TRUST BOARD MEETING

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

NHS Maidstone and Tunbridge Wells NHS Trust

9.45am to circa 1pm THURSDAY 28TH MARCH 2019

LECTURE ROOMS 1 & 2, THE EDUCATION CENTRE, TUN. WELLS HOSPITAL

A G E N D A – PART 1

Ref.	Item	Lead presenter	Attachment
3-1	To receive apologies for absence	Chair of the Trust Board	Verbal
3-2	To declare interests relevant to agenda items	Chair of the Trust Board	Verbal
3-3	Minutes of the Part 1 meeting of 28th February 2019	Chair of the Trust Board	1 (to follow)
3-4	To note progress with previous actions	Chair of the Trust Board	2
3-5	Safety moment	Chief Nurse/Medical Director	3
3-6	Report from the Chair of the Trust Board	Chair of the Trust Board	4
3-7	Report from the Chief Executive	Chief Executive	5
	Staff experience		
3-8	Junior Doctors' experience	The Guardian of Safe Working Hours / Jr Doctor representatives	Verbal
3-9	Integrated Performance Report for February 2019	Chief Executive	6
	▪ Effectiveness / Responsiveness	Chief Operating Officer	6
	▪ Well-Led (finance)	Chief Finance Officer	6
	▪ Finance and Performance Committee, 26/03/19	Committee Chair	7 (to follow)
	▪ Safe / Effectiveness / Caring (incl. update on progress with the Perinatal Mortality Review Tool; and planned and actual ward staffing for February 2019)	Chief Nurse / Head of Midwifery and Gynaecology	6
	▪ Safe / Effectiveness (incl. mortality)	Medical Director	6
	▪ Safe (infection control)	Director of Inf. Prev. and Control	6
	▪ Patient Experience Committee, 05/03/19	Committee Chair	8
	▪ Quality Committee, 13/03/19	Committee Chair	9
	▪ Well-Led (workforce)	Director of Workforce	6
3-10	6-monthly review of Nurse staffing Ward and non-Ward areas	Chief Nurse	10
3-11	Update on Clostridium difficile reporting for 2019/20	Director of Inf. Prev. and Control	11
3-12	Update from the Best Care Programme Board	Chief Executive	12
	Quality items		
3-13	Quarterly mortality data	Medical Director	13
	Planning and strategy		
3-14	Approval of the Trust's final 2019/20 plan	Director of Strategy, Planning and Partnerships	14
3-15	Update on the NHS Long Term Plan	Director of Strategy, Planning and Partnerships	15
3-16	The development of an Integrated Care Partnership in West Kent	Director of Strategy, Planning and Partnerships	16
3-17	The actions arising from the workforce-related Executive Team Meeting on 12/02/19	Director of Workforce	17
	Assurance and policy		
3-18	Ratification of Standing Orders (annual review)	Trust Secretary	18[1]
3-19	7 Day Services board assurance self-assessment	Medical Director	19
3-20	Update from the Senior Information Risk Owner (incl. approval of the 2018/19 Data Security & Protection Toolkit submission & annual refresher training on Info. Governance)	Chief Nurse	20
	Reports from Trust Board sub-committees (and the Trust Management Executive)		
3-21	Audit and Governance Committee, 14/03/19	Committee Chair	21
3-22	Charitable Funds Committee, 26/03/19	Committee Chair	Verbal
	Other matters		
3-23	Annual Review of Board Terms of Reference	Chair of the Trust Board	22
3-24	**To consider any other business**		
3-25	**To receive any questions from members of the public**		
3-26	To approve the motion (to enable the Trust Board to convene its 'Part 2' meeting) that in pursuance of Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest	Chair of the Trust Board	Verbal
	Date of next meeting: 25th April 2019, 9.45am, Pentecost/South rooms, The Academic Centre, Maidstone Hospital		

David Highton, Chair of the Trust Board

[1] N.B. The full document has been circulated as a "supplement" to the main set of reports

MINUTES OF THE TRUST BOARD MEETING ('PART 1') HELD ON THURSDAY 28TH FEBRUARY 2019, 9.45A.M, AT MAIDSTONE HOSPITAL

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	David Highton	Chair of the Trust Board	(DH)
	Sean Briggs	Chief Operating Officer	(SB)
	Maureen Choong	Non-Executive Director	(MC)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Neil Griffiths	Non-Executive Director	(NG)
	Nazeya Hussain	Non-Executive Director	(NH)
	Peter Maskell	Medical Director	(PM)
	Claire O'Brien	Chief Nurse	(COB)
	Steve Orpin	Chief Finance Officer	(SO)
	Miles Scott	Chief Executive	(MS)
In attendance:	Simon Hart	Director of Workforce	(SH)
	Amanjit Jhund	Director of Strategy, Planning & Partnerships	(AJ)
	Sara Mumford	Director of Infection Prevention and Control (except item 2-13)	(SM)
	Emma Pettitt-Mitchell	Associate Non-Executive Director	(EPM)
	Kevin Rowan	Trust Secretary	(KR)
	Jenni Douglas-Todd	Candidate, NHS aspirant Chair Program (until item 2-14)	(JDT)
	Fiona Mason	Patient Relative (for item 2-14)	(FM)
	Gavin Mason	Patient Relative (for item 2-14)	(GM)
	Nick Mason	Patient Relative (for item 2-14)	(NM)
Observing:	Jo Garrity	Head of Staff Engagement & Equality (for item 2-14)	(JG)
	Wendy Glazier	Associate Director, Quality Governance (for item 2-14)	(WG)
	Kate Holmes	Matron, Emergency Medicine (for item 2-14)	(KH)
	James MacDonald	Clinical Director, Emergency Medicine (for item 2-14)	(JMC)
	Jenny Pelly	Director of Performance, RTT and Cancer	(JP)
	Darren Yates	Head of Communications	(DY)
	Guy Bell	Kent Messenger reporter	(GB)
	Louise Cavanagh	BBC Inside Out South East (for item 2-14)	(LC)
	Ed Cook	BBC Inside Out South East (for item 2-14)	(EC)
	Casandra Daubney	Liaison	(CD)
	Ben Leete	BBC Inside Out South East (for item 2-14)	(BL)
	Vince Rogers	BBC Inside Out South East (for item 2-14)	(VR)
	Deborah Woodham-Jones	Member of the public (for item 2-14)	(DWJ)
	Nick Woodham-Jones	Member of the public (for item 2-14)	(NWJ)

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

At the start of the meeting, DH noted that item 2-14 would be filmed by the BBC Inside Out South East TV programme, so there would be a short break after item 2-13.

2-1 To receive apologies for absence

Apologies were received from Tim Livett (TL), Non-Executive Director. DH noted that the meeting would have been TL's last, as he ended his term as a Non-Executive Director on that day.

2-2 To declare interests relevant to agenda items

No interests were declared.

2-3 Minutes of the 'Part 1' meeting of 31st January 2019

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

2-4 To note progress with previous actions

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

- **1-8 ("Liaise to consider the ideas to improve staff representation that were discussed during the "The joint Chairs of Staffside" item at the Trust Board on 31/01/19").** COB reported that she had met with the Senior Royal College of Nursing Officer for the South East Region and would meet with them again soon, to engage further.
- **1-9a ("Ensure that a commentary on ambulance handover times was included in the "operational performance report…" section of future Integrated Performance Reports").** SB reported that some information had been included in that month's performance report but a more detailed commentary would be included in the report to the next Trust Board meeting.

2-5 Safety moment

COB referred to Attachment 3 and highlighted that the theme for February was to raise awareness of a 'just culture'. COB added that the issue had been discussed at the Trust's Nursing and AHP forum and it had been recognised that it was difficult time for staff when they were named in a complaint or incident. COB noted that it had also been acknowledged that more work was needed to ensure staff learned lessons.

PM added further details, noting that the discussion under item 2-14 would help the Trust in its efforts on the latter point. PM continued that he was focused on making it easier for staff to do the right thing, and the clinically led structural changes had been successful thus far, but more could be done in relation to quality governance and some useful discussions had been held recently.

MS also highlighted the importance of the Trust Board being an exemplar in relation to a 'just culture', in terms of the questions Trust Board Members asked and the behaviours they demonstrated. The point was acknowledged.

2-6 Report from the Chair of the Trust Board

DH referred to Attachment 4 and stated that it was important to note that a decision had been made regarding the establishment of Hyper Acute Stroke Units (HASUs) and Acute Stroke Units (ASUs) across Kent and Medway, and although the Trust Board would formally consider the Business Case at its March 2019 meeting, the Trust Board welcomed the decision. PM added that the latest Sentinel Stroke National Audit Programme results rated Maidstone Hospital (MH) as an 'A', which was the best in Kent, and rated Tunbridge Wells Hospital (TWH) as a 'B'.

DH then continued, and highlighted the following points:

- DH would like to thank TL for his contribution. MC would chair the Audit and Governance Committee for the time being, and NG would become the Chair of the Finance and Performance Committee. If the current recruitment process for a Non-Executive Director was not successful, DH would engage an external search company to assist. DH and MS had also been discussing the skillset for a new Associate Non-Executive Director, and consideration was being given to strengthening the Trust's links with the Kent and Medway Medical School. An advertisement would therefore be issued in due course
- Two Advisory Appointments Committee panels had been held, although DH had not been at either

2-7 Report from the Chief Executive

MS referred to Attachment 5 and highlighted that the second meeting of the new Senior Leaders Forum had been held that week and MS wanted to recommend that the Trust Board approve some investment in staff facilities and amenities. MS elaborated that as the Board would later hear that the Trust was on plan to deliver a surplus and attract Provider Sustainability Fund (PSF) monies, he would like the Board to agree to invest some of the PSF monies in such facilities, if the Quarter 4 PSF was achieved.

MS then continued, and stated that an important Executive Team Meeting session had been held with clinical and managerial leaders, and an action plan was due to be issued w/c 04/03/19. MS noted that that would be submitted to the Workforce Committee, but stated that he would like to have an item at the Trust Board explaining what was being done.

MS then noted he attended an event exploring Integrated Care Systems (ICS) and Integrated Care Partnerships (ICPs) and this had emphasised the point that simply doing more of the same would not work. MS added that AJ was leading the ICP work at the Trust and proposed that an item be scheduled for the next Trust Board meeting on that issue.

DH referred to MS' proposed investment in staff facilities and amenities and stated that he agreed in principle, but the sum involved would obviously need to be balanced against other priorities. NH agreed and asked what type of amenities had been proposed. MS replied that there had been no surprising suggestions, but these had included having somewhere for staff to take breaks and eat their lunch, as well as using staff expertise by, for example, expanding the evening events on the menopause that the Women's Services Directorate had held. COB added that a Trust Consultant had offered to hold an event on cervical smears, which would be popular with female staff.

COB then pointed out that there may be an opportunity to review the floor plan for the new HASU/ASU, as there was currently only a small space identified for staff to place their bags; whilst MC suggested that support for staff with musculoskeletal issues, such as yoga, may be beneficial. The suggestions were acknowledged.

The Trust Board therefore approved the proposal in principle. DH stated that he looked forward to seeing more detailed proposals in the coming months.

2-8 Integrated Performance Report for January 2019

MS referred to Attachment 6 and highlighted 4 questions he believed Trust Board members should consider when reviewing the report:

1. The Trust was seeing improvements in a range of areas, but needed to perform against the target as well as the underlying purpose
2. The plan for 2018/19 was being delivered with the Trust's 'plan b' rather than its 'plan a'
3. There was evidence that the improvements seen had resulted in improved patient experience, but there was less evidence that this had resulted in improved staff experience
4. The Trust was heading in the right direction, but the further improvements would only be able to be identified by delving into the detail

MS then invited each relevant Member of the Trust Board to address the specific areas of performance within their remit.

Effectiveness / Responsiveness

SB referred to Attachment 6 and highlighted the following points:

- The A&E 4-hour waiting time target performance in January had been very good, and the performance in February was 87%, which was only slightly under the trajectory of 88%. Performance for the year averaged 91.6% and staff should be commended for their hard work during what had been the Trust's most challenging month
- The Referral to Treatment (RTT) waiting list had reduced, and one of the major challenges for the team was to consider how far the Trust could go with its RTT performance. It was felt that the Trust could achieve 83% by the end of 2018/19

SDu asked whether the recent RTT improvement was due to things being done differently or to there being a reduced number of patients as a result of data validation. SB replied that both factors had had an impact, in that the Trust had undertaken more activity and there had been some good improvements in theatre utilisation. SB added that more was needed on data validation, but this was likely to result in some negative impacts on performance.

DH asked for an update on the data validation work on the RTT issues that had arisen from the implementation of the new Patient Administration System (PAS). SB replied that the Trust had worked with the North of England Commissioning Support Unit and had also engaged a company

called Acumentice, but had also started to build an in-house team, led by JP, who was observing the meeting.

SB then continued and highlighted that the Trust was slightly below trajectory for December in relation to the 62-day Cancer waiting time target, but was very close to achieving the 65% trajectory for January, although validation of that performance was still required. SB added that there was a challenge in Urology, as that speciality constituted at least 50% of the 62-day breaches, but they had significantly improved performance and reduced their waiting list backlog.

SDu asked what had changed with Urology i.e. how had the turnaround been achieved, and how had staff felt. SB explained the actions that had been taken in relation to Urology pathways and stated that he believed there had been a positive effect on the staff. SB added that there had also been some additional support in relation to administrative staff and CT capacity. SDu asked whether that additional support and capacity would continue to be funded. SB replied that discussions were continuing with West Kent Clinical Commissioning Group (CCG). However, SO acknowledged that that was a risk for 2019/20 and elaborated on the nature of the discussions being held with West Kent CCG.

DH then emphasised that although percentage-based targets provided an incentive to focus on the patients that had not yet breached the target, it was important that a balanced approach be taken, that took into account the patients that had waited over 104 days, and in that context the Urology department should be commended for taking such a balanced approach.

Well-Led (finance)

SO then referred to Attachment 6 and highlighted the following points:

- The Trust was on course to deliver a forecast that would achieve its control total for the year, but this had been achieved by the deployment of mitigations against the original plan. The Cost Improvement Programme (CIP) was, for example, below plan
- One of the mitigations included the Trust's property/asset disposals
- Activity had increased, so credit should be given to the teams involved
- The Trust was in the midst of delivering the winter plan, but demand should return to more normal levels into March
- The capital expenditure programme included two large value items, one of which was a replacement Linear Accelerator that would be purchased during 2018/19 but deployed during 2019/20

DH asked whether any significant items had being disputed by other NHS bodies. SO noted that a number of key assumptions had been made in relation to delivery of the forecast in the plan, but the only outstanding issue was the disposal of the Trust's assets at Springwood Road, Maidstone. DH asked whether there was an outstanding issue on Neonatal Intensive Care funding, as had been the case in previous years. SO confirmed that issue was not present for 2018/19, and added that there were no fundamental issues of dispute in the Trust's debtors or creditors positions.

SDu referred to the non-delivery of the CIP and asked what was being done with the Divisions to promote the need to do things differently for 2019/20. SO explained the approach being taken and added that he had been pleased with the engagement of the Chiefs of Service in the development of the CIP for 2019/20. SO did however acknowledge that the Trust was not in the position it needed to be in at that point in the year, but there was a commitment to achieve far greater clarity by the March 2019 Trust Board meeting.

DH commented that the primary shortfall against the CIP related to external factors, including the late delivery of the Prime Provider contract for Planned Care, the Avastin medication scheme, and the plans to establish a wholly owned subsidiary, which had been taken over by a change in national policy. The point was acknowledged.

Finance and Performance Committee, 26/02/19

In TL's absence, NG referred to Attachment 7 and highlighted the following points:

- The Committee had discussed the lessons to be learned from 2018/19 and it had been noted that there was momentum on which to capitalise, as well as more organisational resilience
- The Director of Operations for Surgery gave a presentation on theatre utilisation
- The Committee had agreed to recommend that the Trust host the Sustainability and Transformation Partnership (STP) for 2019/20 but cease to be the host from 2020/21
- The STP budget had been approved

KR pointed out that the Trust Board was asked to approve the Committee's recommendation regarding the Trust's hosting of the STP. DH highlighted that the recommendation was in accordance with the STP's own plans regarding the hosting. SDu asked about the costs of hosting and SO explained that the situation. SDu opined that, as a principle, the Trust should not incur any charges as a result of the hosting. SO confirmed that he had raised the issue of the Trust being paid some form of administration charge.

The Trust Board therefore approved the Finance and Performance Committee's recommendation to continue to host the Kent and Medway STP for 2019/20, but cease to be the host from 2020/21.

MS then drew the Trust Board's attention to Appendix 1 of Attachment 7 (a briefing for Trust Board Members on the lessons learned from the Trust's 2018/19 performance and planning).

Safe / Effectiveness / Caring (incl. planned and actual staffing for January 2019)

COB referred to Attachment 6 and highlighted the following points:

- Falls continued to be a major issue. A number of patients had fallen multiple times, despite preventative measures
- Pressure ulcers were also an area of focus. Work was taking place on mattresses and beds
- Ten Serious Incidents (SIs) had been reported
- Attachment 6 included the key learning that had been made in the month, which included that from a staff assault. Trust staff had stated they felt scared when dealing with patients with mental health issues and COB had discussed the situation with the Chief Nurse from Kent and Medway NHS and Social Care Partnership Trust. It had been agreed to share some Mental Health Nurse support, to upskill the Trust's staff in managing such patients
- Twenty-three patients had to be placed in a mixed sex environment, but these had not been reported as formal Mixed Sex Accommodation breaches as COB felt this would be too literal an interpretation of the guidance. NHSI had confirmed their support for the Trust's approach
- Complaints response compliance for January was 82%. There had been a varied response among Divisions but all were focused on the issue. A new Standard Operating Procedure had been introduced and the report described how Surgery had improved their response rate

DH commended the improvement in complaints response rate.

MS then asked COB to give further details of the lessons learned in falls, particularly at TWH, noting that the Trust would continue to experience periods of extreme pressure in the future. COB explained that the issues were multifactorial, but patients would always fall in hospital, so the focus was on managing that risk. COB elaborated on the measures that had been introduced, which included alarms that indicated to staff when a patient had stood up, and non-slip socks for patients who did not wear shoes or slippers. COB added that falls was everyone's business, and the key issue was to undertake a falls risk assessment, as the Trust had an Enhanced Care policy that could be deployed. COB added that engaging with families was also important. COB also stated that she wanted to know how many patients who had fallen had had a delayed stay in hospital and a community falls clinic would aim to monitor that. PM added that a pharmacy review of medications also played a factor in falls and noted that most patients fell on Ward 22 but many of those patients should not really be in hospital, so the Trust should continue to work with community and social care partners to ensure that such patients were able to be discharged home.

MS welcomed the actions being taken, but stated that these did not specifically address the increased activity seen in January 2019 so asked COB to consider ensuring that the staffing plan for January 2020 would enable a specific number of permanent staff to be allocated to TWH i.e. rather than rely on best endeavours. MS added that the Trust's escalation plan could perhaps be more focused on clinical triggers rather than just on capacity triggers. DH remarked that he would

leave the Executive Team to consider such issues. COB noted that efforts had been made to increase the number of volunteers, which should help relieve the boredom felt by many patients, whilst the Best Care programme would help review the staffing requirements as MS had suggested. DH therefore suggested that the Board needed to understand the multifactorial issues involved in falls in a more concise way. The point was acknowledged.

COB then referred to the "Safe staffing" section and highlighted that work was taking place to prepare for the UK's exit from the EU whilst the data revealed that there were some staffing gaps.

Safe / Effectiveness (incl. mortality)

PM then referred to Attachment 6 and invited questions or comments. None were received.

Safe (infection control)

SM then referred to Attachment 6 and reported the following points:

- There continued to be an above expected number of Clostridium difficile cases in January. The Ward in which the cases had mainly occurred (Pye Oliver) had been deep cleaned, and the action plan had been revisited. There had been an issue with contaminated beds being returned to the Ward but this had now been addressed
- The Infection Prevention and Control Committee met on 27/02/18 and had discussed the need to clean tables prior to serving meals and ensuring that hand wipes were given directly to all patients before they ate. The Committee had been assured that the issue was being addressed. The Committee had also focused on ensuring that mattresses were cleaned
- For gram negative bacteraemia, the Trust had completed implementation of the catheter passport initiative
- There had been two cases of MSSA bacteraemia in January. These had also been discussed at the Infection Prevention and Control Committee, which highlighted the need to swab patients
- The number of influenza cases showed no sign of reducing in February and remained a significant issue and a major drain on resources

DH asked whether the influenza cases had been covered by the vaccine. SM noted that some of the cases had been vaccinated.

Well-led (workforce)

SH then referred to Attachment 6 and reported the following issues:

- The Trust's efforts to reduce its vacancies continued
- w/c 04/03/19 was National Apprentice week
- The Trust's influenza vaccination campaign would finish at the end of 28/02/18, and the report contained details of the latest uptake. The Commissioning for Quality and Innovation (CQUIN) target had been achieved, but the rate was below the Trust's internal target, although lessons had been learned. SH paid tribute to the peer vaccinators, who had been very effective

DH welcomed the improvement in influenza vaccination uptake from the previous campaign.

Workforce Committee, 31/01/19

NH referred to Attachment 8 and invited questions or comments. None were received, but DH noted MS' earlier comment that the next Trust Board meeting would discuss the action plan arising from the workforce-related ETM that had been held on 12/02/19.

2-9 Update from the Best Care Programme Board

MS referred to Attachment 9 and highlighted that the programme had delivered much in its first year, but had not achieved the levels of efficiency that had been planned. MS added that lessons had however been learned from 2018/19 and the next month's report would show the intentions for 2019/20 along with the Board's desire that there be a focus on interdependencies.

NG added that the Finance and Performance Committee had heard that the CIP for 2019/20 would be primarily delivered via the Divisions, with the Best Care programme acting as an enabler.

DH referred to the Avastin scheme and asked why there had been a delay in obtaining external legal advice, noting that the issue affected all acute Trusts nationally. SO accepted that advice could be sought from NHS Improvement (NHSI). MC suggested that the National Pharmacy advisor be asked for advice. SO welcomed the suggestion. SDu then noted that the latest Quality Committee 'deep dive' meeting had received a presentation from the Ophthalmic team, and they had expressed some reservations regarding the scale of impact of the savings from the use of Avastin, as that required a monthly injection whilst the currently-used medication only needed to be injected every two months. SDu continued that the implication was that there would need to be increased resources in Ophthalmology infrastructure and staffing. SM noted that a Business Case was being developed regarding the use of Avastin, which included staffing implications. SO gave assurance that the Ophthalmology Department was involved in the Avastin-related work.

2-10 Review of the Board Assurance Framework 2018/19

KR referred to Attachment 10 and highlighted the following points:

- The meeting was the last time the Trust Board would see the Board Assurance Framework (BAF) before the end of 2018/19, but a year-end review would then be considered in April 2019
- The full BAF had been reviewed by the Executive Team Meeting on 19/02/19 whilst the content for objectives 1 to 4 had been reviewed by the Finance and Performance Committee on 26/02/19. The Responsible Directors' ratings of confidence that their objectives would be achieved by the end of 2018/19 were confirmed as valid at both meetings
- The prompts for Trust Board members were listed on page 1

DH pointed out that there was only 1 red-rated objective but several were amber-rated, which reflected that although progress had been made, the Trust was not in the position it desired. SO elaborated on the amber rating for objective 4 ("To deliver the financial plan for 2018/19").

Planning and Strategy

2-11 Update on the Trust's 2019/20 plan

AJ referred to Attachment 11, and highlighted the following points:

- The document contained the narrative that had been submitted to NHSI
- The final plan needed to be submitted to NHSI in April, so the March 2019 meetings of the Finance and Performance Committee and Trust Board would have the opportunity to review that plan before submission. AJ would therefore appreciate some direction on the level of assurance the Board wanted to enable it to approve the plan in March

NG added details of the discussion on the plan that had been held at the Finance and Performance Committee on 26/02/19.

DH referred to AJ's query and stated that the highest level of green-rated schemes available would provide some good assurance. DH continued that the Board would also like to see that the Trust's operational plans were supported by the Aligned Incentives Contract (AIC), as well as seeing the extent to which the plans were supported by out of hospital care. DH also stated that the 62-day Cancer waiting time target trajectory was scheduled to meet the 85% standard by the end of May, but the current draft plan did not include any significant advancement toward the required RTT standard. NG noted that the Finance and Performance Committee considered some of DH's points, in terms of contingency in the plan, but it was noted that that needed to be strengthened.

DH stated that he would also want to see some attempt, through the Strategic Clinical Service Plans, to address the Consultant workforce constraints that existed in certain areas.

PM then referred to DH's comment on green-rated CIP schemes and noted that a green rating required a completed Quality Impact Assessment (QIA), which in turn required considerable detail, so a different rating category may be necessary. DH agreed it may be sensible to consider a more granular rating to reflect that a QIA had not been completed, but emphasised that the next Board meeting would take place only two days before the start of 2019/20. The point was acknowledged.

MS then emphasised the need to consider what the Trust would do if its recruitment plans did not work. DH agreed and stated that a discussion on that was warranted at the Best Care Programme Board, focusing on how to remove any constraints.

EPM remarked that she would like to be clear on the timescales in relation to delivering the plan throughout the year.

2-12 Stakeholder assessment and engagement plan

AJ referred to Attachment 12 and highlighted that the document reflected a first draft; whilst the next steps included mapping the stakeholders according to the functional relationships that needed to be held with individuals.

AJ then reported that DY would leave the Trust before the next Trust Board meeting. DH thanked DY for his contribution during his time at the Trust.

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

2-13 Quality Committee, 06/02/19

SDu referred to Attachment 13 and highlighted that the Ophthalmology department had felt that the AIC did not reflect the full level of activity they had expected. SO acknowledged the point.

[N.B. At this point, DH called a short recess, to enable the BBC Inside Out South East TV programme crew to assemble their equipment]

2-14 A patient's experience of the Trust's services

DH welcomed FM, GM and NM to the meeting and explained that it was important that the Trust Board was able to have sessions that discussed the quality of clinical care, including failings, to enable lessons to be learned. DH added that the item also offered the chance for the Trust Board to offer its condolences and apologies for Tim Mason's death.

PM then briefly introduced the item before inviting FM and GM to speak. FM firstly reported the following points:

- FM firstly wanted to describe the personality of their son, Tim. Tim was young and fiery, highly organised, pro-animal, and socially and politically engaged, with an opinion about most things. He was happy to discuss issues such as global warming and Brexit, and had a strong moral compass which led him to act on injustice and stand up to people
- Tim's loyalty was immeasurable. He was fun to be with and irreverent, and FM, NG and NM would miss his noise and passion for life. Their life was poorer now, and they had no idea how lucky they had been
- On 15/03/18, Tim began vomiting violently, so he was taken to Tonbridge Cottage Hospital. Tim was told to go to the Emergency Department (ED) at TWH, and was advised that it would be better to drive there, as that would be quicker. The family duly did that, and that was their first mistake, as Tim was treated like a second class patient, due to him being a walk-in patient. Tim was discharged despite family protests and despite being very ill
- Further symptoms developed and FM brought Tim back to the TWH ED, where he was made to wait rather than being seen by a doctor promptly, as had been promised when Tim had been discharged
- The ED receptionists refused to look up from their desks in the 3 times FM begged for help
- Eventually a Nurse responded and agreed to see Tim. Once the Nurse realised how ill Tim was, she transferred him to a clinical area and summoned help. A large number of clinical staff then attended
- FM and GM's last words to Tim were lies, which broke their hearts, as they stated that they would wait for him and would be there when he woke up, even though Tim had stated that he was dying
- The doctors explained how desperately ill Tim was. Tim's heart failed and he was declared dead at 9.46pm. FM and GM then left after 10pm and drove home in a state of shock & disbelief

GM then highlighted the following points:

- Tim's death was brought about by systemic failures, one after the other, and they continued afterwards. The systemic failures included poor communication and denial of responsibility
- The family was told that there would be a post-mortem and stated that someone would be in contact. A person from the mortuary eventually then called the family and stated that there would not be a post-mortem, as HM Coroner had stated they had accepted the hospital's cause of death, which was stated as meningococcal meningitis
- GM attended the hospital to obtain some answers but had to 'make a scene' before someone from the PALS office spoke with him. GM asked what impact the management of Tim's condition in the morning had on his prospects for the evening. The PALS office were unable to help but a doctor then made contact with the family
- WG also then contacted the family to state that Tim's death was subject to a Serious Incident (SI) investigation
- Tim's death certificate was then rescinded and replaced with a 'fact of death certificate'
- The family were told that the SI investigation would be led by SM, and having made enquiries into SM's background and standing, they were pleased
- The family were also told they would receive the report of the SI investigation, and 111 days after Tim died, they finally received the report
- The SI report was a distressing whitewash, with no acceptance of responsibility. SM had not presented the SI, as she was on compassionate leave, so the case had been presented by the clinical lead for the ED
- It was later discovered that "failure to conduct a sepsis screen" had been removed from the first SI report, by a third party, enabling the original claim that the hospital was not responsible for Tim's death, and that merited investigation
- A further recorded meeting was held with SM, which was very difficult. The communication failures were discussed
- The second version of the SI report was then provided and that now included the misdiagnosis of gastroenteritis. The "failure to conduct a sepsis screen" "Route Cause" had also been corrected to read "indicators for sepsis screen not escalated or acted upon", and the report contained a statement from the Triage Nurse from Tim's first attendance (albeit dated 4 and a half months after Tim had died). It was not the full disclosure the family wanted but it was a step in the right direction
- The Coroner's Inquest date was then set
- The family then received a letter from the Trust's solicitors, which contained 3 key aspects: "admission of liability"; "breach of duty: admitted", and "causation: admitted"
- The Coroner's Inquest raised issues that were not included in either SI reports, which included that the triage Nurse had not started the course of antibiotics as that role was not expected of triage Nurses at TWH. The clinical lead had caused a gasp in the Coroner's courtroom when she flatly denied this, effectively calling the triage Nurse a liar
- The clinical lead also admitted that there was no specific doctor assigned to the Rapid Assessment during the night
- With the marked exception of the clinical lead, many of the Trust's doctors had expressed a desire to improve
- The Coroner issued the Trust with a Preventing Future Deaths (PFD) report

GM concluded by emphasising that he felt bitter. FM then continued and noted that the family had met with PM and SM on 10/12/18 to discuss what the hospital had done since Tim's death, which included the mandatory completion of a sepsis screening tool; enabling all triage Nurses to commence sepsis antibiotics; and ensuring that all patients with abnormal results received a senior review prior to their discharge. FM pleaded with the Trust Board to ensure that the latter 2 changes were fully implemented.

FM then continued and noted that the dictionary definition of "triage" was to undertake a rapid assessment of priority, to enable those with most need to be treated first, but at TWH, triage was a bottleneck that relied on a patient's order of arrival. FM stated that she would therefore like the Trust to consider introducing fast streaming assessment on arrival, and prioritisation. FM acknowledged that may incur a cost but would be beneficial.

FM then asked that receptionists who record patient's details be encouraged to actually look at the patient, and respond accordingly, rather than just insist on them waiting their turn. FM elaborated that staff should respect the concerns a mother had for her child, as no one knew a child better that their parents.

FM emphasised that no one stated that Tim should be given antibiotics, and if this had been communicated, FM would have made sure that happened.

FM pointed out that contact with families should be swift after an incident, and if an SI was initiated, the family should be told immediately, with an investigator allocated within 1 week and staff statements done immediately. FM added that families should also be allowed to be involved in the investigation, as despite offering to be involved, this was not the case for FM and GM.

FM then concluded by stating that the Consultant in charge of the department being investigated should not be allowed to present the SI report as this would only have a detrimental effect on the perceived or actual objectiveness of that report; whilst those who learn from mistakes and want to improve would become better medics. FM noted that in that regard, FM and GM had offered to help the Trust learn in whatever capacity it could.

DH thanked FM, GM and NM and gave assurance that he and the Trust Board would ensure all the points raised were given due consideration.

JMC then confirmed that the 6 points from the SI action plan had been embedded, which included the response to ED walk-in patients.

DH then noted that the Trust had a duty of candour and apologised for the delays that lengthened the pain and suffering of Tim's family.

SDu also thanked FM, GM and NM and stated that she had been moved by their account. SDu then explained that she was the Chair of the Trust's Quality Committee, whose role was to review clinical systems, and although clinicians had given assurance that things had changed, she would arrange for a response to the issues raised to be considered.

Action: Arrange for a response to the issues arising from the "Patient experience" item at the Trust Board meeting on 28/02/19 to be considered at the Quality Committee (Chair of the Quality Committee / Trust Secretary, February 2019 onwards)

DH then referred to FM's offer to help the Trust learn and stated that he would like the Trust to find the most effective way of accepting that offer.

MS added his own thanks to FM, GM and NM, and stated that the item was an important event for all Trust Board Members, who were accountable for what had happened. MS added that the Trust's commitment to improve was as much about engaging with Tim's family as it was about addressing the clinical care issues. FM stated that the level of transparency shown by the Trust Board meant a lot.

DH concluded the item by again thanking FM, GM and NM for attending the meeting.

2-15 To consider any other business

There was no other business.

2-16 To receive any questions from members of the public

No questions were received.

2-17 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 – March 2019

Maidstone and Tunbridge Wells NHS Trust

3-4 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]
1-8 (Jan 19)	Liaise to consider the ideas to improve staff representation that were discussed during the "The joint Chairs of Staffside" item at the Trust Board on 31/01/19	Director of Workforce / Chief Nurse	January 2019 onwards	The Chief Nurse has met with the Senior Royal College of Nursing (RCN) Officer for the South East Region, but further liaison with the Director of Workforce is required

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
1-9a (Jan 19)	Ensure that a commentary on ambulance handover times was included in the "operational performance report…" section of future Integrated Performance Reports	Chief Operating Officer	February 2019	An expanded commentary has been included in the Integrated Performance Report submitted to the March meeting, and will be included in future monthly reports
2-14 (Feb 19)	Arrange for a response to the issues arising from the "Patient experience" item at the Trust Board meeting on 28/02/19 to be considered at the Quality Committee	Chair of the Quality Committee / Trust Secretary	March 2019	A response was considered at the 'main' Quality Committee meeting on 13/03/19

Actions not yet due (and still 'open')

Ref.	Action	Person responsible	Original timescale	Progress
12-9b (Dec 18)	Consider amending the "planned and actual ward staffing" report to the Trust Board to show the proportion of the average fill rate undertaken by Agency staff	Chief Nurse	The end of March 2019	The work to amend the report is underway but not yet complete

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

Trust Board meeting – March 2019

Maidstone and Tunbridge Wells NHS Trust

3-5 Safety Moment **Chief Nurse/Medical Director**

The Safety Moment for March aimed to raise awareness of the Accessible Information Standard. This is a national standard meaning that people who have a disability, impairment or sensory loss (such as hearing or eye sight) get information that they can easily find and understand. It also means that anyone who needs help talking with us gets it.
Key messages that have been shared each week are as follows:

Week One 04/03/2019

The Trust has been legally required to follow the Accessible Information Standard since 2016.

As the Accessible Information Standard (AIS) Steering Group has been out and about talking to people, it turns out that a lot of staff do know what it is. They may not use the term AIS but they know how to approach people to provide support if they have a hearing or sight impairment, a learning difficulty or dementia. Below are the first five steps we need to take to make sure that people with a disability, impairment or sensory loss get the information they need in an accessible and understandable way. The five steps are:

- **Step 1** – Ask people if they have any communication or information needs and find out how to meet them.
- **Step 2** – Records their needs clearly
- **Step 3** – Flag the person's record so it is clear that they have information or communication needs and how to meet them.
- **Step 4** – Share the needs of people with other NHS and social care providers (make a note in a referral letter, make it part of handover).
- **Step 5** – Act to make sure people get the support they need.

The group have done lots of work at the Trust:

- An AIS Steering Group has been developed who are leading the implementation of the Standard.
- Working with Healthwatch to identify improvements as noted by patients – they even came to Trust Board and got the Executive Directors to wrap presents using glasses emulating sight impairment.
- AIS posters can be found around the sites
- Communication and information needs can now be flagged using Alerts on Allscripts
- Accessible menus can now be found on IPads on all wards at both sites
- AIS Champions have been recruited who will help others in their areas to ensure we are meeting the standard.
- AIS Champions have undergone guided sight training – learning how to assist people with sign impairments.
- A range of patient information leaflets is now available in Easy Read (using pictures, easy words, short sentences and larger fonts).

Week Two 11/03/2019

The week's focus of AIS is to ensure we always ask our patients if they need additional support, whether that is providing information in an easy read format, using a hearing loop or providing information in large print. Here's an easy guide as to what you need to **ASK** and how that information can be shared and acted on.

- Do you need any communication support? And follow this up with asking 'what support do you need?'
- Do you need written information in another format? Find out what format the person needs the information in.
- Do you have a preference on how to be contacted? And then clarify how they would like us to

contact them.
- Once you've asked whether they need support, please **ACT** on the information and **SHARE** with other teams, services or agencies during referral, discharge or handover. You may be able to meet people's communications needs promptly by printing out and having to hand the helpful Hospital Communication Book, which includes simple pictures, gestures and signs to help people who have difficulties understanding and / or communicating.
- You will need to **RECORD** this information too either on our patient systems or on their paper patient records, so next week's Safety Calendar will focus on how you should be marking and flagging a person's record to ensure we meet their communications needs.

You can download a copy of the AIS poster, read the Trust's policy and find out more information about the standard on the dedicated AIS intranet page.

Week Three 18/03/2019

We continue our Safety calendar Accessible Information Standard (AIS) theme with a focus this week on communicating with people with learning disabilities. MTW launched its work on the Accessible Information Standard in June last year coinciding with Mencap's "Treat me well" campaign, which aims to transform how the NHS treats people with a learning disability in hospital. So what steps can you take to improve the care for people with learning disabilities?

- **Identify** – The first step to improving care for people with learning disabilities is to identify them. Before contact is made with the person check on clinical systems – do they have a Learning Disability Flag? If yes consider allowing more time for appointment/patient contact.
- **Ask** – Find out what needs the person has? Ask – what can I do to help you communicate? What can I do to help you understand? What would make your hospital stay better?
- **Advice** – Seek advice from the people who know the patient best. Seek advice from the Hospital Learning Disability Liaison Nurse. Find out information by reading the hospital passport.
- **Adjust** – Provide the necessary Reasonable Adjustments that the person needs. Reasonable adjustments are about delivering person centred care; adjusting practice so that every person gets the treatment they need and ensuring nobody is disadvantaged because they have a disability.
- **Flag** – Notify the learning disability liaison nurse to add a flag to clinical systems.

Here is a short case study which reflects on how some small changes can make a big difference in making our hospitals more accessible following a visit to Maidstone Hospital ED by a volunteer with a learning disability:
The volunteer identified the following:
- The accessible information standard poster behind the main reception desk was too small and didn't have enough pictures. Therefore it was difficult for the volunteer to understand the content.
- The clock in the reception area was an analogue clock which the volunteer couldn't read.
- The toilets were sign posted with words not pictures.
- The hospital communication book wasn't readily available.

Since this visit the emergency department have made the following changes:
- The ED matron is liaising with estates to ensure a digital clock is displayed in the waiting area.
- Four hospital communication books are available in four areas in ED - Majors, Resus, Reception and Triage.
- The AIS steering group is working with East Kent Hospitals and Kent Community Health to amend the AIS poster to ensure it is bigger, has pictures and is accessible to all.
- The ED matron is liaising with the estates department to facilitate picture signs on toilet doors.

Week Four 25/03/2019

As part of our plans to meet the Accessible Information Standard (AIS), MTW wants to make sure that our patients, their carers and parents can find and understand the information they are given. This includes making information available in large print, braille, easy read or in an email if they want it. MTW also provides British Sign Language (BSL) translators, deaf/blind translators or

people to help with talking to our staff. This week, we look at how departments and services can produce patient information in an easy read format. Did you know that around 1 in 5 people struggle with reading and understanding information. Here are some simple tips to get you started.

- **Easy read format** - uses simple, jargon free language, shorter sentences and supporting images. Before you start writing an easy read leaflet, make sure you download the correct template from Q-pulse.
- **Words and language** – check that the information talks to the reader, using I, we or you, no abbreviations have been used and that numbers are written as figures. Use easy words, break information up into clear chunks and avoid writing words with capitals.
- **Design and layout** – make sure you use arial font in size 14 or 16, and check that words are not in italics and the leaflet is clearly spaced and does not look cluttered on the page.
- **Using pictures** – check that the pictures you use are of a good quality, are clear and have not been distorted when changing their size / moving them etc. Do not use abstract graphics or symbolic pictures and make sure the picture is close to the text it is referencing.

When drafted, circulate for consultation amongst your team / service for feedback. Once happy, email the leaflet to the Accessible Information Standard Group who will review the leaflet and upload to Q-pulse. Contact them at mtw-tr.accessible-information@nhs.net

Remember it is everyone's responsibility to ask a patient if they need help with communicating, to flag and share that information with colleagues and external partners, and to act on it by providing support in a way that suits the patient's needs.

Case Study:

A patient with a learning disability at Tunbridge Wells Hospital was very anxious about being discharged from hospital. The team provided reassurance that she would be able to go home when she was better but, despite this reassurance the patient was concerned that she may have been considered less cognitively able and be discharged to a nursing home. The patient was presenting with daily challenging behaviour and was evidently distressed by the thought of going to a nursing care home.

The ward completed a referral through all scripts to the learning disability liaison nurse who created a bespoke easy read document for the patient. The booklet was in an easy read format with pictures and provided the patient with details of the plan for the patients discharge. Whenever the patient started to become distressed about discharge location the staff would go through the booklet with her and this was much more effective than verbal reassurance alone and the patient retained the information for longer.

This is just one example of using accessible information in practice. To access easy read trust leaflets, simply type in document search "easy read". For more information about AIS, how to write an easy read leaflet, policy documents and to download the hospital communication book, visit the intranet and search for 'AIS'. If you cannot find the easy read information you require please email mtw-tr.accessible-information@nhs.net.

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, discussion, 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 – March 2019

NHS Maidstone and Tunbridge Wells NHS Trust

3-6 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**
12/03/2019	Dr	Dunnya	De-Silva	Haematology	TBC

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 – March 2019

NHS Maidstone and Tunbridge Wells NHS Trust

3-7 Report from the Chief Executive — Chief Executive

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

1. NHS England has published proposals to trial new standards of measuring performance for Cancer, Emergency Department (ED), Referral To Treatment (RTT- planned care) and accessing mental health and community services.

   This follows a clinically-led review of standards across the NHS, involving doctors, patient groups and local health leaders. The new standards have been developed to help meet the goals of the NHS Long Term Plan, improve care and save more lives.

   The proposals aim to put what matters most to patients at the heart of how performance is measured, with a stronger focus on earlier diagnosis, assessment and treatment of serious conditions; helping, rather than penalising, hospitals who modernise treatment and care models; establishing standards guaranteeing short waits for mental health and community health services; and providing a more complete picture of trust performance by measuring the whole wait experienced by every patient.

   The Trust's ambition to be an Outstanding provider of care remains and MTW is committed to working through the implications of the new standards for the benefit of our patients.

   Under the current plans, the potential impact for MTW is:

   A: **Cancer:** The proposals outline standards that are closely aligned to the improvement work we are already implementing in our cancer services. The proposed changes streamline the number of performance measures and give greater focus on the time to diagnosis for all patients. We know this is the area most trusts (including ours) have found the most challenging to deal with.

   B: **RTT**: The NHS Constitution commits to treating patients within 18 weeks of being referred for planned treatment. The way this has been classified and monitored has changed over time. While the objective of the proposed new standards for planned care remains the same, there are some changes to the way performance will be measured, which we will accommodate.

   This isn't a national standard that we are delivering often enough. It is an urgent priority for the Board that we get back to meeting the standard, ensuring patients receive a high quality and timely experience.

   C: **ED**: The proposed standards for Emergency Department performance have sparked much discussion among NHS and professional bodies. Currently, performance is measured by a trust's ability to admit, transfer or discharge within four hours. Achieving the standard is a reflection of the whole hospital's ability to respond to the needs of acute patients.

   The proposed new standards aim to identify different groups of emergency patients and set better ways of measuring how we respond to them, so that the sickest patients, such as those with heart attacks, stroke, sepsis or mental health crisis, are seen the quickest.

   Having worked so hard to improve our performance in our Emergency Departments – we are now regularly in the top 25 best performing trusts – we are well placed to be able to respond to these new standards.

   The NHS will be piloting these proposals and we will monitor the outcome of the trials. Using the new standards will be a good opportunity to improve our services further for patients.

   We will update the Board when we have more information and our progress to meet the proposed new ways of measuring our performance.

2. The Executive Directors and Chiefs of Service continue to meet on a weekly basis at Executive Team Meetings. Key areas of discussion at our meetings over the past month have included:
   - Further developing the frailty service at Tunbridge Wells Hospital, following its success this winter.
   - Reviewing the Trust's plans to recruit and retain staff, and develop our leaders at MTW.

- EU Exit planning (themes include staffing levels, potential travel disruption and partnership working) and reviewing risks and associated actions.
- Updating plans to develop a Hyper Acute Stroke Unit/Acute Stroke Unit at Maidstone Hosp.
- Delivering the 95% Emergency Department 4-hour waiting time target in March.
- Organisational Development and the role of the Divisions.
- Reviewing and discussing the Trust's plans to become Outstanding.
- Developing and implementing the Trust's Patient Experience Strategy.
- Reviewing the proposed quality objectives for the year ahead.

3. Delivering our Winter Plan this year has allowed us to weather the huge and unprecedented demands placed on our hospitals better than in previous years. We have improved our ED performance, seen fewer outliers and treated more elective (planned care) patients.

   As part of our ongoing improvement work, we have challenged ourselves to meet the 95% national target of seeing, admitting or discharging those who attend our EDs within four hours for the whole of March. We're on track to achieve this and if we do so, this will be the first time since August 2014 (for the whole month). Even if we fall short by a small number of breaches, this will still be the best performance we've achieved since that period of time.

4. Maidstone and Tunbridge Wells NHS Trust is set to open a new 24 hour helipad at Maidstone Hospital thanks to the generous support of the HELP (Helicopter Emergency Landing Pads) Appeal. Currently helicopters are using a temporary landing site at the rear of the oncology unit at Maidstone Hospital, but this site is frequently waterlogged. The new helipad will permanently replace this.

5. MTW marked National Apprenticeship Week with a series of events, including information stands at our hospitals, with our Learning and Libraries team on hand to talk to people who wanted to know more about apprenticeships at the Trust. One of our apprentices, Hannah Morris, took over the Trust's social media accounts for a couple of hours on one of the days to answer questions from anyone considering an apprenticeship.

6. The Trust's charity hosted the first South East Region Fundraising Support Group Meeting on behalf of the Association of NHS Charities. Our Charitable Fund is a member of the Association whose member charities collectively give £1 million every day to the NHS.

   Our Fundraising Manager Laura Kennedy was joined by fundraisers from Medway NHS Foundation Trust Charity, East Kent Hospitals Charity, Darent Valley Hospital Charity and the Sussex Partnership Charity, 'Heads On'. NHS charities help to fund major capital projects, pioneering research and medical equipment.

7. Congratulations to our Research and Development team, who won 'Highly Recommended' in the Improvement and Innovation category at the Kent and Medway Clinical Research Network (KMRCN) Partnership Board Partner Awards. The Trust was presented with the accolade for its work in improving patient recruitment to clinical trials over the last year.

8. MTW has exceeded its Commissioning for Quality & Innovation (CQUIN) target for vaccinating 75% of frontline staff for flu. We will be awarded more than £220,000 for achieving this.

9. On behalf of the Board, I would like to wish Dr Sharon Beesley, our outgoing Chief of Service for Cancer Services, all the very best on her retirement this month. Dr Henry Taylor will be taking over her role.

   Sharon joined the Trust in April 1999, specialising in Urology. She was instrumental in setting up the Prostate Brachytherapy service and we are now one of the largest centres to offer this facility for patients.

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

3-9	**Integrated Performance Report, February 2019**	**Chief Executive / Members of the Executive Team**

The enclosed report includes:

- The 'story of the month' for February 2019 (including Emergency Performance (4 hour standard); Delayed Transfers of Care (DTOCs); Cancer 62 day First Definitive Treatment); Referral to Treatment (RTT)
- A Quality and Safety Report (including an update on complaints performance and an update on progress with the Perinatal Mortality Review Tool)
- Planned and actual ward staffing for February 2019
- An Infection Prevention and Control Report
- A financial commentary
- A workforce commentary (including healthcare worker flu vaccination information)
- The Trust performance dashboard
- An explanation of the Statistical Process Control charts which are featured in the "Integrated performance charts" section
- Integrated performance charts
- The Board finance pack

Which Committees have reviewed the information prior to Board submission?

- Finance & Performance Committee (in part)

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

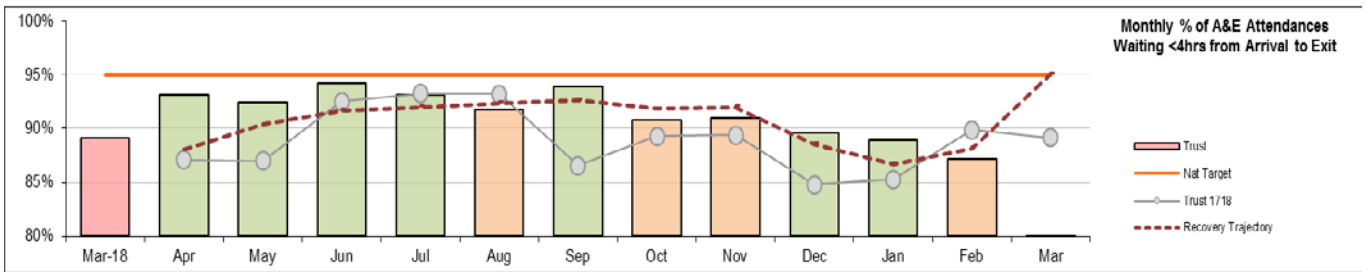
Review and discussion

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

OPERATIONAL PERFORMANCE REPORT FOR FEBRUARY 2019

1. 4 Hour Emergency Target

- Performance fell in February (calendar month) to 87.12% (including MIU), and did not achieve the trajectory target of 88.14% (-0.98%). YTD the Trust is 0.73% above the full-year Trajectory at 91.56%.
    - Q3 came in at 90.46%, just below the trajectory target of 90.77%, but above the funding threshold of 90.0%. 1819 is currently forecasting to come in at 91.59%, compared to 89.08% in 1718 and 87.12% in 1617. If trends continue, 1819 will be our best year since 1415 YTD at 28-Feb, the Trust was at 91.49% against a YTD trajectory of 90.43% and a year-end target of 90.82%.
    - Q3 performance came in at 90.46%, missing the trajectory target of 90.77%, but achieving the PFS funding threshold of 90.00%.
    - Q4 funding relies entirely on achieving 95.0% in March. We are currently at 94.22%, so need to average ~95.7% or better for the rest of the month
    - Compared to other trusts nationally, our Type 1 score is 8.1 percentage points above average, and we rank 30th out of 140



2. Ambulance Handovers

- There were 622 30min delays for February and 4,385 YTD, which is a 2.1% improvement on last year

- For 60min delays there were 83 for February and 583 YTD, which is a 2.2% worse than this point last year

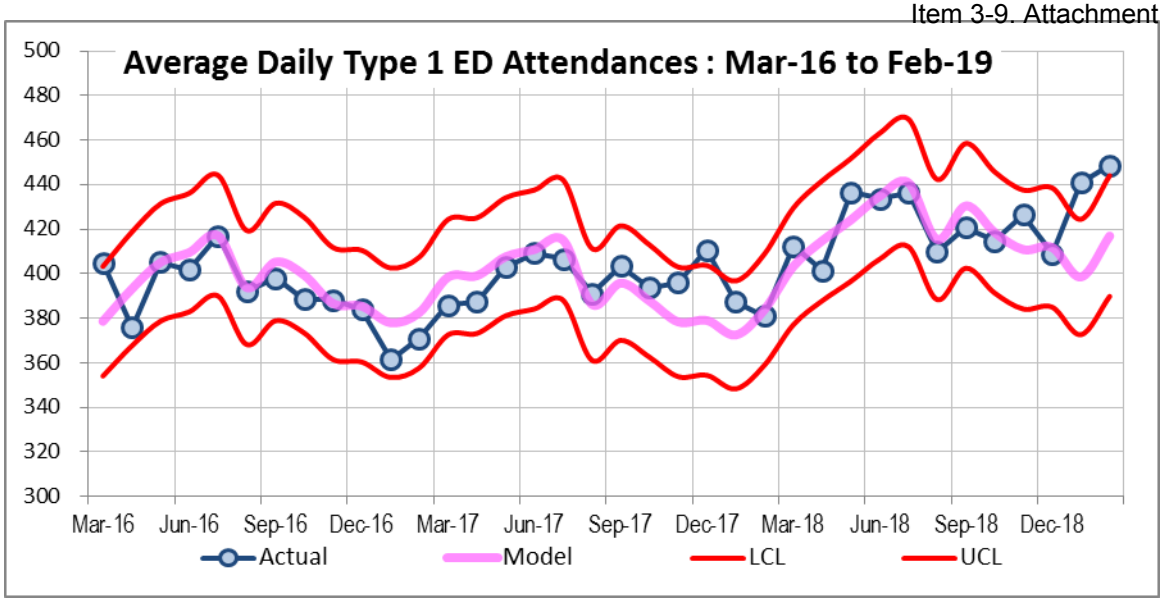
  A note must be made that SECamb data sometimes reports a delay however when reviewed Patients are triaged, seen and in a bed inside the required standards however this data is not updated on SECamb systems and therefore remains as a delay. These examples are sent back to SECamb to advise outcomes

  Although a very busy time with enormous pressure on all services we have continued to manage handover effectively and this is backed up by the figures above.

  We have introduced a flow coordinator in majors improving flow through the department as well as a receptionist within RAT to speed up hand overs even more with a key responsibility to make sure pin numbers are adding in a timely fashion to improve data quality

3. ED Attendances & Emergency Admissions

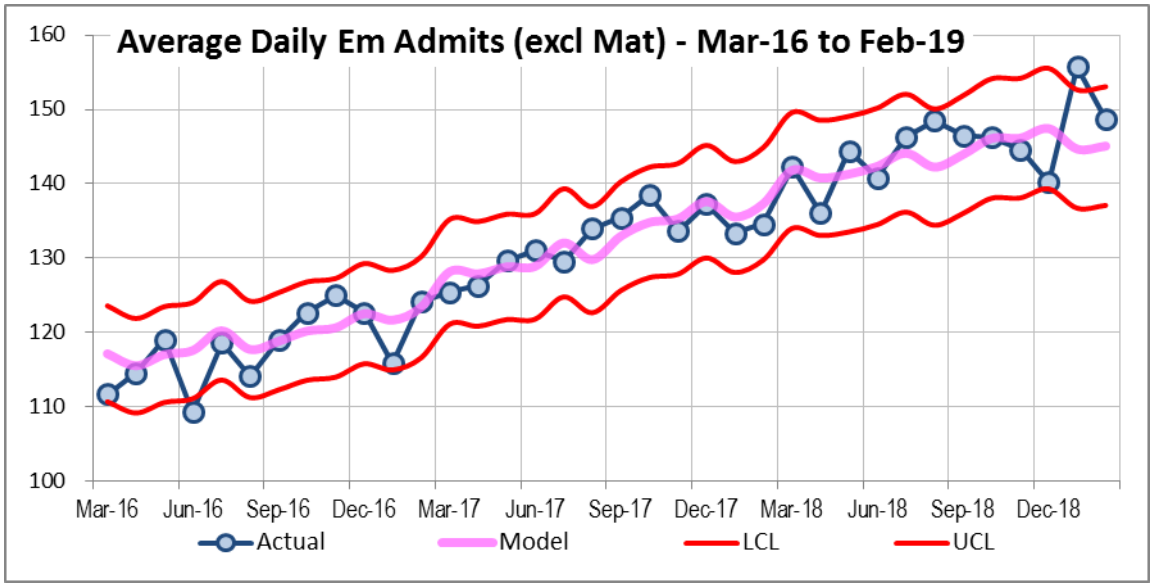
- A&E Attendances continue to increase. Over the last 5 years, annualised growth has averaged 4.4%. This is against a local population increase of around 1.1% per year, and a demographic 'bulge', where the people born during the 1946-64 spike in birth rates are hitting the age when A&E attendances become more frequent.



- Since the New Year, we have seen an unprecedented spike in attendances that has eased off, but is still continuing. Total Feb Type 1 attendances were 7.4% up on model, and 13.7% up on trajectory at 12,568. This is 17.8% up on last February. YTD type 1 attendances are 1.5% up on model, 4.7% up on trajectory and 6.8% up on this time last year. Average weekly attendances were at record levels over the summer, but surpassed that in Jan & Feb, which are usually the quietest month of the year.

- The week ending 10-Feb was the busiest week ever seen with 3,338 type 1 attendances – 15.9% higher than expected. Monday 11-Feb was the busiest day ever recorded – 21.3% higher than expected

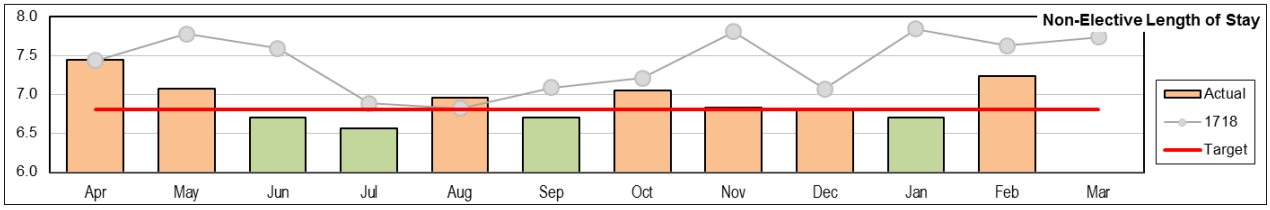
- Non-Elective Activity (excluding Maternity) was 15.7% above plan in February and 14.3% higher than last Feb at a record 4,559 discharges. Over the summer, NE activity had been its highest ever level, but January surpassed that by over 4%. 1718 activity was 28.1% above plan and 13.2% higher than 1617 at 50,905 discharges. The plan for 1819 was just 0.2% higher than 1718 at 51,248. YTD, we are now running at 11.4% above plan & 12.5% above last year. Much of this is driven by increased use of CDU & Assessment areas.



4. Length of Stay

- Non-Elective LOS was 7.23 days in February, and 6.91 YTD vs 7.41in 1718.

- NE LoS tends to increase by 0.5 to 1.0 days in the winter. This year, a small spike is observable in February.



- The average occupied bed-days remained similar to January at 749 in February, compared to an average of 764 for the whole of 1718.
    - LOS: Stranded patients, supporting and embedding flow coordinator role and use of CUR to identify patients who are nonqualified and specific delay themes. Transfer of LOS schemes where appropriate to BAU in preparation for 19/20 project work. Development of triumvirate specialty leads through re alignment of matron roles within Medical Specialties. Live Bed State in place across 4 wards. Tweaks to programme following user feedback. Criteria Led Discharge – working with other Directorates to share paperwork and project plans.
    - Frailty: Bronze model in place at MS and TWH. CPMS lead working with Frailty nurse to complete CGA on the system with added printing options 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
    - Regular operational and BI meetings to sense check and troubleshoot frailty data. Matron to continue to embed process with ward staff. Darzi matching decision Pathways between ED and Ward 32/Mercer improving Frailty and HIT training video completed for CPMS
    - AEC: Planned Ambulatory in the community -. All process now in place ready for the commencement of the service.
    - Development of direct GP referral to AEC. Enhanced clinical engagement with the AEC model for all specialties specifically Surgery Under new clinically led structure surgical teams have signed up to ambulatory network.
    - Hospital at Home - Fast track pathways improvement has been maintained.
    - Hilton has had an increase in capacity for winter period to 60 beds over weekend. Usage has improved during February.
    - Pathway 3 has seen significant discharges in February, currently 35 patients on P3 and 19 on Commercial scheme. No CHC DST completed in Acute in February, showing improved processes, with 22 patients admitted to the scheme.
    - Super stranded numbers increased in early January but are now stabilising. Reduction in early February and then a rise in later parts of the month.
    - Hospital at Home (H@H) saw a spike of 18 at end of February. Analysis of first 80 referrals shows vast majority IVAB's and medicine. Slow uptake for Orthopaedics and surgery. Working with teams to increase referrals.
    - #NOF project discussed at A&E delivery board 11-Feb and 11-Mar. Aim to release capacity in acute sector with the use of KCHFT community beds.

5. Delayed Transfers of Care (DTOC)

The percentage of occupied bed-days to DToC reduced again in February to 3.79%, down from 4.07% in January. YTD we are 4.37%

The number of lost bed days due to DTOCs decreased by 126 to 761. 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. We

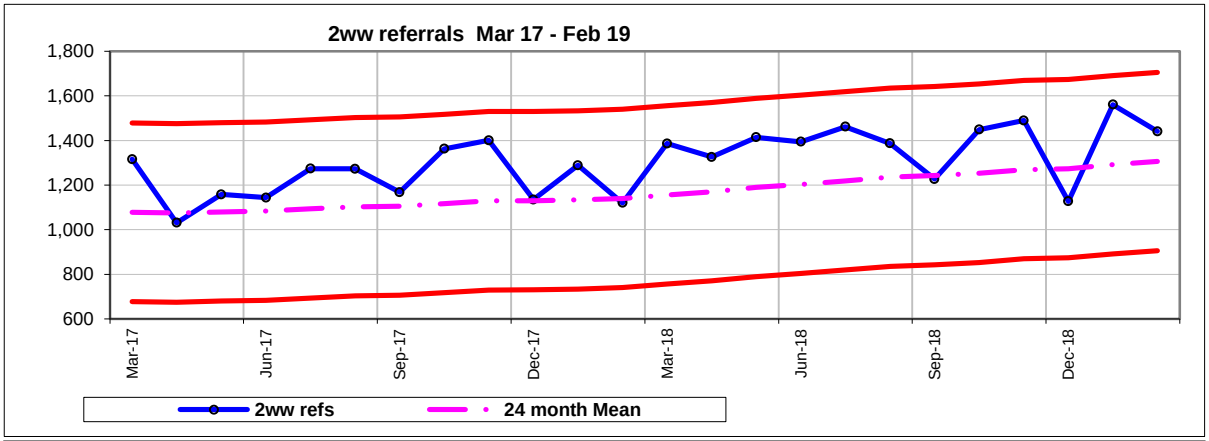
have averaged 4.36% over the past 12 months. On average, 29.4 beds per day have been lost to delays in 1819 compared to 36.7 for the equivalent period last year.

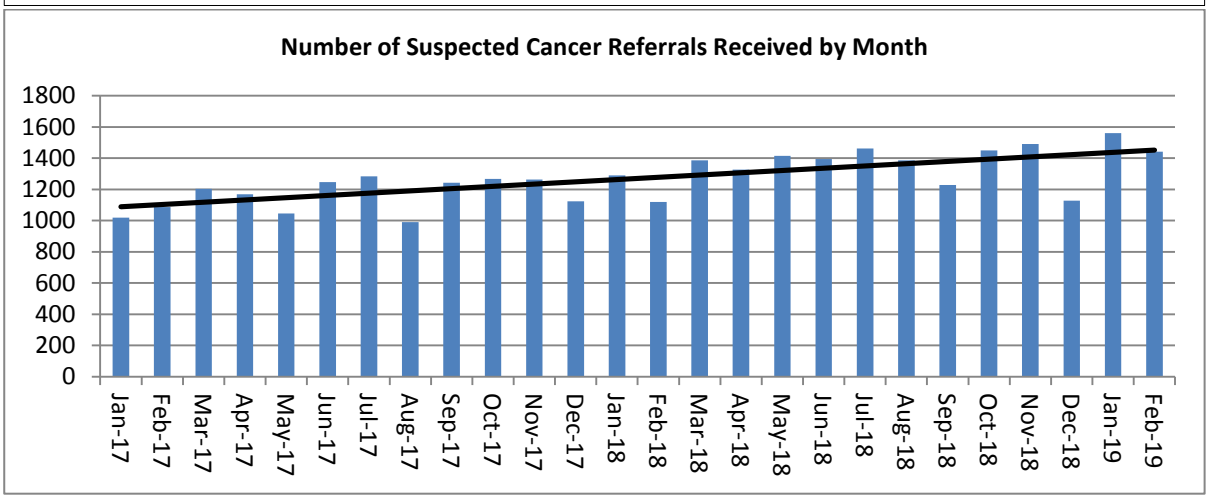
We have experienced a greater focus from external partners on the exit routes from the hospital and have now rolled out Pathway 1, 2 & 3 of the Home First initiative in full. Both sites have now got functioning frail elderly units, which has helped to reduce the number of longer stay admissions.

Category	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Rolling 12 Month
A : Awaiting Assessment	1	2	5	3	8	17	21	13	12	17	36	27	**162**
B : Awaiting Public Funding	1	2	4	0	0	4	3	0	0	2	9	3	**28**
C : Awaiting Further Non-Acute NHS Care	21	12	20	14	17	22	14	21	19	18	34	20	**232**
Di : Awaiting Residential Home	40	15	23	29	22	9	32	22	21	8	7	12	**240**
Dii : Awaiting Nursing Home	54	53	43	26	34	54	27	35	33	21	23	16	**419**
E : Awaiting Care Package	28	20	31	18	29	24	28	16	22	10	17	7	**250**
F : Awaiting Community Adaptations	7	15	7	6	4	8	10	7	3	3	7	3	**80**
G : Patient or Family Choice	10	3	14	11	9	14	9	17	9	4	10	13	**123**
H : Disputes	0	1	0	0	0	1	1	0	0	4	2	0	**9**
I : Housing	2	6	2	7	5	4	4	4	2	2	0	3	**41**
Grand Total	**164**	**129**	**149**	**114**	**128**	**157**	**149**	**135**	**121**	**89**	**145**	**104**	**1,584**
Rate	**4.26%**	**4.56%**	**4.34%**	**4.39%**	**5.03%**	**4.77%**	**5.89%**	**4.52%**	**3.58%**	**3.17%**	**4.07%**	**3.79%**	**4.36%**

6. Cancer 62 Day First Definitive Treatment

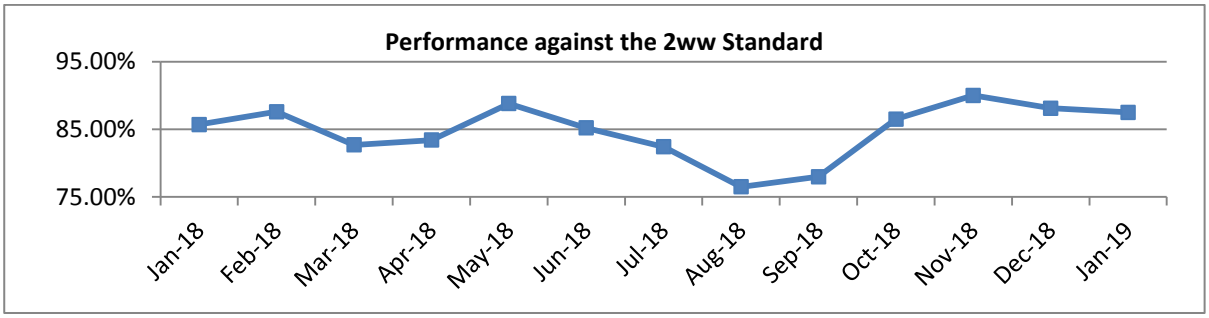
Cancer 2 week waits



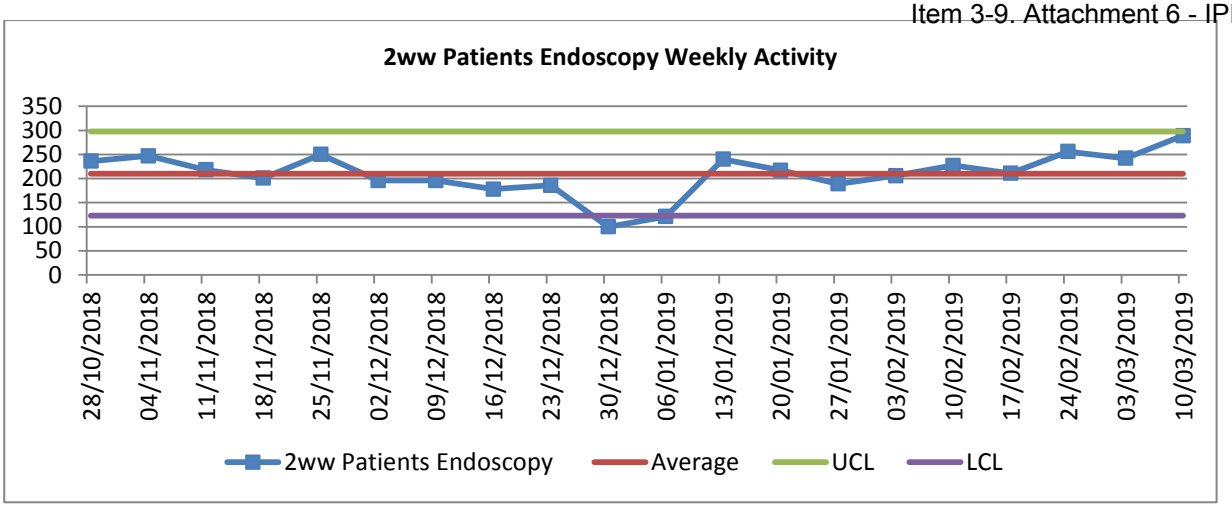


Growth in 2 week referral demand has continued to increase at a higher rate than expected. January 2019 saw 21.1% more referrals than January 2018, with 28.7% more referrals in February 2019 than February 2018.

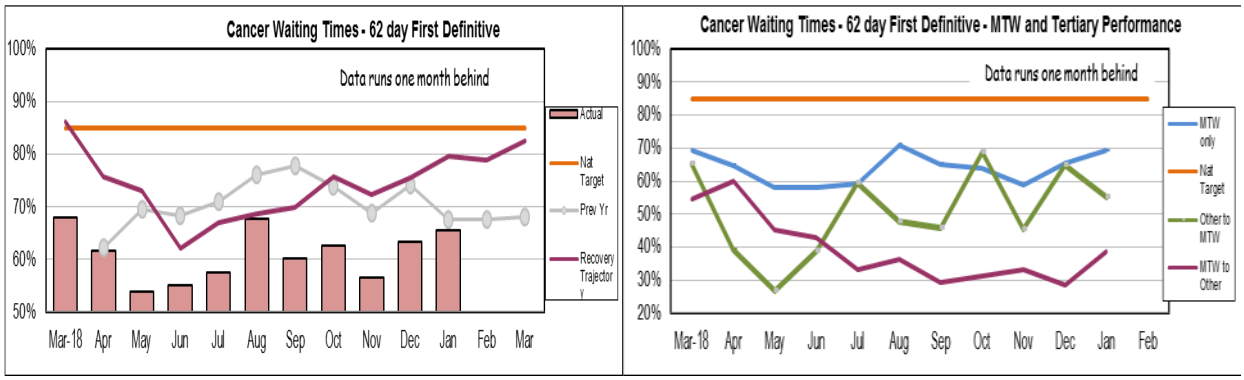
Despite the continual increase in demand, 2ww performance has improved month on month since August 2018 and has been sustained in recent months. Further capacity is being established for breast one stop clinics where the majority of breaches are being incurred and regular outsourcing to the independent sector is in place in order to continue improving performance to achieve and exceed the 93% standard.



Further endoscopy capacity is required to reduce the 2 week wait breaches in lower and upper GI, where the patients mainly go straight to test. An insourcing solution is currently being used and increased activity is being delivered.

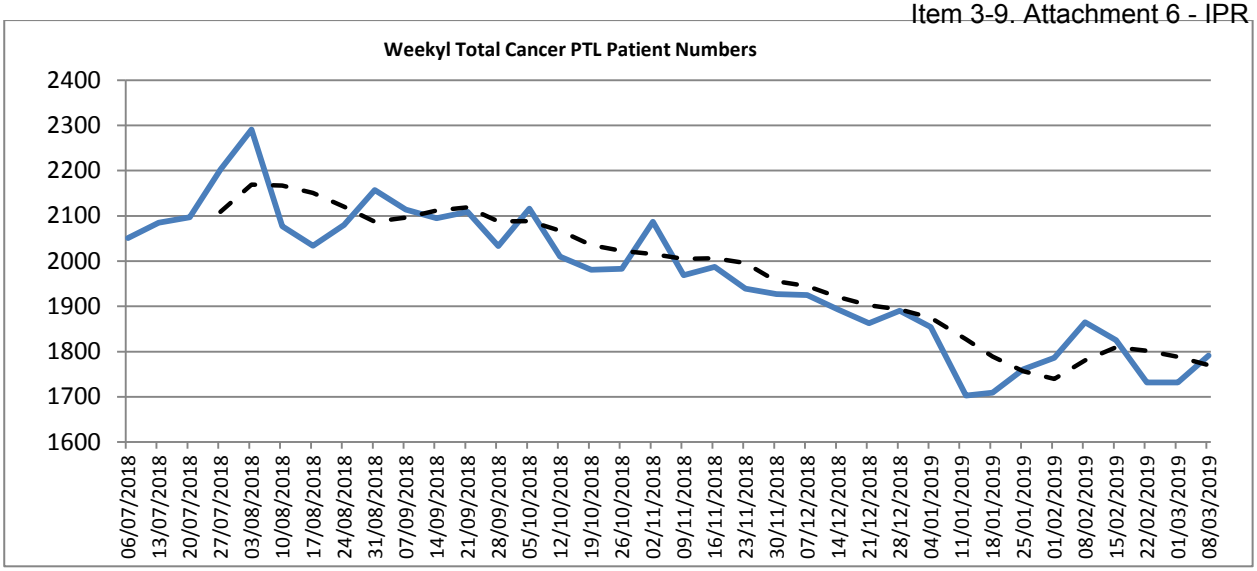


62 day performance for January was 65.6% (against a predicted performance of 64.1% in the trajectory) and 61% for 1819 Q3. 1718 finished on 70.4%.

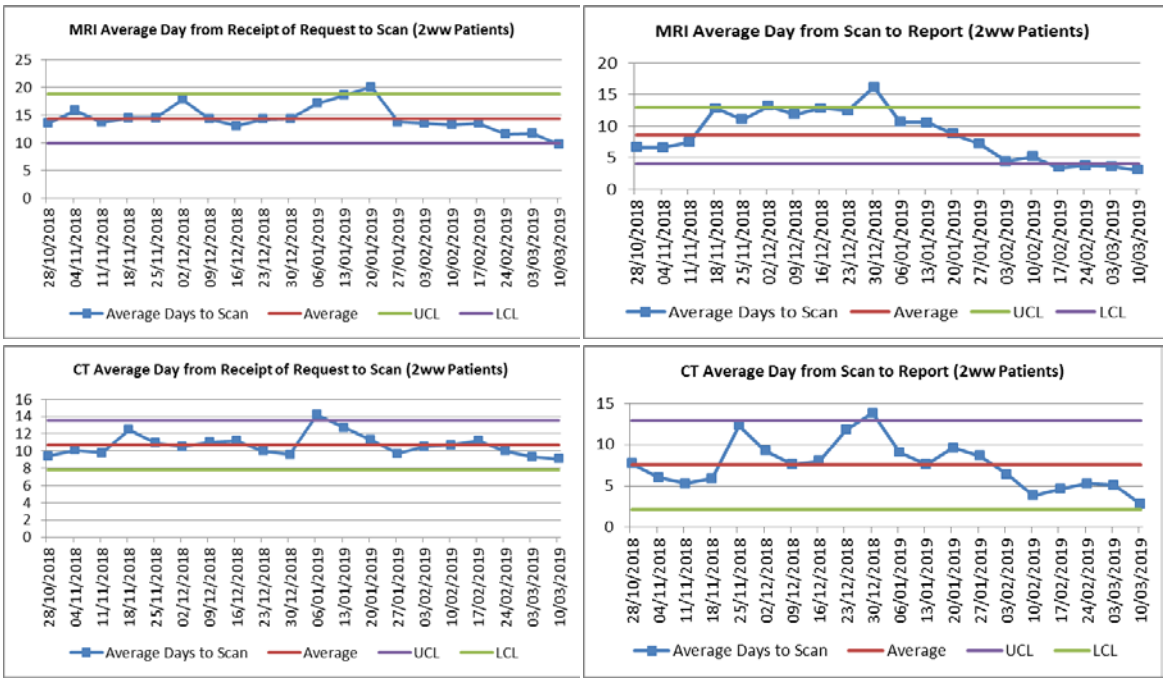


62 Day Performance						
January 2019	All reportable patients			MTW only patients		
	Total	Breach	%	Total	Breach	%
Breast	19.5	5.0	74.4	18	4	77.8
Gynae	12.0	1.0	91.7	8	0	100.0
Haematology	5.5	1.5	72.7	5	1	80.0
Head & Neck	2.5	1.0	60.0	0	0	#DIV/0!
Lower GI	18.5	5.5	70.3	17	4	76.5
Lung	6.0	1.5	75.0	2	1	50.0
Other	3.5	3.5	0.0	2	2	0.0
Upper GI	10.0	5.5	45.0	8	4	50.0
Urology	34.5	14.0	59.4	31	12	61.3
TOTAL	**112.0**	**38.5**	65.6	**91**	**28**	69.2

There has been particular focus on management of the patient tracking list in order to reduce its size so that those patients with a cancer diagnosis can be easily identified and progressed more quickly through their pathway.



Increased imaging capacity has been identified and is supporting a reduction in the time between request and scan and between scan and report in order to deliver faster diagnosis and staging so that patients can be treated more quickly.



The prostate pathway has been revised from the start of March to use nurse-led triage to assess patients to go straight to MRI scan. Biopsy capacity has been significantly increased to reduce the time from MRI scan to biopsy in order to achieve histological diagnosis by day 21 to day 28. This will meaningfully reduce the number of 62 breaches incurred by Urology and is expected to provide up to a 10% improvement in performance in the next two months.

A second straight to test nurse has been appointed and the clinical nurse specialists are now included in the rota to increase the lower GI straight to test triage capacity. Combined with the increased capacity for endoscopy, it is expected that 62 day breaches will be reduced in this tumour site over the next four to six weeks.

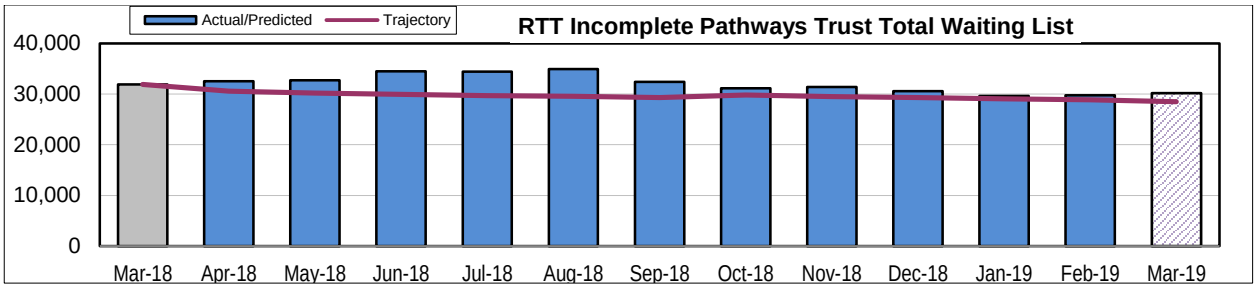
7. Referral To Treatment – 18 weeks

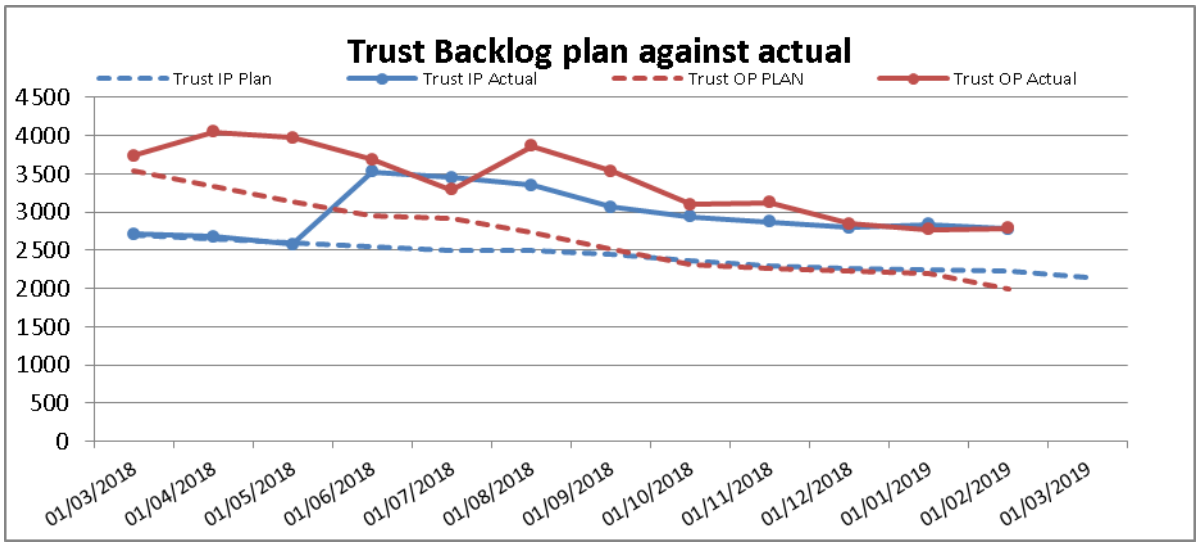
February performance shows a similar position to January in the Incomplete RTT performance achieving 81.3% against a target of 84.69%. The objective remains to achieve a waiting list position at the end of March 2019 that is no greater than the March 2018 position of 31,871.

		Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
TRUST	Trajectory Total WL	31871	30573	30211	29955	29700	29583	29329	29836	29488	29276	29064	28851
	Actual Total Waiting List	32256	32976	33170	34935	34885	35401	32844	31588	31932	31003	30106	29771
	Actual IP Waiting List	5741	5736	5841	7641	7519	7273	6986	7024	6944	7043	7042	7104
	Actual OP Waiting List	26515	27240	27329	27294	27366	28128	25858	24564	24988	23960	23064	22667
	Trajectory Backlog	6438	6186	5935	5685	5437	5416	5170	4884	4601	4539	4478	4416
	Actual Total Backlog	6451	6728	6547	7214	6743	7220	6607	6036	5997	5642	5612	5572
	Actual IP Backlog	2716	2682	2577	3530	3454	3352	3068	2939	2875	2793	2841	2781
	Actual OP Backlog	3735	4046	3970	3684	3289	3868	3539	3097	3122	2849	2771	2791
	Trajectory % Performance	**79.8%**	**79.8%**	**80.4%**	**81.0%**	**81.7%**	**81.7%**	**82.4%**	**83.6%**	**84.4%**	**84.5%**	**84.6%**	**84.7%**
	Actual Total % Performance	**80.0%**	**79.6%**	**80.3%**	**79.4%**	**80.7%**	**79.6%**	**79.9%**	**80.9%**	**81.2%**	**81.8%**	**81.4%**	**81.3%**

A detailed piece of work has been undertaken to produce a revised forecast of future performance for February and March 2019 based on the RTT Recovery Plan (as below).

RTT Forecasted Performance with Estimate for Prime Provider from February 2019	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	31509	30530	29668	29771	30157
Total Backlog	6680	6728	6547	7214	6743	7220	6609	6036	5997	5642	5612	5572	6460
Total %	**79.0%**	**79.4%**	**80.1%**	**79.1%**	**80.4%**	**79.3%**	**79.6%**	**80.7%**	**81.0%**	**81.5%**	**81.1%**	**81.3%**	**78.6%**





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.

Although an RTT recovery plan was put in place until the end of October 2018 and further extra waiting list initiatives being performed throughout November and December, it was recognised that further input was required to ensure the Trust met the requirement of the waiting list being no greater in March 2019 than in March 2018 and that the Trust needed to significantly reduce patients waiting over 40 weeks for treatment. A business case was therefore submitted in December 2018 and agreed by the Trusts Finance & Performance Committee which consists of the following actions:

- Continue WLI theatre and outpatient sessions for all specialities from Jan-March 2019 – Scheduled (40 x theatre sessions and 18 x outpatient sessions).
- Recruit an additional 2 x B3 Booking clerks within Head and Neck until March 2019 - Recruited and in place.

- Recruit 4 x B3 additional validators into the central team – recruitment has been unsuccessful so overtime is being offered to all CAU staff.
- Recruit a second GM within Surgery for 3 months – Recruited and in post.
- Surgical Registrar to be based in ED at TWH - Recruitment has been unsuccessful.
- Implement MyPreOp (cloud based integrated IT system) pre-operative assessment tool for all specialities which will also require 2 x B5 nurses to double run the current service - Task & finish group continues with implementation planned for April.
- Outsource non AIC activity where possible – in progress.

Continuous actions:

- Elective activity increased for Gynaecology and Ear, Nose and Throat from 4 March 2019 to normal levels. Weekly forward planning meeting continues with a plan to increase elective activity across all specialities from 1 April 2019. be monitored in line with the winter plan to ensure elective activity is maintained as much as possible – Weekly forward planning meeting in progress.
- Specialities to focus on reducing 40+ week patients – monitored weekly.
- 52 week breach weekly meeting in progress to address root causes and contributory factors and ensure harm reviews have taken place– monitored.
- Review all gaps in medical rotas on a weekly basis and ensure any locum requests have been submitted.
- Forward look meeting in progress to review theatre schedules against planned lists.
- Hospital at Home has been implemented to support a reduction of length of stay and release of bed capacity – monitored daily at the bed meeting and weekly at the forward look meetings.

Elective Activity and New Outpatient Activity:

Currently the Elective activity YTD is 1444 (3%) above plan. Outpatient New Activity (excluding Therapies and Ward Attenders) is -4759 (-3.9%) below plan with general surgery and ophthalmology being furthest from plan. The inability to deliver the planned elective work internally is a risk to our ability to meet the forecast. There is an assumption in our forecast that the activity is delivered to plan.

Activity (Main Specialties):	Elective Activity YTD				Outpatient New Activity YTD			
	Actual	Plan	Variance	% Variance	Actual	Plan	Variance	% Variance
Trauma & Orthopaedics	3022	2407	615	25.6%	23955	20286	3669	18.1%
General Surgery (Not inc Endoscopy)	2681	2902	-221	-7.6%	16365	18355	-1990	-10.8%
Urology	2073	2193	-120	-5.5%	6191	5712	479	8.4%
ENT	1709	1877	-168	-9.0%	8382	8188	194	2.4%
Ophthalmology	4509	5159	-650	-12.6%	24027	26383	-2356	-8.9%
Gynaecology	2089	2290	-201	-8.8%	6768	7170	-402	-5.6%
Cardiology					5445	5779	-334	-5.8%
Gastroenterology					3634	4106	-472	-11.5%
Rheumatology					2234	1901	333	17.5%
Respiratory					4070	3851	219	5.7%
Diabetes					1572	1472	100	6.8%
Endocrinology					1385	1301	84	6.4%
Neurology					2726	2853	-127	-4.5%
Care of the Elderly					1417	1994	-577	-28.9%
Other	30705	29002	1703	6%	10141	14070	-3929	-27.9%
Trust Total (All Specialties)	46788	45344	1444	3%	118312	123071	-4759	-3.9%

NB: Plan excludes Prime Provider Activity
The key issues that contribute to lower than planned elective work remain:

- Planned reduction of activity during PAS implementation, prolonged by on-going data and admin issues post go-live.
- 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.

- 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 during the Four-Eye scoping exercise across elective and outpatients.
- Winter assessment of demand going beyond the worst case scenario requiring escalation of more surgical beds - the capacity and demand has identified the bed gaps based on expected activity levels using previous years' data. A number of schemes were implemented in December to provide additional out of hospital capacity. The 9 trolleys for day surgery have not been retained at TWH for around 3 weeks and recovery 1 and holding bay have been escalated for around 2 weeks due to a period of prolonged OPEL 3/4.

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 forecasts 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.

52 week breaches

Total Trust	Apr-18	May-18	Jun-18	Q1 Total	Jul-18	Aug-18	Sep-18	Q2 Total	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	YTD
RTT >52kw Breach Occurrences	3	2	8	13	8	5	9	22	9	13	10	8	10	85

The Trust has incurred 85 x 52 week breaches year to date (8 of these patients rolled over as they were not treated within the reporting period), 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.

There were 10 breaches in total for February. 6 breaches occurred due to data quality issues and 2 were down to capacity issues. All patients have been given a date for surgery.

All patients have had a harm review by the managing Consultant and no harm found.

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.
- All patients over 40 weeks are being monitored by the Head of Performance and Delivery, the speciality General Managers, Assistant General Managers and CAU's on a daily basis to ensure treatment occurs before 52 weeks and ensure patients are booked in chronological order.
- 52 Week Panel has been established to fully investigate the breaches and identify trends.
- The updated Allscripts/RTT training has been rolled out with good attendance and good feedback. Dates scheduled through to March June 2019.
- RTT recovery plan has been implemented and is monitored weekly.

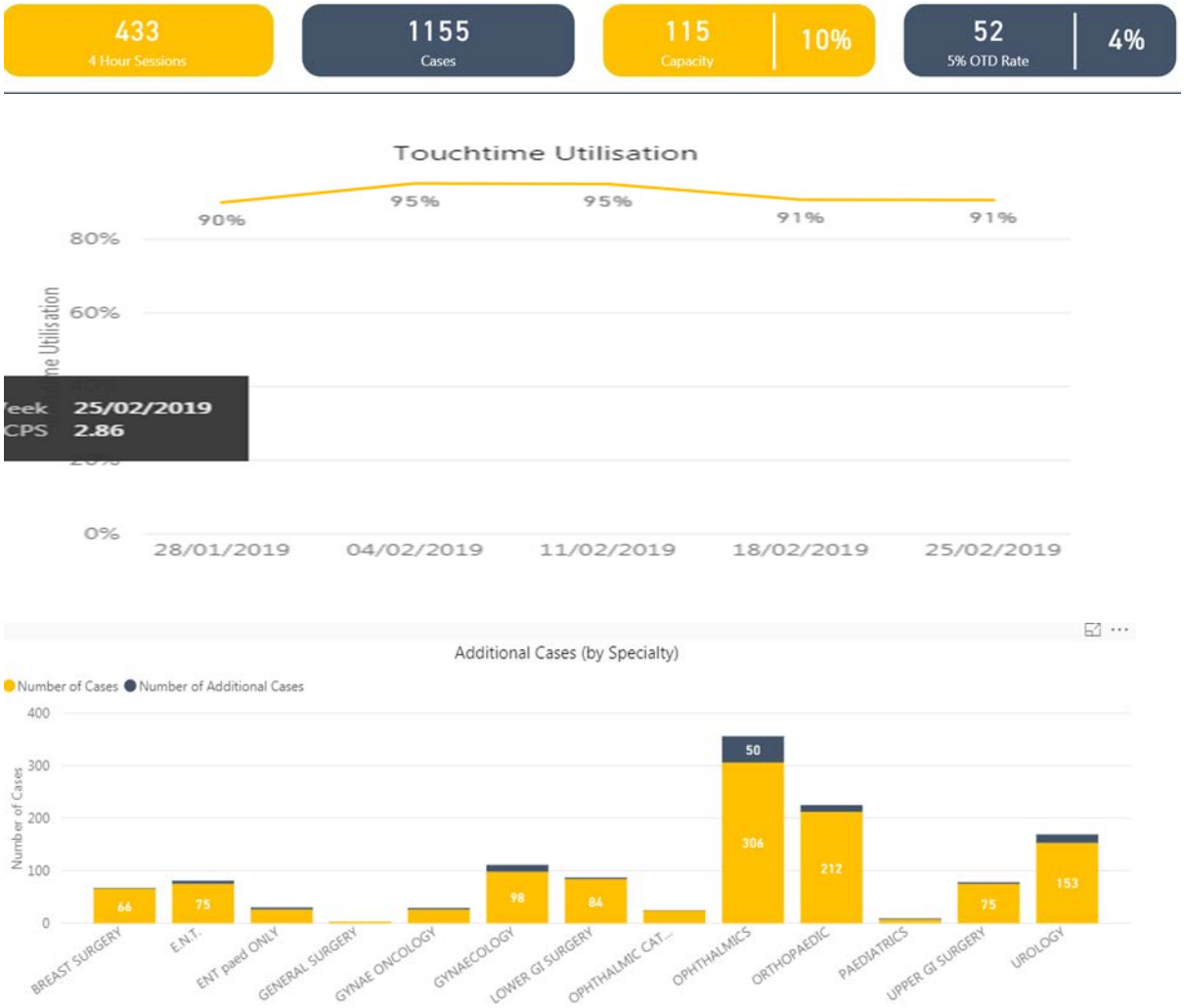
8. Theatre Productivity

The graphs below are taken from the Four Eyes Theatre Dashboard and show the Theatre Utilisation from 1/2/19 – 28/2/19 overall. 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.

- Ophthalmology remains an outlier with a 10% opportunity which is being addressed by adding an extra Cataract case to each list managed by the Clinical Director.
- The admission lounge is coming under the management of critical care at TWH to improve start times and productivity.
- The Winter schedule has now converted back to the normal schedule, one month above plan.
- Q4 plan to introduce electronic POA system (-MYPREOP) is on track with potential reduction in non-face to face assessment by 30%.

Overall Touch time Utilisation



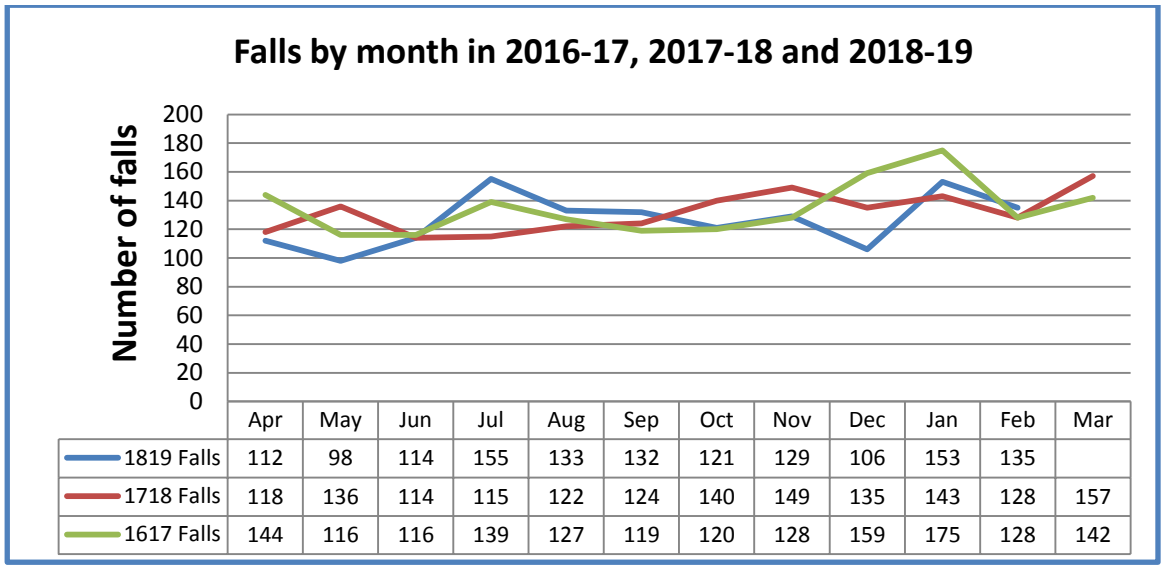
Quality and Safety Trust Board (February data)

Patient Falls incidents

There were 135 patient falls reported for February, at a rate of 6.73. The YTD is 6.13 against a limit of 6.00. 40 falls were at Maidstone and 95 were at Tunbridge Wells.
In terms of numbers it is a reduction however February is a shorter month.

The 2017-18 total falls was 1,581 (rate of 5.98) and in 16-17 the total number of falls was 1,613 (rate of 6.07)

The YTD rates are 1388 (rate of 4.90 Maidstone and 6.51 Tunbridge Wells)
Of the 135 falls reported, 105 resulted in No Harm, 26 resulted in Low Harm, 2 Moderate & 1 Severe Harm. Two were declared as an SI in February and one is due to be declared in March each of these is currently being investigated.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1819 Falls	112	98	114	155	133	132	121	129	106	153	135	
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

Pressure Ulcers:

During the month of February there were 7 new Hospital Acquired (HA) pressure ulcers and 1 deterioration of pressure ulcer previously reported.
Of the 7 HA pressure ulcers 2 were Deep Tissue Injuries to the malleolus (ankle) area, in both cases the patient' medical condition was very poor and '*heelpro'* boots were being used for prevention of heel damage. 2 Deep Tissue Injuries to sacral area, one of each recovered well and the other remains under monitoring. 1 category 2 to sacral area, 1 deep tissue to heel and finally 1 deep tissue injury to a lower lip due to the need of respiratory intubation.

The incidence for February continued to show improvement from same period last year, considering the increase on the inpatient flow this is a good sign of good care. However it is important to keep in mind that there was also an increase in incidence of surgical and trauma wounds which take priority to be reviewed in relation to pressure ulcers.

Promoting education and the need for a full body assessment and monitoring even on independent patients, unless they have capacity to decline assessment, is always relevant as we aspire to systematically improve in our care.

Updates to the Ward managers and TVN link Staff continue to be sent regularly to ensure that departments are updated on changes and recommendations.

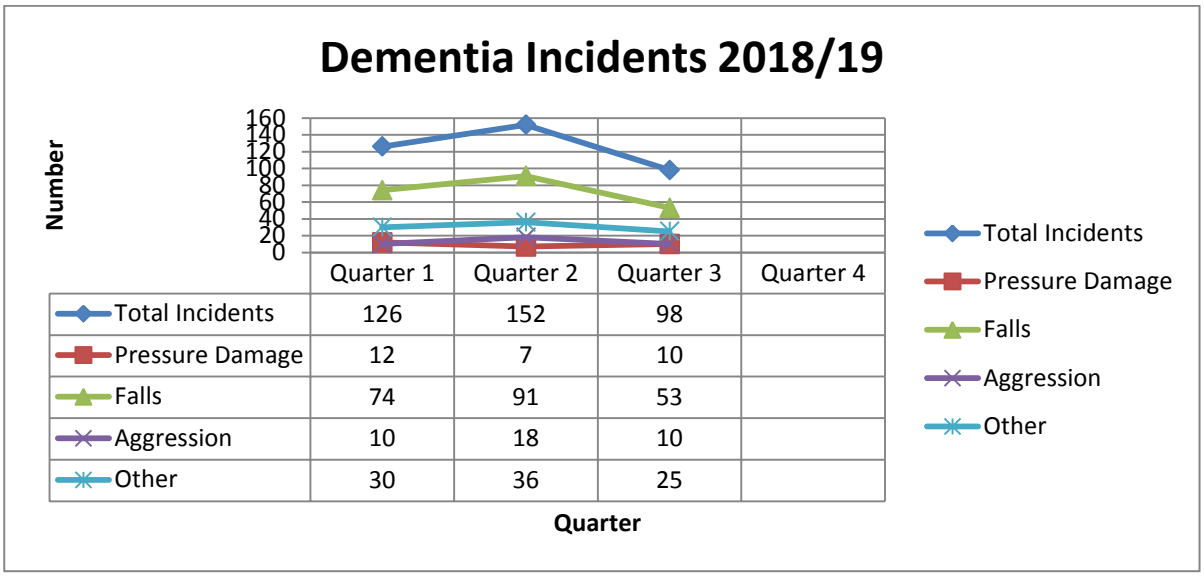
Training focusing on wound assessment and dressing choice is now available for booking for 4 dates. In addition to this training bespoke training is ongoing in response to demand and where specific needs have been identified.

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.

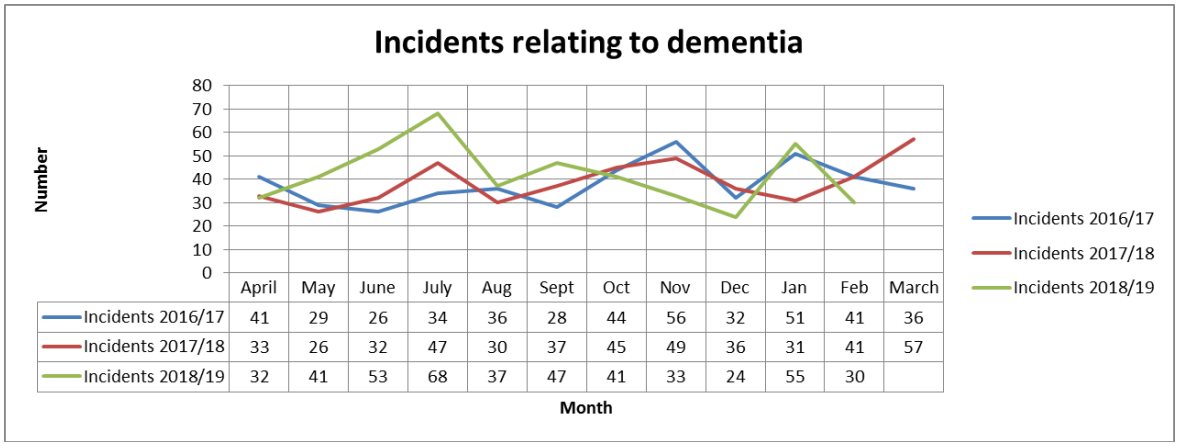
Graph 3 – Dementia Incidents



	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Total Incidents	126	152	98	
Pressure Damage	12	7	10	
Falls	74	91	53	
Aggression	10	18	10	
Other	30	36	25	

Graph 3 demonstrates the number of incidents per category that occurred during Quarter's 1, 2 & 3 (2018/19). There has been a significant reduction in total incidents since Quarter 1 & 2 and a reduction in Quarter 3 incidents on the previous 2 years of reporting (Q3: 2016/17 = 132; 2017/18 = 130).

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	24	55	30	

Graph 4 plots the number of incidents relating to dementia patients per month for 2016/17; 2017/18 and 2018/19. There has been a decrease in incidents in February compared to January. In February

there were 21 incidents at TWH and 9 at Maidstone, of these falls continues to be the main cause of incidents totalling 15 (11 at TWH and 4 at Maidstone), however this is a reduction on January when there were 31 falls incidents at TWH and 5 at Maidstone relating to dementia patients.

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.

Single Sex Compliance:

No Single sex breaches were declared for February 2019.

There were 17 occasions when bays were mixed. These occasions were due to the need to mix stroke patients on the stroke unit or acutely unwell patients in ITU due to their clinical needs, which could not be provided elsewhere in the trust at the time when they were admitted due to high operational demands. However this remains an internal breech but justified in terms of clinical need.

The clusters of Breeches reported in January were due the acute clinical need of each patient admitted at a time of high demand, patient flow and capacity across the trust.

Friends and Family Test:

Overall response rates for February have shown an increase in A+E response rates but a slight decrease in inpatient response rates (IP) and all other areas however, percentage positive response rates have increased overall. There continues to be fluctuating consistency with response rates during the month in line with the sustained increase in capacity and demand across services as a known contributory factor.

Services that were added to the IWGC system have now started to order and receive the IWGC forms to start rolling out collection. There has been a significant reduction in rejected forms and the dedicated IPads are being encouraged with 30 tablet reviews and 12 online reviews recorded in February. Unfortunately this is a reduction from last month due to a fault identified with the app. IT are currently working on a solution.

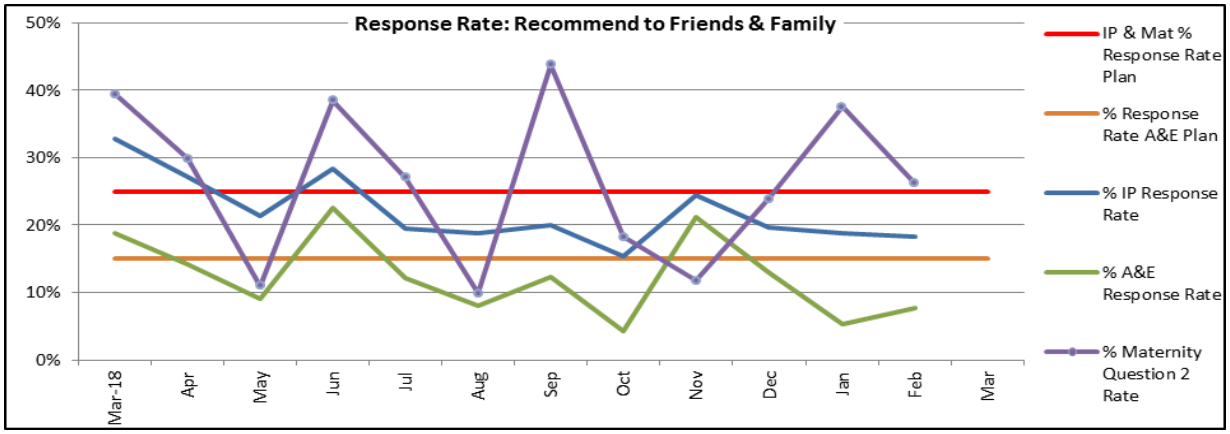
Response rates for February IP: decreased minimally from 18.7% in January to18.2% in February. Although the number of respondents was higher in January, it was offset by a larger number of eligible respondents. A&E (including children) increased from 5.4% in January to 7.6% in February. This was after the issue last month where the Jan figures were sent slightly too early therefore it is acknowledged that the figures may be slightly skewed.
Maternity Q2 has decreased from 37.6% in January to 26.2% in February.

In terms of number of respondents from OP, the number of responses for February is in no way comparable to January with a reporting figure of 102 responses. It has been identified that no files were uploaded after the 8th February therefore the full month's data is currently unavailable to confirm activity.

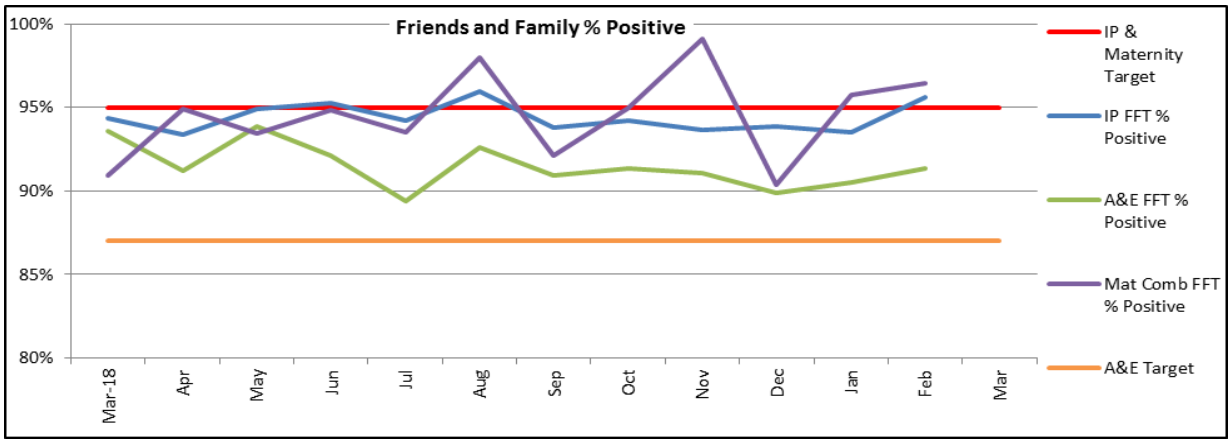
For the % Positive for January, inpatients has increased from 93.5% in January to 95.6% in February, A&E increased from 90.5% in January to 91.3% in February Maternity (all 4 combined) increased from 95.8% in January to 96.5% in February.

YTD Response: 21.1% IP, 11.7% A&E and 24.8% Mat
YTD % Positive: 94.4% IP, 91.3% A&E and 94.5% Mat

Graph 5- FFT Response Rates:



Graph 6 - FFT Positive Responses:

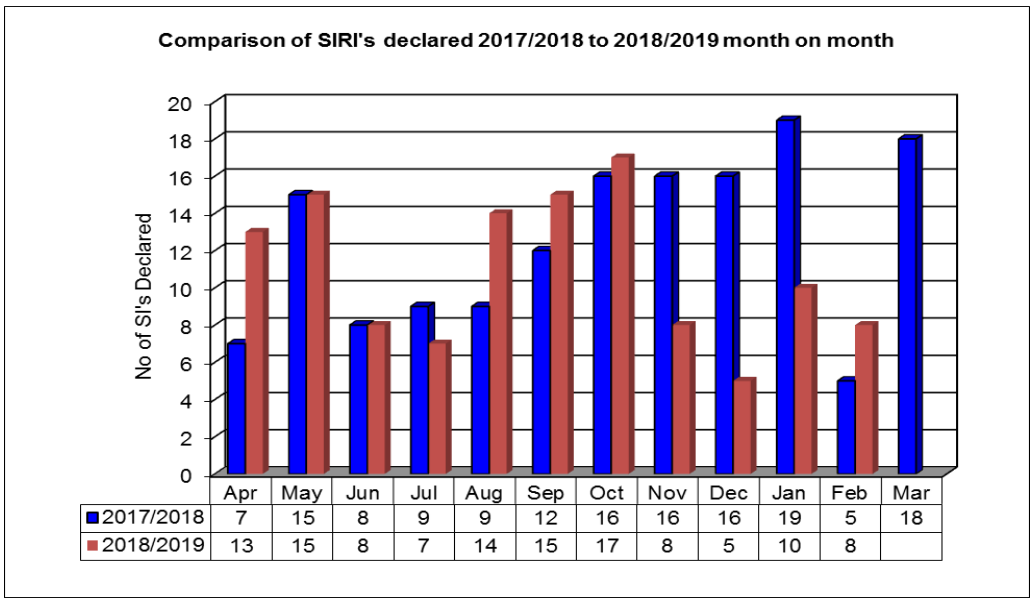


Serious Incidents (SI's):

There were 8 Serious Incidents reported in February 2019 (3 at MGH and 5 at TWH).

- 5 Main SI's in 3 Directorates:
  - Two SI's reported in Emergency Medicine (1x MGH, 1xTWH)
  - Two SI's reported in Women's and Children's (TWH)
  - One SI reported in Pathology (MGH)
- 1 Pressure Damage – reported in Medical Specialties (TWH)
- 2 Falls – reported in Emergency Medicine (MGH) and Orthopaedics (TWH)

The total number of SI's open on STEIS has decreased year to date at 81 compared to 98 in 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	15	8	7	14	15	17	8	5	10	8	

During the month of February 2019, 9 SI's were closed, in addition 4 were downgraded which included:-

Directorate	SI Number	Category	Ward and Site
Emergency Medicine	2018/13915	12 hour breach	A & E Department
Medical Specialties	2018/26829	STF - supra condylar fracture to left elbow	Ward 21
Women's Services	2018/27395	DVT- Omission of Post-natal Thromboprophylaxis	Postnatal Ward
Medical Specialties	2018/25964	Cardiac lab - device implant	Cardiac Cath Lab

Learning from the Falls Panel:

- Patient at risk of falls to have falls risk assessment completed and falls prevention care plan implemented.
- Patient identified as requiring mobility aid to have the aid accessible to them at all times.
- Staff to undertake and document mental capacity assessment on patient's capacity for use of call bell and risk of falling.
- Patients at risk of falls who are able to safely stand to have lying and standing blood pressure undertaken.
- Patient identified as requiring supervision for risk of falling should not be left unattended.
- Post fall, before moving patient carry out assessment for injury and assess for most appropriate moving and handling method to reduce the risk of distress and further harm.
- Falls prevention assessment and care plan to be reviewed post fall to reduce risk of further falls.
- Falls prevention care plan to be reviewed and updated when patient's condition changes (deteriorate or improve) to reflect current needs.

Learning from the VTE Panel – key actions identified

- To ensure staff understand the importance of complete and legible documentation.
- 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 adhere to guidance and policy relating to blood transfusion and VTE, i.e. Haemoglobin checks

Learning from the main panel – key actions identified

Policy and Procedures

- Delay in incident reporting and declaration of serious incidents / patient delays which impact on timeliness of investigation
- Sepsis protocol must be followed at all times to enable identification of patients who are at risk of deteriorating
- Policy should be in place / written to ensure all scan results are reviewed regardless of treatment plan being in place and appropriately documented in patients notes
- 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
- 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.
- Importance of clear and accurate record keeping regarding involvement of medical staff opinion, time, printed name, designate and signature

Consent

- Ensure complete and accurate documentation of risks and associated risks to ensure adequate and complete consent has been obtained
- To promote good practise to others on robust consenting and documentation

Information Governance

- Ensure new processes are put in place and reviewed for typing and sending out clinic letters
- To ensure process for receiving and storing patient identifiable data is followed at all times and not partially completed

Support of staff

- Clear guidance on referral process for staff following violence and aggressive incidents to be included in flowchart and policy with appropriate designation of duties.
- Introduction of competencies that allow extended roles for experienced nurses.

Medication

- Mental capacity assessment to be undertaken before considering use of chemical restraint.
- Patient at risk of falls to have medication review
- Improved education of appropriate selection and monitoring of intravenous fluid therapy
- To ensure all nurses on the ward are aware of the time critical drugs guidance

Training and Education

- Training for all staff members on how to undertake an appropriate swab count as per Local guidelines.

Safeguarding Learning and Improvement SI panel

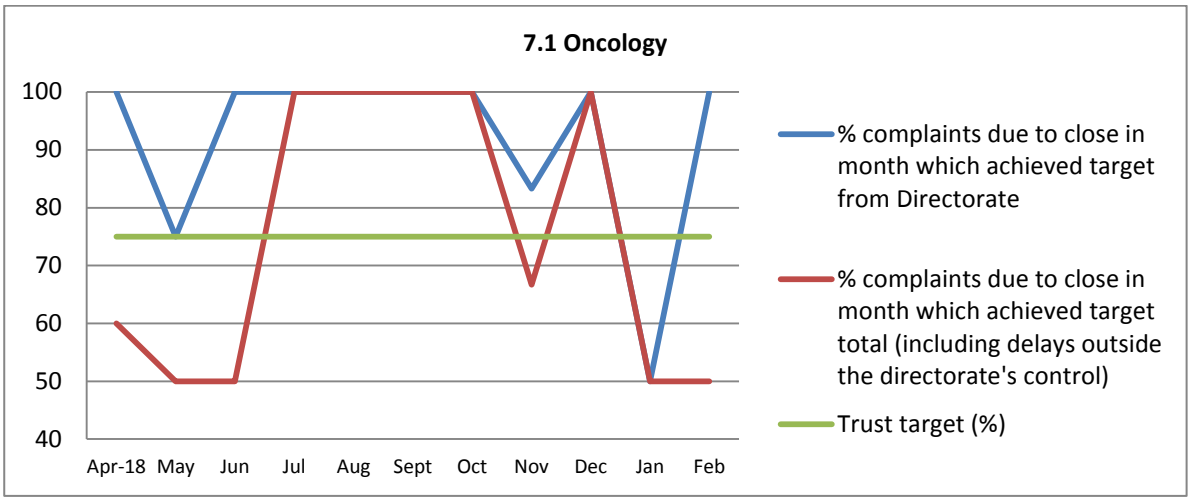
- The Panel has been convened fortnightly from January until June 2019 to allow for joint closure of investigations with the Local Authority for both the current and back log of investigations and sharing the learning across the divisions. Once the backlog is cleared the meetings will revert to monthly.
- As work is ongoing to clarify the issue, there will be a further update quantifying the position in the March report.
- A key learning theme from the panels to date is the importance of both verbal and written communication and ensuring detailed discharge summaries are shared.

Complaints:

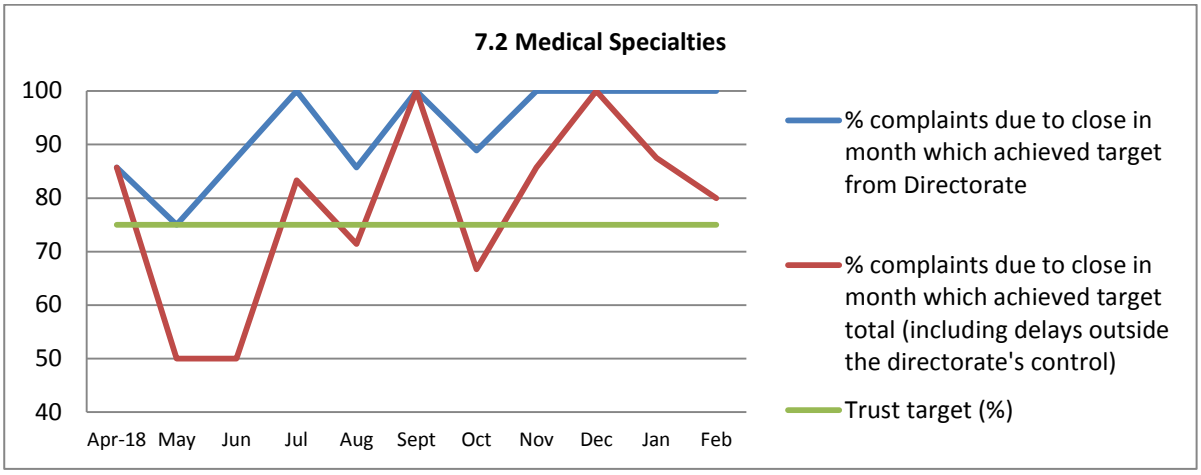
There were 41 new complaints reported for February which equates to a rate of 2.04 new complaints per 1,000 occupied bed days. This is a decrease compared to 2.23 for January. There were 120 open complaints at the end of February, compared to 130 in January.

73.3% of complaints were responded to within deadline compared to a target of 75%. Graphs 7.1 to 7.11 (below) provide information on the performance for year to date by each directorate.

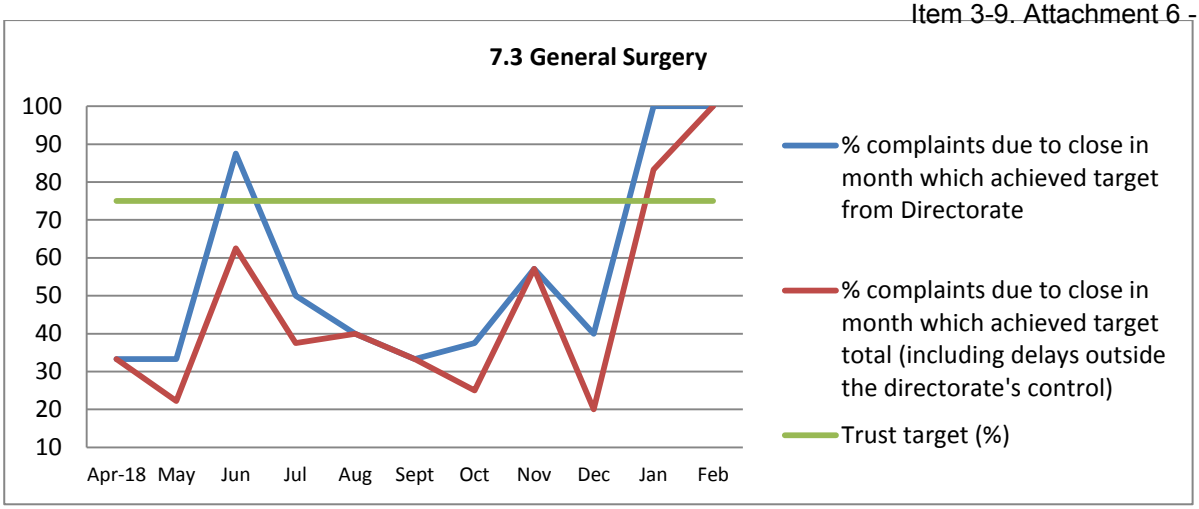
Graph 7 - Complaints performance against Trust target



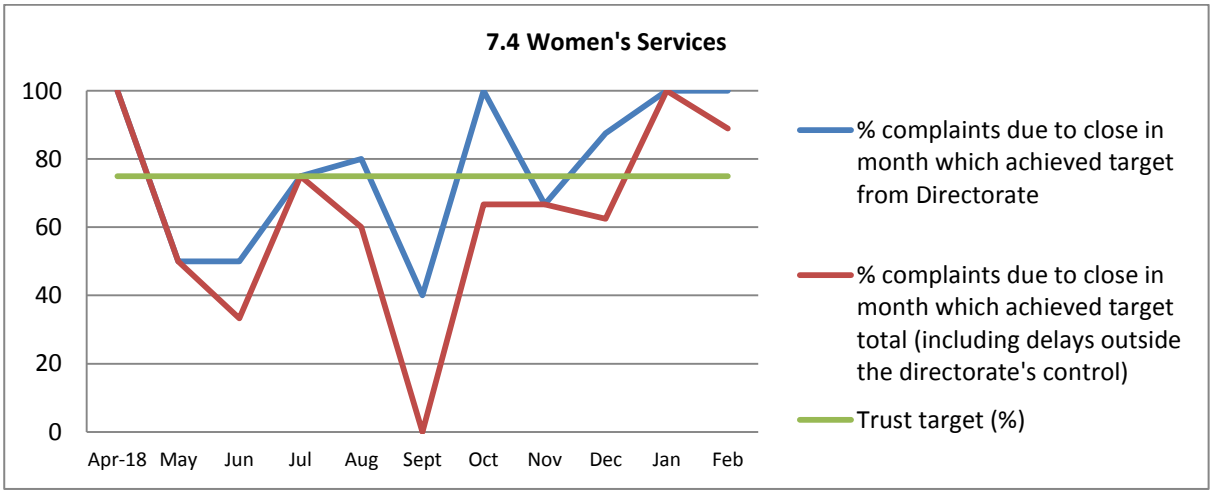
Oncology	Apr 18	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Number of complaints due to close in month	5	4	2	2	2	1	2	6	1	4	4
Number of complaints responded to in month	5	5	2	2	4	2	4	7	2	2	5



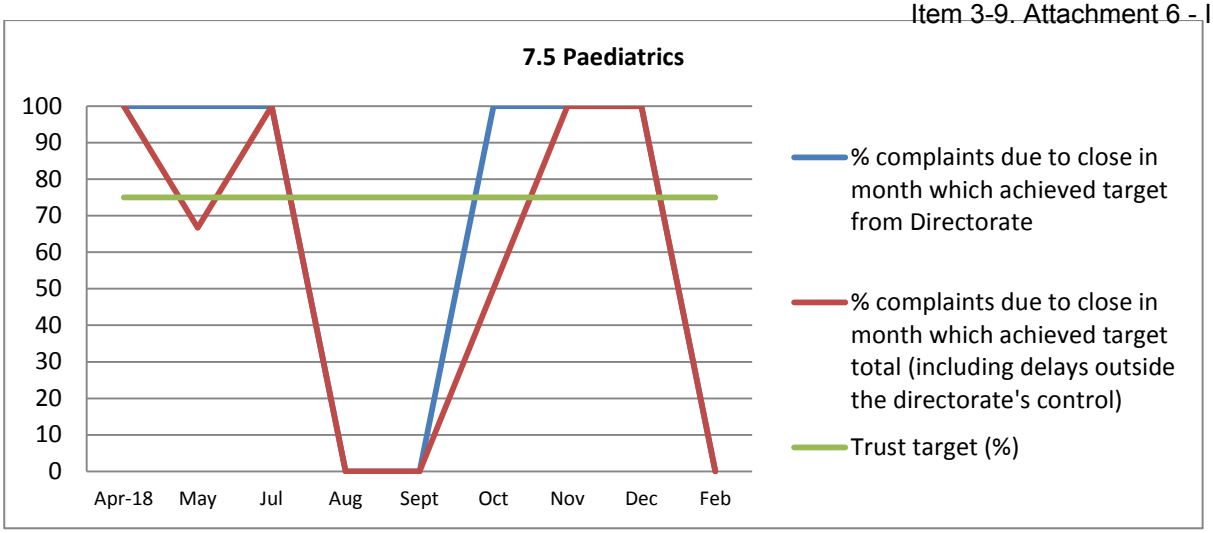
Medical Specialties	Apr -18	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Number of complaints due to close in month	7	12	8	6	7	7	9	7	1	8	5
Number of complaints responded to in month	17	7	11	10	15	9	12	8	3	10	6



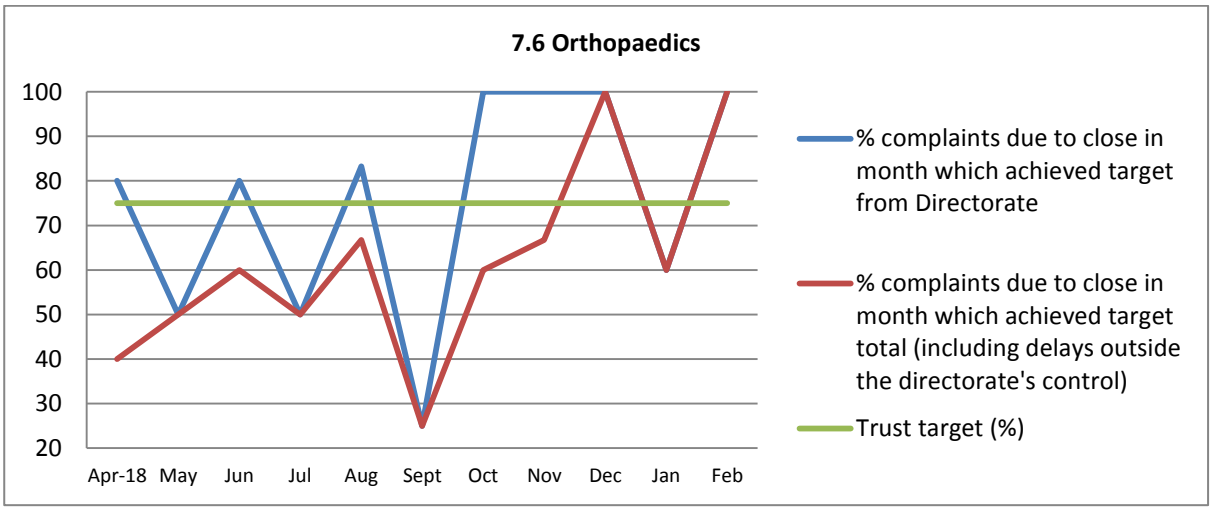
General Surgery	Apr -18	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Number of complaints due to close in month	6	9	8	8	5	3	8	7	5	6	6
Number of complaints responded to in month	12	6	9	5	10	4	10	12	6	10	7



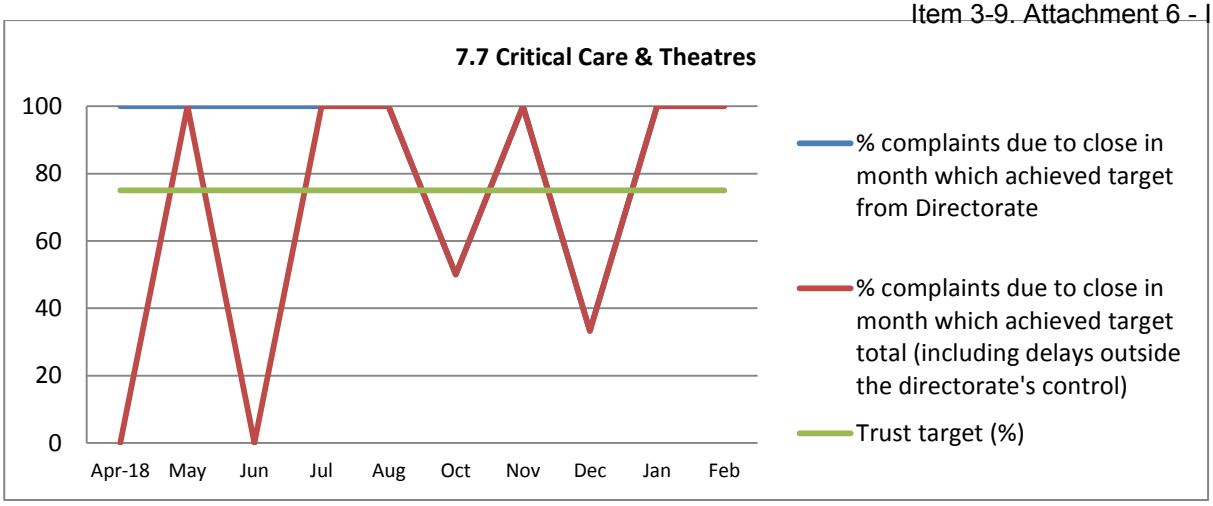
Women's Services	Apr-18	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Number of complaints due to close in month	5	2	6	8	5	5	3	3	8	8	9
Number of complaints responded to in month	8	5	9	10	8	13	11	10	6	10	9



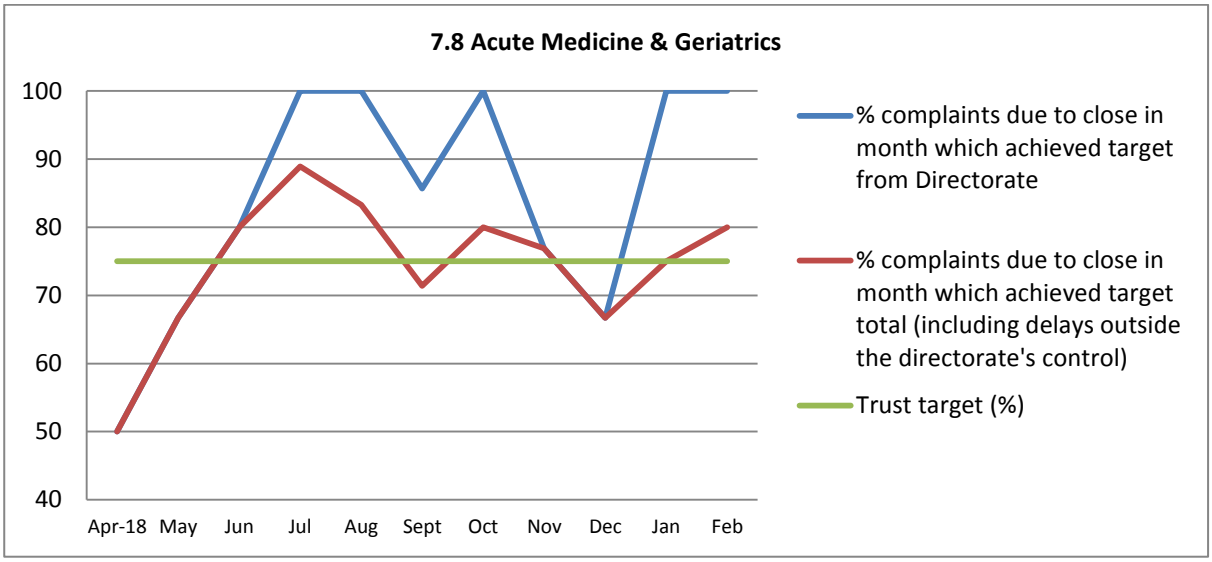
Paediatrics	Apr-18	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Number of complaints due to close in month	3	3	0	3	0	0	2	4	2	0	1
Number of complaints responded to in month	7	2	0	3	1	2	4	2	3	0	0



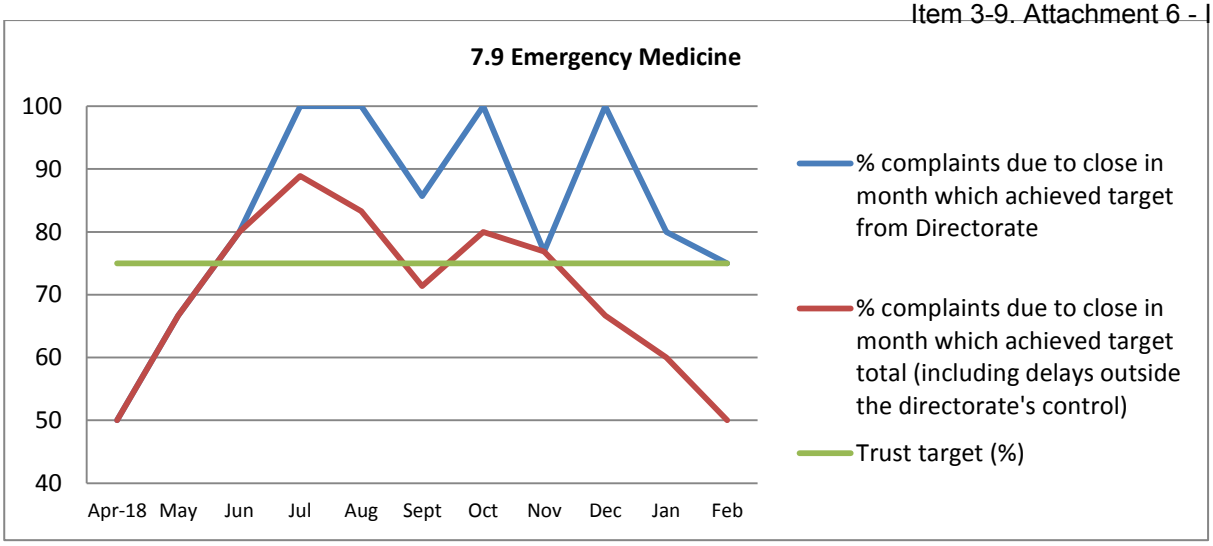
Orthopaedics	Apr-18	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Number of complaints due to close in month	5	2	5	4	6	4	5	3	3	5	1
Number of complaints responded to in month	8	3	3	6	8	3	8	4	3	6	2



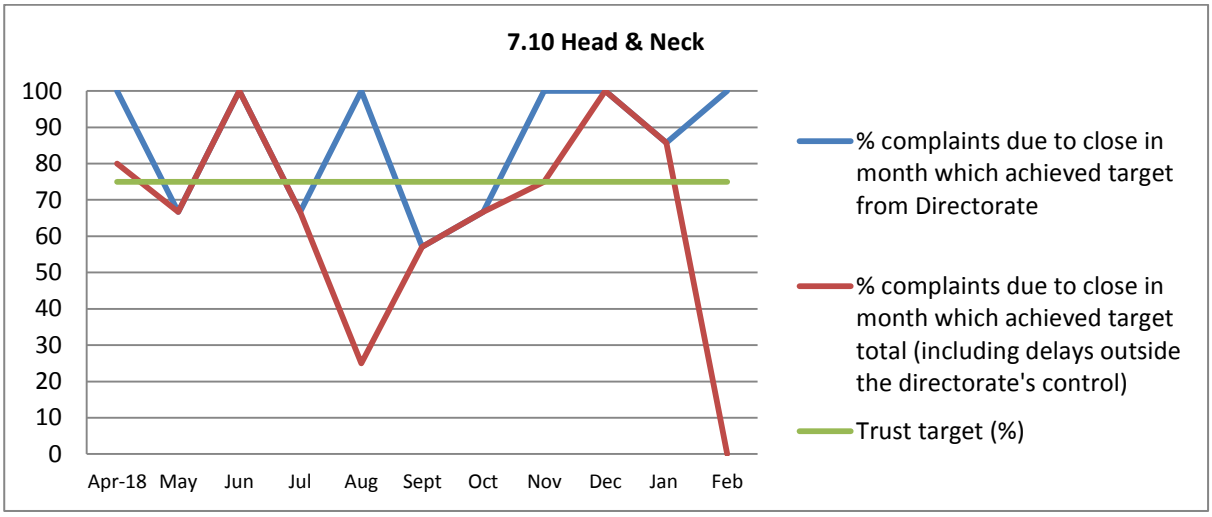
Critical Care & Theatres	Apr-18	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Number of complaints due to close in month	1	3	1	2	3	0	2	1	3	5	2
Number of complaints responded to in month	0	3	2	2	4	2	1	2	1	7	1



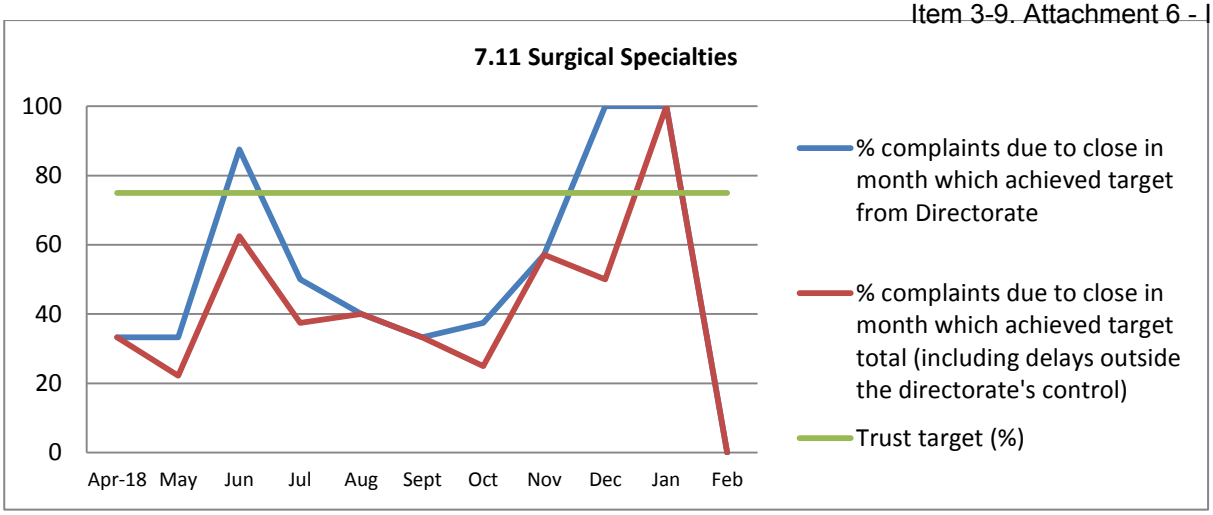
Acute Medicine & Geriatrics	Apr-18	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Number of complaints due to close in month	4	9	5	9	6	7	10	13	3	4	5
Number of complaints responded to in month	6	7	7	7	5	10	12	13	3	8	10



Emergency Medicine	Apr-18	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Number of complaints due to close in month	4	9	5	9	6	7	10	13	3	5	4
Number of complaints responded to in month	6	7	7	7	5	10	12	13	1	6	2



Head & Neck	Apr-18	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Number of complaints due to close in month	5	6	4	3	4	7	3	4	2	7	1
Number of complaints responded to in month	6	4	4	1	3	0	5	7	1	9	4

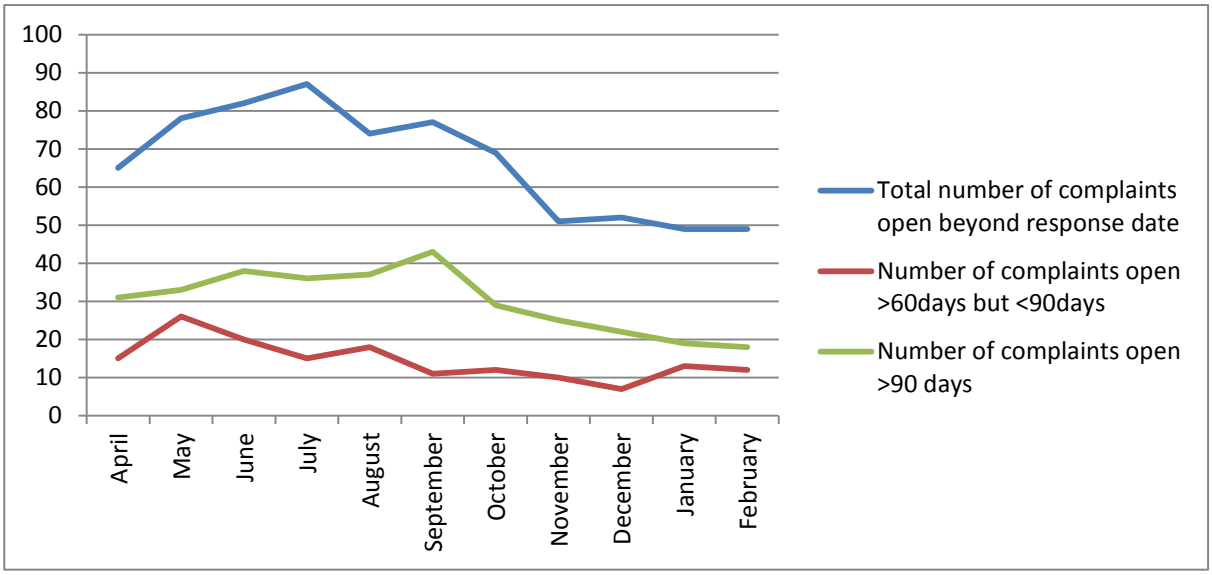


Surgical Specialties	Apr -18	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Number of complaints due to close in month	6	9	8	8	5	3	8	7	2	5	1
Number of complaints responded to in month	12	6	9	5	10	4	10	12	3	5	2

Every directorate listed above achieved or exceed the Trust's target of 75% for January, except: Oncology, (50%), Emergency Medicine (50%), Head and Neck (0%), Paediatrics (0%) and Surgical Specialties (0%).

In total, 5 complaints breached due to delays within the lead directorate, which account for 11.1% of the lost performance. However, a further 7 complaints breached for other reasons: 3 due to capacity within the CCT, 1 was the subject of SI investigation which had not yet been completed, 1 was awaiting comments from a third party organisation and 2 responses were delayed as contributing (non-lead) directorates did not provide their comments within the required timeframe. These delays accounts for 15.6% of the lost performance.

Graph 8: Number of overdue open complaints



Focused work continues around clearing older cases. Targeted reports are being regularly shared with the senior directorate management teams around the oldest open complaints to support ongoing focus on these cases, whilst still working towards maintaining the 75% performance target.

Work continues to deliver the Trust wide complaints action plan. In addition, specific actions are being undertaken within divisions. This month we are featuring feedback from the Cancer Services Division.

The Cancer Division strive to ensure that any complaints received are dealt with in a swift and professional manner adhering to the Trust policy and timescales and reports that they consistently attempt to maintain the standard of 100% compliance however on the rare occasion that this is not maintained it is normally due to either the complexity of the issues being raised or cross service impacts.

The Division holds fortnightly meetings with the complaints team at which progress is reviewed and actions are delegated whilst ensuring that concerns are escalated in a timely and appropriate manner.

Key Learning is shared with staff in a number of forums including the Cancer Services divisional board, clinical governance and local team meetings. An action that they are keen to progress is to cascade their learning even further via the Divisional Corporate Team Brief.

There are two common themes that can be evidenced from the Divisions complaints which are:-

1. The need for clear communication ensuring that patients and relatives understand the content which is discussed.

Actions that the division is supporting to address these issues are as follows:

- Common themes of complaints are discussed at local staff meetings, the haematology and oncology governance meetings as well as in the team cascade.
- Re-launching clinical governance meeting in May as over the years it has become very consultant led. The new structure is more inclusive and will have a section discussing learning from complaints.
- This is on the agenda for the next CNS meeting to ensure CNS are re-enforcing that patients can call them for clarification of recent appointments.
- Discussing at the consultant care group to ensure consultants check with patients they have understood the consultation and if there are any further questions/information required.

2. Delays in radiology reporting especially for patients being seen at East Kent.

This is a red risk on the Division risk register; the issues are being managed by the general manager for oncology who is regularly attending East Kent Ops meeting to ensure this is frequently raised with East Kent.

Actions that the division is supporting to address these issues are as follows:

- The clinic coordinators for the clinics at East Kent will ensure all results are available for the clinic they are planning.
- If there is a scan without a report they will contact the reporting department in East Kent and ask for it to be reported as a matter of urgency.
- If the result is still unavailable it is escalated to the consultant responsible for the patient who can then make a decision to see if it is appropriate to still see the patient.

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.

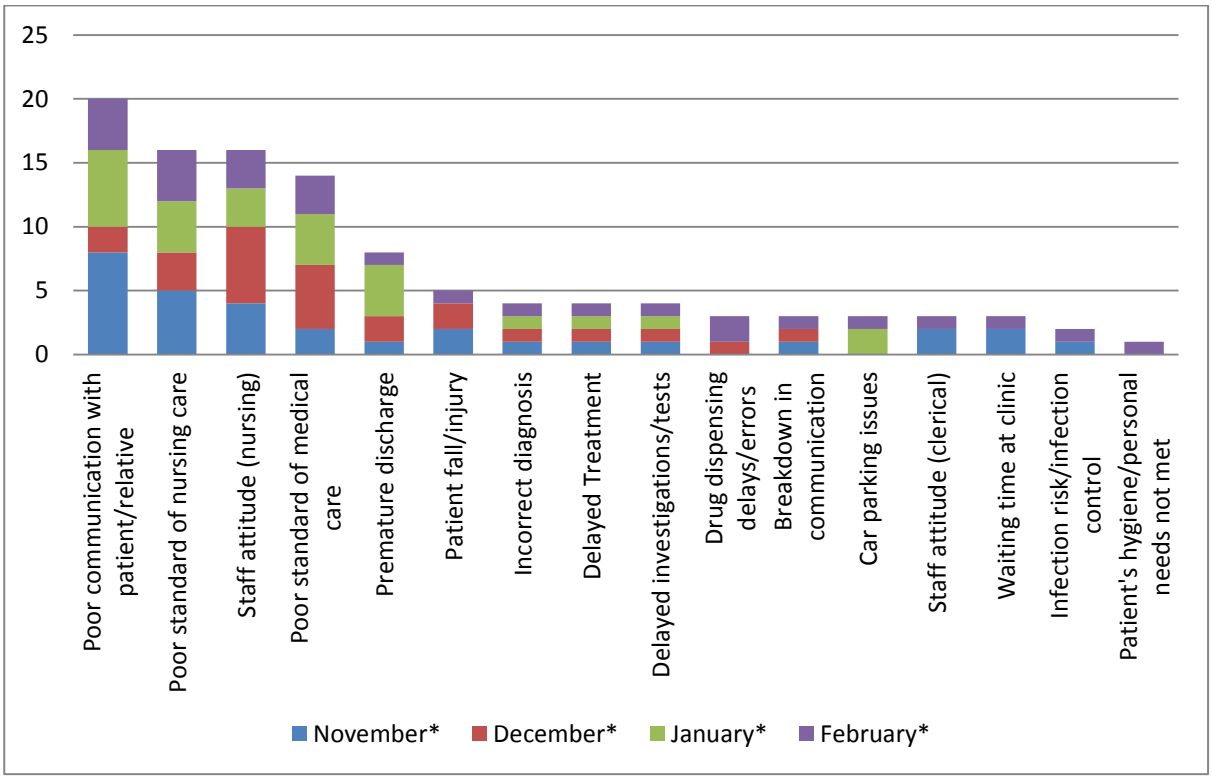
Graph 9 - Complaints by Sub-subject – most frequently raised in February 2019

	November*	December*	January*	February*
Poor communication with patient/relative	8	2	6	4
Poor standard of nursing care	5	3	4	4
Poor standard of medical care	2	5	4	3
Staff attitude (nursing)	4	6	3	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 February 2019.

Graph 10: All themes/subjects raised in complaints made about events that occurred in February 2019.



As with previous reports, communication with patients/relatives remains a key theme within complaints, being the most frequently raised issue in the reporting period (November – February), albeit with a decreasing trend.

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

- Poor standard of medical care
- Premature discharge
- Drug dispensing delays/errors
- Car parking issues
- Patient's hygiene/personal needs not met

All other subjects listed in graph 10 show stable or reducing trends. 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.

Perinatal Mortality Review Tool (PMRT) report

1. Introduction

Data on perinatal deaths in England, Scotland and Wales are collected by MBRRACE-UK (Reducing Risk through Audits and Confidential Enquiries across the UK). MBRRACE-UK is the collaboration appointed by the Healthcare Quality Improvement Partnership (HQIP) to run the national Maternal, Newborn and Infant clinical Outcome Review Programme (MNI-CORP) which continues the national programme of work conducting surveillance and investigating the causes of maternal deaths, stillbirths and infant deaths.

MBRRACE have developed and established a national standardised Perinatal Mortality Review Tool (PMRT) which aims to standardise the review of perinatal deaths and encourage parent involvement and provide an opportunity for external scrutiny and challenge

The tool supports:

- Systematic, multidisciplinary, high quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care;
- Active communication with parents to ensure they are told that a review of their care and that of their baby will be carried out and how they can contribute to the process;
- A structured process of review, learning, reporting and actions to improve future care;
- Coming to a clear understanding of why each baby died, accepting that this may not always be possible even when full clinical investigations have been undertaken; this will involve a grading of the care provided;
- Production of a report for parents which includes a meaningful, plain English explanation of why their baby died and whether, with different actions, the death of their baby might have been prevented;
- Other reports from the tool which will enable organisations providing and commissioning care to identify emerging themes across a number of deaths to support learning and changes in the delivery and commissioning of care to improve future care and prevent the future deaths which are avoidable;
- Production of national reports of the themes and trends associated with perinatal deaths to enable national lessons to be learned from the nation-wide system of reviews.
- Parents whose baby has died have the greatest interest of all in the review of their baby's death. Alongside the national annual reports a lay summary of the main technical report will be written specifically for families and the wider public. This will help local NHS services and baby loss charities to help parents engage with the local review process and improvements in care.

The PMRT has been designed to support the review of the following perinatal deaths:

- Late fetal losses where the baby is born between 22+0 and 23+6 weeks of pregnancy showing no signs of life, irrespective of when the death occurred, or if the gestation is not known, where the baby is over 500g;
- All stillbirths where the baby is born from 24+0 weeks gestation showing no signs of life;
- All neonatal deaths where the baby is born alive from 22+0 but dies up to 28 days after birth;
- Post-neonatal deaths where the baby is born alive from 22+0 but dies after 28 days following neonatal care; the baby may be receiving planned palliative care elsewhere

2. Process

The maternity service reports stillbirths, perinatal deaths and infant deaths via the MBRRACE-UK online reporting system.uk. All stillbirths and neonatal deaths from 22 weeks gestation will be notified to the directorate by datix. All cases are referred to the bereavement team for the families to be supported. The families are told that a review of the care will take place and they have the opportunity to ask questions that will be included in the investigation terms of reference.

The online perinatal mortality tool requires information to be inputted about the mother and the pregnancy. This is usually done by one of the bereavement or risk team midwives.
PMRT meetings will be held monthly in the Trust. The membership of this meeting is multidisciplinary and includes midwives, obstetricians, neonatal nurses, ANNPs and Neonatologists. There should also be an invited healthcare professional from another trust to aid transparency.

The case will be discussed in a round table discussion and the answers to questions in the review tool will be inputted into the online database. A report is then produced with recommendations that will also be shared with the family.

3. Eligible cases

The Trust has been required to report all perinatal deaths on the online database and review the care given using the Perinatal Mortality review tool from December 2018. The maternity service started using the tool from January 2018.

There are currently 11 cases that fit the criteria to be reviewed using the PMRT model.

Date	Case type	SI declared	RCA	On PMRT
Jan 2018	22+4 SB	No	Yes	Yes
Feb 2018	Term IUD	Yes	Yes	Yes
May 18	Term IUD	No	Yes	Yes
May 18	35 IUD	No	Yes	Yes
July 18	36 IUD	Yes	Yes	Yes
Aug 18	Term IUD	Yes	Yes	Yes
Sept 18	23+6 SB	No	Yes	Yes
Nov 18	25 IUD	No	No (transfer from other Trust after IUD confirmed)	Yes
Jan 19	25 SB	No	No	Yes
Jan 19	Term IUD	Yes	In progress	No
Mar 19	Term TOP for fetal anomaly	No	Yes	Yes although this was started in error as fetal anomalies are excluded

4. Progress against inputting data

We have 11 cases in progress and one to be investigated and uploaded. One case needs to be deleted as it does not fit the criteria for using the PMRT tool. We have faced an extra challenge in recent weeks as one of our key members of staff has been on long term sick leave. We have recruited an interim person to take on some of the work and this includes ensuring that all the cases are completed on the database. The majority of the cases have had a review by the risk team but will get a second review by the PMRT panel which will include an external representative from another Trust. The meetings are monthly and will commence on the 1st April 2019. The cases will be discussed and information inputted at the meeting to produce a timely report.

6. Summary

The maternity service at Maidstone Tunbridge Wells NHS Trust aims to embed the use of the PMRT tool into the risk process as standard. The requirement by CNST incentive scheme mandates that all eligible cases from December 2018 should be inputted on the database within 4 months of each death. Of the 2 cases we have, one both are is on the database and the other will have commenced by 27th March 2019 which equates to 100% compliance; however, it is to note that we commenced data review from January 2018 and therefore we have exceeded the standards that are currently set. .

Of the eligible cases identified, 8 out of 9 cases have had a full review and will be included in the new PMRT board meeting commencing in April 2019.

Safe staffing: Planned versus actual for February 2019

The attached paper shows the planned v actual nursing staffing as uploaded to UNIFY for February 2019. This data is also published via the NHS Choices website and the Trust website as directed by NHS England and the National Quality Board.

Wards of note include:

Cornwallis: Cornwallis team moved to Peale ward location on the 10th November 2018. Cornwallis remained closed until 31st December when it reopened as part of the winter escalation plan. Reduced fill rate according to acuity and dependency in an escalation ward.

John Day: 1 fall above threshold demonstrating a reduction in falls in comparison to January data. Reduced RN fill rate due to sickness, vacancies and lack of available temporary staff. Skill mix adjustment to backfill with CSW support and additional CSW requests for enhanced care requirements.

Chaucer: Increased fill rates to support unit escalation throughout the month. Reduced CSW fill rate during the day due to lack of available temporary staff.

Lord North: 2 falls above threshold. Reduced RN fill rate due to lack of available temporary staff recorded on 2 occasions. Increased CSW fill rate to support enhanced care requirements.

UMAU (MDGH): Reduced RN fill rate due to lack of available temporary staff across 25 shifts. Increased fill rate at night due to ongoing escalation**.**

Ward 22: Sustained improvement in falls during February remaining within threshold. Reduced fill rate due to vacancies levels and shifts not covered with a lack of available temporary staffing throughout month.

MAU (TWH): 4 falls above threshold. Reduced RN fill rate due to uncovered shifts throughout the month due to vacancy rate and lack of temporary staff.

Ward 32: 4 falls above threshold. Reduced fill rate daily due to high vacancy factor and inability to cover due to lack of available temporary staff. In addition, enhanced care requirements during month.

Ward 10: 2 falls above threshold. Skill mix adjustment a considered risk by the ward team in line with a high dependency and moderate acuity. Staff redeployed on 2 occasions to support safe staffing levels in the Trust.

Ward 11: 5 falls above threshold. Increased fill rate due to enhanced care requirements throughout the month across 16 days.

Ward 20: 4 falls above threshold which is an improvement with a reduction in the number of repeat falls in month. Reduced RN fill rate due to lack of available temporary staff. Increased CSW fill rate at night to support enhanced care requirements

Ward 2: Decrease to 6 falls above threshold in month. AFU escalated through the month alongside enhanced care requirements

Maternity Services: Whilst the fill rate is recording as more reduced than previous reporting this is not reflective of a sudden change in staffing levels. This is reflective of an ongoing review and re work on the rosters to ensure accuracy. No new concerns raised by HOM regarding staffing levels in month.

Neonatal Unit: Reduced fill rate according to lower occupancy during the month. Recorded 3 black, 8 Amber and NO red escalation.

Peale: Reduced RN fill rate at night in line with bed occupancy and an increase in bed base for team as part of the planned Winter escalation. Cornwallis team currently on Peale ward with effect from 18th November 2018.

SSSU: Increased fill rates due to unit escalation throughout the month including escalation into recovery 1 for 9 days in the month and holding bay across 3 days

A+E (MH + TWH): MH- Reduced RN fill rate due to uncovered shifts and increase in demand and capacity. TWH- 22 days reported uncovered shifts across days and nights due to lack of available temporary staff. Additional staff requirements at night for escalation.

Foster Clarke: Peale team now on Foster Clarke with an increase in bed base to 27. Reduced fill rate for CSW support at night according to reduced ward occupancy. CSW also redeployed to support safe staffing levels.

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 February. 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

Feb-19		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	92.3%	88.5%	96.0%	98.2%	7.5	24.2%	100.0%	1	0	3	Short term sickness unable to be covered with temporary staff	138,263	136,271	1,992
MAIDSTONE	Cornwallis	89.2%	83.8%	95.5%	89.3%	5.5	79.5%	94.3%	3	1	11	Medical escalation ward as part of winter planning. Redcution in fill rate due to lack of available temporary cover	115,598	69,546	46,052
MAIDSTONE	Culpepper (Inc CCU)	92.9%	97.1%	98.1%	96.4%	7.5	6.7%	100.0%	0	0	0	CSW's redeployed on 5 occasions to support safe staffing levels	109,337	99,636	9,701
MAIDSTONE	John Day	83.3%	120.3%	98.4%	105.4%	6.1	25.6%	80.0%	6	2	5	1 fall above threshold Reduced RN fill rate due to sickness, vacancies and lack of available temporary staff. Skill mix adjustment to backfill with CSW support and additional CSW requests for enhanced care requirements.	131,925	123,823	8,102
MAIDSTONE	Intensive Treatment Unit (ITU)	86.6%	86.5%	86.5%	66.7%	31.9			0	0	0	Reduced fill rate in line with the lower occupancy throughout the month.	185,671	175,369	10,302
MAIDSTONE	Pye Oliver	91.6%	91.5%	92.9%	102.4%	5.8	18.2%	100.0%	5	0	6	9 RN shifts uncovered due to sickness and lack of available temporary staff	116,339	115,882	457
MAIDSTONE	Chaucer	101.1%	78.0%	147.3%	172.1%	12.5	382.9%	94.8%	3	0	2	Increased fill rates to support unit escalation throughout the month. Reduced CSW fill rate during the day due to lack of available temporary staff	118,267	126,651	(8,384)
MAIDSTONE	Lord North	84.1%	131.3%	96.3%	121.4%	7.4	22.7%	80.0%	7	0	4	2 falls above threshold Reduced RN fill rate due to lack of available temporary staff recorded on 2 occasions. Increased CSW fill rate to support enhanced care requirements.	102,318	98,983	3,335
MAIDSTONE	Mercer	105.0%	102.2%	129.5%	99.8%	6.8	68.2%	93.3%	8	0	6	2 falls above threshold	101,048	111,831	(10,783)
MAIDSTONE	Edith Cavell	96.3%	104.8%	98.8%	121.4%	5.6	55.6%	100.0%	0	2	2	Increased CSW fill rate at night due to enhanced care requirements and skill mix adjustment on occasion to bacfill RN	71,882	71,735	147
MAIDSTONE	Urgent Medical Ambulatory Unit (UMAU)	89.3%	91.5%	128.0%	174.2%	8.7	3.1%	100.0%	3	0	4	Reduced RN fill rate due to lack of available temporary staff across 25 shifts. Increased fill rate at night due to ongoing escalation	131,489	122,234	9,256
TWH	Stroke/W22	76.5%	79.8%	95.6%	92.7%	9.2	91.7%	81.8%	6	0	7	Reduced fill rate due to vacancies and shifts not covered with a lack of available temporary staffing throughout month.	150,502	145,918	4,584
TWH	Coronary Care Unit (CCU)	92.9%	87.5%	90.0%	-	10.5	138.5%	100.0%	0	0	3	Reduced CSW fill rate due to redeployment of staff to support safe staffing levels across the Trust	67,825	61,860	5,965
TWH	Gynaecology/ Ward 33	94.0%	99.5%	98.8%	100.0%	12.3	1.2%	100.0%	1	0	0		79,636	97,973	(18,337)
TWH	Intensive Treatment Unit (ITU)	93.1%	110.1%	99.8%	93.8%	27.1			0	1	1	Escalated on 4 occasions during the month	195,061	165,335	29,726
TWH	Medical Assessment Unit	75.3%	90.6%	99.4%	98.3%	7.6	0.0%	0.0%	10	0	9	4 falls above threshold Reduced RN fill rate due to uncovered shifts throughout the month due to vacancy rate and lack of temporary staff	189,499	190,092	(593)
TWH	SAU	98.8%	80.1%	100.0%	96.8%	7.5			0	0	0	Escalated on 8 occassions. Reduced CSW fill rate to to lack of available temporary staff	61,940	59,769	2,171
TWH	Ward 32	78.8%	89.7%	99.0%	95.3%	5.9	12.8%	100.0%	10	1	6	4 falls above threshold Reduced fill rate daily due to high vacancy factor and inability to cover due to lack of available temporary staff. In addition, enhanced care requirements during month.	139,808	203,856	(64,048)
TWH	Ward 10	93.8%	89.1%	78.1%	139.3%	6.1	0.0%	-	4	0	3	2 falls above threshold Skill mix adjustment a considered risk by the ward team in line with a high dependency and moderate acuity. Staff redeployed on 2 occasions to support safe staffing levels in the Trust.	120,565	117,759	2,806
TWH	Ward 11	93.4%	126.5%	105.5%	148.3%	6.9	0.0%	-	9	0	3	5 falls above threshold Increased fill rate due to enhanced care requirements throughout the month across 16 days.	126,638	127,745	(1,107)
TWH	Ward 12	99.2%	95.0%	114.1%	92.8%	6.4	9.9%	85.7%	13	2	9	7 falls above threshold Increased fill rate at night due to 24 hr RMN requirements.	121,446	136,613	(15,167)
TWH	Ward 20	81.3%	90.3%	94.0%	129.3%	5.4	31.6%	100.0%	11	1	9	4 falls above threshold Reduced RN fill rate due to lack of available temporary staff. Increased CSW fill rate at night to support enhanced care requirements	123,611	112,581	11,030
TWH	Ward 21	93.3%	96.4%	96.3%	101.5%	6.2	35.9%	100.0%	1	0	5	Uncovered shifts recorded throughout the month with lack of available temporary staff to fill.	134,850	138,907	(4,057)
TWH	Ward 2	82.8%	99.9%	104.9%	128.5%	7.3	60.8%	96.8%	13	0	11	6 falls above threshold AFU escalated through the month alongside enhanced care requirements	131,973	140,508	(8,535)
TWH	Ward 30	90.8%	95.0%	100.0%	90.6%	5.7	67.6%	100.0%	8	0	6	3 falls above threshold Uncovered shifts recorded throughout the month with lack of available temporary staff to fill.	122,715	116,349	6,366
TWH	Ward 31	90.8%	85.7%	94.6%	96.3%	6.4	4.7%	100.0%	6	1	3	Reduced fill rate for both CSW and RN's due to lack of avilable temporary staff to cover sickness and vacancies.	139,943	118,724	21,219
Crowborough	Birth Centre	85.5%	99.7%	95.8%	71.4%				-	0		Considered action to prioritise the night with Community teams support during the day. Reduced MSW fill rate at night due tolack of available temporary staff	71,096	74,480	(3,384)
TWH	Maternity Services (incl Ante/Post Natal, Delivery Suite & Triage)	89.2%	88.0%	95.0%	89.8%	5.5	56.6%	96.5%	0	0		Whilst the fill rate is recording as more reduced than previous reporting this is not reflective of a sudden change in staffing levels. This is reflective of an ongoing review and re work on the rosters to ensure accuracy . Confirmed no concerns raised by HOM regarding staffing levels in month.	690,933	672,064	18,869
TWH	Hedgehog	86.4%	28.0%	108.6%	N/A	11.4	0.0%	-	2	0	8	Reduced fill rate due to lack of available temporary staff and enhanced care requirements on 6 reported occasions. Reduced CSW fill rate due to lack of paediatric CSW cover.	208,979	186,102	22,877
MAIDSTONE	Birth Centre	104.5%	97.6%	98.7%	89.6%				0	0			62,876	54,533	8,343
TWH	Neonatal Unit	84.7%	71.6%	102.0%	N/A	13.3			0	0	4	Reduced fill rate according to lower occupancy during the month. Recorded 3 black, 8 Amber and NO red escalation.	178,696	176,423	2,273
MAIDSTONE	MSSU	106.1%	95.9%	114.5%	N/A	12.6			0	0	0	Increased fill rate associated with unit remaining open at a weekend to support capacity	41,893	45,915	(4,022)
MAIDSTONE	Peale	102.6%	100.1%	66.7%	89.3%	8.5	17.4%	100.0%	1	0	7	Reduced fill rate at night in line with bed occupancy and lack of available temporary staff.	91,179	84,635	6,544
TWH	SSSU	147.7%	127.3%	171.4%	367.8%	6.8			0	0	12	Increased fill rates due to unit escalation throughout the month including escalation into recovery 1 for 9 days in the month and holding bay across 3 days	181,731	118,483	63,248
MAIDSTONE	A&E	87.2%	102.9%	100.9%	81.7%		10.3%	91.9%	2	0		MH- Reduced RN fill rate due to uncovered shifts and increase in demand and capacity. TWH- 22 days reported uncovered shifts across days and nights due to lack of available temporary staff. Additional staff requirements at night for escalation	214,550	223,281	(8,731)
TWH	A&E	87.6%	90.9%	93.0%	89.7%		5.1%	90.2%	1	0			341,646	330,772	10,874
MAIDSTONE	MOU	77.3%	85.7%	76.5%	N/A				1	0	3	1 fall above threshold Reduced fill rate due to short term sickness however, small team which means data can be skewed if 1 shift short in team. Safe staffing maintained throughout month	34,612	41,630	(7,018)
MAIDSTONE	Foster Clarke	105.3%	97.1%	86.6%	56.3%	7.5	0.0%	-	2	0	7	Reduced fill rate at night according to reduced ward occupancy.	76,274	114,739	(38,465)
												Total Established Wards	5,422,614	5,309,007	113,607
												Additional Capacity be Cath Labs	36,509	39,318	-2,809
												Whatman	99,470	669	98,801
												Other associated nursing costs	2,701,998	2,890,141	-188,143
												Total	8,260,591	8,239,135	21,456

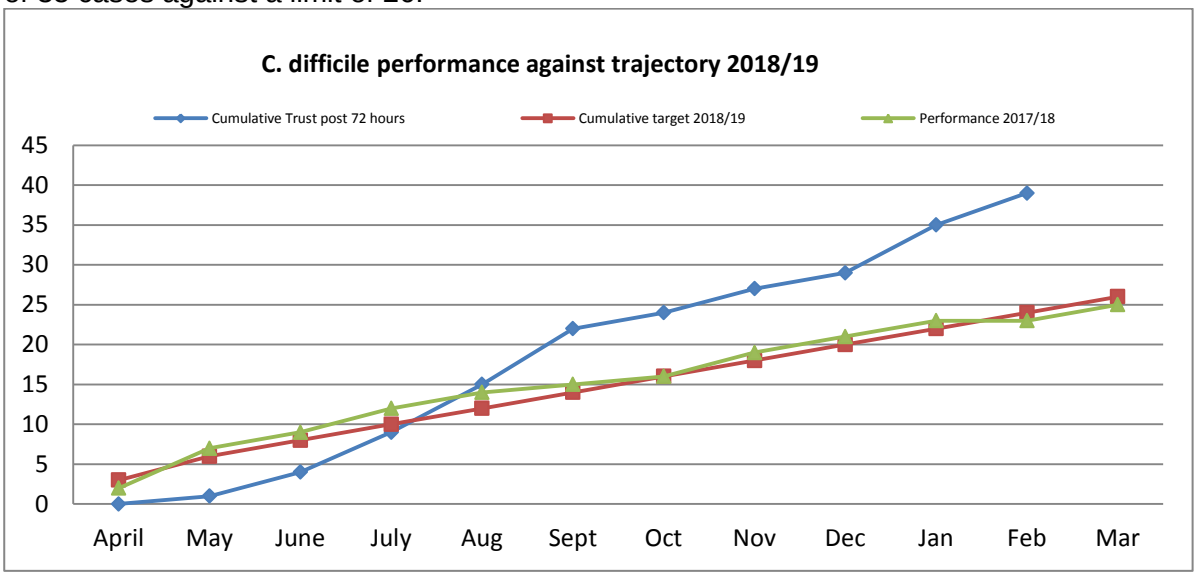
RAG Key
Under fill
Over fill

Infection Prevention and Control

MRSA

There were no cases of MRSA blood stream infection in February.

C. difficile - There were four cases of post-72 hour *C. difficile* infection in February against a monthly limit of two cases. The Trust has breached the C. difficile objective for the year with a total of 35 cases against a limit of 26.

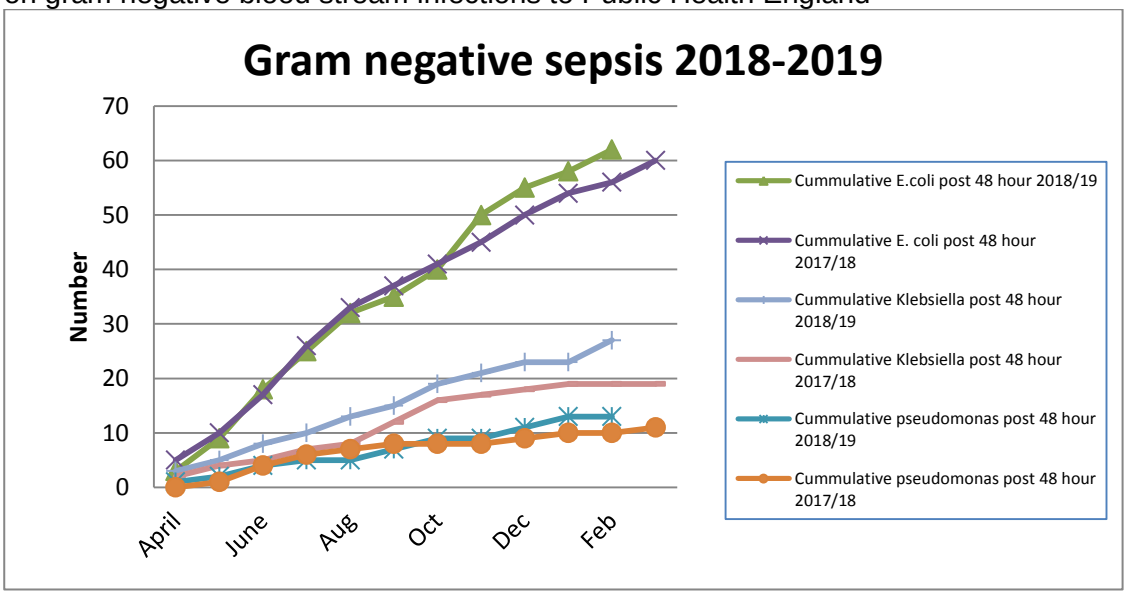


One ward at Maidstone saw a total of four hospital-acquired and one community cases during January and February. Three incident meetings have been held. No evidence of cross infection has been found despite extensive testing. Root cause analysis has not shown any link between the cases. The ward has been decanted and deep-cleaned twice and has been audited weekly for the last 10 weeks. Infection control support and ad hoc ward based training are in place. The last case was identified on 22 February.

Gram negative bacteraemia

Eight cases of hospital-attributable gram negative blood stream infection were seen in February. Four cases were due to *E. coli*, four due to *Klebsiella* and none due to *Pseudomonas* species
The urinary catheter passport has been successfully re-launched with the assistance of the urology CNS. Other trusts in Kent and Medway are working towards implementation to have a single document across the STP. NHSI have released a national care plan for urinary catheters which we are reviewing with the aim of replacing two 'Saving Lives' documents for catheters with the single care plan.

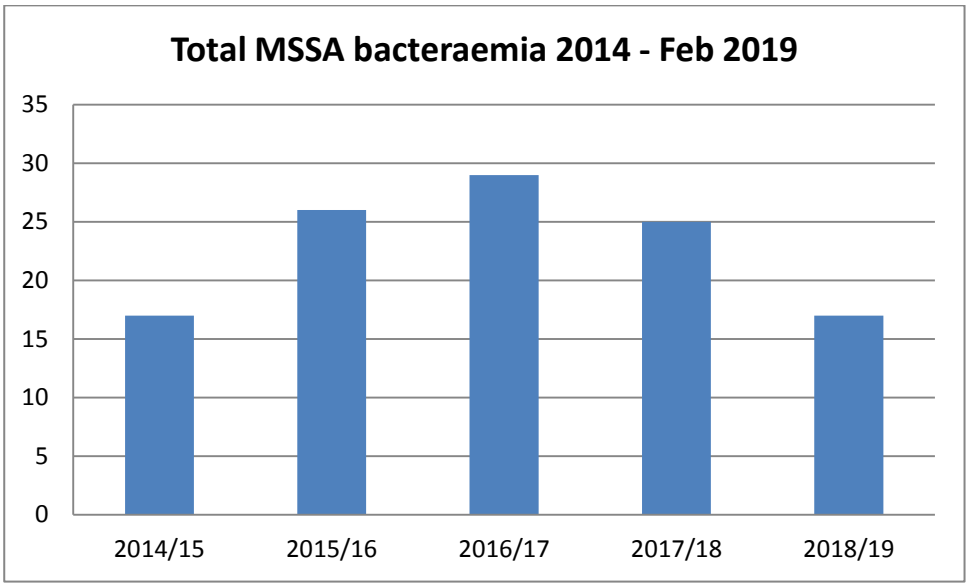
All cases of gram negative sepsis are subject to epidemiological data collection and full RCA is completed where lapses of care are identified. The trust submits all mandatory and voluntary data on gram negative blood stream infections to Public Health England



Methicillin sensitive *Staphylococcus aureus* bacteraemia

No cases of hospital-attributable MSSA blood stream infection were seen in February.

There has been a significant reduction in MSSA bacteraemia in the current year (to M11).Seventeen cases have been seen, 2 at MDGH and 15 at TWH. Further analysis has been undertaken to understand the changes in epidemiology.



Influenza

The flu season has continued with 104 inpatient cases of Influenza A in January. Eleven patients required ITU level care, some for an extended period of time.

No cases of Influenza B have been seen this winter which is in contrast to last year when Influenza B was the predominant strain in our catchment area.

Financial commentary

- The Trusts deficit including PSF was £0.5m in February which was £3m adverse to plan but £1m better than the forecasted position. The Trust was adverse to the control target before PSF by £1.6m which was due to £1.8m CIP slippage, £0.4m overspend against other budget pressures partly offset by £0.6m over performance from disposal of asset.
- The Trusts normalised run rate in February was £4.4m deficit pre PSF which was £2.5m adverse to normalised plan (pre PSF).
- In February the Trust operated with an EBITDA deficit of £1.9m which was £3.8m adverse to plan.
- The Trust has a year to date deficit of £1.4m which is £7m adverse to plan , the key variances against plan are: CIP Slippage (£10m) overspends within pay budgets (£3.1m) and non-pay budgets (£5.4m) and PSF slippage (£3m) partly offset by non-recurrent items (£2.1m) , release of contingency reserve (£5.3m) , earlier than planned phasing of Non Recurrent Income support (£3m) , over performance within Clinical Income (£2.6m), benefits on asset sale (£0.6m) and underspends within depreciation (£0.5m).
- The key current month variances are as follows:
  - Total income net of pass-through related income is £2.3m adverse to plan, £1.5m due to PSF slippage and £0.7m relating to Clinical Income and £0.2m relating to other operating income. The Trusts normalised run rate in February was £4.4m deficit pre PSF which was £2.5m adverse to normalised plan (pre PSF). Other Operating Income excluding pass-through costs was £0.2m adverse to plan which was due to underperformance within Private Patients (£0.2m).
  - Pay budgets overspent by £0.5m in February and were £0.3m favourable to forecast this was mainly due to underspends within Medical (£0.2m) and Nursing (£0.1m) due to spend relating to winter escalation costs less than forecasted.
  - Non Pay adjusted for pass through costs and reserves was overspent by £1.1m in February and was £0.4m favourable to forecast. The main benefits relate to Clinical Supplies and Services (£0.3m) which mainly related to Theatres and Orthopaedics consumables and £0.1m bad debt reduction mainly relating to Private Patients.
- The Trust achieved £1m savings in February which was £1.8m adverse to plan and £10m adverse year to date. This is mainly due to STP Medical rate slippage (£1.5m), Prime Provider (£4.7m), Private Patient income slippage (£0.9m).
- The Trust held £10.6m of cash at the end of February which is higher than the plan of £1m. This is primarily due to the Trust selling its residential property of 32 High Street, Pembury with proceeds of c£5.65m received in February, this sale was not included within the original cash plan. The Trust is using the £1.6m related to the NBV of the asset to fund additional capital projects within 2018/19 and will use the remaining balance to pay creditors. In March the Trust is planning to sell its Maidstone residences for c£12.5m. The Trust is seeking approval from NHSI to carry forward the NBV of £2.4m into 2019/20 to fund capital projects. Additionally the Trust will request to carry forward more of the proceeds (c£6m) to fund further capital projects. However there is a risk that NHSI will require the Trust to repay an element of the outstanding working capital loan balance which the Trust received an extension on this month. The Trust is continuing to work 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’s originally approved Capital Plan was £14.46m. This has been adjusted during the year to take account of the following revisions:
  - Linac 5 national PDC capital was funded at £32k less than planned.
  - Linac 6 was additionally funded towards the end of the year from further national capital (£1.7m)
  - CT scanners (£2.5m) were planned as a capital loan. NHSI indicated that it was extremely unlikely that capital reliant on DHSC financing would be available in 2018/19 - therefore the Trust agreed to defer and include as a loan in 2019/20 plans;
  - Salix energy improvement loans for Phase 4 at Maidstone and Phase 1 at TWH were agreed at £270k more than the plan;
  - The HODU/Cardiology plan scheme of £2.5m was not agreed – instead there has been £142k for the Cardiology Cath Lab enabling works with the equipment funded from a charitable legacy

- A raft of additional national PDC bids were agreed for ICT schemes (£1m); and additional £26k PDC for MRI scanning & Pharmacy IT.
- The Trust has recently sold a property at 32 High Street, Pembury with a Net Book Value of £1.63m which has provided additional resource to support previously approved but deferred medical equipment, EPR initial phase and other ICT equipment.
- The Trust's in year depreciation is forecast to be £463k lower than plan, partly related to schemes that have not proceeded (e.g. CT scanners) or slippage on projects. The Trust has to balance its capital spending to the level of actual resource it generates plus any external funding. Therefore overall the Trust is forecasting to spend £13.7m outturn capital.

- The Trust is forecasting to deliver the plan which will require delivery of various actions which include: £13.9m profit on disposal of assets of which £3.9m has been completed in February. The full list of key actions and risks are detailed in slide 4a of the report.

Workforce Commentary

February Dashboard

Key Workforce Risks & current actions to note:

Trust Vacancy Rate 9.5% (Target >9%)
The vacancy rate has decreased marginally from that reported in February. This is in part due to a planned increase in establishment due to additional winter pressures posts which are staffed on a temporary basis.

Trust Turnover Rate 8.9% (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.

Current Actions

- Issuing of letter to all Year 3 Nursing students within MTW offering a guaranteed job (subject to completion of training) and asking for preferences for substantive roles
- Finalising agreement with an additional recruitment company for the recruitment of overseas nursing staff
- 4 additional international agencies being appointed to support nurse recruitment, one of these will have a particular focus on the recruitment of theatres staff
- 10 specialty doctor medical staff offered posts in paediatrics, surgery and medicine following interview sourced via an international recruitment agency. Further interviews planned for surgery medicine and ED.
- The communications team are working with colleagues from KCHFT comms team to develop a trust marketing and advertising strategy for Q1
- Year 1 Nurse promise launched
- Internal Transfer scheme pilot launched
- Further schedule of recruitment events agreed with a focus on recruiting at TWH
- Dedicated recruitment event held at the Somerfield Hospital to attract staff from the organisation as it closes.
- All non-framework agency nurses now moved to framework agencies with concurrent reduction in costs.

Sickness Absence 3.9% (Target =>3.3%)
Sickness absence is currently above target but much lower than the same period last year (4.7%), this is primarily due to a lower than expected amount of short term sickness relative to the winter period and increased uptake of flu vaccination.

Short term Absence 52.3%, Long term absence 47.7%
Key challenges in

- Facilities (6.31%)
- Women's Services (5.95%)
- Outpatients (8.33%)

Current Actions

- The Flu Vaccination campaign achieved a final coverage of 78% of the clinical workforce. Whilst this was short of the 85% target the total achieved was above that required to achieve the CQUIN target and was the highest level of uptake achieved by any acute trust in the Kent, Surrey and Sussex region.

- 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 83.2% (Target <85%)

Current Actions

- Individual e-reminders to all staff now automatically issued by the Learning Management System
- System reconfigured to reflect revised organisational structures to allow directorate based report generation
- Data cleansing following transfer of information from the old to the new system

Appraisals 92% (Target 90%)

- Planning is underway to move to an electronic system of appraisal recording for 2019 with the aim of reducing the administrative burden on line managers.

Trust Performance Dashboard

Position as at: 28 February 2019

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)	0.00	19.9	10.4	17.4	7.0	6.7	11.5	16.7	
'1-02	Number of cases C.Difficile (Hospital)	0	4	23	39	16	15	26	41	
'1-03	Number of cases MRSA (Hospital)	0	0	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	92.5%	No data	92.5%	No data	No data	98.0%	No data	
'1-06	**Rate of Hospital Pressure Ulcers	2.62	0.36	2.22	1.15	- 1.07	- 1.86	*3.01*	1.15	3.00
'1-07	***Rate of Total Patient Falls	5.98	6.73	5.92	6.18	0.26	0.18	*6.00*	6.18	
'1-08	***Rate of Total Patient Falls Maidstone	6.76	4.76	5.50	5.46	- 0.05			4.50	
'1-09	***Rate of Total Patient Falls TWells	5.45	7.73	6.17	6.79	0.62			5.70	
'1-10	Falls - SIs in month	0	2	31	21	- 10				
'1-11	Number of Never Events	0	0	4	1	-3	1	*0*	1	
'1-12	Open SIRIs	50	65			15				
'1-13	Number of New SIs in month	5	8	155	146	- 9	36			
'1-14	***Serious Incidents rate	0.23	0.40	0.64	0.65	0.01	0.59	*0.0584 - 0.6978*	0.65	*0.0584 - 0.6978*
'1-15	Rate of Patient Safety Incidents - harmful	1.08	0.53	1.17	1.01	- 0.16	- 0.22	*0 - 1.23*	1.01	*0 - 1.23*
'1-16	Number of CAS Alerts Overdue	0	1			1	1	*0*		
'1-17	VTE Risk Assessment - month behind	96.6%	97.2%	96.4%	97.2%	0.8%	2.2%	95.0%	97.2%	95.0%
'1-18	Safety Thermometer % of Harm Free Care	97.5%	98.5%	96.6%	97.8%	1.2%	2.8%	95.0%		93.4%
'1-19	Safety Thermometer % of New Harms	2.39%	1.52%	3.16%	2.11%	-1.05%	-0.9%	*3.00%*	2.11%	
'1-20	C-Section Rate (non-elective)	14.4%	14.3%	13.7%	13.7%	0.06%	-1.3%	*15.0%*	13.7%	

	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)******			1.0492	1.0391	- 0.0101	0.0391	Band 2	Band 2	1.0
2-02	Standardised Mortality HSMR			104.1	101.2	- 2.9	1.2	Lower confidence limit to be <100		100.0
2-03	Crude Mortality	1.1%	1.1%	1.7%	1.0%	-0.7%				
2-04	****Readmissions <30 days: Emergency	12.1%	14.4%	11.7%	14.6%	2.9%	1.0%	*13.6%*	14.6%	14.1%
2-05	****Readmissions <30 days: All	11.8%	14.0%	11.0%	14.0%	3.1%	-0.7%	*14.7%*	14.0%	14.7%
2-06	Average LOS Elective	2.90	3.21	2.55	3.13	0.58	- 0.07	*3.20*	3.13	
2-07	Average LOS Non-Elective	7.84	7.23	7.43	6.91	- 0.52	0.11	*6.80*	6.91	
2-22	NE Discharges - Percent zero LoS	38.4%	45.6%	36.8%	45.0%	8.3%			45.0%	
2-08	******FollowUp : New Ratio	1.76	1.42	1.69	1.59	- 0.10	0.07	*1.52*	1.59	
2-09	Day Case Rates	88.0%	84.8%	88.0%	87.5%	-0.5%	7.5%	80.0%	87.5%	82.2%
2-10	Primary Referrals	10,080	8,793	108,736	112,451	3.4%	1.3%	121,638	122,630	
2-11	Cons to Cons Referrals	4,192	4,254	52,514	63,013	20.0%	21.2%	56,704	68,717	
2-12	First OP Activity (adjusted for uncashed)	15,332	15,881	176,351	192,282	9.0%	2.7%	204,495	209,687	
2-13	Subsequent OP Activity (adjusted for uncashed)	22,524	21,234	299,506	286,196	-4.4%	-17.7%	379,945	312,101	
2-14	Elective IP Activity	415	442	6,018	5,660	-5.9%	-19.0%	7,674	6,172	
2-15	Elective DC Activity	3,053	3,153	38,050	39,948	5.0%	-1.9%	44,403	43,564	
2-16	**Non-Elective Activity	4,552	5,053	52,884	58,508	10.6%	9.4%	58,582	63,938	
2-17	A&E Attendances (Calendar Mth) Excl Crowboro	13,082	14,622	156,527	165,835	5.9%	3.8%	174,428	181,680	
2-18	Oncology Fractions	5,335	5,249	55,518	59,618	7.4%	-4.2%	67,890	71,542	
2-19	No of Births (Mothers Delivered)	478	420	5,513	5,397	-2.1%	-1.5%	5,977	5,888	
2-20	% Mothers initiating breastfeeding	80.5%	84.0%	80.5%	81.9%	1.5%	3.9%	78.0%	81.9%	
2-21	% Stillbirths Rate	0.4%	0.23%	0.41%	0.16%	*-0.2%*	*-0.3%*	*0.47%*	0.16%	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	21	0	42	35	-7	35	0	35	
3-02	*****Rate of New Complaints	2.38	2.04	3.64	2.21	-1.4	0.89	*1.318-3.92*	2.21	
3-03	% complaints responded to within target	59.5%	73.3%	74.3%	67.5%	-6.9%	-7.5%	75.0%	70.1%	
3-04	****Staff Friends & Family (FFT) % rec care	71.4%	78.2%	71.4%	78.2%	6.8%	-0.8%	79.0%	78.2%	
3-05	*****IP Friends & Family (FFT) % Positive	95.3%	95.6%	95.3%	94.4%	-0.9%	-0.6%	95.0%	94.4%	95.8%
3-06	A&E Friends & Family (FFT) % Positive	91.0%	91.3%	91.4%	91.3%	-0.2%	4.3%	87.0%	91.3%	85.5%
3-07	Maternity Combined FFT % Positive	94.8%	96.5%	93.6%	94.5%	0.9%	-0.5%	95.0%	94.5%	95.6%
3-08	OP Friends & Family (FFT) % Positive	84.1%	0.0%	83.0%	83.7%	0.6%			83.7%	

* 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	89.9%	87.12%	88.9%	91.5%	2.5%	1.4%	90.8%	91.5%	76.4%
4-02	Emergency A&E >12hr to Admission	0	0	0	2	2	2	*0*	2	
4-03	Ambulance Handover Delays >30mins	476	622	4,295	4,385	90			4,784	
4-04	Ambulance Handover Delays >60mins	87	83	596	583	- 13			636	
4-05	RTT Incomplete Admitted Backlog	2,298	2,781	2,298	2,781	483	558	2,151	2,781	
4-06	RTT Incomplete Non-Admitted Backlog	718	2,807	718	2,807	2,089	614	1,995	2,807	
4-07	RTT Incomplete Pathway	83.6%	81.3%	83.6%	81.3%	-2.3%	-3.4%	85.5%	81.3%	
4-08	RTT 52 Week Waiters (New in Month)	3	8	4	69	65	69	*0*	69	
4-09	RTT Incomplete Total Backlog	5,685	5,588	5,685	5,588	- 97	1,172	4,146	5,588	
4-10	% Diagnostics Tests WTimes <6wks	99.15%	99.5%	99.5%	99.5%	0.0%	0.5%	99.0%	99.0%	
4-11	*Cancer WTimes - Indicators achieved	5	0	3	0	- 3	- 9	9	9	
4-12	*Cancer two week wait	84.8%	87.6%	92.1%	87.6%	-4.5%	-5.4%	93.0%	93.0%	
4-13	*Cancer two week wait-Breast Symptoms	75.7%	69.4%	87.9%	69.4%	-18.4%	-23.6%	93.0%	93.0%	
4-14	*Cancer 31 day wait - First Treatment	97.7%	95.9%	92.6%	95.9%	3.2%	-0.1%	96.0%	96.0%	
4-15	*Cancer 62 day wait - First Definitive	74.3%	65.6%	66.2%	65.6%	-0.6%	-16.5%	85.0%	85.0%	
4-16	*Cancer 62 day wait - First Definitive - MTW	71.7%	69.2%	71.7%	69.2%	-2.5%		85.0%		
4-17	*Cancer 104 Day wait Accountable	15.5	11.5	88.5	153.5	65.0	153.5	*0*	153.5	
4-18	*Cancer 62 Day Backlog with Diagnosis	79	99	79	99	20				
4-19	*Cancer 62 Day Backlog with Diagnosis - MTW	54	90	54	90	36				
4-20	Delayed Transfers of Care	3.89%	3.79%	5.02%	4.37%	-0.65%	0.87%	3.50%	4.37%	
4-21	% TIA with high risk treated <24hrs	83.9%	91.7%	72.7%	72.5%	-0.3%	12.5%	60%	72.5%	
4-22	*******% spending 90% time on Stroke Ward	95.0%	88.2%	91.6%	91.1%	-0.4%	11.1%	80%	91.1%	
4-23	*******Stroke:% to Stroke Unit <4hrs	42.6%	69.8%	57.4%	58.2%	0.7%	-1.8%	60.0%	58.2%	
4-24	*******Stroke: % scanned <1hr of arrival	59.3%	67.9%	64.9%	58.6%	-6.3%	10.6%	48.0%	58.6%	
4-25	*******Stroke:% assessed by Cons <24hrs	95.9%	81.1%	83.8%	83.8%	0.0%	3.8%	80.0%	83.8%	
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	28	2	28	25	-3	25	*0*	25	

RTT Incomplete Pathway Monthly Plan is Trust Recovery Trajectory

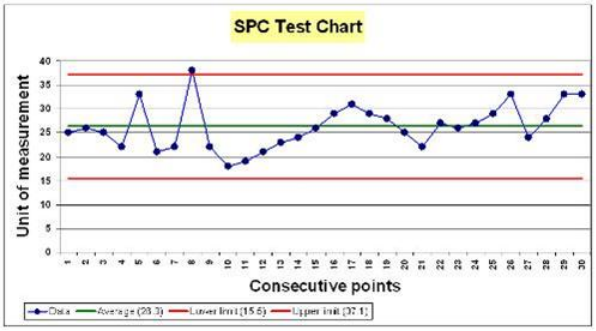
**CWT run one mth behind, YTD is Quarter to date, Monthly Plan for 62 Day Wait First Definitive is Trust Recovery Trajectory*

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

	Well-Led	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
5-01	Income	36,920	34,981	399,543	420,729	5.3%	-0.5%	466,408	464,866	
5-02	EBITDA	210	(1,934)	13,243	21,960	65.8%	-27.6%	38,910	27,514	
5-03	Surplus (Deficit) against B/E Duty	(2,216)	(457)	(13,231)	(1,354)			11,743	11,743	
5-04	CIP Savings	2,174	986	20,074	11,271	-43.9%	-47.1%	24,111	13,998	
5-05	Cash Balance	8,558	10,625	8,558	10,625			1,000	3,400	
5-06	Capital Expenditure	1,059	430	20,188	6,700			*13,762*	13,010	
5-07	Establishment WTE	5,608.4	5,684.0	5,608.4	5,684.0	1.3%	0.0%	5,684.0	5,684.0	
5-08	Contracted WTE	5,033.3	5,145.2	5,033.3	5,145.2	2.2%	2.6%	5,016.9	5,016.9	
5-09	Vacancies WTE	575.2	538.8	575.2	538.8	-6.3%	-19.2%	667.1	667.1	
5-11	Vacancy Rate (%)	10.3%	9.5%	10.3%	9.5%	-0.8%	-2.3%	11.7%	11.7%	
5-12	Substantive Staff Used	4,897.6	5,008.7	4,897.6	5,008.7	2.3%	-0.6%	5,036.6	5,036.6	
5-13	Bank Staff Used	394.6	442.2	394.6	442.2	12.1%	15.7%	382	382.3	
5-14	Agency Staff Used	242.3	285.7	242.3	285.7	17.9%	7.8%	265.1	265.1	
5-15	Overtime Used	47.3	47.3	47.3	47.3	0.0%				
5-16	Worked WTE	5,581.8	5,783.9	5,581.8	5,783.9		1.8%	5,684.0	5,684.0	
5-17	Nurse Agency Spend	(626)	(860)	(7,124)	(8,605)	20.8%				
5-18	Medical Locum & Agency Spend	(1,472)	(1,674)	(14,264)	(17,176)	20.4%				
5-19	Temp costs & overtime as % of total pay bill	17.2%	18.4%	15.4%	17.3%	1.8%				
5-20	Staff Turnover Rate	11.5%	8.9%		8.9%	-2.7%	-1.6%	*10.5%*	8.9%	11.05%
5-21	Sickness Absence	4.7%	3.8%		3.5%	-0.9%	0.2%	*3.3%*	3.5%	4.3%
5-22	Statutory and Mandatory Training	87.4%	No data		87.1%	-87.4%	2.1%	85.0%	87.1%	
5-23	Appraisal Completeness	89.4%	92.1%		92.1%	2.7%	2.1%	90.0%	92.1%	
5-24	Overall Safe staffing fill rate	97.0%	95.8%	98.1%	96.9%	-1.2%		93.5%	96.9%	
5-25	****Staff FFT % recommended work	62.5%	50%	62.5%	50%	-12.5%	-12.0%	62.0%	50%	
5-26	***Staff Friends & Family -Number Responses	56	78	56	78	22				
5-27	*****IP Resp Rate Recmd to Friends & Family	25.3%	18.2%	23.7%	21.1%	-2.5%	-3.9%	25.0%	21.1%	25.7%
5-28	A&E Resp Rate Recmd to Friends & Family	11.4%	7.6%	21.4%	11.7%	-9.7%	-3.3%	15.0%	11.7%	12.7%
5-29	Mat Resp Rate Recmd to Friends & Family	28.0%	26.2%	30.0%	24.8%	-5.2%	-0.2%	25.0%	24.8%	24.0%

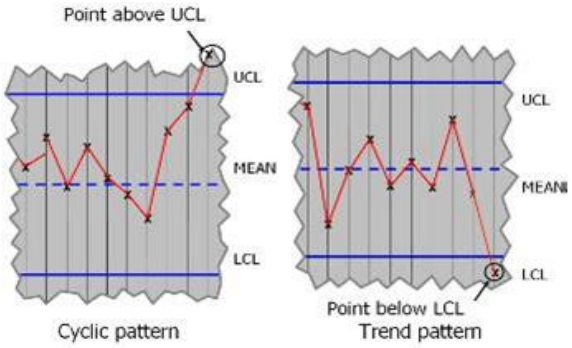
Explanation of Statistical Process Control (SPC) Charts

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

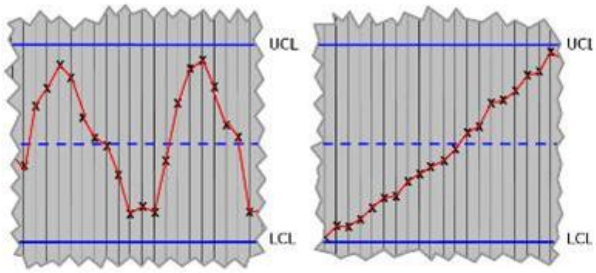


SPC is a type of charting that shows the variation that exists in the systems that are being measured. When interpreting SPC charts there are 4 rules that help to identify what the system is doing. If one of the rules has been broken, this means that 'special cause ' variation is present in the system.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

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

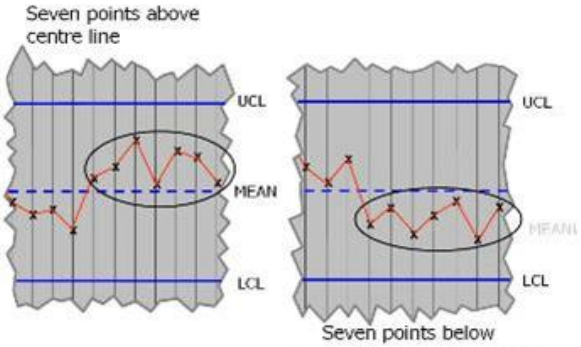


Rule 2: Any unusual pattern or trends within the control limits. The most obvious example of a cyclical pattern is seasonality but we also see it when looking at daily discharges where the weekends have low numbers. To qualify as a trend there must be at least 6 points in a row. This is one of the key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

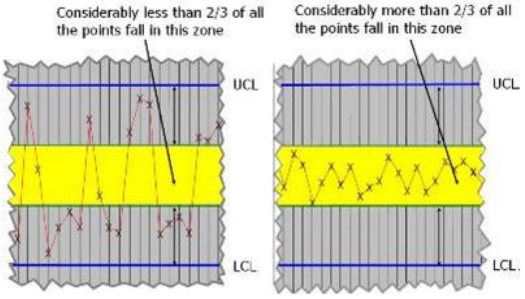


Rules 1 and 2 are the main reason for displaying SPC charts on our performance reports as it makes abnormally high or low values and trends immediately obvious. However there are two other rules that are also used to interpret the graphs.

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

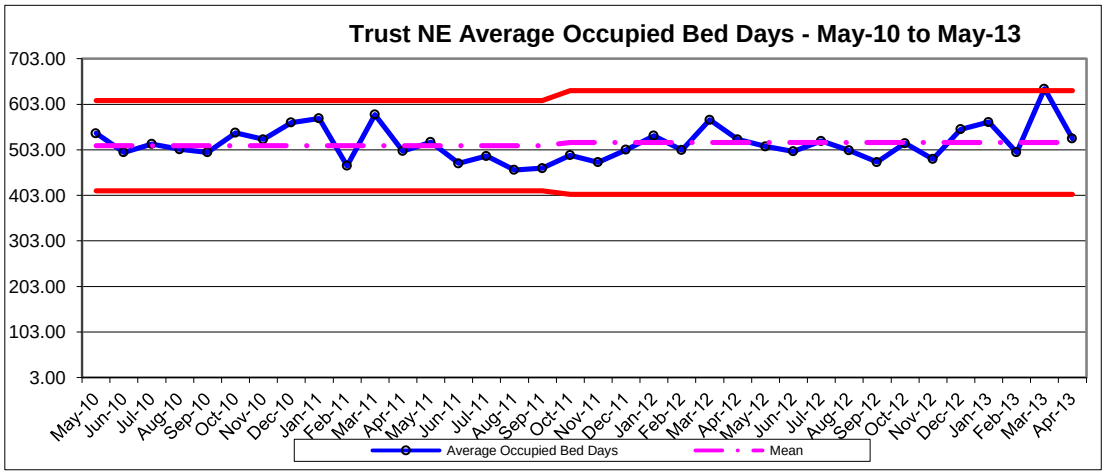


Rule 4: The number of points within the middle third of the region between the control limits differs markedly from two -thirds of the total number of points. This gives an indication of how stable a process is. If controlled variation (common cause) is displayed in the SPC chart, the process is stable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

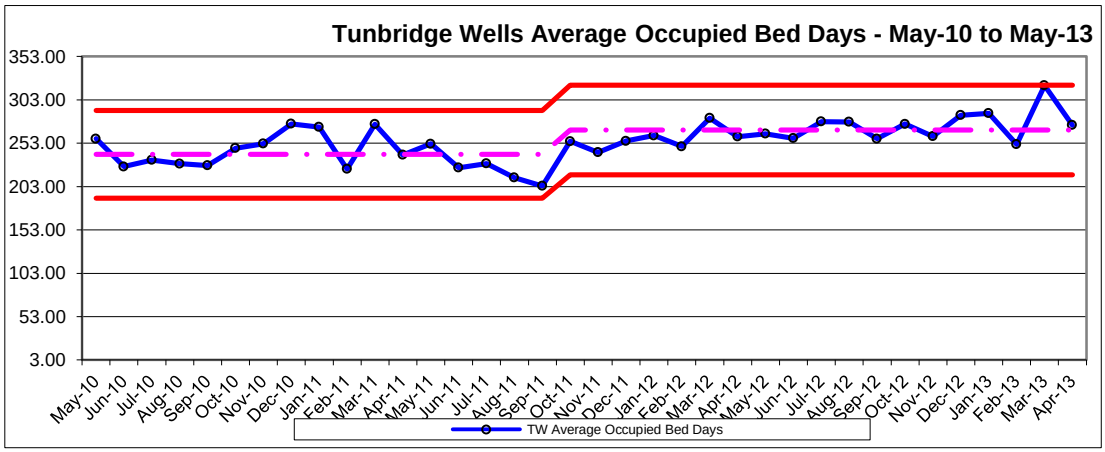


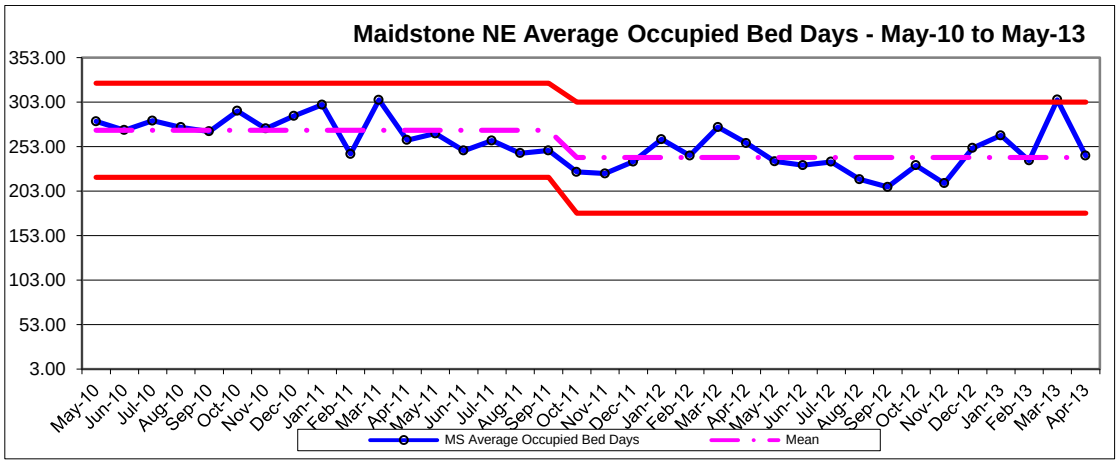
Changes to Control Lines

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



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

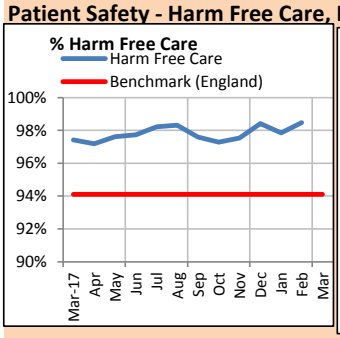


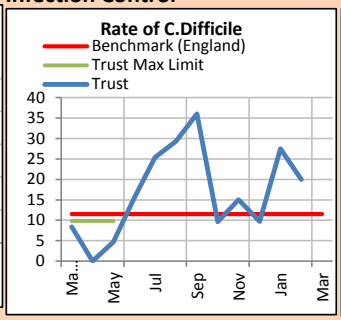


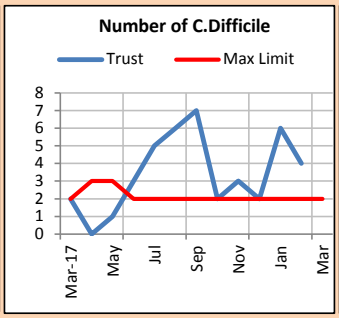
So in the examples given we have calculated a mean and control limits based on the data for May 2010 to September 2011 and then calculated them based on the period October 2011 to April 2013. The lines are all a result of the SPC calculations, only the date of the change is decided by the Information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

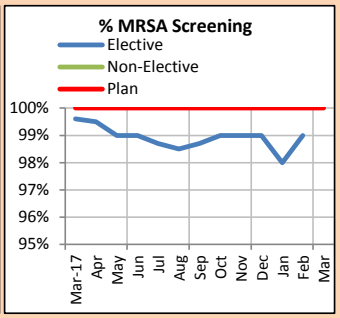
INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

Patient Safety - Harm Free Care, Infection Control

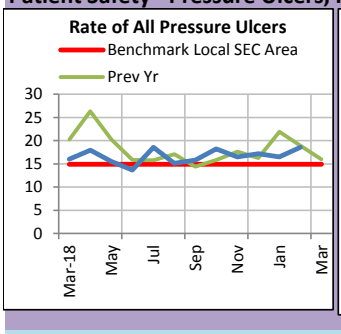


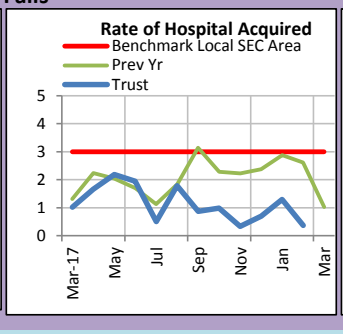


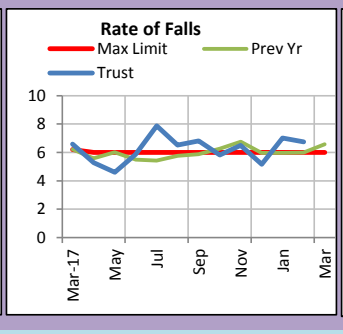


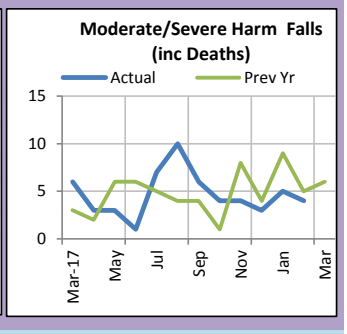


Patient Safety - Pressure Ulcers, Falls

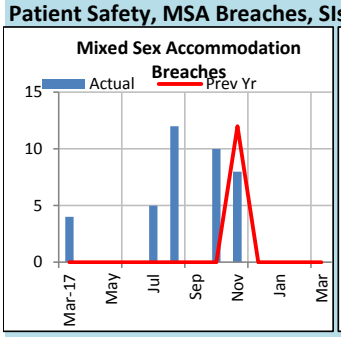


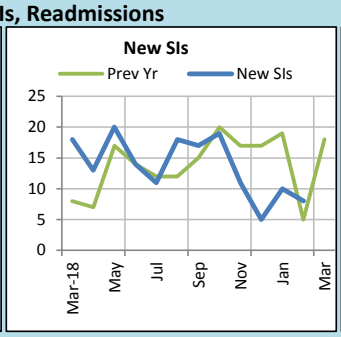


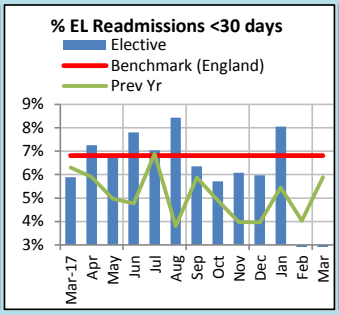


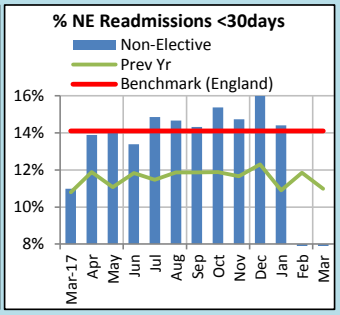


Patient Safety, MSA Breaches, SIs, Readmissions

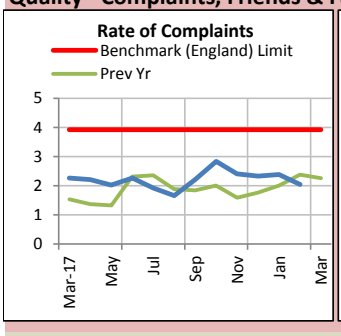


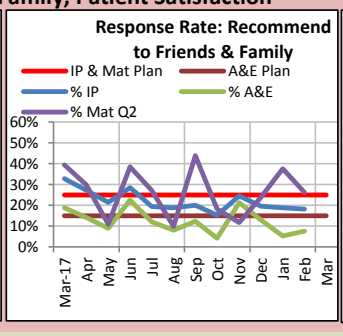


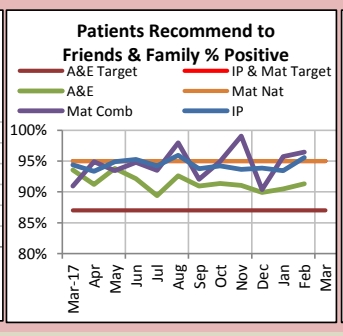


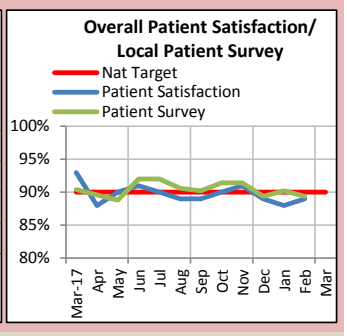


Quality - Complaints, Friends & Family, Patient Satisfaction

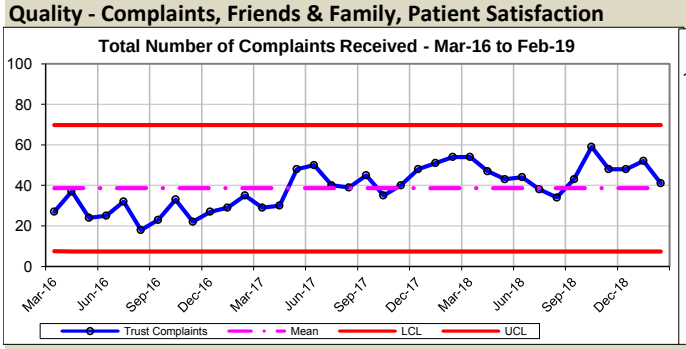


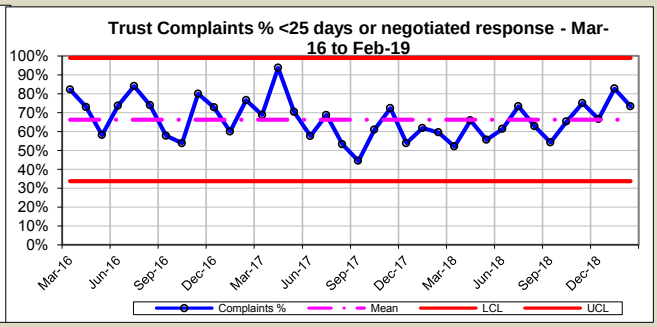




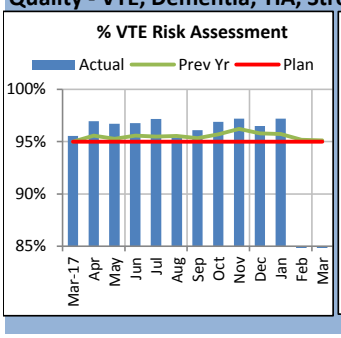


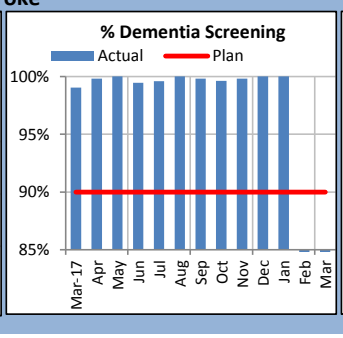
Quality - Complaints, Friends & Family, Patient Satisfaction

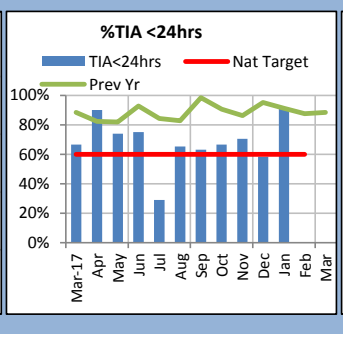


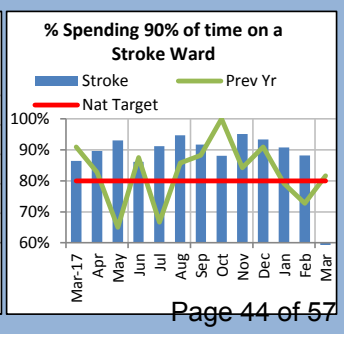


Quality - VTE, Dementia, TIA, Stroke



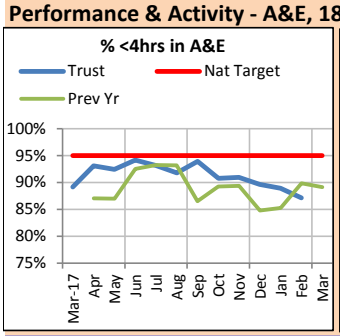


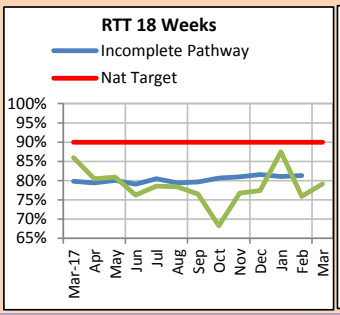


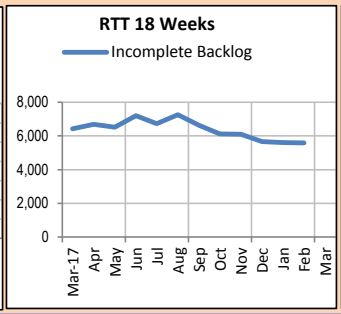


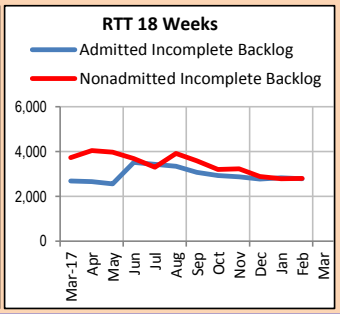
INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

Performance & Activity - A&E, 18 Weeks

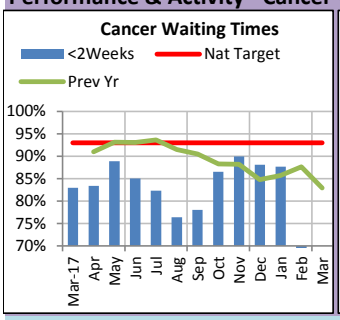


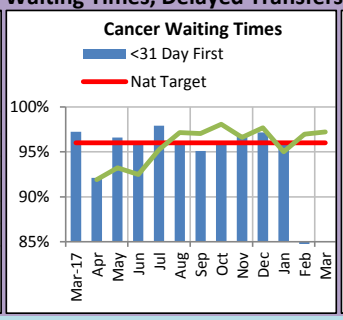


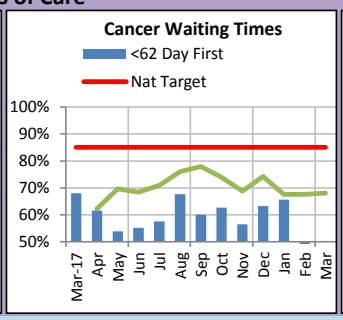


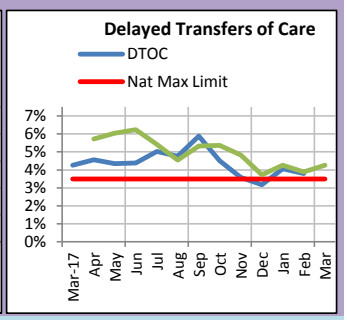


Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care

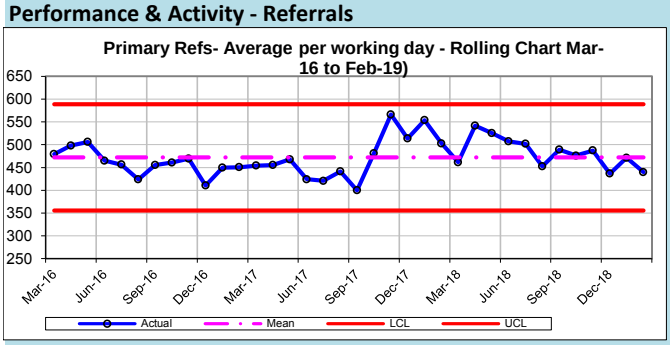


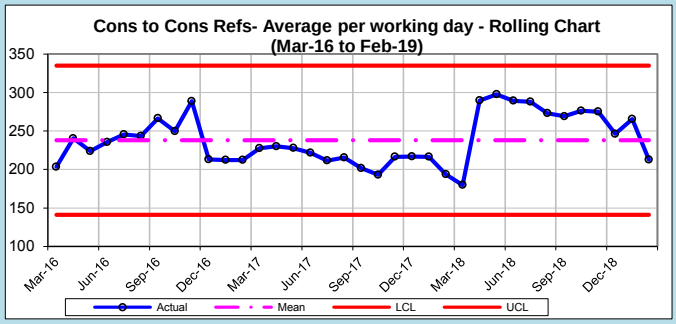




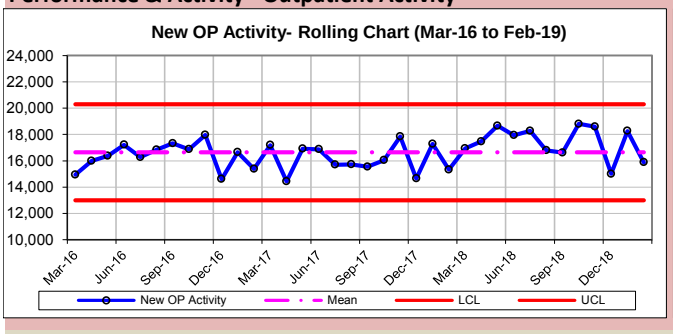


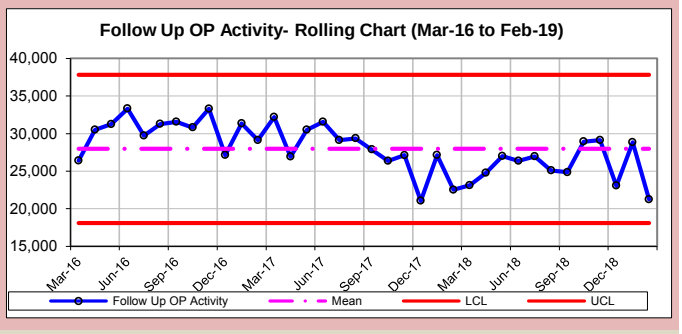
Performance & Activity - Referrals



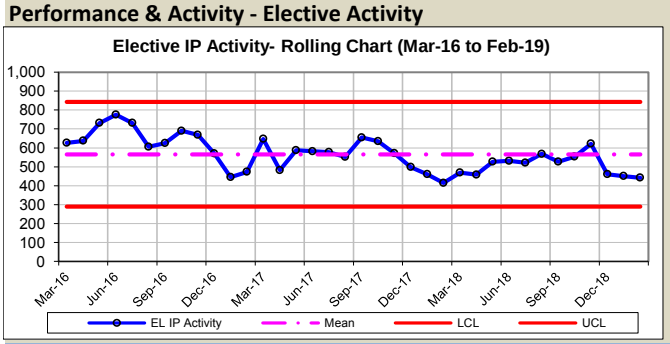


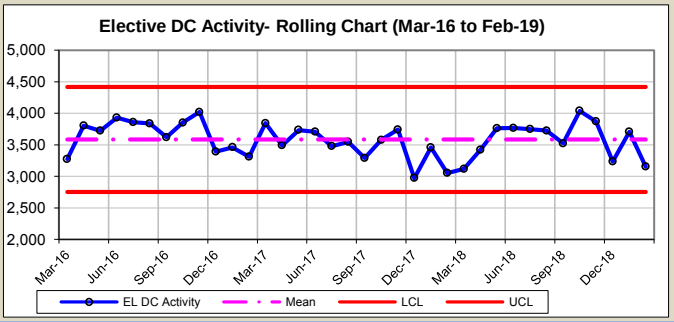
Performance & Activity - Outpatient Activity



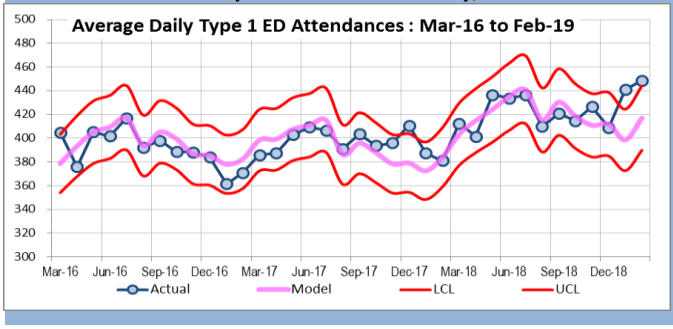


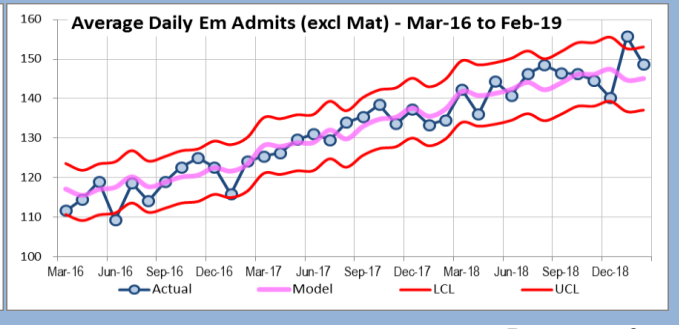
Performance & Activity - Elective Activity





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

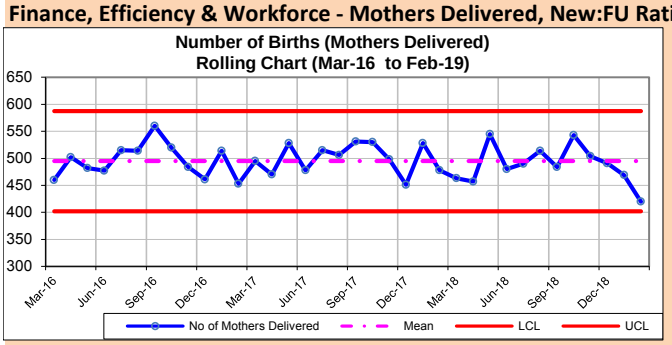


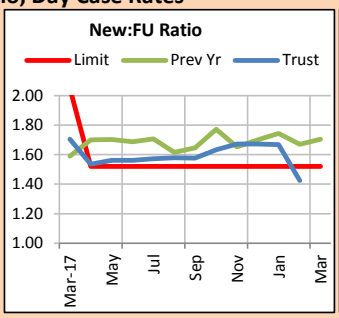


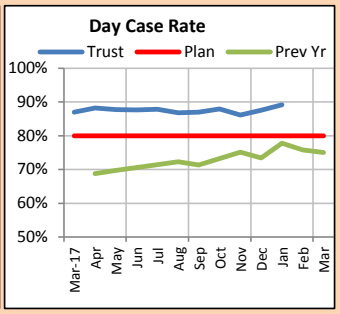
These have been changed to show actual against model, since emergency activity is subject to both growth and seasonal variation. Control limits are 2 standard deviations of variance, so a count outside the control limits will be expected around one month in 20.

INTEGRATED PERFORMANCE REPORT ANALYSIS - FINANCE, EFFICIENCY & WORKFORCE

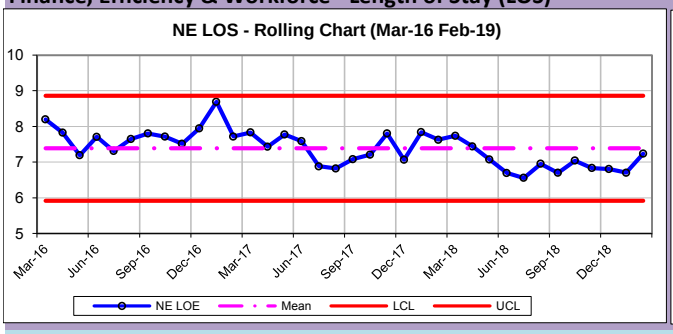
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates

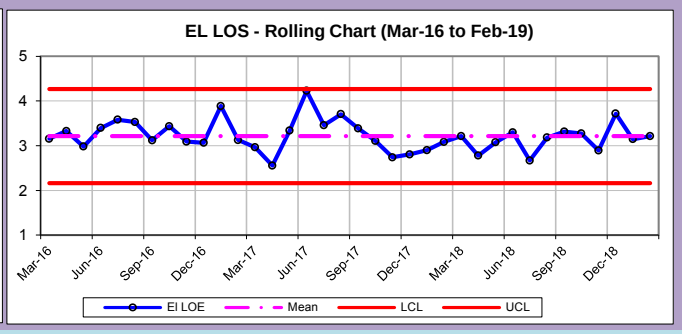




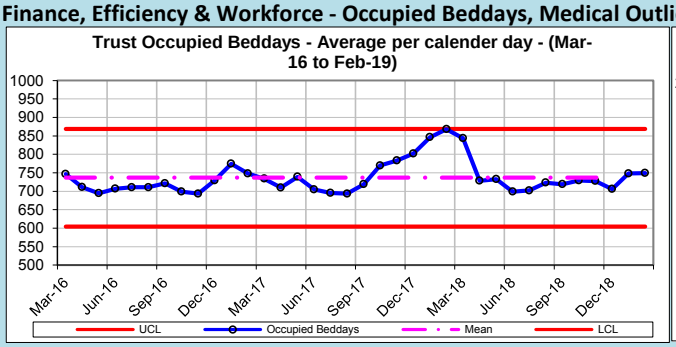


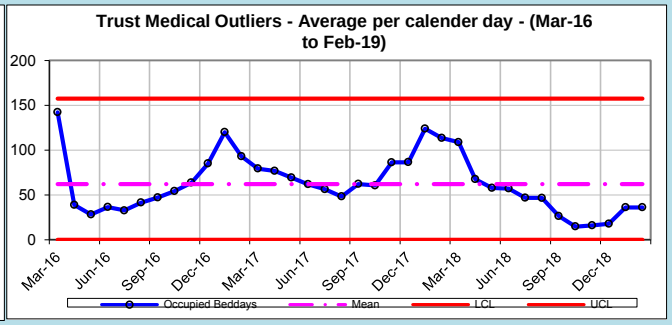
Finance, Efficiency & Workforce - Length of Stay (LOS)



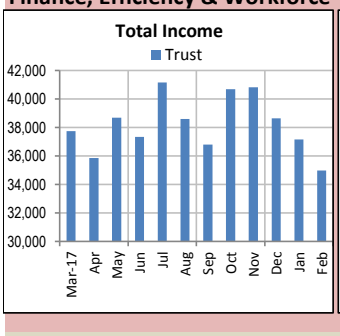


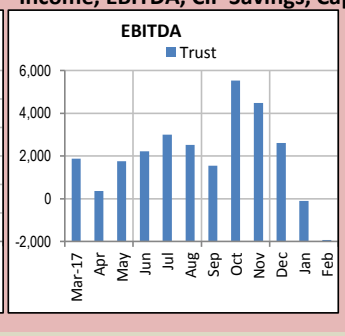
Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

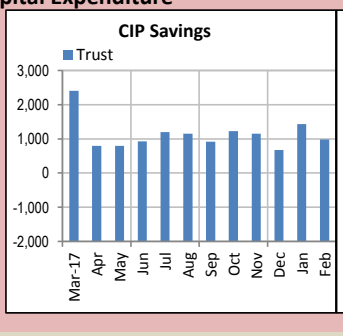


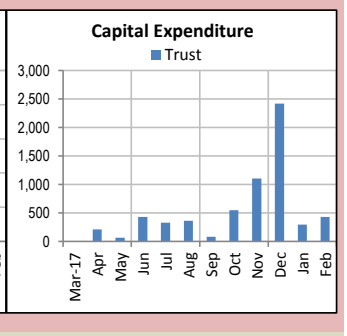


Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure

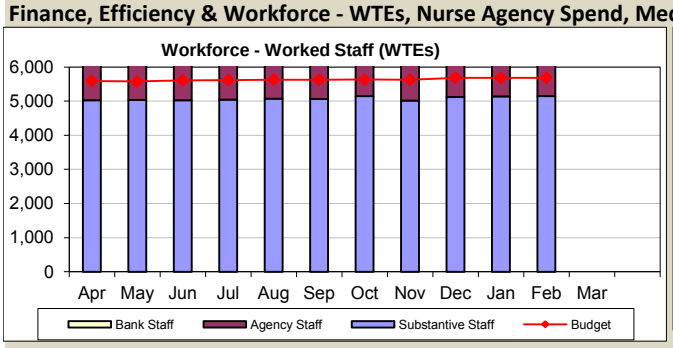


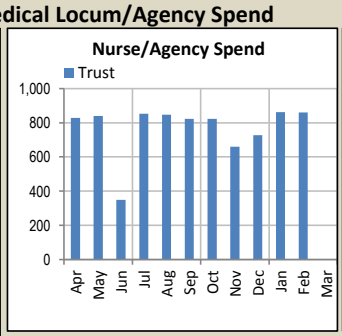


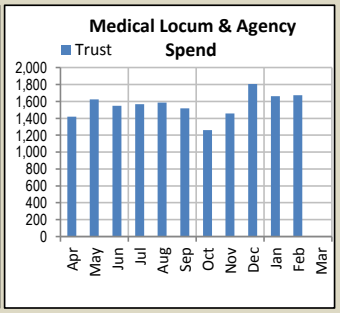




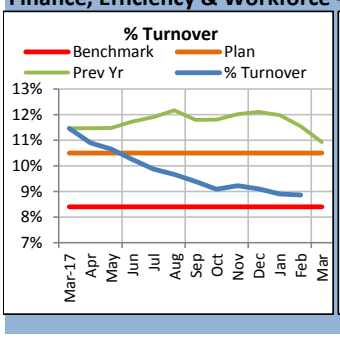
Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend

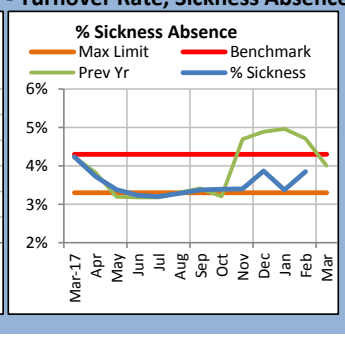


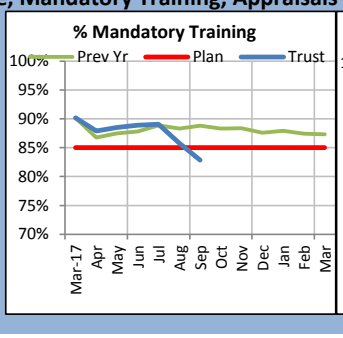


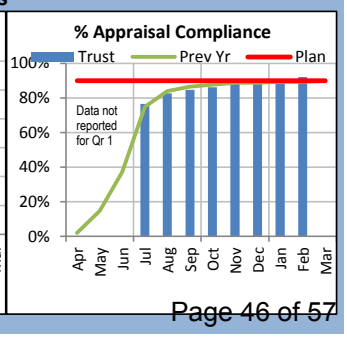


Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals









Maidstone and Tunbridge Wells NHS Trust

Trust Board Finance Report

Month 11
2018/19

Maidstone and Tunbridge Wells NHS Trust

Trust Board Finance Report for February 2019

Maidstone and Tunbridge Wells NHS Trust

1a. Dashboard

February 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	35.0	37.7	(2.7)	(0.3)	(2.3)		420.7	427.5	(6.8)	(1.2)	(5.5)		464.9	471.3	(6.5)	
Expenditure	(36.9)	(35.8)	(1.1)	0.3	(1.4)		(398.8)	(397.2)	(1.6)	1.2	(2.8)		(437.4)	(432.4)	(5.0)	
EBITDA (Income less Expenditure)	(1.9)	1.8	(3.8)	(0.0)	(3.8)		22.0	30.3	(8.4)	(0.0)	(8.4)		27.5	39.0	(11.4)	
Financing Costs	1.4	0.8	0.7	0.0	0.7		(24.0)	(25.1)	1.1	0.0	1.1		(17.2)	(28.2)	11.1	
Technical Adjustments	0.0	0.0	0.0	0.0	0.0		0.7	0.5	0.2	0.0	0.2		1.4	1.0	0.4	
Net Surplus / Deficit (Incl PSF)	**(0.5)**	**2.6**	**(3.0)**	**(0.0)**	**(3.0)**		**(1.4)**	**5.7**	**(7.0)**	**0.0**	**(7.0)**		**11.7**	**11.7**	**(0.0)**	
CIPs	1.0	2.8	(1.8)		(1.8)		11.3	21.3	(10.0)		(10.0)		14.0	24.1	(10.1)	
Cash Balance	10.6	1.0	9.6		9.6		10.6	1.0	9.6		9.6		3.4	1.0	2.4	
Capital Expenditure	0.4	2.5	2.1		2.1		6.7	9.4	2.7		2.7		13.0	13.8	0.8	
Capital service cover rating							4	4					4	4		
Liquidity rating							4	4					4	4		
I&E margin rating							3	1					1	1		
Agency rating							4	4					4	4		
Finance and use of resources rating							4	4					3	3		

Summary:

- The Trusts deficit including PSF was £0.5m in February which was £3m adverse to plan but £1m better than the forecasted position. Year to date the Trust has a deficit of £0.4m whic h is £7.1m adverse to plan , the key variances against plan are: CIP Slippage (£10m) overspends within pay budgets (£3.1m) and non pay budgets (£5.4m) and PSF slippage (£3m) partly offset b y non-recurrent items (£2.1m), release of contingency reserve (£5.3m) , earlier than planned phasing of Non Recurrent Income support (£3m) , over performance within Clinical Income (£2.6m) , benefit on asset sale (£0.6m) and underspends within depreciation (£0.5m).
- The Trust completed the sale of 32 high street generating a profit on disposal of £3.9m, £0.6m more than planned.
- The Trust has spent £10.5m more than the YTD agency ceiling set by NHSI (£11.8m per annum)
- The Trust has delivered £11.3m savings YTD which is £10m adverse to plan (47% slippage)

Key Points:

- The Trusts normalised run rate in February was £4.4m deficit pre PSF which was £2.5m adverse to normalised plan (pre PSF).
- The Trust was adverse to the control target in February and therefore received no PSF fore the month. If the Trust delivers the control target at the end of the financial year the full PSF will be received including this months slippage. The PSF relating to A&E performance in quarter 4 relates to delivering 95% in March only.
- The main non pay pressures (excluding CIP) relate to clinical supplies (£4.2m adverse year to date) specifically within Sur gery Division (£0.7m), Diagnostics and Clinical Support (£1m) and Medical and Emergency Services (£1m).
- The Trust has managed the YTD financial position by implementing non recurrent actions, as a result the Trusts recurrent def icit has increased from a planned deficit of £8.4m to a forecasted deficit of £26.5m.

Risks:

- The Trust is forecasting to deliver the planned £1m deficit pre PSF. The actions required to achieve this and the risks of non delivery are shown on slide 4a.

Maidstone and Tunbridge Wells NHS Trust

1b. Summary Income & Expenditure (Exceptional Items)

Income & Expenditure February 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	35.0	36.2	(1.2)	(0.3)	(0.8)	407.0	416.3	(9.3)	(1.2)	(8.1)
Expenditure	(37.2)	(35.8)	(1.3)	0.3	(1.7)	(404.4)	(397.2)	(7.3)	1.2	(8.5)
Trust Financing Costs	(2.5)	0.8	(3.2)	0.0	(3.2)	(27.9)	(25.1)	(2.8)	0.0	(2.8)
Technical Adjustments	0.0	0.0	0.0	0.0	0.0	0.7	0.5	0.2	0.0	0.2
Net Revenue Surplus / (Deficit) before Exceptional Items	**(4.6)**	**1.1**	**(5.7)**	**(0.0)**	**(5.7)**	**(24.7)**	**(5.5)**	**(19.2)**	**(0.0)**	**(19.2)**
Exceptional Items	4.2		4.2		4.2	15.1		15.1		15.1
Net Position	**(0.5)**	**1.1**	**(1.6)**	**(0.0)**	**(1.6)**	**(9.6)**	**(5.5)**	**(4.1)**	**(0.0)**	**(4.1)**
PSF Funding	0.0	1.5	(1.5)	0.0	(1.5)	8.3	11.2	(3.0)	0.0	(3.0)
Net Revenue Surplus / (Deficit) Incl PSF and Exceptional Items	(0.5)	2.6	(3.0)	(0.0)	(3.0)	(1.4)	5.7	(7.0)	(0.0)	(7.0)

Key messages:
The Trust benefited by £4.2m of exceptional adjustments this month which related to profit on sale of Asset (£3.9m) and £0.3m release of reserves .

Income:
Income YTD net of pass-through related costs and exceptional items is £8.1m adverse to plan, which is due to CIP slippage (£10m) and Private Patient income £0.9m partially offset by income over performance within non AIC contracted clinical income (£2.6m) and £3m non recurr ent income support.

Expenditure:
Expenditure budgets net of pass-through and exceptional items are £8.5m adverse, which is due to budget overspends within Pay b udgets (£3.1m) and Non Pay (£5.4m).
The main pressures within expenditure budgets (net of pass though, CIP and exceptional items) relates to: Clinical Supplies a nd Services (£4.2m and Medical (£2.5m).

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

PSF: The Trust was adverse to the control target in February and therefore received no PSF fore the month. If the Trust delivers the control target at the end of the financial year the full PSF will be received including this months slippage. The PSF relating to A&E performance i n quarter 4 relates to delivering 95% in March only.

Maidstone and Tunbridge Wells NHS Trust

2a. Income & Expenditure

Income & Expenditure February 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	26.6	28.1	(1.5)	(0.2)	(1.3)	322.6	325.7	(3.1)	(0.5)	(2.6)	354.8	356.3	(1.6)
High Cost Drugs	4.0	3.5	0.5	(0.1)	0.6	39.8	39.7	0.1	(0.3)	0.4	43.2	43.2	0.0
Total Clinical Income	**30.6**	**31.6**	**(1.0)**	**(0.3)**	**(0.7)**	**362.3**	**365.4**	**(3.1)**	**(0.8)**	**(2.3)**	**398.0**	**399.6**	**(1.6)**
PSF	0.0	1.5	(1.5)	0.0	(1.5)	8.3	11.2	(3.0)	0	(3.0)	12.7	12.7	0
Other Operating Income	4.4	4.6	(0.2)	(0.0)	(0.2)	50.1	50.9	(0.7)	(0.5)	(0.3)	54.2	59.0	(4.9)
Total Revenue	**35.0**	**37.7**	**(2.7)**	**(0.3)**	**(2.3)**	**420.7**	**427.5**	**(6.8)**	**(1.2)**	**(5.5)**	**464.9**	**471.3**	**(6.5)**
Substantive	(18.7)	(19.1)	0.4	0.3	0.1	(204.8)	(210.1)	5.2	0.6	4.6	(224.3)	(229.0)	4.7
Bank	(1.3)	(1.1)	(0.2)	0.0	(0.2)	(12.2)	(11.2)	(0.9)	0.0	(0.9)	(13.3)	(12.3)	(1.0)
Locum	(0.7)	(0.5)	(0.3)	0.0	(0.3)	(7.7)	(5.0)	(2.7)	0	(2.7)	(9.0)	(5.5)	(3.5)
Agency	(2.1)	(2.1)	(0.0)	(0.0)	0.0	(21.2)	(20.2)	(1.0)	(0.0)	(1.0)	(23.3)	(22.2)	(1.1)
Pay Reserves	(0.2)	(0.1)	(0.2)	0.0	(0.2)	(0.9)	(1.6)	0.7	0	0.7	(1.1)	(1.6)	0.6
Total Pay	**(23.0)**	**(22.8)**	**(0.2)**	**0.3**	**(0.5)**	**(246.9)**	**(248.1)**	**1.2**	**0.6**	**0.6**	**(270.9)**	**(270.6)**	**(0.4)**
Drugs & Medical Gases	(4.5)	(4.1)	(0.4)	0.1	(0.5)	(48.3)	(47.9)	(0.4)	0.3	(0.6)	(52.8)	(52.0)	(0.9)
Blood	(0.2)	(0.2)	(0.0)	0.0	(0.0)	(2.0)	(2.0)	(0.0)	0	(0.0)	(2.2)	(2.2)	(0.0)
Supplies & Services - Clinical	(2.8)	(2.7)	(0.0)	0.2	(0.2)	(31.7)	(29.3)	(2.4)	0.5	(2.9)	(35.0)	(32.1)	(2.9)
Supplies & Services - General	(0.4)	(0.4)	(0.0)	(0.0)	(0.0)	(5.1)	(4.6)	(0.5)	(0.0)	(0.5)	(5.7)	(5.0)	(0.7)
Services from Other NHS Bodies	(0.2)	(0.8)	0.6	0.7	(0.0)	(8.9)	(9.1)	0.2	0.7	(0.4)	(10.4)	(9.9)	(0.4)
Purchase of Healthcare from Non-NHS	(0.4)	(0.4)	0.0	0.0	0.0	(3.3)	(5.1)	1.7	0	1.7	(3.8)	(5.4)	1.7
Clinical Negligence	(1.5)	(1.6)	0.0	0.0	0.0	(17.0)	(17.5)	0.4	0	0.4	(18.6)	(19.0)	0.5
Establishment	(0.3)	(0.3)	(0.0)	(0.0)	0.0	(3.4)	(3.2)	(0.2)	(0.1)	(0.1)	(4.0)	(3.5)	(0.5)
Premises	(1.9)	(1.6)	(0.3)	0.0	(0.3)	(21.6)	(19.8)	(1.8)	0.2	(2.0)	(23.6)	(21.4)	(2.2)
Transport	(0.1)	(0.1)	(0.0)	0.0	(0.0)	(1.5)	(1.2)	(0.3)	0	(0.3)	(1.7)	(1.3)	(0.3)
Other Non-Pay Costs	(1.5)	(0.6)	(0.9)	(0.9)	0.0	(9.1)	(7.5)	(1.6)	(0.9)	(0.7)	(8.7)	(8.1)	(0.6)
Non-Pay Reserves	0.0	(0.1)	0.1	0.0	0.1	0	(1.9)	1.9	0	1.9	0.0	(1.8)	1.8
Total Non Pay	**(13.9)**	**(13.0)**	**(0.9)**	**0.1**	**(0.9)**	**(151.9)**	**(149.1)**	**(2.8)**	**0.7**	**(3.5)**	**(166.4)**	**(161.8)**	**(4.6)**
Total Expenditure	**(36.9)**	**(35.8)**	**(1.1)**	**0.3**	**(1.4)**	**(398.8)**	**(397.2)**	**(1.6)**	**1.2**	**(2.8)**	**(437.4)**	**(432.4)**	**(5.0)**
EBITDA	**(1.9)**	**1.8**	**(3.8)**	**(0.0)**	**(3.8)**	**22.0**	**30.3**	**(8.4)**	**(0.0)**	**(8.4)**	**27.5**	**39.0**	**(11.4)**
	(0.0)	*0.0*	*0.0*	*%*		*5.2%*	*7.1%*	*123.7%*	*0.4%*	*151.5%*	*5.9%*	*8.3%*	*177.1%*
									0	0			
Depreciation	(1.1)	(1.1)	0.1	0	0.1	(11.9)	(12.3)	0.4	0	0.4	(13.0)	(13.5)	0.5
Interest	(0.1)	(0.1)	0.0	0	0.0	(1.5)	(1.4)	(0.0)	0	(0.0)	(1.6)	(1.6)	(0.0)
Dividend	(0.1)	(0.1)	0.0	0	0	(1.2)	(1.2)	0	0	0	(1.3)	(1.3)	0
PFI and Impairments	2.7	2.1	0.6	0	0.6	(9.4)	(10.1)	0.7	0	0.7	(1.3)	(11.9)	10.7
Total Finance Costs	**1.4**	**0.8**	**0.7**	**0.0**	**0.7**	**(24.0)**	**(25.1)**	**1.1**	**0**	**1.1**	**(17.2)**	**(28.2)**	**11.1**
Net Surplus / Deficit (-)	**(0.5)**	**2.6**	**(3.1)**	**(0.0)**	**(3.1)**	**(2.0)**	**5.2**	**(7.3)**	**(0.0)**	**(7.2)**	**10.3**	**10.7**	**(0.4)**
Technical Adjustments	0.0	0.0	0.0	0.0	0.0	0.7	0.5	0.2	0.0	0.2	1.4	1.0	0.4
Surplus/ Deficit (-) to B/E Duty Incl PSF	**(0.5)**	**2.6**	**(3.0)**	**(0.0)**	**(3.0)**	**(1.4)**	**5.7**	**(7.0)**	**0.0**	**(7.0)**	**11.7**	**11.7**	**(0.0)**
Surplus/ Deficit (-) to B/E Duty Excl PSF	**(0.5)**	**1.1**	**(1.6)**	**(0.0)**	**(1.6)**	**(9.6)**	**(5.5)**	**(4.1)**	**0.0**	**(4.1)**	**(1.0)**	**(1.0)**	**(0.0)**

Commentary

The Trusts deficit was £0.5m in February which was £3m adverse to plan but £1m better than forecast. Year to date the Trust has a deficit including PSF of £1.4m which is £7m adverse to plan.

The Trusts normalised run rate in February was £4.4m deficit pre PSF which was £2.5m adverse to normalised plan (pre PSF).

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 £1.3m adverse to plan in February. The key adverse variances are Outpatients (£0.4m) and the Aligned Incentives adjustment (£0.8m). This is mainly driven by significant over-performance in Non-Electives in February which was £1.4m above the plan.

The Trust was adverse to the control target in February and therefore received no PSF fore the month. If the Trust delivers the control target at the end of the financial year the full PSF will be received including this months slippage. The PSF relating to A&E performance in quarter 4 relates to delivering 95% in March only.

Other Operating Income excluding pass-through costs was on £0.2m adverse in the month which related to underperformance within Private Patients (£0.2m).

Pay budgets overspent by £0.5m in February and were £0.3m favourable to forecast this was mainly due to underspends within Medical (£0.2m) and Nursing (£0.1m) due to spend relating to winter escalation costs less than forecasted.

Non Pay adjusted for pass through costs and reserves was overspent by £1.1m in February and was £0.4m favourable to forecast. The main benefits relate to Clinical Supplies and Services (£0.3m) which mainly related to Theatres and Orthopaedics consumables and £0.1m bad debt reduction mainly relating to Private Patients.

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)

		Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Change between Months
Revenue	Clinical Income	31.2	33.8	30.7	33.5	32.3	35.4	33.1	32.0	33.7	35.5	33.1	32.4	30.6	(1.8)
	STF / PSF	0.0	3.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	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	5.7	3.9	5.1	5.2	5.0	5.7	5.5	4.8	7.0	5.3	5.5	4.7	4.4	(0.3)
	Total Revenue	**36.9**	**40.8**	**35.9**	**38.7**	**37.3**	**41.2**	**38.6**	**36.8**	**40.7**	**40.8**	**38.6**	**37.1**	**35.0**	**(2.2)**
Expenditure	Substantive	(17.5)	(17.9)	(18.3)	(18.7)	(18.4)	(19.4)	(18.5)	(18.9)	(17.6)	(18.9)	(18.7)	(18.8)	(18.7)	0.1
	Bank	(1.1)	(1.3)	(1.0)	(1.0)	(1.0)	(1.0)	(1.2)	(1.1)	(1.0)	(1.1)	(1.2)	(1.2)	(1.3)	(0.1)
	Locum	(0.6)	(0.7)	(0.5)	(0.6)	(0.5)	(0.6)	(0.7)	(0.7)	(0.6)	(0.8)	(1.0)	(0.9)	(0.7)	0.2
	Agency	(1.8)	(2.6)	(2.0)	(2.1)	(1.7)	(2.1)	(2.1)	(1.9)	(1.8)	(1.7)	(1.7)	(1.9)	(2.1)	(0.2)
	Pay Reserves	(0.3)	(0.2)	(0.2)	(0.2)	(0.2)	(0.1)	0.2	0.0	0.4	(0.2)	(0.2)	(0.1)	(0.2)	(0.1)
	Total Pay	(21.3)	(22.7)	(22.0)	(22.7)	(21.9)	(23.2)	(22.3)	(22.5)	(20.7)	(22.7)	(22.8)	(23.0)	(23.0)	(0.1)
Non-Pay	Drugs & Medical Gases	(4.3)	(4.5)	(4.2)	(4.8)	(4.3)	(4.5)	(4.3)	(4.4)	(4.4)	(4.8)	(4.2)	(3.9)	(4.5)	(0.6)
	Blood	(0.1)	(0.2)	(0.2)	(0.1)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	0.0
	Supplies & Services - Clinical	(2.5)	(2.1)	(2.6)	(2.9)	(2.7)	(2.9)	(3.0)	(2.8)	(3.1)	(3.0)	(3.1)	(3.0)	(2.8)	0.2
	Supplies & Services - General	(0.5)	(0.6)	(0.4)	(0.4)	(0.4)	(0.4)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.4)	0.1
	Services from Other NHS Bodies	(0.7)	(0.3)	(0.6)	(0.6)	(1.1)	(0.7)	(0.7)	(1.1)	(0.8)	(1.3)	(0.9)	(0.9)	(0.2)	0.7
	Purchase of Healthcare from Non-NHS	(0.2)	(0.3)	(0.3)	(0.3)	(0.2)	(0.2)	(0.3)	(0.4)	(0.3)	(0.2)	(0.3)	(0.3)	(0.4)	(0.1)
	Clinical Negligence	(1.7)	(1.7)	(1.6)	(1.6)	(1.6)	(1.6)	(1.6)	(1.6)	(1.6)	(1.3)	(1.5)	(1.5)	(1.5)	0.0
	Establishment	(0.3)	(0.3)	(0.3)	(0.3)	(0.2)	(0.3)	(0.4)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.0)
	Premises	(3.8)	(3.0)	(1.9)	(1.8)	(1.8)	(2.6)	(2.2)	(1.8)	(1.7)	(1.5)	(1.8)	(2.6)	(1.9)	0.7
	Transport	(0.1)	(0.2)	(0.2)	(0.2)	(0.2)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.2)	(0.1)	0.0
	Other Non-Pay Costs	(1.1)	(0.2)	(1.0)	(1.0)	(0.3)	(1.2)	(1.1)	(0.2)	(1.1)	(0.4)	(0.3)	(1.0)	(1.5)	(0.5)
	Non-Pay Reserves	(0.0)	(0.0)	(0.2)	(0.2)	(0.2)	(0.2)	0.5	0.6	(0.4)	0.0	0.0	0.0	0.0	0.0
	Total Non Pay	(15.4)	(13.2)	(13.5)	(14.3)	(13.2)	(14.9)	(13.8)	(12.7)	(14.5)	(13.6)	(13.2)	(14.3)	(13.9)	0.4
	Total Expenditure	(36.7)	(35.9)	(35.5)	(36.9)	(35.1)	(38.2)	(36.1)	(35.3)	(35.2)	(36.3)	(36.0)	(37.3)	(36.9)	0.3
EBITDA	EBITDA	0.2	4.9	0.4	1.8	2.2	3.0	2.5	1.5	5.5	4.5	2.6	(0.1)	(1.9)	(1.8)
		1%	*12%*	*1%*	*5%*	*6%*	*7%*	*7%*	*4%*	*14%*	*11%*	*7%*	*0%*	*-6%*	
Other Finance Costs	Depreciation	(1.1)	(1.2)	(1.1)	(1.1)	(1.1)	(1.0)	(1.0)	(1.2)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	0.0
	Interest	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	0.0
	Dividend	(0.1)	0.2	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	0.0
	PFI and Impairments	(1.2)	17.5	(1.2)	(1.2)	(1.2)	(1.2)	(1.2)	(1.3)	(1.4)	(1.2)	(1.2)	(1.2)	2.7	3.9
	Total Other Finance Costs	**(2.5)**	**16.3**	**(2.5)**	**(2.5)**	**(2.5)**	**(2.5)**	**(2.5)**	**(2.7)**	**(2.7)**	**(2.5)**	**(2.5)**	**(2.5)**	**1.4**	**3.9**
Net Surplus / Deficit (-)	Net Surplus / Deficit (-)	(2.2)	21.2	(2.2)	(0.8)	(0.3)	0.5	0.0	(1.1)	2.8	2.0	0.1	(2.6)	(0.5)	2.1
Technical Adjustments	Technical Adjustments	0.0	(18.9)	0.0	0.0	0.0	0.0	0.0	0.1	0.3	0.0	0.0	0.0	0.0	(0.0)
Surplus/ Deficit (-) to B/E Duty Incl STF	Surplus/ Deficit (-) to B/E Duty	(2.2)	2.3	(2.2)	(0.8)	(0.3)	0.6	0.1	(1.0)	3.1	2.0	0.1	(2.6)	(0.5)	2.1
Surplus/ Deficit (-) to B/E Duty Excl STF	Surplus/ Deficit (-) to B/E Duty	(2.2)	(0.7)	(2.2)	(0.8)	(0.3)	0.6	0.1	(1.0)	3.1	2.0	0.1	(2.6)	(0.5)	2.1

Maidstone and Tunbridge Wells NHS Trust

3a. Cost Improvement Plan

Savings by Division

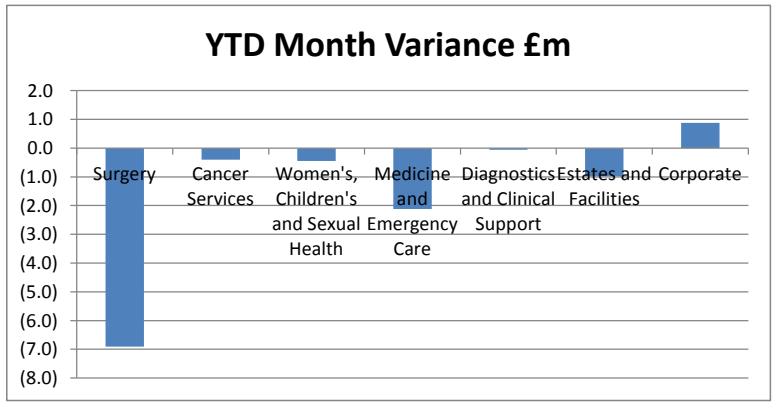
	Current Month			Year to Date			Forecast (Risk Adjusted)		
	Actual	*Original Plan*	*Variance*	*Actual*	*Original Plan*	*Variance*	*Forecast*	*Original Plan*	*Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Surgery	0.13	1.29	(1.16)	3.09	10.00	(6.91)	3.22	11.29	(8.07)
Cancer Services	0.08	0.14	(0.05)	0.75	1.15	(0.41)	0.83	1.29	(0.46)
Women's, Children's and Sexual Health	0.12	0.23	(0.11)	1.43	1.88	(0.45)	1.56	2.11	(0.55)
Medicine and Emergency Care	0.13	0.46	(0.33)	1.09	3.20	(2.11)	1.23	3.66	(2.43)
Diagnostics and Clinical Support	0.05	0.08	(0.02)	0.67	0.73	(0.05)	0.77	0.81	(0.04)
Estates and Facilities	0.17	0.40	(0.23)	1.57	2.55	(0.98)	1.93	2.95	(1.02)
Corporate	0.29	0.22	0.07	2.67	1.79	0.88	4.47	2.01	2.46
Total	**0.99**	**2.82**	**(1.83)**	**11.27**	**21.30**	**(10.03)**	**14.00**	**24.11**	**(10.11)**

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	0.22	0.15	0.06	2.38	3.02	(0.64)	2.59	3.17	(0.58)
Non Pay	0.77	1.02	(0.25)	7.97	7.38	0.59	9.00	8.40	0.60
Income	0.00	1.64	(1.64)	0.93	10.90	(9.98)	2.42	12.55	(10.13)
Total	**0.99**	**2.82**	**(1.83)**	**11.27**	**21.30**	**(10.03)**	**14.00**	**24.11**	**(10.11)**

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	0.60	1.87	(1.27)	8.87	15.13	(6.26)	11.01	16.99	(5.98)
Amber	0.30	0.31	(0.02)	1.70	2.42	(0.71)	2.19	2.73	(0.53)
Red	0.09	0.64	(0.54)	0.70	3.76	(3.06)	0.79	4.39	(3.60)
Total	**0.99**	**2.82**	**(1.83)**	**11.27**	**21.30**	**(10.03)**	**14.00**	**24.11**	**(10.11)**



Comment

The Trust was £1.8m adverse to plan in the month and £10m adverse YTD. The main schemes adverse to plan YTD are:
- STP Medical Rates £1.5m (£0.2m adverse in month)
- Prime Provider £4.7m (£0.9m adverse in month)
- Private Patient Income £0.9m (£0.1m adverse in month)
- Estates and Facilities £1.1m (£0.3m adverse in month)

The Trusts risk adjusted savings forecast is £10m 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 £1.2m)
- Private Patient Income = £1m
- STP Medical Rates = £1.7m
- Prime Provider = £5.5m
- Medicines Management = £1.1m (£0.7m relates to Avastin)
- Urgent Care Centre = £0.4m

The year end forecast includes £1.5m non recurrent income overperformance to plan.

Maidstone and Tunbridge Wells NHS Trust

4a. Year End Forecast (Pre PSF) - Risk and Assumptions

Year End Forecast February 2018/19

Year End Forecast - Pre PSF £m

	Actual										Forecast				
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Forecast	Budget	Variance
Income	35.2	38.0	36.7	40.3	37.8	36.0	39.4	39.5	37.4	37.1	35.0	38.6	451.1	458.6	-7.5
Pay	-22.0	-22.7	-21.9	-23.2	-22.3	-22.5	-20.7	-22.7	-22.8	-23.0	-23.0	-23.2	-270.1	-270.6	0.5
Non Pay	-13.5	-14.3	-13.2	-14.9	-13.8	-12.7	-14.5	-13.6	-13.2	-14.3	-13.9	-14.4	-166.3	-161.8	-4.4
Other Finance Costs	-2.5	-2.5	-2.5	-2.5	-2.5	-2.7	-2.7	-2.5	-2.5	-2.5	1.4	6.8	-17.1	-28.2	11.1
Technical Adjustments	0.0	0.0	0.0	0.0	0.0	0.1	0.3	0.0	0.0	0.0	0.0	0.7	1.4	1.1	0.3
Surplus/ Deficit (-) to B/E Duty	**-2.8**	**-1.4**	**-0.9**	**-0.3**	**-0.8**	**-1.9**	**1.8**	**0.8**	**-1.1**	**-2.6**	**-0.5**	**8.6**	**-1.0**	**-1.0**	**0.0**

Key Assumptions

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Asset Sales	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.9	10.0	**14.0**
Non Recurrent Income Support	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.6	1.4	0.0	0.0	2.3	**5.3**
Risk Reserve - West Kent	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	**1.6**
Cancer and RTT Income - Phase 1 (Net)	0.0	0.0	0.0	0.0	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	**0.8**
Cancer and RTT Income - Phase 2 (Net)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.2	0.3	0.3	**1.1**
Partially Completed Spells	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	**0.5**
Clinical Income - Oral Chemo	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3	**0.3**
Risk Reserve -High Weald	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.2**
Total Key Assumptions	**0.2**	**0.2**	**0.2**	**0.2**	**0.3**	**0.3**	**0.3**	**2.0**	**2.3**	**0.4**	**4.4**	**13.1**	**23.7**

Commentary

The Trust is forecasting to deliver the plan however has the following assumptions are included in the forecast;

- **Asset Sales.** The Trust is pursuing disposals that will increase the profit on sale of assets to £14m, an additional £10.7m over plan and i nitial mitigations. This has included discussions with NHSI CFO, the Capital and Cash team and the Regional Finance Team. The first disposal (£3.9m benefi t) was completed in February.

- **Risk Reserve** – Criteria to access the risk reserve has been triggered. West Kent CCG risk reserve has been agreed, seeking final confirmatio n from High Weald / Sussex CCGs.

- **Cancer and RTT Income** – Additional support has been agreed from WK CCG to cover the costs of improvements to Cancer and RTT performance in an open bo ok way. Contract variations are being enacted.

- **Non Recurrent Provider Support** – this has been agreed with commissioners and system partners.

- **Additional Recovery Plan** – Divisions meeting with CEO and CFO on a weekly basis to review financial recovery plans.

Maidstone and Tunbridge Wells NHS Trust

5a. Balance Sheet

February 2019

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	February Reported	February Plan	Variance	January Reported
Property, Plant and Equipment (Fixed Assets)	287.4	288.9	(1.5)	289.5
Intangibles	2.3	2.0	0.3	2.4
PFI Lifecycle	0.0	0.0	0.0	0.0
Debtors Long Term	1.5	1.2	0.3	1.2
Total Non-Current Assets	**291.2**	**292.1**	**(0.9)**	**293.1**
Current Assets	0.0	0.0	0.0	0.0
Inventory (Stock)	7.7	7.9	(0.2)	8.2
Receivables (Debtors) - NHS	25.7	27.4	(1.7)	26.8
Receivables (Debtors) - Non-NHS	10.7	10.0	0.7	13.6
Cash	10.6	1.0	9.6	8.0
Assets Held For Sale	0.0	0.0	0.0	0.0
Total Current Assets	**54.7**	**46.3**	**8.4**	**56.6**
Current Liabilities				
Payables (Creditors) - NHS	(3.8)	(4.0)	0.2	(4.1)
Payables (Creditors) - Non-NHS	(40.6)	(40.2)	(0.4)	(40.0)
Deferred Income	(8.4)	(4.1)	(4.3)	(11.5)
Capital Loan	(2.3)	(2.2)	(0.1)	(2.3)
Working Capital Loan	(29.3)	(12.1)	(17.2)	(29.3)
Other loans	(0.4)	(0.1)	(0.3)	(0.4)
Borrowings - PFI	(5.0)	(5.3)	0.3	(5.0)
Provisions for Liabilities and Charges	(1.8)	(2.0)	0.2	(1.8)
Total Current Liabilities	**(91.6)**	**(70.0)**	**(21.6)**	**(94.4)**
Net Current Assets	(36.9)	(23.7)	(13.2)	(37.8)
non-current liabilities: Borrowings - PFI > 1yr	(188.3)	(188.4)	0.1	(188.8)
Capital Loans	(9.3)	(11.6)	2.3	(9.1)
Working Capital Facility & Revenue loans	(14.0)	(19.9)	5.9	(14.1)
Other loans	(1.4)	(1.3)	(0.1)	(1.4)
Provisions for Liabilities and Charges- Long term	(0.8)	(0.7)	(0.1)	(0.9)
Total Assets Employed	**40.5**	**46.5**	**(6.0)**	**41.0**
Financed By:				
Capital & Reserves				
Public dividend capital	209.0	207.3	1.7	209.0
Revaluation reserve	29.8	29.8	0.0	29.8
Retained Earnings Reserve	(198.3)	(190.6)	(7.7)	(197.8)
Total Capital & Reserves	**40.5**	**46.5**	**(6.0)**	**41.0**

Commentary:

The month 11 balance sheet position is consistent with the plan that was submitted in June. The overall working capital within the month results in a small decrease in debtors and a slight increase to 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 the sale of 32 High Street in February which was not included within the plan.

Non-Current Assets -

Capital additions for 2018/19 have reduced from the plan of £14.46m to £13.7m 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 has remained unchanged from the planned spend of £0.7m. The planned depreciation for the year has also been revised from £13.5m to £13m to reflect the slippage in the capital programme. The month 11 capital spend is £0.4m against a plan of £2.5m.

Current Assets -

Inventory of £7.7m is in-line of the planned value of £7.9m. The main stock balances are pharmacy £2.6m, TWH theatres £1.5m, Materials Management £1.1m and Cardiology £1.1m.

NHS Receivables have decreased from the month 10 position by £1.1m to £25.7m. Of the £25.7m reported balance, £9.2m relates to invoiced debt of which £2.5m is aged debt over 90 days. Invoiced debt over 90 days has decreased by £0.1m from the mth 10 reported position. The remaining £16.5m relates to uninvoiced accrued income including work in progress partially completed spells and a accrual for m7-9 PSF funding £3.8m. 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 by £2.9m to £10.7m from the month 10 reported position. Included within the £10.7m balance is trade invoiced debt of £2.4m and private patient invoiced debt of £0.4m. Also included within the £10.7m are prepayments and accrued income totalling £6m. 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 £10.6m is higher than plan of £1m by £9.6m. In February the Trust sold its residence property at TW, with sale proceeds of c£5.65m which was not included within the plan. WKCCG also paid invoices totalling £2.5m in February which were planned to be received in March.

Current Liabilities -

NHS payables have decreased from the January's reported position by £0.3m to £3.8m. Non-NHS trade payables have increased slightly by £0.6m giving a combined payables balance of £44.4m.

Of the £44.4m combined payables balances, £9.9m relates to actual invoices of which £4.7m are approved for payment and £34.5m relates to uninvoiced accruals. The accruals include expected values for Tax , NI, Superannuation and PDC payments.

Deferred income of £8.4m primarily is in relation to £1.6m advanced contract payment received from WK CCG and £2m from High Weald CCG in April, both these will be cleared by the financial year end. Other items within the deferred income balances are £1.9m maternity pathway, Education and Training £1m.

The Trust has 3 working capital loans totalling c£43m. Two of the working capital loans are in current liabilities, £16.9m due February 2019 which has been extended by NHSI and £12.132m which is due to be repaid in October 2019. The remaining £14m loan is due to be repaid in 2020/21 and is in non-current liabilities.

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

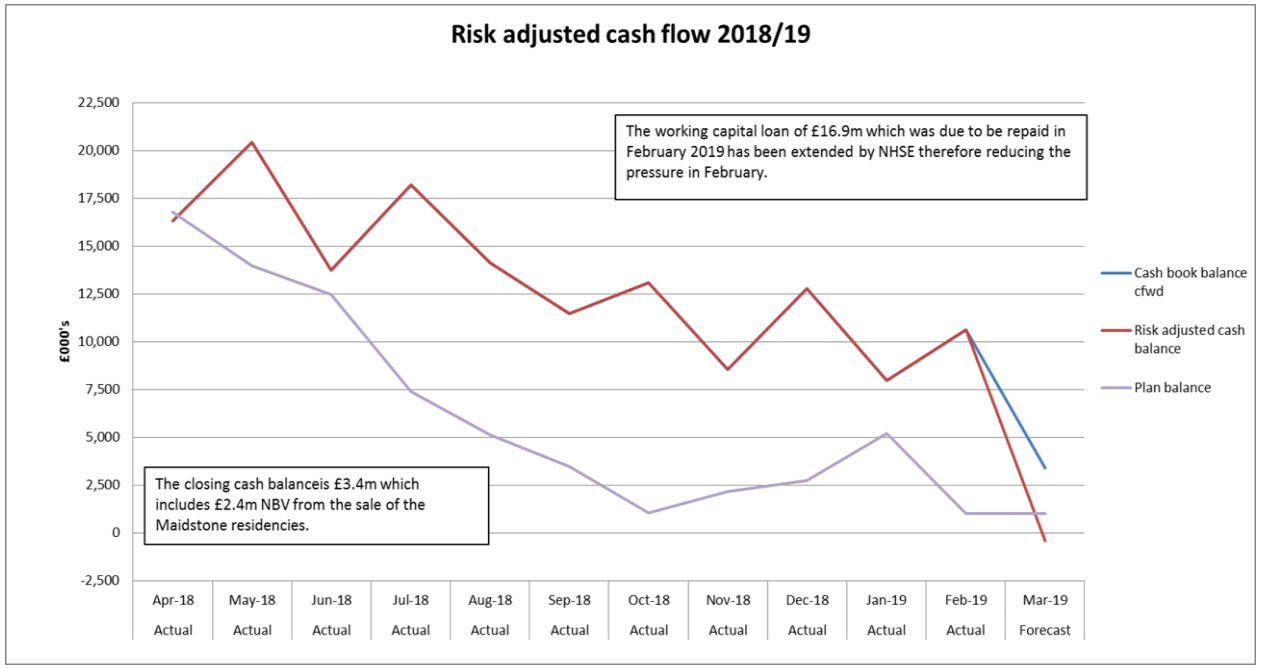
Revised FOT

Due to the extension of the single currency loan of £16.9m the Trust will not be requesting any additional financing, previously the Trust was planning on taking an additional loan of between £6m and £13m to assist with the repayment.

The Trust is planning to sell the Maidstone residencies in March and is requesting to NHSI to carry forward the NBV of £2.4m, therefore the closing cash position has increased from £1m to £3.4m. Additionally the Trust is requesting to NHSI if it is able to carry forward any additional proceeds to use for capital projects in 2019/20, currently the balance shows the proceeds reducing trade payables in the FOT position

Maidstone and Tunbridge Wells NHS Trust

5b. Cash Flow



Information on loans:

	Rate	Value £m's	18/19 Annual Repayment £m's	18/19 Annual Interest Paid £m's	Repayment Date
Interim Single Currency Loan					
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
interim working capital loans	3.50%	2.544	2.54	0.06	14/01/2019
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)	0.00%	2.217	0.37	0.00	2024/25

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 and including January and the forecast is based on the latest I&E forecast before additional recovery measures.

In February the Trust sold its residential property of 32 High Street, Pembury with proceeds of c£5.65m which was not included within the plan. The Trust will use £1.6m which is the NBV of the asset to fund additional capital projects in 2018/19.
In March the Trust is planning to sell its Maidstone residences for c£12.5m. The Trust is seeking approval from NHSI to carry forward the NBV of £2.4m into 2019/20 to fund capital projects. Additionally the Trust will request to carry forward more of the proceeds to fund capital projects. The cash flow is balancing back to the £3.4m closing cash balance by paying supplier invoices therefore reducing the creditor balance carry forward. If the Trust is given approval to carry forward an additional value (current expectation of an additional £6m) the Trust will not release as much to creditors.
There is a risk that NHSI will require the Trust to repay an element of the outstanding loan balance instead of being able to carry forward any additional cash balance.

The Trust has been given an extension from NHSI in respect to repaying the Single currency interim loan of £16.9m which was due to be repaid in February.
Confirmation of the length of extension is still waiting notification from NHSI.
In 2019/20 the Trust has to repay its second working capital loan of £12.132m, therefore potentially the Trust may have to repay both these loans within the same year.
The third working capital loan totalling £13.99m is due for repayment in 2020/21.

The risk adjusted items relate to:
In March the Trust is forecasting receipt of £3.8m quarter 3 PSF funding, if this is not received the Trust will review supplier payments for the remainder of the financial year.
In respect to all of the risk items which relate to capital including the planned asset sales of £2.4m. If the income or external financing are not received the associated expenditure will not happen.

Maidstone and Tunbridge Wells NHS Trust

5c. Capital Programme

Capital Projects/Schemes

	Year to Date			Annual		
	Plan	*Actual*	*Variance*	*Plan*	*Forecast*	*Variance*
	£000	£000	£000	£000	£000	£m
Estates	2,986	2,661	325	5,788	4,001	-1,787
ICT	952	1,179	-227	1,002	2,562	1,560
Equipment	7,005	3,438	3,567	6,501	5,976	-525
PFI Lifecycle (IFRIC 12)	233	373	-140	471	471	0
Donated Assets	680	0	680	700	697	-3
Total	**11,856**	**7,651**	**4,205**	**14,462**	**13,707**	**-755**
Less donated assets	-680	0	-680	-700	-697	3
Asset Sales (net book value)	0	-1,632	1,632	-2,402	-1,632	770
Contingency Against Non-Disposal						
Adjusted Total	**11,176**	**6,019**	**5,157**	**11,360**	**11,378**	**18**

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 £13.7m which takes account of: 1) Linac 5 funding is £32k less than plan; 2) the outturn forecast for depreciation is £463k 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) the majority of the HODU/Cardiology has been removed, leaving £142k for the Cardiology enabling works 6) additional PDC funding for Linac 6 (£1.7m), ICT schemes (£1m), MRI scanning (£10k) and Pharmacy IT (£16k)

The Trust has recently sold the property at 32 High Street, Pembury with a Net Book Value of £1.63m

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 are progressing and expected to be completed by 31st March. The EPR project is well underway.

The prioritised list of equipment schemes was approved by TME and Execs, subject to individual Business case approval. Some equipment schemes have been deferred to support the ICT EPR project. Linac 4 replacement at Maidstone is now up and running. Linac 5 machine was delivered in December and is currently being commissioned for clinical use. Linac 5 replacement funding has been agreed with NHSE as additional PDC from the national programme. Additional funding for Linac 6 has also been agreed in this financial year, the machine will be delivered on 29th March to an off-site storage warehouse until ready for installation in July.

The donated equipment plan is mainly made up of the remaining Cardiology legacies, and a large donation for Urology/Oncology equipment, which are being delivered by the end of the financial year.

Trust Board Meeting – March 2019

NHS Maidstone and Tunbridge Wells NHS Trust

3-9	Summary report from the Finance and Performance Committee, 26/03/19	Committee Chair (Non-Exec. Director)

The Finance and Performance Committee met on 26th March 2019.

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

- It was agreed that best practice from similar meetings at the Trusts rated as "Outstanding" by the Care Quality Commission should be sought, to assess whether any aspects should be adopted by the Committee. It was confirmed that a report would be considered at the May 2019 meeting. It was also agreed to replace the "Safety Moment", with a "Finance or performance moment".
- The month 11 financial performance was reviewed in detail, and it was noted that several judgements were required by the Executive Team in relation to the 2018/19 year-end financial position. It was therefore agreed that the Chief Finance Officer should arrange for Committee members to be notified (before the next meeting) of the judgements made.
- The financial aspects of the Best Care programme were reviewed. The Committee recognised that the approach in the coming year will be developing with a focus on organisation wide transformation schemes supporting Divisions. There would also be a clearer distinction from Cost Improvement Programme (CIP) delivery.
- The month 11 non-finance related performance was discussed, which included the A&E 4-hour, Referral to Treatment (RTT), and 62-day Cancer waiting time targets. The Committee noted the strong performance and effort being made to meet the 4-hour target particularly. It was also understand that cancer compliance would deteriorate with the focus on managing the backlog. The Committee agreed this approach was the right one in the long run to deliver sustainable improvement.
- A report on RTT data quality was considered, which clarified the size of the current data validation requirement and the next steps needed to address this. There was consensus in supporting moving this work forward at pace subject to review of the final estimate of costs by the Executive.
- The Director of Strategy, Planning and Partnerships presented the Trust's final 2019/20 plan. The plan was discussed in detail and the Committee confirmed it was content to recommend that the Trust Board approve the plan recognising that there were still elements needing to be finalised in the coming days. This particularly related to commissioning levels regarding RTT. The financial plan was also discussed at length. It was noted that additional support was being put in place to help Divisions develop and deliver their CIPs & this was welcomed. There were a high number of schemes rated red or amber which needed attention in the coming weeks. The Committee supported the Executive view of a need for strong delivery against targets in Quarter 1 – both financial & operational.
- The usual update on the Lord Carter efficiency review (incl. SLR) was given and it was agreed that the report submitted to the June 2019 Committee should include details of the improvements made from the use of Model Hospital data
- The latest six-monthly update on the options being considered in relation to the PFI contract at Tunbridge Wells Hospital was received, and the Committee was given assurance that there would be no disruption in the service provided by Interserve (which went into administration in March 2019)
- The standing "Breaches of the external cap on Agency staff pay rate" report was noted, as were the recent uses of the Trust's Seal

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

- The Chief Finance Officer and Chief Operating Officer should develop the performance reporting to include a shift of emphasis towards forecasting and address the 'governance questions' identified at Trust Board 'Away Day' held on 04/12/18
- The Trust Secretary and Committee Chair should liaise to finalise the practical aspects of implementing the "Finance or performance moment" item at future Committee meetings
- The errors on the "Underlying Deficit to 2019/20 Plan" chart submitted to the Committee on should be corrected and re-submitted to the Trust Board, ahead of its meeting on 28/03/19

- The Chief Operating Officer should prepare a report on the sustainability of the recovery of the 62-day Cancer waiting time target
- The Chief Operating Officer and Trust Secretary should arrange for an "Update on Wells Suite income" report to be submitted to each Committee meeting, from April 2019

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

- The Committee confirmed it was content to recommend that the Trust Board approve the 2019/20 plan that was reviewed at the meeting

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 – March 2019

Maidstone and Tunbridge Wells NHS Trust

3-9	Summary report from the Patient Experience Committee, 05/03/19	Committee Chair (Non-Executive Director)

The Patient Experience Committee (PEC) met on 5th March 2019.

The key matters considered at the meeting were as follows:

- An update on actions raised at previous meetings was noted, which included consideration of the arrangements in place for patients requiring assistance from the car park to the main hospital buildings
- The draft Patient and Carer Experience Strategy, "Making it Personal" was considered and endorsed. It was noted that final feedback on the strategy was due by 18/03/19 and agreed to schedule a further review of the Strategy's progress for the PEC meeting in June. It was additionally agreed that the annual review of the PEC Terms of Reference (ToRs), scheduled for the June meeting, should be expanded to include consideration of how support for the Strategy might be incorporated into the ToRs
- The Deputy Chief Nurse proposed a case for change relating to how the Trust collected patient feedback through the local Inpatient survey, on the basis that response rates had reduced to such an extent that the findings were no longer a reliable information source. The Committee supported the proposal that the local survey be discontinued and feedback sought in a more accessible way through a refreshed Friends and Family Test, alongside feedback and assurance obtained through internal assurance inspections, and other measures
- An update was given on progress against the Quality Accounts priorities, 2018/19 and the proposed priorities for 2019/20 were considered. Committee members were invited to submit their own ideas and comments on the proposals by 18/03/19
- The latest Sentinel Stroke National Audit Programme (SSNAP) data for the Trust was reported, confirming that Maidstone Hospital had achieved an A rating and Tunbridge Wells Hospital a C rating. An update on the plans to develop a Hyper Acute Stroke unit on the Maidstone Hospital site, and associated build of a new Acute Medical Unit, was given
- An update on the Trust's ambulance handover performance was reported
- The Deputy Chief Nurse reported on the significant progress made by the Trust against Healthwatch's previously reported Accessible Services recommendations
- It was confirmed that the Patient and their Medicines Working Group had been relaunched with a focus on time critical medicines and self-management of medicines and that the Group would include Trust staff and patient representatives
- A report on Complaints and PALS contacts was received and noted. The Committee agreed that it would be useful for future reports to provide a more focussed update on key identified themes and changes made/required in response to them, and that this request should be conveyed to the Complaints and PALS manager (who was unable to attend the meeting)
- A report on the outcome of the latest Quality Assurance Rounds was received and the schedule of planned visits noted. There was a query about volunteer involvement in the Rounds and it was confirmed that visits were routinely undertaken with public/patient representatives, but that this had exceptionally not occurred in February due to the Round taking place in Escalation areas. It was agreed that the Deputy Chief Nurse would liaise with the Voluntary Services Co-ordinator on the comments made at the meeting about volunteer involvement in the Quality Assurance process
- A newly formatted report from the Patient-Led Assessments of the Care Environment (PLACE) Action Group was received and it was agreed that consideration should be given to the comments received at the meeting on the value of "soft intelligence" collected as part of the PLACE programme and how it might be incorporated into and used in future PLACE updates. It was confirmed that a newsletter had recently been circulated to 300 volunteers to promote engagement with the PLACE inspection process and the Deputy Chief Nurse agreed to check if this had been distributed in the League of Friends shop at Maidstone Hospital and advertised via Twitter
- An activity report from Healthwatch Kent was noted, which included a report on patient feedback for the period April 2018 to September 2018

- The Associate Director Quality Governance provided an update on the work of the Patient Information and Leaflets Group (PILG), which included confirmation of plans to archive out of date policies not confirmed as being subject to active review
- A report from the Quality Committee meetings on 11/12/18, 16/01/18 and 06/02/19 was noted

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

- That the issues raised at the meeting around the introduction of charges by the cash machine at Maidstone Hospital should be clarified and developments updated to the Committee
- That a presentation / update on the introduction of an Electronic Patient Record system within the Trust should be scheduled for the next PEC meeting on 10/06/19

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 – March 2019

NHS Maidstone and Tunbridge Wells NHS Trust

3-9	**Summary report from Quality Committee, 13/03/19**	**Committee Chair (Non-Executive Director)**

The Quality Committee met on 13th March 2019 (a 'main' meeting).

1. The key matters considered were as follows:

- The Clinical Director for Theatres and Critical Care gave an **update on the concerns** he had raised at the last 'main' meeting **regarding the Consent to Treatment and pre-Theatre processes**. This noted that a group had been formed to discuss the issues, and a cluster of Serious Incidents (SIs) had been declared which would be fully investigated. It was also noted that the work would inform the development of a revised Consent to Treatment policy
- The **Children's Services** & **Medical Specialities** Directorates presented their latest **clinical outcomes reports**, both of which highlighted the importance of having the correct medical workforce. The ensuring discussions acknowledged the efforts both Directorates were making to improve that aspect, including the development of long term staffing plans and Business Cases for additional Consultant cover
- The report of recent **Trust Clinical Governance Committee** meetings was discussed, and those present at the meeting reported the key issues from their areas, which included staffing vacancies, SIs, patient falls, and some IT-related issues
- The Deputy Medical Director presented a **response to the issues arising from the "Patient experience" item at the 'Trust Board meeting on 28/02/19**. It was agreed that the Chairs of the Trust Board and Quality Committee would liaise, to arrange for a letter to be sent to the parents of the patient concerned, confirming that a response had been discussed at the Committee. It was also agreed that the Deputy Medical Director would submit a brief update report to the 'Part 2' Trust Board meeting on 28/03/19, and submit a more detailed update on the response to the issues to the 'main' Quality Committee in May 2019
- The Medical Director presented the **outcome of the general review of Trust quality** that had commenced in the autumn of 2018. The key issues raised were the adverse effect that bed occupancy appeared to have on quality, and the fact that SIs was the Medical Director's area of most concern. It was noted that the intended implementation of a new incident IT system was hoped to improve the Trust's processes, but full implementation would take 6 months once the order was placed
- The **draft quality priorities for 2019/20** (for the Quality Accounts 2018/19) were reviewed
- The **Meticillin-sensitive Staphylococcus aureus (MSSA) action plan** was reviewed
- The standing updates on **mortality** and **SIs** were given, and the reports of the **Quality Committee 'deep dive' meeting** held on 06/02/19 and **recent findings from relevant Internal Audit reviews** were noted
- A report from West Kent CCG on **MTW Quality concerns, support and monitoring** was noted, but as it was issued late, it was agreed to be considered again at the May meeting
- The Chief of Service for Surgery submitted an **Emergency Laparotomy Pathway.** It was noted that there may be an external requirement for this to be approved by the Trust Board, and that point would be clarified with Commissioners. However, as the pathway needs to be approved by the end of March, it has been included in Appendix 1, and the Board is asked to approve it, on recommendation from the Quality Committee

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

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

- The Deputy Medical Director presented a response to the issues arising from the "Patient experience" item at the 'Trust Board meeting on 28/02/19
- The Trust Board is asked to approve the Emergency Laparotomy Pathway in Appendix 1

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

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

1. Information and assurance
2. To approve the Emergency Laparotomy Pathway in 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

Appendix 1: Emergency Laparotomy Pathway (for approval)

MTW Emergency Laparotomy Pathway

For all patients who may require non-elective abdominal surgery on the GI tract (Open or Laparoscopic)

*Except: Appendicectomy / Cholecystectomy / Complication of non-GI surgery**

Screening and resuscitation

- NEWS2 within 30 mins (escalate as per Trust Escalation Policy)
- Lactate / FBC / U+Es / LFTs / Amylase / G+S
- Screen and treat for sepsis as per Trust Sepsis Policy
- Commence IV fluid resuscitation
- ST3+/Consultant to request CT scan (State "Code Laparotomy" when requesting)

⇩

Diagnosis and Plan

- Senior Surgical Review
- P-POSSUM / NELA Risk scoring / Frailty Score
  - If mortality risk ≥ 20% pre– op MDT discussion required (Consultant Anaesthetist/Surgeon/Intensivist)
- Theatre Booking (Surgeons)
  - Complete Sections 1—3 of electronic NELA form at: https://data.nela.org.uk
  - Complete Theatre Booking Form
  - Discuss with Anaesthetist and inform Critical Care

Surgical Consultant to ensure NELA sections 1—3 completed prior to surgery

⇩

Surgery and Post-operative Care

- Knife to skin within 6 hours of decision to operate for Urgent / Emergency Cases
- Consultant Anaesthetist and Surgeon in theatre
- Intra-operative Goal-directed Fluid Therapy
- Complete Sections 3—6 of electronic NELA form (Anaesthetist)
- Critical Care Post operatively with daily surgical review
- Consider referral to elderly care.

Anaesthetic Consultant to ensure NELA sections 3—6 completed before patient leaves theatres

* For further information (including full inclusion/exclusion criteria) search for "NELA" on the Trust Intranet or see www.nela.org.uk

NELA National Emergency Laparotomy Audit

Trust Board meeting – March 2019

NHS Maidstone and Tunbridge Wells NHS Trust

3-10 6-monthly review of Nurse staffing Ward and non-Ward areas Chief Nurse

Summary / Key points

This paper provides the board with the outcomes of the staffing establishment reviews that have been undertaken in non-ward areas, ward areas and specialities across the organisation It is critical that the Trust has the right level of staff in place to support the on-going ability of the nursing and midwifery workforce to deliver high quality care.

The review is in line with recommendations set out by the National Quality Board (NQB) 'Right staff, right Skills, in the right place' (2013), 'Safe, sustainable productive staffing' (July 2016) and the new Developing workforce safeguards: Supporting providers to deliver high quality care through safe and effective staffing (October 2018).

Section 1 of the report covers the review outcomes for Non ward areas and Specialities to include:

- Accident & Emergency
- Paediatrics
- Critical Care
- Theatres
- Head & Neck
- Oncology
- Maternity
- Gynaecology
- Endoscopy

Recommendations from relevant Royal Colleges, professional bodies and NICE guidance have been considered where appropriate.

Section 2 of the report focuses on the review outcomes of the In Patient Ward Areas:

Maidstone Hospital	**Tunbridge Wells Hospital**	
Ambulatory Medical Unit (AMU)	Short Stay Surgical Unit (SSSU)	
Acute Stoke Unit (ASU)	Surgical Assessment Unit	
Chaucer Ward	Ambulatory Medical Unit (TAMU)	
Cornwallis	Coronary Care Unit (CCU)	
Culpepper / CCU	Ward 2 / Acute Frailty Unit	
John Day	Ward 10	Ward 22
Lord North	Ward 11	Ward 30
Mercer	Ward 12	Ward 31
Maidstone Orthopaedic Unit	Ward 20	Ward 32
Maidstone Short Stay Surgical Unit (MSSU)	Ward 21	Ward 33
Peale		

Ward establishments were reviewed in line with National Quality Board Guidance (2016), NICE guidance (2017), Shelford Acuity & Dependency model and Professional Judgement (Telford) model, Carter Model Hospital (CHPPD) and Developing workforce safeguards: Supporting providers to deliver high quality care through safe and effective staffing (October 2018).
There are a number of changes that are being explored which will potentially alter the skill mix of

our teams. Some examples of ideas that are being considered include the appointment of a dual trained role for an Adult and RMN nurse to manage the increasing demand on mental health attendances within the emergency department and Orthopaedics, Oncology and respiratory services are considering the benefit of having a physiotherapist on the ward as part of the ward establishment

As part of any proposed change in skill mix, there will need to be a formal review of skill mix supported by the completion of a quality impact assessment undertaken to ensure that any impact on the provision of safe staffing is clearly understood.

New ways of working to deliver safe, effective and high quality care was the subject of much discussion and in line with workforce recommendations. Services continue to need to consider the integration of new roles and apprenticeships as we begin to map out what a future nursing workforce looks like with the inclusion of roles including the Trainee Nursing Associates, Nursing Associates, CSW apprenticeships and potential apprenticeships in development.

The Advanced Clinical practice competency framework is allowing us to consider the ongoing development of new advanced roles that will enhance our patient pathways but also support us in meeting the wider workforce needs.

In summary the budget establishment for the departments is broadly correct when at establishment. The key challenges remain centred on recruiting to establishments. The approach of funding to planned substantive and temporary staffing may have had some perceived impact on recruitment however there is no evidence to suggest that opportunity to recruit suitably qualified staff has been missed.

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

[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

Report to: **Trust Board**

Report from: **Claire O'Brien - Chief Nurse**

Date: **March 2019**

Subject **Nursing & Midwifery Staffing Review :**
A Comprehensive review of Maidstone and Tunbridge Wells NHS Trust Ward Areas, Non-Ward Areas and Speciality Services.

1. Introduction:

1.1 This paper provides the board with information relating to staffing establishment reviews undertaken in non-ward areas, ward areas and specialities.

1.2 This is in line with recommendations set out by the National Quality Board (NQB) 'Right staff, right Skills, in the right place' (2013), 'Safe, sustainable productive staffing' (July 2016) and the new Developing workforce safeguards: Supporting providers to deliver high quality care through safe and effective staffing (October 2018).

Section 1 of the report covers Non ward areas and Specialities to include:

- Accident & Emergency
- Paediatrics
- Critical Care
- Theatres
- Head & Neck
- Oncology
- Maternity
- Gynaecology
- Endoscopy

Section 2 of the report focuses on the In Patient Ward Areas to include:

Maidstone Hospital

Ambulatory Medical Unit (AMU)
Acute Stoke Unit (ASU)
Chaucer Ward
Cornwallis
Culpepper / CCU
John Day
Lord North
Mercer
Maidstone Orthopaedic Unit
Maidstone Short Stay Surgical Unit (MSSU)
Peale

Tunbridge Wells Hospital

Short Stay Surgical Unit (SSSU)
Surgical Assessment Unit
Ambulatory Medical Unit (TAMU)
Coronary Care Unit (CCU)
Ward 2 / Acute Frailty Unit

Ward 10	Ward 22
Ward 11	Ward 30
Ward 12	Ward 31
Ward 20	Ward 32
Ward 21	Ward 33

2. Background

2.1 The NQB published guidance on nursing and midwifery staffing capacity and capability in November 2013.

2.2 The document sets out to articulate the underpinning principles of setting safe staffing levels, ensuring that wards have not only the right numbers of staff but have staff with the right skills. The document acknowledges that mandating for minimum numbers or ratios 'misses the point', rather hospitals should use an evidence base approach to support professional judgement, as no one model will fit all specialties at all times.

The NQB published further guidance in July 2016 (with updates in 2017) to support the provision of safe, sustainable and productive staffing. This document sets out 3 expectations that are applicable to all acute care settings (where the previous document focussed primarily on in-patient ward areas).

These expectations are:

Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff: 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

More recently NHS improvement published the Developing workforce safeguards: Supporting providers to deliver high quality care through safe and effective staffing (October 2018). This new guidance was published to address an identified gap in support around workforce design and deployment for safe staffing planning with recommendations to ensure a consistent approach setting out good practice for:

- Effective workforce planning
- Deployment of staff by using evidence based tools
- Governance considerations when redesigning roles/skills mix
- Responding to unplanned workforce challenges

2.3 There is a requirement that Trusts formally ensure NQB's 2016 guidance is embedded in their safe staffing governance and ensure the triangulated approach is used in their safe staffing processes which include:

- evidence-based tools (where they exist)
- professional judgement
- outcomes

Based on patients' needs, acuity, dependency and risks,

2.4 The purpose of this review is to address Expectation 1 and 2 as set out by the NQB and to move to compliance in the recommendations set out the NHSi Developing workforce safeguards with consideration to new roles and integrating these into workforce plans.

2.5 The NQB recommend the use of other quality data sets to inform professional judgement including acuity and dependency tools, review of incident data, completion of key clinical processes such as drug administration, sickness/absence, and user feedback.

In addition to this, relevant guidance from the National Institute for Health and Care Excellence (NICE) and relevant Royal Colleges and professional bodies have been considered. This will be noted in the body of the report as appropriate.

2.6 Other elements of the NQB expectations, as outlined above, are supported via a number of work streams within the Best Care Programme.

3. Methodology:

3.1 The key methodology used for the establishment review is the Professional Judgement (Telford) model the National Audit Commission, endorsed by the RCN, supported by the NQB and NHSi Developing Workforce Standards. For ward areas the Carter Model was applied to include consideration of Care hours Per Patient Day (CHPPD).

3.2 There is an expectation that the reviews should ideally be a combination of 'bottom-up'; that is informed by the Ward / Unit / Speciality team led by the Ward Sister / Unit manager , and 'top-down'; informed by the Chief Nurse, Divisional Directors of Nursing and Quality and Head of Midwifery. Discussion / review meetings in MTW included Ward / Unit Manager, Matron, Finance Manager, Divisional Director of Nursing and Quality, Deputy Chief Nurse using a triangulation of ward quality indicators (pressure injury, falls, medication administration errors, nursing care complaints and FFT results), performance and incidence.

3.3 The review period for non-ward areas took place during June / July 2018 and for ward areas and specialities during November 2018 through to January 2019. Quarter 3 data has been used during and post-meeting analysis. Consideration has also been given to the following:

- Acuity & dependency (Shelford Acuity Tool/Safer Nursing Care Tool (SNCT)
- Geography of ward / unit and relationship with co-dependent departments (eg: surgical ward in relation to theatres).

3.4 To facilitate such a wide review across all of these services the reviews were staged over an extended period to ensure a comprehensive review of all ward, non-ward and speciality areas were included. The process was consciously undertaken at this time in the year to ensure that any recommendations for changes to establishments could be considered as part of the directorate business planning processes later in the year.

Any issues that might give cause for concern would have been escalated to the Chief Nurse, Chief Operating Officer and other relevant Executives throughout the review period should the need arise.

There were no issues of concern that required immediate escalation.

4.0 Section 1:

Non Ward Areas and Specialities Current Position:

Accident & Emergency:

4.1 Accident & Emergency (A&E) departments at both Maidstone and Tunbridge Wells were reviewed. Reference was made to NICE guidance for Safe Staffing in A&E departments (2015). It was acknowledged that this was only a consultation document, having never been finally published. Reference was also made to Royal College of Nursing (RCN) acuity and dependency tool for emergency care. This had been piloted previously, but there was

insufficient data to inform this round of discussions. This tool, whilst developed by the RCN, has not been fully validated.

Maidstone A&E

Maidstone A&E generally runs with 10 Registered Nurses (RN) per shift to cover the Resuscitation room (3 adults bays and 1 child bay), 2 rooms, 8 majors cubicles, 8 minors cubicles, 10 chairs, Clinical Decision Unit 6 chairs, Rapid Assessment (3 trolleys) and Triage.

This staffing profile provides a ratio of nurse to patients as:
1:2 in Resus
1:4 in Majors
This is in-line with current recommendations.

The unit also provides a paediatric service. This is staffed by an RN (Child) between 10am and 10pm. This is based on attendance data which indicates this is the peak period for paediatric attendances.
There is a business case awaiting consideration to increase paediatric RN provision in partnership with the Paediatric Directorate; however this needs to be considered in the wider context of future service developments.

Quality indicators

Time to triage: the waiting standard should be less than 15 minutes. At times this has been up to 60 minutes with one RN covering triage.
This data has been used to inform a business case for an additional RN to cover peak demand in the afternoons. This case has been approved.

Medication errors: the unit reports an average of 1 – 2 medication errors per month. Given the volume of attendances this may be lower than expected. However under reporting of medication error is a national issue. The emerging themes from incident reviews indicate the most common issue relates to penicillin allergy.

Falls: the unit is below agreed threshold consistently for patient falls within the department.

Pressure Ulcer incidence: the unit is rarely implicated in any pressure ulcer root cause analysis. The unit is frequently noted to have undertaken fully body assessments and body mapping and frequently completes datix reports and tissue viability referrals.

Complaints: complaints related to nursing care are low. When complaints are made, the themes generally relate to time of discharge.

Friends & Family: the unit achieves a return rate at or above the national average and achieves a level of positive scores well above the national average.

4.2 **Summary:** establishments are satisfactory if fully recruited to. This is with a reducing vacancy factor. Significant work has been undertaken to successfully recruit. Currently no paediatric trained nurse which is filled with temporary staffing. Consideration to be given to additional CSW to support flow in majors / resus with increasing attendances and consider new roles including an RMN across sites (ideally dual trained).

Recommendation: to undertake a further review of staffing requirements and impact of any future changes as part of the Quality Impact Assessment of service development such as RAP, AMU, HASU and geographical boarders.

Tunbridge Wells A&E

Tunbridge Wells A&E runs with 12RNs during the day, and 13 RNs (from June'18) at night. There are 3 Emergency Nurse Practitioners between 8am to mid-night.
This provides cover for 6 resus cubicles, 15 majors cubicles, 8 minors cubicles, 6 Rapid Assessment (RAP) cubicles, 6 clinical decision unit chairs, 10 red chairs and Triage.

This staffing profile provides a nurse to patient ratio of:

1:2 in resus
1:5 in majors
1:6 in RAP (+ a doctor)

There is a separate paediatric unit located adjacent to the main department. This is staffed by 1 RN (Child) and 1 Nursery Nurse, increasing to 2 RN (child) from 12.00 to 00.30 to cover peak demand.

Quality Indicators:
Medication error: only 1 error reported in the preceding 3 months. This related to a prescribing error rather than an administration error. This indicator was not considered a reliable indicator given the low reporting nature.

Falls: the unit has a low incidence of patient falls within the unit.

Pressure Ulcers: the unit is rarely implicated in any pressure ulcer root cause analysis. The unit is frequently noted to have undertaken fully body assessments and body mapping and frequently completes datix reports and tissue viability referrals. The unit also ensure adult safeguarding concerns, where related to community care, are reported.

Complaints: Lost property is a recurring theme. There was a background level of complaints relating to staff attitude, this was identified and rectified. Work is in progress Trust wide to review our procedures for the management of property.

Friends & Family: as with Maidstone, the unit generally has a good response rate, though it is more variable than Maidstone. Overall positive responses remain above the national average, and do not alter significantly when the response rate increases.

4.3 **Summary:** the key issue for the unit is the overall 72% vacancy factor and recruitment. The unit has (at the time of the review) 27.29 wte split between Bands 5 (31 vacant) and Bands 6 (10 vacant). There has been an impact on our ability to cover shifts following the STP agency review. This resulted in a review of internal enhancements to support and incentivise our own bank staff to work additional shifts. The team have been proactive in considering new roles and currently are supporting two trainee nursing associates (TNAs) in practice. They are actively considering how they can support ongoing development of their CSW workforce to enable them to progress onto TNA training and also considering how the role of the TNA role would work in the ED setting. The department are also considering dual roles including an RMN and adult trained role to support the increasing demand on mental health attendances within the emergency department

The team are fully engaged in recruitment work and actively support new roles and innovative ways of working including the trial of having paramedics within ED.

4.4 **Recommendation:** to undertake a further review of staffing requirements and impact of any future changes as part of the Quality Impact Assessment of service development which include: Additional staffing levels to fully meet recommended guidance would suggest requirement of the following which is being supported by the division as part of their business planning and their ongoing review of staffing:

Four Trained in majors to meet safe staffing recommendations as per RCN guidelines
Need additional CSW at night for minors to achieve 1:4 safe staffing
Need additional CSW for fit to sit with NIC oversight
Support 3rd resus nurse mon-fri
Increase CSW in RAP to have 2 24/7

4.5 **Paediatrics**

The majority of paediatric services are provided at the Tunbridge Wells Hospital. There is a paediatric provision at the Maidstone Hospital for day attenders, and Accident & Emergency department.

The service based at Tunbridge Wells provides an inpatient service for neonates, children and young people, accident & emergency cover, out-patient and community services.

This review considered the inpatient services. As part of this review reference was made to the relevant national guidance including the NQB 'Safe, sustainable and produce staffing. An improvement resource for children and young people's inpatient wards in acute hospitals' (June 2018), NQB 'An improvement resource for neonatal care (June 2018) and the RCN document 'Defining staffing levels for children and young people's services' (August 2013).

The service is compliant against the NCQ recommendations.
The RCN have 18 standards which cover the full range of paediatric provision. The service is compliant with all the standards bar one. This one relates to the recommended 'head room' allowance to cover leave. The head room for this service is set in line with the rest of the Trust (21% compared to an RCN recommendation of 25%).

There are a number of challenges for the service, most notably the increasing demand for mental health services and the challenges in onward referral to the Children, Adolescent Mental Health Service (CAMHS). The team are exploring the opportunity of recruiting mental health nurses with paediatric experience.

Neonatal services are exploring the potential of a transitional care service to support the capacity and demand issues for the unit.

Clinical incidents related to nursing are low.

Friends & Family: response rates are variable however positive response scores are high, generally greater than 95%.

4.6 **Summary:** Debate has been had within the directorate regarding the number of RNs on night duty. Current ratio provides 1:5 which would meet the safe care standard for urgent care patients. Therefore a professional judgement would not support any changes to the night RN numbers at this point. No changes to current establishment

4.7 **Critical Care**

The underpinning approach for setting safe staffing levels within Critical Care is based on a concordance of recommendations from the British Association of Critical Care Nursing, the Rcn Critical Care Forum and the Critical Care Society published as the Core Standards for Intensive Care Units (2013). The recommendations for setting safe staffing levels are based on the acuity and levels of care provided based on national definitions.

The historical definitions have been levels 1,2 and 3 with level 3 being either full mechanical ventilation plus support for one or more organ/system failure, level 2 being respiratory support or support for a single organ/system failure, and level 1 being 'ward fit' care.

This approach was rationalised for the purposes of staffing establishments and capacity planning.

The traditional level 3 care bed is scored as 1 and level 2 or HDU style care being scored as 0.5. This means a critical care unit can flex both bed base and staffing accordingly.

The trust has provision for critical care beds on both sites. Both sites have a capacity equivalent to a dependency score of 7, with both units having physical capacity for 9 beds each.

Both units are staffed to the same level.

Both units have a shift leader or coordinator who is supervisory, with a unit manager providing overarching supervision and support Monday to Friday as part of their overall leadership role.

The nursing workforce involved in direct patient care is all Registered Nurses, with a small number of CSWs utilised for 'runner' activity and to support direct patient care on an ad hoc basis.

There is a clinical educator on both sites who supports the accredited Foundations of Critical Care Course.

Quality Indicators:
Capacity and delays in admission to ICU and transfer to ward are the key issue, particularly for the Tunbridge Wells site.

Medication errors: low reports of medication errors at Tunbridge Wells. Maidstone unit saw an increased number during the early summer, however this has since decreased. Noted that there is an increasing openness and willingness to report incidents.

Falls: both units have minimal or no falls.

Pressure Ulcers: Infrequent. One incident at the time of review which was related to competing/conflicting treatment needs (i.e. frequent repositioning would have been detrimental to respiratory support and care).

Complaints: minimal for both units

Friends & Family: not formally reported as critical care does not fit the inclusion criteria for national FFT. However both units get a high number of compliments.

4.8 **Summary:** shift profiles in line with national critical care guidance. Key staffing risk is age related (7 experienced staff reach potential retirement age within the next 2 years).
There is scope to increase critical care course numbers; external funding permitting. This would need additional resource to support learners in practice; this could be achieved by closer cross-site working and deployment of staff.
Recommendation: undertake review annually or as part of the Quality Impact Assessment for any planned service change.

4.9 **Theatres**

The methodology used for setting safe staffing levels for theatres is as described previously. Evidence base and guidance from the Association of Perioperative Practitioners (AfPP 2008 & 2011) was referenced to.

The principles for a single operating theatre are:

- Operating Department Practitioner (ODP) x 1
- Scrub Practitioner (either ODP or RN) x 2
- Runner x 1 (may be a CSW)
- Recovery RN x 1

A theatre suite may consist of several theatres, and as such there is a degree of flexibility in requirements for recovery personnel. However these fundamental principles need to be met for each theatre with a theatre suite to ensure safe delivery of care.

Tunbridge Wells Hospital has a theatre suite comprising of 8 theatres (including 8 anaesthetic rooms), 2 dedicated obstetric theatres, ophthalmic (11 theatres in total) and 3 recovery areas.

Obstetric Theatres are staffed to the same principles with an additional recovery RN for elective lists. This has been put in place by the team in response to learning from previous incidents and Serious Incidents (SIs).

For out of hours obstetric theatre cover the minimum staffing set for 1 theatre is on-call on site.

Maidstone Hospital has 11 theatres but not contained in a full suite. The theatre complex comprises of:

4 main theatres (1 suite)
2 ophthalmic theatres
2 short stay surgery theatres
2 procedure rooms (chronic pain and brachy therapy)
1 Orthopaedic theatre (MOU)

The theatres are staffed to the same principles as Tunbridge Wells Hospital in line with AfPP recommendations.

The Maidstone Hospital theatre case mix is predominately elective however the staff also provide cover to a range of satellite services including electrophysiology studies, interventional radiology, line insertion and cover to Priority House for electroconvulsive therapy.

Each theatre is led by a Band 6 and is overseen by the Theatre Coordinator.

The Theatre Coordinator is supernumerary.

Quality Indicators:
The generic indicators used for in-patient care do not transpose well to theatres.
The key issue for theatres is maintaining flow through the recovery room. On both sites there are often delays in transferring patients to a ward bed. This is an operational/capacity challenge rather than a staffing challenge.

Complaints: are generally related to time delays between admission lounge and theatres, or when one of the recovery rooms is used for escalation.

4.10 **Summary:** budgeted establishment is correct to meet the AfPP recommendations. Challenges related to recruitment and retention, though improvements in recruitment have been seen. There is a risk this may change if utilisation of theatres changes.
Recommendation: undertake bi-annual review or as part of the Quality Impact Assessment for any planned service change.

5. Head & Neck

Head & Neck provide discrete services for ophthalmology and ENT across both sites. The service has a satellite eye clinic in Medway.

Eye services provide both outpatient and day surgery services, with their own dedicated theatre/minor operations room. Patients requiring overnight care are cared for from within the main surgical ward bed base, predominantly on short stay surgery.

ENT Services are provided on both sites including an outreach service. Inpatient care is provided from within the main surgical bed base, predominantly on short stay surgery.

The ENT Clinical Nurse Specialist Team provide an outreach service and support junior doctors. The ENT CNS provides onsite advice for the management of tracheostomy care and will support accident & emergency with pre-transfer reviews and care planning.
The services are small in terms of whole time equivalents which means there is limited resilience within the team. The key challenge for the team is attraction to the specialty as junior staff are not routinely exposed to the specialty early in their education pathway. The team have adopted a creative approach with the Bank Office team to attract and train staff, as well as actively supporting education and training in-house as part of their succession planning.

There is no validated tool to support the review of staffing establishments for this specialty, as it is so dependent on location and colocation to other support services.
The professional judgement of the combined sisters and matron suggest that the funded establishment is currently meeting need.

Quality Indicators:
Medication errors: nil reported across all areas. Drug administration in this specialty is not typical of a general ward or department. Drugs are generally limited to PGD supply and administration and a limited range of topical medications.

Falls: despite the perceived risks associate with ophthalmology patients, the number of falls is almost zero, in the last year there has been on slip in Maidstone ophthalmology out-patients.

No other nursing care related incidents

Complaints: Nil related to clinical nursing care. There were a number of complaints/concerns earlier in the year related to the implementation of All Scripts which were quickly resolved.

Friends & Family: FFT is not in operation in outpatient care settings in the same way it is for other wards and departments. However the service does get positive feedback via NetCall. Maidstone Eye Day Care Unit (MEDU) achieves both a high return rate and a high positive response rate.

5.1 **Summary:** the budgeted establishment is sufficient to meet the current demands. However should be reviewed annually and as part of the Quality Impact Assessment for any planned service change

6. Oncology

6.1 The Kent Cancer Centre operates services across both hospital sites as well as satellite units at Kent and Canterbury and supporting oncology service provision for Kent. The safe staffing review focused on the oncology out patients department, the roll out of a haematology ambulatory service, the Chemotherapy units Charles Dickens Day Unit(CDDU) (MH) and Haematology Oncology Unit (HODU) (TWH). The Trust does not have a specific oncology ward however has an 18 bedded haematology ward which has been included in the ward review section of this report. The service is supported further by a workforce of Clinical Nurse Specialists which are reviewed continuously in line with service delivery.

Oncology OPD: based at MDG consists of 10 rooms with clinics running both AM and Pm across 5 days. Outreach clinics are supported at the TWH main out patients department with support from oncology staffing for these clinics. The unit is run on 2 RN (1 x nurse led clinic and 1 x manage unit) and supported by CSW.

CDDU: based at MDG consisting of 21 chairs, PICC room, Brachy Theatre, 3 rooms and an iodine treatment room. The unit provides chemotherapy treatment, immunotherapies, nurse led clinics, chemotherapy information session, PICC placements and supportive therapies. The unit runs a Mon- Fri service with 9 trained (staggered start and finish times) supported by 2/3 CSW depending on theatre lists running.

HODU: based at TWH consisting of 11 chairs, treatment room and provision of nurse led clinic in this space. The unit provides chemotherapy, immunotherapy, and supportive therapies. The unit has increased in size over the last few years in line with service demand. Nursing establishments were set at 1:1 (RN: Chair) space ratio to deliver safe staffing levels however current establishment at 11.05WTE. Rheumatology continues to use HODU for treatment delivery. The unit is staffed Mon – Fri 07.30 – 18.30 with staggered start and finish times delivered by 7 trained nurses and 1 CSW.

Quality Indicators (all units):
Medication errors: 1 medication error on HODU with medication given prior to checking blood results. 1 prescribing error on CDDU.

Falls: 4 falls recorded in oncology OPD no themes / trends identified. Visitors who slip / trip / fall are attributed to Onc OPD

Complaints: 1 reported in CDDU whereby a patient believed they had received wrong drug due to change in appearance however this was related to manufacturing changes rather than an

administration error. 1 complaints on HODY due to skin tear on a patient with fragile skin when removing stat lock.

Friends and Family: FFT recently rolled out to day unit and outpatient areas and consistently achieve 100% recommended scores. In addition HODU won star awards Team of the Year

6.2 **Summary:** There is no validated tool to support the review of staffing establishments for this specialty, as it is so dependent on location and colocation to other support services. However, anecdotal evidence suggests 1:1 per chair space. Therefore the professional judgement of the combined sisters and matron suggest that the funded establishment is broadly meeting need. However, HODU would need to increase to 12.1 WTE to meet this requirement and consideration will be given to how this could be achieved within budget through integrating new roles as natural turnover occurs. Units are utilising skill mix adjustments e.g. – supportive therapies delivered by non-chemo trained and chemo trained for specialist skills. Future workforce planning required with change in SACT delivery. Future mapping of service will need to plan for 6 day working (could be chemo or supportive treatments) and / or evening clinics. This would need to be part of business planning and business cases. Increase in monoclonal treatments. Consider new roles and the role of the TNA and NA to integrate into oncology. Ongoing recruitment and continue to support chemotherapy training.

7. Maternity

7.1 All acute Maternity services across both sites were part of the safe staffing review alongside the Community Midwifery Team, the Maidstone Birthing Centre and Crowborough Birth Centre. These reviews were undertaken with consideration using a traditional model of midwifery through the NICE guideline: Safe midwifery staffing for maternity settings (February 2015). The methodology acknowledged the Birthrate Plus framework for workforce planning and strategic decision-making which has been in variable use in UK maternity units for a significant number of years. An additional paper which sets out the proposed new framework to determine safe staffing required for antenatal inpatient and outpatient services, postnatal care of women and babies in hospital and community care of the local population birthing in either the local hospital or neighbouring ones is set out in **Appendix 1.** In addition to this, Continuity of carer is being rolled out throughout England from 2018 over a three year period and will impact on future staffing reviews and business case planning.

All acute maternity areas: based at the TWH site and consisting of the 17 bedded Antenatal ward, Labour ward with 2 theatres (emergency and elective), 2 bay recovery area, 26 bed Post-natal / Transitional care ward, 4 couches in Triage and Day assessment unit 3 couches. Current staffing establishment is combined across all acute services with a total WTE 167.27 MW and MSW. Ratios are as follows: Antenatal ward 2:1, Post Natal ward 2:3
Transitional care 1:1, Triage 2:0.5, DAU 1:0.5, Labour ward 8:2, ANC – dependant on clinic activity and Theatre 2:1.

Quality Indicators (all units)
Medication errors: Failure to prescribe Fragmin for high risk VTE cases; failure to prescribe Anti D and 1 error when using syntometrine.

Falls: Acknowledge risk post epidural / elective surgery however nil reported.

Pressure Ulcers: a known risk to patients post epidural however Nil reported.

Complaints: Complaints managed and compliance of turnaround improving. Themes are predominately staff attitude and failure of good communication.

Friends and Family: Improving compliance with consistently achieving high scores 95%.

Community Midwifery Team: establishment covers the full service of community midwifery with current caseloads based on 1:120 and a 48.61 WTE workforce. This has the potential to require change with the impact of continuity of care.

Quality indicators:
Complaints: 1 midwifery complaint in reporting period – no theme / trend identified.

Friends and Family: ongoing work to improve compliance in this area. Figures included in All Maternity areas.

Crowborough Birth Centre: offers services to women living in the High Weald area and North East Sussex. It is a small unit consisting of 2 delivery room and 3 post-natal rooms. There is potential for converting a PN into the 3rd delivery room. Current establishment consists of 21.61 WTE with a MW : MSW split of 2:1.

Maidstone Birth Centre: offers services for women to deliver and learn how to care for their baby during normal births for "low risk" women. The unit has 2 birthing rooms and 3 postnatal rooms (1 of which can be converted to a labour room if required. Current establishment consists of 15.83 WTE with a MW: MSW split of 2:1.

Quality Indicators for both birth centres: 2 complaints received

Friends and Family: both units are signed up and compliance is good based on attendances to the unit. Score included in overarching maternity scores.

7.2 **Summary:** Acute: the team have been working on their electronic roster system which has been challenging to manage given the complexity of planning staffing across the whole service. The head of Midwifery has now got to the position where all of the rosters are clinically led and that the accountability sits firmly with each ward manager (currently it is collective). A new app based version of an Acuity tool is being explored to enable more accurate collection of acuity which is vital in managing staffing requirements. The team have relaunched the triage acuity data process that has been created in house by the IT lead.

Uplift (headroom) for staff is currently 21% and this equates to approx. 2.5 study days per year per member of staff. Midwives currently have 5 mandatory training days to ensure they remain skilled. This is currently a cost pressure for all midwifery staffing and is being reviewed by the Head of Midwifery.

Community Midwifery: The current profile meets the demands of the service; however there is a focus on the national agenda towards the Continuity of Carer work and this will require a business case to increase the current staffing levels to align with the recommendations.

Crowborough Birth Centre: The current profile meets the demands of the service; however there is a focus on the national agenda towards the Continuity of Carer work and this will require a business case to increase the current staffing levels to align with the recommendations.

7.3 **Recommendations:** The establishment is currently combined across all of the acute services. This needs to be separated into individual areas to ensure each area is staffed well and has clinical ownership. There is focus on succession planning and considering the need for changes to service delivery in line with the National agenda for midwifery care whilst continuing to ensure safe staffing is prevailed throughout the service. Some examples of key initiatives being explored are as follows: as follows:

- To ensure apprenticeship schemes are used when developing band 3 and band 4 staff with the backfill required.
- To be aware that with the new continuity of care model this will require an uplift of an anticipated additional 17 WTE midwifery posts within maternity in order to achieve the 20% compliance target. This will be increased to 35% in the forthcoming year. A business Case will be required for proposed changes to align staffing levels with the recommendations of Continuity of Carer

- Increasing the band 3 staffing at the birth centres would enable the division to improve the length of stay based on the improved infant feeding services within the community. This would also align with the BFI accreditation and support the recommendations of the BR+ staffing review.

8. Gynaecology Out Patient services:

8.1 The Trust provides gynaecology outpatient services across both sites of the Trust. These are based in the Women's Whitehead department on the Maidstone Hospital site and the Gynaecology OPD based in Women's and Children's, Green zone at the Tunbridge Wells Hospital. The reviews were undertaken with consideration to the following guidance: NICE guidance: Endometriosis (February 2018), Royal College Obstetricians and Gynaecologists (RCOG) Quality care for women 2016, RCOG Hysteroscopy 2011, NHSCSP Colposcopy 2016.

8.2 Both units offer outpatient clinics and procedural clinics to include: colposcopy, uro-gynaecology, fertility, Early Pregnancy Assessment Clinic, Consultant new patient and follow up clinics, Rapid Assessment Clinic and Hormone Replacement Therapy clinic.

8.3 Clinical activity and services are subject to increase in March 2019. Currently services are planned with RN/ CSW 1:1 per clinic session with up to 3 sessions to support daily.
Mostly there are 2 x clinics for 5 x days .Colposcopy 1:1, Best Practice in Out Patient Hysteroscopy suggests 1:1 would not achieve best practice guidance. Women's Whitehead unit is currently established at 7.02 WTE whereas Gynaecology OPD at TWH is established at 3.51.

8.4 The Band 8A Colposcopy lead often helps clinically if needed (predominantly at TWH). Within her current role also undertakes the BSCCP lead measured against strict criteria.
Within the TWH establishment is also the requirement of an Endometriosis Specialist Nurse-regional accreditation. This role is currently providing 10hrs per week.

Quality Indicators (all units)
Medication errors: reported potential to occur with specialist drugs such as HRT. No significant concerns raised.

Complaints: Nil

Friends and Family: Both units now signed up to FFT and will be starting to collect patient feedback.

8.5 **Summary:** Clinical activity is due to increase in March 2019. Services are likely to notice a small increase initially with minimal impact however; as clinics become full then impact will increase on current nursing establishments. The Band 8a role – National Guidance cites it should have accountability of 8B level to undertake BSCCP role for reporting cancer figures therefore currently outside guidance.
Recommendations: Nursing establishments in Gynaecology OPD should mirror Women's Whitehead to work towards parity across services. Business cases need to consider nursing establishments when increasing clinical activity. Consider within the division using medical hours to offset costs. Need to start considering succession planning and as part of that to consider the implementation of new roles as part of the annual business planning process in line with service needs.

9. Endoscopy

9.1 The underpinning approach for setting safe staffing levels within Endoscopy is based on a concordance of recommendations form the Joint Advisory Group on GI endoscopy (JAG recommendations). The JAG accreditation is the formal recognition that an endoscopy service has demonstrated competence. The scheme is both patient centred and workforce focused.

Both the Maidstone and Tunbridge Wells Endoscopy units are JAG accredited.

Maidstone unit consists of 7 Recovery bays, 2 admitting rooms and 3 procedure rooms (one that is lead lined). The establishment is set at 23.4 WTE

Tunbridge Wells' unit consists of 10 trolley spaces and 3 procedure rooms.

Procedures include; colonoscopy, endoscopy, bowel scope, EBUS, EUS and ERCP. On call GI belled service, decontamination and emergency lists.

Quality Indicators (all units)
Medication errors: Nil

Falls: 1 in reporting period – mobile patient slipped in the unit

Complaints: 2 complaints regarding patient comfort / consent. Previous complaints following OGDs / flexi sig procedure after a change in guidance on sedation levels.

Friends and Family: Consistently receive high scores. Most recent 4.9 / 5.0 at time of report

9.2 **Summary:** Staff working increasing hours due to introduction of Saturday working through waiting list initiatives.(WLI) Due to speciality substantive staff are covering these duties. Current staffing overspend correlates directly to the additional lists
Recommendations: To discuss with finance the total cost of WLI / additional list and to consider more sustainable ways in which the service can be staffed in line with the JAG recommended guidance. The team are also looking at how integrating new roles into the team may support a more defined career pathway and succession planning.

10. Section 2:

10.1 Ward reviews were undertaken using the methodology as described at the outset of this report and in line with National Quality Board Guidance (2016), NICE guidance (2017), Shelford Acuity & Dependency model, Professional Judgement (Telford) model and Carter Model Hospital (CHPPD). The areas reviewed include:

Maidstone Hospital

Ambulatory Medical Unit (AMU)
Acute Stoke Unit (ASU)
Chaucer Ward
Cornwallis
Culpepper / CCU
John Day
Lord North
Mercer
Maidstone Orthopaedic Unit
Maidstone Short Stay Surgical Unit (MSSU)
Peale

Tunbridge Wells Hospital

Short Stay Surgical Unit (SSSU)
Surgical Assessment Unit
Ambulatory Medical Unit (TAMU)
Coronary Care Unit (CCU)
Ward 2 / Acute Frailty Unit
Ward 10 Ward 22
Ward 11 Ward 30
Ward 12 Ward 31
Ward 20 Ward 32
Ward 21 Ward 33

A summary of the outcomes from each ward review are seen in **Appendix 2** of this report. The summary provides details of each ward including the agreed and budgeted establishment, the skill mix for each ward, total number of vacancies on each ward, a summary of the nurse sensitive indicators and some commentary relating to each review.

10.2 Guiding Principles for our ward establishments

Ratios: RN:CSW = 65/35, RN:Pt 1:5 – 1:8
Supervisory time for ward managers on each ward- largely one day per week.
Ward Clerk – not included in nursing numbers
Headroom allowance 21% (to cover mandatory training, annual leave and sickness)

10.3 Carter Model Hospital comparisons:

NHSI Model Hospital Data: Nursing, December 2018 (latest available update; accessed 13.03/19).
Care Hours Per Patient Day:
National Median: 7.32
Peer Mean: 7.70
MTW: 8.85
Safety Thermometer:
National Median: 93.1% harm free
MTW : 98.48%

Weight Activity Unit (cost for average inpatient episode)
MTW in Quartile 2 (mid – low cost per episode)

10.4 Overview:

- No significant changes to establishments recommended if able to recruit to establishments.
- Minor changes, primarily within budgeted establishments to adjust skill mix. For example increase in band 6 funded from existing Band 5 monies for TSSSU.
- Changes within establishment generally volunteered by Ward Manager & Matron.
- Finance engaged with process, so changes included within business planning
- Data set reflect position as at January 2019.
- Staffing establishment are appropriate for ward specialty and layout.
- Wards are safe when nursing levels are at establishment
- Vacancy and recruitment are key risks
- Capacity and demand impacts on both substantive and temporary fill rates.
- Vacancy total (bands 2 – 7) 241.87 WTE (reflective of ward areas reviewed only)

11. Conclusion:

11.1 In summary the budgeted establishment for the departments is broadly correct when at establishment. The key challenges remain centred on recruiting to establishments. The approach of funding to planned substantive and temporary staffing may have had some perceived impact on recruitment however there is no evidence to suggest that opportunity to recruit suitably qualified staff has been missed.

11.2 There are a number of changes that are being explored which will potentially alter the skill mix of our teams. Some examples of ideas that are being considered include the appointment of a dual trained role for an Adult and RMN nurse to manage the increasing demand on mental health attendances within the emergency department and Orthopaedics, Oncology and respiratory services are considering the benefit of having a physiotherapist on the ward as part of the ward establishment.

As part of any proposed change in skill mix, there will need to be a formal review of skill mix supported by the completion of a quality impact assessment undertaken to ensure that any impact on the provision of safe staffing is clearly understood

11.3 New ways of working to deliver safe, effective and high quality care was the subject of much discussion and in line with workforce recommendations. Services need to consider integration of new roles and apprenticeships as we being to map out what a future nursing workforce looks like with Trainee Nursing Associates, Nursing Associates, CSW apprenticeships, the Advanced Clinical practice competency framework and potential apprenticeships in development.

11.4 New roles and apprenticeships

A number of changes to operational delivery are being explored which will, potentially, alter the skill mix requirements. The changes being proposed will need to consider the implications for safe staffing, so a review of staffing establishment and skill mix should be undertake as part of the Quality Impact Assessment process.

12. Key recommendation summary:

12.1 Increase in establishment recommended in line with business planning and workforce plan and the requirement of business case for A+E TWH and Maternity to support the move to staffing recommendations in line with “Better Births

12.2 New roles and apprentices to be considered across all areas to include supporting Trainee Nursing Associate and integrating the Nursing Associate role in further workforce planning

Backfill of CSW workforce to areas supporting apprenticeships, new roles and new learners

12.3 The new continuity of care model for maternity will require an uplift of an anticipated additional 17 WTE midwifery posts within maternity in order to achieve the 20% compliance target. This will be increased to 35% in the forthcoming year.

12.4 Integrate TNA and NA into nursing workforce structure across the organisation.

12.5 Business cases to increase clinical activity MUST include nursing establishment reviews.

BIRTHRATE PLUS®

MIDWIFERY SERVICES WORKFORCE PLANNING & DECISION MAKING

MAIDSTONE & TUNBRIDGE WELL NHS TRUST

November 2018

Birthrate Plus ®: THE SYSTEM

Birthrate Plus® (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units for a significant number of years.

It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology is consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the RCM and RCOG.

The RCM strongly recommends using Birthrate Plus® (BR+) to undertake a systematic assessment of workforce requirements, since BR+ is the only recognised national tool for calculating midwifery staffing levels. Birth outcomes are not influenced by staff numbers alone. Nevertheless, a recognised and well-used tool like BR+ is crucial for determining the number of midwives and support staff required to ensure each woman receives one-to-one care in labour (as per recommendation 1.1.3).

An individual service will produce a casemix based on clinical indicators of the wellbeing of the mother and infant throughout labour and delivery. Each of the indicators has a weighted score designed to reflect the different processes of labour and delivery and the degree to which these deviates from obstetric normality. Five different categories are created - the lower the score the more normal are the processes of labour and delivery. Other categories classify women admitted to the delivery suite for other reasons than for labour and delivery. *Appendix 1 explains the Birthrate categories (p.7).*

Together with the casemix, the number of midwife hours per patient/client category based upon the well-established standard of one midwife to one woman throughout labour, plus extra midwife time needed for complicated Categories III, IV & V, calculates the clinical staffing for the annual number of women delivered.

In addition, BR+ determines the staffing required for antenatal inpatient and outpatient services, postnatal care of women and babies in hospital and community care of the local population birthing in either the local hospital or neighbouring ones.

The method works out the clinical establishment based on agreed standards of care and specialist needs and then includes the non-clinical midwifery roles to manage maternity services. Skill mix adjustment of the clinical staffing between midwives and competent & qualified support staff have been applied.

Summary of Results

The recommendation is to provide total care to women and their babies throughout the 24 hours 7 days a week inclusive of 21% for annual, sick & study leave allowance and 12.5% for travel in community. Non-clinical midwifery roles are included. *A detailed summary is included on page 5.*

The overall clinical establishment for total of births is summarised as follows:

(a)	Hospital	134.59 wte
(b)	Community & Freestanding Birth Centres	78.44 wte
(c)	**Total Clinical WTE Hospital & Community**	**213.03 wte**
(d)	Additional Non-Clinical midwifery roles @ 9%	19.17 wte

1. Annual activity data are from 2017/18 and provided by the senior midwifery team. Data sets for community, outpatients, and birth centre activity were also obtained.

2. Total Births are 5976 of which 5202 are on Delivery Suite, 471 in Maidstone Birth Centre, 156 in Crowborough Birth Centre and 147 at home/BBAs.

3. Two months' casemix data was obtained for the months of April and May 2018 as shown below. The casemix is analysed in 3 ways, namely, generic for all births taking place; those in the Delivery Unit and births in the co-located Birth Centre. This is to provide a comparative casemix with similar maternity services and also to enable calculation of midwifery staffing based on the models of care for respective place of birth.

%CASEMIX	Cat I	Cat II	Cat III	Cat IV	Cat V
D/S % Casemix	3.0	22.8	16.3	29.9	28.0
Generic % Casemix	5.5	24.0	15.5	28.4	26.6

4. The Delivery Unit casemix will predominantly be those women in categories III to V thus impacting on the workload for this service and also for postnatal care in the ward. The Birth Centre models of care are based on a casemix of category I and II and any higher category activity is included as transfers and included in DS casemix. 74.2% of DS births are in Categories III, IV & V which does impact on the staffing requirements.

5. The Generic Casemix indicates that 29.5% of births are in the lower categories I & II with 70.5% in the moderate to high categories, of which 55% are in IV & V. Key contributory factors include obesity, Postpartum Haemorrhage, Massive Obstetric Haemorrhage, Prelabour Rupture of Membranes (requiring augmentation and IV antibiotics) method of delivery and vulnerability with specific reference to mental health issues. Of the 54 maternity units in England who have undertaken a BR+ assessment from 2015 to 2017, the average % of women in Categories IV & V is 56% ranging from 41 to 69%.

6. The assessment of midwives for the Alongside Midwife Unit (AMU) activity is based on a 'package of care' that includes intra-partum care with 2 midwives at for the birth, postnatal care until transfer home and examination of the new-born. There are women who commence labour in the Birth Centre but transferred to Delivery Suite prior to or at delivery due to maternal or fetal complications. The care given to the women is included in the AMU staffing whilst the actual birth and post-delivery care is within the D/S establishment. In addition, there are women who attend with a labour query but not admitted.

7. The casemix is an indicator of the needs of women and their babies for the postnatal stay in hospital so used to calculate the staffing. It is often where the significant safeguarding/social issues have an impact on midwifery staffing to ensure systems are in place to deal with such matters.

8. The table on page 7 lists the full activity and services covered in the workforce assessment.

9. The BR+ staffing is based on the activity and methodology rather than on where women may be seen &/or which midwives provide the care.

10. The total clinical wte is 213.03wte, this figure will contain the contribution from suitably qualified and competent support staff in hospital and community postnatal services.

11. Applying a 90/10% skill mix to the total of 213.03wte equates to 191.73wte RMs & 21.30wte MSWs.

12. Most maternity units work with a minimum of 90/10% skill mix split of the clinical total wte, although this is a local decision by the Senior Midwifery Team. To have a skill mix adjustment greater than 85/15% would not ensure that midwives are available to cover peak activity on the delivery suite.

13. In addition, there is a requirement for other support staff on the DS, Outpatients and Maternity Ward, usually Band 2s. The wte is calculated based on numbers per shift and not on a clinical dependency method.

14. The total clinical establishments do not include the following roles:
    - Head of Midwifery & Matrons with additional hours for team leaders to participate in strategic planning & wider Trust business.
    - Practice Development role
    - Clinical Governance role
    - Time for Baby Friendly Initiative, which is not to assist women with breast feeding, but to produce & monitor guidelines & undertake audits
    - Additional hours for antenatal screening over & above the time provided in actual clinics
    - Coordination for such work as Safeguarding Children
    - PMAs (A-Equip)

15. The above additional roles can be included based on adding in % of the total clinical establishment, as suggested by Birthrate Plus® and cited in the RCM Staffing Guidance 2016. It is a local decision as to the % increase, for e.g. addition of 9% equates to 19.17wte. Applying an agreed % avoids duplication of roles irrespective of which midwives undertake the non-clinical duties. Adding in a % means there is no duplication of roles between clinical and non-clinical.

Using ratios of births/cases to midwife wte for projecting staffing establishments

The ratios below are based on the BR+® dataset, national standards with the BR+ methodology and local factors, such as % uplift for annual, sick & study leave, case mix of women birthing in hospital, provision of outpatient/day unit services and total number of women having community care irrespective of place of birth.

To calculate for staffing based on increase in activity, it is advisable to apply ratios of births/cases to midwife wte, as this will consider an increase or decrease in all areas and not just the intrapartum care of women. There will be changes in community, hospital outpatient and inpatient services if the annual number of women giving birth alters.

Once the clinical 'midwifery' establishment has been calculated using the ratios, a skill mix % can be applied to the total clinical wte to work out what of the total clinical 'midwifery' wte can be suitably qualified support staff, namely MSWs Band 3. Nursery Nurses and RGNs working in postnatal services only.

In addition, a % is added (usually 9%) to include the non-clinical roles as these are outside of the skill mix adjustment as above. However, the addition of other support staff (usually Band 2s MCAs) that do not contribute to the clinical establishment will be necessary.

Calculating staffing changes using a ratio to meet increase in births assumes that there will be an increase in activity across ALL models of care and areas including homebirths.

If there is an increase or decrease in activity, then the appropriate ratio can be applied depending on the level of care provided to the women.

For example:

A woman who births in the Delivery Suite but is 'exported' to another community, then the ratio of 39 births to 1 wte should be applied. The main factor in using ratios is to know if having total care for the 'Trust' midwives or only hospital or community.

If the women just have community care as birth in a neighbouring unit, it is only necessary to estimate the increase in community staffing so the ratio of 104 cases to 1 wte is the correct ratio to apply. To use the 1:28.7 ratio will overestimate the staffing as this covers all ante, intra and postnatal care.

Maidstone & Tunbridge Wells Ratios:

- Delivery Suite births (all hospital care) — 39 births to 1 wte midwife
- Maidstone Birth Centre — 56 births to 1 wte midwife
- Crowborough Birth Centre — 51 births to 1 wte midwife
- Home births — 35 births to 1 wte midwife
- Ante & Postnatal Community care only — 104 cases to 1 wte midwife
- Overall ratio for **all** births — 28.7 births to 1 wte midwife

It is advisable to use own ratios calculated from a detailed assessment for workforce planning purposes rather than the nationally cited ratios due primarily to variables in allowances, casemix, cross border cases.

COMPARISON OF BR+ WTE WITH CURRENT FUNDED WTE (21% UPLIFT)

MAIDSTONE & TUNBRIDGE WELLS 21% uplift	**30.08.18**		
	RMs	**MSWs**	**Bands 3 - 7**
Current Total Clinical	195.87	9.56	207.83
Contribution from Specialist MWs	2.40		
Total Current Funded	**198.27**	**9.56**	**207.83**
BR+ Clinical wte			**213.03**
Skill Mix Adjustment (90/10)	191.73	21.30	
Variance +/-	6.54	-11.74	
TOTAL CLINICAL VARIANCE		**-5.20**	-2.56
	BR+	Current	**Variance**
NON CLINICAL (9%)	19.17	15.75	**-3.42**

N.B. The current MSWs in post require upskilling to meet the full requirements of this role, therefore the Head of Midwifery plans to address this. The current establishment of midwives are off setting the deficit of support workers.

The summary of data table on page 7 provides the required WTE for the clinical areas, which will enable comparison to the current staffing.

The table below demonstrates the clinical contribution included from the Specialist Midwives roles:-

Funded Specialist Midwives (*list roles)*	WTE	*BR+ assessment*	Senior Management *(list roles)*	WTE	*Clinical input*
teenage pregnancy	1.4	1.4	Head of Midwifery	1	0
bereavement	1	0.0	Deputy HOM	1	0
infant feeding	1	0.0	Community Matron	0.95	0
mental health nurse	0.8	0.0	Inpatient Matron	1	0
safeguarding	1	0.4	Delivery suite	1	0
practice development	1.2	0.2	IT/Project Lead	1	0
student support	0.6	0.0	Consultant Midwife	0.8	0.4
IT support	0.6	0.0			
screening	2.2	0.4			
risk/governance	1	0.0			
compliance	1	0.0			
	11.80	2.40		6.75	0.40

30/9/18	Birthrate Plus staffing	Current funded wte	Variance
Delivery Suite • Births – based on casemix • Prostin/Propess/Balloons *(may need to add to ward* • Cats A1 & A2 – moderate & high risk antenatal cases • In-utero transfers with m/w escort • PN readmissions • Non-viable pregnancies	60.83wte		
Triage	12.65wte		
Alongside Midwife Unit - Maidstone BC • Births inc. P/N care & NIPE • Unplanned a/n cases • Escorted transfers to DS	8.28wte		
Ante &/or Postnatal Ward (s) • A/N inpatients • A/N ward attenders • IOLs • P/N women (D/S births) • P/N ward attenders • P/N readmissions • Extra care babies • NIPE/*BCGs*	53.98wte		
Outpatients Services: • Obstetric Clinics • Midwife Led Clinics • Specialist Clinics • Fetal Medicine • Day Unit	7.14wte		
Community Services • Home Births/*BBAs* • Community cases – A/N &/or P/N care • Attrition cases	67.14wte		
Freestanding Birth Centre - Crowborough	3.02wte		

Method for Classifying Birthrate Plus® Categories by Scoring Clinical Factors in the Process and Outcome of Labour and Delivery

There are five [5] categories for mothers who have given birth during their time in the delivery suite [Categories I – V)

CATEGORY I **Score = 6**

This is the most normal and healthy outcome possible. A woman is defined as Category I [*lowest level of dependency*] if:
The woman's pregnancy is of 37 weeks gestation or more, she is in labour for 8 hours or less; she achieves a normal delivery with an intact perineum; her baby has an Apgar score of 8+; and weighs more than 2.5kg; and she does not require or receive any further treatment and/or monitoring

CATEGORY II **Score = 7 – 9**

This is also a normal outcome, very similar to Category I, but usually with the perineal tear [score 2], or a length of labour of more than 8 hours [score 2]. IV Infusion [score 2] may also fall into this category if no other intervention. However, if more than one of these events happens, then the mother and baby outcome would be in Category III.

CATEGORY III **Score = 10 – 13**

Moderate risk/need such as Induction of Labour with syntocinon, instrumental deliveries will fall into this category, as may continuous fetal monitoring. Women having an instrumental delivery with an epidural, and/or syntocinon may become a Category IV.

CATEGORY IV **Score = 14 –18**

More complicated cases affecting mother and/or baby will be in this category, such as elective caesarean section; pre-term births; low Apgar and birth weight. Women having epidural for pain relief and a normal delivery will also be Category IV, as will those having a straightforward instrumental delivery.

CATEGORY V **Score = 19 *or more***

This score is reached when the mother and/or baby require a very high degree of support or intervention, such as, emergency section, associated medical problem such as diabetes, stillbirth or multiple pregnancy, as well as unexpected intensive care needs post-delivery. Some women who require emergency anaesthetic for retained placenta or suture of third degree tear may be in this category.

Category X women are those who are admitted to the delivery suite, but after assessment/monitoring are found not to be in labour or to need any intervention. These women are either sent home or transferred to the antenatal ward for observation.

Categories A1 & A2 women are those who require some intervention such as intravenous infusion and/or monitoring, e.g. antepartum haemorrhage, pre-eclampsia or premature labour. Such women often spend considerable time on delivery suite before being transferred to the antenatal ward or to another maternity unit with neonatal facilities. However, some women with moderate risk/needs will go home following assessment and treatment.

Category R women are re-admitted after delivery as postnatal cases, often requiring medical care. Inductions of labour with prostins are recorded, as are escorted transfers to another maternity unit and the non-viable pregnancies.

Appendix 2

Staffing Review by ward					Ratios		Nurse Sensitive Indicators (Q3)					Comments	Recommendation
Site	Ward	Budgeted Est. (wte)	Staff (wte)	Vacancy (RN & CSW wte)	RN:CSW	RN:Pt (E, L & N)	P'Ulcers (cat2+)	Falls	Med Errors	Nursing Care Complaints (6 months)	FFT (resp/%positive)		
Maidstone	AMU	35.51	26.64	8.87	60/40	1;4, 1:4 , 1,4 or 1:5	0	8	0	1	8.3%/95%	Vacancy reflects true vacancywith the addition to this there are 2 wte on secondment and 1.8 on mat leave. Falls relates to three months. Consideration given that during seasonal variation AMU is escalated + 8 trolleys consistently requiring 1+1 at night Discussion as to if mapping workforce to 22 with trolleys. Concern that these will be considered as in patient beds and would change the emphasis on flow therefore to mitigate safe staffing budget to map the 1+1 during seasonal escalation – health roster	No change to establishment if reamins at 14 beds. Encourage Band 2's to recruit to TNAs next cohort and backfill with CSW
	ASU	39.78	31.16	8.62	60/40	1:5, 1:5, 1:6.5	0	12	1	1	46.2%/88.9%	Continue to work collaboratively with recruitment. Actively recruited junior nurses and are developing these nurses in their expertise within stroke.RN:PT ratio assumes Thrombolysis nurse in numbers. When this role is off the ward ratios increase to 1:6 and 1:9 Stroke assessors. Actively supporting and considering new roles including TNA's – additional CSW support would be beneficial to help with transitioning new structures within workforce. Some uncertainty around the new HASU – positive that initial recommendation includes MH however impact from neighbouring areas if workforce reduce before official implementation of HASU.	To continue with additional CSW at night to support enhanced care needs within establishment. TNA planned for next year and actively supporting now. Working collaboratively with the STP regarding HASU workforce planning for future recommendations.
	Chaucer	28.61	24.72	3.89	70/30	1:5. 1:5. 1:7	0	8	1	0	95%/100%	Chaucer now fully rolled out as a Frailty unit conissting of 14 in patient beds, 11 assessments beds and treatment suite with 7 chairs. RN: PT ratio at night reflective of when assessment beds are closed. Seasonal escalation can often seas area escalated. Treatment open Mon-fri on 50:50 split with 1 Rn and 1 CSW. The unit often has to support patient transfers which can impact on nursing levels. Currently waiting decision as to if ward will move to alternative location.	No Change to establishment. Wihtin establishment support appointment to Flow Coordinator role to support high number of complex discharges. Look to introdcue TNA role but with CSW backfill
	Cornwallis	25.68	19.05	6.63	60/40	1:6, 1:6, 1:6	0	5	0	1	51.7%/91.8%	Band 6 down grade and reduced staff at weekend and during the week. Sometimes difficult with 3:2 ratio Managing flow / EDNs / post op patients / emergency admission 2 x csw covering ward clerk responsibilities as well Staffing review undertaken during winter esclation with Cornwallis team locatred on Peale ward (13 beds)	No Change to establishment if ward base remains the same after winter escalation. Continue to support TNA's will need CSW backfill to support overseas nurses and TNA apprentices Even with 2 new B5 starters still carrying a 5.0 WTE vacancy – to over recruit to CSW to manage current gaps
	Culpepper/CCU	32.4	29.34	3.06	50/50 70/30	1:6 Culp, 1:3 CCU	2	10	0	0	102.9%/91.7%	RN:CSW ratio reflects CCU dependency. CCU and med combined (6 CCU beds, 13 medical. No changes in establishment previously. Establishment consistent with case mix unless escalation into Cath Lab recovery.	No change to establishment
	John Day	44.93	32.61	12.32	60/40	1:6, 1:6, 1:6	2	17	19	2	79%/94%	Pull a report on acuity and dependency from CUR for all wards – so that we can begin to raise the profile/awareness. 5 new nurses – 4/52 induction PDN. 4 newly qualified – preceptorship – new programme in the new year .Concerned about winter – with anticipated increase in acuity of patients .Reliance on agency staff especially on nights – 2/3 per night – some regular lines.	No change to establishment.
	Lord North	29.95	26.12	3.83	75/25	1:4, 1:4, 1:6	4	5	3	3	20.8%/90%	High ratio of RNs to cover chemo regimes. WM is supervisory all week for this reason but often in num,bers due to vacancy. RN:CSW ratio reflects chemo requirements. Increase in PU for LDN no trends identified. Consideration of Haemtology MDM to move to Tuesday to better mange patient flow	No change to establishment. Consider new roles within budgeted establishment and how to support new roles / apprentices.
	Mercer	36.04	32.04	4	55/45	1:7, 1:7, 1:10	1	20	1	0	83%/85%	LOS significantly changed with closure of Whatman and ward admission criteria changed with increased pathway 3 patients and impact of waiting POC / DTOC. Acuity of patients changed with an increase in the MFFD. Staff morale impacted with changes however high retention and nominated for Kent Messenger Staff Awards	No change to establishment To consider opportunities to look at new roles and ways of working including TNA's and apprentice CSW's when working with recruitment

Staffing Review by ward					Ratios		Nurse Sensitive Indicators (Q3)					Comments	Recommendation
Site	Ward	Budgeted Est. (wte)	Staff (wte)	Vacancy (RN & CSW wte)	RN:CSW	RN:Pt (E, L & N)	P'Ulcers (cat2+)	Falls	Med Errors	Nursing Care Complaints (6 months)	FFT (resp/%positive)		
	MOU	19.22	13.24	5.98	60/40	1:4, 1:4, 1:6	0	4	0	0	4.93 score	Band 5's Appointed 4.0 WTE to start in 2 April / 2 Sept leaving 1.24. Some anxiety at night with redeployment of 2nd trained to support trust wide safe staffing levels.Excellent work with support new starters and learners. Current CSW on track to complete CSW certificate and keen to pursue TNA / NA role with ultimate aim to achieve RN status	No change to establishment.
	MSSU	15.74	14.43	1.31	60/40	1:6, 1:6, 1:9	0	3	0	6	23%/94%	Establishment generally good. Increased activity noted, particularly in relation to additional surgical capacity to allow wider use of in-patient surgical beds.With effect from the 26th November 2018 1.0 wte member of staff transferring to winter escalation (Foster Clark) this is an agreed action within planned care to mitigate risk of escalation ward. This will need to be back filled with temporary staff.	No change to establishment. Consider twilight shift B2 :6-11pm which would cover a high demand time in service over handover where there is an increase in discharging patients but still high volume of post op. Need to consider options within budget to support this. Will improve discharge time, FFT, complaints: Finance to provide costing for 25hrs B2 – 0.82 WTE
	Peale	23.9	23.9	0	60/40	1:6. 1:6, 1:6	0	1	0	0	57%/97%	Peale team moved to Cornwallis Ward as part of winter esclation at time of staffing review tranistioning from 13 to 27 beds. Review undertaken to consider base ward as awaiting decision regarding longer term plan for ward moves.	No change to establishment Will need repeat review pending ward allocation post winter escalation
	Pye Oliver	37.57	33.17	4.4	50/50	1:7, 1:7, 1:10	4	8	signing drug chart	2	46%/92%	RN:CSW ratio reflects the client group (gastro). Keen to imrpove EOLC experience for patients within the ward environment.	No change to establishment Consider recruiting a Nursing Associate to integrate role into establishments. Support CSW keen to develop into TNA role.
	SSSU	27.56	11,93	15,63	60/40	1:6, 1:6, 1:12	0	1	yes (1 x RN)	Yes	0	Discussed current workforce structure and senior level support currently 1x B7 and 1 x B6 Staffing ratio established according to original plan of 12 beds and 9 trolleys – permanently escalated to 15 which increases as escalation increases to a potential total of 41 spaces therefore often difficult to establish definitive levels. Increasing the CSW support at night has helped significantly to reduced risk of falls in addition, SSSU does not have housekeeping support and the additional care to refreshment and dietary needs can be met with the CSW support. CSW support has been reported as over filled through on safe staffing information to board.Discussed plans to increase FFT and using a nominated named nurse per shift or ward clerk	No change to establishment Recommend and support an additional B6 post to offer further senior nursing level support within budget. 2 x CSW rostered at night has reduced risk of falls and if remains escalated at 15 +9 or more then this is additional care requirements and need to be part of planned numbers. Consider current workforce structure and how new roles and apprentices could be Possibilities to include: CSW supported as TNA Backfill CSW with Apprentice CSW Advertise now for NA as other areas will have qualified NA's Consider implementing "Always Event" "Hello my name is" to help with privacy and dignity issues / communication themes arising
	SAU	19.85	15.59	4.26	75/25	1:4, 1:4, 1:4	1	2	1	1	Average score 4.5-4.7	Capacity is 8 bed + 3 assessment bays. Takes GP and A&E referrals. Covers surgical assessment clinic. Key challenges: - Daily management of capacity - SAU admissions/triage busier, increase in throughput	No change to establishment Consider New Roles? Potential for ACP roles/advanced assessment roles within the unit
	TAMU	58.08	42.95	15.13	60/40	1;6	0	14	1	0	41%/96%	Capacity is 28 beds + Ambulatory (1 trolley 6 chairs average 25 patients per day)and AEC 3 trolleys 4 chairs average 17 per day. Shortlisted 11 candidates for doctors assistance consider how this can be developed into physician associate. Unit will run short due to vacancies not set staffing recommendations	Considering current vacancies -what other roles could deliver safe and appropriate care. If vacancies were filled then staffing level correct.
	CCU	20.8	10.83	10	60/40	1:3, 1:4, 1:4	0	1	IV infusion / chart not signed	0	90%/96%	Capacity is 8 rooms. Difficulties in recruiting to band 5 posts, leading to unfilled shifts or high agency use which dilutes skill mix significantly in specialist area. Continued escalation- reliance on bank/agency to fill out-of-hours shifts.	No Change to establishment Consider new roles to support career progression within the unit. Such as ACP role. Recently Appointed to PDN role Due to speciality unable to utilise more than 1 x CSW per shift therefore consider the remaining WTE CSW establishment this could be realigned to supporting new role / developing TNA and integrating the band 4 into the workforce structure
lge Wells	2 / AFU	43.57	25.42	18.15	50/50	1:7, 1:7, 1:9	1	26	0	0	67.3%/91.4%	RN:CSW ratio shift following review remains outside accepted practice however need to fill vacancy before final impact of change be assessed. Introduction of AFU did not change bed base but changed patient needs and new ways of working. Commended for supporting new learniers / roles and apprentices	No Change to current establishment. Consider seprate review for AFU pathways. Conitnue to support and devlop new roles integrating these into workforce structure.

Staffing Review by ward					Ratios		Nurse Sensitive Indicators (Q3)					Comments	Recommendation
Site	Ward	Budgeted Est. (wte)	Staff (wte)	Vacancy (RN & CSW wte)	RN:CSW	RN:Pt (E, L & N)	P'Ulcers (cat2+)	Falls	Med Errors	Nursing Care Complaints (6 months)	FFT (resp/%positive)		
Tunbridge	10	42.02	32.22	9.8	50/40	1:5, 1:10, 1:7	0	10	0	3	21.5%/100%	Skill mix adjustment at night a considered risk by the ward team in line with a high dependency and moderate acuity.	Change has been consistent over last year therefore to amend PvA to refelct this change to 3:3 at night Seek to support 1/2 TNA's with a request of backfill CSW
	11	40.1	26.28	13.82	60/40	1:5, 1:7, 1:7	0	7	0	3	36%/96%	RN:CSW ratio will work flexibly and review skill mix to downgrade RN to CSW to cover shifts due to high vacancy	No change to establishment Use vacancy to support CSW apprentice and potentially 2 TNAs to start integrating Band 4 role into ward structure.
	12	42.42	25	17.95	60/40	1:6, 1:6, 1:10	0	23	0	2	12.3%/90%	High level of vancancies.53% vacancies for trained. Continue to recruit to vacancies. Consider new roles suporting TNA's	No change to total establishment but skill mix adjustment at night 4 trained 3 CSW to support complexity and acuity on ward.
	20	32.14	23.42	8.72	50/50	1:10, 1:10, 1:10	1	42	2	1	34.4%/90.9%	RN/PT ratio reflect MFFD case mix. However, there was some concern voiced that the number of appropriate pts is less therefore acuity was becoming higher than the current establishment would naturally support. Quality reviews have been ongoing to monitor and support imrpovements and stricter admission criteria however this reamins a challenge.	Staffing requirement changes accordng to dependency requiremtns on ward. Establishment includes a discharge coordinator. Continuing to review and recruit to vacancies looking at new roles / ways of working.
	21	43.27	33.27	10	70/30	1:5, 1:6, 1:6	1	10	1	1	12.3%/90%	RN:CSW ratio reflects acute respiratory care. Potential impact on case mix from introduction of 24hr critical care outreach as referrals for NIV have increased.	No change to establishment Supporting TNA
	22	53.48	28.76	24.72	60/40	1:5, 1:5, 1:6	1	27	0	0	50%/89%	Combined acute stroke and rehab plus 10 medical beds. Difficulty in managing high vacancy rate and hard to recruit with uncertainty as to future of ward. Staff morale low. Need to continue service until spring 2020.	No change to establishment Await decision as to future of ward 22
	30	38.65	28	10.65	60/40	1:5, 1:7, 1:10	4	26	4	4	75%/93%	If fully recruited to all vacancies then current staffing level would be appropriate.	No change to establishment Consider supporting a B2 to TNA with an ask for additional CSW to support the ward. Use this CSW to revert to 3:4 at night to decrease risk of falls.Over recruit to B2's within budget Reduce supervisory hours to 4 days
	31	47.04	31.4	15.64	60/40	1:5, 1:7, 1:7	3	26	0	0	21%/87%	PDN appointed between ward 30 & 31 to support new staff. Once vacancy filled then WM feels staffing would be appropriate..	No change to establishment To consider new roles to fill vacancies such as AHP physio, twighlight shift, TNAs
	32	44.22	25.2	19	60/40	1:5, 1:5, 1:10	1	22	0	4	27%/93%	Previous staffing reviewed to reflect change in focus and increase in NHS beds. Due to frailty pathway Ward 32 receiving prolonged LOS patients associated with complex, multiple co morbity patients. Consistently requiring additional staffing support with Enhanced Care/RMN needs	No change to establishment however within establishment consider Dementia Coordinator role to support patient pathways and look to introduce TNAs into skill mix and recruit to vacancies
	33	23.6	22.48	1.12	60/40	1:7, 1:7, 1:7	0	2	0	1	0.7%/100%	Ratios for RN:Pt reflect the in-patient beds. The staff also cover the EGAU. EGAU have now commenced a 24hr servicewhich has resulted in an increase staffing requirement and has resulted in a reduced fill rate in Q3.	Business case will be rquired to increase staffing levels accroding to activity based on the introduction of a 24hr EGAU service

Staffing Review by non ward areas					Ratios		Nurse Sensitive Indicators (Q4)					Comments	Recommendation
Site	Non Ward Areas	Budgeted Est. (wte)	Staff (wte)	Vacancy (RN & CSW wte)	RN:CSW	RN:Pt (E, L & N)	P'Ulcers (cat2+)	Falls	Med Errors	Nursing Care Complaints	FFT (resp/%positive)		
Maidstone													
	Endoscopy	23.4	21.4	2	X 2 RN per endoscopy room for 2 rooms and one RN & x1 CSW for the 3rd room X 2 RN pre assessing X 2 RN recovery x 1 CSW for some of the time X3 CSW in decontamination		0	0	0		4.9 score	Saturday list was not part of the previous safe staffing reviews or mapping Current overspend of 42K directly correlates to Bank / agency / overtime to support lists and is a cost pressure. Staff are consistently working increased hours to support additional work. Due to area of speciality	To discuss with finance total cost of WLI / additional list and need to map additional staffing levels according to the JAG recommended guidance If uplift required will need to also consider new roles to develop staff, offer career structure and succession planning. To include in Business planning
	Womens Whitehead Unit	7.02	6.54	0.48	50:50 proceduarla clinical	1;1 during procedure	N/A	0	0	0	To start FFT now	Clinical activity and services subject to increase in March 2019. RN/ CSW 1:1 per clinic session with up to 3 sessions to support Mostly 2 x clinics for 5 x days Coloposcopy 1:1 (Best Practice in Out Patient Hysteroscopy 1:1 would not achieve best practice guidance	Business case needs to ensure nursing establishment is reviewed in line with increase in services. Services likely to grow small initially with minimal impact to nursing however, as clinics become full will increase on nursing establishment requirements. To consider new roles in business planning in line with service needs ? TNA ? medical support
Tunbridge Wells													
	Gynae OPD	3.51	4.46	Band 5- 1.90 (actual 1.73 in post (dual role to include 0.27 endo CNS))(0.17vacancy) Band 3- 0.68 (actual 0.64)(0.2 vacancy) Band 5- 1.90 (actual 1.73 in post (dual role to	50:50 per clinic session	RN/ CSW 1:1 per clinic session with up to 3 sessions to support	N/A	0	Specialist drugs such as HRT	0	To start FFT now	Band 8a – Across site Colposcopy not on budget but support mainly at TWH) Clinical activity and services mirror level as that provided at Women's Whitehead however staffing levels significantly different. Vacancy factor in previous budget setting has impacted on staffing level. Band 8A Colposcopy lead often helps clinically if needed. Within her current role is the BSCCP lead – strict criteria	Need to mirror whitehead Band 8a – National Guidance cites it should have accountability of 8B level to undertake BSCCP role for reporting cancer figures therefore currently outside guidance. Need to start considering succession planning - what role would this be? Band 7 to manage unit and specialise To work towards parity across services Consider using medical hours to offset costs Business case requirements

Trust Board meeting – March 2019

Maidstone and Tunbridge Wells NHS Trust

3-11	Update on Clostridium difficile reporting for 2019/20	Director of Infection Prevention and Control

Reporting of C. difficile cases to the Public Health England Data Collection System has been mandatory for a number of years. From April 2017, reporting trusts were asked to provide information on whether patients with CDI had been admitted to the reporting trust within the three months prior to the onset of the current case. This allows a greater granulation of the healthcare association of cases and brings England into line with definitions used by CDC and ECDC. Based on PHE data, it is likely that the proportion of healthcare associated cases will increase to around 65% of the total number of cases

Cases are split into one of six groups:
* **Hospital-onset healthcare-associated (HOHA)** - Date of onset is > 2 days after admission (where day of admission is day 1)
* **Community-onset healthcare-associated (COHA)** - Date of onset is ≤ 2 days after admission and the patient was admitted to the trust in the 4 weeks prior to the current episode.
* **Community-onset indeterminate association (COIA)** - Date of onset is < 2 days after admission and the patient was admitted in the previous 12 weeks, but not the previous 4 weeks prior to the current episode
* **Community-onset community-associated (COCA)** - Date of onset is < 2 days after admission and the patient had not been admitted to the trust in the previous 12 weeks prior to the current episode.
*** Unknown 3 months** - The reporting trust answered "Don't know" to the question regarding admission in the 3 months prior to the current episode.
*** All unknown** - The reporting trust did not provide any answer for questions on prior admission.
MTW always submit full data on cases hence we do not have any cases that fall into the last two categories.

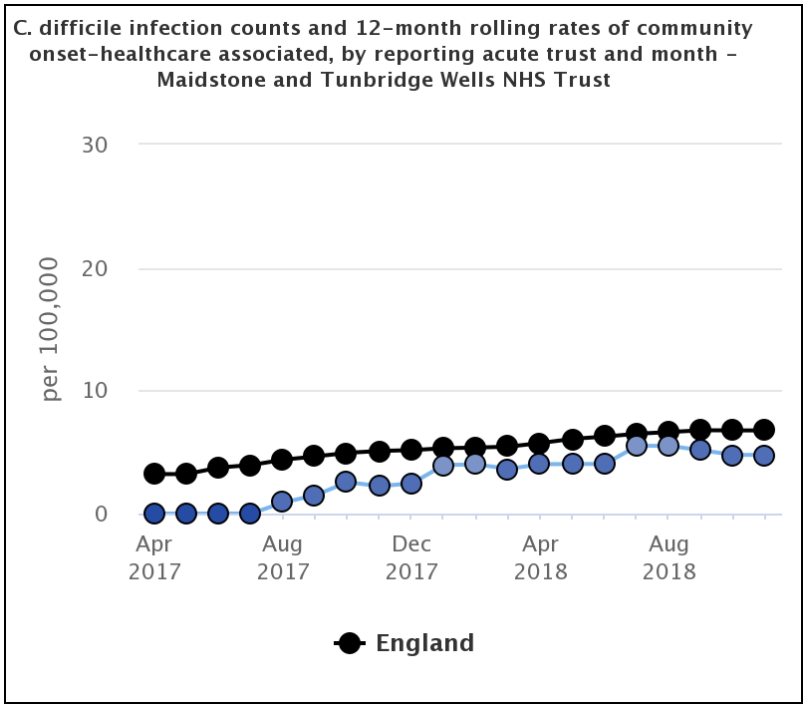
From April 2019 C. difficile objectives will be based on these definitions rather than the current definitions of community apportioned (date of onset is on the day of admission, the next day or the day after that) and hospital apportioned (date of onset is after day 2 where day of admission is day 0).

The new definitions will inevitably increase the perceived number of healthcare associated cases seen apportioned to the Trust although it is not expected that there will be an increase overall.

	Current definition	HOHA	COHA	COIA	COCA
Jan-18	2	2	4	1	2
Feb-18	0	0	1	0	1
Mar-18	2	2	0	0	0
Apr-18	0	0	1	0	1
May-18	1	1	0	0	1
Jun-18	3	3	0	2	4
Jul-18	5	5	4	0	3
Aug-18	6	7	1	3	4
Sep-18	7	8	0	1	5
Oct-18	*2*	*2*	*1*	*1*	*4*
Nov-18	*3*	*4*	*0*	*1*	*4*
Dec-18	*2*	*3*	*2*	*1*	*2*
Total	*33*	*37*	*14*	*10*	*31*

Using the new definitions we would have had 51 cases assigned to the Trust for the calendar year 2018.

The rate of COHA cases seen at MTW is well below the national average as shown below.



The objectives for 2019/20 have now been published. The objective for MTW is **55 cases** equivalent to a rate of 21.4 per 100 000 bed days.

From 2020/21 the faecal sampling and CDI testing rates for all NHS providers willl be reviewed to determine how they compare. Failure to diagnose CDI raises the possibility of poor outcomes for patients and missed opportunities for CDI control. There will be a particular focus on providers with high CDI rates but low sampling/testing rates relative to their peers.

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

[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 – March 2019

NHS Maidstone and Tunbridge Wells NHS Trust

3-12 Update from the Best Care Programme Board — Chief Executive

Enclosed is an update from the Best Care Programme Board

Which Committees have reviewed the information prior to Board submission?

- -

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

Information, 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

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Trust Board
Best Care Programme 18/19
March 2019

MTW
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Content

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1a. Executive Summary

Workstreams Update	Workstreams Update
KEY PROGRESS Best Patient Flow – Frailty Unit - GP advice line commenced on Monday 18th March and Community Frailty nurses attending board rounds on both sites by the end of March Frailty business case to be updated with additional information following Clinical Cabinet feedback. Prime Provider - Quattro system for electronic patient tracking to also include outpatients finalised. KPIs and performance monitoring implemented of prime provider into current systems. Operational policy submitted to PRC for approval . Finalised contract variation for prime provider with WKCCG Best Safety – Medical Productivity - All job plans to be added to the system, and reconciliation of pay and budgets against job plans. 7 day services - Quarterly Review with NHSE/I and CCG held on 14.03.19. GIRFT – MTW has been praised for a robust GIRFT process which has now been replicated at MFT at the request of the National GIRFT team. Best Workforce –Clearmedi for nursing contract agreed and Skype interviews scheduled for April . Implementation of the nurse bank shift booking app on track for 31 May 2019. Nursing workshop to be scheduled for early April to significantly increase nursing recruitment numbers rapidly, identifying solutions to any constraints. Procurement and finance approval to be secured in order to progress with corporate video by 31 March.	**KEY PROGRESS** Best Quality – Pressure Sores - Updated policy goes to Policy Ratification Committee in April and 5 key points developed to support staff with new reporting. WKA Dementia workshop on 19th March Best Use of Resources – Asset Sale (Pembury) completed. WKA Diabetes service following a 2 year planning and implementation phase went live, with the 1st clinic on 15/03/19. WKA Radiology Virtual Colonoscopies DORIS changes went live meaning GP's use Kinesis to prior to referral. WKA Pathology LFT – guidance has now successfully added unto ICE.
KEY RISKS Best Patient flow – Request to extend H@H at the end of the trail period submitted for approval. Recruitment of skilled staff continues to be an issue. Best Safety – GIRFT – delay in completing Litigation actions, due to resource issues, plan now in place to complete this review. 7 Day Services – risk associated with the number and recruitment of consultants for Medicine & Emergency Divisions to be compliant. Best Workforce – Percentage of Nursing shifts requested over 6 weeks in advance has deteriorated along with the percentage of Medical shifts requested Retrospectively	**KEY RISKS** Best Quality – PPEE remains unsupported without resource. Unsuccessful attempts to appoint to Band 5 Transition Nurse post – after going out to advert 3 times. Best Use of Resources – Avastin continues to be a risk. Asset Sales of Springwood Road, scheduled for completion on Thursday 28th March.

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**
- **West Kent Diabetes Community Clinics**

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WORKSTREAM	Best Use of Resources Summary Report	BEST CARE BOARD DATE	March 2019
WORKSTREAM LEAD	Steve Orpin	PMO SUPPORT	Toyin Falana

DESCRIPTION	MILESTONE ACTUAL (M11)	DELIVERY RAG		ACTIONS FOR NEXT REPORTING PERIOD (M12)
		LAST MONTH	THIS MONTH	
Estate & Facilities	• Commercial negotiations with PFI on Energy Procurement completed. • Commercial negotiations with PFI on LED maintenance and life cycling completed.			• Complete disposal of High Brooms by end of March 2019 • Agree contracts with PFI on Energy by the end of March 2019.
Procurement	• International recruitment for nurses & doctors – contract live, and recruitment progressing well, supporting HR with processes, savings on recruitment fees and contract changes on track. • Theatre consumable contract delivered • Endoscope maintenance contract went live on 10th Feb with a target savings of £101K of which £85 will roll over. £26K already saved • Product swop with NHS supply chain Feb FYE £56K and in year £6K. • STP meetings revived with 1st one this month, programme high level time table completed and signed off. • Othoptic in –soles - £20K savings identified for next financial year, will start to deliver from April 2019.			• International recruitment ongoing, will continue within each divisions until all substantive vacant posts are filled. • Photocopier contract - £1m savings over 5 years in discussion with suppliers with a £300K to claim by April 2019. • Review Discharge Services contract – rolling annual contract (current contract ends in May 2019) • Point of care testing - £80K savings was planned to deliver by end of March 2019 but delays with supply route as products not in market yet, has moved delivery of savings to June 2019, firming things up with NHS supply chain. • Reduction in Printing and postage , background work started but savings will not start to deliver until June2019.
Medicine Management	Avastin Legal position not changed as of yet and MHRA has not responded to the outcome of the JR, so risk of progressing has been highlighted in a draft QIA which is in the process of being finalised by the team and will be presented at the next QIA clinic. Business case for Group 2 &3in progress.			• Present completed QIA for review by April 2019. • Progress with work on Business Case
	• 2019/20 planning still in progress – scheme identification and scoping ongoing. • Weekly recovery meetings still in progress.			• Develop detailed plans and other project documentation around new schemes for 2019/20.
	• Joint Formulary Resource - issues ongoing with recruiting to substantive post, post has been advertised twice with no suitable candidate, plans to recruit agency staff in the interim, to prevent further delays with the commencement of work.			• Agency staff already in place.
	Adalimumab – switch to Humira still ongoing and progressing well, uptake report on DEFINE shows quarter target met with 28% use of Humira in Feb and 22% in Jan.			Adalimumab – continue to monitor monthly uptake.
	Aseptic Service – proposal sent to NHSi for review in Feb 2019.			Aseptic Service – await NHSi review of proposal by end of March 2019.
	Dossette Box – pilot commenced end of January and will continue for the next 6 months.			Dossette Boxes / MAR Chart – continue work on pilot till June 2019, and collate data.

DESCRIPTION	MILESTONE ACTUAL	DELIVERY RAG		ACTIONS FOR NEXT REPORTING PERIOD
		Last Month	This Month	
Medicines Management.	Outsourcing – Business Case complete, and approved at the Pharmacy Outsourcing Board.			Outsourcing - obtain approval of Business Case at the Finance Committee on the 26th March and Trust Board on the 12th March.
	Paediatric Feed – policy agreed and price reduction implemented.			Finance to quantify savings. JC liaising with MJ to get details.
WKA - Pathology	Sodium – guidance updated and added unto ICE			Sodium – Update guidance and add unto ICE. CL chased and made aware actions are still required.
	Faecal Calprotectin – actions completed and comms sent out.			Further work has been incorporated into the 2019/20 work plan.
	LFT – guidance has now successfully added unto ICE. Further LFT work needs to be done to reduce demand, work plan added to 2019/20 WKA Diagnostics plan with detailed scheme plan to be developed.			Detailed work planning taking place with work stream leads to develop plans under three main strands of activity – IT enablers, Demand and capacity management and the role of diagnostics within the ICS. These will be signed off at the WKA Diagnostics Steering Group in April 2019. Date TBC.
	FIT Testing – work on service evaluation still ongoing, and expected to last for least 6 months, joint Business Case will be developed at the end of evaluation.			FIT Testing – now also part of the STP work stream, agree pathway on 2 week wait patients and run a pilot. Details of actions are still been scoped.
	Immunology – guidance completed, awaiting Clinical leads sign off.			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.
STP Pathology	Strategic Outline Case (SOC)completed and approved Terms of Reference completed and approved Outline Business Case (OBC) written but yet to be approved by all Trust Boards			Present OBC at all Trust Boards for approval Organise working group meetings Review timeline and achievements so far.
WKA Radiology	Virtual Colonoscopies DORIS changes now complete, it now reads that GPs should obtain consultant approval via Kinesis before referring for VC.			No further action, now part of BAU.
	NG12 – all actions on audit completed			continue to monitor activity and NB to link in with Sally Allen at the CCG, work needs to continue into 2019/20 but detailed plan of action yet to be developed.
	Direct Access Requests – all actions completed.			No further action.
	Internal demand – continue to work with ENT surgeons to reduce MRI requests. Currently not progressing much, as clinicians not engaging.			Internal demand - work with Chief of Service to review service and device ways to engage better with clinicians.

DESCRIPTION	MILESTONE ACTUAL	DELIVERY RAG		ACTIONS FOR NEXT REPORTING PERIOD
		Last Month	This Month	
Radiology	Electronic Reports –work still ongoing with practices experiencing issues with receiving electronic reports			Electronic Reports – CCG and Radiology PACS team to review responses from practices as to whether they are receiving electronic results, to ensure the stop to paper reporting.
	Obstetric Scanning – price agreed, planned start for April 2019 still going ahead. Communication will be sent through patient letters for next appointments.			Obstetric Scanning – update leaflet and install machines by the end of March 2019.
	Radiology Tender – progressing with scoping exercise which is expected to continue to the end of April. All financial detail have been submitted to the scoping partners who have submitted revised costing for the project.			Continue work on scoping and decide what the next steps are at the end of April 2019.
WKA Diabetes	MTW CDSN laptops installed with VPN software. Trial of laptop off site w/c 18/02/19.			Vision software to be uploaded once training and logins assigned. MTW IT services and Federation to review firewall protocols for MTW VPN access.
	1st clinic to be held 15/03/19. Delay was due to internal communications at practice level.			Review initial clinic roll out and discuss concerns/improvements after 1 month of clinics.
	Contract novation WKCCG:MTW. / WKH:MTW. WKH to provide MTW with costings for Q3/4. Indemnity policy has been received. MTW and WK CCG to review costings against contract.			Meeting between MTW and WKCCG 21/02/19. MOU requires a minor changes which has been agreed. Outstanding costs from WKH for Q3/4 has been escalated to GP Federation (WKH).
	CDSN ERS training 22/02/19.			Review outstanding ERS training requirements.
	Outset completed Community Data flow report which was signed off by DIG with support 07/02/19. Final draft of data sharing agreements submitted to WKHealth Ltd/KCHFT/MTW for approval			DPIA to be completed by Outset UK by 22/02/19 for final ratification by DIG via email WKHealth Ltd/KCHFT/MTW to sign Data sharing agreements by next DIG 07/03/19
	Prescribing protocols and guidelines discussed in MOG 10/01/19 and agreed. DIG 24/01/19			Guidelines to be cascade through joint comms through MTW/CCG. Guidance to be uploaded to DORIS KPI agreed to monitor guidance adherence: Clinical Outcome - Prescribing: (£300k) reduction in diabetic non-formulary prescribing costs – KPI baselining/financial methodology.
	GP Federation Project Manager granted access to Vision 15/02/19			GP Federation Project Manager to arrange training schedules with MTW/Spoke/Federation/PCBS for vision inline with practice roll out of clinics and to prepare instruction manuals. CDSNs training scheduled 01/03/19.
	Interim proposal for waiting list approved at DIG 24/01/19 whilst Vision does not hold a waiting list			

Non Recurrent Savings / Financial Mitigation Schemes				
Contingency Reserve	All of reserve already in use YTD.			No further action.
Assets Sales	• 32 High Street, Pembury sold for £5,650,000 • Business case submitted to NHSI for Springwood Road • Commercial and Legal negotiations with Springwood Road			• Receive NHSI approval for sale of Springwood Road • Complete sale of Springwood Road
West Kent CCG Income	Confirmation of £3.7m income support from the CCG. £3m assumed in the YTD position.			£1.5m received from the CCG. No further action.

KEY ISSUES/RISKS TO FINANCIAL PERFORMANCE

DESCRIPTION	MITIGATION	DATE last reviewed	LAST MONTH	THIS MONTH
Asset Sales - Risk of Springwood Road Business case not being approved through NHSI in time to complete sale by end of financial year. NHSI have no further questions that haven't been addressed with the exception of wanting an opinion from the Trusts auditors	Trust's Auditors are in week beginning 11th March to give an opinion on the proposed accounting treatment.	02/19		

KPIS	Target	LAST MONTH	THIS MONTH
Procurement		JAN	FEB
95% of transactions lines on e-catalogue	95%	96.1	95.8
90% invoice (by no) on purchase order	90%	90.7	89.8
90% of invoice (by value) on purchase order	90%	95.9	95.7
E&F			
Energy Volume Reduced	806609	886165	798915
Medicines Management			
Transzuzimab uptake rate	80%	82	82
Rixuzimab uptake rate	80%	68	78
Ethernacept uptake rate	80%	85	NA (due to data quality issues)
Infliximab uptake rate	80%	92	92
Adalimumab uptake rate	20% for Q1	22	28

CRITICAL PATH MILESTONES (next 4 weeks)

Task	Milestone Date	Status	RAG Last Month	RAG This month
Meds Mgt – obtain approval for Business Case at the Trust Board on the 12th March and Finance & Performance on the 26th March 2019.	02/19	On track		
Receive NHSI approval for sale of Springwood Road		On track	New	
Complete legal documentation and sale of Springwood road		On track subject to NHSI approval	New	

Maidstone and Tunbridge Wells NHS Trust

Finance Narrative

Month 11 Delivery

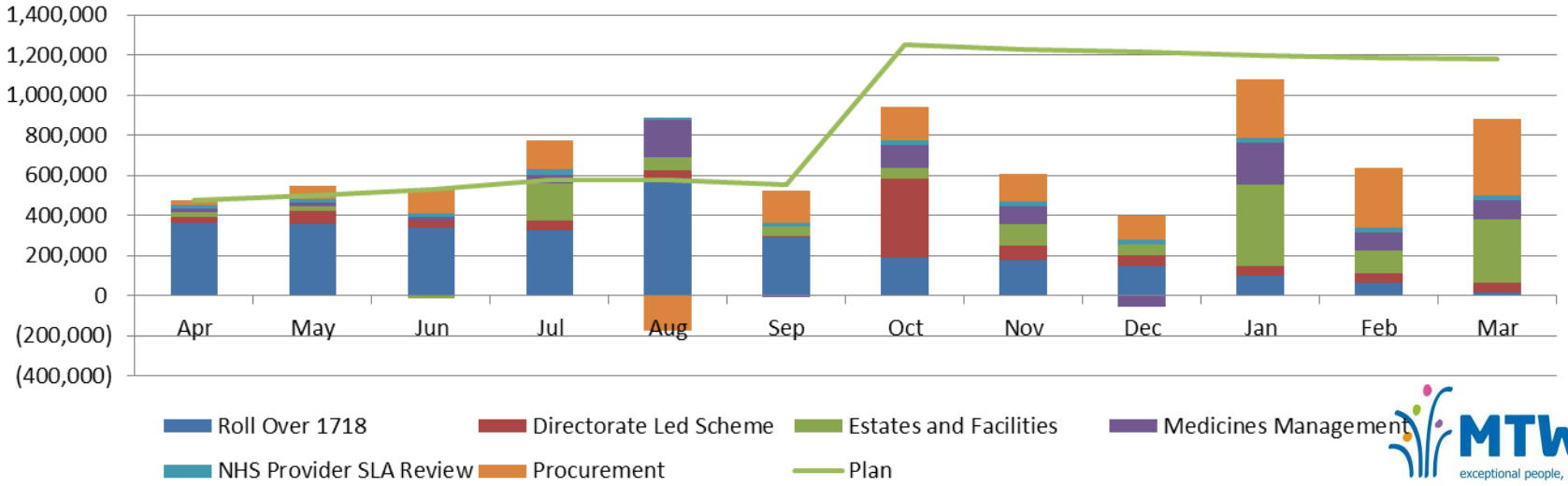
Total delivery of £638K against a plan of £1.1m

YTD Delivery

YTD actual / forecast - £7.1m delivered against YTD plan - £9.2m.

£8m delivered against year Forecast of £10.5m, with slippage currently at £2.5m.

	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	100,078	64,958	16,238
Directorate Led Scheme	31,970	66,778	36,408	50,128	54,009	5,326	388,897	71,113	52,949	46,490	43,479	45,275
Estates and Facilities	23,083	23,083	-11,417	183,393	62,628	49,310	55,109	103,628	53,629	406,528	116,070	316,786
Medicines Management	17,633	17,264	17,553	44,246	182,380	-2,221	112,728	90,374	-58,020	209,235	87,378	96,097
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	120,510	291,333	300,916	382,916
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



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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**

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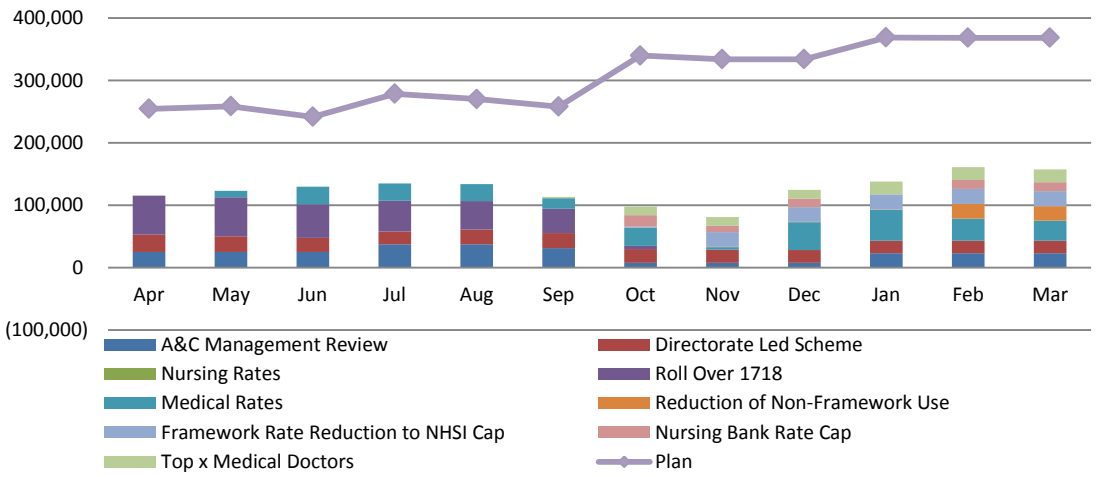
WORKSTREAM	Best Workforce	BEST CARE BOARD DATE	March 2019
WORKSTREAM LEAD	Simon Hart/Tracey Karlsson	PMO SUPPORT	Steve Bryant/Steph Pearson

Project	Actions/Milestones completed	DELIVERY RAG		Actions for next reporting period
		LAST MONTH	THIS MONTH	
Temporary Staffing Controls Group	• Two Care of the Elderly consultants are due to start in Mar 2019 moving from agency. • Further review sessions held on medical bank rates. Rates agreed in principle, which includes single rates across divisions with exception to consultant grade, with areas requiring enhancements to be identified. • MLAG has asked for HR bank to undertake IR35 assessment for ED Consultant due to concerns over time taken since first request on 8 Jan 19. • Ambition, non-framework nursing supplier removed - regular workers identified and transitioned to framework affiliate BNA on protected rates. • Medics Pro nursing supplier suspended from the framework – regular workers identified and compliance data received to minimise impact.			• Areas requiring enhancement to the consultant grade for medical bank rates to be identified. Agreed rates to be circulated to CoSs and implementation date to be agreed by 31 March 2019. • IR35 assessment for ED Consultant to be completed by 31 March. • Complete plans to achieve STP rate targets by 31 March. • Centralise medical bank plan finalised 31 March. • Continue to identify nurses from Medics Pro who are integral and facilitate meeting compliance requirements in order to continue working. • Work with agencies/bank to supply at cap in clinical areas at risk. • New Medical Agency contracts to be issued – supplier meetings planned 14/18 March.
New Roles and Apprentice -ships	• As at 12 Mar, 95 apprenticeships enrolled on programme. This a slight reduction as a number of apprentices have withdrawn from the programme. • Interviews scheduled for Fri 15 March for a Band 7 nurse to undertake scoping activity of Advanced Clinical Practitioners across the Trust. • Currently advertising to recruit Nursing Associates at B4 in General Medicine as first wave joined the NMC register in Jan 2019. • Administrator Apprenticeship Working Group held 12 Feb identifying need for a pool of administrators. Determining how apprenticeship framework can support these.			• Further requirements for Physician Associates to be included in plan once Workforce Plans finalised 15 March 19. • Advanced Clinical Practitioner scoping work to commence for nursing 1 April 19. • Implementation plans to be completed for all trust-wide roles by 31 March 19. • Levy transfer opportunities to be identified by 31 March 19. • Timeline for MTI fellow placement to be determined for Paeds and Obs/Gynae. • Shortlisted next cohort of Trainee Nursing Associates due to commence in September.
Directorate CIPs	• The Best Workforce schemes are forecasting a year end achievement of £1.51m against the target of £3.7m and therefore forecasting a year end shortfall of £2.17m. • Medical Rates CIP is currently forecasting £303K for the year against a £2m plan. In last 4 months seen improvements reporting £30K to £45K per month.			• 18/19 CIPs shortfall mainly due to the underperformance of the STP medical rate reduction delivery. The key enabler to addressing reliance on temporary staffing is to fill medical vacancies and improve rostering performance. This is now a priority for 19/20.
E-Rostering	• Support continued with all nursing approvers to ensure review or time balances and reconciliation against hours / shifts worked by end of financial year. • Reviewing roster performance calculations and working to ensure this information is meaningful and accurate to meet future reporting requirements. • Safecare demo completed 22nd Feb 2019. • Testing currently being undertaken to implement nurse bank shift booking app. • Commencement of work to update roster templates to meet budgeted establishment. • Rostering KPIs agreed as 1) Roster signed off 6 weeks in advance 2) Shifts released to bank 4 weeks in advance 3) Utilisation of contract hours 4) Leave management.			• Implement nurse bank shift booking app by 31 May 2019. • Continue work to update roster templates to meet budgeted establishment. Cross check safe staffing reviews with workforce establishment by 31 Mar 2019. • Engagement with clinical leads to commence roster challenge / review meetings by 31 March 2019. • Creation of Workforce Performance Reports for HRBPs to use with divisions to track/challenge performance by 21 March. • Support for Managers to produce rosters up to the 19th May following evaluation of Brexit risk. • Finalisation of Medical E-Roster business case by 31 Mar 2019.
Recruitment	• Medical recruitment agency partnership BDI progressing well with 17 new recruits in the pipeline. • Clearmedi for nursing 1st draft proposal received. • Meeting held with HRD and SPPD to agree lead on Recruitment Marketing Strategy. KCHFT has been approached to provide expertise. • DMD has raised with CDs for improved engagement needed with medical recruitment process. • Corporate video to be funded from recruitment advertising budget to avoid further delays. • Nursing and Medical substantive forecasted numbers in Workforce Plans to be tracked instead of vacancies. Draft values to incorporated until Workforce Plans are finalised.			• Prompt review of further CV's put forward by BDI so swift progression to interview / conditional offers for successful candidates can be achieved. • Clearmedi for nursing contract agreed and Skype interviews will be scheduled after that in April. • HRD and SPPD to secure support from KCHFT for expertise in supporting completion of Recruitment Marketing Strategy along with branding and comms resource by 22 March. • Nursing workshop to be scheduled for early April to significantly increase nursing recruitment numbers rapidly, identifying solutions to any constraints. • Procurement and finance approval to be secured in order to progress with corporate video by 31 March.

KEY ISSUES/RISKS TO FINANCIAL PERFORMANCE

DESCRIPTION	MITIGATION	DATE REC	LAST MONTH	THIS MONTH
ISSUE – Project is forecasting a £2m shortfall. This is mainly due to underperformance of the STP medical CIP target.	The key enabler to addressing reliance on temporary staffing is to fill medical vacancies and improve rostering performance. Priorities from Exec Workforce are on recruitment to fill TWH nursing vacancies in addition to filling all other vacancies. Nursing Recruitment workshop to be scheduled for early April.	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 in process of implementing Medical Agency Contracts by 31/02/2019, which should result in more CVs provided at a lower rate.	Aug-18		
ISSUE – Transparent and robust information not available on medical vacancies / gaps due to multiple rostering systems and approaches. Taken medical recruitment team 3 months to deliver quick wins.	PMO launched recruitment project with full review of medical recruitment activity, roles, responsibilities and timelines in Nov-18. However concerns exists over capability of team in order to achieve project objectives. Long term sick leave also affecting performance and raised at Medical Productivity Board. Backfilling of long term sick leave resource required and radical change to overall performance. Escalated to HRD.	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.	Further review sessions held on medical bank rates. Rates agreed in principle, which includes single rates across divisions with exception to consultant grade, with areas requiring enhancements to be identified. Agreed rates to be circulated to CoSs by 31 March 2019.	Oct-18		
RISK – Key apprenticeship resource about to go on long term sick leave without backfill impacting on ability to deliver project.	Escalate to Workforce Board. Role to be backfilled immediately and additional resource to be requested in business case to be submitted by L&D.	Feb-19		



KPIS	Target	LAST MONTH	THIS MONTH	
Public Sector Target for workforce on Apprenticeships Apr 18 to Mar 19	2.30%	1.36%	1.29%	↓
Medical				
Medical Shifts Requested		3,591	3,086	↓
Percentage of Medical agency shifts over STP break glass rates	0%	96.1%	85.7%	↓
Percentage of Medical shifts requested more than 6 weeks in advance	> 80%	34.3%	36.4%	↑
Percentage of Medical shifts requested Retrospectively	< 5%	16.8%	22.2%	↑
% Medical Shifts covered by bank workers	> 70%	35.5%	41.7%	↓
% Medical Shifts covered by Framework agency workers	< 24%	34.4%	28.1%	↓
% Medical Shifts covered by Non-Framework agency workers	< 1%	0.6%	0.2%	↓
% Medical Shifts Unfilled	< 5%	30.1%	30.0%	↓
Nursing				
Nursing Shifts Requested		6,160	6,160	-
Percentage of Nursing agency shifts over NHSI Caps	0%	12.2%	3.9%	↓
Percentage of Nursing shifts requested over 6 weeks in advance	> 80%	26.6%	22.3%	↓
Percentage of Nursing shifts requested Retrospectively	< 5%	7.7%	7.6%	↓
% Nursing Shifts covered by bank workers	> 70%	44.8%	45.1%	↑
% Nursing Shifts covered by Framework agency workers	< 24%	29.0%	25.5%	↓
% Nursing Shifts covered by Non-Framework agency workers	< 1%	4.0%	3.5%	↓
% Nursing Shifts Unfilled	< 5%	22.2%	25.9%	↑
Average roster performance score for in-patient nursing areas	> 85%	68.96%	72.26%	↑

FINANCE NARRATIVE

Year to Date

The Best Workforce achievement to date is £1.35m against a plan of £3.31m. The shortfall of £2m is largely within the STP Medical rate CIP underachievement(£1.51m).

The key achieving CIP in Months 1 – 11 are the 2017/18 Roll Over schemes and Medical rate reduction reporting 41% of the workstream between the two schemes.

Forecast Position

The Best Workforce schemes are forecasting a year end achievement of £1.51m against the target of £3.7m and therefore forecasting a year end shortfall of £2.17m.

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**

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WORKSTREAM	Best Patient Flow	BEST CARE PROGRAMME BOARD DATE	18.03.2019
WORKSTREAM LEAD	Sean Briggs	TRANSFORMATION SUPPORT	Fiona Redman / Jodie Kennett

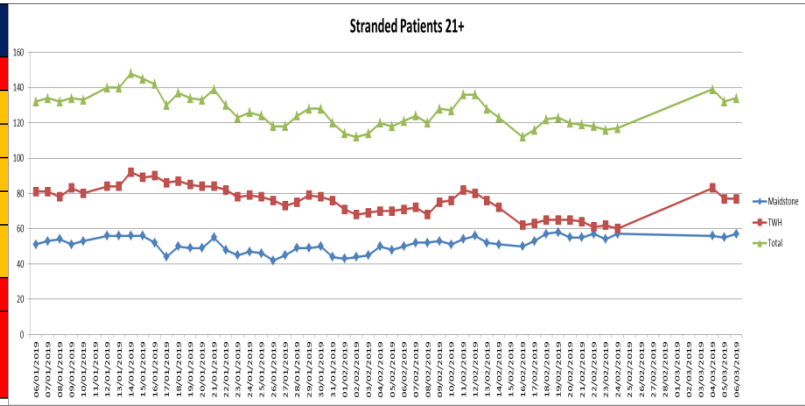
DESCRIPTION	ACTIONS / MILESTONES COMPLETED	DELIVERY RAG		ACTIONS FOR NEXT REPORTING PERIOD
		LAST MONTH	THIS MONTH	
Frailty at TWH and WKAEG Frailty	Bronze model in place at MS and TWH CPMS lead working with Frailty nurse to complete CGA on the system with added printing options CPMS decision as to pas 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 Regular operational and BI meetings to sense check and troubleshoot frailty data. Matron to continue to embed process with ward staff. Darzi matching decision Pathways between ED and Ward 32/Mercer improving Frailty and HIT training video completed for CPMS			GP advice line to commence on Monday 18th March Community Frailty nurses to attend board rounds on both sites by the end of March Frailty business case to be updated with additional information following Clinical Cabinet feedback HTS Workshop with both teams to highlight benefits of the service Raise awareness within AFUs, ED, W32 with new falls service-new form to be circulated.
Out of Hospital Capacity	Fast track pathways improvement has been maintained. Hilton has had an increase in capacity for winter period to 60 beds over weekend. Usage has improved during February. Pathway 3 has seen significant discharges in February, currently 35 patients on P3 and 19 on Commercial scheme. No CHC DST completed in Acute in February, showing improved processes, with 22 patients admitted to the scheme. Super stranded numbers increased in early January but are now stabilising. Reduction in early February and then a rise in later parts of the month. Hospital at Home (H@H) saw a spike of 18 at end of February. Analysis of first 80 referrals shows vast majority IVAB's and medicine. Slow uptake for Orthopaedics and surgery. Working with teams to increase referrals. #NOF project discussed at A&E delivery board 11.2 and 11.3.19 Aim to release capacity in acute sector with the use of KCHFT community beds.			New member of staff in place to assess and pull patients through to caseload. Team leaders to target wards and consultants to gain buy in for H@H. Starting Long stay (super stranded) Wednesday/Thursday focus meetings with matrons and senior IDT from 13.3.19. New target for Super Stranded has been set at 90 by end Mar 20 by NHSE H@H Paper to go to MTW Executive Team 19.3.19 to review funding for 19/20. Sunhill Court: potential new scheme to support specific complex discharges.
LoS Increased number of 0 LOS	Stranded patients – over 7 days – supporting and embedding flow coordinator role and use of CUR to identify patients who are non qualified and specific delay themes. Transfer of LOS schemes where appropriate to BAU in preparation for 19/20 project work. Development of triumvirate specialty leads through re alignment of matron roles within Medical Specialties. Live Bed State in place across 4 wards. Tweaks to programme following user feedback. Criteria Led Discharge – working with other Directorates to share paperwork and project plans.			CUR implementation manager working with BI to automate daily reports for all operational staff. Reports to be available at Exec and CCG level Continue rollout of live Bed State to all wards. Identification of key workstreams for 19/20 – likely to be EDN/ EDD/ CLD/ real time reporting.
Therapies	Therapies Directorate working with Corporate Nursing team to develop pilot for Therapy Associate if funding available. Engagement with external partners to improve integrated working through development of Single Assessment document. Review of TADS capacity/ availability to be included on SHREWD to support visibility of system pressures. Working with KCC on pathways to support clinical triage within Local Referral Unit.			Trial Single Assessment document in one service. Review possibility of using e forms to support Single Assessment. Meaningful data in place for TDI/ IT IS i.e. to support Therapies Agreement of JD for Therapy Associate B4
AEC	Planned Ambulatory in the community -. All process now in place ready for the commencement of the service. Development of direct GP referral to AEC Enhanced clinical engagement with the AEC model for all specialties specifically Surgery Under new clinically led structure surgical teams have signed up to ambulatory network.			Increased governance in place to ensure delivery of objectives Process supported by MTW and KCHFT project management teams Working with matron/ GM for T&O/ ENT to produce similar criteria but need clinical engagement. CD for Acute Medicine and Geriatrics to support. Signage for AEC TW to be in place Plans for creation of waiting room Relocation of planned radiology recovery patients to be managed with Planned Care.

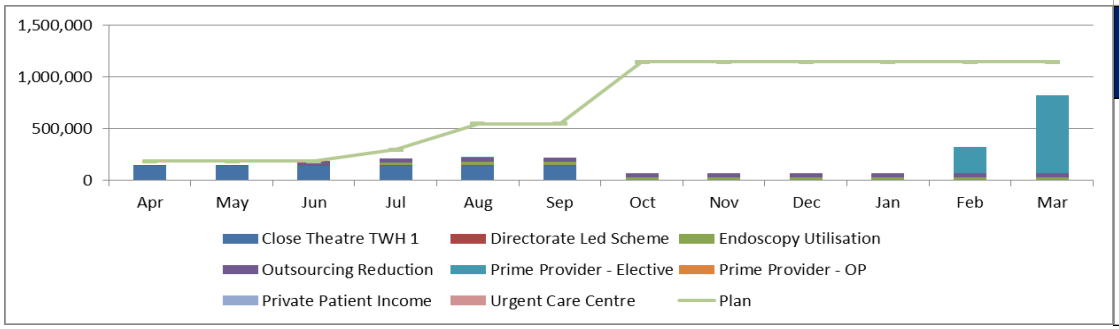
Non-Elective Surgical LOS	• Further embedding of the red to green days by site team through CUR to develop further improvement projects – this is ongoing • Project plans to be worked up with new project lead to increase opportunities. • Implementation of SEACU (Surgical Ambulatory Care) project from 1 April			• Continue embedding of red to green days by site teams, work to BAU. • Project plans to be delivered - NHSI submission10th April 2019. • Agreement of new clinical lead
Increase in private activity	• PPU Outpatients open since Feb 4th 2019 with 114 procedures through the unit to 10th March 2019, over £77490 revenue was generated. • Working with ADO's to identify a detailed plan to release IP beds for PPU • PPU recruitment programme continues and is a challenge.			• Continue with recruitment programme. • Identify key tasks for PPU Inpatient Plan • Monitor of patients through robust KPIs
Prime Provider	• MTW awarded the appointment of prime provider Jan 2019 • Robust communication pathways to GPs and SPoA services including visits • Additional MTW consultant engagement session held • RAS templates completed and published – being used by referrers • Business planning for internal/outsourcing numbers final draft. • Final draft of contracts with IS for outsourcing. • Received MOUs from IS in order to continue outsourcing whilst contracts being drafted. • PCCT training completed.			• Finalise Quattro system for electronic patient tracking to also include outpatients. • Embed KPI and performance monitoring of prime provider into current systems. • Submit operational policy to PRC for approval • Sign finalised contract variation for prime provider with WKCCG • The project is green as project has gone live, but still waiting to see finances.
Operational Productivity	**My POA** •Theatre list review of patient pathway processes. •KPI's agreed and signed of at Divisional meeting 06.03.2019. •QIA to be presented at QIA Clinic – March 2019. •POA raised. **Theatre Productivity** •MRSA "screen on the day" formally signed off– Feb 2019. •KPI's agreed at Divisional meeting 06/03/2019. •Stocking Up process has been implemented •Late escalation SOP written and ready for sign off. **Loan Kits** •Develop Financial Methodology to provide spending data.. •Loan Kit usage and financial information presented at Directorate mtg Feb 2019. •Approval process to be reviewed.			**My POA** •Review of POA data and clinic templates – 30/03/2019 •CAU and POA Workshop March 14/03/2019 •Implementation planning to be completed end March 2019. •DPIA to be presented 13/03/2019. **Theatre Productivity** •Continue deep dive into consultant procedure times. •Late Escalation SOP to be signed off **Loan Kit** •Continued analysis of loan kit data, to identify loan kits to reduce the usage •Rewrite approval process if required •Finalise financial methodology
Outpatient Productivity	**Ophthalmology** •opportunity of glaucoma Virtual clinics reviewed – Feb 2019 •Meeting with West Kent CCG re Ophthalmology opportunities 05.03.2019 •Plans in place to review CNS establishment •Agreed Ophthalmology baseline and KPIs – Feb 2019. **Focal and Soap** •Full review of FOCAL and SOAP to formulate action plan •GRS Electronic scheduling business case submitted. •Review of DNA rates and cancellations in progress •6-4-2 scheduling process plans in place for implementation **RTT** •Data Quality Programme Director commenced. •Project plan being scoped. •Accumentice scoping exercise - awaiting final report.			**Ophthalmology.** •Provide feedback on glaucoma virtual clinics – April 2019 •Work up Ophthalmology opportunities identified by CCG – March 2019 **Focal and Soap.** •Write action plan for FOCAL and SOAP. •Mitigation plan for DNA KPI – Continue to monitor DNA rate, use 2 way text messaging, increase communication to Outpatient areas and internet. **RTT** •RTT Training continued to be provided and develop increased training for the CAU's - March 2019 •Deliver project plan. •Review of Accumentice report – April 2019.
Outpatient Transformation	•Ophthalmology: recruited 2 x Failsafe Officers; patients being referred to Practice in North Kent/Medway; validation letters sent to urgent patients who are unreachable; additional MTW Saturday clinics in place to support capacity •Cardiology: SET meeting agreed in principle proposal for GPwSI and direct access echo for TW (i.e. 12 echo's a week from MTW); GPwSI training programme continues – anticipate service 11/19. •Charcot: additional clinic commenced 18/2/19; additional podiatry support contract requires financial review •MTW accepted as NHSI Attend Anywhere virtual IT solution system – meeting 18/3/19 to discuss implementation •Inaugural respiratory sprint meeting 6/3/19 with MTW/KCHFT/WKCCG •initial scoping for Gastro. •Patient Survey circulated.			• Ophthalmology: Failsafe officer recruitment continues; review impact of referring patients to practice for monitoring; failsafe officers to continue to validate urgent patients and diagnosis coding; review impact of additional MTW clinics; develop project expansion by 28/3/19 •Cardiology: WKCCG develop business case for both GPwSI and direct access. Set next meeting date late April 2019. Develop Attend Anywhere and prison services work streams. •Charcot: business case to be completed; review impact of additional clinic. •Respiratory: Data analysis with West Kent Alliance partners to develop areas of focus including Attend Anywhere and prison services. •Gastro: analysis of scoping to develop areas of focus including Attend Anywhere and prison services. •Patient survey result analysis and report; seek new patient/carer representative.
MSK	•MSK KPI combined dashboard progression and monitoring of SPoAs.			•MSK 2019/20 work plan development including C/Fellow b/case postings.

KEY ISSUES/RISKS TO FINANCIAL PERFORMANCE: DESCRIPTION	MITIGATION	DATE REC	LAST MONTH	THIS MONTH
NOF – Risk of recruitment of therapists to enable the enhanced rehabilitation pathway.	Working with KCHFT to develop a recruitment plan.	23.03.2019		
Releasing internal capacity to undertake additional Prime provider work.	Operational Productivity project underway. Transformation managers working on project plans to improve productivity:	08/10/18		
Releasing internal capacity to undertake additional IP Private Patients	Bed Modelling workstream to be in place for 19/20. Working through options with Senior Managers	08.02.2019		
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/ included in action plan to achieve 95% in March 2019-?	01/02/18		
Recruitment of skilled staff to support assessment pathways, including appropriate notification of funding streams to allow substantive staff to be recruited	Rolling recruitment programme	12.03.2019		

Critical Path Milestones	Milestone Date	Status	RAG Last month	RAG This month
Appoint staff and implement 8 – 8/ 7 days a week AEC until TW	31/12/2018	75%		
Recruit to posts substantively and in the short term through bank to support increased opening hours of TW AFU	13/11/18	90% for Bronze model		
Commence PP additional activity in EGAU	15/08/2018	0% PPU acquired		
Achieve 100% opportunity (c. 95% utilisation) within theatres creating capacity for prime provider (stepped increase)	01/10/2018	w/c22.02.2019 92% all specialities. T&O 100%		
Agreement of funding for Frailty/ AEC / H@H to support beyond 1.4.19 to allow for substantive recruitment and build on pathways	28.2.19	In business planning, paper to go to Execs 19/3 for H@H		
Implementation of My POA				
De escalation of Frailty Units to support improved pathways				

KPIS	Target	LAST MONTH	THIS MONTH
NE LOS Medical	7.4	7.2	8.1
NE LOS Surgery	5.5	5.9	5.5
NE LOS T&O	10.3	10.4	10.8
Achieve or exceed DTOC target (%) ***Estimate only as actual figure not yet available.**	3.5%	4.1%	3.75%
Super-Stranded Patients : All Patients In a Bed & Having LoS >21 days	113.1	130	123.1
Theatre Utilisation for Prime Provider (%) Step up KPI to 100 opportunity (95%) utilisation	95	82 T&O= 100	92 T&O= 100
Outpatients DNA Target (new)	5%	Oct 5.6%	Mar 7.01%
Cancellations on the Day (theatres)	5%	8.4%	8.4%





FINANCE NARRATIVE

At month 11 the year to date planned savings delivery was £7.7m but actual savings of only £1.5m, i.e a slippage against plan of £6.2m. This is driven by prime provider slippage of £4.7m (£1.0m outpatients and £3.7m elective), Private patient income generation £0.9m, Endoscopy utilisation £0.2m and Urgent Care Centre £0.3m.

The year-end forecast slippage is £7.2m (82% of the planned savings of £8.8m). The £1.6m forecast/achieved savings include: £0.9m theatre 8 closure for 6 months, £0.4m outsourcing savings and £0.3m from reduction in WLI costs associated with bowel screening delivery.

NHS
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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**

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WORKSTREAM	Best Quality	BEST CARE BOARD DATE	March 19
WORKSTREAM LEAD	Gemma Craig	PMO SUPPORT	Hannah Pearson

PROJECT	MILESTONE ACTUAL	DELIVERY RAG Jan	DELIVERY RAG Feb	FORWARD VIEW: KEY MILESTONES TO TAKE PLACE IN THE NEXT 4 WEEKS
	Decision to begin Delirium Group and add to BQ Workstream			
Complex Needs	**MTW Dementia** • Emergency Services Dementia Event Planned for 21st May at MTW – Collaborative work with SECAMB, KFRS and West Kent Police. • Communications and invitations to Emergency Services event sent out – aim of event is improve knowledge on Dementia Services for Emergency Services staff. • First Draft of KPIs and Project Objectives and Success Criteria • Continual monitoring of admissions from care homes - no flags as of yet.	A	A	**MTW Dementia** • Continuation of multi agency work supporting diversion from A&E attendance where appropriate. • Comms re Emergency Services Dementia Event • Finalisation of Project outcomes / Success Criteria • Sign off of KPIs • Business Case to be produced / application of BC funding to support Project.
	WKA Dementia • Formalisation of governance arrangements between SIG, AIC collaborative and Best Quality Programme in place to begin for April. • Accountable officers confirmed	A		**WKA Dementia** • QIA to be written and signed off. • JPMO Workshop 19/03/2019 • Scoping of Dementia project and key outcomes to be delivered by West Kent Alliance
	MCA • Project objectives to be defined following outcomes of the TIAA MCA and Safeguarding Audit	NEW	B	**MCA** • Meeting to define project objectives and goals • Publication of TIAA Audit outcomes – date TBC
	Transition • Rebranding of Transition Nurse – with a Learning disability element after unsuccessful attempts to appoint to Band 5 Transition post • Details to be sought regarding Best Care funding Reapplication • Policy for care of 16&17 year olds on adults wards draft finalised • SOP for 16/17 year olds on ITU in development	R	A	**Transition** • Decision to be made about scope of project , outcomes to be delivered and requirement for additional Best Care resources in 19/20 • Trustwide policy for care of 16/17 year olds in adult areas – draft to be shared with all matrons/ area managers . And shape reengagement with Adult areas on project group.
	Patients and their own Medications • Project Group Established • Response to National inpatient survey • Objectives defined • Review of one option to manage own medicines	NEW	R	**Patients and their own Medications** • Research to find how other organisations manage issues • To work with procurement to get samples of other options for pts managing own medicines – boxes /lockers etc. • QIA to be undertaken • Meeting with finance to work up finance methodology.
Effectiveness and Excellence	**Maternity Safer Births / CNST** • Continuing monitoring and management of performance against the new 10 safety criteria • Ongoing risk assessment and action planning against the new 10 safety criteria • On track to meet all deadline dates • Assessment and identification of performance and areas of non compliance risk • Monthly project meetings continue	G	G	**Maternity Safer Births / CNST** • Working up KPI reporting for continual monitoring to establish early escalation of Risks
	Crowborough • Refurbishment works complete • Planning for end of works celebratory event • 6 month Marketing Plan being managed by communications team. • Positive feedback received from mothers about refurbished birth room	G	G	**Crowborough** • Detailed planning for End of Works celebratory event • Unexplained drop in antenatal care figures for Feb – investigating with staff.
	Pressure Sores: • Continue monitoring progress against Gap Analysis • New policy in line with NHSi Guidelines has been approved at NMAHP on 20/02/2019 • Policy reviewed at NELF to share with Staff.	G	G	**Pressure Sores** • Updated policy goes to Policy Ratification Committee in April • Getting Key rings laminated for staff – to assist with pressure grading • 5 key points developed to support staff with new reporting
	#EndPJParalysis: • Liaising with fundraising manager - Plans in place to organise launch week fundraising event to celebrate anniversary of 70 day challenge • New Lead engagement for project • Refresh of project group TOR and establishment of monthly meetings • Retrospective data analysis –data to back up 'relaunch'	A	A	**#EndPJParalysis** • Further fundraising planned including celebrity patient led walks around hospital sites • Exec engagement for relaunch event to be confirmed • Ops lead to be confirmed
	Nutrition • Visit from NHSi on 21st Feb – very positive feedback received from NHSi • On the job training sessions continue to be delivered on pilot wards • Dieticians now approaching wards to deliver adhoc training to increase MUST compliance engagement • Data analysis continues to show upward trend. Positive responses from Staff involved • Nutrition and Hydration w/c 11th March – Tea Party to be held on Edith Cavell • Take 5 Comms to go out on MUST as part of nutrition and hydration week.	G	G	**Nutrition** • Meeting with Learning and Development to Correct MUST elearning • Attendance at Final collaborative event • Continual re-auditing to establish improvement margins

WORKSTREAM	Best Quality	BEST CARE BOARD DATE	March 19
WORKSTREAM LEAD	Gemma Craig	PMO SUPPORT	Hannah Pearson

PROJECT	MILESTONE ACTUAL	RAG Jan	RAG Feb	FORWARD VIEW: KEY MILESTONES TO TAKE PLACE IN THE NEXT 4 WEEKS
E&E continued	**CQUINS** • Publication of 1920 CQUINs • Confirmation of Q3 achievement	G	G	**CQUINS** • 1920 CQUINs to be finalised by CCG • Decisions to be made regarding national CQUIN uptake • Draw up CQUIN plans and assign leads in line with the finalised CQUINs
Experience and Engagement	**PPEE** • Second draft strategy – *Making it Personal* shared internally and externally for comment and feedback including TME and Patient Experience Committee • Invest to Save proposal developed for securing resource for strategy implementation - Business case drafted.	G	R	**PPEE** • Third pre publication draft prepared responding to comments/ feedback received. • Development of plan and materials for communication and launch of strategy • Strategy launch and implementation – This phase of project remains at risk due to reduced support – business case drafted.
	Staff Experience and Engagement • Collation and analysis of feedback received from staff • Staff Engagement 1920 Plan Drafted and Shared with HR Director • 2018 Staff Survey results published and communications to staff • Crowdfixing events to support Directorates and action change identified • Outreach staff engagement sessions scheduled	G	G	**Staff Experience and Engagement** • Staff engagement 1920 Plan to be signed off • Staff engagement plan publication and launch • National NHS Staff Survey plans in place by April
Quality Improvemen t	**Quality Improvement** • To move to BAU –monthly reporting established to TCGC • All 17 Should Dos without exception have actions against them and transitioning into business as usual approach. • On track with regards to the Internal Assurance Inspection Programme with some new volunteers.	G	G	**Quality Improvement** • Transition from CQC Tracker to appropriate action plans monitored through Best Care programme, PLACE, QIC, etc. • Embed the QIC Agenda into BAU.

KEY ISSUES/RISKS

DESCRIPTION	MITIGATION	DATE REC	Jan	Feb
Risk: PPEE remains unsupported without resource post project phase in BAU mode	Production of Business case for to include provision for PPEE support. PMO Support not in place to support strategy launch.	11/12/18	A	R
Issue: Unsuccessful attempts to appoint to Band 5 Transition Nurse post – after going out to advert 3 times	Project Team agreed to edit job – Transition and you people Learning Disability nurse. Merge Job Description with current LD Nurse to progress.	11/02/19	R	A

KPIS	TARGET	Jan	Feb
Total Number of Labours commenced at Crowborough Birthing Centre	18	14	25
Number of Births at Crowborough Birthing Centre	14	11	19
Total Number of women receiving Ante Natal Care at Crowborough	200	212	173

CRITICAL PATH MILESTONES

TASK	DATE	STATUS	RAG Jan	RAG Feb
WKA Dementia :Review of Governance for Dementia SIG to convert to delivery vehicle of AEG Dementia Project	15/01/19	In progress	G	G
WKA Dementia: 1st Dementia SIG converted to WKA Project Group with attendance from Exec sponsors	26/03/19	In progress	NEW	G
Dementia: Emergency Services Dementia Event	21/05/19	On Target	NEW	G
MCA: Publication of TIAA Audit	?	In progress	NEW	G
Transition: Recruitment to Transition Lead (New plan in place)	30/08/18	Overdue	R	A
CNST: PRMT Action plan signed off at board level	10/03/19	Completed	G	C
Crowborough Practical Completion Phase 2	04/03/19	Completed	G	C
Pressure Sores: Policy to Policy Ratification Committee	26/05/19	On Target	NEW	G
EndPJParalysis – Re launch week 1 year anniversary	15/04/19	On Target	G	G
Nutrition NHSi Visit	21/02/19	Complete	G	C
Nutrition – completion of NHSi Collaborative	21/03/19	On Target	G	G
Publication of 1920 CQUINs	11/03/19	Overdue	R	C
Launch of PPEE Strategy sharing with staff and pt network	29/01/19	On target	G	G

WORKSTREAM	Best Quality	BEST CARE BOARD DATE	March 19
WORKSTREAM LEAD	Gemma Craig	PMO SUPPORT	Hannah Pearson

FINANCE NARRATIVE

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

Safer Births / CNST:

Ongoing monitoring of performance against NHS Resolution new 10 safety criteria. Monthly monitoring meetings in place – action planning to address any concerns or possible under performance. Monthly meetings in place to monitor KPI mapping underway.

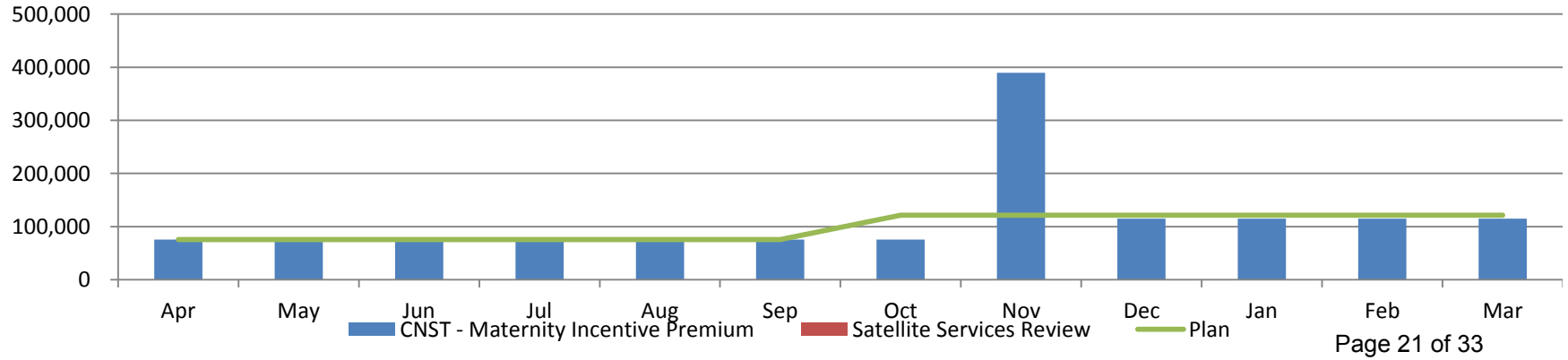
Crowborough Birthing Centre:

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	M8	M9	M10	M11 - Reporting	M12	Sum
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	75,708	75,708	75,708	75,708	75,708	75,708	75,708	389,554	114,939	114,939	114,939	114,939	1,379,266
Variance	0	0	0	0	0	0	0	313,846	39,231	39,231	39,231	39,231	470,766
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
Sun of 1819 Actual	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
Overall													
Total Sum of NHS 1819Plan	**75,708**	**75,708**	**75,708**	**75,708**	**75,708**	**75,708**	**121,541**	**121,541**	**121,541**	**121,541**	**121,541**	**121,541**	**1,183,500**
Total Sum of 1819 Actual	**75,708**	**75,708**	**75,708**	**75,708**	**75,708**	**75,708**	**75,708**	**389,554**	**114,939**	**114,939**	**114,939**	**114,939**	**1,379,266**
Total Variance	**0**	**0**	**0**	**0**	**0**	**0**	**-45,833**	**268,013**	**-6,602**	**-6,602**	**-6,602**	**-6,602**	**195,766**



Maidstone and Tunbridge Wells NHS Trust

2e.Best Safety

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

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

The projects include:

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

MTW exceptional people, outstanding care

WORKSTREAM	Best Safety	BEST CARE BOARD DATE	6th March 2019
WORKSTREAM LEAD	Lynne Sheridan	PMO SUPPORT	Abigail Hill (Medical Productivity/Preventing Harm and GIRFT) 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 National Board Assurance Template (BAT) has been completed as is due for submission to NHSI on the 28.2.19, following sign off by the Medical Director. A detailed supporting paper has been written to accompany the BAF to provide the required context. The national BAF and accompanying paper will also be submitted for the March Trust Board. The meeting regarding next steps for the Surgical Directorate (following the telecon with Celia Ingham-Clark of NHSI took place with the, Lead Clinician and GM on 14th Feb to discuss solutions and mitigation. The virtual ward round went live on 21.1.19 as planned. The Lead Clinician is exploring ways to cover the evening ward rounds 7 days per week with a face to face consultant-delivered solution. The Medicine and Emergency Care plan continues to be progressed and a review took place at the 7DS Core Team meeting on 12th February 2019 and a further meeting with the Deputy Medical Director on 26.2.19. A meeting has been arranged with the ENT Team for 13.3.19 to confirm their plans. The final paper for Women's Health has been completed and signed off by the Chief of Service. This will be submitted to the Quarterly Review Meeting on 14.3.19. 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 (review pending) • Urology - Non compliant - standard 2 at weekends – (awaits 6th Consultant appointment) • Women's Health – Informally compliant (for ratification at quarterly review in March) • Specialist Medicine and Acute and Geriatric Medicine – Non-compliant – standard 8– major investment and reconfiguration of services is required. Whilst plan in place to mitigate as far as possible, it is known that full compliance by March 2020 is not going to be achieved. Standard 5 & 6 – Non complaint (just for Endoscopy) until 24/7 GI Bleed rota is implemented – plans in progress. • T&O – Technically compliant for standard 8, but decision to revert back to non-compliant state until all potentially medically active patients can be assessed thorughout their LOS. The CD has produced an SOP and an update on progress with implementation will be received in March 2019. This will also be discussed at the March Quarterly Review. All remaining areas compliant or exempt for the 4 priority standards. Work is to commence on the remaining 6 National standards (non-priority ones) commencing with a meeting with the CCG Lead in March.			• Further discussions regarding approach for Med & Emer Division (in respect std 8) • Work with CCG (Mark Atkinson) to review position with Med & Emer Division. • Continue to meet with ENT, Urology, Surgery and Med & Emer Div to agree next steps and actions • Meeting with Mark Atkinson (14.3.19) to discuss work on 6 remaining National standards. • Meeting with ENT Team on 13.3.19 to progress compliance options. • Monthly reports from the Medicine and Emergency Care and Surgical Divisions. • Quarterly Review with NHSE/I and CCG on 14.03.19.
Mortality	• Word versions of the mortality review forms; Preliminary Screening Tool (form1), First Stage Review (form 2) and SJR (form3) have been sent to Ruth Dickens to update the documents on Q-Pulse alongside the updated policy. Once Q-Pulse has been updated the forms will be circulated to the wards and Bereavement Office for immediate use. Old forms will be removed from the wards. • All options for the electronic Mortality database have now been reviewed and considered with Datix being the preferred option. The Datix Mortality module could potentially be implemented within 6 weeks. The results of the options appraisal will be included in the Business Case which will be finalised by LS by the end of February. • Medical Examiner role has been discussed further and funding arrangements have now been agreed. However the release of National Guidance has been delayed so agreement has been reached to wait for this guidance before any further development of an implementation plan can take place. • Audit of notes for patient deceased between June and November 2018, was completed on 20th February, preliminary findings were that all cases reviewed were appropriately graded as not requiring an SJR. • Draft for Intranet page has been completed and is being finalised before a go live date is agreed.			• The temporary Band 2 Mortality Data inputting clerk resource will finish on 5th March. • Completion of Business case for Datix.
Learning Lessons	<u>Action Planning & Learning Source Identification</u> A business case is being finalised to recommend full migration to Datix IQ. The review of the Patient Safety Team has now concluded and the planned stocktake meeting of this project took place with the Team on 12th February 2019. The requirements of the project were discussed in detail. It was confirmed that the resource is not currently available within the Governance Team to fulfil the requirements of this aspect of the project . A business case will be produced by the Associate Director of Quality Governance and updates to the timing of this aspect of the project will be provided at the next Best Safety Board. <u>Clinical Governance Meetings & Infrastructure</u> SF and LS have circulated the pack proposing arrangements for a revised clinical governance agenda and infrastructure for Directorate and Divisional meetings to the Chiefs of Service. On 26.2.19, a meeting took place with the Chiefs of Service to discuss the pack with a view to agreement to implement. This meeting also involved the Deputy Medical Director. The Chiefs agreed with the proposals and are now going to implement locally. <u>Evidencing and Embedding Learning</u> The outputs from the second workshop were put forward as proposals for consideration to the stocktake meeting on 12th February 2019, as outlined in 1) above. The outputs proposed were 1 x metric based measurement, 1 x people-based measurement and 1 x system based measurement. These were agreed by the Group and as outlined in 1) above, will be subject to the resource requirements to be set out in the business case. As previously reported, resource has been lost to this project - (The Project Lead) due to pressure of work. LS is covering.			• Datix Recovery Business Case completion. • Datix system specification production (for use by Head of Procurement in the process). • Continued work on the Datix system recovery (led by the new secondi – Datix System Administrator) • Stocktake meeting – February 19 • Discussion, with a view to agreement and implementation of the draft new Directorate/Divisional CG agenda and supporting infrastructure for discussion with Chiefs of Service. • Commencement of business case for resources required for sections 1 and 3 of this project (as part of the overall development of the Patient Safety Team).
Medical Productivity	<u>Job planning</u> A CD training session on job planning and slight amendments to the PAAT was held in January and all GMS have be written to highlighting changes and offering individual training, plus PMO support. The updated version of the Policy, Standards and PAAT has been agreed with the JMCC and is now on the intranet. Feedback has been given to the teams on areas of focus for this round of job planning. Support is being provided to the GMs and CDs for individual issues. The directorates are focussing on ensuring job plans are completed in the time frame. <u>Demand and Capacity</u> The BI team have finished the first round of work comparing outpatient capacity against job planning and demand and capacity plans. This has been shared with the directorates and the BI analysed is meeting with directorates to understand queries. This will form the basis of the personalised metrics. The BI analyst has also developed a simpler process for demand and capacity planning mapping for next year, which will improve the accuracy. The team are replicating this for theatres. <u>Best Value</u> The team have requested the data to reconcile PAs against job plans. The work to look at localised WAU metrics against DCCs is continuing. <u>National Project</u> MTW remain in contact with NHSI and had a teleconference this month. NHSI have asked MTW to be part of a pilot testing a medical productivity metric. <u>Internal Audit</u> Job planning is subject to internal audit currently. The team have provided the auditors with the required information and the report is expected in the next couple of weeks.			• All job plans to be added to the system and signed off • Personalised metrics to be drafted • Reconciliation of pay against job plans • Reconciliation of job plans against budgets

WORKSTREAM	Best Safety	BEST CARE BOARD DATE	6th March 2019
WORKSTREAM LEAD	Lynne Sheridan	PMO SUPPORT	Hazel Hill (Medical Productivity/Operational Improvement GIRFT)/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	Long Elective Waits The Datix team are now in a position to support the development of an electronic Harm Review form , accessible via the intranet, that will auto generate an IR1. This will save considerable time as will remove the need for double entry and will hopefully speed up the process and increase reporting. This is currently being tested for both Cancer Harm Reviews and Long Elective Waits. This will also mean that we can increase the scope to doctors reporting any patient who they consider may have come to harm as a result of an excess wait, rather than the plan to only review patients waiting over 52 weeks and a sample of patients waiting over 42 weeks. Through making the process electronic, it will make report running and identifying trends over a longer period of time easier Once we have three months of data we will set up an Review Panel and consider the outcomes of the forms and next steps.			LEW • Finalise the plan for Longo Elective Waits Audit
	Documentation and Record Keeping • A presentation and paper were provided to the Quality Committee in December. The paper reflected 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 project was endorsed and the work has commence in January 2019 – starting with a letter from the Medical Director to all doctors. This was to remind all doctors of their responsibilities in respect of minimum standards for medical record keeping. • The next stage is to send out a survey to all doctors on compliance and barriers to compliance against the standards. This has been designed and developed as a Survey Monkey. Feedback has been sought from junior doctors regarding the survey structure and questions. Once this has been received this will be ready to send.			Documentation and Record Keeping • Design Survey • Launch of project
	Consent: • Consent Working Group met on the 14th February, chaired by Alistair Challiner. Agenda items included:- • Presentation by eNotes company to demonstrate the eConsent module that MTW have already purchased. This product follows the national guidance for Consent forms 1-4 and in addition provides and evidence trail for the consenting process and provision of patient information (leaflets can be attached and sent). • Consent policy was discussed and expediency in regard to the requirement to get a revised copy completed by the end of March 2019. • Speciality Consent forms were discussed and it was felt that this option may still be required alongside the eConsent as many are compliant with Alliance or Royal College requirements. Process for 'logging' of each form is through the Medical Records committee; this will need to be outlined in the Consent Policy.			Consent: • Next Consent working party planned for the 23rd March, 2019 • Draft consent policy is being reformatted into new Trust Policy template and being further revised with the aim for this to be sent out for further comment prior to the meeting.
GIRFT	The second meeting of the internal panel was held on the 26th February. There was good divisional attendance at this meeting, with a focus on Head and Neck. **Meeting and data requests ahead of meetings** **Anaesthetics and Perioperative Medicine** -26th March **Diabetes -**16th July **Vascular -** data set completed and submitted –awaiting date for London meeting. **Acute Medicine** - Data collection submitted -Review date yet to be set **Cardiology** - Date pending, in discussion with GIRFT Team. **Rheumatology** - Data collection submitted –Review date yet to be set **Respiratory** - Data collection submitted –Review date yet to be set **Coding** - Data request submitted **T&O -** Prof Briggs returning 9th May Nationwide Theatre Productivity Report has been received and is currently being reviewed by the teams. **Recently reviewed area updates** **Radiology** - Review date: 6th February 2019. Observation notes received. Largely positive with a number of notable good practices identified. IT functionality was one of the key issues identified along with productivity areas to focus on. **Stroke -**The regional event was held in November. MTW is awaiting the data packs. Implementation team are chasing internally for these. **Other** The **Litigation** action plan has yet to be updated, and a revised plan for its completion has been developed. A meeting has been set for March to discuss the Urology Area Networks.			• 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	6th March 2019
WORKSTREAM LEAD	Lynne Sheridan	PMO SUPPORT	Abigail Hill (Medical Productivity/Preventing Harm and GIRFT)/ 7DS

KEY ISSUES/RISKS

DESCRIPTION	MITIGATION	DATE REC	LAST MONTH	THIS MONTH
7DS: Exemption Pathways not accepted by NHSI/E and CCG	LS working with Directorates and producing papers with evidence for submission to NHSI/E.	18.10.18		
7DS: Consultant numbers and recruitment constraints in Med & Emer Division	Work ongoing with Division and Director of Workforce in respect of recruitment aids	05.05.18		
7DS: Temporary Case notes – 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 Rotas (to achieve compliance for Priority standards 5 and 6).	Estimated potential date for delivery is Q2 of 2019/20.	18.10.18		
7DS: Surgery unable to provide resident Consultant cover at w/e at TW for standard 8.	Commenced virtual ward round. Reviewing options re: a change to handover time on site at w/e for existing surgeons and/or use of on-call elective cover	10.1.19		
Mortality: Business Case in development for Funding of Mortality Module (Datix)	Continued use of manual process (lacks transparency, but no current alternative)	25.10.18		
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	Deputy MD will work through Dof S 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		
Medical Productivity: All job plans to be added to the system and signed off by Directorate Management Teams by April 2019	Progress is tracked by the project Team and reported through Divisional EPRs,	28/01/19		
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. Substantive Datix resource is being reviewed within Datix recovery business case.	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		
Learning Lessons: Potential for capacity constrains in Patient Safety Team to take forward the first and third stages in the project (Datix and Action Planning and Evidencing & Embedding)	Stocktake meeting 12 Feb 2019, following Patient Safety Team review has confirmed that the resource is not currently available a business case is required.	28.1.19		
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 once the staffing issues are resolved.	16.10.18		
GIRFT: Dedicated staffing to support the GIRFT programme	A band 7 WTE has been appointed and due to start in April 2019.	26.11.18		
Consent: Vacancies , sickness and workload within the Legal Services team is impacting on ability to focus on Next Steps	Weightmans are currently overseeing interim support	29.10.18		
Consent: Time factor to complete revised Consent Policy against competing priorities	A Challiner aware of timeframe			

CRITICAL PATH MILESTONES

TASK	DATE	STATUS	RAG	
			LAST MONTH	THIS MONTH
7DS: Confirmation of position for Med & Emer Division and how to relay this to Regional Team (NHSE/CCG).	Decision by End Mar 2019	Ongoing		
7DS: Implementation of GI Bleed Rota in Urgent Care	Estimated Q2 2019/20	Ongoing		
7DS: Continuation of implementation of actions for remainder of Surgery Division Services to achieve compliance or exemption (via exception pathways) by March 2020.	March 2020	Ongoing		
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	Complete		
GIRFT: Set up a KPI dashboard, integrated into the single oversight framework	24/1/19	In progress		
GIRFT: Refresh data from the older action plans where feasible	24/1/9	In progress		
Medical Workforce: All job plans to be added to the system and signed off	31/3/19	In progress		
Medical Workforce: Personalised metrics to be developed	31/3/19	In progress		
Medical Workforce: Reconciliation of pay against job plans	31st March	In progress		
Document & Record Keeping: Survey Monkey	Feb 19	In development		
Document & Record Keeping: Survey Analysis	Mar 19	Yet to start		
Document & Record Keeping: Local specialty audits, action plans and collation of results	April – Oct 19	In development		
Document & Record Keeping: Trust wide report (production)	Dec 19	Yet to start		
Document & Record Keeping: Trust wide report (review and agreement of recommendations)	Jan 20	Yet to commence		
Document & Record Keeping: Implementation of agreed actions	Jan 20 onwards	Yet to commence		
Consent: Consent form circulated for final consultation prior to presentation at PRC	~~31/10/18~~			
Consent: Consent form circulated for final consultation prior to presentation at PRC	31/03/19			

WORKSTREAM	Best Safety	BEST CARE BOARD DATE	6th March 2019
WORKSTREAM LEAD	Lynne Sheridan	PMO SUPPORT	Vince Roose / Fiona Bedman (7DS) / Abigail Hill (Preventing Harm)

	KPIS	TARGET	ACTUAL	THIS MONTH
** KPI'S PAPER WENT TO BEST SAFETY BOARD 06/06/2018 – MORE KPI'S TO BE FINALISED AS PROJECTS PROGRESS				
7DS	Generic KPIs have been in existence since project was first initiated , but will be reviewed if they can be localised by Division once each Division has completed their actions against the Challenge Day action plan.	NA	NA	
MORTALITY	HMSR (Monthly)	100.0	102.3	
	SHMI (Quarterly)	1.0	1.0391	
	% compliance with all mortality forms following a patient death (death cert, preliminary screening form, first stage mortality form and where appropriate, SJR)	95.0	82.5	
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) *This is based on 18/19 Job Planning, the system has now been closed and re opened for 19/20 job planning	332	312	
	Number of Job plans signed off on the e-job planning software (see detail below) *This is based on 18/19 Job Planning, the system has now been closed and re opened for 19/20 job planning	332	180	
GIRFT	KPI GIRFT Dashboard will be set up. It is also planned to identify the GIRFT metrics on the Single Oversight Framework.	TBC	TBC	

As at 27/2/19

	Directorate	Total Job plans to be completed	Awaiting Sign off by Management Team	Percentage awaiting sign off	Signed off	Signed off
Cancer Services	Haematology	6	1	17%	0	0%
	Oncology	33	2	6%	0	0%
	Palliative Care	1	1	100%	0	0%
Diagnostics and Clinical Support	Radiology	22	10	45%	0	0%
	Biochemistry	1	0	0%	0	0%
	Histopathology	19	2	11%	0	0%
	Microbiology	4	1	25%	0	0%
Surgery	Generalists	24	17	71%	0	0%
	Intensivists	15	9	60%	0	0%
	SAS Doctors	19	2	11%	0	0%
	Breast	6	0	0%	0	0%
	Gynae Oncology	3	1	33%	0	0%
	Urology	10	0	0%	0	0%
	LGI	9	0	0%	0	0%
	UGI	6	0	0%	0	0%
	Emergency	4	0	0%	0	0%
	ENT	10	3	30%	0	0%
	Ophthalmology	22	4	18%	0	0%
	Trauma and Ortho	18	5	28%	0	0%
Medicine and Emergency Care	Emergency Dept	14	0	0%	0	0%
	Acute Medicine	5	0	0%	0	0%
	Geriatrics	8	1	13%	0	0%
	Cardiology	10	4	40%	0	0%
	Diabetes and Endo	4	1	25%	0	0%
	Gastroenterology	7	1	14%	0	0%
	Neurology	6	2	33%	0	0%
	Respiratory	4	1	25%	0	0%
	Rheumatology	5	2	40%	0	0%
W&C	Sexual Health	5	1	20%	0	0%
	Obs and Gynae	20	1	5%	0	0%
	Paediatrics	16	1	6%	0	0%
		332	33	10%	0	0%

3.0 Best Care Programme - Financial Summary

Maidstone and Tunbridge Wells NHS Trust

Comment

The Trust was £1.8m adverse to plan in the month and £10m adverse YTD. The main schemes adverse to plan YTD are:

- STP Medical Rates £1.5m (£0.2m adverse in month)
- Prime Provider £4.7m (£0.9m adverse in month)
- Private Patient Income £0.9m (£0.1m adverse in month)
- Estates and Facilities £1.1m (£0.3m adverse in month)

The Trusts risk adjusted savings forecast is £10m 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 £1.2m)
- Private Patient Income = £1m
- STP Medical Rates = £1.7m
- Prime Provider = £5.5m
- Medicines Management = £1.1m (£0.7m relates to Avastin)
- Urgent Care Centre = £0.4m

The year end forecast includes £1.5m non recurrent income overperformance to plan.

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4.0 Aspyre – Programme Management

Maidstone and Tunbridge Wells NHS Trust

Following the implementation of Aspyre, which is a cloud-based portfolio, programme and project management software tool, there will be a number of changes:

- Best Care Programmes and Projects will be managed using Aspyre, all reporting will be generated directly from the central data repository, including risks and issues, project plans including critical path, interdependencies, QIAs, KPIs and financial data
- Report templates will change (examples below)
- Best Care Programme data can be accessed via mobile devices
- Aspyre roll out to all of West Kent NHS Partners, to ease access to collaborative programme plans and documentation
- Training held for MTW, WKCCG, KCHFT and KMPT staff
- Go live scheduled for 1st May 2019 (Aspyre V9.0)
  - Parallel run with V8.0 for one month to ensure data transfer
  - V9.0 available on 1st April

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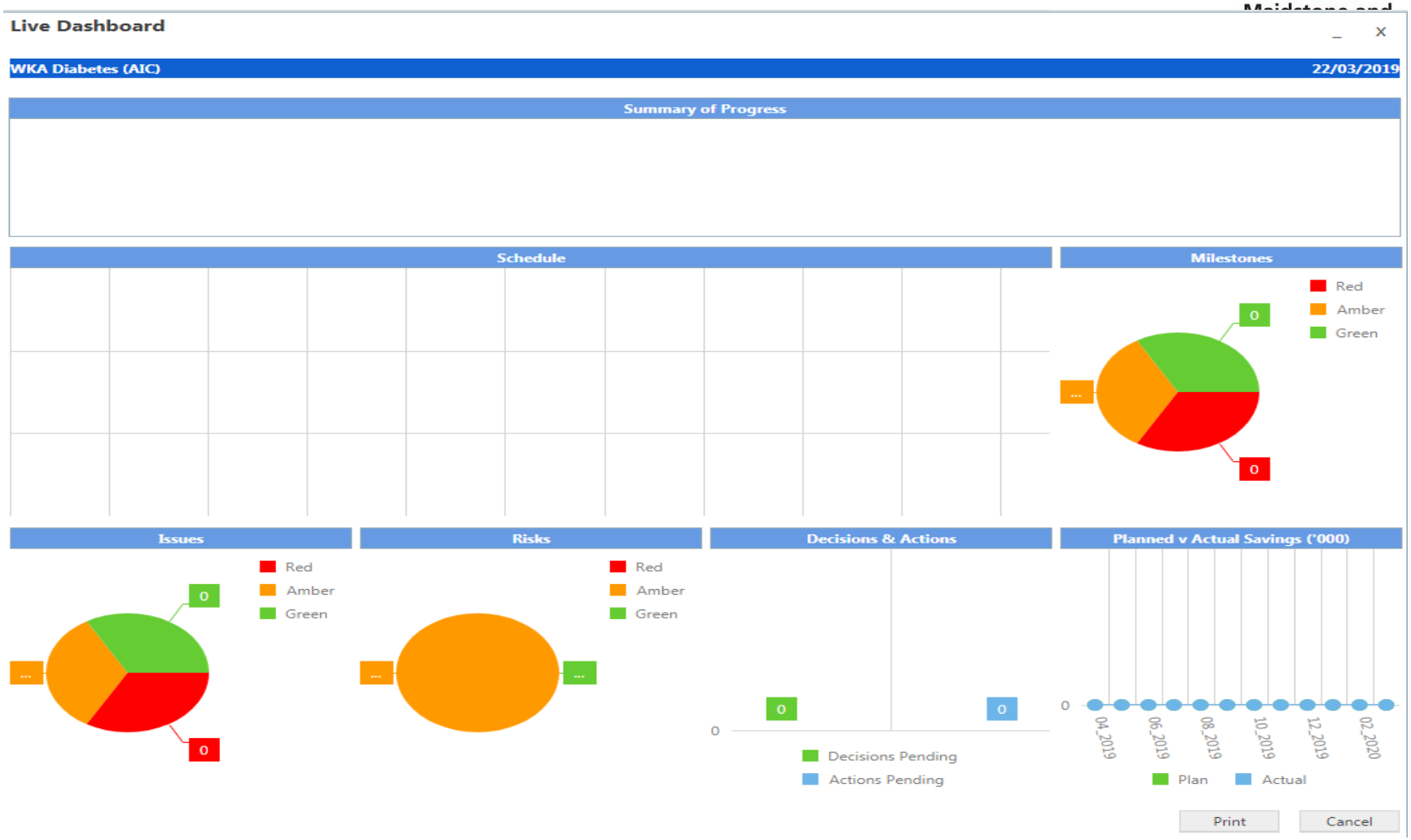
4.0 Aspyre – Report Template (V8.0)



4.0 Aspyre – Report Template (V8.0)

NHS
Maidstone and Tunbridge Wells

Live Dashboard

WKA Diabetes (AIC) 22/03/2019

Summary of Progress

Summary Information

Overall Status		Timescale Status	Budget Status
Quality Status		Resource Status	Benefit Status

Costs ('000)

	Full Year Costs			Year to Date Costs		
	Plan	Act	Var	Plan	Act	Var
Revenue						
Capital						
Total						

Savings ('000)

	Full Year Savings			Year to Date Savings		
	Plan	Act	Var	Plan	Act	Var
Income	0	0	0	0	0	0
Non-Pay	0	0	0	0	0	0
Pay	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**

Top 3 Issues

Top 3 Risks

AIC-DI...	Contracts and Finance have not yet been agreed ...
AIC-DI...	
AIC-DI...	Non elective admissions take longer to reduce th...

Milestones Due

Metrics

No of open risks	14
No of open issues	0
% milestones completed on time	0
% deliverables completed on time	0

Project Status

- Diabetes (KCHFT)
- Diabetes (KMPT)
- Diabetes (MTW)
- Diabetes (WKCCG)

Print Cancel

4.0 Aspyre Dashboard (v9.0)

NHS Maidstone and Tunbridge Wells

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5.0 Communication & Engagement

Best Care Key Messages

Best Use of Resources

- Adalimumab switch – Quarter target met with uptake currently at 28%

Best Patient Flow

- ED Performance - Currently positioned 11/137 nationally for Type 1.

  Neighbouring trust positions:

  East Kent 111/137
  Medway 125/137
  DVH 65/137

5.0 Communication & Engagement

Best Care Key Messages

Best Quality

- Crowborough Birthing Centre works completed on time. New facilities now in use with positive feedback from both staff and users.
- Positive feedback received from patient network on the first draft of MTW Patient and Public Engagement Strategy 'Making it Personal' with comments being incorporated into the second draft.

Best Safety

- As part of the Learning Lessons Project, the revised Clinical Governance Pack (standard agenda, meeting membership and infrastructure) has been agreed by the Chiefs of Service for implementation within their Directorates and Division.
- Long elective waits electronic forms have been drafted and will shortly be launched for use.
- The Regional GIRFT Team have recognised MTW's internal GIRFT process as an exemplar Medway Hospital have adopted MTW's GIRFT process.

West Kent Alliance Event

- Successful event held on 19th March, with 90+ attendees from 18 organisations to review progress made on the following collaborative programmes
  - Frailty
  - Dementia
  - Diagnostics
- Positive feedback received from all who attended, this was the 5th successful event held on the West Kent Collaboration Programmes

Trust Board meeting – March 2019

Maidstone and Tunbridge Wells NHS Trust

3-13	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 December 2017 – November 2018.

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

Information, assurance and discussion.

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 December 2017 to November 2018 show our HSMR to be 101.2, which is a decrease compared to last month's position of 103.

Figure 1. Rolling 12 Month view

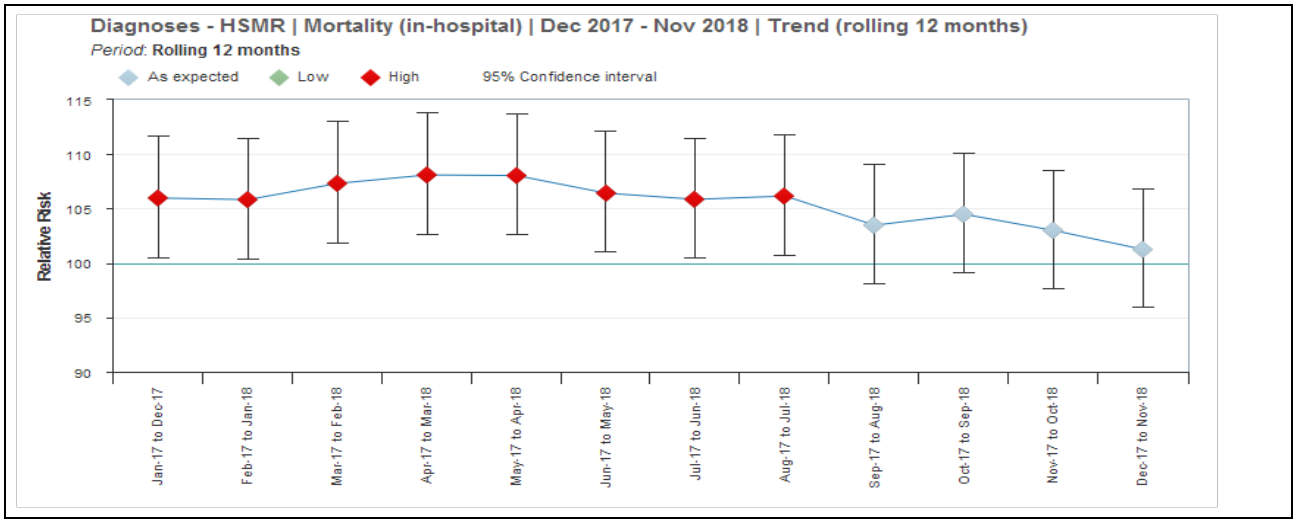
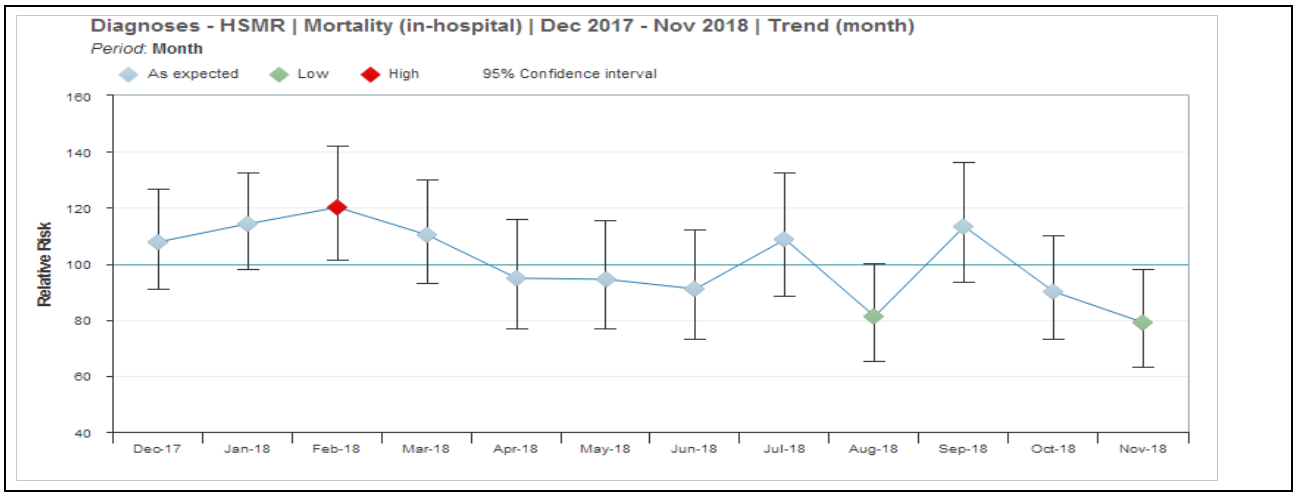


Figure 2 shows a monthly view of our HSMR performance. The latest month should be viewed with caution as this often shows a false position due to the lag in coding activity. Viewing the previous month, so October 2018 in this case, shows that the Trust's position has decreased to 90.0 from 113.3 in September 2018.

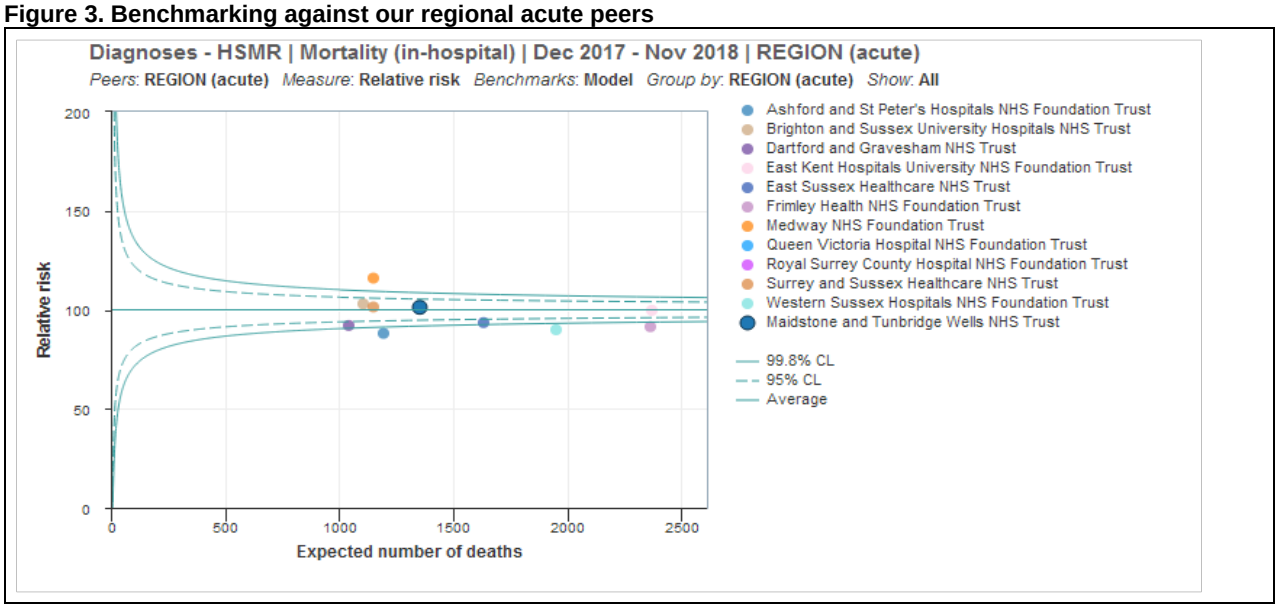
Figure 2. Monthly view



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

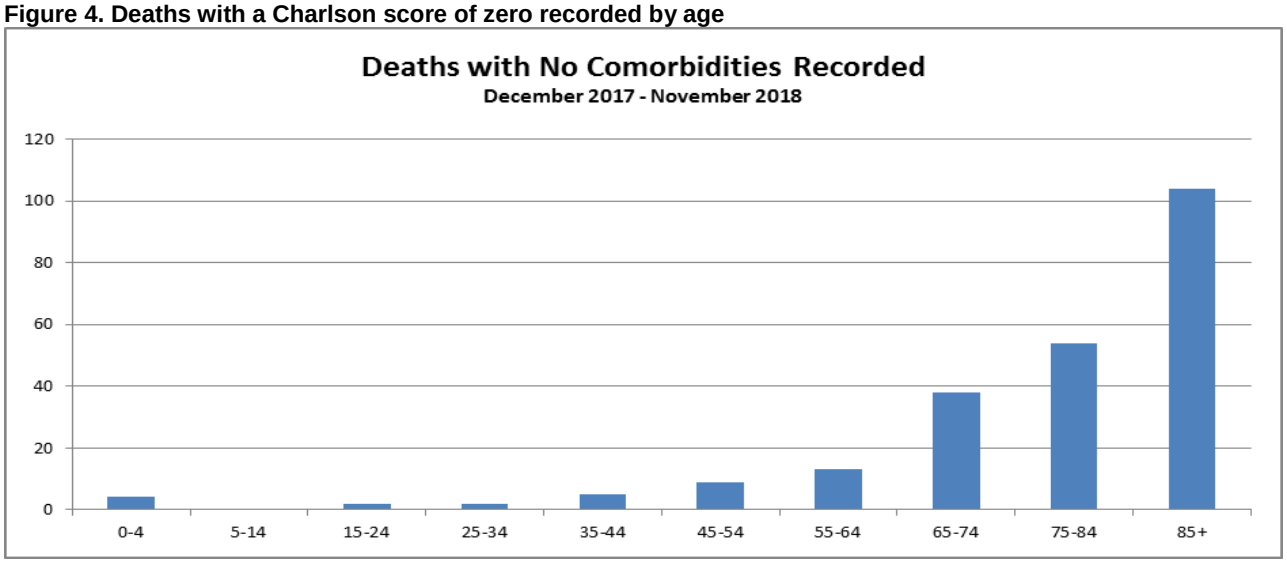
Guidance from Dr Foster has been instrumental in directing the work of the Mortality Surveillance Group (MSG). In line with this progress has been made, and continues in regard to:-

- *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 1371 deaths recorded in the period December 2017 to November 2018, 231 had no comorbidities recorded (16.8%).

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



Specialties with Zero Comorbidities – All Ages

	Sep17-Aug18		Oct17-Sep18		Nov17-Oct18		Dec17-Nov18	
Specialty (of discharge)	**Deaths**	**%age**	**Deaths**	**%age**	**Deaths**	**%age**	**Deaths**	**%age**
Geriatric Medicine	88	35.9%	96	38.9%	93	39.6%	90	39.0%
General Medicine	37	15.1%	33	13.4%	31	13.2%	31	13.4%
Respiratory Medicine	32	13.1%	31	12.6%	31	13.2%	34	14.7%
General Surgery	29	11.8%	28	11.3%	28	11.9%	27	11.7%
Gastroenterology	15	6.1%	15	6.1%	14	6.0%	11	4.8%
Cardiology	13	5.3%	16	6.5%	15	6.4%	15	6.5%
Endocrinology	9	3.7%	9	3.6%	8	3.4%	9	3.9%
Paediatrics	5	2.0%	4	1.6%	4	1.7%	4	1.7%
Clinical Haematology	4	1.6%	2	0.8%	2	0.9%	3	1.3%
Accident & Emergency	3	1.2%	2	0.8%	1	0.4%	1	0.4%
Stroke Medicine	3	1.2%	4	1.6%	4	1.7%	3	1.3%
Trauma & Orthopaedics	2	0.8%	2	0.8%	2	0.9%	2	0.9%
Urology	2	0.8%	2	0.8%	1	0.4%		0.0%
Anaesthetics	1	0.4%	1	0.4%	0	0.0%		0.0%
Diabetic Medicine	0	0.0%	0	0.0%	0	0.0%		0.0%
Gynaecology	1	0.4%	1	0.4%	1	0.4%	1	0.4%
Neonatology	1	0.4%	1	0.4%	0	0.0%		0.0%
Obstetrics	0	0.0%	0	0.0%	0	0.0%		0.0%
All	**245**		**247**		**235**		**231**	

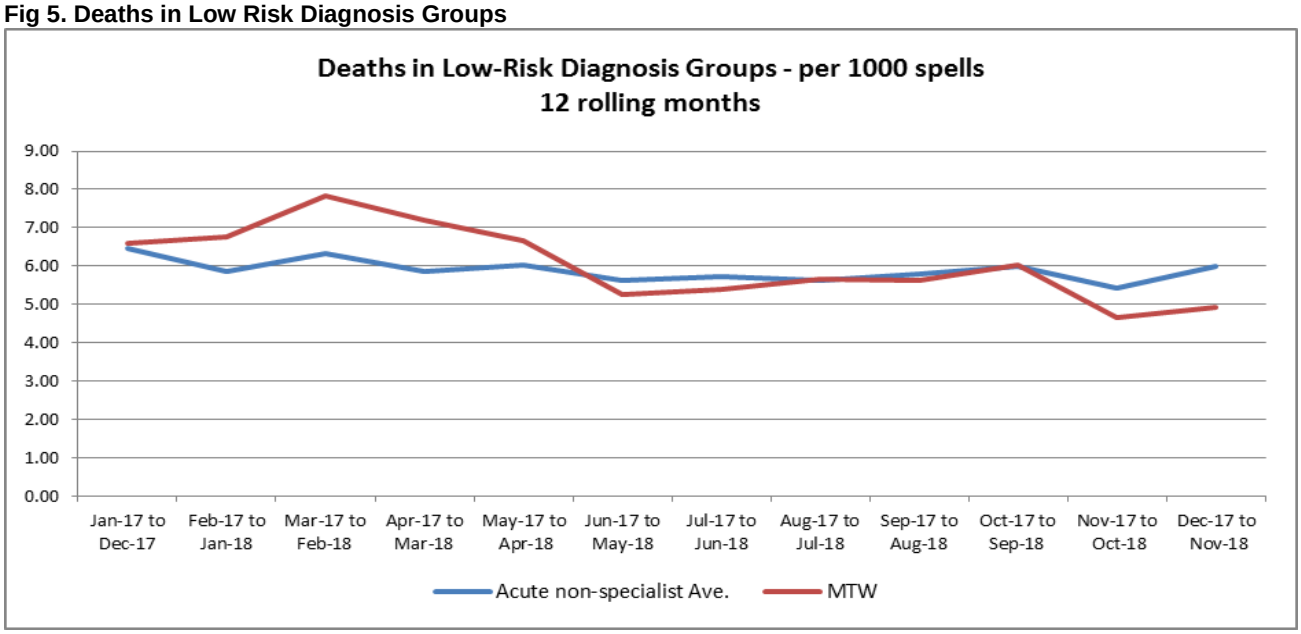
Significant progress is being made by the Head of Clinical coding in regard to our coding of deaths. In addition to the production of coding information for clinicians she is working with Directorates to improve their understanding and knowledge of how patients are coded and has been invited to join Grand Rounds. 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 is now below the Acute, Non Specialist Trusts average when looking at deaths in low risk diagnosis groups. The current average is 4.94 which is below the national average of 6.01. 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 is a method of identifying areas where there are an unexpected cumulative number of mortalities which have been following treatment for a specific diagnosis; this can be both due to more and less than expected deaths. The below chart (Fig. 14) 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

Relative risk & CUSUM alerts

Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend	LOS	Readm.	Peers
All Diagnoses	1 6	111282	1588	1610.5	1.4	98.6				
HSMR (56 diagnosis groups)	3	36591	1371	1354.2	3.7	101.2				
Acute bronchitis	1	1179	39	23.8	3.3	163.8				
Aspiration pneumonitis, food/vomitus	1	218	87	65.8	39.9	132.3				
Cancer of bronchus, lung	1	219	39	31.5	17.8	124.0				
Congestive heart failure, nonhypertensive	1	619	69	62.6	11.1	110.2				
Other and ill-defined cerebrovascular disease	1	20	7	1.5	35.0	477.2				
Pneumonia		2043	303	265.4	14.8	114.2				
Secondary malignancies	1	523	23	24.8	4.4	92.6				
All Procedures	3	72958	963	1011.2	1.3	95.2				
Pilonidal sinus operations		103	1	0.0	1.0	14165.9				
Reduction of fracture of neck of femur	1	69	6	2.0	8.7	302.5				
Rest of Arteries and veins (diagnostic/minor)	1	200	17	6.5	8.5	261.0				
Surgical arrest of bleeding from internal nose	1	84	3	1.0	3.6	302.8				

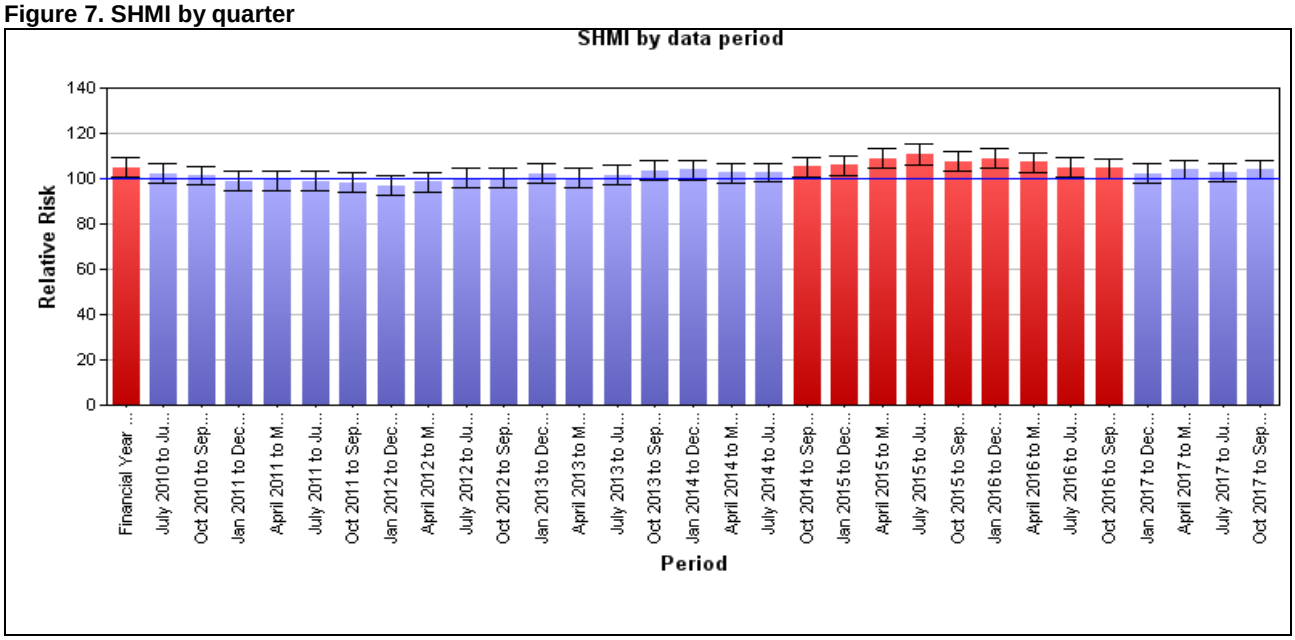
These alerts are regularly discussed at the Mortality Surveillance group with patient level data supplied to the Mortality leads to review. To date fractured neck of femurs, pneumonia, non-Hodgkin's lymphoma and phlebitis have had further reviews undertaken. Congestive Heart Failure and Aspiration pneumonia 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 October 2017 – September 2018 shows SHMI as 1.0391 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	4.7	19
Dartford and Gravesham NHS Trust	3.7	15
East Kent Hospitals University NHS Foundation Trust	3.9	19
Maidstone and Tunbridge Wells NHS Trust	4.6	19
Medway NHS Foundation Trust	4.8	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	298,836	99,687	100,279	33.4	33.6
Dartford and Gravesham NHS Trust	1,615	835	835	51.7	51.7
East Kent Hospitals University	4,237	990	990	23.4	23.4

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
NHS Foundation Trust					
Maidstone and Tunbridge Wells NHS Trust	2,510	771	771	30.7	30.7
Medway NHS Foundation Trust	2,081	512	512	24.6	24.6

A recent review of palliative care coding has identified that MTW remains in line with the National Average and those reviewed were found to be correctly coded.

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	298,836	211,396	87,440	70.7	29.3
Dartford and Gravesham NHS Trust	1,615	1,135	480	70.3	29.7
East Kent Hospitals University NHS Foundation Trust	4,237	2,744	1,493	64.8	35.2
Maidstone and Tunbridge Wells NHS Trust	2,510	1,639	871	65.3	34.7
Medway NHS Foundation Trust	2,081	1,445	636	69.4	30.6

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 - Feb 19)

Trust	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	2018/19 YTD
No of Deaths	127	126	126	128	122	148	126	108	128	180	142	1461
No of Completed Reviews	115	113	117	111	104	128	106	87	114	146	102	1243
%age completed reviews	90.6%	89.7%	92.9%	86.7%	85.2%	86.5%	84.1%	80.6%	89.1%	81.1%	71.8%	85.1%

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 63.3% in March 2018 to 85.1% in March 2019.

Learning from Mortality Reviews includes the need for:-

- Improved communication with patient and/or family re decision making for DNACPR
- Improved documentation in regard to decision making re ceiling of care and plan for palliation
- Prompt senior oversight of decision making re End of Life Care (EOLC), to include review of DNACPR form signed by Consultant lead
- Prompt referral to palliative care team when decision made for EOLC
- When discharging patient home for EOLC ensuring that the family know what to expect ie what death looks like and prompt review by Hospice palliative care team
- Consideration for appropriateness of clinical treatment ie scans, blood test and antibiotics for a patient at the end of their life
- Consideration for intravenous medication when patient can no longer swallow time critical medications ie anti-epilepsy medication.
- Consideration of fluid and nutritional replacement when patient nil by mouth due to inadequate swallow, prompt referral to SALT and Dietetics and consideration re feeding at risk.
- Patients clearly dying should, wherever possible, be fast-tracked to a side-room with clear communication with receiving ward so staff aware of imminent death.

Learning from Deaths Project Working Group (LFD).

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 5th April, 2019. The objectives of the group include:-

- 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 the Trust-wide Mortality Coordinator role to oversee 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:-

- 85.1% of all deaths having been reviewed year to date up to and including February 2019.

- All Mortality review documentation has been revised and is in the process of being relaunched.
- Interim Datix Administrator Project lead started in post 5th December, 2018. This person has supported the LFD Project Group in selecting a fit for purpose database for mortality reviews.
- 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 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 on a regular basis.
- Lead Consultant for Child Deaths has presented the outcomes and learning from the Child Death over-view Panel and taken forward recommendations that this report is submitted to the Paediatric and ED Clinical Governance sessions to disseminate learning.

Next Steps for both MSG and LFD's project groups:-

- Await outcomes from the audits in regard to learning from deaths for patients who died of Congestive Cardiac Failure and Aspiration pneumonia.
- Await the outcome of the business case submitted for the recommended Database to support the Mortality review process.
- Continue to rollout training and education at Clinical Governance sessions and ward rounds /grand rounds in regard to coding.
- Head of Midwifery to present the MBRRACE report to outline key areas of learning for Maidstone & Tunbridge Wells NHS Trust.

Trust Board meeting – March 2019

NHS Maidstone and Tunbridge Wells NHS Trust

3-14 Approval of the Trust's final 2019/20 plan

Director of Strategy, Planning & Partnerships

Enclosed is the Trust's final 2019/20 Plan for approval.

Which Committees have reviewed the information prior to Board submission?

- Finance and Performance Committee, 26/03/19

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

Review, approval

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

NHS
Maidstone and Tunbridge Wells NHS Trust

MTW 19/20 Operational plan

22nd March 2019

MTW
exceptional people outstanding care

Executive Summary

Activity planning

- It has been agreed that apart from A&E all other growth rates reflect demographic growth rates, in A&E growth rate has been set as 5% with 1% QIPP adjustment as agreed with the CCG. Note: ED attendances in January and February have been in excess of forecast. Out of hospital capacity and same day emergency care will have to be expanded to limit the impact of increased attendances on NEL admissions.
- Elective activity has been phased according to working days while non-elective (including ED) activity has been phased according to a 3 year profile of seasonal variation
- The Trust trajectories are currently set as:
  - A&E – 2019/20 performance of 91.67% an increase on 2019/20 performance
  - RTT – 86.7% performance by March 2020 with an ~4.5k reduction in waiting list – note this excludes the potential benefits from further validation work or on work on data quality resulting from NECSU
  - Cancer – Achievement and sustainable maintenance of 62 day performance at 85% from May 2019
  - Diagnostics – Maintenance of the standard

Quality planning

- Our joint Executive leads for quality are the Chief Nurse and the Medical Director
- The Trust has created a comprehensive quality strategy with 5 key priority and 22 quality goals. The quality goals are component parts of larger projects within the Best Care Programme. This strategy also forms the basis for our Quality Accounts ensuring synergy in our objectives and outcome measures.
- The Trust has a robust and well embedded QIA process.
- Building quality improvement capability is a key pillar of the Trust's OD programme and we are rolling out the QSIR methodology as a means for doing this.

Workforce planning

- Whilst the trust has seen a considerable improvement in the turnover of staff in 2018/19 (reduced from 12% to 8.9%) it continues to face significant challenges in attracting clinical staff in a number of key areas
- MTW will be part of the STP programme to issue contract to medical agencies in 2019/20 to further reduce medical agency rates. It is expected that this will target junior medical staff initially. In 2018/19 MTW has taken steps to increase the size and usage of its own bank through additional recruitment and the conversion of agency clinicians to the trust bank
- Retention plans for MTW in 2019/20 will aim to continue the consistent downward trend in turnover that has been seen in 2018/19. The trust will deliver the remainder of its plan to improve nurse retention as part of the NHSi nurse retention programme.

Financial planning

- The Trust is planning to meet its control total target of £7.0m deficit before MRET and PSF
- Including the impact of MRET and PSF funding would improve the financial position to a £6.9m surplus
- The Trust is planning a CIP target of £16.6m in addition to £5.7m of full year effect of 18/19 schemes
- The Trust has identified £16.6m of new savings schemes for 2019/20 with £0m unidentified.
- Whilst the trust plans to continue to reduce its reliance on agency staffing and consequent spend it anticipates that it will continue to breach the overall cap set by NHSi in 2019/20. The reason for the breach of the cap relates to the continued recruitment challenges faced by the trust in a number of key areas, notably consultant physicians, middle grade paediatricians and surgeons and qualified nursing staff for medicine and Emergency department specialisms
- The Trust's initial operational plan includes a five year capital programme of total value £56m (excluding donated assets)
- The programme reflects plans for essential improvements in Maidstone estates (£11.5m) and Tunbridge Wells Hospital lifecycle (£5.4m).

STP alignment

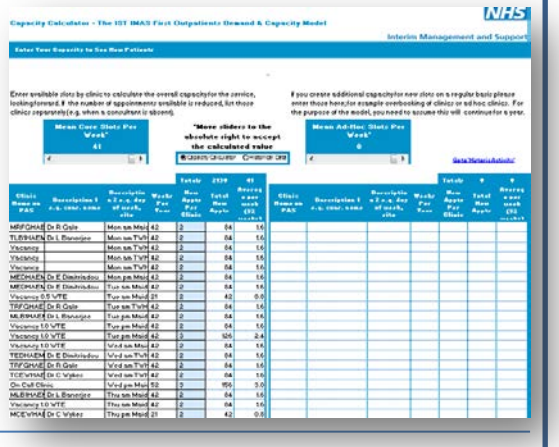
- The STP workstreams directly inform the Trusts operational planning through both Trust specific deliverables and by informing expected improvements in finance, activity , workforce and quality (e.g. reduction of medical agency rates)

In order to ensure that we have the capacity to service our demand we have used both NHSI IMAS IMT models and proprietary top down and bottom up modelling

NHS
Maidstone and Tunbridge Wells

Demand and capacity planning

- This year across the Trust we have moved to using the NHSI IMAS IMT models for demand and capacity planning which has had the following advantages
  - We have modelled demand and capacity not just for inpatient and outpatient activity but also for diagnostic activity including:
    - Imaging (for all main modalities)
    - Endoscopy
  - The outputs of the demand and capacity tool have been used to inform discussions on service developments and workforce planning to ensure that all of the Trusts plans are underpinned by robust demand and capacity modelling



Improvement potential

- In order to identify their improvement initiatives for 19/20 a variety of sources from internal data and expertise to the model hospital and GIRFT were used to identify improvements
- In a departure from previous years divisions and directorates have sized their improvement initiatives by individual lever to ensure that we can accurately forecast the levels of activity that we can deliver next year in house and the levels to be outsourced under our prime provider contract
- This has also allowed us to accurately forecast the implications on our waiting list and backlog and therefore likely RTT profile for 19/20

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

Bottom up bed modelling

- LoS identified by POD and specialty
- LoS improvement set at 0.5 for non-elective activity
- Detailed calculation of bed requirement built from specialty specific demand and capacity work converted into bed days and therefore bed requirement

Tunbridge Wells Hospital
Summary

Directorate	Core Beds: Bedstock	Core Beds: % Days within allocation	Core Beds: Requirement for 85% of days	Core Beds: Variance	Core Beds: % Elective	Core Beds: Elective Beds Requirement	Winter Beds: Requirement 95% of Days	Winter Beds: % Elective	Winter Beds: Elective Beds Requirement	Winter Beds: Additional
Trust G&A	345	2%	397	-52	7%	28	447	6%	3	50
Plus 2% Demographic Growth	345	4%	405	-60	2%	7	456	6%	3	51

Tunbridge Wells
Bedstock

	Core	Escalated	Total
Acute Medicine Unit (AMU)	32	4	36
Ward 2	24	2	26
Ward 20	30	0	30
Ward 21	30	0	30
Ward 22	22	0	22
Ward 12	30	0	30
Acute Stroke Unit	10	0	10
CCU	5	0	5
Cath Lab	0	3	3
TW32	20	9	29
Ward 10	30	0	30
Ward 11	30	0	30
Surgical Assessment Unit	0	3	11
Short Stay Surgery	12	12	24
TW33 - Female Surgical	10	0	10
Ward 31	30	0	30
Ward 30	0	0	20
Total	345	33	393

Currently 4 beds closed due to building work and 2 used as AFU pop-ups(therefore put as escalation)

Top down bed modelling

- Bed modelling used for previous years
- Based on actual patients in bed every night at Midnight set at the 85th percentile
- Growth then added on top to provide estimation of bed capacity for 19/20

Activity planning assumptions and trajectories

The Trust recognises the importance of being able to understand the likely effects of variations flowing through from both elective referral and non-elective driven demand. The Trust monitors historic patterns and uses these to model likely future demand as well as using intelligence obtained through working with our own clinical teams and stakeholders such as Commissioners, individual GPs and other trusts.

Activity

- The Trust's activity plans have been set based on a forecast outturn calculated from Month 10 of the current year.
- The Trust has used SUS PBR data to generate it's activity baseline
- The Trust has determined it's likely 19/20 demand from triangulating between both a projection of referrals and 18/19 activity
- The Trust has calculated likely 19/20 demand by adding both demographic growth and the growth in waiting lists to the forecast outturn to calculate 19/20 demand

Growth rates

- It has been agreed that apart from A&E all other growth rates reflect demographic growth rates which are as follows:
  - Non elective admissions – 2.3%
  - OP app – 4.9%
  - Electives – 3.6%

A&E attendances

- It has been agreed with the CCG that the growth rate for A&E will be modelled through as 5% with a 1% QIPP adjustment which is in line with our Trust internal modelling.

Phasing of activity

- Elective activity has been phased according to working days while non-elective (including ED) activity has been phased according to a 3 year profile of seasonal variation
- Beds have been phased according to seasonal demand. Beds are currently modelled using a 0.5 LoS improvement in non elective activity (to build upon the work to reduce LoS in 2018/19)

Operational standards

- For A&E the Trust starts in a strong position with a performance of >90%. However with the increased growth rate seen in A&E attendances (as agreed with the CCG) of 4% net of QiPP performance will be challenged in the winter of 2019/20 (likely to dip below 90%). The Trust is likely to achieve a maximal performance of 94.3% in June with a full year performance of 91.67%.
- The RTT trajectory has been modelled using the detailed demand and capacity work undertaken with the NHSI IMAS IMT models in order to both define the likely effect of additional capacity on waiting list and backlog and also to identify additional initiatives needed to improve performance. The waiting list in March 2020 is forecast to be 4599 lower than in March 2019 and performance is forecast in March 2020 to reach 86.7%. The Trust also continues to work on additional initiatives on a specialty by specialty basis to improve performance. The Board is committed to agreeing and implementing a plan to recover the RTT standard on a sustainable basis. The detail of this will be agreed with commissioners once the NECSU work is completed.
- For Cancer performance in most standards is forecast to continue above the constitutional standard. In Cancer 62 days the Trust is forecasting sustainable performance above 85% as of May 2019.
- For diagnostics the Trust is forecasting maintenance of the standard. Detailed demand and capacity work has been undertaken (through the NHSI IMAS IMT models) in order to identify capacity shortfalls (e.g. in ultrasound and CT) to allow initiatives to be fully worked up and implemented in order to fill the capacity gap and maintain performance

Quality planning is embedded at all levels of the Trust through the quality strategy

Maidstone and Tunbridge Wells NHS Trust

Quality of care is at the core of the Trust's day to day business, and is embedded within all aspects of care delivery, performance and service development. To refresh our approach to the management of our quality agenda, the views and priorities of a wide range of our staff, patients and partners have been sought, culminating in the ongoing development and delivery of the Trust's Quality Strategy. The Trust's quality improvement activities are informed and directed by ongoing work from our Care Quality Commission (CQC) inspection process and through collaboration with our local CCGs and patient groups such as Healthwatch Kent. Our Executive lead for quality is the Chief Nurse and Quality improvement assurance is overseen through the Best Care Programme and the Trust's Quality Committee, (a sub-committee of the Board). Quality improvement is monitored by the Trust Clinical Governance Committee and the Trust Management Executive Committee.

The Trust has created a comprehensive quality strategy (founded on the Trust's Corporate Strategy) which has been informed by conversations with staff, patients, families and carers. These discussions were distilled into 5 key priority areas which then culminated in 22 quality goals. The quality goals are component parts of larger projects within the Best Care Programme and their delivery will be monitored through the governance arrangements of that programme. This strategy also forms the basis for our Quality Accounts ensuring synergy in our objectives and outcome measures. Creating a safety culture and learning lessons is one of the key priority areas of the quality strategy and progress against 2 of the key elements of this are shown below.

Learning from deaths

The Trust has fully implemented the recommendations of "Learning, Candour and Accountability: A review of the way NHS trusts review and investigate the deaths of patients in England", and the 8 key national recommendations in the follow-up letter from Dr Kathy McLean and Professor Sir Mike Richards (Feb 2017). To oversee this process, the Trust established a Learning from Deaths project group which is still in place, reporting via the Best Care Programme (Best Safety Workstream). Its latest projects focus upon the implementation of a dedicated electronic mortality system (including investigation and learning modules) and the implementation of the new Medical Examiner process (the latter of which awaits further national guidance). The new electronic mortality system will incorporate a facility to allow learning from all deaths, (including the Structured Judgement Review process) and this will be interfaced with the Trust's Learning Lessons project to ensure all learning is fully integrated with the clinical governance processes, widely cascaded across the Trust and tested for embedding and change. The Learning Lessons project also reports via the Best Safety Workstream. The Trust's monthly Mortality Surveillance Group reviews the findings of all SJRs across the Trust and is currently manually cascading the learning until the electronic mortality system and Learning Lessons project is fully implemented.

NEWS2 and reduction in gram negative blood stream infections

The Trust fully implemented NEWS2 in December 2018. The Trust is working closely with the Kent and Medway Infection Control and Antimicrobial Stewardship Committee, chaired by the K&M system Director of Infection Prevention and Control, to implement the HCAI action plan. The Kent and Medway catheter passport was fully implemented in December 2018 and the new national catheter care plan is being reviewed with a view to implementing across the Trust. Universal prophylaxis for patients undergoing ERCP has been implemented to prevent post-ERCP sepsis. Review of the cholecystitis pathway will be undertaken to ensure consistent antimicrobial prescribing for this group of patients. Case review and trend analysis is ongoing to guide further work. Epidemiological information is collected on all cases of gram negative blood stream infection and reported to the PHE Data Collection System

The Trust monitors it's progress against the quality improvement goals and compliance with national quality priorities

Maidstone and Tunbridge Wells NHS Trust

CQC Domains:-

Safe | Effective | Caring | Responsive | Well-Led

Goal No.	Goal Title	Evidence of Success
Objective 1: Creating A Safety Culture & Learning Lessons		
1	Learning Lessons & Blame Free Culture	Action plans are centralised and effectively implemented Central database implemented Multidisciplinary attendance at Clinical Governance Meetings Human Factors training is implemented The number of repeat incidents is significantly reduced Sustained increase in incident reporting A blame free culture where learning lessons is paramount Presence of human factors training course within the Trust Effective root cause analysis investigations via trained staff
2	Establishing the MTW Quality Mark	High visibility to patients, staff and visitors Improved patient safety Staff reward and recognition High levels of staff engagement Quality Mark embedded and owned amongst staff System is linked to Trust Annual Awards
3	Duty of Candour	Compliance with 10 day standard Monthly reporting of compliance to the Trust Clinical Governance Committee Training programme in place and staff awareness raised Reduced incidence of complaints
4	Seven Day Services (7DS)	10 national priority standards implemented Reduction in unwarranted variation by day of week Weekend effect eliminated A more even distribution of workload throughout the week
5	Mortality	Improved HMSR and SHMI statistics 100% compliance with the completion of all mortality forms following a patient death Implementation of a single database Improvement in coding and the sequencing of recorded co-morbidities (Charlson index) for all deceased patients
6	Sepsis	Compliance with national targets for screening and timely management Improved antibiotic stewardship Rollout of the updated National Early Warning Score (NEWS2) system to identify deteriorating patients Achievement of the rapid screening of at risk patients Staff all kept up to date via the e-learning module
7	Preventing Harm	The reduction of unintended or unexpected harm Audit of patients who have breached the referral to treatment time for elective and outpatients undertaken Learning identified from audit to develop necessary actions Effective learning (facilitated by the Learning Lessons Project)
Objective 2: Improving Patient and Experience (Personalised Care)		
8	Better Births	Implementation of the ambitions set out in 'Better Births'. Reduction in the number of stillbirths and neonatal deaths by 20% (by 2020) and 50% (by 2025). Services meet the needs of women in the Community. Safety improvements achieved through work with other maternity units within the NHS.
9	Enhancing Functional Independence	Supporting patients to proactively manage their long-term conditions at home Further development of ambulatory pathways of care to support treatment without admission Development of assessment units in all specialities that will rapidly assess, treat and promote discharge with appropriate support at home. Prompt discharge home from hospital once medically optimised with support packages insitu. Implementation of the 'End PJ Paralysis' campaign aims
10	Engagement	The development of an Engagement Strategy, co-designed with local people and communities An effective and representative patient experience group Regular workshops held with public representative groups Effective use of the learning from complaints, surveys, Friends and Family Tests, and other patient participation groups Develop a clear communication strategy providing direction and accessibility of Executive/Senior leads to engage and support staff Enable staff to provide feedback/comments easily and demonstrate the actions being taken
Objective 3: Clinical Effectiveness and Tailored Pathways		
11	Improving Stroke Services	Attainment of Sentinel Stroke National Audit Programme (SSNAP) level A Collaborative working with the STP Clinical Reference group to ensure appropriate pathways of care are in place at point of reconfiguration of services Use of patient feedback to improve patient experience Collaboration with community and charitable organisations to streamline patient care following discharge from hospital.
12	Commissioning for Quality and Innovations (CQUINs)	Improvements in the quality and safety of patient care Service changes implemented that support improved patient outcomes Pathways are designed which support improved patient outcomes Successful implementation of the CQUIN Agenda identified for 2017-2019, and further CQUINs agreed to 2021.

Goal No.	Goal Title	Evidence of Success
Objective 3: Clinical Effectiveness and Tailored Pathways		
13	Improving Patient Flow	Patient access to increased number of ambulatory pathways Frailty models of care on both hospital sites 7 day working in both frailty units and to support ambulatory pathways Further pathways of care to facilitate supportive and timely discharge Creation of a virtual ward to support patients at home.
14	Falls	A reduction in patient falls (per 1.000 occupied beddays) to at least the target of 6.00. Monthly audits in place Achievement of the identification of the triggers for falls (e.g.. medications, sight, risks of hypotension) and that these are embedded into practice Increased availability of mobility aids in all areas where patients are at risk Safety huddles implemented and embedded into practice Trust-wide action plan in place.
15	Pressure Ulcers	A reduction in the incidence of category 2 pressure damage for our patients Tissue viability Link Nurse system enhanced Improved access to Tissue Viability Team expertise through increase of hours of service Trust-wide improvement plans in place.
Objective 4: Supporting our Staff to be the Best		
16	Attract, Retain, Support & Develop Staff	An increase in recruitment rates Decreased staff turnover rates / leaver rates Increased scores for staff morale within the Annual Staff Survey and local Friends and Family Tests.
17	Develop New & Extended Roles	An increase in recruitment rates A higher number of filled new role positions Increase in the use of apprenticeship roles within the organisation.
18	Listen to Staff and Encourage Feedback	An increase in responses from the Annual Staff Survey and local Friends and Family Tests Lower scores for bullying, harassment and discrimination Increased scores for staff morale Better active engagement of staff at all levels with the LiA programme.
19	Develop Objectives at Directorate Level	Each Division and Directorate have a set of well- defined strategic objectives that reflect their service improvement and development aspirations, linked to their annual business plans The appraisal process incorporates a review of each staff members' contribution to the achievement of the strategic objectives for their area Service improvement and development occurs in the context of the organisations strategic objectives and priorities.
Objective 5: Recognising and Responding to Complex Needs		
20	Patients with Dementia and their Carers	Patients preferences for care are implemented Personalised care is in place in line with the 'This is Me' document The needs of family and carers are identified and acted upon Specialist staff are available to offer support, advice assessment when required An effective dementia care report is in place for reporting to the Board Participation with the National Dementia Audit and Triangulation of Care-Givers Audit.
21	Adult Safeguarding and Mental Capacity Act	Patients who lack the capacity to make decisions in relation to their care are empowered to do so MTW has an appropriately trained workforce who can identify and support those at risk of abuse or neglect Staff know how to access specialist advice and support when required Pathways of care are in place to prevent harm from occurring Effective working relationships are in place with other healthcare partners to ensure seamless services are in place.
22	Safeguarding Children	All staff in the Trust are able to comply with their statutory responsibilities and comply with best practice guidance A child-centred approach is in place across the Trust which will include staff who are trained at Level 3 Safeguarding in non-Children's Service areas. The safeguarding of children will be everyone's business Effective working relationships are in place with other healthcare partners to ensure seamless services are in place.

MTW exceptional people delivering outstanding care

The Trust has a robust and embedded QIA process which ensures quality is not compromised

Maidstone and Tunbridge Wells NHS Trust

QIA Process

The Trust's Quality Impact Assessment (QIA) process is a well embedded and robust business as usual practice within the Trust. It is clearly documented in the Programme Management Office (PMO) manual, which is reviewed and updated on an annual basis to reflect any changes identified in the NHS Operational Planning and Contracting guidelines. All change, whether linked to a cost improvement or a service improvement will be subject to a QIA. With the scale of the challenge that the Trust is facing, mitigation in terms of patient quality and safety of any service change is an essential component of the Trust's assurance process. The Trust assigns a clinical lead to every project or scheme, engaged at all stages of the assessment and sign off process. The clinical lead completes the quality assessment of every project which includes:

- Identification and agreement of KPIs to provide sensitive early warning systems, which will lead to responsive and timely action as required.
- A detailed risk assessment identifying any risks to patient safety, patient experience or clinical effectiveness. This allows risks to be mitigated at the earliest possible stage.

It should be noted that even if a scheme/project is in its analysis phase, a QIA will still be required to meet the NHS Operational Planning and Contracting timeline with the likely outcome that a detailed QIA will be required at the point of analysis completion or further detail available.

The QIA template incorporates all key components such as patient safety, clinical effectiveness, patient experience, staff experience, inequalities and targets/performance. The Clinical Lead completes the template with the risk rating and can allocate mitigation actions to provide a residual score.

All approved QIAs are formally signed by the Medical Director and Chief Nurse and scanned to provide an electronic audit trail

Deep dive reviews of appropriate projects will be conducted to provide the assurance that the transformational or cost improvement project has not affected quality

Deep dives will be coordinated by the Programme Management Office (PMO) and will provide a proforma to the Medical Director, Chief Nurse and appointed Non-Executive Director for completion. In addition to the report, which will contain analysis data and soft intelligence, the deep dive will consist of a walk about or meeting with the area for change by the Medical Director or Chief Nurse, plus the appointed Non-Executive Director. Subject to findings, this will provide the assurance that the project scope has not changed following the QIA sign off and therefore the QIA is still fit for purpose and that the proposed change and the associated QIA scoring be documented and mitigated. There will be an annual Quality Committee report reviewing the yearly QIA performance of all schemes and provide suggestions of any changes which need to be made for the following year.

7 Day services

Significant progress has been made within this project since its inception in January 2017. The project reports via the Best Care Programme (Best Safety Workstream). Almost full compliance is being achieved against the 4 priority standards during the weekdays and weekends across the majority of the Surgical, Critical Care and Women's and Children's Directorates. A small compliance issue remains in respect of standard 2 in some of these services during part of the weekend, for which mitigating arrangements are in place until full compliance can be achieved to comply with the March 2020 national requirement. With respect to Acute and Geriatric Care and Specialist Medicine, full compliance has been achieved with standard 2, but there is a significant consultant workforce challenge in respect of standard 8 and thus, these services will be very unlikely to be in a position to achieve full compliance by March 2020.

Building Quality Improvement capability is central to the Trust's plans and forms one of the key pillars of our organisational development programme and our plans to move to an outstanding organisation

Maidstone and Tunbridge Wells NHS Trust

Quality, Service Improvement and Redesign Programme

To develop skills for improvement across the Trust, we are investing in the Advancing Change and Transformation (ACT) Academy's Quality, Service Improvement and Redesign Practitioner Programme (QSIR Practitioner Programme) developed by NHS Improvement. QSIR is a nationally recognised successful quality and service improvement programme that has been delivered over many years to thousands of NHS staff. It covers the breadth of universal quality and service improvement skills (for example, elements of Lean, Six Sigma, Model for Improvement). It takes an action based learning approach with participants delivering an improvement project during the programme.

We are actively engaging with and learning from other Trusts who have adopted QSIR as to how to maximise the impact of the Programme, including which support mechanisms we could put in place to provide practical help, advice and coaching to staff engaging in improvement work. This will be in addition to the ongoing support from the ACT Academy.

Clinically led structure and organisational development

As part of our move towards a clinically led structure we have embedded QSIR into our organisational development programme to ensure that we are equipping our clinical staff with both quality improvement capabilities and also the pre-requisite skills to effectively both run and improve their services.

Staff are offered leadership and management development opportunities throughout their career path in order to ensure that we have a diverse and capable cohort of leaders at all levels of the talent pipeline in line with the aims and aspirations of the NHS long term plan

Getting to Good and Outstanding improvement plan

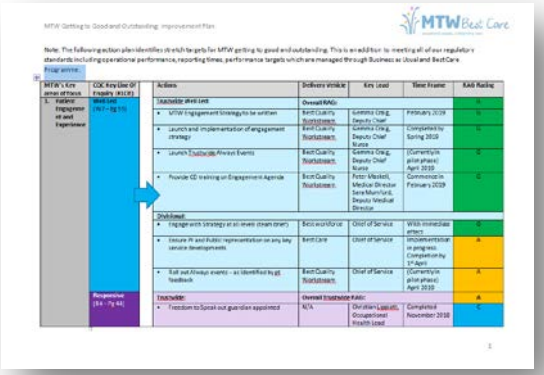
Under the leadership of our Chief Nurse we have developed an action plan with a number of key actions that we believe will help us to progress on our journey to good to outstanding with the CQC.

The plan consists of ten core areas that we have identified in a detailed action plan. A number of the actions are already in hand through the Best Care programme

We would aim to monitor progress with this plan at the Trust Quality improvement committee

A gap analysis is being undertaken against each of the CQC Key Lines Of Enquiry to ensure that the plan is comprehensive and addresses all areas for improvement

The Trust has also signed up to the NHSI moving to good programme and this will form a key plank of our plans to move to good and outstanding



Workforce planning (1/2)

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Workforce planning is an integral part of the Trust's annual business planning process. Workforce plans are developed in conjunction with the organisation's strategic objectives, demand and capacity assessments, operational and financial plans including the Cost Improvement Programme (CIP) and income forecasts. The workforce plans support the delivery of the requirements of the NHS constitution and other service delivery targets.

An Executive Team challenge programme of scrutiny ensures all local plans are aligned to organisational plans and objectives and have been subject to a robust QIA process. The integrated business planning process ensures that recruitment strategies, education commissioning, organisational development initiatives and workforce resource management are affordable and can be developed at a Trust-wide level and at scale. Divisional and directorate workforce plans are formally approved by the relevant Chief of Service prior to review by the relevant executive committee to form a recommendation for approval or variation at the Trust Board.

The Workforce Plan delivers:

- Appropriate staffing levels to meet operational demand as agreed with our commissioners and local partners
- Relevant skill-mix within clinical units to ensure the efficient, safe care of patients within the Trust
- Reduced dependence on temporary staffing (particularly high-cost agency sourcing) but protecting the ability to flex as service and contractual demands require.

Current workforce challenges at Trust and STP level (See page 11 for additional detail)

Whilst the trust has seen a considerable improvement in the turnover of staff in 2018/19 (reduced from 12% to 8.9%) it continues to face significant challenges in attracting clinical staff in a number of key areas. These include

- Consultant physicians
- Consultant radiologists
- Some Oncology specialisms
- Middle grade paediatricians
- Middle grade general surgeons
- Qualified nurses for Accident & Emergency
- Qualified nurses for medical wards
- Qualified theatre staff
- Qualified nurses for Trauma & Orthopaedics
- Senior Radiographer and senior Pharmacy positions

Whilst the trust has been able to continue to provide the requisite quality of care expected of it, it has done so through the use of agency staff with the consequent increase in costs. The demand for agency staff across the STP and more widely has meant that rate reductions have been hard to achieve although some progress has been made in this area in 2018/19, most notably with qualified nurse agency rates. MTW will be part of the STP programme to issue contract to medical agencies in 2019/20 to further reduce medical agency rates. It is expected that this will target junior medical staff initially. In 2018/19 MTW has taken steps to increase the size and usage of its own bank through additional recruitment and the conversion of agency clinicians to the trust bank. This will continue in 2019/20 and the trust will look to utilise available technologies to further encourage the take up of bank shifts.

Workforce planning (2/2)

Due to the limited supply within the local labour market MTW has sourced qualified nurses from overseas. The political impact of Brexit has led to a considerable reduction in interest from EU countries and therefore attention has focused on the wider international market. The trust is planning to expand the number of recruitment agencies it works with in 2019/20 to increase this supply. MTW has also been developing links with an Indian nursing school and aims to recruit an initial cohort from this source in 2019. These nurses will arrive in the UK 'OSCE ready' so as to reduce the amount of time spent as supernumerary. International recruitment will also be used to address vacancies within the medical workforce, primarily for middle grade paediatricians, surgeons and physicians. Recruitment will take place for both substantive and Medical Training Initiative (MTI) positions

Local recruitment will continue to take place with a focus on closer working with local universities to attract newly qualified healthcare professionals. All year 3 nursing students placed at MTW have been offered a job on successful qualification to improve recruitment from this group. For specific hard to fill vacancies, recruitment and retention premium (RRP) will be considered. RRP was used in 2018/19 for the recruitment of consultant Care of the Elderly consultants following consultation with STP partners. This will be repeated in 2019/20 for other select consultant posts which have remained vacant despite multiple recruitment attempts.

Given the challenges of the UK labour market and the time factors involved in international recruitment MTW plans to continue recruiting to alternative clinical roles and has been redesigning care pathways and work to support this. In 2019/20 MTW will recruit additional Physician Associates to surgery, general medicine and obstetrics and gynaecology. It will also recruit further advanced clinical practitioners in paediatrics, ophthalmology, radiology and emergency medicine to support care pathways and reduce the need for medical agency cover.

MTW will continue to expand its use of apprenticeships in 2019/20 to deliver a long term sustainable solution to the workforce. Apprenticeships are being used for entry level posts in administrative functions and for Care Support Workers. 15 trainee nurse associates have been appointed and a further cohort will be recruited in 2019/20 as part of a local consortia of provider organisations including 3rd sector. New apprenticeship roles will be introduced for scientific grades and therapies as the apprentice programmes become available. In order to increase usage of the MTW levy we will work with partner organisations in the STP and specifically within the forming West Kent ICP to transfer the levy to facilitate the development of shared posts.

Retention plans for MTW in 2019/20 will aim to continue the consistent downward trend in turnover that has been seen in 2018/19. The trust will deliver the remainder of its plan to improve nurse retention as part of the NHSi nurse retention programme. Key elements of this plan are being extended to other professional groups including therapies and laboratory staff. More widely the trust engagement plan will focus on the following areas to develop a positive organisational culture and assist in the retention of staff

- Provision of mental health support to individuals and teams in the immediate aftermath of an incident
- Implementation of the BMA Fatigue & Facilities charter
- Support for staff going through the menopause
- Review of the Employee Assistance programme
- Provision of a range of additional programmes for staff including art classes, a staff choir, meditation and mindfulness etc.
- A programme of staff focus groups to identify local issues
- Implementation of the new Freedom to Speak Up strategy and an expansion of the number of FTSU champions, drawn from staff volunteers, staff networks and staff side
- Harassment and Bullying training for all line managers going through all trust leadership programmes
- Joint review of all Employment relations cases by HR, staff side and staff networks to ensure fair and appropriate outcomes and processes are in place
- Revised publicity to emphasise to patients and public the commitment of the organisation to tackle violence and abuse of its staff by members of the public.
- Active 'shop floor' commitment of all senior leaders

Workforce challenges, risks and mitigations

Maidstone and Tunbridge Wells NHS Trust

Current workforce challenges at a local and STP/ICS level

Description of workforce challenge	Impact on workforce	Initiatives in place
i) Shortage of Adult trained nurses, particularly at TWH for ED, medicine, T&O and theatres ii) Shortage of consultant physicians and Radiologists iii) Shortage of middle grade surgeons and paediatricians iv) Stroke	Difficulty in recruiting to establishment; difficulty in rostering, reliance on bank and agency, additional training & development support required to support overseas nurses, apprentice programmes	NHSi Nurse retention programme Overseas nurse recruitment contracts in place with plans for further expansion of contracts. TNA programme in place. Guaranteed job offers made to all year 3 student nurses. Use of alternative roles e.g. Emergency Department practitioners, physician associates, Advanced Clinical Practitioners, Reporting Radiographers University recruitment events Local & regional recruitment events Overseas recruitment for middle grades Increased use of MTI programmes 'Golden handshake' and retention premium for Care of the Elderly consultants

Current workforce risks issues and mitigations in place to address them

Description of workforce risk	Impact of risk (high, medium, low)	Risk response strategy	Timescales and progress to date
High levels of vacancy of qualified nurses in ED, medical wards at TWH, T&O wards at TWH and TWH theatres	High	Using bank and agency staff as a temporary solution to cover gap. Identifying reasons for leaving through exit interviews and engagement with staff through focus groups. Implementing 'itchy feet' conversations as part of NHSi Retention programme. Automatic offers of employment to all year 3 nurse students, introduction of TNAs (15 commenced in December 2018)	
Long term vacancies for consultant physicians for respiratory, Care of the Elderly	High		

Long term vacancies

Maidstone and Tunbridge Wells NHS Trust

Long term vacancies and how we plan to fill these

Description of long-term vacancy, including the time this has been a vacancy post	Whole-time equivalent (WTE) impact	Impact on service delivery	Initiatives in place, along with timescales
Consultant Respiratory physician Consultant Care of the Elderly Physician Consultant AMU Consultant Radiologist Consultant Neurologist Consultant Oncologist Physician Middle grade Paediatrician Middle grade general surgeon	2.0 3.0 3.0 1.0 1.0 4.0 X y	Service delivery affected by the use of expensive long term medical agency impacting on budget	More flexible approach to job plans available including additional opportunities for research, teaching etc. Golden handshake of £20k available for Consultant CoE posts. 2 offers made International recruitment agency BDI supporting recruitment of middle grade medical staff. 10 offers pending. Plan to expand use of MTI posts across trust. 10 MTI posts planned for 2019/20. Development of alternative roles; ACPs, physician Associates, Reporting Radiographers. Succession planning with senior trainees

Financial forecasts and modelling

Maidstone and Tunbridge Wells NHS Trust

The Trust is planning to meet its control total target of £7.0m deficit before MRET and PSF. Including the impact of MRET and PSF funding would improve the financial position to a £6.9m surplus. The financial plan has been modelled using a consistent and integrated approach with the activity and workforce models. The plan has used the starting point of the forecast outturn for 2018/19 as at month 9. The Trust has then applied a number of assumptions to this, these include:

- 2019/20 Tariff changes have been reflected
- A CIP target of £16.6m in addition to £5.7m of full year effect of 18/19 schemes.
- A contingency reserve (£4.9m)

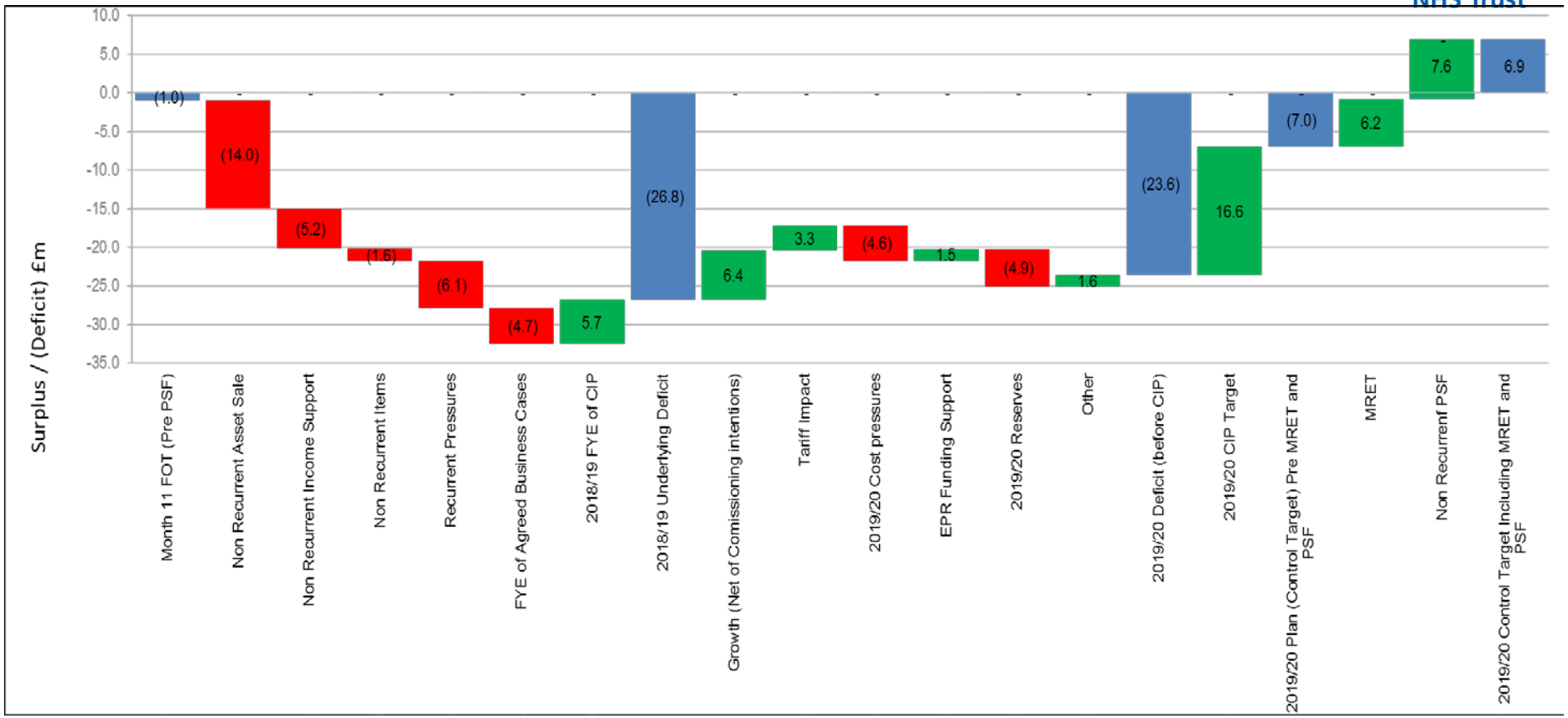
The table on the right shows the income and expenditure position for 2018/19 to 2019/12.

	2018/19 Budget £m	2018/19 Forecast £m	2019/20 Plan £m
Clinical Income	396.0	393.4	431.9
Commerical Income	3.7	3.8	4.0
Education Training & Research	11.0	11.1	10.9
Private Patients	3.4	1.5	5.1
Other Income	44.3	41.2	39.5
PSF	12.7	12.7	7.7
MRET	0.0	0.0	6.2
Total Income	**471.2**	**463.7**	**505.3**
A&C/Sen Man Staff	-35.9	-35.5	-41.4
Medical Staff	-80.2	-82.5	-85.8
Nursing	-96.7	-95.9	-99.2
Scientific Therap & Tech Staff	-41.3	-40.9	-44.7
Support Staff	-14.8	-14.2	-14.8
Apprenticeship Levy	-1.0	-1.0	-1.0
Pay Reserves	-0.6	0.0	-2.6
Total Pay	**-270.6**	**-270.1**	**-289.5**
Clinical Negligence	-19.0	-18.6	-17.6
Drugs & Medical Gases	-52.0	-52.7	-51.5
Purch healthcare from non NHS	-5.4	-3.8	-14.9
Supplies & Services	-37.2	-40.6	-38.9
Other Non Pay	-46.3	-50.7	-52.2
Reserves	-1.8	0.0	-2.3
Total Non Pay	**-161.7**	**-166.3**	**-177.3**
Other Finance Costs	-28.2	-17.0	-32.6
Technical Adjustments	1.1	1.4	1.1
Total Surplus Including MRET and PSF	11.7	11.7	6.9
Total Deficit Excluding MRET and PSF	-1.0	-1.0	-7.0

MTW exceptional people outstanding care

Bridge 2018/19 Outturn to 2019/20 Plan

Maidstone and Tunbridge Wells NHS Trust



Non Recurrent Items (£1.6m): Clinical income £3.3m (£1.0m 2017/18 old year, £1.8m RTT income, £0.5m PCS benefit), CNST Maternity Premium savings (£1.4m) and Fleming rebate £0.7m less £4m reversal of AIC adjustment.

Recurrent Pressures (£6.1m): Adjusted for Agreed business cases and non recurrent items in 2018/19 Divisional Workforce are forecasting to spend c£5.5m more than outturn.

FYE of Agreed Business Case (£4.7m): EPR Business Case £2.9m, Clinical led Organisation £1m, PAS AllScripts £0.5m, RTT Data Quality £0.5m, Best Care Programme (£0.4m), A&E Minors and Majors (£0.4m), £0.4m FYE of Frailty, BI Team (£0.2m) less Private Patient Unit benefit £1.9m.

2018/19 FYE CIPS £5.7m: Prime Provider £4.2m, Medicines Management £0.5m, Procurement £0.3m, Estates and Facilities £0.6m.

Growth Net of Commissioning Intentions and RTT reserve (Excluding Prime Provider) £6.4m.

Tariff Impact net of inflation and CNST reduction £0.9m (£8.9m income reduction, £1.5m CNST cost reduction, £0.5m supply chain cost reduction offsetting £10m cost inflation uplift) and MRET

Cost Pressures (£4.6m): Energy £1.5m, PFI and Depreciation £2m, Accommodation Rental £0.8m

EPR funding support £1.5m: Assumes £1.5m NHS Digital funding will be received towards the EPR project.

CIP £16.6m: The Trust has identified £16.6m of new savings plans

Efficiency savings for 2019/20

Maidstone and Tunbridge Wells NHS Trust

The Trust has a total savings plan for 2019/20 of £22.3m. £5.7m Roll over from 2018/19 and £16.6m new 2019/20 schemes.

Roll over savings £5.7m relate to Prime Provider £, Biosimilar savings £0.5m, E&F savings (£0.5m of which £0.2m classified as opportunity relating to Energy Procurement), £0.5m Procurement and £0.2m other savings.

The Trust has identified £16.6m of new savings schemes for 2019/20

£m

Programme	Scheme	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Best Patient Flow	Operational Efficiency	0.0	0.0	0.0	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	4.8
	Ward Closure	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	1.3
	T&O Activity Plan	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	1.0
	Other - Scheme <£50k	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
Total Patient Flow		**0.0**	**0.0**	**0.0**	**0.8**	**0.8**	**0.8**	**0.8**	**0.8**	**0.8**	**0.8**	**0.8**	**0.8**	**7.1**
Best Quality	CNST - Maternity	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.8
	Other - Scheme <£50k	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
Total Quality		**0.1**	**0.1**	**0.1**	**0.1**	**0.1**	**0.1**	**0.1**	**0.1**	**0.1**	**0.1**	**0.1**	**0.1**	**0.8**
Best use of Resources	Procurement	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	1.1
	Estates and Facilities	0.1	0.1	0.1	0.1	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	1.0
	ICD/Pacemaker	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.7
	Aseptic Dispensing - Income Generation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.5
	Biosimilar	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.5
	Printing Review	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.4
	Other - Scheme <£50k	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3
	STP Sendaway Test Repatriation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
	ICT Contract Review	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
	Tongue Tie	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
	Cath Lab Outsourcing (medtronic contract)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
	NHS Provider SLA Review	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
	NHSE Dispensing Charge - Homecare	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
	Loan Kit Review	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
	Therapies Income Review	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
	Community Peads service review	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
	Overseas Visitor Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
	Outreach clinic notice - JY at sevenoaks and all	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
Total Best Use of Resources		**0.3**	**0.3**	**0.4**	**0.4**	**0.6**	**0.4**	**0.5**	**0.5**	**0.5**	**0.5**	**0.5**	**0.5**	**5.5**
Best Workforce	Workforce Review	0.1	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	1.4
	Temporary Staffing Saving	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.8
	Roster Management	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.5
	A&C Review	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
	Other - Scheme <£50k	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
Total Workforce		**0.2**	**0.2**	**0.2**	**0.2**	**0.2**	**0.2**	**0.3**	**0.3**	**0.3**	**0.3**	**0.3**	**0.3**	**3.0**
Best Safe	Medical Job Planning Review	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
Total Safe		**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.2**
Grand Total		**0.5**	**0.6**	**0.7**	**1.5**	**1.7**	**1.5**	**1.7**	**1.7**	**1.7**	**1.7**	**1.7**	**1.7**	**16.6**
%		3%	3%	4%	9%	10%	9%	10%	10%	10%	10%	10%	10%	

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Agency Rules

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Whilst the trust plans to continue to reduce its reliance on agency staffing and consequent spend it anticipates that it will continue to breach the overall cap set by NHSi in 2019/20. The reason for the breach of the cap relates to the continued recruitment challenges faced by the trust in a number of key areas, notably consultant physicians, middle grade paediatricians and surgeons and qualified nursing staff for medicine and Emergency department specialisms. These challenges are driven by national shortages in these areas as well as more local geographical issues, most notably on the Tunbridge Wells site which is impacted more particularly by the cost of housing, cost of transport, ease of access and proximity to hospitals offering London weighting.

Key actions to continue to reduce agency spend in 2019/20 are part of the Trust Best Workforce programme and include work at local and STP level. The trust is working through the STP with neighbouring trusts to introduce STP agency contracts for medical agencies following introduction of similar contracts for qualified nurses in 2018/19. The Trust has plans to expand its international recruitment for qualified nurses and middle grade medical staff through the development of further contracts with recruitment agencies. It is also looking to expand its use of alternative roles such as advanced clinical practitioners and physician associates to offset shortages in hard to recruit specialisms.

The Trust will apply the advice gained from recently provided NHSi support on the management and use of agencies to apply further pressure on agency prices whilst at the same time actively working to continue the expansion of its bank provision. The trust will continue to maintain the level of governance, control and use of data that was endorsed by NHSi colleagues in their visit of 15th January.

Agency spend reduction will be achieved by

1. Elimination of use of non-framework nurse agency usage (with the exception of one non framework agency which supplies within NHSi CAP) from month 1. Non framework agency nurses have all been moved to framework agencies from February 2019 and will drop to framework rates of pay with effect from 1/4/19
2. Maintenance of the STP Nurse agency contract which sets a standard nurse agency rate for all acute trust work in the Kent & Medway STP area
3. Implementation of the STP Medical agency contract which will set a standard set of rates for medical agencies across the STP region. The contract includes a series of step down points to reduce the agreed rates on a quarterly basis. The step down in rates has been graduated such that there is confidence that these will be achievable
4. Improved use of electronic rostering. Analysis of current roster use indicates that there are opportunities for improvement in the allocation of shifts that will reduce the need for additional agency staff. Roster improvement will be supported by an agreed set of KPIs and monitored via Divisional Performance reviews in terms of CIP delivery
5. Improved rostering will deliver allow for earlier release of shifts to bank, encouraging a reduction in agency usage through earlier visibility of shifts to bank
6. Increased substantive recruitment as a result of a significant expansion in international recruitment with the aim of recruiting 175 registered nurses from international sources in 2019/20.
7. Increased substantive recruitment of middle grade medical staff from international sources with the intention of eliminating the vacancies in surgery and paediatrics in this area, both of which have incurred significant agency expenditure in 2018/19. Successful recruitment to these posts via international recruitment agency has been ongoing since December.
8. Increase in the size of the bank for all staff groups to minimise the need for agency shift usage.

The increase in substantive staff in excess of the numbers of agency staff displaced reflects the recruitment intentions noted above as well as specific service developments including the funding of the Frailty service at Tunbridge Wells.

Capital planning (1/2)

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The Trust's updated operational plan includes a five year capital programme of total value £56m (excluding donated assets) which is focussed on delivering the clinical strategy, driving access and operational performance improvements and reducing backlog and clinical risk to ensure appropriate patient safety and experience within an efficient environment.

The programme reflects plans for essential improvements in Maidstone estates (£11.5m) and Tunbridge Wells Hospital lifecycle (£5.4m). The Maidstone improvements include a new AMU (£7.9m); £5.6m of this is proposed to be funded from resource that the Trust is requesting to carry forward from the planned sale of Springwood Rd residences in 2018/19 into 2019/20. Assuming the asset is sold in 208/19, the funding arrangement will require approval from DHSC in terms of the allowing the cash carried forward to be spent as capital resource.

The planned HASU as part of the STP business case has not been included on NHSI instruction as it has not yet reached final approval through the complete governance process.

The Trust has assumed that the NHSE capitally funded national programme of updating linear accelerators will continue and has planned for a replacement linac on an annual basis. The Trust has brought forward its capital loan plan for "emergency" capital to finance replacement critical medical imaging equipment (£3.2m over two years).

The Trust's plan includes replacement equipment provision of c. £8.4m over the 5 year period from internal resources. This includes the remaining resource being requested to carry forward from the Springwood Rd sale planned for 2018/19 (£2.8m). In total the carry forward resource is proposed as £8.4m (£2.4m net book value, plus £6m of the overall gain on disposal).

ICT projects of £7.0m including the implementation of an Electronic Patient Record system and an EPMA prescribing system for which national PDC funding is being sought. .

The main source of capital funding is internally generated cash through deprecation net of repayments of principal on existing capital loans, PFI lease repayments and PFI lifecycle. The Trust continues to re-prioritise its programme in the light of the constraints on external capital, the approach to accounting for PFI capital repayments introduced in 2016/17, and also to reflect its stretching of the existing asset base (e.g. linac operational lives increased to 13 years from 10 to reflect actual usage) and the impact of valuation impairments.

Capital planning (2/2)

Maidstone and Tunbridge Wells NHS Trust

Draft Capital Spend - all figures £000	2019/20	2020/21	2021/22	2022/23	2023/24
Estates					
Backlog maintenance	500	363	650	650	570
AMU - funded 19/20 from £6m c/f from asset sale 18/19	5,565	2,306			
Pharmacy Outsourcing	150				
Estates Projects - other renewals			319	319	300
Linac estates work	373	375	375	375	375
Subtotal - internally generated funds	**6,588**	**3,044**	**1,344**	**1,344**	**1,245**
ICT					
ICT - Infrastructure	440	500	600	550	500
ICT - EPR (excluding EPMA: see below in external)	1,880	651	52		
Subtotal - internally generated funds	**2,320**	**1,151**	**652**	**550**	**500**
Equipment					
Trustwide equipment (inc. £2.8m from asset sale c/f from 19/20)	4,074		1,410	928	773
Linac equipment and commissioning	250	250	250	250	250
Subtotal - internally generated funds	**4,324**	**250**	**1,660**	**1,178**	**1,023**
Externally financed projects					
TWH - Lifecycle (IFRIC 12 PFI capital)	601	987	1,252	1,283	1,316
ICT - HSLI (HISBI) funding b/f from 2018/19	300				
ICT - EPMA - pending funding approval	1,500				
Linac replacement programme - PDC	1,730	1,730	1,730	1,750	1,750
Critical Medical Imaging replacement - Loans	2,500	700			
Oncology Site replacement - East Kent - Loan		5,000	5,000		
HASU Stroke - STP bid PDC - pending outcome					
Subtotal - external finance	**6,631**	**8,417**	**7,982**	**3,033**	**3,066**
Total Capital Spend Plans	**19,863**	**12,862**	**11,638**	**6,105**	**5,834**

The draft 5 year capital plan is balanced to the forecast internally generated capital resource, net of repayments of PFI and capital loans, plus some specific assumptions of external finance. Headlines for 2019/20:

- £5.6m in estates projects is assumed for AMU conversion in 19/20. The funding for this is part of the requested carry forward of £6m from the planned gain on disposal of Springwood residences in 2018/19. NHSI have agreed that the Trust can carry forward the cash in plans but the capital resource needs to be agreed by DHSC before it can be used.
- The remaining proposed c/forward from the asset sale is set against equipment requirements (£2.8m = NBV £2.4m + rest of £6m)
- The HASU PDC capital is not included in the plan in accordance with NHSI instructions as it is subject to final sign off the business case.
- £1.9m of internal funds has been set aside to finance EPR project. The Trust is bidding for external finance via NHSE for £1.5m for the EPMA component but this process is unlikely to conclude before the final plan submissions.
- The Trust is assuming a continuation of the NHSE funded linac replacement programme (PDC)
- The Trust has included a loan bid item for 2019/20 for £2.5m for critical Medical Imaging kit. This is brought forward from the 2018/19 plan submission

MTW exceptional people, outstanding care

The challenge faced by the STP mirrors that of the Trust itself with demographic challenges impacting on provision of care

Maidstone and Tunbridge Wells NHS Trust

The Kent and Medway Health and Social Care System's case for change sets out a range of challenges that are being faced by health and social care that are driving the transformation of care, being pursued by the STP (as summarised below).

The challenges outlined above are already being experienced by the Trust as outlined in this document, characterised by an increased demand for services due to changes in the population and increased challenges in delivering constitutional targets and maintaining expenditure within control totals.

Health and wellbeing

- **Population growth:** Projected to grow by c5% (≈ 89,000 people) over the next five years, with uneven growth across the patch putting pressures on some parts of the system
- **Ageing population:** Largest age group growth is in demographic of 85+ years bringing increased needs for health and social care
- **Health inequality:** Range of life expectancies for both men and women related to deprivation exist, with the main causes of death being from preventative interventions and the gap has not closed over the last 10 years
- **Housing growth:** Kent and Medway earmarked for significant housing growth e.g. Ebbsfleet, adding to the demand for health and care services

Quality of Care

- **Stresses in the system:** Services close to capacity across the patch with acute occupancy over 90%; a number of providers in special measures; a high ratio of patients to GPs and a number of GPs giving up general medical services (GMS) contracts or retiring
- **Delivery of constitutional targets:** Delayed transfer of care, A&E targets, RTT, cancer targets, ambulance response times and other services pressures (e.g. stroke) continue to be an ongoing issue
- **Workforce issues:** Significant workforce issues around recruitment, rotas and maintaining a viable workforce impacting health and social care

Sustainability

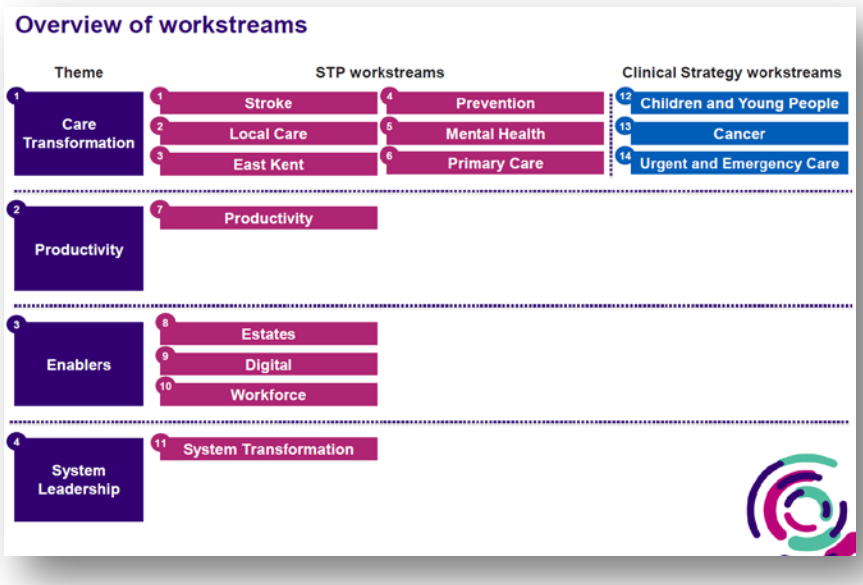
- **Financial sustainability:** 15/16 deficit of £109m forecast to rise to £434m by 20/21 in a 'do nothing' scenario (this excludes social care budget pressures (KCC £45m, Medway Council £7m).
- **Clinical sustainability:** Growing reliance on agencies due to workforce issues around unsustainable rotas, recruitment and retention.

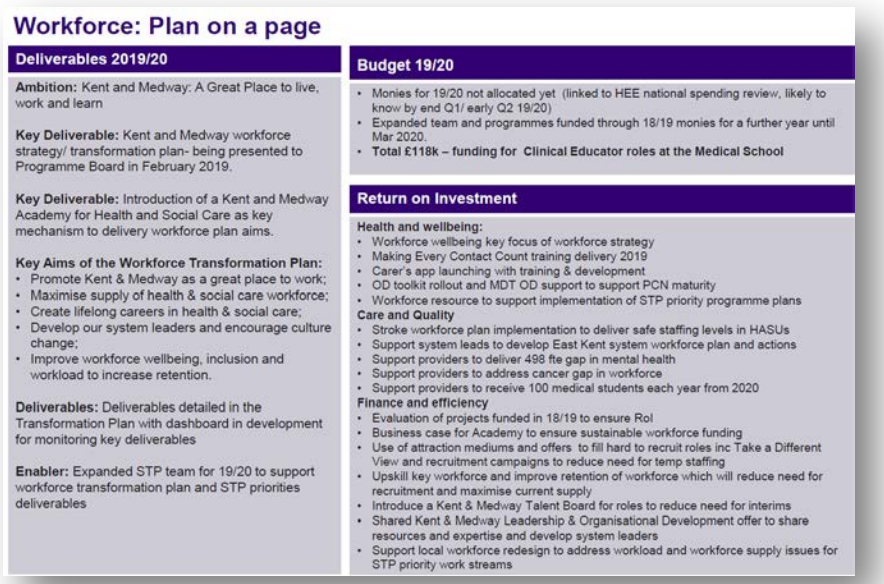
MTW exceptional people outstanding care

The STP workstreams directly inform the Trusts operational planning through both Trust specific deliverables and by informing expected improvements in finance, activity , workforce and quality

Maidstone and Tunbridge Wells NHS Trust

For all of the STP work streams they have been translated into the critical deliverables for 19/20 including for each individual Trust which constitutes part of the STP (e.g. on the implementation of Hyper Acute Stroke Units across Kent)





Key workstreams where the STP workstreams have informed the operating plan include:

- **Productivity**: A Key focus is on temporary staffing through Expanding the work to date with Nursing agencies to include Medical and then AHPs delivering collaborative bank solutions and harmonising bank rates.
- **Stroke:** MTW has developed it's plans for both a new AMU and HASU as part of the new stroke service model with evident implications on our capital and workforce plans for 19/20
- **Workforce:** The workforce plans at an TSP level support the MTW specific priorities for 19/20 (e.g. the improvement of workforce provision both in Stroke to support the implementation or new HASU's and also support to providers to address the cancer workforce gap which will directly support our operational performance and ability meet constitutional standards)
- **Local care:** As MTW progresses with it's partners towards developing an integrated care partnership (ICP) to support the Integrated Care System at a Kent wide level the work on local care will underpin both a multidisciplinary approach to care which will underpin plans at the same time as directly reducing both A&E activity, non elective activity and outpatient attendances which will help enable the Trust to effectively respond to the priorities set out in the long term plan on same day emergency care and face to face outpatient attendance reduction.

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Appendix – not for submission as part of narrative

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Trajectories (1/2)

Maidstone and Tunbridge Wells NHS Trust

- All Trajectories have been signed off by Chief executive, Chief Operating Officer and responsible manager (Lynn Gray – A&E, David Fitzgerald – Cancer, Sarah Turner – RTT, Neil Bedford – Diagnostics)
- **RTT trajectory assumes** the Trust achieves **84% year end performance**, **prime provider** to the level agreed with individual divisions and directorates for insourcing and outsourcing (through demand and capacity work) and all **capacity initiatives** required to fulfil this activity are **funded. Trajectory excludes** effect of further **validation or data quality** work

RTT		Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-2019	Diff Mar 20 to Mar 19
TRUST	Total Waiting List	28580	29152	28932	28908	29273	28433	28261	25964	25959	26446	25094	24398	23980	-4599
	IP Waiting List	6476	6733	6688	6773	6926	6830	6922	6880	6863	6790	6606	6557	6552	75
	OP Waiting List	22103	22419	22245	22135	22347	21603	21339	19084	19096	19656	18488	17841	17428	-4675
	IP Backlog	2523	2575	2545	2596	2713	2674	2721	2699	2653	2585	2421	2344	2315	-209
	OP Backlog	2064	2231	2032	2026	2377	1903	1822	838	1087	1657	1027	832	872	-1192
	Total %	84.0%	83.5%	84.2%	84.0%	82.6%	83.9%	83.9%	86.4%	85.6%	84.0%	86.3%	87.0%	86.7%	2.8%

		Baseline	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Total	Q1	Q2	Q3	Q4
A&E Type 1, Type 3 (inc Crowb)	Total Patients Seen	188,833	16,030	17,087	17,046	17,552	16,487	16,739	16,337	15,424	15,881	15,480	14,973	16,847	195,883	50,162	50,778	47,642	47,301
	>4hr Wait	16,212	1,401	1,142	977	1,177	980	1,222	1,262	1,209	1,907	1,857	1,585	1,591	16,310	3,520	3,380	4,378	5,032
	Peformance %	91.41%	91.26%	93.32%	94.27%	93.29%	94.05%	92.70%	92.27%	92.16%	87.99%	88.00%	89.42%	90.56%	91.67%	92.98%	93.34%	90.81%	89.36%

NB: Baseline include Crowborough full year

		Baseline	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Total	Q1	Q2	Q3	Q4
Diagnostics	Total Patients Waiting	6,082	6235	6491	6381	6454	5828	6308	6534	6449	5679	5689	6524	6994	75,566	19,107	18,590	18,662	19,207
	Patients waiting >6wks	24	56	49	46	44	46	48	44	52	56	47	44	50	582	151	138	152	141
	Peformance %	0.4%	0.9%	0.8%	0.7%	0.7%	0.8%	0.8%	0.7%	0.8%	1.0%	0.8%	0.7%	0.7%	0.8%	0.8%	0.7%	0.8%	0.7%
		99.6%	99.1%	99.2%	99.3%	99.3%	99.2%	99.2%	99.3%	99.2%	99.0%	99.2%	99.3%	99.3%	99.2%	99.2%	99.3%	99.2%	99.3%

		Baseline	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Total	Q1	Q2	Q3	Q4
Cancer 2WW (93%)	Total Patients Seen	1,390	1,382	1,536	1,305	1,518	1,474	1,356	1,510	1,518	1,315	1,449	1,322	1,529	17,213	4,222	4,348	4,343	4,300
	>2 week wait	101	88	107	85	101	99	90	99	105	92	125	82	94	1,167	280	290	296	301
	Peformance %	92.73%	93.63%	93.03%	93.48%	93.35%	93.28%	93.36%	93.45%	93.08%	93.00%	91.37%	93.80%	93.85%	93.22%	93.37%	93.33%	93.18%	93.00%
			8.0%	8.9%	7.6%	8.8%	8.6%	7.9%	8.8%	8.8%	7.6%	8.4%	7.7%	8.9%					

		Baseline	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Total	Q1	Q2	Q3	Q4
Cancer 2WW Breast (93%)	Total Patients Seen	129	133	167	155	135	162	142	156	178	132	152	125	142	1,779	455	439	466	418
	>2 week wait	25	37	35	30	31	35	28	25	22	19	25	17	12	316	102	94	66	54
	Peformance %	80.57%	72.20%	79.07%	80.66%	77.09%	78.35%	80.27%	83.99%	87.65%	85.61%	83.54%	86.38%	91.52%	82.24%	77.60%	78.58%	85.85%	87.09%

		Baseline	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Total	Q1	Q2	Q3	Q4
Cancer 31 Day First (96%)	Total Patients Seen	212	128	161	149	130	156	137	151	172	127	146	120	136	1,714	439	423	449	403
	>2 week wait	7	5	6	6	4	4	5	4	6	5	10	2	4	61	17	13	15	16
	Peformance %	96.69%	96.10%	96.28%	95.99%	96.93%	97.43%	96.34%	97.34%	96.51%	96.07%	93.17%	98.34%	97.07%	96.44%	96.13%	96.93%	96.66%	96.03%

		Baseline	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Total	Q1	Q2	Q3	Q4
Cancer 31 Day Surgery (94%)	Total Patients Seen	23	32	19	26	28	26	35	25	34	13	31	30	23	323	77	89	72	85
	>2 week wait	3	8	-	4	1	1	7	2	7	-	6	2	3	41	12	9	9	11
	Peformance %	87.15%	75.00%	100.00%	84.62%	96.43%	96.15%	80.00%	92.00%	79.41%	100.00%	80.65%	93.43%	87.15%	87.30%	84.42%	89.89%	87.50%	87.03%

Trajectories (2/2)

Maidstone and Tunbridge Wells NHS Trust

		Baseline	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Total	Q1	Q2	Q3	Q4
Cancer 31 Day Drugs (98%)	Total Patients Seen	143	139	130	153	112	126	100	146	166	125	189	127	154	1,669	422	339	437	470
	>2 week wait	3	6	-	3	-	2	1	1	2	2	4	1	3	27	10	3	5	9
	Peformance %	97.90%	95.35%	100.00%	97.89%	100.00%	98.29%	98.92%	99.26%	98.70%	98.28%	97.71%	99.15%	97.90%	98.38%	97.70%	99.04%	98.77%	98.16%

		Baseline	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Total	Q1	Q2	Q3	Q4
Cancer 31 Day Radio (94%)	Total Patients Seen	317	311	308	292	331	297	265	388	336	248	301	251	317	3,645	911	893	972	869
	>2 week wait	16	17	15	15	16	8	16	8	11	2	25	12	16	161	47	40	21	53
	Peformance %	94.94%	94.53%	95.13%	94.86%	95.17%	97.31%	93.96%	97.94%	96.73%	99.19%	91.69%	95.23%	94.94%	95.58%	94.84%	95.52%	97.84%	93.90%

		Baseline	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Total	Q1	Q2	Q3	Q4
Cancer 62 days (85%)	Total Patients Seen	136.3	138.0	124.5	142.0	123.0	152.5	123.0	171.5	126.0	128.5	142.0	138.0	150.0	1,659	405	399	426	430
	>62 day wait	41.0	32.0	18.5	21.0	18.0	22.5	17.5	25.5	18.5	19.0	22.5	19.0	21.0	255	72	58	63	63
	Peformance %	69.92%	76.81%	85.14%	85.21%	85.37%	85.25%	85.77%	85.13%	85.31%	85.21%	84.15%	86.23%	86.00%	84.63%	82.32%	85.45%	85.21%	85.47%

		Baseline	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Total	Q1	Q2	Q3	Q4
Cancer 62 day Screening (90%)	Total Patients Seen	14.5	11.0	17.0	14.0	19.5	24.5	14.5	17.0	18.5	16.5	19.5	13.0	14.5	200	42	59	52	47
	>62 day wait	2.5	5.0	2.5	2.0	4.0	4.0	4.5	2.0	0.5	2.5	4.0	1.5	2.5	35	10	13	5	8
	Peformance %	82.76%	54.55%	85.29%	85.71%	79.49%	83.67%	68.97%	88.24%	97.30%	84.85%	79.49%	88.46%	82.76%	82.46%	77.38%	78.63%	90.38%	82.98%

		Baseline	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Total	Q1	Q2	Q3	Q4
Cancer 62 day Upgrade (85%)	Total Patients Seen	11.0	8.5	6.5	4.5	6.5	9.0	5.0	11.0	16.0	6.5	7.5	7.5	11.0	100	20	21	34	26
	>62 day wait	3.5	6.0	2.5	1.0	2.5	2.0	2.5	1.5	5.0	2.0	2.0	1.0	3.5	32	10	7	9	7
	Peformance %	68.18%	29.41%	61.54%	77.78%	61.54%	77.78%	50.00%	86.36%	68.75%	69.23%	73.33%	86.67%	68.18%	68.34%	51.28%	65.85%	74.63%	75.00%

Cancer 62 days - Backlog (open pathways >62 Days)	Baseline	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20					
	231	198	191	187	181	178	185	172	168	161	170	162	154					

MTW exceptional people outstanding care

Financial, operational and performance contingencies

Maidstone and Tunbridge Wells NHS Trust

Financial contingencies

- The Trust will ensure that a contingency of £4.9m
- Divisions have been set a CIP target of £19.4m which includes as internal contingency of £2.8m

Operational contingencies

- Movement to a month 10 baseline position would indicate that there will be operational contingency in the following services:
  - Cardiology 8% contingency in outpatients
  - Neurology 8% contingency in outpatients
  - Rheumatology 16% contingency in outpatients
  - Respiratory 2% contingency in outpatients
  - Endocrinology 3% contingency in outpatients
  - Urology 8% contingency in outpatients
  - ENT 6% contingency in outpatients
- Due to maximising prime provider activity the available operational contingency within the Trust for elective activity is <2%
- Additional independent sector capacity provides contingency for operational performance but will be associated with an additional cost

Performance contingencies

A&E – The contingencies for A&E performance not currently factored in to performance trajectory (And would cause a 2-3% uplift in performance in totality) include:

- Movement of Stroke to Maidstone and de-compression of Tunbridge Wells site by 10-19 beds (assumes surgical activity move +/- Gastroenterology move to establish digestive diseases unit)
- Maximal deployment of hospital at home across surgical wards to improve flow
- Improvements in same day emergency care
- Expansion of community beds

RTT and Cancer – Contingencies are constituted of 3 areas:

- Internal capacity contingency - As above for outpatient activity
- External capacity contingency – Either utilisation of:
  - Additional capacity on MTW site – Vanguard unit
  - Independent sector capacity freed up through MTW efficiencies allowing increased insourcing of prime provider work
- Data contingency – Further validation to the levels seen in December 2018 would have an additional effect of 2% on the RTT trajectory. Data quality work may allow for further contingency if a positive effect is obtained however a negative effect is equally as likely in which case contingency from validation would have to be deployed against it to offset for any performance loss.

Key constraints within the operating plan

Maidstone and Tunbridge Wells NHS Trust

- Within the plans the key constraints preventing additional activity is funded theatre capacity (including the availability of workforce to staff as well as infrastructure). In order constraints vary by specialty but are generally:
  - Workforce availability
  - Theatre availability
  - Bed availability
- Directorate teams have been working on schemes to improve:
  - The volume of staff available to maximise use of current theatre capacity (e.g. employ additional consultants)
  - The availability of staff to work within currently available maximal theoretical capacity (e.g. through MOU planned list extension outside of NHS time to accommodate additional activity paid at incentivised rates)
  - The available on site capacity (e.g. deployment of vanguard unit)
- Theoretically achievement of the 92% standard would be possible but would require all additional identified internal capacity to be used for waiting list and backlog whilst all prime provider activity would need to be outsourced to the independent sector

T&O example schemes to improve insourcing

	2019/20 Part Year Effect	
Scheme	Activity Impact Elective	Outpatients
Appointment of 4 x new Orthopedic Consultants	1,670	7,182
Hire of Vanguard Unit - theatre only (no additional beds)	*840*	
Hire of Vanguard Unit - weekend sessions	*158*	
Backfill of current lost activity	*672*	
Increase in Outpatient clinics		*5,670*
SCP led clinics		*1,512*
MOU Planned list extension (outside NHS time) to accommodate additional activity paid at incentivised rates	210	
Remove Spinal activity - Elective	126	
Remove Spinal activity - Outpatient		500
Upper Limb Sholder fellow - 2 x additional lists of 6 cases per month	72	
Reducing Outpatient numbers to MTW new:FU		5,389
Total Cost of Schemes	**2,680**	**15,614**
Remaining Activity to Outsource - Elective (+ = gap in capacity leading to outsourcing cost, - = excess capacity)	58	
Remaining Activity to Outsource - Outpatients		4,296
Total Revised cost including required outsourcing of capacity gap		
Benefit (+)/Pressure (-) Compared to 1920 Budget for Outsourcing		
Benefit (+)/Pressure (-) Compared to 1920 Anticipated Costs to Outsource		

Activity requirements for 92% performance (based on Month 5 projections)

Spec		Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-2019	Diff Mar 20 to Mar 19
TRUST	**Total Waiting List**	28425	28020	26269	27123	26701	25265	24826	22231	22213	22838	21712	21280	20895	-7531
	IP Waiting List	6322	6378	6179	6066	6004	5656	5559	5308	5207	5038	4756	4630	4536	-1786
	OP Waiting List	22103	21642	20089	21057	20697	19609	19267	16923	17007	17800	16956	16650	16359	-5745
	IP Backlog	2416	1854	1635	1477	1334	1132	1047	945	881	810	701	652	634	-1782
	OP Backlog	2195	1277	697	1276	1185	1093	1135	571	812	1365	1099	1057	1028	-1167
	Total %	**84%**	**88.8%**	**91.1%**	**89.9%**	**90.6%**	**91.2%**	**91.2%**	**93.2%**	**92.4%**	**90.5%**	**91.7%**	**92.0%**	**92.0%**	**8.3%**

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2019/20 Financial Plan

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2019/20 Financial Plan

Maidstone and Tunbridge Wells NHS Trust

Control Total

The Trust has received a Control Total of a surplus of £6.90m (including PSF and MRET).
The Trust will receive PSF of £7.65m and MRET of £6.2m which gives a £6.9m deficit pre PSF and MRET.
For 19/20 there is only one requirement for PSF which is to meet the pre PSF financial position.
The Trust must agree to sign up to the Financial Control Total in the Financial Plan submission on the 4th April.

Financial Plan

The financial plan proposes to meet the control total however this includes a CIP target for 19/20 of £22.3m which is 4.8% of 18/19 turnover. The Trusts total CIP target for 2019/20 includes £5.7m roll over and £16.6m new CIP schemes.

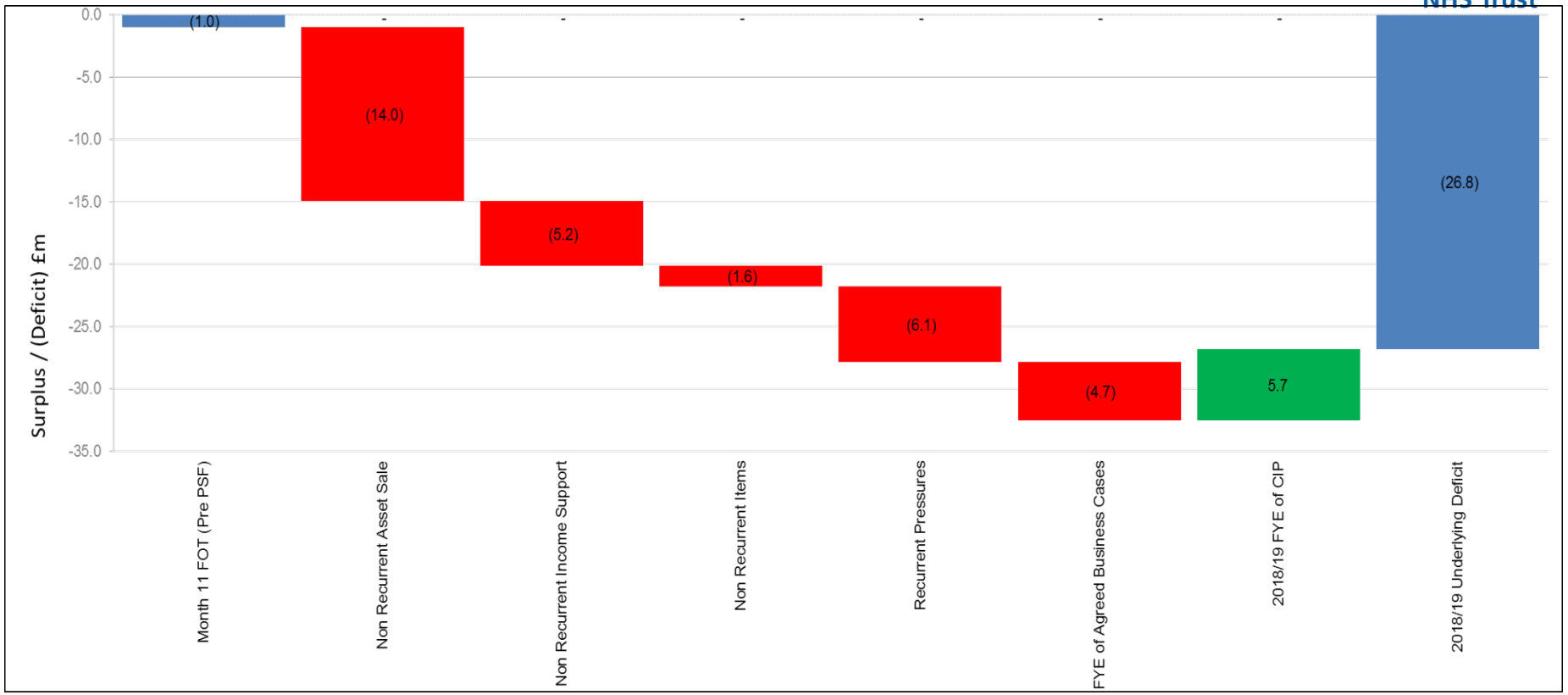
The movement and key variances are shown on the next bridges.

Agency Celling

The Trusts agency celling for 2019/20 has been set at £11.8m. The Trusts plan for 2019/20 is £16.5m (£4.7m) adverse although the plan is £6.5m less that the forecast outturn for 2018/19.

Bridge 2018/19 Outturn to Underlying Deficit

Maidstone and Tunbridge Wells NHS Trust



Non Recurrent Items (£1.6m): Clinical income £3.3m (£1.0m 2017/18 old year, £1.8m RTT income, £0.5m PCS benefit), CNST Maternity Premium savings (£1.4m) and Fleming rebate £0.7m less £4m reversal of AIC adjustment.

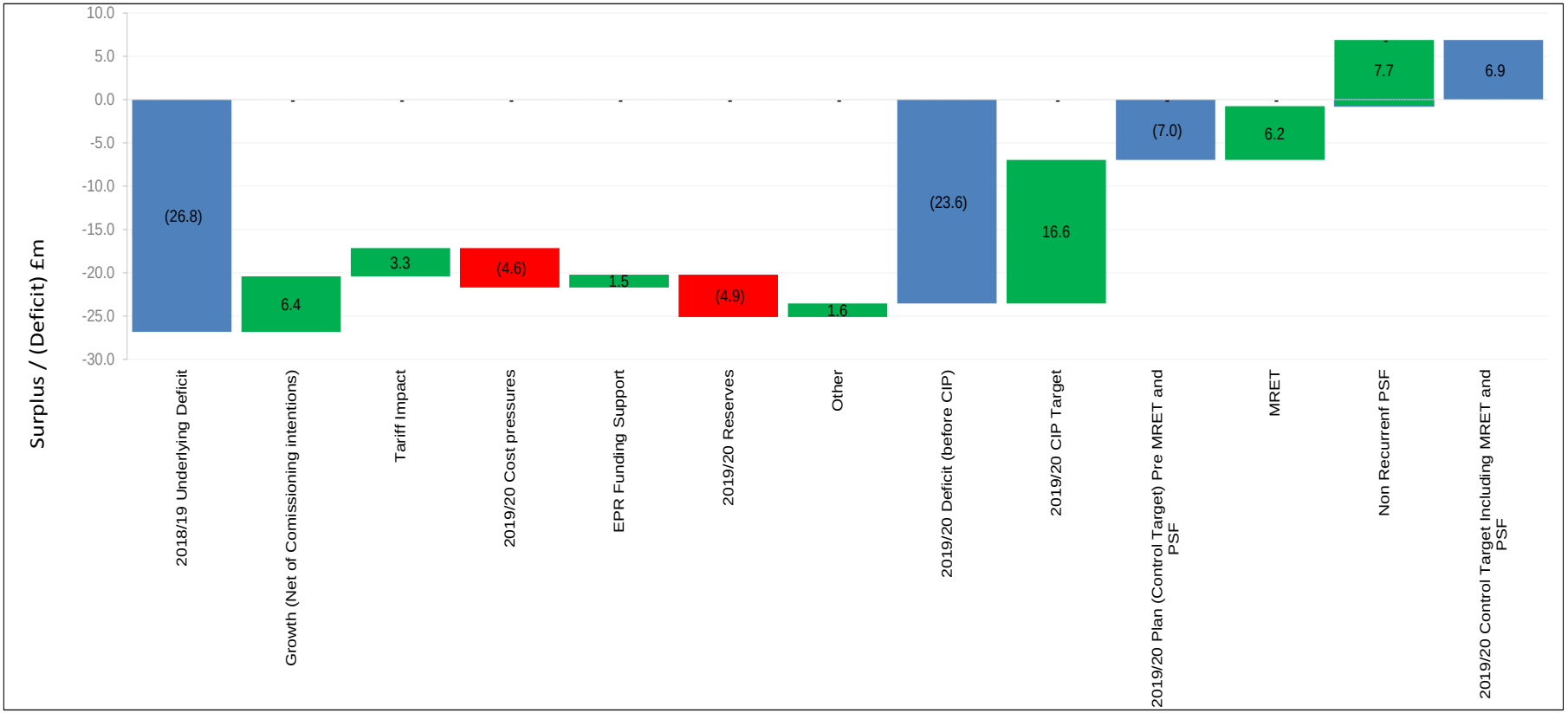
Recurrent Pressures (£6.1m): Adjusted for Agreed business cases and non recurrent items in 2018/19 Divisional Workforce are forecasting to spend c£5.5m more than outturn.

FYE of Agreed Business Case (£4.7m): EPR Business Case £2.9m, Clinical led Organisation £1m, PAS AllScripts £0.5m, RTT Data Quality £0.5m, Best Care Programme (£0.4m), A&E Minors and Majors (£0.4m), £0.4m FYE of Frailty, BI Team (£0.2m) less Private Patient Unit benefit £1.9m.

2018/19 FYE CIPS £5.7m: Prime Provider £4.2m, Medicines Management £0.5m, Procurement £0.3m, Estates and Facilities £0.6m

Underlying Deficit to 2019/20 Plan

Maidstone and Tunbridge Wells NHS Trust



Growth Net of Commissioning Intentions and RTT reserve (Excluding Prime Provider) £6.4m.

Tariff Impact net of inflation and CNST reduction £0.9m (£8.9m income reduction, £1.5m CNST cost reduction, £0.5m supply chain cost reduction offsetting £10m cost inflation uplift) and MRET

Cost Pressures (£4.6m): Energy £1.5m, PFI and Depreciation £2m, Accommodation Rental £0.8m

EPR funding support £1.5m: Assumes £1.5m NHS Digital funding will be received towards the EPR project.

Summary I&E Table

	2018/19 Budget	2018/19 Forecast	2019/20 Plan
	£m	£m	£m
Clinical Income	396.0	393.4	431.9
Commerical Income	3.7	3.8	4.0
Education Training & Research	11.0	11.1	10.9
Private Patients	3.4	1.5	5.1
Other Income	44.3	41.2	39.5
PSF	12.7	12.7	7.7
MRET	0.0	0.0	6.2
Total Income	**471.2**	**463.7**	**505.3**
A&C/Sen Man Staff	-35.9	-35.5	-41.4
Medical Staff	-80.2	-82.5	-85.8
Nursing	-96.7	-95.9	-99.2
Scientific Therap & Tech Staff	-41.3	-40.9	-44.7
Support Staff	-14.8	-14.2	-14.8
Apprenticeship Levy	-1.0	-1.0	-1.0
Pay Reserves	-0.6	0.0	-2.6
Total Pay	**-270.6**	**-270.1**	**-289.5**
Clinical Negligence	-19.0	-18.6	-17.6
Drugs & Medical Gases	-52.0	-52.7	-51.5
Purch healthcare from non NHS	-5.4	-3.8	-14.9
Supplies & Services	-37.2	-40.6	-38.9
Other Non Pay	-46.3	-50.7	-52.2
Reserves	-1.8	0.0	-2.3
Total Non Pay	**-161.7**	**-166.3**	**-177.3**
Other Finance Costs	-28.2	-17.0	-32.6
Technical Adjustments	1.1	1.4	1.1
Total Surplus Including MRET and PSF	11.7	11.7	6.9
Total Deficit Excluding MRET and PSF	-1.0	-1.0	-7.0

Maidstone and Tunbridge Wells NHS Trust

Comments:

Income increase of £38.5m between years

- Clinical Income is forecasted to increase by £38.5m between years. This is mainly due to: Prime Provider £15m, Tariff changes £9m, Growth including RTT activity £12m and Cancer recovery £3.9m.
- The level of private patient income at the Wells Suite has been based upon the business cases agreed in 2018/19 and therefore includes £3.4m increase
- Reduction in other income relates to non recurrent income of £1.5m received in 2018/19

Pay £19.4m Increase between years

- Inflation £8.5m, 2018/19 Non recurrent benefits £0.9m, FYE of agreed business cases (£3.4m), Recurrent pay pressures form workforce plan (£5.5m), Cancer recovery investment (offset by income) £2.5m, reserve £2.6m) less 2019/20 CIP (£4.6m)

Non Pay £11m increase

- FYE of business cases (£5.1m), Growth reserve (£15.4m), Inflation £1.8m, reserves £2.3m less 2019/20 CIPS £10.7m.

Other Finance £15.6m increase

- Non Recurrent asset sale in 2018/19 (£13.9m), depreciation and PDC increase (£1.7m)

Capital planning (1/2)

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The Trust's updated plan includes a five year capital programme of total value £56m (excluding donated assets)

The programme reflects plans for essential improvements in Maidstone estates (£11.5m) and Tunbridge Wells Hospital lifecycle (£5.4m). The Maidstone improvements include a new AMU (£7.9m); £5.6m of this is proposed to be funded from resource that the Trust is requesting to carry forward from the planned sale of Springwood Rd residences into 2019/20. Assuming the asset is sold in 208/19, DHSC will need to approve the cash carried forward to be spent as capital resource.

The planned HASU as part of the STP business case has not been included on NHSI instruction as it has not yet reached final approval through the complete governance process.

The Trust has assumed that the NHSE capitally funded national programme of updating linear accelerators will continue and has planned for a replacement linac on an annual basis. The Trust has brought forward its capital loan plan for "emergency" capital to finance replacement critical medical imaging equipment (£3.2m over two years).

The Trust's plan includes replacement equipment provision of c. £8.4m over the 5 year period from internal resources. This includes the remaining resource being requested to carry forward from the Springwood Rd sale planned for 2018/19 (£2.8m). In total the carry forward resource is proposed as £8.4m (£2.4m net book value, plus £6m of the overall gain on disposal).

ICT projects of £7.0m including the implementation of an Electronic Patient Record system and an EPMA prescribing system for which national PDC funding is being sought.

The main source of capital funding is internally generated cash through deprecation net of repayments of principal on existing capital loans, PFI lease repayments and PFI lifecycle.

Capital planning (2/2)

Maidstone and Tunbridge Wells NHS Trust

Draft Capital Spend - all figures £000	2019/20	2020/21	2021/22	2022/23	2023/24
Estates					
Backlog maintenance	500	363	650	650	570
AMU - funded 19/20 from £6m c/f from asset sale 18/19	5,565	2,306			
Pharmacy Outsourcing	150				
Estates Projects - other renewals			319	319	300
Linac estates work	373	375	375	375	375
Subtotal - internally generated funds	**6,588**	**3,044**	**1,344**	**1,344**	**1,245**
ICT					
ICT - Infrastructure	440	500	600	550	500
ICT - EPR (excluding EPMA: see below in external)	1,880	651	52		
Subtotal - internally generated funds	**2,320**	**1,151**	**652**	**550**	**500**
Equipment					
Trustwide equipment (inc. £2.8m from asset sale c/f from 19/20)	4,074		1,410	928	773
Linac equipment and commissioning	250	250	250	250	250
Subtotal - internally generated funds	**4,324**	**250**	**1,660**	**1,178**	**1,023**
Externally financed projects					
TWH - Lifecycle (IFRIC 12 PFI capital)	601	987	1,252	1,283	1,316
ICT - HSLI (HISBI) funding b/f from 2018/19	300				
ICT - EPMA - pending funding approval	1,500				
Linac replacement programme - PDC	1,730	1,730	1,730	1,750	1,750
Critical Medical Imaging replacement - Loans	2,500	700			
Oncology Site replacement - East Kent - Loan		5,000	5,000		
HASU Stroke - STP bid PDC - pending outcome					
Subtotal - external finance	**6,631**	**8,417**	**7,982**	**3,033**	**3,066**
Total Capital Spend Plans	**19,863**	**12,862**	**11,638**	**6,105**	**5,834**

The draft 5 year capital plan is balanced to the forecast internally generated capital resource, net of repayments of PFI and capital loans, plus some specific assumptions of external finance. Headlines for 2019/20:

- £5.6m in estates projects is assumed for AMU conversion in 19/20. The funding for this is part of the requested carry forward of £6m from the planned gain on disposal of Springwood residences in 2018/19. NHSI have agreed that the Trust can carry forward the cash in plans but the capital resource needs to be agreed by DHSC before it can be used.
- The remaining proposed c/forward from the asset sale is set against equipment requirements (£2.8m = NBV £2.4m + rest of £6m)
- The HASU PDC capital is not included in the plan in accordance with NHSI instructions as it is subject to final sign off the business case.
- £1.9m of internal funds has been set aside to finance EPR project. The Trust is bidding for external finance via NHSE for £1.5m for the EPMA component but this process is unlikely to conclude before the final plan submissions.
- The Trust is assuming a continuation of the NHSE funded linac replacement programme (PDC)
- The Trust has included a loan bid item for 2019/20 for £2.5m for critical Medical Imaging kit. This is brought forward from the 2018/19 plan submission

Key Risks

Maidstone and Tunbridge Wells NHS Trust

Contract Negotiations

Contracts have not yet been finalised with commissioners. The main risks for West Kent and Surrey and Sussex CCGs relates to the additional activity to maintain RTT performance and Cancer performance. There is only one risk with NHSE which relates to the funding of the Aseptic suite (c£1m).

CIPs

The Trust fully identified schemes totalling £16.6m however £9.7m of are risk rated as red. Divisions have been set a target of £19.4m to try and mitigate any slippage or non delivery. The Trust is looking at additional support to work with the divisions to develop and implement plans with regular meetings to be held.

Business cases and Services developments

Business cases and Services developments to be cost neutral or funded via contingency reserve. Pilots currently in progress such as AEC and hospital at home are not included in this plan.

Capital funding

The plan assumes£1.5m support for EPR project is received from NHS Digital Funding.

Stroke Reconfiguration

The plan assumes the current stroke services will continue until April 2020 and therefore no additional income assumptions have been made for any additional stroke activity at the Maidstone site.

Next Steps

Maidstone and Tunbridge Wells NHS Trust

Contract Negotiation

The financial and operational plan include the activity necessary to deliver the constitutional standard trajectories, but as of yet, no contracts have been agreed with commissioners. The Trust will continue to negotiate with commissioners but is clear within the parameters it can reach agreement.

Workforce Challenge / reviews

The current plan includes the Divisional draft workforce plans which are £5.5m higher than the 18/19 adjusted outturn. This will be a key focus of further work on delivering pay CIPs, and driving towards the £19.4m CIP stretch target.

CIP generation

The Trust has engaged external support during Q1 to improve its current CIP position and achieve the necessary savings. Divisions and corporate Directorates will be further supported by the Best Care programme to deliver Transformational savings.

Deadlines	Submission	Date	Achieved
Finance Committee	Final Plan Review	26th March 2019	
Trust Board	Final Plan Review	28th March 2019 (National deadline is 29th March 2019)	
NHSI Submission	Full Draft Submission (Finance, Workforce, Activity and Operational Plan)	4th April 2019	

Appendices

Maidstone and Tunbridge Wells NHS Trust

- Planning Assumptions – Income
- Planning Assumptions – Pay, Non Pay, Other
- Income, Pay and Non Pay Comparisons
- Clinical Income Bridge
- Contracts Update
- Pay Bridge
- Non Pay Bridge
- Summary I&E Trend
- Detailed I&E Trend
- 2019/20 CIP Plan (RAG and Status)
- CIP Summary Phasing
- CIP Phasing by scheme
- CIP scheme RAG rating

Planning Assumptions - Income

Clinical Income		
National Tariff inflator	Activity has been priced using the 2019/20 National planning Tariff	
Local prices & block items	Local prices & block items 2.7%, high cost drugs 0.6% (as per National planning guidance) & devices 1.8%)	
Demographic growth	5.0% for A&E 2.3% Non Electives 3.6% for Daycase and Electives 4.9% for Out Patients	A&E based on historical activity growth patterns and other activity as per 2018/19 National Planning guidance. Commissioners are planning to try and restrict this growth by planned QIPP schemes to reduce to local expected growth levels.
Commissioning intentions (QIPP)	Agreed Commissioning intentions have been included the majority relates to drugs and demand management of growth. No QIPP has been recognised for NHSE / Specialist commissioning.	
CQUIN	CQUIN applied at 100% (1.25%) as per National guidance	
Prime Provider	Prime Provider has been incorporated in to the contract and trust plan for West Kent independent sector (IS) activity equating to £15.1m. Out of area IS activity has yet to be agreed and has therefore not been included, it is expected to have a zero net impact on the Trust plan.	
Marginal Rate Emergency Tariff (MRET)	Marginal Rate Emergency Tariff (MRET) has been rebased to the 2017/18 outturn deduction in the contract and this will be matched £ for £ by central funding as part of the Trust control total target equating to £6.2m.	
Market Forces Factor	Market Forces Factor (MFF) has been reduced in line with the national guidance and will incrementally over the next five years to new MFF. The reduction in 2019/20 is c£2m.	
Additional RTT Activity	Income has been included in the plan to reflect the additional activity required to achieve the Trusts planned RTT trajectory for 2019/20.	

Other Income	
Inflation	2% inflation for Private Patients and 1% for other income

Planning Assumptions – Pay, Non Pay and Other

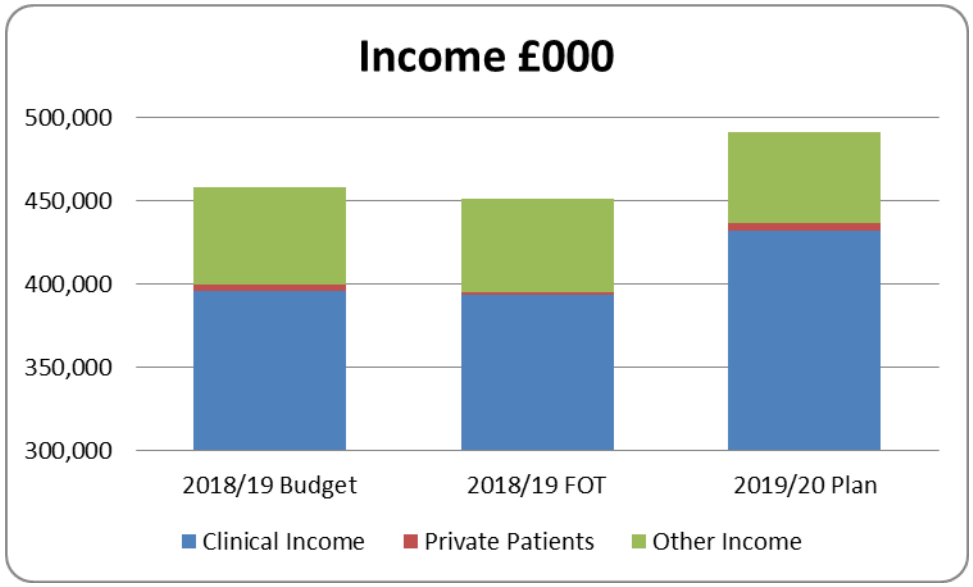
Pay	
AFC Staffing	AFC Staffing - 3.3% inflation uplift which incorporates pay award and incremental drift
Medical Staffing	Medical Staffing - 2% inflation uplift which incorporates pay award and incremental drift
Non Recurrent	Adjusted for Non Recurring and Full Year Effect (FYE) items
Workforce Plans	Divisions as part of the planning process have completed workforce plans which forecast substantive, bank and agency usage. The workforce plans are showing a pressure above outturn adjusted for agreed changes for business cases / service developments of c£5.5m mainly impacting STT and A&C staffing groups.

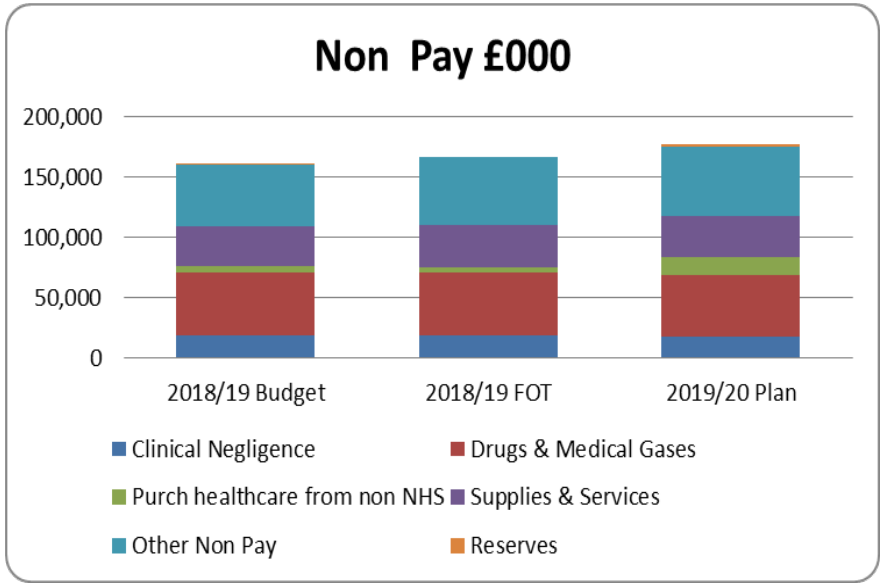
Non Pay	
Non Recurrent	Based on an assessment of the recurrent non pay expenditure adjusted for Non Recurring and Full Year Effect (FYE) items
Inflation	Assumes 0.6% Drug inflation, 1.8% non pay and Premises 3%
CNST	CNST based on notified levels (£1.5m reduction to 2018/19 core charge)
Winter Escalation	£1.8m additional costs for winter escalation has been incorporated into the plan which includes: £0.6m Escalation of ward at Maidstone, £0.4m Escalation of Short Stay Surgical unit, £0.35m Medical outlier team, £0.15m Peale / Cornwallis switch, £0.1m A&E seasonal increase, £0.1m ITU seasonal increase and £0.1m other items.
Other	The plan includes £1.5m FYE cost pressure associated with Energy price inflation and £0.8m Accommodation rental costs.

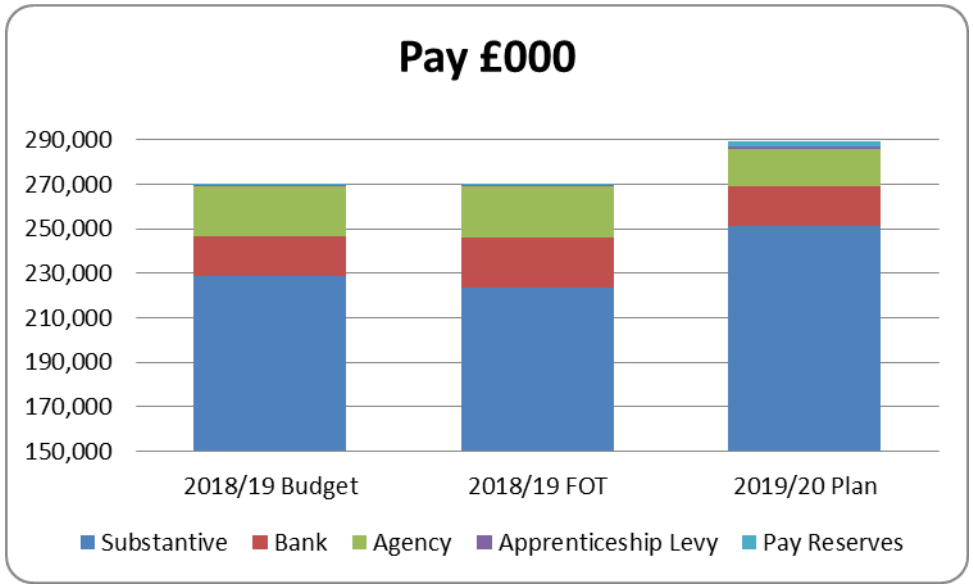
Other	
Reserves	Assumes £4.9m contingency reserve
Depreciation and PDC	Depreciation and PDC charges are based on 2019/20 planned levels
CIP	The Trusts total CIP target for 2019/20 is £22.3m which includes £5.7m roll over and £16.6m new CIP schemes. This Target represents 4.8% of 18/19 forecast turnover.
Cost of Growth	The plan includes £15.8m (before CIP) outsourcing reserve to fund additional costs to bridge between baseline capacity and demand. This reserve has been based on all points of delivery.

Income, Pay and Non Pay Comparisons

Maidstone and Tunbridge Wells NHS Trust

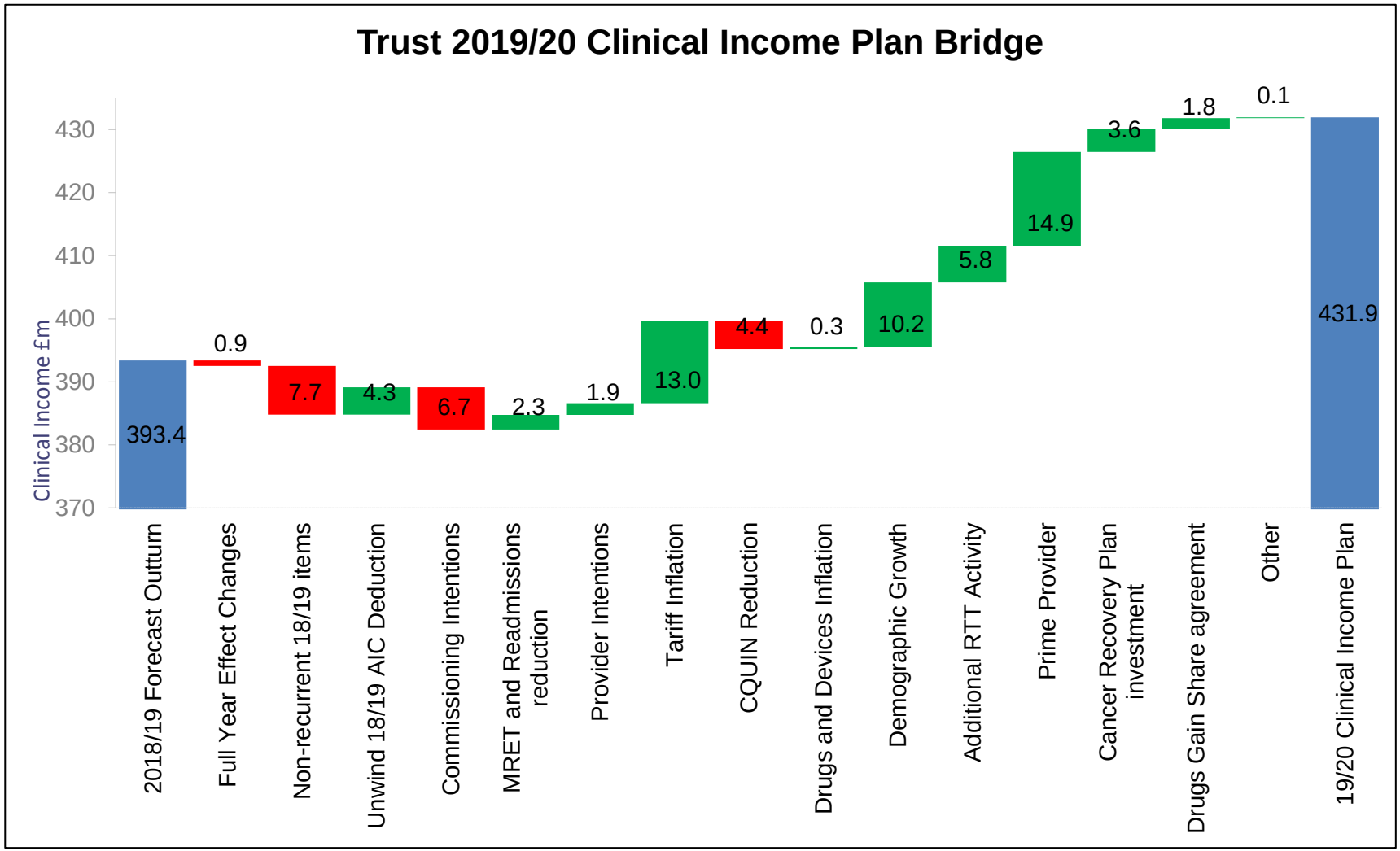






Clinical Income Bridge

Maidstone and Tunbridge Wells NHS Trust



Contracts Update

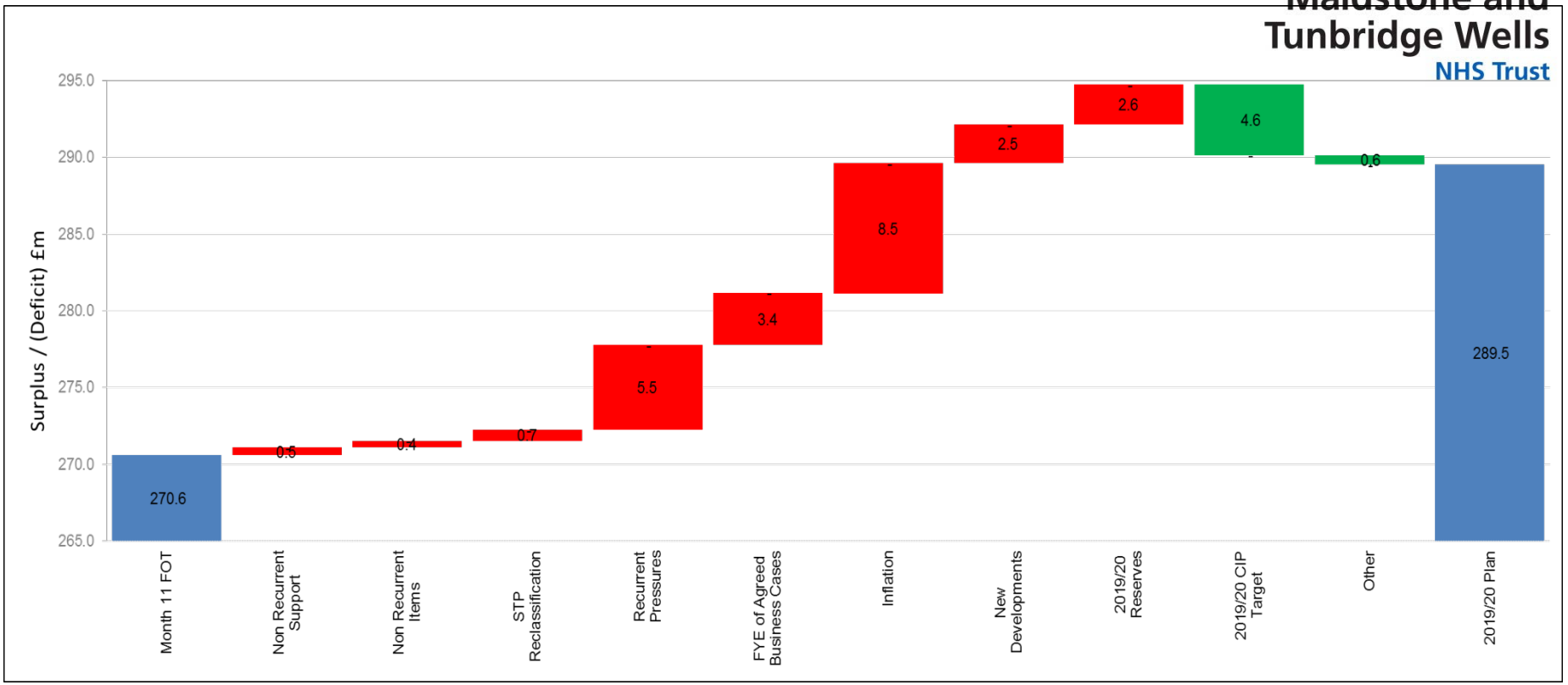
Maidstone and Tunbridge Wells NHS Trust

Aligned Incentives Contracts	Contract Update	Status
NHS West Kent CCG	Contract discussions are on-going, the key areas of concern are relating to RTT and Cancer. The additional investment required to achieve the RTT trajectory and fund the Cancer recovery plan are causing an affordability gap for the CCG. They are in the process of reassessing their financial offer to reduce the current gap of circa £10.6m. The Trust is expecting an offer in the next few days with a proposal to close the gap and manage the risk as part of the System work already underway as part of the West Kent Alliance.	Not Agreed
Sussex and East Surrey CCGs	Contract discussions continue and are focussed on 2 main areas, as with West Kent CCG the commissioners are seeking further assurance on the level of additional activity required to support RTT performance. In addition the CCG are also seeking further detailed modelling to confirm the tariff impact assessment, a joint set of actions have been agreed and the outcome should allow the contract to be agreed. In the event that the above issues are not agreed, the Trust may offer to revert to a PbR contract with the Sussex and East Surrey Commissioners and accept the challenge risk that may arise from this change.	Not Agreed
NHS Medway CCG	The Trust has offered the Commissioner the opportunity to contract on an Aligned Incentives basis in 2019/20, the CCG is in the process of considering this offer, however in the event that this is not accepted the contract will be agreed on a PbR basis and the financial value should be agreed in the near future regardless of the contract type.	Not Agreed

PbR Contracts	Contract Status	Status
NHS England Specialised Commissioning	NHS England have made a formal offer that the Trust is expecting to accept in the near future, subject to a firm commitment from NHSE to fund the costs associated with the Aseptic Unit (c£1m) for which notice was served to the commissioners during 2018/19. QIPP has been proposed to a value of £2.5m, however this would be a commissioner risk if undelivered and is likely to phased in Q4 to avoid creating a cash risk to the Trust.	Not Agreed
Other Contracted Commissioners	Contract offers are being considered for the North Kent and South London CCGs, it is expected that these will be agreed in the near future. East Kent CCGs have yet to share any contract offers with the Trust however these are not high risk areas for the Trust with an overall contract value of less than £3m, the Trust will be paid based on actual activity.	Not Agreed

Pay Bridge

Maidstone and Tunbridge Wells NHS Trust



Comments:

Non Recurrent Support (£0.5m): Part of the £5.2m non recurrent income support in 2018/19 related to additional charges for TADs and HIT service.

Non Recurrent Items (£0.4m): The Trusts benefited by £0.4m agency accrual benefit form 2017/18

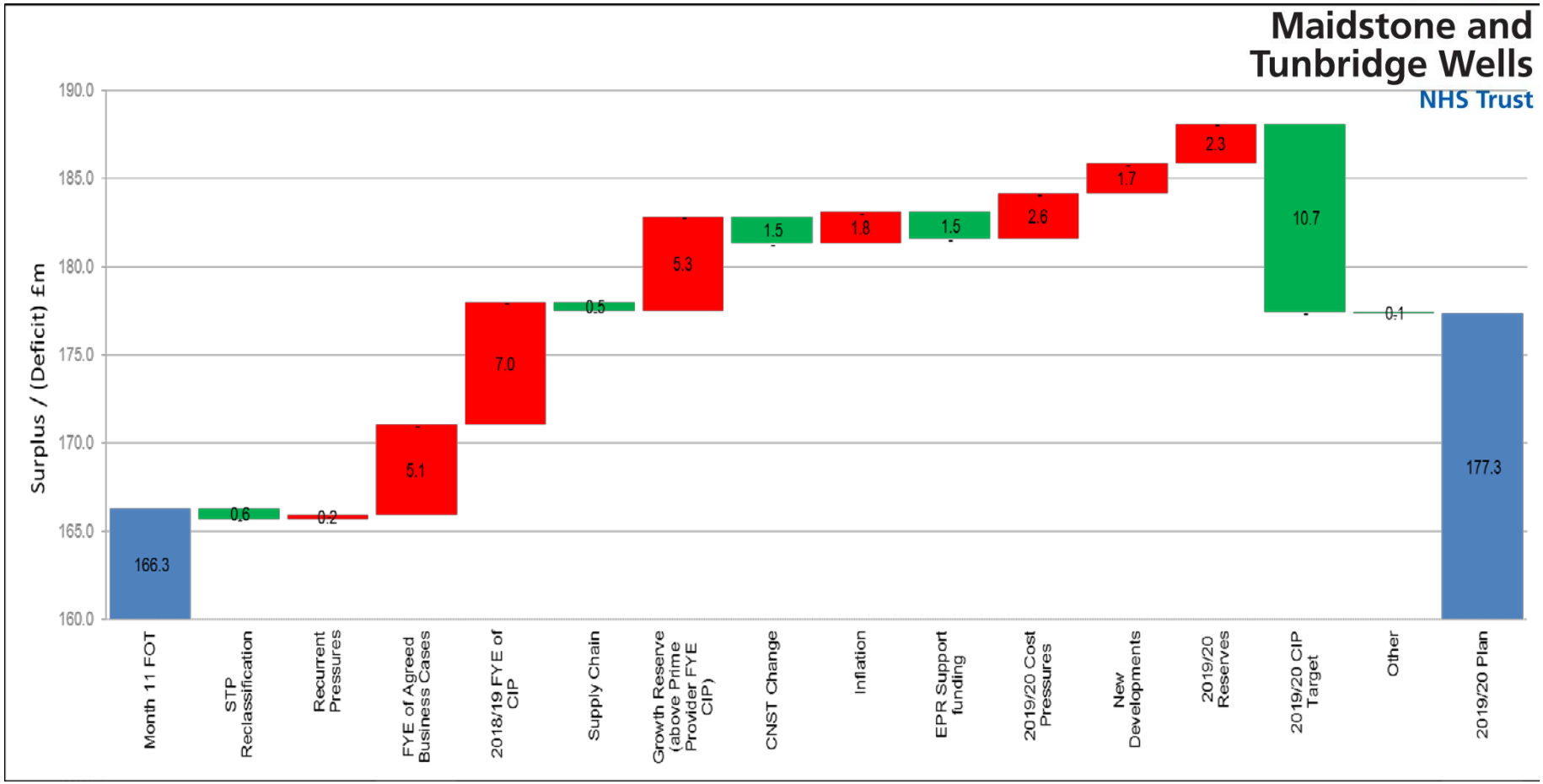
STP Reclassification (£0.7m): The plan has been a reduction of non pay with a corresponding increase within pay (zero net impact).

Recurrent Pressures (£5.5m): Divisional Workforce plans are forecasting to spend £5.5m more than outturn (above known changes)

FYE of Agreed Business Cases (£3.4m): Clinically led Management Structure (£0.9m), RTT and Data quality (£0.5m), FYE of Best Care Investment (£0.4m), FYE of A&E Minors and Majors Business Case (£0.3m), Clinical Coding (£0.2m) Private Patient Unit (£0.3m), Frailty service (£0.3m), Other services (£0.5m).

New Developments (£2.5m): The plan includes £2.4m Cancer recovery costs and £0.1m vision screening costs offset by additional income.

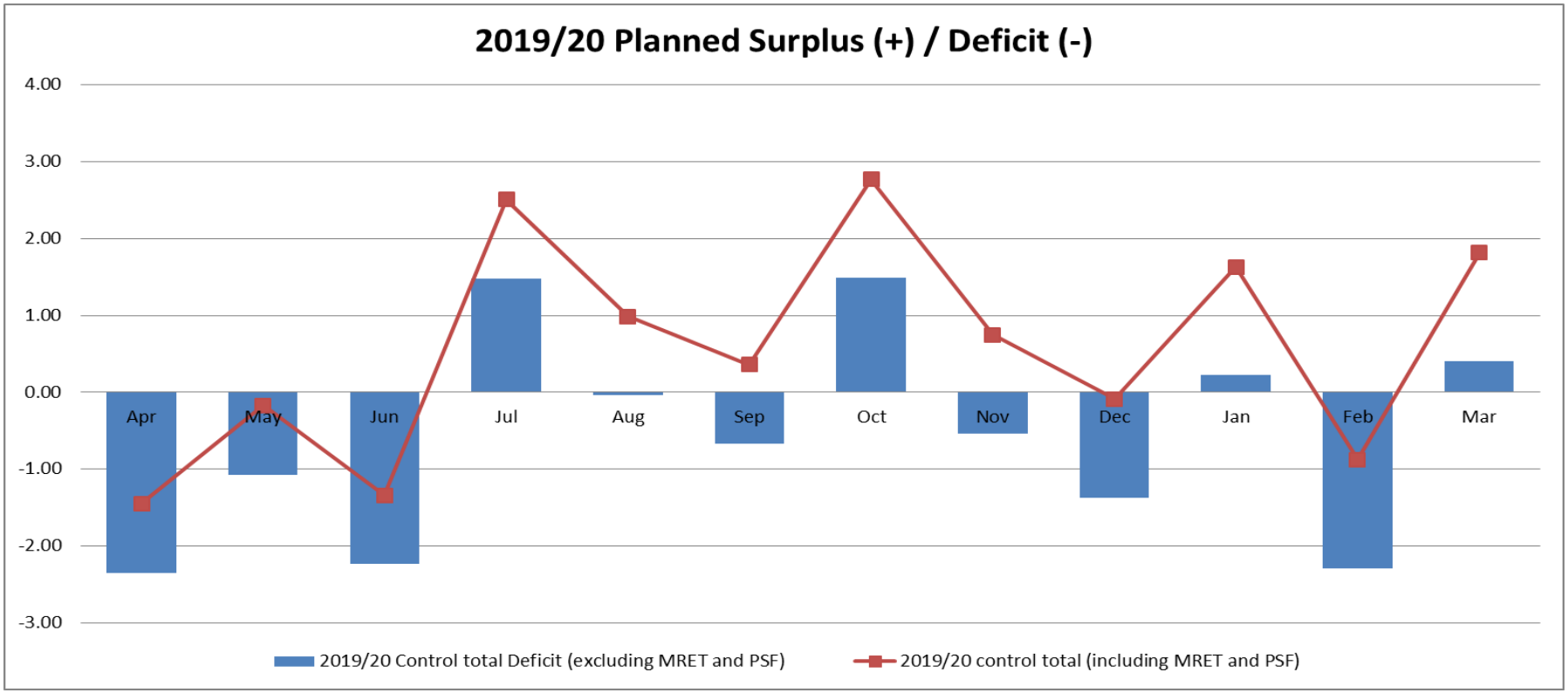
Non Pay Bridge



STP Reclassification (£0.6m): The plan has been a reduction of non pay with a corresponding increase within pay (zero net impact).
Agreed Business Cases (£5.1m): EPR (£2.9m), Private Patient Unit (£1.1m), Diabetes Service (£0.6m) although offset by additional income, PAS Allscripts (£0.5m)
FYE of CIP (£7m): This includes the costs associated with prime provider outsourcing (offset by income) net of savings associated with Biosimilar, procurement and Estates and Facilities savings schemes.
Supply Chain (£0.5m): The reflects the changes associated with funding NSH Supply chain through tariff rather than mark up.
Growth Reserve (£5.3m): The total growth reserve (including the element for prime provider) equates to £15.8m
Cost Pressures (£2.6m): Energy (£1.5m), Accommodation charges (£0.8m) and PFI (£0.3m)
New Developments (£1.7m): The plan includes £1.6m Cancer recovery costs and £0.1m vision screening costs offset by additional income

Summary I&E Trend

Maidstone and Tunbridge Wells NHS Trust



£m

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2019/20 Control total Deficit (excluding MRET and PSF)	**-2.35**	**-1.07**	**-2.24**	**1.48**	**-0.04**	**-0.67**	**1.49**	**-0.53**	**-1.37**	**0.22**	**-2.29**	**0.41**	**-6.95**
MRET Funding	0.52	0.52	0.52	0.52	0.52	0.52	0.52	0.52	0.52	0.52	0.52	0.52	**6.20**
Surplus / Deficit including MRET	**-1.83**	**-0.56**	**-1.72**	**2.00**	**0.48**	**-0.15**	**2.00**	**-0.02**	**-0.86**	**0.74**	**-1.77**	**0.93**	**-0.75**
PSF Non Recurrent Funding	0.38	0.38	0.38	0.51	0.51	0.51	0.77	0.77	0.77	0.89	0.89	0.89	**7.65**
2019/20 Control total (including MRET and PSF)	**-1.45**	**-0.17**	**-1.34**	**2.51**	**0.99**	**0.36**	**2.77**	**0.75**	**-0.09**	**1.63**	**-0.88**	**1.82**	**6.90**

2019/20 Trend

Maidstone and Tunbridge Wells NHS Trust

£m

	2018/19 Budget	2018/19 Forecast	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total 2019/20 Plan
Clinical Income	396.0	393.4	34.7	36.0	34.7	37.6	36.0	35.5	37.9	35.7	35.4	37.0	34.4	37.0	431.9
Commerical Income	3.7	3.8	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	4.0
Education Training & Research	11.0	11.1	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	10.9
Private Patients	3.4	1.5	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	5.1
Other Income	44.3	41.2	3.3	3.3	3.3	3.3	3.4	3.3	3.3	3.3	3.3	3.3	3.3	3.3	39.5
PSF	12.7	12.7	0.4	0.4	0.4	0.5	0.5	0.5	0.8	0.8	0.8	0.9	0.9	0.9	7.7
MRET	0.0	0.0	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	6.2
Total Income	**471.2**	**463.7**	**40.5**	**41.8**	**40.5**	**43.6**	**42.1**	**41.5**	**44.1**	**42.0**	**41.6**	**43.4**	**40.8**	**43.4**	**505.3**
A&C/Sen Man Staff	-35.9	-35.5	-3.4	-3.4	-3.4	-3.5	-3.5	-3.5	-3.5	-3.5	-3.4	-3.5	-3.5	-3.5	-41.4
Medical Staff	-80.2	-82.5	-7.2	-7.2	-7.2	-7.1	-7.2	-7.2	-7.1	-7.1	-7.2	-7.2	-7.1	-7.1	-85.8
Nursing	-96.7	-95.9	-8.4	-8.3	-8.3	-8.2	-8.2	-8.2	-8.1	-8.1	-8.4	-8.4	-8.4	-8.3	-99.2
Scientific Therap & Tech Staff	-41.3	-40.9	-3.7	-3.7	-3.7	-3.7	-3.7	-3.7	-3.7	-3.8	-3.8	-3.8	-3.8	-3.7	-44.7
Support Staff	-14.8	-14.2	-1.3	-1.2	-1.2	-1.2	-1.2	-1.2	-1.2	-1.2	-1.2	-1.2	-1.2	-1.2	-14.8
Apprenticeship Levy	-1.0	-1.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-1.0
Pay Reserves	-0.6	0.0	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-2.6
Total Pay	**-270.6**	**-270.1**	**-24.2**	**-24.2**	**-24.2**	**-24.0**	**-24.1**	**-24.1**	**-23.9**	**-23.9**	**-24.3**	**-24.3**	**-24.3**	**-24.2**	**-289.5**
Clinical Negligence	-19.0	-18.6	-1.5	-1.5	-1.5	-1.5	-1.5	-1.5	-1.5	-1.5	-1.5	-1.5	-1.5	-1.5	-17.6
Drugs & Medical Gases	-52.0	-52.7	-4.3	-4.3	-4.3	-4.3	-4.3	-4.3	-4.3	-4.3	-4.3	-4.3	-4.3	-4.3	-51.5
Purch healthcare from non NHS	-5.4	-3.8	-1.7	-1.7	-1.7	-1.1	-1.1	-1.1	-1.1	-1.1	-1.1	-1.1	-1.1	-1.1	-14.9
Supplies & Services	-37.2	-40.6	-3.3	-3.3	-3.2	-3.2	-3.2	-3.2	-3.2	-3.2	-3.2	-3.2	-3.2	-3.2	-38.9
Other Non Pay	-46.3	-50.7	-4.2	-4.3	-4.3	-4.3	-4.3	-4.3	-4.3	-4.3	-4.5	-4.5	-4.5	-4.4	-52.2
Reserves	-1.8	0.0	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-2.3
Total Non Pay	**-161.7**	**-166.3**	**-15.3**	**-15.4**	**-15.2**	**-14.6**	**-14.6**	**-14.6**	**-14.6**	**-14.6**	**-14.7**	**-14.7**	**-14.7**	**-14.6**	**-177.3**
Other Finance Costs	-28.2	-17.0	-2.6	-2.6	-2.6	-2.6	-2.6	-2.9	-2.7	-2.6	-2.9	-2.6	-2.6	-3.0	-32.6
Technical Adjustments	1.1	1.4	0.0	0.0	0.0	0.0	0.0	0.3	0.0	0.0	0.3	0.0	0.0	0.4	1.1
Total Surplus Including MRET and PSF	11.7	11.7	-1.6	-0.3	-1.5	2.4	0.8	0.2	2.9	0.9	0.0	1.8	-0.8	2.0	6.9
Total Deficit Excluding MRET and PSF	-1.0	-1.0	-2.5	-1.2	-2.4	1.4	-0.2	-0.8	1.7	-0.4	-1.3	0.4	-2.2	0.6	-7.0

2019/20 CIP Plan

Maidstone and Tunbridge Wells NHS Trust

Savings by RAG Rating

£m

Best Care Programme	Green	Amber	Red	Total
Roll Over	**5,517**	**200**		**5,717**
Best Patient Flow	19	0	7,100	7,119
Best Quality	845	0	0	845
Best use of Resources	1,808	2,324	1,332	5,464
Best Workforce	1,646	127	1,181	2,954
Best Safe	28	84	94	206
Total 2019/20 New Schemes	**4,347**	**2,534**	**9,707**	**16,588**
Grand Total	**9,864**	**2,734**	**9,707**	**22,306**

Savings by Status

£m

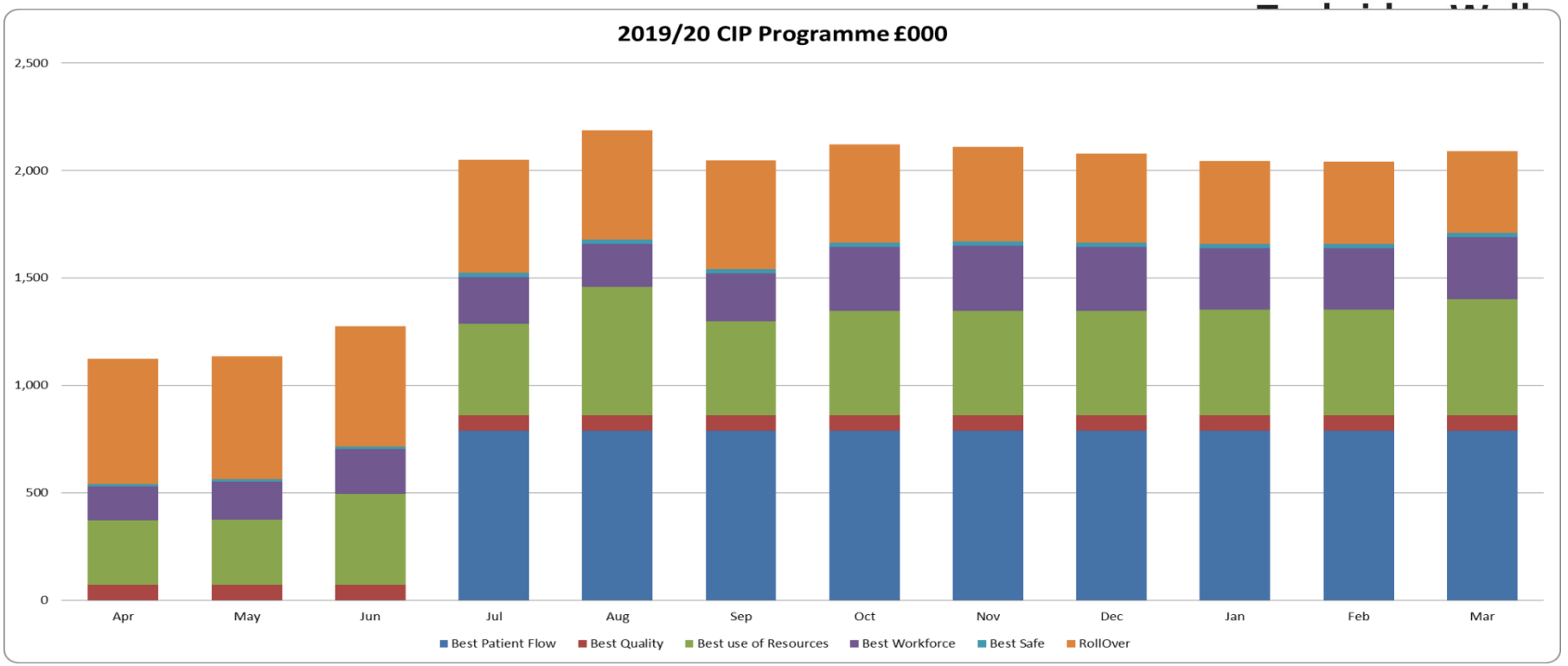
Best Care Programme	Fully Developed	Plans in Progress	Opportunity	Total
Roll Over	**5,517**	**200**		**5,717**
Best Patient Flow	9	1,010	6,100	7,119
Best Quality	0	840	5	845
Best use of Resources	815	3,545	1,104	5,464
Best Workforce	1,382	1,102	470	2,954
Best Safe	0	39	167	206
Total 2019/20 New Schemes	**2,206**	**6,536**	**7,846**	**16,588**
Grand Total	**7,724**	**6,736**	**7,846**	**22,306**

Comment

- The Trust has a total savings plan for 2019/20 of £22.3m. £5.7m Roll over from 2018/19 and £16.6m new 2019/20 schemes.
- Roll over savings £5.7m relate to Prime Provider £, Biosimilar savings £0.5m, E&F savings (£0.5m of which £0.2m classified as opportunity relating to Energy Procurement), £0.5m Procurement and £0.2m other savings.
- The Trust has identified £16.6m of new savings schemes for 2019/20. The main elements relates to the following schemes:
  - Operational Efficiencies (£5.8m)
  - Workforce Savings (£3m)
  - Ward Closure (£1.3m)
  - Procurement (£1.1m)
  - Estates and Facilities (£1m)
  - CNST Maternity Premium (£0.8m)

2019/20 CIP Phasing

Maidstone and



£000

Programme	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Best Patient Flow	2	2	2	791	791	791	791	791	791	791	791	791	7,119
Best Quality	70	70	71	71	71	71	71	71	71	71	71	71	845
Best use of Resources	301	304	423	426	596	436	485	485	485	491	491	541	5,464
Best Workforce	158	176	208	217	201	225	298	305	299	288	288	288	2,952
Best Safe	11	11	11	19	19	19	19	19	19	19	19	19	206
RollOver	582	572	560	527	511	507	457	439	414	387	382	381	5,717
Total	1,123	1,136	1,274	2,051	2,189	2,048	2,121	2,109	2,078	2,046	2,040	2,090	22,304

2019/20 CIP Phasing

Maidstone and Tunbridge Wells NHS Trust

£m

Programme	Scheme	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Best Patient Flow	Operational Efficiency	0.0	0.0	0.0	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	4.8
	Ward Closure	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	1.3
	T&O Activity Plan	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	1.0
	Other - Scheme <£50k	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
Total Patient Flow		**0.0**	**0.0**	**0.0**	**0.8**	**0.8**	**0.8**	**0.8**	**0.8**	**0.8**	**0.8**	**0.8**	**0.8**	**7.1**
Best Quality	CNST - Maternity	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.8
	Other - Scheme <£50k	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
Total Quality		**0.1**	**0.1**	**0.1**	**0.1**	**0.1**	**0.1**	**0.1**	**0.1**	**0.1**	**0.1**	**0.1**	**0.1**	**0.8**
Best use of Resources	Procurement	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	1.1
	Estates and Facilities	0.1	0.1	0.1	0.1	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	1.0
	ICD/Pacemaker	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.7
	Aseptic Dispensing - Income Generation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.5
	Biosimilar	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.5
	Printing Review	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.4
	Other - Scheme <£50k	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3
	STP Sendaway Test Repatriation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
	ICT Contract Review	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
	Tongue Tie	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
	Cath Lab Outsourcing (medtronic contract)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
	NHS Provider SLA Review	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
	NHSE Dispensing Charge - Homecare	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
	Loan Kit Review	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
	Therapies Income Review	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
	Community Peads service review	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
	Overseas Visitor Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
	Outreach clinic notice - JY at sevenoaks and all	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
Total Best Use of Resources		**0.3**	**0.3**	**0.4**	**0.4**	**0.6**	**0.4**	**0.5**	**0.5**	**0.5**	**0.5**	**0.5**	**0.5**	**5.5**
Best Workforce	Workforce Review	0.1	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	1.4
	Temporary Staffing Saving	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.8
	Roster Management	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.5
	A&C Review	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
	Other - Scheme <£50k	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
Total Workforce		**0.2**	**0.2**	**0.2**	**0.2**	**0.2**	**0.2**	**0.3**	**0.3**	**0.3**	**0.3**	**0.3**	**0.3**	**3.0**
Best Safe	Medical Job Planning Review	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
Total Safe		**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.2**
Grand Total		**0.5**	**0.6**	**0.7**	**1.5**	**1.7**	**1.5**	**1.7**	**1.7**	**1.7**	**1.7**	**1.7**	**1.7**	**16.6**
%		3%	3%	4%	9%	10%	9%	10%	10%	10%	10%	10%	10%	

2019/20 CIP (New Saving Schemes)

Maidstone and Tunbridge Wells NHS Trust

£m

Programme	Scheme	Green	Amber	Red	Total
Best Patient Flow	Operational Efficiency	0.0	0.0	4.8	4.8
	Ward Closure	0.0	0.0	1.3	1.3
	T&O Activity Plan	0.0	0.0	1.0	1.0
	Other - Scheme <£50k	0.0	0.0	0.0	0.0
Total Patient Flow		**0.0**	**0.0**	**7.1**	**7.1**
Best Quality	CNST - Maternity	0.8	0.0	0.0	0.8
	Other - Scheme <£50k	0.0	0.0	0.0	0.0
Total Quality		**0.8**	**0.0**	**0.0**	**0.8**
Best use of Resources	Procurement	0.1	1.0	0.0	1.1
	Estates and Facilities	0.2	0.5	0.3	1.0
	ICD/Pacemaker	0.7	0.0	0.0	0.7
	Aseptic Dispensing - Income Generation	0.0	0.0	0.5	0.5
	Biosimilar	0.5	0.0	0.0	0.5
	Printing Review	0.0	0.4	0.0	0.4
	Other - Scheme <£50k	0.1	0.1	0.1	0.3
	STP Sendaway Test Repatriation	0.0	0.0	0.2	0.2
	ICT Contract Review	0.0	0.1	0.1	0.2
	Tongue Tie	0.0	0.1	0.0	0.1
	Cath Lab Outsourcing (medtronic contract)	0.0	0.0	0.1	0.1
	NHS Provider SLA Review	0.1	0.0	0.0	0.1
	NHSE Dispensing Charge - Homecare	0.1	0.0	0.0	0.1
	Loan Kit Review	0.0	0.1	0.0	0.1
	Therapies Income Review	0.1	0.0	0.0	0.1
	Community Peads service review	0.0	0.0	0.1	0.1
	Overseas Visitor Income	0.1	0.0	0.0	0.1
	Outreach clinic notice - JY at sevenoaks and all QVH	0.0	0.0	0.0	0.0
Total Best Use of Resources		**1.8**	**2.3**	**1.3**	**5.5**
Best Workforce	Workforce Review	1.4	0.0	0.0	1.4
	Temporary Staffing Saving	0.2	0.1	0.6	0.8
	Roster Management	0.0	0.0	0.5	0.5
	A&C Review	0.0	0.1	0.1	0.2
	Other - Scheme <£50k	0.0	0.0	0.0	0.1
Total Workforce		**1.6**	**0.1**	**1.2**	**3.0**
Best Safe	Medical Job Planning Review	0.0	0.1	0.1	0.2
Total Safe		**0.0**	**0.1**	**0.1**	**0.2**
Grand Total		**4.3**	**2.5**	**9.7**	**16.6**
%		26%	15%	59%	

Trust Board meeting – March 2019

Maidstone and Tunbridge Wells NHS Trust

3-15 Update on the NHS Long Term Plan

Director of Strategy, Planning & Partnerships

Enclosed is an update on the NHS Long Term Plan.

Which Committees have reviewed the information prior to Board submission?

- -

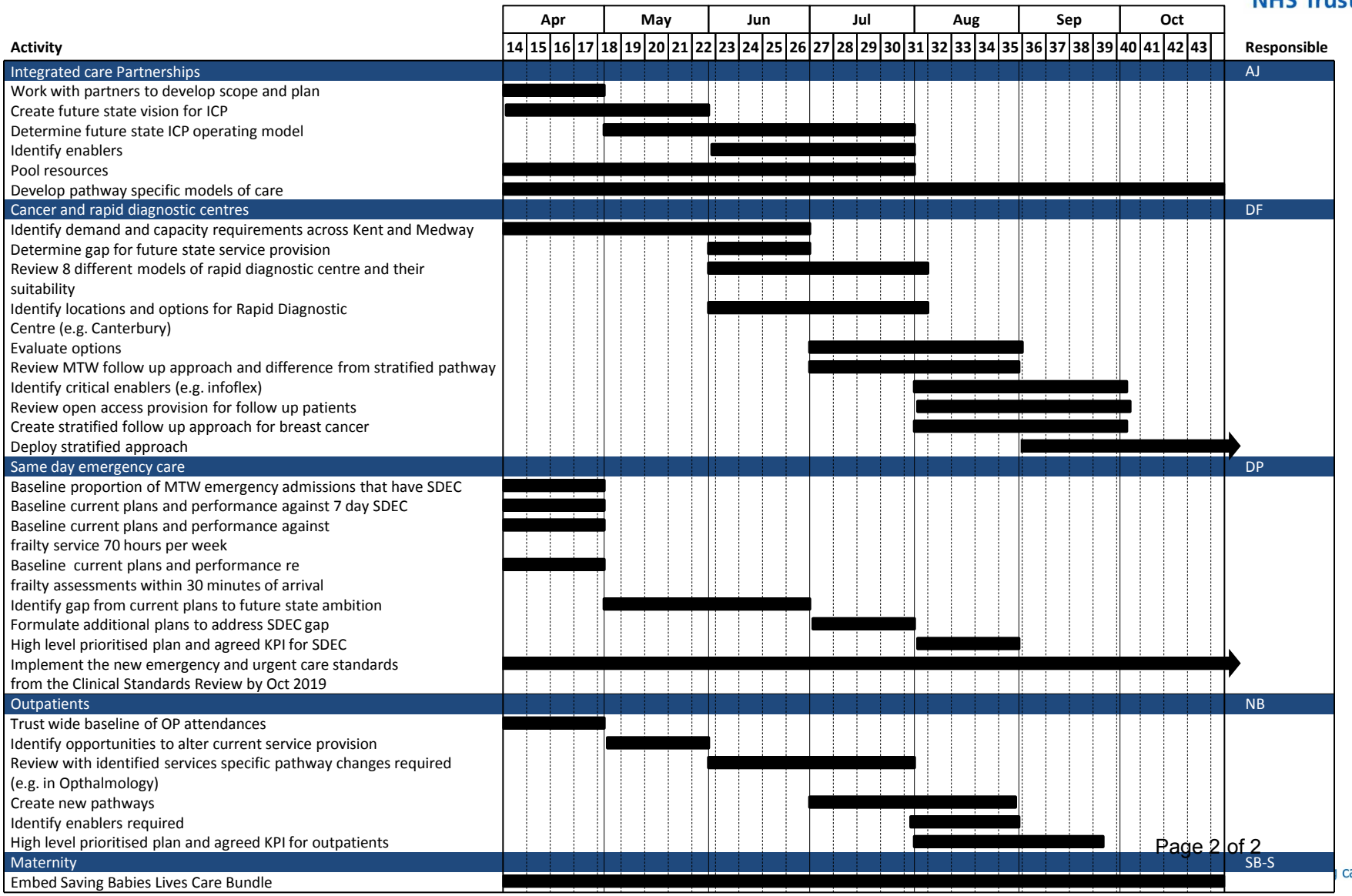
Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]

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

In order to formulate a response to the long term plan we have started by focusing on the key areas for MTW identified in the review of the plan in January

Maidstone and Tunbridge Wells NHS Trust



Trust Board meeting – March 2019

NHS Maidstone and Tunbridge Wells NHS Trust

3-16	The development of an Integrated Care Partnership in West Kent	Director of Strategy, Planning & Partnerships

Enclosed is a timeline for the development of an Integrated Care Partnership in West Kent.

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting, 26/03/19

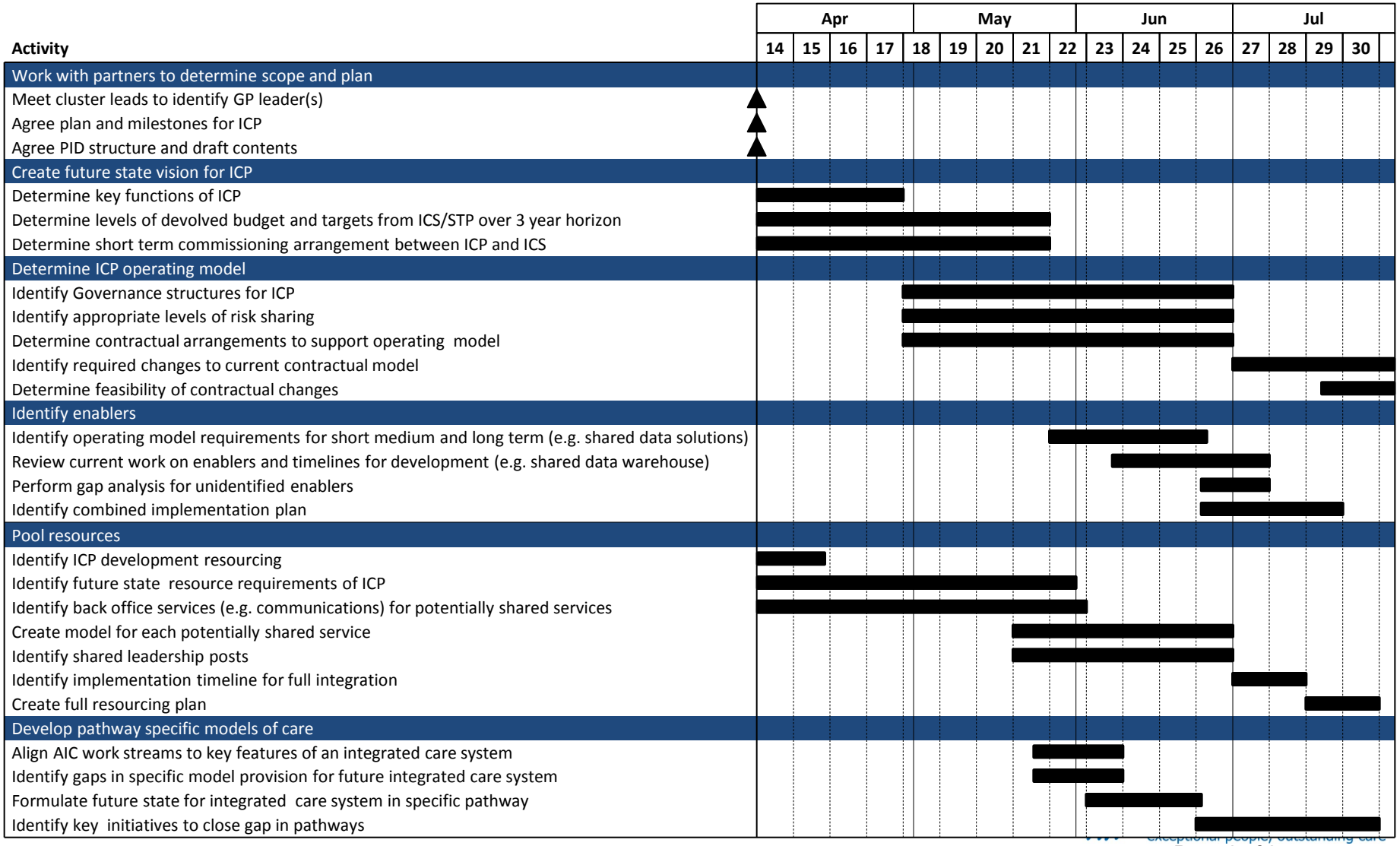
Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]

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

In light of both feedback from partner organisations and the delays to planning an ICP the timeline has been re-defined with additional steps

Maidstone and Tunbridge Wells NHS Trust



Trust Board meeting – March 2019

NHS Maidstone and Tunbridge Wells NHS Trust

3-17	The actions arising from the workforce-related Executive Team Meeting on 12/02/19	Director of Workforce

Workforce risks have been highlighted by the Trust Board and the Executive as a critical challenge facing the Trust. The ability of MTW to deliver high quality, safe patient care to those it serves is dependent on the organisation having sufficient numbers of motivated and engaged staff.

The Executive team identified and discussed the following key themes at an extended executive meeting on 12th February 2019.

- Recruitment of qualified nurses, particularly at Tunbridge Wells Hospital
- Recruitment of consultant physicians and middle grade surgical and paediatric medical staff
- Improved levels of staff engagement to support transformation and retention
- Effective use of roster management to achieve more consistent levels of staffing

The following document sets out the key outputs that we will be looking to achieve in 2019/20 in relation to these issues.

Which Committees have reviewed the information prior to Board submission? Executive Team Meeting , 26/03/19

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

Key Workforce Challenges for 2019/20

Workforce risks have been highlighted by the Trust Board and the Executive as a critical challenge facing the Trust. The ability of MTW to deliver high quality, safe patient care to those it serves is dependent on the organisation having sufficient numbers of motivated and engaged staff. The workforce challenge faced by MTW is against a national backdrop of rising demand, high levels of vacancies and a shortfall in the output of trained clinical staff across medicine, nursing and other clinical professions.

The Executive team identified and discussed the following key themes at an extended executive meeting on 12th February 2019.

- Recruitment of qualified nurses, particularly at Tunbridge Wells Hospital
- Recruitment of consultant physicians and middle grade surgical and paediatric medical staff
- Improved levels of staff engagement to support transformation and retention
- Effective use of roster management to achieve more consistent levels of staffing

The following document sets out the key outputs that we will be looking to achieve in 2019/20 in relation to these issues.

1. Recruitment

The ability to sustain safe levels of staffing is predicated on the Trust's ability to recruit sufficient numbers of substantive staff. These can then be supplemented by temporary staffing from the Trust bank and agency as required. The use of substantive staff over temporary staff provides greater assurance of the quality and continuity of care due to familiarity with trust systems and processes, effective team working and organisational loyalty. It is therefore imperative that the use of substantive staff is maximised where possible to minimise the need for bank and agency staff.

1.1 Recruitment of Qualified Nurses to TWH

Wards that are fully staffed with a workforce that is substantively employed by MTW is the ideal position that the Trust wishes to attain as we believe that it provides the best guarantor of quality care. Nonetheless, the ability of MTW to recruit and retain qualified nursing staff at Tunbridge Wells Hospital in particular has been very challenging in recent years against a backdrop of national shortages of qualified nursing staff. This is influenced by a range of factors including the location of the site, the cost of housing and transport and the relative intensity of the work.

The immediate plan set out below aims to recruit 350 qualified nursing staff to MTW in 2019/20. Of this number, 220 will be recruited to Tunbridge Wells Hospital. Assuming turnover at 2018/19 rates, this will reduce the existing nurse vacancy position to under 10%. Further schemes will be added over the year to mitigate against any shortfall and if possible to exceed the numbers below. The plan is based on a significant increase in the numbers of international recruits delivered via an expansion in the number of international recruitment agencies being used as well as the potential pilot project with Clear Medi. We will need to ensure that these numbers are able to be supported professionally and pastorally with support from both corporate and divisional teams so as to reap the full fruits of the campaign.

Progress will be monitored on a monthly basis against the plan via the Best Workforce Board and the Nurse Recruitment & Retention group.

Starters	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
Business as usual	7.3	7.3	7.3	7.3	7.3	7.3	7.3	7.3	7.3	7.3	7.3	7.3	**87.6**
Overseas Agency current	4	3	4	4	4	4	8	4	4	4	4	4	**51**
Overseas Agencies x4	0	0	0	0	0	0	12	12	12	12	12	12	**72**
Clear Medi	0	0	0	10	0	0	10	10	10	10	0	0	**50**
Trust Staff Nurse Recruitment Events	0	5	0	5	2	5	0	5	0	5	0	0	**27**
External Events	0	0	6	0	4	10	0	3	0	0	0	0	**23**
Current CSW Completing CBT training	0	0	0	0	0	0	5	5	0	0	0	0	**10**
Nursing Associates	0	0	4	0	0	0	0	0	0	0	0	0	**4**
3rd year student offer	6	0	0	0	0	20	0	0	0	0	0	0	**26**
Total Starters	**17.3**	**15.3**	**21.3**	**26.3**	**17.3**	**46.3**	**42.3**	**46.3**	**33.3**	**38.3**	**23.3**	**23.3**	**350.6**

1.2 Consultant Physicians

Whilst MTW has been successful in recruiting consultants to a range of specialties, the recruitment of consultant physicians remains challenging and as with qualified nurses is against a backdrop of national shortages. Nonetheless, the ability of the Trust to drive the transformation of services and deliver a clinically led structure relies in part on the need for substantive appointments in these key roles. There are currently 10.65wte vacant consultant physician posts in MTW which are currently either vacant or filled using agency staff with attendant financial costs.

Each vacant position will have a specific recruitment plan agreed by the division. This will include job description, job plan, advertising and marketing plan and specific recruitment and retention premia where deemed appropriate.

1.3 Middle Grade Surgical and Paediatric medical staff

Shortage of both surgical and paediatric middle grade staff has required a significant use of agency staff over the last 12 months so as to be able to sustain safe rotas and quality of care. MTW has been able to make a number of appointments in these grades to both specialties since January via international recruitment with the support of an agency and as such has been significantly improve the position for both paediatrics and surgery. The planned changes in surgery will have a further positive impact on the requirement for middle grade surgical staff due to the consolidation of rotas at TWH allowing for the closure of the remaining vacancy gap by the end of 2019/20. Currently 7wte surgical posts and 1.4wte paediatric posts remain unfilled.

Utilising a combination of substantive recruitment via agency and Medical Training Initiative (MTI) posts we will fill all surgical and paediatric middle grade vacancies by the end of 2019/20.

1.4 Recruitment and Marketing Plan

Recruitment to all posts will be supported by a Trust recruitment and marketing plan and associated materials that will deliver a consistent and branded message promoting MTW as the organisation that clinicians working in Kent and the south east will wish to work for. The plan will include use of social media as well as public events, and traditional advertising. This will be produced in quarter 1 of 2019/20.

Key Outputs

- Recruit 350 qualified nurses by end of 2019/20 of which 220 for TWH
- Fill all middle grade surgical and paediatric vacancies by the end of 2019/20
- Individual recruitment plan for all hard to fill consultant vacancies by Q1 2019/20
- Recruitment and Marketing plan agreed by Q1 2019/20

2. Improved Staff Engagement

A common theme of organisations that are rated as outstanding is evidence of high levels of staff engagement as demonstrated by their national staff survey results. High levels of engagement support a strong culture of openness and transformation, improves the retention of staff and assists in the recruitment of new staff via word of mouth reputation.

Staff engagement at MTW is average when compared with other NHS acute trusts and has remained largely unchanged over successive national staff surveys. The response rate to surveys has declined and over the same period. As part of the MTW goal to be recognised as an outstanding organisation the immediate aim will be to achieve a better than average staff engagement score in the 2019 national staff survey. This survey will be issued in October of this year. The full engagement plan for 2019/20 is under consideration by the Trust Workforce committee and will be monitored via this committee and the Trust Clinically Led committee. The key elements of the plan include

- Ensuring that each Division has a locally produced engagement plan that is based on feedback from the national staff survey and discussed and agreed with staff. This will be monitored via Divisional Performance reviews
- Repurposing the Staff Friends & Family survey to include the opportunity for staff to give specific feedback and areas for improvement. The survey will be delivered through divisions to support the Clinically Led agenda and reinforce the importance of locally led engagement on the 'shopfloor'. Issues impacting across divisions will be able to be identified for corporate planning.
- Utilising local electronic surveys for divisions to gain immediate feedback on the impact of actions taken in their engagement plans
- Regular locally held staff focus groups to gain direct feedback from staff on local and corporate actions
- Leadership development via existing leadership programmes and a new programme for senior leaders to be commissioned in Q1 of 2019/20
- Clear expectations within appraisal guidance for all leaders to ensure that they demonstrate a shop floor presence and embody trust values in their actions
- Deliver the Freedom to Speak Up Guardian plan in full to ensure that the role is well understood and easily accessible by all staff, clinical and non-clinical

Key Outputs

- Staff engagement scores in the 2019 national staff survey are better than average when compared with other NHS acute trusts
- The % response rate to the staff friends and family and national staff survey is at least equivalent to the national average
- MTW is able to evidence an open culture to issues and concerns through increased use of the Freedom to Speak Up Guardian as reported by returns to the National Freedom to Speak Up Guardian

3. Improved Roster management

MTW currently uses the Allocate rostering system for the majority of its workforce with the final roll out completed in early 2019. Ward teams have been utilising the system since 2017/18. The estates and facilities directorate utilise a separate system, Kronos, which incorporates additional clocking in features and has been in use since 2015. The Allocate roster system for medical staff will be deployed in 2019/20. This will complement the existing Allocate job planning software that was rolled out in 2018.

Analysis of current roster practice indicates that there is a significant opportunity to deploy the current workforce more effectively via better planning of leave, earlier publication of rosters and better use of flexible working. In addition to providing additional assurance that wards are safely staffed, improved roster quality will support a reduction in agency usage due to earlier visibility of bank shifts and improve staff retention due to staff being able to better balance work and home commitments.

A total of £2.4m CIP savings has been identified as achievable from improved roster efficiencies within nursing. These will be monitored via an agreed set of KPIs with each division as part of the Best Workforce programme.

To support the achievement of the identified savings the following actions will be taken

- An agreed data set of KPIs will be in use from April 2019 for all nursing areas. The KPIs will include data on unused hours, publication of rosters at least 6 weeks in advance, annual leave and study leave usage.
- Implementation of the 'Safe Care' Nursing module from Q1 for four pilot areas and Q2 for the remainder of the trust. This will allow visibility of the daily staffing position for nurses on a ward by ward basis for both Site and Corporate nursing teams
- Implement the Allocate Medical Rostering system in Q2/Q3 subject to business case approval. This will provide allow divisional teams better oversight and scrutiny of the medical staffing position in order to ensure safe levels of staffing, increase the use of medical bank staff over agency staff and maximise the benefits derived from the Medical Productivity workstream focus on job planning. The reduction in agency use will in turn allow greater pressure to be placed on agencies to offer rates in line with those set by the STP.

Key Outputs

- Achieve £2.4m CIP savings from improved roster management in 2019/20
- Support Safe Staffing quality measures
- Meeting the STP target for reduction of medical agency expenditure £353k

Trust Board meeting – March 2019

NHS
Maidstone and Tunbridge Wells NHS Trust

3-18 Ratification of revised Standing Orders — Trust Secretary

The Trust's Standing Orders (SOs) are due their routine annual review. Having been reviewed a number of changes are proposed. The SOs are directly linked to the Standing Financial Instructions and Reservation of Powers and Scheme of Delegation, which were ratified at the Trust Board meeting in December 2018 (the Standing Orders were not ready to be ratified at that point).

The main changes are as follows:

- Amendment of the procedures to be applied in response to the "Fit and Proper Persons: Directors" Regulations, to note that only "Standard" Disclosure and Barring Scheme (DBS) checks will be undertaken for Non-Executive Directors/Associate Non-Executive Directors (and for other members of the Executive Team that do not meet the eligibility criteria for higher-level DBS checks) (The Trust Board was notified of this potential change in a report to the 'Part 2' Board meeting in May 2018)
- Inclusion of checks for County Court Judgments (CCJs) within the Trust's Fit and Proper Persons: Directors" process. Although this is not a requirement of the "Fit and Proper Persons: Directors" Regulations, the Trust is often asked to confirm whether its Directors have been subject to CCJs are part of the service tender submission process of commissioning parties
- Inclusion of the new roles created by the clinical management restructure (which was approved by the Trust Board in September 2018)
- Splitting of the document appendices into separate files (to mirror the approach taken with Appendices to Trust-wide policies)
- Inclusion of the Trust Committee Structure as an Appendix
- Housekeeping changes (job titles, committee names etc.)
- Addition of "Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England" (Professional Standards Authority, 2013) as an Appendix (rather than just a cross-reference)

The Audit and Governance Committee reviewed and "approved" the full revised Standing Orders document at its meeting on 14/03/19. The Trust Board is therefore asked to "ratify" the revised Standing Orders.

The same process used last year has been deployed, in that the full Standing Orders documents (including Appendices) (with all proposed changes shown as 'tracked') have been circulated as a supplement to the formal 'pack' of Board reports (i.e. Attachment 18a). Trust Board Members are therefore welcome to read the supplement (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 and Performance Committee, 27/11/18 (summary of proposed changes)
- Audit and Governance Committee, 14/03/19 (full revised document, 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 – March 2019

Maidstone and Tunbridge Wells NHS Trust

3-19 7 Day Services board assurance self-assessment **Medical Director**

Enclosed is a copy of the national return sent to NHS England on 27/02/19 in respect of the Trust's 7 Day Services Board Assurance Template (BAT) requirement. The return has been supplemented with a supporting paper which provides the context to the Trust's current position. The BAT format does not allow for responses by service and thus, any area that shows as non-compliant will trip the RAG rating to Red on a Trust-wide basis. Therefore, the attached paper examines each service separately to provide the current position.

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

7 Day Hospital Services Self-Assessment

Organisation	**Maidstone and Tunbridge Wells NHS Trust**
Year	**2018/19**
Period	**Autumn/Winter**

Maidstone and Tunbridge Wells NHS Trust: 7 Day Hospital Services Self-Assessment - Autumn/Winter 2018/19

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	This document should be read in conjunction with the attached paper entitled "7DS National BAT Return, Supporting Report". COMPLIANT OR EXEMPT SERVICES (note: 'exempt' relates to services that do not have non-elective patients under the direct care of the specialty consultant, but are under the primary care of another service (normally a physician due to co-morbidities). * Acute Medicine and Geriatrics - compliant * Specialist Medicine - compliant * Emergency Medicine - Exempt (standard starts from point of admission, counted in Acute Med) * Paediatarics - Compliant * Critical Care - Compliant * T&O - Compliant * Oncology - Exempt (non-bed-holding) * Clinical Haematology - Exempt - (nature of casemix) * Ophthalmology - Exempt - (nature of casemix) NON-COMPLIANT SERVICES - (plans in progress for each service) All non-compliant services have achieved full compliance for weekdays except for a small number of patients in ENT which is currently being resolved. The issue for all is a gap at weekends when the consultants are non-resident (normally from mid-afternoon until 08.00hrs the next morning - Sat and Sun). The activity levels are generally low in this period and the middle grade cover is strong. The detail for each is as follows: * Surgery – Sat & Sun (No resident cons from 14.00hrs - 08.00hrs Sat & Sun) - 8.5 NEL adms per w/e * Urology - weekends (No resident consultants at w/e - 3 NEL admissions per weekend - ave)	Yes, the standard is met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Yes available on site	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available on site	
	The upper GI endoscopies can be at risk to full compliance during out of hours periods until the 24/7 GI Bleed Rota is implemented (planned for Q2 2019/20). Currently, informal arrangements exist with London Teaching Hospitals for tertiary referrals out of hours when there is not a Gastro consultant on the GIM rota. However, these arrangements are not via a formal SLA.	Echocardiography	Yes available on site	Yes available on site	
		Magnetic Resonance Imaging (MRI)	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Upper GI endoscopy	No the test is only available on or off site via informal arrangement	No the test is only available on or off site via informal arrangement	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Not Met
		Interventional Radiology	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Interventional Endoscopy	No the intervention is only available on or off site via informal arrangement	No the intervention is only available on or off site via informal arrangement	
		Emergency Surgery	Yes available on site	Yes available on site	
	The upper GI endoscopies can be at risk to full compliance during out of hours periods until the 24/7 GI Bleed Rota is implemented (planned for Q2 2019/20). Currently, informal arrangements exist with London Teaching Hospitals for tertiary referrals out of hours when there is not a Gastro consultant on the GIM rota. However, these arrangements are not via a formal SLA.	Emergency Renal Replacement Therapy	Yes available on site	Yes available on site	
		Urgent Radiotherapy	Yes available on site	Yes available on site	
		Stroke thrombolysis	Yes available on site	Yes available on site	
		Percutaneous Coronary Intervention	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Cardiac Pacing	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	COMPLIANT OR EXEMPT SERVICES (exempt relates to services that do not have non-elective patients under the direct care of the specialty consultant, but are under the primary care of another service (normally a physician due to co-morbidities). * Surgery * Urology * T&O (Note: CD has requested to be graded boarderline to ensure escalation processes are secure) * Paediatarics - Compliant * Women's Health * Critical Care - Compliant * Emergency Medicine * Oncology - Exempt (non-bed-holding) * Clinical Haematology - Exempt - (nature of casemix) * Ophthalmology - Exempt - (nature of casemix) * Surgery NON-COMPLIANT SERVICES - (plans in progress for each service) Once Daily Ward Rounds Compliance: * Specialist Medicine (please see attached paper) * Acute & Geriatric Medicine (please see attached paper) * ENT (plans to implement daily WR weekdays - currently 3 days per week) and a virtual WR at W/E - NEL activity is very low (ave 2.5 pts per day and complex patients are always consultant led)	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met
		Twice Daily: No the standard is not met for over 90% of patients admitted in an emergency	Twice Daily: No the standard is not met for over 90% of patients admitted in an emergency	

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
Provide a brief overall summary of performance against these standards, highlighting areas where progress has been made since 2015 The Trust programme has planned for work to commence on the detail of the remaining 6 objectives in March 2019, in partnership with CCG colleagues.

7DS and Urgent Network Clinical Services

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 5	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 6	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 8	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
Provide a brief summary of issues in cases where not all standards are met. N/A

Template completion notes

Trusts should complete this template by filling in all the yellow boxes with either a free text assessment of their performance as advised or by choosing one of the options from the drop down menus.

7 DAY SERVICES
NATIONAL BOARD ASSURANCE TEMPLATE RETURN – 28.2.19
SUPPORTING REPORT

This report provides important context to the attached Board Assurance Template (BAT). The high level format of the return does not allow for the full position of the project to be demonstrated.

1: Situation

Trusts are now required to submit a revised Board Assurance Template (BAT) to the NHSI/E twice yearly, to demonstrate progress with the implementation of the 10 National Standards *(please see appendix 1 for detail).* This new process has replaced the previous national survey system which was not well-received by all Trusts. This was mainly because the survey system did not truly reflect the position of the implementation due to the inability to provide supporting narrative and documentation errors/manual medical records causing survey results to be misleading. Whilst the new national process now provides the opportunity for some limited explanatory narrative, it does not allow for the full position of implementation to be demonstrated by service. Any non-compliant area will automatically override the RAG rating and present a position of Red for the whole organisation. Therefore, this paper provides the important detail by service. The new BAT format still includes the requirement for the survey process which MTW have previously demonstrated does not work well for the Trust's current position (as stated above) mainly as the EPR process is not yet live and a manual survey provides misleading results. (Further detail can be supplied if required).

The new BAT was due to commence in June 2019 and the 7DS Team had been working with the National Team during the development of the process. In mid-December 2019, a change to this timetable was announced and a trial-run return was requested with a deadline of 28.2.19. Due to the short notice of this trial run request, this return does not include the survey as the interval was too short to accommodate the full 3 month study process. Work on the survey for the June return is timetabled as previously planned.

2: Background:

MTW established a programme to support the implementation of 7DS standards in January 2017 which has since migrated to become a project within the Best Safety Workstream of the Best Care Programme. Significant progress has been made within the project during this time, with almost full compliance being achieved against the 4 priority standards during the weekdays and weekends across the majority of the Surgical and Women's and Children's Directorates. All services are expected to achieve full compliance by the National deadline of March 2020. Acute and Geriatric Care and Specialist Medicine have a significant challenge in respect of standard 8 *(please see appendix 2 for detail).* This highlights the key issues in respect of compliance challenges and identifies that these services will be very unlikely to be in a position to achieve compliance with standard 8 by March 2020.

3: Assessment

The table below provides the detail of the current compliance status by service, with the specific actions listed to address these gaps. For standards 2 and 8, the focus of the standards is upon patients who could be considered as 'medically active' (having a non-confirmed diagnosis or are at risk to being clinically unstable and not fit to be placed upon a standard pathway or protocol). These patients are considered as requiring consultant-delivered care. Patients who have been worked-up and are able to be placed upon a pathway or protocol and thus, do not require

consultant-delivered care are determined as 'medically optimised'. The remaining group are those patients who are determined to be 'fit for discharge' and thus, do not require consultant-delivered care.

Table 1: Compliance Status

'Exempt' relates to services that do not have non-elective patients under the direct care of the specialty consultant, but are under the primary care of another service (normally a physician due to co-morbidities).

Service	Std 2	Std 5	Std 6	Std 8	Comment/Actions in progress
Surgery	✓(weekdays) X (weekends)	✓	✓	✓	There is not a resident consultant on site on Saturdays and Sundays from 14.00hrs – 08.00hrs (consultants are on call from home). There are on average 8.5 non-elective admissions each day Saturday & Sunday which could be medically active. Service reconfiguration is the longer term solution. Mitigation in the meantime is the implementation of a virtual ward round between 18.00 and 20.00hrs on Saturday and Sunday, (went live on 21.1.19) and further exploration of potential for a face to face evening post-take ward round from existing consultant staff via changes to working patterns prior to reconfiguration.
Urology	✓(weekdays) X (weekends)	*N/A	✓	✓	The gap relates to a small number of NEL admissions (who could be potentially medically active) on Saturday and Sundays (a total of 1.2 – 1.4 patients per weekend, on average). A business case for a 6th Consultant has been submitted which will allow full implementation of the standards. Pathways are being finalised for all medically optimised patients. Mitigation for the NEL patients is the implementation of a virtual ward round during the evenings on Saturday and Sundays (requires confirmation of w/e shifts of all middle grades prior to implementation).
Women's Health	✓(weekdays) X (weekends)	✓	*N/A	✓	Principle for an exception pathway for a very small cohort of patients (<1 per weekend) has been informally agreed via the Challenge Event with NHSI/E/CCG in October 2018. – To sign off at Quarterly Review with NHSI/E/CCG on 14.3.19 – Please see appendix 3.
T&O	✓	*N/A	✓	✓/X	This service is technically compliant but the CD made decision to declare non-compliance for standard 8 until re-escalation processes have been assured for all patients who may become or revert back to a medically active status throughout their LOS. An SOP has been drafted by the Clinical Director and this is being implemented. This includes piloting a

Service	Std 2	Std 5	Std 6	Std 8	Comment/Actions in progress
					new rota for 2 months from April which will release the Consultants time to be able to see all medically active patients as per SOP. The results of the implementation will be reviewed in May 2019.
ENT	X	*N/A	*N/A	X	The NEL activity for this service has been identified and is on average 2.5 patients per day. Work is in progress with the ENT Team to identify the medically active cohort who are under the direct care of an ENT surgeon and not under the care of a physician due to comorbidities. Once fully understood, a mixture of consultant-delivered assessment/review and pathway delivered care is required. Discussions are taking place with the ENT Team to increase the number of daily ward rounds from 3 days per week to daily and to implement a virtual ward round each evening as a mitigating measure in the interim.
Acute and Geriatric Care and Specialist Medicine	✓	X (Endoscopy)	X (Interventional Endoscopy)	X	Non complaint for standards 5 & 6 until the 24/7 GI Bleed rota is implemented – plans in progress to implement this by the end of quarter 2 of 2019/20. There is a major compliance issue for standard 8 – the main contributory factor is consultant numbers. *(Please see appendix 2 for full detail).*
Paediatrics	✓	*N/A	✓	✓	Compliant
Critical Care	✓	*N/A	✓	✓	Compliant
Ophthalmology	Exempt	*N/A	*N/A	Exempt	Exempt: All medically activity patients are under the care of a Physician.
Clinical Haematology	✓	*N/A	*N/A	Exempt	Nature of casemix – patients are known to the service. Audit undertaken to demonstrate.
Emergency Medicine	Exempt	*N/A	✓	Exempt	Standards commence from point of admission

**. Note: N/A means that the service is not responsible for providing that part of the standard and is thus compliant by default.*

4: Recommendations

This paper is put forward as supporting information only.

Peter Maskell
Medical Director
27.02.18

Appendix 1

The 10 National 7 Day Services Clinical Standards

A series of clinical standards for seven-day services in hospitals were developed in 2013 through the Seven Day Services Forum, chaired by Sir Bruce Keogh and involving a range of clinicians and patients. The standards were founded on published evidence and on the position of the Academy of Medical Royal Colleges (AoMRC) on consultant-delivered acute care. Ten standards were agreed and are now being rolled out across the NHS in England in acute hospitals. The purpose of the standards is to deliver safer patient care, to improve patient flow through the acute system, to enhance patients' experience of acute care, to reduce the variation in appropriate clinical supervision at weekends and, potentially, to mitigate the excess mortality that has been shown in large studies to be associated with weekend admission to hospital. With the support of the AoMRC, four of these were identified as priority clinical standards on the basis of their potential to positively affect patient outcomes. These are:

The 4 National Priority Standards:

- **Standard 2**: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours of arrival at hospital.

- **Standard 5**: Hospital inpatients must have scheduled 7-day access to diagnostic services such as x-ray, ultrasound, CT, MRI, echocardiography, endoscopy, bronchoscopy and pathology. Consultant directed diagnostic tests and completed reporting will be available 7-days a week.

- **Standard 6**: Hospital inpatients must have timely 24-hour access, 7-days a week, to consultant-directed interventions that meet the relevant speciality guidelines, either on-site or thorough formally agreed networked arrangements with clear protocols.

- **Standard 8**: All patients on the Acute Medical Unit (AMU), Acute Surgical Assessment Unit (SAU), and Intensive Therapy Unit (ITU) and other high dependency areas are seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate) . Once transferred from the acute area of the hospital to a general ward patients should be reviewed during a consultant-delivered ward round at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

The remaining 6 standards:

- **Standard 1:** Patients, and where appropriate families and carers, must be actively involved in shared decision making and supported by clear information from health and social care professionals to make fully informed choices about investigations, treatment and on-going care that reflect what is important to them. This should happen consistently, seven days a week.

- **Standard 3:** All emergency inpatients must be assessed for complex or on-going needs within 14 hours by a multi-professional team, overseen by a competent decision-maker, unless deemed unnecessary by the responsible consultant. An integrated management plan with estimated discharge date and physiological and functional criteria for discharge must be in place along with completed medicines reconciliation within 24 hours.

- **Standard 4:** Handovers must be led by a competent senior decision maker and take place at a designated time and place, with multi-professional participation from the relevant in-coming and out-going shifts. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week.

- **Standard 7:** Liaison mental health services should be available to respond to referrals and provide urgent and emergency mental health care in acute hospitals with 24/7 Emergency Departments 24 hours a day, 7 days a week.

- **Standard 9:** Support services, both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken.

- **Standard 10:** All those involved in the delivery of acute care must participate in the review of patient outcomes to drive care quality improvement. The duties, working hours and supervision of trainees in all healthcare professions must be consistent with the delivery of high-quality, safe patient care, seven days a week.

Supplementary Paper – Medicine & Emergency Care Division: **Appendix 2**

Maidstone and Tunbridge Wells NHS Trust

Medicine & Emergency Care Division

Work in Progress

7 Day Services Strategy to achieve Core Standards

The Government's 7DS directive states that patients need to receive the same high quality urgent and emergency care regardless of the day of the week they are admitted to hospital. By 2020, the four priority standards that define a seven day service must be achieved in all relevant clinical specialties. The priority standards are:

- **Standard 2 – Time to first consultant review**

All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital (n.b. the Division is complaint with this standard)

- **Standard 5 – Access to diagnostic tests**

Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant directed diagnostic tests and completed reporting will be available seven days a week:

- Within 1 hour for critical patients
- Within 12 hours for urgent patients

- **Standard 6 – Access to consultant-directed interventions**

Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.

- **Standard 8 – Ongoing review by consultant twice daily if high dependency patients, daily for others.**

All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate).

This paper outlines the Urgent Care Division's strategy for meeting the core standards including proposals for the GI Bleed rota for OOH Endoscopy (Standards 5 and 6) and on-call rotas to enable timely initial and daily patient review (Standards 2 and 8). Reconfiguration of clinical services as an enabler to meet the standards is also included.

Background

The Medicine & Emergency Care Division comprises three; Directorates; Emergency Medicine, and Acute Medicine and Geriatircs and Medical Specialties. The current consultant establishment is 64.79WTE with 52.84WTE in post (February 2019). Core vacancies are within Acute Medicine (3.00), Respiratory (2.00), COE (5.00), the remainder being within the ED department at TW. Several of the vacancies have been open for 2 or 3 years with no successful recruitment. A revised recruitment strategy will form part of the Division's compliance plan for 7DS.

All clinical services operate on both sites with core bed numbers of 208 at Maidstone and 205 at Tunbridge Wells. Activity growth over several years has meant that daily average demand in summer and winter outstrips this bed stock and often with an average of 219 (MS)/241 admissions (TW) and 246 (MS)/278 admissions respectively. Consequently, the Division experiences a shortfall in bed stock of around 90 beds during winter, resulting in patients outlying to non-medical wards and escalation areas.

It is estimated that the inpatient cohort cross site is as follows:

- Medically active (anticipated being 51% of inpatients) – this equates to 116 patients at MS and 130 at TW. These patients be seen daily by a consultant and not delegated. This includes all patients causing nursing concern, all patients on end-

of-life care pathways, all new admissions to a ward in the previous 24 hours and all patients who require a potential same-day discharge decision.

- Medically optimised (22%) – this equates to 51 patients at MS and 57 at TW. This cohort needs daily consultant input via the board round to ensure the multidisciplinary team (MDT) discusses progress on therapy and social assessments. Many if not all of these may be delegated to a registrar/staff grade if it is unlikely that there would be any change to management requiring consultant input. Some may need consultant input 'from time to time' if highlighted by EWS, nurse, juniors etc.

- Medically-fit-for-discharge (27%) - (including people who are delayed transfers of care) will be reviewed by a senior nurse or equivalent. There still needs to be a safety netting process in place so that if such a patient deteriorates unexpectedly a system ensures that a consultant assesses them promptly.

These numbers will be followed up with a formal audit.

A 4-hour (1.33PA) ward round currently equates to the full review of approximately 24 patients. Extra Consultant resource would still be required to undertake daily review of active patients and supervise ward rounds, especially during winter pressures. Winter pressures are generally addressed through winter planning funding via the provision of additional junior doctors for a 4 month period.

GI Bleed Rota

The British Society of Gastroenterologists (BSG) advises that a dedicated GI Bleed service should be provided as a service for any trust seeing more than 300 cases a year. Service provision should include on-site access to therapeutic endoscopy, surgery and interventional radiology or a formal network arrangement should be in place to enable patients to be sent to a Trust that offers those services. The BSG position paper makes case for a 1 in 8 GI Bleed rota without any commitment to GIM. Implementation of this rota would enable compliance against 7DS Standards 5 and 6.

In order for this to be achieved, the Gastroenterology team would need to become centralised on one site (see page 5 re reconfiguration of services) and due to the co-dependency with Surgery out of hours services and Inpatient activity would need to be aligned on the Tunbridge Wells site. Outpatient services and Endoscopy would still continue at both sites. It is estimated that could be enabled by the end of Q2 2019/20.

Strategy

i. Tunbridge Wells Hospital Site

Currently the Tunbridge Wells rota consists of a single consultant on-call at the weekend undertaking a post take ward rounds on Fridays 5.00 – 9.00pm, Saturdays 8.00am – 12.00pm and 5.00 – 9.00pm, Sundays 8.00am – 12.00pm and 5.00pm – 9.00pm and Monday 9.00 – 10.00am unless a bank holiday which runs from 8.00am – 12.00pm. This is a 1:14 rota. Implementation to a full 7DS would occur in phases. This confirms compliance with 7DS standard 2.

The following models are based on 1:12 to 1:8 rotas which is it felt is the highest intensity that is operationally viable for the consultant workforce. A phased approach to implementation will be followed.

Phase 1

Implementation of Phase 1 at Tunbridge Wells Hospital would create a 24/7 GI bleed rota *and* enable the Gastroenterologists to review of some medically active pts (on gastro ward 12) in conjunction with the main GIM rota. In order for this to be enabled, the MGH gastroenterology team would relocate to TWH for the on-call. This would leave a deficit at MGH which would need to be filled, possibly by a concurrent relocation of acute stroke, elderly care or respiratory, for example.

It is proposed that Acute Respiratory (NIV) and Stroke (following recommendation of Stroke Review confirmed in September 2018) could potentially re-locate to Maidstone Hospital, which would also continue to deliver Care of Elderly, AMU/Frailty services, Diabetes and Cardiology inpatient activity. This would provide an opportunity to re-organise rotas to support 7DS.

Consequently, Gastroenterology, non-NIV Respiratory, Care of Elderly, AMU/Frailty services, and Diabetes would remain on the Tunbridge Wells hospital site.

The following rota would be implemented in Phase 1. **It is dependent on recruiting into vacant posts which are currently out to advert (August 2018)**. This creates a 1:12 1st on-call and a 1:8 GI Bleed/Gastro 2nd on-call rota. Both rotas would run from 5pm on a Friday to 8am on a Monday.

The 1st on-call team would work to the same pattern as the existing rota, undertaking PTWRs and *some* specialty review of patients. The 2nd on-call would also review specialty patients predominantly those on Ward 12 and those requiring an urgent review. This phase would mean that a large cohort of patients would not be reviewed due to capacity limitations.

	Existing consultants participating in rota	**Vacant posts**	
1st On-call (1:12) weekends	2 Acute Physicians 2 Diabetes Physicians 2 respiratory physicians 3 COE Physicians 1 Rheumatologist	2 Acute Vacancies *2 COE Vacancies – to backfill what was gastro ward at MGH*	**Stroke – to be determined**
2nd On-call / GI Bleed Rota (1:8) weekends	7 Gastroenterologists	1 Gastro *Vacancy (starts March 2019)*	

Phase 2

In order to have adequate resource to meet the demand of medically active patients it is proposed that an additional **7 consultant** posts are recruited to enable the daily review of these patients at a weekend.

The rota would work across both teams – on-call 1, on-call 2 with all individuals contributing to both rotas.

	Existing consultants participating in rota	**Vacant posts**	
1st On-call PTWR & 2nd on-call Medical Wards (1:10)	2 Acute Physician 2 Diabetes Physicians 3 COE Physicians 2 respiratory physicians 1 Rheumatologist **7 New Consultant Posts** 1 post of 8 gastroenterologists *(shared slot)*	2 Acute *Vacancies*	**Stroke – to be determined**
GI Bleed Rota (1:8)	7 Gastroenterologists	1 Gastro *Vacancy* *2 COE Vacancies – to backfill what was gastro ward at MGH*	

It is likely that 1st on-call team will focus on the PTWR following the existing rota and 2nd on-call team the review of medically active patients.

The 1st on-call team would work to the existing PTWR rota undertaking post take ward rounds on Fridays 5.00 – 9.00pm, Saturdays 8.00am – 12.00pm and 5.00 – 9.00pm, Sundays 8.00am – 12.00pm and 5.00pm – 9.00pm and Monday 9.00 – 10.00am unless a bank holiday which runs from 8.00am – 12.00pm.

The 2nd on-call team would work Saturday and Sunday 9.00am – 5.00pm on both days. This would equate to 2 ward rounds (2.5PAs).

As well as sharing in the 1 in 10 GIM on call (either first or second on), the GI Bleed team would be on-call for GI Bleeds 24/7, 365.

ii. Maidstone Hospital Site

The Maidstone site currently operates a 1:12 GIM rota made up of 9 slots covered by specialty and acute physicians and 3 slots shared between 3 Gastroenterologists and 1 Rheumatologist (1:16). Currently 2 slots of the 9 are vacant as is 1 slot of the 4 shared between Gastroenterology and Rheumatology. N.B. Rheumatology no longer input into the rota. These empty slots are filled either by locums or by cross cover amongst the physician team. From 2pm on a Friday to 8am on a Monday, the rota is covered by 2 physicians sharing the weekend on-call and take as illustrated below.

Current on call		
	On call Physician 1	**On call Physician 2**
Friday	PTWR PM	
	WR 5-8.30pm	
	Unpredictable on-call overnight from home	
Saturday	PTWR 8-12	On call from home 8am
		PTWR 5-9pm
Sunday		PTWR 8-12
		PTWR 5-9pm
		On call from home to 8am Monday

It is proposed that in order to meet the 7DS standards, a phased approach of change and increase to specialty ward rounds and daily patient review will be required. This is based on a change to the workforce and required consultant numbers to make the new working patterns operationally viable.

Phase 1

	On call 1 (1:8)	**On call 2 (1:8)**	**Stroke (HASU/ASU) 1:6 – to be determined**
Friday	PTWR PM		
	WR 5-8.30pm		
	Unpredictable overnight from home		
Saturday	PTWR 8-12	On call from home 8am	
	Specialty WR 1300-1700	***Specialty WR 1300-1700***	
		PTWR 1700-2100	
		On-call from home overnight	
Sunday	***Specialty WR 0800-1200***	PTWR 8-12	
		Specialty WR 1300-1700	
		PTWR 5-9pm	
		On call (home) to 8am Monday	

It is proposed that the above model works on a 1:8 rota i.e. 2 consultants on each weekend every 8 weeks. This intensity has been deemed as viable amongst the consultant body and would require 16 physicians (or slots) to be in post in order for it to be work. This could be enabled by:

- Move 2 vacant TWH COE posts to Maidstone site to backfill the loss of gastro consultants on Pye Oliver ward
- Existing 9 physicians taking 1 slot each
- Recruiting to existing 7 vacancies – 2 Respiratory, 3 COE, 2 Acute – taking 1 slot each

This phase includes the contribution of 'Stroke' physicians into the rota.

Phase 2

	On call 1 (1:8) – eg. Acute & D+E	**On call 2 –(1:8) eg. Respiratory**	**On call 3 –(1:8) eg.COE**	**Stroke (HASU/ASU 1:6 – to be determined**
Friday	PTWR PM 1400 onwards			
	PTWR 5-8.30pm			
	Unpredictable overnight from home			
Saturday	PTWR 8-12	On call from home 8am	***Specialty WR 0800-1200***	
	Specialty WR 1300-1700	***Specialty WR 1300-1700***		
		PTWR 1700-2100		
		On-call from home overnight		
Sunday	***Specialty WR 0800-1200***	PTWR 8-12		
		Specialty WR 1300-1700	***Specialty WR 1300-1630***	
			PTWR 5-9pm	
			On call from home to 8am Monday	

The 2nd phase of implementation would include a 3rd on-call consultant to provide further specialty ward rounds reviewing 'medically active' patients. This rota would equate to needing 24 consultants i.e. each on-call group doing a 1:8, ideally with each on call consultant from a different specialty to help ensure wider variety of specialty cover across the wards. This in turn would enable Respiratory Physicians to undertake a twice daily review of high dependency medically active patients.

The above rota would require:

- 9 existing post holders
- Recruiting to existing vacancies – 3 for COE, 2 for Acute and 2 for Respiratory
- Creation of 8 new consultant posts – 2 Respiratory, 3 COE, 3 acute

n.b. currently 3 of the COE physicians are on the stroke rota. The outcome of the stroke review may impact on this rota and a further 3 physicians may need to be recruited into the on-call rota.

iii. Strategy - Site reconfiguration

In order for the above models to be viable it is suggested that services may ultimately be provided by site as follows:
TW – Acute Medicine, Gastroenterology, respiratory (non-NIV), COE & Frailty, Diabetes
MS – Acute Medicine, Respiratory (NIV), Cardiology, COE & Frailty, Diabetes and Stroke (TBC)

Junior Doctor Support

Due to the number of additional ward rounds and patients being reviewed under this model, the existing junior doctor establishment deployed at a weekend would not be sufficient enough to support the consultant body nor undertake the clinical duties required to enable the benefits from a weekend daily review of patients. It is proposed that an additional workforce of 1 SHO and 2 Physicians Associates are employed at each site between 9.00am and 9.30pm at the weekend to mitigate the risk associated with a gap in workforce.

Respiratory & Level 2 patients – Twice daily review

By centralising NIV Respiratory services on one site, consolidation of the workforce, supported by additional recruitment will enable twice daily review of hyper-acute patients. It is proposed that NIV respiratory services are based at Maidstone hospital but **the full scope of this work is yet to be determined.** In order for the site consolidation to occur, the respiratory consultant workforce would need to equate to 8.0 WTE, this is an increase of 4.0 WTE.

Consultant Engagement

The above proposals will be discussed further at consultant meetings and this paper has been shared with the consultant body. On agreement of the final model, each clinician will be written to formally notifying them of the change and allowing for 3 months' notice for a change in working pattern.

Opportunities associated with increased Consultant Workforce

The proposed growth in consultant workforce required to undertake a daily review of medically active patients 7 days a week also provides significant opportunities for improvements in service delivery, quality, safety and patient experience and outcomes. The provision of an extra 7 to 8 consultants per site will enable the following benefits to be realised.

- **Daily consultant ward rounds** – an increase in workforce will enable the medical specialties to adopt a *Consultant of the Week* model (COW) thereby enabling extended daily consultant ward rounds. Under this model a ward round equates to 2 sessions. With a daily Consultant available 20-30 patients could be seen in 4-6 hours on average. This is as opposed to the current system where Consultants see patients twice per week on a 4 hour ward round – where a maximum seen tends to be

c.20 patients. The additional capacity will mean that patient management is expedited, therefore supporting a reduction in length of stay (LOS).

- **Compliance with the NHSI SAFER patient flow bundle** – an increase in consultant ward rounds will ensure that a senior review of patients is undertaken before midday by a clinician able to make management and discharge decisions (S=Senior Review). This will help to reduce length of stay.

- **Reduction in LOS** – a reduction in length of stay for NEL medical patients released through several strategies including those outlined above, results in improved availability of medical beds. With NEL growth at 4.5% per year there is increased pressure on medical beds and a continued risk of demand outstripping capacity. Consultant resource is a key enabler to ensuring that medical outliers and escalation is negated.

- **Additional Outpatient capacity** – several specialties across specialist medicine do not have enough new or FU outpatient capacity to meet demand. This has resulted in non-compliance with the RTT access target for some specialties and a FU backlog of around 30,000 appointments. Additional consultant resource provides an opportunity for further OP capacity including virtual activity which will help reduce waiting times and improve patient management and outcomes.

- **Diagnostic capacity** – additional consultant resource provides an opportunity for increased Endoscopy and Bronchoscopy/EBUS capacity. This improves capacity for routine diagnostics and for those patients on the GI and Lung Cancer pathways. In addition, further resource provides an opportunity to scope the 7 day provision of some diagnostics supporting compliance with 7DS standards 5 and 6.

- **Supporting new pathways** – the provision of an extended consultant workforce provides an opportunity to redesign current practice and put new pathways of care in place. Examples include geriatrician presence at community MDTs to support recognised frailty patients or training in specific respiratory pathways by respiratory consultants in the community to support chronic frequent attender patients. In addition increased consultant resource at the “front door” and pulling patient from AMU on a daily basis to specialty wards will improve patient care and reduce length of stay. These pathways are key to future flow and delivery of healthcare and will be further scoped with the existing consultant body.

- **Workflow redesign** - MTW is in partnership with KCHFT, West Kent CCG, KMPT and High Weald CCG under an Aligned Incentive Contract (AIC) under the West Kent Alliance Executive Group (WKAEG). This shared approach to healthcare gives considerable opportunities to redesign pathways and workflow, increasing patient care and ensuring that the right patient is in the right place at the right time. The pathways will be designed to cover 7 day services to suit the needs of the population and in line with a COW model, additional consultant resource provides an opportunity for this. Clinical engagement and advice will be sought to design and support these pathways**.**

- **Clinically led organisation** – the increase of consultant resource will support the Trust vision to become a more clinically led organisation. NHS organisations with high levels of engagement achieve better results and report better staff and patient experience. This is supported by recent examples at MTW such as the Listening into Action projects, improving the fractured neck of femur pathway and addressing the challenge of GIRFT in orthopaedics. This will support the Trust ambition to become an outstanding organisation. The GIRFT programme is now launching in the Medicine and Emergency Care Division and will require consultant resource in order to succeed.

These opportunities will require further modelling with the consultant body including identifying in which specialties additional resource would add the most benefit.

Financial impact

Phase 1 – costs to implement phase 1 only (assumption that all vacancies are filled)

TW	Cost	Saving
Change from 1:14 – 1:8 – 8 Gastroenterologists – Category A (5%) intensity payment	18,115	
GI Bleed weekend working PA – 1.33PA (52 weeks)	5,740	
4 vacant consultants posts recruited	450,260	
4 Agency (Consultants Acute/COE/Gastro) savings		960,000
Additional junior doctor support (working 9.00am – 9.30pm Saturday & Sunday – 52 weeks): 1 x SHO 2 x Physicians Associates	112,242	
Maidstone		
Change from 1:12 to 1:8 rota – Category B (2%) – 16 GIM consultants intensity payment	38,400	
7 vacant consultant posts recruited	847,000	
7 Agency (consultants Resp/COE/Acute) savings		1,764,000
Additional junior doctor support (working 9.00am – 9.30pm Saturday & Sunday – 52 weeks): 1 x SHO 2 x Physicians Associates	112,242	
Specialty ward round Sat / Sunday – 5.32 PAs – 52 weeks	293,792	
TOTAL	**1,584,000**	**2,724,000**

*savings from moving from agency to substantive consultant posts have already been accounted for under the Best Care Programme

Phase 2 – additional costs moving from phase 1 to phase 2 (assumption that all phase 1 vacancies are filled)

TW	Cost
2nd on-call weekend working W/R – 2.5PAs (52 weeks)	10,876
7 new consultant posts	847,000
Maidstone	
8 new consultant posts	968,000
Additional specialty ward rounds Sat/Sun – 2.49PAs – 52 weeks	275,016
Additional 8 consultants on-call doing 1:8 rota – Category B (2%) intensity payment	19,200
TOTAL	**2,128,092**

Strategy to reduce admissions

One of the key pressures within the Medicine and Emergency Division is managing increasing demand. Traditionally once an initial assessment is made emergency patients are admitted to hospital to an inpatient ward to receive a diagnosis and treatment. Many of these patients are medically active and will require a daily review by a consultant. However, there are an increasing number of strategies across secondary and primary care that support admission avoidance or the management of patients on 0 day LOS pathways (Ambulatory & Frailty). These schemes once fully implemented will potentially reduce the total number of admitted patients that require a daily review by a consultant or mitigate further growth in medical admissions requiring further staffing resource to meet Standard 8 and a daily review of medically active patients.

This strategy links to the delivery of the NHS England NHS Long Term Plan 2019 and the Strategic Alignment NHS Operational Planning and Contracting Guidance 2019/20, both of which stipulate a move to a comprehensive model of Same Day Emergency Care (SDEC). This will increase the proportion of acute admissions discharged on the day of attendance from a fifth to a third.

Investment in Ambulatory and Frailty services at MTW forms a core part of the 2019/20 business plan and is proposed as a service development.

In addition, there are several programmes being proposed for 2019/20 between WKCCG and MTW that support a growth in 0 day LOS and ED attendance avoidance. Those currently being deployed are summarised in the table overleaf. The majority of these schemes will be reviewed under the WK Local Care Programme Board of which MTW has membership. However, the Division and internal governance regarding the oversight of these strategies is yet to be defined, but is likely to be picked up under Best Flow and the AEG (formerly AIC) model for Emergency Care.

Further analysis of this data will need to be undertaken internally to identify the full impact of the schemes on medical admissions and the number of patients requiring a daily consultant review. This will require BIU support and will need to be addressed during Q1 19/20.

Scheme Name	Scheme Description	Implementation date? Is it in 19-20?	If so which month?	What patient numbers does each scheme cover?	What assumptions have been made in reduced attendances to ED by patient group?	Key risks to scheme delivery?
Integrated COPD service	Existing service in place across MTW & WKCCG	Review to take place with service specification update for Integrated COPD service, PR and Oxygen Service. Review of pathways to increase and improve proactive elements.	Q2	8208 registered COPD patients in WK. (QOF data)	TBC Approx. 70 COPD admissions per month. (839 previous 12 months). Preliminary audit of medicine reviews within practices by community Resp team taking place.	Delay in implementation of proactive COPD pathway resulting in no change to current ICP service, limited/no reduction in admissions seen Delay in implementing Spirometry training resulting in poor COPD quality spirometry for diagnosis and monitoring within primary care
Home Treatment Service & Rapid Response (in addition please see Local Care Board schemes for expansion of these services)	7/7 service. The service's aim is to avoid patients being admitted to MTW by diagnosing, assessing and treating patients in their homes. HTS runs as a virtual ward, with patients under the care of a consultant geriatrician	Commissioned Expansion monies agreed	Sep 2015 Dec 2018	04/17- 03/18 baseline average referrals = 103pcm. Anticipated ↑in average referrals = 176pcm 04/ 17-03/18 baseline average referrals = 448 Anticipated ↑ in average referrals = 664	45% of HTS referrals result in avoided ED attendance or admission (new % agreed following deep dive with MTW/KCHFT/CCG) 46% of RR referrals result in avoided ED attendance or admission	Recruitment is challenging across the health sector. Vacant posts are backfilled with agency in order to support the increase in productivity and demand but this has a ceiling also. Relationship with Trusts need building to smooth process of increased referrals from the Acute
Liaison Psychiatry Service	NHSE funded winter resilience pilot scheme	Pilot ends March 2019 no clear plans for 2019/20				

Scheme Name	Scheme Description	Implementation date? Is it in 19-20?	If so which month?	What patient numbers does each scheme cover?	What assumptions have been made in reduced attendances to ED by patient group?	Key risks to scheme delivery?
	(additional hours at TWH).	until pilot evaluation complete				
Flu Vaccines to housebound	Commissioned. Supported through LAEDB			tbc	tbc	tbc
Community Cluster Geriatrician sessions (Geriatrician / GPWSI)	Weekly community MDT teleconference. Focus on frail patient management in community	2019/20	June 2019	All patients in West Kent 65+ (c. 91,000)	Improved MDT working and proactive care to reduce unnecessary A& E attendances and short stay admissions	Recruitment is challenging across the health sector.
Community Cluster Frailty Nurse		2019/20	June 2019	All patients in West Kent 65+ (c. 91,000)	Improved MDT working and proactive care to reduce unnecessary A& E attendances and short stay admissions	Recruitment is challenging across the health sector.
Community Cluster Dementia nurses	Weekly community MDT teleconference – discussing community management of dementia patients	2019/20	Potentially in post by April 2019	All patients in West Kent 65+ with a diagnosis of Dementia or suspected Dementia, excluding patients in Care Homes where the nurses will only do their Dementia Annual Reviews on GP request.	Improved MDT working and proactive care to reduce unnecessary A& E attendances and short stay admissions where Dementia is the primary or secondary diagnosis. Reduction in long stay admissions where Dementia is the Primary Diagnosis	Recruitment Lack of Engagement Quality of Data
Cluster Clinical pharmacists	As above – focus on medicines management	2019/20	June 2019	All patients in West Kent 65+	Improved MDT working and proactive care to reduce unnecessary A& E attendances and short stay admissions	Recruitment is challenging across the health sector.
Community Cluster Therapists	As above focus on community	19/20	N/A	All patients in West Kent 65+	Improved MDT working and proactive care to reduce	Recruitment

Scheme Name	Scheme Description	Implementation date? Is it in 19-20?	If so which month?	What patient numbers does each scheme cover?	What assumptions have been made in reduced attendances to ED by patient group?	Key risks to scheme delivery?
	therapy				attendances and admissions	
Care Home strategy - improved primary care support	GP practices mapped to care homes to enable regular ward rounds/patient review	19/20	n/a	All patients in the 74 care homes in West Kent (approximately 3100 residents) 16/17 baseline activity in A&E Long Stay Admissions = 724. **Anticipated reduction in A&E long stay admissions = 36** 16/17 baseline activity in A&E Short Stay Admissions = 280 **Anticipated reduction in A&E Short stay admissions = 14**	Improved proactive care with 1-2-1 mapping GP practices to care homes, regular home reviews depending on the complexity of patients in each home, improvements in education and training especially in EOLC, dementia, rehab and re-enablement, hydration and nutrition and others 16/17 baseline activity in A&E Attendances = 3,029. **Anticipated reduction in A&E attendances = 303**	
Falls service	Recommissioning of falls service to keep patients at home	19/20		91,202 (19% of WK population) are aged 65 or over and may be referred to the falls service if they are deemed at risk of falls or have fallen	Reduction in falls related activity (attendances and admissions of over 65s with primary cause being a fall)	Recruitment; new service model for West Kent due to launch next week. The model therefore might need to evolve over time to outcomes are met
Mental Health Local Care model		To be agreed by Governing Body – late Feb 2019	TBC - ? June 2019	Not calculated	TBA	Approval of proposed investment by Governing Body. Recruitment to new posts

Risks

- *Medical caseload and ability to review all 'medically active' patients* – bed use for medical patients at both sites varies extensively between summer and winter. Maidstone currently see a range in use between 219 and 246 throughout the year and Tunbridge Wells 241 and 278. Medically active patients are currently being anticipated to be 51% of inpatients. Best Care and Best Patient Flow Initiatives supporting a reduction in LOS are anticipating a reduction in bed use as a minimum by 30 beds cross site during 18/19. With each ward round enabling a review of 24 patients, further investment into consultant resource and the ability to recruit needs to be considered in order to enable the Trust to meet 7DS, otherwise there is a risk that standard 2 would not be met.

- *Compensatory rest and impact on service delivery* – due to the intensity of the rota and the requirement for a full 48 hours rest in 2 weeks there is a potential risk that if compensatory rest is put in place as part of the new on-call rota that this will have an impact on weekday service delivery due to a reduced consultant presence on site. This could impact on operational performance (RTT/ED/LOS) if presence on the wards and in clinics were reduced. This will need to be job planned amongst the consultant body. Additional consultant recruitment could mitigate this.

- *Consultant recruitment* – there are currently more than 10 Consultant vacancies within the Urgent Care Division many of which have been vacant for more than 3 years. There is a risk that many of these remain empty which will impact on the delivery of revised on-call rotas and reasonable intensity of these. Recruitment to further posts to support meeting 7DS may also be challenging. The Division has recently revised job descriptions and adverts to support filling these positions and is moving to using head-hunters in some services.

- *Junior doctor support for weekend specialty ward rounds* – it is proposed that there is insufficient junior doctor resource to support the increase Consultant ward rounds and associated actions i.e. test requesting etc which could impact on the benefits of consultant daily review. The use of Physicians Associates working on a 1:1 basis with each Consultant over the weekend is proposed as an option to address this.

- *ITU capacity MS* – Respiratory services are high users of ITU particularly over winter. If respiratory services were to be predominantly based at the Maidstone site, there is a risk that patients would not be able to be accommodated within the ITU at Maidstone if surgical activity were maintained during winter. This activity needs to be fully modelled with Planned Care as part of site reconfiguration so that appropriate care pathways can be put in place.

- *Continuity of Care* – there is a risk inherent in the model at both sites regarding lack of continuity of care. There is a potential for lack of consistency in clinical management of patients as each on-call team reviews the medically active patients which could result in impacting on quality of care and length of stay. This would be offset by robust handover processes and clinical documentation.

Conclusion

In conclusion, there are several challenges to enabling compliance with the four core 7DS standards within the Urgent Care Division including a financial impact of £3.71m. Standard 2 is already being met. The implementation of the GI Bleed rota will enable the Division to meet Standards 5 and 6. The largest area of risk lies in meeting Core Standard 8 in terms of recruitment, site reconfiguration and mitigation of operational risks which all need to be overcome to enable compliance against standard 8.

Claire Cheshire
Head of Performance & Delivery
Medicine & Emergency Care Division

WOMEN'S, CHILDREN'S AND SEXUAL HEALTH DIVISION

Appendix 3

1: Summary of Compliance:

Std 2	Std 5	Std 6	Std 8
✓ (weekdays) X (weekends)	✓	*N/A	✓

The Women's Health Directorate are in a position of almost full compliance. As the summary table above demonstrates, the Directorate have a potential compliance issue with standard 2 at weekends. This relates to the period from 15.00hrs to 8.30hrs on Saturdays and Sundays. Weekdays are fully compliant over the full 24 hour period.

2: Examination of Compliance Issue:

2.1: Standard 2 - Weekends after 15.00hrs:

During weekdays, there is a consultant on site until 21.00hrs (Monday to Friday), with a Consultant in attendance at every handover meeting at the end of each day at 20.30hrs. At weekends, the Consultant is not routinely present after 15.00hrs which leaves a potential period of 17 hours with no Consultant presence until the normal handover meeting at 08.30hrs each morning (including weekends). Therefore, mathematically, there is an opportunity for a woman to be admitted and not be seen within in the 14 hour window required by the standard. There are two distinct client groups in this Directorate – Obstetric patients and emergency Gynaecology patients. Each group will be taken separately below.

2.1.1: Obstetric Patients: It is evident that the Obstetric caseload are outside of this standard as they will qualify for 'delegated care with robust and rapid escalation to a Consultant where appropriate' as all patients are on the Maternity pathway. If women are identified as requiring Consultant intervention, at this point, a Consultant would be called and will attend within a worst case of 30 minutes. Therefore, the 1 hour standard is always met.

2.1.2: Emergency Gynaecology Patients: On examination of the casemix, it is clear that there are a number of emergency Gynaecology patients who are in their first trimester of pregnancy and present with either a miscarriage or an ectopic pregnancy. This group of patients are fully protocolised and therefore, are believed to be in the same category as the Obstetric caseload, namely delegated care. Again, if women are identified as requiring Consultant intervention and at this point, a Consultant would be called and will attend within a worst case of 30 minutes. The 1 hour standard is always met. This leaves only a small cohort of emergency Gynaecology patients who will present and be classified as medically active. If presenting at weekends after 15.00hrs, these patients cannot currently be guaranteed to be seen and assessed by a Consultant within 14 hours of admission. The casemix that is likely to present in this category are women is attached as appendix 1. Below is a summary of this activity, grouped into 10 categories:

Presenting Diagnosis (Grouped)	Incidence in 2 years	Non-Medically Active/Protocolised Care
Non-specific lower abdominal/pelvic pain	36	✓ Most are protocolised, but a small proportion are acute
Vaginal Bleeding/Menstrual Issues	32	✓
Readmissions/other (wound/complications/infection)	19	
Genital disorders (inflammation/prolapse)	18	✓
Ovarian/Fallopian Tube disorders	12	✓
Bartholin cysts	5	✓
Urinary tract issues	2	✓
Total	**124**	

To aid understanding, the volume of patients that fall into this category at the weekends is an average of 62 per annum, or 1.19 patients per weekend. In addition, the vast majority of the non-specific lower abdominal pain group are more appropriate for primary care review than to be admitted into the secondary care sector. There are very few readmissions and the Directorate is below the national average for this statistic. The readmissions would fall into three broad categories, those with urinary retention *(who are protocolised),* those with an infection *(again, who are protocolised*), and a tiny proportion of patients with underlying pain, (query cause), and would result in the Senior Registrar calling the Consultant and the Consultant Surgeon if appropriate.

When the protocolised patients (or delegated care patients) are removed from this cohort, the risk of potentially medically active patients presenting in the non-resident consultant period at weekends reduces to <20 cases in 2 years (<10 cases per annum, which is <1 weekend patient per month). All of the patients in this very small, potentially medically active group will be identified by the Senior Registrar on the rota (who will have 4-5 years' experience in the specialty, be at ST5 and above and will have either completed their final MRCOG or will be in the process of completing this). The Senior Registrar would instigate calling in the Consultant in O&G if appropriate. There may be a rare example of a patient with a severe pelvic infection who develops sepsis, but again, there is a protocol for this and the Senior Registrar would instigate the call to the Consultant in these cases.

I acknowledge that there is a compliance issue for this very small group of patients with respect to standard 2 but there is no evidence that these patients are at clinical risk. The only solution to providing a consultant assessment between 3pm and 08.30am on Saturdays and Sundays would be to bring another consultant into the hospital at this time. The cost of providing this routine consultant cover (with no required additional duties than being available in case of an unplanned admission with an occurrence rate of less than 1 weekend per month) would be unjustifiable in the current financial climate and where there is no evidence of a patient safety issue.

Miss Sarah Flint
Clinical Director and Deputy Medical Director – Feb 2019

Appendix 1

2 Years of Non-Elective Admissions by diagnosis, ranked in order of highest presentation volume

Diagnostic Presentation	Number of admissions (sample - 2 years)
Abdominal and pelvic pain	36
Other abnormal uterine and vaginal bleeding	14
Complications of procedures, not elsewhere classified	7
Excessive, frequent and irregular menstruation	6
Other inflammation of vagina and vulva	6
Non-inflammatory disorder of ovary, fallopian tube & broad ligament	6
Diseases of Bartholin gland	5
Open wound of abdomen, lower back and pelvis	5

Diagnostic Presentation	Number of admissions (sample - 2 years)
Other female pelvic inflammatory diseases	5
Endometriosis	5
Complications of genitourinary prosthetic devices implants & grafts	5
Other infection	4
Leiomyoma of uterus	3
Other disorders of urinary system	2
Salpingitis and oophoritis	2
Menopausal and other perimenopausal disorders	2
Female genital prolapse	2
Malignant neoplasm of ovary	2
Complications associated with artificial fertilization	2
Other non-inflammatory disorders of vulva and perineum	1
Malignant neoplasm of cervix uteri	1
Iron deficiency anaemia	1
Benign neoplasm of ovary	1
Other anaemias	1
Grand Total	**124**

Trust Board meeting – March 2019

NHS Maidstone and Tunbridge Wells NHS Trust

3-20	Update from the SIRO (incl. approval of the IG Toolkit submission for 2017/18 & Board annual refresher training on Information Governance)	Chief Nurse

Summary / Key points

In 2015 the Information Governance Alliance issued guidance for Boards entitled Information Governance Considerations for NHS Board Members. This guidance document identified a number of key points for NHS Boards and is used as the basis for this report:

Key points for NHS Boards to note are that:

- An annual IG performance assessment1 using the IG Toolkit (IGT) must be published for review by commissioners and care partners, citizens, CQC and the Information Commissioner. Used appropriately the IGT is a proven change management tool that can be used to monitor performance and drive improvements in policy and practice.
- A Senior Information Risk Owner (SIRO) must be appointed to take responsibility for managing the organisation's approach to information risks & to update the Board regularly on information risk issues.
- A Caldicott Guardian, a senior clinician, must be appointed to advise the Board and the organisation on confidentiality and information sharing issues.
- Appropriate annual IG training2 is mandatory for all staff who have access to personal data with additional training for all those in key roles.
- Details of incidents involving cyber security, loss of personal data or breach of confidentiality must be published in annual reports and reported through the HSCIC Serious Incident Requiring Investigation (SIRI) reporting tool3

NHS Board members should seek assurance on the following:

1. Is the duty to share information for care introduced by the Health and Social Care (Safety and Quality) Act 2015 and promoted by the National Data Guardian4 being effectively addressed? Are arrangements for integrated care working effectively?
2. Is the organisation's IG Toolkit assessment satisfactory? Is it a true reflection of performance? Has it been independently audited? Are there any known weaknesses or auditor recommendations and if so, how are they being addressed? Does the organisation have the capacity and capability to guarantee that plans for improved IG can be implemented?
3. Are the Board satisfied with the indicators of IG performance reported to it, e.g. are key roles filled? Are all staff trained in the basics? Are levels of missing or untraceable case notes acceptable etc?
4. Are IG staff – IG managers, SIRO, Caldicott Guardian - trained appropriately? Are IG staff encouraged to participate in regional Strategic IG Network (SIGN)5 meetings, contributing to and receiving support from the IGA6?
5. Are all significant IG Risks being managed effectively and considered at an appropriate level? Have there been any serious incidents requiring investigation reported? How confident is the organisation that all such incidents are reported? How many cyber-attacks have occurred and were they all successfully prevented?
6. Do the organisation's IG arrangements adequately encompass all teams and work areas, including hosted activity and contracted work that the organisation is legally accountable for?

1 This must be provided via the Information Governance Toolkit (IG Toolkit),

2 This may be provided through the Information Governance Training Tool (IGTT) or equivalent local resource, supplemented where appropriate by additional role specific local training

3 The SIRI reporting tool is accessed from within the IG Toolkit

4 Dame Fiona Caldicott, the National Data Guardian conducted a review of care sector information governance available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192572/2900774_InfoGovernance_accv2.pdf

5 SIGN groups meet regionally with their chairs meeting bi-monthly in a national meeting chaired by the IGA.

6 The Information Governance Alliance (IGA) was established in July 2014 at the request of the National Data Guardian to support the Care Sector with authoritative advice and guidance on information governance issues, more details at IGA@nhs.net

This guidance document is used as the basis for this report which aims to provide assurance in relation to the six key areas detailed above.

Data Security and Protection Toolkit

The Data Security and Protection Toolkit is an online self-assessment tool that allows organisation to measure their performance against the National Data Guardian's 10 data security standards and replaces the Information Governance Toolkit.

The 10 standards are as follows:

1 Personal Confidential Data
All staff ensure that personal confidential data is handled, stored and transmitted securely, whether in electronic or paper form. Personal confidential data is only shared for lawful and appropriate purposes.

2 Staff Responsibilities
All staff understand their responsibilities under the National Data Guardian's Data Security Standards, including their obligation to handle information responsibly and their personal accountability for deliberate or avoidable breaches.

3 Training
All staff complete appropriate annual data security training and pass a mandatory test, provided linked to the revised Information Governance Toolkit.

4 Managing Data Access
Personal confidential data is only accessible to staff who need it for their current role and access is removed as soon as it is no longer required. All access to personal confidential data on IT systems can be attributed to individuals.

5 Process Reviews
Processes are reviewed at least annually to identify and improve processes which have caused breaches or near misses, or which force staff to use workarounds which compromise data security.

6 Responding to Incidents
Cyber-attacks against services are identified and resisted and CareCERT security advice is responded to. Action is taken immediately following a data breach or a near miss, with a report made to senior management within 12 hours of detection.

7 Continuity Planning
A continuity plan is in place to respond to threats to data security, including significant data breaches or near misses, and it is tested once a year as a minimum, with a report to senior management.

8 Unsupported Systems
No unsupported operating systems, software or internet browsers are used within the IT estate.

9 IT Protection
A strategy is in place for protecting IT systems from cyber threats which is based on a proven cyber security framework such as Cyber Essentials. This is reviewed at least annually

10 Accountable Suppliers
IT suppliers are held accountable via contracts for protecting the personal confidential data they process and meeting the National Data Guardian's Data Security Standards.

The 10 Data Security Standards detailed above are devolved into mandatory and supplementary 'assertions' that widen the scope of the previous toolkit requirements.

In order to achieve a fully compliant DSP Toolkit, all mandatory assertions must be achieved by the organisation.

These standards address modern data security threats as well as inherent information governance processes operated at NHS organisations.

All organisations that have access to NHS patient data and systems must use the toolkit to provide

assurance that they are practising good data security and that personal information is handled correctly.

The Board are advised that the Trust is continuing to work towards providing the 100 mandatory evidence requirement of the Toolkit.
In order to provide assurance that the organisation has in place effective data security and information governance controls and processes as directed by the new DSP Toolkit, TIAA have conducted a review of a sample of these Standards.

The review tested a sample of five of the ten Data Security Standards for completeness and validity of evidence and statements supporting the mandatory assertions associated with those standards.

The review adopted a two stage approach and the draft audit report has just been received. The Trust achieved 'Significant Assurance'. The overall conclusions contained within the report state:
The five Data Security Standards selected for audit testing cover 71 mandatory evidence items. 70 mandatory evidence items from the audit sample were claimed as 'Met'. Of those, 63 were agreed with by the audit with the remaining 7 requiring additional or improved evidence to support the claimed position.

The Trust has an appropriate Information Governance and Data Security structure with the IG Committee providing oversight.

There were no IG Incidents that were reportable to the ICO.

The Board are advised that throughout the year the Information Governance Committee has received regular reports on the Toolkit progress. It reviewed the latest Toolkit position on 20 March and received the Audit report from TIAA which described substantial assurance in their final report to the Trust. As a consequence the Committee are happy to recommend that a 'Standards Met' year-end submission be made prior to 31 March 2019. The Board are asked to support this position.

In additional to the work undertaken to complete the mandatory evidence requirements for the Toolkit the Information Governance Committee has also received regular reports on the work being undertaken in relation to Cyber Security and Brexit Preparations.

Cyber Security

The Trust is moving ahead with the work required to achieve the Cyber Essentials Plus Accreditation. Cyber Essentials Plus is a government-backed, industry-supported scheme designed to help organisations protect themselves against common on-line threats. It is mandatory that all NHS organisations are Cyber Essentials Plus accredited by 2021 and it is the intention to complete the accreditation by Summer 2019.

Brexit Preparation

As part of the work being undertaken to ensure the Trust is prepared for a 'No Deal' Brexit the Trust has reviewed its contracts and data flows to ensure that data flows required to support patient care are not interrupted.

IG Incidents

In the year to date there have been four incidents, the detail of which triggered the use of the Data Security and Protection Incident Reporting Tool.

Reference What Happened
4527 A staff member sent patient identifiable data to the in response to queries around age and eligibility to participate in the National Adult Inpatient Survey. Later the same day a staff member resubmitted the Trust sample file to the Co-ordination Centre via email instead of using the secured FTP server.

7349 Nineteen letters containing personal data were sent in error to eighteen recipients.

10538 A nurse handover sheet containing sensitive personal information was found in the street by a member of the public.

10474 An excel workbook containing a hidden sheet incorporating person identifiable data was sent by

secure email to a number of individuals in error.

None of the above incidents met the threshold for notification to the ICO. However each has been subject to the Trust internal incident investigation process whereby root causes are identified and remedial actions detailed and implemented.

In addition to the above two further IG incidents have been reported internally as Serious Incidents for review:

Reference	What Happened
2018/21532	A patient, on discharge from A&E, was given paperwork pertaining to four other individuals.
2018/11433	Sample file containing data of 471 patients sent to the Picker Institute Europe Survey Co-ordination Centre in error. The file should have been the sample declaration file.

In each of the above incidents process have been reviewed and where relevant changes have been implemented.

Information Risks

The Board are advised that no new Information Governance risks have been added to the Trust risk register since my last annual report in March 2018.

All Directorates and Departments have been requested to review their Business Continuity Plans to ensure they have been updated to reflect to Trust's ongoing journey to a paper-light environment.

Which Committees have reviewed the information prior to Board submission?

- Information Governance Committee

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

This report is provided to the Board for assurance purposes.

Trust Board meeting – March 2019

NHS Maidstone and Tunbridge Wells NHS Trust

3-21	Summary report from Audit and Governance Committee, 14/03/19	Committee Chair (Non-Executive Director)

The Audit and Governance Committee (AGC) met on 14th March 2019.

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

- An update on open actions was received, which included advice that the "Management of Conflicts of Interest Policy" would be finalised for approval prior to the next meeting. Actions closed since the last meeting were noted
- Under the Safety Moment, the Trust Secretary reported that March's theme was the Accessible Information Standard. The Committee agreed that all future "Safety Moment" items to the AGC should be accompanied by a written report
- 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, in formulation of the BAF for 2019/20, consideration should be given to how performance and improvement over the year might be better presented and that the issues raised at the meeting about the agreement and content of the BAF should be considered as the subject as a future Trust Board Seminar. It was noted that these actions required engagement by all Board Members to support any changes
- An update on progress with the Internal Audit plan for 2018/19 (including progress with actions from previous Internal Audit reviews) was reported. The list of recent Internal Audit reviews is shown below (in section 2). It was noted that there were 6 outstanding audit recommendations and 1 outstanding ICT audit recommendation. It was agreed that the owners of the 2 outstanding actions were no updates had been provided should be invited to the next AGC meeting to report on the action, but stood down if a satisfactory response was received in the interim. It was further agreed that a policy of inviting owners of actions where an update was outstanding for more than one month to the next AGC meeting should be adopted with effect from the next meeting
- The Chief Finance Officer was asked to consider if a formal management response was required to the "Aligned Incentives Contract (Advisory Review)" and/or if information needed to be shared with the Trust Board to allow findings to be incorporated into future plans for wider system working
- The Internal Audit Plan for 2019/20 was reviewed and approved
- A Counter Fraud update was reviewed and the Counter Fraud Work Plan for 2019/20 was approved, with a request noted that the intended proactive review of conflicts of interest be moved to later in the year to allow the new policy to be embedded within the Trust
- A 'Progress and emerging issues' report was received from External Audit and it was noted that a report on the Trust's two significant property asset disposals would be included in the next report to the AGC
- The External Audit Plan for 2018/19 was reviewed and approved
- The findings from the evaluations of the Internal Audit & External Audit Services were reviewed. No issues in need of immediate action were identified and it was agreed that a response to the survey findings should be prepared by TIAA Ltd and GT respectively for consideration at the next AGC meeting on 09/05/19. It was further agreed that the surveys should be reviewed to remove any questions that did not add value to the process
- Details of Payments for compensation under legal obligation for the period 01/10/18 to 27/02/19 were received. It was agreed that future reports should be amended to include a column to indicate if an incident report was required/ had been raised
- The losses & compensations data for the period 01/04/18 to 31/01/19 was reviewed and the Chief Finance Officer undertook to share the issues discussed about salary overpayments with the Executive Team and make a proposal at the next AGC meeting re whether further action was required
- The latest single tender waivers (STW) data was reviewed, which represented a decrease both in volume and value compared with the previous quarter. The Chief Financial Officer undertook to clarify the reasons for the volume and value of HR Single Tender Waivers in

December 2018

- A report detailing gifts, hospitality and sponsorship declared in the period 05/12/18 to 06/03/19 was considered. It was agreed that confirmation should be sought from the Drugs, Therapeutics & Medications Management Committee of whether it reviewed prescribing trends in the context of identifying potential conflicts of interest
- An update was given on the 2018/19 Accounts process and, in reflection of the late circulation of the accompanying report, the Committee agreed that the accounting policies / approach to accounting estimates were approved subject to objections being received from AGC members by the Trust Secretary before 22/03/19
- The annual benchmarking report for the MTW NHS Trust Annual Report was considered and the areas where the Trust's performance had improved or deteriorated since the previous year noted. The Director of Audit, Grant Thornton UK LLP, agreed to facilitate a conversation between the Trust Secretary and the author of the report to discuss the rationale for the findings in more detail
- The Chief Finance Officer provided a verbal summary of the latest financial position
- The Committee agreed to recommend the circulated revisions to the Trust's Standing Orders for ratification by the Trust Board at its meeting in March. The Trust Secretary highlighted updates to the procedures to be applied in response to the "Fit and Proper Persons: Directors" Regulations within the standing orders
- The findings from the Committee's self-assessment / compliance with Terms of Reference exercise were considered and it was agreed that there were no significant areas of concern. It was however agreed that the Committee would be asked to review and approve an updated Internal Audit Charter in May 2019 and that an additional item should be included at the end of each future AGC meeting agenda to evaluate the meeting. It was further agreed to amend the next AGC committee evaluation to reflect the comments made at the meeting
- The Committee's forward programme was noted and it was agreed to confirm NED attendance at the year's AGC meetings in advance to ensure that a quorum was achieved.

2. The Committee received details of the following Internal Audit reviews:

- "Aligned Incentives Contract" (advisory review)
- "CFA – Payroll"
- "A&E Temporary Staffing Follow Up"
- "Data Security Protection Toolkit Part 1 – Status Update"
- "Clinical Governance"

3. The Committee was also notified of the following "Urgent" priority outstanding actions from Internal Audit reviews:

- Non Patient Related Income – 1 outstanding action

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:

N/A

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

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

Trust Board meeting – March 2019

NHS Maidstone and Tunbridge Wells NHS Trust

3-23 Annual Review of Board Terms of Reference — Chair of the Trust Board

The Terms of Reference for the Trust Board are required to be reviewed and approved at least every 12 months. That review and approval last took place in March 2018.

The Terms of Reference have therefore been reviewed, and a number of minor amendments are proposed, which are shown as 'tracked' on the following pages. None of the proposed amendments are significant, and can be categorised as 'housekeeping', to reflect changes that have already been agreed (as part of the approval of revised Standing Orders), or occur in practice.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Approval

[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

Terms of Reference

Purpose and duties

1. The Trust exists to 'provide goods and services for any purposes related to the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and the promotion and protection of public health'.

2. The Trust has a Board of Directors which exercises all the powers of the Trust on its behalf, but the Trust Board may delegate any of those powers to a committee of Directors or to a Member of the Executive Team. The voting members of the Trust Board comprise a Chair (Non-Executive), five other Non-Executive Directors, the Chief Executive, and four specified Members of the Executive Team). Other, non-voting members of the Trust Board attend Trust Board meetings, and contribute to its deliberations and decision-making.

3. The Trust Board leads the Trust by undertaking three key roles:
   3.1. Formulating strategy;
   3.2. Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable;
   3.3. Shaping a positive culture for the Trust Board and the organisation.

4. The general duty of the Trust Board and of each individual Trust Board Member, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the patients and communities served and members of the organisation.

5. The practice and procedure of the meetings of the Trust Board – and of its sub-c~~C~~ommittees – are described in the Trust's Standing Orders.

General responsibilities

6. The general responsibilities of the Trust Board are:
   6.1. To work in partnership with all stakeholders and others to provide safe, accessible, effective and well governed services for the Trust's patients;
   6.2. To ensure that the Trust meets its obligations to the population served and its staff in a way that is wholly consistent with public sector values and probity;
   6.3. To exercise collective responsibility for adding value to the Trust by promoting its success through the direction and supervision of its affairs in a cost effective manner.

7. In fulfilling its duties, the Trust Board will work in a way that makes the best use of the skills of all Trust Board Members.

Leadership

8. The Trust Board provides active leadership to the organisation by:
   8.1. Ensuring there is a clear vision and strategy for the Trust that is implemented within a framework of prudent and effective controls which enable risks to be assessed and managed;
   8.2. Ensuring the Trust is an excellent employer by the development of a workforce strategy and its appropriate implementation and operation.

Strategy

9. The Trust Board:
   9.1. Sets and maintains the Trust's strategic vision, aims and objectives ensuring the necessary financial, physical and human resources are in place for it to meet its objectives;
   9.2. Monitors and reviews management performance to ensure the Trust's objectives are met;
   9.3. Oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required;

9.4. Develops and maintains an annual plan and ensures its delivery as a means of taking forward the strategy of the Trust to meet the expectations and requirements of stakeholders;
9.5. Ensure that national policies and strategies are effectively addressed and implemented within the Trust.

Culture

10. The Trust Board is responsible for setting values, ensuring they are widely communicated and that the behaviour of the Trust Board is entirely consistent with those values.

11. A ~~Board~~ Code of Conduct has been developed to guide the operation of the Trust Board and the behaviour of Trust Board Members. This Code is incorporated within the Trust's Gifts, Hospitality, Sponsorship and Interests Policy and Procedure

Governance

12. The Trust Board:
    12.1. Ensures that the Trust has comprehensive governance arrangements in place that ensures that resources are appropriately managed and deployed, that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements;
    12.2. Ensures that the Trust complies with its governance and assurance obligations;
    12.3. Ensures compliance with the principles of corporate governance and with appropriate codes of conduct, accountability and openness applicable to Trusts;
    12.4. Reviews and ratifies Standing Orders, Reservation of Powers and Scheme of Delegation, and Standing Financial Instructions as a means of regulating the conduct and transactions of Trust business;
    12.5. Ensures that the statutory duties of the Trust are effectively discharged;
    12.6. Acts as the agent of the corporate trustee for the Maidstone and Tunbridge Wells NHS Trust Charitable Fund. This includes approving the Annual Report and Accounts of the Charitable Fund.

Risk Management

13. The Trust Board:
    13.1. Ensures an effective system of integrated governance, risk management and internal control across the whole of the Trust's clinical and corporate activities;
    13.2. Ensures that there are sound processes and mechanisms in place to ensure effective patient and carer involvement with regard to the review of quality of services provided and the development of new services;
    13.3. Ensures there are appropriately constituted appointment arrangements for senior positions such as Consultant medical staff and Members of the Executive Team.

Ethics and integrity

14. The Trust Board:
    14.1. Ensures that high standards of corporate governance and personal integrity are maintained in the conduct of Trust business;
    14.2. Ensures that Trust Board Members and staff adhere to any codes of conduct adopted or introduced from time to time.

Sub-Committees

15. The Trust Board is responsible for maintaining sub-committees of the Board with delegated powers as prescribed by the Trust's Standing Orders and/or by the Board from time to time

Communication

16. The Trust Board:

16.1. Ensures an effective communication channel exists between the Trust, staff and the local community;
16.2. Ensures the effective dissemination of information on service strategies and plans and also provides a mechanism for feedback;
16.3. Ensures that those Trust Board proceedings and outcomes that are not confidential are communicated publically, primarily via the Trust's website;
16.4. Approves the Trust's Annual Report and Annual Accounts.

Quality Success and Financial success

17. The Trust Board:
17.1. Ensures that the Trust operates effectively, efficiently, economically;
17.2. Ensures the continuing financial viability of the organisation;
17.3. Ensures the proper management of resources and that financial and quality of service responsibilities are achieved;
17.4. Ensure that the Trust achieves the targets and requirements of stakeholders within the available resources;
17.5. Reviews performance, identifying opportunities for improvement and ensuring those opportunities are taken.

Role of the Chair

18. The Chair of the Trust Board is responsible for leading the Trust Board and for ensuring that it successfully discharges its overall responsibilities for the Trust as a whole;

19. The Chair is responsible for the effective running of the Trust Board and for ensuring that the Board as a whole plays a full part in the development and determination of the Trust's strategy and overall objectives;

20. The Chair is the guardian of the Trust Board's decision-making processes and provides general leadership of the Board.

Role of the Chief Executive

21. The Chief Executive reports to the Chair of the Trust Board and to the Trust Board directly.
22. The Chief Executive is responsible to the Trust Board for running the Trust's business and for proposing and developing the Trust's strategy and overall objectives for approval by the Board;
23. The Chief Executive is responsible for implementing the decisions of the Trust Board and its committees, providing information and support to the Board

Membership of the Trust Board

24. The Trust Board will comprise the following persons:
24.1. The Chair of the Trust Board
24.2. Up to 5 Non-Executive Directors. One of these will be designated as Vice-Chair
24.3. The Chief Executive
24.4. The Chief Finance Officer~~Director of Finance~~
24.5. The Medical Director
24.6. The Chief Nurse
24.7. The Chief Operating Officer

Non-voting Trust Board Members (as stated in the Trust's Standing Orders) will be invited to attend Trust Board meetings at the discretion at the Chair.

Quorum

25. The Board will be quorate when four Trust Board Members including at least the Chair (or Non-Executive Director nominated to act as Chair), one other Non-Executive Director, the Chief Executive (or member of the Executive Team ~~Executive Director~~ nominated to act as

Chief Executive), and one other ~~Executive Director~~ member of the Executive Team ~~(~~voting member) are present[2].

26. An Officer in attendance for a voting member of the Executive Team ~~n Executive Director~~ but without formal acting up status may not count towards the quorum at Trust Board meetings

Attendance

27. The Trust Secretary will normally attend each meeting.

28. Other staff members and external experts may be attend Trust Board meetings to contribute to specific agenda items, at the discretion of the Chair

Frequency of meetings

29. The Board will sit formally at least ten times each calendar year. Other meetings of the Board will be called as the need arises and at the discretion of the Chair.

Board development

30. The Chair, in consultation with the Trust Board will review the composition of the Board to ensure that it remains a "balanced board" where the skills and experience available are appropriate to the challenges and priorities faced;

31. Trust Board Members will participate in Board development activity designed to support shared learning and personal development.

Sub-committees and reporting procedure

32. The Trust Board has the following sub-committees
    32.1. The Quality Committee
    32.2. The Patient Experience Committee
    32.3. The Audit and Governance Committee
    32.4. The Finance and Performance Committee
    32.5. The Workforce Committee
    32.6. The Charitable Funds Committee
    32.7. The Remuneration and Appointments Committee

33. For the Quality Committee, Patient Experience Committee, Audit and Governance Committee, Finance and Performance Committee, Charitable Funds Committee, and Workforce Committee, a summary report from each meeting will be provided to the Trust Board (by the Chair of that meeting) in a timely manner

34. The Terms of Reference for each sub-committee will be approved by the Trust Board. The Terms of Reference will be reviewed annually, agreed by each sub-committee, and approved by the Trust Board.

Emergency powers and urgent decisions

35. The powers which the Board has reserved to itself within the Standing Orders Set may in emergency or for an urgent decision be exercised by the Chair of the Trust Board and Chief Executive ~~and the Chair of the Trust Board~~ after having consulted at least two Non-Executive Directors.

36. The exercise of such powers ~~by the Chief Executive and Chair~~ shall be reported (by the Chair of the Trust Board) to the next formal meeting of the Trust Board in public session ('Part 1') for formal ratification.

[2] This number is set to accord with the relevant section of the Standing Orders, which states that "No business shall be transacted at a Trust Board meeting unless at least one-third of the whole number of the Chair~~man~~ and members (including at least one Executive Director and one Non-Executive Director) is present"

Administration

37. The Trust Board shall be supported administratively by the Trust Secretary whose duties in this respect will include:
    37.1. Agreement of the agenda for Trust Board meetings with the Chair and Chief Executive;
    37.2. Collation of reports for Trust Board meetings;
    37.3. Ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward on an action log;
    37.4. Advising the Trust Board on governance matters.

38. A full set of papers comprising the agenda, minutes and associated reports will be sent within the timescale set out in Standing Orders to all Trust Board Members and others as agreed with the Chair and Chief Executive.

Conflict with Standing Orders Set

39. In the event of a conflict between these Terms of Reference and the content of the Standing Orders Set, the content of the Standing Orders Set should take precedence.

Review

40. These Terms of Reference will be reviewed and approved at least every 12 months.

Approved by the Trust Board, 28~~9~~th March 2019~~8~~