Maidstone and Tunbridge Wells NHS Trust

Trust Board Meeting (Part 1) - Formal meeting, which is open to members of the public (to observe)

25 July 2019, 09:45 to 13:00
Lecture Rooms 1 and 2, Education Centre, Tunbridge Wells Hospital Formal

Agenda

07-1

To receive apologies for absence

David Highton

07-2

To declare interests relevant to agenda items

David Highton

07-3

To approve the minutes of the Part 1 Trust Board meeting of 27th June 2019

David Highton

Board minutes 27.06.19 (Part 1).pdf (10 pages)

07-4

To note progress with previous actions

David Highton

Board actions log (Part 1).pdf (1 pages)

07-5

Safety moment

Claire O'Brien / Sara Mumford

Safety Moment.pdf (3 pages)

07-6

Report from the Chair of the Trust Board

Verbal report David Highton

07-7

Report from the Chief Executive

Miles Scott

CEO report.pdf (2 pages)

Staff experience

07-8

Update from the Trust's Staff Network Chairs

Verbal item/presentation The Trust's Staff Network Chairs

Staff experience - Staff Networks (presentation).pdf (10 pages)

07-9

Integrated Performance Report for June 2019

Miles Scott

IPR (M3).pdf (50 pages)

07-9.1

Finance and Performance Committee, 23/07/19

Sarah Dunnett

07-9.2

Safe (infection control)

Sara Mumford

07-9.3

Safe

Claire O'Brien

07-9.4

Quality Committee, 10/07/19

Maureen Choong

Quality C'ttee, 10.07.19.pdf (6 pages)

07-9.5

Effective (mortality)

Sara Mumford

07-9.6

Effective

Sean Briggs

07-9.7

Caring

Claire O'Brien

07-9.8

Planned and actual staffing for June 2019

Claire O'Brien

Planned v Actual staffing - June 2019.pdf (3 pages)

07-9.9

Responsive

Sean Briggs

07-9.10

Well-led (workforce)

Steve Orpin

07-9.11

Well-Led (finance)

Steve Orpin

07-10

Update from the Best Care Programme Board

Miles Scott

Best Care.pdf (33 pages)

Quality items

07-11

Approval of the Trust's CNST maternity incentive scheme submission

The full suite of documentary evidence in support of the submission is available within the "Documents" folder within Admincontrol

C. O'Brien/S. Blanchard-Stow

CNST Submission.pdf (72 pages)

07-12

Safeguarding children update (Annual Report to Board, including Trust Board annual refresher training)

Claire O'Brien

Safeguarding Children Annual Report 2018-19.pdf (12 pages)

07-13

Safeguarding adults update (Annual Report to Board, including Trust Board annual refresher training)

Claire O'Brien

Safeguarding Adults Annual Report 2018-19.pdf (18 pages)

Planning and strategy

07-14

The transfer of Stroke services from Tunbridge Wells Hospital to Maidstone Hospital

Sean Briggs

Transfer of Stroke Services - TWH to MH.pdf (1 pages)

07-15

Approval of the refreshed Trust IT Strategy

Steve Orpin / Sue Forsey

Refreshed IT strategy - for approval.pdf (20 pages)

07-16

Update on the NHS Long Term Plan

Amanjit Jhund

Update on the NHS Long Term Plan.pdf (12 pages)

Assurance and policy

07-17

Report from the Freedom to Speak Up Guardian

Christian Lippiatt

FTSU Quarterly report.pdf (2 pages)

07-18

7 Day Services board assurance self-assessment

Sara Mumford

7DS Board Assurance Self assessment.pdf (5 pages)

Reports from Trust Board sub-committees

07-19

Finance and Performance Committee, 23/07/19: Approval of Business Case for a patient tracking system

Sarah Dunnett / Sean Briggs

Business Case for Real Time Patient Flow and Tracking Solution.pdf (50 pages)

07-20

Charitable Funds Committee, 23/07/19

Verbal update

Sarah Dunnett

07-21

To consider any other business

David Highton

07-22

To receive any questions from members of the public (please note that questions should relate to one of the agenda items)

David Highton

07-23

To approve the motion (to enable the Board to convene its 'Part 2' meeting) that:

David Highton

In pursuance of Section 1 (2) of the Public Bodies (Admission to Meetings) Act 19 60, representatives of the press and public be excluded from the remainder of the m eeting having regard to the confidential nature of the business to be transacted, pub licity on which would be prejudicial to the public interest

Date of next meeting: 26th September 2019, 9.45am, Pentecost/South rooms, The Academic Centre, Maidstone Hospital

0 minutes

MINUTES OF THE TRUST BOARD MEETING ('PART 1') HELD ON THURSDAY 27TH JUNE 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)
	Peter Maskell	Medical Director (except item 06-10, 06-11,and 06-13)	(PM)
	Claire O'Brien	Chief Nurse	(COB)
	Steve Orpin	Chief Finance Officer	(SO)
	Miles Scott	Chief Executive	(MS)
In attendance:	Selina Gerard-Sharp	NExT Director (from item 06-8)	(SGS)
	Simon Hart	Director of Workforce	(SH)
	Amanjit Jhund	Director of Strategy, Planning & Partnerships	(AJ)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Kevin Rowan	Trust Secretary	(KR)
	Gemma Craig	Deputy Chief Nurse (for items 06-8 and 06-12)	(GC)
	Saki Makena	Unit Manager, Ward 22 (for item 06-8)	(SMa)
	Caroline Berry	Patient's relative (for item 06-8)	(CB)
Observing:	Hannah Davies	Acting Head of Communications (from item 06-14)	(HD)
	Saki Makena	Unit Manager, Ward 22 (for items 06-1 to 06-8)	(SMa)
	John Weeks	Head of Emergency Planning & Response (from item 06-11)	(JW)
	Cassandra Daubney	Liaison Group	(CDa)

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

06-1 To receive apologies for absence

No apologies were received, but it was noted that Emma Pettitt-Mitchell (EPM), Associate Non-Executive Director, would not be in attendance. DH also reported that Professor Karen Cox (KC), who had been appointed as an Associate Non-Executive Director was also unable to attend.

06-2 To declare interests relevant to agenda items

No interests were declared.

06-3 Minutes of the 'Part 1' meeting of 23rd May 2019

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

06-4 To note progress with previous actions

The circulated report was noted.

06-5 Safety moment

COB referred to the relevant attachment and reported that the theme for June was being open and the duty of candour. COB then highlighted the following points:

- The Trust was required to comply with the duty of candour when there had been significant harm
- It was important to recognise that apologising to patients did not indicate that the Trust was liable for any harm
- The duty of candour required a letter to be sent containing an apology

- The work to comply with the duty aligned well with a number of initiatives including the work that SM was undertaking in relation to the case of Tim Mason
- Work was underway to address the shortfall in the issuing of duty of candour letters, as compliance was currently at 39%. However, the overall figure somewhat masked the fact that compliance was much higher for cases involving more serious harm

PM added that clinicians often needed support in writing duty of candour letters but he expected the compliance to improve.

SDu asked whether all new staff joining the Trust received any information on the duty of candour during their induction. PM stated that he did not know, but would check and confirm.

Action: Check and confirm whether the induction for new staff included reference to the Duty of Candour (Medical Director, June 2019 onwards)

MC stated that she was uncomfortable with the 39% compliance and queried whether something needed to be included in staff members' employment contracts. COB acknowledged the point but stated that such inclusion needed to be properly considered, and in the first instance she and PM would prefer to focus on the aforementioned staff induction.

SDu then asked for an update on the Task and Finish Group that had been established to respond to the issues arising from the Tim Mason case. SM confirmed an update report would be submitted to the next Quality Committee but explained that the action plan was being implemented although some of the actions would take time to complete. SM continued that there had been good engagement with the Divisions and the changes in the clinical governance structure would hopefully align with the work of the Task and Finish Group.

MS then referred back to compliance with the duty of candour and proposed that COB and PM liaise with SH and AJ to ensure that any communication and training opportunities were taken to promote the duty, including extending the principles to non-clinical staff.

Action: Liaise with the Director of Workforce and Director of Strategy, Planning and Partnerships to take advantage of any additional training and/or communications opportunities to improve compliance with the Duty of Candour requirements (including promoting the principles of the Duty among non-clinical staff) (Chief Nurse / Medical Director, June 2019 onwards)

06-6 Report from the Chair of the Trust Board

DH referred to the relevant attachment and highlighted the following points:
- He was sad to report that Nazeya Hussain (NH) had resigned as a Non-Executive Director, due to difficulties in allocating the required amount of time to the role. DH would like to write to NH, on behalf of the Trust Board, to thank her for her contribution. DH would consider what to do with the resulting vacancy
- KC had been appointed as an Associate Non-Executive Director and DH had asked her to become a member of the Workforce Committee
- Interviews for the other Non-Executive Director vacancy would be held on 16/07/19
- The Consultant interviews that had taken place were listed in the report, but it had been disappointing not to appoint more than one Consultant Oncologist due to the absence of a representative from the Royal College of Physicians. It was hoped to consider the issue further.

PM referred to the latter point and noted that a meeting had been held recently to consider the situation in oncology and the concept of appointing non-consultant staff.

06-7 Report from the Chief Executive

MS referred to the relevant attachment and highlighted the following points:
- NHS England had published its interim People Plan, which did not contain many measures, but did give direction. It would be useful to map the five themes with the Trust's actions, although the work being undertaken at the Trust aligned well with the themes. The Trust was therefore in a good position in relation to the priorities in the People Plan, but further work would continue

- The Trust's new interim Director of Estates and Facilities, Doug Ward, would start on 15/07/19, for one year. In addition to the day-to-day management of Estates and Facilities, Mr Ward would work with MS and the members of the Executive Team to consider what the future of Estates and Facilities should be for the Trust
- A new Divisional Director of Operations for Cancer Services, Katie Goodwin, would start soon
- As a correction, British Army Major Simon Dean came to the Trust at the beginning of the month, but not as part of the formal D-Day celebrations

SDu referred to section 2 of the report and stated that she had received feedback that it must have been devastating for the Trust's staff to have seen and read the recent media coverage regarding cancer access standard performance, and asked what had been done to communicate the improvements that had been made. MS confirmed that communications had taken place, including an interview he had done with the BBC, and more communications would follow. PM added that despite the Trust's performance, the Trust's outcomes were satisfactory and there had been some disappointment among staff regarding the media coverage. PM added that the harm reviews that had been undertaken on cancer patients that had breached the access targets, which had not identified any concerns, had also provided some assurance to staff. MC remarked that she felt the message MS had issued in his last weekly email bulletin to staff had achieved the right balance.

DH then referred to the overseas nursing recruitment the Trust was undertaking and asked for details of the clinical support being provided to help the recruits whilst they passed their Objective Structured Clinical Examination (OSCE). COB reported that a successful OSCE 'boot camp' had been established, whilst a meeting was scheduled on 28/06/19 to consider the vacancies, the recruits, the number of recruit who would arrive 'OSCE ready', the pastoral support needed, and accommodation (which was COB's main concern). COB added that she was keen to listen to the concerns from the Trust's Matrons in order to address these.

06-8 A patient's experience of the Trust's services

DH welcomed CB, GC and SMa to the meeting and explained that the Trust Board considered it important to hear patients' stories. SMa then reported the following points:

- Mr Berry, who liked to be known as Sam, was an inpatient on Ward 22 (the Stroke Unit) at Tunbridge Wells Hospital (TWH) following a stroke. Sam was in hospital for approximately 87 days, recovering from his stroke and undergoing a rehabilitation programme. Sam was diagnosed with a Left Middle Cerebral Artery Infarct (Stroke) and that affected his speech and swallowing, as well as his mobility
- Prior to his admission, Sam had led an active and independent lifestyle, and he lived with CB, his wife of 60 years. Sam had a strong Christian faith and was a founding member of "A Rocha", a Christian international environmental charity. He was also a Professor and an author of various publications and books.
- Sam's recovery from the stroke was slow, despite everyone's best efforts, and he was unable to return to his previous baseline and independent lifestyle. He was discharged home to live with CB, with support from carers, and was referred to the Community Neurological Rehabilitation team, for them to maximise his independence as much as possible
- Following his discharge, Sam's daughter, Alison, who was a nurse, met with SMa, the ward Matron, and one of the ward Occupational Therapists, to explain how distressing and frustrating it had been at times for Sam and his family during Sam's inpatient stay. Alison discussed her experience during that time as a daughter, not just as a nurse. It was not all bad, as Alison felt that her father was treated with dignity and respect, and staff always called him Sam, which was what he liked to be called. Alison and Sam's wife felt his care was "OK" but the ward wanted the care they provided to be better than "OK"
- The meeting with Alison was very moving and personal. SMa and her colleagues were very saddened by some of the feedback. They felt humbled and knew they needed to reflect on it. In particular they felt the need to review lessons learned and make some changes in how they communicated information with patients and families (particularly those staying on the ward for extended periods of time) and discharge planning. They did not want any family to feel unsupported or have that experience again on their ward.

- Several points Alison made during the meeting would remain with SMa and her colleagues for a long time. Alison talked about the waiting and not knowing who to ask for information, from the Emergency Department right through to her father's stay on Ward 22. For example, waiting for a diagnosis, waiting for the treatment plan, waiting for blood results and stool sample results. Alison had stated that she always wondered when she would be updated and what the results would be and she often felt that results were not being discussed with her father or CB. SMa and her colleagues asked themselves whether they would expect such questions to be answered if they had a relative in hospital, and they all agreed they would. They therefore knew they needed to make some changes to avoid that happening again.
- SMa and her colleagues had recognised that a hospital admission could be a stressful time for patients and their relatives; and that effective communication was important. Although they could not eliminate the waiting completely, patients and their relatives needed to be kept up to date on their progress, treatment plans and investigation results, as well as managing their expectations from the beginning. SMa had shared Alison's feedback at ward staffing meetings and at the bi-monthly Stroke Operational meetings, to review what changes could be made.
- Since the feedback, the ward had made some changes, and these were now embedded into daily practice: Each patient was allocated a key worker, and key workers were now allocated whilst patients were on the acute stroke section, to enable relatives to be introduced to their key worker as early as possible on the stroke pathway. Key workers would arrange an initial meeting with the patient and family if that was required.
- The ward had now successfully appointed a psychologist who was on the ward one day a week. They attended the ward's Board Round and supported patients (and families) who were recovering from a stroke as required i.e. joining in family meetings, home visits etc.
- The Clinical Nurse Specialists had introduced a Stroke Education Group across both hospital sites and these groups were held monthly for patients and their family and friends on the ward. Each multi-disciplinary team member introduced themselves and explained their role in how they would assist patients' recovery following a stroke. The Group was also supported by the Stroke Association for ongoing support in the community when patients were discharged.
- A Flow Coordinator, who helped support the team with discharge planning, had been introduced on Ward 2. This was a new role in the Trust and was currently being developed. The role helped communication with families when arranging family meetings.
- There was a new revised leaflet on the ward for families and relatives named "Welcome to the Stroke Unit at Tunbridge Wells Hospital". The leaflet was issued to patients and families as they were admitted to the ward.
- The nursing team now had a new 'Shift Brief' so that all members of staff were aware of any safety issues on the ward and any specific personalised care required for the patients
- MSa had allocated one hour, three times per week, to talk to relatives on the ward and these times were advertised

SMa then concluded by stating that although hearing negative feedback could be difficult, the ward staff needed to hear if things had not gone well, and then listen in order to reflect, learn lessons and make improvements. SMa added that staff should never forget that their patients were also the husband, father or friend of someone who was often extremely worried and anxious about their future. SMa stated that she would therefore like to thank Alison and CB for sharing their experiences, for reminding the team of that point, and for helping them make changes. SMa asserted that the team wanted their patient care to be excellent.

MC thanked CB for attending and asked SMa what happened when she was not available. MC also asked how SMa had tested whether the actions that had been taken had made a difference. SMa explained the arrangements and the approach to monitoring the impact of the actions.

SDu asked whether, if she was to walk onto Ward 22, she would see a poster that invited patients' family members to communicate with staff, and also identify who the staff where. SMa explained that pictures of staff were available, as was the aforementioned leaflet. CB added that she welcomed the introduction of a specified time at which SMa was available. SMa clarified that she was not only available for the three hours to which she had referred.

SDu referred to the Stroke Education Group and asked if patients that had been discharged between the dates of the Group's meetings had access to the Group. SMa confirmed that all patients had access to the Group, but it was acknowledged that more communication was required for patients who had been discharged.

NG stated that he was very struck by CB's comments regarding waiting and the comments had resonated with the recent experience of one of his own family members.

COB thanked SMa for her work in response to the case, and also thanked Alison and CB.

CB then clarified that the family had not made a complaint. COB acknowledged the point.

DH commented that 87 days was a very long length of stay and acknowledged that the situation must have been difficult to deal with. DH then thanked CB, GC and SMa for attending and added that the Trust Board would ensure that communication improved.

[N.B. CB left the meeting at this point]

PM then highlighted that the situation had occurred on a unit that was facing a large degree of uncertainty, which reiterated the importance of the response that had been given. PM then specifically thanked SMa for the work she had done.

DH asked whether relatives were present when ward rounds were undertaken. PM explained the situation & SMa added that families were always encouraged to attend ward rounds if they could.

06-9 Integrated Performance Report for May 2019

DH referred to the relevant attachment and highlighted that an Executive Summary had been included for the first time. MS added that the Summary intended to draw attention to the key issues requiring discussion and proposed that each of the domains in the Executive Summary be considered separately in the first instance.

SM therefore referred to the "Safe" domain and highlighted that the rehydration programme had been successful. DH acknowledged the good position in relation to Clostridium difficile infections.

SDu referred to the outbreak of Group A streptococcal infections in Essex and asked what assurance could be given that there would not be an incident in Kent. SM noted that there had been a higher level of Group A streptococcal infections for the year but that was not considered a cause for concern at present, although the situation was being closely monitored. SDu asked whether infection control procedures needed to be changed as a result but SM confirmed that the controls already in place at the Trust were adequate.

PM added that the Trust was caring for a patient who had been subject to the recent listeria outbreak, but that patient had not obtained the sandwich they had eaten from the Trust.

COB then referred to the "Safe" domain and highlighted that although the dashboard showed that there were no Never Events for May, a Never Event had been reported in June and the details were contained within the report. COB added that the incident had occurred in February 2019 and the duty of candour steps had been taken.

MS then noted that the points from the "Effective" domain would be covered via other aspects of the report and/or other agenda items.

COB then highlighted the details regarding the "Caring" domain:

- There had been some improvement in Friends and Family Test (FFT) response, except in Maternity, which had reduced. COB intended to report some feedback from the FFT surveys in future reports. A new company would soon be engaged for the FFT and the process would be changed as a result
- Complaints response performance had been appalling, at only 37%. Some of that was due to vacancies and sickness absence in the Central Complaints Team, but a new member of staff

would start on 01/07/19. The performance for June should be closer to 50%. COB was however confident that the process was correct.

SDu referred to the latter point and asked what work was being done to gain assurance on the Divisions' processes for responding to complaints. COB noted that she had not attended the Divisional Performance Review (DPR) meetings that had been held on 26/06/19, so asked others to comment. PM noted that the largest area of challenge for the Divisions was the administrative aspects of the complaints process, which were primarily being undertaken by General Managers, although the establishment of the Divisional clinical governance arrangements would assist. PM added that he had asked all Divisions to provide a robust plan as to how they would manage complaints for the next DPRs, as well as on their readmissions performance. SDu acknowledged the point but stated that the Finance and Performance Committee meeting on 25/06/19 indicated some concerns regarding ownership by Divisions. PM asserted that he had confidence in the quality governance arrangements.

MC asked whether the Divisions cared enough about the issue, as if it mattered enough, it would be a priority. COB acknowledged that she needed to be assured that there was full engagement by the Divisions.

SGS asked for an explanation of the data on the number of complaints open between 60 and 90, or more than 90 days. COB explained the approach and gave assurance that communication was undertaken with complainants in the event of a delay to the response. KR added that the understood that all complaints received were acknowledged within 48 hours, and COB confirmed that was the case.

SO then added further details of the discussion that had been held at the DPRs on 26/06/19.

DH then noted PM's reference to General Managers being involved in administrative processes of complaints and noted that he understood that such processes would be easier once the Datix IT system had been upgraded, which seemed to be taking a while to implement. PM explained the current situation with the Datix upgrade, but COB clarified that she understood the administrative aspects referred to by PM were more related to obtaining healthcare records.

NG asked about the 'earned autonomy' aspect of the Trust's performance management framework. AJ acknowledged the need to be more prescriptive with Divisions on certain aspects, whilst SB highlighted the large number of challenges faced by the Surgery Division, which had performed particularly poorly on complaints, and emphasised the need to give the Divisional leadership team support. SGS asked whether it would be easier to make complaints responses a higher priority. SB noted that complaints responses needed to be balanced with all of the other issues faced by the Division. The point was acknowledged.

SB then highlighted the following details for the "Effective" and "Responsive" domains:

- Performance against the A&E 4-hour waiting time target was slightly below the trajectory in May but the Trust was still within the top 20 best performing Trusts nationwide. June's performance was 94.23%, which was very close to the month's trajectory, and which placed the Trust as the fifth best performing in the country. The difference between the performance in June and in March 2019 was that the March performance had not felt sustainable but that was not the case for June
- Good progress was being made in achieving the Referral to Treatment (RTT) target

DH noted that the NHS Long Term Plan had a more transformational approach to outpatient appointments and follow-up appointments, and asked if any work had been undertaken to consider what that might mean over the next two years. SB confirmed that the Divisional Director of Nursing & Quality for Medicine & Emergency Care and Divisional Director of Operations (DDO) for Women's, Children's & Sexual Health were working on that aspect.

SB then continued, and highlighted the following points:

- SB wished to thank David Fitzgerald, the DDO for Cancer Services, who would leave the Trust soon. A new General Manager for Cancer performance had started and had already helped make improvements

- The total Patient Tracking List (PTL) was now just under 1500 patients
- The Trust's relative position nationally had improved but the performance in June and July was expected to worsen, given the focus on clearing the waiting list backlog

DH asked whether the Trust had been more proactive in its liaison with other Trusts who referred patients late in their cancer pathway. SB explained that that had been the case, but the recent rule change regarding such referrals provided opportunities, if the Trust treated referred patients within 24 days.

SH then highlighted the following points for workforce under the "Well Led" domain
- Thanks should be given to nursing colleagues who had participated in the large number of Skype interviews that had been held with overseas nursing candidates
- The Trust Board should be made aware that the support package being developed for overseas recruits would have a significant financial impact
- A Sustainability and Transformation Partnership (STP)-wide contract for medical agency staff would take effect from July 2019, and that was expected to have financial benefits

SDu asked whether work had been undertaken with local universities to see if they were able to contribute to the OSCE training support required by the overseas nursing recruits. COB confirmed that she believed there was sufficient internal capacity without needing to seek such support.

SO then highlighted the following points for finance under the "Well Led" domain
- The Trust was on plan overall, but there were some specific variances, which included an underperformance on private patient income
- Due to uncertainties regarding the capital programme, the Trust had explored ways to shift capital expenditure to revenue expenditure, but the costs for the Electronic Patient Record (EPR) that had been moved to revenue had now been moved back to capital
- The month 3 position would involve a forecast, which would be reviewed at the July 2019 meeting of the Finance and Performance Committee
- The Trust's cash position was strong
- There was now some certainty regarding the capital situation, and the pharmacy aseptic unit was the first development that would be progressed

DH then asked COB to highlight the content of the performance report that related to the Perinatal Mortality Review Tool (PMRT). COB duly highlighted the key points, noting that the Trust was compliant with the relevant requirements, but the next stage of development was to learn and identify any further actions that should be taken.

Finance and Performance Committee, 25/06/19

NG referred to the relevant attachment and highlighted the following points:
- The meeting had discussed the proposed development of the Acute Medical Unit (AMU) at Maidstone Hospital (MH), but it was noted that further discussions were needed on the governance, so these were scheduled for the 'Part 2' Trust Board meeting later that day
- The Surgery Division had been reviewed in detail and the discussion had focused on the support to be provided to Divisions
- It had been a long meeting, with lots of agenda items, so NG would liaise with KR to see what options existed for future meetings

Patient Experience Committee, 10/06/19

MC referred to the relevant attachment and highlighted that a workshop would be held in place of the next meeting, to discuss the future of the Committee. MC also noted that the Committee had challenged the response to the cancer patient survey to be more ambitious.

Workforce Committee, 23/05/19

MC referred to the relevant attachment and highlighted the key points therein. COB then highlighted the launch of the Schwartz Rounds and encouraged Trust Board members to attend.

06-10 Update from the Best Care Programme Board

MS referred to the relevant attachment and highlighted the following points:

- SO and his team had worked with each Senior Responsible Officer (SRO) to re-set the plans for each workstream
- A detailed alignment needed to be undertaken between the month 3 financial forecast and the savings profiles
- The Best Care Programme Board would transform into the Exceptional People Outstanding Care oversight programme and would be able to oversee all aspects of that programme

DH noted that he expected to see different reporting format from the Best Care programme in future. MS confirmed that that would be the case.

06-11 Review of the Board Assurance Framework 2019/20

KR referred to the relevant attachment and highlighted the following points:

- It was first time that Board Assurance Framework (BAF) had been considered by the Trust Board during 2019/20, following the Board's approval of the objectives in June 2019
- Ordinarily, the BAF would be considered by the Executive Team Meeting and Audit and Governance Committee before being submitted to the Trust Board, but that had not been feasible that time as the objectives were not approved until June
- The content of the report should not be a surprise, based on discussion held under item 06-9

SDu agreed with the latter point but noted that the content of the BAF did not address the cultural aspects that had been discussed under other agenda items. DH acknowledged the point but noted that the diagnostic phase of the Exceptional People Outstanding Care programme would be able to inform discussion regarding the measurement of such aspects, and therefore proposed to use the diagnostic phase rather than create a separate process. SDu agreed.

Quality items

06-12 Approval of Patient and Carer Strategy

GC referred to the relevant attachment and highlighted the following points:

- The strategy, "Making it Personal", had been co-produced by staff, patients and carers, which included patient engagement events at both Trust sites and local community centres
- Further engagement events had also been undertaken with 'hard to reach' groups
- The draft strategy had been discussed at various forums, including the Trust Management Executive (TME), and the final version of the strategy had been submitted for approval
- The next series of engagement events were being planned, as it had been agreed to hold these annually
- The key themes of the strategy were leadership and culture, engagement and responsiveness, information and communication, choice and control and integration and working across healthcare systems. The strategy also contained 10 priority areas
- The key deliverables would be overseen via the Best Quality workstream of the Best Care programme

MC added that the earlier versions of the strategy had been considered at the Patient Experience Committee. MC also commended the contribution of Kent Healthwatch.

COB thanked GC for the work and emphasised the importance of the engagement events.

DH also emphasised the importance of having well documented pathways when engaging with patients and carers and in that regard, the implementation of the EPR should help. COB and GC concurred.

AJ proposed that it would be helpful to make a specific reference between the objectives, priorities and deliverables and the Trust's PRIDE values, and offered to work with GC on that. GC agreed.

Action: Arrange for the Patient Experience Strategy 2018/19 – 2021/22 to be amended to make a specific reference between the objectives, priorities and deliverables and the Trust's PRIDE values (Chief Nurse, June 2019 onwards)

SO remarked that many of the priorities in the strategy had a leadership component and asked how many of these were aligned with the work SH was undertaking on leadership behaviours. SH confirmed it would be sensible to ensure that the key leadership aspects from the strategy were incorporated into that work from the start.

NG asked how the strategy linked to the Quality, Service Improvement and Redesign (QSIR) programme. GC acknowledged the need for such links and added that she was on the same QSIR Practitioner cohort as PM and SO.

MS stated that it was important for staff to be clear on the concrete aspects of what the strategy actually meant i.e. rather than just doing more of the same. The point was acknowledged

The strategy was approved subject to the amendment proposed by AJ.

06-13 Update on the response to the issues raised during the "A patient's experience of the Trust's services" item at the Trust Board meeting on 25/04/19

COB referred to the relevant attachment and highlighted the following points:
- A privacy sign had been agreed for use on all side rooms across the Division
- The Practice Development Nurses continued to work with Clinical Support Workers
- The patient's family had now confirmed they had received a cheque for the lost wedding ring
- The patient's daughter had been involved in the revision of the Trust's patient property policy

06-14 Approval of Quality Accounts, 2018/19

COB referred to the relevant attachment and highlighted the following points:
- Earlier drafts of the document had been considered at the Quality Committee and Patient Experience Committee
- The content hopefully aligned with the Patient and Carer Strategy considered under item 06-12

The Quality Accounts were approved as submitted.

06-15 Quarterly mortality data

PM referred to the relevant attachment and highlighted the following points:
- The Trust's Hospital Standardised Mortality Ratio (HSMR) continued to decline and figure 3 showed the latest position
- The Mortality Surveillance Group (MSG) was widening its remit to consider other aspects, and was also reviewing the differences in mortality between the weekend and weekdays
- The MSG was also leading the work to introduce the Medical Examine role
- PM had congratulated the Medicine & Emergency Care Division at the DPRs held on 26/06/19 for its work in relation to the completion of mortality reviews

DH commended the progress that had been made in relation to mortality over the last two years. PM stated that he believed there was a relationship between the improvements and the engagement with the MSG. MS asked PM whether he believed the MSG was genuinely interested in learning lessons from the data. PM confirmed that was the case.

06-16 Findings of the national inpatient survey 2018

COB referred to the relevant attachment and highlighted the key points therein. COB then noted that the survey would be discussed in more detail at the Quality Improvement Committee and the resulting action plan would be submitted to the Patient Experience Committee.

Planning and strategy

06-17 Winter planning and Operational Resilience 2019/20

SB referred to the relevant attachment and highlighted the following points:
- A winter group would start to meet during July and August to develop the plans
- There had been close working with community services
- Various initiatives from the previous year had been successful, and would be repeated

- The Trust Board would continue to be updated on progress

MC commended the clarity of the Boarding Guidelines in Appendix 1.

06-18 Six-month review of the implementation of the plans to develop a clinically led organisation

AJ referred to the relevant attachment and highlighted the following points:
- The details had been discussed at the Trust Board 'Away Day' in June 2019, but the document had since been updated, as the content had been discussed at other forums
- AJ would work closely with the Divisional and Directorate boards in response to the findings, and that work would include setting out the clear deliverables expected from each triumvirate

Assurance and policy

Reports from Trust Board sub-committees

06-19 Audit and Governance Committee, 23/05/19

MC referred to the relevant attachment and highlighted that the deadline for completion of the delayed Conflict of interest policy had been set for August.

06-20 Workforce Committee, 23/05/18: Quarterly report from the Guardian of Safe Working Hours

DH and MC referred to the relevant attachment and highlighted the key points therein.

06-21 Rainbow Badge pledge

PM referred to the relevant attachment and highlighted the key points therein, which included that the Trust had improved its Stonewall profile. PM also read out the wording of the pledge.

SDu asked what assurance could be given to staff members who worked in areas in which the Rainbow Badge was not worn. MS replied that although wearing the badge was a choice, he would expect the Trust's PRIDE values to be used to challenge any staff member not exhibiting expected behaviours. DH added that the assumption that anyone not wearing a Rainbow Badge was in some way anti-LGBT+ should be challenged. The points were acknowledged. DH also emphasised that it was not compulsory for Trust Board members to sign the pledge as individuals.

The Trust Board supported the Rainbow Badge pledge. Individual Trust Board Members were then invited to sign the pledge after the meeting.

06-22 To consider any other business

PM referred back to the first action agreed under item 06-5 and confirmed that duty of candour was included in staff induction.

KR then asked that the Trust Board delegate the authority to the 'Part 2' Trust Board meeting scheduled for later that day to make decisions regarding the revised AMU at MH and the internal configuration of the Trust's current stroke service. The requested authority was duly delegated.

06-23 To receive any questions from members of the public

No questions were posed.

06-24 To approve the motion (to enable the Trust Board to convene its 'Part 2' meeting) that in pursuance of Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest

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

Trust Board Meeting – July 2019

NHS Maidstone and Tunbridge Wells NHS Trust

Log of outstanding actions from previous meetings **Chair of the Trust Board**

Actions due and still 'open'

Ref.	Action	Person responsible	Original timescale	Progress[1]
N/A	N/A	N/A	N/A	N/A
				N/A

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
6-5a	Check and confirm whether the induction for new staff included reference to the Duty of Candour	Medical Director	27th June 2019	It was reported under the "To consider any other business" item at the Trust Board meeting on 27/06/19 that the Duty of Candour included in induction
6-5b	Liaise with the Director of Workforce and Director of Strategy, Planning and Partnerships to take advantage of any additional training and/or communications opportunities to improve compliance with the Duty of Candour requirements (including promoting the principles of the Duty among non-clinical staff)	Chief Nurse / Medical Director	July 2019	The Patient Safety Manager has scheduled a programme of one-hour lunchtime duty of candour workshops, aimed at all staff, and these sessions will then be incorporated into the rolling programme of patient safety learning. The Patient Safety Manager will also be giving presentations on the duty of candour at clinical governance meetings
6-12	Arrange for the Patient Experience Strategy 2018/19 – 2021/22 to be amended to make a specific reference between the objectives, priorities and deliverables and the Trust's PRIDE values	Chief Nurse	July 2019	The requested amendment has been made

Actions not yet due (and still 'open')

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

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

Safety Moment — **Chief Nurse/ Deputy Medical Director**

The Safety Moment for July has been focussed on diabetes. A key reason for choosing this safety moment for July is in response to a serious incident that has identified learning opportunities for the Trust to implement in practice to improve the overall management of diabetic patients when they are inpatients in the Trust. A summary of the key messages that have been shared each week have been as follows:

Week One 01/07/2019

Staff were informed during the first week that Variable rate Insulin Infusion guidance is now on QPulse - our system to support staff to access important policies and guidelines to support patient care.

There is a quick reference tool with 5 other appendices. Some key points :

- Withhold usual diabetes treatment but continue the background long acting insulin when starting VRIII
- Monitor Blood glucose levels hourly
- Use concomitant fluid as per appendix in the VRIII policy and do not swap substrates according to blood glucose level
- Check electrolytes daily
- Review the patient within 6 hours to make sure CBG are in target range
- Use the traffic light points appendix for stopping and starting VRIII safely
- Managing Hyper or hypo glycaemia following discontinuation of VRIII

Week Two 08/07/2019

During this week staff were asked to think about where the hypo box on their ward or department is located with some key messages.

Do you know where the hypo box is for your ward / area and what is in it?

Check it out and read the summary of Hypoglycaemia policy in the box

Key messages:

- All readings below 4 should be treated as a hypo
- Check Blood glucose 15 mins after treating a hypo
- Don’t give starchy food until the hypo has resolved with glucose (juice etc.)
- Don't omit regular insulin after treating a hypo
- Reduce the insulin dose if appetite poor
- Increase frequency of monitoring after a patient has had a hypo:

Test BG level: 1hrly for first 2 hours, then 2hrly for 4 hours, then pre meals, 22.00 hours and 02.00 until DSN or medical review.

Avoid hypos by:

- Ensuring carbohydrate at each meal
- Giving diabetes medication with meals
- Omit diabetes tablets if not eating
- Reducing diabetes medication doses if CBG < 6 mmols/L and appetite is poor

Weeks Three and four

The remainder of the month has focussed on providing information about the National Diabetes inpatient audit

National **D**iabetes **I**npatient **A**udit – which measures key NaDIA Harms - **measures frequency of avoidable harmful episodes**

Part of National Diabetes Audit (NDA) programme commissioned by Healthcare Quality Improvement Partnership (HQIP)

All hospitals in England are expected to submit data on 4 types of Diabetes Harms

Key objectives

- Measures frequency of avoidable harmful episodes
- Help reduce the rates of serious inpatient harms
- Local and National benchmarked reports to help drive improvements in care

NaDIA Harms:

- Applies to all diabetes inpatients aged 17 and older
- Assesses frequency of four types of harm

National Findings

- Around 1 in 25 in patients with type 1 diabetes develop DKA during their hospital stay.
- 1 in 4 will experience a hypo
- The percentage of hospital-acquired foot ulceration has halved amongst people with insulin-treated diabetes
- But 1/3 with active foot disease didn't have their feet assessed within 24hrs

HARM 1: Severe Hypoglycaemia-The Patient required injectable rescue treatment more than 6 hours after they were admitted to MTW

- Nationally **1 in 4** will experience a **hypo** whilst in hospital
- Required Injectable treatment of either:
    - Glucagon injection
    - 10% or 20% dextrose by infusion to correct a hypo

Hypoglycaemia can be avoided by:

- Matching insulin with carbohydrate
- Reducing medication if the person's appetite is reduced or if renal function declines
- Anticipating changes that affect diabetes control
- Listening to the patient about how they manage their diabetes

NaDIA HARM 2: New onset **Hyperglycaemic Hyperosmolar State (HHS)** > 24 hours after admission to hospital?

- This can develop due to dehydration during severe hyperglycaemia
- High dose steroids can precipitate extreme hyperglycaemia

Underlying factors/common themes

- Patient is not self-managing/lack of clarity re "ownership" of diabetes
- Previous incidents of DKA with that patient
- Communication breakdown between staff (e.g. during transfer of care)
- Delay in escalating/recognising potential risks
- Low staffing levels/high level of temporary staff
- Night time omission of basal insulin

Monitor - Identify risks- Communicate - Escalate to senior

Inform Diabetes team if a patient is at risk of, or develops DKA or HHS on your ward

See DKA policy on MTW Intranet guidelines

HARM 3 New onset **Diabetic Ketoacidosis (DKA)** > 24 hours after admission to hospital?

- Nationally around 1 in 25 in patients with type 1 diabetes develop DKA during their hospital stay.
- DKA develops in type 1 diabetes due to insufficient insulin

HARM 4: New Foot Ulcer

Was the patient diagnosed with a **new** onset foot ulcer more than 72 hours after admission?

- Nationally the percentage of hospital-acquired foot ulceration has halved amongst people with insulin-treated diabetes but 1/3 with active foot disease didn't have their feet assessed within 24hrs
- Ward needs evidence within first 24 hours of no foot ulcer
- Complete foot assessment chart on back of blood glucose monitoring chart
- A foot ulcer is a broken area of skin on the foot (below ankle)
- Increased risk in hospitalised patients with diabetes
  - Due to neuropathy and peripheral vascular disease
  - Patient may not recognise that trauma has occurred
  - Tight shoes/socks/stockings or pressure from end of bed/bedding
  - Catching feet on bedside trolley
- Complete the Foot Assessment Form within first 24 hours (document evidence of no foot ulcer) Escalate any abnormalities
- Check feet daily thereafter and record any new changes on a new foot assessment form
- Number of new diabetic foot ulcers reported to DSNs:

Underlying factors/common themes

- Patient is not self-managing/lack of clarity re "ownership" of diabetes
- Previous incidents of DKA/ hypos with that patient
- Communication breakdown between staff (mostly during transfer of care)
- Low staffing levels/high level of temporary staff
- Night time omission of basal insulin
- Delay in escalating/recognising potential risks
- Surgical patients

Recommendations:

- **"**Think Glucose" Referrals
- Escalate
- Monitor
- Complete Foot assessments within 24 hours of admission
- Look out for new policies being launched for diabetes
- Robust shift hand over and ward transfer hand over of glycaemic management of diabetes

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

Report from the Chief Executive **Chief Executive**

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

1. As a result of significant specialist nursing recruitment challenges, in particular to our Thrombolysis service, we will be making some temporary changes to our stroke services. From late September we will be consolidating our stroke services on one site and moving our stroke ward at Tunbridge Wells Hospital to Maidstone Hospital. This move will ensure we can continue to deliver high quality and safe stroke care for patients. While the move is temporary, it is unlikely the decision will be reversed before the configuration of stroke services in Kent and Medway. We are not creating a hyper acute stroke unit (HAUS) / acute stroke unit (ASU). This will come later once detailed implementation plans as part of the Kent and Medway Stroke Services Review have been agreed and following the outcome of the judicial reviews and referral to the Secretary of State for Health and Social Care. We will be talking to patients, carers and other groups over the coming weeks about the temporary move and our plans.

2. More than 200 of our staff, including the Trust Board, have signed the NHS Rainbow Pledge and are now proudly wearing the NHS Rainbow badge. The badge is just one of the ways that we can show MTW is an open, non-judgemental and inclusive environment. It also acts as a visual aid to help increase awareness of these issues, allowing us to take steps to improve the experiences of healthcare for LGBT+ patients and their families. Staff also joined the recent Canterbury Pride event and will be walking in the Tunbridge Wells Pride parade in August.

3. New flagpoles have been erected at both hospital sites, which will fly the Rainbow flag during Pride season as well as at other times of LGBT importance, and the Union flag for the rest of the year.

4. Thanks to the Teenage Cancer Trust, Lord North Ward at Maidstone Hospital has undergone a makeover. The charity funded the cost of new signage in the ward and bright and bold wall murals depicting some of the scenic sights in Kent. These improvements have created a more homely, social environment to help teenagers and young adults combat isolation and loneliness. The quiet room has also been rejuvenated to provide a relaxing space to socialise with family and friends.

5. Staff from Kent Oncology Centre have been passing on their knowledge to help cancer patients across the country. Clinicians have mentored staff at The Royal Marsden NHS Foundation Trust to carry out their first ever Low Dose Rate (LDR) prostate brachytherapy using cutting-edge 4D technology. MTW is one of the largest centres in the UK to provide the treatment, performing over 750 implants since 2006.

6. MTW teamed up with East Kent Hospitals University Foundation Trust to host a stand at the Kent County Show. The stand featured displays of the Trust's history as well as information about careers, apprenticeships and volunteering. More than 30 attendees signed up to volunteer in our hospitals or expressed a strong interest in working at the Trust.

7. A programme to improve the staff experience at MTW has been rolled out. We are undertaking a number of exciting projects to develop our facilities and amenities for staff across our hospitals. Some of the things we're doing include making improvements to our outside and inside breakout spaces; providing health and wellbeing sessions; giving free fruit for staff; upgrading our changing facilities; and developing plans to extend our staff bus service. A huge thank you to the Morrisons Foundation who have donated £10k to rejuvenate the Café Plus One restaurant at Maidstone Hospital.

8. A new purpose-built acute assessment unit (AAU) at Maidstone Hospital has been given the go-ahead and work on the £8m project is now progressing at pace. The AAU, which will be located next to the Emergency Department, will house 14 short stay beds, eight assessment

beds and a treatment suite comprising three separate treatment rooms. The modular unit is already being built off-site and ground works will start on-site from August. It is anticipated the unit will be fully operational by January 2020.

9. Congratulations to our Research and Development team who have been ranked 3rd in the National Institute for Health Research (NIHR) research activity league table for Kent, Surrey and Sussex. A total of 3,023 people took part in our research projects in 2018/19 – a 96% increase on the previous year.

10. MTW is one of only nine trusts in England that have been selected to pilot a virtual consultation system. The system will allow patients to attend their clinical consultation using a computer or mobile device. Sexual Health, Specialist Medicine and the Emergency Department services will trial the virtual system with the first clinics due to start in the summer.

11. Thank you to Maidstone Hospital League of Friends for their generous donation, which has funded a life-saving piece of equipment for the Emergency Department at Maidstone Hospital. The £51k Sonosite X-Porte ultrasound machine provides the latest image guidance technology, enabling clinicians to further improve the care we give our patients.

12. Our Fundraising team hosted our first ever NHS Big Tea events across both our hospitals. Staff were busy baking cakes and hosting special tea parties to raise funds for our charity. In total nearly £300 was raised.

13. The Executive Directors and Chiefs of Service continue to meet weekly at Executive Team Meetings. Key areas of discussion over the past month have included:
    - Implementation of our digital transformation programme, including rolling out our new Electronic Patient Record system
    - Performance updates on cancer, RTT and ED
    - Review of financial position
    - Development of the West Kent Integrated Care Partnership (ICP)
    - Review of the Trust's stroke services
    - Winter planning
    - Nurse recruitment and future plans

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

Integrated Performance Report, June 2019	**Chief Executive / Members of the Executive Team**

Enclosed is the new format Integrated Performance Report for Month 3.

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

NHS
Maidstone and Tunbridge Wells NHS Trust

Integrated Performance Report

July 2019

MTW
exceptional people, outstanding care

Contents

Coming Soon

Please note that this report is still in development, future developments will include the following:

- Improved forecasting for key KPIs
- New overview scorecard presentation ‘steering wheel’
- Data quality star ratings for each KPI
- Additional clinical outcome measures to be included in the ‘Effectiveness’ section
- Glossary

Executive Summary

July 2019

Safe

Infection Control:

The Trust continues to achieve the trajectory for the rate of Cdifficile, having reported 14 cases (5 in June) against a maximum limit of 15 to date. Gram Negative Bacteraemia blood stream infections and MSSA cases remain below the level of cases reported for 2018/19.

There were no incidents of MRSA blood stream infections reported, however screening compliance for the non-elective pathway deteriorated in June to 90% against a target of 95%. Screening for the elective pathway remains above target.

Harm-Free Care:

The Trust continues to deliver a high level of Harm Free Care (98%). The number of falls and hospital acquired pressure ulcers reported remained the same in June as it was for May, however the rate of falls and pressure ulcers increased as the number of occupied beddays was lower in June. The rate of falls year to date is now slightly above the maximum limit at 6.2 falls per 1,000 occupied beddays.

The number and rate of falls continues to be higher for the Tunbridge Wells site, with an increase in the rate of falls in June for Trauma & Orthopaedics (T&O) in particular (11.5 compared to a full year rate of 7.2 in 1819), However, the rate of falls within the Medical and Emergency Care Division is starting to show a downward trend at this site.

Serious Incidents (SIs):

There was one Never Event reported in June relaing to the Neonatal Unit at TWH.

There has been a reduction in the number of SIs reported in both May and June with 8 SIs reported in June resulting in a rate of 0.41%. The number still open remains at a similar level to last year. There are 52 SIs currently open that have passed their breach date for closure

Of the 8 SIs reported 1 related to a patient fall compared to six in May.

Patient Safety Incidents:

The rate of Patient Safety Incidents that have caused severe harm has reduced in June, following the increase in May, and there has been a decrease in the numbers reported for patients with Dementia in both May and June.

The number of incidents recorded of abuse towards staff from patients increased from 22 to 31 in June which is 78% of all incidents of aggression reported (similar level to 2018/19).

Safe Staffing:

The Safe Staffing fill rate is showing a slightly downward trend since February 2019 at 94% in June, however this remains above the target of 93.5%.

Effective

Mortality:

The Risk Adjusted Hospital Standardised Mortality Rate (HSMR) and SHMI both remain within acceptable limits. The HSMR over the last 12 month period has been below 100 for the last four reporting periods.

Emergency Readmissions:

There continues to be an increase in emergency readmission rate for patients who were originally admitted on a non-elective pathway. This increase is attributed largely to the increased use of the short stay units. The cohort of patients that are treated on a same day emergency care (SDEC) pathway have a higher likelihood of re-attending and the SDEC models of care are designed to manage these patients within these settings, rather than requiring the patient to be admitted for a longer hospital spell.

Year to date the rate of emergency readmissions for those who were originally admitted as a non-elective patient has remained similar to 2018/19 at 14.8% compared to 14.7%. If the patients who had a zero LOS (are on SDEC pathway) are removed from the calculation, then the rate has been fairly similar over the last few years (consistently between 10% and 11% since April 2017).

The emergency readmission rate for patients with a zero LOS only (including patients returning to the Clinical Decision or Assessment Units without then being admitted to a main ward) has shown a significant upward trend from a low of 10.9% in April 16 to 15.5% in June 19. Further work needs to be completed to understand increase and agree the best method of reporting this information in future reports, given the different pathways involved.

Emergency readmissions for those who were originally admitted on an elective pathway have remained constant.

Stroke:

There has been a change in the way that Stroke Indicators are calculated to ensure best practice. A full report on these indicators is being developed and will be reported on in next month's Board papers.

Performance for patients spending 90% of their time on a Stroke Ward dipped in April and May but has improved in June to 80%, therefore achieving the national target

Performance for TIA cases with a higher risk of stroke being treated within 24hrs decreased in May (data runs one month behind) to 53.3% which is therefore below the 60% national target (57.1% YTD)

Caring

The Friends and Family Test positive feedback rates are showing an improving trend for inpatients which remains above the 95% target, however the response rate decreased in June. Maternity positive feedback performance has dipped to just below the target in June.

The positive feedback rates for A&E were above the national target across both sites all year round during 2018/19. April and May performance was lower than plan for both sites which may have been linked to the increase in A&E Attendances. There has been a significant improvement in June to 91.6% which is back to previous levels and above the target for both sites. FFT leads will continue to monitor progress through the monthly review meetings.

Maternity have identified the key cause for the fluctuating response rate and are progressing actions to mitigate this in future.

The overall number of complaints received has remained fairly consistent month on month. This, along with the results of the Friends and Family surveys indicates a good level of satisfaction in the services we provide from our patients and relatives; however communication with patients/relatives remains a key theme within complaints, being the most frequently raised issue. However, this area has shown a significant reduction in June.

Achievement of the required complaints response times has been more challenging. Performance in June improved but remains significantly lower than target at 45.7%. Divisional performance was at 82.6%, however, vacancies in the central complaints team and other external factors (SI process, third party involvement) impacted on the Trust's overall performance.

A new post for the complaints team is currently in the recruitment process and the vacant Complaints Lead post was filled on 1 July

The number of complaints open between 60 and 90 or more than 90 Days is increasing. Whilst there had been some improvement in this area, we have seen a decline in performance which is now an area of focus.

Responsive

Non-Elective Flow:

June 2019 saw 13,577 attendances, the 4th highest monthly total, and the 2nd busiest month ever in terms of average daily attendance. July is on course to be the busiest month ever, and the week ending 14-Jul was the busiest week ever at 3,490 type 1 attendances.

Type 1 attendances in Quarter 1 were 1.4% higher than the trajectory and total attendances including the MIUs were 2.3% above trajectory. The full year projection now stands at 165,404, which would be 6.1% higher than 2018/19 and 3.9% above the trajectory. The last 52 week's attendances are 7.5% higher than the preceding 52 weeks.

The number of patients being streamed to the on-site GP is increasing this year and is 9% of all A&E Attendances.

Fortunately, emergency admissions are not increasing at the same level. So far this year 19.1% of A&E Attendances were admitted to a main inpatient ward compared to 20.8% last year. Another 11.6% were admitted to the Clinical Decision Unit (CDU) but did not then need to occupy a general and acute bed or go outside of the Emergency Department.

The level of non-elective admissions that were same-day emergency care is increasing. June was 26.7% and YTD the level is 25.4% compared to 23.7% last year.

Delayed Transfers of Care (DToC) has improved further in June to 3.93%, 4.14% YTD. The average daily bed occupancy across the Trust has been 92.9% so far this year, with escalated beds accounting for 2.8% of total, compared to 3.23% for Quarter 1 last year.

4 Hour Emergency Target

Despite near record attendances in June, the Trust managed to improve 4 hour performance with 94.50% in June, delivering the 2nd highest monthly score since 2015, and achieving the most challenging trajectory target of the year. The Trust remains in the top 15% of performing Trusts in the country, and in the first quarter of the year, the Trust performance 5.7% higher than the national average for all attendances, and 11.1% higher for Type 1 only attendances.

The trajectory target for July is 93.29% and as at 16-Jul, performance is at 93.85%. The Trust continues to develop processes to improve patient flow.

Ambulance Handovers:

Following the increase in delays of 30-60minutes seen in May performance improved in June but delays remain higher than the average per month usually seen during the summer months (358 in June and an average of 470 per month in Quarter 1 compared to the average of 300 per month usually seen in summer months). Delays of more than 60 minutes also decreased to 26 which is below the average level (35) usually seen in summer months. Ambulance activity has increased in line with the overall increase in Type 1 A&E Attendances, with ambulance activity currently running at 8%.

The Trust is ensuring that there is consistent liaison with the Ambulance Trust (SECAmb) on each day to manage peak demand. In addition, there is an increased use AEC/Frailty services and funding has been approved for flow coordinator.

The Trust is in discussion with SECAmb to ensure that when their new ambulance system is developed (ePCR) it will include a process for handover confirmation in real-time to improve the data quality of the handover delays information

Elective Flow:

Referrals are 1.3% below plan year to date (YTD). However, the expected increase in demand due to the implementation of the Prime Provider Model can be seen for T&O and General Surgery but has been offset by a decrease in demand for Ophthalmology and ENT. It is anticipated that the reduction in Ophthalmology may be due to delays in the triaging service. The Trust are working with the Clinical Commissioning Group (CCG) to resolve this.

The Musculo-skeletal (MSK) pathway for T&O has a backlog of 2,200 patients YTD. The Trust are working with the CCG as it is estimated that 23% of patients will convert to surgery.

New Outpatient activity decreased from May and is now at the average for the year and is 1.7% below plan YTD. However, for the main Referral to Treatment (RTT) Specialties this is 7.9% below plan YTD. Specialties furthest from plan remain Gastroenterology, T&O, ENT and Ophthalmology which is directly impacting on their achievement of their non-admitted RTT Trajectories. Options to increase capacity further to meet demand are currently being explored.

It should be noted that the activity levels since April will be slightly understated due to the activity being done in the independent sector not currently being recorded on the Trust Patient Administration System (PAS) in a timely manner. A new process has been implemented from 1st July to ensure capture of this data.

There are some data quality issues regarding the outpatient utilisation figures as the clinic templates need changing so current performance is understated, however utilisation remains low in some areas. A plan to change the templates and improve utilisation is being devised.

The Trust is currently implementing the Outpatient Transformation Project. The aim of this is to ensure that the team are able to achieve the system wide delivery expectations and to identify new and innovative ways to deliver quality of care to our patients, such as by reducing face to face outpatient appointments, one stop clinics and clinical pathway reviews. It is anticipated that this will provide further efficiencies in outpatients.

Following the increase in overall elective (inpatient and day case) activity seen in May, activity reduced in June and was 9.6% below plan (4.4% below plan YTD). This reduction was mainly driven by Ophthalmology and General Surgery day case activity as well as a decrease in inpatient activity for General Surgery and Trauma & Orthopaedics (T&O). The specialties furthest from plan year to date

remain T&O, Ophthalmology, Urology, Cardiology and Gynaecology which is directly impacting their achievement of the RTT admitted pathway trajectories. General Surgery is 4% above plan overall.

The operational teams within those specialties are currently devising plans to bring activity back on plan. These will be monitored through the new Weekly Access & Performance Meetings commencing in August.

Overall Theatre Utilisation has remained fairly static at 86.4%. For theatre sessions that started within 15 minutes of their scheduled time there was a 10% improvement in May. June performance dipped by 3% but remains 7% higher than previous levels. However, this performance remains low at 38%. There was a drop in Theatre activity in June which equated to a drop of an average of 6 cases per working day. The drop was across all specialties but was predominantly in Ophthalmology.

Operational teams are reviewing capacity plans and looking at ways to further improve efficiency. new Weekly Access & Performance Meetings are commencing in August

Referral to Treatment (RTT) Incomplete Pathway:

June performance has increased further for the Incomplete RTT Pathway constitutional target, achieving 85.78% against a trajectory target of 84.01%. The Trust Waiting List has increased slightly for June 2019 and was slightly higher than trajectory; however the backlog was 459 (10%) lower. The over 18week backlog is continuing to show a downward trend with a further 3.3% reduction in June from the May position. The majority of main specialties achieved their RTT Trajectory for June with the exception of Ophthalmology.

Whilst the overall Trust performance has increased, partly due to the ongoing validation, due to the reduced level of activity in June previously mentioned some specialties are significantly below their activity plan YTD which has led to an increase in the waiting list or backlog for some areas. If this level of activity continues this will start to have an impact on the Trust's ability to achieve the RTT Trajectory. The current level of validation will reduce in future months as the Patient Targeted List (PTL) becomes cleaner.

Weekly monitoring of the specialty plans for activity, diagnostics, theatre scheduling, backlog and waiting list size continues through the PTL and specialty meetings.

There were 6 52 week breaches reported for June (3 New in month) although these patients have not yet been fully validated. All patients will have a harm review by the managing Consultant. No harm has been found as yet for the ones which have been completed.

The Trust RTT Data Quality Project continues and the training for RTT has been revised with more advanced training for some staff currently being scheduled.

Diagnostic Waiting Times <6 weeks:

Due to both the technical issues experienced in this and other Trusts with the GE RIS (Imaging system) during June as well as an increase in breaches in endoscopy, for the first time the Trust was not able to achieve the 99% target for patients who had been waiting less than 6 weeks for their diagnostic test as at the end of June (98.7%)

Cancer Waiting Times: Two Week Wait (2WW)

Referrals continue to show an increase year on year across all tumour sites except Urology, however the rate of growth has stabilised. There has been a 16.3% increase over the last 12 months with Breast seeing a 23.2% increase (inc Symptom referrals). The biggest proportion of referrals are for the Breast and Lower GI tumour sites.

Whilst there has been an increase in referrals the conversion rate from those referred and those which resulted in cancer diagnosis has decreased (from around 8.75% in the whole of 2018 to 7% in 2019 to date).

Following the decrease in 2ww performance in April, performance has improved in May back to previous levels but remains below target at 87.6%. The majority of breaches remain in the Breast and Lower GI tumour sites.

Lower GI and lung are increasing the proportion of patients through the Straight to Test (STT) pathway to reduce time to first seen. Breast and lower GI are reviewing the vetting process and working with the e-referrals team to manage 2ww capacity effectively.

Cancer Waiting Times: 31 Day First Definitive Treatment (FDT)

May's performance for the 31 day FDT dipped slightly in June but remained above the 96% national target. The Trust has achieved the national target each month since October 2018 (with the exception of being 0.1% below target in January 2019). The 31 Day subsequent treatment standards for Surgery and Drugs were also achieved in June.

Cancer Waiting Times: 62 Day First Definitive Treatment (FDT)

Performance against the Cancer Waiting Times Constitutional Target for the 62 Day (FDT) remains extremely challenging, however performance improved in May to 70.9% (80.4% for MTW only) and was the best performance since December 2017.

The overall backlog (patients waiting over 62 days for treatment with a diagnosis of cancer) and those over 104 days has shown a significant downward trend and continues to decrease. There are now 64 patients in the backlog (9 of which are over 104) compared to a high of 180 in February 2019. All tumour sites have seen a reduction in backlog with the exception of Lung. Backlog clearance continues and is expected to improve performance of the 62 Day Target further.

The Trust are expecting to use June and July to continue to ensure reduction of the backlog to a sustainable level so that from August onwards the Trust will be able to achieve the 62 day standard.

The areas showing the biggest improvement were Breast, Haematology and Upper GI. Urology performance has improved further following the revised prostate pathway and revised clinic templates introduced in March.

Action plans for each pathway, as part of the cancer transformation programme are being developed for each tumour site with timeframes and accountability clearly assigned. Daily huddles with each tumour site team are in place for Lower GI, Upper GI, Breast, Urology, Gynaecology, Lung and Haematology.

Daily huddles with each tumour site team are in place.

Additional funding is still being discussed with the CCG and Cancer Alliance to support proposed actions and posts required to continue cancer pathway improvements. This is crucial to ensure the Trust sustainably achieves the standard.

Well Led

Workforce:

The Trust Vacancy rate remains at 13.1% for the Trust with Registered Nursing, Midwifery & Health Visitors at a rate of 19% and Medical and Dental and a rate of 15.5%, however both have seen a slight improvement in June (0.5%).

One of the highest vacancy levels for both nursing and medical vacancies is for the Medical and Emergency Care Division (with Nursing being higher). However, the level of sickness and turnover in these areas remains lower than the Trust total and other areas. The level of nursing vacancy is the highest for T&O and this area has also seen a significant increase in sickness levels in May and June to (6.2%) of which 83% is long term sick.

Overall Sickness rates are more stable; however the proportion of sickness that is short-term sickness is reducing.

The Trust continues to implement a number of initiatives to increase recruitment of key staff and all divisions have plans in place for the recruitment to vacant consultant posts. The Recruitment Task and Finish group is working on a number of specific projects aimed at improving the attractiveness of the Trust to potential applicants as well as supporting retention of existing staff.

Following the increase in the use of bank staff seen in May, the number reduced in June back to previous levels. Agency use has remained fairly static this year to date. The Trust is using Bank staff instead of higher cost Agency staff where possible but will continue to look for further opportunities to reduce the use of the Agency staff.

The nurse agency spend reduced further in June and is the lowest level reported in any one month throughout last year and this year to date (20% reduction compared to the same period last year). Medical & Locum Agency Spend has increased since November 2018 with June remaining high (10.5% increase compared to the same period last year).

Mandatory Trainining compliance has improved to 86.1% for June and is now above the 85% target.

Finance:

The Trusts deficit including PSF was £1.3m in June which was on plan, The main pressures (excluding CIP) in the month related to Clinical Income slippage (£0.7m adverse) due to £0.3m slippage associated with RTT activity reserve (offset by underspend in expenditure), £0.25m elective underperformance relating to non AIC contracts and £0.13m Neo Natal income slippage. This income slippage was offset by £0.4m release of old year provisions as underspends within pay budgets.

The Trust is YTD on plan. The key YTD variances against plan are: Adverse variances relating to CIP slippage (£0.4m), underperformance in Private Patient Income (£0.6m net) and £0.4m pressure relating to EPR costs that were previously planned to be capitalised. These pressures have been offset by release of prior year provisions and back dated credit notes from NHS Property Services (£0.8m), over performance relating to clinical income (£0.4m) and £1.5m underspend within expenditure budgets. The Trust has increased the reserves held by relating to the CIP stretch target (£0.7m).

Trust Performance Summary Scorecard

30th June 2019

Safe		Curr Month		Year to Date		Year End		Change on Prev Mth
ID	Key Performance Indicators	Plan	Actual	Prev Yr	Curr Yr	Plan	FOT	
S1	Rate C-Diff (Hospital only)	25.7	25.6	9.7	23.0	22.4	22.1	↓
S2	Number of cases C.Difficile (Hospital)	5	5	6	14	55	54	↓
S3	Number of cases MRSA (Hospital)	0	0	1	0	0	0	→
S4	Cases of Gram Negative Bacteraemia	14	7	30	19	113	102	↓
S5	Rate of Hospital Pressure Ulcers	*0.90*	0.2	1.9	0.3	0.9	0.7	→
S6	Rate of Total Patient Falls	*6.00*	6.14	*5.53*	6.24	*6.00*	6.00	↘
S7	Number of Never Events	*0*	1	0	1	0	1	↓
S8	Number of New SIs in month	12	8	47	40	144	144	↑
S9	SIs not closed <60 Days Monthly Snapshot	24	52	No data	52	24	24	↘
S10	Overall Safe staffing fill rate	93.5%	94.0%	97.6%	94.3%	93.5%	94.3%	↘

Effective		Curr Month		Year to Date		Year End		Change on Prev Mth
ID	Key Performance Indicators	Plan	Actual	Prev Yr	Curr Yr	Plan	FOT	
E1	Hospital-level Mortality Indicator (SHMI)	Band 2	1.0235	1.044	1.0235	Band 2	Band 2	→
E2	Standardised Mortality HSMR	Lower conf <100	92.7	104.4	92.7	Lower conf <100	92.7	↗
E3	% Total Readmissions	14.1%	13.4%	0.0%	14.2%	14.1%	14.1%	↗
E4	Readmissions <30 days: Emergency	14.7%	14.2%	0.0%	14.8%	14.7%	14.7%	↗
E5	Readmissions <30 days: Elective	6.9%	5.6%	0.0%	6.7%	6.9%	6.7%	↗
E6	Stroke BPT Part 3: 90% Time on Stroke Ward	80.0%	80.0%	81.0%	75.8%	80.0%	80.0%	↑
E7	% TIA <24hrs	60.0%	53.3%	81.4%	57.1%	60.0%	60.0%	↓

Caring		Curr Month		Year to Date		Year End		Change on Prev Mth
ID	Key Performance Indicators	Plan	Actual	Prev Yr	Curr Yr	Plan	FOT	
C1	Single Sex Accommodation Breaches	0	0	0	0	0	0	→
C2	Rate of New Complaints	3.92	2.71	2.16	2.40	2.93	2.80	↓
C3	% complaints responded to within target	75.0%	45.7%	61.4%	51.3%	75.0%	69.0%	↑
C4	IP Resp Rate Recmd to Friends & Family	25.0%	16.5%	28.4%	18.6%	25.0%	25.0%	↘
C5	IP Friends & Family (FFT) % Positive	95.0%	96.7%	95.3%	95.5%	95.0%	95.5%	↗
C6	A&E Resp Rate Recmd to Friends & Family	15.0%	12.3%	22.5%	12.7%	15.0%	15.0%	↘
C7	A&E Friends & Family (FFT) % Positive	87.0%	91.6%	92.1%	86.5%	87.0%	87.0%	↑
C8	Mat Resp Rate Recmd to Friends & Family	25.0%	45.5%	38.4%	23.4%	25.0%	25.0%	↑
C9	Maternity Combined FFT % Positive	95.0%	94.2%	94.8%	94.5%	95.0%	95.0%	↘
C10	OP Friends & Family (FFT) % Positive	84.0%	81.5%	83.2%	82.2%	84.0%	94.0%	↘

Responsive		Curr Month		Year to Date		Year End		Change on Prev Mth
ID	Key Performance Indicators	Plan	Actual	Prev Yr	Curr Yr	Plan	FOT	
R1	Emergency A&E 4hr Wait	94.3%	94.5%	93.2%	92.8%	91.7%	92.0%	↗
R2	Emergency A&E >12hr to Admission	0	0	1	0	0	0	→
R3	Ambulance Handover Delays >60mins	45	26	94	142	540	540	↑
R4	RTT Incomplete Pathway	84.0%	85.8%	79.1%	85.8%	84.0%	89.0%	↗
R5	RTT 52 Week Waiters (New in Month)	0	3	12	19	0	19	↑
R6	% Diagnostics Tests WTimes <6wks	99.0%	98.7%	99.4%	98.7%	99.0%	99.0%	↘
R7	Cancer two week wait	93.0%	87.6%	88.9%	85.1%	93.0%	93.0%	↗
R8	Cancer two week wait-Breast Symptoms	93.0%	65.2%	87.5%	60.7%	93.0%	93.0%	↑
R9	Cancer 31 day wait - First Treatment	96.0%	96.0%	96.6%	96.2%	96.0%	96.2%	↘
R10	Cancer 62 day wait - First Definitive	85.1%	70.9%	53.8%	67.6%	86.0%	86.0%	↑

Responsive - Flow		Curr Month		Year to Date		Year End		Change on Prev Mth
ID	Key Performance Indicators	Plan	Actual	Prev Yr	Curr Yr	Plan	FOT	
R11	Average LOS Non-Elective	6.85	6.99	7.07	7.09	6.85	6.85	↗
R12	Theatre Utilisation	90.0%	86.4%	77.4%	86.9%	90.0%	90.0%	↗
R13	Primary and Non-Primary Refs	15,673	15,131	48,526	47,184	199,052	199,052	↓
R14	Cons to Cons Referrals	4,086	5,015	18,155	17,251	51,898	51,898	↑
R15	OP New Activity	17,806	17,548	54,066	53,365	226,133	226,133	↘
R16	OP Follow Up Activity	27,317	24,273	78,148	78,633	346,845	346,845	↘
R17	Elective Inpatient Activity	585	515	1,515	1,642	7,426	7,426	↓
R18	Day Case Activity	3,954	3,586	10,948	11,593	50,210	50,210	↓
R19	Non Elective Activity (inc Maternity)	6,913	5,362	15,475	16,097	84,338	84,338	↗
R20	A&E Attendances : Type 1	13,698	13,577	38,596	41,260	159,252	159,252	↗

Well-Led		Curr Month		Year to Date		Year End		Change on Prev Mth
ID	Key Performance Indicators	Plan	Actual	Prev Yr	Curr Yr	Plan	FOT	
W1	Surplus (Deficit) against B/E Duty	- 1,279	- 1,272	- 3,213	- 3,344	- 3,370	- 3,370	↗
W2	CIP Savings	1,279	1,291	2,519	3,028	3,558	3,558	↘
W3	Cash Balance	35,605	44,793	13,358	44,793	3,000	3,000	↗
W4	Capital Expenditure	715	380	713	783	1,270	1,270	↘
W5	Finance use of Resources Rating	3	3	4	3	3	3	→
W6	Staff Turnover Rate (%)	10.5%	10.1%	10.3%	9.8%	10.5%	9.8%	↘
W7	Vacancy Rate (%)	13.0%	13.1%	11.3%	13.1%	13.0%	13.0%	↗
W8	Total Agency Spend	1,518	1,531	5,891	4,835	15,426	15,426	↗
W9	Statutory and Mandatory Training	85.0%	86.1%	88.9%	84.7%	85.0%	85.0%	↗
W10	Sickness Absence	3.3%	3.3%	3.2%	3.3%	3.3%	3.3%	↗

Target Indicator Key:	
On or above Target	
Review and Corrective Action required	
Significantly below target - urgent action required	

Change on Previous Indicator Key:		Change on Previous Indicator Key:	
Significant improvement on Previous (>5%)	↑	Deterioration on previous (<5%)	↘
Improvement on previous (<5%)	↗	Significant deterioration on previous (>5%)	↓
No Change	→		

Headlines

Safe:	**Positives:**	**Challenges:**
Lead Director(s): Claire O'Brien/ Peter Maskell	**Infection Control:** There were 5 cases of C.difficile reported in June. Year to date the Trust remains on trajectory with 14 cases reported against a maximum limit of 15. There have been no MRSA blood stream infections reported YTD and performance for MRSA Screening in Elective pathways continues to remain above the target at 99%. The number of gram negative blood stream infections remains below the 1819 levels and MSSA remains at a similar level to 1819 to date. **Falls:** The number and rate of falls continues to be higher for the Tunbridge Wells site, however the rate of falls within the Urgent Care Division is starting to show a downward trend at this site. There was a reduction in the number of Falls reported as an SI in June (1). **Pressure Ulcers:** 1 category 2 pressure ulcer reported for the Trust (Medical specialty at Maidstone) **Serious Incidents (SIs):** There was a reduction from 15 to 8 new SIs reported in June resulting in a rate of 0.41% against a limit of 0.70% **Incidents:** The rate of incidents that have caused severe harm have reduced in June following the increase in May and are now below the limit of 1.23 at 1.13 The number of reported incidents relating to patients with Dementia has decreased in both May and June **Duty of Candour:** Training being delivered by the Patient Safety Manager at Clinical Governance meetings including Clinical Directors and Chiefs of Service. This has been received well.	**Infection Control:** Performance for MRSA Screening Compliance in Non-Elecive pathways has deteriorated in June to 90% against a target of 95%. **Falls:** The number of Falls per 1,000 occupied beddays is slightly above the maximum limit for June (6.14). The rate of falls appears to be showing a slightly increasing trend with 1819 being slightly higher than 1718. Across the Sites Tunbridge Wells has a higher rate of Falls than Maidstone. Both sites have shown an increase in the rate of falls in June. **Pressure Ulcers:** The results for the Pressure Ulcer prevalence audit, completed in May, show the prevalence has increased from 3% to 3.5%. It was the first time that Deep Tissue Injuries were counted within the Pressure Ulcer Prevalence audit so an increase was expected. **Serious Incidents (SI)s:** There was one Never Event reported in June relating to the Neonatal Unit at TWH. This is being investigated. There are 52 SIs currently open that have passed their breach date for closure (23 waiting for MTW and 29 waiting for the CCG). **Incidents:** Incidents reported remains higher at Maidstone Hospital (MH) than Tunbridge Wells Hospital (TWH) despite the higher occupied beddays at TWH. The number of incidents recorded of abuse towards staff from patients increased from 22 to 31 in June which is 78% of all incidents of aggression reported. **Duty of Candour:** Supporting staff to complete the documentation to confirm that verbal duty of candour is being completed – whilst we know from anecdotal evidence that this is happening in practice this is not always documented.

Headlines

Effective:	**Positives:**	**Challenges:**
Lead Director(s): ***Peter Maskell***	**Mortality:** The Risk Adjusted Hospital Standardised Mortality Rate (HSMR) and SHMI are both within acceptable limits and the Trust is no longer an outlier. The HSMR has been below 100 for the last three reporting periods. **Emergency Readmissions:** Year to date the rate of emergency readmissions for those who were originally admitted as a non-elective patient has remained similar to 2018/19 at 14.8% compared to 14.7%. If the patients who had a zero LOS (are on SDEC pathway) are removed from the calculation, then the rate has been fairly similar over the last few years (consistently between 10% and 11% since April 2017). Emergency readmissions for those who were originally admitted as an elective patient has remained constant. **Stroke:** Performance for patients spending 90% of their time on a Stroke Ward dipped in April and May but has improved in June to 80%, therefore achieving the national target.	**Emergency Readmissions:** There continues to be an increase in emergency readmission rate for patients who were originally admitted on a non-elective pathway. This increase is attributed largely to the increased use of the short stay units. The cohort of patients that are treated on a same day emergency care (SDEC) pathway have a higher likelihood of re-attending and the SDEC models of care are designed to manage these patients within these settings, rather than requiring the patient to be admitted for a longer hospital spell. **Stroke:** Performance for patients spending 90% of their time on a Stroke Ward remains below plan YTD at 75.8% Performance for TIA cases with a higher risk of stroke being treated within 24hrs decreased in May (data runs one month behind) to 53.3% which is therefore below the 60% national target (57.1% YTD)

Headlines

Caring:	**Positives:**	**Challenges:**
Lead Director(s): Claire O'Brien/ Peter Maskell	**Complaints:** The overall number of complaints received has remained fairly consistent month on month Divisional compliance with regards to complaints responded to within target improved to 82.6% in June. Communication with patients/relatives remains a key theme within complaints, being the most frequently raised issue, however June saw a significant reduction **Friends and Family:** The level of satisfaction rates for inpatients is showing an improving trend over the last few months. April and May performance was lower than plan for both sites which may have been linked to the increase in A&E Attendances. There has been a significant improvement in June to 91.6% which is back to previous levels and above the target for both sites. **Single Sex Accommodation:** Delivery of the Same Sex Accommodation (SSA) remains a priority, promoting privacy and dignity for our patients. There have been no mixed sex breaches reported since December 2019 **VTE Risk Assessment:** The Trust continues to consistently achieve the 95% National Target for patients receiving a VTE Risk Assessment **Patients with Dementia:** The Trust continues to consistently achieve all the National Targets	**Complaints:** Following the significant decrease in complaints responded to within the target date seen in May this improved in June but remains significantly lower than target at 45.7%. The increase in the number of overdue complaints has been impacted by a sustained period of vacancies within the complaints team, which are being addressed. Number of overdue complaints has reduced in June to 72, but remains high. With the vacant Complaints Lead post being filled on 1 July, focused work will begin on closing overdue cases. **Friends and Family:** There continues to be fluctuating consistency in the response rates (particularly for Maternity). This has been highlighted at the monthly review meetings to explore any new / recurrent engagement or process issues. Response rates have decreased further for Inpatients and A&E in June. Inpatients response rate was 4% lower than the average of last year and both remain below plan. The response rate for A&E continues to remain significantly lower at the Maidstone site.

Headlines

Responsive:	**Positives:**	**Challenges:**
Lead Director(s): ***Sean Briggs***	**Emergency Flow:** In Emergency Departments (ED) an increasing number of patients are being streamed to the on-site GP, from 36.3 per day in 2018/19 to 40.1 per day so far this year – or around 9.0% of all A&E attendances **A&E admissions** are reducing, despite higher attendances, and the percentage of patients that are zero LoS (excluding Clinical Decision Unit (CDU) patients) is 23-25%, compared to 19-21% this time last year **Escalated beds, Delayed Transfers of Care (DTOC) and stranded patient counts**, patients with a length of stay (LOS) over 21 days, are all running significantly lower than this time last year, and there are now around 10-20 patients on the Hospital at Home scheme, each one of which effectively frees up an acute bed **4 hour Emergency Access Standard:** June performance was above the trajectory target at 94.50%. The forecast for July performance is between 94% and 94.5%, above the trajectory target of 93.29%. In 2018/19, the Trust ranked 28th out of 141 trusts for 4hr scores, and so far this year we rank 21st out of 133. **Referrals:** There has been a 5% reduction in Consultant to Consultant referrals year to date (YTD) compared to the previous year. **Outpatient Efficiency:** Following a downward trend seen last year DNA Rates have remained fairly static so far this year just above the target. The New:FUP rate is steadily improving.	**ED Attendances:** The past 52 weeks have been 7.3% busier than the preceding 52, and 2019/20 attendance is forecast to be 5.6% higher than 2018/19. July is heading towards being the busiest month ever. **Ambulance Handovers:** Performance improved in June but delays remain higher than the average per month usually seen during the summer months (358 in June and an average of 470 per month in Quarter 1 compared to the average of 300 per month usually seen in summer months). Delays of more than 60 minutes also decreased to 26 which is below the average level (35) usually seen in summer months. **Beds:** Despite many of the flow indicators moving in the right direction, the bed occupancy remains high around 92-95% at 7am, and many of the available beds are specialist or paediatric beds not available for general acute admissions. **New Outpatient Activity:** June saw a reduction in Activity compared to May and is 1.7% below plan YTD. This is further below plan for the main RTT Specialties at 7.9% below plan YTD. Specialties furthest from plan remain T&O, ENT and Ophthalmology which is directly impacting on their achievement of their non-admitted RTT Trajectories.

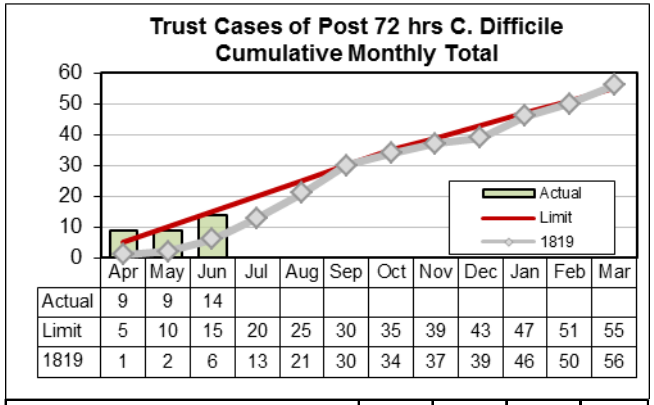
Headlines

Responsive:	**Positives:**	**Challenges:**
Lead Director(s): ***Sean Briggs***	**Inpatient Efficiency:** Theatre Utilisation has remained static at 86.4%. **RTT Incomplete Pathway**: Performance increased further achieving 85.78% against a target of 84.01%. The overall backlog (patients who have been waiting over 18 weeks) has continued to decrease to 4,163 in June which is 459 lower than the submitted trajectory of 4,622. Of this the admitted pathway backlog is 440 below trajectory. The RTT waiting list and backlog have shown a downward trend. The Waiting List is now nearly 3,000 lower than March 18 and the backlog is over 2,000 lower. **Cancer:** Performance against the 62 Day first definitive treatment (FDT) target improved in May to 70.9% and was the best performance since December 2017. The overalll backlog (patients waiting over 62 days for treatment with a diagnosis of cancer) and those over 104 days has shown a significant downward trend and continues to decrease. All tumour sites have seen a reduction in backlog with the exception of Lung. Following the decrease in 2ww performance in April, performance has improved by 5% in May back to previous levels, but remains below target. The Trust achieved the 31 Day FDT Target in May along with 31 Day subsequent treatment targets for Surgery and Drugs.	**Elective Activity:** Following the increase in activity seen in May, activity reduced in June and was 9.6% below plan (4.4% below plan YTD). The specialties furthest from plan year to date remain T&O, Ophthalmology, Urology, Cardiology and Gynaecology which is directly impacting achievement of the RTT admitted pathway trajectories Activity year to date will be slightly understated due to the activity being done in the independent sector not currently being recorded on the PAS system in a timely manner. A new process has been implemented from 1st July to ensure capture of this data. **RTT Incomplete Pathway:** The Trust is still reporting some 52 week breaches on a monthly basis (6 reported for June – 3 new in month). All patients will have a harm review by the managing Consultant. No harm has been found as yet for the ones which have been completed The Elective and Outpatient New Activity was lower than plan in June which has led to an increase in the RTT Waiting List and backlog for some specialties. **Diagnostic Waiting Times <6weeks:** Due to the technical issues experienced in Kent with the RIS system (Imaging System) which lead to a period of downtime, for the first time the Trust was not able to achieve the 99% target for patients who had been waiting less than 6 weeks for their diagnostic test as at the end of June (98.7%) **Cancer:** Despite the increase in performance in May against the 62 Day target, this has not improved as quickly as hoped and remains below trajectory. 2ww performance also remains below target.

Headlines

Well Led:	**Positives:**	**Challenges:**
Lead Director(s): Steve Orpin/ Simon Hart	**Finance:** £1.3m deficit in Month 3 as planned and Year to Date a £3.4m deficit as planned. The Trust is forecasting to meet its control total by the end of the year. Pay is underspending against plan Year to Date, and temporary staffing is lower than the same period in 2018/19. CIP delivery on plan in month 3. The Trust has delivered £3.2m savings YTD which is £0.4m adverse to plan (11% slippage). Favourable cash position at the end of month 3. Capital underspent against plan at the end of month 3 but all capital is committed in 19/20 **Sickness Rate:** The overall sickness rate has become more stable over the last 12 month, slightly above the maximum limit. The proportion of sickness that is short-term sickness is reducing. **Mandatory Training:** Compliance has improved to 86.1% for June and is now above the 85% target with Information Governance showing the biggest improvement, followed by an improvement for Intermediate Dementia Awareness	**Finance:** Shortfall year to date relating to private patient income. A plan has been developed to improve this through opening additional beds. Variances within forecast of £10.7m are mitigated by contingency, the expected release of the CCG RTT risk reserve and full delivery of the CIP programme. £0.4 m CIP slippage but forecasting to meet CIP target by the end of the year If the I&E forecast moves adversely this will reduce the level of cash available. The Trust has agreed a revised capital plan with the Kent and Medway STP and the NHS South East Regional team. The Treasury has confirmed that IFRS 16, the new standard on leasing, will be implemented in the public sector from April 2020 (FY 2020/21). This will bring existing operating leases onto the balance sheet as capitalised finance leases. **Vacancy Rate:** remains at around 13% for the Trust with Registered Nursing, Midwifery & Health Visitors at a rate of 19% and Medical and Dental at a rate of 15.5%, however both have seen a slight improvement (0.5%). **Key Vacancy risks:** remain Nursing for medical and T&O wards at TWH, Nursing for Emergency Departments (ED) on both sites but primarily TWH, TWH theatres, Consultant physicians, AMU and respiratory. Areas with high vacancy rates continue to put pressure on agency rates, particularly nursing in ED Recruitment Task and Finish group to work on a number of specific projects aimed at improving the attractiveness of MTW to potential applicants as well as supporting retention of existing staff

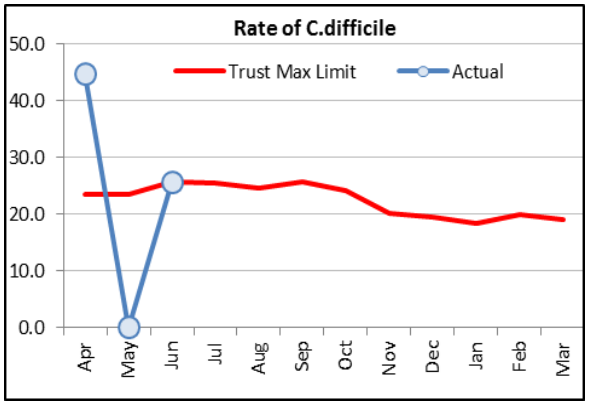
Safe	Infection Control	Jun-19



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	9	9	14									
Limit	5	10	15	20	25	30	35	39	43	47	51	55
1819	1	2	6	13	21	30	34	37	39	46	50	56

MSSA Bacteraemia	Apr	May	Jun	YTD
1516	0	3	2	5
1617	4	1	2	7
1718	2	0	0	2
1819	2	2	2	6
1920	1	3	0	4

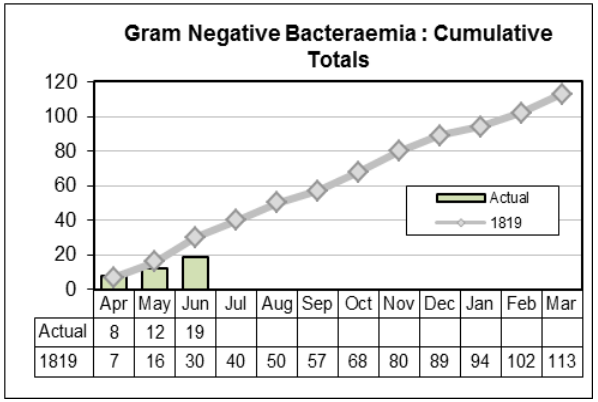
MSSA: The number of MSSA cases reported during 1819 was a signficant reduction compared to previous years, however this redution was seen in the winter months from September to March. So far in 1920 the number of cases reported is slightly lower than the level reported in 2018/19 to date.



C.difficile: The objective for 2019/20 has been set at 55 cases taking into account the changes in case attribution presented to the Board in February. In June there were five cases of C.Difficile reported. Year to date there have been 14 cases reported against a maximum limit of 15.

Focussed work on CA-UTI prevention. Catheter Passport re-launched in December.

Incident meeting held for Pye Oliver ward – three cases of C. difficile – ward deep cleaned x2



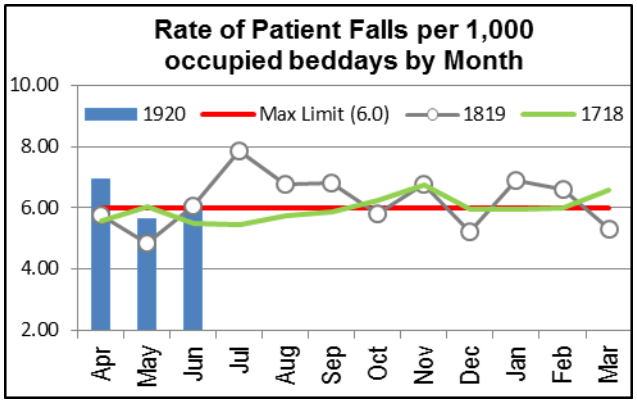
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	8	12	19									
1819	7	16	30	40	50	57	68	80	89	94	102	113

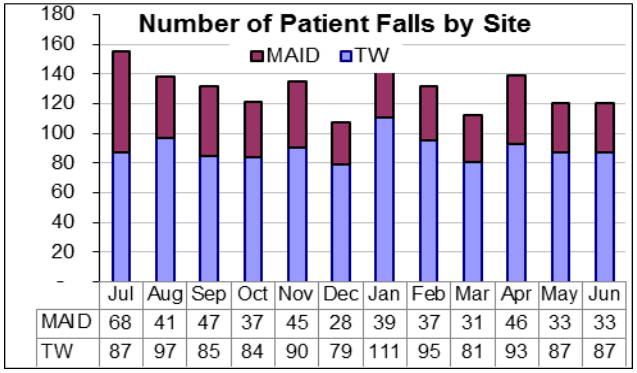
Gram Negative Bacteraemia (E.Coli, Klebsiella, Pseudomonas): The overall level of Gram Negative Bacteraemia blood stream infections remains below the levels reported last year. In June there were 7 cases of E.Coli reported (16 YTD) and so far this year there have been 2 cases of Klebsiella and 1 case of Pseudomonas reported.

MRSA Bacteraemia: There have been no cases of MRSA blood stream infections reported year to date. Compliance against the MRSA screening rates has decreased in June for the non-elective pathway at 90% against a target of 95%. Compliance for the Elective pathway continues to remain above the 98% target.

Summary:	Actions:	Assurance:
There were 5 cases of C.difficile reproted in June. Year to date the Trust remains on trajectory with 14 cases reported against a maximum limit of 15. Performance for MRSA Screening Compliance in Non-Elecive pathways has deteriorated in June but performance for the Elective pathway continues to remain above the target. No MRSA Cases reproted YTD. Gram Negative Bacteraemia remains below the 1819 levels	All new junior doctors receive infection control and antibiotic prescribing training. Action plan from outbreak re-visited to ensure changes embedded. Prevention of de-hydration in elderly patients Task and Finish group to implement control measures for gram negative blood stream infections.	Routine cleaning with Difficil S remains in place across both sites. HPV and UVC light cleaning remains in place for C diff cases, carriers and multi resistant organisms. 2018 Safety focus on Infection Control. Weekly C. difficile huddle held by DIPC and ICT.

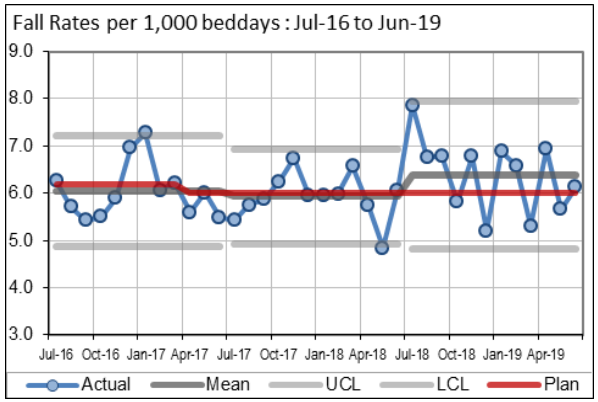
Safe	Harm Free Care	Jun-19





	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
MAID	68	41	47	37	45	28	39	37	31	46	33	33
TW	87	97	85	84	90	79	111	95	81	93	87	87

For June the rate of Falls is 4.48 for Maidstone and 7.14 for Tunbridge Wells which is a slight increase.



Severity of Harm 1920	Apr	May	Jun
No Harm	94	92	97
Low Harm	37	21	20
Moderate Harm	6	3	2
Severe Harm	2	4	1
Death	1	-	-
Total	140	120	120

SIs: There was 1 Falls Serious Incident declared in June.

Patients with Dementia: There were 13 Falls for Patients with Dementia in June compared to 31 (unvalidated) in the previous year. YTD there have been 37.

Harm Free Care: The percentage of Harm Free Care remains at 98% in June compared to 97.7% last June.

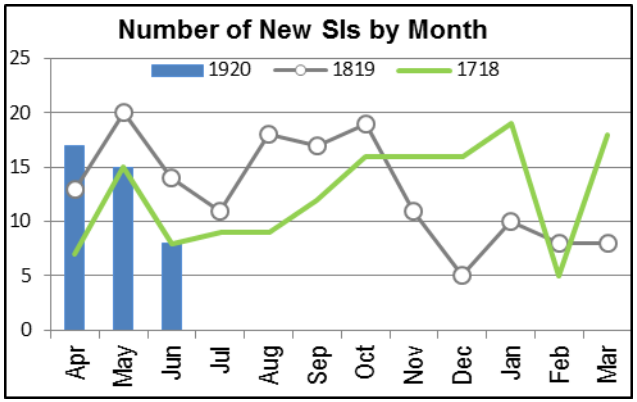
Falls: The number of Falls remained the same as May at 120 (Rate of 6.14 per 1,000 occupied bed days). The rate of falls appears to be showing a slightly increasing trend with 1819 being slightly higher than 1718. Across the Sites Tunbridge Wells has a higher rate of Falls than Maidstone. Both sites have shown an increase in the rate of falls in June although the numbers were the same.

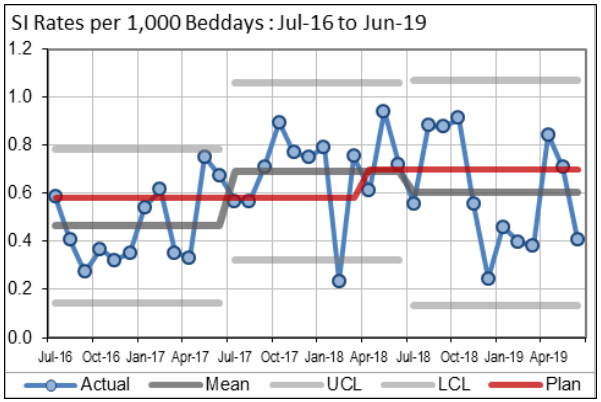
Falls by Division: Across the Divisions the Rate of Falls for the Medical and Emergency Care Division is showing a downward trend this year to 6.0 for June compared to full year rate of 6.9 for 1819. The decrease has been at the TWH site. T&O falls increased from 7 in May to 21 in June (rate of 11.5) compared to an average of 14 per month in 2018/19 (Full year rate of 7.2)

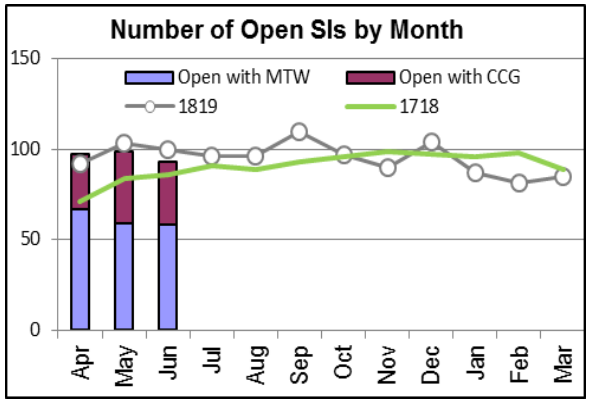
Pressure Ulcers: The rate of pressure ulcers per 1,000 admissions has improved with 1 Grade 2 ulcer reported in both May and June (rate of 0.20). The average number reported in 1819 per month was 6. The results for the Pressure Ulcer prevalence audit, completed in May, show the prevalence has increased from 3% to 3.5%

Summary:	Actions:	Assurance:
Overall the number of Falls remains the same as the previous month at 120 in June (rate of 6.14 per 1,000 occupied beddays) which is just above the maximum limit. The rate of falls appears to be showing a slightly increasing trend, however falls for the medical specialties at TWH are showing a downward trend. One Pressure Ulcer reported.	Roll out plan for the NHSi Falls Collaborative project commenced in April 2019. NHSi project focussing on Lying and Standing Blood Pressure. Rollout planned for four wards to commence on the project each month and for all inpatient wards to be on the project by November 2019.	As at the end of June 10 wards have commenced on the Falls Project. Audits at Week 4, Week 8 and Week 12 undertaken to monitor progress. Further audits to be carried out at Month6, 9 and 12 to monitor sustainability. It was the first time that Deep Tissue Injuries were counted within the Pressure Ulcer Prevalence audit so an increase was expected.

Safe	Serious Incidents (SIs)	Jun-19

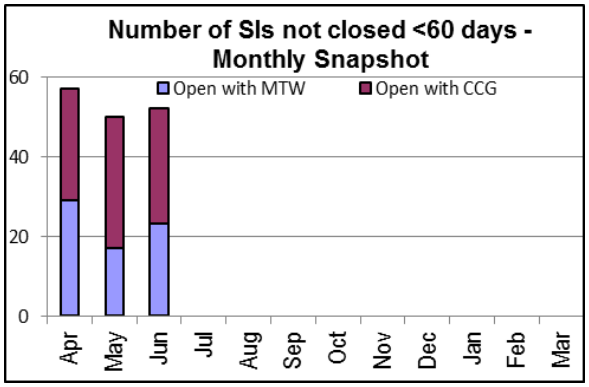






New SIs Category	Apr	May	Jun
Pressure Damage	1	1	-
Falls	3	6	1
Main	12	8	7
Total	16	15	8

SIs: One Never Event reported in June for Neonatal Unit at TWH. Of the 8 New SIs reported in June 4 were in Urgent Care, 3 were in Women & Children Division, and 1 in Support Services (Imaging). The number of open SIs was showing a downward trend from October to March 2018 but increased to previous levels in April 2019. June has seen a reduction of 7 SIs since May.



Downgraded SIs: In June, 2 SIs were downgraded.

The number of SIs open at the end of each month has remained similar to that of last year. As at the end of June there were 93 SIs open of which 52 had passed their breach date and had not been closed within the 60 day target (23 waiting for MTW and 29 waiting for the CCG). Of the 93 open 58 are waiting for closure by MTW and 35 are waiting for closure by the CCG. The largest proportion of Open SIs are with the Medical and Emergency Care Division, however there was a reduction in June.

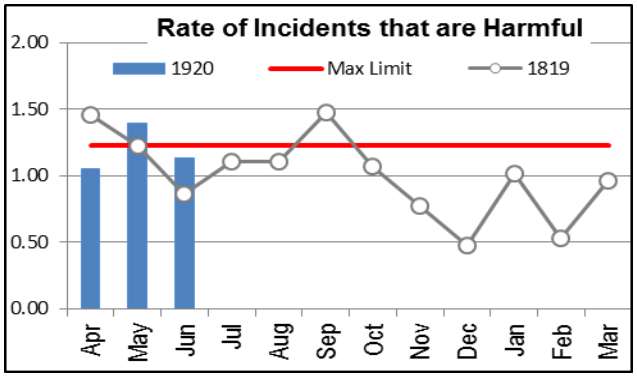
Summary:	Actions:	Assurance:
One Never Event reported in June. 8 SIs reported in June resulting in a rate of 0.41%. There has been a reduction in the numbers reported in both May and June. The number open remains at a similar level to last year. There are 52 SIs currently open that have passed their breach date for closure	SI Teleconferences taking place three times a week with patient safety and the Executives for decision on declarations and closures. Use of the monthly Governance Gazette to share information in regard to Never Event and additional learning from SI's. An improvement trajectory for closing SIs is being developed.	Review of and Changes made to the SI process for declaration with the introduction of a new SI Triage form. Dissemination of this Triage form will be shared in the July edition of the Governance Gazette. Development and monitoring of a SMART action plan for overall patient safety performance. Recruitment and a review of current processes are underway to improve efficiency.

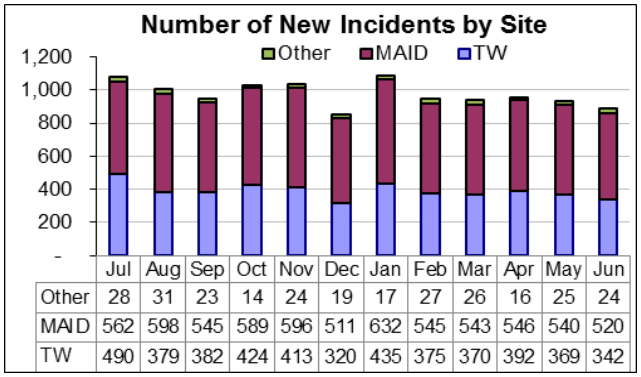
Safe	Learning from SIs and Falls Panels	Jun-19

Learning from Main Serious Incident (SI) Panel:

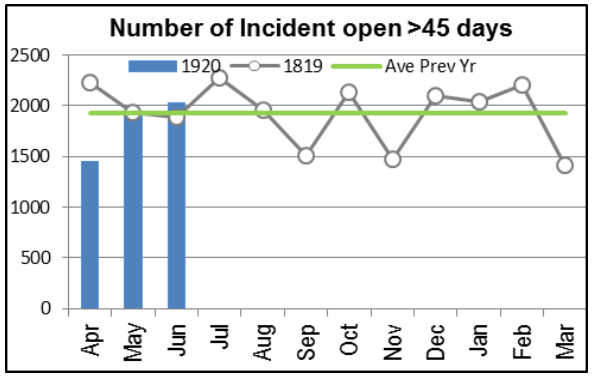
Care/Service Delivery Issue:	Learning:
Treatment Delay – hyponatraemia/renal impairment. Handover of patients at weekend / bank holidays. Failure to act upon and appropriately repeat blood tests	Formal handover procedure to ensure appropriate seniority review for patients at risk of deterioration. Put in place system to ensure blood results are reviewed in a timely manner and acted upon/escalated accordingly.
Missing Controlled Drugs: Controlled drug registers should be maintained in a clear and legible fashion	Good record keeping and trust protocols to be reinforced with all staff
Infection – C.diff Incident Relative of C.difficile positive patient did not always wear PPE or adhere to the Trust infection control policy	All ward staff to ensure infection control policy to relatives enforced and that all barrier nursed patients have the relevant signage & posters to educate visitors about PPE. Explore the option of giving leaflets to patients and relatives.
Treatment Delay: Failure to document all discussions and findings to support diagnosis	Need for contemporaneous documentation
Missed Diagnosis: Patient attended clinic without notes or on clinic list Patient recalled and staff were unaware of the area to be reviewed.	Procedure to be written to ensure all patients are listed on assessment clinics. Procedure to be written ensuring patients letter requesting recall identifies area under review
Learning from Falls Panel:	**Learning:**
Patient at risk of falls did not have falls prevention care plan reviewed on daily basis.	Patient at risk of falls to have the falls assessment and care plan reviewed daily.
Patient at risk of falls with delirium did not have Lying and standing blood pressure completed prior to fall as part of assessment for orthostatic hypotension.	Lying and standing Blood Pressure to be completed on admission or as soon as appropriate as part of multifactorial falls assessment.
Patient did not have a AMTs completed on admission to give a baseline.	AMTS should be completed on admission to enable a baseline.

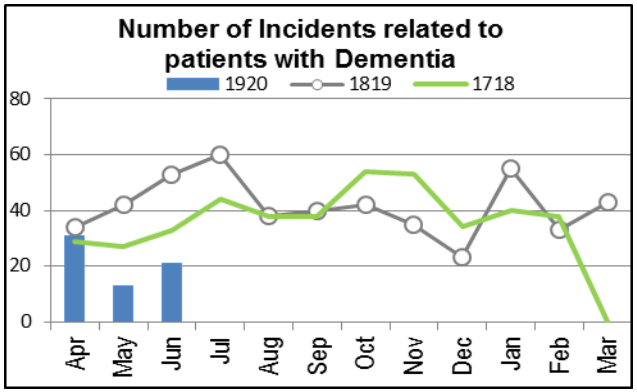
Safe	Incidents	Jun-19



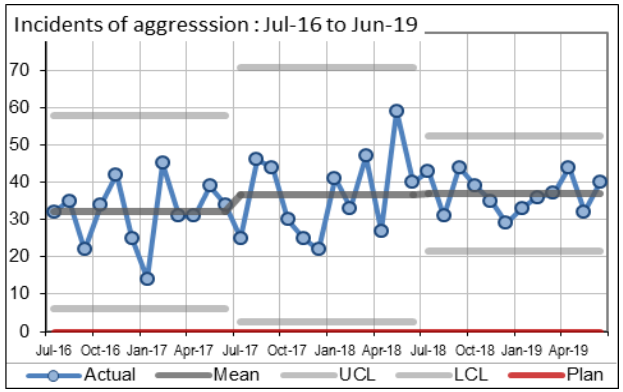


	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Other	28	31	23	14	24	19	17	27	26	16	25	24
MAID	562	598	545	589	596	511	632	545	543	546	540	520
TW	490	379	382	424	413	320	435	375	370	392	369	342





There has been a decrease in May and June in the level of Incidents related to patients with Dementia



Incidents of Aggression (Abusive, violent, disruptive or self-harming behaviour)

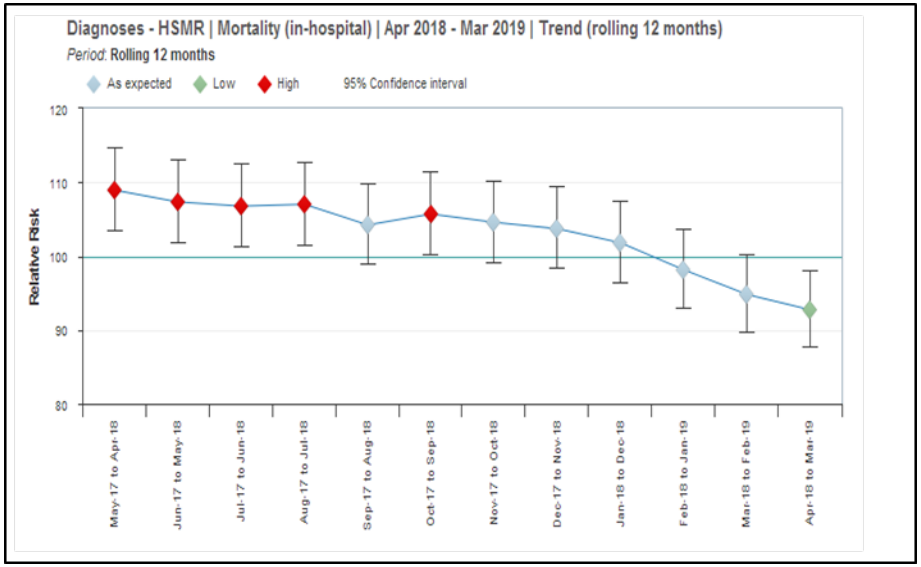
The number of incidents open more than 45 days has increased further in June to 2025 which is slightly above the average of 1931 at any given time in 2018/19.

Incidents by Site: The number of incidents remains higher for Maidstone (MH) than Tunbridge Wells (TWH) despite there being a higher number of occupied beddays at TWH.

Incidents of Abuse towards Staff: The number of incidents recorded of abuse towards staff from patients increased from 22 to 31 in June which is 78% of all incidents of aggression reported (40 in June) which has remained similar to the average last year.

Summary:	Actions:	Assurance:
The Rate of incidents that are severly harmful has reduced in June, following the increase in May and are now below the maximum limit of 1.23 at 1.13 Incidents reported remains higher at MH than TWH despite the higher occupied beddays at TWH. There has been a decrease in incidents related to patients with Dementia.	All Directorates updated on a monthly basis in regard to the number of incidents they have open and reminded of the need for timely investigations and closures. Improvement trajectory to be included within Patient Safety Action plan. Datix Web upgrade planned for July prior to migration across to IQ Cloud once contract signed.	Oversight of incidents and learning disseminated to Divisional Governance meetings. Dementia incidents overseen and actions required discussed at Dementia Strategy meeting. Abuse towards staff overseen at Health & Safety Committee.

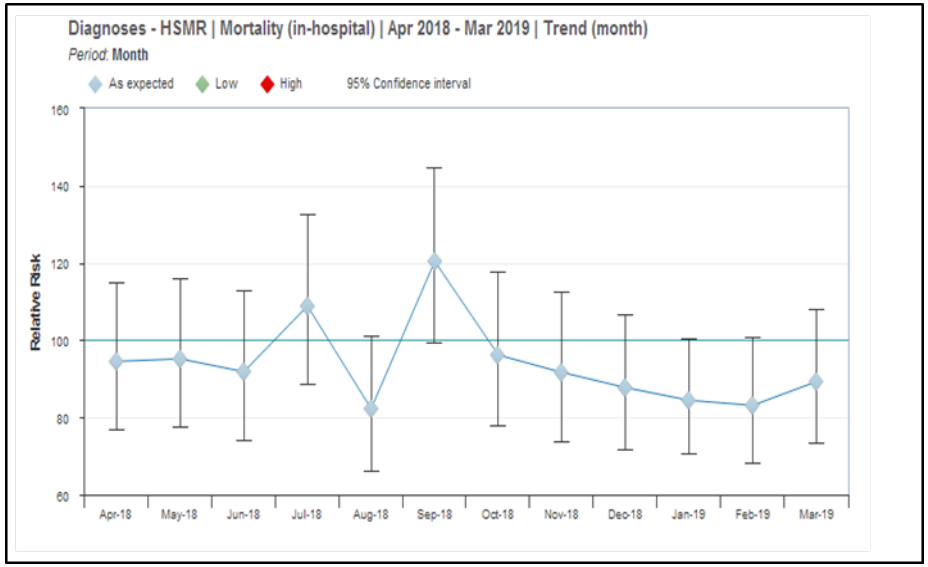
Effective	Mortality	Jun-19



The Trust has seen significant improvements in the Relative Risk Rates & the Crude Rates since Oct-17, the volume of spells has continued to rise in the same period due to the change in casemix. This has resulted in the Trusts Expected Risk Rate reducing to 3.5

The Maidstone HSMR site position is 91.9 & the TWH HSMR site position is 93.4.

Both the weekend & weekday HSMR Rate have significantly improved since Dec-17; 100.8 & 89.1 respectively as at Mar-19. General Medicine is showing as a red risk with a weekend Relative Risk of 135.6 (66 deaths).

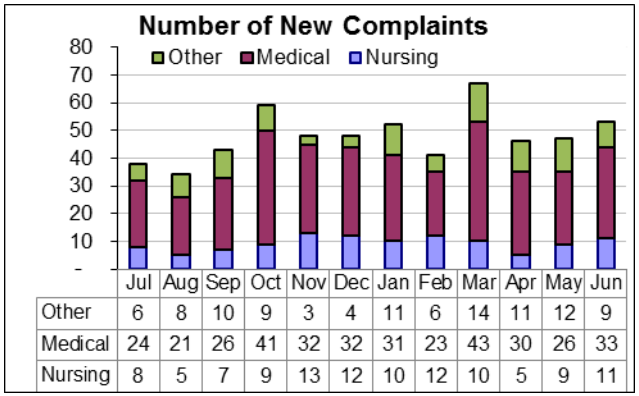


The Medicine & Emergency care division have already taken action to address the weekend/weekday anomaly having increased the weekend on call team, having acknowledged the challenge with increased attendances and the need to cover the wards without impacting on prompt patient assessment in Emergency Departments. There is also acknowledgement that further work is required to ensure that the requirements for seven day services (7DS) are met and consistent effort is being taken to recruit to the vacant Consultant posts and to attract trainees.

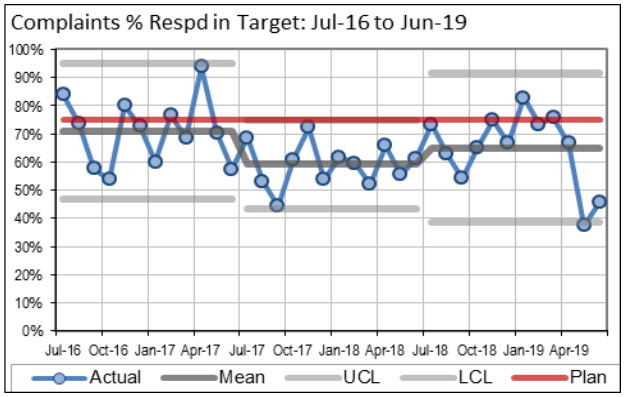
Mortality review documentation has been revised and relaunched. The revised document makes explicit the need to identify learning which can then be disseminated to the Directorates and Divisions.

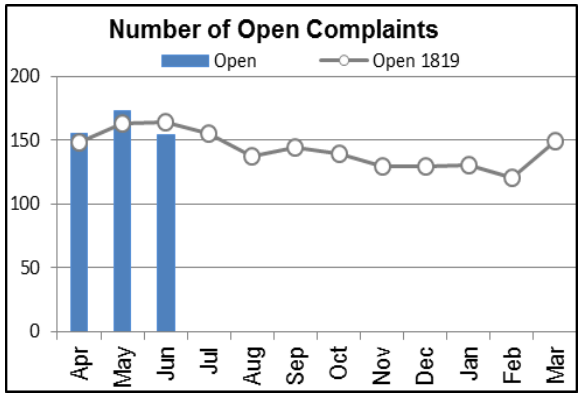
Summary:	Actions:	Summary:
The Risk Adjusted Hospital Standardised Mortality Rate (HSMR) and SHMI are both within acceptable limits and the Trust is no longer an outlier. The HSMR has been below 100 for the last three reporting periods. HSMR: Apr-18 – Mar-19 92.7 (87.6 – 98.1) SHMI: Feb-18 – Jan-19 102.35 (89.27 – 121.1)	Working group in place to review the role of the Medical Examiner & Medical Examiner officer in conjunction with our Bereavement services team. Working Group established with Mortality Leads from other NHS organisations in Kent and Dr Foster to review their mortality data and how this can be further used to inform the mortality review process.	**Presentation by Maternity:** marked improvement in perinatal deaths through the work of the Saving Babies lives campaign and Better Births initiatives. **Presentation from Learning Disability Liaison Nurse following review of PWLD deaths**: Key findings were the prompt assessment & treatment in Emergency Departments; timely senior review and positive family/carer involvement.

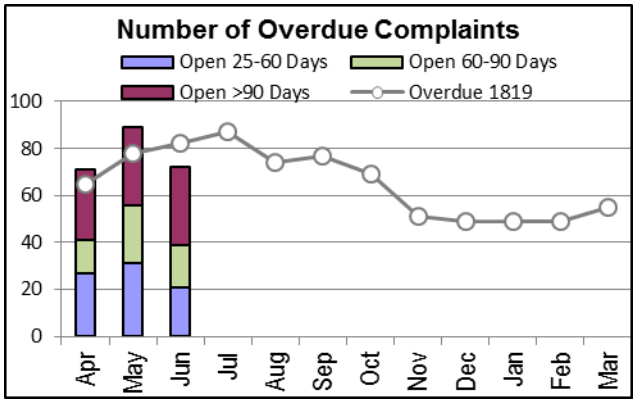
Caring	Complaints	Jun-19



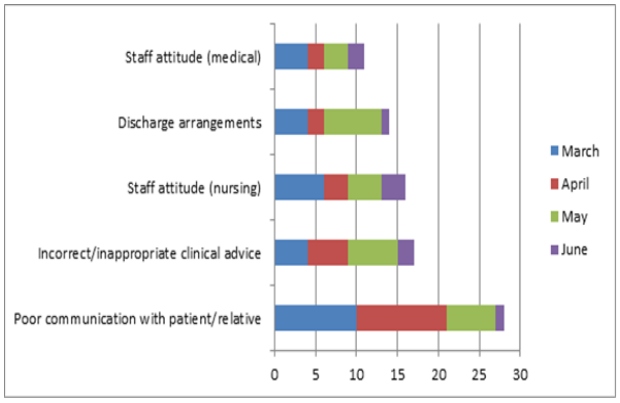
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Other	6	8	10	9	3	4	11	6	14	11	12	9
Medical	24	21	26	41	32	32	31	23	43	30	26	33
Nursing	8	5	7	9	13	12	10	12	10	5	9	11







Overdue complaints have reduced in June to 72 but remain higher than the average of 65 last year. Number currently overdue is lower than June 2018.

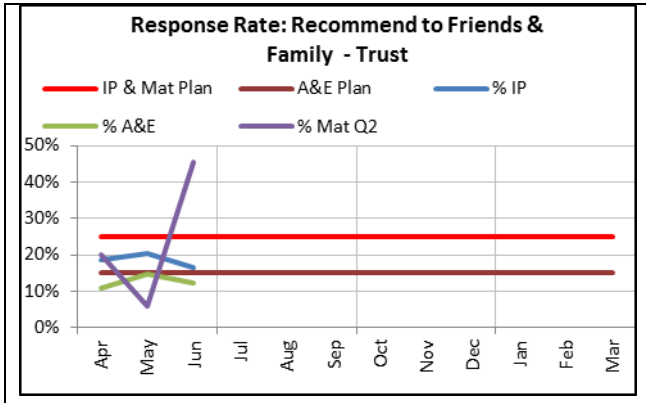


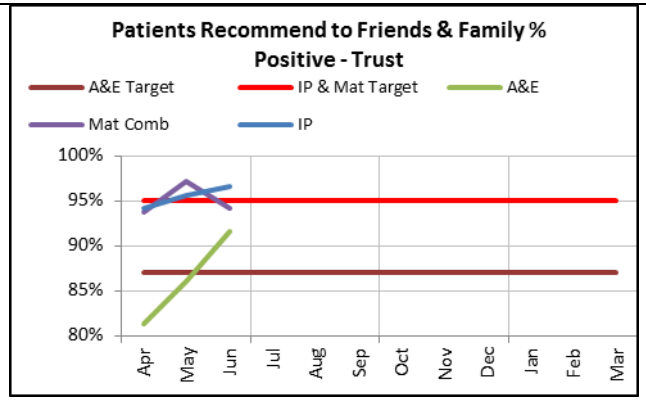
Top Five themes/subjects raised in complaints made about events that occurred in June 2019.

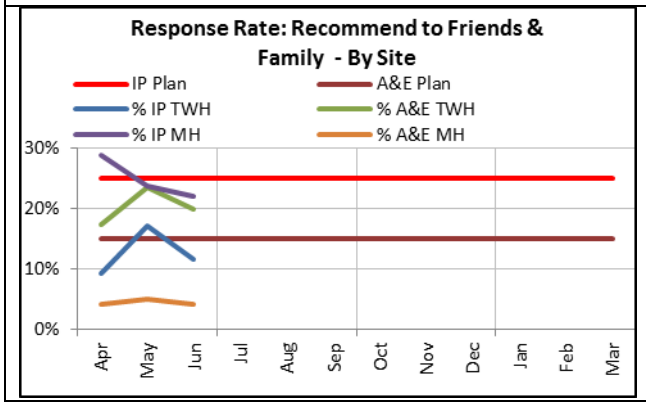
Open Complaints: Of the 154 complaints currently open, the largest proportion are with the Surgical Division with the number increasing month on month. The Medical and Emergency Care Division has seen a decrease in the last few months, with focused work around closing overdue complaints and improved performance.
Of the complaints open more than 90 days, 10 have been open for more than 6 months.
Themes of Complaints: The subject of complaints with the highest number remains poor communication with patients/relative; however this area has shown a significant reduction in June. Patient survey results also show communication with patients/relative as an area of lower satisfaction. There were 15 compliments recorded in June, however not all compliments get recorded centrally.

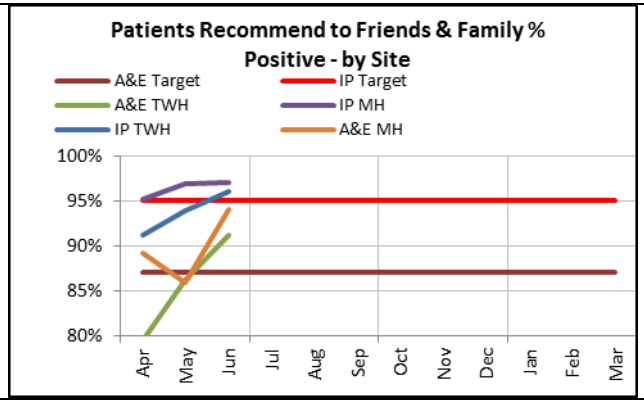
Summary:	Actions:	Assurance:
Performance in June improved but remains significantly lower than target at 45.7%. Divisional performance was at 82.6%, however, vacancies in the central complaints team and other external factors (SI process, third party involvement) impacted on the Trust's overall performance.	A Job Description for a new Band 7 post has been submitted to the banding panel, but due to unavailability of staff-side representatives, this is being delayed. Prospective weekly reports sent to all directorates to support achievement of response target.	Continued weekly monitoring of all open complaints with reports to CN. New Complaints Lead in post from 1 July 2019. Knowledge-sharing tools are in place in the divisions to ensure learning from key themes in order to identify issues and take actions to make improvements.

Caring	Friends and Family Survey (FFT)	Jun-19









FFT Response Rates: There continues to be fluctuating consistency in the response rates particularly for Maternity with June showing a significant increase following the May decrease

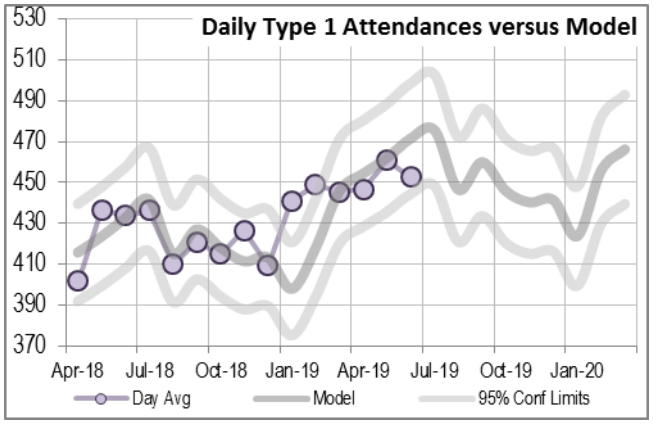
FFT By Site/Ward: The response rate for A&E continues to remain significantly lower at the Maidstone site (MH) and the response rate for Inpatients (IP) continues to remain lower at the Tunbridge Wells site (TWH).

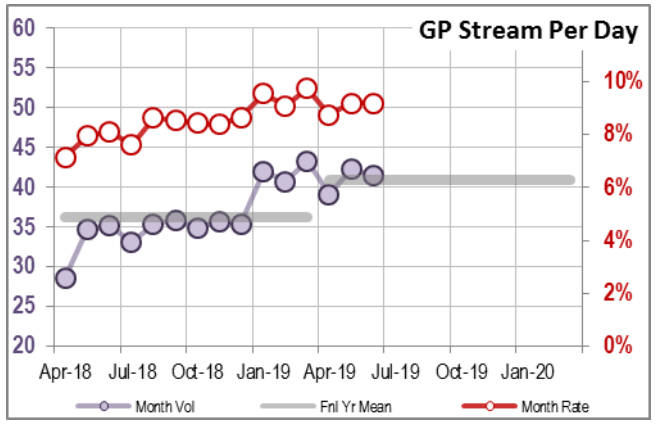
Outpatient (OP) FFT: The positive feedback rate for OP dipped in June to 81.5% and is below the average of last year (83.5%).

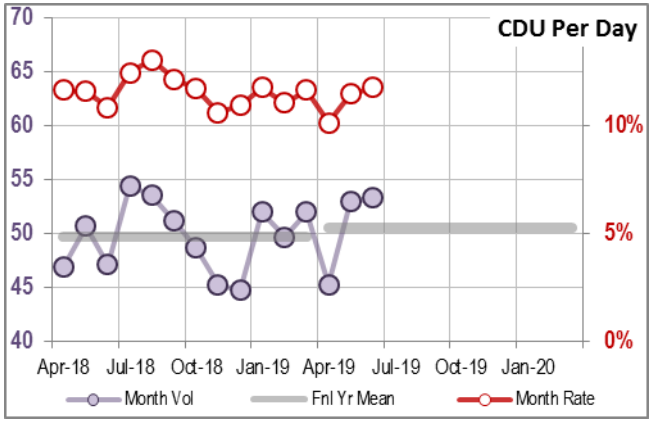
FFT Percentage Positive: The Friends and Family Test satisfaction rates are showing an improving trend for inpatients and remains above the target. Maternity performance has dipped to just below the target. The positive feedback rates for A&E were above the national target across both sites all year round during 2018/19. April and May performance was lower than plan for both sites but there has been a significant improvement in June to 91.6% which is back to previous levels and above the target

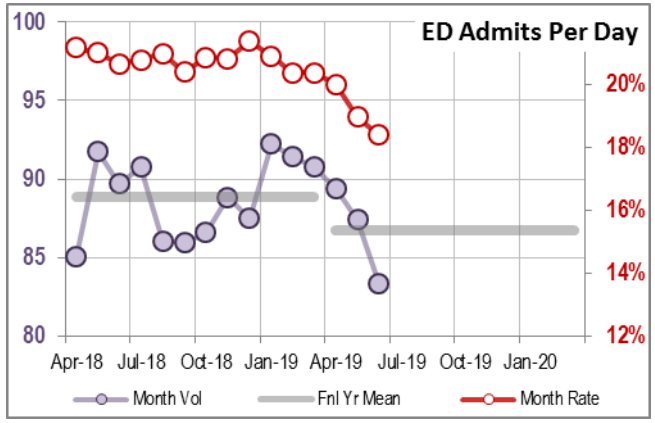
Summary:	Actions:	Assurance:
Overall response rates for June decreased for both IP and A&E but increased significantly for Maternity (Maternity has fluctuating consistency in response rates). IP response rate was 4% lower than the average for last year (June decrease was mainly at TWH) For the % Positive there was an improvement in June for IP and A&E but a decrease for Maternity.	The fluctuating consistency in response rates is monitored through the review monthly meetings. Maternity have identified key cause for last months fluctuating response and are progressing actions to mitigate this in future. FFT provider to ensure reports for area leads are available earlier, prior to the monthly review meeting to enable timely review and follow up of any issues identified.	Improved positive response rates for inpatients and A+E. Monthly review meetings in place with the new Iwantgreatcare account manager. Following a review of issues reported in previous months for OP, the FFT data process is now running correctly and response rates have realigned to expected levels.

Responsive	Non-Elective Flow: Into Hospital	Jun-19









Attendances: Type 1 attendances averaged 427 per day in 2018/19 – 7.1% up on the previous year. We are currently forecasting a 5.6% increase on that for 2019/20

June was lower than expected at 452.6 per day.

GP Stream: This averaged 36.3 per day, 8.5% of arrivals through 2018/19. At the beginning of 2019, it stepped up somewhat, and is 41 per day so far this year or 9% of arrivals

Clinical Decision Unit per day: In 2018/19, an average of 49.7 patients per day were admitted to CDU, but went no further. This was 11.6% of all attendances. So far this year it is 50.5 per day and 11.1% of attendances.

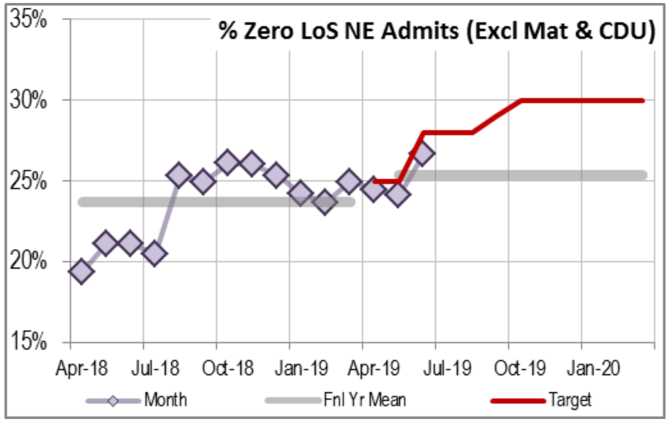
These patients are counted as NE admissions for commissioning purposes, but don't actually leave the ED, don't occupy a general or acute bed, and are not counted as admissions by the Emergency department.

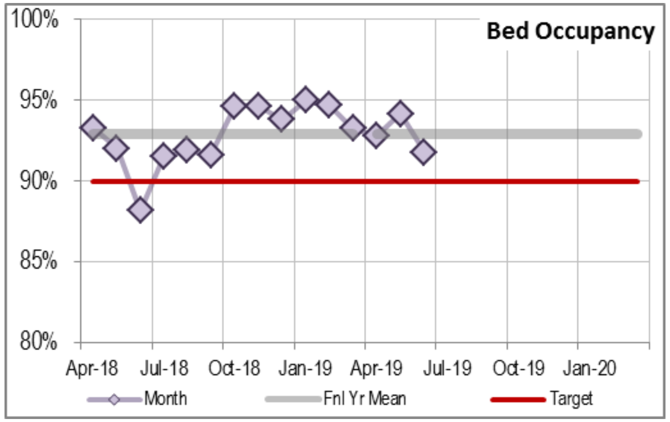
ED admits per day: This counts all patients leaving the Emergency Department to go into the main hospital. CDU patients only count here if they are transferred to another ward.

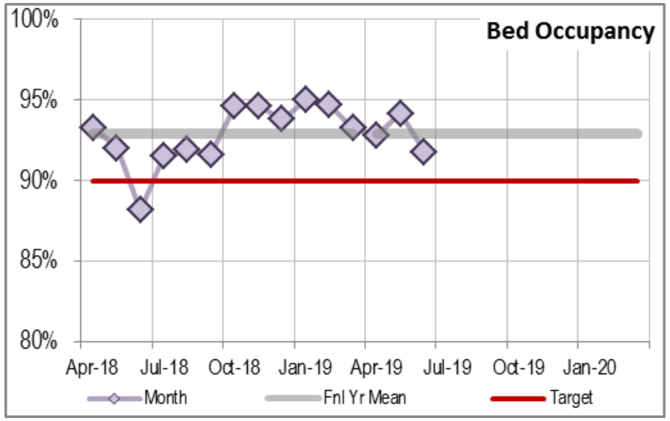
2018/19 averaged 88.9 per day. Or 20.8% of attendances. Recent months have dropped sharply, and June was 83.1 per day, or 18.4%

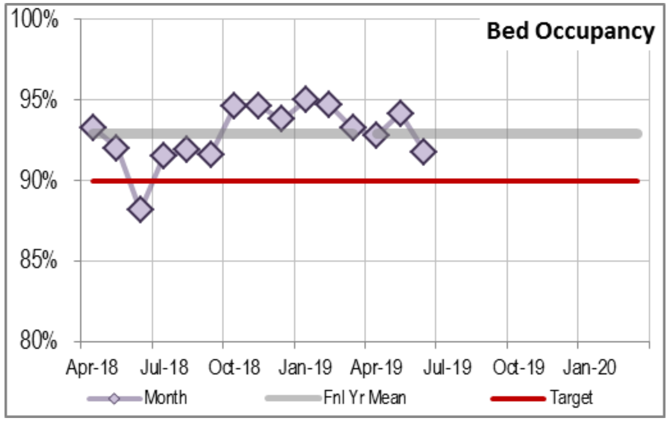
Summary:	Actions:	Assurance:
Type 1 attendances are currently showing an annualised growth of 7.3%, and July is set to be the busiest month ever. GP streaming is currently 9.0% of all arrivals, and another 11.1% go into CDU, then home	Increase AEC on Maidstone site by improving referral process. Increase frailty services to 7 days a week	Continued focus on daily management of capacity and patient flow. Work continuing to ensure all departments within Trust feel a part of the 4Hour Access Standard – Breach Bag concept embedded in ED and Ops Room, now rolled out to assessment units and IDT. Focused bed meetings on actions.

Non-Elective Flow: Bed Management









The percentage of Non Elective (NE) admits that are zero LoS has been steadily rising as increasing numbers of patients go through Assessment / Ambulatory type wards. 23.7% in 1819, 25.4% so far this year, and 26.7% in June. This indicator excludes Clinical Decision Unit (CDU) only patients & Maternity. CDU patients are not generally receiving treatment.

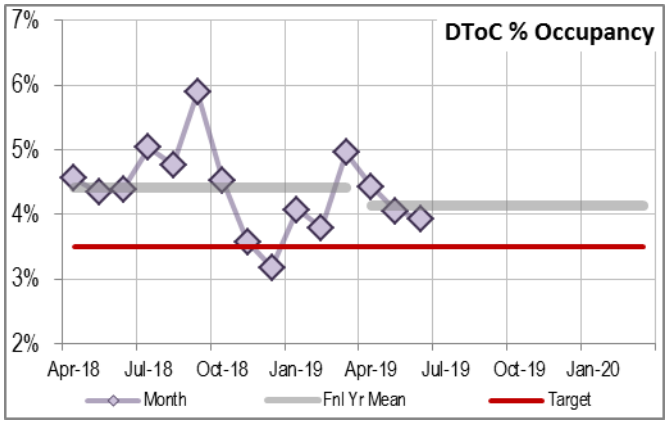
Bed occupancy averaged 92.9% last year (based on the 7am bed census). So far this year it's almost exactly the same. Bed occupancy tends to hit a minimum in late Spring / early Summer, but this has not happened this year. Many of the beds flagged as available on this census are paediatric, ITU or specialist wards not available for general NE admissions

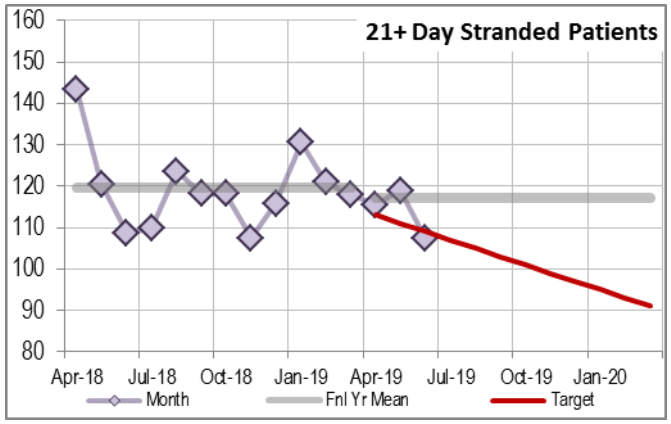
Escalated Bed Occupancy. Last year, escalated beds made up an average of 3.6% of our total occupancy, rising to 5.8% in Feb-19. So far this year, we are at 2.8%, which is an improvement on last year

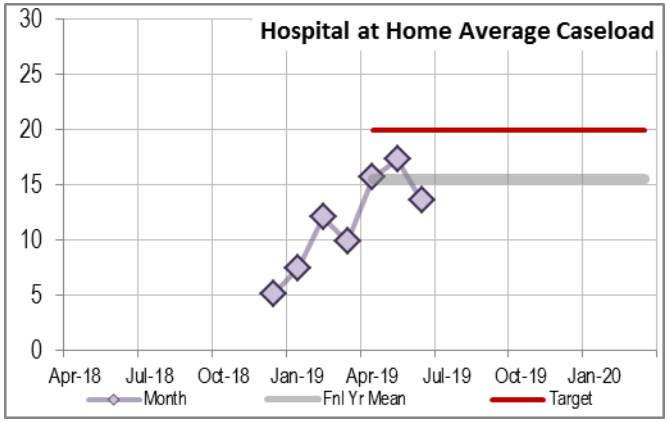
Non Elective Length of Stay (LoS) is something the Trust is actively trying to reduce, as it feeds directly into bed occupancy. Last year the Trust averaged 7.05 days. This year so far it's slightly higher at 7.09

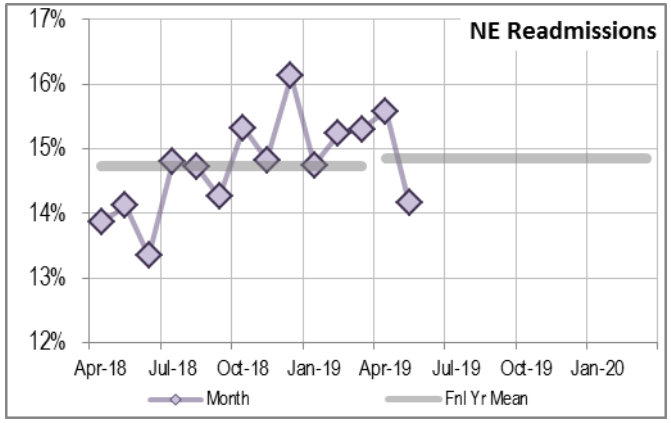
Summary:	Actions:	Assurance:
24.4% of all Non-elective (NE) admissions are now zero LoS (not counting CDU patients). Bed occupancy is consistently between 92% and 95%, but escalated beds are a significant improvement on the same period last year. Non-Elective length of stay (LoS) was 7.05 days last year, and is slightly higher so far this year at 7.09	LOS: Continue to use Clinical Utilisation Review (CUR) to identify delays in flow, including red and green days. Achievement of Q4 CQUIN for CUR. KPIs show reduction in Medical LOS from 23.2 (June 18) to 23.9 (June19). LOS Electronic Discharge Notification (EDN) projects have completed audits and identified schemes to pilot with clinical buy in. EDD data reporting to be reviewed and actions created from the review. Live Bed State in place across 20 wards.	Criteria Led Discharge – fully embedded to show delivery of targets. Clinical Utilisation Review (CUR) linked to Smarties to show real time discharge delays this was shown at a conference in London to other trusts as an example of good practise.

Responsive	Non-Elective Flow: Out of Hospital	Jun-19









Delayed Transfers of Care (DToC) are (broadly) a subset of MFFD, representing patients whose care needs to be transferred to another provider via the Integrated Discharge Team. These were 4.42% of occupancies in 2018/19, and 4.14% so far this year

Stranded patients is a daily snapshot of the number of patients with a current LoS of 21 days or over. Last year, this averaged 119.5 patients. So far this year, we are at 113.9, and June was 107.2

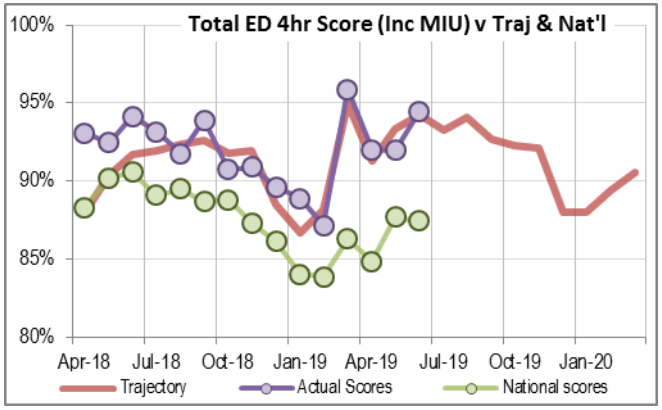
Hospital at Home is an average of the daily snapshot of patients on the H@H scheme. The intention is to run at around 20 patients. Every patient on the scheme effectively frees up a bed

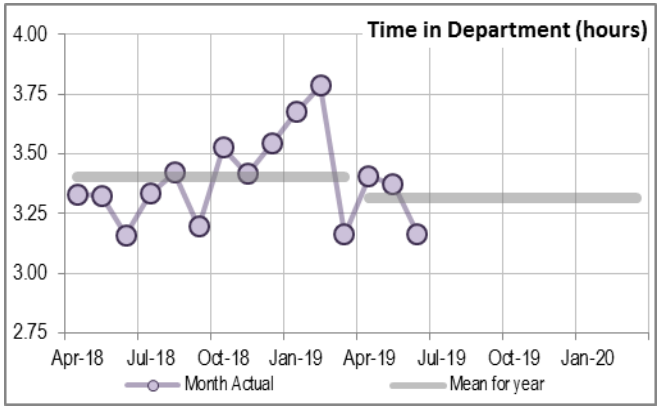
NE Readmissions. Averaged 14.7% in 2018/19, rising steadily through the year. This year's rate (to 31-May) is 14.8%. The latest month is generally prone so slight undercounting. This is the official 30 day Readmission key performance indicator, with cancer and Mental Health patients excluded

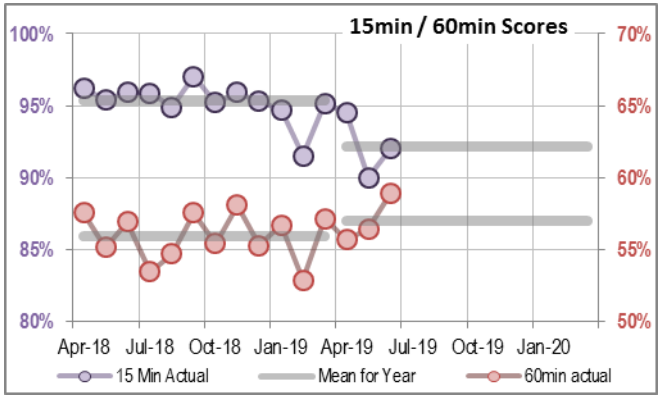
Increasing use of short stay units applies upward pressure on readmission rates by capturing in the count patients who would otherwise have gone home from ED

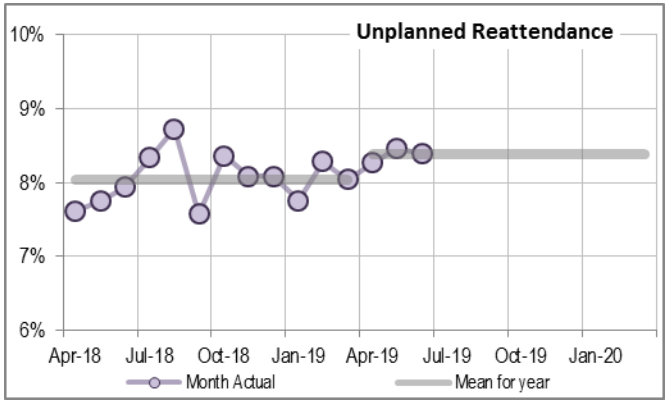
Summary:	Actions:	Assurance:
DToC has been coming down over time, but MFFD has been back over 14% for 5 months now. Stranded patients averages 113.9 so far this year compared to 119.5 last year, and the Hospital at Home scheme has effectively freed up 10-20 beds. Readmissions continues to rise, and is 14.8 so far this year.	**DTOC** - Reduction to base line of 42 packages within Pathway 1 has impacted same day discharges – this service is commissioned by social services and the impact has been escalated. Both sites have now got functioning frail elderly units, which has helped to reduce the number of longer stay admissions. Consider the medical oversight for Hospital at Home with a view to transferring care to the Community Trust Kent Community Hospital Foundation Trust (KCHFT)	Daily sign off of Delayed transfer of Care at team leader level which is giving a greater level of assurance and action Long length of stay walk arounds have commenced on 'long stay Tuesday' initiative. All patients with a LOS greater than 14 days are reviewed for their discharge plans

A&E Performance Indicators









4 Hr Time in Department: For the year 2018/19, performance was 91.86% against a trajectory target of 90.82%; This was the best full-year score since 2014/15 and was 8.5% above the national average scores for Type 1 attendances, and 3.7% for all attendances. June performance was 94.50% against a target of 94.27% and the National performance of 87.48%

Total Time in Department averaged 3.45 hours for Type 1 attendances through 2018/19, but have reduced significantly over the past couple of months. YTD the Trust are $3^{h}19^{m}$.and June was 3^{h} 09^{m}

15 minute arrival to assessment performance was 95.35% for 2018/19, but is averaging 92.16% so far this year

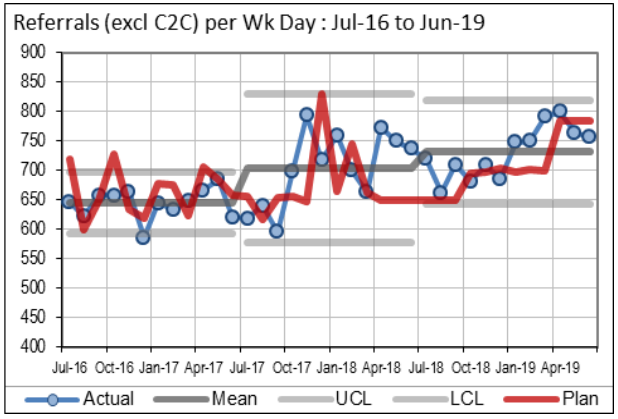
60 minute time to treatment averaged 55.89% for 2018/19, and are slightly higher this year at 56.98%

Unplanned re-attendance rate is a second unplanned visit, arriving less than 168 hours since the last attendance conclusion. This averaged 8.04% in 2018/19, and is 8.38% so far this year

Ambulance Handovers: Last year, 9.6% of ambulances were delayed 30-60 mins, and 1.5% were delayed > 60. This year so far it's 12.2% delayed 30-60 mins and 1.4% >60.

Summary:	Actions:	Assurance:
Performance continues to closely match the agreed trajectory, despite attendances being around 3-4% higher than anticipated, and the Trust remains in the top quartile of English Trusts, achieving 94.50% in June against a target of 94.27% YTD, the average Time in Department is 3h19m, 15 min pass rate is 92.16%, 60min pass rate is 56.98%, and unplanned re-attendance rate is 8.23%.	Continue to recruit a substantive workforce for the Emergency Departments. Finish the trial of the "Hello" nurse to improve identification of seriously unwell patients through triage. Secure funding for trollies required to run efficient ED departments	Continued focus on staff provision and demand analysis. Commencement of winter planning to ensure bed capacity.

Responsive	Elective Flow – Referrals and Outpatients Activity	Jun-19

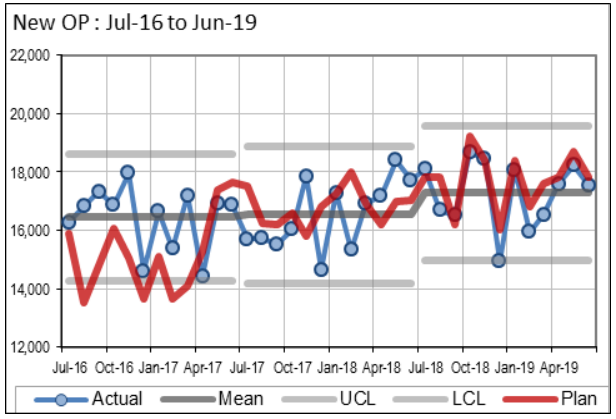


Referrals: The level of Referrals (excluding Cons to Cons Referrals) is slightly above the average per working day in June. June referrals were 3.5% below plan (YTD 1.3% below plan).

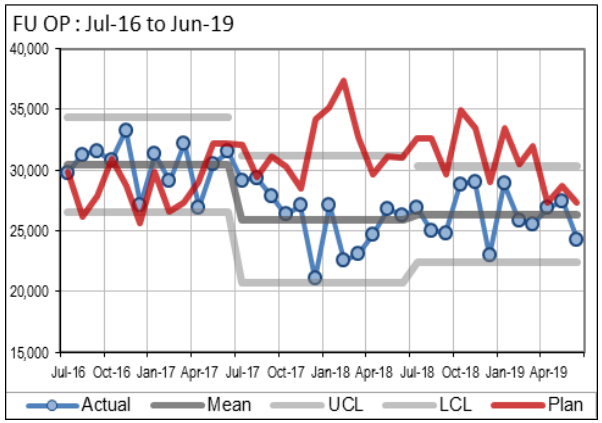
Ophthalmology has seen a 20% reduction in referrals YTD. It is anticipated that this reduction may be due to delays in the triaging service which is currently being investigated.

With regards to the expected increase in demand due to the Prime Provider Model General Surgery has increased by the level expected and T&O referrals are 10% above plan and 13% higher than last year.

There has been a 5% reduction in Consultant to Consultant referrals YTD compared to the previous year.



New outpatient activity: June activity decreased from May and is now at the average for the year and is 1.7% below plan YTD. The dip in June was mainly due to a dip in activity for T&O (although this may be understated due to the activity being done in the independent sector not currently being recorded on the PAS system in a timely manner) and Gastroenterology.
The YTD variance from plan is mainly due to over-performance for specialties such as GUM, Maternity and Oncology. Without the non-RTT specialties included activity would be 7.9% below plan YTD (9% below plan in June). The specialties furthest from plan remain Gastroenterology, T&O, ENT and Ophthalmology which is directly impacting on their achievement of their non-admitted RTT Trajectories. Cardiology and Gynaecology are both 15% and 13% above plan YTD respectively.



Outpatient New Activity for GUM increased significantly in June due to a change in service whereby activity that was previously managed by the Community Trust (KCHFT) is now recorded as MTW Activity (this is for some areas in the North of Kent).

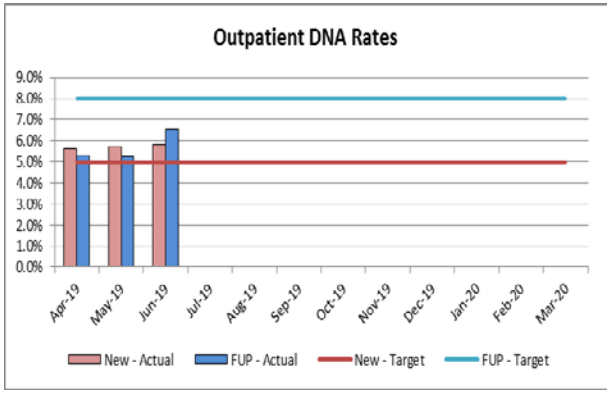
OP Follow Up Activity:
Follow up activity dropped in June and is below the average. Activity was 17.3% below plan in June and 12.1% below plan YTD. As with the New OP Activity T&O, Gastroenterology, ENT and Urology are furthest from plan

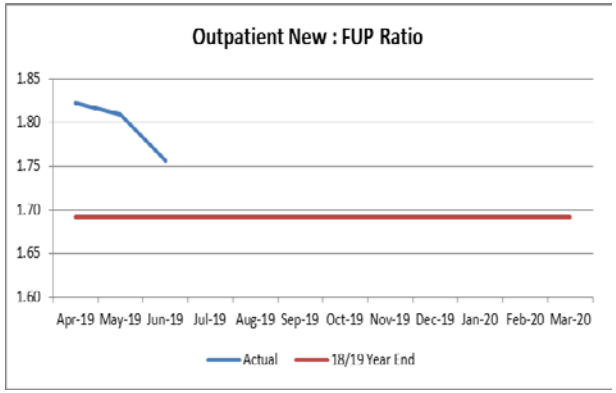
The key issues that contribute to lower than planned New Outpatient work remain:

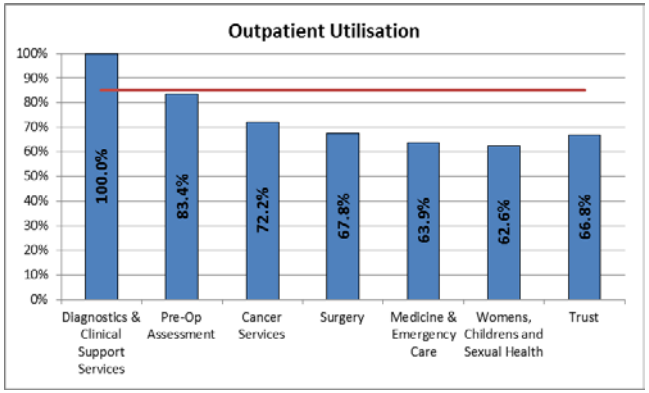
Productivity challenges in Ophthalmology.

Summary:	Actions:	Assurance:
Referrals are 1.3% below plan. However the expected increase in demand can be seen for T&O and General Surgery but has been ofset by a decrease in demand for Ophthalmology and ENT. New Outpatient activity is 1.7% below plan YTD. However, for the main RTT Specialties this is 7.9% below plan YTD. Specialties furthest from plan remain T&O, ENT and Opthalmology	Musculo-skeletal (MSK) pathway for T&O has a backlog of 2,200 patients YTD. MTW are working with the Clinical Commissioning Group (CCG) as it is estimated that 23% of patients will convert to surgery. Ophthalmology triage may also have a backlog due to the decrease in referrals. MTW working with the CCG. IS patient pathway information is not coming back to MTW in a timely manner but a new process has been agreed from 1st July 2019.	T&O plan has being agreed for implementation from October Communication to IS completed. Information returns are currently being validated. Weekly Patient Targeted List (PTL) with the Independent Sector (IS)'s are being implemented.

Responsive	Elective Flow – Outpatient Efficiency	Jun-19







New DNA Rate: The New OP DNA Rate showed a downward trend during 2018/19 from a high of 6.7% but has been static at an average of 5.7% Apr-Jun 2019. Endocrinology, Gastroenterology and Gynae-Oncology has seen a large increase in their Jun-19 DNA Rate; 10.5%, 11.4% & 6.3% retrospectively. There has been a significant improvement within Paediatrics, T&O and Vascular Surgery which has kept the overall trust rate steady.

FUP DNA Rate: This also showed a downward trend but has seen a significant increase in Jun-19 to 6.5% from 5.2% in May-19; this has been driven by Diabetes (13.1%), Dietetics (7.7%), Gynaecology (10%) and Paediatrics (15.8%). However as a Trust we remain below the 8% target.

New:FUP: The New:FUP rate is steadily improving, driven by an improvement in Diabetes, Endocrinology, Paediatric T&O, Paediatrics, Speech Therapy and Vascular Surgery.

Cancellations <6weeks of Outpatient Appointment: The cancellation of appointments <6weeks continues to be an issue at 16% YTD compared to a target of 8% with the majority of specialties higher than the target.

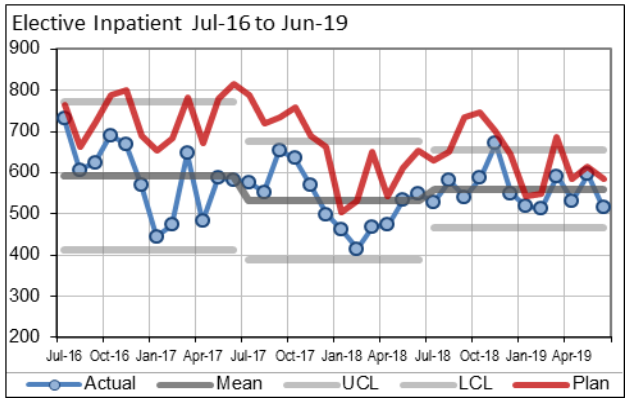
ERS Slot Unavailability: The ERS Unavailable Slot %age was high in May-19 (this runs 1 month behind) at 24.1%. There was a particular issue in the Medical specialties (24.3%) and Gynaecology (34.5%).

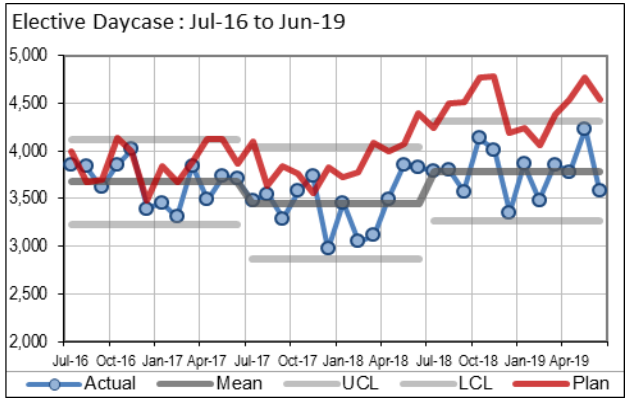
There are several data quality issues being discussed around the outpatient utilisation figures including allocating the 'unallocated' slots in the clinic templates to either a new or FUP slot. A piece of work is ongoing to identify the unused clinics and get them removed from the PAS system. The OP Utilisation figures are therefore currently understated.

Although the monthly utilisation figures have been decreasing there are still a considerable amount of uncashed up appointments in May and June (727, 1821 retrospectively) which will affect the utilisation.

Summary:	Actions:	Assurance:
There are some data quality issues regarding the outpatient utilisation figures so current performance is understated, however utilisation remains low in some areas. Following a downward trend seen last year DNA Rates have remained fairly static so far this year. ERS Slot unavailability was 21.4% in May.	Appointment Slot Issues (ASI's) have grown within paediatrics, cardiology and lipid services. Separate meetings have taken place with the specialities in order to implement a plan. Speciality templates remain an issue and are ongoing from the changeover to Allscripts in Oct 17. All templates need changing. Uncashed clinics have decreased and are being cleared as part of the data quality project.	Plans agreed and are being implemented and monitored weekly. ERS working group has been re-established. Plan to change the outpatient clinic templates is being devised. Uncashed clinics are monitored with the specialities as part of the weekly PTL meetings.

Responsive	Elective Flow – Inpatient Activity	Jun-19





Inpatient activity: was 11.9% below plan in June and year to date (YTD) is -7.9% below plan. Following the increase in activity seen in May, both General Surgery and T&O saw a reduction in June back to a similar level to April which led to the overall reduction in June.

T&O is 31% below plan YTD. Gynaecology and Urology also saw a slight reduction is June and remain 24% and 21% below plan YTD respectively. General Surgery and ENT are 17% and 25% above plan YTD respectively.

The reduction in day case activity in June has had a direct impact on the RTT performance for Ophthalmology.

Day Case Activity: Following the increase seen in May, day case activity reduced in June and was 9.3% below plan, 3.9% below plan year to date (YTD).

Ophthalmology saw a 22% increase in day case activity in May (483) but June activity was significantly lower (364) and below the average of last year (390) which has contributed to the overall decrease in June.
Ophthalmology is now 32% below plan YTD.

Surgery, Urology and ENT also saw a 10% decrease in June compared to May. Urology and ENT are below the average for last year and 27% and 13% below plan YTD but Surgery remains 2% above plan YTD, despite the reduction in June. T&O activity increased in June but remains 40% below plan YTD.

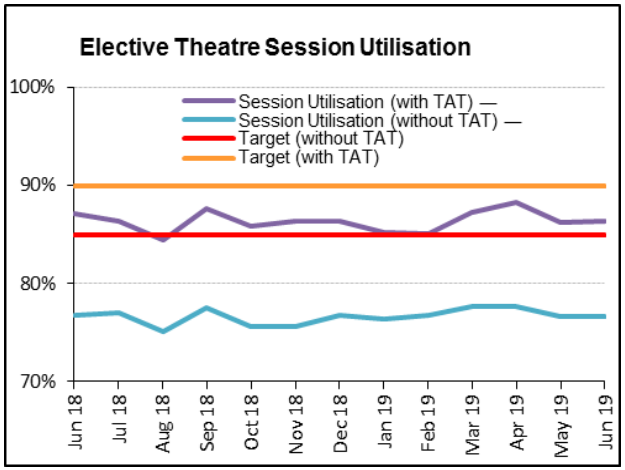
Total Elective Activity (IP and DC Combined):
Overall activity was 9.6% below plan in June and is 4.4% below plan YTD. There was a 15% reduction in June compared to May. This reduction was mainly driven by Ophthalmology and General Surgery day case activity as well as a decrease in inpatient activity for General Surgery and Trauma & Orthopaedics (T&O)

T&O activity increased slightly in June but remains 40% below plan and Ophthalmology is 31% below plan YTD.
Surgery is now 4% above plan YTD (17% above for IP and 2% for DC). Gynaecology remains 15% below plan, and Cardiology is 25% below plan
The key issues that contribute to lower than planned elective work remain:

Key vacancies in consultant and trainee posts in a variety of specialties (General Surgery, Neurology & Endocrinology)
Capacity issues in some specialties (Ophthalmology, T&O and General Surgery)
Plans to improve efficiency have not all yet been fully realised in some areas. Operational teams are reviewing capacity plans and looking at ways to further improve efficiency
Activity year to date will be slightly understated due to the activity being done in the independent sector not currently being recorded on the PAS system in a timely manner. A new process has been implemented from 1st July to ensure capture of this data.

Summary:	Actions:	Assurance:
Following the increase in activity seen in May, activity reduced in June and was 9.6% below plan (4.4% below plan YTD). The specialties furthest from plan year to date remain T&O, Ophthalmology, Urology, Cardiology and Gynaecology which is directly impacting achievement of the RTT admitted pathway trajectories. General Surgery is 4% above plan overall.	Weekly monitoring of the specialty plans for activity to ensure activity booked does not get cancelled. High number of cancelltions due to internal processes within health records Specialities to devise plans for getting back on trajectory.	Daily monitoring of operating lists at the bed meetings. Admission teams working with health records to ensure notes arrive in a timely manner. New Weekly Access & Performance Meetings commencing in August

Responsive	Elective Flow – Inpatient Efficiency	Jun-19

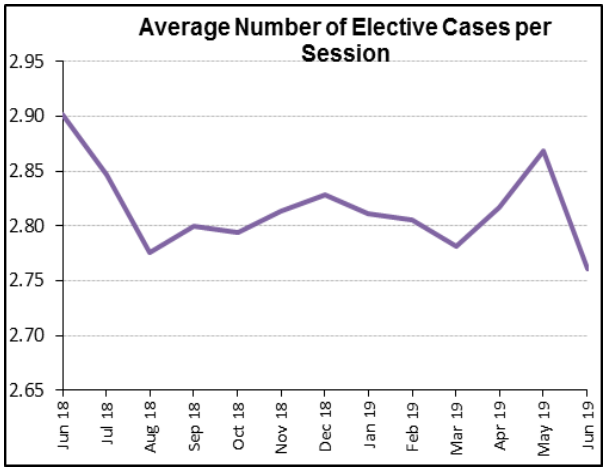


Utilisation with Turnaround Time (TAT) has remained static at 86.4%.

There was a decrease in the number of elective theatre sessions that started within 15 minutes of the planned start time to 35% compared to 38% in May-19 (which was a 10% improvement on previous months)

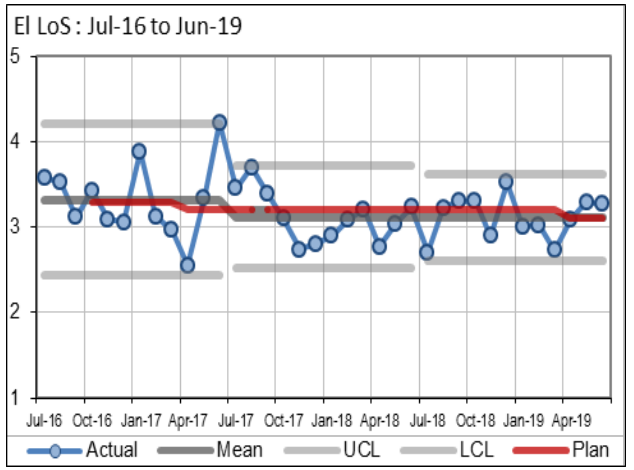
On day cancellations increased to 7.2% from 6.9% in May 19. Jun-19 consisted of 75 hospital cancellations, 21 patient cancellations and 19 DNAs.

The rate of last minute reportable cancellations remained below the 0.8% maximum limit at 0.4% in June (0.6% YTD). There were 2 patients not re-scheduled within 28 days (9 YTD) compared to 8 last year.



There was a dip in theatre activity in Jun-19 (1481 operations) with 205 less operations being completed compared to May-19. The drop was across all specialties but predominantly in ophthalmology.

The activity equated to 74.1 elective cases per working day, a drop from 80.3 in May-19.

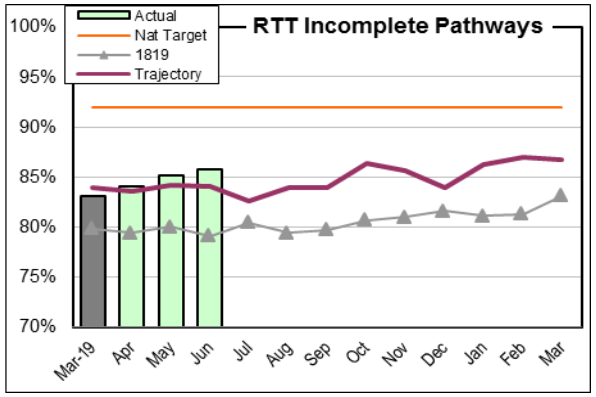


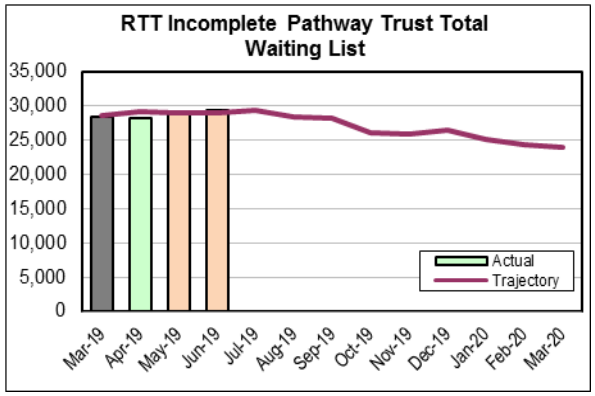
The Elective LOS has remained fairly static just above the plan and the average.

Area	YTD EL LOS
Trust	3.2
Surgical Specialties	3.0
T&O Directorate	3.1
Medical & Emergency Division	5.1

Summary:	Actions:	Assurance:
Theatre Utilisation has remained fairly static at 86.4%. Following the 10% improvement in theatre sessions that started within 15 minutes seen in May, this decreased by 3% in June. There was a drop in Theatre activity in June which equated to a drop of an average of 6 cases per working day. The drop was across all specialties but was predominantly in Ophthalmology.	Weekly monitoring of theatre scheduling. Specialities revisiting Consultant booking data to ensure procedure times are correct.	Reviewed at weekly PTL meeting Procedure times to be agreed with Consultants and communicated to the booking teams. New Weekly Access & Performance Meetings commencing in August

Responsive	RTT – Incomplete Pathway	Jun-19



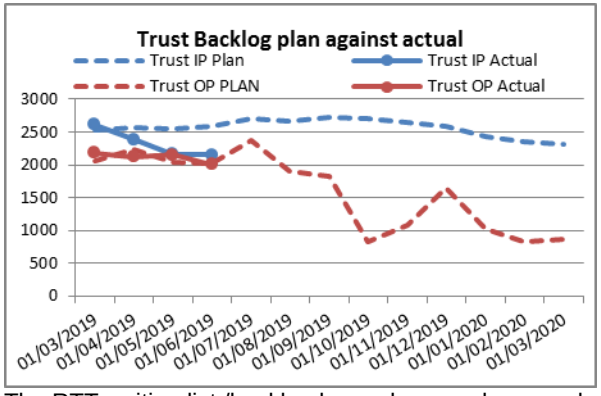


RTT by Specialty: All Specialties achieved their trajectory for June with the exception of Ophthalmology (-3.5%), Neurology (8.7%), Rheumatology (-6.4%), and Cardiology (-5.8%), however both Cardiology and Rheumatology remain above the national target. Both ENT and General Surgery were 5.5% above their trajectory but performance dipped slightly compared to May due to the decrease in activity. For Ophthalmology inpatient admitted pathway performance is 4.9% below trajectory and non-admitted pathway performance is 3.3% below trajectory due to activity being significantly below plan as previously mentioned in the Effective Section. T&O, General Surgery, Urology and ENT saw an increase in the OP Waiting List due to the decrease in outpatient activity and the OP Backlog overall is now above plan.

RTT Backlog: 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

RTT 52 week Breaches: 6 reported for June (3 New). All patients will have a harm review by the managing Consultant. No harm has been found as yet for the ones which have been completed.
52 Week Panel has been established to fully investigate the breaches and identify trends

RTT Data Quality: Ongoing validation continues. The training for RTT has been revised. NHSi have released their 10 module on line training to the Trust for a 3 month period with access for 500 staff. Advanced RTT training for 15 staff is in the process of being scheduled.



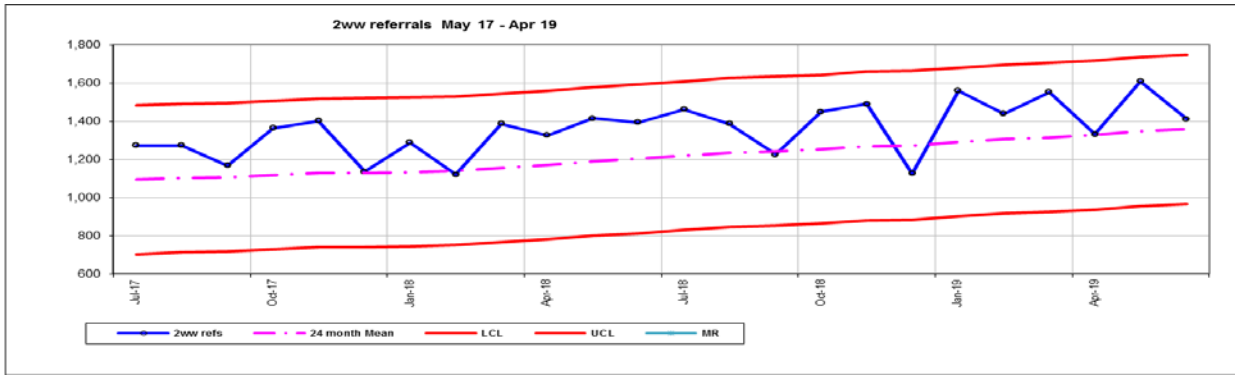
The RTT waiting list /backlog have shown a downward trend. The Waiting List is now nearly 3,000 lower than March 18 position and the backlog is over 2,000 lower.

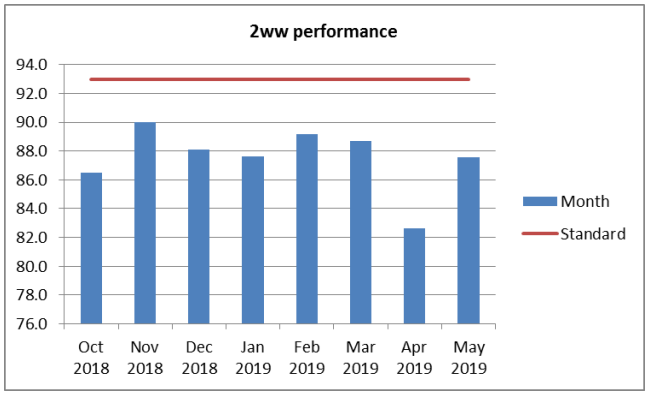
Trust	Mar-19	Apr-19	May-19	Jun-19
Trajectory Total WL	28508	29152	28932	28908
Actual Total Waiting List	28412	28268	29027	29269
Actual IP Waiting List	6494	6045	6037	5978
Actual OP Waiting List	21918	22223	22990	23291
Trajectory Backlog	4146	4806	4578	4622
Actual Total Backlog	4797	4510	4305	4163
Actual IP Backlog	2611	2391	2157	2156
Actual OP Backlog	2186	2119	2148	2007
Trajectory % Performance	**85.5%**	**83.5%**	**84.2%**	**84.01%**
Actual Total % Performance	**83.12%**	**84.05%**	**85.17%**	**85.78%**

RTT performance has shown an increasing trend since November 2019 to a high of 85.78% in June.

Summary:	Actions:	Assurance:
Performance increased further achieving 85.78% against a target of 84.01%. The Trust Waiting List has increased slightly to 29,269 which is therefore 361 higher than the Trust submitted Trajectory of 28,908, however the backlog has continued to decrease to 4,163 in June which is 459 lower than the submitted trajectory of 4,622. IP Backlog is 440 below trajectory.	Continue to ensure achievement of Incomplete targets at an aggregate level by reducing RTT backlog through implementation of speciality plans. Hospital at Home has been implemented to support a reduction of length of stay and release of bed capacity – monitored daily. Review all gaps in medical rotas on a weekly basis and ensure any locum requests have been submitted.	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 on a daily basis to ensure treatment occurs before 52 weeks and ensure patients are booked in chronological order.

Responsive	Cancer Waiting Times – 2 Week Wait (2ww)	Jun-19





	Average GP 2ww referrals to MTW per month											
Period	Breast	Gynae	Haem	Head & Neck	Lower GI	Lung	Other	Upper GI	Urology	Total	Breast Symptoms	Breast total
2017	319	119	9	109	261	47	8	139	154	1164	165	404
2018	343	141	17	123	310	48	4	146	207	1289	141	484
2019 (Jan - Jun)	427	159	28	137	351	56	1	149	188	1498	169	596
% change vs 12 mths	24.6%	12.7%	60.8%	11.3%	13.3%	15.2%	-77.4%	2.0%	-9.2%	16.3%	20.4%	23.2%

Demand: Referrals continue to increase year on year across all tumour sites except Urology. There has been a 16.3% increase over the last 12 months with Breast seeing a 23.2% increase (including Symptom referrals). The biggest proportion of referrals are for the Breast and Lower GI tumour sites.

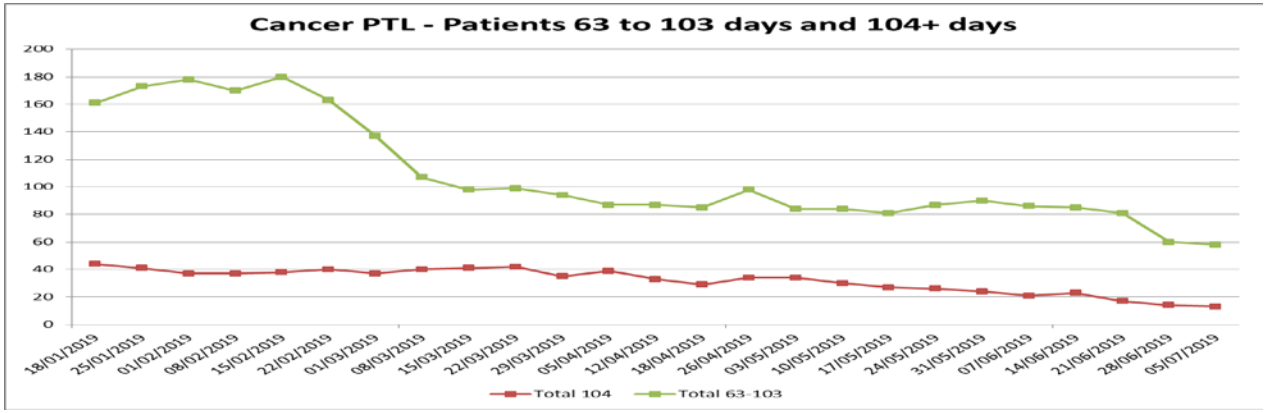
2 Week Wait (2WW) Performance:
Following the decrease in performance seen in April, performance has increased by 5% in May but remains below target at 87.6%. Performance is at a similar level to that since October 2018 despite the introduction of triaging across various tumour sites. The majority of 2ww breaches in May were incurred in breast and lower GI.
The breaches in Lower GI have been due to delays in booking outpatient appointments and CT scans following straight to test triage telephone calls. This has been addressed with the 2ww booking office team and with Radiology. Lower GI and Lung are increasing the proportion of patients through the Straight to Test (STT) pathway to reduce time to first seen. Breast and LGI are reviewing the vetting process and working with the e-referrals team to manage 2WW capacity effectively.
Performance for the 2ww target for Breast Symptoms also improved following the decrease in performance seen in April but remains significantly below target.

Summary:	Actions:	Assurance:
Referrals continue to show an increase year on year across all tumour sites except Urology, however the rate of growth has stabilised. Following the decrease in 2ww performance in April, performance has improved in May back to previous levels but remains below target. The majority of breaches remain in the Breast and Lower GI tumour sites.	Supporting the 2ww office to ensure that the Straight to Test (STT) clinic appointments are fully utilised and that outpatient appointments and CT scans are booked within target following triage call Straight to test triage capacity has been increased for lower GI by the whole CNS team supporting and now delivering 75 appointments per week	Additional one stop breast capacity has been put in place through a limited amount of internally created additional clinics and largely through outsourcing. A more sustainable solution is being worked through which includes recruitment to Mammographer and Consultant Radiographer posts.

Responsive	Cancer Waiting Times – PTL / Backlog	Jun-19

PTL comparison

	Date	24/03/2019	21/04/2019	19/05/2019	20/06/2019	05/07/2019
All	Total	1799	1553	1497	1519	1509
	63 - 104	92	96	82	82	57
	>104	41	32	27	18	14
	Backlog %	8.2	8.2	7.3	6.6	4.7
Lung	63 - 104	9	9	14	24	16
	>104	3	2	3	4	2
Breast	63 - 104	11	8	6	9	12
	>104	5	2	0	3	0
Urology	63 - 104	15	21	16	14	8
	>104	12	5	5	3	2
LGI	63 - 104	20	10	13	11	6
	>104	5	6	4	4	6
UGI	63 - 104	20	10	13	11	4
	>104	5	6	4	4	0



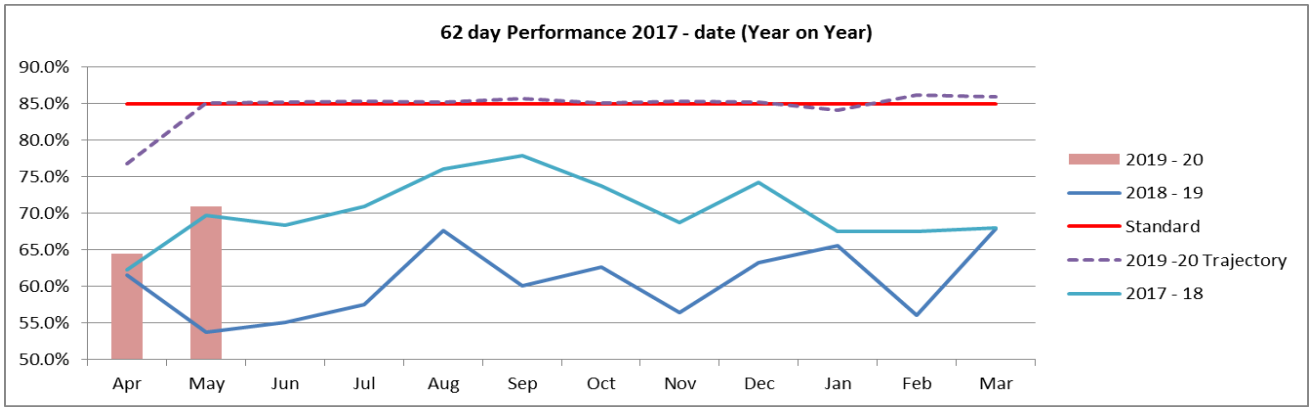
The number of patients being managed continues to fall, as do those who are untreated after day 62. This suggests patients are being seen and diagnosed as benign earlier in the pathway. This will be auditable once the Faster Diagnosis data starts to be collected

The overall backlog (patients waiting over 62 days for treatment with a diagnosis of cancer) has decreased from a high of 180 in February 2019 to 71 as at 5th July (4.7%). There has been a decrease of 22 in the last four weeks. The biggest improvements in the last four weeks have been for Upper GI, Urology and Lower GI. Breast and Upper GI now have none over 104 days. The number over 104 days has reduced to 14.

Backlog clearance has been continued in April, May and June and is expected to continue into July in order to enable a sustainable backlog position that will result in improving performance against the standard in July and August. Early indications are that June's performance will be around 70% and so performance improvement is beginning to be seen as the backlog is cleared.

Summary:	Actions:	Assurance:
The overalll backlog and those over 104 days has shown a significant downward trend and continues to decrease. There are now 71 patients in the backlog (14 of which are over 104). All tumour sites have seen a reduction in backlog with the exception of Lung. Backlog clearance continues and is expected to improve performance of the 62 Day Target.	Specific focus on the lung pathway to ensure the new model is working effectively, including changing the day of the radiology meetings and integrating the STT nurse to reduce delays at the beginning of the pathway. We are also reviewing SABR capacity to increase capacity and reduce waiting times for treatment.	Harm reviews are conducted for all patients treated over 104 days. This is being led by the clinical director for cancer performance.

Responsive	Cancer Waiting Times – 62 Day FDT	Jun-19



62 Day Performance						
May 2019	All reportable patients			MTW only patients		
	Total	Breach	%	Total	Breach	%
Breast	22.0	1.0	95.5	22	1	95.5
Gynae	10.5	2.5	76.2	8	2	75.0
Haematology	9.5	3.5	63.2	9	3	66.7
Head & Neck	3.0	3.0	0.0	0	0	#DIV/0!
Lower GI	14.5	5.0	65.5	12	3	75.0
Lung	11.0	6.0	45.5	8	4	50.0
Other	6.5	4.5	30.8	5	3	40.0
Upper GI	6.5	2.0	69.2	6	2	66.7
Urology	35.0	7.0	80.0	27	1	96.3
TOTAL	118.5	34.5	70.9	97	19	80.4

Now that the backlog is reducing to a sustainable size, further actions have been instigated in order to highlight patients with a new cancer diagnosis. Daily PTL meetings are held with each of the tumour site teams and all patients from day 20 onwards are reviewed for the next action. A new process is in place to request urgent imaging for any patient with cancer that ensures that the patient is scanned and reported within a couple of days, rather than within 2 weeks

A similar process is planned for escalating patients with a cancer diagnosis to endoscopy.

Further data analysis has been undertaken in order to identify actions required to remove barriers from diagnostic pathways and tumour site specific dashboards have been created that are updated and shared with the clinical teams on a monthly basis

Trust Performance: 62 day first definitive treatment (FDT) performance for May (runs one month behind) was 70.9% (against a predicted performance of 85.1% in the trajectory).

Performance improved in May and was the best performance since December 2017. MTW only performance was also the highest since December 2017. The improvement in the backlog position is driving up overall performance against the 62day standard.

June and July's performance is forecast to be similar to May, whilst the backlog is further reduced.

Tumour Specific Performance: The areas showing the biggest improvement were Breast, Haematology and UGI. Urology performance has improved further following the revised prostate pathway and revised clinic templates.

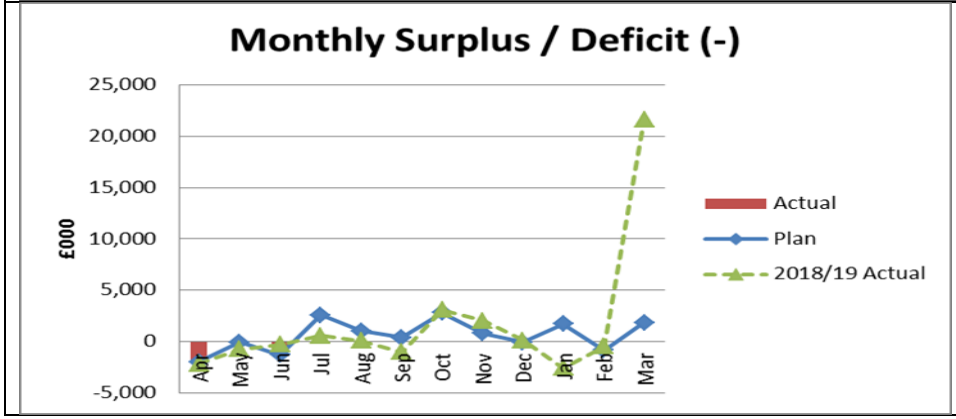
There was a marked under-performance in the Head & Neck and Lung Tumour Sites (Lung also saw an increase in the backlog). Please see actions above.

Conversion rates for 2ww referrals: For patients referred from Jan-Apr 2019 compared to those referred in the whole of 2018, those which resulted in a cancer diagnosis fell to 7% from 8.75%, with the biggest comparative falls being in Lung, Head & Neck, Urology and Upper GI.

Summary:	Actions:	Assurance:
Performance against the 62 day target has improved again to 70.9% in May, the best performance since December 2017.	Action plans for each pathway, as part of the cancer transformation programme are being developed for each tumour site with timeframes and accountability clearly assigned. 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.	Daily huddles with each tumour site team are in place for Lower GI, Upper GI, Breast, Urology, Gynaecology, Lung and Haematology Additional funding has been secured from the CCG and Cancer Alliance to support proposed actions and posts required to continue cancer pathway improvements.

Well Led	Finance	Jun-19

	Current Month						Year to Date						Annual Forecast			
	Actual £m	Plan £m	Variance £m	Pass-through £m	Revised Variance £m	RAG	Actual £m	Plan £m	Variance £m	Pass-through £m	Revised Variance £m	RAG	Actual £m	Plan £m	Variance £m	RAG
Income	40.4	40.6	(0.2)	(0.2)	(0.0)		121.9	122.8	(0.9)	0.0	(0.9)		503.6	503.0	0.6	
Expenditure	(38.5)	(39.3)	0.8	0.2	0.7		(117.0)	(118.5)	1.5	(0.0)	1.6		(465.2)	(465.2)	0.0	
EBITDA (Income less Expenditure)	1.9	1.3	0.6	0.0	0.6		4.9	4.3	0.6	0.0	0.6		38.4	37.8	0.6	
Financing Costs	(2.5)	(2.5)	(0.0)	0.0	(0.0)		(7.7)	(7.6)	(0.0)	0.0	(0.0)		(32.0)	(32.0)	0.0	
Technical Adjustments	(0.6)	0.0	(0.6)	0.0	(0.6)		(0.6)	0.0	(0.6)	0.0	(0.6)		0.5	1.1	(0.6)	
Net Surplus / Deficit (Incl PSF and MRET)	**(1.3)**	**(1.3)**	**0.0**	**0.0**	**0.0**		**(3.3)**	**(3.4)**	**0.0**	**0.0**	**0.0**		**6.9**	**6.9**	**0.0**	
CIPs	1.3	1.3	0.0		0.0		3.2	3.6	(0.4)		(0.4)		18.7	22.3	(3.6)	
Cash Balance	44.8	35.6	9.2		9.2		44.8	35.6	9.2		9.2		3.0	3.0	0.0	
Capital Expenditure	0.4	0.7	0.3		0.3		0.8	1.3	0.5		0.5		14.8	14.8	0.0	



The Trusts deficit including PSF was £1.3m in June which was on plan. The key YTD variances against plan are: Adverse variances relating to CIP slippage (£0.4m), underperformance in Private Patient Income (£0.6m net) and £0.4m pressure relating to EPR costs that were previously planned to be capitalised. These pressures have been offset by non-recurrent items (£0.8m), over performance relating to clinical income (£0.4m) and £1.5m underspend within expenditure budgets. - The Trust has spent £1.4m more (41%) than the YTD agency ceiling set by NHSI (£11.8m per annum) – although nurse agency spend is lower than the same period last year

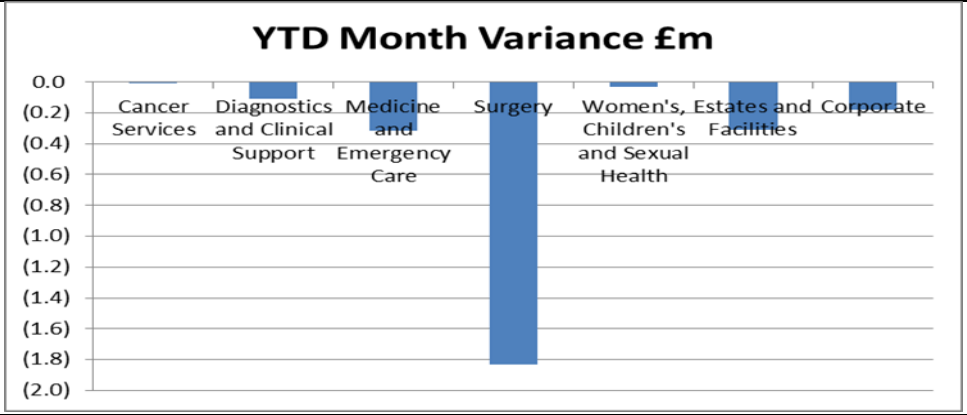
The Trust has delivered £3.2m savings YTD which is £0.4m adverse to plan (11% slippage)

Summary:	Actions:	Assurance:
The Trust is delivering the finanical plan but has had to use £0.8m of non-recurrent items to help offset the CIP slippage (£0.4m) and other budget pressures.	Continue financial management of budgets. Continue CIP programme support. Workforce vacancy review for non-ward based staffing.	Monthly budget statements and reports send to budget holders. Financial position reported at Directorate and Divisional Boards. Monthly Exec-led Divisional Performance Reviews. Finance and Performance Committee and Trust Board

Well Led	Finance: Cost Improvement Plan	Jun-19

Savings by Division

	Current Month			Year to Date			Forecast (Risk Adjusted)				
	Actual	Original Plan	Variance	Actual	Original Plan	Variance	Forecast	Additional Savings	Revised Forecast	Original Plan	Variance
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Cancer Services	0.11	0.12	(0.01)	0.36	0.36	(0.00)	1.34	0.10	1.45	1.45	0.00
Diagnostics and Clinical Support	0.28	0.28	0.00	0.74	0.85	(0.11)	2.44	0.67	3.11	3.11	0.00
Medicine and Emergency Care	0.32	0.34	(0.03)	0.62	0.93	(0.31)	4.57	0.89	5.46	5.46	0.00
Surgery	0.09	0.68	(0.60)	0.22	2.06	(1.84)	4.32	3.83	8.15	8.15	0.00
Women's, Children's and Sexual Health	0.24	0.21	0.03	0.60	0.63	(0.03)	2.26	0.31	2.56	2.56	0.00
Estates and Facilities	0.14	0.21	(0.06)	0.33	0.64	(0.31)	1.78	0.52	2.30	2.30	0.00
Corporate	0.12	0.17	(0.06)	0.33	0.51	(0.18)	1.02	1.07	2.09	2.09	0.00
Total	**1.29**	**2.02**	**(0.73)**	**3.20**	**5.98**	**(2.78)**	**17.73**	**7.39**	**25.12**	**25.12**	**0.00**
Internal Savings Plan stretch	0.00	(0.74)	0.74	0.00	(2.42)	2.42	0.99	(3.78)	(2.79)	(2.79)	0.00
Total	**1.29**	**1.28**	**0.01**	**3.20**	**3.56**	**(0.36)**	**18.72**	**3.61**	**22.33**	**22.33**	**0.00**



The Trust was on plan in the month, £0.4m adverse YTD.

The Trust has an internal CIP plan of £25.1m with an external plan of £22.3m, therefore creating a savings stretch of £2.8m.

The operational efficiencies savings (£5.8m) included within the CIP and the internal savings stretch (£2.8m) have been phased into divisions in twelfths with a corresponding adjustment back to the submitted CIP phased plan reported outside of the divisions position (£0.8m in June, £2.4m YTD).

Summary:	Actions:	Assurance:
The YTD slippage relates to Prime Provider (£1m) being partly offset by additional Non recurrent savings (£0.6m).	Meetings with Divisions and CFO, COO and Director of Workforce are being setup to specifically focus on CIP and forecast outturn recovery actions.	Best Care Programme Directorate CIP check and challenge sessions Divisional Performance Reviews

Well Led	Finance: Capital	Jun-19

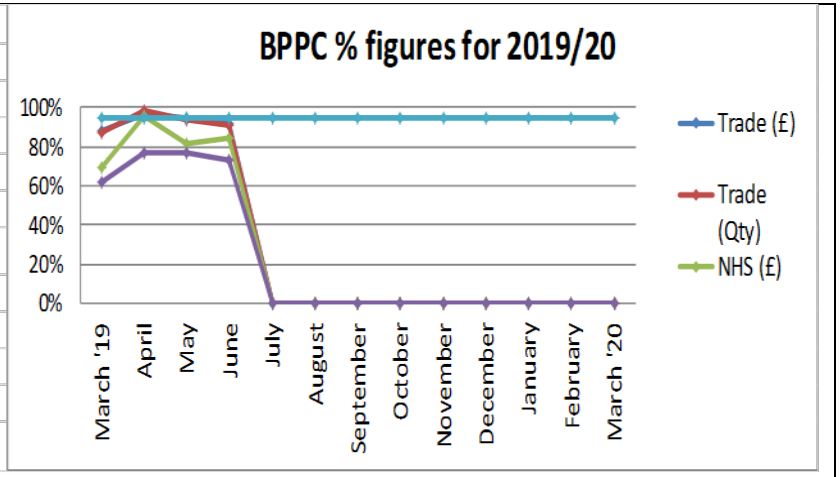
	Year to Date			Forecast			*Committed & orders raised
	Plan	*Actual*	*Variance*	*Plan*	*Actual*	*Variance*	
	£000	£000	£000	£000	£000	£000	£000
Estates	85	119	-34	6,588	6,903	315	758
ICT	950	621	329	4,103	3,967	-136	306
Equipment	160	35	125	3,163	2,984	-179	132
PFI Lifecycle (IFRIC 12)	0	0	0	594	594	0	594
Donated Assets	-75	0	-75	400	400	0	747
Total Including Donated Assets	**1,195**	**775**	**420**	**14,448**	**14,448**	**0**	**1,791**
Donated Assets	75	0	75	-400	0	0	
Total Excluding Donated Assets	**1,270**	**775**	**495**	**14,048**	**14,448**	**0**	

The Trust has resubmitted a revised capital plan on the 15th July reducing the capital programme from £14.4m (excluding donated) to £8.4m (excluding donated assets). The revised capital plan is following the national review that was undertaken by the STP in conjunction with NHSI/E Regional Office. The Trust has retained £0.85m in relation to a potential loan for a replacement CT Scanner which was in the original plan.

Summary:	Actions:	Assurance:
In July the Trust has agreed the rental of the modular build for the AMU therefore this will now be treated as an operating lease, this has released the £6m from the asset sales which was previously earmarked for the AMU project out of capital. The Trust is now planning to defer the £6m along with the original planned deferral of £2m therefore the full £8m carried forward into 2020/21 and 2021/22 with the plan to spend £4m in 20/21 and £4m in 21/22.		Capital is prioritised and all non-essential capital is on hold.

Well Led	Finance: Balance Sheet	Jun-19

	Reported	June Plan	Variance	May Reported	March 2020 Plan FOT
Total Non-Current Assets	294.6	294.8	(0.2)	296.3	311.8
Total Current Assets	96.1	90.9	5.2	96.3	44.7
Total Current Liabilities	(102.4)	(98.0)	(4.4)	(102.6)	(74.3)
Total Non Current Liabilities	(222.8)	(222.8)	(0.0)	(223.3)	(191.1)
Total Assets Employed	**65.5**	**65.5**	**65.5**	**65.5**	**65.5**
Financed By:					
Public dividend capital	211.8	211.8	0.0	211.8	213.3
Revaluation reserve	31.8	31.8	0.0	31.8	46.2
Retained Earnings Reserve	(178.1)	(178.7)	0.6	(177.5)	(168.4)
Total Capital & Reserves	**65.5**	**64.9**	**0.6**	**66.2**	**91.1**

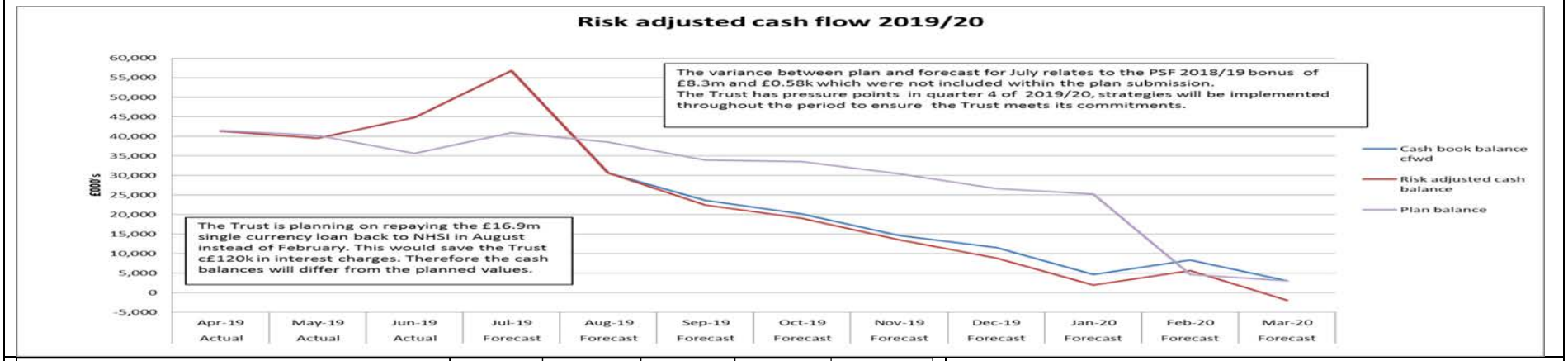


Aged Debtors	0-30 days £000's	31-60 days £000's	61-90 days £000's	over 90 days £000's	Total at mth 3 £000's
NHS Debtors	2,187	3,135	720	2,020	8,062
Trade Debtors	866	237	539	837	2,479
Compucare	67	27	3	410	507
Total outstanding debtors	**3,120**	**3,399**	**1,262**	**3,267**	**11,048**

Aged Creditors	0-30 days £000's	31-60 days £000's	61-90 days £000's	over 90 days £000's	Total at mth 3 £000's
NHS Creditors	424	48	195	1,737	2,405
Trade Creditors	8,917	580	379	712	10,587
Total creditors	**9,341**	**628**	**574**	**2,449**	**12,992**

Summary:	Actions:	Assurance:
The overall working capital within the month results in a slight decrease in Debtors of £3m against plan with a small increase in creditors of £4.1m compared to the revised plan submitted in May. The cash balance held at the end of the month is slightly higher than the plan by £9.2m.	Ensure debtors are raised and collected promptly. Continue to chase invoice approvers to authorise supplier invoices to ensure payments are made within terms.	

Well Led	Finance: Cash Flow	Jun-19



	Interest Rate	Value £m's	19/20 Annual Repayment £m's	19/20 Annual Interest Paid £m's	Repayment Date
Revenue loans:					
Interim Single Currency Loan	1.50%	16.908	0	0.253	18/02/2020
Interim Revolving Working Capital Facility (IRWCF)	3.50%	12.132	0	0.425	19/10/2020
interim working capital loans	3.50%	13.990	0	0.492	18/03/2021
Capital loans:					
Capital investment loan	2.02%	12.000	1.200	0.055	15/09/2020
Capital investment loan	3.91%	11.000	0.734	0.193	15/09/2025
Capital investment loan	4.73%	6.000	0.240	0.160	15/09/2035
Other loans:					
Salix loan (interest free)	0	2.217	0.371	0.000	2024/25

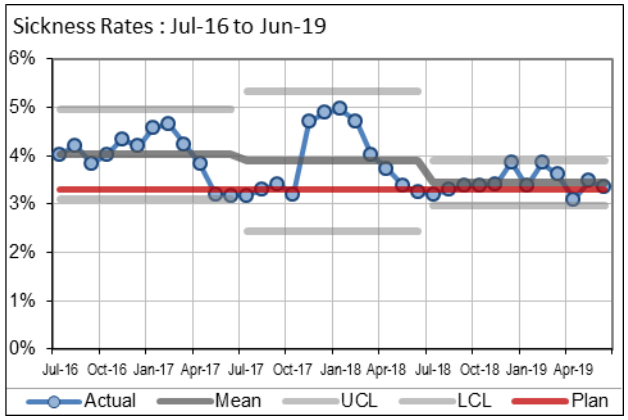
The blue line shows the cash Trust's cash position for 2019/20 which is in line with the plan (purple line). The red risk adjusted line shows the position if the relevant risk items is not received.

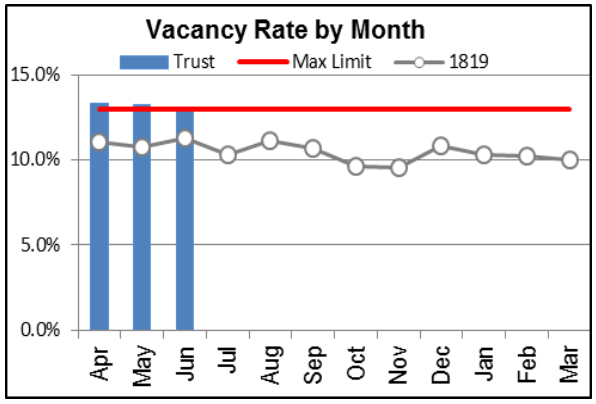
The closing cash balance at the end of June 2019 was £44.8m which is slightly higher than plan of £35.6m. The reason for the high cash balance is due to the Trust carrying forward £8.4m from the asset sales to fund capital projects in 2019/20 and following the SLA contracts being signed invoices raised in Mth 3 were raised with the contract value plus any catch up value from Mth 1 and 2 as these invoices were raised based on 2018/19 values.

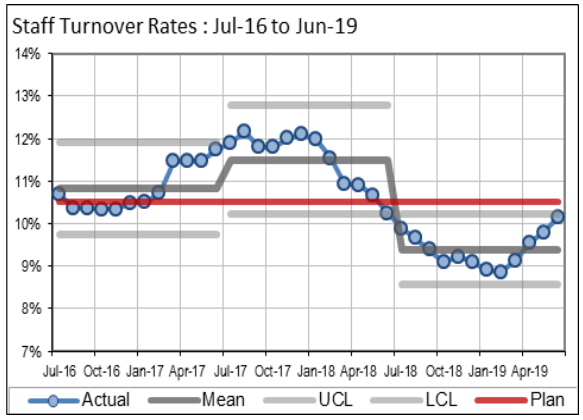
The Trust is planning to repay the single currency loan of £16.908m early in August instead of February 2020, this will save the Trust c£120k in interest.

Summary:	Actions:	Assurance:
The closing cash balance at the end of June was £44.8m, the Trust has cash pressures towards the end of the financial year which will use the surplus funds. The cash flow is balanced to the I&E, therefore if the I&E position starts to move adversely away from plan this will have a negative impact on the cash flow.	Ensure that the I&E remains to plan, if this moves adversely this will have a negative impact on the cash flow and further strategies will need to be implemented.	The cash flow is balanced every day and reconciled to the I&E forecast regularly to ensure it has the most recent position.

Well Led	Workforce	Jun-19







	Vacancy %		
Staff Group	**Apr-19**	**May-19**	**Jun-19**
Registered Nursing, Midwifery & HV	20.32%	19.86%	19.25%
Medical and Dental	16.55%	16.16%	15.59%
AHP	13.17%	14.48%	14.82%
Other ST&T	5.64%	10.92%	11.22%
Other	8.53%	8.39%	8.56%
Grand Total	**13.31%**	**13.27%**	**13.11%**

41 offers made via the Aryavarat pilot for OSCE ready nurses - expected to join August. 102 offers made in Kerala for nurses who will require OSCE support

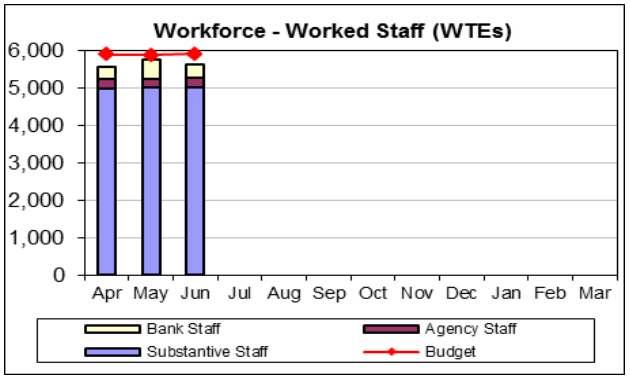
Vacancy rate calculation changed in April, however last years' figures have been run using the new methodology for comparison

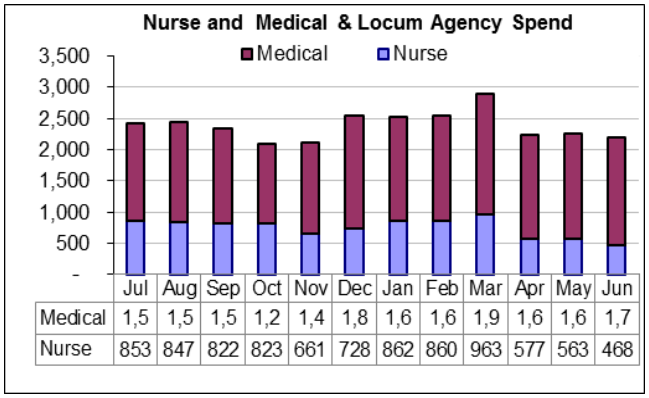
Vacancy Rate: There was a significant increase in April compared to March 2019 due to the increased establishment arising from Business and Workforce planning. For both the Nursing and Medical vacancies one of the highest levels are in the Urgent Care Division for both (with Nursing being higher). However, the level of sickness and turnover in these areas remains lower than the Trust total and other areas.
The level of Nursing vacancy is the highest for T&O and this area has also seen a significant increase in sickness levels in May and June to (6.2%) of which 83% is long term sick.

Turnover Rate: The methodology used to calculate turnover changed in April this year to bring the Trust in line with NHSi reporting. This will result in a higher overall number than previously reported over the course of the year.
Sickness Rate: The overall sickness rate has become more stable over the last 12 months slightly above the maximum limit.
Key Vacancy risks include: Nursing for medical and T&O wards at TWH, Nursing for ED on both sites but primarily TWH, TWH theatres. Consultant physicians, AMU and respiratory. Areas with high vacancy rates continue to put pressure on agency rates, particularly nursing in ED.

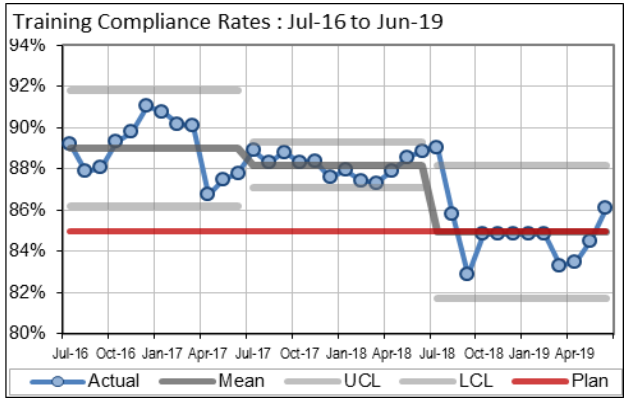
Summary:	Actions:	Assurance:
Vacancy rate remains at around 13.1% for the Trust with Registered Nursing, Midwifery & Health Visitors at a rate of 19% and Medical and Dental and a rate of 15.5%, however both have seen a slight improvement (0.5%). Sickness rates are more stable, however the proportion of sickness that is short-term sickness is reducing.	A further recruitment trip to Manilla and Cebu is planned for September. Recruitment presence at a range of events in Kent over the summer. Surgery recruitment day held in June. Ongoing programme of skype interviews for overseas nurses. Ongoing specialty doctor recruitment for paediatrics, surgery, medicine & ED	Recruitment Task and Finish group to work on a number of specific projects aimed at improving the attractiveness of MTW to potential applicants as well as supporting retention of existing staff. Projects identified from recruitment workshop held with senior staff. All divisions have plans for the recruitment to vacant consultant posts.

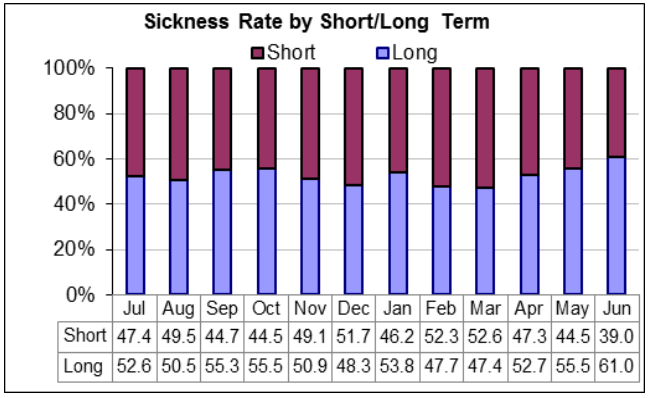
Well Led	Workforce	Jun-19





	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Medical	1,5	1,5	1,5	1,2	1,4	1,8	1,6	1,6	1,9	1,6	1,6	1,7
Nurse	853	847	822	823	661	728	862	860	963	577	563	468





	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Short	47.4	49.5	44.7	44.5	49.1	51.7	46.2	52.3	52.6	47.3	44.5	39.0
Long	52.6	50.5	55.3	55.5	50.9	48.3	53.8	47.7	47.4	52.7	55.5	61.0

Bank and Agency: The nurse agency spend reduced further in June and is the lowest level reported in any one month throughout last year and this year to date. Medical & Locum Agency Spend has increased since November 2018 and June is the second highest level reported in any one month throughout last year and this year to date.

Quarter 1 FFT Staffing: Based on the 368 responses, 75.3% said they would recommend the Trust for care and 53.3% said they would recommend the Trust as a place to work

The proportion of sickness that is long-term sickness has increased since April 2019 from an average of 47% in 1819 to an average of 56% (61% in June). Therefore short term sickness levels have reduced.

Mandatory Training: The three areas that are below 80% compliance are T&O, Surgery and Acute Medicine. Key areas of improvement this month are Information Governance (from 77% to 81%) , Intermediate Dementia Awareness (from 78% to 81%) and Sepsis (from 84% to 86%
Appraisals: The current appraisal window is now open and as such appraisal data is not reported during this period

Summary:	Actions:	Assurance:
The nurse agency spend reduced further in June, however the medical & locum agency spend has continued to increase. Since April 2019 there has been a higher proportion of long-term sickness compared to short-term sickness. Mandatory Training compliance has improved to 86.1% for June and is now above the 85% target with Information Governance showing the biggest improvement.	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. New electronic appraisal system launched at the beginning of April along with a longer appraisal window should improve compliance and ease of completion.	HR staff are working with line managers to ensure that all those on long term absence have a management plan in place. Individual e-reminders to all staff now automatically issued by the Learning Management System to help inprove compliance for Mandatory Training.

Safe		2018/19	2019/20	Q1			Q2			Q3			Q4			Q1			YTD	FOT	YTD Var from Plan	Data Qualtiy Star Rating
ID	Key Performance Indicators	Outturn	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun				
S1	Rate of Cdifficile per 100,000 beddays	22.8	22.4	4.7	4.7	20.5	35.5	39.2	46.4	19.2	15.1	9.7	32.1	19.9	28.4	44.6	0.0	25.6	23.0	22.1	-5.1%	TBC
S2	CDifficile (Post 72hrs) - Hospital	56	55	1	1	4	7	8	9	4	3	2	7	4	6	9	0	5	14	54	-1	TBC
S3	MRSA Bacteraemia (Post 48hrs) Hospital	3	0	1	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	TBC
S3.1	% Elective MRSA Screening	98.0%	98.0%	99.5%	99.0%	99.0%	98.7%	98.5%	98.7%	99.0%	99.0%	99.0%	98.0%	99.0%	98.0%	99.0%	99.1%	99.0%	99.0%	99.0%	1.0%	TBC
S3.2	% Non-Elective MRSA Screening	93.1%	95.0%	No data	No data	No data	No data	No data	No data	93.0%	95.2%	95.0%	86.0%	92.5%	93.1%	89.0%	92.0%	90.0%	90.0%	95.0%	-5.0%	TBC
S4	Cases of Gram Negative Bacteraemia	113	113	7	9	14	10	10	7	11	12	9	5	8	11	8	4	7	19	102	-11	TBC
S4.1	MSSA Bacteraemia (Post 48hrs)	19	19	2	2	2	2	5	0	1	0	1	2	0	2	1	3	0	4	17	-2	TBC
S4.2	E. Coli Bacteraemia (Post 48hrs)	69	69	3	6	9	7	7	3	5	10	5	3	4	7	6	3	7	16	67	-2	TBC
S4.3	Catheters inserted	1,160	225	214	No data	No data	222	No data	No data	310	209	No data	No data	No data	205	213	224	245	245	245	20	TBC
S5	Rate of Hospital Acquired Pressure Ulcers	0.97	0.85	1.66	2.19	1.95	0.51	1.79	0.87	0.66	0.34	0.70	0.81	0.18	-	0.70	0.16	0.17	0.3	0.7	- 0.5	TBC
S5.1	Rate of All Pressure Ulcers	16.5	16.0	17.9	15.5	13.6	18.6	15.1	15.8	18.2	16.5	17.2	16.5	18.6	14.4	23.0	20.9	23.8	22.5	16.0	6.5	TBC
S5.2	Pressure Ulcers Grade 2	49	36	7	11	9	1	5	2	4	2	4	3	1	0	1	1	1	3	30	- 6	TBC
S5.3	Pressure Ulcers Grades 3	3	0	2	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	-	TBC
S5.4	Pressure Ulcers Grades 4	3	0	0	0	0	0	1	0	0	0	0	2	0	0	0	0	0	0	0	-	TBC
S5.5	Pressure Ulcers Deemed "Un-gradeable"	13	24	0	2	2	2	4	3	0	0	0	-	-	0	3	0	0	3	21	- 3	TBC
S5.6	Pressure Ulcers Total	68	60	9	13	11	3	11	5	4	2	4	5	1	0	4	1	1	6	51	- 9	TBC
S6	Rate of Patient Falls	6.21	6.00	5.74	4.84	6.06	7.86	6.76	6.80	5.81	6.79	5.21	6.88	6.58	5.31	6.94	5.66	6.14	6.24	6.00	0.24	TBC
S6.1	Rate of Patient Falls TWH	6.75	6.30	6.27	4.98	6.38	6.90	7.53	6.90	6.38	7.18	6.19	8.29	7.73	6.28	7.48	6.53	7.14	7.03	6.30	0.73	TBC
S6.2	Rate of Patient Falls MH	5.31	5.05	4.93	4.62	5.53	9.57	5.44	6.62	4.84	6.11	3.60	4.64	4.76	3.78	5.96	4.18	4.48	4.87	5.05	-0.13	TBC
S6.3	Falls resulting in "No Harm"	1,170	1,116	96	82	96	122	93	97	99	97	82	115	102	89	93	92	97	282	1,119	3	TBC
S6.4	Falls resulting in "Low Harm"	312	300	23	18	21	39	35	29	18	34	22	31	26	16	37	21	20	78	300	3	TBC
S6.5	Falls resulting in "Moderate Harm"	33	24	1	-	1	7	5	2	2	3	2	2	2	6	6	3	2	11	24	5	TBC
S6.6	Falls resulting in "Severe Harm"	22	24	2	3	0	0	5	3	2	1	1	3	1	1	2	4	1	7	24	1	TBC
S6.7	Falls resulting in "Death"	2	0	0	0	0	0	0	1	0	0	0	0	1	0	1	0	0	1	1	1	TBC
S6.8	Total Number of Patient Falls	1,525	1,464	122	103	118	155	138	132	121	135	107	150	132	112	140	120	120	380	1,464	14	TBC
S6.9	Total Number of Patient Falls TWH	1,033	996	81	65	78	87	97	85	84	90	79	111	95	81	93	87	87	267	996	18	TBC
S6.10	Total Number of Patient Falls MH	492	468	41	38	40	68	41	47	37	45	28	39	37	31	46	33	33	112	463	- 5	TBC
S7	Never Events	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	1	1	1	TBC
S8	Number of New SIs in month	154	144	13	20	14	11	18	17	19	11	5	10	8	8	17	15	8	40	144	4	TBC
S8.1	Serious Incidents rate	0.63	0.59	0.61	0.94	0.72	0.56	0.88	0.88	0.91	0.55	0.24	0.46	0.40	0.38	0.84	0.71	0.41	0.66	0.60	0.00	TBC
S8.2	Number of Open Sis	100	95	92	103	100	96	96	110	97	90	104	87	81	85	97	99	93	93	93	- 2	TBC
S9	SIs not closed <60 Days Monthly Snapshot		24													57	50	52	52	24	28	TBC
S10	Overall Safe staffing fill rate	96.8%	93.5%	98.9%	98.1%	95.8%	95.8%	94.3%	95.0%	99.2%	99.5%	95.3%	98.0%	95.8%	95.5%	94.8%	94.2%	94.0%	94.3%	94.3%	0.8%	TBC
S11	Safety Thermometer % of Harm Free Care	97.4%	98.0%	97.2%	97.6%	97.7%	98.2%	98.3%	97.6%	97.3%	97.5%	98.4%	97.9%	98.5%	97.4%	97.5%	98.5%	98.0%	98.0%	98.0%	0.0%	TBC
S11.1	Safety Thermometer % of New Harms	2.6%	1.9%	2.7%	2.2%	2.3%	1.8%	1.7%	2.4%	2.6%	2.3%	1.6%	2.1%	1.5%	2.6%	2.4%	1.5%	1.9%	1.9%	1.9%	-0.1%	TBC
S12	Number of Central Alerting System Alerts Overdue	8	12	0	0	1	0	2	0	1	1	0	1	1	1	1	2	1	4	12	1	TBC
S13	Medication Errors - Low Harm	86	72	5	12	6	8	10	3	2	8	3	6	6	17	7	4	12	23	72	5	TBC
S13.1	Medication Errors - Moderate Harm	11	12	0	0	0	1	3	0	0	1	1	0	4	1	3	0	1	4	12	1	TBC
S13.2	Medication Errors - Severe Harm	4	0	0	0	2	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	TBC
S14	Number of Incidents reported in month	11,737	11,700	823	983	931	1,083	1,088	950	1,026	1,033	850	1,084	947	939	954	934	886	2,774	11,549	-151	TBC
S14.1	Rate of Incidents that are Harmful	1.01	0.92	1.46	1.22	0.86	1.11	1.10	1.47	1.07	0.77	0.47	1.01	0.53	0.96	1.05	1.39	1.13	1.19	0.99	0.27	TBC
S14.2	Number of Incidents open >45 days	23,172	23,172	2,235	1,935	1,889	2,273	1,959	1,515	2,135	1,469	2,095	2,046	2,205	1,416	1,448	1,931	2,025	5,404	22,783	-389	TBC

Effective		2018/19 Outturn	2019/20 Target	Q1			Q2			Q3			Q4			Q1			YTD	FOT	YTD Var From Plan	Data Qualtiy Star Rating
ID	Key Performance Indicators			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun				
E1	Hospital-level Mortality Indicator (SHMI)	Band 2	Band 2	1.0440	1.0440	1.0440	1.0440	1.0219	1.0219	1.0371	1.0244	1.0244	1.0391	1.0391	1.0391	1.0391	1.0296	1.0235	1.0235	1.0235	Band 2	TBC
E2	Standardised Mortality HSMR	Lower Confidence <100		103.7	103.7	104.4	106.7	105.8	104.8	103.7	102.4	103.3	102.3	101.2	99.4	96.3	97.2	92.7	92.7	92.7	-7.3	TBC
E2.1	Crude Mortality	1.0%	1.0%	0.9%	0.9%	0.9%	0.9%	0.9%	1.1%	0.9%	0.8%	1.0%	1.2%	1.1%	1.1%	1.0%	0.8%	0.7%	0.9%	0.9%	-0.1%	TBC
E3	% Total Readmissions	14.1%	14.1%	13.4%	13.5%	12.8%	14.2%	14.2%	13.6%	14.5%	14.0%	15.4%	14.3%	14.6%	14.7%	15.0%	13.4%		14.2%	14.1%	0.1%	TBC
E4	Readmissions <30 days: Emergency	14.7%	14.7%	13.9%	14.1%	13.3%	14.8%	14.7%	14.3%	15.3%	14.8%	16.1%	14.7%	15.2%	15.3%	15.6%	14.2%	Data runs one month behind	14.8%	14.7%	0.1%	TBC
E5	Readmissions <30 days: Elective	6.9%	6.9%	7.1%	6.5%	7.5%	7.5%	8.1%	6.1%	5.4%	6.0%	6.0%	8.0%	6.6%	7.7%	7.9%	5.6%		6.7%	6.7%	-0.2%	TBC
E6	Stroke BPT Part 3: 90% Time on Stroke Ward	89.7%	80.0%	83.3%	83.3%	76.7%	86.7%	84.0%	84.6%	85.7%	92.3%	91.1%	90.6%	91.8%	89.7%	77.6%	70.1%	80.0%	75.8%	80.0%	-4.2%	TBC
E7	% TIA <24hrs	64.7%	60.0%	90.0%	73.9%	75.0%	29.2%	65.2%	63.2%	66.7%	70.6%	58.3%	91.7%	61.9%	42.1%	60.6%	53.3%	Mth Behind	57.1%	60.0%	-2.9%	TBC
E8	C-Section Rate (elective or non-elective)	27.9%	25.0%	25.6%	26.2%	29.6%	26.9%	28.8%	24.0%	29.7%	30.2%	26.5%	31.3%	29.5%	27.0%	31.1%	32.3%	27.5%	30.3%	25.0%	5.3%	TBC
E8.1	% Mothers initiating Breastfeeding	82.2%	78.0%	82.5%	83.6%	81.0%	79.1%	84.0%	81.7%	77.7%	83.5%	80.4%	84.4%	84.0%	85.2%	83.3%	83.8%	79.3%	82.1%	82.1%	4.1%	TBC
E8.2	% Stillbirths Rate	0.2%	0.47%	0.00%	0.36%	0.00%	0.20%	0.19%	0.20%	0.00%	0.20%	0.00%	0.42%	0.23%	0.21%	0.48%	0.39%	0.21%	0.35%	0.35%	-0.1%	TBC

Caring		2018/19 Outturn	2019/20 Target	Q2			Q3			Q4			Q1			YTD	FOT	YTD Var from Plan	Data Qualtiy Star Rating
ID	Key Performance Indicators			Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun				
C1	Single Sex Accommodation Breaches	35	0	5	12	0	10	8	0	0	0	0	0	0	0	0	0	0	TBC
C2	Rate of New Complaints	2.30	2.93	1.93	1.67	2.22	2.84	2.41	2.34	2.39	2.04	3.17	2.28	2.21	2.71	2.40	2.80	-0.51	TBC
C3	% complaints responded to within target	75.7%	75.0%	73.3%	62.8%	54.3%	65.3%	75.0%	66.7%	82.8%	73.3%	75.7%	66.7%	37.5%	45.7%	51.3%	69.0%	-23.7%	TBC
C3.1	Total Open Complaints	149	140	155	137	144	139	129	129	130	120	149	155	173	154	154	140	14	TBC
C3.2	Number of new complaints received	564	720	38	34	43	59	48	48	52	41	67	46	47	53	146	686	- 34	TBC
C3.3	Number of Nursing Complaints	107	108	8	5	7	9	13	12	10	12	10	5	9	11	25	106	- 2	TBC
C3.4	Number of Medical Complaints	353	336	24	21	26	41	32	32	31	23	43	30	26	33	89	336	5	TBC
C3.5	Number of Complaints open 60-90 days	182	180	15	18	11	12	10	11	13	12	19	14	25	18	57	180	12	TBC
C3.6	Number of Complaints open >90 days	349	348	36	37	43	29	25	20	19	18	20	30	33	33	96	348	9	TBC
C4	% IP Response Rate Friends & Family	17.9%	25.0%	19.5%	18.7%	20.1%	15.3%	24.5%	19.6%	18.7%	18.2%	17.9%	18.7%	20.4%	16.5%	18.6%	25.0%	-6.4%	TBC
C5	IP Friends & Family (FFT)% positive	94.8%	95.0%	94.2%	95.9%	93.8%	94.2%	93.7%	93.9%	93.5%	95.6%	94.8%	94.2%	95.6%	96.7%	95.5%	95.5%	0.5%	TBC
C6	% A&E Response Rate Friends & Family	8.9%	15.0%	12.1%	8.1%	12.3%	4.2%	21.2%	12.9%	5.4%	7.6%	8.9%	11.0%	14.6%	12.3%	12.7%	15.0%	-2.3%	TBC
C7	A&E Friends & Family (FFT) % positive	92.0%	87.0%	89.4%	92.6%	90.9%	91.4%	91.0%	89.9%	90.5%	91.3%	92.0%	81.2%	86.1%	91.6%	86.5%	87.0%	-0.5%	TBC
C8	% Maternity Combined Q2 Response Rate	20.3%	25.0%	27.0%	9.9%	43.8%	18.2%	11.8%	23.9%	37.6%	26.2%	20.3%	20.1%	6.0%	45.5%	23.4%	25.0%	-1.6%	TBC
C9	Maternity Combined FFT % Positive	98.4%	95.0%	93.5%	98.0%	92.1%	95.0%	99.1%	90.4%	95.8%	96.5%	98.4%	93.8%	97.1%	94.2%	94.5%	95.0%	-0.5%	TBC
C10	OP Friends & Family (FFT) % Positive	81.2%	84.0%	85.2%	81.7%	83.9%	82.7%	84.1%	84.2%	84.4%	84.3%	81.2%	82.5%	82.5%	81.5%	82.2%	84.0%	-1.8%	TBC
C10.1	OP Friends & Family (FFT) Response Rate	68.5%	68.0%	66.2%	66.2%	67.4%	68.6%	68.8%	67.4%	69.0%	68.5%	68.5%	49.3%	62.5%	56.9%	56.3%	68.0%	-11.7%	TBC
C11	VTE Risk Assessment (%)	96.4%	95.0%	97.2%	95.4%	96.1%	96.9%	97.2%	96.5%	97.2%	97.4%	96.4%	96.9%	96.8%	96.1%	96.6%	96.6%	1.6%	TBC
C12	Nat CQUIN: % Dementia Screening	98.8%	90.0%	99.6%	100.0%	99.8%	99.6%	99.8%	100.0%	100.0%	99.8%	98.8%	94.3%	92.3%	Data runs one month behind	93.3%	93.3%	3.3%	TBC
C12.1	Nat CQUIN: % Dementia Risk Asssessed	98.7%	90.0%	94%	96%	90%	96%	100%	99%	100%	100%	99%	98%	94%		96.2%	96.2%	6.2%	TBC
C12.2	Nat CQUIN: % Dementia Referred to Specialist	100.0%	90.0%	98%	100%	99%	100%	100%	100%	100%	100%	100%	98%	100%		99.0%	99.0%	9.0%	TBC
C13	Patient Overall Satisfaction	91.0%	90.0%	90.0%	89.0%	89.0%	90.0%	91.0%	89.0%	88.0%	89.0%	91.0%	87.0%	87.0%	87.0%	87.0%	90.0%	-3.0%	TBC
C14	Involvement in Decisions about treatment/care	87.0%	90.0%	88.0%	85.0%	87.0%	87.0%	90.0%	85.0%	84.0%	87.0%	87.0%	86.0%	89.0%	82.0%	82.0%	90.0%	-8.0%	TBC
C14.1	Hospital Staff being available to talk about worries/concerns	93.0%	90.0%	94.0%	89.0%	93.0%	94.0%	94.0%	92.0%	91.0%	92.0%	93.0%	90.0%	91.0%	91.0%	91.0%	91.0%	1.0%	TBC
C14.2	Privacy when discussing condition/treatment	96.0%	90.0%	98.0%	98.0%	97.0%	98.0%	96.0%	97.0%	98.0%	97.0%	96.0%	99.0%	97.0%	96.0%	96.0%	96.0%	6.0%	TBC
C14.3	Being informed of side effects of medication	84.0%	90.0%	86.0%	89.0%	83.0%	86.0%	82.0%	84.0%	83.0%	88.0%	84.0%	86.0%	86.0%	87.0%	87.0%	90.0%	-3.0%	TBC
C14.4	Being informed of who to contact if worried after leaving hospital	90.0%	90.0%	94.0%	92.0%	91.0%	92.0%	95.0%	89.0%	95.0%	94.0%	90.0%	93.0%	96.0%	98.0%	98.0%	98.0%	8.0%	TBC

Responsive		2018/19	2019/20	Q1			Q2			Q3			Q4			Q1			YTD	FOT	YTD Var From Plan	Data Qualtiy Star Rating
ID	Key Performance Indicators	Outturn	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun				
R1	A&E % 4hrs Arrival to Exit - Trust (Inc MIU)	91.9%	91.7%	93.08%	92.45%	94.17%	93.16%	91.79%	93.93%	90.75%	90.93%	89.6%	88.91%	87.16%	95.85%	92.03%	91.96%	94.50%	92.82%	92.01%	-0.2%	TBC
R1.1	A&E % 4hrs Arrival to Exit - Maidstone	95.0%	95.2%	97.00%	95.76%	96.72%	94.41%	93.42%	97.17%	96.26%	95.21%	92.22%	92.87%	90.80%	97.81%	94.24%	93.87%	95.81%	94.64%	94.89%	-1.3%	TBC
R1.2	A&E % 4hrs Arrival to Exit - TWells	85.8%	85.1%	86.89%	86.43%	89.27%	88.79%	86.60%	88.45%	82.33%	84.05%	83.58%	81.32%	78.91%	92.60%	86.62%	86.94%	90.85%	88.10%	86.22%	0.7%	TBC
R1.3	A&E Conversion Rate	20.8%	20.8%	21.2%	21.0%	20.7%	20.8%	21.0%	20.4%	20.9%	20.8%	21.4%	20.9%	20.4%	20.4%	20.0%	19.0%	18.4%	19.1%	19.1%	-1.8%	TBC
R1.4	A&E Left without being Seen Rate (%)	2.8%	2.8%	2.5%	2.9%	3.0%	3.4%	3.2%	2.5%	2.3%	2.4%	2.5%	2.6%	3.3%	2.4%	2.8%	2.4%	2.5%	2.5%	2.5%	-0.2%	TBC
R1.5	A&E Time to Assessment 15 mins	95.3%	95.0%	96.2%	95.4%	95.9%	95.9%	94.9%	97.0%	95.2%	95.9%	95.3%	94.7%	91.5%	95.2%	94.5%	90.0%	92.0%	92.2%	95.0%	-2.8%	TBC
R1.6	A&E Time to Treatment 60 mins	55.9%	55.9%	57.5%	55.1%	56.9%	53.5%	54.7%	57.5%	55.4%	58.1%	55.3%	56.7%	52.9%	57.2%	55.7%	56.4%	58.9%	57.0%	57.0%	1.1%	TBC
R1.7	A&E Unplanned Re-Attendance Rate (%)	8.0%	8.0%	7.6%	7.7%	7.9%	8.3%	8.7%	7.6%	8.4%	8.1%	8.1%	7.8%	8.3%	8.0%	8.3%	8.5%	8.4%	8.4%	8.0%	0.3%	TBC
R1.8	A&E Average Time in Department (Hours)	3.40	3.10	3.33	3.33	3.16	3.33	3.42	3.19	3.53	3.42	3.54	3.68	3.79	3.16	3.41	3.38	3.17	3.32	3.10	0.07	TBC
R2	A&E 12hr Breaches	2	0	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	TBC
R3	Ambulance Handover Delays >60mins	596	540	44	27	23	22	60	31	67	82	70	74	83	13	57	59	26	142	540	5.2%	TBC
R3.1	Ambulance Handover Delays >30mins	4,487	4,428	296	287	264	250	400	284	486	442	441	613	444	280	494	531	384	1409	4428	27.3%	TBC
R4	RTT Incomplete Pathway	83.1%	84.0%	79.4%	80.0%	79.1%	80.4%	79.4%	79.7%	80.7%	81.0%	81.6%	81.1%	81.3%	83.1%	84.0%	85.2%	85.8%	85.8%	89.0%	1.8%	TBC
R4.1	RTT Incomplete Admitted Backlog	2,606	2,315	2,652	2,555	3,520	3,434	3,348	3,065	2,930	2,867	2,779	2,829	2,781	2,606	2,389	2,154	2,145	2,145	1,940	-17.4%	TBC
R4.2	RTT Incomplete Non-Admitted Backlog	2,182	872	4,048	3,972	3,687	3,298	3,911	3,578	3,200	3,235	2,886	2,781	2,807	2,182	2,119	2,149	2,000	2,000	760	-1.3%	TBC
R4.3	RTT Specialties Not Achieved Nat Target	9	0	11	10	10	11	12	10	10	9	9	9	9	9	9	10	9	28	28	28	TBC
R4.4	RTT Incomplete Total Backlog	4,788	3,186	6,700	6,527	7,207	6,732	7,259	6,643	6,130	6,102	5,665	5,610	5,588	4,788	4,508	4,303	4,145	4,145	2,699	-10.3%	TBC
R5	RTT 52 Week Waiters (New in Month)	8	0	2	2	8	6	4	8	8	11	5	7	8	8	6	10	3	19	19	19	TBC
R6	% Diagnostics Tests WTimes <6wks	99.2%	99.0%	99.1%	99.4%	99.4%	99.7%	99.6%	99.4%	99.5%	99.4%	99.1%	99.1%	99.5%	99.2%	99.1%	99.1%	98.7%	98.7%	99.0%	-0.3%	TBC
R7	*Cancer two week wait	88.7%	93.0%	83.4%	88.9%	85.0%	82.3%	76.4%	78.0%	86.5%	90.0%	88.1%	87.6%	89.2%	88.7%	82.6%	87.6%	Data runs one month behind	85.1%	93.0%	-7.9%	TBC
R8	*Cancer WT - Breast Symptons 2WW	73.2%	93.0%	65.8%	87.5%	61.0%	67.5%	58.5%	71.3%	83.1%	81.7%	58.3%	69.4%	74.7%	73.2%	56.4%	65.2%		60.7%	93.0%	-32.3%	TBC
R9	*Cancer 31 day wait - First Treatment	96.1%	96.0%	92.1%	96.6%	95.9%	97.9%	96.2%	95.1%	96.2%	96.8%	97.2%	95.9%	96.2%	96.1%	96.5%	96.0%		96.2%	96.2%	0.2%	TBC
R9.1	*Cancer 31 day - Subs Treatment - Surgery	92.9%	94.0%	76.7%	100.0%	84.6%	96.4%	96.2%	82.4%	92.0%	79.4%	100.0%	82.4%	96.0%	92.9%	87.1%	96.3%		91.4%	94.0%	-2.6%	TBC
R9.2	*Cancer 31 day - Subs Treatment - Drugs	99.0%	98.0%	95.1%	100.0%	98.6%	100.0%	99.1%	98.7%	99.3%	98.7%	98.3%	96.7%	98.2%	99.0%	100.0%	100.0%		100.0%	100.0%	2.0%	TBC
R9.3	*Cancer 31 day Subs Treatment Radio	92.8%	94.0%	95.7%	95.1%	95.2%	95.4%	97.6%	93.7%	98.2%	96.7%	99.2%	90.5%	94.5%	92.8%	92.5%	91.4%		92.0%	94.0%	-2.0%	TBC
R10	*Cancer 62 day wait - First Definitive	67.9%	86.0%	61.6%	53.8%	55.2%	57.5%	67.7%	60.1%	62.6%	56.4%	63.3%	65.6%	56.0%	67.9%	64.5%	70.9%		67.6%	86.0%	-17.5%	TBC
R10.1	*Cancer 62 day wait - First Definitive - MTW	72.8%	85.0%	64.7%	58.1%	57.9%	59.3%	70.9%	65.1%	63.8%	58.8%	65.6%	69.2%	58.8%	72.8%	68.6%	80.4%		74.3%	85.0%	-10.7%	TBC
R10.2	*Cancer WT - 62 Day Screening Referrals	74.4%	90.0%	50.0%	84.8%	92.3%	79.5%	83.7%	69.0%	88.2%	97.3%	84.8%	80.6%	55.2%	74.4%	84.6%	87.8%		86.6%	90.0%	-3.4%	TBC
R10.3	*Cancer WT - 62 Day Cons Specialist	82.4%	85.0%	25.0%	58.3%	77.8%	61.5%	76.5%	40.0%	86.4%	72.2%	69.2%	64.0%	86.7%	82.4%	100.0%	41.7%		62.2%	85.0%	-22.8%	TBC

Responsive		2018/19	2019/20	Q1			Q2			Q3			Q4			Q1			YTD	FOT	YTD Var From Plan	Data Qualtiy Star Rating
ID	Key Performance Indicators	Outturn	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun				
R11	Non-Elective LOS	6.90	6.85	7.44	7.08	6.70	6.56	6.95	6.70	7.04	6.83	6.80	6.71	7.22	6.75	7.13	7.15	6.99	7.09	6.85	24.1%	TBC
R11.1	Elective LOS	3.11	3.00	2.78	3.07	3.30	2.67	3.18	3.31	3.27	2.89	3.72	3.15	3.20	2.88	3.10	3.30	3.27	3.23	3.00	22.7%	TBC
R11.2	% Bed Occupancy	90.8%	90.0%	92.0%	89.8%	85.5%	89.6%	90.5%	89.7%	92.8%	92.7%	91.2%	92.0%	93.4%	90.5%	92.0%	93.4%	90.1%	91.9%	90.0%	1.9%	TBC
R11.3	Occupied Beddays Average Per Day	673	673	708	686	649	636	659	647	671	663	663	703	716	681	672	684	652	670	670	-1.7%	TBC
R11.4	Delayed Transfers of Care	4.4%	3.5%	4.6%	4.3%	4.4%	5.0%	4.8%	5.9%	4.5%	3.6%	3.2%	4.1%	3.8%	5.0%	4.4%	4.1%	3.9%	4.1%	3.5%	0.6%	TBC
R12	Theatre Utilisation (Elective)	90.5%	90.0%	86.3%	86.0%	87.1%	86.4%	84.5%	87.6%	85.9%	86.5%	86.3%	85.5%	85.6%	87.0%	88.3%	86.2%	86.4%	86.9%	90.0%	-3.1%	TBC
R12.1	Day Case Rate	87.6%	87.1%	88.2%	87.7%	87.6%	87.8%	86.8%	87.0%	87.9%	86.2%	87.5%	89.1%	88.4%	87.2%	87.7%	87.7%	87.4%	87.6%	87.2%	0.5%	TBC
R12.2	Cancelled Operations (last minute)	0.7%	0.8%	0.5%	0.7%	0.5%	0.6%	0.8%	0.8%	0.7%	0.6%	0.6%	0.7%	1.2%	0.7%	0.7%	0.7%	0.4%	0.4%	0.4%	-0.4%	TBC
R12.3	Patients not treated <28 days of cancellation	26	0	3	4	1	4	2	0	6	2	0	1	2	1	4	3	1	8	8	8	TBC
R12.4	Urgent Ops Cancelled for 2nd time	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	TBC
R12.5	Outpatient Utilisation	65.1%	85.0%	63.8%	65.8%	65.8%	65.4%	64.2%	65.1%	64.4%	66.2%	63.5%	66.3%	66.4%	64.5%	67.5%	66.9%	66.4%	67.0%	85.0%	-18.0%	TBC
R12.6	Outpatient Follow Up : New Ratio	1.51	1.53	1.42	1.45	1.47	1.48	1.50	1.50	1.54	1.57	1.54	1.59	1.61	1.51	1.53	1.51	1.38	1.38	1.38	-15.1%	TBC
R12.7	Outpatient New DNA Rates	5.7%	5.0%	6.2%	6.5%	6.1%	6.7%	6.4%	6.2%	6.4%	6.1%	5.7%	5.6%	5.0%	4.6%	5.6%	5.7%	5.8%	5.7%	5.0%	0.7%	TBC
R12.8	Outpatient Follow Up DNA Rates	6.1%	8.0%	8.5%	7.5%	7.4%	8.3%	7.9%	7.4%	7.8%	7.4%	6.5%	6.6%	6.4%	6.2%	5.3%	5.2%	6.5%	5.6%	5.6%	-2.4%	TBC
R13	Primary Referrals	124,181	139,143	10,841	11,043	10,663	11,054	9,974	9,815	11,011	10,832	8,502	10,794	9,679	9,973	10,958	10,452	9,243	30,653	136,380	-8.3%	TBC
R13.1	Non-Primary Referrals	63,092	59,909	5,181	5,408	5,390	5,394	5,205	4,915	5,209	5,202	4,833	5,873	5,040	5,442	5,043	5,600	5,888	16,531	59,909	14.9%	TBC
R14	Cons to Cons Referrals	68,987	51,898	5,795	6,251	6,109	6,349	6,026	5,399	6,378	6,091	4,718	5,987	5,126	4,758	6,249	5,987	5,015	17,251	51,898	38.4%	TBC
R15	OP New Activity	209,257	226,133	17,464	18,657	17,944	18,278	16,794	16,615	18,808	18,590	15,012	18,294	16,081	16,719	17,596	18,221	17,548	53,365	226,133	-1.7%	TBC
R16	OP Follow Up Activity	316,538	346,845	24,810	26,991	26,347	26,978	25,111	24,880	28,933	29,129	23,078	29,068	25,966	25,247	26,879	27,481	24,273	78,633	346,845	-5.6%	TBC
R17	Elective Inpatient Activity	6,171	7,426	458	526	531	521	568	527	554	622	460	450	435	519	531	596	515	1,642	7,426	-7.9%	TBC
R18	Day Case Activity	43,599	50,210	3,421	3,760	3,767	3,749	3,725	3,523	4,038	3,871	3,233	3,692	3,300	3,520	3,777	4,230	3,586	11,593	50,210	-3.9%	TBC
R18.1	Total IP & DC Activity	49,770	57,636	3,879	4,286	4,298	4,270	4,293	4,050	4,592	4,493	3,693	4,142	3,735	4,039	4,308	4,826	4,101	13,235	57,636	-4.4%	TBC
R19	Non Elective Activity (inc Maternity)	64,187	84,338	4,949	5,409	5,117	5,344	5,582	5,245	5,542	5,272	5,246	5,749	5,050	5,682	5,167	5,568	5,362	16,097	84,338	-23.2%	TBC
R20	A&E Attendances : Type 1	155,838	159,252	12,049	13,536	13,011	13,526	12,707	12,627	12,861	12,793	12,684	13,668	12,567	13,809	13,401	14,282	13,577	41,260	159,252	1.4%	TBC
R20.1	A&E Attendances : Total, inc MIU	191,158	195,883	14,640	16,670	16,332	16,995	15,716	15,758	15,766	15,420	15,316	16,437	15,276	16,832	16,641	17,718	16,952	51,311	195,883	2.3%	TBC
R21	Oncology Fractions	65,671	67,260	5,667	5,148	5,304	5,605	5,379	4,698	5,648	5,994	5,059	5,867	5,292	6,010	6,911	6,559	5,532	19,002	67,260	17.6%	TBC
R22	Number of Births (Mothers Delivered)	5,857	5,856	457	545	480	490	514	484	543	504	491	469	420	460	415	504	465	1,384	5,856	-5.5%	TBC

Well-Led		2018/19	2019/20	Q1			Q2			Q3			Q4			Q1			YTD	FOT	YTD Var From Plan	Data Qualtiy Star Rating
ID	Key Performance Indicators	Outturn	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun				
W1	Surplus (Deficit) against B/E Duty	12,006	- 3,370	- 2,160	- 759	- 293	574	82	- 1,014	3,075	2,030	136	- 2,567	- 457	13,359	- 2,001	- 71	- 1,272	- 3,344	- 3,370	-0.8%	TBC
W2	CIP Savings	13,825	3,558	794	797	928	1,200	1,151	917	1,221	1,151	678	1,428	986	2,574	725	1,012	1,291	3,028	3,558	-14.9%	TBC
W3	Cash Balance	10,405	3,000	12,872	20,190	13,358	18,207	14,126	13,493	12,640	8,566	12,766	7,956	10,625	10,405	41,294	39,537	44,793	44,793	3,000	25.8%	TBC
W4	Capital Expenditure	19,185	1,270	214	68	431	327	365	82	547	1,106	2,420	295	430	12,900	358	45	380	783	1,270	-38.3%	TBC
W4.1	Income	465,038	122,719	35,863	38,684	37,337	41,154	38,606	36,805	40,695	40,821	38,634	37,148	34,981	44,309	40,150	41,400	40,363	121,913	122,719	-0.7%	TBC
W4.2	EBITDA	28,347	4,256	358	1,755	2,218	2,998	2,515	1,545	5,533	4,475	2,603	- 104	- 1,934	6,386	540	2,452	1,895	4,887	4,256	14.8%	TBC
W5	Finance use of Resources Rating	3	3		4	4	4	4	4	3	3	3	3	4	3		3	3	3	3	0	TBC
W6	Staff Turnover Rate	9.1%	10.5%	10.9%	10.7%	10.3%	9.9%	9.7%	9.4%	9.1%	9.2%	9.1%	8.9%	8.9%	9.1%	9.5%	9.8%	10.1%	9.8%	9.8%	-0.7%	TBC
W7	Vacancy Rate (%)	10.0%	13.0%	11.1%	10.8%	11.3%	10.3%	11.1%	10.7%	9.6%	9.6%	10.8%	10.3%	10.3%	10.0%	13.3%	13.3%	13.1%	13.1%	13.0%	0.1%	TBC
W7.1	Contracted WTE	5,153	5,347	5,024	5,034	5,028	5,049	5,069	5,064	5,148	5,017	5,124	5,139	5,145	5,153	5,147	5,105	5,122	5,122	5,122	-4.2%	TBC
W7.2	Establishment WTE	5,670	5,921	5,589	5,576	5,612	5,617	5,627	5,628	5,632	5,631	5,685	5,684	5,684	5,670	5,906	5,891	5,921	5,921	5,921	0.0%	TBC
W7.3	Substantive Staff Used	5,012	5,374	4,885	4,944	4,907	4,907	4,937	4,949	4,996	5,036	5,002	4,995	5,009	5,012	4,998	5,019	5,032	5,032	5,032	-6.4%	TBC
W7.4	Worked WTE	5,826	5,921	5,596	5,654	5,596	5,597	5,732	5,654	5,688	5,631	5,733	5,747	5,784	5,826	5,623	5,808	5,667	5,667	5,667	-4.3%	TBC
W7.5	Vacancies WTE	517	574	564	542	584	568	558	564	483	614	561	545	539	517	758	786	799	799	799	39.3%	TBC
W8	Total Agency Spend	22,651	15,426	2,008	2,147	1,736	2,113	2,072	1,901	1,787	1,734	1,747	1,901	2,097	1,408	1,649	1,655	1,531	4,835	15,443	0	TBC
W8.1	Nurse Agency Spend	- 9,434	- 1,840	- 829	- 839	- 348	- 853	- 847	- 822	- 823	- 661	- 728	- 862	- 860	- 963	- 577	- 563	- 468	- 1,608	- 1,608	-12.7%	TBC
W8.2	Medical Locum & Agency Spend	- 19,052	- 4,449	- 1,420	- 1,623	- 1,547	- 1,567	- 1,585	- 1,517	- 1,261	- 1,456	- 1,806	- 1,663	- 1,674	- 1,933	- 1,656	- 1,699	- 1,718	- 5,073	- 5,073	14.0%	TBC
W8.3	Bank Staff Used	500	338	359	362	356	338	448	383	372	365	416	433	442	500	332	511	356	356	356	5.5%	TBC
W8.4	Agency Staff Used	277	210	294	302	289	310	302	277	271	229	270	283	286	277	249	241	243	243	243	15.8%	TBC
W8.5	Overtime Used	36	No data	59	46	44	42	46	46	49	-	45	37	47	36	45	37	35	35	35	No data	TBC
W8.6	Temp costs & overtime as % of total pay bill	No data	13.3%	16.7%	17.0%	15.5%	16.6%	18.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	16.0%	16.1%	15.9%	15.9%	15.9%	2.7%	TBC
W9	Statutory and Mandatory Training	83.3%	85.0%	87.9%	88.5%	88.9%	89.0%	85.8%	82.9%	No data	No data	No data	No data	No data	83.3%	83.5%	84.5%	86.1%	84.7%	85.0%	-0.3%	TBC
W10	Sickness Absence	3.6%	3.3%	3.7%	3.4%	3.2%	3.2%	3.3%	3.4%	3.4%	3.4%	3.9%	3.4%	3.8%	3.6%	3.1%	3.5%	3.3%	3.3%	3.3%	0.0%	TBC
W11	Staff FFT % recommended work	82.2%	57.0%	48.7%	48.7%	48.7%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	82.2%	82.2%	82.2%	53.3%	53.3%	53.3%	53.3%	57.0%	-3.7%	TBC
W11.1	Staff Friends & Family (FFT) % rec care	89.0%	80.0%	77.6%	77.6%	77.6%	78.2%	78.2%	78.2%	78.2%	78.2%	78.2%	89.0%	89.0%	89.0%	75.3%	75.3%	75.3%	75.3%	80.0%	-4.7%	TBC
W12	Appraisal Completeness	92.0%	90.0%	Data not reported for Q1			76.5%	82.6%	84.7%	86.2%	88.1%	90.2%	91.0%	92.1%	92.0%	Data not reported for Q1				90.0%	-78.3%	TBC

Summary report from Quality Committee, 10/07/19	Committee Chair (Non-Executive Director)

The Quality Committee met on 10th May 2019 (a 'main' meeting). This was the first meeting of the Quality Committee since the Trust Board approved significant changes to the Committee's Terms of Reference in May 2019 (which led to the disestablishment of the Trust Clinical Governance Committee, among other things).

1. The key matters considered were as follows:

- The Deputy Medical Director gave an update on the **response to the issues arising from the "Patient experience" item at the 'Trust Board meeting on 28/02/19** and it was agreed to check and confirm whether Sepsis training was mandatory for all clinical staff
- An **Update on Referral to Treatment (RTT) data quality** was noted, but as the Chief Operating Officer was unable to attend the meeting, it was agreed to submit a further update to the 'main' Quality Committee in September 2019
- A **closure report from the Trust Clinical Governance Committee** was considered
- Each of the five **clinical Divisions then gave a report**. It was noted that the format of the reports would take some time to finalise, so the last reports that the Directorates had given to the Trust Clinical Governance Committee were used as the basis. The reports raised a number of common themes, one of which was replacement equipment, so the Chief Executive agreed to ask the Chief Finance Officer and new Interim Director of Estates and Facilities to develop a corporate approach to the replacement of clinical equipment
- The Chief of Service for Chief of Service, Medicine & Emergency Care gave the **latest update on mortality**, which included the work being done in relation to mortality related to Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders
- The latest **update on Serious Incidents (SIs)** was given (which incorporated a report from the Learning & Improvement (SI) Panel, which was now a sub-committee of the Committee)
- The **Complaints Annual Report 2018/19** was considered, which included a discussion on the action being taken to address complaints response time performance
- An **annual review of Quality Impact Assessments (QIAs)** was discussed & it was agreed to schedule an update on the QIA process for the 'main' Quality Committee in January 2020
- The Deputy Chief Nurse presented the **Safeguarding Adults Annual Report, 2018/19** & it they agreed to provide the Chief of Service for Surgery with a year-on-year comparison of the number of Kent Adult Safeguarding Alert Forms (KASAFs) raised at the Trust
- The Named Nurse for Safeguarding Children presented the **Safeguarding Children Annual Report, 2018/19**
- The final version of the **Quality Accounts 2018/19** was noted, as was the **External Audit of Quality Accounts**
- Reports from the **Complaints, Legal, Incidents, PALS, Audit (CLIPA) group** and **Infection Prevention and Control Committee** (which are also now sub-committees) were noted, and the revised Terms of Reference of the latter Committee were approved
- The Chief Nurse gave a verbal update on the recent activity of the **Safeguarding Adults Committee** (which is also now a sub-committee of the Quality Committee)
- The summary report from the **Patient Experience Committee** on 10/06/19 was noted
- The Committee also agreed a proposal that the **Drugs, Therapeutics and Medicines Management Committee become a sub-committee of the Committee** (instead of being a sub-committee of the Diagnostics & Clinical Support Services Clinical Governance Committee). As this amends the Quality Committee's Terms of Reference, the Trust Board needs to approve the change. Amended Terms of Reference are therefore enclosed. It was further agreed that the Clinical Director of Pharmacy & Medicines Optimisation should become a member of the 'main' Quality Committee, so the Terms of Reference also reflect that change. As the change affects the Trust Committee structure (which is an Appendix to the Standing Orders), the Board is also asked to ratify the amended Standing Orders

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 Committee agreed a proposed amendment to its Terms of Reference, which the Board is asked to approve (and in doing so also ratify the amendments to the Committee structure with the Standing Orders)

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 revised Terms of Reference for the Quality Committee
3. To ratify the associated amendments to the Standing Orders

[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

QUALITY COMMITTEE - TERMS OF REFERENCE

NHS Maidstone and Tunbridge Wells NHS Trust

1. Purpose

The Quality Committee is constituted at the request of the Trust Board to:

a) seek and obtain assurance on the effectiveness of the Trust's structures, systems and processes to enable delivery of the Trust's objectives relating to quality of care
b) Oversee quality within the clinical divisions

2. Membership

- Non-Executive Director or Associate Non-Executive Director (Chair)*
- Non-Executive Director or Associate Non-Executive Director (Vice Chair)*
- 1 other Non-Executive Director or Associate Non-Executive Director*
- Chief Operating Officer*
- Chief Nurse*
- Medical Director*
- Deputy Medical Director*
- Director of Infection Prevention & Control (if not represented via another role within the membership)
- Associate Director, Quality Governance*
- The Chiefs of Service for the five clinical divisions
- The Divisional Directors of Nursing & Quality (DDNQs) for the five clinical divisions
- The Clinical Director of Pharmacy & Medicines Optimisation

* Denotes those who constitute the membership of the 'deep dive' meeting (see below)

Members are expected to attend all relevant meetings, but will be required to attend at least four of the 'main' Quality Committee meetings (those who are also members of the 'deep dive' meeting will be required to attend at least three such meetings). Failure of a committee member to meet this obligation will be referred to the Chair of the Quality Committee for action.

3. Quorum

The 'main' meeting of the Committee will be quorate when the following members are present:

- The Chair or Vice Chair of the Quality Committee or one other Non-Executive Director or Associate Non-Executive Director[2]
- Two members of the Executive Team
- Three clinical divisional representatives (i.e. either the Chief of Service, DDNQ or an appropriate deputy for either)

The 'deep dive' meeting (see below) will be quorate when the following members are present:

- The Chair or Vice Chair of the Quality Committee or one other Non-Executive Director or Associate Non-Executive Director[1]
- Two members of the Executive Team

4. Attendance

The following are invited to attend each 'main' meeting

- Representatives from Internal Audit
- The Chief Nurse from West Kent Clinical Commissioning Group (CCG) (or an appropriate deputy in their absence)

Other staff may be invited to attend, as required, to meet the Committee's purpose and duties.

[2] For the purposes of quorum, the Chair of the Trust Board will be regarded as a Non-Executive Director

All other Non-Executive Directors (including the Chair of the Trust Board), Associate Non-Executive Directors, and members of the Executive Team (i.e. apart from those listed in the "Membership") will be invited to attend all meetings of the Committee.

5. Frequency of Meetings

Meeting will be generally held every month, but will operate under two different formats. The meeting held on alternate months will be a 'deep dive' meeting, which will enable detailed scrutiny of a small number of issues/subjects For clarity, the other meeting will be referred to as the 'main' Quality Committee.

Additional meetings will be scheduled as necessary at the request of the Chair.

6. Duties

6.1 To seek and obtain assurance on all aspects of the quality of care across the Trust, and if not assured, to oversee the appropriate action or escalate relevant issues to the Trust Board, for consideration

6.2 To oversee all aspects of quality within the clinical divisions, and to obtain assurance that an appropriate response is given

6.3 To seek and obtain assurance on the mitigations for significant risks relating to quality

6.4 To seek and obtain assurance that the Trust Risk Management Policy is implemented, in relation to quality issues

6.5 To seek and obtain assurance on compliance with relevant policies, procedures and clinical guidance

6.6 To receive details of the learning arising from complaints, claims, inquests, and Serious Incidents (SIs)

6.7 To seek and obtain assurance on the Trust's compliance with the Fundamental Standards (as defined by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and reflected in the Care Quality Commission's 5 domains)

7. Parent committees and reporting procedure

The Quality Committee is a sub-committee of the Trust Board. The Committee Chair will report activities to the next Trust Board meeting following each Quality Committee meeting.

Any relevant feedback and/or information from the Trust Board will be reported by Executive and Non-Executive (including or Associate Non-Executive Directors) members to each meeting of the Committee, as deemed required by the Committee Chair.

The Committee's relationship with the Trust Clinical Governance and Patient Experience Committees is covered separately, below.

8. Sub-committees and reporting procedure

The Committee has the following sub-committees.

1. The Cancer Services Divisional Clinical Governance Committee
2. The Diagnostics & Clinical Support Divisional Clinical Governance Committee
3. The Medicine & Emergency Care Divisional Clinical Governance Committee
4. The Surgery Divisional Clinical Governance Committee
5. The Women's, Children's & Sexual Health Divisional Clinical Governance Committee
6. The Complaints, Legal, Incidents, PALS, Audit (CLIPA) group
7. The Infection Prevention and Control Committee
8. The Learning and Improvement (SI) Panel
9. The Safeguarding Adults Committee
10. The Safeguarding Children Committee
~~10.~~11. The Drugs, Therapeutics and Medicines Management Committee

A report from the Clinical Governance Committees of the five clinical divisions will be submitted to each 'main' Quality Committee meeting, using a format approved by the Chair of the Quality Committee.

Unless specifically requested by the Quality Committee, the Chair of the Learning and Improvement (SI) Panel will only report SI-related issues to the 'main' Quality Committee by exception (as such issues would be included within the reports the Clinical Governance Committees of the five clinical divisions.

The minutes of each Infection Prevention and Control Committee meeting will be submitted to the next 'main' Quality Committee meeting.

The Quality Committee may establish fixed-term 'Task & Finish' Groups to assist it in meeting its duties as it, or the Trust Board, sees fit.

10. Patient Experience Committee

The Quality Committee may commission the Patient Experience Committee to review a particular subject, and provide a report. Similarly, the Patient Experience Committee may request that the Quality Committee undertake a review of a particular subject, and provide a report.

The Patient Experience Committee should also receive a summary report of the work undertaken by the Quality Committee, for information/assurance (and to help prevent any unnecessary duplication of work). The summary report submitted from the Quality Committee to the Trust Board should be used for the purpose. Similarly, a summary report of the Patient Experience Committee will be submitted to the Quality Committee (the summary report submitted from the Patient Experience Committee to the Trust Board should be used for the purpose).

11. Administration

The minutes of the Committee will be formally recorded and presented to the following meeting for agreement and the review of actions

The Trust Secretary will ensure that each committee is given appropriate administrative support and will liaise with the Committee Chair on:

- The Committee's forward programme, setting out the dates of key meetings & agenda items
- The meeting agenda
- The meeting minutes and the action log

12. Emergency powers and urgent decisions

The powers and authority of the Quality Committee may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted at least two of the Committee's members The exercise of such powers by the Committee Chair shall be reported to the next meeting of the Quality Committee, for formal ratification.

13. Review of Terms of Reference

These Terms of Reference will be agreed by the Quality Committee and approved by the Trust Board. They will be reviewed annually or sooner if there is a significant change in the arrangements.

- Agreed by Quality and Safety Committee: 13 March 2013
- Approved by the Board: March 2013
- Agreed by the Quality & Safety Committee 'deep dive' meeting: 25th April 2014

- Terms of Reference (amended) agreed by the Quality & Safety Committee: 9th May 2014
- Approved by the Board: May 2014
- Terms of Reference (amended) agreed by the Quality & Safety Committee: 21st January 2015 (to remove reference to the Health & Safety Committee, which is a sub-committee of the Trust Management Executive)
- Revised Terms of Reference agreed by the Quality & Safety Committee, 13th May 2015
- Revised Terms of Reference approved by the Trust Board, 27th May 2015
- Revised Terms of Reference agreed by the Quality Committee, 6th January 2016
- Revised Terms of Reference approved by the Trust Board, 27th January 2016
- Revised Terms of Reference agreed by the Quality Committee, 11th January 2017
- Revised Terms of Reference approved by the Trust Board, 25th January 2017
- Terms of Reference approved by Trust Board, 18th October 2017 (to add Associate Non-Executive Directors to the membership)
- Revised Terms of Reference agreed by the Quality Committee, 10th January 2018
- Revised Terms of Reference approved by Trust Board, 25th January 2018
- Revised Terms of Reference agreed by the Quality Committee, 8th May 2019
- Revised Terms of Reference approved by Trust Board, 23rd May 2019
- Revised Terms of Reference agreed by the Quality Committee, 10th July 2019 (to add the Drugs, Therapeutics and Medicines Management Committee as sub-committee, and add the Clinical Director of Pharmacy & Medicines Optimisation as a member of the 'main' Quality Committee)
- Revised Terms of Reference approved by Trust Board, 25th July 2019

RAG Rating

Red	Less than	**80%**		
Amber	Between	**80%**	and	**90%**
Green	Between	**90%**	and	**110%**
Red	Greater than	**130%**		

Jun-19		DAY		NIGHT		TEMPORARY STAFFING								Nurse Sensitive Indicators						Financial review		
Hospital Site name	Health Roster Name	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Bank/Agency Usage	Agency as a % of Temporary Staffing	Bank / Agency Demand: RN/M (number of shifts)	Bank Agency Demand RN/M comparison of previous month	WTE Temporary demand RN/M	Temporary Demand Unfilled -RM/N (number of shifts)	Temporary Demand Unfilled - RM/M comparison of previous month	Overall Care Hours per pt day	FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	QuESTT Score	Comments	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Stroke Unit (M) - NK551	91.2%	95.3%	100.0%	139.1%	36.9%	42.4%	117	↓	8.06	12	↓	8.1	77.4%	91.7%	0	0	3	Increased CSW fill rate at night due to enhanced care requirements	147,455	145,941	1,514
MAIDSTONE	Cornwallis (M) - NS959	82.0%	87.8%	73.4%	80.0%	21.8%	24.2%	50	↓	3.28	4	↓	7.5	14.3%	100.0%	1	0	2	Reduced RN fill rate in line with bed occupancy range between 14 - 19 throughout the month and supporting bed management for operational flow. Redcued CSW fill rate with unfilled shifts and enahnced care requirements during the month.	80,936	91,979	(11,043)
MAIDSTONE	Culpepper Ward (M) - NS551	103.8%	95.7%	99.2%	96.7%	11.7%	11.0%	32	↑	2.23	1	↓	8.0	51.4%	100.0%	3	0	0	2 falls above threshold Escalation on 7 ocassions.	113,018	108,814	4,204
MAIDSTONE	John Day Respiratory Ward (M) - NT151	89.6%	122.3%	96.6%	128.3%	43.0%	51.4%	175	↓	12.33	21	↓	6.4	40.0%	91.7%	11	0	8	6 falls above threshold Reduced RN fill rate due to vacacnices and 21 unfill shifts. Increased CSW fill rate to support with enhanced care requirements throughout the month.	132,407	140,837	(8,430)
MAIDSTONE	Intensive Care (M) - NA251	92.3%	92.3%	84.9%	-	3.5%	11.3%	22	↓	1.43	3	↑	37.6			0	0	3	Reduced fill rate in line with low bed occupancy. Staff redeployed to support staffing levels at TWH ITU	162,182	157,608	4,574
MAIDSTONE	Pye Oliver (Medical) - NK259	96.5%	93.5%	102.2%	95.1%	31.3%	51.2%	117	↓	7.89	16	↓	5.7	43.4%	95.7%	4	1	7		116,590	110,416	6,174
MAIDSTONE	Whatman Ward - NK959	108.5%	90.1%	153.0%	103.0%	51.1%	36.9%	137	↓	9.46	20	↓	7.2	11.3%	66.7%	4	0	5	Increased RN fill rate at night due to night escalation recorded on 21 occasions	92,369	102,659	(10,290)
MAIDSTONE	Lord North Ward (M) - NF651	98.5%	180.3%	101.3%	96.7%	24.9%	8.2%	59	↑	3.75	10	↓	7.2	18.0%	100.0%	2	0	2	Increased CSW fill rate to support increased dependency levels of patient's on the ward.	88,181	95,140	(6,959)
MAIDSTONE	Mercer Ward (M) - NJ251	97.2%	105.3%	97.8%	130.0%	25.7%	30.7%	72	↓	4.57	6	↓	6.4	65.4%	100.0%	2	1	3	Mercer moved to FC to support deep clean. Additional bed capacity requiring additional CSW fill rate during this period.	123,416	102,301	21,115
MAIDSTONE	Edith Cavell (M) - NS459	108.3%	106.2%	100.1%	120.0%	15.2%	31.7%	41	↓	2.66	5	↓	5.8	100.0%	100.0%	0	0	2	Increased CSW fill rate at night to support enhanced care requirements on 2 ocassions	85,229	79,542	5,687
MAIDSTONE	Acute Medical Unit (M) - NG551	92.0%	94.3%	124.1%	190.0%	33.1%	49.2%	141	↑	9.23	34	↓	8.9	4.1%	100.0%	5	0	4	1 fall above threshold Increased fill rate at night due to continued escalation throughout the month	117,548	138,561	(21,013)
TWH	Ward 22 (TW) - NG232	78.5%	97.2%	94.8%	119.5%	43.4%	41.6%	250	↓	15.55	68	↑	9.8	66.7%	100.0%	6	0	7	Reduced RN fill rate due to vacancies and shifts not covered with a lack of available temporary staff across 68 shifts. Increased CSW fill rate at night due to enhanced care requirements throughout the month	153,840	150,117	3,723
TWH	Coronary Care Unit (TW) - NP301	102.6%	85.4%	97.0%	-	31.6%	21.3%	70	↑	4.32	6	↓	11.0	130.8%	94.1%	1	0	3	1 fall above threshold Reduced CSW fill rate due combination of unfilled shifts and redeployment of staff to support safe staffing levels across the Trust.	69,051	64,279	4,772
TWH	Ward 33 (Gynae) (TW) - ND302	94.6%	85.0%	100.0%	94.4%	19.4%	13.1%	67	↓	4.23	21	↓	10.5	0.0%	n/a	1	0	0	1 fall above threshold Reduced fill rate due to sickness and unfilled shifts	81,592	92,414	(10,822)
TWH	Intensive Care (TW) - NA201	100.9%	99.0%	100.5%	96.7%	4.5%	0.0%	27	↓	1.74	6	↓	28.2			1	0	0	1 fall above threshold	192,626	183,763	8,863
TWH	Acute Medical Unit (TW) - NA901	79.5%	91.3%	92.3%	98.8%	32.6%	31.5%	250	↓	18.03	77	↓	7.8	6.7%	100.0%	8	0	7	2 falls above threshold Reduced fill rate due to vacancies and lack of available temporary staff across 77 shifts	184,478	194,931	(10,453)
TWH	Surgical Assessment Unit (TW) - NE701	93.1%	94.2%	100.0%	100.0%	27.3%	15.4%	37	↓	2.65	4	↓	13.6			0	0	2		61,354	65,169	(3,815)
TWH	Ward 32 (Wells Suite) (TW) - PP010	97.3%	80.7%	104.3%	111.4%	43.3%	31.1%	117	↑	7.94	23	↑	6.2	0.0%	n/a	11	0	8	5 falls above threshold Increased fill rate at night due to enhanced care requirements on 8 occasions. Reduced CSW fill rate recorded during the day due to lack of available temporary staff.	120,322	122,271	(1,949)
TWH	Ward 10 (TW) - NG130	92.9%	95.4%	89.2%	135.1%	43.1%	23.4%	147	↑	8.72	26	↓	6.1	0.0%	n/a	3	0	7	1 fall above threshold Skill mix adjustment a considered risk by the ward team in line with a high dependency and moderate acuity. Enhanced care requirements recorded across 16 episodes during the month	117,919	119,609	(1,690)
TWH	Ward 11 (TW) - NG131	91.6%	92.7%	95.8%	138.1%	36.7%	26.5%	147	↑	9.43	24	↔	6.2	0.0%	n/a	5	0	5	1 fall above threshold	122,488	125,361	(2,873)
TWH	Ward 12 (TW) - NG132	88.5%	98.2%	100.0%	94.3%	38.0%	32.0%	146	↓	9.31	36	↓	5.9	52.8%	97.4%	4	0	7	Reduced RN fill rate due to staff sickness, unfilled shifts and late cancellations	128,010	119,619	8,391
TWH	Ward 20 (TW) - NG230	93.7%	98.8%	101.1%	118.0%	49.3%	24.1%	121	↓	8.41	14	↓	5.6	0.0%	n/a	7	0	13	Increased CSW fill rate at night to support enhanced care requirements throughout the month.	112,116	111,948	169
TWH	Ward 21 (TW) - NG231	80.7%	104.7%	97.9%	100.0%	22.3%	47.9%	133	↑	8.37	50	↑	5.8	51.3%	90.0%	3	0	7	Reduced RN fill rate due to lack of available temporary staff with 50 unfilled shifts.	144,422	122,249	22,173
TWH	Ward 2 (TW) - NG442	74.7%	97.0%	102.4%	108.9%	29.0%	44.8%	137	↑	9.17	46	↓	6.4	46.7%	89.3%	13	0	7	6 falls above threshold Reduced RN fill rate due to lack of available temporay staff.	121,794	106,479	15,315
TWH	Ward 30 (TW) - NG330	90.9%	88.4%	101.1%	110.0%	45.0%	26.3%	162	↔	10.57	27	↑	5.7	0.0%	n/a	14	1	8	9 falls above threshold Increased fill rate at night due to enhanced care requirements.	119,617	125,524	(5,907)
TWH	Ward 31 (TW) - NG331	103.7%	75.2%	103.0%	97.7%	42.2%	51.8%	185	↓	12.09	28	↓	6.4	0.0%	n/a	6	2	9	Reduced CSW fill rate due to LTS and unfilled shifts. RMN requirements recorded during the month	131,209	133,526	(2,317)
Crowborough	Crowborough Birth Centre (CBC) - NP775	85.2%	100.0%	100.4%	94.6%	10.1%	0.0%	17	↑	1.01	1	↑		113.3%	94.2%		0		Considered action to prioritise the night with Community teams support during the day	67,938	70,474	(2,536)
TWH	Midwifery (multiple rosters)	81.6%	63.3%	94.8%	82.1%	14.6%	9.0%	500	↓	29.22	62	↓	21.8			0	0		Reduced fill rate due to lack of available temporary staff. Delivery suite prioritised to ensure safe staffing levels. High level of maternity leave within service.	669,897	679,011	(9,114)
	Midwifery Services - Specialist Midwives - NF102	133.1%	No Hours	No hours	No Hours	0.0%	No hours	No Demand	No Demand	No Demand	No Demand	No Demand	14.5									
	Midwifery MSW (TW)	No hours	78.2%	No hours	76.9%	25.1%	0.0%	No Demand	No Demand	No Demand	No Demand	No Demand										
	Midwifery Services - Delivery Suite - NF102	101.4%	No Hours	91.1%	No Hours	28.0%	33.0%	210	184	12.81	34	15										
	Midwifery Services - Antenatal Ward - NF102	106.3%	96.6%	95.3%	No Hours	33.7%	1.1%	134	135	7.81	16	20										
	Midwifery Services - Management - AY451	37.3%	No Hours	No hours	No Hours	0.0%	No hours	No Demand	No Demand	No Demand	No Demand	No Demand										
	Community Midwifery Services - NJ160	79.9%	33.4%	No hours	No Hours	2.8%	0.0%	34	30	1.64	0	2										
	Midwifery Services - Antenatal Clinic - NF102	69.6%	91.4%	No hours	No Hours	3.7%	0.0%	4	10	0.23	0	0										
	Midwifery Services - Postnatal Ward - NF102	77.3%	89.0%	79.5%	No Hours	23.2%	3.6%	118	98	6.73	12	12										
TWH	Hedgehog Ward (TW) - ND702	90.0%	39.4%	102.9%	-	16.5%	30.9%	141	↑	8.53	18	↑	14.5	7.7%	100.0%	1	0		1 fall above threshold Reduced CSW fill rate due to lack of paediatric cover.	210,170	192,292	17,878
MAIDSTONE	Maidstone Birth Centre - NP751	110.1%	90.4%	93.8%	93.6%	12.3%	0.0%	13	↑	0.85	0	↔		75.0%	100.0%	0	0			69,611	57,618	11,993
TWH	SCBU (TW) - NA102	76.2%	60.0%	100.5%	-	10.0%	0.0%	70	↑	3.88	3	↔	13.3				0	4	Bed occupancy fluctuated between 7 - 18. 10 days recorded at Amber and 1 episode in Red.	188,542	172,387	16,155
MAIDSTONE	Short Stay Surgery Unit (M) - NE751	114.6%	86.4%	87.7%	-	13.0%	31.8%	24	↑	1.47	2	↑	15.4			1	0	0	1 fall above threshold Fill rate in line with fluctuating bed occupancy during the month. Ward closed over night on 3 occassions, increased fill rate to support theatre list requirements and 2 x Sunday lists.	43,595	43,322	273
TWH	Short Stay Surgical Unit (TW) - NE901	93.6%	106.8%	111.6%	215.4%	63.8%	24.2%	129	↑	8.07	29	↓	7.2			1	0	7	1 fall above threshold Increased fill rate at night to support ward escalation recorded on 19 occasions	87,651	78,269	9,382
MAIDSTONE	Accident & Emergency (M) - NA351	87.2%	112.3%	98.3%	100.0%	26.3%	34.0%	227	↑	14.34	37	↑		4.3%	94.0%	0	0		MH- reduced RN fill rate due to lack of available temporary staff across 37 shifts. TWH - Reduced fill rate due to 53 unfilled shifts.	200,715	201,330	(615)
TWH	Accident & Emergency (TW) - NA301	93.9%	85.6%	95.6%	88.1%	44.3%	58.1%	446	↑	30.54	53	↑		19.9%	91.1%	2	0			354,735	340,498	14,237
MAIDSTONE	Maidstone Orthopaedic Unit (M) - NP951	69.6%	57.3%	88.3%	-	29.8%	47.1%	72	↓	5.05	13	↓				0	0	1	Reduced fill rate due to a combination of lack of available temporary staff and sickness. Ward closed on 2 occasions	43,693	53,556	(9,863)
MAIDSTONE	Peale Ward (M) - NE959	90.3%	104.6%	100.0%	103.3%	7.4%	23.5%	21	↑	1.32	1	↑	9.0	6.0%	100.0%	0	0	2		81,332	65,521	15,811
																			Total Established Wards	5,138,048	5,063,949	74,099
																			Additional Capacity beds Cath Labs	40,411	41,755	(1,344)
																			Whatman	0	-282	282
																			Other associated nursing costs	3,029,344	2,668,756	360,588
																				8,207,803	7,774,177	433,626

RAG Key

Under fill / Overfill

Green: Greater than 90% but less than 110%
Amber Less than 90% OR greater than 110%
Red Less than 80% OR greater than 130%

Only complete sites your organisation is accountable for			Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
Ward name	Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff									
	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
Acute Stroke	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	2,059	1,878	1,640	1,564	1,363	1,363	704	979	91.2%	95.3%	100.0%	139.1%	718.00			
Cornwallis	100 - GENERAL SURGERY	101 - UROLOGY	1,599	1,311	1,134	996	1,320	969	330	264	82.0%	87.8%	73.4%	80.0%				
Culpepper (incl CCU)	320 - CARDIOLOGY	300 - GENERAL MEDICINE	1,527	1,584	1,089	1,043	1,320	1,309	330	319	103.8%	95.7%	99.2%	96.7%				
John Day	340 - RESPIRATORY MEDICINE	300 - GENERAL MEDICINE	2,148	1,924	1,197	1,463	1,650	1,595	660	847	89.6%	122.3%	96.6%	128.3%				
Intensive Treatment Unit (ITU)	192 - CRITICAL CARE MEDICINE		3,066	2,831	150	139	2,795	2,371	0	0	92.3%	92.3%	84.9%	No data				
Pye Oliver	301 - GASTROENTEROLOGY	300 - GENERAL MEDICINE	1,576	1,521	1,523	1,424	990	1,012	981	932	96.5%	93.5%	102.2%	95.1%				
Chaucer	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	0	0	0	0	0	0	0	0	No data	No data	No data	No data				
Lord North	370 - MEDICAL ONCOLOGY	800 - CLINICAL ONCOLOGY	1,722	1,696	384	693	1,078	1,092	360	348	98.5%	180.3%	101.3%	96.7%				
Mercer	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1,582	1,538	1,475	1,553	990	968	660	858	97.2%	105.3%	97.8%	130.0%				
Edith Cavel	300 - GENERAL MEDICINE		1,279	1,385	937	996	990	991	330	396	108.3%	106.2%	100.1%	120.0%				
Urgent Medical Ambulatory Unit (UMAU)	180 - ACCIDENT & EMERGENCY	300 - GENERAL MEDICINE	2,308	2,122	1,202	1,134	990	1,229	330	627	92.0%	94.3%	124.1%	190.0%				
Stroke/Ward 22	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	2,374	1,864	1,853	1,801	1,650	1,564	990	1,183	78.5%	97.2%	94.8%	119.5%				
Cornary Care Unit (CCU)	320 - CARDIOLOGY	300 - GENERAL MEDICINE	1,158	1,189	360	308	990	961	0	0	102.6%	85.4%	97.0%	No data				
Gynaecology/Ward 33	502 - GYNAECOLOGY	100 - GENERAL SURGERY	1,467	1,388	629	534	990	990	396	374	94.6%	85.0%	100.0%	94.4%				
Intensive Treatment Unit (ITU)	192 - CRITICAL CARE MEDICINE		3,452	3,484	353	349	2,649	2,662	330	319	100.9%	99.0%	100.5%	96.7%				
Medical Assessment Unit	180 - ACCIDENT & EMERGENCY	300 - GENERAL MEDICINE	3,346	2,661	1,518	1,386	2,077	1,918	1,035	1,023	79.5%	91.3%	92.3%	98.8%				
SAU	180 - ACCIDENT & EMERGENCY	100 - GENERAL SURGERY	1,083	1,008	360	339	660	660	330	330	93.1%	94.2%	100.0%	100.0%				
Ward 32	300 - GENERAL MEDICINE		1,590	1,547	1,764	1,424	990	1,033	1,309	1,459	97.3%	80.7%	104.3%	111.4%				
Ward 10	100 - GENERAL SURGERY		2,032	1,887	1,455	1,388	1,122	1,001	814	1,100	92.9%	95.4%	89.2%	135.1%				
Ward 11	100 - GENERAL SURGERY		2,254	2,065	1,320	1,224	1,309	1,254	660	912	91.6%	92.7%	95.8%	138.1%				
Ward 12	320 - CARDIOLOGY	301 - GASTROENTEROLOGY	1,962	1,737	1,304	1,280	990	990	1,320	1,245	88.5%	98.2%	100.0%	94.3%				
Ward 20	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1,200	1,124	1,586	1,566	990	1,001	990	1,168	93.7%	98.8%	101.1%	118.0%				
Ward 21	340 - RESPIRATORY MEDICINE	302 - ENDOCRINOLOGY	2,195	1,772	1,107	1,160	1,650	1,616	660	660	80.7%	104.7%	97.9%	100.0%				
Ward 2	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1,793	1,339	1,649	1,600	978	1,001	990	1,078	74.7%	97.0%	102.4%	108.9%				
Ward 30	110 - TRAUMA & ORTHOPAEDICS		1,989	1,808	1,321	1,167	990	1,001	987	1,086	90.9%	88.4%	101.1%	110.0%				
Ward 31	110 - TRAUMA & ORTHOPAEDICS		1,989	2,063	1,718	1,292	1,320	1,360	990	967	103.7%	75.2%	103.0%	97.7%				
Birth Centre (Crowborough).	501 - OBSTETRICS		803	684	345	345	702	705	344	326	85.2%	100.0%	100.4%	94.6%				
Midwifery Services (ante/post natal & Delivery Suite)	501 - OBSTETRICS		20,976	17,458	5,383	3,888	5,471	4,889	2,250	1,846	83.2%	72.2%	89.4%	82.1%				
Hedgehog	420 - PAEDIATRICS		5,175	4,660	562	222	2,223	2,288	0	0	90.0%	39.4%	102.9%	No data				
Birth Centre	501 - OBSTETRICS		744	819	358	324	657	617	323	302	110.1%	90.4%	93.8%	93.6%				
Neonatal Unit	420 - PAEDIATRICS		4,038	3,078	150	90	2,305	2,317	0	0	76.2%	60.0%	100.5%	No data				
MSSU	100 - GENERAL SURGERY		900	1,032	523	452	440	386	0	0	114.6%	86.4%	87.7%	No data				
Peale	100 - GENERAL SURGERY		1,505	1,359	743	777	660	660	330	341	90.3%	104.6%	100.0%	103.3%				
SSSU	100 - GENERAL SURGERY		1,574	1,472	576	615	582	649	286	616	93.6%	106.8%	111.6%	215.4%				
Whatman	300 - GENERAL MEDICINE		1,542	1,673	1,218	1,097	627	959	319	329	108.5%	90.1%	153.0%	103.0%				

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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Trust Board
Best Care Programme 19/20
July 2019

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Content

Maidstone and Tunbridge Wells NHS Trust

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3. Communication and Engagement

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1a. Executive Summary

Workstreams Update

KEY PROGRESS

Best Patient Flow – Cancer Transformation structure in progress to prioritise Cancer transformation projects. MY POA has had over 1500 patients use the walk in clinics since go live on 22nd May, the team are continuing with PDSA cycles with the CAU's to refine the process and patient pathway. The first staff and patient engagement session was held on 19/07.2019 for the online Outpatients platform 'Attend Anywhere'. This was to provide demonstrations and seek volunteers for the working group. Next demo is at TWH on 29.07.19. Outpatient's survey data has been analysed and supported telephone and video consultation and one stop clinics. The Out of Hospital - #NOF Pathway change project continues to be worked on and sign off is planned for earlier August, Knowledge sharing visits have been arranged with KCHFT and MTW. SDEC – Surgical division signed up to cohort 4 of National Surgical Ambulatory Emergency care network. Medical AEC – first patient seen / treated at Tonbridge Cottage Hospital.

SDEC excellent engagement with National team for Surgical SDEC work at SAU. Detailed plans created. Recruitment underway to support increased provision of Frailty services. LOS - work continues to try to ensure engagement across all Divisions to support LOS projects, working on PDSA cycles for EDN process.

Best Safety – GIRFT Programme continues as planned, the trust has been chosen as a pilot for the Outpatient Review and are in the process of agreeing dates.

Best Workforce – Best Workforce scope reviewed and updated to include new Attract and Retain project whilst Temporary staffing and other service improvement initiatives have been moved out of the Best Care Programme. The first larger group of overseas nurses are arriving on 18th July when we will welcome 15 new arrivals. We have 393 overseas nurses that have been conditionally offered positions with the trust with 41 of these predicted start date of August. There are currently 109 apprentices in the Trust and the Trust is about to launch new cohorts of management and nursing associate apprenticeships. The team are planning to launch a number of other apprenticeships including pharmacy, science and occupational therapy.

KEY RISKS

Best Patient flow – Recruitment of skilled staff continues to be an issue across all workstreams. There is a significant risk that increased non elective demand will continue to rise beyond the agreed levels for 19/20. In addition there is a financial risk to the Divisional CIPs related to Best flow.

Best Safety – Medical Productivity - not all divisions have signed off job plans. This has been escalated and raised at the Divisional Performance reviews. As of w/c 15th July 86% have been signed off against a target 0f 95%. Sufficient resources to meet 7DS still remains an issue.

Best Workforce – eRostering: triangulation of roster templates, safe-staffing levels and financial establishment not completed. Divisions need this completed before signing up to CIPs and KPIs. Original scale of change underestimated. Plans revised and included in request for rebaseline. New Roles and Apprenticeships: currently losing £70k per month of levy. Resource to support growing the range and number of apprenticeships required. Detailed plans need to be submitted to support request.

Workstreams Update

KEY PROGRESS

Best Quality – Patient Experience and Engagement – revised sub-workstream structure in place to launch and embed the agreed Trust Patient Experience and Engagement Strategy. First meeting planned for the 17th July. Strategy signed off at Trust Board on 26/6

Patients and their medication – Agreement following QIA to pilot self administration for assessed Parkinson patients. Journey to outstanding – Peer reviews to take place to review self-assessments finishing 9th August. MCA – project meetings in place and objectives set.

CNST – documentation finalised for submission to Trust board for final submission to NHS Resolution on 15th August.

Best Use of Resources – Pharmacy Outsourcing - Meeting with NEDs and management team held on 25th June to discuss details of the commercial negotiation, it was agreed that an extra resource with extensive experience in commercial negotiations would be needed to help in the ongoing contract negotiations. There has also been positive conversations with NHSE in regards to the dispensing fee which will benefit MTW financially.
Meals aligned to Bed Occupancy implemented in ED at Tunbridge wells for all Lunches. Reduction in Food Waste – menu cards introduced in all wards at Tunbridge wells, apart from Maternity wards, these means plated meals will now be served according to bed occupancy rather than ward capacity .
Procurement on track with plan , to date £581K delivered against target of £580K.

KEY RISKS

Best Quality – Patient Experience and Engagement Project is delayed due to a lack of resource. Role is out to advert closing 2nd August, which will mitigate the risk. Resource to deliver journey to outstanding. Request made for additional resource. No schemes yet identified to plug the current CIP gap of £160k

Best Use of Resources – Funding not yet in place for big capital projects such as car parking.
Unable to source replacement parts for 2 old CT scanners presently used in the department, which may result in loss of activity.
Delay with provider solicitor signing off legal requirements for Energy Procurement VAT savings, work stream is adverse to plan by £50K due to delay.

2a. Best Use of Resources

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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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Best Use of Resources

Summary of Progress

Explanation for Status:

08/07/2019: At month 3, the work stream is adverse to plan by £19K, the shortfall in STP Sendaway Test Repartriation (£16K) is mitigated by PTS Transport and other income schemes.

Procurement - On track with plan, till date £581K delivered against plan of £580K. SCCL savings is not included in the figures as Supply Chain is yet to release data relating to this savings.
Post MS contract - put on hold till Dec 2019 when current contract expires.
Phone Hardware - project put on hold until resource available
IT Hardware - at risk of delivery on time due to delays with finalising STP requirements.

Pharmacy Outsourcing - Meeting with NEDs held on 25th June with S.Orpin, H.Ferris, M.Johnson and D.Highton to discuss details of the commercial negotiation, it was agreed that an extra resource with extensive experience in commercial negotiations would be needed to help in the ongoing contract negotiations.In this regards the Execs have recommended Mr Risbrow, who has been in contact with M.Johnson and first meeeting with is underway. Also further meetings with Pharma@Sea is underway for July to continue discussions regarding the contract.

Estates & Facilities -
. Meals aligned to bed occupancy implemented in ED at Tunbridge wells Hospital for Lunches, whilst supper still continued to be served. Target savings of £100K will not be achieved as a result, but savings achieved will be calculated at the end of July 2019.
. Food Waste - Menu card introduced in all wards at Tunbridge wells Hospital aside maternity wards, Savings to be quantified savings by the end of July.
. Energy Procurement - CMS Lawyers have responded with an offer which is currently being reviewed by the Trust's Legal team.
. Other opportunities like Retail Opportunity within MGH and introducing a Trolley Facility at both sites are currently being explored to bring in more savings.

Decisions Required by Board:

08/07/2019:

Summary Information

Overall Status	Amber	Risk Status	
Timescale Status	Amber	Issue Status	

Metrics

No. of open risks	28	% milestones completed on time	50%
No. of open issues	7	% deliverables completed on time	0%

Project Status

Code	Project Name	Last Month	This Month
MTW-BC-1920-019	Procurement	Amber	Green
MTW-BC-1920-020	EME	Green	Green
MTW-BC-BUR-DIAG-NPEx	NPEx	Red	Amber
MTW-BC-BUR-DIAG-POCT	Point of Care Testing (POCT)	Green	Green
MTW-BC-BUR-DIAG-SAT	Repatriation of Send away testing	Red	Red
MTW-BC-BUR-EFM-MABC	Meals Aligned to Bed Occupancy	Green	Green
MTW-BC-BUR-EFM-RFW	Reduction in Food Waste	Green	Green
MTW-BC-BUR-ICT-DOCMAN	DOCMAN	Amber	Amber
MTW-BC-BUR-MM-PO	Pharmacy Outsourcing	Green	Green

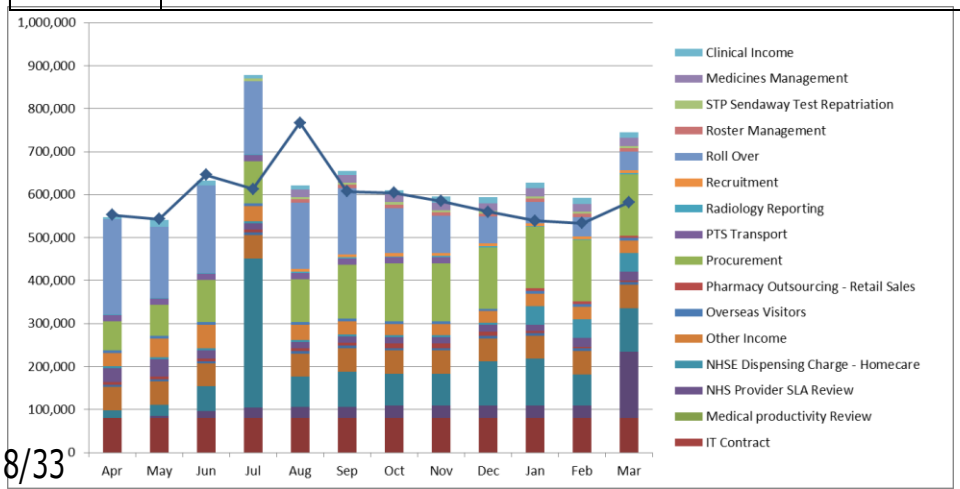
Top Risks					
ID	Description	Mitigation	Date Opened	Owner	RAG
Radiology MES Contract	Unable to source replacement parts for 2 old CT scanners presently used in the department, which may result in loss of activity.	Temporary use of mobile scanners, but these cannot accommodate the current capacity of work, which will result in reduction in capacity and increase in waiting list.	07/05/19	Neil Bedford	Red
DIAG-05 - Repatriatoon of send away tests	Obtaining baseline data of current volumes and prices of tests sent away	Timeline for final completion by all labs has been revised to 11/05	17/04/19	STP	Red
EFM-03 - Extra car park funding	Extra car park funding - risk to delivery as funding expected from external source may fall through	Source alternative joint venture	15/05/19	Darren Bulley	Red

Top Issues					
ID	Description	Action	Date Opened	Owner	RAG
PROC-01	Team down in number with one vacant post and one long term sickness, which is impacting on the delivery of projects.	Bring in an interim for 3 months to fill in, interviews will hold week beginning 8th June and possible start on the 15th June if successful.	08/07/2019	Bob Murray	Amber
	ED Contract renewed with Symphony for another year till end of March 2020, therefore planned savings from M7 will not deliver.	Get assurance that Symphony will not be needed in parallel with Sunrise due to accessing existing records, then approach EMIS to see if the contract can be ended earlier and request a refund.	13/05/2019	Jane Saunders	Red
EFM-01	Capital funding for 2019/20 schemes yet to be released by the Trust, these has delayed the delivery of some projects.	Review alternatives to capital funding.	10/05/2019	Darren Bulley	Red
EFM-02	Delay with provider solicitor signing off legal requirements for Energy Procurement VAT savings	Escalate to provider and MTW CEO	03/06/19	Kev Pearson	Red

Milestones Missed				
ID	Entity Name	Milestone	Expected Date	RAG
ICT-08	ICT	start to deliver monthly savings for Apsense Block Solutions from M2	31/05/19	Red
DIAG-21	Diagnostics	MRI Tender - Write and approve Business Case / financial modelling	08/05/19	Red
PROC-03	Procurement	International Recruitment - deliver £10K savings from agency fees reduction in M3	28/06/19	Red
PROC-09	Procurement	Start to deliver planned savings for SCCL from M1	30/04/19	Red
PROC-15	Procurement	IT Hardware - finalise specification	31/05/19	Red
PROC-26	Procurement	Phone Hardware - re-negotiate contract	29/03/19	Red
PROC-27	Procurement	Phone Hardware - deliver monthly £10K savings	30/04/19	Red
EFM CIPs-35	Energy Procurement	obtain legal sign off from partners	19/06/19	Red

Milestones Due in Next Reporting Period				
ID	Entity Name	Milestone	Expected Date	RAG
DIAG-17	Diagnostics	Write Business case	31/07/19	Green
POCT-05	Point of Care Testing (POCT)	Finalise contract negotiations	31/07/19	Green
POCT-08	Point of Care Testing (POCT)	Present Business Case to F&P committee for approval	15/07/19	Green
POCT-10	Point of Care Testing (POCT)	make decision about preferred supplier for Glucose / Ketone meters	31/07/19	Green

Metrics / KPI					
ID	KPIs	Baseline	Target	Last Month (May 19)	This Month (Jun 19)
1	Adalimumab Uptake Rate	0	80	65.00	91.00
2	95% of transactions lines on e-catalogue	0	95	95.30	96.00
3	90% of invoice (by no.)on purchase order	0	90	97.50	93.50
4	90% of invoice (by value) on purchase order	0	90	91.20	89.30



2b. Best Workforce

Best Workforce 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**
- **Attract and Retain**

Summary of Progress
Explanation for Status:
02/07/2019: Status improved to amber due to: - eRostering: triangulation of roster templates, safe-staffing levels and financial establishment completed with the exception of ED. All Divisions need this completed before signing up to CIPs and KPIs. Original scale of change required was underestimated hence delays. Plans revised for e-Rostering and Recruirtemnt and both signed off for rebaseline. - New Roles and Apprenticeships: now losing £70k per month of levy. Additional two WTE Band 5 Apprenticeship resource appointed. Additional Best Workforce resource requested.
Decisions Required by Board:
02/07/2019: - Attract and Retain Project now included included and Temporary Staffing moved to BAU and will be monitored under Workforce Business Unit Service Improvements.

Summary Information			
Overall Status	Amber	Risk Status	Red
Timescale Status	Red	Issue Status	Red

Metrics			
No. of open risks	15	% milestones completed on time	0%
No. of open issues	12	% deliverables completed on time	0

Project Status			
Code	**Project Name**	**Last Month**	**This Month**
MTW-BC-BWF-AR	Attract and Retain		Amber
MTW-BC-BWF-eR	eRostering	Amber	Red
MTW-BC-BWF-NRA	New Roles and Apprenticeships	Red	Red
MTW-BC-BWF-Rec	Recruitment	Amber	Amber

Top Risks					
ID	Description	Mitigation	Date Opened	Owner	RAG
NRA-05	Procurement of training providers - there is a risk that the lack of procurement of training providers will mean that we recruit low numbers of apprentices. The impact of this is that we will not be able to use all the funds in the digital account by July 2019.	Workstream Lead to work with Apprenticeships team (once lead is back from long term sickness) to secure further training providers.	14/11/18	Jeanette Barlow	Amber
Rec-08	Visas for international nursing recruits still not issued by the Home Office. Nurses due to travel on 18 July so the may be delayed, which will delay start dates.	Accept if delay occurs. Recruitment pipeline is strong but will mean start dates are delayed.	04/07/19	Simon Hart	Red

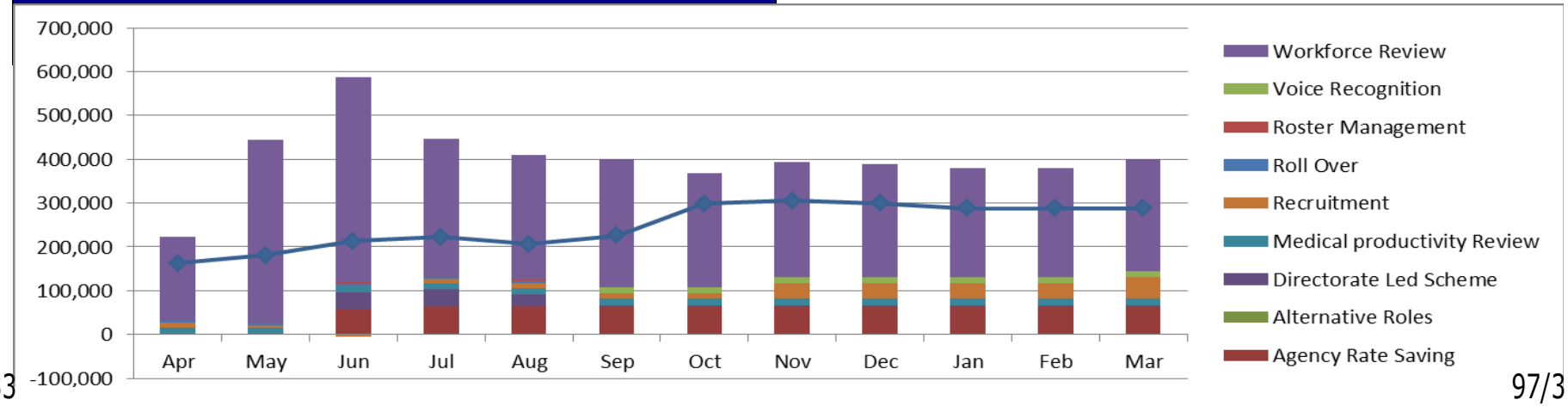
Top Issues					
ID	Description	Action	Date Opened	Owner	RAG
AR-01	Marketing expertise - procurement of marketing expertise delayed, impacting promotion of job vacancies, recruitment along with meeting other trust promotion requirements.	AJ and SH agreed the need for trust-wide business case to secure marketing expertise. Requirements to be collected from Execs and SON by 12 July. Completion of business case to be included in Attract and Retain Project. Issue to turn green on approval of new scope.	14/05/19	Amanjit Jhund	Red
BWF-01	Significant change is required to MTW Workforce systems, processes, practices and establishment control (vacancies). Currently there is no clear strategy or road map on how we will achieve this over the next 3 years. As a result there is pressure to do everything now.	Revised scope of Best Workforce completed based on high level Workforce Directorate road map. New scope approved by by Best Care SRO on 28 June. Best Workforce SRO to inform CEO and to request plans to be re-baselined. Issue to closed once completed.	14/11/18	Simon Hart	Amber
BWF-03	Request for additional resource to support the Best Workforce Programme has not yet been approved at Best care Board, impacting ability to achieve objectives.	Resource request revised based on review of Best Workforce. Detailed plans completed for eRostering and Recruitment to support request.	30/05/19	Simon Hart	Red
eR-12	Divisions have not signed-up to Workforce 19/20 KPIs on rostering improvement. Potential to reduce reliance on temporary staffing missed.	Workforce lead to complete roster templates and triangulation with safe-staffing, finance establishment and continue to review plans with Divisions in order to improve confidence. Plan also revised to reflect scale of work. Issue severity and priority to reduce to Amber once plans re-	14/05/19	Lisa Wolvey	Red
NRA-01	Resource constraints - limited staffing resources are appropriately focused on the apprenticeships programme. Key apprenticeship resource also on long term sick as of 24th April without back-fill.	Apprenticeship resource not backfilled, however business case has been approved to recruit 2 band 5 apprenticeship resources (interviews due to take place in July).	15/03/18	Simon Hart	Red
NRA-04(R)	Loss of apprenticeship levy - there is a risk that we will not spend the apprenticeship levy by July 2019. If this happens we will lose unspent funds.	c.£70K per month will be lost from July of the unspent funds, which are around £2m. Resource request for Nursing Professional Lead and AHP Professional Lead needs to be approved to progress apprenticeship promotion, which are included in the resource request.	03/04/18	Jeanette Barlow	Red
Rec-02	Nursing Vacancies - significant nursing vacancies in medicine at TWH. Impacting morale, retention and recruitment.	Nursing vacancy workshop help on 12 April to identify obstacles and objectives. New Attract and Retain Project established to provide governance of key deliverables to address issue. Once new scope approved by board, issue	14/05/19	Simon Hart	Amber
Rec-16	Due to significant vacancies in nursing, capacity not available to interview, support and induct new nurses on wards. Only 8 out of a potential 50 job ready nurses appointed via MSI.	Gemma and Pam have a worked out plan for handling mass OSCE nurses. This has been set out to senior nurses and matrons.	13/06/19	Gemma Craig	Green

Milestones Missed				
ID	Entity Name	Milestone	Expected Date	RAG
eR-17	eRostering	Resources approved	20/05/19	Red
eR-21	eRostering	KPIs and CIPs approved by divisions	29/03/19	Red
eR-24	eRostering	Initiation Phase Complete	20/05/19	Red
eR-29	eRostering	Project Team established	10/06/19	Red
eR-36	eRostering	Health roster templates, finance establishment and safe staffing aligned	29/03/19	Red
eR-37	eRostering	Validation of Nursing Rosters Complete	29/05/19	Red
NRA-62	New Roles and Apprenticeships	Resources approved	20/05/19	Red
NRA-71	New Roles and Apprenticeships	Project Team Established	17/06/19	Red
NRA-103	New Roles and Apprenticeships	Trust-wide Roles Working Groups Established	14/06/19	Red
NRA-113	New Roles and Apprenticeships	Commence New Roles and Apprenticeships reporting	05/07/19	Red

Milestones Due in Next Reporting Period				
ID	Entity Name	Milestone	Expected Date	RAG
AR-02	Attract and Retain	Detailed Plan Created	19/07/19	Green
AR-03	Attract and Retain	Marketing Requirements Gathered	19/07/19	Green
eR-78	eRostering	Reporting and Monitoring System Implemented	02/08/19	Green
Rec-02	Recruitment	New nursing recruits (c.18) commence induction	22/07/19	Red

Metrics / KPI					
ID	KPIs	Baseline	Target	Last Month (May 19)	This Month (Jun 19)
BW-KPI-1a	Increase of Substantive Staff - Nursing and Midwifery	1,332.75	1,415.13	1333.41	1389.74
BW-KPI-1b	Increase of Substantive Staff - Medical	631.98	670.15	641.76	658.41
BW-KPI-5a	Temporary Staffing Requirements Sent to Bank 6 Weeks in Advance - Nursing and Midwifery	19.70	100	28.50	23.40
BW-KPI-5b	Temporary Staffing Requirements Sent to Bank 6 Weeks in Advance - Medical	34.70	100	28.50	19.75

Financial Information



2c. Best Flow

Maidstone and Tunbridge Wells NHS Trust

The Best Flow workstream aims to promote best patient flow across the system, to reduce stranded patients, reduce red days and improve the patient journey.

Demand continues to increase for acute beds without an equal increase in capacity or resources. The rationale for this workstream is to increase overall capacity and ensure that the right patient is in the right place at the right time.

The transformational projects include:

- **Length of Stay**
- **Same Day Emergency Care (SDEC)**
- **Planned Day Case**
- **Out of Hospital Capacity**
- **Outpatient Productivity**

The Divisional Improvement projects are all reported in other forums and include:

- **Stroke**
- **Data**
- **Theatre Transformation (My POA)**
- **Cancer Transformation**
- **Outsourcing**

Further project governance to be completed on:

- **Private Patients**

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Best Flow Transformational

Summary of Progress

Explanation for Status:

02/07/2019: No red status

Decisions Required by Board:

02/07/2019: None

Summary Information			
Overall Status	Amber_#FF9900	Risk Status	Amber_#FF9900
Timescale Status		Issue Status	

Metrics			
No. of open risks	37	% milestones completed on time	1.85%
No. of open issues	5	% deliverables completed on time	0

Project Status

Code	Project Name	Last Month	This Month
MTW-BC-BPF-LOS	Length of Stay		
MTW-BC-BPF-LOS-DT	Digital Transformation		
MTW-BC-BPF-LOS-EDD	EDD		
MTW-BC-BPF-LOS-EDN	EDN		
MTW-BC-BPF-OOHC	Out of hospital capacity		
MTW-BC-BPF-OOHC- FBC	Frailty Bed in the Community		
MTW-BC-BPF-OOHC-CHA	Carehome Admissions		
MTW-BC-BPF-OOHC-H@H	Hospital@Home		
MTW-BC-BPF-OOHC-NOF	NOF		
MTW-BC-BPF-OOHC-SUN	Sunhill Court (Flat)		
MTW-BC-BPF-PDC	Planned Day Care		
MTW-BC-BPF-SDEC	Same Day Emergency Care (SDEC)		
MTW-BC-BPF-SDEC-AFU	SDEC Acute Frailty		
MTW-BC-BPF-SDEC-AFU-1	SDEC Medical		
MTW-BC-BPF-SDEC-ASS	SDEC Assessment Floor (year 2) (Not Started)		
MTW-BC-BPF-SDEC-SAEC	SDEC Surgical		

Top Risks					
ID	Description	Mitigation	Date Opened	Owner	
LOS-02	There is a financial risk to delivery of the financial CIPs related to Flow, which are held at Divisional level.	Assurance group to monitor reporting and hold programmes to account concerning delivery of the best practice.	07/05/19	Sean Briggs	
LOS-05	There is a risk that the workforce establishment is not recruited to substantively in order to drive forward the changes. Considerable lead time is required to support substantive workforce	Work with Best Workforce and provide robust links between workstreams. Plan for future years with strategy to ensure that this risk does not recur every year. Mitigate through the request of increased resources through Best Care	07/05/19		
SDEC-02	There is a risk that substantive skilled staffing will not be available to support the new SDEC pathways.	development of new roles and responsibilities, working with Best Workforce	11/06/19		
SDEC-AEC-02	There is a risk that there will not be sufficient skilled workforce to support the development of ambulatory emergency care.	The team will develop new roles to support an enhanced workforce. The team will work with the Exec team to ensure that funding is in place with enough time to support substantive recruitment processes.	20/05/19	Lynn Gray	

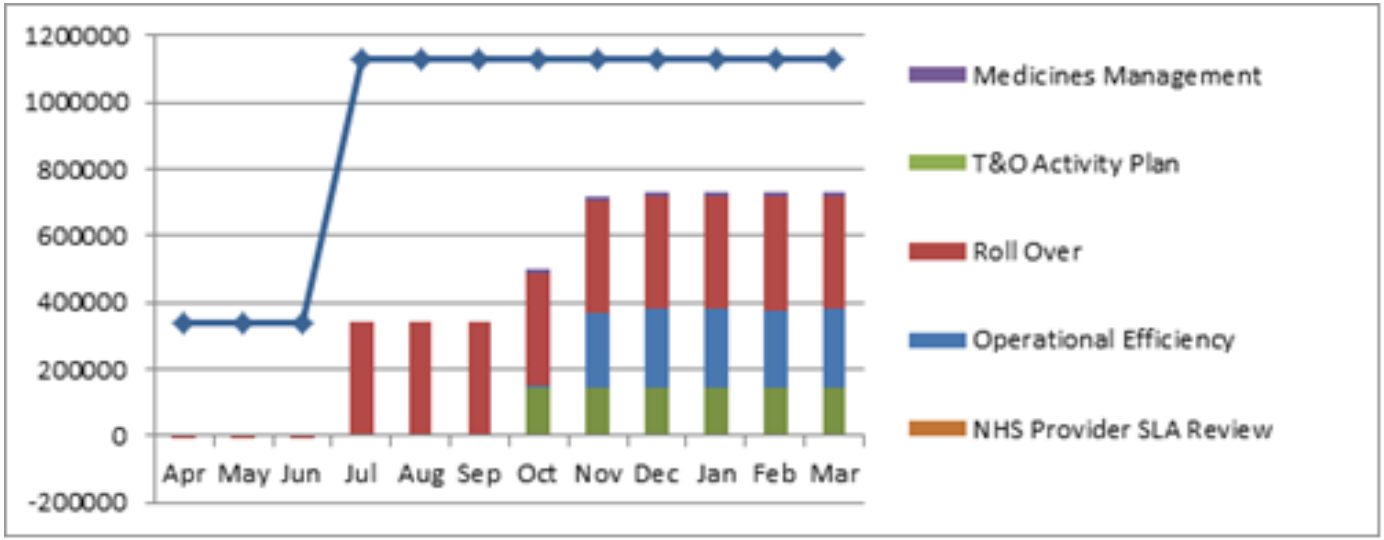
Top Issues					
ID	Description	Action	Date Opened	Owner	RAG
LOS-01	There is an issue that despite having requested increased resources to deliver the LOS workstream, there has been no agreement on this to date.	Escalation to Transformation Team Programme Director and SRO for Best Flow	26/06/19	Lynn Gray	
SDEC-AFU-1-01	There is an issue that the Division has not yet received the funding from business planning 19/20 and hence the recruitment process has not been able to be processed.		03/07/19	Steve Orpin	

Milestones Missed				
ID	Entity Name	Milestone	Expected Date	RAG
PDC-08	Planned Day Care	KPIs Identified	11/06/19	
PDC-14	Planned Day Care	Arrange initial project meeting to kick of project	13/06/19	
PDC-30	Planned Day Care	Detailed costing and savings identified	07/06/19	
OOHC-SUN-30	Sunhill Court (Flat)	Agree what the requirements for flat improvements will be and confirm MTW / KCHFT will not have to p	28/06/19	

Milestones Due in Next Reporting Period				
ID	Entity Name	Milestone	Expected Date	RAG
LOS-35	Length of Stay	Complete PDSA	12/07/19	
LOS-39	Length of Stay	Ensure all medical wards have localised plan	31/07/19	
LOS-57	Length of Stay	Teletracking Business case approved by Finance and Performance Committee	23/07/19	
LOS-58	Length of Stay	business case approved by Trust Board	25/07/19	
LOS-65	Length of Stay	Beautiful information (KCHFT/ MTW) merged onto one dashboard	31/07/19	
PDC-05	Planned Day Care	Create detailed project plan	15/07/19	
PDC-23	Planned Day Care	Agree actions for procedures, with plans and dates.	26/07/19	
PDC-34	Planned Day Care	Confirm Baseline	31/07/19	
OOHC-CHA-07	Carehome Admissions	Meeting with external partner to look at actions from Audit.	09/07/19	
OOHC-SUN-37	Sunhill Court (Flat)	Building work signed off and agreed ready?	01/07/19	
OOHC-SUN-38	Sunhill Court (Flat)	Flat ready to used by patients.	12/07/19	
OOHC- NOF-22	NOF	Confirm requirements needed in KCHFT, i.e therapist recruitment, equipment, transport	19/07/19	
SDEC-SAEC-17	SDEC Surgical	All beds removed: only trolleys in SAU	01/08/19	
SDEC-SAEC-34	SDEC Surgical	agree additional capacity with DDO Diagnostics and Clinical Support Services	01/08/19	
SDEC-SAEC-66	SDEC Surgical	front line surgeon support in place	09/07/19	
SDEC-AFU-1-06	SDEC Medical	ensure roles recruited to at Maidstone HospitaL	01/07/19	
SDEC-AFU-1-49	SDEC Medical	weekly report in place	10/07/19	

Metrics / KPI					
ID	KPIs	Baseline	Target	Last Month (May 19)	This Month (Jun 19)
MTW-BC-BPF-TRANS 1.1	Percentage of non elective take seen within 0 LOS		28.0%	20.90%	23.9%
MTW-BC-BPF-TRANS-1.2	Daily medical outliers		4.20%	4.05%	
MTW-BC-BPF-TRANS-3.8A	Non elective LOS in Medicine		7.7	7.8	7.8

Financial Information



Best Flow Service Improvement

Summary of Progress

Explanation for Status:

03/07/2019: Private Patients Outpatients : The PPU is fully recruited to and outpatient appointments have begun at Maidstone. However the financial delivery of the project is a risk, the target for 19/20 is £3.8 million and is based on an income figure from last year which is now being reviewed. Their plans for mitigation are being overseen by the Executive Sponsor and Head of Contracts have started with a Review of the Contract between MTW and the Housden Group on 03/07/2019 and further planning meeting on 05/07/2019.

Decisions Required by Board:

03/07/2019: None

Summary Information

Overall Status		Risk Status	
Timescale Status		Issue Status	

Metrics

No. of open risks	14	% milestones completed on time	0%
No. of open issues	8	% deliverables completed on time	0

Project Status

Code	Project Name	Last Month	This Month
MTW ST	**Stroke**		
MTW-BC-1920-063	FINANCIAL ASSESSMENT AND CONTROL		
MTW-BC-1920-066	AMU Project Group		
MTW-BC-1920-065	CONSTRUCTION PROJECT GROUP Ward Design and Build		
MTW-BC-1920-064	**STROKE OPERATIONAL PROJECT GROUP**		
MTW-BC-1920-067	HR WORKSTREAM Recruitment/Workforce		
MTW-BC-1920-068	CLINICAL REFERENCE WORSTREAM – Model of Care		
MTW-BC-1920-069	COMMUNICATIONS WORKSTREAM		
MTW-BC-1920-070	REHAB WORSTREAM		
MTW-BC-1920-071	I.T. and PROCUREMENT WORKSTREAM		
MTW-BC-1920-072	TRANSITION PLANNING WORKSTREAM		
MTW-BC-1920-074	Private Patients (In Patients) Project not started.		
MTW-BC-1920-078	Outsourcing		
MTW-BC-BFSI	Private Patients (outpatients)		
MTW-BC-BPF-MPO	My Pre Op (Theatre Transformation)		
MTW-BC-BPF-OP	Outpatient Productivity		
MTW-BC-BPF-SI-CT	Cancer Transformation		
MTW-BC-Data	Data		

Top Risks

ID	Description	Mitigation	Date Opened	Owner	RAG
BFSI-PPOut-01	The income predicted for the private patient outpatient unit was based on the incorrect figure of £3.8 Million target.	Recruit to enable unit to be open 23hrs x 7 days/week. If stroke moves out of W22 this could potentially free up bed capacity to allow PP to use between 4-8 inpatient beds–proposal needs further discussion with Execs as there may be other plans for free capacity of W22	01/07/19	David Fitzgerald	

Top Issues

ID	Description	Action	Date Opened	Owner	RAG
1920-Stroke-03	Stroke and the judicial review	There is no feedback from the Independent Review or the two Judicial Reviews. The STP are responding but no timescale of a response.	01/07/2019	Sean Briggs	

Milestones Missed

ID	Entity Name	Milestone	Expected Date	RAG
-03	STROKE OPERATIONAL PROJECT GROUP	Rehabilitation data for STP is still work in progress (was due in early June) due to challenge disaggregating the acute and rehab phases of the pathway. This is coming to a conclusion and should be available to the STP by the end of this week (5th July)	01/07/19	

Milestones Due in Next Reporting Period

ID	Entity Name	Milestone	Expected Date	RAG
MTW-BC-PPI-01	Private Patients (In Patients)	Work up plan for delivery of CIP 19/20.	31/07/19	

Metrics / KPI

ID	KPIs	Baseline	Target	Last Month (May 19)	This Month (Jun 19)
MTW-BC-BPF-TRANS 1.1	Percentage of non elective take seen within 0 LOS		28.0%	20.90%	23.9%
MTW-BC-BPF-TRANS-1.2	Daily medical outliers				
MTW-BC-BPF-TRANS-3.8A	Non elective LOS in Medicine		7.7	7.8	7.8

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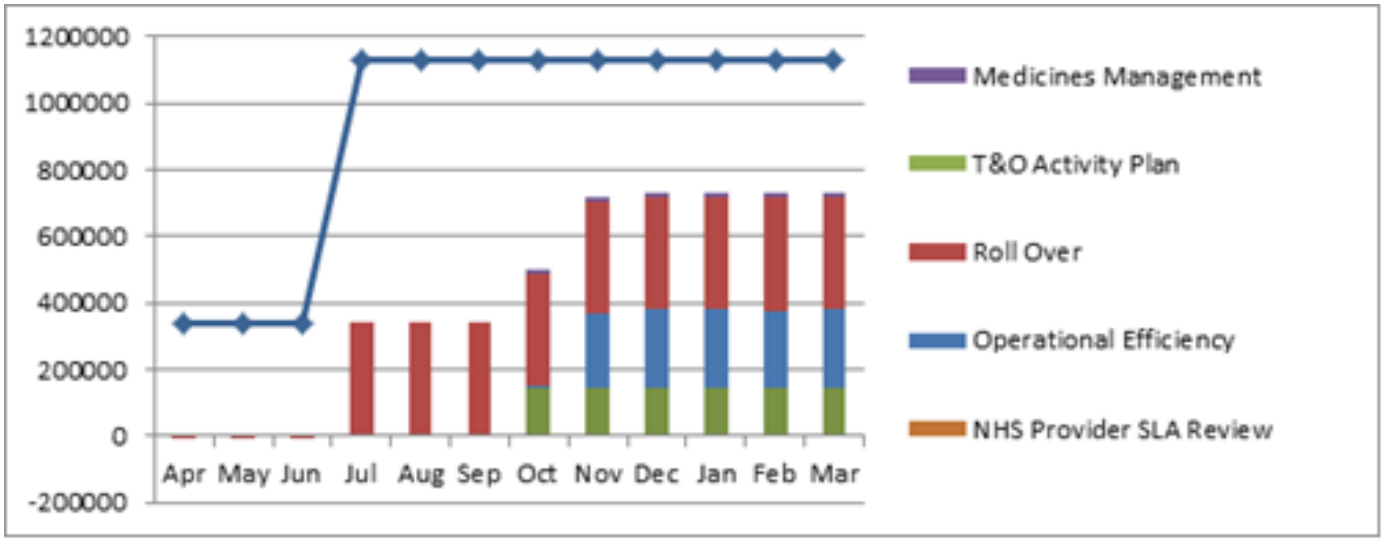


2d. Best Quality

Maidstone and Tunbridge Wells NHS Trust

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**

MTW exceptional people, outstanding care

Best Quality

Summary of Progress

Explanation for Status:

28/06/2019: Patient Experience and Engagement Project is delayed due to a lack of resource. Business Case approved and Job description approved by agenda for change and being advertised. Patient Experience Strategy now transformed into a formal strategy document, presented at Trust Board 26/06/2019.
CQUINs / Pressure Ulcers /Staff Engagement removed from workstream
Patient Experience and Engagement transformed to a workstream incorporating other projects to facilitate divisional engagement.
MCA . Meetings are now in place. Governance and project objectives formally be agreed at the July meeting to present to Best Quality Workstream Board in August.
Nutrition Red due to reduced staffing provision to deliver project objectives.

Decisions Required by Board:

28/06/2019: None

Summary Information			
Overall Status	Amber	Risk Status	Amber
Timescale Status	Amber	Issue Status	Amber

Metrics			
No. of open risks	26	% milestones completed on time	1.9%
No. of open issues	2	% deliverables completed on time	0

Project Status			
Code	**Project Name**	**Last Month**	**This Month**
MTW-BC-BQ-CNST	Maternity Safer Births /CNST	Green	Green
MTW-BC-BQ-DEL	Delirium	Green	Green
MTW-BC-BQ-DEM	Dementia	Green	Green
MTW-BC-BQ-ENDPJP	#EndPJParalysis	Green	Green
MTW-BC-BQ-MCA	MCA		Amber
MTW-BC-BQ-NUT	Nutrition	Green	Red
MTW-BC-BQ-PPEE	Patient and Public Experience and Engagement	Red	Red
MTW-BC-BQ-PT	Paediatric Transition	Green	Amber
MTW-BC-BQ-PTOM	Patients and their Medicines	Green	Green

Top Risks					
ID	Description	Mitigation	Date Opened	Owner	RAG
BQ-02	Inability of projects within Best Quality to Identify Financial CIP stretch target of £160,000.00	Although Best Quality will be able to secure the money assigned to the CNST Maternity Rebate the projects do not align themselves to the stretch target aligned with the programme.	08/05/19	Claire O'Brien	Red
CNST-02	Uncertainty/Lack of confidence in new IT reporting system to understand compliance with training for Safety action 8 (90% of each maternity unit staff group have attended an 'in house' MDT Maternity Emergencies Training session within the last year)	Currently at 70% compliance with 3 dates still available, data cleanse being carried out, predicting 91% by August 1st achieving the 90% compliance target by August 15th. Staff alerted to the fact that this is a priority, and escalation routes provided by best care workstream in order to manage and resolve escalated issues quickly	26/02/18	Sarah Blanchard-Stowe	Amber
DEL-01	Provision of delirium service within the Trust means that there is a lack of awareness of Delirium. Patientswith Delirium are not always supported or detected, as there isno dedicated team tosupport staff tomanage thesepatients.	Delirium project group gathering information andevidence to supportprovision of adedicated deliriumre source, comparing with other Trustslocally to progress business case.	09/05/19	Claire O'Brien	Amber

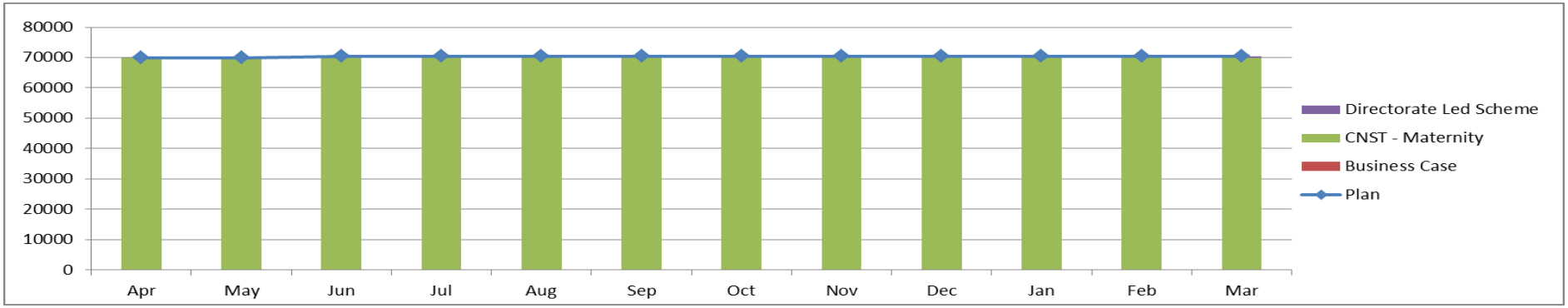
Top Issues					
ID	Description	Action	Date Opened	Owner	RAG
NUT-01(R)	Sustaining focus and momentum on work carried out during the NHSi Collaborative due to staffing issues within Dietetic team.		08/05/19	Judy Durrant	Amber
PPEE-01(R)	PPEE remains unsupported without resource post project phase in BAU mode	Approval of Business case for to include provision for PPEE support. PMO Support not in place to support strategy launch.	08/05/19	Gemma Craig	Red

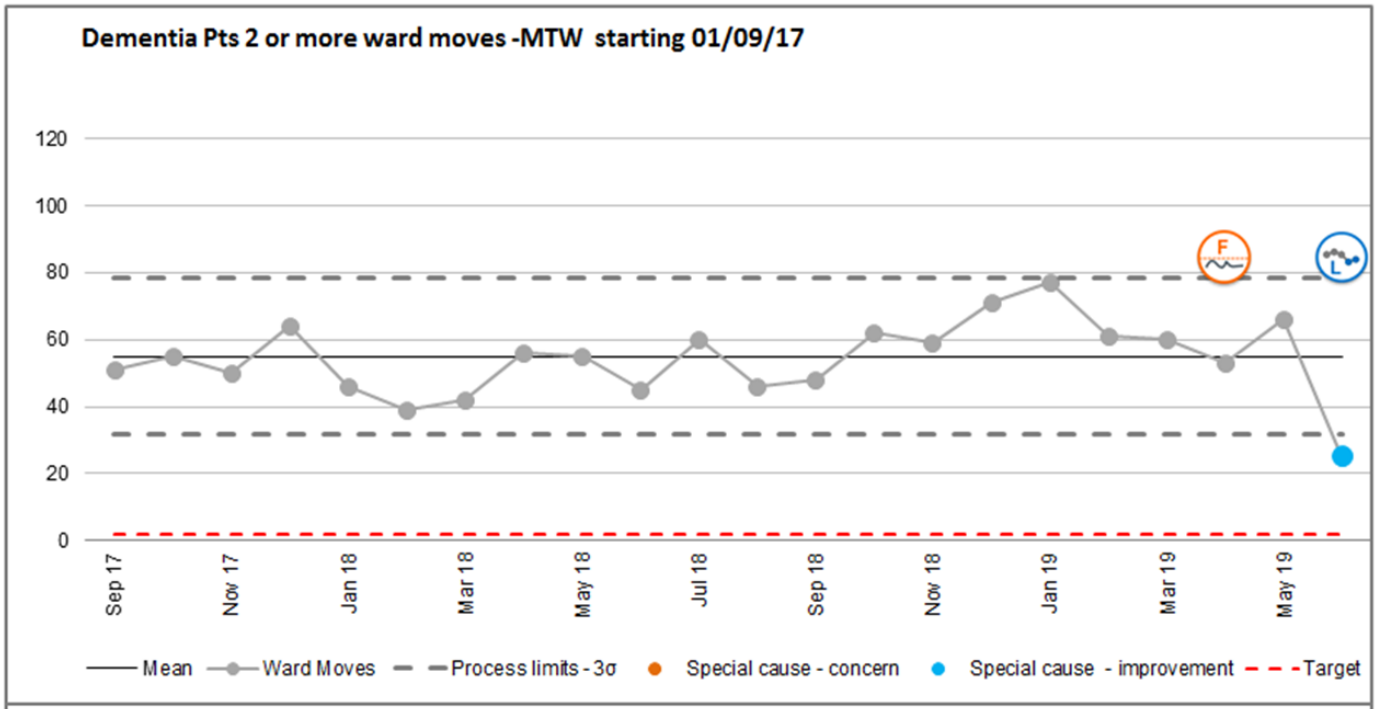
Milestones Missed				
ID	Entity Name	Milestone	Expected Date	RAG

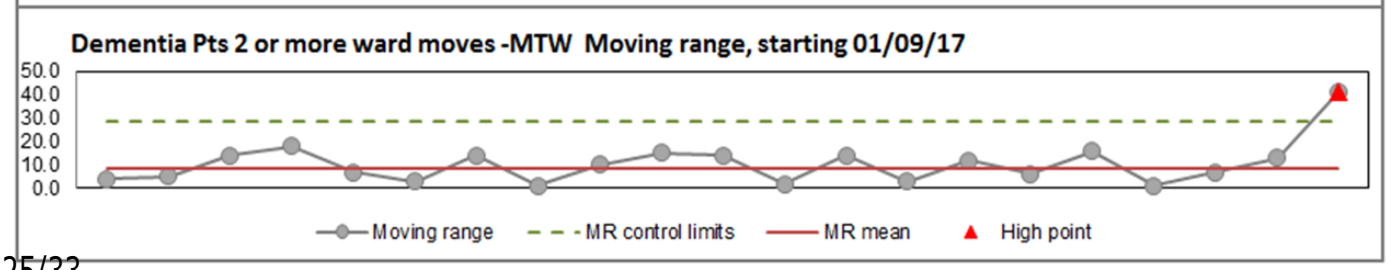
Milestones Due in Next Reporting Period				
ID	Entity Name	Milestone	Expected Date	RAG
DEL-14	Delirium	Identify patient representative for the project	02/08/19	Green
DEL-95	Delirium	Agree tasks to improve the current process for identifying patients with Delirium in A&E	12/07/19	Green
DEM-92	Dementia	Dementia Lead nurses ageed within Divisions	19/07/19	Green
MCA-07	MCA	TIA Audit and Review	02/08/19	Green
MCA-11	MCA	Project objectives Agreed	12/07/19	Green
MCA-22	MCA	KPI Reporting Established	31/07/19	Green
MCA-24	MCA	ToR signed off	31/07/19	Green
CNST-01	Maternity Safer Births /CNST	Full Evidence review with Chief Nurse Prior to Trust Board	11/07/19	Green
CNST-02	Maternity Safer Births /CNST	Final Paper with Evidence Submitted to Trust Board	17/07/19	Green
CNST-03	Maternity Safer Births /CNST	Trust Board Sign off of each CNST Safety Action	25/07/19	Green
DEL-100	Delirium	Sign off Delirium communication plan at project group	31/07/19	Green
DEL-118	Delirium	Presentation of Delirium at Grand Round	19/07/19	Green
DEL-119	Delirium	Presentation of delirium at Clinical Governance	19/07/19	Green
DEM-101	Dementia	Pathway maps signed off	31/07/19	Green
PPEE-65	Patient and Public Experience and Engagement	Patient experience leads identified for each Division	31/07/19	Green
PPEE-91	Patient and Public Experience and Engagement	Engagement Events agreed	05/07/19	Green
PTOM-18	Patients and their Medicines	QIA signed off	05/07/19	Green
PTOM-52	Patients and their Medicines	Funding agreement	31/07/19	Green
PTOM-56	Patients and their Medicines	Agreement to pilot prior to agreement of the policy	05/07/19	Green
PPEE-116	Patient and Public Experience and Engagement	Present the lessons learned of Always Events to Best Quality Board	31/07/19	Green
ENDPJP-99	#EndPJParalysis	Collation of 'After action review's following PJ Birthday Anniversary Weeks	12/07/19	Green

Metrics / KPI					
ID	KPIs	Baseline	Target	Last Month (May 19)	This Month (Jun 19)
BQ-DEMENTIA-05	Dementia patients with more than one ward move	58	TBC	66	25
BQ-PPEE-01	No. of Best Care Project with active patient engagemnet	5	TBC	5	5
BQ-DELIRIUM-01	% of patients coded for Delirium with a flag on Allscripts	12.4%	TBC	2.20%	2.6
BQ-DEMENTIA-04	Intermediate Dementia Training Compliance	65.00%	67.90%	78.00%	

Financial Information







2e. Best Safety

Maidstone and Tunbridge Wells NHS Trust

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**

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Best Safety

Summary of Progress

Explanation for Status:

03/07/2019: Explanation for Status: Medical Productivity remains red as the delay in job planning impacts on the later stages of the project. However the team anticipate that key milestone will still be met e.g. D&C deadlines but this is putting significant pressure on the project team. 7DS remains at Amber, the 7DS Steering Board concluded that the MEC Division is unable to meet the 7DS standards by March 2020 without a significant increase in workforce (approximately 25 consultants) see issues log. This has accepted by the Board and will remain an issue past the 2020 deadline. Documentation and Record Keeping is now green, the objectives have been reviewed by the SRO and it has been decided to de-scope this project to form part of Clinical Audit core business. The rapid PDSA cycles will still continue. Consent is Amber as the policy is yet to be signed off. Learning Lessons has moved to Amber as there are potential delays to timescales whilst the team continue contractual discussions with the provider of Datix. The financial status remains Amber and a risk is contained in the risk log relating to the achievability of the £206k plan. The focus of job planning has been increasing productivity and not reducing PAs. However the financial plan was identified by directorates and the gap may reflect that change forms have not been completed and actioned on ESR. The financial reconciliation against ESR on completion of job plans will answer this.

Decisions Required by Board:

03/07/2019: The project team request continued support from the Board to question Surgical Division regarding job planning progress at DPR. The plan for Learning Lessons will need to be rebase lined due to the delays in contract negotiations with the Datix supplier.

Summary Information			
Overall Status	Amber	Risk Status	Amber
Timescale Status		Issue Status	Red

Metrics			
No. of open risks	23	% milestones completed on time	
No. of open issues	4	% deliverables completed on time	

Project Status

Code	Project Name	Last Month	This Month
MTW-BC-BS-7DS	7DS	Green	Amber
MTW-BC-BS-Consent	Consent	Amber	Amber
MTW-BC-BS-DRK	Documentation and Record Keeping	Amber	Green
MTW-BC-BS-GIRFT	GIRFT	Green	Green
MTW-BC-BS-LEW	Long Elective waits	Amber	Green
MTW-BC-BS-LL	Learning Lessons	Green	Red
MTW-BC-BS-Med Prod	Medical Productivity	Red	Red
MTW-BC-BS-Mortality	Mortality	Green	Green

Top Risks

ID	Description	Mitigation	Date Opened	Owner	RAG
BS MP-07	The financial target may not be met as the directorates have focused on increasing productivity rather than reducing PAs. In addition as job plans are still being signed off, some change forms have not been completed -and therefore it is unclear if this reflects a true position.	Once the financial reconciliation has taken place, any change forms that have not been completed will be back dated to the start date of the job plan (April 19 in most cases).	14/06/19	Sara Mumford	Amber

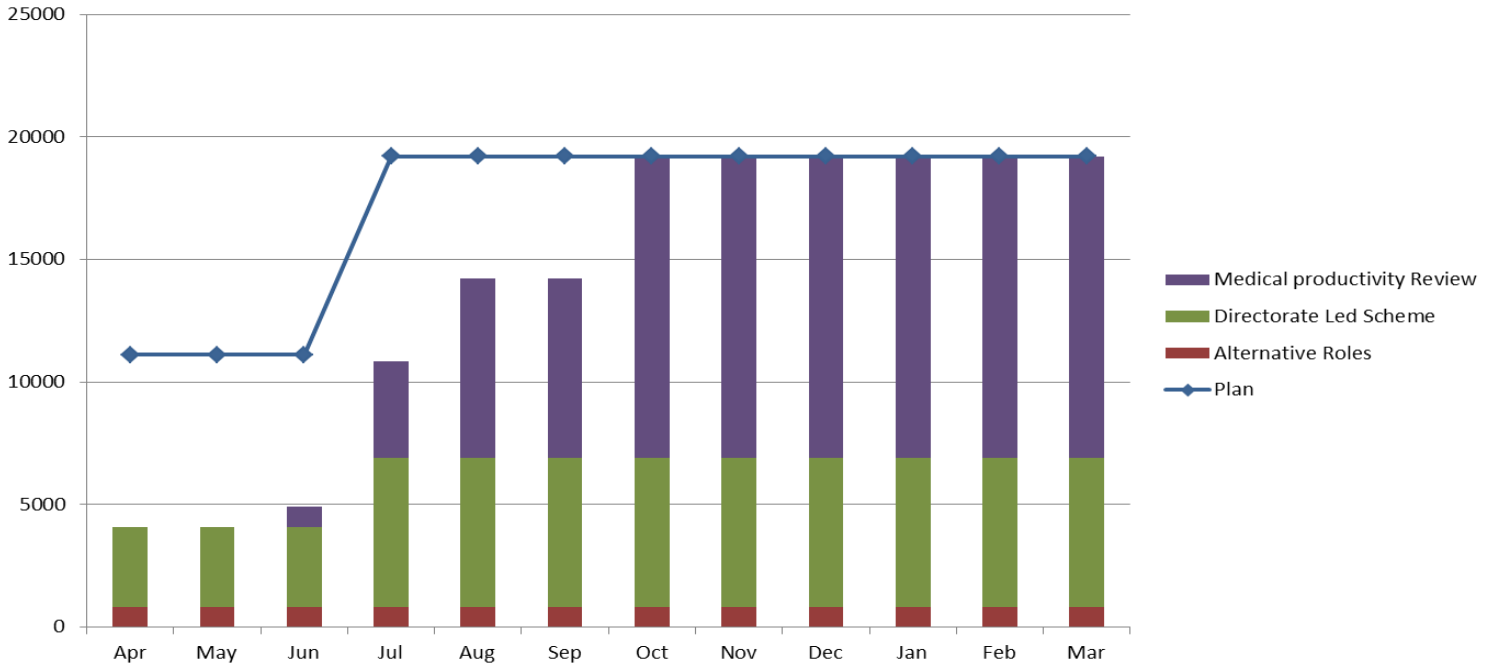
Top Issues					
ID	Description	Action	Date Opened	Owner	RAG
BS 7DS-01	As previously notified to the Trust Board and the National Team, the Medicine and Emergency Care Division have reviewed the numbers of non elective medically active patients and the required workforce to review these patients within the 7DS standards due by March 2020. This project is overseen by the Chief of Service. The 7DS Steering Board has concluded that the MEC Division is unable to meet the 7DS standards by March 2020 without a significant increase in workforce (approximately 25 consultants). Despite mitigations being put in place.	Continue working with the Division on recruitment plans and moving closer to compliance.	14/06/19	Lynne Sheridan	Red
BS-MP07	All job plans to be added to the system and signed off by Directorate Management Teams by April 2019	This has been escalated to Deputy CE via SM. This will be discussed at Divisional Performance Review meetings on the 22/5/19. In advance of this the teams have been asked to provide details of the status of any incomplete job plan and plans to sign off by the 29th May and any blockers to hitting this deadline.	22/01/18	Abigail Hill	Red
BS-LL-04	Contract negotiations with Datix Supplier has delayed the implementation of the project.	This is in the process of being resolved. However it will impact on the later aspects of the project. The project therefore needs to be rebase lined.	03/07/19	Wendy Glazier	Red

Milestones Missed				
ID	Entity Name	Milestone	Expected Date	RAG
BS MP-38	Medical Productivity	All job plans complete	29/03/19	Red

Milestones Due in Next Reporting Period				
ID	Entity Name	Milestone	Expected Date	RAG
BS MP-64	Medical Productivity	Post MJPCC Review Feedback sent for Cancer Services	31/07/19	Green
BS MP-67	Medical Productivity	Post MJPCC Review Feedback sent for Specialist Medicine	01/08/19	Green
BS LEW-14	Long Elective waits	Process of completing forms returns to BAU	01/08/19	Green
BS Consent-23	Consent	Policy signed off at TME	16/08/19	Green
BS Mortality-27	Mortality	Workshop to agree implementation plan for ME role and understand impact on patient services	24/07/19	Green

Metrics / KPI					
ID	KPIs	Baseline	Target	Last Month (May 19)	This Month (Jun 19)
BS MP KPI1	Percentage of Job Plans signed off	0	95%	58%	70%
BS MP KPI2	Percentage of Job Plans in discussion	0	3%	19%	11%
BS Mort KP1	90% Compliance with all mortality forms	0	0	84.4%	54.5%

Financial Information



3. Best Care Programme - Financial Summary

Comment

The Trust was on plan in the month, £0.4m adverse YTD, the YTD slippage relates to Prime Provider (£1m) being partly offset by additional non recurrent savings (£0.6m).

The Trust has an internal CIP plan of £25.1m with an external plan of £22.3m, therefore creating a savings stretch of £2.8m.

The operational efficiencies savings (£5.8m) included within the CIP and the internal savings stretch (£2.8m) have been phased into divisions in twelfths with a corresponding adjustment back to the submitted CIP phased plan reported out side of the divisions position (£0.7m in June, £2.4m YTD).

The divisions are currently forecasting £18.7m savings to be delivered in 2019/20 therefore requiring additional savings of £3.6m to be identified to deliver the CIP plan. The main forecasted CIP slippage relates to Operational efficiencies (£4.6m) and Prime Provider (£1m) partly offset by additional non recurrent savings (£1m) and workforce savings (£1.6m).

4. Communication & Engagement

Best Care Key Messages

Best Use of Resources

- The Trust has agreed an investment for the Aseptic Unit which will be beneficial to patients.
- The Trust has had positive conversations with NHSE in regards to the Pharmacy Outsourcing dispensing charge which will benefit MTW financially.

Best Patient Flow

Outpatient Transformation

- The 1st of 2 Video Consultation Clinic Engagement Events for staff and patients is taking place 19/7/19 at Maidstone Hospital. We have already received interest in the event and look forward to welcoming people to the drop in event where we'll be distributing information, giving live demos and seeking volunteers to join our Co-Design Working Group. The 2nd session is planned for 29/7/19 at Tunbridge Wells Hospital.

Best Quality

- Crowborough Births Increase: 133.3% increase on Births for June 2019 compared to June 2018 (9:21).
- #EndPJParalysis Birthday week was very successful and there has been some great staff feedback.
- MCA Project has been set up with key leads identified and work plan being agreed.

Best Safety

- At the recent Anaesthetic and Perioperative GIRFT review -4 areas of good practice have been identified. The team are currently reviewing which ones to put forward for the National GIRFT Database.

4. Communication & Engagement

Best Care Key Messages

Best Workforce

- What a weekend the Recruitment Team had at Pub in The Park. Glorious sunshine, hundreds of lovely local people and most importantly some fantastic leads which will hopefully benefit staff numbers on wards and offices soon.

  Many of these leads were staff already working for the NHS in other Trusts but wanting to move to the local area. These numbers exceeded our expectations and showed that 'getting out there' and being proactive is a great way to attract new staff.

4. Communication & Engagement

Maidstone and Tunbridge Wells NHS Trust

Best Care Key Messages

Best Workforce Cont

- Our next event will be the War And Peace Show held at the Hop Farm, Paddock Wood from Tuesday 23rd to Saturday 27th July. We will be promoting our 'Step Into Health' campaign and are excited to gain some more valuable leads for new staff members. If you are planning on coming to the event please do stop by and say hi!

- Due to the increase with the overseas recruitment campaign the first larger group of overseas Nurses are arriving on 18th July and will start work within MTW the following week. We hope everyone in MTW will welcome our 15 new arrivals and support them in adjusting to life in the UK. The Recruitment Team would like to say Thank you to all members of staff who have helped making this a success with Skype interviews and recent trips to India

- Other Information: We have 393 overseas nurses that have been conditionally offered positions with the trust with 41 of these predicted start date of August.

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Approval of the Trust's Clinical Negligence Scheme for Trusts (CNST) incentive scheme submission

Chief Nurse

As part of Department of Health's Maternity Safety Strategy, the CNST incentive scheme seeks to reward providers of maternity services who improve maternity safety. The scheme identifies 10 key maternity safety actions against which Trusts are invited to evidence progress and compliance (see Appendix 1).

The "Q&A regarding Maternity Safety Strategy actions and Clinical Negligence Scheme for Trusts (CNST) incentive scheme" states that "Trusts will be expected to provide a report to their Board demonstrating progress (with evidence) against each of the 10 actions using the template Board report for result submission.

Submission for the maternity incentive scheme must be received no later than 12 noon on Thursday 15 August 2019 to MIS@resolution.nhs.uk

MTW is required to submit a completed electronic version of the "Board Declaration form and action plan template" (Appendix 2) provided by NHS resolution (and a signed copy of the board declaration form if there is no electronic signature added). Evidence should not be sent to NHS Resolution.

The Board declaration form must be signed and dated by the trust chief executive to confirm that:

- The Board is satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required standards as set out in the safety actions and technical guidance document.
- The content of the Board declaration form has been discussed with the commissioner(s) of the trust's maternity services.

The Board must give their permission to the chief executive to sign the Board declaration form prior to submission to NHS Resolution.

This report has been prepared using the template specified by NHS Resolution. Trust Boards are tasked with assessment and self-certification of the evidence provided.

Further information about the CNST incentive scheme is provided in Appendix 3.

A number of embedded documents are included within the report as evidence of compliance, and these have been saved within the "Documents" section of the Trust Board's meeting portal, Admincontrol, for reference.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

The Board is invited to sign off and self-certify the report to NHS Resolution that will be submitted by 15/08/19

[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

Board report stating Maidstone and Tunbridge Wells NHS Trust progress against the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme – Year two

SECTION A: Evidence of Trust's progress against 10 Safety Actions:

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved?
Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?				
	a) A review of 95% of all deaths of babies suitable for review using the Perinatal Mortality Review Tool (PMRT) occurring from Wednesday 12 December 2018 have been started within four months of each death.	A report has been received by the trust Board each quarter from Wednesday 12 December 2018 until Thursday 15 August 2019 that includes details of the deaths reviewed and the consequent actions plans. The report should evidence that the required standards a) to c) above have been met. *NHS Resolution will use MBRRACE-UK data to cross ref against self-certification the no. of eligible deaths from 12th Dec -15th Aug 2019*	100% compliant on MBRRACE, all reviews have been started	Achieved
	b) At least 50% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018 will have been reviewed, by a multidisciplinary review team, with each review completed to the point that a draft report has been generated, within four months of each death.		Currently at 84% compliance on 11th July with regular MDT monthly reviews in the calendar.	Achieved
	c) In 95% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018, the parents were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of their baby have been sought.		100% compliant this is built into the Bereavement process	Achieved
	d) Quarterly reports have been submitted to the trust Board that include details of all deaths reviewed and consequent action plans.		Trust Board Schedule:	Achieved

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved?
			Trust Board meeting - Forward programme **Report in Trust Board Papers March 2019** Detailing all deaths of babies suitable for review using PMRT occurring from 12th December *(1st case in January as none in December)* March Board Papers (Pg 27): Item 3-9. Attachment 6 - IPR.p March Board Minutes: Item 4-3. Attachment 1 - Board June Trust Board Papers (pg31) Agenda (06.19, TB).pdf Integrated Performance Report (June Trust Board Draft Minutes: Board minutes 27.06.19 (Part 1) - e)	

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved?
Safety Action 2: Are you submitting data to the Maternity Services Data Set to the required standard				
	This relates to the quality, completeness of the submission to the Maternity Services Data Set (MSDS) and readiness for implementing the next version of the dataset (MSDSv2) *The assessment will include data from the MSDS from January 2019.* *This data needs to be submitted to MSDS for the deadline of 31 March 2019.* *One MSDS criterion relates to data for six months, from October 2018 to March 2019, which needs to be submitted to MSDS for deadlines between 31 December 2018 and 31 May 2019.* *One criterion relates to the submission of data for the first month of MSDSv2. This data relates to April 2019 and needs to be submitted to the deadline of 30 June 2019.*	NHS Digital will issue a monthly scorecard to data submitters (trusts) that can be presented to the Board. The scorecard will be used by NHS Digital to assess whether each MSDS data quality criteria has been met and whether the overall score is enough to pass the assessment. It is necessary to pass all three mandatory criteria and 14 of the 19 other criteria.	**January 2019 data** shows compliance with mandatory criteria 1 & 2 and 19/19 of the optional criteria. And was submitted to NHS Digital before the deadline of 31st May 2019:  CNST Criteria v2 - January 2019.xlsx  FW Deadline Fri 1 March 2019 Maternit **Confirmation email/screenshot showing accepted MSDSv2 file on Friday 28th June at 9:58PM**  MSDS v2.0 File Accepted Email.msg  2019-04 submission proof.PNG **Email from NHS Resolution stating that the Deadline for MSDSv2 extended to 5th July**  RE CNST Maternity Incentive Query - Sal	Achieved.

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved?
Safety Action 3: Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?				
	a) Pathways of care for admission into and out of transitional care have been jointly approved by maternity and neonatal teams with neonatal involvement in decision making and planning care for all babies in transitional care. *By Sunday 3rd Feb*	Local policy available which is based on principles of British Association of Perinatal Medicine (BAPM) transitional care where: 1. There is evidence of neonatal involvement in care planning 2. Admission criteria meets a minimum of HRG XA04 but could extend beyond to BAPM transitional care framework for practice 3. There is an explicit staffing model 4. The policy is signed by maternity/neonatal clinical leads	**Transitional Care Guideline** Ratified: 13 September 2017  Transitional Care Guideline.doc	Achieved
	b) A data recording process for transitional care is established, in order to produce commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2. *By Sunday 3rd Feb*	Data is available (electronic or paper based) on transitional care activity which has been recorded as per XA04 2016 NCCMDS.	**File attached shows that we have been using the transitional care HRG for neonates since well before Feb 19.** These codes are generated by extracting all daily records from Badgernet (national neonatal database) and running them through our HRG grouper.  Dailies by HRG allocation 2019-03 CN	Achieved.
	c) An action plan has been agreed at Board level and with your Local Maternity Systems (LMS) and Operational Delivery Network (ODN) to address local findings from Avoiding Term	An audit trail providing evidence and a rationale for developing the agreed action plan to address local findings from ATAIN reviews.	**Audit trail for ATAIN Action Plan Development**	Achieved.

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved?
	Admissions Into Neonatal units (ATAIN) reviews. *By Sunday 10th March*	Evidence of an action plan to address identified and modifiable factors for admission to transitional care. Action plan has been signed off by trust Board, ODN and LMS.	ATAIN January 2019 Newsletter.pdf ATAIN PROGRAMME Summary Feb 2019.d **MTW ATAIN Action Plan:** Atain action plan MTW 2019-2020.xlsx **Action Plan Board Level Sign off:** RE ATAIN for consideration as AoB RE ATAIN for consideration as AoB **Action Plan Sign off by ODN and LMS:** ATAIN Workstream monitored in the LMS Safety and Quality Workstream Minutes confirming that all ATAIN action plans were received by ODN & LMS and approved: S and Q minutes - 22nd February 2019. S&Q MInutes 29.03.19 JM.docx FW ATAIN Action Plan -CNST Deadline..	
	d) Progress with the agreed action plans has been shared with your Board and your LMS & ODN	Progress with action plan is documented within minutes of meetings at Board ODN/LMS.	**Minutes from LMS Safety and Quality Workstream through which all ATAIN action plans are monitored, issues raised as necessary:**	

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved?
	By Sunday 19th May 2019		SQ MInutes 26.04.19.docx SQ Minutes 17.5.19.docx **Email sharing progress of action plan with LMS and ODN leads.** FW ATAIN Action Plan -CNST Deadline.. **Trust Board : Papers 25th April (Pg44):** Agenda-and-Reports -Part-1-April-2019.pd **Trust Board Minutes 25th April:** Item 5-3. Attachment 1 - Board	

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved?
Safety Action 4: Can you demonstrate an effective system of medical workforce planning to the required standard?				
	a) Formal record of the proportion of obstetrics and gynaecology trainees in the trust who 'disagreed/strongly disagreed' with the 2018 General Medical Council National Training Survey question: 'In my current post, educational/training opportunities are rarely lost due to gaps in the rota.' In addition, a plan produced by the trust to address lost educational opportunities due to rota gaps.	a) Proportion of trainees formally recorded in Board minutes and the action plan to address lost educational opportunities should be signed off by the trust Board and a copy submitted to the Royal College of Obstetricians and Gynaecologists (RCOG) at workforce@rcog.org.uk	**In the GMC survey 2018 41.67% of trainees disagreed or strongly disagreed that educational/ training opportunities were rarely lost due to rota gaps.** **Results to GMC 2018 Survey:**  O&G 2018 - Rota Design.pdf This falls within the 'mean' and therefore there was no requirement to formulate formal action plans. However Rotas/Gaps are discussed at every Local Faculty Group meeting and the College Tutor works with the Clinical Director to formulate plans to recruit to the vacancies.  Re CNST medical workforce question.m Regular O&G rota meetings set up in Nov 2018, chaired by CD or college tutor to look at staffing issues and recruitment, in addition to discussions at Directorate Clinical Governance Meetings. In summary the meetings have been productive in several ways : • Early identification and manage middle grade rota gaps to mitigate the impact on patient safety, and ensuring balance between training and service needs.	Achieved.

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved?
			• Resulted in successful recruitment efforts with appointment of MTIs & International doctors with support of medical staffing team • Implemented actions and recommendations relating to Rota gap/issues from Local Faculty Group • Enabled targeted rota system to ensure trainee portfolio requirements achieved • Support for Current Rota Administrator **Example minutes from meeting attached:** Minutes of Rota Meetings 2018-19.dc Exception reporting is reported to the Board by the Guardian of Safe Working on a quarterly basis. The Director of Medical Education (DME) confirms in the report if there have been any exception reports for missed educational opportunities. All GMC results are reported at TME by the DME. Due to O&G having a mean score action plans weren't required at Trust Board, the data was presented at TME highlighted that no Red Flags were triggered. **TME September 2018 Minutes & attachment:** Item 10-3. Attachment 1 - TME n Item 9-22. Attachment 17 - DME	
	b) An action plan is in place and agreed at Board level to meet Anaesthesia Clinical Services Accreditation (ACSA) standards 1.2.4.6, 2.6.5.1	b) Board minutes formally recording the proportion of ACSA standards 1.2.4.6, 2.6.5.1 and	**Critical Care Directorate Board Minutes** stating that MTW is fully compliant with ACSA standards 1.2.4.6, 2.6.5.1 and 2.6.5.6 as highlighted under Safety	Achieved

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved?
	and 2.6.5.6.	2.6.5.6 that are met. Where trusts did not meet these standards, they must produce an action plan (ratified by the Board) stating how they are working to meet the standards. *(Six month period between January 2019 and June 2019).*	action 4 (pg 6)  CC Directorate Board Minutes 19-06-19.doc	

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved?
Safety Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard? (Covering any consecutive three month period between January to July 2019)				
	a) A systematic, evidence-based process to calculate midwifery staffing establishment has been done.	A bi-annual report that includes evidence to support a-c are being met should include: • A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated. • Details of planned versus actual midwifery staffing levels • An action plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken. Where deficits in staffing levels have been identified, maternity services should detail progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls.	**Safe Staffing Report is submitted 6 monthly to Trust Board, supported by Birthrate Plus** Maidstone Tunbridge Wells Draft **Local Area Calculations to develop Trust Board Paper:** Community Midwifery Safe Staffing Review: 27.02.2019 Safe staffing review community midwifery Crowborough Birthing Centre Safe Staffing Review: 27.02.2019 Safe staffing review Crowborough BC 27.2 Maidstone Birthing Centre Safe Staffing Review: 27.02.2019 Safe staffing review Maidstone BC 27.2.19 Acute Maternity Safe Staffing Review: 15.02.2019	Achieved

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved?
		• The midwife: birth ratio • The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 9% of the establishment which are not included in clinical numbers. This includes those in management positions and specialist midwives. • Evidence from an acuity tool (which may be locally developed) and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward status and the provision of one-to-one care in active labour and mitigation to cover any shortfalls • Number of red flag incidents (associated with midwifery staffing) reported in a consecutive six month time period within the last 12 months, how they are	 Staffing Review Maternity acute 15.0	
	b) The obstetric unit midwifery labour ward coordinator has supernumerary status (defined as having no caseload of their own during that shift) to enable oversight of all birth activity in the service		**Safe Staffing review for Acute Midwifery Services –** Labour Ward Safe Staffing Review stating Labour ward coordinator is a Band 7 with Supernumerary Status: (15.02.2019)  Staffing Review Maternity acute 15.0	Achieved
	c) Women receive one-to-one care in labour (this is the minimum standard that Birthrate+ is based on)		**One to one labour for financial year 18/19 taken from MTW Maternity Dashboard:**  2018-19 One to One Care in Labour.docx	Achieved.
	d) A bi-annual report that covers staffing/safety issues is submitted to the Board		Nursing & Midwifery Staffing Review Report is presented to Trust Board bi-annually providing a comprehensive review of Maidstone and Tunbridge Wells NHS Trust Ward Areas, Non-Ward Areas and Speciality Services (including maternity) **Safe Staffing Report:**  Board Report Non ward and ward staffi **Safe Staffing Report Board Papers / Minutes (March 2019):** **Safe Staffing Item 3-10. Minutes (Attachment 3-10, pg48)**	Achieved.

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved?
		collected, where/how they are reported/monitored and any actions arising (Please note: it is for the trust to define what red flags they monitor. Examples of red flag incidents are provided in the technical guidance).	 Agenda-and-Reports -Part-1-March-2019.p **Supported by Birthrate+ as an appendix:**  Maidstone Tunbridge Wells Draft **Safe staffing: Planned versus actual is reported monthly to the Trust Board:** Feb 2019 Trust Board Papers and Reports –Safe Staffing (pg 43): https://www.mtw.nhs.uk/wp-content/uploads/2019/02/Agenda-and-Reports-Part-1-February-2019-1.pdf March 2019 Trust Board Papers and Reports –Safe Staffing (pg 48): https://www.mtw.nhs.uk/wp-content/uploads/2019/03/Agenda-and-Reports-Part-1-March-2019-full-pack.pdf April 2019 Trust Board Papers and Reports –Safe Staffing (pg 43): https://www.mtw.nhs.uk/wp-content/uploads/2019/04/Agenda-and-Reports-Part-1-April-2019.pdf May 2019 Trust Board Papers and Reports –Safe Staffing (pg 43):	

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved?
			https://www.mtw.nhs.uk/wp-content/uploads/2019/05/Agenda-Reports-Part-1-May-2019.pdf June 2019 Trust Board Papers and Reports –Safe Staffing (pg 61): http://www.mtw.nhs.uk/wp-content/uploads/2019/06/Board-papers-June-27-2019.pdf	

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved?
Safety Action 6: Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?				
	Board level consideration of the Saving Babies' Lives (SBL) care bundle (Version 1 published 21 March 2016) in a way that supports the delivery of safer maternity services. Each element of the SBL care bundle implemented or an alternative intervention in place to deliver against element(s). *The scheme will take into account the position of trusts at end July 2019.* *Thursday 15 August 2019 at 12 noon*	Board minutes demonstrating that the SBL bundle has been considered in a way that supports delivery and implementation of each element of the SBL care bundle or that an alternative intervention put in place to deliver against element(s).	**Element 1:** Reducing Smoking in Pregnancy **Element 2:** Carry out risk assessment and surveillance for fetal growth restriction **Element 3:** Raise awareness of reduced fetal movement **Element 4:** Provide effective fetal monitoring during labour **SBLCB discussed at maternity board 17th June 2019 as part of item 5 Head of Midwifery / Gynaecology Report:** Agenda Maternity Board 17June19.doc Maternity HoM report May 2019 (2). Maternity Board minutes 17June19.do **Smoking Stats are monitored monthly (April and May 2019 figures attached, supporting Element 1):** Smoking Stats for April 2019.xls Smoking Stats for May 2019.xls **Saving Babies Lives driver diagram: (Supporting all 4 elements of saving babies lives).**	Achieved.

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved?
			Driver Diagram - Saving Babies Lives C **Fetal Wellbeing Midwife Job Description:** Fetal Wellbeing RM FINAL MTW 14.01.20 Fetal Wellbeing Midwife has been recruited, currently not in post due to delays in Recruiting to current role. However it has been recognised across the LMS and South East Coast that this role is an excellent addition to the team and now the LMS is fully rolling this out. (This JD supports all four elements of saving babies lives bundle). **MTW Maternity Red Flag Monitoring:** MTW Maternity Red Flag monitoring.docx	

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved?
Safety Action 7: Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?				
	User involvement has an impact on the development and/or improvement of maternity services.	Evidence should include: Acting on feedback from, for example a Maternity Voices Partnership. User involvement in investigations, local and or Care Quality Commission (CQC) survey results. Minutes of regular Maternity Voices Partnership and/or other meetings demonstrating explicitly how a range of feedback is obtained, the action taken and the communications to report this back to women.	**Maternity Board TOR included for evidence of MVP invitation (consider user feedback):** Maternity Board TOR updated June 2018.d **Maternity Board Minutes – Update from MVP and LMS System Update giving a chance for feedback:** Feb 2019- Including Big Baby Study of which the MVP gained feedback for the Trust about the information given to women with large babies Agenda Maternity Board 15Feb19.docx Big baby women's experiences MTW Fel Maternity Board minutes 15Feb19.doc April 2019: Agenda Maternity Board 12Apr19.docx Maternity Board minutes 12Apr19.doc June 2019: Agenda Maternity Board 17June19.docx Maternity Board minutes 17June19.do **Maternity Forum (Bi monthly meeting with evidence of Consumer Representation/ MVP/NCT invite)**	Achieved.

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved?
			Terms of Reference [25.09.18 SB-S].docx Maternity Forum minutes 25March 19.(**Maternity Screening Meeting TOR (Quarterly Meeting, evidence of MVP invite "Client Representative":** Screening Group terms of reference 2(AN NB Screening Meeting minutes 30. AN NB Screening Meeting minutes 01. **Complaints:** Feedback is obtained by complaints is responded to. Women's and Children's Complaint response rate is embedded below: Complaints Targets - W&C Figures.xlsx W&C Complaint Data 1920.xlsx **Maternity Complaints Data against target of 75%:** Jan 2019: (nil complaints) Feb 2019: (nil complaints) Mar 2019: 100% Apr 2019: 33.3% May 2019: 66.7% June 2019: 100% A table top exercise was performed by the MVP chair and group; they reviewed a number of anonymised complaints and their responses and	

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved?
			provided us with feedback. This is scheduled in for to take place quarterly. Complaints review by MVP June 2019.msg **ECHO Monthly Maternity Newsletter** for staff incorporating 'update on complaints'. Example below: Women's ECHO Feb 19.docx **MTW MVP Minutes 24th April** (held every 3 months): The MVP have also reintroduced the 'Walk the Patch' sessions, of which the first one since the new chair in post, is due to take place in July: MTW MVP Agenda 24 April 2019.docx MTW MVP Minutes 24th April 2019.docx **CQC Survey Results:** Link to January 2019 CQC Survey Results: https://www.cqc.org.uk/provider/RWF/survey/5 Maternity CQC 2018 Survey results 24.4.1 Quality improvement weekly walkabout me	

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved?
Safety Action 8: Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?				
	90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year. *The scheme will take into account the position of trusts by Thursday 15 August 2019.*	Evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year through Board sight of a staff training database or similar.	On 11th July 2019 day 90.3% compliance with PRMT training, with an additional 25 members of trained to be trained in August 2019. This evidence is a screenshot of MTW learning and has been mapped specifically with all staff that are eligible to undertake PROMPT. Screenshot of PROMPT Compliance prompt complinace on 1st July 2019.xlsx	Achieved.

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved?
Safety action 9: Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?				
	a) The Executive Sponsor for the Maternal and Neonatal Health Safety Collaborative (MNHSC) is actively engaging with supporting quality and safety improvement activity within: i. the trust ii. the Local Learning System (LLS)	Evidence of executive sponsor engagement in quality improvement activities led by the trust nominated Improvement Leads for the MNHSC as well as other quality improvement activity for trusts in waves one and three Evidence that the trust Board have been sighted on the local improvement plan, updated on progress, impact and outcomes with the quality improvement activities being undertaken locally Evidence of attendance at one or more National Learning Set or the annual national learning event Evidence of engagement with relevant networks and the collaborative LLS Evidence of a safety dashboard or equivalent, visible to staff which reflects action and progress made on identified concerns raised by staff	Examples of Chief Nurse engaging with Quality Improvement Activities, Engagement with Maternity and Neonatal Staff providing the opportunity for feedback and steps taken by Chief Nurse to address Safety Concerns visible to staff: Monthly Best Quality Workstream Board Meetings. SRO is Chief Nurse Claire O'Brien and two maternity improvement projects currently sit within this work stream: Crowborough Birth Centre Activity Improvements and Better Births. These projects are exception reported to the Trust Board monthly. Best Quality Meeting Notes: November 18 BQ Notes.docx December 18 BQ Notes.docx February BQ Notes Draft.docx March BQ Notes Draft.docx April BQ Notes and Actions Final 0905201 May BQ Notes and Actions Approved.do June BQ Notes and Actions 12062019.do **Best Quality- Monthly reports to Trust Board** "update from the best care programme board": December Trust Board: https://www.mtw.nhs.uk/wp-content/uploads/2018/12/Agenda-and-Reports-Part-1-	Achieved.
	b) The Board level safety champions have implemented a monthly feedback session for maternity and neonatal staff to raise concerns relating to relevant safety issues			
	c) The Board level safety champions have taken steps to address named safety concerns and that progress with implementing these are visible to staff			

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved?
		Evidence that safety concerns raised by staff feedback sessions are reflected in the minutes of Board meetings and include updates on progress, impact and outcomes relating to the steps and actions taken to address these concerns	December-2018.pdf January Trust Board: https://www.mtw.nhs.uk/wp-content/uploads/2019/01/Agenda-and-Reports-Part-1-January-2019-full-pack.pdf February Trust Board: https://www.mtw.nhs.uk/wp-content/uploads/2019/02/Agenda-and-Reports-Part-1-February-2019-1.pdf March Trust Board: https://www.mtw.nhs.uk/wp-content/uploads/2019/03/Agenda-and-Reports-Part-1-March-2019-full-pack.pdf April Trust Board: https://www.mtw.nhs.uk/wp-content/uploads/2019/04/Agenda-and-Reports-Part-1-April-2019.pdf May Trust Board: http://www.mtw.nhs.uk/wp-content/uploads/2019/05/Agenda-Reports-Part-1-May-2019.pdf **The Best Quality Structure has been updated as of July 2019 to include 'Maternity Transformation' Workstream, including the 8 projects to deliver the long term plan.**  Best Quality Governance July 201 Head of Midwifery meets weekly with Chief Nurse as	

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved?
			part of the Chief Nurse Management Team Meeting (CNMT) providing the opportunity to raise any issues. Chief Nurse chairs bi-monthly Maternity Board with attendance from Head of Midwifery and Obstetrician Lead. **Maternity Board TOR and Minutes:** Maternity Board TOR updated June 2018.d Maternity Board minutes 15Feb19.doc Maternity Board minutes 12Apr19.doc Maternity Board minutes 17June19.do **Chief Nurse, Head of Midwifery and Women's Clinical Director have bi-monthly scheduled Safety Champion Meetings:** Fwd Safety Champions Meeting.ic **ECHO Monthly Maternity Newsletter is designed to provide a forum to staff where key elements are shared, inclusive of positive feedback:** Women's ECHO Christmas Newsletter Women's ECHO Jan 2019 - FINAL.docx Women's ECHO Feb 19.docx	

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved?
			Newsletter for Maternity MarchApril ECHO newsletter [April May 2019].doc **Suggestion Boxes are situated on all areas and incorporated into a 'You said we did'.** **Monthly Report to Trust Clinical Governance Committee:** TCGC report Jan 19.docx Women's report FebMar19.docx WomenTCGC report April 19.docx Women's TCGC Report May 19.docx **MatNeo Team Certificate evidenced in ECHO:** Newsletter for Maternity MarchApril **PRECEPT emails embedded below:** FW PReCePT-March 2019-100% again!.m PReCePT May 2019.msg **Weekly Quality Assurance Walk Around by Senior Midwifery Teams are in place.** Chief Nurse attends Quality Assurance Walk Arounds when possible.	

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved?
			5 topics are covered on a rota: • Consent • CQC inspection • Fetal monitoring • Documentation • Medicines Management These were based in the key elements which caused main concern and will be adjusted annually. Template for feedback is sent out following the walk arounds and ward managers will use a whiteboard/chalkboard to disseminate messages that are pertinent to their area. **Agenda for Quality Assurance Walk Arounds:**  walk about agenda.docx **Example of feedback poster sent out to staff:**  27.06.19 Medicines Management Poster.p **NMC Visit on 4th June 2019. Chief Nurse attended afternoon closing feedback session.**  NMC visit 4 6 19.docx **Internal Assurance Inspections** carried out on an annual rota by Corporate Nursing Team, Patient Representatives and CCG. Reports are written and	

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved?
			updates to action plans discussed at Quality Improvement Committee, chaired by Chief Nurse, with Head of Midwifery Attendance. Internal Assurance Inspection Reports April 2019:  Internal Assurance Inspection Report CB  Maternity TWH Internal Assurance Ir To be discussed at Quality Improvement Committee 18th July 2017:  Q I C agenda 18 07 2019.docx **Chief Nurse did a half-day session shadowing Women's Services Clinical Director.** **Head of Midwifery and Chief Nurse have regular one to ones.** **Chief Nurse chairs the Learning and Development Panel in which Maternity SI's are reviewed**	

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved?
Safety action 10: Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?				
	Reporting of all qualifying incidents that occurred in the 2018/19 financial year to NHS Resolution under the Early Notification scheme reporting criteria.	Trust Board sight of trust legal services and maternity clinical governance records of qualifying Early Notification incidents and numbers reported to NHS Resolution Early Notification team.	100% of cases reported to NHSR under ENS financial year 2018/19. HSIB/EBE & NHS R Maternity Database May 2019:  HSIB, ENS & EBC Case Database Anony In addition to the database, any incidences that the head of midwifery feels need notification to the chief nurse, will do so on an ad hoc basis, based on seriousness of incident.	Achieved.

Appendix 2

Maternity incentive scheme - Guidance

Resolution

Trust Name	**Maidstone and Tunbridge Wells NHS Trust**
Trust Code	**T571**

This document **must** be used to complete your trust self certification for the maternity incentive scheme safety actions and a completed action plan must be submitted for actions which have not been met. Please select your trust name from the drop down menu above. Your trust name will populate each tab. **If the trust name box is coloured pink please update it.**

Guidance Tab - This has useful information to support you to complete the maternity incentive scheme safety actions excel spreadsheet. **Please read the guidance carefully.** There are three additional tabs within this document:

Tab A - Safety actions entry sheet - Please select 'Yes' or 'No' to demonstrate compliance with each maternity incentive scheme safety action. Note, entering 'Yes' denotes full compliance with the safety action as detailed within the condition of the scheme. The information which has been populated in this tab, will automatically populate onto tab C which is the board declaration form

Tab B - Action plan entry sheet - This must be completed for each maternity incentive scheme safety action which has **not** been met. If you are not requesting any funding to support implementation of your action plan - Please enter 0. **If cells are coloured pink then please update them.**

Tab C - Board declaration form - This is where you can track your overall progress against compliance with the maternity incentive scheme safety actions. This sheet will be protected and fields cannot be altered manually. If there are anomalies with the data entered, then comments will appear in the validations column (Column I) this will support you in checking and verifying data before it is discussed with the trust board, commissioners and before submission to NHS Resolution. Once the submission has been discussed and approved at trust board, please add an electronic signature into the document. If you are unable to add an electronic signature, the board declaration form can be printed, signed then scanned to be included within the submission.

Any queries regarding the maternity incentive scheme and or action plans should be directed to **MIS@resolution.nhs.uk**

Technical guidance and frequently asked questions can be accessed here :
https://resolution.nhs.uk/resources/maternity-incentive-scheme-year-two

Submissions for the maternity incentive scheme must be received no later than **12 noon on Thursday 15 August 2019** to **MIS@resolution.nhs.uk**

You are required to submit this document (and a signed copy of the board declaration form, if there is no electronic signature added). Please do not send evidence to NHS Resolution.

Section A : Maternity safety actions - Maidstone and Tunbridge Wells NHS Trust

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set to the required standard?	Yes
3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?	Yes
4	Can you demonstrate an effective system of medical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?	Yes
7	Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?	Yes
8	Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	Yes
9	Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	Yes
10	Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?	Yes

Section B : Action plan details for Maidstone and Tunbridge Wells NHS Trust

An action plan should be completed for each safety action that has not been met

Action plan 1

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**		**When?**	
Monitoring					

Action plan 2

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the*		
Lead executive director	*Does the action plan have executive*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**		**When?**	
Monitoring					

Action plan 3

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 4

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 5

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 6

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 7

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 8

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 9

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 10

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Maternity incentive scheme - Board declaration Form

Trust name	**Maidstone and Tunbridge Wells NHS Trust**
Trust code	**T571**

An electronic signature must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	Yes		-	
Q2 MSDS	Yes		-	
Q3 Transitional care	Yes		-	
Q4 Medical workforce planning	Yes		-	
Q5 Midwifery workforce planning	Yes		-	
Q6 SBL care bundle	Yes		-	
Q7 Patient feedback	Yes		-	
Q8 In-house training	Yes		-	
Q9 Safety Champions	Yes		-	
Q10 EN scheme	Yes		-	
Total safety actions	**10**	**-**		
Total sum requested			**-**	

Sign-off process:

Electronic signature

For and on behalf of the board of Maidstone and Tunbridge Wells NHS Trust

Confirming that:

The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

The content of this form has been discussed with the commissioner(s) of the trust's maternity services

If applicable, the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)

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

Name:
Position:
Date:

NHS Resolution

Maternity incentive scheme – year two

Conditions of the scheme

Ten maternity safety actions with technical guidance

Questions and answers related to the scheme

Contents

Introduction

NHS Resolution is operating a second year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care.

The maternity incentive scheme applies to all acute trusts that deliver maternity services and are members of the CNST. As in year one, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

As in year one, the scheme incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved **all** of the **ten** safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

Trusts that **do not meet** the ten-out-of-ten threshold will **not** recover their contribution to the CNST maternity incentive fund, but may be eligible for a small discretionary payment from the scheme to help them to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

This document provides guidance on the safety actions for year two of the maternity incentive scheme.

Maternity incentive scheme year two: conditions

In order to be eligible for payment under the scheme, trusts must submit their completed Board declaration form (see Appendix 1) to NHS Resolution (MIS@resolution.nhs.uk) by 12 noon on Thursday 15 August 2019 and must comply with the following conditions:

- Trusts must achieve all ten maternity safety actions
- The Board declaration form must be signed and dated by the trust chief executive to confirm that:
    - The Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required standards as set out in the safety actions and technical guidance document.
    - The content of the Board declaration form has been discussed with the commissioner(s) of the trust's maternity services.
- The Board must give their permission to the chief executive to sign the Board declaration form prior to submission to NHS Resolution.

Evidence for submission

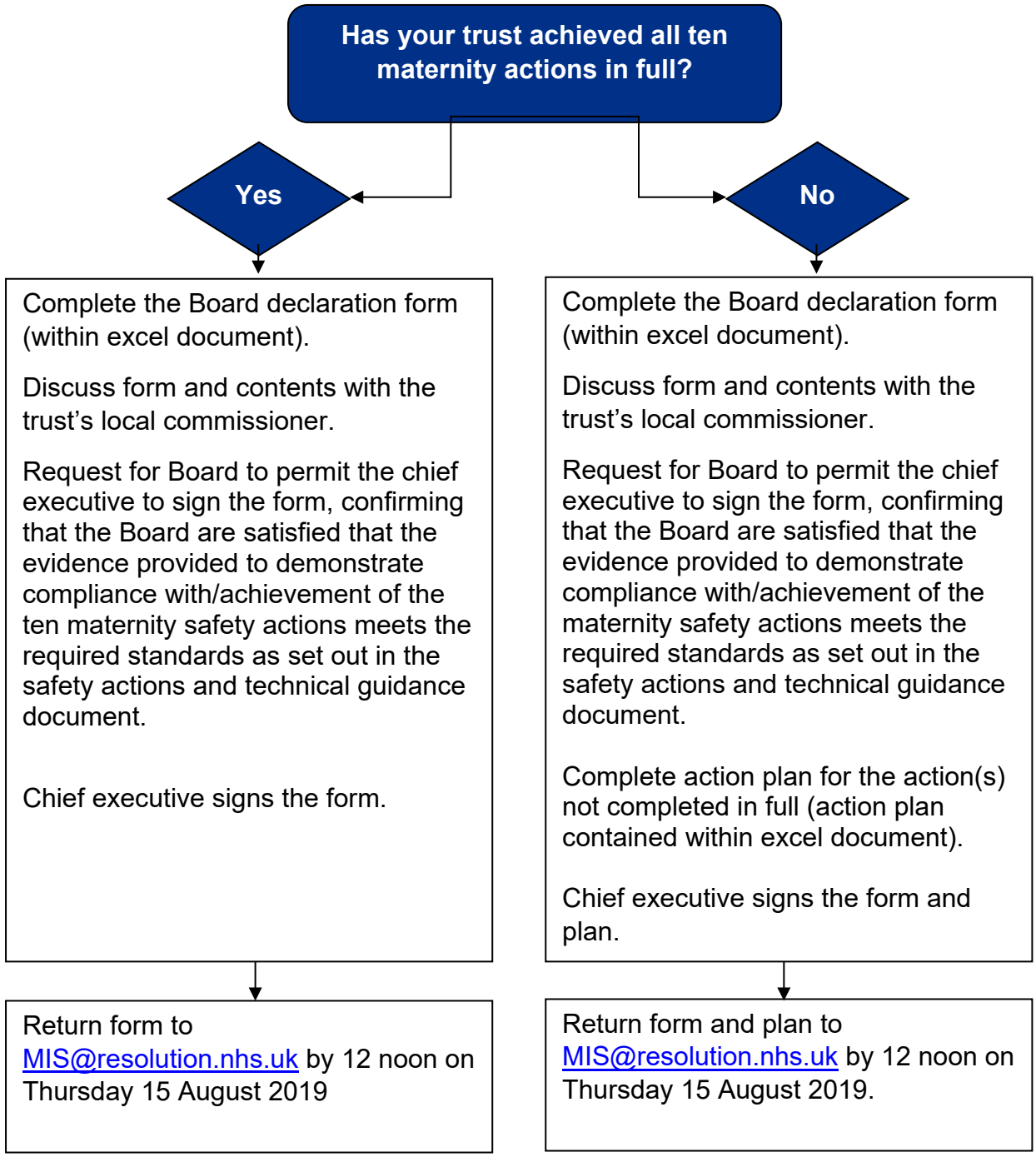
- The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided to the trust Board only, and will not be reviewed by NHS Resolution.
- Trust submissions will be subject to a range of external verification points, these include cross checking with: MBRRACE-UK data (Safety action 1), NHS Digital regarding submission to the Maternity Services Data Set (Safety action 2), and against the National Neonatal Research Database (NNRD) for number of qualifying incidents reportable to the Early Notification scheme (Safety action 10)
- Trust submissions will also be sense checked with the Care Quality Commission (CQC).

Timescales and appeals

- Any queries relating to the ten safety actions must be sent in writing by e-mail to NHS Resolution (MIS@resolution.nhs.uk) prior to the submission date.
- The Board declaration form must be sent to NHS Resolution (MIS@resolution.nhs.uk) by 12 noon on Thursday 15 August 2019. An electronic acknowledgement of trust submissions will be provided within 48 hours.
- Submissions and any comments/corrections received after 12 noon on Thursday 15 August 2019 will not be considered
- Trusts will be notified of results by the end of September 2019.
- Appeals must be submitted in writing by the trust chief executive and sent to NHS Resolution (MIS@resolution.nhs.uk) by Monday 14 October 2019. Further detail on the appeals process will be communicated at a later date. The payments to be made under the maternity incentive scheme will be communicated to trusts by the end of November 2019.

For trusts who have not met all ten maternity actions

Trusts that have not achieved all ten actions may be eligible for a small amount of funding to support progress. In order to apply for funding, such trusts must submit an action plan together with the Board declaration form by 12 noon on Thursday 15 August 2019 to NHS Resolution (MIS@resolution.nhs.uk). The action plan must be specific to the action(s) not achieved by the trust and must take the format of the template (see Appendix 1). Action plans should not be submitted for achieved safety actions.


Has your trust achieved all ten maternity actions in full?
Yes
No
Complete the Board declaration form (within excel document).
Discuss form and contents with the trust's local commissioner.
Request for Board to permit the chief executive to sign the form, confirming that the Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the ten maternity safety actions meets the required standards as set out in the safety actions and technical guidance document.
Chief executive signs the form.
Return form to MIS@resolution.nhs.uk by 12 noon on Thursday 15 August 2019
Complete the Board declaration form (within excel document).
Discuss form and contents with the trust's local commissioner.
Request for Board to permit the chief executive to sign the form, confirming that the Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards as set out in the safety actions and technical guidance document.
Complete action plan for the action(s) not completed in full (action plan contained within excel document).
Chief executive signs the form and plan.
Return form and plan to MIS@resolution.nhs.uk by 12 noon on Thursday 15 August 2019.
Send any queries relating to the ten actions to NHS Resolution (MIS@resolution.nhs.uk) prior to the submission date

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

Required standard	a) A review of 95% of all deaths of babies suitable for review using the Perinatal Mortality Review Tool (PMRT) occurring from Wednesday 12 December 2018 have been started within four months of each death. b) At least 50% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018 will have been reviewed, by a multidisciplinary review team, with each review completed to the point that a draft report has been generated, within four months of each death. c) In 95% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018, the parents were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of their baby have been sought. d) Quarterly reports have been submitted to the trust Board that include details of all deaths reviewed and consequent action plans.
Minimum evidential requirement for trust Board	A report has been received by the trust Board each quarter from Wednesday 12 December 2018 until Thursday 15 August 2019 that includes details of the deaths reviewed and the consequent actions plans. The report should evidence that the required standards a) to c) above have been met.
Validation process	Self-certification by the trust Board and submitted to NHS Resolution using the Board declaration form. NHS Resolution will use MBRRACE-UK data to cross-reference against trust self-certification the number of eligible deaths from Wednesday 12 December until Thursday 15 August 2019.
What is the relevant time period?	**From Wednesday 12 December until Thursday 15 August 2019**
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon

Technical guidance for Safety action 1
Are you using the PMRT to review perinatal deaths?

Technical guidance	
What should we do if we do not have any deaths to review within the time period?	If you do not have any babies that have died from Wednesday 12 December to Thursday 15 August 2019 then you should partner up with a trust to which you have a referral relationship to participate in case reviews. NHS Resolution will verify with MBRRACE-UK data the number of deaths occurring in your partner trust in the relevant period.
How does the involvement of the Healthcare Services Investigation Branch (HSIB) in investigations affect meeting this action?	It is recognised that for a small number of cases (intrapartum stillbirths and early neonatal deaths) investigations will be carried out by HSIB that will contribute to the report generated by the PMRT for a baby. Achieving section b) of the standard may therefore be impacted on by timeframes beyond the trust's control. This should be noted in the quarterly report and if this is the case, those babies not included in calculating the 50%.
What does multidisciplinary review mean?	Helpful guidance can be found at the following website: www.npeu.ox.ac.uk/mbrrace-uk
We have contacted parents, but they do not want to be involved - what should we do?	Please document accordingly within the review in the PMRT.
Parents have not responded to our messages, and therefore we are unable to discuss the review - what should we do?	Parents should guide the process and advise how involved they would like to be. The trust should record the attempts made to make contact with the parents within the review in the PMRT.
Is the quarterly review of the Board report based on a financial or calendar year?	This can be either financial or calendar year.

Safety action 2: Are you submitting data to the Maternity Services Data Set to the required standard?

Required standard	This relates to the quality, completeness of the submission to the Maternity Services Data Set (MSDS) and readiness for implementing the next version of the dataset (MSDSv2).
Minimum evidential requirement for trust Board	NHS Digital will issue a monthly scorecard to data submitters (trusts) that can be presented to the Board. The scorecard will be used by NHS Digital to assess whether each MSDS data quality criteria has been met and whether the overall score is enough to pass the assessment. It is necessary to pass all three mandatory criteria and 14 of the 19 other criteria (please see table below for details).
Validation process	Self-certification by the trust Board and submitted to NHS Resolution using the Board declaration form. NHS Resolution will cross-reference self-certification against NHS Digital data.
What is the relevant time period?	The assessment will include data from the MSDS from January 2019. This data needs to be submitted to MSDS for the deadline of 31 March 2019. One MSDS criterion relates to data for six months, from October 2018 to March 2019, which needs to be submitted to MSDS for deadlines between 31 December 2018 and 31 May 2019. One criterion relates to the submission of data for the first month of MSDSv2. This data relates to April 2019 and needs to be submitted to the deadline of 30 June 2019.
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon

Technical guidance for Safety action 2
Are you submitting data to the Maternity Services Data Set to the required standard?

Technical guidance	
What do we do if we are unable to submit data to MSDS for a particular category	If a trust feels that there are exceptional circumstances, they should raise this with NHS Digital at an early stage. This might include evidence of a fall in birth rate, or of services covered in the assessment not being available at the trust.

Assessment to cover January 2019 data submitted for the deadlines of March 2019, one criteria relates to data between October 2018 and March 2019, submitted to deadlines December 2018 - May 2019, and one around MSDSv2 data for April 2019 being submitted to the deadline of June 2019	
	Mandatory categories 1-3 must be met to pass Safety action 2
1	January 2019 data contained at least 90% of HES births expectation, based on number of days in month (unless reason understood)
2	MSDSv2 readiness questionnaire completed and returned to NHS Digital within required timescales
3	Submit MSDSv2 data for April 2019 by the submission deadline of end of June 2019
	14 of the 19 optional categories 4-22 must be met to pass Safety action 2
4	Made a submission in each of the six months October 2018 - March 2019 data, submitted to deadlines December 2018 - May 2019
5	January 2019 data contained valid smoking at booking for at least 80% of bookings
6	January 2019 data contained valid smoking at delivery for at least 80% of births
7	January 2019 data contained all of the tables 501, 502, 404, 409, 401, 406, 408, 602 (unless justifiably blank)
8	January 2019 data contained all of the tables 101, 102, 103, 104, 112, 201, 205, 305, 307, 309, 511 (unless justifiably blank)
9	January 2019 data contained method of delivery for at least 80% of births
10	January 2019 data contained valid baby's first feed for at least 80% of births
11	January 2019 data contained valid in days gestational age for at least 80% of births
12	January 2019 data contained valid presentation at onset for at least 80% of births where onset of labour recorded
13	January 2019 data contained valid labour induction method (including code for no induction) for at least 80% of births where onset of labour recorded
14	January 2019 data contained valid place type actual delivery for at least 80% of births
15	January 2019 data contained valid site code for at least 80% of births
16	January 2019 data contained valid genital tract trauma code for at least 80% of vaginal births
17	January 2019 data contained valid Apgar score at five minutes for at least 80% of births
18	January 2019 data contained valid fetus outcome code for at least 80% of births
19	January 2019 data contained valid birth weight for at least 80% of births
20	January 2019 data contained valid figure for previous live births for at least 80% of bookings
21	MSDSv2 event or webinar attended in late 2018 / early 2019, or had 1:1 call with one of the NHS Digital team in lieu of attendance
22	January 2019 data contained valid (including "Not Stated") ethnic category (Mother) for at least 80% of bookings.

Safety action 3: Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?

Required standard	a) Pathways of care for admission into and out of transitional care have been jointly approved by maternity and neonatal teams with neonatal involvement in decision making and planning care for all babies in transitional care. b) A data recording process for transitional care is established, in order to produce commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2. c) An action plan has been agreed at Board level and with your Local Maternity Systems (LMS) and Operational Delivery Network (ODN) to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews. d) Progress with the agreed action plans has been shared with your Board and your LMS & ODN
Minimum evidential requirement for trust Board	Local policy available which is based on principles of British Association of Perinatal Medicine (BAPM) transitional care where: 1. There is evidence of neonatal involvement in care planning 2. Admission criteria meets a minimum of HRG XA04 but could extend beyond to BAPM transitional care framework for practice 3. There is an explicit staffing model 4. The policy is signed by maternity/neonatal clinical leads Data is available (electronic or paper based) on transitional care activity which has been recorded as per XA04 2016 NCCMDS. An audit trail providing evidence and a rationale for developing the agreed action plan to address local findings from ATAIN reviews. Evidence of an action plan to address identified and modifiable factors for admission to transitional care. Action plan has been signed off by trust Board, ODN and LMS and progress with action plan is documented within minutes of meetings at Board ODN/LMS.

Validation process	Self-certification by the trust Board and submitted to NHS Resolution using the Board declaration form
What is the relevant time period?	a) By Sunday 3 February 2019 b) By Sunday 3 February 2019 c) By Sunday10 March 2019 d) By Sunday 19 May 2019
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon.

Technical guidance for Safety action 3
Can you demonstrate that you have transitional care facilities in place and are operational to support the implementation of the ATAIN Programme?

Technical guidance	
Where can we find guidance regarding this safety action?	Helpful guidance can be found at the following websites: www.bapm.org/sites/default/files/files/TC%20Framework-20.10.17.pdf www.bapm.org/sites/default/files/files/NCCMDS.%20Neonatal%20HRGs%20and%20Reference%20Costs%20-%20A%20Guide%20for%20Clinicians%20Dec%202016.pdf
What is the suggested time period for transitional care pathways?	We would expect that all trusts should at least have pathways agreed by 31 January 2019.
What is the definition of transitional care?	Transitional care is not a place but a service and can be delivered either in a separate transitional care area, within the neonatal unit and/or in the postnatal ward setting. Principles include the need for a multidisciplinary approach between maternity and neonatal teams; an appropriately skilled and trained workforce, data collection with regards to activity, appropriate admissions as per HRGXA04 criteria and a link to community services.

Safety action 4: Can you demonstrate an effective system of medical workforce planning to the required standard?

Required standard	a) Formal record of the proportion of obstetrics and gynaecology trainees in the trust who 'disagreed/strongly disagreed' with the 2018 General Medical Council National Training Survey question: *'In my current post, educational/training opportunities are rarely lost due to gaps in the rota.'* In addition, a plan produced by the trust to address lost educational opportunities due to rota gaps. b) An action plan is in place and agreed at Board level to meet Anaesthesia Clinical Services Accreditation (ACSA) standards 1.2.4.6, 2.6.5.1 and 2.6.5.6.
Minimum evidential requirement for trust Board	a) Proportion of trainees formally recorded in Board minutes and the action plan to address lost educational opportunities should be signed off by the trust Board and a copy submitted to the Royal College of Obstetricians and Gynaecologists (RCOG) at workforce@rcog.org.uk b) Board minutes formally recording the proportion of ACSA standards 1.2.4.6, 2.6.5.1 and 2.6.5.6 that are met. Where trusts did not meet these standards, they must produce an action plan (ratified by the Board) stating how they are working to meet the standards.
Validation process	Self-certification by the trust Board and submitted to NHS Resolution using the Board declaration form
What is the relevant time period?	a) 2018 GMC National Training Survey (covers the period 20 March to 9 May 2018) b) Six month period between January 2019 and June 2019.
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon.

Technical guidance for Safety action 4
Can you demonstrate an effective system of medical workforce planning?

Technical guidance	
What if training opportunities are not being lost due to rota gaps and action plan not deemed necessary?	If training opportunities are not being lost due to rota gaps, then a copy of the trust Board minutes acknowledging and recording this, including the relevant 2018 GMC National Training Survey results, should be submitted to RCOG instead.
Anaesthesia Clinical Services Accreditation (ACSA) standards and action	
1.2.4.6	**Where there are elective caesarean section lists there are dedicated obstetric, anaesthesia, theatre and midwifery staff**
2.6.5.1	**A duty anaesthetist is available for the obstetric unit 24 hours a day, where there is a 24 hour epidural service the anaesthetist is resident**
2.6.5.2	**A separate anaesthetist is allocated for elective obstetric work**
2.6.5.3	**Where the duty anaesthetist has other responsibilities, an anaesthetist must be immediately available (within five minutes) to deal with obstetric emergencies**
2.6.5.4	**Medically-led obstetric units have, as a minimum, consultant anaesthetist cover the full daytime working week (equating to Monday to Friday, morning and afternoon sessions being staffed)**
2.6.5.5	**There is a named consultant anaesthetist or intensivist responsible for all level two maternal critical care patients (where this level of care is provided on the maternity unit)**
2.6.5.6	**The duty anaesthetist for obstetrics should participate in labour ward rounds**
How is an elective caesarean section list defined?	A scheduled list, resourced separately from the general workload of the delivery unit. A separately run list requires a full theatre team and should include a consultant obstetrician and a consultant anaesthetist. The list should be managed in the same way and to the same standards as other elective surgery lists. This may not be cost effective in units with a low elective workload (e.g. one or fewer elective caesareans per weekday or approximately 250 planned operations per year) but for all other units, separate resources should be allocated.

What is level two care or a level two maternal critical care patient?	Since 2007, the obstetric population has been included in the Intensive Care Society (ICS) definitions of levels of care in the adult population. Levels of care as defined by the ICS: **Level 0** Patients whose needs can be met by normal ward care **Level 1** Patients at risk of deterioration, needing a higher level of observation or those recently relocated from higher levels of care **Level 2** Patients requiring invasive monitoring/intervention that includes support for a single failing organ (excluding advanced respiratory support i.e. mechanical ventilation) **Level 3** Patients requiring advanced respiratory support alone or basic respiratory support in addition to support of one or more additional organs
Please access the following for further information on the ACSA standards	https://www.rcoa.ac.uk/system/files/ACSA-STDS2018.pdf

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Required standard	a) A systematic, evidence-based process to calculate midwifery staffing establishment has been done. b) The obstetric unit midwifery labour ward coordinator has supernumerary status (defined as having no caseload of their own during that shift) to enable oversight of all birth activity in the service c) Women receive one-to-one care in labour (this is the minimum standard that Birthrate+ is based on) d) A bi-annual report that covers staffing/safety issues is submitted to the Board
Minimum evidential requirement for trust Board	A bi-annual report that includes evidence to support a-c being met. This should include: •A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated. •Details of planned versus actual midwifery staffing levels. •An action plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken. Where deficits in staffing levels have been identified, maternity services should detail progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls. •The midwife: birth ratio. •The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 9% of the establishment which are not included in clinical numbers. This includes those in management positions and specialist midwives. •Evidence from an acuity tool (which may be locally developed) and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward status and the provision of one-to-one care in active labour and mitigation to cover any shortfalls

	•Number of red flag incidents (associated with midwifery staffing) reported in a consecutive six month time period within the last 12 months, how they are collected, where/how they are reported/monitored and any actions arising (Please note: it is for the trust to define what red flags they monitor. Examples of red flag incidents are provided in the technical guidance).
Validation process	Self-certification to NHS Resolution using the Board declaration form
What is the relevant time period?	Any consecutive three month period between January to July 2019
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon.

Technical guidance for Safety action 5
Can you demonstrate an effective system of midwifery workforce planning?

Technical guidance	
What midwifery red flag events could be included (examples only)?	• Delayed or cancelled time critical activity. • Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing). • Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication). • Delay of more than 30 minutes in providing pain relief. • Delay of 30 minutes or more between presentation and triage. • Full clinical examination not carried out when presenting in labour. • Delay of two hours or more between admission for induction and beginning of process. • Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output). • Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour. Other midwifery red flags may be agreed locally. Please see the following NICE guidance for details: www.nice.org.uk/guidance/ng4/resources/safe-midwifery-staffing-for-maternity-settings-pdf-51040125637

Safety action 6: Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?

Required standard	Board level consideration of the Saving Babies' Lives (SBL) care bundle (Version 1 published 21 March 2016) in a way that supports the delivery of safer maternity services. Each element of the SBL care bundle implemented or an alternative intervention in place to deliver against element(s).
Minimum evidential requirement for trust Board	Board minutes demonstrating that the SBL bundle has been considered in a way that supports delivery and implementation of each element of the SBL care bundle or that an alternative intervention put in place to deliver against element(s).
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	The scheme will take into account the position of trusts at end July 2019.
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon

Technical guidance for Safety action 6
Can you demonstrate compliance with all four elements of the SBL care bundle?

Technical guidance	
Where can we find guidance regarding this safety action?	SBL care bundle and guidance: www.england.nhs.uk/wp-content/uploads/2016/03/saving-babies-lives-car-bundl.pdf
Further guidance regarding element 2 of the SBL care bundle	In reference to element 2 of the Saving Babies' Lives care bundle, compliance with the intervention for surveillance of low-risk women does not mandate participation in the Perinatal Institute's Growth Assessment Protocol (GAP) or the use of customised fundal charts. Providers should however ensure that for low risk women, fetal growth is assessed using antenatal symphysis fundal height charts by clinicians trained in their use. All staff must be competent in measuring fundal height with a tape measure, plotting measurements on charts, interpreting appropriately and referring when indicated.

Safety action 7: Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?

Required standard	User involvement has an impact on the development and/or improvement of maternity services.
Minimum evidential requirement for trust Board	Evidence should include: Acting on feedback from, for example a Maternity Voices Partnership. User involvement in investigations, local and or Care Quality Commission (CQC) survey results. Minutes of regular Maternity Voices Partnership and/or other meetings demonstrating explicitly how a range of feedback is obtained, the action taken and the communications to report this back to women.
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	From January 2019 to July 2019
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon

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

Required standard	90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year.
Minimum evidential requirement for trust Board	Evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year through Board sight of a staff training database or similar.
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	The scheme will take into account the position of trusts by Thursday 15 August 2019.
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon

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

Technical guidance	
What training should be included?	Training should include fetal monitoring in labour and integrated team-working with relevant simulated emergencies and/or hands-on workshops.
What training syllabus should be used?	Training syllabus should be based on current evidence, national guidelines/recommendations, any relevant local audit findings, risk issues and case review feedback, and include the use of local charts, emergency boxes, algorithms and pro-formas.
Should there be feedback?	There should be feedback on local maternal and neonatal outcomes.
Which maternity staff attendees should be included?	Maternity staff attendees should be 90% of each of the following groups: • Obstetric consultants • All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota • Obstetric anaesthetic consultants • All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) contributing to the obstetric rota. • Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) • Maternity theatre and maternity critical care staff (Including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit) • Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum) There will be other relevant clinical members of the maternity team that for best practice should be included in maternity emergency training for example neonatal clinical staff however evidence of their attendance is not required to meet the safety action.

What if staff have been booked to attend training after 15 August 2019	Only staff who have attended the training will be counted toward overall percentage. If staff are only booked onto training and/or have not attended training, then they cannot be counted towards the overall percentage.
Will we meet the action if one of our staff group is below the 90% threshold?	No, you will need to evidence to your Board that you have met the threshold of 90% for each of the staff groups before Thursday 15 August 2019.

Safety action 9: Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

Required standard	a) The Executive Sponsor for the Maternal and Neonatal Health Safety Collaborative (MNHSC) is actively engaging with supporting quality and safety improvement activity within: i. the trust ii. the Local Learning System (LLS) b) The Board level safety champions have implemented a monthly feedback session for maternity and neonatal staff to raise concerns relating to relevant safety issues c) The Board level safety champions have taken steps to address named safety concerns and that progress with actioning these are visible to staff
Minimum evidential requirement for trust Board	• Evidence of executive sponsor engagement in quality improvement activities led by the trust nominated Improvement Leads for the MNHSC as well as other quality improvement activity for trusts in waves one and three • Evidence that the trust Board have been sighted on the local improvement plan, updated on progress, impact and outcomes with the quality improvement activities being undertaken locally • Evidence of attendance at one or more National Learning Set or the annual national learning event • Evidence of engagement with relevant networks and the collaborative LLS • Evidence of a safety dashboard or equivalent, visible to staff which reflects action and progress made on identified concerns raised by staff • Evidence that safety concerns raised by staff feedback sessions are reflected in the minutes of Board meetings and include updates on progress, impact and outcomes relating to the steps and actions taken to address these concerns
Validation process	Self-certification to NHS Resolution using the Board declaration form

What is the relevant time period?	a) All Board level safety champions and exec sponsor for MNHSC must have set up the required mechanisms for supporting quality and safety improvement activity in both the trust and LLS by Sunday 27 January 2019 b) Must be implemented by Wednesday 27 February 2019 c) Must be implemented by Wednesday 27 March 2019 with ongoing feedback to staff on a monthly basis
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon

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

Technical guidance	
Where can we find guidance regarding this safety action?	Helpful guidance can be found at the following websites: • https://improvement.nhs.uk/documents/2440/Maternity_safety_champions_13feb.pdf • https://improvement.nhs.uk/resources/maternal-and-neonatal-safety-collaborative/ • https://improvement.nhs.uk/documents/2956/MatNeo_Collaborative_Driver_Diagram_June_2018.pdf • https://improvement.nhs.uk/resources/patient-safety-collaboratives/

Safety action 10: Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?

Required standard	Reporting of all qualifying incidents that occurred in the 2018/19 financial year to NHS Resolution under the Early Notification scheme reporting criteria.
Minimum evidential requirement for trust Board	Trust Board sight of trust legal services and maternity clinical governance records of qualifying Early Notification incidents and numbers reported to NHS Resolution Early Notification team.
Validation process	Self-certification to NHS Resolution using the Board declaration form NHS Resolution will cross reference Trust reporting against the National Neonatal Research Database (NNRD) number of qualifying incidents recorded for the Trust.
What is the relevant time period?	1 April 2018 to 31 March 2019
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon

Technical guidance for Safety action 10
Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?

Technical guidance	
Where can I find information on the Early Notification scheme?	Early Notification scheme guidance has been circulated to NHS Resolution maternity contacts. Please contact ENTeam@resolution.nhs.uk to request further copies.
What are qualifying incidents?	Qualifying incidents are term deliveries (≥37+0 completed weeks of gestation), following labour, that resulted in severe brain injury diagnosed in the first seven days of life. These are any babies that fall into the following categories: • Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) **[OR]** • Was therapeutically cooled (active cooling only) **[OR]** • Had decreased central tone **AND** was comatose **AND** had seizures of any kind.

	The above definition is based on the criteria set by the Each Baby Counts (EBC) programme of the RCOG. As a guide, if any incident of severe brain injury occurs which meets the above criteria and is accepted by EBC, then NHS Resolution will treat it as a qualifying incident. Incidents of intrapartum stillbirth or neonatal death as defined by EBC do not need to be notified.
General Data Protection Regulations points	We strongly recommend that all families be told of NHS Resolution involvement at the outset. NHS staff are bound by the statutory Duty of Candour. This includes an obligation to advise the 'relevant person' (i.e. the patient/their family) what further enquiries into the incident the trust believes are appropriate, one of which will be the Early Notification process. The NHS Constitution states that patients have the right to an open and transparent relationship with the organisation providing their care. This is central to maintaining the relationship of trust between the trust and family and in promoting an open and safe learning culture. NHS Resolution's Early Notification scheme involvement should be communicated soon after the incident, to coincide with notification that an internal investigation will take place. For more information please see *Saying Sorry* leaflet https://resolution.nhs.uk/wp-content/uploads/2017/04/NHS-Resolution-Saying-Sorry-2017.pdf NHS Resolution are able to seek disclosure of medical records without the consent of the patient/family. However it is important that individuals know that their personal data is being shared with NHS Resolution, even if you are not asking for their consent. It may also, in some circumstances, be helpful to have an indication of their authority/agreement to their information being used. However, this should not be conflated with 'consent' as the legitimising condition under GDPR. Footnote: under the General Data Protection Regulation, processing is necessary for (1) the management of healthcare systems and services (under Article 9(2)(h) GDPR/Schedule 1 paragraph 2 of the Data Protection Act 2018); (2) the establishment, exercise or defence of legal rights (under Article 9(2)(f) GDPR); and/or (3) undertaken in the substantial public interest (that is, the discharge of functions conferred on NHS Resolution further to s. 71 of the NHS Act 2006 – further to Article 9(2)(h) GDPR).

What if we are unsure whether a case qualifies for the Early Notification scheme?	If the case meets the above criteria and has been accepted by Each Baby Counts, it will be treated as a Qualifying Incident. Should you have any queries, please contact a member of the Early Notification team to discuss further. (ENTeam@resolution.nhs.uk)
We are unsure about how to grade an incident, what should we do	The risk assessment wording has recently been amended to bring it in line with assessments used regularly by front-line staff. It is hoped that this makes the process of grading risk more straightforward. However, should you have any queries, please contact a member of the Early Notification team to discuss further. (ENTeam@resolution.nhs.uk)
We have reported all qualifying incidents, but have not reported within the required 30 day timescale. Will we be penalised for this?	Trusts are strongly encouraged to report all incidents within the 30 day timescale set out in the reporting guidelines however there will be no penalty for reporting incidents from 2018/19 outside of the 30 day timescale. Trusts will meet the required standard if they can evidence to the trust Board that they have reported all qualifying 2018/19 incidents to NHS Resolution and this is corroborated with data held by NNRD.

FAQs for year two of the CNST maternity incentive scheme

Does 'Board' refer to the trust Board or would the Maternity Services Clinical Board suffice?	We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. It is recommended that all executive members e.g. finance directors are included in these discussions If subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of governance which we may escalate to the appropriate arm's length body/NHS system leader.
Where can I find the trust reporting template which needs to be signed off by the Board?	Please follow the link to the Board declaration form **(see link below).**
What documents do we need to send to you?	Send the Board declaration form to NHS Resolution. Ensure the Board declaration form has been approved by the trust Board, signed by the chief executive and, where relevant, an **action** plan is completed **(see link below)** for each action the trust has not met. **Please do not send your evidence or any narrative related to your submission to us.** Any other documents you are collating should be used to inform your discussions with the trust Board.
Do we need to discuss this with our commissioners?	Yes, your submission should be discussed with commissioners prior to submission to NHS Resolution.
Will you accept late submissions?	We will not accept late submissions. The Board declaration form and any action plan will need to be submitted to us no later than **12 noon on Thursday 15 August 2019**. If a completed Board declaration form is not returned to NHS Resolution by **12 noon on Thursday 15 August 2019**, NHS Resolution will treat that as a nil response.

Will NHS Resolution be cross checking our results with external data sources?	Yes, we will cross reference results with external data sets from MBRRACE-UK, NHS Digital and the NNRD for the following actions: Safety action 1, Safety action 2 and Safety action 10 respectively. Your overall submission may also be sense checked with CQC maternity data.
What happens if we do not meet the ten actions?	Only trusts that meet **all ten** maternity safety actions will be eligible for a payment of at least 10% of their contribution to the incentive fund. Trusts that do not meet this threshold need to submit a completed action plan for each safety action they have not met. Trusts that do not meet **all ten** safety actions may be eligible for a small discretionary payment to help them to make progress against one or more of the ten safety actions.
Our trust has queries, who should we contact?	Any queries prior to the submission date must be sent in writing by e-mail to NHS Resolution via MIS@resolution.nhs.uk
Please can you confirm who outcome letters will be sent to?	CNST maternity incentive scheme outcome letters will be sent to chief executive officers, finance directors and your nominated leads.
What if my trust has multiple sites providing maternity services	Multi-site providers will need to demonstrate the evidential requirements for each individual site. The Board declaration should reflect overall actions met for the whole trust
Will there be a process for appeals this year?	Yes, there will be an appeals process and trusts will be allowed 14 days to appeal the decision following the communication of results.

Q&A regarding Maternity Safety Strategy and CNST maternity incentive scheme

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

The Maternity Safety Strategy sets out the Department of Health and Social Care's ambition to reward those who have taken action to improve maternity safety.

Using CNST to incentivise safer care received strong support from respondents to our *2016 CNST consultation* where 93% of respondents wanted incentives under CNST to fund safety initiatives. This is also directly aligned to the Intervention objective in our *Five year strategy: Delivering fair resolution and learning from harm.*

Maternity safety is an important issue for all CNST members as obstetric claims represent the scheme's biggest area of spend (c£500m in 2016/17). Of the clinical negligence claims notified to us in 2017/18, obstetric claims represented 10% of the volume and 48% of the value of new claims reported. These figures do not take into account the recent change to the Personal Injury Discount Rate.

Q2) Why have these Safety actions been chosen?

The ten actions have been agreed with the national maternity safety champions, Matthew Jolly and Jacqueline Dunkley-Bent, in partnership with NHS Digital, NHS England, NHS Improvement, the Care Quality Commission (CQC), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE), Obstetric Anaesthetists Association, Royal College of Anaesthetists, Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives. The Collaborative Advisory Group (CAG) previously established by NHS Resolution to bring together other arm's length bodies and the Royal Colleges to support the delivery of the CNST maternity incentive scheme has also advised NHS Resolution on the safety actions.

Q3) Who has been involved in designing the scheme?

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

- NHS England
- NHS Improvement
- NHS Digital
- MBRRACE-UK
- Royal College of Obstetricians and Gynaecologists
- Royal College of Midwives
- Royal College of Anaesthetists
- Care Quality Commission

- Department of Health and Social Care
- NHS Resolution
- Clinical obstetric, midwifery and neonatal staff

Q4) Who does the scheme apply to?

The scheme will only apply to acute trusts in 2018/19. However, given the schemes aim to incentivise the improvement of maternity services in all settings, we will consider extending it in future years.

Q5) How will trusts be assessed against the safety actions and by when?

Trusts will be expected to provide a report to their Board demonstrating achievement (with evidence) of each of the ten actions. The Board must consider the evidence and complete the Board declaration form for result submission.

Completed Board declaration forms must be discussed with the commissioner(s) of the trust's maternity services, signed off by the Board and then submitted to NHS Resolution (with action plans for any actions not met) at MIS@resolution.nhs.uk **by 12 noon on Thursday 15 August 2019.**

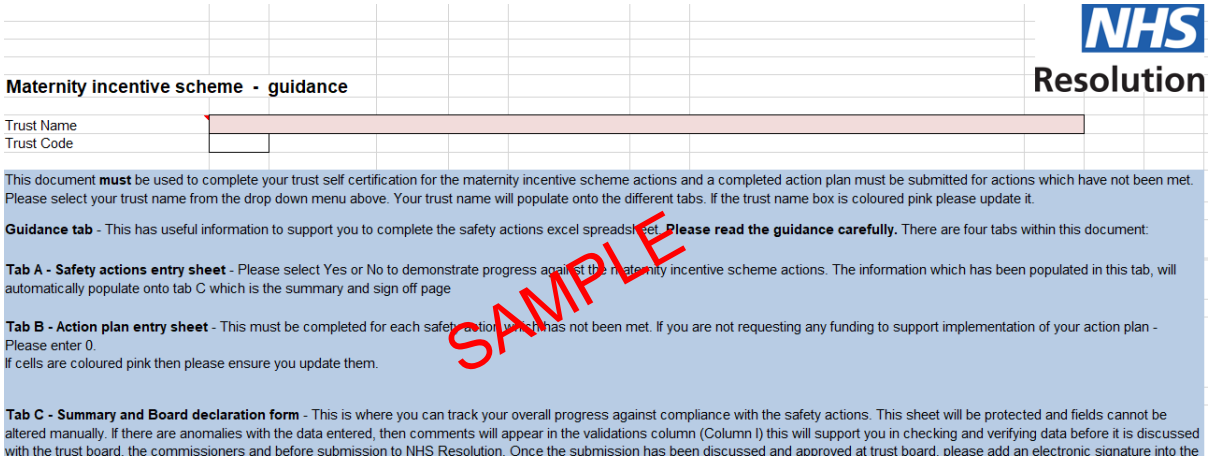
Please note that:

- Board declaration forms will be reviewed by NHS Resolution and discussed with Collaborative Advisory Group.
- NHS Resolution will use external data sources to validate some of the trust's responses, as detailed in the technical guidance above.
- **If a completed *Board declaration form* is not returned to NHS Resolution by 12 noon on Thursday 15 August 2019, NHS Resolution will treat that as a nil response.**

Appendix 1: Board declaration form and action plan template

To access the combined *Board declaration form and action plan template* visit:

https://resolution.nhs.uk/resources/board-declaration-form-and-action-plan-template



Maternity incentive scheme - guidance

NHS Resolution

Trust Name

Trust Code

This document **must** be used to complete your trust self certification for the maternity incentive scheme actions and a completed action plan must be submitted for actions which have not been met. Please select your trust name from the drop down menu above. Your trust name will populate onto the different tabs. If the trust name box is coloured pink please update it.

Guidance tab - This has useful information to support you to complete the safety actions excel spreadsheet. **Please read the guidance carefully.** There are four tabs within this document:

Tab A - Safety actions entry sheet - Please select Yes or No to demonstrate progress against the maternity incentive scheme actions. The information which has been populated in this tab, will automatically populate onto tab C which is the summary and sign off page

Tab B - Action plan entry sheet - This must be completed for each safety action which has not been met. If you are not requesting any funding to support implementation of your action plan - Please enter 0.
If cells are coloured pink then please ensure you update them.

Tab C - Summary and Board declaration form - This is where you can track your overall progress against compliance with the safety actions. This sheet will be protected and fields cannot be altered manually. If there are anomalies with the data entered, then comments will appear in the validations column (Column I) this will support you in checking and verifying data before it is discussed with the trust board, the commissioners and before submission to NHS Resolution. Once the submission has been discussed and approved at trust board, please add an electronic signature into the

SAMPLE

NHS
Maidstone and Tunbridge Wells
NHS Trust

Safeguarding children update (Annual Report to Board, including Trust Board annual refresher training) — **Chief Nurse**

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

The full report was presented to and discussed by TME and the Quality Committee in July 2019 and covers the period April 2018 – March 2019.

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

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

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

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

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

Which Committees have reviewed the information prior to Board submission?

- 'Main' Quality Committee, 10/07/19
- Trust Management Executive, 17/07/19

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

Information & assurance

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

Safeguarding Children Declaration

Maidstone and Tunbridge Wells NHS Trust is fully committed to ensuring that all patients including children are cared for in a safe, secure and caring environment. The Trust adheres to its statutory duties in line with Section 11 of the Children Act. A number of Safeguarding Children arrangements are in place in order to support this. A section 11 audit was last presented to the Kent Safeguarding Children Board in June 2018 and amended version in November 2018.

These include:

- Maidstone and Tunbridge Wells NHS Trust meets its statutory requirements in relation to Disclosure and Baring (DBS) checks – all staff employed at the Trust undergo a DBS check prior to employment and those working with children undergo an enhanced level of assessment.
- The Trust Safeguarding Children policies and systems are up to date and robust and are reviewed on a regular basis, ultimately by the Trust Board. The last full policy review occurred in April 2017 and was ratified on 7th July 2017. An interim review took place in October 2018 following changes in statutory guidelines. Policies and procedures are available to staff through a dedicated safeguarding children intranet site.
- The Trust has a process in place for following up children who are not bought to outpatient appointments within any speciality to ensure their care and health is not affected in any way.
- The Trust has a system in place for flagging children who are subject to a child protection plan. The Trust has implemented the national Child Protection Information Sharing System (CP-IS) in the ED and will follow this in both Paediatrics and Maternity. The trust has further implemented the national FGM-IS.
- All eligible staff are required to undertake relevant Safeguarding Children training and this is regularly reviewed to ensure it is up to date. The Trust has a training strategy in place with regard to delivering safeguarding training. The training strategy has been updated to take into account the revised Intercollegiate Document (January 2019).

Safeguarding Professionals

- The Trust has Named Safeguarding Professionals who lead on issues in relation to the safeguarding of children. They are clear about their role, have sufficient time and receive relevant support, and training, to undertake their roles, which includes close contact with other social and health care organisations. This complies with the current Working Together Guidelines (2018) and the Intercollegiate Document (2019).
- The total number of professionals in these roles is 6.4 WTE which includes a Named Nurse Safeguarding Children, 2 x Safeguarding Children Nurses, a Deputy Named Midwife Safeguarding Children and a Peri-Natal Mental Health Nurse; there is also a named Midwife (1.0 WTE), Named Doctor for Safeguarding Children and a Named Doctor who leads on Child Death.
- The Chief Nurse is the Executive Director lead for Safeguarding Children.
- The Trust's Safeguarding Children Committee leads and supports all Safeguarding Children activity and ensures that the Trust executes its statutory duties in relation to the safeguarding of children
- The Trust Board takes the issue of safeguarding extremely seriously and receives an annual report on safeguarding children issues. A bi-monthly Safeguarding Children report is presented to the Safeguarding Children committee
- The Trust continues to be an active member of the Local Safeguarding Children Boards (LSCBs)[2]. This is through membership and work of the Boards and the sub committees.

[2] Interim Safeguarding arrangements are in place following the enactment of the Children and Social Worker Act 2017. The Kent Safeguarding Children Board will be replaced by a Local Safeguarding Partnership which is a tripartite arrangement between Health, the Local Authority and the Police. The

Any issues related to safeguarding children will be discussed at these Boards each quarter.

- The Trust has an audit programme to provide assurance that safeguarding systems and processes are working. In addition to single agency audits the Trust takes part in multi-agency audits with partner agencies.
- The Trust continues to review and challenge its arrangements in order to support safe and consistent practice, adhere to its statutory duties and will respond positively and assertively to any changing guidance and national reviews.

July 2019
Alison Jupp Named Nurse Safeguarding Children

LSP will be fully operational by April 2020. The Health Lead is currently Paula Wilkins (Chief Nurse WKCCG). See section 3.1.1.

1.0 – Introduction

The purpose of the annual report is to update the Trust Board on the governance arrangements and progress made in relation to safeguarding children since the last report in 2018. Every Trust Board requires an update at least yearly advising of key issues relating to the safeguarding of children and this has been scheduled to go to the July 2019 Trust Board Meeting. The Board is reminded that children are defined by the Children Act 1989 as young people up to but not including their 18th birthday.

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

A revised Safeguarding Children Policy and Practice Document was ratified on 7.7.17; this document was further reviewed in 2018 following publication of the revised Working Together Guidelines (2018) and a change in the Local Authority referral processes. The Trust Safeguarding Children Policy is automatically updated on a 6 monthly basis to reflect updates in the Kent and Medway Safeguarding Children Policy. Statutory guidance from both the Kent Safeguarding Children Board and HM Government provide the strategic framework for our day to day working.

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

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

2.0 - Children's Specialist Services

Maidstone and Tunbridge Wells NHS Trust submitted 270 referrals to Children's Specialist Services in the 12 months to 30.6.19.This number is on a par with the previous 12 months. We believe that this figure may not be a true reflection of the actual number of referrals due to staff not reporting referrals to the Safeguarding Children team. As a team we continue to remind staff to send a copy of any referral to the Safeguarding team. The majority of referrals are made by ED or Paediatric staff with Midwife's being the next group.

Please see section 3.4 for a brief narrative on the current Request for Support process in Kent. The referral process in East Sussex is very different but works well. We make a limited number of referral to East Sussex Children's Social Services (<10% of total).

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

The Safeguarding Children team work very closely with Children's Specialist Services; the Named Nurse regularly meets with Children's Specialist Services colleagues in both the Maidstone and Tunbridge Well's areas. These forums provide an excellent opportunity for joint working, information sharing and developing new working relationships. The Named Nurse sits on a number of Local Authority led multi-disciplinary panels including the Adolescent Risk Management Panel and the Multi-Agency Sexual Exploitation Board. The

Named Nurse also takes part in multi-agency Safeguarding audits based on the JTAI model.[3]

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

Currently Kent County Council has 1354 children subject to a Child Protection Plan – the Trust flags these children on our IT systems. We also flag known Children in Care and other high risk children.

3.0 - What does the Board need to know?

3.1 – Working Together Guidelines 2018

The Working Together Guidelines 2018 were published on 4.7.2018. There are substantial changes to processes which will mean the replacement of Local Safeguarding Children Boards (LSCBs) with Local Safeguarding Partners (LSP), the establishment of a new national Child Safeguarding Practice Review Panel (CSRP), and the transfer of responsibility for child death reviews from Local Safeguarding Boards to new Child Death Review Partners (CDRP). The interim arrangements for Kent are in place.

3.1.1 - Kent Safeguarding Children Multiagency Partnership (KSCMP) -

On 17.6.19 the Kent Safeguarding Children Board published the definitive version of what the Safeguarding Children arrangements will look like in Kent from 17.9.19[4]. The Kent Safeguarding Children Board will be replaced by the Kent Safeguarding Children Multiagency Partnership (KSCMP) and will have overall responsibility for Safeguarding Children policy in Kent. The document sets out the vision that the Kent Safeguarding Children Multiagency Partnership has for the children in Kent and how they will be safeguarded and their welfare promoted. It establishes a tripartite partnership between health, the police and the Local Authority with each partner having equal status. This recognises the importance of the role that health has to play in safeguarding children and will enable the 'voice of health' to be heard. The Executive Lead for Safeguarding in the Trust will sit on the Health Providers Safeguarding Partnership.

The published document also provides clarity on the new Child Death Process and Child Safeguarding Practice Reviews (CSPR) which will replace Serious Case Review's.

Child Death - The new Child Death Guidelines[5] set out the full process that follows the death of a child who is normally resident in England. It builds on the statutory requirements set out in Working Together Guidelines (2018) and clarifies how individual professionals and organisations across all sectors involved in the child death review should contribute to reviews. The guidelines place a responsibility on all organisations to improve the experience of bereaved families, and professionals involved in caring for children. They also ensure that information from the child death review process is systematically captured in every case to enable learning to prevent future deaths.

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[3] https://www.gov.uk/government/publications/joint-inspections-of-the-response-to-child-sexual-abuse-in-the-family-environment
[4] https://www.kscb.org.uk/__data/assets/pdf_file/0003/96258/Kent-Safeguarding-Children-Multiagency-Partnership-Arrangements-FINAL-VERSION-APPROVED-FOR-PUBLICATION-17.06.2019-RS.pdf
[5] https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england

The new arrangements are in place in Kent and Maidstone and Tunbridge Wells NHS Trust has held one review meting following the death of a child well known to our services. The Named Doctor for Child Death and the Named Nurse Safeguarding Children are fully conversant with the new guidelines and have attended training on their implementation. It is the responsibility of the organisation where the child was certified dead to identify a *key worker* for the family. The role could be taken by a range of practitioners but may include a clinical nurse specialist or another practitioner who knows the child well. This has (so far) worked well at Maidstone and Tunbridge Wells NHS Trust.

Maidstone and Tunbridge Wells NHS Trust has been notified of 22 child deaths since 1.5.18 of which 7 were either in the Trust or brought into the Trust having sadly passed away. Very sadly 2 deaths occurred on Hedgehog Ward. Both deaths were 'expected' and staff were supported throughout this process. The Hedgehog Ward staff are to be commended for their care and sensitivity in supporting both families though these difficult processes.

3.2 - Kent and Medway Safeguarding procedures

The above procedures have been updated (April 2019)[6] to include new guidance on (amongst others) Information Sharing, Responding to Abuse and Neglect, e-safety, Serious Case Review's, Honour based Violence/Abuse, Working with Sexually Active Young People, Surrogacy and Modern Slavery and Human Trafficking. These have been included in the updated Safeguarding Policy. A further update in October 2019 will be issued.

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

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

Maidstone and Tunbridge Wells NHS Trust went live with CP-IS in March 2018. This has enabled Children's Social Services to be informed in 'real time' of a child presenting to ED who is subject to a Child Protection Plan or who is a Child in Care. This has considerably enhanced our Safeguarding capability.

3.4 - New referral process to Children's Social Care

In late 2018 Kent County Council introduced a new referral process to Children's Social Care for all professionals who wish to raise a concern about a child. The process moved to a 'single front door' process by which a professional 'notifies' Children's Social Care of a concern. Children's Social Care will immediately triage that referral (now known as a 'Request for Support') to either a Child in Need or Child Protection process. Any Request for Support that does not meet the criteria for support will be sent back to the referrer with advice to refer to another service.

The acute trusts in Kent (including Maidstone and Tunbridge Wells NHS Trust) have challenged this process. The Local Authority has provided no guidance or 'directory' of what services are available both locally and/or Kent wide. It is clearly inappropriate to make a family wait in A&E for referral to a service that opens at 9am. The Named Nurse (alongside other safeguarding colleagues) has raised this at the QE committee of the Safeguarding Children Board for their support The process is very much based on a working week service

[6] https://www.proceduresonline.com/kentandmedway/chapters/amendments.html

which does not fit in with an acute trust. The Named Nurse will update the Board as more information becomes available.

Comprehensive training has been provided since the introduction of the new process. However it is anticipated that the Local Authority will revise this process in late 2019 and the Named Nurse Safeguarding Children will update the Trust as necessary.

3.6 – Children with Mental Health needs

Within this Trust it is apparent that an increasing number of children are being admitted with self-harm and overdoses. Staff are ill-prepared for the risk that these children pose to themselves and struggle with the limited services provided by CAMHS. There are some challenges in supporting admission to a tier 4 Mental Health bed, often this can take up to 4 weeks; this leaves very vulnerable children on an acute Paediatric ward receiving Mental Health care from agency RMN staff. The 'We can Talk' training has been successfully introduced into the Paediatric areas. This has allowed staff to be more confident with working with these very challenging children and has reduced too need to employ agency RMN staff. Both staff and the children are better supported.

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

An Information Sharing form has been developed in conjunction with our local tier 4 Mental Health providers. This form travels with a child when they present to ED and enables ED staff to have a clear understanding of the child's Mental Health needs and how this may impact on their ability to provide physical care. It also ensures that the Trust complies with any Mental Health Act provisions. This has worked very successfully and a SOP will be published shortly that will enable our Mental Health providers to triage their children and signpost them to other health providers rather than ED (if appropriate).

3.7 - CQC Paediatric Transition Project

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

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

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

Representatives from both paediatrics and adult services at Maidstone and Tunbridge Wells NHS Trust have continued to meet on a monthly basis to implement better Transition pathways between paediatrics and adult services.

The Specialist Nursing teams have adopted the '*Ready, Steady, Go Transition'* programme to use with young people under their services from approximately 12 years of age, and have specific transition pathways for these young people with their tertiary units. Within the Transition project work, we have identified that there is a particular need for support of young people with learning disabilities and have therefore requested the Trust support a post for a Transition/Learning Disability Nurse.. This work continues under Maidstone and Tunbridge Wells NHS Trust Best Quality Workstream as we are committed to meet the needs of young people where ever they are cared for within our service

Young people admitted to ED and adult wards present with increased levels of risk around safeguarding, consent to treatment and increased risk of poor experiences of care. The Trust does not admit children over 16 to the Paediatric wards (unless there are specific circumstances) but the Named Nurse receives daily data on all children admitted to non-Paediatric areas. In the 12 months to 30.6.19 the Trust admitted 1190 16 and 17 year olds to non-Paediatric areas. This data is reviewed to ensure that the children receive appropriate care and that their needs are being met. Excellent liaison has been established between non-Paediatric wards and the Safeguarding Children team. This has empowered staff to feel more confident in caring for our young people and allowed for a robust review of their care.

4.0 - Safeguarding Children Training

4.1 - The Safeguarding team places a high priority on ensuring that all the Safeguarding Children training delivered is robust, fit for purpose and follows the national guidelines as agreed in the Intercollegiate Document (2019) and other local and national guidelines.

4.2 - Traditionally compliance for level 1 and 2 Safeguarding Children Training has been high at greater than 90%. Level 3 compliance has traditionally been less than 85% and is currently at 68%. Staff areas with low compliance are targeted and managers are informed of staff who are non-compliant. It is unclear why compliance is low but it may be due to the commitment required (1 day) and the difficulty in releasing clinical staff for this period of time.

As a team we are developing more creative ways of delivering training and will offer shorter annual 'workshop' type sessions which staff can attend to enable them to build up sufficient hours to become compliant over a three year period.

4.3 – The Named Nurse and Head of Learning and Development have mapped and remapped training requirements for the Trust. As an organisation we offer a minimum of 10 Level 3 days for all staff plus 6 x half days on Domestic Abuse. The re-mapping exercise brought more staff into the mandatory cohort and this may go some way to explain why compliance appears to be low. Both the Named Nurse Safeguarding Children and Head of Learning and Development have targeted staff groups where compliance is low and the Named Nurse Safeguarding Children will offer bespoke training to individual staff groups.

4.4 – The Named Nurse Safeguarding Children and the Adult Safeguarding Lead have started discussions on joint training as there is much crossover between both adult and children safeguarding training. This will require a rethink of how training is delivered to ensure that the Trust training is compliant with both the Adult Intercollegiate Document (2018) and the Intercollegiate Document (2019) for children.

4.5 - All the Safeguarding Children Training packages are reviewed and updated on a regular basis by the Named Nurse and the wider Safeguarding Children team. Internal training is well received. The Named Nurse is also an associate trainer for the Kent Safeguarding Children Board and also delivers training to partner agencies as requested.

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

4.7 – Level 5 training for Trust Executives
All NHS Trust executives are required to be compliant with Safeguarding Children training. The Chief Nurse (as Executive Lead for Safeguarding Children) is Level 5 compliant. The Intercollegiate Document sets out the training requirements for Trust Executives (page 59).[7] The Named Nurse Safeguarding Children is currently compliant with Level 4 training.

5.0 – Child Exploitation, Gang Activity and Trafficking

5.1 - In December 2015 Operation Willow was established alongside the Child Sexual Exploitation Team (CSET). This is a Kent wide multi-agency team that identifies victims of Child Sexual Exploitation and aims to disrupt exploitative activity. Following a reorganisation of Kent Police and the establishment of the Vulnerable Investigation Teams (VIT) and the MCET (Missing & Child Exploitation Team) the role of CSET was widened to include all forms of exploitation (including sexual and criminal exploitation, forced marriage, modern slavery). MCET has a clear remit to monitor all children who experience 'missing episodes' and safety plans are developed to support these young people. The Named Nurse Safeguarding Children works closely with MCET and the Adolescent Risk Management Team to identify and flag young people at risk. The Named Nurse currently sits on the Multi-Agency Sexual Exploitation panel for both Kent and Medway; this now discusses all forms of exploitation.

5.2 – There has been increased concern from both police and Children's Social Care about increased 'gang related violence' and 'county lines' activity in Kent. A Kent and Medway Gang Strategy was been published in 2018[8] which the Named Nurse contributed to. The Trust has limited experience in dealing with gang related violence but we do flag all children who present with stab related injuries (>3 in the last 12 months); the Safeguarding Children team have all attended training sessions on raising awareness of gang related violence. This is now included in all Safeguarding Children training.

5.3 – 'County Lines'. 'County Lines' is a term used when drug gangs from big cities expand their operations to smaller towns, often using violence to drive out local dealers and exploiting children and vulnerable people to sell drugs. These dealers will use dedicated mobile phone lines, known as 'deal lines', to take orders from drug users. Heroin, cocaine and crack cocaine are the most common drugs being supplied and ordered. In most instances, the users or customers will live in a different area to where the dealers and networks are based, so drug runners are needed to transport the drugs and collect payment.

A common feature in county lines drug supply is the exploitation of young and vulnerable people. The dealers will frequently target children and adults - often with mental health or

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[7] https://www.rcn.org.uk/professional-development/publications/007-366
[8] https://www.kscb.org.uk/__data/assets/pdf_file/0005/81455/Final-Version-Kent-and-Medway-Gangs-Strategy.pdf

addiction problems - to act as drug runners or move cash so they can stay under the radar of law enforcement. In some cases the dealers will take over a local property, normally belonging to a vulnerable person, and use it to operate their criminal activity from. This is known as 'cuckooing'.

People exploited in this way will quite often be exposed to physical, mental and sexual abuse, and in some instances will be trafficked to areas a long way from home as part of the network's drug dealing business.

The NCA (National Crime Agency) published a resume of county lines activity nationwide in January 2019. The report can be found via the following link - https://www.nationalcrimeagency.gov.uk/who-we-are/publications/257-county-lines-drug-supply-vulnerability-and-harm-2018/file

There is increasing evidence that Kent and Medway are being targeted by gangs in large urban areas (often London) to supply Class A drugs. There have been some high profile court cases recently which serve to highlight the importance of the role of health in identifying victims. The Named Nurse Safeguarding Children works closely with all agencies to identify and flag vulnerable young people to safeguard them. The Guardian published a useful article to highlight the increasing problem in Kent - https://www.theguardian.com/uk-news/2019/mar/10/county-lines-drugs-kent-knife-crime-rise-cuts

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

Practitioners are reminded that '*movement'* can simply be a journey from one town to another and is not solely about children who come into the UK from abroad. Trafficking is included in all Safeguarding Children training.

Guidance is available for all professionals who may have a concern that a child has been trafficked.[9]

6.0 – Serious Case Reviews (SCR) –

Since the 2018 report the Kent Safeguarding Children Board had commissioned 5 Serious Case Reviews of which the Trust has contributed to 4; we have also submitted a report to a Serious Case Review commissioned in East Sussex. The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children. Reviews should seek to prevent or reduce the risk of recurrence of similar incidents.

All but one of the reviews involved the death of a child (age range – 10 week to 16 years), with two of the children having been murdered by a parent.

The common themes arising out of the Kent reviews are Fathers (absent or not), Disguised Compliance, Neglect, Keeping the Child in Focus, Resolution of Professional Disagreement, Information Sharing and Supervision. As part of the on-going training review these themes have been incorporated into level 2 and 3 training.

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

6.1 - New arrangements - The new arrangements for review of serious Safeguarding Children cases will be known as Child Safeguarding Practice Reviews (CSPR). There are procedures in place which enable the safeguarding partners and relevant agencies to identify serious child safeguarding cases which raise issues of importance in relation to the area, commission and oversee the review of those cases and identify learning points both locally and nationally. Information can be found in chapter 7 of the document published by the Kent Safeguarding Children Board on 17.6.19.[10]

7.0 – Safeguarding supervision

7.1 - The Safeguarding Children team have reviewed the trust policy for Safeguarding Children supervision provided to staff working with children and the new policy was ratified in late 2018. This policy is in line with recommendations from recently published Serious Case Review's. Currently compliance stands at 60% with the aim of achieving 85% by March 2020.

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

7.3 – Debriefs are provided to any staff group where there has been a challenging or upsetting case; this is organised through the Paediatric Matron or the Named Nurse Safeguarding Children.

8.0 – Midwifery Safeguarding

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

All referrals to Children's Social Care are quality assured and outcomes monitored to ensure the correct level of support is provided. Heather Lawrence liaises with her counterparts in Kent to ensure that information is shared about high risk women who may be evading Midwifery services.

All Midwives receive mandatory Safeguarding supervision from Heather Lawrence and the Safeguarding Children Nurses (Jane Waterhouse and Gerry Finney) on a 3 month basis. Heather Lawrence delivers mandatory Safeguarding Children training to Midwifery staff and organised specialist training in Learning Disabilities for Midwives in late 2018.

9.0 – Safeguarding audits

The Paediatric team have an on-going audit programme. The current audit relating to Safeguarding involves providing assurance on the new NICE guidelines on 'When to Suspect Neglect' (NICE CG89).

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[10] https://www.kscb.org.uk/newarrangements

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

The Named Nurse is part of a Kent wide audit on agency response to interfamilial sexual abuse. Updates will be provided when completed.

10.0 - Was Not Brought

As part of a national initiative to support children who do not (or are unable to) access medical appointments (for whatever reason) the Trust will be changing its focus from a 'Did Not Attend (DNA)' approach to a '**Was Not Brought'** (WNB) emphasis. There is a national move towards the concept of 'Was Not Brought' rather than 'Did Not Attend' (DNA) for children due to the safeguarding indicators of abuse and neglect. This is as a result of recommendations from both Serious Case Review's and the Kent Safeguarding Children Board. Practitioners will be asked to consider the impact on the child of the non-attendance and to take appropriate steps to ensure that this episode is recorded in the Healthcare Records as a Was Not Brought episode. The term DNA will no longer be used.

Children and Young People (CYP) have a right to receive appropriate healthcare and it is the responsibility of parents/carers to access this on their behalf. Any failure in a planned contact should be regarded as a serious matter and must be risk assessed.

Children and Young People thrive when their health needs are met to enable them to develop to their full potential. Children whose health needs are not met are unlikely to reach a reasonable standard of health and development; CYP who do not have access to appropriate healthcare may put them at direct risk of significant harm.

Maidstone and Tunbridge Wells NHS Trust will have a clear framework to respond effectively and reduce any risk associated with missed appointments for Children and Young People. There will be a robust system to follow when children are not brought to appointments by their parents/carers. When practitioners share information about a child this process helps to safeguard that child.

The new policy will go back to the Safeguarding Children Committee in July 2019 for ratification by the end of 2019.

10.0 - Areas of risk for ongoing monitoring and review

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

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11.0 – Conclusion

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

Alison Jupp, Named Nurse Safeguarding Children
July 2019

NHS
Maidstone and Tunbridge Wells NHS Trust

Safeguarding adults update (Annual Report to Board, including Trust Board annual refresher training) — **Chief Nurse**

The Trust is required to produce an annual Safeguarding Adults report, which should have oversight by a committee of the Board and cover the key elements of safeguarding including the provision of policies, procedures, training and safeguarding alerts. The report provides assurance that statutory requirements are met, particularly in relation to the Mental Capacity Act and the Deprivation of Liberty Safeguards. The report has been prepared by the Safeguarding Adults Matron with oversight of the Safeguarding Adults Committee. The full report was presented to the Trust Management Executive Committee and Quality Committee in July 2019.

Which Committees have reviewed the information prior to Board submission?

- 'Main' Quality Committee, 10/07/19
- Trust Management Executive, 17/07/19

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

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

Safeguarding Adults Annual Report 2018/19

Summary / Key points

This Safeguarding Adults Annual Report for 2018/19 provides the Trust Board with an overview of safeguarding activities within Maidstone and Tunbridge Wells NHS Trust.

This report identifies the extent to which the Trust Board can be assured that they, in partnership with the local authority are effectively discharging their safeguarding functions for adults.

It highlights areas where improvements are required for the trust to better ensure that there are effective systems in place to safeguard adults in the future.

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

The Trust is an active participant with the Kent & Medway Safeguarding Adults Board (KMSAB) and its constituted working groups.

The Trust has a local Safeguarding Adults Committee, with multi-agency representation including social services and Clinical Commissioning Group (CCG) Designated Nurse.

The committee has a named Non-Executive Director to champion, support and challenge the safeguarding agenda.

The Trust has engaged with the KMSAB self-assessment and peer review of safeguarding provision

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

The Trust is meeting the standard of 85% compliance for safeguarding adults at levels 1, 2 and MCA. The trust has met the PREVENT training standard and achieved 87%, although WRAP is lower at 64%.

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

Safeguarding concerns are raised via the Datix incident reporting system internally and via the Kent Adult Safeguarding Alert Form (KASAF). A total of 85 concerns have been raised in the reporting period (April 2018 to March 2019).

Deprivation of Liberty Safeguards (DoLS) understanding has improved over the last year. There have been a total of 264 applications made during the reporting period.
The Trust has undertaken 2 IMR's for a DHR in the last year involved with 0 SAR IMRs and 1 DHR.

Safeguarding supervision is provided for the Safeguarding Adults Matron via the local Safeguarding Adults professional network, and from the Deputy Chief Nurse for day to day managerial support.

Supervision is provided to front line staff involved in significant or complex cases by the Matron for Safeguarding Adults

1. Purpose

This Safeguarding Adults Annual Report for 2018/19 provides the Trust Board with an overview of safeguarding activities within Maidstone and Tunbridge Wells NHS Trust

This report identifies the extent to which the Trust Board can be assured that they, in partnership with the local authority are effectively discharging their safeguarding functions for both adults.

It highlights areas where improvements are required for the trust to better ensure that there are effective systems in place to safeguard adults in the future.

2. Introduction

The purpose of this annual report is to inform the Trust Board and the Quality Committee on how the Trust is meeting its statutory duties to safeguard adults by preventing and responding to concerns of abuse, harm or neglect of adults from April 2018 to March 2019.

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

The NHS Accountability and Assurance Framework (2015) sets out that NHS Trusts are required to ensure that they have appropriate systems in place for discharging their responsibilities in respect of safeguarding. This report forms part of the Maidstone and Tunbridge Wells NHS Trust Boards assurance processes in respect to its statutory duties and responsibility around safeguarding.

The Statutory requirements for Safeguarding; The Care Act 2014, Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLs,) and Prevent are described within Appendix 1.

3. Governance & Safeguarding Adults Structure

The Trust is accountable to the West Kent Clinical Commissioning Group (CCG), and reports to the Performance & Quality Committee via the Quality Review Group (Chaired by the CCG Chief Nurse).

The Designated Nurse for Safeguarding Adults is a member of the Quality Review Group and Trust's internal Safeguarding Adults Committee and attends the Safeguarding Learning and Improvement Panels.

The Trust Executive Lead for Safeguarding Adults is the Chief Nurse, who additionally delegates responsibilities to the Deputy Chief Nurse.

Operational oversight of safeguarding adults is delegated to the Matron for Safeguarding Adults via the Deputy Chief Nurse

The Trust Board has a responsibility to ensure that there is a policy and process in place that details the processes to protect adults at risk of harm. The Safeguarding Adults at Risk Policy and Procedure was updated and advertised out to staff summarising the changes during 2018-19.

The Board receives assurance via the Trust Clinical Governance Committee, which receives reports, risks and plans to mitigate via the Trust's Safeguarding Adults Committee

The Trust Safeguarding Adults Committee is a constituted sub-committee of the Trust Clinical Governance Committee. It is chaired by the Deputy Chief Nurse and has core

representation from the directorates, therapies, Social Services/LA, Dementia Lead, Hospital Learning Disability Liaison Nurse, Learning & Development and CCG.

The Committee has a Named Non-Executive Director to support and champion safeguarding.

The committee met bi-monthly until October 2018, terms of reference were reviewed to propose moving to meet quarterly to fit within the quarterly reporting cycle to the CCG. Therefore the committee met 5 times during 2018.

The purpose of the committee is to implement and monitor the Safeguarding Adult's Framework, to ensure training provision is available to equip staff with the knowledge and skills required for the identification of adults at risk of harm, to make and respond to referrals and concerns and to carry out safeguarding enquiries and investigations.

The Trust Safeguarding Adults Committee draws its work plan and objectives from both the KMSAB and from emerging themes resulting from safeguarding incidents and investigations.

The committee also provides a forum for the review of practice, to provide practical advice and support and to facilitate feedback and discussion between directorate, commissioner and local authority representatives.

The Matron for Safeguarding Adults leads on the key areas of work necessary to safeguard adults at risk of harm. These include:

- Design & delivery of training including the principles of the care act, the role of lead agency, application of the mental capacity act, domestic abuse, PREVENT (anti-terrorism and radicalisation agenda recognition and reporting),
- Policy and procedure development and review, ensuring that Trust policies are in line with both the Care Act and Kent & Medway Policy and Procedures.
- PREVENT Lead and Home Office approved trainer for the PREVENT agenda.
- Domestic Violence Lead, working closely with staff in key areas including:
- Emergency Department and Women's services. Links have also been established with Human Resource Business Partners to develop strategies to support and manage staff for whom domestic violence is a personal issue.
- Internal Management Review (IMRs): author of IMRs in response to requests for the preparation of Safeguarding Adult Reviews (SARs) and Domestic Homicide Reviews (DHRs)
- Represents the Trust at KMSAB sub-groups; Policy & Procedures, Learning & Development and the Quality Assurance Working Group.
- The Matron attends the Mental Capacity Act Local Implementation Network (MCA LIN).
- Safeguarding supervision: provides supervision to staff involved in complex or serious safeguarding cases. The Matron receives managerial supervision from the Deputy Chief Nurse. Specialist safeguarding supervision for named individuals and safeguarding leads is provided by an appropriately qualified supervision facilitator external to the trust.
- Line manages the Learning Disability Hospital Liaison Nurse.

4. Interagency partnership working

The Local Authority, Kent County Council (KCC) provides the statutory service for leading and managing Safeguarding investigations and plans.

The Kent and Medway Safeguarding Adults Board (KMSAB) is a statutory service which exists to make sure that all member agencies are working together to help keep Kent and Medway's adults safe from harm and protect their rights. The Chief Nurse and Executive lead for Adult Safeguarding attends the board or will delegate responsibilities to the Deputy Chief Nurse.

The KMSAB has a number of sub-groups to ensure a consistent approach across Kent in relation of quality assurance, learning & development, practice, policy & procedure and Safeguarding Adults Reviews (SARs).

Health services have a separate group to enable debate and information sharing, which also acts a conduit for communication between organisations and the board, which is attended by the Chief Nurse.

The Local Authority has an escalation process available on their website which enables practitioners at any and every level to escalate a concern or query if they feel the response is in appropriate or untimely.

Appendix 2 summarises how the trust met the priorities of the KMSAB during 2018-19 and the edited contribution to the KMSAB Annual Report.

5. Oversight and scrutiny

5.1. Self-Assessment Framework (SAF)

The Trust undertakes a self-assessment against the core standards on an annual basis. The SAF has been developed by the KMSAB and includes a mechanism of peer review to validate the assessment outcomes. The peer review is then reported to the Quality Assurance Group, a sub- group of the SAB.

The Trust scored positively overall in the 2019 exercise.

5.2. Care Quality Commission

There is regular liaison with the CQC Liaison Officer on a monthly basis, where any safeguarding concerns may be address. To date, the Trust has always been able to answer any external question in a timely manner having already initiated an investigation or having completed the investigation and awaiting final closure with the Local Authority.

There has not been a formal CQC Inspection during 2018-19; the last visit was in 2017. However there have been informal CQC engagement visits, Safeguarding was part of a positive CQC engagement visit on the 5th September 2018.

6. Quality and Safeguarding

6.1. Launch of Best Care

Safeguarding Adults is a recognised priority in the Trust and staff demonstrate good knowledge about how and when to raise a Kent Adult Safeguarding Alert Form (KASAF) with the Local Authority. Safeguarding Adults and MCA sit within the Best Quality work stream.

Whether we're looking after our patients, or supporting our staff, we want everyone to have the best possible experience with us.

We have launched the Best Care Programme to help us provide high quality, safe services. **Best Care** focuses on the following five key areas.

- Best Safety – Executive Sponsor, Medical Director.
- Best Quality – Executive Sponsor, Chief Nurse
- Best Flow – Executive Sponsor, Chief Operations Officer
- Best Workforce – Executive Sponsor, Director of Workforce
- Best Use of Resources – Executive Sponsor, Chief Finance Officer

When we deliver patient care safely, in the right place and in the correct manner, at all times, this safeguards patients from being harmed in the first place.

6.2 Safeguarding Investigations, Learning and Improvement Panels

Staff are aware that they do not need permission to raise a KASAF, but will raise one using their professional judgement to ensure that Section 42 Enquiry requirements are notified to the Local Authority. All KASAFs raised, are copied to the Matron for Safeguarding Adults.

Trust staff raise safeguarding alerts for hospital related incidents, complaints and disciplinary issues

All safeguarding concerns are reported using a Kent wide Kent Adult Safeguarding Alert Form (known as a KASAF).

Directorate Matrons support the safeguarding agenda and either undertake or oversee any safeguarding related investigation.

The Trust holds Safeguarding Learning and Improvement panel meetings to review all KASAF alerts and any subsequent investigation with ward managers and matrons, in partnership with the Local Authority and CCG Designated Nurse.

The Matron for Safeguarding Adults coordinates this panel and liaises with the directorate level investigators to ensure appropriate support is offered.

This multi-agency approach to review of the investigation allows for open debate and the opportunity to agree the best way to involve the individual and to feedback on findings.

This approach allows for prompt closure with the Local Authority and ensures a robust level of oversight by both the Deputy Chief Nurse and the Local Authority Safeguarding Adults Coordinator.

Trust practitioners are keen to learn lessons when the patient journey has not been as event free as it should have been and following all investigations staff will usually find areas where practice could have been improved and will share that learning across the Trust so that practice can be improved. These lessons are shared quickly and widely through the Trust.

Day to day safeguarding activity is primarily overseen by the Directorate Matrons, and front-line clinical staff with guidance, advice and support provided by the Matron for Safeguarding Adults.

Supervision for staff involved in complex or serious safeguarding cases is provided by the Matron for Safeguarding Adults

The total number of KASAFs raised in relation to MTW provided care during the reporting period is 85.

This year 2018 – 2019, 39.5% of hospital incidents relating to safeguarding have been raised by Trust staff – this demonstrates increasing confidence that staff are open and transparent in their practice.

60.5% of KASAFs raised about Trust practice are raised by a variety of practitioners, patients, family and friends from outside of the Trust – all of which are investigated when the Local Authority deem that they meet the requirement for a Section 42 Enquiry.

Of the 85 KASAFs raised about practice in MTW outcomes of investigations are noted as:

- 15 (17.65%) upheld
- 49 (57.65%) not upheld

- 5 (5,8%) insufficient evidence
- 14 (16.47%)are still to be heard either at panel or via an alternative process

There is a robust process for reviewing completed KASAF investigations that have been raised about the Trusts practice as follows:

1. Investigation Officer invited to present their report of investigation to the Safeguarding Learning and Development Panel, Sub-panel to the Serious Incident panel.
2. Decision made by the panel as to whether or not the allegations are upheld, not upheld or there is insufficient evidence.
3. Safeguarding Panel is chaired by the Deputy Chief Nurse, in attendance Matron for SGA's, Safeguarding Senior Practitioner from the Local Authority, and the CCG Designated Nurse in an advisory capacity.
4. Investigation Officers are reminded to give feedback to the referrer and the adult at risk, about the investigation outcomes and developed action plans.

This process has been received positively and has enabled the Trusts KASAFs to be reviewed and closed in a timely manner than previously.

Trust staff are keen to look for learning and improvement from these investigations and are tasked to put this learning and improvement into action, either locally in their department, directorate/division wide or Trust wide.

Trust staff have raised 120 KASAFs for community investigations to be carried out by the Local Authority.

7. Mental Capacity Act (MCA) 2005

Mental Capacity is the ability to make a decision. Capacity can vary over time, and according to the decision to be made.

The MCA sets out statutory responsibilities which apply to everyone who works in health and social care who are involved in the care and treatment or support of people over the age of 16 years In England or Wales.

8. Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards (DoLS) form part of the MCA 2005.

The process requires an application to be made to the Local Authority who will then approve the application.

The DoLS Office for the Local Authority triages all requests and should action with specified time frames. However, it continues to be unclear how many applications are converted to authorised DoLS. This issue has been raised with the KMSAB and has become a standing agenda item.

The Trust is achieving a good compliance with MCA training uptake, but 2018-19 TIAA were commissioned by the Trust to undertake an internal audit of Safeguarding processes, including the application of the Mental Capacity Act (MCA), results indicated that the principles of MCA are not embedded into every practitioners practice. This has resulted in a specific project in the Best Quality Work-stream, to ensure that practitioners are involved and motivated to improve the application of the MCA and DOLS into every practitioners practice and will continue to be an area of focus for the Trust in the forthcoming year.
This does not necessarily mean that MCA principles are not being applied, rather a failure to explicitly evidence the approached used to determine capacity within the health care records.

The Mental Capacity Act and Deprivation of Liberty Safeguards Policy and Procedure will be separated into two stand-alone policies and procedures, in preparation for the upcoming changes emanating from the Mental Capacity Act (Amendment) Bill and the expected development of the Liberty Protection Safeguards.

The Trust has made a total of 215 DoLS applications in the year April 2018 to March 2019. The 215 made up of 105 at Maidstone Hospital and 110 at Tunbridge Wells Hospital.

Best Interest Meetings following the MCA take place across the Trust and the most complex of these are chaired by a Senior Nurse or manager with the appropriate skills. Trust staff need to improve how they document whether a patient has got capacity for a particular decision or not.

9. PREVENT

The Prevent Duty is a set of definitions and responsibilities approved under the Counter-terrorism and Security Act 2015 which sets out duties for specific authorities.
PREVENT training focuses on the identification of vulnerable people who are (or maybe) at risk of radicalisation.

The trust has met the PREVENT training standard and achieved 87%, although WRAP is lower at 64%.

There have been no CHANNEL referrals during 2018-19.

10. Safeguarding Adults Review (SAR) & Domestic Homicide Reviews (DHR)

10.1. A Safeguarding Adults Review (SAR) is requested by the Safeguarding Adults Board when certain criteria or thresholds are met. These include

- An adult at risk dies (including death by suicide), and abuse or neglect is known or suspected to be a factor in their death.
- An adult at risk has sustained any of the following:
  A life threatening injury through abuse or neglect
- Serious sexual abuse
  Serious or permanent impairment of development through abuse or neglect

  and / or

- The case(s) give rise to concerns about the way in which local professionals and services worked together to protect and safeguard adult (s) at risk.

10.2. A Domestic Homicide Review (DHR) is a review undertaken when an adult dies as result of domestic abuse. This is led by the Police and is a multi-agency review in a similar format to that of a SAR.

In 2018-19, 2 IMRs were provided for DHRs and none requested for SARS.

The outcomes of published SARs are monitored by the Trusts Safeguarding Adults Committee with any pertinent learning for the Trust disseminated out further to practitioners.

11. Learning Disability

The Learning Disability Hospital Liaison Nurse (LDLN) has been in post since February 2018. Over the past year the LDLN has established good links with a multitude of professionals both internally within the Trust and externally within the community teams.

The LDLN has implemented a range of reasonable adjustments with individual patients, which has positively impacted on their individual patient experience, and their ability to access health services.

The LDLN has trained 353 staff to support them to make reasonable adjustments for people with learning disabilities to ensure people with learning disabilities receive great care.

The LDLN has made progress in setting up an electronic referral system to which staff from inpatient areas have responded positively. The Trust learning disability register now holds a total of 260 patients.

The LDLN continues to engage with people with learning disabilities in service improvement projects.

For the next year the LDLN plans to focus on the NHS Improvement benchmarking standards to ensure these standards are implemented throughout the trust.

12. Learning Disability Mortality Review (LeDeR)

The Learning Disability Mortality Review (LeDeR) process was established in April 2018. This national process has been commissioned by NHS England as result of the Confidential Inquiry into Premature Deaths of People with Learning Disability (CIPOLD).

All deaths of adults and children with learning disability must be reported to the LeDeR programme. Reviews are allocated by the CCG Local area coordinator to reviewers, to undertake a review of all care from all the care providers involved with the deceased leading up to their death.

The Trust has 2 individuals who have undertaken the LeDeR review training (Matron for Safeguarding Adults, and Learning Disability Hospital Liaison Nurse). To date no LeDeR review has yet been undertaken. However all patients with a learning disability, who have died following care in the trust have a structured mortality review of the care and clinical management within the Trust.

The Trust will be exploring with the CCG whether this will be sufficient to contribute to a LeDeR review going forward.

13. Serious Incidents

A Serious Incident (SI) is defined by NHS England as an event in healthcare where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Whilst there is no definitive list of events or incidents that constitute an SI there are a number of descriptors that contribute to the classification of an incident as an SI; this includes

Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery, all of which were: healthcare did not take appropriate action / intervention to safeguard against such abuse occurring; or abuse occurred during the provision of NHS-funded care

The Trust reported 14 SIs related to safeguarding adults between April 2018 & March 2019.

Month	Number of Declared SIs	Downgrades	Total
April 2018	1	1	0
May 2018	4	1	3

Month	Number of Declared SIs	Downgrades	Total
June 2018	2	0	2
July 2018	1	1	0
August 2018	1	1	1
September 2018	2	0	2
October 2018	2	0	2
November 2018	2	0	2
December 2018	0	0	0
January 2019	0	0	0
February 2019	0	0	0
March 2019	0	0	0

Key learning from these cases includes the management of expectations whilst minimising anxiety during the consent process, provision of clear handover and identification of risks.

14. Education & Training

The Trust provides a range of education and training opportunities for safeguarding adults, in line with the draft intercollegiate documents and Kent County Council training requirements.

The Matron for Safeguarding Adults oversees the internal training content and provides much of the training in relation to MCA and PREVENT.

The Matron for Safeguarding Adults works closely with the Named Nurse for Safeguarding Children in both the development and delivery of training. Training is offered in a variety of ways including e-learning, group sessions and bespoke to wards and departments.

The Trust can also access multi-agency training via the KMSAB team. The KMSAB run a number of learning events throughout the year to enable practitioners to hear and discuss the learning from both local and national SARs.

The Trust is meeting the standard of 86% compliance for safeguarding adults at levels 1,but slightly lower for level 2 at 80.3% The table shows the Trust training update for the year 2018/19 is:

Prevent Basic Awareness (3 Year Update)	**Prevent WRAP (Three Year Update)**	**Safeguarding Vulnerable Adults Level 1** (3 Year Update)	**Safeguarding Vulnerable Adults Level 2** (3 Year Update)	**Mental Capacity Act (once only)**
87.7%	**64.0%**	**86.3%**	**80.3%**	**92.6%**

15. Priorities for 2019/20

15.1. Best Care: MCA & Consent

As noted earlier, there is a need to be able to ‘evidence’ the approach taken to ascertain capacity. The Trusts transformation programme ‘Best Care’ has adopted MCA under the Best Quality work stream. The Best Safety work stream is also undertaking a piece of work to strengthen the evidence around informed consent.

As MCA is a corner stone of informed consent these two work streams will be closely aligned. It anticipated that this work will also identify further MCA champions from the clinical areas to support embedding this work.

15.2. Learning Disabilities

The Trust will explore with the CCG how to contribute effectively to LeDeR reviews.
The LDLN plans to focus on the NHS Improvement benchmarking standards to ensure these standards are implemented throughout the trust.

15.3. Education & Training

Safeguarding training is being reviewed against the newly published Adult Safeguarding Intercollegiate Document 2018. A new modular programme is proposed, this is intended to make each level of training more explicit and dovetails with the children's safeguarding training, using a more holistic "Think family" approach. Additionally this approach is intended to make the modes of training more accessible to assist all staff to attend the requisite levels for their role.

Appendix 1: **Statutory duties for Safeguarding Adults**

National & Local Policy

National policy pertaining to Safeguarding adults is underpinned by the Care Act 2014, along with a number of other acts or policies including (but not limited to) the Mental Capacity Act and Deprivation of Liberty Safeguards, Counter-Terrorism and Security Act (including CONTEST the UK's counter-terrorism strategy).

1. The Care Act 2014

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

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

- A personalised approach that enables safeguarding to be done with, not to, people.
- Practice that focuses on achieving meaningful improvement to people's circumstances rather than just on 'investigation and conclusion'
- An approach that utilises social work (and health care) skills rather than just 'putting people through a process'
- An approach that enables practitioners, families, teams and Safeguarding Adults Boards (SABs) to know that difference has been made

Safeguarding practice is, therefore, underpinned by six principles of

- Empowerment
- Prevention
- Proportionate
- Protection
- Partnership
- Accountable

NHS England and the Local Authority have in place and Accountability and Assurance Framework (2015) that sets out the expectations of role, duty and responsibility including: .

- Staff are suitably skilled and supported
- Safeguarding leadership and commitment at all levels of the organisation
- Fully engaged with and support local accountability and assurance structures, in particularly via the SABs and their commissioners
- Have effective arrangements in place to safeguard adults
- A named lead for adult safeguarding

2. Mental Capacity Act (MCA) 2005

Mental Capacity is the ability to make a decision. Capacity can vary over time, and according to the decision to be made. Lack of capacity may be due to either a permanent condition such as stroke or temporary due to a mental health problem or unconsciousness because of illness or the treatment for the illness (e.g.: ICU admission).
The MCA sets out statutory responsibilities which apply to everyone who works in health and social care who are involved in the care and treatment or support of people over the age of 16 years In England or Wales.

The MCA is underpinned by 5 principles:

- Assume Capacity, unless it is established otherwise
- Practical steps taken to maximise decision making capacity (e.g.: use of non-verbal communication)

- Unwise decisions: a person has the right to make an unwise or eccentric decision
- Best Interest: any act or decision must in the person's best interest (not the practitioner or organisation).
- Least restrictive: alternative acts or decisions must be considered with regard to the purpose for which it is needed and whether it can be achieved in a way that is less restrictive for the person's rights and freedom to act.

2.1 Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards (DoLS) form part of the MCA 2005. The DoLS provide a mechanism to ensure that appropriate safeguards and least restrictive options are in place for a person lacking mental capacity where it is considered to be in the persons best interest to keep them in a hospital or care home.

The 'acid test' from previous Supreme Court Judgements (P&Q vs Surrey Council and P vs Cheshire West) remains in place. The 'acid test' criteria are applicable if the person is assessed as lacking mental capacity and is:

- Under continuous supervision and control **AND**
- They would not be free to leave

The process requires an application to be made to the Local Authority who will then approve the application.

The DoLS Office for the Local Authority will triage all requests and should action with specified time frames. However, it continues to be unclear how many applications are converted to authorised DoLS. This issue has been raised with the K&MSAB and has become a standing agenda item. DoLS applications for individuals within acute care settings are often seen as a lower priority for the Local Authority

3. PREVENT

The Prevent Duty is a set of definitions and responsibilities approved under the Counter-terrorism and Security Act 2015 which sets out duties for specific authorities.

Key responsibilities for health are:

- Partnership: working with regional safeguarding forums to have oversight of compliance with the duty.
- Organisations should have a lead and access to networks for advice and support to make referrals to Channel
- Risk Assessment; all Trusts should have a Prevent Lead who acts as a single point of contact within their organisation
- Staff Training, relevant to role in safeguarding adults and children.

PREVENT training focuses on the identification of vulnerable people who are (or maybe) at risk of radicalisation.

Appendix 2

Kent & Medway Safeguarding Adults Board
Annual Agency Report

Vision

The strategic plan sets out how the KMSAB will work towards achieving their vision of:
"The Kent and Medway Safeguarding Adults Board Partnership will all work together to ensure adults at risk of abuse or neglect are supported and empowered to live safely"

Mission

To achieve the vision the Board is seeking assurance, through partnership working with agencies and local communities, to prioritise and deliver: prevention, awareness and quality of safeguarding.

Priorities

Priority 1 – Prevention - We will deliver a preventative approach in all that we do.
Priority 2 – Awareness - We will improve awareness of adults at risk and safeguarding within, and across, our partner agencies and communities.
Priority 3 – Quality - We will quality assure our work, learn from experience and consequently improve our practice.

Actions taken by the organisation to achieve this priority;

Priority 1	**PREVENTION**

"I want to feel and be safe in the community where I live"

Our priority is to deliver a preventative approach in all that we do. We will:

1. assurance that agencies are clear about their obligation to deliver safeguarding and that they are clear that this constitutes the prevention of abuse, crime, neglect and self-neglect
2. assure partnership accountability
3. raise public awareness of the work of the KMSAB and adult safeguarding
4. listen to the voice of the adult and make sure that safeguarding is personal wherever possible

Safeguarding Adults is a recognised priority in the Trust and staff demonstrate good knowledge about how and when to raise a Kent Adult Safeguarding Alert Form (KASAF's) with the Local Authority. Staff are aware that they do not need permission to raise a KASAF, but will raise one using their professional judgement to ensure that Section 42 Enquiry requirements are notified to the Local Authority. All KASAF's raised, are copied to the Matron for Safeguarding Adults.
Trust staff raise safeguarding alerts for hospital related incidents, complaints and disciplinary issues that reach the threshold for raising a KASAF.
In Year 2017 – 2018, 30% of the hospital incidents were alerted by Trust staff.
This year 2018 – 2019, 39.5% of hospital incidents relating to safeguarding have been raised by Trust staff – this demonstrates increasing confidence that staff are open and transparent in their practice.
The robust process for reviewing completed KASAF investigations that have been raised about the Trusts practice is that:

5. Investigation Officer invited to present their report of investigation to the Safeguarding Learning and Development Panel, Sub-panel to the Serious Incident panel.
6. Decision made by the panel as to whether or not the allegations are upheld, not upheld or there is insufficient evidence.
7. Safeguarding Panel is chaired by the Deputy Chief Nurse, in attendance Matron for SGA's, Safeguarding Senior Practitioner from the Local Authority, and the CCG Designated Nurse in an advisory capacity.
8. Investigation Officers are reminded to give feedback to the referrer and the adult at risk,

about the investigation outcomes and developed action plans.

This process has been received positively and has enabled the Trusts KASAF's to be reviewed and closed in a timely manner than previously.
Trust staff are keen to look for learning and improvement from these investigations and are supported to put this learning and improvement into action, either locally in their department, directorate/division wide or Trust wide.
Safeguarding KASAF's are also put on the Trust incident reporting systems which allows for triangulation of key themes from all our investigations.
Trust staff have raised 120 KASAF's that for community investigations to be carried out by the Local Authority.

Priority 2 AWARENESS

"I know what abuse is and where to get help"

Our priority is to improve awareness of adults at risk and safeguarding within, and across, our partner agencies and communities. We will:

1. Improve awareness across Kent and Medway
2. Improve engagement with local communities
3. Assess the effectiveness of the work we do, and review and share the learning

Actions undertaken by the organisation to achieve this priority;

The Safeguarding Adults at Risk Policy and Procedure was updated and advertised out to staff summarising the changes during 2018-19.

The Mental Capacity Act and Deprivation of Liberty Safeguards Policy and Procedure will be separated into two stand-alone policies and procedures, in preparation for the upcoming changes emanating from the Mental Capacity Act (Amendment) Bill and the expected development of the Liberty Protection Safeguards.

The Internet and intranet pages in relation to Safeguarding Adults were reviewed and updated, To inform staff and the public alike, about safeguarding measures (for individuals) and priorities in Kent. These pages provide links to the KMSAB Safeguarding Adults Web pages

The Safeguarding Adults Training is designed and delivered by the Matron for SGA's within the Trust with assistance from a small pool of practitioners. The level of KASAF's that are appropriately raised by Trust staff would indicate that this learning is having a positive impact upon practitioners decision-making and referrals made.

The Chief Nurse and Executive Lead for Safeguarding attends the KMSAB to be aware of emerging information and to engage effectively with our multi-agency partners.

The Safeguarding Adults Matron engages with the Sub-Groups of the KMSAB Board.

Published Safeguarding Adults Reviews (SARs) are monitored by the Trusts Safeguarding Adults Committee with any pertinent learning for the Trust disseminated out further to practitioners.

As part of the Trust's ongoing engagement with the CQC, our Matron for Safeguarding Adult's delivered a presentation on how we meet the key lines of enquiry for each of the CQC domains.

Priority 3	QUALITY

"I am confident that professionals will work together and with me to achieve the best outcome for me"

Our priority is to quality assure our work, learn from experience and consequently improve practise. We will:

1. Ensure agencies are accountable for having competency and quality in practice
2. Ask for feedback, learn from people's experiences and put learning into practice.
3. Define our quality parameters and measure performance accordingly

Actions undertaken by the organisation to achieve this priority;

Accountable quality in practice – competent

The trust is compliant and meets its statutory duties pertaining to Safeguarding Adults.

The Executive lead for Adult and Children safeguarding is the Chief Nurse, who additionally delegates responsibilities to the Deputy Chief Nurse.

The Named Professional for Adult Safeguarding is known as the Matron for Safeguarding Adults, an expert practitioner in the field of Safeguarding Adults, Mental Capacity Act and Learning Disability.

The Trust engages effectively with the KMSAB Self-Assessment Framework and welcomes the challenge about systems and processes that are currently in practice.

Adult Safeguarding Training is designed and delivered by the Matron for SGA's; this is under review against the guidance within the Safeguarding Adults Intercollegiate Document (2018).

Trust practitioners are keen to learn lessons when the patient journey has not been as event free as it should have been and following all investigations staff will usually find areas where practice could have been improved and will share that learning across the Trust so that practice can be improved. These lessons are shared quickly and widely through the Trust.

In alternate months, patients will be invited to the Trust Board Meeting to tell their story. The Trust Board welcomes these opportunities to hear directly from the patient about experiences both good and bad.

When the outcome of an investigation is known, Trust staff make contact with the patient and their family inform them of the findings. If they seek more clarity, a further meeting is offered to discuss this in depth with the appropriate practitioners available to answer any lingering queries.

Best Interest Meetings following the MCA take place across the Trust and the most complex of these are chaired by a Senior Nurse or manager with the appropriate skills. Trust staff need to improve how they document whether a patient has got capacity for a particular decision or not. During 2018-19 TIAA were commissioned by the Trust to undertake an external audit of Safeguarding processes, including the application of the Mental Capacity Act (MCA), results indicated that the principles of MCA are not embedded into every practitioners practice. This has resulted in a specific project in the Best Quality Work-stream, to ensure that practitioners are involved and motivated to improve the application of the MCA and DOLS into every practitioners practice and will continue to be an area of focus for the Trust in the forthcoming year.

1. **Strategic issues for organisation over the previous year;**

There was a backlog of KASAF completed investigations that needed to be reviewed and outcomes agreed towards the end of 2018-19.

Actions were to increase the number of Safeguarding, Learning and Improvement Panels held in the last quarter of year 2018 – 2019. This enabled the Trust and Local Authority to agree outcomes and ensure cases were closed with effective learning and improvement plans in place.

There remains a small backlog which will be worked though by the Matron SGA's and the Local Authority Representative.

The Trust is developing a project plan to address poor application of the principles of the MCA and documentation thereof, with appropriate senior leaders to drive this forward and expect that in future audits of this area of care they will show that practice is on an improving trajectory.

The increased awareness of staff about Adult Safeguarding has resulted in an increase in demand for advice and support for Safeguarding Adults.

A review of Safeguarding Services within the Trust to assist with the demands of the Safeguarding Adults and Children's will be undertaken during 2019-20

2. **Actions taken to improve effectiveness over the year;**

Consolidation of the Safeguarding Learning and Improvement Panel giving the ability to share practice and knowledge in relation to safeguarding within the hospital.
Inviting the Designated Nurse for Safeguarding Adults to be a core member of the Safeguarding learning and improvement panels has strengthened professional relationships.
Inviting Social Care as the lead agency for Safeguarding to attend the Safeguarding learning and improvement panels has improved a greater understanding of different roles and collaboration to safeguard patients.

3. **Summary of routine collection and evaluation of key safeguarding activity, performance and workforce data**

The Trust submitted quarterly Safeguarding reports to the CCG, informed the CCG of KASAFs raised and invites the designated Nurse to attend Safeguarding in committee and Safeguarding learning and improvement panels.
All KASAF's are reviewed by the Matron SGA's with feedback given to each referrer where needed.
DOLS activity within the Trust is collected and DOLS Forms reviewed by Matron SGA's

4. **Regulatory inspections**

There has not been a formal CQC Inspection during 2018-19; the last visit was in 2017. However there have been informal CQC engagement visits, Safeguarding was part of a positive CQC engagement visit on the 5th September 2018.

Assessment of your own organisation's safeguarding effectiveness;

The Executive lead for the Safeguarding Adults is the Chief Nurse who takes a keen interest in this important area of work.

The Trust has effective governance processes in place to oversee and monitor the safeguarding adult's activity within the Trust.

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Staff are aware of their duties to raise their concerns and do so effectively as is shown by the number of alerts they raise for both hospital incidents and community incidents.

The Trusts Safeguarding Learning and Improvement Panel is well received by West Kent Safeguarding Team and hospital staff alike and is a method of learning for staff to find out more about multi-agency working.

NHS
Maidstone and Tunbridge Wells NHS Trust

The transfer of Stroke services from Tunbridge Wells Hospital to Maidstone Hospital — **Chief Operating Officer**

The 'Part 2' Trust Board meeting on 27th June 2019 considered a report outlining the Case for Change to move the stroke ward at Tunbridge Wells Hospital (TWH), (Ward 22) to Chaucer Ward at Maidstone Hospital. The reason for the proposed change related to two areas of staffing:

1. Thrombolysis nursing cover
2. Registered nurse cover on the ward

The Board, having considered the current and pending staffing issues, was satisfied that the information given at the 'Part 2' meeting allowed that decision to be taken without the usual consultation, as the staffing challenges on the stroke unit at TWH presented a risk to safety or welfare of patients or staff, and there was therefore insufficient time for such consultation (in accordance with Regulation 23(2) of The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013).

The staffing challenges require an urgent response to the current and ongoing difficulties to enable safe delivery of the current stroke service. The changes agreed do not impact negatively on the wider Stroke Review Programme timescales for delivery of the three Hyper Acute Stroke Units (HASUs) /Acute Stroke Units (ASUs) in Kent and Medway.

The Independent Reconfiguration Panel review and Judicial Reviews that are pending may result in changes to the locations of the HASU/ASUs. The changes to the MTW stroke service are reversible should the need arise.

The Trust has undertaken a communications process with all external stakeholders and will continue to keep partners apprised of the progress with the move.

The internal process with regard to staff consultation, the preparation of the estate and the planning of the move is in hand and being managed through the Operations Group which is part of the Maidstone and Tunbridge Wells NHS Trust stroke governance arrangements.

Which Committees have reviewed the information prior to Board submission?

- -

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

Information, assurance

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

Approval of the refreshed Trust IT Strategy	**Chief Finance Officer / Head of Digital Programmes**

The Trust's IT Strategy, 2018-23 was approved by the Trust Board at its meeting in January 2019. At that meeting, it was agreed that a refresh of the Strategy should be scheduled for June or July 2019 (to allow fuller consideration of relevant aspects within the NHS Long Term Plan, the publication of which had coincided with the Trust's IT Strategy).

The refreshed Strategy, as circulated, was considered and supported by the Finance and Performance Committee at its meeting on 27/06/19. The Strategy is now enclosed for review and approval by the Trust Board.

Which Committees have reviewed the information prior to Board submission?
Finance and Performance Committee, 25/06/19

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

Maidstone and Tunbridge Wells NHS
NHS Trust

IT Strategy

2018 - 2023

Contents

1.Introduction

The current Maidstone and Tunbridge Wells NHS Trust IT strategy was published 5 years ago. In this time both the IT requirements of our staff and the potential IT solutions available have changed dramatically. As such a new IT strategy is required.

The strategy must consider the needs of the end-users to ensure that IT supports our staff in providing the best possible patient care. This whilst also meeting the requirements of local and national strategies and drivers, along with consideration of how current and future technology could be used to the benefit of the organisation.

The strategy provides an opportunity to develop a road map over the next 5 years that begins to harness the investment in IT which has already been made and transform our systems into ones that genuinely support our patients, and their carers enabling our staff to deliver modern safe and reliable healthcare services as described in the Trust's vision.

2.Where we are today?

Maidstone and Tunbridge Wells (MTW) is a large Acute Hospital Trust in the South East of England. It provides a full range of general hospital services to around 590,000 people living in West Kent and East Sussex. The Trust also provides some aspects of specialist care to a wider population.

The Trust employs a team of over 5,000 staff. It operates from two main sites but also has services at Canterbury and Crowborough Hospitals and an outpatient provision at several community locations. It has over 800,000 patient visits a year, 150,000 of these coming through our Emergency Departments which are accessible on the main sites. Maidstone Hospital has 325 overnight beds and Tunbridge Wells Hospital 475 overnight beds.

An honest appraisal of our current IT provision reveals:

Our Strengths:

- The new PAS implementation in October 2017, although disruptive, has upgraded our underlying software and hardware which can now be used as a platform to build upon.

- In 2017 the NHS reviewed Acute hospitals IT infrastructure allowing us to compare ourselves to our neighbours. This peer review revealed MTW to be above average on each three metrics; Readiness, Capabilities and Infrastructure.

- Wi-Fi connectivity within the Trust has been designed for data, voice and location services, making it extremely advanced compared to other NHS Trusts. This currently provides services to support mobile working and patient internet access – but could offer much more in the future.

Our Weaknesses:

- The IT strategy since 2014 was to pursue a 'best of breed' formula with many different IT products woven and interfaced together. This has the benefit of giving clinicians the choice of a variety of bespoke products but it also has the downside of difficulties with interfacing and having to log into numerous systems every day. This has an impact on productivity and is a key area of focus for MTW.

- Clinicians and admin staff using the PAS in its current form find it slow and difficult to navigate, this not only causes frustration but also makes MTW staff less productive.

- Some parts of the Trust's IT infrastructure require updating or replacing. Due to financial constraints the Trust's IT replacement cycle has been extended which has impacted the performance of some of our infrastructure over a period of time.

3. Where do we want to be?

MTW must address three sets of needs over the next 5 years:

1. Local clinical needs – what do our Doctors, Nurses and Allied Health Care Providers need IT to do?
2. Regional needs – what can we do to collaborate more effectively across Kent and into London to improve care for our patients?
3. National needs – how can we deliver the national best practice highlighted in national strategies and guidance such as the Lord Carter report and NHS 5 year forward view?

3.1 Our Local Clinical Needs:

The most valuable thing to this organisation and to patients is our clinician's time.

This five-year strategy must make IT work *for* our staff, rather than limit and hinder them. MTW staff currently use numerous poorly integrated systems – this causes frustration and inefficiency on many levels with staff logging into numerous different systems each day.

Our clinicians want:

- A simple, intuitive and fully integrated Electronic Patient Record (EPR) clinical system for the vast majority of clinical work
    - Wherever possible parallel systems should be accessed via the EPR without further logins required – for instance PACS, E-Notes and E-Referrals
    - Where bespoke systems offer significant advantages, they should be promoted but linked to the EPR for ease of use

- The end user devices our staff use to access clinical systems must be:
    - Reliable and resilient
    - Device performance meets the needs of the user – supporting not hindering our staff in their work
    - The right technology available at the right time

- Access to all the data we hold, promoting audit and good clinical governance and intelligent reporting dashboards.

- MTW to become a leader within Kent for sharing information across organisations, empowering our staff to access patient records whenever and wherever they need to. We should also promote patients having access to their own data - involving them more in their own care will help us all.

- A regular, clinically led, forum to feedback on and direct IT developments within the Trust.

3.2 Our Regional Needs:

The Trust believes strongly that by working with our partner organisations across Kent and into London we can deliver better, more efficient care.

- MTW is already a partner in the Kent and Medway Care Record as part of the Kent and Medway Strategic Transformation Programme (STP), which will deliver information sharing on a new level. This will assist our staff to treat our patients wherever and whenever they need to.
- Support the development of the Integrated Care Partnership (ICP) within West Kent. Supporting both the transformation of services within the partnership through integration and digital innovation. While ensuring the improved utilisation of data to support population health.
- Wider management of patient flow across care settings to improve patient care and flow of patients through organisations. This will also include elements of decision support/system intelligence to aid process flow.
- Closer collaboration with GPs and the community trust to minimize length of stay in hospital. Initiatives such as the 'virtual ward' will require IT support to make them work.

3.3 Our National needs:

The government has set out a series of information technology drivers and strategies for the NHS to achieve over the next five years which have been published in a series of papers, such as the 'Five year Forward View'[1], 'Personalised Health and Care 2020'[2], the 'Lord Carter Report'[3] and the 'Wachter Report'[4]. Most recently the latest NHS Strategy, the 'NHS Long Term Plan'[5] also has a significate focus of digital enabled care. As a result, the strategy needs to ensure that it adopts and delivers against these national objectives.

The key digital deliverables from these national agendas are as follows:

- Ensure that an Electronic Patient Record solution is implemented within the organisation.
- Straightforward digital access for patients to access and update their electronic records, and engage with services to help patients and cares manage their health.

[1] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

[2] https://www.gov.uk/government/publications/personalised-health-and-care-2020

[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

[4] https://www.kingsfund.org.uk/sites/default/files/media/T5_Bob_Wachter.pdf

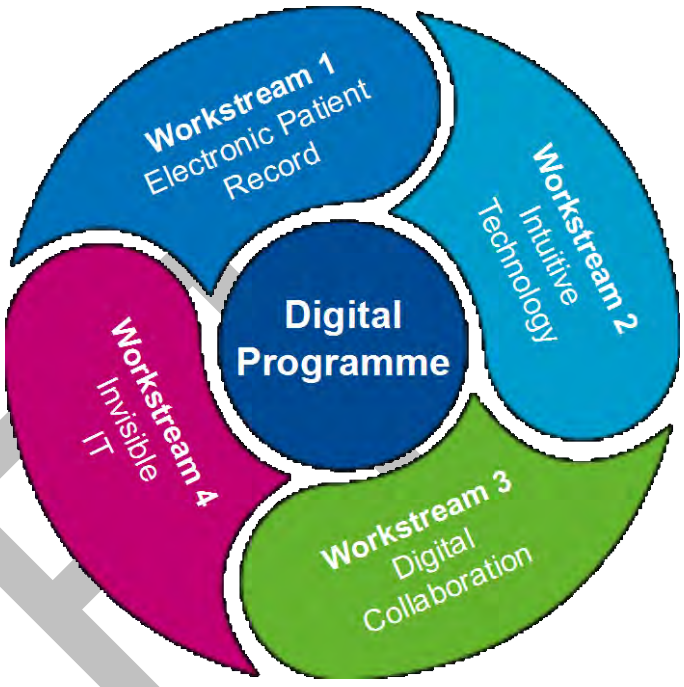
[5] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf

- Ensure that clinicians can access patient records wherever they are.
- Integrated health records to pass information between services both in and out of the NHS. Enabling improved outcomes across the heath and care system.
- Clinicians are provided with a range of decision support tools including advanced analytics and artificial intelligence.
- Other key system implementations include e-rostering; patient level costing and accounting; e-catalogue and inventory management.
- Reduce clinician's administration requirements through electronic data capture intuitive tools and automating processes.
- Adopt technology standards to aid interoperability both now and in the future.
- Ensure that data and systems within the NHS are secure.

The current financial pressures within the NHS generally and some of the specific challenges facing MTW require the Strategy to also focus on efficiency and productivity gains and to consider the financial impact on the organisation to deliver the Strategy.

4. How do we get there?

With the objectives of the IT strategy covering a broad area, we have broken down the plan to deliver the programme of work into 4 workstreams. The aim is to ensure focus on delivering key projects with clear benefits whilst ensuring these meet the aims of the IT Strategy.



Workstream 1 - Electronic Patient Record

The development of the Trusts Electronic Patient Record (EPR) and how this data can support staff in providing better patient care.

Workstream 2 - Intuitive Technology

Focusing on user technology, meeting the needs of our users to support, not hinder their working processes.

Workstream 3 - Digital Collaboration

Developing the ability to share data across our partner organisations, and with patients and carers directly, with the aim of improving care and the patient experience through data collaboration.

Workstream 4 - Invisible IT

Ensuring the IT infrastructure in the Trust meets the needs of the organisation both now and in the future.

- Each workstream will either be clinically led or have clinical engagement.
- There will be a focus on Information Governance, Data Quality and Security throughout all workstreams.
- All initiatives impacting clinical users will be approved by the Clinical Advisory Group

Below are some of the key deliverables achieved by these workstreams to deliver the overall IT strategy.

Cyber Essentials Plus 2018	Single Sign-On 2019	New Data Centre 2019	Allscripts Sunrise 2019	Kent Care Record 2020	Automated Patient Flow 2021	Integrated EPR 2022

4.1 Electronic Patient Record

The workstream focuses on the development of the Trust's Electronic Patient Record (EPR) and how this data can support staff in providing better patient care whilst improving the flow of patients throughout the organisation.

More than a computer system, EPR will transform the way everyone at both Trusts works, making sense of busy, complex health services, analysing information in clever ways and helping to manage many every-day tasks. This system will not only help to treat patients more effectively by giving healthcare staff easier access to up-to-date information, it will also use this information to improve care, and give healthcare staff the tools needed to be safer and more efficient.

It would be easy to think of EPR as simply a computer system that takes paper-based health records and stores them digitally. In reality, EPR will bring about a step-change in how healthcare staff work. The Trust cares for thousands of patients every day, with different and complex health conditions. Having up to date, accurate information, available to everyone, whenever they need it helps us to offer the best care we can and ensure that patients get the treatment they need.

EPR goes beyond being a system for storing information. When patient records are stored on paper, the information can only be understood and analysed by staff reading through all of it every time they see a patient. EPR is capable of taking this information and applying the knowledge, intelligence and experience of a much wider network. This means the system is capable of suggesting plans of care, supporting clinical decision-making and acting as a double check.

In addition to this, an EPR can be a valuable tool in managing the wider healthcare system. The EPR workstream will focus on how the data provided by the system can help to manage the flow of patients through our hospitals, helping them respond to increases in demand by identifying where beds are available (or where they might be available tomorrow) and offering insights into how services are used and where they could be more efficient. This will support and align to the Trusts Business Intelligence strategy.

The Trust will therefore implement a single EPR solution, building upon the platform of the PAS already in place. The aim would be to complete the initial EPR core product implementation in Spring 2020 with Emergency Department functionality and Order Comms going live, however there would be continuous growth in the use of the system over the duration of the next 10 years with key functionality around Electronic Prescribing and Medicines Management (ePMA) and inpatient clinical documentation following in 2020 with Surgery following in 2021, with additional departmental functionality utilised following this.

This increased data which is recorded within the EPR will provide support for the Trusts Information Strategy and the development of the Trusts data warehouse which will be utilised to support population health data analysis, aiding further service transformation across providers.

Although the objective is to consolidate the patient record into a single EPR system there is a requirement for specialist department systems in some areas. Maternity, Ophthalmology, Critical Care, Oncology, Radiology and Pathology all have specialist applications to support the care that these services are providing, where a generic EPR may not provide the full benefits available. These systems should be developed further to achieve a paper lite service. However, it is important to ensure that the objective of providing a complete electronic record is realised through the use of integration and contact aware viewing with the Sunrise EPR solution.

Providing a single view of the patient record is not the only IT system to aid improving patient experience. The ability to manage patient flow within an organisation also provides benefits of better resource utilisation and reducing length of stay within the hospital. The Trust should look to adopt a patient flow solution, linked

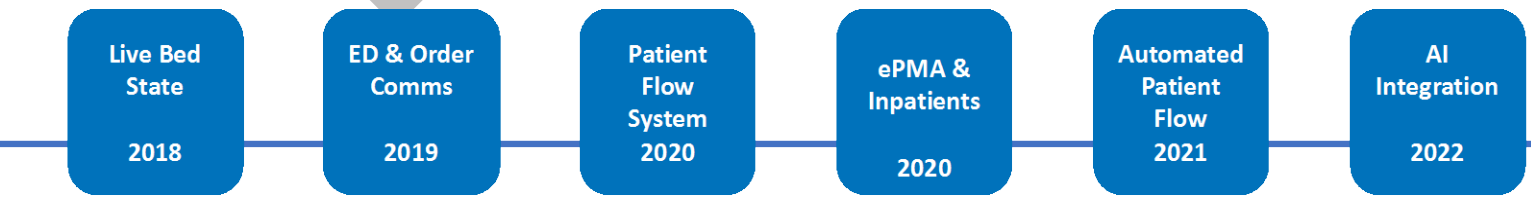
to the EPR which provides these benefits. In the initial instance this will be a manual solution with the implementation of RFID and/or infrared technology to automate the process at a later date.

Globally we are seeing companies such as IBM and Google continue to develop Artificial Intelligence (AI) functionality, with the benefits now starting to be utilised within healthcare. The Trust should look to adopt AI functionality to first act as a further decision support tool for clinicians, automate management of patient pathways and support the Trust with process management, alerting, implementing optional resolution plans and supporting population health analytics. This would be integrated to the EPR to provide the biggest benefits, working closely with the Trusts EPR supplier following the successful implementation of Sunrise. However, AI would also be adopted into staff rostering and procurement processes to streamline and automate, as well as in areas Radiology and Pathology to aid diagnosis.

It is important that as an organisation MTW looks to support innovation in technology and integrates this into its digital vision to improve patient care. One example which will have a significate impact on healthcare moving forward is genomics'. Testing costs mean that utilisation of these services is currently limited. However, the benefits this will bring in the form of precision medicine and genetic mapping means that we should be ensuring that we are planning to ensure we are in a position to utilise these services within our EPR in the form of prescribing, decision support, analytics, and results reporting.

Due to its nature, this workstream is more about the change it will bring to the organisation rather than the IT that is being implemented. As a result, it will be a clinically led transformation programme.

Below is an overview of the key projects/schemes to be delivered within this workstream:



4.2 Intuitive Technology

There needs to be a key focus on technology meeting the needs of our users. This could be as simple as 'Does an outpatient clinic room have the right type of computer in it?' or the introduction of a Single Sign-On solution.

At present, the lack of limitations of technology can dictate how staff work. The aim is to ensure that the technology supports the workflows and processes of our staff, both now and in the future.

Not unreasonably, Trust staff increasingly expect the ease with which they use technology and data at home to be replicated within the NHS. The workstream will also look at how new technology can be adopted to the benefit of our users. Security and data protection will always be paramount when looking at new technology, but the Trust should adopt an attitude of embracing technology where possible, where it would aid our users.

Therefore, the workstream will focus on:

- How users can gain easier access to information from wherever they are. This could be by the bedside, at their desks or at home.
- Is the right technology there to meet user's needs? Addressing working environments to ensure IT infrastructure meets the workflows of our users.
- Ease of use – How easy can we make it to use our IT solutions? Benefits would include reducing the time wasted accessing information, mistakes made due to misunderstandings and reduction in support calls. Examples could be simplifying data entry on an application, reducing PC logon times and making it easy to access systems via smart card or biometric access.
- Looking at the introduction of new technology and how this may support staff in their jobs.

This workstream will look not just improving the user experience regarding end user devices in isolation. The all aspects need to be considered from accessing Trust systems such as the electronic patient record and departmental systems through to reduced logons and customised screens. This means that instead of just replacing devices like for like, we need understand the change in working practices form adopting a paper lite approach as well as other service transformation work taking place. This may result different requirements on end user devices. As well as reviewing our need the Trust will begin to review other organisations approach to end user technology, look at innovative new technology that is coming to the

market and how this can be used within the hospital, whilst allowing the device types and deployment approach to be driven by users through the clinical advisory group.

Areas of focus will initially start with clinical areas to support direct patient care and act as an enabler for the EPR programme. Example of improvements will be outpatient rooms, in 2018/19 additional screens will be added to make it easier to view data from different systems. Improvements in logon speeds and single sign-on to be adopted, which should lead to reduction in time it takes to access records. In 2019 we also expect an increase in computers on wheels (COW's) in ward areas, following successful pilots in the previous year. This will provide patient data being available during ward rounds, at the patient's bedside. As well these additional mobile PC's we will also be looking to provide touch screen PC's on wards to aid bed management and access patient results. This will again aid staff and support the reduction in length of stay.

Bring Your Own Devices (BYOD) offers the organisation the opportunity to provide users with the ability to utilise personal devices within the work place. The objective will be to make it easier for staff to access information, systems and data to support the jobs they do, while increasing the number of end user devices in operation around the organisation. BYOD will be introduced within the organisation over several stages which the BYOD Wi-Fi being delivered in 2019, with full virtualisation scheduled for 2020.

The Trust is also looking to adopt technology to improve productivity and in turn patient care. Examples of this include the introduction of voice recognition for the creation of correspondents, reducing admin time for staff and should improve the turnaround time of letters within the Trust. Also, the introduction of video consultants and tele-medicine will be introduced within the organisation. Video outpatient consultations will continue to grow across Oncology, Sexual Health from 2019, followed by a wider implementation, providing patients with more access to our services. Tele-medicine will follow supporting virtual wards, and more advanced remote consultations in future years.

Instant messaging applications have become common with in everyday life, and are now becoming an important part of how our staff communicate with each other to manage operations. However, are see examples of how these applications are being used to directly manage patient care. We need to ensure that me meet or information governance requirements in regards to patient date, however that should not mean that we reject communicating via this method. Working with specialist suppliers we will look at secure communication applications which will add this information directly to the EPR.

4.3 Digital Collaboration

With the increasing need to collaborate with our health and social care partners, there is a requirement to ensure that we are providing our clinical staff not just with MTW patient data but data from any health or social care provider, to ensure the best possible care. As we move forward with Kent and Medway service redesign this requirement will continue to grow. This workstream, therefore, focuses on the ability to share data across our partner organisations and with our patients.

The Trust has already engaged with West Kent CCG with their Care Pathway Management System (CPMS) and this should be further developed in 2018/19 to ensure a comprehensive data set is available to care providers to aid patient care. The Trust will also look at fully integrating this solution with its future EPR allowing for a context aware view for ease of access to clinicians.

To further support multidisciplinary teams working across organisations and support the vision of the STP and the development of the Integrated Case System (ICS), the Trust will be an active partner in the development of a Kent Care Record during its development over the next 3-5 years, with the aim of providing a clinical portal containing a complete care record across the county. This would also include access for patients and carers and the ability to add to their patient record, improving patient engagement and outcomes.

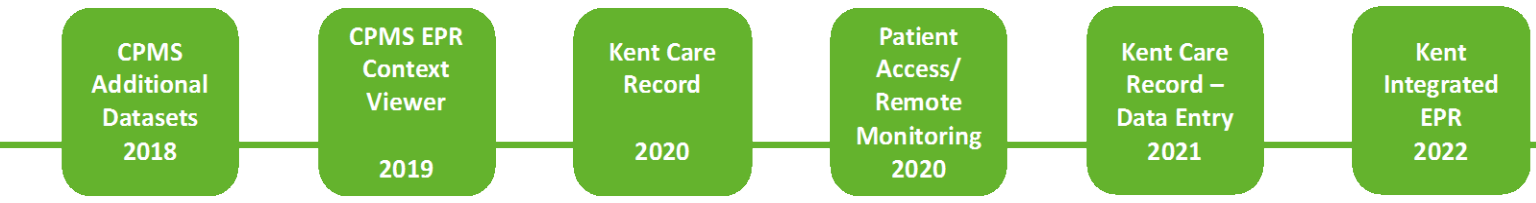
As the West Kent Integrated Health Partnership (ICP) develops we will see a need to develop Integrated service models with the need to align of clinical IT systems and IT infrastructure to support both our users in providing services which could be provided by multiple providers. The Trust will also see a greater need for to utilise patient data to support population health data analysis, aiding further service transformation across the ICP.

Although ICP development is in an early stage it is key that IT engages at an early stage to act as an enabler in the process. A Digital Collaboration group will be established initially reporting via the West Kent Alliance, but eventually to the ICP board which contains IT and Information leads from all providers and the CCG within West Kent. The aim with be to ensure our strategies align, we look to how data can be shared between organisations and the group supports wider West Kent transformation.

There is also a need to share data with our patients and their carers to both inform and support patient care. This will improve engagement with patients and their carers, promote data quality and provide additional opportunities to improve patient care. Providing access to Trust services via 'apps', accessing appointment information via email and video consultations are also key to improving patient interaction and providing improved services.

The Trust needs to ensure that its long term external patient interaction aligns with both the Kent and Medway STP and NHSX in the form of building upon the KMCR and solutions such as the NHS App. However, in the interim we should look to embrace specialist products, working with suppliers to integrate and shape these solutions to achieve our long-term strategy. Examples include patient appointment letters being replaced by electronic correspondents, patient record portals for long term condition management, allowing patients to enter in information on their condition which will aid their treatment. We will also see an increase in video consultations as described within the Intuitive Technology workstream.

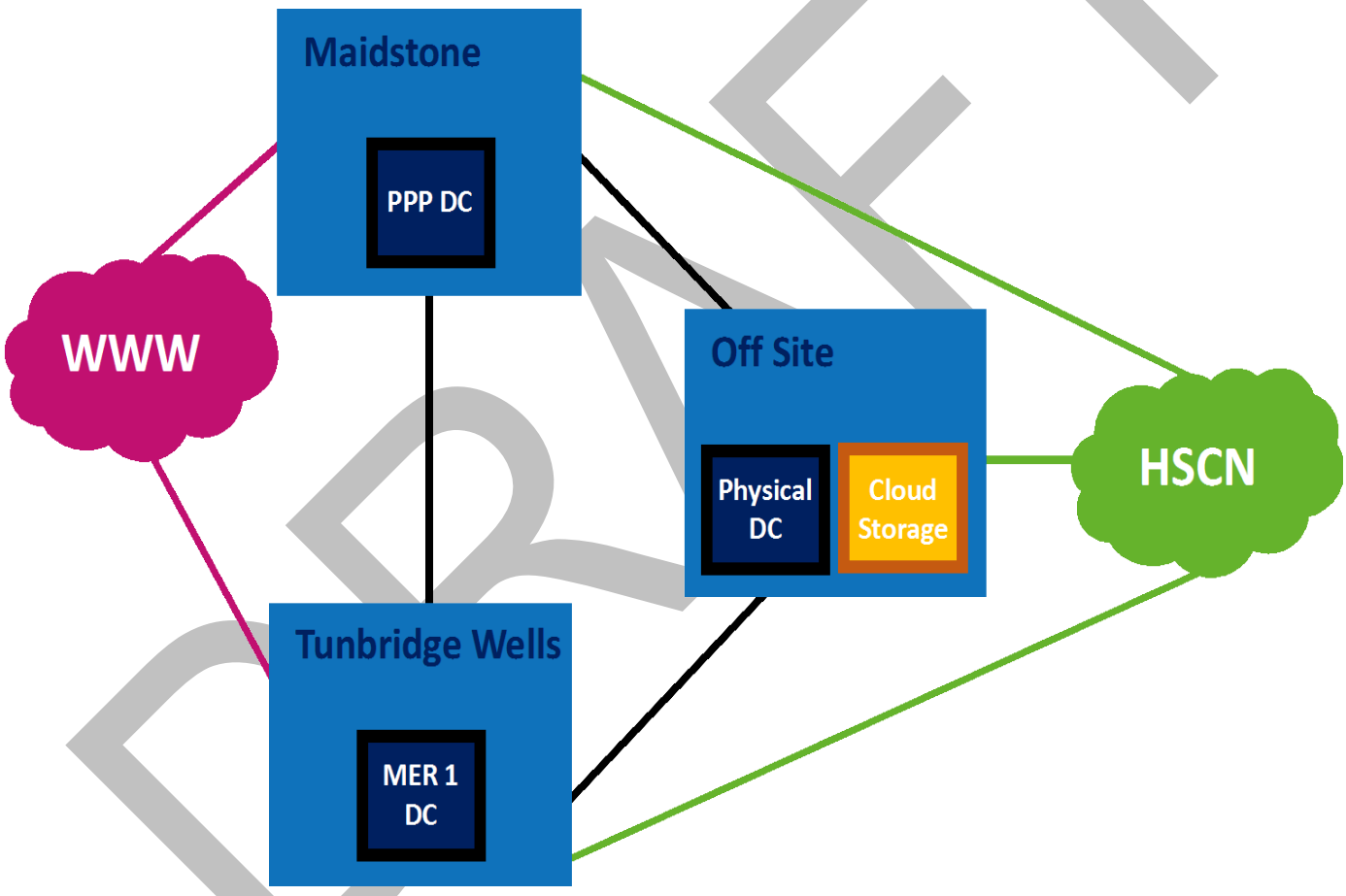
The Trust has also recently embarked on the implementation of a 'virtual ward', allowing patients to be managed remotely. It is anticipated that this type of practice will be implemented further and due to technology enablers now available, the workstream will also look at real-time remote monitoring of patients via provided devices and patient own equipment, such as smart phones to improve remote patient care.



4.4 Invisible IT

The workstream focuses on ensuring the IT infrastructure in the Trust meets the needs of the organisation both now and in the future. This focuses on capacity, availability, speed and security. This includes projects such as increased storage, ability to provide more applications across the Trust and increase communications (voice, data, video) around the organisation.

The demands on IT infrastructure will continue to increase with the expectation that storage requirements for holding patient data will double every 73 days by 2020. It's key that the workstream ensures it understands the needs of the organisation to allow it to deliver the IT infrastructure needed.



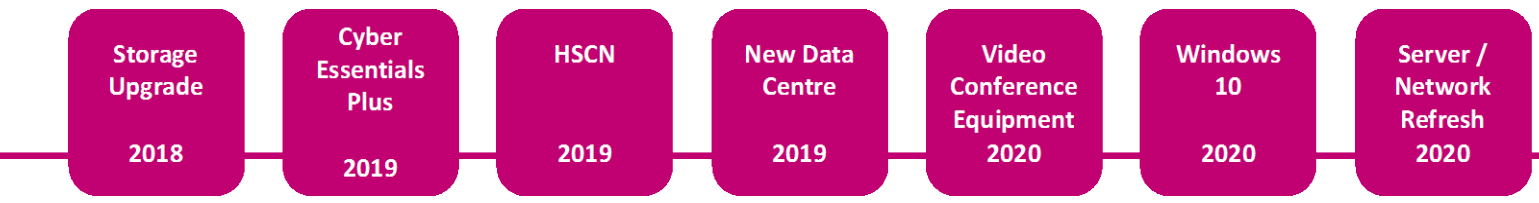
Key projects identified include the implementation of increased network resiliency with the introduction of the Health and Social Care Network (HSCN) and a second off-site data centre. This will improve the resilience of the Trust systems, whilst providing the Trust with the ability to expand its IT capacity in the future. It will also provide a platform for further solutions to support our users. Examples include the introduction GovRoam across Kent, which will make it easier for staff to contact to any care network to access network drives and systems, without an additional layer of authentication. This will benefit users such as MDT's, community midwifes.

The Infrastructure structure developed will also maintain options for collaborative working and/or IT outsourcing opportunities with other NHS organisations moving forward. This approach would provide increased resilience for the IT team for specialist roles.

The Trust will also need to focus on end user devices with engagement from the intuitive technology workstream and the requirement to migrate from Windows 7 and Microsoft Server 2008 by 2020. However, in line with the Intuitive Technology workstream the Trust needs to ensure that this is not just a case of taking the easy option or view it as a like for like replacement, as it has previously done. This approach has left IT infrastructure as a patched-up estate, unable to function at its optimum.

Therefore, all hardware or software replacement, migration or upgrade will be completed with the clear objective of ensuring that the IT estate maintains a warranted environment, based on Microsoft and Cisco best practice to ensure it is manageable and sustainable moving forward for the organisation.

The invisible IT Workstream will also focus on cyber security, ensuring that all solutions have the latest security patches installed and being proactive in addressing new vulnerabilities. This includes ensuring that the Trust obtains the Cyber Essentials Plus accreditation, as required by NHS England by 2020.



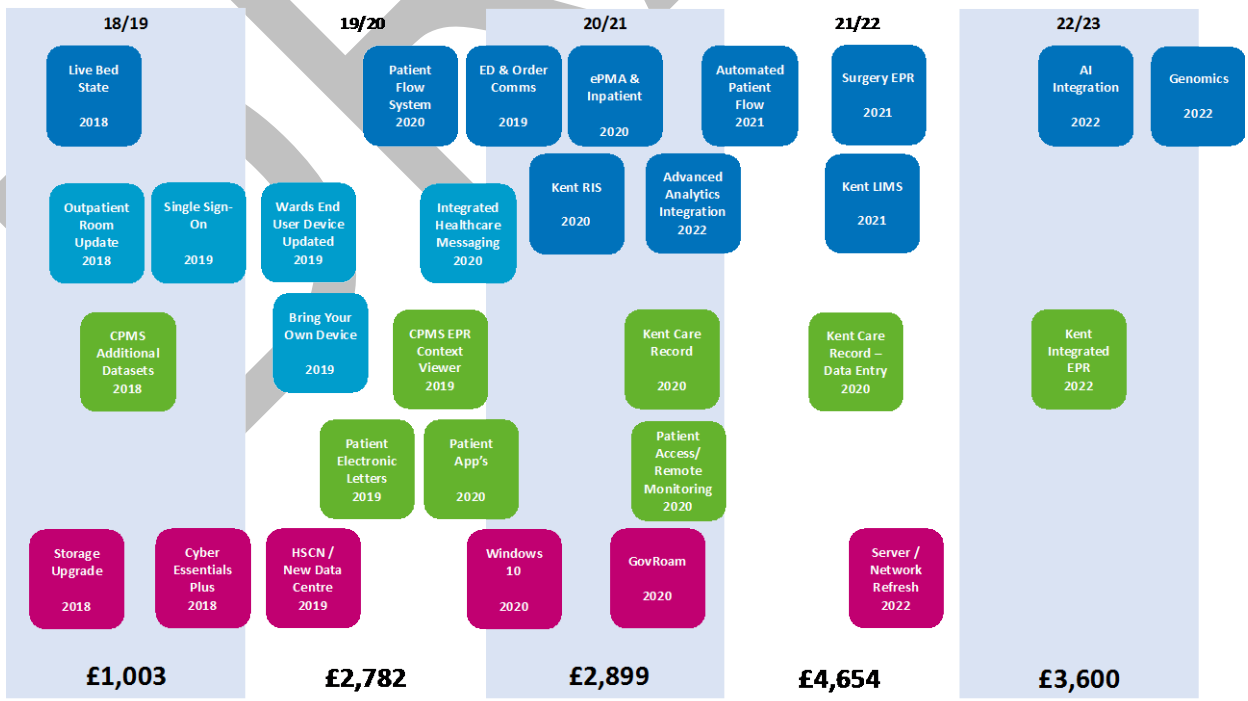
5. How will it be delivered?

To support the delivery of the strategy over the next 5 years a high-level plan is essential to ensure success. The plan has been developed in the form of a roadmap to provide a graphical overview to show which deliverables and go-live dates are achieved each year.

Although detailed planning has not been completed for all initiatives at this point the development of the roadmap has considered:

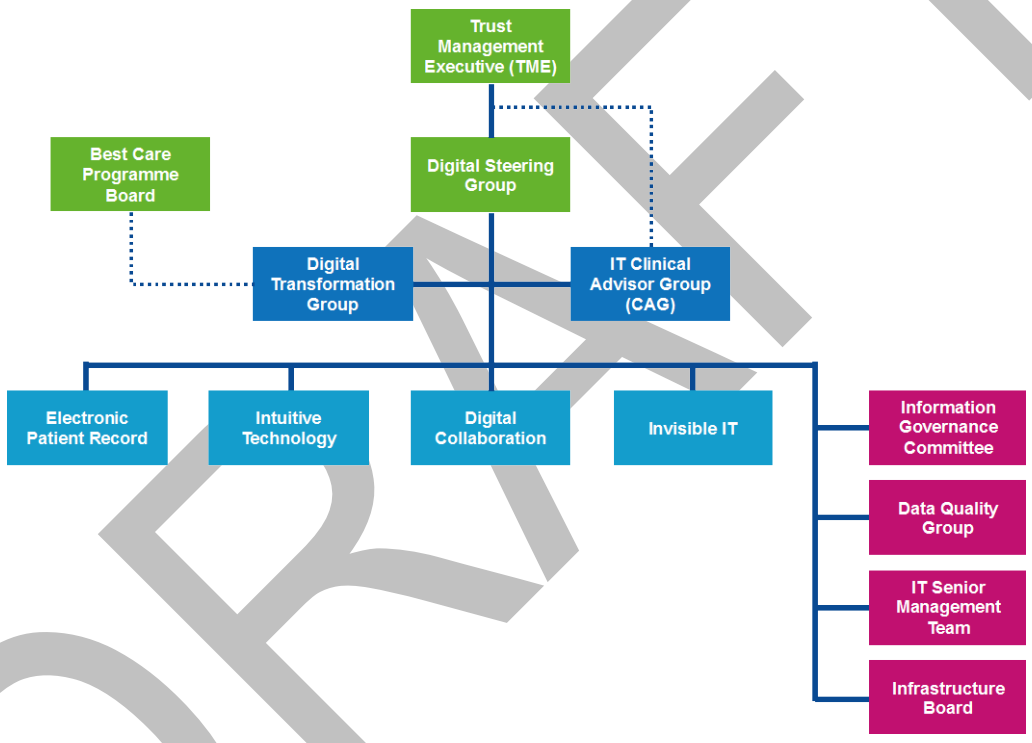
- National Targets – A number of national targets have been set (e.g. ePrescribing implemented by April 2020) which the Trust must meet.
- Local clinical needs, as detailed in section 3.1
- Interdependencies – What tasks must be completed to allow another initiative to achieve its objectives, such as the development of the ICP.
- Benefit – Ensure solutions are delivered to maximise the benefits for the organisation
- Change/Capacity – The ability of the Trust to manage and absorb the change resulting in the solutions being implemented.
- Costs – The overall cost of delivering the programme needs to be spread over 5 years and should not put undue financial pressure on the organisation.

Taking these into account has resulted in the development of the below Roadmap and forecast capital costs (£'000):



Funding for these initiatives will be sourced via Trust capital and revenue savings, as well as national funding schemes such as Health System Led Investment.

The Trust Digital Steering Group will oversee the delivery of the Trust's IT Strategy, with programme boards established for each workstream and the IT Clinical Advisory Group ensuring clinical engagement and leadership across the IT programme. The Trust has also established a Digital Transformation Group which aims to ensure that IT and deliverables of this strategy support and align to other strategic programmes across the organisation, including the best care programme. The below diagram provides an overview to the governance structure, with terms of reference available for each group.



A business case for each project will be developed and approved in line with the Trust's business case approval process before work is commenced and project activity will be reported back to the Digital Steering Group.

Each project will have an identified Senior Responsible Officer (SRO), Project Manager and Clinical Lead as a minimum. With other project members defined within the Project Initiation Document.

On completion of each project within the strategy a project closure report will be produced. This will include details of hand-over back to operations, a benefits realisation plan and lessons learnt.

Update on the NHS Long Term Plan	**Director of Strategy, Planning & Partnerships**

Enclosed for consideration is an update on the NHS Long Term Plan.

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
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NHS Trust

NHS long term plan implementation framework implications for MTW

18th July 2019

MTW
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The Seven Chapters of the NHS Long Term plan

Not covered in this document

Maidstone and Tunbridge Wells NHS Trust

1. A new service model for the 21st century
2. More NHS action on prevention and health inequalities
3. Further progress on care quality and outcomes
4. NHS Staff will get the backing they need
5. Digitally – enabled care will go mainstream across the NHS
6. Taxpayer's investment will be used to maximum effect
7. Next steps

MTW exceptional people, outstanding care

1 A new service model for the 21st century (1/2)

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How will the NHS deliver this?	What is required from us in the implementation framework?
1. Boosting ' out – of – hospital ' care' • Increased funding for GP practices to work together forming integrated multidisciplinary teams of GPs, social care and community health. Vanguards of this approach have proven ability to make a positive impact on emergency admissions • Investment in primary medical and community services will grow faster than the overall NHS budget. • Community health teams with new standard contracts supporting people in their own homes and there will be an enhanced health in care homes (EHCH) scheme • Building on recent gains, in partnership with local councils **further action to cut delayed hospital discharges will help free up pressure on hospital beds** • Improved responsiveness of community health crisis response services to deliver the services within two hours of referral	• Support PCN development • Linked to phased improvements, system plans will need to set out the quantified impacts expected on "downstream" hospital NHS utilisation, as well as better outcomes. This may be undertaken in the next 12-24 months in the light of planned improvements, rather than now. Leading systems should include some detail now
2. Redesign and reduce pressure on emergency hospital services • A single multidisciplinary Clinical Assessment Service (CAS) within integrated NHS 111, ambulance dispatch and GP out of hours services from 2019/20. By 2023 CAS will typically act as the single point of access carers and health professionals for integrated urgent care and discharge from hospital care. • **Fully implement the Urgent Treatment Centre model by autumn 2020** so that all localities have a consistent offer for out-of-hospital urgent care, with the option of appointments booked through a call to NHS 111. • Same Day Emergency Care. (SDEC). **Every acute hospital with a type 1 A&E department will move to a comprehensive model of Same Day Emergency Care. By 2019-20.** This will **increase the proportion of acute admissions discharged on the day of attendance from a fifth to a third.** • **Hospitals will also reduce avoidable admissions through the establishment of acute frailty services,** • **The SDEC model should be embedded in every hospital, in both medical and surgical specialties during 2019/20.** • Building on hospitals' success in improving outcomes for major trauma, stroke and other critical illnesses conditions, **'new clinical standards will ensure patients with the most serious emergencies get the best possible care.'**	• System plans should show how local urgent and emergency care services will continue to develop to provide an integrated network of community and hospital-based care. • Where systems can reduce the pressure on their emergency services they will benefit from an upside financial, capacity and staffing 'dividend' that can be reinvested in their local priorities

1 A new service model for the 21st century (2/2)

NHS
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How will the NHS deliver this?	What is required from us in the implementation framework?
3. People will get more control over their own health, and more personalised care when they need it. • Expansion of 'social prescribing' and personal health budgets reaching 2.5 million people by 2023/24 • Over 1,000 trained social prescribing link workers will be in place by the end of 2020/21 rising further by 2023/24	• Systems will be expected to set out how they will implement the six components of the NHS Comprehensive Model for Personalised Care as set out in Universal Personalised Care.
4. Digitally-enabled primary and outpatient care will go mainstream across the NHS. • Digital technology will provide convenient ways for patients to access advice and care. • A digital NHS 'front door' through the NHS App will provide advice, check symptoms and connect people with healthcare professionals – including through telephone and video consultations. • Over the next five years, every patient will have the right to online 'digital' GP consultations • Technology means an outpatient appointment is often no longer the fastest or most accurate way of providing specialist advice on diagnosis or ongoing patient care**. Over the next five years patients will be able to avoid up to a third of face-to-face outpatient visits, removing the need for up to 30 million outpatient visits a year.**	• Systems should identify which specialties they intend to prioritise as they work towards removing the need for up to a third of face-to face outpatient visits • Systems should also demonstrate in their plans how they will work with their CCGs and GP practices to deliver the commitments relevant to digital primary care – This includes the delivery of an online consultation offer in each practice by April 2020 and a video consultation offer to all patients by April 2021

2 More NHS action on prevention and health inequalities

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What is required from us in the implementation framework?

- Delivering service transformation of this scale requires a well-developed system and effective underpinning infrastructures. Plans must therefore set out how STPs will develop to become an ICS by April 2021
- Plans will be expected to conform to the ICS maturity matrix on the characteristics expected of Integrated Care Systems.
- Systems must show how they will reach the 'mature' level by April 2021.
- The characteristics of a mature ICS include:
  - Collaborative and inclusive multi-professional system leadership, partnerships and change capability, with a shared vision and objectives including an independent chair;
  - An integrated local system, with population health management capabilities which support the design of new integrated care models for different patient groups, with strong PCNs and integrated teams and clear plans to deliver the service changes set out in the Long Term Plan; improving patient experience, outcomes and addressing health inequalities;
  - Developed system architecture, with clear arrangements for working effectively with all partners and involving communities as well as strong system financial management and planning (including a way forward for streamlining commissioning, and clear plans to meet the agreed system control total moving towards system financial balance);
  - A track record in delivering nationally agreed outcomes and addressing unwarranted clinical variation and health inequalities;
  - A coherent and defined population, where possible contiguous with local authority boundaries.
  - Systems are expected to set out how they see the provider and commissioner landscape developing, for example to overcome challenges faced by providers in rural or remote locations. Proposals may include developing group structures or new approaches to collective decision-making. Guidance for aspirant provider groups will be published later in 2019, followed by the new 'fast-track' approach to assessing transactions for groups.
  - The Integrated Care Provider Contract will be published during summer 2019.

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3 Further progress on care quality and outcomes

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How will the NHS deliver this?

Better care for major health conditions

- Cancer
  - A new ambition that, by 2028, the **proportion of cancers diagnosed at stages 1 and 2 will rise from around half now to three-quarters of cancer patients**.
  - Lower the Bowel Cancer Screening Programme starting age for screening from 60 currently to 50
  - A **new faster diagnosis standard from 2020 to ensure most patients receive a definitive diagnosis or ruling out of cancer within 28 days of referral** from a GP or from screening underpinned by the start of **roll-out of new Rapid Diagnostic Centres (RDCs) in 2019**
  - Investment in new equipment, including CT and MRI scanners

What is required from us in the implementation framework?

- Local systems should engage with their Cancer Alliances to set out practically how they will deliver the Long Term Plan commitments for cancer over the next five years including on early diagnosis and survival, while improving operational performance through interventions by:
  - Improving the one-year survival rate.
  - Improving bowel, breast and cervical screening uptake;
  - Roll-out of FIT for symptomatic and non-symptomatic populations in line with national policy, and HPV as a primary screen in the cervical screening programme;
  - Improving GP referral practice;
  - Implementation of faster diagnosis pathways;
  - Improving access to high-quality treatment services, including through roll out of Radiotherapy Networks, strengthening of Children and Young People's Cancer Networks, and reform of Multi-Disciplinary Team meetings;
  - Roll-out of personalised care interventions, including stratified follow-up pathways, to improve quality of life.
  - Cancer Alliances will need to set out how the plans will address unwarranted variation, improve patient experience, and be supported by appropriate workforce.
- By 2023/24 over £400 million of additional funding will have been distributed to Cancer Alliances on a fair shares basis to support delivery of the Long Term Plan ambitions for cancer. Targeted funding will also be available to support the development and spread of innovative models of early identification of cancer:
- In 2019/20, Cancer Alliances are working to implement the first round of Rapid Diagnostic Centres (RDCs). RDC rollout will be agreed as part of LTP implementation planning in the Autumn.

3 Further progress on care quality and outcomes

NHS
Maidstone and Tunbridge Wells

How will the NHS deliver this?	What is required from us in the implementation framework?

• Adult mental health services
  • Spending at least £2.3bn more a year on mental health care
  • Helping 380,000 more people get therapy for depression and anxiety by 2023/24
  • Delivering community-based physical and mental care for 370,000 people with severe mental illness a year by 2023/24
  • Mental health liaison services will be available in all acute hospital A&E departments and 70% will be at 'core 24' standards in 2023/24, expanding to 100% thereafter.
	• Growing CCG allocations across the five-year period are available to systems to deliver the plan including stabilising and expanding core community teams for adults and older adults with severe mental health illnesses. This includes testing and rolling out adult community access standards once agreed, services for people with specific and complex needs for people with a diagnosis of 'personality disorder', Early Intervention in Psychosis (EIP), adult eating disorders, and mental health community rehabilitation.
	• In addition, all areas will receive a fair share of transformation funding from 2021/22 to 2023/24 to deliver these services in new models of care integrated with primary care networks

• Short waits for planned care
  • Patients will have direct access to MSK First Contact Practitioners (FCP).
  • Allocation of sufficient funds over the next five years to **grow the amount of planned surgery year-on-year, to cut long waits, and reduce the waiting list**.
	• Systems need to set out how they will expand the volume of planned surgery year-onyear, cut long waits, and reduce the size of waiting lists over the next five years.
	• Systems should confirm they are continuing to provide patients with a wide choice of options for quick elective care, including expanding provision of digital and online services.
	• Systems will ensure that no patient will have to wait more than 52-weeks from referral to treatment (RTT). They will also need to implement a planned NHS-managed choice process across the country for all patients who reach a 26-week wait, starting in areas with the longest waits and rolling out best practice through a combination of locally established targeted initiatives and nationally-driven pilots.
	• By 2023/24, systems should have scaled their provision of First Contact Practitioners (FCP) so that all patients across England have access. This will provide faster access to diagnosis and treatment for people with MSK conditions and support more patients to effectively self-manage their conditions

4 NHS Staff will get the backing they need

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What is required from us in the implementation framework?

- In line with the themes of the interim NHS People Plan, system plans will need to set out specific action to:
- Make the NHS the best place to work: Delivering the themes set out in the interim NHS People Plan, including setting targets for BME representation across its leadership team and broader workforce by 2021/22, improving mental and physical health and wellbeing and enabling flexible working. This includes responding to the requirements of the new Workforce Disability Equality Standard, introduced in April 2019
- Improve leadership culture: Establishing the cultural values and behaviours we expect from our senior leaders, implementing system-wide processes for managing and supporting talent, and developing strategies to support all staff to work in compassionate and inclusive leadership cultures;
- Deliver a holistic approach to workforce transformation and workforce growth ('more people, working differently'), including:
  - Setting out (after taking account of these efficiency plans) the workforce growth planned for different groups;
  - Show the action that will be taken locally to improve retention, international recruitment and maximise use of the Apprenticeship Levy;
  - Ensuring that overall efficiency and productivity plans (Chapter 8) include practical, system-wide action to improve workforce efficiency and release greater time for care, including changes in skill mix, new ways of working, better use of scientific and technological innovation, and reductions in sickness absence.
- Change the workforce operating model: Describing – as part of broader ICS development – plans to develop the capacity (including prioritising urgent action on nursing shortages), capability, governance and ways of working. This will enable ICSs to take on growing responsibility for workforce and people activities, informed by the capacity building diagnostic and tool that we have developed with local systems.

5 Digitally – enabled care will go mainstream across the NHS

Key questions for the board

NHS Maidstone and Tunbridge Wells

What is required from us in the implementation framework?

- Systems need to develop a comprehensive digital strategy and investment plan consistent with the Tech Vision that describes how digital technology will underpin their local system's wider transformation plans over the next five years. This includes, amongst other priorities, their approach to ensuring all secondary care providers are fully digitised by 2024 and that these are integrated with other parts of the health and care system, for example through a local shared health and care record platform.
- These strategies should describe:
  - How and when each organisation will achieve a defined minimum level of digital maturity;
  - How they will adopt Global Digital Exemplar (GDE) Blueprints and an approach based on IT system convergence to reduce unnecessary duplication and costs;
  - How they will adhere to controls and use approved commercial vehicles such as the Health System Support Framework to ensure technology vendors and platforms comply with national standards for the capture, storage and sharing of data.
- Systems are expected to set out plans for how they will significantly improve the provision of services and information though digital routes aligned to national standards and requirements. The newly created NHSX will ensure that the NHS has clear guidance and support to accelerate progress in this area. Systems can draw on a range of national platforms, such as the NHS App and NHS Login and nationally led support and programmes to develop and deliver their plans, such as the Provider Digitisation programme. Local systems should drive forward digitisation focussed on the user need and engage staff and patients in its development.
- The priority for NHSX will be defining and mandating technology standards for all systems and platforms used in the NHS and ensuring all publicly funded source code is open by default. Details of the mechanisms that will be used to support and drive the implementation of these universally across the NHS will be published later this year. Following this, systems will need to ensure any locally developed or procured services meet these standards, ensuring full interoperability with the national infrastructure and other local services.
- The security of data within the NHS is critical. By summer 2021, it is expected there will be 100% compliance with mandated cyber security standards across all NHS organisations

7 Next steps

NHS
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Milestone	Date
Interim People Plan published	3 June 2019
Publication of the Long Term Plan Implementation Framework	June 2019
Main technical and supporting guidance issued	July 2019
Initial system planning submission	End of September 2019
System plans agreed with system leads and regional teams	Mid November 2019
Further operational and technical guidance issued	December 2019
Publication of the national implementation programme for the Long Term Plan	December 2019
First submission of draft operational plans	Early February 2020
Final submission of operational plans	By end March 2020

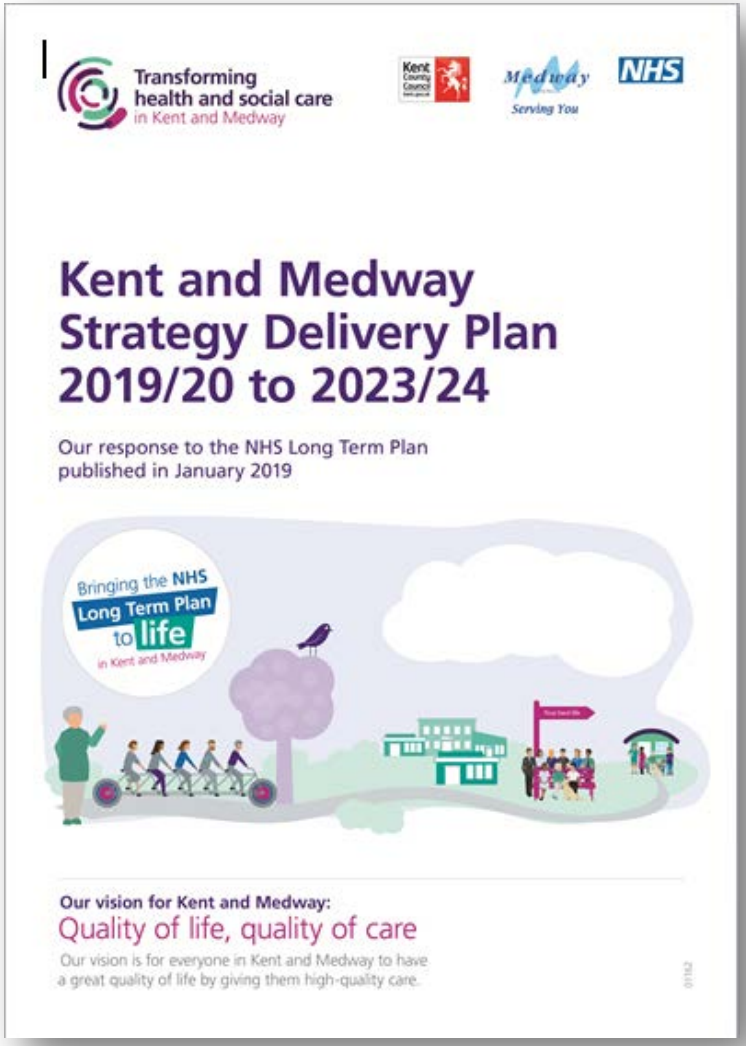
Systems are asked to provide two elements at both the September and November milestones:

- **Strategy delivery plan: A document that sets out what the system plans to deliver over the next five years. Whilst there is no template for this document, systems are encouraged to ensure that their plan covers all the elements set out in Chapter 1 of the Implementation Framework, including: a description of local need; what service changes will be taken forward and how; how the local system infrastructure will be developed – including workforce, digital and estates; how efficiency will be driven through all local activity, how local engagement has been undertaken to develop the plan and how financial balance will be delivered;**
- **Supporting technical material: Successful delivery will require systems plans to be underpinned by realistic plans for workforce and activity, which must be delivered within the local financial allocation. A full version of the finance and activity template will be provided in early July 2019.**

7

The STP has begun the formulation of a response to the implementation framework but most of the content is still in development

Maidstone and Tunbridge Wells NHS Trust



Transforming health and social care in Kent and Medway

Kent and Medway Strategy Delivery Plan 2019/20 to 2023/24

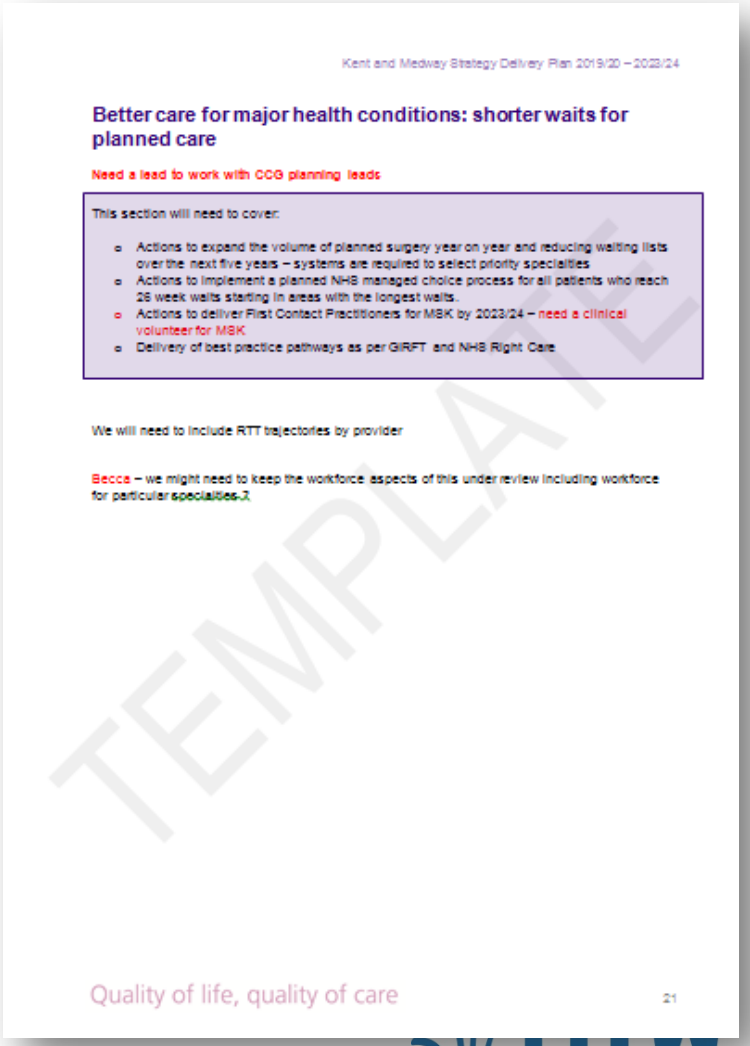
Our response to the NHS Long Term Plan published in January 2019

Bringing the NHS Long Term Plan to life in Kent and Medway

Our vision for Kent and Medway:

Quality of life, quality of care

Our vision is for everyone in Kent and Medway to have a great quality of life by giving them high-quality care.



Better care for major health conditions: shorter waits for planned care

Need a lead to work with CCG planning leads

This section will need to cover:

- Actions to expand the volume of planned surgery year on year and reducing waiting lists over the next five years – systems are required to select priority specialities
- Actions to implement a planned NHS managed choice process for all patients who reach 26 week waits starting in areas with the longest waits.
- Actions to deliver First Contact Practitioners for MSK by 2023/24 – need a clinical volunteer for MSK
- Delivery of best practice pathways as per GIRFT and NHS Right Care

We will need to include RTT trajectories by provider

Becca – we might need to keep the workforce aspects of this under review including workforce for particular specialities ?

NHS
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Report from the Freedom to Speak Up Guardian **Freedom to Speak Up Guardian**

Enclosed is the second report to the Board by the Freedom To Speak Up Guardian (FTSUG) which now outlines and identifies trends, issues and the resource requirement to move the FTSU agenda forward.

Introduction

The FTSUG's purpose is to;
- Protect patient safety and the quality of care
- Improve the experience of workers
- Promote learning and improvement

By ensuring that;
- Workers are supported in speaking up
- Barriers to speaking up are addressed
- A positive culture of speaking up is fostered
- Issues raised are used as opportunities for learning and improvement

The main trend has been concerns of bullying and harassment, in particular on the Tunbridge Wells site. This trend is reasonably in line with national concerns that are being raised through the Speaking Up process. Whilst these concerns are not directly about patient care in themselves, there are direct links between patient care / patient outcomes and staff wellbeing.

In the last quarter there have been 15 concerns raised, 8 of which are bullying and harassment and all apart from 1 at the TWH site. Of most note, one concern has been raised to the FTSU Guardian relating to a breach of confidentiality from a concern they previously raise within a department on the TWH site. This is clearly not in line with the national or local policy of enabling staff to raise concerns in confidence and receive no detriment in doing so. A breach of confidentiality in such instances can have a significantly detrimental impact upon staff feeling safe and protected in raising concerns. This concern is being investigated and a report and findings / recommendations will follow.

Growing the Speaking Up Agenda

Further to recruiting Debbie O'Reilly (Site Lead Orthoptist @ TWH) as an Ambassador, Nayadzai Priscillah Ruzayi (Ward Manager SSSU @ TWH) has also been recruited and discussions have taken place with other staff members and volunteers to seek out speaking up ambassadors. The TWH site will be targeted as an area to find appropriate individuals to be Ambassadors alongside the recruitment aims of having a spread of Ambassadors across the Trust.

Currently resourcing the FTSU Guardian role to provide a full and effective process and promotion of speaking up has been a challenge. The FTSUG role sits as a dual role within the Occupational Health Department. A review of this department and its structure has taken place and through moving budget allocation within the department's finances, a change in structure and staffing is hoped to help release time to enable the FTSUG to better serve the increasing demands of this role. However this will not have worked through until the 3rd quarter of 19/20.

Re-Writing the Policy (Freedom to speak up: raising concerns policy and procedure)

The new policy has concluded the consultation process and is being prepared for submission to the Policy sub Committee. The new policy will provide a platform to promote the speaking up agenda and publicise the speaking up team.

Networking

The Guardian continues to attend Regional and Local Network Meetings to share best practice and provide peer support in undertaking the role. The networks also provide an opportunity to raise requests to the National Office as a collective on aspects of undertaking to role.

Data Collection; Concerns Raised

'19/'20 Month	No. of contacts	Anonymous	All Open Cases
April	4	1	1
May	6	2	2
June	5	2	4
July			
August			
September			
October			
November			
December			
January			
February			
March			
Total	**23**	**9**	**7**

Quarter	Month/Year	No. of Contacts
Q1	April-June '18	0
Q2	July-September '18	0
Q3	October-December '18	2
Q4	January-March '18	8
Total	**2018/19**	**10**

Quarter	Month/Year	No. of Contacts
Q1	April-June '19	15
Q2	July-September '19	
Q3	October-December '19	
Q4	January-March '20	
Total	**2019/20**	**15**

Staff Group	Number
Estates & Facilities	1
Nursing	2
Midwifery	0
Medical	0
AHP's	0
Clinical Support	6
A&C	1
Unknown	5
Total	**15**

Theme	Number
Patient Safety	0
Bullying/ Harassment	8
Fraud	0
Health & Safety	2
Other	5
Total	**15**

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information, assurance, 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

7 Day Services board assurance self-assessment	**Deputy Medical Director**

Enclosed is a copy of the national return sent to NHS England on 26/06/19 in respect of the Trust's 7 Day Services Board Assurance Template (BAT) requirement.

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	**2019/20**
Period	**Spring/Summer**

Priority 7DS Clinical Standards

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.

Board/sub-committee that signed off this template as an accurate reflection of the Trust's position:	**Scheduled for July Board**
Date the template and supporting documentation went to Board/sub-committee:	**Scheduled for July Board**
Was this template accompanied by supporting documentation, if so what?	**Casennote Audit/Survey Report and Service Model Report with compliance**

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.	The Trust has adopted a thorough assessment process to identfy the compliance status of all service models which is triangulated with job plans. Following 2 years of project effort, all Trust services are now complaint during weekdays for this standard. There now remains only a very small proportion of weekend activity in ENT, Urology and General Surgery (a total of 12.2 cases on Saturday and on Sunday - ENT = 2.5, Urology = 1.2 and Surgery = 8.5) that cannot curently be covered by on-site, job planned consultant cover until strategic plans deliver later in the year. During these periods, mitigating measures have been established for these services which include an evening virtual ward round on Saturdays and Sundays between the on-call Consultant and the resident senior middle grade tier. During the call, all new admissions and any medically active patients are reviewed. The Consultant will then attend if concerns are identified. To achieve full complaince by March 2020, strategic plans are in place which involve moving all of surgery to a single site (by end October 2019) and the appointment to consultant vacancies in surgery and additional consultants in urology (by December 2019). A review of the consultant workforce is currently underway in ENT which includes the average daily (weekend) 2.5 non-elective admissions that cannot currently be covered by resident consultant cover. An ambulatory care model is also being reviewed for ENT. The Trust is unable to fully evidence its compliance status via the 7DS casenote audit process as the figures are negatively distorted due to the presence of manual records and subsequent issues with documentation standards. To demonstrate, the casenote audit undertaken for this Board Assurance Return showed a compliance rate of only 67% for standard 2, which does not reflect what we know is taking place in each service. In light of this, the Trust has implemented a Documentation and Record-keeping review project via the Best Safety Workstream of the Best Care Programme.	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 could be at risk to full compliance during out of hours periods until the 24/7 GI Bleed Rota is implemented (planned for Q4 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 available off site via formal arrangement	Yes available off site via 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 could be at risk to full compliance during out of hours periods until the 24/7 GI Bleed Rota is implemented (planned for Q4 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.	The casenote audit undertaken for this Board Assurance return showed a 82% compliance rate. As stated in standard 2 above, the Trust has adopted a thorough assessment process to identfy the compliance status of all service models which is triangulated with job plans. For the once daily reviews, our service models are now compliant for Surgery, Urology, T&O, Paediatrics, Women's Health, Emergency Medicine, Clinical Haematology, Ophthalmology and Critical Care. Medical sub-specialties are currently unable to deliver a job planned daily ward round across both sites 7 days per week due to Consultant workforce constraints. This has been analysed in detail and is outlined in full in the Medicine & Emergency Care Division's paper which was previously submitted (with the February 2019 Board Assurance return). This shows that in spite of various service model changes and best practice developments, 23 further Consultants would need to be in post (inclusive of the 5 existing vacancies) to cover both sites on a 24/7 basis. ENT have a very small amount of non-elective activity (average 2.5 per day) which cannot be guaranteed to have full resident cover due to the small number of consultants and two-site working. As stated in standard 2, a consultant workforce review is in progress, together with a review of improving ambulatory care options. For the twice-daily ward rounds, all patients who are ICS Level 2 or above receive a twice daily ward round via a combination of their specialty consultant and the ICU consultant Team (who are present 24/7). The exception is respiratory (NIV) patients who will need to be cohorted on one site to achieve this standard, (part of the Medicine & Emergency Care Division's paper previously submitted).	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: Yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is 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
Standard 1: Involvement: MTW's new patient engagement strategy: "Making it personal – Improving the Experience of Patients and Carers' sets out to ensure that patient experience is everyone's responsibility. This builds on our organisation's values putting the patient at the centre of everything we do. Through external events, we asked our patients for feedback on what they identified as their priorities for us to deliver. Using this feedback and information that we were able to co-produce and design, the new patient engagement and experience strategy which is being launched following presentation to the Trust Board in July 2019. There are ten key commitments in the strategy, of which patient involvement is both the golden thread through the strategy, as well as being one of the 'always do' commitments. The strategy is a key enabler of the cultural shift that puts patients and staff at the heart of planning and decision making in a healthy, responsive organisation as envisaged in the Trust's Quality Strategy. Patient satisfaction reflects patient's involvement in decision making and their role as partners in improving the quality of healthcare services. Listening to our patients, carers and service users through feedback obtained in an accessible way for both patients and staff will provide the essential information gathering required to be responsive to make change and improvements. Our latest Friends & Family statistics show an overall position of 4.70/5.00 for patient, family and carer involvement across the Trust. The results of the National In-patient Survey show a steadily improving picture (over the last 5 years of data) in respect of the fields that include information giving, involvement, understandable discussions and consistency. The Trust are aiming to improve upon this by embedding the strategy and the commitment to resourcing a dedicated Patient Experience Lead. Standard 3: There is a multi-professional approach to the delivery of care to all patients across all ward areas daily. All AHP disciplines are allocated to specific wards as part of the multi-professional team. A holistic patient assessment is undertaken on every patient by the admitting nurse, supported by the integrated care plan (which compliments the 14 hour consultant-led assessment). Discharge planning commences at the point of admission and involves the whole system Integrated Discharge Team (IDT) which works collaboratively with the Social Care and Community Nursing Teams. The Trust has also implemented a Therapy Assisted Discharge Team (TADS) which offers a 7 day service to provide therapy as required to patients on discharge from hospital. . Medicines' reconciliation is at 80% across the Trusts (which is higher than the National average). Standard 4: The Trust's clinical disciplines undertake shift handovers twice daily, led by a senior clinical decision-maker, 7 days per week, where there are services 7 days a week. There are a few small exceptions (eg., weekend Urology) which is part of the workforce review referred to earlier in this report. Nursing handovers take place at 7am and 7pm, 7 days per week. Site handovers take place 3 times per day at 09.00hrs, 13.00hrs and 16.30hrs, 7 days per week (during which complex patients are discussed). This includes all Divisions and AHPs. Not all handovers are recorded electronically but it is hoped that the implementation of the Trust's Electronic Patient Record System, (Sunrise) from Oct 19 will support a change. At night, the Clinical Site Manger participates in the medical handover to have oversight of the Trust position and highlight key concerns to the Critical Care Outreach team who are available 24/7. Standard 7: Maidstone and Tunbridge Wells Hospitals do not yet have a formal Core 24 liaison psychiatry service. However, following on from our winter plan and a test of change we have put in place, Maidstone Hospital has access to urgent assessment in A&E 24/7. This has been well received and there are plans to implement the same service at Pembury. There is ongoing discussion about developing a Core 24 Service that would offer a 24/7 psychiatric service to the whole hospital. A pilot model has been put in place which aims to provide a consistent 1 hour response to Maidstone A&E Department in line with some of the Core 24 Liaison Psychiatry model specification principles, as supported by the Five Year Forward View for Mental Health. The Liaison Psychiatry Service (LPS) at Maidstone General Hospital will continue to operate from 8am to 8pm but will shorten their target response times from 2 hours to 1 hour for referrals from A&E and from 48 hours to 24 hours for referrals from the inpatient wards. The Crisis Resolution Home Treatment (CRHT) team will provide dedicated resource to the A&E Department overnight, from 8pm to 8am, and continue to provide the same 1 hour response. Standard 9: Compliant (Confirmed by CCG - 2.5.19). The system has the following services in place: • Appropriate senior clinical expertise (e.g. via phone call), provided by NHS 111 CAS, the Home Treatment Service (HTS) and IC24 professional on scene line • G4S provide a 7 day service with MTW's Tier 1 transport support • Local A&E Delivery Board is the forum used to develop strong health and social care relationships Standard 10: The Trust currently compiles a CLIPA (Complaints, Litigation, Incidents, PALs and Audit) report highlighting key issues identified and lessons learned which is circulated to every clinical area on a monthly basis. In addition a Trust-wide Governance Gazette and Medicines Safety News is produced to raise awareness of key areas of concern. The Trust is in the process of implementing a 'Lessons Learned' programme across the organisation to support each Directorate to extract their monthly learning outcomes (via a new electronic system; Datix Cloud IQ system). This new system will also support a new way of undertaking mortality reviews and a full performance dashboard which has the ability to provide detailed searches on all fields. The Lessons Learned project will ensure that all learning outcomes are discussed and disseminated to all staff. This will be further supported through the revised monthly Directorate, Divisional and Trust level Clinical Governance Meetings.

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

Finance and Performance Committee, 23/07/19: Approval of Business Case for a patient tracking system	**Chair, Finance & Performance Committee / Chief Operating Officer**

Enclosed is the Business Case for a real time patient flow and tracking system. The Case requests approval for the purchase of two separate initiatives to support patient flow. The two initiatives are entirely independent of each other and are to be considered in isolation.

Part 1 Real Time Patient Flow Tracking Solution

This proposal requests the purchase of a real time patient tracking solution to reduce the wasted time currently seen within MTW of the existing bed stock whilst discharging and admitting patients. This is achieved by real time visibility of the available bed stock, alerting the site operations team that the patient has left the bed and automatically mobilising portering and bed cleaning teams to ensure that the bed is turned around in a timely manner. The system will automate many of the functions of patient flow releasing nursing time back to care and reducing the administrative burden on managing patient flow. Currently MTW take in excess of 400 minutes to turnaround each bed, international best practice shows with this type of system the turnaround can take place in 29 minutes.

Part 2 Hygiene Solutions

Hygiene Solutions already supply the Trust with room decontamination equipment, they have developed their technology and this proposal discusses the benefits from the Trust adopting this newer technology. The time to undertake a level 4 clean will reduce to 2 hours from in excess of 4 hours due to the technology changes described in the case. This has the benefit of releasing a further 55 bed days each year due to the reduced time taken for each clean.

As the Case exceeds the threshold by which Trust Board approval is required (£1m), the Finance and Performance Committee will be asked to review the Case and make a recommendation to the Trust Board (hopefully to approve the Case), to inform its decision on the Case. The outcome of the review by the Finance and Performance Committee will be reported at the Trust Board meeting on 25/07/19.

Which Committees have reviewed the information prior to Board submission?

- Finance and Performance Committee Meeting, 23/07/19 (am)
- Executive Team Meeting, 23/07/19 (pm)

Reason for receipt at 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

ID Reference	Business Case Title
668	**Real Time Patient Flow and Tracking System**

Context:-

The current approach to patient flow at MTW is a traditional model based on wards reporting their current situation and escalation / planning meetings that take place throughout the day. This is supported by bed management and patient flow staff that visit wards, assessment and procedural areas throughout the day to; assess progress of potential discharges and gain visibility of available capacity. There are a significant number of ward visits and phone calls to wards by patient flow staff.

Proposed Benefits:

- The benefits of utilising a Real Time Patient Flow system is that it can provide real time views of patient flow and bed capacity across, single hospitals, multiple hospitals and Post-acute capacity.
- Cash releasing - Opportunity to reduce cost of Winter Resilience plan, avoided costs from investment in additional bed capacity, potential option to remove the patient flow coordinator role and resize the portering services.
- Non-cash releasing – Improved position with RTT and ED performance
- Quantifiable & Qualitative benefits - Release of nursing time, improved staff experience, reduction in patient outliers and a subsequent reduction in length of stay, reduction in patient harm

Proposed delivery risks:

- Failure to comply with best practice to recognise benefits and savings delivered by a Real Time Patient Flow solution. Likely due to the change required in staff behaviour. This will be mitigated by using champions of the system available on both sites and support from the provider of a solution.
- The organisation is about to embark on a major EPR deployment (Allscripts) for Spring 2020. A Real Time Patient Flow solution implementation and transformation process would have to be coordinated with as the 2 projects have mutual benefit.

ID Reference	Business Case Title
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Context:-

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- The benefits of utilising a Real Time Patient Flow system is that it can provide real time views of patient flow and bed capacity across, single hospitals, multiple hospitals and Post-acute capacity.
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- The organisation is about to embark on a major EPR deployment (Allscripts) for Spring 2020. A Real Time Patient Flow solution implementation and transformation process would have to be coordinated with as the 2 projects have mutual benefit.

Additional Information:

Finance Summary

Revenue:-

- £1.3m investment in year 1 (2019-20) with cash releasing savings of £0.6m starting from year 2.
- Ongoing investment of £1.5m from year 2 partly offset by £0.6m cash releasing savings creating a net pressure of £0.9m.
- There are non-cash releasing savings identified of c£1.8m in a full year starting from year 2 mainly relating to bed closures and patient flow co-ordinator savings. One of the objectives is to reduce the current high bed occupancy rate and as a result it is unlikely that the Trust will close beds and therefore will not generate the cash releasing saving.

Capital:

- The required capital investment is £280k over the 10 years of the project (£140k in 2019-20).

The revenue and capital requirements are not included in the Trust Plan or Month 3 forecast outturn position. Therefore is the preferred option (3a) is agreed additional CIP of £1.3m will need to be delivered in year. Further prioritisation of the capital plan would be required.

Maidstone and Tunbridge Wells NHS Trust

Business Case - Real Time Patient Flow and Tracking Solution

Issue date	July 2019
Department	Trust-wide
Directorate	Trust-wide
Author	
Clinical lead	
Executive sponsor	
ID reference	

Approved by	Name	Signature	Date
General manager			
Finance manager			
Clinical Director			
Executive sponsor			
Supported by	**Name**	**Signature**	**Date**
Director Estates & Facilities			
Director of Informatics			
HR Business Partner			
Approved by	**Name**	**Minute**	**Date**
Directorate Board			
Investment Appraisal Group			
Trust Management Executive			
Finance Committee			
Trust Board			

The Business Case Summary

Strategic context

Following a live audit of patient flow (See appendix 3) beds at MTW are unavailable for **>400 minutes per day** as they are; unnecessarily occupied, empty but undeclared in real time, allocated to a patient but unoccupied, empty but not cleaned, or clean but undeclared this is our 'idle bed time' (table 1: described various examples of Idle bedtime).

Table 1: Examples of Issues that contribute to long periods of Idle Bedtime

Idle Bedtime examples	
Area of Idle bedtime	Real World examples
Lack of Real-Time Notification (90 min)	Beds empty but undeclared
	Patients in beds who could be in a discharge lounge
	Beds only found by bed manager finds them (clean or uncleaned)
	No clear view of patients who could be or scheduled for discharge by day or by time of day
	Declaring an empty bed left to administration staff / nursing staff - who often batch this activity
Area of Idle bedtime	
Bed Turnaround time (287 min)	Bed cleaning left to nursing staff (who often have other priorities)
	Bed cleaning not a priority in ward work
	Non-standard bed cleaning or confusion on terminal cleaning regime leads to delay or rework
	When bed is cleaned no notification that it is available and clean
Area of Idle bedtime	
from bed assignment to bed Occupied (114 min)	Patients with a DTA but are still unstable in ED, but have been allocated a bed on a ward
	A patient in Admissions lounge / Operation Theatre / Recovery with a bed allocated to them and portering delays

Source of baseline assumption data on Idle Bed time taken from baseline measurements from Trusts before deployment of a Real Time Patient Flow Solution

Many Trusts using a Real time Patient flow solution have the potential to reduce this Idle bed time to as little as **85 minutes**.

Royal Wolverhampton (NHS) Hospitals have reduced their bed cleaning time from 280mins to a consistent 30 mins per bed which significantly contributed to saving 56 beds

The current approach to patient flow at MTW is a traditional model based on ward reporting their current situation and escalation / planning meetings, that take place throughout the day. This is supported by bed management and patient flow staff that visit ward, assessment and procedural areas throughout the day to; assess progress of potential discharges and gain visibility of available capacity. There are a significant number of ward visits and phone calls to wards by patient flow staff.

The deployment and support from the deployment of a Real Time Patient Flow solution would; significantly support the current Maidstone and Tunbridge Wells strategies to:

1. Maintain sustainable year-round elective activity. Equivalent to ~40 to ~60 beds per year available to the Trust (worth ~3m per annum in bed capacity)
2. De-risks the delivery and costs of operationalising Winter Plans
3. Reduce the instances and scale of disruption caused during periods of high demand to front line wards. By releasing ~2000 hours of nursing time per month.
4. A positive impact on Nursing sickness, absence and attrition & Modest reductions in Nursing Agency costs
5. Support the Trust in achieving 'real time' patient flow in line with the NHSI expectation on 'electronic bed monitoring' by Q3 FY19-20.

Additionally, positively impact Length of Stay ambitions and capacity challenges especially across the Winter periods. Improving RTT and ED performance and create opportunities to reduce the numbers of elective cases 'outsourced' from MTW.

The conclusion is that

- The Trust has the leadership commitment and approach for a successful implementation of a Real Time Patient Flow solution.
- The Trust has proven management and transformation capability to deploy large scale change and IT programmes
- The Trust has senior management and management capability to ensure a competent deployment of a Real Time Patient Flow solution.
- The Trust commits to work actively with the provider best practices to drive the benefits from using the systems.

- There are 'NO' red flags in terms of the transformation work and operational bandwidth required to deploy a real time tracking solution, with existing processes and structures in place.

Return significant amounts of direct nursing time, improve planning and reduce the variable costs of the nursing workforce positively impacting clinical safety. Removing the need for the 'ward level' Patient flow coordinator role.

Objectives of the investment and the problems with the status quo

The objective aim of the investment is to fully utilise the productivity of the current bed base at the two sites. It is the view that there is significant bed availability within the current bed base that can be released by providing a real time patient flow solution. The real time solution should have an auto discharge function to automatically identify when a bed is empty and automate the functions required immediately a patient has left a bed.

The current approach to patient flow is a traditional model based on: wards reporting their current situation and escalation/ planning meetings that take place throughout the day.

This is supported by bed management and a number of ward-based patient flow coordinators and senior peripatetic patient flow staff/nurses that visit ward, assessment and procedural areas throughout the day to; assess progress of potential discharges and gain visibility of available capacity. The issues are as follows:

- There are a significant number of ward visits and phone calls to wards by patient flow staff. With significant liaison on patient movement and flow between the two main sites.
- Despite the efforts of this process and inputs from the experienced teams in managing patient flow the trust is experiencing significant issues with maintaining a live real time bed state to support demand and capacity planning,
- Need to invest in escalation beds, especially over the 'winter period'
- Winter Planning related costs incurred in doing this from the additional staffing.
- Reduced capacity across the Winter Period for Planned Care activity, that worsens RTT performance
- Poor Flow contributes to the activity that is outsourced incurring additional cost
- The current process also generates a number of patient outliers, who extend length of stay
- Creates significant additional work burden for ward-based nurses in managing patient flow vs time for direct patient care. Which attributes to poor morale and staff attrition

In the 2017/2018 annual report, from NHS England, on Delayed Transfers of Care (DToC) and it showed an improvement in the total numbers of bed days lost due to DToC. But, continued to show that 25% of the discharge delays, in hospitals, are attributable to delays in placing patients in nursing and residential homes.

Table 2: Breakdown of DToC patients waiting for post-acute placement

Reason	Percentage
Awaiting placement in a residential home	11.4%
Awaiting placement in a nursing home	14.3%

(source NHSE annual DToC report 17/18)

One of the key challenges to MTW is simple visibility of beds available in specific Residential and Nursing Homes within its catchment area, that provide either Pathway 3 provision or Social Care step down, and ensuring that this information is available to support discharge planning without logging into multiple IT systems or making multiple phone calls.

Nursing and Residential Home providers also want to communicate their current capacities to health and social care providers again without multiple touch points and calls.

The benefits of utilising a Real Time Patient Flow system is that it can provide real time views of patient flow and bed capacity across, single hospitals, multiple hospitals and Post-acute capacity.

The do-nothing option is not acceptable as it will perpetuate the current issues with patient flow for both sites

The main benefits expected from the investment

The Trust would expect benefits in the form of three main areas:

- Cash releasing - Opportunity to reduce cost of Winter Resilience plan, avoided costs from investment in additional bed capacity, potential option to remove the patient flow coordinator role and resize the portering services.
- Non-cash releasing – Improved position with RTT and ED performance
- Quantifiable & Qualitative benefits - Release of nursing time, improved staff experience, reduction in patients 'outlied' and a subsequent reduction in length of stay, reduction in patient harm

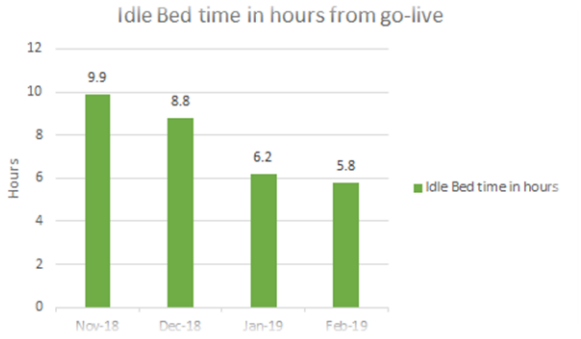
Table 3

Benefits of Making Post-Acute Capacity	
MTW & Partners	Nursing & Residential Homes / Community and Social Care
Daily visibility of available capacity of post-acute beds	One system to log into (usually daily)
Available capacity visibility at the time of discharge ward rounds and complex discharge reviews – without delaying tasks till later and prolonging LOS and decisions	Updates on capacity and availability live on system without need for multiple calls out and in from multiple organisations
Improved communication with Post-Acute facilities	Can describe any specific notifications to commissioners and MTW on e.g. Infectious out breaks / or bed closures due to staffing
Support the development of new models of care / widen integration	Describe beds available by use e.g. respite, nursing, residential, dementia nursing
	Provide viability of virtual ward and rapid response capacity

New Ways of working

In relation to post-acute capacity, a Real Time Patient Flow solution would consider all capacity either physical or virtual beds (Virtual Wards) to be available capacity in the system. Post-acute capacity would also include slots in rapid response/Pathway 1 that schedule care around the patient at home. All of this can be visualised via a patient flow system expanding the scope and capacity for patient care.

Appendix 1 describes the year one benefit to MTW, this is based on full year effect of year 1 go live so this would span 2 financial years



The main risks associated with the investment

1. Failure to comply with best practice to recognise benefits and savings delivered by a Real Time Patient Flow solution. Likely due to the change required in staff behaviour. This will be mitigated by using champions of the system available on both sites and support from the provider of a solution.
2. The organisation is about to embark on a major EPR deployment (Allscripts) for Spring 2020. A Real Time Patient Flow solution implementation and transformation process would have to be coordinated with as the 2 projects have mutual benefit.

Available options

1. Do nothing
2. Do Nothing - continue trying to effect bed management/patient flow through the current PAS
3. (a) Implement a Real Time Patient Flow solution with Auto Discharge to realise benefits before Winter bed pressures this FY
   (b) Implement a Real Time Patient Flow solution with Auto Discharge to realise benefits following Winter bed pressures, April 2020
4. Implement a Real Time Patient Flow system with a full Real Time Location Services (RTLS) provision.

The preferred option

Purchase and implement a Real Time Patient Flow solution with RTLS Auto Discharge (3a) with costing and provision to expand the service to a RTLS capability for ward level: Asset finding, Staff and Patient Tracking and asset tracking within 18 months of initial deployment.

Funding, affordability	Revenue Investment in year 1 (2019-20) £1.3m with cash releasing savings of £0.6m from year 2 with an ongoing investment of £1.5m. Net pressure of £0.9m. There are non-cash releasing savings identified of C£1.8m in a full year (from year 2).
	Capital £140k in 2019-20 and £140k again in year 6.

Management arrangements

The preferred supplier will be expected to include a project manager and implementation team for the role out of the software solution and to provide initial training in a "train the trainer" model.

An 8a Project Manager will be required to liaise between the preferred supplier and the directorates, produce and manage project documentation and monitor and manage progress against the project plan.

A project team and steering board would be established to oversee the rollout of the new software and to ensure that budget, timelines and best practice are adhered to and that there is a hand over to 'business as usual teams', who will be responsible for maintaining the system throughout the contract.

The conclusion of the assessment is that

- The Trust has the leadership commitment and approach for a successful implementation of a Real Time Patient Flow Solution.
- The Trust has proven management and transformation capability to deploy large scale change and IT programmes
- The Trust has senior management and management capability to ensure a competent deployment of a Real Time Patient Flow Solution and the will and insight to drive the benefits from using the systems.
- There are 'NO' red flags in terms of the transformation work and operational bandwidth required for implementation, with existing processes and structures in place.
- There are challenges – for instance the go-live of an Allscripts EPR which is planned to go live Spring 2020 will need to be planned if at the same time as a potential Real Time Patient Flow Solution go-live.
- Failure to comply with best practice to recognise benefits and savings delivered by a Real Time Patient Flow solution. This could occur due to the change required in staff behaviour to managing discharge and patient flow. This will be mitigated by providing suitably trained champions of the system available on both sites and support of organisational change from the provider of a solution.
- The organisation is about to embark on a major EPR deployment (Allscripts) for Spring 2020. A Real Time Patient Flow solution implementation and transformation process would have to be coordinated with as the 2 projects have mutual benefit.

The Business Case

Strategic Context (Strategic Case) Case for Change - Business Needs - *The objective/s of the proposed investment*

The investment will improve patient flow at each site and improve patient flow between the two sites in support of the operating model.

The current situation

The current approach to patient flow is a traditional model based on ward reporting their current situation and escalation / planning meetings, that take place throughout the day. This is supported by bed management and patient flow staff that visit ward, assessment and procedural areas throughout the day to; assess progress of potential discharges and gain visibility of available capacity. There are a significant number of ward visits and phone calls to wards by patient flow staff.

Leadership – Both sites have several senior experienced divisional directors with significant experience in leading patient flow supported by a small number of bed managers who work across 24 hours.

The operational patient flow meetings are held joint between both sites and supported by video conferencing- this is needed due to the considerable flow of patients between the sites – to support hot and cold site operations.

In summary the current approach to patient flow is creating the following issues:

Table 4 Summary of issues with Current state of Patient flow

Lag in visibility of current bed state (no real time visibility), Paucity of data needed for daily capacity and demand planning	Poor patient flow is contributing to bed shortfall forecast	Poor flow contributing to ED breaches and average hold times in ED, cancelled operations due to lack of bed availability and current RTT position
Additional roles - Wards need support from additional Patient Flow Co-ordinator roles (additional cost)	Poor patient flow is contributing to the cost of funding the Winter Resilience plan	Current system contributing to patients being outlied and increasing Length of Stay
Contributing to a large number of non-clinical patient moves and transfers	Large amount of Ward Nursing time being utilised in managing patient flow	Contributes extra costs and lost activity to outsource and additional activity
Poor patient experience	Managing patient flow for nurses contributing to work based stress job satisfaction and morale	Large amount of senior nursing and management time and capacity taken in managing patient flow

The Operations Centres

Both sites have operations rooms with access / view of the Emergency Department (ED) system and the current situation in the ED's and video conferencing. The operations centres are also the bases for clinical site management. Patient flow meetings are supported by reports generated from the wards. Plus, there is additional reporting that that the Trust provides 'up-wards' called 'the Single Health Resilience Early Warning Database (SHREWD) to alert the regional systems of any system demand and capacity stress.

On the Ward

There are patient whiteboards on the wards. But, no interactive 'electronic' whiteboards deployed.

Plus, the Trust has been instructed, as part of NHSI turnaround plans, to have a live 'bed electronic bed boards' in place by Q3 2018/2019.

In interviews with ward managers they report significant amounts of senior nursing time being taken in managing patient flow. To this end the divisional directors of nursing and quality have used some of the nursing budget to establish the ward based '**Patient Flow Co-ordinators'** role. Patient Flow Co-ordinators are administrative staff (circa AfC band 3) employed to be based on key wards 9am to 5pm, 5 days a week, to manage all aspects of patient flow.

Table 5: The role of the Ward-Based Patient Flow Co-ordinator

Provide Administrative support to the ward manager for: patient flow and the daily board rounds	Record the actions from the daily board rounds	Creating the ward patient flow reports (that are shared with operational teams.)	Work on all the actions from the 'board round' – for instance chasing referrals, reviews booking transport.	Take all the 'patient flow' calls	Be the main point of contact with the patient flow team on the ward to avoid unnecessary disruption to the nursing team.

Escalation and Winter Resilience

In relation to day to day working of patient flow, MTW has a clear policy for managing escalation when there is pressure on bed availability. This includes GP streaming in ED, increasing ED staffing, opening formally closed beds – in exceptional circumstances. Supporting increased extra beds for urgent patients at Maidstone for 'treat and transfer', bedding and extending the operating hours of key 'assessment units' (elderly frailty and ambulatory units at TWH), Extra medical team support to 'outliers', the outsourcing surgical activity and pre-emptive cancellation of planned activity.

All, of these interventions are intended to make a positive difference to 'flow' over the winter periods. However, they also create additional costs and have a negative effect for planned surgical capacity and income loss across the winter period (however the majority of the income is protected by the Aligned Incentive Contract). They also create a challenge to maintaining a year-round focus on Referral to Treatment (RTT) waiting times.

In support of the Winter Resilience plans is the Transformation programme called the 'Better Care - patient flow programme'. Whose aim is to take transformation and change approaches to improving patient flow.

Patient flow Conclusion

In conclusion although MTW take a 'traditional' approach to managing patient flow supported by experienced leadership, policies, change and plans. There remains a lack of real time visibility of patient flow.

Capacity Challenges

MTW has undertaken significant Bed modelling and identified the bed capacity currently available per site by division and compared it to the bed's capacity needed over the winter period to manage the expected activity.

This is based on demand profile modelling through the year and latest LOS performance. The shortfall in bed capacity is identified as 150 beds for Medicine and Emergency Care across the Trust at peak demand in winter, mainly at TWH and 15 beds for Planned care across the Trust.

Case for change – Benefits (The Economic Case)

Real-time Patient flow and Tracking system will express benefits in the form three areas;

- Cash releasing
- Non-cash releasing
- Quantifiable & Qualitative benefits

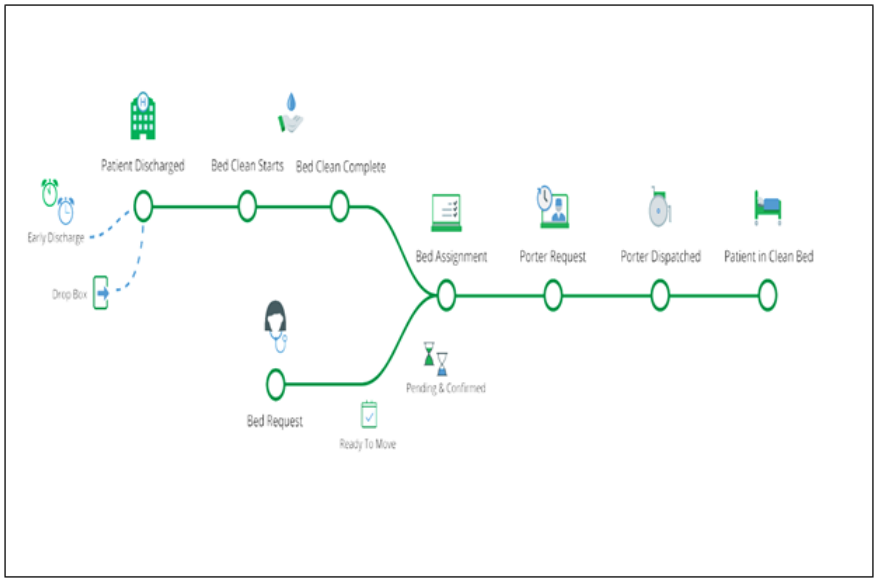
To outline the economic case, it is vital that there is understanding of 'Idle Bed Time' as it is from this the majority of the Cash realising benefits come from.

Idle Bed Time

Key to improved patient flow and release of benefits and recognises 'Idle Bed Time' is one of significant contributing factors to poor patient flow performance.

Definition - IDLE BED TIME; is defined as time when a hospital's bed capacity is unavailable for patients.

Figure 1: Illustration of Idle bed time



It is simply illustrated with the following examples of idle bed time:

- **The patient has met all the criteria for discharge but is still occupying the bed?**
- **The bed is empty but 'Undeclared' and no one is aware of the bed being empty?**
- **The bed is empty but not clean?**
- **The bed is clean and has been assigned to a patient however the bed is unoccupied**

The above statements are all causes of Idle bed time and all will contribute to a lack of bed availability. Real-time Patient flow and Tracking solutions recognise that current approaches to patient flow and available data will not enable latent bed capacity combined in Idle bed time to be released.

Patient flow and Tracking system are tuned to provide a capability to; visualise and 'unlock' the capacity that idle bed time uses.

MTW have described many challenges and opportunities associated with capacity:

- Based on bed capacity modelling indicated a shortfall in bed capacity for Winter Resilience:
  - 70 beds for Urgent care across the Trust, mainly at TWH
  - 15 beds for Planned care across the Trust
- The pressure on Beds at both sites to support 'Hot and Cold' site working
- Opportunity available to MTW for sustaining and increasing income relating to the Private Patient's facility at TWH

All of which would benefit from reduction in Idle Bed Time.

In the below tables: Real-time Patient flow and Tracking system has estimated to areas of Idle bed time for MTW Trusts. Idle bed time due to a none real-time notification of bed status changes and the idle bed time in turnover – meaning the time from a bed becoming vacant and it being in a state for it to be occupied.

Idle Time associated with lack of real time notification - The assumptions used on the current states of notification time and on bed turnaround time are based on baseline reporting from numerous previous and current clients. These assumptions of 90 mins and 300 mins are considered conservative estimates.

Table x : Lost bed time due to a lack of notification (for 100% compliance with Real-time Patient flow and Tracking system best practices and 50% compliance with Real-time Patient flow and Tracking system best practices

Table 5 Lost Bed Time (no notification)	
Number of Beds	640
Number of annual admissions (excluding day cases)	103,700
Current assumed time before notification in mins	90
Real-time Patient flow and Tracking system Best Practice assumed bed notification in mins*	10
Idle bed time before bed notification) in mins (number of admissions x current notification time)	8M
Time before bed notification) in hours	138k
Time before bed notification) in days	6k
Potential Capacity in number of beds from real time notification (100% compliance with Real-time Patient flow and Tracking system Best Practices)	**16**
Potential Capacity in number of beds from real time notification (75% compliance with Real-time Patient flow and Tracking system Best Practices)	**12**
Potential Capacity in number of beds from real time notification (50% compliance with Real-time Patient flow and Tracking system Best Practices)	**8**
***NHS client average**	

Table 5 – indicates the time lost due to the notification of a bed's status being reported due via traditional patient flow. Found by a bed manager, recorded in a PAS or reported by a ward nurse. We will all recognise that there are challenges in timely reporting here. From batch recording of discharge notifications from nurses and batched PAS entries by ward clerks. That bed managers are limited in number and visit one ward at time as part of their rounds.

Table 6: describes the bed time lost from the patient leaving the bed, to the bed being cleaned, to the bed being declared available for occupancy.

Table 6 Improved Bed Turnover time	
Number of Beds	640
Number of annual admissions (excluding day cases)	103,700
Current assumed bed turnover time (mins)*	287
Real-time Patient flow and Tracking system Best Practice Bed Turnover goal (mins)	45
Current bed turnover time (mins)	25M

Current bed turnover time (hrs)	418k
Current bed turnover time annual (days)	17k
Potential Capacity in number of beds from improved Bed Turnover time (100% compliance with Real-time Patient flow and Tracking system Best Practices)	**48**
Potential Capacity in number of beds from improved Bed Turnover time (75% compliance with Real-time Patient flow and Tracking system Best Practices)	**36**
Potential Capacity in number of beds from improved Bed Turnover time (50% compliance with Real-time Patient flow and Tracking system Best Practices)	**24**
***NHS client average**	

Table 6: describes the bed time lost from the patient leaving the bed, to the bed being cleaned, to the bed being declared available for occupancy.

Another area where Idle bed time is found is from the time lost from when a bed is assigned for a 'waiting' patient to when they occupy the assigned bed. In Real-time Patient flow and Tracking system's experience this can be an average of mins and with Real-time Patient flow and Tracking system the visibility of Idle bed time means clients can achieve access to significant capacity. Table 5: indicates the potential capacity available to MTW.

Table 7: Idle Bed time in bed Assigned to Occupied

Table 7 Time from assigned to occupied (annual)	
Number of Beds	640
Number of annual admissions (excluding day cases)	103,700
Current assumed time from assigned to occupied (mins)*	114
Real-time Patient flow and Tracking system Best Practice assigned to occupied (mins)	30
Idle Bed time in mins (annual)	9M
Current Idle Bed time in hours (annual)	145k
Current Idle Bed time in days (annual)	6k
Potential Capacity in number of beds from improved Bed Turnover time (100% compliance with Real-time Patient flow and Tracking system Best Practices)	**17**
Potential Capacity in number of beds from improved Bed Turnover time (75% compliance with Real-time Patient flow and Tracking system Best Practices)	**12**
Potential Capacity in number of beds from improved Bed Turnover time (50% compliance with Real-time Patient flow and Tracking system Best Practices)	**8**
***NHS client average**	

Table 8: Potential of available capacity with unlocking of Idle bed time from table x, table x & table x.

Table 8 Idle Bed Time (Notification + Turnaround + Occupied)	Total number of beds
100% Compliance with Real-time Patient flow and Tracking system Best Practices Bed Gain	**80**
75% Compliance with Real-time Patient flow and Tracking system Best Practices Bed Gain	60
% Compliance with Real-time Patient flow and Tracking system Best Practices Bed Gain	40

Table 8: Potential additional surgical beds that could be released from a 37% reduction in Medical Outliers

Beds Associated by Outliers (at 37% reduction)	5

Achieving the bed gains

The extra capacity that can be released form tackling Idle Bed Time is dependent of utilising the Real-time Patient flow and Tracking system best practices. This supported by the Implementation process and Real-time Patient flow and Tracking system team.

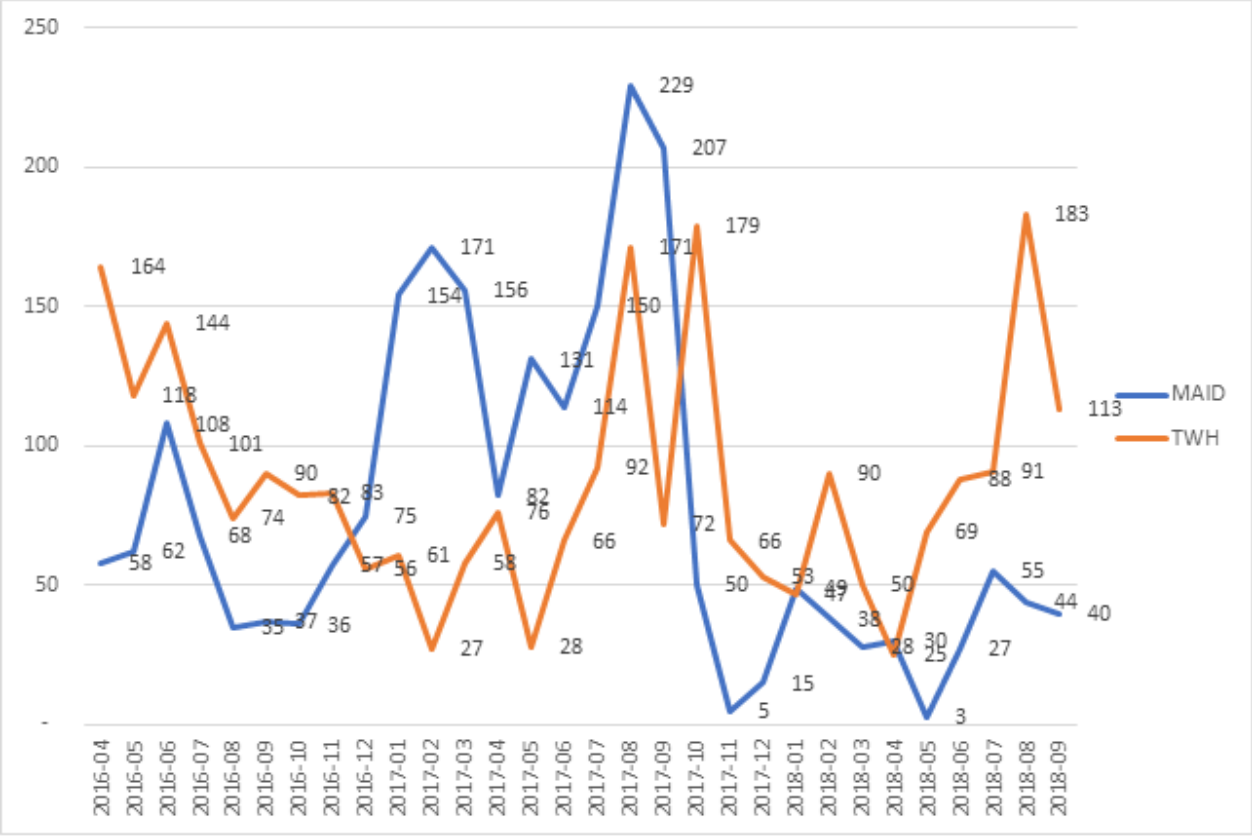
Table 9: Options for using Capacity from Idle bed time

Previous Real-Time Patient flow and Tracking systems have 'unlocked' capacity from idle bed time to reduce their bed base and this would be equivalent to closing 3 wards within the initial weeks of go live. This however is not practical due to the capacity not being aligned to the time it is required.
Royal Wolverhampton (NHS) Trust using a Real-Time Patient Flow Solution to significantly reduce the investment in Extra capacity for winter has not needed to invest in extra winter capacity since 2016. Saving them ~£15m.
Improvement in 18-week RTT performance / Opportunities for increased income / sustained year around surgical programme
Anticipate reduction in winter resilience costs.

Outliers

Definition: OUTLIERS are patients in beds not intended for their care e.g. Medical patients occupying surgical beds.

Fig 3: Numbers of Medical Outliers per month 9 /2017 to 9 /2018 at MTW



There is significant work already underway as part of the 'better care' programme to reduce the instances of Outliers. However, Real-time Patient flow and Tracking system clients have consistently achieved significant and sustained impact on Outliers.

Medical outliers are twice as likely to have an extended Length of Stay, up-to 2 days longer than patients who are allocated beds intended for their care need. MTW information department showed the average number of medical outliers per month is ~36, occupying surgical beds. Based on the past performance of Real-time Patient Flow and Tracking system users like Royal Wolverhampton (NHS) Trust we have been able to model the potential impact on medical outliers at MTW.

Table x: Current numbers of medical outliers at MTW (monthly)

Current Number of Medical Outliers (Monthly Average)	36
Total LOS associated with medical outliers on surgical Wards (Monthly)	**230**

Table 10: Likely impact on medical outliers at MTW (monthly) with implementation of Real-time Patient flow and Tracking system

Number of Outliers (Monthly) *37% reduction with Real-time Patient flow and Tracking system **/*	22
Extra days LOS associated with medical outliers on surgical Wards (Monthly) following Real-time Patient flow and Tracking system	141
Annual days released if Real-time Patient flow and Tracking system reduction on Medical Outliers is achieved	1075

* based on a 37% sustained reduction of medical outliers achieved at UK Real-time Patient flow and Tracking system clients / ** This is only based on medical patients on surgical wards / ***The above assessment does not account for medical patients placed on surgical wards during 'escalation'

Table x: Opportunity for additional Planned care activity from the release of bed days from reductions in Medical outliers

If annual days released could be converted into additional planned cases (based on 3.3-day LOS per case)	326

Table 11: Or a Potential additional surgical bed that could be released from a 37% reduction in Medical Outliers

Beds Associated by Outliers (at 37% reduction)	5

Table 12: Options of benefits, from further than planned, reductions in medical outliers

Impact begins from go live
Improved patient safety – Medical patients allocated to the right bed for their needs
Reduction in LOS / Improvement in 18 weeks RTT performance
Increased capacity for planned care activity / increased income and reduction in outsourced activity / reduction in on the day of procedure cancellations
Additional 5 Surgical beds per year
Patient benefit – reduced delays in proposed treatment plan / improved satisfaction
Staff benefit – reduced stress in looking after patient's needs, they may be unfamiliar with / reduced harms of care /Improved Productivity of medical teams due to reduction in Safari Ward Rounds and reduction dedicated resources to manage outliers / increased satisfaction

Risks (The Economic Case)

Risk	Detail	Scoring	
Project Overspend	Unforeseen costs incurred/additional purchases required	3 x 2 = 6	
User Acceptance	Users refuse to accept the system and demand administrative establishment is maintained	4 x 3 = 12	4 x 2 = 8

System Ability	Selected system cannot perform required functions	3 x 1 = 3	2 x 1 = 2
Staff Concerns	Staff raises concerns and potential grievances as feel this is an attempt to reduce staffing levels	4 x 2 = 8	

Constraints (The Economic Case)

- Server capacity for user numbers
- Availability of external company to carry out integration work for linking solution with Allscripts
- Availability of capital

Dependencies

- Workforce engagement
- Project management/clear roll out plan
- Hardware to support new process (speech mikes/re-use current dictation equipment or purchase new) [servers capable of supporting the Trust-wide roll out are already available in Oncology]
- Completion of procurement/tendering process
- Band 8a implementation manager for the project

The short list of options (The Economic Case)

Option 1. The do-nothing option -***Discounted***

The approach to managing patient flow, at MTW, is traditional, largely paper-based and a mature working model, but does not offer **'Real-Time Visibility of Patient Flow'.** There is added complexity from the 'hot and cold' site working across the two sites. Meaning that there is a need not only for a 'tight-grip' on patient flow at each site but for the flow of patients between sites too.

Option 2. Do Nothing - continue trying to effect bed management/patient flow through the current processes and PAS.

There is no 'real-time' visibility of demand or available or coming available capacity or demand at the Trust without logging into different systems, asking busy ward and department areas for create and share reports on capacity and demand, or that bed management staff and operational leaders need to visit and contact ward area many times a day for up-dates and progress reports, or using considerable amounts of time in bed meetings. Meaning that almost all data needed for real time and future patient flow, is out of date. Even if ward-based staff are where mandated to prioritise Admission, Transfer and Discharge up-dates into a number of current systems on top of their current priorities this would not resolve the issues of bed visibility.

The senior operational leaders for planned and urgent care are dissatisfied with the limitations to the current approaches. They recognise that things could be better and burden on frontline staff in supporting patient flow needs to change. That any information generated in real time would be welcome to generate the visibility needed for proactive patient flow management and reduce the burden on front line staff in managing information and tasks associated with patient flow from them.

Option 3 (a). Implement a Real Time Patient Flow solution with Auto Discharge to realise benefits before Winter bed pressures this Financial Year, 'go live' November 2019.

Is a comprehensive approach to providing 'real-time' visibility of the status and location of beds, real time visibility of demand and capacity across the MTW hospitals simultaneously. The automation and synchronisation of various operational processes across the hospital to; release additional bed capacity, from idle bed time to the Hospitals, ahead of winter 19/20 and reducing the investments needed for winter escalation beds and capacity and improve planned care bed availability across winter 19/20. To release200 hours of nursing time from go live, while reducing the overhead on managing patient flow from front line wards at the busiest time of the year.

To deliver and coordinate operational care delivery, via a single command centre, across the two MTW sites, centralising control for all patient placement and ensuring there is reliable communications and visibility to support to real-time needs, across a complex system. Provide coordinated approach to portering and bed cleaning available to the Trust to improve bed turnaround time and bed availability for winter 19/20. Improving performance against ED and RTT access standards.

Need to Establish a Single Command Centre for Patient Flow Operations as part of option 3 (a)

Essential to ensuring the effective working of patient flow using a real time patient flow solution it is necessary to establish a 'Single Patient Flow Command Centre'. A single Command Centre for MTW will bring a 'single' system wide view for; patient flow, patient placement and generate situational awareness that would support immediate planning and balance of patient flow across both sites. We recommend two options:

1. Establish an initial Operations room at Tunbridge Wells (replacing the operations rooms at Tunbridge Wells & Maidstone)
2. Plan for offsite at Operations room in offsite facilities

Option 3 (b). Implement a Real Time Patient Flow solution with Auto Discharge following Winter bed pressures, April 2020

As with Option 3a above, although the delayed implementation would be reflected in increased pressure and costs this Winter due to using the traditional paper system offering no **'real time'** view of bed availability and the additional cost being planned for winter 19/20. Continued burden on front line nursing staff in managing significant levels of patient flow tasks and activity for winter 19/20, which may impact retention and sickness and absence.

Opportunity to complete the implementation of the EPR and deploy a Real-Time Patient Flow solution post winter 19/20 with savings for winter 20/21

Option 4. Implement a Real Time Patient Flow system with a full Real Time Location Services (RTLS) provision.

In addition to Option 3. Using these technology products with active and passive locating services to provide Workflow automation, and reduced need for human-to- computer interaction.

See Appendix for detail on the Real Time Tracking Capability for consideration in Option 4.

The Preferred Option (The Economic Case)

Option 1 (Do nothing) – Is to assume current processes and costs

Option 2 (Increase Patient flow activity to create real time flow with current capabilities) – Creation of Additional Capacity (with related staffing and capital implications), Employment of increased numbers of Patient Flow Co-Ordinator Roles on all wards, increased cost of Winter Resilience Plan and continued stress on staff.

Option 3 (a) (Invest in Real Time Patient Flow Solution FY 19/20) – Investment in a Real Time Patient Flow solution, in FY 19-20, with reduced costs of up-coming winter resilience plans for winter 19-20, increased bed availability from released capacity from idle bed time, increased income opportunity from year around planned care activity in FY19-20. Reduce non-clinical moves, decreasing the pressure on staff from managing patient flow. Improve portering productivity and release nursing time back to care for FY 19-20.

Option 3 (b) (Invest in Real Time Patient Flow Solution FY 20/21) – Investment in Real Time Patient Flow Solution with implementation in April 2020. reduce the anticipated costs for winter resilience plans for winter FY 20-21, increased bed availability from released capacity from idle bed time, increased income opportunity from year around planned care activity in FY20-21. Reduce non-clinical moves, decreasing the pressure on staff from managing patient flow. Improve portering productivity and release nursing time back to care for FY 20-21.

Option 4 (Invest in Real Time Patient Flow Solution and Tracking Solution either FY 19/20 or FY 20/21) – As per option 3 (a), (b) - Increase automation and synchronisation with Real Time Patient Flow. Provide a capability for; Asset, patient and staff tracking. Reducing time taken in finding equipment for clinical staff, support full utilisation of equipment and improved planned preventative maintenance. Reduced costs of replacing lost and poorly maintained clinical equipment. Clinical safety and care quality opportunity from tracking.

Services and /or assets required

- MTW 8a Implementation Manager for the length of the project.
- 10 x Per site Patient Flow super users (to support training, configuration and champion the Real Time Patient Flow Solution)
- IT Resource allocated to System Administration support for duration & First line Response to system

Workforce impact

There are options that impact workforce that from part of the economic case below.

Real Time Visibility

Deploying a Real-time Patient flow and Tracking solution means a capability to centralise all patient placement in a single command centre, for our two sites. Giving the Trust an operational overview and 'real-time' information from the ward and procedural areas of patient demand and levels of capacity this is supported by automated workflow that produces this information in 'real-time'. This visibility significantly reduces the need for the current high levels of phone calls, meetings and trips to the wards.

Other UK Trusts who have deployed a Real Time Patient Flow Solution have been able to rationalise the size and coverage of their dedicated patient flow teams. These staff are often highly experienced nursing practitioners, whose skills can be redeployed back into 'clinical site management' or senior staff who can be offered opportunities to return to leading bedside care.

The Electronic Interactive Bed Board on the Ward

Real-time Patient flow and Tracking system would be to deploy electronic interactive whiteboards on each ward and procedural area. Theses interactive boards become the focus for 09:30am Multi-Disciplinary Team (MDT) patient flow/ safety / discharge board rounds. Meaning recording of key patient flow information from an MDT in real time and instantly visible to the Command Centre to support planning. The Patient Flow solution includes a capability to automatically up-date of the patient's status from other downstream systems like the EPR.

Example of automatic up-dates

If a key step to a patient being discharged is a timely completion of an 'Electronic Discharge Notification' (EDN). This is completed by a member of the medical staff. If on completion of this task a message can be sent to Real-time Patient flow and Tracking system. Up-dating the patient's status automatically. Without the need for a member of the ward or patient flow team's intervention

Reducing the Burden of Patient Flow through Automation

A Real Time Patient Flow Solution can automate workflow to reduce the burden on nursing and ward clerk staff in needing to up-date systems to generate 'Admission, Transfer and Discharge' massaging, in multiple calls to requesting bed cleaning or in requesting portering.

This simple automation reduces interactions with IT systems and provides a real time notification of bed availability to the bed cleaning team and the patient placement staff within the Command Centre.

Portering

A Real-time Patient flow and Tracking system will also offer a full 'dispatcher-less' Portering solution for both ad-hoc and scheduled portering work. On wards Nurses can order porters for patient movement via the interactive white boards without going via a 'porters lodge / portering dispatcher. As well as ordering 'items' like O2 cylinders, and linen via the same system. Dispatcher less Portering significantly reduces the need for multiple phone calls for nurses and between portering supervisors and porters. With the main impact on portering productivity. Typically improving productivity from carrying out 2.5 jobs per hour to 3.5 jobs per hour.

The impact of no manual dispatch and the zoning logic in Real-time Patient flow and Tracking system means an increased service with the current portering workforce.

Instituting a Bed Cleaning Team

As part of establishing a Real-Time Patient Flow solution we propose in institution of a dedicated bed Cleaning team for each site. The effective cleaning of beds in a timely manner is key to reducing 'Idle bed time' and maintaining a steady availability of beds throughout the day.

The number of bed cleaners in the team is to ensure that there is a 247 service. This is based on 37 bed cleans per day. The team size is based on sites previously deployed with Real-time Patient flow and Tracking system Patient Flow Commands in the UK. The team size caters for time off and holiday cover. There is obviously less pressure on beds during the night and at weekends. So, less persons are needed at night and at weekends. Advice is to employ bed cleaning team on a flexible basis as MTW adjusts to new bed cleaning demand

A bed cleaning team has benefits above and beyond any investment. As will be discussed, in detail, later. Removing 'Bed Cleaning' from nursing offers a significant bounty in released Nursing Time directly back to care. That benefits nursing and nursing morale and importantly patient care and patient safety. Without inflating staffing levels or breaching planned caps and targets on flexible staff (Bank & Agency).

Additionally, other UK sites report a consistent improvement on the quality of bed and bed area cleaning in line with bed cleaning policy, including improved speed in complex cleaning regimes like HPV cleaning.

Summary of Benefits of a Dedicated Bed Cleaning Team
Dedicated team available to clean beds to a consistent high standard 247 (increased compliance with bed cleaning regime standards)
To reduce the time from a bed needing cleaning to being available for a patient in the shortest time possible
To remove the responsibility for bed cleaning from busy nursing staff – thus releasing time back to direct care. To release time back to domestic and housekeeping staff to dive up accommodation standards. Releasing circa 2000 hours per month of nursing time

Released Nursing Time

There is opportunity to release nursing time with the deployment of a Real Time Patient Flow Solution by releasing nursing time taken up in with 'administrative' tasks like up-dating multiple IT systems and from carrying out non-clinical tasks like bed cleaning. Also, to achieve efficient patient flow the quick turnaround of beds is vital and the institution of a dedicated bed cleaning team will release significant nursing time.

Table 13: shows the impact on nursing time when the responsibility for bed cleaning is removed from frontline nursing teams, not only is there a significant impact to benefit to patient flow, from reducing idle bed time. But, in addition there is up-ward of ~2k hours of trained and untrained nursing time that can be released back to car per month.

Table xx: Trained and Untrained nursing time released back to direct care for MTW

Direct Nursing time released from Bed Cleaning (MTW)	
Number of admissions (annual) MTW	111,520
Currently Tunbridge Wells (TW) *63% Beds are Cleaned by nurses	35k
Currently Maidstone Hospital (MH)*63% Beds are Cleaned by nurses	35k
Currently Time taken by nurses cleaning beds TW (mins) annually **(based on 30 mins per bed clean)**	1,054k
Currently Time taken by nurses cleaning beds MH (mins) annually **(based on 30 mins per bed clean)**	1,054k
TW - Time Released direct nurses time from cleaning beds (hours) annually (**beds now cleaned by a bed cleaning team at 30 mins per bed clean**)	18k
MH -Time Released direct nurses time from cleaning beds (hours) annually (**beds now cleaned by a bed cleaning team at 30 mins per bed clean**)	18k
MH Direct Nursing time released Monthly (hours)	**1k**
TW Direct Nursing time released Monthly (hours)	**1k**
MH 37.5 hours (1 x WTE Trained / Untrained Nurse) per month	**468**
TW 37.5 hours (1 x WTE Trained / Untrained Nurse) per month	**468**

*Based on 63% of bed cleans being done by nurses

Assumptions – that when nurses cleaning a bed it takes an average of 30 mins per bed area for a terminal clean (reflecting based on number of annual admissions divided equally for TW & MH – excluding internal transfers and non-clinical patient moves).

Table 14: Options of benefits, from the release of nursing time from bed cleaning

Increased time in giving direct care ~2k hours per month from go live
Expectation of no increases in bank & agency usage – caps and targets for agency spent not exceeded
Increased throughput of patients with same nursing staffing level

Reduction in Patient safety incidents (Falls, Pressure Ulcers, VTE, dehydration and malnutrition incidents, Medicines administration harms.) / Reduction in untoward incidents
Reduced staff sickness and absence (associated with stress) / improved retention / improvement in staff satisfaction scores and reductions in complaints
Patient benefit – reduced delays in commencing treatment / reduced LOS / improved satisfaction
Staff benefit – reduced stress in looking after patient's needs, they may be unfamiliar with / reduced harms of care / increased satisfaction

In summary the amount of current nursing time spent making and cleaning beds is not a value-added task for nursing. The time released from bed making and cleaning is better utilised in direct patient care and for the small investment of a bed cleaning team supported via the Real-time Patient flow and Tracking system solution is a worthwhile investment considering the time back to nursing being released.

Summary

A Real-Time Patient Flow Solution will provide visibility, tools, and automation to provide MTW the opportunity to consider the following disinvestments:

- To remove the 'Patient Flow Coordinator' Role from the ward areas
- To consider options in reducing or changing the roles of Bed management nurses to further benefit nursing and patient care

If pursued will offset the investment in the bed cleaning team

Investment

- A 247 Bed Cleaning Team for each site

Below in table x. Is an illustration of the likely impact for workforce with the investment of the Real-time Patient flow and Tracking system platform.

Table 15: Illustration of the impact of Real-time Patient flow and Tracking system Solution on the patient flow workforce

Workforce Impact				
Additional roles		AfC banding	Gross Annual Cost per WTE	Total Gross Annual Cost
*Bed Cleaning team	20 WTE (10 MH, 10 TW)	2	£27,187	£543,746
System Manager	1 WTE	8a	£58,196	£58,196
Site Team - Reduction	**(2 WTE)**	**7**	**57,600**	**(115,200)**
Total Investment				**486,742**

Roles Reduced (Non Cash Releasing)				
		AfC banding	Annual Salary	Annual Salary without on costs
Patient Flow Co-ordinator Role	10	3	£28,307	£283,068
Total				£283,068
**Number of bed cleaners is to provide 247 service based on bed cleans 179 per day (less persons are needed at night and at weekends and based on the numbers employed at other UK sites (MSB and Chester) / Advice is to employ bed cleaning team on a flexible basis as MTW adjusts to new bed cleaning demand*				
Number of bed cleans Admissions minus day cases and reduce by 63% (not all beds cleaned need the bed cleaning team)				
Roles reduced non cash releasing. This includes10 WTE Patient Flow Co-ordinators. These posts are still being reviewed as to whether they could be cash releasing.				

Table 16: Options of benefits, with workforce impacts

	Impact from go live
	Investment in a Bed Cleaning Team to release significant time back to care / Reduce Idle bedtime associated with bed cleaning and readiness / Standardised cleaning of beds and bed spaces alongside Hospital bed cleaning policy
	Reduce the number of senior nurses in Patient flow/ Bed management roles – returning those skills and experience back to front line nursing
	Improve Portering Productivity (increased Jobs per hour) / Opportunity to centralise and rebalance the portering resources / Show how Portering is a vital function to effective patient flow

Estates impact

For Options 3 (a) & 3 (b)

- To support Real Time Patient Solution that Interactive Electronic White Boards are installed on each Ward in a central location (these boards will replace any current dry wipe boards)
- To support Real Time Patient Solution that Interactive Electronic White Boards are installed on each main procedural area (e.g. Main X ray / imaging / OR department / ED / Endoscopy) in a central location (these boards will replace any current dry wipe boards)

- Installation of a 'Automated Discharge Drop Box' one on each Ward area (near the nurse's station) to facilitate automated discharge notification and bed cleaning 'triggers'

**All specifications of the boards will be shared by the Patient Flow software supplier.

For Option 4

- As per above for Options 3 (a) & 3 (b)
- In addition, the support from a third party (known to or preferred supplier to MTW) to install the Real Time Locating Services Hardware (mostly ceiling work)
- Resources to collect clean and allocate – Patient Real Time Locating Badges, Real Time Locating Staff Badges & Real Time Locating Asset Tags

The Commercial & Finance Case

Income and Expenditure Impact	Cash Releasing (CR) / Non-Cash Releasing (NCR)	Year 1 (2019-20) £	Year 2 (2020-21) £	Years 3 -10 (per year) £	Total £
Benefits					
Variable cost reductions Reduced Nursing attrition (reducing retention and recruitment costs)	CR	0	50,000	400,000	450,000
Reduces Cost of winter plan (based on the availability of 40 beds released across winter for a 3 month period)	CR	0	474,081	3,792,645	4,266,726
Site Team	CR	0	115,200	921,600	1,036,800
Total benefits		**0**	**639,281**	**5,114,245**	**5,753,526**
Costs					
Local Investment and Costs					
Bed Cleaning Team		181,249	543,746	4,349,968	5,074,963
System Manager		19,399	58,196	465,568	543,163
Local Implementation costs (Non Rec)		185,000	0	0	185,000
Wrist bands		0	4,000	64,000	68,000
Capital charges (Equipment) - £140k year 1 and £140k Year 5 (replacement)		32,410	31,430	240,660	304,500
		418,057	637,372	5,120,196	6,175,625
System Charges					
Cost of Real Time Patient Flow system		250,800	752,400	6,019,200	7,022,400
System Hosting Costs		47,200	141,600	1,132,800	1,321,600
Implementation		612,000	0	0	612,000
		910,000	894,000	7,152,000	8,956,000
Total costs		**1,328,057**	**1,531,372**	**12,272,196**	**15,131,625**
Total I&E Impact includng cash releasig benefits (- = pressure)		**-1,328,057**	**-892,091**	**-7,157,951**	**-9,378,099**

The Business Case identifies investment in year 1 (2019-20) of £1.3m. In Year 2 and subsequent years the investment is £1.5m partly offset by £0.6m of cash releasing benefits.

Benefits:-

- Reduction in Nursing agency spend of £50k per annum from year 2 is expected by improving nursing retention.
- Savings of £474k per annum has been included relating to preventing the need to open 40 escalation beds over the winter period (3 months). The 2019-20 plan includes escalation cost of opening an additional ward equating to the £474k.

Investment:-

- Bed cleaning team 20 WTE has been included in the costing equating to £540k per annum.
- Systems costs have been included based on existing quotes and VAT has been applied where appropriate.

Appendix 4 shows the investment phasing over the 10 year project period.

Non Cash Releasing benefits

	Cash Releasing (CR) / Non-Cash Releasing (NCR)	Year 1 (2019-20) £	Year 2 (2020-21) £	Years 3 -10 (per year) £	Total £
Benefits					
Idle Bed Time Nursing time back to care (reduce agency budget)	NCR	0	100,000	800,000	900,000
Increased year round planned activity (based on 40 addiitonal beds for 9 month period)	NCR	0	1,422,242	11,377,936	12,800,178
Patient flow co-ordinator	NCR	94,356	283,068	2,264,544	2,641,968
Total Non Cash releasing benefits		**94,356**	**1,805,310**	**14,442,480**	**16,342,146**

Total Net Pressure (-) / Saving (+) including non cash releasing benefits	**-1,195,301**	**913,219**	**7,284,529**	**7,002,447**

The additional opportunities for non-cash releasing benefits have been estimated to equate to £1.8m per annum (from year 2). Including these non-cash releasing benefits, it is estimated the overall potential benefit over the 10 year period would be £7m, however this will still be a net investment of £1.2m in year 1 with benefits not arising until year 3.

- 40 bed saving has been calculated based on direct ward staff costs (using W10 at Tunbridge Wells) as the baseline. It has been estimated that 40 beds could be released but one of the objectives is to reduce the current high bed occupancy rate as a result it is unlikely that the Trust will close beds and therefore will not generate the cash releasing saving. Divisions are also working through the detail to understand the bed potential saving at Specialty and site level.
- The Trust has 10 Patient Flow co-ordinators. This is labelled as non-cash releasing until it has been clarified how many of these posts will still be required post implementation.

Capital

The Business Case requires £140k capital investment in year 1 and year 6 for IT equipment.

Procurement Route (The Commercial Case)

Preferred process is to procure and award contract through Countess of Chester Real Time Healthcare Tracking and Patient Flow Systems Framework (detail below):

- Single Supplier National Framework Agreement
- F/033/TR/16/RB OJEU: 2016/S 094-169616 framework

The Management Case

Quality Impact Assessment (The Management Case)
Clinical Effectiveness
Have clinicians been involved in the service redesign? If yes, list who.
Clinical Teams will be involved in configuration of a real time patient flow solution for trust. Including supporting training, system set up, change and monitoring
Has any appropriate evidence been used in the redesign? (e.g. NICE guidance)
Are relevant Clinical Outcome Measures already being monitored by the Directorate? If yes, list. If no, specify additional outcome measures where appropriate.
A real-time patient flow solution will clinical outcomes e.g. reducing Length of stay, number of non-clinical moves, numbers of patients outlined or delayed in ED awaiting a bed on an appropriate ward. Release of nursing time.
Are there any risks to clinical effectiveness? If yes, list
NO
Have the risks been mitigated?
NA
Have the risks been added to the departmental risk register and a review date set?
NA
Are there any benefits to clinical effectiveness? If yes, list
Increased nursing time per patient per day, reduction in outliers, reduced delays in ED
Patient Safety

Has the impact of the change been considered in relation to:	
Infection Prevention and Control?	Y/~~N~~
Safeguarding vulnerable adults/ children?	Y/~~N~~
Current quality indicators?	Y/~~N~~
Quality Account priorities?	Y/~~N~~
CQUINS?	Y/~~N~~
Are there any risks to patient safety? If yes, list	
NO	
Have the risks been mitigated?	
NA	
Have the risks been added to the departmental risk register and a review date set?	
NA	
Are there any benefits to patient safety? If yes, list	
More patients being placed in beds on ward based on their needs, reductions in outliers, reduce dwell time	
Patient experience	
Has the impact of the redesign on patients/ carers/ members of the public been assessed? If no, identify why not.	
YES	
Has the impact of the change been considered in relation to: • Promoting self-care for people with long-term conditions? • Tackling health inequalities?	
Yes	
Does the redesign lead to improvements in the care pathway? If yes, identify	
Access to beds based on patients' individual needs	
Are there any risks to the patient experience? If yes, list	
NO	
Have the risks been mitigated?	
NA	
Have the risks been added to the departmental risk register and a review date set?	
NA	
Are there any benefits to the patient experience? If yes, list	
Expectation of a real time patient flow solution to improve patient experience as in getting them to beds without delays. To be better informed of plans for discharge.	

Equality & Diversity					
Has the impact of redesign been subject to an Equality Impact Assessment?					
YES					
Are any of the 9 protected characteristics likely to be negatively impacted? (If so, please attach the Equality Impact Assessment)					
NO					
Has any negative impact been added to the departmental risk register and a review date set?					
NA					
Service					
What is the overall impact on service quality? – please tick one box					
Improves quality	X	Maintains quality		Reduces quality	
Clinical lead comments					

Project Management Case

The preferred supplier will be expected to include a project manager a technical project manager and implementation team for the following:

- To begin the Technical Implementation
    - Including any interface work with third party systems to support synchronisation and automation of patient flow workflow (e.g. ADT HL7 message capture from EPR)
- MTW Estates and any third-party suppliers to install Interactive White Boards and Automated Discharge 'Drop Box'
- Begin design and configuration
- Begin workflow and business change
- To 'roll-out' the software solution
- To provide initial training in a "train the trainer" model.
- A MTW 8a Project Manager - will be required to liaise between the preferred supplier and the directorates, produce and manage project documentation and monitor and manage progress against the project plan.
- Option 4 planning for later RTLS hardware installation and technical work

Governance

Establish a Senior Responsible Officer to oversee the deployment of the Real Time Patient Flow and Tracking Solution. To establish a senior and project team steering board to oversee and assure the deployment to ensure that budget, timelines and best practice are adhered to. That there is a clear path to handing over the project to Business as usual teams.

Timetable

Dependent on chosen options the proposed timetable is as follows:

May 2019

- Development and approval of business case

June 2019

- Procure, and Award contract through Countess of Chester Real Time Healthcare Tracking and Patient Flow Systems Framework:
    - Single Supplier National Framework Agreement

- F/033/TR/16/RB OJEU: 2016/S 094-169616 framework

- Contract negotiation and Signing

July 1st 2019

Start implementation process

November 2019

- 1st week November supported 'go live' at Tunbridge Wells hospital (to enable quick access to bed capacity at main acute site)
- 3rd week November supported 'go live' at Maidstone hospital

Training arrangements

It is expected that the preferred supplier would provide a project manager and implementation team once awarded and training would be delivered in a "train the trainer". We would expect the supplier to provide comprehensive training to our local trainers and key operational leads in a mixture of formal and informal settings. This approach ensures that the knowledge in relation to the use of the system and processes embeds in our organisation.

To support the on-going training, we would look to have a range of videos, presentations and quick reference guides. In addition, a competency-based assessment of our internal trainers to ensure that the training they deliver to our workforce remains of the highest quality.

Local "super users" would then support the on-going training of clinical staff to use the system as required.

Business assurance and benefits realisation arrangements

Risk Management and Contingency plans

Establish a Senior Responsible Officer to oversee the deployment of the Real Time Patient Flow and Tracking Solution. To establish a senior and project team steering board to oversee and assure the deployment to ensure that budget, timelines and best practice are adhered to. That there is a clear path to handing over the project to Business as usual teams.

Establish active risk assessment and management function as part of deployment to assure and report and mitigate any risks arising.

Arrangements for post project evaluation

- On-going monitoring of compliance and performance to Real Time Patient Flow Best Practice
- Monitoring of Performance against the following:
    - ED Access Standard for Breaches associated with lack of bed availability
    - Number of escalation beds or need to escalate to extra capacity by occasion and beds opened
    - Monitoring Nursing satisfaction, retention
    - RTT Access Standard reporting performance and number of long waiters
    - Monitor volume and cost of outsourced planned care activity
    - Number of Outliers (e.g. medical patients in surgical beds)
    - Number of one the day cancelled operations
    - Portering Productivity

Recommendation

The recommendation is to support Option 3 (a). This option for the implementation of a Real Time Patient Flow Solution in FY 19-20. As it will provide a real-time visibility of patient flow for both sites, give opportunity to create real-time situational awareness for patient flow for both sites. MTW can release, significant nursing time and reduce the burden of managing patient flow from front line staff. Have a positive impact on patient experience of patient flow from reduced delays in accessing beds, reduced outliers and reduced non-clinical moves, better information on discharge.

The investment allows MTW to reduce the funding planned for winter resilience planning for winter 19-20 (as per summary at head of this document). To support releasing bed capacity needed to fulfil the 'Prime-Provider' contract, maintain opportunity for year around planned care activity and improve performance against ED and RTT access standards.

Appendix 1 – Tracking (Real Time Locating Services as per Option 4)

Tracking (Real Time Locating System)

There is opportunity to use alongside the Real-Time Patient flow a Real-Time Locating System that uses RFID (Radio Frequency Identification) and/or Wi-Fi technology to allow the tracking; Patients, Staff and Assets.

Using Real-Time Locating Systems (RTLS) to optimise patient throughput and asset management can be revolutionary for any hospital.

An ability to pinpointing the location of patients, staff and assets in real time can bring new insights into hospital operations, productivity and patient safety benefits.

Assets

Tracking and finding of mobile equipment in the context of operational workflows is critical to improving asset utilisation and operational efficiency. It is accepted that clinical and support staff will waste valuable time searching for hidden, lost or missing equipment. This is no longer acceptable. This inefficiency can drive leads for new equipment purchases, rentals and replacement costs, which are ultimately unnecessary.

Meanwhile, Electrical and Bio-Mechanical Engineering Departments and Equipment Library staff spend a great deal of time locating assets such as infusion pumps to perform planned preventative maintenance (PPM) or service and software updates. Preventative maintenance on-time completion is low, equipment recalls are laborious and rarely 100% successful. With RTLS asset tracking those wasted hours looking for equipment are regained.

In short, RTLS asset tracking enables, staff can locate equipment using a hospital computer or mobile device-anywhere in your hospital in real time and shows whether equipment is in use, available, or out of service for cleaning or repair.

It can help staff Instantly find the closest available equipment and eliminate the frustration of dozens of phone calls and room searches. The nurses can see both map and list views with options to search by equipment type or by specific item.

Table x: Indicating lost nursing time from direct care in locating equipment

Lost Nursing Time lost locating equipment (One Ward Example)	
Current Time lost per nurse shift looking for Kit (mins)	40
Three Shifts per day	120
Hours Per Year	730
Equivalent 8.5 hour shifts per year	86

40 min Current time based on NHSI Perfect Ward national analysis

Table 1: outline on potential savings in equipment loss at ward level

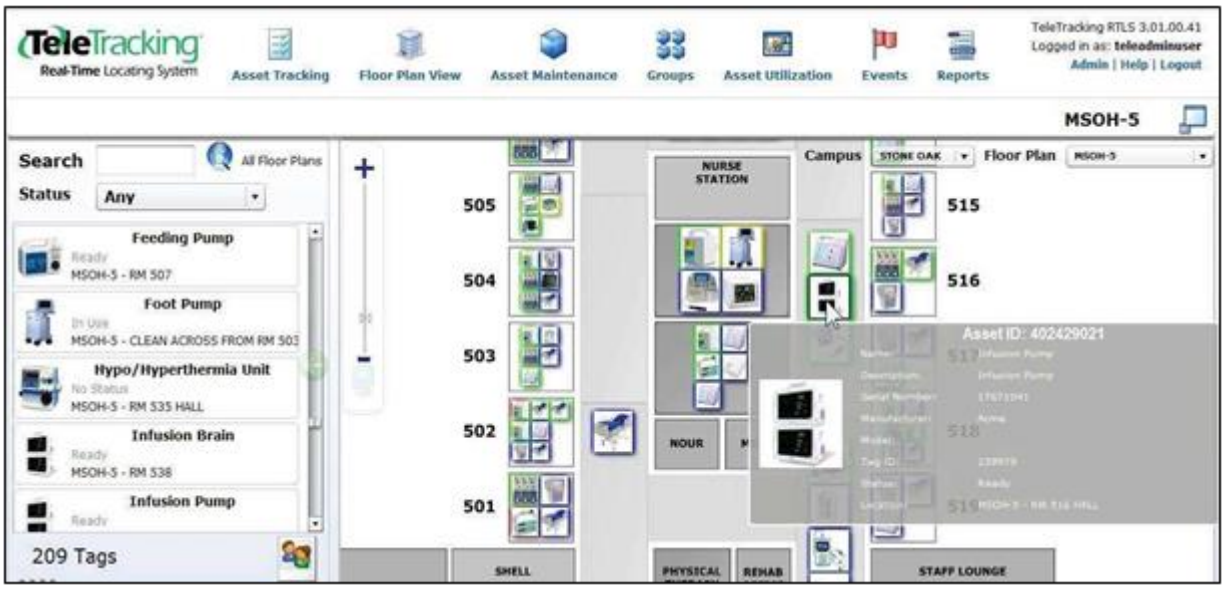
Equipment replacement n a single ward			
Equipment List that can be tagged for Tracking	Cost per Item (costs estimated)	Assumed equipment Replacement Cost (pa)	Assumed saving on Replacement with Asset Tracking Capability (pa)
Bladder Scanner	£800.00	£2,400	£800
Infusion Pump	£1,200.00	£12,000	£2,400
VTE Prevention Pumps	£200.00	£2,000	£400
Blood Glucose Monitor	£50.00	£200	£50
Air loss Mattress	£500.00	£1,500	£500
Vital Signs Recorder	£1,200.00	£2,400	£0
Portering Transfer Chair	£900.00	£2,700	£900
Total		£23,200	£5,050
One Ward Saving (pa)	£18,150		
Saving for 10 x wards (pa)	£181,500		

The choice of RTLS technology between RFID and Wi-Fi depends on the level of granularity and location accuracy desired by the trust. The consideration for MTW is an RTLS infrastructure level of granularity **(to ward level initially then on further assessment to a bay / bed level)** it affords a ward view of care interaction monitoring, whereas Wi-Fi would allow the trust to leverage the existing access points while limiting the functionality around patient tracking and flow.

A description of functionality in tracking of staff and patients for the improvement of service quality and safety:

- Easily accessible auditing on the locations of patients and staff on wards over a timespan to track potential exposure to an infection risk
- Data that can be used to improve setting of safe rotas and staffing levels
- Automated discharging of patients
- Automated time stamps for patient movement in and off wards

Illustration X : Typical Asset Map View of a Ward Area



Patient and staff badging can be used to automate the patient or caregiver location in Real-time Patient flow system's software by providing precise, location-based time stamps. This eliminates wait time associated with manual documentation and improves the accuracy of data and reports. In addition, patient and staff badging provides valuable real-time information like how long it has been since a patient was last seen by a caregiver, where to find patients scheduled for time- sensitive treatment or when a high-risk patient is leaving a "safe" area.

Patient, staff and asset location data also drives powerful reporting, such as caregiver interaction reports that can be used to measure the duration of time spent between a patient and caregiver or to track the spread of infection.

Advanced RTLS Integration with Real Time Patient Flow Solution

Visibility to Last Seen and Care-in-Progress

Family members can find out at the nursing unit whether the patient is being seen by a caregiver, or the last time that he or she was seen.

Users can set thresholds in minutes, customisable by unit, to provide a red visual indicator when too much time has gone by without a patient being seen by a caregiver.

Automated Patient Location

- Automated Patient Location
- Automate the occupation of beds in the Real-Time Patient Flow Solution which reduces manual steps in the patient flow process.
- Get the most accurate real-time view of where patients are located within a healthcare setting.
- Reduce manual steps, eliminate human errors and increase documentation compliance.
- Improve accuracy of data and reports so that historic reporting on patient movement can be used to predict future demand.

Interaction Reporting

Patient and Staff Interaction Durations

This report provides data about the frequency and the length of interactions between patients and staff with Real-time Patient flow and Tracking system. This information can be helpful when researching patient care and can also help reassure family members about the how often their loved ones are receiving care. The data can also be useful when researching costs associated with staff and patient interactions.

Asset/Patient/Staff Interaction Report

This report shows instances when assets, patients, and staff members have been in the same location. This information is helpful if you are attempting to track the spread of infection or to audit an incident reported by a patient or staff member. It can also be used for tracking the interactions of patients and staff with devices that may have malfunctioned or are suspected to have spread infection/disease. The patient staff interaction reporting is also used to find out how much direct care a patient receives from nursing or medical staff, this can also be split and reported on by staff qualification.

Patient and Staff Alarms

Patient Walkout Alarm

The patient walkout alarm can promote safety and security, especially in units with special patient populations, such as those with dementia patients or prisoners. If the alarm is enabled, then when a badged patient leaves the unit without a badged staff member, an alarm sounds. In addition to an audible alarm ringing, a warning will appear on the Real Time Patient Flow application screen.

Isolated Area Alarm

Similar to the patient walkout alarm, when patients are badged, an alarm can be enabled to alert staff whenever a patient has spent too much time in an isolated area without staff assistance. The time thresholds are configurable to meet the individual standards of each healthcare facility.

Staff Assistance Alarm

In addition to the patient centric alarms, staff members can push a button on their staff badge to indicate the need for immediate assistance. For example, this can be useful when a staff member needs to physically move or attend to a patient and cannot do so without help.

An audible alarm will ring and a warning will appear on the Real Time Patient Flow Solution application screen whenever staff members press the assistance button.

Indicative pricing for planning:

5/9/2019						
Estimate for:	**Maidstone Tunbridge Wells NHS Foundation Trust** Budgetary Estimate for AutoDischarge and adding Asset Tracking at 2 sites based on a combined total of 759 beds, 40 wards, and similarly sized deployments.	**Beds -->**	GBP 303 Maidstone Auto Discharge	GBP 429 Tunbridge Auto Discharge	GBP Maidstone ADD: Ward Level Asset Patient Staff Tracking	GBP Tunbridge ADD: Ward Level Asset Patient Staff Tracking
Monthly Fees:						
	Upfront Fee for Hardware		£ 36,334	£ 41,314	£ 152,916	£ 187,938
	Upfront Fee for Implementation and Training		£ 66,240	£ 66,240	£ 304,198	£ 323,288
	5 years - 60 month term		£ 1,967	£ 2,673	£ 3,704	£ 4,887

Hardware Included:	Quantity	Quantity	Quantity	Quantity
Beacon	20	20	527	623
Virtual Divider	20	20	-	-
Collector	20	20	77	104
Timing Collector	1	1	1	1
Patient Badges	394	560	-	-
Staff Badges	-	-	-	-
Asset Tags	-	-	-	-
Drop Box	20	20	-	-

Tag and Dropbox Options:	GBP Price Ea	GBP Maint / Mo
Asset Tag, Mini	£ 44.00	£ 0.55
Asset Tag, Micro	£ 52.50	£ 0.66
Patient Badge, Mini	£ 30.00	£ 0.38
Patient Badge, 31-Day	£ 4.00	
Staff Badge	£ 60.00	£ 0.75
Drop Box with Virtual Divider	£ 452.50	£ 5.66

Notes: This pricing is a guide for future planning and subject to notes below

(1) Number of Collectors and Beacons is estimated by bed count, square footage, and similarly sized deployments. Final pricing would be determined by a review of workflows, validation of CAD drawings and final solution design.

(2) Proposal does not include required servers or PoE ports and assumes PoE ports are available for required Collectors. Installation of infrastructure (Collectors and Beacons) is not included. The

Client will install this infrastructure to supplier specifications. A Technical Sale Specialist will review specifications with the Client.

(3) Base Software includes our latest version of Asset, Patient, and Staff Management.

(4) Estimate valid for 90 days.

Version history

Version	Issue date	Brief summary of change	Owner's name

Pre- submission checklist

Item	Complete
Completed fully signed business case template	Yes/~~no~~
Revenue breakdown completed	Yes/~~no~~
Capital breakdown completed	Yes/~~no~~
Supporting statements from stakeholders attached	Yes/~~no~~
Quality impact assessment completed	Yes/~~no~~
Commissioner support agreed	N/A
Appendices attached	N/A

Appendix 2

Year one Expectation (Full Year Effect)

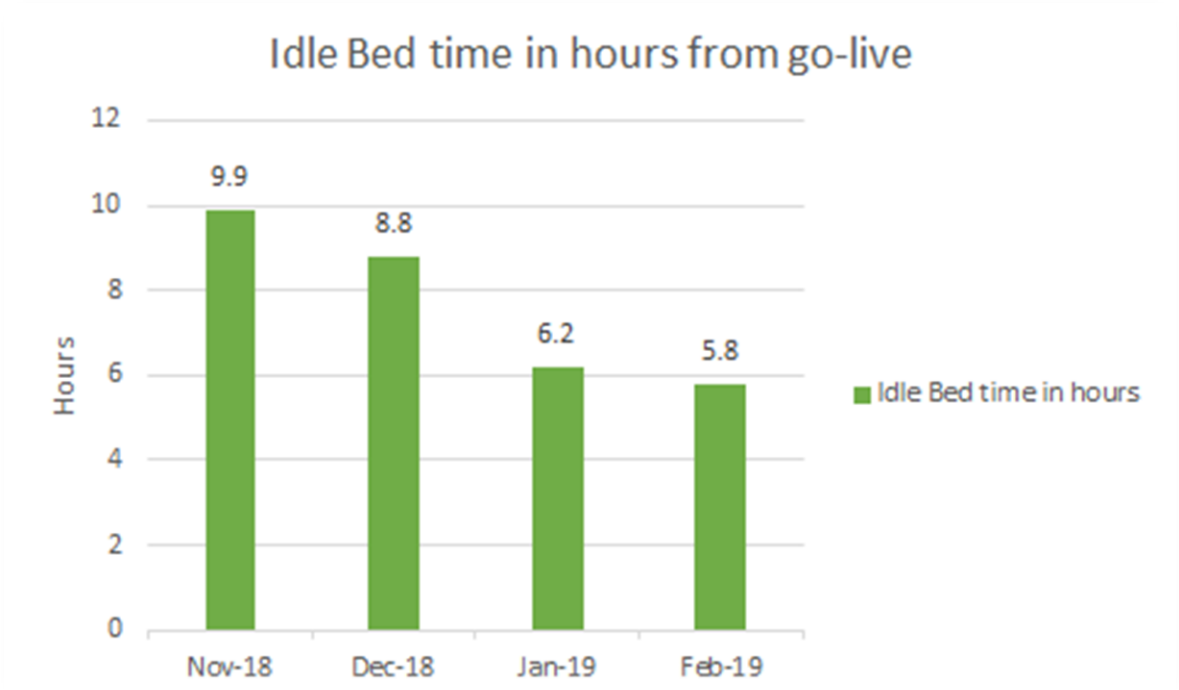
In this section we have outlined in more detail benefits realisation in the 'first half-year' operation of a real-time patient flow solution. It is worth emphasising that directly from go-live using a real time patient flow solution MTW will have a full both site real time view of beds, demand and bed status and status of patients' readiness for discharge in a single system and coordinated from a single operation centre. However, it is worth detailing further detail on benefit realisation in the first period post go live.

The areas of benefits realisation are based on benefits released from reducing Idle bed time and the release of nursing time from managing patient flow and bed cleaning.

Idle Bed Time

Idle bed time is the symptom of poor, non-real time patient flow. Using a real time patient flow solution is key to visualising the areas of idle bed time and the action of utilising the solution begins from day one to reduce idle bed time and improve flow and release latent bed time from the current bed stock.

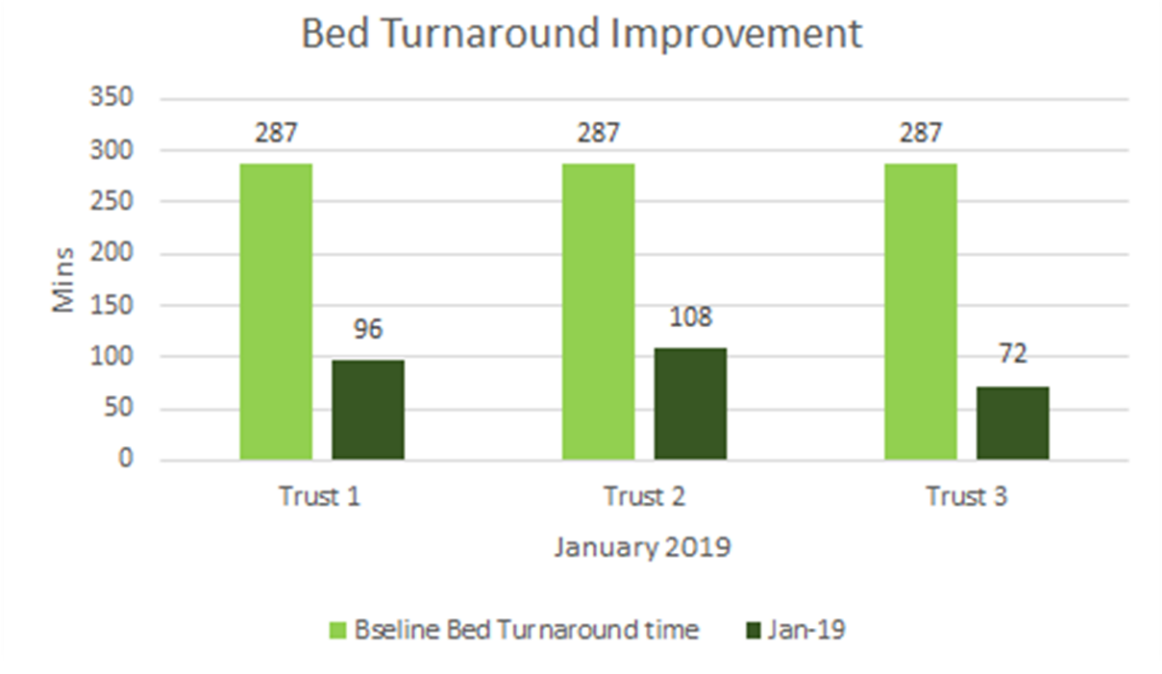
Figure 1: Illustration of reduction in Idle Bed time in hours for an English NHS Trust using a Real Time Patient Flow Solution



Source: Real Time Patient Flow Solution NHS Client (assuming Nov 2018 as baseline)

A significant contributing factor for early return on investment is the impact to idle bed time contributed by bed turnaround time and

Figure 2: Bed turnaround improvement (January 2019 two-months post go –live)

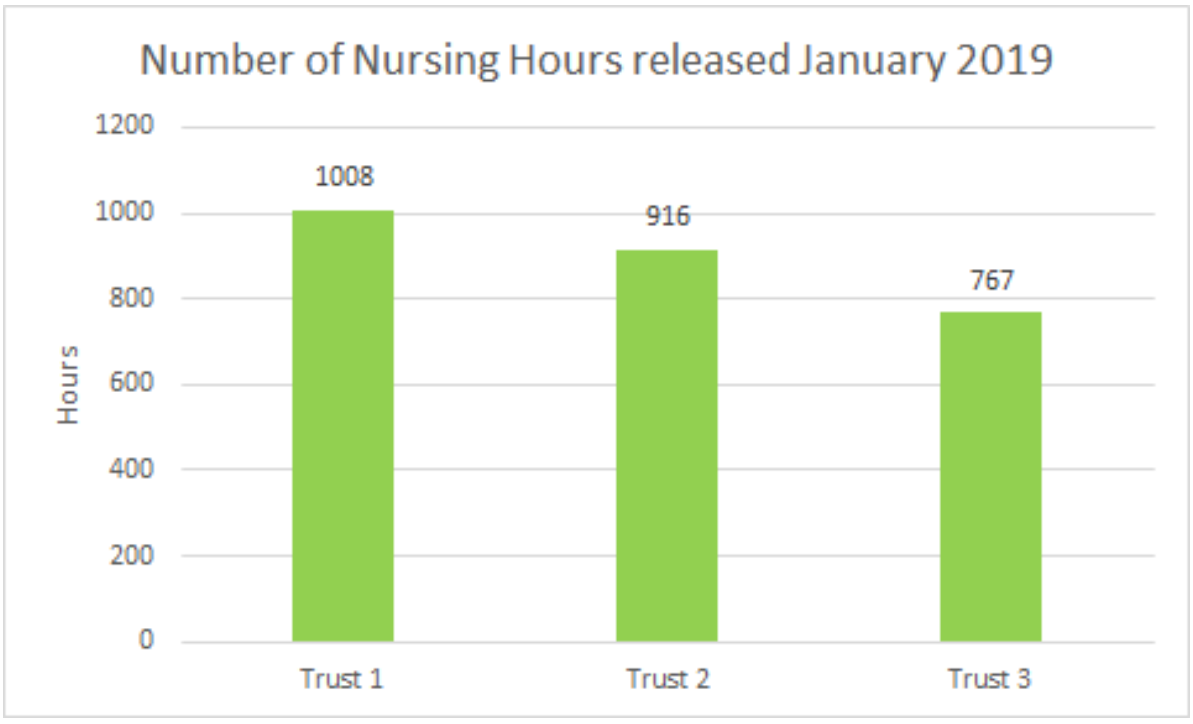


Source: Real Time Patient Flow Solution NHS Client

In this above example of performance improvement in idle bed time was the equivalent of **14 to 20** beds in the first four-month period from go-live.

The institution of a bed cleaning team to support turnaround and generate real time patient flow information, the release of nursing time as a benefit directly from go-live.

Figure 3: Release of Nursing hours in January 2019 (two months post go live)



Source: Real Time Patient Flow Solution NHS Client

Soft Benefits

All trusts deploying Real Time patient flow solutions report significant changes in patient flow and patient flow work load on the wards and in the command centre / operations room from go-live.

Following is a list of the reported changes experienced:

- Reduced Phone calls regarding patient flow up dates
- Reduced Escalation / patient flow meetings and need to generate sit-reps
- Reduced calls to portering
- Reduced ward interruptions on the ward from bed managers
- Reduced need for on-call management staff to come into site out of hours
- Improved levels of communication across other health partners.

Appendix 3

Full report from the live audit embedded below for complete narrative

MTW report March 2019 v 9 NS.docx

Appendix 4 (Investment)

Costs	Description	Yr1	Yr2	Yr3	Yr4	Yr5	Yr6	Yr7	Yr8	Yr9	Yr10	Total
Local Investments and Costs												
* Bed Cleaning Team	Additional staff to increase the clearning team, creating a central bed clearning team as sepcificed within the business case.	181,249	543,746	543,746	543,746	543,746	543,746	543,746	543,746	543,746	543,746	**5,074,963**
System Manager	System manager (band 7) to reside within CSMT to provide management and support of the application.	19,399	58,196	58,196	58,196	58,196	58,196	58,196	58,196	58,196	58,196	**543,163**
Wristbands	Replacement tracking wristband. To replenish stock when wristbands are lost or broken.		4,000	8,000	8,000	8,000	8,000	8,000	8,000	8,000	8,000	**68,000**
Bed Management IT Infrastructure	The TWH site office will be developed to become the central command base for bed management across the Trust. There is also a requirement to add addiitonal 42" screens to each Ward to allow for easier visability of bed data.	32,410	31,430	30,450	29,470	28,490	32,410	31,430	30,450	29,470	28,490	**304,500**
Local Implementation Costs	Trust side implementation costs, including management, technial and change resource.	185,000										**185,000**
Supplier Cost												
Cost of Real Time Patient Flow system (+)	Annual software subscription cost for the patient flow system and utilisation and configuration costs	250,800	752,400	752,400	752,400	752,400	752,400	752,400	752,400	752,400	752,400	**7,022,400**
System Hosting Costs	Annual management cost for the patient flow solution, including support and hosting.	47,200	141,600	141,600	141,600	141,600	141,600	141,600	141,600	141,600	141,600	**1,321,600**
Implementation	Supplier implementation costs including configuration, technical install, project management and trasformation services. Also provision of initial hardware (wristbands and readers)	612,000										**612,000**
Total Costs		**1,328,057**	**1,531,372**	**1,534,392**	**1,533,412**	**1,532,432**	**1,536,352**	**1,535,372**	**1,534,392**	**1,533,412**	**1,532,432**	**15,131,625**

Part 2

Hygiene Solutions

Introduction

The Trust currently uses products from Hygiene Solutions in order to undertake level 4 cleans post discharge of patients that meet these infection control requirements. This process takes 4 hours to complete and can often be longer due to the need to wait for Interserve to isolate ventilation and cap off the smoke detectors in the affected room. There is a significant number of bed days lost due to this process.

Hygiene Solutions have developed their technology and have this proposal discusses the benefits from the Trust adopting this newer technology.

Proposal detail

HS Your Proposal 160719.pdf

The significant difference in this technology is the active withdrawing of the chemical from the room rather than waiting for the chemical to dissipate. There will also be training for the domestic staff to cap off the smoke alarms again to reduce the time.

Benefit

The time to undertake a level 4 clean will reduce to 2 hours due to the technology changes described in the embedded proposal. This has the benefit of releasing a further 55 bed days each year due to the reduced time taken.

Costs

Costs and options for purchase, rental or lease are included in the embedded file above a summary of the options is below

Description of Goods	3 Year Cost Summary	6 Year Cost Summary
Purchase Option: • Initial equipment purchase • Annual Service Level Agreement **Total:**	 £186,632.00 £56,151.36 **£242,783.36**	 £186,632.00 £109,969.20 **£296,601.20**
Lease Purchase Option: • Expected lease purchase costs for all equipment inclusive of Service Level Agreement **Total:**	 £271,416.40 **£271,416.40**	 £347,767.36 **£347,767.36**
Rental Option: • Rental costs for ProXcide systems inclusive of Annual Service Level Agreement • Initial accessories equipment purchase costings **Total:**	 £215,328.00 £27,900.00 **£243,228.00**	 — — —

Please note: All prices are exclusive of VAT. Subject to Terms and Conditions.

Savings

Based on a saving of 55 bed days there is a potential cash releasing benefit of £27,500 but the main benefit is the reduction time cleaning allowing for beds to be available at the time that they are needed and reducing delays in getting patients to the right bed.