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

9.45am – c.12.30pm THURSDAY 20TH DECEMBER 2018

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

A G E N D A – PART 1

Ref.	Item	Lead presenter	Attachment
12-1	To receive apologies for absence	Chair of the Trust Board	Verbal
12-2	To declare interests relevant to agenda items	Chair of the Trust Board	Verbal
12-3	Minutes of the Part 1 meeting of 29th November 2018	Chair of the Trust Board	1
12-4	To note progress with previous actions	Chair of the Trust Board	2
12-5	Safety moment	Chief Nurse	Verbal
12-6	Report from the Chair of the Trust Board	Chair of the Trust Board	3
12-7	Report from the Chief Executive	Chief Executive	4
	Patient experience		
12-8	Kent Healthwatch / Kent Association for the Blind	Chief Nurse	Verbal
12-9	Integrated Performance Report for November 2018	Chief Executive	5
	▪ Effectiveness / Responsiveness	Chief Operating Officer	5
	▪ Well-Led (finance)	Chief Finance Officer	5a (to follow)
	▪ Finance and Performance Cttee, 12/12/18 & 18/12/18	Committee Chair	6 & 7 (to follow)
	▪ Safe / Effectiveness / Caring (incl. planned and actual ward staffing for November 2018)	Chief Nurse	5 & 5b (to follow)
	▪ Patient Experience Committee, 03/12/18	Committee Chair	8
	▪ Safe / Effectiveness (incl. mortality)	Chief Nurse	5
	▪ Safe (infection control)	Chief Nurse	5
	▪ Well-Led (workforce)	Director of Workforce	5
	▪ Workforce Cttee, 29/11/18 (incl. quarterly report from the Guardian of Safe Working Hours)	Committee Chair	9
12-10	Update from the Best Care Programme Board	Chief Executive	10
	Quality items		
12-11	Quarterly mortality data	Chief Nurse	11
	Planning and strategy		
12-12	Review of the Strategic Outline Case (SOC) to create a single Pathology service for Kent & Medway	Chief Executive	12
12-13	Update on the Trust's planning for 2019/20	Director of Strategy, Planning and Partnerships	13 (to follow)
	Assurance and policy		
12-14	Ratification of Standing Financial Instructions & Reservation of Powers and Scheme of Delegation (annual review)	Trust Secretary / Chief Finance Officer	14 (N.B. full documents to be circulated as "supplements" to the main set of reports)
	Reports from Trust Board sub-committees (and the Trust Management Executive)		
12-15	Charitable Funds Committee, 27/11/18 (incl. approval of revised Terms of Reference and approval of Annual Report and Accounts of MTW Charitable Fund, 2017/18))	Committee Chair	15
12-16	Audit and Governance Committee, 10/12/18 (incl. approval of revised Terms of Reference)	Committee Chair	16
12-17	Quality Committee, 11/12/18	Committee Chair	17
12-18	Finance and Performance Cttee, 18/12/18 (incl. approval of Business Case for the proposed establishment of a Hyper Acute Stroke Unit (HASU) / Acute Stroke Unit (ASU))	Committee Chair / Chief Operating Officer / Consultant, Elderly Care[1]	18 (to follow)
12-19	**To consider any other business**		
12-20	**To receive any questions from members of the public**		
12-21	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: 31st January 2019, 9.45am, Lecture Rooms 1 & 2, Education Centre, Tunbridge Wells Hospital		

David Highton,
Chair of the Trust Board

[1] The Director of Acute Strategy and Partnerships for the Kent & Medway Sustainability & Transformation Partnership will also attend for this item

MINUTES OF THE TRUST BOARD MEETING ('PART 1') HELD ON THURSDAY 29TH NOVEMBER 2018, 9.45A.M, AT TUNBRIDGE WELLS HOSPITAL

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	David Highton	Chair of the Trust Board (from item 11-6)	(DH)
	Maureen Choong	Non-Executive Director	(MC)
	Sarah Dunnett	Non-Executive Director (N.B. Chair of the meeting until item 11-6)	(SDu)
	Angela Gallagher	Chief Operating Officer	(AG)
	Nazeya Hussain	Non-Executive Director (from item 11-2)	(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:	Sean Briggs	Chief Operating Officer (designate)	(SB)
	Neil Griffiths	Associate Non-Executive Director	(NG)
	Simon Hart	Director of Workforce	(SH)
	Amanjit Jhund	Director of Strategy, Planning and Partnerships (from item 11-2)	(AJ)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Emma Pettitt-Mitchell	Associate Non-Executive Director (from item 11-2)	(EPM)
	Kevin Rowan	Trust Secretary	(KR)
	John Weeks	Head of Emergency Planning & Response (for item 11-15)	(JW)
Observing:	John Weeks	Head of Emerg. Planning & Response (except for item 11-15)	(JW)
	Eva Beazley	Weva Leadership Consultants	(EB)

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

11-1 To receive apologies for absence

It was noted that several Trust Board Members, including DH, would be late for the meeting because of traffic problems.

There were no apologies, but it was noted that Selina Gerard-Sharp (SGS), NExT Director, would not be in attendance. SDu then welcomed SB to his first Trust Board meeting and noted that it would be AG's last Trust Board meeting.

11-2 To declare interests relevant to agenda items

No interests were declared.

11-3 Minutes of the 'Part 1' meeting of 25th October 2018

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

11-4 To note progress with previous actions

The circulated report (Attachment 2) was noted.

11-5 Safety moment

COB reported that the focus for November was pressure ulcer prevention and measurement and described the actions that had taken place during the month. PM also highlighted the importance of holistic care in preventing pressure ulcers.

11-6 Report from the Chair of the Trust Board

DH referred to Attachment 3 and remarked that it was good that the Trust had appointed 3 more Consultants.

11-7 Report from the Chief Executive

MS referred to Attachment 4 and highlighted the following points:

- MS had received much positive feedback from the Staff Star Awards and Long Service Awards, and thanked MC for her involvement in the latter
- The next steps in the implementation of the clinically-led plans were progressing. Some key appointments had been made, but some remained unfilled, including some of the 18 Clinical Directors. The new arrangements would commence w/c 03/12/18 and it was hoped to have all post-holders in place on an established basis from January 2019. Communication and engagement remained an important aspect and to this end, MS was meeting with General Managers and Matrons on the morning of 30/11/18 and the key message MS wanted to give was the need for them to engage with their staff

SDu referred to section 4 of Attachment 4 asked why Health Education England had visited the Trust. MS confirmed the visit had been at the Trust's request and was related to MS' and PM's desire to promote education as a core element of the Trust's business. MS then commended the Medical Education team for their organisation of the visit.

11-8 Integrated Performance Report for October 2018

MS referred to Attachment 5 and highlighted that performance had been discussed in detail at the Finance and Performance Committee meeting on 27/11/18 and also at the latest monthly Integrated Assurance Meeting (IAM) with NHS Improvement (NHSI) on 28/11/18. MS continued that NHSI had challenged the Trust on its performance relating to complaints, workforce, cancer, Referral to Treatment (RTT), ambulance handovers, and finances, but MS believed that for each area, the Trust understood the situation and had the correct plan in place, perhaps with the exception of ambulance handovers.

SP asked whether NHSI had made suggestions for alternative or additional actions that could be taken, or whether they had just challenged the speed of the Trust's actions. MS replied that the Trust had received support from NHSI in a number of areas, but they had also challenged the pace of action. MS then invited each relevant Member of the Executive Team to address the specific areas of performance within their remit.

Effectiveness / Responsiveness

AG referred to Attachment 5 highlighted the following points:

- AG had learned that the response to the problems with 62-day Cancer waiting time target performance had been focused at the wrong cause for some time, as previous recovery plans had focused on treatment capacity. However in March 2018 it had been established that the main issue was the demand at the start of the pathways, and diagnostic capacity in particular. Identifying that root cause had enabled the correct plan to be developed and the Trust was now 4 months into the delivery of that plan, which AG firmly believed was the right plan
- A new process had been implemented to 'fast track' patients that were very likely to have Cancer, and this was expected to lead to improvements. However, this would eventually plateau unless other actions were implemented
- AG was very proud at the recovery of A&E 4-hour waiting time target performance. This had taken a number of years and the Trust had now adopted all of the best practice processes.
- RTT performance had not been as required in Quarter 1 but action had been taken. However, there was no swift route to achieving the 92% target and this would likely take 6 to 12 months. Staff were however very dedicated to the patients affected by the performance and there were examples of Clinical Administration Unit (CAU) staff staying at work to ensure patients were contacted

AG then concluded by thanking her executive colleagues and the Trust's Matrons for their commitment to clinical operations.

SDu noted that ambulance handover performance had not been discussed at the Finance and Performance Committee meeting on 27/11/18 and there was no relevant commentary in Attachment 5. AG confirmed that the issue had been discussed at that week's Executive Team Meeting and would feature within future monthly performance reports. SB then elaborated on the action being taken by the General Manager for Acute & Emergency Medicine.

MC commented that Attachment 5 contained no information about the areas where staff had exercised their autonomy to make improvements, and asked if such details could be expected to be reported. SO gave assurance that there were several good examples that demonstrated that the progress MC had referred to was taking place.

Safe / Effectiveness / Caring

COB referred to Attachment 5 and highlighted the following points:

- Falls had reduced in October. The Trust was on the cusp of not meeting its threshold (of 6 falls per 1000 occupied bed days), but there had been recent recovery. The Safety Moment for December 2018 would be on falls and COB was likely to request that this be focused on patients who experienced more than one fall
- Pressure ulcers were lower than the previous month. "Grades" would now be renamed as "Categories". There had been 1 Category 4 ulcer, which had been reported as a Serious Incident (SI) & COB would update on the relevant investigation at a future Trust Board meeting
- There had been an increase in (unintentional) violence and aggression against staff by patients with dementia. Staff had been supported by the provision of additional conflict resolution training, and work had been taken to expedite the discharge of patients with dementia
- The Trust continued to be a high reporter of SIs, but there was a preference to err on the side of caution and declare an SI if there was doubt, and then downgrade at a later point as necessary
- There had been some instances of Mixed Sex Accommodation. The Director of Nursing at NHSI had been invited to attend the Trust to walk the patients' pathways, to understand the issues
- The Friends and Family Test (FFT) response rate had been lower than required, but the reliance on the paper-based system remained, as the iPad system was not yet implemented
- The complaints response rate was still below the internal target of 75%, but there had been improvement in some areas. COB had given NHSI a commitment to achieve 75% performance by Christmas and this was the aspiration. There was a clear need to engage all the new Divisional staff, including the Divisional Directors of Nursing & Quality

DH asked whether the complaints response target was based on working days or calendar days. COB explained that complaints were categorised as 'simple' or 'complex' upon receipt, and simple complaints had a 25-day target response, whilst complex complaints had a 60-day target response. COB continued that the 75% target was related to the responses that were due at any point in time. COB added that she had compared the Trust's processes against others and did not advocate any changes. DH asked whether the response performance differed for simple and complex category complaints. COB replied that she did not know but would establish this.

Action: Establish whether complaints response performance differed between simple and complex category complaints (Chief Nurse, November 2018 onwards)

SDu noted that Attachment 5 contained details of the Directorates' complaints response performance, but did not include the reason/s for such performance being below trajectory, and the action being taken. COB agreed to include such details in future reports.

Action: Ensure that the "Complaints" section of the Integrated Performance Report for November 2018 included the reason/s for any Directorate's performance being below their trajectory, and the action being taken in response (Chief Nurse, December 2018)

SDu also noted that pages 19 and 20 of Attachment 5 contained details of emerging issues from complaints but asked that future reports included details of the lessons learned. COB agreed to include the requested detail in the next report.

Action: Ensure that the "Complaints" section of the Integrated Performance Report for November 2018 included details of the lessons learned from complaints (Chief Nurse, December 2018)

MC stated that she concurred with SDu's point and noted that she would like to explore the lessons learned at the Patient Experience Committee meeting on 03/12/18.

EPM asked whether SI investigations took significant time. COB replied that there were key processes required for such investigations, which included identifying the actions to be taken within 72 hours and completing the investigation within 60 days. COB added that investigations were then submitted to the Learning and Improvement (SI) Panel for review. DH asked whether all SIs included a Root Cause Analysis (RCA), noting that this was very time consuming. COB confirmed that both points were correct.

COB then referred to the "Safe staffing: Planned versus actual for October 2018" section of Attachment 5 and highlighted that the Trust's actual staffing largely matched that planned for Ward areas, although there were some exceptions. COB added the report from the UNIFY system did however hide the Trust's reliance on temporary staffing.

Safe / Effectiveness (incl. mortality and an update on the traceability of blood components following an MHRA visit)

PM referred to Attachment 5 and highlighted the following points:

- Mortality continued to slowly reduce. PM had previously stated he was not expecting more significant reductions until the Clinical Coding engagement actions had been fully implemented, but the continued reduction illustrated that such engagement was having some benefit
- The Datix IT system was key to developing the work in the Best Safety workstream, and funding had been agreed to appoint a Datix administrator to support the system and engage with clinical teams to promote its use for incidents, SIs and mortality. The Mortality Surveillance Group was very aware of the Trust Board's request that the quarterly mortality reports be more proactive
- PM had attended the Trust Cancer Committee meeting earlier that week, which SDu also attended. The Trust Lead Cancer Clinician was very well engaged and PM wanted to formally record his commendation of their appointment. The development of Tumour specific dashboards would be beneficial
- There were currently 5 different types of harm reviews occurring: retrospective and prospective reviews for both RTT and Cancer, plus a review in Ophthalmology. The reviews intended to assess whether patients had been harmed by not being treated within the target period. The prospective audits were still being undertaken and 1 case of serious harm had been identified in the lung cancer pathway, so a retrospective 12 month review was now being carried out
- The 'Getting It Right First Time' (GIRFT) programme continued to gather pace, and a recent review had been undertaken for Endocrinology. A review in Stroke was also due to start soon
- The latest Sentinel Stroke National Audit Programme (SSNAP) data now showed that Maidstone Hospital (MH) was rated as a B, not a C

PM then deferred to SM, who reported the following points in relation to the Medicines and Healthcare products Regulatory Agency (MHRA) inspection at Tunbridge Wells Hospital (TWH) on 01/11/18:

- The inspection identified no critical non-conformances, but identified 2 major and 6 minor non-conformances, which was a good result
- One of the non-conformances related to the traceability of blood components, for which the Trust was achieving 98% rather than the required 100%. However, the 2% of cases without traceability all had incidents raised
- Action was being taken to address the issue, including the full implementation of the MSoft Bloodhound IT system, which was scheduled for April 2019
- The MHRA inspector asked that the issue be escalated, so this was brought to SM's attention, who in turn escalated it to the Executive Team. As a result of the escalation, the Inspector only rated the non-conformance as a minor
- The Inspector also wanted monthly updates to be reported to MS, and a lookback of the non-traced cases to 2015 undertaken, to review the outcomes.

- The action plan and response had been submitted to the MHRA

DH asked for details of the obstacles that had occurred with the previous implementation of the Bloodhound IT system and SM described these. SDu asked whether all other hospitals had failed on the standard, given that the Bloodhound system appeared to be used by all hospitals. SM explained that the Trust had chosen to split the implementation into phases, whilst other Trusts had implemented the full system in 1 phase.

SDu referred to the latter point and asked whether the Trust's process took account of the downsides when the implementation of projects had to be split into phases. MS acknowledged the validity of the point but suggested that all Trust Board Members consider the point in relation to the implementation of future projects, including Electronic Patient Record (EPR). DH remarked that sometimes implementation was split into phases as a project was too large to be implemented at once, but he believed that making such decisions on financial grounds was wrong. PM noted that he chaired the EPR Programme Board and offered to provide further details to the Trust Board. DH instead proposed that subject be scheduled at future Trust Board seminar. This was agreed.

Action: Liaise with relevant persons to schedule an item at a future Trust Board Seminar on the plans to deploy the Electronic Patient Record (including reference to phasing decisions and identifying controls and mitigations, as appropriate) (Trust Secretary, November 2018 onwards)

SDu then referred to the "Cons to Cons Referrals" indicator on the "Trust Performance Dashboard" and asked why the indicator was included under "Effectiveness", as she thought it had been noted at the Trust Cancer Committee that such referrals were longer relevant. PM agreed that the indicator was not relevant so he was therefore unsure why it remained on the dashboard. AG explained that "Cons to Cons Referrals" was an indicator of the management of demand, and it would be a cause for concern for the CAUs if that demand increased. SDu acknowledged the point, but queried whether it needed to be a primary focus for the Trust Board. AG advocated that the indicator remain, but DH proposed that this be considered further outside the meeting as he did not know how to interpret the increase i.e. was this positive or negative. This was agreed.

Action: Consider whether "Cons to Cons Referrals" data should continue to be reported on the Trust Performance Dashboard (Chief Operating Officer / Chief Finance Officer, November 2018 onwards))

Safe (infection control, incl. SSI update)

SM then referred to Attachment 5 and drew the Board's attention to the Kent and Medway System Infection Management Leadership section. SM continued that there was now a Sustainability and Transformation Partnership (STP)-wide Director of Infection Prevention and Control, and the individual had been a former member of the Trust's Infection Prevention and Control Team. SM also highlighted that a letter had been sent to the Chief Executives in the STP outlining the action points listed on pages 26 and 27, and the Trust already undertook some of the actions.

DH asked whether the STP work would result in a standardisation of infection control policies across the 4 acute Trusts. SM confirmed this was being worked towards.

Well-Led (finance)

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

- The phasing and profiling of the delivery of a number of programmes in the 2018/19 plan was to start in month 7 & this was demonstrated in the current financial position, in that the delivery for the remainder of the year needed to be better than for the year to date. Therefore although the Trust had achieved its plan thus far, the planned increase in delivery had not been seen
- A number of mitigations had also been identified in the plan, and SO had deployed a significant amount of the Trust's reserve. However, further action was required to try and obtain additional benefit from the Trust's one-off mitigations (which would be discussed within an item in the 'Part 2' Trust Board meeting scheduled for later that day). All areas would also be asked to reduce their run-rate
- The issue had previously only been raised as a concern, but the risk had now crystallised and additional action was therefore now required

- Discussions were continuing with commissioners

DH noted that an extraordinary Finance and Performance Committee meeting had been scheduled for 12/12/18 which would focus more specifically on finances, and all Non-Executive Directors were invited to attend that meeting.

Well-led (workforce)

SH then referred to Attachment 5 and reported the following issues:
- Sickness absence (both long-term and short-term) continued to be subject to focus
- The influenza vaccination campaign was progressing well and 62% of front-line staff had now been vaccinated. Under the previous year's campaign, that level had not been reached until January. The key challenge was to maintain the trajectory to be able to reach the 85% target, and the focus would now shift to identifying those who had not yet come forward
- Statutory and mandatory compliance remained below target, but actions continued
- Turnover and vacancy rates had reduced, although this was not uniform, as MH was performing better than TWH, and there were some differences between specialties.
- Appraisals were actually just below the 90% target rate despite page 31 reporting the rate as 84.7%. Some anomalies had been identified in the data and these had been corrected

EPM noted that the sickness absence rate was higher in back-office departments and asked if the reasons for this were known. SH stated that he did not believe there were any particular reasons, so the aforementioned focus on short-term absence would ensure that such absence was not allowed to drift and become long-term absence. SH did however agree to undertake some further analysis to identify the reasons for the higher rates.

Action: Undertake further analysis to identify the reasons for the higher rates of sickness absence in back-office departments (Director of Workforce, November 2018 onwards)

11-9 62-day Cancer waiting time target: capacity needed compared to that currently available

This was covered under item 11-8.

11-10 Detailed review of the Best Care programme (incl. update from the Best Care Programme Board)

MS referred to Attachment 6 and reported the following issues:
- Some key progress had been made, including the additional circa £500k that had been received from the NHS Resolution Maternity incentive scheme and the award of the contract to be the Prime Provider for Planned Care, which would start from January 2019. There were however still some challenges, and the programme was behind plan
- The last Best Care Programme Board meeting focused on the lessons learned
- It had been agreed to re-set each of the projects, in terms of timescales and deliverables, and to provide new expectations on what should be escalated, to whom, and when. This would take a few weeks to complete but was very important
- The other action agreed was for the Best Care workstreams to generate their plans for 2019/20, as the Programme Board had been very clear that there was major value in the approach and methods that had been deployed

SO added that the software solution to support the monitoring of the programme had also been agreed. DH also noted that prioritisation had been discussed, given the large number of projects under Best Care and the need to distinguish between the critical and less-critical projects.

11-11 Review of the Board Assurance Framework 2018/19

DH referred to Attachment 7 and highlighted that the ratings were all 'green' or 'amber' apart from objectives 2 ("To deliver the trajectory agreed with NHS Improvement for the 62-day Cancer waiting time target") and 3 ("To deliver the Referral to Treatment (RTT) trajectory agreed with NHS Improvement for patients on an 'incomplete' pathway") and the Finance and Performance Committee had considered what further action could be taken to improve the position on both. DH also pointed out that further detail on the ratings was contained within Attachment 7.

SDu noted that objective 8 (To deliver the agreed medical productivity plan for 2018/19") was rated as 'amber' whilst the ratings for the Medical Productivity project on page 24 of Attachment 6 were 'red', and asked whether further details could be provided. KR pointed out that a report on the Medical Productivity project had been considered at the Finance and Performance Committee meeting on 27/11/18, in response to concerns that had been raised at the previous Committee meeting. TL acknowledged the point but stated that he remained unaware of the detailed issues. PM therefore reported on the aspects that had prevented all Job Plans being signed off by Consultants, and highlighted that the process being implemented by the Trust was very robust but not straightforward. PM added that there was no national comparator for productivity and the Trust was considered to be leading the way nationally in relation to identifying what a productive Programmed Activity (PA) was. PM continued that although the specific indicators may be rated 'red', 'amber' and 'green', the overall programme was as rated in the BAF (i.e. 'amber'), but there were however some specific challenges, including in surgery.

SM added that work was continuing on demand and capacity, and this would inform the work AJ was undertaking with the Divisions. SM also stated that despite only circa 50% of Job Plans had been signed off thus far, improvement was expected in Quarter 4, although a significance difference was not expected to be made until 2021. SH added that the introduction of electronic rostering for Medical staff, to monitor the Job Plans, would be a further important step.

MS proposed that the Finance and Performance Committee be asked to review the issue in 3 months, to establish whether progress had been made. PM instead proposed that this be scheduled for the Best Care Programme Board, as the work was currently overseen by that forum. This was agreed. MS therefore asked SO to ensure that the Programme Director scheduled the item for March 2019.

Action: Ensure that the Programme Director scheduled a review of progress with the Medical Productivity project at the Best Care Programme Board meeting in March 2019 (Chief Finance Officer, November 2018 onwards)

Quality Items

11-12 Closure report on the Clostridium difficile outbreak

SM referred to Attachment 8 and highlighted the following points:

- Seven patients had died during the outbreak but it had been identified that none had died as a result of their Clostridium difficile, although 2 of the cases had had their management complicated
- There had been a single case of cross infection at MH, so an SI had been declared. The investigation was ongoing

Planning and Strategy

11-13 Update on the project to create a single Pathology service for Kent & Medway

MS referred to Attachments 9 and 9a and conveyed the following points:

- A commitment to develop a single service across Kent and Medway had been made several months ago
- A Strategic Outline Case (SOC) would be submitted to the Trust Board in December 2018 and if that was approved, swift progress would be made thereafter
- The 4 tests that MS had asked that the SOC answer were: 1) whether the downsides of the options had been identified; 2) whether there was clarity about risk; 3) whether the project management support was sufficient; and 4) whether the governance arrangements had been identified

DH asked whether the option of a single employer would be one of the existing Trusts or a separate company, and if the latter, whether that would be adversely affected by the new arrangements that had been introduced for the establishment of wholly-owned subsidiary companies. MS replied that this was a key consideration to be outlined in the SOC.

SDu noted that Attachment 9 included 2 references to "reasonable" (i.e. "There has been reasonable engagement…" and "…we have a reasonable chance of delivering the efficiency savings…"), and also noted the previous failures to establish similar arrangements, so asked what was now different. MS replied that there had been engagement but emphasised that no group of Pathology staff would choose the most radical option unless they believed their Trust would be the hub for the new service. MS continued that the decision therefore needed to be a Trust Board decision, although this did however need to be based on realistic assessments.

NH then noted that Attachment 9a stated that "…the single service will more than likely deliver the minimum productivity requirement set by NHS Improvement…" and questioned whether this was good enough. DH concurred with the challenge and acknowledged the previous failures, but stated that he did not believe a status quo option would be allowed to be taken.

SP opined that the deliverability of the options was important, in relation to the gains outweighing the risks. MS agreed and noted that the level of benefit currently being forecast was insufficient to justify radical change but he believed there should be more benefit.

NG asked for clarity on the decision to be taken in December. MS explained that this would be a decision to proceed to the development of a Full Business Case (FBC), and it was therefore important to get the SOC right.

SP asked whether the options could be sequential rather than being mutually exclusive. MS agreed that was worthy of consideration.

11-14 Update on funding of replacement Linear Accelerator (LinAc) programme

DH referred to Attachment 10 and confirmed it was an update and had not been submitted for approval. SO then reported that the funding only paid for the LinAc, not for the enabling works and other items such as software licenses. SO confirmed that the Trust would therefore be required to pay £620k, but would receive circa £1.7m.

SDu asked whether there was cost to the Trust for the storage of the LinAc, given the interest that would be incurred on the Public Dividend Capital (PDC). SO confirmed this would be the case. SDu stated that she therefore believed there should be some negotiation, and a request that the Department of Health and Social Care pay the interest on the PDC during that period. SO agreed that was one option that could be considered but highlighted that other options to reduce the cost were being explored. MS queried whether liaison could occur with the other Trusts that had received LinAc funding offers, including The Royal Marsden NHS Foundation Trust. SO acknowledged the point and agreed to consider the suggestions.

Action: Consider the suggestions made at the Trust Board meeting on 29/11/18 to reduce the costs associated with the storage and installation of the latest replacement Linear Accelerator (Chief Finance Officer, November 2018 onwards)

Planning and Strategy

11-15 Emergency Planning update (annual report to Board) (incl. "When tragedy strikes" briefing from NHS Confederation)

DH welcomed JW to the Board table. JW then referred to Attachment 11 and showed a video, "A year in partnership". After the video, DH asked whether "SERV Bloodrunners" and "South East 4x4" were voluntary organisations. JW confirmed this was the case.

SDu commended the video and opined that it would be beneficial to show it in the Outpatients waiting area. The suggestion was acknowledged.

JW then drew attention to the query raised on page 1 of Attachment 11, which had arisen from an action at the Finance and Performance Committee, and asked whether the Trust Board was content with the current arrangements for the oversight of Business Continuity, or whether it felt a Trust Board sub-committee should provide more specific oversight. JW stated that he believed the

oversight should be via the Divisions and Directorates, as part of their core business. DH agreed this was sensible.

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

11-14 Quality Committee, 14/11/18

SDu referred to Attachment 12 and reported that it was very encouraging that agreement had been reached to take action to resolve a problem that had been raised in relation to theatre utilisation.

11-17 Trust Management Executive (TME), 21/11/18 (incl. revised Terms of Reference, for information)

MS referred to Attachment 13 and reported that under the new management arrangements, TME would in future meet quarterly and be more of a formative than decision-making body. KR confirmed that the Terms of Reference for TME had been submitted for information, not approval, as TME was not a Trust Board sub-committee.

DH stated that it would be beneficial to determine which of the decisions made at the Executive Team Meeting should be reported to the Trust Board, for information, although he did not believe the full notes of such meetings should be submitted. MS replied that he would welcome the issue being discussed further at the Trust Board 'Away Day' on 04/12/18, but agreed that he and KR would discuss DH's challenge.

Action: Liaise to consider the best method of ensuring that the Executive Team Meeting's decisions were reported to the Trust Board, for information (Chief Executive / Trust Secretary, November 2018 onwards)

11-18 Finance and Performance Committee, 27/11/18 (incl. quarterly progress update on Procurement Transformation Plan; and approval of request for an uncommitted loan facility (in advance of PSF payments))

TL referred to Attachments 14, 15 and 16 and highlighted the key issues, which included the quarterly progress update on the Procurement Transformation Plan and the Committee's recommendation for an uncommitted loan facility application, in advance of Provider Sustainability Fund (PSF) payments.

The proposed request for an uncommitted loan facility was approved by the Trust Board as circulated. Specifically, the Trust Board resolved to:

1. Approve the proposed loan application to advance against PSF payments to a maximum value of £10.81m (being the total of Quarters 2 (£2.544m), 3 and 4 in 2018/19, actual and planned). Specifically, to:
    a. Approve the financing proposed via the loan agreement in line with Schedule 1 of the Loan facility documentation ("Conditions Precedent") i.e.:
        - Approve that the loan facility can be signed by the Chief Finance Officer under delegated authority
        - Agree to the terms of and the transactions contemplated by the loan
    b. Authorise the Chief Finance Officer as the nominated officer to execute the agreement ("the Finance Documents")
    c. Authorise the Chief Finance Officer to manage the agreement i.e. to sign and/or despatch all documents and notices including any Utilisation Requests required under the agreement.
    d. Agree to the additional terms and conditions set out in the relevant schedule of the facility agreement (i.e. schedule 8)

11-19 Charitable Funds Committee, 27/11/18

TL reported that the Committee had agreed the Annual Report and Accounts for 2017/18, and it was noted that these would be submitted for approval to the Trust Board on 20/12/18. TL also reported that the Committee had approved the management and administration fee for 2018/19, and whilst the level of donations and legacies had fallen, a Fundraiser had now been appointed.

11-20 To consider any other business

KR asked that the Trust Board delegate the authority to the 'Part 2' Trust Board meeting scheduled for later that day to make decisions regarding the disposal of the Trust's properties at Springwood Road, Maidstone and 32 High Street, Pembury. The requested authority was duly delegated.

11-21 To receive any questions from members of the public

No questions were posed.

11-22 To approve the motion (to enable the Trust Board to convene its 'Part 2' meeting) that in pursuance of Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest

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

Trust Board Meeting – December 2018

Maidstone and Tunbridge Wells NHS Trust

12-4 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]
10-9c (Oct 18)	Ensure that all Non-Executive Directors received an appraisal	Chair of the Trust Board	October 2018 onwards	One appraisals has been undertaken, a further appraisal has been scheduled for after the Trust Board meeting on 20/12/18, and the remainder are being arranged
11-8d (Nov 18)	Liaise with relevant persons to schedule an item at a future Trust Board Seminar on the plans to deploy the Electronic Patient Record (including reference to phasing decisions and identifying controls and mitigations, as appropriate)	Trust Secretary	November 2018 onwards	The next available slot for an item at a Trust Board Seminar is February 2019, so the item has been provisionally scheduled for then
11-8e (Nov 18)	Consider whether "Cons to Cons Referrals" data should continue to be reported on the Trust Performance Dashboard	Chief Operating Officer / Chief Finance Officer	November 2018 onwards	Further discussion is required, including with the Medical Director, so the matter will be considered in January 2019
11-14 (Nov 18)	Consider the suggestions made at the Trust Board meeting on 29/11/18 to reduce the costs associated with the storage and installation of the latest replacement Linear Accelerator	Chief Finance Officer	November 2018 onwards	The Trust is waiting for confirmation from NHS England that it has received funding for an additional Linear Accelerator. In the meantime the Trust is exploring how storage costs can be defrayed or supported by commissioners as part of the process.

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
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	December 2018	The details of the appointments to the Chiefs of Service were forwarded to the Non-Executive Directors by email on 21/11/18. Details of the individuals who have been appointed to the other various roles under the new clinical Divisions was forwarded to the Non-Executive Directors by email

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

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
				on 05/12/18.
11-8a (Nov 18)	Establish whether complaints response performance differed between simple and complex category complaints	Chief Nurse	December 2018	The requested information has been included in the "Complaints" section of the Integrated Performance Report for November 2018
11-8b (Nov 18)	Ensure that the "Complaints" section of the Integrated Performance Report for November 2018 included the reason/s for any Directorate's performance being below their trajectory, and the action being taken in response	Chief Nurse	December 2018	The "Complaints" section of the Integrated Performance Report for November 2018 includes the requested details
11-8c (Nov 18)	Ensure that the "Complaints" section of the Integrated Performance Report for November 2018 included details of the lessons learned from complaints	Chief Nurse	December 2018	The "Complaints" section of the Integrated Performance Report for November 2018 includes the requested details
11-8f (Nov 18)	Undertake further analysis to identify the reasons for the higher rates of sickness absence in back-office departments	Director of Workforce	December 2018	Corporate departments have a sickness absence rate below the Trust average although there are some departments that are above that rate. However, they tend to be departments with small numbers of staff that are disproportionally affected by sickness absence. The Estates and Facilities department has an above average sickness absence rate, but this primarily relates to musculoskeletal problems (which is more likely to result in sickness absence). The line managers in Estates and Facilities are being followed-up to ensure that the appropriate actions are being taken
11-11 (Nov 18)	Ensure that the Programme Director scheduled a review of progress with the Medical Productivity project at the Best Care Programme Board meeting in March 2019	Chief Finance Officer	December 2018	The requested review has been scheduled Best Care Programme Board meeting in March 2019
11-17 (Nov 18)	Liaise to consider the best method of ensuring that the Executive Team Meeting's decisions were	Chief Executive / Trust Secretary	December 2018	Liaison has occurred and it has been agreed that the key decisions made at Executive Team Meetings will be included in the Chief

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
	reported to the Trust Board, for information			Executive's report to each Board meeting (starting in January 2019)

Actions not yet due (and still 'open')

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

Trust Board meeting – December 2018

NHS Maidstone and Tunbridge Wells NHS Trust

12-6 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.

AAC recommended Consultant appointments (dependant on compliance or withdrawal)					
Date of AAC	**Title**	**First name**	**Surname**	**Department**	**Potential/Actual Start date**
12/12/18	Dr	Aimay	Mirdin	Emergency Med	ASAP
12/12/18	Dr	Malik	Hussain	Emergency Med	ASAP

STP NED Oversight Board

I will be attending the first STP Non-Executive Directors (NED) Oversight Board on 7th January 2019. I am one of 6 NEDs and we will be discussing Terms of Reference and the appointment of a Chair.

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 – December 2018

NHS Maidstone and Tunbridge Wells NHS Trust

12-7 Report from the Chief Executive — Chief Executive

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

1. December marks the official start of winter for the NHS. We've already seen our busiest week of the year, with high numbers of emergency department (ED) attendances across both hospital sites. We're expecting a tough and challenging winter ahead. We've made significant investment in our winter plans this year, over and above previous years, to help us better manage these anticipated demands.

   We've invested more in our ambulatory services and specialist frailty units, extending the opening hours for these areas at Tunbridge Wells Hospital, and have secured beds in the community to care for patients waiting for social services support.

   A particularly good example of how we're managing capacity in our hospitals is our partnership with Kent Community Health Foundation NHS Trust, via our new Hospital @ Home service which supports suitable patients to return home to finish their acute care.

   Additionally, we have introduced more GP hours within our ED's, which will free up time for senior clinicians to see the sickest patients more quickly. We have focused on improving theatre and outpatient efficiency too, by moving elective work from Tunbridge Wells Hospital to Maidstone Hospital over the winter period, as well as adding theatre sessions and outpatient clinics at weekends. Plus we're implementing a process to ensure our patients are cared for in the right bed, appropriate to their clinical needs, meaning that patients will be admitted to a ward at either of our hospitals, regardless of which ED they attended.

   These practices have been proven to work and, importantly, do what our patients tell us they want – to be treated and cared for well and in a timely manner, so they can get home without delay.

2. We have received £140,000 in additional funding to help improve our diagnostic pathways for urology cancer patients. The award is part of a £10 million fund that has been made available to the NHS following a significant increase in referrals seen this year across all tumour sites. This is clearly good news for MTW and supports our ongoing focus to meet cancer waiting time standards for our patients.

3. Enabling our patients to shape and develop the future of healthcare - and how we deliver it - is vital. Research plays a critical role in achieving this and being an active Trust in this field is essential for us to become Outstanding.

   Thanks to our research team, which comprises nurses, midwives, physiotherapists, radiographers and research practitioners, we are making great progress and currently have more than 100 studies, in a range of clinical areas, running across the Trust. We have already exceeded our recruitment target this year, with more than 2,400 patients recruited to trials. We're continuing to build on this good work with many more clinicians getting actively involved in, and leading, research studies. We've opened new trials in new disease areas, for example in melanoma (skin cancer), and have expanded our Patient Research Ambassador (PRA) initiative by recruiting more research volunteers to support patients and be independent advocates for them.

   A number of our clinicians are participating in research that's directly modernising and improving healthcare provision, helping to reshape the treatment and services we deliver. Two great examples of this are Karina Cox, Consultant Breast and Onco-plastic Surgeon, who is looking at developing radiological skills in detecting cancer, and Nick Bowman, Trauma and Orthopaedic Surgeon, who is involved with a study to improve paediatric Anterior Cruciate Ligament surgery.

Importantly, feedback from our patients who have been involved in research with us demonstrates that they feel really valued. Actively engaging with our staff and feeling they are helping to make a real difference in how we deliver healthcare makes for a better patient experience. Ensuring as many patients as possible have the opportunity to get involved in clinical studies will help us to lead the way in making sure we deliver the very best treatment and patient care.

4. MTW has welcomed a group of 15 trainee Nursing Associate apprentices who are leading the way in shaping the future nursing workforce in West Kent. For the past year, MTW has collaborated with 6 other health and social care organisations, and together have formed the 'West Kent Nursing Associate Consortium'. The Consortium will be supporting a total of 31 Trainee Nursing Associate apprentices in the first cohort. The new Nursing Associate role is a key part of national plans to create a strong, sustainable nursing workforce for the future. Nursing Associates will work alongside existing Clinical Support Workers and Registered Nurses to deliver hands-on care for patients. Once qualified, the Nursing Associates will register with the Nursing and Midwifery Council and will take on more duties than in their previous roles, enabling Registered Nurses to spend more time on the assessment and care associated with complex needs.

5. Christian Lippiatt, Head of Occupational Health, has been appointed as the new Freedom to Speak Up Guardian for the Trust. The FTSU Guardian role is about ensuring our patients are cared for in a safe way. Should staff have concerns they feel are not being heard or they feel unable to raise with management, Christian will listen in confidence, take on board concerns and raise the issue through the appropriate channels.

6. Our Emergency Laparotomy Team are the faces of this year's National Emergency Laparotomy Audit (NELA) annual report thanks to being amongst the best performers in the South East and one of the best performing trusts in the country over the last five years. The latest results from the audit highlight the innovative work our team has been doing over the last year, which puts our mortality rate at among the lowest across England and Wales. An emergency laparotomy is a surgical bowel operation for patients, often with severe abdominal pain, to find the cause of the problem and to treat it, which is considered as one of the most risky emergency operations. Almost 30,000 laparotomies are performed across England and Wales each year, with many of these patients at high risk of death or serious complications.

7. Congratulations to 19 members of staff who have celebrated the completion of courses and qualifications at our Annual Learning and Development Achievement Awards. All the members of staff who receive funding each year, ranging from Estates and Facilities Management to the Palliative Care team, are invited to attend and reflect on their achievements, which are made through undertaking various programmes of study. Many staff completed their studies whilst balancing busy work and family commitments with the ceremony taking time to thank and acknowledge the value of the attendee's achievements not just for their personal development but for the overall value to the Trust and our patients as a whole.

8. A major project to refurbish the birthing centre at Crowborough is well underway with new-look facilities being unveiled at the end of January. Work at the centre, which remains open while the refurbishment takes place, has been made possible thanks to the generosity of the Friends of Crowborough Hospital. The Friends contributed £92,000 to the refurbishment and improvement works. Their ongoing support is enormously appreciated by our Trust and will make a huge difference for women using these facilities.

9. We have appointed a consultancy to develop a deliverable plan to increase the number of visitor car parking spaces at Tunbridge Wells Hospital.

   The move follows positive pre-application advice from Tunbridge Wells Borough Council and is another step towards alleviating some of the parking pressures we have seen. We believe our emerging idea is a more cost-effective method of increasing parking provision on site. The Trust was unable to progress outline plans for a modular car parking deck in 2013 due to competing clinical priorities for capital funding.

We are working with the planning consultant to identify a timeline for the development and submission of a full planning application.

10. I would like to take this opportunity to publicly thank all of our hardworking colleagues within all of our staff groups. The difference they make on a daily basis to so many people's lives is truly immeasurable.

    While our thoughts turn to so many of our own loved ones this Christmas, we do so safe in the knowledge that there are truly exceptional people working in every area of our public services to keep us safe and well.

    I would like to share two examples of people who typify the spirit of our NHS. There are, of course, many more people who, like Nikki and James, give so much. I would like to thank them all.

    Nikki Moore, who works in our Pre-Assessment Clinic at Tunbridge Wells Hospital, is preparing to donate a kidney. She was inspired to sign up when a friend was told their kidney was functioning at just seven per cent and would require a donation. Nikki and her friends' blood groups were not compatible, but the mother of four remained eager to help someone else and has since joined an NHS database for altruistic kidney donations - something done by on average just 100 people each year. Nikki now waits to hear whether she can find a suitable match on the database.

    Last week I was fortunate to attend the volunteers Christmas tea party at Maidstone Hospital and present awards to some of our longest serving colleagues. I would like to give a special mention to James Lakeland who began volunteering with us in 1967. His commitment and dedication to helping others is nothing short of remarkable and another wonderful reflection, at this special time of year, of the kindness and generosity that exists within our NHS.

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 – December 2018

NHS Maidstone and Tunbridge Wells NHS Trust

12-9	**Integrated Performance Report, November 2018**	**Chief Executive / Members of the Executive Team**

The enclosed report includes:

- The 'story of the month' for November 2018 (including Emergency Performance (4 hour standard); Delayed Transfers of Care (DTOCs); Cancer 62 day First Definitive Treatment) – please note Referral to Treatment (RTT) data will not be available until w/c 17/12/18
- A Quality and Safety Report (including an update on complaints performance) (Safe Staffing data will follow (as Attachment 5b) as it is not available until w/c 17/12/18)
- Planned and actual ward staffing for November 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 (to follow, w/c 17/12/18 (as Attachment 5a))

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

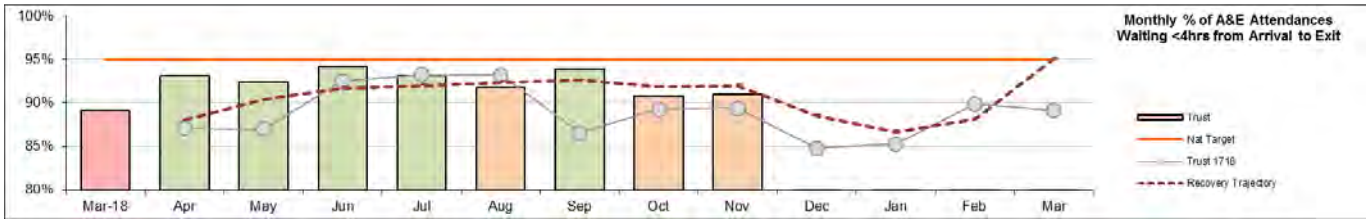
[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; 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 DECEMBER-18

1. 4 Hour Emergency Target

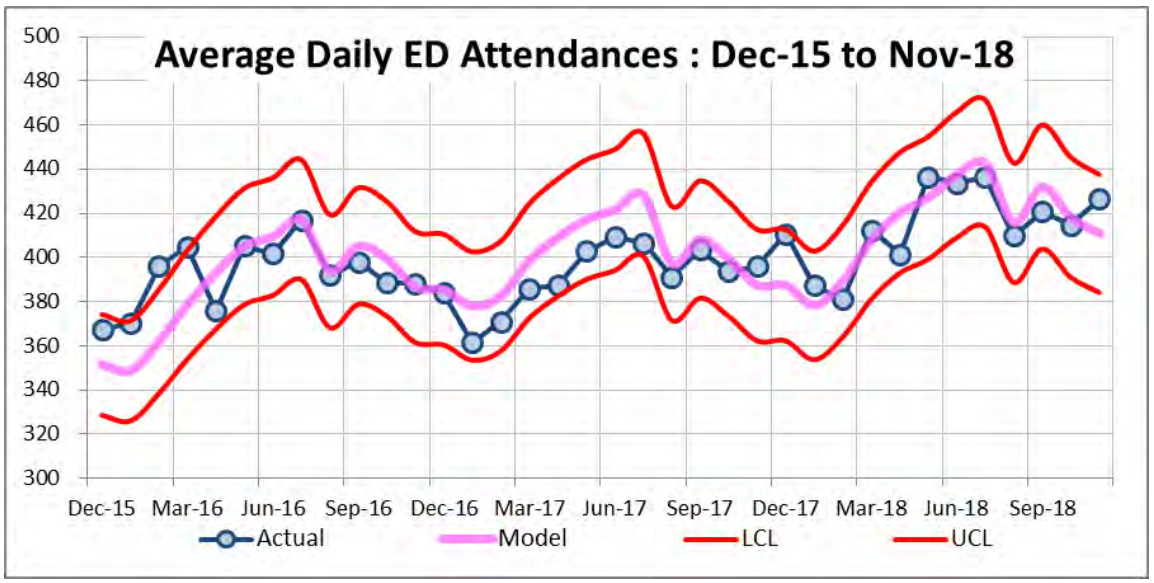
The Trust was above the recovery trajectory for each month from April to July 2018. Performance dipped slightly below trajectory in August, recovered in September but has dipped again, coming in at 90.93% in November (including MIU), against the target of 91.96% (-1.03%).

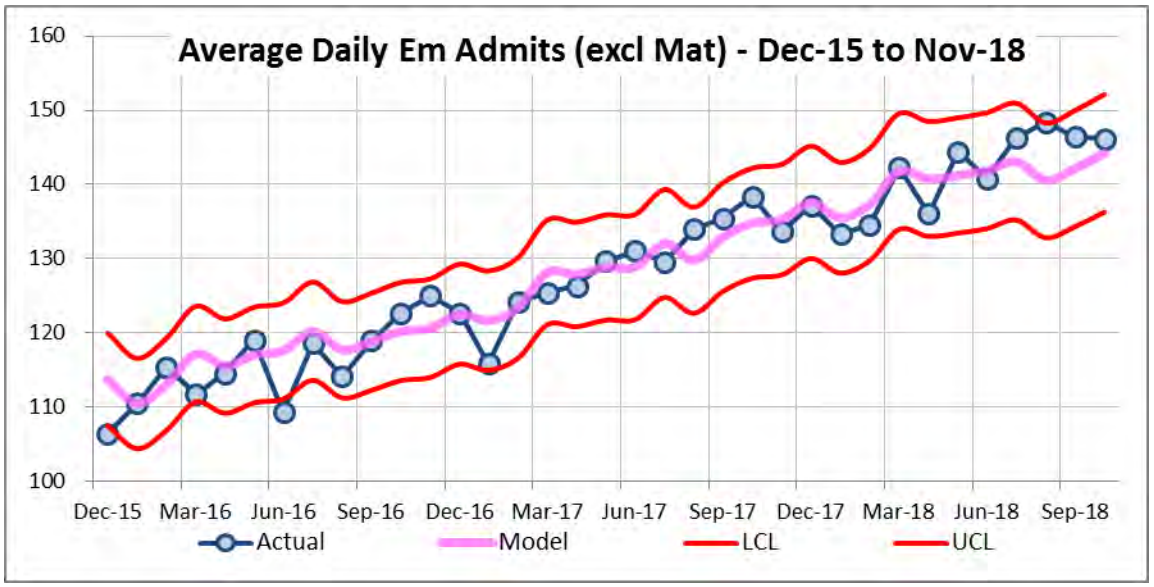
- YTD at 30-Nov, the Trust was at 92.56% against a YTD plan of 91.36% and a year-end target of 90.82%.
- December performance is however is currently challenging at 89.05% against a target of 88.54%.
- The Trust achieved Q2 with 92.99% against a target of 92.30%.
- At the end of 11-Dec, Q3 was scoring 90.56% against a target of 90.77%. PFS Funding relies on achieving 90% or better, which requires us to average around 88.0% for the remainder of December
- For the year 1718 the Trust scored 89.08%, compared to 87.12% in 1617.



2. ED Attendances & Emergency Admissions

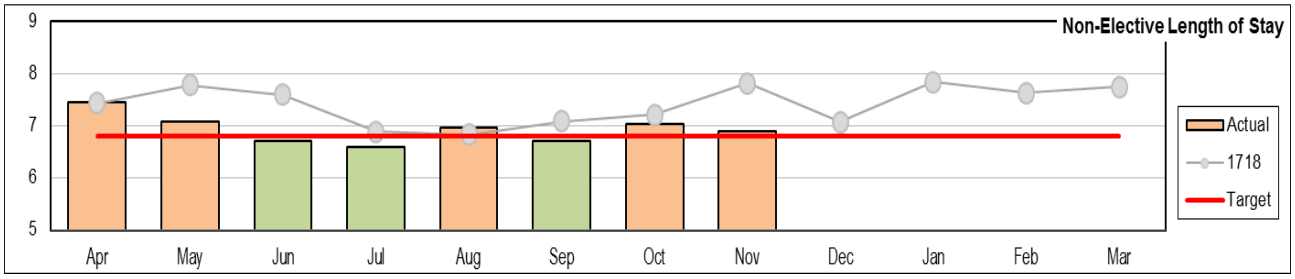
- A&E Attendances continue to increase. Over the last 5 years, annualised growth has averaged 4.4%. This is against a local population increase of around 1.1% per year, and a demographic 'bulge', where the people born during the 1946-64 spike in birth rates are hitting the age when A&E attendances become more frequent.
- Total November attendances were 1.9% up on model, and 7.5% up on trajectory at 15,420. This is 6.7% up on last November (like-for-like). YTD attendances are 0.5% up on model, 3.1% 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 11.1% above plan in November and 10.4% higher than last November at 4,698 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 10.6% above plan & 12.9% above last year.





3. Length of Stay

- Non-Elective LOS was 6.88 days in October, and 6.92 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 1 in November to 728, 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 tools such 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 fell back from 4.52% in October to 3.58% in November. This is the lowest level for some considerable time. YTD we are 4.63%

The number of lost bed days due to DTOCs fell 228 to 712. We ended 1718 on 4.95%, and apart from a spike in September we have been reporting under 5.0% for the past year or so, and have averaged 4.42% over the past 12 months. On average, 30.8 beds per day have been lost to delays in 1819 compared to 38.4 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.

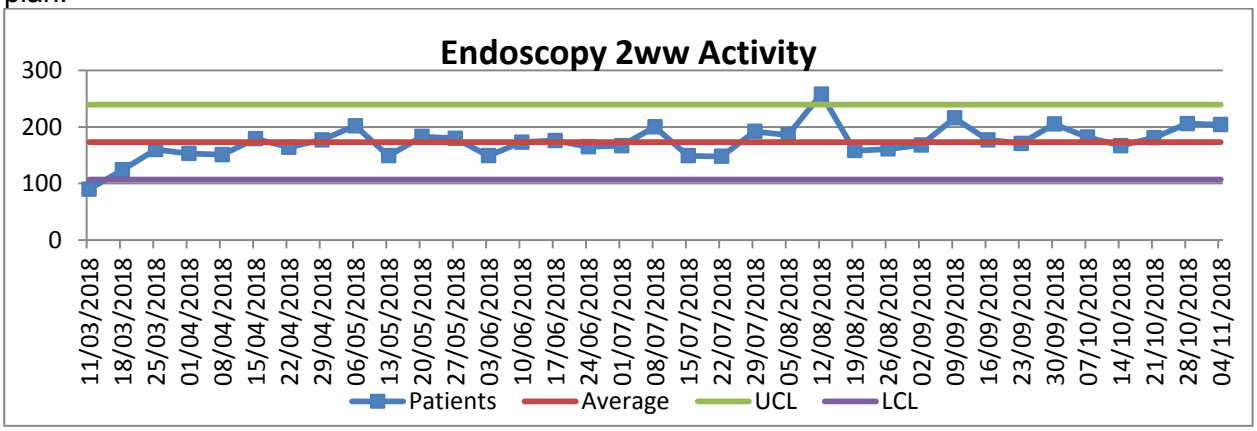
Category	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Rolling 12 Month
A : Awaiting Assessment	2	5	2	1	2	5	3	8	17	21	13	12	**91**
B : Awaiting Public Funding	0	1	5	1	2	4	0	0	4	3	0	0	**20**
C : Awaiting Further Non-Acute NHS Care	18	21	9	21	12	20	14	17	22	14	21	19	**208**
Di : Awaiting Residential Home	18	24	18	40	15	23	29	22	9	32	22	21	**273**
Dii : Awaiting Nursing Home	38	37	47	54	53	43	26	34	54	27	35	33	**481**
E : Awaiting Care Package	14	18	20	28	20	31	18	29	24	28	16	22	**268**
F : Awaiting Community Adaptations	4	12	10	7	15	7	6	4	8	10	7	3	**93**
G : Patient or Family Choice	13	11	5	10	3	14	11	9	14	9	17	9	**125**
H : Disputes	0	0	0	0	1	0	0	0	1	1	0	0	**3**
I : Housing	2	3	3	2	6	2	7	5	4	4	4	2	**44**
Grand Total	**109**	**132**	**119**	**164**	**129**	**149**	**114**	**128**	**157**	**149**	**135**	**121**	**1,606**
Rate	**3.73%**	**4.27%**	**3.89%**	**4.26%**	**4.56%**	**4.34%**	**4.39%**	**5.03%**	**4.77%**	**5.89%**	**4.52%**	**3.58%**	**4.44%**

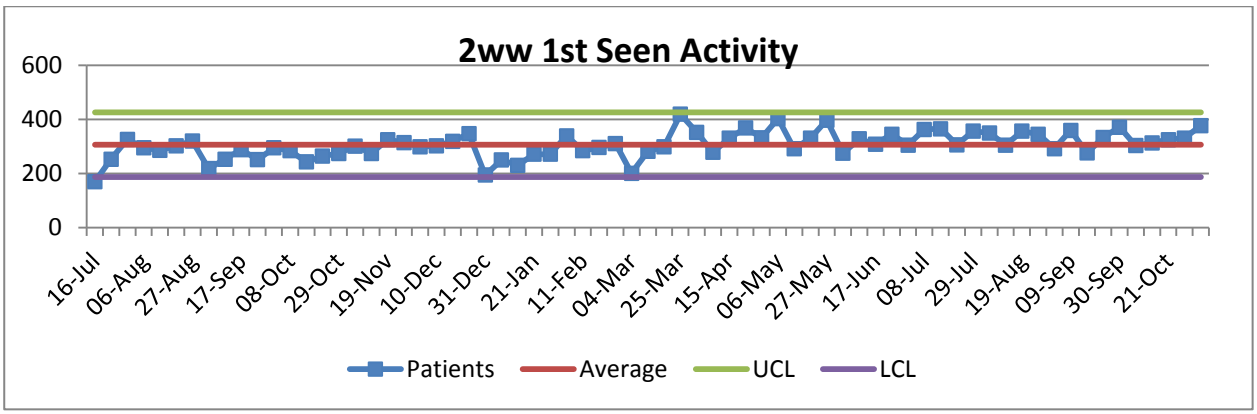
5. Cancer 62 Day First Definitive Treatment

62 day performance for October was 62.6% and 62.2% for 1819 Q2. 1718 finished on 70.4%.

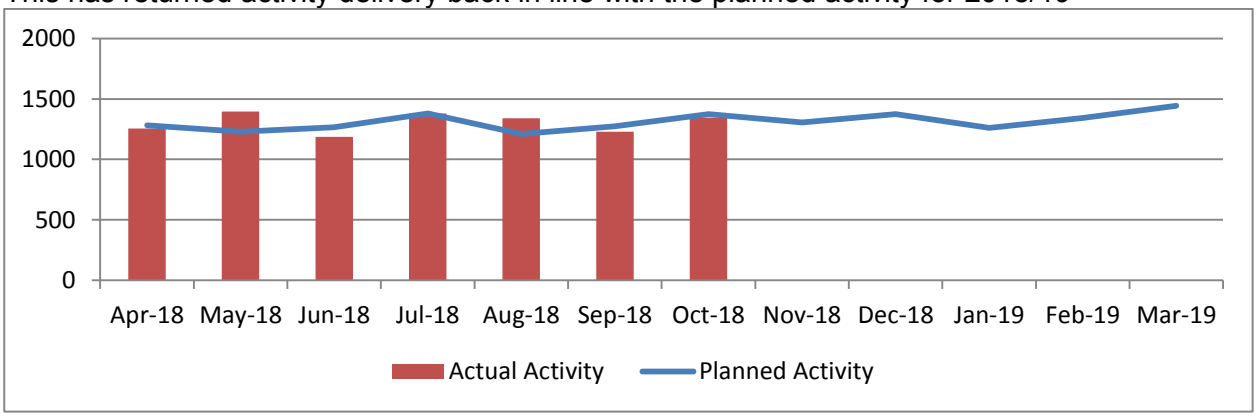
The delivery plan is focussed on increasing capacity at the front end of the pathway (i.e. 2ww capacity, outpatients and diagnostics) as has been demonstrated in the recent analysis. However, treatment capacity will be continually reviewed as more patients are diagnosed faster and cross-over with patients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

Increases in endoscopy and first seen appointment activity have increased in line with the recovery plan.

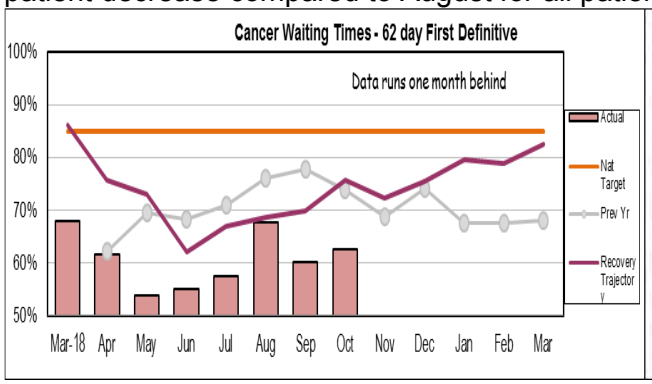


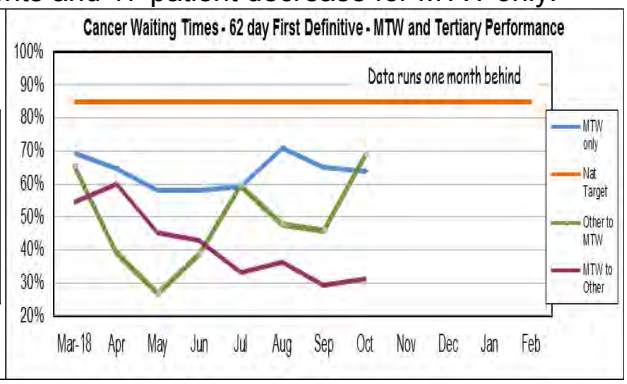


This has returned activity delivery back in line with the planned activity for 2018/19



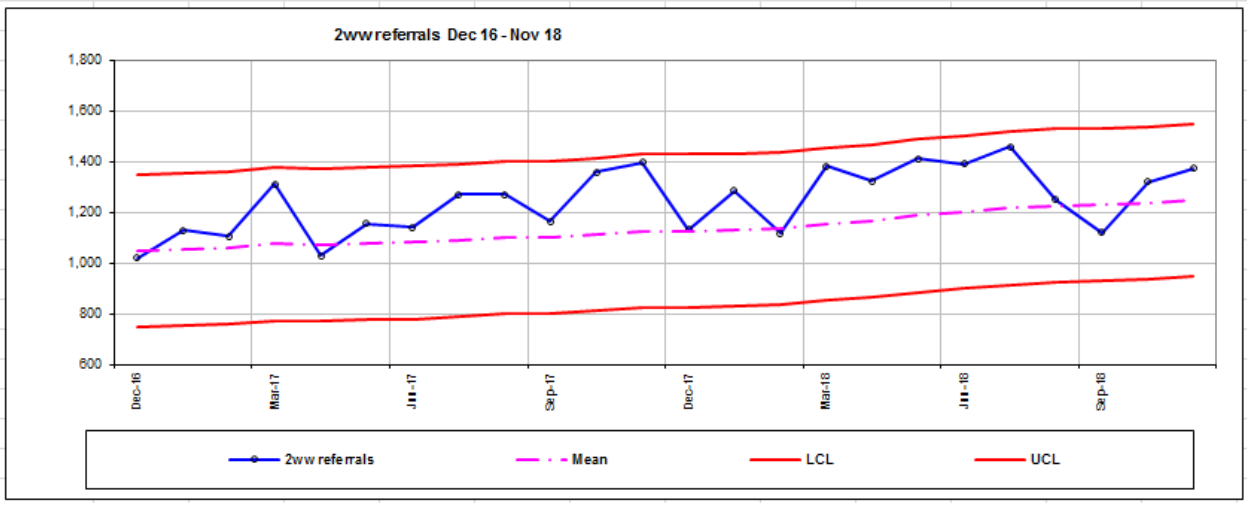
The size of the backlog at the end of September was 71 patients (patients waiting over 62 days for treatment with a diagnosis of cancer). For the MTW only patients the backlog was 34. This is a 9 patient decrease compared to August for all patients and 17 patient decrease for MTW only.





62 Day Performance						
October 2018	All reportable patients			MTW only patients		
	Total	Breach	%	Total	Breach	%
Breast	26.5	7.5	71.7	24	7	70.8
Gynae	8.0	0.5	93.8	5	0	100.0
Haematology	10.0	5.0	50.0	10	5	50.0
Head & Neck	5.5	3.0	45.5	3	2	33.3
Lower GI	27.0	8.0	70.4	25	7	72.0
Lung	12.5	2.5	80.0	8	2	75.0
Other	2.0	1.0	50.0	2	1	50.0
Upper GI	15.0	8.5	43.3	13	7	46.2
Urology	46.0	21.0	54.3	40	16	60.0
TOTAL	152.5	57.0	62.6	130	47	63.8

Since January, the volume of 2ww referrals has increased significantly (particularly in Urology and Breast). Lower GI referrals had increased but this was due to e-referral being available in MTW but not in Medway. Medway have now gone live for e-referral and so referral rates appear to be returning to a lower level. The average weekly number of referrals has increased by over 20%. October's referrals have reached about the same level as the highest point seen in July.



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.

Capacity and demand reviews for the modalities in Radiology is underway but is hampered from by gaining access data from the radiology information system. Discussions are taking place with East Kent about how this data can be accessed as they have already achieved a better data flow.

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 and started at the beginning of November for the prostate pathway. 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. The peak number of patients was seen at the start of October but there has been a steady decrease in the number of patients over the last 6 weeks.

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).

A revised trajectory is in development to take in to account actions that are being taken and when and what benefit will be seen.

Cancer 2 week waits

Endoscopy capacity has been significantly increased from the start of September (as per the graph above) 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 output from the IST regarding capacity has identified a shortfall in breast clinics and a likely positive balance for urology outpatients.

In September, the breast service contributed 22.5% of breaches (0.5% reduction compared to last month), Lower GI 36.5% (-1.5% compared to last month) and Upper GI 19.2%.

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 or imaging capacity.

Upper GI breaches have increased in the last couple of months but has decreased by 4% compared to last month. Again, this is due to endoscopy capacity, which has been significantly increased since the start of September.

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.

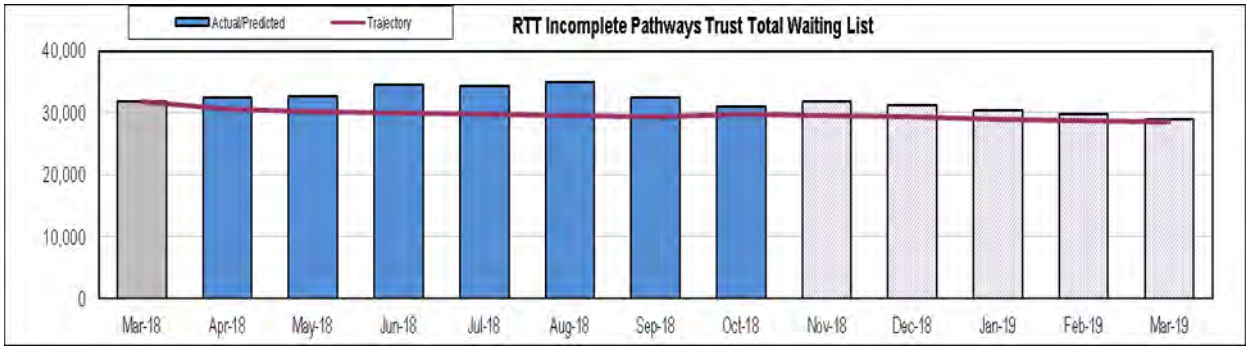
6. Referral To Treatment – 18 weeks

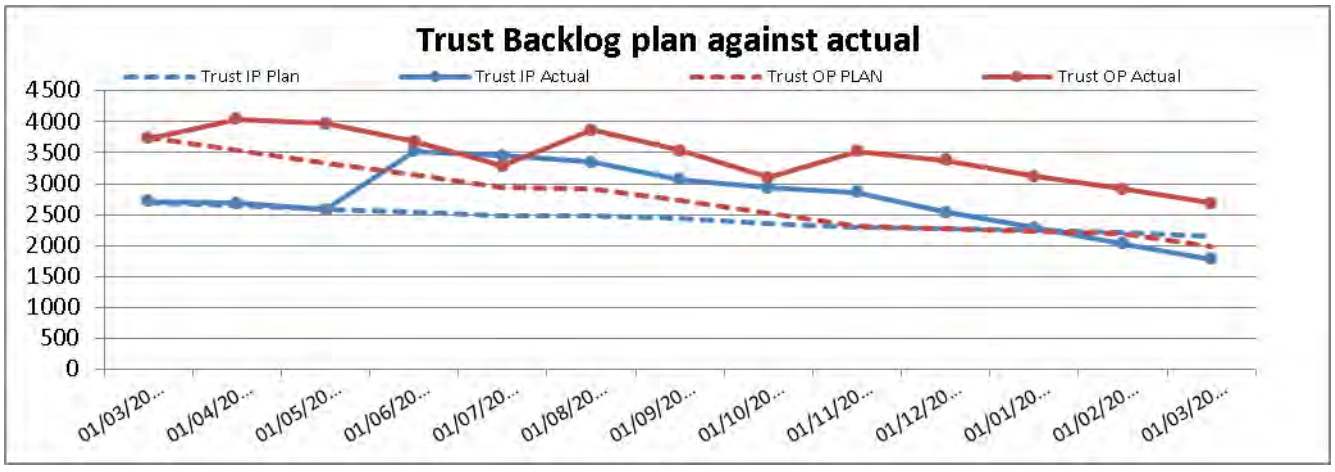
October performance shows an improvement in the Incomplete RTT performance achieving 80.67% against a target of 83.63%. The updated recovery plan is focused on retrieving the activity during November to March as well as undertaking some additional activity. The objective remains to achieve a waiting list position at the end of March 2019 that is no greater than the March 2018 position of 31,871.

		Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
TRUST	Trajectory Total WL	31871	30573	30211	29955	29700	29583	29329	29836
	Actual Total Waiting List	32074	32729	32888	34584	34420	34856	32386	31236
	Actual IP Waiting List	5741	5736	5841	7641	7519	7273	6986	7024
	Actual OP Waiting List	26333	26993	27047	26943	26901	27583	25400	24212
	Trajectory Backlog	6438	6186	5935	5685	5437	5416	5170	4884
	Actual Total Backlog	6451	6728	6547	7214	6743	7220	6607	6036
	Actual IP Backlog	2716	2682	2577	3530	3454	3352	3068	2939
	Actual OP Backlog	3735	4046	3970	3684	3289	3868	3539	3097
	Trajectory % Performance	**79.8%**	**79.8%**	**80.4%**	**81.0%**	**81.7%**	**81.7%**	**82.4%**	**83.6%**
	Actual Total % Performance	**79.9%**	**79.4%**	**80.1%**	**79.1%**	**80.4%**	**79.3%**	**79.6%**	**80.7%**

A detailed piece of work has been undertaken to produce a revised forecast of future performance from November until the end of March 2019 based on the RTT Recovery Plan (as below). Prime Provider activity has not been included in this plan.

RTT Forecasted Performance	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	31236	31832	31224	30477	29782	29068
Total Backlog	6680	6728	6547	7214	6743	7220	6609	6036	6808	6338	5826	5363	4897
Total %	**79.04%**	**79.44%**	**80.09%**	**79.14%**	**80.41%**	**79.29%**	**79.59%**	**80.68%**	**78.61%**	**79.70%**	**80.88%**	**81.99%**	**83.15%**





The impact from an earlier data quality issue means that the IPWL part of the Total Waiting List from July increased by 1528 patients and the IP Backlog increased by 921 patients which will have an ongoing effect. The validation process has demonstrated a reduction in both these lists in October 2018.

Elective Activity and New Outpatient Activity:

Currently the Elective activity YTD is 17.9% below plan at 4,316. Outpatient New Activity (excluding Therapies and Ward Attenders) is 4.5% above 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.

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 (General Surgery, Urology, Neurology & Endocrinology)
- Reduced activity in January 2018 to support Non-Elective 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-Eye work across elective and outpatients.

The majority of the RTT backlog continues to be concentrated in surgical specialties with the exception of 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. Work continues to validate the remaining 2300 duplicate pathways. 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	Oct-18	YTD
RTT >52kw Breach Occurrences	3	2	8	13	8	5	9	22	9	44

The Trust has incurred 44 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 well received and continues to be a priority for all specialities.
The Trust has set itself a Weekly 52wk breach trajectory of improvement to get to zero by 31st March 2019:

Trajectory for Reduction in 52+ week Waiters to zero by week ending 31st March 2019																					
	Trajectory for Improvement by 31st March 2019																				
	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
TRUST	10	10	10	10	10	10	10	10	8	8	8	8	8	5	5	5	4	3	2	1	0

Oversight:

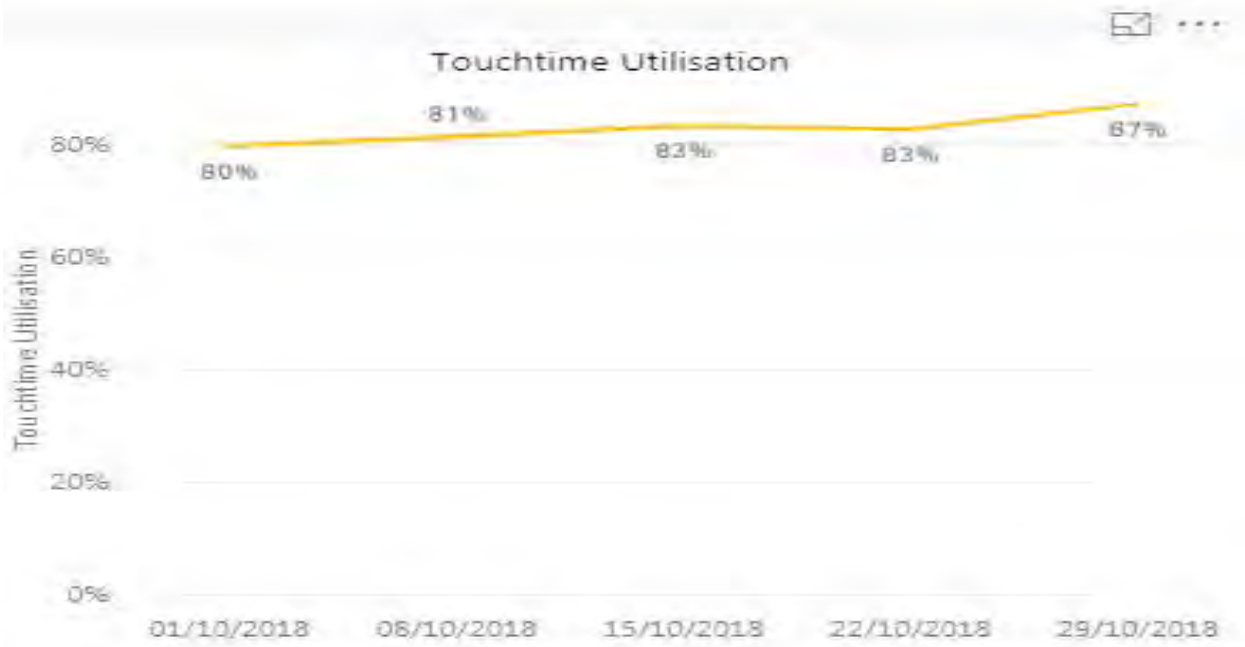
- Weekly monitoring of the specialty plans for activity, diagnostics, and theatre scheduling, backlog and waiting list size, through the PTL and specialty meetings.
- Daily focus on the 40+ week patients to ensure treatment occurs before 52 weeks.
- 52 Week Panel has been established to fully investigate the breaches and identify trends.
- Ensure backlog patients are booked chronologically to avoid long waits/52 week breaches.
- Two Operational Transformation Managers joined the Trust in 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 through to March 2019.
- 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.

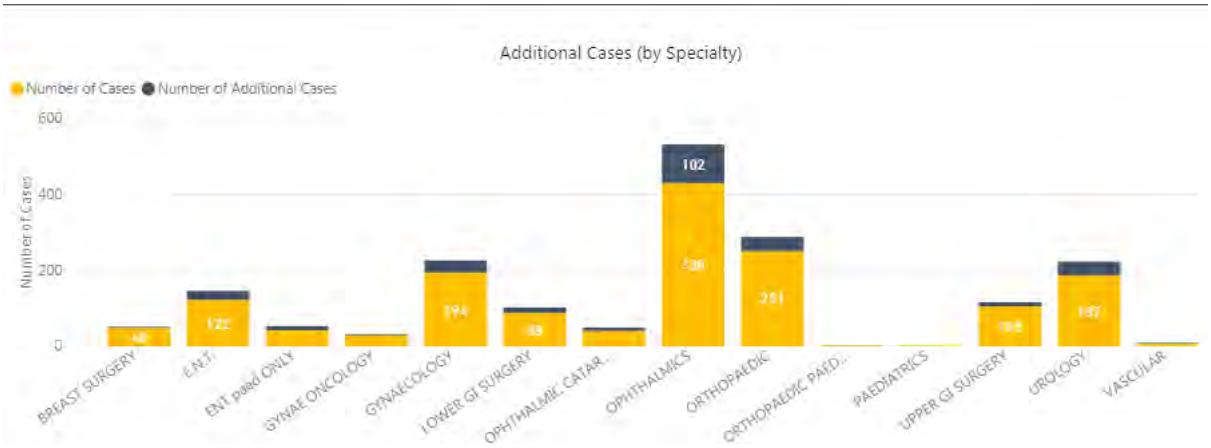
7. Theatre Productivity

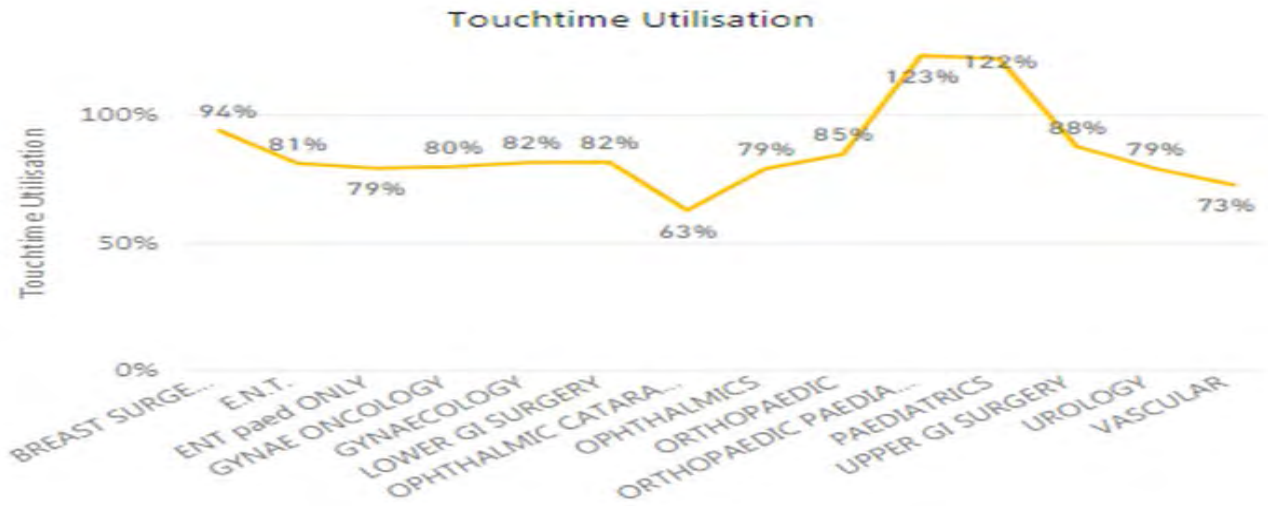
The graphs below are taken from the Four Eyes Theatre Dashboard and show the Theatre Utilisation from 1/10/18 – 29/10/18 overall and per speciality. The target for utilisation is 85% Overall Touch time Utilisation and this has to be delivered by monitoring that we have effective booking, listing and pre-operative assessment in place; start and finish times by specialty; number of cases per session; cancellations and DNAs; appropriate allocation of NCPOD lists and case-mix. Specialty level exception reports are provided and reviewed at the theatre utilisation group.

In order to improve theatre productivity the Trust has resurrected the Head and Neck task and finish group following the appointment of the new Clinical Director; Critical Care and T&O management team have meet and agreed that all lists in MOU will contain 5 majors or 4 majors and 2 day cases as standard; No face to face Pre-Operative Assessments for American Score of Anaesthesiology (ASA) grade 1 patients, screening and observations will take place in out-patients; MRSA screening validity has increased from 8-12 weeks and the Admission Lounge at Tunbridge Wells processes will be reviewed to support winter plan.



Touch time per Speciality, excluding Chronic Pain (CPU), Portacath and Endoscopy as the time stamps result in inaccurate data collection.


Additional Cases (by Specialty)
Number of Cases
Number of Additional Cases
600
400
200
0
Number of Cases
102
BREAST SURGERY
E.N.T.
ENT paed ONLY
GYNAE ONCOLOGY
GYNAECOLOGY
LOWER GI SURGERY
OPHTHALMIC CATAR...
OPHTHALMICS
ORTHOPAEDIC
ORTHOPAEDIC PAED...
PAEDIATRICS
UPPER GI SURGERY
UROLOGY
VASCULAR


Touchtime Utilisation
Touchtime Utilisation
100%
50%
0%
94%
81%
79%
80%
82%
82%
63%
79%
85%
123%
122%
88%
79%
73%
BREAST SURGE...
E.N.T.
ENT paed ONLY
GYNAE ONCOLOGY
GYNAECOLOGY
LOWER GI SURGERY
OPHTHALMIC CATARA...
OPHTHALMICS
ORTHOPAEDIC
ORTHOPAEDIC PAEDIA...
PAEDIATRICS
UPPER GI SURGERY
UROLOGY
VASCULAR

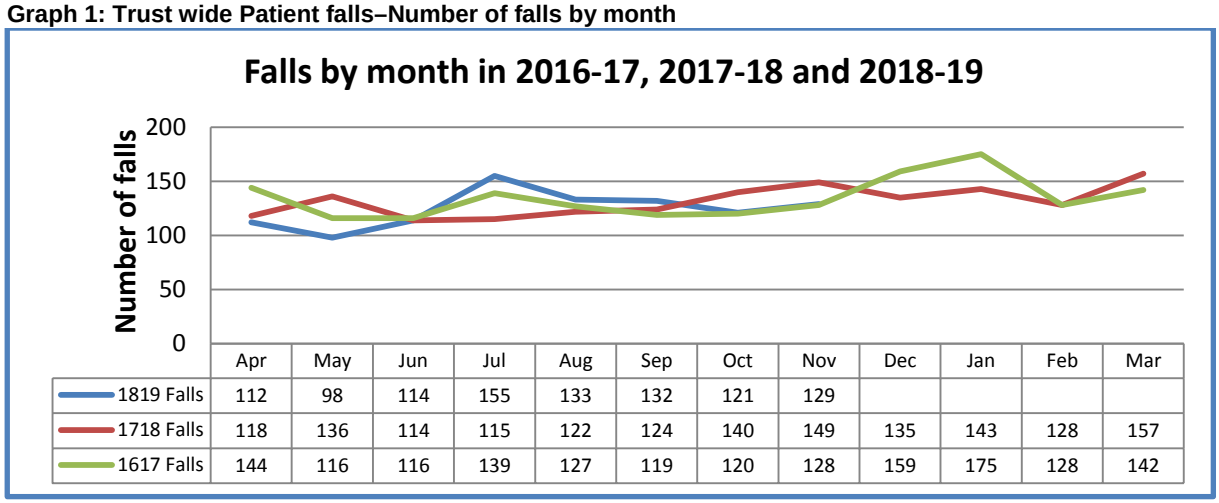
Quality and Safety December Trust Board (November data)

Patient Falls incidents

There were 129 falls incidents reported during November, compared to 121 for October 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 45 falls at Maidstone and 84 at Tunbridge Wells. The monthly falls rate per 1000 occupied bed days (OBD) for November was 6.48; comparison to previous months can be seen in Graph 2. The year to date falls rate for 2018/19 is 6.13 per 1000 OBD against the threshold of 6.0.

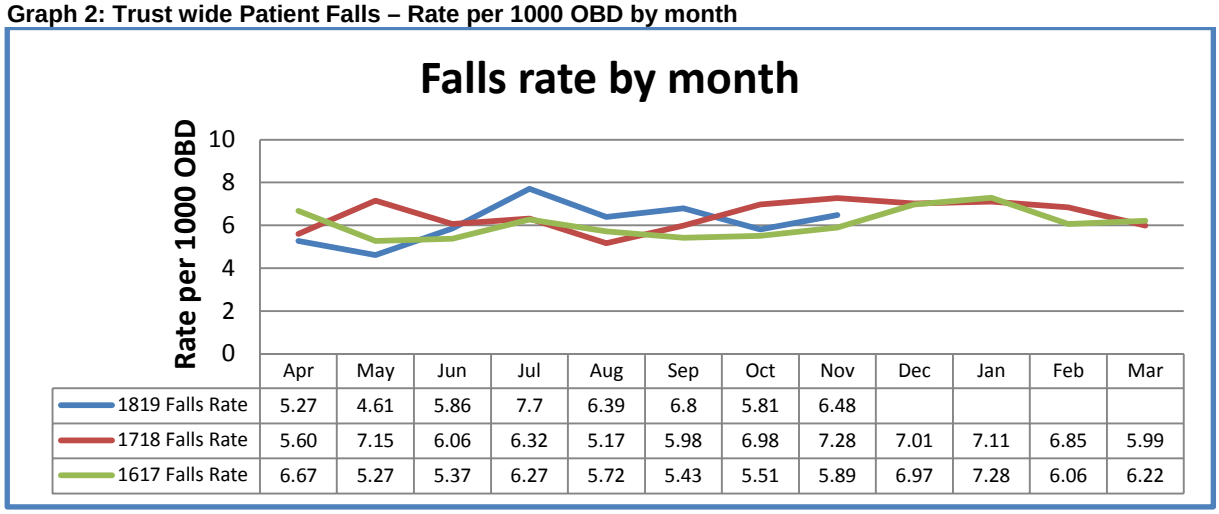
There were two falls resulting in injury declared as Serious Incident's (SI) in November 2018. One SI at Maidstone Hospital where a member of the public fell and this resulted in a hip fracture. The second SI was for an inpatient fall at Tunbridge Wells Hospital that resulted in a fracture of the left distal humerus.

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	121	129				
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	5.81	6.48				
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

The safety calendar for December is concentrating on falls prevention and reduction. Falls prevention continues to be an important patient safety focus for MTW and our participation with the NHSI Falls Collaborative is supporting renewed energy with this agenda. During the month staff are being asked to focus on the key indicators for falls prevention during their Safety Huddles.

There are 7 key indicators considered to be essential to falls prevention practice and should be included in the patients risk assessment. These include:-

- Assessment for the presence or absence of delirium or a documented diagnosis of delirium
- A continence or toileting care plan that is tailored to meet the patient's needs
- Measurement of lying and standing blood pressure

- An assessment for medication that increase the patient's falls risk
- Any assessment of vision for visual impairment
- Ensuring that the call bell is in sight and in reach of patient (as appropriate)
- Ensuring that an appropriate mobility aid is within reach.

Pressure Ulcers:

The incidence rate of confirmed Hospital acquired Pressure Ulcers for November 2018 was 0.34 (per 1000 admissions) compared to 2.22 for the same month last year. This equates to 8 patients who have developed hospital acquired (HA) pressure ulcers and 2 that deteriorated further whilst in our care. Of the 8 HA pressure ulcers 7 of these relate to heels and one as a result of a medical device causing ulceration of the patient's nose.

We have not declared any pressure ulcer related serious incidents during November. The incidence for November demonstrates a slight improvement from October 0.98 per 1000 admissions.

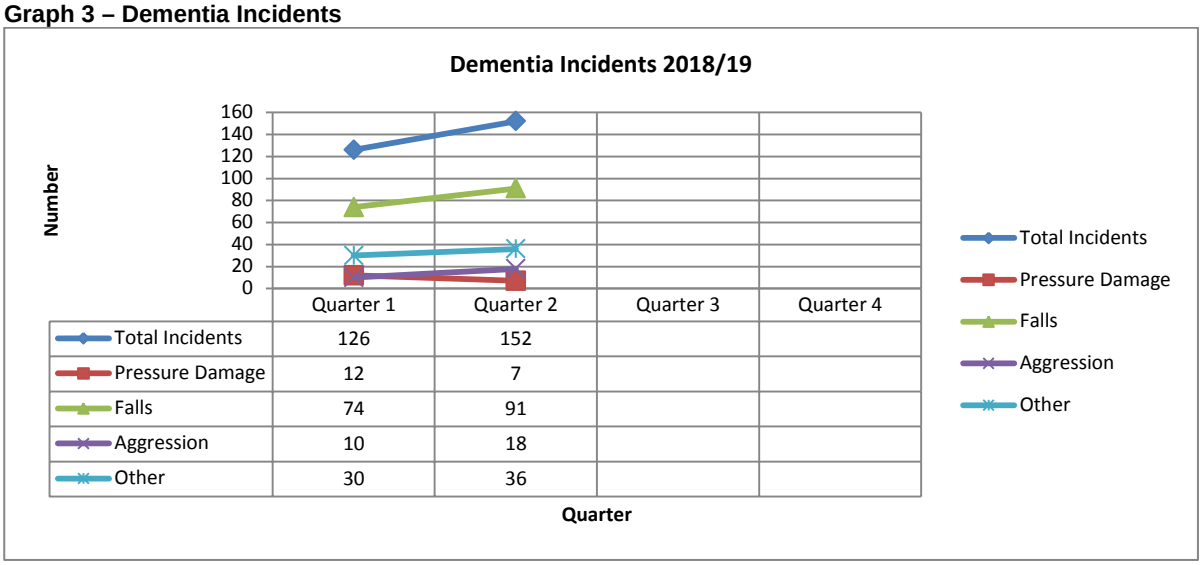
Further to October's report, the increase of injury to heels remains evident; education is pivotal in regard to the need for a full body assessment even for patients who are considered to be independent, unless they are deemed to have capacity to decline assessment.

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.

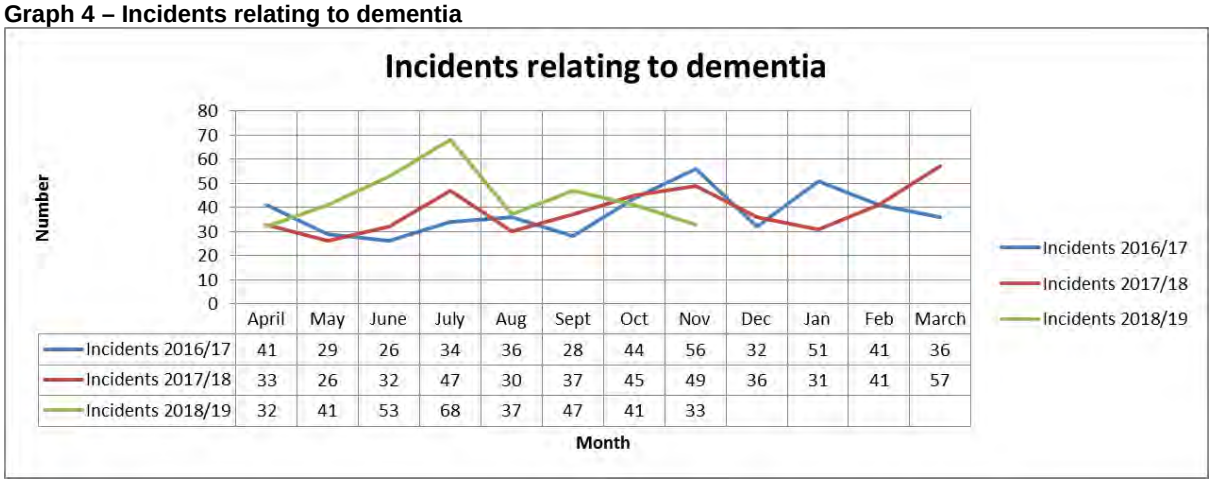
The incidents have been analysed by the Lead Nurse for Dementia Care, following a search on the Datix system of all incidents relating to patients with dementia. The identification of patients with a known diagnosis of dementia is via the Datix form and this has been validated by the Lead Nurse for Dementia 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).

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	41	33				

Graph 4 plots the number of incidents relating to dementia patients per month for 2016/17; 2017/18 and 2018/19. There continues to be a decline in incidents in November from the previous 2 years and since last month. There were 25 incidents at TWH and 8 at Maidstone, of these falls continues to be the main cause of incidents totalling 18 (13 at TWH and 5 at Maidstone).

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.

Serious Incidents (SI's):

There were 11 Serious Incidents reported in November 2018 (6 at TWH and 5 at MGH).

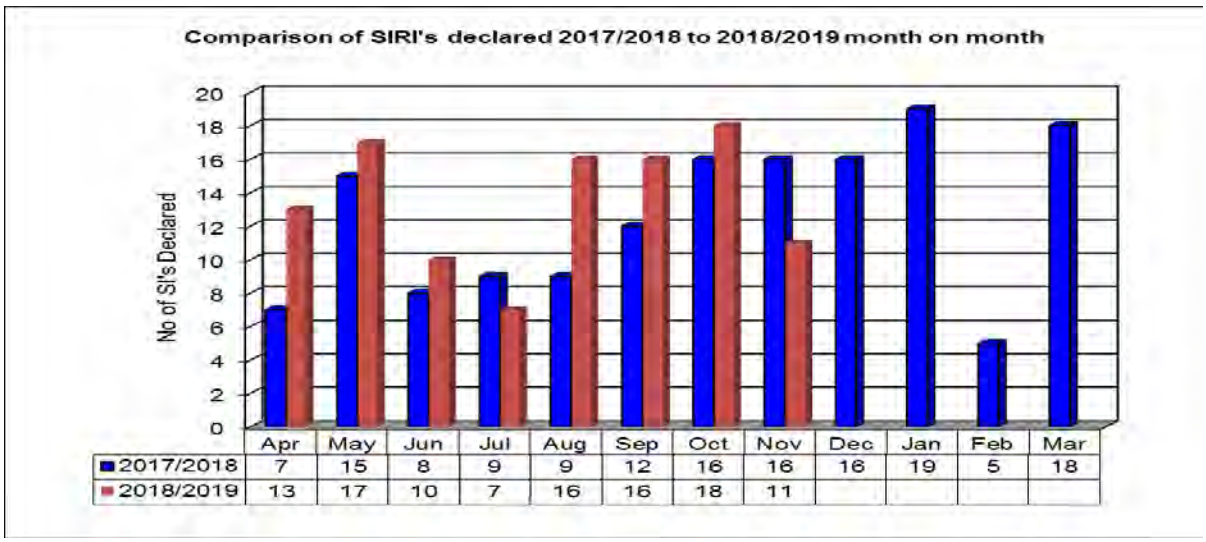
11 main SI's in 7 Directorates:

- 2 in Acute and Emergency Medicine (TWH)
- 1 in Corporate (MGH)
- 1 in Critical Care (MGH)
- 1 in Pathology and Pharmacy (MGH)
- 4 in Specialist Medicines and Therapies (TWH(3) MGH (1))
- 1 in T&O (MGH)
- 1 in Women's and Sexual Health (TWH)

Of the 11 main SI's reported in November 2018:

-2 Falls – 1 in Corporate and 1in Specialist Medicines and Therapies
-2 Safeguarding – both in Acute and Emergency Medicine

The total number of SI's open remains increased year to date at 93 compared to 63 during 2017/18.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/2018	7	15	8	9	9	12	16	16	16	19	5	18
2018/2019	13	17	10	7	16	16	18	11				

During the month of November, 12's were closed and of that 12, 5 SI's were downgraded as detailed below:

SI 2018/15177 – Maternal/Obstetric – baby only declared June18
SI 2018/16983 – Fall declared July18
SI 2018/17347 – Maternal/Obstetric – baby only declared July18
SI 2018/20273 – Pressure Damage declared Aug18
SI 2018/25406 – Treatment Delay declared October18

Learning from the Falls Panel:

Identified the need for appropriately documented rationale for the reasons to step down enhanced care. Also for staff to ensure that they have good visibility of patients identified as needing constant observation. Ensure that Trust protocols are followed at all times, in this instance the protocol for neurological observations.

Learning from the VTE Panel:

- To ensure all staff are aware of the VTE risk assessment and prescribing; and following that assessment, document why the patient will not be prescribed/did not receive prophylaxis.
- To ensure treatment dose is prescribed on suspected VTE whilst awaiting a scan.
- To ensure VTE prevention policy is adhered to by implementation of VTE safety check list on ward round.
- To ensure staff escalated delays in Doppler scans to consultant radiologist and follow VTE prevention policy regarding prescription of treatment dose in a suspected VTE

Learning from the main panel included:-

SI and category	Care/Service Delivery Issue	Learning
2018/16367 Failure to review test result - deterioration in sight	No process for confirming scan results have been reviewed by a doctor	Policy should be in place / written to ensure all results are reviewed regardless of treatment plan being in place and appropriately documented in patients notes
2018/10237 Attempted Suicide	Ligature Risk Assessment form to be completed for all patients admitted to the ward under the Mental Health Act and especially if declared at risk of suicide	Assessment form to be completed by the admitting staff at the time and recorded in the patient notes. Assessment form and policy found on QPulse.
2018/12672 Missing prescription	FP10's to be locked in designated place during clinic time	Investigate suitable areas to securely store prescription pads during operational working hours of the outpatient

SI and category	Care/Service Delivery Issue	Learning
pads	Re-issuing of the Local SOP for the Management of FP10's in Outpatient Settings	departments. Reissue the Standard Operating Procedure to all staff in contact with prescription pads, to familiarise themselves with the correct process/procedures in handling FP10's.
2018/21532 IG Breach	Practitioners do not always check where their computer is defaulted to for printing requests	For all practitioners to be reminded how to reset their default printer when working in another area. ED Leads to check with staff that they understand how to do this. Organisational for all staff to have a printing code so that what they have requested to be printed can only be printed via their personal code.
2018/21536 Instrumental delivery	Poor documentation of Consent	Ensure complete and accurate documentation of risks and associated risks to ensure adequate and complete consent has been obtained.
2018/22034 IG Breach	Internal processes need to be clearly defined around National Surveys	Internal processes to be appropriately documented Development and adherence to an operational level agreement on national surveys between the Clinical Governance (Patient Outcomes) and the Business Intelligence Unit

Single Sex Compliance:

There were 8 incidences of mixed sex accommodation reported during the month of November. These occurred on the Surgical Assessment Unit at TWH on the 26th November at 22.50hrs. The area was unmixed the following day at 15.47hrs. These breaches occurred due to high operational demands.

Friends and Family Test:

Overall response rates for November have shown an increase. Following the decrease in October's FFT response rates a review and subsequent identification of service issues for FFT during this month was undertaken which identified new issues that have now been resolved. This included an unexpected change in MTW's account manager for FFT which initially interrupted the usual methods of communication and therefore early identification of low numbers or ability to load the FFT forms. This resulted in more than 700 forms not being uploaded for October and 650 forms which were rejected.

With established new services / pathways of care within the Trust to include AEC, AFU, CAFU and ambulatory pathways we have worked to include these new services onto the IWGC system. All new areas are assigned unique codes to ensure feedback is attributed to the correct area. These codes have been provided to the Trust procurement department so that the units IWGC cards can be requested. This will help reduce the risk of photocopies for those departments previously waiting for delivery of cards.

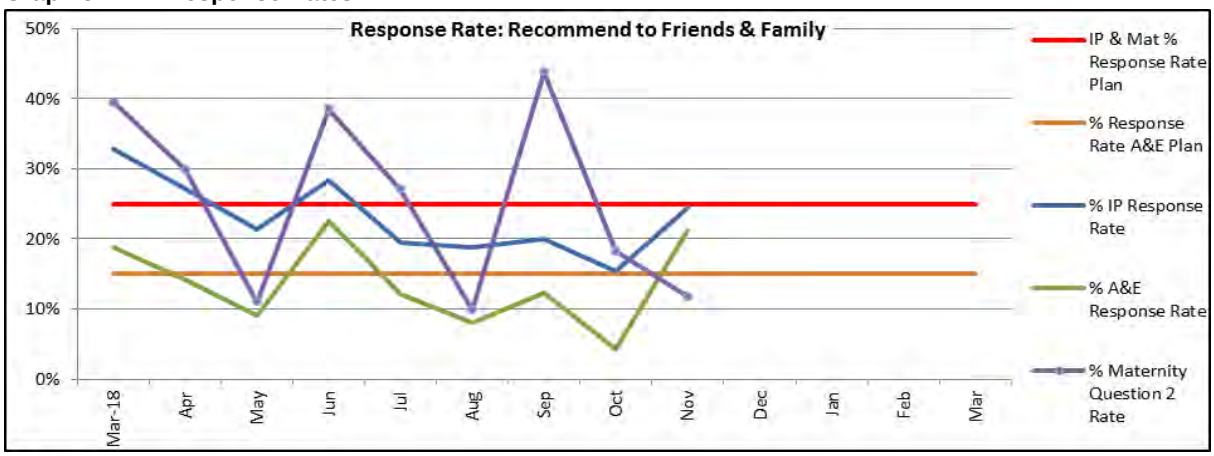
Dedicated IPads have now been rolled out to 26 areas with successful test submissions. The reporting system will be able to monitor utilisation of the app version. In addition, there is also an app available for all the community midwives which are accessed via the surface tablets.

Response rates for November: inpatients increased from 15.4% in October to 24.5% in November. This was over a 50% increase in the number of respondents from the October data. A&E increased from 4.2% in October to 21.2% in November. Maternity Q2 decreased from 18.2% in October to 11.8% in November.

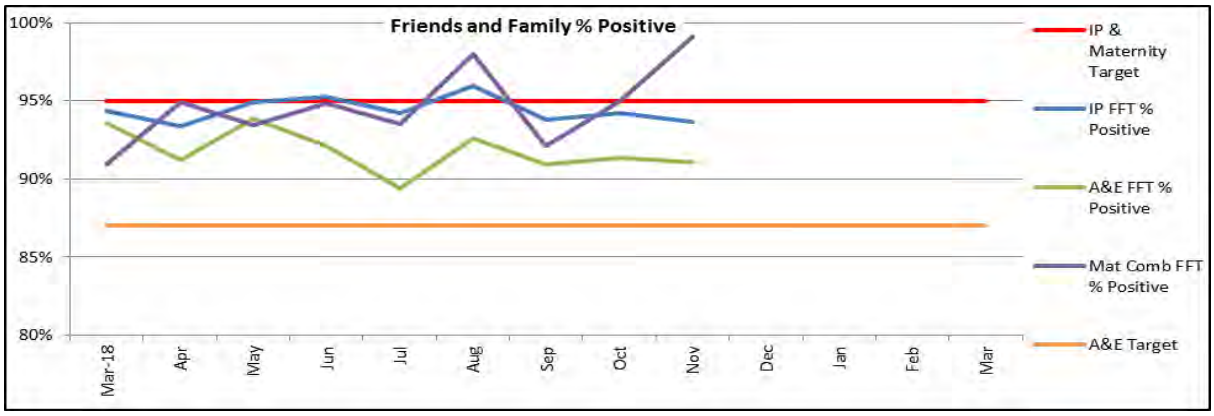
For the % Positive for November, inpatients has decreased slightly from 94.2% in October to 93.7% in November, A&E decreased from 91.4% in October to 91.0% in November and Maternity (all 4 combined) increased from 95.0% in October to 99.1% in November.

In terms of number of respondents from OP, the response rate has increased from 1769 in October to 2034 in November.

Graph 5- FFT Response Rates:



Graph 6 - FFT Positive Responses:

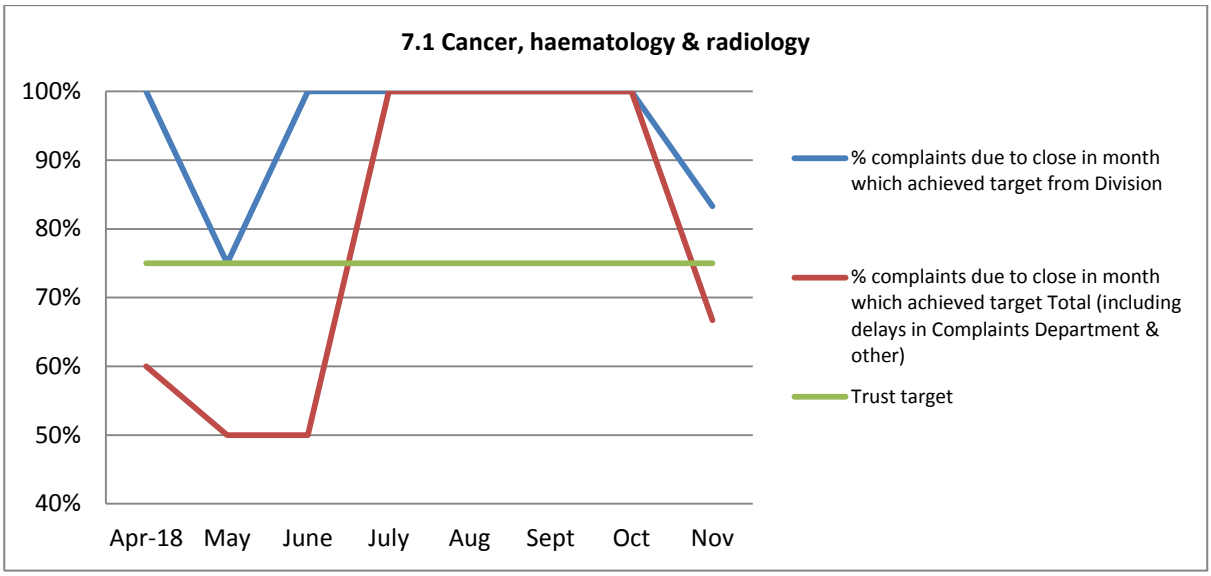


Complaints:

There were 48 new complaints reported for November which equates to a rate of 2.41 new complaints per 1,000 occupied bed days. This is a decrease compared to 2.84 for October. There were 139 open complaints at the end of November which has remained static from the 139 reported in October.

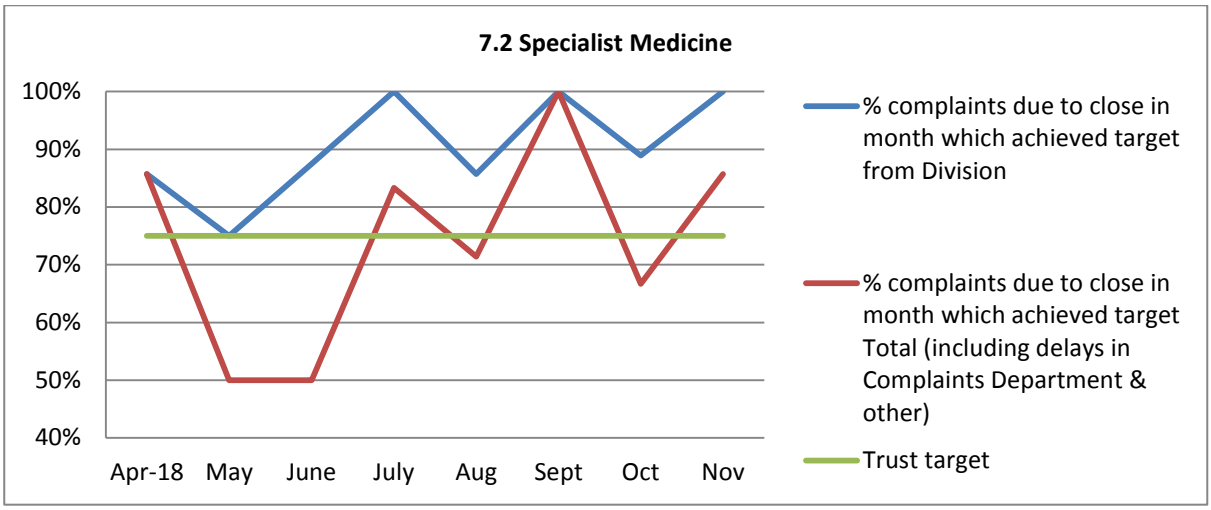
75% of complaints were responded to within deadline compared to a target of 75%. Graphs 7.1 to 7.9 (below) provide information on the performance for year to date by each directorate.

Graph 7.1 - Complaints performance against Trust target and agreed trajectories



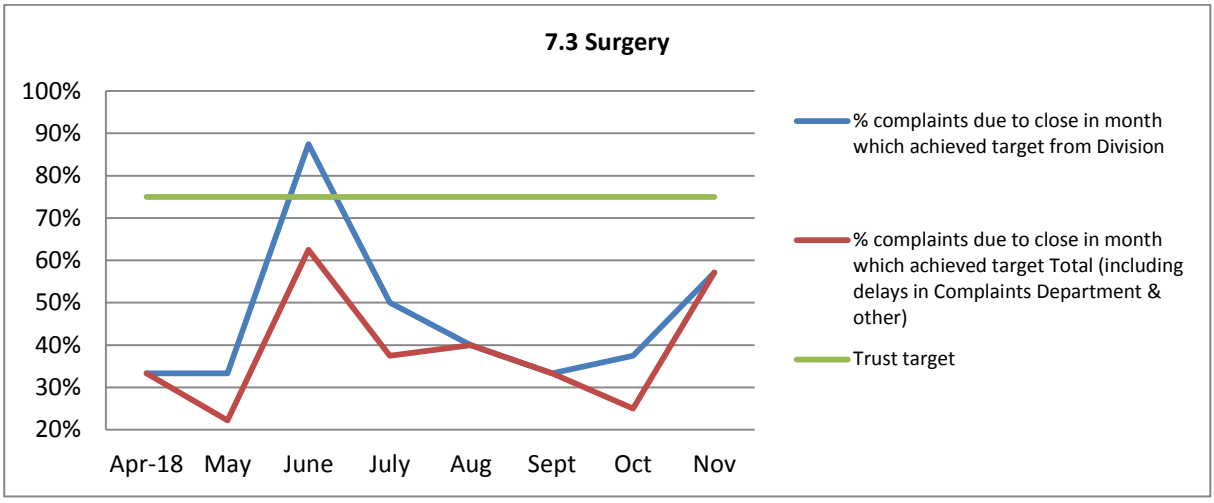
Cancer, Haematology & Radiology	Apr-18	May	June	July	Aug	Sept	Oct	Nov
Number of complaints due to close in month	5	4	2	2	2	1	2	6

Graph 7.2



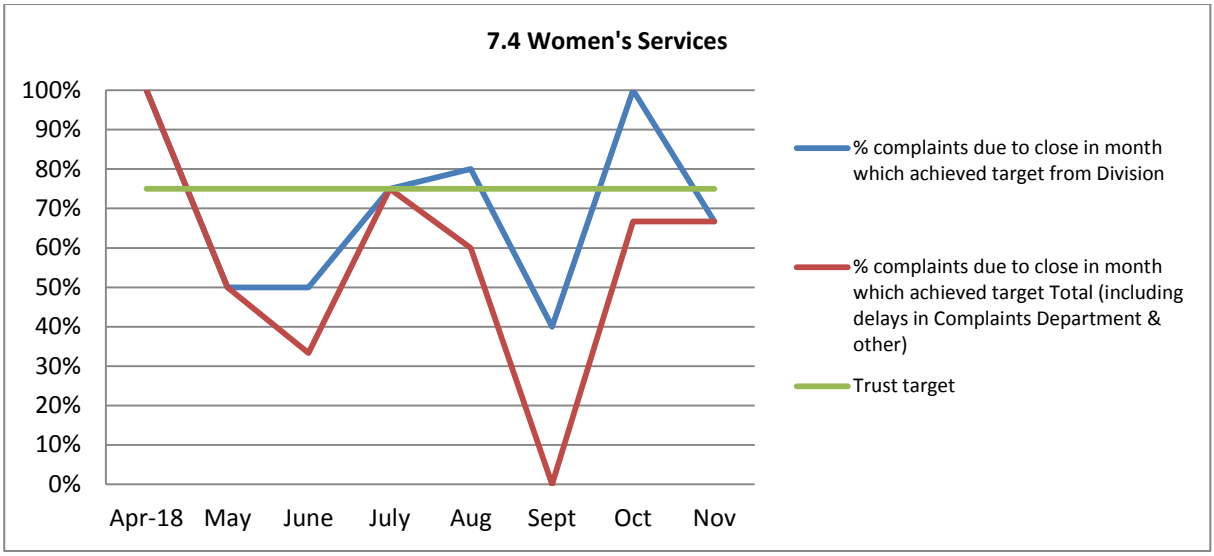
Specialist Medicine	Apr-18	May	June	July	Aug	Sept	Oct	Nov
Number of complaints due to close in month	7	12	8	6	7	7	9	7

Graph 7.3



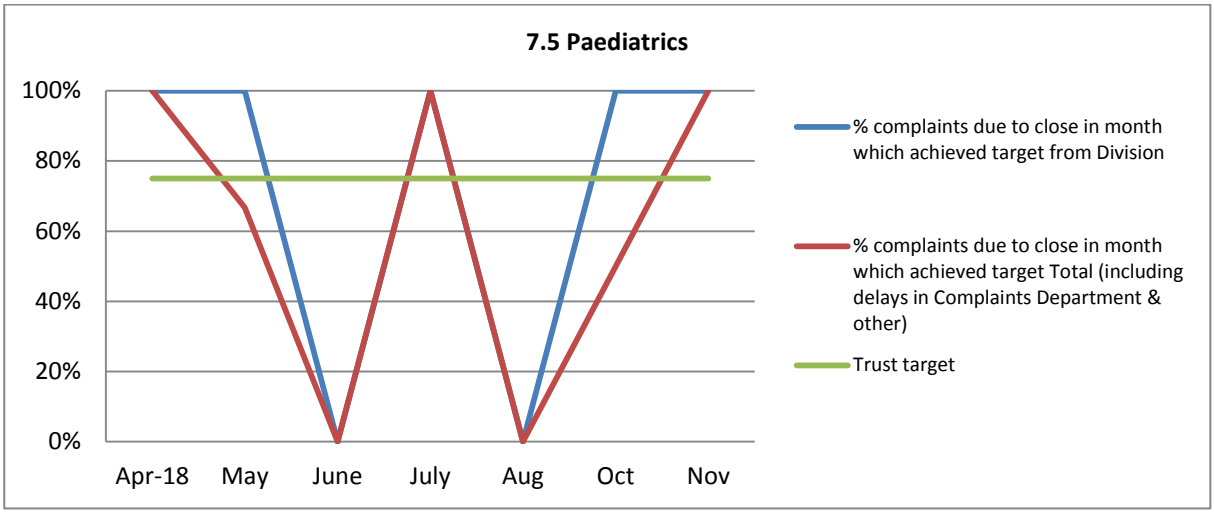
Surgery	Apr-18	May	June	July	Aug	Sept	Oct	Nov
Number of complaints due to close in month	6	9	8	8	5	3	8	7

Graph 7.4



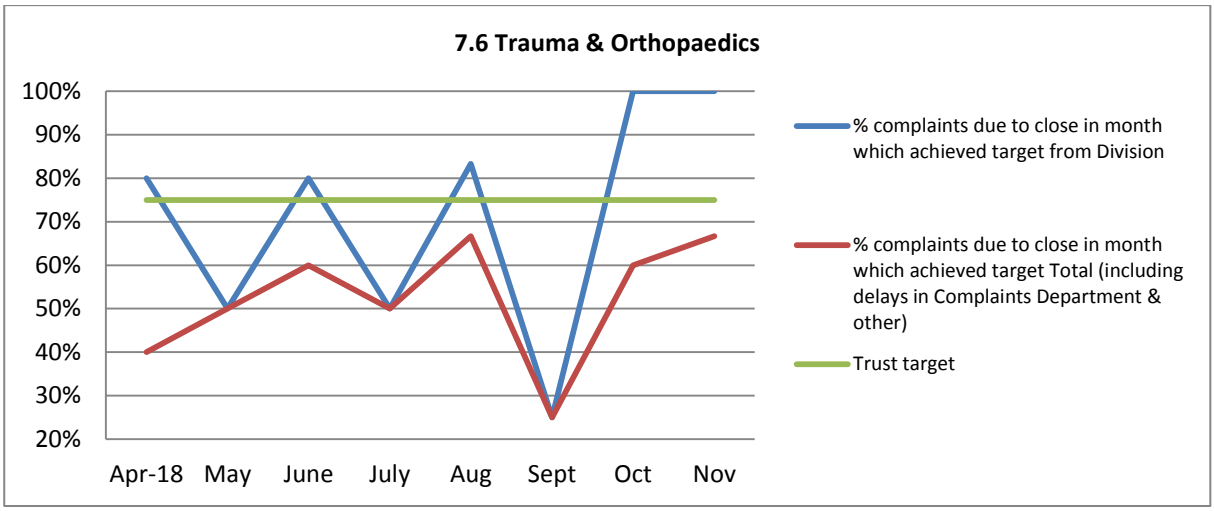
Women's Services	Apr-18	May	June	July	Aug	Sept	Oct	Nov
Number of complaints due to close in month	5	2	6	8	5	5	3	3

Graph 7.5



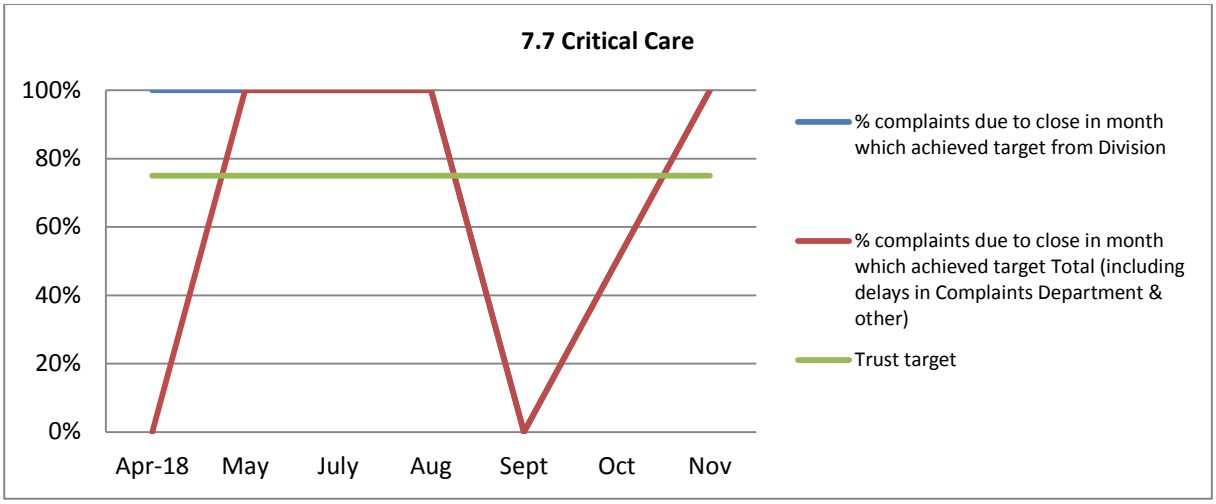
Paediatrics	Apr-18	May	June	July	Aug	Sept	Oct	Nov
Number of complaints due to close in month	3	3	-	3	3	1	2	4

Graph 7.6



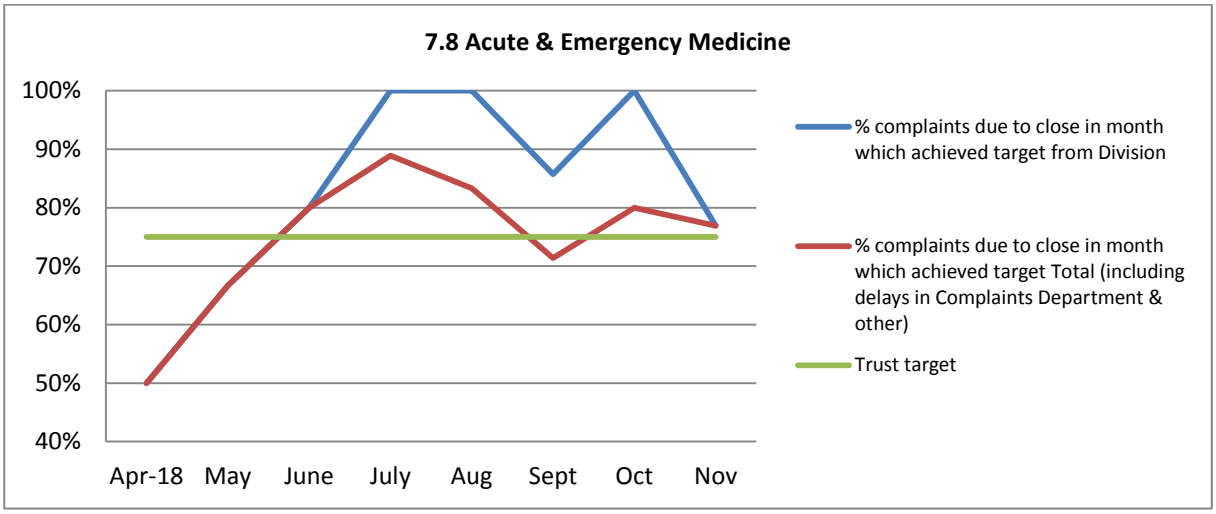
Trauma & Orthopaedics	Apr-18	May	June	July	Aug	Sept	Oct	Nov
Number of complaints due to close in month	5	2	5	4	6	4	5	3

Graph 7.7



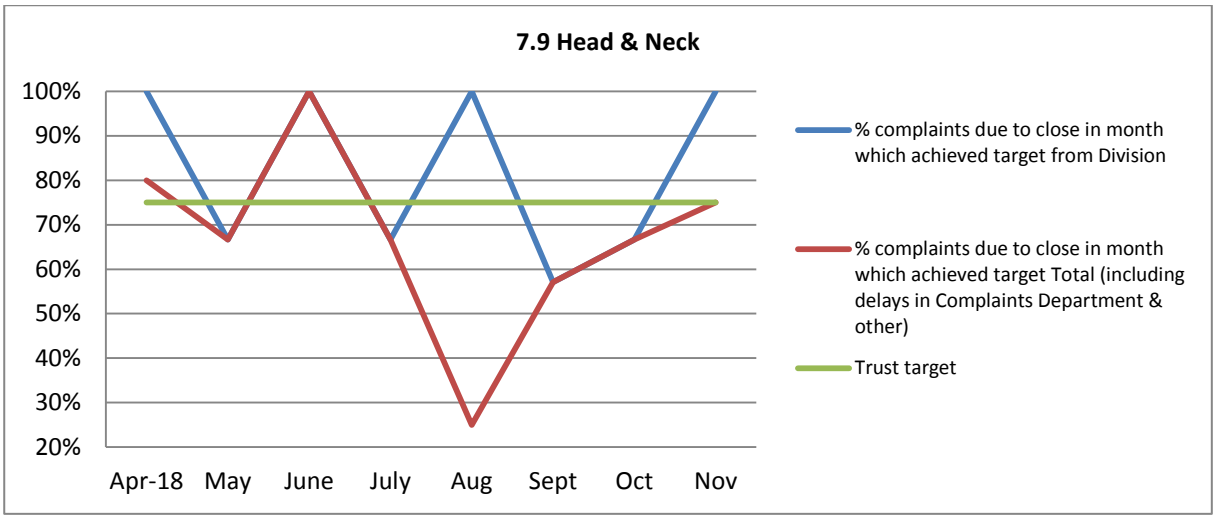
Critical Care	Apr-18	May	June	July	Aug	Sept	Oct	Nov
Number of complaints due to close in month	1	3	1	2	3	-	2	1

Graph 7.8



Acute & Emergency Medicine	Apr-18	May	June	July	Aug	Sept	Oct	Nov
Number of complaints due to close in month	4	9	5	9	6	7	10	13

Graph 7.9

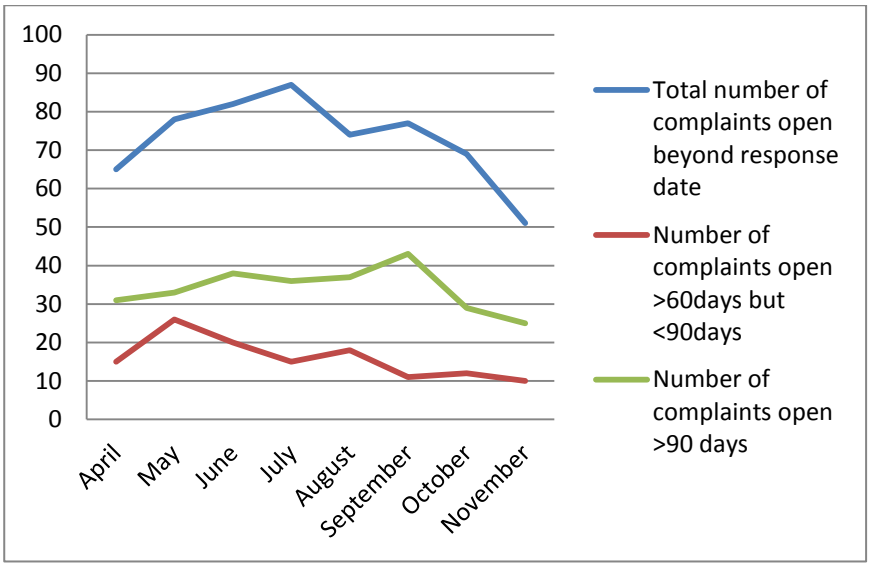


Head & Neck	Apr-18	May	June	July	Aug	Sept	Oct	Nov
Number of complaints due to close in month	5	6	4	3	4	7	3	4

Only two of the directorates above failed to achieve or exceed the Trust's target of 75% for November. These were Surgery (57.1%) and Women's Services (66.7%). Due to ongoing challenges in meeting the 75% target, further deep dive review sessions have been planned with Surgery, Women's and Paediatrics.

Although, the Trust achieved the 75% performance target for November, in total, 8 complaints breached due to delays within the lead directorate, which account for 16.7% of the lost performance. However, a further 4 complaints breached for other reasons: 1 due to capacity issues within the central complaints team, 3 responses were rejected by the executive team at a stage too late for recovery and 1 was delayed due to an outstanding SI investigation. These delays accounts for 8.3% of the lost performance.

Graph 8: Number of overdue open complaints



There continues to be focused work on clearing the backlog of complaints, with positive progress being made on closing older cases. Graph 8 shows the progress over the course of the year.

Work continues to deliver the Trustwide complaints action plan. In addition, specific actions are being undertaken within divisions, including:

Medicine & Emergency Care Division

This Division has since June consistently achieved the 75% standard through the introduction of a standard operating procedure and close monitoring through the Governance Lead and Divisional Director of Nursing and Quality. In addition they have concentrated on the learning lessons aspect of Complaints management through the introduction of a Complex Care study day. They have completed 3 courses with a 4th planned for the New Year. These are open to all staff and are tailor made to address the current themes and trends identified through complaints. During October the programme included discharge planning, communication and mouthcare.

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.

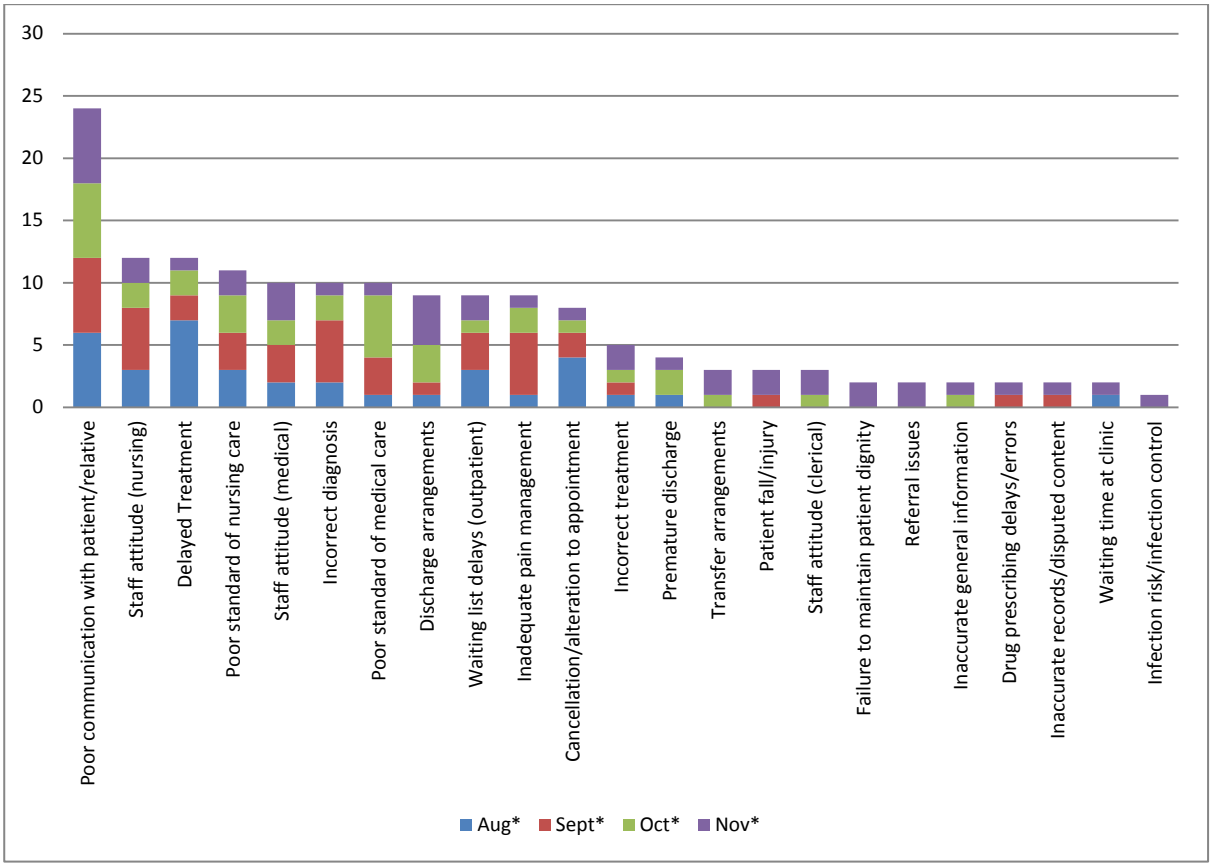
Graph 9 - Complaints by Sub-subject – most frequently raised in November 2018

	Aug*	Sept*	Oct*	Nov*
Poor communication with patient/relative	6	6	6	6
Discharge arrangements	1	1	3	4
Staff attitude (medical)	2	3	2	3

*reflects the date of the event being complained about

The following graph (Graph 10) shows an expanded view of the themes of complaints that occurred in October 2018.

Graph 10: All themes/subjects raised in complaints made about events that occurred in November 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 (August – November). However, for this period, this has remained stable.

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

- Poor standard of medical care
- Discharge arrangements
- Incorrect treatment
- Premature discharge
- Transfer arrangements
- Patient fall/injury
- Staff attitude (clerical)
- Failure to maintain patient dignity
- Referral issues
- Inaccurate general information
- Infection risk/infection control

Other areas show stable or slightly reducing trends, with the most significant reduction in complaints in regard to incorrect diagnosis, inadequate pain management and cancellation/alteration to appointments. 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.

Complaints performance by type

Performance for complaints with a 25 day response date = 77.8% (45 qualifying complaints, 10 breaches: 19810, 19789, 19796, 19831, 19801, 19806, 19779, 19780, 19824, 19829)

Performance for complaints with a 60 day response date = 33.3% (3 qualifying complaints, 2 breaches: 19733 & 19617)

Safe staffing: Planned versus actual for November 2018

To follow – data not available until w/c 17/12/18

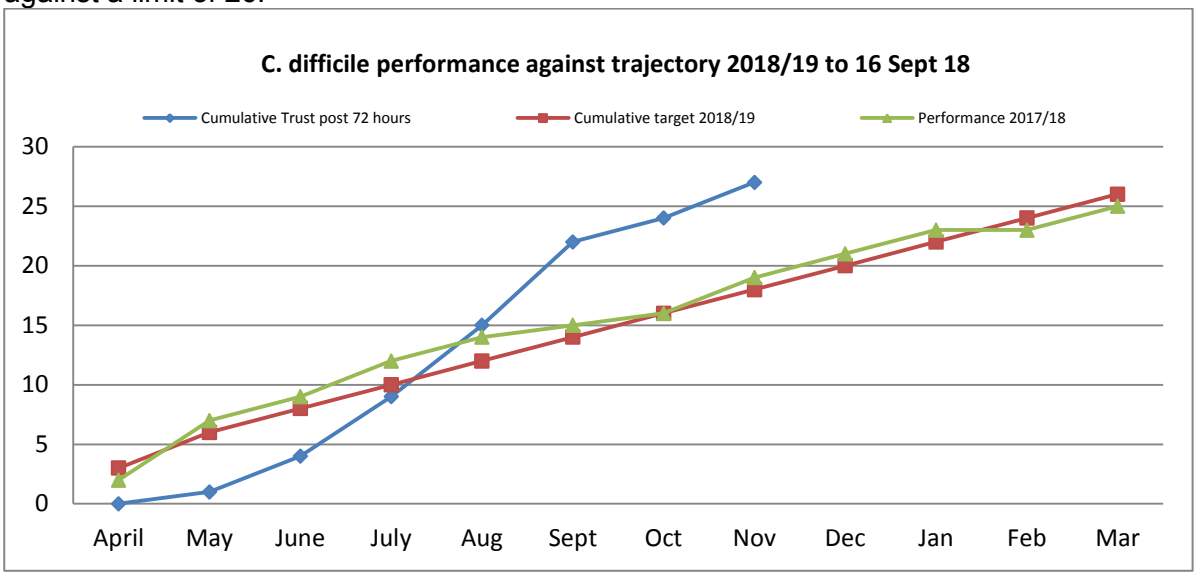
Infection Prevention and Control

MRSA

There was one case of trust-attributable MRSA blood stream infection in November. An SI has been declared and investigation is ongoing.

C. difficile

There were three cases of post-72 hour *C. difficile* infection in November against a monthly limit of two cases. The Trust has now breached the C. difficile objective for the year with a total of 27 cases against a limit of 26.



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

Methicillin sensitive *Staphylococcus aureus* bacteraemia

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

Gram negative bacteraemia

Thirteen cases of hospital-attributable gram negative blood stream infection were seen in October. Ten cases were due to *E. coli*, three due to *Klebsiella* and none due to *Pseudomonas* species

Norovirus

Ten confirmed cases of norovirus have been seen on TW20 between 10/11/18 – 5/12/18. Two members of staff and three visitors also reported symptoms.

Infection prevention precautions were put in place together with a high level of Infection Prevention team support. The affected ward areas have now all been cleaned and no further new patients have been seen. There were no bed days lost as a result of this incident.

Financial commentary

To follow

Workforce Commentary

November Dashboard

Key Workforce Risks & current actions to note

Trust Vacancy Rate 8.76% (Target >9%)
Trust Turnover Rate 9.4% (Target >10%)

Key Vacancy risks include
- Nursing for medical and T&O wards at TWH
- Nursing for ED on both sites but primarily TWH
- TWH theatres
- Specialty grade medical staff, General Surgery & Paediatrics
- Consultant physicians, AMU and respiratory
- Areas with high vacancy rates continue to put pressure on agency rates, particularly nursing in ED. A coordinated approach between MFT, EKHUFT and MTW is being taken to address issues with ED nursing.

Current Actions
- Issuing of letter to all Year 3 Nursing students within MTW offering a guaranteed job (subject to completion of training)
- Open day for 25 Year 3 Brighton university students at TWH
- Implementation of Nurse Recruitment clinics with ward managers to expedite recruitment process
- Review of Medical recruitment processes to improve consistency and timeliness of medical recruitment
- Working with an agency (BDI) to supply potential specialty grade medics on a substantive basis. Interviews being arranged before Christmas
- The Communications team are developing proposals for a sequence of films marketing the trust and specific professional groups
- Year 1 Nurse promise launched
- Internal Transfer scheme pilot launched

Sickness Absence 3.4% (Target =>3.3%)
Short term Absence 54.5%, Long term absence 45.5%
Key challenges in
- Estates & facilities (5.95%)
- Women's Services (5.14%)
- Clinical Governance (5.46%)

Current Actions
- Flu campaign focusing on areas of low uptake, as of 11th December 64.5% of frontline staff vaccinated. The trust remains on trajectory to hit its target of 85%. Areas with low uptake have been targeted with line managers and professional leads and additional Occupational Health and Peer vaccinator support provided.
- HR are providing line managers with updates on staff hitting absence triggers and are following up to ensure that sickness meetings are held and OH referrals made.
- HR staff are working with line managers to ensure that all those on long term absence have a management plan in place.

Mandatory Training 83% (Target <85%)

Current Actions
- Individual e-reminders to all staff now automatically issued by the Learning Management System
- Divisions now have the ability to generate local reports on uptake directly from the new system
- A review of training requirements for specific posts is being undertaken with clinical leads
- Data cleansing following transfer of information from the old to the new system

Appraisals 88.1% (Target 90%)

- Corporate Services (81%) and Surgery & Critical Care (84%) remain below target
- Divisional and directorate action plans in place to achieve the target with specific areas being targeted by HR Business partners to ensure compliance

Trust Performance Dashboard

Position as at: 30 November 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)	13.59	15.1	13.3	16.6	3.3	5.5	11.5	13.8	
1-02	Number of cases C.Difficile (Hospital)	3	3	19	27	8	9	26	35	
1-03	Number of cases MRSA (Hospital)	0	1	0	3	3	3	0	3	
1-04	Elective MRSA Screening	98.0%	99.0%	98.0%	99.0%	1.0%	1.0%	98.0%	99.0%	
1-05	% Non-Elective MRSA Screening	No data	95.2%	No data	99.0%	No data	No data	98.0%	No data	
1-06	**Rate of Hospital Pressure Ulcers	2.22	0.34	2.08	1.28	- 0.79	- 1.73	*3.01*	1.31	3.00
1-07	***Rate of Total Patient Falls	6.75	6.48	5.90	6.13	0.22	0.13	*6.00*	5.87	
1-08	***Rate of Total Patient Falls Maidstone	5.76	6.11	5.27	5.90	0.63			5.12	
1-09	***Rate of Total Patient Falls TWells	5.93	6.63	6.11	6.25	0.14			5.56	
1-10	Falls - SIs in month	5	2	24	17	- 7				
1-11	Number of Never Events	1	0	2	1	-1	1	*0*	1	
1-12	Total No of SIs Open with MTW	67	70			3				
1-13	Number of New SIs in month	17	11	114	123	9	43			
1-14	***Serious Incidents rate	0.77	0.55	0.66	0.76	0.10	0.70	*0.0584 - 0.6978*	0.76	*0.0584 - 0.6978*
1-15	Rate of Patient Safety Incidents - harmful	0.84	0.77	1.16	1.12	- 0.03	- 0.11	*0 - 1.23*	1.12	*0 - 1.23*
1-16	Number of CAS Alerts Overdue	0	1			1	1	*0*		
1-17	VTE Risk Assessment - month behind	96.6%	96.9%	96.4%	96.9%	0.5%	1.9%	95.0%	96.9%	95.0%
1-18	Safety Thermometer % of Harm Free Care	97.8%	97.5%	96.6%	97.7%	1.0%	2.7%	95.0%		93.4%
1-19	Safety Thermometer % of New Harms	2.39%	2.31%	3.29%	2.24%	-1.05%	-0.8%	*3.00%*	2.24%	
1-20	C-Section Rate (non-elective)	14.0%	14.1%	13.7%	13.4%	-0.27%	-1.6%	*15.0%*	13.4%	

	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	1.0244	- 0.1	0.0	Band 2	Band 2	1.0
2-02	Standardised Mortality HSMR	Prev Yr: Apr 15 to Mar 16		104.3	102.4	- 1.9	2.4	Lower confidence limit to be <100		100.0
2-03	Crude Mortality	1.1%	0.8%	1.1%	0.9%	-0.2%				
2-04	****Readmissions <30 days: Emergency	12.3%	15.1%	11.7%	14.3%	2.6%	0.7%	*13.6%*	14.3%	14.1%
2-05	****Readmissions <30 days: All	11.8%	14.4%	11.0%	13.8%	2.8%	-0.9%	*14.7%*	13.8%	14.7%
2-06	Average LOS Elective	3.70	2.89	2.55	3.06	0.51	- 0.14	*3.20*	3.06	
2-07	Average LOS Non-Elective	6.82	6.88	7.43	6.92	- 0.51	0.12	*6.80*	6.92	
2-22	NE Discharges - Percent zero LoS	36.7%	45.8%	36.1%	45.0%	8.8%			45.0%	
2-08	******FollowUp : New Ratio	1.76	1.62	1.69	1.58	- 0.11	0.06	*1.52*	1.58	
2-09	Day Case Rates	88.0%	85.6%	88.0%	87.3%	-0.7%	7.3%	80.0%	87.3%	82.2%
2-10	Primary Referrals	12,494	9,711	77,158	82,754	7.3%	3.3%	121,638	122,437	
2-11	Cons to Cons Referrals	5,125	5,539	39,023	47,421	21.5%	23.7%	56,704	70,161	
2-12	First OP Activity (adjusted for uncashed)	17,847	18,526	129,082	143,142	10.9%	4.5%	204,495	211,783	
2-13	Subsequent OP Activity (adjusted for uncashed)	27,117	27,906	228,794	211,200	-7.7%	-17.1%	379,945	312,477	
2-14	Elective IP Activity	571	630	4,644	4,316	-7.1%	-17.9%	7,674	6,386	
2-15	Elective DC Activity	3,742	3,747	28,566	29,731	4.1%	-0.8%	44,403	43,988	
2-16	**Non-Elective Activity	4,825	5,284	38,246	42,456	11.0%	8.9%	58,582	63,510	
2-17	A&E Attendances (Calendar Mth) Excl Crowboro	13,804	14,735	114,247	120,764	5.7%	1.8%	174,428	178,938	
2-18	Oncology Fractions	5,393	5,942	39,900	43,390	8.7%	-5.4%	67,890	74,383	
2-19	No of Births (Mothers Delivered)	506	503	2,497	4,017	60.9%	0.8%	5,977	6,026	
2-20	% Mothers initiating breastfeeding	82.3%	83.5%	82.3%	81.6%	-0.7%	3.6%	78.0%	81.6%	
2-21	% Stillbirths Rate	0.2%	0.20%	0.20%	0.15%	*-0.1%*	*-0.3%*	*0.47%*	0.15%	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	8	13	35	22	35	0	35	
3-02	*****Rate of New Complaints	1.59	2.41	3.41	2.19	-1.2	0.88	*1.318-3.92*	2.10	
3-03	% complaints responded to within target	72.3%	75.0%	74.3%	64.3%	-10.0%	-10.7%	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%	93.7%	95.3%	94.4%	-0.8%	-0.6%	95.0%	94.4%	95.8%
3-06	A&E Friends & Family (FFT) % Positive	91.9%	91.0%	91.4%	91.5%	0.1%	4.5%	87.0%	91.5%	85.5%
3-07	Maternity Combined FFT % Positive	93.9%	99.1%	93.6%	94.4%	0.8%	-0.6%	95.0%	94.4%	95.6%
3-08	OP Friends & Family (FFT) % Positive	84.3%	84.1%	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	89.4%	90.93%	89.8%	92.5%	2.7%	1.6%	90.8%	91.6%	76.4%
4-02	Emergency A&E >12hr to Admission	0	0	0	2	2	2	-	2	
4-03	Ambulance Handover Delays >30mins	486	442	2,662	2,709	47			4,644	
4-04	Ambulance Handover Delays >60mins	60	82	326	356	30			610	
4-05	RTT Incomplete Admitted Backlog	Data not currently available								
4-06	RTT Incomplete Non-Admitted Backlog									
4-07	RTT Incomplete Pathway									
4-08	RTT 52 Week Waiters (New in Month)									
4-09	RTT Incomplete Total Backlog									
4-10	% Diagnostics Tests WTimes <6wks									
4-11	*Cancer WTimes - Indicators achieved	4	4	3	3	-	- 6	9	9	
4-12	*Cancer two week wait	93.6%	86.5%	92.1%	79.0%	-13.1%	-14.0%	93.0%	93.0%	
4-13	*Cancer two week wait-Breast Symptoms	87.4%	83.1%	87.9%	65.4%	-22.4%	-27.6%	93.0%	93.0%	
4-14	*Cancer 31 day wait - First Treatment	95.3%	96.2%	92.6%	96.4%	3.8%	0.4%	96.0%	96.0%	
4-15	*Cancer 62 day wait - First Definitive	70.9%	62.6%	66.2%	62.2%	-4.0%	-20.0%	85.0%	85.0%	
4-16	*Cancer 62 day wait - First Definitive - MTW	71.7%	63.8%	71.7%	65.7%	-6.0%		85.0%		
4-17	*Cancer 104 Day wait Accountable	15.5	18.5	88.5	104.5	16.0	104.5	*0*	104.5	
4-18	*Cancer 62 Day Backlog with Diagnosis	82	60	82	60	-22				
4-19	*Cancer 62 Day Backlog with Diagnosis - MTW	60	40	60	40	-20				
4-20	Delayed Transfers of Care	4.84%	3.58%	5.43%	4.63%	-0.81%	1.13%	3.50%	4.63%	
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%	88.1%	92.4%	90.1%	-2.3%	10.1%	80%	90.1%	
4-23	*******Stroke:% to Stroke Unit <4hrs	65.2%	64.2%	59.2%	57.9%	-1.3%	-2.1%	60.0%	57.9%	
4-24	*******Stroke: % scanned <1hr of arrival	75.8%	59.1%	64.5%	57.9%	-6.5%	9.9%	48.0%	57.9%	
4-25	*******Stroke:% assessed by Cons <24hrs	80.3%	79.4%	85.3%	85.3%	0.0%	5.3%	80.0%	85.3%	
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	16	2	16	22	6	22	*0*	22	

RTT Incomplete Pathway Monthly Plan is Trust Recovery Trajectory

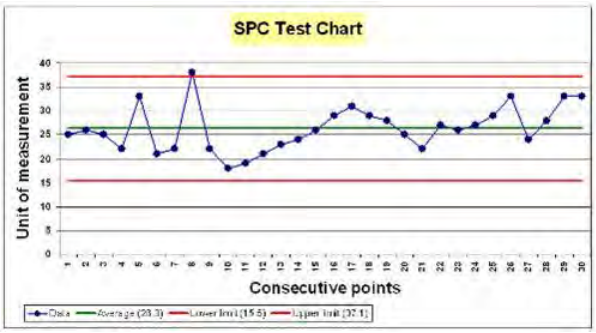
**CWT run one mth behind, YTD is Quarter to date, Monthly Plan for 62 Day Wait First Definitive is Trust Recovery Trajectory*

**** 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	34,516	40,821	291,107	309,966	6.5%	0.6%	466,408	466,408	
5-02	EBITDA	(451)	4,475	13,129	21,395	63.0%	-1.9%	38,910	38,910	
5-03	Surplus (Deficit) against B/E Duty	(2,895)	2,030	(6,760)	1,533			11,743	11,743	
5-04	CIP Savings	2,290	1,151	13,645	8,229	-39.7%	-35.9%	24,111	24,111	
5-05	Cash Balance	9,489	8,566	9,489	8,566			1,000	1,000	
5-06	Capital Expenditure	421	1,106	7,658	3,555			*13,762*	11,119	
5-07	Establishment WTE	5,609.0	5,630.5	5,609.0	5,630.5	0.4%	0.0%	5,630.5	5,630.5	
5-08	Contracted WTE	5,060.7	5,142.6	5,060.7	5,142.6	1.6%	2.5%	5,016.9	5,016.9	
5-09	Vacancies WTE	548.3	487.9	548.3	487.9	-11.0%	-20.5%	613.6	613.6	
5-11	Vacancy Rate (%)	9.8%	8.7%	9.8%	8.7%	-1.1%	-2.2%	10.9%	10.9%	
5-12	Substantive Staff Used	4,929.1	5,014.4	4,929.1	5,014.4	1.7%	-0.4%	5,036.1	5,036.1	
5-13	Bank Staff Used	371.6	401.1	371.6	401.1	7.9%	9.9%	365	365.1	
5-14	Agency Staff Used	246.6	253.3	246.6	253.3	2.7%	10.5%	229.3	229.3	
5-15	Overtime Used	54.0	48.0	54.0	48.0	-11.1%				
5-16	Worked WTE	5,601.3	5,716.8	5,601.3	5,716.8		1.5%	5,630.5	5,630.5	
5-17	Nurse Agency Spend	(738)	(795)	(4,916)	(6,156)	25.2%				
5-18	Medical Locum & Agency Spend	(1,388)	(1,513)	(9,908)	(12,033)	21.4%				
5-19	Temp costs & overtime as % of total pay bill	16.2%	16.8%	15.8%	16.9%	1.1%				
5-20	Staff Turnover Rate	12.0%	9.2%		9.1%	-2.8%	-1.4%	*10.5%*	9.1%	11.05%
5-21	Sickness Absence	4.7%	3.4%		3.4%	-1.3%	0.1%	*3.3%*	3.4%	4.3%
5-22	Statutory and Mandatory Training	88.4%	No data		87.1%	-88.4%	2.1%	85.0%	87.1%	
5-23	Appraisal Completeness	88.7%	88.1%		88.1%	-0.6%	-1.9%	90.0%	88.1%	
5-24	Overall Safe staffing fill rate	98.4%	99.5%	98.4%	97.1%	-1.3%		93.5%	97.1%	
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%	24.5%	23.7%	21.9%	-1.8%	-3.1%	25.0%	21.9%	25.7%
5-28	A&E Resp Rate Recmd to Friends & Family	21.2%	21.2%	21.4%	12.9%	-8.5%	-2.1%	15.0%	12.9%	12.7%
5-29	Mat Resp Rate Recmd to Friends & Family	28.9%	11.8%	31.7%	23.3%	-8.4%	-1.7%	25.0%	23.3%	24.0%

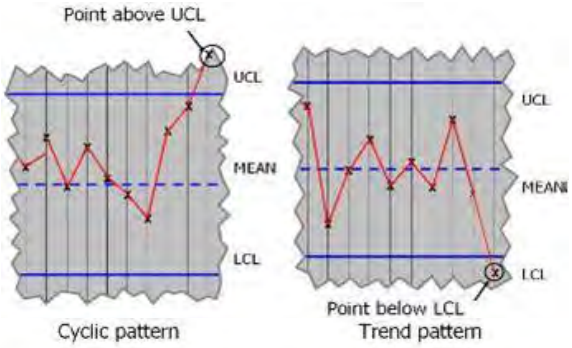
Explanation of Statistical Process Control (SPC) Charts

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:

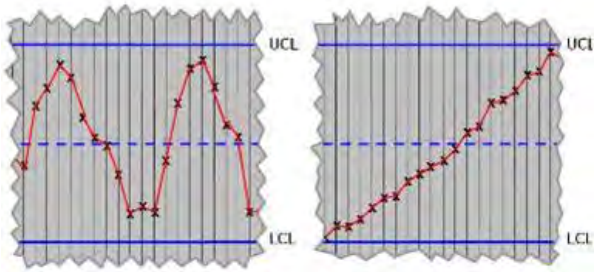


SPC is a type of charting that shows the variation that exists in the systems that are being measured. When interpreting SPC charts there are 4 rules that help to identify what the system is doing. If one of the rules has been broken, this means that 'special cause ' variation is present in the system.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

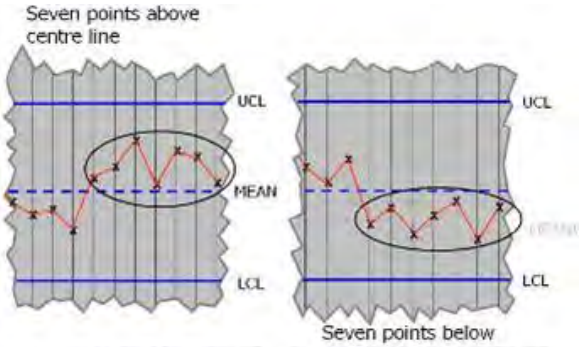


Rule 2: Any unusual pattern or trends within the control limits. The most obvious example of a cyclical pattern is seasonality but we also see it when looking at daily discharges where the weekends have low numbers. To qualify as a trend there must be at least 6 points in a row. This is one of the key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

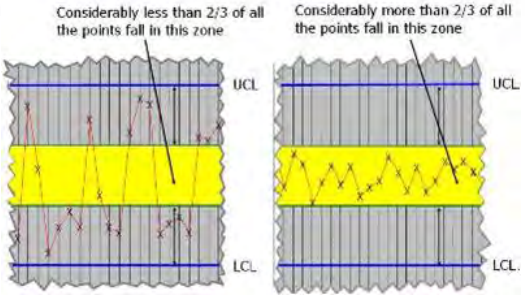


Rules 1 and 2 are the main reason for displaying SPC charts on our performance reports as it makes abnormally high or low values and trends immediately obvious. However there are two other rules that are also used to interpret the graphs.

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.

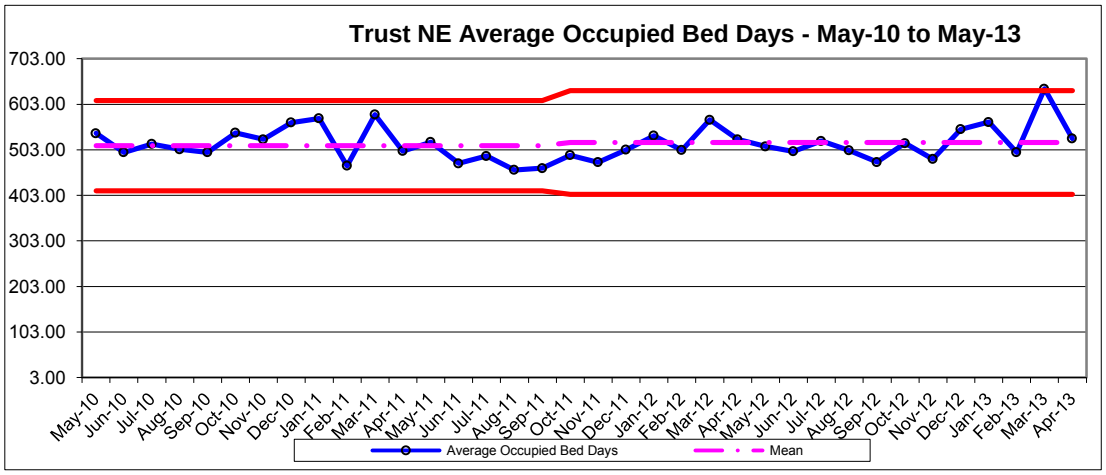


Rule 4: The number of points within the middle third of the region between the control limits differs markedly from two -thirds of the total number of points. This gives an indication of how stable a process is. If controlled variation (common cause) is displayed in the SPC chart, the process is stable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

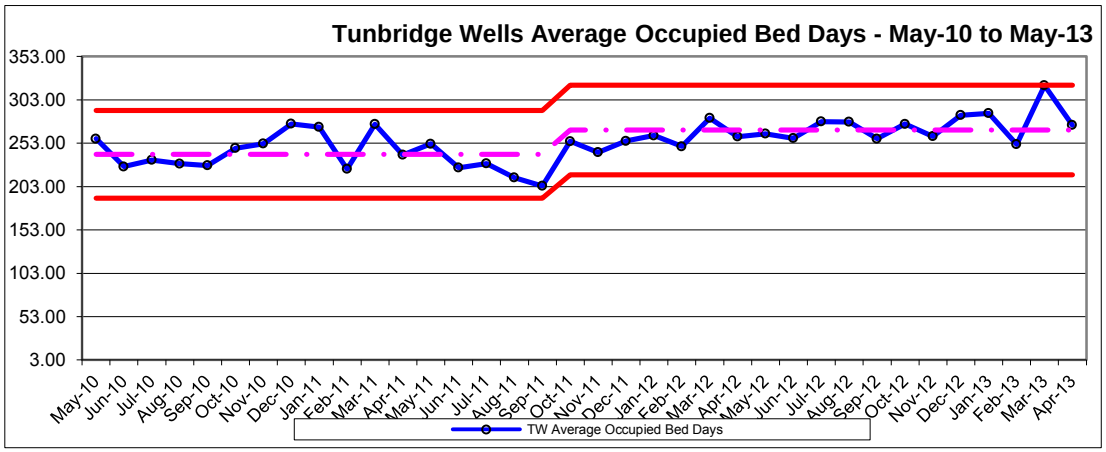


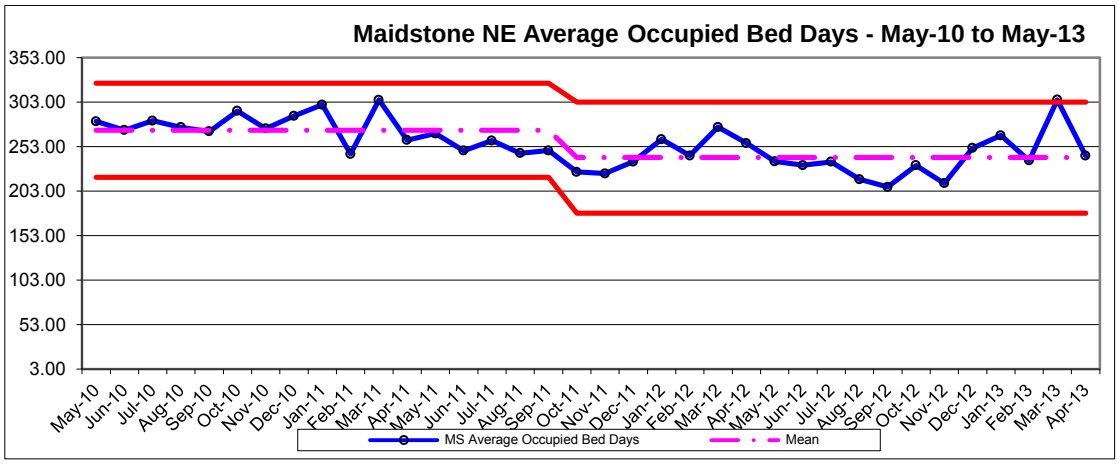
Changes to Control Lines

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:

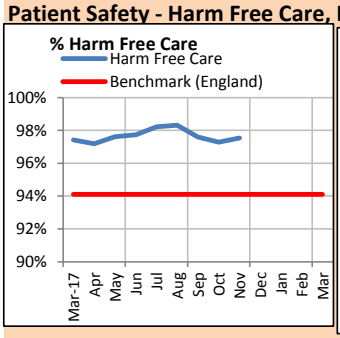


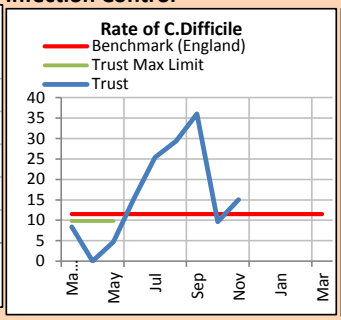


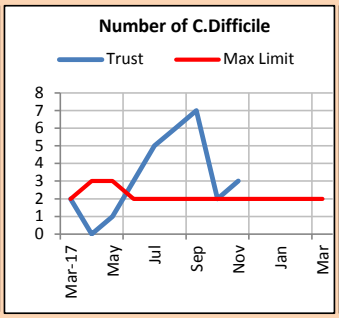
So in the examples given we have calculated a mean and control limits based on the data for May 2010 to September 2011 and then calculated them based on the period October 2011 to April 2013. The lines are all a result of the SPC calculations, only the date of the change is decided by the Information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

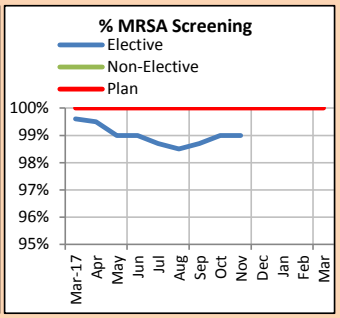
INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

Patient Safety - Harm Free Care, Infection Control

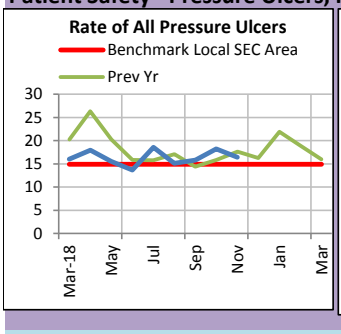


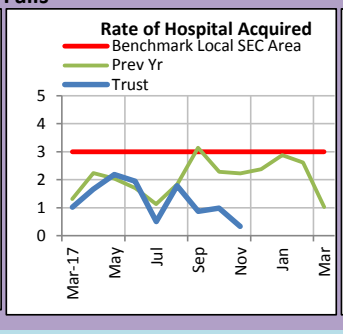


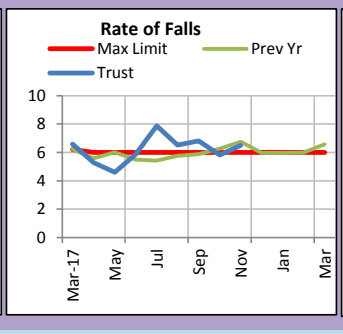


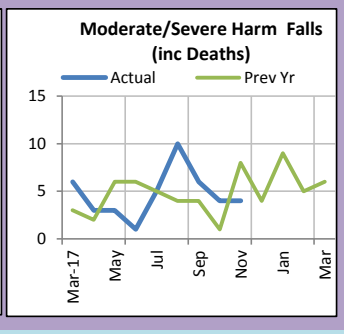


Patient Safety - Pressure Ulcers, Falls

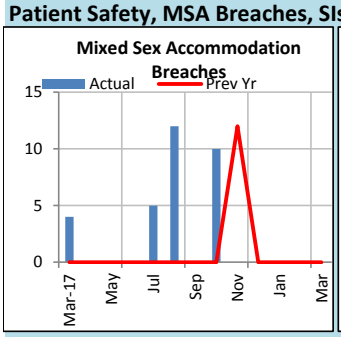


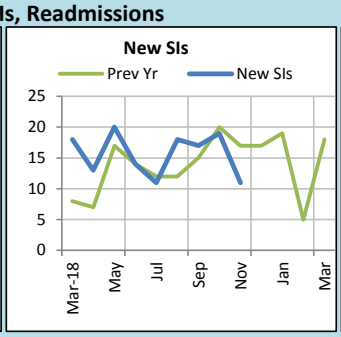


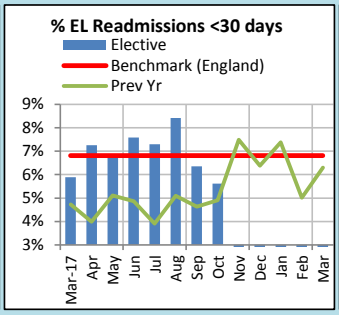


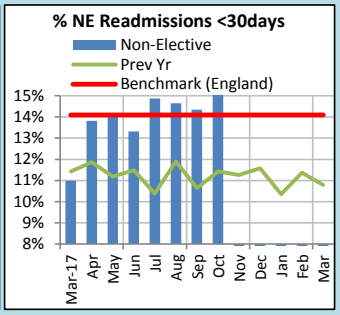


Patient Safety, MSA Breaches, SIs, Readmissions

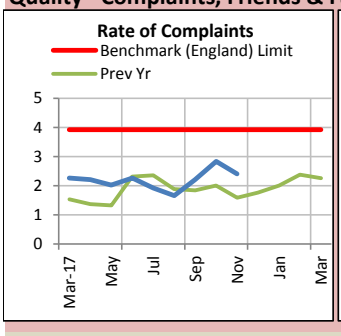


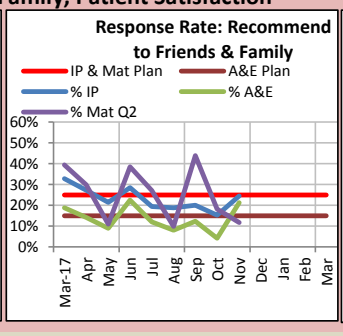


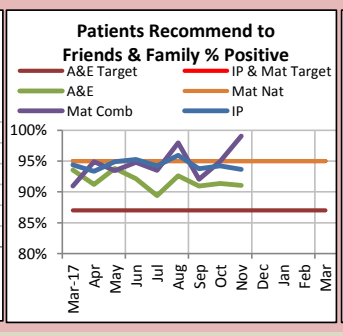


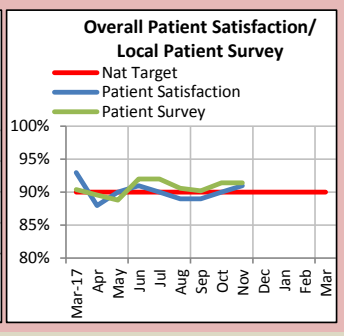


Quality - Complaints, Friends & Family, Patient Satisfaction

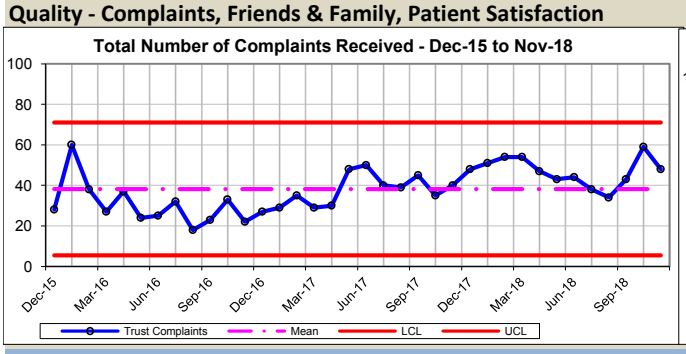


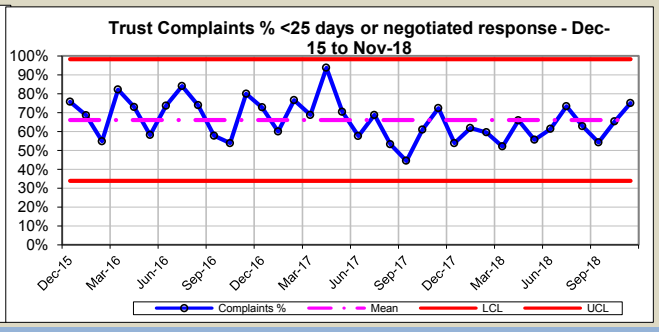




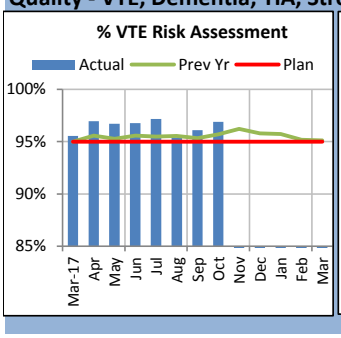


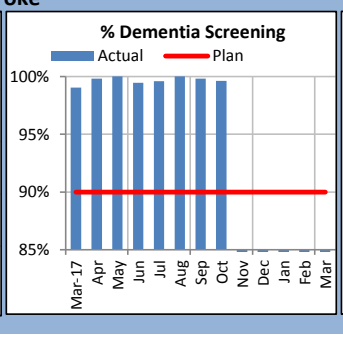
Quality - Complaints, Friends & Family, Patient Satisfaction

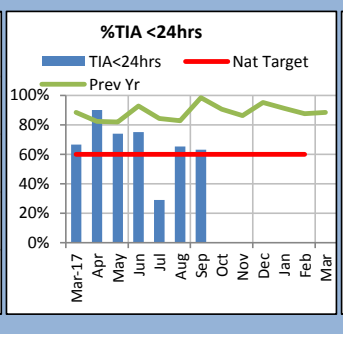


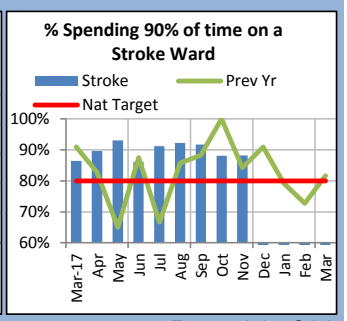


Quality - VTE, Dementia, TIA, Stroke



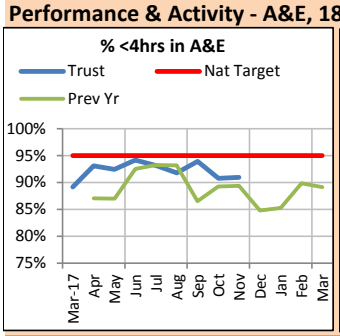


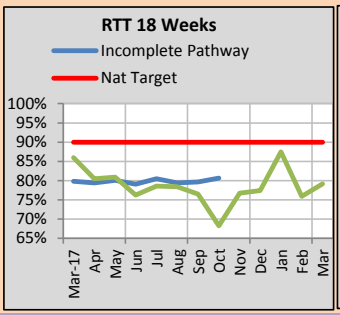


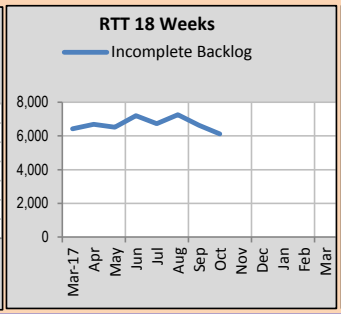


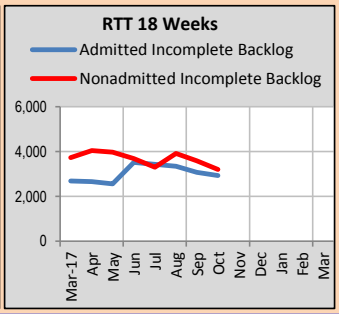
INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

Performance & Activity - A&E, 18 Weeks

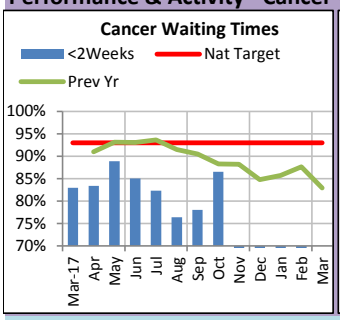


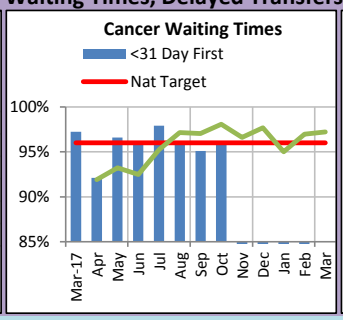


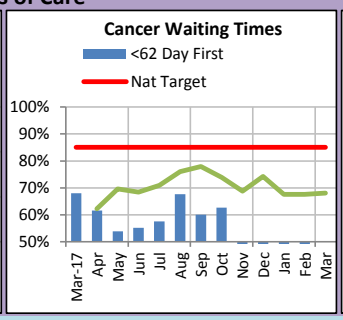


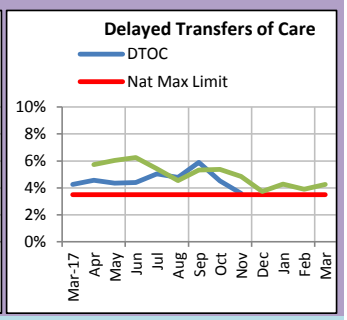


Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care

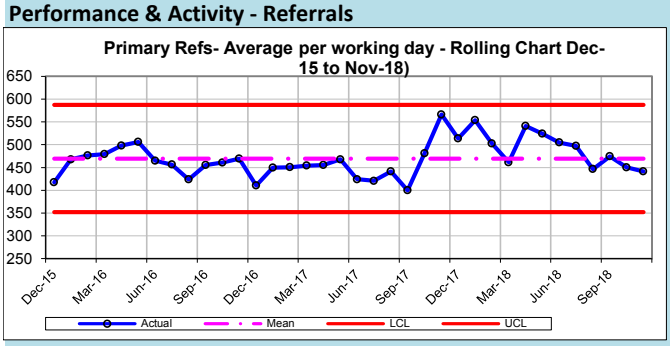


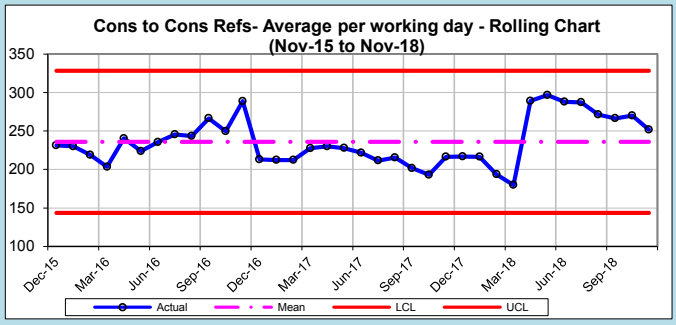




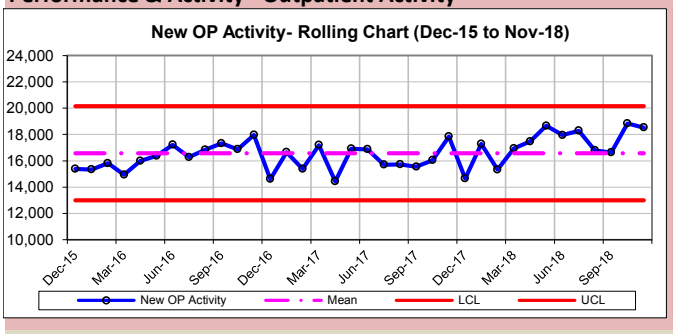


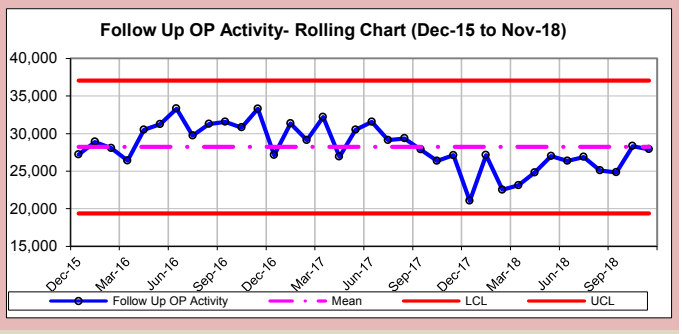
Performance & Activity - Referrals



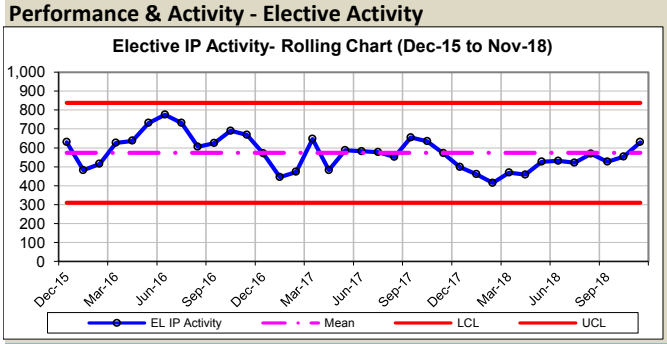


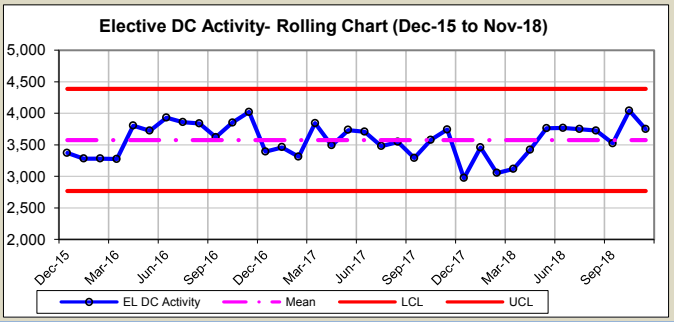
Performance & Activity - Outpatient Activity



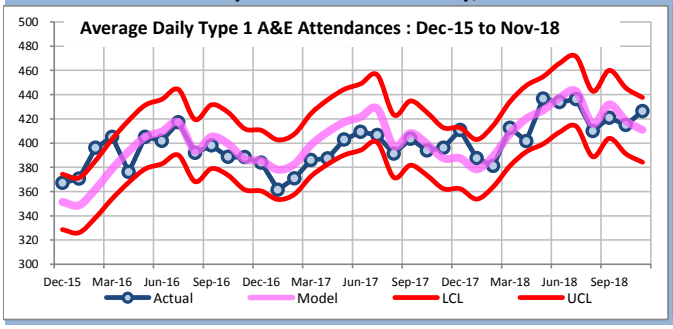


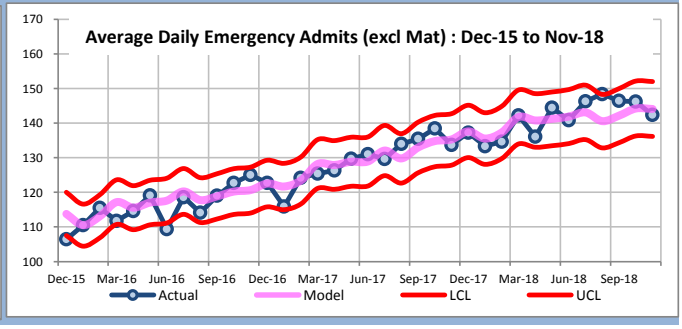
Performance & Activity - Elective Activity





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

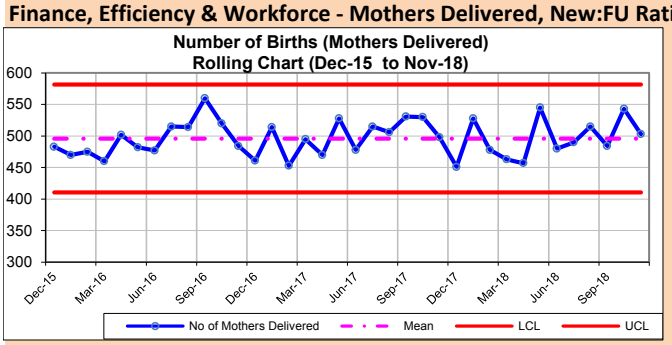


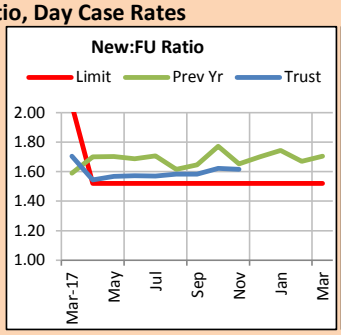


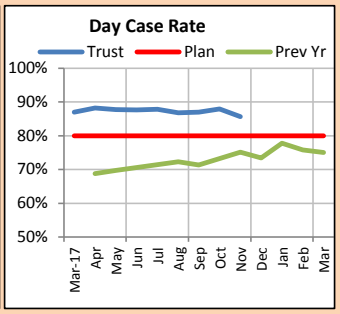
These have been changed to show actual against model, since emergency activity is subject to both growth and seasonal variation. Control limits are 2 standard deviations of variance, so a count outside the control limits will be expected around one month in 20.

INTEGRATED PERFORMANCE REPORT ANALYSIS - FINANCE, EFFICIENCY & WORKFORCE

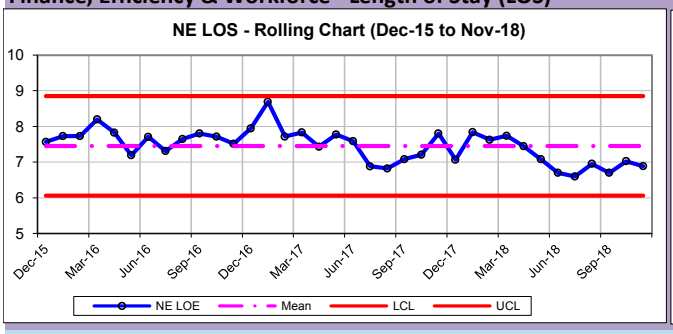
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates

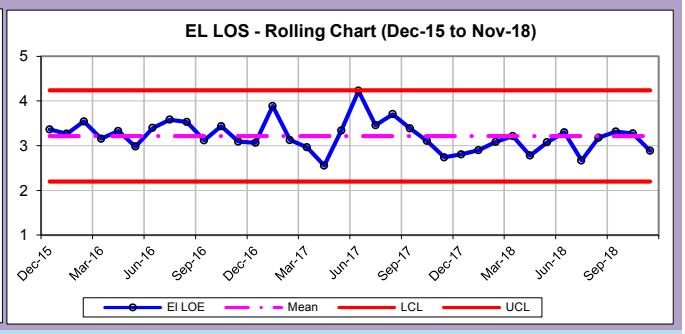




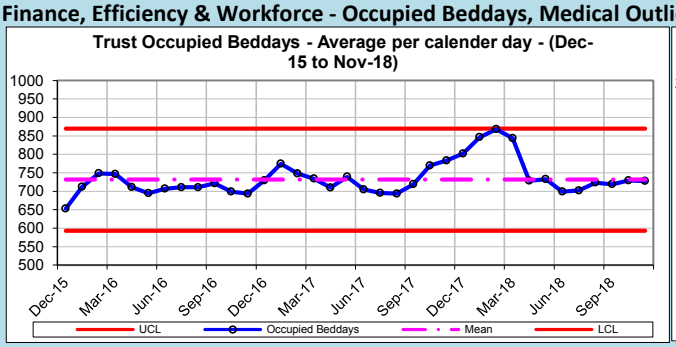


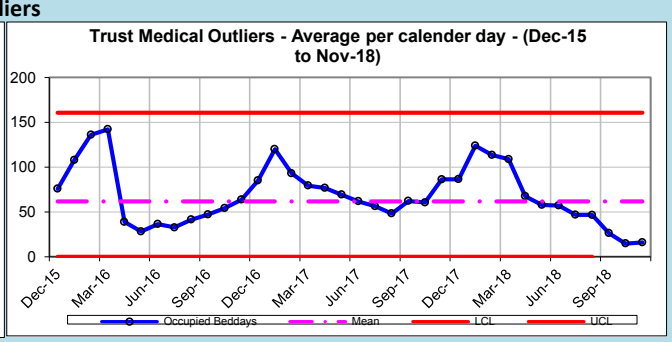
Finance, Efficiency & Workforce - Length of Stay (LOS)



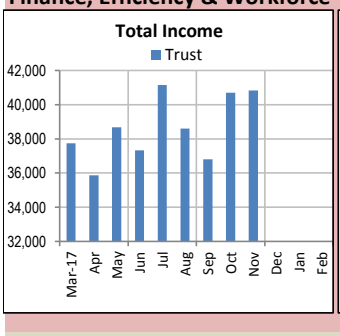


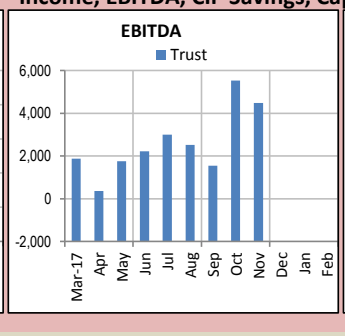
Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

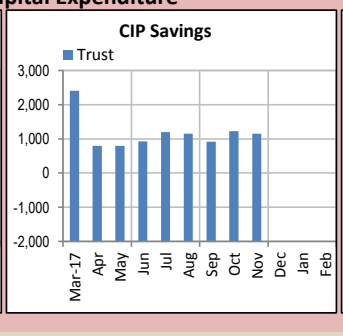


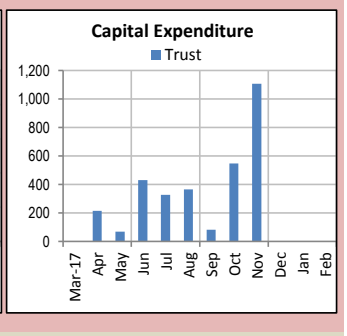


Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure

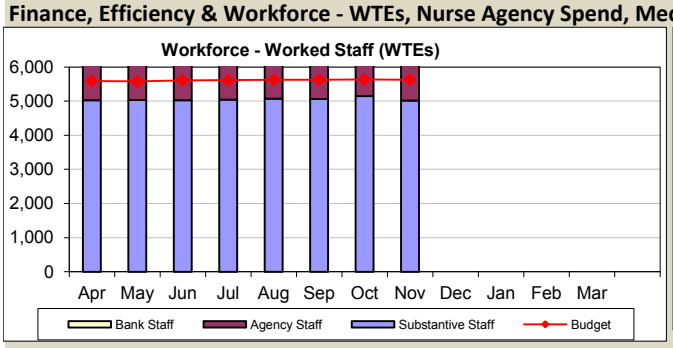


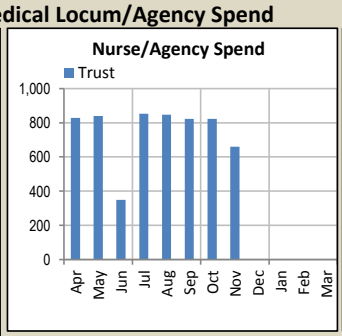


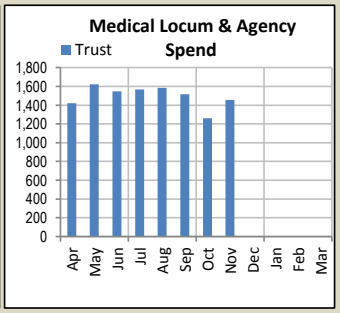




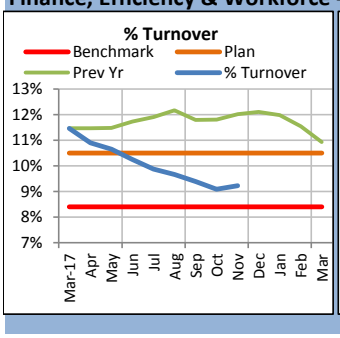
Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend

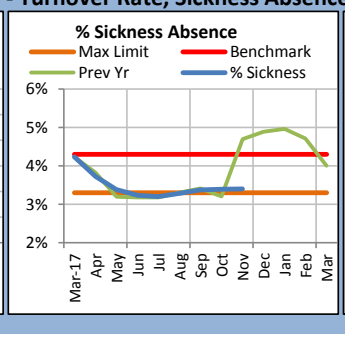


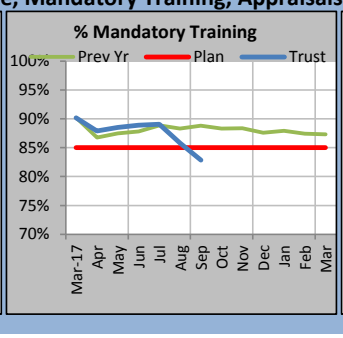


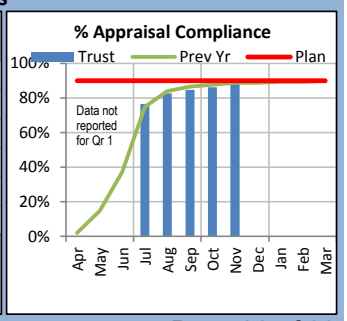


Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals









Trust Board meeting – December 2018

NHS Maidstone and Tunbridge Wells NHS Trust

12-9	Integrated Performance Report, November 2018 – Well led (finance)	Chief Finance Officer

- The Trusts surplus including PSF was £2m in November which was on plan. The Trust was £1.7m adverse to the CIP target and had to include £1.6m non recurrent income support earlier than planned.
- The Trusts normalised run rate in November was £1.3m deficit pre PSF which was £2.1m adverse to plan.
- In November the Trust operated with an EBITDA surplus of £4.5 which was £0.1m adverse to plan.
- The Trust year to date has a deficit including PSF of £1.5m which is on plan, the key variances to plan are: CIP Slippage (£4.6m) overspends within pay budgets (£1.6m) and non-pay budgets (£2.6m) offset by non-recurrent items (£1.9m), release of contingency reserve (£4.3m) , earlier than planned phasing of Non Recurrent Income support (£1.6m) and underspends within income and depreciation (£1m).
- The key current month variances are as follows:
  - Total income net of pass-through related income is £0.2m favourable to plan. Clinical Income excluding HCDs was £0.8m favourable to plan in November which included £1.6m benefit relating to Non Recurrent Income support incorporated earlier than planned. The key adverse variances are Daycases (£0.2m) and Electives (£0.4m). This is mainly in relation to the delay to the Prime Provider tender process.
  - Other Operating Income excluding pass-through costs is £0.6m adverse to plan in the month which mainly relates to £0.3m Private Patient income underperformance and £0.3m provider to provider underperformance.
  - Pay budgets overspent by £0.2m in November this was due to medical staffing overspends within Surgery (£0.1m) and Paediatrics (£0.1m). Surgery's Medical Staffing vacancy percentage (17%) is 4% higher than planned and Paediatrics is 6% higher than planned which is causing a higher than planned usage of Agency staff.
  - Non Pay adjusted for pass through costs and reserves was overspent by £0.3m in November this is due to continued pressures within Pathology (£0.2m) and Audiology (£0.1m).
- The Trust achieved £1.2m savings in November which was £1.7m adverse to plan and £4.6m adverse year to date. This is mainly due to STP Medical rate slippage (£1m), Prime Provider (£2.2m), Private Patient income slippage (£0.4m).
- The Trust held £8.6m of cash at the end of November which is higher than the plan of £2.1m. This is primarily due to the Trust receiving income earlier than forecasted in the first half of the year. This cash balance will continue to reduce as pressure points within the remaining four months of 2018/19 materialise. The Trust is working closely with neighbouring NHS bodies and where possible “like for like” arrangements are organised with local providers. MTW usually receives a benefit as we a net provider of services so we seek a proportionate arrangement to bring the debtor/creditor positions in line with each other.
- The Trust has an approved Capital Plan of £14.46m and is forecasting to spend £12.23m which takes account of: 1) Linac 5 funding is £32k less than plan; 2) NHSI have indicated that it is extremely unlikely that capital expenditure reliant on DHSC financing will not be available in 18/19 - therefore the Trust is no longer forecasting the purchase of CT scanners (£2.5m) through a potential capital loan in this year; the Trust will reserve its right to bring this back into the planning submission for 2019/20; 3) the outturn forecast for depreciation is £380k lower than plan due to slippage on schemes - this reduces the available resource so it is balanced by some equipment schemes being deferred; 4) the total Salix loan for Phase 4 at MS and Phase 1 at TWH has increased by £270k for this year; 5) additional donations from various sources have increased by £410k and 6) taking into account all these variations there is

currently a shortfall in the programme of £315k and this is being managed by deferring some equipment schemes until the property sales are concluded. The combination of these factors means that the outturn is projected to be £2.23m lower than original plan

- The Trust is forecasting to deliver the plan which will require delivery of an additional £6.4m recovery plans. The Trust is exploring additional opportunities such as exploring additional funding for RTT and Cancer recovery plan and are meeting Divisions weekly to discuss progress towards their recovery targets.

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 / Assurance, to discuss the November financial position

[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

Maidstone and Tunbridge Wells NHS Trust

Trust Board Finance Report

Month 8
2018/19

Maidstone and Tunbridge Wells NHS Trust

Trust Board Finance Report for November 2018

1. Executive Summary
- a. Dashboard
- b. I&E Summary

2. Financial Performacne
- a. Consolidated I&E
- b. I&E Run Rate

3. Cost Improvement Programme
- a. Savings by Division

4. Year End Forecast
- a. Trust Forecast

5. Balance Sheet and Liquidity
- a. Balance Sheet
- b. Cash Flow
- c. Capital Plan

Maidstone and Tunbridge Wells NHS Trust

1a. Dashboard

November 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	40.8	40.2	0.6	0.4	0.2		310.0	311.4	(1.5)	(0.3)	(1.2)		463.4	471.2	(7.8)	
Expenditure	(36.3)	(35.7)	(0.7)	(0.4)	(0.3)		(288.6)	(289.6)	1.1	0.3	0.8		(431.9)	(432.3)	0.4	
EBITDA (Income less Expenditure)	4.5	4.6	(0.1)	(0.0)	(0.1)		21.4	21.8	(0.4)	(0.0)	(0.4)		31.5	38.9	(7.4)	
Financing Costs	(2.5)	(2.5)	0.1	0.0	0.1		(20.4)	(20.3)	(0.1)	0.0	(0.1)		(21.2)	(28.2)	7.0	
Technical Adjustments	0.0	0.0	0.0	0.0	0.0		0.6	0.0	0.5	0.0	0.5		1.4	1.0	0.4	
Net Surplus / Deficit (Incl PSF)	**2.0**	**2.0**	**0.0**	**(0.0)**	**0.0**		**1.5**	**1.5**	**0.0**	**0.0**	**0.0**		**11.7**	**11.7**	**(0.0)**	
CIPs	1.2	2.8	(1.7)		(1.7)		8.2	12.8	(4.6)		(4.6)		24.1	24.1	0.0	
Cash Balance	8.6	2.2	6.4		6.4		8.6	2.2	6.4		6.4		1.0	1.0	0.0	
Capital Expenditure	1.1	0.4	(0.7)		(0.7)		3.6	4.5	0.9		0.9		11.1	13.8	2.6	
Capital service cover rating							3	3					4	4		
Liquidity rating							4	4					4	4		
I&E margin rating							2	2					1	1		
Agency rating							4	4					4	4		
Finance and use of resources rating							3	3					3	3		

Summary:

- The Trusts surplus including PSF was £2m in November which was on plan. Year to date the Trust has a Surplus of £1.5m which is on plan however the key variances within plan are: CIP Slippage (£4.6m) overspends within pay budgets (£1.6m) and non pay budgets (£2.6m) offset by non-recurrent items (£1.9m) , release of contingency reserve (£4.3m) , earlier than planned phasing of Non Recurrent Income support (£1.6m) and underspends within income and depreciation (£1m).
- The Trust has spent £7.9m more than the YTD agency ceiling set by NHSI (£11.8m per annum)

Key Points:

- The Trusts normalised run rate in November was £1.3m deficit pre PSF which was £2.1m adverse to plan.
- The Trust in November delivered 90.93% A&E 4 hour performance which achieved the requirement for PSF funding (90%), the Trust therefore fully delivered the YTD PSF income for both A&E and the delivery of the financial plan.
- The main non pay pressures relate to clinical supplies (£2.1m adverse year to date) specifically within T&O (£0.7m), Cancer (£0.4m), Pathology (£0.5m) and ENT (£0.2m).
- The Trust has managed the YTD financial position by implementing non recurrent actions, as a result the Trusts recurrent deficit has increased from a planned deficit of £8.4m to a forecasted deficit of £17.5m.

Risks:

- The Trust is forecasting to deliver the planned £1m deficit pre PSF however recovery plans of £6.4m will have to be identified which are covered in section 5 of this report.

Maidstone and Tunbridge Wells NHS Trust

1b. Summary Income & Expenditure (Exceptional Items)

Income & Expenditure November 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	37.6	39.0	(1.3)	0.4	(1.7)	299.3	304.4	(5.1)	(0.3)	(4.9)
Expenditure	(36.6)	(35.7)	(1.0)	(0.4)	(0.6)	(293.1)	(289.6)	(3.5)	0.3	(3.7)
Trust Financing Costs	(2.5)	(2.5)	0.1	0.0	0.1	(20.4)	(20.3)	(0.1)	0.0	(0.1)
Technical Adjustments	0.0	0.0	0.0	0.0	0.0	0.6	0.0	0.5	0.0	0.5
Net Revenue Surplus / (Deficit) before Exceptional Items	**(1.4)**	**0.8**	**(2.2)**	**(0.0)**	**(2.2)**	**(13.7)**	**(5.5)**	**(8.1)**	**(0.0)**	**(8.1)**
Exceptional Items	2.2		2.2		2.2	8.2		8.2		8.2
Net Position	**0.8**	**0.8**	**0.0**	**(0.0)**	**0.0**	**(5.5)**	**(5.5)**	**0.0**	**(0.0)**	**0.0**
PSF Funding	1.3	1.3	0.0	0.0	0.0	7.0	7.0	(0.0)	0.0	(0.0)
Net Revenue Surplus / (Deficit) Incl PSF and Exceptional Items	2.0	2.0	0.0	(0.0)	0.0	1.5	1.5	0.0	(0.0)	0.0

Key messages:
The Trust benefited by £2.2m of exceptional adjustments this month which included: £1.6m income benefit relating to the earlier than planned reporting of the Non recurrent income support funding (plan assumed March), £0.3m release of reserves and the Capitalisation of £0.3m of costs.

Income:
Income YTD net of pass-through related costs and exceptional items is £4.9m adverse to plan, which is due to CIP slippage (£5.1m) and Private Patient income £0.6m partially offset by income over performance within non AIC contracted clinical income (£1.3m)

Expenditure:
Expenditure budgets net of pass-through and exceptional items are £3.7m adverse, which is due to budget overspends within Pay budgets (£1.6m) and Non Pay (£2.6m) partly offset by CIP over performance of £0.5m.
The main pressures within expenditure budgets (net of pass though, CIP and exceptional items) relates to: Clinical Supplies and Services (£2.3) and Medical (£1.4m).

Reserves: The Trust has fully released the YTD held reserves.

PSF: The Trust in November delivered 90.93% A&E 4 hour performance which achieved the requirement for PSF funding (90%), the Trust therefore fully delivered the YTD PSF income for both A&E and the delivery of the financial plan.

Maidstone and Tunbridge Wells NHS Trust

2a. Income & Expenditure

Income & Expenditure November 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	31.7	30.8	0.9	0.0	0.9	237.0	238.2	(1.2)	(0.3)	(1.0)	352.5	356.3	(3.9)
High Cost Drugs	3.8	3.5	0.3	0.3	(0.1)	29.3	29.1	0.2	0.2	(0.0)	43.2	43.2	0.0
Total Clinical Income	**35.5**	**34.3**	**1.1**	**0.4**	**0.8**	**266.3**	**267.3**	**(1.1)**	**(0.1)**	**(1.0)**	**395.7**	**399.6**	**(3.9)**
PSF	1.3	1.3	0.0	0.0	0.0	7.0	7.0	(0.0)	0	(0.0)	12.7	12.7	0
Other Operating Income	4.1	4.6	(0.5)	0.0	(0.6)	36.7	37.1	(0.4)	(0.2)	(0.2)	54.9	58.9	(3.9)
Total Revenue	40.8	40.2	0.6	0.4	0.2	310.0	311.4	(1.5)	(0.3)	(1.2)	463.4	471.2	(7.8)
Substantive	(18.9)	(19.1)	0.2	0.0	0.2	(148.5)	(152.7)	4.2	0.3	3.8	(225.0)	(228.9)	4.0
Bank	(1.1)	(1.0)	(0.1)	0.0	(0.1)	(8.5)	(8.0)	(0.5)	0.0	(0.5)	(13.3)	(12.3)	(1.0)
Locum	(0.8)	(0.5)	(0.3)	0.0	(0.3)	(5.1)	(3.6)	(1.5)	0	(1.5)	(8.6)	(5.5)	(3.2)
Agency	(1.7)	(1.9)	0.2	(0.0)	0.2	(15.5)	(13.9)	(1.6)	(0.0)	(1.6)	(23.3)	(22.2)	(1.1)
Pay Reserves	(0.2)	(0.0)	(0.1)	0.0	(0.1)	(0.4)	(1.4)	1.0	0	1.0	(1.1)	(1.7)	0.6
Total Pay	(22.7)	(22.5)	(0.2)	0.0	(0.2)	(178.0)	(179.6)	1.5	0.3	1.2	(271.3)	(270.6)	(0.7)
Drugs & Medical Gases	(4.8)	(4.2)	(0.6)	(0.3)	(0.3)	(35.7)	(35.6)	(0.2)	(0.2)	0.0	(53.8)	(52.0)	(1.8)
Blood	(0.2)	(0.2)	0.0	0.0	0.0	(1.4)	(1.4)	(0.0)	0	(0.0)	(2.1)	(2.2)	0.0
Supplies & Services - Clinical	(3.0)	(2.7)	(0.2)	(0.0)	(0.2)	(22.9)	(21.1)	(1.8)	0.3	(2.1)	(34.0)	(32.1)	(1.9)
Supplies & Services - General	(0.5)	(0.4)	(0.1)	(0.0)	(0.1)	(3.7)	(3.5)	(0.3)	(0.0)	(0.2)	(5.3)	(5.0)	(0.3)
Services from Other NHS Bodies	(1.3)	(0.8)	(0.5)	(0.2)	(0.3)	(6.8)	(6.6)	(0.3)	(0.0)	(0.3)	(10.8)	(9.9)	(0.9)
Purchase of Healthcare from Non-NHS	(0.2)	(0.5)	0.3	0.0	0.3	(2.3)	(3.8)	1.5	(0.0)	1.5	(4.7)	(5.3)	0.6
Clinical Negligence	(1.3)	(1.6)	0.3	0.0	0.3	(12.4)	(12.7)	0.3	0	0.3	(18.6)	(19.0)	0.5
Establishment	(0.3)	(0.3)	(0.1)	(0.0)	(0.0)	(2.5)	(2.3)	(0.2)	(0.1)	(0.1)	(4.0)	(3.5)	(0.5)
Premises	(1.5)	(1.6)	0.1	0.3	(0.2)	(15.3)	(15.0)	(0.3)	0.4	(0.7)	(22.9)	(21.4)	(1.5)
Transport	(0.1)	(0.1)	(0.0)	0.0	(0.0)	(1.1)	(1.0)	(0.2)	0	(0.2)	(1.7)	(1.3)	(0.4)
Other Non-Pay Costs	(0.4)	(0.6)	0.2	(0.1)	0.3	(6.2)	(5.7)	(0.6)	(0.4)	(0.2)	(9.0)	(8.1)	(0.9)
Non-Pay Reserves	0.0	(0.2)	0.2	0.0	0.2	0	(1.4)	1.4	0	1.4	6.3	(1.8)	8.1
Total Non Pay	(13.6)	(13.1)	(0.5)	(0.4)	(0.1)	(110.5)	(110.1)	(0.5)	(0.0)	(0.4)	(160.6)	(161.7)	1.1
Total Expenditure	(36.3)	(35.7)	(0.7)	(0.4)	(0.3)	(288.6)	(289.6)	1.1	0.3	0.8	(431.9)	(432.3)	0.4
EBITDA	4.5	4.6	(0.1)	(0.0)	(0.1)	21.4	21.8	(0.4)	(0.0)	(0.4)	31.5	38.9	(7.4)
	0.0	*0.0*	*(0.0)*	*%*		*6.9%*	*7.0%*	*27.5%*	*0.0%*	*33.9%*	*6.8%*	*8.3%*	*95.1%*
									0	0			
Depreciation	(1.1)	(1.1)	0.1	0	0.1	(8.7)	(9.0)	0.3	0	0.3	(13.1)	(13.5)	0.3
Interest	(0.1)	(0.1)	0.0	0	0.0	(1.1)	(1.0)	(0.0)	0	(0.0)	(1.6)	(1.6)	(0.1)
Dividend	(0.1)	(0.1)	0.0	0	0	(0.9)	(0.9)	0	0	0	(1.3)	(1.3)	0
PFI and Impairments	(1.2)	(1.2)	(0.0)	0	(0.0)	(9.8)	(9.5)	(0.3)	0	(0.3)	(5.2)	(11.9)	6.8
Total Finance Costs	(2.5)	(2.5)	0.1	0.0	0.1	(20.4)	(20.3)	(0.1)	0	(0.1)	(21.2)	(28.2)	7.0
Net Surplus / Deficit (-)	2.0	2.0	(0.0)	(0.0)	**(0.0)**	1.0	1.5	(0.5)	(0.0)	(0.5)	10.3	10.7	(0.4)
Technical Adjustments	0.0	0.0	0.0	0.0	0.0	0.6	0.0	0.5	0.0	0.5	1.4	1.0	0.4
Surplus/ Deficit (-) to B/E Duty Incl PSF	2.0	2.0	0.0	(0.0)	**0.0**	1.5	1.5	0.0	0.0	0.0	11.7	11.7	(0.0)
Surplus/ Deficit (-) to B/E Duty Excl PSF	0.8	0.8	0.0	(0.0)	**0.0**	(5.5)	(5.5)	0.0	0.0	0.0	(1.0)	(1.0)	(0.0)

Commentary

The Trusts surplus including PSF was £2m in November which was on plan, year to date the Trust has a surplus of £1.5m which is on plan.

The Trusts normalised run rate in November was £1.3m deficit pre PSF which was £2.1m 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 £0.8m favourable to plan in November which included £1.6m benefit relating to Non Recurrent Income support incorporated earlier than planned. The key adverse variances are Daycases (£0.2m) and Electives (£0.4m) . This is mainly in relation to the delay to the Prime Provider tender process.

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

Other Operating Income excluding pass-through costs is £0.6m adverse to plan in the month, this is mainly due to £0.3m underperformance within Private Patients and £0.2m slippage within provider to provider SLA income.

Pay budgets overspent by £0.2m in November this was due to medical staffing overspends within Surgery (£0.1m) and Paediatrics (£0.1m). Surgery's Medical Staffing vacancy percentage (17%) is 4% higher than planned and Paediatrics is 6% higher than planned which is causing a higher than planned usage of Agency staff.

Non Pay adjusted for pass through costs and reserves was overspent by £0.3m in November this is due to continued pressures within Pathology (£0.2m) and Audiology (£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)

		Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Change between Months
Revenue	Clinical Income	31.2	31.7	32.0	31.2	33.8	30.7	33.5	32.3	35.4	33.1	32.0	33.7	35.5	1.8
	STF / PSF	0.0	0.0	0.0	0.0	3.0	0.0	0.0	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	3.4	3.8	4.0	5.7	3.9	5.1	5.2	5.0	5.7	5.5	4.8	7.0	5.3	(1.7)
	Total Revenue	**34.5**	**35.5**	**36.0**	**36.9**	**40.8**	**35.9**	**38.7**	**37.3**	**41.2**	**38.6**	**36.8**	**40.7**	**40.8**	**0.1**
Expenditure	Substantive	(18.0)	(17.8)	(17.9)	(17.5)	(17.9)	(18.3)	(18.7)	(18.4)	(19.4)	(18.5)	(18.9)	(17.6)	(18.9)	(1.3)
	Bank	(0.9)	(1.2)	(1.2)	(1.1)	(1.3)	(1.0)	(1.0)	(1.0)	(1.0)	(1.2)	(1.1)	(1.0)	(1.1)	(0.1)
	Locum	(0.6)	(0.5)	(0.5)	(0.6)	(0.7)	(0.5)	(0.6)	(0.5)	(0.6)	(0.7)	(0.7)	(0.6)	(0.8)	(0.2)
	Agency	(1.8)	(1.9)	(2.3)	(1.8)	(2.6)	(2.0)	(2.1)	(1.7)	(2.1)	(2.1)	(1.9)	(1.8)	(1.7)	0.1
	Pay Reserves	(0.2)	(0.2)	(0.2)	(0.3)	(0.2)	(0.2)	(0.2)	(0.2)	(0.1)	0.2	0.0	0.4	(0.2)	(0.5)
	Total Pay	(21.6)	(21.6)	(22.2)	(21.3)	(22.7)	(22.0)	(22.7)	(21.9)	(23.2)	(22.3)	(22.5)	(20.7)	(22.7)	(2.1)
Non-Pay	Drugs & Medical Gases	(4.5)	(4.2)	(4.5)	(4.3)	(4.5)	(4.2)	(4.8)	(4.3)	(4.5)	(4.3)	(4.4)	(4.4)	(4.8)	(0.4)
	Blood	(0.2)	(0.2)	(0.2)	(0.1)	(0.2)	(0.2)	(0.1)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	0.0
	Supplies & Services - Clinical	(2.6)	(2.5)	(2.6)	(2.5)	(2.1)	(2.6)	(2.9)	(2.7)	(2.9)	(3.0)	(2.8)	(3.1)	(3.0)	0.1
	Supplies & Services - General	(0.5)	(0.5)	(0.4)	(0.5)	(0.6)	(0.4)	(0.4)	(0.4)	(0.4)	(0.5)	(0.5)	(0.5)	(0.5)	0.0
	Services from Other NHS Bodies	(1.3)	(0.9)	(0.7)	(0.7)	(0.3)	(0.6)	(0.6)	(1.1)	(0.7)	(0.7)	(1.1)	(0.8)	(1.3)	(0.5)
	Purchase of Healthcare from Non-NHS	(0.4)	(0.4)	(0.2)	(0.2)	(0.3)	(0.3)	(0.3)	(0.2)	(0.2)	(0.3)	(0.4)	(0.3)	(0.2)	0.1
	Clinical Negligence	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.6)	(1.6)	(1.6)	(1.6)	(1.6)	(1.6)	(1.6)	(1.3)	0.3
	Establishment	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.2)	(0.3)	(0.4)	(0.3)	(0.3)	(0.3)	(0.0)
	Premises	(1.8)	(2.2)	(1.8)	(3.8)	(3.0)	(1.9)	(1.8)	(1.8)	(2.6)	(2.2)	(1.8)	(1.7)	(1.5)	0.2
	Transport	(0.1)	(0.1)	(0.2)	(0.1)	(0.2)	(0.2)	(0.2)	(0.2)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	0.0
	Other Non-Pay Costs	(0.0)	(1.0)	(1.1)	(1.1)	(0.2)	(1.0)	(1.0)	(0.3)	(1.2)	(1.1)	(0.2)	(1.1)	(0.4)	0.6
	Non-Pay Reserves	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.2)	(0.2)	(0.2)	(0.2)	0.5	0.6	(0.4)	0.0	0.4
	Total Non Pay	(13.4)	(14.2)	(13.7)	(15.4)	(13.2)	(13.5)	(14.3)	(13.2)	(14.9)	(13.8)	(12.7)	(14.5)	(13.6)	0.9
	Total Expenditure	(35.0)	(35.8)	(35.8)	(36.7)	(35.9)	(35.5)	(36.9)	(35.1)	(38.2)	(36.1)	(35.3)	(35.2)	(36.3)	(1.2)
EBITDA	EBITDA	(0.5)	(0.3)	0.2	0.2	4.9	0.4	1.8	2.2	3.0	2.5	1.5	5.5	4.5	(1.1)
		-1%	*-1%*	*1%*	*1%*	*12%*	*1%*	*5%*	*6%*	*7%*	*7%*	*4%*	*14%*	*11%*	
Other Finance Costs	Depreciation	(1.1)	(1.0)	(1.2)	(1.1)	(1.2)	(1.1)	(1.1)	(1.1)	(1.0)	(1.0)	(1.2)	(1.1)	(1.1)	0.0
	Interest	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	0.0
	Dividend	(0.1)	(0.1)	0.5	(0.1)	0.2	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	0.0
	PFI and Impairments	(1.2)	(5.2)	(1.1)	(1.2)	17.5	(1.2)	(1.2)	(1.2)	(1.2)	(1.2)	(1.3)	(1.4)	(1.2)	0.2
	Total Other Finance Costs	**(2.5)**	**(6.4)**	**(1.9)**	**(2.5)**	**16.3**	**(2.5)**	**(2.5)**	**(2.5)**	**(2.5)**	**(2.5)**	**(2.7)**	**(2.7)**	**(2.5)**	**0.2**
Net Surplus / Deficit (-)	Net Surplus / Deficit (-)	(2.9)	(6.7)	(1.7)	(2.2)	21.2	(2.2)	(0.8)	(0.3)	0.5	0.0	(1.1)	2.8	2.0	(0.8)
Technical Adjustments	Technical Adjustments	0.0	4.0	0.0	0.0	(18.9)	0.0	0.0	0.0	0.0	0.0	0.1	0.3	0.0	(0.2)
Surplus/ Deficit (-) to B/E Duty Incl STF	Surplus/ Deficit (-) to B/E Duty	(2.9)	(2.6)	(1.6)	(2.2)	2.3	(2.2)	(0.8)	(0.3)	0.6	0.1	(1.0)	3.1	2.0	(1.0)
Surplus/ Deficit (-) to B/E Duty Excl STF	Surplus/ Deficit (-) to B/E Duty	(2.9)	(2.6)	(1.6)	(2.2)	(0.7)	(2.2)	(0.8)	(0.3)	0.6	0.1	(1.0)	3.1	2.0	(1.0)

Maidstone and Tunbridge Wells NHS Trust

3a. Cost Improvement Plan

Savings by Division

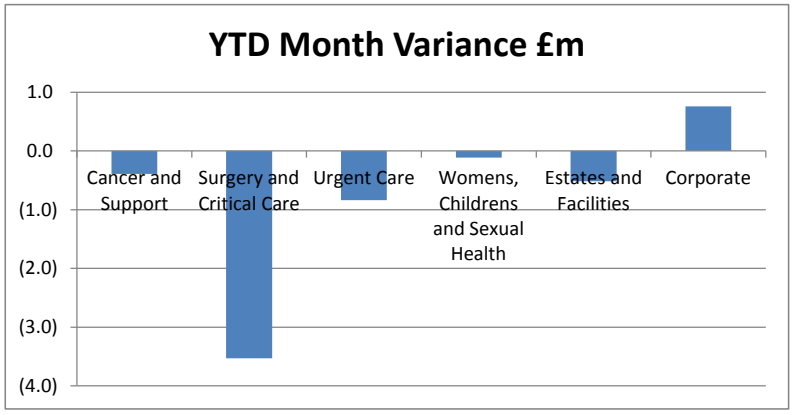
	Current Month			Year to Date			Forecast (Risk Adjusted)		
	Actual	*Original Plan*	*Variance*	*Actual*	*Original Plan*	*Variance*	*Forecast*	*Original Plan*	*Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Cancer and Support	0.27	0.36	(0.08)	1.22	1.61	(0.39)	2.04	3.01	(0.97)
Surgery and Critical Care	0.03	1.34	(1.32)	2.62	6.15	(3.53)	4.07	11.38	(7.31)
Urgent Care	0.43	0.36	0.07	1.03	1.86	(0.84)	1.82	3.66	(1.84)
Womens, Childrens and Sexual Health	0.38	0.23	0.15	1.08	1.19	(0.11)	1.56	2.11	(0.55)
Estates and Facilities	0.16	0.45	(0.30)	0.83	1.35	(0.52)	1.90	2.95	(1.04)
Corporate	(0.12)	0.08	(0.20)	1.45	0.69	0.76	2.35	1.00	1.35
Total	**1.15**	**2.82**	**(1.67)**	**8.23**	**12.85**	**(4.62)**	**13.75**	**24.11**	**(10.37)**

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	0.15	0.13	0.01	1.78	2.58	(0.80)	2.58	3.17	(0.59)
Non Pay	0.94	1.00	(0.06)	5.64	4.35	1.30	9.25	8.40	0.85
Income	0.07	1.69	(1.62)	0.80	5.92	(5.12)	1.92	12.55	(10.63)
Total	**1.15**	**2.82**	**(1.67)**	**8.23**	**12.85**	**(4.62)**	**13.75**	**24.11**	**(10.37)**

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	0.81	1.87	(1.07)	7.06	9.52	(2.47)	10.71	16.99	(6.28)
Amber	0.26	0.31	(0.04)	0.73	1.49	(0.76)	2.22	2.73	(0.50)
Red	0.08	0.65	(0.57)	0.44	1.83	(1.39)	0.81	4.39	(3.58)
Total	**1.15**	**2.82**	**(1.67)**	**8.23**	**12.85**	**(4.62)**	**13.74**	**24.11**	**(10.37)**



Comment

The Trust was £1.7m adverse to plan in the month and £4.6m adverse YTD. The main schemes adverse to plan YTD are:
- STP Medical Rates £1m (£0.2m adverse in month)
- Prime Provider £2.2m (£0.9m adverse in month)
- Private Patient Income £0.4m.
- Estates and Facilities £0.5m.

The Trusts risk adjusted savings forecast is £10.4m adverse to plan, the main schemes forecasting slippage are:
- Estates and Facilities Subsidiary £1.75m (although £0.6m new schemes have been added to reduce impact to £1.1m)
- Private Patient Income = £1m
- STP Medical Rates = £1.8m
- Prime Provider = £4.5m, the forecast currently assumes £1m benefit in 2018/19
- Medicines Management = £1.2m (£0.7m relates to Avastin)
- Urgent Care Centre = £0.4m

Maidstone and Tunbridge Wells NHS Trust

4a. Year End Forecast

Year End Forecast November 2018/19

		Latest Forecast Excluding RTT and Cancer Recovery Plans																Additional Actions		
	Annual Plan £m	*CIP Non Delivery £m*	*Pay Pressures*	*Private Patient Income*	*Non Recurrent Income Support*	*Establishment Expenditure Pressures*	*Non Pay Pressures*	*Asset Sales*	*2017/18 Benefits*	*Divisional Recovery Plan*	*Bad Debt*	*Release of Reserves*	*RTT and Cancer Recovery Plans*	*Pass through Items*	*Other*	*Risk Adjusted Forecast £m*	***Variance £m***	*Cancer Recovery Plan - Income £m*	*Additional Recovery Actions*	***Revised Variance £m***
Income	458.6	(10.6)		(0.7)	(0.7)				1.8	(0.3)			0.7	0.5	1.3	450.6	**(8.0)**	0	0	**(8.0)**
Pay	(270.6)	(0.6)	(6.6)						0.7	2.1		4.3	(0.6)		0.0	(271.3)	**(0.6)**	0	0	**(0.6)**
Non Pay	(161.8)	0.9				(0.5)	(3.9)		(0.5)	0.9	(0.6)	2.5	(1.8)	(0.5)	(1.5)	(166.9)	**(5.1)**	1.4	5.0	**1.3**
Other Finance Costs	(28.2)							7.0							0.0	(21.2)	**7.0**	0	0	**7.0**
Technical Adjustments	1.1														0.3	1.4	**0.3**			**0.3**
Surplus/ Deficit (-) to B/E Duty	**(1.0)**	**(10.4)**	**(6.6)**	**(0.7)**	**(0.7)**	**(0.5)**	**(3.9)**	**7.0**	**1.9**	**2.7**	**(0.6)**	**6.8**	**(1.7)**	**0**	**0.2**	**(7.3)**	**(6.4)**	**1.4**	**5.0**	**0.0**

Commentary

The Trust is forecasting to deliver the plan however has a risk adjusted 'business as usual' forecast deficit of £7.3m pre PSF. The Trust will be implementing recovery actions of £6.4m to meet the planned deficit of £1m.

The Trusts risk adjusted forecast includes the following assumptions:
- CIP Delivery of £13.7m (£10.4m shortfall, mainly within Income)
- Implementation of £2.7m divisional recovery plans (£0.5m relating to Maternity CNST benefit is also incorporated within the CIP forecast)
- Divisional Pay Pressures (£6.6m)
- Non Pay pressure (£3.9m)
- £10.3m Profit on sale of Assets (£7m higher than planned)
- Full release of reserves (£6.8m)

Recovery Actions -

The Trust is currently focusing on the following actions to close the current shortfall to plan:

- Maintain weekly meetings with Divisions to focus on identification and delivery of Divisional Recovery plans / Divisional Control Targets
- Best Care Programme leads have been asked to identify potential opportunities for 2018/19 to assist with delivery of Divisional control targets
- Maximise benefit from asset sales. There is a potential additional benefit from sale of assets that could be delivered. Further work is being completed to validate / finalise the opportunity
- In line with previous years recovery plans and NHSi 'Grip and Control' processed a review of contingencies, provisions and other balance sheet opportunities is underway.
- Seek additional funding from Commissioners to support Cancer Recovery plans

The Trust is forecasting to deliver a surplus of £11.7m including PSF.

Maidstone and Tunbridge Wells NHS Trust

5a. Balance Sheet

November 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	November Reported	November Plan	Variance	October Reported
Property, Plant and Equipment (Fixed Assets)	289.0	290.1	(1.1)	288.8
Intangibles	2.4	2.1	0.3	2.5
PFI Lifecycle	0.0	0.0	0.0	0.0
Debtors Long Term	1.2	1.2	0.0	1.2
Total Non-Current Assets	**292.6**	**293.4**	**(0.8)**	**292.5**
Current Assets	0.0	0.0	0.0	0.0
Inventory (Stock)	7.1	8.2	(1.1)	7.4
Receivables (Debtors) - NHS	27.2	26.0	1.2	22.3
Receivables (Debtors) - Non-NHS	14.4	12.3	2.1	15.3
Cash	8.6	2.1	6.5	12.6
Assets Held For Sale	0.0	0.0	0.0	0.0
Total Current Assets	**57.3**	**48.6**	**8.7**	**57.6**
Current Liabilities				
Payables (Creditors) - NHS	(4.5)	(4.5)	0.0	(4.9)
Payables (Creditors) - Non-NHS	(37.4)	(32.6)	(4.8)	(37.4)
Deferred Income	(13.5)	(9.3)	(4.2)	(14.8)
Capital Loan	(2.2)	(2.2)	0.0	(2.2)
Working Capital Loan	(29.0)	(29.0)	0.0	(29.0)
Other loans	(0.4)	(0.1)	(0.3)	(0.1)
Borrowings - PFI	(5.0)	(5.2)	0.2	(5.0)
Provisions for Liabilities and Charges	(1.8)	(1.9)	0.1	(1.8)
Total Current Liabilities	**(93.8)**	**(84.8)**	**(9.0)**	**(95.2)**
Net Current Assets	(36.5)	(36.2)	(0.3)	(37.6)
Borrowings - PFI > 1yr	(189.4)	(189.7)	0.3	(189.8)
Capital Loans	(9.1)	(9.1)	0.0	(9.1)
Working Capital Facility & Revenue loans	(14.0)	(14.0)	0.0	(14.0)
Other loans	(0.9)	(1.3)	0.4	(1.3)
Provisions for Liabilities and Charges- Long term	(0.9)	(0.8)	(0.1)	(0.9)
Total Assets Employed	**41.8**	**42.3**	**(0.5)**	**39.8**
Financed By:				
Capital & Reserves				
Public dividend capital	207.3	207.3	0.0	207.3
Revaluation reserve	29.8	29.8	0.0	29.8
Retained Earnings Reserve	(195.3)	(194.8)	(0.5)	(197.3)
Total Capital & Reserves	**41.8**	**42.3**	**(0.5)**	**39.8**

Commentary:
The month 8 balance sheet position is consistent with the plan that was submitted in June. The overall working capital within the month results in a increase in both debtors and 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 cash which was not included within the plan.

Non-Current Assets -
Capital additions for 2018/19 have reduced from the plan of £14.5m to £12.2m to reflect the reduction in the in year capital programme including the removal of £2.5m loan following recent notification from NHSI on capital funding, donated assets have increased from the planned spend of £0.7m to £1.1m. 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 8 capital spend is £1.1m against a plan of £0.4m.

Current Assets -
Inventory of £7.1m is a reduction from the planned value of £8.2m. The main stock balances are pharmacy £2.8m, TWH theatres £1.5m, Materials Management £1.1m and Cardiology £0.2m.
NHS Receivables have increased from the month 7 position by £4.9m to £27.2m. Of the £27.2m reported balance, £9.5m relates to invoiced debt of which £3.1m is aged debt over 90 days. Invoiced debt over 90 days has decreased by £1m from the mth 7 reported position. The remaining £17.7m relates to uninvoiced accrued income including work in progress partially completed spells and a accrual for m4-8 PSF funding £5.1m. 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 £0.9m to £14.4m from the month 7 reported position. Included within the £14.4m balance is trade invoiced debt of £2.6m and private patient invoiced debt of £0.6m. Prepayments and accrued income totalling £9m. Prepayments primarily relate to rates & annual service maintenance contracts, which will reduce throughout the year as they are expensed. The Trust is currently using a company called Patient Billing Ltd which are supporting the PPU department with improving the quality of invoices and debt collecting.
The cash balance of £8.6m is higher than plan of £2.1m by £6.5m. As the Trust has pressure points within 2018/19 the cash balance will gradually reduce as these pressures materialise.

Current Liabilities -
NHS payables have decreased from the October's reported position by £0.4m to £4.5m. Non-NHS trade payables have remained the same at £37.4m, giving a combined payables balance of £41.9m.

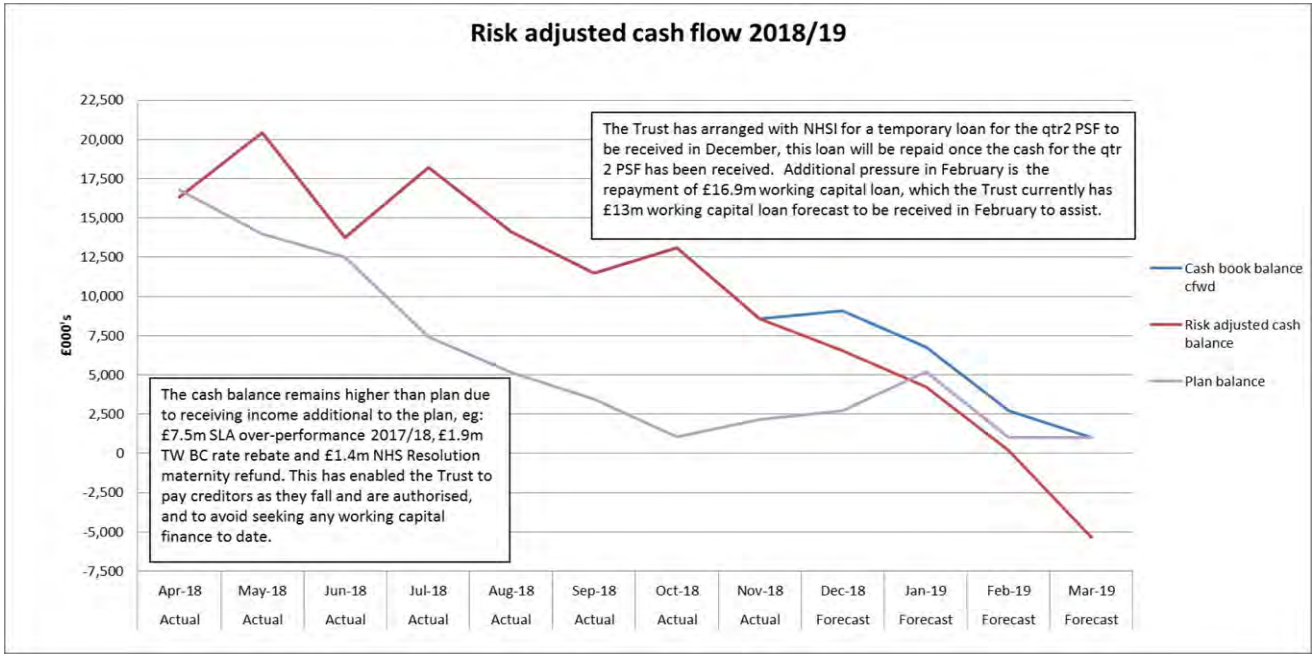
Of the £41.9m combined payables balances, £12.9m relates to actual invoices of which £7.5m are approved for payment and £29m relates to uninvoiced accruals. The accruals include expected values for tax , NI, Superannuation and PDC payments.
Deferred income of £13.5m primarily is in relation to £6.6m advanced contract payment received from WK CCG and £2m from High Weald CCG in April, the WKCCG income reduces by £2.28m over each of the remaining 11 months. Other items within the deferred income balances are £2.2m Learning & Development income and £1.9m maternity pathway.
Included within the £29m working capital loan are £16.9m which is repayable in February 2019 and £12.132m repayable in October 2019 (previously in long term creditors).
Other loans for both current and non current liabilities relate to the Salix loan which has been taken out to improve the ene rgy 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 £13.990m which was taken out in 2017/18 and is repayable in 2020/21.

Capital and Reserves-
For each area within this element for month 8 are consistent with the plan.

Maidstone and Tunbridge Wells NHS Trust

5b. | Cash Flow



Commentary

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

The cash flow forecast reflects the actual position up to November and the forecast is based on the latest I&E forecast before additional recovery measures.

Due to uncertainties within the financial position the current cash flow assumes a working capital loan in February of £13m, this has increased from the planned version of £6m.

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 £13m. If the PSF funding is not received and if the I&E position move adversely from the plan, the Trust will need to implement strategies to ensure the loan can be repaid before increasing the value of the working capital loan request.

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

Information on loans:

	Rate	Value £m's	18/19 Annual Repayment £m's	18/19 Annual Interest Paid £m's	Repayment Date
Revenue loans:					
Interim Single Currency Loan	1.50%	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:	0.00%	0.000	0.00	0.00	00/01/1900
Capital investment loan					
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) £1.4m to be rec in 18/19	0.00%	1.414	0.10	0.00	2023/24

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	1,940	1,746	194	5,788	6,058	270	3,225
ICT	750	787	-37	1,002	1,651	649	1,015
Equipment	1,386	648	738	6,501	2,939	-3,561	2,496
PFI Lifecycle (IFRIC 12)	233	373	-140	471	471	0	471
Donated Assets	625	0	625	700	1,110	410	594
Total	**4,934**	**3,554**	**1,379**	**14,462**	**12,229**	**-2,233**	**7,801**
Less donated assets	-625	0	-625	-700	-1,110	-410	0
Asset Sales (net book value)	0	0	0	-2,402	-2,402	0	0
Contingency Against Non-Disposal							
Adjusted Total	**4,309**	**3,554**	**754**	**11,360**	**8,717**	**-2,643**	**7,801**

**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 £12.23m which takes account of: 1) Linac 5 funding is £32k less than plan; 2) the outturn forecast for depreciation is £380k lower than plan due to slippage on schemes 3) the Trust is longer applying for a loan for the Critical Imaging Equipment in this financial year of £2.5m 4) additional Salix loan amount of £270k 5) additional donated schemes of £410k and 6) there is a shortfall of £315k on the programme and therefore some equipment projects are being deferred until the property sales are concluded.

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 £724k for Phase 1 TWH LED. Agreement from DH to provide the necessary Capital resource cover is being obtained by NHSI.

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 is now up and running. Linac 5 enabling work has begun, delivery of the Linac machine is due mid-December. Linac 5 replacement funding has 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 – December 2018

NHS Maidstone and Tunbridge Wells NHS Trust

12-9	**Integrated Performance Report, November 2018 – planned and actual ward staffing**	**Chief Nurse**

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

ASU: Increased fill rate at night due to enhanced care needs recorded on 13 days in month

Cornwallis: Decrease in RN fill rate with staff redeployed to support safe staffing. Increased CSW fill rate to support ward move as part of planned winter escalation. Cornwallis ward has now moved to Peal Ward with effect from Saturday 10th November.

Chaucer: Increased fill rate due to unit requirements during escalation throughout month and norovirus management across 5 days.

Mercer: 3 falls above threshold Increased CSW fill rate at night with Enhanced Care required on 14 occasions.

UMAU (Maidstone): Increased fill rate at night to staff night escalation on 29 nights.

Ward 22: 4 falls above threshold. Reduced RN fill rate due to lack of available temporary staff

Ward 33 / Gynae: EGAU commenced 24hr service and staff requirements changed. Reduced fill rate against new plan.

ITU (TWH): 1 fall above threshold. Increased fill rate due to unit escalation on 14 occasions in month

MAU (TWH): 3 falls above threshold. Decreased fill rate due to lack of available temporary staff. AMU escalated throughout the month.

Ward 10: 1 fall above threshold. Skill mix adjustment a considered risk by the ward team in line with a high dependency and moderate acuity. Reduced CSW fill rate during the day due to sickness and lack of available cover.

Ward 12: 0 falls recorded in month which shows continued improvement. Reduced RN fill rate due to staff sickness and lack of available temporary staff to cover

Ward 20: 7 falls above threshold which is a decrease on previous month. Increased fill rate with enhanced care requirements through the month. Quality reviews continue to monitor against actions.

Ward 2: 4 falls above threshold. Staffing requirements for AFU Mon - Fri. Escalation on 16 occasions.

Ward 30: Enhanced care requirement throughout the month. Amber QuESTT score escalated to Matron and DDNQ.

Neonatal Unit: Reduced fill rate due to short term sickness throughout month. Improved acuity / dependency during November rag rated 11 ambers and 17 reds in month (No black recorded).

Peale: Increased fill rate in line with planned Winter escalation to move from Peale to Foster Clarke ward. High dependency noted in month and bed base increase to 28 beds with effect from 18th November.

A+E (MH + TWH): Reduced RN fill rate due to lack of available temporary staff through the month including 11 Agency bookings which DNA'd. MH A+E supported redeployment of staff to support TWH site + AMU on 3 occasions

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 is currently being supported 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.
With the introduction of apprenticeships and the start for the new Trainee Nursing Associates (TNAs) this will impact on the current workforce structure. This will require a revised methodology when considering our workforce needs to ensure consideration to the future structure of new learners, apprentice's and the introductions of TNA's leading to the Nursing Associate role.

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

_____
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 remains at 100% (not including maternity) for the month of October. 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 & ICU	
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

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 / 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

Nov-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	97.0%	99.0%	100.6%	122.1%	8.3	46.2%	88.9%	2	0	3	Increased fill rate at night due to enhanced care needs recorded on 13 days in month	140,066	145,634	(5,568)
MAIDSTONE	Cornwallis	87.4%	117.2%	93.3%	76.7%	8.2	41.6%	97.3%	2	0	7	Decrease in RN fill rate with staff redeployed to support safe staffing. Increased CSW fill rate to support ward move as part of planned winter escalation	91,179	73,696	17,483
MAIDSTONE	Culpepper (Inc CCU)	97.4%	98.9%	102.5%	96.7%	11.2	132.0%	90.9%	3	2	0	1 fall above threshold	109,337	110,577	(1,240)
MAIDSTONE	John Day	97.8%	117.4%	102.8%	93.3%	6.2	79.6%	94.9%	8	2	6	3 falls above threshold Increased fill rate at night due to additional RMN requirment on two nights and increase dependancy recorded one night	134,925	136,420	(1,495)
MAIDSTONE	Intensive Treatment Unit (ITU)	93.4%	83.6%	94.4%	N/A	27.9			0	0	0	Reduced CSW fill rate due to lack of available temporary staff. Escalated on 4 occasions	157,740	191,960	(34,220)
MAIDSTONE	Pye Oliver	98.3%	91.1%	97.8%	99.9%	5.8	46.4%	92.3%	4	0	8		116,339	111,781	4,558
MAIDSTONE	Chaucer	114.1%	75.6%	152.1%	180.0%	13.2	135.2%	97.3%	2	0	0	Increased fill rate due to unit requirements during escalation throughout month and norovirus management across 5 days	118,267	123,518	(5,251)
MAIDSTONE	Lord North	92.1%	123.6%	99.9%	105.7%	7.0	20.8%	90.0%	1	0	2	Increased in dependency on the ward suppoted through additional CSW support during the day	102,318	98,525	3,793
MAIDSTONE	Mercer	100.8%	100.5%	100.0%	118.4%	7.3	126.7%	94.7%	9	0	3	3 falls above threshold Increased CSW fill rate at night due to enhanced care requirements on 14 nights.	101,048	98,083	2,965
MAIDSTONE	Edith Cavell	98.2%	104.8%	100.0%	156.2%	5.7	111.8%	94.7%	4	1	2	Increased fill rate at night due to enhanced care needs recorded across 14 days	71,882	81,320	(9,438)
MAIDSTONE	Urgent Medical Ambulatory Unit (UMAU)	96.9%	91.5%	124.7%	193.3%	9.6	8.3%	94.9%	4	0	7	Increased fill rate at night to staff night escalation on 29 nights.	131,489	130,426	1,063
TWH	Stroke/W22	83.8%	95.0%	98.7%	95.5%	9.6	50.0%	88.9%	11	1	7	4 falls above threshold Reduced RN fill rate due to lack of available temporary staff throughout the month	150,502	152,242	(1,740)
TWH	Coronary Care Unit (CCU)	93.7%	90.1%	94.7%	N/A	11.2	134.4%	100.0%	1	0	3	1 fall above threshold	67,825	62,078	5,747
TWH	Gynaecology/ Ward 33	94.4%	91.5%	89.6%	43.4%	11.1	0.7%	100.0%	0	0	3	EGAU commenced 24hr service and staff requirements changed. Reduced fill rate to new plan.	79,636	74,398	5,238
TWH	Intensive Treatment Unit (ITU)	101.0%	114.1%	107.9%	80.3%	27.2	0.0%	-	1	0	1	1 fall above threshold Increased fill rate due to unit escalation on 14 occasions in month	187,483	179,146	8,337
TWH	Medical Assessment Unit	84.8%	89.3%	98.1%	98.9%	8.0	41.7%	96.0%	9	0	9	3 falls above threshold Decreased fill rate due to lack of available temporary staff. AMU escalated throughout the month.	184,788	188,440	(3,652)
TWH	SAU	98.9%	97.8%	100.0%	93.3%	8.8			0	0	0		61,940	56,679	5,261
TWH	Ward 32	95.7%	104.6%	101.9%	118.1%	6.8	25.0%	100.0%	6	0	7		139,808	174,763	(34,955)
TWH	Ward 10	98.7%	89.6%	76.9%	188.3%	6.3	21.5%	100.0%	3	0	2	1 fall above threshold Skill mix adjustment a considered risk by the ward team in line with a high dependency and moderate acuity Reduced CSW fill rate during the day due to sickness and lack of available cover	120,565	119,985	580
TWH	Ward 11	92.9%	111.7%	96.8%	117.7%	6.3	26.2%	84.4%	3	0	5	Increased acuity over 3 days	126,638	132,074	(5,436)
TWH	Ward 12	94.0%	92.7%	62.6%	91.5%	6.2	1.1%	100.0%	4	1	11	Reduced RN fill rate due to staff sickness and lack of available temporary staff to cover	121,446	133,316	(11,870)
TWH	Ward 20	92.0%	112.7%	98.9%	146.8%	6.3	65.4%	94.1%	14	0	7	7 falls above threshold Increased fill rate due to enhanced care requirements	123,611	114,651	8,960
TWH	Ward 21	96.4%	94.9%	100.0%	106.5%	6.4	62.0%	90.3%	4	0	4	High dependency requirements throughout the month	134,850	127,056	7,794
TWH	Ward 2	90.7%	88.9%	105.3%	99.9%	7.0	67.3%	91.4%	11	0	5	4 falls above threshold AFU escalated on 16 occasions	131,973	126,733	5,240
TWH	Ward 30	94.7%	107.6%	103.9%	113.5%	6.3	75.0%	93.3%	4	0	13	Enhanced care requirement throughout the month. Amber QuESTT score escalated to Matron and DDNO.	122,715	125,650	(2,935)
TWH	Ward 31	100.2%	95.4%	100.8%	97.7%	6.8	21.1%	87.5%	10	1	3	4 falls above threshold	139,943	122,101	17,842
Crowborough	Birth Centre	75.4%	95.5%	95.5%	86.7%				0	0		Considered action to prioritise the night with Community teams support during the day	71,096	77,852	(6,756)
TWH	Maternity Services (incl Ante/Post Natal, Delivery Suite & Triage)	99.3%	90.4%	99.0%	-	10.4	22.3%	99.1%	0	0			690,933	692,808	(1,875)
TWH	Hedgehog	104.1%	52.0%	110.7%	-	11.9	9.5%	100.0%	1	0	6	1 fall above threshold Increased RN fill rate at night due to RMN required 1 night. Lack of available paediatric csw cover	182,315	213,283	(30,968)
MAIDSTONE	Birth Centre	101.2%	83.3%	95.4%	86.7%				0	0			62,876	60,552	2,324
TWH	Neonatal Unit	83.8%	76.4%	105.0%	-	13.0			0	0	2	Reduced fill rate due to short term sickness throughout month. Improved acuity / dependency during November rag rated 11 ambers and 17 reds in month (No black recorded).	178,696	174,662	4,034
MAIDSTONE	MSSU	122.9%	102.9%	108.7%	-		23.2%	94.3%	1	0	0	1 fall above threshold	41,893	49,338	(7,445)
MAIDSTONE	Peale	121.3%	187.7%	131.3%	112.9%	14.8	57.8%	97.3%	0	0	4	Increased fill rate in line with planned Winter escalation to move from Peale to Foster Clarke ward. High dependcy noted in month and bed base increase to 28 beds	76,274	90,123	(13,849)
TWH	SSSU	113.8%	120.4%	100.0%	186.7%	7.0			1	0	10	1 fall above threshold Increased fill rate due to unit escalation throughout the month.	128,087	96,240	31,847
MAIDSTONE	A&E	81.1%	107.7%	97.1%	99.9%		15.8%	92.1%	3	0		Reduced RN fill rate due to lack of available temporary staff through the month including 11 Agency bookings which DNA'd.	205,934	226,073	(20,139)
TWH	A&E	97.5%	87.7%	99.5%	85.5%		26.1%	90.4%	4	0		MH A+E supported redeployment of staff to support TWH site + AMU on 3 occasions	325,498	356,251	(30,753)
												Total Established Wards	**5,131,915**	**5,228,432**	**(96,517)**
												Additional Capacity be Cath Labs	36,509	38,805	-2,296
												Whatman	99,470	1,893	97,577
												Other associated nursing costs	2,730,534	2,719,506	11,028
												Total	7,998,428	7,988,636	9,792

RAG Key

Under fill

Over fill

Trust Board Meeting – December 2018

NHS Maidstone and Tunbridge Wells NHS Trust

12-9	Summary report from Finance and Performance Committee, 12/12/18	Committee Chair (Non-Exec. Director)

The Finance and Performance Committee held an extraordinary meeting on 12th December 2018, which focused primarily on financial matters (the Trust Board will recall that the Committee's meeting on 27/11/18 was primarily focused on non-finance related performance, most notably the 62-day Cancer and Referral to Treatment (RTT) waiting time targets).

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

- A detailed review and discussion was held on the financial forecast for 2018/19, including the current status of risks and mitigations. It was agreed that the Committee's recommendation to the Trust Board should be that the Trust was still aiming to achieve its plan, and should continue to press the organisation to deliver what it could. It was however emphasised that the opportunities to mitigate further were reducing, given the time left in the year.
- A detailed discussion on the emerging 2019/20 financial plan was then held, and it was noted that a fully-developed plan was not yet possible, as the Trust did not know its 2019/20 control total (so it had been assumed that the Trust would need to break-even). The other uncertainties were also highlighted, in relation to the Provider Sustainability Fund, Marginal Rate for Emergency Tariff, and the 3.6% national increase in NHS funding. The Committee was advised that the Trust's initial plan submission needed to be made by 14/01/19 which was before the Jan. 2019 Committee and Board meetings, and therefore the December 2018 meetings were the only opportunity to review the initial plan before this was submitted. However these meetings were too soon to be able to discuss a well-developed plan, so it was likely that the Committee and Board would be asked to delegate the authority to the Executive Team to finalise that submission. The draft plan then needed to be submitted on 12/02/19 with the final plan needing to be submitted on 04/04/19
- A report on the cash flow position was considered, which included the debtor/creditor position with other local NHS providers and the aged debt from the Kent and Medway Sustainability and Transformation Partnership (STP). The report prompted a discussion on the Trust's hosting of the STP, and it was agreed that the Trust Secretary would confirm the arrangements/schedule for the formal review of the Trust's hosting. It was also agreed that an updated cash position would be submitted to the Committee in January, but that this should include a proposed cash strategy rather just an updated cashflow forecast
- Cancer target recovery proposals were discussed, which noted the total additional cost of new initiatives was £1.44m. The Chief Executive emphasised that the funding, once agreed, needed to result in the delivery of the 62-day Cancer waiting time target of 85% by May 2019
- RTT target recovery proposals were also discussed, and the Committee supported one of the options put forward (which included continuing with Waiting List Initiative theatre and Outpatient sessions for all specialities from January to March 2019; not outsourcing any activity; recruiting additional booking clerks within Head & Neck until March 2019; recruiting additional validators until March 2019; having a Surgical Registrar based in the Emergency Department at Tun. Wells Hospital; and implementing "MyPreOp" pre-operative assessment tool (a cloud-based integrated IT system) (which would require 2 x Band 5 Nurses to double run the current service). It was therefore confirmed that Trauma & Orthopaedics outsourcing would not start until the funding for this had been agreed with commissioners. Support was however given to the Chief Operating Officer's proposal to outsource the circa 22% of activity was not included in the Aligned Incentives Contract (which included Ophthalmology)

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

- The Chief Finance Officer should ensure that the "cash receipts" value of items listed in future monthly cash flow forecasts matched the value allocated to the same items within the overall financial forecast

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

Trust Board Meeting – December 2018

NHS Maidstone and Tunbridge Wells NHS Trust

12-9	Summary report from Finance and Performance Committee, 18/12/18	Committee Chair (Non-Exec. Director)

The Finance and Performance Committee met on 18th December 2018.

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

- The actions from previous meetings were reviewed and it was agreed that a progress report on the work of the Theatre utilisation Best Flow programme; and a "Review of the Trust's hosting of the Kent and Medway Sustainability and Transformation Partnership" should be scheduled for the Committee in February 2019
- Under the "Safety Moment", it was reported that the theme was falls prevention and reduction
- The Director of Strategy, Planning and Partnerships attended to give an update on the Trust's planning submissions for 2019/20. A lengthy discussion was held and it was noted that 3 main areas of development were still needed, in relation to demand and capacity, triangulation, and several specialty-specific issues. It was agreed that the Trust's annual plan for 2019/20 reflects the agreements made at the Committee meeting
- The month 8 financial performance was reviewed in brief, on the basis that this had been covered in detail at the Committee's extraordinary meeting on 12/12/18. However, it was agreed that the Chief Finance Officer would produce a 1-page summary of the key initiatives and improvements that needed to deliver to achieve the 2018/19 financial target i.e. showing value, progress and key milestones/dates. An update was also given on the planned disposal of the Trust's properties at 32 High Street, Pembury & Springwood Rd, Maidstone, and it was agreed that the Chief Finance Officer would arrange for a 'critical path' to be developed (i.e. outlining the key steps being undertaken by the Finance/Estates & Facilities departments), to enable the Chief Executive to monitor progress during the Christmas/New Year period
- The financial aspects of the Best Care programme were reviewed in brief and clarification was requested of the Trust's intended start date for the use of Avastin medication in Ophthalmology in the event of the High Court Judgment of 21/09/18 being confirmed
- The month 8 non-finance related performance was discussed, which included the A&E 4-hour waiting time target, 62-day Cancer Referral to Treatment (RTT) waiting time targets.
- The usual update on the Lord Carter efficiency review (incl. SLR) was given
- The Committee reviewed the Business Case for the proposed establishment of a Hyper Acute Stroke Unit (HASU) / Acute Stroke Unit (ASU), and gave its support in principle. The Chief Operating Officer was however asked to clarify any caveats that the Trust Board should be recommended to consider as part of its decision in relation to the Business Case (which is scheduled under a separate agenda item at the Board meeting on 20/12/18)
- The Committee approved Business Cases for the implementation of RTT reporting from the Allscripts Patient Administration System (PAS); and for a replacement Radiology Information System (RIS). The Chief Finance Officer was however asked to clarify why GE Healthcare was not liable for any of the costs relating to the latter replacement, given the historic and on-going performance, functionality and usability issues with the current System
- A post-project review of approved Business Cases report was received
- A report on recent findings from relevant Internal Audit reviews was noted, as was the standing "breaches of the external cap on Agency staff pay rate" report

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

3. **The issues that need to be drawn to the attention of the Board are as follows:**

- The Committee supported the Business Case for the proposed establishment of a HASU / ASU in principle, but the Chief Operating Officer was asked to clarify any caveats that the Board should be recommended to consider as part of its decision in relation to the Case (which is scheduled under a separate agenda item at the Board meeting on 20/12/18)

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 – December 2018

NHS Maidstone and Tunbridge Wells NHS Trust

12-9	Summary report from the Patient Experience Committee, 03/12/18	Committee Chair (Non-Executive Director)

The Patient Experience Committee (PEC) met on 3rd December 2018.

The key matters considered at the meeting were as follows:

- An update on actions raised at previous meetings was given, as part of which, it was agreed to provide further clarity on the policy for provision of wheelchair assistance/support from the carpark to hospital building for patients attending Maidstone and Tunbridge Wells Hospitals
- The End of Life Care Clinical Nurse Specialist and Trust Chaplain attended the meeting and provided an update on the positive progress with the Swan initiative pilot on Pye Oliver Ward (MH) and Ward 10 (TWH) and on plans to institute an all faith annual memorial service for babies. It was agreed to circulate a copy of the updated "Individualised Care Plan for the Dying Patient" to PEC members
- The Lead Matron for Cancer, Haematology and Radiology presented the findings of the Cancer Patient Experience Survey 2017 and it was agreed to circulate to PEC members, once available, a copy of the Trust's Action Plan in response to the survey findings
- The Committee approved the "Development and Production of Written Patient Information Policy and Procedure"
- The 6-monthly Stroke performance report was considered, which included confirmation that both of the Trust's Stroke Units had achieved Sentinel Stroke National Audit Programme (SSNAP) B ratings. An update on the plans to develop a Hyper Acute Stroke unit on the Maidstone site was given
- It was confirmed that the Patient and their Medicines Working Group was to be relaunched with a focus on time critical medicines and self-management of medicines; the Group would include Trust staff and patient representatives
- An update was given on the work undertaken to address the Trust's challenged performance against its complaints response target and backlog, and it was noted that an initiative to review the methodology and process of complaints handling was being explored with the Trust's Project Management Office. It was agreed to ensure that the "Update on Complaints and PALS contacts" for the PEC meeting in March 2019 provided an update on this review and further breakdown of the numbers and themes of complaints by site
- An update was given on progress against the Quality Accounts priorities, 2018/19
- A report on the outcome of the latest Quality Assurance Rounds was received and the schedule of planned visits noted. The latest work of the Trust's Quality Improvement Committee in monitoring the CQC Tracker/Quality Improvement Plan in response to the CQC report (March 2018) was also highlighted
- The latest update from the Patient-Led Assessments of the Care Environment (PLACE) Action Group was reviewed and it was agreed that the report was not effective in providing the assurance required in its current format. It was therefore agreed that the Chief Nurse and Chair of the PEC should liaise to clarify the required content and format of future PLACE reports. It was also agreed to undertake further follow-up with departmental staff on feedback received about out of date disposable curtains in the Haemato-Oncology Day Unit at TWH
- The Committee heard the results of the most recent local patient surveys which indicated that overall patient satisfaction had remained consistent for the year, between 88 to 94% on the questions 'how would you rate the care you received at the hospital?'. It was agreed to schedule an item for the PEC meeting in March 2019 to consider and discuss how patient feedback might be more effectively sought; acted upon and response rates improved
- An activity report from Healthwatch Kent was noted and it was agreed that an update on progress made against Healthwatch's Accessible Services recommendations should be reported to the next PEC meeting
- The Patient Outcomes and Innovations Manager provided an update on the work of the Patient Information and Leaflets Group (PILG) and it was agreed that the PILG report to the PEC in March 2019 should provide assurance of the measures taken to ensure that incorrect/out of date patient information was being prioritised and addressed

- An update on planned service changes was received which included confirmation of the recent structural changes to develop a more clinically led organisation
- A report from the Quality Committee meetings on 07/08, 12/09, 15/10 and 14/11/18 was noted

In addition to the actions noted above, the Committee agreed:

- That an update on "Patient and Public Engagement and Experience activities" should be scheduled to be presented by the Chief Nurse/Programme Director at the PEC meeting in March 2019
- That the forward programme should be amended to reflect the decision to remove the standing "Reflections from a Junior Doctor / AHP" item from future PEC agendas
- That liaison with the Chief Finance Officer should occur to confirm i) if the VAT paid by the Trust in respect of parking facilities could be reclaimed and ii) the costs to the Trust of managing its car parking facilities/services

The issues that need to be drawn to the attention of the Board are as follows:

- N/A

Which Committees have reviewed the information prior to Board submission?

- N/A

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

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 – December 2018

NHS Maidstone and Tunbridge Wells NHS Trust

12-9	Summary report from Workforce Committee, 29/11/18	Committee Chair (Non-Exec. Director)

The Workforce Committee met on 29th November 2018.

- **The key matters considered at the meeting were as follows:**
  - The actions from previous meetings were reviewed,
  - The committee reviewed and agreed the risk register of the workforce committee and noted actions taken to mitigate the potential risk of a newly implemented clinically led organisational structure
  - The committee noted the presentation of the current workforce indicators and discussed in detail the sickness absence data in relation to line manager engagement and recording and the progress of the trust winter flu vaccination campaign. The committee noted the current support available to staff in respect of mental health and the further actions being taken to increase this support
  - The committee noted the Freedom to Speak Up guardian appointment and initial self-assessment. The committee noted the requirement for a FTSU strategy and agreed that it would review the self-assessment tool alongside a draft FTSU strategy at the January committee
  - The committee approved the Annual Report of the Guardian for Safer Working and noted that the pattern and volume of exception reports mirrored that of previous years. The committee also noted the issue of a small number of educational supervisors who were not promptly responding to exception reports and the risk that this lack of attention had a detrimental effect on the experience of trainees and would be reflected in the annual GMC survey. The committee was satisfied however that these had been raised with the Medical Director and that the Guardian for Safer Working was receiving appropriate support from the Medical Director to address these issues.
  - The committee considered a paper on Bank and agency usage and noted the actions taken to manage and oversee the use of both nursing and medical agency so as to ensure that spend was appropriate. In particular the committee noted the application of the new STP wide contract for nurse framework agency rates and the immediate impact that this had had on the number of breaches being reported to NHSi on a weekly basis.
  - The committee heard a presentation from the Best Workforce work stream that was supporting the implementation of apprenticeships and new roles. The presentation highlighted the 5 key roles being developed, Physician Associates, Medical Training Initiative Fellows, Advanced Clinical Practitioners, Nursing Associates and apprentice administrators. The opportunity to find creative ways to utilise these roles was part of the challenge to divisions in the formulation of their workforce plans for 2019/20. The committee also noted the ability of the trust to transfer some of its unused apprenticeship levy to other partners where a level of reciprocal return could be provided, opportunities for work with care homes and SECAmb were highlighted.

- **The issues that need to be drawn to the attention of the Board are as follows:**

Annual report of the Guardian for Safer Working (Appendix 1)

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

Reason for receipt at the Board (decision, discussion, information, assurance etc.)
Information and assurance

WORKFORCE COMMITTEE – November 2018

09/11/18	GUARDIAN FOR SAFE WORKING – ANNUAL REPORT 2017 - 2018	MATT MILNER, GUARDIAN FOR SAFE WORKING

Summary / Key points

Annual report from the Guardian for Safe Working for the period October 2017 – October 2018.

Points to be noted:

- The Terms & Conditions of service for doctors in training commenced in August 2016.
- All of the doctors in training are now on the new contract (total 321).
- A total of 233 exception reports have been raised during the year October 2017 – October 2018.
- In the past year fines to a value of 22 hours work have been imposed as a result of exception reports raised.
- A small proportion of Education Supervisors are slow to respond to exception reports raised in their area. The supervisors have been reminded of their responsibilities in light of the last GMC report.
- To reduce the number of exception reports next year, it would be prudent to employ extra physician's assistants in each directorate to cover periods of leave/sickness and off days and to cover vacant positions.

Which Committees have reviewed the information prior to Workforce Committee submission?
None

Reason for receipt at the Workforce Committee (decision, discussion, information, assurance etc.) [1]
- Information
- Assurance

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

Annual Report:

Introduction:

In August 2016 the new Terms & Conditions of Service (TCS) for doctors in training were introduced. In August 2017 all grades of doctors in training were working under the same TCS.

At Maidstone & Tunbridge Wells we have 321 doctors in training ranging from FY1 to SPR grades. At induction our doctors in training receive a presentation from the Guardian for Safe Working Hours regarding the TCS, the method and reasons to raise an exception report, the subsequent review process for exception reports and the possible outcomes that may result.

Report:

This report covers the period October 2017 – October 2018. During this period 230 exception reports were filed by doctors in training.

During this year the pattern of exception reports being filed has chiefly mirrored that of the previous year, in that there is an exponential rise in reports in the first six months of the period, with the number falling off significantly at the later stage of the year.

The majority of reports filed are by FY1/FY2 grade doctors and mainly relate to extra hours worked. Reasons given for this are excessive work load, staffing levels due to sickness/leave or vacancies or patients becoming more unwell late in a shift. Also cited is teaching and weekend handover responsibilities.

I am reassured to say that the trust has had only two exception reports related to poor supervision over the past year. These occurred in Urology there was not SHO support for FY1 due to leave/sickness and Consultant/Registrar being in theatre. The issue has been raised with the Clinical Lead for Urology.

A corresponding issue in Urology and Surgery occurs with a roster for 71.5 hours on call week. The maximum hours under the 2016 TCS is 72 hours for a trainee doctor. This issue occurred twice during the last year, resulting in fine of 22 hours to the directorate.

The exception reports for this were discussed with the General Manager and College Tutor for the department and as a result the rota'd hours for the week in question have been reduced to avoid a reoccurrence of this issue.

As Guardian my biggest disappointment this year has been the poor representation of trainee doctors as the Junior Doctors Forum. I appreciate that the meeting takes time out of trainee's day and there are other meetings trainees attend with similar issues.

To help rectify this problem contact is being made with doctors in training via the bleep and directorate social messaging groups to remind trainees of the meeting and also offering simple refreshments to encourage better attendance. It this is not successful I will ask trainees on what would be the most suitable way for me to support them in my role as Guardian for Safe Working.

The other main issue this period has been the response time to exception reports of a small proportion of Educational/Clinical Supervisors who are not replying within the agreed time frames under the contract.

I currently send two reminders by email to the staff involved and if a third reminder is required I escalate this to the Medical Director for further action. I hope for an improvement in the next year as it is generally the same supervisors I have to chase.

I would also like to propose, as Guardian for Safe Working, that it would be prudent, both economically and practically to employ several Physicians Assistants to support the doctors in training across all directorates, particular at times of low staffing due to lieu days, leave or sickness. The majority of exception reports are raised due to doctors in training taking on extra work load due to low staffing levels and often staying late to cover the work.

The costs incurred in paying doctors in training for exception reports raised would, in the long run be saved by employing physician's assistants. Rota co-ordinators could prospectively fill vacant trainee posts with "floating" physician's assistants when planning rotas. This in turn, should significantly reduce the number of exception reports raised and improve the working lives of our trainee doctors.

Trust Board meeting - December 2018

NHS Maidstone and Tunbridge Wells NHS Trust

12-10 Detailed review of the Best Care programme — 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, 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

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MTW Best Care

exceptional people, outstanding care

Trust Board

December 2018

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    a. Financial Summary

1a. Executive Summary

Workstreams Update	Workstreams Update
KEY PROGRESS Best Patient flow – Hospital@Home implemented on 3rd December, successfully transferring patients. Both Super-Stranded patients and DTOC metrics are performing above planned target. Prime Provider contract to be signed 2nd Jan, with new referrals from 4th Feb. Best Safety – GIRFT – New Internal panel held including GIRFT Clinical Ambassadors. ED GIRFT – both MTW and WKCCG contributing to plan to deliver against key initiatives identified. Positive regional event held on Stroke Services Best Workforce – Recruitment schedule in progress to map reduction in temporary workforce upon forecasted substantive appointments. Divisions continue to explore and roll out new roles to offset difficult to recruitment areas. Plans in place to reduce/remove Non Framework agency usage. Medical led authorisation group (MLAG) continues with a slight change following the implementation of Chief of Service. Preparation underway for NHSI workforce workshop scheduled for 15th Jan.	**KEY PROGRESS** Best Quality – Dementia system wide workshop held, involving 13 organisations that support the dementia pathway. Process mapped the pathway from 'Pre-diagnosis, Diagnosis, Crisis to End' for all 13 organisations. Next Steps – Meeting in January, to confirm mapping, identify any duplication/waste in the pathway , which will result in the 'System Wide Dementia Roadmap' involving patients and carers, to allow easier navigation of the system wide support and pathway. Number of births at Crowborough Birthing Unit has continued to over perform against target. Best Use of Resources - Avastin – Operational readiness plan agreed. Subject to legal advice on proposal, team are developing business case to support proposal for patients who fall under pre-NICE category. Phase 5 LED programme has commenced.
KEY RISKS Best Patient flow – Extending Frailty Unit to 7 day service, impacted due to resourcing issues. Best Safety – GIRFT – delay in completing Litigation actions, due to resource issues, agreed this will be completed in January. Dedicated PMO support required to support the increasing GIRFT programme. Best Workforce – Percentage of shifts requested retrospectively increased this month at 33.3% against a target of <5% for medical staff and 9.8% against a target of <5% for nursing staff. Medical staff action to be addressed by MLAG and nursing by Chief Nurse Management.	**KEY RISKS** Best Quality – Criteria Led Discharge leadership to be agreed as a matter of priority to accelerate progress. Best Use of Resources – Avastin legal complications continue to be an issue.

All Workstreams are undertaking a stocktake on current projects and identifying projects for 2019/2020 programme.

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	Dec 2018
WORKSTREAM LEAD	Steve Orpin	PMO SUPPORT	Caroline Tsatsakis & Toyin Falana

DESCRIPTION	MILESTONE ACTUAL (M7)	DELIVERY RAG		ACTIONS FOR NEXT REPORTING PERIOD (M8)
		LAST MONTH	THIS MONTH	
Estate & Facilities	• Identified some 2019/20 schemes which are still being scoped and includes: Car Parks expansion / sell off, removal of 6x Bus contract, Laundry income etc. further identification of schemes in development. • CVs for potential interim project manager to work with Director of E&FM on new opportunities and deliver recovery plan currently being reviewed, interviews being arranged. • Operational Variations agreed with PFI partner on energy procurement scheme at TWH. • Continued roll out of the CAFM across other directorate services • Commercial and legal documentation issued to EKHUFT for the Renal unit land rent. • Works have commenced on Phase 5 for LED schemes			• Start to develop detailed plans and other project documentation around new schemes • Complete formal Operational Variation agreements with PFI on energy procurement scheme • Complete Operational Variation agreements for TWH LED scheme with PFI partner
Procurement	Target £2m, YTD delivered £1.2m, planned to deliver £89K before the end of the year, at risk of not delivering £167K which will be rolled over 2019/20 if not delivered. • Catering provision delivered savings went up to £115k from £54K originally planned. • Delivered an extra £20K on landlines • Photocopier contract extended with a reduction of £150K savings ongoing, supplier have offered a payment holiday of 3 months which will bring in £319K savings from Jan - March 2019. • Theatre consumable contract savings part delivered - £34K delivered, and another £40k will be delivered in Feb 2019 depending on clinicians acceptance. • Block contract for telephone services £100K will deliver by Dec 2018			• International Nurse recruitment – reducing fees on bringing in foreign nurses £250K (still being scoped) • Maintenance of Endoscopes with potential of £250K savings • Deliver another £40K savings of the Theatre consumable contract by Feb 2019.
Medicine Management	Avastin • Task and finish group meeting weekly to develop operational readiness plan, group awaiting advise from the legal team on using Avastin on a specific cohort of ophthalmology patients that don't yet meet the NICE guidelines for treatment with Eyelea/Lucentis before commencing further implementation work.			• Map out 6 months schedule of injection schedule and develop a Business Case and benefit summary in regards to patients who fall under the Pre – NICE category and present to board in the new year, to set out a case for commissioning.
	• Identified some 2019/20 schemes which are still being scoped and includes: reducing wastage, IV Paracetamol reduction, Prescription charges in A&E and Day Cases. • Joint Formulary Resource Business Case - funding agreed from CCG • Weekly recovery meetings still in progress.			• Start to develop detailed plans and other project documentation around new schemes • Finalise Joint Formulary Business Case .

DESCRIPTION	MILESTONE ACTUAL	DELIVERY RAG		ACTIONS FOR NEXT REPORTING PERIOD
		This Month	Last Month	
Medicines Management.	• Adalimumab – switch implemented on the 26th Nov, all new patients will be put straight unto the new biosimilar. All existing patients will be switched from Jan 2019. Uptake report due in the new year. • Dossette Box – WKCCG pharmaoutcomes multi-user licence agreed. papers presented to EAIC group on 08/11/18. Board recommended extension of pilot to 6months. KCC agreed to fund 2 months pilot • Subcutaneous Methotraxate – proposal paper will be presented to the MOG on the 13th Dec with a view to get their preferred choice and for this to be shared with the EAIC Board in the new year. • Outsourcing – meeting needs to be rescheduled due to cancellation of the last one. Financial baseline model and business case will be ready for discussions at the meeting.			• Dossette Boxes / MAR Chart – CCG have extended phamaoutcome license, however there has been a barrier with funding an extra £900 that would be required to start the pilot. Discussions with KCC to take place, also schedule pilot and workshop. • Adalimumab – quantify savings. Send patient letters to inform existing patients of the switch on their next prescription from 01/19. • Aseptic Service – develop proposal paper for submission to NHSE (deadline moved to end of Nov) • Ethernacept – quantify savings (deadline moved to the end of Nov.) • Outsourcing - reschedule steering group meeting, decision on preferred option • Paed Feed – Primary Care and MTW dieticians to agree pathway, meeting scheduled for mid Nov.
AIC Diagnostics	**Pathology** **AIC** •LFT – guidance has now successfully added unto ICE •Faecal Calprotectin – actions completed and comms sent out. •Direct Access Requests - 18/19 data for FBC received. Pathology are aware of increase and do not believe there is scope to reduce this. •Immunology – Guidance with J.Sheldon for advice and guidance. Outlined business case completed and with clinical lead for sign off **STP** •Strategic Outline Case completed •Send Away Test – not going ahead with deal, repatriate work on STP. East Kent have agreed to charge marginal price, and savings will be got from the difference of the current price. Savings will be shared equally amongst the 4 Trusts.			**Pathology** **AIC** •Sodium – Update guidance and add unto ICE. CL chased and made aware actions are still required. •Immunology - J.Sheldon to provide advice and guidance Clinical lead chased this action. Once update received add to ICE. Outline Business Case for Thyroid Receptor Antibodies to be approved by Clinical Lead •FIT Testing – clinical lead still progressing with clinical staff and will escalate if further support is required. **STP** •Present SOC for approval at Medway Board in Dec 2019 and at MTW & East Kent respective Boards in Jan 2019. •Start to realise savings for Sendaway tests from Dec 2018.
	Radiology •I-refer up and running. DORIS form has been reviewed, WKCCG to ensure i-refer is referenced. •Ultrasound – Subcontract to Diagnosis world confirmed. CCG have been in contact with top 10 users •Electronic Results –plan in place to resolve ongoing issues , go live planned for 1st week in December. •Obstetric Scanning – Go live delayed till January due to issues with GDPR. •Internal demand – commenced meeting with ENT surgeons to discuss reduction in MRI requests.			**Radiology** •Internal demand - •NG12 – continue to monitor demand •Direct Access Requests – review impact •WKCCG to review DORIS forms to include message regarding Virtual Colonoscopies by end of Dec 2018. MTW to provide audit of Virtual colonoscopies with WKCCG by end of Dec 2018

Non Recurrent Savings / Financial Mitigation Schemes				
Contingency Reserve	£3.4m of reserve already in use YTD, in line with forecast			Hold money until the need arises for use. (£2.3m left)
Assets Sales	• High Street – Trust Board agreed to proceed with sale pending PWC advice on accounts. • Due diligence works have commenced on bidders with highest offers. • Draft Heads of Terms with Lawyers			Finance to confirm outcome from work by PWC, in order to proceed to full commercial and legal negotiation with preferred bidders.
West Kent CCG Income	Confirmation of a £2.7m savings from the CCG. £1m expected			Discuss accessing funds and utilising if required to meet financial plan.

KEY ISSUES/RISKS TO FINANCIAL PERFORMANCE

DESCRIPTION	MITIGATION	DATE last reviewed	LAST MONTH	THIS MONTH
Procurement - Slippage on STP work plan - issues with confirming projects start date and leads Difficulties with analysing data due to different systems amongst the Trusts.	Discuss issue at group meetings . Supply chain has agreed do all the analytical work and supply data.	12/18		
Avastin - 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.	12/18		

CRITICAL PATH MILESTONES (next 4 weeks)

Task	Milestone Date	Status	RAG Last Month	RAG This month
Avastin - Develop Business Case & Benefit summary for Pre-Nice Patients	12/18		New	
Quantify savings for Adalimumab	12/18	On Track		
Finalise Joint Formulary Business Case	12/18	Delayed		
Agree preferred option for pharmacy outsourcing	12/18	Delayed		
Quantify Ethernacept savings	12/18	Delayed		

KPIS	Target	LAST MONTH	THIS MONTH
Procurement			
Number of tenders completed each month	13	13	20
National metrics - % of spend under a catalogue	80	96.8	96
% of spend under a purchase order	80	75.5	75
E&F			
Energy Volume Reduced		867500	846128

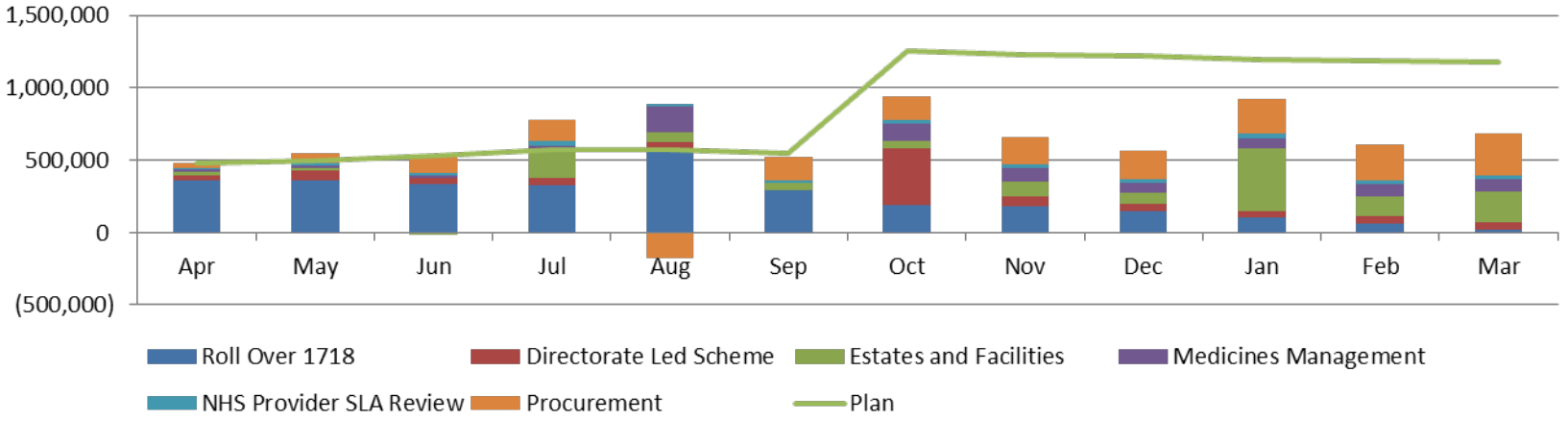
Finance Narrative

Month 8 Delivery

Month 8 total delivery is £600K against a plan of £1.2m.Main areas of delivery include E&F - £78K, Med mgt - £65K, Procurement £184K, roll over - £146K,

Area of shortfall includes - Meds Management with a gap of £1.2m which includes £700K for Avastin and £500K stretch target. E&F with a gap of gap is £1m,

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Roll Over 1718	362,105	357,275	337,632	324,483	573,617	290,388	191,061	179,624	146,787	101,328	64,958	18,738
Directorate Led Scheme	31,970	66,778	36,408	50,128	54,009	5,326	388,897	71,113	48,672	47,072	47,072	47,964
Estates and Facilities	23,083	23,083	-11,417	183,393	62,628	49,310	55,109	103,628	78,629	431,528	141,070	214,071
Medicines Management	17,633	17,264	17,553	44,246	182,380	-2,221	112,728	90,374	64,934	73,653	82,360	91,078
NHS Provider SLA Review	13,833	15,250	15,250	27,645	14,479	14,479	25,645	25,645	25,645	25,645	25,645	25,645
Procurement	26,222	70,291	131,120	144,131	-172,752	162,500	165,041	138,874	184,733	377,900	396,900	436,943
Plan	478,343	499,430	528,168	574,543	575,478	550,883	1,251,693	1,226,511	1,216,516	1,195,557	1,184,127	1,178,088



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:

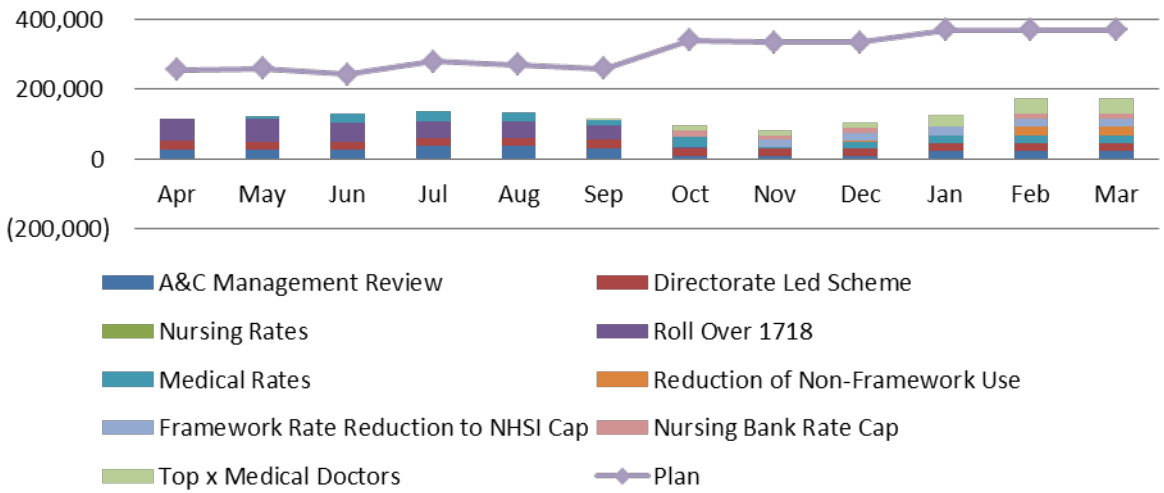
- **Recruitment**
- **Temporary Staffing**
- **New Roles and Apprenticeships**
- **Workforce Productivity**

WORKSTREAM	Best Workforce	BEST CARE BOARD DATE	December 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	• IR35 Re-assessment for Radiology Reporting Locum completed. Outcome confirmed how locum is currently engaged falls inside IR35. • Proposed set of medical bank rates submitted to HRD and Medical Lead for review and comment. • Strong focus on medical recruitment streamlining / improvement continues . • Ongoing work in progress to streamline non-framework nurses to bank and facilitate the exit of Ambition. • Non-standard offer template(s) now in place.			• Paul Sigston to confirm exit strategy for Radiology Reporting Locum. • Medical Led Authorisation Group meetings to be scheduled and in calendars to take place weekly. • NHSi workshop scheduled for 15-Jan-18, and pre-preparatory work to be completed in advance. • Execs briefed on NHSi workshop. • CoSs to be briefed on temporary staffing controls, rules, policy and governance requirements. • CoSs to identify areas requiring medical bank rate enhancements . • Medical bank rates proposal to be sent to Execs for approval.
New Roles and Apprentice-ships	• As at 3 Dec, 80 apprenticeships enrolled on programme. • 3 Physician Associates now working in T&O with 5 more due to start in other areas this financial year. This is an increase from 1 to 8. • 15 Trainee Nursing Associates started apprenticeships on 03/12/2018. • First Medical Workforce Working Group met that will focus on trust-wide implementation of Physician Associates, Medical Training Initiative Fellowships and Dr Assistants. • Working Groups for Advance Clinical Practitioner met and agreed priorities on 03/12/2018. • Trust management considering proposal submitted for levy transfer.			• Working Groups to complete plans. 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. 2 PA Students on placements in the Trust – previously in Medicine returning next week to commence placement in Emergency Medicine. • Timeline for MTI fellow placement to be determined for Paeds and Obs/Gynae • Determine KPI for spread across MTW of new roles and apprenticeships.
Directorate CIPs	• Delivery of directed CIP schemes currently reporting £656K at risk of delivery. • PMO leads working with directorate GMs and FMs to review plans to deliver CIPs and identify new ones.			• Further CIPs to be identified as part of directorate CIP recovery plans.
E-Rostering	• Phase II rollout not completed. Further work required to ensure governance requirements are in place prior to agreeing completion of Phase II delivery date. • Review and evaluation of payroll processing from Allocate completed. • Allocate system upgrade applied on 3rd December 2018. • Meeting took place with Chief Nurse and ADNS's to agree full review of all nursing roster templates . • All nursing full / partial approvers emailed to communicate requirement to review time balances and ensure reconciliation against hours / shifts worked before end of financial year. • Reviewing roster performance calculations and working to ensure this information is meaningful and accurate to meet future reporting requirements.			• Allocate's Nurse Rostering Baseline Assessment to be presented to key stakeholders by end December 2018. • Trustwide communication of approval and finalisation processes to be sent from HRD and CoF to facilitate timely and accurate payroll processing. • Additional wording to be incorporated when finalising shifts to reiterate SFI / audit / governance requirements. • Commencement of work to update roster templates to meet budgeted establishment. • Retrospective payroll process implemented further to system upgrade and controls are now in place to enable managers to reconcile hours balances. • Engage with key stakeholders to review and establish rostering KPIs.
Recruitment	• Further meeting with Clearmedi scheduled for 22-Jan-19. • Meetings held with external recruitment agency to fill medical vacancies. References taken up. Single point of contact within medical recruitment team identified to facilitate a timely and consistent approach. Proceed week commencing 10-Dec-18. • Medical Recruitment KPIs shared produced monthly. Fortnightly progress meetings taking place.			• Medical Recruitment Workshop scheduled for 17-Jan-19. • HRBPs to determine vacancies as part of 19/20 workforce planning and ensure all medical locum usage is against budgeted establishment. • Workshop with Medical Recruitment an Operational Staff set up for 14th January to resolve issues and improve recruitment pathway • Update recruitment roles and responsibilities

KEY ISSUES/RISKS TO FINANCIAL PERFORMANCE

DESCRIPTION	MITIGATION	DATE REC	LAST MONTH	THIS MONTH
ISSUE – Project is forecasting a £2.2m shortfall. This is mainly due to underperformance of the STP medical CIP target. Savings for Jan 19 also at risk as dependent on Top X locums having moved to substantive, which has not happened.	The key enabler to addressing reliance on temporary staffing is to fill medical vacancies. External agency engaged and activity to improve medical recruitment continues, Workshop scheduled 17/01/19.	May-18		
ISSUE - Agencies are not providing quality CVs at a reduced rate.	Starting to see an increase in CVs although still at high rates. Head of Temporary Staffing challenging rates. Medical Led Authorisation Group to undertake agency challenge.	Aug-18		
ISSUE – Transparent and robust information not available on medical vacancies / gaps due to multiple rostering systems and approaches.	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.	Two levels of rates for each grade proposed one being standard and the other enhanced. Briefing sessions to be scheduled with CoSs to identify areas that require enhancements.	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%	0.94%	1.24%	↑
Medical				
Medical Shifts Requested		2,580	2,408	↓
Percentage of Medical agency shifts over STP break glass rates	0%	94.5%	76.0%	↓
Percentage of Medical shifts requested more than 6 weeks in advance	> 80%	16.7%	32.5%	↑
Percentage of Medical shifts requested Retrospectively	< 5%	24.4%	33.3%	↑
% Medical Shifts covered by bank workers	> 70%	39.2%	44.5%	↑
% Medical Shifts covered by Framework agency workers	< 24%	32.6%	35.7%	↑
% Medical Shifts covered by Non-Framework agency workers	< 1%	0.7%	0.9%	↑
% Medical Shifts Unfilled	< 5%	27.5%	18.9%	↓
Nursing				
Nursing Shifts Requested		5,245	5,041	↓
Percentage of Nursing agency shifts over NHSI Caps	0%	42.6%	9.7%	↓
Percentage of Nursing shifts requested over 6 weeks in advance	> 80%	19.0%	25.8%	↑
Percentage of Nursing shifts requested Retrospectively	< 5%	8.7%	9.8%	↑
% Nursing Shifts covered by bank workers	> 70%	48.9%	51.5%	↑
% Nursing Shifts covered by Framework agency workers	< 24%	39.2%	33.9%	↓
% Nursing Shifts covered by Non-Framework agency workers	< 1%	4.2%	4.1%	↓
% Nursing Shifts Unfilled	< 5%	11.8%	10.5%	↓
Average roster performance score for ALL nursing areas	> 85%	70.96%	N/A	

FINANCE NARRATIVE

Year to Date

The Best Workforce achievement to date is £927k against a plan of £2.2m. The shortfall of £1.3m is largely within the STP Medical rate CIP underachievement (£1.1m).

The key achieving CIP in Months 1 – 8 are the 2017/18 Roll Over schemes reporting 34% of the workstream.

Forecast Position

The Best Workforce schemes are forecasting a year end achievement of £1.5m against the target of £3.7m and therefore forecasting a year end shortfall of £2.2m.

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 (elective and non elective)	BEST CARE BOARD DATE	Dec 2018
WORKSTREAM LEAD	Sean Briggs	PMO SUPPORT	Fiona Redman / Sarah Smith/ Caroline Tsatsaklas

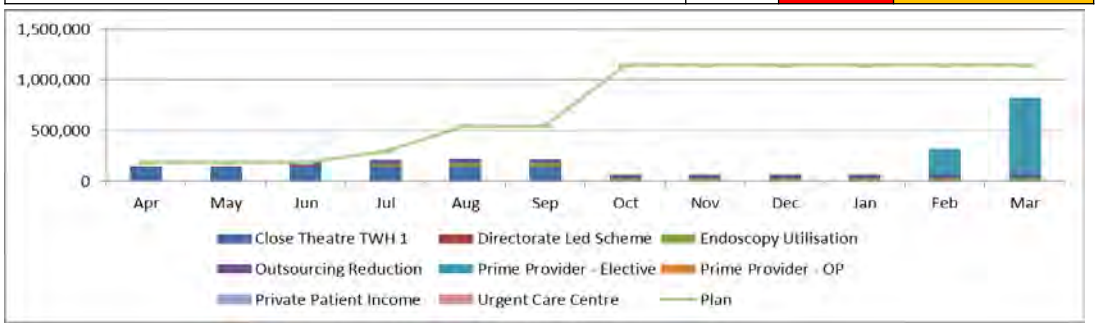
DESCRIPTION	ACTIONS / MILESTONES COMPLETED	DELIVERY RAG		ACTIONS FOR NEXT REPORTING PERIOD
		LAST MONTH	THIS MONTH	
Frailty at TWH and AIC Frailty	Patient flow journey audit completed and to be distributed to frailty working group. Meetings have taken place between MTW, heart of Kent hospice, CCG and KCHFT in order to develop a single EOL care document. Decision reached by frailty team and community that frailty patients having 3+ admissions within 6/12 to be referred to community MDM going forwards. Posters promoting MDM referral to be put up within AFUs and guidelines distributed by 30/11/18. SECamb direct conveyancing more complicated than originally thought due to SECamb working across 3 counties rather than localities. Implementation to continue but robust 7 day services need to be developed and embedded before roll out. 7 day service launched 3/12 on TAFU but difficulty recruiting sufficient consultants to staff at weekends. Meeting 11/12 to discuss possibility of extended hours week day/6 day service to utilise additional staff recruited. Decision required as to if funding will be pulled and if frailty unit to be removed/moved down escalation policy. Frailty unit coding issue resolved- further work required with MAFU ward clerks to fully embed.		*	*Decision regarding 7 day service funding If funding to continue, extended service to be delivered as staffing allows. Decision regarding frailty unit escalation Matching decision regarding Darzi fellow to support Interface Geriatrics model for AIC frailty MAFU coding solution to be fully embedded on MAFU to reflect throughput through unit CPMS decision as to pas team taking over system management, plan going forwards for training and log in creation. Re launch of CPMS service development group with MTW frailty membership to compile 'wish list' for system. Upgrade of CPMS to go to panel for funding approval for body map and free text capability for CGA.
Out of Hospital Capacity	Meeting with CHC and Rapid Response revealed lack of increased capacity but will continue to bridge fast track patients to support flow. Ongoing monitoring work with hospices to hold beds over winter period. Super stranded patient target has been achieved for this reporting period. Hospital at home Staffing in place. First patient successfully transferred to 'Healthcare at Home' 28/11. Launch 3/12 with initial capacity for 5 patients. 4 patients taken out. Drop in sessions around trust to answer questions, promote and troubleshoot plus clinical governance. Continuing to work at identifying appropriate patients. Meeting in place 12/12 between KCHFT, IDT, MTW to review current LOS data and existing pathways for #NOF patients. Aim to release Edith Cavel capacity with the use of KCHFT community beds to support patient rehab using an enhanced recovery pathway. Discharge lounge delay project started at both sites to improve capacity and improve patient flow			Hilton capacity-full roll out from current capacity of 48 Super stranded - In-depth review work to continue to maintain target and reduce as able along with daily medically fit for discharge numbers. Hospital at Home continued clinical engagement, increased identification of patients and service capacity ramp up. Ward 20 Proactive recording of 10-15 patients recording key points along the timeline from referral to discharge. Key timed points: Date referral started to Pathway 3, Date referral sent, Date additional info asked for, Date patient discharge #NOF meeting between KCHFT, IDT, MTW to review current LOS data and existing pathways and begin scoping how alternative model will look and work operationally Discharge lounge ward manager to collect capacity and delay data. Review 17/12 and write change plan
LoS Increased number of 0 LOS	47.04% of beds currently occupied by patients with LOS >7 days. This represents a 1.3% reduction on this time last month. Previous 6 week average 46.28% from 47.74% representing a further 1.5% reduction. CUR compliance has seen a gradual and planned improvement over the last quarter due to a phased approach of communications, training and coaching or ward staff. The plan is to continue to review this and maintain the 85% standard throughout winter. Criteria led discharge Task and Finish group established building on the work from the national CLD event attended by LOS leads.			Access to Smarties for all Matrons/ GMs/ AGMs. Switch on end of w/c 10/12/18 Flow co-ordinator training needs to be repeated on rolling basis. To be undertaken by CUR Implementation Manager throughout December. Acute Physician Dr Jitesh Choyi leading criteria led discharge work from a medical perspective and working on a push throughout December on wards 2, AMU and 21 to seek to maximise this opportunity. New initiative for December will focus on day before actions with the end ambition being to prevent 2 consecutive red days going forward. This will be a phased approach bringing down the longest consecutive red days moving down towards 2. SMARTIES go live with CUR day to monitor and review internal delays in diagnostic fields, referral to specialties and CNSs.
Therapies	Therapies Directorate to cross to new Division but to continue to deliver against Best Flow. Meeting with therapy leads to explore transformation initiatives and development of new roles within ward workforce has taken place. 19/20 plans to be created			Identify plan for next 3 – 6 months 19/20 plans to be created Continue to embed TDI and development of performance reports
AEC	7 day Business case approved 27.11.18 for TWH with aim to implement unit by 1.12.18.. Risk around recruitment of appropriately skilled staff to support increased hours (lack of medical agency for w/e, can use bank medical but they are also being used for Frailty/ outlier/ winter oncall. Nursing in place & EDP) Fortnightly meetings in place for planned ambulatory at TCH. QIA prepared for approval within MTW. Agreed that patients will be discharged from MTW. IT solutions from H@H to be used i.e. EDN to communicate management care plan. Lack of data to provide demand as this is a new pathway, which is holding up the developing of staffing ratios. AEC moved to opposite side of ward to increase accessibility. AEC throughput highlighted at site meetings. Ongoing training of ED staff to ensure appropriate triage. Exclusion criteria in place for Medicine. Draft criteria in place for Surgery, to be signed off by CD by end Dec and presented at Clinical Governance Jan 19. Need increased engagement with T&O & ENT clinicians to replicate.			Appointment of CD for Acute and Emergency to improve profile and clear clinical leadership on 7.12.18 Improve flow from ED to AEC through more robust and electronic handover method Review staffing within AEC with AMU ward manager Work with T&O and ENT to develop their exclusion criteria Permanent signage to be put up by Estates to ensure greater access Work with Radiology GM to give AEC same turnaround times as ED; data collection to be undertaken and to escalate to CDs Identify a strategy for Emergency Floor pathways at TW

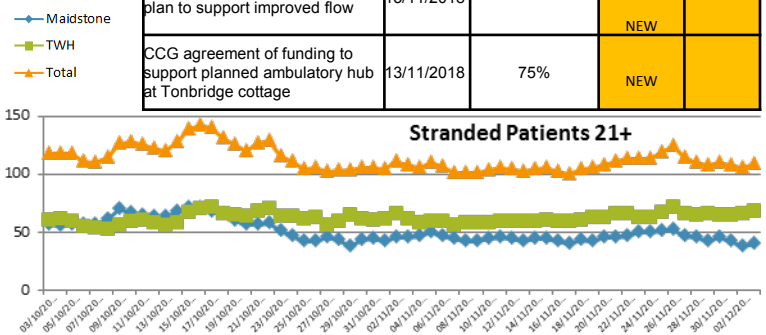
DESCRIPTION	ACTIONS / MILESTONES COMPLETED	RAG LAST MONTH	RAG THIS MONTH	ACTIONS FOR NEXT REPORTING PERIOD
Non-Elective Surgical LOS	- Golden Patient for MRCP pathway finalised and approved. - Hot Chole pathway: Job planning complete. Surgical coordinator and emergency surgery secretary taking ownership to ensure lists populated - Hospital at Home underway- excellent engagement from clinicians- especially breast. Pathways for breast & urology .			- Full roll out of MRCP pathway for golden patient. - Further embedment of the red: green days by site team. - Further work on the breast patients – could increase numbers, plus other patient types to be identified on an individual basis.
Increase in private activity	- Housden support staff member working 1 day per week to help with the initiation of the PPU including SOPs/ invoices etc. - Business manager from the Housden group to start 10.12.18 - Commencement of the estates process for a kitchenette to be installed - Matron and 1 band 6 nurse appointed. Starting 24th Jan. Advert for other band 6 out and closing 14th Dec. - Medical devices ordered and supplied - Band 5 team leader and band 3 booking officer appointed and start date tba - 2 x CSWs appointed and start dates tba			- Procurement to be finalised for some small furniture pieces, artwork etc.. - Interview other band 6 staff nurse. - Confirm start dates for admin staff and CSWs. - Start to prepare for 4th Feb opening i.e. comms / open day - Sign off contract with Basildon and Thurrock.
Prime Provider	- Held first Joint Exec Working group - Formulation of a joint operations T&FG and finance &contracting T&FG - Planned Care Coordination Team set up finalisation, 1 x typist out to advert. - Timeline drafted. Proposed for PP Contract to be signed 2.1.19 with new referrals from 4.2.19 - Table top exercises completed for operational policy. - Invoice process finalised - VEAT notice given - Operational theatre winter scheduling completed to optimise elective activity.			- Complete timeline for programme. - Finalise quattro system for electronic patient tracking. - Submit operational policy to divisional board and PRC for approval - Develop a comms strategy for internal and whole system for IS / GPs/ MTW - Complete contract variation for prime provider - Complete contracts with IS for prime provider outsourcing - Undertake whole system process mapping exercise to identify any potential gaps in the proposed system - Finalise governance and quality process
Operational Productivity	- Review POA patients to go through Outpatients in POA. - Training to be identified for Outpatient nurses for POA. - POA and Outpatients working to implement POA in Outpatients in January 2019 . - MRSA screen on the day continues in second month. - Deep dive into consultant level procedure times-Critical Care CD undertaking with DL supporting - Winter Plan removing ophthalmology from SSU-this is completed and will be starting Dec 24th. - Theatre list review- this is ongoing and will need to be discussed in theatre CG to cement. - Late escalation SOP written and ready for sign off. - Stoking Up process has been implemented, using theatre stock personnel to stock theatres at the request of theatre staff. - Ophthalmology Golden Patient requirement to be implemented	Th	Th	- Theatre list review of process and KPI's on review 7th Jan. - Outpatient nurses to be trained in POA processes. - QIA to be presented – Jan 2019. - Mr Katchburian and Ayodele have theatre editing rights as a pilot to improve theatre list structure ordering and content. - Ophthalmology T&F group to be started Jan 2019.
Outpatient Trans-formation	- OPT - Benefit summary and next steps presented to EAIC Group submission 6.12.18 - E-Referral – 3.12.18 agreed to move project to business as usual under ERS Project Group. - Managers commenced scoping exercises underway for new schemes for next year business planning - Developing BC for expansion of validation for specialist medicine to reduce waiting lists. - Cardiology sprint expansion of GPwSI paper drafted by CCG for review with at CCG SET meeting 18.12.18. - Charcot pathway expansion agreed target date of mid-January. - Ophthalmology continues to validate and arrange appointments patients from waiting list audit. - W&C Physician Associate recruitment process underway anticipated start date 03.19 - W&C Myosure business case draft being developed with benchmarking against Croydon to define numbers - VFC IT Solution confirmed as Sunrise. The project roll out for this is underway with the Health Informatics Team and the anticipated date will be 09/19. - Clinical Fellow business case still requires development. Looking at additional funding from Deanery to support. Draft job plan. - Quattro blocked report, working with Information to resolve issues around blocked clinics. - Continue to investigate the quality issues around Focal and Soap reports. - Under utilised clinic review continues with clinics being identified correctly, making plans for resolution. - A SPRINT in ophthalmology with support from PMO - Review of CAU Recruitment, requested new data from finance, ESR data is not correct.			Week commencing 10.12.18 review scoping and next steps for outpatient transformation. To report to AIC Execs by 14.1.19 Prepare papers for E-referral to move to BAU. Next steps to be agreed on following scoping exercise. To report to AIC Execs by 14.1.19 Cardiology Submit business case for approval by 01.19 Cardiology discussion between MTW/WKCGG/Federation to review a target date for implementation and agree next steps by 02.19 Next step formal contract agreement to be drafted with MTW and KCHFT Continue validation of waiting list 01.19 Develop job plan for PA quarter 1 training 2019/2020. Prepare final draft of BC for CAU resourcing 01.19 Awaiting Urology AGM to return from leave to make decision about what they want to do with CNS clinic AB to share clinic usage info with T&O & Women's Meeting with Dan to discuss theatres and outpatient productivity.

KEY ISSUES/RISKS TO FINANCIAL PERFORMANCE: DESCRIPTION	MITIGATION	DATE REC	LAST MONTH	THIS MONTH
Due to lack of confirmation of Prime Provider, it is likely that this route will not deliver the savings.	Formulation and commencement of a joint exec working group.	9/3/18		
There is a risk that teams cannot recruit to posts due to national recruitment shortages and lead time.	Working with Best Workforce to develop smarter recruitment campaigns	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 have all commence. Governed by operational prod group.	08/10/18		
Private patient service staff recruitment process causing delays In the opportunity and therefore impacting on overall financial contribution.	Housden business manager now in post full time. All but one post have been appointed.. Starting dates in January.	16/10/18		
Clinical admin teams have some vacancies or training needs causing ineffective booking of inpatients/ day cases. This can affect operational productivity.	Repeated RTT training underway. Vacancies are being appointed to. Outpatient and CAU transformation managers commenced work in order to help processes to improve efficiencies.	16/10/18		
Internal standards for turnaround time for Diagnostics is different in ED to AEC which is stopping direct admission to AEC.	Working with Radiology to remedy.	6/11/18	NEW	
The financial plan is based upon assumptions that LOS will maintain its level and that AEC/frailty will be funded for 7 days.	A decision of what staff is going to be substantially funded for the frailty/ AEC 7 day service. Approval for funding for 7 day services at TWH for frailty / AEC			
Theatre transformation manager resource currently assisting the operational teams du e to staffing pressures.; potentially impacting transformational work.	Theatre transformation manager now working full time on transformation.	09/11/18		
Completion of EDNS not completed as a day before action-impacting on LOS	Escalated to CD Laurence Maiden-for review of process		NEW	
The continued use of AFUs as escalation areas will impact on unit performance and flow	Monitor site performance and compare MH 5 day service to TWH 7 day service		NEW	

Critical Path Milestones	Milestone Date	Status	RAG Last month	RAG This month
Fit for purpose coding and data collection in place for MAFU	11/18	75%		
Fit for purpose coding and data collection in place for TAFU	11/18			
Appoint staff and implement 8 – 8/ 7 days a week AEC unit at TW	01/12/2018	75%	NEW	
Rollout of Red and Green days within CUR	31/08/18			
Recruit to posts to support increased opening hours of TW AFU	13/11/18	60%	NEW	
Hospital at Home (virtual ward) Go Live 1/12 with agreed bed base	13/11/18			
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 29.09.18: 94% all specialities. T&O 100%		
Receive income from Prime Provider (primarily from outsourcing) in August 2018	01/08/2018	0		
Creation of Therapies 3-6 month plan to support improved flow	13/11/2018		NEW	
CCG agreement of funding to support planned ambulatory hub at Tonbridge cottage	13/11/2018	75%	NEW	

KPIS	Target	LAST MONTH	THIS MONTH
NE LOS Medical	7.4	7.7	7.6
NE LOS Surgery	5.5	5.2	5.2
NE LOS T&O	10.3	11.5	10.4
Achieve or exceed DTOC target (%) ***Estimate only as actual figure not yet available.**	3.5%	4.5%*	3.5%
Super-Stranded Patients : All Patients In a Bed & Having LoS >21 days	113.1	118.2	107.3
Theatre Utilisation for Prime Provider (%) Step up KPI to 100 opportunity (95%) utilisation	95	82 T&O = 89	94 T&O= 100
Outpatients DNA Target (new)	5%	Sept 5.7%	Oct 5.6%
Cancellations on the Day (theatres) 2 way SMS to be rolled out End Nov 18	5%	9.1%	7.7%





FINANCE NARRATIVE

At month 8 the savings target of £8.8m is forecast to be £6.2m adverse at the end of the year (70%). This is driven by prime provider slippage of £4.5m (£1.2m outpatients and £3.3m elective), £1m of the overall £5.5m is forecast to achieve after the CCG received the go ahead from NHSI/E to award the contract, although a go live date from the CCG is anticipated to be 3rd February, which does not leave a lot of time to realise any potential/forecast savings. Other schemes that make up the remaining £1.7m slippage are £1m private patient income, £0.4m urgent care centre, £0.2m endoscopy utilisation and £0.1m outsourcing reduction.

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	December 18
WORKSTREAM LEAD	Gemma Craig	PMO SUPPORT	Vince Rouse / Hannah Pearson

PROJECT	MILESTONE ACTUAL	DELIVERY RAG		FORWARD VIEW: KEY MILESTONES TO TAKE PLACE IN THE NEXT 4 WEEKS
		LAST MONTH	THIS MONTH	
Overarching	• Joint Best Safety and Best Quality Meeting to discuss key projects and issues which overlap both workstreams. • Addition of Patients' own drugs (time critical medicines) to be captured within this workstream following on from BS / BQ joint meeting			
Complex Needs	**Dementia** • AIC Show and Tell Event took place on 12 December beginning process of dementia pathway mapping • 2nd Emergency Services round table meeting 4/12/18. • Still awaiting information re executive lead.	A	A	**Dementia** Development of dementia pathway following Show and Tell Event Formalisation of governance arrangements between SIG, AIC collaborative and Best Quality Programme to be discussed and agreed. Continuing development of provider relationships across West Kent
	• **Transition** • Minor delay in recruiting to Transition Coordinator post -Post needing to be grade evaluated before recruitment. • Transition Coordinator post to be advertised and shortlisted • Level 3 Safeguarding Training continues to be delivered • Policy for care of 16&17 year olds on adults wards being drafted • Ramping up of awareness raising and relationship development with adult wards • November Meeting to focus on Diabetes and the Best Practice Tariff which could generate some income • Relaunch in January meeting – with Corporate Nursing representation to gain Adult nursing engagement	A	A	**Transition** • Banding of post to be confirmed by HR and progression to advert • January Project Team to focus business case for retaining 16 & 17 year olds in paed diabetes tariff • Level 3 Safeguarding Training continues to be delivered • Policy for care of 16&17 year olds on adults wards continues being drafted • Ramping up of awareness raising and relationship development with adult wards
Experience and Engagement	• **PPEE** • Second engagement events take place on 24 and 29 November at Ditton Community Centre and Camden Centre. Focus on co designing improvements prioritised by patients , carers and vol sector participants. • Agreement about how continue working with patients, carers and vol sector partners in development of patient experience and engagement strategies and improvement programmes • Development of business plans for securing continuity and sustainability of patient engagement and experience activity.	G	G	**PPEE** Drafting of Patient Experience and Engagement Strategy and Plans Outreach to harder to reach groups such gypsy and traveller community, offenders, carers
	• **Staff Experience and Engagement** • Plans for other engagement outreach at other sites and dates agreed, plans to target areas such as CAU's, radiology • 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	G	G	**Staff Experience and Engagement** Writing up and theming of feedback received from staff Continuing outreach to staff groups in workplace settings
Quality Improvement	• **Quality Improvement** • November QIC provides detailed discussion on 4 SD actions which the team need • Detailed plan in place with Trust employees who have had experience as CQC Specialist Advisors and Corporate nursing team will pull together a paper to describe key focus for moving the organisation to 'good' and ultimately 'outstanding'. • Launch of Quality strategy along with QSIR Methodology for completeness • Unannounced inspection Cascade update • Emphasis on ensuring Lead attend or appoint a deputy so that all areas are represented at the QIC	G	G	QIC provides detailed discussion on 4 SD actions

Effectiveness and Excellence	• **Maternity Safer Births / CNST** • Maintenance of performance against existing 10 criteria and preparation for publication of stretch criteria and development of action plan • New Safety Criteria published on 12 December	G	G	**Maternity Safer Births / CNST** Continuing monitoring and management of performance against the old 10 safety criteria Risk assessment and action planning against the new refreshed 10 safety criteria
	• **Crowborough** • Contractors to survey site and plan actual start date once tender awarded • Once plans available review feasibility of remaining open during entire project • Ascertain any potential disruption to services i.e. water being turned off • Communications- Preparation of information for women due to deliver regarding impact of building work on them • Ensure community midwives are well informed regarding plan • Video clips edited and placed on MTW Maternity website • Further comms meeting planned between potential for more use of social media in order to promote out of hospital births generally with a focus on Crowborough during refurbishment works • Consider additional fund raising for environment improvements not covered by refurbishment funds	A	A	**Crowborough** Video vignettes published on website, Instagram and Facebook Preparation for End of Refurbishment Works Celebratory Event in February
	CQUINS: • Alcohol pathway is yet to be finalised and launched. • Compliance and awareness of Sepsis pathway remains of concern with clinical teams. • Interface issues between MTW and CGL for alcohol referral • Rollout of Risky Behaviours pathway of referral • Development of CQUIN Dashboard for future submissions.	A	G	**CQUINS** Rollout of Risky Behaviours pathway of referral
	#EndPJParalysis: • Discuss project at NMAHPSG to gain ideas for dementia patients and going forward with project / new ideas • Signage / banners not obtained to promote the campaign • Next PJ w/c 10.12.18 all staff encouraged to come to work in xmas PJ's • Cake sale both sites on 27.11.18 to generate some monies towards activities for patients. • Christmas activities across all wards • Initiate gathering of engagement data / KPI's across the board • Introduce competitions for wards with published data – rewarded with tea party for winner • Red bag scheme initiative – to support project • Purchasing of items for volunteers to use with patients (xmas themed) • Asking larger supermarket chains if we can be considered for the green token scheme	G	G	**#EndPJParalysis** • Christmas activities across all wards • Gathering engagement data • Introduce competitions for wards with published data – rewarded with tea party for winner – plans being developed for this • Purchasing of items for volunteers to use with patients (xmas themed) • Asking larger supermarket chains if we can be considered for the green token scheme
	Criteria Led Discharge Inaugural project group meeting set up following inaugural NHSi Event. 30 day NHSi Event in Leeds too k place	A	R	**Criteria Led Discharge** Leadership / resourcing arrangements and plan being confirmed and developed as matter of urgency
	Pressure Sores: Implementation of new policy in line with new guidelines	G	G	**Pressure Sores** Continuing implementation of new policy
	• **Falls:** • Members of the project team will be attended the 90 day event on 18th October 2018. • Plan for the pilot wards to sustain improvement made on lying and standing blood pressure and to progress on to another key indicator. • Project roll out discussed at Slips, Trips and Falls Group; plan for project to be rolled out to another 2 to 4 wards. • Ward 30 has been nominated by orthopaedic Matron and waiting for other wards to be identified.	G	G	**Falls:**

WORKSTREAM	Best Quality	BEST CARE BOARD DATE	December 18
WORKSTREAM LEAD	Gemma Craig	PMO SUPPORT	Wendy Rooney / 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
Quality Improvement Losing momentum and key directorate representation as the process transforms to take a business as usual approach especially with winter capacity challenges	Actively engage with nominated leads and dissemination through appropriate forums	11/10/18	NEW	A
Data collection could mean PJ paralysis becomes and onerous on staff re data collection. Runs risk of staff resentment and disengagement	working closely with clinical areas and rolling out slowly at a local level to ensure engagement with teams and implementation in a way which works best with the staff undertaking the work	06/11/18	NEW	A

CRITICAL PATH MILESTONES				
TASK	DATE	STATUS	RAG	
			LAST MONTH	THIS MONTH
Recruitment to Transition Lead	30/08/18	Delayed	A	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	A	A
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	G	G
Delivery of Criteria Led Discharge collaborative 120 day milestones	20/02/19	On target	G	G
NHSR submit decision on % rebate of CNST rebate (up to £908K)	30/08/18	Complete	C	C
Crowborough Out to Tender for works	16/07/18	Complete	C	C
Crowborough Practical Completion	21/12/18	At risk	A	A
Invitations sent for multi organisation Dementia Show and tell event	09/11/18	In progress	NEW	G
Plan for PJ Paralysis Xmas week w/c 10/12	10/12/18	On target	NEW	G
Engagement with wards to Collect PJ data	10/12/18	On target	NEW	G

KPIS	TARGET	Oct	Nov
Total Number of Labours commenced at Crowborough Birthing Centre	18	20	23
Number of Births at Crowborough Birthing Centre	14	16	18
Total Number of women receiving Ante Natal Care at Crowborough	200	198	224

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

FINANCE NARRATIVE

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

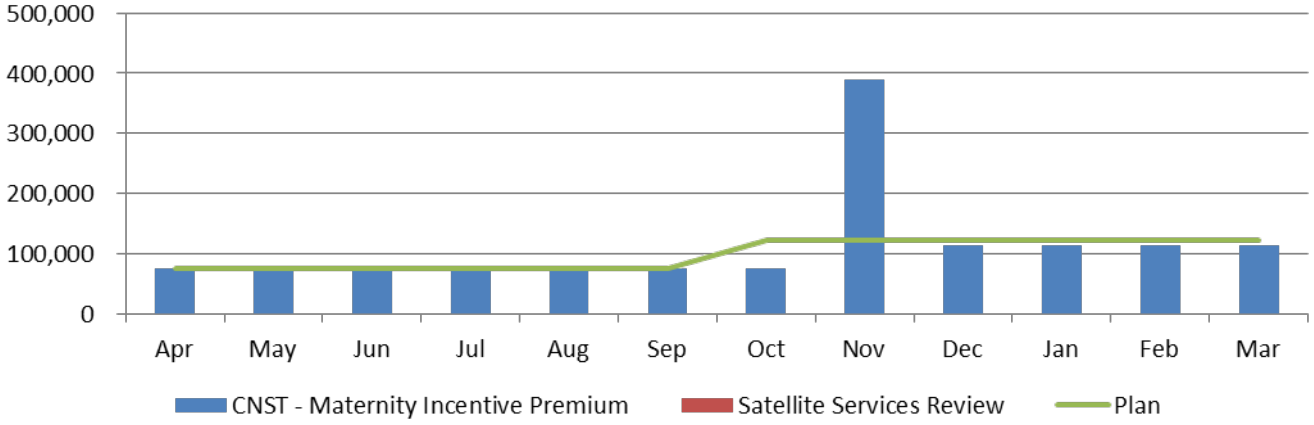
Safer Births / CNST:
NHS Resolution has confirmed achievement of all 10 safe births made rebate payment of 908k. Still awaiting confirmation and payment of additional rebate from unallocated maternity incentive scheme resource. Need to maintain delivery against safer births performance criteria in preparation for 'stretch' of refreshed maternity incentive scheme.

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 are being identified, assessed, developed and costed so that support can be targeted to those priority schemes that are 'high' value and considered to be more readily deliverable.

FINANCES

	M1	M2	M3	M4	M5	M6	M7 – Reporting	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 workstream 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	5th December 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	The report from the Challenge Event has been submitted to TME and to the West Kent Quality and Performance (Q&P) Committee for discussion. The Core Team are working through the actions with the Directorate Teams. The Core Team are meeting again on 6th December to review progress. A discussion will take place with the Regional Lead on the 6th December to further discuss the National Board Assurance Framework. Dates for the Quarterly Review Meetings (with NHSE and CCG presence) have been arranged for 2019. The relevant Chiefs of Service will be in attendance at each meeting (Medicine and Planned Care). Discussion has taken place with a peer site (Plymouth) regarding specialties with small volumes of NEL patients, low consultant numbers working across multiple sites, good middle grade cover . Not significantly helpful as they are a single site Trust but some useful comparators have been identified. Discussion has taken place with Mark Atkinson (CCG) with respect to ongoing reporting to Q&P and commencement of work on 6 remaining standards. As a reminder, the current compliance status for the 4 priority standards (for the non-compliant services) is as follows: ENT – Non compliant - standards 2 & 8. Surgery – Non compliant - standard 2 at weekends Urology - Non compliant - standard 2 at weekends – possible exception pathway Women's Health – Agreed as compliant (Exception Pathway process agreed) Urgent Care – Non-compliant – standard 2 – major mitigating factors understood and further work with CCG and NHSE has been agreed. Standard 5 & 6 – Non complaint until 24/7 GI Bleed rota is implemented – plans in progress. T&O – Borderline compliant for standard 8, but decision to revert back to non-compliant until all potentially medically active patients can be assessed throughout their LOS. All remaining areas compliant or exempt for the 4 priority standards.			• Core Team Planning Meeting – 6.12.18 (for next stages of project) • Drafting of exception pathways • Discussions regarding approach for Urgent Care (in respect of the March 2020 deadline for std 8) • Work with CCG (Mark Atkinson) to identify if support can be achieved via the West Kent Forum. • Meet with each Directorate Team to agree next steps and actions from Challenge Event. • NHSE to provide support to obtain benchmarking information from peer organisations.
Mortality	• Several bank staff members expressed an interest in the Band 2 support role and following successful recruitment, the temporary Mortality Data Clerk will start on 26.11.18 for a period of 3 months. • The reformatting of the SJR form to a Word document (10 pages) has been completed. There are two versions which will be presented at the next MSG for final agreement before circulating to the SJR Reviewers, Mortality Leads, Matrons, Ward Managers and Ward Clerks. • A meeting to discuss the format of Directorate reports was held on 02.11.18 with Kathryn Ely and a draft format was agreed. Comments from each Directorates are awaited before finalising the design/layout. • A meeting was held with the EKHUFT information team with a view to helping MTW build a mortality review system, if cost appropriate, before making a final decision to purchase the Datix Cloud IQ option. Richard Ewins provided a demonstration of the in-house system that EKHUFT are currently using and keen to develop further. Development of the database should be able to incorporate MTW's requirements which may also be adopted by EKHUFT. • Approval of the Business Case to support a Datix System Administrator for a period of 6 months has now been approved. HR processes are now being worked through to ensure a prompt start date is facilitated.			• Launch Word versions of the mortality review forms; Preliminary Screening Tool (form1), First Stage Review (form 2) and SJR (form3). • James Jarvis to send MTW's mortality reviews to Richard Ewins at EKHUFT to explore available options before making final decision whether to move to Datix Cloud IQ or develop an in-house system.
Learning Lessons	<u>Action Planning & Learning Source Identification</u> The secondment for the Datix System Administrator has been approved and arrangements are in place for a start date. A further meeting to discuss the next steps for the overarching Datix business case is being arranged. The functionality specification is being produced within the Governance Team (required for production of the Business Case). <u>Clinical Governance Meetings & Infrastructure</u> The half day workshop of the Directorate Clinical Governance Leads is due to take place on 4.12.18. All of the Clinical Governance Leads have agreed to attend. All meeting preparation has been undertaken. The expected outcome of the workshop is a revised, standard Clinical Governance agenda for Directorates and the response to four key questions on the infrastructure to support these meetings. <u>Evidencing and Embedding Learning</u> Planning has taken place for the second workshop. This will take place with Core team plus one of our NEDs (Maureen Choong) and a representative from Healthwatch. 3 areas are being put forward as proposals for consideration – 1 x metric based, 1 x people-based and 1 x system based. As reported last month, resource has been lost to this project - (The Project Lead) due to pressure of work. Also, a key staff member is currently unavailable who was leading on Datix which has added to the need to identify the secondment funding for the Datix System Administrator role.			• Datix next steps meeting with Core Team • Datix Business Case creation (system specification from WG) – End Nov • Agreement of Evidencing & Embedding proposals (for Best Safety Workstream Board – 5.12.18) • Analysis of outputs from CG Leads Workshop and creation of a draft new Directorate CG agenda and supporting infrastructure (for initial discussion at Best Safety Workstream Board – 5.12.18).
Medical Productivity	<u>Job planning</u> 310 of 330 (94%) job plans are now on the e-job planning software and 53% of the required 330 job plans have been fully signed off (3 stage process). (As at 23rd November 2018). This is behind schedule and is being monitored by the Medical Workforce Productivity Working Group, and is also contained within Directorate EPRs. The delay has been escalated through the Workstream The issues with SAS job plans has largely been resolved now and W&C job plans are in the process of being added to the system. ED have now added their job plans onto the system and 83% are signed off. The MJPCC is being launched this month. A briefing session has been arranged for Tuesday 27th November and Radiology is the first directorate being reviewed on the Friday 30th November. Critical Care has been scheduled for 11th December. <u>Demand and Capacity</u> The BI team are working on demand and capacity templates received from the directorates and initial discussions have commenced regarding how to convert this into PAs and a meeting is scheduled with the Strategy Director to discuss further. It is likely that this will be based on an average usage for this first year and refined in future years. Our information analyst is ow working reviewing capacity against job plans and this will form part of the feedback to directorates ahead of the next cycle of business planning. <u>Best Value</u> 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. This approach was discussed with the National Team on the 2nd November.			• All job plans to be completed and signed off onto the e-job planning software Allocate. • MJPCC to be set up and first reviews to have been undertaken. • Agreed the system rebuild of Allocate for the new Clinically Led Structure. • Undertake detailed lessons learned exercise ahead of issue job planning letter for next year.

WORKSTREAM	Best Safety	BEST CARE BOARD DATE	5th December 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 LAST MONTH	DELIVERY RAG THIS MONTH	FORWARD VIEW: KEY MILESTONES TO TAKE PLACE IN THE NEXT 4 WEEKS
Preventing Harm	LEW It has been agreed to undertake an ongoing harm review of all patients that have waited longer than 52 week and a sample of patients that have waited longer than 44 weeks for elective treatment –either as an inpatient or daycase. The information team have advised that the number of patients in this category are as follows: Month / RTT 44 weeks plus (inc 52weeks plus) No of Patients Treated (Admitted pathway) / RTT 52 weeks plus No of Patients Treated (Admitted pathway) (Unvalidated) June: 138 / 9 July: 125 / 8 August: 125 / 14 Sept: 114 / 9 The Project Team are working on the process for the Clinical Harm Reviews. It is anticipated that between 10-20% of patients that fall into this category will be reviewed on a monthly basis by the treating Clinician and an IR1 raised if Harm is deemed to have occurred. The process of escalation if the reviews are not undertaken in a timely fashion are still to be worked through. Alongside this, Clinicians will still have the existing process of completing an IR1 form for any patient they feel has come to harm as a result of an extended wait and the project team will also review Datix reports for evidence of patients that have had an IR1 form raised as a result of a Long Elective Wait. This approach was reviewed and noted by the November Quality Committee.			LEW Finalise the plan for Long Elective Waits Audit.
	Documentation and Record Keeping A paper is being produced for the Quality Committee in December. This paper reflects the process that is proposed for a compliance project for medical staff as an interim measure to raise the awareness of the importance of the documentation and record keeping standards in advance of the EPR work. The latter will include rationalising the number of forms and setting clear data fields for completion as part of the medical record going forward. The process design for the compliance project will incorporate surveys, and local speciality audits to identify any actions that need to be taken. An action plan will then be produced to address any short falls.			Documentation and Record Keeping • Finalisation of project design • Discussion with Quality Committee – Dec 2019 • Launch of project – Estimated Jan/Feb 2019
	Consent: • Wendy Glazier has escalated challenges in regard to timeframes for delivery of workstream to Peter Maskell. • WG to support Alistair Challiner, chair of the Working Group to devise action plan, meeting is being reconvened.			Consent: • Governance PA is in the process of re-convening a 'Consent Working Group' to review the Policy and Consent forms that have been submitted, with the aim of finalising a clear policy and process. In particular for the agreement of speciality specific consent forms.
Quality Mark	The Quality Mark project is currently under review. PM and COB confirmed that the Quality Mark was required by the Trust but that the timing for implementation should be delayed until the next financial year. It was agreed that a presentation would be taken to the overarching Best Care Board for broad discussion to agree direction. In the meantime, GC and LS are working on a presentation for the Best Care Board (to be informed by information from other Trusts who have implemented similar processes).			• LS and GC to continue drafting presentation for Best Care Board (for the April 19 meeting). • Joint meeting of Best Safety and Best Quality to review above draft presentation and confirm content. • Arrangements to be made for discussions with other sites who have implemented similar processes. • HP to schedule Quality Mark discussion for April Best Care Board.
GIRFT	• The infrastructure for the new Internal Panel has been set up and a briefing session was held last month. The monthly meetings have been set up from January. Membership includes the Project Team, Divisional Representation, Quality Team, GIRFT local implementation Team and the CCG. The Speciality Clinical Lead and Lead manager will be invited for their action plan reviews. • The PMO team are working with the Directorates to ensure the action plans are up to date. This is proving difficult in some instances where reviews were undertaken some time ago and personnel has changed during this period. However it is anticipated that this will be aided through implementing the panel. • The Litigation action plan has yet to be updated, due to staffing difficulties it has been agreed with the GIRFT panel to review this in January but they have agreed to the approach to wait until the internal staffing issues are resolved rather than involve an outside agency to undertake the work. • The SSIR report was released at the end of October. MTW's return only included Breast and General Surgical Infections rates. The Trust is awaiting feedback from the GIRFT as to where this data was obtained from. • Following ED GIRFT review, the team have reviewed the actions plan and assigned leads. • Endocrinology GIRFT visit was held on the 26th October. This was a largely positive visit. The observation notes have been received and the directorate are to start developing an action plan. • The Stroke regional event was held last month and was again a positive event. Action plans now need to be drafted.Data requested have been received and sent for Acute services and Respiratory Services. • The Radiology GIRFT Review is booked for February 2019.			• Ensure each action plan has a clinical lead assigned to it and they are clear on their responsibilities. • Action plans all updated by clinical leads

WORKSTREAM	Best Safety	BEST CARE BOARD DATE	5th December 2018
WORKSTREAM LEAD	Lynne Sheridan	PMO SUPPORT	Abigail Hill (Medical Productivity/Preventing Harm and GIRFT)/Fiona Redman 7DS

KEY ISSUES/RISKS

DESCRIPTION	MITIGATION	DATE REC	LAST MONTH	THIS MONTH
7DS: 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		
7DS: Delay or inability to implement the 24/7 GI Bleed Rota (to achieve compliance for Priority standards 5 and 6).	Estimated potential date for delivery is Q2 of 2019/20.	18/10/18		
Mortality: Business Case not approved for Funding for Mortality Module (Datix)	Continued use of manual process (not safe, but no alternative)	25.10.18		
Datix System Administrator Funding not approval (Secondment)	None – cannot implement new electronic version without in house Datix expertise	25.10.18		
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		
Medical Productivity: 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		
Medical Productivity: Additional costs from the implementation of the PAAT	All CDs are aware of their responsibilities to remain within budget., and it will be the responsibility of the MJPCC to check for consistency across departments	01/09/17		
Medical Productivity: Significant cultural change required to obtain buy in to undertake and implement Best Value DCC and Personalised Metrics	AMD will work through DMD and CDs to resolve concerns. Project to be standard agenda item on CD meeting to keep Directorate Management Teams informed and updated. This will provide an opportunity to voice concerns and resolve issues arising.	12/09/18		
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. Clinical Leads are providing strong support.	25/10/18		
Learning Lessons: Datix Recovery Business case (System migration to IQ and substantive System Administrator Funding not approved) – work in progress to create business case	None – system functionality not available without the Datix Health Check (which requires the in-house System Administrator).	25.10.18		
GIRFT: All action plans need to be fully updated with detailed evidence.	The PMO team are working with the Clinical Leads and Managers to ensure these are fully updated.	16/10/18		
GIRFT: Litigation action plan is not yet up to date	The team have provided assurance that work has commenced against the action plan but this still requires updating –with a clear plan for outstanding actions.	16/10/18		
GIRFT: Dedicated staffing to support the GIRFT programme	It is planned to employ a WTE band 7 to support his programme, funding is currently being identified.	26/11/18		
Consent: Vacancies and workload within the Legal Services team is impacting on ability to focus on Next Steps	Weightmans have been approached to provide interim support	29/10/18		

CRITICAL PATH MILESTONES

TASK	DATE	STATUS	RAG LAST MONTH	RAG 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	Completed		
7DS – Challenge Event with Regional Team (NHSI/E) 18.10.18 to confirm compliance status	18.10.18	Completed		
7DS – Confirmation of position for Urgent Care and how to relay this to Regional Team (NHSE/CCG).	Decision by End Jan 2019	Ongoing		
7DS – Implementation of GI Bleed Rota in Urgent Care	Estimated Q2 2019/20	Ongoing		
7DS – Continuation of implementation of actions for Planned Care Services to achieve compliance or exemption (via exception pathways) by March 2020.	March 2020	Ongoing		
Learning Lessons: Delay to date for meeting with CG Leads (now 4.12.18).	Delayed	On target		
Learning Lessons: Creation of a standard CG agenda for all Directorates.	End Jan			
Learning Lessons: Automation of learning outcomes via Datix on a monthly basis (for distribution to CG Leads and other key comms sources – Team Brief/Senior Leaders etc)	TBC – awaits Datix Recovery Business Case			
Learning Lessons: Creation of a Datix Recovery Business Case for migration to IQ and substantive resource for Datix System Administrator.	Feb 2019			
GIRFT: Ensure all Action Plans are up to date.	15/11/18	ongoing		
GIRFT: Set up the Internal Panel meetings	15/11/18	In progress		
Medical Productivity: MJPCC set up and first meeting held.	3/9/18	In Progress		
Medical Productivity: Personalised metrics to be developed	12/12/18	Yet to start		
Medical Productivity: All job plans on the system and signed off by directorate management teams.	3/09/18	In progress		
Consent form circulated for final consultation prior to presentation at PRC	31/10/18			

WORKSTREAM	Best Safety	BEST CARE BOARD DATE	5th December 2018
WORKSTREAM LEAD	Lynne Sheridan	PMO SUPPORT	Vince Roose / Fiona Redman (ZDS) / Abigail Hill (Preventing Harm)

	KPIS	TARGET	ACTUAL	THIS MONTH
** KPI'S PAPER WENT TO BEST SAFETY BOARD 06/06/2018 – MORE KPI'S TO BE FINALISED AS PROJECTS PROGRESS				
7DS	Generic KPIs have been in existence since project was first initiated , but will be reviewed if they can be localised by Division once each Division has completed their actions against the Challenge Day action plan.	NA	NA	
MORTALITY	HMSR (Monthly)	100.0	102.4	
	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	81.8	
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 (see detail below)	329	304	
	Number of Job plans signed off on the e-job planning software (see detail below)	329	152	

As at 23/11/18

	Directorate	Total Job plans to be completed	Total on the system	% on the system	No in Discussion/ sign off by Dr	Awaiting Sign off by Management Team	Signed off	Signed off
Cancer and Haematology	Haematology	5	5	100%	5	0	0	0%
	Oncology	31	29	94%	12	4	13	42%
	Palliative Care	1	1	100%	1	0	0	0%
	Radiology	21	21	100%	2	1	18	86%
Critical Care	Generalists	25	25	100%	2	0	23	92%
	Intensivists	15	15	100%	0	1	14	93%
	SAS Doctors	19	19	100%	3	2	14	74%
Genera Surgery	Breast	6	6	100%	4	2	0	0%
	Emergency	3	3	100%	3	0	0	0%
	Gynae Oncology	3	1	33%	1	0	0	0%
	LGI	9	9	100%	9	0	0	0%
	UGI	6	6	100%	6	0	0	0%
	Urology	9	6	67%	6	0	0	0%
Head and Neck	ENT	10	10	100%	8	1	1	10%
	Ophthalmology	22	22	100%	9	1	12	55%
Pathology	Biochemistry	1	1	100%	0	0	1	100%
	Histopathology	20	20	100%	0	0	20	100%
	Microbiology	4	4	100%	0	0	4	100%
T&O	Trauma and Ortho	19	19	100%	5	2	12	63%
Acute and Emergency	Acute Medicine	5	2	40%	0	2	0	0%
	Emergency Dept	12	12	100%	1	1	10	83%
Speciality Medicine	Cardiology	10	9	90%	2	0	7	70%
	Care of the elderly	9	9	100%	3	2	4	44%
	Diabetes and Endo	4	4	100%	1	1	2	50%
	Gastroenterology	7	7	100%	3	1	3	43%
	Neurology	6	6	100%	1	0	5	83%
	Respiratory	4	4	100%	1	1	2	50%
	Rheumatology	5	5	100%	1	1	3	60%
W&C	Sexual Health	5	5	100%	0	0	5	100%
	Obs and Gynae	19	11	58%	10	0	1	5%
	Paediatrics	15	14	93%	10	4	0	0%
		330	**310**	94%	**109**	**27**	**174**	53%

3a.Best Care Programme - Financial Summary

Comment

Original Plan Savings - £24.1m / Risk Adjusted - £13.75m

The Trust was £1.7m adverse to plan in the month and £4.6m adverse YTD, this is mainly due to slippage on STP Medical rate (£1.0m), Prime Provider (£2.2m), Private Patients (£0.4m) and Estates & Facilities (£0.5m)

Risk adjusted forecast is £10.4m adverse to plan, the main schemes forecasting slippage are:

- Estates & Facilities Subsidiary - £1.75m (reduced to £1.1m, due to £0.6m schemes added)
- Private Patients Income - £1.0m
- STP Medical Rates - £1.8m
- Medicine Management - £1.2m (Avastin - £0.7m)
- Prime Provider - £4.5m (forecast assumes £1m benefit in 2018/19)
- Urgent Care Centre - £0.4m

Trust Board meeting – December 2018

Maidstone and Tunbridge Wells NHS Trust

12-11 Quarterly mortality data — Medical Director

Summary / Key points

This report is submitted in line with guidance from the National Quality Board, March 2017. This stipulates that Trusts are required to collect and publish on a quarterly basis specified information on deaths. This should be through a paper and an agenda item to a public board meeting in each quarter to set out the Trust's policy and approach and publication of the data and learning points.

This report also provides an update into the further actions that have subsequently been taken to understand and improve our Trust position, as a previous outlier, in regard to the Hospital Standardised Mortality Ratio (HSMR).

This report is based upon the Trust's most recent data, published by Dr Foster for the period of September 2017 – August 2018.

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, assurance 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

Mortality Surveillance Report

Hospital Standardised Mortality Ratio (HSMR)

The HSMR is a calculation used to monitor death rates in a trust. The HSMR is based on a subset of diagnoses which give rise to around 80% of in-hospital deaths. HSMRs are based on the routinely collected administrative data often known as Hospital Episode Statistics (HES), Secondary Uses Service Data (SUS) or Commissioning Datasets (CDS).

Measuring hospital performance is complex. Dr Foster understands that complexity and is clear that HSMRs should not be used in isolation, but rather considered with a basket of other indicators that give a well-rounded view of hospital quality and activity.

HSMR Current Performance

The standard HSMR calculation uses a 12 month rolling view of our performance. The latest results of this are shown below in Fig. 1. The 12 months September 2017 to August 2018 show our HSMR to be 102.4, which is an improvement against last month's position of 105.7.

Figure 1. Rolling 12 Month view

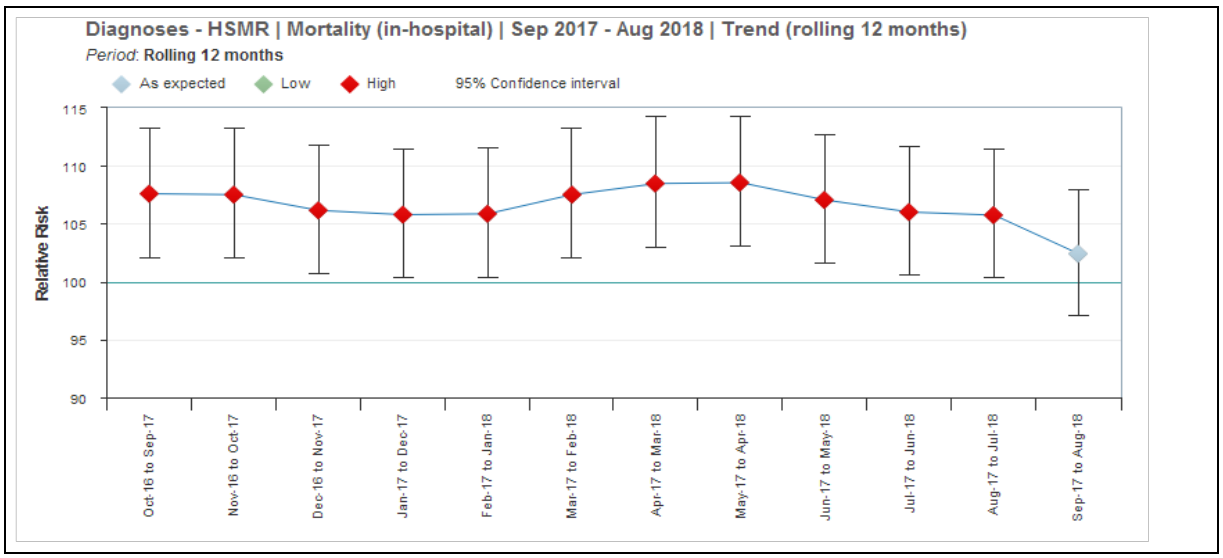
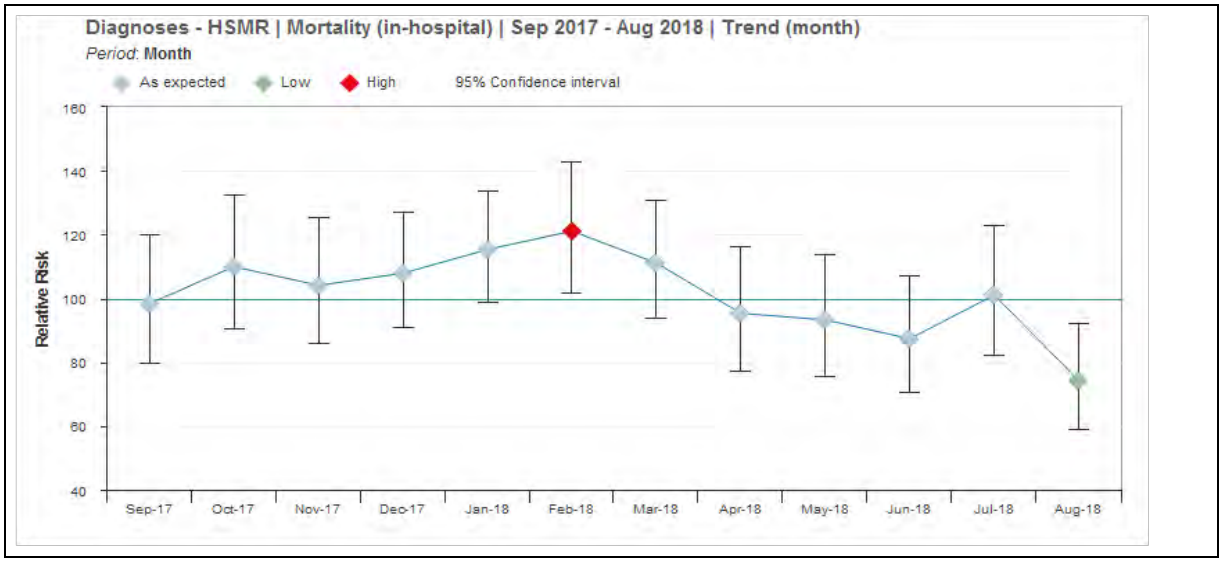


Figure 2 shows a monthly view of our HSMR performance. The latest month should be viewed with caution as this often shows a false position due to the lag in coding activity. Viewing the previous month, so July 2018 in this case, shows that the Trust's position has increased to 101.0 from 87.3 in June 2018.

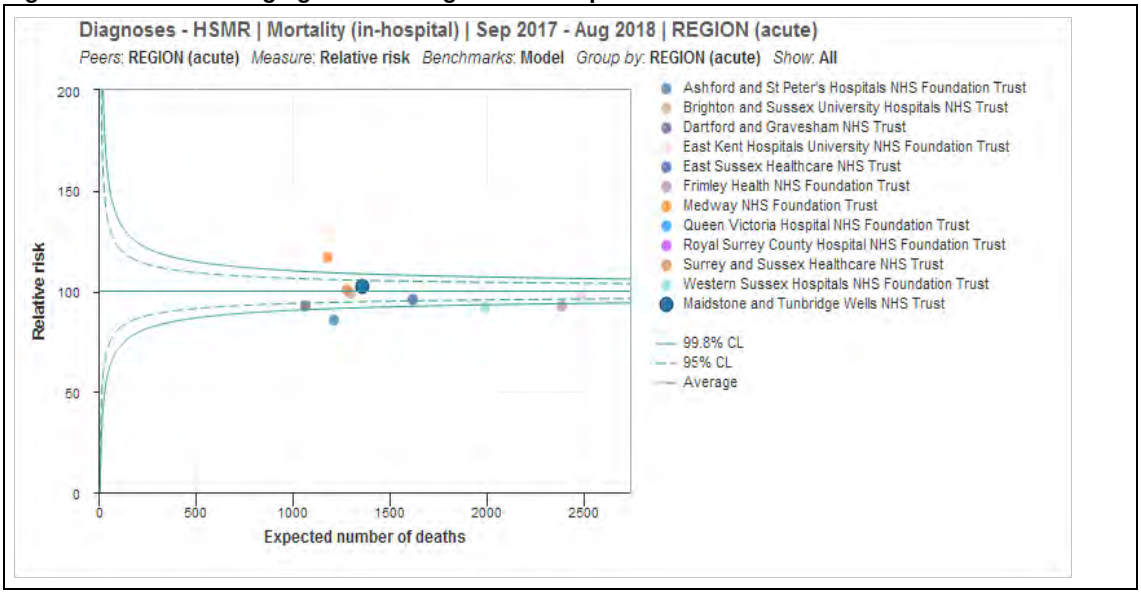
Figure 2. Monthly view



Benchmarking

Dr Foster enables us to benchmark our performance against our peers. There are various peer groups available e.g. GIRFT and Carter groups, but our local acute peers have been selected below in Figure 3. This shows the Trust is no longer a major outlier against this group; Medway & Ashford & St Peter's are the next outlier trusts for this period.

Figure 3. Benchmarking against our regional acute peers



Understanding and Improving upon a high HSMR

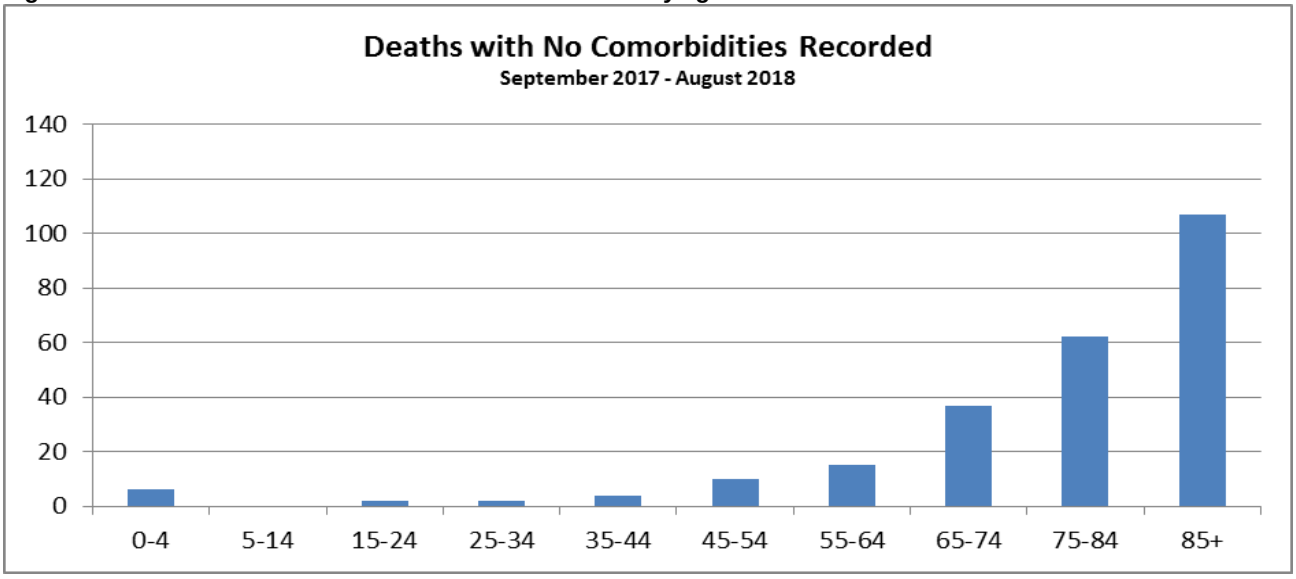
Guidance from Dr Foster has been instrumental in directing the work of the Mortality Surveillance Group (MSG). In line with this progress has been made, and continues in regard to:-

- *Coding*- poor depth of coding can affect HSMR and it is recommended that coders and clinicians work more closely together.

Expected Deaths- Comorbidities

There are various factors that influence the level of 'expected' deaths assigned to a Trust for the purposes of reporting the HSMR these include; Sex, Age, Diagnosis, type, time and month of admission, Socio-economic factors, palliative care and diagnosis/procedure subgroups. One of the key factors is patients Co-morbidities (based on Charlson score) as this informs the Trust's casemix. Of the 1391 deaths recorded in the period August 2017 to July 2018, 243 had no comorbidities recorded (17.5%).

Figure 4. Deaths with a Charlson score of zero recorded by age



Specialties with Zero Comorbidities – All Ages

	Apr17-Mar18		Jun17-May18		Jul17-Jun18		Aug17-Jul18		Sep17-Aug18	
Specialty (of discharge)	**Deaths**	**%age**	**Deaths**	**%age**	**Deaths**	**%age**	**Deaths**	**%age**	**Deaths**	**%age**
Geriatric Medicine	110	39.1%	96	37.9%	98	38.7%	90	37.0%	88	35.9%
General Medicine	39	13.9%	34	13.4%	34	13.4%	35	14.4%	37	15.1%
Respiratory Medicine	34	12.1%	32	12.6%	32	12.6%	32	13.2%	32	13.1%
General Surgery	26	9.3%	26	10.3%	25	9.9%	25	10.3%	29	11.8%
Gastroenterology	25	8.9%	20	7.9%	18	7.1%	17	7.0%	15	6.1%
Cardiology	11	3.9%	10	4.0%	11	4.3%	11	4.5%	13	5.3%
Endocrinology	8	2.8%	9	3.6%	9	3.6%	10	4.1%	9	3.7%
Paediatrics	5	1.8%	7	2.8%	7	2.8%	6	2.5%	5	2.0%
Clinical Haematology	4	1.4%	4	1.6%	5	2.0%	4	1.6%	4	1.6%
Accident & Emergency	4	1.4%	3	1.2%	3	1.2%	3	1.2%	3	1.2%
Stroke Medicine	2	0.7%	3	1.2%	3	1.2%	3	1.2%	3	1.2%
Trauma & Orthopaedics	2	0.7%	2	0.8%	2	0.8%	2	0.8%	2	0.8%
Urology	2	0.7%	2	0.8%	2	0.8%	2	0.8%	2	0.8%
Anaesthetics	1	0.4%	1	0.4%	1	0.4%	1	0.4%	1	0.4%
Diabetic Medicine	2	0.7%	1	0.4%	0	0.0%	0	0.0%	0	0.0%
Gynaecology	1	0.4%	1	0.4%	1	0.4%	1	0.4%	1	0.4%
Neonatology	1	0.4%	1	0.4%	1	0.4%	1	0.4%	1	0.4%
Obstetrics	4	1.4%	1	0.4%	1	0.4%	0	0.0%	0	0.0%
All	**281**		**253**		**253**		**243**		**245**	

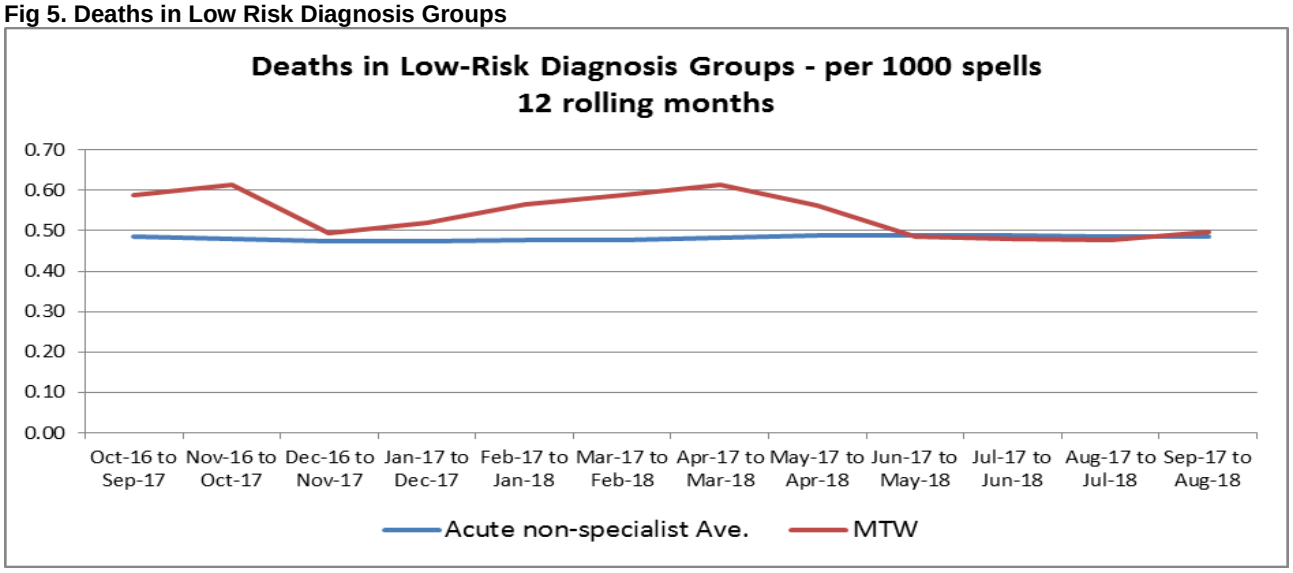
Significant progress is being made by the Head of Clinical coding in regard to our coding of deaths. In addition to the production of coding information for clinicians she is working with Directorates to improve their understanding and knowledge of how patients are coded. In particular targeted work with Speciality Medicine has been undertaken to address this potential under-reporting of comorbidities to ensure the 'expected' deaths assigned to the Trust are accurate.

- Process- at this point, consider is there a potential issue with quality of care.

Deaths in Low Risk Diagnosis Groups

MTW has come back in line with the Acute, Non Specialist Trusts average when looking at deaths in low risk diagnosis groups. The current average is 0.48 which is the same as the national average. This is a metric used by the CQC in their insight report and MTW was flagged as being consistently worse than average for this measure, hence its inclusion in this report.

Fig 5. Deaths in Low Risk Diagnosis Groups



CUSUM (Cumulative SUM control chart) is a method of identifying areas where there are unexpected cumulative numbers of mortalities which have occurred following treatment for a specific diagnosis; this can be both due to more and less than expected deaths. The chart below (Fig. 6) demonstrates the diagnosis groups where the Trust has received negative alerts when using a 'high' (99%) detection threshold over the past 12 months.

Figure 6. Dr Foster CUSUM alerts

Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend	LOS	Readm.	Peers
All Diagnoses	1 8	108982	1603	1603.2	1.5	100.0				
HSMR (56 diagnosis groups)	1	35676	1388	1355.5	3.9	102.4				
Acute bronchitis	1	1167	37	24.5	3.2	151.2				
Aspiration pneumonitis, food/vomitus	1	219	85	65.9	38.8	128.9				
Cancer of bronchus, lung	1	208	41	27.7	19.7	148.1				
Cancer of liver and intrahepatic bile duct	1	35	9	4.2	25.7	214.4				
Cancer, other respiratory and intrathoracic		16	5	1.4	31.3	363.2				
Congestive heart failure, nonhypertensive	2	639	80	66.2	12.5	120.9				
Other and ill-defined cerebrovascular disease	1	22	7	2.2	31.8	316.0				
Other and unspecified benign neoplasm		1126	4	1.0	0.4	414.3				
Other complications of pregnancy		871	1	0.0	0.1	8761.2				
Other nervous system disorders		969	10	4.4	1.0	227.9				
Pneumonia		2003	303	261.6	15.1	115.8				
Secondary malignancies	1	554	30	25.6	5.4	117.0				
Sprains and strains	1	84	1	0.1	1.2	861.3				
All Procedures	3	71297	920	981.3	1.3	93.7				
Pilonidal sinus operations		94	1	0.0	1.1	21700.7				
Reduction of fracture of neck of femur	1	76	8	2.4	10.5	339.7				
Rest of Arteries and veins (diagnostic/minor)	1	194	16	6.6	8.2	241.7				
Surgical arrest of bleeding from internal nose	1	82	4	0.9	4.9	453.8				

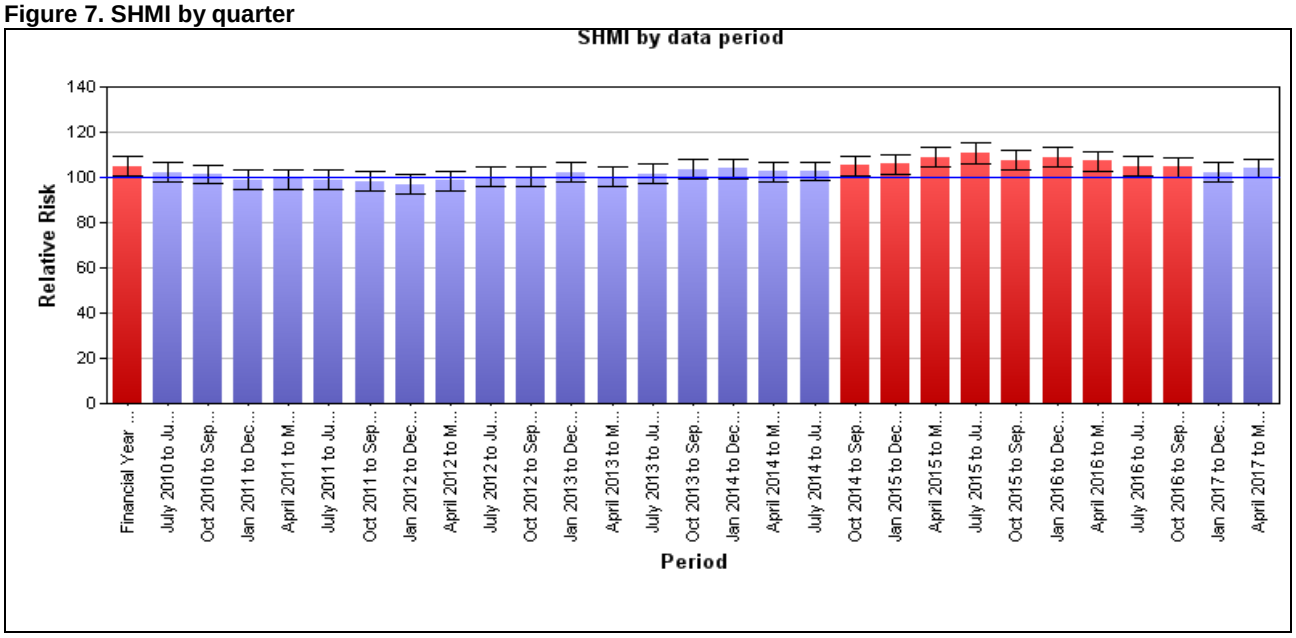
These alerts are regularly discussed at the Mortality Surveillance group with patient level data supplied to the Mortality leads to review. To date fractured neck of femurs, pneumonia, non-Hodgkin's lymphoma and phlebitis have had further reviews undertaken. Congestive Heart Failure and Aspiration pneumonia have both been requested.

Summary Hospital-Level Mortality Indicator (SHMI)

SHMI is a measure of mortality and performance which includes all deaths in hospital regardless of diagnosis, in addition to all those individuals who die within 30 days of discharge from hospital.

SHMI published by HSCIC for the period January – December 2017 shows SHMI as 1.0219 which is banded as level 2 "as expected.

Figure 7. SHMI by quarter



SHMI - Supplementary information: Depth of Coding

In the pack of information provided as part of the SHMI release each quarter, there is information included about depth of coding. As can be seen from the table below, MTWs mean depth for non-elective admissions is higher than the national average and our local acute peers. This also highlights that our coding of secondary diagnosis is rich as the maximum has been reached.

Figure 8. Depth of Coding

Provider name	Mean coding depth for non-elective admissions	Maximum number of secondary diagnosis codes for non-elective admissions
England	4.4	19
Dartford and Gravesham NHS Trust	3.6	15
East Kent Hospitals University NHS Foundation Trust	3.8	13
Maidstone and Tunbridge Wells NHS Trust	4.6	19
Medway NHS Foundation Trust	4.6	19

SHMI - Supplementary information: Palliative Care Coding

Information is also included about our palliative care coding and as can be seen below, the Trust's coding is slightly higher than the England levels. Previously this had been an area where MTW fell below the national average, so this demonstrates an improved position.

Figure 9. Palliative Care Coding

Provider name	Observed deaths	Number of deaths with palliative care diagnosis coding	Number of deaths with either palliative care speciality or diagnosis coding	Percentage of deaths with palliative care diagnosis coding	Percentage of deaths with either palliative care speciality or diagnosis coding
England	300,219	98,727	99,296	32.9	33.1
Dartford and Gravesham NHS Trust	1,629	858	858	52.7	52.7
East Kent Hospitals University NHS Foundation Trust	4,242	1,022	1,022	24.1	24.1
Maidstone and Tunbridge Wells NHS Trust	2,455	714	714	29.1	29.1
Medway NHS Foundation Trust	2,035	521	521	25.6	25.6

SHMI - Supplementary information: % of Deaths in the Community

The table below shows the number of deaths that occurred in the community within 30 days of discharge from the Trust. This shows that MTW is the same as the national average.

Figure 10. % of Deaths in the Community

Provider name	Observed deaths	Number of deaths which occurred in hospital	Number of deaths which occurred outside hospital	Percentage of deaths which occurred in hospital	Percentage of deaths which occurred outside hospital
England	300,219	212,897	87,322	70.9	29.1
Dartford and Gravesham NHS Trust	1,629	1,149	480	70.5	29.5
East Kent Hospitals University NHS Foundation Trust	4,242	2,750	1,492	64.8	35.2
Maidstone and Tunbridge Wells NHS Trust	2,455	1,644	811	67.0	33.0
Medway NHS Foundation Trust	2,035	1,429	606	70.2	29.8

The Mortality Surveillance Group (MSG):-

The MSG has been operational in its current format since February 2016 and has made consistent progress in improving the reported positon of Mortality reviews, with acknowledgment that 100% compliance needs to be reached.

Figure 11. Trust Position of Mortality Reviews – (Apr - Oct 18)

Trust	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	YTD
No of Deaths	127	126	126	128	122	149	125	903
No of Completed Reviews	110	110	111	111	97	127	73	739
%age completed reviews	**86.6%**	**87.3%**	**88.1%**	**86.7%**	**79.5%**	**85.2%**	**58.4%**	**81.8%**

The percentage of mortality reviews completed has dramatically improved since the process was changed in October 2017. At this time all Doctors completing the Death Certificate were asked to complete the preliminary screening tool and those completing the Cremation form then undertake the first stage reviews. Those deaths where a burial is preferred then have the first stage reviews completed by the Directorates. This has improved our compliance from 42.9% in September 2017 to 85.2% in September 2018.

Learning from Deaths Project Working Group.

The project group has been operational since May 2017 and set up in response to the National agenda for learning from deaths and last met on the 15th August, 2018. The objectives of the group are:-

- To develop a single database for all mortality data and mortality form recording (including SJR's)
- To improve compliance of completion of all mortality forms
- Implementation of a Trust-wide Mortality Coordinator role to oversee the process and compliance.
- Clarifying the role and effectiveness of the MSG (including the extraction of learning from this process)

- Identify how the responsibility for Duty of Candour issues should be taken forward.
- Clarify the role of the Informatics Team in monitoring and supporting this process.
- Reducing the observed rates of mortality, by identifying the patient deaths in which there was suboptimal care and learning through our revised processes (link to Learning Lessons Project). Record the key learning themes each month.
- Review and develop the monthly mortality report produced by Business Intelligence, (after review in MSG) that feeds the Trust Clinical Governance Meeting, the Quality Committee and the Trust Board.
- Audit the notes of deceased patients who do not progress to SJR. The Trust's policy states "A random sample of expected deaths will be audited by Clinicians, supported by the Clinical Audit Department, twice yearly as a quality assurance mechanism (and reported to the MSG)". Investigate how the Trust can identify patients who die within 30 days of discharge.
- Review and identify the link/process for all 'other' deaths in more 'specialist' categories – ie., perinatal mortality, maternal deaths, child deaths, LEDER for Learning Difficulties.

Recent achievements include:-

- 81.8% of all deaths having been reviewed year to date up to and including October 2018.
- All Mortality review documentation has been revised and is ready to be relaunched.
- Interim Datix Administrator Project lead started in post 5th December, 2018. This person has an objective to review the Mortality database as proposed by Datix and support next steps.
- New process for reporting deaths to the Coroner commenced on the 3rd December, 2018. All Doctors now make referrals to the Coroner via a web-based portal.
- Learning Disabilities Lead Nurse is now working collaboratively with Kent Community Health Foundation Trust Learning Disability team to share learning from mortality reviews for patients with a Learning Disability. This will then be reported back to MSG as required.

Next Steps:-

- Await outcomes from the audits in regard to learning from deaths for patients who died of Congestive Cardiac Failure and Aspiration pneumonia.
- Datix to present the Mortality review module with support from Datix Administrator Project Lead.
- Finalise the business case in regard to the Database that is recommended to support the Mortality review process.
- Continue to rollout training and education at Clinical Governance sessions in regard to coding.
- Lead Consultant for Child Deaths to present outcomes and learning from Child Death over-view Panel.
- Head of Midwifery to present the MBRRACE to outline key areas of learning for Maidstone & Tunbridge Wells NHS Trust.
- Learning Disability Nurse to attend KCHFT's Learning Disability Mortality review meetings.

NHS Learning from Deaths Dashboard

Organisation	Maidstone & Tunbridge Wells NHS Trust
Financial Year	2018-19
Month	October

Learning from deaths dashboard V2.1, updated 08/03/2017

Learning from Deaths Dashboard

Purpose of the dashboard

This suggested dashboard is a tool to aid the systematic recording of deaths and learning from the care provided by NHS Trusts. Trusts may use this to record relevant incidents of mortality, deaths reviewed and lessons learnt to encourage future learning and the improvement of care.

Guidance on what should be recorded in individual fields is provided below, alongside instructions for completing and updating the dashboard. This guidance on individual fields complements the wider guidance provided in the National Framework on Learning From Deaths and separate methodology guidance on the Structured Judgement Review (SJR) as developed by the Royal College of Physicians (RCP). The dashboard is not prescriptive and Trusts may set their own definitions according to local goals and data availability, although minimum requirements are set out in the framework.

To update this dashboard - enter your data on the "Data" worksheet. The dashboard sheet is automatically updated.

Guidance on individual fields

Field No.	Field	Description of Field
Recording data on structured judgement reviews:		
1	**Total Number of Deaths in scope**	This must as a minimum include all adult inpatient deaths excluding maternity services. Where additional deaths are included (for example maternal deaths, deaths post-discharge or deaths of outpatients etc) the inclusion criteria should be made clear in this field, which can vary by trust. The total number of deaths in scope defined in this field must be used in all subsequent relevant fields in this work book. If a post-discharge period is being included in scope, (eg deaths within 30 days of discharge) then the death should be counted in the month where the death actually occurred rather than time of admittance or discharge. Note that where it has been identified that a patient has a learning disability the death should be recorded separately (see Data item 6, below).
2	**Total Number of Deaths Reviewed under the SJR methodology**	This is the total number of deaths for which the care provided to the patient has been reviewed by your Trust. This may be a combination of deaths reviewed under national and local minimum requirements and random sampling of all other deaths in scope.
3	**Total number of deaths considered to have more than a 50% chance of having been avoidable**	The Structured Judgement Review methodology, for use in relation to adult acute inpatient deaths, allows for reviewers to score a death as having a more than 50% chance of having been avoidable when this judgement is made in relation to the care provided by the trust conducting the review. This is the equivalent of a score of 3 or less. If using the RCP SJR then the number of such deaths scored in this way is equivalent to this field If not using RCP SJR, then the method used to judge whether a death was more likely than not to have been avoidable in relation to the care provided by the trust conducting the review (or another provider if appropriate) should be stated here including any definitions used. Note that if you are applying other methodologies to specific groups, such as learning disabilities patients, those methodologies may require a degree of judgement to determine whether the death was more likely than not to be avoidable. It may be appropriate to cross-reference those outputs with the processes for assessing structured judgement reviews, and if appropriate to include those outputs here. If the RCP SJR methodology is being used for structured judgement reviews Trusts are able to include monthly totals of reviewed deaths that were in each category 1 to 6. If the Trust is not using this methodology these fields can be either left blank or edited as appropriate.
Recording data on LeDeR reviews:		
4	**Total Number of Deaths in scope**	This must include all adult inpatient deaths for patients with identified learning disabilities. The total number of deaths in scope defined in this field must be used in all subsequent relevant fields. If a post-discharge period is being included in scope, (eg deaths within 30 days of discharge) then the death should be counted in the month where the death actually occurred rather than time of admittance or discharge.
5	**Total Deaths Reviewed Through the LeDeR Methodology**	Formally, the LeDeR review methodology should be applied to all of the deaths shown as 'in scope'. You should record the total number of deaths reviewed here.
6	**Total Number of deaths considered to have been potentially avoidable**	Record the total number of deaths for which review evidence leads to a conclusion that it is more likely than not that the death was potentially avoidable. This will require that a degree of judgement is applied to the outputs of the LeDeR review, and it may be appropriate to cross-reference these outputs with the processes for assessing structured judgement reviews

How to update the dashboard

To update this dashboard - enter your data on the "Data" worksheet. The dashboard sheet is automatically updated.

To update the dashboard with new data:
1. Enter data for appropriate month(s) in the Data tab. Note that the RCP1 to RCP6 and Trust comparison fields are optional and the dashboard will still function correctly if these fields are left blank.
- In the first 3 columns enter the data for your structured judgement reviews (number of deaths in scope, numbers reviewed, and numbers deemed potentially avoidable)
- You have the option of recording how many of the SJR reviews placed cases in each of the RCP1 to RCP 6 categories.
- For learning disabilities patients, enter the number of deaths in scope, numbers reviewed under the LeDeR methodology, and numbers deemed potentially avoidable

2. Change the month and year on the Front Sheet tab to the most recent month of data.
3. Change the data range on the time series charts as required by using the interactive dropdowns on the Dashboard tab (eg cell V4). Note that the time series charts are not linked to the front sheet selection and are driven entirely by the dropdowns.

Maidstone & Tunbridge Wells NHS Trust: Learning from Deaths Dashboard - October 2018-19

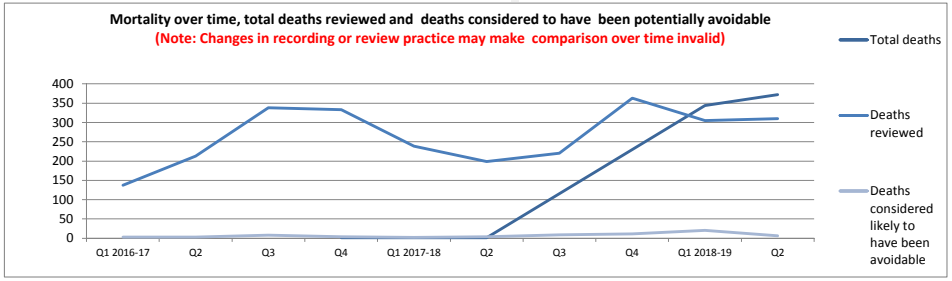
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
117	137	70	115	0	1
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
117	372	70	310	0	6
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
833	1	685	1021	26	26

Time Series: Start date 2016-17 Q1 End date 2018-19 Q2



Total Deaths Reviewed by RCP Methodology Score

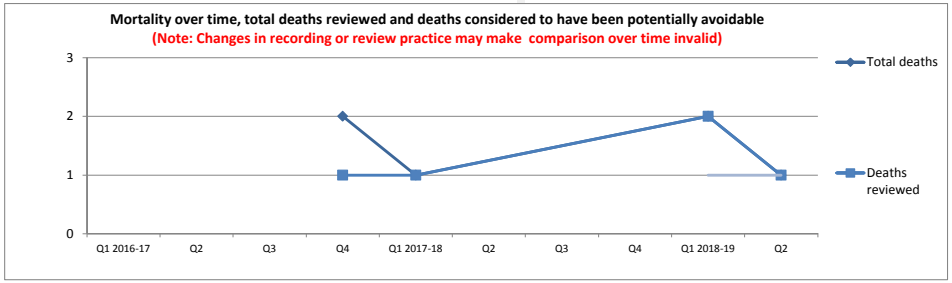
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	69	100.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	69	100.0%
This Year (YTD)	6	0.9%	This Year (YTD)	0	0.0%	This Year (YTD)	20	3.1%	This Year (YTD)	5	0.8%	This Year (YTD)	6	0.9%	This Year (YTD)	618	94.4%

Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	1	0	1	0	1
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	1	0	1	0	1
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
3	1	3	1	2	0

Time Series: Start date 2016-17 Q1 End date 2018-19 Q2



Trust Board meeting - December 2018

NHS Maidstone and Tunbridge Wells NHS Trust

12-12	Review of the Strategic Outline Case (SOC) to create a single Pathology service for Kent & Medway	Chief Executive

Purpose of Paper

The purpose of this paper is to present to Trust Boards for approval the Strategic Outline Case (SOC) for the development of the single pathology service across the Kent and Medway STP. In considering the approval of the SOC, Trust Boards will be asked to consider key issues which will need to be tested at Outline Business Case (OBC) stage; and approve the funding arrangements for the production of the OBC.

Background

In September 2017, Dr Jeremy Marlow, Executive Director of Operational Productivity NHSI, and Professor Tim Briggs, National Director of Clinical Productivity, wrote to all Trusts in England confirming the establishment of 29 pathology networks. The letter established a clear national case for change which stated: the consolidation of these services allows for more consistent , clinically appropriate turnaround times, ensuring the right test is available at the right time, as well as making better use of the highly skilled workforce to deliver improved, earlier diagnostic services supporting better outcomes.

The work was based on two national reviews of pathology services led by Lord Carter which demonstrated up to £200m could be saved nationally across England if pathology services where created, services consolidated and unwarranted variation removed. In Kent and Medway, NHSI have confirmed £4.6m of costs could be removed based on median benchmarks across England.

The response from the Kent and Medway STP partners was to acknowledge this was a key productivity work stream to tackle the service and financial sustainability of the system, and created a Project Steering Group chaired by the CEO from Medway NHSFT to lead the work on developing a single pathology service (subsequently chaired by the CEO of Maidstone and Tunbridge Wells NHS Trust from October 2018). The Pathology Steering Group has led the production of the SOC with highly participative involvement from the pathology leadership community. In the late Spring 2018, the four Trust CEOs approved a series of key principles and requirements from the pathology services in Kent and Medway in response to the NHSI national case for change. These established a clear basis upon which the SOC would be developed and see a clear goal for the service which was:-

"The creation of a single pathology service across Kent and Medway under a single management to deliver a high quality, sustainable service and embrace new technologies and diagnostic requirements for primary and secondary care. It aspires to become a nationally leading pathology service in the areas it concentrates on by 2030; and the best place for staff to learn, work and participate in research. The service will deliver a net £5.6m reduction in its costs from 2017/18 outside of investment in the service. This will be secured in 2020/21 and will be net of individual Trust efficiency requirements in 2018/19 - 2020-21".

This key goal along with the key principles and requirements from the four Trusts have been the foundation for the SOC production.

What has the SOC concluded?

The SOC has concluded that there are considerable challenges to the services which, unless addressed, will increasing make the services operationally and financially unsustainable based on;-

- rising demand
- rising service complexity requested from users
- a lack of a sustainable workforce plan

- the need to use current assets more effectively
- the level of financial challenge now and in the future

The opportunity to make a difference and confront these challenges head on are equally compelling through a change in strategic direction which the SOC focuses on around:-

- The development of a single pathology service which is run by a dedicated team focused on the pathology service across the county to anticipate and respond to the current and future needs of general practitioners, secondary care clinicians and commissioners.
- Driving the clinical effectiveness agenda in the current pathology service and supporting more effectively clinicians in the future use of the service to answer the clinical questions they are seeking to resolve. This will be based on a more outward facing, consumer focus that works with clinical groups across the county; since it is clear that investing in diagnostic platforms can reduce total care pathway costs for Trusts and primary care as well as reducing inappropriate testing
- Developing the right number of staff with the right skills, in the right locations who have the right capacity and capability to meet the current and future service models in Kent and Medway. This will be centred on more local care, increased specialisation, new diagnostic platforms and the need for more diagnostic work to be delivered in the county from the current volumes sent outside the county.
- Reducing unwarranted variation in the existing diagnostic services to improve equity, fairness and consistency for referrers.
- Investing in the harmonisation of information technology and managed equipment services to ensure scalable, safe and effective interoperability and interconnectivity between laboratories, hospitals and primary care. This will support improved productivity, service resilience and specialised skills development in the workforce.
- Developing improved logistics for secondary and primary care around streamlining the pre-analytical and analytical pathway for referrers
- Reviewing the location of laboratory services to develop the best solution for the future to improve service resilience, improve productivity and financial sustainability that can be optimally staffed.

The Project has considered carefully the lessons from the past attempts at pathology integration in Kent and Medway; and the implementation plan seeks to incorporate these lessons by proposing scalable, safe and effective strategic implementation of activities which secure key basics in the first two to three years, builds organisational capability and then offers more radical development of service configuration thereafter when the fundamental infrastructure is in place and working.

The SOC has concluded that through a range of measures to harmonise, standardise and reduce unwarranted variation in cost; the efficiency levels which NHSI have identified at £4.6 m will be secured. These levels of efficiency will, however, be insufficient to secure financial and operational sustainability, given the year on year efficiencies required over the next decade. Accordingly, there is a need to develop more ambitious approaches which are based on different configuration of laboratories, and these are operated by a number of different commercial solutions.

The SOC concludes that there should be an examination of a one, two or three hub option with supporting emergency laboratories and that a preferred option is secured at the end of February 2019.

Then there will be an examination of the commercial delivery options which will be - in house, strategic partner and outsourced solutions; and these will be developed by July 2019. These commercial models already show there are additional benefits which will improve sustainability. This suggests there is real merit in pursuing the options in the SOC to build further the financial and operational sustainability of the service.

Proposed costs of OBC

The proposed project costs to deliver the OBC phase and build from the £4.6m savings to a greater number is £225k which is comparable to other pathology networks OBC costs in England. The funding of this will need to come from the four Trusts and this is proposed to be on a straight 25% each share of this sum from April - December 2019. This is understood to be the basis on which the SOC work was resourced. Trust Boards should note the low level of investment for the likely returns already established and the bigger returns from the exploration of the service delivery and commercial options to secure the goal required.

Issues for trusts to consider for the OBC phase

There are a number of issues that Trust Boards will need to consider in the OBC stage and the Project Steering Group would welcome Trust Board's thoughts on certain aspects of these around the following:-

- Are the options we have radical enough to meet the goal given the ambition of the trusts; and, if not, what else should we consider in the OBC phase ?
- Are we correct in assuming that the cost of capital should be financed from external partners or would Trust Boards have the risk appetite to finance these costs; and what would be the relative rate of return they would consider sensible?
- Are the reasons for investing clear in the first three years given the case for change, service resilience issues and the need for IT interconnectivity between primary and secondary care to the laboratories; and the laboratories to, themselves, gain wider financial and operational benefits; or do we need to strengthen this at the OBC stage ?
- What are the perspectives and issues Trust Boards would wish to consider around the creation of a form of joint venture for the single service in the OBC?
- The implementation plan seeks to pace the change against known risks and feasible timescales for implementation:- have we got these correct; or do we need to accelerate them in the OBC ?
- Do Boards have the appetite for all the commercial forms outlined in the OBC phase?

The outcome of these considerations should be fed back to the Programme Director following the Trust Board consideration.

Recommendations

The Trust Boards are asked to approve the following recommendations:-

1) the agreement of the enclosed SOC for submission to NHSI for approval
2) the agreement to resource the project costs for the OBC and the proposed funding arrangements
3) the consideration of the issues for the OBC phase and the key feedback to the Programme Director and lead CEO

Mark Hackett, Programme Director
10 December 2018

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, assurance and consideration of the enclosed recommendations

[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

The development of a single pathology network across Kent & Medway

Strategic Outline Case

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Introduction & Our commitment to working together

The four NHS Acute Hospital Trusts have come together in Kent & Medway to develop a long-term strategic plan for the future of pathology services. This is a unified strategy, backed by the Sustainability and Transformation Partnership (STP) and the four Acute NHS Trusts to improve the quality and effectiveness of local pathology services and help improve the financial value we get from our investment in these services. The aim of the Kent & Medway system in developing this strategy has been to consider, from the perspective of the local service and the needs of the local population, where we can work differently to improve the service we provide.

We have collaborated to produce a Strategic Outline Case (SOC) for the development of a single pathology network, one that shows an intention to, not just talk about change, but to making it happen; and we set out a practical plan in this document to ensure that we deliver the key changes that the pathology service requires over the coming years. The development of this plan has been led by a core group of clinical leaders and general managers from each Acute NHS Trust. It has been supported by a small project team within the STP and comes with the endorsement of all four Acute Trust chief executives.

Below we set out the signatories from the four organisations committed to this strategic outline case and the future actions required. These Organisational signatories are:

- East Kent University Hospitals NHS Foundation Trust (EKHUFT)
- Dartford and Gravesham NHS Foundation Trust (DGT)
- Medway NHS Foundation Trust (MFT)
- Maidstone and Tunbridge Wells NHS Trust (MTW)

In addition to the four Acute NHS Trusts the plan has also been signed by Kent & Medway STP on behalf of the seven Clinical Commissioning Groups (CCGs) across Kent & Medway.

INSERT SIGNATURES OF EACH CHIEF EXECUTIVE

Executive Summary

This Strategic Outline Case (SOC) considers the future of pathology services in Kent and Medway. This future is one where there are considerable opportunities and challenges for these services that are a fundamental bedrock for the diagnosis and monitoring of the treatment of conditions for the 2.2m patient population in Kent and Medway.

In September 2017, Dr Jeremy Marlow, Executive Director of Operational Productivity, NHSI and Professor Tim Evans National Director of Clinical Productivity wrote to all Trusts confirming the establishment of 29 pathology networks across England. This letter set out the national case for change in these services which stated the consolidation of services allows for a more consistent, clinically appropriate turnaround times ensuring the right tests is available at the right time as well as making better use of the highly skilled workforce to deliver improved, earlier diagnostic services supporting better outcomes.

This work was based on two national reviews of pathology services by Lord Carter which demonstrated up to £200m could be saved nationally across England if pathology networks where created, services consolidated and unwarranted variation removed. NHSI have recently conformed that £4.8 m of costs could be reduced if we pursued this agenda based on median benchmarks across England.

The response in Kent and Medway has been to support the creation of a pathology single service where all four acute Trusts will work together to establish a single organisation under a single management to develop and lead the service going forward.

The Trusts have defined a goal for the new service that is "**The creation of a single pathology service across Kent and Medway under a single management to deliver a high quality, sustainable service and embrace new technologies and diagnostic requirements for primary and secondary care. It aspires to become a nationally leading pathology service in the areas it concentrates on by 2030 and the best place for staff to learn, work and participate in research. The service will deliver a net £5.6 m reduction in its costs from 2017/18 outside of investment in the service. This will be secured by 2020/21 and will be net of individual Trust efficiency requirements in 2018/19 - 2020/21."**

This was supported by Chief Executives on behalf of their Trust Boards, agreeing a series of key principles and requirements for the service to avoid some of the difficulties in the past in working across Kent and Medway within pathology.

The challenges to the service revolve around the sustainable nature of the service in operational, financial and workforce terms going forward. The five major factors driving the case for change are:-

- The demand for the pathology services are rising each year
- The complexity of the service is rising each year
- There is no sustainable approach to the workforce in the future
- The current assets available could be more effectively utilised
- The services face significant financial challenges now and in the future

In order to focus on meeting these challenges, five strategic objectives for the single service were developed. They are:

- Delivery of a clinically and financially sustainable single pathology service based on a viable service that is clinically led, standardised, innovative and creative.
- Delivery of a high quality diagnostic service for the patients, hospital clinicians and general practitioners that meets their current and future needs.
- Creating a workforce that feels they are valued, involved and own the single pathology service as partners in the service.
- Transforming the service models in pathology in Kent and Medway to deliver technological change to create a more responsive service with increased efficiency. Developing meaningful roles for our staff to maximise their potential and meet the needs of Trust's and commissioners.
- Managing the transition to the single service in a creative, competent manner.

The opportunities to make a difference and confront these challenges head on are equally compelling. The Trusts have a strong commitment with the wider pathology leadership community to addresses these challenges and grasps the opportunities through a change in strategic direction focused on:

- The development of a single pathology service which is run by a dedicated team focused on the pathology service across the county to respond and anticipate the current and future needs of general practitioner, secondary care clinicians and commissioners.

- Driving the clinical effectiveness agenda in the current pathology services and supporting more effectively clinicians in the future use of the service to answer the clinical questions they are seeking to resolve. This will be based on a much more outward facing, consumer focus that works with general practitioners in their localities and with specialty groups across the county. It is clear that investing in new diagnostic platforms can reduce the total care pathway costs for Trusts as well as reducing inappropriate testing.

- Developing the right number of staff with the right skills, in the right locations who have the capacity and capability to meet the current and future service models in Kent and Medway. These will be based on more local care, increased specialisation, new diagnostic platforms and the need to undergo increasingly levels of pathology work in the county. This will be achieved through the harmonisation of terms and conditions, removing unwarranted variation in staffing profiles and grades, a clear workforce development plan, a exciting staff experience and a single pathology management structure.

- Reducing unwarranted variation in the existing diagnostic services to improve the equality, consistency and fairness for referrers and developing new exciting diagnostic platforms to support clinicians in the delivery of modern clinical practice.

- Investing in the harmonisation of the information technology and managed equipment services to ensure scalable, safe and effective interoperability and interconnectivity between laboratories to enable improved productivity, service resilience and specialised skills development in the pathology workforce.

- Developing improved logistics for secondary and primary care around the streamlining of the pre- analytical and post analytical pathways for referrers.

- Reviewing the location of laboratory services to develop the best solution for the future to improve service resilience, improve operational productivity and financial sustainability that can be optimally staffed.

The development of the SOC has enabled us to understand the needs of the service better. Moreover, it has enabled the Trusts to set a very clear set of goals and principles on which they wish to see the pathology services flourish as well as a clear set of strategic objectives.

The SOC process also has reminded the Trusts that there have been a number of attempts at pathology restricting in the county in the past and these have either failed or provided limited success to date. The Trust's have considered the lessons from these and are committed to developing a single service with a clear goal and a realistic set of aspirations combined with a sensitivity of the scale and complexity of such a large-scale change.

The SOC has established that through a range of measures to harmonise, standardise and reduce unwarranted variation in cost, the efficiency levels that NHSI nationally have identified as £4.8m that can be secured over a four-year period.

These levels of efficiency will not secure a financially or operational sustainable service. The continuous needs of the Trust's to generate year on year efficiencies over the next decade will increase the level of financial improvement required. The OBC will explore in more detail the feasibility of a wider configuration of pathology laboratories by examining a one, two or three hub option with supporting emergency services laboratories (ESLs).

There will be then an examination of the options to agree the preferred model based on NHS delivery, a strategic partner or outsourced the service. These different operating options have already shown that there are additional benefits that will improve financial sustainability. They will be examined in more detail at the OBC stage. The SOC lays out the process for achieving these aims in the OBC and the resources needed to secure this that are in line with other networks across the South of England estimates.

The Trusts are committed to working together at the OBC stage to secure the benefits identified to date and the benefits of looking at the wider configuration options to create a vibrant, high quality pathology service across Kent and Medway which is clinically, operationally and final tally sustainable.

Our situation: Why we need to change to meet the local needs

Background

In September 2017, Dr Jeremy Marlow, Executive Director of Operational Productivity, NHSI and Professor Tim Evans, National Director of Clinical Productivity, NHSI, wrote to all Trusts confirming the establishment of 29 pathology networks across England.

The letter stated that consolidating pathology services allows for the most consistent, clinically appropriate turnaround times ensuring the right test is available at the right time. It makes better use of our highly skilled workforce to deliver improved, earlier diagnostic services supporting better patient outcomes. It also stated that taking a hub and spoke approach to this consolidation can ensure the appropriate critical mass to support specialist diagnostics, so that patients have equal access to key tests and services that are sustainable. The response to this letter is set out in Appendix 1.

These proposals followed two reviews by Lord Patrick Carter, which highlighted that up to £200m could be saved nationally across England if pathology networks were established, services were consolidated, and unwarranted variation removed. NHSI have set the Kent & Medway network a combined savings target of £4.8m compared to the 2015/16 budget.

Pathology data collected from NHS Trusts across the country and made available on The Model Hospital shows considerable variation in terms of pay and non pay costs which are not linked to the size or type of hospital, but seems to be linked to the adoption of best practice and innovation within pathology services.

Within the remit of Pathology services there are five core services, all of which fall under the scope of this strategic case. They are:

- Blood sciences (Clinical Biochemistry, Haematology, Immunology, Point of Care and Blood Transfusion).
- Clinical Microbiology (bacteriology, serology, virology)
- Cellular Pathology (Histopathology, Cytology and Molecular pathology)
- Logistic services

Why we need to change to meet local needs

Pathology services across Kent and Medway face five significant challenges over the next decade. The development of a single service will look to confront these challenges to better equip the service for the future.

1. T**he service faces significant financial challenges, now, and in the future.** There are considerable financial improvements in the service that can help the system deficit.

    a. The current structure and staffing of the laboratory services shows that there are at least £4.8m of efficiency opportunities in the service compared to national benchmarks at median levels based on variation on staff and other costs. This excludes annual tariff deflation which requires a continuous delivery of £2.2 m per annum in the pathology services in Kent and Medway over the next five years to meet national efficiency requirement set for the health sector and meet internally generated cost pressures (e.g. 3% per annum).

    b. There are further potential opportunities in improving the financial performance of the service through standardisation of the services into a single service for Kent and Medway and the potential use of third parties in the supply and operation of services as well as focusing on the clinical effectiveness agenda in pathology.

    c. To achieve these and develop further opportunities there will need to be an investment in pathology services centered on two broad approaches.

    d. Firstly, with minimal transformation and disruption to create the single service, standardise the service around productivity, repatriate out of county testing, reduce unwarranted demand variation and invest in new LIMS and MES schemes. These could generate financial savings but would unlikely be at the required levels. It is also unlikely that they would resolve sustainability issues in the workforce and the financial sustainability challenge.

    e. Secondly, in addition to the changes above there could be a more radical approach involving fewer hub sites along and new commercial partnerships that could generate significantly more economies and deal with the wider sustainability issues around workforce, demand, productivity and financial sustainability.

2. **The demand for pathology services is increasing each year.** There are a number of contributing factors to this that include:

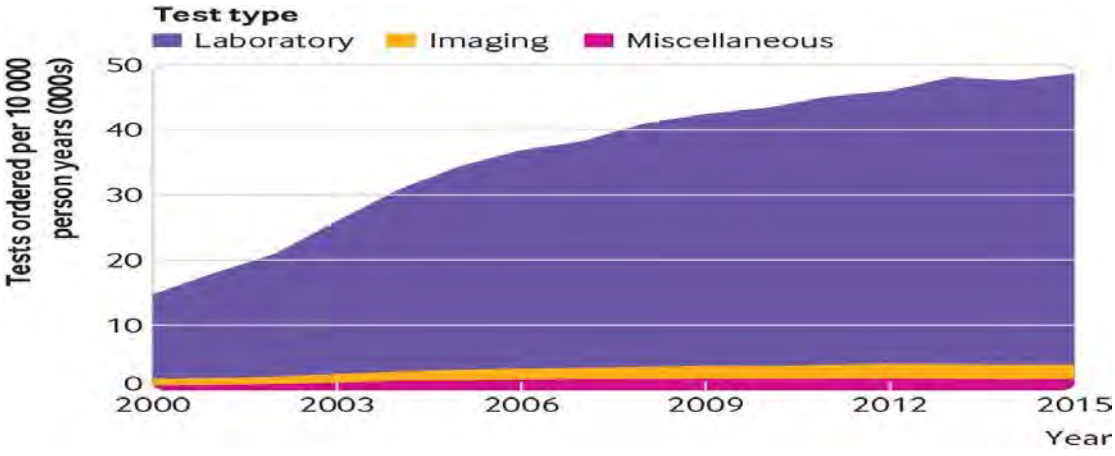
    a. **The local population is growing rapidly**: From 2011 to 2031, planned housing developments are expected to bring an additional 414,000 people to Kent and Medway in 188,200 new homes.

    b. **Local people are living longer and older:** the number of older people is growing quickly, and older people tend to use health and social care services more than other age groups. Growth in the number of over 65s is over four times greater than those under 65; an ageing population means increasing demand for health and social care in general, as well as for pathology services specifically. The impact on pathology of this is increased disease incidence and increased disease survival, that contribute to rising demand for pathology, services.

    c. **We are getting better at diagnosing disease earlier**: This includes increased efforts to ensure a reduction in the threshold for referrals, changes to clinical practice resulting in increased demands on pathology services, an increased sensitivity to other demands or tests in diagnostic areas, and improved detection rates.

    d. **An opportunity to improve how we remove unnecessary testing.** There is clear evidence that Pathology services can improve their efficiency and effectiveness by supporting a reduction in demand where there is little, or no, patient value. The removal of unwarranted variation in service provision and unwarranted variation in demand via requesting is an opportunity to reduce the current pressures on pathology services.

    e. **Nationally, we saw a 300% increase in the number of tests ordered per person between 2000-2015.** The table below, recently published in the BMJ shows the continuous increase in laboratory tests ordered.[1]



[1] O'Sullivan et al BMJ 2018;363:k4666 https://www.bmj.com/content/363/bmj.k4666

3. **The complexity of service required in pathology is increasing each year.** Alongside the increase in demand there is also an increase in the amount of work required for each patient referred to pathology. The information from laboratories shows that complexity is rising driven by changes in clinical practice and newer tests that are required in addition to existing tests. There are a number of evidence sources for this that include:

    a. **The demand on Histopathology is growing at a faster rate than the number of patients:** Data obtained from laboratories shows that he number of blocks and slides processed within histopathology are growing faster than the number of requests suggesting a greater amount of complexity per patient due to more biopsies per patient and the introduction of newer tests in addition to existing tests. For example, between 2015/16 and 2017/18 MTW have seen a rise in requests from 66,543 to 67,788, an increase in slides from 320,420 to 358,902 and an increase in ICC slides from 40,568 to 46,590.

    b. **The services are seeing a rise in the test to request ratios in blood sciences over the past 3 years.** For example, MTW has seen an increase in their test to request ratio from 3.8 in 2015/16 to 4.8 in 2017/18. East Kent have also seen a rise in, albeit smaller, of 4.07 to 4.16 across the same period for their test/sample ratio. There has also been an increase in blood cultures in microbiology. For example, MTW has seen an increase in the number of microbiology blood cultures from 14,224 in 2015/16 to 15/982 in 2017/18.

    c. **A difficulty in meeting demand within the current configuration of services.** The turnaround times within Pathology are getting worse with the number of patients being seen within six weeks dropping over the past 2 years. There is a growing pressure on services, particularly histology with the increased times for cancer service diagnosis which will accelerate with the introduction of the 28 day GP referral to diagnosis standard across the NHS when implemented in 2020.

4. **We currently do not have a sustainable approach to our workforce.** An opportunity to improve how we use the skills of our staff across Kent & Medway. The increase in demand for pathology services has not been matched by a proportionate increase in the number of staff across Kent & Medway. For example, between 16/17 and 17/18 there was a total increase of only 2 whole time equivalent (wte) (0.26%). Between 15/16 and 16/17 at MTW and EKHUFT there was an increase of 17 wte (3%).

    a. **Improving the sustainability of our workforce:** A critical part of improving patient care and expediting patient pathways will be linked

to the short, medium and long term staff numbers and skills capabilities of a pathology workforce. A key part of the case for change is to recognise and act on the current and predicted shortages in clinical and scientific staff such that the right staff are in post and ensuring that we attract and retain highly skilled staff at all levels.

b. **Improving skill mix across Pathology sites:** The delivery of Pathology services is currently more expensive due to the mix of skills between sites, the total numbers of staff employed as well as the increasing cost of overtime and temporary staffing. In 2017/18 the agency cost across the services was £1,478,000. To tackle this, and the shortage of certain staff groups, pathology will need to utilise skill mix approaches where health professionals operate in different but complementary roles and activities.

c. In the long term, a need to increase scientific and clinical staff skill sets: The Pathology Service across Kent & Medway will be required to learn new skill sets to take advantage of new technology and digital developments, optimise test requesting by closely supporting clinicians, concentrate key testing in certain sites and increase the ability of the service to undertake testing work currently outside the Kent & Medway region. They will also need to develop business and commercial skills in order to run as a single service.

5. We currently do not make the most of the assets we have available.

a. An opportunity to embrace new technology. The technology available to pathology services is changing which present new opportunities to change clinical practice and improve the efficiency and effectiveness of pathology within the laboratory, presenting new opportunities to improve the impact of pathology within the laboratory and in wider clinical practice. For example, NHS England have considered the provision of molecular testing to understand where patients are not receiving the requisite level of testing. In Kent and Medway there are capacity shortfalls which mean a considerable number of tests are sent outside the county which could be delivered within it at lower cost and faster turnaround times supporting a wide range of clinical conditions.

b. **An opportunity to upgrade our ageing estate.** The current services have a wide range of buildings ranging from modern PFI estate to poor condition NHS estate with a level of backlog maintenance needs and functional content which is not fit for purpose in delivering modern laboratory services. These conditions will need to be addressed in the medium term in the NHS owned estate.

c. **An opportunity to upgrade our ageing IT systems.** The current laboratory information systems (LIMS) are ageing, nearing the end of

their useful life and are in need of replacement and harmonisation. There are Managed Equipment Service (MES) schemes in all laboratories that are in various stages of contract and provide an opportunity to be harmonised to ensure that the technology platforms including LIMS can effectively work together.

Our current pathology service: Where are they located?

- The services employ over 750 staff and operate on a £75m annual income.
- The annual test volumes are approximately (insert figure) tests per annum in 2017/18
- The population covered is 2.2m.
- The county is approximately 3555 sq. km with good radial routes to London but poor roads running north to south in the county. The county is predominantly rural in nature with medium sized towns and a dispersed population.

- **Darent Valley Hospital** at Dartford provided by Dartford and Gravesend NHS Trust operates a hub site for hot and cold work under North Kent Pathology Service (NKPS).

- **Medway Maritime Hospital** at Gillingham provided by NKPS operates as the Essential Service Laboratory (ESL) as well as Andrology and Fetal Medicine Unit screening.

- **Queen Elizabeth Queen Mother** at Margate provided by East Kent Hospitals University NHS Foundation Trust operates a traditional ESL with some blood film work.

- **Kent and Canterbury Hospital** at Canterbury provided by East Kent operates an ESL with some specialised testing and the haemophilia service.

- **William Harvey at Ashford** provided by East Kent provides hot and cold pathology services including full pathology support to the Kent Cancer Centre. East Kent also conduct the majority of immunology work for the region.

- **Maidstone Hospital** provided by Maidstone and Tunbridge Wells NHS Trust (MTW) operates a full hot and cold laboratory with Blood Sciences, Microbiology and Cellular Pathology. In addition, Cellular Pathology provides the Histology and Cytology services for the MFT and D&GT. The regional Kent Cancer Centre is located and serviced by Pathology here.

- **Pembury Hospital** at Tunbridge Wells provided by MTW operates an ESL with average activity in excess of that at Maidstone hospital.

Our approach: Working together as a system

Previously, we have not worked as well together as we might. The failure to implement the Kent Pathology Partnership (KPP) is a good example of where we have, as a system, not been able to find a non-adversarial way through the problems we have faced. We are seeking to learn the lessons from this endeavor. Too often we have relied on contractual solutions when better relationships would have improved our collective ability to deal with the problems outlined above; and is something the pathology community has been, and is keen to, keep improving.

The recent North Kent Pathology Service difficulties have shown us that we need to be realistic about the pace and scale of change that we can deliver. It also shows the crucial need to ensure that core systems are carefully integrated and standardized. This will help to deliver high quality, safe services in areas such as primary care electronic ordering, pre analytics pathway, and having a common integrated information platform. Moreover, it has shown us the need to pace developments whilst creating new organisational forms and the importance of primary care engagement. We set these out in more detail in Appendix 3.

Implementing large-scale change is difficult and it will be challenging to ensure that our programme is a success. However, we have put in place what we believe to be the right building blocks including the strong, visible, collective leadership of our executives and frontline clinical, operational, and finance experts; alongside a credible delivery plan. We have designed a robust structure to drive the work, engaging and involving stakeholders and have recruited a competent team with the range of skills we need to oversee the programme throughout the next period.

Key Principles

In May 2018, the Pathology Steering Group agreed the following key principles for change. These principles are;

- Every Trust should benefit from the creation of the single pathology service. There should be no loss from any partner entering into a single pathology service based on their current financial profit or loss in their individual pathology services. Partners will derive benefits from either cost reduction or profit margins on new income generating work additional to the base entry levels onto the single service in proportion to their total I&E contribution to the service.

- All partners agree that there needs to be investment to secure the reconfiguration of pathology services and this should be based on the best option subject to clear benefits criteria being agreed.

- There should be a direct cost reduction in direct access pathology costs for commissioners in creating the pathology network over the next five years. The Acute Trusts should retain the benefit of the further savings from the

creation of the single service to support their financial positions over the next five years. In return, the Acute Trusts should agree to this in return for five-year minimum commitment from the CCGs to the direct access contracts with the current Trusts.

- There should be an independent external project director appointed to lead the production of the business case on behalf of the partners, supported by a resourced project team comprising of appropriate experts from the Trust partners committing to the principles outlined. A Project Board will oversee the process led by Executives and a CEO from the Kent and Medway system.

With regards to the operating model:

- There should be a single organisation that contracts with commissioners for Kent pathology services. The partnership will operate as a contractual joint venture of the four acute Trusts irrespective of the final legal / contractual form decided.

- There should be a form of contractual joint venture between the acute Trusts based on a model of shared ownership that should determine the share of profit, loss and investment in the contractual joint venture.

- There should be an agnostic view on where direct access pathology and other services should be located, but all major acute emergency centres will require an essential services laboratory. The service location will be determined by the Target Operating Model that offer the best value and meet the key requirements of the Trusts. This will be decided at an option appraisal at the OBC stage of the programme.

- The Target Operating Model outcome will consider as part of the options appraisal process the public/ private partnership potential in all options appraised.

- The service models will be evaluated based on two core requirements - sustainable quality delivery (e.g. turnaround times and transport stability) and financial and regulatory delivery. These will be set out in the detailed evaluation criteria.

With regards to the future:

- The partners commit to delivering a single pathology management structure by 2019 Q1. Any partners who cannot currently commit to these principles will be considered at a later date.

- There will be support in terms of development, facilitation and team working for the pathology leadership community to develop a “Team Kent & Medway

Pathology " – lifelong learning, behaviour, culture and working relationships that the Trusts will support.

- There will be approaches made to other trusts in the South who may wish to participate in the consortium.

The Kent and Medway Pathology Steering Group

The Kent and Medway pathology steering group was established in January 2018 chaired by Lesley Dwyer, Chief Executive of the Medway NHS Foundation Trust. In October 2018 Miles Scott (CEO MTW) took over this role. The group is part of the STP productivity work-stream and meets on a monthly basis. It is accountable to the STP Productivity Board. This work stream is seen as a major part of the STP service and financial plan to ensure a sustainable health and social care system in the STP footprint.

The Steering Group comprises of representatives of the Executive Directors from each Trust, the clinical and laboratory management representatives from each Trust, the Programme Director, members of the Project Team, and the Communications Lead. The membership and terms of reference are contained in Appendix 2.

The Kent and Medway Pathology Network was asked in January 2018 to confirm their commitment to moving to a hub and spoke model. The Network confirmed its commitment to this challenge, stating "We agree with the network and are working towards the options and commercial vehicle for the network. We also recognise that we should also be exploring partnership working and opportunities to work with our neighbouring footprints to derive even greater benefits".

Our ambition: A clinical vision for the future

The goal

The strategic objectives for the single pathology network were agreed by the four Acute NHS Trust CEOs in May 2018 and approved by the Pathology Steering Group in June 2018. The ambition was defined as:

> "The creation of a single pathology service across Kent under a single management to deliver high quality, sustainable pathology services and embrace new technologies and diagnostics requirements of primary and secondary care. It aspires to become a nationally leading pathology service in the areas it concentrates on by 2030 and the best place to learn, work and participate in research. The service will deliver a net £4.8m reduction in its own costs from 2017/18 outside any investment in the service. This will be secured by 2020/21 and will be net of individual trust efficiency requirements for 2018/19 - 2020/21 for the pathology services"

In July 2018 the steering group agreed to five strategic objectives linking back to the major challenges set out in the case for change:

- **Objective 1:** The delivery of a clinically and financially sustainable single pathology service based on a strong, viable service that is clinically led, standardised, innovative and creative.

- **Objective 2:** Delivery of a high quality diagnostic service for patients, hospital and general practitioners that meets their current and future needs.

- **Objective 3:** Creating a workforce that feels valued, involved and owns the single pathology service as partners in the service; and it's a great place to work.

- **Objective 4:** Transforming service models in the pathology service in Kent and Medway to deliver technological change, increased efficiency and meaningful roles for staff that maximises their potential, and meets the needs of the client Trusts and Commissioners.

- **Objective 5:** Managing the transition to the new service in a creative and competent manner.

The Trusts set out the key requirements for the service to be created that provide a clear set of deliverables for the single service around quality, workforce and financial parameters contained in Appendix 4.

A clinical vision for the future

The clinical vision for the single pathology service in Kent and Medway has been developed following discussions with the senior pathology leadership in the county and a successful workshop involving the senior pathology leadership team, departmental heads across the four acute Trusts along with accredited trade union representatives in pathology, and the project team.

The clinical vision we have built seeks to reflect the needs of the service, the needs of referring clinicians in primary and secondary care and the needs to the Trusts centered on the goal the Trusts set for the service in its entirety. The clinical vision is:-

" We will create a single pathology service across Kent and Medway which delivers high quality, modern diagnostics services to secondary and primary care, which are affordable to Trusts and commissioners and are delivered in a single pathology organisation where the best people wish to learn, work and research.

Our services will need to anticipate and respond to the needs of our clinical referrers, the development of new ways of working and the significant technological change over the next decade in the range of new and existing diagnostic testing opportunities.

We will become a service that seeks to understand, provide and support our clinical referrers. We will achieve this by developing a service focused on their needs to answer the clinical questions they need resolving for patients with relevant, appropriate and timely diagnostics services. These diagnostic services will be designed to support the patient more effectively through to collecting and testing the sample to the production of the report for decision taking.

This will mean we will seek to operate services to support this clinical goal by redesigning our pre-analytics pathways, analytics and post analytic support for the clinicians who use the service. It will also mean we will need to develop new services locally in the county which provide increased capacity and capability in areas such as molecular testing, genomics, toxicology and other areas.

We will develop a standardised range of access to pathology tests across the county so all patients have access to the latest and best diagnostic support, increasing the delivery of phlebotomy services in primary and secondary care, having a dedicated and modernized logistics, a common information system across all laboratories, a focus on paperless processes for ordering and results and more modern diagnostics platforms that are common across the laboratories.

We will develop new arrangements with our primary care partners to provide more local responsive diagnostic services using current and new approaches to ensure timely, relevant and appropriate diagnostic services. We will work with them on improving their use of the services and assisting in managing the use of the service

so they maximise efficiency and effectiveness. This will mean the creation of better relationships, improved teamwork and a focus on supporting the increased capacity and capability of primary care to manage patients closer to their homes in the new service models they and commissioners are creating.

With our secondary partners we will ensure closer support to the specialties accessing pathology to enable better use of the current services offered, the improved clinical effectiveness of the service, and the development of new diagnostic tests which will help improve the clinical and cost effectiveness of the patient pathways.

We will use current and new technologies to ensure we are providing diagnostic services that the county needs, and improve our workforce sustainability and productivity in areas such as digital histopathology, point of care testing in local settings outside hospital and common, paperless order communications across primary and secondary care. There will be a common information architecture across the laboratories to support inter connectivity and interoperability of the services based on investment in a new LIMS and MES harmonisation.

To secure these changes we will create a single contractual joint venture[2] for pathology owned by the four Trusts and operated by a dedicated management team where our pathology staff will work. The single service will deliver its obligations to its partners through a series of contractual relationships to ensure that the needs of each are secured.

The staff will be seen as partners in the service and we wish the single service to be a great place to learn, work and research. This will be secured by the organisation having a clear set of values and behaviours with a focus on training and educating the current and future workforce. We will establish advancing and changing roles that staff undertake to deliver the service in more innovative and creative ways, developing strong scientific, clinical and operational career pathways in the service to attract and retain staff. We will also develop our non-registered workforce so that everyone maximises their potential and we achieve an excellent staff experience.

To secure the vision for the service the workshop defined a range of key requirements that will be addressed in the OBC:-

- improving the use of technology platforms to improve diagnostic testing and the delivery of the service which focuses on digital pathology, more local testing in secondary and primary care, developing our capacity and capability in new diagnostic disciplines or areas e.g. genomics, proteomics, molecular sequencing as well as innovations in the pre analytics pathways such as RFID.

[2]There are a number of ways of doing this which will be explored during the OBC before a recommended solution is proposed to the four Acute Trust Boards for approval

- the development of a more proactive customer relationships across primary and secondary care focused on patient outcomes, care pathways and better decision support for clinicians. The emerging themes, that will be explored in the OBC, will be: the clinical and cost effectiveness agenda with referrers, the need for a reliable customer care centre to support user queries, and the development of the clinical informatics function to better establish the effectiveness of diagnostics being requested.

- the challenges and opportunities for the new single service that will focus on the need to develop common information and technology platforms, standardising testing catalogues across the county, developing a robust research infrastructure with the medical school and centralisation of specialisation in the single service.

- the development of the workforce by creating a strong scientific and non-registered career structure distinct from the operations management of the service. The creation of harmonised terms and conditions and grades for work delivered, as well as creating the potential for better remuneration and terms and conditions. There is also a fundamental requirement to ensure the training and development of staff to deliver new roles and improve their abilities in the current roles can be met. Finally, a need to focus on improving recruitment and retention.

- the organisation of the service including the need to develop better communication systems with users to understand their need, better customer support, the need to consider the merits of a more centralised mortuary provision and histopathology service; as well as increasing the control that pathology has on POCT, logistics and phlebotomy.

Our long list strategic options

Over the past nine months, the Pathology steering group has overseen the development of a set of options and evaluation criteria, and sought involvement and agreement from the clinical and scientific community in Kent & Medway.

In May 2018 a long list set of options was presented to the Pathology Steering Group:

- **Option 1: do nothing**
- **Option 2: integration of single management and technology platforms with current 3 hubs and 4 ESLs**
- **Option 3: single hub with 6 ESLs**
- **Option 4: dual hub with 5 ESLs**
- **Option 5: Centralisation by service line with 3ESLs**
- **Option 6: Strategic Partner with one hub and 6 ESLs**
- **Option 7: outsource provision with single hub and 6 ESLs**

The Steering Group agreed that at the SOC stage the following would be consistently applied across all options:

- The scope of services remains as at present, including the location of emergency laboratory sites based on the clinical service disposition and the current three pathology services portfolio.
- The histopathology configurations will remain at the current sites, except for molecular pathology and other specialised testing and non-cellular pathology. During the OBC we will test whether this would be located in the hub options at one site.
- The number of ESLs will vary based on the number of hubs considered.
- That we would not identify named sites in the formulation of the long list of options because the work was considering high-level configurations. This will be undertaken at the OBC following a thorough examination of the financial and non-financial benefits of the options.
- A requirement for changes to MES, integration of LIMs and implementation of a single management structure to occur, regardless of the configuration of services or commercial options chosen.

We set out more detailed information in Appendix 5 and 6.

Hurdle Criteria & Evaluation Approach

The hurdle criteria set out below were then applied to the original long list of seven options. Using advice from the South of England diagnostics lead the steering group approved discounting two options:

- Option 1 due to the group deciding to pursue a single LIMS and MES regardless of configuration or delivery choices; and

- Option 5 due to it not being deliverable or financially viable.

It also led to renaming Option 2 to "three hubs" as the integration of single management and technology platforms will occur concurrently with the development of an OBC and FBC.

In Appendix 7 we set out the basis for the decision in more detail to demonstrate the consistent use of the evaluation criteria and the requirement of any options in a SOC approved by the STP to meet its own hurdle criteria.

	Criteria	Sub-criteria
1	**Quality of care for all**	• Clinical effectiveness and responsiveness
2	**Access to care**	• Ability to meet Turnaround times
3	**Workforce**	• Scale of impact • Sustainability
4	**Ability to deliver**	• Expected time to deliver • Trust ability to deliver
5	**Affordability and value for money**	• Delivery of financial savings

In September, the Programme Steering Group approved the simplification of the options by agreeing three options for the configuration of services, and three commercial delivery options. The criteria that these will be evaluated against are set out in Appendix 8.

Our refined strategic options for configuring pathology services

There are three agreed configurations of pathology services across Kent & Medway. These have been discussed and refined from the original list provided in May 2018 and will be considered in more detail at the OBC stage. The options are as follows;

1) **The three-hub option with 4 ESLs -** The Trusts will continue to provide pathology services from the three existing hubs and ESLs. A single pathology organisation with a single management would be created with a new single LIMS, a new logistics service and a single MES supplier. The trusts would maintain the current service provision and there would be initiatives to re-engineer current operational processes so these are standardized; including harmonisation of workforce skill mix and grades and staffing levels.

2) **The dual hub option with 5 ESLs -** There would be the creation of two sites for the provision of direct access work and non-urgent work form secondary care. The non-cellular pathology and microbiology would be located in one of the hubs, or either service would be located in the hubs. There would be a new single LIMS, a new logistics service and a single MES supplier. The service would be delivered through a single organisation and there would be initiatives to re-engineer current operational processes so these are standardised including harmonisation of workforce skill mix and grades and staffing levels.

3) **The single hub option with 6 ESLs -** There would be single hub for the direct access and non-urgent hospital work that would service the whole of Kent and Medway. There would be a new single LIMS, a new logistics service and a single MES supplier. The service would be delivered through a single organisation and there would be initiatives to re-engineer current operational processes so these are standardised including harmonisation of workforce skill mix and grades and staffing levels.

Strategic Options for delivery models

There are three delivery methods to provide the pathology services. These have been discussed and refined from the original list provided in May 2018, and will be considered in more detail at the OBC stage. The design of the future commercial model for the network will be complex, and will require specialist advice to consider all commercial, contracting and tax elements associated with the delivery options. The options are as follows;

4) **Internal provider** – The current pathology providers will become a single service operating as a contractual joint venture on behalf of the Trusts. This will be based on either a 1, 2 or 3-hub model.

5) **Strategic Partnerships** – a private provider bringing commercial expertise into a contractual joint venture to help with potential service expansion, consolidation or redesign. The speed at which the provider could mobilise may mean that the achievement of efficiencies may be realised earlier. Again, delivery will be via the 1, 2, or 3 Hub model.

6) **Outsourcing** – this would entail the whole of the single network being outsourced under a full tendered procurement process. This delivery method would center on a hub and spoke model, but external outsource providers may suggest alternative delivery models.

At the commercial stage Kent and Medway and potential service providers will need to acknowledge the plans of bordering pathology networks, particularly with regards to their pathology delivery model, in order to ensure that there is not the risk of a duplication of service model operating in proximity.

Our Implementation plan

The development of the single service ensilages the following sequence of changes for the trusts and commissioners over the next five years.

2019 Implementation plan

Jan- Feb	March- April	May-June	Jul-Aug	Sep-Oct	Nov-Dec
Deliver SOC approval January 2019 through all boards and NHSI. Secure the cost improvement plans for pathology in the existing trust CIPs. Complete review of £3.8m outsourced tests and approve the repatriation of work into Kent & Medway	Deliver review of unwarranted variation in numbers and grades of staff across the single service & implement changes in 2019 Commence the clinical effectiveness work-stream and define core prices Review procurement of non pay expenditure Procurement of tests sent outside of county commences (£1.6m)	Scope the future organisation the pre-analytics pathway and the technological innovations confirm the total resource for the trusts and agree plan. Implement clinical effectiveness plan.	OBC approval through Trust Board Review of grade compliance implemented Deliver a plan for the use of advanced scientific roles to reduce vacancies and cost in clinical staff and improve capability	OBC approval with NHSI. Create single management Commence procurement of the new LIMS Workforce grade and volumes harmonised across the single service and lowest cost per test implemented	FBC approval NHSI Develop Digital Pathology for Histology, Haematology and Microbiology Commence procurement of MES December 2019as Creation of single organization

2020 onwards Implementation plan

2020	2021	2022	2023	2024
Planning for LIMS implementation Planning for MES Implement clinical effectiveness plan Workforce development Hub development (subject to OBC)	Hub development Logistics implemented LIMS system and order comms to go live in Q1 MES contract award September and implementation from Q4 2020/21 Implement clinical effectiveness plan	dHub development (subject to OBC) Implement improvement schemes Implementation of MES completed Implementation of clinical effectiveness plan	Hub development (subject to OBC) Implement improvement schemes Implementation of MES Implement clinical effectiveness plan	Implement improvement schemes Implement clinical effectiveness plan Hub development (subject to OBC)

What these changes mean

For staff

One of the five fundamental challenges facing all pathology services in Kent and Medway is ensuring that we have the right number of staff with the right skills and capabilities required to meet new service models.

In our case for change we set out a summary of the challenges that we face but in addition to these there are a number of more specific issues facing the current service making our current staffing models unsustainable in the short, medium and long term including;

- An ageing workforce profile. The current services have a third of staff over 50 years of age (266 staff) (28%) over 50 years of age and at least 84 over 55 so there is a risk of retirement over the next few years.
- A lack of suitably skilled BMS staff in certain areas and disciplines to deliver the current service. This is evidenced by the use of overtime, agency and bank staff as well as the vacant posts in the establishments. Current vacancies across the services are 79 and the detail of vacancies by staff group and pay band can be seen in Appendix 9. In addition this is compounded by the proximity to the large market for skilled staff in the London heath economy and good transport links to the capital.
- The variation in the current terms and conditions of staff and the remuneration for certain skilled roles. For example, there are different local agreements for on-call, recruitment premium for hard to attract staff and retention premia.
- The variation in the level of staff profiles between the laboratories and their bandings. This can be seen in the workforce data Appendix 9. For example, different proportion of band 2 and band 3 clinical staff; different categorization across organizations for healthcare scientists.
- The difficulties in recruiting and retaining staff in certain high cost locations or in rural areas in the county (see vacancy and agency/bank data in Appendix 9).
- The increase in time and skills needed to deliver increasingly complex tests. This is being driven by rapidly evolving technology in pathology an increase in the clinical demands from secondary and primary care.
- The current staffing profile is contained in the table below for the services across Kent and Medway.

Workforce Development

The development of the workforce will be fundamental to ensure the best people working, learning and training in the single service. In order to support this there will be a focus on the following over the next 24 months;

- Developing the values of the new service, clearly setting out the leadership style and culture whilst investing in the support to make this happen.
- We have already developed an outline for the proposed management arrangements for the new service and this will further be refined once we have established in the OBD the preferred method of delivering the service.
- Creating the single management team in the OBC stage during 2019 and implementing the new single service following FBC approval.
- Launching recruitment drives to help attract and retain the best people we can.
- Commitments to improving the staff experience from current levels recorded in the staff survey and also improving patient experience.
- The development of a comprehensive workforce plan based on the preferred delivery and commercial model working with our staff, our leaders and the accredited representatives in pathology.
- Lessons learnt from workforce plans in previous local services, other UK networks and international models will be referenced.

Training and Development

The single service will need to include NHS scientific and specialist scientific or medical training programmes. These programmes are essential to develop high calibre scientists and medical staff who can progress to consultant grade clinical scientists or medical consultants. The creation of the new Kent and Medway medical school and the recent changes to the postgraduate training arrangements provide an opportunity to better develop our offer to staff to attract and retain high calibre staff. In 2017/18, the services had over 60 trainees.

We will develop an in-house education and training offer to complement that provided by education partners. We will focus on increasing skill-sets to enable multi-skilled and advanced working. The clinicians and scientific staff have an increasingly important role in educating others, particularly around point of care testing and new testing technologies. We will develop in greater detail in the OBC our approach to training and development.

Key assumptions

The following workforce assumptions have been agreed by the Pathology Steering group;

- Modeling of the consultant medical workforce will be excluded from consideration until the OBC.
- Trainees from the deanery will be excluded from the business case process.
- Modeling of the mortuary, Point of Care Testing and phlebotomy workforces will be excluded until the OBC as these teams will be required at each Trust acute site regardless of the configuration of services.
- All baseline figures outlined in appendix 10 are WTE and all models include out of hours pay.
- All bands are based on role descriptions aligned to national Agenda for Change profiles
- During the business case period all HR policies for each of the Trusts will remain in place as business as usual whilst working to a common set of change principles

We set out in Appendix 10 the baseline data for total pay costs using the NHSI return in 2017/18 (aside for DGT & Medway which is from 2016/17).

Next Steps

Over the coming month, upon approval of the SOC, we will establish a workforce sub group that will be focusing on the following areas in the OBC;

- The harmonisation of terms and conditions across the pathology laboratories so that single service is working together with each other rather than trusts potentially competing for staff with each other.
- Reducing unwarranted variation in out of hour's agreements, overtime and recruitment premiums.
- Standardising laboratory profiles across specific bands where possible.
- Exploring the differences between bands to ensure consistency across laboratories as to the expectations of a given band.
- Examine and deciding on the best options for the single service to develop local teams to deliver essential roles in the future e.g. development of advanced roles in clinical or biomedical scientist reporting e.g. histology.
- Developing a short and medium term recruitment, training and retention strategy which considers the age profile and the future workforce needed over the next five years to meet demand and the goal the trusts have set for the efficiency in the service.

- Considering the workforce needs to repatriate the out of county testing.
- Considering the service levels provided in and outside core hours Monday to Friday and at weekends to understand the impact of any change to these and the plans to harmonise these across the network where necessary.
- Developing plans for organizational change and development involving union and staff representatives and using lessons learnt in previous local changes, other UK networks and international models.

These will be undertaken by February 2019 and we will use specific expertise externally to support the project team. We will establish the staffing changes pre and post any implementation options selected at the OBC stage. We will also assess the impact of the technological investment and changes that the LIMS, MES and logistics models have on staffing.

For clinical quality and effectiveness

At the heart of our case for change is the clinical effectiveness agenda. There is widespread international evidence that the effectiveness agenda improves efficiency, clinical effectiveness, and reduces patient harm.

The single service will develop a common standardised approach to assessing the performance and effectiveness of pre-analytical, analytical and post analytical phases of pathology interventions in care pathways.

We will consider the internal laboratory effectiveness and the wider clinical care pathways involving diagnostic testing. By doing this we will look to improve the scope, volume and type of diagnostics tests provided to secondary and primary care. In the short and medium term we can deliver significant value through changing interventions in care pathways. For example, the development of Faecal Immunochemical Test (FIT) testing in pathology will potentially have up to a 40% reduction in screening endoscopic interventions for colo-rectal screening. By doing this we will reduce unnecessary patient harm and risk and release capacity for the trusts in Kent and Medway to deliver the national cancer waiting time standards.

To develop this we will create a clinical effectiveness group, led by a clinical director, who will develop clinical pathways alongside the relevant clinical groups across Kent and Medway. We will prioritise work streams for focus with the STP clinical leadership so the needs of primary and secondary care are catered for. The group will have managerial support and representatives from secondary and primary care localities at a clinical level.

It is envisaged the clinical and scientific advisors will design the test specifications for the clinical group to consider, monitor deviations from it, and take corrective actions with the appropriate clinical groups or localities where this is required to ensure standardisation.

An annual programme of work will be developed with Trusts and clinical representatives in primary care. This will ensure any changes to clinical pathways are approved by suitable governance forums across the STP. The OBC will explore the future governance structures, organisation and delivery of this concept and develop a 1-3 year plan.

For our financial situation

A detailed data collection exercise has been completed that we have set out in Appendix 10. This sets out the cost for pathology services across the four trusts in 2017/18 as well as at a system level over the previous four years. NHSI analysis suggests the Kent and Medway trusts will need to reduce the costs in the system by £4.8m.

The providers have delivered cost improvement savings since 2015/16 through a combination of workforce/ skill mix, contract renegotiation and managed service contracts. The delivery of the efficiency levels required by the trusts will require a radically different approach to developing and implementing savings so far to date.

The approach to developing transformational savings in the future will be based on

- Reducing unwarranted variation in existing skill mix
- Reducing the cost per test in the county for providers to the lowest current level
- Developing advanced scientific roles to expand roles available, fill current recruitment gaps saving agency costs and reduce the relative cost of Consultant staffing
- Increasing the delivery of in-house testing by reducing the reliance on out of county testing
- Harmonisation of the managed equipment services to one supplier
- Reducing unwarranted variation in the demand for testing through standard test repertoires, pathway change and information and support to clinical staff
- Developing a common LIMs system to allow interoperability and interconnection of the laboratories.
- Reviewing and modernising the pre analytics pathway through a dedicated single logistics service, improved use of technology and the consideration of the use of centrifuging samples and storage for direct access
- The concentration of high volume low complexity testing in fewer sites for hospital and primary care work
- The concentration of certain specialties on fewer site set microbiology and specialised low volume, high complexity testing
- The use of technology to improve productivity e.g. Digital pathology
- The development of new laboratory diagnostics to reduce the cost of the patient
- The development of a single pathology management structure

We will set out in the OBC more detail regarding each of the areas above, an approach that is currently supported by NHSI. We believe that the clinical effectiveness agenda, the harmonisation of the equipment and information architecture, the repatriation of out of county testing and the

skill mix and workforce re-balancing will deliver the overall efficiency ask from NHSI after investment in these areas based on the national and local evidence.

The investment required will be around £3.2 - £4 m for a new LIMS system (approximately a cost of £150k pa capital charge) and interoperability and interconnectivity with order communications and trust EPR systems and the combination of the above will generate savings of around £4.5 - 5m before the cost of the LIMS. These savings whilst substantial will be delivered over at least a three-year period between 2019 and 2021.

They will be insufficient to deliver the goal the trusts have set without consideration of a more radical approach to service configuration and commercial forms which will be explored in the OBC. Market intelligence suggests, for example, that strategic partners can offer savings levels considerably in excess of the current NHSI median benchmarks. Moreover, the do minimum at this stage will address certain sustainability issues but not all issues. Hence, there is a need to consider the various delivery and commercial options in the OBC stage.

In the OBC we will establish whether the reconfiguration of service will deliver a clear improvement in value for money, clinical quality and workforce sustainability to provide credible returns on investment.

The benefits of these changes will be shared in accordance with the principles agreed between the trusts to ensure we deliver savings at a Kent and Medway level. This will ensure no Trust suffers financial loss with any change arising from the SOC. These principles are set out in Appendix 11.

Investment

The relative capital costs of the options considered in the SOC will be an important criterion in the assessment of the options. The current assumption from a capital perspective is that the investment in technology linking providers and the harmonisation of the equipment platforms, with the measures to look at unwarranted variation and outsourced work, will present a cost effective option. The investment in the new information systems is £3.2- £4m for the LIMS and interoperability / interconnectivity with trust EPR systems and order communications. The MES investments are resourced through managed equipment scheme and the national evidence that these are reducing in value for new contracts over a given time period based on the purchasing power of the national pathology networks linked to critical mass.

The cost of delivering hub options which result in fewer hubs will be considerable, and will vary based on the sites chosen; particularly around the operational solution and the use of either PFI or non-PFI estate. These will be substantial capital investments in excess of £10m minimum and will need to demonstrate considerable rate of return on this investment to justify the investment for

the Trusts. These investments may be delivered through the Trusts, which is unlikely; or through strategic partners or outsourcing provision.

The OBC will explore the investments required for logistics solutions, POCT, phlebotomy; and new service developments and solutions such as digital pathology.

However, the OBC will explore the added value of further consolidation of services along with the commercial options explored; which could result in significantly more benefits for the trusts. The scarcity of capital investment available to the trusts is recognised unless there is an external source of finance.

For our IT systems

The single service needs a new LIMS replacement to improve interconnectivity and interoperability. This is key to ensure improvements in sustainability, a reduction in variation and supporting workforce changes. There are currently two different Laboratory Management Systems (LIMS) in operation across the different sites. The North Kent Pathology Service and Maidstone and Tunbridge Wells Trusts use the Telepath system and East Kent University Hospitals use Apex, both of which are over 15 - 20 years old and rely on the same maintenance supplier, DXC.

The essential elements of a pathology information system are:-

- Guiding clinicians for the appropriate use of tests
- Recording tests ordered by GPs and secondary care clinicians and their patient details
- Interfacing with the analytical equipment and third party systems
- Undertaking data analysis and supporting the access interpretation of results for primary and secondary care clinicians
- Supporting business continuity and contingency plans
- Providing management information
- Managing access to information across multiple organisations and geographies
- Storing data and supporting POCT connectivity and Telemedicine

Currently, the IT systems we use in Pathology are old, with some being over 25 years, and all are in need of replacement. The recent cyber attack on the NHS in 2017 left NHS services reliant on paper slowing down process or cancelling tests altogether. There are a number of specific issues facing Pathology with the current LIMs systems, including;

- **Poor Architecture:** Three electronic systems are currently used across laboratory services. The lack of integration results in limited data sharing, leading to duplication of data entry and the potential for inconsistent data capture and/or transcription errors.

- **Unavailability of Data:** Limited data availability to support medical audit, research, clinical risk management, outcome evaluation FOI requests, service evaluation, planning and delivery.

- **Inefficiency:** Information available at the point of care needs to be gathered from multiple sources. These inefficient processes and data availability reduce the time available for request and sample processing and management and increase costs.

- **Poor Value for Money**: All the above results in an increasing cost of ownership, through inefficiency and duplication of effort.

- **Patient Safety:** Incomplete and/or unavailable information at the point of care has an adverse impact on Clinical Decision Support (CDS) and patient safety.

The age of our systems allows the Trusts an opportunity to work closely together to procure an integrated system, helping to improve sustainability, reduce variation, support workforce change, generate common operating platforms and improve standardisation. Throughout the past nine months it has become clear that regardless of the option selected at OBC a single, interoperable LIMs is a priority for Kent & Medway and will be pursued as a priority.

The OBC will establish the best way forward to create a common LIMS by examining a straight replacement with a single supplier and the standardisation of order communications across primary and secondary care; against a middleware option of integrating the current two systems in a relational database and software solution.

Although the capital investment for a single LIMS solution will be substantial (£3.2-£4m); many of the single service benefits, financially and clinically, are enabled by an integrated LIMs. Different options will be explored during the creation of a specific business case, such as future rounds of STP capital funding.

The three laboratory organisations have a number of MES contracts in place with a number of core suppliers. There are widespread MES agreements in place but the principle ones in blood sciences are - The North Kent Pathology service use Beckman Coulter; Maidstone and Tunbridge Wells use Roche Diagnostics; and East Kent use Abbot Diagnostics.

The contract duration of these MES contracts vary; but the majority of contracts are up for renewal in 2021. This provides a significant opportunity to replace the contracts with a harmonised single supplier, develop the technology platforms across the single service to gain standardisation in certain areas, and make effective use of equipment and plan for better service resilience.

The impact of harmonisation on existing costs will be substantial; as the combination of the single supplier and the access to leading edge technology that reduces pre- analytics and analytics workforce costs will result in very significant savings. This has been tested in preliminary discussions with industry and engagement with other NHS organisations.

We will engage with the industry suppliers in more detail at the OBC stage to establish how they can best meet our needs and the preferred delivery option; and the innovation they can bring along with reducing our current cost of the three main MES suppliers.

For our estates

The creation of ESLs on sites currently providing a full range of urgent and non-urgent pathology testing will release some estates capacity, regardless of the option chosen. This will be defined in detail at the OBC stage as it is currently unknown whether the delivery method or service provider will convert this space or not. Each site will be assessed at the next stage of the plan, and the relative financial implications will be clarified; but there is potential for a reduction in costs for rates, utility charges, water rates and other estates expenditure if significant floor spaces are impacted.

Appendix 12 sets out a detailed list of estates assumptions for the SOC.

For our logistics

It is recognised that the road infrastructure in Kenton Medway is challenging, due to rural locations and due to the demand for road services with proximity to the Channel. Part of the commercial case at the OBC will include market testing to see what other logistic methods could provide efficiencies and innovation to redesigned transport networks. It is possible that the providers who wish to provide a single network can provide bespoke logistic solutions.

It should be considered that in a new single pathology network there may be more opportunity to explore methods of using more widespread centrifuging of samples in primary care to ensure assurance of integrity; even if redesigned logistics improve sample collection times. New findings from Nesta's Flying High programme indicate that drone deliveries could become a reality for NHS hospitals in London; but further testing is needed before the technology can be used.

We are conscious that there are cases where consolidation of logistics has increased cost. The implications of this have not been fully considered in this SOC; but during the development of the OBC and FBC we will set out the logistics costs to deliver each option.

Our next Steps

On submission and approval of this document by NHSI and the relevant Trust Board's; the project team will work towards delivering a completed OBC by July 2019. The work needed to deliver this broadly fits in two stages:

Firstly, by March 2019 we will have costed and evaluated each service configuration model and will seek to reach a preferred solution for the arrangement of Hubs and ESLs across Kent & Medway.

In order to do this over the next three months the Pathology community will;

- Establish sub groups for key areas such as workforce, IT, clinical effectiveness and logistics & operations broadening membership to more actively include GP and CCG colleagues.
- Develop the single management structure and seek approval from Trust Boards.
- Develop detailed workforce and financial assumptions for each of the options listed in the SOC for configuring services based on 1,2 or 3 hubs.
- Develop a business case for LIMS investment.
- Evaluate the 1,2 or 3 hub models against the set of criteria set out in the appendix.
- Continue with the delivery of transformation objectives set out in the implementation plan.

Secondly, between April and July we will explore the commercial options available ensuring that we propose a preferred final option written up in a completed OBC by July 2019 for approval by NHSI and the Trust Boards.

In order to do this the Pathology community will;

- Ensure agreement has been reached on the preferred configuration of services
- Outline a clear service specification based on the preferred configuration
- Seek potential solutions from strategic partners or outsource opportunities
- Form a recommendation, write the OBC and seek approval from each Trust Board before submitting a formal OBC to NHSI for approval

Resources required for OBC & FBC

Resource	Details	Cost
Programme Director	Two days per week	£54k
STP Productivity lead	One day per week 8C	£0
Workforce lead	Three days per week 8d	£37k
Finance lead	Two days per week 8d	£25k
Darzi Fellow	Full time, 8a	£32k
Secretarial support		£25k
Specialist advisors (e.g. procurements)	Band 8a	£24k
Workforce support		£25k
Total		**£225k**

The proposed project costs to deliver the OBC phase is a total of £225k (£56k per organisation) that is comparable to other pathology networks OBC costs in England. The funding of this will need to come from the four Trusts and this is proposed to be on a straight 25% each share of this sum.

Our Risks & Barriers

The project steering group is aware of the material strategic, clinical and financial risks that must be mitigated in order to secure the vision. These will evolve as the project progresses but he most critical risks at this stage are:-

- All partners do not support and resource the work needed to take forward the vision and the contents of the SOC.
- We do not secure wider stakeholder engagement in this complex change

The current specific risks are listed below together with a high level summary of current mitigations

Risk	Likelihood	Impact	RAG	Mitigation
The savings from the remodeled pathology service do not align to trust and NHSI expectations leading to a rejection of the plan	Low	High	Green	OBC and FBC will identify the direct and indirect benefits and savings from the single service. Trust have agreed this in their goal
Trusts and /or CCGs reject the SOC as to does not see their expectations	Low	High	Green	Trust have committed to key goal and principles and requirements of SOC, engagement of stakeholders throughout OBC / FBC process and key issue addressed as they arise
The resources to secure the OBC are not approved	Medium	High	Red	Secure the support of Trust boards and STP before board meetings
There is insufficient management and clinical capacity to support the delivery of the plans	Medium	High	Amber	Resource plan in SOC approved, prioritise the input of clinical and managerial staff and project team. Involve the departmental teams more across the county
There is insufficient interconnectivity across the county to support the integration of services, standardisation and the consolidation of testing in county and out of area	Medium	High	Amber	Progress the common LIMS development; and interoperability of the IT systems and interfaces across primary and secondary care

The recruitment and retention of staff deteriorates, impacting on the service capacity and capability to deliver the change	Medium	Medium	Amber	Develop an effective recruitment and retention strategy for pathology, identify and implement the skill mix and technological solutions to maintain or improve service delivery, involve staff in the development and creation of the new service
The delivery of current CIP plans are disrupted by the focus on creating the new service across pathology	Medium	Medium	Amber	Concentrate effort on the short to medium term wins in the SOC and resource the schemes
The impact on quality as the integration occurs	High	High	Red	Ensure robust transitional plan is in place for creating the new service, implement changes in a timely and scalable manner, maintain laboratory accreditation
The clinical time for the effectiveness agenda and the commitment is lacking	Medium	Medium	Amber	Ensure the resource is available for the work programme, engage stakeholders and increase participation from primary and secondary care
The potential failure of current pathology partnerships in Kent and Medway	High	Medium	Amber	Ensure issues are addressed they arise, develop a clear contingency plan and look to share management expertise to resolve issues

Appendix 1 & 2: Response to NHSI & Governance Structure

Dear Dr Marlow and Professor Evans,

Subject:
Kent Pathology Steering Group response to "Establishing and implementing 29 Pathology Networks across England" (dated 7 September 2017)

Thank you for your letter "Establishing and implementing 29 Pathology Networks across England", 7 September 2017. This letter represents a joint response on behalf of the Kent Pathology Steering Group, which brings together the 4 acute providers across Kent. It is a supplement to the CEO letters returned by each Trust at the end of October 2017.

In line with your requirements, we outline below:

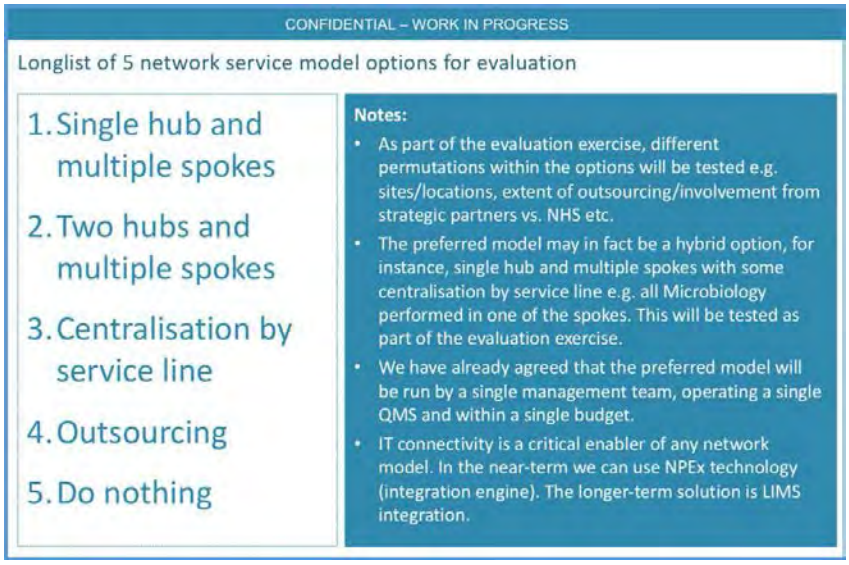
1. An emerging long-list of South 8 network options for evaluation
2. Our signed-off Kent Pathology Steering Group Terms of Reference (see appendix) and governance structure
3. Our workplan and priorities
4. What we will require from NHS Improvement as we progress towards our future service model

1. Pathology network options

The South 8 network proposed by NHS Improvement is in line with the co-terminus network of four acute providers working together as part of the STP. We agree with the network and are working towards the options and commercial vehicle for the network. We also recognise that we should also be exploring partnership working and opportunities to work with our neighbouring footprints to derive even greater benefits (e.g. SEL, East Sussex).

Since our last communication with you, the Kent Pathology Steering Group has now held further meetings to explore a range of network model options. The agreed long-list for evaluation is shown in Exhibit 1.

Exhibit 1 – Network model options

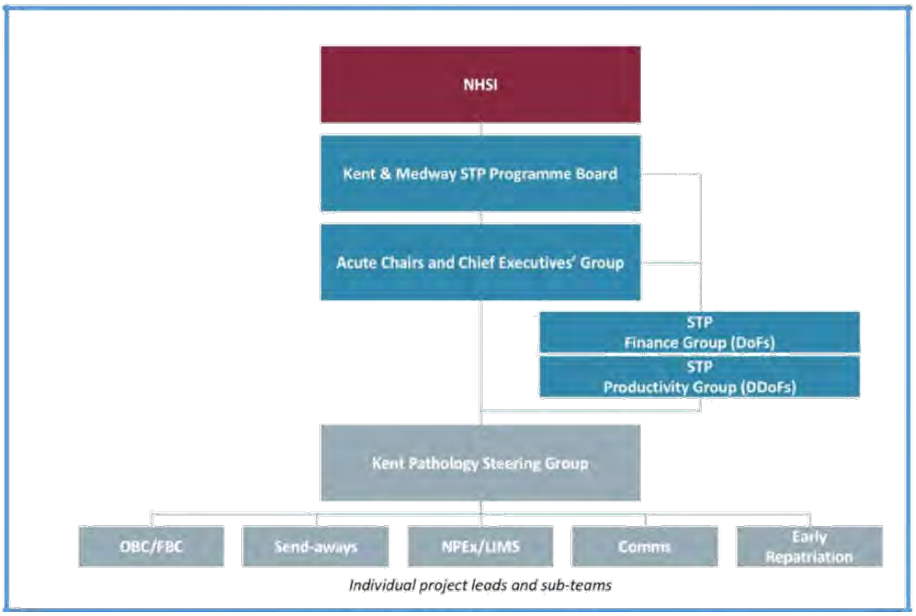


The Kent Pathology Steering Group will now move to develop evaluation criteria for appraising the network options. In the coming 2 months, the Kent Pathology Steering Group will hold a series of workshops to develop and apply these criteria to narrow down the options for detailed evaluation and financial modelling.

2. Terms of Reference and Governance Structure

The Kent Pathology Steering Group has now signed-off its agreed Terms of Reference (see appendix) and a revised governance structure to support the work. The Kent Pathology Steering Group will report to the Acute Chairs and Chief Executives' Group. The governance structure is shown below in Exhibit 2.

Exhibit 2 – Governance Structure

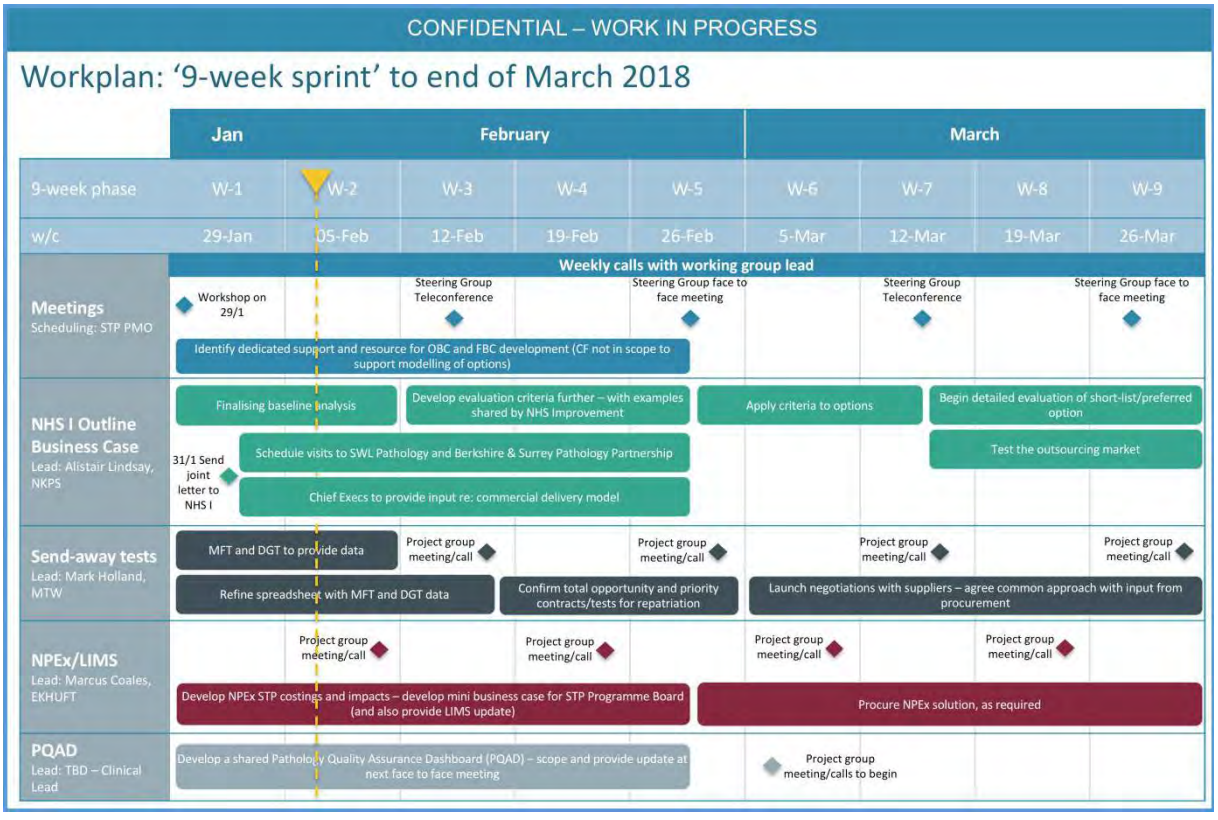


3. Workplan and priorities

The Kent Pathology Steering Group is working towards an ambitious timeline to develop the Outline Business Case document throughout the next 2 months. The workplan for February to March 2018 is shown below in Exhibit 3.

During the CEO-led workshop on 29 January 2018, the Kent Pathology Steering Group agreed to undertake a 9-week 'sprint' to ensure we have focus and pace.

Exhibit 3 – Workplan



Priorities for the Kent Pathology Steering Group during this 'sprint' include:

1. Identify dedicated programme management and analytical resource to support development of business cases
2. Visit NHS services operating a networked model already to understand their lessons learned and ambition for the future (e.g. Frimley and SWL Pathology)
3. Hold workshops to finalise and apply evaluation criteria to reach a shorter list of model options
4. Finalise high level baseline activity, cost and contract information for market testing
5. Agree, with Chief Executive input, the commercial vehicle required to deliver the preferred model option
6. Develop an OBC document and seek sign-off from Trust Boards for submission to STP Programme Board and NHS Improvement

4. Support needed from NHS Improvement

The Kent Pathology Steering Group will ensure regular and proactive communication with NHS Improvement. We have been in contact with Professor Evans, and Ewan Cameron is a member of the Kent Pathology Steering Group.

We have identified three areas where NHS Improvement can provide further support:

1. Identifying available resource to support the development of business cases
2. Sharing of documents, such as Outline Business Cases and evaluation criteria developed in other networks, to eliminate duplicated work
3. Progress updates from different networks as they reach key milestones, to allow us to reach out to those more advanced networks

We hope that this letter satisfies your requirements and provides the necessary assurances that we are developing proposals at the required pace.

If you have any queries, please do not hesitate to get in touch.

KENT PATHOLOGY STEERING GROUP

TERMS OF REFERENCE

APPROVED: 29 January 2018

1. NAME

Kent Pathology Steering Group

2.PURPOSE AND SCOPE

The Kent Pathology Steering Group has been formed to ensure sustainable and quality pathology services across Kent. The Kent Pathology Steering Group has a dual focus: 1) to design, launch and implement pathology efficiency schemes as part of the STP productivity workstream and 2) to develop plans and implement a networked pathology service model in response to NHS Improvement's proposed South 8 network.

3. BACKGROUND AND CONTEXT

NHS organisations and Local Authorities in Kent & Medway have come together to form a Sustainability and Transformation Partnership (STP). The STP partnering organisations are working collaboratively to design and implement strategic change initiatives to improve quality of care and health outcomes, and to ensure financial and resource sustainability.

The Kent 'footprint' faces a significant "Do Nothing" financial challenge, with the system deficit by 2020/21 estimated at £568m. As part of closing this financial gap, the STP productivity recurrent savings requirement is >£200m. Pathology is one of 5 working groups charged with delivering productivity savings to close this gap by FY 20/21.

NHS Improvement have constructed a comprehensive map of pathology services across the country building upon the Lord Carter's pathology service reviews of 2006 and 2008 and work looking into operational performance and productivity in acute trusts published in 2016.

Using the national data from acute non-specialist providers, NHS Improvement has identified 29 regional pathology networks across England to operate as a 'hub and spoke' service model. The purpose of this redesign work is that NHS Improvement believe these new structures will support high quality services to patients and facilitate the introduction of a new generation of investigations; enhance the career opportunities for clinical scientific and technical staff working within the service; and be more efficient, delivering recurrent projected annual savings to the whole NHS of £200m.

According to NHS Improvement analysis, integrating Pathology services across the Kent region, and forming the proposed South 8 networked model, could save the system £5.6m annually. here have been a number of local precursors to the STP's efforts to deliver efficiencies and improvements in pathology services through collaboration, for instance the merger between services at Maidstone and Tunbridge Wells hospitals; the merger of services in East Kent; and most recently, the ongoing merger between services at Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust. Consultations have been completed for North Kent Pathology Service (NKPS) and it is expected to be operational by Spring 2018.

4. AIMS AND OBJECTIVES

The long-term objective of the Kent Pathology Steering Group is to work towards a sustainable, single pathology service in Kent.

In response to NHS Improvement's proposed pathology networks, the Kent Pathology Steering Group will develop and agree an Outline Business Case (OBC) in early 2018 that evaluates the options recommended after applying evaluation criteria. The workshop will inform and provide initial insights for the Full Business Case (FBC) to be submitted to NHS Improvement.

The Kent Pathology Steering Group will continue to devise and implement savings initiatives as part of the STP Productivity work. The Kent Pathology Steering Group have agreed the aim to bring Kent to above top-quartile (where applicable) performance against comparator peers and national figures. It is anticipated that these objectives shall be met by designing, launching and implementing a number of collaborative schemes, including but not limited to:

- Collaborative productivity improvements (e.g. procurement, staffing, provision of capacity during high demand)
- New transfers of activity done at cost, with benefit sharing if needed
- Initiatives to improve workforce recruitment and retention, including usage of temporary staff
- The alignment of MES contracts
- Working collectively to gain accreditation (UKAS)
- The consolidation of specialist work across Kent
- The harmonisation of prices paid for referred activity (send-aways)
- Improvements in IT and logistics connectivity, initially via NPEx integration but longer-term via a single LIMS

5. WORKPLAN AND TIMELINE

The Kent Pathology Steering Group has committed to meeting the ambitious timelines set by NHS Improvement to develop proposals for a networked service model. In addition, the Kent Pathology Steering Group is charged with delivering productivity savings and improvements within FY 18/19

6. GROUP STRUCTURE

The Kent Pathology Steering Group consists of the Pathology Clinical Directors and General Managers from the acute providers within the Kent footprint. The Kent Pathology Steering Group has nominated 1 Operational Lead and 3 Clinical Leads to drive and oversee the Kent Pathology Steering Group:

- **Clinical Leads:** Edmund Lamb, CD, EKHUFT, Sara Mumford, CD, MTW and Maadh Aldouri, CD, North Kent Pathology Services
- **Operational Lead:** Alistair Lindsay, General Manager, North Kent Pathology Services

Leads will be responsible for setting the overall direction of the Kent Pathology Steering Group and ultimately responsible for assuring quality of delivery to the agreed deadlines. Leads will be responsible for reporting to the Productivity Group and STP governance groups detailed below in Section 11. Governance.

Decisions should ideally be made consensually. Where there is a dispute, a decision shall be made by majority vote. Decisions can be appealed to the STP Productivity Group or to the Acute Chairs and Chief Executives' Group by any member.

7. MEMBERSHIP

The Kent Pathology Steering Group will be chaired by Lesley Dwyer, CEO of MFT and member of the Acute Chairs and Chief Executives' Group.

In addition to the Leads listed above, the core membership of the Kent Pathology Steering Group consists of the Clinical Directors and General Managers of each acute provider trust, as well as regional representatives for the Finance, HR and Procurement disciplines:

- Mark Holland, GM, MTW
- Marcus Coales, GM, EKHUFT
- Sheila Stenson, KMPT, Productivity Workstream Lead
- Procurement Lead – Dan Small, STP Procurement Lead
- HR Lead – To be determined
- Finance Lead – To be determined
- Comms Lead – To be determined

Executive-level representatives from each Trust will also attend monthly Kent Pathology Steering Group meetings to ensure decisions can be taken quickly and Trust Boards are kept informed of developments.

The Kent Pathology Steering Group will coordinate with other established STP groups where addressing issues of joint focus. For instance, with the Supplies & Services group to address procurement, contract negotiation, and joint bidding initiatives; with the Temporary Staffing group where initiatives relate to the reduction of bank and agency spend and usage; and with the clinical workstreams of the STP, where pathways may be reviewed and include the standardisation of diagnostic requests.

8. SUB-WORKING GROUPS

The Kent Pathology Steering Group may decide to set up sub-working groups to design and implement specific initiatives as required. Currently, five sub-groups have been proposed:

1) Networked service model (to develop OBC submission to NHS I)
2) Send-away tests
3) NPEx/LIMS connectivity
4) Communications (internal/ staff communications as well as external messaging, and
5) Early repatriation (exploring opportunities to repatriate activity/ tests throughout the footprint in advance of implementation of the future service model).

9. ROLES AND RESPONSIBILITIES

Each member of the Kent Pathology Steering Group has an important role to play in designing, launching and implementing initiatives across Kent, with a particular responsibility for ensuring buy-in and delivery within their own organisation.

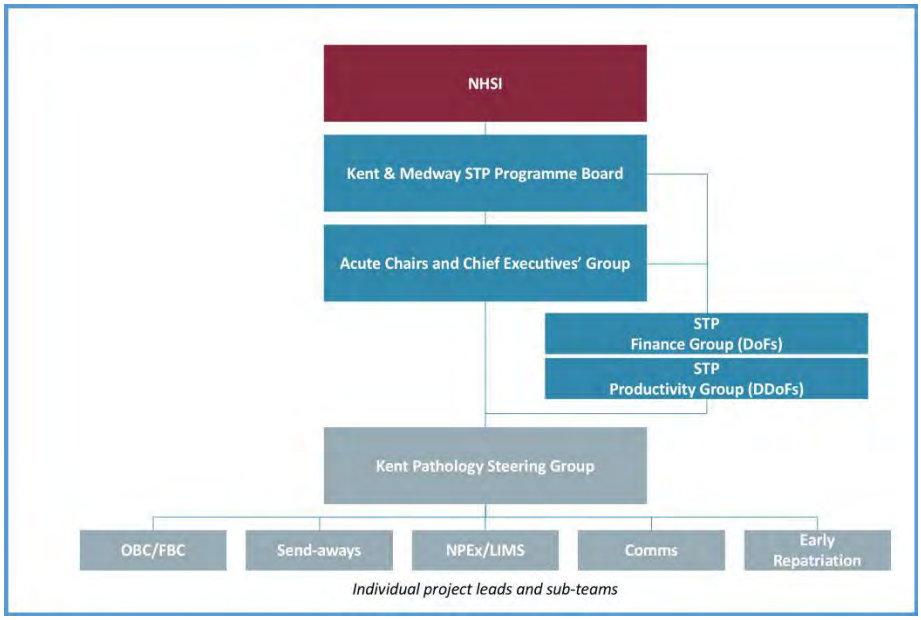
Where members take on leadership of particular projects within the Kent Pathology Steering Group, they are accountable for delivery to the Kent Pathology Steering Group and STP governance groups.

10. DECLARATION OF INTERESTS

Where a member participating in the Kent Pathology Steering Group has a personal or organisational interest, or becomes aware of an interest which could lead to a conflict of interests with the aims and objectives of the Kent Pathology Steering Group this must be declared at the beginning of the meeting, or as soon as possible after the individual becomes aware of the conflict.

11. GOVERNANCE

The Kent Pathology Steering Group shall be accountable to the STP Acute Chairs and Chief Executives' Group. To enable this, the nominated lead of the Kent Pathology Steering Group shall report regularly to the STP Acute Chairs and Chief Executives' Group and a representative of the STP Acute Chairs and Chief Executives' Group may attend meetings of the Kent Pathology Steering Group. This work will report to the STP Acute Chairs and Chief Executives' Group and STP Programme Board (incl. Medical Directors), ensuring finance and activity elements are signed-off by the Finance Group via the DDoFs Productivity Group. Highlight reports will be developed and shared with STP governance groups and with statutory organisations via group members.



12. WAYS OF WORKING AND COLLABORATIVE PRINCIPLES

Recognising that the work of the Kent Pathology Steering Group could be sensitive in nature and breach traditional organisational boundaries, the Kent Pathology Steering Group have devised and agreed the following collaborative principles to guide the way in which members work together:

- This work will be clinically-led and facilitated by professional project managers with Pathology experience
- We will be realistic but ambitious in our commitment to identify and provide resource for this work (e.g. backfilling)
- We will identify and resolve any conflicts of interest at the earliest opportunity

- In line with the STP principles, we will adopt an open book approach to data and provide accurate and quality data in a timely fashion and share data with openness and transparency
    - We will work in partnership with clinical colleagues and other workstreams
    - We will involve staff early and regularly communicate to avoid unnecessary uncertainty
    - We will collaborate where possible and centralise where necessary, recognising the specific challenges posed by the K&M geography
    - We will feedback the outcomes of work to other organisations
    - We will remain innovative in our service model proposals – future-proofing our services as much as possible
    - We will not lose sight of incremental changes or easy wins in pursuit of the future service model
    - Where work has already been done, we will reuse or repurpose it, not repeat it
    - We will conduct this work for the good of the system, optimising for the overall benefit of the health economy – this may not always mean pursuing the preferred or optimal solution for statutory organisations
    - We will strive to surpass top-quartile performance on average across Kent
    - We will invest in developing the capability of the Kent Pathology Steering Group and other colleagues to sustainably deliver Pathology gains on an ongoing basis

13. MEETING FREQUENCY

The Kent Pathology Steering Group will meet on a monthly basis face-to-face and will have fortnightly conference calls to update on actions and escalate risks and issues. The STP PMO will support the scheduling of meetings, the capturing of actions and decisions in meetings and with the provision of meeting venues, which will rotate around the four Trusts.

If a designated member is unable to attend, they should send apologies in advance and send a representative or deputy in their place, only by exception.

Meetings will be minuted by the STP PMO. Draft minutes will be shared between meetings for approval at the beginning of the next meeting.

14. QUORUM

In order for the meeting to be quorate and for formalisation of any decisions, representation from every organisation must be present. Deputies attending in the absence of members must be nominated by their organisation with decision-making authority.

15. REVIEW AND APPROVAL

These Terms of Reference and membership were approved on 29 January 2018. Any recommendations for any changes should be made through the Kent Pathology Steering Group. The ToRs will then be reviewed and updated every 3 months. This may occur earlier at the discretion of the Kent Pathology Steering Group and STP Acute Chairs and Chief Executives' Group.

16. RESOURCES

The Kent Pathology Steering Group will be supported by a combination of:

- Any internal or external resource provided by the Kent Pathology Steering Group members and their organisations
- Analytical and project management resource that is assigned to the Kent Pathology Steering Group by the STP Productivity Group
- Dedicated support, as agreed and resourced by the Kent Pathology Steering Group

If the Kent Pathology Steering Group feels they need additional resource this should be flagged with the Operational Lead who can escalate.

17. CONFIDENTIALITY

Documents circulated by the Kent Pathology Steering Group, sub-groups and the notes from the meetings, can be shared by members externally unless expressly stated as confidential or in draft form. Members are required to respect confidentiality of specific topics discussed at the meeting as requested by other members of the Kent Pathology Steering Group or guest speakers.

Appendix 3: Lessons from previous pathology integrations in Kent

Risk no.	Consolidation Programme	Issue	Lesson Identified	How would you do things differently
1	Previous Transformations	Change fatigue (multiple attempts halted)	Lack of trust between organisations	Collaborate in the first instance before attempting to consolidate to gain trust to achieve partnership working together for mutual benefit, rather than one trust taking charge and taking all the benefits
2	Previous Transformations	Communication 'being open and transparent'	The individuals involved in the transformation are often personally impacted by the proposed changes. This can lead to unintentional resistance to share information and can impede progress	Agree and regularly review and discuss principles of working together to create and maintain a safe and effective working environment

3	Previous Transformations	Poor Governance Framework	▯ Importance of clinical leadership ▯ identification of potential conflicts of interest ▯ Mechanism for decision making based predominantly on finances ▯ Lack of quick decision making	▯ Clinically led and facilitated by a professional project manager ▯ with no conflicts of interest and an agreed method for decision making ▯ Method for decision making should be developed around patient, staff mobility, space, transport, infrastructure, quality e.g. accreditation etc.
4	Previous Transformations	Lack of early staff and union engagement	Involve staff early and regularly communicate (even if there is nothing to say tell them)	Develop and implement a communication and engagement strategy and plan utilising a variety of communication channels (meetings, written brief, notice boards, FAQ's and website)
5.	Previous Transformations	Lack of adequate resource to develop and mobilise plans	Day job comes first impacting on transformation and timescales. Investment required to mobilise key enablers e.g. end to end IT and infrastructure	Realistic identification and provision of resources: ▯ dedicated project manager / team freeing up frontline staff ▯ Identification of funding for key enablers

Appendix 4: Goal & Strategic Objectives statement

Strategic Objectives for the Single Pathology Service

Purpose

The purpose of this paper is to define the strategic objectives for the pathology service to deliver the goal of the single service agreed by CEOs in May 2018 and approved by the Pathology Steering Group in June 2018.

Background

The CEOs and the Steering Board agree the following Goal for the single pathology service in May 2018 that sets the vision for the service. This was defined as
"**The creation of a single pathology service across Kent under a single management to deliver high quality, sustainable pathology services and embrace new technologies and diagnostics requirements of primary and secondary care. It aspires to become a nationally leading pathology service in the areas it concentrates on by 2030 and the best place to learn, work and participate in research. The service will deliver a net £4.8m reduction in its own costs from 2017/18 outside any investment in the service. This will be secured by 2020/21 and will be net of individual trust efficiency requirements for 2018/19-2020/21 for the pathology services."**

This sets a clear direction and is completed by the set of key requirements the CEOs wish to see from the service.

To develop the key what we do steps one to the next three years to deliver this the pathology leadership community and the independent consultant met in 6 June 2018 to discuss a number of potential strategic objectives which will guide the delivery of the single service creation and operation to delivery of the goal.

Proposed strategic objectives for the single pathology service

1) The delivery of a clinically and financially sustainable single pathology service based on a strong, viable service which is clinically led, standardised, innovative and creative.

2) The delivery of a high quality diagnostic service for patients, hospital and general practitioners which meets their current and future needs.

3) Creating a workforce which feels they are valued involved and owns the single pathology service as partners in the service and it's a great place to work.

4) Transforming the service models in the pathology service in Kent to deliver technological change for a more responsive service, increased efficiency and meaningful roles for staff which maximises its potential and meets the needs of the client Trusts and Commissioners.

5) Managing the transition to the new single service in a creative, competent manner.

Recommendation

The Pathology Steering group is asked to comment and approve these proposed strategic objectives for the creation of the single pathology service to support the goal agreed by CEOs at the June meeting. Following discussion, the independent consultant with the project team will develop a number of critical success factors to deliver each objective over the next three years. These will then form the basis of the Steering Group's focus for the delivery of the vision and strategic objectives and will be reviewed every 6 months formally.

16 July 2018 Final Version v0_2

Appendix 5: Draft Options: May 2018

Purpose of Paper

The purpose of this paper is to provide a background to the current formulation of options, the final options appraisal criteria and the process for moving from the current 6 options to a narrower range to select a preferred option and Target Operating model for the SOC.

Background

The current work to date for the Project Team has generated 5 options which were approved by the Project Steering Group and a further one approved by the Project Steering Group in May 2018 around the use of a strategic partner to work Trusts on investment, development and operation of certain pathology services. These options now are:-

1. Single Hub and Multiple Spokes
2. Two hubs and Multiple Spokes
3. Centralisation by service line or the Distributed Model
4. Strategic Partner with Trusts
5. Outsourcing
6. Three Hubs and Multiple Spokes

There is a need in each of these to define the options more in terms of their high level Target Operating Models to allow a sensible comparison for each around strengths, weaknesses, opportunities and threats based on the key principles the CEOs set for the single pathology service to enable unambiguous comparison and then effective, fair evaluation against key criteria. There is a requirement in each to scope the role the private sector will take in each option since we will inevitably need the private sector to support at the minimal end of the spectrum e.g. MES strategies and plans to the other end of the spectrum e.g. Full outsourcing of the entire pathology operation. The options are described in this way in appendix 1 of this paper following discussion with the Project Team members.

The current view of the Project Team is that there will be different permutations of the site and service locations which is satisfactory but it is not recommended to have

multiple permutations of strategic partnerships for example across each option but rather specific public / private options for clarity and the need to address the service options appraisal rapidly to meet the deadlines for the SOC.

Outcomes of the comments received on the evaluative draft options

Following the Project Steering Group in May 2018, it was agreed the independent consultant would consult with project steering group members and the pathology leadership community in the four trusts to obtain further comment on the draft evaluation criteria presented in the paper entitled " Development of the Economic Case for the Kent Pathology Network - Options Appraisal for Service Options " This was completed on 25/5/18 and here have been four comments received which are contained in appendix 2 of this paper from the pathology leadership community and the CEOs have set a clear expectation in the final goal of the project on the financial delivery.

- The weighting given to the savings and value for money set against clinical sustainability and strategic fit /innovation. There is a different view from the pathology community to the trusts around this with the trust wishing to increase the overall savings requirement.

- The need to reflect maintenance or improvement of patient outcomes and views that the relative weighting of these criteria may be reduced because consolidation will not affect this.

- The consensus is that the introduction of a new LIMS should be common to all options.

- Different views on the standardisation of clinical standardisation with some wishing to see this weighting increased and others it decreased.

- A view that the achievability level should have a higher weighting given the need for future proofing and flexibility.

- A view that the value for money weighting should be reduced and an increase in the infrastructure criterion.

- The importance of all acute sites to have essential services laboratories or hot laboratories or spokes depending on people's terminology.

- Comments on the wording of the criteria on staffing and patient safety and experience e.g. sample transport times or staff travel times.

- a series of comments on the options and whether we needed to include the private sector in all options because it will generate more options
- A strong view that the options needed to be explained in more detail to allow effective comparison and the scoring against the final evaluation criteria.
- The need to ensure a sustainable cost effective workforce and maximise the use of innovative technologies to improve the delivery of the service and reduce workforce costs.
- The need to emphasise the development potential of the options to grow new services or markets.

In considering the comments the following conclusions were reached by the Independent Consultant and the Chair of the Steering Group to prove for a final version of the evaluation criteria outlined below.

- The weighting for the quality and general, financial and regulatory main criteria are an equal 50 % reflecting the goal of the development of a single pathology service and these are reasonable. Indeed some systems have placed a higher emphasis on the financial, regulatory and general main criteria at 60%.
- The need to reflect the current services securing as a minimum the current outcomes for patients is accepted and will be included in the patient safety and experience section under quality and patients but the weighting will reduce to 25% to reflect comments from everyone.
- The achievability weighting will increase to 20% based on we need a future serve which can be delivered.
- The development of a LIMS is essential to all options for the four laboratories in all options and is in the section under facilities, IT and equipment systems.
- The clinical standardisation sub criteria should remain the weighting it is currently of 20% since there were different views which were opposed to each other.
- The value for money sub criteria should rise to 35% and the governance and control reduce to 10%.
- All sites providing 24 hour emergency care should have an essential services or hot laboratory.

- The comments on the staffing and patient safety sub criteria should be incorporated into the wording of the relevant sections under patients and quality.
- The private sector partnerships should be described in each option to reduce many different iterations of options.

Appendix 6: SWOT analysis of Options

In order to set out each option, including the target operating model (TOM) and a SWOT analysis four overarching assumptions were made and signed off by the Pathology Steering Group. These are:-

- The scope of services remains as at present operated by the three pathology services
- The histopathology service configurations remain as is except for non-cellular pathology e.g. molecular pathology, cytology and specialist testing.
- The number of ESLs will vary depending logically on the number of hubs in the option considered.
- There will be no identification of the sites in the options since we are considering the high level configurations at his stage. Within the OBC we will set out the configurations based on the outcome of the SOC.

We set out six options within the main strategic outline case:

Options for configuration of services:

Option 1: Existing Hubs & 4 ESLs
Option 2: Two Hubs & 5 ESLs
Option 3: Three Hubs & 4 ESLs

Options for delivery model:

Option 4: Internal NHS Provider
Option 5: Strategic Partnerships
Option 6: Outsourcing

Option 1: Existing Hub's & 4 ESLs

This option will retain the current three hubs in the Kent pathology system and provides for 4 ESLs in the single service. The service would be a single pathology management team, standardised systems, a single governance structure and a single LIMS, IT and logistics service and a single MES.

- There would be a pathology contractual joint venture between the four Trusts with a single service contracting to them for a defined set of operational, quality and financial outputs. The economic model would be income based on contracts with the current level of GP direct access, other income, income and research, education income, and returning send-aways would be distributed to the individual trusts as per the pathology principles document.

- The management model would be a NHS contractual joint venture with the four trusts owing the pathology service with a management team and a Board dedicated to the single pathology service and accounting to the individual trust boards through a contract which sets out the service required in an operating agreement.

- A consortium of the four Trusts would be an oversight Board with delegated authority from the individual trust boards to oversee the delivery of the strategy for the service, agree the annual plan and consider investment cases and hold the pathology management team to account for the performance against the operating contract provided by the NHS contractual joint venture.

- The staff would transfer to the NHS contractual joint venture and be hosted by an individual trust to ensure the maintenance of NHS terms and conditions and pensions.

- The financial model would assume a level of new capital investment in LIMS, IT, MES conformance, the refurbished or new single hub and investment in new technology to maximise workforce resilience and savings and /or the opportunities for income growth above the status quo case. There will need to be additional revenue to support capital charges, any additional logistics costs of the service and costs of resizing the workforce and protection costs.

- The financial model would ensure there will be more opportunities for new technology and diagnostics platforms to be invested in. The full costs of the laboratories will be absorbed by the new company including the estates maintenance and funding its borrowing needs for capital and its repayment. The stranded costs of the PFI will be include in the case.

- The commercial model would be based on the Trust all being shareholders in the service based on their respective I&E contributions into the new service and this shareholding would determine their respective benefits and liabilities for profit or loss in the service and investment shares. The Trusts would have a legal agreement with the NHS Company for the delivery of the service and an operating agreement which sets out the expectation of the trusts on the company to deliver high quality, efficient and effective pathology services to the hospitals and the GP direct access work.

SWOT Analysis

STRENGTHS	WEAKNESSES
Easy to achieve Limited capital investment required for LIMS, IT and MES Least disruptive change to staff, Trusts and stakeholders Limited change to staff base Creates a single, more autonomous service, single governance and single platforms Marginal improvement in resilience Retains clinical links with laboratories onsite Limited disruption to transport, logistics and travel times for specimens Retains high level of by control by Trusts Perceived that all Trusts 'win' something Gradual move to uniform ways of operating (see below under opportunities) Increased ability to discuss areas of improvement, for example when there are skill shortages	Poor efficiency and financials: both may be worse than the status quo Does not meet the goal set by the Trusts Unable to meet VFM requirement Fails to meet NHSI pathology strategy plan Does not address workforce, financial or clinical sustainability Lack of sufficient size to undertake major projects Multiple platforms for work that could be centralised and done more efficiently Harder to deliver standardisation Poorer communication between sites/disciplines Potential difficulty accessing NHSI/E capital funding given low rate of return on investment compared to other options

OPPORTUNITIES	THREATS
Joint working gives opportunity for areas of common interest to be addressed. Sharing of best practice Some savings over do nothing option e.g. standardisation of equipment with a single MES/MLS/MSC, single Quality management system and its management, single IT system (LIMS) and its management, as well as single management structure No structural changes and little local politics from staff or stakeholders PFI's are utilised Plays to different Pathology strengths across Kent Some standardisation of working practices, SLAs, KPIs etc. Potentially more critical mass for research and training Opportunities for further change in service models at a later date potential to retain and grow share in North and West Kent	Vulnerable to outsourcing or NHS organisation taking over Politically not seen as doing anything Little potential for savings based on large facility model Significant risk to patient safety Potential loss of contracts due to stakeholder dissatisfaction Not seen to offer the NHSI/STP solution being looked for Does not meet the goals of the Trusts Limited innovation potential Limited ability to address emerging needs in pathology Workforce sustainability not effectively addressed

Option 2: Two Hubs & 5 ESLs

There will be similar issues to the single hub model regarding the need for capital investment, revenue and capacity needs including the implications of reconfiguring potential PFI buildings. The reduction in the number of ESLs (because there will be two hubs which can provide the ESL services) will reduce costs. These are likely to be offset by less efficient hubs and duplication of functions such as pre analytics e.g. specimen handling. The private sector involvement in this option would be similar to option 1

- **The management, financial and commercial models would remain the same as option 1** however there are likely to be more staff cost and possibly better resilience in terms of the workforce recruitment and retention and capacity. The capital requirements may or may not be higher than the single hub option.

- The management model would be a NHS contractual joint venture with the four trusts owing the pathology service with a management team and a Board dedicated to the single pathology service and accounting to the individual trust boards through a contract which sets out the service required in an operating agreement.

- A consortium of the four Trusts would be an oversight Board with delegated authority from the individual trust boards to oversee the delivery of the strategy for the service, agree the annual plan and consider investment cases and hold the pathology management team to account for the performance against the operating contract provided by the NHS contractual joint venture.

- The governance system would be standardised across the single service. The Trusts would develop a single oversight framework for the governance of the clinical and non-clinical quality of the service provided by the contractual joint venture.

- The staff would transfer to the NHS contractual joint venture and be hosted by an individual trust to ensure the maintenance of NHS terms and conditions and pensions.

- The financial model would assume a level of new capital investment in LIMS, IT, MES conformance, the refurbished or new single hub and investment in new technology to maximise workforce resilience and savings and /or the opportunities for income growth above the status quo case. There will need to be additional revenue to support capital charges, any additional logistics costs of the service and costs of resizing the workforce and protection costs.

- The financial model would be similar for the income sources to Option 1 but there will be more opportunities for new technology and diagnostics platforms

to be invested in. The full costs of the laboratories will be absorbed by the new company including the estates maintenance and funding its borrowing needs for capital and its repayment. The stranded costs of the PFI will be include in the case.

SWOT Analysis

STRENGTHS	WEAKNESSES
☐ Increased resilience of services ☐ Could be easier to deliver than 1 hub model depending on sites chosen and more acceptable to staff around changes in base, staffing and supporting rotations across hub and ESL for professional development ☐ Safe intermediate option to move to more radical options later or retain flexibility and future proofing ☐ Allows for better phasing of consolidation of services and is not “a big bang “ ☐ Allows 'mirroring' of all services for risk and capacity issues ☐ Less transport issues than single hub but may increase logistic complexity ☐ Major service change can help to achieve NHSI/STP goals locally ☐ Likely to meet the Trusts goal for the single service ☐ Could reduce impact of stranded cost of PFI space ☐ Likely to limit any market share loss to London	☐ Unlikely to be as efficient and effective as a single hub but more cost effective than options 1/2 ☐ IT solution may be increased over single hub model (Option 3) ☐ Duplication of equipment and services compared with option 3 ☐ Higher level of capital investment, ☐ More difficult to agree on clinical governance and quality management system ☐ This model was used in Cambridge and failed ☐ Movement of staff potentially very destabilizing (if staff choose to move at all) ☐ Increased logistics risk ☐ Less significant clinical risk with moving samples than single hub ☐ Spreading consultant input across two locations not one ☐ Less released space for Trusts to reuse for other service developments
OPPORTUNITIES	**THREATS**
☐ Some opportunities for combined expertise for all disciplines ☐ Some ability to extend working day and week ☐ Some opportunities for R&D (and associated income for Trusts) ☐ Better opportunities for training and staff development and ability to attract skilled staff from both ends of Kent system and conurbation ☐ Potential for some repatriation of tests due to consolidation of work ☐ Ability to standardise across Kent	☐ Easy to become two separate organisations in the future ☐ Two hub Trusts fighting and negative to process ☐ More management structure needed than ☐ single hub models ☐ May not realise savings required ☐ Standardisation more difficult ☐ The staffing of two hubs may be difficult

Option 3: One Hub & 6 ESLs

This model would see each hospital site operate an emergency services laboratory (ESL) for undertaking the urgent Turnaround work (TAT). All non-urgent TAT work and GP direct access work would be transferred to a new laboratory from hospital sites on a existing hub site. The site with the hub will have an ESL because it will be operating as a conventional laboratory and all urgent requests will be accommodated based on the TAT time definitions hence allowing better the sharing of resources and maximising workforce efficiency.

This option allows for the potentially high level of savings through the optimisation of all laboratory processes but will require a high level of capital investment in a new build or a refurbished facility on a current site. The ESL locations will require additional capital investment to resize them. There will be a capital need for a common LIMS, IT connectivity, and additional revenue costs in logistics, potential stranded PFI costs and in creating a new organisation.

- A new service model with the centralisation of all non-urgent TAT time work in a refurbished hub for GP direct access and non-urgent hospital work.

- The management model would be an NHS contractual joint venture with the four Trusts owning the pathology service with a management team and a Board dedicated to the pathology service and accounting to the individual trust boards through a contract which sets out the service required in an operating agreement.

- A consortium of the four Trusts would be an oversight board with delegated authority from the individual trust boards to oversee the delivery of the strategy for the service, agree the annual plan and consider any investment cases, and hold to account for performance against the operating contract the delivery of the service provided by the NHS contractual joint venture.

- The governance system would be standardised for the delivery of the single service across all four trusts into a single governance framework. The Trusts would develop a single oversight framework for the governance of the clinical and non-clinical quality of the contractual joint venture to ensure the single service delivery the operating agreement effectively. The staff would transfer to the single service and be hosted for example by a Trust to ensure NHS service is protected and pension rights for example.

- **The financial & commercial model would be the same as Option 1**. The financial model would assume a level of new capital investment in LIMS, IT, MES conformance, the refurbished or new single hub and investment in new technology to maximise workforce resilience and savings and /or the

opportunities for income growth above the status quo case. There will need to be additional revenue to support capital charges, any additional logistics costs of the service and costs of resizing the workforce and protection costs.

- The financial model would be similar for the income sources to Option 1 but there will be more opportunities for new technology and diagnostics platforms to be invested in. The full costs of the laboratories will be absorbed by the new company including the estates maintenance and funding its borrowing requirements for capital and its repayment. The stranded costs of the PFI will be include in the case.

SWOT Analysis

STRENGTHS	WEAKNESSES
Likely to be the best VFM Highly likely to meet the Trusts goal for the single service Created new working practices, innovative technology and new roles for staff including rotation if desired across ESLs and the hub Meets better the emerging needs for pathology Simpler logistics “one site “ Attractive for MES supplier options and cost Maximises the release of potential space in ESL sites for other Trust on site use The ESLs could retain capacity for improved resilience to support the hub failure which is better than current arrangements Could create opportunities in ESLs for rapid innovation using remote supervisor, control centres in one location, new more reliable kit and different skill mix acceleration e.g. cross training Allows opportunity for more lean pre analytics pathways	The highest capital option potentially because refurbished hub site requires a high level of capital The refurbished single hub will be cheaper than a greenfield site but could be in a location which is not optimal for staffing it and logistics Most challenging option to implement and most disruptive service model The NHS capital not available for the Greenfield site. This would be a treasury business case approval which could be a long time period for approval risking delivery in 2021-2022 there is no capital for the current providers in Kent and Medway to invest from their own resources and they would need to borrow these or find a partner Need for considerable restructuring of current lab space on ESL sites Consultants would increase travel time to staff service and potentially inefficient working from base clinical services Cost of current facilities needs to be written off in terms of PFI builds if they cannot be reused e.g. estates, PFI charges Lack of contingency within the group Movement of staff potentially very destabilising (if staff choose to move at all)

	• Increased logistics and transport risk • Potential increase in clinical risk with moving samples than other options
OPPORTUNITIES	**THREATS**
• Potentially the best financially efficient model against all options except outsourcing • Optimally planned and designed IT, lean working systems equipment platforms refurbished • Combined expertise for all disciplines • Provision of 24/7 services for Microbiology and extended working day/week for Cellular Pathology • Good opportunities for R&D (and associated income for Trusts) • Opportunities for training and staff development • Repatriation of tests due to consolidation of work • Increased research and training opportunities	• Business continuity could be a real issue with a hub failure which would need ESL over capacity to address • Capital may not be forthcoming for a refurbished site • Staff may not want to work in what is perceived as a 'factory' on the 'hub site' • Difficult to disinvest from if the service model changes in the future or there is a change in national pathology strategy • Would the single service have the capacity and capability to deliver the solution • Risks of a "big bang " on service continuity and implementation • Trust resistance to potential stranded PFI costs • may not show sufficient rate of return on capital investment

Commercial Option 1: NHS owned and delivered service

These in house commercial forms would apply to the preferred delivery model outlined in option 1-3 above;

The development of an in house commercial solution would be based on the creation of a single contractual joint venture form for the Kent and Medway pathology services which is owned by the trusts and the service is delivered by a single pathology service. The OBC will consider these forms with the following explored as a minimum

- a contracted (host) joint venture where one of the trusts holds the relevant contracts but decisions as to the joint management are taken collectively with governance structures and a liability / risk share model

- a hybrid corporate model which is run in accordance with contractual agreement between the parties and can mimic shareholdings with a governance arrangement that shares liability and risks

In considering these forms in the OBC the trusts will also consider existing contractual joint venture forms in Kent and Medway and the merits of joining these existing entities such as the 2gether contractual joint venture in East Kent.

In the OBC we will consider these forms with the partner trusts, establish the benefits and drawbacks against each, the key features of each structure and the key legal, commercial and financial implications of each. We will explore the key legal issues after the preferred delivery model has been created and selected in February 2019.

Commercial Option 2: Strategic Partner

This option would involve the procurement of a strategic partner who would support investment, operating certain services (to be defined by February 2019) and the potential management of the service. This could be provided by the private sector such as with companies like Viapath or Doctors Laboratory. The service could be operated as a contractual joint venture with the Strategic Partner and the NHS Trusts.

The NHS Trusts would maintain the majority share of the new pathology organisation. This option would require the creation of a separate organisation. Different management structures could be explored, for example. Trusts may decide to give the management of the service to the strategic partner with the staff remaining in the NHS under a secondment agreement. The forms of contractual joint venture will be similar to those in the commercial option 1.

There is the potential for staff to TUPE to the strategic partner if it operates certain services and employment is retained for the services run by the NHS trusts. The option would require a strong contractual basis for the relationship, and much improved governance and contract management compared to some of the other options. The four Trusts would operate as a single NHS pathology service but with a strategic partner in the oversight board and in the operating pathology company.

- The management model would be a contractual joint venture with the Strategic Partner and the four Trusts which allowed the Trusts to take the majority control. There would be a single pathology oversight board comprising of the Strategic Partner and the Trusts. This board would agree the strategy for the organisation, the annual plan, investment cases and monitoring the performance of the services received under the operating agreement between the Strategic Partner and the NHS pathology service.

- An operating company with a board and management team would be created and this would include the Strategic Partner. The Partner and the NHS Trusts would need to agree a loss and profit share with the Partner for the financial performance of the operating company and issues such as shareholding in the contractual joint venture. The governance system would be a single oversight framework for the Trusts to ensure effective governance of the contractual joint venture for the single service that would be overseen in the single service by the NHS Trusts and the strategic partner.

- The financial model would change with the costs of capital being met by the strategic partner, and financed from their share of the profit of the NHS pathology services run by the Trusts and any services they operate in the single pathology service. The Strategic Partner would be responsible for the costs agreed in contracts for the services supplied, and there would need to be an agreement of the annual

rise in workloads, and how this was recompensed with the strategic partner and the Trust serves. There would be more risk transfer to the strategic partner than under all other options except for Outsourcing.

- The service the Partner operates will likely result in either, the staff being TUPE or for the Partner to manage the service on the Trusts' behalf through a management contract. This would result in the staff remaining in the NHS and retain their terms and conditions and pension entitlement.

SWOT Analysis

STRENGTHS	WEAKNESSES
☐ Access to capital to meet standardised LIMS, IT and MES and for new innovation as well as physical expansion of the hub at a faster rate than NHS ☐ Likely to deliver the focus on financial savings ☐ Strong KPIs as contract in place with provider ☐ Transfer of some operational and financial risk to strategic partner ☐ Externalising the change decreases the opportunity for in-house resistance ☐ Access to knowledge, know-how and business acumen form partner ☐ More opportunities for developing the single service and bigger critical mass in the market ☐ Greater purchasing power with suppliers of hardware and software linked to critical mass ☐ A mixed economy on service provision can maximise innovation, productivity and quality and get results faster than direct in house provision and is not as threatening as outsourcing for staff ☐ Better risk sharing than in house options for the Trusts	☐ Perceived poor track record e.g. staffing issues and TAT's ☐ Poor track record on research and training investment ☐ Local innovation may be lost ☐ Staff resistance could be very strong if the partner operates certain services but not as strong as resistance to outsourcing ☐ Stakeholders may have negative views ☐ Overcoming existing long term contracts in some Trusts very difficult unless taken on by the outsourcing organisation - may actually mean little interest is shown ☐ Trusts/NHS will not achieve the full benefit of financial savings. ☐ Danger the strategic partner may choose to cherry pick profitable work (However, this could be overcome in a partnership agreement)

OPPORTUNITIES	THREATS
Working in a contractual joint venture will enable us to use resources and contracts more effectively. Working with a strategic partner in a contractual joint venture will enable cost savings There will be a 'gain /loss share agreement' sharing profit and loss Ability to borrow money to fund potential newer refurbished estate, new technology and solutions which accelerate service change for the single service and the customers faster Economies of scale in management, capability and capacity improvement More agile than the direct NHS provision of services and less rigid than outsourcing One brand new organisation comes in and helps to support, finance and implement change Opportunity to improve current areas of poor performance if the NHS service cannot deliver through asking partner to operate a service to break through inefficient out dated practices Commercial benefits of private organisation e.g. improved marketing, business acumen The strategic partner may increase its investment in Kent and disinvest in expensive routine labs in high cost areas such as London which creates more opportunities for recruitment, financial improvement Robust KPIs with users established	Staff may perceive less security working with a private provider and have real concerns about a service operated by one Risk of staff leaving for other Trusts This option could change the delivery of the Trust's clinically driven services Control by Trusts only as good as specification document and management which could cause problems with future proofing Cost containment in meeting contracts could mean lower quality of service Stakeholders with much higher expectations and increased sensitivity to the services The caliber of the strategic partner may not meet the needs of the trusts There is a risk of the partner failing and the trust being left with liabilities The same potential drawbacks of going for a single hub on workforce sustainability

Commercial Option 3: Outsourcing

The service for all four pathology services would be procured from a single pathology provider, either from the private sector or an NHS organisation. The provider would finance, operate and deliver pathology services to the four Trusts as well as the GP direct access work. The service option is likely to be the same as option 3 or 4.

The Trusts would procure the outsourcing partner and work as a single NHS client to operate the contract with the outsourced partner through a form of consortia board.

The Trusts may or may not choose to invest capital in the service dependent on a case by case approach dependent on the present and the future rate of return on investment. This option would have the most significant governance and monitoring requirements but also potential to be more creative around market growth, financing, VAT benefits, and more efficient healthcare supply chain and procurement arrangements.

- The management model would be an outsourced supplier who is procured through a contract by the four NHS Trusts as clients to deliver the financing, operations and delivery of the pathology service to hospitals and GP direct access. The contract would be managed by the Trusts through an oversight board and a management resource that would monitor the contract compliance. The NHS staff would TUPE to the outsourced private sector or NHS organisation. The outsourced supplier would ensure the contract delivered the full range of clinical and non-clinical quality compliance and improvement as set out in a service agreement and monitored through an NHS governance framework.

- The financial model would ensure that the Trust's would receive income from the service delivered to GP direct access, research and education, and pay an annual service charge for the costs of delivering the service to the outsourced supplier, which would be over a given time period. The annual service charge would vary based on the demand and capacity needed to deliver this to support demand in GP direct access or hospital generated work.

- The commercial model would be based on some joint agreement between the Trusts and the outsourced provider. As part of the payment mechanism set out in the contract, the outsourced provider would share the profit and loss on the service.

SWOT Analysis

STRENGTHS	WEAKNESSES
☐ Access to capital for single or dual hub which would be faster than via NHS routes ☐ Greater focus on financial savings ☐ KPIs very strong as contract in place with provider ☐ Full transfer of operational risk to provider ☐ Externalising the change decreases the opportunity for in-house resistance ☐ Access to larger critical mass of service which helps with MES, LIMS IT contracts and increases pace of delivery of single service (no OJEU required) ☐ Single clear brand and organisational identity ☐ Would achieve the goal of the Trusts	☐ Poor track record on research and training cuts with outsourced companies in pathology ☐ Local innovation may be lost ☐ Staff resistance would be very strong and the highest of all options ☐ The business continuity of losing staff will be problematic if they can be attracted to other NHS providers and retain their NHS benefits ☐ Stakeholders may have very negative views of this option ☐ Trusts/NHS will not achieve full benefit of financial savings since outsourcer will secure profit on the business and then share surplus with trust ☐ Major change in contract management arrangements and potential difficulties in effectively managing the contract ☐ The trusts may face escalating costs form the increase in hospital generated work which overtime erode initial savings received.
OPPORTUNITIES	**THREATS**
☐ One brand new organisation comes in and implements change ☐ Opportunity to improve current areas of poor performance ☐ Commercial benefits of private organisation ☐ Improved marketing ☐ Robust KPIs with users established ☐ Faster adoption of new working practices, diagnostic tests and innovation ☐ Increased pace of implementation ☐ Growth potential is higher for the single service	☐ Risk of staff leaving for other Trusts and recruitment to posts in long term ☐ Extremely damaging to staff relationships and will have significant implementation costs and time from Trusts dealing with staff negotiation and hidden costs ☐ Consultant staff not being part of the outsourcing is a very significant risk. This would completely change the nature of the Trust's clinically driven services ☐ Control by Trusts only as good as specification. Could cause problems with future proofing ☐ Cost containment in meeting contracts could mean lower service ☐ Stakeholders with much higher expectations and increased sensitivity to our services ☐ No plan B if private sector gives notice of termination

Appendix 7: Application of Hurdle criteria to original options

Key:
Further work needed at OBC

	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6	Option 7
	Do nothing	Three Hubs & 4 ESLs	Single hub & 6 ESLs	Two Hub & 5 ESLs	Centralisation of service labs	Strategic Partner	Outsourcing
Hurdle Criteria	Configuration	Configuration	Configuration	Configuration	Configuration	Delivery model	Delivery model
Quality of care for all	Yes	Yes	Yes	Yes	Yes	?	?
Access to care	No	?	?	?	?	?	?
Workforce	No	No	Yes	?	No	?	?
Ability to deliver	Yes	Yes	?	?	No	Yes	Yes
Affordability & value for money	No	Yes	Yes	Yes	No	?	?
Outcome	**Non-Viable**	**Viable**	**Viable**	**Viable**	**Non-Viable**	**Viable**	**Viable**

Appendix 8: Evaluation Criteria

Section	Percentage of total weighting	Question
1. strategic fit	10%	1.1.1 Does the option provide the best strategic fit for pathology services across Kent & Medway?
		1.1.2 Does the option provide the best strategic fit with other initiatives underway?
		1.1.3 Does the option reflect an alignment with national policy regarding consolidation of pathology services?
		1.1.4 Does the option support the retention of current revenues?
		1.1.1 Does the option support the future needs of the GPs and Trusts?
2. Potential affordability	10%	1.2.1 Does this option minimise the request for public sector capital (central gov, NHSI, Trust)?
		1.2.2 Does this option maximise the potential return on investment?
		1.2.3 Does this option embrace the potential to introduce new technologies to reduce costs?
3. Potential Value for Money	18%	1.3.1 Does the option maximise the available savings & help deliver the required £4.8m savings over and above the current delivery model?
4. Facilities, IT & Systems	7%	1.4.1 Does this option allow for a new IT solution to be introduced (e.g LIMS)?
		1.4.2.Does this option enable the improvement & investment in estates?
		1.4.3 Does this option allow for investment into equipment?
5. Control & Governance	5%	1.5.1 Does this option allow Kent to retain sufficient control of the service to prevent adverse impacts on patient care?
		1.5.2 Does this option allow Kent to retain an autonomous governance structure?

1. Clinical & Workforce sustainability	18%	2.1.1 Does this option provide clinical oversight & ensure that clinicians can retain control of the service?
		2.1.2 Does this option provide a role for clinicians to shape service delivery throughout the future?
		2.1.3 Does this option provide sustainable staffing for the service?
		2.1.4 Does this option maximise the chance for recruitment & retention of staff & provide the best staff experience?
		2.1.5 Does this option maximise the use of innovative technologies such as new diagnostic platforms or Artificial Intelligence?
2. Patient Safety & experience	12%	2.2.1 Does this option maintain a service that matches a Trust's hot testing requirements?
		2.2.2 Does this option ensure it is easy for Trust clinicians and pathology staff to interact?
		2.2.3 Does this option minimise the service failures from arising due to testing too far away from trust location?
		2.2.4 Does this option ensure a realistic travel time for specimens based on the location of labs?
		2.2.5 Does this option minimise risk to patient safety?
		2.2.6 Does this option preserve current service outcomes?
3. Achievability	10%	2.3.1 Is there evidence that other places in the country have delivered this model successfully without negative impacts on quality?
		2.3.2 Is it achievable to deliver this option by 2021?
4. Standardisation	10%	2.4.1 Does this option support the introduction of common processes?
		2.4.2 Does this option support the introduction of common KPIs & clinical reporting?

Appendix 9: Staffing

	2017/18					2016/17					2015/6				
Staff	MTW	EK	MFT	DGT	TOTAL	MTW	EK	MFT	DGT	TOTAL	MTW	EK	MFT	DGT	TOTAL
Clinical AFC Band 2	11	73	32	16	**133**	13	91	32	16	**153**	10	68	34	15	**127**
Clinical AFC Band 3	52	25	6	14	**97**	55	22	6	14	**98**	56	31	10	1	**98**
Clinical AFC Band 4	10	13	2	1	**26**	7	10	2	1	**21**	9	5	1		**15**
Clinical AFC Band 5	33	39	18	5	**94**	20	37	18	5	**81**	30	40	13	5	**89**
Clinical AFC Band 6	41	51	16	31	**138**	38	45	14	28	**125**	32	46	17	22	**116**
Clinical AFC Band 7	37	39	12	6	**94**	35	38	12	6	**92**	33	39	14	6	**92**
Clinical AFC Band 8a	9	15	5	4	**33**	10	16	5	4	**36**	12	16	6	4	**38**
Clinical AFC Band 8b	5	3	0	0	**8**	3	8	0	1	**12**	4	7	0	2	**13**
Clinical AFC Band 8c	1	0	0	0	**1**	2		0	0	**2**	2		0	54	**56**
Clinical AFC Band 8d	0	0	0	0	**0**		1	0	0	**1**			0		**0**
Total for Clinical Staff	**198**	**257**	**91**	**78**	**624**	**188**	**269**	**89**	**76**	**622**	**187**	**251**	**94**	**54**	**587**
Consultant Clinical Scientist	0	2	0	0	**2**	17	1	0	0	**19**		2			**2**
Management	1	10	0	5	**16**	2	3	0	5	**10**	3	4	2	2	**11**
Admin & Clerical	29	10	7	3	**49**	28	11	5	3	**48**	27	14	4	4	**50**
Consultant	24	20	4	3	**51**	4	18	3	3	**6**	21	18	4	3	**46**
Other Medical Staff	0	6	0	1	**7**	10	5	0	1	**16**	7	6	1	1	**15**
Non-AFC HCPC Registered	0	0	0	0	**0**		0	0	0	**0**					**0**
Other Staff	0	6	0	0	**6**		7	0	0	**7**		9			**9**
Total	**252**	**312**	**101**	**89**	**754**	**251**	**315**	**97**	**87**	**752**	**245**	**304**	**106**	**64**	**719**

	VACANCIES WTE				AGENCY WTE				BANK WTE			
	MTW	EK	NKPS	TOTAL	MTW	EK	NKPS	TOTAL	MTW	EK	NKPS	TOTAL
Clinical AFC Band 2	1.0	13.7	5.2	**19.9**				**0.0**	1.7		**3.9**	**5.5**
Clinical AFC Band 3	7.0	0.9	4.3	**12.2**				**0.0**	3.9			**3.9**
Clinical AFC Band 4		0.4	0.3	**0.7**	**0.5**			**0.5**	0.5			**0.5**
Clinical AFC Band 5	1.5	10.6	8.0	**20.0**		1.0	3.1	**4.1**	0.2		**2.4**	**2.6**
Clinical AFC Band 6	1.4	2.0		**3.4**	**39.7**	1.0		**40.7**	7.5			**7.5**
Clinical AFC Band 7	1.9	1.8	2.3	**6.0**			1.2	**1.2**	9.9		**1.2**	**11.1**
Clinical AFC Band 8a	2.0	1.3	2.2	**5.4**				**0.0**				**0.0**
Clinical AFC Band 8b		1.0		**1.0**				**0.0**				**0.0**
Clinical AFC Band 8c		-1.0		**-1.0**				**0.0**				**0.0**
Clinical AFC Band 8d		-0.1		**-0.1**				**0.0**				**0.0**
Total for Clinical Staff	**14.8**	**30.5**	**22.3**	**67.5**	**40.2**	**2.0**	**4.3**	**46.4**	**23.7**	**0.0**	**7.4**	**31.1**
Consultant Clinical Scientist		0.0		**0.0**				**0.0**				**0.0**
Management		-0.5		**-0.5**				**0.0**				**0.0**
Admin & Clerical	2.8	4.0		**6.8**				**0.0**	3.6			**3.6**
Consultant	1.0	0.7		**1.7**	**3.3**	2.0		**5.3**				**0.0**
Other Medical Staff		2.5		**2.5**				**0.0**				**0.0**
Non-AFC HCPC Registered				**0.0**				**0.0**				**0.0**
Other Staff				**0.0**				**0.0**				**0.0**
Total	**18.6**	**37.1**	**22.3**	**77.9**	**43.5**		**4.3**	**47.7**	**27.3**		**7.4**	**34.7**

Appendix 10: Financial baseline

Overall costs (2017/18)

	MTW	EK	MFT	D&G	Total
	£'000	**£'000**	**£'000**	**£'000**	**£'000**
Pay Costs	11,689	12,410	4,046	3,928	**32,073**
Non-Pay Costs	13,066	14,784	9,463	6,300	**43,613**
Gross Cost of Pathology	**24,755**	**27,194**	**13,509**	**10,228**	**75,686**
Income	(14,294)	(12,286)	(5,776)	(3,780)	**(36,136)**
Net Cost of Pathology	**10,461**	**14,908**	**7,733**	**6,448**	**39,550**

Overall costs (2013-17)

SUMMARY	**2013/14**	**2014/15**	**2015/16**	**2016/17**
Pay Costs	32,270	33,604	34,002	34,195
Non-Pay Costs	28,381	29,553	30,670	31,688
Gross Cost of Pathology	**60,651**	**63,157**	**64,672**	**65,883**
Income	(34,681)	(34,043)	(35,289)	(36,872)
Net Cost of Pathology	**25,970**	**29,114**	**29,382**	**29,011**

WTE

Staff	WTE MTW	WTE EK	WTE MFT	WTE D&G	WTE Total
Clinical AFC Band 2	11	73	32	16	**133**
Clinical AFC Band 3	52	25	6	14	**97**
Clinical AFC Band 4	10	13	2	1	**26**
Clinical AFC Band 5	33	39	18	5	**94**
Clinical AFC Band 6	41	51	16	31	**138**
Clinical AFC Band 7	37	39	12	6	**94**
Clinical AFC Band 8a	9	15	5	4	**33**
Clinical AFC Band 8b	5	3	0	0	**8**
Clinical AFC Band 8c	1	0	0	0	**1**
Clinical AFC Band 8d	0	0	0	0	**0**
Total for Clinical Staff	198.3	257.0	91.1	77.7	624.1
Consultant Clinical Scientist	0	2	0	0	**2**
Management	1	10	0	5	**16**
Admin & Clerical	29	10	7	3	**49**
Consultant	24	20	4	3	**51**
Other Medical Staff	0	6	0	1	**7**
Non-AFC HCPC Registered	0	0	0	0	**0**
Other Staff	0	6	0	0	**6**
Total	252.4	311.6	101.3	89.1	754.4

TOTAL COSTS (17/18)	MTW		EK		MFT		D&G		Total	
Staff	**£'000**	**WTE**	**£'000**	**WTE**	**£'000**	**WTE**	**£'000**	**WTE**	**£'000**	**WTE**
Clinical AFC Band 2	212	10.70	1,308	73.32	683	32.48	349	16.43	2,552	132.93
Clinical AFC Band 3	1,173	52.02	534	24.80	145	6.20	316	14.11	2,168	97.13
Clinical AFC Band 4	281	10.03	333	12.57	52	2.15	28	1.00	694	25.75
Clinical AFC Band 5	988	32.75	1,130	38.73	594	17.64	172	5.03	2,884	94.15
Clinical AFC Band 6	2,066	40.89	2,033	50.89	831	15.61	1,484	30.59	6,415	137.98
Clinical AFC Band 7	1,916	37.34	1,832	38.78	690	11.84	335	6.27	4,773	94.23
Clinical AFC Band 8a	520	8.88	859	15.00	354	5.22	261	4.24	1,994	33.34
Clinical AFC Band 8b	358	4.69	145	2.89	0	0.00	0	0.00	503	7.58
Clinical AFC Band 8c	88	1.00	0	0.00	0	0.00	0	0.00	88	1.00
Total for Clinical Staff	**7,603**	**198.30**	**8,174**	**256.98**	**3,349**	**91.14**	**2,945**	**77.67**	**22,071**	**624.09**
Consultant Clinical Scientist	0	0.00	195	2.00	0	0.00	0	0.00	195	2.00
Management	119	1.00	558	10.00	0	0.00	321	4.80	998	15.80
Admin & Clerical	690	29.41	206	10.21	165	6.52	94	2.50	1,155	48.64
Consultant	3,278	23.67	3,027	20.10	532	3.66	449	3.10	7,286	50.53
Other Medical Staff	0	0.00	200	6.00	0	0.00	119	1.00	319	7.00
Other Staff	0	0.00	50	6.30	0	0.00	0	0.00	50	6.30
Total PAY	**11,689**	**252.38**	**12,410**	**311.59**	**4,046**	**101.32**	**3,928**	**89.07**	**32,073**	**754.36**
Equipment and Maintenance	459		337		2,208		341		3,345	
Reagents	4,837		4,428		337		1,331		10,933	
Consumables	90		2,110		339		247		2,786	
Blood products	2,308		2,604		98		6		5,016	
Logistics	82		88		40		29		239	
Estates (not overheads)	169		25		118		0		312	
IT / LIMS	50		0		0		87		137	
Tests referred out	1,605		1,338		3,423		2,828		9,194	
Trust overheads	3,323		3,677		2,760		1,431		11,191	
Other / Not Known	142		177		140		0		459	
Total Non-Pay Costs	**13,066**		**14,784**		**9,463**		**6,300**		**43,613**	
Referrals from other NHS Providers	(4,310)		(1,655)		(785)		(192)		(6,942)	
Income from non-NHS organisations	(833)		(1,664)		(594)		(126)		(3,217)	
Direct Access Blood Sciences	(6,893)		(6,777)		(3,146)		0		(16,816)	
Direct Access Histology / Cellular Sciences	(950)		(1,065)		(716)		0		(2,731)	
Direct Access Microbiology	(1,170)		(1,125)		(518)		0		(2,813)	
Other sources of income	(138)		0		(17)		(3,462)		(3,617)	
Total Income	**(14,294)**		**(12,286)**		**(5,776)**		**(3,780)**		**(36,136)**	
Net trading position	**10,461**		**14,908**		**7,733**		**6,448**		**39,550**	

Appendix 11: Financial Principles

In order to develop the OBC, we have developed a set of assumptions covering service configuration, workforce and non-pay that are set out below. More detailed assumptions are provided in a separate document.

Like Stroke, the Pathology OBC seeks to identify only the material differentiating factors between options and use these to rank order those options using a review panel. Based on the scores from the review panel the options will be prioritized; and this prioritised list will be used as to select the proposal on which a full business case will be developed. Due to the nature of the SOC process and the short deadlines set by NHSI; the team have had very limited time and resource, but have modeled the differentiators at a high level akin to that used in the Stroke SOC.

Main Differentiators:

- The nature of Pathology services means that work can be divided between samples which must be dealt with urgently (either due to the needs of patients or the stability of samples to be tested) and work which is not as time critical. This segregation of work means all options need a mixture of Emergency Service Laboratories (ESLs) at all acute hospitals; and a central hub or hubs that perform the more routine, non-urgent work. The SOC examines only the material differences between the base and other service options in order that ranking of alternatives can be performed.

- The team have considered the following material differentiators to enable scoring of options: -

- The cost of outsourcing

The costs of working with a strategic partner or outsourcer

The remaining differential costs are made up of workforce and non-pay costs. There will be a modelling of the workforce costs for the 1, 2 and 3 hub options based on national experience, best practice and the arrangements agreed for the use of scientific leads and clinical leads across the single service. A management structure for operational and scientific management will be agreed in December / January 2019.

The impact of skill mix, grade harmonisation, T&Cs and productivity improvement will be applied to the model for workforce. there will be the incorporation of the

cost of the current mortuary service and body storage facilities in the OBC based on the current revenue and capital charge costs.

The costs of medical staff will be at the current levels net of no- recurrent costs and including funded service developments and postgraduate deanery funding where applicable. Changes in skill mix to secure a more sustainable service will be at actual costs.

The current SLA/PLICS data will be used for each pathology service with their host trust for the internal corporate support to pathology e.g. occupational health, HR, Finance support delivered outside the core pathology budgets.

Regarding non-pay costs we have assumed that there will be **no differential** in non-pay costs that **are directly related to activity** (this includes reagent costs, consumables, blood products and tests referred out).

The actual costs of ESLs and Hubs have been determined and applied to the options as required. The costs included for accommodation include all facilities management costs (e.g. cleaning, maintenance etc.) as well as utility and rates etc. along with capital charges, PDC and PFI costs. These costs have been calculated on a square metre rates and then applied to the floor area for the various options.

The costs of the current logistics service vary across trusts and there will be a detailed data collection on the current service levels, frequency of sample collection and costs undertaken. The options for providing a dedicated service will be costed and selected which will look at the preferred hub options, the greater use of technology, the feasibility of spinning samples down in primary care locations and therefore more cost effective options.

There will be a similar exercise conducted for phlebotomy and current POCT testing to establish the current service and financial baselines and the options for supporting the hub options for service delivery. These will be costed as an average cost.

Estimates of the differing cost of LIMs/IT and equipment managed service contracts in the different models have been determined and applied. A Wave 5 capital funding bid is already being put together to request funding for a central LIMs system.

Capital costs will be treated as per the NHS manual for accounts.

Appendix 12: Estates assumptions

Estates, capital charges and charges for PFI assumptions were agreed by the Pathology steering group are as follows;

- To get a baseline capita charges and service charges by current pathology services
- Establish the square metres of each current lab excluding mortuary space
- Service an average square metre capital charges and service charge across all current labs
- Define the size of the ESL (s) in square metres and use the average service charge and capital charge to fix the cost
- Identify the notional imputed benefit of released space but not calculate this in the cash saving
- For all hubs use the new build cost for all increased space in a single or dual hub from current sites to set a range of capital and service charges for the three existing hubs which will be anonymised
- Under the terms of a contractual joint venture the capital charge for a PFI will be costed using the following assumptions;
- Facilities management costs
- PFI costs
- Depreciation costs

- Energy and utilities

Appendix 13 – Our approach to engaging with staff through the OBC

Principles

- Consistent messages
- Openness and transparency
- Using plain English
- Regular even if there is not much to say
- Learn from other networks and previous Kent and Medway pathology change processes.

Engagement to date

- Monthly staff bulletins following each steering group meeting; drafted by Communications Lead for approval by pathology leadership; signed off by Programme Director, and distributed from Communications Lead via HR Directors and pathology leadership. Target release date of a week after the meeting.
- Monthly staff bulletins mid-way between steering group meetings written by Communications Lead and Workforce and OD lead.
- Monthly briefings for each constituent Trust Board from project team and signed off by Programme Director.
- Bi-monthly updates and items for discussion to STP HR Directors' meeting from Workforce and OD Lead.
- Targeted communications for GP's and CCG's from draft SOC stage.
- Stakeholder group/s to be launched for the OBC stage of the project.
- Frequently asked questions – weekly updates to be posted online following project team meeting with access to the pathology community.
- Generic email address – this has been set up for any member of the pathology community to send queries and comments to project team. Responses will be used to add to frequently asked questions to ensure consistent messages.

Unions and Staff Engagement
Principles

- Engagement and involvement during SOC and OBC stages is at local level with each employing organisation.
- Single set of change principles in line with Trust organisational change policies and following employment law, good practice and NHS and Trust values and behaviours.
- Harmonisation of HR policies where possible before organisational change.
- Assurances about organisational change given only when clear and must be consistent but, as a principle, impact on staff will be minimized and compulsory redundancy will be a last resort.
- Learn from other networks and previous Kent and Medway pathology change processes.
- Not all staff are union members so staff representation needs to be inclusive of all, and link JNCC and LNC.
- Workforce and OD lead is main point of contact between pathology programme and accredited union and staff representatives, HR directors and pathology HR business partners.

Engagement to date

- Accredited union representatives attended visioning workshop on 23.11.18 including workforce session.
- Workforce and OD lead meeting Trust representatives to agree engagement mechanisms at each stage.
- Trust representatives joining sub-groups from OBC stage in January to inform detail.
- Communications lead's team supporting engagement with materials for staff meetings and union meetings.
- Workforce and OD lead attending local joint consultative meetings where requested.

- Workforce and OD lead attending each site at least once a month from OBC stage for staff queries.
- Workforce and OD lead presenting core principles to HRD's for change process in early December – following their approval, core principles will be presented to union and staff representatives for approval.
- Regional representatives will be kept informed.
- Formal consultation will be two stage for single management structure and workforce transition to single organisation.

Trust Board meeting – December 2018

NHS Maidstone and Tunbridge Wells NHS Trust

12-13 Update on the Trust's planning for 2019/20 Director of Strategy, Planning and Partnerships

An update on the Trust's planning submissions for 2019/20 is enclosed.

Which Committees have reviewed the information prior to Board submission?
- Finance and Performance Committee, 18/12/18

Reason for submission to 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

NHS
Maidstone and Tunbridge Wells
NHS Trust

2019/20 Planning update

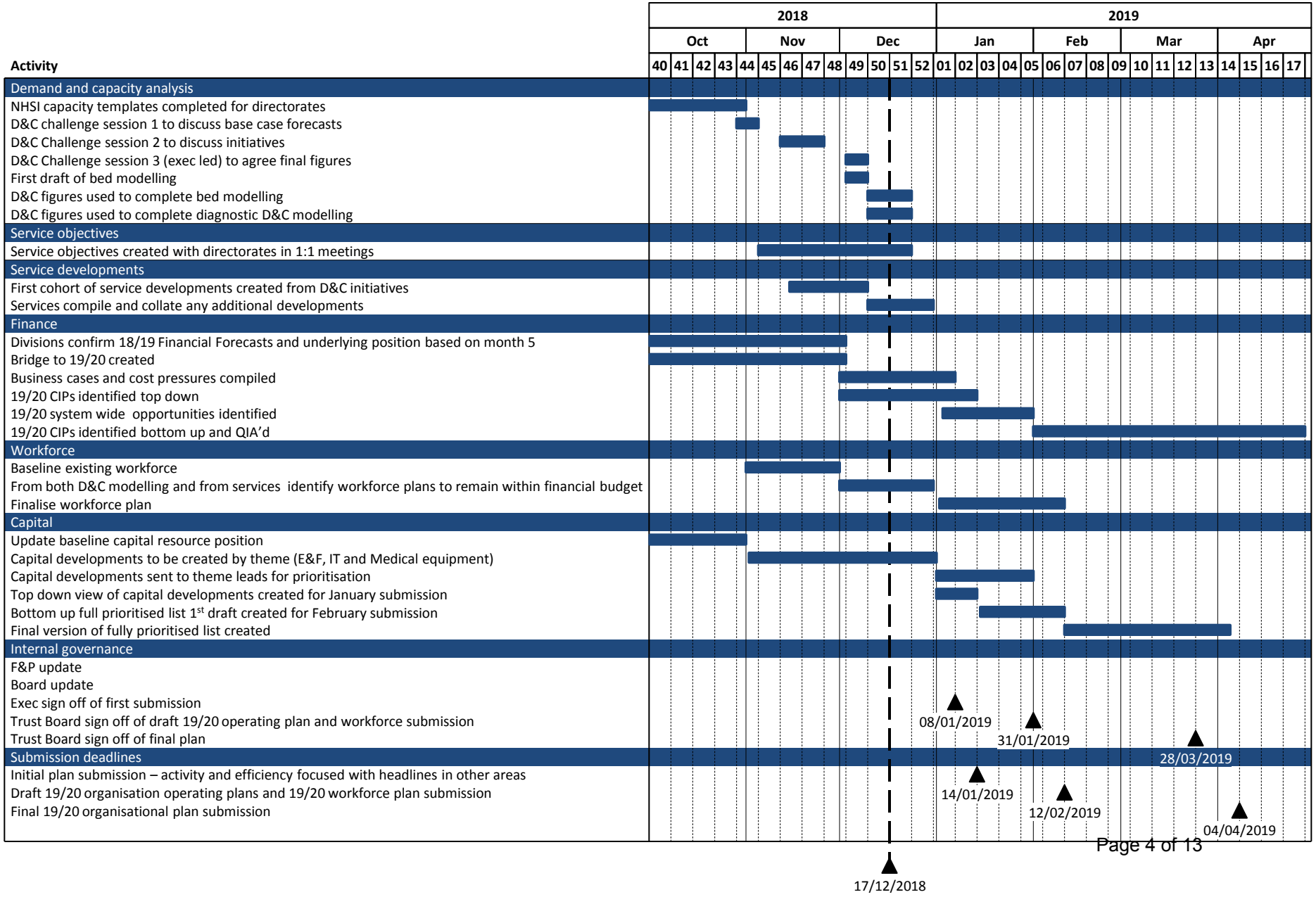
20th December 2018

MTW
exceptional people, outstanding care

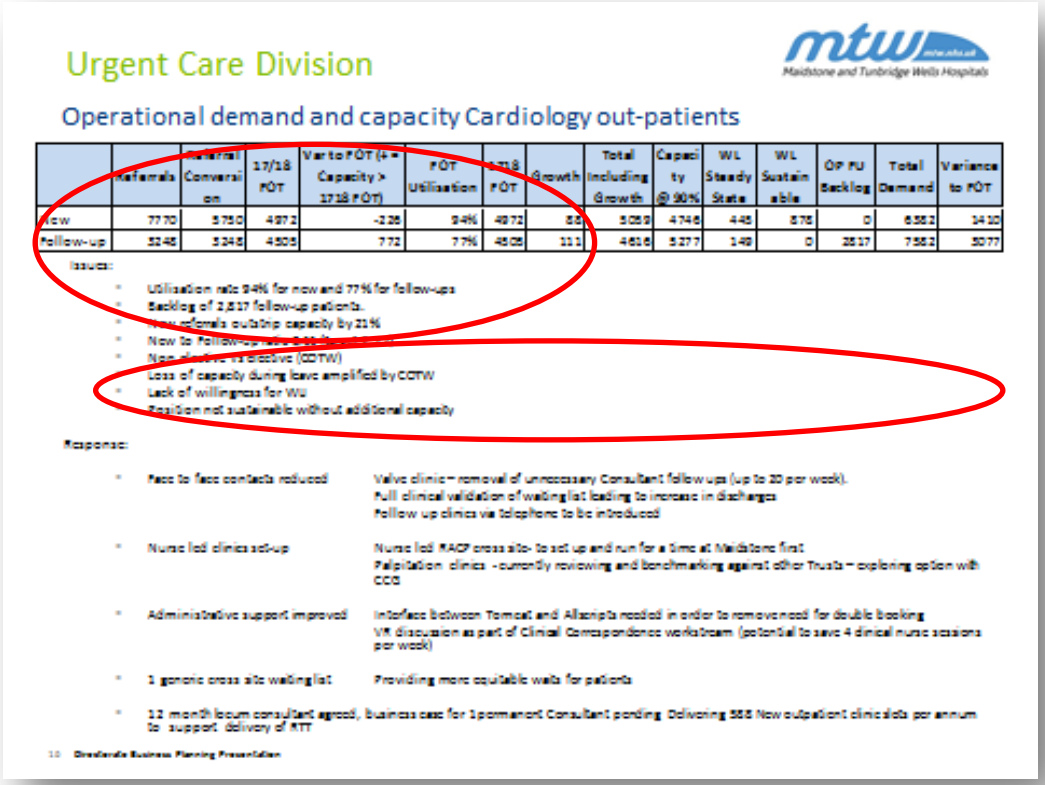
Executive Summary

- We have focused initially on finalising the demand and capacity plans for 19/20 in order to provide a basis for the associated plans
- While there were specific strengths to the 18/19 demand and capacity analysis we have focused on **strengthening the analysis for 19/20** in 3 key areas:
  - Ensuring that the **improvement potential defined through benchmarking or external reviews is translated into actual improvement opportunity** connected to a plan to realise the opportunity (while for 18/19 high level assumptions were used to calculate the improvement potential from the same data)
  - **Calculating service improvements on a case by case** basis to give a true reflection of their impact
  - Working through the **demand and capacity excess or shortfall as a result of this and the impact of proposed prime provider activity**
- In many areas services have managed to negate any capacity shortfall and in some have identified additional capacity to provide even more activity than that originally conceived under prime provider
- For those areas where there remains a shortfall there will have to be a decision made to either:
  - **Plan on the basis of demand** if the shortfall is small to medium. As the improvement opportunity calculations will be inexact in these cases it would be acceptable to plan based on demand
  - **Identify the additional activity that may have to be directed to the private sector** (e.g. at KIMS or Horder).
- The key next steps for the January 14th submission are:
  - **ED attendances are currently forecast to grow at 5.7% in 19/20** and there is additional work to be done to:
    - **Work with system partners to negate some of the demand**
    - Work internally **to identify mechanisms to prevent ED attendances translating into NEL activity**
  - **Complete bed modelling** in light of the above
  - Complete **diagnostic capacity analysis** to ensure that there is sufficient capacity for the Trust to meet it's activity plan and the national standards on cancer and RTT
  - **Agree which service developments are being funded** and which are not

2019/20 Operational planning timeline



Progress to date has focused on compilation of demand and capacity figures generated bottom up



Urgent Care Division

Maidstone and Tunbridge Wells Hospitals

Operational demand and capacity Cardiology out-patients

	Referrals	Referral Conversion	17/18 FOT	Var to FOT (+ = Capacity > 17/18 FOT)	FOT Utilisation	17/18 FOT	Growth	Total including Growth	Capacity @ 90%	WL Steady State	WL Sustainable	OP FU Backlog	Total Demand	Variance to FOT
New	7770	5750	4972	-236	94%	4972	88	5059	4746	445	676	0	6582	1410
Follow-up	5248	5248	4508	772	77%	4508	111	4619	5277	149	0	2817	7582	3077

Issues:

- Utilisation rate 94% for new and 77% for follow-ups
- Backlog of 2,817 follow-up patients.
- New referrals outstrip capacity by 21%
- New to Follow-up ratio 0.66 (target 0.5)
- Non-clinic time reflective (CDTW)
- Loss of capacity during leave amplified by CDTW
- Lack of willingness for WLI
- Position not sustainable without additional capacity

Response:

- Face to face contacts reduced — Valve clinic – removal of unnecessary Consultant follow ups (up to 20 per week). Full clinical validation of waiting list leading to increase in discharges. Follow up clinics via telephone to be introduced
- Nurse led clinics set-up — Nurse led RACP cross site- to set up and run for a time at Maidstone first. Palpitation clinics - currently reviewing and benchmarking against other Trusts – exploring option with CCG
- Administrative support improved — Interface between Tomcat and Allscripts mooted in order to remove need for double booking. VR discussion as part of Clinical Correspondence workstream (potential to save 4 clinical nurse sessions per week)
- 1 generic cross site waiting list — Providing more equitable waits for patients
- 12 month locum consultant agreed, business case for 1 permanent Consultant pending. Delivering 588 New outpatient clinic slots per annum to support delivery of RTT

10 Directorate Business Planning Presentation

While the 18/19 plans had several strengths there were distinct improvement areas for the demand and capacity analysis

- 18/19 plans identified the opportunities that services may have from efficiency opportunities and the potential improvement initiatives but did not size these
- The implications of the demand and capacity balance on waiting list and backlog reduction were not explicitly identified
- No identification of diagnostic capacity requirements

This year we have made several improvements to the calculation of demand and capacity - Trauma & Orthopaedics Elective Inpatients EXAMPLE (1/3)

Data split for several specialties to sub specialty level

Inpatients		Demand	Capacity	Capacity	Excess/ Shortfall	% Excess/ Shortfall	1819 FOT	1819 Outturn + Growth	Var from FOT	Var from Outturn + Growth
T&O	Total Elective	3631	3494	3494	**-137**	**-4%**	3574	3631	57	0
Foot	*Total Elective*	*584*	*408*	*408*	***-176***	***-30%***	577	584	8	0
Knee, Lower Limb & Hip Comb	*Total Elective*	*1272*	*1078*	*1078*	***-194***	***-15%***	1248	1272	24	0
Upper Limb (inc Shoulder)	*Total Elective*	*542*	*466*	*466*	***-76***	***-14%***	533	542	8	0
Paeds	*Total Elective*	*525*	*580*	*580*	*55*	*10%*	519	525	6	0
Hands	*Total Elective*	*545*	*376*	*376*	***-169***	***-31%***	538	545	7	0
Spine and hips	*Total Elective*	*156*								

Utilisation opportunity calculated and services asked to define what they propose to do to realise it

	Current Excess/Shortfall
Foot Non Fractures	-176
Knee, Lower Limb & Hip Comb	-194
Shoulder Non Fractures	-76
Paeds Non Fractures	55
Hands Non Fractures	-169
Spine and Hips Non Fractures	-4

	theatre Utilisation	Target utilisation
Tunbridge Wells	89%	90%
Maidstone (MOU)	80%	90%

	Remaining opportunity	Source of opportunity	What opportunity is achievable	What opportunity is not achievable
Tunbridge Wells	1%	0	0	0
Maidstone (MOU)	10%	349 patients	252 patients (MOU only)	97

This year we have made several improvements to the calculation of demand and capacity - Trauma & Orthopaedics Elective Inpatients EXAMPLE (2/3)

Services were asked to define both their improvement initiatives and to size the effect

Initiatives	Demand management/ Productivity improvement or New ways of working	Size of initiative
Theatre Utilisation (Foot Non Fractures)	TWH	48 slots
Review of job plan when recruiting new Substantive Foot and Ankle consultant	One additional list/month of 5 patients (assumed in post by May 2019)	50 slots
Theatre Utilisation (Knee, Lower Limb and Hip Comb)	MOU, Maidstone	252 slots
Funded Knee WLI		40 slots
Upper Limb Shoulder Fellow	Two additional lists of 6 patients	456 slots
Theatre Utilisations (Shoulder Non Fractures)	TWH	49 slots
Funded Shoulder WLI		30 slots
New Hand and Shoulder Consultant from Sept 19	Using budget from Spine Consultant retiring in Sept 19, Full year effect = 266 appts	Half year effect = 133 slots
New Hand and Shoulder Consultant from Sept 19	Conversion of shoulder to hand theatre lists from Sept 2019	205 slots
Review of procedures that could be done in outpatient setting	To be worked through	To be worked through

This year we have made several improvements to the calculation of demand and capacity - Trauma & Orthopaedics Elective Inpatients EXAMPLE (2/3)

Data split for several specialties to sub specialty level

Prime provider was factored in to identify the demand and capacity shortfall compared to currently proposed levels of activity and to identify areas where additional prime provider activity could be done in house and where additional outsourcing may have to occur

T&O	Total Elective											780
Foot	*Total Elective*											
Knee, Lower Limb & Hip Comb	*Total Elective*											
Upper Limb (inc Shoulder)	*Total Elective*											
Paeds	*Total Elective*	0										
Hands	*Total Elective*	0										
Spine and hips	*Total Elective*	0										

		Excess/Shortfall	Size of Initiatives	Excess/shortfall with initiatives	Proposed prime provider in house activity*	PP Capacity Excess/shortfall	Proposed waiting list reduction	conversion of Shoulder to Hand theatre lists	Final Capacity Excess/ shortfall
Foot Non Fractures		-176	98	-78	129	-207			
Knee, Lower Limb & Hip Comb		-194	292	98	380	-282			
Shoulder Non Fractures		-76	535	459	173	286		-205	81
Paeds Non Fractures		55		55	n/a	55			
Hands Non Fractures		-169	133	-36	169	-205		205	0
Spine and Hips Non Fractures		-4		-4	178	182			
				Other	93	-93			

Any waiting list or backlog reductions were then calculated from the remaining opportunity

Next steps

1. On ED work:
   a) With system partners on **additional schemes to negate the ED growth**
   b) On internal schemes to **prevent ED demand translating into NEL activity**
2. Complete **bed modelling** – a first draft has been created but this then needs to be refined with the outputs of any changes to ED figures
3. **Identify unfunded service developments** (several have been identified through demand and capacity work shown as yellow on initiative pages, but a complete list with relevant business cases is required)
4. Calculate **diagnostic capacity requirements**
5. **Complete workforce planning**
6. **Hold final challenge session prior to the 14th January submission** to:
   1. Review bed modelling and agree LoS proposals and initiatives
   2. Go through proposed service developments and clearly agree on whether or not they will be funded
   3. Workforce plans to remain within budget

- **General Surgery Example**

For General Surgery elective inpatients although there is a significant theatre opportunity within LGI and vascular the greatest shortfall in capacity is within breast

Inpatients		Demand	Capacity	Capacity	Excess/ Shortfall	% Excess/ **Shortfall**	1819 FOT	1819 Outturn + Growth	Var from FOT	Var from Outturn + Growth
General Surgery (excl Endo)	Total Elective	3774	3940	3940	166	4%	3026	3082	748	693
Breast (Excl Endo)	*Total Elective*	*2221*	*1121*	1121	*-1100*	***-50%***	*1055*	*1070*	*1167*	*1151*
LGI (Excl Endo)	*Total Elective*	*1502*	*1485*	1485	*-17*	*-1%*	*1052*	*1071*	*449*	*431*
UGI (Excl Endo)	*Total Elective*	*849*	*1208*	1208	*359*	*42%*	*837*	*849*	*12*	*0*
Vascular (Excl Endo)	*Total Elective*	*137*	*126*	126	*-11*	***-8%***	*135*	*137*	*2*	*0*

	Current Excess/Shortfall
Breast	-1100
LGI	-17
UGI	359
Vascular	*-11*

	Current theatre Utilisation	Target utilisation
Breast	93%	90%
LGI	81%	90%
UGI	86%	90%
Vascular	60%	90%

	Remaining opportunity	Source of opportunity	What opportunity is achievable	What opportunity is not achievable
Breast	0%	n/a		
LGI	9%	9% opportunity =165	(2 case/day x 2 days/week) 168	0
UGI	4%	n/a		
Vascular	52%	Review of operating lists & sessions 3 cases	63 cases	

The Surgery team have worked on initiatives to address their capacity shortfall in all subspecialties

Initiatives	Demand management/Productivity improvement or New ways of working	Size of initiative
Benign breast surgery lists	Reinstated 1 x list per week for middle grade following winter plan	Approx 210 cases
Surgical Care Practitioners	Benign list 4 x cases per week from September 2019	168 cases per year
Moving minor procedures to outpatient setting	Potential for epidermal cysts to be undertaken in sterile OP setting	Minimum expected cases 210 but further workup required
LGI Theatre Utilisation	9% opportunity Benign Cases	168 cases
Review of UGI and LGI case mix to meet demand	Transfer of 359 UGI cases to LGI	359 cases
Vascular Theatre Utilisation	3 per session twice per month	63 cases
Result of Vascular Tender	Await result. Review of SLA agreement with GSTT and Medway	
Review of establishment required against the level of demand for Breast Surgery (GIRFT)	To be worked through to address capacity shortfall	Minimum 512 cases

Through the initiatives that the Surgery team are planning they have created enough capacity to perform ~80% of the proposed prime provider activity, however there remains a significant shortfall in breast capacity

						In-house		OS	
Inpatients	WL Steady	Sustainable WL	Possible Prime Provider	In-House	OS	DC	IP	DC	IP
General Surgery (excl Endo)	693	618	678	617	61	582	35	23	38
Breast (Excl Endo)	*1151*	*0*							
LGI (Excl Endo)	*0*	*0*							
UGI (Excl Endo)	*0*	*0*							
Vascular (Excl Endo)	*0*	*0*							

	Excess/Shortfall	Size of Initiatives	Excess/shortfall with initiatives	Proposed prime provider in house daycase activity	Proposed prime provider in house inpatient activity	PP Capacity Excess/shortfall	Proposed waiting list reduction	Conversion from LGI to UGI List	Final Capacity Excess/shortfall
Breast	-1100	588	-512	n/a	n/a	-512			-512
LGI	-17	168	151	582	35	-466		359	-107
UGI	359	0	359		n/a	359		-359	0
Vascular	-11	63	52	n/a	n/a	52		n/a	52

Trust Board meeting – December 2018

NHS Maidstone and Tunbridge Wells NHS Trust

12-14	**Ratification of Standing Financial Instructions & Reservation of Powers and Scheme of Delegation (annual review)**	**Trust Secretary**

The Trust's Standing Orders, Standing Financial Instructions (SFIs) and Reservation of Powers and Scheme of Delegation (SoD) are due their routine annual review. Having been individually reviewed, a number of changes are proposed to each document. The 3 documents were submitted to the Audit and Governance Committee on 10/12/18 for approval, but the Committee determined that the approval of the Standing Orders should be deferred until a comprehensive consultation had been undertaken. The Standing Orders are therefore intended to be submitted for ratification at the Trust Board meeting in January 2019 (on the basis that the approval of the Audit and Governance Committee will be sought using the Committee's "Emergency powers and urgent decisions" provisions). Such consultations had however been carried out for the SFIs and Reservation of Powers and SoD, so they were approved.

The main proposed changes to the SFIs are listed below:

- 'Housekeeping' changes (changes of title of national institutions, inclusion of additional cross-references and/or associated documents (internal), changes of the names of posts &/or committees etc.). This includes the posts arising from the new clinical management structure
- Clarification that the Audit and Governance Committee does not approve the schedule of losses, write offs and compensations
- Removal of references to capital projects for the Kent and Medway Health Informatics Service
- Clarification that Associate Non-Executive Directors are formal members of certain Trust Board sub-committees (with reference to the Terms of Reference for details)
- The inclusion of the Executive Team Meeting as one of the 3 forums that comprise the central spine through which the Trust conducts its formal business (the other 2 being the Trust Management Executive (TME) and Trust Board)
- Clarification that the Senior Independent Director for the Trust is the Vice-Chair of the Board
- Confirmation that the Chief Executive will now be the Security Management Director (the role transfers from the Chief Operating Officer)
- Removal of any references to the Deputy Chief Executive
- Clarification that the Trust Board will be asked to approve the opening or closing of any commercial (i.e. non- Government Banking Service) bank accounts (following a recommendation from the Finance and Performance Committee)
- Removal of any references to manual tenders and non-electronic procurement communication (this is now mandatory)
- Inclusion of reference to contractors' use of a Dynamic Purchasing System (DPS), if available
- Removal of any references to non-written tender quotations
- Clarification that any invoices received where no purchase order has been raised will not be paid and will be returned to managers who will be required to raise a retrospective order and justify the reason for the expenditure and why a purchase order was not raised initially
- Clarification that capital projects under £250k are approved by the Chief Finance Officer; that the Chief Executive approves projects of £250k and over but under £500k; that the Finance and Performance Committee approves the relevant Business Case for projects of £500k and over but under £1m and that the Trust Board approves projects of £1m and over (although for projects of £15m and over NHSI approval is also required i.e. in addition to Board approval)
- Addition of provision that consignment stock loan kits must be ordered at a minimum value of £5k to ensure the appropriate authorisation (and that a record must be kept of all items used from a kit and this must be reconciled against the invoice when received)

The main proposed changes to the Reservation of Powers and SoD are listed below:

- 'Housekeeping' changes (as described above for SFIs)
- Confirmation that the Chair of the Trust Board appoints the Vice-Chair of the Trust Board, not the Trust Board itself
- Clarification that the Remuneration and Appointments Committee does not appoint, appraise, discipline and/or dismiss members of the Executive Team

- Clarification that the Trust Board does not appoint and/or appraise the Trust Secretary
- Clarification that the Trust Board will be asked to approve the opening or closing of any commercial (i.e. non-Government Banking Service) bank accounts (following a recommendation from the Finance and Performance Committee)
- Removal as a function reserved for decision by the Board for any proposed non-budgeted expenditure over £500k (i.e. over-spending not provided for in an approved budget)
- Removal of the Trust Board's role in authorising Orders, tenders and competitive quotations of £500k and over
- Removal of the Trust Board's role in approving contracts and SLAs of £500k and over
- Clarification regarding the Trust Board's role in authorising extra statutory, extra regulatory and extra contractual payments to contractors £10k and over
- Raising the threshold for the Trust Board's approval of the introduction or discontinuance of any significant activity or operation if that activity or operation has a gross annual income or expenditure (that is before any set off) of £1m and over (raised from £500k)
- Clarification that the Trust Board should approve the waiving of quotation or single tender action for £500k and over
- Clarification that the Trust Board should approve the writing-off of losses (theft, fraud, salary, overpayments, loss of cash) bad debts, write-offs (including fruitless payments), abandoned claims, of £250k and over
- Clarification that the Trust Board should authorise ex-gratia payments to patients and staff for loss of personal effects £20k and over
- The transfer of the development of the Trust's plans (and other associated duties) from the Chief Finance Officer to the Director of Strategy, Planning and Partnerships
- Clarification that the Executive Team Meeting (as the Investment Appraisal Group) shall approve Business Cases for capital or revenue investment of less than £500k (rather than individual members of the Executive Team)
- Updating of the tender thresholds from the Official Journal of European Union
- Clarification that the thresholds for the approval of losses for compensation only applies if such losses are not covered by the Trust's membership of NHS Resolution's risk pooling schemes
- Clarification that the Sustainability and Transformation Partnership (STP) Programme Director can authorise requisitions and invoices relating solely to the K&M STP up to £50k; with the Chief Executive of the STP authorising those between £50k and £250k, and the Chief Executive of Maidstone and Tunbridge Wells NHS Trust authorising those £250k and over

The Audit and Governance Committee reviewed and approved the full revised SFIs and Reservation of Powers and SoD documents at its meeting on 10/12/18. The Trust Board is therefore asked to "ratify" the revised SFIs and Reservation of Powers and SoD. It should however be noted that 4 issues remain outstanding for the Reservation of Powers and SoD, relating to the engagement of Estates and other project consultancy staff; the renewal of Fixed Term Contracts within funded establishment; the authorisation of extensions of contract beyond normal retirement age in exceptional circumstances; and the authorisation of New Drugs. However, the Trust Board is asked to agree that the content of the SoD is updated to reflect what actually happens in practice i.e. without being further submitted to the Trust Board for ratification.

As was the case for the 2017 review/ratification, the full SFIs and Reservation of Powers and SoD documents, with the proposed changes shown as 'tracked' has been circulated as supplements to the formal 'pack' of Board reports (i.e. Attachment 14s). Board Members are therefore welcome to read the supplements (an electronic copy of which has been provided), to obtain the precise details of the proposed changes, but are not expected to do so.

Which Committees have reviewed the information prior to Board submission?

- Finance Committee, 27/11/18 (summary of proposed changes)
- Audit and Governance Committee, 10/12/18 (full revised documents, for approval)

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

Ratification

[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 – December 2018

NHS Maidstone and Tunbridge Wells NHS Trust

12-15	**Summary report from the Charitable Funds Committee, 27/11/18 (incl. approval of revised Terms of Reference and approval of Annual Report and Accounts of MTW Charitable Fund, 2017/18))**	**Committee Chair (Non-Executive Director)**

Summary / Key points

The Charitable Funds Committee (CFC) met on 27th November 2018.

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

- Under the Safety Moment, the Trust Secretary reported that the month's theme was pressure ulcer prevention
- The Committee agreed proposed changes to its ToRs (Appendix 1), which included agreement for the Trust Secretary to discuss proposed amendments to the Committee's membership (to replace the Director of Workforce with the Director of Strategy, Planning and Partnerships) and to change the frequency clause to reflect that the Committee "shall meet at least twice annually"
- The draft Maidstone and Tunbridge Wells NHS Trust Charitable Fund Annual Report and Accounts 2017/18 were reviewed and a material change to the audited 2016/17 Income & Expenditure position noted. The Committee recommended the Annual Report and Accounts (Appendix 2) for approval by the Trust Board, prior to filing with the Charity Commission by the 31st January 2019 deadline
- The financial overview at Month 7 was considered and it was noted that:
  - The fund balance at the end of October stood at c£1.5m
  - The Trust had received 15 donations exceeding £1k; the largest donation in the period was a single donation of £356k for purchase of haematology/oncology equipment
  - Overall expenditure in the period was approximately £71k
  - No items of expenditure had been refused during the period
  - There had been no items of revenue expenditure in excess of £150k
  - A tax and National Insurance liability of £16.3k had been incurred in respect of staff receiving monetary awards at the annual staff awards ceremony hosted by the Trust. It was agreed to explore with HMRC potential alternative scenarios to address future such liabilities arising from the annual Staff Awards Ceremony
- It was agreed that the Head of Financial Services should liaise with the Divisional Director of Operations, Cancer Services, to confirm the plan and timescales for expenditure from the Sutcliffe Haema Oncol Fund
- The proposed Management and Administration fee for 2018/19 was agreed (at £43,444). There was wider discussion about the size of the fee proportionate to the Fund's size and it was agreed that alternative options for calculation of the fee should be considered for 2019/20 onwards, including review of activity/expenditure on a 3 year rolling basis to reduce variables
- It was also agreed to explore the benchmarking data available from the wider Charitable sector in respect of i) funds raised to income and ii) management/admin costs
- The recent appointment of a new Trust Fundraiser was confirmed and the basis of funding for the role was agreed (i.e. through pro-rata allocation of costs across all unrestricted funds with a balance £1,000 or over)
- It was also agreed to:
  - Schedule a "Fundraising update" item for each future CFC meeting
  - Schedule a review of the funding arrangements for the Fundraiser post for the CFC meeting in March 2019
  - Schedule a review of the fundraising plan for 2019/20 (including projected income) as part of the Fundraising update to be presented to the CFC meeting in March 2019

2. **In addition to the actions noted above, the Committee agreed that:** N/A

3. **The issues that need to be drawn to the attention of the Board are as follows:** N/A

Which Committees have reviewed the information prior to Board submission?

- N/A

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

- For information and assurance; To approve the revised Terms of Reference for the Charitable Funds Committee (Appendix 1); To approve the Annual Report and Accounts for the Charitable Fund 2017/18 (Appendix 2)

[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

Appendix 1

CHARITABLE FUNDS COMMITTEE

Terms of Reference

Maidstone and Tunbridge Wells NHS Trust

Purpose

The Charitable Funds Committee has been established as a sub-committee of the Trust Board to ensure that the Maidstone and Tunbridge Wells NHS Trust Charitable Fund is managed efficiently and effectively in accordance with the directions of the Charity Commission, relevant NHS legislation and the wishes of donors.

Membership

Membership of the Committee is as follows:

- The Committee Chair – a Non-Executive Director or Associate Non-Executive Director appointed by the Chair of the Trust Board
- The Committee Vice-Chair - a Non-Executive Director or Associate Non-Executive Director appointed by the Chair of the Trust Board
- The Chief Finance Officer~~Director of Finance~~
- The ~~Director of Workforce~~Director of Strategy, Planning and Partnerships
- The Head of Financial Services
- The Deputy Director of Finance (Financial Governance)
- The Trust Secretary

If a member cannot attend a meeting, they may send a representative in their place.

3. Quorum

The Committee shall be quorate when one Non-Executive Director (or Associate Non-Executive Director) and one member of the Executive Team~~Executive Director~~ are present. Deputies representing Members of the Executive Team will count towards the quorum.

4. Attendance

The Committee Chair may invite other staff, Non-Executive Directors (or Associate Non-Executive Directors) to attend, as required, to meet the objectives of the Committee.

Frequency

The Committee shall meet at least twice~~three times~~ per financial year (and more frequently if required to meet the objectives of the Committee).

Duties

The Committee will act on behalf of the Corporate Trustee (Maidstone and Tunbridge Wells NHS Trust) and will:

- Develop and approve the strategy and objectives of the Charitable Fund
- Ensure that the Charitable Fund complies with relevant law~~,~~ and with the requirements of the Charity Commission as regulator; in particular ensuring the submission of Annual Returns and A~~a~~ccounts
- Oversee the development and delivery of the Trust's fundraising strategy
- Oversee the Charitable Fund's expenditure and investment plans, including:
  - Approving relevant policies and procedures
  - Agreeing approval and authorisation limits for expenditure from charitable funds
  - Considering applications for support (as recommended by the Head of Financial Services)
  - Approving and monitoring investment strategies

The specific duties of the Committee in relation to the Charitable Fund are to:

Policy matters

- To approve, on behalf of the corporate Trustee:
  - A Reserves policy (if considered by the Committee to be required)
  - An Investment strategy (and to formally review the strategy annually)
  - A Grant Making policy (if considered by the Committee to be required)
  - Guidance for fund raising activities (if considered by the Committee to be required)

Operational matters

- Approve the annual management and administration fee payable to the Trust
- Be advised of and consider the application of all new legacies
- Approve proposals regarding the establishment of any new funds
- Authorise financial procedures and financial limits
- Receive details of any expenditure refused
- To approve the banking arrangements of Maidstone and Tunbridge Wells NHS Trust Charitable Fund
- To authorise expenditure in accordance with the Trust's Reservation of Powers and Scheme of Delegation

Internal and External control

- Seek assurances that all income is secured and that expenditure is within the objects of the Maidstone and Tunbridge Wells NHS Trust Charitable Fund
- Ensure compliance of all statutory legislation and Charity regulations, and seek assurance on compliance
- Ensure there is adequate provision for the independent monitoring of investment activity
- Receive all relevant internal and external audit reports, and ensure compliance with any recommendations

Financial reporting

- Review income and expenditure reports for each of the reporting periods
- Review and agree the Principal Accounting Policies to be adopted
- Review, and agree the Annual Report and Annual financial accounts, for approval by the Trust Board
- Receive, where appropriate, the annual investment report
- Ensure the Chief Finance Officer ~~Director of Finance~~ is compliant with the reporting requirements of the Committee and the Trust Board (as the agent of the Trustee)
- To review Fundholders' spending plans

Parent committees and reporting procedure

The Charitable Funds Committee is a sub-committee of the Trust Board.

A summary report of each Charitable Funds Committee meeting will be provided to the Trust Board. The Chair of the Charitable Funds Committee will present the Committee report to the next available Trust Board meeting.

Sub-committees and reporting procedure

The Charitable Funds Committee has no standing sub-committees, but may establish fixed-term working groups, as required, to support the Committee in meeting the duties listed in these Terms of Reference.

Emergency powers and urgent decisions

The powers and authority which the Trust Board has delegated to the Charitable Funds Committee may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted ~~at least one~~ either the Chief Finance Officer~~Director of Finance~~ or Director of Workforce. The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the Charitable Funds Committee, for formal ratification.

Administration

The minutes of the Committee will be formally recorded and presented to the following meeting for agreement and the review of actions.

The Trust Secretary will ensure that each committee is given appropriate administrative support and will liaise with the Committee Chair on:

- The Committee's Forward Programme, setting out the dates of key meetings and agenda items
- The meeting agenda
- The meeting minutes and the action log

Review

The Terms of Reference of the Committee will be reviewed annually, and approved by the Trust Board

History

Agreed at Charitable Funds Committee, July 2014
Approved at Trust Board, September 2014
Agreed at Charitable Funds Committee, July 2015
Approved at Trust Board, September 2015
Agreed at Charitable Funds Committee, November 2016
Approved at Trust Board, December 2016
Agreed at Charitable Funds Committee, 16th October 2017
Approved at Trust Board, 29th November 2017
Agreed at Charitable Funds Committee, 27th November 2018 (annual review)
Approved at Trust Board, 20th December 2018

mtw.nhs.uk
Charitable Fund

NHS
Maidstone and Tunbridge Wells
NHS Trust

Annual Report and Accounts

For the year ended 31st March 2018

Charity Number 1055215

mtw.nhs.uk
Charitable Fund

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Annual Report for the year ended 31 March 2018

The Corporate Trustee (Trustee) presents the Maidstone and Tunbridge Wells NHS Trust Charitable Funds (the Charity's) Annual Report and the audited financial statements for the year ended 31st March 2018.

The financial statements set out on pages 18 to 33 comply with the charity's trust deed, Accounting Standards in the United Kingdom and the Statement of Recommended Practice (SORP) relevant to charities preparing their accounts in accordance with the Financial Reporting Standard (FRS) applicable in the UK and Republic of Ireland (FRS 102) (effective 1 January 2015).

Trustee Statement

The generosity of the many people who have raised funds, given donations and made provisions in their will, is recognised by both the Trustee, the Charitable Funds Committee, and staff. The Trustee, Charitable Funds Committee and staff would like to express their sincere gratitude to all those who have made a contribution which has enabled the Charity to enhance the standard of care, services and facilities provided by Maidstone and Tunbridge Wells NHS Trust to patients, their relatives, visitors and staff.

The role of the Charity

Maidstone and Tunbridge Wells NHS Trust ('the Trust') is the Corporate Trustee of the charitable fund under paragraph 16c of Schedule 2 of the NHS and Community Care Act 1990. The Charity is constituted by a Trust Deed and registered with the Charity Commission under charity number 1055215, and includes funds in respect of the hospitals of Maidstone and Tunbridge Wells NHS Trust.

During the year the Charity was situated on two main sites in Kent: Maidstone Hospital and Tunbridge Wells Hospital.

The Charity is a 'NHS Umbrella Charity' under which there are individual sub-funds that are held for administrative purposes, principally to respect the wishes of the donors.

Within the Umbrella there were a total of 36 individual funds at the 31st March 2018 with a total value of £1,129k. The number of funds in each category is as follows:

- 14 restricted funds[1].
- 2 endowment funds (capital in perpetuity) - only the net income to be spent, whilst the capital remains invested.
- 20 unrestricted[2] or designated[3] funds created for donations received for use by hospitals, wards and departments to reflect donors' wishes. These do not form a binding trust.

The major funds within each of these categories are disclosed in Note 8 in the accounts.

[1] Restricted funds are the funds of the charity that are required to be expended in a certain way, or limited to expenditure for a particular purpose.
[2] Unrestricted funds are the funds of the charity that may be spent entirely at the discretion of the Trustee
[3] Designated funds are funds set aside for designated purposes. Designated funds are unrestricted as the Trustee can remove the designation at any time

The Corporate Trustee

Maidstone and Tunbridge Wells NHS Trust is the sole Corporate Trustee of the Charity.

The Trust Board effectively adopts the role of Trustee as defined by the Charity Commission (it is considered to be the agent of the Trustee). Individual members of the Trust Board are therefore not trustees under Charity Law.

Details of appointments and terminations within the financial year are tabled below:

Executive Directors	Non-Executive Directors	Other Directors
Glenn Douglas – Chief Executive (until 19th September 2017) Miles Scott – Chief Executive (from 8th January 2018)	David Highton – Chair of the Trust Board (from 8th May 2017)	Sara Mumford – Director of Infection Prevention and Control
Stephen Orpin – Director of Finance	Steve Tinton – Chair of the Charitable Funds Committee (until 28th Sept 2016) Steve Phoenix (from December 2017)	
Jim Lusby – Deputy Chief Executive	Sarah Dunnett	
Peter Maskell – Medical Director	Kevin Tallett (until July 2017)	
Angela Gallagher – Chief Operating Officer	Maureen Choong (from August 2017)	
Claire O'Brien – Chief Nurse (from March 2018 previously interim Chief Nurse from February 2017)	Alex King (until 21st March 2018)	
Richard Hayden – Director of Workforce (until June 2017) Simon Hart – Director of Workforce (from December 2017)	Nazeya Hussain (from July 2017)	
	Tim Livett (from June 2017)	

None of the Members of the Trust Board have received any remuneration from the Charity in this financial year for work relating to their responsibilities for the Charity as agent of the Corporate Trustee (in 2017/18 this was also none)

The principal office of the Charity is:

Trust Headquarters, Maidstone and Tunbridge Wells NHS Trust
Maidstone Hospital
Hermitage Lane
Maidstone
Kent ME16 9QQ

Principal advisors:

External Auditor Grant Thornton UK LLP 30 Finsbury Square London EC24 1AG	Bankers National Westminster Bank Kent Corporate Business Centre PO Box 344 Maidstone Kent ME14 1AT
Solicitors Brachers Solicitors Somerfield House 59 London Road Maidstone Kent ME16 8JH	Bankers Scottish Widows 67 Morrison Street Edinburgh EH3 8YJ
Solicitors Capsticks Solicitors LLP 1 St George's House East St George's Road Wimbledon, London SW19 4DR	Bankers Santander Business Banking Bridle Road Bootle Merseyside L30 4GB
Investment Managers Charities Aid Foundation 25 Kings Hill Avenue Kings Hill West Malling Kent ME19 4TA	Bankers Clydesdale Bank 6/8 London Road Unit 5 Peveril Court Crawley RH10 8JB
	Bankers National Westminster Bank PLC (RBS/GBS) 2nd Floor 280 Bishopsgate London EC2M 4RB

Governance and Management of the Charity

Governance

The Board of Maidstone and Tunbridge Wells NHS Trust became responsible for the funds with effect from the 1st April 2000, following the merger of Kent and Sussex Weald NHS Trust, which was based at Tunbridge Wells, and Mid Kent Healthcare NHS Trust, which was located at Maidstone. The Trust Board delegates the daily stewardship of the funds to the Charitable Funds Committee, which within its annual programme of meetings, includes relevant training and updates as required to assist in the performance of its role as Trustee.

The Charitable Funds Committee plans to meet at least three times a year.

The proceedings and decisions of the committee are recorded. The minutes of each meeting are formally agreed by the Chair of the Committee and circulated to all members. A written summary of each Charitable Funds Committee is also submitted to the Trust Board.

Recruitment and Training of Trust Board and Charitable Funds Committee Members

All Trust Board and Committee members undertake an induction programme within the Trust upon joining. They are also able to focus on a particular area of the Trust in which they have a special interest or concern.

Management of the Charity

The management of the Charity is operated in accordance with the Trust's "Policies and Procedures for Charitable Funds", which are approved by the Charitable Funds Committee. There is a tightly controlled scheme of authorisation in place in order to spend the funds. This is achieved by delegating the day to day expenditure to the duly authorised Fund Holders. The Fund Holders consist mainly of senior department managers. Each individual Fund Holder is approved by the general manager or Clinical Director of the Directorate, and also made aware of the Trust's Standing Orders and Standing Financial Instructions, that apply to Charitable Funds. Each Fund Holder receives a detailed financial statement of the fund each month.

Risk Management

The major risks to the Charity have been assessed, and in the opinion of the Corporate Trustee, all necessary action has been taken and procedures have been put in place to minimise those risks wherever possible. The risk policies and financial controls of the Trust also apply to the Charitable Funds. The Corporate Trustee has identified that the main area of financial risk for the Charitable Funds is the performance of the investments.

To mitigate the risk of investment performance the Corporate Trustee has adopted a relatively low risk policy, but 50% of funds will remain exposed to those risks normally associated with investing in stocks and shares and regarded as medium to long term investment. The cash balances will be invested in bank accounts which have a low credit risk and are covered by the Financial Services compensation scheme up to a maximum of £85,000 per banking institution operating under a separate banking licence. The adopted policy is that the maximum investment is up to £85,000 in each banking institution outside the Government banking Scheme. Therefore there is no risk on these investments.

Investment Powers

The investment powers of the charitable fund are stated in the Declaration of Trust registered with the Charity Commission, which provides for the following:

‘‘*to invest the trust fund and any part thereof in the purchase of or at interest upon the security of such stocks, funds, securities or other investments of whatsoever nature and where so ever situate as the trustee in their discretion think fit but so that the trustees:*

a) shall exercise such power with the care that a prudent person of business would in making investments for a person for whom he felt morally obliged to provide;

b) shall not make any speculative or hazardous investment (and, for the avoidance of doubt, this power to invest does not extend to the laying out of money on the acquisition of futures or traded options);

c) shall not have power under this clause to engage in trading ventures; and

d) shall have regard to the need for diversification of investments in the circumstances of the Charity and to the suitability of proposed investments.’’

Investment strategy

The investment strategy of the charity is defined, by the charitable fund committee on behalf of the corporate trustee as follows:

“*to maximise total returns whilst minimising any risk to the total value of the fund in both the short to medium term.*”

The strategy identifies the current preferred investment mix for the charity as:

- 50% Cash;
- 25% Equities; and
- 25% Bonds.

The Charitable Funds Committee monitors the performance of the investments on a regular basis.

Professional Advisors

Grant Thornton UK LLP is the Trust’s appointed External Auditors. For the 2017/18 financial year, an independent examination will be carried out due to the charity’s gross income falling below £1m.

In addition, TIAA, the Internal Auditors of the Trust, review on a planned basis the systems and procedures put in place by the Corporate Trustee.

Aims and Objectives for the Public Benefit

The key objective of the Trustee of the Maidstone and Tunbridge Wells NHS Charity is to ensure that donations and legacies received are used in accordance with the wishes of the donor and the aims of the Trust. The Trustees therefore consider that the charity clearly falls within the definition of a public benefit entity under the terms of FRS 102.

The Corporate Trustee confirms that the guidance provided by the Charity Commission has been referred to with regard to the need for public benefit when reviewing their aims and objectives and future activities.

The purpose of the Charity is to provide benefit to the public by supporting the prevention and treatment of illness in all its forms and to promote research and education in healthcare through:

- Improving the patient and carer experience;
- Improving healthcare facilities and equipment;
- Facilitating high quality research programmes;
- Encouraging and supporting innovation in the development of services; and
- Supporting the training, personal development and welfare of staff.

The objects of the Charity are stated in the Trust deed as follows:-

"*The Trustees shall hold the trust fund upon trust to apply the income, and at their discretion, so far as may be permissible, the capital, for such purposes relating to Hospital Services (including Research), or to any other part of the Health Service associated with any hospital as the Trustees think fit.*"

The restricted funds have individual specified purposes that govern their use, in conjunction with the objects of the Charity.

Strategy for Achieving its Objectives

The Charitable Funds are used to support the overall objectives of the Trust, and include the provision of a wide range of equipment and facilities for both patients and staff. This allows the Trust to develop its services through new equipment and facilities and to provide training for staff which enhances their skills and knowledge allowing them to improve their contribution to the provision of its services to the public benefit.

The development of the Trust's services may be dependent on both the Charitable Funds and the funds received from the Exchequer. This interdependency provides opportunities for the Charity to contribute to services which make a greater impact than the cash sum would make on its own.

Reserves and Commitments

Charity Reserves as defined by Charities SORP (FRS 102) are those funds which become available to the charity to be spent at the Trustee's discretion in furtherance of the charity's objectives, excluding funds which are spent or committed or could only be realised through the disposal of fixed assets. These are therefore classified as 'free'.

The Corporate Trustee has not made any changes to policy during the year and still requires that commitments against each fund are made only when the resources needed are available.

Major items of expenditure for both goods and services are agreed in advance in order that the necessary liquid resources can be released from the Investment Managers on a planned and

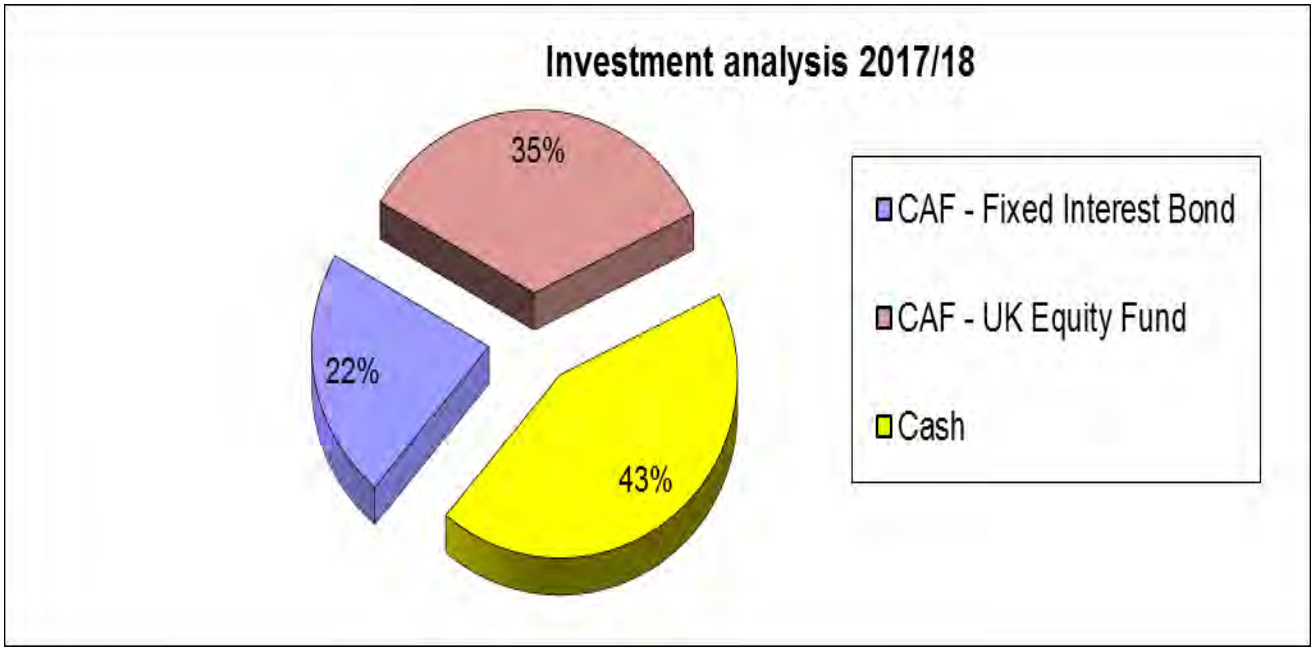
timely basis. None of the funds held by the Investment Managers are committed on a long term basis as the Corporate Trustee has a policy to put the funds to the best possible use as quickly as is reasonably possible, taking into consideration any particular restrictions imposed by individual donors.

Investment Performance

Investment income for the year was £21k (in 2016/17, £21k). In the current economic climate this is considered to indicate an acceptable performance for an investment strategy based on a low risk portfolio of investments. The total performance return on the portfolio of the investments (equity and bond) was a loss of £12k which equates to a loss of -1.88% on the opening portfolio value (in 2016/17, 8.67% gain). This reflects a downturn in market performance compared with the previous year. The Trustee continues to review its investment strategy to seek to maximise its resources whilst maintaining liquidity and security of assets.

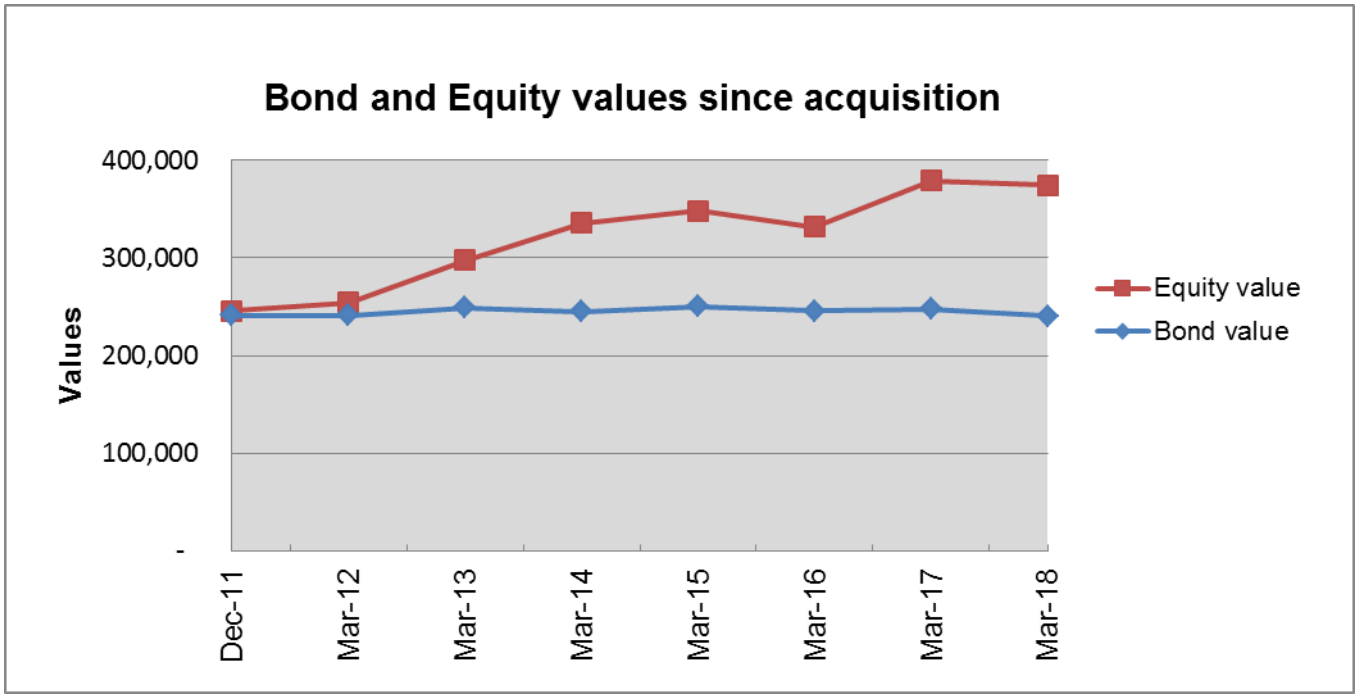
The value of equities and bonds varies according to market forces with the CAF bonds and equities portfolio decreasing in market value to £615k at 31 March 2018 (£627k at 31 March 2017). The cash investment at 31 March 2018 was £470k (£1,081k at 31 March 2017).

The current asset portfolio of cash and investment allocation totalling £1,085k at 31 March 2018 is shown in the following graph:



The cash allocation at 43% is slightly lower than the strategy of Cash of 50%. The bonds investment of 22% is lower than the 25% bond strategy; whilst the equities investment is higher at 35% than the planned strategy of 25%. The Charity has eliminated the creditor balance brought forward and so reduced its cash holding. This will be reviewed as part of the annual investment strategy update. Both the bond and equity investments have not performed as well as last year, although equity investments continue to perform better than bond investments over time.

The graph below demonstrates the performance of the bonds and equities since their purchase in December 2011.

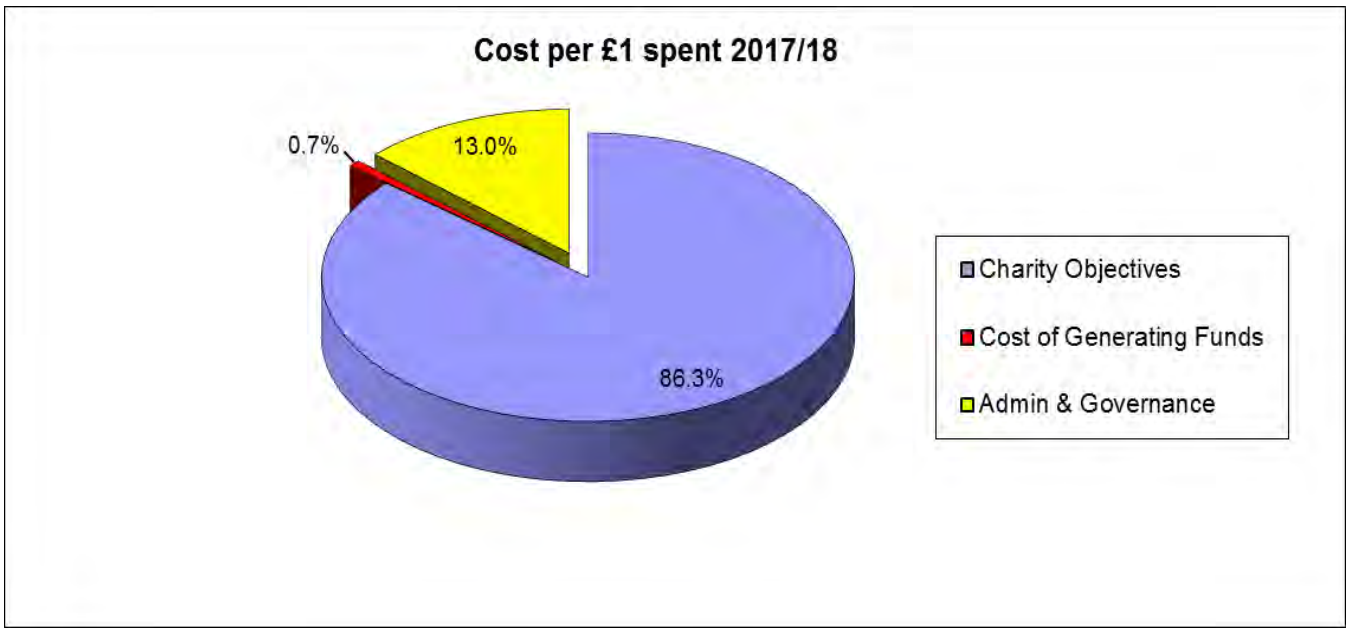


Performance of the portfolio is monitored and reviewed by the Charitable Funds Committee.

Achievement of public benefit

The Trust applies its charitable funds to enhance services and amenities for the public both as patients and visitors as well as staff through the purchase of equipment and support for projects.

The graph below shows that in this financial year for every £1 of expenditure, 86 pence was spent in achieving the objectives of the charity. This is less than the equivalent ratio for 2016/17 (93 pence) as a result of the administrative costs remaining relatively fixed whilst expenditure reduced in 2017/18.



Expenditure

Total resources expended by the Charity within this financial year were £416k (in 2016/17, £716k), breakdown as follows:

Contribution to NHS:

- £225k Medical Equipment (in 2016/17, £347k)
- £66k Oncology rapid plan licences (in 2016/17, none)
- £53k Governance costs (in 2016/17, £51k)
- £40k Radial lounge building costs (in 2016/17, none)
- £12k Furniture and Fittings (in 2016/17, £137k)

Staff Welfare:

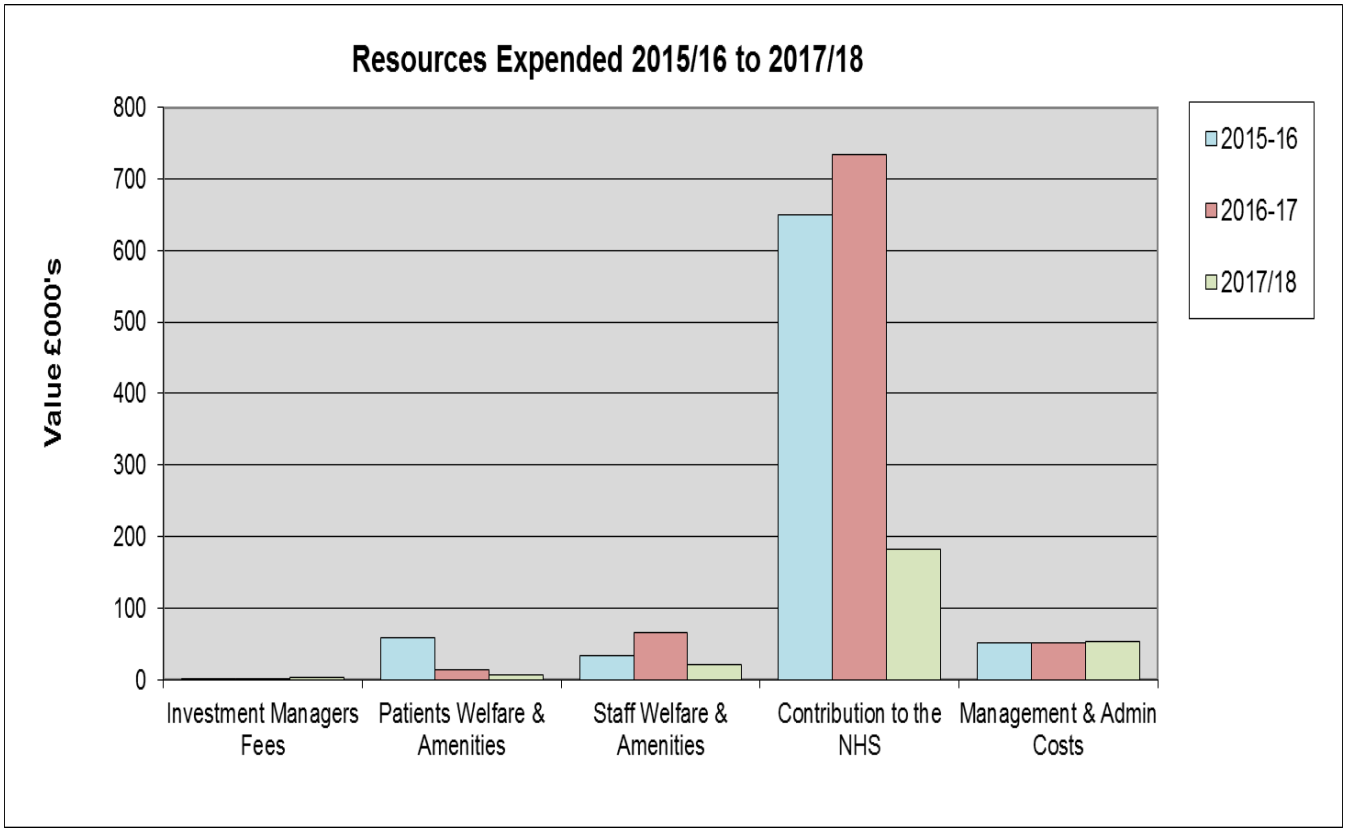
- £21k Staff Welfare and amenities (in 2016/17, £65k)

Patients Welfare:

- £6k patients welfare and amenities (in 2016/17, £14k)

Included within the governance cost of £53k are the internal management fees for administering the funds. The fees are agreed each year by the Trustees. These costs are charged proportionately across the individual funds on a quarterly basis.

The following graph provides an analysis and comparison with previous years:



Charitable expenditure for the year is detailed below.

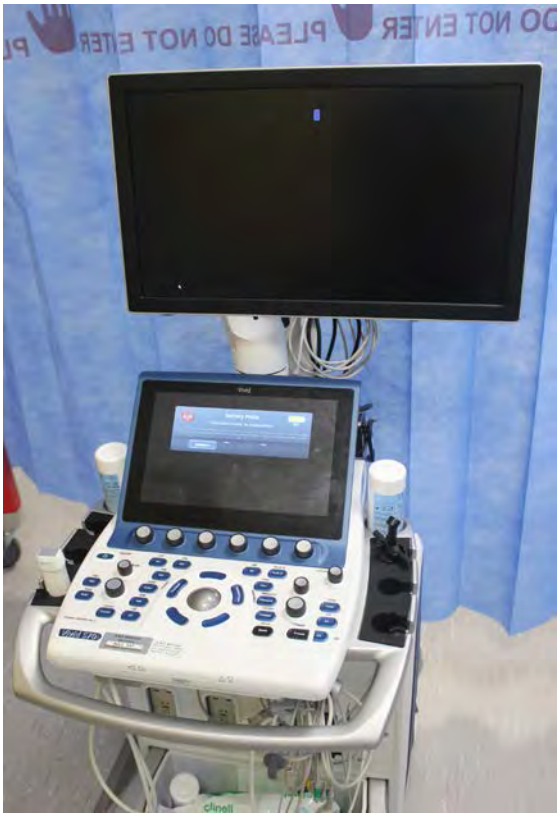
Medical Equipment – Total spend £225k (in 2016/17, £347k)

Medical equipment has been purchased within the reporting year to provide additional resources to enhance the quality of treatment, services and amenities within the Trust.

The most significant purchases were:

- 2 Portable echocardiogram Machines – Cardiology (£71k)
- Ultrasound for Oncology (£49k)
- 10 Pactosafe mobile Chemotherapy System (£18k)
- Ultrasound machine Cardiology £16k)
- 5 Automatic electrocardiogram (ECG) event recorders (£11k)

Portable Echocardiogram Machines in Cardiology



Oncology Ultrasound

Patient Welfare and amenities – Total spend £6k (in 2016/17, £14k)

The most significant spends were:

- Complementary therapy (£3k)

Staff Amenities and Welfare – Total spend £21k (in 2016/17, £65k)

Staff throughout the Trust 'go the extra mile' to ensure the best quality of care for patients. The corporate Trustee recognises this commitment and the hard work and care given to patients and to those who visit the Trust.

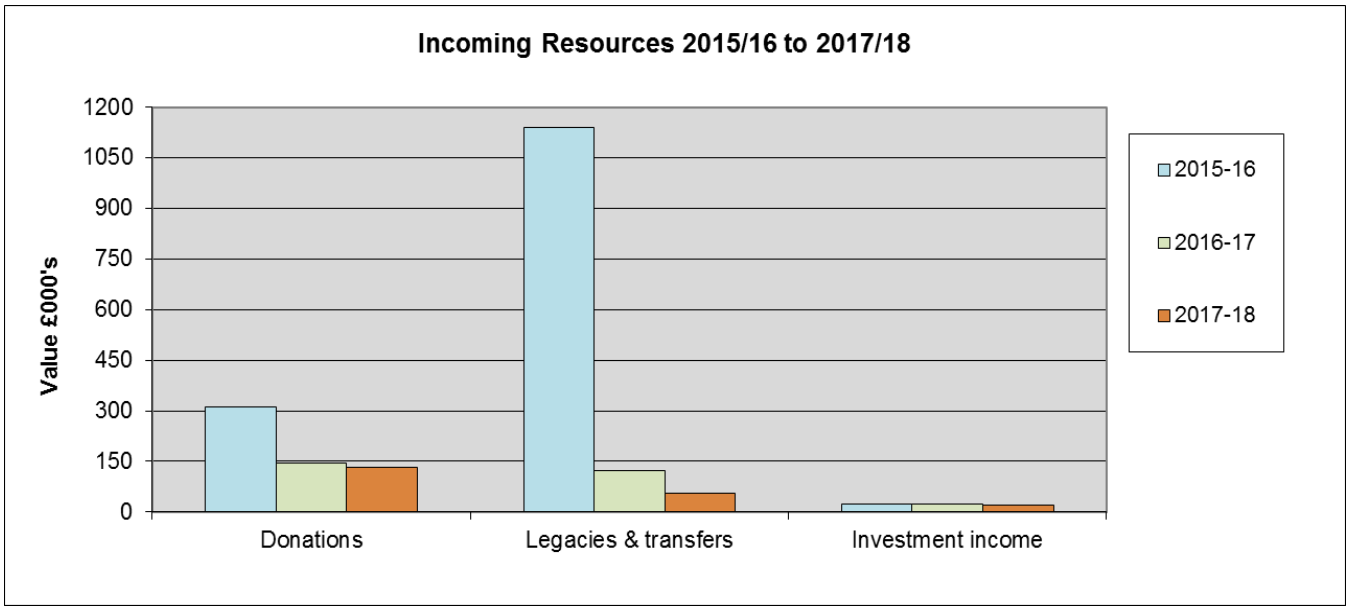
The majority of the expenditure (61%) is focussed on additional training, allowing staff to develop within their roles and allowing them to enhance patient care and experience.

Other – Total spend £95k (in 2016/17, £26k)

The most significant spend was on the purchase of 2 Rapid Plan licences totalling £66k.

Income

The graph below shows an analysis of income sources for the current and two previous financial years:



The majority of income received by the Charity is from grateful patients and relatives who wish to support the Trust in appreciation of the work and care provided by the Trust staff.

A total of £131k was received from donations (in 2016/17, £145k) and £56k from legacies (in 2016/17, £125k). We have immense appreciation of the generosity of all donors and their families.

The Trust received 2 significant (>£10k) donations both from the Tunbridge Wells Area Diabetes Resources Appeal (TWADRA), totalling £42k.

Legacies

Legacies were received from the estates of the following:

	£000's
Cynthia D M Shuttle	42
Robert Garofalo	10
Mrs Jean Avery	2
D A Eversden	2
Total legacy funding received	**56**

The Trust holds no material assets bequeathed to the charity but subject to a life tenancy interest held by a third party.

Fundraising

The Trust has a 'just giving' page that received donations of £7k this year compared to £17k last year. The Trust did not undertake any other fundraising activity during 2017/18 specifically for the MTW Charity.

Gift Aid is being encouraged and staff have been reminded to ask donors to use the donation

and gift aid forms to increase their donation.

The Trust is pursuing the recruitment of a dedicated Fundraiser

Intangible Income

The Statement of Financial Activity does not include any estimation of intangible income in respect of volunteers' services or the free use of Trust premises.

Looking Forward - our plans for the future

The Trustee is dedicated to strengthening the long term viability of the Charity, working in partnership with the Trust to achieve their aim to deliver a first class healthcare service for our patients.

The Trust is a member of the Association of NHS Charities and continues to work with colleague organisations to ensure best practice in the Charity's activities.

The charity received good levels of voluntary income in 2017/18, thanks to the generosity of various donors, some of which are highlighted above.

Making donations

There are several ways that the generosity of those wishing to donate to our funds can be enhanced through tax saving schemes such as Gift Aid and through the internet at www.justgiving.com/mtwnhscharitablefund.

We hope that you will continue to support the Trust as it seeks to enhance patient care and support staff in delivering a first class service to patients, relatives and visitors.

If you would like to find out more about the work of the Charity, make a donation, or raise funds, please contact the Trust at the principal office (details on page 4), via the Trust website at www.mtw.nhs.uk or complete the attached form at the end of this Report and send it to the Trust.

Statement of Trustee responsibilities in respect of the Trustee Annual Report and the financial statements

Under charity law, the Corporate Trustee is responsible for preparing the Annual Report and the financial statements for each financial year which show a true and fair view of the state of affairs of the Charity and of the financial position at the end of the year.

In preparing these financial statements, the trustee is required to:

- select suitable accounting policies and then apply them consistently;
- observe the methods and principles in the Charities SORP
- make judgements and estimates that are reasonable and prudent;
- state whether applicable UK accounting standards have been followed, subject to any material departures disclosed and explained in the financial statements;
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue its activities.

The trustee is required to act in accordance with the trust deed of the charity, within the framework of trust law. They are responsible for keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the charity and to enable them to ensure that the financial statements comply with the Companies Act 2006. They are also responsible for safeguarding the assets of the charity and the group and hence taking reasonable steps for the prevention and detection of fraud and other irregularities. They have general responsibility for taking such steps as are reasonably open to them to safeguard the assets of the charity and to prevent and detect fraud and other irregularities.

The trustee is responsible for the maintenance and integrity of the corporate and financial information included on the charitable company's website. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Statement as to disclosure to our auditors

In so far as the trustee is aware at the time of approving its Annual Report:

- there is no relevant information, being information needed by the auditor in connection with preparing their report, of which the group's auditor is unaware, and
- the trustee, having made enquiries of fellow directors and the group's auditor that they ought to have individually taken, have each taken all steps that he/she is obliged to take as a director in order to make themselves aware of any relevant audit information and to establish that the auditor is aware of that information.

By Order of the Trustee

Signed:

David Highton,
Chair of the Trust Board
Maidstone and Tunbridge Wells NHS Trust

Date: …….

Independent examiner's report to the trustees of Maidstone and Tunbridge Wells NHS Charitable Fund

I report on the accounts of Maidstone and Tunbridge Wells NHS Charitable Fund for the year ended 31 March 2018, which are set out on pages 19 to 34.

Your attention is drawn to the fact that the charity's trustees have prepared the charity's accounts in accordance with the Statement of Recommended Practice 'Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) (effective 1 January 2015) issued in May 2014 in preference to the Statement of Recommended Practice 'Accounting and Reporting by Charities: Statement of Recommended Practice (revised 2005)' issued in April 2005 which is referred to in the Charities (Accounts and Reports) Regulations 2008 but has been withdrawn. I understand that the charity's trustees have done this in order for the charity's accounts to give a true and fair view in accordance with United Kingdom Generally Accepted Accounting Practice effective for reporting periods beginning on or after 1 January 2015.

This report is made solely to the charity's trustees, as a body, in accordance with the regulations made under section 154 of the Charities Act 2011. My work has been undertaken so that I might state to the charity's trustees those matters I am required to state to them in an independent examiner's report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the charity and the charity's trustees as a body, for my work, for this report, or for the opinions I have formed.

Respective responsibilities of trustees and examiner

The charity's trustees are responsible for the preparation of the accounts. The charity's trustees consider that an audit is not required for this year under section 144(2) of the Charities Act 2011 and that an independent examination is needed.

It is my responsibility to:

- examine the accounts under section 145 of the Charities Act 2011;
- to follow the procedures laid down in the general Directions given by the Charity Commission under section 145(5)(b) of the Charities Act 2011; and
- to state whether particular matters have come to my attention.

Basis of independent examiner's report

My examination was carried out in accordance with the general Directions given by the Charity Commission. An examination includes a comparison of the accounts with the accounting records kept by the charity. It also includes consideration of any unusual items or disclosures in the accounts, and seeking explanations from you as trustees concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit and consequently no opinion is given as to whether the accounts present a 'true and fair' view and the report is limited to those matters set out in the statement below.

Independent examiner's statement

In connection with my examination, no matter has come to my attention:

- which gives me reasonable cause to believe that in any material respect the requirements:
    - to keep accounting records in accordance with section 130 of the Charities Act 2011;
    - to prepare accounts which accord with the accounting records; and

- to comply with the applicable requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations 2008 have not been met; or

- to which, in my opinion, attention should be drawn in order to enable a proper understanding of the accounts to be reached.

Darren Wells CPFA
Grant Thornton UK LLP
Chartered Accountants
2nd Floor, St John's House
Haslett Avenue West
RH10 1HS
[**Date**]

Statement of Financial Activities for the year ended 31st March 2018

					2017/18	2016/17
	Note	Unrestricted Funds	Restricted Funds	Endowment Funds	**Total Funds**	Total Funds
		£000	£000	£000	**£000**	£000
Income	2					
Donations		84	47	0	**131**	145
Legacies		56	0	0	**56**	125
Total Donations and Legacies		**140**	**47**	**0**	**187**	**270**
Investment income		7	14	0	**21**	21
Total income		**147**	**61**	**0**	**208**	**291**
Expenditure	3					
Costs of generating funds	3.1	(2)	(1)	0	**(3)**	(2)
Charitable Activities						
Activities in furtherance of Charity's objectives	3.2	(80)	(333)	0	**(413)**	(714)*
Total expenditure		**(82)**	**(334)**	**0**	**(416)**	**(716)***
Gains / (losses) on investments	4	(3)	(9)	0	**(12)**	50
Net income/expenditure		**62**	**(282)**	**0**	**(220)**	**(376)***
Fund transfer	4	0	0	0	**0**	0
Net movement in funds	4	62	(282)	-	**(220)**	(376)*
Fund balances brought forward at 31 March 2017		213	1128	9	**1,350**	1,726
Fund balances carried forward at 31st March 2018		**275**	**846**	**9**	**1,129**	**1,350***

*restated 2016/17 expenditure to reflect the credit note received in 2017/18, see note 1.13

The notes at pages 22 to 34 form part of these financial statements.

Please note there may be some rounding's within the numbers

Balance Sheet as at 31st March 2018

					2017/18	2016/17
	Note	Unrestricted Funds £000's	Restricted Funds £000's	Endowment Funds £000's	**Total Funds £000's**	Total Funds £000's
Fixed Assets	5					
Investments	5.1	150	465	0	**615**	627
Total Fixed Assets		**150**	**465**	**0**	**615**	**627**
Current Assets	**6**					
Cash at bank and in hand	6.1	114	348	9	**470**	1,081
Debtors due within one year	6.2	11	33	0	**44**	0
Total current Assets		**125**	**381**	**9**	**514**	**1,081**
Liabilities						
Creditors due within one year	7.1	0	0	0	**0**	(358)*
Net Current Assets / (Liabilities)		**125**	**381**	**9**	**514**	**723***
Total Net Assets		**275**	**846**	**9**	**1,129**	**1,350***
Funds of the Charity	8					
Endowment Funds		0	0	9	**9**	9
Restricted Funds		0	846	0	**846**	1,128*
Unrestricted Funds		275	0	0	**275**	213
Total Funds		**275**	**846**	**9**	**1,129**	1,350*

*2016/17 restated creditor balance to reflect the credit note received in 2017/18, see note 1.13
For purposes of splitting assets / liabilities by category, restricted and unrestricted funds are categorised by transactions, whilst endowment funds are categorised only as cash.

The charitable funds financial statements were approved by the Trust Board on the 20th December 2018 and signed on its behalf as Trustee by:

_____ _____

David Highton, Date
Chair of the Trust Board, Maidstone and Tunbridge Wells NHS Trust

Statement of cash flows

Cash flows from operating activities:	**2017/18**	2016/17
	£000	£000
Net income / (expenditure) for the reporting period (as per the statement of financial activities)	**(220)**	(376)*
Adjustments for:		
(Gains) / losses on investments	**12**	(50)
Dividends, interest and rents from investments	**(21)**	(22)
(Increase) / decrease in debtors	**(44)**	0
Increase / (decrease) in creditors	**(358)**	(7)*
Net cash provided by (used in) operating activities	**(631)**	(455)*
Cash flows from investing activities:		
Dividends, interest and rents from investments	**21**	22
Net cash provided by (used in) investing activities	**21**	22
Cash flows from financing activities:		
Net cash provided by (used in) financing activities	**0**	0
Change in cash and cash equivalents in the reporting period	**(611)**	(433)
Cash and cash equivalents at the beginning of the reporting period	**1,081**	1,514
Cash and cash equivalents at the end of the reporting period	**470**	1,081
Analysis of cash and cash equivalents:		
Cash in hand	**470**	1,081

*Restated 2016/17 expenditure and creditor balances to reflect the credit note received in 2017/18, see note 1.13

Notes to the financial statements for the year ended 31st March 2018

1. Principal accounting policies

1.1. Basis of preparation

The financial statements have been prepared in accordance with applicable Accounting and Reporting by Charities: Statement of Recommended Practice (SORP) applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) effective 1 January 2015 and the Charities Act 2011. A summary of the principal accounting policies, which have been applied consistently, are set out below.

The financial statements are prepared in accordance with the historical cost convention, except for Investments, which are included at market value. During the year, the Charity reviewed its accounting policies and made no changes.

The Trustees consider that there are no material uncertainties about the Charity's ability to continue as a going concern and uncertainties affecting the current year's accounts. The charity ended the year with £1.1m in available funds which the trustees consider to be sufficient to ensure that the charity is able to meet its existing plans and obligations. The charity receives donations and legacies at differing levels from year to year but the underlying healthcare activities are continuing which supports a reasonable assumption of future donations. The Trustees are considering a range of proposals to enhance the visibility of the charity and to increase its fundraising effectiveness.

1.2. Reconciliation with previous generally accepted accounting practices

These accounts are continued to be prepared in accordance with FRS 102 and the charities SORP FRS 102.

Governance and administration costs are classified as a support cost and have therefore been apportioned between fundraising activities and charitable activities on a cost basis (see note 3). The Trustees consider this is an equitable treatment to avoid disadvantaging funds with high volume low value transactions. All funds attract administrative costs even without any expenditure as these have to be monitored, fund managers approached for future plans, investment transactions and overhead charges. The cost of the transaction does not necessarily reflect on the work involved to achieve that expenditure and therefore consistency is maintained by working with an activity cost based apportionment.

1.3. Income

Donations, grants, legacies and gifts in kind (voluntary Income)
All incoming resources are recognised once the charity has evidence of entitlement and it is probable (more likely than not) that the resources will be received and the monetary value can be measured with sufficient reliability. It is not the charity's policy to defer income.

Where there are terms or conditions attached to the incoming resource (particularly grants) then these must be met before the income is recognised as the entitlement will not be evidenced, or where there is uncertainty that the conditions can be met, and then the income is not recognised in the year. It is not the Charity's policy to defer income even where a pre-condition for use is imposed.

Legacies are accounted for as incoming resource either on receipt or where the receipt of the legacy is probable. Receipt is provable when:

- Confirmation has been received from the representatives of the estate(s) that probate has been granted
- The executors have established that there are sufficient assets in the estate to pay the legacy and
- All conditions attached to the legacy have been fulfilled or are within the charity's control
- Where the amount of the legacy can be reliably estimated.
- Legacies which are subject to a life interest party are not recognised.

Where a reliable estimate cannot be identified, then the legacy is disclosed as a contingent asset.

Income resources from Capital Endowments are placed into an income fund when received. Income will be placed into funds in accordance with donors' wishes, but without forming a binding trust, unless a signed document is received and approved by Trustees.

Gifts in kind are valued at a reasonable estimate of their value to the Charity. Gifts donated for resale are included as income either when they are sold or at the estimated resale value after deduction of the cost to sell the goods.

Intangible Income
Intangible income, which comprises donated services or use of Trust property, is included in income at a valuation which is an estimate of the financial cost borne by the donor where such a cost is material, quantifiable and measurable. No income is recognised when there is no financial cost borne by a third party.

Investment Income
Investment Income and gains and losses on investments are credited / charged to the funds quarterly using the average fund balance to apportion the gain / loss.

1.4. Expenditure

All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs related to the category of expense shown in the Statement of Financial Activities. All expenditure is recognised when the following criteria are met:

- There is a present legal of constructive obligation to make a payment to a third party – primarily to the Trust in furtherance of the charitable objectives.
- It is more likely than not that a transfer of benefits (usually a cash payment) will be required in settlement
- The amount of the obligation can be measured or estimated reliably.

The Trustees have control over the amount and timing of grant payments and are usually given with the condition that an item or service has been purchased. Conditions have to be met before the liability is recognised.

Irrecoverable VAT
Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

Allocation of support costs
Support costs are those costs which do not relate directly to a single activity. These include some staff costs, costs of administration, internal and external audit costs and IT support.

These costs include recharges of appropriate proportions of the staff costs and overheads from Maidstone and Tunbridge Wells NHS Trust and are apportioned on an average fund balance monthly across all funds.

Charitable activities
Expenditures are given as grants made to third parties (including NHS bodies) in furtherance of the charitable objectives of the funds. They are accounted for on an accruals basis, in full, as liabilities of the Charity when approved by the trustees and accepted by the beneficiaries.

Exceptional Items
Exceptional Items are shown on the face of the Sofa under the category to which they relate with further detail, where appropriate, provided in the notes.

Costs of generating funds
The costs of generating funds are the costs associated with generating income for the funds held on trust. This will include the costs associated with Investment Managers and other promotional and fundraising events including any trading activities.

Recognition of liabilities
Liabilities are recognised as and when an obligation arises to transfer economic benefits as a result of past transactions or events.

Analysis of grants
The Charity does not make grants to individuals. All grants are made to the Trust to provide for the care of NHS patients in furtherance of it charitable aims. The total cost of making grants, including support costs, is disclosed on the face of the Statement of Financial Activities and further analysis in relation to activity is provided in note 3.

1.5. Structure of funds

Unrestricted funds are general funds, which are available for use at the discretion of the Trustee in furtherance of the objectives of the Charity. Funds which are not legally restricted but which the Trustee has chosen to earmark for set purposes are designated funds.

Where there is a legal restriction or a binding agreement with a donor, on the purpose for which a donation may be use, the fund is classified in the accounts as a restricted fund.

Endowment Funds are funds that hold capital in perpetuity. Investment income resulting from these capital holdings may be utilised in accordance with the donor's wishes.

Transfers between funds are made at the discretion of the Trustee, taking account of any restrictions imposed by the donor.

The purposes of each fund with a balance in excess of £10,000 at the year-end are set out in note 8.1 to the financial statements.

1.6. Finance and Operating Leases

The Charity has no finance or operating leases

1.7. Fixed Assets

Tangible Fixed Assets
The Charity held no tangible fixed assets during the year.

Investments Fixed Assets
Investments held by the Trustee's investment advisers are included at closing market value at the balance sheet date. Any realised and unrealised gains and losses on revaluation or disposal are combined in the Statement of Financial Activities. All investments held are pooled across all of the funds. Please see investment strategy on page 7 for further information.

Investment properties
The Charity held no investment properties during the year

1.8. Stocks

The Charity held no stocks during the year

1.9. Gains and losses

Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (or date of purchase if later).

Unrealised gains and losses are calculated as the difference between market value at the year end and opening market value (or date of purchase if later). Investment income and gains/losses are allocated quarterly according to the average fund balance, to the appropriate fund and included within the Statement of Financial Activities.

1.10. Cash and Cash equivalents

Cash is represented by the balance maintained in the charity bank accounts and is used to meet the operational costs of the charity as they fall due.

Cash equivalents are short term liquid investments held for a period of 3 months or less in interest bearing accounts that are readily convertible to cash with no risk of change in value.

As a requirement of FRS 102, a statement of cash flows has been included in the accounts to provide information about the ways in which the charity uses the cash generated by its activities and about changes in cash and cash equivalents held by the charity.

1.11. Financial Instruments

The Charity only has financial assets and financial liabilities that qualify as basic financial instruments. Basic financial instruments are initially recognised at transaction value and subsequently measured at their settlement value with the exception of investments which are subsequently measured at fair value.

1.12. Pensions

The Charity has no employees.

1.13. Prior Year Adjustments

In 2016/17 the accounts included accruals for two invoices for cardio echo machines from two suppliers with different values. During 2017/18 it became clear that these were for the same machine and by mistake the primary supplier had invoiced the charity rather than NHS Supply Chain with whom the Trust had contracted. The primary supplier invoice was cancelled with a credit note for £150k and only the NHS Supply Chain invoice was paid as contracted. This transaction is material in relation to the Charity's net assets and has therefore been treated as a prior year adjustment with the relevant balances adjusted.

2. Income

				2017/18	2016/17
Voluntary Income	Unrestricted Funds	Restricted Funds	Endowment Funds	**Total Funds**	Total Funds
	£000	£000	£000	**£000**	£000
Donations	77	47	0	**124**	128
Donations – website	7	0	0	**7**	17
Legacies	56	0	0	**56**	125
Total Donations and Legacies	**140**	**47**	**0**	**187**	**270**
Investment income					
Dividends from investment portfolio	5	12	0	**17**	18
Interest from investment portfolio	1	1	0	**2**	0
Bank Interest	1	1	0	**2**	3
Total Investment income	**7**	**14**	**0**	**21**	**21**
Total incoming resources	**147**	**61**	**0**	**208**	**291**

3. Expenditure

3.1. Cost of generating funds				**2017/18**	2016/17
	Unrestricted Funds	Restricted Funds	Endowment Funds	**Total Funds**	Total Funds
	£000	£000	£000	**£000**	£000
Investment managers fees	(2)	(1)	0	**(3)**	(2)

				2017/18	2016/17
3.2. Charitable Activities	Unrestricted Funds	Restricted Funds	Endowment Funds	**Total Funds**	Total Funds
	£000	£000	£000	**£000**	£000
Patients welfare and amenities					
Hospitality	0	0	0	0	0
Other	(3)	0	0	(3)	(8)
Complementary Therapies	0	(3)	0	(3)	(6)
Total patients welfare and amenities	**(3)**	**(3)**	**0**	**(6)**	**(14)**
Staff welfare and amenities					
Training	(8)	(5)	0	(13)	(56)
Hospitality	0	0	0	0	0
Christmas Events	0	0	0	0	(7)
Other	(8)	(0)	0	(8)	(2)
Total staff welfare and amenities	**(16)**	**(5)**	**0**	**(21)**	**(65)**
Medical and Rehabilitation Equipment	(24)	(201)	0	(225)	(347)*
Furniture and Fittings	(12)	0	0	(12)	(137)
Other	(13)	(82)	0	(95)	(26)
IT	0	0	0	0	(73)
Governance - Salaries & overheads	(10)	(41)	0	(51)	(47)
Governance - Audit Fees (external)	(2)	(1)	0	(3)	(4)
Total contribution to Maidstone and Tunbridge Wells NHS Trust	**(61)**	**(325)**	**0**	**(386)**	**(634)***
Total cost of charitable activities	**(80)**	**(333)**	**0**	**(413)**	**(714)***
Total resources expended	**(82)**	**(334)**	**0**	**(416)**	**(716)***

*Restated 2016/17 balances to reflect credit note received in 2017/18

Employee Information

The Charity does not employ any staff directly, although members of the finance team support the governance and administration function of the Charity. Their costs have been included in the table above.

During the year none of the members of the NHS Trust Board or senior NHS staff or parties related to them were beneficiaries of the Charity. Neither the Corporate Trustee nor any member of the NHS Trust Board has received honoraria, emoluments, or expenses in the year and the Corporate Trustee has not purchased trustee indemnity insurance.

4. Net Movements in Funds

				2017/18	2016/17
	Unrestricted Funds	Restricted Funds	Endowment Funds	**Total Funds**	Total Funds
	£000	£000	£000	**£000**	£000
Net Incoming/(outgoing) resources before other recognised gains and losses	65	(273)	0	**(208)**	(426)*
Gains/Losses on Investments	(3)	(9)	0	**(12)**	50
Total net movement in funds	**62**	**(282)**	**0**	**(220)**	(376)*
Funds transfers	0	0	0	**0**	0
Total net movement in funds after transfers	**62**	**(282)**	**0**	**(220)**	(376)*
Fund balances at 1st April 2017	213	1128	9	**1,350**	1,726
Fund balances carried forward at 31st March 2018	**275**	**846**	**9**	**1,129**	1,350*

*Restated 2016/17 balances to reflect credit note received in 2017/18

5. Analysis of Movement of Fixed Asset Investments

5.1. Investments	Carrying value at 01/04/17	Additions to investment at cost	Disposals at carrying value	Net gain / (loss) on revaluation	**Carrying value at 31/03/2018**
	£000	£000	£000	£000	**£000**
CAF Bond Income Fund (UK)	248	0	0	(8)	**240**
CAF Equity Growth Fund (UK)	379	0	0	(4)	**375**
Total Fixed Asset Investments	**627**	**0**	**0**	**(12)**	**615**

6. Current Assets

6.1. Cash and cash investments	**2017/18**	2016/17
	Total Funds	Total Funds
	£000	£000
Cash Investments:		
Santander	**82**	82
Clydesdale	**87**	86
CAF	**80**	80
Operational Bank Accounts:		
Government Banking Service (GBS) bank account	**200**	750
Nat West bank account	**21**	83
Total Cash and Cash Investments	**470**	**1,081**

6.2. Debtors	**2017/18**	2016/17
	Total Funds	Total Funds
	£000	£000
Intercompany debtor between Trust exchequer and charity accounts	**44**	0
Total Debtors due within one year	**44**	**0**

7. Current Liabilities

7.1. Creditors	**2017/18**	2016/17
	Total Funds	Total Funds
	£000	£000
Amounts falling due within one year:		
Trade Creditors	**9**	(7)*
Other Creditors	**0**	0
Intercompany creditor between the charity and the Trust exchequer account	**0**	(342)
Accruals	**(9)**	(9)
Total Creditors due within one year	**0**	**(358)***

*Restated 2016/17 balances to reflect credit note received in 2017/18

8. Details of Funds

Description	Fund number	Fund Type	Balance 01-Apr-2017	Incoming Resources	Resources Expended	Gain & (losses) on revaluation & disposal of investment assets	Balance 31-Mar-2018
			£000	**£000**	**£000**	**£000**	**£000**
A.Haines – Capital in perpetuity	67020	Endowment	7	0	0	0	7
E.C.Beedle Fund - Capital in perpetuity	67010	Endowment	2	0	0	0	2
Total Endowment Funds			**9**	**0**	**0**	**0**	**9**

Description	Fund number	Fund Type	Balance 01-Apr-2017	Incoming Resources	Resources Expended	Gain & (losses) on revaluation & disposal of investment assets	**Balance 31-Mar-2018**
			£000	£000	£000	£000	**£000**
Cardiac Equip Fd Ms Crow Legacy	65450	Restricted	164*	1	(90)	1	**76**
Cardio Equip TW Hayling Legacy	65460	Restricted	597**	5	(54)**	8	**556**
E&M Dir Diabetes Fund Tw	65410	Restricted	60	46	(17)	(13)	**75**
Gastrointestinal Fund	65340	Restricted	11	1	(2)	(2)	**8**
Neurology Fund	65990	Restricted	11	0	(5)	(1)	**7**
Oncology Centrifuge Fund	61490	Restricted	25	0	(1)	0	**24**
Oncology Equipment Fund	67170	Restricted	151*	5	(156)	0	**0**
Oncology Prostate Equip Fund P Ward Legacy	61310	Restricted	10	0	(0)	0	**9**
Pierre Fabre Grant Fund	61720	Restricted	61	1	(4)	(1)	**57**
E&M Directorate - Frances Gibson Legacy	65180	Restricted	25	1	(2)	(1)	**24**
Other Restricted Funds (closing balances <£10,000)			13	0	(2)	0	**10**
Total Restricted Funds			**1128****	**62**	**(334)****	**(8)**	**846**

* The opening balances for these three accounts have been restated to reflect the actual ledger balances, these were incorrectly reported in 2016/17 accounts

**Restated opening balance and in year expenditure to reflect the credit note received in 2017/18

Description	Fund number	Fund Type	Balance 01-Apr-2017	Incoming Resources	Resources Expended	Gain & (losses) on revaluation & disposal of investment assets	Balance 31-Mar-2018
			£000	**£000**	**£000**	**£000**	**£000**
Trust Management Dir Fund	61000	Unrestricted	25	8	(16)	0	**17**
Emergency & Medical Directorate	61020	Unrestricted	0	23	(10)	0	**13**
Surgery Directorate Fund	61140	Unrestricted	29	3	(1)	0	**31**
Cancer Services Fund	61350	Unrestricted	6	26	0	0	**32**
Radiology Fund	61590	Unrestricted	38	8	(7)	0	**39**
Cardiac Fund	65400	Unrestricted	39	11	(3)	(2)	**45**
Haematology Development Fund	65600	Unrestricted	14	0	(2)	0	**12**
Special Care Baby Unit Fund TW	65660	Unrestricted	24	9	(27)	0	**6**
Peggy Wood Breast Care Centre	67160	Unrestricted	0	44	(1)	0	**43**
Other Unrestricted Funds (closing balances <£10,000)		Unrestricted	37	15	(15)	(1)	**37**
Total Unrestricted Funds			**212**	**147**	**(82)**	**(3)**	**275**

8.1. Nature and Purpose of Material Funds (Closing balance > £10,000)

Restricted Funds	**Nature and purpose of Fund**
Medical Equipment Maidstone	Supports Maidstone Hospital
Haematology Fund	Supports the Haematology Department at Maidstone Hospital
Oncology Equipment Fund	Supports the Oncology Centre for the purchase of Equipment.
Pierre Fabre Grant Fund	Supports the Oncology Department at Maidstone Hospital with specialist procedures.
Gastrointestinal Fund	Supports the Gastrointestinal Unit at Maidstone Hospital
Neurology Fund	Supports the Neurology Department at Tunbridge Wells Hospital
Oncology Centrifuge Fund	Supports the purchase of a centrifuge for the Oncology Centre
Oncology Prostate Equip Fund	Supports the purchase of Prostate equipment for the Oncology Centre
E&M Directorate Gibson Legacy Fund	Supports the Emergency & Medical Directorate
Cardio Equip Hayling Legacy Fund	Supports the Cardio Respiratory Unit at Tunbridge Wells Hospital
Cardiac Equip Crow Legacy Fund	Supports the Cardiac Unit at Maidstone Hospital
E&M Dir Diabetes Fund TW	Supports the Diabetic Unit at Tunbridge Wells Hospital
Unrestricted Funds	
Trust Management Dir Fund	Supports Maidstone and Tunbridge Wells NHS Trust
Emergency & Medical Directorate	Supports the Emergency & Medical Directorate
Surgery Directorate Fund	Supports the Surgery Directorate
Cancer Services Fund	Supports the Cancer Services department
Radiology Fund	Supports the Radiology Department at Maidstone Hospital
Cardiac Fund	Supports the Cardio Respiratory Unit at Tunbridge Wells Hospital
Haematology Development Fund	Supports the development of Haematology across all sites of the Trust
Special Care Baby Unit Fund TW	Supports the Special Care Baby Unit at Tunbridge Wells Hospital
Peggy Wood Breast Care Centre	Supports the Peggy Wood Breast Care Centre

9. Charity Tax

Maidstone and Tunbridge Wells NHS Trust Charity is considered to pass the tests set out in Paragraph 1 Schedule 6 Finance Act 2010 and therefore it meets the definition of a charitable trust for UK income tax purposes. Accordingly, the charity is potentially exempt from taxation in respect of income or capital gains received within categories covered by Part 10 Income Tax Act 2007 or Section 256 of the Taxation of Chargeable Gains Act 1992, to the extent that such income or gains are applied exclusively to charitable purposes.

10. Related Parties

The Charity is established to hold the charitable funds of Maidstone and Tunbridge Wells NHS Trust.

During the year none of the NHS Trust Board or members of key management staff or parties related to them has undertaken any material transactions with Maidstone and Tunbridge Wells NHS Trust.

The Charity has made revenue and capital payments, in the form of grants, to Maidstone and Tunbridge Wells NHS Trust, the Corporate Trustee of the charity. In addition £54k (in 2016/17, £51k) was payable by the Charity to the Trust in respect of contribution to salaries and overheads to support the administration of the Charity. The amount owed at the balance sheet date to the Charity by the Trust was £44k, (in 2016/17, £0k). Total amount owed by the charity to the Trust for 2017/18 £0k (in 2016/17, £342k).

11. Events after the reporting year

In 2018/19 the Trust received £356k single donation from Mr and Mrs Sutcliffe. The Trust has not been advised of any other significant donation or legacies to be received in 2018/19.

mtw.nhs.uk
Charitable Fund

Donation Form

Registered Charity Number 1055215

Name: _____

Address: _____ Post Code: _____

Email: _____

Whilst recognising that this does not form a binding trust I would wish my donation of

£……..……..to be used for: (please tick one of the following)

☐ Wherever it will be most useful within the whole Trust to benefit patients and staff as determined by the Charity (This will be the default if no additional information is provided)

☐ The Directorate fund that supports ……..…Ward / Department.

Payment Methods

1 Cheques made payable to **Maidstone and Tunbridge Wells NHS Trust Charitable Fund**
2 Standing Order - Please call us on 01622 224500 to arrange for documentation to be sent
3 Make A Donation By Phone – If you would prefer to make a donation over the phone, please call 01622 224500. If you have an email address, we can send you bank details for electronic payments. We will require a remittance advice to enable us to receipt your donation. We currently accept the following cards: Maestro UK; MasterCard; Visa;
4 Visit our 'just giving' page www.justgiving.com/mtwnhscharitablefund

Gift Aid

If you are a UK taxpayer the Maidstone and Tunbridge Wells NHS Trust Charity (MTW) can reclaim the tax you have paid on every donation you make. You must have paid sufficient UK income or capital gains tax to cover the claim. For every £1 you give we can claim 25p back from the HM Revenue and Customs at no extra cost to you.

☐ YES, I am a UK taxpayer and would like MTW to reclaim tax on this and any future donations

Date……../……./…… Signature……..……..…….

☐ Please tick here if you DO NOT wish the Maidstone and Tunbridge Wells NHS Trust Charity to contact you by phone or post about our work

☐ Please tick here if you DO NOT wish the Maidstone and Tunbridge Wells NHS Trust Charity to contact you by email.

Please return to:

Maidstone and Tunbridge Wells NHS Trust, Financial Services, Maidstone Hospital, Hermitage Lane, Maidstone, Kent ME16 9QQ. Telephone 01622 224500 Website: www.mtw.nhs.uk

THANK YOU FOR YOUR SUPPORT

Trust Board meeting – December 2018

NHS Maidstone and Tunbridge Wells NHS Trust

12-16	Summary report from Audit and Governance Committee, 10/12/18 (incl. approval of revised Terms of Reference)	Committee Chair (Non-Executive Director)

The Audit and Governance Committee met on 10th December 2018.

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

- Revised Terms of Reference were agreed (as part of their annual review), and are submitted to the Board for approval (see Appendix 1 – with proposed changes 'tracked')
- Under the Safety Moment, the Trust Secretary reported that the month's theme was Falls and highlighted the key initiatives underway for the month
- A review of the Board Assurance Framework (BAF) and Summary of the status of the Trust's Risk Register was undertaken. It was agreed that for 2019/20, the BAF should be scheduled for consideration before review by the Trust Board where possible. See also point 5
- An update on progress with the Internal Audit plan 2018/19 was reviewed and it was agreed to explore the sharing of access to the internal audit database/client portal between TIAA Ltd and the Trust
- The intended process for the review/survey of the Internal Audit service, including the content of proposed survey documentation, was confirmed. It was agreed that TIAA Ltd's response (considered at the AGC meeting on 02/05/18) to the Review/Survey of the Internal Audit Service 2017/18 should be reviewed and key points issued with the Survey for 2018/19
- A Counter Fraud update was reviewed, and a summary of proactive and reactive workstreams given, along with an outline of the wider role of Counter Fraud in the review of Trust policies
- A 'Progress and emerging issues' report was received from External Audit and an early view on the approach to be taken for the Value For Money Conclusion given. It was confirmed that the audit of the Accounts for the MTW Charitable Fund 2017/18 was complete and that the Annual Report and Accounts for the Charitable Fund would be submitted for approval at the Trust Board meeting in December
- The intended process for the review/survey of the External Audit service, including content of the proposed survey documentation, was agreed. It was agreed to issue the "External Audit Response to the Review/Survey of the External Audit Service 2017/18 " (considered at the AGC meeting on 02/05/18) with the Survey for 2018/19, and to confirm the annual audit fee within the Survey
- A report detailing gifts, hospitality and sponsorship declared in the period 31/07/18 to 04/12/18 was considered, which showed a pro rata decrease in the volume of declarations to that of the previous reporting period. It was agreed to compare the Trust's policy on payment of fees/expenses for events attended by staff whilst on study leave with peer trusts' policy on this matter
- Details of Payments for compensation under legal obligation and the latest losses & compensations data were received
- The losses & compensations data to 30/11/18 was reviewed, and an outline of the measures in place to ensure pre-payment for treatment of overseas patients given
- The latest single tender waivers (STW) data was reviewed, which showed a significant reduction in the volume and values of waivers, compared with the same period and YTD of the prior year
- An update on the intended Annual Accounts process for 2018/19 and key dates was provided
- The Chief Finance Officer provided a verbal summary of the latest financial issues
- Revised Standing Orders were reviewed and it was agreed that the updated version should be issued for consultation by the Trust Secretary and the final version circulated to the AGC for approval out of meeting (in accordance with 11.1 of the Committee's ToRs) in time for ratification of the updated document by the Trust Board in January 2019

- Revised Standing Financial Instructions (SFIs) were considered and recommended for ratification by the Trust Board in December 2018
- The revised Reservation of Powers and Scheme of Delegation were considered and it was agreed to update the document with the outstanding points agreed at the AGC meeting on 10/12/18 and submit it for ratification by the Trust Board in December 2018
- It was agreed that both the Trust's Standing Financial Instructions and Reservation of Powers and Scheme of Delegation should be circulated to the Executive Team and Chiefs of Service, highlighting the relevance of the documents to individuals' roles and responsibilities, and inviting any queries to the Trust Secretary in advance of the Trust Board meeting in December 2018
- The Committee agreed the method and timing by which it would undertake its next self-assessment

2. The Committee received details of the following Internal Audit reviews:

- "Discharge Processes including Delayed Transfers of Care Follow Up"
- "Readiness Assessment EU General Data Protection Regulations"
- "Server Management"

3. The Committee was also notified of the following "Urgent" priority outstanding actions from Internal Audit reviews:

- Non Patient Related Income – 1 recommendation.
- Activity and Income – 2 recommendations.

4. The Committee agreed that (in addition to any actions noted above):

- None

5. The issues that need to be drawn to the attention of the Board are as follows:

Under the review of the BAF, the status of the objective to deliver the trajectory agreed with NHS Improvement for the 62-day Cancer waiting time target was noted, and there was discussion about whether the failure to meet significant targets was a reflection of a weakness in the governance measures in place to optimise assurance for delivery against key BAF objectives. It was therefore agreed to invite the Trust Board to review if further measures should be considered

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
- To approve the revised Terms of Reference for the Audit and Governance Committee (Appendix 1)

[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

Audit and governance Committee

Terms of Reference

Maidstone and Tunbridge Wells NHS Trust

Constitution / Purpose

1.1 The Audit and Governance Committee has been established by the Trust Board as a non-executive sub-committee of the Trust Board. The Committee has no executive powers, other than those specifically delegated in these Terms of Reference.

1.2 The Committee supports the Trust Board by critically reviewing the governance and assurance processes on which the Trust Board places reliance. This therefore incorporates reviewing Governance, Risk Management and Internal Control (including the Board Assurance Framework (BAF)); oversight of the Internal and External Audit, and Counter Fraud functions.

1.3 The Committee also undertakes detailed review of the Trust's Annual Report and Accounts.

1.4 The Trust Board has also appointed the Audit and Governance Committee as the Trust's Auditor Panel, in accordance with Schedule 4, Paragraph 1 of the Local Audit and Accountability Act 2014. The Auditor Panel will advise the Trust Board on the selection, appointment and removal of External Auditors, and on the maintenance of independent relationships with such Auditors.

Authority

2.1 The Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

2.2 The Committee is authorised to undertake all relevant actions to fulfil its role as the Trust's Auditor Panel.

Membership

3.1 The Committee shall be appointed by the Trust Board from amongst the Non-Executive Directors of the Trust (other than the Chair of the Trust Board), and shall consist of not less than three members. A Non-Executive Director Chair of the Committee will be appointed by the Trust Board, together with a Vice-Chair. If a Non-Executive Director member is unable to attend a meeting they will be responsible for finding a replacement to ensure quoracy for the meeting. The Chair and Vice-Chair of the Committee will also act as Chair and Vice-Chair (respectively) of the Auditor Panel.

3.2 Other individuals may be co-opted to become formal members of the Committee, ~~attend~~ to address issues of specific concern, at the discretion of the Committee Chair.

3.3 When undertaking the role of the Auditor Panel, the membership shall comprise the entire membership of the Audit and Governance Committee, with no additional appointees. This means that all members of the Auditor Panel are independent, Non-Executive Directors.

3.4 Conflicts of interests relevant to agenda items must be declared and recorded at the start of each meeting (including meetings of the Auditor Panel). If a conflict of interest arises, the Chair may require the affected member to withdraw at the relevant discussion or voting point.

Quorum

4.1 The Committee shall be quorate when two Non-Executive members are present (including either the Committee Chair or Vice Chair).

4.2 However, when the Committee is undertaking the role of the Trust's "Auditor Panel", the Committee shall be quorate when three Non-Executive members are present (including either the Committee Chair or Vice Chair)[2].

Attendance

5.1. The following will routinely attend meetings of the Committee (but will not be members):

- Associate Non-Executive Directors
- ~~Director of Finance~~Chief Finance Officer
- Deputy Director of Finance (Financial Governance)
- Head of Internal Audit and/or other appropriate representatives
- External Audit Engagement Lead and/or other appropriate representatives
- Local Counter Fraud Specialist
- Trust Secretary

5.2 Members (listed above) are expected to be present at all meetings of the Committee. Those listed in section 5.1 are expected to be in attendance at all meetings of the Committee.

5.3 The Chief Executive and other members of the Executive Team will be invited to attend if ~~when~~ the Committee is discussing areas of risk or assurance that are the responsibility of that individual and it is felt that their attendance is necessary to fully understand or address the issues

5.4 The Chief Executive may be invited to attend to discuss the process for assurance that supports the Annual Governance Statement; and the agreement of the Internal Audit annual plan. The decision as to whether to invite the Chief Executive for these items rests with the Committee Chair.

5.5 The Committee will meet privately with the External and Internal Auditors regularly, at the start of each meeting.

5.6 The Trust Secretary will provide appropriate support to the Chair and Committee members, and will be responsible for the administration of the Committee (see section 10).

5.7 The Chair may also invite others to attend when the Committee is meeting as the Auditor Panel. These invitees are not members of the Auditor Panel

6. Frequency of meetings

6.1 Meetings shall be held not less than four times a year. The Chair of the Committee will have the discretion to agree additional meetings in order to adequately meet the objectives of the Committee.

6.2 The External Auditor or Head of Internal Audit may request an additional meeting if they consider that one is necessary. Any member of the Trust Board may also put a request in writing to the Chair of the Committee for an additional meeting, stating the reasons for the request. The decision whether or not to arrange such a meeting will be at the sole discretion of the Chair of the Committee.

[2] Independent members of the Auditor Panel must be in the majority and there must be at least two independent members present or 50% of the auditor panel's total membership, whichever is the highest

6.3 As a general rule, the Auditor Panel will meet on the same day as the Audit and Governance Committee. However, Auditor Panel business shall be identified via a separate agenda, and Audit and Governance Committee members shall deal with these matters as Auditor Panel members, not as Audit and Governance Committee members. The Auditor Panel's Chair shall formally state (and this shall be formally recorded) when the Auditor Panel is meeting in that capacity.

7 Duties

7.1 The duties of the Committee can be categorised as follows:

Governance, Risk Management and Internal Control

7.2 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

7.3 In particular, the Committee will review the adequacy of:

7.3.1 All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit Opinion, Eexternal Aaudit opinion or other appropriate independent assurances, prior to endorsement and/or approval by the Trust Board

7.3.2 The underlying assurance process that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements

7.3.3 The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self certification.

7.3.4 The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Authority ~~Protect~~ (or successor bodies).

7.4 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from members of the Executive Team and managers, as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

7.5 This will be evidenced through the Committee's use of an effective ~~Board Assurance Framework (~~BAF~~)~~ to guide its work and that of the audit and assurance functions that report to it.

7.6 As part of its integrated approach, the Committee will have effective relationships with other key committees, so that it understands processes and linkages. However, these other committees must not usurp the Audit and Governance Committee's role.

Internal Audit

7.7 The Committee shall ensure that there is an effective Internal Audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee, Chief Executive and Trust Board.

This will be achieved by:

7.6.1 Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal

7.6.2 Review and approval of the Internal Audit Charter (or equivalent), operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the BAF~~Board Assurance Framework~~

7.6.3 Consideration of the major findings of Internal Audit work (and management's response), and ensure co-ordination between the Internal and External auditors to optimise audit resources
7.6.4 Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation
7.6.5 Carrying out an annual review of the effectiveness of Internal Audit

External Audit

7.8 The Committee shall review the work and findings of the Trust's External Auditor and consider the implications and management's responses to their work. This will be achieved by:

- Consideration of the appointment and performance of the External Auditor
- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the annual plan, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy
- Discussion with the External Auditors of their evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- Review all External Audit reports, including the report to those charged with governance, agreement of the Annual Audit Letter (before submission to the Trust Board) and any work carried outside the annual audit plan, together with the appropriateness of management responses
- Ensuring that there is in place a clear framework for the engagement of external auditors to supply non audit service

Other Assurance Functions

7.9 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, as it sees fit, and consider the implications to the governance of the organisation, in so far as they affect the Trust's agreed objectives. These will include, but will not be limited to, any reviews by Department of Health and Social Care's Arm's Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

Counter Fraud

7.10 The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud that meet NHS ~~Protect's~~ Counter Fraud Authority's (NHSCFA) standards and shall review the outcomes of Counter Fraud work. The Committee will ensure that any suspicions of fraud, bribery and corruption are referred to the NHSCFA.

Management

7.11 The Committee shall request and review reports and positive assurances from members of the Executive Team and managers on the overall arrangements for governance, risk management and internal control.

7.12 They may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

Annual Report and Financial Reporting

7.13 The Committee shall monitor the integrity of the financial statements of the Trust and the formal announcements relating to the Trust's financial performance.

7.14 The Committee should ensure that the systems for financial reporting to the Trust Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Trust Board.

7.15 The Committee shall review the Annual Report and Financial Statements before submission to the Trust Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
- Changes in, and compliance with, accounting policies and practices
- Unadjusted mis-statements in the financial statements
- Significant judgements in preparation of the financial statements
- Significant adjustments resulting from the audit
- The letter of Management Representation
- Explanations for significant variances
- Qualitative aspects of financial reporting

Whistleblowing ("Speaking Out Safely")

7.16 The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently. The usual method of meeting this duty would be to commission an Internal Audit review of the arrangements, as the Committee sees fit.

Auditor Panel

7.17 As the Auditor Panel, the Committee shall advise the Trust Board on the selection and appointment of the Trust's External Auditor. This includes:

- Agreeing and overseeing a robust process for selecting the External Auditors in accordance with the Trust's normal procurement rules
- Making a recommendation to the Trust Board as to who should be appointed (ensuring that any conflicts of interest are dealt with effectively)
- Advising the Trust Board on the maintenance of an independent relationship with the appointed External Auditor
- Advising (if asked) the Trust Board on whether or not any proposal from the External Auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable
- Advising on (and approving) the contents of the Trust's policy on the purchase of non-audit services from the appointed External Auditor
- Advising the Trust Board on any decision about the removal or resignation of the External Auditor

8. Parent committee and reporting procedure

8.1 The committee is a sub-committee of the Trust Board.

8.2 The minutes of Committee meetings shall be formally recorded by the Trust Secretary. The Chair of the Committee shall also provide a brief written report to the Trust Board, summarising the issues covered at the meeting and drawing to the attention of the Trust Board any issues that require disclosure to the full Board, or require executive action.

8.3 The Committee will report to the Trust Board annually (via a written Annual Report) on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the B~~oard Assurance Framework~~AF, the completeness and embeddedness of risk management in the organisation, and the integration of governance arrangements.The Annual Report should also describe how the Committee has fulfilled its Terms of Reference, and give details of any significant issues that the Committee considered in relation to the financial statements, and how these were addressed. The work of the Committee as the Trust's Auditor Panel should also be included.

8.4 The Committee shall undertake an annual self assessment to ensure the objectives of the Terms of Reference are being met.

8.5 The Chair must report to the Trust Board on how the Auditor Panel has discharged its responsibilities.

8.6 The Chair must draw to the attention of the Trust Board any issues that require disclosure to the Board in relation to Auditor Panel duties.

9. Sub-committees and reporting procedure

9.1 The Committee has no sub-committees.

10. Administrative arrangements

10.1 The Committee shall be supported administratively by the Trust Secretary, whose duties in this respect will include:

- Maintenance of a forward programme of work, setting out the dates of planned meetings and key agenda items
- Agreement of agenda for next meeting with Chair, allowing adequate notice for reports to be prepared which adequately support the relevant agenda item.
- Collation and distribution of agenda and reports one week before the date of the meeting
- Ensuring the minutes are taken and that a record is kept of matters arising and issues to be carried forward
- Advising the Committee on all pertinent areas

11. Emergency powers and urgent decisions

11.1 The powers and authority which the Trust Board has delegated to the Audit and Governance Committee may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted at least two Non-Executive Director members. The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the Audit and Governance Committee, for formal ratification.

12. Review of Terms of Reference and Monitoring Compliance

12.1 These Terms of Reference will be agreed by the Audit and Governance Committee and approved by the Trust Board. They will be reviewed annually or sooner if there is a significant change in the arrangements.

History

Terms of Reference agreed by Audit and Governance Committee: April 2013
Terms of Reference approved by the Board: May 2013
Terms of Reference agreed by the Audit and Governance Committee, November 2014
Terms of Reference approved by the Trust Board, December 2014
Terms of Reference agreed by the Audit and Governance Committee, November 2015
Terms of Reference approved by the Trust Board, November 2015
Terms of Reference agreed by the Audit and Governance Committee, February 2016 (N.B. the Board had already authorised the Audit and Governance Committee to agree changes in relation to the Committee's role as Auditor Panel)
Terms of Reference agreed by the Audit and Governance Committee, November 2016
Terms of Reference approved by the Trust Board, November 2016
Terms of Reference agreed by the Audit and Governance Committee, November 2017
Terms of Reference approved by the Trust Board, November 2017
Terms of Reference agreed by the Audit and Governance Committee, December 2018
Terms of Reference approved by the Trust Board, December 2018

Trust Board Meeting – December 2018

NHS Maidstone and Tunbridge Wells NHS Trust

12-17 Summary report from Quality Committee, 11/12/18 — **Committee Chair (Non-Executive Director)**

The Quality Committee has met once since the last Board meeting, on 11th December (a 'deep dive'). Regrettably, the meeting was not quorate as only 1 Executive Director was able to be present, but the meeting proceeded as scheduled.

1. The key matters considered were as follows:

- A **Review of infection prevention and control** was presented by the Director of Infection Prevention and Control (DIPC), which included an overview of the current data for MRSA, *C. difficile,* MSSA and *E. coli* in the Trust. There was discussion about what further actions might be taken to raise the profile of MSSA in the Trust, including identification of any improvements in current practices /processes. The Chief Nurse and DIPC were asked to consider this further out of the meeting for further report to the Quality Committee. Some of the initiatives in progress to reduce the rates of Gram negative sepsis were outlined, including the piloting of a hydration project on two MTW wards to assess reduction in UTIs in elderly patients and the pending re-introduction of revised catheter passport across Kent and Medway. An overview was given of the actions taken in response to the recent *C. difficile* outbreak, along with a forward view of the proposed changes to *C. difficile* definition, apportionment and objective setting from 2019/2020. The challenges presented by the recent incidence of Norovirus at Ward 20, TWH, were highlighted. There was discussion about the lack of robust data on surgical site infection (SSI) in the Trust (outside of T&O) and the Chief Nurse and DIPC were asked to consider how the lack of resource to collect and collate accurate data on SSIs at MTW might be addressed through more innovative staffing.

- The second main item reviewed was a **Review of / response to the compliance with the requirement to date and time all entries within patient healthcare records**, presented by the DIPC (in the absence of the Medical Director). The challenge of upholding the National guidance on record keeping was outlined and the decision to link the Trust's proposed documentation rationalisation aims with the EPR system implementation, scheduled for September 2019, confirmed. Planned intermediate action to undertake local speciality audits to identify any actions that needed to be taken in advance of the EPR work were underway. The Committee agreed that the Medical Director should be invited to consider the appointment of a clinical / medical trainee representative to the EPR team.

- The Health Records Manager then presented a **Review of the availability of Healthcare records.** It was noted that this subject had arisen at the Serious Incident (SI) panel held in August 2018. An overview of the numbers, involving around 1400 healthcare records per day, and scale of Healthcare records requests across the Trust was provided and it was reported that the backlog of 5000 outstanding requests at the implementation of Allscripts had since been reduced to approximately 100. The Committee acknowledged the progress made and highlighted the need to raise the profile of the Healthcare records function within the Trust. It was therefore agreed that this should be raised with the Chief Finance Officer (as responsible Executive for the function) and that Trust Board members should be encouraged to visit the Health Records departments across the Trust.

- The **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 February 2019:
  - "Review of the Serious Incidents process
  - "Review of the processes for oversight of clinical audit"
  - "Review of the Ophthalmology outpatient clinic"
  - "Update on the Surgical Complaints reviewed by the Chair of the Quality Committee"
- It was also confirmed that the following items should be scheduled for the Quality Committee 'deep dive' meeting in April 2019:
  - "Review of the next steps arising from the Mortality Review audit, to include special

categories (e.g. children and learning disabilities)"
  - "Response to the recommendations within the CQC's 'A national review of radiology reporting within the NHS in England' report" (subject to agreement by the Medical Director, in liaison with Radiology, that this did not need to be considered earlier)
- The Committee Vice-Chair reported on hearing from a patient regarding problems with the follow-up appointments process. This had been raised with the Chief Executive and Chief Operating Officer and it was agreed that the Committee may wish to consider any further work necessary once the preliminary findings emerged.

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:** Trust Board members were encouraged to visit the Health Records departments across the Trust

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 – December 2018

NHS Maidstone and Tunbridge Wells NHS Trust

12-18	**Finance and Performance Committee, 18/12/18 - approval of Business Case for the proposed establishment of a Hyper Acute Stroke Unit (HASU) / Acute Stroke Unit (ASU))**	**Committee Chair / Chief Operating Officer / Consultant, Elderly Care**

Due to the additional work required to finalise the Business Case for the proposed establishment of a Hyper Acute Stroke Unit (HASU) / Acute Stroke Unit (ASU)), it has been agreed to consider this item at the Trust Board 'Part 2' meeting.

Which Committees have reviewed the information prior to Board submission?

- Finance and Performance Committee, 18/12/18

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

N/A