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

NHS Maidstone and Tunbridge Wells NHS Trust

10am – c.12.30pm THURSDAY 26TH JULY 2018

LECTURE ROOMS 1 & 2, THE EDUCATION CENTRE, TUNBRIDGE WELLS HOSPITAL

A G E N D A – PART 1

Ref.	Item	Lead presenter	Attachment
7-1	To receive apologies for absence	Chair of the Trust Board	Verbal
7-2	To declare interests relevant to agenda items	Chair of the Trust Board	Verbal
7-3	Minutes of the Part 1 meeting of 28th June 2018	Chair of the Trust Board	1
7-4	To note progress with previous actions	Chair of the Trust Board	2
7-5	Safety moment	Chief Nurse / Medical Director	Verbal
7-6	Report from the Chair of the Trust Board	Chair of the Trust Board	3
7-7	Report from the Chief Executive	Chief Executive	4
	Patient experience		
7-8	A patient's experience of the Trust's services	Chief Nurse[1]	Verbal
7-9	Review of the Board Assurance Framework 2018/19 (incl. review of the key objectives)	Trust Secretary	5 (to follow)
7-10	Integrated Performance Report for June 2018	Chief Executive	
	▪ Effectiveness / Responsiveness (incl. Recovery plan for 62-day Cancer waiting time target)	Chief Operating Officer	
	▪ Safe / Effectiveness / Caring (incl. complaints response times recovery; and planned and actual ward staffing for June 2018)	Chief Nurse	6 (to follow)
	▪ Safe / Effectiveness (incl. mortality)	Medical Director	
	▪ Safe (infection control)	Dir. of Infection Prev. and Control	
	▪ Well-Led (finance)	Chief Finance Officer	
	▪ Well-Led (workforce)	Director of Workforce	
7-11	Update from the Best Care Programme Board	Chief Executive	7
	Quality items		
7-12	Safeguarding children update (Annual Report to Board, including Trust Board annual refresher training)	Chief Nurse / Named Nurse, Safeguarding Children	8
7-13	Safeguarding adults update (Annual Report to Board, including Trust Board annual refresher training)	Chief Nurse / Matron Safeguarding Adults	9
	Assurance and policy		
7-14	Estates and Facilities Annual Report 2017/18	Chief Operating Officer	10
7-15	Bribery Act - Statement of Support	Chief Finance Officer	11
	Reports from Trust Board sub-committees (and the Trust Management Executive)		
7-16	Quality Committee, 04/07/18	Committee Chair	12
7-17	Patient Experience Committee, 05/07/18 (incl. proposed amendment to Terms of Reference)	Committee Chair	13
7-18	Trust Management Executive (TME), 18/07/18	Committee Chair	14 (to follow)
7-19	Finance and Performance Committee, 24/07/18	Committee Chair	15 (to follow)
7-20	**To consider any other business**		
7-21	**To receive any questions from members of the public**		
7-22	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

Date of next meetings:

- 27th September 2018, 10am, Pentecost/South Rooms, Academic Centre, Maidstone Hospital
- 25th October 2018, 10am, Pentecost/South Rooms, Academic Centre, Maidstone Hospital
- 29th November 2018, 10am, Lecture Rooms 1 & 2, The Education Centre, Tunbridge Wells Hospital
- 20th December 2018, 10am, Lecture Rooms 1 & 2, The Education Centre, Tunbridge Wells Hospital

David Highton,
Chair of the Trust Board

[1] A patient will also be in attendance for this item

MINUTES OF THE TRUST BOARD MEETING ('PART 1') HELD ON THURSDAY 28TH JUNE 2018, 10A.M, AT TUNBRIDGE WELLS HOSPITAL

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	David Highton	Chair of the Trust Board	(DH)
	Maureen Choong	Non-Executive Director	(MC)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Angela Gallagher	Chief Operating Officer	(AG)
	Nazeya Hussain	Non-Executive Director	(NH)
	Peter Maskell	Medical Director	(PM)
	Claire O'Brien	Chief Nurse (apart from item 6-11)	(COB)
	Steve Orpin	Director of Finance	(SO)
	Steve Phoenix	Non-Executive Director	(SP)
	Miles Scott	Chief Executive (apart from items 6-19 to 6-23, and 6-27 to 6-30)	(MS)
In attendance:	Michael Beckett	Interim Director of Health Informatics (for items 6-12 to 6-17)	(MB)
	Ritchie Chalmers	Trust Lead Cancer Clinician (for item 6-10)	(RC)
	David Fitzgerald	Associate Director or Operations, Cancer and Clinical Support (in attendance for item 6-10, but observed for all other items)	(DG)
	Jo Garrity	Head of Staff Engagement and Equality (for item 6-8)	(JG)
	Neil Griffiths	Associate Non-Executive Director	(NG)
	Simon Hart	Director of Workforce	(SH)
	Sharon Melville	LGBT+ Staff Network Co-Chair (for item 6-8)	(SMe)
	Emma Pettitt-Mitchell	Associate Non-Executive Director	(EPM)
	Kevin Rowan	Trust Secretary	(KR)
	Mick Stupples	LGBT+ Staff Network Co-Chair (for item 6-8)	(MSt)
	Violet Whiting	Cultural Diversity Network member (for item 6-8)	(VW)
Observing:	Mark Cohen	Cymbio Ltd	(MCo)

[N.B. Some items were considered in a different order to that listed on the agenda]

6-1 To receive apologies for absence

Apologies were received from Tim Livett (TL), Non-Executive Director. It was also noted that Selina Gerard-Sharp (SGS), NExT Director and Sara Mumford (SM), Director of Infection Prevention and Control, would not be in attendance. DH then welcomed DG and EPM to their first Trust Board meeting since being appointed as Associate Non-Executive Directors.

6-2 To declare interests relevant to agenda items

No interests were declared.

6-3 Minutes of the 'Part 1' meeting of 24th May 2018

The minutes were approved as a true and accurate record of the meeting.

6-4 To note progress with previous actions

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

- **5-9a ("Arrange for the details of the workforce-related key objectives for 2018/19 to be confirmed at the June 2018 Trust Board meeting")**. KR reported the rationale for the 2 objectives, which were approved as proposed.
- **5-9b ("Arrange for a review of the key objectives for 2018/19 to be undertaken after the first quarter of the year").** KR confirmed the action would be addressed at the July 2018 Trust Board meeting
- **2-10b ("Investigate the issues raised by the Chair of the Quality Committee following her attendance at the Emergency Department / Trauma simulation training")**. PM reported that

he had spoken with the Trust's Trauma Lead, who recognised the issue SDu had raised but stated that they would meet with the Anaesthetic team to discuss it further. PM continued that the process of staff proactively introducing themselves was best practice that was already taught, although it had been accepted that further work was required to embed compliance. PM added that the Trauma Lead had committed to providing PM with a further update. DH therefore proposed that the action remain open until PM had received that further update. This was agreed.

6-5 Safety moment

COB deferred to PM, who noted that if the Trust Board was content, he would share the presentation of Safety Moment items with COB on occasion. DH confirmed this was acceptable.

PM then reported that the focus for June 2018 was consent to treatment, and described a landmark legal case, Montgomery v Lanarkshire Health Board, which provided the current legal framework for consent issues. PM added that consent issues had been raised at the Trust in relation to Endoscopy procedures and it needed to be understood that consent could be withdrawn at any time. PM noted that consent was inextricably linked with a patients' mental capacity, and this needed to be, and was, being incorporated into the Trust's consent training. PM also noted that the Trust's Consent to Treatment policy was in the process of being updated, but gave assurance that current Trust practice reflected the latest guidance. DH asked that the ratified policy be issued to Trust Board Members with a note explaining what had changed. PM asked KR to comment on the timescales involved in the policy being ratified. KR explained that the process to update the policy required consultation and then approval (most likely at the Trust Clinical Governance Committee) before ratification, and therefore stated that he would not expect the process to conclude in the near future.

MC asked what had been done to raise awareness of the changes PM had described. PM confirmed that the changes had been communicated to staff, and COB added further details.

DH then stated that he would prefer for a deadline to be set for the updated policy to be ratified, and suggested this be October 2018. KR remarked that this seemed optimistic, so PM stated that the end of 2018 would be more realistic. KR then instead proposed that Trust Board Members be included in the consultation for the policy, rather than wait until it was ratified. This was agreed.

SDu asked if patients would be included in the policy consultation. PM accepted this as a good idea and asked COB if the Patient Experience Committee was routinely included in the consultation of policies. MS instead suggested that Healthwatch Kent be included in the consultation, to represent patients. This was also agreed.

Action: Arrange for Trust Board Members and representatives from Healthwatch Kent to be included in the consultation for the revised Consent to treatment policy and procedure (Medical Director, June 2018 onwards)

6-6 Report from the Chair of the Trust Board

DH reported the following points:

- He had attended the most recent NHS Providers' Chairs and Chief Executives network meeting, and the recently-announced national funding settlement for the NHS had been discussed. It had been highlighted that the announcement should be celebrated, but tempered with caution
- Two Associate Non-Executive Directors (NG and EPM) had been appointed
- DH had represented the Trust at a dinner to celebrate the new Kent and Medway Medical School (KMMS), and the Trust would, at some future point, need to develop an accommodation strategy to be able to house potential students
- There had been no confirmed Consultant appointments to announce, but an Advisory Appointments Committee had been held and it was hoped that 3 appointments would be able to confirmed at the next Trust Board meeting

6-7 Report from the Chief Executive

MS referred to Attachment 3 and highlighted the following points:

- Interviews had been held on 25/06/18 to appoint a new Chief Operating Officer, to succeed AG. An appointment had been made and this would be announced in due course. Interviews for the Director of Strategy, Planning and Partnerships would be held on 29/06/18
- SH was ensuring that the Listening into Action programme was being given a new lease of life in its second year
- The refurbishment works taking place at Maidstone Hospital (MH) were very encouraging
- MS had previously stated that he would provide an update on the Kent & Medway Sustainability and Transformation Partnership (STP) each month, and the key item from the last STP Programme Board related to estates and capital planning. Despite the NHS funding announcement DH had referred to under item 6-6, capital funding would remain very constrained and the national capital programme was predicated on some very large asset disposals. The Trust therefore needed to be fully aware of the capital discussions that were taking place, in relation to both funding, and the permissions to spend. MS and SO were therefore involved in this
- The Medway and North West Kent (MNWK) Delivery Board had met and discussed the services that were intended to be developed on a Kent-wide basis. An agreement had been reached that Cancer, Stroke, Vascular and Trauma services would continue to be developed Kent-wide and all other services would be developed via local discussions
- Local Trusts had also agreed to work together on the planning for the new KMMS, although liaison also needed to occur with the GP Federations. The KMMS Dean appointment would be made in July and MS was on the appointment panel. MS added that PM was working with the Trust's Clinical Lead for Research and Medical Education department to plan for the KMMS

NH then asked for an update on the Kent and Medway Stroke services consultation. MS reported that the consultation had closed and the Clinical Commissioning Groups (CCGs) would make a decision in August 2018. PM emphasised the importance of the Trust continuing to engage with the CCGs. NH asked when the decision would be communicated to the public. MS replied that he understood the decision would be announced at the time it was made.

SDu asked for details of the independent oversight in place for the decision-making process. MS stated that Carnall Farrar Ltd., who he understood had been engaged to analyse the consultation responses, were arguably independent, but noted that NHS England (NHSE) were also involved. PM added that the local Clinical Senate would also provide oversight.

NG asked if national NHS funding settlement was likely to be channelled via the STPs. DH replied that he understood that it had been decided that the current control total regime was not fit for purpose, but decisions still had to be made regarding baseline funding allocations. DH continued that the role of the STP and the new regional construct of NHSE/NHS Improvement (NHSI) also required clarification but it was more likely that NHSE's Regional Director would be the key person in that regard. DH added that he understood that the relevant processes would be incorporated within the plan being developed for the national funding but some uncertainty remained.

Staff Experience

6-8 The Trust's Staff Network Chairs

DH welcomed, JG, SMe, MSt and VM to the meeting. VM firstly then delivered a presentation on the Cultural Diversity Network. SM and MSt then delivered a presentation on the LGBT+ Staff Network and JG concluded by delivering a presentation on the Disability Network.

MC commended the presentations and stated that she was interested to know how improvements had been measured. SMe replied that the Stonewall Workplace Equality Index was one measure of improvement as a series of questions were posed as part of that process. SMe added that increasing the membership of the Networks was also important, so she would welcome Trust Board Members encouraging staff to join.

SP commented that he was pleased to see the level of progress that had been made, compared to the situation when he had worked substantively in the NHS. SH then noted his support for the Networks, and emphasised the need for the Networks to challenge processes.

NH opined that achieving a more diverse set of responses for the next Trust staff survey was a further measure of success, so she welcomed the extension of the survey to all staff. SMe agreed and added that that aim could be promoted and supported by the Networks. JG concurred.

DH then thanked JG, SMe, MSt and VM for attending the meeting and proposed that the Networks present at the Trust Board in June 2019, to enable progress to be assessed. This was agreed.

Action: Schedule a "Staff Experience: Update from the Trust's Staff Network Chairs" item at the Trust Board in June 2019 (Trust Secretary, June 2018 onwards)

6-9 Integrated Performance Report for May 2018

MS referred to Attachment 4 and highlighted the following points:

- There appeared to be a seasonal impact on the trends, particularly in A&E attendances, which continued to rise
- It was important to be clear on the emphasis that needed to be given to elective activity and Cancer care
- The report included a commentary on complaints response performance

Effectiveness / Responsiveness

AG then highlighted the following points:

- A&E 4-hour waiting time target performance continued to be good, and the Trust was currently within the top 20% of Trust nationally. However A&E attendances continued to break records, and the Trust continued to see an increase in elderly patients
- Patient flow was being maintained through delivery of best practice in emergency care. All initiatives had been launched and were largely in place at both hospital sites
- Length of Stay (LOS) continued to improve and this had enabled patient demand to be managed within capacity. There had been an increase in patients with a zero-day LOS
- The rate of Delayed Transfers of Care was currently below 5%, which was a major improvement from previous years. The main factor in this was the Home First Pathway 3 service
- Cancer performance would be covered under item 6-10
- Referral to Treatment & elective pathways were now key areas of focus. A backlog had formed following a previous focus on non-elective activity. There was a specific risk in General Surgery as a result of competing priorities and the significant vacancy rate among Surgical Middle Grade (i.e. Specialty and Associate Specialist (SAS) doctors). There was a plan regarding the delivery of the 18-week waiting time target, but this would take time to deliver improvements. All Directorates had an agreed improvement trajectory, but there were risks to the delivery plan

SDu referred to page 2, which noted that Crowborough Minor Injuries Unit (MIU) patients had been excluded from A&E attendances, and asked for a comment. AG explained that it had been decided not to include such patients, to enable proper comparison with the previous year. AG added that the Crowborough MIU was provided by East Sussex Healthcare NHS Trust.

EPM also referred to page 2, and asked whether the reasons for the 7.7% growth in A&E attendances were known. AG replied that such increases had been experienced nationally, and several factors were involved (including demographic pressure and difficulty in accessing GP services), but stated that the situation reflected the method by which healthcare was now accessed. DH added that demographic pressures were being felt nationally.

Safe / Effectiveness / Caring (incl. complaints response times recovery plan; and planned and actual staffing for June 2018)

COB highlighted the following points:

- Falls had reduced in May, which gave a level of 4.9% per 1000 Occupied Bed Days, compared to the Trust's limit of 6%. The Trust had joined NHSI's Patient falls improvement collaborative programme, which COB intended to expand upon at the July 2018 Trust Board meeting
- Pressure ulcers had increased slightly and a Grade 3 ulcer had been seen, which was being investigated via the Serious Incident (SI) process. A Band 7 Tissue Viability Nurse was however being recruited that week which would increase the resilience of the Tissue Viability service. National work on the classification of pressure ulcers was also underway

- The Friends and Family Test (FFT) response rate had decreased, for several reasons, but the relevant teams were working hard to ensure there was no time lag in processing the FFT cards
- Despite what was stated at the top of page 4, there were no cases of mixed sex accommodation for the month
- The complaints response rate was still below the required performance. COB had met with all areas at the end of May, and a detailed summary of the outcome was included in Attachment 4. COB gave assurance that the issue was being taken seriously and illustrated this by noting that discussion had taken place at the latest Executive Performance Reviews. The common issues identified in complaints, which included communication, were also described in the report
- 20 SIs were reported in May, which was an increase on the previous year. The SIs that involved Safeguarding allegations were, in general, very closely aligned to consent issues. The report also included some of the learning that had arisen from the Falls and VTE SI panels
- W/c 18/06/18 had been national Learning Disability week, and the Learning Disability Nurse used the opportunity to operate a stand at both hospital sites and also liaise with the Learning Disability Nurse from Kent Community Health NHS Foundation Trust. The Trust would also undertake an assessment of its Learning Disability provision

SO then added that he had led the questions regarding complaints response performance at the aforementioned Executive Performance Reviews, to demonstrate that the issue was of concern to the whole Executive Team, not just COB. MC commended the approach.

SDu then referred to the investment that had been made in the management of complaints and the associated divestment from certain areas, but noted that there was a finite capacity for individuals to undertake actions, noting that many of the same persons were involved in the large number of current projects in place at the Trust, including those linked to the Best Care programme. COB acknowledged the point, and noted that this had been taken into account when setting specific improvement targets for each area. COB added that some simple process changes had however been identified, along with the need for individuals to focus on the quality of complaints responses.

NH noted that she understood that there was now additional resource in the central complaints team but asked if such resources were sufficient. COB replied that she believed there was sufficient central resource, if the responses were being managed consistently at all levels, but problems emerged when Directorates submitted multiple responses at the same time.

COB then referred to the planned and actual Ward staffing for May 2018, which was included within Attachment 4, and highlighted the key points therein. DH noted that Whatman Ward had been closed and the staff had been re-deployed, and asked if the staff had been able to be retained by the Trust. AG answered that there had been 5 substantive staff involved, and all had been retained, mainly on John Day Ward. COB did however acknowledge the adverse impact that such deployments had on staff.

Safe / Effectiveness (incl. Mortality)

It was noted this would be covered under item 6-12.

Safe (infection control)

COB then highlighted the following points:

- There had been no cases of MRSA bacteraemia
- The Trust was 5 cases below its Clostridium difficile trajectory, which was 26 for the year
- The Infection Prevention and Control Committee had met w/c 18/06/18 and had acknowledged the need to continue to focus on compliance with Bare Below the Elbows practice, as well as staff not wearing Theatre scrubs on, for example, public transport. Staff would therefore be reminded of the 'Bare Below the Elbows' requirements

Well-Led (finance)

SO highlighted the following points:

- The Trust's position was in accordance with its plan at the end of month 2. For income, the Trust was also performing better than plan, and better than the same point in 2017/18

- Elective inpatient activity was improving, but further improvement was still required. Trauma & Orthopaedics had improved in particular, but General Surgery was a cause for concern
- The Trust remained under pressure on temporary staffing expenditure, and the Trust was liaising with NHSI's Agency Intelligence Unit to consider what further actions could be taken
- The cash position was strong, but this mainly related to the receipt of cash relating to the 2017/18 contract with NHSE

DH then noted that SO, MS and PM would attend the monthly Financial Special Measures (FSM) review meeting with NHSI on 04/07/18, and highlighted the latest Finance and Performance Committee meeting had acknowledged the fact that there was too many red-rated schemes in the Cost Improvement Programme. SO agreed, and noted this would be covered in more detail in the Trust Board Seminar scheduled for later that afternoon.

Well-led (workforce)

SH then reported the following points:
- The recent improvement in staff turnover and sickness absence continued
- The overall vacancy rate had also improved, but some specific departments had very high rates. Some of the temporary staffing expenditure was related to this, particularly that for Medical Agency staff. NHSI had published new guidance for the controls for such staff, and this would be implemented in full w/c 02/07/18.
- The Trust was taking a holistic approach for rota requirements and high cost Medical staff i.e. with the aim of transferring such staff to substantive or Bank contracts. However, this was challenging for particular specialities, including Radiology, which had severe staffing shortages
- Efforts were being made to have more flexible Job Plans when recruiting Consultants, including Acute Medical Unit Consultants. Posts were also being promoted more via social media, and the impact of this would be assessed in due course
- COB and SH had met with NHSI on 24/06/18 to assess current progress in relation to Nursing retention. NHSI had confirmed they were content with the actions the Trust was taking, but gave some further suggestions. Recruitment efforts would focus on 2 areas: maximising Student Nurse conversions by making earlier offers for third year Nursing students to join the Trust; and focusing on longer-term recruitment by expand international recruitment, from the European Union staff and beyond, utilising the existing STP-related international recruitment contract. However, additional overseas recruitment contracts would be required, as such contracts took up to 10 months to deliver

DH noted the decision to remove the restriction on recruitment of Medical and Nursing staff through the Tier 2 visa route, and asked if the Trust had previously experienced a significant number of visa refusals. SH replied that the Trust had only previously received a small number of Tier 2 visa applications, and had experienced no refusals, but the change represented an opportunity for the Trust to establish a supply line of staff. DH asked whether a specific programme of work was required in that regard. SH noted that PM and SH had established a Senior Medical Recruitment Group a recruitment through the Tier 2 visa route would be discussed via that forum.

SDu then referred back to the high vacancy rate among SAS doctors in several specialties and asked what support was provided for the substantive staff in those specialities, who were likely to be subject to additional pressure. SH explained the support being provided, particularly in relation to the "Charter for staff and associate specialist and specialty doctors".

6-10 The recovery plans for the 62-day Cancer waiting time target

DH welcomed RC and DF to the meeting. RC then referred to Attachment 5 and highlighted the following points:
- The graphs on page 2 showed the increase in all Cancer referral rates, and the reduction in meeting the waiting time target
- The system was being inundated by the number of referrals from GPs, and far less GP triage was taking place. The Patient Tracking List (PTL) had increased in size. Such increases had been seen nationally, but the Trust was slightly unique in relation to the rapidity of that increase.

Certain factors were also relevant, including FSM and the high vacancy rate among Surgical SAS doctors
- The risk of breaching the 62-day target was related to the time a patient was first seen, and there was a 20% chance of a breach if a patient was not seen until 14 days after referral. The time to a definitive first Radiological investigation was also currently at circa 14 days
- Page 5 listed the proposed 3 main areas of focus: demonstrating the extra capacity requirements, re-setting the system (in terms of short-term capacity) and long-term sustainability/cultural change (which included altering the current 'orange dot' process)

SO referred to RC's statement that FSM had affected performance and asked RC to explain. RC noted that the Clinical Administration Units (CAUs) had experienced several restructures and there had been delays within the CAUs which were potentially related to CAU staffing. RC continued that the culture that had arisen from the Trust being in FSM meant that more was trying to be achieved with the same level of resource. DF added that in this context, frontline services struggled with the concept of investing in an area, even if such investment was required.

NG asked when the target was expected to be met. RC replied by pointing out that small changes had significant adverse effects and elaborated on the decline in Breast Care performance that had occurred following the retirement of a member of staff. MS added that the Trust had acknowledged that it would not achieve the trajectory that had been submitted to NHSI, but further work was required before a new trajectory was finalised.

NH then asked about for further details of the plans to 're-set the system'. RC explained that she believed some short-term action was required, noting that this was likely to have more lasting effects on culture than if change occurred more slowly.

NH also asked about best practice from elsewhere. RC replied that she was aware of the success that had been achieved in Nottingham, which had been presented at a recent Breast care meeting.

DH then concluded by stating that the Trust Board would monitor performance each month but emphasised that the Board wanted to support, and not just inspect. RC acknowledged the point.

6-11 Update from the Best Care Programme Board

The content of Attachment 6 was noted, and it was acknowledged that the Best Care Programme would be discussed further at the Trust Board Seminar that was scheduled for later that afternoon.

Quality Items

6-12 Update on the compliance status of the 10 maternity safety actions in the CNST incentive scheme

COB referred to Attachment 7 and highlighted that a previous version of the report had been considered at the Trust Board in May 2018. COB continued that Standards 8 and 10 had now been confirmed as compliant, so the Trust was able to declare compliance with all 10 Standards

Questions were invited. None were received. The Trust Board duly agreed for the proposed self-certification to be sent to NHS Resolution as submitted.

6-13 Quarterly mortality data

PM referred to Attachment 8 and highlighted the following points:
- The Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) continued to reduce
- The percentage of completed Mortality Reviews had increased, although the data for the latest month was not yet compete
- The data for relative risk by day of admission had raised a concern regarding Thursdays, and page 5 suggested that General Medicine was the highest area of risk. However caution should be exercised, as the issue was still under investigation.
- A cluster of deaths at a Ward at MH had been identified by the Bereavement Office, but PM had been assured that there were no concerns regarding the deaths

SDu commended the quality of the report, and the fact that the Trust was much better able to articulate its mortality performance than had previously been the case.

6-14 Findings of the national inpatient survey 2017

COB referred to Attachment 9 and highlighted the following points:

- The survey was carried out during the summer of 2017
- The Trust's response rate was 47%, which was comparatively good
- Key findings included the fact that 97.73% of patients felt they were treated with respect and dignity, and 95% felt that the Trust had done everything to control their pain, which was an issue that the Care Quality Commission (CQC) had identified as an area for improvement
- The Trust's score was statistically significantly different from the national average on 6 questions
- A similar report would be submitted to the Patient Experience Committee on 05/07/18
- Many of the actions required were related to workstreams with the Best Care programme

Questions were invited. None were received.

6-15 Approval of Quality Accounts, 2017/18

COB referred to Attachment 10 and highlighted the following points:

- SDu and MC had reviewed and commented on the document, in light of the cancellation of the 'main' Quality Committee meeting in May 2018, and the postponement of the Patient Experience Committee meeting from June to July 2018
- The format and content of the Quality Accounts was set nationally
- The Trust had received a "limited assurance" External Audit report which related to the scope of the audit

KR referred to the latter point, and clarified that the key aspect of the External Audit was that it had provided an "unqualified" conclusion (i.e. not that it was a "limited assurance" report). The point was acknowledged.

COB then gave thanks to Wendy Glazier, Associate Director, Quality Governance, noting that the Quality Accounts required a significant amount of work to prepare. DH agreed that Ms Glazier should be congratulated for producing a very comprehensive document.

COB concluded by confirming that consideration would be given to changing the format of the 2018/19 Quality Accounts following comments from several Trust Board Members.

Questions were invited. None were received. The Trust Board duly approved the Quality Accounts for 2017/18 as submitted.

Planning and strategy

6-16 Approval of revised Quality Strategy

COB referred to Attachment 11 and highlighted that the report had been considered at length during a previous Trust Board Seminar, and the comments made had been incorporated.

Questions were invited. None were received. The Trust Board duly approved the Quality Strategy as submitted.

6-17 Electronic Patient Record - Review of changes between the Outline Business Case & Full Business Case (FBC)

DH welcomed MB to the meeting, noted that the Outline Business Case (OBC) had been approved by the Trust Board in May 2018, and so the focus of the item was therefore on the differences between the OBC and the FBC. DH added that the entire FBC had however been made available to Trust Board Members (via a supplement, Attachment 12s). MB then referred to Attachment 12 and highlighted the following points:

- The main difference between the OBC and FBC was the period of deployment, which had now been agreed to be 12 months
- The Trust had also been able to negotiate a reduction in the Patient Administration System (PAS) contract by choosing the Allscripts Electronic Patient Record (EPR) product (Sunrise)
- Work would continue to maximise the cash releasing benefits from the Case. Allscripts had identified cost reductions of 11% at the other Trusts who had implemented their product, as a result of introducing E-prescribing (which was incorporated within the product). However, the Trust's own Pharmacy Department had identified a lower level of possible savings, so the FBC had set the expected level of savings at 5%
- Option 4 (a single supplier EPR – fully managed service model) remained the preferred option

DH reminded Trust Board Members of the context, in that rather than to continue with contractual disputes with the PAS supplier, a price for an EPR product had been negotiated, which was predicated on the Trust signing the contract by a certain point, and on the basis that NHSI approval was not required. SO confirmed that NHSI had been notified of the Trust's intention to proceed and no concerns had been raised to date. DH therefore clarified that if the FBC was approved, a Letter of Intent could be provided to Allscripts.

MS then reported that 3 issues had been discussed with Allscripts' Chief Executive and the third of which was that additional support would be provided for the implementation, but there was no reference to this in the FBC. MB acknowledged the point and confirmed that although the provision of additional support had been agreed there was no written commitment from Allscripts, although this could be added to the contract. MS proposed that this be added to the aforementioned Letter of Intent to be issued to Allscripts. This was agreed.

Action: Ensure that the verbal commitment from Allscripts to provide additional support for the implementation of an Electronic Patient Record be formalised in the Letter of Intent that the Trust issued to Allscripts (Chief Operating Officer, June 2018)

DH then pointed out that in practice, the deployment would likely last circa 14, not 12, months. MB confirmed this was correct.

MS then asked about the external review of the FBC and the implementation plan. MB explained that a review had been undertaken by the Chief Digital Officer from Greater Manchester Health and Social Care Partnership (who was formally the Chief Information Officer at Wrightington, Wigan and Leigh NHS Foundation Trust, which had implemented the Sunrise EPR product in 2016), although a formal report had not yet been received. MS asked if the review had given specific assurance on the deployment, noting that he did not want to approve an FBC that required additional resources (which the Trust did not have) at a later point. MB confirmed this had been included in the review, and added that some contingency funding had been incorporated within the FBC. MS asked for the value of that contingency and MB and SO confirmed the value was hundreds of thousands of pounds.

NH asked for further details of the external review. MB explained that the reviewer had made it clear that his review did not include any legal indemnity, as such a review would be expensive, so the review was intended to seek the views of someone who had successfully deployed the same EPR product. DH pointed out that a review by NHSI or NHSE would also not provide legal indemnity.

MC commented that there were opportunities to increase the pace of deployment, but she was conscious of the staff being taken away from their duties to participate in the work. MB explained the approach that would be taken and gave assurance on the arrangements, including the provision for backfill. NG acknowledged this, but noted that the proposed benefits required significant change to be implemented. MB explained that the benefits included increased electronic data capture which would result in a gradual reduction (over 5 years) in the staff required to manage hard copy healthcare records.

On consideration, the Trust Board approved the Full Business Case for the Electronic Patient Record, as submitted.

6-18 Winter planning and Operational Resilience 2018/19

AG referred to Attachment 13 and highlighted the following points:

- Attachment 13 represented the first iteration of the plan, but gave assurance on the areas being covered. The plan would consider issues such as activity, workforce and communication, as well as revised patient pathways and the proposed introduction of a 'Virtual Ward'
- A key part of the planning process was to review the underlying assumptions
- The Trust had also been asked by NHSI to undertake an assessment on the factors affecting good or poor performance, or good or poor quality of care over the winter period
- The final version of the plan was intended to be considered at the Trust Board in October 2018

MC commended the work, but emphasised the need to consider staff welfare during periods of particular pressure. AG acknowledged the point, and noted that if the Trust was approaching Operational Pressures Escalation Level (OPEL) Level 4, refreshments would be provided for staff, whilst the number of days that staff worked continuously would also be more closely monitored.

6-19 Principles for Pathology reconfiguration in Kent

DH referred to Attachment 14 and highlighted that the principles had been discussed at the Acute Partnership Board and the report had been developed to establish a framework for further discussions. Questions or comments were invited. None were received

Assurance and policy

6-20 Cyber security threat – assurance report

The content of Attachment 15 was noted.

6-21 Outcome of review the Trust's current policy regarding the start and end dates of the staff Annual Leave year

SH referred to Attachment 16 and highlighted that the Workforce Committee had considered the issue and determined that the status quo should remain. This was agreed.

6-22 Review of the formal hosting arrangements for the Kent & Medway Sustainability and Transformation Partnership (and approval of the Trust's STP contribution)

SO referred to Attachment 17 and highlighted that the Trust had ended 2017/18 with no debt arising from the STP, noting that the process of issuing invoices in advance had been successful. SO also highlighted that the Trust's own STP contribution was required to be approved.

SDu acknowledged the concerns that had been raised regarding the effectiveness of the STP and asked if there was risk to the Trust of other organisations not paying their allocated contribution. DH stated that that issue had been discussed at the Acute Partnership Board meetings, but he did not believe it was an option for Trusts to withdraw their payments. DH added that there had however been some concerns regarding the STP Programme Board and DH and MS were due to meet with a representative from the STP regarding governance. SO added that the majority of staff involved in STP work were employed on fixed-term contracts.

The Trust's contribution to the Kent and Medway Sustainability and Transformation Partnership was approved as submitted.

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

6-23 Audit and Governance Committee, 24/05/18

SP referred to Attachment 18 and invited questions or comments. None were received.

6-24 Workforce Committee, 24/05/18

SP referred to Attachment 19 and invited questions or comments. None were received.

6-25 Quality Committee, 19/06/18

SDu referred to Attachment 20 and highlighted the discussion held with Paediatrics and the concerns at the gaps in their substantive workforce. SDu added that she was concerned that gaps in Medically-qualified posts were being addressed by recruiting non-Medical staff, noting that the responsibility for the practice of such staff rested with Consultants. SDu therefore urged caution in relation to the employment of, for example, Enhanced Nurse Practitioners and Physician Associates. The point was acknowledged.

6-26 Trust Management Executive (TME), 20/06/18

In MS' absence, AG referred to Attachment 21 and highlighted that the meeting had involved useful discussions on the development of clinical management and the outcome of the Trust's recent visit to Northumbria Healthcare NHS Foundation Trust.

6-27 Finance and Performance Committee, 26/06/18

DH referred to Attachment 22 and invited questions or comments. None were received.

6-28 To consider any other business

There was no other business.

6-29 To receive any questions from members of the public

No questions were posed.

6-30 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 – July 2018

Maidstone and Tunbridge Wells NHS Trust

7-4 Log of outstanding actions from previous meetings — Chair of the Trust Board

Actions due and still 'open'

Ref.	Action	Person responsible	Original timescale	Progress [1]
5-23 (May 18)	Investigate the issues raised by the Chair of the Quality Committee following her attendance at the Emergency Department / Trauma simulation training	Medical Director	May 2018 onwards	At the Trust Board in June 2018, it was noted that the Trust's Trauma Lead who recognised the issue raised and stated that they would meet with the Anaesthetic team to discuss it further and provided the Medical Director with a further update. A verbal update will be given at the Trust Board meeting on 26/07/18.
6-5 (June 18)	Arrange for Trust Board Members and representatives from Healthwatch Kent to be included in the consultation for the revised Consent to treatment policy and procedure	Medical Director	June 2018 onwards	A verbal update will be given at the Trust Board meeting on 26/07/18.

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
5-9b (May 18)	Arrange for a review of the key objectives for 2018/19 to be undertaken after the first quarter of the year	Trust Secretary	July 2018	The requested review has been scheduled to be undertaken at the July 2018 Trust Board meeting, as part of the "Review of the Board Assurance Framework 2018/19" item that was already scheduled
6-17 (June 18)	Ensure that the verbal commitment from Allscripts to provide additional support for the implementation of an Electronic Patient Record be formalised in the Letter of Intent that the Trust issued to Allscripts	Chief Operating Officer	June 2018	The Trust does not issue a Letter of Intent to Allscripts (it just signs the contract). However, Allscripts have provided the Trust with a Letter of Intent that provides written confirmation of their commitment to provide additional support
6-8 (June 18)	Schedule a "Staff Experience: Update from the Trust's Staff Network Chairs" item at the Trust Board in June 2019	Trust Secretary	June 2018	An item has been scheduled for June 2019

[1] Not started | On track | Issue / delay | Decision required

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
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	The requested information has been included in 2017/18 Annual Report, which had been submitted to the July 2018 Trust Board meeting

Actions not yet due (and still 'open')

Ref.	Action	Person responsible	Original timescale	Progress
N/A	N/A	N/A	N/A	N/A
				N/A

Trust Board meeting – July 2018

Maidstone and Tunbridge Wells NHS Trust

7-6 Report from the Chair of the Trust Board — Chair of the Trust Board

I attended the NHS Providers Governance Conference, which had a key theme of how Provider Boards and the NEDs managed the duty to their own Trust and a duty to patients across a wider area - this may be the STP or population across an STP boundary. It was clear from the presentations that there are many models of STP governance with very different levels of Chair and NED involvement in delegated decision making. The presentations from the conference will be made available and I will circulate to Board members. It is clearly an opportune time for the Kent & Medway STP to be reviewing governance arrangements and Miles Scott and I met with the STP as part of the review. We urged an extra level of formal oversight over and above the STP Programme Board.

I was very pleased to cut the ribbon to open the Marks & Spencer Simply Food outlet at Maidstone Hospital. I think a good healthy food offer on-site will be popular with staff, and the opportunity for busy shift workers to also carry out food shopping for home will also add to convenience for our staff.

I attended an event at Valley Park School, with several colleagues from the Trust, to present certificates to primary and secondary school pupils from the Valley Invicta Academy Trust who had won prizes for birthday card design, poetry and art, all celebrating the NHS 70th birthday. I hope we will be able to display some of the art at the hospital in due course.

Consultant Appointments

As noted previously, I and my Non-Executive colleagues are responsible for chairing Advisory Appointment Committees (AACs) for the appointment of new substantive Consultants, and the Trust follows the Good Practice Guidance issued by the Department of Health, in particular delegating the decision to appoint to the AAC, evidenced by the signature of the Chair of the AAC and 2 other Committee members. The delegated appointments made by the AAC since the previous report are shown below.

New substantive Consultant appointments				
Start date	**Title**	**First name**	**Surname**	**Department**
TBC	Dr	Joanne	Davies	Radiology
TBC	Dr	Nicky	Dineen	Radiology
1/9/18	Dr	Benjamin	Rudge	Anaesthetics-Obs
TBC	Dr	James	Peerless	Anaesthetics-Obs
TBC	Dr	Arun	Kochhar	Anaesthetics-Obs

Which Committees have reviewed the information prior to Board submission?
- N/A

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
Information

[1] 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 – July 2018

NHS Maidstone and Tunbridge Wells NHS Trust

7-7 Report from the Chief Executive — Chief Executive

I wish to draw the points detailed below to the attention of the Board:

1. We joined the nation's celebrations this month to mark the 70th anniversary of the NHS. Members of staff from our hospitals and colleagues from across the country attended special celebratory events at Westminster Abbey and 10 Downing Street.

   I had the privilege of attending a special NHS70 service at Westminster Abbey with Angela Gallagher, our Chief Operating Officer, and Matron Glenda Sonquit. Another MTW colleague, Karen Wickins, joined 200 NHS staff from across the country at 10 Downing Street. They've worked for the NHS for over 40 years and received long service awards from the Prime Minister and Secretary of State for Health and Social Care. Locally, Kent Fire and Rescue gave us a huge birthday card and students at Mid Kent College, and our own catering staff, made some amazing cakes.

   This important milestone gives us all a chance to think about the vital role the NHS plays in so many people's lives. It also reminds us to recognise and thank our extraordinary NHS colleagues, the every-day heroes, who are there to guide, support and care for patients, day in, day out.

2. As we celebrate 70 years, it is also right that we look to the future. I have spent time with many of our clinical and non-clinical colleagues this month focusing on our patient and staff experience.

   I am constantly struck by the lengths colleagues are going to everyday to meet our patient needs and bring innovation to the workplace in the face of increasing demand for our services.

   Our virtual fracture clinical is just one example of how we are seeing and treating patients differently today and in a much better way. Thanks to new technology and better working practices patients are being managed more effectively and only coming to hospital when clinically necessary.

   We are applying the same vision to the development of a virtual ward, which will enable patients to leave hospital sooner, and continue their non-acute care at home. This is hugely beneficial in maintaining their independence and overall wellbeing. Moving more of our non-acute care into the community improves patient flow through our hospitals, enabling more patients who are acutely unwell to be seen sooner.

   We continue to visit providers of outstanding clinical care, seeking out new clinical models to widen our thinking and inform our own service transformation. A team from MTW has visited Whitstable Medical Practice in East Kent to see first-hand their extended primary care and community services and work to support patients to stay well. More patients are receiving more of their care in their communities as a result, rather than having to travel to hospital. This is being delivered through a seamless service of specialist GPs, allied health professionals and community based consultants working with the voluntary sector, patients groups and social care. Public events were held in West Kent in June and July to help shape plans for similar care hubs here.

3. Continuing the theme of partnerships, we have held a highly successful Joint Programme Management Office Aligned Incentive Workshop. The event brought together five NHS organisations, including West Kent CCG, Kent Community Health Foundation Trust and Kent and Medway NHS and Social Care Partnership Trust. The event enabled colleagues from different roles and specialities to proactively take forward collaborative programmes to transform local care. Seeing so many colleagues from different organisations in one place, working collaboratively and breaking down boundaries with a renewed vigour for improving our local health services, was a hugely positive step forward.

4. Staff at MTW are being invited to come to work in their pyjamas to help continue promoting

#endpjparalysis. Since the start of the campaign in April, 984 patients across the Trust have got up and dressed during their stay in hospital, and 1,255 have also been up and moving around.

It's well known that staying in bed can sometimes do more harm than good, even when someone isn't feeling 100% - #endpjparalysis aims to get patients up, dressed and moving while they are in hospital so the problems caused by staying in bed too long can be prevented and, hopefully, they can get home quicker.

Feedback from patients has also been very positive. 72 year old Peter, who stayed on the Edith Cavell Ward at Maidstone Hospital, said: "It's so much nicer to get out of bed and get dressed, it aids the process of getting better. I am the first person in the bay to get up in the morning and I am eager to get going as I know it will get me back home quicker! I like to get dressed as not only is it more comfortable to wear my own clothes, it means that I look and feel better when I go to physio or see visitors and so on; it makes me feel human."

5. Since our last board meeting we have made three key appointments to the leadership team at MTW. Sean Briggs joins MTW as our new Chief Operating Officer, Dr Amanjit Jhund has been appointed as our new Director of Strategy, Planning and Partnerships, and Sarah Blanchard-Stow joins us as our new Head of Midwifery. All three have strong experience in the NHS and I look forward to them starting work for MTW in the autumn.
6. The Trust relies greatly on the goodwill of its volunteers and support of our local community. This month I would like to formally thank, and publicly recognise, the efforts of a Sevenoaks-based charity.

   The Alexandra Sales Trust has donated toys and play equipment to help children undergoing cancer treatment at Tunbridge Wells Hospital. The charity, which aims to raise a smile for children and young people affected by cancer, presented a large selection of toys and art and craft materials as well as three iPads, five DVD players and toy boxes to Hedgehog Ward. The generous donation will be used for MTW's special toy box scheme, which provides children who are cared for in isolation while receiving chemotherapy with a dedicated, named box of new toys.

   The Alexandra Sales Trust was set up to create a legacy in memory of Alexandra Sales, who died in September 2014 of Metastatic Rhabdomysarcoma, a rare, rapidly spreading soft tissue cancer. For more information about The Alexandra Sales Trust go to www.thealexandrasalestrust.co.uk

Which Committees have reviewed the information prior to Board submission?

- N/A

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]

Information and assurance

[1] 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 – July 2018

NHS Maidstone and Tunbridge Wells NHS Trust

7-9	Review of the Board Assurance Framework 2018/19 (incl. review of the key objectives)	Trust Secretary

The management of the Board Assurance Framework (BAF) and link with the Risk Register

The BAF is the document through which the Trust Board identifies the main risks to the Trust meeting its key objectives, and to ensure adequate controls are in place to manage those risks. The BAF model applied at the Trust is based on the most accepted model of best practice[1]. The ultimate aim of the BAF is to help ensure that the key objectives are met. The BAF is managed by the Trust Secretary, who liaises with "Responsible Directors" to update it through the year. The BAF differs from the Risk Register as the BAF only includes risks that pose a threat to the achievement of the Trust's key objectives (and the risks listed on the BAF are not required to be subject to a detailed risk assessments/risk-rating). There are therefore some red-rated risks on the Risk Register that are not referenced in the BAF. These are however managed via the Risk Register. However, the selection of key objectives took into account the risks faced by the Trust.

Key objectives for 2018/19, and summary of year-to-date position

The key objectives in the 2018/19 BAF were approved at the Board on 24/05/18 (objectives 1-8) and 28/06/18 (objectives 9-10). The latest summary rating of the 10 objectives in terms of the Responsible Director's confidence of achievement by year-end (based on month 3 performance) is as follows:

Key objective	Confidence[2]
1. To deliver the trajectory agreed with NHS Improvement for the A&E 4 hour waiting time target	Green
2. To deliver the trajectory agreed with NHS Improvement for the 62-day Cancer waiting time target	Red
3. To deliver the Referral to Treatment (RTT) trajectory agreed with NHS Improvement for patients on an 'incomplete' pathway	Amber
4. To deliver the financial plan for 2018/19	Green
5. To ensure a falls rate of no more than 6.0 per 1000 occupied bed days	Green
6. To ensure a pressure ulcer rate of no more than 3.0 per 1000 admissions	Green
7. To deliver the agreed 'lessons learned' plan for 2018/19	Amber
8. To deliver the agreed medical productivity plan for 2018/19	Amber
9. To deliver a vacancy rate of no more than 9%	Amber
10. To deliver a staff turnover rate of less than 10%	Amber

Format of the BAF

The Trust Board approved the proposal that the format of the BAF document/reports remain primarily unchanged for 2018/19, as this accorded with the accepted best practice for BAFs (and the format had not been subject to any negative feedback). However, the Audit and Governance Committee asked that the BAF incorporated assurances on the data quality of performance information, so a further question/section has been added to cover this. The Finance and Performance Committee also asked that external factors be included within the "What could prevent this objective being achieved?" section, so the heading has been amended to include this. In addition, the question "Where can assurance be obtained on the actions taken to date?" has been extended to "Where can assurance be obtained on the performance and actions taken to date?", as this better reflected the content of that section within the 2017/18 BAF.

Review by the Trust Board

This is the first time during 2018/19 that the Trust Board has seen the populated BAF. Board members are asked to review and critique the content, by considering the following prompts:

- Are the key objectives appropriately described? Should the wording of any be amended?
- Do the RAG ratings of confidence that the objective will be achieved reflect the situation as understood by the Board (and its sub-committees)?
- Is the Board assured that actions reported as being undertaken are satisfactorily evidenced?
- Does any of the content require further explanation?
- Does the format of the BAF need to be amended?

[1] HM Treasury: Assurance frameworks

[2] This is the confidence of the Responsible Director that the objective will be achieved by the end of 2018/19

The Board is reminded of the options available to it, in terms of a response, which include:

- Accepting the information or requesting amendments, to objectives, risks, ratings &/or content
- Requesting further information on any of the BAF items
- Requesting that a Trust Board sub-committee review the risks to an objective in more detail

Review of key objectives

When the BAF was reviewed in 2017, it was agreed that the BAF should include some strategic objectives. However, this agreement was superseded by the discussion that led to the key objectives being agreed by the Trust Board on 24/05/18 (see Appendix 1 for the minute of the discussion). That Trust Board meeting did however agree that the Trust Secretary should arrange for a review of the key objectives for 2018/19 to be undertaken after the first Quarter of 2018/19. The Trust Board is therefore asked to consider whether the key objectives require amendment (or to confirm they are appropriate).

Additional aspects relating to the Risk Register

A summary of the status of the Risk Register is enclosed in Appendix 1. Having reviewed the current list of red-rated risks, it is considered that the substance of each are either accounted for within the BAF (to some aspect) or are being considered by an appropriate forum. Further details supporting this conclusion are contained in Appendix 1, but the Trust Board is obviously free to challenge this.

Which Committees have reviewed the information prior to Board submission?

- Finance and Performance Committee (for objectives 1 to 4), 24/07/18

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [3]

1. Review and discussion (taking into account the prompts listed on page 1)
2. Consider whether the 10 key objectives require amendment (or confirm they are appropriate)

[3] 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 Assurance Framework 2018/19

What does the Trust want to achieve? (i.e. the key objective)[4] *Key objective*

1 To deliver the trajectory agreed with NHS Improvement for the A&E 4 hour waiting time target[5]

Relevant CQC domain/s: Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well-led ☒

What could prevent this objective being achieved? (including external factors) *Risks to key objective*

1. The capacity required to deliver the 'new norm' for non-elective activity being insufficient
2. A&E attendances continuing to remain higher than plan
3. Bed occupancy remaining above 92%
4. The level of Delayed Transfers of Care (DTOCs) remaining higher than the expected standard
5. If there is failure to follow best practice in response
6. If there is lack of ownership by Clinical Directorates

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*

a. Demand and capacity planning for 2017/18 (including winter resilience planning) is based on the new normal for non-elective activity using the parameters of attendances, admissions, age-profile and reason for admission as basis for planning (1)

b. The Directorate management team and the Information Department have agreed a set of monthly targets to facilitate how the required performed is monitored (the Trust must achieve 90% or above for Q1, Q2 & Q3, and then 95% in March 2018). Monthly targets are also in place (2)

c. GP streaming is now fully operational (5)

d. The Chaucer Acute Frailty Unit (CAFU) is fully operational at Maidstone Hospital whilst the Frailty Unit at Tunbridge Wells Hospital opened as planned in June 2018 (5)

e. There continues to be intensive focus by the Urgent Care team on resolving capacity and flow issues, supported by Emergency Care Improvement Programme (ECIP) (4, 5)

f. The 'Home First' Pathway 3 programme has been fully implemented

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*

The monthly Trust Performance report submitted to the Finance and Performance Committee and Trust Board (including the 'story of the month')

Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*

If "No", what other data is needed?

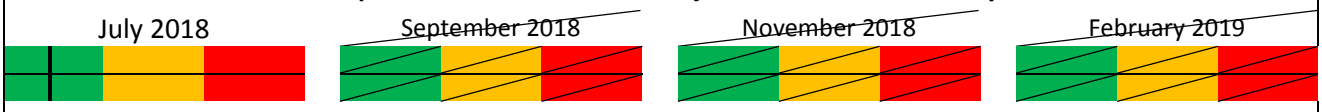
Does specific assurance exist on the data quality of the performance information? Yes ☒ No ☐

Details: The 2017/18 Internal Audit "Review of A&E Data Capture and Recording" published in December 2017 gave an overall conclusion of "Reasonable assurance", although 2 "Important" [6] and 2 "Routine" [7] priority recommendations were made, which have been monitored via the standard follow-up process (which is overseen by the Audit and Governance Committee)

Risk owner/s:	Responsible Director:	Main committee/s responsible for oversight:
Chief Operating Officer	Chief Operating Officer	TME / Finance and Performance Committee / Trust Board

How confident is the Responsible Director that the objective will be achieved by the end of 2018/19?[8]

July 2018 | ~~September 2018~~ | ~~November 2018~~ | ~~February 2019~~



Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):

- The latest monthly performance (for month 3, June 2018) was 94.18%
- The latest year to date performance (at month 3, June 2018) was 93.2%

[4] On 24/05/18, the Board approved the proposal to continue to focus on a deliberately small number of higher-level key objectives to act as proxy indicators (a 'litmus test') for broader performance. All the objectives for 2018/19 are intended to address the underlying risk that the Trust is unable to demonstrate clinical operational or financial sustainability

[5] The agreed trajectory performance (%) is as follows

Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Total	Q1	Q2	Q3	Q4
87.99	90.38	91.7	91.97	92.35	92.62	91.8	91.96	88.54	86.68	88.14	95.03	90.82	90.07	92.3	90.77	90.05

[6] The 2 recommendations were "All relevant members of staff be reminded of the requirement for ensuring that up to date data is consistently captured within the live A&E patient tracker on Symphony with regards to patient status notes" and "Review current user access to establish whether individuals with access to edit discharge times can be minimised. Alternatively, regular monitoring of changes to discharge times to be undertaken with any significant changes being investigated"

[7] The 2 recommendations were "Clinicians be reminded of the requirement for timely and accurate recording of patient discharge times within Symphony" and "Review operational processes with regards to the administrative responsibilities of the clinical members of staff responsible for the day to day live monitoring of the A&E patient tracker and whether these can be undertaken by administrative members of staff on a permanent basis"

[8] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2018/19

What does the Trust want to achieve? (i.e. the key objective)[9] *Key objective*

2 To deliver the trajectory agreed with NHS Improvement for the 62-day Cancer waiting time target[10]

Relevant CQC domain/s: Safe ☒ Effective ☒ Caring ☐ Responsive ☒ Well-led ☒

What could prevent this objective being achieved? (including external factors) *Risks to key objective*

1. Insufficient engagement by clinical staff outside of the Cancer and Haematology Directorate
2. Pathways not being optimal in relation to achieving the required performance
3. Insufficient communication of the performance needed beyond Cancer & Haem. (only $^1/_3$ of delivery is within that Directorate's control – the remainder is within Diagnostics, Surgery & Medicine)
4. Insufficient capacity to meet the increased demand for 2-week wait clinics and diagnostics (Endoscopy and Radiology)

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*

a. Cancer Summits, and Tumour Site-specific mini-Summits have been held (1, 2, 3)
b. The issues have been discussed in Governance meetings & the Cancer Clinical Board (1, 2, 3)
c. Action/Recovery Plans are in place for each of the tumour sites (1, 2, 3)
d. The weekly Cancer Patient tracking Lists (PTLs) meeting is being further revised to include administrative staff responsible for booking inpatient and outpatient appointments. This will enable real time changing of appointments and for dates to be pre-booked for patients when a next key event is known (e.g. likely for surgery).
e. Changes have been made to pathways, including Straight to test triage clinics for colorectal referrals (which is reducing the interval between referral and initial diagnostic and OP appointments for these patients and will eventually enable the number of breaches to be reduced) (2)
f. Individual Cancer pathway workshops are taking place, to focus on key issues in those specific areas (i.e. Breast, Lung, Colorectal) (2)
g. There has been improved engagement with all Tumour Site MDT leads and Directorate management teams, which has increased focus & accountability (1, 3)
h. Improvements in administrative processes will enable better performance especially for Urology, such as the implementation of the Endoview reporting system in Tun. Wells (to reduce the number of letters dictated & appropriate patients to be removed earlier from the pathway) & the clinic outcome proforma (to reduce the number of letters dictated & to remove the patient earlier) (2)
i. The 'To come in' (TCI) form for surgery is being updated to provide a reminder to clinicians to record the data needed to apply waiting time adjustments where appropriate (2)
j. Oncology has implemented a new process to identify patients referred after day 38 where breaches can be avoided if the patient is treated within 24 days. Oncologists will reserve 1 new patient appointment per week & the process is being piloted to book the 24-day patients to these
k. A daily 'huddle' has been implemented for patients between day 40 & day 61, to expedite actions on their pathways (2)
l. A review of the Cancer-related operational governance has been undertaken by the NHS Intensive Support Team (IST)
m. The Trust's recovery plan is focused on demand management and capacity provision

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*

The monthly Trust Performance report submitted to the Finance and Performance Committee and Trust Board (including the 'story of the month')

Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*

If "No", what other data is needed?

Does specific assurance exist on the data quality of the performance information? Yes ☒ No ☐

Details: The 2015/16 Internal Audit "Assurance Review of Data Quality of Key Performance Indicators" published in June 2016 reviewed the KPIs relating to the Cancer 62-day waiting time parget. This gave an overall conclusion of "Reasonable assurance" and stated that "The figures reported to the Board for the Cancer 62 day wait…were found to be accurately reported"

[9] On 24/05/18, the Board approved the proposal to continue to focus on a deliberately small number of higher-level key objectives to act as proxy indicators (a 'litmus test') for broader performance. All the objectives for 2018/19 are intended to address the underlying risk that the Trust is unable to demonstrate clinical operational or financial sustainability

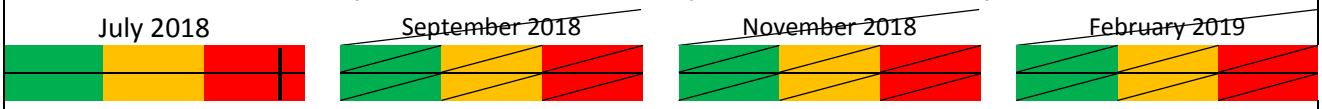
[10] The agreed trajectory performance (%) is as follows

Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Total	Q1	Q2	Q3	Q4
75.73	73.11	71.7	75.65	79.46	82.08	85.48	83.17	83.96	83.74	85.58	86.96	80.5	73.48	78.98	84.29	85.04

Risk owner:	**Responsible Director:**	**Main committee/s responsible for oversight:**
Chief Operating Officer	Chief Operating Officer	Trust Management Executive / Finance and Performance Committee / Trust Board

How confident is the Responsible Director that the objective will be achieved by the end of 2018/19?[11]

July 2018 | September 2018 | November 2018 | February 2019



Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):

- At month 2, 2018/19, the "Cancer 62 day wait - First Definitive" performance (overall) for the quarter to date was 57.8%. For MTW-only patients, performance was 61.5%
- A detailed review was submitted to NHS Improvement in July 2018 outlining the Trust's Root Cause Analysis (RCA) and recovery plan (this was submitted to the Finance and Performance Committee in July 2018)

[11] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2018/19

What does the Trust want to achieve? (i.e. the key objective)[12] *Key objective*

3 To deliver the Referral to Treatment (RTT) trajectory agreed with NHS Improvement for patients on an 'incomplete' pathway[13, 14]

Relevant CQC domain/s: Safe ☐ Effective ☒ Caring ☐ Responsive ☒ Well-led ☒

What could prevent this objective being achieved? (including external factors) *Risks to key objective*

1. An insufficient level of elective and outpatient activity being undertaken
2. Non-elective activity increasing beyond current levels (incl. A&E attendances)
3. Additional data quality issues and/or technical 'glitches' following the implementation of the Allscripts Patient Administration System (PAS)

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*

a. Close monitoring continues for the highest-risk non-complaint specialties (T&O, Gynaecology, and Cardiology) against action plans put in place to reduce their longest waiters
b. These specialities are trying to continue to reduce their backlogs by maximising available capacity across both hospital sites and focusing capacity on booking patients within the backlog to all available sessions, including Saturdays
c. Operational teams are focused on their recovery plans to increase elective activity
d. The Trust engaged a productivity company, Four Eyes Insight Ltd, to optimise theatre and outpatient productivity and efficiency (to maximise the potential for increased activity to be undertaken within the Trust's baseline capacity)
e. The Waiting List Office has been reorganised with the addition of a validation team to manage ongoing issues relating the PAS, and ensure that data is reported correctly

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*

The monthly Trust Performance report submitted to the Finance and Performance Committee and Trust Board (including the 'story of the month')

Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*

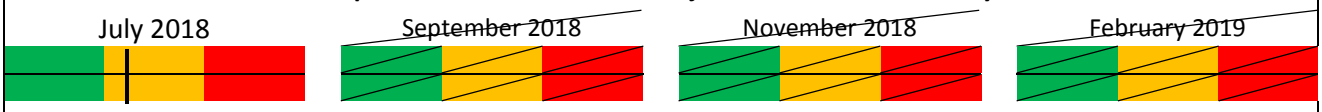
If "No", what other data is needed?

Does specific assurance exist on the data quality of the performance information? Yes ☒ No ☐

Details: The 2017/18 Internal Audit "Assurance Review of Data Quality of Key Performance Indicators" published in May 2018 reviewed the KPIs relating to the RTT incomplete pathway and gave an overall conclusion of "Reasonable assurance", although 2 "Important" priority recommendations were made[15], which will be monitored via the standard follow-up process (which is overseen by the Audit and Governance Committee)

Risk owner:	Responsible Director:	Main committee/s responsible for oversight:
Chief Operating Officer	Chief Operating Officer	Trust Management Executive / Finance and Performance Committee Trust Board

How confident is the Responsible Director that the objective will be achieved by the end of 2018/19?[16]



Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):

- The latest monthly performance (for month 3, June 2018) was 79.1%
- The year to date (which equates to the quarter to date) performance (at month 3, June 2018) was 79.1%

[12] On 24/05/18, the Board approved the proposal to continue to focus on a deliberately small number of higher-level key objectives to act as proxy indicators (a 'litmus test') for broader performance. All the objectives for 2018/19 are intended to address the underlying risk that the Trust is unable to demonstrate clinical operational or financial sustainability

[13] An 'incomplete' pathway is where a referral has been received and the patient is still waiting for something, be that an Outpatient appointment, diagnostic test, elective admission etc. 92% of patients on an incomplete pathway should be waiting less than 18 weeks from receipt of referral.

[14] The agreed trajectory performance (%) is as follows

Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
79.77	80.35	81.02	81.69	81.69	82.37	83.63	84.4	84.5	84.59	84.69	85.46

[15] The 2 recommendations were to "Resolve the technical issue in regards to the outpatient clock stop dates not transferring to Quattro from AllScripts within an agreed reasonable timeframe"; and "Documented evidence to support the referral date captured on the system to be retained within the patient file in all cases with the date of receipt recorded"

[16] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2018/19

What does the Trust want to achieve? (i.e. the key objective)[17] *Key objective*

4 To deliver the financial plan for 2018/19

Relevant CQC domain/s: Safe ☐ Effective ☐ Caring ☐ Responsive ☐ Well-led ☒

What could prevent this objective being achieved? (including external factors) *Risks to key objective*

1. If there was a lack of senior leadership and commitment
2. If there were poor financial controls (or if good controls were poorly applied)
3. If there was a lack of commitment by managers
4. If the CIP schemes were not delivered (regardless of their RAG rating or identified value)
5. If the Trust's plans for 2018/19 had been developed without consideration of best practice elsewhere
6. If there was insufficient engagement with external stakeholders

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*

a. The Executive has continued to mobilise the organisation since the Trust was put into Financial Special Measures (1)
b. The Trust has signed up to its control total, and submitted a plan to achieve this (1)
c. Agreed budgets have been set for each Directorate (2)
d. A number of 'Grip and Control' measures have been implemented to ensure delivery (1, 2, 5)
e. The Performance Management Framework is now embedded (2, 3)
f. Action has been taken to engage with external stakeholders, including agreeing an Aligned Incentives Contract with West Kent CCG , which now includes Kent Community Health NHS FT (5, 6)
g. The Trust has introduced a Best Care programme which seeks to bring a consistent approach to transformation and improvement across the Trust (1, 3, 4)
h. The 2018/19 CIP will be delivered via the Best Care programme (1, 3, 4)

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*

1. Monthly financial performance reports to the Best Care Programme Board (monthly) TME, Finance and Performance Committee and Board
2. Monthly detailed Best Care Programme report to the Finance and Performance Committee and Trust Board

Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*

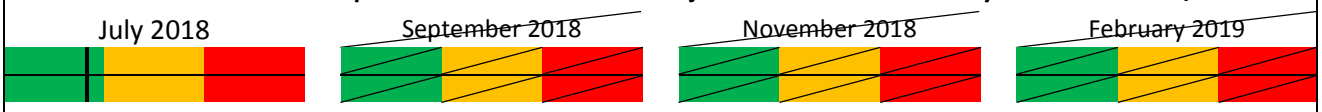
If "No", what other data is needed?

Does specific assurance exist on the data quality of the performance information? Yes ☒ No ☐

Details: The financial position is subject to annual external review via the Annual Audit of the financial accounts, which is reported to the Audit and Governance Committee and Trust Board each May

Risk owner:	**Responsible Director:**	**Main committee/s responsible for oversight:**
Director of Finance	Director of Finance	Finance and Performance Committee / Trust Board

How confident is the Responsible Director that the objective will be achieved by the end of 2018/19?[18]



Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):

- At month 3, the Trust has delivered against its plan and not committed contingency spend. However a number of non-recurrent adjustments had to be made to achieve this

[17] On 24/05/18, the Board approved the proposal to continue to focus on a deliberately small number of higher-level key objectives to act as proxy indicators (a 'litmus test') for broader performance. All the objectives for 2018/19 are intended to address the underlying risk that the Trust is unable to demonstrate clinical operational or financial sustainability

[18] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2018/19

What does the Trust want to achieve? (i.e. the key objective) [19] *Key objective*

5 To ensure a falls rate of no more than 6.0 per 1000 occupied bed days

Relevant CQC domain/s: Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well-led ☒

What could prevent this objective being achieved? (including external factors) *Risks to key objective*

1. Failure/inability to meet national best practice standards
2. Lack of full MDT approach to falls prevention
3. Lack of flexibility and suitability of clinical support systems

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*

a. The Trust has joined the NHS Improvement (NHSI) Falls Prevention Collaborative (1 & 2)
b. Clear identification of pilot and control Wards to test & check falls prevention strategies (in line with recommendations resulting from point a.)
c. Initially specific focus on one action (lying & standing blood pressure) across all disciplines (2)
d. Review and updating of relevant clinical systems to enable full recording and tracking of interventions via Nerve Centre IT system (3)
e. Ensuring all areas have access to relevant equipment to enable implementation of best practice standards (1)

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*

The monthly Trust Performance report submitted to the Trust Board (including the 'story of the month')

Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*

If "No", what other data is needed?

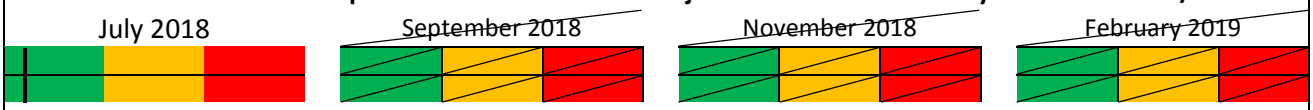
Does specific assurance exist on the data quality of the performance information? Yes ☒ No ☐

Details: The 2017/18 Internal Audit "Assurance Review of Data Quality of Key Performance Indicators" published in May 2018 reviewed the KPIs relating to falls and gave an overall conclusion of "Reasonable assurance", no recommendations, and the statement that "Testing of a sample of twenty cases confirmed timely recording of Falls incidents and that the information contained in source records and the source data system were consistent with the information reported"

Risk owner:	**Responsible Director:**	**Main committee/s responsible for oversight:**
Chief Nurse	Chief Nurse	Trust Clinical Governance Committee

How confident is the Responsible Director that the objective will be achieved by the end of 2018/19? [20]

July 2018 | September 2018 | November 2018 | February 2019



Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):

- The rate of falls for latest month (month 3, June 2018) is 5.86 (5.53 at Maidstone Hospital and 6.05 at Tunbridge Wells Hospital)
- The rate of falls for the year to date at month 3 (June 2018) is 5.23 (5.01 at Maidstone Hospital and 5.37 at Tunbridge Wells Hospital)

[19] On 24/05/18, the Board approved the proposal to continue to focus on a deliberately small number of higher-level key objectives to act as proxy indicators (a 'litmus test') for broader performance. All the objectives for 2018/19 are intended to address the underlying risk that the Trust is unable to demonstrate clinical operational or financial sustainability

[20] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2018/19

What does the Trust want to achieve? (i.e. the key objective)[21] *Key objective*

6 To ensure a pressure ulcer rate of no more than 3.0 per 1000 admissions

Relevant CQC domain/s: Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well-led ☒

What could prevent this objective being achieved? (including external factors) *Risks to key objective*

1. Failure to deliver personalised care (i.e. care planning & delivery not tailored to individual patient need)
2. Prolonged 'trolley time' in A&E, Radiology, Theatres
3. Unscheduled absence/gaps in the Tissue Viability Nurse (TVN) service
4. Failure to prevent the new NHS Improvement (NHSI) guidance on reporting Deep Tissue Injury (issued in June 2018)

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*

a. Education programmes in place, informed by lessons learnt from Root Cause Analysis (RCA) (1)
b. Good links with wound care supplier representatives who provide local ad hoc training & support in and out of hours (1 & 3)
c. Good awareness of risks, leading to prompt transfer of 'high risk' patients to appropriate bed in A&E (2)
d. Key therapeutic Radiotherapy risks are known and consideration is given to planning transfers to minimise waits (2)
e. Good quality trolley are mattresses in place (2)
f. There is early recognition of high risk patients in Theatres with appropriate pressure relief measures in place (2)
g. There are links with Community TVNs for provision of clinical advice and assessment to telephone triage system (3)
h. There are Key Link Nurses & Ward Managers who can support locally for short periods of time (3)
i. There is a fully established TVN service in place (3)
j. Gap analysis against the new NHSI guidance has shown that the Trust is compliant with 19 of the 28 new recommendations (4)
k. There is a minor impact of new NHSI reporting guidance with the inclusion of Deep Tissue Injury (DTI) data

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*

The monthly Trust Performance report submitted to the Trust Board (including the 'story of the month')

Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*

If "No", what other data is needed?

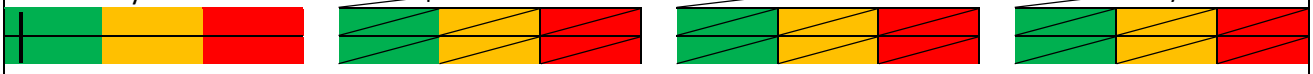
Does specific assurance exist on the data quality of the performance information? Yes ☒ No ☐

Details: The 2017/18 Internal Audit "Assurance Review of Data Quality of Key Performance Indicators" published in May 2018 reviewed the KPIs relating to Pressure Ulcers and gave an overall conclusion of "Reasonable assurance", although 1 "Urgent" [22] and 2 "Routine" [23] priority recommendations were made, which will be monitored via the standard follow-up process (which is overseen by the Audit and Governance Committee)

Risk owner:	**Responsible Director:**	**Main committee/s responsible for oversight:**
Chief Nurse	Chief Nurse	Trust Clinical Governance Committee

How confident is the Responsible Director that the objective will be achieved by the end of 2018/19?[24]

July 2018 | ~~September 2018~~ | ~~November 2018~~ | ~~February 2019~~



Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):

- The rate of hospital pressure ulcers for latest month (month 3, June 2018) is 1.94
- The rate of falls for the year to date at month 3 (June 2018) is also 1.94

[21] On 24/05/18, the Board approved the proposal to continue to focus on a deliberately small number of higher-level key objectives to act as proxy indicators (a 'litmus test') for broader performance. All the objectives for 2018/19 are intended to address the underlying risk that the Trust is unable to demonstrate clinical operational or financial sustainability

[22] The recommendations was to "Ensure that the notes on Datix are maintained up to date to accurately reflect and evidence that the patient has been independently assessed by the Tissue Viability Nurse and that the severity of the harm reported has been verified"

[23] The 2 recommendations were "Process notes held by the Lead Tissue Viability Nurse for populating the monthly Safer Smarter Care Template to be formalised" and "Relevant staff to be reminded that all pressure ulcer incidents are to be recorded on Datix within a timely manner following the occurrence of the incident"

[24] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2018/19

What does the Trust want to achieve? (i.e. the key objective)[25] *Key objective*

7 To deliver the agreed 'lessons learned' plan for 2018/19

Relevant CQC domain/s: Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well-led ☒

What could prevent this objective being achieved? (including external factors) *Risks to key objective*

1. The Datix IT system not being able to provide the required functionality
2. The availability of IT resource to complete Datix upgrade(s)
3. Clinical Directorates not being able to release key staff to attend clinical governance meetings
4. The identification of meaningful/measurable metrics to assure that learning is shared and embedded
5. Lack of agreement/support/resource to implement new clinical governance processes proposed (agenda, learning levels, action planning processes)
6. The learning input and output from Datix is not consistently of the right quality to provide clarity for lessons to be learned

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*

a. A meeting was arranged with Datix for 24/07/18 to discuss issues with functionality and press them for a solution/support to resolve (1)
b. Problems with Datix are reported to their service desk (1)
c. The Interim Director of Health Informatics is involved in discussions, and will oversee upgrades requests and allocate required resource. Assurance has been received for the current upgrade and an IT project manager has been allocated (2)
d. Meetings are being arranged with Directorate clinical governance leads for September to discuss their attendance and cascade strategy from clinical governance meetings (3, 4)
e. Meetings have been arranged with a wide group (including 2 Non-Executive Directors and other key staff) to devise mechanisms to test for learning/evidencing/embedding and to scope and agree options for recording/metrics
f. The Patient Safety Team will deliver a programme of training on reporting/investigating incidents (6)

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*

1. The Learning Lessons Core Team and the documents considered at the Best Safety Board

Do we have all the data needed to judge performance? Yes ☐ No ☐ *Gaps in assurance*

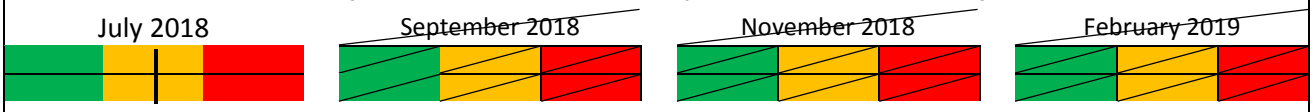
If "No", what other data is needed?

Does specific assurance exist on the data quality of the performance information? Yes ☐ No ☒

Details: The project is still in formulation

Risk owner:	**Responsible Director:**	**Main committee/s responsible for oversight:**
Medical Director	Medical Director	Best Care Programme Board

How confident is the Responsible Director that the objective will be achieved by the end of 2018/19?[26]



Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):

- A 'plan B' is in place which will allow manual extraction of data if necessary
- Some investment may be required from the Clinical Directorates
- There are known to be national-level difficulties in achieving clear metrics (including Human Factors benefits)

[25] On 24/05/18, the Board approved the proposal to continue to focus on a deliberately small number of higher-level key objectives to act as proxy indicators (a 'litmus test') for broader performance. All the objectives for 2018/19 are intended to address the underlying risk that the Trust is unable to demonstrate clinical operational or financial sustainability

[26] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2018/19

What does the Trust want to achieve? (i.e. the key objective)[27] *Key objective*

8 To deliver the agreed medical productivity plan for 2018/19

Relevant CQC domain/s: Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well-led ☒

What could prevent this objective being achieved? (including external factors) *Risks to key objective*

1. The resource at Directorate level to complete all Job Planning requirements in line with the project timeline
2. The resource to support the project in the timescales set out in the plan overview, including Project Management Office (PMO) and Business Intelligence support
3. Lack of enforcement of local standards at Directorate level for job planning (unwarranted variation)
4. Resistance or lack of support from the Joint Medical Consultative Committee (JMCC)
5. The significant cultural change required to obtain buy in to undertake and implement Best Value Direct Clinical Care (DCC) and Personalised Metrics.
6. If seasonal Job Plans are not well received by the Consultant body and unenforceable
7. Directorate Leadership Teams' ability to deliver significant cultural change and challenging work programme

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*

a. Full support given by Core Team, close working with Clinical Directors and General Manager, management of targets, and the secondment of the PMO Lead to project (1)
b. Dedicated Business Intelligence resource has been recruited at corporate level which will also support Directorate requirements. The PMO support is also now dedicated (2)
c. The project has the full support of Clinical Directors and the Divisional/Directorate management Teams (3)
d. There has been Trust-wide approval of the Job Planning policy/standards/PA allocation table and the Medical Job Planning Consistency Committee (MJPCC) Terms of Reference (4)
e. There has been close working with the JMCC, co-design of the MJPCC Terms of Reference and membership of JMCC representatives on MJPCC (4)
f. The Associate Medical Director will work through the Deputy Medical Directors and Clinical Directors to resolve concerns (5 and 7)
g. The project will be a standard agenda item on Clinical Directors' Committee meetings, to keep the Directorate Management Teams informed and updated. This will provide an opportunity to voice concerns and resolve issues arising (6)
h. The Associate Medical Director will test out through Clinical Directors and develop a workable compromise (7)

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*

1. The Medical Productivity Working Group and Best Safety Board

Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*

If "No", what other data is needed?

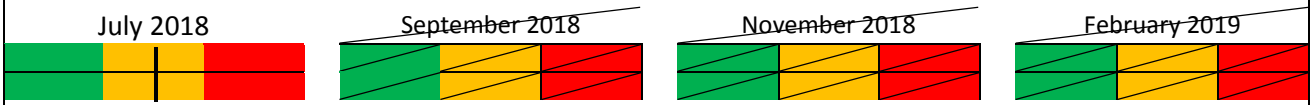
Does specific assurance exist on the data quality of the performance information? Yes ☒ No ☐

Details: Allocate system reports. There will also be Business Intelligence analyst involvement upon commencement of their new role

Risk owner:	**Responsible Director:**	**Main committee/s responsible for oversight:**
Medical Director	Medical Director	Best Care Programme Board

How confident is the Responsible Director that the objective will be achieved by the end of 2018/19?[28]

July 2018 | ~~September 2018~~ | ~~November 2018~~ | ~~February 2019~~



Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):

- Directorate resource to complete all Job Plans, load onto system and sign off (still within critical path deadline)
- Initial review of some of the Job Plans going through the sign off process indicates some non-compliance with the standards and may indicate lack of buy-in to the process, or inability to shift culture at Directorate level. The Associate Medical Director is liaising with the relevant Directorates. However, this was expected and will be resolved through the shadow MJPCC in the first year

[27] On 24/05/18, the Board approved the proposal to continue to focus on a deliberately small number of higher-level key objectives to act as proxy indicators (a 'litmus test') for broader performance. All the objectives for 2018/19 are intended to address the underlying risk that the Trust is unable to demonstrate clinical operational or financial sustainability

[28] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2018/19

What does the Trust want to achieve? (i.e. the key objective)[29] *Key objective*

9 To deliver a vacancy rate of no more than 9%

Relevant CQC domain/s: Safe ☐ Effective ☒ Caring ☐ Responsive ☐ Well-led ☒

What could prevent this objective being achieved? (including external factors) *Risks to key objective*

1. A national shortage of certain staff groups
2. If there was a lack of clarity/focus on the key actions required
3. If there was a lack of clarity over the performance required by each Directorate, and the monitoring of such performance
4. If there was inefficiency of recruitment processes
5. If there was a lack of urgency/commitment by recruiting managers
6. If there was uncertainty over the status of vacancies

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*

a. The Trust Workforce Strategy 2015-20 and associated workplan ("Recruitment & Retention" is the first of 6 workforce priorities) (1, 2, 3)
b. The establishment of the Nurse Recruitment and Retention Group (Chaired by the Chief Nurse) (5)
c. Implementation of TRAC electronic recruitment system (4)
d. Divisional New Ways of Working Task and Finish Groups (4, 5)
e. Establishment of a New Roles and Apprentices group within the Workforce workstream of the Best Care Programme (1)
f. Establishments and workforce requirements have been reviewed as part of the Business Planning process for 2018/19 (6)
g. Establishment levels are likely to be reviewed as part of the Business Planning for 2019/20 (6)
h. Listening into Action (LiA) Crowdfixing events held during January and February 2018 (4)
i. HealthRoster KPIs have been implemented in order to report on effective rostering of staff and usage of contractual hours and to challenge poor practice (5, 6)

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*

1. The Trust Performance Dashboard, which contains the "Vacancy Rate (%)" (as well as "Vacancies WTE")
2. Reports to the Workforce Committee (which includes a commentary on the latest issues regarding the vacancy rate)
3. Directorate performance dashboards
4. The 6-monthly review of Ward and non-Ward areas submitted to the Trust Board in March 2018
5. The monthly Planned and Actual Ward Staffing reports to the Trust Board (re the establishments)

Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*

If "No", what other data is needed?

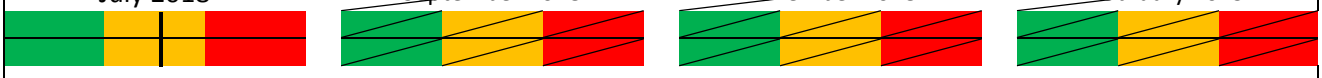
Does specific assurance exist on the data quality of the performance information? Yes ☐ No ☒

Details:

Risk owner:	**Responsible Director:**	**Main committee/s responsible for oversight:**
Director of Workforce	Director of Workforce	Trust Management Executive / Workforce Committee / Trust Board

How confident is the Responsible Director that the objective will be achieved by the end of 2018/19?[30]

July 2018 | September 2018 | November 2018 | February 2019



Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):

- The vacancy rate for the latest month (month 3, July 2018) was 10.4%
- The vacancy rate for the year to date (at month 3, July 2018) was 10.4%

[29] On 24/05/18, the Board approved the proposal to continue to focus on a deliberately small number of higher-level key objectives to act as proxy indicators (a 'litmus test') for broader performance. All the objectives for 2018/19 are intended to address the underlying risk that the Trust is unable to demonstrate clinical operational or financial sustainability

[30] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2018/19

What does the Trust want to achieve? (i.e. the key objective)[31] *Key objective*

10 To deliver a staff turnover rate of less than 10%

Relevant CQC domain/s: Safe ☐ Effective ☒ Caring ☐ Responsive ☐ Well-led ☒

What could prevent this objective being achieved? (including external factors) *Risks to key objective*

1. A national shortage of certain staff groups creates a more mobile workforce
2. Higher than planned vacancy rates (resulting in more temporary staffing use) typically reduces staff morale

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*

a. The Trust Workforce Strategy 2015-20 and associated workplan ("Recruitment & Retention" is the first of 6 workforce priorities) (1, 2)
b. The establishment of the Nurse Recruitment and Retention Group (Chaired by the Chief Nurse) (1, 2)
c. Agreement of the Staff Engagement Strategy and associated action plans at the Workforce Committee in March 2018 (1)
d. A Staff Retention group has been established within the Quality workstream of the Best Care Programme (1)

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*

1. The Trust Performance Dashboard, which contains the "Staff Turnover Rate (%)"
2. Reports to the Workforce Committee (which includes a commentary on the latest issues regarding the turnover rate)
3. Divisional and Directorate monthly workforce reports
4. Directorate performance dashboards

Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*

If "No", what other data is needed?

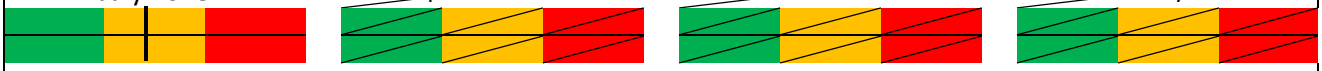
Does specific assurance exist on the data quality of the performance information? Yes ☐ No ☒

Details: Some internal work has been completed to improve the accuracy and data quality used to calculate workforce KPIs. Further refining work is completed throughout the year.

Risk owner:	**Responsible Director:**	**Main committee/s responsible for oversight:**
Director of Workforce	Director of Workforce	Trust Management Executive / Workforce Committee / Trust Board

How confident is the Responsible Director that the objective will be achieved by the end of 2018/19?[32]

July 2018 | ~~September 2018~~ | ~~November 2018~~ | ~~February 2019~~



Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):

- The turnover rate for the latest month (month 3, July 2018) was 10.3%
- The turnover rate for the year to date (at month 3, July 2018) was 10.3%

[31] On 24/05/18, the Board approved the proposal to continue to focus on a deliberately small number of higher-level key objectives to act as proxy indicators (a 'litmus test') for broader performance. All the objectives for 2018/19 are intended to address the underlying risk that the Trust is unable to demonstrate clinical operational or financial sustainability

[32] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Appendix 1: Summary of the status of the Trust's Risk Register

Each risk on the Risk Register has a designated “Manager” and is allocated a review date. The management of the Risk Register is overseen by the Trust’s Risk and Compliance Manager, who instigates formal reviews every 2 months. The full Risk Register is submitted to the Trust Management Executive (TME) and Audit and Governance Committee. Red-rated risks are now also subject to detailed review at Executive Team Meetings each quarter, whilst Clinical Directorate-based red-rated risks are discussed as part of the report that Directorates give to the ‘main’ Quality Committee (via the Trust Clinical Governance Committee).

The latest review of red-rated risks at the Executive Team Meeting took place on 17/07/18, and it was recommended that several of the red-rated risks be moderated (and therefore have their risk rating downgraded to either an ‘amber’ or ‘green’ rating). This moderation has not yet been completed, but once completed, will affect the risk profile, by reducing the number of red-rated risks and increasing the number of amber- and green-rated rated risks. The pre-moderated Risk Register therefore contained the following risks at 20/07/18:

- 14 red-rated risks
- 59 amber-rated risks
- 18 green-rated risks
- 1 blue-rated risks

The risk matrix and associated guidance has been included in Appendix 2, for reference.

The issues covered by the 14 current red-rated risks should be familiar to the Trust Board and its sub-committees, as these have been previously discussed at the Trust Board, Quality Committee, Finance and Performance Committee and/or Workforce Committee. These issues are as follows:

- High staffing, vacancies and turnover for Nursing staff in the Specialist Medicine Directorate
- Achieving the Cancer waiting time targets
- The cost pressures associated with the use of temporary staff
- The shortage of Paediatric Specialty and Associate Specialist (SAS) (‘middle grade’) doctors on day shifts for paediatrics
- 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
- Medical staffing shortage in Surgery impacting on inability to deliver emergency and elective care
- Impact of staffing levels on ability to sustain accreditation in Microbiology
- Risk associated with failing to learn from incidents
- Risk of no qualified speech and language therapy service to non-stroke neuro patients
- Neonatal Transport Incubator (NTI) frequently out of service due to gas leakage issue, putting babies requiring transfer at risk
- The risk of fire in a Trust building as a result of ageing infrastructure

As was noted on the cover page of this report, it was agreed at the Audit and Governance Committee in February 2017 that the substance of all red-rated risks in the Risk Register should be accounted for in the Board Assurance Framework (BAF), or where this is not the case, that the risk is identified for separate further consideration by the appropriate forum. Having reviewed the red-rated risks listed above, it is considered that the substance of each are either accounted for in the BAF or are being considered by an appropriate forum.

Appendix 2: Risk grading matrix and associated guidance

Guidance on consequences / severity

Score / Consequence	CLINICAL OUTCOME / SAFETY	QUALITY	AGREED TARGETS	FINANCE, DAMAGE & LITIGATION	IMPACT ON TRUST - CORPORATE RISK
1 NEGLIGIBLE	No obvious harm Some distress Temporary loss of dignity	Minor non-compliance of standards	No obvious effect	<£2K	No obvious risk
2 MINOR	No-permanent harm Increased length of stay <7 days Minor psychological harm Injury requiring first aid Resolved in <1 Month <3 days work absence	Single failure to meet internal standards Failure to follow procedure or protocol	1% off planned Target Fail to meet national target for 1 quarter	£2K - £20K Litigation unlikely Complaint possible	Local adverse publicity for <1d Clinical service disrupted for <1 day
3 MODERATE	Semi-permanent harm Increased length of stay 7-15 days Increased level of care Injury requires medical attention Resolved within 1 year >3 days work absence	Repeated failures to meet internal standards Single failure to meet national or professional standards Repeated failure to follow procedures or protocols	2% - 4% off planned Target Fail to meet national target for 2 quarters.	£20 K - £1M Litigation possible Complaint received	Local adverse publicity for >1d Clinical service disrupted for >1 day Temporary interruption of clinical service
4 MAJOR / SEVERE	Major permanent harm Increased length of stay >15 days Permanent disability > 10 people affected Major psychological harm Injury requires hospital admission Over 1 year to resolve >10 days work absence	Repeated failure to meet national or professional standards Failure to meet NICE guidelines.	5% - 10% off planned Target Fail to meet national target for >2 quarters.	£1M - £5M Litigation certain Breach of legislation Incident reported to external Agency (SI declared, RIDDOR etc) HSE investigation	National adverse publicity for <1d Clinical service disrupted for >1 day Sustained interruption of clinical service MP concerns
5 CATASTROPHIC	DEATH Many people affected (e.g. cervical screening)	Gross failure to meet national or professional standards	>10% off planned Target Fail to meet national target for >2 quarters by more than 20%.	>£5M Class litigation Major breach of legislation HSE prosecution or prohibition notice	Major national adverse Publicity Public enquiry Loss of clinical service

Guidance on likelihood / probability

Score / likelihood	DEFINITION	TIME SCALE	OCCURRENCE
1 **HIGHLY UNLIKELY**	Cannot believe that circumstances exist now or ever.	Could occur once in a lifetime.	Control measures are in place and will prevent harm from arising. Control measures have been put in place to prevent situation arising again
2 **UNLIKELY**	There is a theoretical risk of the problem causing harm	Could re-occur every few years A single issue	Investigation has been completed and action plan has been developed. Resources are available and guaranteed Project is being managed and timescale is acceptable Proposed control measures will prevent situation arising again.
3 **POSSIBLE**	Risk of harm is considered to be 50/50	Could re-occur annually An occasional issue	Control measures are not followed or ineffective to prevent occurrence Resources are inadequate to prevent occurrence Not known if control measures are effective or adequate. Low confidence the project will be completed or time scale is un-acceptable
4 **LIKELY**	It is only a question of time before harm occurs.	Could re-occur monthly A common issue	Control measures are limited and/ or ineffective. Resources are not available when required. Near misses may be occurring occasionally
5 **CERTAIN**	The risk of harm is considered real and imminent	Certain to re-occur A persistent issue	Circumstances for occurrence exist. Existing practices and processes would not prevent incident from occurring. Near misses may be occurring routinely

Risk grading matrix

	CONSEQUENCE/ SEVERITY				
LIKELIHOOD / PROBABILITY	**None 1**	**Low 2**	**Moderate 3**	**Severe 4**	**Catastrophic 5**
Highly Unlikely 1	**Blue 1**	**Blue 2**	**Blue 3**	**Blue 4**	**Green 5**
Unlikely 2	**Blue 2**	**Blue 4**	**Green 6**	**Green 8**	**Amber 10**
Possible 3	**Blue 3**	**Green 6**	**Green 9**	**Amber 12**	**Red 15**
Likely 4	**Blue 4**	**Green 8**	**Amber 12**	**Red 16**	**Red 20**
Certain 5	**Green 5**	**Green 10**	**Amber 15**	**Red 20**	**Red 25**

Appendix 3: Minute of "Board Assurance Framework (BAF): Agreement of key objectives for 2018/19" item at the Trust Board meeting held on 24/05/18

MINUTES OF THE TRUST BOARD MEETING ('PART 1') HELD ON THURSDAY 24TH MAY 2018, 10A.M, AT MAIDSTONE HOSPITAL

NHS Maidstone and Tunbridge Wells NHS Trust

Present:	David Highton	Chair of the Trust Board	(DH)
	Maureen Choong	Non-Executive Director	(MC)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Angela Gallagher	Chief Operating Officer	(AG)
	Nazeya Hussain	Non-Executive Director	(NH)
	Tim Livett	Non-Executive Director	(TL)
	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)

5-9 Board Assurance Framework (BAF): Agreement of key objectives for 2018/19

KR referred to Attachment 4 and the information therein and highlighted that:

- The Trust Board was asked to consider the approach it wished to take for the BAF and key objectives for 2018/19. For the former, it was proposed that the approach used in 2017/18 be taken, in terms of the layout and questions asked etc., although the format would be revised slightly to reflect the 2 amendments requested by the Audit and Governance and Finance and Performance Committees. The format was illustrated in Appendix 1
- Ten key objectives for 2018/19 were proposed. This was an increase from the 6 in 20171/8, but still retained the principle that the key objectives were a 'litmus test'/proxy for wider performance, rather than reflecting the full range of objectives the Trust had. The Trust had previously had a more comprehensive set of BAF objectives, but had deliberately chosen to adopt the current approach
- The proposed objectives had been discussed with individual Members of the Executive Team and with MS, and were now submitted for approval. Any approval given at the meeting was however not fixed, as changes could be made throughout the year, as the Board desired

MS referred to the discussion at the last Trust Board meeting regarding setting achievable objectives, and stated that he wanted assurance that the 2 workforce-related objectives were the product of a plan, and did not just reflect an aspiration. MS elaborated that the 8.5% vacancy rate in particular appeared aspirational. SH remarked that the turnover rate proposed reflected the Trust's participation in the NHS Improvement (NHSI) retention programme; and whilst the vacancy rate proposed was more challenging, a plan was in place (although a number of variables affected performance). MS proposed that those 2 objectives be approved in principle, but that the final details be confirmed at the June 2018 Trust Board meeting. This was agreed.

Action: Arrange for the details of the workforce-related key objectives for 2018/19 to be confirmed at the June 2018 Trust Board meeting (Trust Secretary, June 2018)

SDu remarked that the proposed objectives were a mixture of very specific objectives and broader themes i.e. the achievement of the financial plan. KR explained the approach, noted that the financial objective related to the delivery of the control total, which was the outcome that SO in particular would be held to account over, but there was no equivalent larger, SMART, objectives that could be applied to other Members of the Executive Team. SDu noted that there were no strategic objectives that reflected what the Board was ultimately trying to achieve. KR highlighted that there were no SMART strategic objectives within the Trust's current Strategy, and strategic objectives were also not linked to the annual framework in which the BAF operated, as they usually had a longer timescale. SDu noted that MS had made reference in his report to a desire to achieve an "outstanding" rating. MS acknowledged the point, but stated that it may be better to start with

the objectives proposed, and consider whether SDu's comments could be addressed at a later point. DH also acknowledged SDu's point, but concurred with MS and proposed that the objectives be approved as circulated, but that a review then be undertaken after the first quarter of the year, at which point the inclusion of more strategic objectives could be considered. This was agreed.

Action: Arrange for a review of the key objectives for 2018/19 to be undertaken after the first quarter of the year (Trust Secretary, May 2018 onwards)

Trust Board meeting – July 2018

Maidstone and Tunbridge Wells NHS Trust

7-10	**Integrated Performance Report, June 2018**	**Chief Executive / Members of the Executive Team**

The enclosed report includes:

- The 'story of the month' for June 2018 (including Emergency Performance (4 hour standard); Delayed Transfers of Care (DTOCs); Cancer 62 day First Definitive Treatment) and Referral to Treatment (RTT)
- Letter from NHS Improvement on Cancer performance
- Cancer Recovery Plan
- A Quality and Safety Report (including an update on complaints performance)
- Planned and actual ward staffing for June 2018
- An Infection Prevention and Control Report
- A financial commentary
- A workforce commentary
- The Trust performance dashboard
- An explanation of the Statistical Process Control charts which are featured in the "Integrated performance charts" section
- Integrated performance charts
- The Board finance pack

Which Committees have reviewed the information prior to Board submission?

- Finance & Performance Committee (in part)

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]

Review and discussion

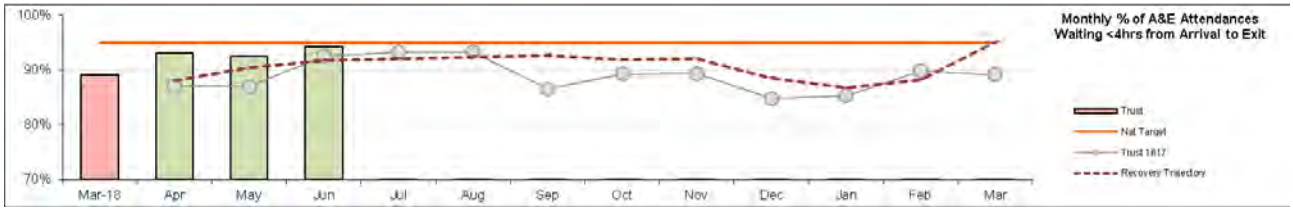
[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; 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

OPERATIONAL PERFORMANCE REPORT FOR JUNE-18

1. 4 Hour Emergency Target

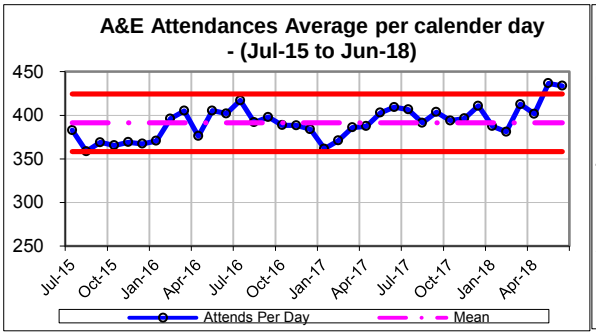
- The Trust delivered significantly above the expected trajectory again in June, scoring 94.20% against a target of 91.70%. Q1 score was 93.25% against the target of 90.07%. For the year 1718 we scored 89.1%, compared to 87.12% in 1617.

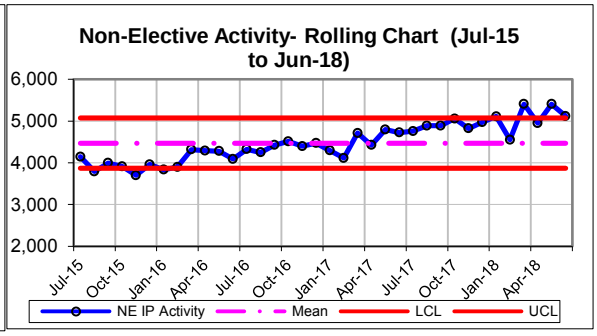
- We continue to perform significantly better than the national average on the 4 hour standard. In Feb-Apr, we scored at least 9 percentage points higher than the national average, and were placed in the top 20% of performing trusts. For May we were 5.6% above average.



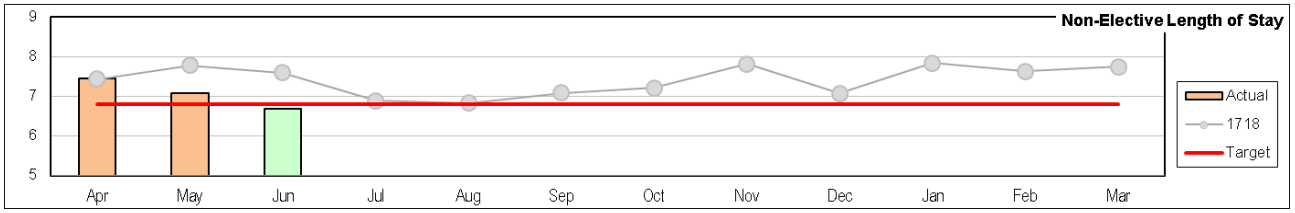
- A&E Attendances continue to increase. The 1718 attendance (excluding Crowborough MIU) was still 3.2% up on the previous year, and there was a significant increase in attendances between mid-November and early January which had no clear reason. June's attendances were 3.0% more than modelled and 3.0% up on the TDA trajectory, also 5.3% higher than Jun-17 (excluding Crowborough MIU)

- Non-Elective Activity (excluding Maternity) continues to grow and was 8.3% above plan & 9.9% higher than last June at 4,546 discharges.





- Non-Elective LOS was 6.69 days in June, vs 7.41 in 1718. It tends to vary by 0.5 to 1.0 days between Winter & Summer.



- The average occupied bed days decreased to 699 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:

- The Best Flow Programme Board has agreed to increase AEC capacity at the Tunbridge Wells site as of 12.6.18 with further plans to increase capacity to a total of 3 bays by September.
- 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 ahead of schedule (4.6.18) to provide up to 16 spaces per day
- Super stranded patient project continuing with downward trajectory
- Community hospital pathways and home treatment service processes projects commenced end of May to yield data end of June
- 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.

2. Delayed Transfers of Care

The percentage occupied bed-days due to DToC rose marginally from 4.34% in May to 4.39% in June. Both the number of patients delayed and the total number of bed-days fell significantly, but so did total occupied bed days. We ended 1718 on 4.95%, and have now been under 5.0% for 8 consecutive months. On average, 29.8 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 4th June 2018.

Category	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 19	Jun 20	Rolling 12 Month
A : Awaiting Assessment	7	2	2	7	6	2	5	2	1	2	5	3	**44**
B : Awaiting Public Funding	3	2	0	2	1	0	1	5	1	2	4	0	**21**
C : Awaiting Further Non-Acute NHS Care	11	8	21	15	10	18	21	9	21	12	20	14	**180**
Di : Awaiting Residential Home	16	23	32	21	19	18	24	18	40	15	23	29	**278**
Dii : Awaiting Nursing Home	53	63	42	46	54	38	37	47	54	53	43	26	**556**
E : Awaiting Care Package	27	27	32	24	36	14	18	20	28	20	31	18	**295**
F : Awaiting Community Adaptations	15	8	5	10	12	4	12	10	7	15	7	6	**111**
G : Patient or Family Choice	10	13	14	28	38	13	11	5	10	3	14	11	**170**
H : Disputes	0	1	0	0	1	0	0	0	0	1	0	0	**3**
I : Housing	6	8	2	2	1	2	3	3	2	6	2	7	**44**
Grand Total	**148**	**155**	**150**	**155**	**178**	**109**	**132**	**119**	**164**	**129**	**149**	**114**	**1,702**
Rate	**5.41%**	**4.54%**	**5.32%**	**5.36%**	**4.84%**	**3.73%**	**4.27%**	**3.89%**	**4.26%**	**4.56%**	**4.34%**	**4.39%**	**4.58%**

3. Length of Stay

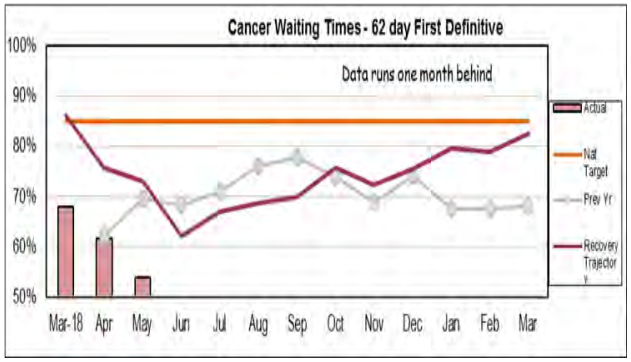
- Non-Elective LOS was 6.69 days in June, vs 7.41 in 1718. It tends to vary by 0.5 to 1.0 days between Winter & Summer.
- Zero LoS admissions have been increasing consistently for about 2 years now, thanks to increased use of Ambulatory & Frailty, and increased capacity in CDU. Increasing the volume of zero LoS will force the average LoS down, but may apply upward pressure to the non-zero indicator if it is moving patients from short stay group into the zero stay.

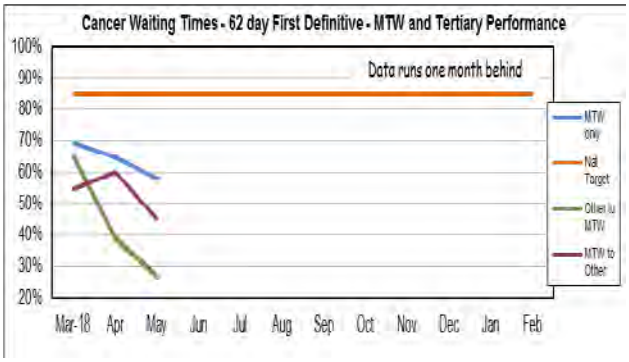
4. Cancer 62 Day First Definitive Treatment

62 day performance for May was 53.8%, 57.8% YTD, which is a major deterioration from our submitted trajectory. The contributory factors to the deterioration is a sharp rise in referrals in the high volume tumour sites alongside a drop in capacity caused by workforce issues as well as short term loss of capacity due to snow and ERS implementation The average weekly number of referrals has increased by over 10%.. The year-end performance for 1718 was 70.4%. The capacity shortfalls are in the first part of the pathway, outpatients and diagnostics which causes patients to receive their diagnosis too late to achieve the treatment within 62 days. The capacity available for treating patients once diagnosed is sufficient for the existing demand for treatment.

The backlog of patients who are waiting for treatment and who have already breached 62 days at the end of May was 56 with 30 of these being MTW patients. This is a 19 patient decrease compared to April for all patients and a 12 patient decrease for MTW only.

Overview of May Performance

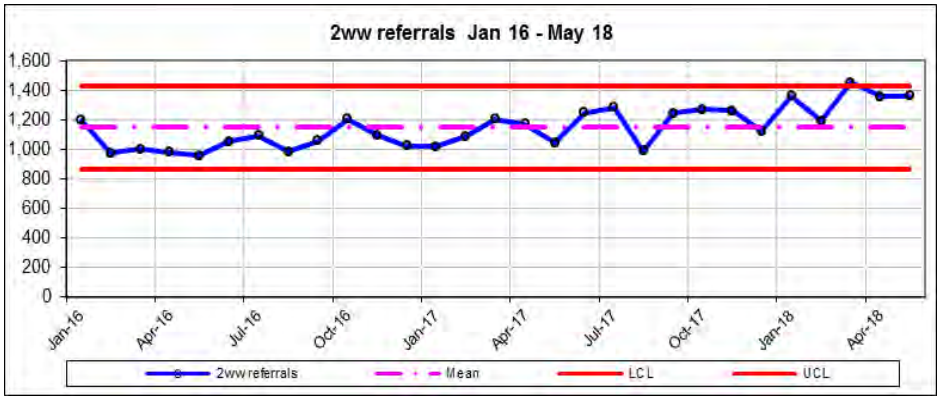




62 Day Performance - All Patients			
Tumour	Total	Brch	%
Breast	22.5	8.5	62.2
Lung	12.5	2.0	84.0
Haemat.	7.0	6.0	14.3
Upper GI	12.0	4.5	62.5
Lower GI	16.0	6.0	62.5
Skin	0.0	0.0	#DIV/0!
Gynae	5.0	1.0	80.0
Urology	25.5	14.5	43.1
Head & Nk	11.0	9.0	18.2
Sarcoma	0.0	0.0	#DIV/0!
Other	0.0	0.0	#DIV/0!
Total	**111.5**	**51.5**	**53.8**

62 Day Performance - MTW Only			
Tumour	Total	Brch	%
Breast	22.0	8.0	63.6
Lung	8.0	0.0	100.0
Haemat.	7.0	6.0	14.3
Upper GI	11.0	4.0	63.6
Lower GI	13.0	3.0	76.9
Skin	0.0	0.0	#####
Gynae	3.0	0.0	100.0
Urology	22.0	12.0	45.5
Head & Nk	7.0	6.0	14.3
Sarcoma	0.0	0.0	#####
Other	0.0	0.0	#####
Total	**93.0**	**39.0**	**58.1**

Since January, the volume of 2ww referrals has increased above our expected plan (particularly in Urology and Breast) and now also for Lower GI. The average weekly number of referrals has increased overall by over 10%.



2ww GP referrals to MTW	Breast	Gynae	Haem	Head & Neck	Lower GI	Lung	Other	Upper Gi	Urology	Total	Breast Sympt	Breast total
2016	269	122	11	93	237	38	5	110	139	1024	135	404
2017	319	119	9	109	261	47	8	139	154	1164	165	484
2018 (Jan - May)	355	136	12	123	285	47	6	128	176	1266	128	483
% change over last 12 months	11.2%	15%	31%	13%	9%	0%	-24%	-8%	14%	9%	-22%	0%

NB: The total number of referrals for suspected breast cancer and the exhibited (non-cancer) breast symptoms has remained steady, however more patients seem to be referred as suspected breast cancer but this will require further investigation.

62 day patients first definitive treatments at MTW	2017									2018					
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Chemo	29	40	46	39	36	30	33	31	31	38	46	33	56	46	46
Other	15	16	31	15	19	17	22	24	8	19	18	32	23	21	16
RT	20	20	23	24	30	11	16	19	19	21	12	21	18	24	23
Surgery	32	28	44	29	41	37	33	41	35	40	35	34	45	33	36
Grand Total	**96**	**104**	**144**	**107**	**126**	**95**	**104**	**115**	**93**	**118**	**111**	**120**	**142**	**124**	**121**

The cancer PTL is monitored via a 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 identified and actioned / escalated within the relevant specialty. The weekly PTL tracks all patients on a cancer pathway from referral through to start of treatment.

Tumour site specific actions are agreed and overseen by the MDT and directorate management teams and a further cancer summit, where all tumour site MDT leads and members present to a peer group.

We have recently introduced a triage (straight-to-test) pathway for LGI and UGI cancer referrals and a cancer pathway navigator in respiratory. This approach reflects best practice and we have received funding from both Macmillan and the Cancer Alliance to support these appointments.

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 agreed to work with them to further improve our approach to demand and capacity and specifically the urology pathway.

5. Cancer 104 day + breaches

There were 12.5 accountable breaches over the 104 days in May, 17 patients treated, of which 10 were MTW only)

5.1 MTW only patients

- 2 x haematological cancer patients both treated with palliative care. The first patient's pathway started in Lower GI, was transferred to lung and then was managed under Haematology (following an admission for a stroke). The second patient's pathway started in breast and was investigated for suspected metastatic disease. The patient was then referred to GSTT to the skin lymphoma service, who returned with the advice for active monitoring locally.
- 2 x head & neck cancer patients, one treated with palliative care and one with radiotherapy. The patient treated with palliative care required a second opinion on the histology and then was referred to The Marsden for investigation of a suspected sarcoma. Investigations did not identify a sarcoma and so the patient was returned for local management. For the patient treated with radiotherapy there appears to have been a delay with review of the histology report and bringing the patient back to clinic for results. The patient was not referred to Oncology until day 102.
- 1 x Lower GI cancer patient treated with chemotherapy. There was a 3 week delay for discussing at MDM due to late referral to the MDM but also because the discussion was deferred from one meeting as there was low attendance due to adverse weather conditions.
- 2 x Upper GI cancer patients both treated with chemotherapy. The first patient required repeated OGDs to achieve diagnosis. The second patient had delays due to the requesting of investigations.
- 3 x Urological cancer patients, treated with palliative care, radiotherapy and chemotherapy respectively. The patient treated with palliative care delayed their biopsy on 3 different

occasions. The patient treated with Radiotherapy had a delay due to capacity for biopsy and the patient treated with chemotherapy cancelled appointments due to snow in February and also had a delay due to capacity for renal biopsy.

5.2 Medway to MTW patients

- 1 x Head & Neck cancer patient treated with radiotherapy was referred to oncology on day 112.

5.3 East Kent to MTW patients

- 1 x head and neck cancer patient treated with radiotherapy and was referred to oncology on day 83 but required further investigations before treatment could be planned.
- 2 x Lower GI cancer patients treated with radiotherapy. One was referred to Oncology on day 108 and the other on day 56 but was not ready for an oncology appointment until day 91.
- 1 x urological cancer patient treated with radiotherapy. The patient was referred to oncology on day 66 but required urological optimisation before treatment. Treatment could not be undertaken until 3 months post optimisation and no adjustments were applicable.

5.4 City Hospital Birmingham to MTW patients

- 1 x breast cancer patient treated with surgery. Patient transferred care on day 56 but was not treated before day 104 due to surgical capacity.

5.5 MTW to East Sussex patients

- 1 x urological cancer patient treated with surgery. The patient was originally offered hormones and radiotherapy but changed his mind and decided to have surgery. Patient was referred to East Sussex on day 76.
-

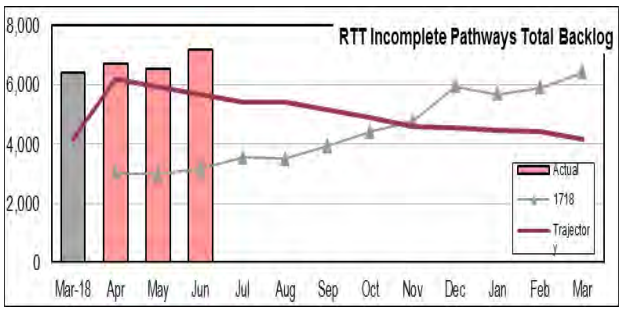
Size of the over 104 day backlog: At the end of May, there were 42 patients in the over 104 day backlog (for diagnosed and undiagnosed patients) which is a 9 patient decrease from the previous month. For MTW only, there were 31 patients over 104 days, which is an 11 patient decrease from last month.

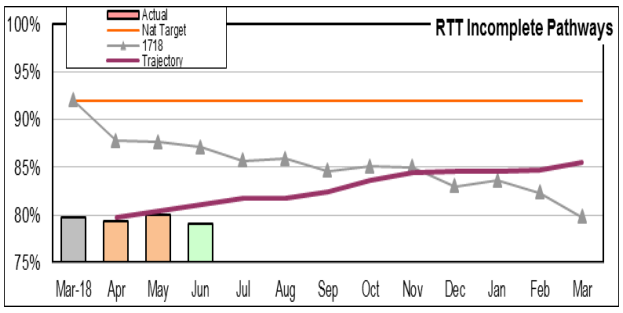
6. Cancer 2 week waits

In order to meet the current demand each of the specialties are required to increase capacity to 85% of the maximum referral rate in order to ensure that capacity meets demand. This is not possible in most of the specialties and other measures are required that is focused on demand management and triage. The Intensive Support Team has provided modelling to identify the capacity needed. Additional breast clinics have been created, templates have been changed in Urology, and straight to test telephone clinics for upper GI started week commencing 9th July 2018. An additional straight to test nurse has been appointed for Lower GI and a Pathway Navigator will also be appointed to support the colorectal pathway. Urology have appointed two locums to increase capacity but the huge rise in referral rate has been difficult to match

7. Referral To Treatment – 18 weeks

The June performance shows the Trust is non-compliant with the trajectory set for the Incomplete RTT standards at an aggregate level –79.1%. The Trust is non-compliant with almost all specialities with the exception of Cardiology, Thoracic and Care of the Elderly.





In June the RTT performance has been negatively impacted due to a data quality issue relating to patients who have had "multiple clocks" identified on the PAS. A technical resolution to this issue was identified and implemented but the impact of this issue means that the IPWL part of the Total Waiting List increased by 1528 and the IP Backlog increased by 921. The monthly position will therefore remain inflated by this amount. Of the 921 added to the IP Backlog there are currently 22 that appear to be 52wk breaches which have been highlighted but these have not been concluded currently. Further validation of the waiting list continues.

Due to the impact of the data quality issue the Trust has produced a revised internal trajectory, however this has not yet been approved by NHSI. The tables below show the performance against the original trajectory as well as the performance against the revised internal trajectory

Original (Submitted) Trajectory:

	June-18	June -18 Trajectory	Variance from trajectory
RTT Backlog Incomplete	7,214	5,685	1,529
RTT Waiting List	34,584	29,955	4,629
RTT Incomplete performance %	79.1%	81.0%	-1.9%

Revised Internal Trajectory due to impact of DQ Issue:

	June-18	June -18 Revised Trajectory (DQ Issue)	Variance from trajectory
RTT Backlog Incomplete	7,214	6,606	608
RTT Waiting List	34,584	31,483	3,101
RTT Incomplete performance %	79.1%	79.0%	0.1%

Specific Actions relating to the impact of the DQ issue are:

Recovery Actions

- Continue with the theatre and outpatient productivity programme to deliver the opportunity identified in the scoping. The teams are currently mitigating the risks relating to staffing (middle grade doctors) in General Surgery & Urology.
- Proposed additional operating lists for General Surgery, Urology and Ophthalmology throughout July, August & September (initially) with increased outpatient capacity coming on line for T&O, respiratory & gastroenterology. The impact of this will be applied to the current plans once the lists are confirmed and the patients fully booked – **ST by 24th July.**
- Ophthalmology are planning to move to a 6 day working model to create further capacity long term **Sarah Turner – plan agreed or not by 30-09-2018**

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7.1 Duplicate Pathways:

Duplicate pathways are still an issue particularly in Ophthalmology and General Surgery which impacts the waiting list. Further training is being rolled out and an RTT task and finish group remains in place to oversee the management and monitoring of all DQ issues.

7.2 Elective Activity:

Currently the RTT Elective activity YTD is 488 cases (-9%) below plan. Of this the main areas of concern are General Surgery (251, -25% below plan), Urology (127, -19% below plan) and Ophthalmology (-177, -12% below plan). Trauma & Orthopaedics is +158, 21 above plan.

Currently the RTT OP New Activity YTD is 1% above plan. However there are key areas that are below plan ie Ophthalmology (-2347, 31% below plan), General Surgery (-1021, 20% below plan), Respiratory (-117,14% below plan) and Gastroenterology (-123,11% below plan

The key issues contributing to the low performance and increased backlog (aside from the data quality issue) remain:

- Insufficient levels of elective work.

- Key vacancies in consultant and trainee posts in a variety of specialties (GS, Urology, Neurology & Endocrinology)

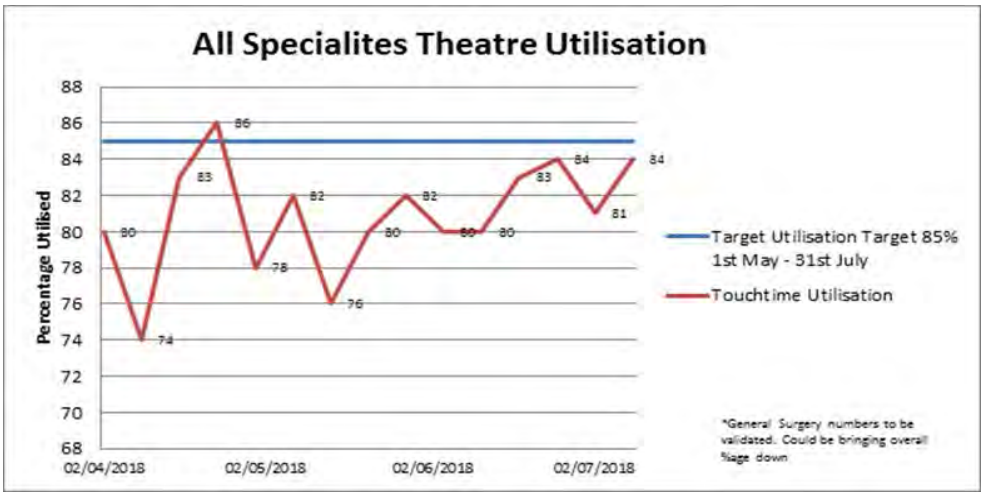
The majority of the backlog continues to be concentrated in T&O, Gynae, ENT, General Surgery, Ophthalmology and Neurology-all of which are being carefully monitored against trajectories and action plans on a weekly basis. Further validation of the waiting list especially the backlog continues.

Operational teams are continuing their plans to increase elective activity and arrange extra clinics to ensure backlog does not grow further.

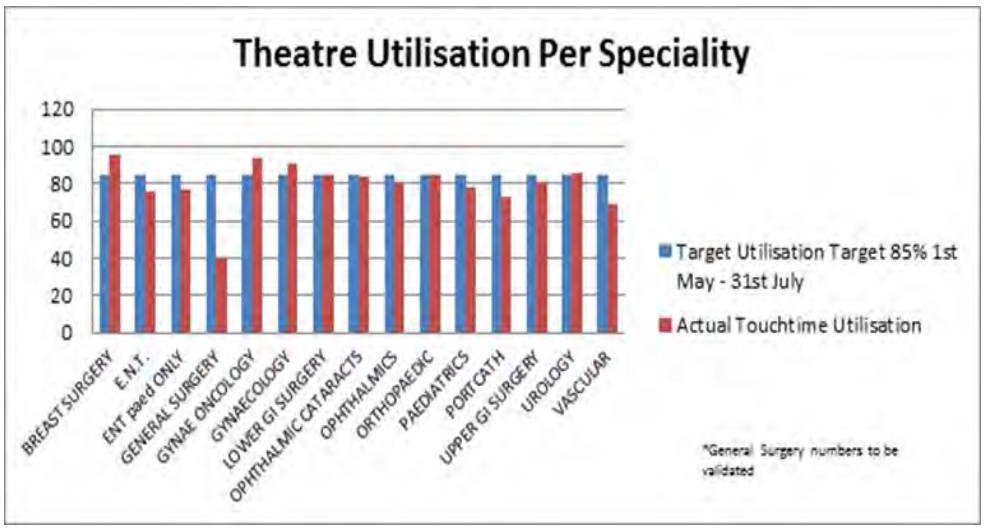
- Continue to ensure achievement of Incomplete targets month on month at an aggregate level by reducing RTT backlog for Incompletes through implementation of speciality plans
- Monitor weekly all Non-Admitted patients at 11wks or over without an OPA and all Admitted patients at 18wks or over without a TCI
- Ensure backlog patients are booked chronologically to avoid long waits/52 wk breaches
- Recruitment in progress for two Operational Transformation Managers who will continue the Four Eyes project.
- PTL management training has been reviewed and continues to be rolled out to all the CAU's which will be ongoing.
- 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

8. Theatre Productivity

The graphs below are taken from the 4Eyes Theatre Dashboard and show the Theatre Utilisation from April to June compared to the current plan for this period of 85%



NB: General Surgery numbers require validation and could be adversely affecting the overall performance


Theatre Utilisation Per Speciality
120
100
80
60
40
20
0
BREAST SURGERY
E.N.T.
ENT paed ONLY
GENERAL SURGERY
GYNAE ONCOLOGY
GYNAECOLOGY
LOWER GI SURGERY
OPHTHALMIC CATARACTS
OPHTHALMICS
ORTHOPAEDIC
PAEDIATRICS
PORT CATH
UPPER GI SURGERY
UROLOGY
VASCULAR
Target Utilisation Target 85% 1st May - 31st July
Actual Touchtime Utilisation
*General Surgery numbers to be validated

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E: paul.bennett8@nhs.net
W: improvement.nhs.uk

Miles Scott
Chief Executive
Maidstone & Tunbridge Wells NHS Trust

17th July 2018

Sent by email

Dear Miles,

Cancer Performance

I am writing to you in Paul Bennett's absence and following your conversation with the sub-regional team in relation to the Trusts cancer performance. Whilst we acknowledge that you and your teams are working hard to drive improvements in a challenging environment, we are extremely concerned about performance against the cancer 62 day standard, and the impact that this will undoubtedly be having on patient outcomes and patient experience.

The organisation did not meet the 62 day standard during 2017/18 and there has been continued deterioration in performance during Q1 2018/19. Performance of 53.8% in May, places you in the worst five performing trusts nationally, and 19.1% behind your improvement trajectory which should have supported delivery of 73.1%. In addition, the trust back log and the number of 104 day waits continue to grow.

As a cancer centre, this level of performance is unacceptable, particularly given the assurances NHSI have received relating to the deliverability of the cancer recovery plan you submitted in April 2018.

I understand that the executive team gave assurance at the last integrated assurance meeting on 20th June 2018 that improving delivery against the 62 day standard is a high priority for the trust board and that appropriate clinical leadership is in place. However, this is not reflected in the organisation's board minutes, nor in any improvements in cancer performance.

Your continued level of underperformance has now triggered both regional and national scrutiny and as such we request that, as a matter of urgency, the trust:

1. Prepare a high level briefing for Cally Palmer National Cancer Director, outlining current performance against trajectory, drivers for underperformance, immediate recovery actions, expected impact and associated timelines.
2. Detail the process for clinical harm review for all patients who have waited a prolonged period of time.
3. Engage in weekly oversight meetings with the sub regional team to review the trusts cancer performance and to monitor progress against the immediate actions that have been identified to arrest a further decline in performance.

4. Establish the West Kent cancer improvement group as a priority with the key stakeholders (trust, local CCGs, NHSE, NHSI and the local Cancer Alliance) to deliver at pace, the actions needed to improve cancer performance

Please submit your response to items 1,2 and 4 to falguni.raja@nhs.net by Monday 23rd July 2018 copying in Paul Bennett. Please do not hesitate to contact me or a member of the sub-regional team should you have any queries or require further clarification.

Yours sincerely

Claudia Griffith

Regional Chief Operating Officer - South Region

CC Paul Bennett
Suzanne Cliffe
Falguni Raja
Amanda Lyons
Nigel Acheson

Maidstone and Tunbridge Wells NHS
NHS Trust

Cancer Recovery Plan

July 2018

Ritchie Chalmers, Trust Cancer Clinical Lead

David Fitzgerald, Associate Director of Operations, Cancer and Clinical Support Services

Maidstone and Tunbridge Wells NHS
NHS Trust

Executive Summary

I. There has been an acute decline against the 62 day target in May 2018 on the background of a chronic challenge
II. Early 2018 has seen a noticeable reduction in 2WW capacity due to surgical middle grade doctor vacancies that have not been covered despite repeated recruitment attempts (both substantive and temporary staffing)
III. April 2018 has seen a further acute increase in 2WW demand that has been sustained to date
IV. 31 day FDT performance has continued to achieve the standard but average day to decision to treat has increased from around day 40 in 2013/2014 to over day 50 in 2018
V. The acute decline therefore represents delays in the diagnostic phase of the pathway
VI. Immediate actions to recover performance are designed to increase 2WW and diagnostic capacity

Contents

Introduction

- Recently there has been an acute deterioration in our achievement against the 62 day standard
- The Trust has not met the 62 day first definitive standard since 2013 and recorded performance of 53.8% in May 2018
- The 62 day standard is a composite measure of both the diagnostic phase (which ends in decision to treat) and the time to first definitive treatment (i.e. 31 day FDT standard or treatment phase)
- The diagnostic phase comprises of 2ww demand (referral level), capacity for 1st seen appointments, first definitive diagnostic investigation and report (e.g. radiology and/or endoscopy), multidisciplinary discussion and ends at decision to treat
- The time to first definitive treatment can be considered to be entirely representative of treatment capacity
- Therefore our analysis of the drivers for recent deterioration in performance will assess these in turn
- Actions for recovery are described, including the governance framework which will deliver progress and preserve patient outcomes and experience

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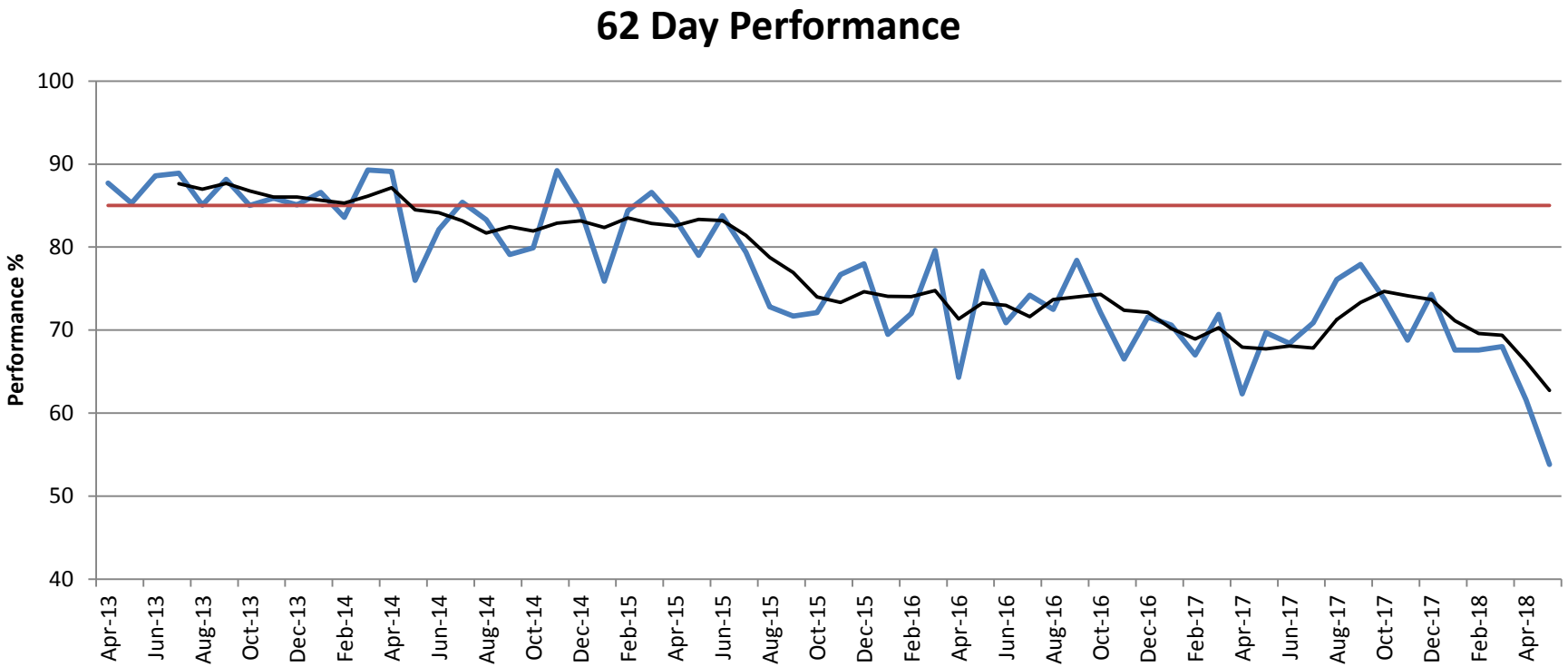
Historical 62 Day Performance



- Monthly 62 day performance percentage shown above as blue line
- Black line demonstrates four monthly average performance
- 2014 saw 62 day performance at MTW drop below the mandated 85% target
- Despite fluctuations there has been a gradual year-on-year decrease in performance
- An acute-on-chronic fall in performance to 53.8% was reported in May 2018
- This has led to a significant deviation from the submitted 2018 performance trajectory

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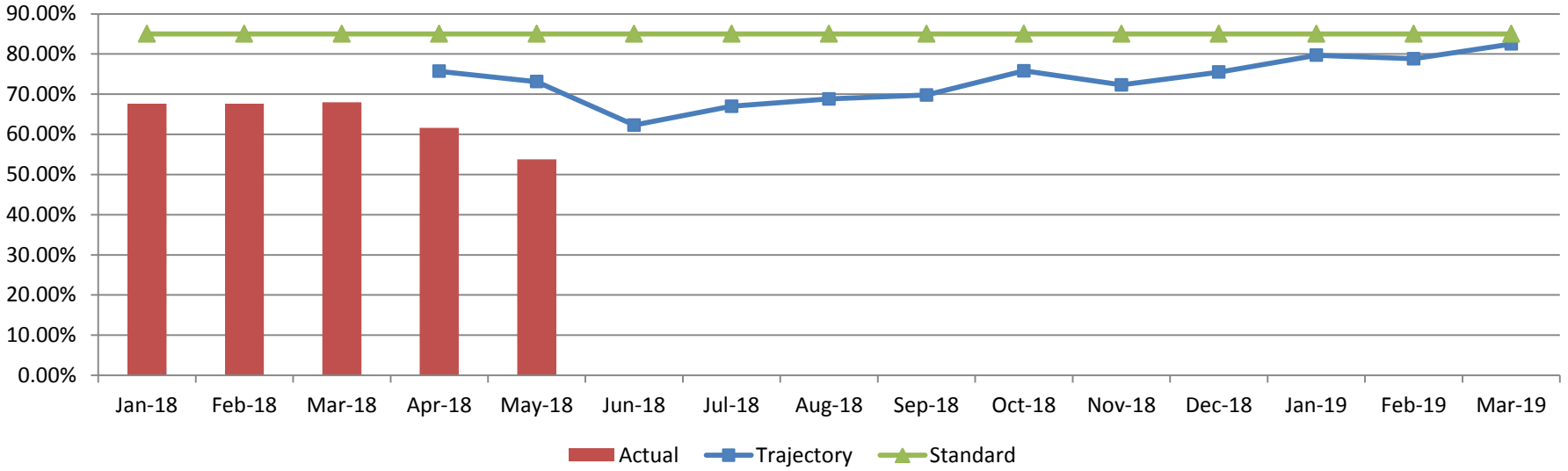
62 Day Performance Trajectory for 18/19



Assumptions on which trajectory was based	Actual Events
That 2WW demand would reflect forecast outturn for 2017/18 plus 8% growth	2ww demand for FY18 has been 14% higher than predicted i.e. a 22% year-on-year increase compared to FY17
That the conversion rate from suspected cancer referral to confirmed cancer would remain the same as the previous year	Conversion rate from 2ww referral to a cancer diagnosis has remained stable
That outpatient 2ww clinic capacity would be at least the same as previous year	2ww clinics delivered in January to March 2018 were 19% lower than for the same period in 2017
That diagnostic capacity would be at least the same as last year and that this was sufficient for the two week wait demand expected	With delay in time to first seen, this has led to a bunching in demand for diagnostics to the end of FY17 but a 22% increase in 2WW demand for FY2018 will result in requirement for increased diagnostic capacity

Drivers for performance

This can be thought of in terms of a diagnostic and a treatment phase.

Diagnostic Phase influenced by:

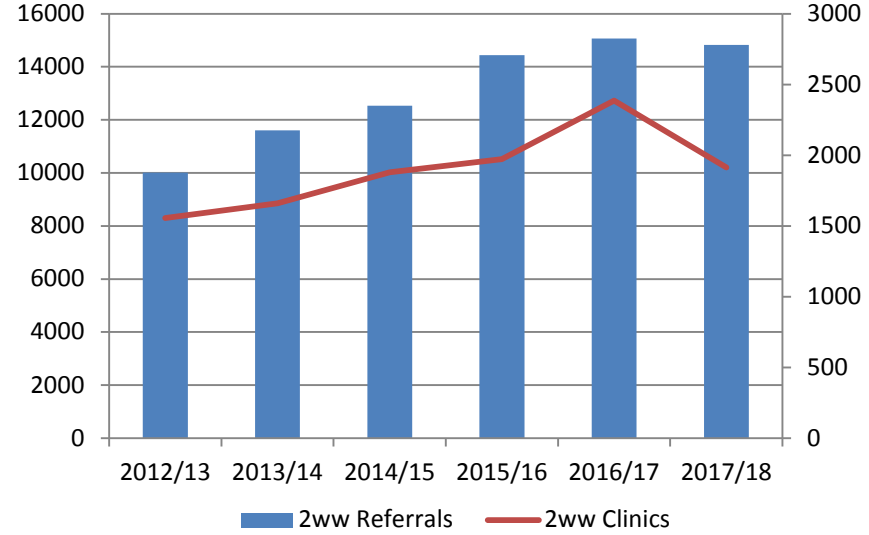
- **Demand:** Referral numbers
- **Capacity:** First seen appointment (2WW clinic) and diagnostics (e.g. radiological or endoscopic investigation)

Treatment phase influenced by:

- **Conversion rate:** The impact of increased referrals on the treatment phase is directly related to the conversion rate
- **Time to delivery of treatment:** (31 day FDT standard)
- **The cumulative nature of delayed pathways**: As a breach is not reported on immediately after day 62 (rather it is counted in the month at which treatment occurs) there may be a delayed contribution to breach figures of longer pathways over time

Drivers for performance – Diagnostic phase: 2WW Demand and Capacity

A



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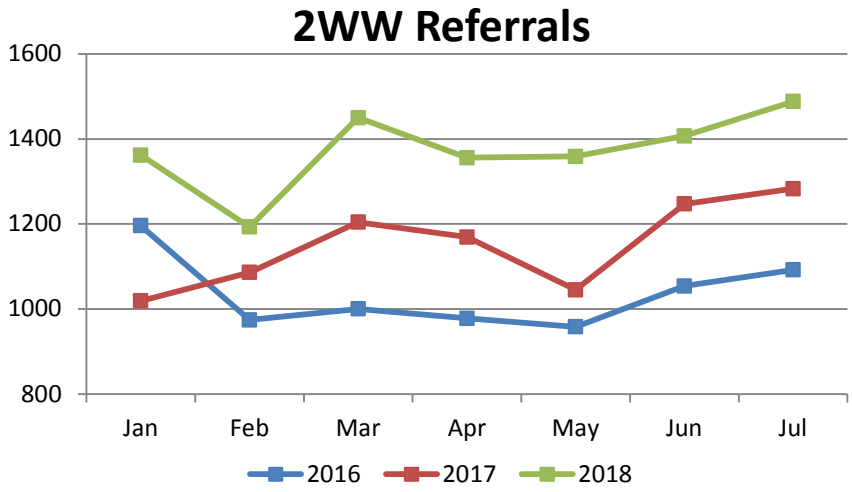

- There has been a steady year on year rise FY13 to FY16 which plateaued in FY17 (Figure A)
- The referral rate has recently accelerated in FY18 with the average increasing from 1,300 in March 2018 to approaching 1,500 in subsequent months (Figure B)
- Capacity for 1st seen appointment (2WW clinic) increased proportionally until the end of 2017 but the system was running at the limits of its capacity and this was seen in a gradual reduction in performance against 62 day standard across this time period
- In early 2018, 2WW clinic capacity suffered two periods of unpredictable acute shortage, snow in late-February/early-March (requiring rebooking of multiple non-attenders and cancelled clinics) and a sudden decrease in surgical staffing
- The majority of 1st seen capacity has been delivered by surgical middle grade doctors and a combination of resignations and inability to cover with locum or permanent appointments in 2018 has resulted in a vacancy rate of 60%. Resignations have been predominantly due to staff moving on to formal training positions. Deanery vacancies and long-term sickness have also contributed. High risk surgical emergency areas have been prioritised over elective activity.
- This has resulted in increased time to first appointment

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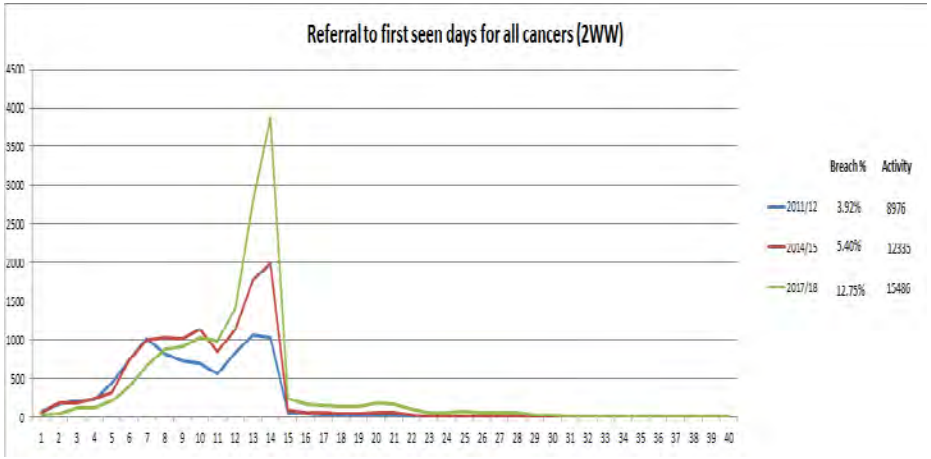
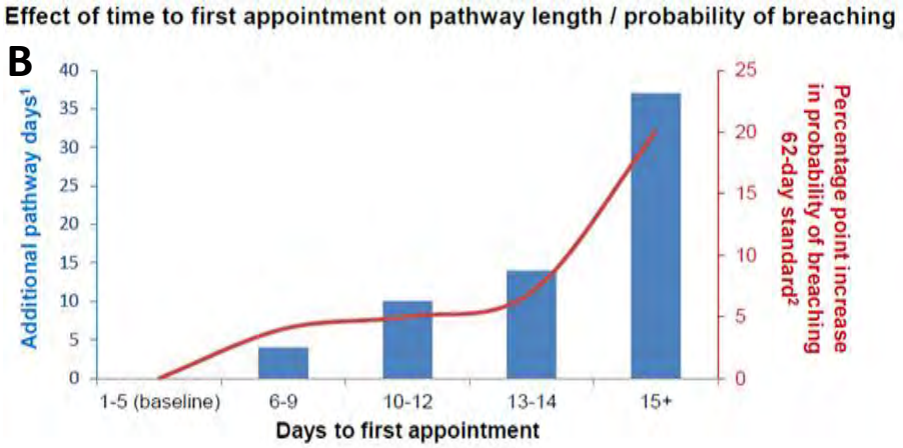
Drivers to performance - Diagnostic phase: Time to First Seen Appointment

A





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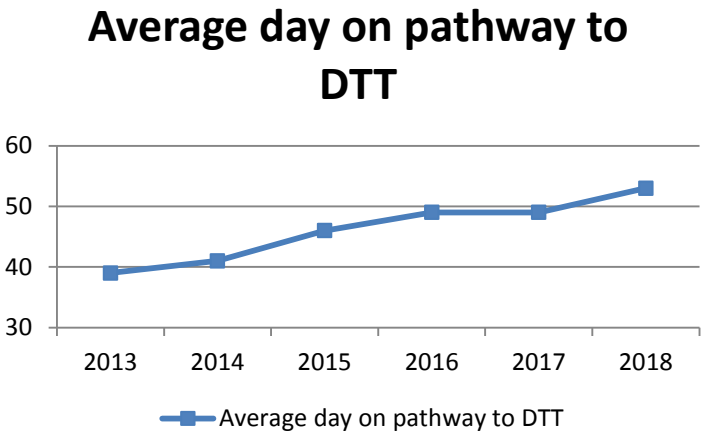

- The greater discrepancy between demand and capacity has led to the number of patients being first seen at or around 14 days is increasing (Figure **A**)
- As per the national review by NHSI, the later a patient is seen for first appointment, disproportionately increases the risk of 62 day breach (Figure **B**)
- Discrepancy between demand and capacity can also be seen as a slowing down of the diagnostic pathway, as evidenced by an increase in average day to decision to treat (DTT) (Figure **C**)

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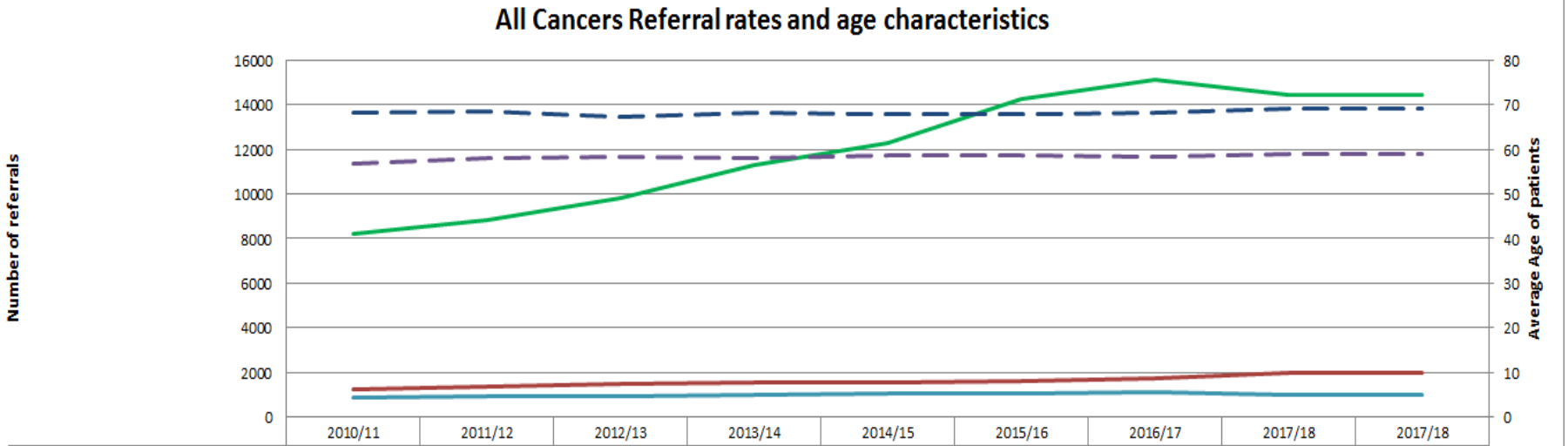
Drivers to performance – Treatment phase: Conversion rate



	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2017/18
No diagnosis	8219	8842	9814	11278	12279	14248	15141	14448	14448
Diagnosis	1256	1398	1492	1578	1568	1617	1755	1972	1972
Screening Referrals	850	913	966	1027	1065	1035	1129	996	996
•Average Age (cancer diagnosed)	68.32	68.62	67.34	68.26	67.98	67.91	68.29	68.99	68.99
•Average Age (cancer not diagnosed)	56.78	58.11	58.26	58.07	58.46	58.51	58.41	58.80	58.80
Ratio	7.54	7.32	7.58	8.15	8.83	9.81	9.63	8.33	8.33

- Over the last five years there has been an increase in the number of cancers diagnosed by 32% (red line) and a highly significant increase in the number of patients referred who require diagnostic assessment but who are then discharged without a diagnosis of cancer (green line)
- In 2017 to 2018 the conversion rate from referral to cancer diagnosis has remained relatively static (10.9% versus 9.8% respectively) leading to the assumption than an increase in referrals will result in an increase in number of diagnoses
- Currently all referrals are treated equally however internal triage of referrals based on clinical likelihood of malignancy will aid prioritisation by separating these two groups earlier in the pathway

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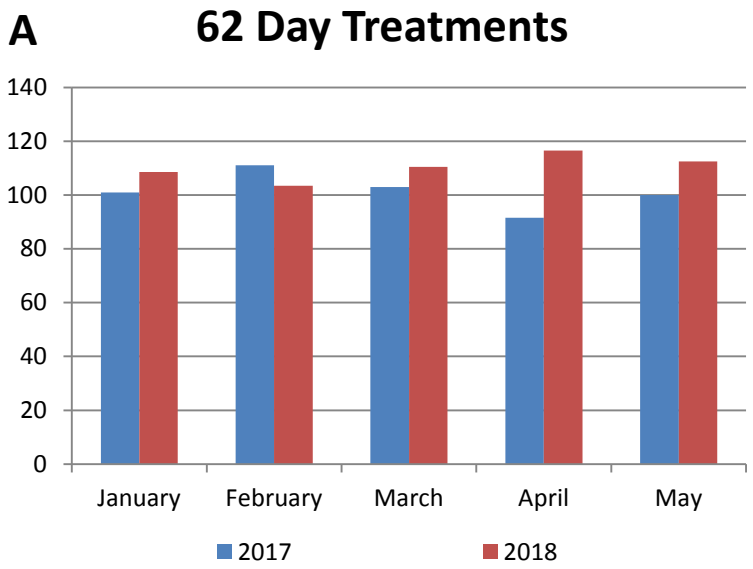
Drivers to performance – Treatment phase: Activity delivered

A



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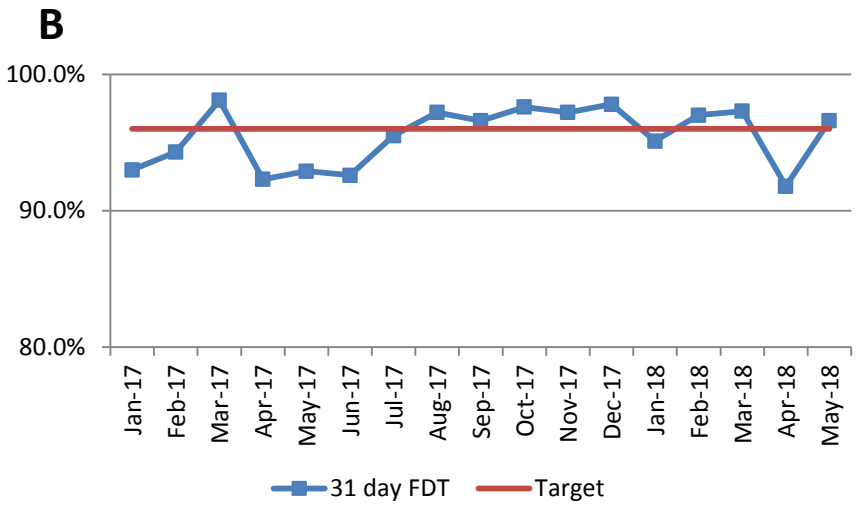
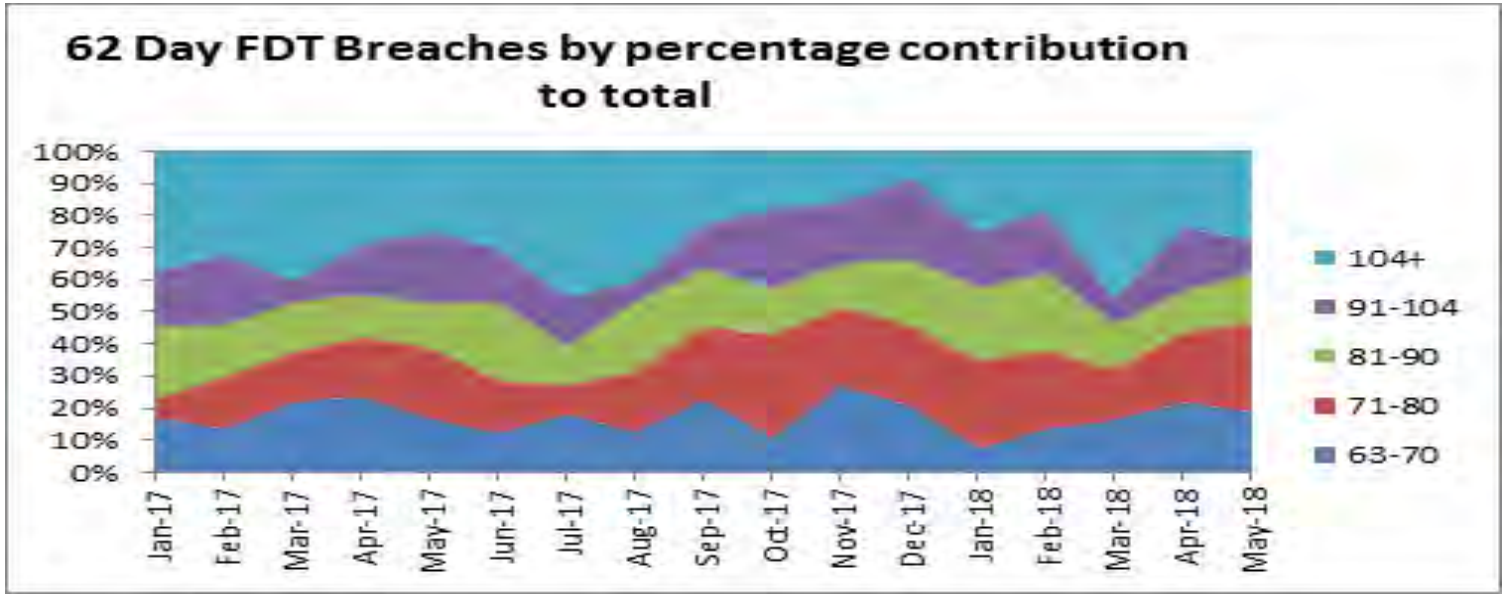


- Treatment activity delivered in 2018 has exceeded that delivered in 2017 consistent with the planned trajectory (Figure **A**)
- This is likely due to activity as a result of backlog
- Despite increased treatments, the 31 day FDT standard has been consistently achieved indicating that treatment capacity is currently sufficient to meet demand (Figure **B**)
- Treatment is therefore being delivered within a reasonable timeframe following diagnosis
- Failure of the 62 day target is therefore considered to be due to delays in diagnosis rather than delays achieving treatment after a decision to treat

Drivers to performance – Diagnostic phase: Cumulative Effect of Delays in Pathways



- Notably, although we had reduced 104+ day pathways significantly towards the end of 2017, this did not result in an improvement in our overall 62 day performance during that period
- Breaches for 104+ days increased in early 2018 to slightly higher levels than those seen in early 2017, and although this may have a minor contribution to the recent acute fall in 62 day performance, it is considered to be unlikely to be a key driver
- The majority of breaches are occurring between 63 and 80 days suggesting that short delays in the pathway, representing discrepancy between demand and capacity, is likely to be a greater influence on decreasing performance
- Delays in the diagnostic phase for patients that require multiple investigations to achieve diagnosis will result in a significantly longer pathway due to the cumulative nature of each delay

Summary

- The cancer two week wait system (outpatients and diagnostics) at MTW has been at capacity for some time
- The main driver of declining performance is an increase in demand combined with a reduction in capacity (due to surgical middle grade doctor vacancies). This has recently worsened resulting in the acute decline in performance reported in May 2018
- Increasing referral levels over FY13 to FY16 then stabilised in FY17
- In FY18 the referral level has risen sharply again. There have been a number of media and public health factors that may have contributed to this new acute rise and it may not translate into further cancer diagnoses. However it will impact on a system which is already under-capacity and must be factored into any further trajectory planning
- The combination of capacity loss and referral demand in FY18 has resulted in an lengthening in time to diagnosis and decision to treat. Once a decision to treat has been made, the time to achieving treatment is meeting the 31 day FDT standard
- Increasing two week capacity is a key priority and it is anticipated that this will shorten the diagnostic phase
- There will be a transient requirement for increased treatment capacity as these patients are managed along with clearing the backlog
- This increased treatment capacity requirement will be prolonged if the recent further rise in 2WW referral demonstrates similar conversion to cancer diagnosis rates as previously seen
- The potential trajectory factoring in changes to the original planning assumptions (19% loss of capacity and 22% increase in 2WW referral) but before recovery actions would lead to a further sharp decline in performance

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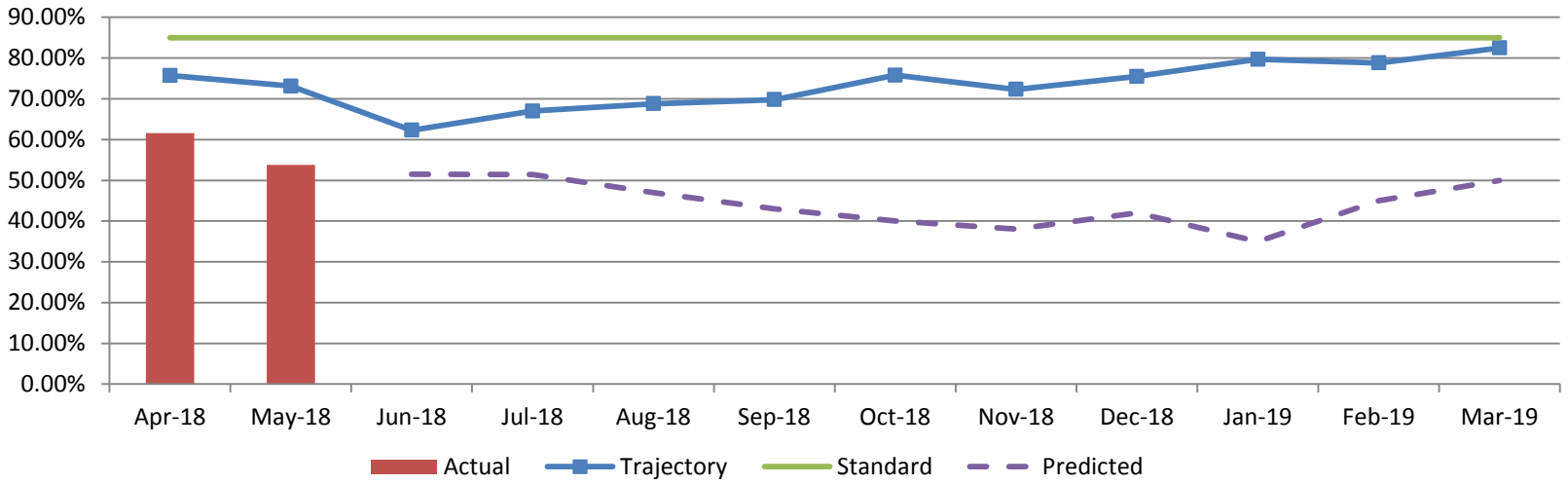
Expected Performance without intervention



Performance Assumptions if no action is taken
There will be no further loss of 2WW capacity than current levels
The current 22% increase in 2WW demand will return to a level more consistent with previous increases in demand from September (i.e. 8% above previous year) as phenomenon causing current high levels subsides
2WW demand will decrease in August due to usual Summer variation
Treatment delivery capacity will be stretched until December as backlog clearance catches up with new diagnoses
Performance will reduce in January due to patient choice to delay treatment until after Christmas (i.e. in line with previous years)

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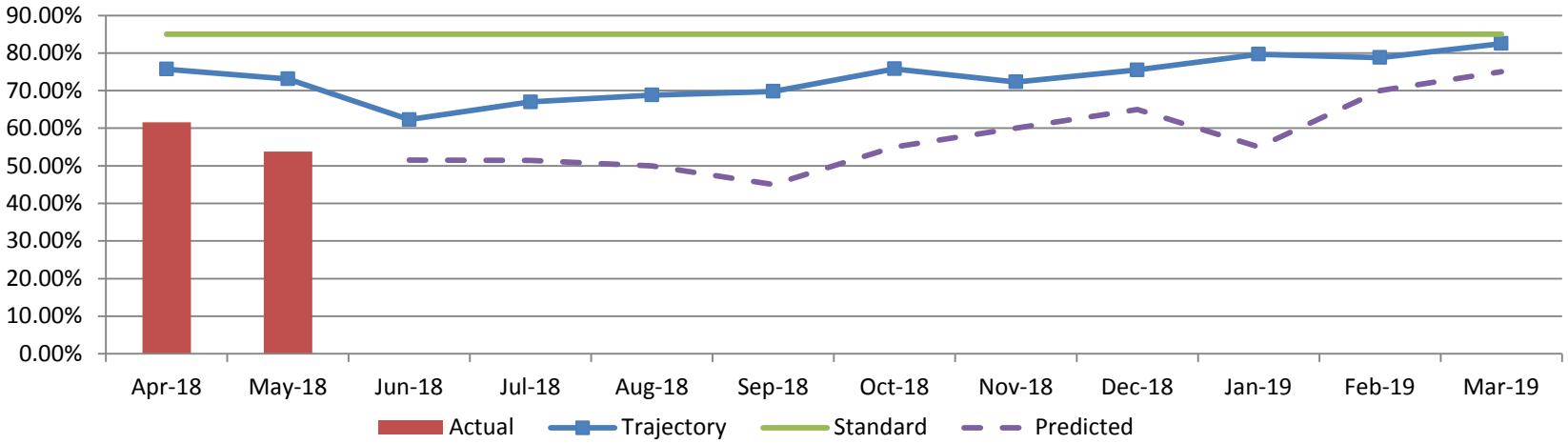
Revised Trajectory



New Assumptions

Reduction in 2ww referral demand in August will lead to a small improvement in October following a reduction in performance due to backlog treatments in September
Increased 2ww capacity in place for delivery by September will start to show an improvement in performance in November
Treatment delivery capacity will be increased to reduce backlog and to accommodate the increase in new diagnoses
Average day to DTT will be reduced as 2ww capacity is increased
Performance will reduce in January due to patient choice to delay treatment until after Christmas (in line with previous years)

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Immediate Recovery Actions: Demand and Capacity

Action Required	Description	Timeline for delivery	Benefit expected by	Impact on 62 Day performance
Capacity: Outsource/ insource diagnostic phase	• Internal 2ww clinic capacity has reduced by 20% in 2018 plus there has been a 15% increase in demand over the last 4 months • This is predominantly due to persistently reduced staffing levels despite repeated advertisement and requests to agencies for locum cover • Therefore, delivery of capacity to meet demand will require out or insourcing of approximately 500 patients per month across breast, lower GI and urology tumour sites • Increased Radiology, Endoscopy and Histopathology capacity will be needed to match any increases above (or included in out/insourcing)	September 2018	November 2018	Revert to previous average performance of 70%
Capacity: Internal	• Inability to recruit middle grade doctors to Surgery has required development of alternative roles to increase capacity • Physician Associate roles in Surgery developed and advertised (interviews 1st August) • Surgical Care Practitioner and Advanced Nursing Practitioner roles for Breast Surgery to be advertised • Cancer Transformation manager has been created and appointed to • Cancer Alliance funding has supported MRI software upgrade and additional template biopsy capacity for prostate	August 2018	January 2019	Increase in 2WW and diagnostic capacity will lead to improvements in 62 day performance for breast, Lower GI and Urology. Expected benefit of 5% improvement each month after appointment.
Demand Management	• Discussed with CCG joint group reporting through West Kent Improvement Board for improving cancer performance to supplement the Trust Cancer Committee (CCG is a member) • CCG developing terms of reference and joint action plan being compiled • Progression towards tumour site specific educational and support nursing roles in the community • Trial of FIT testing in primary care • PSA follow-up in primary care	September 2018	December 2018	Will be proportional to decreased in referral levels

Maidstone and Tunbridge Wells NHS Trust

Immediate Recovery Actions continued

Action Required	Description	Timeline for delivery	Benefit expected by	Impact on 62 Day performance
Improved internal 2WW triage processes	• Aims to streamline number of appointments in relevant pathway • Increase colorectal telephone triage and number of patients diverted to straight to test (2nd nurse appointed, current staffing undertaking additional sessions as overtime) • Straight to test model implemented for Upper GI w/c 9th July • Exploring nurse-led triage for Urology in conjunction with improved 2WW referral pro forma to enable straight to test model	September 2018	November 2018	Colorectal service saw 1,200 patients through telephone triage/STT model last year. On average, 80% were treated by day 62. It has been identified that there were a further 1,500 patients that could have been seen through this route. Tumour site specific performance could be improved between 20 and 40%. The expectation is that the performance improvement described above will be replicated for Upper GI Effect will need to be evaluated once process is developed and embedded in to the pathway

Maidstone and Tunbridge Wells NHS Trust

Immediate Recovery Actions continued

Action Required	Description	Timeline for delivery	Benefit expected by	Impact on 62 Day performance
Improved prioritisation system for imaging	• Expanded list of options for requesting Radiology investigations through orderComms is being implemented to improve streaming of patients for appointment booking and scan reporting • Needs education and support from clinical teams to gain greatest benefit	July 2018	December 2018	Improved turnaround times for booking and reporting of studies for patients most likely to have a cancer diagnosis. Longer term sustainability of performance is expected rather than immediate improvement.

Maidstone and Tunbridge Wells NHS
NHS Trust

Governance: Oversight

Local Oversight:

i) Named Executive Director Lead for Cancer – Chief Operating Office

ii) Monthly review of performance at Trust Management Executive Meeting

iii) Monthly review of performance at Trust Board

iv) Trust Cancer Committee representing tumour site specific clinical leads, MDT leads, diagnostic services and including CCG clinical and managerial representation bi-monthly

v) Escalation of review of performance with presentations at Finance and Performance Committee and at Trust Board

System-wide Oversight:

i) Intensive support team review in February 2018 with report received in March 2018

Recommendations for support: On-going capacity and demand and pathway mapping work for Urology

i) Formation of West Kent Cancer Group, reporting to West Kent Improvement Board

ii) Continued engagement with Cancer Alliance (regional strategy in development with performance as a key priority)

iii) Weekly progress oversight meetings with NHSI

iv) “Buddying” with other NHS Acute Provider – Cancer Alliance has introduced Frimley Health NHS Foundation Trust Cancer Manager

Maidstone and Tunbridge Wells NHS
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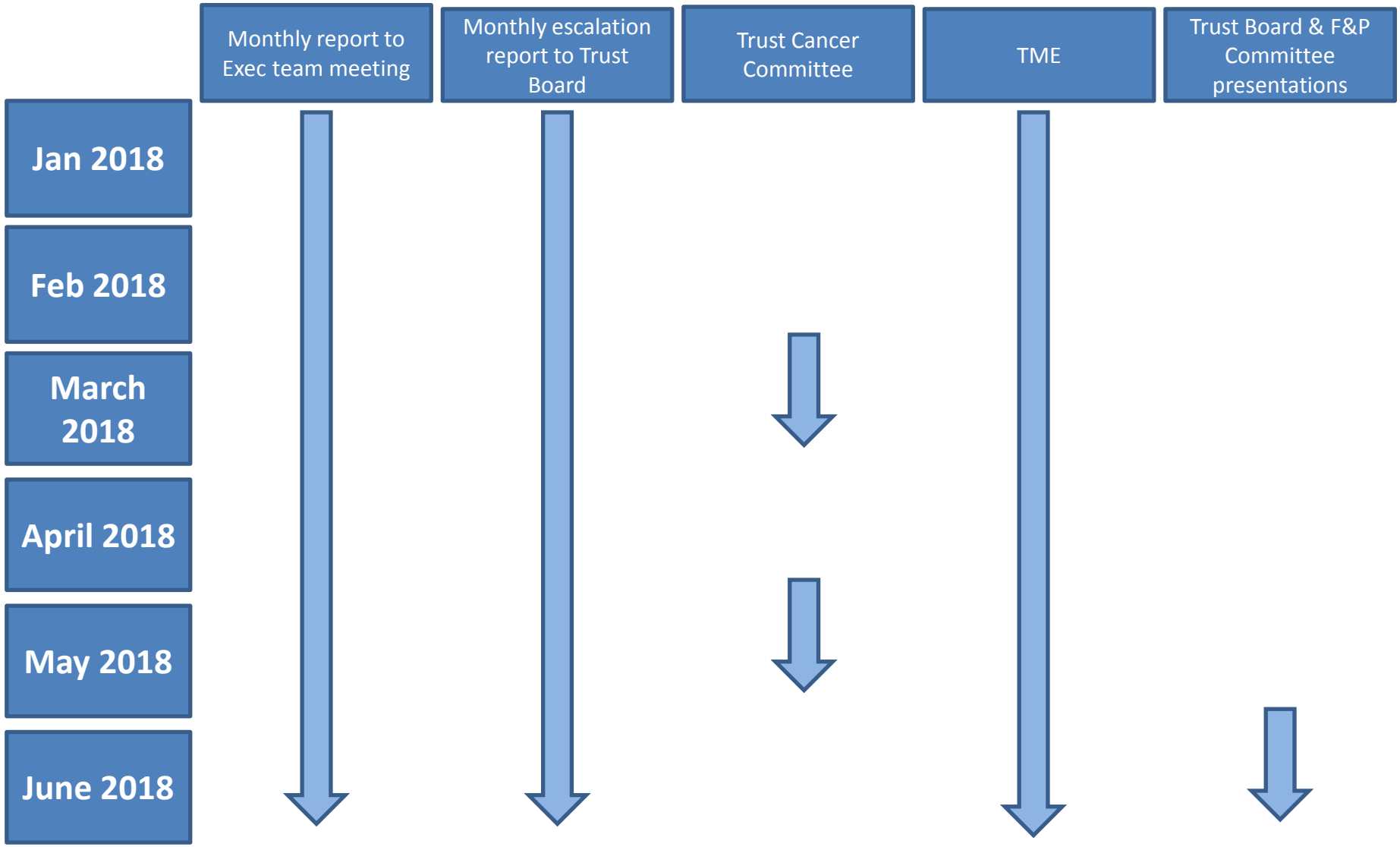
Governance: Internal escalation



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Governance: Harm Review MTW Current process

40 -85 days	• Daily huddle ensures that all patients over day 40 have a specific next key action that is allocated to the relevant department
85-104 days	• Patients on the PTL between days 85 and 90 are escalated to clinical leads on a weekly basis
104+ days	• Formal clinical review of every 104+ day treatment recorded in 2018 by MDT Chair with reporting to Trust Cancer Committee. • Tumour site specific MDTs are responsible for raising incident forms if clinical harm is believed to have occurred, ensuring clinical ownership • Incident forms are escalated to serious incident declaration and formal investigation process if initial review indicates that harm has occurred • No incident forms or serious incidents have been raised due to longer waits for treatment

Maidstone and Tunbridge Wells NHS
NHS Trust

Governance: Harm Review MTW Further actions

- Whilst 62 day performance for MTW has not been meeting the mandated 85% standard since 2013, patient satisfaction scores from the National Cancer Patient Survey have consistently been maintained at above England averages

- Patients waiting 104+ days for treatment may represent a group that pose diagnostic difficulty. As shown previously, numerous investigations may lead to cumulative delay. Improvement of capacity in the diagnostic phase along with streamlined radiological prioritisation is expected to minimise delay between investigations for this group resulting in shorter pathways
- A significant proportion of the 104+ day waits have occurred in the Urology tumour group and represent the prostate pathway, for which MTW acts as a regional referral centre for diagnostics. Delays in this pathway are often encountered after a diagnosis of prostate cancer has been made but there are a number of possible treatment options ranging from active surveillance only to surgery and it is not felt that delay at this juncture impacts upon either progression or prognosis

- Formal clinical review of all 104+ pathway patients will be reported to the next Cancer Committee and a summary report of these cases will be prepared

Maidstone and Tunbridge Wells NHS
NHS Trust

Appendix 1 – IST Action Plan

Recommendation number	Recommendation	Action	Due date	Owner	RAG status
1	Develop terms of reference and governance arrangements for the cancer huddle	In progress	April 18	D Fitzgerald	
2	Amend the daily huddle meeting perimeters to include patients at day 30/35.	This has been implemented and the MDT co-ordinators are aware that any patients of concern below day 40, can be escalated for senior review/support through the daily huddle at any point on their pathway	March 18	S Young	
3	Apply milestone markers for timed pathways to help with timely tracking and completing actions	Support from IST on 18th May to develop timed pathway for Urology. NHS Elect to support with mapping one other tumour site (date to be confirmed). IST pathway mapping tool to be used for all other tumour sites.	June 18	General Managers	

4	Apply day 38 milestone for those patients on an inter trust provider pathways	Meeting to be arranged to discuss how to identify patients that are going to be referred out of the organisation. Other Providers and Cancer Alliance contacted to identify if there is a robust process that is already being used for this. All patients are referred using the agreed IPT processes using the pro formas in Infoflex and transmitted by email as soon as appropriate.	May 18	MDT Team	
5	Themes and issues emerging from the huddle need to be documented and a process put in place to raise at the appropriate cancer committee/board for action	To be done in conjunction with data-driven/evidence-based approach for reviewing pathways with clinical teams. Themes to from the huddle to be fed in to Cancer Committee (next meeting May 18)	May 18	D Fitzgerald	
6	Ensure huddle meeting methodology is embraced and rolled out for pro active management of all cancer pathways moving forward	All managers reminded of the importance of the huddle and the need to continue to engage with the process	March 18	D Fitzgerald	

7	Develop terms of reference for the cancer access board. This should include a remit to address issues and themes arising from the cancer huddle and wider PTL meeting for action	Cancer Committee TOR has been developed and is scheduled for review and approval at the next meeting (May 18)	May 18	D Fitzgerald	
8	Develop formal communication channels and protocols with other providers to ensure timely flow of information and MDS	MTW has well-established processes and protocols for flow of information and minimum dataset for oncology and specialist test (template biopsy, staging lap etc) referrals in to the organisation. Pro formas for referrals out of the Trust to main receiving organisations (GSTT and Kings) are available and used in Infoflex. Weekly inter-provider conference calls and shared PTLs have been in place for approximately 2 years and are working well. Regional MDT co-ordinator is developing a Kent & Medway inter-provider transfer policy and process supported and approved by the Cancer Alliance.	February 18	D Fitzgerald	

9	Develop navigator role as planned and implement in pressured tumour sites initially to support pathway management	Appropriate team members are attending a conference in Manchester w/c 16th April to learn from the Manchester model and implement locally. On track for new navigator role to be in place by the end of April.	April 18	S Young	
10	Define appropriate governance/performance management structure in light of new cancer board development	Completed	March 18	D Fitzgerald/ R Chalmers	
11	Develop a SOP for escalation of issues affecting cancer delivery for all staff to ensure problems are highlighted appropriately	Included in the huddle/governance structure document (linked with recommendation 1 and 10)	March 18	D Fitzgerald/S Young	

12	Ensure mitigation plans are in place for"orange dot" issues with both training and assessment of electronic means of ordering tests	On-going issues with OrderComms facility in Allscripts PAS. Radiology and Pathology are working with the Trust EPR team to improve the situation and then increase the volume of tests requested by electronic means. "Orange dot" pathways/patients are highlighted to the services through the daily huddle escalation process.	April 18	N Bedford/ M Holland	
13	Implement national best practice timed pathways in urology with predefined milestones and track patients against these in the daily huddle.	IST supporting with pathway/process mapping on 18th May. Urology have changed their pathway to meet the national best practice timed pathway as closely as possible and will continue this work with the Cancer Alliance clinical lead for prostate.	April 18	General Manager, Surgery	

14	Undertake demand and capacity modelling in urology – focusing on 1st o/p appointment, diagnostics and reporting turnaround (particularly biopsy separated by type) and develop an action plan	IST supporting with this work on 18th May	April/May 18	General Manager, Surgery supported by D Fitzgerald and IST	
15	Implement dedicated 2ww clinics in urology	Dedicated 2ww clinics are already in place. Capacity and demand work support by the IST on 18th May will enable greater clarity on the capacity needed and how to delineate from other clinics	May 18	General Manager, Surgery	
16	Provide staff in ERS and 2ww office with clarity on upcoming changes to the ERS system	Completed and 2ww services are live in ERS	February 18	ERS Team	
17	Review clinic templates in challenged specialties. Particularly with regards to: -Total slot capacity -New/follow up ratios	(linked with recommendations 14 and 15). Demand reviews have been completed and sent to all GMs requesting that they implement changes to clinic templates to achieve 85% of the maximum referral rate per week for 52 weeks of the year.	June 18	D Fitzgerald and all GMs	

18	Review how bank holidays are factored into the capacity planning. Identify services which will be disproportionately affected and plan additional capacity in advance.	As above	June 18	D Fitzgerald and all GMs	

Quality and Safety (June data)

Patient Falls incidents

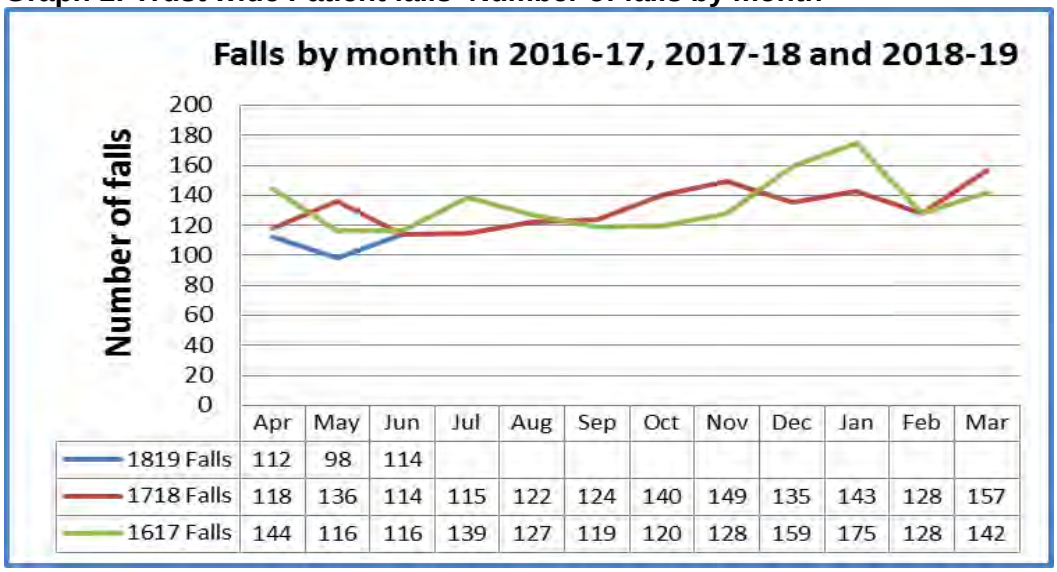
There were 114 falls reported for the month of June, compared to 98 for May 2018. The comparison against June 2017 at 114 can be seen in Graph 1. The breakdown of incidents by site equates to 40 falls at Maidstone and 74 at Tunbridge Wells.

The rate per 1000 occupied bed days is for the month of June is 5.86. (Year to date rate for 2018/19 was 5.23 per 1000 occupied bed days against the threshold of 6.0). Comparison of falls rate per 1000 occupied bed days for pervious months is shown in graph 2.

There were no Serious Incidents declared in June 2018.

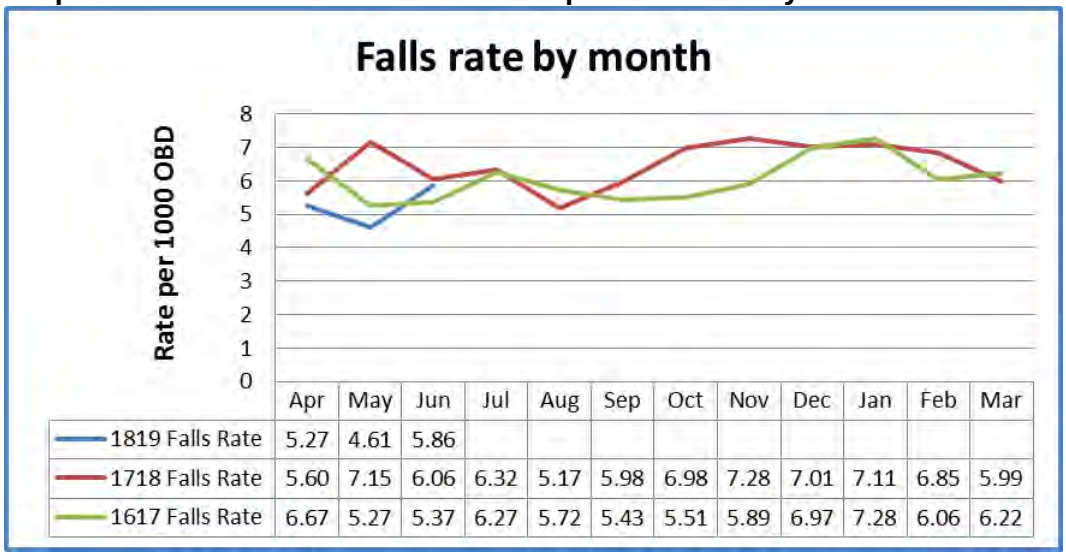
The Trust has signed up to participate in the NHSI falls collaborative which we hope will provide some further opportunities for us to review practice and support a reduction in the level of serious incidents relating to falls incidents. The Trust falls prevention practitioner attended a launch event on 20th June 2018. The agreed focus of our work is around the recording of Lying and Standing blood pressure for patients at risk of falls. We have identified two pilot wards to participate with this work which are wards 32 and ward 2. The ward managers are actively engaged. A small multi professional project group has been established to lead on this work which is supported by the Chief Nurse as executive sponsor for this work.

Graph 1: Trust wide Patient falls–Number of falls by month



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1819 Falls	112	98	114									
1718 Falls	118	136	114	115	122	124	140	149	135	143	128	157
1617 Falls	144	116	116	139	127	119	120	128	159	175	128	142

Graph 2: Trust wide Patient Falls – Rate per 1000 OBD by month



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1819 Falls Rate	5.27	4.61	5.86									
1718 Falls Rate	5.60	7.15	6.06	6.32	5.17	5.98	6.98	7.28	7.01	7.11	6.85	5.99
1617 Falls Rate	6.67	5.27	5.37	6.27	5.72	5.43	5.51	5.89	6.97	7.28	6.06	6.22

Pressure Ulcers:

The incidence of confirmed Hospital acquired Pressure Ulcers for June 2018 is 14.
The rate (per 1000 admissions) for June is 1.94 compared to 1.70 for the same month last year.
The incidence rate for the year is 1.94 against a threshold of 3.0.

Recruitment of the Band 7 TVN role is now complete, with an offer having been made. A start date will be confirmed once the usual pre-employment checks have been completed.

NHS Improvement published revised guidance on the reporting of pressure damage this month (June 2018).

The aim of the guidance is to develop a level of consistency in reporting pressure damage, and to develop a national data base. Currently there is no single national reporting structure that captures all pressure damage in month. The only national reporting system is the National Safety Thermometer, which captures data on one day in each month. Whilst this is useful 'over time' to establish a trend of improvement (or deterioration), it only accounts for pressure ulcers staged at Category 2 and above.

The NHSI document makes 28 recommendations for change at both national and local level. The recommendations range from setting a standard definition of pressure damage in line with the European Pressure Ulcer Advisory Panel, to local collection of data including unstageable, deep tissue injury (DTI) and moisture associated damage. There is also provision for reporting damage associated with medical devices (most commonly seen with the prolonged use of non-invasive ventilation masks).

A gap analysis is currently being undertaken, and early indications are indicating that Trust practice is compliant with 19 of the 28 recommendations. The outstanding recommendations relate to minor policy amendments, adaptation of the local reporting templates to include device related pressure damage, DTI and moisture lesion. There are a number of external templates that are likely to change, however this is not anticipated as being an issue for compliance.

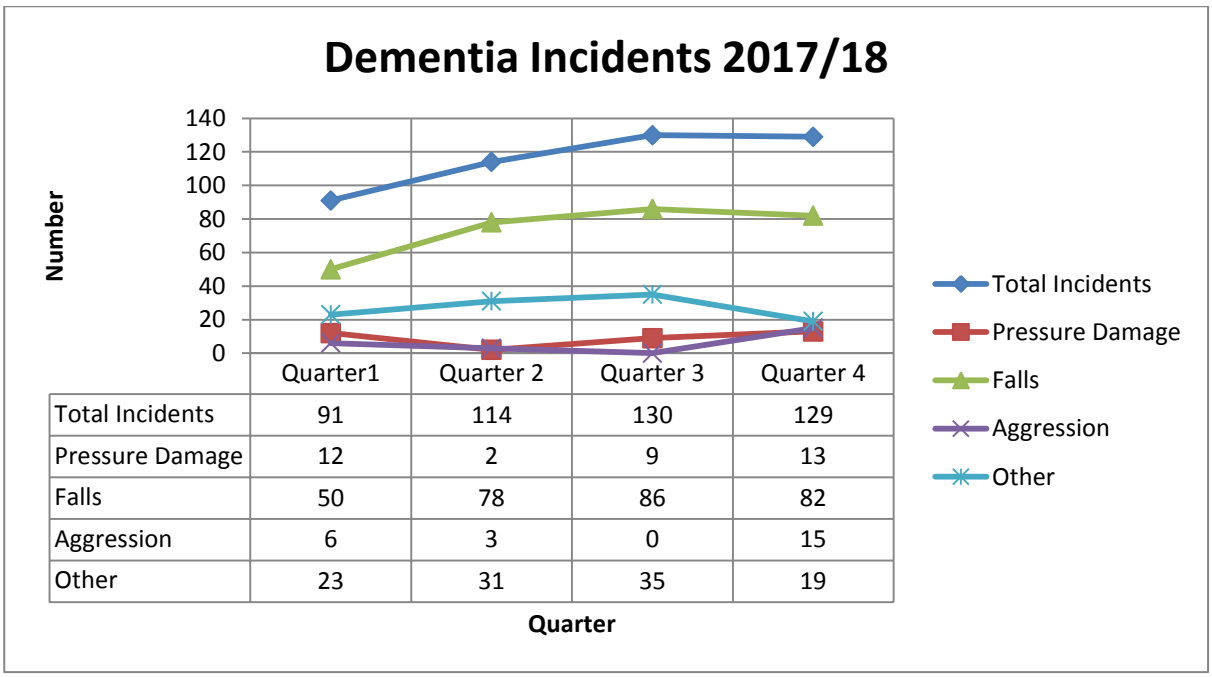
Impact for the Trust will be related to an apparent rise in pressure damage once DTI and moisture lesions are formally reported. Whilst there has not been a requirement to report nationally, this data is already collected at ward level as part of the routine assessment of skin integrity. This is discussed at the Pressure Ulcer Review Panel. Learning from this is disseminated via ward and directorate meetings.

The Trust currently has a prevention strategy/action plan in place. This includes provision of pressure reliving aids, twice yearly full prevalence audits and teaching programmes. This action plan is under-review as part of the annual review cycle.

Incidents relating to inpatients with Dementia:

As part of the Trust's Dementia Strategy (2013 – 2016) one of the objectives was to monitor the number of incidents relating to inpatients with dementia in our hospitals. In the Strategy for 2017 – 2020 one of the strategic aims is to modernise our approach to monitoring falls in patients with dementia and identify ways to reduce these. In the process for delivery it states we will: Monitor all incidents associated with dementia patients and report to dementia strategy group e.g. falls.

The incidents have been analysed by the Lead Nurse for Dementia Care, following a search on the Datix system of all incidents relating to patients with dementia. The identification of patients with a known diagnosis of dementia is via the Datix form and this has been validated by the Lead Nurse for Dementia through the flagging system on Allscripts. The incidents have been split into 4 categories: Pressure Damage; Falls; Aggression and Other. Incidents included in the Other category include issues such as drug omissions/errors, patient transfer communication issues between wards and similar low harm incidents.



	Quarter1	Quarter 2	Quarter 3	Quarter 4
Total Incidents	91	114	130	129
Pressure Damage	12	2	9	13
Falls	50	78	86	82
Aggression	6	3	0	15
Other	23	31	35	19

The above chart shows the comparisons per category of incidents over the year 2017/18. This data is collected and reviewed quarterly by the Dementia Strategy Group and findings are presented to the Trust Clinical Governance Committee as part of the Safeguarding Adults Group.

Friends and Family test:
Overall response rates for June have shown an increase. The recent IWGC meeting considered the issue of a previous fall in responses and further emphasis has been made to raise awareness. There has been additional discussion around the number of cards collected at Trust level and ensuring this data correlates to the final upload. This can be attributed to cards used in departments that are not accepted if they are photocopied or damaged in any way. Regular meetings with IWGC will enable a cross check of cards collected and uploaded.

The establishment of weekly card collection has enabled a more timely review of response rates and allows for a more rapid response and feedback to areas that may have fewer returns than anticipated.

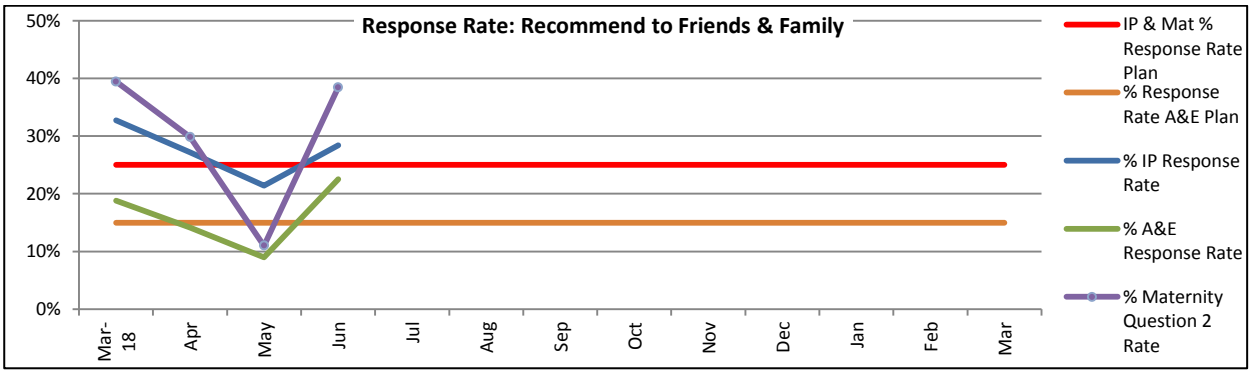
Response rates for June saw an increase across all areas: IP 28.4% compared to 21.4% in May, A&E saw a significant increase to 22.5% compared to 9.0% in May and Maternity also demonstrated a significant increase to 38.43% compared to 11% in May

The challenges noted last month potentially contributed to additional cards being uploaded to June's data in addition to the weekly collections.

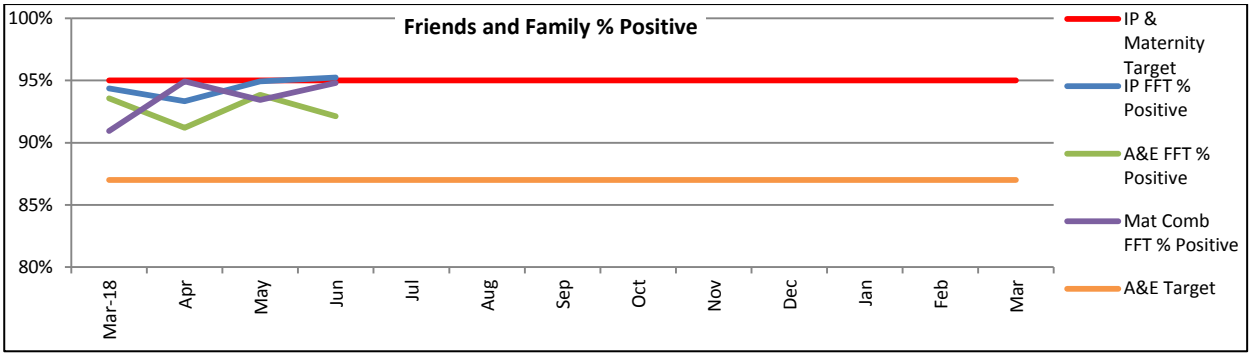
The positive responses has increased slightly from 94.9% in May to 95.3% in June, A&E decreased from 93.8% in May to 92.1% in June but remains above Trust plan and Maternity (all 4 combined) increased from 93.4% in May to 94.8% in June.

In terms of number of respondents from OP June is 5715 which is an increase from 5229 in May.

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 June 2018.

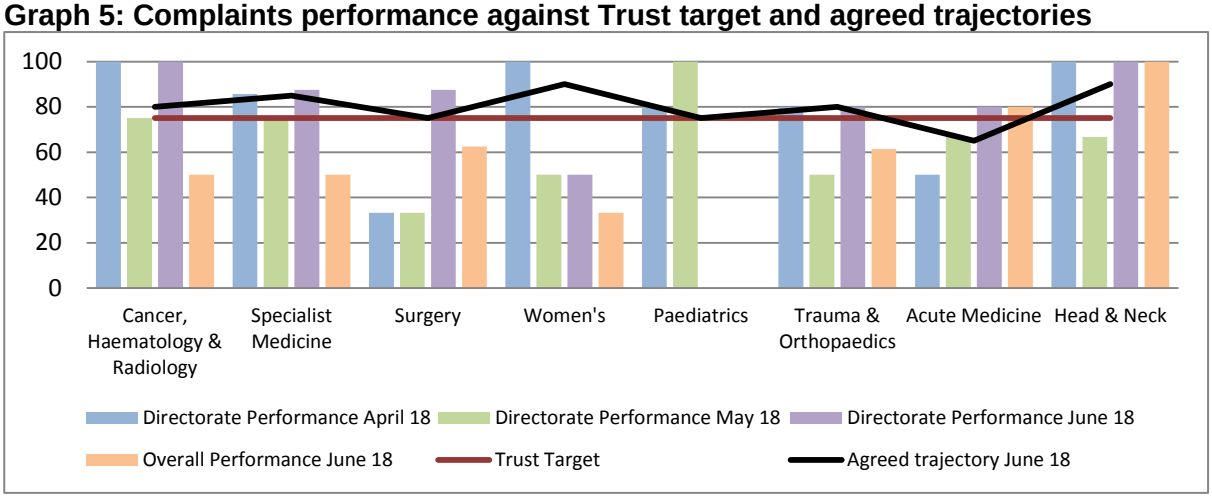
Complaints:

There were 44 new complaints reported for June which equates to a rate of 2.26 new complaints per 1,000 occupied bed days. This is an increase compared to 2.02 for May. There were 164 open complaints at the end of June compared to 163 in May.

61.4% of complaints were responded to within deadline compared to a target of 75%.

Following on from the series of challenge sessions held to address poor compliance with performance targets, Graph 5 (below) provide information on the performance for year to date against the Trust overall target and the agreed performance trajectories.

Graph 5: Complaints performance against Trust target and agreed trajectories



It is worth noting that all the directorates listed above achieved or exceeded their performance trajectory for June, other than Women's. However, overall, the Trust did not reach the 75% performance target for June, due to delays outside of the directorate's control. This included 1 complaint which breached due to capacity issues within the central complaints team and 9 complaints which breached for other reasons (including delays in contributing directorates providing comments, delays within the signing processes, healthcare records being unavailable, delays whilst awaiting corresponding SI investigations to be completed). These delays accounts for 22.7% of the lost performance.

The table below provides the detail of the frequency of each sub subject raised as issues within complaints received in the Trust. 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.

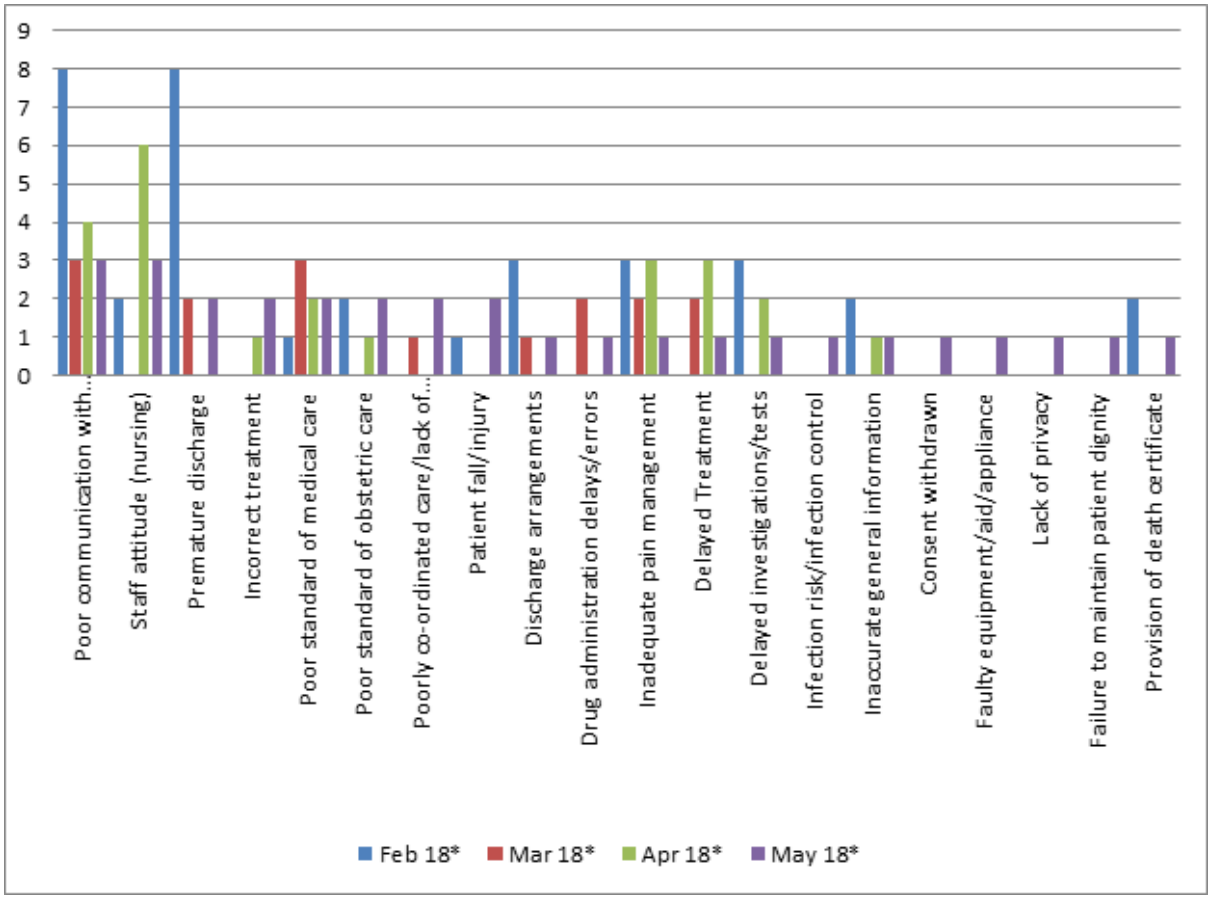
Graph 6: Complaints by Sub-subject – most frequently raised in June 2018

	Mar-18*	Apr-18*	May-18*	Jun-18*
Poor standard of nursing care	3	3	1	3
Treatment/drug not available	1	0	0	2
Staff attitude (nursing)	0	6	5	2

*reflects the date of the event being complained about

The following graph (Graph 7) shows an expanded view of the themes of complaints that occurred in June 2018.

Graph 7: All themes/subjects raised in complaints made about events that occurred in June 2018.



As with previous reports, communication with patients/relatives remains a key theme within complaints. Between March and June, this has remained one of the most frequently raised subjects in new complaints with 13 issues raised over this reporting period. However, we have received the same number of issues raised about attitude of nursing staff. This is followed by poor standards of nursing care and poor standards of medical care (both 10).

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

- Attitude of nursing staff
- Treatment/drug not available
- Poorly co-ordinated care/lack of continuity

Other areas show stable or slightly reducing trends, with the most significant reduction in complaints about poor standards of medical care, poor communication (despite these remaining frequently raised issues) and outpatient waiting list.

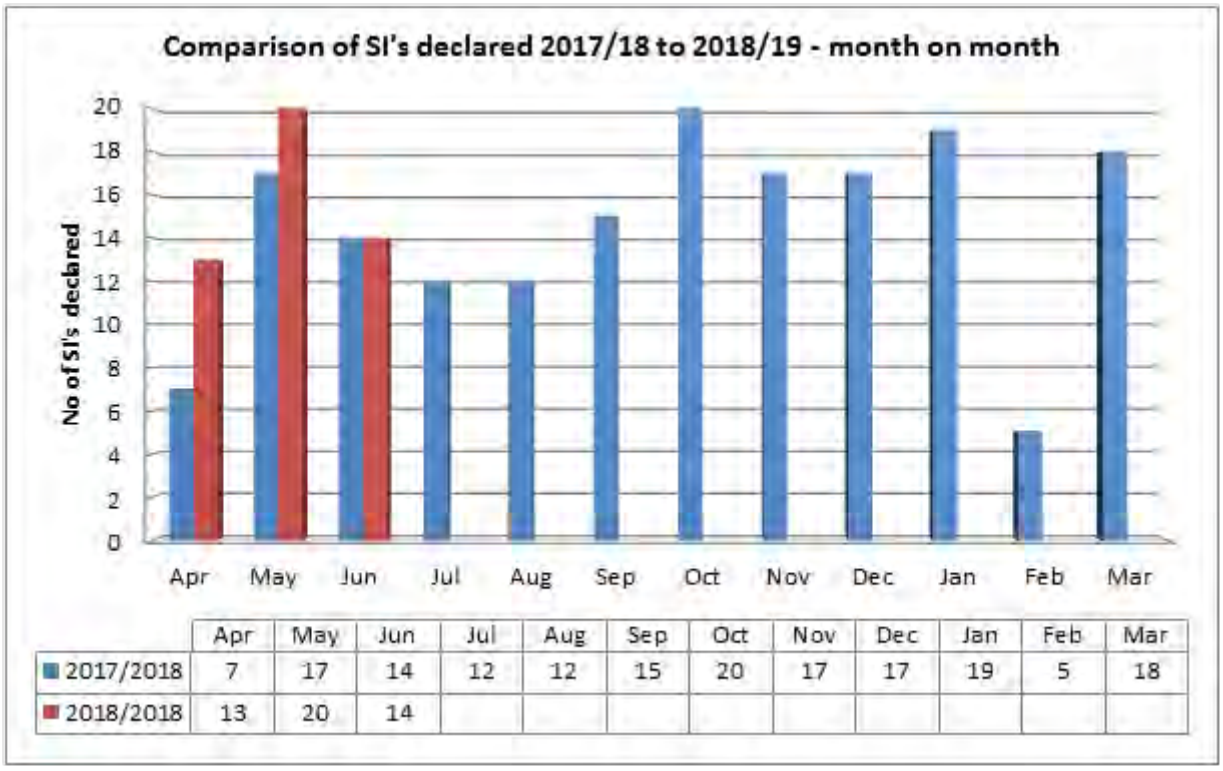
Complaint case studies are published in the Governance Gazette to highlight key themes and trends seen coming through complaints and the learning taken from complaint investigations.

Serious Incidents (SI's)

There were 14 Serious Incidents reported in June 2018 which was the same number reported for the corresponding period in 2017:

- 1 Pressure damage – category 3 in Specialist Medicine & Therapies
- 2 Safeguarding in Specialist Medicine & Therapies – both allegation of abuse
- 11 Main SI's spanning 5 divisions
  - 3 each in Acute & Emergency / Critical Care / Women's & Sexual Health
  - 1 each in Pathology & Pharmacy and Surgery

Graph 8: Total SI's Declared



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/2018	7	17	14	12	12	15	20	17	17	19	5	18
2018/2018	13	20	14									

During the month of June, 11 SI's were closed and 5 SI's were downgraded. The 5 downgrades were agreed by WKCCG on the basis that there were no significant failings in the care provided by MTW:-

- Cancer, Haematology & Diagnostic - Delayed Diagnosis Lung Cancer
- Women's & Sexual Health - 38wk Intrauterine death
- Women's & Sexual Health - Maternity Unit Closure

- Women's & Sexual Health - Transfer from Crowborough to TWH
- Children's Services - Unexpected neonatal collapse

The learning from the Falls panel identified the importance of ensuring that lying and standing blood pressure is undertaken, that alternative falls preventative measures are considered when existing measures are not effective, documenting assessment for injury and undertaking assessments for falls prevention including mental capacity assessments for personal safety and risk of falls.

Learning from the VTE panel has identified the importance of full completion of the VTE risk assessment and documentation of rationale for stopping chemical anticoagulation. Alternative prophylaxis should be considered when chemical prophylaxis is stopped or contra-indicated was another important learning point.

Safe staffing: Planned versus actual for June 2018

The enclosed information details the planned verus actual nursing staffing as uploaded to UNIFY for June 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: Incidence of Falls continues to decrease. Increased fill rate at night to support enhanced care needs on 9 nights

John Day: RN fill rate reflects skill mix required according to the wards level of acuity and dependency need throughout the month.

Mercer: Increased CSW fill rate at night reflective of enhanced care need requirements. Falls increased this month 2 above agreed threshold.

Edith Cavell: Increased CSW fill rate at night reflective of enhanced care need requirements on 10 nights

UMAU (Maidstone): Increased CSW fill rate at night to support ward escalation on 26 nights

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

Ward 32: CSW increased fill rate reflects need for enhanced care on 8 nights

Ward 10: Skill mix adjustment a considered action by the ward team in line with a high dependency and moderate acuity.

Ward 20: Increased CSW requirement to support enhanced and cohort care for patients with cognitive impairment and/or risk of falls. Increase in falls this month to 16 which is 9 above the agreed threshold of 7. QuEST score of 12 rated amber requiring further enquiry.

Crowborough Birth Centre: RM fill rate an accepted risk during the day, as community midwives accompany women or can provide support to the unit. This ensures safe staffing levels over night.

Hedgehog: RMN required 24/7 through the month of June for enhanced care need. Unit escalated on 4 occasions and HDU level acuity 21 days / nights

Neonatal Unit: Low RN fill rate due to inability to fill with temporary staffing. High level of LTS being managed.

Whatman: Part month data only: Ward closed 25th June as part of planned Winter de-escalation programme. Whilst showing 'red' against budgeted plan, the staffing numbers were reduced incrementally through the month as beds closed. Staffing was appropriate for the dependency needs.

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:

The 'overall RAG' ratings have been replaced with QuESTT; 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 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.

The RAG rating for QuESTT is rated as:
Green: 0 - 11
Amber: 12 – 15 Trend analysis and further enquiry
Red : 16 + Immediate enquiry and action to be taken

The Quality, Effectiveness & Safety Trigger Tool (QuESTT) collection tool is now available to all wards. Completion and review rate is at 75% (including maternity) for the month of June. QuESTT to be further embedded into the monthly reporting systems and continue to raise awareness from the Chief Nurse's senior team.

Table 1

QuESTT: Quality, Effectiveness and Safety Trigger Tool		Score if True		
Name of person completing review:	**Date of Review:**	**1**	**2**	**3**

Section One:
The content of this completed tool should be used to form the basis of a *monthly* 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.
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.

Indicators	True?
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%	
No monthly review of key quality indicators by peers, e.g. peer review or governance team meeting	
Planned annual appraisals not performed	
No involvement in Trust-wide multi-disciplinary meetings	
No 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	
No evidence of resolution to recurring themes	
Unusual demands on service exceeding capacity to deliver, e.g. national targets, outbreak	
Hand hygiene audits not performed	
Cleanliness audits not performed	
Ward/Department appears untidy	
No evidence of *effective* multi-disciplinary/multi-professional team working	
Ongoing investigation or disciplinary investigation (including RCA's & infection control RCA's)	
Overall Score:	

Insert comments below (if appropriate):

June '18		Day		Night			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 (%)	Overall Care Hours per pt day	FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	QuESTT Score	Comments	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Acute Stroke	91.0%	103.7%	98.3%	115.9%	7.9	42.9%	100.0%	6	0	N/S	Decrease in falls - outside threshold of 5 9 days/ nights of enhanced care needs	136,633	127,980	8,653
MAIDSTONE	Cornwallis	105.6%	105.4%	98.2%	106.7%	7.1	61.1%	95.7%	0	0	7		89,447	82,474	6,973
MAIDSTONE	Culpepper (Inc CCU)	96.0%	104.6%	97.3%	110.0%	8.3	116.7%	97.6%	1	0	0		107,155	100,481	6,674
MAIDSTONE	John Day	106.0%	118.1%	98.8%	98.3%	7.1	65.8%	95.8%	4	0	N/S	Considered action for skill mix requirements	126,238	156,463	(30,225)
MAIDSTONE	Intensive Treatment Unit (ITU)	87.2%	80.9%	82.2%	N/A	31.9			0	0	5	23 days of low occupancy in Month of June	155,506	135,276	20,230
MAIDSTONE	Pye Oliver	95.1%	85.4%	101.2%	98.9%	5.7	40.6%	92.3%	6	1	2	Falls remain 1 above threshold Reduced fill rate due to lack of available temporary staff	113,849	110,345	3,504
MAIDSTONE	Chaucer	91.4%	84.2%	100.3%	103.3%	9.9	29.0%	95.6%	4	0	2	Reduced fill rate due to lack of available temporary staff	115,628	100,959	14,669
MAIDSTONE	Lord North	94.9%	101.3%	99.8%	100.0%	7.6	21.7%	80.0%	2	1	3		100,372	95,743	4,629
MAIDSTONE	Mercer	101.3%	99.6%	99.9%	143.3%	6.2	52.6%	100.0%	8	0	5	Increase in Falls above threshold of 6 23 episodes of enhanced care requirements	103,678	109,786	(6,108)
MAIDSTONE	Edith Cavell	90.9%	112.5%	99.1%	150.0%	8.4	144.4%	92.3%	1	0	0	10 days / nights of enhanced care requirements	69,757	74,189	(4,432)
MAIDSTONE	Urgent Medical Ambulatory Unit (UMAU)	98.1%	97.4%	118.4%	180.0%	13.6	16.9%	97.0%	1	0	2	26 episodes of ward escalation over night RMN required on episodes for enhanced care.	129,135	141,347	(12,212)
TWH	Stroke/W22	86.2%	92.7%	100.0%	97.8%	10.0	143.8%	91.3%	9	1	7	Increase in Falls above threshold of 7 20 day shifts not covered by temporary staffing, priority given to cover at night with support from directorate team.	147,193	142,495	4,698
TWH	Coronary Care Unit (CCU)	112.9%	80.9%	94.0%	N/A	10.9	175.0%	93.7%	0	0	5	Reduced fill rate due to lack of available temporary staff	66,907	48,773	18,134
TWH	Gynaecology/ Ward 33	88.4%	94.9%	98.4%	95.5%	7.9	55.9%	100.0%	1	0	3	Reduced fill rate due to lack of available temporary staff	77,920	75,286	2,634
TWH	Intensive Treatment Unit (ITU)	98.3%	93.1%	98.4%	86.7%	31.6	0.0%	-	0	2	N/S	6 days of decrease in dependency	184,533	179,642	4,891
TWH	Medical Assessment Unit	92.6%	94.7%	98.8%	93.3%	7.9	7.9%	92.9%	12	0	13		186,019	197,287	(11,268)
TWH	SAU	100.0%	100.0%	99.7%	100.0%	5.5			0	0	2		60,652	60,876	(224)
TWH	Ward 32	95.1%	97.8%	107.6%	111.0%	6.8	50.7%	97.1%	3	3	N/S	8 days / nights of enhanced care requirements	136,521	171,426	(34,905)
TWH	Ward 10	99.3%	93.1%	74.1%	150.0%	9.4	32.5%	100.0%	0	1	5	Skill mix adjustment a considered risk by the ward team in line with a high dependency and moderate acuity	117,435	105,251	12,184
TWH	Ward 11	97.2%	90.6%	97.4%	116.7%	6.0	16.8%	100.0%	1	0	3		123,751	112,272	11,479
TWH	Ward 12	89.8%	109.7%	100.0%	103.3%	6.2	31.0%	95.5%	6	0	4	Reduced fill rate due to lack of available temporary staff and short term sickness	118,597	129,118	(10,521)
TWH	Ward 20	112.3%	109.1%	111.1%	118.3%	6.9	70.8%	88.2%	16	0	12	Increase in fall above threshold of 7. Cohorting and enhanced care need throughout the month.	115,008	138,095	(23,087)
TWH	Ward 21	95.3%	110.8%	101.3%	125.0%	6.8	65.2%	95.6%	7	1	8	Decrease in fall - ouside threshold of 6 Enhanced care requirements throughout the month on 16 days / nights	131,980	137,536	(5,556)
TWH	Ward 2	85.7%	83.8%	102.2%	85.8%	7.0	66.2%	97.7%	8	1	N/S	Increase in falls- outside Threshold of 1 Reduced fill rate due to lack of available temporary staff	133,780	112,321	21,459
TWH	Ward 30	101.2%	87.2%	99.9%	97.8%	6.0	9.1%	100.0%	8	1	7	Increase in falls - outside threshold of 5 Reduced fill rate due to lack of available temporary staff	120,058	116,577	3,481
TWH	Ward 31	86.7%	95.4%	96.7%	94.4%	6.7	28.8%	95.2%	1	2	5	Reduced fill rate due to lack of available temporary staff	137,102	132,907	4,195
Crowborough	Birth Centre	73.7%	99.3%	95.3%	93.3%				0	0		Considered action to maintain cover at night. Support provided to the unit by community midwifery teams during the day	69,998	72,763	(2,765)
TWH	Maternity Services (incl Ante/Post Natal, Delivery Suite & Triage)	83.0%	96.1%	96.2%	94.1%	5.8			0	0			679,190	679,821	(631)
TWH	Hedgehog	85.7%	62.4%	116.6%	N/A	14.5	21.7%	82.8%	0	0	N/S	RMN required 24/7 through month of June for enhanced care need.Unit escalated on 4 occasions and HDU level acuity 21 days / nights	179,806	208,665	(28,859)
MAIDSTONE	Birth Centre	100.8%	85.8%	97.6%	93.3%				0	0			61,580	59,404	2,176
TWH	Neonatal Unit	77.7%	76.2%	88.3%	N/A	17.8			0	0	8	High level of LTS throughout the month. Reduced fill rate due to lack of available temporary staff.	176,176	159,950	16,226
MAIDSTONE	MSSU	96.3%	124.8%	90.4%	N/A		19.1%	95.9%	3	0	3	Escalated on 4 nights in the month	41,043	36,932	4,111
MAIDSTONE	Peale	100.0%	85.8%	96.7%	103.3%	9.6	26.4%	95.8%	0	0	5		74,874	73,865	1,009
TWH	SSSU	108.3%	88.8%	78.2%	138.0%				0	0	3	Escalated throughout the month	137,516	93,715	43,801
MAIDSTONE	Whatman	69.8%	53.9%	63.3%	83.3%	6.5	90.9%	70.0%	2	0	5	Part month data only: Ward closed 25th June as part of planned Winter de escalation programme Whilst showing 'red' against budgeted plan, the staffing numbers were reduced incrementally through the month as beds closed. Staffing was appropriate for the dependency needs.	97,360	86,555	10,805
MAIDSTONE	A&E	89.5%	88.4%	95.4%	93.3%		14.1%	92.6%	1	0		Reduced fill rate due to lack of available temporary staff	193,788	182,648	11,140
TWH	A&E	101.0%	106.5%	101.2%	93.5%		31.0%	91.9%	3	0			295,467	310,712	(15,245)
												Total Establishment Wards	**5,111,652**	**5,059,937**	**51,715**
												Additional Capacity beds	36,003	33,091	2,912
												Other associated nursing costs	2,706,926	2,295,296	411,630
												Total	7,854,581	7,388,324	466,257

RAG Key

Under fill

Over fill

Infection Prevention and Control

MRSA

There were no cases of Trust-attributable MRSA bacteraemia in June

C. difficile

There were three cases of post-72 hour C. difficile infection in June against a monthly limit of two cases. We are currently 4 cases below trajectory for the year to date.

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 June. Root cause analysis is being carried out on both cases and they will be reviewed at the C. difficile panel

Gram negative bacteraemia

Fourteen cases of hospital attributable gram negative blood stream infection were seen in June. Nine cases due to E. coli, three due to Klebsiella species and two 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 has now been finalised and will be launched over the summer.

A hydration project will be launched and piloted on two wards over the next few weeks. Research has shown that good hydration reduces the incidence of urinary tract infection – a common underlying cause of blood stream infection in hospital patients

Infection Prevention and Control Committee (IPCC)

The IPCC met in June. Key points of interest were:

- A renewed focus on ‘bare below the elbows’ is required to maintain good hand hygiene.
- An audit of patients undergoing ERCP who subsequently developed gram negative blood stream infection showed that antibiotic prophylaxis is not used consistently. This has been addressed and will be implemented universally for all patients undergoing ERCP.
- An audit of the MRSA care pathway showed that it is not used consistently on all wards. Additional training will be given by the infection control team to wars which scored badly on the audit.

Financial commentary

- The Trusts deficit including PSF was £0.3m in June which was on plan, the Trust was £0.1m adverse against the CIP plan which was offset by income over performance.
- The Trust's normalised pre PSF run rate in June was a deficit of £1.8m, an improvement of £0.3m compared to last month. The position for June included £0.9m of exceptional items, £0.6m release of 2017/18 provisions, £0.2m release of YTD demographic reserve, £0.1m release of contingency reserve to fund YTD Four Eyes consultancy costs.
- In June the Trust operated with an EBITDA surplus of £2.2m which was on plan.
- The Trust year to date has a deficit including PSF of £3.2m which is on plan, the key variances to plan are: CIP Slippage (£0.4m), overspends within pay budgets (£0.6m) offset by non recurrent items (£1m).
- The key YTD variances are as follows:
  - Total income net of pass-through related income is £0.2m adverse to plan. Clinical Income excluding HCDs is £0.3m favourable to plan. The key favourable variances are Non-Electives (£1.7m) and A&E (£0.3m) offset by an adverse adjustment of £1.6m relating to the aligned incentive contract and £0.4m elective activity (Daycase and In Patients). Other Operating Income is £0.5m adverse to plan the main adverse items relate to Private Patient Income (£0.2m), £0.1m offset within Technical adjustments, £0.1m adverse relating to provider to provider SLA (mainly within Diagnostics) and £0.1m relating to Commercial income (Accommodation, Catering and Car Parking. The Trust achieved the financial control target for quarter 1 and the A&E trajectory and has therefore full delivered the PSF funding for quarter 1.
  - The level of pay expenditure remains the main area of concern, without the release of £0.6m 2017/18 provisions pay budgets would have been £1m adverse to plan, £0.4m due to CIP slippage (mainly relating to STP Medical rates) and £0.6m associated with overspends to budget. The main pressures to budget relate to Medical (£0.5m) and Nursing (£0.3m) with all other staff groups underspending to budget.
  - Non Pay budgets net of pass-through related costs are £0.6m favourable to plan, this includes £0.3m non recurrent benefit relating to release of 2017/18 provision, £0.1m CIP over performance and £0.3m drugs underspend.
- The Trust achieved £0.9m savings in June which was £0.1m adverse to plan and year to date is £0.4m adverse. This is mainly due to STP Medical rate slippage (£0.2m) and Outsourcing reduction slippage (£0.2m).
- The Trust held £13.4m of cash at the end of June which is slightly higher than the plan of £12.5m. This is primarily due to KCC paying both month 1 and 2 sexual health invoices of £0.7m against the plan expectation of July. 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; national funding for the next replacement Linac of £1.7m (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 has an approved Salix loan of £755k for Phase 4 and agreement from DH to provide the necessary Capital resource cover is being obtained by NHSI. A further loan application will be made at a later stage. The ICT schemes have been prioritised and approved by the ISG in principle but will require IAG Business case sign off. The prioritised list of equipment schemes was approved by TME and Execs, subject to individual Business case approval. Linac 4 replacement at Maidstone was delivered in early May and commissioning the equipment has begun and will be ready for clinical use by Oct 18. Linac 5 replacement funding has now been agreed with NHSE as additional PDC from the national programme. The donated equipment plan is mainly made up of the remaining Cardiology legacies, and a large donation for Urology/Oncology equipment.
- The Trust is forecasting to deliver its financial plan but has potential risks of £11.3m. The main risks include: CIP slippage (£5.1m), ongoing pay pressures (£4.5m), non-pay pressures (£0.9m) (mainly within T&O and Diagnostics) and £0.9m income pressures. The Trust is taking action to control

these risks such as continued management of the CIP programme to fully deliver and budgetary recovery plans to bring pay overspends back to budgets. Should mitigation be necessary the Trust will deploy its contingency, pay investment reserve and other opportunities

- This report includes a series of changes to start to reflect the areas of improvement discussed with the Chair of the Finance and Performance committee in May. These improvements will be consolidated in August with further changes to be made from September.

Workforce Commentary

As at the end of June 2018, the Trust employed 5027.8 whole time equivalent substantive staff, a 6.0 WTE decrease from the previous month. Agency use is higher than planned, in line with the higher than anticipated vacancy levels.

Sickness absence in the month (May) decreased by 0.15% to 3.24%, 0.06% below target and continuing the downward movement over recent months. Directorates demonstrating the highest sickness rates include Patient Administration (6.16%), ICT (5.13%) and Facilities (4.92%), but with rates having decreased in two of the three areas since last month. At a divisional level, Women, Children and Sexual Health have the highest sickness levels at 3.61% although this is significantly reduced from the previous month. At a trust level, the breakdown in May is 49.88% short-term, 50.12% long term, reversing the balance from previous months. 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 0.35% to 88.89%, 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 (79.42%), General Surgery (83.66%) and Children's Services (85.12%); only General Surgery has increased from the previous month.

Turnover has decreased since last month to 10.25%, higher than target, with outliers in Finance (18.66%) and Medical Education (18.79%). 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.

At closure of the appraisal window, appraisal compliance is stands at 52.48% compared with a target of 90%, although this figure is higher than the same period last year. It is normal for a lag in reporting, even for those appraisals completed during the window, while the documentation is completed and processed. HR Business Partners are working with directorates to highlight areas of non-compliance.

Trust Performance Dashboard

Position as at: 30 June 2018

Delivering or Exceeding Target	
Underachieving Target	
Failing Target	

Please note a change in the layout of this Dashboard to the Five CQC/TDA Domains

******A&E 4hr Wait monthly plan is Trust Recovery Trajectory

	Safe	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
1-01	*Rate C-Diff (Hospital only)	9.63	15.4	12.4	6.5	-6.0	- 6.5	11.5	8.4	
1-02	Number of cases C.Difficile (Hospital)	2	3	8	4	-4	- 4	26	22	
1-03	Number of cases MRSA (Hospital)	0	0	0	1	1	1	0	1	
1-04	Elective MRSA Screening	98.0%	99.0%	98.0%	99.0%	1.0%	1.0%	98.0%	99.0%	
1-05	% Non-Elective MRSA Screening	Not currently available								
1-06	**Rate of Hospital Pressure Ulcers	1.70	1.94	1.99	1.94	- 0.05	- 1.07	*3.01*	1.99	3.00
1-07	***Rate of Total Patient Falls	5.49	5.86	5.71	5.23	- 0.48	- 0.77	*6.00*	4.95	
1-08	***Rate of Total Patient Falls Maidstone	5.92	5.53	5.46	5.01	- 0.45			4.36	
1-09	***Rate of Total Patient Falls TWells	6.09	6.05	6.06	5.37	- 0.70			4.73	
1-10	Falls - SIs in month	3	0	9	4	- 5				
1-11	Number of Never Events	0	0	0	0	0	0	*0*	0	
1-12	Total No of SIs Open with MTW	41	76			35				
1-13	Number of New SIs in month	14	14	38	47	9	17			
1-14	***Serious Incidents rate	0.67	0.72	0.59	0.76	0.17	0.70	*0.0584 - 0.6978*	0.70	*0.0584 - 0.6978*
1-15	Rate of Patient Safety Incidents - harmful	1.15	0.86	1.32	1.17	- 0.15	- 0.06	*0 - 1.23*	1.17	*0 - 1.23*
1-16	Number of CAS Alerts Overdue	0	1			1	1	*0*		
1-17	VTE Risk Assessment - month behind	96.6%	96.4%	96.4%	96.4%	0.0%	1.4%	95.0%	96.4%	95.0%
1-18	Safety Thermometer % of Harm Free Care	97.3%	97.7%	96.6%	97.5%	0.9%	2.5%	95.0%		93.4%
1-19	Safety Thermometer % of New Harms	2.67%	2.27%	3.19%	2.39%	-0.80%	-0.6%	*3.00%*	2.39%	
1-20	C-Section Rate (non-elective)	15.9%	13.8%	13.7%	13.5%	-0.19%	-1.5%	*15.0%*	13.5%	

	Effectiveness	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
2-01	Hospital-level Mortality Indicator (SHMI)******	Prev Yr: July 14 to June 15		1.0878	1.0440	- 0.0	0.0	Band 2	Band 2	1.0
2-02	Standardised Mortality HSMR	Prev Yr: Apr 15 to Mar 16		106.8	104.4	- 2.4	4.4	Lower confidence limit to be <100		100.0
2-03	Crude Mortality	1.0%	0.9%	1.0%	0.9%	-0.1%				
2-04	****Readmissions <30 days: Emergency	12.0%	10.8%	11.7%	12.2%	0.4%	-1.4%	*13.6%*	12.2%	14.1%
2-05	****Readmissions <30 days: All	13.2%	13.2%	11.0%	13.3%	2.3%	-1.4%	*14.7%*	13.3%	14.7%
2-06	Average LOS Elective	4.23	3.24	2.55	3.04	0.48	- 0.17	*3.20*	3.04	
2-07	Average LOS Non-Elective	7.59	6.69	7.43	7.07	- 0.37	0.27	*6.80*	6.80	
2-22	NE Discharges - Percent zero LoS	35.9%	42.1%	34.4%	42.6%	8.2%			42.6%	
2-08	******FollowUp : New Ratio	1.74	1.52	1.69	1.52	- 0.17	- 0.00	*1.52*	1.52	
2-09	Day Case Rates	88.0%	87.0%	88.0%	87.6%	-0.4%	7.6%	80.0%	87.6%	82.2%
2-10	Primary Referrals	9,359	9,261	27,455	30,210	10.0%	6.8%	121,638	123,276	
2-11	Cons to Cons Referrals	5,295	5,250	14,935	16,935	13.4%	21.9%	56,704	69,106	
2-12	First OP Activity (adjusted for uncashed)	16,871	18,446	48,219	54,932	13.9%	11.6%	204,253	694,889	
2-13	Subsequent OP Activity (adjusted for uncashed)	31,554	26,697	88,976	78,074	-12.3%	-15.1%	382,155	318,592	
2-14	Elective IP Activity	583	552	1,652	1,560	-5.6%	-13.5%	7,674	6,366	
2-15	Elective DC Activity	3,708	3,690	10,932	10,998	0.6%	3.3%	44,403	44,879	
2-16	**Non-Elective Activity	4,722	5,119	13,946	15,476	11.0%	6.5%	58,582	62,074	
2-17	A&E Attendances (Calendar Mth) Excl Crowboro	14,592	15,367	42,799	45,161	5.5%	0.8%	174,428	174,428	
2-18	Oncology Fractions	6,039	5,282	17,200	16,097	-6.4%	-3.2%	67,890	64,388	
2-19	No of Births (Mothers Delivered)	478	480	1,476	1,482	0.4%	-0.8%	5,977	5,928	
2-20	% Mothers initiating breastfeeding	82.4%	81.0%	82.4%	82.4%	0.0%	4.4%	78.0%	82.4%	
2-21	% Stillbirths Rate	0.0%	0.00%	0.00%	0.13%	*0.1%*	*-0.3%*	*0.47%*	0.13%	0.47%

	Caring	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
3-01	Single Sex Accommodation Breaches	0	0	0	0	0	0	0	0	
3-02	*****Rate of New Complaints	2.31	2.26	3.10	2.16	-0.9	0.84	*1.318-3.92*	2.05	
3-03	% complaints responded to within target	57.6%	61.4%	74.3%	60.4%	-13.9%	-14.6%	75.0%	75.0%	
3-04	****Staff Friends & Family (FFT) % rec care	76.0%	77.6%	76.0%	77.6%	1.5%	-1.4%	79.0%	79.0%	
3-05	*****IP Friends & Family (FFT) % Positive	95.9%	95.3%	95.3%	94.5%	-0.7%	-0.5%	95.0%	95.0%	95.8%
3-06	A&E Friends & Family (FFT) % Positive	92.3%	92.1%	91.4%	92.2%	0.8%	5.2%	87.0%	92.2%	85.5%
3-07	Maternity Combined FFT % Positive	90.7%	94.8%	93.6%	94.6%	1.0%	-0.4%	95.0%	95.0%	95.6%
3-08	OP Friends & Family (FFT) % Positive	84.5%	83.2%	83.0%	83.5%	0.4%			83.5%	

* 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

	Responsiveness	Latest Month Prev Yr	Latest Month Curr Yr	Year/Qtr to Date Prev Yr	Year/Qtr to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
4-01	******Emergency A&E 4hr Wait	92.5%	94.18%	88.9%	93.2%	4.3%	3.6%	90.8%	90.8%	76.4%
4-02	Emergency A&E >12hr to Admission	0	0	0	1	1	1	*0*	1	
4-03	Ambulance Handover Delays >30mins	248	265	927	843	-84			3,372	
4-04	Ambulance Handover Delays >60mins	16	23	98	94	-4			376	
4-05	RTT Incomplete Admitted Backlog	2,298	3,520	2,298	3,520	1,222	977	2,151	2,151	
4-06	RTT Incomplete Non-Admitted Backlog	718	3,687	718	3,687	2,969	545	1,995	1,995	
4-07	RTT Incomplete Pathway	87.0%	79.1%	87.0%	79.1%	-7.9%	-1.9%	85.5%	85.5%	
4-08	RTT 52 Week Waiters (New in Month)	0	7	0	11	11	11	*0*	11	
4-09	RTT Incomplete Total Backlog	3,167	7,207	3,167	7,207	4,040	1,522	4,146	4,146	
4-10	% Diagnostics Tests WTimes <6wks	99.71%	99.4%	99.7%	99.4%	-0.2%	0.4%	99.0%	99.0%	
4-11	*Cancer WTimes - Indicators achieved	3	1	1	1	-	- 8	9	9	
4-12	*Cancer two week wait	93.1%	88.9%	92.1%	86.2%	-5.8%	-6.8%	93.0%	93.0%	
4-13	*Cancer two week wait-Breast Symptoms	90.4%	87.5%	87.9%	77.9%	-9.9%	-15.1%	93.0%	93.0%	
4-14	*Cancer 31 day wait - First Treatment	93.2%	96.6%	92.6%	94.3%	1.6%	-1.7%	96.0%	96.0%	
4-15	*Cancer 62 day wait - First Definitive	69.7%	53.8%	66.2%	57.8%	-8.4%	-24.3%	85.0%	85.0%	
4-16	*Cancer 62 day wait - First Definitive - MTW	71.7%	58.1%	71.7%	61.5%	-10.2%		85.0%		
4-17	*Cancer 104 Day wait Accountable	15.5	15.0	88.5	33.0	-55.5	33.0	*0*	33.0	
4-18	*Cancer 62 Day Backlog with Diagnosis	101	89	101	89	-12				
4-19	*Cancer 62 Day Backlog with Diagnosis - MTW	69	62	69	62	-7				
4-20	Delayed Transfers of Care	6.24%	4.39%	6.00%	4.43%	-1.57%	0.93%	3.50%	3.50%	
4-21	% TIA with high risk treated <24hrs	58.8%	73.9%	69.4%	72.5%	3.1%	12.5%	60%	72.5%	
4-22	*******% spending 90% time on Stroke Ward	96.4%	83.7%	92.2%	88.7%	-3.5%	8.7%	80%	88.7%	
4-23	*******Stroke:% to Stroke Unit <4hrs	58.9%	52.7%	56.6%	51.6%	-5.0%	-8.4%	60.0%	60.0%	
4-24	*******Stroke: % scanned <1hr of arrival	58.6%	54.1%	57.5%	52.4%	-5.1%	4.4%	48.0%	52.4%	
4-25	*******Stroke:% assessed by Cons <24hrs	77.6%	88.6%	85.2%	85.2%	0.0%	5.2%	80.0%	85.2%	
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	8	1	8	8	0	8	*0*	8	

RTT Incomplete Pathway Monthly Plan is Trust Recovery Trajectory

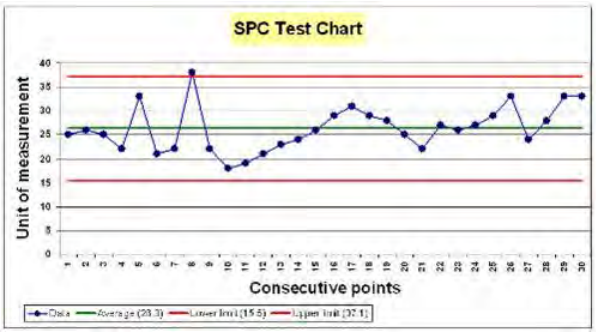
**CWT run one mth behind, YTD is Quarter to date, Monthly Plan for 62 Day Wait First Definitive is Trust Recovery Trajectory*

**** Contracted not worked includes Maternity /Long Term Sick* ***** Staff FFT is Quarterly therefore data is latest Quarter*

	Well-Led	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
5-01	Income	36,454	37,337	110,227	111,884	1.5%	0.0%	466,760	466,760	
5-02	EBITDA	1,862	2,218	4,083	4,329	6.0%	-1.4%	38,910	38,910	
5-03	Surplus (Deficit) against B/E Duty	(693)	(293)	(3,525)	(3,214)			11,691	11,691	
5-04	CIP Savings	1,443	928	3,440	2,634	-23.4%	-12.9%	24,013	24,013	
5-05	Cash Balance	4,931	13,358	4,931	13,358			1,000	1,000	
5-06	Capital Expenditure	67	431	464	713			*13,762*	13,730	
5-07	Establishment WTE	5,601.4	5,611.8	5,601.4	5,611.8	0.2%	0.0%	5,611.8	5,611.8	
5-08	Contracted WTE	5,058.4	5,027.8	5,058.4	5,027.8	-0.6%	0.1%	5,023.4	5,023.4	
5-09	Vacancies WTE	543.0	584.1	543.0	584.1	7.6%	-0.7%	588.4	588.4	
5-11	Vacancy Rate (%)	9.7%	10.4%	9.7%	10.4%	0.7%	-0.1%	10.5%	10.5%	
5-12	Substantive Staff Used	4,931.5	4,906.8	4,931.5	4,906.8	-0.5%	-2.1%	5,010.9	5,010.9	
5-13	Bank Staff Used	391.2	355.7	391.2	355.7	-9.1%	-2.6%	365	365.1	
5-14	Agency Staff Used	226.1	288.7	226.1	288.7	27.7%	22.4%	235.8	235.8	
5-15	Overtime Used	44.0	44.4	44.0	44.4	0.9%				
5-16	Worked WTE	5,592.8	5,595.6	5,592.8	5,595.6		-0.3%	5,611.8	5,611.8	
5-17	Nurse Agency Spend	(547)	(348)	(1,806)	(2,016)	11.6%				
5-18	Medical Locum & Agency Spend	(998)	(1,547)	(3,376)	(4,589)	35.9%				
5-19	Temp costs & overtime as % of total pay bill	13.7%	15.5%	16.6%	16.4%	-0.2%				
5-20	Staff Turnover Rate	11.7%	10.3%		10.3%	-1.5%	-0.2%	*10.5%*	10.3%	11.05%
5-21	Sickness Absence	3.2%	3.2%		3.5%	0.1%	0.2%	*3.3%*	3.3%	4.3%
5-22	Statutory and Mandatory Training	87.8%	88.9%		88.4%	1.1%	3.4%	85.0%	88.4%	
5-23	Appraisal Completeness	Data not reported for Quarter 1								
5-24	Overall Safe staffing fill rate	98.2%	95.8%	98.4%	97.6%	-0.8%		93.5%	97.6%	
5-25	****Staff FFT % recommended work	50.9%	49%	50.9%	49%	-2.3%	-13.3%	62.0%	62%	
5-26	***Staff Friends & Family -Number Responses	701	263	701	263	-438				
5-27	*****IP Resp Rate Recmd to Friends & Family	23.8%	28.4%	23.7%	25.6%	2.0%	0.6%	25.0%	25.6%	25.7%
5-28	A&E Resp Rate Recmd to Friends & Family	20.2%	22.5%	21.4%	15.2%	-6.3%	0.2%	15.0%	15.2%	12.7%
5-29	Mat Resp Rate Recmd to Friends & Family	37.7%	38.4%	30.9%	25.7%	-5.2%	0.7%	25.0%	25.7%	24.0%

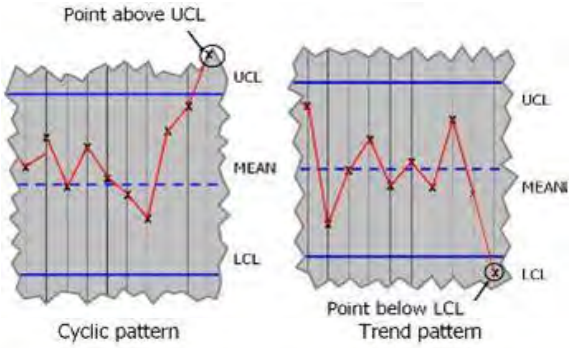
Explanation of Statistical Process Control (SPC) Charts

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

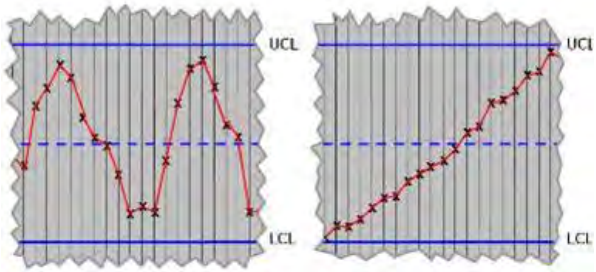


SPC is a type of charting that shows the variation that exists in the systems that are being measured. When interpreting SPC charts there are 4 rules that help to identify what the system is doing. If one of the rules has been broken, this means that 'special cause ' variation is present in the system. 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.

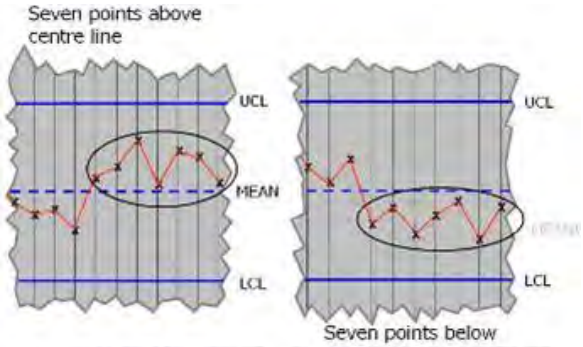


Rule 2: Any unusual pattern or trends within the control limits. The most obvious example of a cyclical pattern is seasonality but we also see it when looking at daily discharges where the weekends have low numbers. To qualify as a trend there must be at least 6 points in a row. This is one of the key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

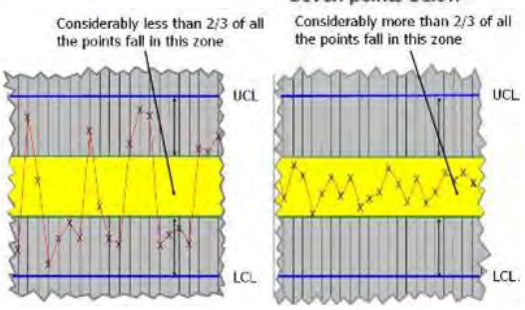


Rules 1 and 2 are the main reason for displaying SPC charts on our performance reports as it makes abnormally high or low values and trends immediately obvious. However there are two other rules that are also used to interpret the graphs.

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.

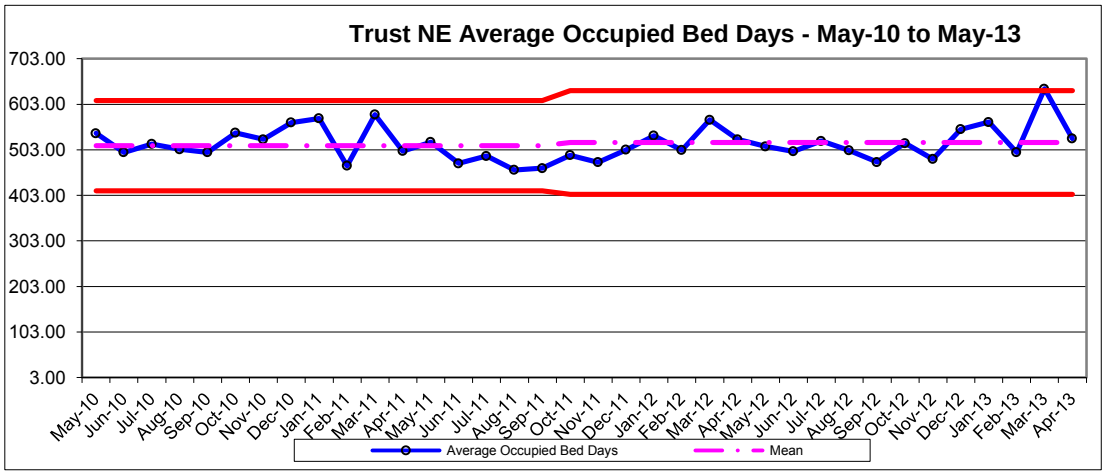


Rule 4: The number of points within the middle third of the region between the control limits differs markedly from two -thirds of the total number of points. This gives an indication of how stable a process is. If controlled variation (common cause) is displayed in the SPC chart, the process is stable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

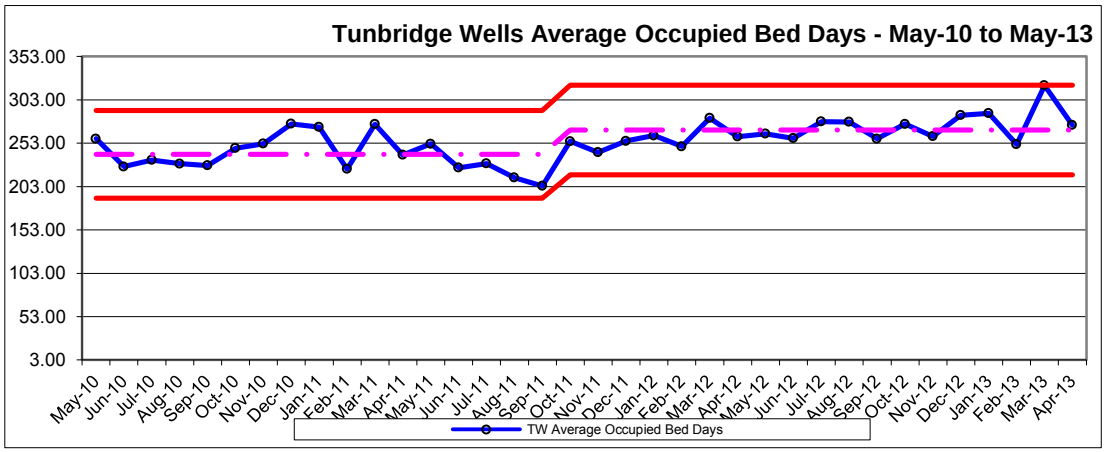


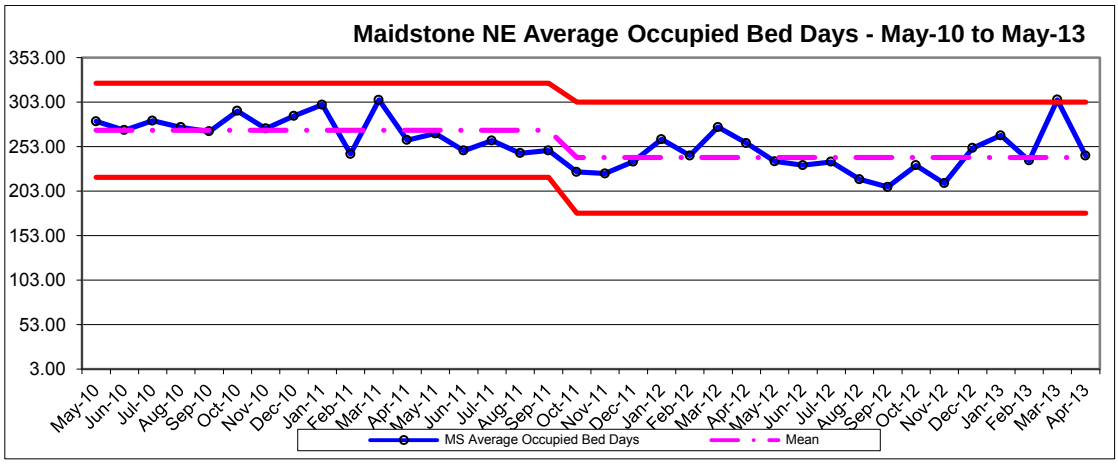
Changes to Control Lines

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:

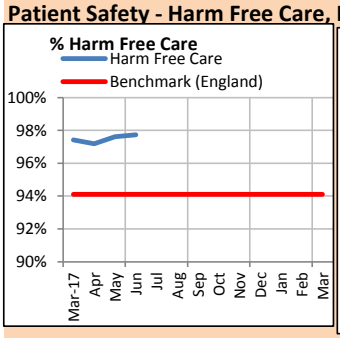


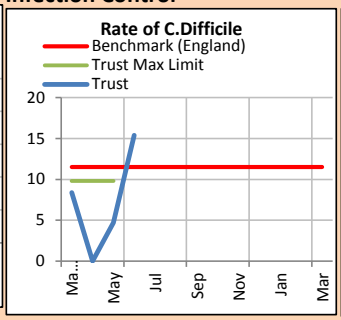


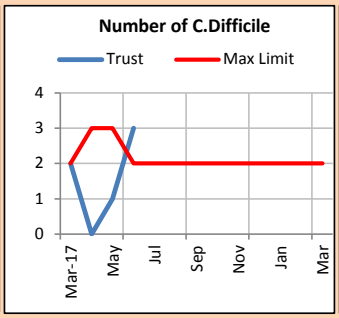
So in the examples given we have calculated a mean and control limits based on the data for May 2010 to September 2011 and then calculated them based on the period October 2011 to April 2013. The lines are all a result of the SPC calculations, only the date of the change is decided by the Information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

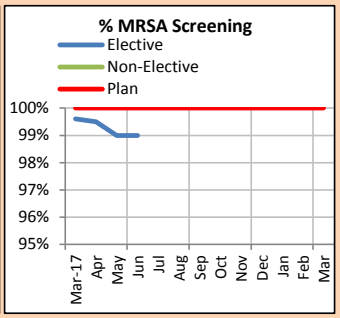
INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

Patient Safety - Harm Free Care, Infection Control

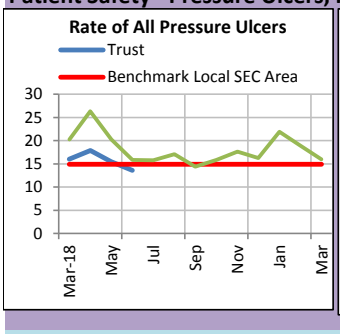


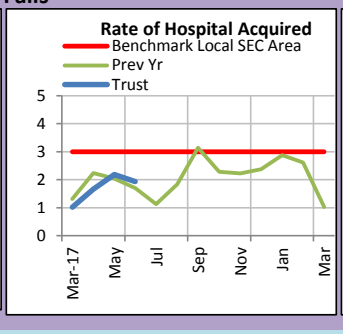


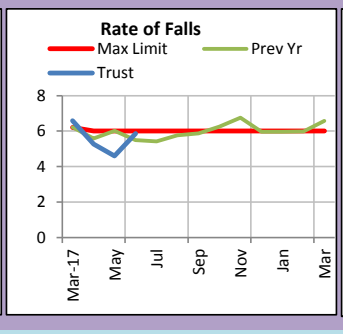


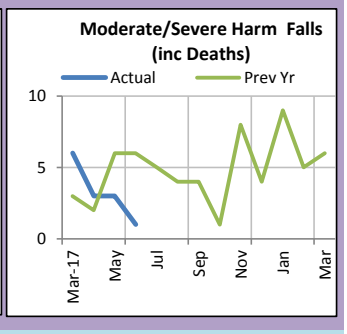


Patient Safety - Pressure Ulcers, Falls

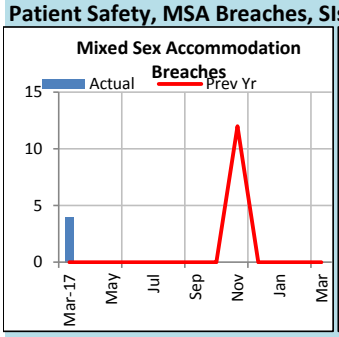


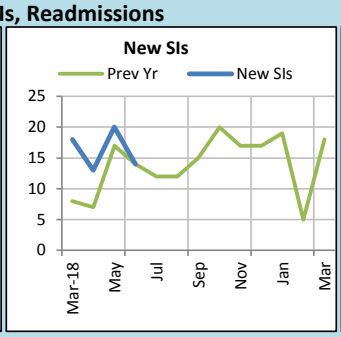


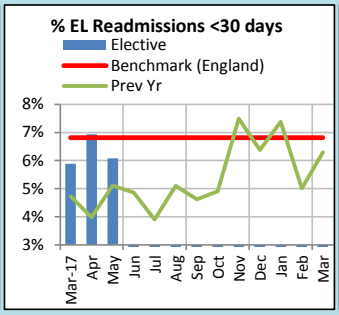


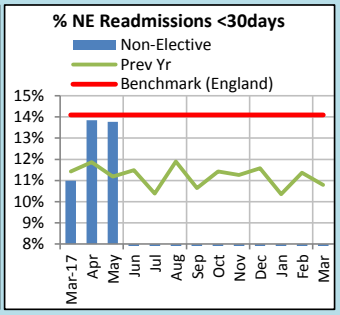


Patient Safety, MSA Breaches, SIs, Readmissions

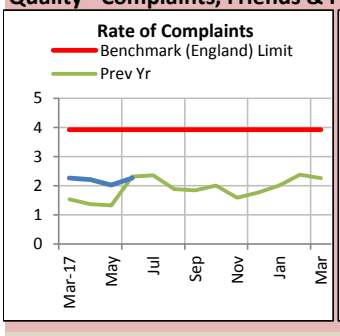


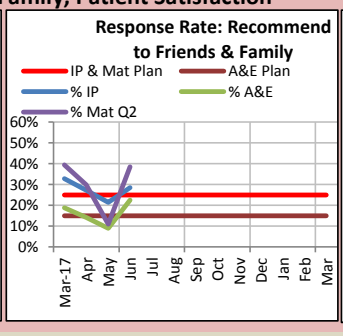


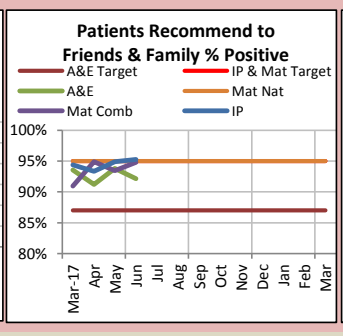


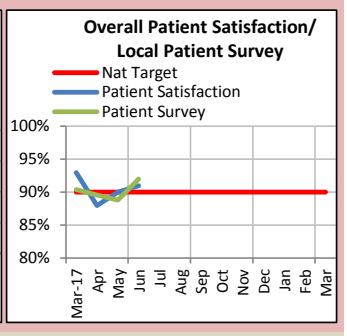


Quality - Complaints, Friends & Family, Patient Satisfaction

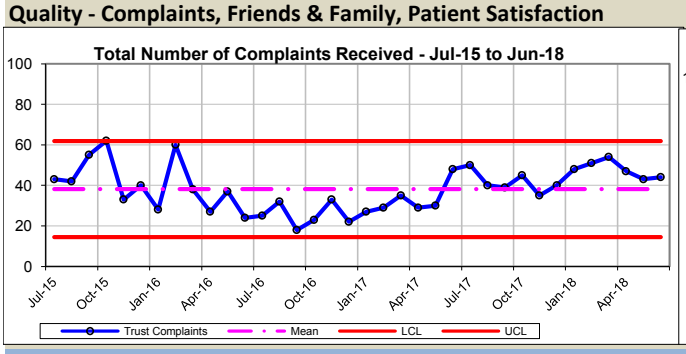


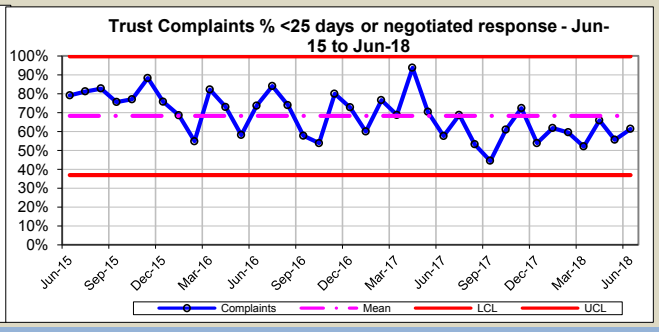




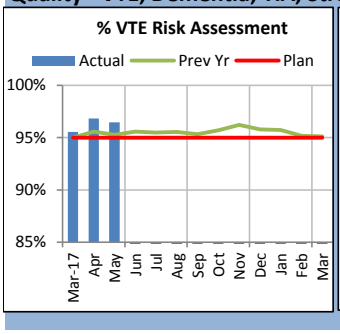


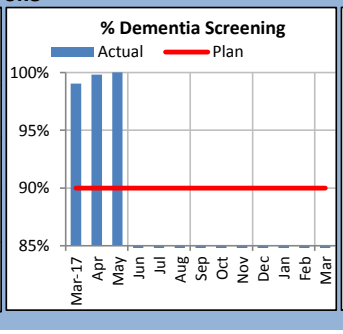
Quality - Complaints, Friends & Family, Patient Satisfaction

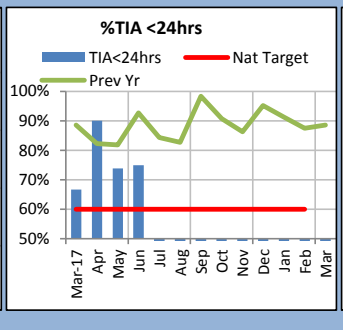


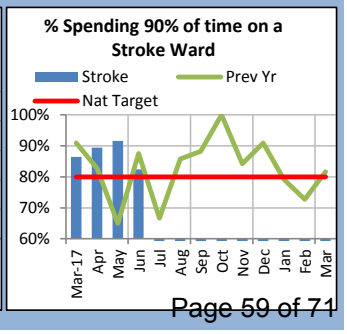


Quality - VTE, Dementia, TIA, Stroke



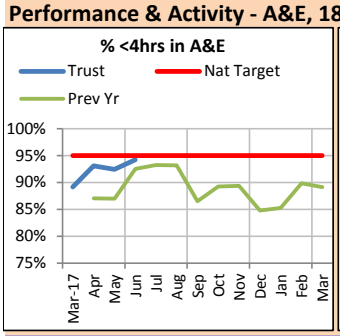


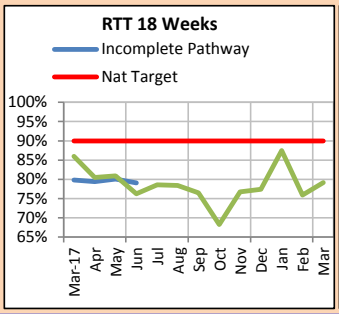


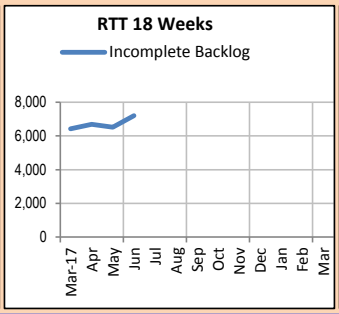


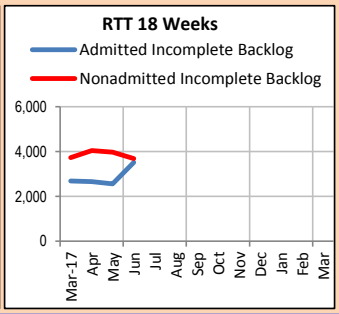
INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

Performance & Activity - A&E, 18 Weeks

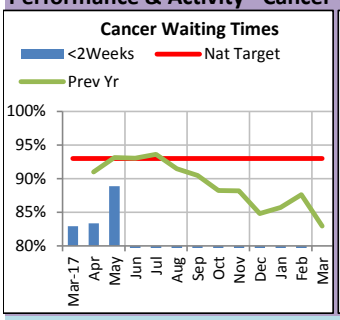


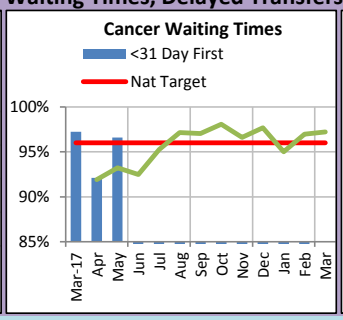


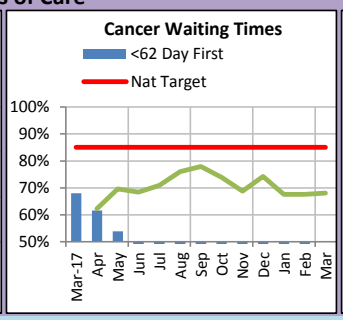


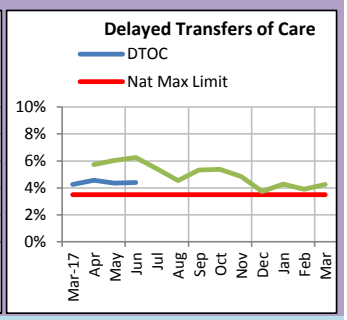


Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care

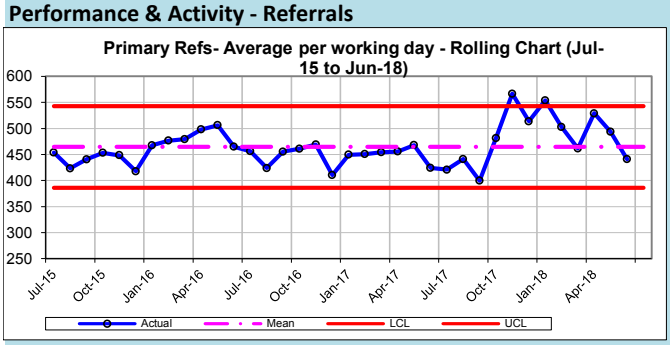


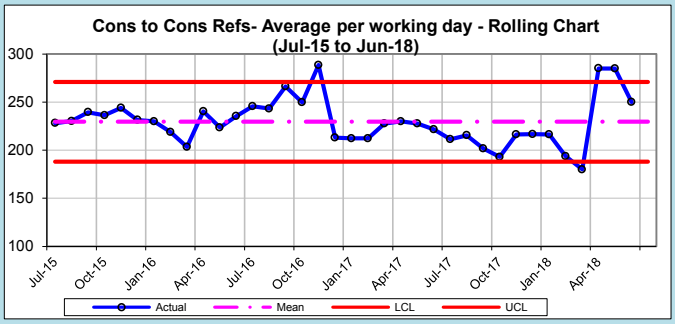




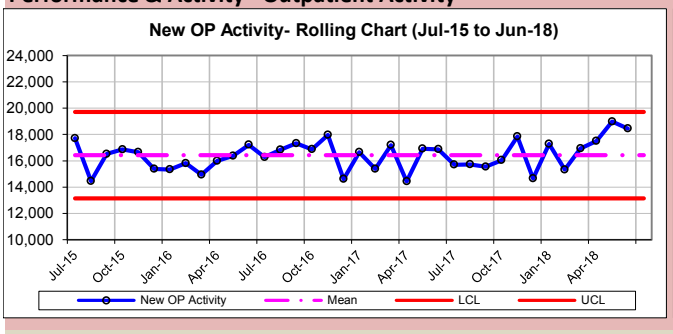


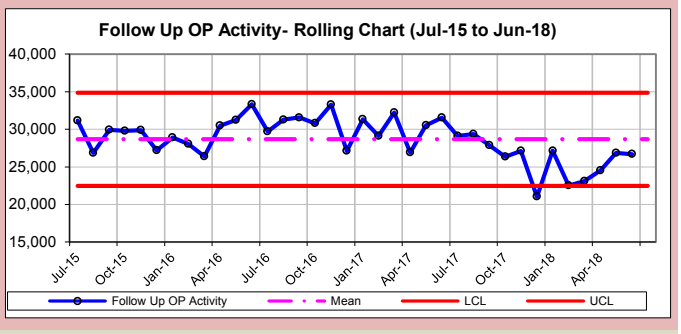
Performance & Activity - Referrals



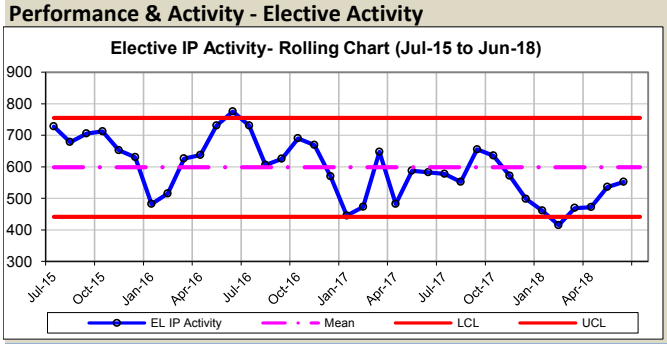


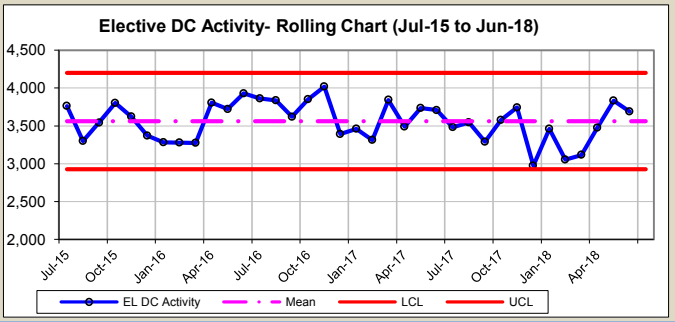
Performance & Activity - Outpatient Activity



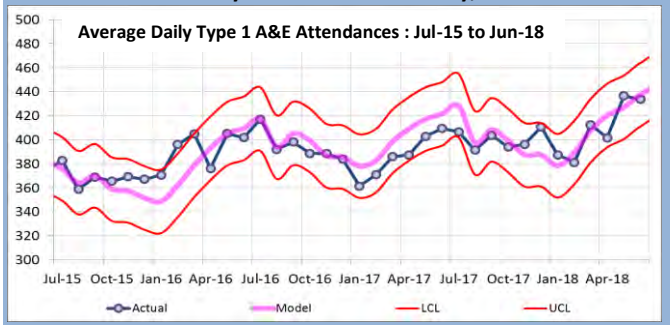


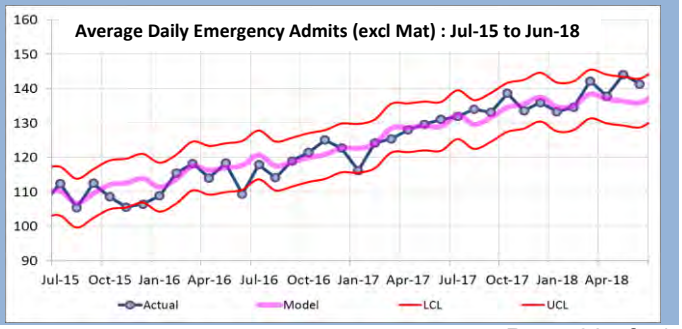
Performance & Activity - Elective Activity





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

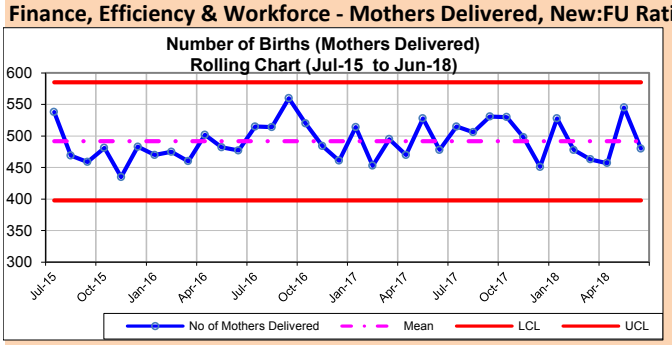


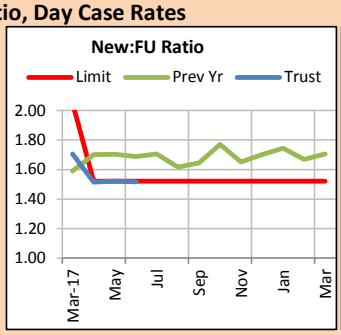


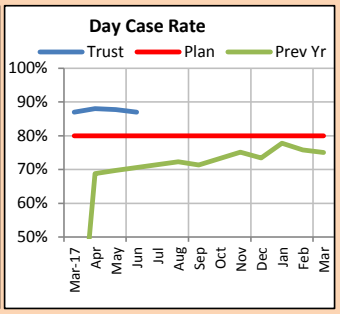
These have been changed to show actual against model, since emergency activity is subject to both growth and seasonal variation. Control limits are 2 standard deviations of variance, so a count outside the control limits will be expected around one month in 20.

INTEGRATED PERFORMANCE REPORT ANALYSIS - FINANCE, EFFICIENCY & WORKFORCE

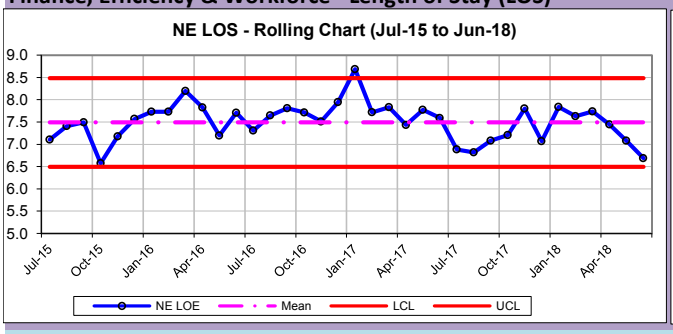
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates

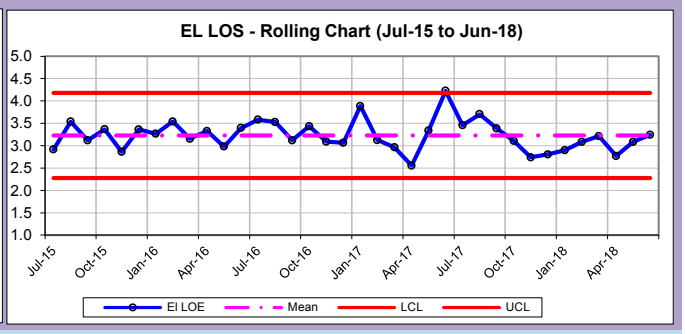




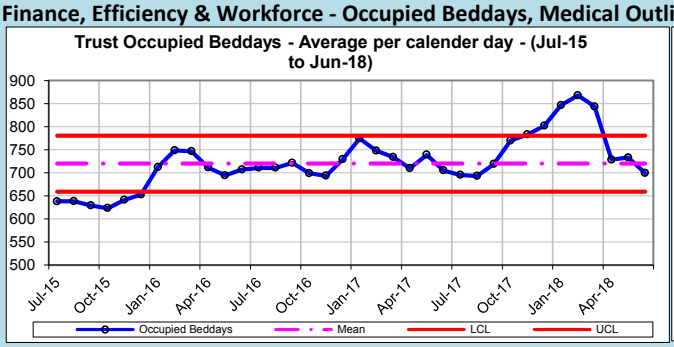


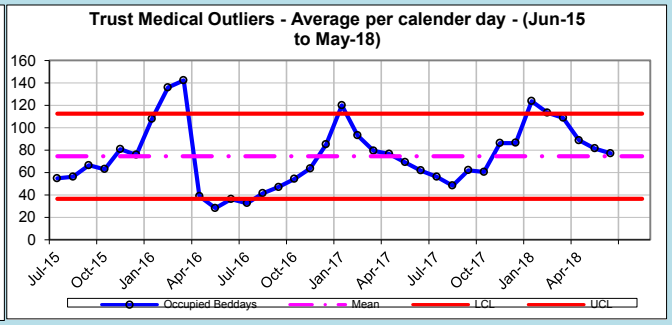
Finance, Efficiency & Workforce - Length of Stay (LOS)



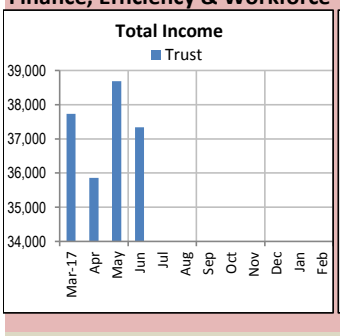


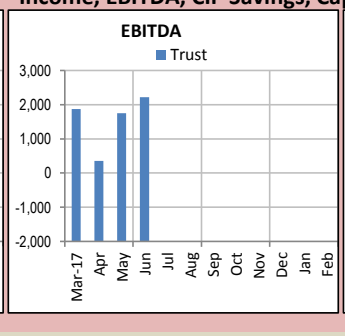
Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

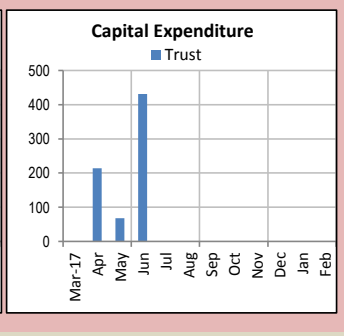




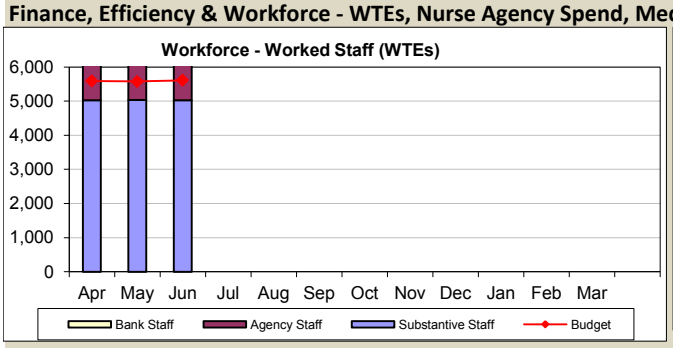
Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure

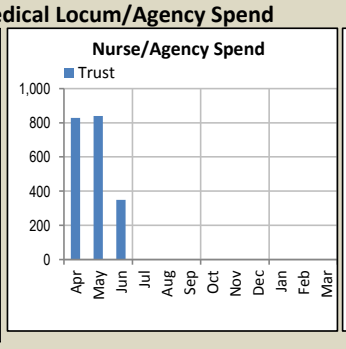


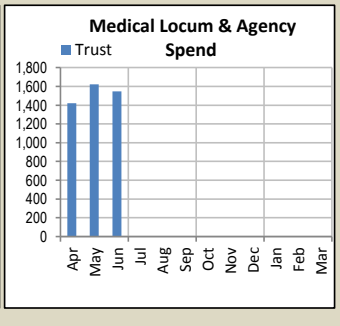




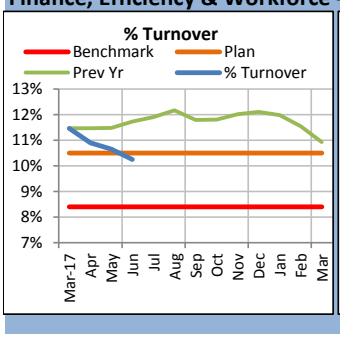
Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend

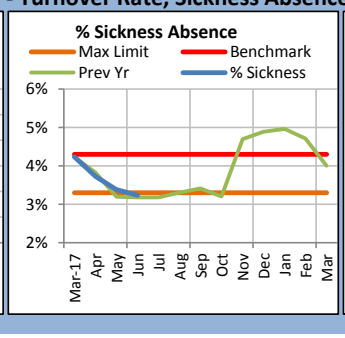


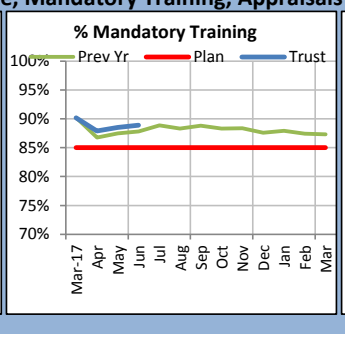


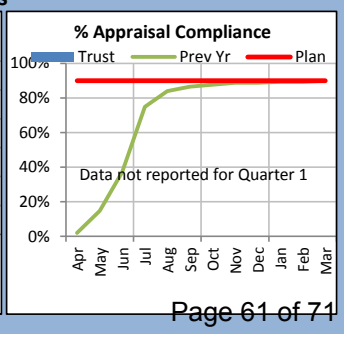


Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals









Maidstone and Tunbridge Wells NHS Trust

Trust Board Finance Report

Month 3
2018/19

Maidstone and Tunbridge Wells NHS Trust

Trust Board Finance Report for June 2018

Maidstone and Tunbridge Wells NHS Trust

1a. Dashboard

June 2018/19

	Current Month						Year to Date						Annual Forecast			
	Actual £m	*Plan* £m	*Variance* £m	Pass-through £m	*Revised Variance* £m	*RAG*	*Actual* £m	*Plan* £m	*Variance* £m	Pass-through £m	*Revised Variance* £m	*RAG*	*Actual* £m	*Plan* £m	*Variance* £m	*RAG*
Income	37.3	38.2	(0.8)	(0.4)	(0.4)		111.9	111.9	(0.0)	0.2	(0.2)		466.8	466.8	0.0	
Expenditure	(35.1)	(35.9)	0.8	0.4	0.4		(107.6)	(107.5)	(0.0)	(0.2)	0.2		(427.9)	(427.9)	0.0	
EBITDA (Income less Expenditure)	2.2	2.2	(0.0)	0.0	(0.0)		4.3	4.4	(0.1)	0.0	(0.1)		38.9	38.9	0.0	
Financing Costs	(2.5)	(2.5)	(0.0)	0.0	(0.0)		(7.6)	(7.6)	(0.0)	0.0	(0.0)		(28.2)	(28.2)	0.0	
Technical Adjustments	0.0	0.0	0.0	0.0	0.0		0.1	0.0	0.1	0.0	0.1		1.0	1.0	0.0	
Net Surplus / Deficit (Incl PSF)	**(0.3)**	**(0.3)**	**(0.0)**	**0.0**	**(0.0)**		**(3.2)**	**(3.2)**	**0.0**	**0.0**	**0.0**		**11.7**	**11.7**	**0.0**	
CIPs	0.9	1.0	(0.1)		(0.1)		2.6	3.0	(0.4)		(0.4)		24.0	24.0	0.0	
Cash Balance	13.4	12.5	0.9		0.9		13.4	12.5	0.9		0.9		1.0	1.0	0	
Capital Expenditure	0.4	0.6	(0.1)		(0.1)		0.7	1.4	(0.7)		(0.7)		13.8	13.8	0	
Capital service cover rating							4	4					4	4		
Liquidity rating							4	4					4	4		
I&E margin rating							4	4					1	1		
Agency rating							4	4					4	4		
Finance and use of resources rating Excl FSM Override							3	3					3	3		

Summary:

- The Trusts deficit including PSF was £0.3m in June which was on plan. Year to date the Trust has a deficit of £3.2m which is on plan however he key variances within plan are: CIP slippage £0.4m, overspends against budget (mainly within pay) £0.6m offset by £1m non recurrent benefits
- The Trust has spent £2.1m more than the YTD agency ceiling set by NHSI (£11.8m per annum)
- The Trust has delivered £2.6m savings in the first quarter which is £0.4m adverse to plan

Key Points:

- The Trust resubmitted the plan to NHSI in June, cumulative adjustments have been made in June to reflect changes impacting April and May, as a result the current month variances reflect April and May adjustments distorting the true subjective performance for June.
- The Trust had a normalised run rate deficit in June of £1.8m which was an improvement of £0.3m between months however this is £1.5m higher than the planned deficit for July (£0.3m).

Risks:

- The Trust is forecasting to deliver its financial plan but has potential risks of £11.3m. The main risks include: £5.1m risk adjusted CIP shortfall, £4.5m pay pressures, £0.9m non pay pressure (mainly within T&O and Diagnostics) and £0.9m income pressures. The Trust is taking actions to control these risks such as the continued management of the CIP programme to fully deliver and budgetary recovery plans to bring pay overspends back to budgets. Should mitigation be necessary the Trust will deploy its contingency, pay investment reserve and other opportunities. The business as usual forecast assumes Prime Provider from October and full delivery of the Estates and Facilities subsidiary (£1.7m) which carry a level of risk.

Maidstone and Tunbridge Wells NHS Trust

1b. Summary Income & Expenditure

Income & Expenditure June 2018/19

	Current Month					Year to Date					Annual Forecast		
	Actual £m	*Plan* £m	*Variance* £m	Pass-through £m	*Revised Variance* £m	*Actual* £m	*Plan* £m	*Variance* £m	Pass-through £m	*Revised Variance* £m	*Actual* £m	*Plan* £m	*Variance* £m
Income	36.6	37.5	(0.9)	(0.4)	(0.5)	109.8	110.0	(0.2)	0.2	(0.4)	454.0	454.0	0.0
Expenditure	(35.9)	(35.9)	0.0	0.4	(0.4)	(108.6)	(107.5)	(1.1)	(0.2)	(0.9)	(427.9)	(427.9)	0.0
Trust Financing Costs	(2.5)	(2.5)	(0.0)	0.0	(0.0)	(7.6)	(7.6)	(0.0)	0.0	(0.0)	(28.2)	(28.2)	0.0
Technical Adjustments	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.1	0.0	0.1	1.0	1.0	0.0
Net Revenue Surplus / (Deficit) before Exceptional Items	**(1.8)**	**(0.9)**	**(0.9)**	**0.0**	**(0.9)**	**(6.4)**	**(5.1)**	**(1.3)**	**0.0**	**(1.3)**	**(1.0)**	**(1.0)**	**0.0**
Exceptional Items	0.9		0.9		0.9	1.3		1.3		1.3			0.0
Net Position	**(0.9)**	**(0.9)**	**(0.0)**	**0.0**	**(0.0)**	**(5.1)**	**(5.1)**	**0.0**	**0.0**	**0.0**	**(1.0)**	**(1.0)**	**0.0**
PSF Funding	0.6	0.6	0.0	0.0	0.0	1.9	1.9	0.0	0.0	0.0	12.7	12.7	0.0
Net Revenue Surplus / (Deficit) Incl PSF and Exceptional Items	(0.3)	(0.3)	(0.0)	0.0	(0.0)	(3.2)	(3.2)	0.0	0.0	0.0	11.7	11.7	0.0

Key messages:
The Trust had to release £0.9m of exceptional items in the month (£1.3m YTD) to help manage the position back to the control total, these were non recurrent one off benefits.

Income:
Income net of pass-through related costs is £0.4m adverse to plan, Private Patient income £0.2m and Provider to Provider SLA income £0.1m are the main areas of overspend.

Expenditure:
Overspending against pay budgets remains the main pressure, to date excluding CIP slippage and non recurrent exceptional items Medical budgets have overspent by £0.5m and Nursing by £0.3m.

Exceptional Items: Exceptional items of £0.9m were released in the month, £625k relating to 2017/18 provisions, £177k release of demographic growth non pay reserve, £63k release of contingency to fund YTD 4 Eyes costs and £50k income for 3 months East Sussex AIC Risk reserve.

Reserves: The Trust is currently holding £1.8m of reserves YTD, £1.2m within Pay and £0.6m in Non Pay.

Maidstone and Tunbridge Wells NHS Trust

2a. Income & Expenditure

Income & Expenditure June 2018/19

	Current Month					Year to Date					Annual Forecast		
	Actual £m	*Plan* £m	*Variance* £m	Pass-through £m	*Revised Variance* £m	*Actual* £m	*Plan* £m	*Variance* £m	Pass-through £m	*Revised Variance* £m	*Actual* £m	*Plan* £m	*Variance* £m
Clinical Income	29.0	29.0	(0.0)	0.1	(0.1)	85.6	85.2	0.4	0.1	0.3	352.4	352.4	0.0
High Cost Drugs	3.4	3.9	(0.5)	(0.5)	0.0	11.0	11.0	(0.0)	(0.0)	(0.0)	43.2	43.2	0.0
Total Clinical Income	**32.3**	**32.8**	**(0.5)**	**(0.4)**	**(0.1)**	**96.6**	**96.2**	**0.4**	**0.1**	**0.3**	**395.6**	**395.6**	0.0
PSF	0.6	0.6	0.0	0.0	0.0	1.9	1.9	0	0	0	12.7	12.7	0
Other Operating Income	4.4	4.7	(0.3)	(0.0)	(0.3)	13.4	13.8	(0.4)	0.1	(0.5)	58.5	58.5	0.0
Total Revenue	37.3	38.2	(0.8)	(0.4)	(0.4)	111.9	111.9	(0.0)	0.2	(0.2)	466.8	466.8	0.0
Substantive	(18.4)	(19.1)	0.7	0.0	0.7	(55.3)	(56.2)	0.9	0.0	0.9	(224.6)	(224.6)	0
Bank	(1.0)	(1.0)	(0.1)	0.0	(0.1)	(3.1)	(2.9)	(0.2)	0	(0.2)	(11.9)	(11.9)	0
Locum	(0.5)	(0.4)	(0.1)	0.0	(0.1)	(1.6)	(1.3)	(0.2)	0	(0.2)	(5.5)	(5.5)	0
Agency	(1.7)	(1.7)	(0.1)	0.0	(0.1)	(5.9)	(5.1)	(0.8)	0	(0.8)	(22.2)	(22.2)	0
Pay Reserves	(0.2)	(0.2)	(0.0)	0.0	(0.0)	(0.7)	(0.7)	(0.0)	0	(0.0)	(2.3)	(2.3)	0
Total Pay	(21.9)	(22.4)	0.5	0.0	0.4	(66.6)	(66.2)	(0.4)	0.0	(0.4)	(266.5)	(266.5)	0
Drugs & Medical Gases	(4.3)	(4.4)	0.1	0.5	(0.4)	(13.3)	(13.7)	0.4	0.0	0.3	0.0 (52.0)	(52.0)	0
Blood	(0.2)	(0.2)	0.0	0.0	0.0	(0.5)	(0.6)	0.1	0	0.1	(2.4)	(2.4)	0
Supplies & Services - Clinical	(2.7)	(2.6)	(0.1)	(0.1)	0.0	(8.2)	(7.8)	(0.4)	(0.1)	(0.2)	(31.9)	(31.9)	0
Supplies & Services - General	(0.4)	(0.4)	0.0	0.0	0.0	(1.3)	(1.4)	0.1	0	0.1	(5.0)	(5.0)	0
Services from Other NHS Bodies	(1.1)	(0.8)	(0.3)	(0.4)	0.0	(2.3)	(2.4)	0.1	0.0	0.1	(9.9)	(9.9)	0
Purchase of Healthcare from Non-NHS	(0.2)	(0.3)	0.1	0.1	0.0	(0.9)	(0.8)	(0.1)	0.0	(0.1)	(5.1)	(5.1)	0
Clinical Negligence	(1.6)	(1.6)	(0.0)	0.0	(0.0)	(4.8)	(4.8)	(0.0)	0	(0.0)	(19.0)	(19.0)	0
Establishment	(0.2)	(0.3)	0.1	0.0	0.0	(0.9)	(0.9)	0.0	(0.0)	0.0	(3.5)	(3.5)	0
Premises	(1.8)	(1.9)	0.1	0.0	0.1	(5.5)	(5.7)	0.2	0.0	0.2	(20.9)	(20.9)	0
Transport	(0.2)	(0.1)	(0.0)	0.0	(0.0)	(0.5)	(0.4)	(0.1)	0	(0.1)	(1.3)	(1.3)	0
Other Non-Pay Costs	(0.3)	(0.6)	0.4	0.2	0.1	(2.3)	(2.3)	0.0	(0.1)	0.1	(8.2)	(8.2)	0
Non-Pay Reserves	(0.2)	(0.1)	(0.0)	0.0	(0.0)	(0.6)	(0.6)	0.0	0	0.0	(1.9)	(1.9)	0
Total Non Pay	(13.2)	(13.5)	0.3	0.4	(0.1)	(40.9)	(41.3)	0.3	(0.2)	0.6	(161.3)	(161.3)	0
Total Expenditure	(35.1)	(35.9)	0.8	0.4	0.4	(107.6)	(107.5)	(0.0)	(0.2)	0.2	(427.9)	(427.9)	0
EBITDA	2.2	2.2	(0.0)	0.0	(0.0)	4.3	4.4	(0.1)	0.0	(0.1)	38.9	38.9	0
	0.0	*0.0*	*0.0*	*%*		*3.9%*	*3.9%*	*271.9%*	*0.0%*	*25.6%*	*8.3%*	*8.3%*	
Depreciation	(1.1)	(1.1)	(0.0)	0	(0.0)	(3.4)	(3.3)	(0.0)	0.0 0	(0.0) (0.0)	(13.5)	(13.5)	0
Interest	(0.1)	(0.1)	(0.0)	0	(0.0)	(0.4)	(0.4)	(0.0)	0	(0.0)	(1.6)	(1.6)	0
Dividend	(0.1)	(0.1)	0.0	0	0	(0.3)	(0.3)	0	0	0	(1.3)	(1.3)	0
PFI and Impairments	(1.2)	(1.2)	(0.0)	0	(0.0)	(3.6)	(3.6)	(0.0)	0	(0.0)	(11.9)	(11.9)	0
Total Finance Costs	(2.5)	(2.5)	(0.0)	0.0	(0.0)	(7.6)	(7.6)	(0.0)	0	(0.0)	(28.2)	(28.2)	0
Net Surplus / Deficit (-)	(0.3)	(0.3)	(0.0)	0.0	**(0.0)**	(3.3)	(3.2)	(0.1)	0.0	(0.1)	10.7	10.7	0.0
Technical Adjustments	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.1	0.0	0.1	1.0	1.0	0.0
Surplus/ Deficit (-) to B/E Duty Incl PSF	(0.3)	(0.3)	(0.0)	0.0	**(0.0)**	(3.2)	(3.2)	0.0	0.0	0.0	11.7	11.7	0.0
Surplus/ Deficit (-) to B/E Duty Excl PSF	(0.9)	(0.9)	(0.0)	0.0	**(0.0)**	(5.1)	(5.1)	0.0	0.0	0.0	(1.0)	(1.0)	0.0

Commentary

The Trusts deficit including PSF was £0.3m in June which was on plan, year to date the Trust has a deficit of £3.2m which is on plan the key variances to plan are: CIP slippage £0.4m, overspends against budget (mainly within pay) £0.6m offset by £1m non recurrent benefits.

The Trust's normalised pre PSF run rate in June was a deficit of £1.8m, an improvement of £0.3m compared to last month. The main normalised adjustments in June related to £0.6m release of 2017/18 accrual provisions, £0.2m release of YTD demographic growth reserve and £50k income assumption for East Sussex AIC risk reserve.

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 £0.1m adverse to plan in June. The key favourable variances in June were Non-Electives (£0.7m), A&E (£0.1m) and Adult Critical Care (£0.1m) offset by adverse variances in Electives (£0.3m) and an adverse adjustment of £0.6m relating to the aligned incentive contract.

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

Other Operating Income is £0.3m adverse to plan in the month, the main adverse item related to Education income (£0.2m), £0.1m is due to a cumulative plan adjustment and £0.1m to correct the YTD Medical education income.

Pay was £0.4m favourable in the month although after adjusting for previous months plan adjustment pay was adverse by £0.2m. The normalised pay spend has increased between years by £2.1m (3.3%) , the main increase is within Medical staffing which has increased by £1.7m (9%).

Non Pay adjusted for pass through costs was overspent by £0.1m in June this was mainly due a cumulative plan adjustment mainly impacting the drug budget. The Trust is £0.6m favourable year to date which is due to £0.3m underspend on drugs and £0.3m release of 2017/18 year end provisions.

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

Maidstone and Tunbridge Wells NHS Trust

3a. Run Rate Analysis

Analysis of 13 Monthly Performance (£m's)

		Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Change between Months
Revenue	Clinical Income	32.3	32.1	31.2	32.6	31.3	31.2	31.7	32.0	31.2	33.8	30.7	33.5	32.3	(1.2)
	STF	0.6	0.3	0.0	2.2	0.0	0.0	0.0	0.0	0.0	3.0	0.6	0.6	0.6	0.0
	High Cost Drugs	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)
	Other Operating Income	3.5	4.3	4.5	4.1	3.8	3.4	3.8	4.0	5.7	3.9	4.5	4.5	4.4	(0.2)
	Total Revenue	**36.5**	**36.7**	**35.7**	**38.9**	**35.0**	**34.5**	**35.5**	**36.0**	**36.9**	**40.8**	**35.9**	**38.7**	**37.3**	**(1.3)**
Expenditure	Substantive	(18.1)	(17.8)	(17.7)	(17.8)	(17.9)	(18.0)	(17.8)	(17.9)	(17.5)	(17.9)	(18.3)	(18.7)	(18.4)	0.3
	Bank	(0.9)	(0.9)	(0.7)	(1.2)	(1.0)	(0.9)	(1.2)	(1.2)	(1.1)	(1.3)	(1.0)	(1.0)	(1.0)	(0.0)
	Locum	(0.1)	(0.4)	(0.5)	(0.5)	(0.5)	(0.6)	(0.5)	(0.5)	(0.6)	(0.7)	(0.5)	(0.6)	(0.5)	0.1
	Agency	(1.8)	(1.4)	(1.7)	(1.9)	(2.0)	(1.8)	(1.9)	(2.3)	(1.8)	(2.6)	(2.0)	(2.1)	(1.7)	0.4
	Pay Reserves	(0.2)	(0.2)	(0.1)	1.5	(0.2)	(0.2)	(0.2)	(0.2)	(0.3)	(0.2)	(0.2)	(0.2)	(0.2)	(0.0)
	Total Pay	(21.1)	(20.8)	(20.8)	(20.0)	(21.6)	(21.6)	(21.6)	(22.2)	(21.3)	(22.7)	(22.0)	(22.7)	(21.9)	0.7
Non-Pay	Drugs & Medical Gases	(4.6)	(4.2)	(4.8)	(4.1)	(4.4)	(4.5)	(4.2)	(4.5)	(4.3)	(4.5)	(4.2)	(4.8)	(4.3)	0.5
	Blood	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.1)	(0.2)	(0.2)	(0.1)	(0.2)	(0.0)
	Supplies & Services - Clinical	(2.7)	(2.7)	(2.7)	(2.2)	(2.5)	(2.6)	(2.5)	(2.6)	(2.5)	(2.1)	(2.6)	(2.9)	(2.7)	0.2
	Supplies & Services - General	(0.5)	(0.5)	(0.3)	(0.5)	(0.5)	(0.5)	(0.5)	(0.4)	(0.5)	(0.6)	(0.4)	(0.4)	(0.4)	0.0
	Services from Other NHS Bodies	(0.6)	(0.7)	(0.7)	(0.7)	(0.6)	(1.3)	(0.9)	(0.7)	(0.7)	(0.3)	(0.6)	(0.6)	(1.1)	(0.5)
	Purchase of Healthcare from Non-NHS	(0.2)	(0.3)	(0.3)	(0.3)	(0.4)	(0.4)	(0.4)	(0.2)	(0.2)	(0.3)	(0.3)	(0.3)	(0.2)	0.1
	Clinical Negligence	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.6)	(1.6)	(1.6)	(0.0)
	Establishment	(0.3)	(0.3)	(0.2)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.2)	0.1
	Premises	(1.6)	(1.7)	(1.9)	(1.5)	(1.8)	(1.8)	(2.2)	(1.8)	(3.8)	(3.0)	(1.9)	(1.8)	(1.8)	(0.0)
	Transport	(0.1)	(0.1)	(0.1)	(0.1)	(0.2)	(0.1)	(0.1)	(0.2)	(0.1)	(0.2)	(0.2)	(0.2)	(0.2)	0.0
	Other Non-Pay Costs	(0.7)	(1.4)	(1.6)	(0.5)	(1.5)	(0.0)	(1.0)	(1.1)	(1.1)	(0.2)	(1.0)	(1.0)	(0.3)	0.7
	Non-Pay Reserves	(0.1)	0.2	0.0	0.3	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.2)	(0.2)	(0.2)	0.0
	Total Non Pay	(13.5)	(13.6)	(14.4)	(11.7)	(14.1)	(13.4)	(14.2)	(13.7)	(15.4)	(13.2)	(13.5)	(14.3)	(13.2)	1.1
	Total Expenditure	(34.6)	(34.3)	(35.2)	(31.6)	(35.7)	(35.0)	(35.8)	(35.8)	(36.7)	(35.9)	(35.5)	(36.9)	(35.1)	1.8
EBITDA	EBITDA	1.9	2.4	0.4	7.3	(0.6)	(0.5)	(0.3)	0.2	0.2	4.9	0.4	1.8	2.2	0.5
		5%	*6%*	*1%*	*19%*	*-2%*	*-1%*	*-1%*	*1%*	*1%*	*12%*	*1%*	*5%*	*6%*	
Other Finance Costs	Depreciation	(1.2)	(1.2)	(1.2)	(1.2)	(0.8)	(1.1)	(1.0)	(1.2)	(1.1)	(1.2)	(1.1)	(1.1)	(1.1)	(0.0)
	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)	0.5	(0.1)	0.2	(0.1)	(0.1)	(0.1)	0.0
	PFI and Impairments	(1.2)	(1.2)	(1.1)	(1.1)	(1.1)	(1.2)	(5.2)	(1.1)	(1.2)	17.5	(1.2)	(1.2)	(1.2)	(0.0)
	Total Other Finance Costs	**(2.6)**	**(2.6)**	**(2.6)**	**(2.6)**	**(2.2)**	**(2.5)**	**(6.4)**	**(1.9)**	**(2.5)**	**16.3**	**(2.5)**	**(2.5)**	**(2.5)**	**0.0**
Net Surplus / Deficit (-)	Net Surplus / Deficit (-)	(0.7)	(0.2)	(2.2)	4.7	(2.8)	(2.9)	(6.7)	(1.7)	(2.2)	21.2	(2.2)	(0.8)	(0.3)	0.5
Technical Adjustments	Technical Adjustments	0.0	0.0	0.0	0.0	0.0	0.0	4.0	0.0	0.0	(18.9)	0.0	0.0	0.0	0.0
Surplus/ Deficit (-) to B/E Duty Incl STF	Surplus/ Deficit (-) to B/E Duty	(0.7)	(0.2)	(2.1)	4.8	(2.8)	(2.9)	(2.6)	(1.6)	(2.2)	2.3	(2.2)	(0.8)	(0.3)	0.5
Surplus/ Deficit (-) to B/E Duty Excl STF	Surplus/ Deficit (-) to B/E Duty	(1.3)	(0.4)	(2.1)	2.5	(2.8)	(2.9)	(2.6)	(1.6)	(2.2)	(0.7)	(2.8)	(1.4)	(0.9)	0.5

Maidstone and Tunbridge Wells NHS

4a. Cost Improvement Plan

Savings by Division

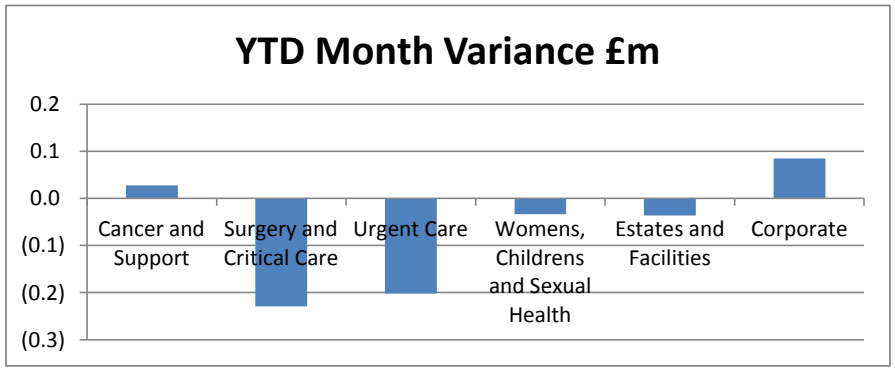
	Current Month			Year to Date			Forecast (Risk Adjusted)		
	Actual	*Original Plan*	*Variance*	*Actual*	*Original Plan*	*Variance*	*Forecast*	*Original Plan*	*Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Cancer and Support	0.10	0.12	(0.02)	0.36	0.33	0.03	1.55	3.01	(1.46)
Surgery and Critical Care	0.38	0.47	(0.09)	1.18	1.41	(0.23)	7.87	11.38	(3.51)
Urgent Care	0.11	0.17	(0.06)	0.31	0.51	(0.20)	1.91	3.37	(1.46)
Womens, Childrens and Sexual Health	0.09	0.11	(0.02)	0.28	0.32	(0.03)	1.80	2.11	(0.31)
Estates and Facilities	0.02	0.07	(0.05)	0.15	0.19	(0.04)	2.83	3.15	(0.32)
Corporate	0.23	0.08	0.14	0.36	0.27	0.08	3.01	1.00	2.01
Total	**0.93**	**1.02**	**(0.10)**	**2.63**	**3.02**	**(0.39)**	**18.96**	**24.01**	**(5.05)**

Savings by Subjective Category

	Current Month			Year to Date			Forecast (Risk Adjusted)		
	Actual	*Original Plan*	*Variance*	*Actual*	*Original Plan*	*Variance*	*Forecast*	*Original Plan*	*Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Pay	0.24	0.35	(0.11)	0.71	1.07	(0.37)	2.57	3.07	(0.50)
Non Pay	0.68	0.62	0.06	1.84	1.79	0.06	8.33	8.40	(0.06)
Income	0.01	0.05	(0.05)	0.09	0.17	(0.08)	8.05	12.55	(4.49)
Total	**0.93**	**1.02**	**(0.10)**	**2.63**	**3.02**	**(0.39)**	**18.96**	**24.01**	**(5.05)**

Savings by Plan RAG

	Current Month			Year to Date			Forecast (Risk Adjusted)		
	Actual	*Original Plan*	*Variance*	*Actual*	*Original Plan*	*Variance*	*Forecast*	*Original Plan*	*Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Green	0.92	0.93	(0.01)	2.59	2.81	(0.22)	14.77	16.99	(2.22)
Amber	(0.02)	0.06	(0.09)	0.01	0.11	(0.10)	1.51	2.73	(1.21)
Red	0.04	0.04	(0.00)	0.04	0.11	(0.07)	2.68	4.30	(1.62)
Total	**0.93**	**1.02**	**(0.10)**	**2.63**	**3.02**	**(0.39)**	**18.96**	**24.01**	**(5.05)**



Comment

The Trust was £0.1m adverse to plan in the month and £0.4m adverse YTD. The main schemes adverse to plan are:
- STP Medical Rates £0.3m
- Reduction in Out Sourcing £0.1m

The Trusts risk adjusted savings forecast is £5m adverse to plan, the main schemes forecasting slippage are:
- Private Patient Income = £1m
- STP Medical Rates = £1.5m
- Medicines Management = £0.9m
- Prime Provider (Delay to October) = £0.5m

The forecast assumes full delivery (£1.7m) relating to Estates and Facilities subsidiary

Maidstone and Tunbridge Wells NHS Trust

5a. Balance Sheet

June 2018

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

	June			May
£m's	**Reported**	**Plan**	**Variance**	**Reported**
Property, Plant and Equipment (Fixed Assets)	291.7	292.2	(0.5)	292.4
Intangibles	2.5	2.4	0.1	2.5
PFI Lifecycle	0.0	0.0	0.0	0.0
Debtors Long Term	1.2	1.3	(0.1)	1.2
Total Non-Current Assets	**295.4**	**295.9**	**(0.5)**	**296.1**
Current Assets	0.0	0.0	0.0	0.0
Inventory (Stock)	7.7	8.2	(0.5)	7.6
Receivables (Debtors) - NHS	21.9	23.9	(2.0)	20.0
Receivables (Debtors) - Non-NHS	16.0	13.6	2.4	12.3
Cash	13.4	12.5	0.9	20.2
Assets Held For Sale	0.0	0.0	0.0	0.0
Total Current Assets	**59.0**	**58.2**	**0.8**	**60.1**
Current Liabilities				
Payables (Creditors) - NHS	(4.6)	(6.5)	1.9	(4.3)
Payables (Creditors) - Non-NHS	(38.5)	(35.1)	(3.4)	(36.7)
Deferred Income	(17.7)	(18.8)	1.1	(21.4)
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)	(5.1)	0.1	(5.0)
Provisions for Liabilities and Charges	(1.8)	(1.8)	0.0	(1.8)
Total Current Liabilities	**(86.8)**	**(86.5)**	**(0.3)**	**(88.4)**
Net Current Assets	(27.8)	(28.3)	0.5	(28.3)
Borrowings - PFI > 1yr	(191.8)	(191.9)	0.1	(192.2)
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	(1.0)	(1.0)	0.0	(0.6)
Provisions for Liabilities and Charges- Long term	(1.1)	(1.0)	(0.1)	(1.0)
Total Assets Employed	**37.5**	**37.5**	**0.0**	**37.8**
Financed By:				
Capital & Reserves				
Public dividend capital	207.3	207.3	0.0	207.3
Revaluation reserve	29.8	29.8	0.0	29.8
Retained Earnings Reserve	(199.6)	(199.6)	0.0	(199.3)
Total Capital & Reserves	**37.5**	**37.5**	**0.0**	**37.8**

Commentary:
The month 3 balance sheet position is consistent with the plan that was submitted in April. The overall working capital within the month results in a small increase of both debtors and creditors compared to the plan, and an increase in the 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 3 capital spend is £0.7m against a plan of £1.5m.

Current Assets -
Inventory of £7.7m is a reduction from the planned value. The main stock balances are pharmacy £3.2m, TWH theatres £1.5m, Materials Management £1.1m and Cardiology £0.6m.
NHS Receivables have increase from the month 2 position by £1.9m to £21.9m. The increase is primarily due to raising Qtr 2 PFI support to NHS England of £2m. Of the £21.9m reported balance, £12.5m relates to invoiced debt of which £4.1m is aged debt over 90 days. Invoiced debt over 90 days has increased slightly by £0.2m from the mth 2 reported position. The remaining £9.4m 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 £3.7m to £16m from the month 2 reported position. Included within the £16m balance is trade invoiced debt of £2.4m and private patient invoiced debt of £0.8m. Prepayments and accrued income totalling £10.7m. Prepayments primarily relate to rates & annual service maintenance contracts, which will reduce throughout the year as they are expensed.
The cash balance of £13.4m is higher than plan by £0.9m, this was due to KCC paying both mth 1 and 2 sexual health invoices of £0.7m against the plan expectation of July.

Current Liabilities -
NHS payables have increased from the May's reported position by £0.3m. Non-NHS trade payables have also increased by £1.8m to £38.5m.

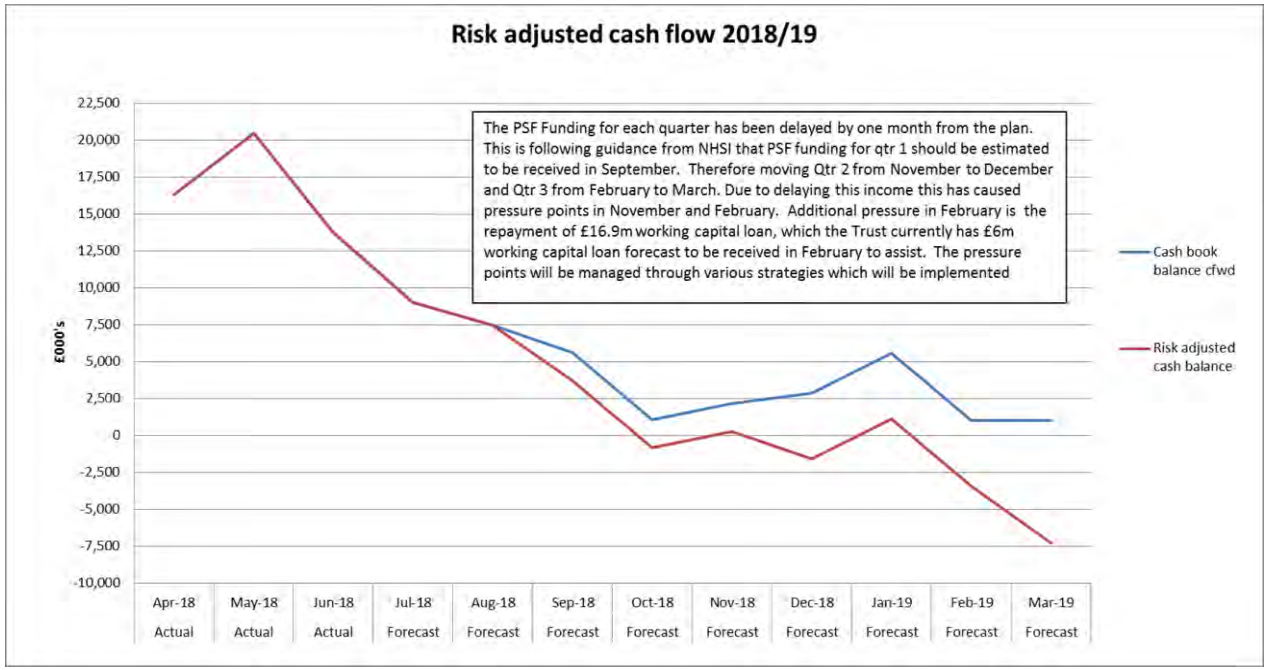
Of the £43.1m combined payables balances, £14.1m relates to actual invoices and £29m relates to uninvoiced accruals. The accruals include expected values for tax , NI, Superannuation and PDC payments.
Deferred income of £17.7m primarily is in relation to c£14.8m advanced contract payment received from WK CCG in April, which reduces by £2.28m over each of 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 19, 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 3 are consistent with the plan.

Maidstone and Tunbridge Wells NHS Trust

5b. | Cash Flow



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.

Following advice from NHSI, PSF funding for qtr1 was moved from the planned date of June to September. Therefore Qtr 2 has been moved from November to December and Qtr 3 from February to March. The delay in receiving this income puts additional pressure in November and February. Therefore strategies to assist these two pressure points will be implemented commencing from August. This is why the cash balance cfwd is slightly higher than the plan value in some months.

The risk adjusted items relate to:

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

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 further working capital financing of £6m. If the PSF funding is not received and if the I&E position move adversely from the plan, the Trust will need to implement strategies to ensure the loan can be repaid before increasing the value of the working capital loan request.

in respect to all of the risk items which relate to capital including the planned asset sales of £2.4m. If the income or external financing are not received the associated expenditure will not happen.

Information on loans:

Information on loans:	Rate	Value £m's	18/19 Annual Repayment £m's	18/19 Annual Interest Paid £m's	Repayment Date
Revenue loans:					
Interim Single Currency Loan	3.50%	16.908	0.00	0.25	18/02/2019
Interim Revolving Working Capital Facility (IRWCF)	3.50%	12.132	0.00	0.43	19/10/2019
interim working capital loans	3.50%	13.990	0.00	0.49	18/03/2021
Capital loans:					
Capital investment loan	2.02%	12.000	1.20	0.06	15/09/2020
Capital investment loan	3.91%	11.000	0.73	0.19	15/19/2025
Capital investment loan	0	6.000	0.24	0.16	15/19/2035
Other loans:					
Salix loan (interest free) £1.2m to be rec in 18/19	0	1.083	0.15	0.00	01/04/2024

Maidstone and Tunbridge Wells NHS Trust

6a. Capital Programme

Capital Projects/Schemes

	Year to Date			Annual		
	Actual	*Plan*	*Variance*	*Plan*	*Forecast*	*Variance*
	£000	£000	£000	£000	£000	£m
Estates	498	465	-33	5,788	5,788	0
ICT	97	250	153	1,002	1,002	0
Equipment	119	651	532	6,501	6,469	32
PFI Lifecycle (IFRIC 12)	0	0	0	471	471	0
Donated Assets	0	125	125	700	700	0
Total	**713**	**1,491**	**778**	**14,462**	**14,430**	**32**
Less donated assets	0	-125	-125	-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
Adjusted Total	**713**	**1,366**	**653**	**11,360**	**11,328**	**32**

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; national funding for the next replacement Linac of £1.7m (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 has an approved Salix loan of £755k for Phase 4 and agreement from DH to provide the necessary Capital resource cover is being obtained by NHSI. A further loan application will be made at a later stage.

The ICT schemes have been prioritised and approved by the ISG in principle but will require IAG Business case sign off. The prioritised list of equipment schemes was approved by TME and Execs, subject to individual Business case approval. Linac 4 replacement at Maidstone was delivered in early May and commissioning the equipment has begun and will be ready for clinical use by Oct 18. Linac 5 replacement funding has now been agreed with NHSE as additional PDC from the national programme. The donated equipment plan is mainly made up of the remaining Cardiology legacies, and a large donation for Urology/Oncology equipment.

The Trust is forecasting an underspend of £32k which relates to the purchase of a linac, the final cost was £32k less than planned which was then matched with the PDC funding.

Trust Board meeting - July 2018

Maidstone and Tunbridge Wells NHS Trust

7-11 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.) [1]

Information

[1] 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

NHS
Maidstone and Tunbridge Wells
NHS Trust

MTW Best Care
exceptional people, outstanding care

Trust Board
July 2018

Content

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    a. Executive Summary
    b. Financial Summary

2. Workstream Update
    a. Best Quality
    b. Best Safety
    c. Best Workforce
    d. Best Use of Resources
    e. Best Patient Flow

1. Executive Summary

1a. Best Care Programme - Executive Summary Update

July Area of Focus – Best Patient Flow Workstream	Workstreams
KEY PROGRESS LOS Reduction Surgery reduction of 1.0 days T&O reduction of 2.5 days, predominately due to successful implementation of #NOF pathway Medicines LOS Target set at 9.4 days. Patients over the age of 75 average LOS is 11 days. Review of proposal to extend Ambulatory Pathways/ Frailty units and implementation of Virtual Ward to increase zero LOS and reduce ALOS. Super stranded patients reduction from 154 in November 2017 to 110 in June 2018 Private Patients - Ambulatory/Day case capacity released to support Phase 1, phase 2 will require IP beds, subject to modelling. Prime Provider – additional admin resources out to advert. Resources - Funding for 21 additional operational resources approved to support the Patient Flow Workstream.	**KEY PROGRESS** Best Quality – Complex Needs/Transition – data gathered identified 70 young people (16/17) in adult wards. Level 3 Safeguarding training being reviewed, aim to target key wards. Best Safety – Acute Kidney Injury (AKI) – AKI Nursing team have provided significant assurance/progress. GIRFT Trust wide process implemented to support the increase in GIRFT programmes. Best Use of Resources - Procurement schemes over performance in Qtr 1. Medicine Management identified a number of schemes that would require agreement from NHSE in terms of allocation of the savings. Best Workforce – Medical Locum personalised plans completed, confirmation received that one candidate has accepted proposal
KEY RISKS Supporting additional Private Patients and Prime Provider capacity. Modelling near completion, including monthly trajectories for IP beds, Day case, Theatre Utilisation, Cases per session, cases per day, Outpatients demand/capacity to support operational contract activity, including winter pressures , private patients and prime provider	**KEY RISKS** Best Quality – Workshop scheduled for 3rd August to identify schemes to support the target increase in October. Best Safety – 7 Day Service – further work required with Urgent Care with regards to link with Clinical Strategy reviews. Best Use of Resources – Avastin - Judicial review results may not be released until September. NHSE may not accept proposal for Medical Management savings. Best Workforce – Continue to exceed breakglass on medical locums and pace in reducing non-framework usage

1b.Best Care Programme - Financial Summary

Comment

The Trust year to date has delivered £2.6m savings which is £0.36m adverse to plan, this is mainly due to STP Medical rate slippage (£0.36m),Outsourcing reduction slippage (£0.083m), but over performance of procurements schemes by £0.08m.

Best Patient Flow :

YTD Plan	-	£561K
YTD Actuals	-	£478K
Variance	-	£83k

Slippage relating to outsourcing reduction within T&O, however position improved in month 3 compare d to month 1 and 2.

Best Workforce:

YTD Plan	-	£730K
YTD Actuals	-	£373K
Variance	-	£357k

Slippage relating to not achieving the STP Medical locum rate reduction

Best Quality YTD financial position are on target, and over performance by **Best Use of Resource** of £80k

2. Workstream Summary

Maidstone and Tunbridge Wells NHS Trust

2a.Best Quality

The Best Quality workstream has worked with colleagues from across the Trust to help identify four key areas of work that can really transform our patient and staff experience.

While the workstream is focused on a number of important and quite specific clinical improvements, it is also the conduit for developing new strategies for patient, staff and public engagement that support and enable future change.

The projects include:

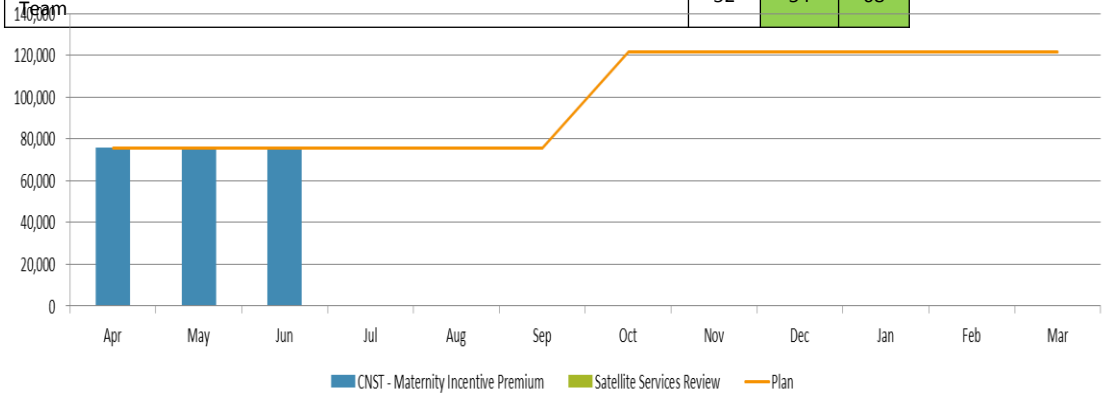
- **Complex Needs**
- **Quality Improvements**
- **Engagement and Experience**
- **Effectiveness and Excellence**

WORKSTREAM	Best Quality	BEST CARE BOARD DATE	June 2018
WORKSTREAM LEAD	JOHN KENNEDY	PMO SUPPORT	VINCE ROOSE / HANNAH PEARSON

PROJECTS	MILESTONE ACTUAL	DELIVERY RAG		FORWARD VIEW: KEY MILESTONES TO TAKE PLACE IN THE NEXT 4 WEEKS
		LAST MONTH	THIS MONTH	
Complex Needs	**Delirium** - snapshot delirium audit has taken place to determine resource requirement for project Audit showed 8% of patients at TWH & 6% of patients at Maidstone had a delirium diagnosis on 16/5/18. **Transition** - data gathered regarding admission of 16/17 year olds across MTW for past 2 years. Daily reporting option being progressed allowing for daily monitoring of safeguarding risks and weekly KPIs. Neighbouring Trust's admission criteria analysed and compared to MTW admission criteria – all Trusts, like MTW, currently admit until 16th Birthday Decision to focus on diabetes in the first instance because of complexity associated with specialist providers in cystic fibrosis. **Dementia:** Cross referencing PID and objectives with Quality Strategy ensuring that objectives align Dementia Strategy group met 15/05/2018 and continues to meet every other month. Dementia Incidents report went to TCGC – April 2018. Preliminary conversations had to identify dementia patients and their carers' to represent on patient experience groups/PLACE audits. Ongoing audit of patients admitted from Nursing and Residential Homes to ascertain frequent admissions. **MCA/DoLS:** MCA policy and procedure up for review – being reviewed Investigating training options involving KCC/Capsticks			**Delirium:** Identification of project objectives and scope (ie restrict to specific group or include all pts with diagnosis of delirium). **Transition** Electronic solution for daily monitoring of 16/17 year old admission 'Transition wards' to be identified so that Safeguarding champions can begin to be appointed – starting on these wards – liaising with site practitioners. Equate how many bed days these 700 16/17 year olds are holding Engagement with Kent Youth Forum to gain user opinion **Dementia:** Confirm if Trust would be willing to support a drop in/nurse led clinics Scope the requirement for drop in / nurse led clinics from stakeholders e.g. People with dementia / carers; GP's. Scope the requirement of emergency services colleagues for information / training re: support services to manage people with dementia and their carers'. **MCA** MCA policy revision going to safeguarding committee in June MCA Deep dive taking place at Quality Committee in June
Experience and Engagement	**PPEE (Pateint and Public Experience and Engagement)**; Scoping exercise (on-going) to develop and establish wider engagement community – identifying local groups, networks, memberships. Engaging local healthwatch to support MTW to identify and generate relationship leads with protected characteristic groups and seldom heard communities Engage Kent drafted plan & quote **Staff Engagement** X2 crowdfixing events held., plus several focus groups. Nurse retention plan developed and submitted to NHSI Draft leadership behaviours proposal submitted MTW branding agreed			**PPEE** – confirm venues for engagement events in September and November and send invites to patient , carer and public rep groups. Agree preferred option for future patient representation and governance. Target participants for invitation and sign off draft invitation ready for sending in July. Add further patient and public group contacts to database. Incorporate pilot work with Healthwatch focusing on patients with Parkinsons and medicines management into plan Ensure GDPR compliance with members and other known groups with a confirmed 'opt in' approach **Staff Experience and Engagement** Develop detailed implementation plan for strategy identifying milestones and responsibilities by month Awaiting publication of leadership behavious
Quality Improvement	• Trust transition from project group to Quality Improvement Committee (QIC) for BAU management of CQC and first committee meeting held. • Committee established, TOR agreed and governance through Best Care Programme board / TCGC • Trust "How to guide" developed • QIC scheduled 2018 / 2019. • Internal assurance inspection process reviewed and updated. Documentation streamlined and inspection plan includes immediate debrief for inspection team to write report and disseminate to areas in a timely manner.			Relaunch Corporate Quality rounds – agree focus areas at QIC Amended tracker for presentation to executives 17.07.18 Strengthen wider engagement with the QI committee
Effectiveness and Excellence	**CNST** - Compliance with the 10 stds confirmed, approved at Board and submitted to NHSR **Crowborough** – numbers of additional births identified with month on month stretch targets agreed. **CQIUNS –** Risky behaviours project meeting held, **#EndPJParalysis:** Champions identified for specialist medicine wards on both sites Presentation given to Trust Board 22/05/2018 Successful roll out on wards: Edith Cavell, Mercer, Whatman, Chaucer, Stroke unit, W20 & W22 – acute areas to follow in the next 2 weeks. Averaging 15-18 patients each ward getting dressed and 18-20 up and moving 11 volunteers recruited **Criteria Led Discharge :** Background work done with Matrons – senior review with corporate nursing team			**Maternity Safer Births / CNST** – secure June Trust Board sign off of NHS Resolution compliance declaration and submit to NHS Resolution on 29 June **Crowborough** – Confirm impact of aligned incentive scheme in relation to additional births **CQUINS:** Confirmation of PMO support / Production of plan to deliver CQUINS **#EndPJParalysis:** Analysis of data on pilot wards – e.g. falls / LOS / Readmission rates / pressure ulcers / complaints / Successful roll out on all Specialist Medicine wards by 26/06/2018 Continuous data collection internally - work out how we maintain this especially during busy periods. / To target ward areas beyond PDN remit – surgical areas / oncology. Marketing larger stores once more for clothes donations (NL has already personally spoken & written to store managers prior to the launch) / Media campaign to promote our success at the end of the national initiative 26/06/18 **Criteria led discharge:** First refreshed kick off meeting to take place next week

KEY ISSUES/RISKS				
DESCRIPTION	**MITIGATION**	**DATE REC**	**LAST MONTH**	**THIS MONTH**
As identified in MTW's CQC 2018 report 16 / 17 year old's admitted to adult areas are not cared for by staff with necessary Level 3 Safeguarding Training	Data is from the past year is being analysed to find out where this cohort of children are being admitted. Planning to work with the Site team these will identify 'Transition' wards which this cohort should be admitted to. These wards will have identified 'Safeguarding Level 3 Champions' to care for this cohort.	24/05/18		
Lack of capacity in project team frustrating ability to deliver project milestones	Analysis and submission of resource requirements to Best Care Programme Board	17/04/18		
Changes in midwifery leadership team and management capacity impact on ability to develop and deliver improvements to information and staff support.	clear project lead responsibility for Crowborough identified from Midwifery Management team, acting up arrangements for HOM identified and recruitment plans in place and ready to be actioned.	02/03/18		

KPIS	TARGET	LAST MONTH	THIS MONTH
Total Number of Labours commenced at Crowborough Birthing Centre	18	16	14
Number of Births at Crowborough Birthing Centre	14	14	11
Total Number of women receiving Ante Natal Care from Crowborough Team	52	54	68



CRITICAL PATH MILESTONES				
TASK	**DATE**	**STATUS**	**RAG**	
			LAST MONTH	**THIS MONTH**
Delirium – snapshot audit to enable project objectives to be mapped	16/05/18	Completed		
Transition – electronic solution to locate 16/17 year olds admitted to adult wards	28/06/18	In progress		
MCA deep dive to take place at quality committee	04/07/18	On target		
Proposal for PPEE strategy to Best Quality Workstream board for sign off	06/06/18	Completed		
Engagement event to be set up off site during October	31/10/18	On target		
Invitations for engagement event to be sent out	31/07/18	On target		
Quality improvement committee	14/06/18	On target		
CQC engagement day	07/06/18	complete d		
CNST maternity criteria to be signed off by Trust Board	28/06/18	On target		
CNST Maternity criteria to be sent to NHSR for review	29/06/18	On target		
NHSR submit decision on % rebate of CNST rebate (up to £908K)	30/08/18	On target		
Crowborough business case sign off	22/06/18	On target		
#EndPJParalysis – presentation to Trust Board	22/05/18	Completed		
#EndPJParalysis - completion of roll out on Specialist Medicine wards Trustwide	26/06/18	On target		

FINANCE NARRATIVE

Only 2 of the projects have financial values: CNST NHSR rebate and Crowborough Birthing Centre Refurbishment.

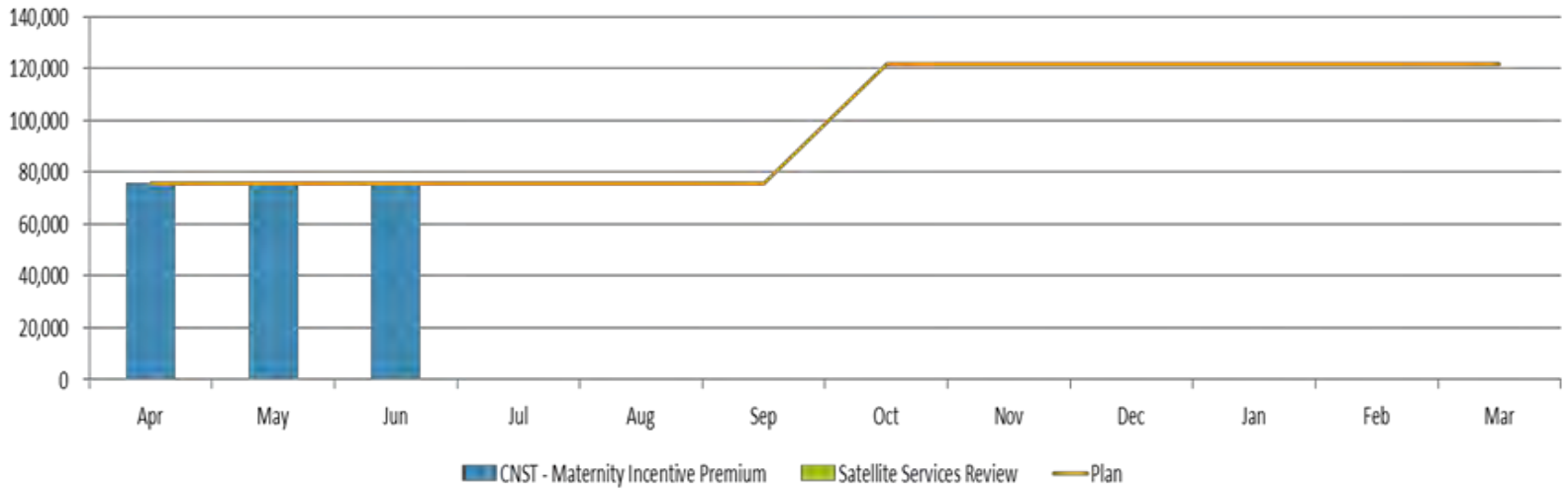
CNST:

Following changes to Criteria from NHSR MTW can evidence compliance with all 10 standards – this will be signed off by the Trust board 28/06/18 and sent to NHSR for review on 29/06/18. NHSR will submit decision in August of the decision taken regarding the Rebate.

Crowborough Birthing Centre:

Friends of Crowborough have agreed to fully fund the refurbishment of 2 birthing rooms at CBC. However an income target of 275,000 remains following closure calculations. Increase in births is unlikely to increase before January – following completion of refurb, alternative CIP being investigated with Maternity teams.

Best Quality – Risk to Delivery



Best Quality YTD financial position on target.

Better Births Criteria

- Financial incentive on target, due to achievement of 10 steps.

Satellite Service Review

- Change to scope for review, will not deliver the financial opportunity.
- Workstream/Directorate has not yet identified additional schemes to plug the gap. Additional workshop scheduled for week commencing 3rd August.

Maidstone and Tunbridge Wells NHS Trust

2b.Best Safety

Providing consistently safe standards of care for all of our patients is at the centre of everything we do at MTW and it's at the heart of the Best Safety workstream.

The workstream is leading on six safety improvement programmes in 2018/19, with the aim of collectively transforming the way we identify safety issues, learn lessons and improve our patient experience.

The projects include:

- **Preventing Harm**
- **Learning Lessons**
- **Mortality**
- **Seven Day Services (7DS)**
- **Quality Mark**
- **Medical Productivity**
- **GIRFT**

WORKSTREAM	Best Safety	BEST CARE BOARD DATE	28th June 2018
WORKSTREAM LEAD	Lynne Sheridan	PMO SUPPORT	Vince Roose / Fiona Redman (7DS) / Abigail Hill (Preventing Harm)

PROJECTS	ACTIONS/MILESTONES COMPLETED SINCE PREVIOUS MEETING	DELIVERY RAG		FORWARD VIEW: KEY MILESTONES TO TAKE PLACE IN THE NEXT 4 WEEKS
		LAST MONTH	THIS MONTH	
7 Day Services	Quarterly Review Steering Group Meeting held on 12.06.18. (Representatives from CCG was present - NHSE representatives x 2 gave apologies). At this meeting, the culmination of many months' of work was presented with proposals being made for compliance in principle for a number of specialties as follows: Women's Health were confirmed as compliant in principle for Standards 2 &8. For Standard 5, a re-review will take place at the September Quarterly Review Meeting to confirm sonography and chaperoning arrangements. T&O were confirmed as 'compliant in principle' for Standard 2, following the implementation of their 2nd daily ward round which has now been place for a number of months. For Standard 8, further assurance was required by the Steering Group in respect of identifying any patients who would not qualify as 'delegated care' and require a consultant review following the initial 14 hour assessment. This will be followed up with James Nicholls by Richard Griffiths. Also, any patients who are under the care of the Ortho-Geriatricians will be discussed to determine whether there is an issue to be reviewed by Urgent Care. Urology have implemented rota changes for weekends and have achieved implementation of their Consultant of the Week (COW) rota (went live 14.5.18). Consultants are now on 1:6 weekly rota and a 1:5 weekend rota. The middle grades are operating a 1:6 rota. The Associate Director of Operations will be monitoring the situation to confirm its impact on Standards 2 & 8 and this will be formally reviewed in the September Quarterly review for compliance. Surgery have implemented a second daily Consultant Ward Round (went live 04.06.18) and monitoring will take place (via the Associate Director of Operations) between now and the September Quarterly Review to confirm recommendation for a 'compliance in principle' status for Standard 2. Progress towards Standard 8 will be monitored in parallel by the Associate Director of Operations, again for report back to the September Quarterly Review Meeting. ICU, Whist already compliant for the 4 overall priority standards, have completed their audit in respect of the 6pm -8pm period of standard 2 (6 hourly review) and this will be discussed at the July Clinical Governance Meeting. ENT have put forward a proposal for compliance in principle via the CD. There is a point of clarity required in respect of whether all ENT admissions will be designated as 'delegated care' following the 14 hour review and that no patients would be remaining as 'medically active'. Richard Griffiths is checking this with Carole Jones (CD) and the results will be presented to the September Quarterly Review Steering Group. Haem-Onc: An audit to determine whether the involvement of a Clinical Haematologist in the pathway of admitted patients would have made any clinical difference is being finalised. If the conclusions are that the Clinical Haematologist's input would not have affected the review of medically active patients, then the service will be proposed for exemption from standards 2 and 8. The findings of the audit will be presented to the September Quarterly Review Steering Group. Urgent Care: A preferred options paper is being drafted by Urgent Care Division incorporating GI bleed 24/7 rota requirements (Deadline 30/06/2018 now extended to 31.07.18 to allow for the TW model to be completed.) 24/7 GI Bleed rota being worked up by Clinical Director). The work was discussed at the Quarterly Review Steering Group Meeting and the 7DS Core Team continue to provide support. National 7DS Survey (April 2018) has been completed and submitted to NHSE via the portal. Due to constraints with the interval of the short reporting period, only 49 casenote reviews were completed, out of a sample of 194 available cases for review. This has been escalated to NHSE on a number of occasions and a set of correspondence has taken place immediately prior to submission between Dr Peter Maskell and the Regional Medical Director. The availability of Temporary Casenotes has been highlighted as an issue throughout the 7DS National Survey work during the last 2 years and this is being added as a programme risk for 7DS.			Women's Health: Review position with Standard 5 for sonography and eradicate barriers to compliance (chaperones, SOP and kit availability). To report to September Quarterly Review Steering Group. - Action with Divisional Director of Operations. T&O: Identify any patients who would not qualify as 'delegated care' and require a consultant review following the initial 14 hour assessment. This will be followed up with James Nicholls by Richard Griffiths. Also, any patients who are under the care of the Ortho-Geriatricians will be discussed to determine whether there is an issue to be reviewed by Urgent Care. Action being led by Richard Griffiths. Urology: The Associate Director of Operations will be monitoring the impact of the rota changes and COW to to confirm its impact on Standards 2 & 8 . This will be formally reviewed in the September Quarterly review for compliance confirmation. Surgery: monitoring will take place (via the Associate Director of Operations) between now and the September Quarterly Review to confirm recommendation for a 'compliance in principle' status for Standard 2. Progress towards Standard 8 will be monitored in parallel by the Associate Director of Operations, again for report back to the September Quarterly Review Meeting ICU: Audit in respect of the 6pm -8pm period of standard 2 (6 hourly review) and this will be discussed at the July Clinical Governance Meeting. ENT: Confirm whether all ENT admissions will be designated as 'delegated care' following the 14 hour review and that no patients would be remaining as 'medically active'. Richard Griffiths is checking this with Carole Jones (CD) and the results will be presented to the September Quarterly Review Steering Group. Haem/Onc: Present findings of the audit to determine requirement for Clinical Haematologist involvement standards 2 & 8to the September Quarterly Review Steering Group. Action with Divisional Director of Operations. Urgent Care: Preferred options paper to be completed for presentation to Dr Peter Maskell by 31.07.18 (to include proposals for GI Bleed rota. National 7DS Survey: Continued discussions on mechanisms for Board assurance (as an alternative to the current National Survey) by Dr Peter Maskell at the National group led by Dr Kathy McClean.
Mortality	MSG meeting continues monthly with variable divisional engagement due to operational challenge of the day and times of the scheduled meetings. This is in the process of being reviewed for future meetings. The number of First Stage Mortality review forms are increasing month on month with improved compliance evident since the new review process was instigated in October 2017, highest compliance achieved to date is 81.7% recorded for March 2018. With the Mortality Co-Ordinator in post the review of the mortality database is now being progressed and compliance issues being investigated and resolved. This is helping to support the Directorates with improving their compliance and resolving issues that occur. In addition the Quattro database for Mortality is currently in development, the intention is that for each death it will be instantly to identify which review forms have been undertaken. The Mortality Assurance Audit is now arranged to take place on the 8th August to review a 10% sample of 1st Stage Reviews that reported no concerns. The audit team will oversee with support from clinicians from the MSG. The Learning Disabilities Mortality Review (LeDeR) process is being supported by the Learning Disability (LD) Nurse who checks all patients reported as having an LD on the Community register. If LD confirmed she then liaises with the Community Matron to ensure that the death is reported appropriately.			Learning from deaths review group due to meet on 11/07/2018 to review progress across all areas. Meetings have been scheduled to take place monthly until September whilst there is a focus on development and improvement, when they will revert to their monthly cycle if expected progress has been achieved. Follow-up meeting with Datix being convened to review contract and 'free' Mortality Database- due to take place within the next 4 weeks.

Preventing Harm	1. Long Elective Waits (RTT >18 weeks) Audit of 1,100 case notes underway . Period of review is October 2017 and involves all Consultants with breached cases (Elective or Outpatient) in study period. The numbers are the same as those reported at last month's meeting: number entered 688, number still outstanding 223. An e-mail has been sent by Dr Peter Maskell (21.6.18) to CDs and Directors of Operations highlighted the Consultants with outstanding cases for review. Summary to date: 10 Cases rated as Moderate Harm (1.5%) and 1 case rated as severe harm (0.1%) (Specialty: ENT) Once the audit has reached critical mass, the audit results will determine the design of the project (if the audit proves conclusive). 2. Documentation and Record Keeping (potential project – in work-up) The project was reviewed, as planned, by the Programme Board (6.6.18). JK reported that he has been asked to review nursing documentation by the Nursing Midwifery and AHP Steering group. He reported that there are approximately 350 Nursing Proformas, which need rationalisation. It was considered sensible to link the two projects together and JK was asked to explore by PM. JK agreed to set up a meeting consisting of PS / JK/ COB / PM / LS and AH to determine objectives of Documentation and Record Keeping. This should be linked to the work of the Nursing Directorate and LiA. The date for the meeting is being arranged JK. 3. Acute Kidney Injury (potential project – in work-up) Meeting held with senior nursing leads who are conducting the task & finish group - 12/06/2018. A full report and gap analysis has been produced for review by the Programme Board on 11.7.18 where the project brief will be further discussed. The report provides the full history of the management and performance of AKI within the Trust, highlights current perceived gaps and a comparison to what a gold standard service could look like. Clarity will be sought on the nature of the potential project . 4. Consent Discussed at Best Safety Workstream Board 06/06/2018 following initial scoping exercise which took place on 05/06/2018 Actions agreed for next steps which include a review of the consent policy with a subgroup involving a wide range of clinicians to support. A Lead clinician from Surgery has been identified (Dr Charles Bailey) and from Mediciine (Dr Bijay Baburajan). A multidisciplinary subgroup membership has been agreed and is in the process of being convened and it is hoped that this will occur before the Best Safety Board on 11.7.18 where an update will be given.		Long Elective Waits: Completion of audits by Directorate Consultants then full analysis of final audit returns Action: Directorate Consultants and Pat Singleton. Documentation & Record Keeping: Identification of project links to the documentation audit already being discussed for Nursing and AHPs. – Action John Kennedy. Acute Kidney Injury: LS and SM to prepare proposed scope from the paper produced by the AKI Lead Nurses and to launch project (if agreed at Best Safety Board 11.7.18). Consent: Sub-group to be established to support the production of the revised Consent Policy – Action: LS & SM
Quality Mark	Core Team re-examined the original brief and need to link to Learning Lessons Project. Review of original aims by Core Group has re-designed the proposals to the Best Safety Board. Decision made to propose a 5th Option to the Best Safety Board that links the Quality Mark to the Trust's Quality Strategy, with an award-based Quality Mark offered against achievements in delivery of the 22 Quality Strategy Goals. Best Safety Board (6.6.18) endorsed the recommendations . LS and WG have meet to discuss the link between the launch of the Quality Strategy and the 'Quality Mark' (title to be confirmed) which will include the governance links to the Best Care Workstreams for delivery of each Goal. Further meeting of Core Team is being arranged by JK to distil the process for release at the launch of the Quality Strategy.		Further work-up and progression of agreed brief for project by Core Team.
Learning Lessons	SMART action guidance produced – also being considered for appending to the SI and Incident Management P&Ps Core team meeting scheduled for 27.6.18 (including Clinical Lead) to review progress and begin scoping work on sharing and embedding learning Meeting being arranged for initial testing of learning levels in order to develop guidance Outline draft of new core Directorate Clinical Governance meeting agenda still in development – awaiting update from MSG to finalise draft content. This will then be discussed with the core team prior to sharing with MD and Best Safety Board – may be ready to table for July meeting depending on progress Datix upgrade pending – project manager appointed by IT Datix action notifications are not functioning correctly and administrator is unable to access email template to rectify - Datix meeting outstanding – highlighted at recent Datix Forum on 20.6.18 and WG in liaison with Datix to secure a date Internal Datix demonstration arranged for 24.7.18 Project milestones agreed (to be confirmed at core group meeting)		Learning levels - meeting being arranged in June to test the levels against definitions & agree guidance for users.
Medical Productivity	Job planning Policy and associated document changes have been agreed with JMCC and are now finalised and on Qpulse. Work is continuing with the directorates to add job plans onto the system. Solutions found for issues with W&C and ED job plans and approved by project working group. W&C should have all job plans on the system by the 6th July. A further meeting is scheduled with ED for 3rd July to agree the plan with the CD and GM. As of 28th June 243 job plans are on the system. Issues remain with SAS job plans which historically have not been job planned in a consistent manor across the Trust. These is being worked through on a directorate by directorate basis. Local PA Allocation Tables have been developed and now being discussed with the directorates for sign off. Demand and Capacity Funding has been agreed for the BI analyst to support the demand and Capacity element of the and interviews are schedules for the WC 3rd July. The Informatics team are in discussion as to how this element of the work stream will be rolled out. The methodology work on activity units for conversion to PAs has commenced. Best Value WAU metrics have been localised to cover all specialities. Work to define Best Value DCCs has commenced. The Pay query work is concluded and paper for Execs is in the process of being written up. National Project The Trust has been invited to take part in Wave 2 of the National Medical Productivity Project. The Trust has now formally accepted this invitation is has commenced the required data collection.		Job planning Continue to support directorates in loading and signing off all job plans into the e-job planning system Work with the directorates to sign off local PAAT Demand and Capacity Recruit BI Analyst and develop induction package. Continue work on Activity units with the BI team. Best Value Finalise WAU metrics through the working group. Pay query report to be signed off by HRD. Produce first draft of Best Value DCC definition by Directorate This programme is considered Amber due to the delay in loading and signing off all job plans. The programme has allowed for some slippage in this and the critical milestone is September for all job plans to be signed doff and complete. National Project Complete the Data Request by the deadline -27th July.

WORKSTREAM	Best Safety	BEST CARE BOARD DATE	28th June 2018
WORKSTREAM LEAD	Lynne Sheridan	PMO SUPPORT	Vince Roose / Fiona Redman (7DS) / Abigail Hill (Preventing Harm)

KEY ISSUES/RISKS

DESCRIPTION	MITIGATION	DATE REC	LAST MONTH	THIS MONTH
Risk of best safety projects being sidelined due to greater operational or corporate pressures	high level of Executive support/ robust governance structure	03/03/18		
7DS: Consultant numbers and recruitment constraints in Urgent Care	Work ongoing with Division and Director of Workforce in respect of recruitment aids	05/05/18		
7DS: Constraints in Urology relating to number of Consultants and ability to implement the Consultant of the week rota. 7DS: Temporary Casenotes – causing issues as amalgamation with permanent set takes a long time and the ability to review the episode (for a number of processes, not just 7DS – includes mortality, SIs and other) is becoming a risk.	New rota being trialled in May 2018 Wendy Glazier has raised this as a corporate risk, so on the corporate risk register for monitoring and action.	01/05/18		
Datix system does not satisfy requirements for Learning Lessons and Mortality Projects	Datix system demo to take place on 6.4.18	05/04/18		
Consultants do not fully comply with audit request regarding the Preventing Harm Project. Therefore, lower study population from health record review of 1,100 patients who had an 18 week breach RTT (IP, DC and OPD) - (sample month Oct 17) against a potential harm scoring system.	Audit now underway - chase up communication sent to consultants who have outstanding reviews to complete - end of March 2018. 600 cases now returned, 150 being chased, but sample likely to be adequate.	08/03/18		
Job Plans not completed and added to e-job planning system within the agreed timescales	Associate Medical Director and PMO lead are working with individual directorates to provide additional training and support. A revised timetable has been agreed via the working group.	17/03/18		

CRITICAL PATH MILESTONES

TASK	DATE	STATUS	RAG	
			LAST MONTH	THIS MONTH
7DS meeting with NHSE and CCG to ratify compliance in principle for 4 priority standards	12/06/18	On target		
7DS submission of paper outlining Urgent Care options for achieving standards	30/07/18	On Target		
Mortality - Audit has been put in place to review a sample of 1st Stage Reviews that reported no concerns (based upon a 10% selection	15/07/18	On target		
Mortality - Learning from deaths review group due to meet on 07/06/2018 to review progress across all areas.	07/06/18	Completed		
Preventing Harm – LEW – completion of audit in order to progress with diagnostic of project	11/07/18	On target		
AKI – Meeting arranged with senior nursing team to discuss output from task and finish group	12/06/18	On target		
Quality Mark – next core group meeting to take place and provide decision re option chosen	05/06/18	Completed		
Learning Lessons – human factors training for approval at TME	16/05/18	Completed		
Learning Lessons – Outline draft of new Directorate Clinical Governance agendas to be presented to Best Safety Board for approval	11/07/18	On target		
Learning Lessons – Meeting with Datix Area manager to discuss issues with action planning notification	15/06/18	On target		
Learning Lessons – internal upgrade of MTW Datix system	30/06/18	On target		
KPI's being finalised following paper to best safety workstream board	11/07/18	On target		
QIA's signed off	21/05/18	Completed		

WORKSTREAM	Best Safety	BEST CARE BOARD DATE	28th June 2018
WORKSTREAM LEAD	Lynne Sheridan	PMO SUPPORT	Vince Roose / Fiona Redman (7DS) / Abigail Hill (Preventing Harm)

	KPIS	TARGET	ACTUAL	THIS MONTH
** KPI'S PAPER WENT TO BEST SAFETY BOARD 06/06/2018 – MORE KPI'S TO BE FINALISED AS PROJECTS PROGRESS				
7DS	Generic KPIs have been in existence since project was first initiated , but will be reviewed if they can be localised by Division once each Division has completed their actions against the Challenge Day action plan.	NA	NA	
MORTALITY	HMSR (Monthly)	100.0	104.8	
	SHMI (Quarterly)	Band2	Band2	
	% compliance with all mortality forms following a patient death (death cert, preliminary screening form, first stage mortality form and where appropriate, SJR)	95.0	50.4	
PREVENTING HARM	Long Elective Waits: Delivery of NHS England report 'External Clinical Review Handbook' Remaining Projects' KPS to be developed once scoping complete and indicators identified for each project.	NA	NA	
QUALITY MARK	KPIs to be agreed when the indicators have been confirmed for the project.	NA	NA	
LEARNING LESSONS	% Reduction in Top 10 recurrent incidents (To be confirmed)	NA	NA	
	% Reduction of duplication of incident occurrence	NA	NA	
	Evidence of learning from successes (Metric TBC)	NA	NA	
Medical Workforce Productivity	Number of Job plans on the e-job planning system	330	243	
	Number of Job plans signed off on the e-job planning software	300	45	

Maidstone and Tunbridge Wells NHS Trust

2c. Best Workforce

Best Worforce is devising innovative strategies to develop new roles and attract and retain staff to the Trust. Implementing more efficient processes to help make people's jobs easier and reviewing temporary staffing are the key areas of focus for Best Workforce.

The workstream's priority areas are:

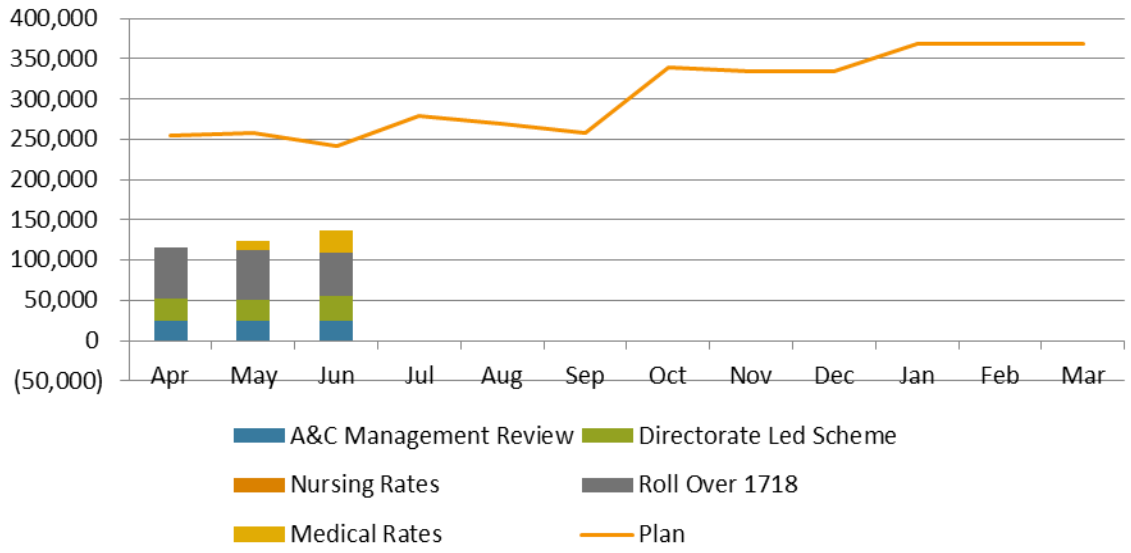
- **Recruitment**
- **Temporary Staffing**
- **New Roles and Apprenticeships**
- **Workforce Productivity**

WORKSTREAM	Best Workforce	BEST CARE BOARD DATE	July 2018
WORKSTREAM LEAD	Simon Hart/Jamie Phipps	PMO SUPPORT	Kathryn Brown/Steph Pearson

Project	Actions/Milestones completed	DELIVERY RAG		Actions for next reporting period
		LAST MONTH	THIS MONTH	
Temporary Staffing Controls Group	• Q1 saving target not achieved, £34k of £341k • Reduction agency rate for one medical locum £131 to £114 per hour • Substantive contract agreed / accepted by one medical locum Personalised plans completed for 7 Urgent Care Top X agency locums • Communications sent out for Q2 rate step down • New NHSI rules shared with Ops Teams at COO Temporary Staffing Meeting • All bookings over £100 to go to CEO for sign-off w/c 16 July • New NHSI dashboard tabled at Exec weekly meeting and COO Temporary Staffing Meeting • F1 rotation almost full. Any gaps will be covered by 5 extra F1 recruited • Interviews to be completed for F2s on 19 July for 6 gaps. 9 interviews taking place with 90 applicants • Review of Bank rates has identified inequalities across directorates at same grades • All non-framework nurses have been taken off rota lines			• Locums have until 23 July to make decision • Replacement CVs to be provided for each post ahead of any agreed contract termination • List of locums not agreeing to transfer to be given to CEO with trajectory for replacement by 30 July • Identify next Top 10 Locums to target - 1 Aug • Financial impact of F1 and F2 successful fulfilment on agency cost to be calculated • Business case to be completed for new Bank Rate proposal 17 Jul • Commence rota approval initiative in order to ensure all rosters approved with 6 week lead time • All framework nurses to adhere to NHSI rates • Submit review project plan for re-baseline approval
New Roles and Apprenticeships	• Further engagement sessions held with directorates (5 complete) • Engagements Sessions booked with all other areas except Corporate Back Office • As at 30 June, 61 apprenticeships enrolled on apprenticeship training in 2018. (This number fluctuates due to completers) • 15-20 Level 2 & 3 new CSW apprentices sign-ups before end 2018 • 30 Nursing associates due to commence September 2018 • 19 enrolled for Management Training with further interest in chartered manager degree and MBA Apprenticeships • Confirmation money in levy account expires after 24 months, any transaction paid in May 17 will expire in May 19			• Complete directorate engagement sessions and Corporate Back Office (31 July) • Hold review meeting to identify priorities for New Roles and Apprenticeships (26 July) • First Nursing Associates are planning for September • First Physician Associates due to start early October • Commence procurement for 10 MBA training places • Set KPI's and targets once requirements identified for new roles and apprenticeships
Directorate CIP's	• All schemes are now Green with the exception of 3 schemes for Surgery and one for Specialist Medicine • RMO Model agreed • Recharge for East Sussex has been paid in month 3			• Outstanding QIA's to be written and presented by Surgery directorate • Continuous monitoring
Workforce Productivity	• Rostering performance report issued to senior nursing team and matrons on 4 weekly roster cycle • Changes to finalisation processes agreed at Project Board			• 1st Stage of finalisation changes plan to be implemented • Meeting with matrons to promote roster approval timetable • Performance focus: Hours Balances
Recruitment	• New project			• Scoping work to be completed with key improvement themes and quick wins identified

KEY ISSUES/RISKS TO FINANCIAL PERFORMANCE				
DESCRIPTION	MITIGATION	DATE REC	LAST MONTH	THIS MONTH
ISSUE - £341k saving target for Q1 was not achieved. This will put at risk the £2m of identified STP savings.	Recovery Plan being implemented. Includes implementing a plan to reduce cost of Top 10 High Cost Locums. Conversations taken place with locums and decisions required to be made by 23 July. List of locums not agreeing to transfer to be given to CEO with trajectory for replacement. 1 Aug to identify next locums to target and repeat process.	May -18		
ISSUE – Due to Recovery Plan being created, there is not a single plan for Temporary Staffing	Recovery Plan now consolidated with original project plan. Delivery has significantly slipped from baseline. Recommend plan submitted to Board for re-baseline approval.	July -18		
Potential for apprenticeships levy not to be used. Only 1.7% of £1m currently spent. If unspent by May 2019 the levy will start to be removed.	Apprentices need to be on the programme for 42 days before triggering payments from the digital account. Based on current training available and if all filled this would see £858K per year spent of the £1.1m funds. After further requirements for apprenticeships have been identified we expect to be able to update the forecast with this data and with fill rates.	Apr - 18		
Lack of ownership of the CIP target by divisions	Planned Care to be picked up as part of FRP fortnightly meetings. Need to set up a mechanism to monitor with Urgent Care and Women's & Children	Jun-18		

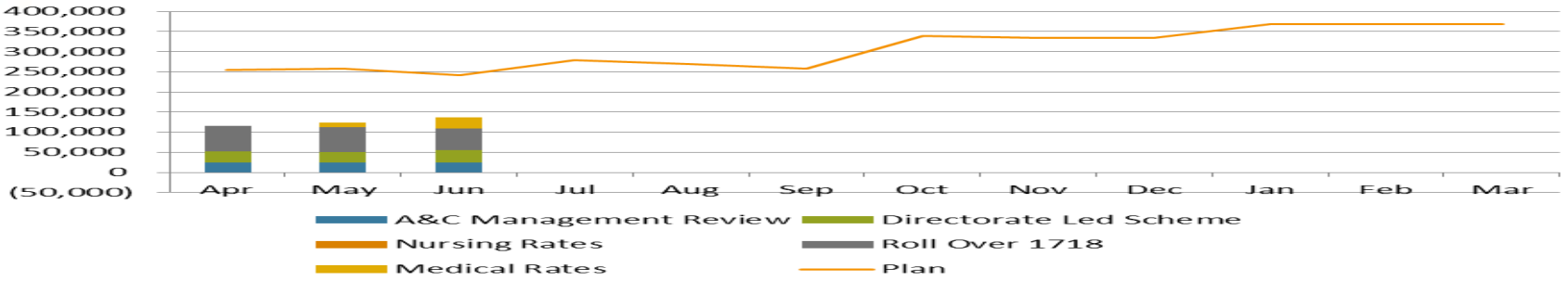
KPIS	Target	LAST MONTH	THIS MONTH
Percentage of medical agency shifts over STP break glass rates	0%	95.9%	94.4%
Percentage of shifts requested more than 6 weeks in advance	80%	13.3%	20%
Non-Framework Nurses Hours	0	2,608	2,231
Average roster performance score for inpatient nursing areas	85%	69.51%	70.56%



FINANCE NARRATIVE

The Best Workforce achievement to date is £373k against a plan of £730k. The shortfall of £357k is largely within the STP Medical rate CIP underachievement. The key achieving CIP in quarter 1 were the 2017/18 roll over schemes reporting 48% of the workstream.

Best Workforce – Risk to Delivery



Due to risk associated with Workforce delivery against plan, this workstream is in the Recovery Process

YTD Adverse to plan (£0.36m)

- Due to non delivery against STP Medical Locum Rates.

Uplift every Qtr due to ongoing reduction to STP Medical Locum rate. Executive review of recovery plan held on 17th July, with 4 key focus areas:

Medical Locums

- Personalised Plan for all Top 10 Medical Locums
  - All completed and with locums for review, cut off date set at 23rd July
- Personalised Plan for next Top 10 Medical Locums to commence immediately

Nursing (Non-Framework)

- Acceleration of the implementation of process to reduce/remove Non Framework
- Sourcing framework agency

Recruitment Campaign (Local and Overseas)

- Acceleration and additional support required to support the local and overseas recruitment campaign

Reversal of year on year increase in Medical Locum Expenditure

- Detailed analysis with recovery plan in place by 16th August

Maidstone and Tunbridge Wells NHS Trust

2d.Best Use of Resources

Best Use of Resources is focused on reducing waste and improving value on the products and services we buy across the Trust.

The workstream has started with five key areas to achieve best value in by reviewing costs and identifying opportunities for savings, whilst ensuring quality of service and patient experience is not comprised and continues to improve.

The key areas are:

- **Estates and Facilities**
- **Procurement**
- **Medicines Management**
- **Aligned Incentive Contracts**
- **STP pathology review**

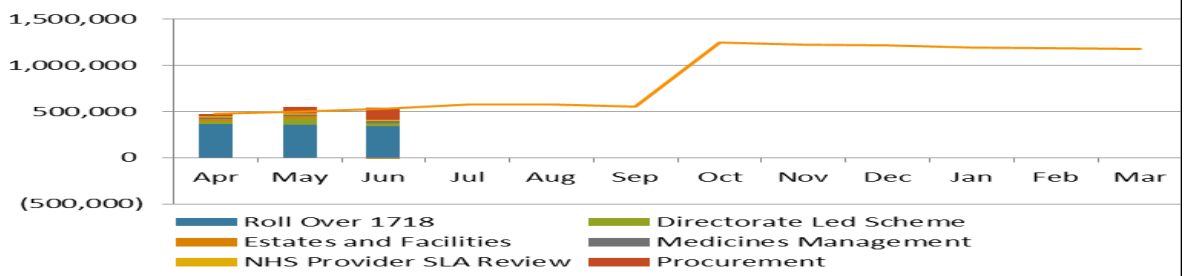
WORKSTREAM	Best Use of Resources Summary Report	BEST CARE BOARD DATE	
WORKSTREAM LEAD	Steve Orpin	PMO SUPPORT	Caroline Tsatsaklas & Toyin Falana

DESCRIPTION	MILESTONE ACTUAL	DELIVERY RAG		ACTIONS FOR NEXT REPORTING PERIOD
		LAST MONTH	THIS MONTH	
Estate & Facilities	Patient Transport task and finish group established. Group met on the 5th July to set objectives.			Produce contingency plan for potential £1m gap.
Procurement	• 6 projects concluded and will start delivery with a total value of £38K savings, this is in addition to M3 plan which is on track. • Identified opportunities to plug gap, delivery plan in place. • QIA signed off for project implemented in June			Deliver additional £18K of savings for M3.
ICT	Verbal sign off obtained for storage QIA, with slight changes to be made and re-presented for final sign off.			Re-present QIA Storage scheme and obtain final sign off.
Medicine Management	Drug contract change (wave 10 & 11) QIA signed off Identified some opportunities towards £750K gap. Home care Expansion – list of drugs identified but are all NHSE commissioned and therefore savings will not be gain shared with WKCCG. (Steve O has said he will contact NHS England about this, as some Trusts have gained share savings with NHSE)			Finance to quantify value of opportunities identified, produce plan and list of drugs for Home care expansion, review current vacancies within the directorate that can back fill resource for Joint Formulary work. Confirm value of Drug contract (wave 11) Complete Business Case proposal for Home Care Expansion. Amend protocols in Aria for Trastuzumab implementation in Oncology by end of July.
AIC Diagnostics	**Pathology** Internal Demand – meeting with Medical Director where a plan of action was agreed.			**Pathology** - Obtain similar data for LFT, FLP, FBC, Thyroid tests Internal Demand - obtain relevant activity data.
	Radiology - I-Refer for West Kent GP now purchased, and roll out commenced on 26/06/2018 Internal Demand – meeting with Medical Director held on 04/07/2018 where a plan of action was agreed.			**Radiology** - complete roll out of I-Refer to all GP practices and resolve any on going issues with them, Go live with Electronic Results (Paper switch off) on 2nd July 2018 Internal demand - obtain relevant activity data.
AIC Diabetes	DSN Funding Agreed 4/6/18 which allowed recruitment drive to commence. Agreed IT process for DSN triage of referrals within 24/5/18 DIG, Confirmation of contractual arrangements , roll out first cluster in Tonbridge by 09/2018			Regular DIG to address and monitor set actions via plan Regular DIG to monitor Financial Meeting scheduled in order to ensure actions to plan

KEY ISSUES/RISKS TO FINANCIAL PERFORMANCE

DESCRIPTION	MITIGATION	DATE REC	LAST MONTH	THIS MONTH
E & F Change - external agreements re: best value to delivery of E&F external & internal agreed business case	Update paper and re-present to Trust Executives in June.	1st sept		
Procurement - Products clinically acceptable but staff preference not to switch delays or prevents product switch	Discussions with General Managers and Clinical Lead to review the evaluation documentation and decide further steps to be	1st March		
Procurement - Slippage on STP work plan - issues with confirming projects start date and leads	Issue discussed at the last group meeting on the 8th of June with a list of actions tasked to all leads to move plans forward with and to submit at next group meeting. Group meets every 1st Friday of the month, next meeting date yet to be scheduled.	6th June		
Avastin - Outcome of judicial process may not go in favour of CCGs involved, if this happens will have a great impact on the Trust implementing Avastin and any planned savings.	AIC has agreed to wait for judicial review which starts in July 2018 - till Sept 2018, but develop a plan in prep for go live.	1st April		

KPIS	Target	LAST MONTH	THIS MONTH
Number of tenders completed each month	13	7	8
National metrics - % of spend under a catalogue	80	98	98
% of spend under a purchase order	80	85	87
Reduction in Vit D Direct Access Tests	20	Q1 16/17 5911	Q1 17/18 6050



CRITICAL PATH MILESTONES (next 4 weeks)

Task	Milestone Date	Status	RAG Last Month	RAG This month
E&F change - Update Paper for Trust Board	28/06	Awaiting Update		
E&F Change – Exec Approval	24/05	Late		
ICT Data Migration – update template and re-submit QIA	TBC	TBC		
Diabetes - MTW obtain KCHFT contracts from WKCCG regards contract novation.	29/06	Delayed but mitigated.		
Service Model: Working Group review activity data to source patient number volume to inform agreement of clinic template	12/07	In Progress		
Obtain prescribing data & expenditure per practice. Working Group (5/7/18) to develop prescribing guidelines in line with WK Committee	30/06	In Progress		
Patient Transport - Internal communication and retraining of Trust's staff	01/08	In Progress		

Finance Narrative

Programme over achieved against plan by over £7K in Q1.

The main over performing area include: Trust Blood Expenditure by £73K, Targeting Drug Returns by £27K, and Procurement by £108K

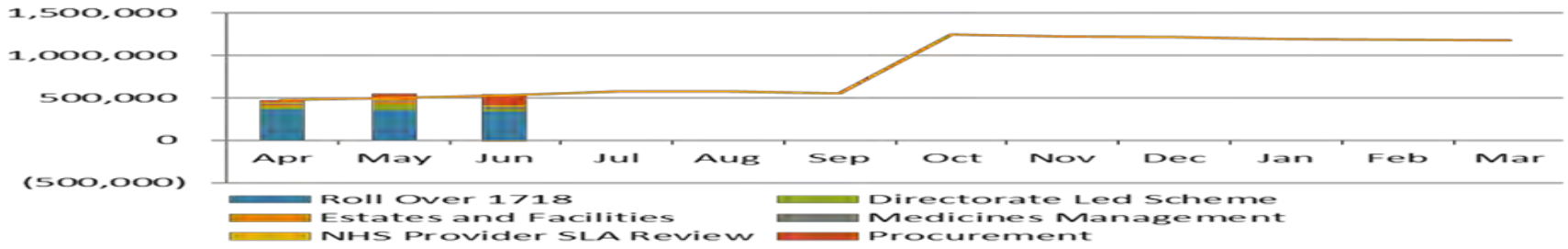
Main areas of Q1 shortfall include:

- Outsourcing with £113K
- Estates & Facilities - £54K (ISTC - £13K, M&S - £25K) this is caused by a review of the delivery date. This is now forecast to achieve in Q4.
- Roll over - £25K (Antenatal Images (£13K), 4 extra beds at Hedgehog to reduce escalation at woodland (£9K), Sale of scan pictures for £5 instead of a donation (£3K))

Forecast Risk area

- Outsourcing
- Avastin
- Pharmacy Stretch Target
- Procurement

Best Use of Resource – Risk to Delivery



Best Use of Resources YTD financial position over performance in procurement, drug returns and blood expenditure, but shortfall in Outsourcing T&O and Estates & Facilities plan re-baseline.

July Uplift (based on baseline plan submission)

- Predominantly due to E&F Subsidiary (£1.7m)
  - Based upon initial report, workstream propose to reforecast savings from Mth 7
  - Risk mitigation - £700k additional Energy efficiency programme including lifecycle one off benefit (NHSI approval required)

October Uplift

- Due to Procurement and Medicine Management
  - Procurement
    - Procurement stretched target gap of £75k
  - Medicine Management
    - Avastin – awaiting outcome of judicial process in July, however unlikely to get final review until Sept / Oct.
    - Medicine Management stretched target – risk to delivery. There a number of opportunities that currently the savings would go straight to NHSE, team are exploring an alternative approach with NHSE, similar to the approach taken by Leeds Teaching Hospital

Due to risk associated with Medicine Management delivery against plan, they will enter the Recovery Process

Maidstone and Tunbridge Wells NHS Trust

2e. Best Flow

The Best Flow workstream is using a number of approaches to improve the safety, efficiency, effectiveness and productivity of MTW's services, by implementing good practice in patient flow and improving the processes that support this.

Through work currently being carried out, processes will be reviewed and analysed to identify pressure points and better ways of working, to benefit staff and patients.

The projects include:

- **Non-elective**
- **Theatre Productivity**
- **Outpatients Productivity and Transformation**
- **CAU Effectiveness**
- **Private Patients**
- **Repatriation of Services**

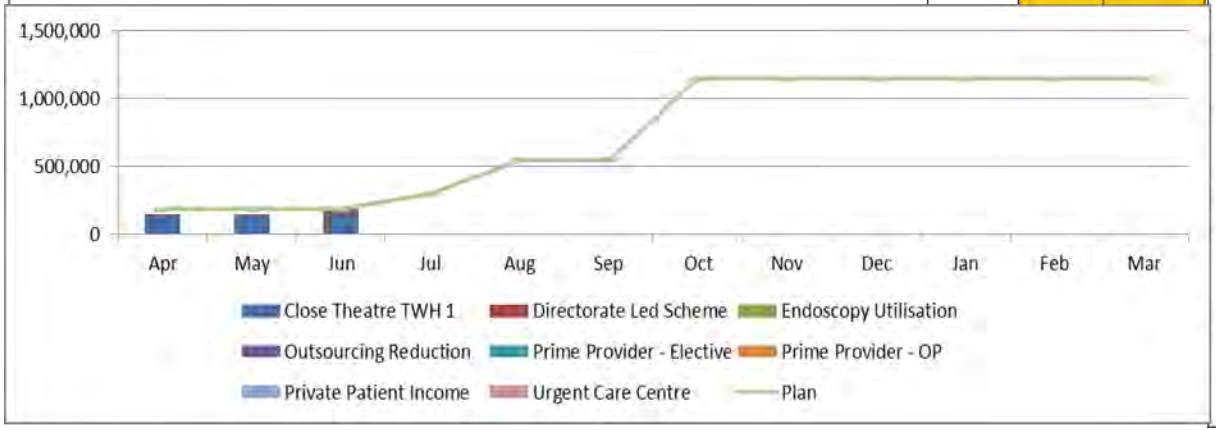
WORKSTREAM	Best Patient Flow	BEST CARE BOARD DATE	July 2018
WORKSTREAM LEAD	Angela Gallagher	PMO SUPPORT	Fiona Redman / Sarah Smith

DESCRIPTION	ACTIONS / MILETONES COMPLETED	DELIVERY RAG		ACTIONS FOR NEXT REPORTING PERIOD
		LAST MONTH	THIS MONTH	
Frailty at TWH. Frailty Unit Implemented at TWH	Frailty manager in place and Specialty Matron in place start date 16/718. Symphony currently used at Maidstone site and '. Symphony being rolled out at Tunbridge Wells site for Frailty unit Frailty paperwork standardised across site.			'Frailty flag' being explored using Symphony across site to highlight frail elderly patients outlying frailty unit and therefore identify missed opportunities. Clinical team to discuss use of standardised MTW frailty scale across site within the next 2 weeks led by Katy Davies.
Out of Hospital Capacity:	Downward trajectory of super stranded patients evident to 6% trust wide. Numbers dramatically reduced at Maidstone site due to focused work (see chart overleaf). Data categorised by speciality and ward hotspots with focussed work to establish delay reasons at board rounds. ECIP teleconference attended and code delays matched against ECIST codes. Data collection on both sites completed 22nd June for Community Hospital Project. Low level data analysis demonstrates 1/3 of referrals do not receive an accept/decline decision within the agreed 2 hour period and only 53% of patients referred are transferred to community hospitals on the same day as the referral is made. HTS data analysis demonstrates poor staff awareness of service and low referral rate from MTW			Discharge manager to present findings to external partners in order to manage external delays and promote MTW patient flow
Length of Stay Increased number of 0 LOS	Appointed 8 out of 10 flow coordinators, awaiting start dates. 2 unfilled posts back out to advert. Appointed CUR lead to start in post end of August, arranged interim cover. Each group to continue with monitoring and reviewing actions from 'Stranded Patient List' and report in weekly. New for this month is that each triumvirate has the following key objectives, to be recorded on template; 1. Identify at ward level the 'blockers' to achieving the early discharge agenda in terms of 5 patients before 10am at each site. 2. Identify the 2 local clinical pathways that would optimise the 'Nurse Led Discharge' profile			Audit compliance and effect of night nurses taking bloods for discharge ready patients. PDN's will lead on this and report back next month. Day Before Actions in place on all wards audit for compliance and impact PDNs to lead on and report back. Accelerate identification of 5 patients per site for priority discharge by meeting with Manager of Discharge lounge to understand blockages To meet with the site team re adding onto 430pm bed meeting agenda number of patients identified for early discharge. To meet with ADs to discuss the prioritisation of early discharges at the 430pm bed meeting
AEC	Division is currently reviewing pay overspend in M1 and 2 which has halted the conversion of the lead ENP hours. Have approached Deputy Chief Nurse to remove 1 CSW (nights) following conversion of 2nd bay but not approved. Agreement of clinical pathways for all specialities (14-led by ENP) also delayed due to this			Identify funding to support lead ENP Roll out further 14 pathways Ensure that BI have provided information for ambulatory pathways – current opportunities Once decision from A&E Board made on 9.7.18, identify funding and implement appropriate app to encourage patients to go to MIU rather than ED. Finalise rollout of CPMS
Non-Elective Surgical LOS	- Identified feasibility of virtual diagnostics being managed by healthcare at home service with Radiology positive to develop pathways to ensure that LOS is reduced. - Issues with patient mobilisation equipment to help reduce LOS now resolved. Working with the league of friends to reinstate funding bid. - Communications for patients and staff relating to discharge now improved - includes posters and leaflet distribution			- Create pathway with radiology for virtual diagnostics. - Undertake further deep dive from the results of the delay studies focus on therapy delays on T&O ward. - Further pursue virtual ward options. - Further embedded I&D pathway.
Increase in private patient capture and activity	- The Housden group have presented their findings to the Trust Board - PPU location agreed as a trial basis on EGAU. Estates engaged and are commencing move plus environment refresh.			- Engage with clinicians to utilise new PPU. - Complete operational policy detailing benefits of private healthcare at MTW. - Resolve private insurance contracts.
Prime Provider	- Bed Modelling meeting held with ADOs and GMS to understand potential capacity for elective activity; primarily over the winter. - Low level process mapping undertaken and lessons learnt of previous outsourcing evaluated.			- High level process mapping of prime provider - Seek approval of the business case for additional resource for prime provider
Releasing Capacity for Prime Provider (Operational Productivity)	- A slight drop in theatre utilisation has slightly recovered to 84% w/c 25/6. - OP vacant slot report launched to improve utilisation. - MSK pathways shown a reduction in new referrals releasing capacity. - CAU RTT training scheduled for roll out. - Text messaging business case completed for approval at Best Flow/ Best Care Board. Delay of roll out to plan. - An increase in attendances per clinic (0.5 attendances/ clinic above baseline) - Cardiology kinesis go live 9/7/18 - UGI CNS clinics commenced 9/7/18			- Further intensive support is being given to the booking teams for theatres. - TCI report being developed to aid the process of: MRSA screening time frame from 8 weeks to 12 weeks. - Working with new outpatients operational lead to develop pathway for 'fit and under forty' who may not need pre- operative assessment. - Identify resource required for further roll out of call outs. - Recruit for operational productivity transformation managers - Launching a 2WW view in the vacant slot report - MSK, focussing on integrated dashboard go live, clinical fellow plan, US guided injection referrals - RATC working group focus on 3 criteria exceptions plus activity audit.

KEY ISSUES/RISKS TO FINANCIAL PERFORMANCE: DESCRIPTION	MITIGATION	DATE REC	LAST MONTH	THIS MONTH
There is a risk of the best flow £9.4 Million target. Even with full delivery of the BCBF programme, enabling elective activity to increase, there is still reliance to the external agreement on the Prime Provider.		9/3/18		
The ability to further reduce LOS by on average of 1 day, in order to ensure that medical patients are not in surgical beds is a risk, as progress has already been made on reducing LOS over the last year and further timely reduction to generate capacity will be more challenging.	Best practice schemes identified within the project delivery plans with associated LOS benefit relation , which will be monitored through the work groups and steering group. The LOS group has been split into two – medicine and surgery/T&O enabling greater focus on specialist areas to help ensure delivery.	9/3/18		
There is a risk that the subgroups are unable to access the skilled staffing resource required to support new initiatives either due to funding or recruitment difficulties (shortage of skilled staff).	Task and finish groups to identify new ways of working and new roles which are link to Best Workforce programme. The Best Care Programme is enabling additional resource to ensure sustainability. These roles are being recruited into.	9/3/18		

Critical Path Milestones	Milestone Date	Status	RAG Last month	RAG This month
Make use of existing I.T solutions to ID Frail patients from ED onwards	30/06/2018	20%		
Gain agreement to increase AEC capacity at TWH	21/05/2018	100%		
Create Task and Finish groups following patient flow workshop	30/06/2018	50%		
Approval of paper requesting that EGAU becomes a dedicated PPU	18/06/2018	50%		
Achieve 75% opportunity within theatres creating capacity for prime provider	31/08/2018	50% target achieved May 2018		

KPIS	Target	LAST MONTH	THIS MONTH
Average LOS Non Elective Trust (days)	6.9	7.1	7.3
Achieve or exceed DTOC target (%)	3.5	4.3	4.4
Theatre Utilisation for Prime Provider (%)	85	80	84



FINANCE NARRATIVE

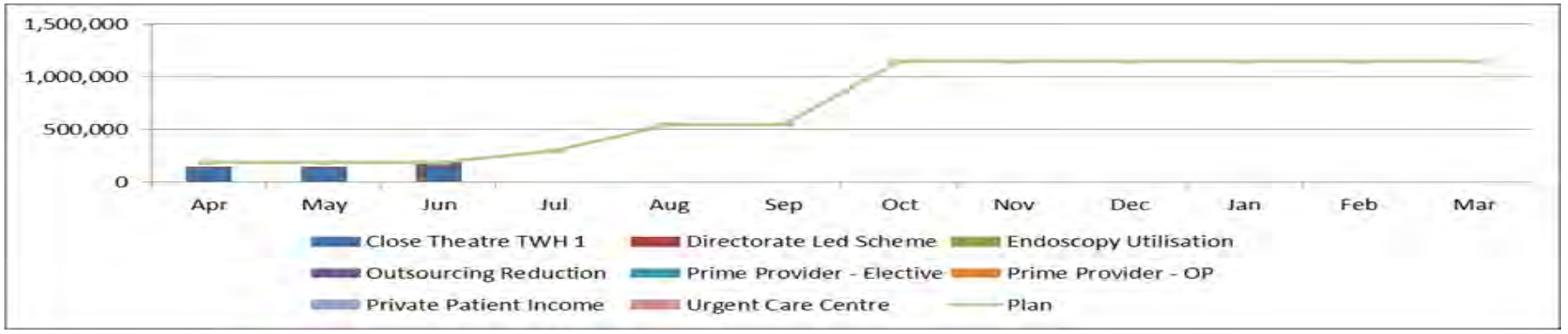
Month plan was to deliver £187k in savings and in month 3 £187k of savings were delivered meaning the workstream was on plan for the month. However, there is a stepped increase in planned delivery next month due to schemes such as increasing PPU income, reducing endoscopy WLIs and increasing bowel scope income all due to start delivering. We are currently forecasting £83k of slippage for month 4 (PPU and bowel scope income will not currently achieve).

Mitigating actions:

Endoscopy patient management will be migrated to theatreman (pending business case approval) which will enable a greater efficiency – in turn enabling more income from surrounding Trusts.

PPU is being trialed in EGAU at TWH from August – enabling additional income.

Best Flow – Risk to Delivery



YTD Adverse to plan (£83k)

- Primarily due to not reducing outsourcing within T&O, month 3 position positive compared to month 1 and 2.

July Uplift

- Predominantly due to Private Patients Income
  - Improve private patient data collection in place
  - Initial analysis identified a net opportunity of £1.3m (Cardiology/Interventional Radiology), which excludes any IP activity.
  - EGAU move agreed, slight delay to original plan.
  - Risk to early July start (likely to be end of July) – mitigation based on financial target set at £1.0m FYE

October Uplift

- Due to additional Private Patients Income and Prime Provider Income
  - Prime Provider
    - Additional admin resources out to advert
    - Bed modelling completed with final modelling to include daycase demand, theatre utilisation and outpatient demand to assess impact of achieving operational contract activity, including Winter, Prime Provider and Patient Patients.
  - Private Patient
    - Further opportunity for IP activity linked with Prime Provider modelling.

Trust Board meeting - July 2018

Maidstone and Tunbridge Wells NHS Trust

7-12	**Safeguarding children update (Annual Report to Board, including Trust Board annual refresher training)**	**Chief Nurse / Named Nurse, Safeguarding Children**

The Trust is required to produce an annual Safeguarding Children's report, which should have oversight by a committee of the Board and cover the key elements of safeguarding including the provision of policies, procedures, training and safeguarding alerts.

The full report was presented to and discussed by TME and the Quality Committee in July 2018 and covers the period April 2017 – March 2018.

The Executive Lead for Safeguarding Children Adults is the Chief Nurse; this agenda is supported by the Named nurse for safeguarding children.

The report includes a declaration which states the Trust's compliance with section 11 of the Children Act and outlines how these statutory requirements are met.

This report details the structure of the Trust' Safeguarding Children's team in the Trust and outlines governance arrangements internally and externally in terms of committee structures and reporting arrangements.

The report includes a section (3), "What does the Board need to know?", on the basis that this provides the necessary instruction for the Trust Board i.e. above and beyond what individual Executives may be required to do, as part of their mandatory training.

The report provides a number of updates relating to key and pertinent issues relating to safeguarding children.

Which Committees have reviewed the information prior to Board submission?

- 'Main' Quality Committee, 04/07/18
- Trust Management Executive, 18/07/18

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]

Information & assurance

[1] 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

Safeguarding Children Declaration

Maidstone and Tunbridge Wells NHS Trust is fully committed to ensuring that all patients including children are cared for in a safe, secure and caring environment. The Trust adheres to its statutory duties in line with Section 11 of the Children Act. A number of Safeguarding Children arrangements are in place in order to support this. A section 11 audit was last presented to the Kent Safeguarding Children Board in February 2017. A new report will be presented in 2018 [date not as yet specified].

These include:

- Maidstone and Tunbridge Wells NHS Trust meets its statutory requirements in relation to Disclosure and Baring (DBS) checks – all staff employed at the Trust undergo a DBS check prior to employment and those working with children undergo an enhanced level of assessment.
- The Trust Safeguarding Children policies and systems are up to date and robust and are reviewed on a regular basis, ultimately by the Trust Board. The last policy review occurred in April 2017 and was ratified on 7th July 2017. Policies and procedures are available to staff through a dedicated safeguarding children intranet site.
- The Trust has a process in place for following up children who are not bought to outpatient appointments within any speciality to ensure their care and health is not affected in any way.
- The Trust has a system in place for flagging children who are subject to a child protection plan. The Trust has implemented the national Child Protection Information Sharing System (CP-IS) in the ED and will follow this in both Paediatrics and Maternity in 2018
- All eligible staff are required to undertake relevant Safeguarding Children training and this is regularly reviewed to ensure it is up to date. The Trust has a training strategy in place with regard to delivering safeguarding training.

Safeguarding Professionals

- The Trust has Named Safeguarding Professionals who lead on issues in relation to the safeguarding of children. They are clear about their role, have sufficient time and receive relevant support, and training, to undertake their roles, which includes close contact with other social and health care organisations. This complies with the current Working Together Guidelines (2015)
- The total number of professionals in these roles is 6.4 WTE which includes a Named Nurse Safeguarding Children, 2 x Safeguarding Children Nurses, a Deputy Named Midwife Safeguarding Children and a Peri-Natal Mental Health Nurse; there is also a named Midwife (1.0 WTE), Named Doctor for Safeguarding Children and a Named Doctor who leads on Child Death.
- The Chief Nurse is the Executive Director lead for Safeguarding Children.

- The Trust's Safeguarding Children Committee leads and supports all Safeguarding Children activity and ensures that the Trust executes its statutory duties in relation to the safeguarding of children
- The Trust Board takes the issue of safeguarding extremely seriously and receives an annual report on safeguarding children issues. A bi-monthly Safeguarding Children report is presented to the Safeguarding Children committee
- The Trust continues to be an active member of the Local Safeguarding Children Boards (LSCBs). This is through membership and work of the Boards and the sub committees. Any issues related to safeguarding children will be discussed at these Boards each quarter.
- The Trust has an audit programme to provide assurance that safeguarding systems and processes are working. In addition to single agency audits the Trust takes part in multi-agency audits with partner agencies.
- The Trust continues to review and challenge its arrangements in order to support safe and consistent practice, adhere to its statutory duties and will respond positively and assertively to any changing guidance and national reviews.

June 2018

Alison Jupp Named Nurse Safeguarding Children

1.0 – Introduction

The purpose of the annual report is to update the Trust Board on the governance arrangements and progress made in relation to safeguarding children since the last report in 2017. Every Trust Board requires an update at least every year advising of key issues relating to the safeguarding of children and this has been scheduled to go to the July 2018 Trust Board Meeting. The Board is reminded that children are defined by the Children Act 1989 as young people up to but not including their 18th birthday.

The Safeguarding Children Team will provide a high quality and accessible Safeguarding Children service to the whole Trust. We expect all staff to meet their statutory responsibilities and comply with best practice guidance. This includes ensuring that the child's welfare is paramount and that the child's safety and welfare is their first concern, as enshrined in the Children Act 1989.

A revised Safeguarding Children Policy and Practice Document was ratified on 7.7.17; this document alongside statutory guidance from the Kent Safeguarding Children Board and HM Government provides the strategic framework for our day to day working.

The Safeguarding Children team continues to 'flag' all children of concern on the Maidstone and Tunbridge Wells NHS Trust IT systems (Allscripts and Symphony); this system works well. The national Child Protection Information System is available in the ED.

Our key message is that Safeguarding is everyone's responsibility.

2.0 - Children's Specialist Services

Maidstone and Tunbridge Wells NHS Trust submitted 280 referrals to Children's Specialist Services in the 12 months to 30.6.17. This is an increase on the previous 12 months. We believe that this figure may not be a true reflection of the actual number of referrals. As a team we continue to remind staff to send a copy of any referral to the Safeguarding team. The majority of referrals are made by ED or Paediatric staff with Midwife's being the next group.

As a team the quality of the referrals are reviewed. We provide training on 'how to make a quality referral' and staff are encouraged to get referrals reviewed by Safeguarding prior to submission.

The Safeguarding Children team work very closely with Children's Specialist Services; the Named Nurse regularly meets with Children's Specialist Services colleagues in both the Maidstone and Tunbridge Well's areas. These forums provide an excellent opportunity for joint working, information sharing and developing new working relationships. The Named

Nurse sits on a number of Local Authority led multi-disciplinary panels including the Adolescent Risk Management Panel and the Multi-Agency Sexual Exploitation Board.

The Safeguarding Children Nurses attend Child Protection Conference's for high risk children known to Maidstone and Tunbridge Wells NHS Trust to support staff whose experience in Safeguarding may be limited. The Safeguarding Children Nurses support staff to provide high quality reports for Child Protection Conference's; the Named Nurse will also attend conferences as time permits.

At some stage in 2018 (date not yet agreed) the Local Authority will revise the process for making Safeguarding Children referrals. The Local Authority will triage all referrals as they are submitted and will decide whether the referral meets the threshold for Early Help, Child in Need or Child Protection. Professionals will still be able to challenge any decisions made in this way. The Local Authority is keen to adopt a single referral system to ensure all concerns are treated equitably across the county. Training will be introduced to ensure Maidstone and Tunbridge Wells NHS Trust follows the new processes. The Named Nurse Safeguarding Children has provided feedback to the Local Authority prior on the new forms and process for referral. It is expected that the process will be in place by November 2018.

Currently Kent County Council has around 1300 children subject to a Child Protection Plan – the Trust flags these children on our IT systems. We also flag known Children in Care and other high risk children.

3.0 - What does the Board need to know?

3.1 – Working Together Guidelines 2018

The Working Together Guidelines 2018 will be published by HM Government imminently. There are substantial changes to processes which will mean the replacement of Local Safeguarding Children Boards (LSCBs) with local Safeguarding Partners, the establishment of a new national Child Safeguarding Practice Review Panel (CSRP), and the transfer of responsibility for child death reviews from Local Safeguarding Boards to new Child Death Review Partners (CDRP). It is unclear what the final arrangements for Kent will look like. The Named Nurse will update the Trust as more information becomes available. The Safeguarding Practice Review Panel became operational on 29.6.18.

3.2 - Kent and Medway Safeguarding procedures

The above procedures have been updated (April 2018) to include new guidance on (amongst others) Female Genital Mutilation (FGM), Responding to Abuse and Neglect, Children from Abroad, Dangerous Dogs and Safeguarding Children, Gang Activity and

Modern Slavery[1]. These have been included in the updated Safeguarding Policy. A further update in October 2018 will be issued.

3.3 – CP-IS (Child Protection –Information System)

CP-IS is a nationwide system that enables child protection information to be shared securely between local authorities and NHS trusts across England. It will be part of the NHS spine portal information and will allow clinicians in urgent care to access Child Protection information when any child presents. It will eventually remove the need to 'flag' up children on our own IT systems.

Maidstone and Tunbridge Wells NHS Trust went live with CP-IS in March 2018. A further roll-out to Paediatrics and Maternity services will occur in late 2018.

3.4 – Child Abuse and Neglect

In October 2017 NICE published an updated guideline to cover specifically child abuse and neglect – NG76[2]; this adds to the previous guidance published in 2009 [NG89 – *When to Suspect Maltreatment in the Under 18's*].

This guideline covers recognising and responding to abuse and neglect in children and young people aged under 18. It covers physical, sexual and emotional abuse, and neglect. The guideline aims to help anyone whose work brings them into contact with children and young people to spot signs of abuse and neglect and to know how to respond. It also supports practitioners who carry out assessments and provide early help and interventions to children, young people, parents and carers.

It advises that practitioners are to have an *awareness* of factors which they need to *consider* which may indicate neglect and abuse - e.g., history, presentation, disability, interaction with parents – these are defined as '*alerting features*'. If consideration leads to *suspicion* then practitioners are to take advice and consider a referral to Children's Specialist Services. Practitioners should continue to consider the possibility of child abuse or neglect as a cause for behavioural and emotional alerting features, even if they are seemingly explained by another cause.

This new guidance is included in all training.

3.5 - New referral process to Children's Social Care

In late 2018 Kent County Council will introduce a new referral process to Children's Social Care for all professionals who wish to raise a concern about a child. The process will move to a 'single front door' process by which a professional will 'notify' Children's Social Care of a concern. Children's Social Care will then triage that referral to either the Early Help service or to a Child in Need or Child Protection process. At present there is a twin track approach

[1] http://www.proceduresonline.com/kentandmedway/chapters/amendments.html
[2] https://www.nice.org.uk/guidance/ng76

whereby a professional must make a decision prior to referral as to which pathway (Early Help versus Child in Need/Child Protection) it wishes Children's Social Care to follow. There are at present two separate referral forms and pathways. The new process will be one form and will take some of the guesswork out of when or where to refer, allowing Children's Social Care to ensure that children receive the appropriate level of support at the right time.

The Named Nurse Safeguarding Children has taken part in trialling the new process and providing feedback to Children's Social Care. It is unlikely to be introduced before October 2018.

3.6 - Teenage suicides

In 2017 the University Of Manchester published a report entitled '*Suicide by children and young people. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)*'. The Kent Safeguarding Children Board has looked at this report as Kent has experienced an increasing number of teenage suicides with Dover and Tunbridge Wells having higher than average rates and admissions of children with suicide intent/ideation. It is a moot point as to the reason why. There have been 16 teenage suicides in Kent since 2016.

The Kent Safeguarding Children Board audited 15 case files on children who had completed suicide from July 2014 – January 2018. It is anticipated that new guidance will be issued.

Within this Trust it is apparent that an increasing number of children are being admitted with self-harm and overdoses. Staff are ill-prepared for the risk that these children pose to themselves and struggle with the limited services provided by CAMHS. Admission to a tier 4 Mental Health bed is fraught with difficulties and can take up to 4 weeks; this leaves very vulnerable children on an acute Paediatric ward receiving Mental Health care from agency RMN staff.

The Paediatric Matron has developed a robust care pathway risk assessments for these children. Staff are supported by both the Paediatric Matron and the Named Nurse Safeguarding Children. Both work closely with the CCG, CAMHS, NHSE (as the 'bed manager' for tier 4 beds) and Children's Social Care to ensure appropriate care for these children is given. Training opportunities for staff are now in place and it is hoped to recruit some staff with Mental Health and Paediatric experience.

3.7 - CQC Paediatric Transition Project

As part of the Complex Needs Programme (sitting under the Best Quality Workstream) it has been recognised that there is a significant opportunity to improve the quality of care for young people when they access our services. This is particularly so for our 16 & 17 year olds who have little or no Paediatric oversight when admitted to our wards. The majority of children are transitioned to adult services after their 16th birthday but there is a small cohort

of children who stay within Paediatric services until they are 17 (but this is for children with specialist needs). This project aims to build on this.

Young people with chronic care needs experience variable quality of transition. Some pockets of service provide good transition with established policies, guidelines and pathways but some areas of service are not so well developed. This means continuity of care may be disrupted, opportunities for increasing awareness/ education about health are missed and adult services may experience higher levels of ED access and children not coming to outpatient appointments.

Patients, parents and carers can struggle to (re-) engage with adult services thus increasing the risk that chronic conditions are poorly controlled and health outcomes will suffer. Staff in adult services can be inexperienced and anxious about identifying and responding to the holistic needs of young people.

Young people admitted to ED and adult wards present with increased levels of risk around safeguarding, consent to treatment and increased risk of poor experiences of care. The Trust does not admit children over 16 to the Paediatric wards; in March 2018 it was identified that 55 children were admitted to non-Paediatric areas on both sites. That is 55 children who have had no Paediatric overview. The CQC in its recent report identified this as a risk and seek improvement.

The aims of this project are to –

- To improve the experience of transition for young people, their families and carers by strengthening the continuity and integration of personalisation of care thus reducing the isolation of paediatrics from adult services
- To develop capacity and capability of staff to care for young people transitioning from paediatrics to adult services
- To improve the health outcomes of young people by maximising opportunities for holistic care, increased health literacy, self-management and 'compliance' with planned chronic care pathways
- To ensure that children admitted to non-Paediatric areas are looked after by staff who are trained at Level 3 in Safeguarding Children.

The project team (lead by the Named Nurse Safeguarding Children and the Paediatric Matron) have identified that children with Type 1 Diabetes would benefit from transitioning to adult services at 18. This cohort (about 50 children) will be in the first wave of children who will remain with Paediatrics until 18.

The second strand to this project will involve the Named Nurse Safeguarding Children and the Paediatric Matron being informed daily of all children occupying non-Paediatric beds. A review will be conducted of these children and advice provided. Ab action n plan for trainkng adult teams in Safeguarding Children has been submitted.

3.9 - Prevent

Prevent is part of HM Government Counter Terrorism Strategy ('Contest'). Its aim is to identify individuals at risk of radicalisation and those at risk of supporting terrorism. The NHS is mandated (by the Prevent Duty) to train all front line staff in raising awareness of the Strategy.

The Trust has now been providing Prevent training since 2017. There are 4 trainers in the Trust of which the Named Nurse Safeguarding Children is one. A review is being conducted in how to raise compliance (currently at 24%).

4.0 - Safeguarding Children Training

4.1 - The Safeguarding team places a high priority on ensuring that all the Safeguarding Children training delivered is robust, fit for purpose and follows the national guidelines as agreed in the Intercollegiate Document (2014)[3] and other local and national guidelines.

4.2 - Traditionally compliance for level 1 and 2 Safeguarding Children Training has been high at greater than 90%. Level 3 compliance has traditionally been less than 85%. It is unclear why this may be so but may be due to the commitment required (1 day) and the difficulty in releasing clinical staff for this period of time.

4.3 – The Named Nurse and Head of Learning and Development will be mapping out training requirements for the Trust following the recent CQC inspection. The report recommended that the Trust should ensure that children admitted to adult wards (or other non-Paediatric areas) are cared for by staff with level 3 safeguarding training. A pragmatic approach is being taken and initially all senior nursing staff (Bands 7 and above) and other nominated staff from every ward will be trained. This will ensure that on all shifts there will be at least one level 3 trained Nurse. As the training is rolled out other staff will be included. As resources are limited this approach will be that start of a rolling programme. It is also anticipated that e-learning will form a substantial part of the level 3 offer to the Trust.

4.4 - All the Safeguarding Children Training packages are reviewed and updated on a regular basis by the Named Nurse and the wider Safeguarding Children team. The Safeguarding Children team will deliver 10 sessions at level 3 by the end of December 2018 and are encouraging staff to access further training outside of Maidstone and Tunbridge Wells NHS Trust. Internal training is well received and the aim is to raise compliance to 85% by 31.3.19. The Named Nurse is also an associate trainer for the Kent Safeguarding Children Board. The Named Nurse delivers training to partner agencies as requested.

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[3] http://www.rcpch.ac.uk/sites/default/files/page/Safeguarding%20Children%20-%20Roles%20and%20Competences%20for%20Healthcare%20Staff%20%2002%200%20%20%20%20(3)_0.pdf

4.5 - The Safeguarding Children team are also accessing training to ensure that their own professional development is up to date. The Named Nurse and one of the Safeguarding Children Nurses will be completing MSc's at the University of Greenwich. The team also access training with the Kent Safeguarding Children Board. All the Safeguarding Children team are compliant with statutory and mandatory training.

4.6 – Level 5 training for Trust Executives

All NHS Trust executives are required to be compliant with Safeguarding Children training. The Chief Nurse (as Executive Lead for Safeguarding Children) is required to be level 5 compliant and details of this training have been sent to her.

The Named Nurse Safeguarding Children is currently compliant with Level 5 training.

5.0 – Child Exploitation, Gang Activity and Trafficking

5.1 - In December 2015 Operation Willow was established alongside the Child Sexual Exploitation Team (CSET). The CSET is a Kent wide multi-agency team that identifies victims and aims to disrupt exploitative activity. Its terms of references (TOR's) are set and reviewed by the MASE (Multi-agency Sexual Exploitation Group) which also identifies the Child Sexual Exploitation profile of Kent and oversees the Kent Safeguarding Children Board Child Sexual Exploitation Strategy and Action Plan. The Named Nurse sits on the MASE and is the lead for Child Sexual Exploitation within Maidstone and Tunbridge Wells NHS Trust.

5.2 – The CSET has recently widened its remit and is now taking soft intelligence on all forms of Child Exploitation. The information will be triaged by Operation Willow and allocated to the appropriate teams. A 'soft intelligence' form has been developed which allows any practitioner to share information that may help CSET to identify areas and children of concern where exploitation may be occurring[4]

5.3 – There has been increased concern from both police and Children's Social Care about increased 'gang related violence' in Kent. At Maidstone and Tunbridge Wells NHS Trust 6 children have presented with serious injuries as a result of gang related violence and exploitation. In one week in June 2018 4 children were admitted to Hedgehog Ward with 2 under 24 hour police protection. New Kent wide guidelines have been published[5] and a Kent gang strategy will be published in 2018. This emerging phenomenon is included in training.

5.4 – Trafficking – the current definition of child trafficking is –

[4] http://www.kscb.org.uk/guidance/sexual-abuse-and-exploitation

[5] http://www.proceduresonline.com/kentandmedway/chapters/p_gangs.html

'*The movement of a child for the purpose of exploitation. Any child transported for exploitative reasons is considered to be a victim of trafficking. Children cannot give informed consent to be trafficked or transported'*.

Practitioners are reminded that '*movement'* can simply be a journey from one town to another and is not solely about children who come into the UK from abroad. Trafficking is included in all Safeguarding Children training. Three children have been identified since April 2018 who we believe fall within the definition of 'child trafficking'; Children's Social Care have been involved in all cases.

Guidance is available for all professionals who may have a concern that a child has been trafficked.[6]

6.0 – Serious Case Reviews (SCR) –

Since the 2017 report 3 Serious Case Reviews have been published in Kent[7]. None involved a child known to Maidstone and Tunbridge Wells NHS Trust. However a report has been submitted to the Kent Safeguarding Children Board following the death of a child in December 2016. Although this will not be a Serious Case Review the Trust needs to be mindful of any recommendations and will develop an action plan following publication.

All the Serious Case Review's relating to Child C and D make mandatory recommendations that have implications for Maidstone and Tunbridge Wells NHS Trust, although the Trust made no contribution to the final reports.

In particular the Trust should be mindful that staff are using chronologies as 'accepted practice' to inform assessments, and aid identification of serious concerns not always apparent in single records (Child B and C); the procedures for supervision should be reviewed to ensure that it provides and evidences critical reflection, robust challenge, risk review and support to staff when dealing with families (Child C and D); all professionals to ensure that they have access to the most up to date advice regarding the current procedures for the of use of 'pre-birth plans; finally all staff to ensure that they have access to the most current advice about 'safe sleeping' (for babies) – Child E.

Both the Named Nurse Safeguarding Children and the Deputy Named Midwife Safeguarding Children are updating current training and policies to incorporate these recommendations.

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[6] http://www.kscb.org.uk/__data/assets/pdf_file/0016/33433/Safeguarding-children-who-may-have-been-trafficked.pdf

[7] http://www.kscb.org.uk/procedures/serious-case-reviews/kent-scrs

NHS
Maidstone and Tunbridge Wells NHS Trust

7.0 – Safeguarding supervision

7.1 - The Safeguarding Children team have reviewed the trust policy for Safeguarding Children supervision provided to staff working with children and the new policy will be ratified imminently. This will be in line with recommendations from recently publishes Serious Case Review's.

7.2 – Safeguarding supervision will be mandatory for all Midwifery staff and specialist Paediatric Nurses who hold caseloads. For all other Paediatric nursing staff (including those in the ED) group supervision can be accessed with ad hoc one to one supervision as requested.

8.0 – Midwifery Safeguarding

The Midwifery Deputy lead for Safeguarding Children (Heather Lawrence) provides an essential service to both the acute based and community Midwifery teams. She has built excellent relationships with local Children's Social Care teams to ensure that pregnant women receive the appropriate level of support both in the ante-natal and post-natal periods. She provides support and specialist advice to all Midwifery staff; this is fundamental especially if a child is to 'removed' at birth into Local Authority care. Heather Lawrence will attend Child Protection Conference's to support staff in high risk cases.

All referrals to Children's Social Care are quality assured and outcomes monitored to ensure the correct level of support is provided.

Heather Lawrence liaises with her counterparts in Kent to ensure that information is shared about high risk women who may be evading Midwifery services.

All Midwives receive mandatory Safeguarding supervision from Heather Lawrence and the Safeguarding Children Nurses (Jane Waterhouse and Gerry Finney) on a 3 month basis.

Heather Lawrence delivers mandatory Safeguarding Children training to Midwifery staff and has organised specialist training in Learning Disabilities for Midwives in late 2018.

9.0 – Safeguarding audits

9.1 – The Paediatric team have an on-going audit programme. The current audit relating to Safeguarding involves providing assurance on the new NICE guidelines on 'When to Suspect Neglect' (NICE CG89); this will Strategy Meeting in September.

A recent audit on Child Protection Medical Reports identified that staff need to be more robust in using body maps and ensuring that all reports are shared with the Named Nurse Safeguarding Children. Both recommendations have been actioned.

10.0 - Areas of risk for ongoing monitoring and review

- The Safeguarding Children Committee will continue to monitor compliance with training with a particular focus on improving the compliance at level 3
- New processes in A&E
- A focus on Safeguarding supervision for all staff working with children

11.0 – Conclusion

- Significant work has been completed in the last 12 months in relation to improving training, services for children and safeguarding arrangements at Maidstone and Tunbridge Wells NHS Trust.
- There is still work to do to improve the standards and processes but we are assured that the right practitioners and processes are in place
- The Safeguarding Children committee will continue to monitor the Safeguarding Children team and will report to the Quality Committee

Alison Jupp

Named Nurse Safeguarding Children

July 2018

Trust Board meeting - July 2018

NHS Maidstone and Tunbridge Wells NHS Trust

7-13	**Safeguarding adults update (Annual Report to Board, including Trust Board annual refresher training)**	**Chief Nurse / Matron Safeguarding Adults**

Summary / Key points

The Trust is required to produce an annual Safeguarding Adults report, which should have oversight by a committee of the Board and cover the key elements of safeguarding including the provision of policies, procedures, training and safeguarding alerts. The report provides assurance that statutory requirements are met, particularly in relation to the Mental Capacity Act and the Deprivation of Liberty Safeguards. The report has been prepared by the Safeguarding Adults Matron with oversight of the Safeguarding Adults Committee. The full report was presented to the Trust Management Executive Committee and Quality Committee in July 2018.

The Trust has a named person at Board level (the Chief Nurse) with executive responsibility for safeguarding adults. The day to day delivery of the safeguarding adults' agenda is delivered by the Matron for Safeguarding Adults with oversight provided by the Deputy Chief Nurse.

The Trust is an active participant with the Kent & Medway Safeguarding Adults Board (K&MSAB) and it's constituted working groups.

The Trust has a local Safeguarding Adults Committee, with multi-agency representation including social services and Clinical Commissioning Group (CCG) Designated Nurse. The committee has a named Non-Executive Director to champion, support and challenge the safeguarding agenda.

The Trust has engaged with the K&MSAB) self-assessment and peer review of safeguarding provision, and has responded to the single area of improvement noted in the 2017 assessment process.

The CQC Inspection earlier in the year did not highlight any shortcoming with the safeguarding adults' processes and responses.

Safeguarding adult's activity is underpinned by a suite of learning and development opportunities, in line with national and local guidance. The Trust as access to multi-agency training via the Kent & Medway Safeguarding Adults Board.

The Trust is meeting the standard of 85% compliance for safeguarding adults at levels 1, 2 and MCA. PREVENT training is lower (82%) however during the course of the year this has improved.

Safeguarding concerns are generally managed by the operational delivery teams with support and guidance from the Matron for Safeguarding Adults.

Safeguarding concerns are raised via the Datix incident reporting system internally and via the Kent Adult Safeguarding Alert Form (KASAF). A total of 76 concerns have been raised in the reporting period (April 2017 to March 2018).

Deprivation of Liberty Safeguards (DoLS) understanding has improved over the last year. There have been a total of 215 applications made during the reporting period.

There have been 3 Safeguarding Adult Reviews (SARs) and 1 Domestic Homicide Review (DHR) undertaken/published in the last year. The Trust was involved with 1 SAR and 1 DHR. In both cases there were no specific issues with the care provided; however the wider learning has been incorporated into the wider safeguarding education and training programmes.

Safeguarding supervision is provided for the Safeguarding Adults Matron via the local Safeguarding Adults professional network, and from the Deputy Chief Nurse for day to day managerial support. Supervision is provided to front line staff involved in significant or complex cases by the Matron for Safeguarding Adults

The Trust now has a Learning Disability Hospital Liaison Nurse in post, and is now better placed to

move forward with the LD agenda. The Trust is engaging with the Learning Disability Mortality Review process and has 3 individuals now appropriately trained to undertake reviews.

Which Committees have reviewed the information prior to Board submission?
Quality Committee, 04/07/18
Trust Management Executive, 18/07/18

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
Information and assurance

[1] 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

1.Introduction

1.1 The purpose of this annual report is to inform the Trust Board and the Quality Committee on how the Trust is meeting its duties to safeguard adults by preventing and responding to concerns of abuse, harm or neglect of adults during April 2017 to March 2018.

1.2 All individuals working for the Trust, or engaged by the Trust, have a responsibility for the safety and wellbeing of patients and colleagues.

1.3 This report aims to provide assurance that the Trust is compliant with the Kent & Medway Safeguarding Adults Policy & Procedures (the Local Authority), the Care Quality Commission standards and the Care Act 2014.

2.0 Background

2.1 The Care Act 2014 puts adult safeguarding on a statutory footing. The guidance states that safeguarding 'is about people and organisations working together to prevent and stop both the risks and experiences of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, there appropriate, having regard to their views, wishes, feelings and beliefs in the deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about the personal circumstances'

2.2 Making Safeguarding Personal, a multi-agency approach led and supported by the Association of Directors of Adult Social Care, seeks to achieve:

- A personalised approach that enables safeguarding to be done with, not to, people.
- Practice that focuses on achieving meaningful improvement to people's circumstances rather than just on 'investigation and conclusion'
- An approach that utilises social work (and health care) skills rather than just 'putting people through a process'
- An approach that enables practitioners, families, teams and Safeguarding Adults Boards (SABs) to know that difference has been made

2.3 Safeguarding practice is, therefore, underpinned by six principles of

- Empowerment
- Prevention
- Proportionate
- Protection
- Partnership
- Accountable

2.4 NHS England and the Local Authority have in place and Accountability and Assurance Framework that sets out the expectations of role, duty and responsibility including:

- Staff are suitably skilled and supported
- Safeguarding leadership and commitment at all levels of the organisation
- Fully engaged with and support local accountability and assurance structures, in particularly via the SABs and their commissioners
- Have effective arrangements in place to safeguard adults
- A named lead for adult safeguarding

3.0 National & Local Policy

3.1 National policy on safeguarding adults is underpinned by the Care Act 2014, along with a number of other acts or policies including (but not limited to) the Mental Capacity Act and Deprivation of Liberty Safeguards, Counter-Terrorism and Security Act (including CONTEST the UK's counter-terrorism strategy).

3.2 The Trust has a core Safeguarding Adults Policy in place which has been drawn from both the Care Act and the Local Authority policy.

3.3 The policy is currently under review in consultation with Local Authority colleagues.

4.0 Safeguarding Adults Structure & Governance

4.1 The Trust is accountable to the West Kent Clinical Commissioning Group (CCG), and reports to the Performance & Quality Committee via the Quality Review Group (Chaired by the CCG Chief Nurse).

4.2 The Designated Nurse for Safeguarding Adults is a member of the Quality Review Group and the Trust's internal Safeguarding Adults Committee.

4.3 The Kent & Medway Safeguarding Adults Board is the Local Authority statutory service which exists to make sure that all member agencies (social care, health, education, emergency services) are working together to keep Kent & Medway's adults safe from harm. The Board is chaired by an Independent Chair

4.4 The K&MSAB has a number of sub-groups to ensure a consistent approach across Kent in relation of quality assurance, learning & development, practice, policy & procedure and Safeguarding Adults Reviews (SARs).

4.5 The Trust Executive Lead for Safeguarding Adults is the Chief Nurse. Operational oversight of safeguarding adults is delegated to the Matron for Safeguarding Adults via the Deputy Chief Nurse

4.6 Attendance to the K&M SAB has been delegated to the Deputy Chief Nurse up to December 2017. From January 2018 a revised board structure has been put in place to ensure equal voice for all agencies. Health is now represented via a Chief Nurse for Commissioners and a Chief Nurse for providers. Health now have a separate group to enable debate and information sharing, which also acts a conduit for communication between organisations and the board.

4.7 The Local Authority has an escalation process available on their website which enables practitioners at any and every level to escalate a concern or query if they feel the response is in appropriate or untimely.

4.8 The Trust Board has a responsibility to ensure that there is a policy and process in place that details the processes to protect adults at risk of harm.

4.9 The Board receives assurance via the Trust Clinical Governance Committee, which receives reports, risks and plans to mitigate via the Trust's Safeguarding Adults Committee

4.10 The Trust Safeguarding Adults Committee is a constituted sub-committee of the Trust Clinical Governance Committee. It is chaired by the Deputy Chief Nurse and has core representation from the directorates, therapies, Social Services/LA, Dementia Lead, Hospital Learning Disability Liaison Nurse, Learning & Development and CCG.

4.11 The Committee has a Named Non-Executive Director to support and champion safeguarding.

4.12 The committee meets bi-monthly, and met 6 times during 2017.

4.13 The purpose of the committee is to implement and monitor the Safeguarding Adult's Framework, to ensure training provision is available to equip staff with the

knowledge and skills required for the identification of adults at risk of harm, to make and respond to referrals and concerns and to carry out safeguarding enquiries and investigations.

4.14 The Trust Safeguarding Adults Committee draws its work plan and objectives from both the K&MSAB and from emerging themes resulting from safeguarding incidents and investigations.

4.15 The committee also provides a forum for the review of practice, to provide practical advice and support and to facilitate feedback and discussion between directorate, commissioner and local authority representatives.

5.0 **The Matron for Safeguarding Adults** leads on the key areas of work necessary to safeguard adults at risk of harm. These include:

5.1 Design & delivery of training including the principles of the care act, the role of lead agency, application of the mental capacity act, domestic abuse, PREVENT (anti-terrorism and radicalisation agenda recognition and reporting),

5.2 Policy and procedure development and review, ensuring that Trust policies are in line with both the Care Act and Kent & Medway Policy and Procedures.

5.3 PREVENT Lead and Home Office approved trainer for the PREVENT agenda.

5.4 Domestic Violence Lead, working closely with staff in key areas including Emergency Department and Women's services. Links have also been established with Human Resource Business Partners to develop strategies to support and manage staff for whom domestic violence is a personal issue.

5.5 Internal Management Review (IMRs): author of IMRs in response to requests for the preparation of Safeguarding Adult Reviews (SARs) and Domestic Homicide Reviews (DHRs)

5.6 Representing the Trust at the relevant K&MSAB sub-groups, in particular the Policy & Procedures, Learning & Development and the Quality Assurance Working Group. The Matron also attends the Mental Capacity Act Local Implementation Network (MCA LIN).

5.7 Safeguarding supervision: provides supervision to staff involved in complex or serious safeguarding cases. The Matron receives managerial supervision from the Deputy Chief Nurse. Specialist safeguarding supervision for named individuals and safeguarding leads is provided by an appropriately qualified supervision facilitator external to the trust.

5.8 Provides line management support to the Learning Disability Hospital Liaison Nurse.

6.0 **Oversight and scrutiny**

6.1 **Self-Assessment Framework (SAF)**

6.2 The Trust undertakes a self-assessment against the core standards on an annual basis. The SAF has been developed by the K&MSAB and includes a mechanism of peer review to validate the assessment outcomes. Peers are allocated at random by the SAB. The peer review is then reported to the Quality Assurance Group, a sub-group of the SAB.

6.3 The SAF covers 4 areas of assessment, each with a number key lines of enquiry, The areas are:

- Outcomes & experiences of people who use services
- Leadership, Strategy and Working Together
- Commissioning, Delivery and Effective Practice
- Performance and Resource Management

6.4 The Trust scored positively overall in the 2017 exercise with the only area for develop being to include PREVENT in the induction training to new staff.

6.5 The most recent CQC inspection did not raise any concern regarding the overall practice of safeguarding adults.

6.6 There is regular liaison with the CQC Liaison Officer on a monthly basis, where any safeguarding concerns may be address. To date, the Trust has always been able to answer any external question in a timely manner having already initiated an investigation or having completed the investigation and awaiting final closure with the Local Authority.

7.0 Safeguarding Practice:

7.1 All safeguarding concerns are reported using a Kent wide Kent Adult Safeguarding Alert Form (known as a KASAF).

7.2 Directorate Matrons support the safeguarding agenda and either undertake or oversee any safeguarding related investigation.

7.3 The Trust has a monthly panel meeting to review all KASAF alerts and any subsequent investigation. This multi-agency approach to review of the investigation allows for open debate and the opportunity to agree the best way to involve the individual and to feedback on findings.

7.4 This approach allows for prompt closure with the Local Authority, and ensures a robust level of oversight by both the Deputy Chief Nurse and the Local Authority Safeguarding Adults Coordinator.

7.5 The Matron for Safeguarding Adults coordinates this panel, and liaises with the directorate level investigators to ensure appropriate support is offered.

7.6 The total number of KASAFs raised in relation to MTW provided care during the reporting period is 76. These are split between the two sites and are detailed in **Appendix A**

7.7 Day to day safeguarding activity is primarily overseen by the Directorate Matrons, and front-line clinical staff with guidance, advice and support provided by the Matron for Safeguarding Adults.

7.8 Supervision for staff involved in complex or serious safeguarding cases is provided by the Matron for Safeguarding Adults

8.0 Mental Capacity Act (MCA) 2005

8.1 Mental Capacity is the ability to make a decision. Capacity can vary over time, and according to the decision to be made. Lack of capacity may be due to either a permanent condition such as stroke or temporary due to a mental health problem or unconsciousness because of illness or the treatment for the illness (e.g.: ICU admission).

8.2 The MCA sets out statutory responsibilities which apply to everyone who works in health and social care who are involved in the care and treatment or support of people over the age of 16 years In England or Wales.

8.3 The MCA is underpinned by 5 principles:

- Assume Capacity, unless it is established otherwise
- Practical steps taken to maximise decision making capacity (e.g.: use of non-verbal communication)
- Unwise decisions: a person has the right to make an unwise or eccentric decision
- Best Interest: any act or decision must in the person's best interest (not the practitioner or organisation).

- Lest restrictive: alternative acts or decisions must be considered with regard to the purpose for which it is needed and whether it can be achieved in a way that is less restrictive for the person's rights and freedom to act.

8.4 The Trust is achieving a good compliance with MCA training uptake, however local audit of application of the MCA principles is poor. This does not necessarily mean that MCA principles are not being applied, rather a failure to explicitly evidence the approached used to determine capacity within the health care records

9.0 Deprivation of Liberty Safeguards(DoLS)

9.1 The Deprivation of Liberty Safeguards (DoLS) form part of the MCA 2005. The DoLS provide a mechanism to ensure that appropriate safeguards and least restrictive options are in place for a person lacking mental capacity where it is considered to be in the persons best interest to keep them in a hospital or care home.

9.2 The 'acid test' from previous Supreme Court Judgements (P&Q vs Surrey Council and P vs Cheshire West) remains in place. The 'acid test' criteria is applicable if the person is assessed as lacking mental capacity and is:

- Under continuous supervision and control **AND**
- They would not be free to leave

9.3 The process requires an application to be made to the Local Authority who will then approve the application. The DoLS Office for the Local Authority will triage all requests and should action with specified time frames. However it continues to be unclear how many applications are converted to authorised DoLS. This issue has been raised with the K&MSAB and has become a standing agenda item. DoLS applications for individuals within acute care settings are often seen as a lower priority for the Local Authority.

9.4 The Trust has made a total of 215 DoLS applications in the year April 2017 to March 2018. The 215 made up of 105 at Maidstone Hospital and 110 at Tunbridge Wells Hospital.

10.0 PREVENT

10.1 The Prevent Duty is a set of definitions and responsibilities approved under the Counter-terrorism and Security Act 2015 which sets out duties for specific authorities.

10.2 Key responsibilities for health are:

- Partnership: working with regional safeguarding forums to have oversight of compliance with the duty.
- Organisations should have a lead and access to networks for advice and support to make referrals to Channel
- Risk Assessment; all Trusts should have a Prevent Lead who acts as a single point of contact within their organisation
- Staff Training, relevant to role in safeguarding adults and children.

10.3 PREVENT training focuses on the identification of vulnerable people who are (or may be) at risk of radicalisation.

11.0 Safeguarding Adults Review (SAR) & Domestic Homicide Reviews (DHR)

11.1 **A safeguarding Adults Review** (SAR) is requested by the Safeguarding Adults Board when certain criteria or thresholds are met. These include

- An adult at risk dies (including death by suicide), **and** abuse or neglect is known or suspected to be a factor in their death.
- An adult at risk has sustained any of the following:
  - A life threatening injury through abuse or neglect
  - Serious sexual abuse
  - Serious or permanent impairment of development through abuse or neglect

OR

  - Where there are multiple victims
  - Where the abuse occurred in an institutional setting
  - A culture of abuse was identified as a factor in the enquiry

AND

The case(s) give rise to concerns about the way in which local professionals and services worked together to protect and safeguard adult (s) at risk.

11.2 **A Domestic Homicide Review** (DHR) is a review undertaken when an adult dies as result of domestic abuse. This led by the Police and is a multi-agency review in a similar format to that of a SAR.

11.3 There have been 3 SARs and 1 DHR published by the KMSAB in the last year. MTW had involvement with 1 SAR and 1 DHR.

11.4 In both cases there were not specific issues with the care provided by the Trust; however the learning from these has been considered at the Trust Safeguarding Adults Committee and has been included in the wider safeguarding adults training.

12.0 Learning Disability

12.1 The Trust has been successful in appointing a Learning Disability Hospital Liaison Nurse. The post-holder took up post in February 2018.

12.2 The post-holder will work with a range of front line staff to provide advice and support to make reasonable adjustments for people with Learning Disability.

12.3 The post-holder has undertaking training to be a reviewer for the Learning Disability Mortality Review process.

13.0 Learning Disability Mortality Review (LeDeR)

13.1 The Learning Disability Mortality Review (LeDeR) process was established in April 2017. This national process has been commissioned by NHS England as result of the Confidential Inquiry into Premature Deaths of People with Learning Disability (CIPOLD).

13.2 All deaths of adults and children with learning disability must be reported to the LeDeR programme.

13.3 Reviewers are allocated by the LeDeR programme team, based on locality.

13.4 The Trust has 3 individuals who have undertaken the LeDeR review training (Head of Patient Safety, Matron for Safeguarding Adults, and Learning Disability Hospital Liaison Nurse).

13.5 The Trust has currently been asked to lead and/or contribute to 3 reviews; one of which is known to MTW.

14.0 Serious Incidents

14.1 A Serious Incident (SI) is defined by NHS England as an event in healthcare 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. Whilst there is no definitive list of events or incidents that constitute an SI there are a number of descriptors that contribute to the classification of an incident as an SI; this includes

- Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery, all of which were:
  - healthcare did not take appropriate action / intervention to safeguard against such abuse occurring; or
  - abuse occurred during the provision of NHS-funded care

14.2 The Trust reported 15 SIs related to safeguarding adults between April 2017 and March 2018. Of these 6 cases were downgraded.

14.3 The remainder include 1 self-harm, 1 absconding, 1 allegation of interference with medical equipment by a relative, 1 alleged excessive use of force and restraint, 3 consent related and 2 alleged assault.

14.4 2 cases resulted in HR/disciplinary proceedings.

14.5 Key learning from these cases includes the management of expectations whilst minimising anxiety during the consent process, provision of clear handover and identification of risks.

15.0 Education & Training

15.1 The Trust provides a suite of education and training opportunities for safeguarding adults, in line with the draft intercollegiate documents and Kent County Council training requirements.

15.2 The Matron for Safeguarding Adults oversees the internal training content and provides much of the training in relation to MCA and PREVENT.

15.3 The Matron for Safeguarding Adults works closely with the Named Nurse for Safeguarding Children in both the development and delivery of training.

15.4 Training is offered in a variety of ways including e-learning, group sessions and bespoke to wards and departments.

15.5 The Trust can also access multi-agency training via the K&MSAB team.

15.6 The K&MSAB run a number of learning events throughout the year to enable practitioners to hear and discuss the learning from both local and national SARs.

15.7 The Trust training update for the year 2017/18 is:

- Level 1 – 90%
- Level 2 – 88%
- MCA – 97.5%
- Prevent – 82.4%

16.0 Priorities for 2018/19

16.1 Best Care: MCA & Consent

As noted earlier, there is a need to be able to ‘evidence’ the approach taken to ascertain capacity. The Trusts transformation programme ‘Best Care’ has adopted MCA under the Best Quality work-stream. The Best Safety work-stream is also undertaking a piece of work to strengthen the evidence around informed consent.

As MCA is a corner stone of informed consent these two work streams will be closely aligned. It anticipated that this work will also identify further MCA champions from the medical workforce.

16.2 **Learning Disability**

With the appointment of the Learning Disability Hospital Liaison Nurse more targeted work will be undertaken around the needs of people with learning disability. This includes raising awareness, developing education and training resources, working with Patient and Carer Engagement groups and developing appropriate accessible information guides.

16.3 Learning Disability Improvement Standards for NHS Trusts, published June 2018 will form the basis for further work. NHS Improvement are working with NHS Benchmarking Network in developing an audit tool to enable providers to undertake a structure self-assessment against the standards.

16.4 **Strengthening Safeguarding Teams**

Further work needs to be undertaken to strengthen the safeguarding adults' team. Currently this consists of a Matron for Safeguarding Adults and a Learning Disability Hospital Liaison Nurse.

Over the last year the Safeguarding Adults and Safeguarding Children teams have been working closely in terms of developing and delivering training. There is scope to further enhance this via the work on supporting young people transitioning from child to adult care.

There is opportunity to be further explored with partner providers in community and mental health settings where there is the potential to share resource and expertise.

Appendix A

Table of Cases The Tunbridge Wells Hospital and Outcomes April 2017 – end of March 2018

Tunbridge Wells Hospital at Pembury									
Month and No	**Concern Raised**	**Raised By**	**Area**	**Upheld**	**Partially Upheld**	**Not upheld**	**Inconclusive**	**Await Report**	**Closed by LA**
APRIL	1 Poor Discharge and communication	E	W 21			✓			
	2 Poor care delivery and rough handling	F	W 20					Report received	
3	Ward 20 and Ward 30		W 30						
	3 Poor Discharge	E	W 12		✓				
MAY	1 Neglect	S	AMU			✓			
2	2 Psychological	S	W 20						✓
JUNE	1 Poor discharge	E	W 20			✓			
2	2 Neglect PU Deterioration	E	W 21	✓					
JULY	1 Rough Handling - physical	S	W 22			✓			
3	2 Unexplained Bruising - physical	E	A&E						✓
	3 Neglect - Pressure Ulcers	E	W 21	✓					
AUGUST	1 Psychological and neglect	S	W 30				✓		
5	2 Poor Handling	S	ASU				✓		
	3 Unconsented intimate touch	S	Outpatient				✓		
	4 Neglect - absconded from ward	S	Ward 21	✓					
	5 Rough Handling	S	Ward 22	✓					
SEPT	1 Neglect poor discharge	E	AMU			✓			
3	3 Physical Rough handling	E	Ward 2				✓		
	4 Psychological – disciplinary - staff resigned	S	Ward 22	✓					
Total	18			5	1	5	4	1	2

Raised by Key – E = External Agency F = Family Member S = MTW Staff Member

Cont:-

Tunbridge Wells Hospital at Pembury									
Month and No	**Concern Raised**	**Raised by**	**Area**	**Upheld**	**Partially Upheld**	**Not upheld**	**Inconclusive**	**Await Report**	**Closed by LA**
OCT 3	1 Neglect Pressure Ulcers	E	AMU					Report received further investigation required	
	2 Neglect – Chemo meds not supplied lack of info to Care home	F	Outpatient		✓				
	3 Neglect Pressure Ulcers	E	Ward 31					Await final report	
NOV 8	1 Missed diagnosis of fracture led to neglect	E	ED			✓			
	2 Neglect Pressure Ulcers		Ward 2						✓
	3 Neglect leading to contractures	S	Ward 2		✓				
			Ward 20						
	4 Organisational – furniture used as restraint	S	Ward 20	✓					
	5 Physical – by family member to patient			Although this slap happened on the Ward it was for Social Services Department (SSD) to manage – our staff reported appropriately					✓
	6 Physical – patient had a black eye	E	Ward 2				✓		
	7 Neglect – Pressure Ulcers	F	ED					Further info required	
	8 Neglect – Pressure Ulcers - case of self-neglect	E	Ward 21			✓			
DEC 2	1 Neglect – Pressure Ulcers	E	Ward 21			✓			
	2 Neglect – Poor discharge	E	Ward 31					Awaiting Report	
TOTALS	13			1	2	3	1	4	2

Cont:-

Tunbridge Wells Hospital at Pembury									
Month and No	Concern	Raised By	Area	Upheld	Partially	Not upheld	Insufficient Evidence	Await Report	Closed by LA
JAN 2018 11	1 Physical – Nurse bruised patients buttocks	E	Ward 2		✓				
	2 Neglect – Leading to patient self-harm	S	AMU	✓					
	3 Neglect – Poor discharge	S	Ward 31					Awaiting Report	
	4 Neglect/discriminatory - DNACPR	E	AMU					Await meeting with SSD	
	5 Physical – alleged assault by staff	S	Ward 20			✓			
	6 Neglect – Use of furniture to restrain patient	S	Ward 2	✓					
	7 Neglect & financial – Missing rings. Neglect of nutrition & hydration and mouth care	F	Ward 20			✓			
	8 Neglect/discriminatory - DNACPR	E	Ward 21					Await meeting with SSD	
	9 Physical – Unexplained injury and blackened heel	E	SSSU		✓				
	10 Sexual – Unconsented examination	S	Ward 12				✓		
	11 Physical – Moving & Handling issues	S	Ward 2		✓				
FEB 2018 3	1 Neglect – Poor discharge	E	AMU					Awaiting Report	
	2 Physical and psychological – staff member to patient	S	Ward 20					Report received now Police Investigation	
	3 Financial – Purse went missing and was found at home	E	SSU						✓
MARCH 2018 3	1 Psychological - LD Son to patient	S	Ward 31	Incident on ward it is for SSD to manage – staff reported appropriately					✓
	2 Neglect – unsafe transfer to another hospital	E	Ward 31			✓			
	3 Neglect – Hydration and nutrition	S	Ward 20			✓			
TOTALS	17			2	3	4	1	5	2

Table of Cases The Maidstone Hospital and Outcomes April 2017 – end of March 2018

The Maidstone Hospital

Month and No	Concern	Raised By	Area	Upheld	Partially	Not upheld	Insufficient Evidence	Await Report	Closed by LA
April 0	None recorded.								
May 6	1 Neglect – Pressure Ulcer	E	Pye Oliver		✓				
	2 Physical - Endoscopy	E	Endoscopy					Awaiting final paperwork	
	3 Mate crime – Ex-patient to patient	S	Whatman	Occurred when a previous patient visited current patients – for SSD management, appropriately raised by MTW staff					✓
	4 Financial - Ex-patient to patient	S	Whatman						✓
	5 Neglect – patient absconded from the ward	S	F/Clarke			✓			
	6 Neglect – Patient absconded from the ward	S	Stroke Unit	✓					
June 5	1 Neglect – Poor discharge	E	Edith Cavell			✓			
	2 Physical – Black eye	S	Pye Oliver	Patient said her boyfriend did it but patient has not got a boyfriend					✓
	3 Neglect – poor discharge	E	Chaucer					✓	
	4 Physical – Staff member and security	S	F Clarke		✓				
	5 Physical – Manhandled by a staff member	S					✓		
July 1	1 Neglect – Pressure Ulcer	E						✓ WM moved wards	
AUG 2	1 Neglect – Pressure Ulcers	E	Edith Cavell			✓			
	2 Neglect – staff not responding to her	S	John Day			✓			
SEPT 1	1 Neglect – Pressure Ulcers	E	Pye Oliver		✓				
TOTALS	15			1	3	4	1	3	3

The Maidstone Hospital									
Month and No	Concern	Raised By	Area	Upheld	Partially	Not upheld	Insufficient Evidence	Await Report	Closed by LA
OCT 4	1 Neglect – patient went missing	S	Mercer			✓			
	2 Physical – Bruised hand alleged to have been caused by staff member	S	Whatman				✓		
	3 Neglect – Chemo meds not sent on for patient	S	Outpatient		✓				
	4 Neglect – Pressure Ulcers	E	Mercer			✓			
NOV 2	1 Neglect – Pressure Ulcers and poor discharge	E	Edith Cavell			✓			
	2 Physical – Assault by security guards	S	ED			✓			
DEC 1	1 Physical - Endoscopy	S	Outpatient					Final report required	
JAN 2	1 Neglect – Poor discharge	S	Edith Cavell					To be presented at Panel	
	2 Domestic Abuse – By husband on wife	S	Whatman	Incident on ward it is for SSD to manage – staff reported appropriately					✓
FEB 3	1 Neglect – Wound care not given	E	Cornwallis			✓			
	2 Neglect – Pressure Ulcers	E	Pye Oliver & Chaucer					Report to be presented to August panel	
	3 Neglect – Poor discharge	E	ED						✓
March 1	1 Neglect – Pressure Ulcers	E						Report to be presented at August panel	
	None Recorded								
TOTALS	13				1	5	1	4	2

Therefore:- 9 = UPHELD, 10 = PARTIALLY UPHELD, 21 = NOT UPHELD, 8 = INCONCLUSIVE, 17 = AWAITING REPORT,

Trust Board meeting - July 2018

NHS Maidstone and Tunbridge Wells NHS Trust

7-14 Estates and Facilities Annual Report 2017/18 — Chief Operating Officer

The enclosed report provides a broad perspective of the Estates, Capital and Facilities Management functions for the financial year 2017/18. The report was received by the Trust Management Executive in July 2018.

Which Committees have reviewed the information prior to Board submission?
Trust Management Executive, 18/07/18

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
Information and Assurance

[1] 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

efm

NHS
Maidstone and Tunbridge Wells NHS Trust

Estates and Facilities Management Annual Report 2017-18

The Maidstone Hospital

Tunbridge Wells Hospital

Abbey Court

Aylesford

Canterbury

Crowborough

Dover

Folkestone

Paddock Wood

Parkwood

Inside this year's Annual Report

1. Key Highlights 2017-18

- April

PLACE Inspections

Annual inspections are completed

August

PET CT

The new centre opens its doors to its first patients.

- 

- September

Energy Efficiency Programme Commences

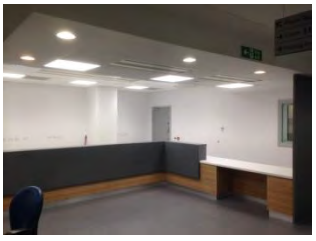
The installation of over 12,000 LED lights at Maidstone.

October

Exercise Neptune at Maidstone

We tested our response to water failure to the whole site as well as managing the delivery and distribution of water bottles and a tanker to provide an external supply.

- 



- December

GP Streaming works are completed

February

Excellence in Sustainability Reporting 2016-2017

Certificate awarded to MTW by Sustainable Development Unit for NHS England and Public Health England in conjunction with the HFMA and NHS Improvement

- 

2. Our year in numbers

926,361 In-patient main meals requested Increase of 25,176	**3,930,768** Laundry and Linen pieces processed per annum for MTW Increase of 176,758	**55,065,018** kWh of Electricity, Gas & Oil Consumed Increase of 970,545
£4,838,340 Capital Investment for improving existing buildings Increase of 2,680,578	**131,414m^2** Gross internal floor area Same	**£2,522,404** Investment to reduce backlog maintenance Increase of 536,642
110 False Fire Alarm Activation Increase of 19	**23.84** Hectare Land Area Same	**£2,522,404** Cost to reduce backlog Increase of 121,410
1,802.33 Waste Tonnes Volume Decrease of 324.91	**£3,493,000** Income from Services Increase of 1,504,321	**2,912** Parking spaces Increase of 175

3. Strategic Overview

This report provides the annual review of the Estates and Facilities Management (EFM), Estate capital programme and Private Finance Initiative (PFI) performance for 2017/18 and also a look ahead for 2018/19.

The figures and information included within this report are those reported for the annual Estates Return Information Collection (ERIC) submitted to the Department of Health on 29th June 2018. This information is utilised to produce the Model Hospital information.

The services included within the Directorate are;

- Capital Building Projects
- Car Parking
- Cashier Service
- Catering
- Cleaning
- Decontamination
- Environment and Sustainability
- Estates Maintenance
- Fire Safety
- Health and Safety*
- Laundry and Linen
- Main Reception
- Non-emergency Patient Transport
- Pest Control
- Private Finance Initiative
- Portering
- Post
- Property Management
- Security
- Staff Residential Accommodation
- Transport
- Travel Planning
- Waste Management
- Window Cleaning

*Transferred to the Directorate within year.

During 2017/18 the following services were transferred;

- EME and Medical Devices to Medical Physics
- Moving and Handling to Clinical Governance

4. Quality

4.1 Capital Projects

4.1.1 Projects Approved

In addition to the backlog maintenance programme the Capital Project team have delivered the following projects within the total £5,028,475 allocation;

- MOU alterations
- PET CT
- Clinical Coding Office development
- Endoscopy Theatre
- CDU and RATS development at M/S
- Radial lounge at TWH
- Energy and Sustainability initiatives
- Linac 1 Enabling works
- Energy Lighting Efficiency programme

4.1.2 In-year Project

The Trust was successful in securing £645k capital funding from the £100m outlined in the spring Budget by the Chancellor for the purpose of easing pressure on emergency departments in time for winter 2017/18 through developing primary care services within the A&E department, GP Streaming. The in-year project was completed on programme and included works within reception, minors, majors and AMU. The building works were completed whilst the areas remained in clinical use.

4.1.3 Backlog maintenance

Backlog maintenance is capital investment in the building infrastructure of the estate to ensure the Trust remains compliant to Health and Safety and legislation and retains the integrity of the buildings physical condition.

The estates department has delivered backlog maintenance at Maidstone Hospital worth £1.3m this included works in relation to fire systems, nurse call, chillers, lighting, Equality Act, asbestos, water hygiene, external road and path repairs. The full list and funding allocation is shown in Appendix 1.

The investment of £1.3m on backlog maintenance issues addressed statutory requirements and some projects deferred from previous years. However, the backlog programme remains in arrears following lack/withdrawal of funding in previous years.

The funding required to address the slip in the capital backlog maintenance programme since 2015 and incorporating the plans for 2018/19 is £2,522,404.

The allocation given for the year 2018/19 is £900,000 leaving £1,622,404 shortfall. Projects have been risk assessed for prioritisation and those outside of the priority will be carried over and added to the lifecycle requirement for 2019/20.

Financial Year	Funding allocated At year start £	Revised Funding Allocated within year £
2015/16	2,500,000	0
2016/17	2,000,000	959,524
2017/18	1,500,000	1,178,733
2018/19	900,000	900,000
Total	6,900,000	3,038,257

4.2 Certificate of excellence in sustainability reporting

Each year, the Sustainability Development Unit (SDU) review all trust and commissioner published sustainability reports against the published criteria to identify the leading practice in transparency in reporting progress across social, economic and environmental sustainability.

Increasingly they are looking for evidence of how health organisations are thinking beyond their walls to how they use their influence as employers, estates and procurers in supporting the wider determinants of health and prevention in communities in line with the principals of the UN Sustainable Development Goals. Society, the environment and economy are critical life support systems.

In March and in recognition of the above, we were awarded the Certificate of Excellence on behalf of the Sustainable Development Unit (SDU), NHS Improvement and the Healthcare Financial Management Association (HFMA).

4.3 Fire

A full Fire Compliance audit was commenced in January 2018 by independent specialists, for which we are currently awaiting the outcome report.

4.4 STP

4.4.1 Members of the Estate development team continue to work collaboratively with STP colleagues to review current estate efficiency and productivity within the Kent and Medway network.

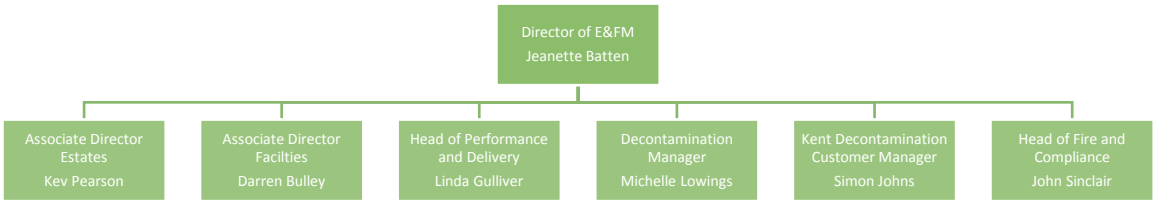
An assessment of the impact of the emerging Local Care model in terms of where future activity will be delivered, alongside an assessment of the current public sector estate footprint will help to identify where any development and or surplus estate is required/identified.

4.4.2 Effective collaborative working has already been implemented through the Kent Waste Consortium and Kent Cluster for Decontamination.

4.4.3 Directors of Estates and Facilities Management across Kent and Medway from Acute and Community currently meet on a monthly basis.

5. Performance

During 2017/18 the senior management team had stabilised and form a strong established unit.



5.1 Premises Assurance Model

The NHS Premises Assurance Model (NHS PAM) is a series of self-assessment questions grouped into five domains, for NHS Providers to use as a basis for assessing compliance and providing assurance on estates and facilities safety and quality and subsequently to compare efficiency with peer NHS providers, from April of 2018 NHSI have made PAM statutory for all trusts however we had implemented it a year previous.

The Directorate, led by the Associate Directors have undertaken the second annual self-assessment, the summary report and progression against year 2016/17 is attached in Appendix 2 for year 2017/18. Improvements have been identified and an action plan has been developed and agreed for implementation. There are no issues highlighted as Red and "inadequate".

5.2 Energy Performance

The energy performance contract was terminated by and at no cost to the Trust due to the poor performance of the contractor. The business case produced did not meet standard requirements for seeking capital resource and did not deliver the savings envisaged.

The Directorate took the opportunity to review key aspects of the work that had been undertaken and subsequently developed a robust LED light replacement programme.

An interest free loan was secured through Salix funding, a route supported by the Lord Carter recommendations.

During the financial year the LED light replacement programme secured £1.5m in Salix funds and replaced a total of 12,849 lights at Maidstone Hospital. The anticipated savings per annum are in excess of £401k, delivering payback on investment in under four years.

5.3 Patient-Led Assessment of the Care Environment

The annual PLACE inspections were undertaken during May 2017, the outcome from the audits is shown in Appendix 3. The inspections for 2018 were undertaken during May and the results will be announced in August 2018.

5.4 Risk Register

The directorate is continuing to proactively manage its risk register with open risks reviewed by the Directorate on a monthly basis. Where necessary red and amber items are escalated to the Trust risk register and Board Assurance Framework. At the end of the financial year there were no red risks identified on the corporate register.

5.5 Cleanliness

Following the implementation of the Ultra-V cleaning (UVc) decontamination system the service now provides three categories of clean above the standard clean; Steam Clean, UV light clean, and Hydrogen Peroxide Vaporisation (HPV). The total number of cleans for each category across the Trust for the year were;

Category	No.
Level 3 steam clean	9,536
Level 3 UVc light clean	1,414
Level 4 HPV clean	971

To reduce the downtime necessary following a level 4 HPV clean the service are undertaking a trial on a new evacuation system which will reduce the whole cycle from 4 hours to 1 hour, and therefore improve bed turnaround times.

5.6 EFM Scorecard

The Directorate report their monthly performance to the Executive team. Included in the monthly report is overview on quality, performance, demand, effectiveness, exceptions, risk register, workforce and Finance.

5.7 Complaints, Compliments and Freedom of Information

The directorate continues to receive more compliments than complaints, which is a significant achievement for a demand led operational service.

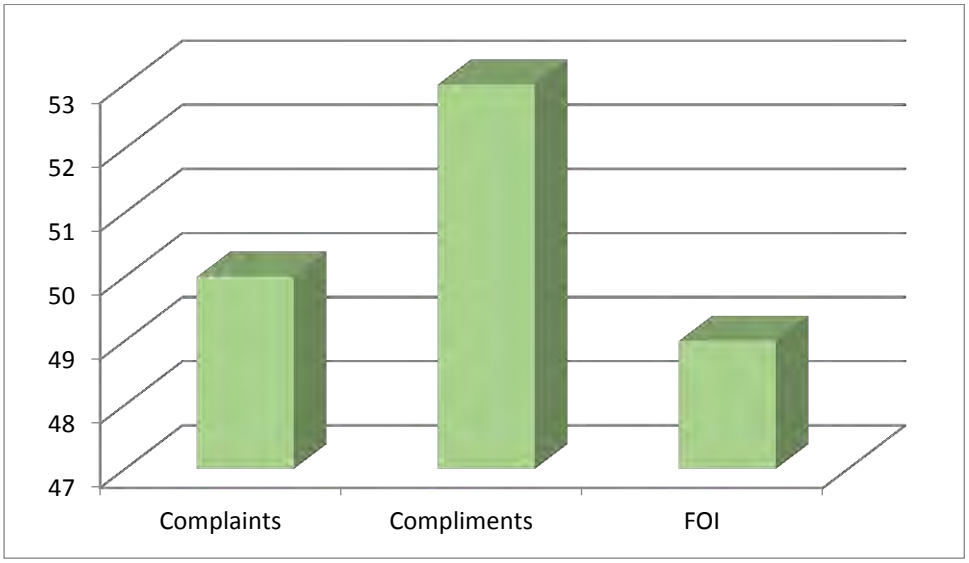


Figure 1 - Complaints, Compliments and FOI

5.7.1 The majority of complaints received within the year have been in respect to parking.

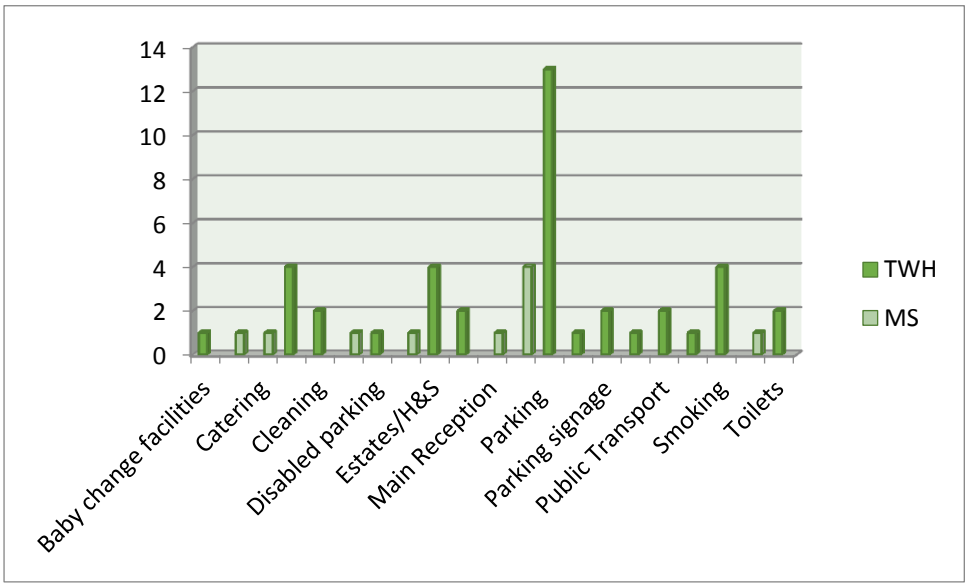


Figure 2, Compliments

5.7.2 The Directorate received 49 Freedom of Information (FOI) requests within the year the majority have been individual/one off items. The single largest theme, total of five, was in regards to car parking.

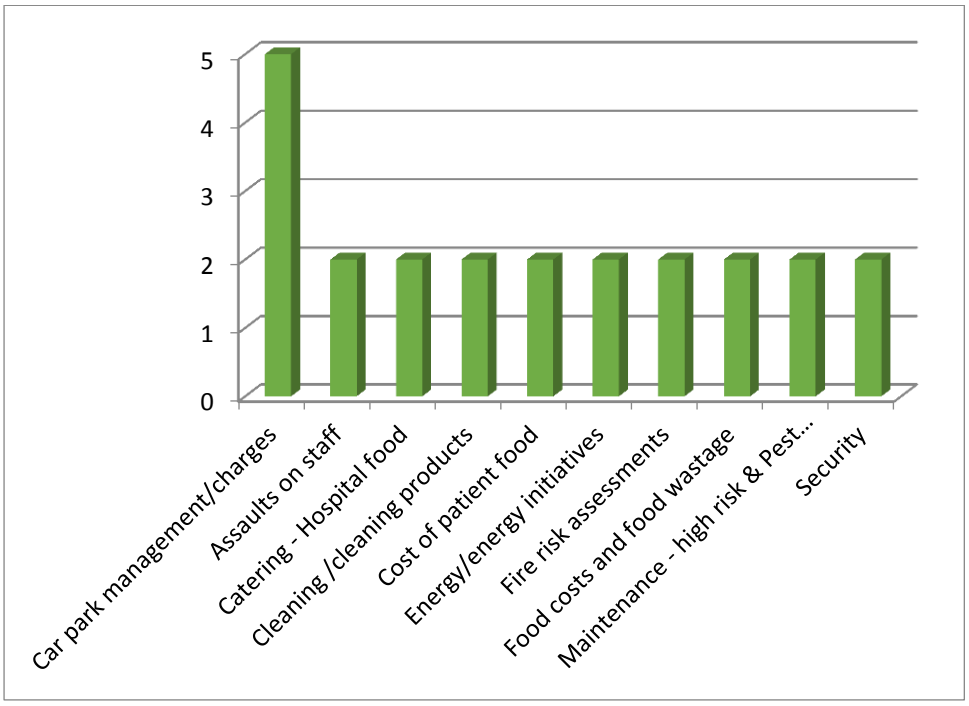


Figure 3, FOI requests

5.8 Workforce

The HR dashboard as at March 2018 is shown below. In summary;

- Compliance training is 90.72%
- Appraisals 96.66%
- Sickness 6.86%
- Turnover 15.25%

A number of long term sickness absences have increased the sickness levels, these are being managed in line with Trust policy.

The turnover average has been higher this financial year than normal, due to a higher turnover in Estates, due to retirements. The department are now at full establishment.

Trust Dashboard Workforce Data

Maidstone and Tunbridge Wells NHS Trust

	Appraisals			Sickness Absence (Previous Month)					Turnover			Training Compliance			Starters		Leavers	
Organisation	Assign-ments	Assign-ments with Completed	Completed Appraisal Rate	FTE Days Available	FTE Days Sickness	Sickness Rate	Short Term	Long Term	FTE for 12 Months	Leavers FTE	Turnover Rate	Require-ment Met	Require-ment Not Met	Compliance Rate	FTE	Head-count	FTE	Head-count
Estates and Facilities	539	521	96.66%	14,657.40	1,006.21	6.86%	45.77%	54.23%	539.73	82.33	15.25%	5364	549	90.72%	4.00	4	6.00	6
Estates	34	33	97.06%	1,174.60	40.00	3.41%	30.00%	70.00%	42.10	8.80	20.90%	440	10	97.78%	1.00	1		
Estates Maintenance	26	26	100.00%	933.80	40.00	4.28%	30.00%	70.00%	32.50	7.80	24.00%	360	7	98.09%				
Estate Maintenance (M)	26	26	100.00%	933.80	40.00	4.28%	30.00%	70.00%	32.50	7.80	24.00%	360	7	98.09%				
Estates Management	8	7	87.50%	240.80	0.00	0.00%	0.00%	0.00%	9.60	1.00	10.42%	80	3	96.39%	1.00	1		
Estates Consultancy & Design	5	5	100.00%	140.00	0.00	0.00%	0.00%	0.00%	6.00	1.00	16.67%	51	1	98.08%	1.00	1		
Estates Directorate Management	3	2	66.67%	100.80	0.00	0.00%	0.00%	0.00%	3.60	0.00	0.00%	29	2	93.55%				
Facilities	505	488	96.63%	13,482.80	966.21	7.17%	46.42%	53.58%	497.63	73.53	14.78%	4924	539	90.13%	3.00	3	6.00	6
Facilities Management	19	18	94.74%	504.37	62.20	12.33%	36.98%	63.02%	18.52	4.35	23.47%	189	5	97.42%				
Facilities Management	13	12	92.31%	336.37	61.20	18.19%	35.95%	64.05%	12.52	4.35	34.72%	130	5	96.30%				
TSSU / HSDU (M)	6	6	100.00%	168.00	1.00	0.60%	100.00%	0.00%	6.00	0.00	0.00%	59	0	100.00%				
TSSU / HSDU (TW)							0.00%	0.00%										
Laundry	26	23	88.46%	789.67	6.00	0.76%	100.00%	0.00%	29.17	10.60	36.34%	247	22	91.82%	1.00	1		
Hospital Supplies Sewing	2	2	100.00%	46.67	0.00	0.00%	0.00%	0.00%	1.67	0.00	0.00%	10	8	55.56%				
MTW Laundry Services	24	21	87.50%	743.00	6.00	0.81%	100.00%	0.00%	27.50	10.60	38.55%	237	14	94.42%	1.00	1		
Residences	3	3	100.00%	65.64	1.33	2.03%	100.00%	0.00%	2.34	0.00	0.00%	24	3	88.89%				
Trust Residences	3	3	100.00%	65.64	1.33	2.03%	100.00%	0.00%	2.34	0.00	0.00%	24	3	88.89%				
Soft Facilities	437	424	97.03%	11,423.11	772.68	6.76%	48.56%	51.44%	422.60	55.58	13.15%	4265	466	90.15%	1.00	1	6.00	6
Catering (M)	23	22	95.65%	790.75	58.00	7.33%	51.72%	48.28%	26.03	4.00	15.37%	278	4	98.58%			2.00	2
Catering (TW)	45	42	93.33%	1,476.46	88.67	6.01%	72.63%	27.37%	54.34	10.40	19.14%	574	20	96.63%				
Domestic Services (M)	138	135	97.83%	3,083.33	267.87	8.69%	19.94%	80.06%	112.13	7.80	6.96%	1266	93	93.16%			1.00	1
Domestic Services (TW)	136	136	100.00%	3,054.32	211.15	6.91%	52.77%	47.23%	109.13	3.88	3.56%	1133	226	83.37%			1.00	1
Portering (M)	35	33	94.29%	1,058.93	76.00	7.18%	67.11%	32.89%	42.53	10.50	24.69%	400	16	96.15%			1.00	1
Portering (TW)	37	35	94.59%	1,147.32	49.00	4.27%	87.76%	12.24%	44.94	11.00	24.48%	377	94	80.04%	1.00	1		
Soft Facilities Management	23	21	91.30%	784.00	22.00	2.81%	100.00%	0.00%	33.50	7.00	20.90%	237	13	94.80%				
Technical Services				28.00	0.00	0.00%	0.00%	0.00%	0.00	1.00	#DIV/0!						1.00	1
Transport	20	20	100.00%	700.00	124.00	17.71%	34.68%	65.32%	25.00	3.00	12.00%	199	43	82.23%	1.00	1		
Central Ambulance Booking	2	2	100.00%	56.00	29.00	51.79%	3.45%	96.55%	2.00	0.00	0.00%	18	1	94.74%				
Transport	18	18	100.00%	644.00	95.00	14.75%	44.21%	55.79%	23.00	3.00	13.04%	181	42	81.17%	1.00	1		

6. Finance

6.1 Capital

The Capital investment for the year was £5,028,475 which was sourced from various funding streams; Trust own generated capital reserve, Salix and NHS I. The investment to reduce backlog maintenance was £1.3m. All planned and in-year projects were delivered to programme and budget. The projects undertaken are shown in Appendix 1.

6.2 Revenue

6.2.1 The Directorate completed 2017/18, as follows;

	Division		
	Actual £	Budget £	Variance £
Pay	-14,580	-15,422	842
Non Pay	-20,845	-19,566	-1,279
Income	5,928	6,932	-1,004
Profit on disposal of Trust Assets	83	0	83
Net Surplus / Deficit (-)	**-29,414**	**-28,057**	**-1,357**

6.2.2 The Directorate's yearend CIP position was a delivery of £1.6m against the target of £2.7m. The shortfall was due to the deferral of the disposal of Springwood Road, Residential Accommodation, which reflected in the yearend deficit position.

6.2.3 The Directorate commence the new financial year 2018/19 with a cost improvement programme (CIP) of £3.1m defining an annual budget of £34.1m (excluding PFI). The savings are monitored on a weekly basis to ensure delivery and any risks that materialise during the year are managed and mitigated accordingly.

6.2.4 The CIP of £3.1m above does not include the release/disposal of assets.

6.3 Cost Pressures

Non Pay was £1,279k overspent for the financial year 2017/18. The most significant factor in the position is due to the £317k of Carillion debt, following the company liquidation in January 2018, which is now treated as bad debt in the I&E and shown in the adverse position of other non-pay.

The overspend in transport and supplies general is offset by favourable variances in medical equipment of £160k and Establishment of £126k .

The cause of the adverse movement in transport is the cumulative effect of the actual expenditure compared to the CIP adjusted budget for bus transport.

In Supplies and Services, the spend linked to the Carillion contract is £630k adverse YTD offset by income expectation at risk with the bad debt provision specified above.

6.4 Estates Return Information Collection (ERIC)

The directorate submitted the annual return in accordance with the timescale. The return for 2017/18 included a number of changes from the previous year which included the separate reporting of costs associated with services provided by and within a PFI, EME, Decontamination and Health Records.

The results of the 2017/18 submission will not be released until Q3. The data submitted this reporting year has been audited and validated by independent advisors, to ensure accuracy in our reporting.

6.5 Model Hospital

The model hospital data produced through the annual Estates Return Information Collection (ERIC) is based on the information a year in arrears.

Through the review of the data for the period 2016/17 NHS I identified that MTW savings opportunities were to achieve £5,992,000. However, £2.5m was attributable to the estates operating costs of the PFI. During 2017/18 the directorate achieved savings of £1.6m and as mentioned above have identified a further £3.7m for the year 2018/19.

This will deliver a total saving of £5,381,000 over the two years, leaving a shortfall of £611k against the opportunities. These savings have been achieved without changes to the PFI Agreement.

The Directorate are now exploring opportunities in conjunction with our PFI partners for any savings/invest to save schemes through the PFI. However, in light of issues arising from other organisations, NHS I have put in place additional controls in respect of any variation which will;

- Alter the risk transfer set out within the project agreement;
- Alter any contractual standards or contract terms;
- Are at the request of the Project Company;
- Provides short term financial gain with increased future costs; or
- Removes services from the PFI agreement.

Where the total cost of any proposed change at current prices exceeds £1m approval will be required by NHS Improvement, before signature.

7. Year Ahead

7.1 Business Plan on a Page

The Directorate's Business Plan on a Page for 2018/19 is shown in Appendix 4. The key areas of focus for the year;

- Service Line Reporting
- Implementation and commissioning of new Computer Aided Facilities Management System
- Sustainability and Transformation Partnership
- Premises Assurance Model review
- Endoscopy Managed Service project
- Activity/Space Utilisation review

7.2 Estates Masterplan

The Development Control Plan (DCP) and programme of works is shown in Appendix 5 for the financial year 2018/19. The plans also identify the future expansion zones within each site.

Report prepared by Director of Estates and Facilities Management, JA Batten
10 July 2018

Appendices

Appendix 1

Estates Capital Investment

Capital Code	PROJECT TITLE	YTD Actual Spend M12
C11560	**Ventilation Systems/Fire Dampers 16/17**	**600**
C11610	**Fixed Wire Testing**	**2,629**
C11670	**Signage 16/17**	**120**
C11680	**L1 Fire Alarm Improvement Works**	**-6,388**
C11720	**Asbestos Works**	**-3,198**
C11780	**Internal Lighting & Security**	**1,180**
C11830	**Block A&D controls (Phase 2)**	**138,675**
C12150	**Chillers Replacement**	**307,885**
C12170	**External Works to Roof**	**12,468**
C12180	**Nurse Call Systems**	**42,473**
C12190	**Window Improvement Works**	**88,384**
C12200	**Redecorations works**	**20,206**
C12210	**Lighting improvements**	**2,009**
C12220	**DDA/Equality Act Works**	**34,885**
C12240	**Heating, Steam and H&CWS Works**	**73,380**
C12250	**Signage**	**16,818**
C12260	**Medical Gas Improvement Works**	**8,944**
C12270	**Security Improvement Works**	**13,409**
C12280	**Equipment Replacement**	**34,202**
C12290	**Site Services resilience**	**77,819**
C12310	**Drainage Repairs**	**20,161**
C12320	**General Remedial Works**	**69,894**
C12330	**Roads and footpath Improvements**	**100,902**
C12350	**Improvements to Fire Doors, compartmentation and escape Routes**	**159,286**
C12370	**Ventilation Systems/Fire Dampers**	**12,064**
C12380	**Water Hygiene Works**	**34,186**
C12390	**Asbestos removal Works**	**18,948**
C12400	**Fire Alarm Improvement works**	**12,893**
C12410	**Ladder and Edge Protection Works**	**15,600**
	100 ESTATES BACKLOG MAINTENANCE GENERAL	**1,310,433**
C11900	**MOU alterations 16/17**	**7,169**
C12660	**PET CT**	**44,816**
C12670	**Clinical Coding development**	**200,278**
C12680	**Shires upgrade**	**121,656**
C12740	**Endoscopy Theatre**	**40,071**
C12780	**CDU and RATS development MS**	**113,095**
C12790	**Radial Lounge TWH**	**45,179**

Appendices

	108 ESTATES - OTHER PROJECTS AND RENEWALS	**572,264**
C12120	**BMS Controls**	**348,752**
C12300	**Boiler Works**	**83,499**
C12340	**Electrical Infrastructure Works**	**422,467**
C12650	**Energy and Sustainability**	**357,252**
	112 ELECTRICAL AND ENERGY	**1,211,970**
C12030	**Linac 1 Enabling Works**	**534,473**
	116 BUNKER ALTERATIONS FOR LA1	**534,473**
C12640	**Energy Lighting Efficiencies**	**754,335**
	124 ESTATES - ENERGY INFRASTRUCTURE (EPC)	**754,335**
C12600	**A&E PRIMARY CARE TWH**	**629,776**
C12610	**A&E PRIMARY CARE MS**	**15,224**
	990 - A&E PRIMARY CARE	**645,000**
	GRAND TOTAL	**5,028,475**

Appendices

Appendix 2

Appendices

CONTENTS:

Introduction

- The NHS Premises assurance model is a management tool, designed to provide a nationally consistent approach to evaluating NHS premises & facilities performance against a set of common indicators.
- This presentation summarises the ratings obtained by your organisation/site on the management of its premises and associated support services. The ratings follow the NHS PAM self-assessment made by your organisation/site on the following five domains:

Effectiveness	The extent to which premises and facilities are functionally suitable, sustainable and effective in supporting the delivery of improved health outcomes.
Efficiency	The extent to which space, activity, income and operational costs of the estates and facilities provide value for money, are economically sustainable and meet clinical and organisational requirements.
Patient Experience	The extent to which patient experience is an integral part of service provision and is reflected in the way in which services are delivered; and the extent to which patients and members of the public are involved in the development of services and the monitoring of performance.
Safety	The extent to which the design, layout, build, engineering, and operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical and social outcomes.
Organisation governance	The extent to which the organisation's board of directors delivers strategic leadership and effective scrutiny of the organisations estates and facilities operations and how the other four domains are managed as part of the internal governance of the NHS organisation

1

Appendices

Rating methodology

- The NHS PAM assesses the organisation/individual sites performance under the five domains described before. Each domain contains key areas of self-assessment which in turn contain a set of sub prompts questions. Prompt questions are answered based on the evidence required and any relevant guidance and mandatory requirements.
- There are six possible answers for each prompt question:

Not applicable	When the prompt question is not applicable to your organisation/site
Outstanding	Compliant with no action required plus evidence of high quality services and innovation.
Good	Compliant with no action required.
Requires minimal improvement	The impact on people who use services, visitors or staff is low.
Requires moderate improvement	The impact on people who use services, visitors or staff is medium.
Inadequate	Action is required quickly - the impact on people who use services, visitors or staff is high.

- Ratings are available at domain level, self-assessment level or prompt question level. The rating provided at self-assessment and domain level will be based on an average of the prompt question ratings that sit below them.

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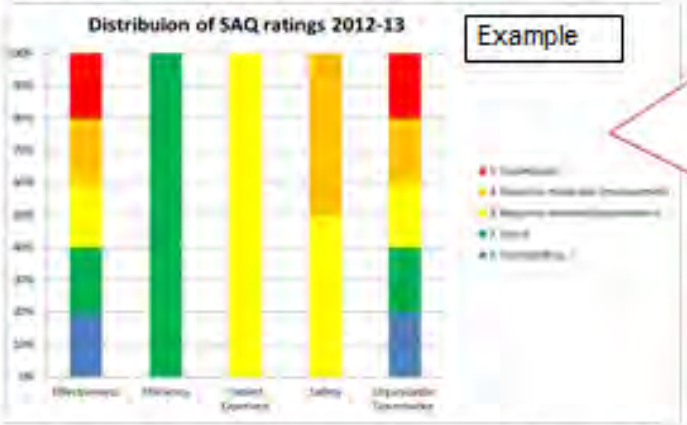
Results in this pack

This pack shows the following results:

1. The average rating for each domain
2. For each domain, distribution of ratings of the self-assessment questions (SAQs) that form it



3. For each domain, the self-assessment questions with a rating of outstanding or inadequate
4. If the self-assessment is carried out for two years, the self-assessment questions with the biggest improvements and declines are also reported

This presentation provides ratings at domain and self-assessment level. More granular prompt level information is also available within the NHS PAM tool

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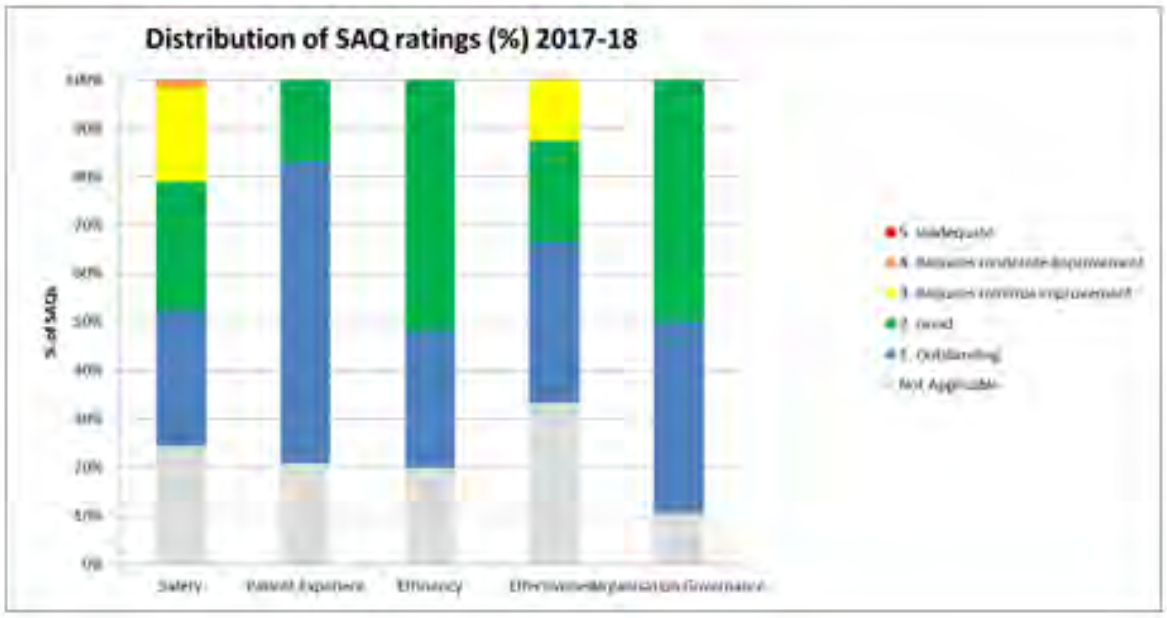
Appendices

CONTENTS:

- Introduction
- Results for current year
- Comparison of current with previous year's results (where applicable)

Average ratings by domain



Appendices

Distribution of SAQ ratings by domain

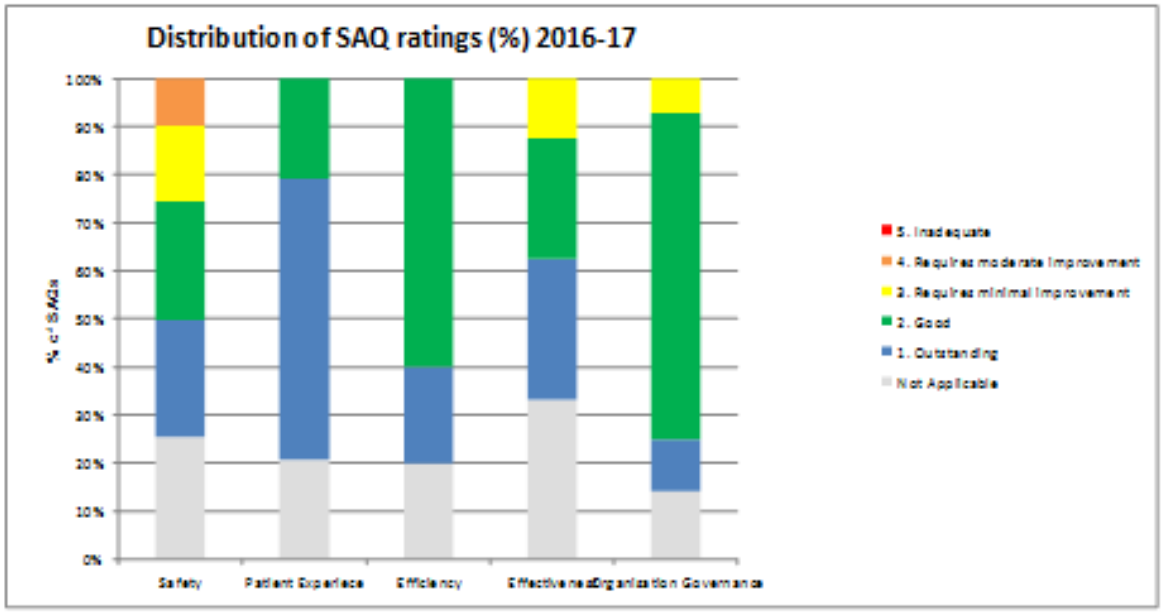
The following table shows, for the second year in the model, the number of SAQs that receive a certain rating in the different domains

2017-18							
Overall Domain Rating:	Not Applicable	1. Outstanding	2. Good	3. Requires minimal improvement	4. Requires moderate improvement	5. Inadequate	Total
Safety	57	64	62	45	4	0	232
Patient Experience	5	15	4	0	0	0	24
Efficiency	5	7	13	0	0	0	25
Effectiveness	8	8	8	3	0	0	24
Organisation Governance	3	11	14	0	0	0	28

CONTENTS:

Appendices

Overview of comparator year: comparison of average ratings by domain with focus year



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Overview of comparator year: distribution of SAQ ratings by domain

The following table shows, for the first year in the model, the number of SAQs that receive a certain rating in the different domains

	2016-17						
Overall Domain Rating:	Not Applicable	1. Outstanding	2. Good	3. Requires minimal improvement	4. Requires moderate improvement	5. Inadequate	Total
Safety	59	56	58	36	23	0	232
Patient Experience	5	14	5	0	0	0	24
Efficiency	5	5	15	0	0	0	25
Effectiveness	8	7	6	3	0	0	24
Organisation Governance	4	3	19	2	0	0	28

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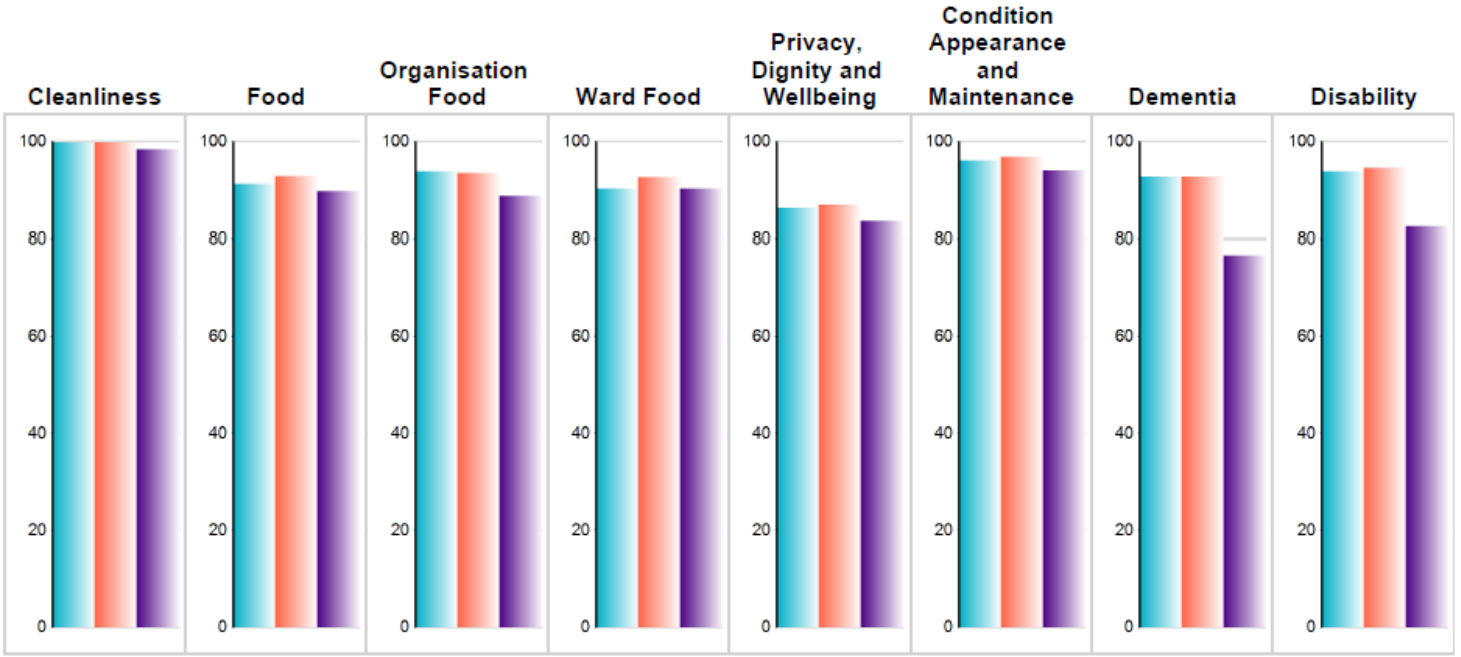
Appendices

Appendix 3

Patient-Led Assessments of the Care Environment (PLACE)

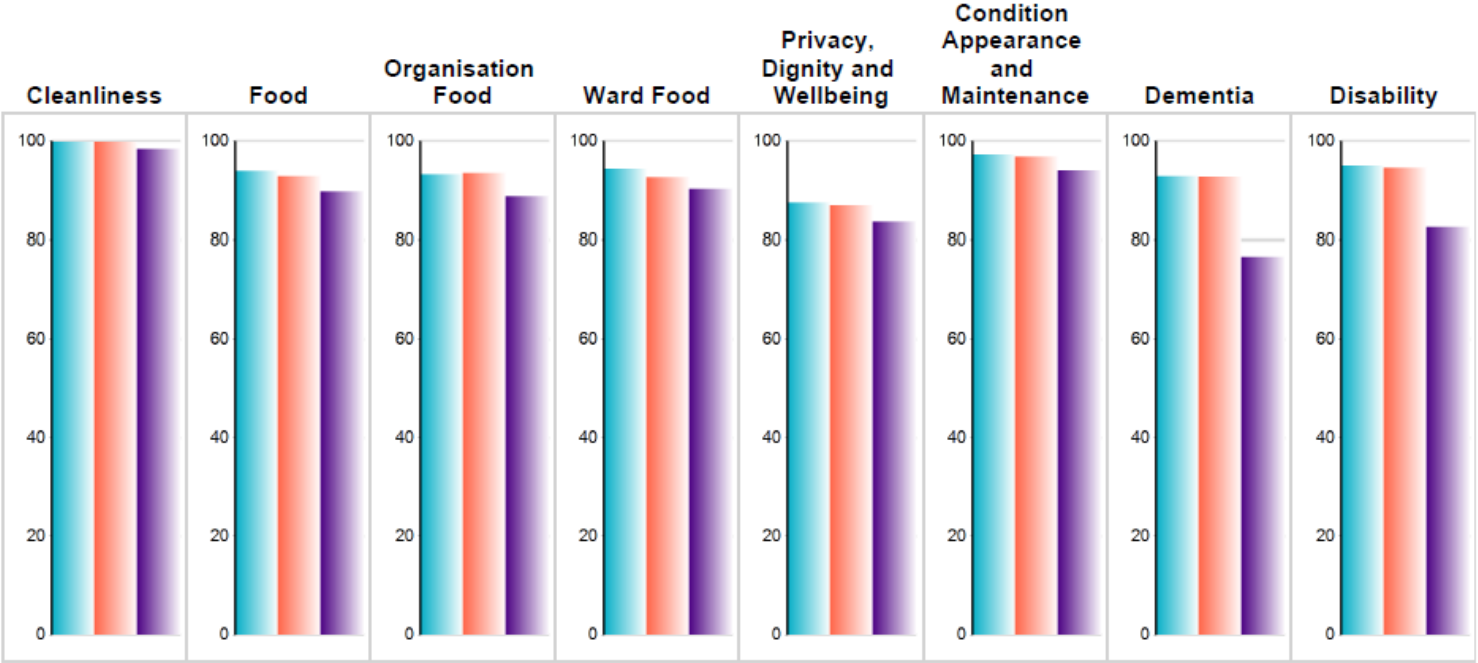
MAIDSTONE GENERAL HOSPITAL- Collection: 2017



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	3683.0000	392.7224	109.4031	283.3193	355.3332	1344.0000	771.9117	493.6680
Available Score (Actual)	3688.0000	430.6888	116.5880	314.1008	412.0000	1398.0000	832.8571	526.3697
Site Score	99.86%	91.18%	93.84%	90.20%	86.25%	96.14%	92.68%	93.79%
Organisation Average	99.81%	92.84%	93.40%	92.66%	86.97%	96.83%	92.79%	94.53%
National Average	98.38%	89.68%	88.80%	90.19%	83.68%	94.02%	76.71%	82.56%

Appendices

THE TUNBRIDGE WELLS HOSPITAL- Collection: 2017



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	3817.0000	404.8022	108.6468	296.1554	297.3333	1679.0000	817.9117	566.6680
Available Score (Actual)	3826.0000	430.6888	116.5880	314.1008	340.0000	1726.0000	880.8571	596.3697
Site Score	99.76%	93.99%	93.19%	94.29%	87.45%	97.28%	92.85%	95.02%
Organisation Average	99.81%	92.84%	93.40%	92.66%	86.97%	96.83%	92.79%	94.53%
National Average	98.38%	89.68%	88.80%	90.19%	83.68%	94.02%	76.71%	82.56%

Appendix 4

EFM Business Plan on a Page 2018-19

mtw mtw.nhs.uk
Estates and Facilities Management

Business as Usual (BaU) Objectives

- Complete the annual capital renewal programme within the budget cycle and effectively spend funding to reduce remedial maintenance.
- Meet or exceed national standards and legislative requirements.
- Efficiently manage the Trust's asset portfolio
- Ensure services are operationally aligned with business demand.

Strategic Objectives

- Service Line Reporting
- Implementation and commission of CAFM
- Sustainability and Transformation Partnership
- Premises Assurance Model
- Endoscopy Managed Service project
- Activity/Space Utilisation

Interdependencies

- Finance
- Human Resources
- Procurement
- Clinical Operations
- Third party providers/contractors

Financial Forecast

Income	£ 6,791,000
Expenditure	£ 33,450,000
Total	**£ 26,661,000**
Current Forecast	£ 24,703,000

Cost Improvement Programme

- Best of E&FM/Property Management Company
- Retail
- Energy efficiencies (LED lighting)
- Premises Leases and Licences renegotiation

Cost Pressures

- Vacancies
- Variable Income
- Non-Emergency Patient Transport Service
- Utilities

Key Risks and Issues

- Plant and Equipment Failure
- Recruitment and Retention
- Sterile Service Third Party Provider
- Budget
- Staff Accommodation redevelopment

Capital Requirements

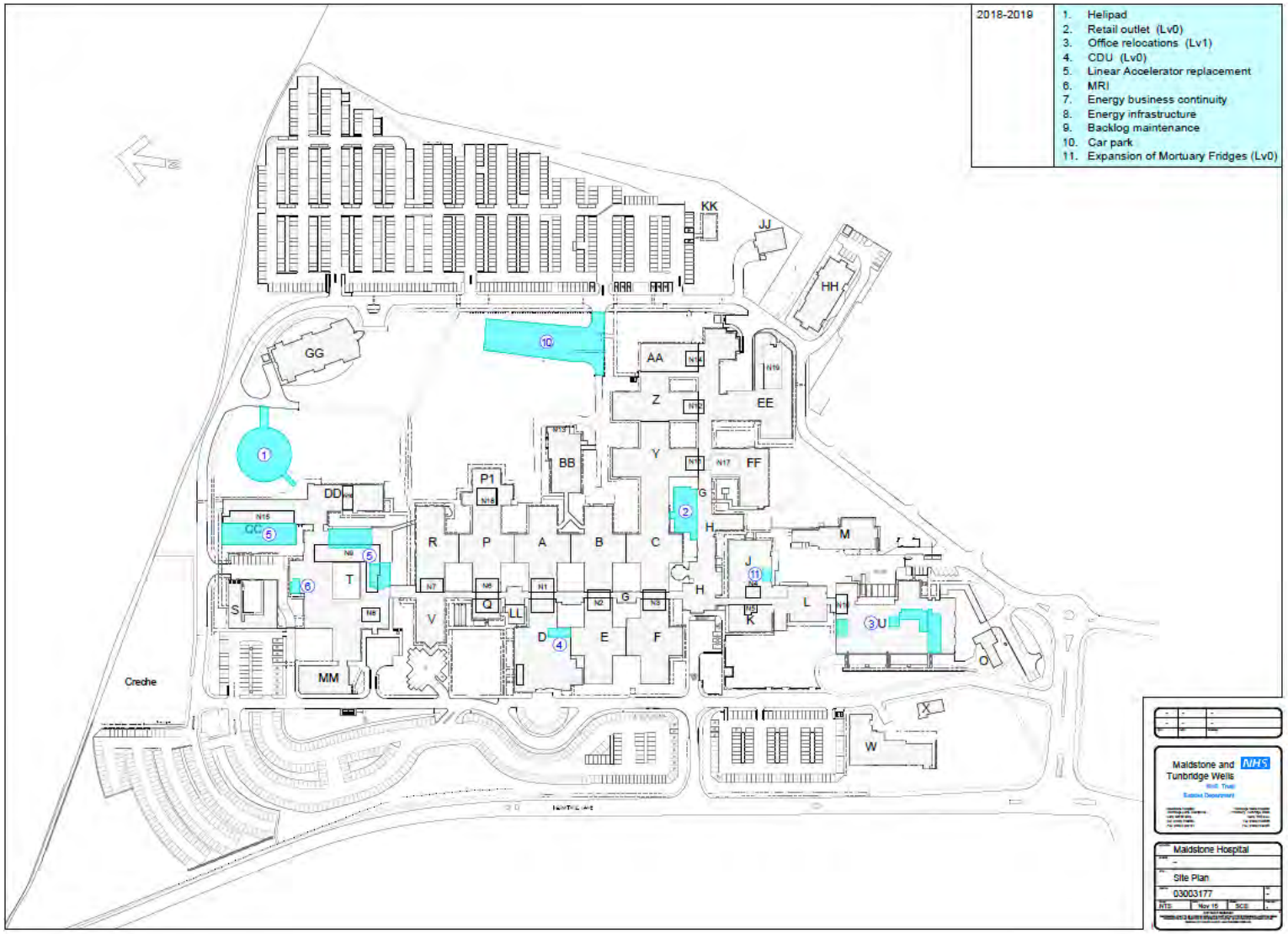
- Backlog Maintenance
- LED Lighting
- Car Park Deck
- Equipment Life-cycling
- Physical asset Life-cycling

Resources

- Training
- Workforce suitable for current/future needs
- Sickness Absence Management
- Statutory and Regulatory Training, Electrical 18th Edition
- Recruitment & Retention

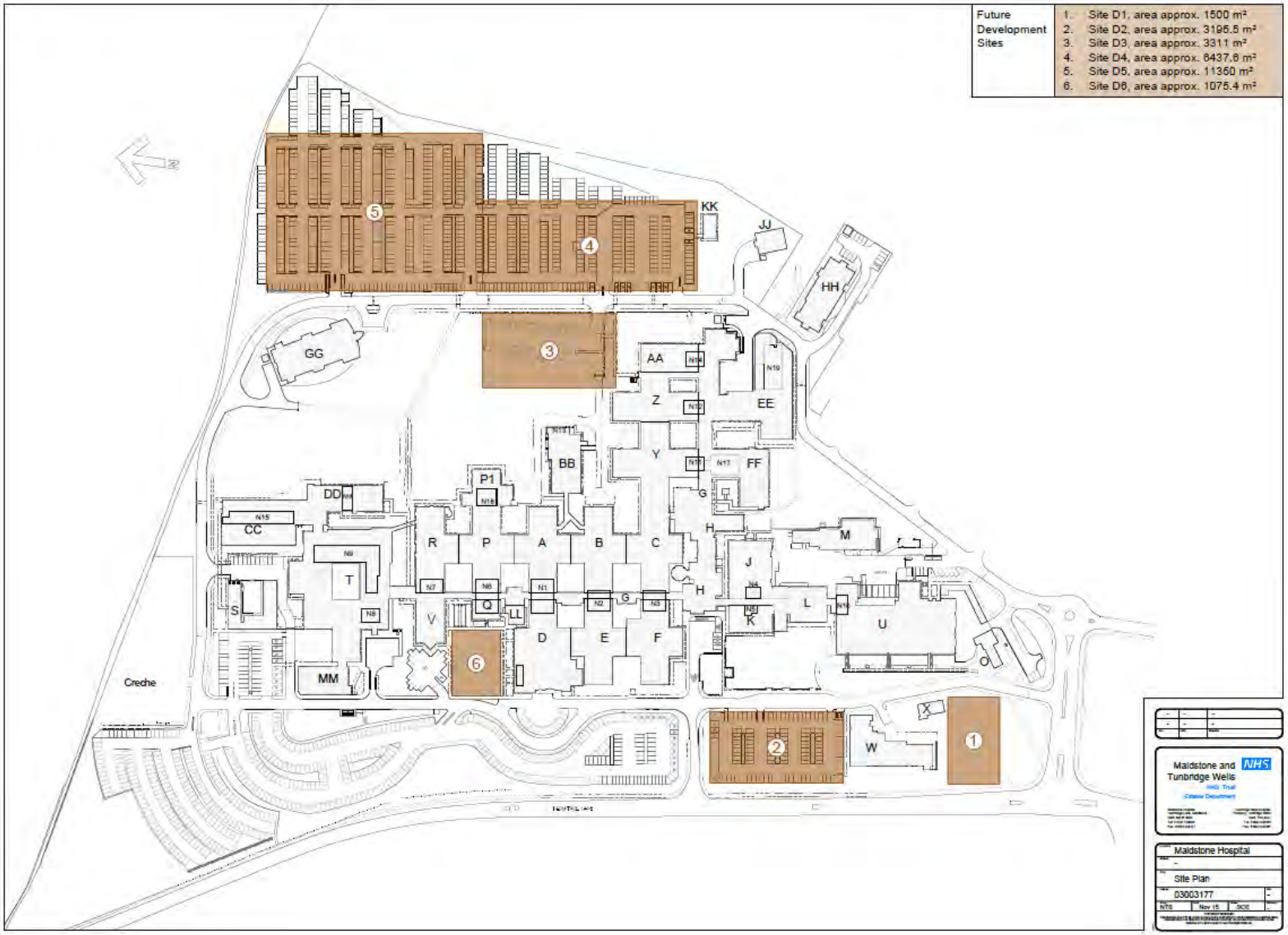
Appendix 5

Estate Strategy 2018/19 - Maidstone



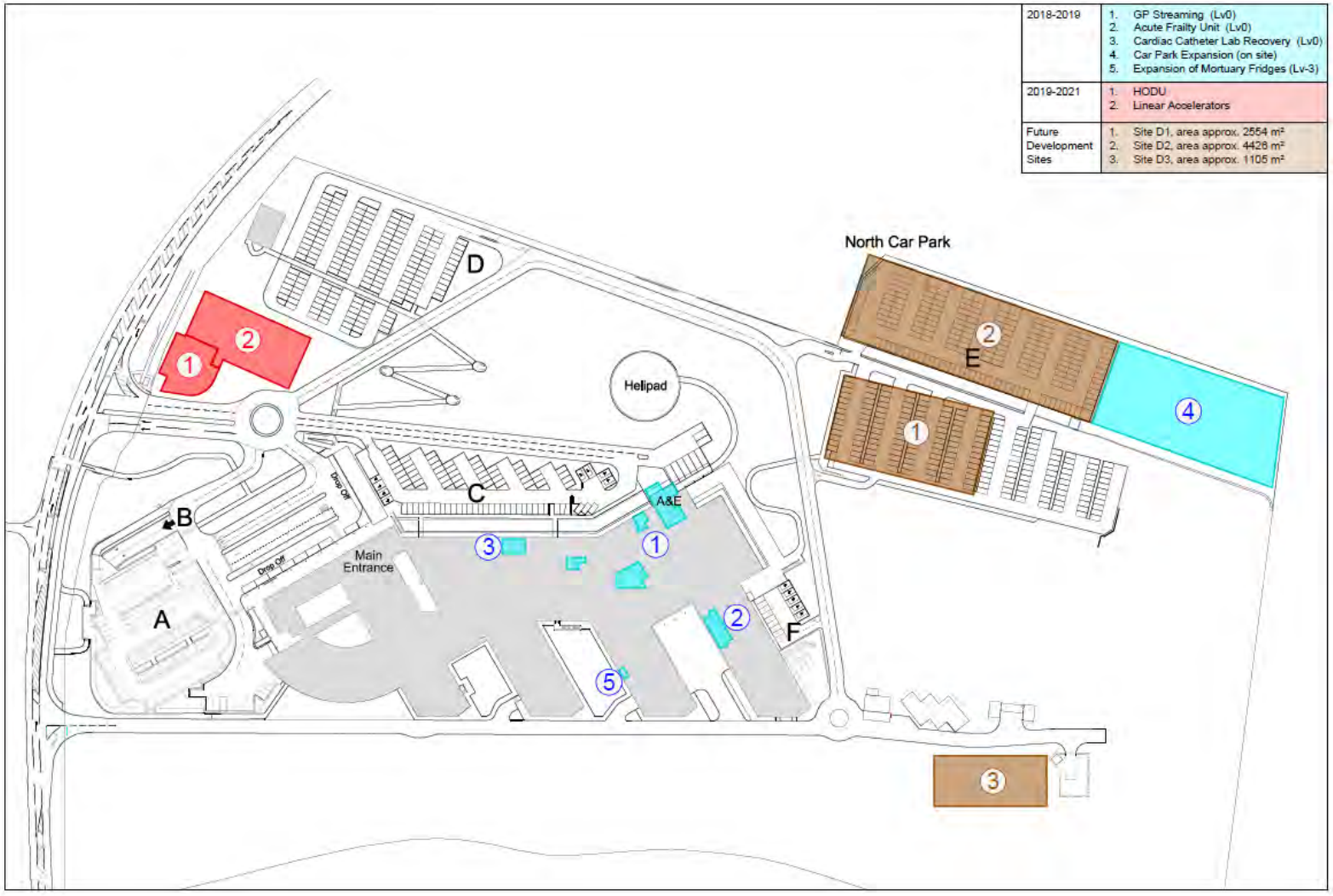
Appendices

Estate Strategy Expansion sites - Maidstone



Appendices

Estate Strategy 2018/19 & Expansion sites - TWH



mtw.nhs.uk

Estates and Facilities Management

IHEEM
Institute of Healthcare Engineering and Estate Management

THE BRITISH ASSESSMENT BUREAU
ISO9001

HEFMA
HEALTH ESTATES & FACILITIES MANAGEMENT ASSOCIATION

QMS OHSAS 18001 REGISTERED

QMS ISO 14001 REGISTERED

QMS ISO 22301 REGISTERED

NHS
Maidstone and Tunbridge Wells
NHS Trust

Trust Board meeting - July 2018

NHS Maidstone and Tunbridge Wells NHS Trust

7-15 Bribery Act – Statement of Support — Chief Finance Officer

The Bribery Act 2010 came into force on 1st July 2011 and is intended to tackle bribery and corruption in both the private and public sector. Although the Trust has a robust "Anti-Fraud, Bribery and Corruption Policy and Procedure", recent investigations have identified that the Trust Board has not officially dispensed a statement of support in respect of the Act. Although such a statement is not formally required, it is the case that several other Trust boards have issued such report. The Trust Board is asked to agree the statement below:

"Maidstone and Tunbridge Wells NHS Trust (hereafter referred to as "the Trust") is committed to delivering good governance and has always expected its directors and staff to meet the highest standards of business conduct.

The Bribery Act 2010 came into force on 1 July 2011. The aim of the act is to tackle bribery and corruption in both the private and public sector.

The Act defines the following key offences with regard to bribery:

- Active bribery (offering, promising or giving a bribe);
- Passive bribery (requesting, agreeing to receive or accepting a bribe); and
- Bribery of a foreign public official.

The Act also sets out a corporate offence of failing to prevent bribery by an organisation not having adequate preventative procedures in place.

One of the six principles of the Act demands that there is top level commitment in the organisation for preventing bribery. The Trust is committed to ensuring compliance with the Act and discussions have been held at both the Board and its Audit Committee to ensure that the requirements of the Act are fully complied with.

The Trust has robust controls, policies and procedures in place to prevent fraud, corruption or bribery. The Trusts Counter Fraud Specialist can be contacted if staff have any concerns of fraud, corruption or bribery and the Trust has an annual plan to mitigate the risks of fraud, corruption and bribery.

On behalf of the Trust I would like to re-affirm our commitment to ensuring that the Trust is free from fraud, corruption or bribery and that all staff are aware of their responsibilities in relation to the prevention of fraud, corruption or bribery.

Do you have concerns about a fraud taking place in the NHS?
NHS Fraud, Bribery and Corruption Reporting Line: 0800 028 40 60 calls will be treated in confidence and investigated by professionally trained staff. Online: www.reportnhsfraud.nhs.uk

Your Nominated Counter Fraud Specialist is, Steffan Wilkinson who can be contacted by emailing steffan.wilkinson@tiaa.co.uk or telephone on 07799 263 978."

Which Committees have reviewed the information prior to Board submission?

- -

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
Agreement

[1] 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 – July 2018

Maidstone and Tunbridge Wells NHS Trust

7-16	Summary report from Quality Committee, 04/07/18	Committee Chair (Non-Executive Director)

The Quality Committee met on 4th July (a 'main' meeting).

1. The key matters considered were as follows:

- The **progress with actions** from previous meetings was noted. It was agreed that one of the open actions (for the Clinical Director, Cancer, Haematology and Radiology to submit a proposal to the Clinical Directors' Committee to address the marked increase in CT scan requests) should be closed, but replaced with an action for the Medical Director to submit a report to the 'main' Quality Committee in September 2018 on the actions planned to reduce requests for Radiology investigations
- The reports from the rolling programme of **Directorate-based clinical outcome reports** were reviewed for Acute and Emergency and Trauma and Orthopaedics. The latter led to an action that the Clinical Director should submit a report to the 'main' Quality Committee in September 2018 containing the outcomes data from the various procedure/sub-specialty registries within Trauma and Orthopaedics, along with Surgical Site Infection data
- The report of recent **Trust Clinical Governance Committee** meetings was discussed, and each Directorate then highlighted their key issues
- The summary report from the **Patient Experience Committee**, 07/03/18, was noted
- The **outcome of the review of patients experiencing a long waiting time** was discussed, and it was agreed that the Medical Director should submit an update on the review to the 'main' Quality Committee in September 2018, and ensure that the report contained a diagram describing the review process (including the action to be taken in response to each review); as well as submit an "Update on the review of patients experiencing a long waiting time" report to the Trust Board in October 2018
- The Director of Workforce attended for a **Review of clinical engagement**, and it was agreed that they and the med should submit another "Update on clinical engagement" report to the 'main' Quality Committee in January 2019
- A **Mortality update** report gave the latest position on Hospital Standardised Mortality Ratio (HSMR) and the Mortality Reviews undertaken by Directorates
- The 2017/18 **Annual Reports for Safeguarding Adults, Safeguarding Children** and **Complaints** were reviewed, and the final version of the **Quality Accounts 2017/18** was received (along with the **External Audit of Quality Accounts 2017/18**)
- The latest **Serious Incidents** and report of the **Quality Committee 'deep dive' meetings** held on 10/04/18 and 12/06/18 were noted
- The occurrence a potential **further Never Event** was reported under Any Other Business, and it was agreed that the Medical Director and Associate Director, Quality Governance should submit a report to the 'main' Quality Committee in September 2018 containing the workplan being developed in response to the occurrences of Never Events at the Trust

2. In addition to the agreements referred to above, the Committee agreed that:

- The Clinical Director, Pathology and Pharmacy should Inform the Trust Secretary of the correct score for the "Omitted & missed doses" Pharmacy KPI, to enable this to be included in the minutes of the meeting
- The Medical Director and Associate Director, Quality Governance should arrange for the Trust Clinical Governance Committee to review the "Omitted & missed doses" Pharmacy KPI, in conjunction with the Chief Pharmacist

3. The issues from the meeting that need to be drawn to the attention of the Board are as follows: None

Which Committees have reviewed the information prior to Board submission?

- N/A

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]

Information and assurance

[1] 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 – July 2018

NHS Maidstone and Tunbridge Wells NHS Trust

7-17	**Summary report from the Patient Experience Committee, 05/07/18 (including proposed amendment to the Terms of Reference)**	**Committee Chair (Non-Executive Director)**

The Patient Experience Committee (PEC) met on 5th July 2018.

The key matters considered at the meeting were as follows:

- An update on actions raised at previous meetings was given, as part of which, it was agreed to circulate a copy of the "Care of the Dying Patient Policy and Procedure" to PEC members, and for the Assistant Deputy Chief Nurse to facilitate an introduction between the Trust's key end of life care contacts and the Tunbridge Wells Over Fifties Forum
- An amendment to the Committee's Terms of Reference (ToRs), was agreed to accept the Patient Representative Group as a sub-committee of the PEC. On wider review, it was also agreed that the ToRs should be further amended to reflect the PEC's agreement to reduce the quorum for members 'external to the Trust' from 4 to 3. The revised ToRs, as agreed by the PEC, with the proposed changes 'tracked', are enclosed at Appendix 1, for approval
- The Committee discussed the challenge of attracting new members to the PEC and it was agreed to invite the Trust's new Learning Disability Hospital Liaison Nurse to a future meeting to explore potential for widening the Committee's contact with other service user groups
- An update from the Patient Representative Group was heard, and the ToRs of the Group agreed. The concerns of patient representatives about the implications of the installation of Amazon lockers at Maidstone (MH) and Tunbridge Wells Hospitals (TWH) on footfall and traffic were noted, and it was agreed that these be conveyed to the Director of Estates and Facilities, including a proposal that the lockers be re-located
- In response to the longstanding action to identify a suitable mirror and a vanity unit for use in patient bathrooms at TWH, it was confirmed that an appropriate portable mirror had been identified, but that no progress had been made in identifying a suitable vanity unit. There was discussion that a plastic chair might be suitable for this purpose and it was agreed that an update should be provided at the next meeting on the introduction of new mirrors for patient bathrooms at TWH and on progress with the decision concerning the need for vanity units
- The 6-monthly Stroke performance report was considered, which included updates on the Sentinel Stroke National Audit Programme (SSNAP) ratings for TWH and MH and a status report on the Stroke Care Review in Kent and Medway
- The Complaints & PALS Annual Report 2018 was received and the key themes discussed. It was agreed that further explanation of the references to "first fit" initiatives within the report should be provided out of meeting. The Committee noted that the complaints referenced within the report represented a very small percentage of the approximately 800,000 contacts per annum received by the Trust
- The complaints made about the Trust's Outpatient telephone booking facilities were noted and it was agreed that progress with the work to improve telephone response times should be reported to the next meeting
- A report on Healthwatch activity was noted
- The final Quality Accounts 2017/18 were reviewed and questions invited for conveying to the Associate Director, Quality Assurance who was unable to attend the meeting
- A report on the PLACE Action Group was considered and it was agreed that equivalent trend data on PLACE programme issues should be provided for both of the Trust's main sites in the next report. It was also agreed for the feedback received about the out of date disposable curtains in the Haemato-Oncology Day Unit at TWH, to be conveyed to departmental staff and for it to be clarified about where responsibility lies for such issues
- Notification of recent/planned service changes was received, including details of the new Frailty Unit at TWH. Recent appointments to senior roles within the Trust were noted and the retirement of John Kennedy (JK) as Deputy Chief Nurse was confirmed. The Committee commended JK for his contribution to the PEC
- A report on recent Quality Assurance Rounds was noted. It was agreed that the issue raised during a recent PLACE assessment at the Intensive Care Unit, TWH, about the inaudibility of

the emergency buzzer for staff to summon assistance should be further explored

- The usual update on communications activity was noted
- An update on the current staff and public engagement work within the Trust was reported. Arising from discussion about volunteer engagement, it was agreed that the issues raised in the meeting about lack of volunteer engagement in the Trust's research trials should be conveyed to the Research and Development Manager, and also that liaison should take place with the Trust's Voluntary Services Coordinator to ensure that offers of volunteer involvement with the Trust were effectively utilised
- The Lead Matron for Paediatrics reported on the findings of and Trust response to the national 2016 Children and Young Patients survey. The PEC particularly commended the advancements made in the use of play specialists for children undergoing MRI scans in the Trust
- The findings of the NHS Inpatient Survey 2017 were briefly outlined and it was agreed that a more detailed review of the Trust's action plan should be scheduled for the next PEC meeting
- A report from the Patient Information and Leaflets Group (PILG) was received and it was agreed that the new Patient Outcomes and Innovations Manager should be invited to attend the next PEC meeting to present the latest update from the PILG
- A report from the Quality Committee meetings on 14/03/18, 10/04/18 and 19/06/18 was noted
- It was noted that the Junior Doctor scheduled to attend for the "Reflections from a Junior Doctor/Allied Health Professional" was unable to attend due to a conflicting commitment
- The Committee's forward programme was noted and it was agreed that the Chair of the PEC and the Chief Nurse should liaise to draft a more focussed agenda for the next meeting

In addition to the actions noted above, the Committee agreed that:

- n/a

The issues that need to be drawn to the attention of the Board are as follows:

- N/A

Which Committees have reviewed the information prior to Board submission?

- N/A

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]

1. To approve the revised Terms of Reference for the Patient Experience Committee (Appendix 1)
2. Information and assurance

[1] 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

PATIENT EXPERIENCE COMMITTEE

TERMS OF REFERENCE

NHS
Maidstone and Tunbridge Wells NHS Trust

1. Purpose

The Committee's purpose is to

1. Aim to capture the patient and public perception of the services delivered by Maidstone and Tunbridge Wells NHS Trust, and
2. 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

2. Membership

From the Trust:

- Non-Executive Director or Associate Non-Executive Director (Chair)
- Non-Executive Director or Associate Non-Executive Director (Vice Chair)
- Chief Nurse
- Director of Finance
- Deputy Chief Nurse (x 1)
- Associate Director for Quality Governance
- Complaints & PALS Manager
- Trust Secretary

External to the Trust:

- Public representatives from the Trust's catchment area
- Representatives from patient and carer support groups within the Trust's catchment area
- Representative from Healthwatch Kent (1)
- Representative from the local Independent Health Complaints Advocacy service (1)
- Representative from the League of Friends of the Maidstone Hospital (1)
- Representative from the League of Friends of Tunbridge Wells Hospital (1)

3. Attendance and quorum

The Committee will be quorate when 4 members from the Trust (including 1 Non-Executive Director or Associate Non-Executive Director) and ~~4~~ **3** members external to the Trust are present. Members may request a deputy to attend meetings in their place. Such a deputy will count towards the quorum.

The Associate Director of Nursing (or equivalent) from each Clinical Division will be invited to attend each meeting.

All other Non-Executive Directors (including the Chair of the Trust Board), Associate Non-Executive Directors, and Executive Directors are entitled to attend any meeting of the Committee.

A representative from the 'Doctors in training' (Junior Doctors) and/or junior members of other healthcare professions working at the Trust will be invited to attend each meeting, and provide a report on their reflections of the patient experience-related matters relevant to their role.

A representative from West Kent Clinical Commissioning Group (CCG) will be invited to attend each meeting, and provide a report on relevant matters.

The Chair/s of the Patient Experience Committee's sub-committee will be invited to attend certain meetings, to provide a report on the sub-committee's activity.

The Committee Chair may also invite others to attend, as required, to meet the Committee's duties.

4. Frequency of meetings

Meetings will be generally held quarterly.
Additional meetings will be scheduled as necessary at the request of the Chair.

5. Duties

- To positively promote the Trust's partnership with its patients and public
- To aim to capture the perspective of patients and the public, and present the patients' and public's perception of the Trust's services
- To oversee the development of patient information within the Trust, via the Patient Information Leaflet Group (PILG)
- To contribute to the development of Trust Policies, procedures, and strategies in so far as they relate to patient experience
- To advise on priorities for patient surveys and on the methods for obtaining local patient feedback
- To act as the primary forum by which the Trust will involve and consult with its patients and public on:
  - The planning of the provision of its services
  - Proposals for changes in the way those services are provided, and
  - Significant decisions that affect the operation of those services
- To monitor (via the receipt of reports) the following subjects:
  - Findings from the national NHS patient surveys (along with a response)
  - Friends and Family Test findings (and response, if required)
  - Findings from local patient surveys
  - Findings from relevant Healthwatch Kent 'Enter & View' visits (with a response, if relevant)
  - Comments from NHS Choices/'My NHS', and Social Media
  - Complaints and PALS contacts information
  - Progress against the "Patient Experience" priorities in the Trust's Quality Accounts
  - Patient experience-related findings from Patient-led Assessments of the Care Environment (PLACE)
  - Patient experience-related findings from the "Patient Representative Working Group", as required
- To review the work being undertaken by Clinical Directorates in relation to patient experience
- To maintain awareness of the developments with the Kent and Medway Sustainability and Transformation Partnership (STP)

6. Parent committees and reporting procedure

The Patient Experience Committee is a sub-committee of the Trust Board. The Committee Chair will report its activities to the next Trust Board meeting following each Patient Experience Committee meeting.

Any relevant feedback and/or information from the Trust Board will be reported by Executive and Non-Executive members (including Associate Non-Executive Directors) to each meeting of the Committee, by exception.

The Committee's relationship with the Quality Committee is covered separately, below.

7. Sub-committees and reporting procedure

The following sub-committees will report to the Patient Experience Committee through their respective chairs or representatives following each meeting:

- Patient Information Leaflet Group (PILG)
- Patient Representative Group

The frequency of reporting will depend on the frequency of sub-committee meetings.

Quality Committee

The Quality Committee may commission the Patient Experience Committee to review a particular subject, and provide a report. Similarly, the Patient Experience Committee may request that the Quality Committee undertake a review of a particular subject, and provide a report.

The Patient Experience Committee should also receive a summary report of the work undertaken by the Quality Committee, for information/assurance (and to help prevent any unnecessary duplication of work). The summary report submitted from the Quality Committee to the Trust Board should be used for the purpose. Similarly, a summary report of the Patient Experience Committee will be submitted to the Quality Committee. The summary report submitted from the Patient Experience Committee to the Trust Board should be used for the purpose.

8. 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, minutes and 'actions log'

9. Emergency powers and urgent decisions

The powers and authority of the Patient Experience Committee may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted with either the Chief Nurse or Director of Finance. The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the Patient Experience Committee, for formal ratification.

10. Review

The Terms of Reference of the Committee will be agreed by the Patient Experience Committee and approved by the Trust Board. They will be reviewed annually or sooner if there is a significant change in the arrangements.

History

- Terms of Reference (amended) agreed by the Patient Experience Committee, 14th October 2009
- Terms of Reference (amended) agreed by the Patient Experience Committee, 4th October 2010
- Terms of Reference (amended) approved by the Patient Experience Committee, 3rd October 2011
- Terms of Reference (amended) agreed by the Patient Experience Committee, 6th February 2012
- Terms of Reference (amended) approved by Patient Experience Committee, 7th March 2013
- Terms of Reference (amended) approved by the Trust Board, 29th April 2015
- Terms of Reference (amended) agreed by the Patient Experience Committee, 7th March 2016
- Terms of Reference (amended) approved by the Trust Board, 23rd March 2016
- Terms of Reference (amended) agreed by the Patient Experience Committee, 8th March 2017
- Terms of Reference (amended) approved by the Trust Board, 29th March 2017
- Terms of Reference approved by Trust Board, 18th October 2017 (to add Associate Non-Executive Directors to the membership)
- Terms of Reference (amended) agreed by the Patient Experience Committee, 7th March 2018
- Terms of Reference (amended) agreed by the Patient Experience Committee, 5th July 2018

Trust Board Meeting – July 2018

Maidstone and Tunbridge Wells NHS Trust

7-18	Summary report from the Trust Management Executive (TME), 18/07/18	Committee Chair (Chief Executive)

The TME met on 18th July 2018.

The key matters considered at the meeting were as follows:

- Learning disability, including consideration of communication needs and reasonable adjustments, was reported to be the focus for the month in the Safety Moment. The ongoing Learning Disabilities Mortality Review programme (LeDeR) was also highlighted
- The Strategic Outline Case for the Provision of Oncology Services in East Kent was noted and comments were invited prior to its next consideration by the Executive Team on 31/07/18
- An options appraisal for implementation of a Virtual Ward within the Trust was discussed and the preferred option for an external provider-run service was noted. It was agreed that the considerations raised by members of the TME be considered for incorporation within the specification for the project, which would shortly proceed to the tender-stage
- Initiatives under the Research Delivery Plan for 2018 to 2020 were reported and discussed, including more flexible ways to widen the number of staff involved in research
- The Interim Director of Health Informatics reported on the Electronic Patient Record (EPR) Project Initiation Summary, which contained a provisional first phase 'go-live' date of September 2019. It was agreed that the implementation plan for the EPR must provide for appropriate and timely proactive engagement with Clinical Directorates
- The Chief Executive reported on the status of work to develop clinical management and confirmed that (as there was no TME meeting in August) a proposal would be circulated for promulgation out of meeting, before the next TME meeting in September
- An update was given on the status of the work to produce a template for facilitating a baseline audit of clinically or financially vulnerable services for North, West Kent and Medway, as part of the development of a wider Acute Strategy
- The Director of Medical Education gave an update on the early plans for intended update from the new Kent and Medway Medical School and the associated opportunities and challenges were discussed
- The Head of Employee Services presented an update on recruitment process improvements
- The key aspects of Month 3, 2018/19 Integrated performance were reported, which included an update from the Chief Operating Officer on deteriorated performance against Cancer access targets. Members were asked for support in raising awareness of the issues discussed and actions required at divisional level to support recovery
- A report was given on Infection Prevention and Control issues
- The 4 clinical Divisions reported on their current key issues, which included the challenges of recovery of Cancer performance, substantive staffing and increased referrals. The Associate Director of Operations (Cancer and Clinical Support) was asked to convey concerns from the Clinical Director, Acute and Emergency to the General Manager, Radiology, about delays in receiving X-ray reporting and the implications for treatment
- Updates were noted on the national 7 day service programme, "Listening into Action", and the key issues from the Clinical Directors' Committee and Executive Team Meetings
- The Safeguarding Adults and Safeguarding Children Annual Reports, 2017/18 and the Estates and Facilities Annual Report were received
- Reports were noted re an update on the 2018/19 Internal Audit plan and recently-approved business cases
- Updates were noted on some of the TME's sub-committees (the Trust Clinical Governance Committee, Clinical Operations & Delivery Committee and Policy Ratification Committee)

1. **In addition to any agreements referred to above, the Committee agreed that:**
A new time should be scheduled for TME consideration of the forthcoming proposals from the Chief Operating Officer regarding the management of Annual Leave

2. **The issues that need to be drawn to the attention of the Board are as follows:** None

Which Committees have reviewed the information prior to Board submission?
N/A

Reason for receipt at the Board (decision, discussion, information, assurance etc.)
Information and assurance

Trust Board Meeting – July 2018

NHS Maidstone and Tunbridge Wells NHS Trust

7-19	Summary report from Finance and Performance Committee, 24/07/18 (incl. revised Terms of Reference)	Committee Chair (Non-Exec. Director)

The Finance and Performance Committee met on 24th July 2018.

1. The key matters considered at the meeting were as follows:

- The actions from previous meetings were reviewed, and this led to an agreement to request that the Workforce Committee provide the primary oversight of the delivery of the Trust's 2018/19 recruitment plan (and for the Finance and Performance Committee to only receive the associated report for information)
- The annual review of the Committee's Terms of Reference was undertaken, and a number of changes were agreed (and which are enclosed (with the proposed changes 'tracked', for approval, in Appendix 1). It was also agreed to ensure that the Trust Board was asked (when it reviews the next annual report on emergency planning, in November 2018) to consider whether it was satisfied with the current arrangements for the oversight of Business Continuity (or whether one of the Trust Board's sub-committees should provide more specific oversight)
- Under the "Safety Moment", it was reported that July's theme was focusing on people with Learning Disabilities
- An update on Financial Special Measures was given, and the month 3 financial performance was reviewed. It was agreed that future monthly reports should be amended to reflect the comments made at the meeting. It was also agreed that the Trust Secretary should schedule an item at the August 2018 Committee meeting to consider the alternatives to achieving the £1.7m of the Cost Improvement Programme (CIP) that had been planned to be delivered by the establishment of a wholly owned subsidiary
- The financial aspects of the Best Care programme at month 3 were reviewed, and it was agreed that the August 2018 Committee meeting should undertake a detailed assessment of the risks relating to the delivery of the CIP, including a forecast and risk-adjusted forecast. It was also agreed that the Project Management Office should ensure that the RAG rating for the "Job Plans not completed and added to the e-job planning system within the agreed timescales" risk took account of the adjusted timescale that the Medical Director had reported to the Best Care Programme Board
- The month 3 non-finance, non-quality, related performance was discussed, and the Chief Operating Officer agreed to arrange for a revised 18-week Referral to Treatment trajectory/forecast to be developed, to reflect the current issues affecting performance (including the shortfall in outpatient clinics) but excluding any data quality issues. The Chief Operating Officer also agreed to arrange for a real-time year-end forecast of the 62-day Cancer waiting time target performance to be developed
- The latest quarterly update on service tender submissions was reviewed, and it was agreed to clarify whether the "Kent Sexual Health" section of the report related to the entire Sexual Health service or just the online sexually transmitted infections home testing service. It was also agreed that future such reports should include details of the financial value/margins of tenders. It was further agreed to clarify whether the potential future tender for HPV Screening had been discussed as part of the STP-wide Pathology productivity work, and also clarify whether the likely locations of the 13 laboratories expected to provide HPV Screening in the future were known (to enable a judgement to be made as to whether the Trust should expend effort in preparing a tender submission)
- The standing update on the Lord Carter efficiency review was received, and it was agreed that future reports should include details of a) the financial opportunities indicated by the Trust's performance on the Model Hospital metrics and b) the 'Getting It Right First Time' (GIRFT) work that had taken place at the Trust
- The Committee received the Trust's latest assessment the status against the Use of Resources Assessment Framework (which the Trust would be subject to at a future point)
- The relevant aspects of the Board Assurance Framework (BAF) were reviewed and the Trust Secretary was asked to ensure that the "What could prevent this objective being achieved?

(including external factors)" section included all relevant external factors
- The Interim Director of Health Informatics and Chief Clinical Information Officer (CCIO) attended to give the 6-monthly update on IT strategy and related matters (which included a draft new IT strategy). Comments on the strategy were given and it was noted that a revised version was likely to be submitted to the Committee in October 2018 (before being submitted to the Trust Board, for approval)
- The Committee agreed the approach to the Trust's Reference Costs submission
- The latest quarterly analysis of Consultancy use was reviewed, and the standing "breaches of the external cap on Agency staff pay rate" report was noted
- The Committee was also notified of the recent usage of the Trust Seal

2. In addition the agreements referred to above, the Committee agreed that:
- The Trust Secretary should arrange for the Finance and Performance Committee, Workforce Committee and Quality Committee to be given the opportunity to influence the content of the Trust's annual Internal Audit plan each year
- The Business Intelligence Team should be asked to ensure that the rules regarding Statistical Process Control (SPC) were being correctly applied to performance information
- The Trust Secretary should request that the 2018/19 Internal Audit "Assurance Review of Data Quality of Key Performance Indicators" assigned an assurance assessment/level for each KPI reviewed (rather than just an overall assurance assessment)

The issues that need to be drawn to the attention of the Board are as follows:
- Revised Terms of Reference were agreed, and these have been submitted to the Board for approval (see Appendix 1)

Which Committees have reviewed the information prior to Board submission?
- N/A

Reason for receipt at the Board (decision, discussion, information, assurance etc.)
1. Information and assurance
2. To approve the revised Terms of Reference for the Finance and Performance Committee (Appendix 1)

Appendix 1: Revised Terms of Reference (with proposed changes 'tracked'), for approval

FINANCE AND PERFORMANCE COMMITTEE

Terms of Reference

NHS Maidstone and Tunbridge Wells NHS Trust

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 key operational targets and the Trust's financial position
- Advice and recommendations on all key issues of financial management, ~~and~~ financial performance and operational performance
- Assurance on Information Technology performance (and IT-related 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~~ Chief Finance Officer
- The Chief Operating Officer
- The Chief Executive

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

- 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 (QIA), 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 Chief Finance Officer~~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 (SLR)
- 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 2018 (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 (to remove the Deputy Chief Executive from the membership, following the discontinuation of that post)
- Terms of Reference (reviewed and revised) agreed by the Finance and Performance Committee, July 2018
- Terms of Reference (revised) approved by the Trust Board, July 2018