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

9.45am – c.12.30pm THURSDAY 25TH OCTOBER 2018

PENTECOST/SOUTH ROOMS, THE ACADEMIC CENTRE, MAIDSTONE HOSPITAL

A G E N D A – PART 1

Ref.	Item	Lead presenter	Attachment
10-1	To receive apologies for absence	Chair of the Trust Board	Verbal
10-2	To declare interests relevant to agenda items	Chair of the Trust Board	Verbal
10-3	Minutes of the Part 1 meeting of 27th September 2018	Chair of the Trust Board	1
10-4	To note progress with previous actions	Chair of the Trust Board	2
10-5	Safety moment	Chief Nurse / Medical Director	Verbal
10-6	Report from the Chair of the Trust Board	Chair of the Trust Board	3
10-7	Report from the Chief Executive	Chief Executive	4
	Patient experience		
10-8	A patient's experience of the Trust's services	Bereavement Support Midwife / Deputy Head of Midwifery	Verbal
10-9	Integrated Performance Report for September 2018 ▪ Effectiveness / Responsiveness ▪ Safe / Effectiveness / Caring (incl. planned and actual ward staffing for September 2018) ▪ Safe / Effectiveness (incl. mortality) ▪ Safe (infection control) ▪ Well-Led (finance) ▪ Well-Led (workforce)	Chief Executive Chief Operating Officer Chief Nurse Medical Director Dir. of Infection Prev. and Control Deputy Director of Finance (Financial Performance) Director of Workforce	5
10-10	Update from the Best Care Programme Board	Chief Executive	6
	Quality items		
10-11	Annual Report from the Director of Infection Prevention and Control (including Trust Board annual refresher training)	Director of Infection Prevention and Control	7
	Planning and strategy		
10-12	Update on 2017/18 Winter and Operational Resilience Plan	Chief Operating Officer	8
	Reports from Trust Board sub-committees (and the Trust Management Executive)		
10-13	Workforce Committee, 27/09/18 (incl. Annual Report from DME on work schedule reviews relating to education and training; Work Race Equality Standard (WRES) report for 2018; and Freedom to Speak Up update)	Committee Chair	9
10-14	Quality Committee, 15/10/18	Committee Chair	10
10-15	Trust Management Executive (TME), 17/10/18	Committee Chair	11 (to follow)
10-16	Finance and Performance Committee, 23/10/18	Committee Chair	12 (to follow)
10-17	Charitable Funds Committee, 23/10/18	Committee Chair	Verbal
10-18	**To consider any other business**		
10-19	**To receive any questions from members of the public**		
10-20	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 meeting: 29th November 2018, 9.45am, Lecture Rooms 1&2, Education Centre, Tunbridge Wells Hospital		

David Highton,
Chair of the Trust Board

MINUTES OF THE TRUST BOARD MEETING ('PART 1') HELD ON THURSDAY 27TH SEPTEMBER 2018, 9.45A.M, AT MAIDSTONE HOSPITAL

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	David Highton	Chair of the Trust Board	(DH)
	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	Chief Finance Officer	(SO)
	Steve Phoenix	Non-Executive Director	(SP)
	Miles Scott	Chief Executive	(MS)
In attendance:	Simon Hart	Director of Workforce	(SH)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Emma Pettitt-Mitchell	Associate Non-Executive Director	(EPM)
	Kevin Rowan	Trust Secretary	(KR)
	Bev Bird	Clinical Support Worker (for item 9-8)	(BB)
	Pam Bridger	Senior Nurse (Practice Development) (for item 9-8)	(PB)
	Georgie Devaney	Ward Manager, Edith Cavell Ward (for item 9-8)	(GD)
	Gayle Epps	Learning Lead - Widening Participation (for item 9-8)	(GE)
	Rob Parsons	Risk and Compliance Manager (for items 9-17 and 9-18)	(RP)
	Paul Sigston	Deputy Medical Director, Urgent Care	(PS)
	Katherine Skinner	Trainee Clinical Support Worker (for item 9-8)	(KS)
Observing:	Darren Yates	Head of Communications	(DY)
	Suzanne Cliffe	Head of Delivery and Improvement, NHS Improvement (NHSI)	(SC)
	Charlotte O'Brien	Head of Delivery and Improvement, NHSI	COBr)

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

9-1 To receive apologies for absence

Apologies were received from Maureen Choong (MC), Non-Executive Director. It was also noted that Neil Griffiths (NG), Non-Executive Director and Selina Gerard-Sharp (SGS), NExT Director, would not be in attendance. DH further noted that SC and COBr would be observing the meeting.

9-2 To declare interests relevant to agenda items

No interests were declared.

9-3 Minutes of the 'Part 1' meeting of 26th July 2018

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

9-4 To note progress with previous actions

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

- **7-20a ("Consider a response to the issues raised by the Chair of the Quality Committee at the Trust Board on 26/07/18 in relation to the Clinical Decisions Unit (CDU)")**. AG explained that the CDU was an area where the continuation of treatment for patients under the care of the Emergency Department (ED) took place, and where assessment was continued. AG stated that the Units were used to maintain patient flow from the ED and there were CDUs at both Maidstone Hospital (MH) and Tunbridge Wells Hospital (TWH). AG added that patients who were moved to the CDU were regarded as being admitted so their waiting time was

stopped upon such admission. SDu clarified that the point she had made related to communication with patients and whether the message that a patient would be moved to the CDU could be softened, given the poor nature of the fabric of the Unit at TWH, which did not have any windows. DH noted that the title of the Unit indicated that further decisions were required. MS added that changes had been made to the Trust's CDUs, following feedback from the Emergency Care Intensive Support Team (ECIST), but accepted that more could be done regarding communication. It was then confirmed that the action could be closed.

- **7-20b ("Reconsider the feasibility of introducing a tablet-based Friends and Family Test system at the Trust").** COB reported that 32 iPads had been identified for use in the Friends and Family Test (FFT) survey. COB added that the change would take some time to implement, but no additional cost had been involved as the iPads were already within the Trust's stock.

9-5 Safety moment

COB reported that the month's theme was Sepsis, and the focus included assessing patients for the risk of Sepsis, as early identification was a key issue that could save lives. COB also noted that a Sepsis study day event had been held, which had been very well attended. PM added that he had been involved in the investigation of a previous Serious Incident (SI) which involved Sepsis, & SM had suggested that the case would be a good subject for a future "patient experience" item. PM stated that he would however meet with the patient concerned in the first instance.

DH asked whether staff knew the indicators for Sepsis. COB replied that she believed staff knew these quite well, but there should never be complacency. DH noted that such indicators could be embedded into the Electronic Patient Record (EPR) and alerts could be set. DH continued that although it was important not to include too many alerts, he believed that a Sepsis-related alert warranted inclusion. COB agreed. It was therefore agreed to ensure that the inclusion of a patient alert for Sepsis was incorporated within the design phase of the implementation plan for the forthcoming EPR.

Action: Ensure that the inclusion of a patient alert for Sepsis was incorporated within the design phase of the implementation plan for the forthcoming Electronic Patient Record (Chief Finance Officer, September 2018 onwards)

9-6 Report from the Chair of the Trust Board

DH referred to Attachment 3 and highlighted that there had also been a successful appointment of a Consultant Gastroenterologist but the details were not yet finalised so these would be included in his next report.

9-7 Report from the Chief Executive

MS referred to Attachment 4 and highlighted the following points:

- The Clinical Commissioning Groups (CCGs) in Kent and Medway had identified their preferred option for the location of Hyper Acute Stroke Units, which included MH. Work was therefore taking place to prepare for what would, in effect, be a new service, but the final decision would not be made until January 2019. Engagement had however started with the Trust's Stroke service staff
- Professor Chris Holland had been appointed as the Foundation Dean of the Kent and Medway Medical School, and the Trust continued to liaise with the School
- Much work had taken place in relation to national planning and a briefing from NHS Providers had been included within Attachment 4. The Trust's new Director of Strategy, Planning and Partnerships would start in October 2018 & would therefore be at the next Trust Board meeting
- The improvements that had been seen in performance were due to a combination of doing more and doing things differently and innovatively, and the partnership with Macmillan Cancer support was very encouraging in relation to the latter
- The Trust would appoint the country's second Consultant Scientist in Cellular Pathology during w/c 01/10/18

SM referred to the latter point and noted that the Trust would shortly also be the first in the country to appoint 2 Consultant Scientists in Cellular Pathology.

Staff experience

9-8 Apprenticeships

DH and SH welcomed BB, PB, GD, GE and KS to the meeting. GE firstly reported that the Trust was now paying an Apprenticeship Levy, which was transferred monthly into a digital account that the Trust could spend on apprenticeship training. GE added that this was seen as positive, but the Trust was required to engage in in lengthy tender procedures to appoint an external training provider, via an OJEU-compliant procurement process, and this has meant that the expenditure of Levy monies had been slow at commencement.

PB then presented the pathway chart "Your Nursing Career with MTW" and explained the key aspects, which included that the Trust had worked successfully with other partner organisations, and had been able to extend the scope of the offers it made.

DH asked for further details of the scope of the aforementioned procurement. GE confirmed that the scope was to procure a training provider to deliver the full details of training. DH asked if the assurance role was contracted for separately, as he understood there was a need to provide assurance that the training met certain standards. GE stated that the scheme was within Ofsted and the Education and Skills Funding Agency's (ESFA's) remit and they would obtain their own assurance.

BB was then introduced, noting that she was about to commence as a Trainee Nursing Associate with a 2-year contract, and during that time BB would undertake a Foundation Degree which was a Diploma-level qualification. It was noted that once BB had been added to the Nursing and Midwifery Council (NMC) register as an NMC Registrant, she would undertake a further 2 years of study and then become a Registered Nurse. It was noted that at least 50% of the individuals that PB and GE interviewed had expressed an aspiration to become a Registered Nurse.

DH remarked that the process therefore enabled an individual not involved in healthcare to undertake a work-based training placement whilst being paid, and become a Registered Nurse in 4 to 6 years, without taking a student loan. This was confirmed to be the case.

KS then described her circumstances, and noted that the Ward staff and GD had been very supportive. KS continued that the initiative had provided a great educational opportunity for which she was very grateful. GD added that she was very privileged to be part of the start of the process, and she knew that her Ward wanted an Apprentice. GD stated that KS brought something new to the Ward and she particularly liked the title of "Apprentice", as this better reflected the hard work that was involved, as KS had to study very hard and justify every aspect of her time.

BB then remarked that she had worked in the NHS for several years and she was excited to be able to receive a wage whilst obtaining a qualification.

MS commented that there were not many discussions which noted that large numbers of people wanted to work for the Trust, so he was interested to know how the scale of the initiative could be increased to meet the Trust's Nurse staffing needs. MS therefore asked GD what she would need to be able to take more Apprentices on her Ward. GD stated that she was lucky enough to be fully established but more could be done to communicate what was involved in being an Apprentice, such as a notice board on arrival at the Ward. MS clarified that he wanted to know what the Trust Board could do to enable GD to expand the number of Apprenticeships on her Ward. GD replied that her establishment would need to be expanded and the Apprenticeships would need to be funded, but she would be happy to take more Apprentices.

COB then commended the work undertaken by GE, particularly with local schools. COB added that some very academic candidates had expressed an interest in the scheme, given the fact that a student loan was not required.

COB then explained the steps required to expand the Nurse Associate posts and noted that creative thought was required. SH added that creative thought was also required to consider how Continuing Professional Development (CPD) could benefit from the Apprenticeship Levy, in terms

of MBA qualifications etc., as the use of the Levy was tightly controlled. DH stated that he understood the Levy could be spent over a 2 year period. GE confirmed this was the case and added that the Levy was transferred to the Trust every month. GE also noted that it was possible for the Trust to transfer some of its Levy to other providers (and vice versa), and she was currently looking at ways in which this could be used to support patient pathways in health and social care locally.

DH thanked BB, PB, GD, GE and KS for attending.

9-9 Integrated Performance Report for August 2018

MS referred to Attachment 5 and invited each relevant Member of the Executive Team to address the specific areas of performance within their remit.

Effectiveness / Responsiveness

AG duly highlighted the following points:

- The A&E 4-hour waiting time target trajectory had been met for 4 consecutive months. Performance had reduced slightly in August but had then recovered in September. Performance was below the 95% national target but ahead of the agreed trajectory. The focus was on patient flow and Length of Stay reductions both of which were supported by the Ambulatory Emergency Care units that were in place at both MH and TWH.
- The rate of Delayed Transfers of Care had not yet been reduced to the 3.5% national limit, but it had stabilised at circa 4%. The focus was on 'stranded' and 'super-stranded' patients

NH referred to the Frailty Units and asked when the decision regarding the proposed increase in operating hours would be taken. AG answered that this was expected very shortly and explained that this involved extending the operating hours to 7 days per week from the current 5 days. AG added that staff would need to be recruited for the extended hours.

AG then continued and highlighted that the Trust was still below its target trajectory for Referral to Treatment (RTT) waiting times. AG elaborated that the waiting list had been affected by duplicate pathways but a validation exercise had commenced which would reduce the number of duplicates. AG added that the validation would be completed by the end of October 2018. DH stated that he understood that one factor in the duplicate pathways was the need for further user training. AG confirmed that operator error was an aspect and the work to reduce the number of additional duplicate pathways being created had led to a reduction. AG added that staff had also been trained to remove duplicates and they would be working at weekends to address the issue.

SP asked whether the October 2018 Trust Board meeting could review the Directorate-specific RTT trajectories. AG noted that the aforementioned validation would not be complete by the time the monthly performance report was issued for the October Board meeting.

SO then referred to the "Theatre Productivity" section in Attachment 7 and asked whether there had been any specific targeting of action in the areas that had not yet reached the 85% target for Theatre utilisation. AG confirmed this was the case and provided further details. DH noted that the areas with the 2 lowest utilisation rates were ENT and Paediatrics and asked if there were particular problems with those specialties. AG explained the specific circumstances affecting both.

NH then remarked that she had recently observed Breast surgery being performed & the staff had commented that Theatre lists were very long, which had caused some issues. AG noted that the Breast surgeons in particular were keen to ensure that all available Theatre time was used, and this had led to a comment during the recent Getting It Right First Time (GIRFT) visit to that area.

MS then highlighted that the RTT issues had arisen predominantly from 2 factors: the multiple 'clock stops' and the activity in the first part of 2018/19 being higher than planned. MS continued that activity had been increased in response to the latter, whilst a validation exercise was underway for the former. MS added that the 2 exercises would potentially result in the waiting list being at the level it was at the end of March 2018, which would meet the national planning requirement, but not the Trust's plan. The point was acknowledged. DH also noted the importance

of the Outpatient transformation work, as the majority of the waiting list backlog was in Outpatients. DH therefore proposed that the next Finance and Performance Committee review the Outpatients-related work being undertaken by Four Eyes Insight Ltd. This was agreed.

Action: Arrange for the October 2018 meeting of the Finance and Performance Committee to review the Outpatients-related work being undertaken by Four Eyes Insight Ltd (Chief Operating Officer / Trust Secretary, October 2018)

SDu then referred to the discussions held at the Finance and Performance Committee meetings on 25/09/18 & 16/08/18 and noted that the Trust needed to be mindful of the sustainability of its plans.

PM then referred to the quality aspects of the RTT performance, noting that the retrospective harm reviews had been completed and had been reviewed at the 'main' Quality Committee, whilst a prospective process had also been established. PM elaborated on the details.

AG then reported the RTT 52 week breaches and the action being taken to address the underlying causes.

DH then asked AG to report on Cancer performance. AG duly referred to Attachment 6 and highlighted the following points:

- The capacity problems were nearly all focused on Surgery, where there was a shortage of Surgical Middle Grade (i.e. Specialty and Associate Specialist) doctors
- The actions focused on the first part of the patient pathway i.e. the diagnostic phase, although this also involved some administrative aspects. MRI and 2-week wait clinics had therefore been increased, along with Endoscopy and Pathology capacity. The report included further details of the work taken place to assess the imbalance between demand and capacity
- Some of the Breast activity had been outsourced and the aforementioned GIRFT visit had highlighted where Breast surgeons were considered to be overworked, given the compact nature of the team
- In terms of the future, page 18 of Attachment 6 included a first draft revised trajectory to the end of 2018/19. This was below the Trust's original agreed trajectory. The focus was now on ensuring that the delivery of the revised trajectory was sustainable. This had been discussed at the Finance and Performance Committee on 25/09/18 and it had been acknowledged that the trajectory would need to be refreshed with updated monthly performance

SP asked for clarification that AG was stating that it was possible that performance would be better than the trajectory shown on page 18, based on the measures that had been put in place. AG clarified that she believed the trajectory needed to be refreshed over the next 1 to 2 months before it was possible to have real confidence in delivery of the trajectory. MS added that the demand and capacity work being undertaken with the NHS Intensive Support Team (IST) did not finish until the end of w/c 01/10/18 so the trajectory within Attachment 6 needed to be caveated with that in mind. SP welcomed this as he remarked that the plan being presented would not be good enough. DH acknowledged the point. DH also agreed that it was important to await the outcome of the IST work, but SDu's earlier point regarding the need to be sustainable should also be borne in mind.

SO then noted that the Trust had been working with West Kent CCG on RTT and Cancer and the CCG had agreed to fund the recovery plans for both. AG added that the West Kent Cancer Improvement Board had also been established, to consider a systems-wide approach.

SDu also emphasised the need to recognise the work that had been undertaken in relation to Cancer-related harm reviews. DH noted that a further discussion on that would be held in the 'Part 2' Trust Board meeting scheduled for later that day, but PM elaborated on the quality-related actions that had been undertaken and noted that the harm reviews that had been completed in Urology did not reveal any issues of concern.

Safe / Effectiveness / Caring (incl. planned and actual ward staffing for June 2018)

COB then referred to Attachment 5 and highlighted the following points:

- Reported patient falls had increased slightly and the number of falls-related SIs had also increased, although the number was fewer than in 2017/18. The Trust had been engaged in

NHSI's Falls Prevention Collaborative and this had gone well so far, but further work was required to embed the lessons that had been learned
- For pressure ulcers, work had been completed to benchmark against the recently issued NHSI guidance document and 9 actions had been identified for the Trust. However, these were related to policy and definitions and no major changes were required to Trust practice
- It was important to monitor the concurrence of incidents in patients with Dementia
- The Trust's performance on the FFT response rate had been very variable in recent months. However some of the performance was likely to be affected by the system, which gave a further imperative to proceed with the electronic solution COB had referred to under item 9-4
- There had been 5 Mixed Sex Accommodation breaches, which involved 1 patient being placed in an area with patients of a different gender. Liaison had therefore taken place with the Site Team to prevent future occurrences
- The complaints response rate had improved in July but reduced again in August, although that reduction had been expected. Meetings had been held with Directorate teams in response

NH referred to the latter point and asked about the resilience within the Central Complaints Team, noting that some of the response breaches had been related to Annual Leave within the Team. COB stated that some additional resource had been identified to support the Central Team and this was expected to lead to an improvement in the next 6 weeks.

COB then referred to page 16 and pointed out that the report contained an error, in that the Parliamentary and Health Service Ombudsman had *not* upheld three complaints against the Trust. The point was acknowledged. COB added that since the report had been produced, a further complaint had been confirmed as not being upheld.

SDu asked about learning lessons from complaints. COB explained the approach and PM added further detail. COB then continued and reported on the SIs that had occurred, and the work that had taken place in response.

COB then referred to the "Safe Staffing" section of the report and highlighted that the Wards of note for July were Mercer, which experienced 20 falls above the required threshold & the Cardiac Care Unit at TWH, which had a low Registered Nurse fill rate. COB then elaborated on the details.

SDu asked what additional support was being provided for the Wards with lower fill rates and higher use of temporary staff i.e. to prevent a downward spiral. COB noted that the report did not provide details of the reviews that were undertaken each day by Matrons and Ward Managers. COB added that work was taking place regarding the use of the SafeCare module of the e-Rostering IT system. SDu proposed that the outcome of that work be reviewed at a relevant Committee in due course. This was agreed.

Action: Liaise to schedule the outcome of the work regarding the use of the SafeCare module of the e-Rostering IT system at the relevant Committee meeting, when completed (Chief Nurse / Trust Secretary, September 2018 onwards)

Safe / Effectiveness (incl. mortality)

This was covered under item 9-13.

Safe (infection control)

SM then referred to Attachment 5 and highlighted the following points:
- Clostridium difficile cases had increased during July and August. There was no evidence of cross-infection but the increase had been discussed at an Executive Team Meeting and it was agreed that the Trust should declare a Clostridium difficile outbreak, to ensure there was increased rigour and oversight, as well as increased engagement from staff
- The number of Clostridium difficile cases at TWH had returned to the baseline level, but the cases at MH had continued to arise. An action plan was in place.
- The outbreak meetings that had been held had raised some issues regarding cleaning, including who should undertook discharge cleans i.e. these were carried out by domestic staff at TWH, whilst at MH these were done by Nurses

- There had been a high number of Clostridium difficile carriers and these were now being assessed by ribotyping, to determine whether there was any link with the cases seen
- The Trust antibiotic policy had changed in the past to use quinolone rather than Tazocin, which had been subject to a world-wide supply shortage
- There had been good engagement with Ward Managers and the action plan was being implemented

DH asked whether the hot summer could have affected the number of Clostridium difficile cases. SM replied that this initially been considered, but the focus was now on addressing behaviour-related issues.

SDu asked whether the carriers that SM had referred to were members of staff. SM confirmed that the carriers were patients.

Well-Led (finance)

SO then referred to Attachment 5 and highlighted the following points:

- The Trust had a surplus of £0.1m in August, and a year to date deficit of £2.6m, which was in accordance with the plan
- The Provider Sustainability Fund (PSF) had been achieved for Quarter 1 and was expected to be achieved for Quarter 2
- The forecast was still to deliver the plan
- The Prime Provider contract for Planned Care was not yet in place and this had adversely affected the position. This was now expected to start in November 2018 and there would therefore be slippage against the benefits planned for September and October

DH expressed frustration at the delay in deciding the award of the Prime Provider contract for Planned Care. SO noted that the delay had been discussed at the recent Systems Assurance Meeting but the contract needed to be awarded by West Kent CCG's Governing Body, which did not meet until the end of October. MS queried whether the Governing Body was required to actually meet to make the decision. SO suggested that some correspondence to the CCG may be beneficial in expediting the matter.

SO then continued, and highlighted that the forecast assumed that the Trust would deploy its mitigations, but this would be reviewed as the year progressed. SO also noted that the Trust's cash position was presently good.

DH gave assurance that the financial position had been discussed in detail at the Finance and Performance Committee on 25/09/18. SDu acknowledged this, but asked SO to expand on the risks associated with the position. SO explained that there were 2 main areas of risk: non-delivery against the Best Care programme and budgetary pressures. SO elaborated that the majority of the latter related to pay, although there were some non-pay pressures. SO added that the next series of budgetary reviews would take place on 28/09/18 and expanded on the specific oversight being applied with each Division.

SDu commented that the performance to date was reassuring but the 'mountain was yet to be climbed' in relation to Cost Improvement Programme (CIP) delivery in particular, and this should be recognised. SDu added that the award of the aforementioned Prime Provider contract was a key aspect. The points were acknowledged.

AG then asked about the potential reduction in capital funding due to depreciation issues, and asked if other schemes would be at risk. SO described the mitigating actions being considered.

Well-led (workforce)

SH then referred to Attachment 5 and reported that sickness absence was expected to rise due to the increasingly cold weather, so managers had been reminded of the need to address this. SH noted that this included ensuring their staff received the influenza vaccination. SH added that the vaccination target would be 85%, which was a challenge, but additional resources had been applied and a multidisciplinary Task & Finish group would meet fortnightly to provide oversight.

SM noted that there had been some discussion regarding the asymptomatic carriage of influenza in which staff had carried the virus home to family members, and suggested that it would be useful to include this in the messages given to staff regarding vaccination. SH acknowledged this & noted that the plans included relaying some personal stories from staff that had contracted influenza.

SH then continued, and highlighted the following points:
- Statutory and Mandatory training compliance had reduced but a new Learning Management System had been introduced and improvement was therefore expected
- Staff turnover was now below 10%
- Automatic job offers would be made to all Nursing Students, provided they passed their exams. The Trust was also seeking to increase overseas recruitment
- The Trust's temporary staffing challenge was intrinsically linked to pay rates and efforts were being made to reduce such rates across the local health economy
- There had been some success in converting Medical staff from Agencies to the Trust Bank, and such efforts would continue. Some good advice regarding this had been received from the Divisional Medical Director at Countess of Chester NHS Foundation Trust

9-10 Performance on the 62-day Cancer waiting time target

This was covered under item 9-9.

9-11 Update from the Best Care Programme Board

MS referred to Attachment 7 and highlighted the following points:
- The Maternity department's compliance with NHS Resolution's Maternity incentive scheme had resulted in a £900k benefit, and that value may yet increase
- Considerable work was taking place regarding patient flow
- The Best Workforce programme had improved its delivery, but there was still more to do

9-12 Review of the Board Assurance Framework 2018/19

KR referred to Attachment 8 and highlighted that content of the Board Assurance Framework (BAF) for objectives 1 to 4 had been reviewed at the Finance and Performance Committee meeting on 25/09/18, and it had been noted that the plans regarding the Virtual Ward should be referenced in objective 1. KR added that this would be included in the next iteration of the BAF.

It was then confirmed that the 'Responsible Director's" ratings of the confidence that the objective would be achieved by the end of 2018/19 were an accurate reflection of the Trust Board's understanding.

Quality Items

9-13 Quarterly mortality data

PM referred to Attachment 9 and highlighted the following points:
- The format was similar to previous reports and the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) were also very similar to that previously reported
- The decline in the HSMR had been very clear up until a few months ago but this had now levelled out. PM had been in correspondence with the Trust's Head of Clinical Coding and PbR Assurance and they had stated that they believed the Trust's clinical coding was sufficient to provide confidence, although PM noted that more work was required to educate Medical staff to write the relevant details in patients' Healthcare Records
- The Mortality Review process had been strengthened by the use of an electronic system, and over 89% of the first stage reviews had been undertaken over the year. It was however acknowledged that more proactive work was needed by the Mortality Surveillance Group, and PM therefore expected the next report to show a slight change in emphasis

SO then referred to PM's remarks regarding the quality of clinical coding and noted that the report contained some useful metrics which were taken from the SHMI additional dataset, and which

showed that the Trust compared favourably against others and against its peers in particular. SO added that the training PM had mentioned would start soon and SO would attend the "Coding for Non-Coders" course, which he would encourage other Trust Board Members to attend. DH noted that Clinical Coding was done different within an EPR than for hard copy Healthcare Records, and that was therefore another aspect that would need to be incorporated within the EPR implementation plan. The point was acknowledged.

Planning and Strategy

9-14 Review and approval of final proposals for developing a clinically led organisation

MS referred to Attachment 10 and highlighted the following points:

- The initial proposals had been shared at the last Trust Board 'Away Day', and work had followed which culminated in a consultation document that was issued in the summer
- There had been an overwhelming response to the consultation and a number of changes had been made to the specific proposals as a consequence of the feedback
- The proposals had been submitted for approval, and if approved, the intention was to launch the plans w/c 01/10/18 and commence the new structure from November 2018, to enable the Trust to enter the winter period under the new structure
- The leadership development and talent management aspect was also being progressed, as was the Organisational Development aspects

SDu noted that there was considerable change involved in the proposals and asked who would therefore oversee this. MS replied that the success would depend on whether the changes were able to be implemented swiftly whilst following due process. MS added that it was important to support the new Chiefs of Service. SDu acknowledged the point, but emphasised the need to ensure there was continued focus on delivery of the Trust's core business. MS agreed and noted that most of the individuals affected by the structure would have very similar roles to those they currently held. MS added that no staff member would be placed at risk as a result of the proposals.

DH agreed that it was important to ensure delivery was not adversely affected, but stated that the longer-term benefits would be felt in terms of delegating authority. SO added that the Executive - led performance reviews with each Division would continue during the transition period and a clear set of metrics would continue to be monitored.

TL asked what interest had been expressed in the new Chief of Service posts. MS noted that the structure had not been designed around individuals but confirmed that MS and PM had held a number of discussions. MS added that it was however possible that not all of the Chief of Service posts would be filled at the first attempt, so the Trust should have the courage of its convictions to not appoint if a candidate was not suitable.

The Trust Board approved the proposals as circulated.

SDu then asked that the Non-Executive Directors be provided with details of the individuals who had been appointed to the key posts within the new structure, once finalised. This was agreed.

Action: Ensure that Non-Executive Directors were provided with details of the individuals appointed to the key posts within the new clinical management structure, once finalised (Trust Secretary, November 2018)

MS concluded by stating that he had asked DY to develop some clear Intranet pages to communicate the appointments to staff. MS also noted that a review of the new structure would be undertaken after 6 months.

Assurance and policy

9-15 Responsible Officer's Annual Report 2017/18

DH welcomed PS to the meeting, who referred to Attachment 11 & highlighted the following points:

- PS would happily circulate his own appraisal documentation as he believed this may support Trust Board Members' understanding of the appraisal and revalidation process. PS confirmed that he had provided his appraisal document to KR for onward circulation
- The process was always able to be improved and reflection was the key consideration
- PS believed the Trust was ahead of many other organisations
- The impact of appraisal on patient care was open to debate, but there was some evidence of a reduction in complaints being associated with appraisal

PM then asked PS to describe the actions that would be taken to improve the process over the next year. PS explained the actions planned but noted that there was not currently a process to provide a complaints folder for each doctor and the solution was not straightforward, particularly given the lack of capacity in the Central Complaints Team.

Questions were invited. None were received. The Trust Board approved the Statement of Compliance within Attachment 11 confirming that the Trust, as a Designated Body, was in compliance with the regulations governing appraisal and revalidation.

9-16 Health & Safety Annual Report, 2017/18 (incl. agreement of the 2018/19 programme and Board annual refresher training on Health & Safety, Fire safety, and Moving & Handling)

DH welcomed RP to the meeting. AG then introduced the item, noting that she was the Executive Lead for Health & Safety. RP then referred to Attachment 12 and highlighted the following points:

- There had been an increase in reported incidents but a decrease in injuries
- The most positive aspect was the reduction of the number of Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) related falls affecting the public and visitors to zero. This reflected the work that had taken place regarding that particular risk
- The report described the range of work that had taken place on sharps injuries
- The report also contained an Appendix outlining what the Trust Board needed to know and included details of the healthcare prosecutions in 2017/18
- An update on the key objectives and roles and responsibilities was also included

DH commended the comprehensive nature of the report. Questions were invited. None were received. The Trust Board approved the Health and Safety work programme for 2018/19.

9-17 Ratification of Health & Safety Policy and Procedure

RP referred to Attachment 13 and reported that the key changes were highlighted. RP also gave assurance that the policy included all the necessary elements of a Health & Safety policy. AG also confirmed that the policy had been reviewed in detail at the Trust's Health & Safety Committee.

The revised Health and Safety Policy and Procedure was ratified as circulated.

9-18 Approval of Emergency Preparedness, Resilience and Response (EPRR) Core Standards self-assessment

AG referred to Attachment 14 and reported that the standards with which the Trust was not compliant related to the fact that further national guidance was awaited.

DH commended the Emergency Planning team's Twitter account, and encouraged Trust Board Members to follow this.

The Emergency Preparedness, Resilience and Response (EPRR) Core Standards self-assessment was approved as circulated.

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

9-19 Workforce Committee, 26/07/18 (incl. quarterly report from the Guardian of Safe Working Hours)

DH noted that the meeting had been SP's last as the Chair, as NH would preside over the Committee for the meeting scheduled later that afternoon and from that point onwards. SP confirmed this was the case and noted that the report included the Guardian of Safe Working Hours report.

9-20 Quality Committee, 07/08/18 & 12/09/18

SDu referred to Attachment 16 and reported the following points:

- The Paediatrics Directorate had explained their challenges at the Quality Committee 'deep dive' meeting on 07/08/18 but it then became clear at the 'main' Quality Committee on 12/09/18 that the support being provided to the Directorate was having the desired effect
- The 'main' Quality Committee meeting had also considered the recent pattern of readmissions, and the further work required was noted
- Concerns had also been raised by the Clinical Director for Head and Neck in relation to the IT problems which affected the Directorate's participation in national outcomes audits. A response had therefore been requested, and this had been included as an Appendix to Attachment 16
- A review of the quality indicators demonstrated that quality may be being challenged, so work had been asked to be undertaken and submitted to a future Quality Committee meeting

SDu also proposed that it would be beneficial to review Inflection Prevention and Control at a future Quality Committee 'deep dive' meeting. SM agreed this would be helpful. This was agreed.

Action: Liaise to schedule a "review of infection prevention and control" item at a future Quality Committee 'deep dive' meeting (Trust Secretary / Director of Infection Prevention and Control, September 2018 onwards)

9-21 Audit and Governance Committee, 08/08/18 (incl. the Annual Audit Letter for 2017/18)

SP referred to Attachment 17 and highlighted that the Annual Audit Letter was enclosed. Questions were invited. None were received.

9-22 Finance and Performance Committee, 16/08/18, 30/08/18 (incl. quarterly progress update on Procurement Transformation Plan) and 25/09/18

TL referred to Attachment 18 and highlighted the following points:

- The meeting on 16/08/18 had focused on operational performance and discussed many of the issues that had already been discussed at that day's Board meeting
- The meeting on 30/08/18 focused exclusively on financial aspects including the £1.7m of opportunities associated with the planned wholly-owned subsidiary which the Trust was no longer pursuing. The Procurement Transformation Plan (which was included in Attachment 18) had also been reviewed at that meeting, and revised Terms of Reference had been agreed

SDu then referred to Attachment 19 and highlighted the main points therein, as she had chaired the meeting on 25/09/18.

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

9-23 Patient Experience Committee, 05/09/18

DH invited questions on behalf of MC. None were received.

9-24 Trust Management Executive (TME), 19/09/18

The circulated report was noted.

9-26 To consider any other business

No other business was raised.

9-27 To receive any questions from members of the public

No questions were posed.

9-28 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 – October 2018

Maidstone and Tunbridge Wells NHS Trust

10-4 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]
N/A	N/A	N/A	N/A	N/A
				N/A

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
7-4 (July 18)	Provide an update to the Trust Board in October 2018 on progress with the plans to apply the improvements to the functioning of the peri-arrest team to the Trauma team	Medical Director	October 2018	The quality improvement methodology used to improve the functioning of the peri-arrest team is being applied to the Trauma team with the support of the Trust's Trauma Lead
9-5 (Sep 18)	Ensure that the inclusion of a patient alert for Sepsis was incorporated within the design phase of the implementation plan for the forthcoming Electronic Patient Record	Chief Finance Officer	October 2018	The Director of Health Informatics has been asked to ensure that the patient alert for Sepsis was incorporated within the design phase
9-9a (Sep 18)	Arrange for the October 2018 meeting of the Finance and Performance Committee to review the Outpatients-related work being undertaken by Four Eyes Insight Ltd	Chief Operating Officer / Trust Secretary	October 2018	The requested item was duly scheduled at the Finance and Performance Committee meeting on 23/10/18
9-9b (Sep 18)	Liaise to schedule the outcome of the work regarding the use of the SafeCare module of the e-Rostering IT system at the relevant Committee meeting, when completed	Chief Nurse / Trust Secretary	October 2018	The work will be reported to the e-Rostering group in the first instance, and then be submitted to the Workforce Committee (if the Chair agrees)

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

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
9-20 (Sep 18)	Liaise to schedule a "review of infection prevention and control" item at a future Quality Committee 'deep dive' meeting	Trust Secretary / Director of Infection Prevention and Control	September 2018	Liaison occurred and the item has been scheduled for the December 2018 Quality Committee 'deep dive' meeting, as the Root Cause Analyses (RCAs) relating to the Clostridium difficile outbreak would not all be complete and reviewed by the Panel until November

Actions not yet due (and still 'open')

Ref.	Action	Person responsible	Original timescale	Progress
9-4 (Sept 18)	Ensure that Non-Executive Directors were provided with details of the individuals appointed to the key posts within the new clinical management structure, once finalised	Trust Secretary	November 2018	The details will be provide once the appointments have been confirmed

Trust Board meeting – October 2018

NHS Maidstone and Tunbridge Wells NHS Trust

10-6 Report from the Chair of the Trust Board **Chair of the Trust Board**

Consultant Appointments

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	Iona	Bell	Gastroenterology

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 – October 2018

NHS Maidstone and Tunbridge Wells NHS Trust

10-7 Report from the Chief Executive — Chief Executive

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

1. Our guiding principle is to ensure that every patient we see in our hospitals receives the best possible care we can provide and that we do no harm. When this doesn't happen, and our care falls far short of what it should be, we have a duty to be open and transparent about the reasons why, to apologise, and ensure we learn lasting lessons. We also have a responsibility to encourage and support this learning to happen.

In March of this year we did not do everything that we could have for 21-year-old Timothy Mason. We failed to diagnose Timothy's sepsis soon enough, and take steps to treat this diagnosis. Timothy died as a consequence of failings in our care.

On behalf of the Trust, I would like to reiterate how sorry we are that we did not manage to do the right thing for Timothy. We have undertaken a full review of Timothy's care and implemented a series of actions to address areas of our practice that fell short of the high standards we would want for our patients, and be so personally passionate about for our own loved one.

While I will never be able to adequately address the loss Timothy's family and friends have suffered, I know that I speak on behalf of the Trust Board when I say that every patient we see is equally important to us. We will identify and support every action we can, in a positive and tireless way, to minimise the risk of this happening again.

For improvement to happen, we need to work together in an environment that supports and encourages clinical learning at every level.

We are accountable both as an organisation and as individuals for the patients in our care. We also need to support our clinicians, our clinical teams and our organisation as a whole to enable learning to happen in an open and non-adversarial way that supports reflection and encourages change. This has to be part of the MTW way that we are creating to improve our patient and staff experience.

2. It is difficult to appropriately and sufficiently describe the significance of, and meaning behind this month's announcement by NHS Improvement that MTW is no longer in financial special measures.

While this is such a big and important milestone for everyone at MTW, and our wider community, i don't want to lose sight of what this genuinely means for our staff and patients both individually and collectively.

Leaving special measures is the big picture, but behind this sits a huge amount of work at MTW that continues to improve the quality and sustainability of our services by focusing our efforts on improving the individual experiences of our patients and staff.

Achieving this milestone is another essential step in our plans to become an Outstanding NHS trust and provider of high quality sustainable health services for patients throughout Kent.

MTW is carefully building the foundations to become a Good, and then Outstanding NHS trust. We have been and continue to work closely with national improvement teams, and some of the most outstanding NHS trusts in the country, to emulate their successes and build on our own achievements to improve our patient experience.

Earlier this year the Care Quality Commission noted `significant and sustained improvements' at MTW rating two thirds of the services it reviewed as good, a significant increase from less than one third in 2015. This latest announcement is further evidence that we are heading in the right direction. But as we've seen, we can't be complacent for a second.

While we have a great deal more hard work to do to fulfil our potential, we are developing our capacity and capability to move forwards. Part of the improvement story at MTW this year includes the creation of our new Best Care initiative, a more inclusive and joined up way for our teams of healthcare professionals to design and deliver clinically-led quality and efficiency improvements. Best Care is linked to our new Quality Strategy giving MTW a stronger focus on patient experience and wellbeing. We've seen some great work coming out of Best Care that improves quality and reduces cost.

Next month we are launching our Clinically-Led Organisation. We are putting more of our doctors and nurses in leadership positions and empowering them to lead the way as a part of a more clinically-led trust. We are also starting an organisational development programme in the New Year to equip more of our staff to be everyday leaders and adopt an `MTW way' of making quality improvements. So coming out of financial special measures means a huge amount for MTW, and to our patients individually and as a whole, because it's a landmark in the steps we are taking to improve our sustainability by focusing on the quality and efficiency of the care our patients receive.

3. The NHS will soon be on the cusp of launching its full winter plans and MTW continues to ready itself for all eventualities. We are working closely with our partners to develop systems of care that enable more of our patients to access the right care, at the right time, in the right place.

This means working collectively throughout our local care system to shape innovation and find ever more appropriate ways of helping people manage long-term conditions, stay well, and support more people to re-cooperate at home with appropriate support in place following an acute hospital admission.

Managing our own wellbeing is also a high priority for MTW. We have started our flu vaccination programme this month. It is everyone's responsibility at MTW to protect our patients from catching flu as well as keeping ourselves – and our families - healthy and well over the next few months.

Our most vulnerable patients, such as those with chronic conditions, the elderly and young children, are most at risk from flu, which can have very serious and complicated consequences for them. With another tough winter looming large, NHS England has been very clear about wanting **all** frontline healthcare staff to be vaccinated - a goal I fully support and endorse.

4. One of the best and most enjoyable parts of my job is meeting the teams and individuals who care for our patients or provide the services that support the running of our hospitals.

One of the teams I met with recently, who are an excellent example of providing good quality and excellence in their field, is the Paediatric Orthopaedic team. They've been progressive in developing a service at a local level that normally would only be found in specialist hospitals. I was particularly impressed with their ambitions to drive their service forward with the aim of becoming a nationally recognised unit. Some of the services they offer for children are highly complex and include treatment for a range of hip conditions, foot deformities, cerebral palsy and procedures for bone diseases, such as brittle bone disease.

It's thanks to teams like this that we can be really proud of the innovative and pioneering work that's taking place across MTW. Our aim must be to provide outstanding care for everyone we see.

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 – October 2018

NHS Maidstone and Tunbridge Wells NHS Trust

10-9	**Integrated Performance Report, September 2018**	**Chief Executive / Members of the Executive Team**

The enclosed report includes:

- The 'story of the month' for September 2018 (including Emergency Performance (4 hour standard); Delayed Transfers of Care (DTOCs); Cancer 62 day First Definitive Treatment) and Referral to Treatment (RTT)
- A Quality and Safety Report (including an update on complaints performance)
- Planned and actual ward staffing for September 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]

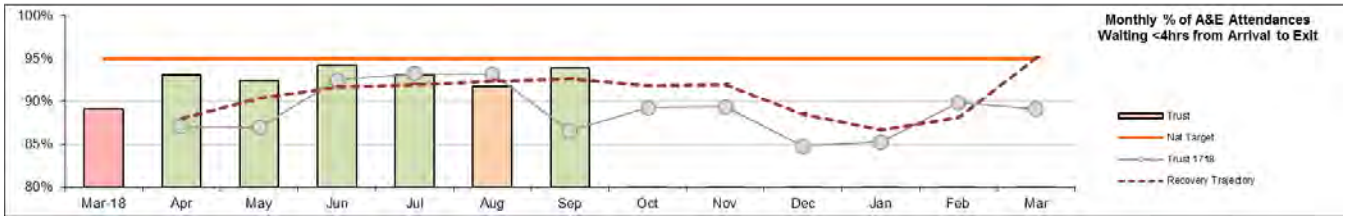
Review and discussion

[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 SEPTEMBER-18

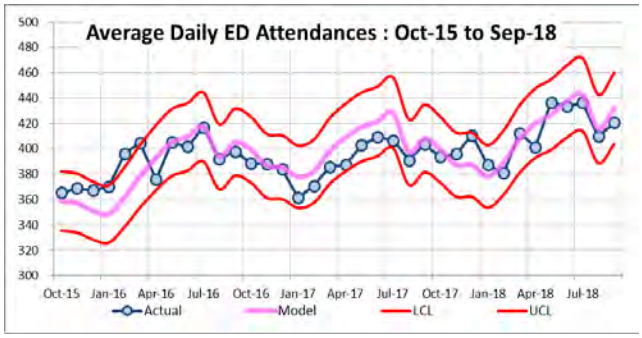
1. 4 Hour Emergency Target

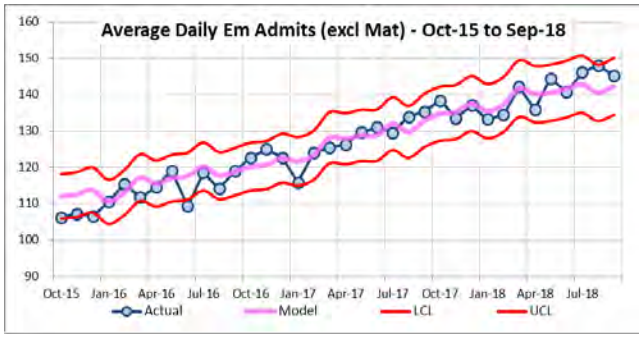
- The Trust was above the recovery trajectory for each month from April to July 2018. Performance dipped slightly below trajectory in August, but has recovered in September to 94.0% (including MIU), against the target of 92.6% (+1.4%).
    - YTD the Trust is at 93.1% against a YTD plan of 91.2% and a year-end target of 90.9%.
    - October performance is however currently challenging at 88.8% against a target of 91.8%.
    - The Trust achieved Q2 with 93.0% against a target of 92.3%.
    - For the year 1718 the Trust scored 89.1%, compared to 87.12% in 1617.



2. ED Attendances & Emergency Admissions

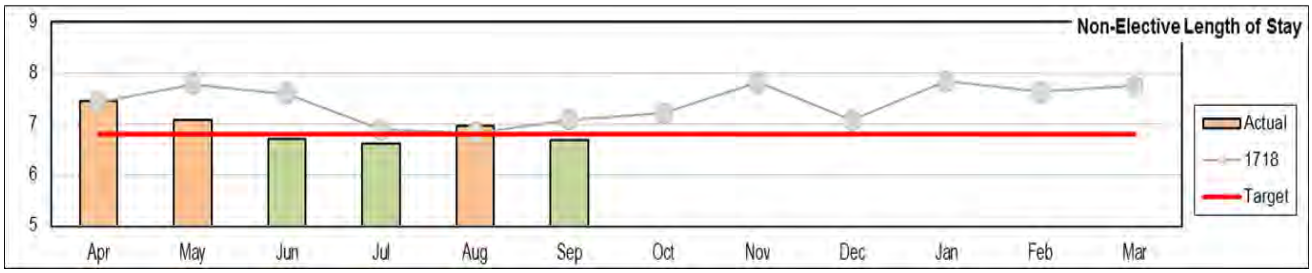
- A&E Attendances continue to increase and 1718 like-for-like (ie excluding Crowborough MIU) attendance is still 3.2% up on 1617. Total type 1 for 1718 was 145,527.
- Total September attendances were 0.2% up on model & 1.8% up on trajectory at 15,759. This is 4.7% up on last September (like-for-like). YTD attendances are 0.7% up on model, 2.4% up on trajectory and 5.7% up on this time last year. Average weekly attendances were at record levels over the summer.
- Non-Elective Activity (excluding Maternity) was 15.5% above plan in September and 12.5% higher than last September at 4,667 discharges. Over the summer, NE activity has been its highest ever level. 1718 activity was 28.1% above plan and 13.2% higher than 1617 at 50,905 discharges. The plan for 1819 is just 0.2% higher than 1718 at 51,248. YTD, we are running at 10.2% above plan & 13.7% above last year.





3. Length of Stay

- Non-Elective LOS was 6.68 days in September, and 6.91 YTD vs 7.41in 1718. It tends to vary by 0.5 to 1.0 days between Winter & Summer.



- The average occupied bed-days is down 4 in September to 719, compared to an average of 764 for the whole of 1718.

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:

Managing LOS to the optimal needed, using such tools as

- CUR (clinical utilisation review) to identify reasons for patient delays.
- Frailty scores for elderly patients to ensure they avail of the most appropriate care and interventions on attendance / admission.
- AEC (ambulatory emergency care), ensuring that patients are streamed appropriately to ensure their pathway is relevant to their reason for attendance and their admission avoided where possible.
- Virtual Ward, working with KCHFT, the Trust is moving forward with implementation of a virtual ward which will extend the capacity for acute care, but delivered in the patient's usual place of residence. The preparations are underway to have a VW up and running by the beginning of December with all specialties (excluding paediatrics) having potential to access.

4. Delayed Transfers of Care (DTOC)

The percentage of occupied bed-days to DToC rose from 4.68% in August to 5.89% in September. There is a change in the required method of counting this month but that has not materially changed the score. (the old method would have returned a score of 5.76%, as the first 2 days in September would have been counted against August).

The level of lost bed days due to DTOCs increased by 170 to 1,143. We ended 1718 on 4.95%, and until September, had been reporting under 5.0% for 10 consecutive months. On average, 32.0 beds per day have been lost to delays in 1819 compared to 38.8 for the equivalent period last year. 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. Both sites have now got functioning frail elderly units which has helped to reduce the number of longer stay admissions.

Category	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 19	Jun 20	Jul 21	Aug 22	Sep 23	Rolling 12
A : Awaiting Assessment	7	6	2	5	2	1	2	5	3	8	17	21	**79**
B : Awaiting Public Funding	2	1	0	1	5	1	2	4	0	0	4	3	**23**
C : Awaiting Further Non-Acute NHS Care	15	10	18	21	9	21	12	20	14	17	22	14	**193**
Di : Awaiting Residential Home	21	19	18	24	18	40	15	23	29	22	9	32	**270**
Dii : Awaiting Nursing Home	46	54	38	37	47	54	53	43	26	34	54	27	**513**
E : Awaiting Care Package	24	36	14	18	20	28	20	31	18	29	24	28	**290**
F : Awaiting Community Adaptations	10	12	4	12	10	7	15	7	6	4	8	10	**105**
G : Patient or Family Choice	28	38	13	11	5	10	3	14	11	9	14	9	**165**
H : Disputes	0	1	0	0	0	0	1	0	0	0	1	1	**4**
I : Housing	2	1	2	3	3	2	6	2	7	5	4	4	**41**
Grand Total	**155**	**178**	**109**	**132**	**119**	**164**	**129**	**149**	**114**	**128**	**157**	**149**	**1,683**
Rate	**5.36%**	**4.84%**	**3.73%**	**4.27%**	**3.89%**	**4.26%**	**4.56%**	**4.34%**	**4.39%**	**5.03%**	**4.77%**	**5.89%**	**4.54%**

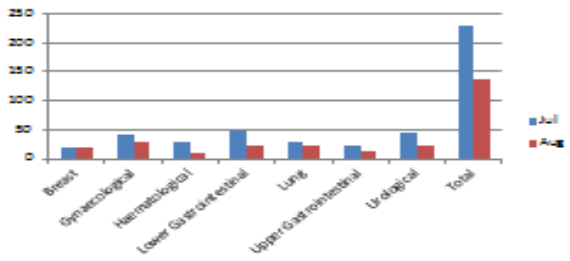
5. Cancer 62 Day First Definitive Treatment

62 day performance for August was 67.7% and 56.9% for 1819 Q1. 1718 finished on 70.4%.

The delivery plan is focussed on increasing capacity at the front end of the pathway (i.e. 2ww capacity, outpatients and diagnostics) as has been demonstrated in the recent analysis. However, treatment capacity will be continually reviewed as more patients are diagnosed faster and cross-over with patients being treated in the backlog.

Through implementation of the recovery plan the Trust has managed to reduce the median time to diagnosis by ~40%

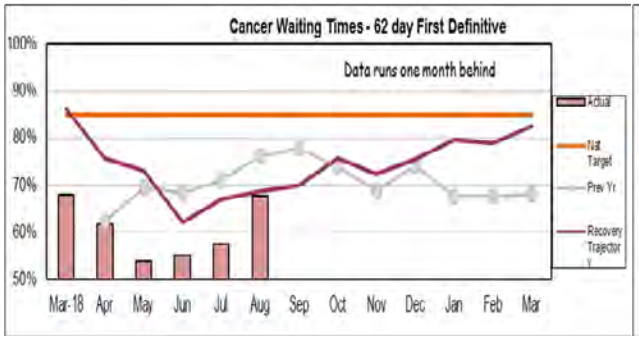
Median Day of Diagnosis by Tumour Site - based on referrals in the month shown

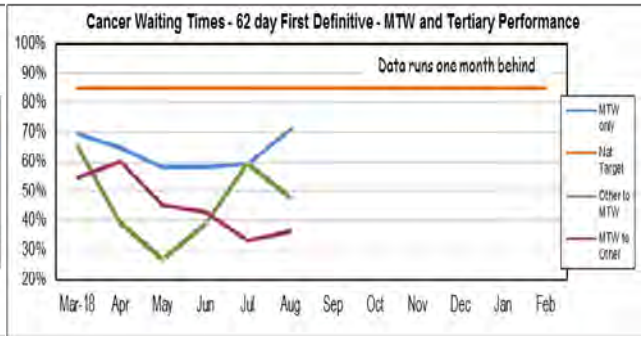


- Since the start of the recovery plan across all tumour groups (excluding head and neck as data is not available for August) the Trust has **reduced the median day of diagnosis by ~40%**
- **The reduction in median day of diagnosis can clearly be linked to the recovery plan** as the reduction between January and August is similar to that seen between July and August

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	% change between January and August 2018	% change between July and August 2018
Breast	18	21	19	17	18	19	19	19	6%	0%
Gynaecological	32	28	21	45	30	38	40	29	-10%	-28%
Haematological	35	48	42	58	26	45	28	9	-74%	-68%
Lower Gastrointestinal	33	29	37	25	32	56	48	22	-33%	-54%
Lung	37	31	29	37	29	36	30	23	-38%	-23%
Upper Gastrointestinal	31	31	39	18	30	32	21	13	-58%	-38%
Urological	43	53	64	76	53	50	44	22	-50%	-51%
Total	229	240	250	275	217	276	230	136	-40%	-41%

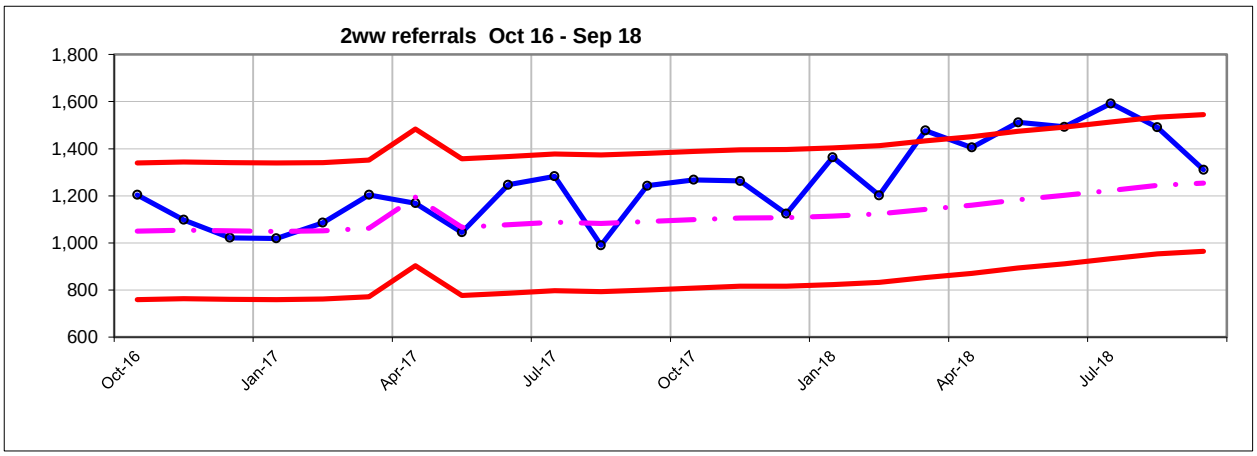
The size of the backlog at the end of August was 71 patients (patients waiting over 62 days for treatment with a diagnosis of cancer). For the MTW only patients the backlog was 34. This is a 9 patient decrease compared to July for all patients and 17 patient decrease for MTW only.





August 2018	62 Day Performance					
	All reportable patients			MTW only patients		
	Total	Breach	%	Total	Breach	%
Breast	15.0	3.0	80.0	15	3	80.0
Gynae	10.5	4.0	61.9	8	3	62.5
Haematology	4.5	0.5	88.9	4	0	100.0
Head & Neck	6.5	4.5	30.8	4	3	25.0
Lower GI	16.5	7.0	57.6	13	4	69.2
Lung	12.0	0.5	95.8	11	0	100.0
Other	1.5	0.0	100.0	1	0	100.0
Upper GI	8.5	1.5	82.4	5	0	100.0
Urology	58.0	22.0	62.1	56	21	62.5
TOTAL	**133.0**	**43.0**	67.7	**117**	**34**	70.9

Since January, the volume of 2ww referrals has increased significantly (particularly in Urology and Breast) and now also for Lower GI. The increase in Lower GI referrals is in part due to e-referral being available in MTW but not in Medway. Medway have now gone live for e-referral and so it is expected that some of the increase will now reverse. The average weekly number of referrals has increased by over 20%. However, July saw the highest number of suspected cancer referrals ever received which has caused additional pressure on clinics and diagnostics. This decreased slightly for August, and September came in at a more reasonable 1,255. Particularly, the recent increase is noticeable for gynaecology, lower GI and upper GI when compared to the average for last year.



The governance structure around PTL management is being revised following advice from the Intensive Support Team. The weekly PTL meetings will continue to focus on patient's day 40 and below, with the daily huddle process being changed slightly to follow up on assigned actions on a Tuesday and Thursday instead of every day. A monthly multi-specialty oversight meeting will be convened, starting in November, to review trends in breaches and to help unlock any bottlenecks in pathways.

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

Tumour site action plans are in place and being managed through the specialty teams and a recovery plan and revised trajectory has been developed and submitted. The teams continue to focus on what additional improvements can be made that will bring forward the date for sustainable delivery of this standard. A revised action plan (attached) has been developed to capture the initial recommendations from the IST.

Additional support from IST has started and the scope of this support is primarily to undertake demand and capacity modelling in urology lower GI and breast. This will be used for more detailed capacity and demand analysis of the whole pathway to ensure sufficient diagnostics capacity to meet demand.

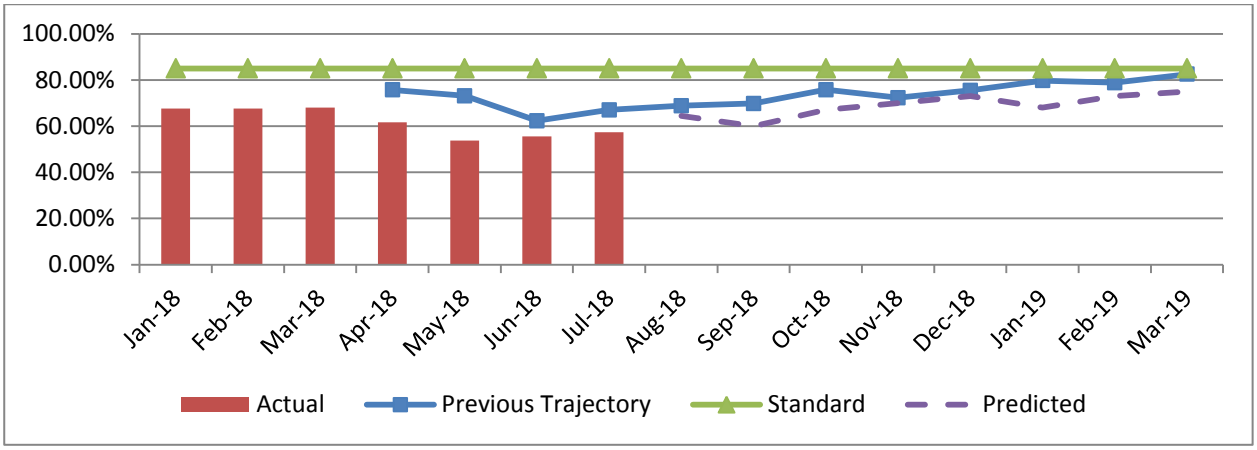
The cancer leadership and clinical management team has increased recently to help expedite the pathway & process improvements that are necessary and also to increase the level of performance management support within the division. This includes a Cancer Transformation Manager 3 x Pathway Navigators (colorectal, UGI and prostate) and a straight to test nurse has been appointed for the prostate pathway and start date is awaited. The straight to test nurse and the pathway navigators are funded through the cancer alliance with clear objectives including:

- increasing capacity for Radiology, Endoscopy and 2ww appointments (both standard OPAs and STT telephone triage clinics for colorectal and upper GI).
- Developing straight to test models for prostate
- establishing the national optimal lung pathway with packages of tests being ordered at the start of the pathway. The lung cancer team have also agreed a new process with GSTT to remove a 7 day wait from MDM to outpatient appointment with the thoracic surgeon. It is expected that the new process will be fully embedded during December.

The number of patients waiting over 104 days on the cancer pathway is another area for improvement and a key priority for the Trust. A large proportion of patients in this category so not have a confirmed diagnosis but nevertheless need to have a clinical review or an admin review of their status followed by a decision to come off the cancer pathway and / or confirm an alternative treatment pathway.

A new dashboard that is updated weekly has been created to track the expected increases in activity and also against 6 key performance indicators (2ww %, 31 day FDT %, 62 day %, median and 90th centile for day of decision to treat, number of patients over 62 days with a cancer diagnosis and total number of patients over 104 days).

The trajectory below will be further revised when the D&C work being undertaken with the IST is more deleloped and when we are confident that the recommended improvement actions from the IST are taking effect.



Cancer 2 week waits

The capacity for straight-to-test (STT) nurse-led triage clinics have been implemented from the end of July. Endoscopy capacity has been significantly increased from the start of September and the majority of patients are now being booked within 2 weeks, having had a wait of up to 6 weeks in June and July. Given the current cancer referral demand, the endoscopy department are required to increase capacity on a permanent basis which involves outsourcing some of this demand to other units, likely to be in the IS. This is the same for Urology diagnostics, and one – stop breast clinics. The initial out-put from the IST regarding capacity has identified a shortfall in breast clinics and a likely positive balance for urology outpatients.

In August, the breast service contributed 23% of breaches (8% reduction compared to last month), Lower GI 38 (+10% compared to last month) and Urology 6% (10% reduction). The number of breaches in Urology has improved significantly in recent months with additional capacity from 2 x locum doctors plus alterations to clinic templates (which will be fully implemented by November). Lower GI breaches have increased due to more patients going through the nurse-led triage for straight to test as this does not stop the clock and the breach has occurred as there has not been sufficient endoscopy capacity.

Upper GI breaches have increased and contributed 23% of the total breaches. Again, this is due to endoscopy capacity which has been significantly increased since the start of September.

6. Referral To Treatment – 18 weeks

September performance shows no change in the Incomplete RTT performance between months standards achieving 79.69% against a target of 82.37%. The recovery plan is focused on retrieving the activity plan by the end of October and completing a validation exercise that removed inappropriate duplicate pathways from the waiting list. The objective remains to achieve a waiting list position at the end of March that is no greater than the March 2018 position.

		Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
	Trajectory Total WL	31871	30573	30211	29955	29700	29583	29329
TRUST	Total Waiting List	31871	32729	32888	34584	34420	34856	32388
	IP Waiting List	5789	5736	5841	7641	7519	7273	6987
	OP Waiting List	25768	26993	27047	26943	26901	27583	25401
	Trajectory Backlog	6438	6186	5935	5685	5437	5416	5170
	IP Backlog	2747	2682	2577	3530	3454	3352	3069
	OP Backlog	3933	4046	3970	3684	3289	3868	3540
	Trajectory Performance %	79.8%	79.77%	80.4%	81.0%	81.7%	81.7%	82.4%
	Total Performance %	79.0%	79.44%	80.1%	79.1%	80.4%	79.3%	79.6%

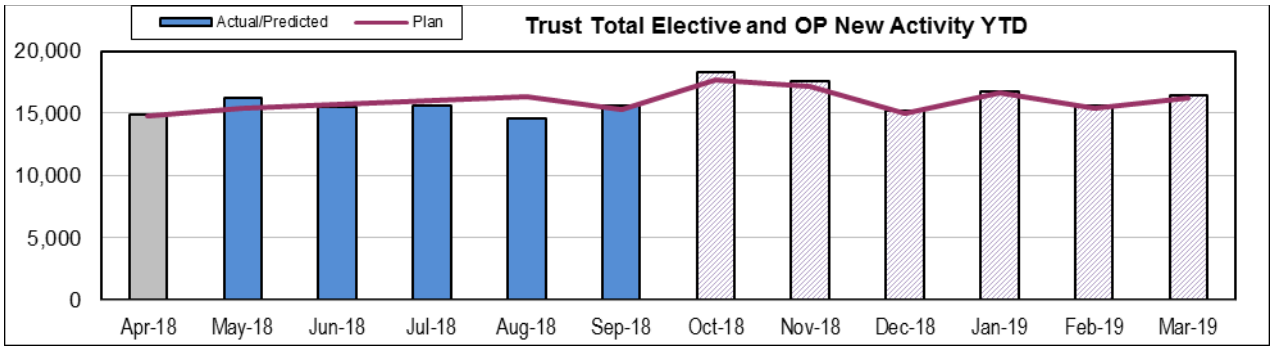
Current Projected Trajectory with the extra activity that GMs have identified but without any validation removals

Possible RTT Trajectory	Mar-18	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 Waiting List	31871	32729	32888	34584	34420	34856	32388	29165	29295	29763	30214	30672	30988
Total Backlog	6680	6728	6547	7214	6743	7220	6609	5930	5319	5180	5030	4880	5415
Total %	79.04%	79.44%	80.09%	79.14%	80.41%	79.29%	79.59%	79.67%	81.84%	82.60%	83.35%	84.09%	82.53%

The impact from an earlier data quality issue means that the IPWL part of the Total Waiting List increased by 1528 and the IP Backlog increased by 921 from July which will have an on-going impact.

Elective Activity:

Currently the Elective activity YTD is -340 (-1.4%) below plan with general surgery and ophthalmology being furthest from plan. The inability to deliver the planned elective work internally is a risk to our ability to meet the trajectory. There is an assumption in our trajectory that the activity is delivered to plan.



Total Elective Activity:	Total Elective Activity YTD April to September 18			
	Plan	Actual	Variance	% Variance
Trauma & Orthopaedics	1819	1742	-77	-4.2%
General Surgery	6166	5416	-750	-12.2%
Urology	1220	1141	-79	-6.5%
ENT	1047	965	-82	-7.8%
Ophthalmology	2907	2555	-352	-12.1%
Gynaecology	1326	1210	-116	-8.7%
Specialist Medicine	6318	6422	104	1.7%
Paediatrics	323	242	-81	-25.1%
Other	4548	5640	1092	24.0%
Trust Total (All Specialties)	25673	25333	-340	-1.32%

Total OP New Activity	RTT Outpatient New Activity YTD			
	Plan	Actual	Variance	% Variance
Trauma & Orthopaedics	11388	13470	2082	18.3%
General Surgery	9859	8535	-1324	-13.4%
Urology	3037	3379	342	11.3%
ENT	4357	4488	131	3.0%
Ophthalmology	14019	12407	-1612	-11.5%
Gynaecology	3819	3679	-140	-3.7%
Cardiology	3069	2983	-86	-2.8%
Gastroenterology	2185	1893	-292	-13.4%
Rheumatology	1085	1188	103	9.5%
Respiratory	2045	2253	208	10.2%
Diabetes	782	872	90	11.6%
Endocrinology	691	786	95	13.7%
Neurology	1515	1489	-26	-1.7%
Care of the Elderly	1059	771	-288	-27.2%
Paediatrics	4429	2901	-1528	-34.5%
Other	4464	4353	-111	-2.5%
Trust Total (All Specialties)	67803	65447	-2356	-3.5%

NB: OP New Actual (Excludes Ward Attenders as well as the Specialties
Maternity, Obstetrics, Therapies, GUM and Audiological Medicine)

The key issues that contribute to lower that planned elective work remain:

- The inability to do a sufficient level of elective work caused by the historic and cumulative impact of increased non-elective activity (TWH specifically) and not using outsourcing to make up the gaps.
- The Trust has not yet met the challenging productivity opportunity in theatres which was intended to release more capacity
- Planned reduction of activity during PAS implementation, prolonged by on-going data and admin issues post go-live.
- Key vacancies in consultant and trainee posts in a variety of specialties (GS, Urology, Neurology & Endocrinology)
- Reduced activity in January to support NEL flow and further reduction in February due to snow, which increased the size of the problem in the new year.
- Reduction of WLI activity which was suspended pending the outcome of the Four-Eyes work across elective and outpatients.

The majority of the RTT backlog continues to be concentrated in surgical specialties with the exception 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 the backlog does not grow further.

Duplicate Pathways:
Duplicate pathways have been an issue particularly in Ophthalmology and General Surgery which has caused the waiting list size to be artificially inflated. A validation exercise of the 4000 duplicate pathways has been completed which has resulted in this number decreasing to around 2300. The assumption is that the remaining duplicates are appropriate and this will be confirmed through on-going validation and monitoring. NHS North Commissioning Support Unit is providing an external review of how we can monitor this in order to support the operational teams and BI teams to avoid this becoming a recurring problem.

52 week breaches

Total Trust	Apr-18	May-18	Jun-18	Q1 Total	Jul-18	Aug-18	Sep-18	Q2 Total	YTD
RTT >52kw Breach Occurrences	3	2	8	13	8	5	9	22	35

The Trust has incurred 35 x 52 week breaches year to date, largely due to historic data and administration issues, particularly in one specialty, T&O. Additional training & support has been initiated to that specialty and this remains on-going. The September breaches are not yet fully validated.

Oversight :

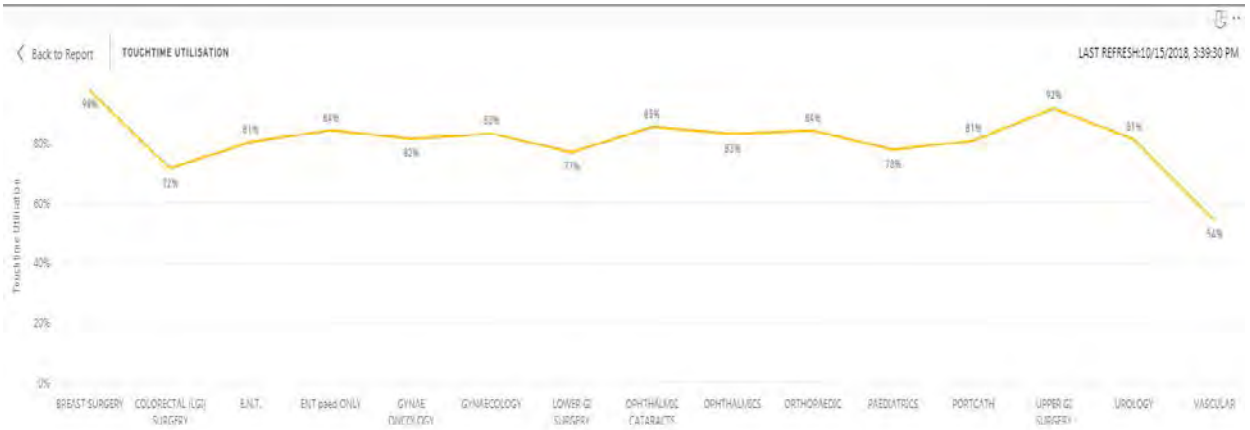
- Weekly monitoring of the specialty plans for activity, diagnostics, theatre scheduling, backlog and waiting list size, through the PTL and specialty meetings
- Daily focus on the 40+ week patients to ensure treatment occurs before 52 weeks.
- Ensure backlog patients are booked chronologically to avoid long waits/52 week breaches
- Two Operational Transformation Managers commence at the end of October and will continue the Four Eyes outpatient's project.
- The updated Allscripts/RTT training has been rolled out with good attendance and good feedback. Dates scheduled throughout September, October and November.
- A Validation plan has been implemented which included external assistance to validate the duplicate pathways.
- RTT recovery plan has been implemented and is monitored weekly.

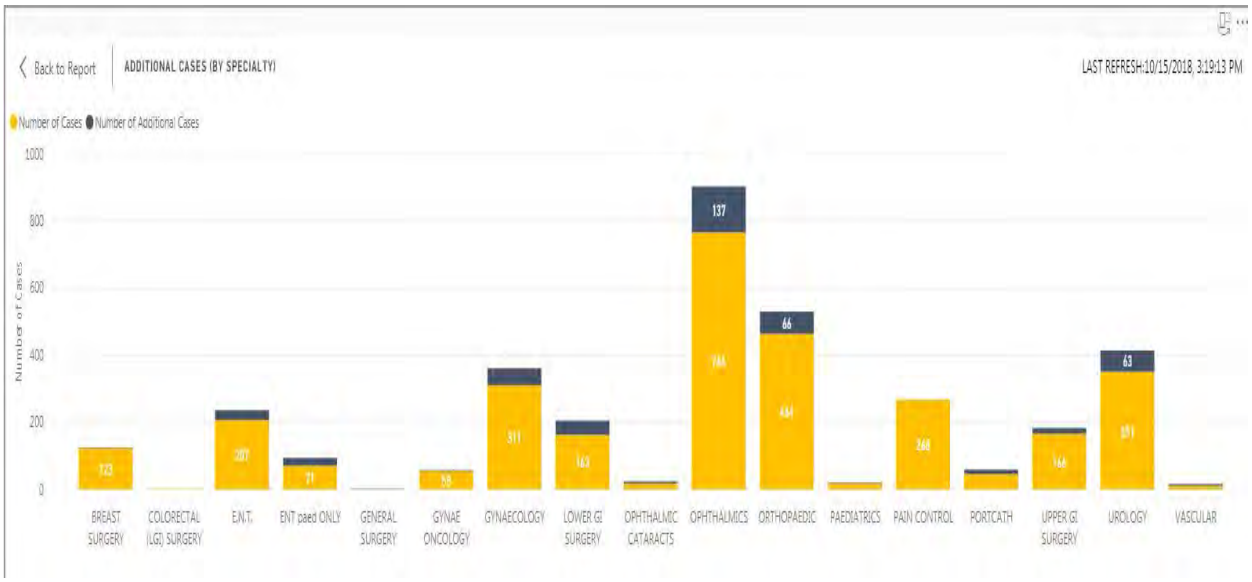
7. Theatre Productivity

The graphs below are taken from the 4Eyes Theatre Dashboard and show the Theatre Utilisation from 21/08/18 – 24/09/18 overall and per speciality. The target for utilisation is 85%. Overall Touch time Utilisation and this has to be delivered by monitoring that we have effective booking, listing and pre-operative assessment in place: monitor start & finish times by specialty, number of cases per session, cancellations & DNAs, appropriate allocation of NCPOD lists and case-mix. Specialty level exception reports are provided and reviewed at the theatre utilisation group.

Week	Touchtime Utilisation
27/08/2018	84.07%
03/09/2018	80.47%
10/09/2018	79.10%
17/09/2018	79.80%
24/09/2018	82.42%

Touch time per Speciality





Quality and Safety September Trust Board (September data)

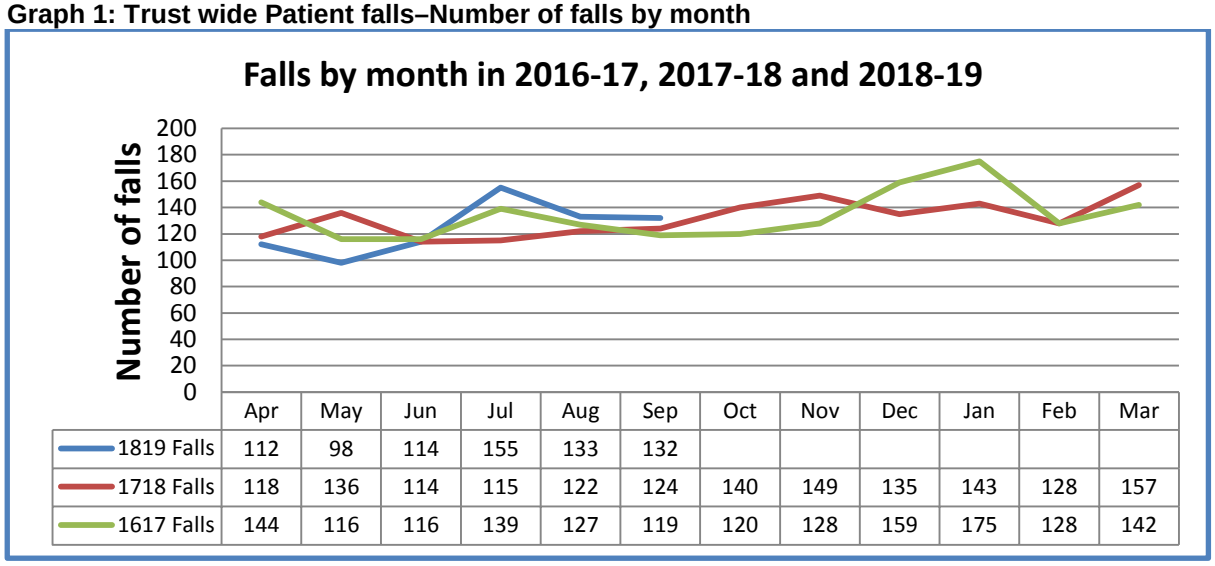
Patient Falls incidents

There were 132 falls incidents reported during September, compared to 133 for August 2018. The monthly figures in Graph 1 provide a comparison for each month and for the same period on the previous year. The breakdown of incidents by site equates to 47 falls at Maidstone and 85 at Tunbridge Wells. The monthly falls rate per 1000 occupied bed days (OBD) for September was 6.8, comparison to previous months can be seen in Graph 2. The year to date falls rate for 2018/19 is 6.12 per 1000 OBD against the threshold of 6.0.

There were four falls resulting in injury declared as Serious Incident's (SI) in September 2018. Of the four, two were hip fractures, a humeral fracture and one subdural haematoma.

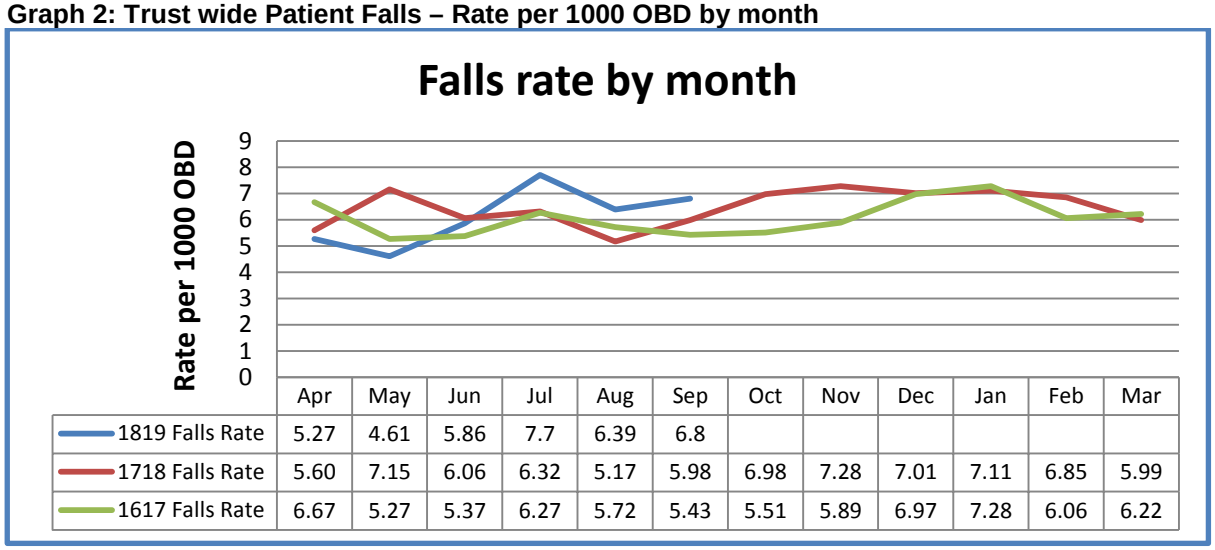
The trust welcomed a visit by the NHSI Falls Collaborative on 28th September 2018. Ward 32 and Ward 2 were able to showcase the progress made with the focus work on the key indicator of assessment and recording of lying and standing blood pressure for patients at risk of falls. We were able to demonstrate improvement in compliance with this key indicator.
Members of the project team will be attending the 90 day event of the NHSI falls collaborative project on 18th October 2018. At the event we will share with the collaborative a presentation on our project.

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	155	133	132						
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	7.7	6.39	6.8						
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 rate of confirmed Hospital acquired Pressure Ulcers for September 2018 was 0.87 (per 1000 admissions) compared to 3.13 for the same month last year.

The incidence for September demonstrates an improvement since August which was reported at 1.78.

Learning from incident reviews has been concentrating on the need to complete thorough initial assessments for the early identification of the patient at risk to ensure that all appropriate preventative measures can then be taken. We have identified an increase of Deep tissue injuries in relation to the use of oxygen masks which is more noticeable than in the preceding months which the TVN is raising awareness of.

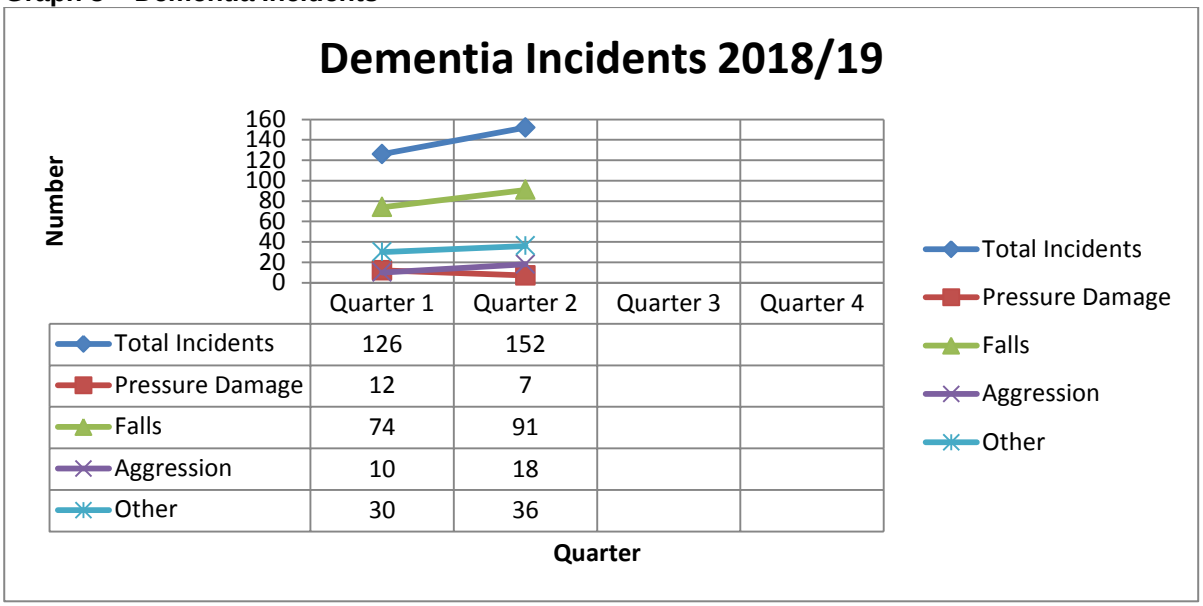
A further key initiative which is taking place during the month of October is to raise the need for the appropriate use of incontinence pads with support from the Ontex Representative who will be going from ward to ward to provide training.

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.

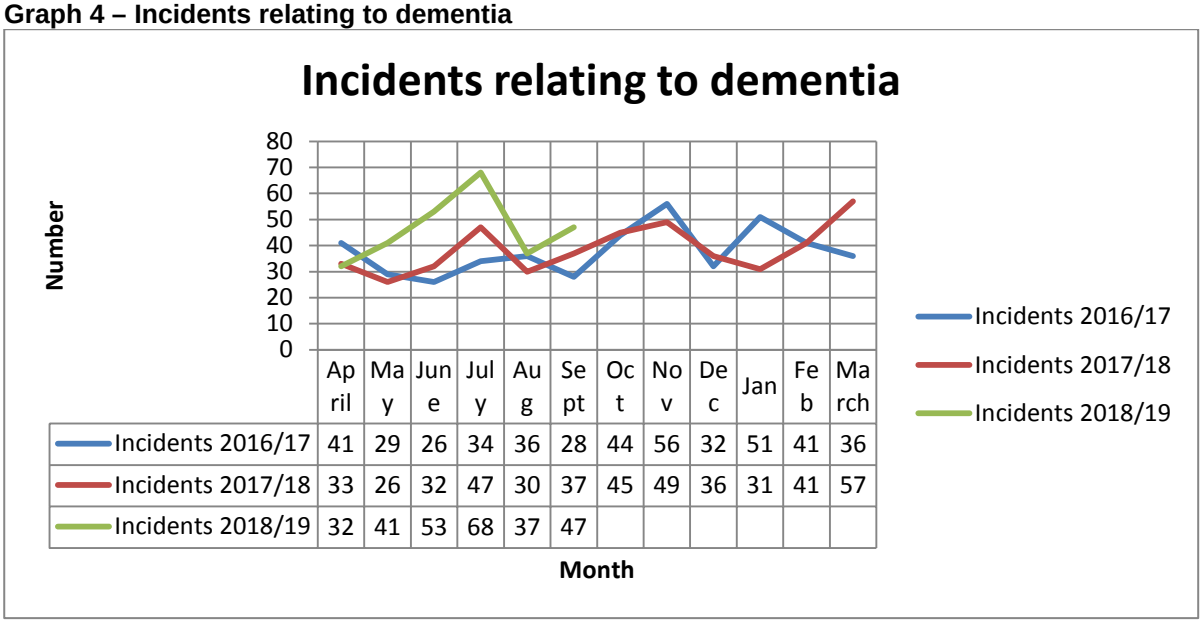
Graph 3 – Dementia Incidents



Graph 3 demonstrates the number of incidents per category that occurred during Quarter's 1 & 2 (2018/19); comparison with data from Quarter 2 (2017/18) it is evident that there has been an increase of total incidents from 114 to 152; Pressure damage incidents have increased from 2 to 7; Falls incidents have increased from 78 to 91 and aggression incidents from 3 to 18; Other incidents have also increased from 31 to 36.

There continues to be an increase in incidents compared with Quarter 1 for total incidents; falls; aggression and other incidents.

Graph 4 – Incidents relating to dementia



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Incidents 2016/17	41	29	26	34	36	28	44	56	32	51	41	36
Incidents 2017/18	33	26	32	47	30	37	45	49	36	31	41	57
Incidents 2018/19	32	41	53	68	37	47						

Graph 4 plots the number of incidents relating to dementia patients per month for 2016/17; 2017/18 and 2018/19. The most significant increases can be seen in July and September compared with the previous 2 years.

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 in September showed an increase. Whilst we continue to drill down into the data collection and data input to ensure MTW numbers correlate with those of iWantGreatCare (IWGC) numbers, there are occasions when an overlap of the previous month's data merge into the following month. However, specific enquiries into speciality areas offered an opportunity to re-focus and see response rates increase to be more in line with expected levels of reporting. The Trust continues to work collaboratively with IWGC to ensure MTW numbers correlate with IWGC numbers and final upload. Any variation can be attributed to cards used that are not accepted if photocopied or damaged in any way. Regular meetings with IWGC continue to enable a cross check of cards collected and uploaded. In addition, IWGC have provided further training to the team in accessing data retrieval from the dashboard.

Implementing a weekly card collection was established to enable a more timely review of response rates and to allow for a more rapid response and feedback to areas that may have fewer returns than anticipated. This way of working has been temporarily interrupted due to unforeseen circumstances however; work is underway to resolve this. In addition, MTW and IWGC are moving ahead with the ability to receive communication alerts on a weekly basis in line with the weekly collection once this is re-established.

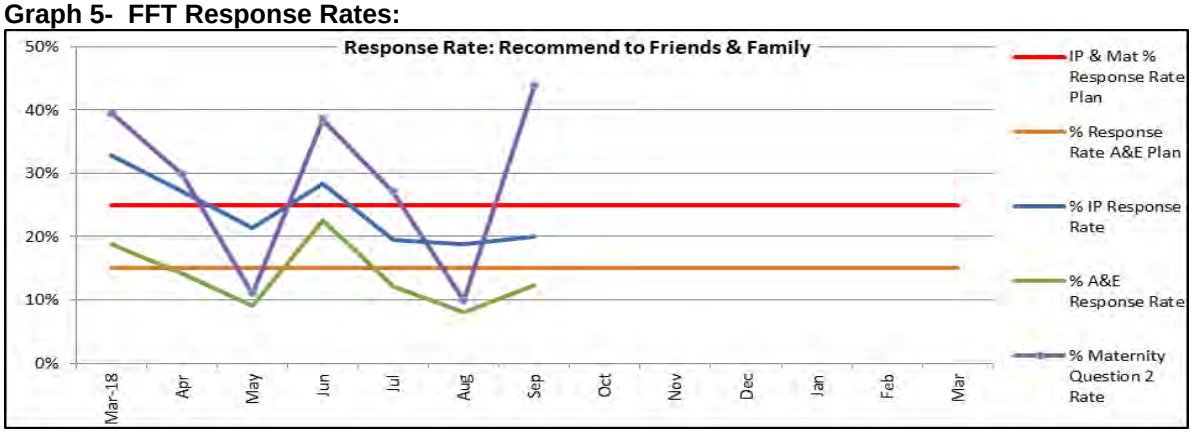
A collection methodology review has identified an opportunity to use stock base IPads specifically dedicated to IWGC to increase accessibility to the survey to promote and increase response rates. Using resources already held within the Trust, IT has developed a new 'platform' on the Trusts IPads. This means there are now dedicated IPads which are only setup to provide the IWGC feature and will be aligned to each department to minimise the risk of equipment moving between areas. The App has been uploaded to 32 IPads which have been delivered and are due to be rolled out to departments. IT is now reviewing the possibility of duplicating these icons onto the Community Midwives' current tablets to promote responses.

Response rates for September: IP 20.1% compared to 18.7% in August, A&E 12.3% compared to 8.1% in August and Maternity 43.8% compared to 9.9% in August.

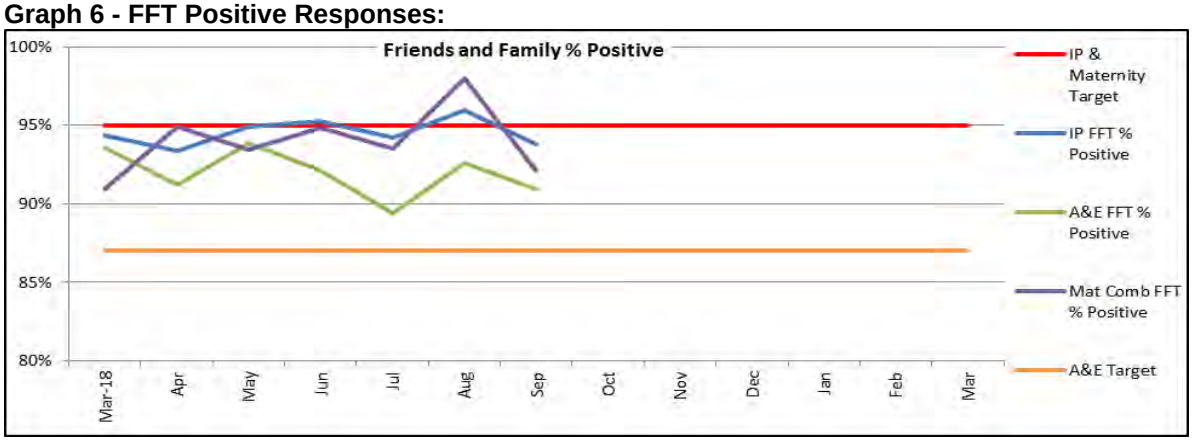
For the % Positive for August, inpatients has decreased slightly from 95.9% in August to 93.8% in September, A&E decreased from 92.6% in August to 90.9% in September and Maternity (all 4 combined) decreased from 98.0% in August to 92.1% in September however, this is in the context of the smaller number of recipients in August.

In terms of number of respondents from OP, the response rate has increased slightly from 1807 in August to 1914 in September

Graph 5- FFT Response Rates:



Graph 6 - FFT Positive Responses:



Single Sex Compliance:

There were zero incidences of mixed sex accommodation reported during the month of September.

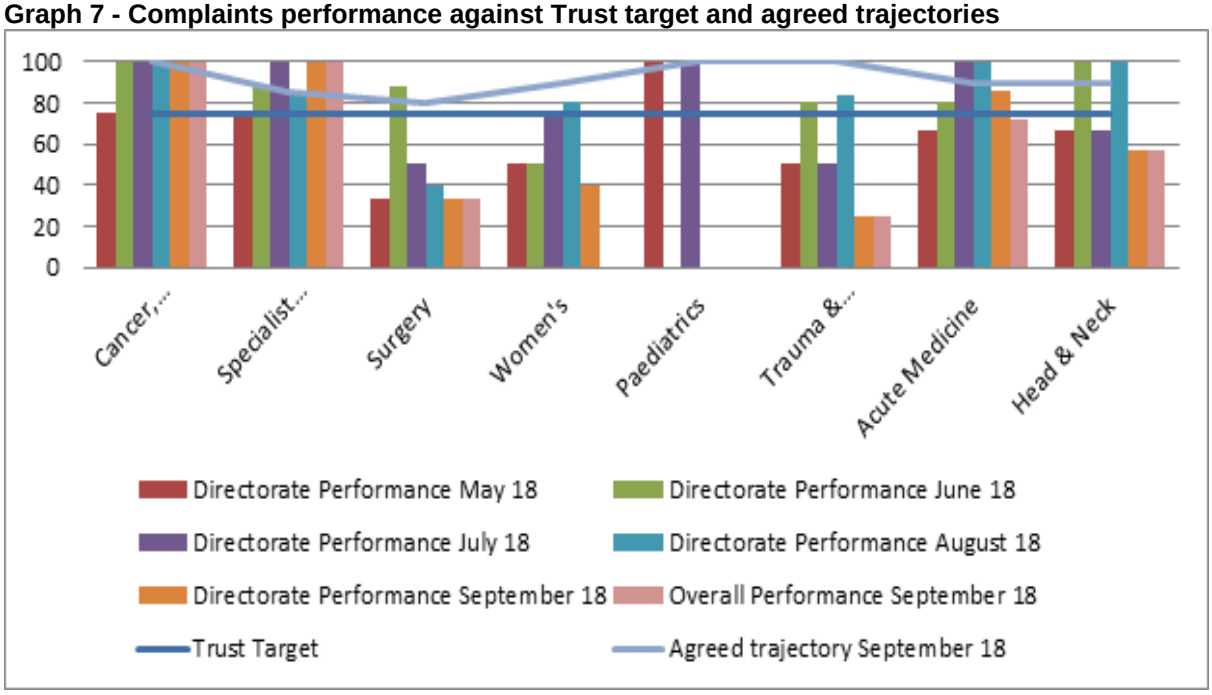
Complaints:

There were 43 new complaints reported for September which equates to a rate of 2.2 new complaints per 1,000 occupied bed days. This is a increase compared to 1.63 for August. There were 144 open complaints at the end of September compared to 137 in August.

54.3% 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 7 - Complaints performance against Trust target and agreed trajectories



Of concern, only two of the directorates listed above achieved or exceeded their performance trajectory for September. The directorates not meeting their performance trajectory were Surgery (33.3% against a target of 80%), Women's (40% against a target of 90%), Paediatrics (0% against a target of 100%), Trauma & Orthopaedics (25% against a target of 100%), Acute and Emergency Medicine (85.7% against a target of 90%) and Head and Neck (57.1% against a target of 90%). Despite missing their performance trajectory, Acute and Emergency Medicine did exceed the Trust's performance target of 75%.

Overall, the Trust did not reach the 75% performance target for September. In total, 13 complaints breached due to delays within the lead directorate, which account for 37.1% of the lost performance. However, a further 3 complaints breached for other reasons: 2 due to awaiting external comments and 1 where there was a delay in making a decision to declare an SI. These delays accounts for 8.6% of the lost performance.

In recognition of the ongoing challenges the Trust has faced in meeting and sustaining performance in responding to complaints, a further series of challenge sessions were held in early October, to review the directorates' progress against their performance trajectories. These discussions clearly illustrated that the directorates recognise the importance of robust complaints management processes and want to consistently achieve an acceptable standard of performance. However, some issues were highlighted in areas where there has been poor or variable performance and the directorates were challenged around how they can address these going forwards. Urgent Care were cited as models of good practice, with consistently high performance and they have been asked to develop an SOP which can be shared with other directorates. 'Deep dive' meetings are being arranged with Head and Neck, Women's and Paediatrics for early November. The complaints action plan has been reviewed and updated accordingly.

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.

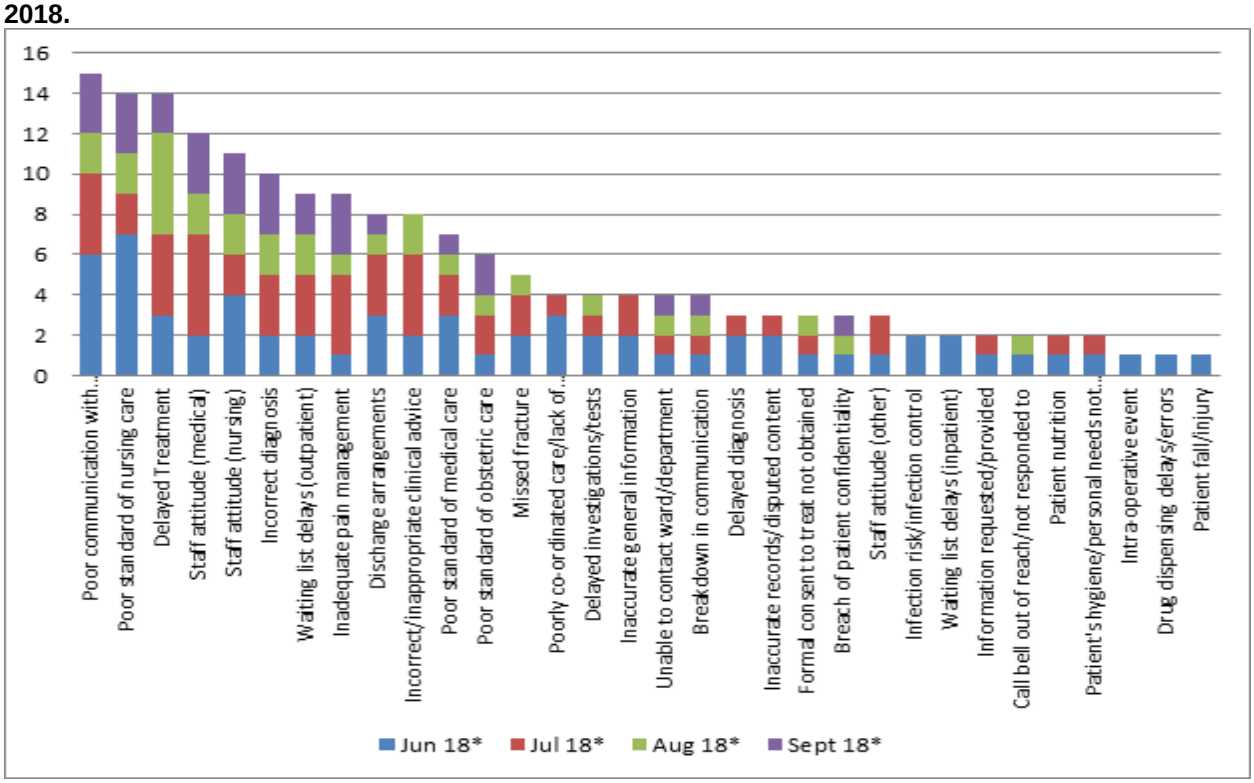
Graph 8 - Complaints by Sub-subject – most frequently raised in September 2018

	Jun 18*	Jul 18*	Aug 18*	Sept 18*
Poor standard of nursing care	7	2	2	3
Poor communication with patient/relative	6	4	2	3
Staff attitude (nursing)	4	2	2	3

*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 September 2018.

Graph 9: All themes/subjects raised in complaints made about events that occurred in September 2018.



As with previous reports, communication with patients/relatives remains a key theme within complaints, being the most frequently raised issue in the reporting period (June – September). However, as a trend, this continues to reduce.

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

- Inadequate pain management
- Incorrect diagnosis
- Poor standard of obstetric care
- Breach of patient confidentiality

Other areas show stable or slightly reducing trends, but no significant reduction in complaints about any one subject.

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.

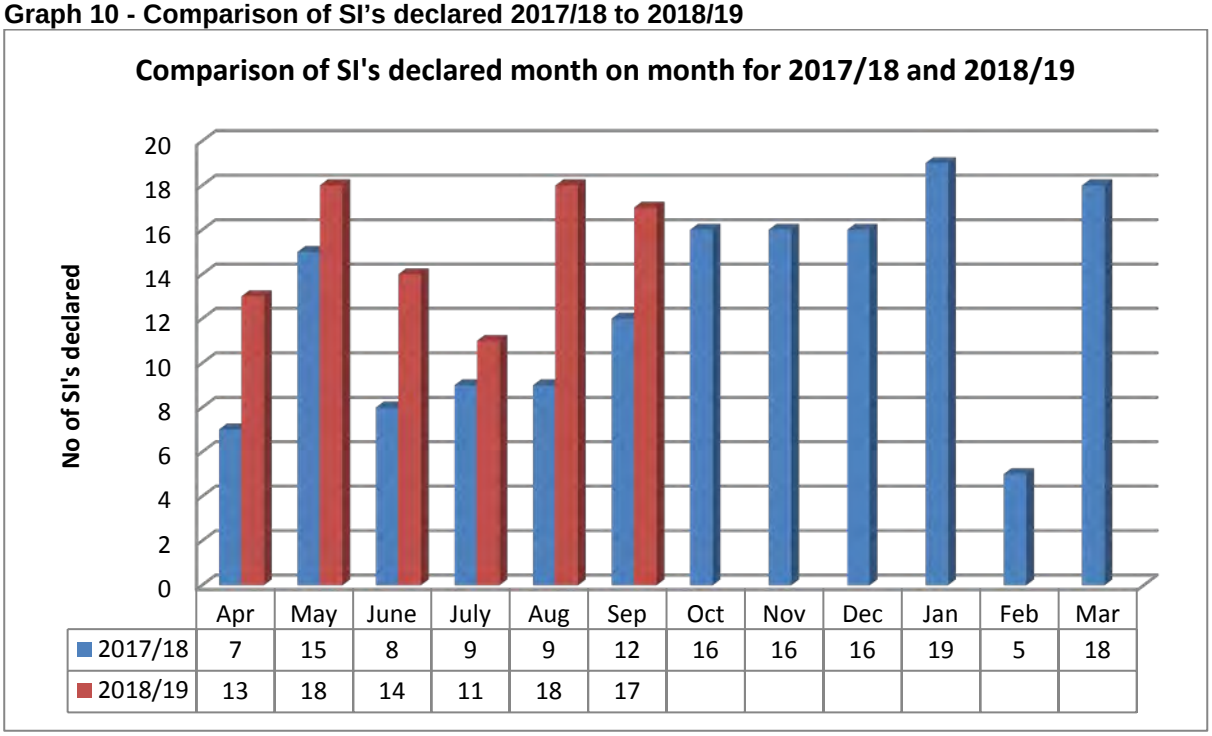
Serious Incidents (SI's):
There were 17 Serious Incidents reported in September 2018.

- 6 Main SI's in 4 divisions
  - 3 in Acute & Emergency
  - 1 each in Womens & Sexual Health, Specialist Medicine & Therapies and Corporate
- 4 falls – 2 in Specialist Medicine & Therapies, 1 in Trauma & Orthopaedics and 1 in Cancer, Haematology & Diagnostics

- 3 Pressure Damage – 2 in Specialist Medicine & Therapies and 1 in Critical Care
- 2 VTE – both in Specialist Medicine & Therapies
- 2 Safeguarding – 1 each in Specialist Medicine & Therapies and Cancer, Haematology & Diagnostics

The total number of SI's open remains increased year to date at 73 compared to 58 during 2017/18.

Graph 10 - Comparison of SI's declared 2017/18 to 2018/19



	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	7	15	8	9	9	12	16	16	16	19	5	18
2018/19	13	18	14	11	18	17						

During the month of September, 7 SI's were closed and in addition 2 SI's were downgraded from the month of June 2018 both of which were unexpected deaths in ED, where no care or service delivery issues were identified on review.

The learning from the Falls panel identified that patients need to be reassessed and their care plans updated when transferring with regards to the change of environment from Bays to single rooms and vice versa and that if the chosen falls prevention measure is not suitable for that particular patient e.g. falls clip is being used which the patient keeps removing, a more suitable falls prevention measure needs to be implemented.

Learning from the VTE panel has identified the importance of reviewing issues of non-compliance of medication and the escalation of omissions of medication to the nurse in charge and medical team responsible for that patient's care. Also the need to document and sign for the wearing of anti-embolic stockings on the drug chart and the need to highlight on nerve centre patients who refuse anticoagulant therapy.

Learning from the Safeguarding panel includes the need to record the patients capacity for decision making prior to undertaking an invasive clinical procedure and to then document evidence of consent within the health records.

Safe staffing: Planned versus actual for September 2018

The attached paper shows the planned v actual nursing staffing as uploaded to UNIFY for September 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 include:

Cornwallis: QuESTT score 12 reflecting amber due to vacancy and sickness levels alongside an increase on service demands against normal reporting level.

John Day: Reduced RN day fill rate due to lack of available temporary staff. Increased RN fill rate at night due to increased acuity.

Chaucer: Increased fill rate at night due to escalation 14 times during September.
Nurse: patient ratio increased on a week day basis to facilitate the Acute Frailty Unit (AFU) pathway which is reflected in the CHPPD.

Edith Cavell: Increased fill rate due to enhanced care requirements across 27 days. In addition to supporting RN phased return to work.

UMAU (Maidstone): Reduced fill rate of due to lack of available temporary. Ward escalation at night throughout month

Ward 22: Reduced RN fill rate due to lack of available temporary staff

CCU (TWH): Low RN fill rate, due to an inability to fill from Bank/Agency across 12 days

Ward 33 / Gynae: Reduced fill rate due to lack of available temporary staff on 13 occasions in month

MAU (TWH): Increased fill rate at night due to escalation throughout the month and increased dependency. QuESTT score 13 reflecting amber due to score associated for new manager, vacancy and sickness levels and, formal complaint.

Ward 10: Skill mix adjustment a consistent and considered action by the ward team in line with a high dependency and moderate acuity. This will be reviewed in the forthcoming round of safe staffing reviews.

Ward 12: 4 falls above threshold. Reduced fill rate across RN's and CSW's due to lack of available temporary staff on 17 occasions

Ward 20: 5 falls above threshold but improvement on previous month. Reduced fill rate due to lack of available temporary staff. Enhanced care needs daily throughout the month. Initial Quality review undertaken 17th August 2018 with follow up review arranged 31st October.

Ward 2: 5 falls above threshold. Reduced fill rate due to inability to fill with temporary staff. Staffing requirements for AFU Mon - Fri. Episode of enhanced care requirements and escalation.
Neonatal Unit: Low RN fill rate due to inability to fill with temporary staffing and increasing capacity.

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

The successful roll out of Health roster enables for further scrutiny of PvA through the Key Performance Indicators to include:

Roster Score	Unfilled Roster	Duties With Warnings	Partially Approved Rosters	Fully Approved Rosters	Roster Approval (Partial) Lead Time
Roster Approval (Full) Lead Time	Net Hours Balance	Bank / Agency Use	Annual Leave	Total Avoidable Cost Per WTE	

For example Annual leave; the headroom allowance for in patient departments is set at 21%. Annual leave parameters should fall between 11 – 15%. Where there is a reduced fill rate in month the KPI will identify if Annual leave is an influencing factor.

The next programme of Safe Staffing reviews are due to be mapped and a new methodology is being worked up. With the introduction of apprenticeships and the imminent start for the new Trainee Nursing Associates (TNAs) this will impact on the current workforce structure. The new methodology will need to consider the future structure of new learners, apprentice's and the introductions of TNA's leading to the Nursing Associate role. The NMC have just published a new version of 'The Code' which now includes Nursing Associates. It is proposed that reviews will be undertaken in collaboration with the Chief Nurse or Deputies, Associate Director of Nursing for the division, Ward Manager, Matron, Finance, Professional standards and Health Roster representation.

Care Hours per Patient Day

Updated information has been communicated by NHS Improvement in June 2018 (CHPPD) Guidance for Acute and Acute Specialist Trusts.

CHPPD is a measure of workforce deployment that can be used at ward, service or aggregated to Trust level. The safe staffing paper uses the CHPPD at ward / department level where service leaders and managers can consider the workforce deployment over time, with comparable wards within a trust or at other trusts as part of a review of staff deployment and overall productivity.
To calculate CHPPD, monthly returns for safe staffing along with the daily patient count at midnight, which is the total number of patients on the ward at 23:59 are aggregated for the month.

Calculation:
Day Shift Hours + Night Shift Hours Worked by both Nursing Support Staff and Registered Nurses & Midwives

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Approximation of Every 24 Hours of In-Patient Admissions by Taking a Daily Count of Patients in Beds at 23:59

The updated guidance references CHPPD for ward-based AHPs and other clinical staff:
'Ward-based Allied Health Professionals (AHPs) and other clinical staff who provide patient care in multi-disciplinary teams alongside nursing or midwifery staff can be included in the Safe Staffing returns for the purposes of calculating CHPPD. This only relates to staff that are part of the ward roster and are included in the ward establishment. Registered clinical staff can be reported alongside registered nursing and midwifery staff. Non-registered clinical staff can be recorded alongside healthcare support workers.'

MTW have looked proactively at AHPs in traditional nursing roles and as such, has successfully appointed an Occupational Therapist to the role of Ward Manager to MAU (TWH). This role will be included in the CHPPD calculation.

Current guidance does not yet include the patient facing hours that centrally deployed AHPs provide to a ward / department on any given day, into the CHPPD metric, as we would not be counting like with like.

QuESTT:

The QuESTT score seeks to offer a more objective approach to the safety and effectiveness of a ward to reflect aspects of good leadership and multi-professional engagement with care. Nurse sensitive indicators and included alongside the QuESTT score.

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 now at 100% (not including maternity) for the month of September. QuESTT continues to be further embedded into the monthly reporting systems and promoted through the Chief Nurse's senior team.

A trigger of Amber of Red will initiate a "Quality Review" relating to the quality indicators over a nominated period of time. This will be a minimum of a one quarter annum period to identify any themes or trends arising. The indicators for review include:
Falls
Complaints
FFT
Workforce KPIS including sickness, vacancy, turnover
Performance
Financial performance
E roster KPIs
Other patient safety incidents

Table 1

QuESTT: Quality, Effectiveness and Safety Trigger Tool		
Name of person completing review:	**Date of Review:**	

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):

Score if True		
1	2	3

September '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	91.4%	88.5%	99.2%	96.4%	7.5	50.0%	93.8%	6	1	7	1 fall above threshold Short term sickness	141,355	127,649	13,706
MAIDSTONE	Cornwallis	96.7%	93.0%	95.6%	86.7%	6.4	19.3%	91.3%	0	0	12	QuESTT score amber due to vacancy and sickness levels alongside an increase on service demands against normal reporting level.	91,179	68,486	22,693
MAIDSTONE	Culpepper (Inc CCU)	99.5%	100.4%	98.5%	120.0%	19.9	76.5%	100.0%	1	1	3	Increased fill rate to support deep clean. CSW's redeployed to support staffing requirements	109,337	109,578	(241)
MAIDSTONE	John Day	87.7%	131.6%	98.7%	110.0%	9.2	55.0%	90.9%	5	1	6	Reduced RN day fill rate due to lack of available temporary staff on 5 occasions. Increased RN fill rate at night due to increased acuity.	130,770	142,711	(11,941)
MAIDSTONE	Intensive Treatment Unit (ITU)	85.9%	76.8%	81.8%	N/A	32.7			0	0	5	Reduced occupancy throughout the month. Staff redeployed to support TWH ITU in line with clinical needs and staffing levels	157,740	162,119	(4,379)
MAIDSTONE	Pye Oliver	100.7%	82.0%	97.8%	98.9%	5.6	72.3%	88.2%	8	0	6	3 falls above threshold Reduced fill rate due to lack of available temporary staff. One occasion RN redeployed to support staffing levels	118,379	103,435	14,944
MAIDSTONE	Chaucer	95.4%	92.9%	130.0%	119.8%	12.2	51.9%	96.4%	5	0	3	1 fall above threshold Increased fill rate to support night escalation	118,267	113,508	4,759
MAIDSTONE	Lord North	89.3%	93.7%	96.7%	122.9%	7.1	42.9%	100.0%	3	1	3	1 fall above threshold Enhanced care requirements required across 4 nights in month	102,318	109,537	(7,219)
MAIDSTONE	Mercer	99.3%	108.5%	100.0%	106.6%	6.1	-	-	6	0	2		106,056	107,544	(1,488)
MAIDSTONE	Edith Cavell	93.8%	123.5%	98.9%	144.0%	7.3	64.3%	100.0%	5	0	2	1 fall above threshold Increased fill rate due to enhanced care requirements across 27 days. In additiona to supporting RN phased RTW	71,882	83,936	(12,054)
MAIDSTONE	Urgent Medical Ambulatory Unit (UMAU)	85.5%	71.1%	95.5%	96.7%	14.2	0.4%	100.0%	4	0	7	Reduced fill rate due to a of lack of available temporay staff. Escalated throughout the month	131,489	137,686	(6,197)
TWH	Stroke/W22	78.0%	96.5%	97.3%	102.2%	9.4	220.0%	90.9%	7	1	9	1 fall above threshold Reduced RN fill rate due to lack of available temporary staff throughout the month	150,502	147,308	3,194
TWH	Coronary Care Unit (CCU)	95.0%	86.8%	97.9%	N/A	10.4	115.4%	100.0%	1	0	3	1 fall above threshold Reduced RN fill rate due to lack of available temporary staff across 12 days	67,825	65,924	1,901
TWH	Gynaecology/ Ward 33	76.1%	100.2%	97.0%	88.0%	8.5	48.7%	93.0%	1	0	1	1 fall above threshold Reduced RN fill rate due to lack of available temporary staff across 13 days	79,636	76,876	2,760
TWH	Intensive Treatment Unit (ITU)	102.1%	86.6%	101.1%	N/A	26.3	-	-	0	0	1	Escalated on 12 occasions.	187,483	189,812	(2,329)
TWH	Medical Assessment Unit	95.0%	94.6%	111.2%	144.9%	5.8	12.5%	97.1%	3	0	13	Increased fill rate due to escalation throughout the month. QuESTT score 13 reflecting amber due to score associated for new manager, vacancy, sickness levels and formal complaint.	184,788	186,912	(2,124)
TWH	SAU	96.0%	93.3%	100.0%	96.7%	6.5			1	0	0		61,940	60,163	1,777
TWH	Ward 32	92.4%	103.8%	101.1%	109.1%	6.6	28.2%	100.0%	12	0	11	6 falls above threshold Enhanced care requirements covered with a combination of RMN's and CSW	139,808	143,663	(3,855)
TWH	Ward 10	96.4%	101.8%	74.3%	183.3%	6.3	26.2%	100.0%	7	0	7	5 falls above threshold Skill mix adjustment a considered risk by the ward team in line with a high dependency and moderate acuity	120,565	122,965	(2,400)
TWH	Ward 11	93.1%	114.6%	97.5%	118.3%	6.3	29.3%	97.2%	4	0	7	Increased fill rate to support patient escort requirements for ongoing treatment	126,638	121,051	5,587
TWH	Ward 12	87.4%	93.2%	94.1%	88.0%	5.7	21.5%	50.0%	10	0	8	4 falls above threshold Reduced fill rate across RN's and CSW's due to lack of available temporary staff on 17 occasions	121,446	137,440	(15,994)
TWH	Ward 20	88.3%	94.6%	96.9%	109.3%	5.9	93.5%	79.3%	12	0	7	5 falls above threshold Reduced fill rate due to lack of available temporary staff . Enhanced care needs daily throughout the month.	118,111	117,169	942
TWH	Ward 21	93.1%	98.1%	101.8%	96.3%	6.0	30.0%	100.0%	3	1	5		134,850	145,775	(10,925)
TWH	Ward 2	83.1%	79.8%	99.8%	80.3%	6.7	66.0%	90.3%	12	0	5	5 falls above threshold Reduced fill rate due to inability to fill with temporary staff. Staffing requirements for AFUMon - Fri. Episode of enhanced care requirements and escalation.	137,473	131,918	5,555
TWH	Ward 30	91.0%	103.0%	100.0%	99.9%	5.8	16.5%	100.0%	9	0	9	4 falls above threshold	122,715	118,421	4,294
TWH	Ward 31	84.7%	97.0%	98.3%	96.7%	6.4	48.4%	100.0%	8	2	7	2 falls above threshold Reduced RN fill rate due to lack of available temporary staff across 15 days. Adjusted skill mix	139,943	138,320	1,623
Crowborough	Birth Centre	69.3%	100.4%	94.7%	90.0%					0		Considered action to prioritise the night with Community teams support during the day	71,096	80,153	(9,057)
TWH	Maternity Services (incl Ante/Post Natal, Delivery Suite & Triage)	80.3%	97.6%	97.1%	94.9%	5.5			0	0		Fill rate influenced with staff moves within directorate to support services according requirements. In addition to unavailable temporary staff.	690,933	677,704	13,229
TWH	Hedgehog	96.2%	35.3%	98.8%	N/A	13.7	20.9%	92.2%	0	0	7	CSW often not backfilled and can be a considered action to support paediatric services outside of the inpatient unit depending on clinical need.	182,315	188,950	(6,635)
MAIDSTONE	Birth Centre	90.8%	81.0%	91.9%	99.5%				0	0		Reduced fill RM rate on 3 occasions	62,876	60,770	2,106
TWH	Neonatal Unit	75.2%	76.0%	97.1%	N/A	15.0				0	4	Reduced fill rate due to inability to cover shifts	178,696	164,520	14,176
MAIDSTONE	MSSU	90.7%	105.4%	93.2%	N/A	11.1	14.8%	92.5%	0	0	0		41,893	44,406	(2,513)
MAIDSTONE	Peale	107.2%	95.6%	99.8%	103.4%	8.7	55.3%	100.0%	0	0	5		76,274	75,770	504
TWH	SSSU	104.7%	106.4%	99.9%	180.0%	7.5			1	0	5	1 fall above threshold Escalated throughout month	128,087	89,180	38,907
MAIDSTONE	A&E	85.5%	83.9%	102.3%	79.7%		7.2%	90.9%		0		Reduced fill rate due to lack of available temporary staff.	209,321	211,661	(2,340)
TWH	A&E	92.6%	92.0%	94.8%	95.2%		17.1%	91.0%	0	0			317,114	352,239	(35,125)
												Total Established Wards	**5,131,100**	**5,115,260**	**15,840**
												Additional Capacity be Cath Labs	36,509	37,174	-665
												Whatman	99,470	-278	99,748
												Other associated nursing costs	2,717,776	2,779,349	-61,573.01
												Total	7,984,855	7,931,505	53,350

RAG Key

Under fill

Over fill

Infection Prevention and Control

MRSA

There were no cases of trust-attributable MRSA blood stream infection in September.

C. difficile - There were seven cases of post-72 hour *C. difficile* infection in September against a monthly limit of two cases. This continued a trend of increasing numbers of cases since June.

Following consultation with the executive team, the DIPC declared an outbreak of C. difficile on 12 September. This was seen as a positive move in order to use the framework of the outbreak policy to prioritise and add rigor to the investigation and recovery. Outbreak meetings have been held on both Trust sites and an action plan was developed. Implementation of the plan is being monitored and expedited through the outbreak meetings. The outbreak will be closed when there has been a month at or below baseline levels of infection. A closure report will be presented to the Board.

We are currently 8 cases above trajectory for the year to date with a rate of 18.1 cases per 100 000 bed days. This is compared with a rate of 14.8 for the same period last year.

No instance of confirmed cross infection has been found. Further tests are being carried out on two cases which may be linked.

All cases have full root cause analysis and are presented at the C. difficile panel with the DIPC and Chief Nurse.

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

Methicillin sensitive *Staphylococcus aureus* bacteraemia

No cases of hospital-attributable MSSA blood stream infection were seen in September. Review of earlier cases continues at the C. difficile panel

Gram negative bacteraemia

Seven cases of hospital-attributable gram negative blood stream infection were seen in August. Three cases were due to *E. coli* and two each due to *Klebsiella* and *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 shortly.

Financial commentary

- The Trust's deficit including PSF was £1m in September which was on plan, the Trust was £0.5m adverse to the CIP target and released £1m of reserves which was in line with the forecast.
- The Trust's normalised run rate in September was £2.7m deficit pre PSF which was £0.8m adverse to plan.
- In September the Trust operated with an EBITDA surplus of £1.5m which was on plan.
- The Trust year to date has a deficit including PSF of £3.6m which is on plan, the key variances to plan are: CIP Slippage (£1.3m), overspends within pay budgets (£1.1m) and non-pay budgets (£1.6m) offset by non-recurrent items (£1.5m), release of contingency reserve (£2.1m) and £0.3m underspend within depreciation and £0.2m over performance within income.
- The key current month variances are as follows:
  - Total income net of pass-through related income is £1.1m adverse to plan. Clinical Income excluding HCDs is £0.9m adverse. The key adverse activity related variances were daycases (£0.3m) and Electives (£0.6m) which is due to the Prime Provider CIP slippage (£1m). Other Operating Income excluding pass-through costs is £0.3m adverse to plan in the month which mainly relates to Private Patient income (£0.2m) and NHS Provider to Provider SLA income (£0.1m)
  - Pay excluding the release of contingency reserve was £0.3m adverse to plan in the month, due to higher than planned agency and bank usage to cover vacant posts. Medical budgets were overspent by £0.4m in September, General Surgery (£0.2m) was the largest overspending directorate due to high number of vacant posts requiring to be covered (17WTE) and Paediatrics (£0.1m) and Specialist Medicine (£0.1m) the other main areas of overspend. Nursing budgets were underspent in September, the only division overspent was Cancer which overspent by £10k in the month.
  - Non Pay adjusted for pass through costs was underspent by £1.3m in September although £0.75m underspend is associated with Prime Provider activity slippage and £0.8m of contingency reserves were released therefore the normalised position was an adverse variance of £0.1m. Supplies and Services continue to be the main overspending area within non pay (£0.2m), the main directorates overspending relate to T&O and Critical Care (£0.1m) and Cancer (£0.1m).
- The Trust achieved £0.9m savings in September which was £0.5m adverse to plan and £1.3m adverse year to date. This is mainly due to STP Medical rate slippage (£0.7m), Prime Provider (£0.5m), Private Patient income slippage (£0.2m) partly offset by over performance relating to procurement (£0.2m) and PFI Insurance rebate (£0.2m)
- The Trust held £13.5m of cash at the end of September which is higher than the plan of £3.5m. This is primarily due to the Trust receiving income earlier than forecasted in July, this balance will gradually reduce as pressure points within 2018/19 materialise. In September the Trust received £1.9m quarter 1 PSF funding which was forecast to be received in October, quarter 2 PSF funding is forecast to be received in December. 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 FOT is £14.1m which takes account of: 1) Linac 5 funding is £32k less than plan; 2) the outturn forecast for depreciation is £300k lower than plan due to slippage on schemes - this reduces the available resource so it is balanced by some equipment schemes being deferred.
- The prioritised list of equipment schemes was approved by TME and Execs, subject to individual Business case approval. Some equipment schemes have been deferred (£300k) to support the ICT EPR project. 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 Trust is forecasting to deliver its financial plan for the year, however it has identified £17.8m of potential risks that require controlling. The main risks include: £9.3m risk adjusted CIP shortfall, £6.8m pay pressures and £2.2m non pay pressure (mainly within T&O and Diagnostics). The Trust is working to control these potential risks, such as by continuing to take corrective action on budgetary overspends and working to fully deliver its CIP programme. Should those control actions fail to deliver the required impact, the Trust will have to implement mitigating actions which will include the full release of the remaining Trust contingency reserves and also other non-recurrent measures.

Workforce Commentary

September Dashboard)

As at the end of September 2018, the Trust employed 5063.6 whole time equivalent substantive staff, a 5.4WTE decrease from the previous month. Bank and agency use is higher than planned, in line with the higher than anticipated vacancy levels.

Sickness absence in the month (August) increased by 0.1% to 3.39%, 0.09% above target. Directorates demonstrating the highest sickness rates include Estates (7.19%), Clinical Governance (5.2%) and Facilities (4.52%), with rates having increased in two of the three areas since last month. At a divisional level, Estates and Facilities have the highest sickness levels at 4.73% a decrease from the previous month. At a trust level, the breakdown in May is 53.87% short-term, 46.13% long term. 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.

The Winter Flu campaign commenced on 3rd October 2018. The trust objective for the 2018/19 campaign is 85% (70% achieved in 2017/18). As of 17th October 20.7% of frontline staff have been vaccinated and the trust is on trajectory for its target.

Statutory and mandatory training compliance has decreased by 2.35% to 82.88%, but remains above the target percentage. The drop is in part attributed to the window during August and early September when training course completion could not be recorded due to the migration to a replacement learning management system. In addition the data now incorporates the PREVENT basic and level 3 training compliance which was introduced in April 2017 and has been on an improvement trajectory since that date. The training is incorporated into the Safeguarding Children and Adults training at level 3. Since September of this year we have had access to the national e learning content as an alternative to face to face training. In general, corporate areas demonstrate a higher level of training compliance, in line with the more limited range of training needs that are required.

Turnover has continued to decrease since last month to 9.41%, lower than target, with outliers in Finance (17.88%), Human Resources (14.15%) and Head and Neck (14.21%). 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 84.66% compared with a target of 90%. 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 and directorate management teams are working to identify individuals who have not yet returned completed appraisal documentation and the data is a focus for Divisional Executive Performance reviews.

Trust Performance Dashboard

Position as at: 30 September 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)	4.73	36.1	14.8	18.1	3.3	6.6	11.5	13.2	
'1-02	Number of cases C.Difficile (Hospital)	1	7	15	22	7	8	26	34	
'1-03	Number of cases MRSA (Hospital)	0	0	0	2	2	2	0	2	
'1-04	Elective MRSA Screening	99.0%	98.7%	99.0%	98.7%	-0.3%	0.7%	98.0%	98.7%	
'1-05	% Non-Elective MRSA Screening	Not currently available								
'1-06	**Rate of Hospital Pressure Ulcers	3.13	0.87	2.01	1.49	- 0.52	- 1.52	*3.01*	1.53	3.00
'1-07	***Rate of Total Patient Falls	5.87	6.80	5.70	6.12	0.43	0.12	*6.00*	5.77	
'1-08	***Rate of Total Patient Falls Maidstone	4.38	6.62	4.92	6.04	1.13			5.21	
'1-09	***Rate of Total Patient Falls TWells	6.68	6.90	6.17	6.17	0.00			5.41	
'1-10	Falls - SIs in month	2	4	17	14	- 3				
'1-11	Number of Never Events	0	0	0	1	1	1	*0*	1	
'1-12	Total No of SIs Open with MTW	58	77			19				
'1-13	Number of New SIs in month	15	17	77	93	16	33			
'1-14	***Serious Incidents rate	0.71	0.88	0.60	0.77	0.16	0.71	*0.0584 - 0.6978*	0.77	*0.0584 - 0.6978*
'1-15	Rate of Patient Safety Incidents - harmful	1.31	1.47	1.20	1.19	- 0.01	- 0.04	*0 - 1.23*	1.19	*0 - 1.23*
'1-16	Number of CAS Alerts Overdue	1	0			-1	0	*0*		
'1-17	VTE Risk Assessment - month behind	96.6%	95.3%	96.4%	95.3%	-1.2%	0.3%	95.0%	95.3%	95.0%
'1-18	Safety Thermometer % of Harm Free Care	97.8%	97.6%	96.6%	97.8%	1.1%	2.8%	95.0%		93.4%
'1-19	Safety Thermometer % of New Harms	4.21%	2.41%	3.33%	2.18%	-1.15%	-0.8%	*3.00%*	2.18%	
'1-20	C-Section Rate (non-elective)	14.0%	11.2%	13.7%	13.1%	-0.63%	-1.9%	*15.0%*	13.1%	

	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	1.0219	- 0.1	0.0	Band 2	Band 2	1.0
2-02	Standardised Mortality HSMR	Prev Yr: Apr 15 to Mar 16		104.6	104.8	0.2	4.8	Lower confidence limit to be <100		100.0
2-03	Crude Mortality	1.1%	1.2%	1.1%	1.0%	-0.2%				
2-04	****Readmissions <30 days: Emergency	12.3%	14.3%	11.7%	14.1%	2.3%	0.5%	*13.6%*	14.1%	14.1%
2-05	****Readmissions <30 days: All	11.8%	13.8%	11.0%	13.5%	2.6%	-1.1%	*14.7%*	13.5%	14.7%
2-06	Average LOS Elective	3.70	2.93	2.55	3.04	0.49	- 0.16	*3.20*	3.04	
2-07	Average LOS Non-Elective	6.82	6.68	7.43	6.91	- 0.52	0.11	*6.80*	6.91	
2-22	NE Discharges - Percent zero LoS	37.2%	46.3%	35.9%	44.4%	8.5%			44.4%	
2-08	******FollowUp : New Ratio	1.76	1.56	1.69	1.56	- 0.13	0.04	*1.52*	1.56	
2-09	Day Case Rates	88.0%	86.7%	88.0%	87.4%	-0.6%	7.4%	80.0%	87.4%	82.2%
2-10	Primary Referrals	8,424	8,489	54,041	60,666	12.3%	5.5%	121,638	121,813	
2-11	Cons to Cons Referrals	4,653	4,784	29,311	34,896	19.1%	23.6%	56,704	70,069	
2-12	First OP Activity (adjusted for uncashed)	15,544	16,444	95,192	105,606	10.9%	5.5%	204,495	212,049	
2-13	Subsequent OP Activity (adjusted for uncashed)	27,869	24,021	175,325	153,455	-12.5%	-17.7%	379,945	308,127	
2-14	Elective IP Activity	655	533	3,438	3,194	-7.1%	-16.3%	7,674	6,413	
2-15	Elective DC Activity	3,290	3,472	21,247	22,127	4.1%	1.2%	44,403	44,430	
2-16	**Non-Elective Activity	4,769	5,246	28,362	31,641	11.6%	8.5%	58,582	63,109	
2-17	A&E Attendances (Calendar Mth) Excl Crowboro	14,301	14,973	86,107	91,035	5.7%	1.1%	174,428	174,428	
2-18	Oncology Fractions	5,369	4,633	34,507	31,737	-8.0%	-6.1%	67,890	63,474	
2-19	No of Births (Mothers Delivered)	506	484	2,497	2,971	19.0%	-0.6%	5,977	5,942	
2-20	% Mothers initiating breastfeeding	82.3%	81.7%	82.3%	82.1%	-0.3%	4.1%	78.0%	82.1%	
2-21	% Stillbirths Rate	0.2%	0.20%	0.20%	0.17%	*0.0%*	*-0.3%*	*0.47%*	0.17%	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	5	17	12	17	0	17	
3-02	*****Rate of New Complaints	1.84	2.22	3.40	2.05	-1.4	0.73	*1.318-3.92*	1.93	
3-03	% complaints responded to within target	44.4%	54.3%	74.3%	62.2%	-12.1%	-12.8%	75.0%	70.1%	
3-04	****Staff Friends & Family (FFT) % rec care	66.7%	78.2%	66.7%	78.2%	11.5%	-0.8%	79.0%	78.2%	
3-05	*****IP Friends & Family (FFT) % Positive	95.6%	93.8%	95.3%	94.6%	-0.7%	-0.4%	95.0%	94.6%	95.8%
3-06	A&E Friends & Family (FFT) % Positive	91.9%	90.9%	91.4%	91.6%	0.2%	4.6%	87.0%	91.6%	85.5%
3-07	Maternity Combined FFT % Positive	93.9%	92.1%	93.6%	94.0%	0.4%	-1.0%	95.0%	94.0%	95.6%
3-08	OP Friends & Family (FFT) % Positive	84.3%	83.9%	83.0%	83.6%	0.6%			83.6%	

* 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	86.5%	93.93%	90.0%	93.1%	3.1%	2.3%	90.8%	92.3%	76.4%
4-02	Emergency A&E >12hr to Admission	-	1	-	2	2	2	-	2	
4-03	Ambulance Handover Delays >30mins	332	284	1,751	1,784	33			3,568	
4-04	Ambulance Handover Delays >60mins	55	60	196	207	11			414	
4-05	RTT Incomplete Admitted Backlog	2,298	3,066	2,298	3,066	768	625	2,151	3,066	
4-06	RTT Incomplete Non-Admitted Backlog	718	3,579	718	3,579	2,861	850	1,995	3,579	
4-07	RTT Incomplete Pathway	85.9%	79.7%	85.9%	79.7%	-6.2%	-2.7%	85.5%	79.7%	
4-08	RTT 52 Week Waiters (New in Month)	3	8	4	30	28	30	*0*	30	
4-09	RTT Incomplete Total Backlog	3,504	6,645	3,504	6,645	3,141	1,475	4,146	6,645	
4-10	% Diagnostics Tests WTimes <6wks	99.65%	99.3%	99.7%	99.3%	-0.3%	0.3%	99.0%	99.0%	
4-11	*Cancer WTimes - Indicators achieved	4	4	3	4	1	- 5	9	9	
4-12	*Cancer two week wait	93.6%	76.4%	92.1%	79.4%	-12.7%	-13.6%	93.0%	93.0%	
4-13	*Cancer two week wait-Breast Symptoms	87.4%	58.5%	87.9%	62.6%	-25.3%	-30.4%	93.0%	93.0%	
4-14	*Cancer 31 day wait - First Treatment	95.3%	96.2%	92.6%	97.0%	4.3%	1.0%	96.0%	96.0%	
4-15	*Cancer 62 day wait - First Definitive	70.9%	67.7%	66.2%	63.1%	-3.1%	-19.0%	85.0%	85.0%	
4-16	*Cancer 62 day wait - First Definitive - MTW	71.7%	70.9%	71.7%	66.0%	-5.7%		85.0%		
4-17	*Cancer 104 Day wait Accountable	15.5	12.0	88.5	71.0	-17.5	71.0	*0*	71.0	
4-18	*Cancer 62 Day Backlog with Diagnosis	74	54	74	54	-20				
4-19	*Cancer 62 Day Backlog with Diagnosis - MTW	51	41	51	41	-10				
4-20	Delayed Transfers of Care	5.32%	5.89%	5.55%	4.82%	-0.73%	1.32%	3.50%	4.82%	
4-21	% TIA with high risk treated <24hrs	81.0%	No data	67.3%	72.5%	5.1%	12.5%	60%	72.5%	
4-22	*******% spending 90% time on Stroke Ward	94.8%	94.7%	92.4%	90.7%	-1.7%	10.7%	80%	90.7%	
4-23	*******Stroke:% to Stroke Unit <4hrs	65.2%	49.3%	59.2%	55.8%	-3.5%	-4.3%	60.0%	55.8%	
4-24	*******Stroke: % scanned <1hr of arrival	75.8%	57.7%	64.5%	56.6%	-7.8%	8.6%	48.0%	56.6%	
4-25	*******Stroke:% assessed by Cons <24hrs	80.3%	82.6%	86.2%	86.2%	0.0%	6.2%	80.0%	86.2%	
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	11	0	11	14	3	14	*0*	14	

RTT Incomplete Pathway Monthly Plan is Trust Recovery Trajectory

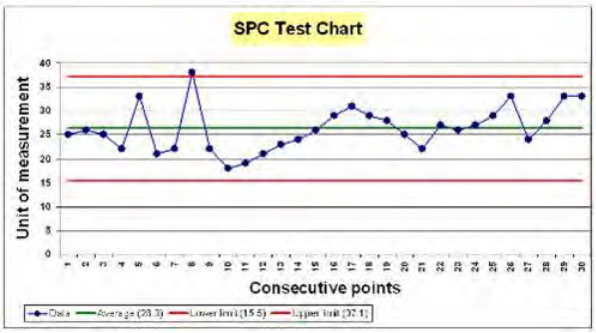
**CWT run one mth behind, YTD is Quarter to date, Monthly Plan for 62 Day Wait First Definitive is Trust Recovery Trajectory*

**** 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	38,933	36,805	221,542	228,450	3.1%	0.5%	466,408	466,408	
5-02	EBITDA	7,291	1,545	14,182	11,386	-19.7%	-2.1%	38,910	38,910	
5-03	Surplus (Deficit) against B/E Duty	4,753	(1,014)	(1,077)	(3,571)			11,743	11,743	
5-04	CIP Savings	1,902	917	9,280	5,884	-36.6%	-17.9%	24,111	24,111	
5-05	Cash Balance	2,227	13,493	2,227	13,493			1,000	1,000	
5-06	Capital Expenditure	623	82	2,903	1,902			*13,762*	13,430	
5-07	Establishment WTE	5,599.0	5,627.6	5,599.0	5,627.6	0.5%	0.0%	5,627.6	5,627.6	
5-08	Contracted WTE	4,992.8	5,063.6	4,992.8	5,063.6	1.4%	0.8%	5,023.4	5,023.4	
5-09	Vacancies WTE	606.2	563.9	606.2	563.9	-7.0%	-6.7%	604.1	604.1	
5-11	Vacancy Rate (%)	10.8%	10.0%	10.8%	10.0%	-0.8%	-0.7%	10.7%	10.7%	
5-12	Substantive Staff Used	4,849.3	4,949.1	4,849.3	4,949.1	2.1%	-1.5%	5,026.7	5,026.7	
5-13	Bank Staff Used	361.2	382.6	361.2	382.6	5.9%	4.8%	365	365.1	
5-14	Agency Staff Used	251.2	276.5	251.2	276.5	10.1%	17.3%	235.8	235.8	
5-15	Overtime Used	51.3	45.9	51.3	45.9	-10.7%				
5-16	Worked WTE	5,513.1	5,654.0	5,513.1	5,654.0		0.5%	5,627.6	5,627.6	
5-17	Nurse Agency Spend	(736)	(822)	(3,427)	(4,538)	32.4%				
5-18	Medical Locum & Agency Spend	(1,313)	(1,517)	(7,208)	(9,258)	28.5%				
5-19	Temp costs & overtime as % of total pay bill	19.0%	17.0%	16.2%	16.9%	0.7%				
5-20	Staff Turnover Rate	11.8%	9.4%		9.4%	-2.4%	-1.1%	*10.5%*	9.4%	11.05%
5-21	Sickness Absence	3.4%	3.4%		3.4%	0.0%	0.1%	*3.3%*	3.4%	4.3%
5-22	Statutory and Mandatory Training	88.8%	82.9%		87.1%	-5.9%	2.1%	85.0%	87.1%	
5-23	Appraisal Completeness	86.5%	84.7%		84.7%	-1.8%	-5.3%	90.0%	84.7%	
5-24	Overall Safe staffing fill rate	98.8%	95.0%	98.5%	96.3%	-2.1%		93.5%	96.3%	
5-25	****Staff FFT % recommended work	60.6%	50%	60.6%	50%	-10.6%	-12.0%	62.0%	50%	
5-26	***Staff Friends & Family -Number Responses	33	78	33	78	45				
5-27	*****IP Resp Rate Recmd to Friends & Family	22.8%	20.1%	23.7%	22.6%	-1.1%	-2.4%	25.0%	22.6%	25.7%
5-28	A&E Resp Rate Recmd to Friends & Family	21.2%	12.3%	21.4%	13.0%	-8.4%	-2.0%	15.0%	13.0%	12.7%
5-29	Mat Resp Rate Recmd to Friends & Family	28.9%	43.8%	31.7%	26.2%	-5.5%	1.2%	25.0%	26.2%	24.0%

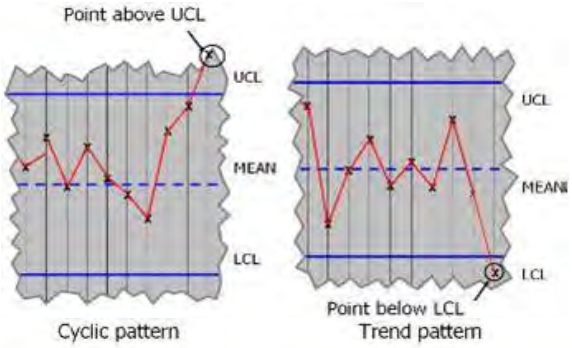
Explanation of Statistical Process Control (SPC) Charts

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:

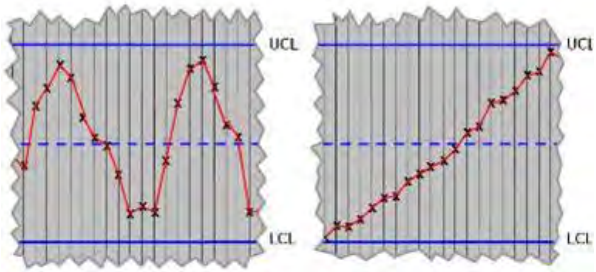


SPC is a type of charting that shows the variation that exists in the systems that are being measured. When interpreting SPC charts there are 4 rules that help to identify what the system is doing. If one of the rules has been broken, this means that 'special cause ' variation is present in the system.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

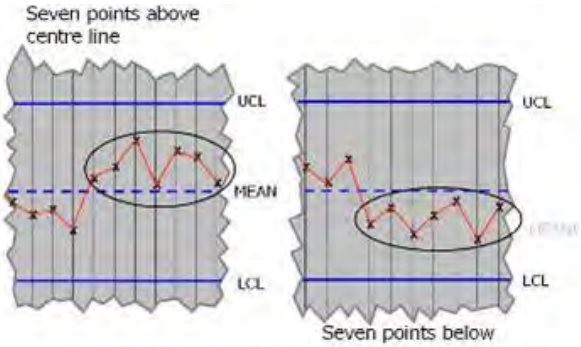


Rule 2: Any unusual pattern or trends within the control limits. The most obvious example of a cyclical pattern is seasonality but we also see it when looking at daily discharges where the weekends have low numbers. To qualify as a trend there must be at least 6 points in a row. This is one of the key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

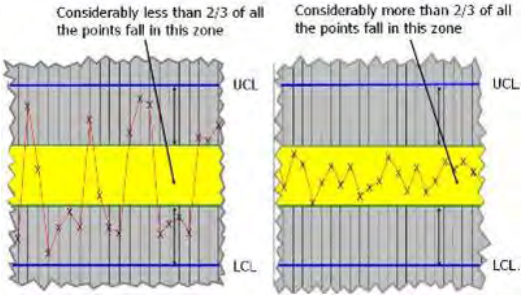


Rules 1 and 2 are the main reason for displaying SPC charts on our performance reports as it makes abnormally high or low values and trends immediately obvious. However there are two other rules that are also used to interpret the graphs.

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.

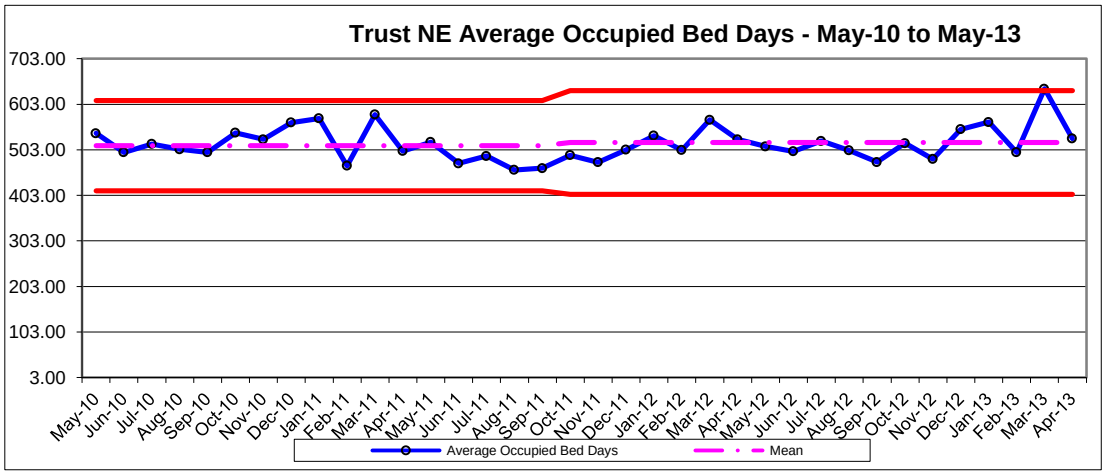


Rule 4: The number of points within the middle third of the region between the control limits differs markedly from two -thirds of the total number of points. This gives an indication of how stable a process is. If controlled variation (common cause) is displayed in the SPC chart, the process is stable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

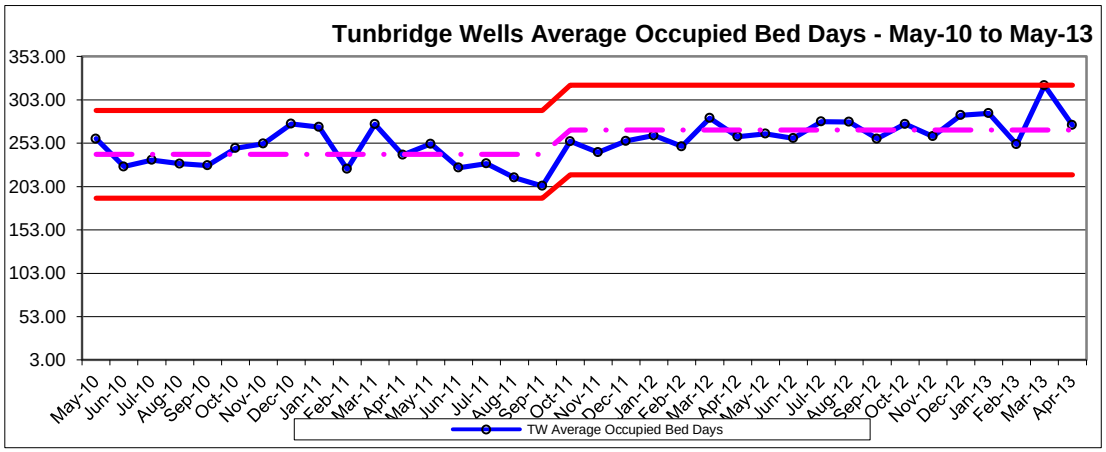


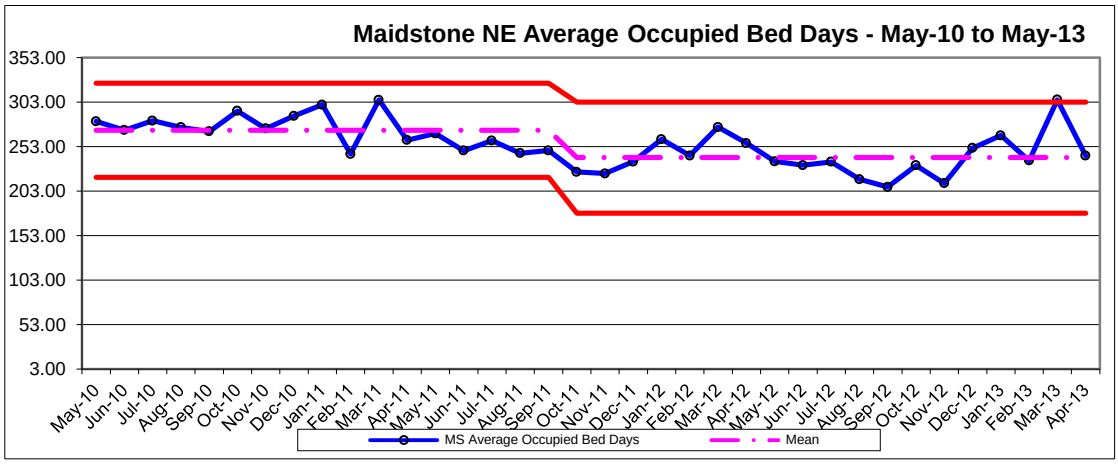
Changes to Control Lines

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:

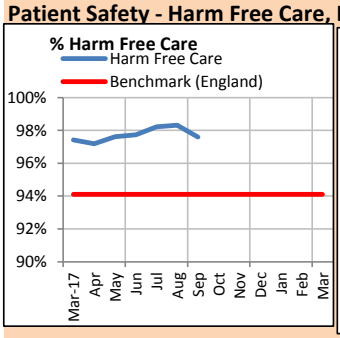


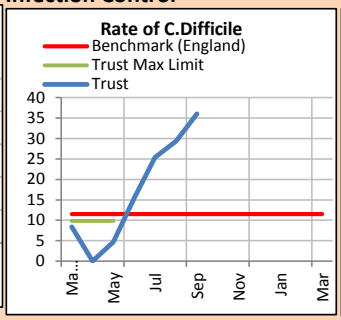


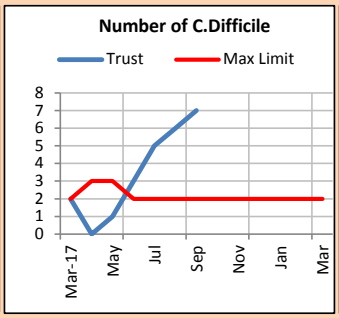
So in the examples given we have calculated a mean and control limits based on the data for May 2010 to September 2011 and then calculated them based on the period October 2011 to April 2013. The lines are all a result of the SPC calculations, only the date of the change is decided by the Information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

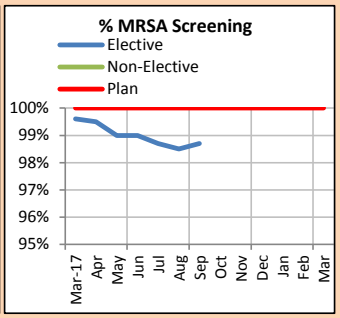
INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

Patient Safety - Harm Free Care, Infection Control

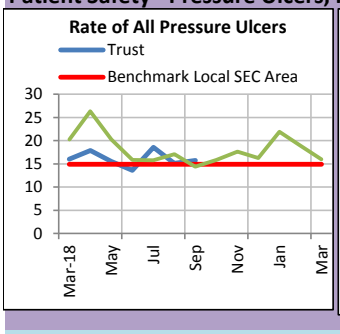


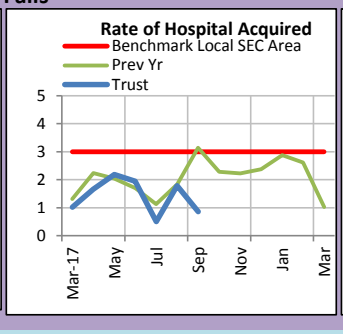


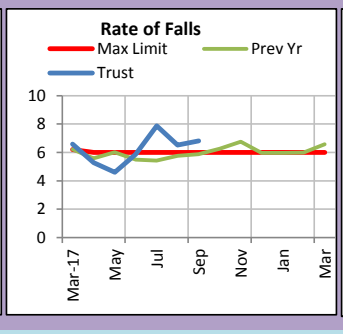


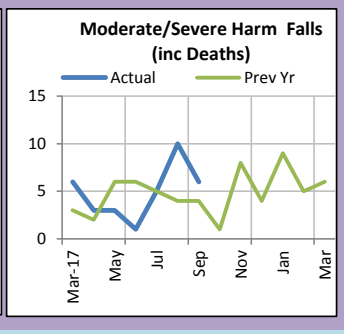


Patient Safety - Pressure Ulcers, Falls

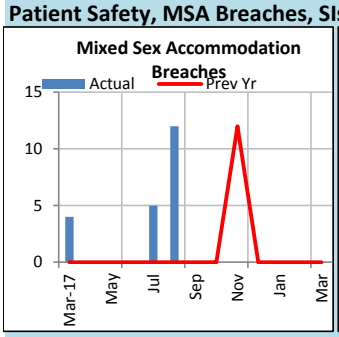


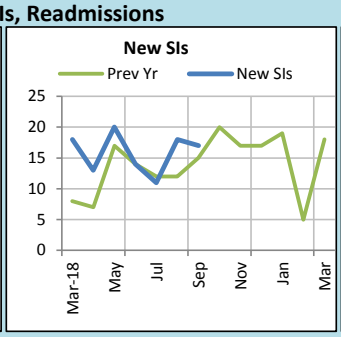


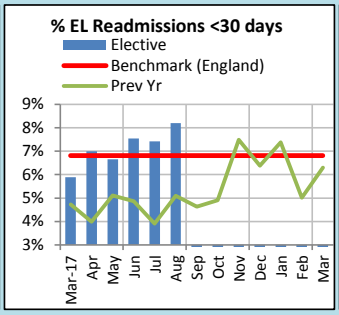


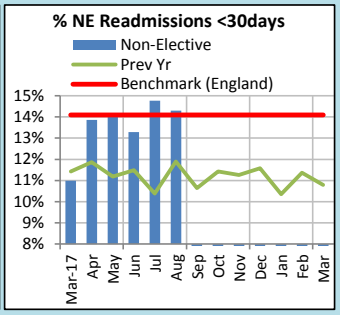


Patient Safety, MSA Breaches, SIs, Readmissions

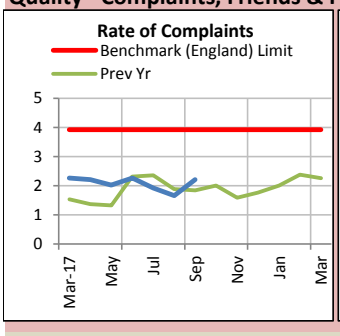


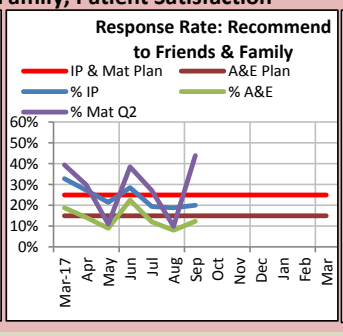


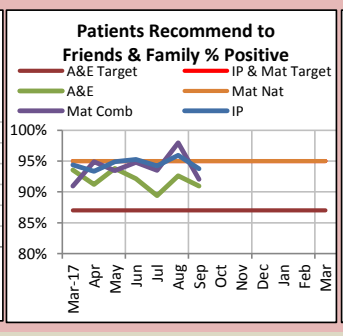


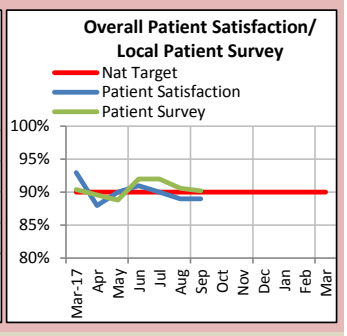


Quality - Complaints, Friends & Family, Patient Satisfaction

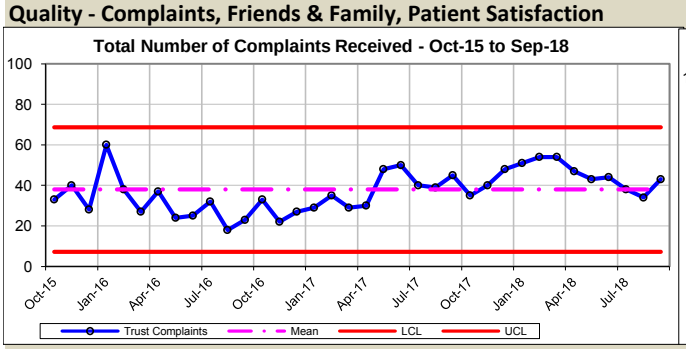


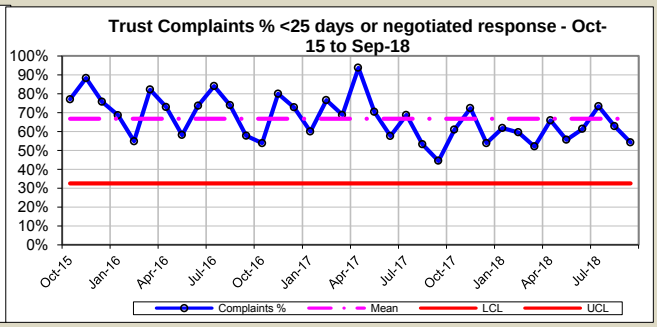




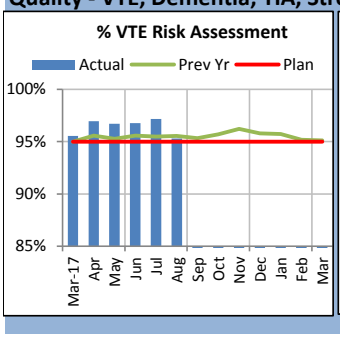


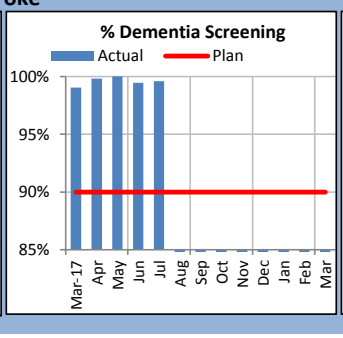
Quality - Complaints, Friends & Family, Patient Satisfaction

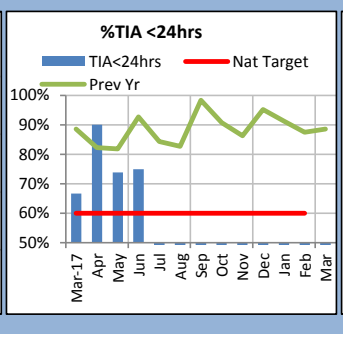


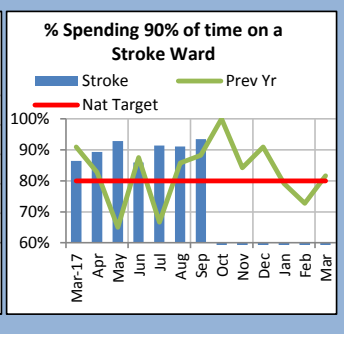


Quality - VTE, Dementia, TIA, Stroke



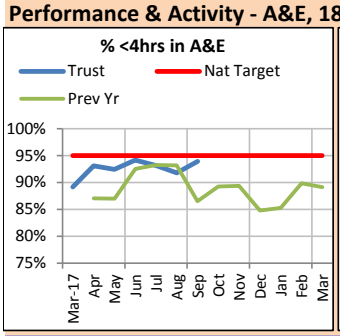


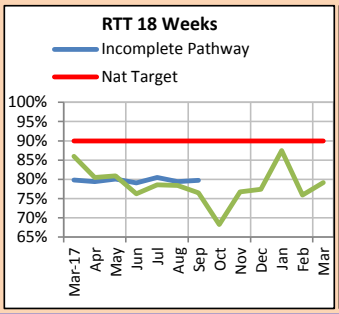


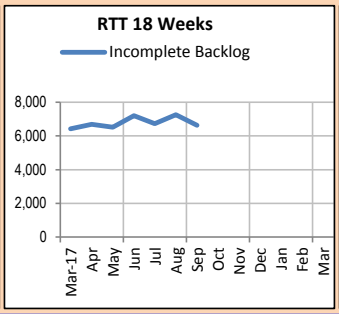


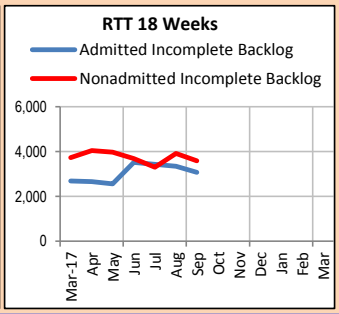
INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

Performance & Activity - A&E, 18 Weeks

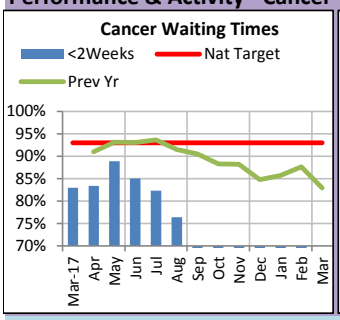


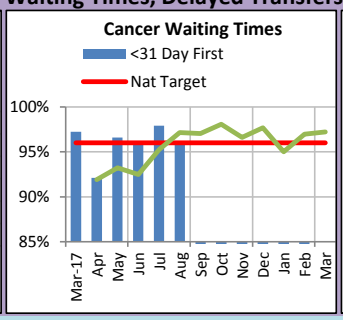


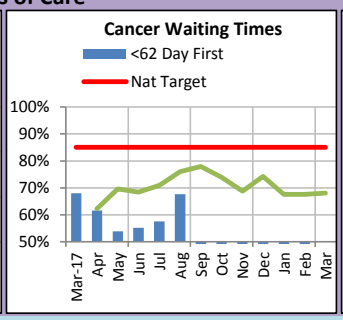


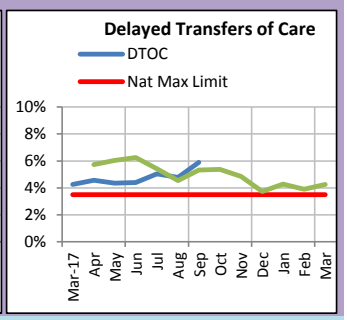


Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care

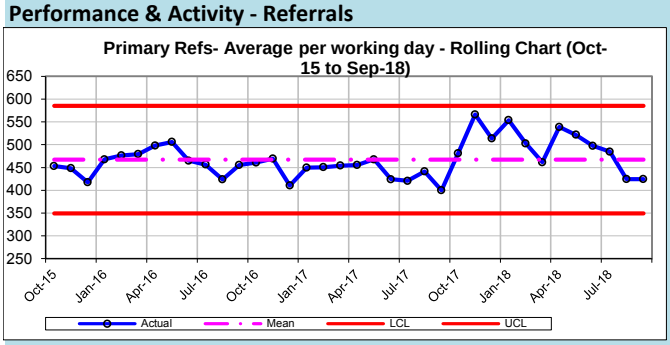


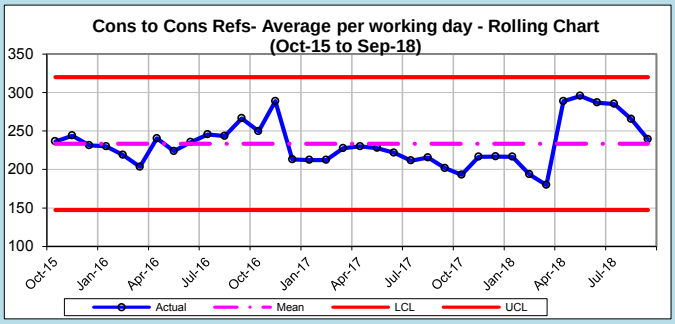




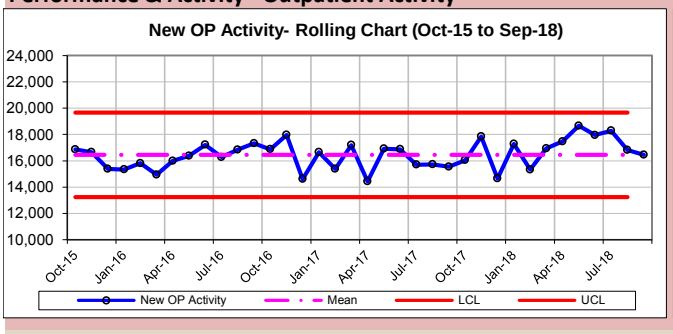


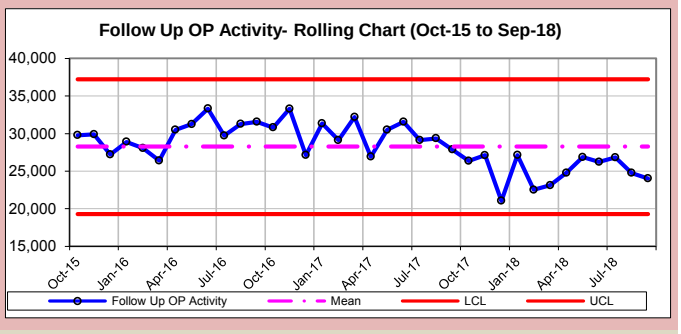
Performance & Activity - Referrals



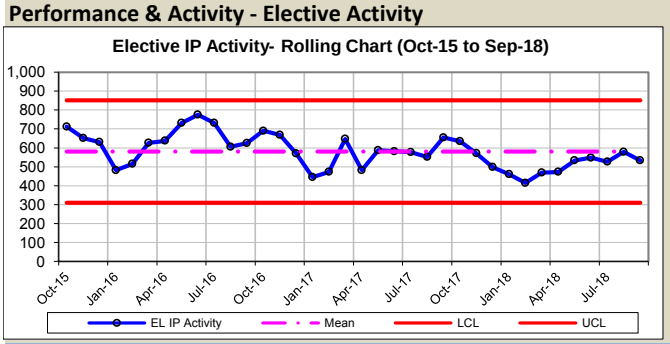


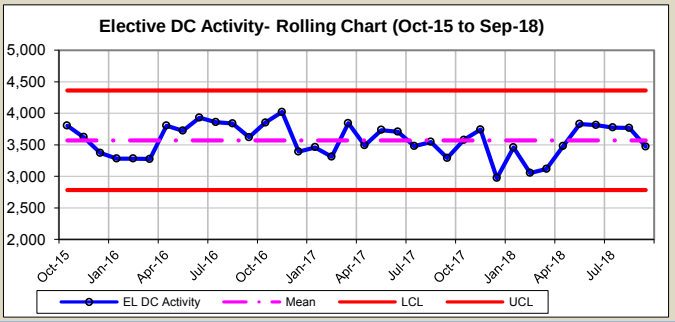
Performance & Activity - Outpatient Activity



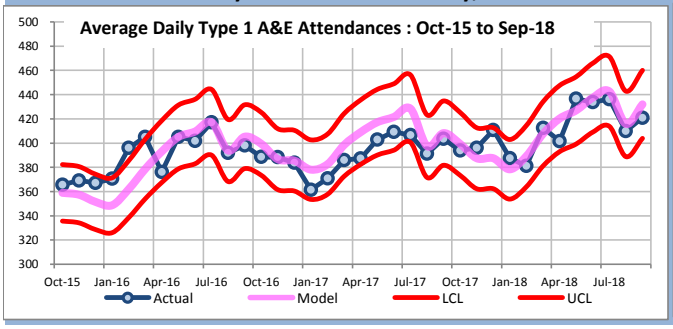


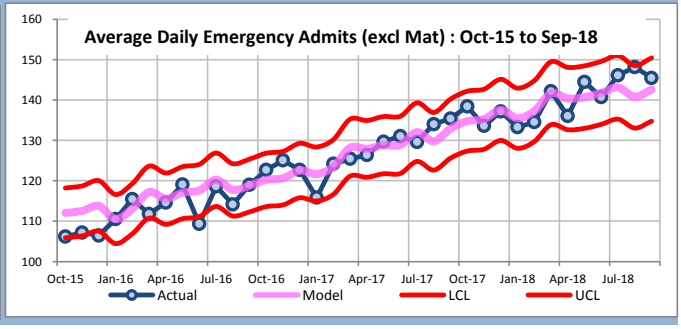
Performance & Activity - Elective Activity





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

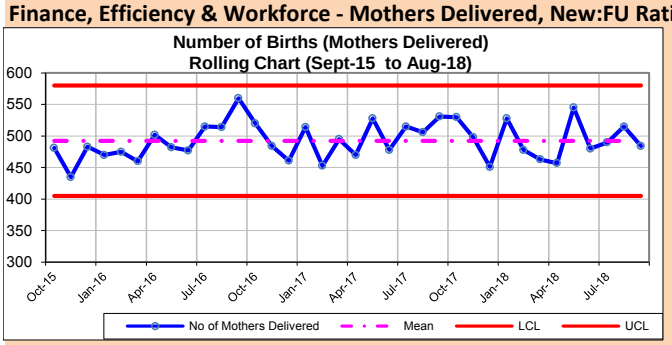


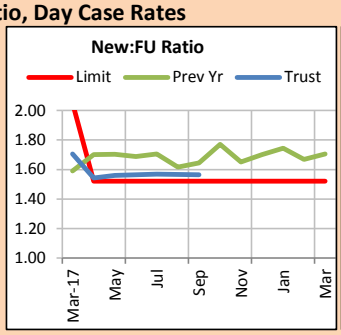


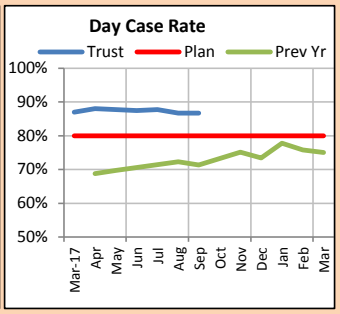
These have been changed to show actual against model, since emergency activity is subject to both growth and seasonal variation. Control limits are 2 standard deviations of variance, so a count outside the control limits will be expected around one month in 20.

INTEGRATED PERFORMANCE REPORT ANALYSIS - FINANCE, EFFICIENCY & WORKFORCE

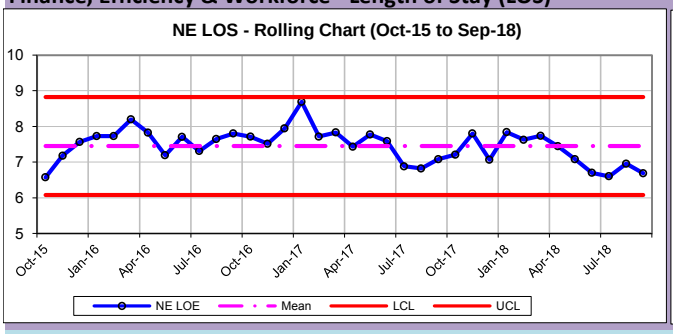
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates

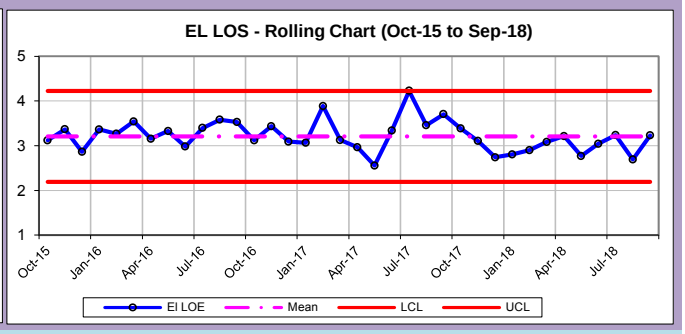




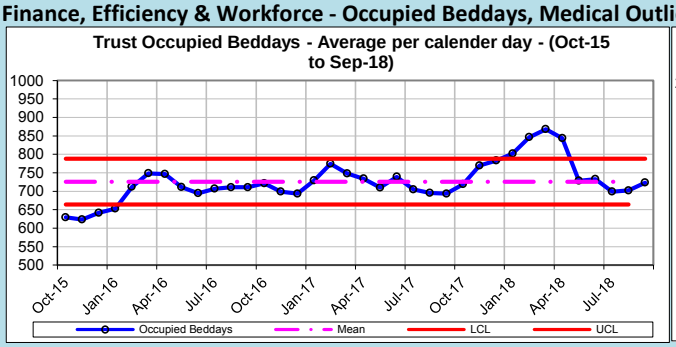


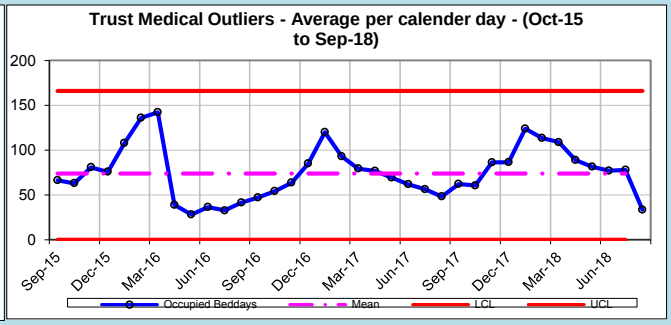
Finance, Efficiency & Workforce - Length of Stay (LOS)



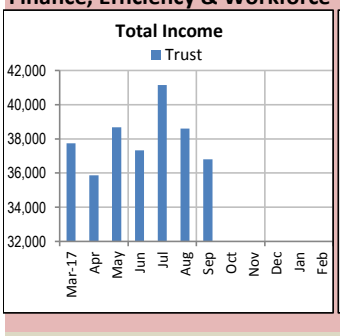


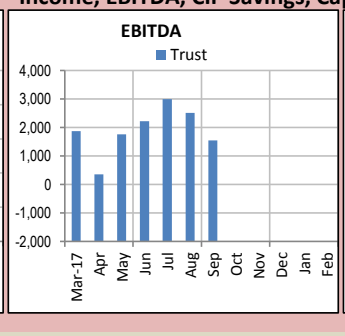
Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

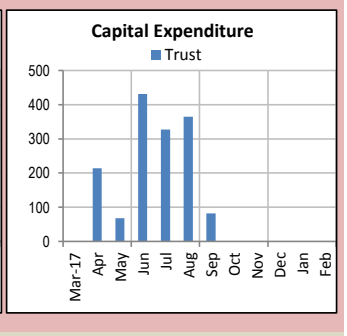




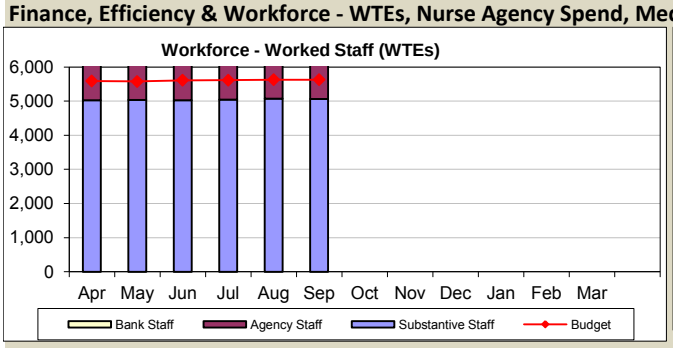
Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure

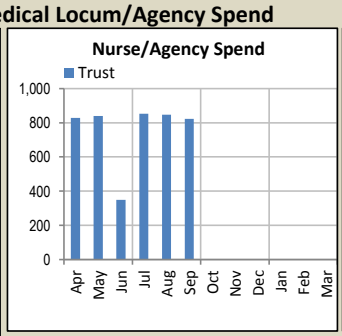


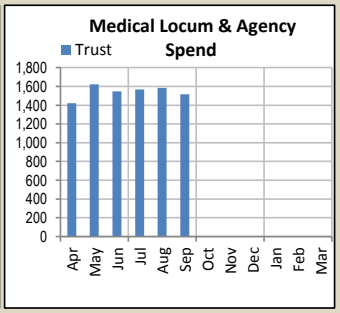




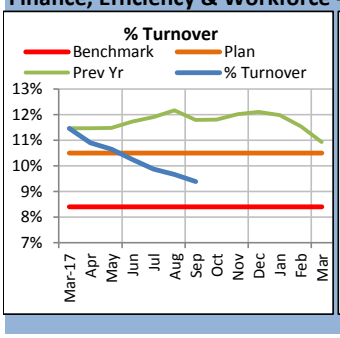
Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend

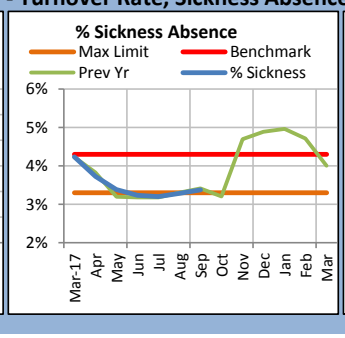


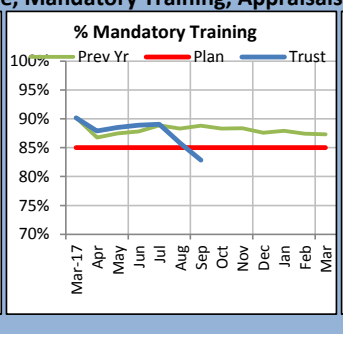


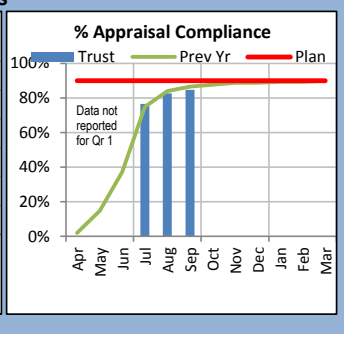


Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals









Maidstone and Tunbridge Wells NHS Trust

Trust Board Finance Report

Month 6
2018/19

Maidstone and Tunbridge Wells NHS Trust

Trust Board Finance Report for September 2018

Maidstone and Tunbridge Wells NHS Trust

1a. Dashboard

September 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	36.8	38.3	(1.5)	(0.4)	(1.1)		228.4	230.0	(1.5)	(0.8)	(0.7)		468.3	471.1	(2.8)	
Expenditure	(35.3)	(36.8)	1.5	0.4	1.1		(217.1)	(218.4)	1.3	0.8	0.5		(432.6)	(432.2)	(0.4)	
EBITDA (Income less Expenditure)	1.5	1.5	0.0	(0.0)	0.0		11.4	11.6	(0.2)	0.0	(0.2)		35.7	38.9	(3.2)	
Financing Costs	(2.7)	(2.5)	(0.1)	0.0	(0.1)		(15.2)	(15.2)	0.0	0.0	0.0		(25.0)	(28.2)	3.2	
Technical Adjustments	0.1	0.0	0.1	0.0	0.1		0.3	0.0	0.3	0.0	0.3		1.0	1.0	0.0	
Net Surplus / Deficit (Incl PSF)	**(1.0)**	**(1.0)**	**0.0**	**(0.0)**	**0.0**		**(3.6)**	**(3.6)**	**0.0**	**0.0**	**0.0**		**11.7**	**11.7**	**0.0**	
CIPs	0.9	1.4	(0.5)		(0.5)		5.9	7.2	(1.3)		(1.3)		24.1	24.1	0.0	
Cash Balance	14.1	5.1	9.0		9.0		14.1	5.1	9.0		9.0		1.0	1.0	0.0	
Capital Expenditure	0.4	0.7	(0.3)		(0.3)		1.8	2.8	(1.0)		(1.0)		13.4	13.8	(0.4)	
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 £1m in September which was on plan. Year to date the Trust has a deficit of £3.6m which is on plan however the key variances within plan are: CIP Slippage (£1.3m,) overspends within pay budgets (£1.1m) and non pay budgets (£1.6m) offset by non-recurrent items (£1.5m) , release of contingency reserve (£2.1m) and underspends within depreciation (£0.3m) and income (£0.2m).
- The Trust has spent £6.3m more than the YTD agency ceiling set by NHSI (£11.8m per annum)

Key Points:

- The Trusts normalised run rate in September was £2.7m deficit pre PSF which was £0.8m adverse to plan.
- The Trust achieved the A&E trajectory for quarter 2 as well as the financial plan therefore has fully delivered the YTD PSF income .
- Year to date Non Pay pressures (£1.3m) net of passthrough and CIP slippage is now greater than the pay pressures. The main non pay pressures relate to T&O and Diagnostics, as part of the EPR executive challenge meetings these directorates have been asked to provide a full analysis and a recovery plan to address the overspend.

Risks:

- The Trust is forecasting to deliver the plan but there are several risks within this forecast which include CIP risk adjusted slippage (£9.3m), Divisional Pay pressures (£6.8m) and non pay overspends within T&O and Diagnostics (£1.7m). The Trust will have to implement recovery plans and mitigating actions to deliver the financial plan are covered in section 5 of this report.

Maidstone and Tunbridge Wells NHS Trust

1b. Summary Income & Expenditure (Exceptional Items)

Income & Expenditure September 2018/19

	Current Month					Year to Date				
	Actual £m	*Plan* £m	*Variance* £m	Pass-through £m	*Revised Variance* £m	*Actual* £m	*Plan* £m	*Variance* £m	Pass-through £m	*Revised Variance* £m
Income	36.0	37.4	(1.5)	(0.4)	(1.1)	222.8	225.5	(2.8)	(0.8)	(2.0)
Expenditure	(35.3)	(36.8)	1.5	0.4	1.1	(217.2)	(218.4)	1.2	0.8	0.4
Trust Financing Costs	(2.7)	(2.5)	(0.1)	0.0	(0.1)	(15.2)	(15.2)	0.0	0.0	0.0
Technical Adjustments	0.1	0.0	0.1	0.0	0.1	0.3	0.0	0.3	0.0	0.3
Net Revenue Surplus / (Deficit) before Exceptional Items	**(1.9)**	**(1.9)**	**0.0**	**(0.0)**	**0.0**	**(9.4)**	**(8.1)**	**(1.3)**	**0.0**	**(1.3)**
Exceptional Items	0.0		0.0		0.0	1.4		1.4		1.4
Net Position	**(1.9)**	**(1.9)**	**0.0**	**(0.0)**	**0.0**	**(8.0)**	**(8.1)**	**0.0**	**0.0**	**0.0**
PSF Funding	0.8	0.8	(0.0)	0.0	(0.0)	4.5	4.5	(0.0)	0.0	(0.0)
Net Revenue Surplus / (Deficit) Incl PSF and Exceptional Items	(1.0)	(1.0)	0.0	(0.0)	0.0	(3.6)	(3.6)	0.0	0.0	0.0

Key messages:
The Trust released £1m contingency reserve this month which was in line with last months forecast.

Income:
Income YTD net of pass-through related costs and exceptional items is £2m adverse to plan, which is due to CIP slippage (£2.2m), and Private Patient income £0.6m partly offset by income over performance within non AIC contracted clinical income (£0.7m)

Expenditure:
Expenditure budgets net of pass-through and exceptional items are £0.4m favourable, which is due to £2.1m release of contingency reserves, £0.9m CIP favourable variance (however £1.5m relates to prime provider (adverse within income)) with offsetting pressures within Pa y (£1.1m) and Non Pay (£1.6m).
The main pressures within expenditure budgets (net of pass though, CIP and exceptional items) relates to: Clinical Supplies a nd Services (£1.3m) and Medical (£1.1m).

Exceptional Non recurrent Items: The Trust did not have any exceptional items in September, the year to date exceptional items relate to benefits from 2017/18 provisions.

Reserves: The Trust is currently holding £1.2m of reserves YTD

PSF: The delivered quarter 2 A&E Trajectory targets and the financial plan therefore achieved the full PSF income

Maidstone and Tunbridge Wells NHS Trust

2a. Income & Expenditure

Income & Expenditure September 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	28.5	29.2	(0.7)	0.1	(0.9)	175.2	175.6	(0.4)	(0.1)	(0.3)	354.1	356.3	(2.2)
High Cost Drugs	3.6	3.7	(0.1)	(0.1)	(0.0)	21.9	22.0	(0.1)	(0.1)	(0.0)	43.2	43.2	0.0
Total Clinical Income	**32.0**	**32.9**	**(0.8)**	**0.0**	**(0.9)**	**197.1**	**197.6**	**(0.5)**	**(0.2)**	**(0.3)**	**397.4**	**399.6**	**(2.2)**
PSF	0.8	0.8	(0.0)	0.0	(0.0)	4.5	4.5	(0.0)	0	(0.0)	12.7	12.7	0
Other Operating Income	3.9	4.6	(0.7)	(0.4)	(0.3)	26.9	27.9	(1.0)	(0.6)	(0.5)	58.2	58.8	(0.6)
Total Revenue	36.8	38.3	(1.5)	(0.4)	(1.1)	228.4	230.0	(1.5)	(0.8)	(0.7)	468.3	471.1	(2.8)
Substantive	(18.9)	(19.1)	0.2	0.0	0.2	(112.1)	(114.5)	2.4	0.3	2.1	(226.9)	(228.8)	1.9
Bank	(1.1)	(1.0)	(0.1)	0.0	(0.1)	(6.4)	(6.0)	(0.4)	0.0	(0.4)	(12.5)	(12.3)	(0.2)
Locum	(0.7)	(0.4)	(0.3)	0.0	(0.3)	(3.6)	(2.6)	(1.0)	0	(1.0)	(8.1)	(5.5)	(2.6)
Agency	(1.9)	(1.7)	(0.2)	(0.0)	(0.2)	(12.0)	(10.1)	(1.9)	(0.0)	(1.9)	(24.8)	(22.2)	(2.6)
Pay Reserves	0.0	(0.2)	0.2	0.0	0.2	(0.6)	(1.3)	0.7	0	0.7	3.9	(1.8)	5.7
Total Pay	(22.5)	(22.4)	(0.1)	0.0	(0.1)	(134.7)	(134.5)	(0.2)	0.2	(0.4)	(268.4)	(270.6)	2.2
Drugs & Medical Gases	(4.4)	(4.5)	0.1	0.1	0.1	(26.6)	(27.2)	0.7	0.1	0.6	(53.4)	(52.0)	(1.4)
Blood	(0.2)	(0.2)	(0.0)	0.0	(0.0)	(1.1)	(1.1)	0.0	0	0.0	(2.1)	(2.2)	0.0
Supplies & Services - Clinical	(2.8)	(2.6)	(0.2)	(0.1)	(0.1)	(16.9)	(15.7)	(1.2)	0.1	(1.3)	(33.5)	(32.1)	(1.4)
Supplies & Services - General	(0.5)	(0.4)	(0.1)	0.0	(0.1)	(2.7)	(2.7)	0.0	(0.0)	0.0	(5.3)	(5.0)	(0.3)
Services from Other NHS Bodies	(1.1)	(0.8)	(0.2)	(0.1)	(0.1)	(4.7)	(4.9)	0.2	0.1	0.0	(9.9)	(9.9)	0.0
Purchase of Healthcare from Non-NHS	(0.4)	(1.0)	0.6	0.0	0.6	(1.8)	(2.9)	1.1	(0.0)	1.2	(5.8)	(5.2)	(0.6)
Clinical Negligence	(1.6)	(1.6)	0.0	0.0	0.0	(9.5)	(9.5)	0.0	0	0.0	(19.0)	(19.0)	0.0
Establishment	(0.3)	(0.3)	(0.0)	(0.0)	(0.0)	(1.9)	(1.8)	(0.1)	(0.0)	(0.1)	(4.0)	(3.5)	(0.5)
Premises	(1.8)	(1.9)	0.1	0.0	0.1	(12.1)	(11.8)	(0.3)	0.1	(0.5)	(23.8)	(21.3)	(2.5)
Transport	(0.1)	(0.1)	0.0	0.0	0.0	(0.9)	(0.8)	(0.1)	0	(0.1)	(1.7)	(1.3)	(0.4)
Other Non-Pay Costs	(0.2)	(0.7)	0.5	0.5	0.0	(4.7)	(4.4)	(0.3)	0.1	(0.4)	(8.4)	(8.1)	(0.4)
Non-Pay Reserves	0.6	(0.2)	0.8	0.0	0.8	0.4	(1.1)	1.5	0	1.5	2.9	(1.8)	4.7
Total Non Pay	(12.7)	(14.4)	1.6	0.3	1.3	(82.4)	(83.9)	1.5	0.6	0.9	(164.2)	(161.6)	(2.6)
Total Expenditure	(35.3)	(36.8)	1.5	0.4	1.1	(217.1)	(218.4)	1.3	0.8	0.5	(432.6)	(432.2)	(0.4)
EBITDA	1.5	1.5	0.0	(0.0)	0.0	11.4	11.6	(0.2)	0.0	(0.2)	35.7	38.9	(3.2)
	0.0	*0.0*	*(0.0)*	*%*		*5.0%*	*5.1%*	*15.5%*	*0.0%*	*32.3%*	*7.6%*	*8.3%*	*113.9%*
									0	0			
Depreciation	(1.2)	(1.1)	(0.0)	0	(0.0)	(6.6)	(6.7)	0.1	0	0.1	(13.2)	(13.5)	0.3
Interest	(0.1)	(0.1)	(0.0)	0	(0.0)	(0.8)	(0.8)	(0.0)	0	(0.0)	(1.6)	(1.6)	(0.1)
Dividend	(0.1)	(0.1)	0.0	0	0	(0.6)	(0.6)	0	0	0	(1.3)	(1.3)	0
PFI and Impairments	(1.3)	(1.2)	(0.1)	0	(0.1)	(7.2)	(7.1)	(0.1)	0	(0.1)	(8.9)	(11.9)	3.0
Total Finance Costs	(2.7)	(2.5)	(0.1)	0.0	(0.1)	(15.2)	(15.2)	0.0	0	0.0	(25.0)	(28.2)	3.2
Net Surplus / Deficit (-)	(1.1)	(1.0)	(0.1)	(0.0)	**(0.1)**	(3.8)	(3.6)	(0.2)	0.0	(0.2)	10.6	10.7	(0.0)
Technical Adjustments	0.1	0.0	0.1	0.0	0.1	0.3	0.0	0.3	0.0	0.3	1.0	1.0	0.0
Surplus/ Deficit (-) to B/E Duty Incl PSF	(1.0)	(1.0)	0.0	(0.0)	**0.0**	(3.6)	(3.6)	0.0	0.0	0.0	11.7	11.7	0.0
Surplus/ Deficit (-) to B/E Duty Excl PSF	(1.9)	(1.9)	0.0	(0.0)	**0.0**	(8.0)	(8.1)	0.0	0.0	0.0	(1.0)	(1.0)	0.0

Commentary

The Trusts deficit including PSF was £1m in September which was on plan, year to date the Trust has a deficit of £3.6m which is on plan.

The Trusts normalised run rate in September was £2.7m deficit pre PSF which was £0.8m adverse to plan.

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 £0.9m adverse to plan in September. The key adverse variances in month were Daycases (£0.3m) and Electives (£0.6m) . This is mainly in relation to the delay to the Prime Provider tender process.

The Trust achieved the A&E trajectory for quarter 2 as well as the financial plan therefore has fully delivered the YTD PSF income .

Other Operating Income excluding pass-through costs is £0.3m adverse to plan in the month, the main pressures relate to Private Patient income (£0.2m) and NHS Provider to Provider SLA Income (£0.1m).

Pay excluding the release of contingency reserve was £0.3m adverse to plan in the month, due to higher than planned agency and bank usage to cover vacant posts. Medical budgets were overspent by £0.4m in September, General Surgery (£0.2m) was the largest overspending directorate due to high number of vacant posts requiring to be covered (17WTE) and Paediatrics (£0.1m) and Specialist Medicine (£0.1m) the other main areas of overspend. Nursing budgets were underspent in September, the only division overspent was Cancer which overspent by £10k in the month.

Non Pay adjusted for pass through costs was underspent by £1.3m in September although £0.75m underspend is associated with Prime Provider activity slippage and £0.8m of contingency reserves were released therefore the normalised position was an adverse variance of £0.1m. Supplies and Services continue to be the main overspending area within non pay (£0.2m), the main directorates overspending relate to T&O and Critical Care (£0.1m) and Cancer (£0.1m).

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

Maidstone and Tunbridge Wells NHS Trust

2b. Run Rate Analysis

Analysis of 13 Monthly Performance (£m's)

		Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Change between Months
Revenue	Clinical Income	32.6	31.3	31.2	31.7	32.0	31.2	33.8	30.7	33.5	32.3	35.4	33.1	32.0	(1.0)
	STF / PSF	2.2	0.0	0.0	0.0	0.0	0.0	3.0	0.0	0.0	0.0	0.0	0.0	0.0	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	4.1	3.8	3.4	3.8	4.0	5.7	3.9	5.1	5.2	5.0	5.7	5.5	4.8	(0.8)
	Total Revenue	**38.9**	**35.0**	**34.5**	**35.5**	**36.0**	**36.9**	**40.8**	**35.9**	**38.7**	**37.3**	**41.2**	**38.6**	**36.8**	**(1.8)**
Expenditure	Substantive	(17.8)	(17.9)	(18.0)	(17.8)	(17.9)	(17.5)	(17.9)	(18.3)	(18.7)	(18.4)	(19.4)	(18.5)	(18.9)	(0.3)
	Bank	(1.2)	(1.0)	(0.9)	(1.2)	(1.2)	(1.1)	(1.3)	(1.0)	(1.0)	(1.0)	(1.0)	(1.2)	(1.1)	0.1
	Locum	(0.5)	(0.5)	(0.6)	(0.5)	(0.5)	(0.6)	(0.7)	(0.5)	(0.6)	(0.5)	(0.6)	(0.7)	(0.7)	(0.0)
	Agency	(1.9)	(2.0)	(1.8)	(1.9)	(2.3)	(1.8)	(2.6)	(2.0)	(2.1)	(1.7)	(2.1)	(2.1)	(1.9)	0.2
	Pay Reserves	1.5	(0.2)	(0.2)	(0.2)	(0.2)	(0.3)	(0.2)	(0.2)	(0.2)	(0.2)	(0.1)	0.2	0.0	(0.2)
	Total Pay	(20.0)	(21.6)	(21.6)	(21.6)	(22.2)	(21.3)	(22.7)	(22.0)	(22.7)	(21.9)	(23.2)	(22.3)	(22.5)	(0.2)
Non-Pay	Drugs & Medical Gases	(4.1)	(4.4)	(4.5)	(4.2)	(4.5)	(4.3)	(4.5)	(4.2)	(4.8)	(4.3)	(4.5)	(4.3)	(4.4)	(0.0)
	Blood	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.1)	(0.2)	(0.2)	(0.1)	(0.2)	(0.2)	(0.2)	(0.2)	(0.0)
	Supplies & Services - Clinical	(2.2)	(2.5)	(2.6)	(2.5)	(2.6)	(2.5)	(2.1)	(2.6)	(2.9)	(2.7)	(2.9)	(3.0)	(2.8)	0.1
	Supplies & Services - General	(0.5)	(0.5)	(0.5)	(0.5)	(0.4)	(0.5)	(0.6)	(0.4)	(0.4)	(0.4)	(0.4)	(0.5)	(0.5)	0.0
	Services from Other NHS Bodies	(0.7)	(0.6)	(1.3)	(0.9)	(0.7)	(0.7)	(0.3)	(0.6)	(0.6)	(1.1)	(0.7)	(0.7)	(1.1)	(0.4)
	Purchase of Healthcare from Non-NHS	(0.3)	(0.4)	(0.4)	(0.4)	(0.2)	(0.2)	(0.3)	(0.3)	(0.3)	(0.2)	(0.2)	(0.3)	(0.4)	(0.1)
	Clinical Negligence	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.6)	(1.6)	(1.6)	(1.6)	(1.6)	(1.6)	0.0
	Establishment	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.2)	(0.3)	(0.4)	(0.3)	0.1
	Premises	(1.5)	(1.8)	(1.8)	(2.2)	(1.8)	(3.8)	(3.0)	(1.9)	(1.8)	(1.8)	(2.6)	(2.2)	(1.8)	0.3
	Transport	(0.1)	(0.2)	(0.1)	(0.1)	(0.2)	(0.1)	(0.2)	(0.2)	(0.2)	(0.2)	(0.1)	(0.1)	(0.1)	0.0
	Other Non-Pay Costs	(0.5)	(1.5)	(0.0)	(1.0)	(1.1)	(1.1)	(0.2)	(1.0)	(1.0)	(0.3)	(1.2)	(1.1)	(0.2)	0.9
	Non-Pay Reserves	0.3	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.2)	(0.2)	(0.2)	(0.2)	0.5	0.6	0.2
	Total Non Pay	(11.7)	(14.1)	(13.4)	(14.2)	(13.7)	(15.4)	(13.2)	(13.5)	(14.3)	(13.2)	(14.9)	(13.8)	(12.7)	1.1
	Total Expenditure	(31.6)	(35.7)	(35.0)	(35.8)	(35.8)	(36.7)	(35.9)	(35.5)	(36.9)	(35.1)	(38.2)	(36.1)	(35.3)	0.8
EBITDA	EBITDA	7.3	(0.6)	(0.5)	(0.3)	0.2	0.2	4.9	0.4	1.8	2.2	3.0	2.5	1.5	(1.0)
		19%	*-2%*	*-1%*	*-1%*	*1%*	*1%*	*12%*	*1%*	*5%*	*6%*	*7%*	*7%*	*4%*	
Other Finance Costs	Depreciation	(1.2)	(0.8)	(1.1)	(1.0)	(1.2)	(1.1)	(1.2)	(1.1)	(1.1)	(1.1)	(1.0)	(1.0)	(1.2)	(0.1)
	Interest	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.0)
	Dividend	(0.1)	(0.1)	(0.1)	(0.1)	0.5	(0.1)	0.2	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	0.0
	PFI and Impairments	(1.1)	(1.1)	(1.2)	(5.2)	(1.1)	(1.2)	17.5	(1.2)	(1.2)	(1.2)	(1.2)	(1.2)	(1.3)	(0.1)
	Total Other Finance Costs	**(2.6)**	**(2.2)**	**(2.5)**	**(6.4)**	**(1.9)**	**(2.5)**	**16.3**	**(2.5)**	**(2.5)**	**(2.5)**	**(2.5)**	**(2.5)**	**(2.7)**	**(0.2)**
Net Surplus / Deficit (-)	Net Surplus / Deficit (-)	4.7	(2.8)	(2.9)	(6.7)	(1.7)	(2.2)	21.2	(2.2)	(0.8)	(0.3)	0.5	0.0	(1.1)	(1.2)
Technical Adjustments	Technical Adjustments	0.0	0.0	0.0	4.0	0.0	0.0	(18.9)	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Surplus/ Deficit (-) to B/E Duty Incl STF	Surplus/ Deficit (-) to B/E Duty	4.8	(2.8)	(2.9)	(2.6)	(1.6)	(2.2)	2.3	(2.2)	(0.8)	(0.3)	0.5	0.0	(1.1)	(1.2)
Surplus/ Deficit (-) to B/E Duty Excl STF	Surplus/ Deficit (-) to B/E Duty	2.5	(2.8)	(2.9)	(2.6)	(1.6)	(2.2)	(0.7)	(2.2)	(0.8)	(0.3)	0.5	0.0	(1.1)	(1.2)

Maidstone and Tunbridge Wells NHS Trust

3a. Cost Improvement Plan

Savings by Division

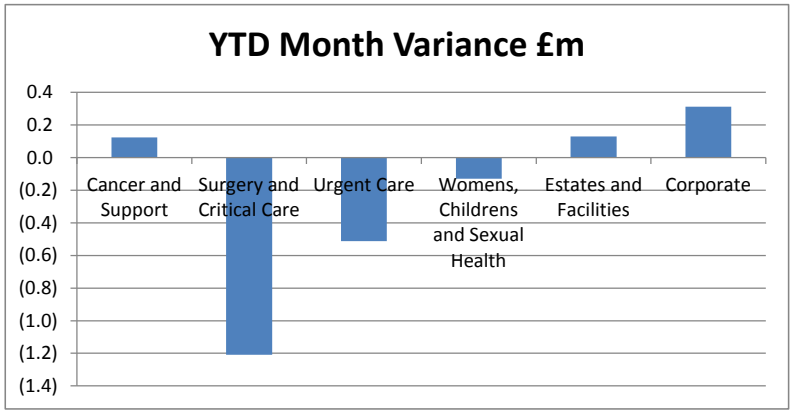
	Current Month			Year to Date			Forecast (Risk Adjusted)		
	Actual	*Original Plan*	*Variance*	*Actual*	*Original Plan*	*Variance*	*Forecast*	*Original Plan*	*Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Cancer and Support	0.34	0.19	0.15	1.02	0.90	0.12	2.01	3.01	(1.00)
Surgery and Critical Care	0.17	0.74	(0.57)	2.25	3.45	(1.21)	6.19	11.38	(5.19)
Urgent Care	0.11	0.19	(0.08)	0.62	1.13	(0.51)	1.83	3.46	(1.64)
Womens, Childrens and Sexual Health	0.10	0.14	(0.04)	0.59	0.72	(0.13)	1.37	2.11	(0.74)
Estates and Facilities	0.10	0.08	0.02	0.57	0.44	0.13	1.68	3.15	(1.47)
Corporate	0.10	0.09	0.01	0.84	0.53	0.31	1.75	1.00	0.75
Total	**0.92**	**1.43**	**(0.51)**	**5.88**	**7.17**	**(1.29)**	**14.82**	**24.11**	**(9.29)**

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	0.38	(0.14)	1.46	2.29	(0.84)	2.97	3.17	(0.20)
Non Pay	0.66	(0.07)	0.73	4.08	2.34	1.74	5.03	8.40	(3.37)
Income	0.02	1.11	(1.10)	0.34	2.53	(2.19)	6.82	12.55	(5.72)
Total	**0.92**	**1.43**	**(0.51)**	**5.88**	**7.17**	**(1.29)**	**14.82**	**24.11**	**(9.29)**

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	0.68	0.94	(0.26)	5.32	5.75	(0.43)	11.47	16.99	(5.52)
Amber	0.14	0.38	(0.24)	0.29	0.97	(0.68)	2.34	2.73	(0.38)
Red	0.10	0.11	(0.01)	0.28	0.45	(0.17)	1.00	4.39	(3.39)
Total	**0.92**	**1.43**	**(0.51)**	**5.88**	**7.17**	**(1.29)**	**14.82**	**24.11**	**(9.29)**



Comment

The Trust was £0.5m adverse to plan in the month and £1.3m adverse YTD. The main schemes adverse to plan YTD are:
- STP Medical Rates £0.7m (£0.1m adverse in month)
- Prime Provider £0.5m (£0.25m adverse in month)
- Private Patient Income (stage 1) £0.2m. The plan includes a further increase from October 18.
- The key schemes over performing against the plan are: Procurement £0.2m and £0.2m PFI Insurance rebate.

The Trusts risk adjusted savings forecast is £9.3m adverse to plan, the main schemes forecasting slippage are:
- Estates and Facilities Subsidiary £1.75m (although £0.35m now schemes have been added to reduce impact to £1.4m)
- Private Patient Income = £1m
- STP Medical Rates = £2.2m
- Prime Provider = £2.2m (1 month delay plus impact of winter escalation leading to increase in outsourced activity)
- Medicines Management = £1.1m (£0.7m relates to Avastin)
- Urgent Care Centre = £0.4m
- Directorate Led workforce schemes £0.5m
- Satellite Service Review = £0.3m
- Endoscopy Income = £0.2m
- Procurement = £0.6m

Maidstone and Tunbridge Wells NHS Trust

4a. Year End Forecast

Year End Forecast September 2018/19

		Risks											Recovery Actions					
	Annual Plan £m	*CIP Non Delivery* £m	*Pay Pressures*	*Non Pay Pressures*	*Net Income Benefits*	*2017/18 Benefits*	*RTT and Cancer Recovery Plan*	*Virtual Ward*	*Pass through Items*	*Other*	*Risk Adjusted Forecast* £m	***Variance*** **£m**	*Release Contingency Reserves* £m	*Reduce CIP Slippage*	*Furtehr Potential Asset Sales*	*Income Support - RTT and Cancer* £m	*Virtual Ward Funding* £m	***Revised Variance*** **£m**
Income	471.1	(5.7)			0.4	1.2			0.5	0	467.5	**(3.6)**	0	0	0	0.8	0	**5.5**
Pay	(270.6)	(0.2)	(6.8)			0.8	(0.4)			(0.0)	(277.2)	**(6.6)**	3.8	4.9	0	0	0	**2.2**
Non Pay	(161.6)	(3.4)		(2.3)		(0.6)	(0.4)	(0.6)	(0.5)	0	(169.4)	**(7.8)**	2.0	2.6	0	0	0.6	**(2.6)**
Other Finance Costs	(28.2)									0.2	(28.0)	**0.2**	0	0	3.0	0	0	**3.2**
Technical Adjustments	1.1									(0.0)	1.0	**(0.0)**				0	0	**(0.0)**
Surplus/ Deficit (-) to B/E Duty Pre PSF	**(1.0)**	**(9.3)**	**(6.8)**	**(2.3)**	**0.4**	**1.5**	**(0.8)**	**(0.6)**	**0**	**0.2**	**(18.8)**	**(17.8)**	**5.8**	**7.6**	**3.0**	**0.8**	**0.6**	**(0.0)**

Commentary

The Trust is forecasting to deliver the plan however has a risk adjusted 'business as usual' forecast deficit of £18.8m pre PSF, £2.8m adverse to last month. The Trust will have to implement recovery actions of £17.8m to ensure delivery of the 2018/19 plan.

The 'business as usual' forecast has been set assuming pay costs will continue at the same levels as the current month and income and non pay costs will continue at the YTD average all adjusted for non recurrent items.
Additional adjustments have been made to this baseline forecast to reflect**,** risk adjusted CIP delivery of £14.8m (shortfall of £9.3m), Winter costs (£2.9m to include opening of escalation wards and additional medical OOH team) , £0.8m investment associated with Cancer and RTT recovery plans and £7.4m non recurrent benefits to be delivered in full which are still to be finalised.

The Trusts risk adjusted forecast includes the following core pressures
- CIP Delivery of £14.8m (£9.3m shortfall, mainly within Income)
- Divisional Pay Pressures (£6.8m)
- Non Pay pressure particularly within T&O and Diagnostics (£1.7m) and Establishment budget pressures of £0.5m relating to recruitment of overseas nurses £0.3m and pressures within printing and telephone costs.

Recovery Actions - £17.8m recovery actions will be required to be implemented, this would involve the following:
- Full Release of Contingency Reserves (Including Directorate held pay reserve) £5.8m.
- Reduction in CIP slippage (£7.6m), the Trust will have to deliver £22.4m savings in 2018/19.
- Asset Sales (£3m). The Trust will have to review further potential disposals of assets to generate profit on sales totalling £3m.
- Income Support for RTT and Cancer Recovery plans (£0.8m), the forecast assumes additional funding above the AIC contract baseline will be paid to fund the costs of this recovery plan.
- Virtual Ward (£0.6m), the forecast assumes that any costs incurred to deliver a virtual ward will be offset by additional income.

Maidstone and Tunbridge Wells NHS Trust

5a. Balance Sheet

September 2018

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

£m's	September Reported	September Plan	Variance	August Reported
Property, Plant and Equipment (Fixed Assets)	289.5	291.1	(1.6)	290.9
Intangibles	2.6	2.2	0.4	2.3
PFI Lifecycle	0.0	0.0	0.0	0.0
Debtors Long Term	1.4	1.2	0.2	1.2
Total Non-Current Assets	**293.5**	**294.5**	**(1.0)**	**294.4**
Current Assets	0.0	0.0	0.0	0.0
Inventory (Stock)	7.3	8.1	(0.8)	7.7
Receivables (Debtors) - NHS	18.8	26.9	(8.1)	21.5
Receivables (Debtors) - Non-NHS	14.4	12.6	1.8	14.5
Cash	13.5	3.5	10.0	14.1
Assets Held For Sale	0.0	0.0	0.0	0.0
Total Current Assets	**54.0**	**51.1**	**2.9**	**57.8**
Current Liabilities				
Payables (Creditors) - NHS	(4.7)	(4.5)	(0.2)	(4.3)
Payables (Creditors) - Non-NHS	(39.2)	(36.2)	(3.0)	(38.6)
Deferred Income	(12.9)	(13.4)	0.5	(15.8)
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)	(5.2)	0.2	(5.0)
Provisions for Liabilities and Charges	(1.8)	(2.0)	0.2	(1.8)
Total Current Liabilities	**(82.8)**	**(80.5)**	**(2.3)**	**(84.7)**
Net Current Assets	(28.8)	(29.4)	0.6	(26.9)
Borrowings - PFI > 1yr	(190.3)	(190.6)	0.3	(190.9)
Capital Loans	(9.1)	(9.1)	0.0	(10.1)
Working Capital Facility & Revenue loans	(26.1)	(26.1)	0.0	(26.1)
Other loans	(1.3)	(1.3)	0.0	(1.3)
Provisions for Liabilities and Charges- Long term	(1.0)	(0.8)	(0.2)	(1.0)
Total Assets Employed	**36.9**	**37.2**	**(0.3)**	**38.1**
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	(200.2)	(199.9)	(0.3)	(199.0)
Total Capital & Reserves	**36.9**	**37.2**	**(0.3)**	**38.1**

Commentary:
The month 6 balance sheet position is consistent with the plan that was submitted in April. The overall working capital within the month results in a decrease in debtors but a small increase in creditors compared to the plan. The cash balance held at the end of the month is also higher than the plan, this is primarily due to receiving the cash in July in advance of the planned expectation.

Non-Current Assets -
Capital additions for 2018/19 have been reduced from the plan of £14.5m to £14.1m to reflect the reduction in this years depreciation, £0.7m on donated assets have remained unchanged from the plan. The planned depreciation for the year has also been revised from £13.5 to £13.1m to reflect the slippage in the capital programme. The month 6 capital spend is £0.1m against a plan of £0.5m.

Current Assets -
Inventory of £7.3m is a reduction from the planned value of £8.1m. The main stock balances are pharmacy £3m, TWH theatres £1.5m, Materials Management £1.1m and Cardiology £0.3m.
NHS Receivables have decreased from the month 5 position by £2.7m to £18.8m. Of the £18.8m reported balance, £12.9m relates to invoiced debt of which £3.6m is aged debt over 90 days. Invoiced debt over 90 days has increased slightly by £0.9m from the mth 5 reported position. The remaining £5.9m 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 decreased slightly £0.1m to £14.4m from the month 5 reported position. Included within the £14.4m balance is trade invoiced debt of £2.9m and private patient invoiced debt of £0.6m. Prepayments and accrued income totalling £9.4m. Prepayments primarily relate to rates & annual service maintenance contracts, which will reduce throughout the year as they are expensed.
The cash balance of £13.5m is higher than plan of £3.5m by £10m, this is due to the Trust receiving income in July which was earlier than plan. As the Trust has pressure points within 2018/19 the cash balance will gradually reduce as these materialise. In September the Trust received £1.9m qtr 1 PSF funding which was forecast to be received in October.

Current Liabilities -
NHS payables have increased from the August's reported position by £0.4m to £4.7m. Non-NHS trade payables have also increased by £0.6m to £39.2m, giving a combined payables balance of £43.9m.
The Balance of £6.6m approved trade invoices at the end of September shows 95% are within 0-30 days outstanding.

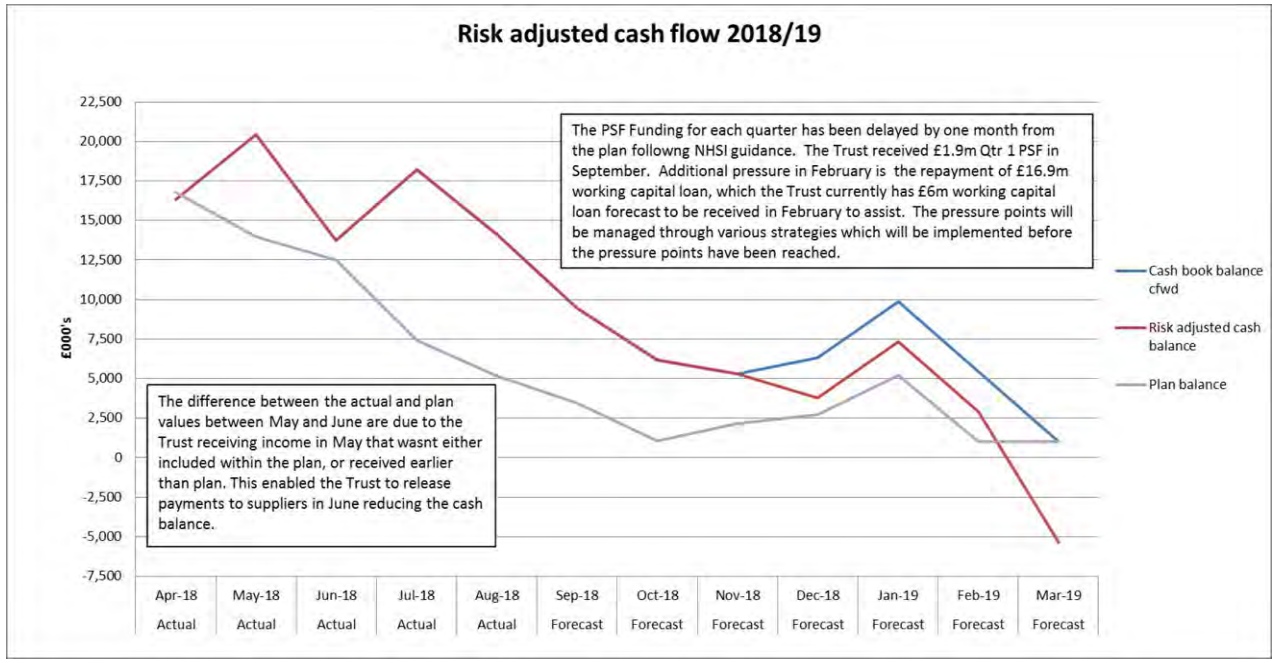
Of the £43.9m combined payables balances, £12.7m relates to actual invoices and £31.2m relates to uninvoiced accruals. The accruals include expected values for tax , NI, Superannuation and PDC payments.
Deferred income of £15.8m primarily is in relation to £11.5m advanced contract payment received from 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 £13.990m taken out in 2017/18 and are repayable in 2020/21.

Capital and Reserves-
For each area within this element for month 6 are consistent with the plan.

Maidstone and Tunbridge Wells NHS Trust

5b. | Cash Flow



Information on loans:

	Rate	Value £m's	18/19 Annual Repayment £m's	18/19 Annual Interest Paid £m's	Repayment Date
Information on loans:					
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	4.73%	6.000	0.24	0.16	15/19/2035
Other loans:					
Salix loan (interest free) £1.2m to be rec in 18/19	0.00%	1.283	0.15	0.00	2024/2025

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 and the purple line shows the monthly plan values.

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.

The cash balance cfwd is higher than the plan values due to the Trust receiving income either that was not included within the plan or received earlier than plan . As the Trust has pressure points within 2018/19 the cash balance will gradually reduce as the pressure points materialise.

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 has received Qtr 1 PSF funding of £1.9m at the beginning of September.

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.

Maidstone and Tunbridge Wells NHS Trust

5c. Capital Programme

Capital Projects/Schemes

	Year to Date			Annual			*Committed & orders raised
	Plan	*Actual*	*Variance*	*Plan*	*Forecast*	*Variance*	
	£000	£000	£000	£000	£000	£m	£m
Estates	1,457	1,463	-6	5,788	5,788	0	2,215
ICT	550	258	292	1,002	1,332	330	522
Equipment	1,092	181	911	6,501	5,839	-662	2,400
PFI Lifecycle (IFRIC 12)	233	0	233	471	471	0	471
Donated Assets	575	0	575	700	700	0	97
Total	**3,907**	**1,902**	**2,005**	**14,462**	**14,130**	**-332**	**5,706**
Less donated assets	-575	0	-575	-700	-700	0	0
Asset Sales (net book value)	0	0	0	-2,402	-2,402	0	0
Contingency Against Non-Disposal							
Adjusted Total	**3,332**	**1,902**	**1,430**	**11,360**	**11,028**	**-332**	**5,706**

**Committed = actual Year to Date spend/accruals/purchase orders & known contractual commitments*

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 FOT is £14.1m which takes account of: 1) Linac 5 funding is £32k less than plan; 2) the outturn forecast for depreciation is £300k lower than plan due to slippage on schemes - this reduces the available resource so it is balanced by some equipment schemes being deferred.

The Estates Backlog Maintenance programme of works is underway, with other Estates projects progressing. 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 is currently being prepared for TWH LED

The ICT schemes have been prioritised and approved by the ISG in principle, most schemes have business cases approved and are progressing.

The prioritised list of equipment schemes was approved by TME and Execs, subject to individual Business case approval. Some equipment schemes have been deferred (£300k) to support the ICT EPR project. 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.

Trust Board meeting - October 2018

Maidstone and Tunbridge Wells NHS Trust

10-10 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
October 2018

Content

1. Executive Summary
    a. Executive Summary

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

3. Financial Summary
    a. Financial Summary

1a. Executive Summary

Workstreams Update	Workstreams Update
KEY PROGRESS Best Patient flow LOS reduction consistent in NE Medical and NE Surgery, target to now be stretched further. PPU starts on 22nd October based within original EGAU space. Teams preparing to be ready for Prime Provider on 1st November. Best Safety – 7DS challenge session schedule on 18th October. GIRFT revised propose to be launched 30th October Best Workforce – Medical Led Authorisation Group, chaired by Deputy Medical Director starts 17th October. Group to review all 'in hours' medical workforce requests, personalised plans for medical locums to convert from agency to bank and 1:2:1 meeting with Agencies to improve quality and quantity of CVs.	**KEY PROGRESS** Best Quality – System wide event held on dementia pathway to improve understanding of full end to end pathway. Successful Patient Engagement & Experience events held at both Maidstone and Tunbridge Wells. Sustainability model to be undertaken on #EndPJP Best Use of Resources - Over performance in both Qtr 1 and 2. Avastin judicial review went in favour of NHS, however no steer from central teams. MTW proposal, of treating a small cohort of patients, seeking feedback from Moorfields, who are proposing same approach.
KEY RISKS Best Patient flow – Urgent Care Centre unlikely to progress until Spring 2019, outsourcing of Endoscopy to mitigate financial loss not possible as no neighbouring services that are JAG accredited. Best Safety – Delay in loading job plans onto allocate, in particular the A&E rota. Acute Medicine will not be compliant by 2020 for 7 day services. Best Workforce – Current schemes will not mitigate the financial gap, recruitment pipeline to be added to the financial forecast.	**KEY RISKS** Best Quality – a number of schemes identified to mitigate the financial gap, however some schemes will not result in quantifiable benefits. Best Use of Resources – E&F proposal to mitigate the gap to be presented to F&P October. Impact on Avastin has created shortfall in Medicines Management.

Maidstone and Tunbridge Wells NHS Trust

2a.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	Overall rag rating moved to amber due to the commencement of a recovery plan to mitigate E&F change gap. • Patient Transport (G4S contract)– New contract now awarded following protracted legal challenge. Value of identified savings confirmed and to be included in CIP forecast. • E&F Change – Decision reached by Trust Board not to pursue at the current time. • Recovery plan in development. Agreement to appoint an interim project manager to work with Director to deliver the new schemes. • Business Cases for additional car parks submitted for approval. • Commissioned new CAFM in Portering and Estates, savings added to CIP list.			• Appoint interim project manager to work with Director of E&FM on new opportunities and deliver recovery plan. • Complete TWH LED Business Case and submit for Salix funding by 30 October 2018. • Progress commercial negotiations with PFI partner on TWH schemes in accordance with the PFI Agreement. • Continued roll out of the CAFM across other directorate services • Revitalise HR to fully commission Kronos. • Conclude commercial and legal documentation with EKHUFT for the Renal unit land rent end of Oct 2018.
Procurement	Overall rag rating remains amber as work on some schemes are still in progress and delivering to plan, and others have missed milestones and have been mitigated against. M6 delivery include: • Negotiations for lab coat contract which delivered £21K • Joined with the STP on patient warming blankets which delivered an additional £7.5K • PTS Tender - Finalised legal challenge on transport contract which means £175K savings can now be delivered from Oct • Delivered clinical outsourcing contract £400K			• Deliver catering provisions contract valued at £100K • Commence Patient Temperature Service contract £20K • Commence Theatres consumables contract • Start to deliver part of Otoptics service £150K savings.
Medicine Management	• Outcome of Judicial review (Avastin) in Sept 2018 went in favour of NHS, but some background work as regards to legal implications still needs to be concluded, there is a potential delivery of over £600K, from Q4. • Joint Formulary Resource Business Case started and progressing well • Transtuzimab fully implemented in Oncology, 1st uptake rate as of Sept 2018 shows a reduction in spend of over £73K, but as pass through, NHSE will benefit from these savings. • Weekly recovery meetings still in progress. • Adalimumab – fortnightly implementation meeting with the wider STP team progressing well, implementation plan in place. • Subcutaneous Methotraxate – Proposal paper completed end of August. • Dexamethoso – savings quantified, will start delivering in Q2.			• Recovery meeting scheduled for w/c 1/10/18 to understand action plan to proceed. Trust Legal team to clarify the professional indemnity implications f the outcome especially for Pharmacy and Clinician. Also need clarification that the judicial review was for starting new patients not switching existing patients. Write proposal paper to start Avastin asap in patients who fall outside NICE criteria for treatment. • Complete Joint Formulary Resource Business Case and obtain execs sign off • Dossette Boxes / MAR Chart – pilot start date to be rescheduled , and funding agreed. • Aseptic Service – develop proposal paper for submission to NHSE • Ethernacept – quantify savings • Outsourcing - evaluate data for financial baseline model, had meetings with interested parties, 1st steering group meeting booked for 18th Oct.

DESCRIPTION	MILESTONE ACTUAL	DELIVERY RAG		ACTIONS FOR NEXT REPORTING PERIOD
		LAST MONTH	THIS MONTH	
AIC Diagnostics	**Pathology** AIC – Agreement with local LFT team to add pop up box to Sunquest ICE to control requests, list of questions developed and advise document completed. STP - SOC (Strategic Outline Case) currently being developed, long list of options have been drawn up and are being looked at. Sendaways – delivery of CIP target £18K still on track			**Pathology** - •LFT guidance- obtain clinical lead sign off •Sodium – Update Guidance •Faecal Calprotectin – update pathway to include NICE Guidance and send out Comms •Immunology – add all agreed adjustments on Sunquest ICE •FIT Testing – Commence Service Evaluation. •SOC – complete, evaluate and score available options. •Rearrange contract meeting with Viapath
	Radiology - Tender (MRI) – Business Case still in progress.			**Radiology** – •Internal demand - meeting with A&E consultants to be rescheduled due to cancellation from A&E. •MRI Tender – Evaluate Financial Benefit •Obstetric scanning - evaluate the legal impact of GDPR, Review patient letters . •CCG Demand – Complete NG12 uptake audit. •Obtain direct access data for Ultrasound, Guided injections, Virtual Colonoscopies and Specialised Referrals. •Paperless Report – meet with CCG on 09/10/2018 to discuss ongoing issues and mitigations.
Directorate Led Schemes	DNA Screen to reduce anti D injection – Business Case Commenced, Patient Pathway Completed.			• Quantify Financial Benefit and complete Business Case • Complete and sign off QIA
Non Recurrent Savings / Financial Mitigation Schemes				
Release Trust Contingency Reserve and Restrict Pay Investment	£1.9 m of reserve already in use YTD, in line to forecast			Hold money until the need arises for use. (£3.8m left).
Assest Sales	**Springwood -** Tenders received and being evaluated. **High Street** •Marketing commenced •Site visits have been undertaken with potential bidders.			**Springwood -** Recommendation of preferred bidder to Trust Board on 25 October 2018, in accordance with programme. **High Street -** Conclude marketing and receive bids, in accordance with programme.
West Kent CCG Income	WKCCG & MTW met with NHSE regional team in June.			Prepare a three way paper (CCG/MTW/KCHFT) that will set out a case for accessing.

KEY ISSUES/RISKS TO FINANCIAL PERFORMANCE

DESCRIPTION	MITIGATION	DATE REC	LAST MONTH	THIS MONTH
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 taken.	03/18		
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.	06/18		
Outcome of judicial process in September 2018 went in in favour of CCGs involved, but there may be other factors that may prevent / delay the implementation of Avastin and any planned savings.	Await MHRA national advice around medicines law which is expected within the next few weeks, this will determine the next steps to take. Also Trust Legal team to clarify the professional indemnity implications of the outcomes especially for Pharmacy and clinicians.	10/18		
Application for drawn down of CCG surplus is not supported by NHSE - £3.6m	Explore other funding sources that could provide a non-recurrent benefit – Education and Training, Research and Development, etc.	07/18		
50/50 gain share of High Cost Drug may not be supported by NHSE		07/18		

CRITICAL PATH MILESTONES (next 4 weeks)

Task	Milestone Date	Status	RAG Last Month	RAG This month
Complete Business Case for TWLED	10/18	On Track		
Conclude commercial and legal documents for Renal Unit land rent	10/18	On Track		
Commence proposal paper to start Avastin	10/18	On Track		
Complete Joint Formulary Business Case and obtain execs sign off.	10/18	On Track		
Develop proposal paper for Aseptic Service for submission to NHSE	10/18	On Track		
Quantify Ethernacept savings	10/18	Delayed but mitigated		
Obtain clinical lead sign off of LFT guidance	10/18	On Track		
Commence Service Evaluation for FIT Testing	04/19			

KPIS	Target	LAST MONTH	THIS MONTH
Number of tenders completed each month	13	8	9
National metrics - % of spend under a catalogue	80	98	96.8
% of spend under a purchase order	80	87	75.5

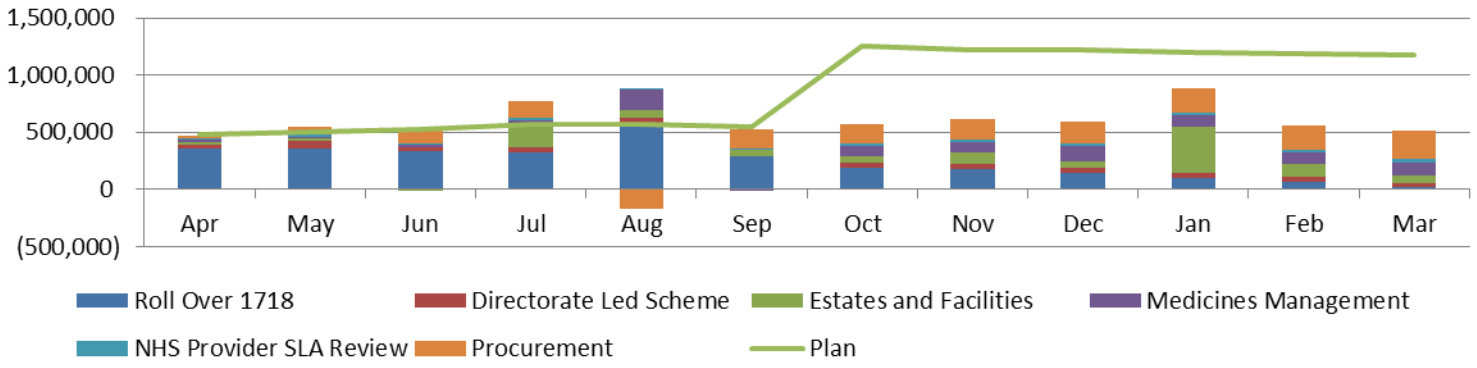
Finance Narrative

Q2 Overview
Plan - £1.7m
Delivered - £2.1m
Programme overachieved by £400K

YTD Overview
Plan - £3.6m
Delivered - £3.2m
Variance - £426K

Annual Plan
Plan - £10.5m
Forecast - £7.2m
Shortfall - £3.2m

Main areas of shortfall of the overall plan include E&F £1.4m, Procurement £968K, and Medicines Management £970K.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Directorate Led Scheme
Estates and Facilities
Medicines Management
NHS Provider SLA Review
Procurement
Plan

Maidstone and Tunbridge Wells NHS Trust

2b. 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	October 2018
WORKSTREAM LEAD	Simon Hart/Tracey Karlsson	PMO SUPPORT	Kathryn Brown/Steph Pearson

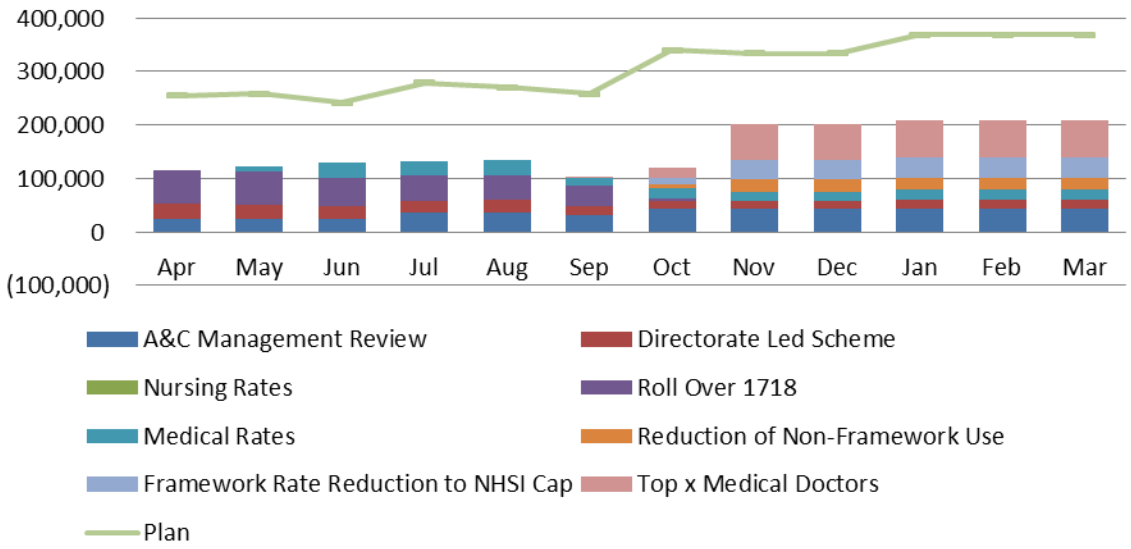
Project	Actions/Milestones completed	DELIVERY RAG		Actions for next reporting period
		LAST MONTH	THIS MONTH	
Temporary Staffing Controls Group	• Paul Sigston confirmed as Medical Lead for Best Workforce. • Medical Led Authorisation Group established - first meeting scheduled 17/10/18. • Locum Radiology Consultant rates reduced further, now under £100 per hour. • Two Ophthalmology Locums converting from agency to bank with significantly reduced rates. • Approximately 18 Locums identified by GMs to move from agency to bank in the next 6 weeks – by 16/11/18. • Further Nurse Agency Rate reduction from 10/09/18. Positive feedback from CNMT. • STP new Contracts go-live on 5/11/18. • Grow Our Bank proposal including revised bank rates shared with CD's on 3/10/18. Rates viewed too low in order to ensure safe fill rates. • Urgent Care have now changed processes to significantly reduce retrospective bookings.			• Medical Led Authorisation Group to make the final decision on any agency locums not accepting personalised plans. • 18 agency locums identified to be recruited to bank by 16/11/18. • Grow Our Bank proposal now to involve a multistep approach and to be determined with CDs input . First step is to move agency locums to bank without fee. Longer term plan needed on stepping down all rates across STP. • New approach for Best Workforce delivery to be submitted to Best Workforce Board on 16/10/18 with stakeholder engagement undertaken prior to Board. • CNMT bank enhancement recommendation that from 22nd October 2018, the nurse bank rate be uplifted to re instate the 20% enhancement for all bank staff including bands 2- 7 in A&E, SCBU, ITU, Theatres, Paediatrics and nurses delivering chemotherapy and that any seasonal enhancements will not apply to these areas. This will be monitored and reviewed.

New Roles and Apprentice-ships	• As at 30 Sep, 80 apprenticeships enrolled for 2018. An increase of 27% since July 18.
	• Procurement for Level 2 Healthcare Science completed and meeting arranged with pathology for next steps.
	• Leads appointed and teams for key roles across the Trust:
	  ◦ Physician Associate/Assistant (Peter Martin and Chris White)
	  ◦ Medical Training Initiative Fellow (Anand Rajeskaran)
	  ◦ Advanced Clinical Practitioner/Nurse Specialist (Gemma Craig)
	  ◦ Nursing Associate (Pam Bridger)
	  ◦ Apprenticeship Administrator B0-B3 pathway (Kym Sullivan)
	• 3 Physician Associates now started.
	• Corporate Back Office engagement session held on 7 September.
				• Working Groups to be established for each role. Priorities over the next 6 months will be benchmarking, completing case studies, defining career pathways, establishing governance structures, establishing support networks, providing templates for business cases and job descriptions, support recruitment of roles.
				• Potentially 5 more Physician Associates due to start subject to exam results. A further 2 more out for advert – Haematology and Paediatrics.
				• Determine KPI for spread across MTW of new roles and apprenticeships.

Directorate CIPs	• Deep Dive review of Vacancy Removal undertaken and initial report submitted to COB, PM,SH and SON on 25/09/18. • Detailed review of all CIPs. Identified need for finance to undertake validation activity across directorates in order to avoid double count.			• Finalise and distribute Deep Dive review of Vacancy Removal report • Medical Led Authorisation Group to identify further CIP opportunities for stretch target. • Finance to undertake validation activity to avoid double count and identify further potential non-recurrent CIPs.
Workforce Productivity	• Senior nurses working with finance team to prepare updated 'in-budget' roster templates . Julie Knowles to meet with Gemma Paling 09/10/18 to progress. • Rostering performance reports updated to include prospective as well as retrospective. • Improvement identified as the requirement for rostering team to finalise shifts prior to payroll deadline has decreased from 40.72% in 06/18 to 27.23% in 09/18. • Phase 2 rollout of Allocate on target for completion by 30/11/18.			• Performance focus: Hours Balances/Roster Approval and Finalisation (Nursing). • Changes to finalisation processes postponed by Executive Lead whilst monitoring impact of system enhancements. • Draft business case to be completed for single rostering. • Roster challenge meetings to commence with matrons. • Complete roster performance training to matrons by 05/12/18.
Recruitment	Further meeting took place with Clearmedi on 02/10/18 to progress sourcing nurses and MTI fellows from India. Medical Recruitment task and finish group met on 29/09/18, with priorities agreed: • Produce a standard advert and letter from medical director/CD with standard items that can then be embellished for specialities • Professional electronic glossy brochure and video to be produced . • Engagement with new recruits to understand why they chose to work at MTW.			• PMO to identify improvement opportunities as a result of recruiting 18 locums from agency to bank. • High level review of end to end process, actions required and gap analysis to be produced. • Workshop to determine joined up recruitment marketing approach. • Clearmedi to provide proposal to enable pilot for 10 nursing staff to commence.

KEY ISSUES/RISKS TO FINANCIAL PERFORMANCE

DESCRIPTION	MITIGATION	DATE REC	LAST MONTH	THIS MONTH
ISSUE - £341k saving target for Q1 was not achieved. This has put at risk the £2m of identified STP savings. Personalised plans to mitigate the original unachieved savings may not deliver additional savings.	Medical Led Authorisation Group established with first meeting to be held on 17 Oct. Group to make decisions on any agency locums not accepting personalised plans and to identify further savings.	May-18		
ISSUE - Agencies are not providing quality CVs at a reduced rate.	Medical Led Authorisation Group ToR to include agency challenge.	Aug-18		
ISSUE – Transparent and robust information not available on medical vacancies/gaps due to multiple rostering systems and approaches.	Business case to be completed for single rostering system by 30/11/18. PMO launched recruitment project with full review of medical recruitment activity, roles, responsibilities and timelines, identifying quick wins.	Oct-18		
RISK – If bank rates were to be reduced to align to STP Q2 rates, directorates including ED, H&N, Paeds, Obs & Gynae will have difficulty ensuring safe fill rates.	Grow Our Bank recommended proposal now to involve a multistep approach that is to be determined with CDs input. First step is to move agency locums to bank without fee. Longer term plan needed on stepping down all rates across STP.	Oct-18		
RISK - Potential for apprenticeships levy not to be used. Spend for 03/18-04/19 is projected to be £153K. Current funds in digital account - £1.358m. If further apprenticeships not added we start losing funds from July 2019 at a loss of approximately £60K per month.	Apprenticeships continue to be promoted through engagement sessions. Five trust-wide roles identified for focus with four involving apprenticeships. A number of training courses are not available until Sep 19, which impacts ability to draw down on the levy. Pressure is being placed on government to extend period for when funds may be lost.	Apr-18		



KPIS	Target	LAST MONTH	THIS MONTH
Public Sector Target for workforce on Apprenticeships Apr 18 to Mar 19	2.30%	-	0.78%
Medical			
Medical Shifts Requested		2,133	2,166
Percentage of Medical agency shifts over STP break glass rates	0%	98.0%	94.8%
Percentage of Medical shifts requested more than 6 weeks in advance	> 80%	9.6%	6.1%
Percentage of Medical shifts requested Retrospectively	< 5%	56.5%	25.5%
% Medical Shifts covered by bank staff	> 70%	46.7%	43.5%
% Medical Shifts covered by Framework agency staff	< 24%	41.6%	38.3%
% Medical Shifts covered by Non-Framework agency staff	< 1%	0.0%	1.0%
% Medical Shifts Unfilled	< 5%	9.9%	17.3%
Nursing			
Nursing Shifts Requested		5,872	5,699
Percentage of Nursing agency shifts over NHSI Caps	0%	43.6%	37.5%
Percentage of Nursing shifts requested more than 6 weeks in advance	> 80%	27.2%	30.7%
Percentage of Nursing shifts requested Retrospectively	< 5%	9.0%	6.3%
% Nursing Shifts covered by bank staff	> 70%	43.0%	42.5%
% Nursing Shifts covered by Framework agency staff	< 24%	35.2%	33.7%
% Nursing Shifts covered by Non-Framework agency staff	< 1%	3.0%	3.5%
% Nursing Shifts Unfilled	< 5%	18.9%	20.3%
Average roster performance score for ALL nursing areas	85%	68.88%	71.10%

FINANCE NARRATIVE

Year to Date

The Best Workforce achievement to date is £738k against a plan of £1.6m. The shortfall of £849k is largely within the STP Medical rate CIP underachievement (£682k).

The key achieving CIP in Months 1 – 6 are the 2017/18 Roll Over schemes reporting 42% of the workstream.

Forecast Position

The Best Workforce schemes are forecasting a year end achievement of £1.9m against the target of £3.7m and therefore forecasting a year end shortfall of £1.8m.

Maidstone and Tunbridge Wells NHS Trust

2c. 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:

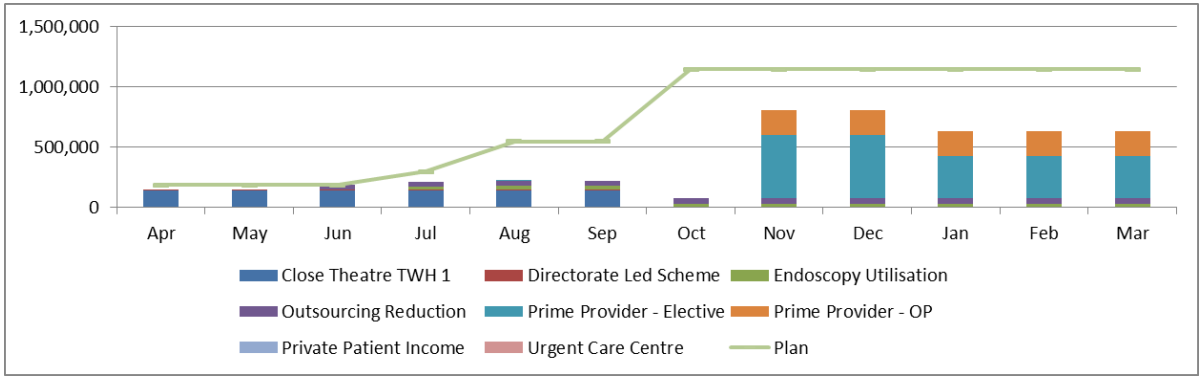
- **Non-elective**
- **Theatre Productivity**
- **Outpatients Productivity and Transformation**
- **CAU Effectiveness**
- **Private Patients**
- **Repatriation of Services**

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

DESCRIPTION	ACTIONS / MILETONES COMPLETED	DELIVERY RAG		ACTIONS FOR NEXT REPORTING PERIOD
		LAST MONTH	THIS MONTH	
Frailty at TWH and AIC Frailty	All scripts frailty flag training completed for Frailty units. JPMO collaborative well attended 24/9 with key work streams identified going forwards: "Finding out" Proactive pathway including pharmacy subgroup, "Living with, planning for" Interface geriatrics and "Towards the end" end of life support. Patients being directly referred to community MDMs Paper audit of MAFU attendances completed highlighting issues with medical patients escalating into MAFU beds reducing physical and virtual space for frailty assessments. Formal role and objectives of frailty nurse specialist in place			Dates in place for Frailty flag Allscripts training for ward clerks trust wide throughout October. Option to attach CGA to CPMS to allow GPs to view not possible. Community version of CGA pared down compared to trust version and therefore not workable. Information being worked through via Michael Beckett to ?create new CGA or attachment add-on (at cost) meeting 22/10 to create plan. AIC next steps include putting revolving patient pathways into place, governance structure, deliverables and workforce. Frailty nurse visit to DVH arranged 9/10. MAFU audit info highlighted to BI, Pas, procurement to understand if MAFU can be coded as a clinic and whether this has funding implications/whether additional virtual space can be created on Allscripts. Initial conversations with SECAMB to accept direct referrals plus GP referrals direct to frailty rather than AMU
Out of Hospital Capacity:	CHC FT: Internal standard of 48 hours processing being maintained – LOS for FT has reduced from13.44 to 11.9 @ Maidstone and 15.91 to 11.9 @ TWH Super stranded SOP in place at both sites. Regular contact with ECIST to review data. Review of super stranded patients discussed twice weekly and daily DTOC sign off. Discharge plan project started- to audit if discharge plan in place and date MFFD. New projects (Frailty health and housing, Resp and #NOF out of hospital pathways) governance in place and work beginning in conjunction with WKCHFT.			Plan to meet with CHC and Rapid Response on 11/10 to see if Maidstone pathway for FT POC can be changed to utilise Rapid Response. Discharge plan project to present at steering group 23/10 with potential solutions to improve patient flow. Trust and WKCHFT meeting to discuss new project pathways w/c 15/10 and development of new schemes Develop Virtual Ward project with KCHFT
Length of Stay Increased number of 0 LOS	48.31% of beds currently occupied by patients with LOS >7 days. Previous 6 week average 47.74% 286 patients currently with LOS >7 days. Previous 6 weeks average 303. 6 weeks of Specialist Medicine CUR data is now showing that the key diagnostics to focus on are MRI and CT. Specialty level LOS Dashboards are in place and available to all ward managers and matrons to review daily. Weekly flow reports in place [an example here from TWH CCU] monitors the success of the day before actions in order to keep patients moving throughout their journey			Inaccuracies in data still being presented on some dashboards which is being focused on by one matron and BI team to support ward staff. Each ward is still finding it a challenge to get the number of patients needed to the discharge lounge each day to maintain flow. Focused work with matrons and ward mangers to understand challenges. Attend ECIST workshop on Stranded Patients Agree PARIS plan with Divisional team to construct early interventions plan with key stakeholders. Development of CUR daily delays on Smarties to allow visibility and increase flow White card Roll out to MAIDSTONE wards by end of October
AEC	Ambulatory exclusion criteria in place for medical patients New policy written for EDP to improve access to ordering Radiology Meeting with Paeds Matron to formalise pathways Additional GP funding discussed at A&E Delivery Board, no agreement for additional funding currently. Consider realigning existing funds if more patients could be streamed to the GP in ED service. More discussion around the provision of the UTC is required and consideration to work more closely with IC24 to enable streaming GP suitable patients to the OoH GP service			AEC Surgical and T&O pathways to be formalised ENP to establish links with HTS to support ambulatory pathways Triage nurses to be supported by PDNs to improve streaming to AEC. Radiology ordering pilot Development of project with KCHFT to provide capacity for planned ambulatory-meeting 11/10 to view potential site at Tonbridge Cottage Hospital
Therapies	Agreement given to recruit to some specific temporary posts, pending substantive appointments. Escalation plans for improved integration of UCTT and Inpatient teams in Draft . AHP supporting patient flow 90 day project entering final phase-Mercer ward Project reporting therapy plan in place and discharge completed on day patient declared MFFD. Earlier OT involvement audit completed, evidence indicates input asap as improves outcomes and flow. Internal professional standards developed: Urgent – same day within 1-2 hours of normal working hours Routine – with 24 hours of normal working day Ward equipment reviewed and matched with community equipment scope. Project achieving 80% of patients return to previous residence			Therapies acceptance criteria-Further focused work will be taken over the next 1-2 months in collaboration with the Chief Nurse and ADN's Therapy representation at boardround audit results and action plan in place. AHP finalisation of project report and recommendations (+ business case) Communication with Discharge Manager regarding delays in Home First Pathways 1, 2 and 3 Explore possibility of reintroducing "Home to Decide" with the Home First Pathway 1 model
Non-Elective Surgical LOS	- Collaborative working with radiology to fully utilise the MRCP morning slots. - Virtual ward assessments – tick box embedded in to CUR system to identify potential virtual ward patients. - Followed ECIP advice re: red: green days, having a positive impact on board rounds and overall discharges. - Implemented local changes, including collaborative working, in order to address issues causing delays. - Purchased some Sara Stedys (mobilisation equipment) with assistance from the LOF which means the equipment is standardised across MTW and the community. - Completed audit on enhanced care pathways for TKR and THRs and gained agreement to implement 0 stand days onto Ward 30.			- Fine-tuning hot chole pathway including job planning. - Continue nurse endoscopy training programme. - Nurse Led Discharge the teams are linking in with the corporate nursing team project for a more robust embedment. - Further review of BADS data for possible improvements to patient pathways. - Continue enhanced care pathways for TKR/THR patients on Ward 30 – commenced Sept 18. - Implement virtual ward as directed by the virtual ward project group. - Continue with red:green days to identify root causes of discharge delays
Increase in private activity	- EGAU patients now moved to ward 33, the new PPU have been decorated and furniture/equipment moved down. - Business manager post appointed to, awaiting start date. - Communication of the new service has gone out to all consultants from Peter Maskell. - Use of the day unit has now commenced for POA and OPAs.			- Appoint nursing staff in order to commence day case activity - Finalise move including pharmacy and basic stock. - Hold an open day for consultants to visit the unit. - Identify feasibility of a kitchenette in the current cleaning cupboard. - Identify the ventilation levels in the ultrasound room to consider differing treatments that can be undertaken.
Prime Provider	- Formulation of an executive steering group with agreed TOR and reporting T&FGs. - Draft of operational policy completed with a view for a final draft to be finalise w/c 8.10.18 - Evaluation of the outsourcing tender bids completed with executive summary drafted and submitted for approval. - Assessment of the admitting criteria completed. - Completed and approved job description for the prime provider general manager. - Prime provider patient tracker starting work on Monday. - Appointment of two admin bookers plus interviews Monday for typists supporting existing CAUs . - Medical records staff in post.			- Clarify quality measures for outsourcing in relation to concerns raised at the steering group. - Consultant job plans to be assessed in line with the operational policy. - Hold working groups to finalise operational plans and financial mitigations. - Financial modelling of 'lot 2' - Development of an electronic patient tracker. - Undertake deep dives into N:FU and RATC impact and include within the operational plan. - Prepare for patients to be outsourced on 1st November. - Recruit for prime provider general manager. - Identify estates location for business unit.
Operational Productivity	- POA processes adapted to avoid unnecessary POA appointments. Being piloted in urology. - 2-way SMS text service has now gone live. - Review of the voice recognition business case in lightof potential STP funding. - Admissions lounge TWH processes adapted slightly - having a positive impact on starting times. - A number of local issues regarding theatre start times have been resolved including using a support worker to escort patients. - Theatre list sign offs have been brought forwards having a positive impact on theatre turnaround times.	Th OP	Th OP	- Phase 2 text messaging service (non-allscripts/ I/Ps) - Approval of the GRS business case - Approval of the voice recognition business case - Roll out a 6-week rolling meeting looking at outpatient and theatre scheduling. - MOU theatre utilisation group to focus on reducing cancellations. - Continue to work through a method to take ophthalmology cases out of short stay theatres in order to further release dedicated capacity over winter for other elective cases.
Outpatient Trans-formation	• UGI CNS has increased from 6 patients to 12. The impact is not yet being shown due to volume of 2WW referrals. • Due to success for MSK pain validation exercise for triaging follow up to community. • Respiratory: Dr Mankragod had 10 patients on telephone clinic with 9 patients discharged. Respiratory telephone triage to run fortnightly with positive feedback from patients. • ERS ASI rate reduction recovery plan completed (4.6%) • Ophthalmology Failsafe officer employed from bank and working on validation of waiting list.			• Review of Breast triage for under 25s due to demand on radiology • Obtain engagement and support from Workforce to progress smartcard roll out escalated to HR Director • To look at commencement date for LGI triage pathway. • To scope further developments for respiratory. • To scope the use of skype within directorates. • Work with directorates to develop the benefit summary to validate service and financial benefits.

KEY ISSUES/RISKS TO FINANCIAL PERFORMANCE: DESCRIPTION	MITIGATION	DATE REC	LAST MONTH	THIS MONTH
There is a risk that the best flow £9.4 Million will not be delivered.. 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.	Expression of Interest shown regarding PIN release from CCG. Capability statement completed, approved by COO and submitted. Executive leads expect to receive feedback from WKCCG to then advise on the timeline for next steps	9/3/18		
The ability to further reduce LOS by on average of 0.5 days, 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 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 speedily access the skilled staffing resource required to support new initiatives either due to funding or recruitment difficulties (shortage of skilled staff) at the pace required. Risk is further exacerbated that without approval for full Frailty and AEC services , LOS unlikely to be maintained or driven lower.	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		
Releasing internal capacity to undertake additional Prime provider work.	Operational Productivity project underway. Theatre trans. Manager in post. Outpatient/CAU trans. Managers to commence Oct/Nov.	08/10/18		

KPIS	Target	LAST MONTH	THIS MONTH
NE LOS Medical	7.6	7.7	7.3
NE LOS Surgery	5.5	5.4	5.2
NE LOS T&O	10.3	10.9	10.5
Achieve or exceed DTOC target (%) ***Estimate only as actual figure not yet available. The counting methodology has changed which means the new & old figures are not entirely comparable.**	3.5	4.9%	5.9%*
Theatre Utilisation for Prime Provider (%) Step up KPI to 100 opportunity (95%) utilisation	95	80	82 T&O = 89
Outpatients DNA Target (new)	5%	Aug: 6.1%	Not received



Critical Path Milestones	Milestone Date	Status	RAG Last month	RAG This month
ID Frail patients from ED onwards	30/06/2018	75%		
Frailty business case to be approved	30/7/18	20%		
Cross site agreement on increased ambulatory pathways	03/09/18	60%		
Rollout of Red and Green days within CUR	31/08/18	60%		
Commence PP additional activity in EGAU	15/08/2018	0% PPU acquired		
Award of CCG tender for prime provider	31/08/2018	50%		
Achieve 100% opportunity (c. 95% utilisation) within theatres creating capacity for prime provider (stepped increase)	01/10/2018	w/c 24.09.18: 82% all specialities. T&O 89%		
Receive income from Prime Provider (primarily from outsourcing) in August 2018	01/08/2018	0		

FINANCE NARRATIVE

The Patient Flow programme after 6 months is currently £0.8m adverse to plan and is forecasting to be £4.1m adverse to plan at the year end. The main schemes forecasting a slippage to plan are:

Prime Provider (£2.3m), Private Patient Income (£1m), Urgent Care Centre (£0.4m) and Endoscopy activity (£0.2m)

2. Workstream Summary

Maidstone and Tunbridge Wells NHS Trust

2d.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	October 18
WORKSTREAM LEAD	Gemma Craig	PMO SUPPORT	Vince Roose /Hannah Pearson

PROJECT	MILESTONE ACTUAL	DELIVERY RAG		FORWARD VIEW: KEY MILESTONES TO TAKE PLACE IN THE NEXT 4 WEEKS
		LAST MONTH	THIS MONTH	
Complex Needs	**Dementia** • Dementia firmed as a multi agency, whole system AIC focus at workshop on 24 September – all work and project support to be channelled through multi agency project. • Ongoing audit of patients admitted from Nursing and Residential Homes to ascertain any frequent admissions. • Proposal for nurse-led clinic presented at September Best Quality Board. • Project is amber as there is no concrete plan	A	A	**Dementia** • Planned 'show and tell' event with whole system providers to map and quantify current service offering. • West Kent Dementia SIG hosting clinical mapping event on 19 October • Ascertain next steps for Nurse-led Clinic. • 2nd Emergency Services round table meeting 29/10/18.
	Transition • Project is amber due to minor delays in recruitment of Transition Coordinator post– post needing to be grade evaluated before recruitment. • Business case for care of 16 & 17 years olds with diabetes within paediatrics rather than transferring to adult services (tariff available for care within paediatrics) in development. Work with Adult Diabetes services underway to identify feasibility and potential benefits –quality and financial. • Level 3 Safeguarding Training has been delivered to 30 members of the adult staffing team, including the majority of Site Practitioners meaning there should always be someone on site to support with giving level 3 care.	G	A	**Transition** • Transition Coordinator post to be advertised and shortlisted. • Level 3 Safeguarding Training continue to be delivered • Policy for care of 16&17 year olds on adults wards drafted • Ramping up of awareness raising and relationship development with adult wards
Experience and Engagement	**PPEE** • 54 patients and vol sector partners recruited to MTW Patient Network • Maidstone Engagement Event with patients and vol sector reps held on 5 October. Insight gathered about what matters to patients. Agreement to 2nd co design event. • Preparations for TW event on 12 October complete. Workshop attendees confirmed.	G	G	**PPEE** • Planned engagement and listening events with patients and vol sector partners taking place on 12th October at Tunbridge Wells • Outreach to hard to reach groups to gather insight about experience of care and priorities for improvement • Analysis and write up of insight gathered from events • Preparation for 2nd co design events in November
	Staff Experience and Engagement • Staff Engagement crowdfixing events held and insight gathered. • Facilitators for events identified and in place. Plan for reaching out to staff in workplaces agreed as way of hearing greater numbers and range of staff voice.	G	G	**Staff Experience and Engagement** • Outreach engagement of staff in workplaces takes place on 1st and 6th November at Maidstone and TWH. • Plans for other engagement outreach at other sites and dates agreed. • Bullying & Harassment Awareness sessions to be produced • Bullying & Harassment poster campaign to be produced • Medical Engagement to be reviewed and updated • LiA pulse check action plans to be created

Quality Improvement	**Quality Improvement Committee** • Continuing oversight of progress in responding to CQC report and ongoing management of relationship with CQC. • Internal Quality Assurance visits providing insight about quality performance and feeding QIC workplan and priorities			• Continuing oversight of progress in responding to CQC report and ongoing management of relationship with CQC. • Internal Quality Assurance visits providing insight about quality performance and feeding QIC workplan and priorities
Effectiveness and Excellence	**Maternity Safer Births / CNST** • NHS Resolution rebated 908k to MTW with prospect of additional amount following completion of appeals. • Maintenance of performance management against 10 safe births criteria			**Maternity Safer Births / CNST** • Extended October BQ Board discussion about performance against existing criteria and proposed new stretch scheme – actions required re risk, management, reporting, support • Maintenance of performance management against 10 safe births criteria - awaiting information from NHSR about new maternity incentive scheme
	Crowborough • Building works tenders returned. Lowest tender considerably in excess of agreed allocation – urgent work underway to develop options including reduce scope of works / reduce cost of tender by closure of facility enabling easier access to site and seeking additional funds to bridge the difference. • Increased risk of delay to start date on site and planned completion. • Delivery of planned improvements to communications including stickers on notes of low risk mothers and distribution of posters, leaflets and face to face marketing in target GP practices.			**Crowborough** • Agreement of revised plan balancing value of works with available allocation. Meeting with Friends on 11 October. • Videoing of mothers and babies for use in social media campaign and editing of videos • Request for establishment of Instagram account for maternity services • Sign off of business case by J Coffey / Execs (delayed from July) • Formal freeholder approval of improvement works (delayed from August)
	CQUINS: • Monitoring of performance at BQ Board • Safety Calendar for the month of September is Sepsis- poster competition, Sepsis Study day taking place next week and staff are walking the floor to raise awareness of the importance of early diagnosis and prompt treatment within an hour of diagnosis. • Referral pathway for Risky Behaviours to be rolled out once IT issues can be resolved.			**CQUINS** • Engagement of PMO support in review of CQUINS process management. Continuing monitoring of performance at BQ Board
	#EndPJParalysis: • 56 Volunteers recruited for the initiative, plus 11 waiting to start in next month. • Ad hoc spot checks being done on wards by PDNs to gage engagement levels • Presented at Trust AGM successfully. LOF eager to be involved • Volunteers presented with cheque for £1500 – keen to use some funds to facilitate activities with volunteers • Ongoing engagement with national initiative • Donations of clothes- Tesco's and Bearsted and Thurnham WI • Signage / banners not obtained to promote the campaign – no funding			**#EndPJParalysis** • PDN's in Specialist Medicine will work with PMO and BI to identify KPIs and success measures for initiative • Spot checking to document when / where / who • Ideas to improve the identification of patients with dementia who are at risk of wandering • Meeting with PJ paralysis team & champions 1/11/18 to organise Christmas activities • Roll out in T&O – PDN contacted to arrange meeting • Discuss project at NMAHPSG to gain ideas for dementia patients and going forward with project / new ideas
	Criteria led discharge: • Registered with NHSi to take part in CLD Improvement Collaborative • Range of Project Team members now identified for Project Team			**Criteria Led Discharge** • CLD Improvement Collaborative webinar on 9th October and planning for delivery of project and participation in NHSi events to end of 2018/19. • Project Team meeting to review documentation, agree PID and commence planning and communications for pilot • Executive webinar to take place on Tuesday 9th October 2019 • First event to take place on 24th October to discuss data collection • Inaugural project group meeting to be set up
	Pressure Sores and Falls: Delivery of planned activity as per group workplans			**Pressure Sores and Falls :** Delivery of planned activity as per group workplans

WORKSTREAM	Best Quality	BEST CARE BOARD DATE	October 18
WORKSTREAM LEAD	Gemma Craig	PMO SUPPORT	Vince Roose / Hannah Pearson

KEY ISSUES/RISKS

DESCRIPTION	MITIGATION	DATE REC	LAST MONTH	THIS MONTH
16 / 17 year old's admitted to adult areas are not cared for by staff with necessary Level 3 Safeguarding Training	Daily reporting of admissions of 16 & 17 year olds to adult wards now in place. 'Safeguarding Level 3 Champions' training being delivered but encouragement and support needed for adult ward take up.	24/05/18	A	G
Lack of capacity in project team and programme management support frustrating ability to deliver project milestones	PMO support now in place but competing pressures on project leads and project team members mean some projects continue to struggle to meet planned milestones. Rescheduling of planned activity to take place where impact on patients is minimal and project outcomes can be secured.	17/04/18	A	G
Changes in midwifery leadership team and management capacity impact on ability to deliver improvements.	Clear project lead responsibility for Crowborough identified from Midwifery Management team. Project team supplemented with Midwifery Mgt Team colleagues. Continuing focus and performance management against NHSR safer births criteria. HOM started in September.	02/03/18	A	G

CRITICAL PATH MILESTONES

TASK	DATE	STATUS	RAG	
			LAST MONTH	THIS MONTH
Recruitment to Transition Lead	30/08/18	Delayed	G	A
Transition – electronic solution to locate 16/17 year olds admitted to adult wards	28/06/18	Complete	C	C
Proposal for paediatrics diabetes care for 16 &17 year olds	30/10/18	Delayed	G	A
Invitations for engagement event to be sent out	31/08/18	Complete	G	C
Engagement events to be set up off site during October & November	31/10/18	On target	G	G
Production of coproduced PPEE strategy	28/2/19	On target	G	G
Delivery of Criteria Led Discharge collaborative 30 day milestones	21/11/18	On target	NEW	G
Delivery of Criteria Led Discharge collaborative 120 day milestones	20/02/19	On target	NEW	G
NHSR submit decision on % rebate of CNST rebate (up to £908K)	30/08/18	Complete	G	C
Crowborough business case sign off	22/06/18	Delayed	G	A
Crowborough Out to Tender for works	16/07/18	Complete	G	C
Crowborough Practical Completion	21/12/18	At risk	G	A

KPIS	TARGET	LAST MONTH	THIS MONTH
Total Number of Labours commenced at Crowborough Birthing Centre	18	23	21
Number of Births at Crowborough Birthing Centre	14	20	18
Total Number of women receiving Ante Natal Care at Crowborough	200	226	213

FINANCE NARRATIVE

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

Safer Births / CNST:

NHS Resolution has confirmed achievement of all 10 safe births made rebate payment of 908k. Awaiting confirmation and payment of additional rebate from unallocated maternity incentive scheme resource. Need to maintain delivery against safer births performance criteria in preparation for 'stretch' of refreshed maternity incentive scheme – major item for extended discussion at October's Best Quality Board.

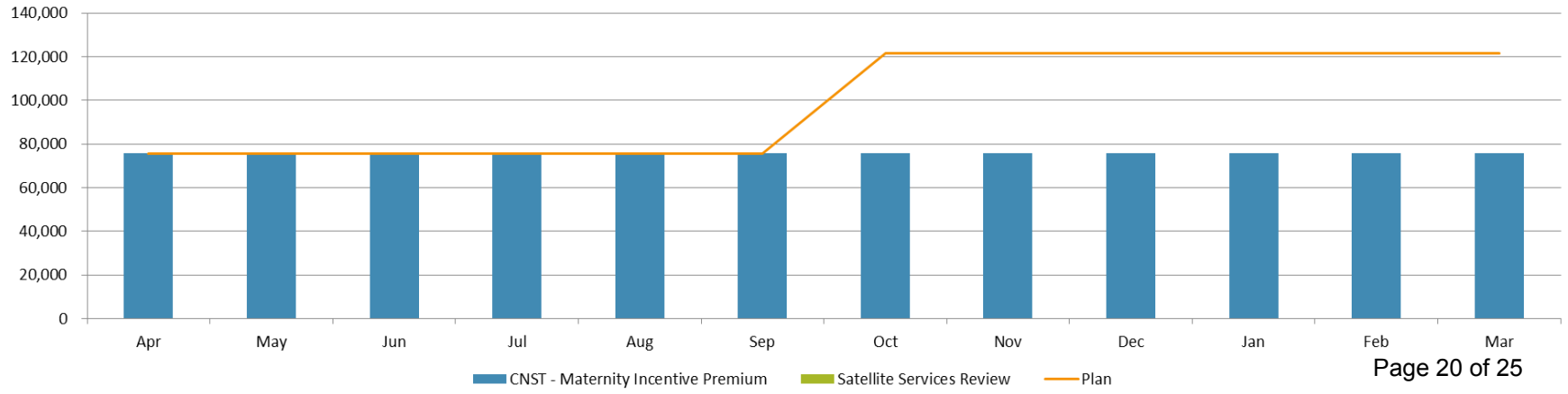
Crowborough Birthing Centre:

No change to KPI and profile of projected increases in no of births.

Women's and Children's Directorate identified a number of schemes to bridge the shortfall, schemes will be costed with W&C and finance colleagues within the 2 weeks.

FINANCES

	M1	M2	M3	M4	M5	M6 - REPORTING MONTH	M7	M8	M9	M10	M11	M12	Sum of NHSI 1819 Non Risk Adjusted Plan
CNST - Maternity Incentive Premium													
Sum of NHSI 1819 Plan	75,708	75,708	75,708	75,708	75,708	75,708	75,708	75,708	75,708	75,708	75,708	75,708	908,500
Sum of 1819 Actual / Forecast	75,708	75,708	75,708	75,708	75,708	75,708	75,708	75,708	75,708	75,708	75,708	75,708	908,500
Variance	0	0	0	0	0	0	0	0	0	0	0	0	0
Crowborough Services Review													
Sum of NHSI 1819 Plan	0	0	0	0	0	0	45,833	45,833	45,833	45,833	45,833	45,833	275,000
Sum of 1819 Actual / Forecast	0	0	0	0	0	0	0	0	0	0	0	0	0
Variance	0	0	0	0	0	0	-45,833	-45,833	-45,833	-45,833	-45,833	-45,833	-275,000



Maidstone and Tunbridge Wells NHS Trust

2e.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 worksteam is leading on seven 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	15th October 2018
WORKSTREAM LEAD	Lynne Sheridan	PMO SUPPORT	Abigail Hill (Medical Productivity/Preventing Harm and GIRFT)/Fiona Redman 7DS

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	7DS Challenge Event - 18.10.18 (With Regional Medical Director and NHSE Medical Director) The preparation for the Challenge Event is now complete and all service models have been updated with the Trust's perceived compliance status . A full pack will be sent to the external panel 3 weeks before the event to ensure that they are fully briefed before the event. The summary of each Directorate/service positon is as follows: T&O – Proposed for compliance in principle across all 4 priority standards, including job plan compliance. This is the Trust's best example of full compliance. Surgery – Further work as been undertaken with the Surgery 7DS Clinical Lead to review the position with compliance with the 2nd daily ward round. This was discussed at the September Surgical Clinical Governance meeting. The service model allows for the 2nd daily ward round and job plans will continue to be updated to reflect the specific function. Surgery is therefore being proposed for weekday only compliance in principle for standard 2, but will full compliance for the other 3 priority standards. This will be discussed with the Regional panel on 18.10.18. Urology: Will be presented for compliance in principle in the same standard profile as surgery (weekday only compliance in principle for standard 2, but will full compliance for the other 3 priority standards). The issue with respect to specialties with small volumes of medical active patients and the best use of consultant resource applies here. The outstanding issue in respect of standard 6 (issue with out of hours Interventional Radiology cover) has been discussed with the Lead Clinician and whilst the standard is compliant, some specific aspects of this will be discussed with the Panel for advice (relating to in-house cover). Women's Health – Being proposed for compliance in principle across all 4 standards, but with a discussion required for standard 2 (a supplementary paper will be included in the pack). This is with respect to the issue of specialties with small volumes of medical active patients and the best use of consultant resource which applies to a number of our services. Urgent Care – We are only able to confirm compliance in principle for standard 2. For standard 8, a full supplementary paper will be sent to the external Panel which sets out the full position and will be the topic for discussion at the event. Urgent Care have been given a longer slot in the programme due to the detail and complexity of the discussion required. ENT: We cannot yet propose ENT for compliance in principle with standards 2 & 8 as a discussion is required with the Panel with respect to the issue of specialties with small volumes of medical active patients and the best use of consultant resource. Critical Care/Clinical Haematology/Oncology/Ophthalmology/Paediatrics: All of these services have either been previously agreed as compliant for the 4 priority standards, or are exempt due to their casemix profile. Quarterly Review and Core Team Meetings The Core Team will meet on 27.9.18 to sign off the pack for the Panel. A further focussed session will be held with the Urgent Care Division on the 9th October and then PM/LS will meet with Laurence Maiden and Claire Cheshire in advance of the Challenge Event to hold a pre-meet. Following the Challenge Event, the normal cycle of Quarterly Reviews will resume.			7DS Challenge Day: - 18.10.18. Pack sent to External Panel by 3.10.18 Urgent Care to meet with PM to undertake a pre-meet for the Challenge Event. Core Team to meet on 27.9.18 to sign off all material for Challenge Event. National 7DS Survey : National Board Assurance proposals now released by NHSI. Being reviewed by internal Team and will be discussed with Panel on 18.10.18. Presentation for PM to give to Panel being drafted for Challenge Event.
Mortality	The decision has been made not to launch the FORMIC forms as the plan to resource this lacks resilience. Instead the forms will be reformatted to Word and made available for use in October as an interim measure., until suitable IT reporting system can be taken forward. The minor revisions to the Mortality Review policy were agreed at the MSG meeting on 22nd August and as there are no material changes just clarifications ,the policy will not need to be passed by the ratification committee. A request has been made to the Best Care process for some temporary band 2 support to assist with the data entry requirements that have arisen due to the lack of availability of the resource that was previously supporting this work and the increased speed of processing of mortality review forms.			Learning from deaths review group met on 11/09/2018 to review progress across all areas. Meetings have been scheduled to take place alternate months until December when it will revert to Quarterly as the Group felt progress was being made and sustained. Follow-up meeting with Datix being convened to review contract and 'free' Mortality Database and has been rescheduled to take place on the 27th September , 2018. Mortality review audit took place on the 8th August 2018, preliminary findings were positive , final report to be presented to MSG in October to discuss next steps.
Learning Lessons	As reported last month, resource has been lost to this project this month (Project Lead) due to pressure of work. Also, a key staff member is currently unavailable who is leading on Datix. At this stage, work is still on schedule but workstream is under pressure. There has been no resolution of the resource issue at this stage. Critical path is still on track. The planned workshop took place with core team plus NEDs to scope out the evidencing and embedding learning aspect of the project – 4.9.18. This is being written up and a second meeting will be arranged in late November, following group members undertaking further research. Meeting with Datix to discuss issues with software set up for 27.9.18. A meeting to review the draft of the new core Directorate Clinical Governance meeting agenda took place wihth the Core Team Lead Clinician on 26.09.18. The draft and the plan for the meeting on 10th October with the Governance Leads was discussed. It was agreed that the 10th October meeting would be in workshop-style format and the content and style of the meetings would be discussed in broader detail (in the context of learning) rather than a more closed discussion in respect of a standard agenda. It was also agreed that a proposal would be put to the CG Leads in respect of local CLIPA meetings, to feed up to the Directorate CG meetings. It was agreed that the view of the new Chiefs of Service would be imperative to the design of the CG meetings going forward and also, that the infrastructure to support the new clinically led structure needed to be understood to ensure that the CG meetings could focus on pure CG issues, rather than areas that would be more aligned to Divisional/Directorate business. LS will enquire of the planned infrastructure for the clinically –led organisation and also discuss the planned approach with PM prior to discussion with the Trust's Clinical Governance Leads on 10.10.18. Datix upgrade pending – key resource required to undertake local work is currently unavailable so delayed (awaiting outcome of 27.9.18 meeting with the Datix Area Account Manager). Roll out plan for launching Datix action planning function within incident reporting agreed for completion by 7.09.18 – overdue (but not affected critical path yet).			Wide discussion of above with CG Leads (10.10.18), following approval in principle with LL Lead Clinicians (S Flint and P Moran) and Peter Maskell. Identification of the planned meetings infrastructure for the new business units within the new clinically led structure, (to allow planning for the content of the CG meetings) Further meeting with Core team plus NEDs to progress the evidencing and embedding learning aspect of the project – (being arranged for Nov 2018) Datix upgrade (internal work) required first, to follow meeting of 27.9.18.with Datix (including Procurement management) to discuss overall contract and functionality. Roll out plan for launching Datix action planning function within incident reporting to be re-scheduled within Governance Team by WG.

WORKSTREAM	Best Safety	BEST CARE BOARD DATE	15th October 2018
WORKSTREAM LEAD	Lynne Sheridan	PMO SUPPORT	Abigail Hill (Medical Productivity/Preventing Harm and GIRFT)/Fiona Redman

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	
Preventing Harm	1. Long Elective Waits (RTT >18 weeks) The diagnostic audit is now completed. The decision of the Best Safety Board was to commence an ongoing prospective audit. The project team are working on a process to undertake this prospective ongoing audit for patients that have breached 18 weeks at the point of treatment and incurred moderate or severe harm as a result of the extended wait. It is estimated that approximately 1,500-1,700 patients per month are treated outside 18 weeks. Approximately a third have undergone elective procedure .The team are working through the points of delivery and a workable solution with the clinical teams. 2. Documentation and Record Keeping (potential project – in work-up) The project has been handed over to GC with JK's retirement. It was discussed at length how this project should be progressed and with the new EPR system scheduled for September next year, if the focus should move to supporting this instead, as a means to achieving the aims of the project. The Board discussed the limitation of notes currently – for example the difficulty in undertaking the 7DS audit and the increase in temporary notes. It was reported that a Survey Monkey is being drafted to identify the issues with documentation and record keeping and working through the LIA process. It was agreed to discuss again next month and invite Steve Williams, Michael Beckett and Di Peach to discuss EPR implementation in the context of record keeping and documentation 3. Consent : The Project has now been confirmed for transfer back to Best Safety (it was decided that Best Quality was not the right programme for this topic). Therefore, Wendy Bates has been given the role as project lead, with Wendy Glazier being responsible for updates to the Best Safety Board on a monthly basis. Reporting will commence from the November Best Safety Board onwards, but work is in progress. The plan to produce a revised Consent Policy for consultation by the end of October 2018 has slipped due to pressure of work within the Legal Team, but this has been agreed with the Programme Lead and will not cause any programme delivery issues. A fuller report will be provided in November.			Long Elective Waits: Completion of audits by Directorate Consultants then full analysis of final audit returns Action: Directorate Consultants and Pat Singleton. Develop and agree plan for implementing on going audit for patients waiting over 18 weeks. Documentation & Record Keeping: Agree how the process could link to the Electronic Patient Record process and whether LiA is appropriate for support work. This will be achieved via a focussed discussion with key leads who are invited to the October Best Safety Board. Consent: Distribution of draft Consent Policy for consultation and establishment of Consent Advisory Group.
Quality Mark	The Best Safety Board discussed the proposal to link the 'Quality Mark' to the Best Care Programme (Best Care Awards), reviewing the paper produced by Sarah Emberson . The timing of the launch of a Quality Mark for the Trust was discussed in some detail and the importance of linking this to the launch of the new Clinically Led Structure and development of the Quality Improvement framework (QSIR etc) was considered a key factor. It was agreed that the project had now reached the point where a discussion with PM and COB was required (with SM, LS, GC, SON and WG /SE in attendance) to either agree the progress of this project, to determine a different timeline for its development, or to produce an exit statement. The meeting has not been possible to establish to date due to consecutive leave of key personnel. A date is being worked on urgently.			Decision-making meeting to be held with Core Team and PM & COB asap.
GIRFT	The Trust has been taking part in GIRFT reviews for the past 18 months , however the GIRFT team have announced further reviews and the pace of will ramp up over the coming months.. We have responded by developing a management infrastructure and process similar to that used for the 7DS project. This process is currently being set up, with the first meeting of the Panel likely to take place at the end of October. The internal process and roles and responsibilities have been defined and the PMO team are working with the Directorates to update delivery plans and develop KPIs. The PMO team are developing a specific band 7 role to support the process. going forward.			Update all action plans with the clinical leads and develop KPIs, clearly identified on the directorate Single Oversight Framework.
Medical Productivity	Job planning 277 of 326 (85%) job plans are now on the e-job planning software and 41% of the required 326 job plans have been fully signed off (3 stage process). (As at 26th September 2018). This is behind schedule and is being monitored by the Medical Workforce Productivity Working Group, and has also added as a KPI to the performance template for the Directorate EPRs. The delay is now impacting on the project within the programme and requires escalating through to the Best Care Programme Board. Issues remain with SAS job plans and these are being solved with each Directorate on a case by case basis.. For SAS doctors, the 2 in LGI/UGI are now in discussion and ENT are awaiting a response from the directorate regarding on-call and will then be published. W&C are being worked on. ED still only have one consultant job plan on the system. Demand and Capacity The BI Intelligence team have designed their approach to Demand and Capacity planning this year. Dr Mumford has highlighted the need for good clinical engagement with CDs and will take this forward. The BI team are currently designing templates and will then work with the Directorates to complete these. At this point the project team will then look at conversion into PAs. Best Value WAU metrics were agreed at the Medical Productivity Working group and will now be produced monthly. Once job plans have been fully signed off at a directorate level , DCCs will be added into this . The definition of Best Value DCCs has been drafted and will be reviewed at the working group on conclusion of the job planning for each directorate. This is to enable the project team to analyse a full set of job plans at speciality level and ensure all relevant components have been included. National Project The initial project meeting is being set up with the NHSI team for the wave 2 work has been s scheduled for the 4th October. A teleconference with NHSI is planned for 27th September to prepare and discuss the format for the 4th October meeting. A further data request has been received for Model Hospital with a deadline of October and the team are starting to work on the approach to this.			Job planning Continue to support directorates in loading and signing off all job plans into the e-job planning system Set up the MJPCC and hold at least one meeting. Demand and Capacity Complete D&C templates with directorates and work on methodology to convert into PAs and personalised metrics. Best Value Agree definition of Best Value DCCs and dependant on job plan completion develop first draft of Best Value DCCs by directorate. National Project Awaiting the next instalment of work package. Complete Data request for Model Hospital This programme is considered Red due to the delay in loading and signing off all job plans. The programme has allowed for some slippage in this , however this is now impacting on completion of other aspects of the programme.

WORKSTREAM	Best Safety	**BEST CARE BOARD DATE**	15th October 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: 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.	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 review meeting to be convened (re-scheduled for 27.9.18)	14/05 /18		
Long Elective Waits Project – risks to completion due to non-compliance by consultants not having time to undertake reviews.	Audit now finished – awaiting results of SI review before paper can be released. Ongoing prospective Audit being designed.	08/03 /18		
All job plans to be added to the system and signed off by Directorate Management Teams.	Delays have been escalated via the Medical Productivity working group and final deadlines have been issued from LS. This will now be escalated to the Best Care Programme Board	17/03 /18		
Learning Lessons: Resource constraints – Project Lead and Datix Lead.	Programme Lead is covering as Project Lead with support from the Associate Director of Governance and Team were possible. Datix resource is being reviewed within the line management structure in the Governance Team.			

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	Completed		
7DS submission of paper outlining Urgent Care options for achieving standards (complex and reasons for delay understood by 7DS Project Board).	30/07/18	In progress		
7DS – Challenge Event with Regional Team (NHSI/E) 18.10.18 to confirm compliance status	18.10.18	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	08/08/18	On target		
Preventing Harm – LEW – completion of audit in order to progress with diagnostic of project (just awaiting results of SI report – otherwise report completed).	11/07/18	In progress		
AKI – Meeting arranged with senior nursing team to discuss output from task and finish group. Diagnostic work completed – now in Best Quality.	12/06/18	Completed		
Quality Mark – Further options being discussed. A paper will be drafted for Miles Scott and Peter Maskell to discuss timing and proposals (noting the Clinically Led Organisation work).	05/06/18	Delayed		
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 (second meeting).	27/09/18	On target		
Learning Lessons – internal upgrade of MTW Datix system Resource issue – key staff member availability problem	30/06/18	Delayed		
KPI's being finalised following paper to best safety workstream board. Not all KPIs can be drafted at this point as some projects are still in their diagnostic phase.	11/07/18	Delayed		
All job plans on the system and signed off by directorate management teams.	3/09/18	In progress		

	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	105.8	
	SHMI (Quarterly)	1.0	1.0219	
	% compliance with all mortality forms following a patient death (death cert, preliminary screening form, first stage mortality form and where appropriate, SJR)	95.0	76.6	
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	287	
	Number of Job plans signed off on the e-job planning software	300	151	

3a.Best Care Programme - Financial Summary

Comment

Original Plan Savings - £24.1m / Risk Adjusted - £14.8m

The Trust was £0.5m adverse to plan in the month and £1.3m adverse YTD, this is mainly due to slippage on STP Medical rate (£0.7m), Prime Provider (£0.5m), Private Patients (£0.2m), over performance of procurements schemes by £0.2m and PFI Insurance rebate of £0.2m.

Risk adjusted forecast is £9.3m adverse to plan, the main schemes forecasting slippage are:

- Estates & Facilities Subsidiary - £1.75m (reduced to £1.4m, due to £0.35m schemes added)
- Private Patients Income - £1.0m
- STP Medical Rates - £2.2m
- Medicine Management - £1.1m (Avastin - £0.7m)
- Prime Provider - £2.2m
- Urgent Care Centre - £0.4m
- Endoscopy Income - £0.2m
- Satellite Services - £0.3m
- Procurement - £0.6m
- Directorate Led Schemes - £0.5m

Trust Board meeting - October 2018

Maidstone and Tunbridge Wells NHS Trust

10-11	**Annual Report from the Director of Infection Prevention and Control (including Trust Board annual refresher training)**	**Director of Infection Prevention and Control**

The enclosed report provides a summary of infection prevention and control activity in the Trust between April 2017 and March 2018.

The Director of Infection Prevention and Control is required to produce an annual report and release it publicly as outlined in 'Winning Ways : Working Together to Reduce HCAI in England' 2003.

This report also provides a briefing and training for Board members on the key information they need to fulfil their duties with respect to infection prevention and control.

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 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

Director of Infection Prevention and Control - Annual Report to the Board 2017/18

1. Executive Summary

This report outlines the activities of the Trust relating to infection prevention and control for the financial year 2017/18 including key achievements. It describes the Trust arrangements to allow early identification of patients with infections and measures taken to reduce the spread of infections to others.

The report also provides a briefing and training for Board members on the key information they need to fulfil their duties with respect to infection prevention and control.

Prevention and control of healthcare associated infections (HCAIs) is a key priority for Maidstone and Tunbridge Wells NHS Trust which has an infection prevention and control strategy and programme of activities including national initiatives for the reduction of infection rates.

The Infection Prevention Team (IPT) advises and co-ordinates activities to prevent and control infection; however it is the responsibility of all staff in the organisation to comply with Trust policies and implement guidelines in their local area. The IPT also works closely with other stakeholders in relation to strategies for prevention of infection including NHSI, Commissioning CCGs, Public Health England and Regional Specialist Laboratories.

Infection control policy and practice have been re-examined in order to achieve consistent progress in reducing HCAI. As a Trust we aim to have no avoidable healthcare associated infections.

By the end of the year the Trust had maintained very low levels of MRSA and *C. difficile* infections.

Maidstone and Tunbridge Wells NHS Trust maintains compliance with the Health & Social Care Act 2008 (and its 2015 update). A compliance statement is available on the Trust website.

2. Our year in numbers

3. Successes

The Infection Prevention team (IPT) has had success in 2017/18, building on previous year's improvements, ensuring sustained reductions in healthcare associated infections (HCAIs) and achieving the planned reductions.

The Trust continued to sustain low levels of *C. difficile* infection. The number of cases seen was 25, two cases less than the nationally set objective achieving a rate of 9.5/100 000 bed days against a limit of 11.5/100 000.

The Trust position with respect to MRSA bacteraemia was maintained with no Trust-attributable cases seen for the year. Two cases were identified; however following the Post Infection Review process with Public Health England, both cases were assigned to a third party.

Root cause analysis (RCA) is carried out for all *C. difficile* infections, MRSA bacteraemias, methicillin sensitive *Staphylococcus aureus* (MSSA) and *E. coli* bacteraemias. The IPT has been supporting the CCGs in their RCA processes for community acquired infections.

Monitoring of infection prevention practice and performance throughout the Trust supported by triangulation audits is reported by the directorates to the Infection Prevention and Control committee (IPCC). This method of monitoring and reporting has been identified as best practice by the NHS Improvement and shared with other organisations

The infection prevention Link Nurse programme remains very active and meets on a monthly basis. An annual conference is held in September with invited speakers and is open to delegates from other healthcare organisations in Kent and Medway and East Sussex.

The Nurse Consultant in infection prevention, Sarah Fielder completed a MSc in Infection Prevention including submitting a dissertation on the justification of the use of UVC light decontamination in the Trust.

The DIPC was invited to speak at the annual 'Don't Panic!' infection control conference in September 2017 on the Trust's ten year journey from 'Zero to Hero'.

4. Structure

The Chief Nurse is the executive lead for Quality within the Trust.

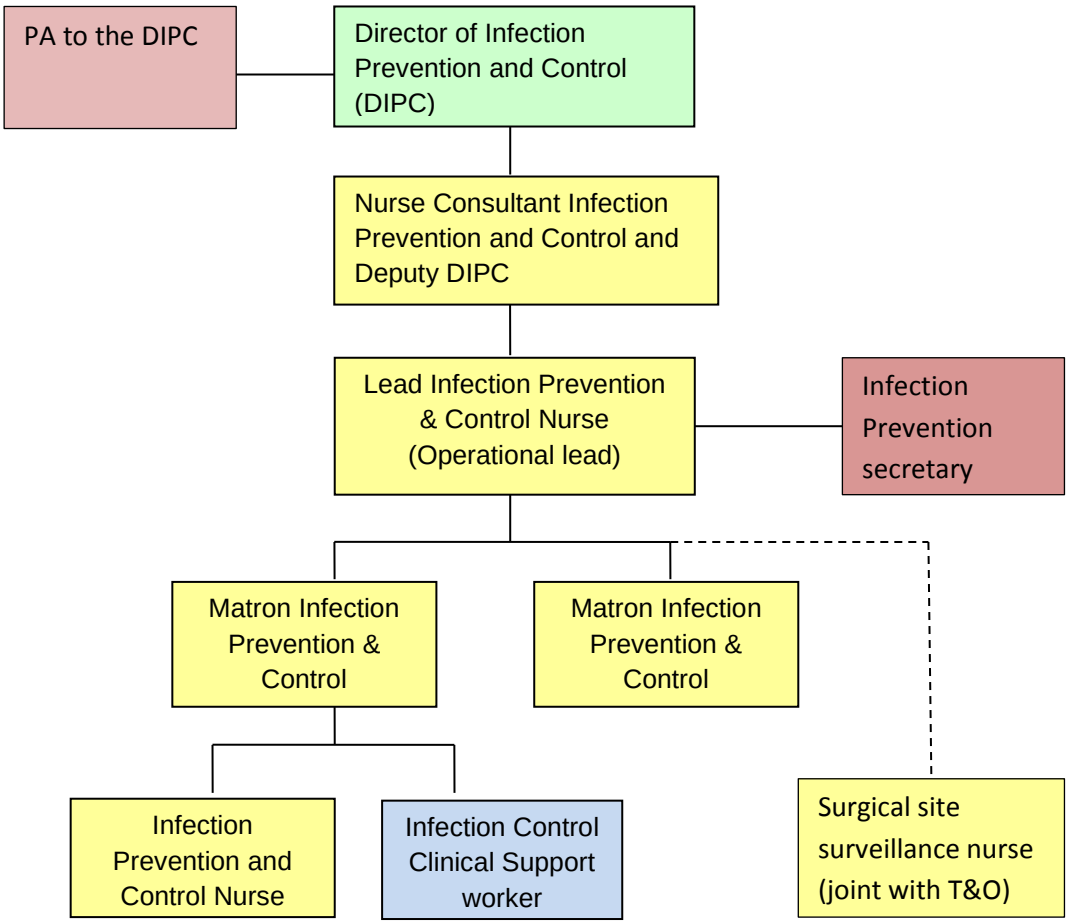
Dr Sara Mumford (consultant microbiologist) is the Director of Infection Prevention and Control (DIPC), attends the Trust Board and leads the Infection Prevention and Control strategy for the Trust, reporting to the Chief Executive Officer.
The Trust Infection Prevention and Control Committee (IPCC) is chaired by the DIPC and meets bi-monthly. The committee has wide representation from throughout the Trust and has external representation from West Kent CCG and Public Health England. The directorates report to the IPCC on all aspects of infection prevention and antimicrobial stewardship. The IPCC reports to the Trust Clinical Governance Committee and through this committee to the Quality Committee and Trust Board.

The DIPC presents a monthly report to the Trust Management Executive.

4.1. Infection Prevention and Control Team

Our mission statement: To promote a culture whereby staff, patients, visitors, volunteers and contractors safety is ensured by the promotion of excellence in all aspects of Infection Prevention and Control which is embedded throughout the organisation and trusted by our community.

Fig 1: Structure of the Infection Prevention and Control Team



Sarah Fielder, Nurse Consultant in Infection Control left the Trust in September 2017 to take up a regional post with NHSI. Lesley Smith was appointed in her place and took up her post in November 2017. Pam Howe, lead nurse retired in February 2018 and Jacqui Griffin was promoted internally to the post, starting in February 2018. Claire Bolden, infection prevention nurse, left the team in January 2018 and Charlotte Campbell joined the team in March.

4.2. Infection Prevention and Control Committee

The IPCC reports to the Trust Clinical Governance Committee and through this committee to the Quality Committee and Trust Board. The Terms of Reference are reviewed annually.

The Chief Nurse is the Executive Director member of the committee.

Monitoring of antimicrobial stewardship and infection prevention practice and performance throughout the Trust, supported by triangulation audits, is reported by the directorates to the Infection Prevention and Control committee (IPCC).

The objectives of the IPCC include:

- To advise and support the Infection Prevention and Control Team.
- To provide assurance to the Trust Clinical Governance Committee with respect to infection prevention and control structure, processes and outcomes and compliance with CQC requirements as set out in the 'Hygiene Code' (The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance).
- To inform the Trust Clinical Governance Committee in a timely manner of any serious problems or hazards relating to infection control.
- To receive reports from the Infection Prevention and Control Team.
- To monitor Healthcare Associated Infection against key performance indicators including receiving reports on compliance data from Directorate representatives.
- To discuss and approve Infection Prevention and Control policies.
- To review the annual infection control programme and audit programme.
- To ensure the implementation of national guidance, and action plans arising from Patient Safety alerts relating to Infection control
- To monitor progress against CQUIN targets related to infection control

The Infection Prevention and Control Committee has no formal sub-committees. However, the Committee receives reports specifically on infection control issues from:

- Directorate Representatives (CD or Matron) from each clinical Directorate.
- The Antimicrobial Pharmacist
- The vascular access specialist practitioner
- Occupational Health Manager
- Director of Estates & Facilities (or deputy)
- Clinical Audit
- The Risk and Compliance Manager
- Learning & Development
- *C. difficile* review panel
- Others as issues arise

Fig 2: Governance structure

The IPCC is a well-attended committee with wide participation. The structured reports delivered by the directorate representatives include ward audit results, triangulation audits provided by the infection prevention team and antimicrobial audits provided by the antimicrobial pharmacist. The reports are also used to feedback to directorate clinical governance meetings on infection prevention matters.

5. What the Board needs to know in order to fulfil its responsibilities in respect of Infection Prevention and Control

5.1. History

Infection prevention and control has been an area of focus within MTW since 2006 when the Trust suffered one of the largest *C. difficile* outbreaks in the UK which was subsequently investigated by the Healthcare Commission and described in their report: *Investigation into outbreaks of Clostridium difficile at Maidstone and Tunbridge Wells NHS Trust*, October 2007. The report estimated that 90 deaths were directly due to C. difficile and a further 241deaths had occurred where *C. difficile* had been a contributory factor.

Crucially the report identified that management systems had failed to provide patient safety and introduced the concept of board-to-ward accountability and responsibility.

The Trust's response to the report was positive and a year later the Healthcare Commission reported that there were encouraging signs of improvement. This improvement has continued and ten years on from the publication of the report, MTW is seen as a high performing Trust for Infection Prevention and Control.

The Trust Board has recognised and agreed collective responsibility for minimising the risk of infection and has delegated responsibility for the strategic and operational leadership to the Director of Infection Prevention and Control.

5.2. Key points

- All employees of the Trust have infection control responsibility detailed within their job description
- Infection prevention and patient safety remain key priorities for the Trust
- There is wide engagement with the infection prevention agenda throughout the Trust
- A challenge culture has been encouraged within the Trust to ensure that all staff comply with infection prevention policies and processes.
- A wide range of infection prevention policies and procedures have been developed and are regularly reviewed and updated
- Emphasis has been placed on the clinical environment and cleanliness. The infection prevention team works closely with the facilities management team. The Trust has been innovative in the introduction of cleaning methods such as Hydrogen Peroxide vapour (HPV) in 2007 and UV-C light in 2016. Cleaning standards are audited regularly and reported through the Trust including to the IPCC.
- *C. difficile* has been reduced to consistently low levels across the organisation.

5.3. Hygiene Code compliance

The Health Act 2008, now superseded by the Health and Social Care Act 2013, contains a Code of Practice usually referred to as the Hygiene Code. The Code was most recently updated in 2015. The 2008 Act requires acute Trusts to comply with the Code and outlines penalties for non-compliance.

The Trust declared compliance with the Hygiene Code in March 2009 and continues to remain compliant, maintaining evidence files and undertaking self-assessment of compliance on an annual basis, reporting the outcome to the IPCC.

There is a compliance statement on the Trust Website

The compliance criteria and some examples (not comprehensive) of how we comply are shown in the table below;

Table 1: Hygiene code compliance criteria (2015)

Compliance criteria		**Examples of how we comply**
1	Systems to manage and monitor the prevention and control of infection.	• Governance and reporting structure • DIPC in post - reports to CEO • Infection prevention team • IPCC ToR • Annual work programme and action plan • Mandatory training • Link nurse network • Annual IC audit programme • IC policies and procedures in place • Side room management • Board level risk register • Outbreak policy • Surveillance systems • This report
2	Provide and maintain a clean and appropriate environment in managed	• Director of Estates and Facilities reports to IPCC

Compliance criteria		Examples of how we comply
	premises that facilitates the prevention and control of infections.	• Policies for decontamination, cleaning and laundry in place including record keeping processes • Cleaning processes agreed with Infection Prevention • Cleaning audits reported to IPCC • Deep clean programme • Hand hygiene facilities, signage and audit • JAG accreditation • Commode audits • Uniform policy
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	• Antimicrobial stewardship group meets monthly • Antimicrobial prescribing policy • Antimicrobial prescribing guidelines • Antimicrobial pharmacists in post • ASG reports to IPCC • 'Start smart then focus' in place • Antimicrobial training for doctors
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.	• Range of information leaflets for patients and relatives • Regular communication with CCG HCAI lead • EDN includes MRSA status • Switchboard messages on norovirus • IC messages on internet site for visitors and patients including numbers of infections • Information for patients on antimicrobials • IC information shared with GPs on case by case basis • ICT attendance at daily site meetings
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	• Urgent microbiology results telephoned to clinicians • Isolation policy • Active side room management by ICT • Risk assessments carried out • Screening in place for MRSA, MSSA, GRE, CRE/CPE as appropriate • Diarrhoea policy • Reporting mechanism for notifiable disease to PHE in place
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	• Mandatory training for all staff and volunteers • Information provided to contractors • Temporary staff handbooks and competency • Bespoke training for certain groups

Compliance criteria		Examples of how we comply
		of staff, eg porters, domestics • Handbooks for various staff groups • Exemplars of documentation provided to wards • IC resource folders on all wards – currently being converted to electronic format • Infection control responsibility included in all job descriptions • Facing to face ward based training for new nurses
7	Provide or secure adequate isolation facilities.	• Isolation policy • Negative pressure rooms available – A&E at TWH and John Day at Maidstone • Active management of side room provision • Clear isolation signage
8	Secure adequate access to laboratory support as appropriate	• Microbiology laboratory on Maidstone site • KPIs monitored • ISO 15189 accredited • All referral labs accredited • Telepath system interfaced with ICNET
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.	• Standard infection control policy • Policies for a range individual infections • Outbreak policy • Other policies in place to meet the requirements of the Code • Audit programme in place to monitor compliance with policies • All policies available on Trust intranet site
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	• Immunisation of staff policy in place • All staff can access on site occupational health services • Influenza vaccination offered to all staff and volunteers • Risk based screening for communicable diseases and assessment of immunity • OH arrangements in place in respect of blood borne viruses

5.4. Governance and Assurance

The Board receives assurance through the governance reporting structure, shown in Fig 2, and directly from the DIPC who attends Board meetings to provide updates on infection control and new guidance relevant to the Trust.

C. difficile and MRSA bacteraemia numbers and rates are on the Board level dashboard together with MRSA screening rates.

5.5. National priorities

There are three key national priorities related to Infection Prevention and Control

- **Antimicrobial resistance** – The UK 5 year antimicrobial resistance strategy was published in 2013. This is an overarching strategy focussing activity around three strategic aims
  - To improve the knowledge and understanding of antimicrobial resistance
  - To conserve and steward the effectiveness of existing treatments
  - To stimulate the development of new antibiotics, diagnostics and novel therapies

  It lists preliminary actions for healthcare organisation, animal health organisation and the pharmaceutical industry. The actions for acute Trusts are many of the antibiotic stewardship and infection control actions that we already do plus developing an understanding of our baseline position with respect to multi-resistant organisms.

  On the back of this strategy and outbreaks in Manchester, Leeds and some of the London hospitals, Public Health England issued a patient safety alert and required Trusts to implement risk based screening for Carbapenemase-resistant organisms (CRO) by June 2014.

  Reduction of antimicrobial use was the subject of a CQUIN for 2017-18. The Trust partially met the targets and further details can be found at 7.4 in this report.

  This continues to be spoken about regularly in the media and is championed by the Chief Medical Officer who is also chair of the WHO committee on antimicrobial resistance.

- **Reducing healthcare associated gram negative blood stream infections by 50% by 2020/21.**

  This initiative was announced at the end of 2016 by the former Secretary of State, Jeremy Hunt. About 35% of these infections are related to poorly managed urinary tract infections and catheter care. The target applies across the whole healthcare economy and the infection prevention and control teams across Kent and Medway, primary and secondary care, local authorities and social care are working together to develop a strategy to reduce these infections.

  At MTW we have increased our data collection on epidemiology of these infections and active submit data to the national Public Health England database. See section 6.8.1 of this report.

- **Early recognition and treatment of Sepsis**

  This initiative is widely spoken about in the media and is the subject of a two year combined CQUIN with antimicrobial consumption (see section 7.4).

  The Trust has an active Sepsis CQUIN team who have had success in raising awareness of the need to diagnose and treat sepsis early. Achievements include:

- Sustained improvement in sepsis treatment instigated within the one hour standard
- Implementation of new screening tool in response to updated NICE guidelines and Sepsis Trust for Amber flag sepsis.
- Sepsis policy updated and ratified
- Mandatory training delivered at all mandatory updates and corporate induction days

The major challenge for the Trust in the next year is the implementation of NEWS2 by December 2018

6. Healthcare Associated Infection

6.1. Surveillance

The IPT actively participates in national surveillance schemes, submitting epidemiological data on all *C. difficile* cases, MRSA, MSSA, *E. coli, Klebsiella* and *Pseudomonas* blood stream infection patients and selected surgical site infections to Public Health England (PHE).

6.2. HCAI action plan

A new HCAI action plan was developed in April 2017 and implemented throughout the year. The plan was monitored through the IPCC and reported to the Trust Clinical Governance committee. The 2016/17 plan was completed with outstanding actions signposted to the new action plan.

Key actions include:

- Improved monitoring of IV antimicrobial usage
- Improved understanding of baseline antimicrobial resistance data
- Achievement of antimicrobial CQUIN
- Improve culture and engagement with IPC
- Reduction of MSSA bacteraemia
- Ensuring compliance with CRE/CPE screening through audit
- Ongoing compliance with NICE Quality standard for surgical site infections
- Sustaining improvement in CA-UTI incidence
- Support nursing with sanichair replacement programme
- Review of cleaning products
- Reduction of gram-negative blood stream infection
- Demonstrate shared learning from root cause analysis

6.3. *Clostridium difficile*

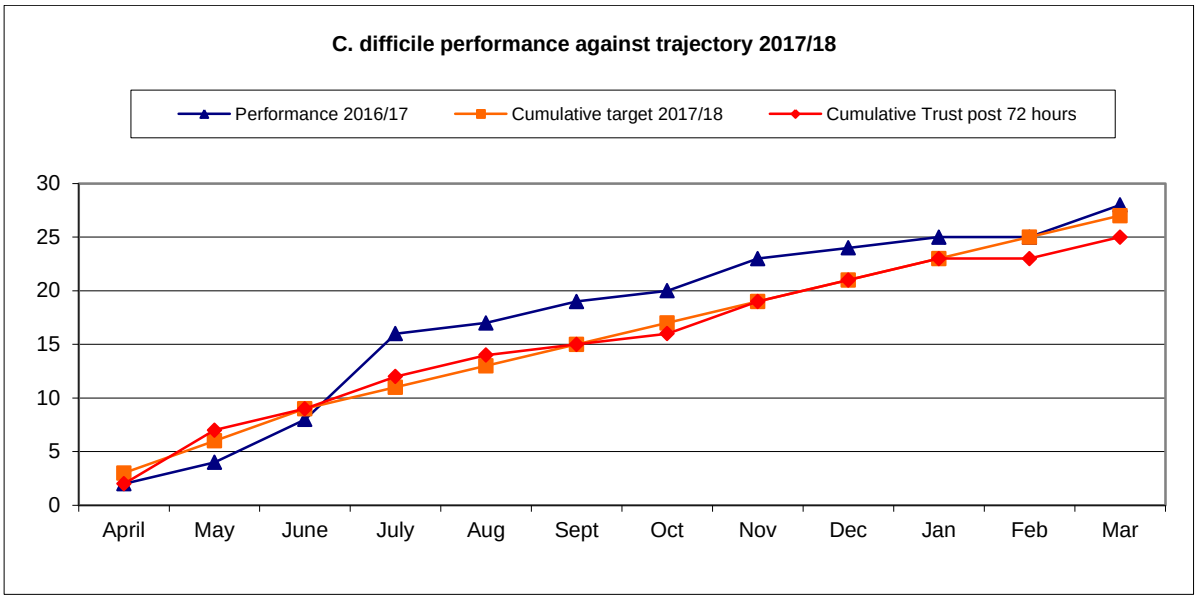
Sustaining previous improvement in *C. difficile* infection rates was one of the key objectives for the IPT throughout 2017/18

6.3.1. Rates of Infection

The Trust saw a small decrease in cases of *C. difficile* infection this year to 25 cases, a rate of 9.14 per 100 000 bed days

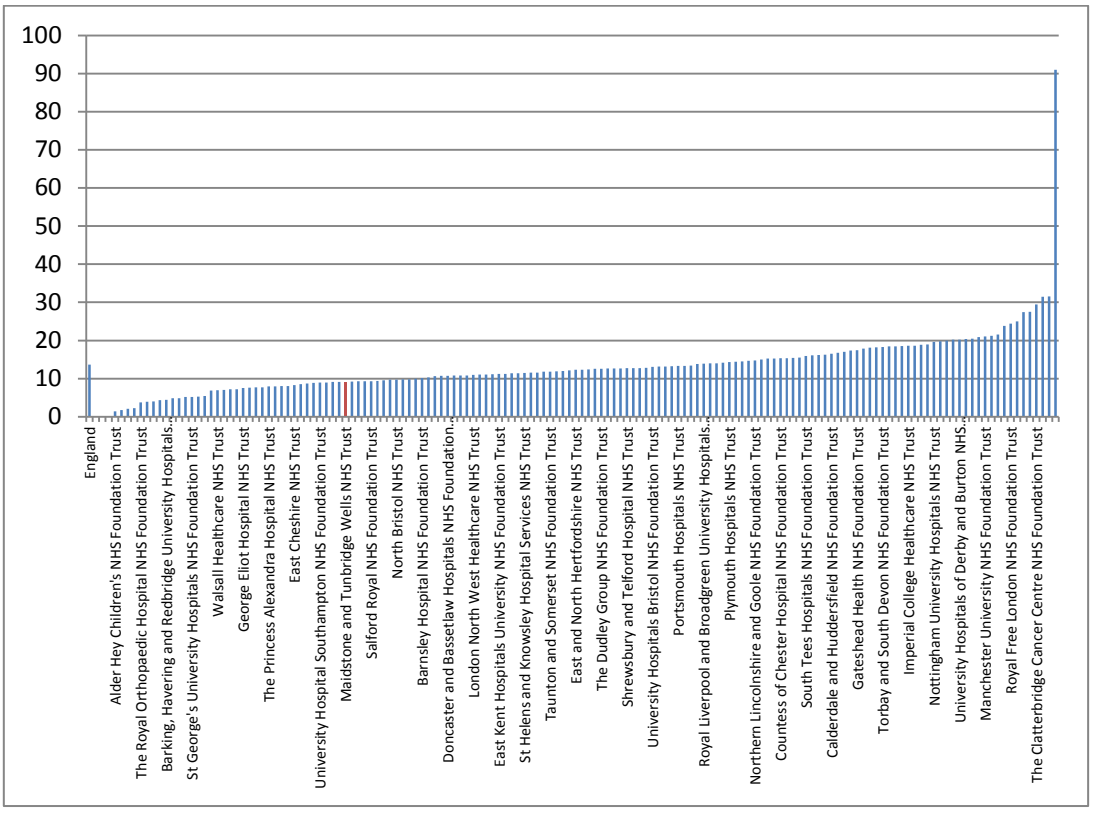
There was a small increase in cases in May when there were five cases compared with a planned limit of three for the month. Remedial and preventative action was taken at the time and monthly rates immediately fell back to baseline levels

Fig 3: *C. difficile* performance against trajectory



The Trust is in the upper (best) quartile for rate of C. difficile infection.

Fig 4: Trust apportioned *C. difficile* rates for England 2017/18



The Trust continues to perform well compared with other acute Trusts in Kent, Surrey and Sussex and against the national benchmark (all England) rate of 13.65/100 000 bed days.

Fig 5. *C. difficile* cases in Kent, Surrey and Sussex

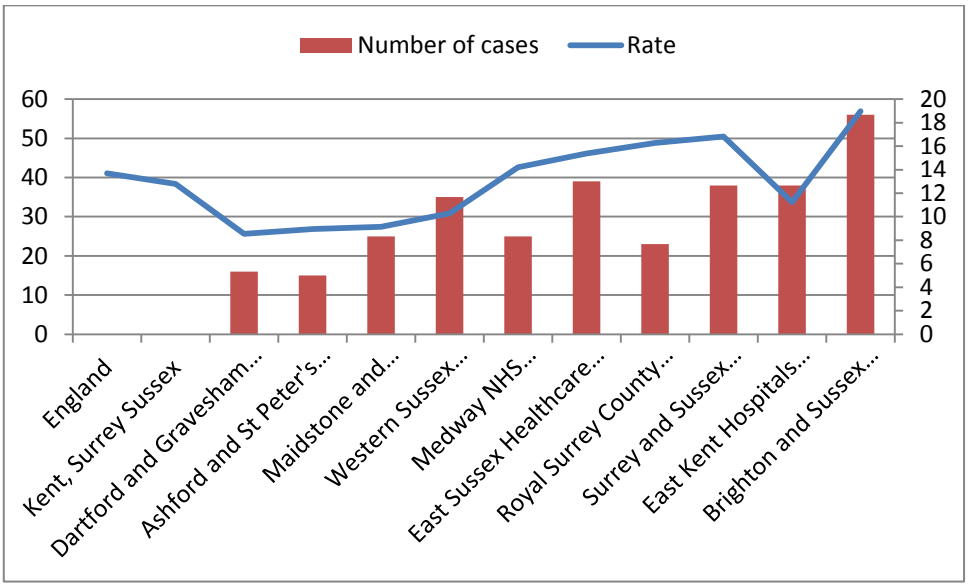
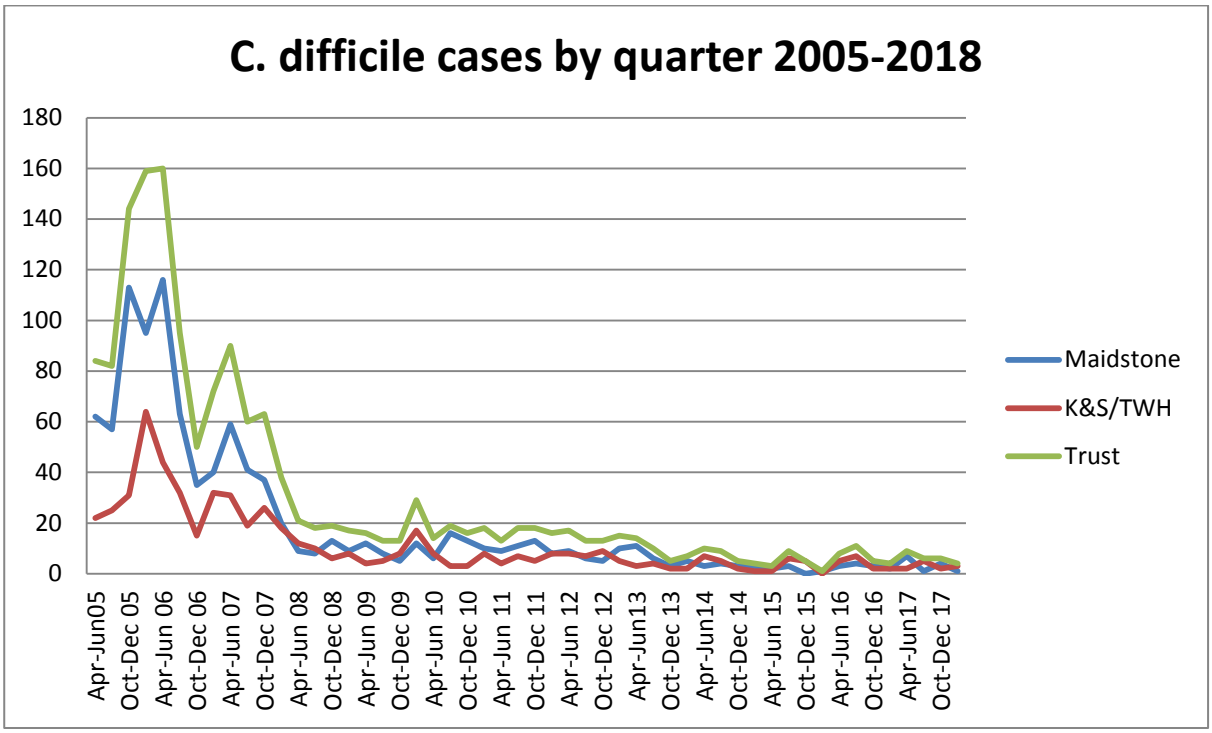


Fig 6. New cases of *C. difficile* from April 2005 to March 2018



The Trust objective for 2018/19 was released by NHS England in February 2018. Objectives were reduced by one case only for the high performing Trusts. The objective for MTW for 2018/19 is 26 cases – one case above the 2017/18 out-turn.

6.3.2. Laboratory diagnosis

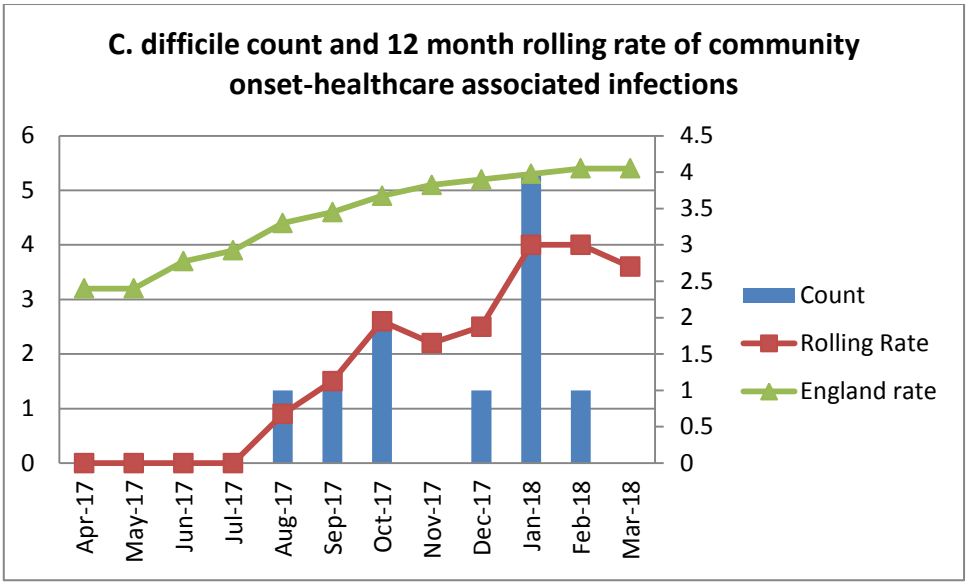
C. difficile tests are processed on diarrhoea samples from all inpatients aged 2 years or over, all GP patients aged 65 and over and all other GP patients aged 2 and over where symptoms suggestive of C. difficile infection or antibiotic use are included on the request form, whether or not the test is specifically requested.

During 2017/18, the microbiology laboratory processed 7345 samples for *C. difficile* on 4676 patients. Of these 1943 were GP patients, the others being inpatients in acute or community settings, MTW A&E or outpatient attenders.

143 patients were newly identified as carriers of toxigenic *C. difficile* (157 in 2016/17). A treatment algorithm is in place to enable identified carriers at high risk to be treated to avoid progression to acute infection.

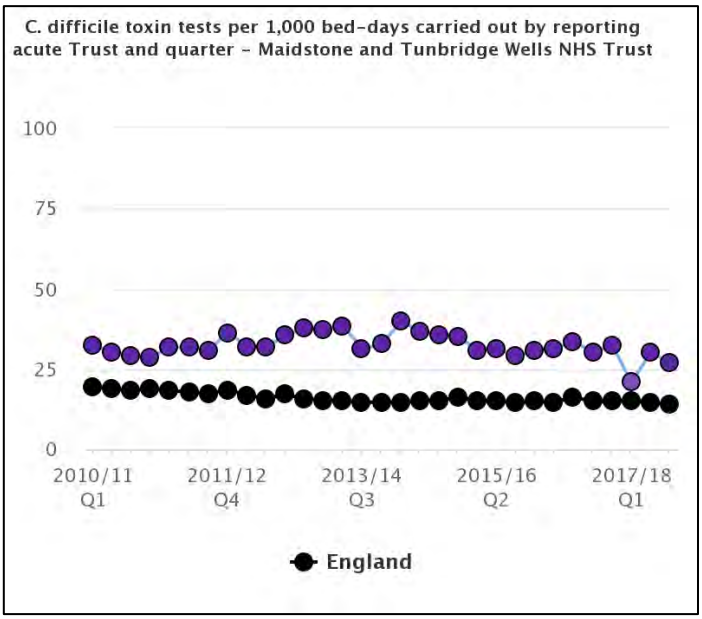
Seventy one patients were diagnosed with acute *C. difficile* infection. 25 cases were attributable to the acute Trust and 46 to the community. Of the community acquired infections, 30 were diagnosed on samples sent in by their GPs and 16 were diagnosed during the first 72 hours of their hospital admission. Ten of the community cases had had recent hospital admission at MTW and are further defined as Community onset-healthcare associated cases. Benchmarking shows that MTW has fewer than the national rate of these cases. In the graph below the rate appears to rise initially as this is a new indicator, retrospectively introduced from April 2017 and the rolling rate takes time to stabilise.

Fig 7: Rolling count and rolling rate of community onset-healthcare associated infections



From 2019/20 Trust objectives will be set based on the total numbers of hospital acquired and community onset-healthcare associated infections together with the relative rate of testing performed by individual Trusts. Trusts with high rates of infection and low testing rates will have the most exacting targets. MTW has a robust testing algorithm and a high rate of testing compared with other Trusts and the national rate as a result.

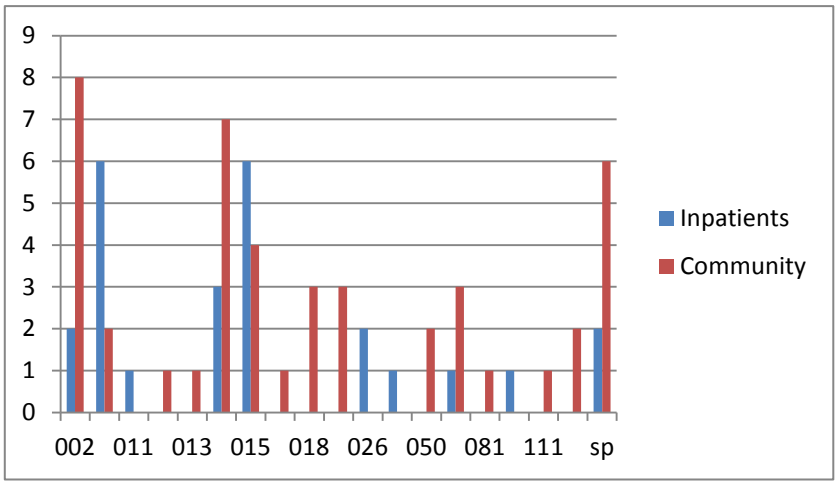
Fig 8. C. difficile testing rate 2010-2018



All cases are sent to the reference laboratory for ribotyping to detect any possible links between cases. Further testing can be requested where a link between cases is possible.

There are no discernible trends in the ribotypes of *C. difficile* either in the acute or primary care setting. Typing of hospital cases tends to reflect those types prevalent in the community. The 027 strain which caused the outbreak in 2005/6 has decreased in prevalence to background levels – no cases were seen this year. The monitoring of ribotypes will continue in order to detect any trends or cross infection and to give an early warning of any new epidemic strains emerging.

Fig 9: Ribotyping of *C. difficile* cases 17/18



6.3.3. Isolation

The standard within the Trust for isolation of patients with potentially infectious diarrhoea is two hours. A rapid risk assessment is in place for all patients with diarrhoea.

All *C. difficile* patients are isolated on diagnosis, if not already in a side room and remain in isolation throughout their admission. In addition, those identified as carriers are isolated whilst they are symptomatic and for at least 48 hours after they become asymptomatic.

Active management of side room provision continues. The Infection Prevention team produce isolation lists on a daily basis to support the bed managers and ensure the best use of the side rooms available at Maidstone Hospital and to alert staff of infection control issues at Tunbridge Wells Hospital. Information includes advice on which patients may be de-isolated if necessary and prioritises lower risk patients who would benefit from isolation. The list also alerts site practitioners to community issues such as outbreaks of norovirus in local nursing homes and community hospitals and any wider outbreaks which may result in patients attending A&E.

6.3.4. Case review

All cases of *C. difficile* infection (CDI), both community acquired and in-patient, are assessed by root cause analysis investigation. The IPT works collaboratively with the CCG infection control teams to investigate community and pre-72 hour cases.

Root cause analysis multidisciplinary meetings are held for all hospital-attributable (post-72 hours) cases and any GP or pre-72 hour cases with recent hospital admission. This enables any lessons associated with cases arising in the community to be learned and ensures that the impact of inpatient treatment on patients is understood. Following the multidisciplinary meeting the case goes to the *C. difficile* panel where the RCA is examined by the DIPC and Chief Nurse. There is an expectation that the ward manager and consultant for the case will attend as a minimum.

The panel considered all 25 hospital-attributable cases and a further two pre-72 hour cases where the patient had recent MTW admission.

The *C. difficile* panel assesses the root cause of the infection and also whether or not any lapses of care have been identified. This allows infections to be identified as avoidable or unavoidable.

Table 2: Outcomes of RCA for hospital-attributable cases April 2017-March 2018

Appropriate antibiotics	Delayed diagnosis of community acquired infection	Inappropriate antibiotics	Community prescribed antibiotics	Cross infection	Multiple antibiotics in complex or immunosuppressed patients
15	3	2	3	0	3

Most (15/25) cases were judged to be due to appropriately prescribed antibiotics. It is likely that these patients were carriers of the organism and the use of antibiotics damaged the balance of their normal bacterial flora and allowed the *C. difficile* to grow and produce toxin.

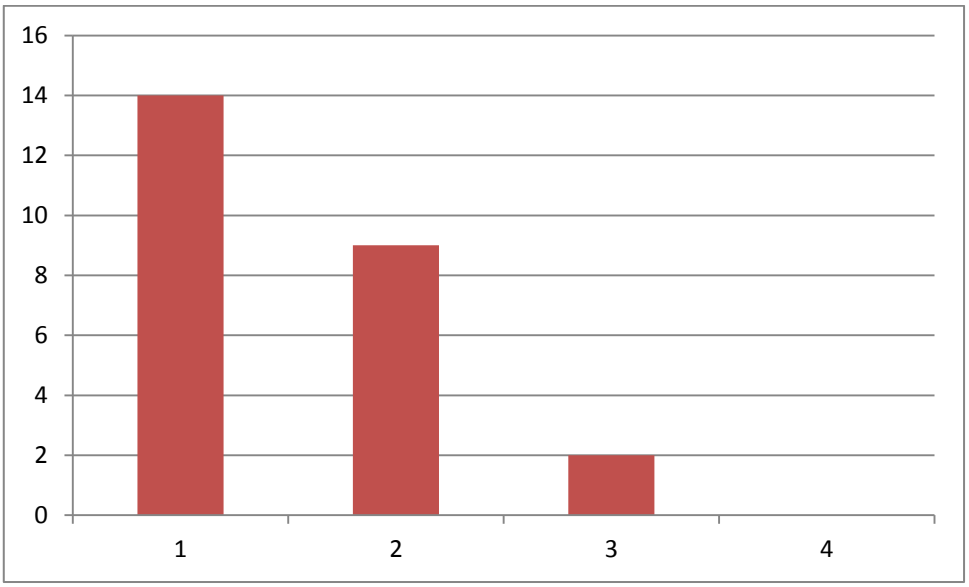
Antibiotics were considered inappropriate if they were prescribed outside the Trust guidance without agreement from a consultant microbiologist, continued for too long, or prescribed for the wrong indication.

Lapses of care are defined and standardised by a Kent and Medway-wide agreement as follows:

0 No sub-optimal care
1 Lapse of care but different management would not have made a difference to the outcome
2 Lapse of care, different management might have made a difference to the outcome
3 Lapse of care, different management would reasonably have been expected to have made a difference to the outcome

The grading of lapses of care in this way means that a finding of a lapse of care does not necessarily indicate that the case was avoidable

Fig 10: Lapses of care for hospital-attributable *C. difficile* 2017/18



Identified lapses of care included
- Delays in collection of specimen
- Inappropriate antibiotic prescribing and poor antimicrobial stewardship
- Delay in isolation
- Poor stool chart documentation
- Low training compliance (one ward only)

Eleven patients (community and hospital acquired) died during the same admission to hospital as their *C. difficile* diagnosis; however *C. difficile* was not the cause of death in any of the cases. The infection was mentioned in part 2 of the death certificate for five patients.

The distribution of cases by directorate is shown in the table below:

Table 3: Balanced scorecard for C. *difficile* by directorate

	Acute and Specialist medicine	Surgery	Clinical Haematology	Critical care	Emerg med	Total
April 16	2					2
May 16	4		1			5
June 16	1		1			2
July 16	3					3
August 16	2					2
September 16	1					1
October 16	1					1
November 16	1			1	1	3
December 16	2					2
January 17		1			1	2
February 17						
March 17	1	1				2
Total	18	2	2	1	2	**25**

6.3.5. Periods of Increased Incidence (PII)

The concept of Periods of Increased Incidence was introduced in the 2009 HPA/DH guidance '*Clostridium difficile* – How to deal with the problem'.

The guidance recommends that a PII should be declared when two cases occur in the same clinical area within a 28 day period. At MTW a PII is declared for the ward area whenever a new case of *C. difficile* is diagnosed. This increased response to a single case was implemented to identify and resolve any issues on the ward or associated with antibiotic prescribing in a timely way and has been successful in mitigating the risk of a second case occurring.

In response to the PII declaration, several actions have to be taken:

- Weekly audits of antibiotic prescribing by the antimicrobial pharmacist
- Weekly audit of the ward using the *C. difficile* High Impact Intervention audit tool until a score of >90% is achieved for three consecutive weeks and there have been no more cases during that time
- If poor audit scores are seen, an escalation meeting is held between the ward manager, matron and infection prevention to assess the need for additional support and training from the IPT
- Increased cleaning with throughout the ward with all single rooms decontaminated on discharge by either UV-C light or HPV fogging (depending on risk)
- Daily review by the infection control team
- When a PII is stepped down the ward is subject to random spot checks over the next month to ensure that improvement is sustained.

If a second case occurs in the same ward area the PII is escalated to an incident and an investigation commences. If ribotyping leads to suspicion of cross infection or there is a third case, the incident is escalated to an outbreak and the Outbreak Policy is followed. A Serious Incident is also declared at this point.

Additional actions taken when an incident is declared include

- Multidisciplinary investigation meeting held
- Intensive infection prevention team support

During 2017/18, twenty four PIIs were declared for *C. difficile*, twelve at Maidstone and twelve at TWH. Seven wards had two PIIs during the year and one ward had three. One PII was re-declared following a failed spot check audit. The PIIs lasted an average of four weeks with the longest period being 10 weeks. Four wards required escalation support to enable them to achieve the standard however the majority of wards achieved the standard required in just three weeks

6.4. Methicillin resistant *Staphylococcus aureus* (MRSA)

6.4.1. Cases

Previous improvement in the incidence of MRSA bacteraemia has been maintained with no hospital-attributable case seen for the year. The single case was assigned to a third party by NHSE following the post infection review process.

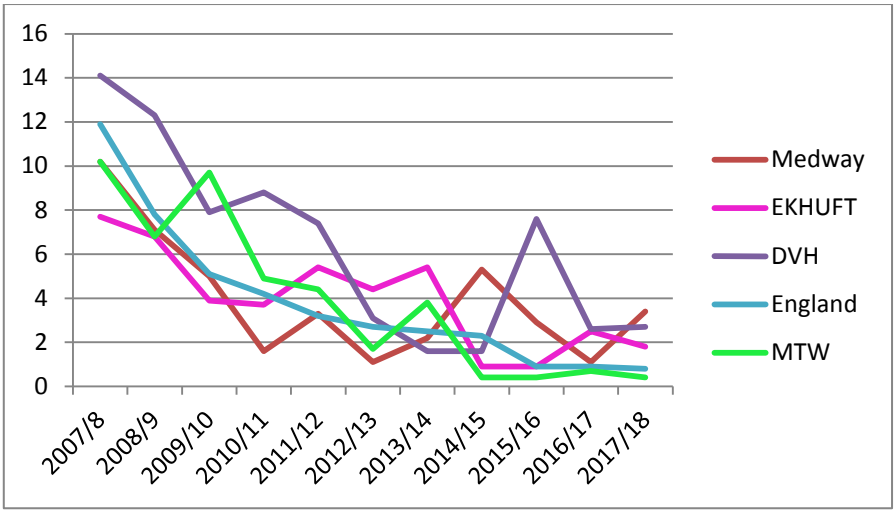
The Public Health England published data is for all cases diagnosed and does not reflect the assignment of cases to a third party. Consequently the PHE published Trust rate for MRSA bacteraemia is 0.4/100 000 bed days.

Despite this the Trust benchmarks well against the other Trusts in Kent and Medway and the all England rate as shown in Fig 10.

Key strategies in sustaining very low rates of post 48 hour MRSA bacteraemia are:

- Dedicated vascular access specialist practitioner to provide training and competencies for junior doctors and registered nursing staff
- MRSA screening for all non-elective admissions and eligible elective admissions.
- Screening all patients prior to elective caesarean sections and other obstetric patients at 36 weeks or on admission (This has been found to be a risk factor at MTW in previous MRSA bacteraemia cases.)
- Antibiotic prophylaxis for known carriers having high risk invasive procedures (RCA has identified this as a risk factor at MTW).

Fig 11: Hospital onset MRSA bacteraemia - MTW benchmarked against local Trusts and the national trend. Rate per 100 000 bed days.



6.4.2. Root Cause Analysis

All cases of MRSA bacteraemia have multidisciplinary root cause analysis completed. The process usually includes colleagues from the CCG and KCHFT. A serious incident is declared for all cases of Trust-attributable cases of MRSA bacteraemia. For pre 48 hour cases, the IPT and the relevant clinical team take part in the RCA led by the CCG. There were two community acquired MRSA bacteraemia cases diagnosed at MTW this year

The process also requires a submission to the NHS England post infection review (PIR) process which apportions responsibility for cases to the acute Trust, the CCG or a third party. The third party can be another acute Trust, a community or mental health Trust, an un-named entity, private healthcare facility or even the patient themselves. The NHS arbitration panel adjudicate the attribution of the case based on information supplied by the acute Trust and the CCG.

The findings at RCA for the single trust apportioned case were as follows:

Case 1: The patient had a long history of MRSA colonisation despite numerous attempts at decolonisation and suffered from a level of self-neglect despite input from community services.

No clear root cause was found. Decolonisation of the patient was carried out as per policy on admission to the hospital. The leg ulcers were dry at the point of admission to hospital having been intensively treated in the community. The blood culture was taken by a doctor trained in blood culture technique and there were no concerns about the level of care. NHSE agreed to assign the case to a non-specific third party.

6.4.3. Screening

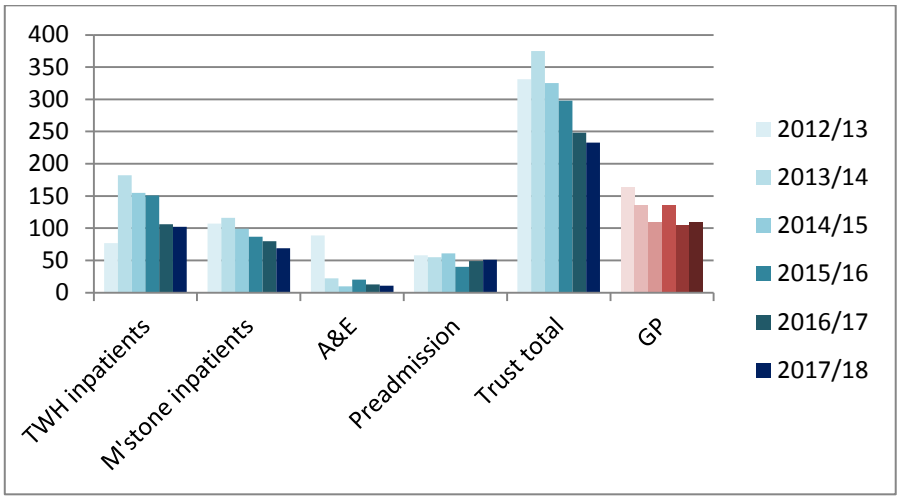
Since 2009, it has been Trust policy to screen all elective admissions (except for certain excluded groups) to comply with Department of Health policy. New guidance was published by the Department of Health in June 2014 (*Implementation of modified admission MRSA screening guidance for NHS* (2014). The guidance outlines a more focussed, cost-effective approach to MRSA screening.

Following the publication of the guidance the screening at MTW was reviewed and revised. The revised policy was implemented in November 2014. As a consequence of this there has been no increase in the incidence of MRSA bacteraemia within the Trust and further revision has not been required

New patients who are colonised are usually identified within 24 hours of admission. Advances in laboratory testing enable a positive result to be available 18 hours after the specimen arrives in the laboratory. Colonised patients are also identified as a result of clinical samples. In turn, this allows effective decolonisation of the patient to be started in a timely manner, reducing the risk of infection and spread to other patients. Patients who remain in hospital for more than a week are rescreened on a weekly basis.

Patients who are known to be colonised are commenced on the decolonisation protocol on admission

Fig 12: New MRSA colonisations 2012 - 18



6.4.4. Periods of Increased Incidence

Where two or more new (post 48 hour) acquisitions of MRSA colonisation are identified by screening on the same ward, a Period of Increased Incidence (PII) is declared for the ward where the acquisitions occurred. A single case of MRSA bacteraemia will also trigger a PII.

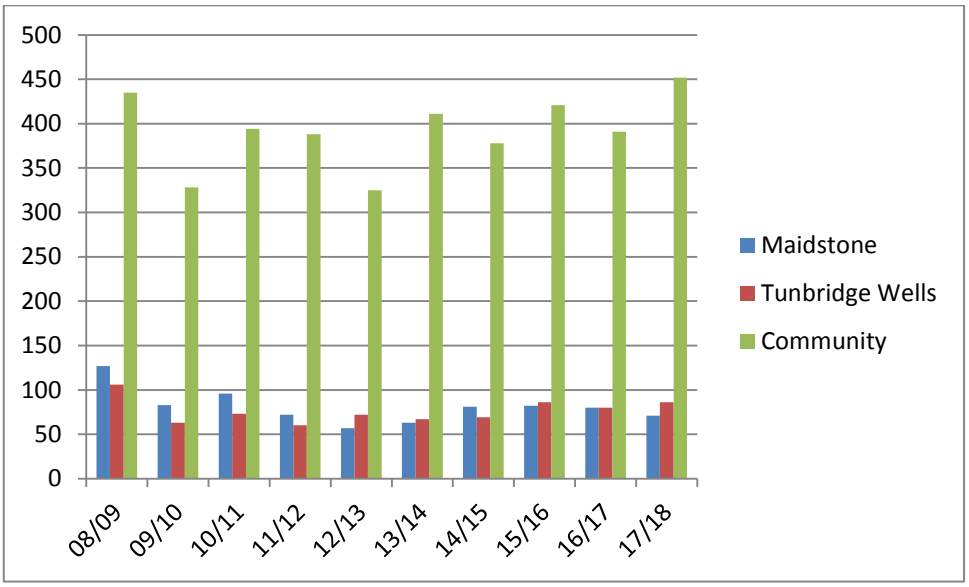
When the PII is declared the following actions are taken:

- Weekly audits of compliance with the *Control and Management of Methicillin Resistant Staphylococcus aureus (MRSA) including Screening and De-colonisation policy*
- Weekly audits of antibiotic prescribing
- The antibiograms of the MRSA isolates are examined for similarity. If the isolates are indistinguishable by antibiogram, they are sent to the reference laboratory for further typing and genetic finger printing.
- Where cross infection is proven:
  - An incident investigation is initiated.
  - Ward staff may be screened if further cases are identified

6.5. Extended Spectrum *Beta*-lactamase producing organisms (ESBLs)

ESBL organisms have the capability to produce enzymes which break down some of the more commonly used antibiotics. The numbers of patients developing infections with these organisms has been rising steadily over the last few years. A number of these organisms also have other mechanisms of resistance which can in some cases severely restrict the choice of antibiotic and may lead to admission to hospital for intravenous antibiotics because there are no options for oral treatment.

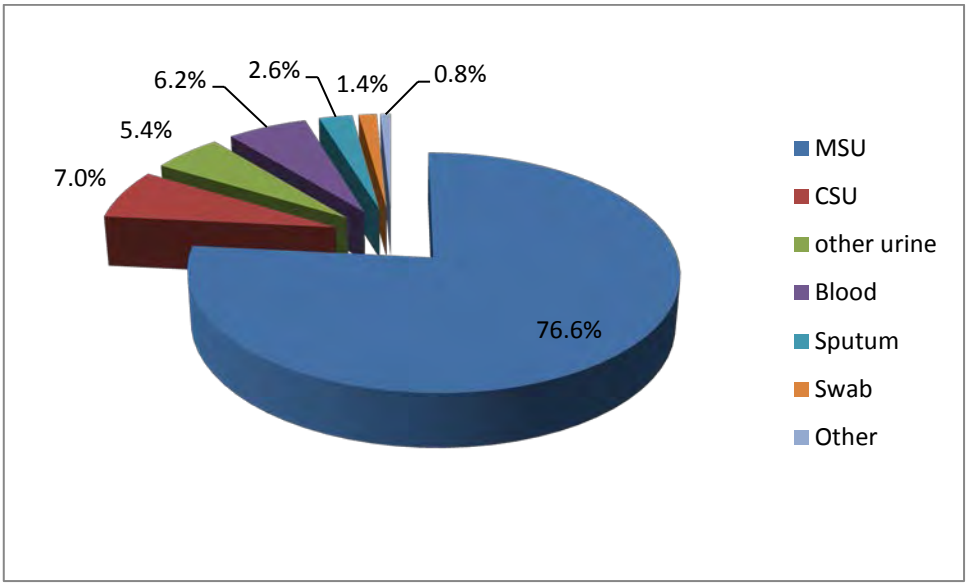
Fig 13: New ESBL isolates 2008-2018



Surveillance has been ongoing in the Trust since 2007. Earlier retrospective data shows that these organisms were seen at the Tunbridge Wells end of the Trust earlier than at Maidstone although the numbers seen at each hospital are very similar now.

There is no significant seasonal variation or trend in the number of cases seen. Most patients affected will carry the organism in their gut and as a result, urinary tract infections are the most commonly seen and account for more than three quarters of cases. Long term catheters is recognised as a risk factor for ESBL organisms, likely to be due to the treatment of recurrent infection with broad spectrum antibiotics, selecting out resistant strains which then colonise the individual's gut, forming a reservoir of infection

Fig 14: New ESBL isolates by specimen type 2017-18



6.6. Influenza

The winter of 2017/18 saw an increase in Influenza cases across the UK.

The Trust diagnosed 134 inpatients with Influenza infection between December 2017 and March 2018. Fourteen flu patients required ITU admission - a total of191 ITU bed days (average 13.6 ITU bed days).

6.7. Screening for other organisms

Screening for organisms other than MRSA has increased substantially over the last few years with the introduction of targeted screening programmes for various groups of patients.

6.7.1. Glycopeptide resistant Enterococci (GRE)

Glycopeptide-resistant enterococci are resistant to at least two important antibiotics widely used to treat infection in immunosuppressed patients. They are of particular concern in haematology patients who can be severely immunosuppressed as a result of both their underlying disease and chemotherapy.

Although the incidence of GRE infection has always been very low at MTW, with just three blood stream infections recorded in 2017/18, it is known that other Trusts in the region have endemic GRE and patients can acquire long-term carriage of this organism.

A screening programme amongst haematology patients was put in place in March 2014 with all haematology patients screened on admission and discharge. The carriage rate amongst this cohort of patients has remained constant at around 20%. 37 carriers of GRE were newly identified from April 2017 – March 2018. Identification of carriers enables antibiotic regimens to be tailored to individual patients depending on their carrier status, improving patient safety.

6.7.2. Methicillin sensitive *Staphylococcus aureus* (MSSA)

MSSA has been known to be a major cause of orthopaedic surgical site infection and prosthesis infection for many years. One third of the normal population have nasal colonisation with *Staphylococcus aureus.* A screening programme for pre-operative total hip and knee patients was introduced in November 2014. Patients found to be positive on screening are treated pre-operatively with nasal antibiotic cream to reduce their risk of post-operative infection.

6.7.3. Carbapenem resistant / Carbapenemase producing Enterobacteriaceae (CRE/CPE)

All Trusts have been required to have a screening programme for Carbapenem resistant organisms in place following a Patient Safety Alert in 2014. In 2017/18, 2075 CRE/CPE screening swabs were processed.

CPE and CRE are organisms found in the gut which are resistant to virtually every antibiotic and represent a major cross infection risk. Some organisms have the ability to transfer their resistance genes from one organism to another and even across species.
Patients are identified as requiring screening by risk assessment – focussing on screening patients transferred in from healthcare abroad and patients who are transferred from (or have recently been in patients in) other UK hospitals and tertiary referral centres, including haematology patients and neonates.

Patients requiring screening are identified on or before admission and are screened by three rectal swabs on different days. Whilst awaiting the outcome of the screening swabs patients are isolated with enhanced barrier nursing precautions including the use of long-sleeved gowns. Neonates are screened by three faecal swabs, the third being at least 48 hours after transfer from another unit. These precautions inevitably put pressure on areas with limited side room provision, especially the neonatal unit, but are necessary to prevent an outbreak of these multi-resistant organisms.

Two adult patients were identified as carriers on screening. Seven further adults and two neonates were transferred to MTW as known carriers. All necessary precautions were implemented according to the policy and there were no episodes of cross infection.
One new case was identified from a clinical sample with no risk factors identified.

6.8. Routine surveillance and alert organisms

Alert organisms are those which indicate potential severe disease or, when seen in high numbers, suggest that there may be an outbreak either in the community or hospital. They often present infection control risks as they are highly infectious.

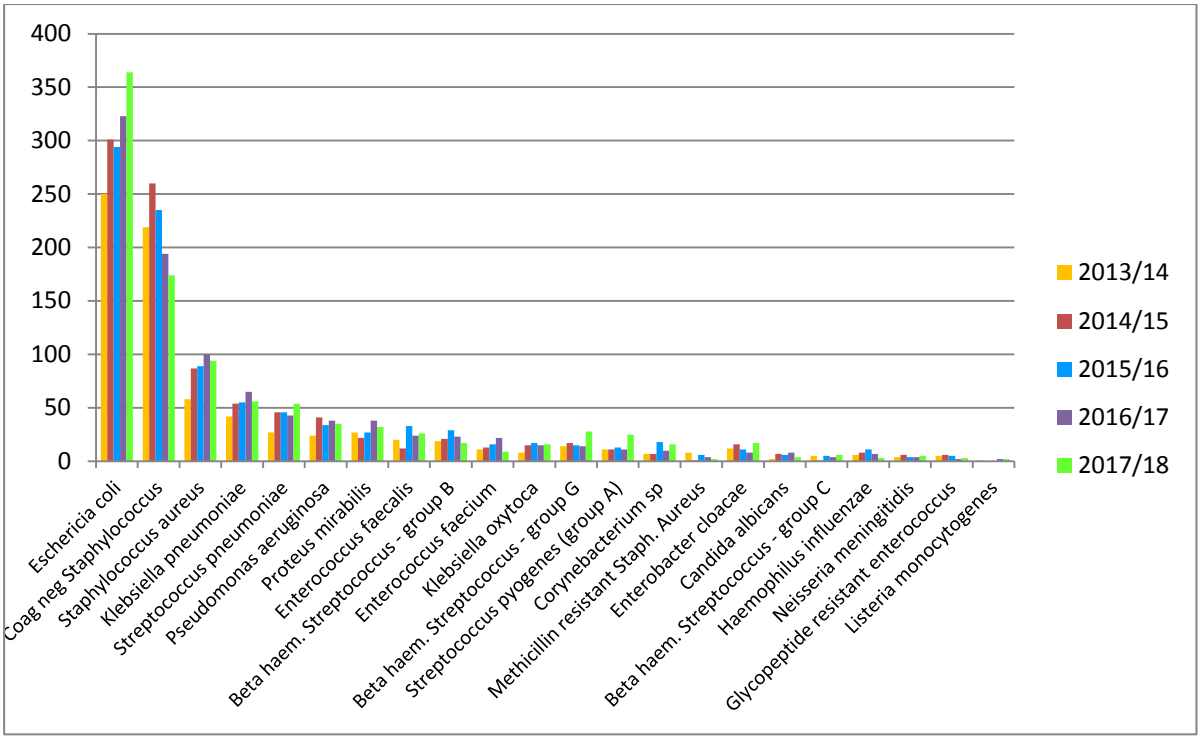
These organisms are routinely reported both to the Infection Prevention team and Public Health England as part of the national surveillance scheme

6.8.1. Blood cultures

A total of 1131 patients had positive blood cultures during 2017/18, a 7% increase on the previous year.

Some isolates are seen in small numbers but are highly significant for their ability to cause severe infection. These include *Neisseria meningitidis* (a cause of meningitis)*, Listeria monocytogenes* and *Streptococcus pneumoniae.*

Fig 15: Commonest significant isolates from Blood Cultures 2013-2018

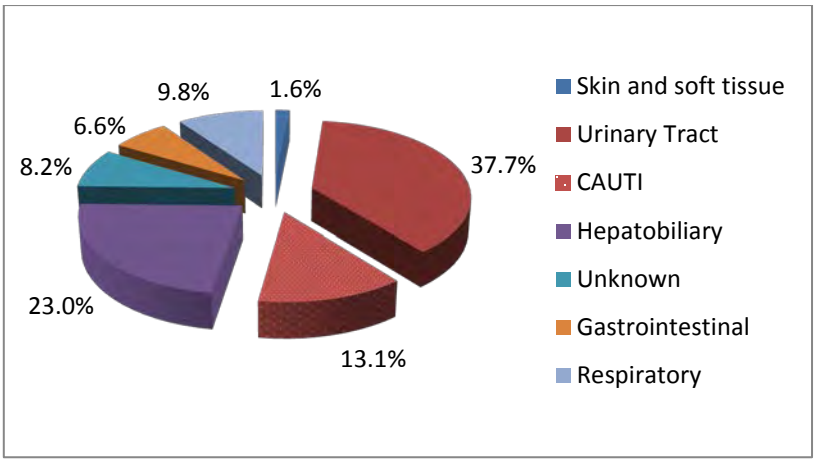


This year there has been a significant increase in streptococcal infections with group G and group A infections increasing by more than 100%. Although still in low numbers, these organisms cause devastating soft tissue infections with high morbidity and mortality rates. There is a cyclical nature to these infections over a period of years which is seen across the country.

Coagulase negative staphylococci may cause infection but also commonly represent contamination of the blood culture at the time of taking the specimen. If all isolates were contaminants this would represent a contamination rate of 15%.

The commonest isolate was *E. coli* , accounting for over 30% of all positive cultures. Infections associated with the urinary tract and especially in patients with urinary catheters are the most common.

Fig 16: Causes of hospital acquired *E. coli* bacteraemia 2017/18

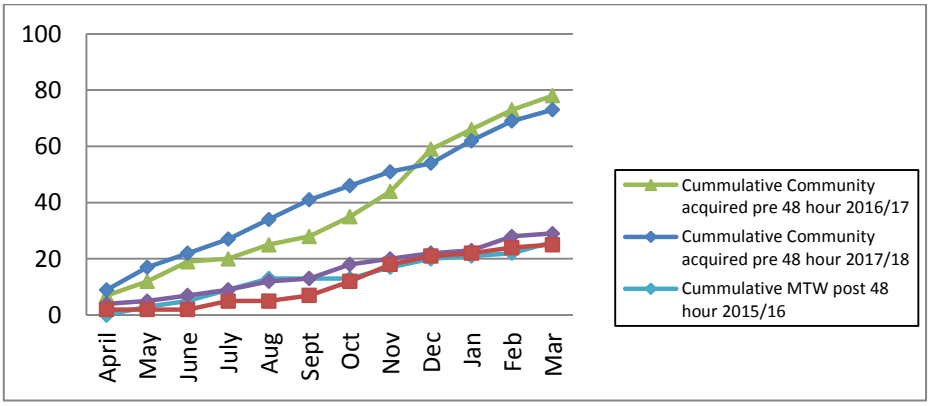


Epidemiological data is collected on all cases of E. coli blood stream infection and submitted to the PHE national database. Trend analysis is completed annually and discussed at the IPCC.

6.8.2. Methicillin sensitive *Staphylococcus aureus* (MSSA)

MSSA has been part of the mandatory surveillance for HCAI since 2010. The Trust collects epidemiological information on all cases and submits it to the national PHE database.

Fig 17: Cumulative MSSA bacteraemia cases 2017/18 compared with 2015/16 and 2016/17



A reduction of five cases (29 to 25) was seen in 2017/18 compared with 2016/7.

The root cause analysis of hospital acquired MSSA bacteraemia is reviewed at the *C. difficile* review panel to provide additional scrutiny and enable learning to be shared across the Trust. Actions related to the panel findings are incorporated into the HCAI action plan for 2018/19.

Eleven cases were found to be unavoidable. The root cause of these infections includes:

- Pre-existing skin condition
- Chronic wound colonised but appropriately treated in hospital
- Immunosuppression
- Non-compliant patient (contamination of line, wound etc)
- Non-surgical soft tissue infection
- Ongoing community acquired infection (osteomyelitis, pneumonia, discitis)
- Chest infection despite all preventative care

Fourteen cases were found to be potentially avoidable with some featuring lapses of care identified which may, or would have altered the outcome including:

- Inadequately treated infection
- Cannula site infection
- Missed prophylaxis
- Delay in acting on microbiology results
- Contaminated blood culture

6.8.3. Invasive Group A streptococci (iGAS)

Invasive GAS (iGAS) infections are uncommon but very serious when they do occur. iGAS causes a range of diseases including necrotizing fasciitis, septic arthritis, meningitis, pneumonia, puerperal sepsis (associated with childbirth), wound infections as well as non-focal bacteraemia.

Case fatality rates are high at approximately 15-20% within one week of diagnosis although in the national outbreak in 2009 the case fatality rate was been reported as up to 23%.

Invasive GAS infections have a seasonal pattern, with highest incidence from December to April. A national increase in invasive GAS infection over and above the expected trend was seen in 2017/18. This triggered enhanced national surveillance and the microbiology laboratory was required to contribute to the surveillance data.

MTW saw an increase of more than 125% in cases with 25 blood stream infections seen.

6.8.4. Norovirus

The incidence of norovirus was very low compared with previous years. The table provides a summary of the wards affected. No bed days were lost.

Table 4: Summary of Norovirus incidents 2016/17

Month	Ward	Patients affected	Staff affected	Bed days lost	Closure	Days closed
December 17	TW20	13	1	None	Beds 1-10	11
December 17	Chaucer	3	0	None	1 bay	3

6.9. Water Safety

Water safety is managed through the monthly Water Hygiene Working party and the quarterly Water Steering Group.

Pseudomonas and Legionella water sampling is carried out twice yearly at TWH and Maidstone Hospital. Positive results are recorded on an action tracker and remedial work is undertaken in a timely manner.

Legionella water risk assessments have been updated and are ongoing working documents. Works identified are prioritised in order of urgency.

Pseudomonas risk assessments have been updated in line with HTM 04-01. Risk assessments are sent out to ward managers when completed.

The Water Hygiene Policy and Procedure was updated and ratified by the PRC in 2017.

7. Antimicrobial Stewardship

The Trust multidisciplinary Antimicrobial Stewardship Group (ASG) is responsible for promoting and monitoring the prudent use of antimicrobials as outlined in the DoH guidance “Antimicrobial Stewardship - Start Smart then Focus” and recommendations from NICE guidelines (NG15). The ASG meets monthly to ensure the Trust antimicrobial stewardship programmes are implemented and review issues relating to antimicrobial use. The group members include consultant microbiologists, antimicrobial pharmacists, deputy chief pharmacist and WK CCG antimicrobial pharmacist. The group reports to the Drugs, Therapeutics and Medicines Management committee (DTMMC) and provides reports to the IPCC of which the antimicrobial pharmacist is a member.

Clinicians are invited to attend the meetings to discuss specialist guidelines.

The group regularly review the Trust antimicrobial guide (on the trust intranet page) to ensure it is accessible and up to data. Existing guidelines are updated and new guidance developed in consultation with the relevant lead clinicians. New and updated guidelines produced this year include:

- Perineal trauma during childbirth
- Neonatal meningitis
- Hospital Acquired Pneumonia (HAP) and Spontaneous Bacterial Peritonitis (SBP) in response to the national shortage of Tazocin
- Uterine perforation during operative procedures
- Antifungal prophylaxis in high risk patients
- Prophylaxis for recurrent UTI
- Antibiotic line lock therapy

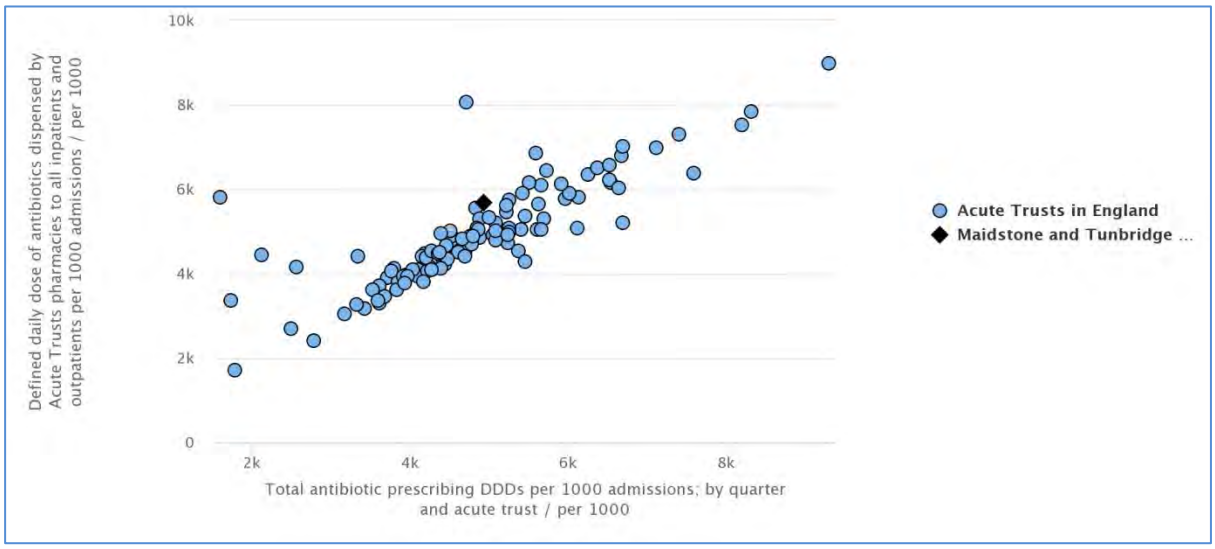
In addition the group advised on updating the guidelines for management of infection in primary care in line with PHE recommendations

The group also reviews any issues arising from the daily meetings between consultant microbiologists and pharmacists and medicines incidents involving antibiotics.

7.1. Antimicrobial usage

The antimicrobial usage data in defined daily doses (DDD) per 1000 admissions is monitored by the group. Any unusual patterns of usage are followed up with clinicians.

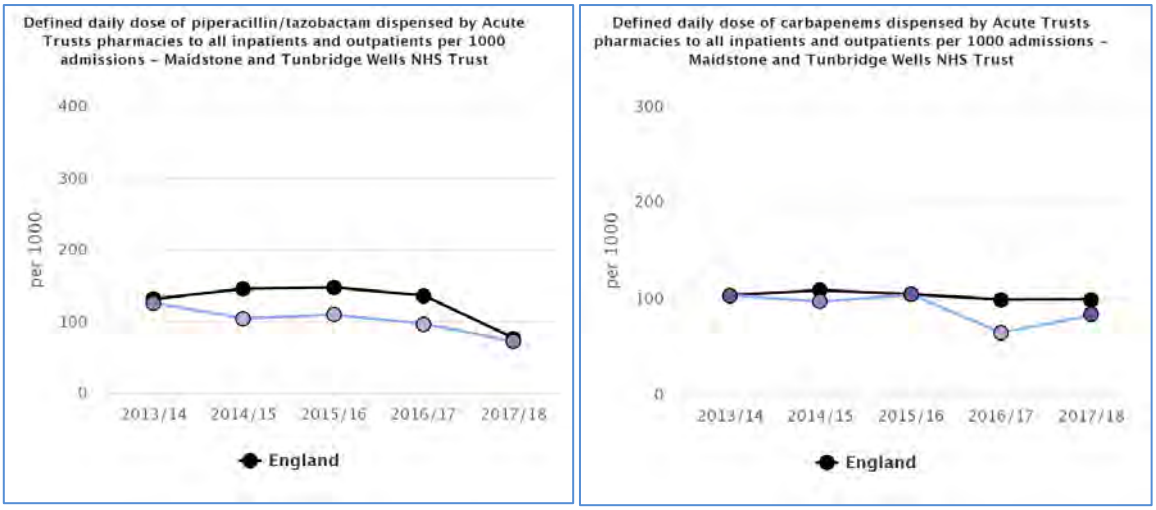
Fig 18: Total antimicrobial usage in defined daily doses (DDDs) per 1000 admissions compared with other England Trusts



Particular interest is taken in the prescribing of Piperacillin/Tazobactam (Tazocin) and Meropenem in the Trust. These are two broad spectrum antibiotics that are used in sepsis but are also associated with a higher risk of *C. difficile* infection. Meropenem is one of the Carbapenem antibiotics, resistance to which is becoming a significant problem nationally as discussed in section 5.5 of this report.

There is an overall downward trend in the use of these antibiotics although there is usually as seasonal increase in the winter due to the increased acuity of patients admitted.

Fig 19: Piperacillin/Tazobactam & Carbapenem usage in DDDs per 1000 admissions



7.2. Antimicrobial training and Education

A number of education sessions were delivered by the antimicrobial pharmacists and consultant microbiologists to medical staff and pharmacists. Education sessions include induction sessions for all new doctors, FY1 and FY2 teaching sessions and more advanced sessions for core medical trainees.
The team has also attended various clinical governance and directorate meetings to discuss topics including surgical prophylaxis, UTI management, audit results and the antimicrobial CQUIN.
In addition, antimicrobial information leaflets are issued to new locum doctors and FY1 as part of their induction welcome packs. An e-learning package for doctors of all grades, nurses, pharmacists and non-medical prescribers is currently under development.

7.3. Antimicrobial Audit

The pharmacists complete bi-monthly audits against the Antimicrobial prescribing policy. The audit results are reported to individual consultants, directorates and to the IPCC through the directorate triangulation reports.

In addition, weekly audits against the policy are carried out on wards where there is a PII in place.

Table 5: Trust-wide bi-monthly antimicrobial prescribing audit 2017-18

Standards	April May	June July	Aug Sept	Oct Nov	Dec Jan	Feb Mar
% Patients with Allergy box completed	100%	100%	99%	100%	100%	100%
% Prescribed in line with guidelines	99%	97%	96%	99%	100%	100%
% with Indication documented in notes	100%	95%	96%	98%	98%	100%
% with indication documented on chart	75%	75%	74%	80%	87%	74%
% with duration documented on drug chart	72%	77%	78%	82%	87%	72%
% of Restricted antimicrobials approved by Microbiology	100%	94%	95%	100%	100%	100%
% of Patients prescribed Probiotics	72%	75%	80%	79%	76%	91%

7.4. CQUIN

The national CQUIN for antimicrobial stewardship was updated for 2017/19 and combined with the sepsis CQUIN. The goals were as follows:

Part A: Timely identification of patients with sepsis in emergency departments and acute inpatient settings measured as the percentage of patients who met the criteria for sepsis screening and were screened for sepsis. **Partially achieved**: 85% Q4 against a target of 90%

Part B: Timely treatment of sepsis in emergency departments and acute inpatient settings. Patients identified as having sepsis to have treatment given within one hour of the decision. **Achieved**: 91% Q4 against a target of 90%

Part C: Assessment of a clinical **antibiotic review** between 24-72 hours of initiation in patients with sepsis who are still inpatients at 72 hours following set review criteria with achievement of 90% by the end of 2017/18. **Achieved**: 93% Q4 against a target of 90%

Part D: Reduction in antibiotic consumption per 1,000 admissions. There are three parts to this indicator:
1. Total antibiotic usage (for both in-patients and out-patients) per 1,000 admissions. **Not achieved**
2. Total usage (for both in-patients and out-patients) of carbapenem per 1,000 admissions. **Not achieved**
3. Total usage (for both in-patients and out-patients) of piperacillin-tazobactam per 1,000 admissions. **Achieved**
The target is 1% reduction for each part of the indicator against a baseline of Jan-Dec 2016.

8. Saving Lives

The Saving Lives programme is embedded in the organisation and compliance with the High Impact Interventions is audited on the wards and monitored through a web based system providing evidence for the nursing and midwifery Key Performance Indicators.

The high impact interventions which are audited monthly are:

- Peripheral line insertion and continuing care
- Central line insertion and continuing care
- Urinary catheter insertion and continuing care

Audit results are reported to the IPCC as part of the triangulation audits reports from the directorates.

9. Surgical site Surveillance

Overall surgical site infections represent one fifth of all healthcare associated infections.

Orthopaedic surgical site infection (SSI) has been included in the mandatory healthcare associated infection surveillance system from April 2004. All NHS Trusts or facilities undertaking orthopaedic surgery must do surveillance in one or more of the orthopaedic categories - total hip replacement, hip hemi-arthroplasty, knee replacement and open reduction of long bone fracture. In any financial year, surveillance must be continued for a minimum of three consecutive months, commencing at the start of a calendar quarter.

The surveillance scheme is coordinated by the Healthcare-associated Infection and Antimicrobial Resistance (HCAI & AMR) Department of the Communicable Disease Surveillance Centre (CDSC) at the Public Health England (PHE) in Colindale.

The PHE web based data capture system also collates data from a number of other categories of surgery which Trusts can complete on a voluntary basis. Since December 2015 only the mandatory orthopaedic surveillance has been completed.

Patients are monitored for the first 60 days and infection rates monitored for up to one year post operatively. Monitoring is completed on inpatients and also by post-discharge surveillance through hospital readmission, outpatient review and patient discharge questionnaires. MTW

completes the modules mandatory surveillance of elective total hip and total knee surgery, fractured neck of femur continuously throughout each year.

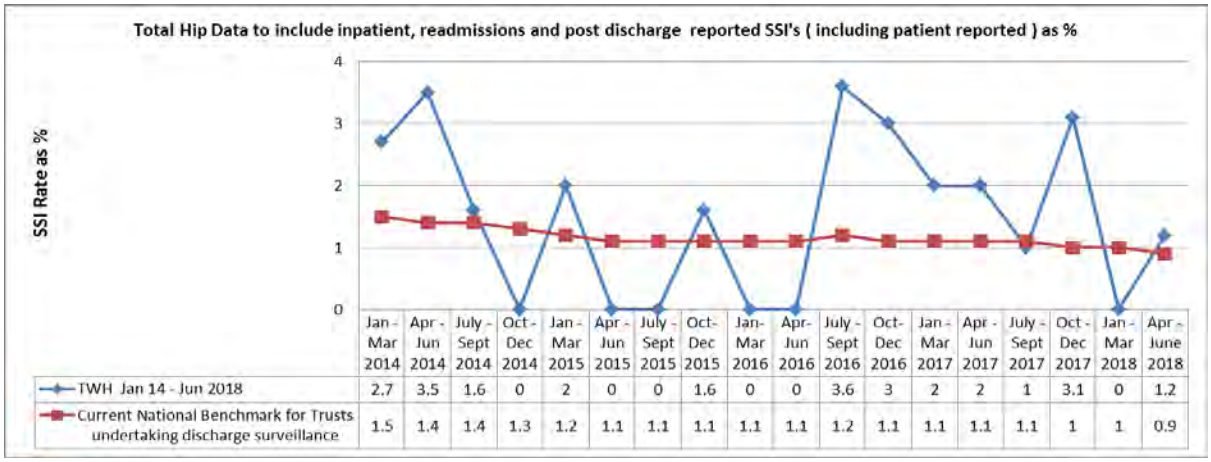
The Trust remains a high outlier in total hip replacement (THR) with surgical site infection rates remaining consistently above the national average since July 2016 except for two quarters. Due to the relatively low numbers of operations, a single case can take the Trust from below to above the national average.

A wide ranging review is currently underway including a case note review going back to 2011.

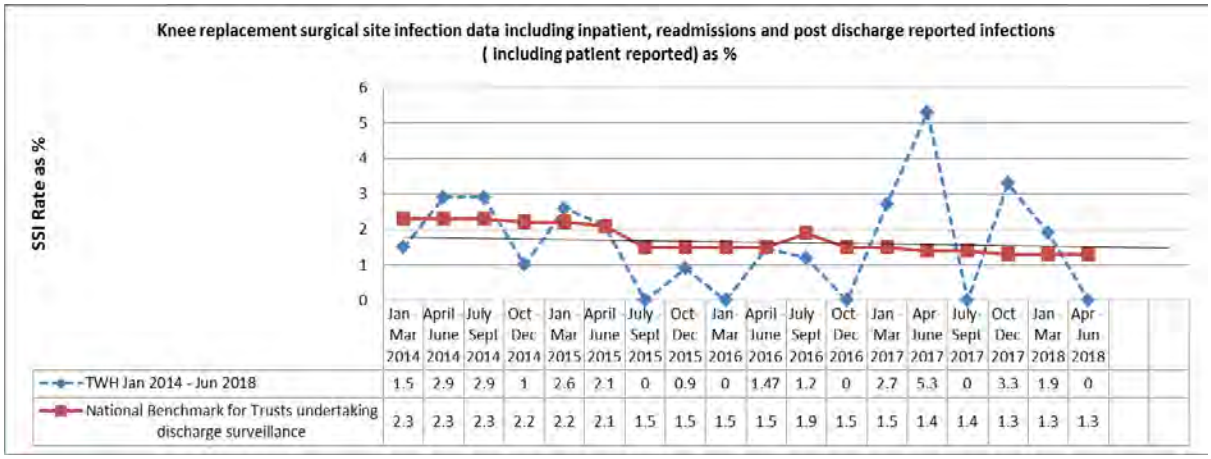
The Trust is also an outlier for repair of fractured neck of femur, where more than one infection in a quarter takes us above the national average.

Further investigation is ongoing to determine if the pathway changes last year to comply with NICE guidance, which were initially successful in maintaining low levels of infection, are sustainably embedded

Fig 20: Results for elective hips and knees

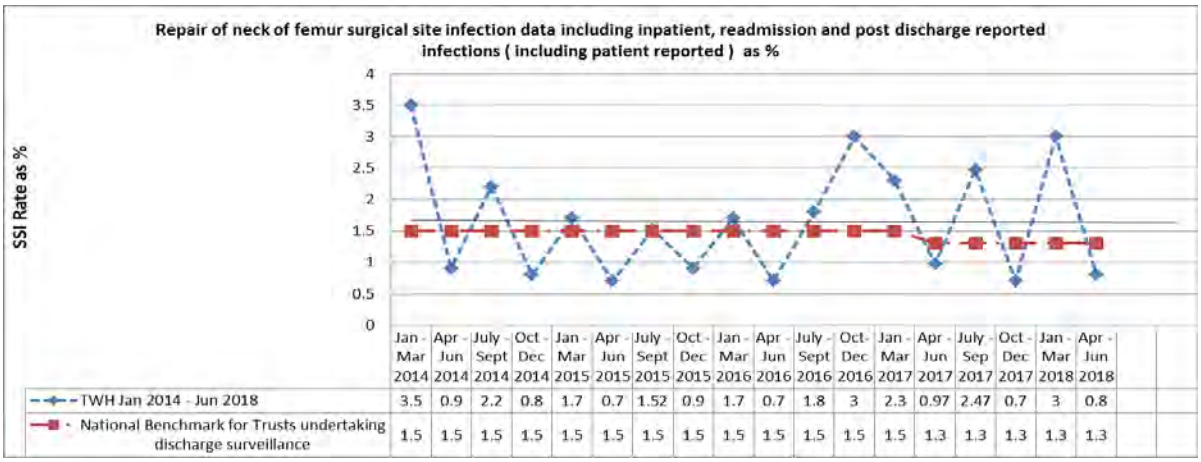


	Jan - Mar 2014	Apr - Jun 2014	July - Sept 2014	Oct - Dec 2014	Jan - Mar 2015	Apr - Jun 2015	July - Sept 2015	Oct - Dec 2015	Jan - Mar 2016	Apr - Jun 2016	July - Sept 2016	Oct - Dec 2016	Jan - Mar 2017	Apr - Jun 2017	July - Sept 2017	Oct - Dec 2017	Jan - Mar 2018	Apr - June 2018
TWH Jan 14 - Jun 2018	2.7	3.5	1.6	0	2	0	0	1.6	0	0	3.6	3	2	2	1	3.1	0	1.2
Current National Benchmark for Trusts undertaking discharge surveillance	1.5	1.4	1.4	1.3	1.2	1.1	1.1	1.1	1.1	1.1	1.2	1.1	1.1	1.1	1.1	1	1	0.9



	Jan Mar 2014	April June 2014	July Sept 2014	Oct Dec 2014	Jan Mar 2015	April June 2015	July Sept 2015	Oct Dec 2015	Jan Mar 2016	April June 2016	July Sept 2016	Oct Dec 2016	Jan Mar 2017	Apr June 2017	July Sept 2017	Oct Dec 2017	Jan Mar 2018	Apr Jun 2018
TWH Jan 2014 - Jun 2018	1.5	2.9	2.9	1	2.6	2.1	0	0.9	0	1.47	1.2	0	2.7	5.3	0	3.3	1.9	0
National Benchmark for Trusts undertaking discharge surveillance	2.3	2.3	2.3	2.2	2.2	2.1	1.5	1.5	1.5	1.5	1.9	1.5	1.5	1.4	1.4	1.3	1.3	1.3

Fig 21: Results for non-elective hip surgery



	Jan - Mar 2014	Apr - Jun 2014	July - Sept 2014	Oct - Dec 2014	Jan - Mar 2015	Apr - Jun 2015	July - Sept 2015	Oct - Dec 2015	Jan - Mar 2016	Apr - Jun 2016	July - Sept 2016	Oct - Dec 2016	Jan - Mar 2017	Apr - Jun 2017	July - Sep 2017	Oct - Dec 2017	Jan - Mar 2018	Apr - Jun 2018
TWH Jan 2014 - Jun 2018	3.5	0.9	2.2	0.8	1.7	0.7	1.52	0.9	1.7	0.7	1.8	3	2.3	0.97	2.47	0.7	3	0.8
National Benchmark for Trusts undertaking discharge surveillance	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.3	1.3	1.3	1.3	1.3

10. Incidents, Outbreaks and Serious Infections

For the period April 2017 to March 2018, the following events were investigated as infection control incidents

- MITU - two cases of multi-resistant pseudomonas. These were different organisms and no cross infection was identified
- John Day ward – Seven cases of Influenza. Concern was raised that cross-infection may be occurring on the ward. This is the respiratory ward at Maidstone Hospital and a high number of infections would be expected. Infection control precautions were increased and patients cared for appropriately

Action plans were developed for all incidents and the IPT provided additional support for ward areas and staff

There were no outbreaks recorded for the year.

11. Waste Management

Concerns were raised during the CQC pre-inspection visits, that clinical waste was found in domestic waste bins. A Task and Finish group was convened to raise awareness and determine a strategy to reduce ongoing non-compliance.
Key actions included:

- Waste infrastructure review
    - Purchase of new bins with interchangeable lids
    - Waste poster reissue
    - Internal waste audits
    - Reuseable sharps containers
- Trust-wide communications including Take 5, Talk 5.

12. Training and Education

The infection control team undertakes both formal and informal teaching as part of its training and education role. The formal sessions take place in lecture/class rooms organised in advance. These take the form of induction/welcome days, mandatory updates, link network and

student training. Informal training is undertaken in the workplace on an ad hoc basis as the need arises.

An on-line package is available for staff to use to fulfil the requirement for annual training. It is recommended that staff attend face to face training one year and access online training the next.

For 2017/18 4585 staff members completed mandatory Infection Control training; a total of 83.65% of staff.

The team also participates in the induction training for junior doctors with the DIPC leading the infection control training. The consultant microbiologists provide training in antibiotic prescribing during induction training. In addition, training on infectious diseases and the use of antibiotics is provided as part of the post graduate educational programme. This year the IPT extended the face to face ward based training given to new starter nursing staff to junior doctors, proactively developing links with the junior doctors and offering support and sharing good practice with them on the wards.

Other bespoke practical training sessions have been developed to provide targeted training to facilitate learning in staff who may not have English as a first language.

A resource pack has been developed for the wards containing a wide range of handbooks for various staff groups (temporary and substantive) and exemplars of how to complete IC documentation.

Link nurse meetings are held monthly on alternate sites. The programme is replicated on each site to enable more staff to attend. Each meeting has an educational element followed by a round table session leading to discussion about issues raised. In addition a Link nurse study day is held annually with invited speakers and this is also open to MTW staff who are not Link nurses and healthcare staff from other organisations.

We have also had educational visits from Greenwich University students and the DIPC teaches on an infection control module for MSc students and the London School of Hygiene and Tropical Medicine

13. Audit

The infection control team have worked closely with the audit department to develop a comprehensive audit programme which monitors all aspects of infection control including compliance with infection control policies within the Trust.

Eleven stand-alone audits were carried out plus monthly elective MRSA screening audits. A further three audits are only carried out following the event to which they relate e.g. outbreak, ward closure etc.

In addition to these audits the IPT undertakes bi-monthly triangulation audits which are compared with the monthly ward audits and reported as a performance report to the IPCC.

The triangulation audits are conducted on:

- Bare below the elbows
- Hand hygiene including patient hand hygiene prior to meals

- Commode cleanliness
- MRSA decolonisation
- MRSA care pathway compliance
- MRSA non-elective screening

As part of the PII process additional audits are completed on

- Ward laundry management
- Decontamination of reusable devices

Audits are reported to the IPCC

14. Challenges for 2018/19

The main challenges for infection prevention and control in the year ahead are:

- Sustaining the previous gains in the rate of *C. difficile* and meeting the objective
- Ensuring compliance with NICE guidance for antimicrobial stewardship
- Ensuring continued compliance with the updated Code of Practice on the prevention and control of infections and related guidance (Hygiene Code) (July 2015)
- Controlling and monitoring the development of antibiotic resistance
- Working with partners in the health economy to develop plans to reduce gram negative blood stream infections
- Control use of broad spectrum antibiotics
- Support the CQUIN for antimicrobial reduction and sepsis
- Ensure the wide availability of IC resource packs on the intranet
- Raise awareness of the new definitions of C. difficile infections
- Implement the 2018/19 Infection Control work-plan

15. Recommendation

The Board is asked to note the contents of this report.

Trust Board meeting - October 2018

Maidstone and Tunbridge Wells NHS Trust

10-12 Update on 2017/18 Winter and Operational Resilience Plan — Chief Operating Officer

An update on the winter plan is enclosed.

Which Committees have reviewed the information prior to Board submission?
- TME, 17/10/18

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

Resilience Planning for Winter 18/19

Trust Management Executive

October 2018

Objectives for winter 18/19

- **Manage all aspects of patient flow safely**
- **Avoid prolonged periods of over-crowding in ED**
- **Avoid 12 hour trolley breaches**
- **Avoid 60 minute Ambulance hand-over delays.**
- **Deliver plan within agreed budget**
- Ensure plans are in place to manage the expected activity scenarios and likely impact of bed capacity
- Deliver the agreed plan of elective activity (this will be modified to account for increased Nel activity)
- Adopt and implement evidence-based best practice to reduce the number of non-elective admissions (111, senior clinical input, AEC, Frailty, Stranded Patients)
- To ensure all clinical and support services have plans to meet expected demand scenarios
- To ensure there is appropriate and safe escalation plans in place
- To ensure that there are sufficient staffing in place to manage the increased demand / escalation

Capacity Demand Analysis

ED: current modelling showing an increase of 2.3% of Type 1 patients over this coming winter compared to last winter

GP streaming: with new service in place, model expecting 200-250 patients to be stream per week – around twice as many as last year

Emergency admissions: expected to be in line with ED attendance increase (2.3%)

DTOC: expected to be maintained at current levels (30 – 32 patients per week)

Non-elective bed occupancy: shortfall identified of circa 90 beds across both sites

Capacity & Demand Analysis

Maidstone and Tunbridge Wells Hospitals

Bed Modelling		2018/2019																											
Capacity		07-Oct	14-Oct	21-Oct	28-Oct	04-Nov	11-Nov	18-Nov	25-Nov	02-Dec	09-Dec	16-Dec	23-Dec	30-Dec	06-Jan	13-Jan	20-Jan	27-Jan	03-Feb	10-Feb	17-Feb	24-Feb	03-Mar	10-Mar	17-Mar	24-Mar	31-Mar
Planned Care (inc T&O)	Total (Both Sites)	184	184	184	184	184	184	184	184	184	184	184	184	184	184	184	184	184	184	184	184	184	184	184	184	184	184	184	184
Urgent Care	Total (Both Sites)	413	413	413	413	413	413	413	413	413	413	413	413	413	413	413	413	413	413	413	413	413	413	413	413	413	413	413	413
Cancer & Haem	Total (Both Sites)	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18
Gynae	Total (Both Sites)	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16
Private	Total (Both Sites)	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9
Total	Grand Total	640	640	640	640	640	640	640	640	640	640	640	640	640	640	640	640	640	640	640	640	640	640	640	640	640	640	640	640
Planned Care (inc T&O)	Maidstone	52	52	52	52	52	52	52	52	52	52	52	52	52	52	52	52	52	52	52	52	52	52	52	52	52	52	52	52
Planned Care (inc T&O)	TWH	132	132	132	132	132	132	132	132	132	132	132	132	132	132	132	132	132	132	132	132	132	132	132	132	132	132	132	132
Urgent Care	Maidstone	208	208	208	208	208	208	208	208	208	208	208	208	208	208	208	208	208	208	208	208	208	208	208	208	208	208	208	208
Urgent Care	TWH	205	205	205	205	205	205	205	205	205	205	205	205	205	205	205	205	205	205	205	205	205	205	205	205	205	205	205	205
Cancer & Haem	Maidstone	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18
Gynae	TWH	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16
Private	TWH	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9
Total	Grand Total	640	640	640	640	640	640	640	640	640	640	640	640	640	640	640	640	640	640	640	640	640	640	640	640	640	640	640	640
Capacity 'minus' Demand (Operational Plan) (Variance). *NE Medicine is lower than previous year as LOS at June is 7.4 compared to an average of 8.4 last year*		07-Oct	14-Oct	21-Oct	28-Oct	04-Nov	11-Nov	18-Nov	25-Nov	02-Dec	09-Dec	16-Dec	23-Dec	30-Dec	06-Jan	13-Jan	20-Jan	27-Jan	03-Feb	10-Feb	17-Feb	24-Feb	03-Mar	10-Mar	17-Mar	24-Mar	31-Mar
Planned Care (inc T&O)	Total (Both Sites)	-7	-4	-3	-1	-6	-9	-10	-10	-12	-19	-22	-24	-14	-14	-16	-14	-15	-14	-13	-12	-12	-10	-10	-11	-12	-12
Urgent Care	Total (Both Sites)	-28	-28	-28	-27	-32	-38	-39	-41	-44	-53	-56	-62	-62	-68	-63	-57	-52	-49	-49	-53	-56	-52	-48	-50	-53	-53
Cancer & Haem	Total (Both Sites)	7	7	6	7	7	8	8	8	8	7	6	5	8	9	9	9	8	7	6	6	6	5	2	1	0	0
Gynae	Total (Both Sites)	1	1	1	1	1	1	2	3	3	4	5	6	7	6	4	3	3	4	4	4	4	3	2	1	1	1
Total Planned and Urgent care shortfall	Grand Total (Variance)	-35	-32	-30	-28	-39	-47	-49	-50	-56	-73	-78	-85	-76	-81	-80	-71	-67	-64	-62	-65	-68	-62	-58	-62	-65	-65
Capacity 'minus' Demand (Operational Plan) (Variance). *NE Medicine is lower than previous year as LOS at June is 7.4 compared to an average of 8.4 last year by Site*		07-Oct	14-Oct	21-Oct	28-Oct	04-Nov	11-Nov	18-Nov	25-Nov	02-Dec	09-Dec	16-Dec	23-Dec	30-Dec	06-Jan	13-Jan	20-Jan	27-Jan	03-Feb	10-Feb	17-Feb	24-Feb	03-Mar	10-Mar	17-Mar	24-Mar	31-Mar
Planned Care (inc T&O)	Maidstone	18	18	18	18	18	18	18	18	18	17	17	17	25	27	24	24	24	23	22	22	22	21	18	18	18	18
Planned Care (inc T&O)	TWH	-25	-22	-21	-20	-24	-28	-28	-28	-30	-36	-39	-40	-40	-40	-40	-38	-39	-38	-36	-35	-34	-31	-28	-29	-30	-30
Urgent Care	Maidstone	19	19	19	20	17	15	14	14	12	8	6	4	4	1	3	6	8	9	10	8	6	8	10	9	8	8
Urgent Care	TWH	-47	-47	-47	-46	-49	-53	-53	-54	-56	-61	-63	-66	-66	-69	-67	-63	-60	-59	-59	-61	-63	-61	-58	-60	-61	-61
Cancer & Haem	Maidstone	7	7	6	7	7	8	8	8	8	7	6	5	8	9	9	9	8	7	6	6	6	5	2	1	0	0
Gynae	TWH	1	1	1	1	1	1	2	3	3	4	5	6	7	6	4	3	3	4	4	4	4	3	2	1	1	1
Total Maidstone	Grand Total (Variance)	44	44	44	45	42	41	40	40	37	32	30	26	37	37	36	39	40	40	38	36	34	34	31	29	27	26
Total Twells	Grand Total (Variance)	-70	-68	-67	-65	-73	-79	-79	-79	-83	-93	-97	-101	-99	-103	-103	-97	-95	-92	-91	-92	-93	-88	-84	-88	-90	-90

Plans to close the GAP Phased benefits realisation of initiative to reduce bed capacity shortfall. **Urgent care**		07-Oct	14-Oct	21-Oct	28-Oct	04-Nov	11-Nov	18-Nov	25-Nov	02-Dec	09-Dec	16-Dec	23-Dec	30-Dec	06-Jan	13-Jan	20-Jan	27-Jan	03-Feb	10-Feb	17-Feb	24-Feb	03-Mar	10-Mar	17-Mar	24-Mar	31-Mar
Urgent Care winter bed requirement	Total (Both Sites)	-28	-28	-28	-27	-32	-38	-39	-41	-44	-53	-56	-62	-62	-68	-63	-57	-52	-49	-49	-53	-56	-52	-48	-50		-53
Frailty and ambulatory 7dy/12hr						0	0	3	5	7	9	11	12	12	12	12	12	12	12	14	14	16	16	18	18	20	20
Open Cornwallis Maidstone site													0	19	19	19	19	19	19	19	19	19	19	14	12	12	10
Virtual ward benefit										10	12	12	12	12	12	15	18	18	18	18	18	18	18	18	18	18	18
move total 40 beds from surgery to Medicine						15	15	15	15	15	15	20	40	40	40	40	40	40	40	36	36	30	25	20	15	10	0
Local Care investment								10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
Manage 'super stranded patients' benefit reducing to 114 from 127										1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Benefit in beds to urgent care						15	15	28	30	43	47	54	75	94	94	97	100	100	100	98	98	94	89	81	74	71	59
shortfall compared to bed requirement for urgent care						-17	-23	-11	-11	-1	-6	-2	13	32	26	34	43	48	51	49	45	38	37	33	24	71	6
extra capacity needed for 6% growth over winter (Jan, Feb, March) as in previous years growth														-18	-18	-18	-18	-18	-18	-18	-18	-18	-18	-18			
new shortfall bed requirement for urgent care if 6% winter growth experienced Jan, Feb, March						**-17**	**-23**	**-11**	**-11**	**-1**	**-6**	**-2**	**13**	**14**	**8**	**16**	**25**	**30**	**33**	**31**	**27**	**20**	**19**	**15**	**24**	**71**	**6**

Phased benefits realisation of initiative to reduce bed capacity shortfall. **Planned care**		07-Oct	14-Oct	21-Oct	28-Oct	04-Nov	11-Nov	18-Nov	25-Nov	02-Dec	09-Dec	16-Dec	23-Dec	30-Dec	06-Jan	13-Jan	20-Jan	27-Jan	03-Feb	10-Feb	17-Feb	24-Feb	03-Mar	10-Mar	17-Mar	24-Mar	31-Mar
Planned Care (inc T&O) shortfall	Total (Both Sites)	-7	-4	-3	-1	-6	-9	-10	-10	-12	-19	-22	-24	-14	-14	-16	-14	-15	-14	-13	-12	-12	-10	-10	-11	-12	-12
Ambulatory inc reduction in NEL LOS						0	0	3	5	7	9	11	12	12	12	12	12	12	12	14	14	16	16	18	18	20	20
Virtual ward benefit						0	0	0	0	8	8	8	8	8	8	10	12	12	12	12	12	12	12	12	12	12	12
move total 40 beds from surgery to Medicine and stop inpt elective activty						-15	-15	-15	-15	-15	-15	-20	-40	-40	-40	-40	-40	-40	-40	-36	-36	-30	-25	-20	-15	-10	0
Benefit in beds to Planned care						-15	-15	-12	-10	0	2	-1	-20	-20	-20	-18	-16	-16	-16	-10	-10	-2	3	10	15	22	32
shortfall compared to bed requirement for Planned care						**-21**	**-24**	**-22**	**-20**	**-12**	**-17**	**-23**	**-44**	**-34**	**-34**	**-34**	**-30**	**-31**	**-30**	**-23**	**-22**	**-14**	**-7**	**0**	**4**	**10**	**20**

Trust Summary

a) Total bed shortfall		-35	-32	-31	-28	-38	-47	-49	-51	-56	-72	-78	-86	-76	-82	-79	-71	-67	-63	-62	-65	-68	-62	-58	-61	-65	-65
b) Total additional capacity						0	0	16	20	43	49	53	55	74	74	79	84	84	84	88	88	92	92	91	89	93	91
Available beds	based on 2.3% growth					**-38**	**-47**	**-33**	**-31**	**-13**	**-23**	**-25**	**-31**	**-2**	**-8**	**0**	**13**	**17**	**21**	**26**	**23**	**24**	**30**	**33**	**28**	**28**	**26**
Available beds	based on 6% growth					**-38**	**-47**	**-33**	**-31**	**-13**	**-23**	**-25**	**-31**	**-20**	**-26**	**-18**	**-5**	**-1**	**3**	**8**	**5**	**6**	**12**	**15**	**10**	**10**	**8**

TWH Elective Activity Plan

	2nd Dec	9th Dec	16th Dec	23rd Dec	30th Dec	December	6th Jan	13th Jan	20th Jan	27th Jan	January	3rd Feb	10th Feb	17th Feb	24th Feb	February	3rd Mar	10th Mar	17th Mar	24th Mar	31st Mar	March
TRAUMA & ORTHOPAEDICS	20	20	15	15	0	70	0	0	16	20	36	20	16	16	16	68	20	20	20	20	20	100
GYNAECOLOGY	5	5	5	2	0	17	2	5	5	5	17	6	6	6	6	24	6	6	5	5	5	27
ENT	2	2	2	0	0	6	0	0	0	2	2	2	2	2	3	9	2	2	2	2	2	8
OPHTHALMOLOGY	10	10	10	10	0	40	0	10	10	10	30	10	10	10	10	40	14	14	14	12	10	50
GENERAL SURGERY	10	10	10	0	0	30	0	10	10	10	30	10	10	10	5	35	6	6	6	6	0	18
UROLOGY	2	2	2	0	0	6	0	2	2	1	5	0	0	0	0	0	0	0	0	0	0	0
CHRONIC PAIN	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
GASTROENTEROLOGY	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	49	49	44	27	0	169	2	27	43	48	120	48	44	44	40	176	48	48	47	45	37	177

This activity plan is based on the assumption of working to scenario 3 (no escalation into recovery 1 or holding bay, 1-9 trolleys in SSSU used for day case procedures, no in patient cases at TWH). This is a snapshot of a 22 week plan, with the assumption the activity will build up from November, reduced activity either side of Christmas and New Year.

The plan will be flexible and reviewed weekly in line with what is happening with non-elective demand. The activity could be increased further or decreased dependent on demand. If the Trust is in full escalation then consideration will be given to outsourcing more activity and if NEL demand and pressure on beds is better than expected additional elective activity will be undertaken internally.

Summary of winter planning actions

Implementation dates 1st to 30th November 2018.

- Pre-emptive reduction of elective work and transfer of elective work from TWH to Maidstone and outsource Prime Provider work.
  - Cornwallis to move to Foster-Clarke Ward from December 1st (date to be confirmed)
  - ENT and Gynae inpatient & some day case activity (as appropriate) to transfer to MS.
  - Cornwallis to open as medical ward from 28th December (or earlier / later as situation dictates)
- Swing the use of beds from surgery to medicine in anticipation of increased NEL medical demand (pre-escalation action)
  - Total of 40 beds
- Identify 10 patients to potentially to potentially move from TWH to Maidstone (flow at MS permitting)
- Implementation of the "winter medical team" to support medical outliers, escalation areas & supporting AEC.
- Increased use of Home First, Home Treatment Service and Rapid Response capacity following increased CCG investment.
- Deliver the Virtual Ward
  - Expected to be available from 1st December, ramping up throughout Dec & January – eventually reducing the OBDs across all specialties, saving 30 beds
  - Implementation plan in place, working collaboratively with KCHFT
  - Pathways being agreed
  - Clinical Co-ordinators x2 being recruited to, one based in MTW and one based at KCHFT
- Implement longer working hours in assessment areas
  - Pilot agreed to cover AEC & Frailty at TWH over 7 days from December
- Further improve the LOS in Surgery and T&O
  - Enhanced Recovery in T&O (started October 2018)
  - I&D and hot choley pathway in surgery

What the resilience plan has already delivered in 2018

- Frailty units on both sites – Plan is to increase frailty from 5 days to 7 days per week.
  - Increase the consultant and registrar cover (BC pending approval)
- AEC on both sites – Plan is to maintain AEC functioning at 100% capacity over 7 days.
- Reduction in LOS
  - Overall reduction of 0.5 days achieved this year and expecting to maintain that gain over winter period.
  - GS & T&O both achieved a reduced LOS compared to last year.
- Increased use of Home First capacity
- Increased focus on SAFER and Stranded Patients

Actions required to secure delivery

All specialities

- Forward Planning
- Maximise ambulatory pathways
- Active engagement with Virtual Ward partners & identification of appropriate pathways
- Collaborative communication around ITU capacity and impact of possible escalation
- Daily review of staffing for next 24 hours (medical/ nursing/ AHPs)
- Identify 30 patients for transfer TW to Maidstone "one site, two Trusts"
- Embedding ECIST/ SAFER/ Red2Green days/ GIRFT
- Stay within own agreed bed base

Planned Care (Surgery/Urology/ T&O)

- Maintain reduction NEL LOS by 1 day
- Clinical attendance at morning huddle
- Senior decision making in ED when requested in 30 mins
- Plan trauma and CEPOD activity at daily elective meeting for next day

Urgent Care

- Maintain reduction NEL LOS by 0.5 days
- Early comms re escalation to relevant senior staff
- Maintain ambulatory/ Frailty flow
- Maintain agreed escalation (i.e. not SSSU/ Recovery)

Paeds

- Early notification of divert/ escalation
- Presence at 4.30pm Site Meeting/ Forward Planning

Haematology

- Reduction of Super Stranded patients to achieve 25% reduction by 1 Dec 18
- No outliers

Diagnostics

- No planned maintenance between Jan to Mar 19
- Early comms of business continuity
- All bloods taken on day of request
- SOP in place

Winter Resilience

- Maintain LOS reduction
  - SAFER- used in all inpatient areas
  - CUR – identifies delays affecting patient flow
  - Pathways 1,2,3 used effectively
  - Virtual ward
  - Home Treatment Service and Rapid Response
  - Maximise use of assessment areas
  - Post take senior nurse in medicine
  - X2 System MADE (multi agency discharge events) arranged for 12/13 Dec and 9/10 January
- Clear escalation plan and communication re the status of Trust and System using OPEL criteria & actions.
  - Boarding (start with 1 patient per ward and increasing as situation dictates)
  - Clear risk assessed plan for use of non-inpatient areas - (CCU trollies, AMU, SSU beds 1-9 & theatre recovery areas)
  - Release consultant staff from outpatient / SPA activity to provide ward & non-elective cover (January)

Summary of winter supplementary actions

- Increased nursing & medical cover in ED (assessment of vulnerable periods)
- Enable access to 111 to book patients directly (work in progress but working on a workaround with SECAM)
- Flu Campaign to maximise availability of staff
- Agreement of incentive payment for temporary staff in advance of peak holiday period – Remains outstanding.
- Mobilisation of non-ward based nurses to undertake regular shifts on wards – Some progress achieved / plan not confirmed
  - CNSs
  - Corporate nursing
- Mobilisation of volunteers to support wards and departments.
- Introduce an electronic bed management system (pilot wards agreed)
- Increased level of site management support (on-call support)
- On-call managers on site at week-ends as necessary (December & early January)
- Minimise annual leave for band 7 & above staff from 1st – 14th January

Day to Day management of flow

- Daily huddle – to include T&O, Surgery & Critical Care from December.
- Lead Director rota
- X4 timer per day site capacity meetings
  - Patient safety
  - Clear decision-making re flow & escalation plans
  - Manage risks
  - Communicate & Escalate internally & system-wide
- Contribute to system-wide data
  - SHREWD
- Manage OPEL assessments & actions
- Oversee escalation

Key issues to manage / mitigate (included in plans)

- Even greater increase in NEL admissions (worse case scenario plan is +6%)
- Failure to increase external capacity
  - System wide collation of plans and risk assessments underway.
- Snow before Christmas
- Noro-virus (affecting more than one ward) at any time
- Any Increase in staff sickness above expected level

Risks and Limitations

- Staffing –
  - More vacancies this year compared to last in nursing
  - particularly medical and nursing for escalation areas
- Vulnerability of out of Hospital capacity (NH places and care packages in particular)
- NEL rise further above plan
- Ability to mitigate bed shortfall
- Financial pressures of dealing with surges in demand.
- Impact on elective work including prime provider delivery.
- Escalation policy requires less (or no) access to non-inpatient areas in TWH
- Christmas Eve on Monday!!
- Impact of stroke decision (Medway situation)

Trust Board Meeting – October 2018

NHS Maidstone and Tunbridge Wells NHS Trust

10-13 Summary report from Workforce Committee, 27/09/18	**Committee Chair (Non-Exec. Director)**

The Workforce Committee met on 27th September 2018.

- **The key matters considered at the meeting were as follows:**
  - The actions from previous meetings were reviewed,
  - The committee noted that Nazeya Hussain was now Chair of the committee. Steve Phoenix was thanked for his chairmanship to date.
  - The committee reviewed the Workforce performance data for the preceding month. The committee were pleased to note the continued reduction in sickness absence in all parts of the organisation. The committee also noted the ongoing downward trend in turnover from its high in December 2017. Turnover was now meeting the trust target of >10%. Mandatory training compliance had dipped due to the switch off of the old learning management system and its replacement coming on line at the end of August/early September.
  - The committee reviewed and agreed the Workforce committee risk register
  - Annual Report from DME on work schedule reviews relating to education and training
    - The committee considered the report of the Director of Medical Education and discussed in detail the findings of the most recent GMC survey of trainees and the actions arising from it. In particular the committee noted the fact that the Trust had been rated in the bottom 5% of trusts for educational supervisor support by trainees. The need for robust job planning and oversight by clinical leads was highlighted
    - The Director of Medical Education (DME) reported that under the new Junior Doctors contract over the last Academic Year, only one work schedule/rota has been changed as a result of educational exception reporting. This related to the Higher Specialty Trainees in ENT and implemented change has resolved the issue. The DME did also however report that he was aware of a number of incidents where Trainees have had not been able to attend their mandatory training due to workload / hour issues, and this will continue to be monitored through the Local Faculty Group meetings
  - The committee reviewed the progress on the trust's nurse recruitment plan and welcomed the progress that was being made in the development of the apprentice pathway and pipeline. The committee also noted the ongoing challenges in recruiting sufficient qualified nurses, particularly for areas such as specialist medicine and theatres.
  - The committee considered the annual Trust Workforce Race Equality Scheme. The committee noted and welcomed the significant improvements in the likelihood of BME staff entering the disciplinary process relative to their white counterparts and the likelihood of being appointed once shortlisted. The committee noted however the ongoing concerns of BME staff in respect of harassment and bullying from patients and staff and their perception of the trust as one that promoted equality of career opportunities. The committee discussed the attached action plan and noted the requirement for the data and action plan to be published on the trust website in line with NHSE guidance.
  - The committee noted the proposed flu vaccination campaign and the trust target of 85% vaccination. The committee discussed reasons why staff did not take up the vaccine and emphasised the need for accessibility and informed and supportive communication rather than cajoling.
  - The committee noted the FTSU report and in particular the appointment of Christian Lippiatt, Occupational Health Manager as the new Freedom to Speak Up Guardian following an open application process and competitive interview. Christian would be undertaking his formal training at the end of September and formally take up his role in October.
  - The committee reviewed and approved the proposed Trust Leadership behaviours and discussed how these would be incorporated into the proposals currently being developed for a trust leadership programme. The programme would be a key support to the implementation of the Clinically Led service proposals approved by the Board in September

- **The issues that need to be drawn to the attention of the Board are as follows:**
- Freedom to Speak Up Report (Appendix 1)
- Workforce Race Equality Scheme and Action Plan (Appendix 2)

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

Appendix 1

NHS
Maidstone and Tunbridge Wells NHS Trust

WORKFORCE COMMITTEE – 27th September 2018

12/09/2018	FREEDOM TO SPEAK UP GUARDIAN UPDATE	SIMON HART – DIRECTOR OF WORKFORCE

Summary / Key points

To inform the Workforce Committee.

Which Committees have reviewed the information prior to Workforce Committee submission?

- None

Reason for receipt at the Workforce Committee (decision, discussion, information, assurance etc.)

- Information
- Assurance

1. Issues Raised

In the last quarter there have been no issues raised with the Freedom to Speak Up Guardian

2. Appointment of the new Freedom To Speak Up Guardian

NHSi guidance on the Freedom to Speak Up role was updated in 2018 to reflect lessons learned from the Southport and Ormskirk investigation. The report concluded that it was critical that the Guardian role was appointed through an open recruitment process rather than being selected by the organisation.

To date at MTW the role has been assigned to individuals identified by the Trust. This includes the current holder of the position, Ruth Bailey.

The post was advertised in June and July of this year via internal advert. Three applicants applied for the position and all were interviewed on 23rd August. The panel comprised of Wendy Glazier, Associate Director of Quality & Governance, Ruth Bailey, Head of Employment Relations and current FTSU Guardian and Tanisha Okoli, Deputy Chair of the Trust Cultural Diversity Network. Christian Lippiatt, Head of Occupational Health was appointed as FTSU guardian following the interviews. Christian will be undertaking his formal Guardian training at the end of September and will thence take over from Ruth Bailey.

Associated communications will go out to the wider organisation to highlight the role and the importance that the Trust attaches to the safety and security of staff to speak up about issues that are of concern.

Subsequent to Christian’s appointment the plan will be to identify a number of Freedom to Speak Up champions across the trust. Staff side and Staff networks are keen to support this process and put forward suitable individuals to act as champions.

Maidstone and Tunbridge Wells NHS
NHS Trust

Appendix 2

WORKFORCE COMMITTEE – 27th September 2018

10/09/18	**WORKFORCE RACE EQUALITY REPORT**	**JO GARRITY** **HEAD OF STAFF ENGAGEMENT & EQUALITY**

Summary / Key points

Workforce Race Equality Standard (WRES) data is submitted annually to NHS England since 2015/16. The WRES is designed to ensure that staff from BME backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

This data is expected to show progress against a number of indicators of workforce equality including a specific indicator to address the low numbers of BME Board members across the NHS.

The data is taken from ESR and the National NHS Staff Survey.

Our ESR data demonstrates improvements in the likelihood of BME staff being appointed from shortlisting and entering the disciplinary process.

Data from the National NHS Staff Survey has shown an increase in the number of BME staff feeling bullied/harassed by patients, visitors and other staff, equal career opportunities and discrimination from a manager/colleague.

The WRES action plan seeks to address the issues highlighted by the data for 2017/18.

Which Committees have reviewed the information prior to Workforce Committee submission?

Reason for receipt at the Workforce Committee (decision, discussion, information, assurance etc.)

- Information
- Assurance

WORFORCE RACE EQUALITY SCHEME

1.1 **Introduction**

1.1.1 The WRES data for 2018 was submitted on 9th August 2018 to NHS England.

1.1.2 Comparisons to 2017 are made and conclusions drawn based on the information available.

Data taken from ESR	**BME 2018**	**White 2018**	**Notes**
Number of staff shortlisted	846	3411	
Appointed from shortlisting	165	873	White people 1.31 times more likely to be appointed Compared to 1.48 in 2017
Number of staff entering formal disciplinary	13	52	BME people 0.88 times more likely to enter disciplinary Compared to 1.13 in 2017
Accessing non mandatory training	580	2168	White staff 1.06 times more likely to access training Compared to 0.75 in 2017
Data taken from 2017 National NHS Staff Survey	BME	White	
Staff feeling bullied/harassed by patients/visitors	31.15%	26.99%	Compared to 22.06% BME and 31.55% White in 2016
Staff feeling bullied/harassed by staff	24.59%	25.69%	Compared to 21.21% BME and 24.86% White in 2016
Staff believe there are equal opportunities for career progression	77.78%	90.69%	Compared to 90.91% BME and 89.30% White in 2016
Discrimination from a manager/team leader or colleague	18.33%	7.95%	Compared to 4.62% BME and 6.84% White in 2016

2.2 **WRES action plan**

2.2.1 The WRES action plan is currently being considered by members of the Cultural Diversity Network and will include:

- Investigation of recruitment data – how many staff applied and how many staff attended for interview.
- Scrutiny of recruitment decisions (along the same lines as the disciplinary and B&H cases)
- Zero tolerance campaign against B&H, learning for staff and managers about B&H and how to deal with it. Identification of appropriate paths to obtain advice and guidance and support to move into formal routes if required.
- Review of the numbers of BME leavers compared to White staff leaving the Trust

2.2.2 The plan needs to go to the Workforce Committee at the end of September and be published on our website.

Trust Board meeting – October 2018

NHS Maidstone and Tunbridge Wells NHS Trust

10-14 Summary report from Quality Committee, 15/10/18	**Committee Chair (Non-Executive Director)**

The Quality Committee has met once since the last Board meeting, on 15th October (a 'deep dive').

1. The key matters considered were as follows:

- A **Review of the quality impact of the 'Virtual Ward' model** was presented by the Medical Director. It was noted that the Virtual Ward service was not yet in place but the presentation covered "What is a Virtual ward?"; "The Benefits of a Virtual Ward" and "Quality and Performance Standards". The Quality Impact Assessment (QIA) that had been completed for the original model was also tabled and discussed. PM referred to the tabled report and highlighted the following points. Following the discussion, it was agreed that the Medical Director would submit a report on the Virtual Ward service to the 'main' Quality Committee in November 2018, ensuring this included the latest position on the governance arrangements and a proposal as to which forum should oversee the service's quality indicators.
- The second main item reviewed was a **Review of high risk Quality Impact Assessments** (including temporary staffing), for which the Programme Director attended. The QIA presented was the "STP Rate Adoption" which was part of the Best Workforce programme. In addition to being assured by the presentation, the Committee asked that the Programme pass on, to the Director of Workforce, the suggestion that the text of advertisements for substantive Consultant posts reflected the potential option that candidates undertook the role on a part-time/job-share basis
- The Medical Director then presented a **proposed scope for a general review of Trust quality**, which is scheduled to be considered at the 'main' Quality Committee in November 2018. The Committee supported the proposed scope, but asked that the report include a separate section on waiting times. The Chief Nurse then shared outcome of the Quality Risk Tool review of the Trust that had been undertaken by West Kent CCG in 2018. The review process was described and it was agreed that the Chief Nurse would submit a report to the 'main' Quality Committee in November 2018 on the outcome and follow-up to the review.
- To **items for scrutiny at future Quality Committee 'deep dive' meetings** was discussed and it was confirmed that the following items should be scheduled for the Quality Committee 'deep dive' meeting in December 2018:
  - "Review of infection prevention and control"
  - "Review of / response to the compliance with the requirement to date and time all entries within patient healthcare records"
  - "Review of the Ophthalmology outpatient clinic"
  - "Review of the availability of Healthcare records"

  It was also confirmed that the following items should be scheduled for the Quality Committee 'deep dive' meeting in February 2019:
  - "Review of the Serious Incidents process"
  - "Review of the next steps arising from the Mortality Review audit, to include special categories (e.g. children and learning disabilities)"
  - "Review of the processes for oversight of clinical audit"
  - "Response to the recommendations within the CQC's 'A national review of radiology reporting within the NHS in England' report" (but it was noted that this could be scheduled for April 2019 if considered acceptable following discussion with the Radiology Dept)

2. In addition to the agreements referred to above, the meeting agreed that: N/A

3. **The issues from the meeting that need to be drawn to the Board's attention are:** N/A

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 – October 2018

NHS Maidstone and Tunbridge Wells NHS Trust

10-15	Summary report from the Trust Management Executive (TME), 17/10/18	Committee Chair (Chief Executive)

The TME met on 17th October. **The key matters considered at the meeting were as follows:**

- Under the Safety Moment, the Chief Nurse reported that the theme was the implementation of the International Dysphagia Diet Standardisation Initiative across the Trust on 01/11/18
- The Trust Lead Cancer Clinician submitted proposals to reform the Cancer MDT meetings, which were supported, although it was noted the funding arrangements needed to be finalised
- The Chief Nurse (as Senior Information Risk Owner/SIRO) submitted a revised Information Governance Management framework (which was ratified). The revised Terms of Reference for the Information Governance Committee were also approved and a reinvigoration of the role of Information Asset Owners was supported
- The projects arising from the visit to Northumbria Healthcare NHS Foundation Trust were confirmed and it was agreed to notify our hosts of the projects that had been agreed to proceed
- The updated 2018/19 winter plan was discussed in detail, and it was agreed that the Director of Medical Education (DME) would circulate the guidance that had been issued during the previous winter in relation to the supervision of Junior Doctors during periods of patient escalation. The Clinical Director for Specialist Medicine and Therapies also agreed to submit a proposal to the next Clinical Directors' Committee meeting on the arrangements for medical Junior Doctors treating inpatients on Surgical Wards during the winter period. It was further agreed that the Chief Operating Officer would arrange for communication to be issued to all relevant persons on the operational details and actions required to implement the Trust's winter plan, and also finalise the outstanding issues within the plan
- The DME delivered his quarterly update on Medical Education, whilst the Clinical Lead for Research and Development presented their quarterly update on Research & Development
- The Director of Strategy, Planning and Partnerships gave an update on the Trust's 2019/20 plan
- The Interim Director of Health Informatics attended for an update on the implementation of the Sunrise Electronic Patient Record (EPR)
- The Director of Workforce reported on the latest workforce matters, which included recruitment process improvements, the work on new/extended roles and the Senior Medical Recruitment Group. It was agreed that the Director of Workforce should arrange for the Surgical Care Practitioner role to be incorporated into the Best Workforce programme's work on the development of extended and alternative roles; whilst the Chief Nurse should review the documentation that had been collated regarding Surgical Care Practitioner roles and consider whether the Job Evaluation process for such roles could be expedited. It was also agreed that the Director of Workforce should investigate whether the Trust's Apprenticeship Levy monies could be used to support the development of clinical support roles within Ophthalmology
- The key aspects of the monthly performance for month 6 were highlighted (which included the continued challenges regarding the 62-day Cancer waiting time target), whilst the latest infection control performance was reported. The 4 clinical Divisions also reported on their key issues
- The Director of Strategy, Planning and Partnerships gave a brief update on the Kent and Medway STP and updates were noted on the key issues from the Clinical Directors' Committee and Executive Team Meetings
- Updates were also noted on some of the TME's sub-committees (the Trust Clinical Governance Committee, Clinical Operations & Delivery Committee, Health and Safety Committee and Policy Ratification Committee)
- The Committee was notified of the Trust's exit from the Financial Special Measures regime

1. **In addition to any agreements referred to above, the Committee agreed that:** N/A

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 – October 2018

NHS Maidstone and Tunbridge Wells NHS Trust

10-16	Summary report from Finance and Performance Committee, 23/10/18	Committee Chair (Non-Exec. Director)

The Finance and Performance Committee met on 23rd October 2018.

1. The key matters considered at the meeting were as follows:

- The actions from previous meetings were reviewed and it was agreed that 2 open actions should be replaced with new actions (to arrange for a one-off analysis of the efficiency of non-Ward-based Nursing staff (on the basis that such staff are excluded from the Care Hours Per Patient Day metric); and for the Chief Operating Officer to liaise with the Associate Medical Director for Clinical Operations to agree the appropriate A/L cover arrangements, by speciality, for the February 2019 half-term school holiday period)
- Under the "Safety Moment", it was reported that October's theme was the implementation of the International Dysphagia Diet Standardisation Initiative (IDDSI) across the Trust.
- The month 6 financial performance was reviewed in depth and it was agreed that the Chief Operating Officer should report to the November meeting on private patient income (covering the underlying position, the original plan for 2018/19, and the recovery plan for 2018/19). It was also agreed that a report should be submitted to the November meeting on the budgets for 2019/20. It was further agreed that the November meeting should include a specific focus on the financial outlook for the second half of 2018/19 and the resulting cash position
- The financial aspects of the Best Care programme at month 6 were reviewed, and it was agreed that a more detailed report on the actions to recover the planned delivery of the "Medical Productivity" project should be submitted to the November 2018 meeting
- The Director, Estates and Facilities Management attended for a review of the further savings opportunities within Estates and Facilities, and it was agreed that the Chief Executive and Chair of the Trust Board should discuss, at the next Provider Partnership Board meeting, the possibility of the non-emergency Patient Transport Service (PTS) contract being held by a consortium of provider organisations rather than a Clinical Commissioning Group. It was also agreed that the Director, Estates and Facilities Management should ensure that the options for the future delivery of the non-emergency PTS were incorporated into the list of potential new opportunities to improve efficiencies within Estates and Facilities
- A report on the delivery of the Provider Sustainability Fund (PSF) was reviewed and it was agreed that clarity would be sought regarding the criteria for the receipt of the PSF in Quarter 4. The Chief Executive also agreed to arrange for the funds available from the PSF to be publicised among staff, to incentivise the delivery of the required performance
- The Head of Contracting & Income gave a briefing on the implications of the possible changes to the 2019/20 Payment by Results (PbR) tariff
- The month 6 non-finance related performance was discussed, which included the latest position on the 62-day Cancer waiting time target. It was agreed that the Chief Operating Officer would arrange for the latest 62-day Cancer waiting time target recovery plan to be circulated to Committee members. Progress with the current Cancer-related demand and capacity analysis was reported, which was noted to inform the development of a revised performance trajectory, and it was agreed that the revised trajectory should be categorised by speciality and extended beyond April 2019
- The Committee received a report on the Outpatients-related work being undertaken by Four Eyes Insight Ltd (this had been an action at the September 2018 Trust Board meeting)
- Quarterly update reports on Service tender submissions and analysis of Consultancy usage were noted, as was the standing update on the Lord Carter efficiency review (incl. SLR)
- The Interim Director of Health Informatics attended to present the proposed revised IT Strategy, but kindly agreed to re-attend in November 2018 as there was insufficient time available to consider the matter in the level of detail it warranted
- The standing "breaches of the external cap on Agency staff pay rate" report was noted, as were the recent uses of the Trust Seal
- A report on the delivery of the Trust's recruitment plan for 2018/19 was received for information (the same report had been submitted to the Sept. 2018 Workforce Committee)

2. In addition the agreements referred to above, the Committee agreed that:

- The Deputy Director of Finance (Financial Performance) should clarify which "critical imaging equipment" was covered by the Capital Investment Loan of £2.5m that was referred to in the "Capital Programme" section of the month 6 financial performance report

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 receipt at the Board (decision, discussion, information, assurance etc.)

Information and assurance