	1
Option 5 - Kent Wide EPR	£0	£0	£0	£0	£996	£1,993	£1,993	£1,993	£1,993	£1,993	£1,993	£12,954	89%	3

Figure 28: Non-Cash Releasing Benefits

Quality Benefits	Score	% of highest benefit	Rank
Option 1 - Do Nothing	0	0%	5
Option 2 - Best of Breed Solution (Capital Programme)	182	82%	4
Option 3 - EPR Solution (Capital Programme)	211	94%	2
Option 4 - EPR Solution (Managed Service)	211	94%	2
Option 5 - Kent Wide EPR	223	100%	1

Figure 29: Quality Benefits Scores

### **3.5.6. Main Benefits for MTW**



Ref	Benefit Title	Enabling functionality/ facility	Changed state resulting	Description of benefit realised
B01	Saving on Diabeta 3 support contract	New application would replace functionality of existing system.	As a result of removal of current applications support contract.	Saving of £13,742.00 per annum from cancellation of support contract
B02	Saving on ICnet support contract	New application would replace functionality of existing system.	As a result of removal of current applications support contract.	Saving of £22,453.00 per annum from cancellation of support contract
B03	Saving on NerveCentre support contract	New application would replace functionality of existing system.	As a result of removal of current applications support contract.	Saving of £118,000.00 per annum from cancellation of support contract
B05	Saving from Enotes support contract	New application would replace functionality of existing system.	As a result of reduction of current applications support contract due to the front end will no longer be required.	Saving of £17,035.20 per annum from cancellation of 20% of the support contract
B06	Savings from eforms support contract	New application would replace functionality of existing system.	As a result of removal of current applications support contract.	Saving of £21,000.00 per annum from cancellation of support contract
B07	Saving on Allscripts PAS support contract	New application would replace functionality of existing Order Comms functionality within PAS system.	As a result of reduction of current applications support contract.	Saving of £50,000.00 per annum from reduction of support contract
B08	Saving on Twinkle Diabetes system	New application would replace functionality of existing system.	As a result of removal of current applications support contract.	Saving of £2,632.00 per annum from cancellation of support contract
B09	Saving on A&E system	New application would replace functionality of existing system.	As a result of removal of current applications support contract.	Saving of £60,545.00 per annum from cancellation of support contract
B10	Saving on Kiosk system	New application would replace functionality of existing system.	As a result of removal of current applications support contract.	Saving of £15,490.00 per annum from cancellation of support contract

Ref	Benefit Title	Enabling	Changed state	Description of benefit
B11	Saving on Dscribe support contract	New application would replace functionality of existing system. As a result, transcription of letters/notes and referral would be replaced within the EPR	As a result of removal of current applications support contract.	Saving of £22,000.00 per annum from cancellation of support contract
B12	Outsourcing Letter Transcription	New functionality within the application will allow for voice recognition.	As a result of voice recognition within the application users will be able to auto populate letters. This will reduce the requirement to outsource transcription.	Saving of £57,000.00 per annum from cancellation of support contract
B14	Admin support for digital dictation removed	Due to the removal of the dscribe product and voice recognition functionality.	There is a reduced need for support due to the removal of the dscribe product and	Saving of £31,000.00 per annum from reduction in internal staff support
B15	Saving on digital dictation devices	existing mobile devices will be able to be used for voice recognition.	This will result in the Trust not also having to invest in digital dictation devices.	Saving of an estimated £20,000.00 per annum from the not purchasing separate digital dictation devices.
B20	Electronic ordering saves paper	Reduction in costs associated with ordering printed order forms	Paperless Radiology Dept does not have stationery costs. It will also improve the Trust audit trail for ordering and improves the ability for staff to hand-over.	reduces Danwood print costs by £9,000 a year
B26	ePrescribing - No longer require charts	New electronic system for charting would be in place.	Paper charts would no longer have to be ordered by the organisation	Annual cost of paper charts is £28,000

Ref	Benefit Title	Enabling	Changed state	Description of benefit
B30	Reduction in drug expenditure	Agreed local drug formulary to reduce diversity of prescribing practice e-Prescribing will impact on and require the support of everyone who prescribes, supplies or administers medicine - engagement with both administrative and clinical leadership	Reduction in drug expenditure through improved formulary control and adherence	Moving from paper prescriptions to e-Prescribing can improve formulary control and adherence by: <ul style="list-style-type: none"> <li>• Preventing the prescribing of key drugs</li> <li>• Restricting the prescribing of key drugs to specific individuals/ specialities</li> <li>• Creating easy to prescribe 'script' regimens e.g. 'Chest infection' script- would automatically prescribe the correct antibiotics.</li> <li>• Checks that all scripts have STOP DATES (e.g. for antibiotics) to prevent overprescribing</li> </ul>
B31	Increased Medicines Reconciliation		Reduction in drug expenditure through increased Medicines Reconciliation because of increased accessibility of the drug chart	e-Prescribing can improve medicines reconciliation because of increased accessibility of the drug chart resulting in cost savings to the drug budget by: <ul style="list-style-type: none"> <li>• preventing the prescribing of key drugs</li> <li>• restricting the prescribing of key drugs to specific individuals/ specialities</li> <li>• ensuring that all scripts have STOP DATES (e.g. for antibiotics) to prevent overprescribing</li> </ul>
B04	Replacement of the TDI/Merlin System	New application would replace functionality of existing system.	Reduced support form Information to support existing solution. Improved data collection of Therapies staff.	Based on a saving of 0.1 WTE Band 7 (£45,960) totalling to support the system.

Ref	Benefit Title	Enabling	Changed state	Description of benefit
B13	Admin Time - Admin Support	Integrated document managed and voice recognition reduces admin time.	Reduction in admin time to transcribe letters.	Saving 2 WTE band 4 staff time which will result in the equivalent of £48,000 pa
B16	A&E time savings	Single solution to access all clinical data across the organisation.	Will reduce time spent looking for patient data across the A&E department.	As data is available centrally on a single system this will reduce time accessing data and allow staff to spend more time with patients and also improve patient follow within A&E. Expected saving of 10 minutes per day of clinical savings (£2.50 based on £30k salary) with an average of 50 users per day, 365 days a year - £2.50 x 50 x 365
B17	Ability to share patient records between organisations	Single solution across all Acute Trusts in Kent.	Ability to share patient records between organisations will improve transfer of care and multi-disciplinary team working across organisations. Information will be full available to all clinicians and the record would be kept up to date.	This will save clinicians time and improve patient care due to the availability of the complete record. Based on a saving of 2 WTE Band 5 (£29,947) totalling which will be redeployed to better support patient care.
B21	Diabetes benefits	Centralisation and full digitalisation of diabetes process.	Currently completing letters accessing multiple systems. Searching for diabetes patients from results so automatically identifying diabetes patients.	Based on a saving of 0.2 WTE Band 5 (£29,947) totalling which will be redeployed to better support patient care.

Ref	Benefit Title	Enabling	Changed state	Description of benefit
B23	Improved discharge process	ePrescribing and EDN process combined within the EPR	Improved information, speed up process,	Expected saving of 10 minutes per day of clinical savings (£5 based on £60k salary) with an average of 85 users per day, 365 days a year - £5 x 85 x 365 - best of breed will only achieve 60% of target
B25	Pathology Orders/test results from the system are delivered to clinicians via single system. Decreased time to access patient results	Integrated system will allow for electronic results to be made available to clinicians.	Best example within A&E where results would be displayed on interactive whiteboards with patient activity. System proactive in saying when results are ready. Reducing time wasted looking/waiting for results. This will also improve discharge earlier in the day which improves patient follow.	Increased effectiveness of care through faster access to results. The ability to review results and place requests from any location reduces time spent walking between locations thus improving speed of treatment and releasing time to care. Expected saving of 10 minutes per day of clinical savings (£5 based on £60k salary) with an average of 35 users per day, 365 days a year - £5 x 35 x 365
B27	Reduced bed costs by reducing drug errors	e-Prescribing will impact on and require the support of everyone who prescribes, supplies or administers medicine - engagement needed with both administrative and clinical leadership Prescribing in all clinical areas Real time Admission-Discharge-Transfer (ADT) Early/timely entry of weights/allergies Review workflow - 'As Is' and 'To Be'	Reduced bed costs by reducing drug errors and avoidable adverse drug reactions during inpatient admissions through improved prescribing and medicines administration decision support.	Excess bed days are avoided by the reduction of drug errors and avoidable adverse drug reactions (contraindicated by treatment) during inpatient admissions by moving the current paper based system of prescribing to electronic, utilising the features identified in 'System Functionality' to address current issues.

Ref	Benefit Title	Enabling	Changed state	Description of benefit
B28	Reduced time required for Pharmacy checks/ interventions	<p>e-Prescribing will impact on and require the support of everyone who prescribes, supplies or administers medicine - engagement needed with both administrative and clinical leadership</p> <p>Prescribing in all clinical areas</p> <p>Real time Admission-Discharge-Transfer (ADT)</p> <p>Early/timely entry of weights/allergies</p> <p>Review workflow - 'As Is' and 'To Be'</p> <p>May need careful support in some specialty areas, who may have difficulties with template-based clinical documentation. The time required for users to become familiar and proficient with template-based documentation can easily result in lost productivity, delayed patient care, and dissatisfaction</p>	<p>Reduced time required for Pharmacy checks/ interventions due to more complete information on To Take Out (TTO) or To Take Away (TTA) (medicines supplied to patients on discharge from hospital stay) releasing time for additional departmental activities to be identified by individual organisations.</p>	<p>Improved efficiency of the discharge prescribing process through selecting and copying forward medicines from the inpatient prescription to the TTO/TTA, resulting in reduced pharmacy check interventions (not including check for doses or clinical relevance).</p>

Ref	Benefit Title	Enabling	Changed state	Description of benefit
B29	Increased clinical productivity	In this case e-Prescribing will impact on Drs/Prescribers Prescribing in all clinical areas	Increased clinical productivity: Reduction in prescriber's time spent writing and rewriting drug charts, releasing time for direct patient care activities	Moving from paper to electronic prescribing will reduce the amount of time required by prescribers to write and rewrite drug charts, as: <ul style="list-style-type: none"> <li>• prescriber's will no longer be required to rewrite drug charts saving considerable staff time.</li> <li>• when a patient is readmitted, the prescriber would have immediate access to their medication record from their previous admission and can quickly re-prescribe these items</li> </ul>

Ref	Benefit Title	Enabling	Changed state	Description of benefit
B32	Reduction in (nursing) time spent on drug rounds	<p>e-Prescribing will impact on and require the support of everyone who prescribes, supplies or administers medicine - engagement needed with both administrative and clinical leadership</p> <p>Consider roll out plan e.g. 1 ward per month to ensure supported patient pathways whilst maintaining capacity for full support</p> <p>Drug round support for all nurses for defined period of time</p> <p>Contingency plan for problems after go live e.g. paper in circumstances where electronic doesn't work</p> <p>Consider - number and type of devices, storage of devices</p>	Reduction in (nursing) time spent on drug rounds, releasing time for direct patient care activities and increase departmental efficiencies	<p>By eliminating misplacing of drug cards and significantly improving the clarity of prescribing, drug round times can be significantly reduced, these are benefits which support the Productive Ward and Releasing Time to Care initiatives, utilising the features identified in 'System Functionality' to address current issues.</p>



Ref	Benefit Title	Enabling	Changed state	Description of benefit
B33	Reduction in pharmacist time supporting medicines reconciliation	e-Prescribing will impact on and require the support of everyone who prescribes, supplies or administers medicine - engagement needed with both administrative and clinical leadership Prescribing in all clinical areas Real time Admission-Discharge-Transfer (ADT) Early/timely entry of weights/allergies Review workflow - 'As Is' and 'To Be' Pharmacists currently have to check all drug charts on the wards when performing the clinical screens. Electronic prescribing can help to redesign clinical pharmacy service, where some screening can happen remotely and only those patients deemed high risk are visited.	Reduction in pharmacist time supporting medicines reconciliation through improved prescribing and access to the prescription	Increased availability of pharmacy staff time for clinical checks, patient and staff drug education etc. due to increased availability of prescriptions chart at point of need and at multiple sites, even when patients are in theatre or having investigations etc. Increased ability to track changes to prescriptions over time including when new drugs were added, when and why they were stopped or changed.
B34	Reduced staff time for prescribing audit	e-Prescribing in all clinical areas	Reduced staff time for audit	Saving of staff time due to significant reduction in time spent collating data from various paper sources for audit purposes  (Can include: CQUIN/ research/ general audit/ coding-PbR/ clinical trials/ direct access requests/ complaints/ litigation etc.)

Ref	Benefit Title	Enabling	Changed state	Description of benefit
B37	Reduced bed costs by reducing readmissions	e-Prescribing will impact on and require the support of everyone who prescribes, supplies or administers medicine - engagement needed with both administrative and clinical leadership Prescribing in all clinical areas Real time Admission-Discharge-Transfer (ADT) Early/timely entry of weights/allergies Review workflow - 'As Is' and 'To Be'	Reduced bed costs by reducing readmissions due to omissions/errors in drug information at discharge	Reduced bed costs through the reduction in readmission as a consequence of drug errors and avoidable adverse drug reactions arising from omissions/errors in drug information on discharge communications
B40	Reduction in staff time to transport drug chart	e-Prescribing will impact on and require the support of everyone who prescribes, supplies or administers medicine - engagement needed with both administrative and clinical leadership Prescribing in all clinical areas Real time Admission-Discharge-Transfer (ADT) Review workflow - 'As Is' and 'To Be'	Reduction in staff time to transport drug chart between patient location (e.g. ward/department) and pharmacy department	Reduction in staff time to transport paper drug chart between patient location (e.g. ward/department) and pharmacy department as electronic prescriptions can be accessed in any location where the user has legitimate access

Ref	Benefit Title	Enabling	Changed state	Description of benefit
B41	Provide up-to date referrals. Removal of repeat and missed referrals for the tissue viability service.	EPR will provide a means of capturing the referral and the treatment/care given to the patient, enabling the follow up care to be viewed by all clinicians managing the patient.	Through the EPR system, referrals will be captured on one system. The clinical care will be viewed by all clinicians and removes the need for the nurse to spend time relaying information, thereby releasing nursing time to treat more patient. Reduces the n	Saving Nursing time which will result in the equivalent of the time of 1 band 5 nursing staff e on £29,000
B44	Clinical staff (Junior DR, DR, Consultant) no longer required to login to multiple systems	The new integrated EPR will not require multiple log-ons to different systems to support clinical workflow for A&E, order comms, clinical notes, bed management and discharges	staff will have more time to treat patients. This will result in more staff time supporting patients through their pathway potentially resulting in an earlier discharge.	Expected saving of 20 minutes per day of clinical savings (£16 based on £100k salary) with an average of 85 users per day, 365 days a year - £16 x 85 x 365 - best of breed will only achieve 80% of target
B45	Clinical Staff (physios, pharmacy, pathology, radiology etc) no longer required to login to multiple systems	The new integrated EPR will not require multiple log-ons to different systems to support clinical workflow for A&E, order comms, clinical notes, bed management and discharges	staff will have more time to treat patients. This will result in more staff time supporting patients through their pathway potentially resulting in an earlier discharge.	Expected saving of 20 minutes per day of clinical savings (£5 based on £30k salary) with an average of 150 users per day, 365 days a year - £5 x 150 x 365
B46	Improved clinical outcomes resulting in reduced length of stay for inpatients	The new integrated workflow from EPR will allow for improved turnaround of discharges, improved bed management through the centralised electronic system and greater use of the clinical workflow by junior doctors	Patients are discharged quicker reducing LOS and improving income flows	Aid completion of data collection resulting in a reduction in LOS by 1%. (No of admissions x cost of stay/bed x %reduction (1)) - best of breed will only achieve 80% of target

Ref	Benefit Title	Enabling	Changed state	Description of benefit
B18	Ability to share patient records between organisations	Single solution across all Acute Trusts in Kent.	Ability to share patient records between organisations will improve transfer of care and multi-disciplinary team working across organisations. Information will be full available to all clinicians and the record would be kept up to date.	
B19	Alerting across system	Single solution to access all clinical data across the organisation.	quality - escalation of results and non-completed activities	Improvement in patient care as alerting will lead to reduced escalation and SI's
B22	Admin time for clinicians	New functionality within the application will allow for voice recognition. Which can be used for updating of notes and letters.	This will allow clinicians to use the some of the same information collected for notes be used for letters, instead of having to repeat the process.	Improve the functionality of the current clinics to ensure they run on time providing clinicians with more time directly with the patient.
B24	Clinical Decision support	Provides decision support to users when placing orders for patients	Reduces orders for pathology radiology, pharmacy through reduction in duplicate and incorrect orders being placed.	NHS England 2017/18: OBJECTIVE 3: To balance the NHS budget and improve efficiency and productivity  FYFV: The funding and efficiency gap
B35	Improved ePrescribing information and quality data		Improved information and quality data to support organisation reporting requirements	Improved access to information, more complete and better quality of data to support mandatory reporting.  (Can include: CQUIN/ research/ general audit/ coding-PbR/ clinical trials/ direct access requests/ complaints/ litigation etc.)

Ref	Benefit Title	Enabling	Changed state	Description of benefit
B36	Improved patient experience/confidence	e-Prescribing will impact on and require the support of everyone who prescribes, supplies or administers medicine - engagement needed with both administrative and clinical leadership Prescribing in all clinical areas Real time Admission-Discharge-Transfer (ADT) Early/timely entry of weights/allergies Review workflow - 'As Is' and 'To Be'	Improved patient experience/confidence through the reduction of drug errors and avoidable adverse drug reactions during inpatient admissions through improved prescribing and medicines administration decision support.	Improved patient (and carer) experience through the reduction of drug errors and avoidable adverse drug reactions (contraindicated by treatment) during inpatient admissions by moving the current paper based system of prescribing to electronic, utilising the features identified in 'System Functionality' to address current issues.
B38	Improved patient care through patients having the right medication	e-Prescribing will impact on and require the support of everyone who prescribes, supplies or administers medicine - engagement needed with both administrative and clinical leadership Prescribing in all clinical areas Real time Admission-Discharge-Transfer (ADT) Early/timely entry of weights/allergies Review workflow - 'As Is' and 'To Be'	Improved patient care through patients having the right medication at the right time.	Improved patient care through patients having the right medication at the right time, through increased compliance/timeliness of giving of drugs on time etc.

Ref	Benefit Title	Enabling	Changed state	Description of benefit
B39	Increased compliance with legal and professional medications management	e-Prescribing will impact on and require the support of everyone who prescribes, supplies or administers medicine - engagement needed with both administrative and clinical leadership Prescribing in all clinical areas Real time Admission-Discharge-Transfer (ADT) Review workflow - 'As Is' and 'To Be'	Increased compliance with legal and professional medications management requirements/standards (e.g. NHS LA)	Increased compliance with legal and professional medications management requirements/standards , e.g. adherence to requirements for accuracy checking
B42	Improving the quality of care and reducing the costs at the health care level.	The EPR system will aid the clinician in making decisions with regard to patient care by providing latest information about drug, cross-referencing patient allergy to a medication and alerts for drug interaction and other patient issues that are flagged b	Clinicians capturing clinical information electronically.	
B43	improved Patient Outcomes and Experiences by having faster and more appropriate treatment.	EPR system will support the populating of a drug list for patients. Controlled drugs could be linked to episode of patient. Worklist available linked to patients on the ward prescribed with antibiotics allowing pharmacists to monitor usage. Monitoring of	Clinicians and Pharmacists will be able to populate the EPR system with interactions, contraindications, allergy and side effects.	Greater capacity and capability to audit the use of drugs. Better management of patients on antibiotics and controlled drugs. Improved patient safety. Better monitoring of the drugs bill.

Ref	Benefit Title	Enabling	Changed state	Description of benefit
B47	Smarter working for ward staff demonstrated by reducing wasted nursing time on use of multiple systems	New integrated EPR and workflow system	nursing staff will only need to access a single system to support workflow for core tasks such as bed management, EDN and notes	Saving Nursing time which can be spent on patient care.
B50	Reduced costs for out of hours retrieval of health records	Due to the complete patient record being available electronically		
B51	Reduced risk of hospital acquired infections	Improvement monitoring of infections across the Trust due to integrated infection control solution.		
B52	Reducing unnecessary follow up appointments (new to follow-up ratio)	Due to the complete patient record being available electronically		
B53	Theatre utilisation and improved use of clinical time	Due to a fully integrated theatres solution within the EPR		
B54	Improved integration with external clinical systems	Interfaces with other local providers provides improved patient information which is accessible to end-users	In areas such as A&E and outreach teams will be provided with more enhanced data on patients improving decision making and as a result patient care.	Improved quality of information and reduction of time triaging of patients at first contact.
B55	Reduction in Health Records Staff	Due to the electronic patient record being in place records will be made available via this system	Paper records will no longer need to be pulled as a result of records being available and accessed via the EPR.	This will result in a reduction of Health Records staff needed to pull records. This will result in a 10% reduction in health records staff. With 103 staff within the current team at an average at a band 3. Only 80% of this benefit would be realised for option 2 due to the reduced integration.

Ref	Benefit Title	Enabling	Changed state	Description of benefit
B56	Reduction in printing costs	Due to the EPR capturing and providing data electronically there will be a reduced need for paper.	Printing of forms and patient notes will reduce.	The current managed print contract costs will reduce by 10%.

**Figure 30: Main Benefits by Category**

### 3.6. Risk appraisal

The risk appraisal has been carried in line with HM Treasury Green book. At the OBC stage all of the risks have been scored and benchmarked against other EPR business cases where necessary. For each option a % contingency has then been added to match the perceived risk at this stage. For FBC a full detailed costed model for risks will be undertaken and the retained risk included in the business case. The risk analysis includes any of the Optimism Bias factors that have not been mitigated and reduced to 'zero per cent' in the Optimism Bias.

The following tables show the risk valuation for each option and the contingency applied:

NHS Retained Risk - Scores	Score	% of highest risk	Rank
Option 1 - Do Nothing	608	100%	5
Option 2 - Best of Breed Solution (Capital Programme)	480	81%	4
Option 3 - EPR Solution (Capital Programme)	467	77%	1
Option 4 - EPR Solution (Managed Service)	467	77%	1
Option 5 - Kent Wide EPR	479	79%	3

*Figure 31: Quantified Risk Analysis*

The risk analysis shows that options 3 and 4 contain the lowest risks. The justification for why is found below.

#### Option 1 – Do Nothing

Although the Trust would not be embarking on a major IT programme there are increased risks of staying 'As-Is'. The Trust would have to negotiate contract extensions with all existing system suppliers and there is a significant risk that this could result in increased charges, with the Trust unable to provide another support vendor. Secondly the suppliers would be under no obligation to meet national reporting requirements or provide security patches which could have an adverse effect on the Trust.

#### Option 2 – Best of Breed

Integration of disparate systems and the ability to meet the full programme objectives are the key risks with the option. A best of breed approach requires additional integration between applications compared to the other options which represents greater risks. This is highlighted by a lack of successful 'best of breed' deployments in the UK. This could lead to the reduced sharing of data between systems and the investment objectives not being met.

#### Option 3/4 –EPR

There are risks to any large IT project, but there is a benefit to dealing with a single supplier during the implementation. With the exception of option 1, these options present the least risk regarding system integration. There are differing risks between the hosting options analysed; the Trust would have control over the infrastructure, however the organisation would need to ensure the correct



internal support was in place to manage the solution. Hosting would ensure the supplier takes full responsibility for the solution, but the Trust must ensure that Infrastructure SLAs are fit for purpose during the life of the contract.

**Option 5 – Kent Wide**

Despite perceived benefits to a Kent Wide EPR solution, with the sharing of data between organisations to support clinicians in patient care, the integration and configuration is more complex with increased interfacing with local systems and the need to maintain agreement on configuration, workflow and protocols across all participating organisations. As a result, there is an increase risk that the project will be delayed and implementation costs would rise.

### 3.7. Optimism Bias

Optimism bias has been undertaken at this stage and the following table details the outcome. These costs have been included in the financial analysis, the detail can be found in Appendix B.

Optimism Bias			Option 1 - Do Nothing		Option 2 - Best of Breed Solution (Capital Programme)		Option 3 - EPR Solution (Capital Programme)		Option 4 - EPR Solution (Managed Service)		Option 5 - Next Wide EPR	
			20%	upper bound	20%	upper bound	20%	upper bound	20%	upper bound	20%	upper bound
Factor that contributes to optimism bias	Contribution to upper bound	How determine contribution after mitigation	Contribution after mitigation	Explanation of extent of mitigation	Contribution after mitigation	Explanation of extent of mitigation	Contribution after mitigation	Explanation of extent of mitigation	Contribution after mitigation	Explanation of extent of mitigation	Contribution after mitigation	Explanation of extent of mitigation
Insufficient user consultation re requirements	4%	How far have users been involved in scoping the system and to what extent have you involved users in the Project Board, Project Teams etc?	0%	users continue with current system as is	1%	Users will have worked on developing the specification, been involved in all aspects of evaluations, site visits, and trust based project teams	1%	Users will have worked on developing the specification, been involved in all aspects of evaluations, site visits, and trust based project teams	1%	Users will have worked on developing the specification, been involved in all aspects of evaluations, site visits, and trust based project teams	1%	Users will have worked on developing the specification, been involved in all aspects of evaluations, site visits, and trust based project teams
User acceptance of solution underplayed	15%	How far have users been engaged in the project and what evidence of user support do you have? You should think about all relevant users, clinical, administrative, management and any external users.	0%	users continue with current system as is	0%	Staff from all disciplines have been involved in the specification and evaluation of the procurement, however with over 4,000 staff this will always be a small subsection of the total users	0%	Staff from all disciplines have been involved in the specification and evaluation of the procurement, however with over 4,000 staff this will always be a small subsection of the total users	0%	Staff from all disciplines have been involved in the specification and evaluation of the procurement, however with over 4,000 staff this will always be a small subsection of the total users	0%	Staff from all disciplines have been involved in the specification and evaluation of the procurement, however with over 4,000 staff this will always be a small subsection of the total users
Level of change from existing systems and work practices underplayed	10%	What magnitude of change will result from the implementation of this project? E.g. a replacement pathology system may involve less change than the implementation of a Trust's first pathology system or a PACS.	0%	users continue with current system as is	1%	The system are mainly replacements for the current systems, there will be some new functionality being introduced the areas and the aim is to join up the system reducing amount of multiple systems staff have to be trained on	1%	The system are mainly replacements for the current systems, there will be some new functionality being introduced the areas and the aim is to join up the system reducing amount of multiple systems staff have to be trained on	1%	The system are mainly replacements for the current systems, there will be some new functionality being introduced the areas and the aim is to join up the system reducing amount of multiple systems staff have to be trained on	1%	The system are mainly replacements for the current systems, there will be some new functionality being introduced the areas and the aim is to join up the system reducing amount of multiple systems staff have to be trained on
Output specification not sufficiently robust	20%	How well have you defined the scope of the system requirements? What is the risk of scope creep? In how much detail have you defined the benefits you expect to accrue as a result of this project?	0%	users continue with current system as is	1%	A detailed specification will be built covering all areas of functional, technical and implementation. The benefits are well defined and a benefits realisation plan has been developed with local owners.	1%	A detailed specification will be built covering all areas of functional, technical and implementation. The benefits are well defined and a benefits realisation plan has been developed with local owners.	1%	A detailed specification will be built covering all areas of functional, technical and implementation. The benefits are well defined and a benefits realisation plan has been developed with local owners.	1%	A detailed specification will be built covering all areas of functional, technical and implementation. The benefits are well defined and a benefits realisation plan has been developed with local owners.
Interfaces to other systems insufficiently understood (number and novelty, including legacy systems and in turn their links to other legacy systems)	5%	Interfaces are a major area of weakness in an IM&T project. In general the more interfaces that are required the more risky the project. You should also consider whether a supplier has interfaced their system to your legacy systems elsewhere.	0%	users continue with current system as is	2%	This risk will be transferred to the prime contractor	1%	The trust will use an interface engine to manage the integration services and will include this service in the procurement. All interfaces will be standards based	0%	This risk will be transferred to the prime contractor	1%	The trust will use an interface engine to manage the integration services and will include this service in the procurement. All interfaces will be standards based
Complexity of required contract structure (including payment mechanisms) misjudged	7%	Which contract will you be using? How will you make your payments - monthly? Against the achievement of agreed milestones? Yearly? How does the contract deal with under-performance? Do you have a system of payment deductions to cover this?	0%	users continue with current system as is	1%	The model OGC contract will be used, with all payments following accepted Milestones, there are SLAs with penalties for failure to deliver	2%	The model OGC contract will be used, with all payments following accepted Milestones, there are SLAs with penalties for failure to deliver	1%	The model OGC contract will be used, with all payments following accepted Milestones, there are SLAs with penalties for failure to deliver	2%	The model OGC contract will be used, with all payments following accepted Milestones, there are SLAs with penalties for failure to deliver
Contractors' capability and capacity underestimated	12%	Does this company have a proven track record of delivery? Do they have the number and quality of staff to deliver the project? What is the competition on the market for these systems? What is the likely interest in the market for this project?	0%	users continue with current system as is	1%	The expected contractors have operated within their respective fields for a number of years, they will have a track record of delivery. However it has to be recognised that there are a large number of procurements underway which could stretch contractors	1%	The expected contractors have operated within their respective fields for a number of years, they will have a track record of delivery. However it has to be recognised that there are a large number of procurements underway which could stretch contractors	1%	The expected contractors have operated within their respective fields for a number of years, they will have a track record of delivery. However it has to be recognised that there are a large number of procurements underway which could stretch contractors	1%	The expected contractors have operated within their respective fields for a number of years, they will have a track record of delivery. However it has to be recognised that there are a large number of procurements underway which could stretch contractors
Client capability and capacity underestimated	12%	What are your resources for delivering the project? Do you have the relevant people to manage the project? Are you using PRINCE2? Do you have trained PRINCE2 trained people on the project? Does the Trust have a track record of successful delivery of IM&T projects?	0%	users continue with current system as is	2%	The trust has identified the resources needed over the 2 year implementation plan and the costs for these are included in the business case. The trust has already engaged in the recruitment of external support where needed as well as internal project, IT, clinical and operational areas.	2%	The trust has identified the resources needed over the 2 year implementation plan and the costs for these are included in the business case. The trust has already engaged in the recruitment of external support where needed as well as internal project, IT, clinical and operational areas.	2%	The trust has identified the resources needed over the 2 year implementation plan and the costs for these are included in the business case. The trust has already engaged in the recruitment of external support where needed as well as internal project, IT, clinical and operational areas.	2%	The trust has identified the resources needed over the 2 year implementation plan and the costs for these are included in the business case. The trust has already engaged in the recruitment of external support where needed as well as internal project, IT, clinical and operational areas.
Sensitivity of project outcomes to legislative and regulation changes underestimated	15%	How stable do you consider the policy environment to be? How likely is it that policy or standards may change during the lifetime of the project? If you don't know then you can't mitigate the very much.	0%	users continue with current system as is	1%	These are core systems used across the NHS, any changes required through legislative or regulatory changes will be delivered through the terms of the contract	1%	These are core systems used across the NHS, any changes required through legislative or regulatory changes will be delivered through the terms of the contract	1%	These are core systems used across the NHS, any changes required through legislative or regulatory changes will be delivered through the terms of the contract	1%	These are core systems used across the NHS, any changes required through legislative or regulatory changes will be delivered through the terms of the contract
	100%		0%		0%	1.6%	16%	1.6%	8%	1.6%	16%	1.6%

Figure 32: Optimism Bias also in Appendix B

### 3.8. Shortlisted Options Outcome

Appendix B pulls together the costs, benefits and risks in order to present all of the information needed to determine relative value for money. The following table summarises the outcome, first using non-discounted figures and then using discounted figures.

#### Summary - Undiscounted:

Summary - undiscounted (all financial figures £000 exc VAT)	Option 1 - Do Nothing	Option 2 - Best of Breed Solution (Capital Programme)	Option 3 - EPR Solution (Capital Programme)	Option 4 - EPR Solution (Managed Service)	Option 5 - Kent Wide EPR
Capital expenditure exc VAT	(5,520)	(5,347)	(6,825)	(2,335)	(5,219)
Capital expenditure optimism bias uplift	0	(88)	(130)	(37)	(99)
Revenue expenditure exc VAT	0	(5,348)	(3,817)	(8,444)	(5,107)
Revenue expenditure optimism bias uplift	0	(85)	(73)	(135)	(97)
<b>Total expenditure exc VAT</b>	<b>(1,520)</b>	<b>(10,836)</b>	<b>(10,844)</b>	<b>(10,951)</b>	<b>(10,522)</b>
Plus cost of risk retained	(1,360)	(1,310)	(1,265)	(1,265)	(1,324)
Less cash releasing benefits	0	9,385	16,623	16,623	13,623
Less non-cash releasing benefits	0	11,545	14,497	14,497	12,954
Less societal benefits	0	0	0	0	0
<b>Total - undiscounted (highest +ve figure = best)</b>	<b>(2,880)</b>	<b>8,784</b>	<b>19,011</b>	<b>18,904</b>	<b>14,731</b>
<b>Risk Score</b>	<b>608</b>	<b>490</b>	<b>467</b>	<b>467</b>	<b>479</b>
<b>Quality benefits score</b>	<b>0</b>	<b>182</b>	<b>211</b>	<b>211</b>	<b>223</b>

Figure 33: Undiscounted Summary Table

#### Summary – discounted:

Summary - discounted (all financial figures £000 exc VAT)	Option 1 - Do Nothing	Option 2 - Best of Breed Solution (Capital Programme)	Option 3 - EPR Solution (Capital Programme)	Option 4 - EPR Solution (Managed Service)	Option 5 - Kent Wide EPR
Capital expenditure exc VAT	(1,303)	(5,007)	(6,581)	(2,243)	(4,964)
Capital expenditure optimism bias uplift	0	(80)	(125)	(36)	(94)
Revenue expenditure exc VAT	0	(4,370)	(3,130)	(7,272)	(4,362)
Revenue expenditure optimism bias uplift	0	(70)	(59)	(116)	(83)
<b>Total expenditure exc VAT</b>	<b>(1,303)</b>	<b>(9,526)</b>	<b>(9,895)</b>	<b>(9,667)</b>	<b>(9,503)</b>
Plus cost of risk retained	(1,148)	(1,121)	(1,083)	(1,083)	(1,137)
Less cash releasing benefits	0	7,457	13,402	13,402	10,778
Less non-cash releasing benefits	0	9,218	11,576	11,576	10,168
Less societal benefits	0	0	0	0	0
<b>Total - discounted (highest +ve figure = best)</b>	<b>(2,452)</b>	<b>6,019</b>	<b>14,000</b>	<b>14,228</b>	<b>10,304</b>
<b>Risk Score</b>	<b>608</b>	<b>490</b>	<b>467</b>	<b>467</b>	<b>479</b>
<b>Quality benefits score</b>	<b>0</b>	<b>182</b>	<b>211</b>	<b>211</b>	<b>223</b>

Figure 34: Discounted Summary Table

This shows that at the economic level all options for delivering the change deliver savings and efficiency improvements to the Trust, with Options 3 and 4 showing the greatest net saving. The economic variation shows that an EPR (delivered via the Capital and Revenue model) provides a lower risk and higher benefits return than the Best of Breed approach. The FBC will further consider the Capital/Revenue model versus the Managed Service model, which will be assessed through the procurement stage to better understand the additional benefits and risk analysis of each option.

#### 3.8.1. Sensitivity analysis

The Sensitivity Analysis tests for the robustness of the preferred option, under a number of scenarios, to determine the overall effect on value for money. This will be undertaken on the preferred option during the FBC stage.

## 4. Commercial Case

### 4.1. Introduction

This section presents the commercial arrangements involved in taking forward the project, based on the preferred approach to emerge from the OBC Options Appraisal. It covers the following:

- The procurement process using the SBS framework
- The executable contract and its key elements;
- An overview of how risk transfer has been effected;
- TUPE issues;
- Payment mechanism;
- Performance mechanism;
- Charging mechanism.

### 4.2. Required services

The products and services to be sought under the procurement are as follows:

#### Phase 1 – Preparation of Existing Systems

- Upgrade roadmap for those systems that are allocated to later replacement phases.
- Review and upgrade roadmap for those systems that require data quality improvements prior to moving into EPR.
- Confirm Infrastructure and Data Centre are fit for purpose.

*For Phase 1 costs, a small budget has been identified within the business case, however the actual cost will not be known until the final EPR procurement process has completed. It is expected that each system requiring upgrade will need a small business case with detailed costings*

#### Phase 2 – Foundation Systems and Preparation:

- Data Warehouse integration reviewed and prepared.
- Electronic Document Management (EDM) integration reviewed and prepared.
- Preparatory investment in programme enablers, such as hardware and PCs.

#### Phase 3 – EPR Core Systems, including:

- Order Entry and Result Reporting with the ability to configure orders that drive worklists (task scheduling) and orders that drive Flowsheet charting;
- Clinical documentation using flowsheets, structured notes, and clinical summary tiles;
- Patient Timeline View
- Patient information, patient lists, patient orders and results
- Interoperability – access to external systems and information
- Integration to third party systems.
- Bed and Ward Management
- Emergency Department
- Clinical Documentation / e-Noting
- ePrescribing
- Rules Engine: Alert escalation, Allergy checking, Dosage range checking, Dosage calculations, Duplicate order checking, Duplicate task checking, Expert dosing, Panic results and conflicting medications, Panic results and conflicting medications;
- Community Services Integration
- Interoperability standards to allow information flows across the region.

**Phase 4 - Departmental Systems, including:**

- Critical Care
- Diabetes
- Voice Recognition integration
- Anaesthetics Record and Pre-Assessment
- Tracking Boards
- Secure Messaging for clinicians
- Mobile EPR
- E-observations

It should be noted that Phase 4 timescales will extend over a number of years, as departmental systems will migrate on expiry of existing contracts. The OBC has assumed a phased delivery over 3 years, which will be refined during the procurement and FBC stage.

**4.3. Agreed Risk Transfer**

The general principle is that risk is passed to 'the party best able to manage them', subject to value for money.

This will be reviewed and agreed with potential suppliers during the procurement process with the initial view of achieving an apportionment of service risks in the design, build and operational phases as follows:

Risk Category	Risk Allocation		
	NHS	Supplier	Shared
1. Design and development risk	40%	40%	20%
2. Deployment risk	40%	60%	
3. Operational risk	10%	90%	
4. Termination risk	90%	10%	

*Figure 35: Transfer of Risk between Organisations*

**4.4. Procurement Strategy**

The Procurement strategy will be different for each of the proposed phases of work:

**4.4.1. Procurement approach**

The options review recommends that the procurement be broken down into the following phases:

Phase	Procurement Route	Description
Phase 1 and 2	System updates	Covered under existing contracts.
Phase 3 / 4	National Framework	Use existing National Frameworks to procure systems reducing costs and the time taken to begin implementation of services.

*Figure 36: Procurement Approach*

The procurement process for the main Phase 3/4 is based on utilising the SBS EPR framework, available to the Trust.

**4.4.2. Procurement Process**

The SBS procurement process the Trust will use for this complex procurement will be divided into the following stages.

Stage	Date
Finalise Specification	14 <sup>th</sup> May 2018
Issue ITT through SBS framework	15 <sup>th</sup> May 2018
Clarification Session	21 <sup>st</sup> & 22 <sup>nd</sup> May 2018
Deadline for Supplier clarifications to be received	5 <sup>th</sup> June 2018
Deadline for Trust responses to clarifications	12 <sup>th</sup> June 2018
Final contract review	18 <sup>th</sup> & 19 <sup>th</sup> June 2018
Deadline for submission of bid	26 <sup>th</sup> June 2018
Full Business Case (FBC) Approval	28 <sup>th</sup> June 2018
Evaluation	29 <sup>th</sup> June 2018
Executable Contract	30 <sup>th</sup> June 2018
Contract Signed	30 <sup>th</sup> September 2018

Figure 37: Procurement Plan

#### 4.5. Contract Details

The contract used will depend upon the procurement route. Framework procurements will use existing term and conditions. The plan will be for a 10-year contract to ensure the financial benefits are fully realised.

#### 4.6. Personnel Implications (including TUPE)

It is not anticipated that the provisions of the Transfer of Undertakings (Protection of Employment) Regulations 1981 will apply to this investment. The service is provided to multiple NHS trusts and there are no plans for staff transfers at outset or exit. Any staff savings identified within the benefits section will be made through natural wastage over time as shown in the benefits profile. There is no anticipation of redundancy costs.

#### 4.7. Accounting Treatment

Capital and Revenue based solutions will use standard Trust Accounting policies.

Accounting treatment for a Fully Managed Service will be tested during the FBC stage to establish whether the service qualifies as off-balance sheet. To qualify as a Fully Managed Service, ownership of the software and hardware must not transfer to the Trust at any point during the contract (or upon completion or termination). The supplier provides the Trust with a package of services, which are supplied and controlled by the supplier, where all risks of providing the system and operating services rests with the supplier and would be eligible for VAT recovery under COS heading 14.



## 5. Financial Case

### 5.1. Introduction

This section evaluates the affordability of the proposed investment by balancing the costs (with optimism bias uplift, relevant non-recoverable VAT and capital charges applied) against sources of funding.

#### 5.1.1. Current Position

MTW is a financially challenged trust, within a financially challenged health economy and has recognised that internal efficiency savings will not be sufficient to secure the infrastructure to support the clinical, operational and financial sustainability of the Trust.

The Trust's financial position was a deficit of -£10.9m in 2016/17 and -£10.9m in 2017/18 (Unaudited).

Financial Year	Final Accounts Outturn (inc STF)
2016/17	-£10.9
2017/18	-£10.9

Figure 38: Financial Position 2016- 2018

### 5.2. Key Assumptions

- The costs presented, in this section, include the optimism bias uplift applied to the Economic Case
- Contingency – a revenue contingency is included to meet the costs of risks that materialise, noting that significant changes to scope will be subject to subsequent variations to the business case. The contingency equals the value of NHS retained risks that would create a cost pressure on the Trust –the risk assessment in the Options Appraisal identifies the risks that could result in extra costs or reduced/delayed realisation of cash releasing benefits.
- Irrecoverable VAT – as VAT goes to HM Treasury, it has no effect on the Public Sector as a whole and is not included in the economic analysis in section 4. However, the affordability and cash flow need to be assessed as the cash outflow needs to be found and is included for items to which it applies.
- Inflation is applied in line with the current CPI forecast quoted by HM Treasury and shown in the Financial Summary.
- Capital charges – assumed to apply to all capital expenditure
- Depreciation - capital items are depreciated to zero on a straight-line basis, over the investment period, with the rate of return being 3.5% per annum
- Balance sheet treatment shows this as a standalone project

### 5.3. Overall Cost of the Investment

The total cost of the investment taking into account local costs for implementing and operating the service and supplier charges is set out below – please note these exclude any savings.

## EPR Outline Business Case – ID545

Version1.0 – 11/05/2018

Costs per option £000	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	Total
<b>Option 1 - Do Nothing</b>												
- Capital	0	0	765	0	0	665	0	0	0	422	0	1,851
- Capital optimism bias uplift *	0	0	0	0	0	0	0	0	0	0	0	0
- Capital contingency **	0	53	124	55	56	113	59	60	61	87	18	688
- Capital total	0	53	889	55	56	778	59	60	61	509	18	2,539
- Revenue	0	0	0	0	0	0	0	0	0	0	0	0
- Revenue optimism bias uplift *	0	0	0	0	0	0	0	0	0	0	0	0
- Revenue contingency **	0	0	0	0	0	0	0	0	0	0	0	0
- Revenue total	0	0	0	0	0	0	0	0	0	0	0	0
- TOTAL CAPITAL + REVENUE	0	53	889	55	56	778	59	60	61	509	18	2,539
<b>Option 2 - Best of Breed Solution (Capital Programme)</b>												
- Capital	230	2,221	2,392	555	0	588	0	28	0	0	0	6,013
- Capital optimism bias uplift *	3	33	36	8	0	9	0	0	0	0	0	89
- Capital contingency **	20	250	286	86	25	86	38	41	39	21	21	913
- Capital total	253	2,504	2,714	649	25	683	38	69	39	21	21	7,016
- Revenue	0	158	543	622	635	688	662	815	691	705	706	6,226
- Revenue optimism bias uplift *	0	3	8	10	10	11	10	13	11	11	11	96
- Revenue contingency **	0	52	93	70	73	80	79	99	86	89	111	833
- Revenue total	0	213	645	702	718	779	752	926	787	805	828	7,155
- TOTAL CAPITAL + REVENUE	253	2,717	3,358	1,351	743	1,462	789	995	826	826	849	14,170
<b>Option 3 - EPR Solution (Capital Programme)</b>												
- Capital	2,278	2,470	2,089	22	0	222	0	0	0	0	0	7,081
- Capital optimism bias uplift *	43	46	39	0	0	4	0	0	0	0	0	133
- Capital contingency **	228	283	258	34	23	51	35	36	37	20	20	1,026
- Capital total	2,549	2,798	2,385	57	23	277	35	36	37	20	20	8,239
- Revenue	0	51	399	450	459	469	479	489	499	510	511	4,315
- Revenue optimism bias uplift *	0	1	8	9	9	9	9	9	9	10	10	82
- Revenue contingency **	0	39	77	52	54	56	58	61	63	66	105	632
- Revenue total	0	91	483	510	522	534	546	559	572	585	626	5,029
- TOTAL CAPITAL + REVENUE	2,549	2,890	2,868	567	545	811	582	595	609	605	646	13,268
<b>Option 4 - EPR Solution (Managed Service)</b>												
- Capital	287	1,450	735	22	0	0	0	0	0	0	0	2,495
- Capital optimism bias uplift *	5	22	11	0	0	0	0	0	0	0	0	38
- Capital contingency **	29	181	123	34	23	29	35	36	37	20	20	567
- Capital total	320	1,653	869	57	23	29	35	36	37	20	20	3,100
- Revenue	300	1,294	1,721	694	709	724	739	755	771	787	788	9,281
- Revenue optimism bias uplift *	5	21	28	11	11	12	12	12	12	13	13	149
- Revenue contingency **	30	166	214	78	81	84	88	92	95	99	139	1,167
- Revenue total	335	1,481	1,963	783	801	820	839	858	878	899	940	10,597
- TOTAL CAPITAL + REVENUE	655	3,133	2,832	840	825	849	874	894	915	919	960	13,697
<b>Option 5 - Kent Wide EPR</b>												
- Capital	450	2,551	2,590	170	0	55	0	0	0	0	0	5,817
- Capital optimism bias uplift *	7	45	46	3	0	1	0	0	0	0	0	102
- Capital contingency **	39	281	295	49	23	35	35	36	37	20	20	871
- Capital total	496	2,876	2,931	223	23	91	35	36	37	20	20	6,790
- Revenue	144	333	686	743	759	775	791	808	825	0	0	5,864
- Revenue optimism bias uplift *	2	6	13	14	14	14	15	15	15	0	0	107
- Revenue contingency **	14	69	107	83	86	90	94	98	102	5	44	791
- Revenue total	161	407	806	840	859	879	900	920	942	5	44	6,763
- TOTAL CAPITAL + REVENUE	657	3,284	3,737	1,063	883	971	935	956	978	25	64	13,552

Figure 39: Overall Costs by Options



## 5.4. Impact on Cash flow, I&E Account and Balance Sheet

### 5.4.1. Impact on Cash Flow

The impact on cash flow is as follows for the preferred Option 4: (all impact can be found in Appendix B finance model)

Maidstone & Tunbridge Wells NHS Trust	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Total
CASH FLOW SUMMARY £000	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	
<b>CASH OUT</b>												
Capital payments - Maidstone & Tunbridge	287	1,389	694	22	0	0	0	0	0	0	0	2,392
Capital payments - optimism bias uplift *	5	22	11	0	0	0	0	0	0	0	0	38
Capital contingency **	29	181	123	34	23	29	35	36	37	20	20	587
<b>Capital payments - total</b>	<b>320</b>	<b>1,591</b>	<b>827</b>	<b>57</b>	<b>23</b>	<b>29</b>	<b>35</b>	<b>36</b>	<b>37</b>	<b>20</b>	<b>20</b>	<b>2,997</b>
Revenue payments - Maidstone & Tunbridg	300	1,294	1,721	694	709	724	739	755	771	787	788	9,281
Revenue payments - optimism bias uplift *	5	21	28	11	11	12	12	12	12	13	13	149
Revenue contingency **	30	166	214	78	81	84	88	92	95	99	139	1,167
<b>Revenue payments - total</b>	<b>335</b>	<b>1,481</b>	<b>1,963</b>	<b>783</b>	<b>801</b>	<b>820</b>	<b>839</b>	<b>858</b>	<b>878</b>	<b>899</b>	<b>940</b>	<b>10,597</b>
VAT	117	532	474	126	124	127	129	132	135	138	138	2,172
Cash releasing benefits	0	0	-873	-1,655	-2,067	-2,310	-2,350	-2,408	-2,458	-2,510	-2,514	-18,072
<b>Total cash out</b>	<b>772</b>	<b>3,604</b>	<b>2,592</b>	<b>-689</b>	<b>-1,138</b>	<b>-1,334</b>	<b>-1,355</b>	<b>-1,381</b>	<b>-1,408</b>	<b>-1,453</b>	<b>-1,416</b>	<b>-3,206</b>
<b>CASH IN</b>												
Recovered VAT	117	471	433	126	124	127	129	132	135	138	138	2,070
Other (specify details)												0
<b>Total cash in</b>	<b>117</b>	<b>471</b>	<b>433</b>	<b>126</b>	<b>124</b>	<b>127</b>	<b>129</b>	<b>132</b>	<b>135</b>	<b>138</b>	<b>138</b>	<b>2,070</b>
<b>NET CASHFLOW</b>												
<b>Net cashflow</b>	<b>655</b>	<b>3,133</b>	<b>2,159</b>	<b>-815</b>	<b>-1,262</b>	<b>-1,461</b>	<b>-1,484</b>	<b>-1,513</b>	<b>-1,543</b>	<b>-1,591</b>	<b>-1,554</b>	<b>-5,276</b>
<b>Brought forward</b>	<b>0</b>	<b>655</b>	<b>3,789</b>	<b>5,947</b>	<b>5,132</b>	<b>3,870</b>	<b>2,410</b>	<b>926</b>	<b>-587</b>	<b>-2,131</b>	<b>-3,722</b>	
<b>Carried forward</b>	<b>655</b>	<b>3,789</b>	<b>5,947</b>	<b>5,132</b>	<b>3,870</b>	<b>2,410</b>	<b>926</b>	<b>-587</b>	<b>-2,131</b>	<b>-3,722</b>	<b>-5,276</b>	
<b>Element of payments in 'cash out' that comprises inflation</b>												
Capital	0	32	33	3	2	3	4	5	5	4	4	98
Revenue	-5	29	78	47	64	80	98	118	134	152	161	959

Figure 40: Impact on Cash Flow Option 4

Note: Positive Values represent cash-out and Negative Values represent cash-in

### 5.4.2. Impact on Income & Expenditure Account

The impact on the income & expenditure account for Option 4 is as follows: (all impacts for I&E can be found in Appendix B finance model)

Maidstone & Tunbridge Wells NHS Trust	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Total
INCOME & EXPENDITURE SUMMARY	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	
<b>COSTS</b>												
Revenue payments	335	1,481	1,963	783	801	820	839	858	878	899	940	10,597
Non-recoverable VAT on revenue	0	0	0	0	0	0	0	0	0	0	0	0
Depreciation (non-cash flow item)	29	214	321	330	333	339	348	359	377	396	53	3,100
Rate of return (non-cash flow item)	5	35	70	75	65	54	43	32	20	8	1	408
<b>Grand total costs</b>	<b>369</b>	<b>1,730</b>	<b>2,354</b>	<b>1,188</b>	<b>1,200</b>	<b>1,213</b>	<b>1,230</b>	<b>1,250</b>	<b>1,276</b>	<b>1,302</b>	<b>993</b>	<b>14,104</b>
<b>FUNDING</b>												
Cash releasing benefits	0	0	673	1,655	2,087	2,310	2,358	2,408	2,458	2,510	2,514	18,972
Other (specify details)									397	403	54	855
<b>Grand total funding</b>	<b>0</b>	<b>0</b>	<b>673</b>	<b>1,655</b>	<b>2,087</b>	<b>2,310</b>	<b>2,358</b>	<b>2,408</b>	<b>2,855</b>	<b>2,913</b>	<b>2,568</b>	<b>19,827</b>
<b>NET COST TO REVENUE SOURCES</b>	<b>369</b>	<b>1,730</b>	<b>1,682</b>	<b>-468</b>	<b>-887</b>	<b>-1,097</b>	<b>-1,128</b>	<b>-1,158</b>	<b>-1,580</b>	<b>-1,611</b>	<b>-1,575</b>	<b>-5,722</b>

Figure 41: Impact on Income and Expenditure Option 4

Note: Positive Values represent cash-out and Negative Values represent cash-in

### 5.4.3. Impact on Balance Sheet

The impact on the balance sheet for option 4 is as follows: (all impact on balance sheet can be found in Appendix B finance model)

Maidstone & Tunbridge Wells NHS Trust	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Total
IMPACT ON BALANCE SHEET £000	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	
Balance brought forward	0	291	1,730	2,277	2,005	1,695	1,385	1,072	749	408	33	
Capital payments	320	1,591	827	57	23	29	35	36	37	20	20	2,997
Non-recoverable VAT on capital payments	0	61	42	0	0	0	0	0	0	0	0	103
Depreciation	-29	-214	-321	-330	-333	-339	-348	-359	-377	-396	-53	-3,100
Balance carried forward	291	1,730	2,277	2,005	1,695	1,385	1,072	749	408	33	0	

Figure 42: Impact on Balance Sheet Option 4

The accounting treatment of the Fully Managed Service will be tested during the FBC Stage to establish whether the solution should be treated as off-balance sheet.

## 6. Management Case

This section describes how the preferred option will be deployed and managed successfully in the operational setting.

### 6.1. Proposed Programme Management Organisational Structure

The Programme will be managed under **PR**ojects **I**N **C**ontrolled **E**nvironments, version 2 (PRINCE2) and Managing Successful Programmes (MSP) methodology. Adoption of this methodology requires a programme management structure that allows for channels of communication to decision making forums and will be supported by role descriptions that specify the responsibilities, goals, limits of authority, relationships, skills, knowledge and experience for all roles within the programme organisation.

The following diagram shows the proposed structure for the EPR Programme and its integration into existing Trust governance structures. It reflects the need to represent each organisation, end user, supplier and the external quality assurance role.

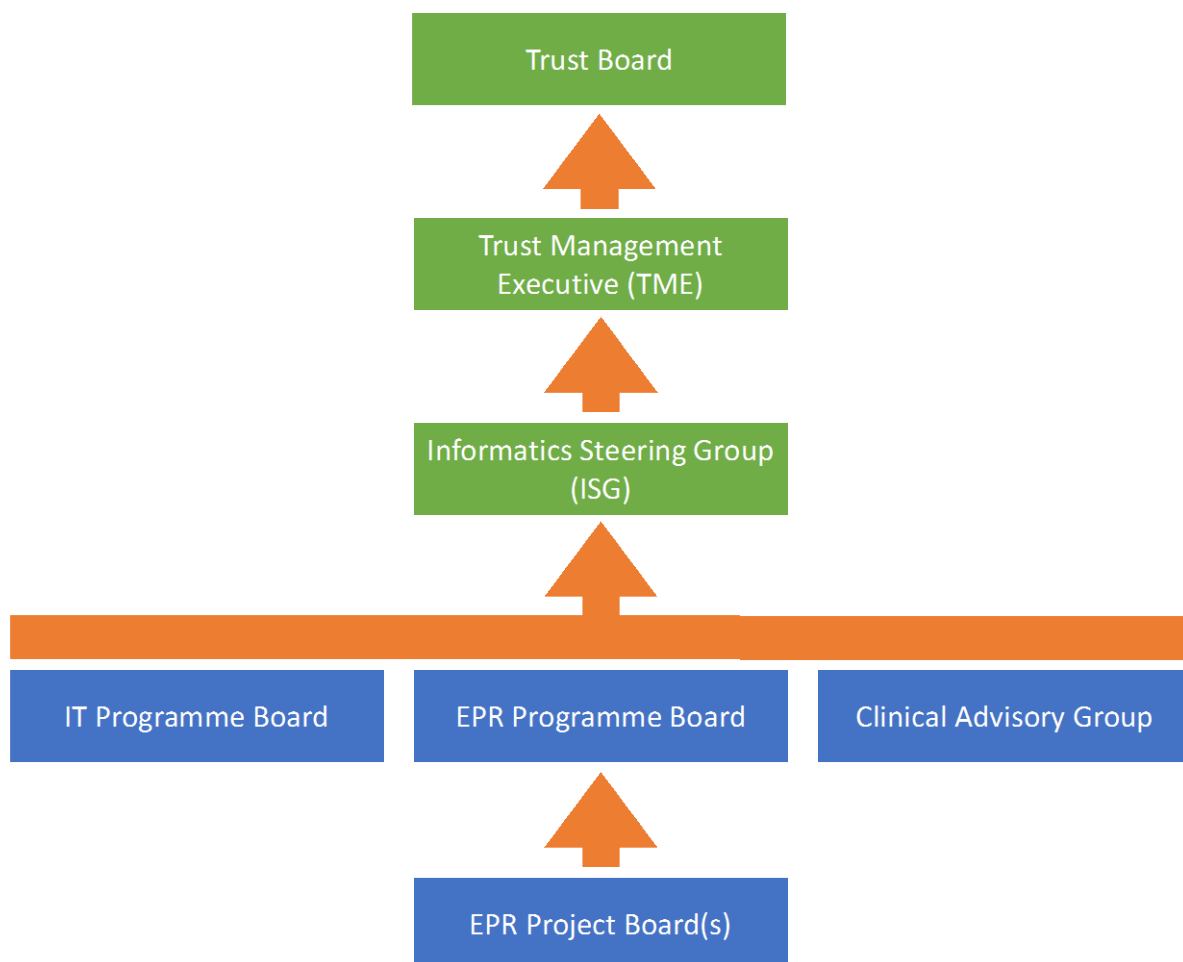


Figure 43: Programme Management Structure

#### 6.1.1. Digital Strategy and Transformation Group

The Digital Strategy and Transformation Group is to be formed reporting to the Management Board. The final terms of reference and Chair are to be agreed. The group will set the direction of travel and ensure that the Trust Board and other key stakeholders are kept informed of the progress to date. The group will provide the governance structure for both informatics projects and operational

performance ensuring that all Informatics development is coordinated to meet the needs of the organisation. The Trust may also consider aggregation of this board with other proposed governance structures for control of organisational change, for example, the existing “Eight Projects” being undertaken by the Change Management Team.

#### **6.1.2. EPR Programme Board**

The EPR Programme Board will provide the overall direction to the EPR Programme in line with the Programme Vision and Blueprint. It has responsibility to formally commissioning enabling projects and committing the required resources. It has the authority to sign off the completion of each phase and authorises the start of the next phase. The EPR Programme will approve Project Initiation Documentation for each project and provide permission to proceed. The EPR Programme Board will be responsible for project governance standards and monitor project progress reporting. The EPR Programme Board will also manage dependencies with the IT Programme Board to ensure the Trust’s infrastructure roadmap supports the EPR Programme. An example of the relationship between the Programme Board and its reporting Project Boards is set out below.

#### **6.1.3. Clinical Advisory Group (CAG)**

The CAG will aid the clinical engagement in the programme ensuring that at all stages clinical sign off in the programme is provided. The chair of the CAG will sit on the EPR programme board as Business Change Manager as well as CAG members taking part in EPR project boards and working groups to ensure clinical engagement at all levels. The Clinical Design Authority will also report via the CAG to the EPR programme board.

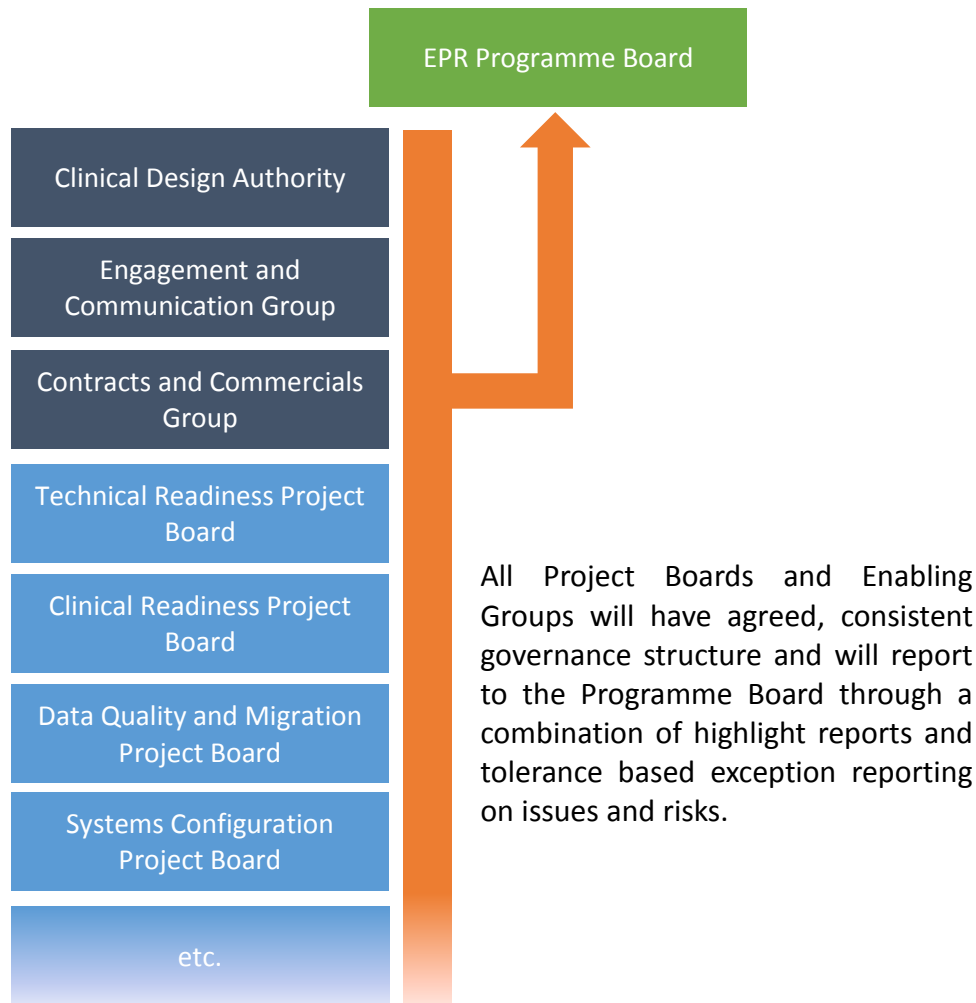


Figure 44: Project Reporting Structure

#### 6.1.4. Senior Responsible Owner / Executive

The SRO for the EPR programme is Angela Gallagher, COO. The SRO is the lead individual responsible for ensuring that the Programme meets its objectives and delivers the projected benefits. The SRO:

- is the visible owner of the overall business change and the evangelist for the programme as a whole; and
- is recognised throughout the organisation; and
- is the key leadership figure in driving the programme forward.

## 6.2. MTW Management Arrangements

Job Descriptions key roles from the Programme Board membership will be included in the Programme Initiation Document. The following is a summary of their main responsibilities.

### 6.2.1. EPR Programme Board – Chair & SRO: Angela Gallagher

- Creates, communicates and evangelises the programme vision both inside and outside the organisation
- Responsible for Overall direction, leadership and guidance for the programme
- Ensures the programme delivers the right capabilities to achieve its strategic outcomes

- Oversee and ensure the ongoing delivery and assessment of benefits associated with the Programme
- Ownership of the Programme's Business Case, including continuous confirmation of its viability
- Set and review overall strategy and interfaces with other initiatives
- Authorise the start and continuation of the programme from the corporate perspective
- Commissioning assurance and audit reviews
- Chair Programme Board meetings

#### **6.2.2. EPR Programme Board – CCIO: Jim McDonald**

- Champion for the programme within the clinical body of the Trust
- Chairs the Clinical Design Authority group
- Ultimate representative to the programme from a user perspective across all functions
- Acts as Business Change Manager (BCM) for clinical function across the organisation (there will be other BCMs on the Programme Board representing other functions of the business, including nursing and administrative)
- Maintains the focus on realising beneficial change
- Owns the design for the future operating model for their function within the Trust
- Monitors relevant business risk, stability and ongoing capacity to cope with the level of change for their function
- Advising the programme manager whether the work of the programme and each constituent project covers the necessary aspects required to deliver the programme outcomes that lead to the defined benefits

#### **6.2.3. EPR Programme Board – EPR Programme Manager: TBC**

- Day to day management of the programme
- Planning and designing the programme and proactively monitoring the overall progress
- Coordination of all reporting projects and their interdependencies
- Manages the programme budget, monitoring costs against benefits
- Facilitates the creation of the future operating model with the CCIO and other BCMs
- Maximises the efficient allocation of resources and skills, including management of PMO resources allocated to the programme and child projects
- Oversight of governance across all reporting projects and may chair a number of child groups

#### **6.2.4. EPR Programme Assurance: TBC**

- Business Assurance on behalf of the Executive
- User Assurance
- Supplier Assurance carried out by spot-check/audit of technical material and Products supplied
- Review of Project Outputs via Quality Review
- Review of Programme Outcomes via Quality Review

### **6.3. Clinical Leadership**

The Trust has undertaken to appoint a Chief Clinical Information Officer as part of preparation for EPR and the surrounding change programme. In addition, it is recommended that the Trust appoint two clinical leaders, two nursing leaders, to provide direction and act as ambassadors with their colleagues. This will embed the programme with clinical staff, nurses, other healthcare professionals and administrative staff from the existing operations of the Trust.

#### 6.4. Resources

It is recognised that a programme of work of this size will require a considerable investment in people and technology to deliver the vision and benefits. The case acknowledges that there will be additional pressures placed on the ICT team, and where required, additional costs have been included for external / backfill support. Costs are based on previous business cases for similar programmes of work.

#### 6.5. Governance Procedures

Full details of programme and project controls will be set out in the relevant Programme / Project Initiation Documents available under separate cover.

A Programme Board review will be conducted when the Full Business Case is approved, and supplier contracts agreed. Documentation will be subject to at least one round of formal review. Lists of reviewers and approvers will be agreed with the programme manager. Product descriptions will accompany documents issued for review.

Each project will also be reviewed by the Programme Board at Project Closure.

Responsibility for all overarching governance will rest with the SRO. Overall responsibility for the successful delivery of outputs of each project will rest with the Executive member of each Project Board.

All formal documentation will be prepared using PRINCE2 standard templates. Documentation will be subject to at least one round of formal review. Lists of reviewers and approvers will be agreed with the project manager. Product descriptions will accompany documents issued for review.

Formal reporting lines within the project organisation structure are as follows:

- The project team will report to the assigned Project Manager
- The Project Manager will issue highlight and exception reports to the Programme Manager on behalf of the Project Executive
- The Programme Manager will report via highlight and exception to the EPR Programme Board with further escalation to the overall Sponsoring Group, the Management Board.

#### 6.6. Implementation Plan

The approach to the programme is based on the requirement to improve clinical and business process enabled by improved informatics and technology whilst minimising the risk and impact of the change to the business. This requirement will be achieved by the phased implementation of a single vendor EPR, the delivery of interfaces to those existing systems that are not replaced in a given phase and those deemed to be commercially or procedurally beneficial to operate alongside the main EPR system in the longer term.

The timescales for the complete programme are uncertain and are dependent on the chosen system. The detail of exact phasing and timescales will therefore be confirmed following the successful signing of contract with the supplier once the full business case has been approved.

#### 6.7. Training

The EPR training strategy and plans will be developed in the period between OBC and FBC alongside the procurement project. This will set out the principles for how the training will be determined,



managed and delivered. It will address the concerns raised and lessons learnt during the recent PAS implementation and ensure appropriate face to face training is provided.

The strategy and plan will provide an understanding of how training will be undertaken within the Programme. It will show links to Programme objectives and benefits delivery by meeting a set of Education and Training objectives, which are to:

- Increase organisations capability and capacity to deliver training required for the project
- Work collaboratively with training leads to ensure strategy and plans are delivered
- Develop new ways of working that will be adopted following effective training in new processes
- Improve staff knowledge and skills, measured by assessment and evaluation of training
- Encourage collaborative working to design appropriate and realistic training packages.
- The training strategy will be developed by the Trust and EPR supplier in partnership and refined as the detailed impact of the programme outcomes are elaborated.

## 6.8. Communications Strategy

### 6.8.1. Approach

The Communication Strategy outlines the approach of the EPR Programme Board will adopt to communicate and engage with the organisation and its stakeholders, supported by a reporting Engagement and Communications Group.

The communications plan will:

- Define the objectives and strategic approach for communications and stakeholder engagement
- Define the key messages to get across to stakeholders
- Identify stakeholder groups and define which key messages are appropriate to each specific group
- Identify appropriate channels of communication for each stakeholder group
- Define the means of monitoring feedback and evaluating the success of communications and stakeholder engagement over the life of the project
- Consideration is given to the communication and engagement needs over the life of the Project in order to achieve:
  - Increased awareness of the Project
  - Increased knowledge of and understanding about the Project
  - Engagement with the relevant stakeholders
  - The delivery of effective training

### 6.8.2. Audience

Audience	Information to Communicate
IT Project Board	Project plans, progress, exceptions and changes
Senior Management	Project plans, progress, exceptions
Project Team	Project activities, progress, exceptions and changes affecting the team
Other Project Teams	Updates on dependencies Project plans, progress, exceptions and changes affecting them



Audience	Information to Communicate
Stakeholders	Project background and brief (why the changes are being implemented) Project progress Project timelines Impact on working environments
Trust Clinical and Administrative Staff	Project background and brief (why the changes are being implemented) Key milestone dates affecting them Impact on their working environment
Supplier	Project plans, progress, exceptions and changes
Health Informatics Service (HIS)	Project plans, progress, exceptions and changes affecting HIS
Strategic Health Authority	Project plans and progress
Kent & Medway Local Health Community Board	Project plans and progress
Other NHS Trusts	Project background and brief (why the changes are being implemented) Project progress Project timelines affecting them Impact on their working environment

### 6.8.3. Frequency of Communication

The frequency of information communicated to the relevant parties will be dependent on the project stage and the needs of the target audience. Communication needs will be agreed with key stakeholders during the stakeholder analysis. Information will also be communicated when key milestones are achieved e.g. supplier & product selection, pre-go live and post-go live.

### 6.8.4. Methods of Communication

The following methods of communication may be used:

- Face to face, e.g. meetings
- Global Emails
- Trust Intranet (Project Section)
- Publications and Newsletters
- Posters and Leaflets
- Stands/Stalls

### 6.8.5. Communications Programme

For each project stage a detailed communications programme will be setup with activities and schedule of the communication necessary to all interested parties. A detailed communications plan can be found in appendix F.

### 6.9. Benefits Realisation Strategy

The introduction of new systems and ways of working, to support the electronic health record will create a significant number of benefits.

The programme is committed to achieving significant benefits from the proposed investment. The benefits will be obtained from:

- The introduction of a solution that will provide greater efficiency and reduced costs.
- Improved processes, working practices, information flows and communications both inside and outside the Trust.
- Efficiencies from making patient information available across the organisation.

It is recognised that an effective Benefits Management Strategy is vital for the success of this programme of work.

The main stages for the benefits management process are:

- Before implementation
  - Identify and quantify benefits;
  - Baseline what happens now;
  - Establish target position;
  - Identify assumptions, issues and risks.
- During/after implementation
  - Measure the expected benefits against the baseline;
  - Take action to rectify if benefit not achieved.

As part of this process, benefits have been categorised as quantifiable & cash releasing, quantifiable but not cash releasing (i.e. re-invested in quality) and qualitative. A full benefits realisation plan is detailed as an early deliverable of the programme board, along with any dependencies (both organisational and system) and who is responsible for each benefit's realisation. Benefits realisation will be conducted as an integral part of the programme and under leadership of its programme management structure.

The plan will be developed as the programme progresses and prior to contract award will indicate:

- Who is responsible from the Trust in ensuring that benefits realisation is managed;
- How each benefit will be monitored.

### 6.10. Change Management Strategy

The key stages for change management are shown below. They are not sequential but iterative:

- Create and share the vision;
- Plan the change;
- Understand the culture;
- Understand the environment;
- Involve people (address attitudes & change types);
- Implement change;
- Monitor;
- Review;
- Communication.

The introduction of this and other electronic processes to replace manual or non-integrated systems will represent a major change to the working practices of many staff at a local level. Therefore, Change Management is an integral component of this programme.

#### **6.10.1. Implementation of Change Management**

The following four stages have been identified and will be confirmed within the change management strategy. These will be developed by the programme manager in coordination with the proposed Engagement and Communication group where existing organisational development and training departments will be represented.

##### **Stage One - Preparing for Change**

- Communication with staff – a dedicated EPR newsletter will be distributed to all departments and users. A subset will be used within the hospital newsletter and shared with the Trust's other partners.

##### **Stage Two**

- Identify numbers of staff involved and how they will be affected.
- Map out existing, medium term and eventual working arrangements (i.e. rollout) in so far as this is possible.
- Continue the consultation process.
- Define future roles and structures for Radiology services and wider clinical / medical imaging management.
- Identify and ring-fence training resources.

##### **Stage Three**

- Train for future roles.
- Undertake the first implementation and document changes.

##### **Stage Four**

- Implement the EPR upgrade
- Continue the consultation process.
- Identify and ring-fence training resources.

#### **6.11. Arrangements for Post Programme and Project Evaluation**

The arrangements for a post implementation review (PIR) and a project evaluation review (PER) will be established by the EPR Programme Board in accordance with best practice and are recommended to incorporate the following:

##### **Post Implementation Review (PIR)**

There will be a Post Implementation Review (PIR) three months after each programme tranche in the deployment. At this point, there will be an objective assessment of the operating environments and the support arrangements. The review will assess operations against service level agreements. It will also be designed to:

- Ascertain the degree of success from the programme, and in particular the extent to which it met its objectives, delivered planned levels of benefit, avoided or dealt with risks and addressed the specific requirements as originally defined.
- Examine the efficacy of all elements of the working business solution to see if further improvements can be made to optimise the benefit delivered.

- Learn lessons from this programme and constituent projects, lessons which can be used to improve future programme phases, related project work and future changes within MTW.

#### **Programme Evaluation Review (PgER)**

This review appraises how well the programme was managed and whether or not it delivered to expectations. It is timed to take place twelve months following closure of the programme. This will build upon the PIRs but will focus on benefits realisation and tracking.

#### **Project Evaluation Reviews (PjER)**

This review appraises how well each project was managed and whether or not it delivered outputs to expectations. It is timed to take place three months following closure of each project.

### **6.12. Risk Management Strategy**

Risk and issues management is an on-going activity within the programme requiring significant interaction with the broader organisation. Principles for risk management within tolerance and escalation to the most appropriate body will need to be carefully applied and interoperate with those risk and issue management practices already in place within MTW. It is important to note that, while management of project and programme risk will be handled within the governance structures of the programme, any programme of the scale of the proposed EPR will inevitably have significant impact on the risk and issue registers, the risk improvement plans and risk response plans across the whole organisation.

A robust and structured risk management strategy will be developed as one of the early deliverables of the EPR Programme Board; the initial risks associated with the successful delivery of this programme will be assessed in detail and are incorporated within a Programme Risk Register. The risk management approach recommended builds upon best practice described within Management of Risk (MoR) as well as the HM Treasury Orange Book, and consists of:

MoR is a route map for risk management, bringing together principles, an approach, a set of interrelated processes, and pointers to more detailed sources of advice on risk management techniques and specialisms.

It also provides advice on how these principles, approach and processes should be embedded, reviewed and applied differently depending on the nature of the objectives at risk. An effective framework based on four core concepts:

- **MoR Principles** - these are essential for the development of good risk management practice. They are all derived from corporate governance principles in the recognition that risk management is a subset of an organization's internal controls.
- **MoR Approach** - the principles need to be adapted and adopted to suit each individual organization. Accordingly, a company's approach to the principles needs to be agreed and defined within a risk management policy, process guide and strategies, and supported by the use of risk registers and issue logs.
- **MoR Processes** - there are four main process steps, which describe the inputs, outputs and activities involved in ensuring that risks are identified, assessed and controlled. Embedding and reviewing MoR - having put in place the principles, approach and processes, an organization needs to ensure they are consistently applied and that their application undergoes continual improvement in order for them to be effective.

**6.13. Recommendation**

The outline business case has confirmed that there are sufficient benefits and savings to be made from procuring an EPR and associated services for MTW. The recommendation is:

- The Trust confirm their intention to invest in an EPR solution from a single supplier.
- The next stage of the EPR specification commences to finalise the required functionality.
- That the procurement phase commences (including contract preparation). This stage is anticipated to require an investment cost of £25k;
- The detailed benefit is developed, once the final configuration and systems are known to support the FBC;
- Prepare the FBC to present to the Trust Board for final approval, that shows the full costs and benefits, once the preferred supplier is identified;
- The decision is made on which enabling systems will be progressed

Signed:

Date:

**Senior Responsible Owner**

## Trust Board meeting - May 2018


**5-16 NHS Provider licence: Self-certification for 2017/18 Trust Secretary**

The Health and Social Care Act 2012 made changes to the way NHS service providers were regulated, and introduced a Licence for providers of NHS services. The NHS Provider Licence was subsequently introduced in February 2013 as the main tool with which providers of NHS services would be regulated. Foundation Trusts were licensed from April 2013, with other providers being licensed from April 2014. It was later confirmed that the Licence would *not* apply to NHS Trusts, but in April 2017, NHS Improvement (NHSI) confirmed that NHS Trusts must undertake a self-certification against the NHS Provider Licence, on the basis that, despite their exemption from needing to hold the Licence, directions from the Secretary of State required NHSI to ensure that NHS Trusts comply with conditions equivalent to the Licence, as it deemed appropriate. As NHSI's Single Oversight Framework bases its oversight on the Licence, NHS Trusts are legally subject to the equivalent of certain Provider Licence conditions, and must self-certify under these licence provisions.

NHS Trusts were required to undertake self-certification for the first time in May 2017 (covering 2016/17), and are now required to self-certify for 2017/18. Specifically, NHS Trusts are asked to self-certify that they have:

- Taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Licence Condition G6(3))
- Complied with required governance arrangements (Licence Condition FT4(8))

The aim of self-certification is for providers give assurance that they are compliant with the conditions. It is up to providers how they do this. Any process should ensure that the provider's Board understands clearly whether or not the provider can confirm compliance. NHSI provide templates for Boards which Boards can use if they wish.

The Trust Board must sign off on self-certification no later than 31<sup>st</sup> May 2018 (for condition G6) and 30<sup>th</sup> June 2018 (for condition FT4). Providers must then publish their G6 self-certification within 1 month following the deadline for sign-off. NHS Trusts are not required to submit their self-certification declarations to NHSI. Instead, from July 2018 NHSI will contact a select number of NHS Trusts (and Foundation Trusts) to ask for evidence that they have self-certified. This can either be through providing the completed templates if they have used them, or relevant Board minutes and reports recording sign-off.

The proposed self-certification, which uses the template provided by NHSI, is enclosed. The Trust Board is asked to review, and approve, the content. Trust Board Members will be aware that the Board has also received the Annual Report for 2017/18 (under a separate agenda item), which contains the Annual Governance Statement. The Annual Report and Annual Governance Statement is considered to provide sufficient information and supporting evidence to enable the Board to self-certify that the Trust has been compliant with the relevant Licence conditions. Therefore, rather than provide a brief response to each of the requirements within the template (which would force brevity) Trust Board Members are encouraged to refer to the full Annual Report and Governance Statement for a more comprehensive overview of (and evidence for) compliance. The same approach to self-certification was taken in May 2017, and the Trust Board duly approved the proposed self-certification, which was then [published on the Trust's website](#).

**Which Committees have reviewed the information prior to Board submission?**

- N/A

**Reason for receipt at the Board (decision, discussion, information, assurance etc.) <sup>1</sup>**

Review and approval of the proposed self-certification

<sup>1</sup> All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

## Worksheet "FT4 declaration"

## Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

1	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	Refer to the content of the 2017/18 Annual Report (incl. the Annual Gov. Statement) for full details (item 5-20/Attachment 17 at the Board on 24/05/18)
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	Refer to the content of the 2017/18 Annual Report (incl. the Annual Gov. Statement) for full details (item 5-20/Attachment 17 at the Board on 24/05/18)
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	Refer to the content of the 2017/18 Annual Report (incl. the Annual Gov. Statement) for full details (item 5-20/Attachment 17 at the Board on 24/05/18)
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	Refer to the content of the 2017/18 Annual Report (incl. the Annual Gov. Statement) for full details (item 5-20/Attachment 17 at the Board on 24/05/18)
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	Refer to the content of the 2017/18 Annual Report (incl. the Annual Gov. Statement) for full details (item 5-20/Attachment 17 at the Board on 24/05/18)
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	Refer to the content of the 2017/18 Annual Report (incl. the Annual Gov. Statement) for full details (item 5-20/Attachment 17 at the Board on 24/05/18)

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature

Signature

Name Miles Scott, Chief Executive

Name

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A N/A

## Worksheet "G6 &amp; CoS7"

# Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

*The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.*

## 1 & 2 General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)

- 1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

Confirmed OK

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature

Signature

Name: Miles Scott

Name:

Capacity: Chief Executive

Capacity:

Date: 24 May 2018

Date:

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

A



## Trust Board meeting – May 2018

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**5-17    Audit and Governance Committee, 02/05/18 & 24/05/18 (incl.    Committee Chair (Non-  
 Audit & Governance Committee Annual Report for 2017/18)    Executive Director)**


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The Audit and Governance Committee met on 2<sup>nd</sup> May 2018, and is scheduled to meet immediately before the Trust Board, on 24<sup>th</sup> May (to review the draft final Annual Report and Accounts for 2017/18). This written report covers the meeting held on 2<sup>nd</sup> May, whilst the outcome of the meeting on 24<sup>th</sup> May will be reported verbally to the Trust Board.

**1. The key matters considered at the meeting on 2<sup>nd</sup> May were as follows:**

- The actions from previous meetings were reviewed, which included notification of the intention that the revised “Managing Conflicts of Interests Policy and Procedure (incorporating the treatment of Gifts, Hospitality and Sponsorship)” would propose to prohibit the acceptance of any bequests by staff from patients (although it was noted this would take time to come into force, as the policy needs to be revised, circulated for consultation, approved and ratified)
- Under the Safety Moment, the Trust Secretary reported that May’s theme was Dementia and highlighted the key areas of focus for the month
- The Trust Secretary presented the year-end review of the 2017/18 Board Assurance Framework (this was the same report considered at the Trust Board in April 2018)
- The Internal Audit Annual Report for 2017/18 (including the draft Head of Internal Audit Opinion) was received, along with an update on progress with actions from previous Internal Audit reviews
- Internal Audit also gave their response to the findings of the review/survey of Internal Audit service that had been considered by the Committee in February 2018
- The Counter Fraud Specialist Manager presented the Counter Fraud Annual Report for 2017/18, as well as their usual routine update
- The External Auditors (Grant Thornton LLP) presented their usual ‘progress and emerging issues report’, which included the management responses relating to the understanding of how the Audit and Governance Committee gains assurance from management (which is requested each year as part of the External Audit of the Accounts)
- The Committee viewed Grant Thornton’s Annual Report Benchmarking report, which compared the Trust’s 2016/17 Annual Report with that of other Grant Thornton clients. The Committee acknowledged the Trust’s “rating for the Annual Report overall” being within the “You are ahead on:” category, but asked that the Audit Manager identify the Trusts that were rated favourably on the “degree of development of integrated care governance arrangements in area” aspect.
- The External Auditors also gave their response to the findings of the review/survey of External Audit service that had been considered by the Committee in February 2018
- The draft Trust Annual Report for 2017/18 (incl. the Annual Governance Statement) and Annual Accounts for 2017/18 were reviewed, noting that the final versions would be reviewed at the Committee meeting on 24<sup>th</sup> May 2018
- The Audit and Governance Committee Annual Report for 2017/18 was reviewed, and approved, subject to the Trust Secretary liaising with Internal Audit to obtain the latest status update for the “E-Rostering” and “Radiology Processes” Internal Audit reviews, and ensuring that status was reflected in the Committee Annual Report for 2017/18 prior to submission to the Trust Board meeting on 24<sup>th</sup> May. The Committee’s Annual Report has been enclosed in full in Appendix 1, as this forms part of the assurances the Board receives when considering the approval of the Trust Annual Report and Accounts. The Trust Secretary has since confirmed that the status reported in Appendix 1 reflects the latest position (but will give a verbal update at the Board meeting on 24<sup>th</sup> May if there has been any subsequent change).
- The latest single tender waivers data was reviewed, as was the latest details of gifts, hospitality and sponsorship declarations
- The Committee reviewed the first report of payments for compensation under legal obligation (this had been requested by the Audit and Governance Committee in February)

- The Trust Secretary explained the process for the meeting on 24<sup>th</sup> May, in that this would be held immediately before the Trust Board meeting on the same day, and the Committee would be asked to review the final Annual Report and Accounts, and consider recommending that the Trust Board approve both. It was noted that the timing of the Audit and Governance Committee meeting involved some degree of assumption that the Committee would be able to make such a recommendation, but also confirmed that the Committee could decide not to make the desired recommendation if it considered it was unable to do so. The process was acknowledged, and it was noted that a similar model was commonplace among other NHS organisations.

**2. The Committee received details of the following Internal Audit reviews:**

- Non Patient Related Income (which received a “Limited Assurance” conclusion)
- Allscripts PAS Implementation Lessons Learned Review (which received a “Reasonable Assurance” conclusion)
- Information Governance Toolkit Part 2 (which received a “Substantial Assurance” conclusion)
- Active Directory Follow Up (which received a “Limited Assurance” conclusion)
- Cyber Security (which received a “Limited Assurance” conclusion)

**3. The Committee was also notified of the following “Urgent” priority outstanding actions from Internal Audit reviews:**

- Health Records (1 outstanding action)
- Non Patient Related Income (2 outstanding actions, though these had been implemented subject to Internal Audit review)

**4. The Committee agreed that (in addition to any actions noted above):**

- The Trust Secretary should arrange for a formal letter of thanks to be sent from the Chair of the Audit and Governance Committee to the Finance team regarding the Annual Accounts for 2017/18 (after the Board had approved the Accounts)

**5. The issues that need to be drawn to the attention of the Board are as follows:**

- The Audit and Governance Committee Annual Report for 2017/18 is enclosed in Appendix 1
- The Committee will meet on 24<sup>th</sup> May, before the Trust Board, to review the final Annual Report and Accounts, and consider the findings from the External Audit. A verbal update on the outcome will be reported to the Trust Board on 24<sup>th</sup> May

**Which Committees have reviewed the information prior to Board submission?**

- N/A

**Reason for receipt at the Board (decision, discussion, information, assurance etc.) <sup>1</sup>**

Information and assurance

<sup>1</sup> All information received by the Board should pass at least one of the tests from ‘The Intelligent Board’ & ‘Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients’: the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors’ understanding of the Trust & its performance

**Appendix 1: Audit and Governance Committee Annual Report, 2017/18****AUDIT AND GOVERNANCE COMMITTEE – 2<sup>ND</sup> MAY 2018**

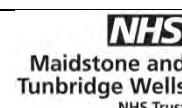
5-17	<b>APPROVAL OF THE AUDIT AND GOVERNANCE COMMITTEE ANNUAL REPORT 2017/18</b>	<b>CHAIR / TRUST SECRETARY</b>
	<ul style="list-style-type: none"> <li>▪ The NHS Executive published an Audit Committee Handbook in 1995. The Department of Health (DH) then published revised versions in 2001 and 2005. The Healthcare Financial Management Association (HFMA) published further revisions in 2011 and 2014.</li> <li>▪ The 1995 and 2001 versions of the Handbook regarded the production of an Annual Report of the activities of NHS Audit Committees as best practice. The 2005 version made this into a requirement, and set out the minimum content for such an Annual Report.</li> <li>▪ The 2014 version emphasises this requirement (“...the Audit Committee should prepare a report to the full Governing Body that sets out how the committee has discharged its responsibilities and met its terms of reference), and stated that the Report should summarise the committee’s work during the year and (as a minimum), confirm that::             <ul style="list-style-type: none"> <li>○ “The organisation’s system of risk management is adequate in identifying risks and allowing the governing body to understand the appropriate management of those risks”</li> <li>○ “The committee has reviewed and used the assurance framework and believes that it is fit for purpose and that the ‘comprehensiveness’ of the assurances and the reliability and integrity of the sources of assurance are sufficient to support the governing body’s decisions and declarations”</li> <li>○ There are no outstanding areas of significant duplication or omission in the organisation’s systems of governance that have come to the committee’s attention.</li> </ul> </li> <li>▪ The Handbook states that the Report should also highlight the main areas that the Committee has reviewed and any particular concerns or issues that it has addressed. These could include:             <ul style="list-style-type: none"> <li>○ “The reliability and quality of the organisation’s financial reporting systems that ‘sit’ behind the financial position reported to the governing body”</li> <li>○ “Any significant issues that the committee has considered in relation to the financial statements”</li> <li>○ “Any major break-down in internal control that has led to a significant loss in one form or another”</li> <li>○ Any major weakness in the governance systems that has exposed, or continues to expose, the organisation to an unacceptable risk”</li> <li>○ “The reliability and quality of clinical information systems and clinical auditing processes and the extent to which the governing body can take assurance from these”</li> <li>○ “An assessment of the performance of the external auditor”; and “</li> <li>○ The value of any non-audit services provided by the external auditors”</li> <li>○ “Any major weakness in the governance systems that has exposed, or continues to expose,</li> </ul> </li> <li>▪ The Handbook expects the Report to be presented to the Board promptly after the financial year-end and before it considers the main Trust Annual Report and statutory declarations. As a result, the Committee’s Annual Report should make a general reference to the Committee’s role in these matters</li> </ul>	

- The Handbook also lists the following as best practice for Audit Committee Annual Reports:
  - The report should not be long (3 or 4 pages should be sufficient)
  - The Committee Chair should take overall responsibility for the report's preparation and share drafts of the report with committee members
  - The final draft report should be shared with the Internal and External Auditors, to ensure that it is consistent with their understanding, and with any other regular attendees to the Committee, such as the Director of Finance. However, the report must be owned by the Committee itself.
- The draft Annual Report from the Audit and Governance Committee for 2017/18 is therefore enclosed, for approval. The draft covers the minimum content outlined above.
- Once approved, the Report will be submitted to the Trust Board meeting scheduled for 24<sup>th</sup> May, at which the Board will be asked to approve the Trust's Annual Report and Accounts for 2017/18

#### Reason for receipt at the Audit and Governance Committee

Review, comment and approval

## Audit and Governance Committee Annual Report 2017/18



### 1. Introduction

This report summarises the key work areas of the Audit and Governance Committee during the period from April 2017 to March 2018. The report supports the primary role of the Committee in ensuring the adequacy and effective operation of the organisation's overall internal control system. The format of the report is informed by the guidance contained within the NHS Audit Committee Handbook (2014), and highlights work and outcomes in the following areas: Meetings and administration; Governance, Risk Management and Internal Control; Internal Audit; External Audit, Audit and Governance Committee assessment; Auditor Panel; Adding value/'making a difference'; and Audit and Governance Committee statement/declaration.

### 2. Meetings and administration

During 2017/18, the Audit and Governance Committee met 5 times, on: 04/05/17, 24/05/17 (to recommend the approval of the Annual Accounts for 2016/17), 27/09/17, 21/11/17 and 26/02/18. The Committee was not required to meet as the Trust's 'Auditor Panel'<sup>2</sup> during 2017/18.

All of the Trust's Non-Executive Directors (apart from the Chair of the Trust Board) are members of the Committee. The membership of the Committee during 2017/18 was as follows:

- Kevin Tallett, Non-Executive Director (Chair, until he left the Trust Board on 27/07/17)
- Alex King, Non-Executive Director (Chair, from 28/07/17)
- Sarah Dunnett, Non-Executive Director
- Maureen Choong, Non-Executive Director (from 16/11/17)
- Tim Livett, Non-Executive Director (from 26/06/17)
- Steve Phoenix, Non-Executive Director (from 01/12/17)

Attendance at each Audit and Governance Committee meeting in 2017/18 is shown below:

<sup>2</sup> The Trust Board has appointed the Audit and Governance Committee as the Trust's Auditor Panel in accordance with Schedule 4, Paragraph 1 of the Local Audit and Accountability Act 2014.

Member	Meetings in 2017/18				
	04/05/17	24/05/17	27/09/17	21/11/17	26/02/18
Kevin Tallett, Non-Executive Director (Chair until 27/07/17) <sup>3</sup>	✓	✓			
Sarah Dunnett, Non-Executive Director	Apologies	✓	✓	✓	✓
Alex King, Non-Executive Director (Chair from 28/07/17)	✓	✓	✓	✓	Apologies <sup>4</sup>
Maureen Choong, Non-Executive Director <sup>5</sup>				Apologies	✓
Tim Livett, Non-Executive Director <sup>6</sup>			Apologies	✓	Apologies
Steve Phoenix <sup>7</sup> , Non-Executive Director					✓

The Committee's Terms of Reference were reviewed and agreed at the Committee meeting on 21/11/17, and approved by the Trust Board on 29/11/17. The Terms of Reference will next be reviewed at the November 2018 Audit and Governance Committee meeting (and then be submitted for approval to the Trust Board in the same month).

The Terms of Reference deliberately do not incorporate clinical audit processes, as this is left to the oversight of the Quality Committee and Trust Clinical Governance Committee.

### 3. Governance, Risk Management and Internal Control

#### a. Board Assurance Framework (BAF) and Risk management

The BAF is the document through which the Trust Board is apprised of the principal risks to the Trust meeting its objectives, and to the controls in place to manage those risks. The 2017/18 BAF was reviewed at the Committee meetings on 27/09/17, 21/11/17 and 26/02/18, whilst a year-end review report for the 2016/17 objectives was received at the meeting on 04/05/17. The Committee also received the Trust's full Risk Register on 27/09/17, 21/11/17 and 26/02/18. The annual Internal Audit review of "Assurance Framework and Risk Management", undertaken at the end of 2017/18, resulted in a "reasonable assurance" conclusion, noting that "It was confirmed that there is an effective committee structure in place and that the BAF and Risk Management processes had been subject to regular review by the Trust Board and Audit and Governance Committee.". The small number of recommendations made (and accepted) will be implemented during 2018/19.

#### b. Counter fraud

The Committee has reviewed activity relating to counter fraud measures in 2017/18, via reports from the Local Counter Fraud Specialist (LCFS). The 2017/18 Counter Fraud Work Plan was approved at the meeting held on 04/05/17, whilst the Annual Report of Counter Fraud Activity for 2016/17 was received at the same meeting.

#### c. Relationship with the Trust Board

<sup>3</sup> Kevin Tallett resigned from the Trust Board (and therefore all Board sub-committees) on 27/07/17

<sup>4</sup> Steve Phoenix (Vice Chair) chaired the meeting

<sup>5</sup> Maureen Choong was appointed a Non-Executive Director (substantive) on 16/11/17

<sup>6</sup> Tim Livett joined the Trust Board on 26/06/17

<sup>7</sup> Steve Phoenix joined the Trust Board on 01/12/17

The reporting from the Committee to the Trust Board takes place via a written summary report of each meeting, presented by the Committee Chair. The report is based on a template, and covers the key matters considered at the meeting; details of the Internal Audit reviews that were discussed; any “high” priority outstanding actions from Internal Audit reviews; the actions agreed at the Committee; and any issues that need to be drawn to the attention of the Board.

**d. Head of Internal Audit Opinion (HoIA)**

The Head of Internal Audit Opinion for 2017/18 states that “I am satisfied that sufficient internal audit work has been undertaken to allow me to draw a reasonable conclusion as to the adequacy and effectiveness of Maidstone and Tunbridge Wells NHS Trust's risk management, control and governance processes. In my opinion, except for the Trust's ability to deliver their planned financial control total, Maidstone and Tunbridge Wells NHS Trust has adequate and effective management, control and governance processes to manage the achievement of its objectives”.

**e. Governance Statement**

The Governance Statement for 2017/18 was reviewed at the Audit and Governance Committee on 02/05/18, as part of the draft Annual Report and Accounts for 2017/18.

Based on this, the detailed work of the Audit and Governance Committee summarised above, and its Internal and External Auditor work programme, the Governance Statement is consistent with the view of the Audit and Governance Committee on the Trust's system of Internal Control, and the Committee supports the Trust Board's approval of the Statement, which is scheduled to take place on 24/05/18.

**4. Internal Audit**

The 2017/18 Internal Audit plan was agreed by the Audit and Governance Committee at its meeting on 02/02/17. The output from the plan is listed below.

System	Assurance Level			
	Substantial	Reasonable	Limited	No
Data Quality of KPIs (carried forward from 2016/17)		✓		
Follow Up Review of Pharmacy		✓		
Follow Up Review of Audiology Stock Management		✓		
Critical Financial Assurance – Payroll		✓		
A&E Data Capture and Recording		✓		
Discharge Processes including Delayed Transfers of Care			✓	
Critical Financial Assurance – Financial Accounting and Non Pay Expenditure		✓		
Cost Improvement Plans		✓		
Non Patient Related Income			✓	
All Scripts PAS Implementation Lessons Learned Review		✓		
Information Governance Toolkit Part 1	N/A - Assurance level allocated following completion of Part 2 (see below)			
Information Governance Toolkit Part 2	✓			
Data Quality of KPIs (Draft Report)		✓		

System	Assurance Level			
	Substantial	Reasonable	Limited	No
Activity and Income Recording including Implementation of SLAM Costing Model (Draft Report)			✓	
Cyber Security			✓	
Follow Up of Microsoft Active Directory			✓	
A&E Temporary Staff (Draft Report)			✓	
Assurance Framework and Risk Management Processes		✓		
Aligned Incentives Contract (Draft Report)	An assurance level was not allocated as this was an advisory review			
E-Rostering	Draft report being produced			
Radiology Processes	Fieldwork is still in progress			

In 2017/18, the Committee undertook a formal assessment of the performance of the Trust's Internal Auditors, and a report of the findings was considered at the Committee meeting held on 26/02/18. A response to the review/survey will be considered at the meeting on 02/05/18.

The Committee reviews the reliability and quality of clinical information systems via the Internal Audit process. In particular, as can be seen from the above table, the reviews of "A&E Data Capture and Recording" and "Data Quality of Key Performance Indicators" both resulted in a "Reasonable assurance" conclusion.

## 5. External Audit

On 27/09/17, the Committee received the Annual Audit Letter for 2016/17. The key issues reported were as follows:

- An unqualified opinion on the Trust's financial statements was given on 31/05/17
- The Auditors were satisfied that the Trust put in place proper arrangements to ensure economy, efficiency and effectiveness in its use of resources except for its arrangements to plan finances effectively to support the sustainable delivery of strategic priorities. The reasons for this 'except for' reporting were:
  - "You have a cumulative reported deficit of £47.48 million as at 31 March 2017. This increased from last year's cumulative deficit by £10.9 million, the 2016/17 reported outturn. Trusts are expected to plan to break even over a rolling three year cycle, achieving this within the political and operational environment in which they have to operate;
  - You have agreed a deficit plan of £4.5 million (prior to any Sustainability and Transformation Funding) for 2017/18, which will require in addition to strong budgetary control, the delivery of £31.7 million CIPs. You achieved 76% of your £32.1 million cost improvement programme in 2016/17. You have continued to improve your systems to support CIP delivery, but the CIP requirement for 2017/18 is challenging. At the start of the financial year you have identified £18.9m risk adjusted CIPs;
  - Your future financial plans anticipate returning to in year break even in 2018/19 and cumulative breakeven by 2020/21.
  - You have been placed in a 'Financial Special Measures' regime by your regulator".
- We therefore qualified our value for money conclusion in our report on the financial statements on 31 May 2017"
- The consolidation schedules submitted to the Department of Health with the audited financial statements were concluded to be consistent
- The Auditors referred a matter to the Secretary of State, as required by section 30 of the Local Audit and Accountability Act 2014, on 17/05/17 to highlight that the

breach of the Trust's statutory duty to achieve a breakeven position over a rolling three year period

- The Auditors certified that they completed the audit of the accounts of the Trust in accordance with the requirements of the Code of Audit Practice
- The Auditors completed a review of the Trust's Quality Accounts and issued their report on 29/06/17. They concluded the Quality Accounts and the indicators they reviewed were prepared in line with the Regulations and guidance

The 'overall value for money conclusion' within the Letter was that "We are satisfied that, in all significant respects, except for the matter of the Trust's financial position, the Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2017."

The External Audit plan and fee for 2017/18 was approved by the Committee on 26/02/18.

In 2017/18, the Committee undertook a formal assessment of the performance of the Trust's External Auditors, and a report of the findings was considered at the Committee meeting held on 26/02/18. A response to the review/survey will be considered at the meeting on 02/05/18.

## **6. Audit and Governance Committee assessment**

At the Audit and Governance Committee meeting on 02/11/17, the Committee reconfirmed the process for the Committee's self-evaluation which, as in 2016, would consist of:

1. Initial assessment, through the completion of a checklist of fact-based questions by the Trust Secretary and
2. Individual, evaluative feedback through completion of a self-assessment form by Committee members and routine attendees

Both forms were based on examples provided within the NHS Audit Committee Handbook 2014 and were closely linked to the Committee's Terms of Reference.

A report of the findings of the evaluation was duly considered at the Committee meeting on 26/02/18, and it was agreed that the Trust Secretary should liaise with the Chair of the Trust Board to incorporate a review of the Committee evaluation findings into a wider review of sub-committee evaluations as part of a Trust Board Seminar (prior to summer 2018).

## **7. Audit and Governance Committee statement / declaration**

The Audit and Governance Committee can confirm that:

- The Trust's Governance Statement for 2017/18 is consistent with the view of the Audit and Governance Committee on the Trust's system of internal control, and the Committee supports the Trust Board's approval of the Statement
- The Committee has reviewed and used the Board Assurance Framework and believes that it is fit for purpose and that the 'comprehensiveness' of the assurances and the reliability and integrity of the sources of assurance are sufficient to support the Trust Board's decisions and declarations
- The system of risk management in the Trust is adequate in identifying risks and allowing the Trust Board to understand the appropriate management of those risks
- There are no areas of significant duplication or omission in the systems of governance in the Trust that have come to the Committee's attention and not been adequately resolved



- There has been no major breakdown in internal control that has led to a significant loss in one form or another for 2017/18; and that
- There have been no major weakness in the governance systems that has exposed, or continues to expose, the Trust to an unacceptable risk

Steve Phoenix,  
Chair, Audit and Governance Committee  
Maidstone and Tunbridge Wells NHS Trust  
May 2018

DRAFT

## Trust Board Meeting – May 2018

5-18	Summary report from the Trust Management Executive (TME), 16/05/18	Committee Chair (Chief Operating Officer)
	<p>The TME met on 16<sup>th</sup> May.</p> <p><b>1. The key matters considered at the meeting were as follows:</b></p> <ul style="list-style-type: none"> <li>▪ In the Safety Moment, the Medical Director highlighted the theme for the month (Dementia)</li> <li>▪ The revised “Management of External Agency Visits, Inspections and Accreditations Policy and Procedure” was approved (which would now be submitted to the Policy Ratification Committee for ratification)</li> <li>▪ The Interim Director of Health Informatics and Chief Clinical Information Officer (CCIO) presented a Business Case for an Electronic Patient Record (EPR). The case was supported, but it was noted that the costs had not been included in the 2018/19 plan that had just been submitted to NHS Improvement, and although there was potential that external funding could be secured, this would result in a further cost pressure if not received</li> <li>▪ The Interim Director of Health Informatics also reported on the development of a revised IT Strategy, noting that the revised Strategy was intended to be submitted to the July TME</li> <li>▪ The CCIO gave an update on other IT issues, including the outcome from the first meeting of the Clinical Advisory Group</li> <li>▪ The Director of Medical Education (DME) gave a presentation on Human Factors, and the TME supported the proposal that Human Factors training become mandatory. It was agreed that the Director of Workforce should arrange for the Head of Learning &amp; Development to liaise with the DME to enact this decision</li> <li>▪ The Head of Strategy attended to give an update on Strategic Clinical Service Plans</li> <li>▪ The Director of Workforce presented a recruitment plan for 2018/19 (this had been requested at the previous TME meeting), and it was agreed that they should ensure that a corporate approach was taken in response to the reported problems in recruiting substantive Medical staff (including the arrangements for external advertising)</li> <li>▪ The Associate Director of Nursing for Planned Care presented the Falls action plan</li> <li>▪ The Director of Operations, Planned Care gave an update the Implementation of the e-Referral Service and Paper Switch Off in Kent, Surrey &amp; Sussex. It was agreed to schedule the receipt of regular updates on the subject at future TME meetings</li> <li>▪ The key aspects of the month 1, 2018/19 Integrated performance (including infection control) were reported. The 2018/19 performance trajectories for the Cancer, A&amp;E 4-hour and Referral to Treatment waiting time targets were also noted</li> <li>▪ The interim arrangements for the Planned Care management team were reported (which related to the impending 6-month secondment of the Division’s Director of Operations)</li> <li>▪ The 3 clinical Divisions reported on their current key issues, which included the continued challenges in recruitment substantive staff</li> <li>▪ The DME and Clinical Lead for Research presented their respective latest updates. Updates were also received on the national 7 day service programme, the key issues from the Clinical Directors’ Committee and the key issues from Executive Team Meetings</li> <li>▪ A recent letter from the Care Quality Commission on winter pressures in Emergency Departments was noted, as were the recently-approved Business Cases</li> </ul>	
	<p><b>2. In addition to any agreements referred to above, the Committee agreed that:</b> N/A</p>	
	<p><b>3. The issues that need to be drawn to the attention of the Board are as follows:</b></p> <ul style="list-style-type: none"> <li>▪ The Business Case for an EPR was supported</li> </ul>	
	<p><b>Which Committees have reviewed the information prior to Board submission?</b></p> <ul style="list-style-type: none"> <li>▪ N/A</li> </ul>	
	<p><b>Reason for receipt at the Board (decision, discussion, information, assurance etc.)</b></p> <p>Information and assurance</p>	

5-19	Finance and Performance Committee, 22/05/18 (quarterly progress update on Procurement Transformation Plan)	Chair of Finance Committee
	<p>The Procurement Transformation Plan (PTP) was approved by the Trust Board on 19th October 2016 and then submitted to NHS Improvement (NHSI) by 31st October, which was the deadline for Board-approved submissions.</p> <p>It was a requirement that every Trust should have a PTP. The PTP is a document which outlines the procurement function within the trust and the key actions and activity within the trust to deliver the Lord Carter targets set within the document.</p> <p>Each PTP must have an action plan at the end of the report and it is the expectation that PTPs are agreed, and signed off, by the Trust Board. NHSI would then publish a review template in the autumn for the PTP and this would need to be reviewed by the Trust Board on a quarterly basis. The template was published in January 2017 with a view that reporting would commence from February and a dashboard would be published in April with data from January, February and March 2017 that would track and benchmark the Trust's progress.</p> <p>Quarterly reports are submitted to the Finance and Performance Committee, and then onwards to the Trust Board.</p>	
	<p><b>Which Committees have reviewed the information prior to Board submission?</b></p> <ul style="list-style-type: none"> <li>Finance and Performance Committee (22/05/18)</li> </ul>	
	<p><b>Reason for submission to the Board (decision, discussion, information, assurance etc.)</b> <sup>1</sup></p> <p>Review</p>	

<sup>1</sup> All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

5-17

**QUARTERLY PROGRESS UPDATE ON PROCUREMENT  
TRANSFORMATION PLAN****DIRECTOR OF  
FINANCE**

The Procurement Transformation Plan (PTP) was originally approved by the Trust Board on the 19<sup>th</sup> October 2016 and then submitted to NHSI by the 31<sup>st</sup> October, which was the deadline for Board approved submissions.

It was a requirement that every trust should have a Procurement Transformation Plan. The PTP is a document which outlines the procurement function within the trust and the key actions and activity within the trust to deliver the Lord Carter targets set within the document.

Each PTP must have an action plan at the end of the report and it is the expectation that PTPs are agreed, and signed off, by the Trust Board.

This report is the quarterly update to the Finance Committee about progress against the PTP. This report highlights the revised Carter model hospital metrics following the new guidance issued in January 2018.

**Reason for receipt at the Finance and Performance Committee**

For review

## 1. INTRODUCTION

- 1.1 The Procurement Transformation Plan (PTP) was originally approved by the Trust Board on the 19<sup>th</sup> October 2016. A refreshed PTP has been submitted to NHSI on 11 May in line with the latest requirements.
- 1.2 The PTP guidance from NHSI states that “Trusts will be asked to provide regular progress updates on their PTPs to their Trust’s board and NHS Improvement. These will take place quarterly.”
- 1.3 In January 2018, NHSI issued new amended procurement model hospital metrics. The metrics are included within the report but with the understanding that new or amended metrics are expected over the year. The model hospital has been updated with some of the new procurement metrics.

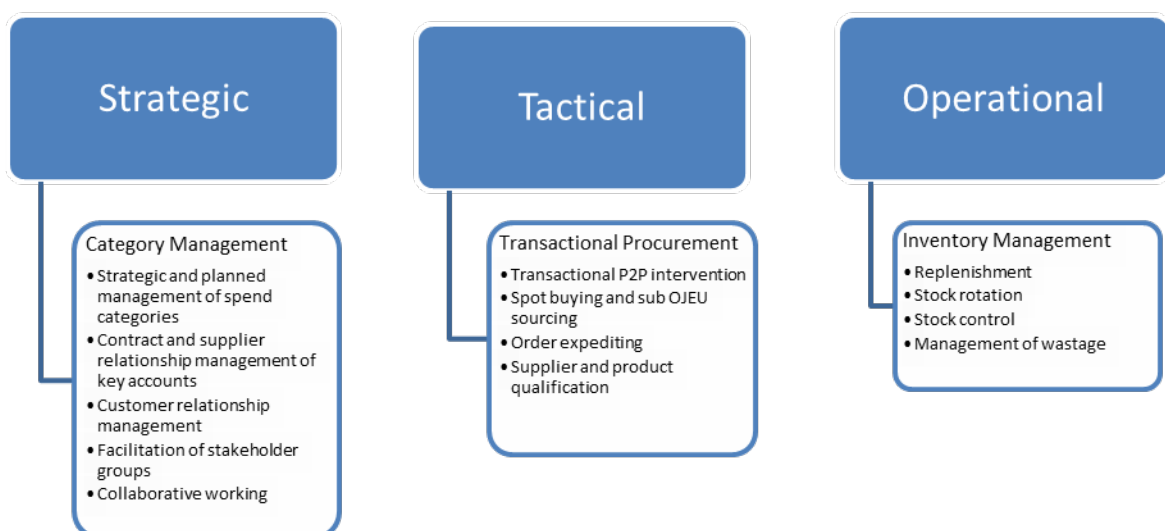
## 2. DETAIL AND BACKGROUND

### Background

- 2.1 The original Procurement Transformation Plan was approved by the Trust Board and submitted to NHSI in 2016. Further updates have been provided on a quarterly basis. The report is the updated PTP plan that was submitted to NHSI in May.

## 3. SUMMARY

- 3.1 Maidstone and Tunbridge Wells NHS Trust procurement team has been through a three year transformation programme. This programme was implemented as the Trust recognised the importance of the procurement function and the need to invest in this area. The business case for the transformation identified savings of £5million to be delivered in 3 years. The team delivered over £5million in the first two years thereby indicating the success of the transformation programme. The procurement team is now an integral part of every divisional CIP programme and is in attendance at all CIP meetings as well as any new initiatives to ensure procurement are part of the planning to take forward new activity.
- 3.2 Maidstone and Tunbridge Wells NHS Trust (MTW) procurement team covers three key areas of procurement.



## **Strategic**

- 3.3 Strategic procurement is a category management procurement function. The team covers all non-pay expenditure except for Pharmacy.

This team is focused on internal stakeholder relationship management; ensuring active and positive engagement throughout the procurement cycle all the way through to contract management stage. The team also covers external supplier management through the splitting of spend into discrete portfolios of categories. This allows a specialist focus on categories to focus on value and total cost of ownership rather than exclusively price down savings initiatives.

## **Tactical**

- 3.4 This is the more recognisable “purchasing” function managing purchase transactions with suppliers, unplanned sourcing activity and sub-OJEU or “tail” spend not managed through the strategic category management function. The team is also focused on catalogue management to ensure compliance with the Trust policy of No PO No Pay.

## **Operational**

- 3.5 This function is more recognisable as the inventory management function responsible for the replenishment and distribution of goods throughout the organisation. This team are responsible for the Trust Omnicell inventory management system. They link with supplier change to identify product switches which support the Trust position on quality cost effective products.

## **4. NEXT STEPS**

- 4.1 **Strategic** – The Trust 2018/19 CIP target is £4.2million. The team have identified the areas where these savings can be delivered by the end of March 2019, including £1.7million of roll-over savings that commenced in 2017/18. There is also a Kent & Medway STP work programme under the Productivity work-stream. A full procurement work programme is monitored by the MTW Best Use of Resources Board, chaired by the Finance Director, on a monthly basis.
- 4.2 **Tactical** – The team have implemented a full P2P system integrated with the finance system Integra2. This provides a full pathway from orders placed on the system, to the receipting of goods and payment of the goods. This supports the work within the Trust on electronic purchase orders and catalogue management within the Trust and is working with finance to establish e-invoicing where possible.
- 4.3 **Operational** – The Trust has implemented an inventory management system, Omnicell within the high cost product areas such as Cardiology cath labs, elective theatres, Ophthalmology and short stay theatres. None of the wards currently have Omnicell deployed, however further areas are being explored for its use including a solution with pharmacy for drug packs to be kept on wards to aid quicker discharge from the wards.
- 4.4 The Omnicell system has enabled the Trust to monitor stock levels and identify the maximum and minimum stock levels to be held in each area. It also allows tracking of stock issued to patient level. The team have conducted visits to other Trusts to review stock management processes to gather best practice and implement internally.

## 5. TRUST PROCUREMENT PERFORMANCE (RAG rating against updated Carter targets)

MEASURES		PERFORMANCE		COMMENTARY (INCLUDING WHAT HAS BEEN IMPLEMENTED SINCE SUBMISSION OF ORIGINAL PTP AND CONSIDERATION AS TO WHAT SUPPORT IS REQUIRED)
		CARTER TARGET	CURRENT	
1	Monthly cost of clinical and general supplier per 'WAU'	<b>WAU</b>	<b>£295</b>	The Trusts has seen continual increase in activity year on year. Fixed costs have been stretched to minimise the increase of costs and sustain a low WAU.
2	Total % purchase order lines through a catalogue	<b>80%</b>	<b>97.9%</b>	The Trust has fully implemented an electronic P2P system integrated with finance. This includes a catalogue which enables end user ordering.
3a	% of invoice value matched to an electronic purchase order	<b>90%</b>	<b>83%</b>	The Trust has a strict no PO no Pay policy. There is also a PO exemption list that is authorised within the Trust SFIs. This includes some services from other NHS organisations.
3b	% by count of invoices matched to an electronically generated purchase order	<b>90%</b>	<b>88.3%</b>	Same response as 3a
4	% of spend on a contract	<b>90%</b>	<b>76%</b>	There is a 34% of tail end spend that is under quotation as well as a small portion that is not under contract. The team are reviewing opportunities to aggregate the tail end spend.
5	Inventory Stock Turns	<b>NA</b>	<b>104.8 Days</b>	This number is high due to one significantly high area within the Trust. This area is under review to understand whether the stock level is correct or is it due to stock not being scanned at use. All other areas in the Trust are less than 50 days of stock held. The Trust has gradually reduced the level of stock held with regular monitoring of each area.
6	NHS Standards Self-Assessment Score (average total score out of max 3)	<b>Appendix 3 includes the metric breakdown</b>		Level standard 1 was assessment in December 2017. MTW are awaiting the outcome of the assessment. MTW understanding is that a recommendation of level 1 achievement has been made.
7	Purchase Price Benchmarking Tool Performance	<b>NA</b>	<b>£716,588</b>	Current variance to Median is showing on PPIB as £716,588. These opportunities are being reviewed within the team to ensure the best price is achieved in the Trust.

## 6. Procurement Transformation Plan - Summary

## 1) People & Organisation :

### People & Organisation

The team have undergone a transformation programme which structured the teams based on the three areas outlined within the executive summary. Two posts within the team have been transformed to apprenticeship roles. These posts will be recruited to in 2018.

MTW has approached the local Christchurch Canterbury University and is now part of their graduate scheme where purchasing and supplies is one of the areas of study within the university. This is all part of the team succession planning and development as historically the team have struggled to fill posts within category management.

Continued development of the team is important and a training matrix has been developed identifying training for each member of the team and how this links to their procurement role. There is also a link to the procurement skills network and sharing learning through peers across the region. Two members of the team are currently studying their CIPS which is being funded by the apprenticeship levy.

Appendix 2 includes a copy of the current procurement structure.

Next steps – The team has conducted two visits to other hospitals as part of staff development to learn new ways of working. This has been very valuable. Further visits are planned in 2018/19.

#### Measures Implemented (200 words max)

All staff appraisals identify training needs and KPIs monitored on numbers of staff qualified. Two members of staff undertaking current CIPS training.

Category management monitors the savings against monthly targets. A data analyst was successfully recruited as a joint appointment with the Informatics department and has proved beneficial. Two apprenticeships posts to be recruited to in 2018/19.

Procurement staff are actively involved in the STP Programme, with some leading on STP-wide tenders.

#### Impediments and support (200 words max)

More shared learning across the STP patch would be useful to develop staff competencies and exposure to larger scale procurements. Some staff require upskilling, or modernising their knowledge base, particularly around commercial awareness, in order to meet the current challenges. Similarly it would be good to be pointed to best practice organisations nationally to enable sharing of learning.

Some departments in the Trust resist Procurement policy and practice as they have customarily undertaken their own contracting. This is being addressed through direct engagement, and moving away from local purchase ordering onto the Trust mainline Procurement system.

The Procurement team does not have an extensive training budget so the PSD to identify and put on training opportunities, maybe lined with the FOM, e.g. around Category Management specialisms.

## 2) Processes, Policies & Systems :



The Procurement strategy was reviewed in September 2017. The strategy was amended to focus more on the regional STP and align the Trust objectives to support the changes in the national landscape.

The objectives and actions outlined in appendix 1 indicate the priorities for the team outlined within the Strategy.

### **Processes, Policies & Systems**

Communication is a key element of the procurement strategy and communications have been issued to the trust on a number of areas. Recent communications include:

- Two Listening into Action (LIA) events focused on procurement to share process and the different ways the Trusts purchases goods and services.
- a reminder of the procurement thresholds within the Trust SFIs,
- product switches within the Trust and the savings this achieved

The Trust has in place a No Purchase order no Pay policy. A reminder has gone out to the Trust regarding this policy as well as letters sent to all suppliers advising them of the implications of this policy. These improvements are focused on ensuring that any request for goods and services has followed the full trust processes and there is a clear audit trail of activity.

From a systems side, the implementation of the Inventory management system and the integrated procurement and finance system has meant the Trust is starting to get real time stock usage information. Work is being developed on how to get this linked to patient level to understand the cost of each patient and procedure variance.

This is then being linked to the model hospital metrics to understand where there are opportunities for the trust to improve on costs. Real time stock levels will allow more accurate management of stock and compare usage across the wards. The integrated finance system has ensured better matching of invoices against the orders to ensure we are paying the price agreed with the supplier.

MTW is part of the Kent and Medway STP. The procurement team work collaboratively together. The heads of procurement have a monthly meeting to review the STP procurement workplan as well as identify future opportunities to collaborate.

Both MTW and EKHFT have onsite support 1 day a fortnight from NHS Supply chain. Part of the work with NHSSC is to review the supply chain expenditure across the STP and identify price variance with the same suppliers and also potential product switches which would allow financial efficiencies for the Trusts as well as create greater supplier resilience in the market and allow each Trust to lower the level of stock held.

MTW and EKHFT both have clinical committees that review products that will be taken to trial within the Trust. It is proposed that clinical representation from MTW attend the EKHFT meeting and vice versa to allow the transition to similar products and to streamline the trials process between the two hospitals. This will help push greater efficiencies but also facilitate the clinical challenge regarding the implementation of a product.

PPIB report is run each month which identifies the opportunities for the Trust. This is reviewed against the Trusts who are performing well in those areas. This validation process allows the buyers to focus on "quick win" opportunities and also opportunities for the category managers to include within their tenders. This work also identifies potential STP opportunities to be taken forward.

The Trust is reviewing the impact on the Future Operating model. There has been some discussion on how this may impact on the influence-able spend the local procurement teams should be focusing on. The category management structure is too small to make any changes to reflect the FOM but there will be more focus on the clinical team to ensure areas such as

National contracted products are implemented as well as use of the different towers to ensure savings.	
<b>Measures Implemented (200 words max)</b>	<p>Procurement send out communications within the Trust to ensure people have a clear understanding of Trust policy and process. There is communication on the number of products in trial and the outcome of each trial.</p> <p>There is a trials' folder indicator which measures the number of products on trial and the number implemented within the Trust. There is a measure on the amount saved on each trial switch as well as any avoidable cost delivered, e.g Trust has changed surgical gloves with a saving of £54k. we have also changed patient wrist bands which saved £12k plus avoidable cost was patient wrist band machines are included free within the contract. This is a £35,000 saving on replacement wrist band machines.</p>
<b>Impediments and support (200 words max)</b>	<p>The Clinical product management committee is the forum where product trials are taken for approval pre and post-trial. The chair of this committee has changed three times in the last year due to the large volume of commitments of senior medical staff. The consistency of overview of this process is important. Part of linking with EKUHFT will support the clinical overview of product switches and take some pressure off the clinical staff on both sites.</p>

### 3) Partnerships :

#### Partnerships - Collaboration

Maidstone and Tunbridge wells NHS Trust is part of the Kent and Medway Sustainability transformation programme (STP) footprint. Part of the STP identifies the need for procurement across the region to work closer together and where possible identify resources that can be shared to achieve best value in the market.

Over the past year the STP has explored and tested an outsourced and in-house solution for a shared service transactional procurement team. This model would support one catalogue across the region as well as remove the price variation where the Trusts purchase the same products. A lot of this work is already happening in the region but part of this back-office model is looking at having one system across the region. Further work is being done in the area before a final decision is made on the way forward.

The SE regionals heads of procurement, Medway Foundation Trust, Dartford and Gravesham NHS trust and East Kent Hospitals University NHS Foundation Trust have begun working together as a region. The Heads of procurement meet every month to discuss opportunities for collaboration and have shared their procurement work plans.

The heads of procurement have shared the contacts across the region as well as identifying the skills of each of their staff, to outline what skills are available within the region. This has been instrumental for longer term discussions on how we work more closely together as there is significant skill shortage in procurement and specifically in the South East (SE) there is difficulty in attracting staff out of London.

The region has held its first joint supplier event on 16 September 2016, where the message to the market was one of collaboration between the trusts in the SE. The event was attended by 85 suppliers with positive feedback and requests for further events. The SE region is planning on holding these events every 6 months as themed events for specific categories.

**Next steps**

As a region there is recognition of the benefit of the alignment of procurement work plans. This is part of the next steps for the STP footprint as well as using the information of the skills of the staff to identify leads for specific categories across the region.

There has been good success within the region on temporary staffing using the model of regional leads. The group has shared sharing bank and agency rates and have agreed some consistent rates across the region in order to manage the market in a consistent way. This work has now led to new areas being explored with stationery being an area currently under review.

**National Agenda**

As a region the heads of procurement share learning and ideas on the national communication and all agree on the support of the national agenda for procurement. Shared learning of the future operating model and standardisation of products is a key agenda at each Heads of procurement meeting.

All four trusts are committed to next steps including include working together based on the Future operating model and links to the supply chain mandated products.

**Measures Implemented (200 words max)**

The Trust lead of an STP tender for Orthopaedics. This was a key success for two of the Trusts and achieved savings in excess of £1million across the two Trusts. This tender has supported joint working and joint contract management meetings with the supplier. The model of this tender will support the STP going forward on how best to work together.

The STP has also completed an internal audit tender together, which has been a success.

**Impediments and support (200 words max)**

This is the first year of the FOM and once the towers are up and running then the team will need support to understand the transition of frameworks and the key information of who to liaise with regarding each tower.

**7. Risks and issues**

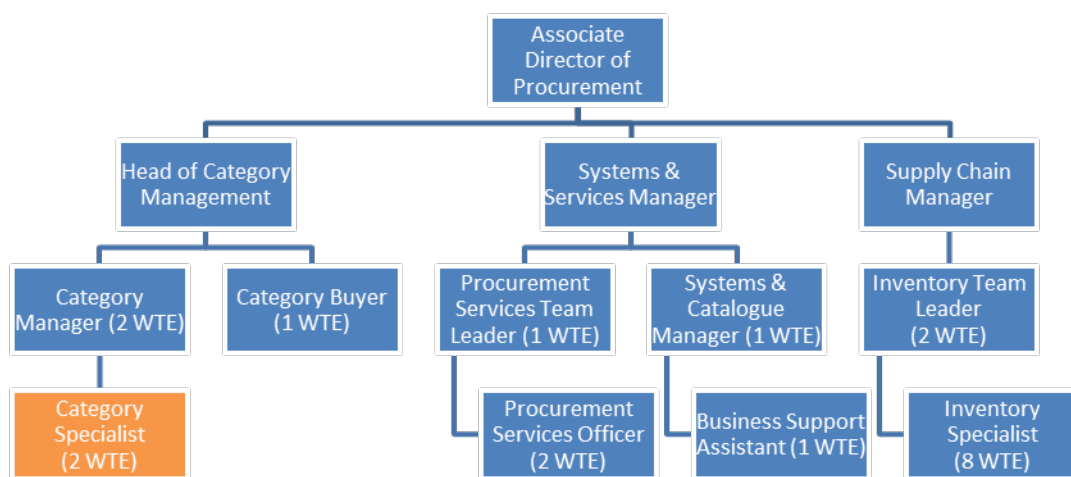
The main risk to the procurement team is the shortage of key procurement skills within the region. To deliver the CIP saving and ensure that the leads identified to support the whole region, requires staff with good procurement knowledge and the ability to negotiate in the market. Maidstone and Tunbridge wells is very fortunate to have a Category management team who are all MCIPS qualified but there is always the risk of losing staff to London where salaries are a lot more attractive.

**Appendix 1 – Procurement action plan**

<b><u>Procurement objective</u></b>	<b><u>Action</u></b>
Procurement strategy	Staff qualifications. An internal target has been set for 50% of procurement team qualified. Training matrix has been pulled together to identify the training requirements of all staff and link this to their role. This will support the Trust in achieving the level 2 procurement standard. There are currently two members of the team training for the CIPS level 4 with a further two planned in September.
Procurement workplan	Completion of 2018/19 procurement workplan. This workplan covers tail spend and improve the trust position on contract spend.
Procurement Savings	Achievement of agreed 2018/19 £4.2million
Communication strategy	Communication to internal and external stakeholders. Focus on Trust

	policy to ensure adherence to spend restrictions as well as improved compliance. This is a key objective within the procurement strategy.
Policies, processes and systems	Policies are reviewed and updated annually or at times of significant change.
Spend controls	Percentage of invoiced expenditure captured electronically through Purchase orders ( P2P systems ). This is monitored at the Trust finance committee and audit committee to ensure compliance.
People and Organisation	Achievement of the procurement standard level 1 and training programme to support level 2.
<b>Collaboration</b>	Alignment of procurement work plans across the region
	Market management engagement – 2 supplier events per year.
	Shared learning and collaboration of the FOM across the region
	2 supplier surveys per year to be sent to support the review of the team's engagement with the market

## Appendix 2 – Current Procurement team structure chart



## 5. RECOMMENDATION

- 5.1 It is recommended that the Finance and Performance Committee note and review the information in the report.

## Appendix 3 – Procurement standards

# NHS Procurement & Commercial Standards : Procurement Transformation Plan re-fresh May 2018

Area	Standard	Level 1	Level 2
		Position at April 2018. If achieved then indicate below (you are not required to insert scores if achieved)	Position at April 2018. If achieved then indicate below (you are not required to insert scores if achieved)
	If achieved through peer review then insert date to the right	Dec-17	
	If not achieved then input self-assessment scores against each area and insert date of peer review to the right		Apr-18
1. Strategy & Organisation	1.1 - Strategy		2
	1.2 - Executive Commercial Leadership		2
	1.3 - Procurement & Commercial Leadership		2
	1.4 - Internal Engagement		2
	1.5 - External Engagement		2
2. People & Skills	2.1 - People Development & Skills		2
	2.2 - Scope & Influence		2
	2.3 - Resourcing		1
3. Strategic Procurement	3.1 - Category Expertise		1
	3.2 - Contract & Supplier Management		1
	3.3 - Supplier Relationship Management		1
	3.4 - Risk Management		1
	3.5 - Sourcing Process		1
	3.6 - Benchmarking		1

Area	Standard	Level 1		Level 2	
		Position at April 2018. If achieved then indicate below (you are not required to insert scores if achieved)		Position at April 2018. If achieved then indicate below (you are not required to insert scores if achieved)	
	If achieved through peer review then insert date to the right	Dec-17			
	If not achieved then input self-assessment scores against each area and insert date of peer review to the right			Apr-18	
	3.7 - Specifications				1
4. Supply Chain	4.1 - Inventory Management & Stock Control				2
	4.2 - Logistics				2
5. Data, Systems and Performance Management	5.1 - Performance Measurement				2
	5.2 - Savings Measurement & Credibility				2
	5.3 - Catalogue Management				2
	5.4 - Procure to Pay (P2P)				2
	5.5 - Cost Assurance				2
	5.6 - Spend Analysis				2
	5.7 - GS1 & Patient Level Costing				1
6. Policies & Procedures	6.1 - Procurement Policy & Guidance				2
	6.2 - Process Compliance				2
	6.3 - Asset Management				1
	6.4 - Corporate Social Responsibility (CSR)				1
	6.5 - SMEs				1
	Overall Average Score	0.00		1.59	

## Trust Board meeting – May 2018



5-19	Finance and Performance Committee - Approval of proposed amendments to Terms of Reference	Chair of Finance and Performance Committee
<p>Given the departure of the Deputy Chief Executive at the end of April 2018, and the intention to appoint a Director of Strategy, Planning and Partnerships rather than another Deputy Chief Executive, the Terms of Reference of the Finance and Performance Committee have been updated to reflect this change.</p> <p>The changes proposed are shown as 'tracked below'.</p> <p>The Finance and Performance Committee agreed the changes at its meeting on 24<sup>th</sup> April 2018, so the Trust Board is asked to approve the changes.</p>		
<p><b>Which Committees have reviewed the information prior to Board submission?</b></p> <ul style="list-style-type: none"> <li>Finance and Performance Committee, 24/04/18</li> </ul>		
<p><b>Reason for submission to the Board (decision, discussion, information, assurance etc.) <sup>1</sup></b></p> <p>Approval</p>		

<sup>1</sup> All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

## FINANCE AND PERFORMANCE COMMITTEE

### Terms of Reference



#### 1. Purpose

The Trust Board has established the Committee to provide the Trust Board with:

- Assurance on the effectiveness of financial management, treasury management, investment and capital expenditure and financial governance
- An objective assessment of the financial position and standing of the Trust
- An objective assessment of performance-related issues affecting the Trust's financial position
- Advice and recommendations on all key issues of financial management and financial performance
- Assurance on Information Technology performance (and business continuity)

#### 2. Membership

Membership of the Committee is as follows:

- The Committee Chair - a Non-Executive Director or Associate Non-Executive Director appointed by the Trust Board
- The Committee Vice-Chair - a Non-Executive Director or Associate Non-Executive Director appointed by the Trust Board
- The Director of Finance
- The Chief Operating Officer
- The Chief Executive<sup>2</sup>
- ~~The Deputy Chief Executive<sup>4</sup>~~

Members are expected to attend all relevant meetings.

#### 3. Quorum

The Committee shall be quorate when one Non-Executive Director or Associate Non-Executive Director and two Members of the Executive Team are present. If a member of the Executive Team cannot attend a meeting, they should aim to send a representative in their place.

For the purposes of being quorate, any Non-Executive Director or Associate Non-Executive Director (including the Chair of the Trust Board) may be present; and any two Members of the Executive Team may be present (including any of those not listed in the Membership). Deputies representing Members of the Executive Team will count towards the quorum.

#### 4. Attendance

All other Non-Executive Directors (including the Chair of the Trust Board), Associate Non-Executive Directors and Members of the Executive Team are entitled to attend any meeting of the Committee.

The Committee Chair may also invite others to attend, as required, to cover certain agenda items, and/or ensure the Committee meets its Purpose and complies with its Duties.

#### 5. Frequency of meetings

The Committee shall generally meet each month, but the Committee Chair may schedule additional meetings, as required (or cancel any scheduled meetings)

#### 6. Duties

The Committee has the following duties:

##### Financial Management

<sup>2</sup> ~~N.B. Either the Chief Executive or Deputy Chief Executive should aim to be present at each meeting. This does not affect the quorum requirements listed above.~~



- Review financial plans and strategies and ensure they are consistent with the Trust's overall vision and strategic goals
- Ensure a comprehensive budgetary control framework is in place and operating effectively
- Monitor financial performance against plan, and ensure corrective action is taken where appropriate
- Develop and monitor key financial performance indicators, and advise the Trust Board on action required to improve performance / address risks.
- Review and monitor the Trust's Cost Improvement Programme (CIP)
- Obtain assurance that all CIP schemes and Business Cases have been subject to a Quality Impact Assessment, and to liaise with the Quality Committee, as appropriate, to ensure the robustness of the process
- Monitors the delivery of the recommendations of the 'Lord Carter report' ("Operational productivity and performance in English NHS acute hospitals: Unwarranted variations")
- Ensure the Trust is actively engaged and addresses all productivity opportunities presented as part of national initiatives

### **Treasury Management**

- Review any significant (in the judgement of the Director of Finance) proposed changes to the Trust's treasury management policies, processes and controls
- Approve external funding and borrowing arrangements, including approval of working capital facilities and capital investment loan applications (within the Committee's delegated authority), or to review such applications, and make a recommendation to the Trust Board if the value exceeds the Committee's delegated authority)
- Ensure proper safeguards are in place for security of the Trust's funds by ensuring approved bank mandates are in place for all accounts, which are updated regularly for changes in signatories and authority levels;
- Monitor compliance with treasury management policies and procedures
- Review the Trust's cash flow and balance sheet, to ensure effective cash management plans are in place

### **Capital Expenditure and Investment**

- Review the Trust's capital plan ensuring its alignment to strategic priorities
- Review and assess the financial implications of the PFI contract for Tunbridge Wells Hospital, including any options for re-financing
- Review Business Cases for capital and service development above the threshold set-out in the Reservation of Powers and Scheme of Delegation, and make a recommendation to the Trust Board regarding the approval of such Cases
- Receive assurance on the effectiveness of the Trust's investment appraisal and approval process

### **Financial Governance, Reporting, Systems and Function**

- Review and assess the arrangements for financial governance
- Review and assess the effectiveness of financial information systems, and monitor development plans, including the development of Service Line Reporting
- Review and assess the capacity and effectiveness of the finance function and ensure development plans are in place to meet the current and future requirements of the Trust
- Assess the organisational awareness and adherence to financial management disciplines and controls and promote congruence between quality patient care and the achievement of financial objectives
- Review and approve the Trust's approach to its Reference Cost submission/s

### **Procurement**

- To monitor performance against the Trust's Procurement Strategy and Procurement Transformation Plan

### **Performance**

- To monitor and review non-quality performance-related issues, particularly in relation to the key patient access targets
- To escalate performance-related issues to the Trust Board in the event of any concerns

### **Informatics (including Information Technology)**

- Review informatics strategies and plans and ensure they are consistent with the Trust's overall vision and strategic goals
- Review plans and proposals for major development and investment in Information Technology, and advise the Trust Board accordingly, paying particular attention to the financial implications and risks of the proposals

### **Assurance and Risk**

- Assure itself on (i) the identification of principal risks associated with the financial performance and financial management of the Trust, and Information Technology, (ii) the effective management of those risks and (iii) the escalation to the Trust Board of matters of significance

## **7. Parent Committees and reporting procedure**

The Committee is a sub-committee of the Trust Board.

A summary report of each Committee meeting will be submitted to the Trust Board. The Chair of the Committee will present the Committee report to the next available Trust Board meeting

## **8. Sub-Committees and reporting procedure**

The Committee has no standing sub-committees, but may establish fixed-term working groups, as required, to support the Committee in meeting the Purpose and/or Duties listed in these Terms of Reference.

## **9. Emergency powers and urgent decisions**

The powers and authority which the Trust Board has delegated to the Committee may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted at least two Members of the Executive Team. The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the Committee, for formal ratification.

## **10. Administration**

The minutes of the Committee will be formally recorded and presented to the following meeting for agreement and the review of actions.

The Trust Secretary will ensure that each committee is given appropriate administrative support and will liaise with the Committee Chair on:

- The Committee's Forward Programme, setting out the dates of key meetings & agenda items
- The meeting agenda
- The meeting minutes and the action log

## **11. Review of Terms of Reference and monitoring compliance**

The Terms of Reference of the Committee will be reviewed and agreed by the Committee at least annually, and then formally approved by the Trust Board.

### **History**

- Terms of Reference agreed by Finance Committee, May 2013
- Terms of Reference reviewed and agreed by Finance Committee, May 2014 (with a minor additional to duties agreed at the June 2014 Finance Committee)
- Terms of Reference approved by Trust Board, July 2014
- Terms of Reference (revised) agreed by Finance Committee, June 2015
- Terms of Reference (revised) approved by Trust Board, July 2015
- Terms of Reference (minor revision) agreed by Finance Committee, September 2015
- Terms of Reference (minor revision) approved by Trust Board, September 2015
- Terms of Reference (reviewed and revised) agreed by Finance Committee, June 2016
- Terms of Reference (revised) approved by Trust Board, June 2016

- Terms of Reference (reviewed and revised) agreed by Finance Committee, June 2017
- Terms of Reference (revised) approved by Trust Board, June 2017
- Terms of Reference approved by Trust Board, October 2017 (to add Associate Non-Executive Directors to the membership)
- Terms of Reference agreed by the Finance and Performance Committee, April (to remove the Deputy Chief Executive from the membership, following the discontinuation of that post)
- Terms of Reference (revised) approved by Trust Board, May 2018

## Trust Board Meeting – May 2018



5-19	Summary report from Finance and Performance Committee, 22/05/18	Committee Chair (Non-Exec. Director)
<p>The Finance and Performance Committee met on 22<sup>nd</sup> May 2018.</p> <p><b>1. The key matters considered at the meeting were as follows:</b></p> <ul style="list-style-type: none"> <li>▪ The actions from previous meetings were reviewed, and this led to a request that the next “Update on IT strategy and related matters” report included an update on current IT user issues (including log-on delays)</li> <li>▪ Under the “Safety Moment”, it was reported that May’s theme was dementia</li> <li>▪ The Director Estates and Facilities Management attended for a review of whether the Trust should continue to provide laundry services to Dartford and Gravesham NHS Trust (DGT), in the context of the bad debt incurred by the liquidation of Carillion. The Committee approved the recommendation that the Trust enter into the new agreement with Serco for the remaining period of the original contract (to 20/07/20), but it was agreed to investigate whether the Trust could obtain any payment underwrite from DGT in the event of a default by Serco. It was also agreed to provide Committee members with information on the STP-wide discussions regarding the development of commercial laundry services</li> <li>▪ The Director of Finance and Chief Operating Officer presented an explanation of the significant increases in temporary Medical staffing expenditure in a) August 2017 and b) March 2017 &amp; 2018 (this was an action from the April meeting), and it was agreed that a plan should be submitted to the Committee in June 2018 in response to the increases. It was also agreed that the Chief Operating Officer should check and confirm the position regarding Annual Leave taken/booked by Medical staff for the 2 Bank Holiday weekends in May 2018</li> <li>▪ A detailed discussion was held on the Financial Special Measures (FSM) meetings held in April and May 2018 (which incorporated the month 1 financial performance), and this led to an agreement to explore the feasibility of adding an item to the agenda of the ‘Part 2’ Trust Board meeting on 24/05/18 regarding the development of a wholly-owned subsidiary</li> <li>▪ The approach being taken regarding the recovery of the Trust’s outpatient activity was reviewed (this had been an action from the April 2018 meeting), and the Chief Operating Officer was asked to ensure that the “outpatient activity” section to be included within future monthly “non-financial performance” reports included information on trends</li> <li>▪ A report was reviewed on the preparations to become the prime provider for elective activity from 01/08/18, and it was agreed to schedule the receipt of a further report at the June 2018 Committee meeting. It was also agreed that the Chief Operating Officer should arrange for proactive steps to be taken to encourage Cardiology referrals from local GPs</li> <li>▪ The month 1 non-finance, non-quality, related performance was discussed, and it was agreed that future “non-financial performance” reports should report length of stay (LOS) data with and without 0-day LOS patients</li> <li>▪ The Director of Workforce presented for a review of the Trust’s recruitment plan, and it was agreed to confirm the interventions that would be taken to deliver the plan</li> <li>▪ The usual monthly update on the Lord Carter efficiency review was noted, as was progress with the Procurement Transformation Plan (that report has been submitted to the Trust Board for separate review – see Attachment 14)</li> <li>▪ The latest quarterly updates on Service Line Reporting (SLR) was reviewed, and it was agreed to confirm the accuracy of the reported position of the Private Patient Unit</li> <li>▪ The Outline Business Case (OBC) for an Electronic Patient Record was reviewed, and the Committee recommend that the OBC be approved by the Trust Board (the OBC will be considered under a separate agenda item and report at the Trust Board). The Committee also confirmed that it should not review the Full Business Case (FBC), but it should receive a report highlighting the changes between the FBC and the OBC.</li> <li>▪ The standing “breaches of the external cap on Agency staff pay rate” report was noted</li> <li>▪ The Committee was notified of the recent uses of the Trust Seal</li> </ul>		

<p><b>2. In addition the agreements referred to above, the Committee agreed that:</b></p> <ul style="list-style-type: none"> <li>▪ A new report should be developed, to replace the current “SLR) – quarterly update” and “Update on the Lord Carter efficiency review” reports submitted to the Committee</li> <li>▪ The “Update on the Workforce Transformation programme” item should be removed from the forward programme (pending confirmation that this was acceptable to the Trust Board), on the basis that the workforce transformation work was now incorporated within the Best Care programme and did not warrant discrete reporting</li> </ul>
<p><b>3. The issues that need to be drawn to the attention of the Board are as follows:</b></p> <ul style="list-style-type: none"> <li>▪ It was agreed to explore the feasibility of adding an item to the agenda of the ‘Part 2’ Trust Board meeting on 24/05/18 regarding the development of a wholly-owned subsidiary (N.B. a report has subsequently been circulated regarding this, which will be considered under “To consider any other business” at the ‘Part 2’ Board meeting on 24/05/18</li> <li>▪ The Outline Business Case (OBC) for an Electronic Patient Record was reviewed, and the Committee recommend that the OBC be approved by the Trust Board</li> <li>▪ The Committee agreed a proposal to remove the “Update on the Workforce Transformation programme” item from the forward programme (pending confirmation that this was acceptable to the Trust Board), on the basis that the work was incorporated within the Best Care programme and did not warrant discrete reporting</li> </ul>
<p><b>Which Committees have reviewed the information prior to Board submission?</b></p> <ul style="list-style-type: none"> <li>▪ N/A</li> </ul>
<p><b>Reason for receipt at the Board (decision, discussion, information, assurance etc.)</b></p> <p>Information and assurance</p>

## Trust Board meeting - May 2018

5-20	Annual Report 2017/18 (including Annual Governance Statement)	Chair of the Audit and Governance Committee
	<p>NHS Trusts are required by statute<sup>1</sup> to produce an Annual Report for each accounting year, in such form as may be determined by the Secretary of State for Health. The minimum content for such Annual Reports is prescribed by the Department of Health (DH), through its 'Group Accounting Manual' (GAM). The GAM also states that "Beyond this [minimum context] however, the entity must take ownership of the document and ensure that additional information is included where necessary to reflect the position of the body within the community and give sufficient information to meet the requirements of public accountability". The Annual Governance Statement is covered by the GAM, but is also subject to separate guidance, issued by NHS Improvement (NHSI) in February 2018.</p> <p>The Annual Report (including Annual Governance Statement) for 2017/18 was duly written to ensure compliance with the aforementioned guidance, and using the same template/format used for the 2016/17 Annual Report. The draft Annual Report is required to be reviewed by the Trust's External Auditors, as part of their Audit of the Financial Accounts. Certain information contained in the "Remuneration and Staff Report" section is subject to audit and will be referred to in the Audit Opinion. Other aspects of the Annual Report are reviewed by the Auditors to ensure consistency with the Financial Accounts. The draft Annual Report was duly provided to the Trust's External Auditors on 30<sup>th</sup> April 2018.</p> <p>The Annual Governance Statement was reviewed (and endorsed) by the Trust Management Executive on 25<sup>th</sup> April. The draft Annual Report (including Annual Governance Statement) was then reviewed by the Audit and Governance Committee on 2<sup>nd</sup> May 2018 and no amendments were requested. Since the meeting, the External Auditors have recommended a number of minor amendments and/or corrections; these have now been made.</p> <p>The enclosed Annual Report therefore represents the final version, and has been submitted for final review by the Audit and Governance Committee, which meets on 24<sup>th</sup> May, before the Trust Board. The Audit and Governance Committee will be asked to review the Report in detail, and recommend that the Trust Board approves the document. The outcome of the Audit and Governance Committee's review will be provided verbally at the Trust Board on 24<sup>th</sup> May.</p> <p>There are no separate submission arrangements for Annual Governance Statements specifically. However, all NHS providers are required to submit their final full Annual Report including full statutory accounts to NHS Improvement. This should be a single PDF document containing both the annual report and full statutory accounts including audit report (opinion) by 16<sup>th</sup> July 2018.</p> <p>It should however be noted that there may be further minor layout/design changes between now and 16<sup>th</sup> July 2018. However, such changes will be cosmetic, and the text will not be materially changed from that approved by the Board. Printed versions will be produced for the Trust's Annual General Meeting, 19th and 20th September 2018.</p>	
	<b>Which Committees have reviewed the information prior to Board submission?</b>	
	<ul style="list-style-type: none"> <li>Trust Management Executive (TME), 25/04/18 (Governance Statement)</li> <li>Audit and Governance Committee, 02/05/18 (earlier draft)</li> <li>Audit and Governance Committee, 24/05/18 (the enclosed draft)</li> </ul>	
	<b>Reason for receipt at the Board (decision, discussion, information, assurance etc.)<sup>2</sup></b>	
	To review and approve the Annual Report (including Annual Governance Statement) for 2017/18	

<sup>1</sup> The National Health Service and Community Care Act 1990

<sup>2</sup> All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance



# Maidstone and Tunbridge Wells NHS Trust



## Annual Report and Accounts 2017/18



Patient First - Respect - Innovation - Delivery - Excellence

# About this Annual Report

The National Health Service and Community Care Act 1990 requires NHS Trusts to produce an Annual Report. The content and format is required to follow the guidance issued by the Department of Health and Social Care (in the form of a 'Group Accounting Manual'). The specific requirements for Annual Reports for 2017/18 are that NHS bodies must publish a single Annual Report and Accounts (ARA) document, comprising the following:

- ▶ A Performance Report (which must include an overview, and a performance analysis)
- ▶ An Accountability Report (which must include: a Corporate Governance Report and a Remuneration and Staff Report<sup>1</sup>)
- ▶ The Financial Statements

The Department of Health and Social Care's guidance sets out the minimum content of the Annual Report. Beyond this however, the Trust is expected to take ownership of the Report and ensure that additional information is included where necessary to reflect the position of the Trust within the community and give sufficient information to meet the requirements of public accountability. The Report is divided into several sections:

- ▶ "Performance Report for 2017/18", which is split into the following sections:
  - An overview. This includes an overview summary; the purpose and activities of the Trust; the Chair and Chief Executive's report; the 'story of the year' (month by month); the key issues and risks affecting delivery of the Trust's objectives; an explanation of the adoption of the going concern basis; and a Performance summary
  - A Performance analysis, which includes details of how the Trust measures performance; the Trust's development and performance in 2017/18; and a review of financial performance for 2017/18
  - A summary of the Trust's Quality Accounts for 2017/18
  - A Sustainability Report. This follows the standard reporting format from the NHS Sustainable Development Unit
- ▶ "Accountability Report for 2017/18", which is divided into the following sections:
  - "Corporate Governance Report for 2017/18", which in turn is divided into:
    - A Directors' report (which provides details of the Trust Board; a Statement as to disclosure to Auditors; attendance at Trust Board meetings; details of Directors' interests; the Trust's Management Structure; complaints performance and the Trust's application of the 'Principles for Remedy' guidance; disclosure of "incidents involving data loss or confidentiality breaches"; & details of Emergency Preparedness arrangements)
    - The "Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust"
    - The "Annual Governance Statement for 2017/18"
  - "Remuneration and Staff Report for 2017/18" (including details of 'off-payroll' engagements)
- ▶ "Financial Statements for 2017/18", which includes Pension Liabilities, exit packages and severance payments; and staff sickness absence data
- ▶ Independent Auditor's report to the Directors of Maidstone and Tunbridge Wells NHS Trust

The Annual Report and Accounts were approved by the Trust Board of Maidstone and Tunbridge Wells NHS Trust on 24<sup>th</sup> May 2018.

<sup>1</sup> The Trust is not required to produce a Parliamentary Accountability and Audit Report, and therefore the required disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included within the Financial Statements and Notes to the Accounts



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# Maidstone and Tunbridge Wells NHS Trust



## Performance Report for 2017/18: Overview



## Summary

The purpose of this overview is to give the reader sufficient, summarised information to understand the Trust, its purpose, the key risks to the achievement of its objectives, and an outline of its performance during the year 2017/18. For those wishing to read more about the Trust's achievements, the issues it faced and its detailed financial situation, further detail is provided in the rest of the Annual Report and Accounts.

## The purpose and activities of Maidstone and Tunbridge Wells NHS Trust

Maidstone and Tunbridge Wells NHS Trust (the Trust) is a large acute hospital Trust in the south east of England. The Trust was legally established on 14<sup>th</sup> February 2000<sup>2</sup>, and provides a full range of general hospital services and some areas of specialist complex care to around 590,000 people living in West Kent and East Sussex. The Trust also provides some aspects of specialist care to a wider population.

The Trust's core catchment areas are Maidstone and Tunbridge Wells and their surrounding boroughs. It employs a team of approximately 5000 full and part-time staff, and operates from three main sites (Maidstone Hospital, Tunbridge Wells Hospital and the Crowborough Birth Centre), but also manages services at Kent and Canterbury Hospital and outpatient services at several community locations. The Trust has over 800,000 patient visits a year, 172,000 of these through its Emergency Departments (EDs) which are accessible on both main hospital sites.

Tunbridge Wells Hospital is a Private Finance Initiative (PFI) hospital<sup>3</sup> and the majority of the site provides single bedded ensuite accommodation for inpatients in a modern, state of the art environment. It is a designated Trauma Unit, undertakes the Trust's emergency surgery and is the main site for Women's and Children's and Orthopaedic services.

Maidstone Hospital benefits from its central county location. It hosts the Kent Oncology Centre, providing specialist cancer services to around 2 million people across Kent and East Sussex, the fourth largest oncology service in the country. The Trust offers PET/CT (Positron Emission Tomography – Computed Tomography) services in a dedicated building and has a rolling programme to upgrade its Linear Accelerator radiotherapy machines. The Maidstone site also has a state of the art Birth Centre, a dedicated ward for respiratory services and an Academic Centre with a 200 seat auditorium. With the Education Centre at Tunbridge Wells Hospital, and its full resuscitation simulation suite, the Trust is able to offer excellent clinical training. The Trust has strong clinical, academic and research links with London hospitals, including joint appointments. Many staff are also nationally recognised for excellence in their fields.

The Trust is registered with the Care Quality Commission to provide the following Regulated Activities:

- ▶ Assessment or medical treatment for persons detained under the Mental Health Act 1983 (at Maidstone and Tunbridge Wells Hospitals)
- ▶ Diagnostic and screening procedures (at Maidstone and Tunbridge Wells Hospitals)
- ▶ Family planning services (at Maidstone and Tunbridge Wells Hospitals)
- ▶ Maternity and midwifery services (at Maidstone and Tunbridge Wells Hospitals and Crowborough Birthing Centre)
- ▶ Surgical procedures (at Maidstone and Tunbridge Wells Hospitals)

<sup>2</sup> See [The Maidstone and Tunbridge Wells National Health Service Trust \(Establishment\) Order 2000](#)

<sup>3</sup> The PFI Project Company is "Kent and East Sussex Weald Hospital Ltd" (KESWHL)

- ▶ Termination of pregnancies (at Tunbridge Wells Hospital)
- ▶ Treatment of disease, disorder or injury (at Maidstone and Tunbridge Wells Hospitals)

For further details of the Trust's CQC Registration, see [www.cqc.org.uk/provider/RWF/registration-info](http://www.cqc.org.uk/provider/RWF/registration-info).

The Trust approved an updated Trust Strategy in October 2017 following engagement with staff, patients and partner organisations (see page 16). The Strategy reflects the NHS Five Year Forward View and is aligned to local plans in the wider health and social care economy. There is a strong focus on the Kent and Medway Sustainability and Transformation Partnership (STP) and working in partnership as a key driver for sustainability. The Trust's objectives and organisational structure are detailed elsewhere within this Annual Report.

The Trust entered into an Aligned Incentives Contract with West Kent Clinical Commissioning Group (CCG) for the 2017/18 financial year. The contract is for a 2 year period and marks a departure from the traditional 'Payment by Results' contract approach, instead seeking to incentivise both contracted parties to work together to deliver common aims, in particular, the removal of costs from the system.

Details of the Trust's business model and environment, organisational structure, objectives and strategies can be found within the Performance Report Overview and Performance Analysis.

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## A message from the Chair and Chief Executive

We would like to jointly welcome you to our Annual Report and Accounts for Maidstone and Tunbridge Wells NHS Trust.

The Trust implemented a series of carefully planned and closely monitored clinically-led service changes during 2017/18 to improve its patient and staff experience. The developments continue into 2018/19 as part of our new Best Care Strategy. Best Care has been developed for the Trust to meet the changing health needs of its population, to improve the quality of its services, address national staffing challenges and continue to carefully reduce its recurrent deficit.

The Trust was independently assessed by the Care Quality Commission (CQC) in 2017/18 and takes confidence from the regulator's feedback, which supports its direction of travel to make our Trust a sustainable, caring and improvement driven organisation. The CQC found 'significant and sustained improvement' through its inspections, and is sufficiently assured that while the Trust remains in Financial Special Measures, it continues to carefully improve quality whilst reducing cost.

The CQC has also found strong leadership and an open and honest culture throughout the Trust. The Trust has taken on board the CQC's improvement ideas and is going many steps further with the development of its own Quality Strategy, which is being delivered through Best Care.

The Trust has sought to improve its staff engagement during 2017/18 with the implementation of Listening into Action (LiA). A number of clinically-led improvements have occurred throughout the year as a consequence of LiA, which seeks to empower our staff to make the changes they want to see that improve our patient and staff experience.

Parts of our Best Care Strategy are going to further improve our patient, staff and stakeholder engagement this year, supporting one of our key quality aims of becoming a truly patient-centred provider of personalised care.

Similar to many NHS Trusts nationally, we have continued to see year on year increases in the number of patients requiring emergency care and hospital admission. The Trust deployed a range of measures during 2017/18 as part of a robust clinically-led Winter Plan to maintain high quality, safe standards of care for its patients. The measures, which steadily improved the Trust's Emergency Department performance at a time of unprecedented demand for patient care, included changes to our patient pathways and development of new clinical roles.

Despite the best efforts of both Maidstone and Tunbridge Wells hospitals to work in unison, the use of more of our finite resources to treat emergency patients safely, national suspension of elective surgery, and prolonged periods of snow, collectively impacted on our ability to maintain the Referral to Treatment (RTT) waiting time standard. The Trust has also struggled to consistently meet the Cancer 62-day standard. Both of these areas are the subject of ongoing programmes of intensive improvement work from the outset of 2018/19.

Looking forward to the year ahead, our annual plan for 2018/19 puts us within touching distance of becoming a strong independent Trust that can make more of its long-held aspirations for its services, patient care and everyday working lives a reality. The plan moves us to within 12 months of securing long-term financial sustainability and has the potential to create enormous investment opportunity along the way.

Over the last two years, we have managed to reduce our underlying deficit from £37 million to £18 million, and it is planned to eradicate that over the next 2 years. Consequently, in 2018/19, we will be delivering a savings programme of £24 million – an amount similar to the savings delivered by the Trust in 2017/18.

By achieving this year's plan, the Trust will:

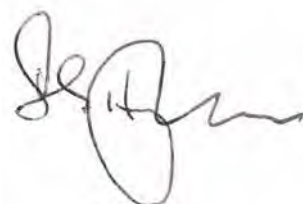
- ▶ move out of Financial Special Measures and be considerably closer to achieving long-term underlying financial sustainability
- ▶ be able to earn £12 million in additional funding from the NHS Provider Sustainability Fund to spend in 2019/20. This will provide more cash for us to invest in capital improvements in future years
- ▶ have its lowest ever underlying deficit to tackle in 2019/20, so we can regain our autonomy and authority to make significant changes for the better.

The Trust Board has undergone significant changes in its membership during the course of the year and, as well as the appointment of a new Chair and a new Chief Executive, has welcomed several new Non-Executive Directors, and Associate Non-Executive Directors, as well a new Director of Workforce. We would to thank all staff, volunteers and non-executives for their hard work and ongoing dedication during the year and to particularly recognise Glenn Douglas, who left the Trust in 2017 after 10 years as Chief Executive, for his commitment and service in that time. With our combined commitment, energy and expertise, we look forward to working together to achieve these aspirations and to creating a better Trust for all of us.



Miles Scott, Chief Executive

24<sup>th</sup> May 2018



David Highton, Chair of the Trust Board

24<sup>th</sup> May 2018

# The story of the year

## April 2017

Looking back a year, emergency admissions were 18% higher for April 2017 than in April 2016 and attendances were up 10% for the same period. This continued to impact on the Trust's ability to see all of its planned patients as quickly as both it, and they, would want, and remains the reason why the Trust continued to devote its time and focus throughout the year ahead on enhancing patient flow through its hospitals.

The Trust agreed its new set of key objectives for 2017/18 in April, focussed on providing safe, high quality services for patients over the coming year. The objectives, approved by the Trust Board, consolidated some of the Trust's most important challenges into a single, 6-point list that all staff could support and apply their collective efforts to achieving for the Trust's patients. Details of these objectives are given on pages 17 and 18.

## May 2017

The Trust welcomed David Highton as the new Chair of the Trust Board in May. David commenced his appointment with an extensive programme of induction visits, site tours and meetings to familiarise himself with the workings and facilities of the Trust. There is more information on David's professional background in the Directors' Report.

The Trust's second 'Rapid Improvement Week' was held during May and included the opening of the Tunbridge Wells Orthopaedic Unit, which enabled the provision of 23 ring-fenced beds for Orthopaedics, thereby increasing the capability to treat more patients & reduce the number of cancellations. The week also saw improved patient flow which enabled the Trust to achieve the highest number of patients ever discharged via the Discharge Lounge in a single day.

## June 2017

June saw confirmation that the Trust's £645,000 bid for national funding had been agreed to help improve patient flow through its Emergency Departments (EDs). This allowed the Trust to move forward at pace to transform its EDs on both sites to provide dedicated co-located areas for GP-led care, thereby allowing up to 20% of ED patients to be seen more appropriately by GPs working in the ED. These changes would require building works at Tunbridge Wells Hospital (including an extension at the front of the ED) and creation of a dedicated area at Maidstone ED to provide a better GP-led service there.



*Opening of the Frailty Unit in June 2017*

Early June also saw the opening of the Chaucer Acute Frailty Unit (CAFU) at Maidstone Hospital. The Unit offered 11 assessment spaces and 14 short-stay inpatient beds, for those patients needing to stay for up to 48 hours. A multi-disciplinary team worked together to set up innovative new pathways, whereby patients are assessed for suitability in ED and then referred to the CAFU according to agreed criteria. The system promotes national best practice, and supports rapid turnover and admission avoidance where it is safe and appropriate to do so.



The results for the 2016 National Inpatient Survey were published in June and provided a platform for further improvements during the year. Looking at two key indicators, 97.4% of patient felt they were treated with respect and dignity, and 97.6% of patients felt well looked after by the Trust's staff. The full survey report is available at: <http://www.cqc.org.uk/provider/RWF/survey/3>

## July 2017

From the beginning of July, the Trust began a 20-week period focused on making 10 clinically-driven changes that had been identified by its staff to improve patient care under the newly launched Listening into Action (LiA) initiative (see page 16). The programme placed more of the ideas that staff had at the centre of improvements within their organisations and has been adopted by other Trusts in recent years with noteworthy results.

Also in July, the Trust received official notification from the Care Quality Commission (CQC) asking it to prepare for unannounced visits as part of its routine inspection process. More information on the outcome of this process is given later in this section.

## August 2017

The Trust was one of the first in the south east of England to introduce Emergency Department Practitioners (EDPs) to work alongside doctors to treat and care for patients with more serious conditions in the ED. The new team was created in August 2017 as part of the Trust's proactive approach to maintaining high quality safe services and its continued commitment to raising standards in patient care. EDPs are Nurses and Paramedics who have been highly trained to perform advanced clinical roles, treating and caring for patients independently, with supervision from consultant doctors. Nine EDPs currently make up the team at the Trust, who work across both hospital sites. The project was so successful and patient satisfaction levels sufficiently improved that, by the end of 2017/18, there were plans to recruit and train additional staff.



A new scanning service based at Maidstone Hospital saw its first patients at the end of August. The brand new PET/CT scanning unit, located next to Kent Oncology Centre, is run by Alliance Medical and replaced the mobile scanner that has been coming to Maidstone for over 10 years. The new unit provided easier and better access for patients in the local area, and meant more patients could be seen and scanned than previously with the mobile scanner.

The end of August also saw the launch of the Trust's International Nursing Recruitment Campaign. Skype interviews were carried out for 9 candidates from

Nigeria, India and the Philippines and 9 conditional offers were made on the day.



## September 2017



### LiA CrowdFixing

The first LiA Crowd Fixing events were held in September at both of the Trust's main hospital sites. Attendance at both events was good and staff from across the Trust worked together in groups to identify and discuss their biggest frustrations with a

view to collectively defining the problem and finding solutions. Many diverse issues were raised along with some great suggestions to tackle them. The feedback from the sessions was very positive with people saying they felt enlightened, encouraged and enthused again after the events. The month also saw the departure, after 10 years service, of Glenn Douglas as the Trust's Chief Executive (see page 15 for more details).

## October 2017

October saw the launch of a new "Allscripts" Patient Administration System (PAS) within the Trust. The new system went live, in phases, across ED, the Intensive Care Unit (ICU) and all inpatient and then outpatient areas across the Trust. The Trust introduced "floorwalkers" and "superusers" at both hospitals to act as the first point of call for help and advice on using the new system. Despite these measures, following the go live, some significant problems were encountered which resulted in patients turning up to clinics that had been cancelled and rescheduled, clinics being double booked and patients not turning up for appointments. The project team worked hard to successfully resolve these issues.

Work commenced in October in the ED at Tunbridge Wells Hospital on improvements to the department and creation of a space for GPs to see patients. This project was part of the Developing Primary Care initiative (GP streaming) and marked realisation of the plans outlined in 'June 2017' (see earlier).

The first of a series of unannounced CQC inspections was held at both main Trust hospital sites during the month.

## November 2017



Late in November 2017, Kent Oncology Centre at Maidstone Hospital officially opened its new radiotherapy machine, which had the very latest state-of-the-art "Truebeam" treatment technology installed. The £2million technology will help to more quickly and accurately treat certain types of cancers which can be relatively mobile within a patient's body. The completion of this project was part of the ongoing 10 year major capital programme being undertaken by the Trust to replace several major pieces of radiotherapy treatment equipment across Kent.

## December 2017

December 2017 saw over 800 more ED attendances and 650 more emergency admissions than in December 2016. This was a challenging backdrop for the roll out of the 'Best Care, Best Patient Flow' project at

Tunbridge Wells Hospital in the month. The Trust worked with an external consultancy, 2020 Delivery Ltd, on 4 weeks of improvement to ensure the Trust's emergency flows were efficient as possible. The work combined interviews, analysis, observations, engagement events and improvement experiments. The latter were conducted in a "sprint" fortnight and focused on three areas: reducing ED pressure; establishing the Ambulatory Emergency Care (AEC) Unit and reducing length of stay in the Acute Medical Unit (AMU); and increasing early in the day discharging. Overall, performance was sustained and the Trust remained 44<sup>th</sup> nationally, against the backdrop of a very challenging period (the Trust experienced its busiest Christmas Day on record in December with more than 360 people attending its two EDs).

Also in December, the CQC conducted the 'Well-Led' aspect of its inspection, carrying out interviews with key members of the Executive Team and senior staff across the Trust.

## January 2018

Miles Scott took up post as the Trust's new Chief Executive early in January and stated that "I am delighted to have been appointed Chief Executive at Maidstone and Tunbridge Wells NHS Trust. I have been very impressed by the staff I have met and look forward to working together to deliver outstanding patient and staff experience." Later in January, Clinical leads for the national Emergency Care Improvement Programme (ECIP) highlighted good practice in the Trust following a review of quality, safety and patient flow in its EDs. ECIP leads identified the Trust's Quality Rounds as one of the best initiatives they had witnessed.

## February 2018

Although the site pressures during February were challenging, the Trust performed exceptionally well against its regional and national peers against the ED 4-hour waiting time standard (that at least 95% of patients attending ED should be admitted to hospital, transferred to another provider or discharged within 4 hours). The Trust was successful in over 90% of all ED attendances being seen within 4 hours and ranked 1<sup>st</sup> in the NHS Improvement Group Benchmarking (out of 49 Trusts being supervised), 3<sup>rd</sup> in the NHS England South Region (out of 11 Trusts locally) and 22<sup>nd</sup> out of 137 Trusts nationally.

Also in February, a large group of staff spent over an hour with the Secretary of State for Health and Social Care, the Rt Hon Jeremy Hunt MP, in an informal question and answer session at Tunbridge Wells Hospital. During his presentation, Mr Hunt told staff that he was impressed with the Trust's infection control journey and that the Trust had set an example for the whole of the NHS.

The NHS e-Referral Service (e-RS) went live within the Trust in late February when the first outpatient Consultant-led appointment slots were made available for GPs and patients to book hospital appointments online. e-RS is intended to improve the referral experience for patients and better support current and future business processes for clinicians and administrative staff. In so doing, it will create a more patient-centred service and support the drive towards paperless referrals and a paperless NHS by 2020.



## March 2018



March 2018 opened with heavy snow and staff went to extraordinary lengths to get to work. Some individuals walked for miles in the snow; others used their vehicles to collect colleagues and then drop them home again after their shifts. Numerous staff also stayed overnight to care for patients and to ensure they could carry out their shift the following day.

The Acute Frailty Unit opened as planned on 21<sup>st</sup> March on Ward 2 at Tunbridge Wells Hospital, in two rooms. Two patients were seen on the first day,

one of whom was discharged the same day. This initiative will be developed in order to improve patient flow and quality of care for this group of patients.

The first cohort of student nurses from Greenwich University started their placements with the Trust in March. The group of 5 pre-registration nurses came into the Trust to undertake their inductions before starting work in acute wards and Outpatients. This was the first time the Trust had taken Greenwich University students on the pre-registration Nursing programme.

## The story of the year: Care Quality Commission (CQC) inspection

The Trust received official notification from the CQC in July 2017, asking it to prepare for unannounced visits to the Trust's facilities as part of its routine inspection process. The Trust was one of the first in the country to undergo the CQC's new-look system of assessment, launched in June 2017, which decreed that every Trust in the country will be reviewed at least once a year by the CQC, using its revised system of review.

The CQC asks the following 5 questions of all healthcare providers that it inspects:

- ▶ Is the practice safe?
- ▶ Is the practice effective?
- ▶ Is the practice caring?
- ▶ Is the practice responsive?
- ▶ Is the practice well-led?

The Trust's preparations for the process included the formation of a central project team to manage the inspections and the Trust's planning for the visits. Informal CQC drop-in sessions were held at alternate hospital sites on a weekly basis throughout autumn 2017, which were open to all staff to discuss any concerns and to share experiences.

The CQC's inspections consisted of 12 separate unannounced and announced visits, carried out between October and December 2017. Five core services at the Trust were inspected.

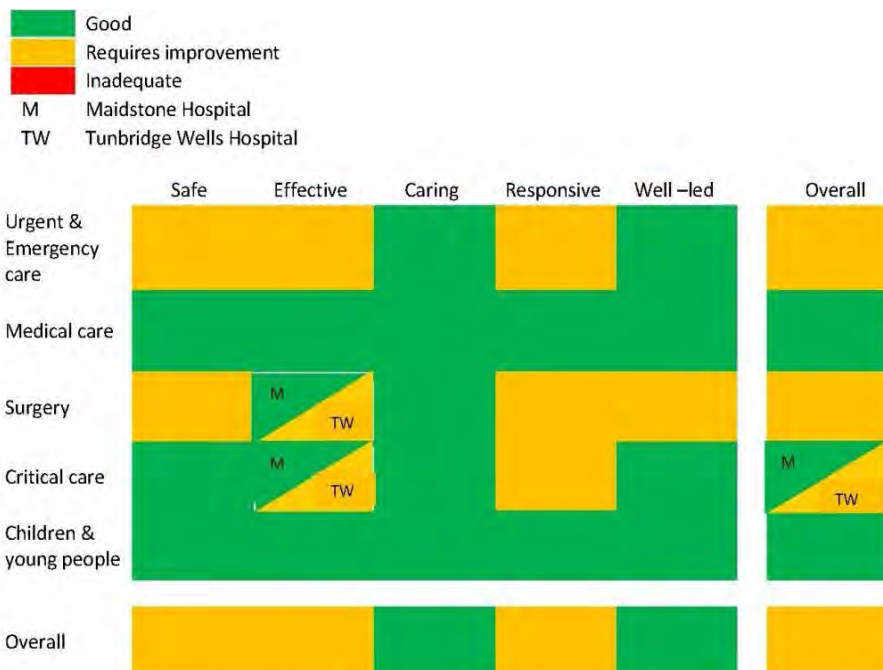
Following these visits, the CQC's inspection report was received on 9<sup>th</sup> March 2018 and awarded the Trust a 'Requires Improvement' rating (the same rating the Trust received at its previous CQC inspection in 2015). However, the report reflects significant improvements since that last inspection, and a 'good' rating was received in over two-thirds of the CQC standards across the 5 core services that were inspected – a significant increase from less than a third in 2015. In addition, no individual standards were rated as "Inadequate", compared to 6 in the 2015 inspection.



The report emphasises "significant and sustained improvement throughout the Trust", with noted improvements in the well-led domain, resulting in a 'good' rating overall for the Trust (compared to a rating of 'inadequate' for this domain at the 2015 inspection). The Trust Board and senior leadership team were recognised as having 'a clear vision and values that were at the heart of all the work within the organisation'.

#### 'Before' - Overview of the ratings for the 2015 inspection

Each one of the Trust's inspected services was rated 'Good' in the Caring domain. The report also highlights the improvements made in several service areas since the last inspection, and examples of outstanding practice in urgent and emergency care, surgery, critical care services and services for children and young people were noted by the CQC's inspectors during their visits.



Overall the Trust received 17 specific recommendations from the CQC which were incorporated into the Trust's Quality Improvement Plan.

The key findings from the Inspection Report and links to the full report were also shared with all staff and open sessions to discuss and reflect on the report with Trust Executives and the CQC Project Team Leads were held in March 2018. The full report can be accessed via the CQC website -

[www.cqc.org.uk/provider/RWF](http://www.cqc.org.uk/provider/RWF).

#### 'After' - Overview of the ratings for the 2018 inspection



## The story of the year: The Kent and Medway Sustainability & Transformation Partnership

One of the ways that the Trust is helping to collectively address the challenges faced in health and social care is through its involvement with the Kent and Medway Sustainability and Transformation Partnership (STP). The STP brings together Clinical Commissioning Groups (CCGs), NHS service providers and Local Authorities to transform services in accordance with the published NHS five year plans and STP Case for Change. The STP serves a population of circa 1.8 million with combined Health and Social Care annual budgets of £3.6 billion.

The Trust is a full partner in the Kent and Medway STP and has been involved in all areas of its programme. Glenn Douglas, who was the Trust's long-standing Chief Executive until September 2017, was Senior Responsible Officer of the STP until his appointment as its Chief Executive in September 2017. In November 2017, the Maidstone and Tunbridge Wells NHS Trust Board formally approved arrangements for the Trust's hosting of the STP's financial and procurement transactions and services, to clarify governance and reporting arrangements and promote a more active engagement from a wider range of staff in STP programmes.

In late March 2018, 6 CCGs across Kent and Medway announced the appointment of Mr Douglas as their single Accountable Officer (a position which he will hold alongside his duties as Chief Executive of the STP). The appointment covers the CCGs of: Ashford; Canterbury and Coastal; Dartford, Gravesham and Swanley; Swale; Medway; and West Kent. Alongside this appointment, the CCGs are establishing a shared management team and a strategic commissioning function. This new shared leadership approach will strengthen how CCGs work together - driving service improvements and channelling resources to where they are most needed - front line services.

## The story of the year: Shaping the future of Stroke services



As the culmination of its Stroke care review which started in 2014, in early 2018 the STP launched a 10-week public consultation on the future of urgent Stroke services in Kent and Medway. The STP's proposal, in response to national evidence, was to establish 3 Hyper Acute Stroke Units (HASUs) operating 24 hours a day, 7 days a week, to care for all Stroke patients across Kent and Medway. The Trust Board formally approved the Trust's response to the consultation in March 2018 and the Trust looks forward to hearing the outcome in the autumn of 2018.

More information about the Stroke care review and other workstreams of the STP is available at:

<https://kentandmedway.nhs.uk/>

## The story of the year: A new Strategy

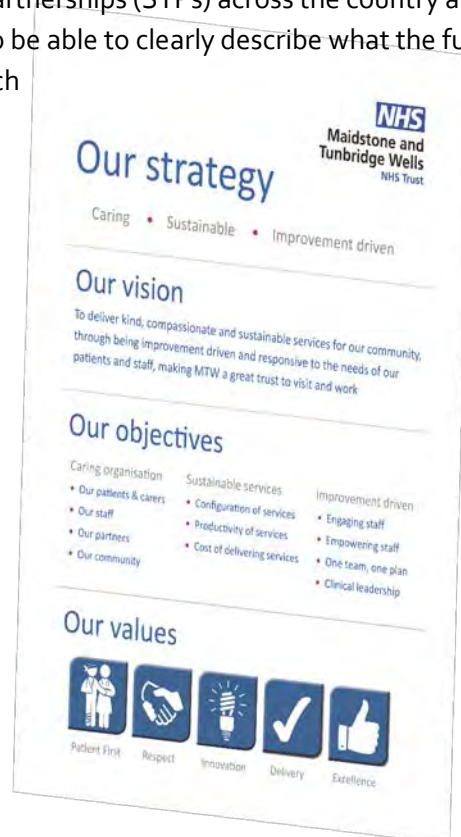
The Trust recognises that the next few years will be vitally important to its future and to the NHS in West Kent and the High Weald. Sustainability and Transformation Partnerships (STPs) across the country are pointing to new ways of working and it is crucial for the Trust to be able to clearly describe what the future looks like for its two hospitals and the wider system within which it provides care.

To ensure clarity in this, the Trust launched its new 5 year Strategy in late 2017, having developed its feedback from staff, patients and partner organisations.

The Strategy establishes the vision to “deliver kind, compassionate and sustainable services for our community, through being improvement driven and responsive to the needs of our patients and staff, making MTW a great Trust to visit and work in”.

Its 3 key strategic objectives in order to achieve its vision and become a high performing organisation are:

1. To be recognised as a caring organisation
2. To provide sustainable services
3. To be improvement driven across all areas



## The story of the year: Listening into Action

The Chief Executive announced the Trust's adoption of 'Listening into Action' (LiA) in June 2017. LiA is a process used successfully by now high performing Trusts that supports and empowers staff to make changes for the better. It does this through providing staff with a voice, across all levels of the organisation, and engaging them to make the changes they feel are important to patients and to the work of the Trust.



Work on LiA was kick-started with a 'Pulse Check' staff survey in June/July 2017, which aimed to determine current levels of staff engagement and help identify the frustrations that staff faced in undertaking their roles. The 'Pulse Check' generated around 1600 completed questionnaires and 2600 comments/ideas for improvement. Staff engagement was revealed as low and frustrations with resolving issues high. The Trust's results were average compared to others at the same stage of the LiA journey. Each Division developed an action plan to address the key concerns raised and these are monitored to track progress.

In July 2017, the Trust launched 10 clinical pioneer teams to bring about change on key identified issues within 20 weeks. To demonstrate a commitment to listening to staff, the Trust asked Consultant and Nursing leads for their top improvement ideas and ran an open evaluation process to select the 10 taken forward, which were:

1. Reducing time to theatre for Fractured Neck of Femur patients
2. Improving care for patients with Inflammatory bowel disease (IBD)
3. Improving access to Diabetes care for young adults
4. Shortening wait times in Ophthalmology through virtual clinics in Medical Retina
5. Shortening time to treatment for Oncology Prostate patients
6. Improving the use of GPs in the Emergency Department (ED)
7. Shortening wait times for Breast Clinic patients
8. Improving antenatal services at Maidstone Hospital
9. Streamlining the Pre Assessment process for the young, fit and well
10. Improving inefficient and frustrating IT systems for our junior doctors

By the end of 2017/18, all the pioneer teams had made a significant change within their areas with beneficial impact. Success was notably achieved through the teams engaging with colleagues and sharing their concerns before jointing identifying and then implementing a solution together. Taking just one of the schemes above - Shortening time to treatment for Oncology Prostate patients – the following differences were made against the original mission to integrate pre-biopsy prostate MRI findings into decision making within the prostate pathway and reduce MRI waiting times for patients:

- ▶ The median time to MRI based decision reduced from 35 days to 4 days
- ▶ The median time to biopsy discussion clinic, 34 days (range 13 to 38 days)
- ▶ No unnecessary post-MRI discussion clinics were held
- ▶ There was a 30% reduction in the number of Transrectal ultrasound guided (TRUS) biopsies

In September 2017, the Trust ran a series of 'crowdfixing' events, open to up to 80 staff at a time, to further explore the changes that staff wished to see. Feedback from those attending was very positive and identified 5 key areas of significant concern for staff. Then, at the beginning of 2018, 'Pass It On' events showcased what had been achieved through LiA to date, particularly celebrating the success of the Clinical Pioneer Teams. Towards the end of 2017/18, the Trust also looked to identify the next clinical teams by providing each Directorate with the opportunity to run an LiA improvement process as well as supporting the first 10 with the next step on their improvement journey.

## Key issues and risks affecting delivery of the Trust's key objectives

The Trust Board agreed the following key objectives for 2017/18:

- ▶ To reduce mortality (Hospital Standardised Mortality Ratio (HSMR)) in line with the national average
- ▶ To deliver the agreed 2017/18 trajectory for the A&E 4 hour waiting time target
- ▶ To maintain a vacancy rate of no more than 8.5%
- ▶ To deliver the control total for 2017/18 (of a pre-Sustainability and Transformation Fund (STF) deficit of no more £4.5m, or otherwise agreed by NHS Improvement)
- ▶ To deliver the agreed 2017/18 trajectory for the 62-day Cancer waiting time target
- ▶ To deliver the agreed Referral to Treatment (RTT) trajectory for patients on an 'incomplete' pathway

The key issues and risks affecting delivery of these (as described in the Trust's Board Assurance Framework – see the "Annual Governance Statement for 2017/18") are outlined on page 18. Details of how the Trust actually performed in response to these can be found in the "Performance analysis" section (pages 23 to 24).

### To reduce mortality (Hospital Standardised Mortality Ratio (HSMR)) in line with the national average

In order to achieve this, it was known that the following potential risks needed to be managed effectively: inappropriate/insufficient being afforded to the priority; insufficient analytical support to understand the data; failure to follow best practice in response; and lack of ownership by Clinical Directorates.

### To deliver the agreed 2017/18 trajectory for the A&E 4 hour waiting time target

In order to achieve this, it was known that the following potential risks needed to be managed effectively: the capacity required to deliver the 'new norm' for non-elective activity being insufficient; A&E attendances continuing to remain higher than plan; bed occupancy remaining above 92%; the level of Delayed Transfers of Care (DTOCs) remaining higher than the expected standard; failure of the Trust to adopt and/or implement the latest best practice in relation to patient streaming and other aspects; and the identified Social Care changes that create capacity failing to materialise

### To maintain a vacancy rate of no more than 8.5%

In order to achieve this, it was known that the following potential risks needed to be managed effectively: a national shortage of certain staff groups; lack of clarity/focus on the key actions required and the performance required by each Directorate, and the monitoring of such performance; inefficiency of recruitment processes; lack of urgency/commitment by recruiting managers; uncertainty over the status of vacancies; and absence of Director-level ownership of the objective.

### To deliver the control total for 2017/18 (of a pre-Sustainability and Transformation Fund (STF) deficit of no more £4.5m, or otherwise agreed by NHS Improvement)

In order to achieve this, it was known that the following potential risks needed to be managed effectively: lack of senior leadership and commitment; poor financial controls (or poor application of good controls); lack of commitment by managers; if the level of the Cost Improvement Programme (CIP) has not been fully identified and CIP schemes were not rated 'green'; development of the Trust's plans for 2017/18 without consideration of best practice elsewhere; non-acceptance of the Trust's plans by NHS Improvement (NHSI); and insufficient engagement with external stakeholders

### To deliver the agreed 2017/18 trajectory for the 62-day Cancer waiting time target

In order to achieve this, it was known that the following potential risks needed to be managed effectively: insufficient engagement by clinical staff outside of the Cancer and Haematology Directorate; pathways not being optimal in relation to achieving the required performance; insufficient communication of the performance needed beyond the Cancer and Haematology Directorate (as only 1/3 of delivery was within that Directorate's control – the remainder is within Diagnostics, Surgery & Medicine).

### To deliver the agreed Referral to Treatment (RTT) trajectory for patients on an 'incomplete' pathway

In order to achieve this, it was known that the following potential risks needed to be managed effectively: an insufficient level of elective and Outpatient activity being undertaken; and continuation of non-elective activity at existing levels (including ED attendances).

The controls in place to manage the identified risks described above were monitored by the Trust Board and other forums throughout the year.



## Adoption of the 'going concern' basis

The Department of Health and Social Care (DHSC) Group Accounting Manual (GAM) requires the management of the Trust to consider the following public sector interpretation of International Accounting Standards (IAS) 1 in respect of applying the going concern assumption when preparing its accounts, stating:

"For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern. DHSC group bodies must therefore prepare their accounts on a going concern basis unless informed by the relevant body or DHSC sponsor of the intention for dissolution without transfer of services of function to another entity. A trading entity needs to consider whether it is appropriate to continue to prepare its financial statements on a going concern basis where it is being, or is likely to be, wound up"

The Trust Board has assessed the Trust's ability to continue for the foreseeable future in the light of the GAM guidance, and assessed material uncertainties arising. The Trust has prepared the 2017/18 accounts on a "going concern" basis following consideration of the following:-

- ▶ There has been no expectation raised in the public arena that healthcare services will not continue to be provided from the two hospital sites.
- ▶ The Trust submitted its initial business plan to NHS Improvement (NHSI) in March 2018 setting out its operational plans for the following financial year (2018/19) and its capital plans for five years. The final plan submission was made on 30<sup>th</sup> April 2018
- ▶ The Trust continues to fully participate in the Sustainability and Transformation Partnership (STP) planning process including the submission of the forward 5 year financial and operating plans on a going concern basis. The Trust is leading some of the significant workstream areas and is a key partner in consideration of the shape of services in the STP for the future.
- ▶ The Trust has existing contracts in place for provision of healthcare services for 2018/19 being the second year of contracts signed in 2017/18. This includes the Aligned Incentives Contract (AIC) with two of its Clinical Commissioning Groups (CCGs): West Kent (the Trust's main commissioner) and High Weald Lewes Havens. The exact value of the year two contracts will be concluded using the agreed contract approach as part of the current business planning round. The current level of difference under discussion is immaterial in value.
- ▶ The Trust has prepared and will be submitting cash-flow forecasts for 2018/19 as part of its planning returns which do not include any assumptions of additional required working capital finance.
- ▶ There are no plans to dissolve the Trust or to cease services without transfer to any other NHS body.

The material uncertainties that the Trust has assessed and disclosed in its annual accounts are:

- ▶ To achieve its 2018/19 control total the Trust will need to deliver a challenging cost improvement programme plus a significant level of other non-recurrent measures. At this stage there is risk around the ability of the Trust to deliver this level of savings within 2018/19
- ▶ Failure to achieve the Trust's control total could necessitate additional in year working capital finance to support the Trust's liquidity position and its ability to repay the first of its working capital loans that falls due for repayment in February 2019 (£16.9m)

## Performance summary for 2017/18

The Trust's performance activities can be found in full within the monthly Trust Board reports, which are available for review at <https://tinyurl.com/MTWTBReports>

Performance for the year was varied. Performance against the Trust's agreed objectives, including the delivery of the financial plan, is described in detail in the "Development and performance in 2017/18" section on the following pages.

The Trust achieved successes in the following areas:

- ▶ Infection prevention and control - the Trust's strong performance in the field of infection prevention and control continued: the Clostridium difficile standard was achieved, with 25 cases against a maximum of 27 cases for the year, equating to a rate of 9.5 cases per 1000 occupied bed days (2016/17, 10.5). There were no cases of post 48 hour MRSA bacteraemia in the year
- ▶ Reduction of patient falls - The rate of Falls per 1,000 occupied bed days was below the Trust maximum limit of 6.0 at 5.98 for the year (2016/17, 6.07)
- ▶ Stroke – 90.9% of Stroke patients spent 90% of their time on a dedicated Stroke ward, attaining a rate of 90.9% (2016/17, 88.5%) against a target of 80%
- ▶ Complaints management – the rate of new complaints fell to 1.93 per 1000 episodes (2016/17, 2.47), which was well within the expected range of between 1.318 and 3.92
- ▶ Accident and Emergency – Less than 5% of patients left the Trust's A&E departments before being seen and the standard of 95% of patients arriving in A&E being assessed within 15 minutes of arrival was achieved. 58.4% of patients arriving in A&E were treated within 60 minutes of arrival against a target of 50% (an increase of 7% on 2016/17)
- ▶ Cancelled operations – The Trust achieved the national maximum limit of 0.8% of operations cancelled at the last minute

Elsewhere, the Trust underperformed on several targets, including those relating to Cancer waiting times, Access to treatment and Delayed Transfers of Care. More details are provided in the "Annual Governance Statement for 2017/18" section later.

Further details on the performance standards for quality of care can be found in the Trust's Quality Accounts for 2017/18, which are available in full on the Trust website ([www.mtw.nhs.uk](http://www.mtw.nhs.uk)).



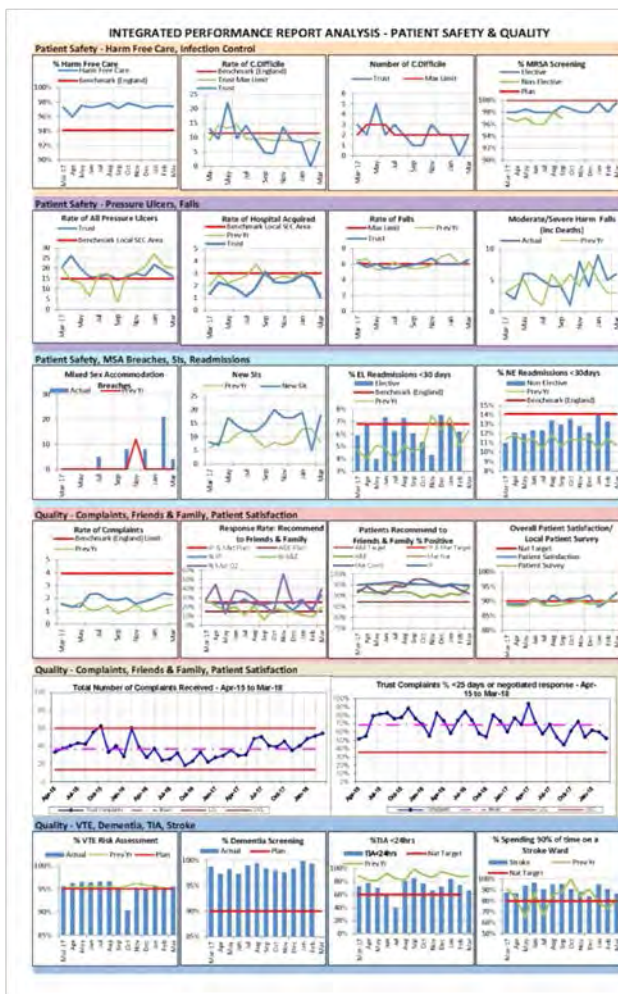
# Maidstone and Tunbridge Wells NHS Trust



## Performance Report for 2017/18: Performance analysis



# How the Trust measures performance



The Trust's Performance Management framework is based upon the national Single Oversight Framework and reinforces accountability for delivery at Divisional level. A 'Ward to Board' approach is applied and is monitored through a sign-off process at Directorate, then Divisional level before presentation at monthly Executive Performance Review meetings and ultimately, the Trust Board.

A whole day each month is devoted to Trust-wide performance management, attended by members of the Executive Team. The Clinical Divisions and Corporate services are accountable for the delivery of their key indicators for quality, performance, finance and workforce, together with their strategic and Trust-wide programme responsibilities. Every 6 months, a 'deep dive' review is held with the Divisions to promote further understanding of data trends and links and to provide focussed challenge and support.

The monthly Trust Board performance dashboard, which encapsulates the result of

these processes, provides the Board with a rich source of information which has been fully reviewed and substantiated at all levels of the Trust. The dashboard contains details of all key aspects of performance, under the CQC domains of "Safety", "Effectiveness", "Caring", "Responsiveness" and "Well-Led". A traditional 'Red, Amber, Green' (RAG) rating system is used to highlight variances against the Trust's plans for the year and/or the required national target. "Green" means "Delivering or exceeding target", "Amber" means "Underachieving target" and "Red" means "Failing target". Additional performance information is provided on financial matters and clinical quality. These reports are available on the Trust's website, as part of the information provided for Trust Board meetings (see [www.mtw.nhs.uk/about-us/trust-board/](http://www.mtw.nhs.uk/about-us/trust-board/)).

The content of the Performance Dashboard is discussed at meetings of the Trust Management Executive (TME) and Trust Board. The Director responsible for each domain is asked to highlight any key issues of note, and provide an explanation for any areas of under / failing performance. At the Trust Board, the previous month's performance is summarised within a "story of the month".

Performance against the Trust's agreed objectives is measured and monitored via the Board Assurance Framework, which is described in more details in the "Annual Governance Statement for 2017/18" later in the Report.

In addition to this, the Trust continues to use nationally-published information (where available), to compare performance. This includes national staff and patient surveys (which are described elsewhere in this Annual Report); and national clinical audits.

## The link between Key Performance Indicators (KPIs), risk and uncertainty

The Trust uses the wide range of KPIs to identify areas of risk and uncertainty. Where these risks and uncertainties can be controlled, these are aimed to be included within the Trust's plans. However, if monitoring of KPIs reveals that performance is at variance from the Trust's plans, mitigating actions may be implemented. The very wide range of information the Trust collates means that the relationship between different pieces of information is very complex. In this regard, the Trust engages the specialist analytical skills of staff within the finance, Human Resources and Business Intelligence departments to identify themes, variance from plans etc., and advise on potential actions to address and variances, or recommend the enacting of mitigations.

## Development and performance in 2017/18

The 'key issues and risks affecting delivery of the Trust's objectives' were described earlier in the Report. The Trust's actual performance against each of its 2017/18 objectives is described below.

### To reduce mortality (Hospital Standardised Mortality Ratio (HSMR) in line with the national average

This objective was fully achieved (i.e. rated green within the Board Assurance Framework). The standard HSMR calculation uses a 12 month rolling view of performance. The data for the 12 months from January to December 2017 showed the Trust's HSMR to be 103.1 (and the lower confidence interval crosses the national average relative risk of 100, which therefore equates to the Trust's rate being within the expected range).

### To deliver the agreed 2017/18 trajectory for the A&E 4 hour waiting time target

This objective was partially achieved (i.e. rated amber within the Board Assurance Framework). The Trust's performance for 2017/18 was 89.08%. However, this compared to 87.12% in 2016/17, and the Trust continues to perform significantly better than the national average. In both February and March 2018, the Trust's performance was more than 10 percentage points higher than the national average, which placed the Trust in the top performing 20% of Trusts.

### To maintain a vacancy rate of no more than 8.5%

This objective was not achieved (i.e. rated red within the Board Assurance Framework). The vacancy rate at the end of 2017/18 was 10.5% (which compared to 8.3% in 2016/17).

### To deliver the control total for 2017/18 (of a pre-STF deficit of no more £4.5m, or otherwise agreed by NHS Improvement)

This objective was not achieved (i.e. rated red within the Board Assurance Framework). The Trust's year-end deficit for 2017/18 was £10.9m (including Sustainability and Transformation Fund (STF)) which was £17.6m adverse to the original plan. The Trust achieved the revised forecast that was set in January 2018 of a pre-STF deficit of £17.9m.

### To deliver the agreed 2017/18 trajectory for the 62-day Cancer waiting time target

This objective was not achieved (i.e. rated red within the Board Assurance Framework). As the data for Cancer waiting times runs one month behind other performance measures, the final year-end position for 2017/18 was not available at the date of publication. However, 62-day waiting time performance remained static in February 2018 at 67.6%, whilst the forecast 62-day position for March (which was undergoing validation at the time of publication) was 67.7%.



## To deliver the agreed Referral to Treatment (RTT) trajectory for patients on an 'incomplete' pathway

This objective was not achieved (i.e. rated red within the Board Assurance Framework). Performance at the end of March 2018 was 81.0% which represented a decrease from that in February 2018. The (revised) trajectory required the Trust to achieve 82.9% by the end of March 2018.

## Financial performance in 2017/18

The Trust has had another challenging year financially and continued to be in financial special measures (FSM) as it has been unable to meet its control total. The Trust has been working with NHS Improvement (NHSI) on FSM and has met some of the requirements to come out of Special Measures, the remaining requirement is to demonstrate delivery of financial plans in 2018/19.

The Trust reported a deficit of £10.9m, post Sustainability and Transformation Funding (STF), which was £17.6m adverse to plan. The key drivers of this variance were as follows:

- ▶ There was a shortfall on STF income of £4.3m
- ▶ The plan included £19m of unidentified cost improvement programme (CIP) schemes which were identified throughout the year however the Trust finished the year £9.2m under delivery on its CIP
- ▶ Income shortfalls on private patient income (£3.5m) and Oncology clinical income (£3.1m)
- ▶ The Trust received additional income for winter pressures (£1.2m) and the Aligned Incentives Contract (AIC) risk reserve (£1.5m)

## Income and Expenditure (Financial Performance)

The table below compares the Trust's income and expenditure plan to the year-end financial position.

Statement of Comprehensive Income	2017/18 (Plan) £m	2017/18 (Actual) £m	Variance £m
Income	436.62	440.27	3.65
Operating expenses	(414.40)	(421.21)	(6.81)
<b>Operating Surplus / (Deficit):</b>	<b>22.22</b>	<b>19.06</b>	<b>(3.17)</b>
Finance income	0.04	0.05	0.01
Finance expense	(15.15)	(15.12)	0.03
PDC dividend charge	(1.47)	(0.45)	1.02
<b>Net finance costs</b>	<b>(16.57)</b>	<b>(15.52)</b>	<b>1.05</b>
Other gains / (losses)	0.00	0.09	0.09
<b>Surplus / (deficit) for the year before technical adjustments</b>	<b>5.65</b>	<b>3.62</b>	<b>(2.03)</b>
Technical adjustments	1.02	(14.55)	(15.57)
<b>Surplus / (deficit) for the year after technical adjustments</b>	<b>6.67</b>	<b>(10.92)</b>	<b>(17.60)</b>

## Income

The Trust's income was £440.27m which was above plan by £3.65m by the end of the financial year. This was mainly due to STF income being below plan by £4.3m and private patient income underperforming by £3.5m. This was offset by favourable variances in clinical income (£1.2m), Education, Training and Research (£0.6m) and on pass through costs for the Sustainability and Transformation Partnership (STP) and Patient Administration System (PAS) implementation of £7.9m and £2.9m respectively.

The Trust had a challenging winter period where it faced an increasing demand of non-elective activity during quarter 4 of 2017/18. The Trust had planned for this with reduced elective activity planned to manage the increases in non-elective activity. However, the period of escalation lasted longer than expected which led to reductions in elective (£11.2m) and outpatient (£5.4m) activity. This was offset by increases in non-elective activity (£11.2m) and Emergency Department (£2.6m). This was the first year of the AIC which meant that the income from West Kent Clinical Commissioning Group (CCG) was protected from these variances in activity by £4.0m. The majority (80%) of the Trust's income was from CCGs or NHS England.

## Expenditure

The Trust's expenditure was £421.21m which was £6.81m adverse to plan. Pay expenditure was £7.56m adverse to plan, mainly due to slippage on Cost Improvement Programme (CIP) schemes of £6.3m, plus Bank and Agency expenditure to cover vacancies, and additional cover for winter escalation, of £1.4m. Non-pay expenditure was £0.75m favourable to plan, £15.7m favourable relating to reversals of impairments (offset as a technical adjustment) and £10.5m of which related to pass through costs for the STP and PAS. The remainder was £2.3m of unachieved CIP, £0.7m for High Cost Drugs and £2.2m for other items.

## Cost Improvement Programme (CIP)

The Trust delivered £22.5m of its cost improvement programme, against a target of £31.7m.

CIP programme by work stream	2017/18 Plan £'000	2017/18 Actual £'000	Variance £'000
Cancer & Haematology (Planned Care)	2,398	1,821	(577)
Critical Care (Planned Care)	2,170	1,519	(651)
Diagnostics (Planned Care)	1,843	1,154	(689)
Head and Neck (Planned Care)	982	865	(117)
Surgery (Planned Care)	1,796	1,042	(754)
Trauma & Orthopaedics (Planned Care)	5,090	5,156	66
Patient Admin (Planned Care)	110	116	6
Private Patients Unit (Planned Care)	163	128	(35)
<b>Total for Planned Care</b>	<b>14,552</b>	<b>11,801</b>	<b>(2,751)</b>
Urgent Care	8,884	4,796	(4,088)
Women's, Children's & Sexual Health	3,651	1,884	(1,767)
Estates & Facilities	2,758	1,555	(1,203)
Corporate	1,877	2,451	574
<b>Total across all work streams</b>	<b>31,722</b>	<b>22,487</b>	<b>(9,236)</b>

## Capital Expenditure plan

During the year the Trust made capital investments of £11.5m including £0.2m of assets funded from donated or charitable fund sources. Significant elements of the programme were £2m of improvements to energy infrastructure (including £0.7m funded from Salix loans<sup>4</sup>), £1.8m on backlog maintenance and estates renewals, £0.6m on GP Emergency Department streaming accommodation funded by central Public Dividend Capital (PDC) and £0.5m was associated with the enabling works for a Linear Accelerator (LinAc) bought in 2016/17.

<sup>4</sup> Salix Finance Ltd. provides interest-free Government funding to the public sector to improve their energy efficiency, and is funded by the Department for Business, Energy and Industrial Strategy, the Department for Education, the Welsh Government and the Scottish Government.

Equipment spend in the year included £1.7m funded by national PDC for another replacement LinAc at the Cancer Centre at Maidstone Hospital, £0.5m on Tunbridge Wells Hospital theatre equipment, and £1.4m for medical equipment replacement.

£2.3m of investment was made in ICT infrastructure and equipment including implementation costs for the new PAS.

## The Trust's statutory (i.e. legal) duties

As an NHS Trust, the organisation has a number of statutory financial duties, which are explained below.

### External Finance Limit (EFL)

The Trust is required to demonstrate that it has managed its cash resources effectively by staying within an agreed limit on the amount of cash it can borrow and spend. In 2017/18 the Trust met its target by managing the year-end position to underspend the EFL by £0.5m with the actual closing cash balance being £1.5m. In order to support the Trust's financial position an additional £13.99m of working capital financing was agreed with the Department of Health and Social Care (DHSC) and issued as interest bearing loans at an interest rate of 3.5%, repayable in 2020/21.

### Capital Resource Limit

The Trust is expected to manage its capital expenditure within its agreed Capital Resource Limit (CRL). For 2017/18 the Trust's CRL was £10.59m which was underspent by £0.98m. This underspend managed the Trust's capital spend within its available cash resource which was lower than its CRL and helped support the Trust's Financial Recovery Plan.

### Break-even duty

Each NHS Trust has a statutory duty to break-even taking one year with another, measured as the Income and Expenditure position adjusted for specific technical exclusions. This duty is formally measured over a 3 year period or a 5 year period if agreed with the DHSC.

The Trust's latest 3 year break-even cycle commenced in 2013/14 and was not met by the end of the period in 2015/16. The Trust's break-even period has therefore been extended with the plans submitted for 2018/19 aimed at reducing the accumulated deficit towards the target of formal cumulative break-even by 2021/22.

## Accounting Issues

The Accounts have been prepared in accordance with guidance issued by the DHSC and in line with International Financial Reporting Standards (IFRS) as applied in the DHSC Group Accounting Manual. The accounts were prepared under the "Going Concern" concept in line with the DHSC Group Accounting Manual requirements for management consideration. This has been set out in the "Overview" section above.

## External Auditors

The Trust's External Auditors are Grant Thornton UK LLP. Their charge for the year was £68,500 excluding VAT (in 2016/17 this was £85,069 excluding VAT) which includes the audit of the Quality Accounts. Grant Thornton UK LLP did not undertake any non-audit work for the Trust in 2017/18.



## Looking forward to 2018/19

The Trust has set a planned surplus of £11.7m which includes receipt of £12.7m Provider Sustainability Fund (PSF) during 2018/19. To deliver this surplus the Trust will need to deliver a £24.1m CIP. The overall plan shows that 2018/19 will continue to be financially challenging but the underlying position is improving. The table below sets out the Trust's 2018/19 financial plan submitted to NHS Improvement.

Statement of Comprehensive Income	2018/19 (Plan) £m
Income	466.2
Expenditure	(427.3)
EBITDA (deficit):	38.9
EBITDA %	8%
Depreciation & other	(10.1)
Net interest	(15.8)
PDC dividend	(1.3)
Impairments	(1.0)
<b>Total financing and impairments</b>	<b>(28.2)</b>
<b>Deficit (before technical adjustments)</b>	<b>10.7</b>
<b>Technical adjustments</b>	<b>1.1</b>
<b>Deficit (after technical adjustments)</b>	<b>11.7</b>

The key movements from the 2017/18 out-turn to the 2018/19 plan are inflationary factors such as pay awards; incremental drift; apprentice levy and non-pay (£7.9m); full year impact of investments and non-recurrent CIP schemes (£10m) and a contingency plan of £3.8m. This is offset by the planned £24.1m CIP, non-recurrent savings of £7.3m and NHS tariff inflation and demographic growth of £6.9m. The plan includes Provider Sustainability Funding (PSF) of £12.7m replacing the STF of £11.2m.

The Trust is planning a rolling five year capital programme of total value £61m (excluding donated assets). This includes the following areas of investment:

- ▶ Essential improvements in Maidstone backlog estates (£6.3m) and Tunbridge Wells Hospital lifecycle (£4.6m)
- ▶ Energy infrastructure improvements that the Trust plans to seek through Salix funding (£1.2m)
- ▶ The Trust is planning to apply for loan funding to renew its theatre block at Maidstone Hospital which is nearly 35 years old (£20m over 2 years: 2019/20 and 2020/21) though this may form part of a future STP bid
- ▶ The plan includes the Trust's bid for NHS England capital funding under the national programme of updating LinAcs (£1.8m) with the associated Trust resourced enabling works and other equipment (£1.2m). Looking forward the Trust will be seeking loan funding to maintain its programme of LinAc replacement (£7.5m over 3 years)
- ▶ The Trust's plan includes essential replacement equipment provision of circa £8m over the 5 year period and ICT projects of £4m. In addition the Trust needs to urgently replace some critical Imaging equipment (CT scanners) and will be looking to apply for capital loans to enable this to take place (£3.2m).

The primary source of capital funding is internally generated cash through depreciation and capital receipts received on the planned sale of assets, net of repayments of principal on the existing capital loans, PFI lease repayments and PFI lifecycle repayments. In addition the Trust plans to seek loan and PDC financing for specific investments as set out above.



# Maidstone and Tunbridge Wells NHS Trust



## Performance Report for 2017/18: Summary of Quality Accounts



Quality Accounts are intended to aid the public's understanding of what the Trust does well; identify where improvements in service quality are required; and list the improvement priorities for the coming year.

This section contains a summary of the Quality Accounts for 2017/18, but the full Quality Accounts can be found on the Trust's website ([www.mtw.nhs.uk](http://www.mtw.nhs.uk)), or the Trust's pages on the NHS Choices website ([www.nhs.uk/Services/Trusts/Overview/DefaultView.aspx?id=1178](http://www.nhs.uk/Services/Trusts/Overview/DefaultView.aspx?id=1178)).

### Performance against selected key priorities for 2017/18

Performance against some of the 2017/18 priorities, as stated in the 2016/17 Quality Accounts, is detailed below.

#### Patient Safety: To create reliable processes that will build a supportive environment to reduce avoidable harm

Examples of the goals set, and the action taken in response is described below:

- ▶ "Demonstrate an embedded safety culture within all departments undertaking invasive procedures, which complies with the World Health Organisation (WHO) surgical safety methodology": The WHO safety checklist has been further revised for use in Theatres to include anaesthetic nerve blocks and to refine the process for the identification and management of specimens. An assurance auditing process has been introduced to monitor the standard of WHO checklists. A review of the National and Local Standards for invasive procedures continues, working with all Directorates and Specialities to ensure these standards are met.
- ▶ "Reduce mortality figures in line with the national average (HSMR/SHMI) through the work of our Mortality Steering group": The observed Mortality rates have been reduced in keeping with expected rates and the Trust is no longer an outlier amongst its peers. A revised mortality review process was introduced in October 2017 as per National Quality Board Guidance (2017) and the Trust's Mortality review compliance is now demonstrating an improvement.
- ▶ "Improve outcomes for expectant mothers and their babies in line with the Maternal and Neonatal Health Safety Collaborative": The Trust's Maternity service has been selected by NHS England to be a Maternity Choice and Personalisation Pioneer and many of the Trust's patients have joined the pilot. In addition work is ongoing to reduce: perineal trauma through the introduction of slow birthing techniques, warm perineal compresses and good birth positioning; reduce unanticipated admission to the Neonatal Unit - introduction of the bobble hat initiative is currently being trialled following positive results in another organisation; and to reduce stillbirths.

#### Patient Experience: To improve the use of current feedback mechanisms and provide more innovative ways to receive and act upon feedback

Examples of the goals set, and the action taken in response is described below:

- ▶ "Achieve consistent monthly response rates to the Friends and Family Test": The Trust's Representative group continues to meet regularly to review the project pathways, data analysis and to maintain a raised awareness of the Friends and Family question. The group continues to explore the feasibility of establishing e-mail alerts to enable earlier response to feedback. Work is progressing between IT and the Paediatric lead for 'iWantGreatCare' (IWGC) to review the IWGC app within Children's services which will seek to promote an increase in feedback
- ▶ "Continued work with external partners such as Healthwatch, NHSI, CQC and West Kent CCG to help inform the Trust Board of areas for concern": Regular contact meetings with Healthwatch, the CQC,

NHSI and West Kent CCG are in place to seek and provide assurance in respect of standards of care provided to the Trust's patients

- ▶ "Development of a framework to report and monitor the incidence of harm affecting those with cognitive impairment (dementia)": A framework for reporting has been devised via the Dementia Strategy Group. A total of 129 incidents were reported for dementia patients, of these 13 were due to pressure damage; 82 due to falls; 15 due to aggression and 19 had other causes.

### Clinical Effectiveness: To improve the management of patient flow

Examples of the goals set, and the action taken in response is described below:

- ▶ "Avoidance of unnecessary admissions to hospital through the increased use of ambulatory pathways of care for patients who attend the Trust's Emergency Departments": An Ambulatory Emergency Care bay opened in the Acute Medical Unit in December 2017, accepting all non-elective ambulatory patients and providing 4 spaces which have been configured as 3 trolleys and 3 chairs. Acute Frailty Units have been opened during the year at Maidstone and Tunbridge Wells Hospitals
- ▶ "Work with mental health partners to reduce the number of frequent attendances of patients in crisis attending the Trust's Emergency Departments": A Multi-Agency Project Group has been established and, at the end of 2017/18 the Trust reported a 43% reduction in attendances of the 25 patients who had been identified as most benefitting from a targeted multi-professional approach of their health needs
- ▶ "Development of pathways that will support the timely discharge of patients": In collaboration with its community colleagues at Kent Community Health Foundation Trust, the Trust has implemented the 'Home First model' which supports three discharge pathways: home with support; transfer to a community hospital for further rehabilitation and an interim placement in a Nursing home. The re-admission rate for patients discharged home is now reducing (from 25.23% baseline period 2016/17 to 23.33% in 2017/18).

### Quality improvement priorities for 2018/19

The Trust's quality improvement priorities are a small sample of the range of quality improvement work undertaken within the Trust in any 12 month period. The initiatives selected in previous years invariably continue into subsequent years, although the focus may change according to need. Selecting new initiatives each year ensures that a wide breadth of areas are covered and prioritised. The Trust's priorities for 2018/19 were developed through the engagement of a wide cross-section of its staff, and this process has culminated in the ongoing development of both the Best Care Programme and the Trust's new Quality Strategy 2018-2021, which will unify the achievement of these key deliverables.

The Trust's 3 quality priorities for 2018/9 are:

#### 1. Patient Safety: To create reliable processes that will build a supportive environment to reduce avoidable harm

The key objectives involve:

- ▶ Embedding an open and transparent culture that embraces 'lessons learned'
- ▶ Achievement of consistent recognition and rapid treatment of sepsis in both emergency and Inpatient departments and reduction in the number of avoidable deaths
- ▶ Improvement in outcomes for expectant mothers and their babies in line with 'Better Births (A Five Year Forward View for maternity care)' and the National Maternity Transformation Programme.

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## 2. Patient Experience: To improve the use of current feedback mechanisms and provide more innovative ways to receive and act upon feedback

The key objectives involve:

- ▶ The development of a patient engagement strategy to ensure views are gained and triangulated with themes and trends from patient surveys and complaints, etc. to improve pathways of care and inform strategic direction
- ▶ Continued work with external partners including Healthwatch, NHS Improvement, CQC and Clinical Commissioning Groups to help inform the Trust of areas for concern, and for inclusion in the Trust's Internal Assurance inspection programme
- ▶ To recognise and respond to the specific needs of patients with complex needs.

## 3. Clinical Effectiveness: To improve the management of patient flow

The key objectives involve:

- ▶ Avoiding unnecessary admissions to hospital through the development of alternative care models/pathways.
- ▶ Working with the Trust's mental health partners to reduce the number of frequent attendances of patients in crisis attending the Trust's EDs
- ▶ Work with the Trust's community and local authority colleagues to further develop pathways that will support the timely discharge of patients.

Progress against these objectives will be monitored as part of the Directorate and Trust-level governance structures. Assurance of progress against the above objectives will be presented at monthly Trust Management Executive meetings; Quality Committee and Patient Experience Committee meetings.



# Maidstone and Tunbridge Wells NHS Trust



## Performance Report for 2017/18: Sustainability Report





As an NHS organisation, and as a spender of public funds, the Trust has an obligation to work in a way that has a positive effect on the communities it serves. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets the Trust can improve health both in the immediate and long term, even in the context of the rising cost of natural resources. Demonstrating that the Trust considers its social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met. In order to fulfil its responsibilities for the role it plays, the Trust has the following sustainability mission statement/vision within its Sustainable Development Management Plan (SDMP): "The provision of Sustainable and Resilient Healthcare and Buildings to ensure Healthy People and Places in Maidstone and Tunbridge Wells NHS Trust".

As a part of the NHS, public health and social care system, it is the Trust's duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020. It is the Trust's aim to supersede this target by reducing its carbon emissions 28% by 2020/2021 using 2013/14 as the baseline year.

## Policies

In order to embed sustainability within the Trust's business it is important to explain where sustainability features in its processes and procedures. Sustainability is considered in relation to Travel, Procurement (environmental), Procurement (social impact) and Suppliers' impact, but not in relation to Business Cases. One of the ways in which an organisation can embed sustainability is through the use of a Sustainable Development Management Plan (SDMP). The Trust Board approved the SDMP during the year and the Trust's plans for a sustainable future are well known within the organisation and clearly laid out.

As an organisation that acknowledges its responsibility towards creating a sustainable future, the Trust helps to achieve that goal by running awareness campaigns that promote the benefits of sustainability to its staff.

## Partnerships

The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner. Crucially for us as a provider, evidence of this commitment will need to be provided in part through contracting mechanisms. However, the Trust has not yet established any strategic partnerships regarding this.

## Performance

### Trust size

Since the 2007 baseline year, the NHS has undergone a significant restructuring process and this is still ongoing. The Table below reflects how the Trust's size has changed over time.

Context info	2007/08	2014/15	2015/16	2016/17	2017/18
Floor space (m <sup>2</sup> )	109,896	138,533	138,533	138,533	138,533
Number of staff (WTE)	3,969	4,800	4,678	5,130	5,022

The Trust has supported the ambition outlined by the national Sustainable Development Strategy in 2014 to reduce the carbon footprint of the NHS by 28% (from a 2013 baseline) by 2020 as detailed below:

### Energy

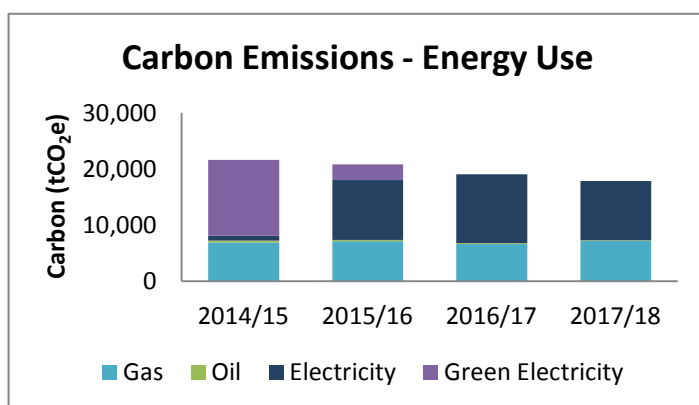
In 2017/18 the Trust saw a reduction of 7.6% in scope 1 and 2 carbon emissions compared with 2016/17 and emissions are now tracking at 12.8% below the baseline year. This is good progress and indicates that the

28% reduction target is achievable by 2020/21, provided the Trust maintains investment and momentum into energy saving and carbon reduction initiatives.

Resource <sup>5</sup>		2013/14	2014/15	2015/16	2016/17	2017/18
Gas	Use (kWh)	34,135,656	32,905,482	34,139,781	31,546,328	33,930,120
	tCO <sub>2</sub> e	7,242	6,904	7,145	6,593	7,194
Oil	Use (kWh)	955,973	1,110,958	635,113	532,926	313,362
	tCO <sub>2</sub> e	305	356	203	147	102
Coal	Use (kWh)	0	0	0	0	0
	tCO <sub>2</sub> e	0	0	0	0	0
Electricity	Use (kWh)	224,551	1,331,564	18,564,756	23,801,508	23,652,117
	tCO <sub>2</sub> e	126	825	10,673	12,301	10,542
Green Electricity	Use (kWh)	22,477,329	21,816,665	4,892,105	0	0
	tCO <sub>2</sub> e	12,585	13,512	2,813	0	0
Total energy CO <sub>2</sub> e		20,258	21,597	20,834	19,041 <sup>6</sup>	17,838
Total energy spend		£4,039,990	£3,814,599	£3,919,681	£3,835,790	£4,535,611

N.B. tCO<sub>2</sub>e = Tonnes of CO<sub>2</sub> equivalent. This is used to measure the equivalent CO<sub>2</sub> concentration which causes the same level of absorption in the atmosphere for other greenhouse gases.

2017/18 has seen the replacement of over 6000 lamps with low energy LED alternatives, all funded through Salix interest free loans. The year has also seen the installation of new energy efficient chillers, the upgrade of Burner Management System (BMS) controls for the theatre blocks and the addition of a heat recovery module to the main flue of one of the boilers.



The main focus for the next year at Maidstone Hospital is to complete the LED upgrade and continue the process of upgrading and optimising Heating, Ventilation and Air Conditioning (HVAC) plant and controls across the site. At Tunbridge Wells Hospital, Interserve FM has developed a similar list of initiatives and it is anticipated that these can be progressed in partnership with KESWHL.

<sup>5</sup> Data for energy resource usage before 2016/17 was reviewed and revalidated in 2016/17

<sup>6</sup> This figure has been amended to correct an error in the Annual Report 2016/17



## Travel

The Trust is committed to reducing the emissions associated with transport and providing efficient low carbon transport services across our operational environment and we have documented this through the publication of a green travel plan.

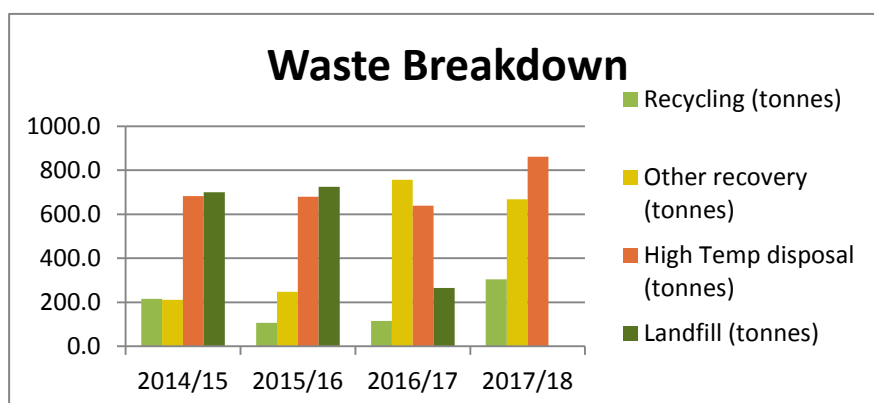
Category	Mode	2014/15	2015/16	2016/17	2017/18
Patient & visitor travel	Miles <sup>Q</sup>	104,162,344	107,404,988	112,158,231	115,563,332
	tCO <sub>2</sub> e	38,272.30	38,841.48	40,535.15	41,178.09
Business travel & fleet	Miles	1,170,280	1,319,789	1,037,636	1,059,360
	tCO <sub>2</sub> e	430	477	375	377
Staff commute	Miles	4,610,964	4,493,769	4,927,968	4,824,221
	tCO <sub>2</sub> e	1,694	1,625	1,781	1,719

N.B. tCO<sub>2</sub>e = Tonnes of CO<sub>2</sub> equivalent. This is used to measure the equivalent CO<sub>2</sub> concentration which causes the same level of absorption in the atmosphere for other greenhouse gases.

<sup>Q</sup> Totals for previous years have been re-stated due to patient & visitor travelled mileages and associated carbon footprint being automatically calculated using externally provided intensity figures

## Waste

The Trust is similarly committed to reducing its environmental impacts and is proud that it has sent no waste to landfill in the reporting period. A formal 3 phase waste strategy has been published that will coordinate and support the Trust's efforts to maintain compliance and to fully integrate the waste hierarchy into all aspects of its operations and to actively demonstrate best practice.



In 2018/19 the Trust has engaged upon several initiatives to reduce the production of waste and to dispose of waste in a more efficient and environmentally friendly manner. It has pioneered the use of the Pacto Safe system for the safe and secure bagging of soft cytotoxic waste, reducing the need for use of single use sharps containers. There has also been a

successful trial of reusable sharps containers in several key clinical environments across both main hospital sites & aims to roll out this initiative Trust-wide in 2018/19.

Waste	2013/14	2014/15	2015/16	2016/17	2017/18
Recycling (tonnes)	268.00	214.97	107.00	115.00	304.00
tCO <sub>2</sub> e	5.63	4.51	2.14	2.42	6.62
Other recovery (tonnes)	166.00	211.00	248.00	756.00	668.00
tCO <sub>2</sub> e	3.49	4.43	4.96	15.88	14.54
High Temp disposal (tonnes)	573.00	682.52	679.00	639.00	861.54
tCO <sub>2</sub> e	126.06	150.15	148.70	140.58	189.54
Landfill (tonnes)	723.00	699.42	724.00	265.00	0.0
tCO <sub>2</sub> e	176.71	170.95	176.96	82.15	0.00
<b>Total Waste (tonnes)</b>	<b>1730.00</b>	<b>1807.91</b>	<b>1758.00</b>	<b>1775.00</b>	<b>1833.54</b>
<b>% Recycled or Re-used</b>	<b>15%</b>	<b>12%</b>	<b>6%</b>	<b>6%</b>	<b>17%</b>
<b>Total Waste tCO<sub>2</sub>e</b>	<b>311.89</b>	<b>330.04</b>	<b>332.76</b>	<b>241.03</b>	<b>210.69</b>

## Water

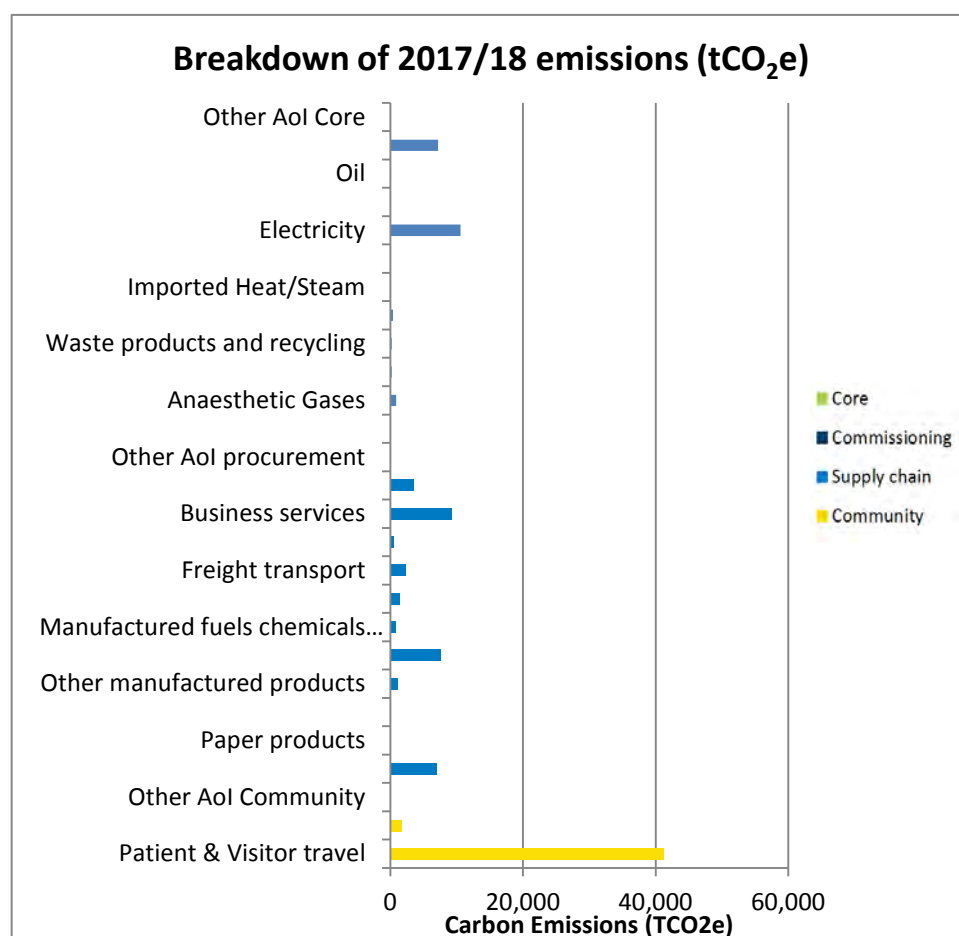
The Trust recognises that its water consumption is increasing on an annual basis, within its hospitals and laundry operations. The acute sites are completely linked to patient attendances and the laundry is due to the increased throughput at the sites and the extension of laundry services to other NHS Trusts. The Trust continues to install water saving equipment where possible in association with Aquafund to ensure that its facilities and equipment operate in the most efficient manner possible.

Water		2013/14	2014/15	2015/16	2016/17	2017/18
Mains	m <sup>3</sup>	186,570	186,441	205,246	209,205	225,383
	tCO <sub>2</sub> e	170	170	187	190	205
Water & Sewage Spend		£684,307	£539,538	£582,869	£661,990	£761,100

## Modelled Carbon Footprint

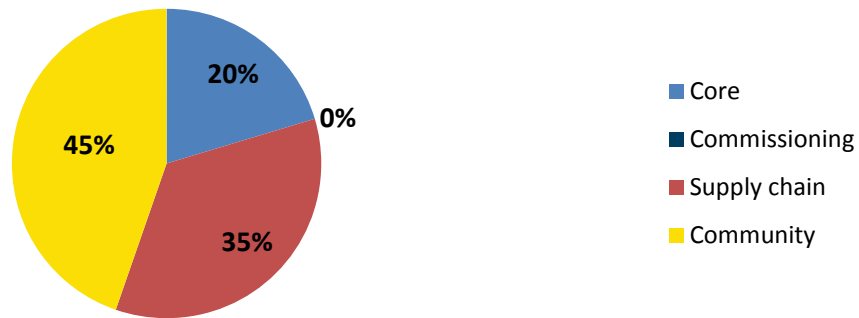
The information provided in the previous sections of this sustainability report uses the Estates Return Information Collection (ERIC) returns as its data source. However, the Trust is aware that this does not reflect our entire carbon footprint. Therefore, the following information uses a scaled model based on work performed by the Sustainable Development Unit (SDU) in 2009/10. More information is available at:

<https://tinyurl.com/NHScarbonfootprint>



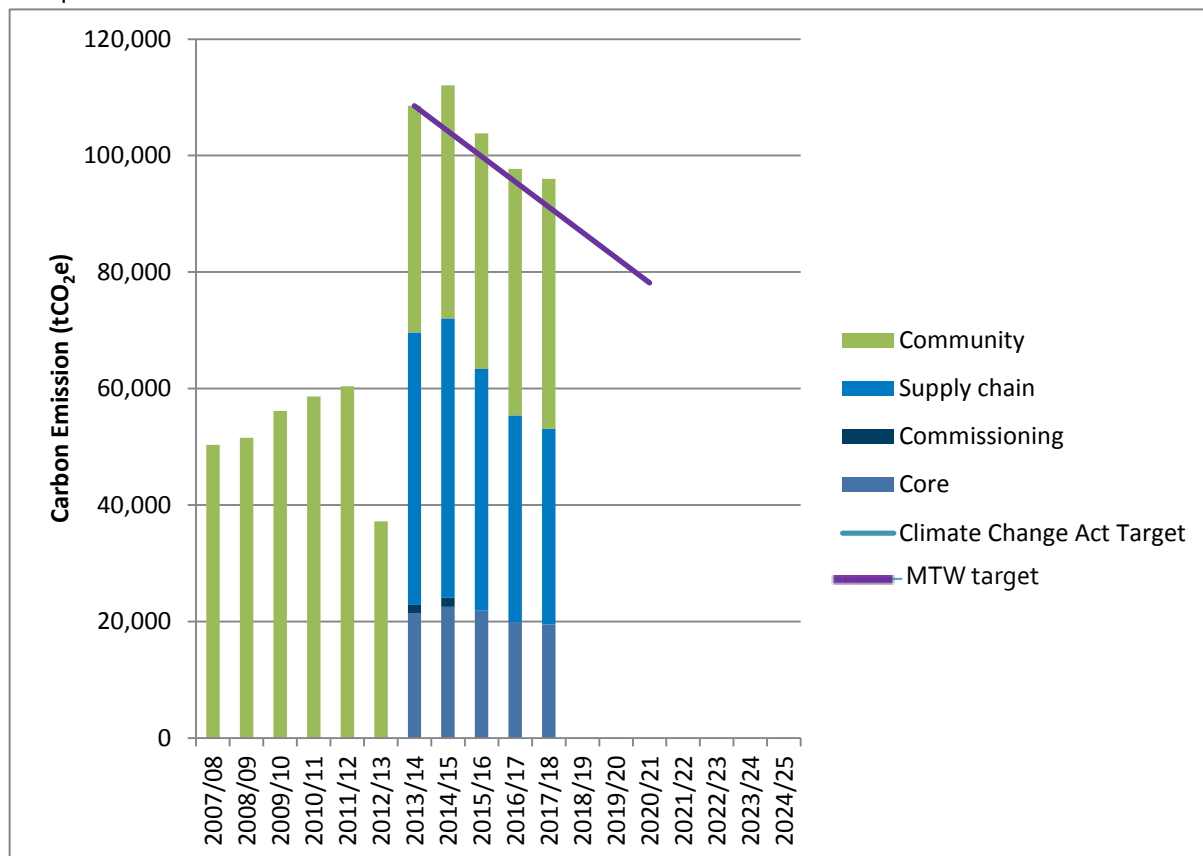
The application of this model results in an estimated total carbon footprint of 54,638 tonnes of carbon dioxide equivalent emissions (tCO<sub>2</sub>e). The Trust's carbon intensity per pound is 132 grams of carbon dioxide equivalent emissions per pound of operating expenditure (gCO<sub>2</sub>e/£). Average emissions for acute services is 200 grams per pound.

## Proportions of Carbon Footprint



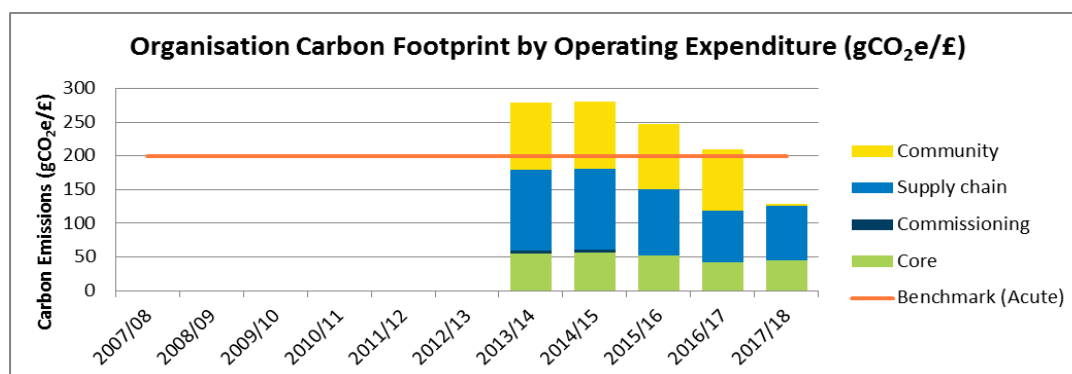
### Modelled trajectory

The Trust is committed to meeting the legal requirements of the Climate Change Act 2008 by reducing its emissions in line with the trajectory above. It is currently on track with reductions in respect to its direct emissions but progress is challenged by increasing patient attendances and their associated carbon footprint.



## Benchmarking

The table below shows the benchmark for acute trusts in carbon intensity against expenditure. The Trust is making good progress in meeting and exceeding this benchmark.<sup>7</sup>



## Adaptation

The Trust recognises that its buildings and facilities have a significant impact on the environment, both due to the embedded carbon and resource depletion involved in their construction and in the energy consumed and carbon produced in their operation. The Trust is ensuring that any refurbishment, redevelopment or new development seeks to minimise the environmental impact and associated carbon footprint of the construction process, the materials used and the subsequent operation of the facility through the use of appropriate technologies and strategies.

The Trust aims to ensure that any redevelopment or new development of its facilities appraises the potential changes to the climate, the potential effects of those changes on the facility and is seeking to mitigate them at the design stage.

The effects of climate change to the Trust have the potential to be severe, and the organisational risk register has been updated to include the appraisal of the legal, financial, infrastructure and service related risks and action plans have been developed to manage the risks that have been identified. The Trust has used standard risk assessment tools and externally available guidance and support to assist with the risk assessment process.

It is recognised that the process of climate change is leading to the normal patterns of weather changing and severe weather events becoming more frequent and prolonged. These include heatwaves, drought and water shortage, extreme cold events and associated snowfall, extreme rainfall and associated fluvial (surface water) flooding, changes to groundwater levels and associated groundwater flooding, severe storms and high winds. The Trust has prepared plans for the risks identified and has integrated the process of planning with the existing processes for Emergency Planning and Business Continuity.

## Green space & biodiversity

The Trust recognises that its grounds and green spaces are an asset, both due to the natural capital that they represent as a habitat and ecosystem but also as a resource for local communities to utilise and enjoy. The Trust is increasing access to its green spaces and natural environments for stakeholders and will maintain and enhance the biodiversity capacity of its managed estate. A Biodiversity Management Strategy for the entire estate is under development and the Trust will engage with local ecological partners and volunteers in its preparation. The Trust is committed to improving the health and welfare of its staff, both in and outside of the workplace, through the promotion of healthy living options, support services and the partnership with organisations that provide specialist services.

<sup>7</sup> Data is not available for the period prior to the 2013/14 financial year.



# Maidstone and Tunbridge Wells NHS Trust



## Accountability Report for 2017/18: Corporate Governance report



# Directors' report

## The Trust Board

The Trust Board meets monthly, except in August, in public. The times and venues of these meeting are available on the Trust's website, which also contains the agendas, minutes & reports (see [www.mtw.nhs.uk/about-us/trust-board/](http://www.mtw.nhs.uk/about-us/trust-board/)). The Trust Board formally operates in accordance with its Terms of Reference, the Trust's Standing Orders, Scheme of Matters Reserved for the Board and Scheme of Delegation, and Standing Financial Instructions.

The role of the Trust Board is to determine strategy and policy for the Trust, to monitor in-year performance against plans, to ensure accountability by holding the organisation to account for the delivery of strategy, and to ensure the Trust is well managed and governed. The Trust Board comprises the roles of Chair (Non-Executive), 5 other Non-Executive Directors (voting members), the Chief Executive, and 4 Executive Directors (voting members). Other Directors (non-voting) also attend the Board, and contribute to its deliberations and decision-making. The Non-Executive Directors (NEDs) bring a range of skills and expertise from outside the NHS; their role is to hold Executive Directors to account.

The Trust Board underwent significant changes during the course of the year with the arrival of a new Chair in May 2017; several new Non-Executive Directors, and Associate Non-Executive Directors; the appointment of the Deputy Chief Executive as Acting Chief Executive in September 2017; and the appointment of a new Director of Workforce and a new Chief Executive in December 2017 and January 2018 respectively. The Trust uses executive search facilities and advertising to attract the broadest range of appropriately skilled candidates when vacancies arise.

A Board Development Framework, informed by the practice of other NHS Trusts and key external guidance from NHS Improvement and the NHS Leadership Academy, was drawn up in November 2017, to reinforce the range of Board development activities already in place to support both new and established Board members. Part of the Board's winter away day in 2017 was then devoted to consideration of Board development needs and, starting in 2018, a programme of regular Board Seminars has been established to allow more focussed consideration of key themes collectively by the Board.

## Trust Board Members

Taking into account the wide experience of all Trust Board Members, the balance and completeness of the Board is considered to be appropriate. At the end of 2017/18, the Trust Board had the following members:

### David Highton

Chair of the Trust Board (from 8<sup>th</sup> May 2017)\*



David joined the Trust Board on 8th May 2017. Prior to this he was Ministerial Advisor on Private Sector Involvement and Public Private Partnership to the Minister of Public Health in Qatar. Since 2011, he was Executive Director of Corporate Development at Hamad Medical Corporation, the main public hospital provider in Qatar. Prior to moving to Qatar, David worked in the independent health sector, and was an NHS Chief Executive from 1991 to 2003, including at the Chelsea and Westminster Hospital NHS Trust and the Oxford Radcliffe Hospitals NHS Trust. Originally a Chartered Accountant, David worked in publishing, property services, the brewing industry, an industrial starches business, and in the City before joining the NHS as a Finance Director in 1990. David, who is married and has a grown up family, has strong links with Kent, having spent his childhood himself in Meopham & Sittingbourne, and currently lives in Whitstable.



## Trust Board Members (continued)

### Miles Scott

Chief Executive (from 8th January 2018)<sup>\*Σ</sup>



As the Trust's "Accountable Officer", Miles is responsible for the overall development and performance of the Trust. In addition to being a Board member, he attends several Board sub-committees. Miles joined the Trust on 8<sup>th</sup> January 2018. Miles has over 30 years' experience in the NHS encompassing acute, community and mental health services, the Department of Health and the King's Fund. Most recently, he worked at a national level with NHS Improvement, focusing on its establishment as a new national organisation and leading the national Ambulance Improvement Programme with NHS England. He was previously Chief Executive of St George's University Hospitals Foundation Trust (2011 to 2016) and prior to that Chief Executive at Bradford Teaching Hospitals NHS Foundation Trust (2005 to 2011) and Harrogate and District NHS Foundation Trust (2001 to 2005). Miles is married to Abbie and has two children aged 12 and 13. He lives in south west London with his family.

### Maureen Choong

Non-Executive Director<sup>\*△</sup>



Maureen joined the Board in August 2017 as an Associate Non-Executive Director, and was then appointed as a substantive Non-Executive Director in November 2017. She is a Registered Nurse with over 40 years of clinical and leadership experience within the NHS, prior to her retirement in 2016 from her role as Clinical Quality Director with NHS Improvement. Her previous roles included Deputy Chief Nurse with NHS London and both clinical and Director roles in NHS Trusts. Since retirement, Maureen has worked with Health Education England as an Improvement Associate. Maureen is married with two stepchildren and lives in Kent.

### Sarah Dunnett OBE

Non-Executive Director<sup>\*△</sup>



Sarah joined the Board in January 2014. Sarah arrived from Dartford and Gravesham NHS Trust, where she had been Chair for the previous 12 years. Sarah's previous experience is in the oil industry, where she held a variety of senior management roles. Her contribution to the NHS was recognised in the 2013 Queen's birthday honours list, when she was awarded an OBE. Sarah is married with three sons. In addition to her role on the Board as Vice Chair, Sarah attends several other Trust Board sub-committees, chairs the Quality Committee, and is the Vice-Chair of the Finance and Performance Committee and Charitable Funds Committee.

### Angela Gallagher

Chief Operating Officer<sup>\*Σ</sup>



Angela is the lead for the delivery of patient services through the Trust's Clinical Directorates. Angela joined the Trust in 2004 from North Middlesex University Hospital, and has worked in a variety of senior Nursing and management roles, most recently as Deputy Chief Operating Officer and previously as the 18-week programme director for the Trust. She joined the Trust Board in October 2011, and in addition to her role on the Board, attends several Board sub-committees.

### Simon Hart

Director of Workforce<sup>Σ</sup>



Simon joined the Trust in December 2017. Prior to this Simon was the Director of Human Resources (HR) & Organisational Development at Oxleas NHS Foundation Trust for 11 years. Before becoming a Director Simon worked in a number of HR positions at Guy's & St. Thomas' NHS Foundation Trust and other NHS organisations in London. Simon has been in the NHS for over 20 years, his first job being to support the introduction of clinical audit to Maidstone GPs in 1993. Simon holds a professional registration with the Chartered Institute of Personnel and Development (CIPD) and completed his MSc in HR leadership in 2006.

## Trust Board Members (continued)



**Nazeya Hussain**

Non-Executive Director<sup>8</sup>

Nazeya joined the Board in July 2017. Nazeya has 18 years' experience in the public sector and is currently Executive Director for Growth at London Borough of Kingston. Her expertise includes public/private sector ventures, asset and estate management, performance management, and organisational transformation.

She is married with two children and lives in Sussex.



**Tim Livett**

Non-Executive Director<sup>\*†</sup>

Tim joined the Board in June 2017. Tim is Chief Financial Officer of the Wellcome Trust, a global foundation which invests around £1bn pa into bio medical research and associated activities. At Wellcome he is responsible for Finance, Risk Management, IT and Grant Management activities. Prior to joining Wellcome in 2014, Tim has spent the majority of his career in commercial aviation, working for British Airways and, after a short break, at Virgin Atlantic, most recently in the role of Chief Financial Officer. He is married with three sons and lives in Surrey.



**Jim Lusby**

Deputy Chief Executive<sup>‡</sup>

Jim joined the Trust Board in April 2015 and leads on the development of strategy. Before joining the Trust Jim was a Portfolio Director at the NHS Trust Development Authority (TDA), with responsibility for oversight of NHS Trusts in the South East. During his final five months with the TDA he acted into the position of Director of Delivery & Development for the South of England. Jim joined the TDA from King's Health Partners where he was Director of Integrated Care. He previously held senior positions in South East London Strategic Health Authority, the Department of Health and the Prime Minister's Delivery Unit. Jim will be leaving the Trust Board at the end of April 2018 to undertake a secondment to join the Kent and Medway Sustainability and Transformation Partnership (STP) as Director of System Resilience and Improvement.



**Peter Maskell**

Medical Director<sup>\*Σ</sup>

Peter joined the Trust Board in February 2017. Peter qualified from The Royal Free Hospital School of Medicine in 1995. He trained in general and elderly medicine at St Thomas' Hospital/Brighton and Sussex University Hospital, where he also studied for an MSc in gerontology and cognitive decline. Peter became a Consultant in General and Geriatric Medicine with an interest in Stroke medicine at the Trust in 2005, and became clinical lead in 2007. Peter was then appointed as Medical Director of Kent Community Health NHS Foundation Trust in 2012 and during his time there, the Trust attained Foundation Trust status and a 'good' rating from the Care Quality Commission. Clinically, Peter continues to have interests in stroke, frailty and liaison geriatrics.



**Sara Mumford**

Director of Infection Prevention and Control

Sara joined the Trust Board in November 2007. She leads the Trust's infection prevention strategy. Sara is also a Consultant Microbiologist, and is the Clinical Director for Diagnostics, Pharmacy and Therapies. Sara joined the Trust in 2007, and has previously worked as Consultant Microbiologist at East Kent Hospitals University NHS Foundation Trust, and as a Consultant in Communicable Disease Control (CCDC) at Kent Health Protection Unit.

<sup>8</sup> Nazeya Hussain served as Associate Non-Executive Director from 19<sup>th</sup> July 2017 until 11<sup>th</sup> April 2018, when she was appointed Non-Executive Director



## Trust Board Members (continued)



**Claire O'Brien**

Chief Nurse<sup>\*Σ</sup>

Claire joined the Trust Board in February 2017 as Interim Chief Nurse and was appointed Chief Nurse (substantive) in March 2018. Claire has worked in the NHS for over 38 years, qualifying as a Registered General Nurse at King's College London in the early 1980s. She specialised in Cardiothoracic Nursing and has enjoyed a variety of general management and senior nursing roles within South London NHS acute Trusts, more recently as the Deputy Director of Nursing in Lewisham and Greenwich NHS Trust. Claire joined the Trust as Deputy Chief Nurse in April 2016, bringing a wealth of experience in all areas related to Nursing standards, Nurse Education, recruitment and Nursing professional issues. She has considerable experience working with patient representatives, and has a particular interest in engaging with staff and supporting them in their development, recognising the relationship between staff and patient experience, and feels it is vital that staff are valued and supported to provide the best possible care at all times.



**Steve Orpin**

Director of Finance<sup>\*Σ</sup>

Steve is responsible for providing information and advice to the Trust relating to all financial management issues. Steve joined the Trust Board in April 2014 from Medway NHS Foundation Trust, where he had been

Deputy Director of Finance; including a 12-month spell as Director of Finance. Steve has held various positions within the Finance function in a number of NHS organisations across London and the South East in a NHS career spanning over 20 years. Steve is a Fellow of Chartered Association of Certified Accountants and holds an MBA. In addition to his role on the Board, Steve attends several Board sub-committees.



**Steve Phoenix**

Non-Executive Director<sup>\*△</sup>

Steve joined the Trust Board on 1<sup>st</sup> December 2017 after a 37-year management career in healthcare, predominantly in the NHS. Between 2006 and 2011 he was Chief Executive of NHS West Kent, which included Maidstone and Tunbridge Wells NHS Trust as a major hospital provider. Steve has spent 30 years at Board level in a number of healthcare organisations, including 16 years as Chief Executive. From 2011 he was appointed Group Chief Executive for General Hospitals for Hamad Medical Corporation in Qatar and in 2017 was appointed as Special Adviser to the Minister. Steve has particular interests in strategic leadership, people management and organisation development in health care. He is married and lives in East Sussex.

\* Denotes Board members with voting rights

Σ Denotes member of the Executive Team

△ Denotes member of the Audit and Governance Committee

The following persons also served on the Trust Board during 2017/18:

- ▶ Glenn Douglas, Chief Executive (joined the Board in December 2007, and left on 19<sup>th</sup> September 2017)
- ▶ Richard Hayden, Director of Workforce (joined the Board in March 2016, and left at the end of June 2017)
- ▶ Alex King, Non-Executive Director (joined the Board in September 2014, and left on 21<sup>st</sup> March 2018)
- ▶ Kevin Tallett, Non-Executive Director (joined the Board in August 2008, and left on 27<sup>th</sup> July 2017)

## Statement as to disclosure to auditors

Each Director can confirm that he or she knows of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and; has taken "all the steps that he or she ought to have taken" to make himself/herself aware of any such information and to establish that the auditors are aware of it.

## Attendance at Trust Board meetings

There were 11 formal Trust Board meetings in 2017/18. Attendance at each meeting is shown below:

Trust Board Member	April 2017	May 2017	June 2017	July 2017	September 2017	October 2017	November 2017	December 2017	January 2018	February 2018	March 2018
David Highton, Chair of the Trust Board	N/A <sup>9</sup>	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Maureen Choong, Non-Executive Director	N/A <sup>10</sup>				Apologies	✓	✓	✓	✓	✓	✓
Glenn Douglas, Chief Executive	✓	✓	✓	✓	✓	N/A <sup>11</sup>					
Sarah Dunnett, Non-Executive Director	✓	✓	✓	✓	Apologies	✓	✓	✓	Apologies	✓	Apologies
Angela Gallagher, Chief Operating Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Simon Hart, Director of Workforce	N/A <sup>12</sup>							✓	✓	✓	✓
Richard Hayden, Director of Workforce	✓	✓	✓	N/A <sup>13</sup>							
Nazeya Hussain <sup>14</sup> , Associate Non-Executive Director	N/A <sup>15</sup>				✓	✓	✓	✓	✓	Apologies	✓
Alex King, Non-Executive Director	✓	✓	✓	✓	Apologies	Apologies	✓	Apologies	Apologies	Apologies	N/A <sup>16</sup>
Tim Livett, Non-Executive Director	N/A <sup>17</sup>		Apologies	✓	✓ <sup>18</sup>	Apologies	✓	✓	✓	✓	✓
Jim Lusby, Deputy Chief Executive <sup>19</sup>	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Peter Maskell, Medical Director	✓	✓	Apologies <sup>20</sup>	✓	✓	✓	✓	Apologies	✓	✓	✓
Sara Mumford, Director of Infection Prevention & Control	✓	✓	✓	Apologies	✓	✓	✓	✓	✓	✓	✓
Claire O'Brien, Chief Nurse	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Steve Orpin, Director of Finance	✓	✓	✓	Apologies <sup>21</sup>	✓	✓	✓	✓	✓	✓	✓
Steve Phoenix, Non-Executive Director	N/A <sup>22</sup>							✓	✓	✓	✓
Miles Scott, Chief Executive	N/A <sup>23</sup>								✓	✓	✓
Kevin Tallett, Non-Executive Director	✓	✓	Apologies	✓	N/A <sup>24</sup>						

<sup>9</sup>David Highton joined the Board on 8<sup>th</sup> May 2017

<sup>10</sup>Maureen Choong joined the Trust Board on 29<sup>th</sup> August 2017, as an Associate Non-Executive Director (i.e. non-voting), and was then appointed as a Non-Executive Director on 16<sup>th</sup> November 2017

<sup>11</sup>Glenn Douglas left the Board on 19<sup>th</sup> September 2017

<sup>12</sup>Simon Hart joined the Trust Board on 1<sup>st</sup> December 2017, but attended the Trust Board meetings on 29<sup>th</sup> November 2017

<sup>13</sup>Richard Hayden left the Board at the end of June 2017

<sup>14</sup>Nazeya Hussain served as Associate Non-Executive Director from 19<sup>th</sup> July until 11<sup>th</sup> April, when she was appointed Non-Executive Director

<sup>15</sup>Nazeya Hussain joined the Board on 19<sup>th</sup> July 2017

<sup>16</sup>Alex King retired from the Board on 21<sup>st</sup> March 2018

<sup>17</sup>Tim Livett joined the Board on 26<sup>th</sup> June 2017

<sup>18</sup>Tim Livett was not present at the Part 2 meeting on 27<sup>th</sup> September 2017

<sup>19</sup>Jim Lusby was Acting Chief Executive between 19<sup>th</sup> September 2017 and 7<sup>th</sup> January 2018

<sup>20</sup>Paul Sigston, Deputy Medical Director, attended in Peter Maskell's place on 28<sup>th</sup> June 2017

<sup>21</sup>Sheila Stenson, Deputy Director of Finance (Financial Performance) attended in Steve Orpin's place on 19<sup>th</sup> July 2017

<sup>22</sup>Steve Phoenix joined the Board on 1<sup>st</sup> December 2017

<sup>23</sup>Miles Scott joined the Board on 8<sup>th</sup> January 2018

<sup>24</sup>Kevin Tallett left the Trust Board on 27<sup>th</sup> July 2017

## Appointment and evaluation of Trust Board Members' performance

The Chair of the Trust Board and its Non-Executive Directors are independently appointed by NHSI. The Chief Executive and other Executive posts serving on the Trust Board are appointed by the Trust in liaison with NHSI. All members of the Trust Board are subject to a performance framework which stipulates that:

- ▶ The Chair of the Trust Board is appraised via a national framework operated by NHSI;
- ▶ Non-Executive Directors and the Chief Executive are appraised by the Chair of the Trust Board and
- ▶ Members of the Executive Team are appraised by the Chief Executive.

Trust Board Members are also subject to an annual self-assessment in accordance with the fit and proper persons requirements (FPPR<sup>25</sup>) for Directors. No concerns have been raised in relation to this in 2017/18.

## Directors' interests

The Trust Board and other committees routinely ask that any interests relevant to agenda items be declared at each meeting. In addition, a Register of Directors' interests is maintained. The interests recorded on the Register at the end of 2017/18 for those on the Board at the end of that year were as follows:

Trust Board Member	Details of notifiable interest
David Highton, Chair of the Trust Board	<ul style="list-style-type: none"> <li>▪ Non-Executive Chairman, Sussex Healthcare Audiology Ltd (company number: 07512308)</li> <li>▪ Chairman Designate, Demelza House Children's Hospice (charity Number: 1039651) – due to take up post in June 2018</li> <li>▪ Owner and Director, Hyperium Ltd (company number: 04684013)</li> </ul>
Maureen Choong, Non-Executive Director	<ul style="list-style-type: none"> <li>▪ Specialist Adviser, Care Quality Commission</li> <li>▪ Improvement Associate, Health Education England</li> </ul>
Sarah Dunnett, Non-Executive Director	Governor of Sevenoaks School ( <a href="http://www.sevenoaksschool.org">www.sevenoaksschool.org</a> / charity number: 1101358; company number: 04908949)
Angela Gallagher, Chief Operating Officer	None
Simon Hart, Director of Workforce	None
Nazeya Hussain, Associate Non-Executive Director	None
Tim Livett, Non-Executive Director	<ul style="list-style-type: none"> <li>▪ Director, Diamond Light Source Ltd (Co. no. 04375679)</li> <li>▪ Director, North London Ventures Ltd (Co. no. 08226374)</li> <li>▪ Director, Wellcome Trust Nominees Ltd (Co. no. 00594081)</li> <li>▪ Director, Henry Wellcome Ltd (Company number: 02636171)</li> <li>▪ Director, Premier Marinas Holdings Ltd (Company number: 05524490)</li> <li>▪ Director, Genome Research Ltd (Company number: 02742969)</li> <li>▪ Director, Wellcome Trust Trading Ltd (Company number: 03227027)</li> <li>▪ Director, Dell Quay Sailing Club Ltd (Company number: 08956103)</li> <li>▪ Director, Oakdale Residents Ltd (Company number: 01385943)</li> <li>▪ Director, Gower Place Investments Ltd (Company number: 08594660)</li> <li>▪ Director, Wellcome Trust GP Ltd (Company number: 05867101)</li> <li>▪ Director, Wellcome Trust Investments 1 Unltd (Company number: 06483238)</li> <li>▪ Director, Wellcome Trust Investments 2 Unltd (Company number: 06576220)</li> <li>▪ Director, Wellcome Trust Investments 3 Unltd (Company number: 05391431)</li> <li>▪ Director, Wellcome Trust Residential 1 Ltd (Company number: 06262798)</li> <li>▪ Director, Wellcome Trust Residential 1 Ltd (Company number: 06262846)</li> <li>▪ Director, WT Construction Ltd (Company number: 04122656)</li> </ul>
Jim Lusby, Deputy Chief Executive	None
Peter Maskell, Medical Director	None
Sara Mumford, Director Infection Prevention & Control	None
Claire O'Brien, Interim Chief Nurse	None
Steve Orpin, Director of Finance	Director NHS Innovations South East Limited (company number: 05210174) – serves as a Director as a result of the Trust acting as Guarantor
Steve Phoenix, Non-Executive Director	None
Miles Scott, Chief Executive	None

N.B. Some Directors' notifiable interests changed during the year. Further details can be obtained from the Trust Secretary, who can be contacted via Maidstone Hospital, Hermitage Lane, Maidstone, Kent ME16 9QQ (or see [www.mtw.nhs.uk/about-the-trust/trust-board.asp](http://www.mtw.nhs.uk/about-the-trust/trust-board.asp)). The interests of Trust Board Members who left the Board during 2017/18 can also be obtained from the Trust Secretary.

<sup>25</sup> As introduced by The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

## Pension Liabilities

Details of how the Trust treats Pension Liabilities are outlined in the Principal Financial Statements (within Note 9).

## Trust Board sub-committees

The Trust Board has a number of sub-committees, to assist it in meeting its role and duties. Further details are provided in the 'Annual Governance Statement for 2017/18' section later in the Annual Report.

## The Trust's Management Structure

The Trust is organised into a number of Corporate and Clinical Directorates. Clinical services are arranged within 3 Divisions, encompassing 10 Directorates:

Division	Directorate
Urgent Care	<ul style="list-style-type: none"> <li>▶ Acute and Emergency</li> <li>▶ Specialist Medicine and Therapies</li> </ul>
Planned Care (Surgery and Critical Care sub-division)	<ul style="list-style-type: none"> <li>▶ Surgery, Urology and Gynae Oncology</li> <li>▶ Head and Neck</li> <li>▶ Trauma and Orthopaedics</li> <li>▶ Critical Care</li> </ul>
Planned Care (Cancer and Clinical Support sub-division)	<ul style="list-style-type: none"> <li>▶ Cancer, Haematology and Radiology</li> <li>▶ Pathology and Pharmacy</li> </ul>
Women's, Children's and Sexual Health	<ul style="list-style-type: none"> <li>▶ Women's and Sexual Health</li> <li>▶ Children's Services</li> </ul>

Each Division is overseen by a Director of Operations or equivalent, while each Clinical Directorate has a Clinical Director, General Manager and Lead Matron. Corporate departments (Human Resources, Finance, Estates & Facilities, Clinical Governance and Trust Management) are all responsible to a Member of the Executive Team.

## Complaints: Ready to listen, ready to learn

The Trust aims to provide the best possible care and treatment but sometimes, despite the best efforts of staff, things can go wrong. In such circumstances, patients and relatives are encouraged to tell a member of staff on the Ward or in the clinic as soon as they can, to enable their concerns to be responded to as soon as possible. However, for circumstances where concerns cannot be resolved in this way, the Trust has a formal complaints process. In 2017/18, the Trust received 503 formal complaints (in 2016/17, this was 326), and 60.2% of complaints received were responded to within the agreed timescale (in 2016/17, this was 69%).

The Trust's Complaints and Patient Advice and Liaison Service (PALS) – Annual Report (due for publication in June 2018) ([www.mtw.nhs.uk/patients-visitors/talk-to-us/making-a-complaint/](http://www.mtw.nhs.uk/patients-visitors/talk-to-us/making-a-complaint/)) provides further detail on: the number of complaints received; the number of complaints which were well founded (upheld); the number of complaints referred to the Parliamentary and Health Service Ombudsman (PHSO); the subject matter of the complaints received; any matters of general importance arising from those complaints or the way in which the complaints were handled; any matters where action has been or is to be taken to improve services as a consequence of those complaints.

## 'Principles for Remedy'

The Trust applies the 'Principles for Remedy' guidance issued by the PHSO as part of its Policy and Procedure for Management of Concerns and Complaints. Under the Trust's Policy, financial remedy is only considered when a complaint is upheld and the complainant has clearly suffered a financial loss as a result of a service failure or breach of a Trust policy. In such circumstances, the Trust will consider paying a sum that restores the person to the position they would have been in prior to the circumstances which necessitated the complaint. The amount of financial remedy is agreed between the Complaints and PALS Manager and senior Directorate management team, with input from Legal Services as required. During 2017/18, the Trust offered financial remedy in 2 cases, totalling £47.27<sup>26</sup>. Financial redress was also recommended by the PHSO in a further 2 cases, at a total of £500.00<sup>27</sup>. This process excludes any claims for clinical negligence, which are pursued under the Trust's Claims Management Policy.

## Disclosure of personal data-related incidents

The Trust had one Serious Incident Requiring Investigation involving personal data that met the criteria for reporting to the Information Commissioner's Office (i.e. a 'Level 2' severity incident) as follows:

Date (month)	Nature of incident	Nature of data involved	No. of people potentially affected	Notification steps
October 2017	Disclosure in error	Name, Address, Date of Birth, Contact Phone Numbers, Sex, GP Details, Appointment Type	67	All individuals affected contacted by telephone and/or letter
Further action on information risk	The Trust notified this breach to the Information Commissioner who considered the case and concluded that sensitive personal data was involved so there was potential for the incident to cause distress/detriment but that significant detriment seemed unlikely. The Trust provided evidence of steps being taken to test the system being used and help prevent such incidents recurring. The Information Commissioner's Office further concluded that it is possible an error occurred with a process that could not have reasonably been foreseen.			

More details of the incident are given in the 'Governance Report'. The Trust also had the following severity 'Level 1' data-related incidents in the year:

Category	Nature of Incident	Total
A	Corruption or inability to recover electronic data	1
B	Disclosed in error	45
C	Lost in transit	2
D	Lost or stolen hardware	1
E	Lost or stolen paperwork	18
F	Non-secure disposal – hardware	0
G	Non-secure disposal – paperwork	3
H	Unloaded to website in error	0
I	Technical security failing (including hacking)	0
J	Unauthorised access/disclosure	5
K	Other	1

## Policy on setting charges

The Trust has complied with HM Treasury's guidance on setting charges for information, as set out in Chapter 6 of HM Treasury's "Managing Public Money" guidance.

<sup>26</sup> This is based on complaints received between 01/4/17 and 31/03/18 inclusive, though some complaints received towards the end of that period are still open at the time of this report, so further financial redress may be offered

<sup>27</sup> This is based on recommendations made by the Parliamentary and Health Service Ombudsman between 01/04/17 and 31/03/18, but not all of the relevant complaints were received within that time span

## Emergency preparedness

During the year the Emergency Preparedness team continued to increase the resilience of the Trust, foster and enhance partnerships across the county and develop innovative training for those involved in emergency response. As a Category One responder under the Civil Contingencies Act 2004, the Trust has specific statutory duties in relation to emergency planning and response. In addition, the Trust has other obligations as required by contracts and performance standards set by NHS England and Clinical Commissioning Groups (CCGs), and throughout the year a continuous process of exercising, testing, training and assurance took place. As part of this, West Kent CCG endorsed the Trust Board's submission to NHS England of full compliance following a round of emergency preparedness, resilience and response (EPRR) assurance visits.

### Incidents that took place during the year

During the year a number of responses were mounted, including the 'WannaCry' cyber-attack which affected the NHS in May 2017. Although the Trust was not directly affected, there were extensive actions and communications taken by the IT directorate to ensure services were able to continue.



2017 was marked by the shocking terrorist attacks in the UK starting with Westminster in March, Manchester in May, London Bridge in June and Parsons Green in September. The national threat level went to Critical on two occasions in both May and September requiring the Trust to implement additional measures and review security. The lessons identified in national debriefs were quickly shared and the Trust considered all of the advice in changing emergency plans. The team, through its extensive networks, has had the opportunity to talk directly to some of those involved and understand the issues they faced.

Roadworks caused business continuity issues for the Trust in 2017/18. The team worked hard with multi agency partners to ensure the needs of the NHS were understood by those undertaking the works.

In early 2018, sudden snow caused business continuity challenges overnight and the Trust activated its agreement with South East 4x4 Response Volunteers to assist in transporting staff to the hospitals.

### Multi-agency cooperation & training

- ▶ Throughout the year, the Trust continued to play a full part in local authority Safety Advisory Groups across its catchment area, thereby playing an important role in protecting public safety at large events. The team undertook multiagency site visits at the War & Peace Event at the Hop Farm, the Kent County Show and various music festivals and concerts, all with the aim of reducing Emergency Department (ED) attendances
- ▶ The Trust presented two partnership awards, firstly to the Kent Event Centre & County Show for work in successfully reducing hospital attendances from large events, and then to the crew of the HM Coastguard Rescue Helicopter Team for their support in live training and exercising
- ▶ The Trust is part of the Kent Resilience Forum made up of all multi agency partners, military and voluntary sector organisations
- ▶ The excellent relationship with all helicopter providers was maintained at both of the Trust's key sites. This allowed for live helicopters during exercises, valuable training provided to both ground staff who make landings safe and the critical care teams who might receive or transfer by air. Partnership options are being explored to make the landing site at Maidstone Hospital more permanent.



Training exercises during the year included:

- ▶ The Trust enjoyed a full year of exercises. The first was a trauma network exercise in March which looked at casualty distribution from a mass casualty incident in conjunction with other trusts in the South East London Kent & Medway Trauma Network
- ▶ During May, unannounced exercises were started in both EDs. These allowed staff to familiarise themselves with lockdown, triage, access to equipment and procedures for clearing the ED, both in and out of hours
- ▶ On July 27<sup>th</sup> Exercise Lockgate was carried out at Tunbridge Wells Hospital in conjunction with Kent Police, South East Coast Ambulance Service NHS Foundation Trust (SECAmb) and HM Coastguard. The exercise consisted of a full activation of the Major Incident Plan. The hospital was expecting one Priority One patient by helicopter, but when it was landing a minibus arrived with a further 12 casualties, unannounced and un-triaged. This aimed to bring in some of the issues identified in recent terrorist incidents where patients arrived without notice in buses, taxis and private transport. The exercise took place on a very busy day in the ED and staff managed well in dealing with normal activity alongside a major incident response as well
- ▶ Exercise Neptune was a live Business Continuity Exercise at Maidstone Hospital which tested a complete failure of water supply in conjunction with South East Water. The exercise tested command & control, live connections to tankers to fill holding tanks, delivery & distribution of thousands of bottles of water and communications both internally and with partner agencies along with media handling
- ▶ The Command Accreditation Courses and Continuing Professional Development for on call teams went from strength to strength and awareness training for non-specialist staff is now provided by a DVD which is available on both the Trust intranet and YouTube channel.



Despite adverse weather, HM Coastguard flew into Maidstone Hospital on 18/10/17 to receive an emergency planning partnership award from the Trust for their contribution to resilience and training, presented by Chair of the Trust Board, David Highton.

# Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust

The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the Trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of the NHS Trust Development Authority (legal entity). These include ensuring that:

- ▶ There are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- ▶ Value for money is achieved from the resources available to the trust;
- ▶ The expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- ▶ Effective and sound financial management systems are in place; and;
- ▶ Annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

I confirm that, as far as I am aware, there is no relevant audit information of which the Trust's Auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant Audit information and to establish that the Trust's Auditors are aware of that information.

I confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the Annual Report and Accounts and the judgments required for determining that it is fair, balanced and understandable.

Miles Scott, Chief Executive

24<sup>th</sup> May 2018



# Annual Governance Statement for 2017/18

## Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum<sup>28</sup>.

## The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Maidstone and Tunbridge Wells NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Maidstone and Tunbridge Wells NHS Trust for the year ended 31<sup>st</sup> March 2018 and up to the date of approval of the Annual Report and Accounts.

## Capacity to handle risk

### The ways in which leadership is given to the risk management process

Risks are identified, analysed and controlled in accordance with the Trust's Risk Management Policy and Procedure. The overall Executive Lead for risk management is the Chief Nurse, who is supported in this role by a range of staff, in particular the Trust Secretary and Risk and Compliance Manager. A number of specific risk-related roles are also held by Trust Board Members, as follows:

- ▶ The Chief Nurse is the Senior Information Risk Owner (SIRO)
- ▶ The Medical Director is the Caldicott Guardian and the Responsible Officer (for Medical Revalidation)
- ▶ The Chief Operating Officer is the Board Level Director (with fire safety responsibility), the Accountable Emergency Officer for Emergency Preparedness, Resilience & Response (EPRR), and the Security Management Director
- ▶ One of the Non-Executive Directors (NEDs) has been appointed as the Non-Executive Lead for Safeguarding and also for Resus<sup>29</sup>
- ▶ The Chair of the Quality Committee is the NED with specific role/responsibilities for leading falls prevention<sup>30</sup>, and is also the Non-Executive lead on mortality and learning from deaths<sup>31</sup>
- ▶ A further NED has been allocated the Emergency Preparedness, Resilience and Response (EPRR) portfolio<sup>32</sup>

The Trust has a Board Assurance Framework (BAF) and a Risk Register in place, the operational of which are informed by accepted best practice. The BAF is the document through which the Trust Board is apprised of the principal risks to the Trust meeting its key objectives, and to the controls in place to manage those risks. In addition to the Trust Board, the BAF and Risk Register are reviewed regularly at the Audit and Governance

<sup>28</sup> See <https://tinyurl.com/NHSAOM>

<sup>29</sup> [Health Services Circular 2000/028](#) states that "Chief executives should ensure that"... "a...NED...of the Trust is given designated responsibility on behalf of the Trust Board to ensure that a resuscitation policy is agreed, implemented, and regularly reviewed within the clinical governance framework"

<sup>30</sup> The [Falls and fragility fractures audit programme \(FFFAP\)](#) pilot national audit of inpatient falls (2015) asks "Does your organisation have a Non-executive Director (or other Board member) who has specific roles/responsibilities for leading falls prevention (can be as part of a wider remit for patient safety)?"

<sup>31</sup> The CQC's ["Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England"](#) report states that "We also recommend that provider Boards strongly consider nominating a non-executive director to lead on mortality and learning from deaths"

<sup>32</sup> The [Core Standards for Emergency Preparedness, Resilience and Response \(EPRR\)](#) assess whether "The organisation has an identified, active Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio for the organisation"

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Committee and Trust Management Executive (TME), whilst the relevant aspects of both are reviewed regularly at the Finance and Performance Committee.

As is the case every year, the BAF and Risk Register are subject to an Internal Audit review. The review for 2017/18, gave an overall assessment of "Reasonable Assurance", and the report's "overall conclusion" included the statements that "The Trust has an appropriately approved and up to date Risk Management Policy and Procedure in place..."; and "It was confirmed that there is an effective committee structure in place and that the BAF and Risk Management processes had been subject to regular review by the Trust Board and Audit and Governance Committee".

### The ways in which staff are trained or equipped to manage risk in a way appropriate to their authority and duties

The Trust has in place a range of systems to prevent, deter, manage and mitigate risks and measure the associated outcomes. In addition to the Trust's Risk Management Policy and Procedure, a comprehensive range of risk management policies and guidance is made available to staff. This includes the policies and procedures for risk assessment, incident reporting, managing complaints, investigation of incidents, health and safety, and 'being open' to staff and patients (to support the statutory Duty of Candour). Additional advice on good practice can be obtained from a range of professional and specialist staff. The remit of the Trust's Clinical Governance department includes clinical risk management; clinical governance; clinical audit; complaints; the Patient Advice and Liaison Service (PALS); medico-legal service and claims handling; research and development. The systems to oversee staff health and safety are managed via the Estates and Facilities department, but there is close liaison between the relevant staff. In addition, Directorates and sub-specialities have clinical governance and risk leads. There is a forum for clinical governance and risk management within each Directorate and within the majority of clinical sub-specialities.

Trust staff are involved in risk management processes in a variety of ways, including raising any concerns they may have (anonymously, if they so wish); being aware of their responsibility to report and act upon any incidents that occur; being involved in risk assessments; and attending regular training updates.

In-house support and advice on risk management is available, which includes advice relating to patient safety, health and safety, information governance etc. Certain types of risk are also addressed via the engagement of external expertise. For example, the risk of fraud is managed and deterred via the appointment of a Local Counter Fraud Specialist (LCFS) and the Trust engages a Dangerous Goods Safety Advisor (DGSA) to advise on the safe management of healthcare waste.

## The risk and control framework

### The key elements of the Risk Management Policy (including the way in which risk (or change in risk) is identified, evaluated, and controlled; and how risk appetites are determined)

Risks are identified, analysed and controlled in accordance with the Trust's Risk Management Policy and Procedure. Most risks are identified at local level and initially managed by department managers. Identified risks are added to the Risk Register and are then either managed locally or escalated through the Trust's management and/or committee structure. The Trust's competent persons (individuals with specialist skills, knowledge and qualifications that are assessed by external bodies who are able to advise managers and employees on all aspects of health, safety and risk) identify hazards within their area of expertise, and undertake Trust-wide risk assessments for hazards that affect multiple areas. Risks are identified, analysed and controlled in accordance with the Trust's Risk Assessment Policy and Procedure and guidance documents, which includes grading risks for their potential impact and likelihood of harm using a standard Risk Categorisation Matrix. The risk score determines the priority, response and level of management required to manage the risk. Risk appetite is the level of risk the Trust will accept for a particular type of risk. When a risk is assessed the uncontrolled risk score is determined, along with a target risk score, which indicates the risk rating that would be considered as satisfactory. This target risk score should be set as high as can be tolerated, and constitutes the risk appetite for that risk.

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### The key elements of the quality governance arrangements (including how the quality of performance information is assessed and how assurance is obtained routinely on compliance with Care Quality Commission (CQC) registration requirements)

The Trust's Quality Governance arrangements are managed via the Trust Clinical Governance Committee (and its sub-committees); and via a number of associated systems and processes. The Quality Committee then aims to seek and obtain assurance on the effectiveness of these structures, systems and processes.

Clinical audit is supported by a central team, within the Clinical Governance department, and is primarily overseen by the Trust Clinical Governance Committee. The investigation of, and learning from, incidents are predominantly managed within Directorates and discussed at Directorate and specialist clinical governance meetings. Serious Incidents (SIs) are discussed and monitored at a corporate level via the Learning and Improvement (SI) Panel. SIs are reported routinely to the 'main' Quality Committee.

Complaints are managed by the central complaints team in partnership with the Directorates concerned. The rate of new complaints and percentage of complaints responded to within target are monitored monthly at the Trust Board, whilst detailed reports on Complaints and Patient Advice and Liaison Service (PALS) contacts are received twice per year by the Patient Experience Committee and 'main' Quality Committee.

The quality of performance information is primarily assessed via the Internal Audit programme. In 2017/18, a "Review of A&E Data Capture and Recording" was undertaken, which aimed to provide assurance on the accuracy of data capture by the A&E department for activity undertaken and the effectiveness of the processes in place for the capturing and recording of this activity. The review gave an overall assessment of "Reasonable Assurance".

Compliance with CQC registration requirements is ultimately assessed via inspections by the CQC, and the Trust was subject to such inspections in the latter part of 2017. The Trust's overall assessment from the inspections remained as "Requires Improvement", but significant improvement had been made since the previous inspection in 2015, particularly in relation to the "Well-Led" domain, which had been previously rated as "Inadequate", but which was rated as "Good" in 2017/18. This improvement was recognised by the CQC in the "What we found" section of its inspection report with the statement that "We found there had been significant and sustained improvement throughout the trust".

The Trust also however monitors compliance with CQC registration requirements itself, primarily through a programme of in-house assurance visits/inspections. Such inspections, which are managed by the Clinical Governance and Corporate Nursing teams, include patient representatives and representatives from West Kent Clinical Commissioning Group, the main commissioner of the Trust's services. The outcome of the inspections are reported to the Trust Clinical Governance Committee, and areas for improvement are identified and acted upon.

### How risks to data security are being managed and controlled

Risks to data security are managed and controlled via a range of methods. The Trust has reviewed the 10 data and cyber security standards that were published jointly by the Department of Health and Social Care, NHS England and NHS Improvement (NHSI) in January 2018 (which were based on the standards recommended by the National Data Guardian, and confirmed by HM Government in July 2017), and a report on compliance with the standard was scheduled to be submitted to the Trust Board on 26<sup>th</sup> April 2018. The Trust has fully implemented the following standards:

1. A named senior executive is responsible for data and cyber security
  2. Achievement of at least level 2 on the current Information Governance Toolkit
  4. All staff must complete appropriate annual data security and protection training
  5. Organisations must act on CareCERT advisories where relevant; confirm within 48 hours that plans are in place to act on High Severity CareCERT advisories, and evidence this through CareCERT Collect; and identify a primary point of contact to receive and co-ordinate the organisation's response to CareCERT advisories, and provide this information through CareCERT Collect.
  7. Staff across the organisation report data security incidents and near misses, and incidents are reported to CareCERT in line with reporting guidelines
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8. Organisations must identify unsupported systems (including software, hardware and applications) and have a plan in place by April 2018 to remove, replace or actively mitigate or manage the risks associated with unsupported systems

The Trust has partially implemented the following standards:

3. Preparation for the introduction of the General Data Protection Regulation (GDPR) in May 2018
6. A comprehensive business continuity plan must be in place to respond to data and cyber security incidents
10. Organisations should ensure that any supplier of IT systems (including other health and care organisations) and the system(s) provided have the appropriate certification

The Trust has not implemented the following standards:

9. Organisations must undertake an on-site cyber and data security assessment if invited to do so by NHS Digital; and act on the outcome of that assessment, including any recommendations, and share the outcome of the assessment with your commissioner. The Trust has not been invited by NHS Digital to undertake an on-site cyber and data security assessment, but has used an external vendor to audit the organisation's data and cyber security risks

**Brief description of the organisation's major risks (including how they are/will be managed and mitigated and how outcomes are/will be assessed)**

In July 2016, the Trust Board approved the proposal to focus the BAF on a deliberately small number of higher-level objectives to act as proxy indicators (a 'litmus test') for broader performance. The Trust Board then confirmed it wished to adopt this principle in 2017/18, and duly approved the following broad risk and associated key objectives for 2017/18:

Broad risk to be managed	Associated key objective
The Trust fails to improve key aspects of clinical care and safety	1. To reduce mortality (HSMR) in line with the national average
The Trust is unable to manage (either clinically or financially) during the winter period	2. To deliver the agreed 2017/18 trajectory for the A&E 4 hour waiting time target
The Trust does not have the correct level of substantive workforce for effective delivery	3. To maintain a vacancy rate of no more than 8.5%
The Trust fails to demonstrate an ability to achieve future financial viability	4. To deliver the control total for 2017/18 (of a pre-Sustainability and Transformation Fund (STF) deficit of no more £4.5m, or otherwise agreed by NHS Improvement)
The Trust fails to maintain and improve its reputation as a Cancer provider	5. To deliver the agreed 2017/18 trajectory for the 62-day Cancer waiting time target
The Trust is unable to manage (either clinically or financially) during the winter period	6. To deliver the agreed Referral to Treatment (RTT) trajectory for patients on an 'incomplete' pathway

The main risks to the achievement of these key objectives (i.e. the issues that could prevent the objectives being achieved) are described within the BAF, and the Trust Board received formal update reports on the performance of each objective, and the management of risks to non-achievement at its meetings in July, September and November 2017 and February 2018. A year-end BAF report regarding the achievement of the objectives is scheduled to be received by the Trust Board in April 2018.

In addition, a number of risks were rated as 'red' in 2017/18. These risks have been discussed at the Trust Board, 'main' Quality Committee, Finance and Performance Committee, Workforce Committee and/or TME throughout 2017/18, and include the following:

- ▶ High staffing, vacancies and turnover, particularly for Nursing staff (in the Acute and Emergency and Specialist Medicine Directorates)
- ▶ Ability to manage patient flow due to capacity and demand issues
- ▶ Achieving the Cancer waiting time targets

- 
- ▶ The gaps in relation to Medical devices training and a trainer/coordinator
  - ▶ The delivery of the annual financial plan
  - ▶ The cost pressures associated with the use of temporary staff
  - ▶ The lack of appropriate Medical cover on night shifts for the Paediatric unit
  - ▶ The shortage of Paediatric Specialty and Associate Specialist (SAS) ('middle grade') doctors on day shifts for paediatrics
  - ▶ The delivery of the Cost Improvement Programme (CIP) for the Urgent Care Division
  - ▶ Nursing staffing levels in Orthopaedics
  - ▶ The governance arrangements for Point of Care testing
  - ▶ Risk to Trust Oncologists who are treating Cancer patients from East Kent, due to East Kent radiology reporting delays
  - ▶ Inability to manage the Haematology workload effectively and in a timely manner due to Consultant vacancies
  - ▶ Staffing levels in the Occupational Therapy and Physiotherapy teams affecting service delivery
  - ▶ Procurement of medical devices using Integra without following due process
  - ▶ Effect of failing to maintain a quality management system in Blood Sciences and Microbiology
  - ▶ The Health & Safety Executive (HSE) Improvement Notice for the Containment Level (CL) 3 laboratory (which was issued on 15/12/17, and for which the compliance date is 28/02/18) – see the "Significant internal control issues" section for more information on this
  - ▶ Unreliable data collection tool increasing number of missed referrals from A&E to Virtual Fracture Clinic
  - ▶ Risk associated with failing to learn from incidents
  - ▶ Specialist Medicine mortality review compliance

Each associated risk assessment describes the efforts being made and/or planned to manage and mitigate the risk, and the Trust's Risk and Compliance Manager oversees the regular reviews of the assessments.

### Are the Trust's services well-led?

As noted above, the CQC inspection in 2017 rated the Trust as "Good" for the Well-led domain. The Trust also undertook a self-assessment against NHSI's Well Led Framework, which was considered by the Trust Board in October 2017. A significant amount of positive assurance / evidence was provided as part of the review (which is publically available within the Board meeting reports on the Trust's website), but some areas for improvement were also identified. Many of these areas had been addressed by the end of 2017/18, but work to improve further will continue into 2018/19.

### The principal risks to compliance with the NHS provider licence, condition 4 and actions identified to mitigate these risks

In May 2017, the Trust Board completed the required self-certification (for 2016/17) that the Trust could meet the obligations set out in the NHS Provider Licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution); and that it complied with governance requirements (condition FT4(8)). The Trust Board confirmed full compliance, on the basis of the content of the Trust's Annual Report, and Governance Statement for 2016/17. The Trust Board will be asked to undertake the required self-certification for 2017/18 at its meeting in May 2018, and it will again be proposed that full compliance be confirmed.

### The key ways in which risk management is embedded in the activity of the organisation

As noted earlier in this Statement, risks are identified, analysed and controlled in accordance with the Trust's Risk Management Policy and Procedure, and a range of supporting systems and processes are in place to embed risk management activity. For example:



- ▶ Incident reporting is openly encouraged across the Trust, and lessons learned from incident investigations are disseminated and promoted (including via the "Governance Gazette" newsletter produced by the Clinical Governance department)
- ▶ Risk is regularly discussed at a wide range of forums, including the Trust Board and its sub-committees (which sets the tone for discussions at Directorate- and departmental-levels forums)
- ▶ Risk management is incorporated into the Trust's planning arrangements, and in 2017/18, the Trust's Quality Impact Assessment (QIA) process was strengthened, following oversight by the Quality Committee

### Care Quality Commission (CQC) registration

The Trust is fully compliant with the registration requirements of the Care Quality Commission.

### NHS Pension scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

### Obligations under equality, diversity and human rights legislation

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

### Obligations under the Climate Change Act and the Adaptation Reporting requirements

The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

## Review of economy, efficiency and effectiveness of the use of resources

A range of processes are applied to ensure that the Trust's resources are used economically, efficiently and effectively. The monitoring of this is overseen by the Trust Board, Finance and Performance Committee and Audit and Governance Committee, although the Workforce Committee, Quality Committee and Patient Experience Committee have all participated in this oversight during 2017/18. The Trust's annual Internal Audit programme for 2017/18 included a range of reviews relating to this area, including "Follow Up Review of Audiology Stock Management", "Payroll", "Financial Accounting and Non Pay Expenditure", and "Cost Improvement Plans", which all achieved overall assessment of "Reasonable Assurance" (although a "limited assurance" assessment was obtained for the reviews of "Non Patient Related Income" and "Activity and Income Recording including Implementation of SLAM Costing Model").

## Information governance

The Trust was required to report one information governance data protection breach incident to the Information Commissioner's Office (ICO) and the Department of Health and Social Care in the year. This related to batch printing from the new Patient Administration System (PAS) ("Allscripts"). The ICO decided that, after careful consideration, formal enforcement action was not appropriate in respect of this incident.

## Annual Quality Account

The Trust's Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

### The steps which have been put in place to assure the Trust Board that the Quality Account presents a balanced view

The Trust's annual Quality Accounts are reviewed by the Quality Committee, approved by the Trust Board, and published as a separate document. The Trust's Quality Accounts are also independently assessed by External Audit, with regards to whether the performance information reported therein is reliable and accurate. The audit of the 2016/17 Quality Accounts (which was concluded in 2017/18) resulted in an unqualified limited assurance report. The External Audit of the 2017/18 Quality Accounts will be available in the summer of 2018.

### The controls in place to ensure the accuracy of data (including the quality and accuracy of elective waiting time data)

The external audit referred to above includes reviewing particular indicators, to help provide assurance that the Quality Account presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data.

The following processes are in place to assure the quality and accuracy of elective waiting time data (and to manage the risks to such quality and accuracy):

- ▶ The Trust has a "Patient Access to Treatment Policy and Procedure", which encompasses Standard Operational Procedures for waiting list management at all stages of a referral to treatment pathway. The Policy also states the responsibilities of key staff, including those for auditing data quality. The Policy is also currently being reviewed to ensure it is aligned with the Trust's new Patient Administration System (PAS) (see the "Significant issues" section below)
- ▶ The Trust also has an "Information Lifecycle Management Policy and Procedure", which describes the Trust's general approach to data quality, including the role of the Data Quality Steering Group
- ▶ There is a weekly validation process involving operational, management and information leads, to assure the quality of local and national waiting times reporting/data

Compliance with the above Policies and processes is audited annually by Internal Audit (TIAA Ltd), as part of a "Data Quality of Key Performance Indicators" review. The latest (2017/18) review aimed to provide assurance that, for a sample of Key Performance Indicators (KPIs) reported to the Trust Board, the systems and data relied on to produce the figures were robust, and as a result Trust performance against the criteria is declared accurately, completely and in a timely manner.

The KPIs reviewed were falls, pressure ulcers and the 18 Weeks Referral to Treatment (RTT) incomplete pathway. The review led to an overall assessment of "Reasonable Assurance", and although some areas for improvement were identified, the key findings included the following points:

- ▶ "The Trust has an appropriately approved and up to date Information Lifecycle Management Policy and Procedure in place"
- ▶ "The figures reported to the Board and on the national submission via the Unify return, for the RTT incomplete pathway, were found to be accurately reported based on the data available from the source data system"

## Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the Internal Auditors, Clinical Audit and the Executive managers and clinical leads within the NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this Annual Report and other performance information available to me. My review is also informed by comments made by the External Auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board and Audit and Governance Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Head of Internal Audit Opinion for 2017/18 states that "I am satisfied that sufficient internal audit work has been undertaken to allow me to draw a reasonable conclusion as to the adequacy and effectiveness of Maidstone and Tunbridge Wells NHS Trust's risk management, control and governance processes. In my opinion, except for the Trust's ability to deliver their planned financial control total, Maidstone and Tunbridge Wells NHS Trust has adequate and effective management, control and governance processes to manage the achievement of its objectives".

The Audit and Governance Committee approves the Internal Audit plan for the year and receives details of the findings from each of the Internal Audit reviews that are undertaken. Summary reports of relevant Internal Audit reviews are also submitted to the TME, Finance and Performance Committee and 'main' Quality Committee during the year. Although a number of the Internal Audit reviews completed in 2017/18 resulted in an overall 'Reasonable assurance' assessment, a number also led to an assessment of 'Limited assurance'. These latter reviews have, or will be, considered at the Audit and Governance Committee, and actions to address the weaknesses identified in controls have been taken (or will be taken during 2018/19).

### The role of the Trust Board in maintaining and reviewing the effectiveness of the system of internal control

The Trust Board meets in public every month (with the exception of August). The agenda for Board meetings is mainly focused around the key aspects of operational performance; quality; planning and strategy; assurance and policy; and reports from its sub-committees. A separate ('Part 2') meeting is held on the same day as the meeting held in public, to consider confidential matters, in accordance with the Public Bodies (Admission to Meetings) Act 1960. A 12-month rolling forward programme of agenda items is actively managed to ensure the Board receives the information, and considers the matters it requires to perform its duties efficiently and effectively.

A key tenet of the information the Board receives at each meeting in public is an Integrated Performance Report, which contains up-to-date details of performance across a range of indicators, including those within NHSI's Single Oversight Framework for NHS providers. The Board also hears 'patient stories', which provide invaluable first-hand experience of being a patient of the Trust; as well as presentations from its Clinical Directors, General Managers and Matrons. Information reviewed at the Trust Board and its sub-committees are supplemented by Trust Board Members' visits of Wards and Departments (which are reported to the Board 4 times a year).

In 2017/18, the following changes in personnel occurred within the Trust Board (in chronological order):

- ▶ Kevin Tallett (NED and Vice Chair of the Trust Board) acted as Chair of the Trust Board from 01/03/17 to 07/05/17
- ▶ David Highton (Chair of the Trust Board) started his term of office on 08/05/17
- ▶ Richard Hayden (Director of Workforce) left the Trust at the end of June 2017
- ▶ Tim Livett (NED) joined the Trust Board on 26/06/17
- ▶ Nazeya Hussain (Associate NED) joined the Trust Board on 19/07/17
- ▶ Kevin Tallett (NED, Vice and Acting Chair of the Trust Board) left the Trust Board on 27/07/17
- ▶ Maureen Choong joined the Trust Board on 29/08/17 as an Associate NED, and was then appointed as a NED on 16/11/17
- ▶ Glenn Douglas (Chief Executive) left the Trust Board on 19/09/17
- ▶ Jim Lusby (Deputy Chief Executive) was Acting Chief Executive from 19/09/17 to 07/01/18
- ▶ Simon Hart (Director of Workforce) joined the Trust on 01/12/17
- ▶ Steve Phoenix (NED) joined the Trust Board on 01/12/17
- ▶ Miles Scott (Chief Executive) joined the Trust on 08/01/18
- ▶ Alex King (NED) left the Trust Board on 21/03/18
- ▶ Claire O'Brien was appointed as substantive Chief Nurse on 19/03/18 (Ms O'Brien had been interim Chief Nurse from 27/02/17)



## The role of the Trust Board sub-committees and other key forums in maintaining and reviewing the effectiveness of the system of internal control

The Board operates with the following sub-committees (which are listed alphabetically):

- ▶ The Audit and Governance Committee. This supports the Trust Board by critically reviewing the governance and assurance processes on which the Board places reliance. This therefore incorporates reviewing Governance, Risk Management and Internal Control (including the Board Assurance Framework); oversight of the Internal and External Audit, and Counter Fraud functions. The Committee also undertakes detailed review of the Trust's Annual Report and Accounts, and has been appointed (by the Trust Board) as the Trust's Auditor Panel, in accordance with Schedule 4, Paragraph 1 of the Local Audit and Accountability Act 2014. The Committee is chaired by a NED, and meets 5 times each year (including a specific meeting to review the Annual Report and Accounts prior to the Trust Board being asked to approve these). All other NEDs (apart from the Chair of the Trust Board) are members.
- ▶ The Charitable Funds Committee. This aims to ensure that the Maidstone and Tunbridge Wells NHS Trust Charitable Fund is managed efficiently and effectively in accordance with the directions of the Charity Commission, relevant NHS legislation and the wishes of donors, which includes reviewing, and agreeing the Charitable Fund Annual Report and financial accounts, for approval by the Trust Board. The Committee is chaired by a NED, and meets three times per year.
- ▶ The Finance and Performance Committee. This aims to provide the Trust Board with: assurance on the effectiveness of financial management, treasury management, investment and capital expenditure and financial governance; an objective assessment of the financial position and standing of the Trust; and advice and recommendations on all key issues of financial management and financial performance. In addition, the Committee receives assurance on Information Technology performance and business continuity; and advice and recommendations on all aspects of informatics, including Information Technology and telecommunications. The Committee is chaired by a NED, and meets monthly.
- ▶ The Patient Experience Committee. This aims to capture the patient and public perception of the services delivered by the Trust, and monitor any aspect of patient experience, on behalf of the Trust Board (or at the request of any Board sub-committee or other relevant Trust committee), as required. The Committee is chaired by a NED, and meets quarterly, and in addition to Trust staff, its membership includes representatives from the Trust's catchment area, Healthwatch Kent, and from Leagues of Friends of Maidstone and Tunbridge Wells Hospitals
- ▶ The Quality Committee. This aims to seek and obtain assurance on the effectiveness of the Trust's structures, systems and processes to enable delivery of the Trust's objectives relating to quality of care. The Committee is chaired by a NED and meets monthly. On alternate months, the Committee meets in the form of a 'deep dive', with a reduced membership, to enable a small number of subjects to be scrutinised in greater detail.
- ▶ The Remuneration and Appointments Committee. This reviews, on behalf of the Trust Board, the appointment of Executive Directors and other staff appointed on Very Senior Manager (VSM) contracts, to ensure such appointments have been undertaken in accordance with Trust Policies. It also: reviews the remuneration, allowances and terms of service of such staff; reviews (with the Chief Executive), the performance of Executive Directors and other staff appointed on VSM contracts; oversees appropriate contractual arrangements for such staff (including the proper calculation and scrutiny of termination payments, taking account of such national guidance, as appropriate); and considers and approves, on behalf of the Trust Board, proposals on issues which represent significant change. The Committee is chaired by the Chair of the Trust Board, and meets on an ad-hoc basis.
- ▶ The Workforce Committee. This aims to provide assurance to the Board in the areas of workforce development, planning, performance and employee engagement; and assure the Board that the Trust has the necessary strategies, policies and procedures in place to ensure a high performing and motivated workforce that is supporting business success. The Committee is chaired by a NED and meets every 2 months.

Attendance records are maintained for the Trust Board and its main sub-committees. The attendance record for Trust Board meetings is reported within the body of the Trust's Annual Report.

Although not a Board sub-committee, the Trust Management Executive (TME) is the senior management committee within the Trust. Its purpose is to oversee and direct: the effective operational management of the Trust, including achievement of standards, targets and other obligations; the delivery of safe, high quality, patient-centred care; the development of Trust strategy, culture and policy; and the identification, mitigation and escalation of assurance and risk issues. The TME meets monthly, and is chaired by the Chief Executive.

In addition to the above committees, there are a range of other forums, structures and processes in place to oversee and manage any issues relevant to particular aspects of risk and governance. In this respect, the Trust has, for example, a Trust Clinical Governance Committee, an Infection Prevention and Control Committee; a Health and Safety Committee; a Medicines Management Committee; an Information Governance Committee; and Safeguarding Adults and Children Committees.

### Significant internal control issues

The following significant internal control issues have been identified in 2017/18:

1. On 15<sup>th</sup> December 2017, the Trust's Microbiology Department was served with an Improvement Notice following a scheduled visit by the Health & Safety Executive (HSE). Action was however taken to address the issues (which related to inadequate arrangements for monitoring and review of the preventative and protective measures necessary to minimise the risk of exposure of employees to hazard group 3 biological agents), and at the follow-up inspection on 27<sup>th</sup> February 2018, the HSE inspector was satisfied that the Notice could be lifted
2. The Trust was placed into Financial Special Measures (FSM) in July 2016. The Trust has been involved in a number of formal FSM review meetings with NHSI since that time, and although significant progress has been made, the Trust remained in FSM at the end of 2017/18
3. The Trust's year-end deficit for 2017/18 was £17.9m (excluding Sustainability and Transformation Fund (STF)) which was £13.4m adverse to the Trust's original plan (and control total), but achieved the revised year-end forecast that was set in January 2018
4. Although the Trust successfully achieved its planned performance on a number of important indicators, it failed to meet a number of key patient access targets for the year, including that relating to A&E 4-hour waits, 18-week Referral to Treatment (RTT) waiting times, and 62-day first definitive treatment for Cancer
5. Four 'Never Events' were declared at the Trust in 2017/18, which were subject to scrutiny to aim to ensure that lessons were learnt

All of the above issues have been subject to detailed scrutiny at a senior-level in the Trust during 2017/18, and action plans are in place to address any issues that had not been resolved by the end of 2017/18.

### Conclusion

The significant internal control issues identified in 2017/18 are described above, in the body of the Annual Governance Statement.

Miles Scott, Chief Executive

24<sup>th</sup> May 2018



# Maidstone and Tunbridge Wells NHS Trust



## Accountability Report for 2017/18: Remuneration and Staff Report



## Our staff

Maintaining a highly skilled and engaged workforce is fundamental to the Trust's ability to provide the highest, consistent, quality care to its patients. This is particularly critical during times of financial constraint and increasingly high demand for the Trust's services. In 2017, the Trust took part in the 15<sup>th</sup> annual National NHS Staff Survey. The results remained broadly in line with 2016 scores and the Trust remains above the national average as a place to work or receive treatment.

Significantly, as many of its staff thought patient care was the Trust's top priority in 2017, as they did in 2016; the Trust continued with its strong performance for the percentage of staff who felt they had been appraised (91%) and scored within the top 20% of acute trusts for this finding; the Trust's score of 3.80 (out of a maximum score of 5) for staff engagement was in line with Trusts of a similar type. Other notable results included:

- ▶ Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion: 90% (national average 85%)
- ▶ Percentage of staff agreeing that their roles make a difference to patients/service users: 92% (national average 90%)
- ▶ Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month: 28% (national average 31%)
- ▶ Percentage of staff satisfied with the opportunities for flexible working patterns 55% (national average 51%)

Whilst the overall results were good, there are some areas on which the Trust needs to focus:

- ▶ Communication between senior management and staff
- ▶ Medical engagement
- ▶ Job satisfaction, primarily around resourcing and support
- ▶ Reporting of discrimination, bullying, harassment and violence

An action plan has been developed to address each of these issues. The full survey results are available at:

<https://tinyurl.com/MTWstaffsurvey17>

## Employee benefits

The details within this section relating to staff benefits, analysed by staff grouping, are included in accordance with section 411 of the Companies Act 2006.

**Staff numbers and costs** (subject to audit)

Average <sup>33</sup> staff numbers	Permanently employed (WTE) <sup>34</sup>	Other (WTE)	Permanently employed (expenditure) (£000s)	Other (expenditure) (£000s)
Medical and dental	650	115	61,902	16,201
Ambulance staff	0	0	0	0
Administration and estates	1054	78	32,575	2,900
Healthcare assistants and other support staff	1216	128	30,135	3,664
Nursing, midwifery and health visiting staff	1351	262	59,091	14,884
Nursing, midwifery and health visiting learners	9	0	257	0
Scientific, therapeutic and technical staff	491	35	21,632	2,577
Social Care Staff	0	0	0	0
Healthcare Science Staff	177	2	8,748	83
Other	0	0	0	0
Apprenticeship levy	0	0	946	45
<b>Total</b>	<b>4948</b>	<b>620</b>	<b>215,286</b>	<b>40,354</b>
Staff engaged on capital projects (excluded from above)	13	5	669	823

**Exit packages** (subject to audit)

The figures disclosed below relate to exit packages agreed in the year. The actual date of departure might be in a subsequent period, and the expense in relation to the departure costs may have been accrued in a previous period. The data here is therefore presented on a different basis to other staff cost and expenditure notes in the accounts.

Exit package cost band (including any special payment element)	*Number of compulsory redundancies	*Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Whole numbers only	£s	Whole numbers only	£s	Whole numbers only	£s	Whole numbers only	£s
Less than £10,000	None	N/A	13	37,000	13	37,000	None	0
£10,000 - £25,000	None	N/A	2	41,000	2	41,000	None	0
£25,001 - £50,000	None	N/A	0	0	None	0	None	0
£50,001 - £100,000	None	N/A	0	0	None	0	None	0
£100,001 - £150,000	None	N/A	0	0	None	0	None	0
£150,001 - £200,000	None	N/A	0	0	None	0	None	0
>£200,000	None	N/A	0	0	None	0	None	0
<b>Total</b>	N/A	N/A	<b>15</b>	<b>78,000</b>	<b>15</b>	<b>78,000</b>	<b>N/A</b>	<b>N/A</b>

<sup>33</sup> The average number of employees is calculated as the whole time equivalent number of employees under contract of service in each week in the financial year, divided by the number of weeks in the financial year.

<sup>34</sup> This excludes any staff on unpaid leave (and therefore does not equate to the WTE reported within the Sustainability Report)

Exit packages – disclosures (excluding compulsory redundancies)	Number of exit package agreements	Total Value of agreements  (£000s)	Number of exit package agreements	Total Value of agreements  (£000s)
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	15	78	27	108
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non contractual payments requiring HMT approval *	0	0	0	0
<b>Total</b>	<b>15</b>	<b>78</b>	<b>27</b>	<b>108</b>
Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	0	0	0	0

Note \* this includes any non-contractual severance payment following judicial mediation and amounts relating to non-contractual payments in lieu of notice.

## Health and Safety at Work

The Trust is committed to ensuring the health and safety of its employees, patients, visitors, volunteers, contractors and others affected by its activities. It aims to provide safe and healthy working conditions and seeks the support of staff in achieving this. The use of risk assessment to identify, assess and manage risk is key to health and safety management within the Trust.

During the year:

- ▶ A new quality and safety initiative, 'Take five Talk Five!', was launched sharing five key quality and safety messages with staff on a weekly basis
- ▶ The Risk Management Policy and Procedure was revised and ratified
- ▶ There was a significant reduction of close to 40% in the number of staff injuries as a result of accidents in the workplace
- ▶ At the end of March 2018, the number of reports to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013 had decreased by more than 35%
- ▶ Work was undertaken to reduce the risk of slips, trips and falls on Trust premises and this was reflected in the large reduction in fractures following falls on site to members of the public and visitors.

## Employee consultation (understanding and learning from the views of staff)

The Trust meets formally on a regular basis with local Trade Union representatives, via the Joint Consultative Forum and the Joint Medical Consultative Committee, to discuss key issues and agree relevant employment policies and procedures. Staff are formally consulted when organisational or other work changes are proposed and have the opportunity to comment and input into proposed changes. A quarterly Open Staff Meeting system also operates, to cascade information to all staff, which involves a face-to-face meeting with two Executive Directors (including the Chief Executive) at both hospital sites. A weekly Chief Executive's update and "MTW News" newsletter are issued to all staff via email, enabling key messages to be given on matters of note. The Trust also conducts quarterly staff Friends and Family tests throughout the year to help it gauge the level of satisfaction and engagement amongst staff. The Trust has a range of support mechanisms for staff, beyond that provided by their line manager. This includes a comprehensive Employee Assistance Programme providing 24 hour support and a full Occupational Health service.



The launch of Listening into Action (see the Performance Report Overview) during the year saw every member of staff given a voice and being asked to complete the LiA Pulse Check census. LiA will be fundamental to ensuring that ideas and innovations from staff are heard and implemented on an ongoing basis.

## Education and Development

The Trust takes the ongoing development of its staff very seriously. Each hospital site has an Education / Academic Centre, giving dedicated teaching space to staff, and a library. Staff can expect to have an annual appraisal with a plan of personal development and access to education teams to support them with advice and guidance about their development needs. Staff are able to take part in in-house learning activities and funding is also available for staff to access external training. In 2017/18 the Trust provided access to local schools for work experience opportunities, and ran training exercises for staff with HM Coastguard Rescue. The Trust held its annual Learning and Development Achievement Ceremony in September 2017, which all members of staff who receive funding each year were invited to attend and reflect on their achievements, made through undertaking various programmes of study.



## Equal opportunities

As demonstrated by the encouraging results in the year's staff survey for this area, which revealed that 90% of staff believed that the Trust provided equal opportunities for career progression or promotion, the Trust is committed to the equality agenda. The strategy demonstrates a commitment to creating a culture that promotes equality & embraces diversity in all its functions as both an employer and a service provider. The Trust's aim is to provide a safe environment, free from discrimination, and a place where all individuals are valued, treated fairly and accepted for who they are without exception. The Trust's drive to embed and mainstream equality into everything it does, is spearheaded by a dedicated Staff Engagement and Equality lead.

A range of activities marked the launch of the Trust's Cultural Diversity Network in June 2017. The Trust hosted talks from NHS Employers (which aims to be the authoritative voice of workforce leaders and experts in HR in the sector), which prompted discussion about what diversity means to individuals, a powerful & poignant talk from a senior member of staff about resilience, and a panel consisting of staff, the NHS Leadership Academy & NHS Digital (the national information and technology partner to the health and social care system) which profiled cultural differences and inclusion within the NHS. The network leads on the Workforce Race Equality Standard (WRES) action plan. This includes the implementation of unconscious bias awareness into recruitment training and the review of selected recruitment and disciplinary outcomes to ensure fair process.

The Trust launched its LGBT (lesbian, gay, bisexual, and transgender) staff network in May 2017 to provide a forum for staff to raise issues and concerns around sexual orientation and gender identity at work, as well as to provide advice and guidance to the Trust as to how it can best support its staff from the LGBT community. The network is open to all staff irrespective of sexual orientation or gender identity. The group has taken part in a number of promotional and awareness raising activities including participation in the first Tunbridge Wells Pride march.

LGBT history month was celebrated with a collaborative event to demonstrate acceptance – entitled "Standing Together, Caring Together". Members of the LGBT+ network and LGBT Ally network joined with staff from Kent Police and Kent Fire and Rescue Service to mark this.

2018 saw the first release of the Trust's Gender Pay Gap – showing a 26% gap between the pay of men and women an action plan has been created. The plan includes understanding more about the data and running a series of articles about inspirational women in the Trust. International Women's Day was celebrated with a timeline showing the job roles of the female relatives of our staff reaching back into the early 1900's. Stories of their experiences were also published. International Men's Day will be celebrated in November 2018.

The Trust operates a translation service, providing a one stop shop for all translation requirements and providing written translation, face to face language translation, British Sign Language (BSL), Deaf/Blind services and telephone interpreting. Telephone interpreting is available 24 hours a day, 7 days a week, 365 days a year. Requests for face to face and BSL interpreting may be made both in-an-out-of-hours through an online portal. The Trust published its new Interpreting and Translation Policy in August 2017 which ensures that patients have equal access to high quality and safe patient care, and enables compliance with equality legislation, Care Quality Commission outcomes and other relevant standards.

The gender, age and ethnic group distribution of staff and Trust Board Members (Senior Managers) at the end of 2017/18 is set out below (the 2016/17 equivalent is in brackets):

Gender	Staff [head count]		Trust Board Members	
Male	1655 (1548)	24.8% (24.3%)	8 (7)	57% (63.6%)
Female	5031 (4819)	75.2% (75.7%)	6 (4)	43 % (36.4%)
Age (age at 31/03/18)	Staff [head count]		Trust Board Members	
16-30	1484 (1329)	22.2% (20.9%)	0 (0)	0% (0%)
31-40	1519 (1363)	22.7% (21.4%)	1 (1)	7.1% (9.1%)
41-50	1750 (1670)	26.2% (26.2%)	4 (3)	28.6% (27.3%)
51-60	1451 (1394)	21.7% (21.9%)	7 (6)	50% (54.5%)
61 and over	482 (611)	7.2% (9.6%)	2 (1)	14.3% (9.1%)
Ethnic group <sup>35</sup>	Staff [head count]		Trust Board Members	
Asian/Asian British: Any other Asian background	384 (360)	5.7% (5.7%)	0 (0)	0% (0%)
Asian/Asian British: Bangladeshi	13 (7)	0.2% (0.1%)	0 (0)	0% (0%)
Asian/Asian British: Indian	410 (342)	6.1% (5.4%)	0 (0)	0% (0%)
Asian/Asian British: Pakistani	68 (52)	1.0% (0.8%)	1 (0)	7.1% (0%)
Black/African/Caribbean/Black British: African	173 (148)	2.6% (2.3%)	0 (0)	0% (0%)
Black/African/Caribbean/Black British: Any other Black/African/Caribbean background	15 (14)	0.2% (0.2%)	0 (0)	0% (0%)
Black/African/Caribbean/Black British: Caribbean	27 (18)	0.4% (0.3%)	0 (0)	0% (0%)
Mixed/Multiple ethnic groups: Any other Mixed/Multiple ethnic background	45 (36)	0.7% (0.6%)	0 (0)	0% (0%)
Mixed/Multiple ethnic groups: White & Asian	41 (39)	0.6% (0.6%)	0 (0)	0% (0%)
Mixed/Multiple ethnic groups: White & Black African	14 (9)	0.2% (0.1%)	0 (0)	0% (0%)
Mixed/Multiple ethnic groups: White and Black Caribbean	18 (19)	0.3% (0.3%)	0 (0)	0% (0%)
White: Any other White background	598 (578)	8.9% (9.1%)	0 (0)	0% (0%)
White: English/Welsh/Scottish/Northern Irish/British	4322 (4213)	64.6% (66.2%)	11 (10)	78.6% (91%)
White: Irish	79 (73)	1.2% (1.1%)	2 (1)	14.3 % (9%)
Any other ethnic group	241 (199)	3.6% (3.1%)	0 (0)	0% (0%)
Not known / not stated / undefined	238 (260)	3.6% (4.1%)	0 (0)	0% (0%)

<sup>35</sup> Recommended Office of National Statistics (ONS) Ethnicity Classifications, 2012



## Staff sickness absence

The staff sickness absence for 2017/18 (and 2016/17) is reported below:

	2017/18	2016/17
Total days lost (adjusted to the Cabinet Office measure)	43,165	47,119
Total staff years (WTE)	5,070	5,197
Average working days lost	9	9

N.B. This data is provided via the Department of Health and Social Care (DHSC) (as it is necessary to reconcile NHS Electronic Staff Record data with the 'Cabinet Office' data reported by central Government, to permit aggregation across the NHS). The sickness absence figures reported for 2017/18 are actually for the calendar year 2017 (i.e. January to December 2017), whilst the figures for 2016/17 are for the calendar year 2016. However, the DHSC considers the figures for the calendar year to be a reasonable proxy for the financial year.

## Disabled employees

The Trust is committed to taking positive action for disabled people and is recognised as a Disability Confident Committed Employer. The Disability Network, launched in September 2017 aims to bring together staff with physical and non-visible disabilities and will help the Trust move from being a Disability Confident Committed Employer to Disability Confident Employer by 2019. The group is also working on raising awareness of disabilities and will be instrumental in creating an action plan following the Workforce Disability Equality Standard (WDES) which will be published later in 2018.

During the year, the Trust has continued to apply its "Recruitment, Selection & Employment Checks Policy and Procedure" which ensures that any disabled applicant who meets the minimum criteria for a role must be offered an interview. The Trust's "Equality and diversity policy and procedure (incorporating Single Equality Scheme (SES))" requires the Trust to make reasonable adjustments for any member of staff with a disability or developing a disability during their time working with the Trust, to prevent them from being placed at a substantial disadvantage in all aspects of employment, and ensures that selection for employment, training and promotion are based solely on objective and job related criteria."

## "Senior Managers" remuneration

In accordance with Section 234b and Schedule 7a of the Companies Act, as required by NHS Bodies, this report includes details regarding "senior managers" remuneration. In the context of the NHS, this is defined as: "Those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments".

It is usually considered that the regular attendees of the entity's Board meetings are its "Senior Managers", and the Chief Executive has confirmed that the definition of "Senior Managers" only applies to Trust Board Members (refer to the 'Directors' Report' for further details). With the exception of the Non-Executive Directors (whose remuneration is set by NHSI) all "Senior Managers" are on "Very Senior Manager" (VSM) contracts and salaries are agreed with each individual.

The Trust Board maintains a Remuneration and Appointments Committee to advise and assist in meeting its responsibilities to ensure appropriate remuneration, allowances and terms of service for the Chief Executive, Directors and other key senior posts (refer to the Annual Governance Statement for 2017/18 for further details of the Remuneration and Appointments Committee).

The Chief Executive and Directors' remuneration is reviewed annually by the Committee and decisions are based on market rates, national pay awards and performance. Reward is primarily through salary adjustment, although non-recurrent awards can be used to recognise exceptional achievements.

Pay rates for Non-Executive Directors of the Trust are determined in accordance with national guidelines, as set by NHS Improvement. Remuneration for the Chair of the Trust Board is also set by NHSI.

The Directors are normally on permanent contracts and subject to a minimum of 6 months' notice period; the Chief Executive's notice period is 6 months. Contract, interim and seconded staff will all have termination clauses built into their letters of engagement, which will be broadly in line with the above. All Director contracts contain a 'Fit and Proper Person' clause stating that the post holder will be unable to continue as a Trust Board Member should they meet any of the criteria for being "unfit" within The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Termination arrangements are applied in accordance with statutory regulations as modified by Trust or National NHS conditions of service agreements, and the NHS pension scheme. The Remuneration and Appointments Committee will agree any severance arrangements following appropriate approval from NHSI and HM Treasury as appropriate. The figures included in the tables below show details of salaries, allowances, pension entitlements and any other remuneration of the Trust's 'Senior Managers' i.e. non-recurrent awards etc.

### Salaries and allowances for the year ending 31<sup>st</sup> March 2018 (subject to audit)

Comparatives for the year ending 31<sup>st</sup> March 2017 are shown in brackets below the figure for 2017/18.

Name and title (alphabetical by surname)	(a) Salary (bands of £5,000)	(b) Taxable expense payments and other benefits in kind, to the nearest £100	(c) Annual performance -related pay and bonuses (bands of £5,000)	(d) Long-term performance- related pay and bonuses (bands of £5,000)	(f) All pension- related benefits (bands of £2,500)	(g) TOTAL (columns a - f) (bands of £5,000)	(h) Payments or compensation for loss of office
	£000	£000 <sup>Λ</sup>	£000	£000	£000	£000	£000
N.B. Dates of service are for the full 2017/18 year unless otherwise disclosed							
Maureen Choong, Non-Executive Director (from 29/08/17)	0-5 (0)	0 (0)	0 (0)	N/A (N/A)	N/A (N/A)	0-5 (0)	N/A (N/A)
Glenn Douglas, Chief Executive (until 19/09/17)	95-100 (200-205)	30 (70)	0 (0)	0 (0)	N/A (0)	95-100 (205-210)	N/A (N/A)
Sarah Dunnett, Non-Executive Director	5-10 (5-10)	0 (0)	0 (0)	N/A (N/A)	N/A (N/A)	5-10 (5-10)	N/A (N/A)
Angela Gallagher, Chief Operating Officer	125-130 (120-125)	0 (0)	0 (0)	0 (0)	100-102.5 (2.5-5.0)	225-230 (125-130)	N/A (N/A)
Simon Hart, Director of Workforce	40-45 (0)	0 (0)	0 (0)	N/A (N/A)	147.5-150 (N/A)	190-195 (0)	N/A (N/A)
Richard Hayden, Director of Workforce (until end June 2017)	30-35 (110-115)	0 (0)	0 (0)	N/A (0)	15-17.5 (85-87.5)	45-50 (195-200)	N/A (N/A)
David Highton, Chair of the Trust Board (from 08/05/17)	35-40 (0)	6 (0)	0 (0)	N/A (N/A)	N/A (N/A)	35-40 (0)	N/A (N/A)
Nazeya Hussain, Associate Non-Executive Director (from 19/07/17)	0-5 (0)	0 (0)	0 (0)	N/A (N/A)	N/A (N/A)	0-5 (0)	N/A (N/A)
Alex King, Non-Executive Director (until 21/03/18)	5-10 (5-10)	0 (0)	0 (0)	N/A (N/A)	N/A (N/A)	5-10 (5-10)	N/A (N/A)
Tim Livett, Non-Executive Director (from 26/06/17)	0-5 (0)	0 (0)	0 (0)	N/A (N/A)	N/A (N/A)	0-5 (0)	N/A (N/A)
Jim Lusby, Deputy Chief Executive <sup>Σ</sup>	135-140 (130-135)	0 (0)	0 (0)	0 (0)	67.5-70 (87.5-90)	205-210 (215-220)	N/A (N/A)
Peter Maskell, Medical Director <sup>Ψ</sup>	195-200 <sup>36</sup> (35-40)	0 (0)	0 (0)	0 (0)	0 (0)	195-200 (35-40)	N/A (N/A)

<sup>36</sup> 155-160 of this relates to Dr Maskell's role as Medical Director; the remainder relates to his clinical duties

Name and title (alphabetical by surname)	(a) Salary (bands of £5,000)	(b) Taxable expense payments and other benefits in kind, to the nearest £100	(c) Annual performance -related pay and bonuses (bands of £5,000)	(d) Long-term performance- related pay and bonuses (bands of £5,000)	(f) All pension- related benefits (bands of £2,500)	(g) TOTAL (columns a - f) (bands of £5,000)	(h) Payments or compensation for loss of office
N.B. Dates of service are for the full 2017/18 year unless otherwise disclosed	£000	£00 Λ	£000	£000	£000	£000	£000
Sara Mumford, Director of Infection Prevention and Control Ψ	160-165 <sup>37</sup> (155-160)	0 (0)	0 (0)	0 (0)	72.5-75 (57.5-60)	235-240 (210-215)	N/A (N/A)
Claire O'Brien, Interim Chief Nurse	110-115 (5-10)	0 (N/A)	0 (N/A)	0 (N/A)	237.5-240 (0)	345-350 (5-10)	N/A (N/A)
Steve Orpin, Director of Finance	125-130 (125-130)	0 (0)	0 (0)	0 (0)	20-22.5. (27.5-30)	150-155 (155-160)	N/A (N/A)
Steve Phoenix, Non- Executive Director (from 01/12/17)	0-5 (0)	0 (0)	0 (0)	N/A (N/A)	N/A (N/A)	0-5 (0)	N/A (N/A)
Miles Scott, Chief Executive (from 08/01/18)	45-50 (0)	0 (0)	0 (N/A)	N/A (N/A)	382.5-385 (N/A)	430-435 (0)	
Kevin Tallett, Non- Executive Director Σ (until 27/07/17)	5-10 (5-10)	0 (0)	0 (0)	N/A (N/A)	N/A (N/A)	5-10 (5-10)	N/A (N/A)

Λ £ hundreds are used for taxable expense payments, and other benefits (column (b)). For this Trust, they relate to the non-cash benefit of a lease car. All other columns are in £ thousands

Ψ Drs Maskell and Mumford hold clinical roles in the Trust alongside their responsibilities as Senior Managers

Σ Kevin Tallett served as Acting Chair of the Trust Board from 01/03/17 to 07/05/17

Σ Jim Lusby served as Acting Chief Executive from 19/09/17 and 07/01/18

### Pension benefits for the year ending 31<sup>st</sup> March 2018<sup>38</sup> (subject to audit)

Name and title Ψ (alphabetical by surname)	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 <sup>st</sup> March 2018 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 <sup>st</sup> March 2018 (bands of £5,000)	(e) Cash Equivalent Transfer Value Λ at 1 <sup>st</sup> April 2017	(f) Cash Equivalent Transfer Value Λ at 31 <sup>st</sup> March 2018	(g) Real increase in Cash Equivalent Transfer Value Σ	(h) Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Glenn Douglas, Chief Executive (until 19/09/17) Ω	0	0	0	0	0	0	0	0
Angela Gallagher, Chief Operating Officer	5.00-7.5	15-17.5	50-55	155-160	936	1105	160	0
Simon Hart, Director of Workforce (from 01/12/17)	2.5-5	0-2.5	40-45	100-105	561	617	17	0
Richard Hayden, Director of Workforce (until end June 2017)	0-2.5	0	20-25	50-55	244	272	6	0
Jim Lusby, Deputy Chief Executive	2.5-5	2.5-5	35-40	90-95	514	606	88	0
Peter Maskell, Medical Director ϣ	0	0	0	0	0	0	0	0
Sara Mumford, Director of Infection Prevention and Control Ψ	2.5-5	2.5-5	50-55	75-80	649	753	97	0
Claire O'Brien, Chief Nurse	10-12.5	32.5-35	45-50	135-140	704	969	257	0

<sup>37</sup> Only 15-20 of this relates to Dr Mumford's role as Director of Infection Prevention and Control; the remainder relates to her clinical duties

<sup>38</sup> The Trust only makes contributions into the NHS pension scheme and the National Employment Savings Trust (NEST) scheme

Name and title $\Psi$ (alphabetical by surname)	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 <sup>st</sup> March 2018 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 <sup>st</sup> March 2018 (bands of £5,000)	(e) Cash Equivalent Transfer Value $\Lambda$ at 1 <sup>st</sup> April 2017	(f) Cash Equivalent Transfer Value $\Lambda$ at 31 <sup>st</sup> March 2018	(g) Real increase in Cash Equivalent Transfer Value $\Sigma$	(h) Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Steve Orpin, Director of Finance	0-2.5	0	45-50	115-120	617	685	62	0
Miles Scott, Chief Executive (from 08/01/18)	15-17.5	47.5-50	70-75	210-215	0	1356	313	0

$\Psi$  As Non-Executive Directors do not receive pensionable remuneration; there are no entries in respect of pensions for Non-Executive Directors

$\Lambda$  A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008

$\Sigma$  Real Increase in CETV reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period

$\Omega$  Mr Douglas did not make any contributions into the NHS Pensions scheme in 2017/18

$\times$  Dr Maskell did not make any contributions into the NHS Pensions scheme in 2017/18

### Fair pay disclosure (subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce. This is calculated at the reporting date i.e. 31<sup>st</sup> March 2018 by "annualising" the March pay information taking into account temporary staff and adjusting for the full-time effect of part-time staff.

The banded remuneration of the highest paid director in the financial year 2017/18 was £215,000 to £220,000 (in 2016/17 this was £200,000 to £205,000). This was 7.5 times (in 2016/17, this was 7.1 times) the median remuneration of the workforce, which was £28,746 (2016/17 £28,462). The difference is due to a change in post holder.

In 2017/18, 2 employees (in 2016/17, this was 11 employees) received remuneration in excess of the highest-paid Director. These were all Medical staff. Remuneration ranged from £12,710 to £234,957 (in 2016/17 the range was from £6,042 to £279,930). The highest paid Director in the financial year 2017/18 was the Chief Executive (in 2016/17 this was the Chief Executive). This is based on annualising the pay of Directors in post as at 31<sup>st</sup> March 2018 and so does not reflect actual remuneration in the year (as reported in the "Salaries and Allowances" table above) where individuals have taken up post during the year.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. The calculations of the median pay included in this analysis is based on the month 12

### Reporting relating to the review of tax arrangements of public sector appointees (not subject to audit)

As part of the Review of Tax arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23<sup>rd</sup> May 2012, the Trust in common with all public bodies, is required to publish information in relation to the number of 'off-payroll' arrangements meeting the specific criteria set by the Treasury. Individuals that are 'on-payroll' are subject to Pay As You Earn (PAYE), with income tax and employee National Insurance Contributions (NICs) deducted by the Trust at source. Individuals engaged to provide services to the Trust but who do not have PAYE and NICs deducted at source are 'off-payroll'.

### All off-payroll engagements as of 31<sup>st</sup> March 2018, for more than £245 per day and lasting for longer than 6 months

	Number
Number of existing engagements as of 31 <sup>st</sup> March 2018	7
Of which, the number that have existed...	
for less than 1 year at the time of reporting =	5
for between 1 and 2 years at the time of reporting =	1
for between 2 and 3 years at the time of reporting =	0
for between 3 and 4 years at the time of reporting =	1
for 4 or more years at the time of reporting =	0

All existing off-payroll engagements have at some point been subject to a risk based assessment, as to whether assurance was required that the individual is paying the right amount of tax. Where necessary, that assurance has been sought.

### New off-payroll engagements between 1<sup>st</sup> April 2017 and 31<sup>st</sup> March 2018, for more than £245 per day that last longer than 6 months

	Number
Number of new engagements, or those that reached 6 months in duration, between 1 <sup>st</sup> April 2017 and 31 <sup>st</sup> March 2018	11
Of which:	
No. assessed as caught by IR35	1
No. assessed as not caught by IR35	9
No. engaged directly (via PSC contracted to department) and are on the departmental payroll	0
No. of engagements reassessed for consistency / assurance purposes during the year	1
No. of engagements that saw a change to IR35 status following the consistency review	0

### Off-payroll Board member / Senior Official engagements

Number of off-payroll engagements of Board members and/or senior officials with significant financial responsibility, during the year	0
Number of individuals that have been deemed "Board members and/or senior officers with significant financial responsibility", during the financial year. This figure includes both off-payroll and on-payroll engagements	0

### Expenditure on consultancy staff

The Trust's internal expenditure on consultancy staff for 2017/18 was £406,000, a reduction of £62,000 (£468,000 in 2016/17). The Trust hosts the Kent and Medway Sustainability and Transformation Partnership (STP) which incurred £7.2m of consultancy spend compared to £3.4m in 2016/17.



# Maidstone and Tunbridge Wells NHS Trust



## Accountability and audit report for 2017/18: Independent Auditor's report to the Directors of the Trust





# Independent Auditor's report to the Directors of Maidstone and Tunbridge Wells NHS Trust

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## Respective responsibilities of Directors, the Accountable Officer and auditor

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## Scope of the audit of the financial statements

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## Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

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## Opinion on financial statements

In our opinion the financial statements:

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## Opinion on other matters

In our opinion:

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## Matters on which we are required to report by exception

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### Basis for Qualified Value for Money Conclusion

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### Qualified Value for Money Conclusion

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### Certificate

We certify that we have completed the audit of the financial statements of Maidstone and Tunbridge Wells NHS Trust in accordance with the requirements of the Act and the Code of Audit Practice.

*Darren Wells*

Darren Wells  
for and on behalf of Grant Thornton UK LLP, Appointed Auditor

2<sup>nd</sup> floor, St John's House,

Haslett Avenue West,

Crawley, West Sussex,

RH10 1HS

xx May 2018



## Glossary of NHS terms

Term	Definition/explanation
Ambulatory (Care)	A service where some conditions may be treated without the need for an overnight stay in hospital
Care Quality Commission (CQC)	The body that regulates all health and social care services in England. The CQC ensures the quality and safety of care in hospitals, dentists, ambulances, and care homes, and the care given in people's own homes. CQC is an executive non-departmental public body, sponsored by the Department of Health and Social Care.
Clinical Commissioning Group (CCG)	CCGs are clinically-led statutory NHS bodies, created following the Health and Social Care Act 2012, responsible for the planning and commissioning of health care services for their local area. CCGs are membership bodies, with local GP practices as the members
Clinical Governance	Clinical Governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence can flourish.
Commissioning	The process of planning, agreeing and monitoring services, ranging from the health-needs assessment for a population, through the clinically based design of patient pathways, to service specification and contract negotiation or procurement, with continuous quality assessment
Control total	A figure calculated by NHSI, on a Trust by Trust basis, which represents the minimum level of financial performance, against which the the Trust's Board/ Governing Body and Chief Executives must deliver in 2017/18, and for which they will be held directly accountable
Cost Improvement Programme (CIP)	Sets out the savings that an NHS organisation plans to make to reduce its expenditure/increase efficiency. It is used to close the gap between the income received by the NHS body and expenditure incurred in any one year
Commissioning for Quality and Innovation (CQUIN)	Introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of patient care. The key aim of the CQUIN framework is to secure improvements in the quality of services and better outcomes for patients
Delayed Transfer of Care (DTOC)	According to NHS England, a 'delayed transfer of care' occurs when an adult inpatient in hospital is ready to go home or move to a less acute stage of care but is prevented from doing so. Sometimes referred to in the media as 'bed-blocking', delayed transfers of care are a problem as they reduce the number of beds available to other patients who need them, as well as causing unnecessarily long stays in hospital for patients
Elective treatment	Treatment that is not urgent and can be planned

Term	Definition/explanation
Emergency Department (ED)	Also known as Accident and Emergency (A&E)
Escalation	The term used to describe circumstances when clinical areas of the Trust, not ordinarily designated for non-elective inpatient care, are required to be used for that purpose due to non-elective demand
Financial Special Measures (FSM)	The Financial Special Measures programme, was launched by NHSI in July 2016 to provide a rapid turnaround package for Trusts which had either not agreed savings targets, or planned to make savings but deviated significantly from this plan
Friends and Family Test (FFT)	A feedback tool, launched in April 2013, that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience
Inpatient	A person who stays in hospital for one or more nights
Length of Stay (LOS)	The period of time a patient remains in hospital or other healthcare facility as an Inpatient
NHS England	An executive non-departmental public body, sponsored the Department of Health and Social Care, which leads the NHS in England. It sets the priorities and direction of the NHS and encourages and informs the national debate to improve health and care
NHS Improvement (NHSI)	The body responsible for overseeing NHS Trusts, and independent providers that provide NHS-funded care. It supports providers to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable
Non-elective treatment	Treatment that is not planned, but requires admission to hospital
Outpatient	A person who goes to a hospital for treatment or assessment, but does not stay overnight
Patient Advice and Liaison Service (PALS)	A service within an NHS Trust offering confidential advice, support and information on health-related matters. It provides a point of contact for patients, their families and their carers
Patient Experience	A term used for individual and collective feedback. (1) Individual patient's feedback about their experiences of care or a service e.g. whether they understood the information they were given, their views on the cleanliness of the hospital where they were treated. (2) A combination of all the intelligence held about what patients experience in services, drawing on a range of sources including complaints, compliments, etc.
Patient flow	The course of patients between staff, departments and organisations along a pathway of care

Term	Definition/explanation
Patient Pathway	The route that a patient will take from entry into a hospital or other healthcare setting until the patient leaves. A template pathway can be created for common services and operations (e.g. emergency care pathway)
Ring-fenced beds	Beds allocated for a specific category of patient / treatment (e.g. Stroke or elective orthopaedic beds), not used for general medical patients when the hospital is busy
Serious Incident (SI)	Events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. SIs can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare
Single Oversight Framework (SOF)	A framework which applies to all NHS Trusts and is designed to help providers attain, and maintain, CQC ratings of 'Good' or 'Outstanding'. The framework replaced the Monitor 'Risk Assessment Framework' and the NHS Trust Development Authority 'Accountability Framework' in October 2016
Sustainability and Transformation Fund (STF)	Money allocated by the NHS to support the transformation of services and systems, which is paid subject to the achievement of stipulated targets. The general element of the STF is allocated primarily to Trusts providing acute emergency care, as they remain under the greatest financial and operational pressure
Sustainability and Transformation Partnership (STP)	STPs are 44 areas covering all of England, where local NHS organisations and councils have drawn up proposals to improve health and care in the areas they serve. STP can also stand for 'sustainability and transformation plan', plans drawn up in each of these areas setting out practical ways to improve NHS services and population health in every part of England. They aim to help meet a 'triple challenge' set out in the NHS Five Year Forward View – better health, transformed quality of care delivery, and sustainable finances.



# Maidstone and Tunbridge Wells NHS Trust



## Financial Statements for 2017/18



## Statement of Directors' responsibilities in respect of the Accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

25 May 2017 Date \_\_\_\_\_ Chief Executive

25 May 2017 Date \_\_\_\_\_ Director of Finance



Thank you for your support



A handwritten signature in black ink, which appears to be 'David Highton'.

Miles Scott, Chief Executive

David Highton, Chair of the Trust Board

The Trust receives support and well wishes from patients, carers, stakeholders, volunteers, fundraisers and Members (of which we have over 10,000). This support is expressed in a varied number of ways, including compliments sent directly to the Trust; letters sent to the local media; comments posted on social media; participation in the Patient Experience Committee; attendance at Trust Board meetings and the Annual General Meeting and fundraising to buy much needed equipment, to name but a few. This support is highly valued by the Trust's staff and the Board - without this, the Trust's task would be far harder. Thank you all.





Maidstone and Tunbridge Wells NHS Trust

Maidstone Hospital | Hermitage Lane | Maidstone | Kent ME16 9QQ

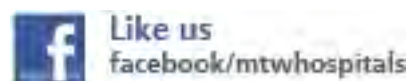


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**Trust Board meeting – May 2018**



5-20/5-21	Annual Report & Accounts, 2017/18 – Amendments	Chair of Audit and Governance Committee
<p>Since the Annual Report for 2017/18 was circulated, some amendments have been made as follows:</p> <ul style="list-style-type: none"> <li>Signature blocks have been inserted at the end of the Performance Report and the Accountability Report in order to comply with the Group Accounting Manual (GAM) 2017/18 requirement that the Accounting/Accountable Officer/Chief Executive must sign and date these sections of the Annual Report to confirm adherence to the reporting framework (this requirement had been overlooked in the previous versions of the Annual Report)</li> <li>Following discussion with the External Auditors, the 'going concern' policy in the Accounts (note 1.1.2) and the corresponding text within the Annual Report (page 19), have been amended, to remove reference to "material uncertainties", and instead to note "challenges to its Financial Plans for 2018/19"</li> </ul> <p>The actual/tracked changes of the latter point made are shown in Appendices 1 and 2.</p> <p>The Audit and Governance Committee had been notified of these amendments.</p>		
<p><b>Which Committees have reviewed the information prior to Board submission?</b></p> <ul style="list-style-type: none"> <li>Audit and Governance Committee, 24/05/18</li> </ul>		
<p><b>Reason for submission to the Board (decision, discussion, information, assurance etc.) <sup>1</sup></b></p> <p>To note the amendments made to the Annual Report and Accounts 2017/18</p>		

<sup>1</sup> All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance



## Appendix 1: Amendments to Annual Report 2017/18

"For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern. DHSC group bodies must therefore prepare their accounts on a going concern basis unless informed by the relevant body or DHSC sponsor of the intention for dissolution without transfer of services of function to another entity. A trading entity needs to consider whether it is appropriate to continue to prepare its financial statements on a going concern basis where it is being, or is likely to be, wound up"

The Trust Board has assessed the Trust's ability to continue for the foreseeable future in the light of the GAM guidance, and ~~assessed material uncertainties arising. The Trust~~ has prepared the 2017/18 accounts on a "going concern" basis following consideration of the following:-

- ▶ There has been no expectation raised in the public arena that healthcare services will not continue to be provided from the two hospital sites.
- ▶ The Trust submitted its initial business plan to NHS Improvement (NHSI) in March 2018 setting out its operational plans for the following financial year (2018/19) and its capital plans for five years. The final plan submission was made on 30<sup>th</sup> April 2018
- ▶ The Trust continues to fully participate in the Sustainability and Transformation Partnership (STP) planning process including the submission of the forward 5 year financial and operating plans on a going concern basis. The Trust is leading some of the significant workstream areas and is a key partner in consideration of the shape of services in the STP for the future.
- ▶ The Trust has existing contracts in place for provision of healthcare services for 2018/19 being the second year of contracts signed in 2017/18. This includes the Aligned Incentives Contract (AIC) with two of its Clinical Commissioning Groups (CCGs): West Kent (the Trust's main commissioner) and High Weald Lewes Havens. The exact value of the year two contracts will be concluded using the agreed contract approach as part of the current business planning round. The current level of difference under discussion is immaterial in value.
- ▶ The Trust has prepared and will be submitting cash-flow forecasts for 2018/19 as part of its planning returns which do not include any assumptions of additional required working capital finance.
- ▶ There are no plans to dissolve the Trust or to cease services without transfer to any other NHS body.

~~However, The material uncertainties that~~ the Trust has assessed and disclosed the following challenges to its financial plans for 2018/19 in its Annual Accounts ~~are~~:

- ▶ To achieve its 2018/19 control total the Trust will need to deliver a challenging cost improvement programme plus a significant level of other non-recurrent measures. At this stage there is risk around the ability of the Trust to deliver this level of savings within 2018/19
- ▶ Failure to achieve the Trust's control total could necessitate additional in year working capital finance to support the Trust's liquidity position and its ability to repay the first of its working capital loans that falls due for repayment in February 2019 (£16.9m)

**Appendix 2: Amendments to Annual Accounts 2017/18**

<b>1.1.2</b>	<b>Going Concern</b>		
	These accounts have been prepared on a going concern basis.		
	The DH Group Accounting Manual (GAM) requires the management of the Trust to consider the following public sector interpretation of IAS 1 in respect of applying the going concern assumption when preparing its accounts, stating:		
	“For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern. DHSC group bodies must therefore prepare their accounts on a going concern basis unless informed by the relevant body or DHSC sponsor of the intention for dissolution without transfer of services of function to another entity. A trading entity needs to consider whether it is appropriate to continue to prepare its financial statements on a going concern basis where it is being, or is likely to be, wound up”		
	The Trust Board have assessed the Trust’s ability to continue for the foreseeable future in the light of the GAM guidance, and <del>assessed material uncertainties arising. The Trust</del> has prepared the 2017/18 accounts on a “going concern” basis following consideration of the following:-		
	<ul style="list-style-type: none"> <li>• There has been no expectation raised in the public arena that healthcare services will not continue to be provided from the two hospital sites.</li> <li>• The Trust has submitted its initial business plan to NHSI in March 2018 setting out its operational plans for the following financial year (2018/19) and its capital plans for five years. The final plan submission will be made on the 30<sup>th</sup> April.</li> <li>• The Trust continues to fully participate in the STP planning process including the submission of the forward 5 year financial and operating plans on a going concern basis. The Trust is leading some of the significant Work-stream areas and a key player in consideration of the shape of services in the STP for the future (e.g. the Stroke services consultation).</li> <li>• The Trust has existing contracts in place for provision of healthcare services for 2018/19 being the second year of contracts signed last year. This includes the “aligned incentives” contract with two of its CCGs, West Kent (the Trust’s main commissioner) and High Weald and Lewes Haven. The exact value of the year two contracts will be concluded using the agreed contract approach as part of the current business planning round. The current level of difference under discussion is immaterial in value.</li> <li>• The Trust has prepared and will be submitting cash-flow forecasts for 2018/19 as part of its planning returns which do not include any assumptions of additional required working capital finance.</li> <li>• There are no plans to dissolve the Trust or to cease services without transfer to any other NHS body.</li> </ul>		
	<del>However, the Trust has assessed the following challenges to its Financial Plans for 2018-19. The material uncertainties that the Trust has assessed are:</del>		
	<ul style="list-style-type: none"> <li>• To achieve its 2018/19 control total the Trust will need to deliver a challenging cost improvement programme plus a significant level of other non-recurrent measures. At this stage there is risk around the ability of the Trust to deliver this level of savings within 2018/19.</li> <li>• Failure to achieve the Trust’s control total could necessitate additional in year working capital finance to support the Trust’s liquidity position and its ability to repay the first of its working capital loans that falls due for repayment in February 2019 (£16.9m).</li> </ul>		

**Trust Board meeting - May 2018****5-21 Approval of Annual Accounts, 2017/18 Chair of the Audit and Governance C'ttee**

The Annual Accounts for 2017/18 are enclosed.

The Accounts, along with the External Auditors' findings, will be reviewed in detail at the Audit and Governance Committee on 24<sup>th</sup> May (before the Trust Board).

The Audit and Governance Committee will be asked to recommend that the Trust Board approves the Accounts, and a verbal update on the outcome of the Committee's review will be given at the Trust Board meeting.

Once approved, the Accounts will be signed, and submitted to the External Auditors for their opinion, the Trust will then submit via the NHSI portal and also post the original set to NHSI by noon Tuesday 29<sup>th</sup> May 2018.

**Which Committees have reviewed the information prior to Board submission?**

- Audit and Governance Committee, 02/05/18 (pre-audit draft)
- Audit and Governance Committee, 24/05/18

**Reason for receipt at the Board (decision, discussion, information, assurance etc.) <sup>1</sup>**

To review and approve the Annual Accounts for 2017/18

<sup>1</sup> All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Maidstone And Tunbridge Wells NHS Trust

Annual accounts for the year ended 31 March 2018

## Statement of Comprehensive Income

		2017/18	2016/17
	Note	£000	£000
Operating income from patient care activities	3	382,745	376,413
Other operating income	4	57,524	54,089
Operating expenses	6, 8	-421,213	-466,121
<b>Operating surplus/(deficit) from continuing operations</b>		<b>19,056</b>	<b>-35,619</b>
Finance income	11	47	34
Finance expenses	12	-15,118	-14,647
PDC dividends payable		-451	-1,851
<b>Net finance costs</b>		<b>-15,522</b>	<b>-16,464</b>
Other gains / (losses)	13	89	17
<b>Surplus / (deficit) for the year from continuing operations</b>		<b>3,623</b>	<b>-52,066</b>
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations	14	0	0
<b>Surplus / (deficit) for the year</b>		<b>3,623</b>	<b>-52,066</b>
<b>Other comprehensive income</b>			
<b>Will not be reclassified to income and expenditure:</b>			
Impairments	7	434	-24,643
Revaluations	18	328	1,161
<b>Total comprehensive income / (expense) for the period</b>		<b>4,385</b>	<b>-75,548</b>
<b>Adjusted financial performance</b>			
Surplus / (deficit) for the period (before consolidation of charity)		3,623	-52,066
Add back all I&E impairments / (reversals)		-14,662	41,293
Surplus / (deficit) before impairments and transfers		-11,039	-10,773
Remove capital donations / grants I&E impact		249	-145
CQUIN Risk Reserve - 1617 CT non achievement adjustment	50	-134	0
Adjusted financial performance surplus / (deficit)	50	-10,924	-10,918
Adjusted financial performance excluding STF		-17,876	-16,595

**Statement of Financial Position**

		<b>31 March 2018</b>	<b>31 March 2017</b>
	<b>Note</b>	<b>£000</b>	<b>£000</b>
<b>Non-current assets</b>			
Intangible assets	15	2,612	3,219
Property, plant and equipment	16	294,014	280,190
Trade and other receivables	24	1,201	1,496
<b>Total non-current assets</b>		<b>297,827</b>	<b>284,905</b>
<b>Current assets</b>			
Inventories	23	7,752	7,945
Trade and other receivables	24	37,454	46,419
Non-current assets held for sale / assets in disposal groups	26	0	1,742
Cash and cash equivalents	27	1,473	1,420
<b>Total current assets</b>		<b>46,679</b>	<b>57,526</b>
<b>Current liabilities</b>			
Trade and other payables	28	-43,893	-50,354
Borrowings	31	-24,469	-9,660
Provisions	33	-1,743	-1,744
Other liabilities	30	-2,620	-5,745
Liabilities in disposal groups	26	0	0
<b>Total current liabilities</b>		<b>-72,725</b>	<b>-67,503</b>
<b>Total assets less current liabilities</b>		<b>271,781</b>	<b>274,928</b>
<b>Non-current liabilities</b>			
Trade and other payables	28	0	0
Borrowings	31	-229,860	-239,601
Provisions	33	-1,106	-1,260
Other liabilities	30	0	0
<b>Total non-current liabilities</b>		<b>-230,966</b>	<b>-240,861</b>
<b>Total assets employed</b>		<b>40,815</b>	<b>34,067</b>
<b>Financed by</b>			
Public dividend capital		207,329	204,966
Revaluation reserve		29,852	30,304
Other reserves		0	0
Income and expenditure reserve		-196,366	-201,203
<b>Total taxpayers' equity</b>		<b>40,815</b>	<b>34,067</b>

The notes on pages 7 to 46 form part of these accounts.

The financial statements on pages 2 to 6 were approved by the Board on 24th May 2017 and signed on its behalf by:

**Chief Executive Officer:**

**Date:** 24th May 2018

**Statement of Changes in Equity for the year ended 31 March 2018**

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
<b>Taxpayers' equity at 1 April 2017 - brought forward</b>	<b>204,966</b>	<b>30,304</b>	<b>0</b>	<b>-201,203</b>	<b>34,067</b>
Surplus/(deficit) for the year	0	0	0	3,623	3,623
Impairments	0	434	0	0	434
Revaluations	0	328	0	0	328
Transfer to retained earnings on disposal of assets	0	-1,214	0	1,214	0
Public dividend capital received	2,363	0	0	0	2,363
<b>Taxpayers' equity at 31 March 2018</b>	<b>207,329</b>	<b>29,852</b>	<b>0</b>	<b>-196,366</b>	<b>40,815</b>

**Statement of Changes in Equity for the year ended 31 March 2017**

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
<b>Taxpayers' equity at 1 April 2016 - brought forward</b>	<b>203,264</b>	<b>53,800</b>	<b>0</b>	<b>-149,151</b>	<b>107,913</b>
Prior period adjustment	0	0	0	0	0
<b>Taxpayers' equity at 1 April 2016 - restated</b>	<b>203,264</b>	<b>53,800</b>	<b>0</b>	<b>-149,151</b>	<b>107,913</b>
Surplus/(deficit) for the year	0	0	0	-52,066	-52,066
Impairments	0	-24,643	0	0	-24,643
Revaluations	0	1,161	0	0	1,161
Transfer to retained earnings on disposal of assets	0	-14	0	14	0
Public dividend capital received	1,702	0	0	0	1,702
<b>Taxpayers' equity at 31 March 2017</b>	<b>204,966</b>	<b>30,304</b>	<b>0</b>	<b>-201,203</b>	<b>34,067</b>

## **Information on reserves**

### **1 Public dividend capital**

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

### **2 Income and expenditure reserve**

The balance of this reserve is the accumulated surpluses and deficits of the Trust. These are not adjusted for technical items as allowed in the break even duty performance, such as impairments or the impact of the on Statement of Financial Position accounting for the Private Finance Initiative.

### **3 Revaluation reserve**

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

### **4 Available-for-sale investment reserve**

This reserve comprises changes in the fair value of available-for-sale financial instruments. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure. The Trust has no available-for-sale investments.

### **5 Other reserves**

The Trust has no other reserves.



## Statement of Cash Flows

	Note	2017/18 £000	2016/17 £000
<b>Cash flows from operating activities</b>			
Operating surplus / (deficit)		19,056	-35,619
<b>Non-cash income and expense:</b>			
Depreciation and amortisation	6.1	13,710	13,255
Net impairments	7	-14,662	41,293
Income recognised in respect of capital donations	4	-159	-361
(Increase) / decrease in receivables and other assets		8,959	-14,436
(Increase) / decrease in inventories		193	341
Increase / (decrease) in payables and other liabilities		-8,813	11,216
Increase / (decrease) in provisions		-156	-774
<b>Net cash generated from / (used in) operating activities</b>		<b>18,128</b>	<b>14,915</b>
<b>Cash flows from investing activities</b>			
Interest received		47	34
Purchase of intangible assets		-198	-902
Purchase of property, plant, equipment and investment property		-12,253	-6,834
Sales of property, plant, equipment and investment property		1,840	0
Receipt of cash donations to purchase capital assets		159	361
<b>Net cash generated from / (used in) investing activities</b>		<b>-10,405</b>	<b>-7,341</b>
<b>Cash flows from financing activities</b>			
Public dividend capital received		2,363	1,702
Public dividend capital repaid		0	0
Movement on loans from the Department of Health and Social Care		9,358	12,416
Movement on other loans		739	0
Capital element of PFI, LIFT and other service concession payments		-5,028	-4,774
Interest paid on PFI, LIFT and other service concession obligations		-13,855	-13,546
Other interest paid		-1,263	-1,095
PDC dividend (paid) / refunded		16	-2,054
<b>Net cash generated from / (used in) financing activities</b>		<b>-7,670</b>	<b>-7,351</b>
<b>Increase / (decrease) in cash and cash equivalents</b>		<b>53</b>	<b>223</b>
<b>Cash and cash equivalents at 1 April - brought forward</b>		<b>1,420</b>	<b>1,197</b>
Prior period adjustments		0	0
<b>Cash and cash equivalents at 1 April - restated</b>		<b>1,420</b>	<b>1,197</b>
Cash and cash equivalents transferred under absorption accounting	44	0	0
<b>Cash and cash equivalents at 31 March</b>	27.1	<b>1,473</b>	<b>1,420</b>

**Notes to the Accounts****1 Note 1 Accounting policies and other information****1.1 Basis of preparation**

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

**1.1.1 Accounting convention**

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

**1.1.2 Going Concern**

These accounts have been prepared on a going concern basis.

The DH Group Accounting Manual (GAM) requires the management of the Trust to consider the following public sector interpretation of IAS 1 in respect of applying the going concern assumption when preparing its accounts, stating:

"For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern. DHSC group bodies must therefore prepare their accounts on a going concern basis unless informed by the relevant body or DHSC sponsor of the intention for dissolution without transfer of services of function to another entity. A trading entity needs to consider whether it is appropriate to continue to prepare its financial statements on a going concern basis where it is being, or is likely to be, wound up"

The Trust Board have assessed the Trust's ability to continue for the foreseeable future in the light of the GAM guidance, and assessed material uncertainties arising. The Trust has prepared the 2017/18 accounts on a "going concern" basis following consideration of the following:-

- There has been no expectation raised in the public arena that healthcare services will not continue to be provided from the two hospital sites.
- The Trust has submitted its initial business plan to NHSI in March 2018 setting out its operational plans for the following financial year (2018/19) and its capital plans for five years. The final plan submission will be made on the 30<sup>th</sup> April.
- The Trust continues to fully participate in the STP planning process including the submission of the forward 5 year financial and operating plans on a going concern basis. The Trust is leading some of the significant Work-stream areas and a key player in consideration of the shape of services in the STP for the future (e.g. the Stroke services consultation).
- The Trust has existing contracts in place for provision of healthcare services for 2018/19 being the second year of contracts signed last year. This includes the "aligned incentives" contract with two of its CCGs, West Kent (the Trust's main commissioner) and High Weald and Lewes Haven. The exact value of the year two contracts will be concluded using the agreed contract approach as part of the current business planning round. The current level of difference under discussion is immaterial in value.
- The Trust has prepared and will be submitting cash-flow forecasts for 2018/19 as part of its planning returns which do not include any assumptions of additional required working capital finance.
- There are no plans to dissolve the Trust or to cease services without transfer to any other NHS body.

The material uncertainties that the Trust has assessed are:

- To achieve its 2018/19 control total the Trust will need to deliver a challenging cost improvement programme plus a significant level of other non-recurrent measures. At this stage there is risk around the ability of the Trust to deliver this level of savings within 2018/19.
- Failure to achieve the Trust's control total could necessitate additional in year working capital finance to support the Trust's liquidity position and its ability to repay the first of its working capital loans that falls due for repayment in February 2019 (£16.9m).

**1.1.3 Critical judgements in applying accounting policies**

The following are the critical judgements, apart from those involving estimations (see below 1.1.4) that management has made in the process of applying the NHS Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

For 2017/18 the Trust has identified the following critical judgements that are required to be disclosed under IAS1 paragraph 122. All other material judgements within this financial year relate to estimations and are disclosed in the relevant notes (see 1.1.4)

Material areas of critical judgements within the 2017/18 accounts are as follows:

The financial statements have been prepared on a going concern basis as set out in note 1.1.2. In preparing the financial statements the directors have considered the Trust's overall financial position and expectation of future contractual income, cost improvements and Sustainability and Transformation Funding (STF). The Trust will be submitting a financial plan for 2018/19 to NHS Improvement which delivers agreed control totals and, including planned STF funding, £17.7m surplus for 2018/19. Note 4 (Other Operating Income) contains a reference in respect of future STF Funding.

- The Trust has applied the concept of Modern Equivalent Asset (MEA) to estimate the valuation of its property assets, as applicable, under the guidance of the DH GAM and its independent professional valuers. This may result in impairment costs or reversals falling to be recognised in reserves or the income and expenditure statement as appropriate. Please see note 18 for further information.

- Charitable Funds are not material for the Trust and have not been consolidated.

- The Trust's PFI contract continues to be judged as falling under IFRIC 12 principles as a service concession arrangement with the trust recognising an infrastructure asset and a corresponding finance lease liability, under IAS 17.

#### 1.1.4 Key sources of estimation uncertainty

Key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year where arising, will be disclosed within the relevant note. The disclosure will include the nature of the assumption and the carrying amount of the asset/liability at the Statement of Financial Position date, sensitivity of the carrying amount to the assumptions, expected resolution of uncertainty and range of possible outcomes within the next financial year. The disclosure will also include an expectation of changes to past assumptions if the uncertainty remains unresolved. The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Material areas including estimations within the 2017/18 accounts are as follows:

- Property, Plant and Equipment valuation including PFI infrastructure assets (see accounting policy note 1.6 below and also accounts note 18)

- Pension fund valuation (see note 9).

#### 1.2 Interests in other entities

The Trust does not have any interests in other entities.

#### 1.3 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of health care services. At the year end, the trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Interest revenue is accrued on a time basis, by reference to the principal outstanding and interest rate applicable.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

The NHS Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The NHS Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

#### 1.3.1 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

#### 1.4 Expenditure on employee benefits

##### Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

## **Pension Costs**

### **NHS Pension Scheme**

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. There, the schemes are accounted for as though they are defined contribution schemes.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

The Trust participates in the National Employees Savings Trust (NEST) scheme as an alternative to those employees who are not eligible to join the NHS Pension Scheme. This came into effect in July 2013 for this Trust as part of the auto enrolment requirements introduced by the Government. NEST is a defined contribution scheme with a phased employer contribution rate which was 1% for 2017/18.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

## **1.5 Expenditure on other goods and services**

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

## **1.6 Property, plant and equipment**

### **1.6.1 Recognition**

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to the NHS Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably;
- the item cost at least £5,000; or
- Collectively, a number of items have a total cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives, where this would lead to a different depreciation profile. In respect of building and dwelling assets, the Trust has determined that it is appropriate to depreciate the component blocks of the two hospital sites and individual dwellings separately, as this takes into consideration the age and condition of the asset components and their differing depreciation profile and follows the external valuation schedules. The individual elements (e.g. walls, floors, lifts, heating etc.) within these blocks are not deemed to be significant in relation to the block assets.

### **1.6.2 Measurement**

#### **Valuation**

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use.
- Specialised buildings – depreciated replacement cost, modern equivalent asset basis.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

The financial year 2017/18 is the third year in the current five year cyclical valuation period. A full valuation was undertaken in September 2014 with desktop valuations at 31st March 2015, 31st March 2016 and 30th September 2016. In keeping with the Trust's policies the Trust commissioned professional valuers, Montagu Evans LLP, to carry out a desktop valuation of the Trust's Land, Building and Dwelling assets at 31st January 2018 with an assessment of materiality conducted for 31st March 2018. The lead relationship partner from Montagu Evans LLP is qualified to BSc MRICS. The results are recorded in the property plant and equipment notes 16 and 18.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use. The Trust periodically reviews annually high value plant and machinery assets (net book value over £100k) to ensure these are held at the correct values and remaining useful lives. IT assets are also subject to annual review.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income. Any residual balance in the revaluation reserve in respect to an individual asset is transferred to the retained earnings reserve on disposal of the asset.

### 1.6.3 Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

### 1.7 Depreciation, amortisation and impairments

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, on a straight line basis over their estimated useful lives. The estimated useful life of an asset is the period over which the NHS Trust expects to obtain economic benefits or service potential from the asset. This is specific to the NHS Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful lives.

At each financial year-end, the NHS Trust checks whether there is any indication that its property, plant and equipment or intangible non-current assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets are tested for impairment at the point that they are brought into use.

#### 1.7.1 Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

#### 1.7.2 Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

**1.7.3 De-recognition (held for sale)**

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable ie:
  - management are committed to a plan to sell the asset
  - an active programme has begun to find a buyer and complete the sale
  - the asset is being actively marketed at a reasonable price
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

**1.7.4 Donated, government grant and other grant funded assets**

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

**1.8 Private Finance Initiative (PFI) transactions**

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FRm, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

- a) Payment for the fair value of services received;
- b) Payment for the PFI asset, including finance costs; and
- c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

**1.8.1 Services received**

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses' in the Statement of Comprehensive Income.

**1.8.2 PFI Asset**

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value or, if lower, at the present value of the minimum lease payments, in accordance with the principles of IAS 17. Subsequently, the assets are measured at current value in existing use, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

**1.8.3 PFI liability**

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the initial value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

**1.8.4 Lifecycle replacement**

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the NHS Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term accrual or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

#### 1.8.5 Assets contributed by the NHS Trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the NHS Trust's Statement of Financial Position.

#### 1.8.6 Other assets contributed by the NHS Trust to the operator

Assets contributed (e.g. cash payments, surplus property) by the NHS Trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the NHS Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

#### 1.9 Useful economic lives of property, plant and equipment

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life <u>Years</u>	Max life <u>Years</u>
Buildings, excluding dwellings	1	60
Dwellings	1	60
Plant & machinery	5	15
Transport equipment (including vehicles)	5	15
Information technology	3	5
Furniture & fittings	10	10
X ray Tubes	2	2
Software Licences (intangibles)	3	5
IT - In House and Third Party Software (intangibles)	2	7

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

#### 1.10 Intangible assets

##### 1.10.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Intangible assets acquired separately are initially recognised at cost. Software that is integral to the operation of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Intangible assets are assessed for impairment when they are first brought into use. Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for
- the Trust intends to complete the asset and sell or use it
- the Trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
- the Trust can measure reliably the expenses attributable to the asset during development.

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

##### 1.10.2 Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

##### 1.10.3 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

#### 1.10.4 Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

#### 1.11 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks. The cost of inventories is measured using the first in, first out (FIFO) method.

#### 1.12 Investment properties

Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure.

The Trust has no investment properties.

#### 1.13 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the NHS Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

#### 1.14 Carbon Reduction Commitment Scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Allowances acquired under the scheme are recognised as intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets.

#### 1.15 Financial instruments and financial liabilities Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made. These are derecognised when the contractual rights have expired or the asset has been transferred or when the liability has been paid or has expired.

##### De-recognition (held for sale)

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

##### Classification and measurement

Financial assets are categorised as financial assets at fair value through income and expenditure, held to maturity investments, or available-for-sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition

Financial liabilities are initially recognised at fair value through income and expenditure. The Trust's liabilities are held at cost as this is not believed to be materially different to fair value in respect of current liabilities.

##### Financial assets and financial liabilities at "fair value through income and expenditure"

Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets/financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the NHS Trust's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset/liability

The Trust does not have any embedded derivatives that have different risks and characteristics to the host contracts, therefore the Trust does not have any financial assets/liabilities at fair value through profit and loss.



### **Loans and receivables**

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and other receivables.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

### **Available for sale financial assets**

Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the trust intends to dispose of them within 12 months of the Statement of Financial Position date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of "other comprehensive income". When items classified as "available-for-sale" are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in "finance costs" in the Statement of Comprehensive Income.

### **Other financial liabilities**

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

### **Impairment of financial assets**

At the Statement of Financial Position date, the trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

## **1.16 Leases**

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

### **1.16.1 The Trust as lessee**

#### **Finance leases**

Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

#### **Operating leases**

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

#### **Leases of land and buildings**

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

**1.16.2 The NHS Trust as lessor**

Amounts due from lessees under finance leases are recorded as receivables at the amount of the NHS Trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

The balance is subsequently released to operating income over the life of the concession on a straight-line basis

**1.17 Provisions**

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.1% (2016/17 positive 0.24%) in real terms. All other provisions are subject to three separate discount rates according to the expected timing of cash flows from the Statement of Financial Position date:

- A short term rate of negative 2.42% (2016/17: negative 2.70%) for expected cash flows up to and including 5 years
- A medium term rate of negative 1.85% (2016/17: negative 1.95%) for expected cash flows over 5 years up to and including 10 years
- A long term rate of negative 1.56% (2016/17: negative 0.80%) for expected cash flows over 10 years.

All percentages are in real terms.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

**1.17.1 Clinical negligence costs**

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS resolution on behalf of the trust is disclosed at note 33 but is not recognised in the Trust's accounts.

**1.17.2 Non-clinical risk pooling**

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

**1.18 Contingencies**

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 33 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 33, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

**1.19 Public Dividend Capital (PDC) and PDC dividend**

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for

(i) donated assets (including lottery funded assets),

(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and

(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

#### 1.20 Value Added Tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

#### 1.21 Corporation tax

The Trust is not liable directly for Corporation tax and has no subsidiary companies or other associated interests that would attract Corporation tax.

#### 1.22 Foreign exchange

The functional and presentational currency of the trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at "fair value through income and expenditure") are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and;
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

#### 1.23 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

#### 1.24 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

For functions that have been transferred to the Trust from another NHS / local government body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain / loss corresponding to the net assets/ liabilities transferred is recognised within income / expenses, but not within operating activities.

For property plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the trust has transferred to another NHS / local government body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss / gain corresponding to the net assets/ liabilities transferred is recognised within expenses / income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve. Adjustments to align the acquired function to the trust's accounting policies are applied after initial recognition and are adjusted directly in taxpayers' equity.

#### **1.26 Research and Development**

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SOCI on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

#### **1.27 Early adoption of standards, amendments and interpretations**

No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

#### **1.28 Standards, amendments and interpretations in issue but not yet effective or adopted**

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2017-18. New accounting standards to be applied in 2018-19 are IFRS 9 and IFRS 15. IFRS 16 will be implemented in 2019/20.

- IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted. The Trust does not consider that application of this standard is likely to have a material impact on its accounts.
- IFRS 15 Revenue from Contracts with Customers - Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted. This standard may affect recognition of some elements of current contractual payments, this is not considered by the Trust to be likely have a material impact. The Trust will continue to assess the impact with its CCG partners in the light of further guidance.
- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted. The impact of applying this standard cannot yet be quantified as guidance on how it will be adopted into NHS accounting is awaited.
- IFRS 17 Insurance Contracts - Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 22 Foreign Currency Transactions and Advance Consideration - Application required for accounting periods beginning on or after 1 January 2018.
- IFRS 23 Uncertainty over Income Tax Treatments - Application required for accounting periods beginning on or after 1 January 2019.

## **Note 2 Operating Segments**

Maidstone and Tunbridge Wells NHS Trust reports under a single segment of Healthcare. The Trust has considered the possibility of reporting two segments, relating to Healthcare and Non Healthcare Income, but this does not reflect current Trust Board reporting practice which reports on both the aggregate Trust position and by Directorate. Each of the significant directorates are deemed to have similar economic characteristics under the Healthcare banner and can therefore be aggregated in accordance with the requirements of IFRS 8.

The Trust's income is predominantly from contracts for the provision of healthcare with clinical Commissioning Groups and NHS England. This accounts for 87% of the Trusts total income.

**Note 3 Operating income from patient care activities**

<b>Note 3.1 Income from patient care activities (by nature)</b>	<b>2017/18</b>	<b>2016/17</b>
	<b>£000</b>	<b>£000</b>
<b>Acute services</b>		
Elective income	69,204	69,577
Non elective income	103,779	99,730
First outpatient income	25,994	27,080
Follow up outpatient income	32,650	37,335
A & E income	21,645	18,681
High cost drugs income from commissioners (excluding pass-through costs)	42,791	35,015
Other NHS clinical income	75,864	74,686
<b>All services</b>		
Private patient income	2,426	4,799
Other clinical income	8,392	9,510
<b>Total income from activities</b>	<b>382,745</b>	<b>376,413</b>

**Note 3.2 Income from patient care activities (by source)**

<b>Income from patient care activities received from:</b>	<b>2017/18</b>	<b>2016/17</b>
	<b>£000</b>	<b>£000</b>
NHS England	71,361	71,154 *
Clinical Commissioning Groups	300,500	290,681
Department of Health and Social Care	0	8
Other NHS providers	3,187	3,451
NHS other	0	505
Local authorities	4,161	4,602
Non-NHS: private patients	2,426	4,799
Non-NHS: overseas patients (chargeable to patient)	270	321
NHS injury scheme	840	762
Non NHS: other	0	130
<b>Total income from activities</b>	<b>382,745</b>	<b>376,413</b>
<b>Of which:</b>		
Related to continuing operations	382,745	376,413
Related to discontinued operations	0	0

NHS injury cost recovery income is subject to a provision for impairment of receivables which the Trust has estimated using historical information for each main site. The provision rates are 22.49% for Maidstone Hospital and 18.14% of Tunbridge Wells Hospital (21.93% Maidstone Hospital and 16.25% Tunbridge Wells in 2016/17). This provision reflect expected rates of collection.

\* Previously included within Note 3.2 was revenue from NHS England in respect of £8m Central PFI financial support, this has been re-categorised as "other income" in Note 4 following 2017/18 guidance in the accompanying summarisation schedules (TACs).

**Note 3.3 Overseas visitors (relating to patients charged directly by the provider)**

	2017/18	2016/17
	£000	£000
Income recognised this year	270	321
Cash payments received in-year	152	120
Amounts added to provision for impairment of receivables	54	165
Amounts written off in-year	29	0

**Note 4 Other operating income**

	2017/18	2016/17
	£000	£000
Research and development	1,696	2,573
Education and training	10,061	10,507
Receipt of capital grants and donations	159	361
Charitable and other contributions to expenditure	0	0
Non-patient care services to other bodies	25,230	20,159
Sustainability and transformation fund income	6,952	5,677
Rental revenue from operating leases	23	23
Other income	13,403	14,789
<b>Total other operating income</b>	<b>57,524</b>	<b>54,089</b>
<b>Of which:</b>		
Related to continuing operations	57,524	54,089
Related to discontinued operations	0	0

Included within other operating income for 2017-18 is £6.952m of Sustainability and Transformation Funding (STF), which includes £3.040m of STF General Distribution. The Trust's 2018-19 plan includes £15.72m of STF funding.

Included within other income is revenue from NHS England for 2017-18 is £8m of Central PFI financial support (2016-17 £8m). The Trust's 2018-19 plan includes £8m recurrent central PFI support. This was previously treated as income from patient care activities in note 3.2.

Included within the non-patient care services to other bodies is income of £8m (£3.3m 2016/17) relating to the Kent and Medway Sustainability and Transformation Partnership (STP). The Trust agreed during 2017/18 to become the financial host of the STP budget. This funding is provided in accordance with agreements made by each STP body with STP management to cover the costs of the planned annual programme. The costs are reported within the Trusts operating costs in note 6.1.

**Further analysis of "other income"**

	2017/18	2016/17
	£000	£000
PFI support income	8,000	8,000
Car Parking income	2,094	2,346
Catering Income	1,041	1,114
Staff Accommodation	478	523
Other	1,790	2,806
	<b>13,403</b>	<b>14,789</b>

**Note 5 Fees and charges relating to "other Income"**

(aggregate of all schemes which individually have a cost exceeding £1m)

	2017/18	2016/17
	£000	£000
Income	4,010	4,247
Full cost	-2,733	-2,913
<b>Surplus / (deficit)</b>	<b>1,277</b>	<b>1,334</b>

**Car Parking**

Income	2,094	2,346
Full cost	-1,884	-1,795
<b>Surplus/(Deficit)</b>	<b>210</b>	<b>551</b>

**Catering Income**

Income	1,041	1,114
Full cost	-437	-648
<b>Surplus/(Deficit)</b>	<b>604</b>	<b>466</b>

**Note 6.1 Operating expenses**

	<b>2017/18</b>	<b>2016/17</b>
	<b>£000</b>	<b>£000</b>
Purchase of healthcare from NHS and DHSC bodies	8,561	7,673
Purchase of healthcare from non-NHS and non-DHSC bodies	4,091	8,643
Staff and executive directors costs	255,640	252,156 **
Remuneration of non-executive directors	73	75
Supplies and services - clinical (excluding drugs costs)	32,514	34,623 *
Supplies and services - general	5,443	5,356
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	52,920	51,700 *
Consultancy costs	7,606	3,839
Establishment	1,764	1,976
Premises	19,130	14,546
Transport (including patient travel)	1,946	2,078 *
Depreciation on property, plant and equipment	12,744	12,303
Amortisation on intangible assets	966	952
Net impairments	-14,662	41,293
Increase/(decrease) in provision for impairment of receivables	731	-421
Increase/(decrease) in other provisions	25	0
Change in provisions discount rate(s)	7	40
Audit fees payable to the external auditor		
audit services- statutory audit	73	89
other auditor remuneration (external auditor only)	9	13
Internal audit costs	159	151
Clinical negligence	20,911	18,231
Legal fees	162	249
Insurance	28	373 *
Research and development	0	0
Education and training	1,113	937
Rentals under operating leases	2,019	2,104 *
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	4,733	4,437 *
Charges to operating expenditure for off-SoFP IFRIC 12 schemes	0	0
Car parking & security	834	816 *
Hospitality	8	0
Losses, ex gratia & special payments	12	29 *
Other services, eg external payroll	282	262
Other	1,371	1,598 *
<b>Total</b>	<b>421,213</b>	<b>466,121</b>
<b>Of which:</b>		
Related to continuing operations	421,213	466,121
Related to discontinued operations	0	0

For further information on impairments please see Note 7.

\* prior year figures have been amended in line with the revised disclosures within this note

\*\* Staff and executive directors costs were previously shown separately under Employee Benefits.

The corresponding operating expenses relating to the STP as mentioned in income note 4, primarily relate to consultancy of £7.2m (£3.4m 2016/17) and purchase of healthcare from NHS and DHSC bodies £0.8m (£0.2m 2016/17).

The audit fees included within Note 6.1 above are reported as the gross position, the value excluding VAT for 2017/18 is £61k (2016/17 £75k).



**Note 6.2 Other auditor remuneration**

	2017/18	2016/17
	£000	£000
<b>Other auditor remuneration paid to the external auditor:</b>		
1. Audit of accounts of any associate of the trust	0	0
2. Audit-related assurance services	0	0
3. Taxation compliance services	0	0
4. All taxation advisory services not falling within item 3 above	0	0
5. Internal audit services	0	0
6. All assurance services not falling within items 1 to 5	0	0
7. Corporate finance transaction services not falling within items 1 to 6 above	0	0
8. Other non-audit services not falling within items 2 to 7 above	9	13
<b>Total</b>	<b>9</b>	<b>13</b>

The £9k reported in note 6.2 relates to the audit of the Trust's quality accounts. As the Trust does not consolidate its charitable funds (see note 1.1.3) the fee for the independent examination of the charitable fund accounts is charged directly to those funds. The total charitable funds income and costs are reported in note 43 as a related party.

**Note 6.3 Limitation on auditor's liability**

	2017/18	2016/17
	£000	£000
Limitation on auditor's liability	2,000	0

**Note 7 Impairment of assets**

	2017/18	2016/17
	£000	£000
<b>Net impairments charged to operating surplus / deficit resulting from:</b>		
Loss or damage from normal operations	0	0
Over specification of assets	0	0
Abandonment of assets in course of construction	0	0
Unforeseen obsolescence	0	0
Loss as a result of catastrophe	0	0
Changes in market price	-14,662	41,293
Other	0	0
<b>Total net impairments charged to operating surplus / deficit</b>	<b>-14,662</b>	<b>41,293</b>
Impairments charged to the revaluation reserve	-434	24,643
<b>Total net impairments</b>	<b>-15,096</b>	<b>65,936</b>

The Trust commissioned its independent professional valuers to undertake an interim desktop valuation as at the 31st January 2018 to support its assessment of year end property valuations. The result of the valuation has been a net increase in property valuations leading to the reversal of previous impairments charged to the Income and Expenditure account. This is reflected in the movement on impairments reported above.

**Note 8 Employee benefits**

	<b>2017/18</b>	<b>2016/17</b>
	<b>Total</b>	<b>Total</b>
	<b>£000</b>	<b>£000</b>
Salaries and wages	189,751	189,250
Social security costs	20,549	18,526
Apprenticeship levy	991	0
Employer's contributions to NHS pensions	22,979	22,850
Pension cost - other	5	6
Temporary staff (including agency)	22,857	23,747
<b>Total gross staff costs</b>	<b>257,132</b>	<b>254,379</b>
Recoveries in respect of seconded staff	0	0
<b>Total staff costs</b>	<b>257,132</b>	<b>254,379</b>
<b>Of which</b>		
Costs capitalised as part of assets	1,492	2,223

Further information on staff benefits by category of staff, exit packages and staff sickness absence is reported in the remuneration and staff section of the Trust annual report.

**Note 8.1 Retirements due to ill-health**

During 2017/18 there were 4 early retirements from the trust agreed on the grounds of ill-health (7 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £209k (£413k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

**Note 9 Pension costs**

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at [www.nhsbsa.nhs.uk/pensions](http://www.nhsbsa.nhs.uk/pensions). Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

**a) Accounting valuation**

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

**b) Full actuarial (funding) valuation**

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

The Trust participates in the National Employees Savings Trust (NEST) scheme as an alternative to those employees who are not eligible to join the NHS Pension Scheme. This came into effect in July 2013 for this Trust as part of the auto enrolment requirements introduced by the Government. NEST is a defined contribution scheme with a phased employer contribution rate, set at 1% for 2017/18. Trust contributions under the NEST scheme for the 2017/18 financial year totalled £5k (£6k 2016/17).

**Note 10 Operating leases****Note 10.1 Maidstone And Tunbridge Wells NHS Trust as a lessor**

This note discloses income generated in operating lease agreements where Maidstone And Tunbridge Wells NHS Trust is the lessor.

The Trust leases an element of land on the Maidstone Hospital site to a day nursery contractor

	2017/18 £000	2016/17 £000
<b>Operating lease revenue</b>		
Minimum lease receipts	23	23
Contingent rent	0	0
Other	0	0
<b>Total</b>	<b>23</b>	<b>23</b>
	<b>31 March 2018 £000</b>	<b>31 March 2017 £000</b>
<b>Future minimum lease receipts due:</b>		
- not later than one year;	23	29
- later than one year and not later than five years;	94	147
- later than five years.	141	206
<b>Total</b>	<b>258</b>	<b>382</b>

**Note 10.2 Maidstone And Tunbridge Wells NHS Trust as a lessee**

This note discloses costs and commitments incurred in operating lease arrangements where Maidstone And Tunbridge Wells NHS Trust is the lessee.

The three main operating leases with values charged to operating expenses in year are disclosed below:

Danwood - Lease of photocopiers and printers under a managed service arrangement, £805k (£875k 2016-17). The contract is expected to complete in June 2021.

Ash Corporate Finance - lease of the laundry land, buildings and equipment, £263k (£323k 2016-17). The lease is for a 25 year term and contains a break clause in December 2020.

Roche Diagnostic Limited - lease of equipment to support the pathology and clinical chemistry managed service, £236k (£253k 2016-17). This arrangement completes in May 2020 with an option to extend for up to a further 3 years.

	2017/18 £000	2016/17 £000
<b>Operating lease expense</b>		
Minimum lease payments	2,019	2,104
Contingent rents	0	0
Less sublease payments received	0	0
<b>Total</b>	<b>2,019</b>	<b>2,104</b>
	<b>31 March 2018 £000</b>	<b>31 March 2017 £000</b>
<b>Future minimum lease payments due:</b>		
- not later than one year;	2,000	2,112
- later than one year and not later than five years;	4,257	8,015
- later than five years.	1,468	1,300
<b>Total</b>	<b>7,725</b>	<b>11,427</b>
Future minimum sublease payments to be received	0	0

**Note 11 Finance income**

Finance income represents interest received on assets and investments in the period.

	2017/18	2016/17
	£000	£000
Interest on bank accounts	47	34
<b>Total</b>	<b>47</b>	<b>34</b>

**Note 12.1 Finance expenditure**

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2017/18	2016/17
	£000	£000
<b>Interest expense:</b>		
Loans from the Department of Health and Social Care	1,248	1,086
Interest on late payment of commercial debt	14	8
Main finance costs on PFI and LIFT schemes obligations	10,657	10,912
Contingent finance costs on PFI and LIFT scheme obligations	3,198	2,635
<b>Total interest expense</b>	<b>15,117</b>	<b>14,641</b>
Unwinding of discount on provisions	1	6
Other finance costs	0	0
<b>Total finance costs</b>	<b>15,118</b>	<b>14,647</b>

**Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015**

	2017/18	2016/17
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	0	0
Amounts included within interest payable arising from claims made under this legislation	14	8
Compensation paid to cover debt recovery costs under this legislation	0	0

The Trust made 15 late payment and interest charges totalling £14k .

**Note 13 Other gains / (losses)**

	2017/18	2016/17
	£000	£000
Gains on disposal of assets	89	17
Losses on disposal of assets	0	0
<b>Total gains / (losses) on disposal of assets</b>	<b>89</b>	<b>17</b>
Gains / (losses) on foreign exchange	0	0
Fair value gains / (losses) on investment properties	0	0
Fair value gains / (losses) on financial assets / investments	0	0
Fair value gains / (losses) on financial liabilities	0	0
Recycling gains / (losses) on disposal of available-for-sale financial investments	0	0
<b>Total other gains / (losses)</b>	<b>89</b>	<b>17</b>

**Note 14 Discontinued operations**

The Trust has no discontinued operations

**Note 15.1 Intangible assets - 2017/18**

	Software licences £000	Internally generated information technology £000	Total £000
<b>Valuation / gross cost at 1 April 2017 - brought forward</b>	<b>579</b>	<b>7,546</b>	<b>8,125</b>
Transfers by absorption	0	0	0
Additions	0	198	198
Impairments	0	-3,665	-3,665
Reversals of impairments	0	0	0
Revaluations	0	0	0
Reclassifications	37	3,789	3,826
Disposals / derecognition	0	0	0
<b>Gross cost at 31 March 2018</b>	<b>616</b>	<b>7,868</b>	<b>8,484</b>
<b>Amortisation at 1 April 2017 - brought forward</b>	<b>431</b>	<b>4,475</b>	<b>4,906</b>
Transfers by absorption	0	0	0
Provided during the year	57	909	966
Impairments	0	0	0
Reversals of impairments	0	0	0
Revaluations	0	0	0
Reclassifications	0	0	0
Disposals / derecognition	0	0	0
<b>Amortisation at 31 March 2018</b>	<b>488</b>	<b>5,384</b>	<b>5,872</b>
<b>Net book value at 31 March 2018</b>	<b>128</b>	<b>2,484</b>	<b>2,612</b>
<b>Net book value at 1 April 2017</b>	<b>148</b>	<b>3,071</b>	<b>3,219</b>

**Note 15.2 Intangible assets - 2016/17**

	Software licences £000	Internally generated information technology £000	Total £000
<b>Valuation / gross cost at 1 April 2016 - as previously stated</b>	<b>458</b>	<b>6,749</b>	<b>7,207</b>
Prior period adjustments	0	0	0
<b>Valuation / gross cost at 1 April 2016 - restated</b>	<b>458</b>	<b>6,749</b>	<b>7,207</b>
Transfers by absorption	0	0	0
Additions	121	781	902
Reclassifications	0	16	16
<b>Valuation / gross cost at 31 March 2017</b>	<b>579</b>	<b>7,546</b>	<b>8,125</b>
<b>Amortisation at 1 April 2016 - as previously stated</b>	<b>366</b>	<b>3,588</b>	<b>3,954</b>
Prior period adjustments	0	0	0
<b>Amortisation at 1 April 2016 - restated</b>	<b>366</b>	<b>3,588</b>	<b>3,954</b>
Transfers by absorption	0	0	0
Provided during the year	65	887	952
<b>Amortisation at 31 March 2017</b>	<b>431</b>	<b>4,475</b>	<b>4,906</b>
<b>Net book value at 31 March 2017</b>	<b>148</b>	<b>3,071</b>	<b>3,219</b>
<b>Net book value at 1 April 2016</b>	<b>92</b>	<b>3,161</b>	<b>3,253</b>

## Item 5-21. Attachment 18 - Annual Accounts 2017-18

## Note 16.1 Property, plant and equipment - 2017/18

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
<b>Valuation/gross cost at 1 April 2017 - brought forward</b>	<b>13,496</b>	<b>235,321</b>	<b>3,480</b>	<b>6,184</b>	<b>80,952</b>	<b>858</b>	<b>19,244</b>	<b>2,764</b>	<b>362,299</b>
<b>Valuation/gross cost at start of period as FT</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
Transfers by absorption	0	0	0	0	0	0	0	0	0
Additions	0	4,612	20	4,630	1,147	0	896	0	11,305
Impairments charged to operating expenses	-38	-466	-37	0	0	0	-411	0	-952
Impairments charged to the revaluation reserve	-116	-2,362	-187	0	0	0	0	0	-2,665
Reversals of impairments credited to operating expenses	0	19,279	0	0	0	0	0	0	19,279
Reversals of impairments credited to the revaluation reserve	0	3,092	7	0	0	0	0	0	3,099
Revaluations	0	328	0	0	0	0	0	0	328
Reclassifications	0	15	0	-6,114	1,918	0	355	0	-3,826
Transfers to/ from assets held for sale	0	0	0	0	0	0	0	0	0
Disposals / derecognition	0	0	0	0	-127	-14	0	0	-141
Transfer to FT upon authorisation	0	0	0	0	0	0	0	0	0
<b>Valuation/gross cost at 31 March 2018</b>	<b>13,342</b>	<b>259,819</b>	<b>3,283</b>	<b>4,700</b>	<b>83,890</b>	<b>844</b>	<b>20,084</b>	<b>2,764</b>	<b>388,726</b>
<b>Accumulated depreciation at 1 April 2017 - brought forward</b>	<b>0</b>	<b>2,681</b>	<b>295</b>	<b>0</b>	<b>60,516</b>	<b>844</b>	<b>16,164</b>	<b>1,609</b>	<b>82,109</b>
Provided during the year	0	5,461	124	0	5,580	5	1,320	254	12,744
Disposals / derecognition	0	0	0	0	-127	-14	0	0	-141
<b>Accumulated depreciation at 31 March 2018</b>	<b>0</b>	<b>8,142</b>	<b>419</b>	<b>0</b>	<b>65,969</b>	<b>835</b>	<b>17,484</b>	<b>1,863</b>	<b>94,712</b>
<b>Net book value at 31 March 2018</b>	<b>13,342</b>	<b>251,677</b>	<b>2,864</b>	<b>4,700</b>	<b>17,921</b>	<b>9</b>	<b>2,600</b>	<b>901</b>	<b>294,014</b>
<b>Net book value at 1 April 2017</b>	<b>13,496</b>	<b>232,640</b>	<b>3,185</b>	<b>6,184</b>	<b>20,436</b>	<b>14</b>	<b>3,080</b>	<b>1,155</b>	<b>280,190</b>

## Note 16.2 Property, plant and equipment - 2016/17

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
<b>Valuation / gross cost at 1 April 2016 - as previously stated</b>	<b>18,275</b>	<b>297,231</b>	<b>4,085</b>	<b>3,016</b>	<b>79,024</b>	<b>960</b>	<b>19,009</b>	<b>2,755</b>	<b>424,355</b>
<b>Valuation / gross cost at 1 April 2016 - restated</b>	<b>18,275</b>	<b>297,231</b>	<b>4,085</b>	<b>3,016</b>	<b>79,024</b>	<b>960</b>	<b>19,009</b>	<b>2,755</b>	<b>424,355</b>
Additions	0	2,400	22	3,830	2,066	0	310	9	8,637
Impairments charged to operating expenses	0	-41,188	0	0	0	0	-118	0	-41,306
Impairments charged to the revaluation reserve	-4,863	-23,329	37	0	0	0	0	0	-28,155
Reversals of impairments credited to operating expenses	0	13	0	0	0	0	0	0	13
Reversals of impairments credited to the revaluation reserve	0	203	0	0	0	0	0	0	203
Revaluations	609	516	36	0	0	0	0	0	1,161
Reclassifications	0	0	0	-662	603	0	43	0	-16
Transfers to / from assets held for sale	-525	-525	-700	0	0	0	0	0	-1,750
Disposals / derecognition	0	0	0	0	-741	-102	0	0	-843
<b>Valuation/gross cost at 31 March 2017</b>	<b>13,496</b>	<b>235,321</b>	<b>3,480</b>	<b>6,184</b>	<b>80,952</b>	<b>858</b>	<b>19,244</b>	<b>2,764</b>	<b>362,299</b>
<b>Accumulated depreciation at 1 April 2016 - as previously stated</b>	<b>0</b>	<b>0</b>	<b>161</b>	<b>0</b>	<b>56,941</b>	<b>924</b>	<b>14,524</b>	<b>1,408</b>	<b>73,958</b>
<b>Accumulated depreciation at 1 April 2016 - restated</b>	<b>0</b>	<b>0</b>	<b>161</b>	<b>0</b>	<b>56,941</b>	<b>924</b>	<b>14,524</b>	<b>1,408</b>	<b>73,958</b>
Provided during the year	0	5,993	139	0	4,308	22	1,640	201	12,303
Impairments	0	-3,309	0	0	0	0	0	0	-3,309
Transfers to/ from assets held for sale	0	-3	-5	0	0	0	0	0	-8
Disposals / derecognition	0	0	0	0	-733	-102	0	0	-835
<b>Accumulated depreciation at 31 March 2017</b>	<b>0</b>	<b>2,681</b>	<b>295</b>	<b>0</b>	<b>60,516</b>	<b>844</b>	<b>16,164</b>	<b>1,609</b>	<b>82,109</b>
<b>Net book value at 31 March 2017</b>	<b>13,496</b>	<b>232,640</b>	<b>3,185</b>	<b>6,184</b>	<b>20,436</b>	<b>14</b>	<b>3,080</b>	<b>1,155</b>	<b>280,190</b>
<b>Net book value at 1 April 2016</b>	<b>18,275</b>	<b>297,231</b>	<b>3,924</b>	<b>3,016</b>	<b>22,083</b>	<b>36</b>	<b>4,485</b>	<b>1,347</b>	<b>350,397</b>

**Note 16.3 Property, plant and equipment financing - 2017/18**

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
<b>Net book value at 31 March 2018</b>									
Owned - purchased	13,342	94,280	2,864	4,700	16,558	9	2,590	901	<b>135,244</b>
Finance leased	0	0	0	0	0	0	0	0	<b>0</b>
On-SoFP PFI contracts and other service concession arrangements	0	157,365	0	0	0	0	0	0	<b>157,365</b>
PFI residual interests	0	0	0	0	0	0	0	0	<b>0</b>
Owned - government granted	0	0	0	0	0	0	0	0	<b>0</b>
Owned - donated	0	32	0	0	1,363	0	10	0	<b>1,405</b>
<b>NBV total at 31 March 2018</b>	<b>13,342</b>	<b>251,677</b>	<b>2,864</b>	<b>4,700</b>	<b>17,921</b>	<b>9</b>	<b>2,600</b>	<b>901</b>	<b>294,014</b>

**Note 16.4 Property, plant and equipment financing - 2016/17**

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
<b>Net book value at 31 March 2017</b>									
Owned - purchased	13,496	90,619	3,185	6,184	18,830	14	3,065	1,155	<b>136,548</b>
Finance leased	0	0	0	0	0	0	0	0	<b>0</b>
On-SoFP PFI contracts and other service concession arrangements	0	141,992	0	0	0	0	0	0	<b>141,992</b>
PFI residual interests	0	0	0	0	0	0	0	0	<b>0</b>
Owned - government granted	0	0	0	0	0	0	0	0	<b>0</b>
Owned - donated	0	29	0	0	1,606	0	15	0	<b>1,650</b>
<b>NBV total at 31 March 2017</b>	<b>13,496</b>	<b>232,640</b>	<b>3,185</b>	<b>6,184</b>	<b>20,436</b>	<b>14</b>	<b>3,080</b>	<b>1,155</b>	<b>280,190</b>



#### **Note 17 Donations of property, plant and equipment**

Within the financial year 2017/18 the Trust purchased medical equipment totalling £159k from Charitable Funds. The three main items purchased were a vascular ultrasound for cardiology at Tunbridge Wells Hospital from the Mollie Hayling Cardiology Legacy for £16k and a portable Echo Machine for Maidstone Cardiology from the David Crow legacy for £67k. The Trust also brought a Ultrasound for Oncology for £49k.

The Tunbridge Wells League of Friends have purchased a Fetal Monitor and Resuscitaire for the Maternity department and they have also bought a bladder scanner for ward 10 in total was £20k. The Maidstone League of Friends at Maidstone have purchased a bladder scanner for MSSU for £7k.

#### **Note 18 Revaluations of property, plant and equipment**

The Trust spent £11.5m on tangible assets from its capital resource in 2017/18. The main items were a £2.3m linear accelerator machine, with £1.7m being funded from central PDC, £4.7m of backlog estates and renewal schemes, £2.3m on information Technology projects, and £1.8m on medical and other equipment. In addition £371k of lifecycle capital was recognised as undertaken by the Trust's PFI partner in the year and accounted for under IFRIC 12.

The Trust's depreciation on tangible assets in the year was £12.7m and for intangible assets it was £1m.

The financial year 2017/18 is the third year in the current five year cyclical valuation period. A full valuation was undertaken in September 2014 with desktop valuations at 31st March 2015, 31st March 2016 and 30th September 2016. In keeping with the Trust's policies the Trust commissioned professional valuers, Montagu Evans LLP, to carry out a desktop valuation of the Trust's Land, Building and Dwelling assets at 31st January 2018 with an assessment of materiality conducted for 31st March 2018. Following the assessment the BCIS movement is immaterial therefore the values at year end are based on the valuation of 31st January 2018.

Specialist properties (main hospitals) have been valued on Depreciation Replacement Cost (DRC) using the modern Equivalent Assets (MEA) valuation concept. Non specialised buildings and land have been valued on an Existing Use Value (EUV) basis and key worker accommodation has been valued on an EUV - Social Housing basis in line with RICS guidelines, and taking account the Trust's previous approach to the application of MEA e.g. the PFI property valued excluding recoverable VAT.

The 31st January 2018 valuation resulted in an overall increase in the carrying value of the Trust's Land and Property assets of £19.5m, of which £18.7m reversed previous I&E impairments reflected in operating expenses and £0.4m reversed previous revaluation reserve entries. The increase was driven by a rise in component BCIS indices with specific areas such as wards increasing significantly.

The Valuers considered the remaining useful economic lives of the Property assets taking into account work undertaken between valuations, and the age and condition of the properties.

For intangible asset classes there is no active market for specialised software / licences. The DH Manual prescribes that in such cases where there is no active market and the asset is not income generating, the asset should be carried at depreciated replacement cost. For the purposes of arriving at fair value, this asset class is held at depreciated historic cost as a reasonable proxy to fair value. The Trust recognises intangible assets initially at cost and then reviews subsequently their measurements at current value in existing use to identify if any impairments arisen.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value. The Trust has reviewed its plant and machinery assets to ensure that both the value and the remaining lives are held at the correct values. A fair value assessment of IT tangible assets has been carried out based on a valuation model as advised by Trust experts, this is in accordance with the Trust's policy 1.6.2.

#### **Note 19.1 Investment Property**

The Trust has no investment properties

**Note 20 Investments in associates and joint ventures**

The Trust has no investments in associates or joint ventures

**Note 21 Other investments / financial assets (non-current)**

The Trust have no other investments

**Note 22 Disclosure of interests in other entities**

The Trust have no interests in other entities

**Note 23 Inventories**

	<b>31 March 2018 £000</b>	<b>31 March 2017 £000</b>
Drugs	2,952	3,336
Work In progress	0	0
Consumables	1,053	888
Energy	153	114
Other	3,594	3,607
<b>Total inventories</b>	<b>7,752</b>	<b>7,945</b>
<b>of which:</b>		
Held at fair value less costs to sell	0	0

Additions of inventories recognised in expenses for the year were £53,044k (2016/17 £53,864k). Write-down of inventories recognised as expenses for the year were £0k (2016/17 £0k).

**Note 24.1 Trade receivables and other receivables**

	<b>31 March 2018 £000</b>	<b>31 March 2017 £000</b>
<b>Current</b>		
Trade receivables	14,439	38,147 *
Capital receivables (including accrued capital related income)	107	107
Accrued income	16,583	1,045 *
Provision for impaired receivables	-1,365	-797
Deposits and advances	0	0
Prepayments (non-PFI)	3,289	3,685 *
PDC dividend receivable	216	683
VAT receivable	2,543	2,068
Other receivables	1,642	1,481
<b>Total current trade and other receivables</b>	<b>37,454</b>	<b>46,419</b>
<b>Non-current</b>		
Prepayments (non-PFI)	439	308
PFI prepayments - capital contributions	193	158
Other receivables	569	1,030
<b>Total non-current trade and other receivables</b>	<b>1,201</b>	<b>1,496</b>
<b>Of which receivables from NHS and DHSC group bodies:</b>		
Current	27,897	35,961
Non-current	0	0

The great majority of trade is with Clinical Commissioning Groups (CCGs) as commissioners for NHS patient care services. As CCGs are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary. A provision for the impairment of trade receivables is made for debts over 120 days.

\* prior year comparators have been reclassified in line with the 2017/18 disclosures

**Note 24.2 Provision for impairment of receivables**

	2017/18	2016/17
	£000	£000
<b>At 1 April as previously stated</b>	<b>-797</b>	<b>-1,273</b>
Prior period adjustments	0	0
<b>At 1 April - restated</b>	<b>-797</b>	<b>-1,273</b>
Transfers by absorption	0	0
Increase in provision	-1,220	421
Amounts utilised	163	55
Unused amounts reversed	489	0
<b>At 31 March</b>	<b>-1,365</b>	<b>-797</b>

The provision of receivables includes provision for all non-NHS invoices over 120 days overdue plus any other invoices that are deemed to be a specific risk. In addition injury cost recovery debt is provided for in accordance with the approach set out in note 3.2

**Note 24.3 Credit quality of financial assets**

	31 March 2018	31 March 2017
	Trade and other receivables	Trade and other receivables
	£000	£000
<b>Ageing of impaired financial assets</b>		
0 - 30 days	13	31
30-60 Days	23	29
60-90 days	92	60
90- 180 days	362	122
Over 180 days	875	555
<b>Total</b>	<b>1,365</b>	<b>797</b>
<b>Ageing of non-impaired financial assets past their due date</b>		
0 - 30 days	0	0
30-60 Days	1,888	2,552
60-90 days	1,295	2,650
90- 180 days	1,078	1,855
Over 180 days	2,311	926
<b>Total</b>	<b>6,572</b>	<b>7,983</b>

The provision of impaired receivables includes provisions for all non-NHS invoices over 120 days overdue plus any other invoices that are deemed to be a specific risk. This includes provisions for impaired injury cost recovery debt.

Non-impaired financial assets over 120 days relates to debt to other NHS bodies, the Trust does not provide for this debt category.

**Note 25 Other assets**

The Trust has no other assets

**Note 26 Non-current assets held for sale and assets in disposal groups**

	2017/18 £000	2016/17 £000
<b>NBV of non-current assets for sale and assets in disposal groups at 1 April</b>	<b>1,742</b>	<b>0</b>
Prior period adjustment		0
<b>NBV of non-current assets for sale and assets in disposal groups at 1 April - restated</b>	<b>1,742</b>	<b>0</b>
Transfers by absorption	0	0
Assets classified as available for sale in the year	0	1,742
Assets sold in year	-1,742	0
Impairment of assets held for sale	0	0
Reversal of impairment of assets held for sale	0	0
Assets no longer classified as held for sale, for reasons other than disposal by sale	0	0
<b>NBV of non-current assets for sale and assets in disposal groups at 31 March</b>	<b>0</b>	<b>1,742</b>

The Trust Board approved the disposal of two residential properties at Pembury in December 2016; the Spring and Hillcroft. These were previously held at fair value as assets surplus to use with no plan to bring back into use. The assets were immediately available for sale, there was a clear plan for disposal (the assets were duly registered on the public sector notification site) and expectation of sale within a year. Therefore the assets were reclassified from non current assets to assets held for sale.

The Hillcroft property was sold and proceeds were received in September 2017. The Spring property was sold and proceeds received in January.

**Note 26.1 Liabilities in disposal groups**

The Trust has no liabilities in disposal groups

**Note 27.1 Cash and cash equivalents movements**

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2017/18	2016/17
	£000	£000
<b>At 1 April</b>	<b>1,420</b>	<b>1,197</b>
Prior period adjustments	0	0
<b>At 1 April (restated)</b>	<b>1,420</b>	<b>1,197</b>
Transfers by absorption	0	0
Net change in year	53	223
<b>At 31 March</b>	<b>1,473</b>	<b>1,420</b>
<b>Broken down into:</b>		
Cash at commercial banks and in hand	67	54
Cash with the Government Banking Service	1,406	1,366
Deposits with the National Loan Fund	0	0
Other current investments	0	0
<b>Total cash and cash equivalents as in SoFP</b>	<b>1,473</b>	<b>1,420</b>
Bank overdrafts (GBS and commercial banks)	0	0
Drawdown in committed facility	0	0
<b>Total cash and cash equivalents as in SoCF</b>	<b>1,473</b>	<b>1,420</b>

**Note 27.2 Third party assets held by the trust**

The Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March	31 March
	2018	2017
	£000	£000
Bank balances	1	1
Monies on deposit	0	0
<b>Total third party assets</b>	<b>1</b>	<b>1</b>

**Note 28.1 Trade and other payables**

	<b>31 March 2018 £000</b>	<b>31 March 2017 £000</b>
<b>Current</b>		
Trade payables	21,144	28,027
Capital payables	2,628	3,410
Accruals	12,994	12,247
Receipts in advance (including payments on account)	0	0
Social security costs	2,801	2,751
VAT payables	0	0
Other taxes payable	2,429	2,409
PDC dividend payable	0	0
Accrued interest on loans	111	105
Other payables	1,786	1,405
<b>Total current trade and other payables</b>	<b>43,893</b>	<b>50,354</b>

\* Deferred income is now in Note 30, was previously in Trade and other payables note

**Non-current**

The Trust does not have any non-current liabilities

**Of which payables from NHS and DHSC group bodies:**

Current	8,767	4,455
Non-current	0	0

**Note 28.2 Early retirements in NHS payables above**

The payables note above includes amounts in relation to early retirements as set out below:

	<b>31 March 2018 £000</b>	<b>31 March 2018 Number</b>	<b>31 March 2017 £000</b>	<b>31 March 2017 Number</b>
- to buy out the liability for early retirements over 5 years	0		0	
- number of cases involved		0		0
- outstanding pension contributions	3,191		3,159	

**Note 29 Other financial liabilities**

The Trust has no other financial liabilities

**Note 30 Other liabilities**

	31 March 2018 £000	31 March 2017 £000
<b>Current</b>		
Deferred income	2,620	5,745
Deferred grants	0	0
PFI deferred income / credits	0	0
Lease incentives	0	0
<b>Total other current liabilities</b>	<b>2,620</b>	<b>5,745</b>

**Non-current**

The Trust does not have any non-current liabilities

**Note 31 Borrowings**

	31 March 2018 £000	31 March 2017 £000
<b>Current</b>		
Bank overdrafts	0	0
Drawdown in committed facility	0	0
Loans from the Department of Health and Social Care	19,082	4,632
Other loans	103	0
Obligations under finance leases	0	0
PFI lifecycle replacement received in advance	0	0
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	5,284	5,028
<b>Total current borrowings</b>	<b>24,469</b>	<b>9,660</b>

**Non-current**

Loans from the Department of Health and Social Care	36,276	41,368
Other loans	636	0
Obligations under finance leases	0	0
PFI lifecycle replacement received in advance	0	0
Obligations under PFI, LIFT or other service concession contracts	192,948	198,233
<b>Total non-current borrowings</b>	<b>229,860</b>	<b>239,601</b>

Department of Health (DoH) loans totalling £29m have been taken out to finance the Trust capital programme. The £11m loan received on the 15th March 2010 has a final repayment date of 15th March 2025, with a fixed interest rate of 3.91%. The loan of £12m taken out on the 15th September 2010 has a final repayment date of 15th September 2020 with a fixed interest rate of 2.02%. The loan of £6m taken out on the 15th December 2010 has a final repayment date of 15th September 2035 at a fixed rate of 4.73%

Included within the £19.1m Loans from the Department of Health and Social Care is £16.9m single currency loan which was previously classed as non current. This loan is to be repaid in February 2019 and has a fixed interest rate of 1.5%.

Within the £36.3m loans from DoH is an interim revolving capital loan of £12.132m which is repayable in 2019/20 and has a fixed interest rate of 3.5%. The remaining balance within the DoH loans is a combination of 3 working capital loans totalling £13.99m which were taken out in 2017/18. These loans are repayable in 2020/21 and have a fixed interest rate of 3.5%

The Trust also took out a Salix loan of £739k which appears in "other loans" in both current and non current borrowings, this relates to improving the energy efficiency of the Trust. This loan is repayable over 5 years and is interest free. Salix Finance Ltd provides interest-free Government funding to the public sector to improve their energy efficiency, reduce carbon emissions and lower energy bills. Salix is funded by the Department for Business, Energy and Industrial Strategy, the Department for Education, the Welsh Government and the Scottish Government and was established in 2004 as an independent, publicly funded company, dedicated to providing the public sector with loans for energy efficiency projects.

**Note 32 Finance leases**

The Trust does not have any finance leases



**Note 33.1 Provisions for liabilities and charges analysis**

	<b>Pensions - early departure costs</b>	<b>Legal claims</b>	<b>Re- structuring</b>	<b>Continuing care</b>	<b>Equal Pay (including Agenda for Change)</b>	<b>Redundancy</b>	<b>Other</b>	<b>Total</b>
	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>
<b>At 1 April 2017</b>	<b>443</b>	<b>413</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2,148</b>	<b>3,004 *</b>
Transfers by absorption	0	0	0	0	0	0	0	0
Change in the discount rate	7	0	0	0	0	0	0	7
Arising during the year	26	261	0	0	0	0	0	287
Utilised during the year	-23	-57	0	0	0	0	-164	-244
Reclassified to liabilities held in disposal groups	0	0	0	0	0	0	0	0
Reversed unused	0	-206	0	0	0	0	0	-206
Unwinding of discount	1	0	0	0	0	0	0	1
<b>At 31 March 2018</b>	<b>454</b>	<b>411</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,984</b>	<b>2,849</b>
<b>Expected timing of cash flows:</b>								
- not later than one year;	23	411	0	0	0	0	1,309	1,743
- later than one year and not later than five years;	92	0	0	0	0	0	675	767
- later than five years.	339	0	0	0	0	0	0	339
<b>Total</b>	<b>454</b>	<b>411</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,984</b>	<b>2,849</b>

Pension early departure costs relate to two ill health injury benefits calculated by current payment made by NHS Pensions Agency adjusted for average life expectancy using tables published by the National Statistics Office. Legal claims include estimates notified by NHS Resolution.

\*Prior year amendment between "Pensions early departure" category and "other" of £17k, no change to the overall balance

Other includes the provision for dilapidations of leased properties/equipment £1.8m and onerous contract provision £0.2k

**Note 33.2 Clinical negligence liabilities**

At 31 March 2018, £209,175k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Maidstone And Tunbridge Wells NHS Trust (31 March 2017: £164,886k).

**Note 34 Contingent assets and liabilities**

	31 March 2018 £000	31 March 2017 £000
<b>Value of contingent liabilities</b>		
NHS Resolution legal claims	-47	-57
Employment tribunal and other employee related litigation	0	0
Redundancy	0	0
Other	0	0
<b>Gross value of contingent liabilities</b>	<b>-47</b>	<b>-57</b>
Amounts recoverable against liabilities	0	0
<b>Net value of contingent liabilities</b>	<b>-47</b>	<b>-57</b>
<b>Net value of contingent assets</b>	<b>0</b>	<b>0</b>

Contingent liability relates to legal claims notified by NHS Resolution of £47k

**Note 35 Contractual capital commitments**

	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	428	710
Intangible assets	0	0
<b>Total</b>	<b>428</b>	<b>710</b>

**Note 36 Other financial commitments**

The Trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	31 March 2018 £000	31 March 2017 £000
not later than 1 year	0	0
after 1 year and not later than 5 years	0	0
paid thereafter	0	0
<b>Total</b>	<b>0</b>	<b>0</b>

**Note 37 Defined benefit pension schemes**

The Trust does not have any defined benefit schemes

**Note 38 On-SoFP PFI, LIFT or other service concession arrangements**

The Trust signed a PFI project agreement on 26th March 2008 for the new Tunbridge Wells Hospital at Pembury. The main building was handed over by the contractor in phases in December 2010 and May 2011 and recognised in the Trust's accounts accordingly. By joint agreement with the Trust's PFI partner the final phase of car parking & landscaping were completed and handed over early in January 2012, although contractual phasing and unitary payments were kept in line with the project agreement completion date of September 2012. The arrangement covers the provision of buildings, hard facilities management services and lifecycle replacement (building & engineering asset renewals). Under the project agreement the Trust has agreed expectations for the provision of these services and has termination options on default. The land remains the Trust's asset throughout the concession. The concession is due to run for 30 years until 2042 when the building will revert to the Trust. The annual unitary payment was contracted at £16.9m at 2005/06 prices, and is subject to an annual uplift by Retail Price Index which for the 2017/18 year was 3.23%. The RPI uplift for 2018/19 is 3.61%.

**Note 38.1 Imputed finance lease obligations**

Maidstone And Tunbridge Wells NHS Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	31 March 2018	31 March 2017
	£000	£000
<b>Gross PFI, LIFT or other service concession liabilities</b>	<b>352,387</b>	<b>368,073</b>
<b>Of which liabilities are due</b>		
- not later than one year;	15,673	15,686
- later than one year and not later than five years;	60,582	61,316
- later than five years.	276,132	291,071
Finance charges allocated to future periods	-154,155	-164,812
<b>Net PFI, LIFT or other service concession arrangement obligation</b>	<b>198,232</b>	<b>203,261</b>
- not later than one year;	5,284	5,028
- later than one year and not later than five years;	21,865	21,462
- later than five years.	171,083	176,771

**Note 38.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments**

Total future obligations under these on-SoFP schemes are as follows:

	31 March 2018	31 March 2017
	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	823,081	846,969
<b>Of which liabilities are due:</b>		
- not later than one year;	24,752	23,888
- later than one year and not later than five years;	105,352	102,782
- later than five years.	692,977	720,299

**Note 38.3 Analysis of amounts payable to service concession operator**

This note provides an analysis of the trust's payments in 2017/18:

	2017/18	2016/17
	£000	£000
Unitary payment payable to service concession operator	23,888	23,142
<b>Consisting of:</b>		
- Interest charge	10,657	10,912
- Repayment of finance lease liability	5,028	4,774
- Service element and other charges to operating expenditure	4,503	4,268
- Capital lifecycle maintenance	371	247
- Revenue lifecycle maintenance	0	0
- Contingent rent	3,198	2,635
- Addition to lifecycle prepayment	131	306
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	230	169
<b>Total amount paid to service concession operator</b>	<b>24,118</b>	<b>23,311</b>

**Note 39 Off-SoFP PFI, LIFT and other service concession arrangements**

Maidstone And Tunbridge Wells NHS Trust incurred the following charges in respect of off-Statement of Financial Position PFI and LIFT obligations:

	31 March 2018	31 March 2017
	£000	£000
Charge in respect of the off SoFP PFI, LIFT or other service concession arrangement for the period	0	0
Commitments in respect of off-SoFP PFI, LIFT or other service concession arrangements:		
- not later than one year;	0	0
- later than one year and not later than five years;	0	0
- later than five years.	0	0
<b>Total</b>	<b>0</b>	<b>0</b>

**Note 40 Financial instruments****Note 40.1 Financial risk management**

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with commissioners and the way those commissioners are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. The Trust's treasury activity is subject to review by the Trust's internal auditors.

**Currency risk**

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

**Interest rate risk**

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health (the lender) at the point borrowing is undertaken.

The Trust therefore has low exposure to interest rate fluctuations.

**Credit risk**

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in the trade and other receivables note.

**Liquidity risk**

The Trust's operating costs are incurred under contracts with primary care Trusts, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

**Note 40.2 Carrying values of financial assets**

	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity at £000	Available-for- sale £000	Total book value £000
<b>Assets as per SoFP as at 31 March 2018</b>					
Embedded derivatives	0	0	0	0	0
Trade and other receivables excluding non financial assets - with NHS and DH bodies	27,363	0	0	0	27,363
Trade and other receivables excluding non financial assets - with other bodies	4,832	0	0	0	4,832
Other investments / financial assets	0	0	0	0	0
Cash and cash equivalents at bank and in hand	1,473	0	0	0	1,473
<b>Total at 31 March 2018</b>	<b>33,668</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>33,668</b>

	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity £000	Available-for- sale £000	Total book value £000
<b>Assets as per SoFP as at 31 March 2017</b>					
Embedded derivatives	0	0	0	0	0
Trade and other receivables excluding non financial assets - with NHS and DH bodies	35,278	0	0	0	35,278
Trade and other receivables excluding non financial assets - with other bodies	6,400	0	0	0	6,400
Other investments / financial assets	0	0	0	0	0
Cash and cash equivalents at bank and in hand	1,420	0	0	0	1,420
<b>Total at 31 March 2017</b>	<b>43,098</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>43,098</b>

**Note 40.3 Carrying value of financial liabilities**

	Other financial liabilities £000	Liabilities at fair value through the I&E £000	Total book value £000
<b>Liabilities as per SoFP as at 31 March 2018</b>			
Embedded derivatives	0	0	0
Borrowings excluding finance lease and PFI liabilities	56,097	0	56,097
Obligations under finance leases	0	0	0
Obligations under PFI, LIFT and other service concession contracts	198,232	0	198,232
Trade and other payables excluding non financial liabilities - with NHS and DH bodies	2,383	0	2,383
Trade and other payables excluding non financial liabilities - with other bodies	28,397	0	28,397
Other financial liabilities	0	0	0
Provisions under contract	0	0	0
<b>Total at 31 March 2018</b>	<b>285,109</b>	<b>0</b>	<b>285,109</b>

	Other financial liabilities £000	Liabilities at fair value through the I&E £000	Total book value £000
<b>Liabilities as per SoFP as at 31 March 2017</b>			
Embedded derivatives	0	0	0
Borrowings excluding finance lease and PFI liabilities	46,000	0	46,000
Obligations under finance leases	0	0	0
Obligations under PFI, LIFT and other service concession contracts	203,261	0	203,261
Trade and other payables excluding non financial liabilities - with NHS and DH bodies	4,455	0	4,455
Trade and other payables excluding non financial liabilities - with other bodies	40,334	0	40,334
Other financial liabilities	0	0	0
Provisions under contract	0	0	0
<b>Total at 31 March 2017</b>	<b>294,050</b>	<b>0</b>	<b>294,050</b>

**Note 40.4 Fair values of financial assets and liabilities**

The Trust uses the book value (carrying value) as a reasonable approximation of fair value

**Note 40.5 Maturity of financial liabilities**

	31 March 2018 £000	31 March 2017 £000
In one year or less	55,249	51,991
In more than one year but not more than two years	19,880	9,916
In more than two years but not more than five years	34,394	50,914
In more than five years	175,586	181,229
<b>Total</b>	<b>285,109</b>	<b>294,050</b>

**Note 41 Losses and special payments**

	2017/18		2016/17	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
<b>Losses</b>				
Cash losses	35	35	40	45
Fruitless payments	0	0	0	0
Bad debts and claims abandoned	11	32	5	2
Stores losses and damage to property	17	2	9	0
<b>Total losses</b>	<b>63</b>	<b>69</b>	<b>54</b>	<b>47</b>
<b>Special payments</b>				
Compensation under court order or legally binding arbitration award	0	0	0	0
Extra-contractual payments	0	0	0	0
Ex-gratia payments	32	11	40	27
Special severance payments	0	0	0	0
Extra-statutory and extra-regulatory payments	0	0	0	0
<b>Total special payments</b>	<b>32</b>	<b>11</b>	<b>40</b>	<b>27</b>
<b>Total losses and special payments</b>	<b>95</b>	<b>80</b>	<b>94</b>	<b>74</b>
Compensation payments received		0		0

The Trust has had no cases exceeding £300k

**Note 42 Gifts**

	2017/18		2016/17	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
<b>Total gifts</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

**Note 43 Related parties**

During the year none of the Department of Health and Social Care Ministers, Trust Board members or members of the key management staff, or parties related to any of them, have undertaken and material transactions with Maidstone and Tunbridge Wells NHS Trust.

The Department of Health and Social Care is regarded as a related party. During the year 2017/18 the Trust has received £13.99m working capital financing and £2.36m capital funding in the form of Public Dividend Capital. The Trust also has loans with DH, interest paid within the year £1.2m, principal repayment of £2.4m and the balance outstanding for the working capital loans is £43m. The Trust has also had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent department. The following entities with material transactions of more than £1m are listed below:

Ashford CCG  
 Medway CCG  
 West Kent CCG  
 High Weald Lewes Havens CCG  
 Dartford, Gravesham and Swanley CCG  
 Swale CCG  
 Hastings and Rother CCG  
 South Kent Coast CCG  
 Canterbury and Coastal CCG  
 Wessex Specialised Commissioning Hub  
 South East Specialised Commissioning Hub  
 Kent Community Foundation Trust  
 East Kent University Hospitals Foundation Trust  
 Medway NHS Foundation Trust  
 King's College Hospital NHS Foundation Trust  
 NHS England - South East Specialised Commissioning Hub  
 NHS England - South East Local Office  
 NHS England - Core  
 Dartford and Gravesham NHS Trust  
 Health Education England  
 HMRC  
 NHS Pension Authority  
 NHS Resolution  
 NHS Supply Chain  
 Kent County Council  
 NHS Blood and Transplant  
 Maidstone Borough Council  
 Tunbridge Wells Borough Council

The Trust has also received revenue and capital payments from the Charitable Funds that it controls, the trustees for which are also members of the Trust Board. The Trust has not consolidated the Charitable Funds on the grounds of materiality to the Trust (see policy notes 1.1.3). The transactions between the Trust and the Charity (Maidstone and Tunbridge Wells NHS Charitable Fund - charity registration number 1055215) are however material to the charity and therefore are disclosed below. Please note that this disclosure is based on the draft unaudited position of the charity. The audited accounts of the charity will be available later this year.

	<b>2017-18</b>	<b>2016-17</b>
	<b>£000s</b>	<b>£000s</b>
Total charitable resources expended with the Trust	<b>267</b>	866
Closing creditor (monies owed to the Trust by the Charity)	<b>0</b>	477
Closing debtor (monies owed to the Charity by the Trust)	<b>43</b>	0
Total income received by the Charity in the reporting period	<b>208</b>	291
<b>Total Charitable Funds at end of the reporting period</b>	<b>1,129</b>	<b>1,151</b>

**Note 44 Transfers by absorption**

The Trust has no transfers by absorption

**Note 45 Prior period adjustments**

The Trust has no prior period adjustments

**Note 46 Events after the reporting date**

The Trust has no events after the reporting period to report

**Note 47 Better Payment Practice code**

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
<b>Non-NHS Payables</b>				
Total non-NHS trade invoices paid in the year	124,829	199,536	103,549	175,490
Total non-NHS trade invoices paid within target	37,856	88,464	59,344	105,628
Percentage of non-NHS trade invoices paid within target	<u>30.33%</u>	<u>44.33%</u>	<u>57.31%</u>	<u>60.19%</u>
<b>NHS Payables</b>				
Total NHS trade invoices paid in the year	3,077	31,872	2,775	32,678
Total NHS trade invoices paid within target	446	22,661	990	21,653
Percentage of NHS trade invoices paid within target	<u>14.49%</u>	<u>71.10%</u>	<u>35.68%</u>	<u>66.26%</u>

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

**Note 48 External financing**

The Trust is given an external financing limit against which it is permitted to underspend:

	2017/18 £000	2016/17 £000
Cash flow financing	7,379	9,121
Finance leases taken out in year	0	0
Other capital receipts	0	0
External financing requirement	<u>7,379</u>	<u>9,121</u>
External financing limit (EFL)	<u>7,852</u>	<u>9,541</u>
Under / (over) spend against EFL	<u>473</u>	<u>420</u>

**Note 49 Capital Resource Limit**

	2017/18 £000	2016/17 £000
Gross capital expenditure	11,503	9,539
Less: Disposals	-1,742	-8
Less: Donated and granted capital additions	-159	-362
Plus: Loss on disposal of donated/granted assets	0	0
<b>Charge against Capital Resource Limit</b>	<u>9,602</u>	<u>9,169</u>
Capital Resource Limit	<u>10,580</u>	<u>12,529</u>
<b>Under / (over) spend against CRL</b>	<u>978</u>	<u>3,360</u>

The Trust underspent its capital resource as part of its financial recovery plan

**Note 50 Breakeven duty financial performance**

	2017/18 £000
Adjusted financial performance surplus / (deficit) (control total basis)	-10,924
Remove impairments scoring to Departmental Expenditure Limit	0
Add back income for impact of 2016/17 post-accounts STF reallocation	0
Add back non-cash element of On-SoFP pension scheme charges	0
Remove CQUIN risk reserve adjustment	134
IFRIC 12 breakeven adjustment	0
<b>Breakeven duty financial performance surplus / (deficit)</b>	<u>-10,790</u>

The breakeven duty performance reports I&E including STF payments

There is no adjustment for the PFI (IFRIC12) accounting as the On-balance sheet impacts to I&E are currently lower than the equivalent Off-Balance sheet reporting

The in year deficit was driven by slippage on the cost improvement programme (£9.2m) and reduction in Private Patient Income (£3.5m)



**Note 51 Breakeven duty rolling assessment**

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
		£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		189	1,710	300	129	-12,374	157	-23,413	-10,918	-10,790
Breakeven duty cumulative position	-3,260	-3,071	-1,361	-1,061	-932	-13,306	-13,149	-36,562	-47,480	-58,270
Operating income		311,889	322,176	345,101	367,391	375,714	403,310	400,930	430,502	440,269
Cumulative breakeven position as a percentage of operating income		-0.98%	-0.42%	-0.31%	-0.25%	-3.54%	-3.26%	-9.12%	-11.03%	-13.24%

The Trusts latest 3 year break-even cycle commenced in 2013/14 and was not met by the end of the period in 2015/16. The Trust's breakeven period has therefore been extended with the plans submitted for 2018/19 aimed at returning the Trust to in year breakeven and reducing the accumulated deficit towards the target of formal cumulative break-even by 2021/22.

The Trust's cumulative deficit position has arisen from a number of factors including high levels of non elective admissions and delayed discharges requiring escalation of emergency capacity, and a consequent reduction the Trust's capacity to manage its elective demand within its capacity, reducing elective income and necessitating private sector usage; reliance on temporary staffing and high levels of agency increasing the cost base; significant cost pressures from clinical negligence premia.

The Trust entered into Financial Special Measures in July 2016 and has worked with a Finance Improvement Director and NHSI to agree a financial recovery plan that is reducing the Trust's underlying deficit position. The Trust continues to be supported by NHSI with regular monitoring meetings.

The Trust has managed its capital and cash positions to ensure it requires the minimum level of working capital finance to sustain operational liquidity. Its plans for 2018/19 aim to manage within its own resources and to repay the first of its existing working capital loans to fall due in February 2019.

**Trust Board meeting – May 2018**

5-22	Approval of Management Representation Letter, 2017/18	Chair of Audit and Governance Committee
<p>The approval of the Letter of Representation from the Trust (management) is a formal part of the Annual Accounts process.</p> <p>The Letter is drafted by the Trust's External Auditors, following the completion of their Audit of the Annual Accounts.</p> <p>The enclosed Letter is scheduled to be reviewed and agreed at the Audit and Governance Committee on 24<sup>th</sup> May (before the Trust Board meeting), with the intention that the Committee recommend that the Board approve the Letter. A verbal update on the outcome of the Committee's review will be given at the Trust Board on 24<sup>th</sup> May.</p> <p>If the Audit and Governance Committee agrees, the Trust Board is asked to approve the Letter. If approved, the Letter will be signed, on behalf of the Trust Board, by the Chief Executive (as Accountable Officer), on 24<sup>th</sup> May 2018, and submitted to the External Auditors.</p>		
<p><b>Which Committees have reviewed the information prior to Board submission?</b></p> <ul style="list-style-type: none"> <li>Audit and Governance Committee , 24/05/18</li> </ul>		
<p><b>Reason for submission to the Board (decision, discussion, information, assurance etc.) <sup>1</sup></b></p> <p>Review and approval</p>		

<sup>1</sup> All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Our Ref -  
Your Ref – GT/1718MTW/LoR

Grant Thornton UK LLP  
2<sup>nd</sup> Floor  
St John's House  
Haslett Avenue West  
Crawley  
RH10 1HS



24 May 2018

Dear Sirs

**Maidstone and Tunbridge Wells NHS Trust**  
**Financial Statements for the year ended 31 March 2018**

This representation letter is provided in connection with the audit of the financial statements of Maidstone and Tunbridge Wells NHS Trust for the year ended 31 March 2018 for the purpose of expressing an opinion as to whether the financial statements are presented fairly, in all material respects in accordance with International Financial Reporting Standards and the Department of Health and Social Care Group Accounting Manual 2017-18.

We confirm that to the best of our knowledge and belief having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves:

**Financial Statements**

- i As Trust Board members, we have fulfilled our responsibilities under the National Health Services Act 2006 for the preparation of the financial statements in accordance with International Financial Reporting Standards and the Department of Health and Social Care Group Accounting Manual 2017-18 (GAM); in particular the financial statements are fairly presented in accordance therewith.
- ii We have complied with the requirements of all statutory directions affecting the Trust and these matters have been appropriately reflected and disclosed in the financial statements.
- iii The Trust has complied with all aspects of contractual agreements that could have a material effect on the financial statements in the event of non-compliance. There has been no non-compliance with requirements of the Care Quality Commission or other regulatory authorities that could have a material effect on the financial statements in the event of non-compliance.
- iv We acknowledge our responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud.
- v Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.
- vi In calculating the amount of income to be recognised in the financial statements from other NHS organisations we have applied judgement, where appropriate, to reflect the appropriate amount of income expected to be derived by the Trust in accordance with the International Financial Reporting Standards and the GAM. We are satisfied that the material judgements used in the preparation of the

financial statements are soundly based, in accordance with International Financial Reporting Standards and the GAM, and adequately disclosed in the financial statements. There are no other material judgements that need to be disclosed.

- vii We acknowledge our responsibility to participate in the Department of Health and Social Care's agreement of balances exercise and have followed the requisite guidance and directions to do so. We are satisfied that the balances calculated for the Trust ensure the financial statements and consolidation schedules are free from material misstatement, including the impact of any disagreements.
- viii Except as disclosed in the financial statements:
  - a there are no unrecorded liabilities, actual or contingent
  - b none of the assets of the Trust has been assigned, pledged or mortgaged
  - c there are no material prior year charges or credits, nor exceptional or non-recurring items requiring separate disclosure.
- ix Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of International Financial Reporting Standards and the GAM.
- x All events subsequent to the date of the financial statements and for which International Financial Reporting Standards and the GAM require adjustment or disclosure have been adjusted or disclosed.
- xi We have considered the adjusted misstatements, and misclassification and disclosures changes schedules included in your Audit Findings Report. The financial statements have been amended for these misstatements, misclassifications and disclosure changes and are free of material misstatements, including omissions.
- xii Actual or possible litigation and claims have been accounted for and disclosed in accordance with the requirements of International Financial Reporting Standards.
- xiii We have no plans or intentions that may materially alter the carrying value or classification of assets and liabilities reflected in the financial statements.

#### **Information Provided**

- xiv We have provided you with:
  - a. access to all information of which we are aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;
  - b. additional information that you have requested from us for the purpose of your audit; and
  - c. unrestricted access to persons within the Trust from whom you determined it necessary to obtain audit evidence.
- xv We have communicated to you all deficiencies in internal control of which management is aware.
- xvi All transactions have been recorded in the accounting records and are reflected in the financial statements.
- xvii We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.
- xviii We have disclosed to you all information in relation to fraud or suspected fraud that we are aware of and that affects the Trust and involves:
  - a. management;

- b. employees who have significant roles in internal control; or
  - c. others where the fraud could have a material effect on the financial statements.
- xix We have disclosed to you all information in relation to allegations of fraud, or suspected fraud, affecting the Trust's financial statements communicated by employees, former employees, analysts, regulators or others.
- xx We have disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing financial statements.
- xxi We have disclosed to you the identity of the Trust's related parties and all the related party relationships and transactions of which we are aware.
- xxii We have disclosed to you all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements.

### **Annual Report**

- xxiii The disclosures within the Annual Report fairly reflect our understanding of the Trust's financial and operating performance over the period covered by the financial statements.

### **Annual Governance Statement**

- xxiv We are satisfied that the Governance Statement fairly reflects the Trust's risk assurance framework and we confirm that we are not aware of any significant risks that are not disclosed within the Governance Statement.

### **Approval**

The approval of this letter of representation was minuted by the Trust's Audit and Governance Committee at its meeting on 24 May 2018.

Yours faithfully

Name.....

Position.....

Date.....

Name.....

Position.....

Date.....

**Signed on behalf of the Trust Board**