Maidstone and Tunbridge Wells NHS Trust

Trust Board Meeting ('Part 1')

26 September 2019, 09:45 to 13:00
Pentecost / South rooms, The Academic Centre, Maidstone Hospital

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

Agenda

09-1

To receive apologies for absence

David Highton

09-2

To declare interests relevant to agenda items

David Highton

09-3

To approve the minutes of the 'Part 1' meeting of 25th July 2019

David Highton

Board minutes 25.07.19 (Part 1).pdf (12 pages)

09-4

To note progress with previous actions

David Highton

Board actions log (Part 1).pdf (2 pages)

09-5

Safety moment

Claire O'Brien / Peter Maskell

Safety Moment.pdf (3 pages)

09-6

Report from the Chair of the Trust Board

David Highton

Chair's report.pdf (1 pages)

09-7

Report from the Chief Executive

Miles Scott

CEO report.pdf (2 pages)

Patient experience

09-8

Outpatient transformation

A presentation will be given at the meeting

C. O'Brien / S. O'Neil / C. Tsatsaklas

Integrated Performance Report

09-9

Integrated Performance Report for August 2019

Miles Scott

IPR (complete).pdf (72 pages)

09-9.1

Safe (infection control)

Sara Mumford

09-9.2

Safe

Claire O'Brien

09-9.3

Effective (mortality)

Peter Maskell

09-9.4

Effective

Sean Briggs

09-9.5

Caring

Claire O'Brien

09-9.6

Responsive

Sean Briggs

09-9.7

Well-Led (workforce)

Simon Hart

09-9.8

Well-Led (finance)

Steve Orpin

09-9.9

Safe (planned and actual ward staffing for July and August 2019)

Claire O'Brien

09-9.10

Safe (update on progress with the Perinatal Mortality Review Tool)

Claire O'Brien

09-10

Review of the Board Assurance Framework 2019/20

Kevin Rowan

Board Assurance Framework 2019-20.pdf (16 pages)

Quality items

09-11

Quarterly mortality data

Peter Maskell

Quarterly Mortality Report.pdf (11 pages)

Planning and strategy

09-12

Briefing on the range of 'virtual' clinic / consultation IT systems used and / or planned for use at the Trust

Miles Scott

Outpatient Digital Transformation.pdf (4 pages)

09-13

The Kent and Medway Sustainability and Transformation Partnership (STP): proposed establishment of a single NHS Clinical Commissioning Group; and update on the System Transformation Programme

Miles Scott

K&M STP update.pdf (9 pages)

09-14

Review of the Kent and Medway STP Strategy Delivery Plan (and approval of relevant aspects)

Amanjit Jhund

STP Strategy Delivery Plan.pdf (23 pages)

KMSTP Strategy Delivery Plan (2).pdf (12 pages)

09-15

Presentation on the Emergency Planning live exercise held in June 2019

A presentation will be given at the meeting which will include a video

J. Weeks / K. Birney / S. Davis

09-16

Update on the Trust's preparations for the UK's exit from the EU

Sean Briggs / John Weeks

Preparations for EU Exit.pdf (4 pages)

Assurance and policy

09-17

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

Sean Briggs / John Weeks

EPRR - Core Standards self assessment.pdf (18 pages)

09-18

Responsible Officer's Annual Report 2018/19

Peter Maskell

Responsible Officer's Annual Report 2018-19.pdf (20 pages)

09-19

Health and Safety Annual Report 2018/19 (incl. agreement of the 2019/20 programme, incl. Trust Board annual refresher training on Health and Safety, Fire Safety and Moving and Handling)

Sean Briggs / Rob Parsons

H&S Annual Report 2018-19 and programme 2019-20.pdf (30 pages)

09-20

Six-monthly update on Estates and Facilities

Doug Ward

Estates and Facilities 6 monthly update.pdf (5 pages)

Reports from Trust Board sub-committees

09-21

Charitable Funds Committee, 23/07/19

Sarah Dunnett

Charitable Funds Cttee, 23.07.19.pdf (1 pages)

09-22

Finance and Performance Committee, 20/08/19 (incl. approval of revised Terms of Reference and quarterly progress update on Procurement Transformation Plan)

Neil Griffiths

Summary of Finance and Performance C'ttee 20.08.19.pdf (14 pages)

09-23

Finance and Performance Committee, 24/09/19

Neil Griffiths

Summary of Finance and Performance C'ttee 24.09.19.pdf (1 pages)

09-24

Audit & Governance Committee, 07/08/19 (incl. the Annual Audit Letter for 2018/19)

Maureen Choong

Audit and Governance Cttee, 07.08.19.pdf (14 pages)

09-25

Quality Committee, 14/08/19 and 11/09/19

Sarah Dunnett

Summary of Quality C'ttee, 14.08.19.pdf (1 pages)

Summary of Quality C'ttee, 11.09.19.pdf (1 pages)

09-26

Patient Experience Committee workshop, 04/09/19

Maureen Choong

Patient Experience Cttee, 04.09.19.pdf (1 pages)

09-27

To consider any other business

David Highton

09-28

To receive any questions from members of the public

David Highton

09-29

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: 31st October 2019, 9.45am, Lecture Rooms 1 and 2, The Education Centre, Tunbridge Wells Hospital

MINUTES OF THE TRUST BOARD MEETING ('PART 1') HELD ON THURSDAY 25TH JULY 2019, 9.45A.M, AT TUNBRIDGE WELLS 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)
	Claire O'Brien	Chief Nurse	(COB)
	Steve Orpin	Chief Finance Officer	(SO)
	Miles Scott	Chief Executive	(MS)
In attendance:	Amanjit Jhund	Director of Strategy, Planning & Partnerships	(AJ)
	Sara Mumford	Director of Infection Prevention and Control//Deputy Medical Director	(SM)
	Emma Pettitt-Mitchell	Associate Non-Executive Director	(EPM)
	Kevin Rowan	Trust Secretary	(KR)
	Sarah Blanchard-Stow	Head of Midwifery and Quality	(SBS)
	Sue Forsey	Head of Digital Programmes (for item 07-15)	(SFy)
	Jo Garrity	Head of Staff Engagement & Equality	(JG)
	Christian Lippiatt	Freedom to Speak up Guardian (for item 07-11)	(CL)
	Sharon Melville	Co-Chair LGBT+ Network (for item 07-8)	(SMe)
	Mick Stupples	Co-Chair LGBT+ Network (for item 07-8)	(MSt)
	Violet Whiting	Cultural Diversity Network member (for item 07-8)	(VW)

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

07-1 To receive apologies for absence

Apologies were received from Karen Cox (KC), Associate Non-Executive Director; Neil Griffiths (NG), Non-Executive Director; Simon Hart (SH), Director of Workforce; and Peter Maskell (PM), Medical Director.

07-2 To declare interests relevant to agenda items

DH declared, in NG's absence, that NG was the UK Managing Director of TeleTracking Technologies International, the company that provided the preferred option in the Business Case to be considered under item 07-19. MS added that NG had however not been involved in any discussions regarding the introduction of the TeleTracking system at the Trust.

07-3 Minutes of the 'Part 1' meeting of 27th June 2019

The minutes were approved as a true and accurate record of the meeting, and DH noted that the minute of item 06-8 had been checked for accuracy by the patient's relative that had attended the meeting for that item.

07-4 To note progress with previous actions

The circulated report was noted.

07-5 Safety moment

COB referred to the relevant attachment and reported that the theme for July was diabetes. COB then highlighted the following points:

- The theme had been selected following a Serious Incident (SI) which led to a patient's death. HM Coroner had then issued a Preventing Future Deaths (PFD) report, to which the Trust had replied

- Work had been undertaken on developing guidelines and raising awareness of the 'hypo box'. There had also been a focus on the national diabetes inpatient audit
- Further work was however needed to embed the issue

AJ referred to the report stating that new onset Hyperglycaemic Hyperosmolar State (HHS) could develop due to dehydration during severe hyperglycaemia, and noted that hydration was currently an issue at Maidstone Hospital (MH). COB agreed that the issue was important and noted that efforts had been made to ensure patients were hydrated. SM added that "hydration stations" had also been implemented on each ward, for staff to be able to drink, which had been supported by the Leagues of Friends.

07-6 Report from the Chair of the Trust Board

DH reported the following points:
- There had been no Advisory Appointments Committee (AAC) panels since the last Trust Board meeting, but two oncologist panels would be held over the next few weeks
- An interview had been held on 16/07/19 for a new Non-Executive Director, and a recommendation had been made to NHS Improvement (NHSI) to appoint a candidate, who would chair the Audit and Governance and Charitable Funds Committees, and be a member of the Finance and Performance Committee. DH thanked MC for chairing the Audit and Governance Committee in the interim period

07-7 Report from the Chief Executive

MS referred to the relevant attachment and highlighted the following points:
- There had been lots of engagement with the Trust's key stakeholders in relation to the decision made at the 'Part 2' Trust Board meeting on 27/06/19 regarding stroke services
- The work to improve staff facilities and amenities continued, and ice cream vans had been commissioned at the Trust on 24/07/19. The vans had been very well received by staff and MS wished to thank Tracey Reeder and Teresa Jarrett for organising the vans

DH referred to point 10, which highlighted that the Trust was one of only nine in England to be selected to pilot a virtual consultation system, and noted that he was unaware of the pilot. MS stated that many 'virtual' systems were used at the Trust, and it would therefore be beneficial to collate the details of such systems. AJ added that he had met with the Director of IT and that mapping was already underway. MS therefore suggested that a report on the issue be submitted to the next Trust Board meeting. This was agreed.

Action: Arrange for a report to be submitted to the Trust Board meeting in September 2019 on the range of 'virtual' clinic/consultation systems used and/or planned for use at the Trust (Chief Executive, July 2019 onwards)

SDu then referred to point 9 and commended the improvements that had been made in Research and Development.

07-8 Update from the Trust's Staff Network Chairs

DH welcomed JG, SMe, MSt and VW to the meeting. VW then gave a presentation on the Cultural Diversity Network which highlighted the following points:
- The network was now two years old. The last Chair had resigned due to clinical commitments and the Deputy Chair left the Trust, so a new Chair (Rantimi Ayodele, Consultant Paediatric Trauma & Orthopaedic Surgeon) was appointed in July 2019
- The network's achievements over the last year included a disciplinary case review; a bullying & harassment case review; an event (in October 2018) to celebrate Black History Month; and "The Power of Me!" Event in July 2019, which had been attended by over 30 staff
- The plans for the year ahead included continued active involvement in Human Resources case reviews; the celebration of Black History Month in October 2019; work on the Workforce Race Equality Standard (WRES) action plan; promoting more involvement in the network; and "Walk the Hospital" 'meet and greets' with Black and Minority Ethnic (BME) and International Staff

JG then gave a presentation on the Disability Network, which highlighted the following points:

- The network, which was previously called the Workability Network, had not been as successful as the other networks and it had not been able to meet that year
- The Workforce Disability Equality Standard (WDES) was a new issue, for which a submission was being developed. The WDES was intended to be used as a catalyst for the future development of the network.
- The WDES submission included a comparison of disabled and non-disabled staff; the number of staff per band (including Trust Board members); the likelihood of staff being appointed from shortlisting; and the likelihood of staff entering formal capability process
- The national NHS staff survey metrics reported on the percentage of disabled staff who had… experienced bullying/harassment from patients, managers and colleagues; reported bullying/harassment; believed that the Trust provided equal career opportunities; felt pressure from managers to come to work despite not feeling well enough to perform duties; were satisfied with the extent the Trust valued their work; and who felt that adequate adjustments had been made to enable them to carry out their work

SO referred to the latter point and noted that the national staff survey findings for finance department staff had identified some issues for staff with long-term conditions who had queried whether adequate adjustments had been made & therefore asked how “disabled” was defined. JG confirmed that anyone with a long-term condition was disabled, and therefore people with cancer were disabled, although some with such conditions would not regard themselves as disabled.

A discussion was then held on hearing loss and the potential to offer staff free hearing tests, and JG suggested that hearing tests be included in the staff ‘MOT’/wellbeing checks that were planned. MS agreed that option should be considered.

Action: Arrange for free hearing tests for staff to be considered for inclusion within the staff ‘MOT’/wellbeing checks that were planned to be introduced (Director of Workforce, July 2019 onwards)

MS asked whether the networks’ members communicated via WhatsApp ‘chat’ groups. JG noted that was not currently used, but agreed it was a good idea.

SMe and MSt then gave a presentation on the LGBT+ Network, which highlighted the following points:

- The network was now two years old, and was co-chaired by SMe and MSt. PM was the Executive Sponsor
- The network’s achievements in the past year including participation in the Brighton Pride (in August 2018) with Brighton and Sussex University Hospitals NHS Trust; a review of bullying & harassment cases (September 2018); an LGBT+ conference in October in 2018 (at which PM had spoken); celebrating LGBT History Month (in February 2019); reviewing the results of the Stonewall Workplace Equality Index (WEI) in March 2019; participating in the Canterbury Pride with Kent and Medway NHS and Social Care Partnership Trust and Kent Community Health NHS Foundation Trust (KCHFT) in June 2019; the launch of the NHS Rainbow Badge (in June 2019); and flying the Trust’s rainbow flag (in July 2019)
- The plans for the year ahead included increased performance in the Stonewall WEI score; updating Human Resources policies and procedures; increased active advertising of the network; continued recruitment of LGBT+ Allies; improved Executive support of the network (to be the voice of the network and respond to negative comments from staff and patients); scrutiny of LGBT inclusion within procurement processes; commitment to the wider community; and consultation with service users

SMe then elaborated on some of the negative comments that had been received from staff and patients. SMe, MSt and VW then thanked JG for her work in supporting all of the networks.

SMe then commented that although the aforementioned ice cream vans had been very well received and managers had been able to release staff to queue for an ice cream, so it would be great if support could be given to enable managers to release their staff to attend the networks’ meetings. The point was acknowledged.

MC then referred to the reference to negative comments being made towards the networks' work and emphasised that any form of abusive behaviour was unacceptable. The point was acknowledged.

AJ noted the importance of PM as the Executive sponsor for the LGBT+ network and asked whether there were Executive sponsors for the other networks. JG confirmed that COB was the sponsor for the Cultural Diversity Network, whilst SH was the sponsor for the Disability Network. JG also reiterated SMe's point of the importance of members of the Executive Team supporting the release of staff to participate in the networks' activities.

DH referred to the impending influx of nurses from India and emphasised the need for them to be appropriately supported. SMe asked whether a 'welcome pack' had been developed for such staff. JG confirmed that a pastoral support group was exploring such issues and that appropriate liaison would be undertaken with the Diversity Networks. COB noted that additional ideas were however welcome. SMe pointed out that some of the original cohort of Filipino nurse recruits still worked at the Trust and suggested they be contacted for advice. The suggestion was acknowledged.

MS emphasised that circa 400 staff would arrive from India, which would be circa 10% of the Trust's total workforce, and although support would be provided, work should also be done to challenge the view that support for one group of staff would occur at the expense of support to other staff groups. The point was acknowledged.

MS then commented that he was unaware of some of the negative issues SMe had referred to earlier and asked whether discussions had been held with the staff members who had made negative comments regarding the networks. JG explained that many of the negative comments had been made via the Trust's anonymous reporting process. MS acknowledged that, but asserted that any specific instances of unacceptable behaviour should be drawn to members of the Executive Team's attention. The point was acknowledged.

MS also asked whether there were any plans to repeat the "Power of Me!" event, which he had not been able to attend. JG replied that there were no such plans, but that would now be reconsidered.

DH concluded the item by thanking JG, SMe, MSt and VW for attending.

07-9 Integrated Performance Report for June 2019

MS referred to the relevant attachment and highlighted that the report required further development, particularly in relation to forecasting and the highlighting of key actions rather than summarising large data sets. MS stated that comments on the format were therefore welcome.

COB then highlighted the following details regarding the "Safe" domain:

- Falls had reduced overall, but Trauma & Orthopaedics had slightly higher levels and the situation was currently under review. There had also been great engagement with the falls Commissioning for Quality and Innovation (CQUIN) target, which required the taking of patients' lying and standing blood pressure. September was also national falls month
- One Never Event had been reported the previous month. Although 52 SIs had passed their breach date, 29 were with West Kent Clinical Commissioning Group (CCG). It was therefore important to develop the narrative in the report to reflect such nuances. Patient Safety would be focused on over the next few months, following the investment in the Patient Safety Team
- The planned v actual staffing data showed a slight improvement overall in the shifts that had been filled, but there had not been a dramatic change since the previous month

SDu referred to MS' remarks regarding forecasting and commented that the report did not yet contain consistent content in relation to the 'so what' aspect, particularly in relation to falls, which was at its highest rate for some time. COB acknowledged the need to refine the data analysis and work with the Business Intelligence Unit.

SM then highlighted the following details for Infection Control:

- Clostridium difficile cases were below the target by one case
- MRSA bacteraemia cases were below last year's level

- The prevention-related work for gram negative bacteraemia continued, but it was too early to state whether there was a trend. Catheter-Associated Urinary Tract Infection (CAUTI) prevention work also continued and the Deputy Director of Infection Prevention and Control was working closely with clinical colleagues
- The new junior doctor intake arrived soon and there would be a focus on antibiotic prescribing and infection control training

SM then highlighted the following details for mortality:
- The Hospital Standardised Mortality Ratio (HSMR) was still well below 100
- Work continued on investigating the difference between weekend and weekday mortality, although the differences appeared to have dissipated in the latest data
- The working group for the implementation of Medical Examiner role was making progress and the role was expected to be introduced by the end of March 2020

MC stated that the 'main' Quality Committee meeting on 10/07/19 had heard that there was still an issue with weekend mortality. SM confirmed that was the case and that the matter was being investigated.

COB then highlighted the details regarding the "Caring" domain:
- The Friends and Family Test (FFT) process would be revised, but there were no concerns regarding the variance in the response rate
- The complaints response rate was 45.7%. However Divisional performance had improved so the delays had mainly been due to factors within the Corporate Complaints Team. Meetings had been held with the Divisional Directors of Nursing and Quality (DDNQs) and appropriate assurance had been given. The focus had therefore now moved to supporting the Corporate Team. COB was confident that improvements would be made, but these would take time

MS asked COB to give more details on the complaints response performance forecast, which was reported as being below the 75% target. MS also asked for the specific steps that would be taken to ensure the improvement was sustainable. COB replied that engagement would continue with Divisions, to ensure that the responses submitted to the Corporate Team were satisfactory. COB added that work would also focus on supporting the staff within the Corporate Complaints Team.

DH stated that he understood that NHS England (NHSE) would be stopping the FFT. COB confirmed the FFT was being reviewed, but no decision had yet been made regarding its future.

SB then highlighted the following details for the "Effective" and "Responsive" domains:
- A&E 4-hour waiting time target performance remained strong, despite the continued record levels of attendances, and Type 1 attendances in particular, which were likely to be above 15,000. The Trust was currently rated as the eighth best Trust nationally
- Ambulance handover performance had been discussed in detail at the Finance and Performance Committee meeting on 23/07/19, and it had been acknowledged that improvement was required. The target would be one of the first Quality, Service Improvement and Redesign (QSIR) projects & the Clinical Director for Emergency Care was engaged in improvement efforts

EPM asked what 'Type 1' attendances were and SB explained that 'Type 1' patients were those with more serious conditions. MS elaborated that the Type 1 patients were often the main focus because such patients were most likely to breach the A&E 4-hour waiting time target.

DH stated that the 7% year-on-year increase in attendances was ahead of demographic changes and therefore likely reflected structural changes, which may include lack of access to primary care, although definitive evidence was not available. SO stated that the largest level of increased activity was for Minor Injuries Unit (MIU) activity, which had risen by 8%, and 'GP in A&E' activity, which had increased by over 20%. SB acknowledged the point but reiterated the significant increase in Type 1 activity. MS asserted that although there had been significant year-on-year growth, the key comparison should be with the activity levels expected in the Trust's 2019/20 plan, and thus far, activity and demand was within that plan. The point was acknowledged.

DH then stated that he would discuss the issue of whether patients conveyed by ambulance should be admitted directly to the Acute Medical Unit (AMU) outside of the meeting, as he had not

been convinced by the arguments against such an approach that had been given at the Finance and Performance Committee meeting on 23/07/19. SB acknowledged the point.

SB then continued, and highlighted that June had been a disappointing month for ophthalmology Referral to Treatment (RTT) performance, so work would take place with the Directorate's Clinical Director and wider team. DH asked whether RTT waiting time performance had been adversely affected by the national pension situation. SB confirmed that was not the case but described some of the issues that had been, and would likely be, affected by the pension situation. A discussion was then held on the matter and it was noted that the current national consultation on a "50/50" arrangement was considered to be insufficient to address the pension problem. MS also explained the SH's department had undertaken a survey which had indicated the proportion of affected staff who expected to work fewer hours, but whom had not done so. DH asked what contractual arrangements existed in relation to reducing Programmed Activities (PAs). SM confirmed that consultants could reduce their PAs to 10, as any PAs above that number were contractual. MS noted that there would however still need to be an agreement. MS then elaborated that the intention was for further work to be undertaken via the Executive Team Meeting and it was then likely that some proposals would be submitted to the Trust Board. DH asked whether the Trust should provide advice to staff. MS confirmed that the Trust had hosted some sessions with Chase de Vere (financial advisers) and added that it was likely that the issue would affect a lot of staff, and not just senior medics.

EPM asked whether the pension problem would get worse, and if so, by when. SM stated that the impact depended on an individual's circumstances but the latest round of consultant Job Planning had seen some pressure from consultants to reduce their sessions. SB added that some issues had already been adversely affected and these would have an adverse effect on the winter plan.

DH then asked for an update on the completion date of the project to implement the Allscripts RTT module. SB stated that an endpoint of Christmas 2019 was expected but the validation process continued to be undertaken via manual means.

SB then continued, and highlighted the following points:
- 62-day Cancer waiting time target performance continued to improve and there were now only 63 patients on the waiting list backlog. NHSI expected the Trust to achieve its best ever performance in August 2019
- Work had been undertaken to communicate the improved position, and MS had attended a 'thank you' event for Cancer Services staff. However the situation remained very fragile

DH asked whether it would be possible to include the number of patients on the backlog in the performance report. MS pointed out that the number was already included in the full "responsive" scorecard, on page 48 of 50.

SO then highlighted the following points for workforce under the "Well Led" domain:
- The vacancy rate remained high, although there had been a slight improvement in the month
- Sickness absence levels were stable and at reasonable levels
- Bank staff usage remained relatively static, but nursing agency use had reduced
- Appraisal compliance was below that required and the target level may not be achieved by the end of July

SO then reported the following points for finance under the "Well Led" domain:
- The financial plan had been achieved in quarters 1 and 2, so the Provider Sustainability Fund (PSF) requirements had been met
- The 2019/20 year-end forecast had been produced for the first time. The full Cost Improvement Programme (CIP) needed to be delivered, and delivery was not currently on track. However further work was required on the forecast, as the first iteration had used quite pessimistic assumptions

SDu then referred to the relevant attachment and highlighted the following points:

- A decision on the West Kent dermatology service needed to be made by the Trust Board, but as the Board did not meet during August, the Board was asked to delegate the decision to the Finance and Performance Committee (which did meet in August)
- A Business Case for a patient tracking system was reviewed and it was agreed to support the Case in principle, on the basis that further assurance was required on several aspects

DH pointed out that the Business Case for a patient tracking system would be considered under item 07-19.

The Trust Board delegated the decision as to whether to take on the West Kent dermatology service to the Finance and Performance Committee, to enable that decision to be made at its meeting in August 2019 (after further due diligence has been conducted).

Quality Committee, 10/07/19

SDu referred to the relevant attachment and highlighted that revised Terms of Reference had been agreed and had been submitted for approval. Questions were invited. None were received.

The revised Terms of Reference were approved as submitted. The associated changes to the Committee Structure (which was an Appendix to the Standing Orders) were also ratified as submitted.

07-10 Update from the Best Care Programme Board

MS referred to the relevant attachment and highlighted the following points:
- Work was being done to embed the new methods and approach, and first tranche of QSIR Practitioners had now graduated. AJ would incorporate the QSIR methods in the planning approach for 2020/21
- Some capacity issues in the Transformation Team were being addressed
- Visits were being planned to Western Sussex Hospitals NHS Foundation Trust, to try and learn from that organisation
- Efforts were focusing on the concept of 'save to invest', rather than just 'invest to save', and that was being discussed with Divisions

Quality items

07-11 Approval of the Trust's CNST maternity incentive scheme submission

DH welcomed SBS to the meeting. COB then referred to the relevant attachment and highlighted that evidence did not need to be included in the submission, which was required by 15/08/19, but COB would review that evidence in detail, for assurance. SBS then highlighted the key points in the attachment, which included a detailed description of the evidence relating to Safety Action 10, which related to the reporting of incidents under NHS Resolution's Early Notification scheme.

DH asked for further details of the activity the Health Safety Investigation Branch (HSIB), noting that the organisation had been subject to some criticism. SBS explained the cases that HSIB were required to investigate and noted the regular liaison she had with the HSIB. SBS continued that the Trust had placed too much faith in the HSIB, so a different approach would now be taken, as, for example, the HSIB did not collect statements for its investigations, so the Trust would collect statements for HSIB investigations.

DH asked whether the Trust had to stop its engagement with families if HSIB were investigating a case. SBS confirmed that was correct, and elaborated on some of the issues arising from that requirement. SBS also outlined some concerns with HSIB's investigation practices, which included the fact that transcripts of interviews by the HSIB were not shared with the staff in advance of the publication of the investigation report; and the anomalies in the consent process that HSIB had originally used. SBS added that the concerns had been escalated via the Maternity Transformation Programme Board of the Sustainability and Transformation Partnership (STP). MS asked whether the concerns had also been escalated via the Royal College of Midwives and Royal College of Obstetricians and Gynaecologists. SBS noted that she had escalated the concerns to the former but not the latter. DH opined that the Trust needed to do something about the issue. COB

confirmed that that she was aware of the concerns, had escalated them, and that the issues would be discussed among her counterparts at other NHS organisations. It was also noted that other escalation avenues were being explored.

The Trust Board then approved the CNST maternity incentive scheme submission as submitted.

07-12 Safeguarding children update (Annual Report to Board, including Trust Board annual refresher training)

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

- It was intended in future years to have a combined annual report covering children and adults safeguarding
- The report included details of the oversight and governance arrangements
- The child death guidelines had required focus
- Children with mental health needs had also been an area of focus and there had been effective engagement with external partners. There had been less incidents than in previous years, but work needed to continue, including liaison with North East London NHS Foundation Trust
- Level 3 Safeguarding training was below the target level and compliance was reviewed at the Safeguarding Committee. It was likely that a more drastic approach would be required
- The Trust had contributed to four Serious Case Reviews which had involved deaths of children outside of the Trust, and these involved a significant undertaking by the Trust's Named Nurse for Safeguarding Children

MS asked where assurance could be obtained regarding the oversight of the Safeguarding children work. COB replied that the Trust Safeguarding Committee reported to the Quality Committee, and the last 'main' Quality Committee meeting had received an in-depth presentation by the Trust's Named Nurse for Safeguarding Children. MC added that the Committee had however acknowledged that further assurance was required in relation to compliance with mandatory training.

07-13 Safeguarding adults update (Annual Report to Board, including Trust Board annual refresher training)

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

- Kent Adult Safeguarding Alert Forms (KASAFs) had been discussed
- The Trust had contributed to two Internal Management Reviews (IMRs) and a Domestic Homicide Review (DHR)
- The Learning Disability Mortality Review (LeDeR) review process had not gone well, and 91 cases remained outstanding. The Trust was required to support the process, and it did that by undertaking a Structured Judgement Review (SJR) into the relevant deaths
- The annual report had been considered by the Quality Committee in July

DH asked who made the judgement on patients' mental capacity. COB replied that an Internal Audit review had been undertaken, which covered the arrangements for mental capacity assessments and it had been identified that improvements needed to be made in the recording of assessments, to help staff do the right thing.

SDu asked whether the KASAF process covered patients from outside Kent. COB confirmed that was the case.

Planning and strategy

07-14 The transfer of Stroke services from Tunbridge Wells Hospital to Maidstone Hospital

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

- The Kent County Council Health Overview and Scrutiny Committee (HOSC) had been supportive of the way the Trust had responded to the staffing challenges it faced, and although there had been some opposition from Councillors from Thanet, that opposition was aimed at the Kent and Medway STP, not the Trust

- SB had met with stroke staff and although they were disappointed at the situation, they were satisfied with the approach the Trust had taken, and were engaged in discussions regarding their own circumstances

A discussion was then held on the media coverage of the issue and the response by other local provider organisations.

07-15 Approval of the refreshed Trust IT Strategy

DH welcomed SFy to the meeting. SO firstly introduced the item by noting that when the Trust Board approved the IT Strategy in January 2019, it was agreed that the Strategy should be refreshed in the light of the publication of the NHS Long Term Plan. SO added that the refreshed Strategy had then been considered by the Finance and Performance Committee in June 2019.

SFy then referred to the relevant attachment and highlighted the following points:
- Sections 3.2 and 3.3 described the main changes that had been made to the Strategy that was approved in January, which included liaison with the STP and support to the wider area
- Most of the major digital deliverables in the NHS Long Term Plan had been included, as a reference at least

MS asked that the Trust Board acknowledged the financial support that had been provided to the Kent and Medway Care Record (KMCR) by Kent Community Health NHS Foundation Trust (KCHFT). The support was duly acknowledged.

AJ proposed that the Strategy be reviewed against the Trust's PRIDE values, as had been the case with the Patient and Carer Strategy the Trust Board approved in June. This was agreed.

Action: Liaise with the Director of IT and/or colleagues to ensure the revised IT Strategy made a specific reference to the Trust's PRIDE values (Director of Strategy, Planning and Partnerships, July 2019 onwards)

The Trust Board approved the refreshed Trust IT Strategy, subject to the agreed action.

07-16 Update on the NHS Long Term Plan

AJ referred to the relevant attachment and highlighted the following points:
- The key next steps were listed in the report and although the timescales for the required submissions were known, the detailed content and templates for those submissions were not. The Trust's approach would be influenced by the content of such templates
- The STP had begun a response to the implementation framework and a discussion would be held at the Executive Team Meeting on 30/07/19 to ensure that the correct individuals were allocated to lead on production of the required content

DH noted that the first draft response from the STP was due by the end of September 2019, but the final submission would not be submitted until mid-November 2019. DH added that it had been agreed to set up a Non-Executive Director meeting, and invite Non-Executive Directors from across the STP, to enable them to contribute to the STP plan before the final submission was made. KR asked whether that would mean that the STP plan would not be considered at each provider organisation's Board. DH explained that the plan was expected to be considered by provider boards, in their public Board meetings, but the Non-Executive Director meeting was intended to allow more time to discuss the plan.

A discussion was then held on the plans regarding the future amalgamation of the CCGs across Kent and Medway, and the allocation of resources.

Assurance and policy

07-17 Report from the Freedom to Speak Up Guardian

DH welcomed CL to the meeting. CL then referred to the relevant attachment and highlighted the following points:
- The report would be submitted to the Trust Board each quarter

- Some bullying and harassment claims had been made which related to staff not being offered the support they should be under the Trust's relevant policy
- More concerns had been raised for Tunbridge Wells Hospital (TWH) than for MH
- The resources allocated to the Freedom to Speak Up agenda had been small, but that was being discussed
- CL believed that the Trust should consider replacing the grievance policy with a "resolutions" policy, as the word "grievance" had negative connotations

MS asked whether SH was responding to the latter proposal. CL confirmed he had raised the issue with SH but MS asked that SH be allocated a specific action in his absence. This was agreed.

Action: Consider the proposal from the Freedom to Speak Up Guardian to rename the Trust's "grievance" policy as a "resolutions" policy (Director of Workforce, July 2019 onwards)

MS asked which staff were included in the "Clinical Support" "Staff Group" on the table on page 2. CL described which staff were included and offered to categorise the groups further. MS explained that his point was whether the reports raised by the "Clinical Support" group were from one particular area or department, as if that was the case, the leaders in that area needed to be asked to respond. CL acknowledged the point and stated he would reflect on the presentation of similar data within future reports.

MC asked how the number of contacts compared to the Trusts with more established Freedom to Speak Up Guardian roles. CL stated that comparative statistics were produced by the National Guardian's Office and the number of reports from the Trust was low, which could be interpreted in two ways.

MC noted that some other Trust's Chief Executives had prepared some videos on the Freedom to Speak Up Guardian role. The point was acknowledged.

SDu asked CL to clarify whether he felt any action was required by the Trust Board to support the Freedom to Speak Up agenda. CL stated that there were likely to be further cases to be reported reported and in that regard, more work was required to raise the profile of the Freedom to Speak Up Guardian role.

COB then asked for further details as to the nature of the concerns raised at TWH and CL elaborated as requested.

EPM then stated that she was concerned at the number of reports raised at TWH and asked what discussion had taken place among the Executive Team. MS confirmed that the report had not been considered at an Executive Team Meeting and that he had not seen the report before it was submitted to the Trust Board. EPM therefore asked what the Executive Team's response would be. MS stated that a similar response to the concerns raised via the Diversity Networks under item 07-8 was appropriate. SO added further details of the work that would raise awareness of CL's role, as well as the cultural issues that would aim to be identified via the diagnostic phase of the 'Exceptional People, Outstanding Care' Programme, which would be submitted to the Trust Board in January 2020.

MS then stated that he would discuss the content of the report with SH and consider whether a report should be submitted to the Trust Board in response.

Action: Liaise with the Director of Workforce regarding the content of the "Report from the Freedom to Speak Up Guardian" considered at the Trust Board meeting on 25/07/19 and consider whether a report should be submitted to the Trust Board in response (Chief Executive, July 2019 onwards)

MC noted that the report would usually be submitted to the Workforce Committee prior to being submitted to the Trust Board. KR clarified that the scheduling of Freedom to Speak Up Guardian reports to the Trust Board was related to the production of the quarterly reports that CL submitted to the National Guardian's office. KR added that it was also considered important that CL had unfettered access to the Trust Board and it was therefore appropriate for CL to submit the report

directly to the Board rather than submit it via the Workforce Committee The point was acknowledged.

07-18 7 Day Services board assurance self-assessment

SM referred to the relevant attachment and highlighted the key points therein, which included that Medicine & Emergency Care would not be compliant by the end of 2019/20, as required, due to staffing issues, but the Division was aiming to address the situation via the development of some Business Cases.

MS asked whether the compliance issues for general surgery would be improved by the implementation of the Strategic Clinical Service plan for surgery. SM confirmed that would be the case.

Reports from Trust Board sub-committees

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

SDu deferred to SB, who referred to the relevant attachment and highlighted the following points:

- The Business Case had been produced at pace and SB therefore acknowledged it had not been developed as fully as he would have liked
- The Trust's bed management system was very traditional and the TeleTracking system was a patient tracking system that would enable automation in a number of areas, such as notifying porters when a patient had been discharged
- The Business Case had been discussed in detail at the Finance and Performance Committee on the morning of 23/07/19 and two actions had been agreed: to review the commercial arrangement to achieve the best value for the Trust; and to be clear on the financial value of the non-cash releasing benefits. SB understood that the Case had been supported in principle
- The Business Case had then been considered at the Executive Team Meeting on the afternoon of 23/07/19, and some further questions had been raised, which included some infection control related issues
- In summary, the Finance and Performance Committee had supported the Case, but noted that further actions were needed, and assurance obtained, before the Case was able to be approved

SDu asked whether the Trust had the capacity to implement the change. SB acknowledged that a significant amount of change was involved and as the Case did not just require the purchase of a new IT system, but required changes in practices and habits. SB added that the reports from other Trusts that had implemented TeleTracking were very supportive of the system, which was reported as being very easy to use. SB noted that further IT support was being considered.

MS added that the Finance and Performance Committee had identified the need to be clear on the direct and indirect (i.e. not cash- and non-cash-releasing) benefits and MS wanted to know if the processes used by the Trust's Project Management Office (PMO) could be used to that effect.

EPM asked why the Business Case had been developed at pace. SB clarified that discussions on the potential introduction of a patient tracking system had taken place for some time, but the results of the bed modelling had prompted the need to introduce a system in the near future, and the Medicine & Emergency Care Division had not yet been able to conclude its discussions with other Divisions. DH also pointed out that it was important for the Trust Board to consider the Case at its July meeting as the Board did not meet in August, and the system was required before the winter period. DH added that given the status of the Business Case, the Trust Board was probably only likely to be able to approve the Case in principle, subject to conditions, and a decision was therefore needed regarding the final decision-making process i.e. whether there should be a formal meeting or teleconference, for example.

COB commented that the Trust already had a Patient Administration System (PAS) which required a patient's discharge to be recorded, and therefore enable a live bed state to be given, but that functionality was not used. COB therefore asked whether a new system would therefore help the situation, as in her view, the main constraint was the ability to make a discharge decision, and that

would not be supported by a tracking system per se. SB acknowledged the points but stated that there had been some debate as to whether the live bed state system in the current PAS was as good as it could be, but the Trusts that had implemented the TeleTracking system considered it to be a step-change, as it removed the need for much manual data entry.

MS then clarified that he understood the three 'exam questions' to be as follows:

1. The need to confirm the direct and indirect benefits with the staff who would be expected to deliver such benefits
2. The need to understand how the Business Case would be funded, noting that the Trust Board could not agree to accept a £1.2m cost pressure
3. The need to confirm, via the procurement process, that the Business Case passed the appropriate 'value for money' tests

MS added that there were only circa two weeks to complete the work. DH stated that a date needed to be set, and a recommendation made, via a report, to enable at least three Non-Executive Directors to consider that report and make a decision. DH continued that the full Business Case did not need to be reviewed again, but the decision should be made following review of a four- to five- page report. SDu added that it was also important for the Business Case to be submitted after a full review by the Executive Team, given the concerns COB had raised. MC added that SM's concerns also needed to be addressed. SM confirmed that her concerns were similar to those of COB.

MS therefore clarified that he would liaise with SB and DH to confirm the timetable and process by which a final decision would be made regarding the Business Case, and that KR would then notify Trust Board Members on 29/07/19. This was agreed.

Action: Liaise to confirm the timetable and process by which a final decision would be made regarding the Business Case for a patient tracking system (Chief Executive / Chief Operating Officer / Chair of the Trust Board, July 2019)

Action: Notify Trust Board Members of the timetable and process by which a final decision would be made regarding the Business Case for a patient tracking system (Trust Secretary, July 2019)

The Business Case was therefore approved in principle, subject to the above agreements.

KR then asked for clarification that the meeting/conference call referred to by DH should include DH and two other Non-Executive Directors, excluding NG. DH confirmed that was correct.

07-20 Charitable Funds Committee, 23/07/19

SDu reported that the draft Maidstone and Tunbridge Wells NHS Trust Charitable Fund Annual Report and Accounts 2018/19 had been reviewed in advance of an independent examination and finalisation for approval at the Charitable Funds Committee meeting in October 2019. SDu also noted that a written report from the Committee would be submitted to the Trust Board meeting in September 2019.

07-21 To consider any other business

No other business was raised.

07-22 To receive any questions from members of the public

No questions were posed.

07-23 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 – September 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]
07-8	Arrange for free hearing tests for staff to be considered for inclusion within the staff 'MOT'/wellbeing checks that were planned to be introduced	Director of Workforce	July 2019 onwards	The matter is under consideration (the Head of Employee Relations is undertaking a review)

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
07-7	Arrange for a report to be submitted to the Trust Board meeting in September 2019 on the range of 'virtual' clinic/consultation systems used and/or planned for use at the Trust	Chief Executive	September 2019	A report has been submitted to the September 2019 Trust Board meeting
07-15	Liaise with the Director of IT and/or colleagues to ensure the revised IT Strategy made a specific reference to the Trust's PRIDE values	Director of Strategy, Planning and Partnerships	July 2019	A meeting was held with the Head of Digital Programmes and the revised IT Strategy was updated to contain the relevant content
07-17a	Consider the proposal from the Freedom to Speak Up Guardian to rename the Trust's "grievance" policy as a "resolutions" policy	Director of Workforce	September 2019	The issue continues to be discussed with StaffSide colleagues but it is likely that the policy will be called "grievances and resolutions" as the term "grievance" is well known among staff
07-17b	Liaise with the Director of Workforce regarding the content of the "Report from the Freedom to Speak Up Guardian" considered at the Trust Board meeting on 25/07/19 and consider whether a report should be submitted to the Trust Board in response	Chief Executive	September 2019	Liaison has occurred and the Freedom to Speak Up Guardian has prepared a report that will be considered at the Workforce Committee in November 2019.
07-19a	Liaise to confirm the timetable and process by which a final decision would be made regarding the Business Case for a patient tracking system	Chief Executive / Chief Operating Officer / Chair of the	August 2019	Liaison occurred and it was confirmed that a decision regarding the revised Business Case would be made via a teleconference held on 22/08/19. In

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

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
		Trust Board		accordance with the discussion at the July Trust Board meeting, it was confirmed that the teleconference would not be constituted as a formal meeting of either the Board or Finance and Performance Committee, but would involve the Chair of the Trust Board, two Non-Executive Directors (the Vice-Chair of the Trust Board and Chair of the Patient Experience Committee), the Chief Executive, Chief Operating Officer, Deputy Chief Operating Officer, Divisional Director of Operations for Medicine & Emergency Care and Deputy Director of Finance (Financial Performance) (covering for the Chief Finance Officer).
07-19b	Notify Trust Board Members of the timetable and process by which a final decision would be made regarding the Business Case for a patient tracking system	Trust Secretary	August 2019	The Trust Secretary issued an email to Trust Board Members on 13/08/19 to notify them of the timetable and process described in the response to action 07-19a (see above)

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

NHS Maidstone and Tunbridge Wells NHS Trust

Safety Moment	Chief Nurse/ Deputy Medical Director

Summary / Key points

The Safety Moment for September has focussed on Sepsis which has continued to be a key area of focus for all staff in MTW. A summary of the key messages that have been shared each week follows:

Week One 02/09/2019

Think Kidneys

Acute kidney injury (AKI) simply means a sudden reduction in renal function that makes maintaining fluid, electrolyte and acid-base balance difficult. AKI may be due to various insults such as impaired renal perfusion, exposure to nephrotoxins, outflow obstruction, or intrinsic renal disease. It is commonly associated with sepsis, cardiovascular collapse, congestive heart failure, major surgery, nephrotoxins (such as antibiotics, intravenous contrast, or other drugs), or urinary outflow obstruction.

Staff were reminded to ensure that the AKI care bundle is completed for all patients who develop AKI with some points to remember:

- If patients have a NEWS score of 5 or more or an AKI diagnosis, consider a fluid balance chart. Monitoring urine output can be a good indicator of deterioration. Please escalate any concerns if patients urine output is low. Always ensure each fluid chart is clearly labelled with the patient information, dated and reason for monitoring. Ensure all staff and patients are aware that the fluid balance needs recording. A poorly documented chart is of no value and could affect patient's on-going treatment.
- Review all patient medication
- A urine dip stick should be undertaken; a positive result for blood and protein may suggest glomerular disease
- Ensure a senior medical review is undertaken so a treatment plan can be commenced.
- **AKI is a marker of a 'sick patient' who requires prompt recognition and management.**

Week Two 09/09/2019

Suspect Sepsis

Sepsis, which is hard to spot, occurs when the body responds poorly to a bacterial infection and attacks its own tissue and organs.

It currently claims 52,000 lives a year in the UK and early treatment is vital to ensure a good outcome for the patient. According to the UK Sepsis Trusts estimates, better awareness could save 14,000 lives every year, and save the NHS £314 million per annum.

Sepsis remains a high priority within our trust.

As a trust we must submit data as part of the NHS contract to prove we are assessing patients, responding to NEWS2 scores and treating patients within an hour of diagnosis to sepsis.

So please remember to ensure:-

- Medical review for all patients with NEWS2 scores 3 in one area or 5 across the board or a new temperature of 38C or more.
- If Red Flag sepsis is diagnosed make sure antibiotics are given within an hour of diagnosis and clearly documented using the Sepsis screening tool.
- If patients do not respond to treatment please ensure a senior medical review is undertaken to ensure a timely admission to ICU if appropriate.
- Remember listen to family concerns, particularly regarding any significant change in behaviour as this could be a sign of deterioration.
- If relative's reports the patient has 'never been this ill before' make sure they are reviewed - they are probably right.

Suspect SEPSIS Save Lives

Week Three 16/09/2019

Blood Cultures

Blood cultures are procedures undertaken to detect an infection in the Blood to identify the cause. Infections of the bloodstream are most commonly caused by bacteria (bacteraemia) but can also be caused by yeasts or other fungi (fungaemia) or by a virus (viraemia).

Early positive results provide valuable diagnostic information on which appropriate antimicrobial therapy can be initiated. Like any tests, however, false-positive blood culture results can limit the utility of this important tool. These false positive results are due to contamination and may lead to errors in clinical interpretation, increased patient stay, additional tests and inappropriate antibiotic use.

Contamination of blood cultures may occur from the patient's skin, the equipment used to take the sample and transfer it to the culture bottle, the culture bottle tops, the hands of the clinician taking the sample, or the general environment.

As part of the update during this week staff were reminded of the correct procedures to be undertaken when taking blood cultures

Week Four 23/09/2019

NEWS2 Escalation

National Early Warning Score (NEWS 2) is a single standardised early warning system across the UK for early detection of the acutely unwell patients and provides common language across the whole NHS. NEWS2 can be used to determine illness severity, support consistent clinical decision making & ensure an appropriate clinical response. It helps to determine the urgency and scale of the clinical response required.

NEWS2 is based on a simple aggregate scoring system in which a score is allocated to physiological measurements, already recorded in routine practice, when patients present to, or are being monitored in hospital. Six simple physiological parameters form the basis of the scoring system:

- respiration rate
- oxygen saturation
- systolic blood pressure
- pulse rate
- level of consciousness or new confusion
- temperature.

Failure to recognize or act on signs that a patient is deteriorating is a key patient safety issue. It can result in missed opportunities to provide the necessary care to give the best possible chance of survival.

Following a safety alert the MTW NHS Trust changed its track and trigger system from PAR (Patient at Risk) to NEWS2 (National Early Warning Score) in December 2018Points to remember:

- Patients observations should be taken according the Trust guidelines and recorded in the Nervecentre or observation chart
- Patients who score high; 3 in one category or 5 in total, should be escalated immediately to the appropriate specialty doctor according to the Trust escalation algorithm

- The Oxygen saturation score is separated into two sections: Scale 1 and Scale 2. Scale 2 has been introduced for patients with Hypercapnic respiratory failure – sometimes referred to as 'type 2' respiratory failure and the most common cause is COPD. It is different from our previous COPD model as patients now score for high saturations on scale 2, prompting a reduction of inspired oxygen.
- The importance of considering Red Flag sepsis in patients is emphasized.
- ACVPU include "New Confusion"; disorientation, delirium or any new alteration to mental state.

Importantly urine output does not score on the NEWS2 system but it does remain a mandatory field. Please remember to escalate to a clinician any patient with a poor urine output and maintain an accurate fluid balance chart

National Early Warning Score (NEWS2)

Physiological Parameter	Score 3	2	1	0	1	2	3
Respiration rate per minute	≤8		9-11	12-20		21 - 24	≥25
SpO_2 Scale 1 (%)	≤91	92-93	94-95	≥96			
SpO_2 Scale 2 (COPD)	≤83	84-85	86-87	88-92 ≥93 on air	93-94 on oxygen	95-96 on oxygen	≥97 on oxygen
Air or Oxygen		Oxygen		Air			
Systolic Blood Pressure (mmHg)	≤90	91-100	101-110	111-219			≥220
Pulse (per minute)	≤40		41-50	51-90	91-110	111-130	≥131
Consciousness				Alert			*CVPU
Temperature	≤35.0		35.1-36.0	36.1-38.0	38.1-39.0	≥39.1	

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 Chair of the Trust Board **Chair of the Trust Board**

Consultant appointments

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

AAC recommended Consultant appointments (dependant on compliance or withdrawal)					
Date of AAC	**Title**	**First name**	**Surname**	**Department**	**Potential/Actual Start date**
06/08/2019	Dr	Victoria	Donovan	Medical Oncologist Gynae and UGI	TBC
06/08/2019	Dr	Meeta	Durve	Clinical Oncologist CNS and LGI	TBC
21/08/2019	Dr	Branimir	Penev	Urology	TBC
21/08/2019	Dr	Ian	Rudd	Urology	TBC

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

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

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

NHS
Maidstone and Tunbridge Wells NHS Trust

Report from the Chief Executive **Chief Executive**

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

1. MTW has hit the national standard of treating 85% of cancer patients within 62 days in August – a month earlier than anticipated. It's been our absolute priority to get back on track to delivering the standard and it's thanks to the incredible efforts of our staff that we've achieved this turnaround in performance in less than a year.

2. MTW has been shortlisted for a Health Service Journal (HSJ) award in the Acute or Specialist Service Redesign category for the significant improvements we've made over the past year in caring and treating patients using our emergency care services. MTW is now in the top ten trusts in the country for Emergency Department performance.

3. Groundworks have now started on the new £8m Acute Assessment Unit at Maidstone Hospital. The AAU is located next to the Emergency Department and will house 14 short stay beds, eight assessment beds and a treatment suite comprising three separate treatment rooms. The new unit will offer state-of-the art clinical facilities for patients and it is expected that it will be fully operational by January 2020. Investing in frontline patient care is a direct result of MTW achieving its financial plan in 2018/19.

4. We have welcomed more than 80 overseas nurses to our hospitals since July as part of our robust recruitment drive for 2019. So far this year we've recruited 368 nurses from the UK and abroad, and each month groups of around 30 – 40 new clinical staff start with us.

5. Thank you to local photographer Clive Talbutt for donating eight stunning photographs of Iceland and Greenland to MTW. The photos are displayed on the walls of the Kent Oncology Centre and have helped transform the patient waiting areas.

6. Our hospital restaurants have introduced a number of environmentally-friendly changes to help reduce waste and plastic use. So far, the restaurants have stopped the use of plastic sauce sachets and use bottled products instead; changed to wooden drink stirrers and biodegradable drinking straws; and provide fresh milk in jugs instead of single-use plastic milk portions. Take-away containers and cutlery are also made from fully compostable plant-based bio-plastics.

7. We've seen some fantastic efforts from our local community to raise funds for our MTW charity. One family organised a sponsored stroll and teddy bear's picnic, and raised more than £200 for the Neonatal unit at Tunbridge Wells Hospital; Skipton Building Society donated more than £1300 to fund new furniture for our patients on the Frailty Unit; Energie Fitness are cycling their way to raise £4000 for the Trust; Waitrose at Hawkhurst raised £375 via their 'Community Matters' scheme; and Bovis Homes gave £1000 to purchase birthing equipment for the Maidstone Birth Centre. Thank you to everyone for your support.

8. Thank you to former patient, Jean Watts, whose legacy of £40,000 has helped to fund a Fibreoptic Endocscopic Evaluation of Swallow (FEES) Stack at Maidstone Hospital. Maidstone Hospital League of Friends also contributed to the cost of the £57k equipment. The FEES Stack is used by the Trust's Speech and Language Therapy Service in the treatment of the throat and airway conditions as well as to assess swallow and voice disorders.

9. We were delighted to welcome Professor Michael West, a renowned and inspirational organisational culture expert, to Tunbridge Wells Hospital on 24 September to launch our culture and leadership programme. Professor West is a senior fellow at The King's Fund and helped develop the programme we're rolling out. Around 80 staff attended his presentation, which focused on compassionate leadership and supporting staff.

10. Alongside my monthly shifts as a Clinical Support Worker on the wards, I'm also getting out and about to other clinical and non-clinical areas to talk to staff and see first-hand the great work that's taking place in our hospitals. In the past month, I've enjoyed visiting our Blood Sciences, Microbiology and Cellular Pathology laboratories; imaging departments at both hospital sites; and our Electrical Medical Equipment team.

11. In west Kent we've taken a positive step forwards towards establishing an Integrated Care Partnership (ICP). John Goulston, Kent Community Health Foundation Trust Chair, Sanjay Singh, GP Federation Clinical Officer, and I are leading the development phase of the West Kent ICP. The ICP will build on the strong foundations already built by the West Kent Alliance and will look at how the NHS and other care organisations jointly deliver and transform care across our region that's fit for the future. Stakeholder engagement events will be taking place over the next two months to establish ICP priorities and plan for the future. The West Kent ICP will look to 'go live' in April 2021.

12. 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:

    - Review of performance on ambulance handovers
    - Implementation of the new Electronic Patient Record system
    - Performance updates on cancer, RTT and ED
    - Review of financial position
    - Corporate strategy for the Trust
    - Planning for 2020/21
    - Staffing and recruitment
    - Appointment to two clinical academic posts
    - Ongoing work with the CQC on engagement days

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

NHS
Maidstone and Tunbridge Wells NHS Trust

Integrated Performance Report

August 2019

MTW
exceptional people, outstanding care

NHS
Maidstone and Tunbridge Wells NHS Trust

Contents

- Performance Wheel & Executive Summary — Pages 3
- Summary Scorecard — Pages 4
- Headlines for each CQC Domain — Pages 5-10
- Exceptions by CQC Domain — Pages 11-18

Appendices (Page 19 onwards)
- Deep Dive into each CQC Domain
- Supporting dashboards for each CQC Domain
- Finance Report
- Safe Staffing Report

Scoring for Performance Wheel

Scoring within a Domain

Each category within the Balanced scorecard is given an overall RAG rating based on the rating of the KPIs within the domain on a YTD basis that appear on the balance scorecard (below) :
Red = 3 or more red KPIs within the domain
Amber = 1 red KPI rating within the domain
Green = No reds and 2 amber or less within the domain

Overall Report Scoring

Red = 4 or more red domains
Amber = Up to 3 red domains
Green = No reds and 3 or less amber domains

MTW
exceptional people, outstanding care

Performance Wheel and Executive Summary

Executive Summary

Staffing has been a key challenge in August with increased levels of annual leave and staff sickness during this summer month. This, along with high vacancy and a reduction in temporary staffing levels has impacted on the Trust's ability to meet key standards in some areas and a 1% drop in the nursing safe staffing fill rate indicator.

The Trust has seen an increased level of falls, incidents and infection rates as well as a reduction in the level of activity undertaken which has led to a reduction in achievement of key standards such as Referral to Treatment (RTT). A&E 4 hour performance at Maidstone Hospital was also impacted in August by a reduced level of the nursing staff fill rate in the department.

Achievement of the Cancer 62 Day FDT Standard has been a key challenge for the Trust, however this has improved significantly from 64.5% in April 2019 to 72.2% in July 2019. The validated (but not finalised) position for August 2019 is 85.3% which is therefore above the national target of 85%.

Items for Escalation

- **MRSA:** one case of MRSA reported in August. First case reported this year.
- **C.Diff:** the number of cases of C.Diff increased in August ,but continues to achieve the trajectory YTD.
- **Falls:** number of SIs reported relating to Falls has increased significantly to 7 which has led to the overall increase in the SIs rate and rate of incidents that are severely harmful.
- **Safe Staffing:** Nursing Safe Staffing fill rate dipped in August to slightly below target, but remains above the 93.5% target YTD.
- **A&E 4 hour Standard:** performance fell in August, to a score of 90.02% against a trajectory target of 94.05%.
- **Referral to Treatment (RTT) Incomplete Pathway:** performance decreased in August due to a reduction in the levels of activity undertaken, however, the Trust RTT Trajectory was still achieved.
- **Cancer 2weeks:** Performance for both the two week wait (2ww) and 2ww Breast Symptoms cancer standards increased in July, but remain below the national target at 87.1% and 81.7% respectively. August performance is currently being finalised but it is estimated to be 86.9% and 90.8% respectively.
- **Cancer 62 Day:** Performance against the Cancer Waiting Times Constitutional Target for the 62 Day has been extremely challenging. From April 2019 the performance has increased from 64.5% to 72.2% in July.
- **Diagnostics Waiting Times <6 weeks:** Below the national 99% target for the third consecutive month
- **Finance:** The Trusts surplus including PSF was £1m in August which was on plan, the main pressures in the month related to Medical Staffing (£0.4m), higher than planned outsourcing of elective work (£0.4m), Private patient unit slippage (Net = £0.2m) offset by release of £1.1m reserves.
- **Workforce (various):** The percentage of staff on Annual Leave in August increased by around 3% compared to July. Agency usage remained the same and bank usage increased slightly. However, the overall staffing fill rate was around 2% lower than July which was also reduced compared to the previous months. Sickness levels also increased slightly in August. The Trust vacancy rate has reduced slightly, however both Nursing and Medical and Dental vacancies remain high and at a similar level to July.

Summary Scorecard

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)	24.5	34.5	20.6	23.6	22.4	22.0	↓
S2	Number of cases C.Difficile (Hospital)	5	7	21	24	55	54	↓
S3	Number of cases MRSA (Hospital)	0	1	2	1	0	1	↓
S4	Cases of Gram Negative Bacteraemia	10	7	50	34	113	97	↑
S5	Rate of Hospital Pressure Ulcers	*0.90*	0.5	1.6	0.4	0.9	0.6	↘
S6	Rate of Total Patient Falls	*6.00*	7.14	*6.23*	6.31	*6.00*	6.00	↓
S7	Number of Never Events	*0*	0	1	1	0	1	→
S8	Number of New SIs in month	12	17	76	66	144	150	↓
S9	SIs not closed <60 Days Monthly Snapshot	24	21	-	21	24	21	↑
S10	Overall Safe staffing fill rate	93.5%	93.4%	96.6%	94.2%	93.5%	94.2%	↘

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	1.0224	1.0219	1.0224	Band 2	Band 2	→
E2	Standardised Mortality HSMR	Lower conf <100	91.5	105.8	91.5	Lower conf <100	91.5	→
E3	% Total Readmissions	14.1%	15.2%	13.6%	14.7%	14.1%	14.7%	↘
E4	Readmissions <30 days: Emergency	14.7%	15.9%	14.1%	15.4%	14.7%	15.4%	↘
E5	Readmissions <30 days: Elective	6.8%	6.3%	7.1%	7.3%	6.8%	7.3%	↗
E6	Stroke: Best Practice (BPT) Overall %	50.0%	36.8%	50.3%	39.0%	50.0%	39.0%	↓
E7	Stroke Best Practice Part 1: First Ward	80.0%	78.9%	79.5%	71.7%	80.0%	71.7%	↗
E8	Stroke Best Practice Part 2: Cons <=14 Hours	58.0%	38.6%	56.8%	48.9%	58.0%	48.9%	↓
E9	Stroke BPT Part 3: 90% Time on Stroke Ward	80.0%	86.0%	82.7%	79.7%	80.0%	80.0%	↗
E10	% TIA <24hrs	60.0%	57.7%	65.9%	56.8%	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	17	0	0	0	→
C2	Rate of New Complaints	3.92	2.51	2.02	2.39	2.93	2.71	↘
C3	% complaints responded to within target	75.0%	65.1%	62.8%	56.6%	75.0%	67.4%	→
C4	IP Resp Rate Recmd to Friends & Family	25.0%	15.4%	18.7%	17.4%	25.0%	17.4%	↘
C5	IP Friends & Family (FFT) % Positive	95.0%	93.9%	95.9%	95.1%	95.0%	95.1%	↘
C6	A&E Resp Rate Recmd to Friends & Family	15.0%	10.1%	8.1%	11.5%	15.0%	11.5%	↗
C7	A&E Friends & Family (FFT) % Positive	87.0%	88.1%	92.6%	87.7%	87.0%	87.7%	↘
C8	Mat Resp Rate Recmd to Friends & Family	25.0%	33.4%	9.9%	29.8%	25.0%	29.8%	↘
C9	Maternity Combined FFT % Positive	95.0%	93.6%	98.0%	94.2%	95.0%	94.2%	↘
C10	OP Friends & Family (FFT) % Positive	84.0%	83.0%	81.7%	82.3%	84.0%	82.3%	↗

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	94.1%	90.0%	92.9%	92.4%	91.7%	91.7%	↘
R2	Emergency A&E >12hr to Admission	0	0	1	0	0	0	→
R3	Ambulance Handover Delays >30mins	369	490	1497	2427	4428	5010	↓
R4	RTT Incomplete Pathway	83.9%	84.4%	79.4%	84.4%	83.9%	89.1%	↘
R5	RTT 52 Week Waiters (New in Month)	8	7	22	29	8	29	↘
R6	% Diagnostics Tests WTimes <6wks	99.0%	96.5%	99.6%	96.5%	99.0%	99.0%	↘
R7	Cancer two week wait	93.0%	87.1%	82.3%	84.6%	93.0%	93.0%	↑
R8	Cancer two week wait-Breast Symptoms	93.0%	81.7%	67.5%	67.1%	93.0%	93.0%	↑
R9	Cancer 31 day wait - First Treatment	96.0%	97.7%	97.9%	96.7%	96.0%	96.7%	↗
R10	Cancer 62 day wait - First Definitive	85.4%	72.2%	57.5%	70.1%	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	6.70	6.92	6.94	7.05	6.40	7.05	→
R12	Theatre Utilisation	90.0%	86.5%	91.3%	86.7%	90.0%	86.7%	↗
R13	Primary and Non-Primary Refs	16,457	14104	80,153	80512	199,052	197279	↘
R14	Cons to Cons Referrals	4,291	5374	30,530	30033	51,898	60,477	↑
R15	OP New Activity	18,696	15201	89,137	88641	226,133	221294	↗
R16	OP Follow Up Activity	28,681	24101	130,237	134963	346,845	338418	↘
R17	Elective Inpatient Activity	614	567	2,604	2813	7,426	7169	↘
R18	Day Case Activity	4,151	3683	18,422	19518	50,210	48972	↘
R19	Non Elective Activity (inc Maternity)	7,143	5335	26,401	27349	84,338	76431	↗
R20	A&E Attendances : Type 1	13,339	13909	64,829	70326	159,252	165174	↗

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	1,028	1,036	- 2,557	261	6,897	6,897	→
W2	CIP Savings	2,191	3,882	4,870	8,778	22,328	22,328	↑
W3	Cash Balance	38,555	45,854	14,126	45,854	3,000	3,000	
W4	Capital Expenditure	488	250	1,405	1,182	14,448	14,448	
W5	Finance use of Resources Rating	3	3	4	3	3	3	→
W6	Staff Turnover Rate (%)	10.0%	10.9%	9.7%	10.9%	10.0%	10.9%	↘
W7	Vacancy Rate (%)	8.0%	12.0%	11.1%	12.0%	8.0%	12.0%	↗
W8	Total Agency Spend	1,295	1,770	10,076	8,457	15,679	16,258	↗
W9	Statutory and Mandatory Training	90.0%	88.9%	85.8%	86.0%	90.0%	90.0%	↗
W10	Sickness Absence	3.3%	3.5%	3.3%	3.3%	3.3%	3.3%	↘

Target Indicator Key:	
On or above Target	
Review and Corrective Action required	
Significantly below target - urgent action required	
KPI Used in score Performance Wheel	

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

Change on Previous Indicator Key:	
Deterioration on previous (<5%)	↘
Significant deterioration on previous (>5%)	↓

Headlines

Safe:	Positives:	Challenges:
Lead Director(s): **Claire O'Brien/** **Peter Maskell**	**Infection Control:** There were 7 cases of C.difficile reported in August. Year to date the Trust remains below trajectory with 24 cases reported against a maximum limit of 25. Performance for MRSA Screening in Non- Elective pathways improved in August and now compliance in both Elective and Non-Elective pathways is above target. The number of gram negative blood stream infections and MSSA cases continue to remain lower than the levels reported in the previous year. **Pressure Ulcers:** 3 pressure ulcers reported for the Trust in August (rate of). This remains significantly lower than the numbers reported last year. There were also 3 Deep Tissue Injuries (DTIs) reported. **Serious Incidents (SIs):** The number of SIs open which had passed their breach date and had not been closed within the 60 day target has reduced month on month to 21 as at the end of August. **Incidents:** There has been a further improvement in performance for those incidents that have been open for more than 45 days. **Duty of Candour:** The Patient Safety Manager is attending Clinical Governance and Clinical Directors meetings to deliver a Q&A session for Duty of candour. This has been received well. The patient safety manager is also delivering Duty of Candour training across the Organisation.	**Infection Control:** One case of MRSA blood stream infection was reported in August on a medical ward at Maidstone. Whilst the overall number of cases of E.Coli reported is lower than the numbers reported in the previous year the level reported for the Lord North Ward remains high. A deep dive is being undertaken. **Falls:** The rate of falls increased in August to 7.1, therefore not achieving the target of 6.0. This was due to a significant increase in the number and rate of falls at the Tunbridge Wells Site (TWH) with the rate of 9.0 being outside of the upper control limit. The number of Falls that caused moderate or severe harm also increased which resulted in 7 Falls SIs being declared. Of the 7 Falls SIs, 2 were for falls in July, 3 were for falls in August at Tunbridge Wells and 2 were for falls in August at Maidstone site. Falls seen in the Medical and Emergency Care Division have increased in August and are now at a similar rate to the previous year. The rate of Falls for T&O continues to remain high **Serious Incidents (SI)s:** The number of SIs reported increased to 17 in August resulting in a rate of 0.84. The main increase was in those related to Falls (7). YTD there have been 20 SIs reported that have related to Falls (31% of the total SIs reported). **Incidents:** The Rate of incidents that are severely harmful has increased in August, above the maximum limit of 1.23 at 1.84. **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. Improving the Organisations compliance with Duty of Candour is included in the Patient Safety Action Plan and is also monitored through the Mason Working Group. **Safe Staffing:** There has been a decrease in the overall nursing fill rate indicator in August to 93.4% which is below the 93.5% target.

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 is 15.4%, compared to 14.7% in 2018. 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 improved further in August, and is 79.7% YTD. Patients admitted to a stroke ward as their first ward also improved, and is 71.7% YTD	**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:** The percentage of patients seen by a Stroke Consultant within 14 days has dropped under 40% in August, and this has caused the percentage of patients to meet all 3 Best Practice indicators to drop in August. This indicator is now 39.0% year to date compared to 48.8% last year. Performance for TIA cases with a higher risk of stroke being treated within 24hrs improved in July to 57.7%(data runs one month behind) but remains below the 60% national target YTD at to 56.8%

MTW
exceptional people, outstanding care

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 with an increase of an extra 5 in August Friends and Family Survey: The percentage of responses that were positive continues to remain fairly high and around target. Inpatients have dipped under target at 93.9% in August, however YTD position remains on target at 95.1%. A&E has dropped down to 88.1% in August against a target of 87%, but this will have been skewed by a lack of data from one site. **Patients with Dementia:** The percentage of patients screened for Dementia increased in July to 91.0% against the 90% national target and remains above target YTD (90.6%). **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	**Complaints:** Divisional compliance with regards to complaints responded to within target decreased to 79.1% in August from 84.6% in July which significantly impacted the Trust overall performance which remains below target at 65.1% Overdue complaints have increased in August to 72, a 14% increase on last month. **Friends and Family:** The response rates continue to fluctuate across the four areas but broadly reflect the internally reported position. Of concern, Maidstone A&E reported only 2 responses in August indicating this needs further investigation.

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 42.2 per day so far this year – or around 9.2% 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 25.8% YTD, 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 **Referrals:** There has been a 2% reduction in Consultant to Consultant referrals year to date (YTD) compared to the previous year. **Outpatient Efficiency:** DNA Rates for both New and Follow Up continue to show a downward trend and are now around the target level of 5% for the Trust.	**ED Attendances:** The past 52 weeks have been 8.2% busier than the preceding 52, and 2019/20 attendance is forecast to be 7.2% higher than 2018/19. August is generally a quieter month because of holidays, and came in very close to expected levels. **4 hour Emergency Access Standard:** A&E performance struggled in August, with a score of 90.02% against a trajectory target of 94.05%. Much of the decreased in performance was at the Maidstone site. **Ambulance Handovers:** 30-60 minute delays fell back to 434 in Aug (11.8%), but still remains 66% higher than the equivalent period in 2018/19. Delays of more than 60 minutes is 36% higher than last year. **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:** Activity was significantly below plan in August and is 5.2% below plan YTD. This is further below plan for the main RTT Specialties at 9% below plan YTD. Specialties furthest from plan remain ENT, Gastroenterology, Ophthalmology and Trauma & Orthopaedics which is directly impacting on their achievement of their non-admitted RTT Trajectories. **Outpatient Efficiency**: ERS Slot unavailability improved in July but remains higher at 23.7%. There is a particular issue in T&O (13.7%), ENT (18%), Medical specialties (14.7%) and Gynaecology (34.7%).Separate meetings have taken place with the specialities in order to implement a plan. ERS working group has been re-established. Cancellation of outpatient appointments with less than 6weeks notice continues to be an area of concern at 15.7% YTD.

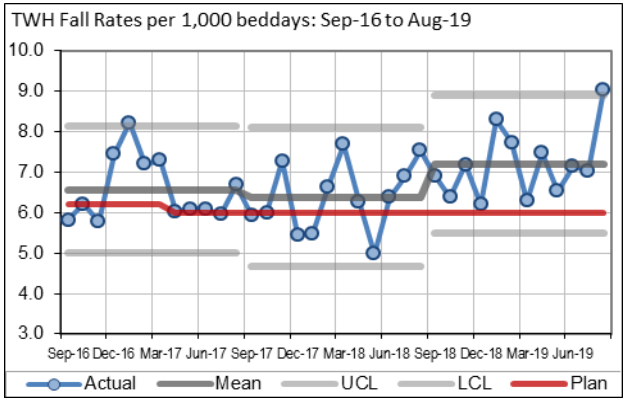
Headlines

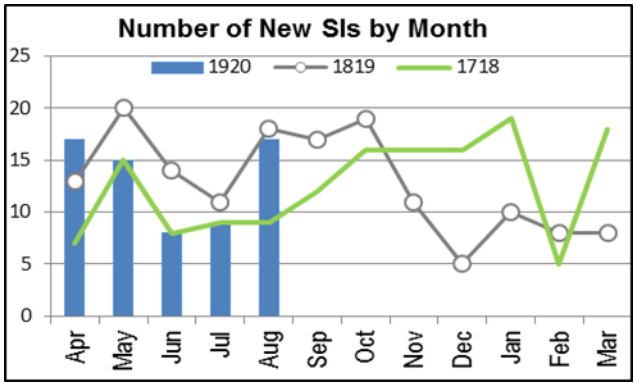
Responsive:	Positives:	Challenges:
Lead Director(s): **Sean Briggs**	**Inpatient Efficiency:** The rate of last minute reportable cancellations remains below the 0.8% maximum limit at 0.6% YTD **RTT Incomplete Pathway:** Performance for August was 84.36% against a target of 83.9%, therefore achieving the trajectory Despite the increase in August the backlog remains 1,407 lower than the March 18 position. **Cancer:** The Trust has achieved the cancer standards for 31 day First Definitive Treatments, 31 day Subsequent Chemotherapy Treatments and 31 day Subsequent Surgery – all of which have been successfully achieved for the last 3 months. Performance against the 62 day standard remains on target with 72.2% (an improvement on the expected position of 68% predicted at the end of June). The current validated (but not finalised) position for the Cancer 62 Day Standard for August is 85.2%, therefore achieving the national target of 85%. The overall 62 day PTL remains below 1400 patients with a backlog of 3.9 – 4.6% through August. Significantly the Trust is reporting on 6 or 7 patients above 104 days on the backlog	**Elective Activity:** Overall activity decreased by around 4 per working day in August compared to July and is 6.3% below plan YTD (daycase is 6% below plan and inpatients are 8.4% below plan). 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 now on plan. **RTT Incomplete Pathway:** The Trust is still reporting some 52 week breaches on a monthly basis (7 reported for August). 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 Due to the lower levels of outpatient activity undertaken in August the Trust OP Waiting List and backlog are now above plan which has meant that the overall RTT Waiting List and Backlog are higher than plan. The IP backlog has increased slightly. The Elective and Outpatient New Activity was lower than plan in August which has led to an increase in the RTT Waiting List and backlog for some specialties. **Diagnostic Waiting Times <6weeks:** Due to some capacity/process issues in Endoscopy performance has dropped to around 97% in August and is therefore below the 99% target for patients who had been waiting less than 6 weeks for their diagnostic test as at the end of August. This is the third consecutive month that the Trust has not achieved the 99% target. **Cancer:** After a drop in 2ww referrals in August, the numbers of incoming referrals is increasing again, with the highest numbers in Breast (including Breast Symptoms) and then Lower GI and Urology. Capacity and patient choice for delay of their first seen appointment remain challenges September has seen a slight rise in the backlog to 5.2% at the beginning of the month but this has continued to decrease towards August's levels.

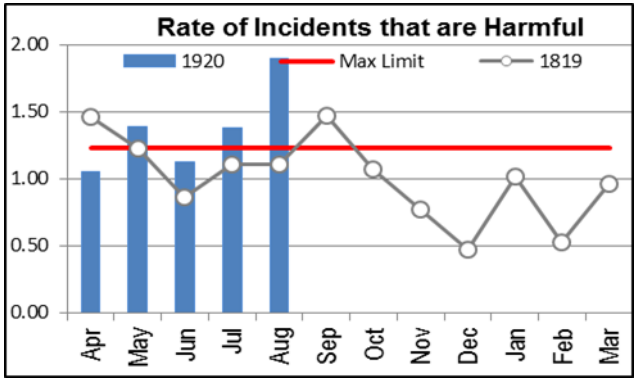
Headlines

Well Led:	Positives:	Challenges:
Lead Director(s): **Steve Orpin/** **Simon Hart**	**Finance:** 1m surplus in Month 5 as planned and Year to Date a £0.3m surplus as planned. The Trust is forecasting to meet its control total by the end of the year. CIP delivery has over-performed by £1.7m in month 5. The Trust has delivered £8.9m savings YTD which is £1.2m favourable to plan (13% over performance). Favourable cash position at the end of month 5. Capital underspent against plan at the end of month 5 but all capital is committed in 19/20 **Sickness Rate:** The overall sickness rate has become more stable over the last 12 months. There was a slight increase in August to just above the maximum limit but YTD remains on plan. The proportion of sickness that is short-term sickness is reducing. **Mandatory Training:** Mandatory Training compliance has continued the upward trend of improvement to 88.9% for August with Information Governance showing the biggest improvement, followed by an improvement for Intermediate Dementia Awareness **Staff Appraisals:** The 201920 appraisal cycle is overall at 87.5% with Estates and Facilities and Women's, Children's and Sexual Health both achieving in excess of 90%.	**Finance:** Medical staffing pay overspent YTD by £1.3m mainly within Medicine and Emergency Division (£0.8m) and Paediatrics (£0.3m). 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 £8.6m are mitigated by contingency, the expected release of the CCG RTT risk reserve, additional income opportunities, full delivery of the stretch CIP programme and a Divisional Recovery plan. CIP 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. **Vacancy Rate:** has improved slightly to 12% for the Trust but remains high with Registered Nursing, Midwifery & Health Visitors at a rate of 19.7% and Medical and Dental at a rate of 11.3% **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 There has been a high level of annual leave and slightly increased sickness in August. Whilst the use of bank staff did increase this was not at the same level of the reduction in substantive staff which has meant that the overall staff fill rate (excluding medical staff) has decreased to 72.3% in August 2019.

Escalation: Falls and Incidents







SIs: The number of New SIs reported increased to 17 in August of which 7 were related to Falls. Of the 7 Falls SIs, 2 were for falls in July, 3 were for falls in August at Tunbridge Wells and 2 were for falls in August at Maidstone site.

YTD there have been 20 SIs reported relating to Falls (31% of the total SIs reported compared to 9 SIs (16%) for the same period last year)

Falls: The number of Falls reported was 30 higher than last month at 145 for August which equates to a Rate of 7.1 per 1,000 occupied bed days, therefore not achieving the trajectory. The main increase was at the Tunbridge Wells (TWH) site. Whilst the overall Trust rate of Falls has remained within the confidence limits as you can see from the graph the rate of Falls for TWH was outside the upper control limit in August with a rate of 9.0. Falls at Maidstone remained consistent.

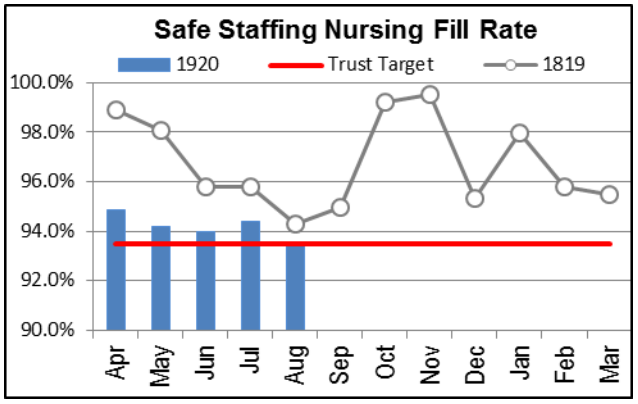
Falls Awareness week on 23rd September which will focus on raising awareness of the importance of falls prevention.

Link Nurse study day planned for 18th October 2019 to bring awareness and improve knowledge on falls prevention and reduction.

Incidents that are Severely Harmful: There has been a significant increase in the rate of incidents that were severely harmful in August to 1.89 which is above the limit of 1.23. This is mainly due to the increase in the number of SIs relating to Falls.

Summary:	Actions:	Assurance:
The rate of falls increased in August to 7.1, not achieving the target of 6.0. This was due to a significant increase in the number and rate of falls at TWH with the rate of 9.0 being outside of the upper control limit. The number of Falls that caused moderate or severe harm also increased which resulted in 7 Falls SIs being declared.	Focused attention to lying and standing blood pressure as part of the NHSI collaborative programme Patients identified at risk of fall on Board rounds daily and recommendations around medication reviews taking place. Matrons ensuring those at risk identified and communicated to MDT. Daily review of those patients at risk, where they are located on the ward and their visibility. Specialist input from Fall Specialist Nurse for patients at high risk. Additional Falls Prevention equipment procured and awaiting delivery.	Wards on the NHSi project are monitored through spot audit at week 4, 8 and 12 intervals followed by further spot audit at month 6, 9 and 12. This is to monitor progress, sustainability as well as opportunity to identify if further support required. Currently on target to complete roll out to all inpatient wards by end of November 2019. Although not validated the total numbers of patient falls are lower at the time of writing the report for September

Escalation: Safe Staffing Rate and Infection Control



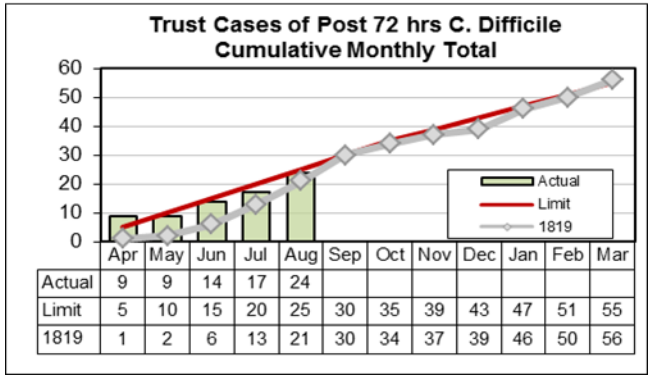
Safe Staffing Nursing Fill Rate: The nursing fill rate decreased in August to just below the Trust target at 93.4%. This was impacted by the high vacancy levels along with staff annual leave and a lack of available temporary staff during this summer month.

The total fill rate reported does not account for any movement of staff that is managed on a day to day basis in response to identification of gaps in the workforce, including the support from our matrons who have been working consistently in practice to ensure safe staffing.

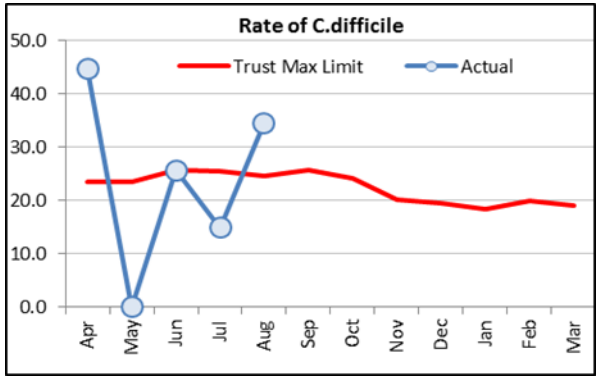
C.difficile: In August there were seven cases of C.Difficile reported equating to a rate of 34.5 per 100,000 occupied beddays. Year to date there have been 24 cases reported against a maximum limit of 25 year to date.

MRSA Bacteraemia: One case of hospital acquired MRSA blood stream infection reported in August on a medical ward at Maidstone.

Compliance against the MRSA screening rates has improved further in August for the non-elective pathway at 95%, achieving the target. Compliance for the Elective pathway continues to remain above the 98% target at 99%.



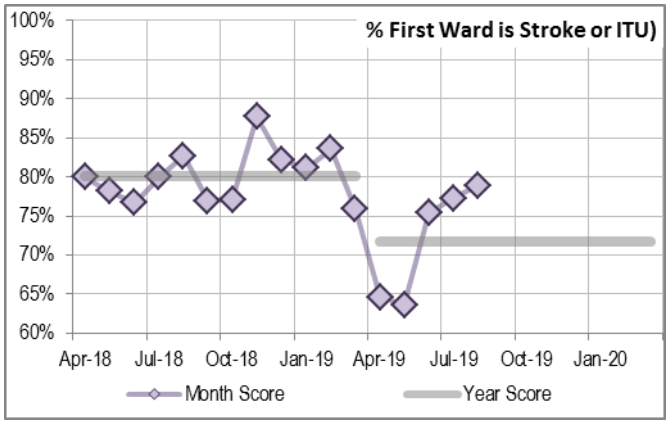
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	9	9	14	17	24							
Limit	5	10	15	20	25	30	35	39	43	47	51	55
1819	1	2	6	13	21	30	34	37	39	46	50	56

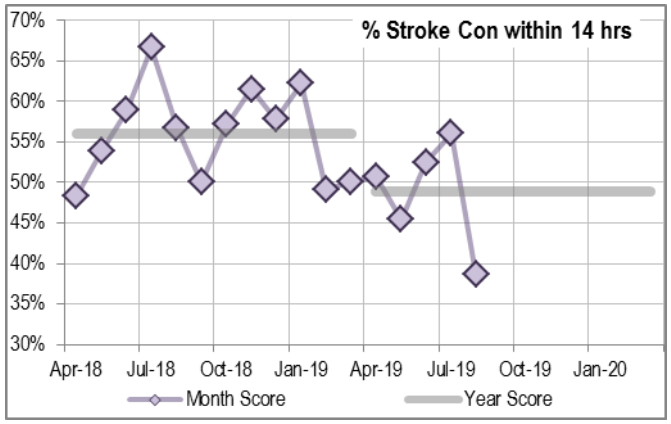


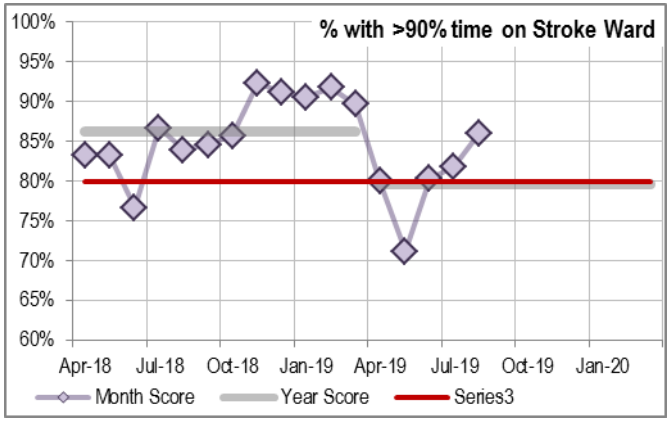
Infection Control Assurance:
Routine cleaning Solution changed to Diff X across the Trust.
HPV and UVC light cleaning remains in place for C diff cases, carriers and multi resistant organisms.
Weekly C. difficile huddle held by DIPC and ICT.
C. diff and MSSA review panels continue with DIPC and Chief Nurse

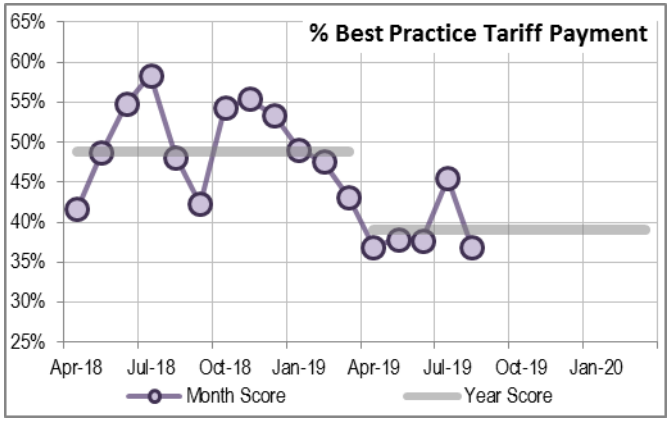
Summary:	Actions:	Assurance:
The Safe Staffing Fill Rate decreased to 93.4% in August which is just below the Trust target of 93.5%. This was impacted particularly in August by staff annual leave and a lack of available temporary staff during this summer month. **Infection Control:** Despite an increase in cases reported in August, year to date the Trust remains on trajectory for cases of C.difficile	**Safe Staffing:** Weekly staffing meetings in place with the Staff bank, DDNQs and Chief Nurse to review staffing position and to identify key actions needed. **Infection Control:** All new junior doctors receive infection control and antibiotic prescribing training. Rehydration stations and UTI diagnosis educational resources rolled out across Trust.	**Safe Staffing:** Arrival of overseas nurses is making a difference – whilst not registered as yet as they are being supported with their OSCE programme, when on the wards they are providing support to our registered workforce to support care delivery.

Escalation: Stroke Best Practice Indicators









There are now three main stroke indicators that constitute Stroke Best Practice. Last year, 823 patients came under this scheme and this year 43.1% met all three targets.

First Ward must be a stroke ward or ITU. Last year averaged 80.2%, but this year has dropped to 71.7% so far. Currently a lot of patients go to CDU first, and that is clinically appropriate until the Hyper Acute Stroke Unit comes online next year.

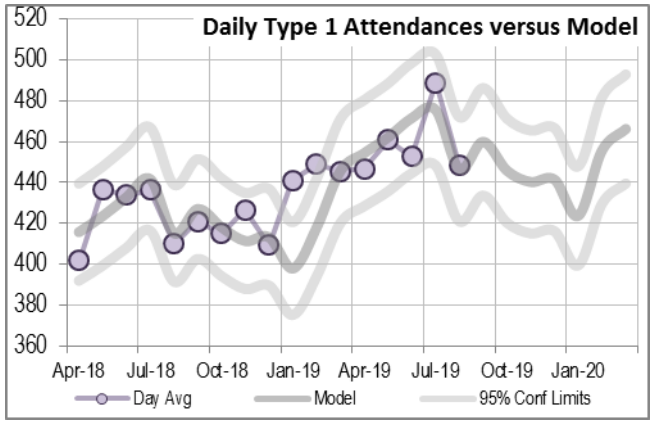
Stroke Consultant within 14 hrs. 2018/19 ran at 56.1%, but we have been below 50% since Feb, and Aug has gone under 40%. YTD we are 48.9%

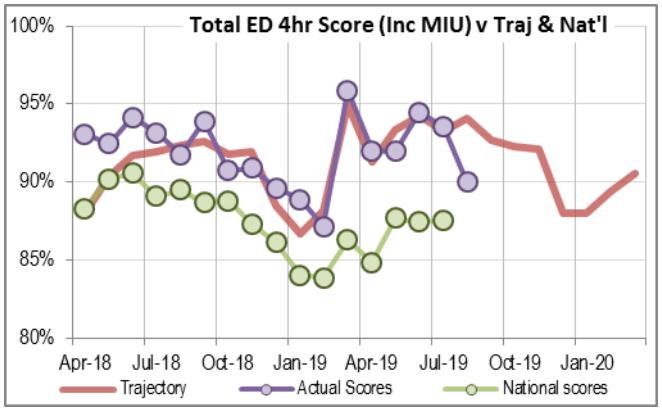
90% of Spell on Stroke Ward. This metric is now slightly different. The qualification is on HRG rather than Diagnosis code, the time is calculated in minutes rather than overnights, and we are no longer able to discount time spent in the Discharge Lounge. 2018/19 was 86.2%, but this year we are at 79.7%. Latest month is incomplete & subject to change

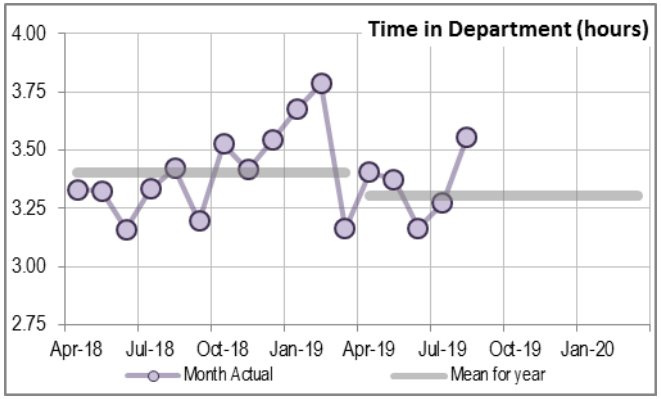
Payment Rate. In 2018/19, the percentage passing all 3 tests & qualifying for a Best Practice Tariff payment was 48.7%. All three indicators have dropped, and the combination rate is 39.0% so far this year.

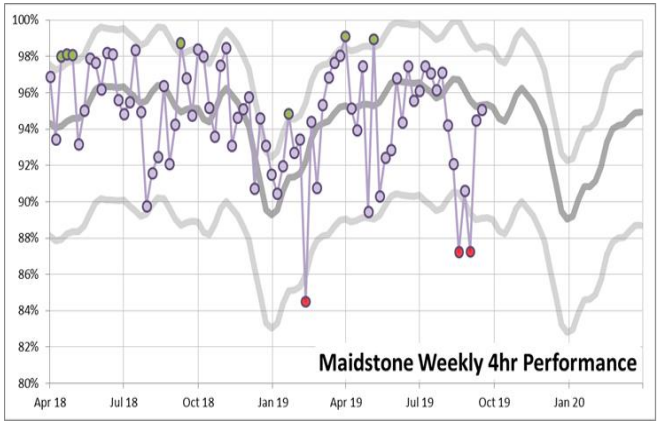
Summary:	Actions:	Assurance:
There are now three main stroke indicators that constitute Stroke Best Practice. a) admitted direct to a stroke or intensive treatment ward, b) See a stroke consultant within 14 hours of arrival or their stroke if that happens on-site, c) Spend 90% of their spell on a stroke ward. 39.0% of patients this year have qualified by meeting all three indicators. Performance for both those spending >90% of their time on a Stroke ward and the % that have a Stroke Ward as a first ward is improving.	1.Stroke CNS team to monitor compliance against BPT 2. Stroke CNS team to investigate non-compliance 3. Current monitoring of these BPT targets have shown that any patient that spend any time on CDU before Stroke ward fails this target 4. Currently Stroke consultants cover 5 days a week 5 90% spell on Stroke often not achieved due to increased capacity issues on the MGH Site / due to diverts from TW	1. BPT data now sent fortnightly 2. Action plan now in place 3. ED teaching by CNS team for early recognition of Stroke symptoms and early referral to Stroke to avoid transfer to CDU. 4. Post reconfiguration of Stroke services with seven day working will improve this target. 5. Daily identifying of most appropriate pts (end of Stroke pathway) to be first to move from Stroke.

Escalation: A&E Performance









Attendances: Type 1 attendances averaged 427.0 per day in 2018/19 – 7.1% up on the previous year. We are currently forecasting a 7.2% increase on that for 2019/20

August was almost exactly as expected at 448.7 per day. Attendance usually slumps a little in August because of holidays.

4 Hr Time in Department: Performance took a hit in August, coming in at 90.02% against an agreed trajectory of 94.05%, one of the worst monthly scores against trajectory for some time. Around 2/3 of the excess breaches occurred at Maidstone, and are related to workforce issues, and a heightened state of infection control in UMAU. Maidstone performance was 89.62%, however this has recovered in September.

Total Time in Department averaged 3h 24m for Type 1 attendances through 2018/19, but have reduced significantly over the past couple of months. YTD the Trust are 3h21m.and Aug was 3h33m

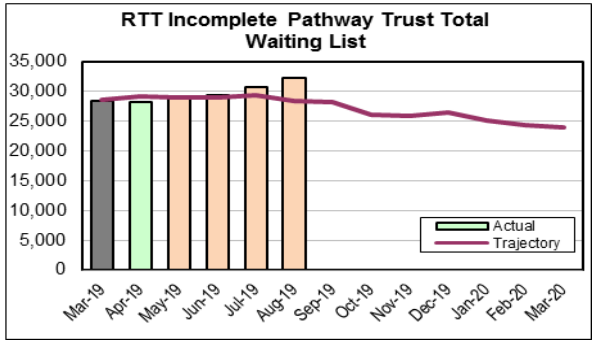
Ambulance Handovers: Last year, 9.6% of ambulances were delayed 30-60 mins, and 1.5% were delayed > 60. This year so far it's 12.3% delayed 30-60 mins and 1.3% >60.

Summary:	Actions:	Assurance:
A&E Attendances were as expected in August, slightly lower than other months due to holidays. However, performance was just over 4 percentage points below target in August, mainly because of issues at Maidstone which achieved 89.62% in August, 94.09% YTD. Performance for this site has started to recover in September.	Increase AEC on Maidstone site by improving referral process. Increase frailty services and AEC to 7 days a week. Scoping work being undertaken to review medical consultant cover at weekends to support patient flow and maintain quality and safety. Medical annual leave processes being reviewed. Surgery to join Huddle by November. 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.	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. Multi-professional Huddle embedded daily at 08.30. Continued focus on staff provision and demand analysis. Commencement of winter planning to ensure bed capacity. Secure funding for trollies required to run efficient ED departments

Escalation: RTT Incomplete Pathways

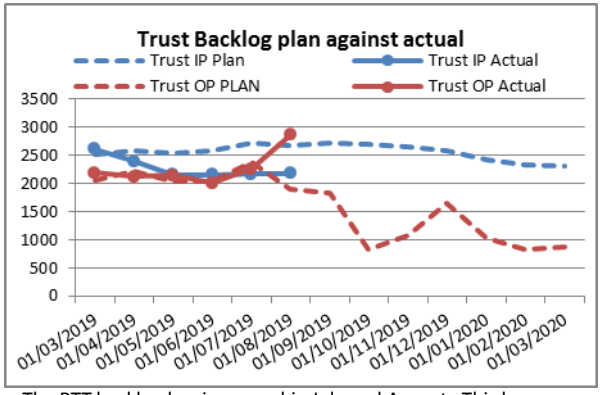
Trust	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Trajectory Total WL	28508	29152	28932	28908	29273	28433
Actual Total Waiting List	28412	28268	29027	29269	30705	32257
Actual IP Waiting List	6494	6045	6037	5978	6102	6049
Actual OP Waiting List	21918	22223	22990	23291	24603	26208
Trajectory Backlog	4146	4806	4578	4622	5089	4576
Actual Total Backlog	4797	4510	4305	4163	4430	5045
Actual IP Backlog	2611	2391	2157	2156	2158	2185
Actual OP Backlog	2186	2119	2148	2007	2272	2860
Trajectory % Performance	85.5%	83.5%	84.2%	84.01%	82.61%	83.9%
Actual Total % Performance	83.12%	84.05%	85.17%	85.78%	85.57%	84.36%

RTT performance had shown an increasing trend since November 2019 to a high of 85.78% in June, but has dipped in both July and then again in August , however August remains above trajectory.

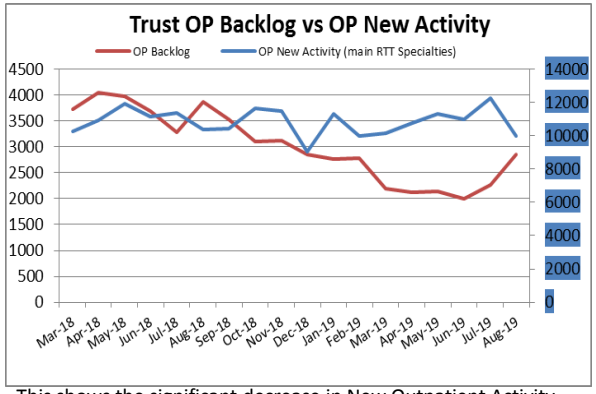


For the Trust the OP Waiting List and backlog are now above plan which has meant that the overall RTT Waiting List and Backlog are higher than plan.

RTT by Specialty All Specialties achieved their trajectory for August with the exception of Ophthalmology (-1.9%), Neurology (-14.5%), Rheumatology (-9.2%), Cardiology (-7.2%), Respiratory (-6%) and Gastroenterology (-2.0%), however Respiratory remains above the national target. General Surgery is now 4.2% above Trajectory, ENT and T&O are slightly above trajectory. Performance dipped in August for T&O, General Surgery and Gynaecology compared to July and there was a significant decrease for ENT (-3.2%). For Ophthalmology the non-admitted pathway performance is 4.7% below trajectory. All specialties saw an increase in both the OP Waiting List and Backlog due to the decrease in outpatient activity. Ophthalmology, ENT and Neurology OP Backlog account for the biggest proportion of the Trust OP Backlog (25%, 18% and 13% respectively)



The RTT backlog has increased in July and August. This has been mainly due to the OP (non-admitted pathway), although the IP (admitted pathway) backlog increased slightly in August



This shows the significant decrease in New Outpatient Activity in August as well as the RTT non-admitted backlog which was showing a downward trend but has increased in July and August due to the decrease in activity levels.

RTT Backlog: The majority of the RTT backlog continues to be concentrated in surgical specialties as well as Neurology, Cardiology and Gastroenterology all of which saw an increase in August. These are being carefully monitored against forecasts and action plans on a weekly basis

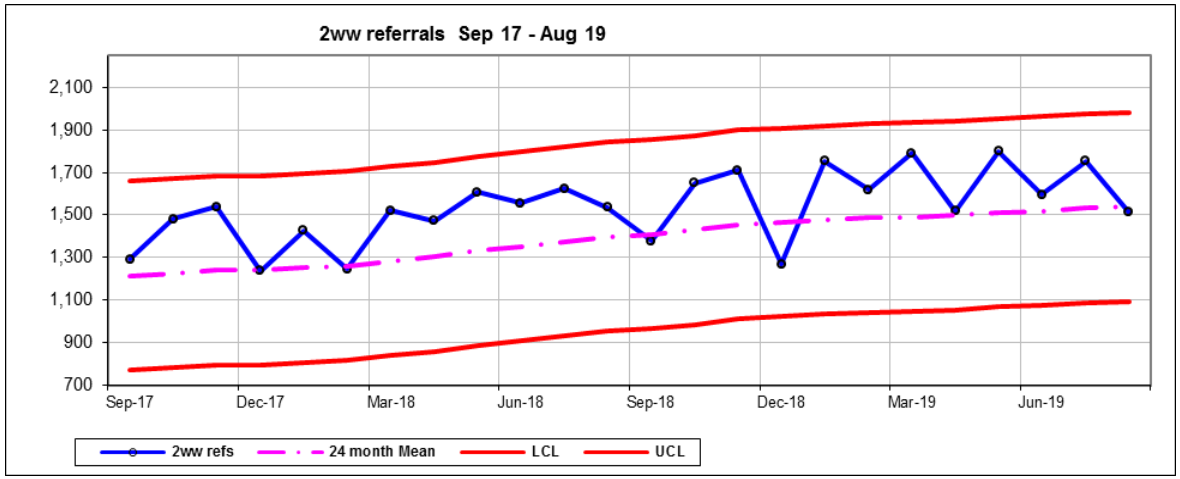
RTT 52 week Breaches: 7 reported for August (all new for August). All patients will have a harm review by the managing Consultant. No harm has been found as yet for the ones which have been completed. 52 Week Panel established.

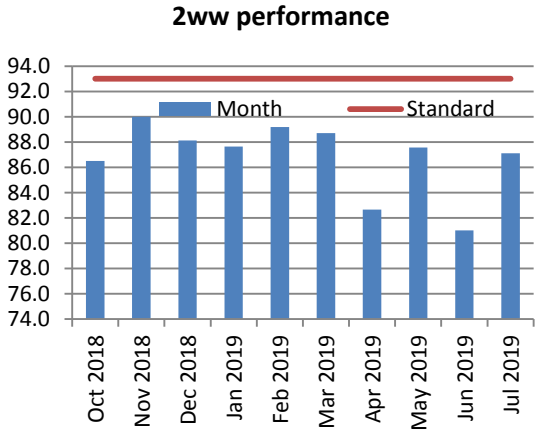
RTT Data Quality: Operational plan, risk assessment and Quality Impact Assessment (QIA) to be completed in order to review when the new reporting system can be implemented.

Diagnostics <6weeks: Decrease to 96.5% in August which is third consecutive month below the 99% target, mainly due to capacity issues in Endoscopy

Summary:	Actions:	Assurance:
Performance decreased in August but remains above Trajectory at 84.36%. The Trust Waiting List has increased further to 32,257 which is therefore 3,824 (13%) higher than the Trust submitted Trajectory of 28,433 and the backlog has increased to 5,045 which is 469 higher (10%) than the submitted trajectory of 4,576 due to the increase in the OP Backlog.	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.	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.

Escalation: Cancer Waiting Times – 2 Weeks





2ww GP referrals to MTW	Breast	Gynae	Haem	Head & Neck	Lower GI	Lung	Other	Upper GI	Urology	Total	BSYM	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 - Aug)	397	160	26	144	357	55	1	144	192	1480	163	560
% change last 12 mths	15.8%	13.1%	50.7%	17.2%	15.4%	13.1%	-77.4%	-1.1%	-6.9%	14.8%	16.1%	15.8%

****Note – for August 2019 IPR report onwards, 2ww referral numbers include the Breast symptoms as well as Rare cancer (Acute Leukaemia, Childrens and Testicular), increase of approx. 180 – 200 for activity**

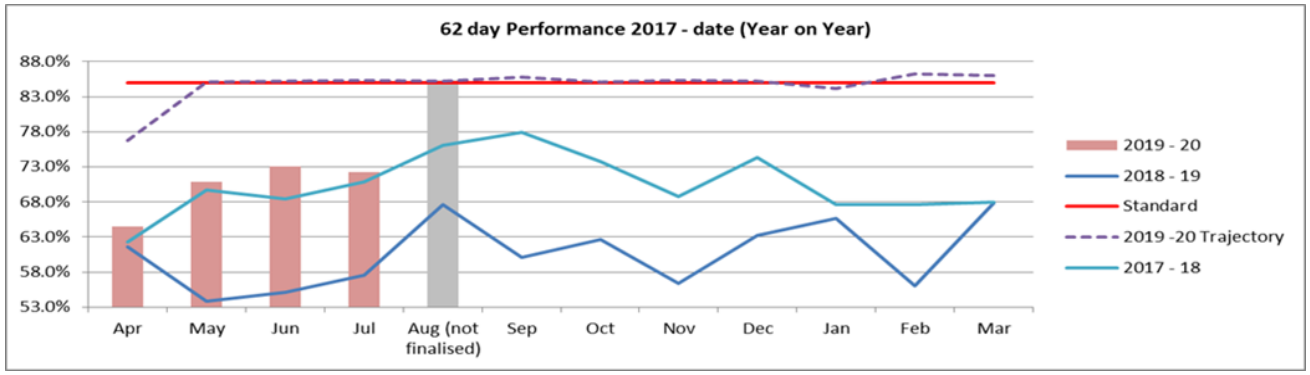
Demand: After a period of continued increased numbers of incoming 2ww referrals from January 2019 there was a decrease in referral numbers for June and August, likely related to the summer holiday period. This is expected to rise again through September, especially with the current Stand Up to Cancer campaigns. There has been a 50% increase in demand for Haematology 2ww referrals which remains a challenge with capacity

2 Week Wait (2WW) Performance:
Performance increased back up to 87.1% in July after a significant decrease in performance in June. August performance is currently being finalised but is estimated to be 86.9% for 2WW and 90.8% for 2WW Breast Symptoms

The majority of 2ww breaches in July were incurred in breast, Lower GI and urology and were among the lowest performing tumour sites along with haematology. Lung hit the 93% target for 2ww in July, and upper GI achieved 93.3 %

Summary:	Actions:	Assurance:
Continued increase of demand for 2ww referrals remains a challenge for clinic capacity, with specialities adding ad hoc clinics to meet demand. There has been a 50% increase in demand for Haematology 2ww referrals which remains a challenge with capacity and in July Haematology achieved 55.6% for the 2ww first seen appointment Following a decrease in June, performance increased back to previous levels in July but remains below target. The majority of breaches remain in the Breast tumour site.	The breast clinics have been re-mapped and additional capacity has been sourced to support the increase in demand in the long term. It has been agreed with the commissioners that Lower GI 2ww referrals that don't meet the criteria can be re-directed to an urgent but non-cancer pathway. Comms is going out to GPs and the new clinic will start in September. Gynae-oncology pathway re-instated for pelvic masses.	A new 2ww working group has been set up with involvement from General Managers across breast, urology, haematology and gynaecology. A new daily report has been developed to highlight any un-booked 2ww appointments and any appointments booked after 7, 10 and 14 days.

Escalation: Cancer Waiting Times – 62 Day



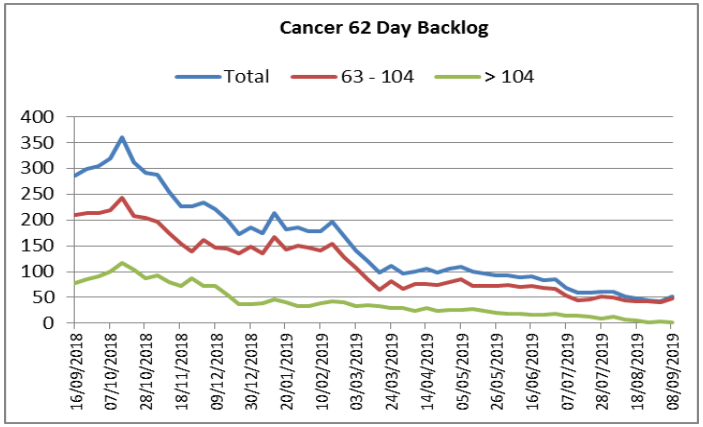
Trust Performance: The performance for July exceeded the forecast of 68% with an achievement of 72.2% for the overall 62 day target. The current validated (but not finalised) position for August is 85.3%, therefore achieving the national target of 85%.
The overall PTL is being maintained below a total of 1400 patients with a comparative backlog under 5% of the total overall PTL
Maintaining the improvement in the backlog position is driving up overall performance against the 62day standard.

Tumour Specific Performance: Gynae has shown an increase in performance in July achieving 90.9% up from 80.0% in June. Haematology showed an increase from 30.8% to 60.0%, however performance has decreased across all other tumour specialities in July, with Head & Neck and Lung being the lowest achieving sites for July

There was a marked under-performance in the Breast Tumour Site

Conversion rates for 2ww referrals: The conversation rate for 2ww referrals remains at 8.1% for patients referred up to June 2019, which remains less than 2018 – likely due to the increased number of 2ww referrals, which are not converting to diagnosed pathways

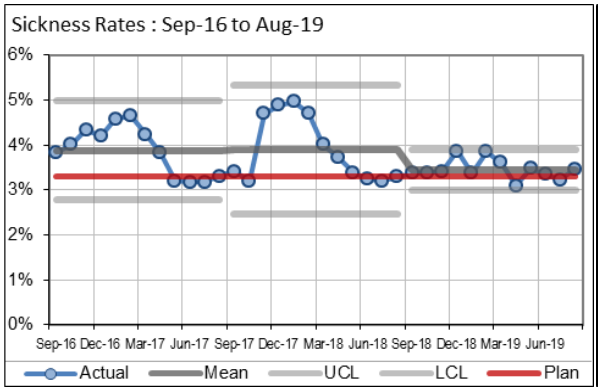
62 Day Performance						
July 2019	All reportable patients			MTW only patients		
	Total	Breach	%	Total	Breach	%
Breast	23.5	5.5	76.6	23	5	78.3
Gynae	11.0	1.0	90.9	9	1	88.9
Haematology	10.0	4.0	60.0	9	3	66.7
Head & Neck	3.0	1.5	50.0	1	1	0.0
Lower GI	21.0	7.0	66.7	18	4	77.8
Lung	10.5	5.0	52.4	7	2	71.4
Other	2.5	0.0	100.0	2	0	100.0
Upper GI	8.5	2.0	76.5	8	2	75.0
Urology	25.0	6.0	76.0	20	3	85.0
TOTAL	115.0	32.0	72.2	97	21	78.4

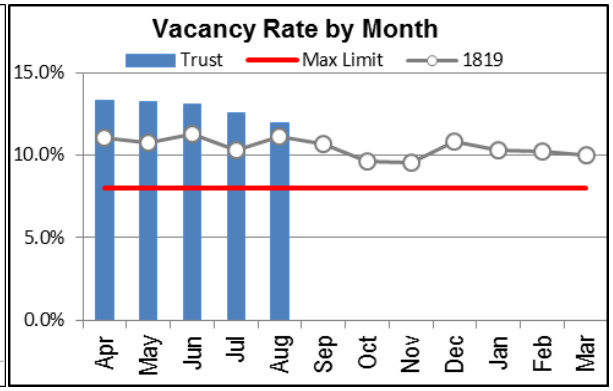


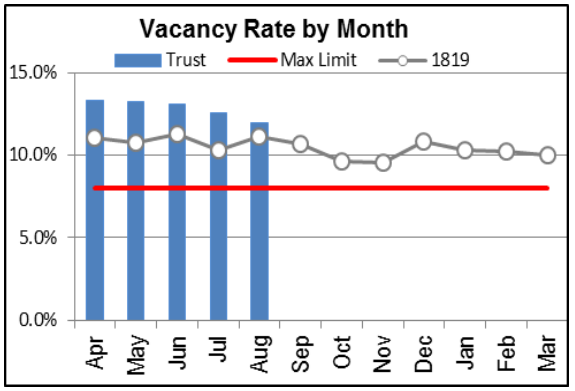
The work implemented over the previous months with specific daily focus on the Cancer PTLs has resulted in a continued improvement in the overall performance of the 62 day standard. All Directorates have been proactive with dealing with escalations and work is continuing to ensure sustainable processes are in place to support the Trust with ongoing achievement of the 62 day standard going forward

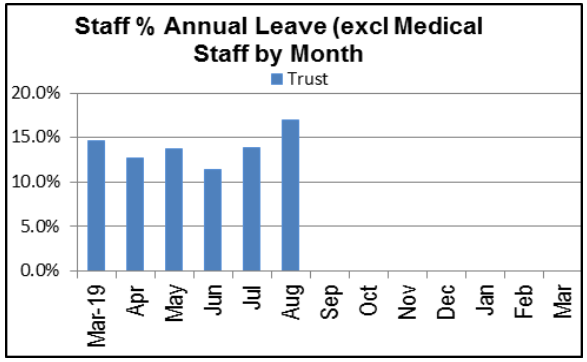
Summary:	Actions:	Assurance:
From April 2019 62 day performance has improved from 64.5% to 72.2 %. The current validated (but not finalised) position for August is 85.3% which is therefore above the 85% national target. The overalll backlog and those over 104 days has shown a significant downward trend and continues to decrease. There are now 57 patients in the backlog (6 of which are over 104	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 Additional funding has been secured from the CCG and Cancer Alliance to support proposed actions and posts required to continue cancer pathway improvements.

Escalation: Workforce









Annual Leave: As expected the level of Annual Leave has increased during July and August to a high of 16.9%.

Vacancy Rate: The overall vacancy rate has reduced slightly in August, however, both Nursing and Medical and Dental vacancies remain at a similar level to July

	Vacancy %				
Staff Group	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**
Registered Nursing, Midwifery & HV	20.32%	19.86%	19.25%	19.25%	19.66%
Medical and Dental	16.55%	16.16%	15.59%	11.58%	11.25%
AHP	13.17%	14.48%	14.82%	13.68%	12.67%
Other ST&T	5.64%	10.92%	11.22%	9.70%	8.12%
Other	8.53%	8.39%	8.56%	8.93%	7.63%
Grand Total	**13.31%**	**13.27%**	**13.11%**	**12.63%**	**11.97%**

Overall Staff Fill Rate (excluding Medical Staff): This has decreased over the last couple of months with a further 2.5% reduction in August to 72.3%

Turnover Rate: Due to the change in the calculation for turnover rate this will not be able to be accurately reported until March 2019.

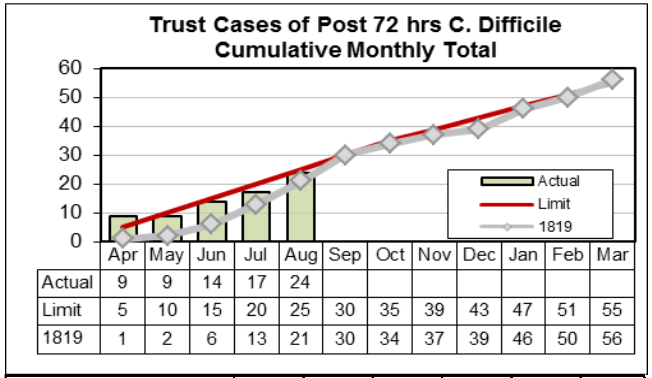
Sickness Rate: The overall sickness rate has become more stable over the last 12 months but has increased slightly to just above the maximum limit for August at 3.5%.

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.

Summary:	Actions:	Assurance:
There has been a high level of annual leave and slightly increased sickness in August. Whilst the use of bank staff did increase this was not at the same level of the reduction in substantive staff which has meant that the overall staff fill rate (excluding medical staff) has decreased to 72.3% in August 2019. Vacancy rate has improved slightly but remains high.	Overseas Sykpe interviews have now been completed. 57 International nurses have arrived to date in 2019. Recruitment have been present at a range of events in Kent over the summer including 'Pub in the park' and 'war and peace' 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.

Appendices

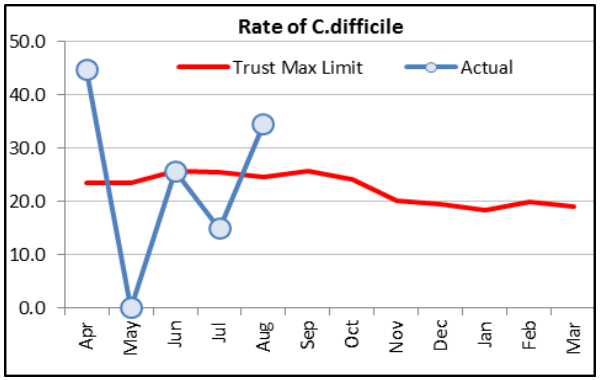
Safe	Infection Control	Aug-19



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	9	9	14	17	24							
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

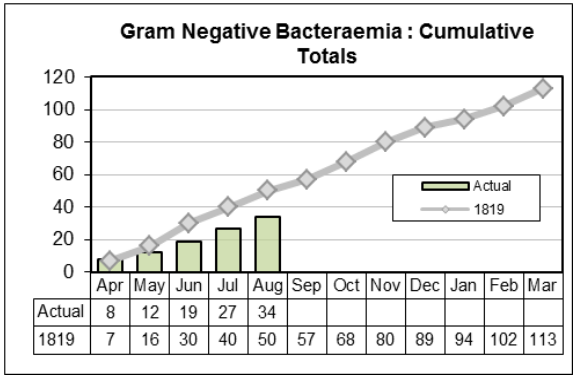
MSSA Bacteraemia	Apr	May	Jun	Jul	Aug	YTD
1516	0	3	2	4	4	13
1617	4	1	2	2	3	12
1718	2	0	0	3	0	5
1819	2	2	2	2	5	13
1920	1	3	0	4	1	9

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 lower than the level reported in 2018/19 to date.



C.difficile: In August there were seven cases of C.Difficile reported equating to a rate of 34.5 per 100,000 occupied beddays. Year to date there have been 24 cases reported against a maximum limit of 25 year to date.

MRSA Bacteraemia: One case of hospital acquired MRSA blood stream infections reported in August on a medical ward at Maidstone. One case of community acquired MRSA bacteraemia in patient with recent surgery at MTW. RCA complete and no avoidable cause found. Compliance against the MRSA screening rates has improved further in August for the non-elective pathway at 95%, achieving the target. Compliance for the Elective pathway continues to remain above the 98% target at 99%.



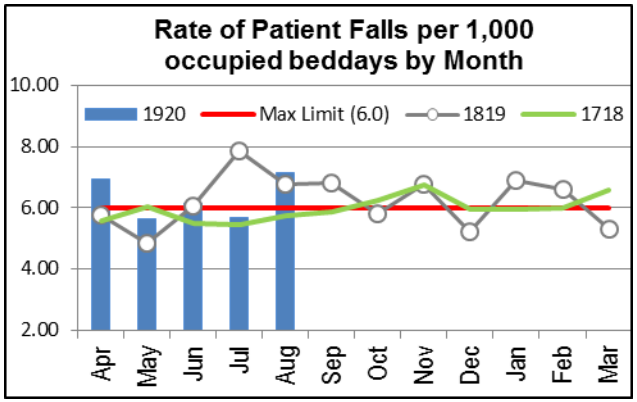
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	8	12	19	27	34							
1819	7	16	30	40	50	57	68	80	89	94	102	113

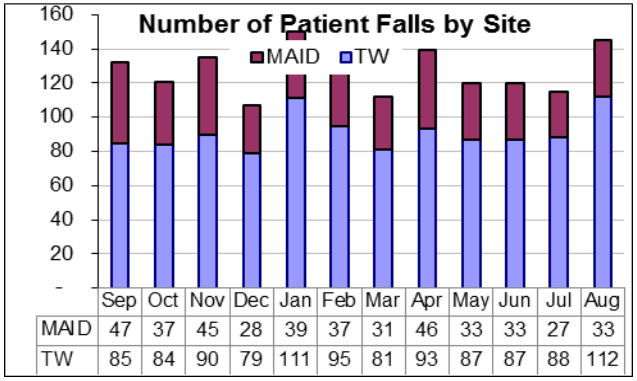
Gram Negative Bacteraemia (E.Coli, Klebsiella, Pseudomonas): The overall level of Gram Negative Bacteraemia blood stream infections remains significantly lower than the levels reported last year. In August there were 7 cases of E.Coli reported (27 YTD) and so far this year there have been 4 cases of Klebsiella and 2 cases of Pseudomonas reported.

Of the 27 cases of E.Coli reported YTD, the biggest proportion remains for patients on the Lord North Ward at Maidstone Hospital with 9 (33%) compared to 3 (9.4%) for the same period in 2018/19.

Summary:	Actions:	Assurance:
Despite an increase in cases reported in August, year to date the Trust remains on trajectory for cases of C.difficile. Performance for MRSA Screening Compliance in Non-Elecive pathways improved and is now above the target for August. Gram Negative Bacteraemia remains significantly lower that the 1819 levels but there cotinues to be a higher level of cases of E.Coli reported for the Lord North Ward	All new junior doctors receive infection control and antibiotic prescribing training. Rehydration stations and UTI diagnosis educational resources rolled out across Trust. Task and Finish group to implement control measures for gram negative blood stream infections. Deep dive to assess trends and preventable factors in Lord North E. coli in progress.	Routine cleaning Solution changed to Diff X across the Trust. HPV and UVC light cleaning remains in place for C diff cases, carriers and multi resistant organisms. Weekly C. difficile huddle held by DIPC and ICT. C. diff and MSSA review panels continue with DIPC and Chief Nurse

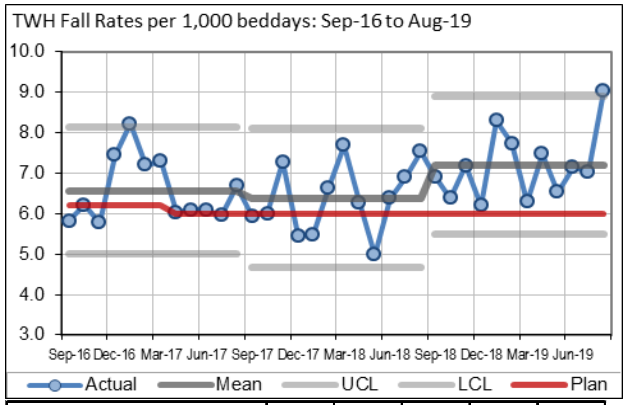
Safe	Harm Free Care	Aug-19





	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
MAID	47	37	45	28	39	37	31	46	33	33	27	33
TW	85	84	90	79	111	95	81	93	87	87	88	112

For August the rate of Falls increased to 9.03 for Tunbridge Wells. Maidstone remained similar at 4.18. YTD TWH is 7.4 and MH is 4.5



Severity of Harm 1920	Apr	May	Jun	Jul	Aug
No Harm	94	92	97	78	119
Low Harm	37	21	20	29	19
Moderate Harm	6	3	2	3	2
Severe Harm	2	4	1	5	5
Death	1	-	-	-	-
Total	140	120	120	115	145

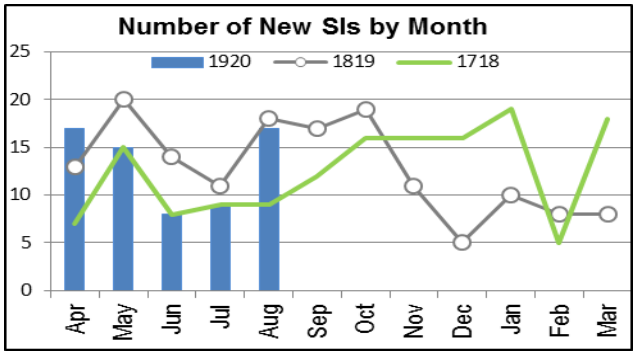
SIs: The number of Falls Serious Incidents declared increased to 7 in August; 2 were for falls in July, 3 were falls in August at TWH and 2 were falls at MH.
Patients with Dementia: The number of Falls for Patients with Dementia remained similar in August at 16 compared to 26 (unvalidated) in the previous year. YTD there have been 70 compared to 144.

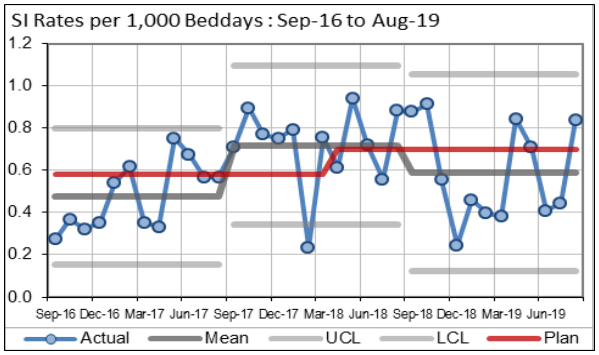
Harm Free Care: The percentage of Harm Free Care increased to 98.3% in August

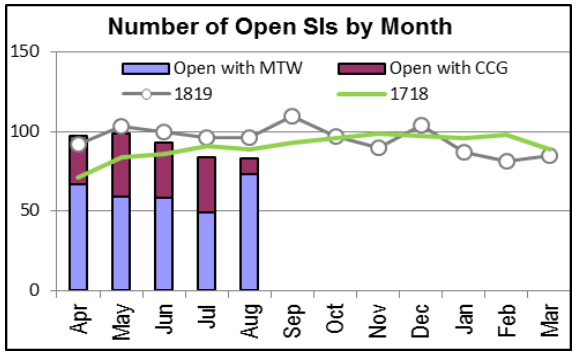
Falls: The number of Falls reported was 30 higher than last month at 145 for August which equates to a Rate of 7.1 per 1,000 occupied bed days, therefore not achieving the trajectory. The main increase was at the Tunbridge Wells (TWH) site. Whilst the overall Trust rate of Falls has remained within the confidence limits as you can see from the graph the rate of Falls for TWH was outside the upper control limit in August with a rate of 9.0. Falls at Maidstone remained consistent.
Falls by Division: Falls seen in the Medical and Emergency Care Division have increased in August and are now at a similar rate to the previous year. The rate of Falls for T&O continues to remain high at 11.3 in August (8.5 YTD).
Pressure Ulcers: There were 3 hospital acquired pressure ulcers reported in August. YTD there have been 11 compared to 47 for the same period last year. The average number reported in 1819 per month was 6. There were also three Deep Tissue Injuries (DTIs) reported.

Summary:	Actions:	Assurance:
The rate of falls increased in August to 7.1, therefore not achieving the target of 6.0. This was due to a significant increase in the number and rate of falls at TWH with the rate of 9.0 being outside of the upper control limit. The number of Falls that caused moderate or severe harm also increased which resulted in 7 Falls SIs being declared.	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 all inpatient wards to commence on the project by November 2019. Falls Awareness week on 23rd September and Link Nurse study day planned for 18th October 2019 to bring awareness and improve knowledge on falls prevention and reduction.	Wards on the project is monitored through spot audit at week 4, 8 and 12 intervals followed by further spot audit at month 6, 9 and 12. This is to monitor progress, sustainability as well as opportunity to identify if further support required. Currently on target to complete roll out to all inpatient wards by end of November 2019.

Safe	Serious Incidents (SIs)	Aug-19

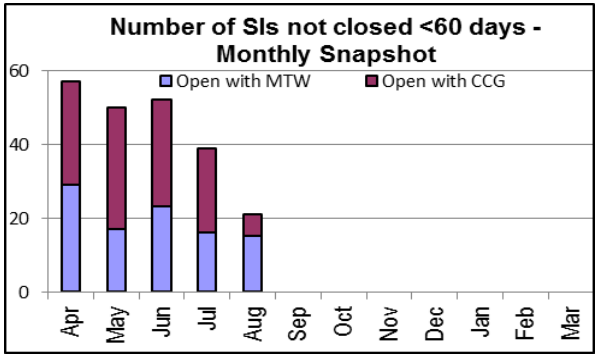






New SIs Category	Apr	May	Jun	Jul	Aug
Pressure Damage	1	1	-	-	-
Falls	3	6	1	3	7
Main	12	8	7	6	10
Total	16	15	8	9	17

SIs: The number of New SIs reported increased to 17 in August of which 7 were related to Falls. YTD there have been 20 SIs reported relating to Falls (31% of the total SIs reported compared to 9 SIs (16%) for the same period last year) .
The rate of SIs reported per 1,000 beddays has increased to 0.84 which is above the limit of 0.70



Downgraded SIs: In August 4 SIs were downgraded.

The number of SIs open at the end of the month has remained similar in August at 83 and remains lower than the previous year. The number of SIs open which had passed their breach date and had not been closed within the 60 day target has reduced month on month to 21 as at the end of August (15 waiting for MTW and 6 waiting for the CCG). Of the 83 open 73 are waiting for closure by MTW and 10 are waiting for closure by the CCG. This is an improving position. The largest proportion of Open SIs remains with the Medical and Emergency Care Division.
Recruitment and a review of current processes are underway to improve efficiency

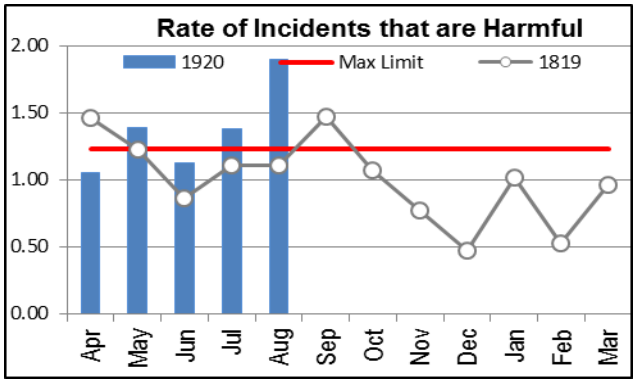
Summary:	Actions:	Assurance:
The number of SIs reported increased to 17 in August resulting in a rate of 0.84. The increase was mainly in those related to Falls (7) and YTD there have been 20 SIs reported that have related to Falls (31% of the total SIs reported). The number of SIs open at the end of August has remained similar and performance for those being closed within the 60 day target has improved month on month to 21 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. Development and monitoring of a SMART action plan for overall patient safety performance.	The patient safety team now has a second Band 6 Patient Safety Lead who joined the team on 16/09/19. Our Band 2 Governance Assistant joins the patient safety team on 23/09/2019 and our Band 3 Patient Safety Administrator joins the team on 14/10/19. In addition to these successful appointments the patient safety team are holding interviews for a Band 7 Deputy Patient Safety Manager on 19/09/19. We are currently out to advert for a further two Band 6 SI Investigators and if successful appointments are made then the patient safety team will be fully staffed.

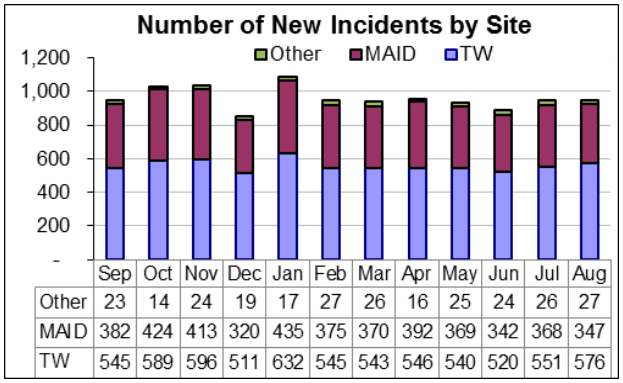
Learning from SIs and Falls Panels

Learning from Main Serious Incident (SI) Panel:

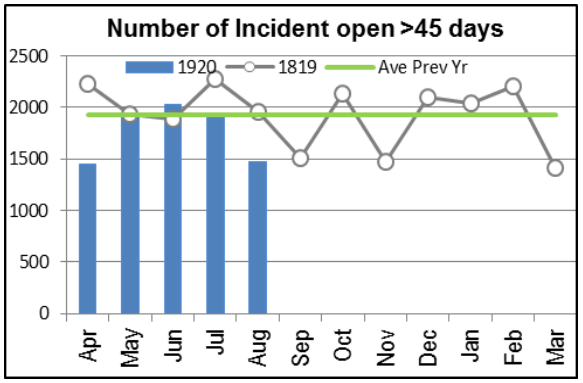
Care/Service Delivery Issue:	Learning:
Poor documentation both Medical and Nursing	Documentation of all events with patients. Including patient refusal to be treated. Review the need for a Specific form for "Special patients"
Patients being removed from site by security	Develop written guidance for escorting people from Trust premises for all security staff to read with competencies signed to show this has been read and understood
Missed opportunity to review and act on raised blood sugars	Sign on all blood gas machines to inform staff to review and act on all results
NEWS2 Algorithm was not followed	Minimum of hourly observations when trigger NEWS2 threshold To inform Doctor as NEWS2 Algorithm states Complete Sepsis screening tool when patient NEWS scores 4
No escalation for senior review	Senior review must be made within 30mins of the sepsis trigger or, the specialty consultant informed, and escalation to the Critical Care Outreach Team
Observations not recorded on NerveCentre	Document observations in patient's medical records when not recording on NerveCentre
Learning from Falls Panel:	**Learning:**
Falls Risk Assessment for patient on the 2nd admission was incomplete which meant actions were not taken to mitigate the risk of falling.	Comprehensive assessment of the patient's risk factors to be undertaken t and falls prevention measures to be implemented in accordance to the patient's needs.
Lying and standing blood pressure assessment should be completed for patient at risk of falls as part of assessment for orthostatic hypotension.	Lying and standing blood pressure assessment to be completed for patient at risk of falls as part of assessment for orthostatic hypotension.
Patient with delirium and restless, identified as high risk of falls did not have all appropriate falls prevention measure in place.	Patient assessment for delirium and identification of risk factors for falls prevention measures implemented to reduce the risk of fall.
Enhanced care assessment should be completed to support decision making on the level of enhanced care required by the patient.	Patient with cognitive impairment affecting their risk of falling did not have comprehensive assessment for enhance care to support decision making on level of enhanced care required by the patient.
Falls Risk Assessment for patient on the 2nd admission was incomplete which meant actions were not taken to mitigate the risk of falling.	Comprehensive assessment of the patient's risk factors to be undertaken t and falls prevention measures to be implemented in accordance to the patient's needs.

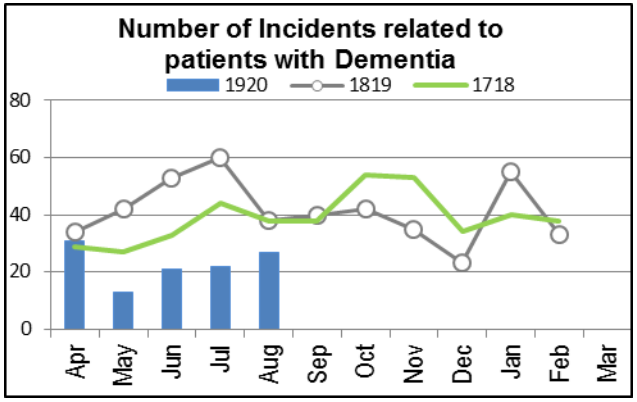
Safe	Incidents	Aug-19



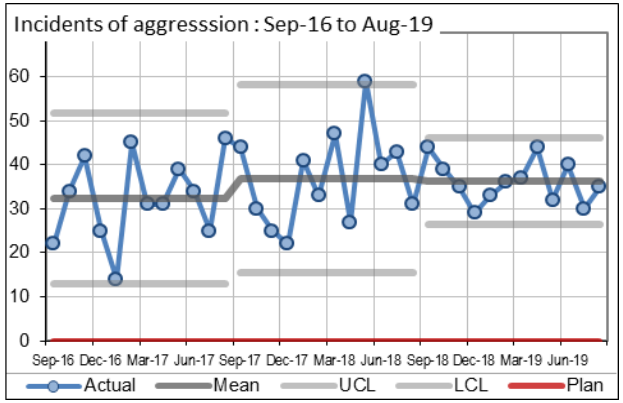


	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Other	23	14	24	19	17	27	26	16	25	24	26	27
MAID	382	424	413	320	435	375	370	392	369	342	368	347
TW	545	589	596	511	632	545	543	546	540	520	551	576





The level of Incidents related to patients with Dementia has increased in August but remains lower than levels seen last year.



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

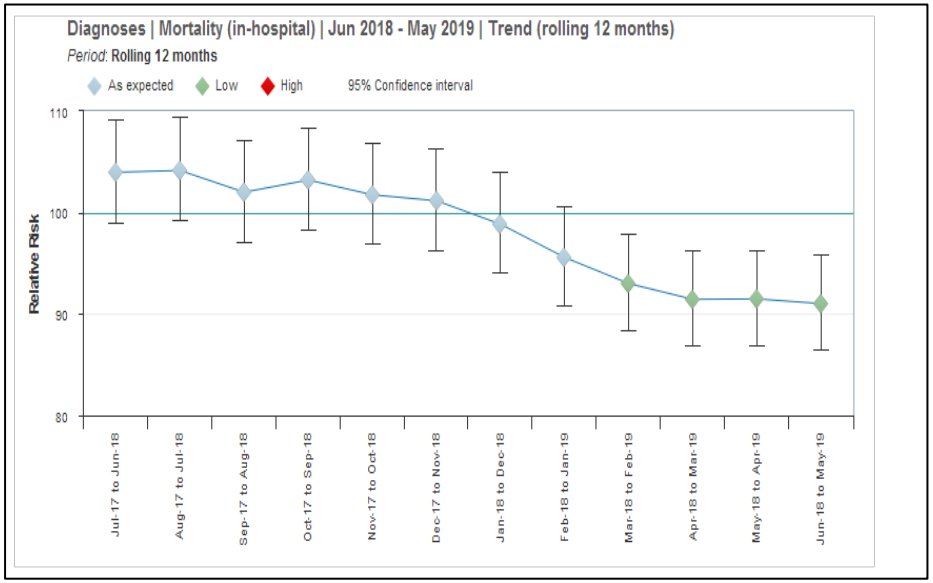
The number of incidents open for more than 45 days has reduced further in August to 1478 which is below the average of 1931 at any given time in 2018/19.

Incidents that are Severely Harmful: There has been a significant increase in the rate of incidents that were severely harmful in August to 1.89 which is above the limit of 1.23. This is mainly due to the increase in the number of SIs relating to Falls.

Incidents of Abuse towards Staff: Incidents have remained fairly consistent at 22 which is 63% of all incidents of aggression reported (35 in August). Similar to the average last year.

Summary:	Actions:	Assurance:
The Rate of incidents that are severly harmful has increased in August, above the maximum limit of 1.23 at 1.89. This is mainly due to the increase in the number of SIs relating to Falls. There has been a further improvement in performance for those incidents that have been open for more than 45 days.	Directorates updated monthly 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. A “kick-off” meeting with Datix is yet to be organised.	Oversight of incidents and learning disseminated to Divisional Governance meetings. Dementia incidents overseen and actions required discussed at Dementia Strategy meeting. Violence and / or aggression towards staff is overseen at Health & Safety Committee.

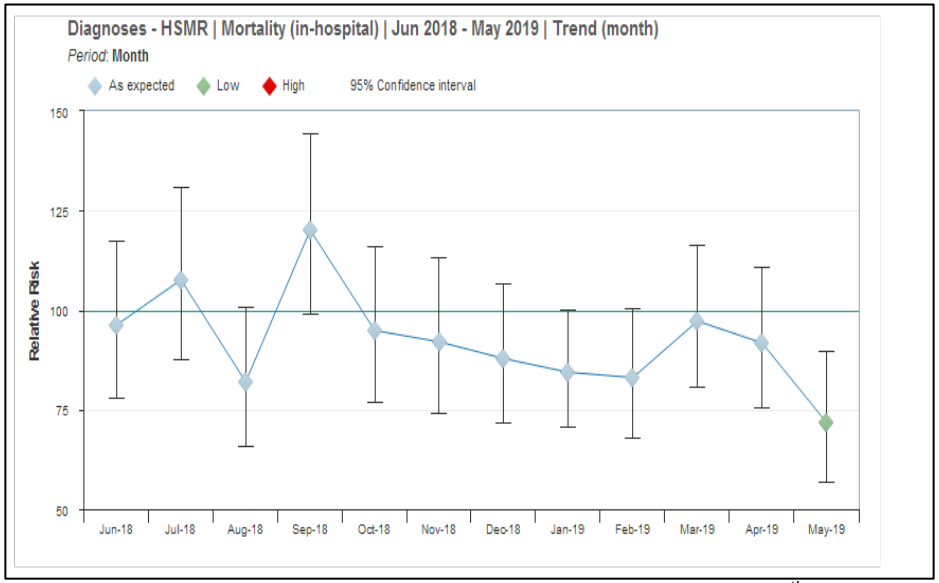
Effective	Mortality	Aug-19



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 89.6 & the TWH HSMR site position is 91.4.

Both the weekend & weekday HSMR Rate have significantly improved since Dec-17; 94.7 & 89.7 respectively as at May-19. Endocrinology is showing as a red risk with a weekday Relative Risk of 157.4 (34 deaths) as well as Respiratory Medicine (118.4 – 154 deaths).



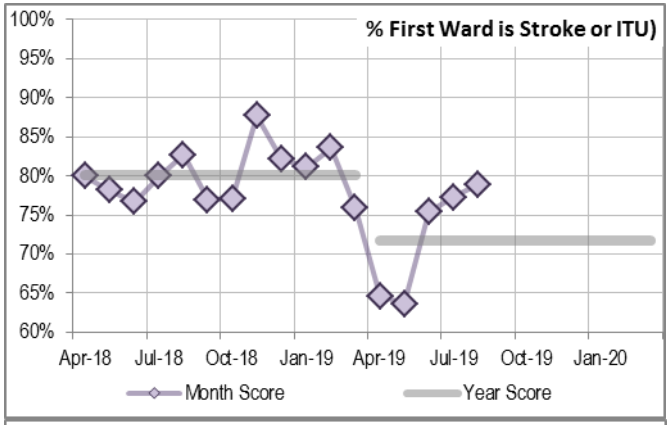
The Learning from Deaths working group was disbanded on the 11th September as its purpose and initial objectives have been delivered. Two new objectives remain, these include : –

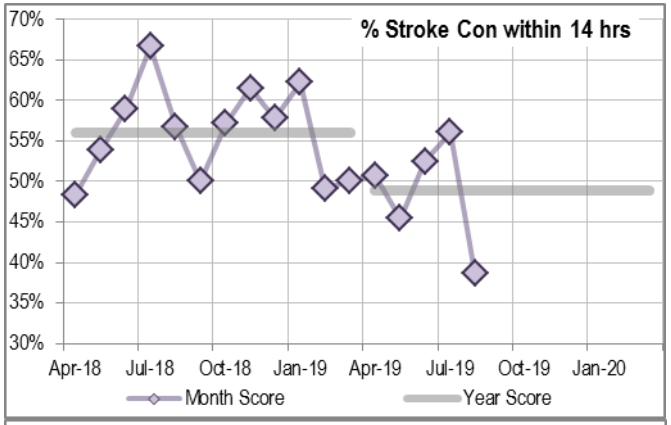
- The introduction of a Mortality Database, this is now being overseen by the Datix Implementation Working Group

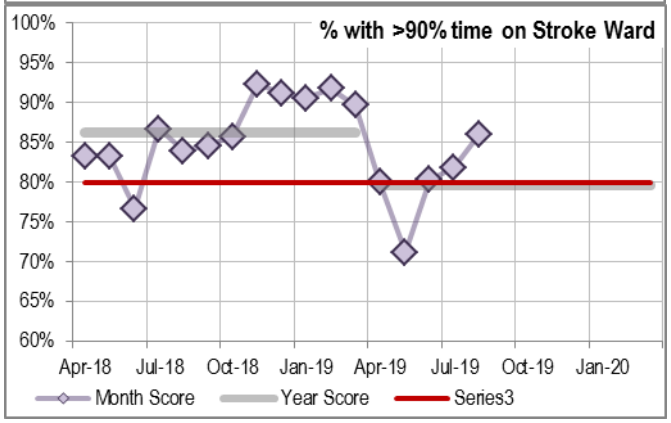
The introduction of the Medical Examiner and Medical Examiner officers role, this is now being overseen by the Medical Examiner Process implementation Working group.

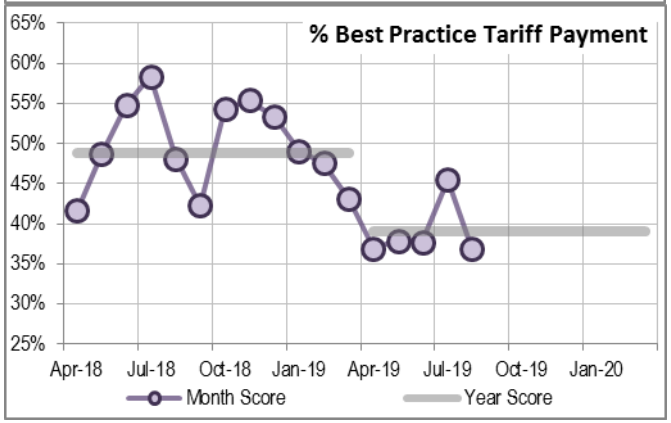
Summary:	Actions:	Summary:
The Risk Adjusted Hospital Standardised Mortality Rate (HSMR) and SHMI are both within acceptable limits and the Trust is no longer an outlier. The HSMR has been below 100 for the last three reporting periods. HSMR: Jun-18 – May-19 91.5 (86.4 – 96.8) SHMI: Apr-18 – Mar-19 102.24 (88.83 - 112.58)	**CUSUM Alert –** Acute Bronchitis under investigation with findings due for discussion at September Mortality Surveillance Group. Previous alert for Congestive Cardiac Failure reviewed by Directorate and is no longer an area of concern. **Mortality Review Audit –** 6 monthly review audit to take place 4th October	**Mortality Datix Module –** working group in place with the aim for rollout anticipated for December. **Medical Examiner working group –** Review of the role of Bereavement services and how this could integrate with Medical Examiner (ME) and ME Officer (MEO) roles has taken place. JD's for the service have been revised and will be reviewed at the next meeting.

Effective	Stroke Best Practice Indicators	Aug-19









There are now three main stroke indicators that constitute Stroke Best Practice. Last year, 823 patients came under this scheme and this year 43.1% met all three targets.

First Ward must be a stroke ward or ITU. Last year averaged 80.2%, but this year has dropped to 71.7% so far. Currently a lot of patients go to CDU first, and that is clinically appropriate until the Hyper Acute Stroke Unit comes online next year.

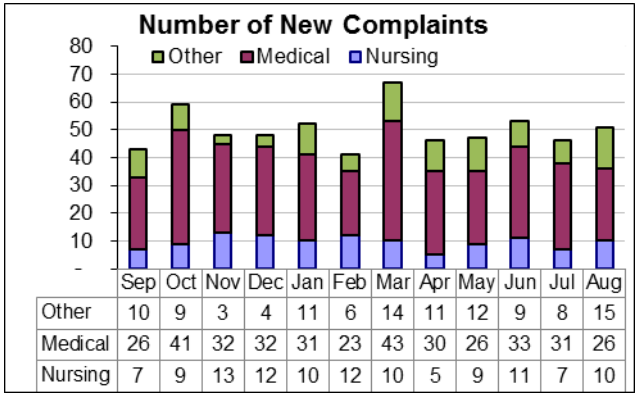
Stroke Consultant within 14 hrs. 2018/19 ran at 56.1%, but we have been below 50% since Feb, and Aug has gone under 40%. YTD we are 48.9%

90% of Spell on Stroke Ward. This metric is now slightly different. The qualification is on HRG rather than Diagnosis code, the time is calculated in minutes rather than overnights, and we are no longer able to discount time spent in the Discharge Lounge. 2018/19 was 86.2%, but this year we are at 79.7%. Latest month is incomplete & subject to change

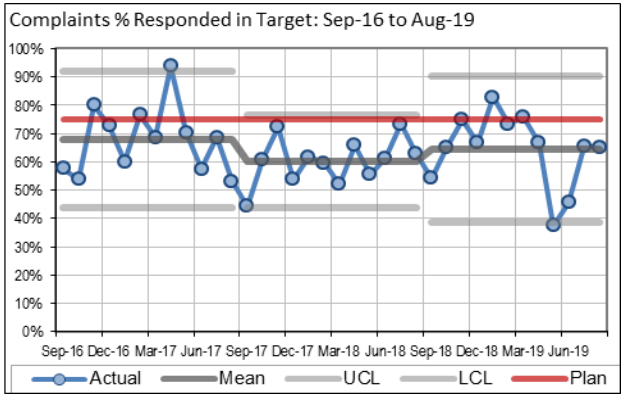
Payment Rate. In 2018/19, the percentage passing all 3 tests & qualifying for a Best Practice Tariff payment was 48.7%. All three indicators have dropped, and the combination rate is 39.0% so far this year.

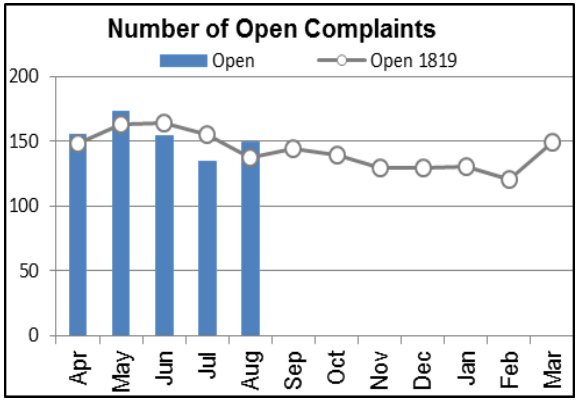
Summary:	Actions:	Assurance:
There are now three main stroke indicators that constitute Stroke Best Practice. a) admitted direct to a stroke or intensive treatment ward, b) See a stroke consultant within 14 hours of arrival or their stroke if that happens on-site, c) Spend 90% of their spell on a stroke ward. 39.0% of patients this year have qualified by meeting all three indicators. Performance for both those spending >90% of their time on a Stroke ward and the % that have a Stroke Ward as a first ward is improving.	1.Stroke CNS team to monitor compliance against BPT 2. Stroke CNS team to investigate non-compliance 3. Current monitoring of these BPT targets have shown that any patient that spend any time on CDU before Stroke ward fails this target 4. Currently Stroke consultants cover 5 days a week 5 90% spell on Stroke often not achieved due to increased capacity issues on the MGH Site / due to diverts from TW	1. BPT data now sent fortnightly 2. Action plan now in place 3. ED teaching by CNS team for early recognition of Stroke symptoms and early referal to Stroke to avoid transfer to CDU. 4. Post reconfguration of Stroke services with seven day working will improve this target. 5. Daily identifying of most appropriate pts (end of Stroke pathway) to be first to move from Stroke.

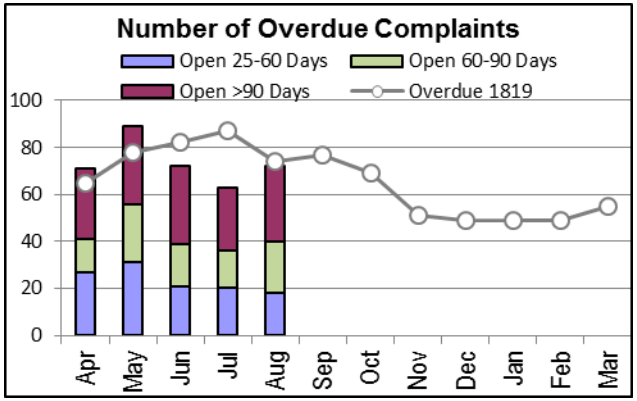
Caring	Complaints	Aug-19



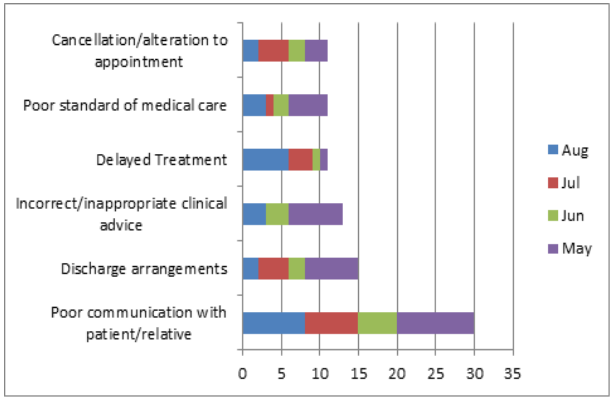
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Other	10	9	3	4	11	6	14	11	12	9	8	15
Medical	26	41	32	32	31	23	43	30	26	33	31	26
Nursing	7	9	13	12	10	12	10	5	9	11	7	10







Overdue complaints have increased in August to 72, above the average of 65 last year. The increase was broadly split between those open 60-90 days and >90 days.



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

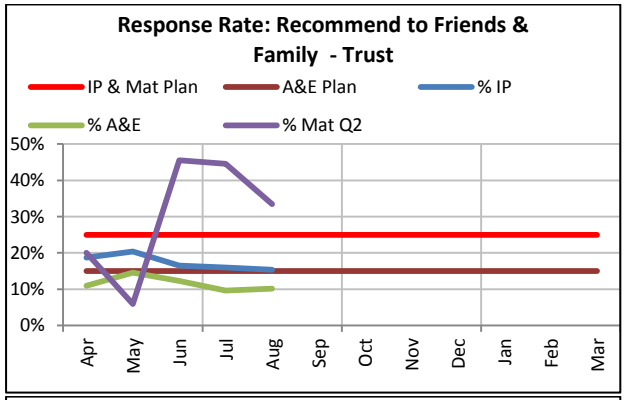
Open Complaints: The number of open complaints increased in August. Of the 149 complaints currently open, the largest proportion is in both the Acute Medicine and Surgical Divisions, with the biggest increase being in Women's & Surgery. Of the complaints open more than 90 days, 6 have been open for more than 6 months (increase of 2 from last month)

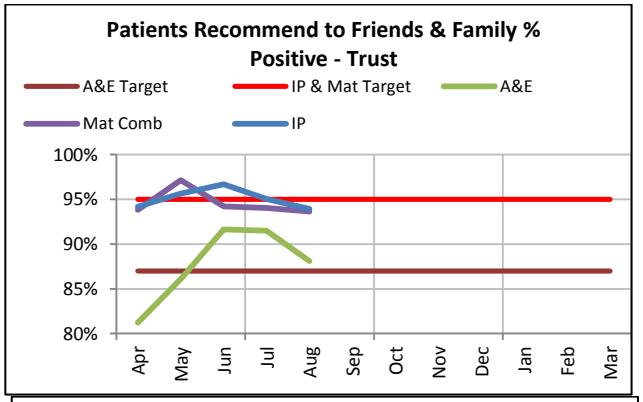
Themes of Complaints: The subject of complaints with the highest number remains poor communication with patients/relative; following a drop in June, this has shown increases month on month. Discharge arrangements continue to feature frequently in complaints but numbers have reduced.

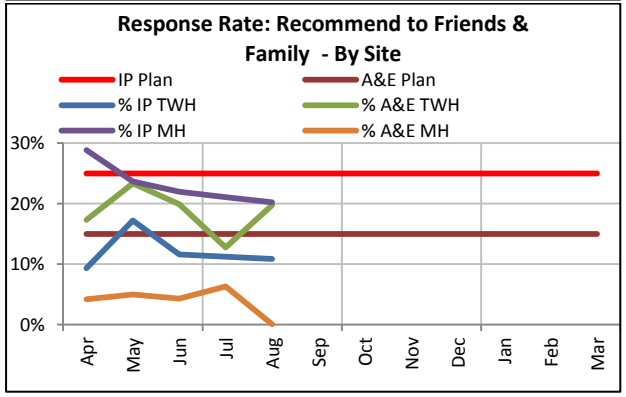
There were 20 compliments recorded in August, however not all compliments get recorded centrally.

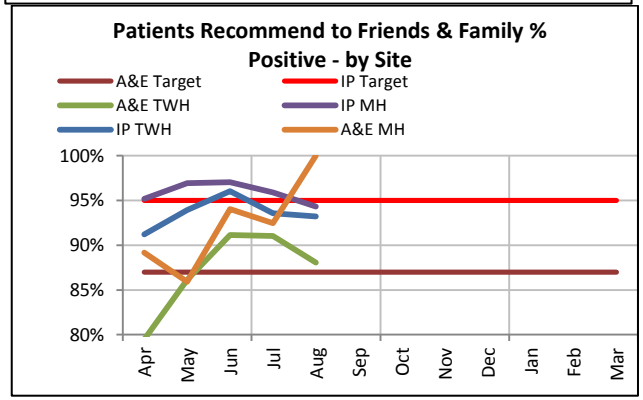
Summary:	Actions:	Assurance:
Performance in August remains broadly similar to last month at 65.1%. Divisional performance reduced to 79.1% in August with YTD at 78.7%.	Deputy Complaints and PALS Manager out to advert September Prospective weekly reports sent to all directorates to support achievement of response target.	Continued weekly monitoring of all open complaints with reports to CN. 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. Learning published in the Governance Gazette.

Caring	Friends and Family Survey (FFT)	Aug-19









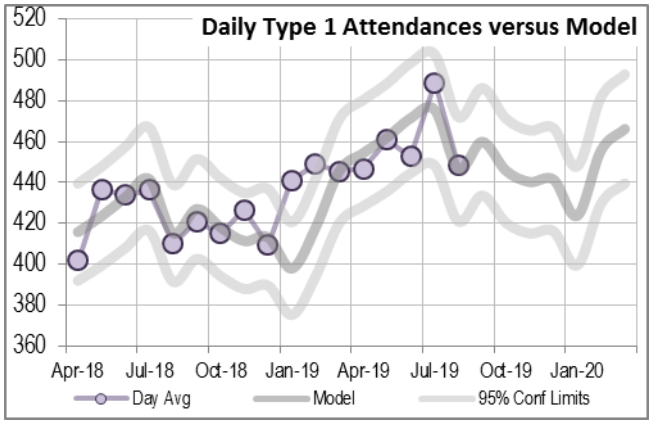
FFT Response Rates: There continues to be fluctuating consistency in the response rates with two of the four areas showing a reduction in the August response numbers. Maternity response rate for Q2 (births) has declined to 33.4% for Aug, down to 29.8% YTD.

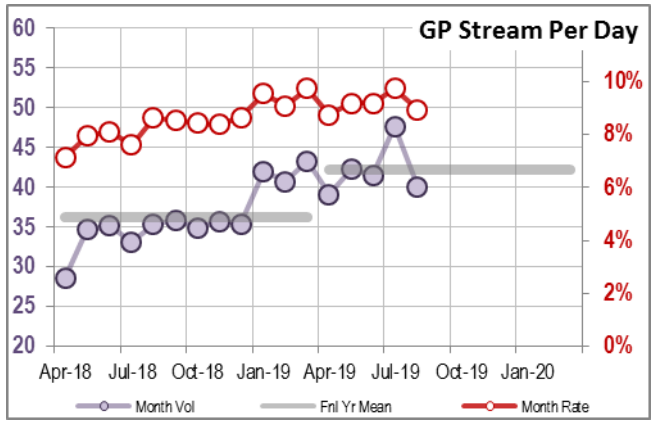
FFT By Site/Ward: The response rate for A&E continues to remain significantly lower at the Maidstone site (MH), this month with only 2 responses, and the response rate for Inpatients (IP) continues to remain lower at the Tunbridge Wells site (TWH).

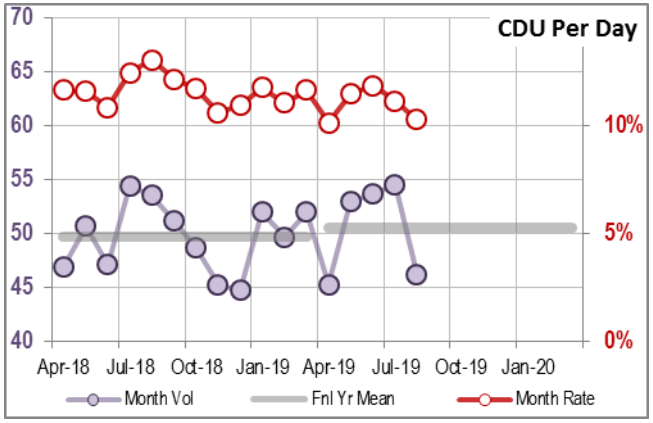
FFT Percentage Positive: The Friends and Family Test satisfaction rates have dipped below target for inpatients for August while remaining on target YTD at 95.1%. Maternity performance for Q2 only (birthplace) has improved against last month but YTD has dipped to 94.2% against 95% target. The positive feedback rates for A&E remain above the national target across both sites so far during 19/20, despite another significant reduction in the response rate at Maidstone in August. The positive feedback rate for OP increased in August to 83.0% with a slight increase in the number of respondents.

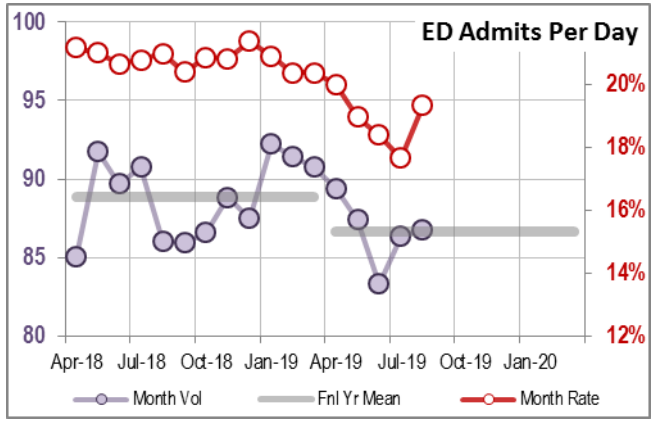
Summary:	Actions:	Assurance:
Response rate for August for IP decreased to 15.4% with a 7% drop in eligible respondents. There were virtually no responses from Maidstone A&E in August, and we continue to see fluctuation in the maternity response rates. For the % positive,there was a decline in August for both IP, Maternity and A&E although this would have been skewed by the reduction in respondents for A&E.	There has been a collection issue identifed in Maidstone A+E accounting for the significant fall in responses for August. The fluctuating consistency in response rates continues to monitored through the review monthly meetings. FFT provider reports shared to all area leads for review. Implementation meetings are underway to prepare for the transition to the new FFT provider. New survey cards in the process of being approved. WeBex demonstration of new system confirmed.	Matron for A+E alerted to collection issue and reviewing process to ensure consistent collection by utilising the flow coordinator role. Regular monitoring continues. "Basecamp" communication tool to track progress and actions. Transition to new provider mid September delayed one week due to approval time for new FFT cards and additional services engaging with process Communication of new provider being shared widely.

Responsive	Non-Elective Flow: Into Hospital	Aug-19









Attendances: Type 1 attendances averaged 427.0 per day in 2018/19 – 7.1% up on the previous year. We are currently forecasting a 7.2% increase on that for 2019/20

August was almost exactly as expected at 448.7 per day. Attendance usually slumps a little in August because of holidays.

GP Stream: This averaged 36.3 per day, 8.5% of arrivals through 2018/19. August has come back to more normal levels after spiking in July. YTD it'

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 50.6 per day and 11.0% of attendances.

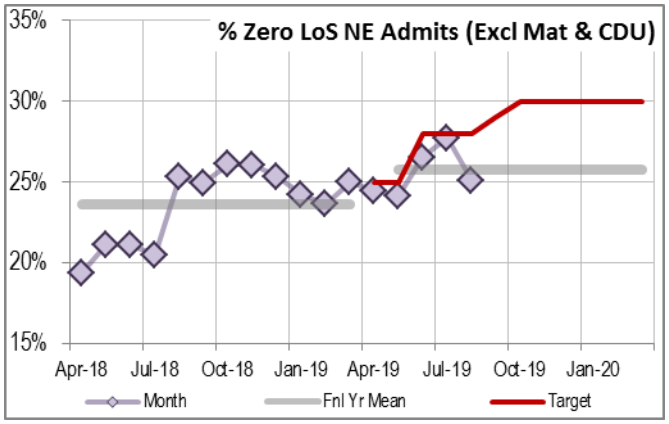
These patients are classed as NE admissions, but don't actually leave the ED, don't occupy a general or acute bed.

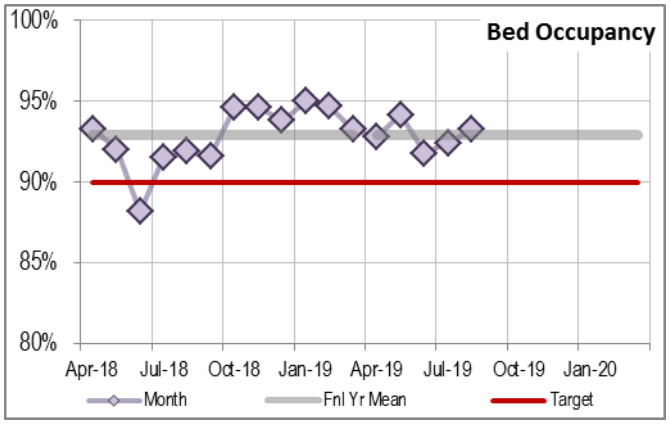
ED admits per day: This counts all patients leaving the Emergency Department to go into the main hospital. CDU patients only count here if they are transferred to another ward.

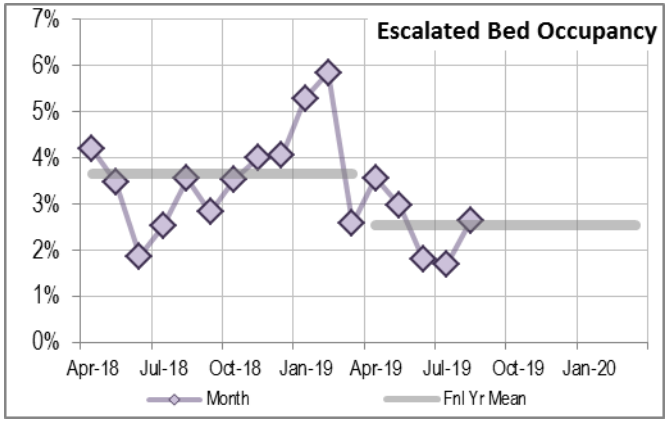
2018/19 averaged 88.9 per day. Or 20.8% of attendances. This year we average 86.7against much higher attendances, so the percentage is now 18.9%. August reversed a significant downward trend in this percentage

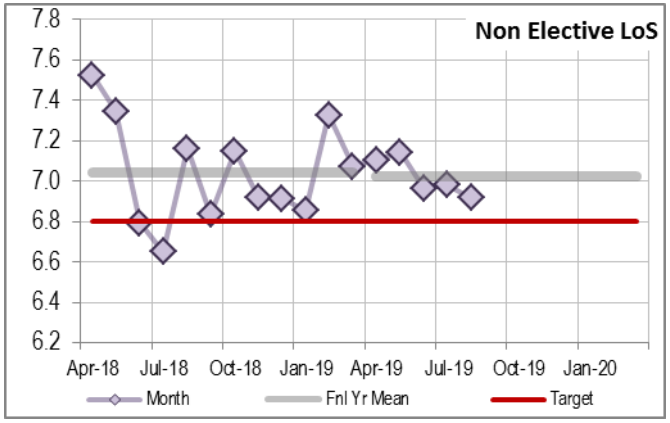
Summary:	Actions:	Assurance:
Type 1 attendances are currently showing an annualised growth of 8.1%. July was the busiest month ever by a margin of 5.8%. YTD, 9.2% of arrivals are streamed to GP, 61.0% are treated in ED, 11.0% are admitted to CDU but no further and 18.9% are admitted beyond CDU.	Increase AEC on Maidstone site by improving referral process. Increase frailty services and AEC to 7 days a week. Scoping work being undertaken to review medical consultant cover at weekends to support patient flow and maintain quality and safety. Medical annual leave processes being reviewed. Surgery to join Huddle by November.	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. Multi-professional Huddle embedded daily at 08.30

Responsive	Non-Elective Flow: Bed Management	Aug-19









The percentage of Non Elective (NE) admits that are zero LoS has been rising as increasing numbers of patients go through Assessment / Ambulatory type wards. 23.7% in 1819, 25.6% so far this year, 25.1% in August. Excludes clinical decision (CDU) only patients & Maternity. CDU patients are not generally receiving treatment.

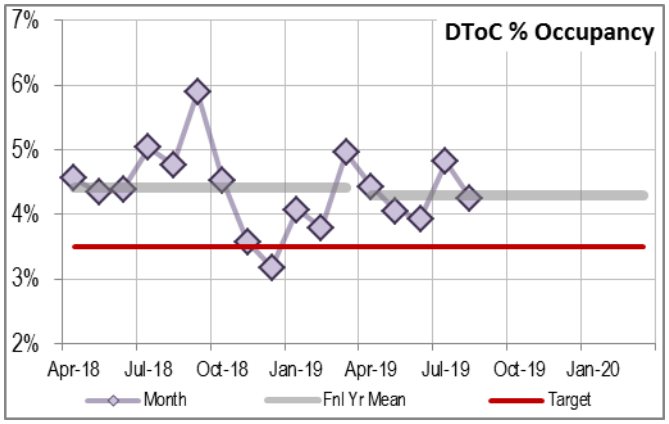
Bed occupancy averaged 92.9% last year (based on the 7am bed census). So far this year it's almost exactly the same. Bed occupancy tends to hit a minimum in late Spring / early Summer, but this has not happened this year. Many of the beds flagged as available on this census are paediatric, ITU or specialist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

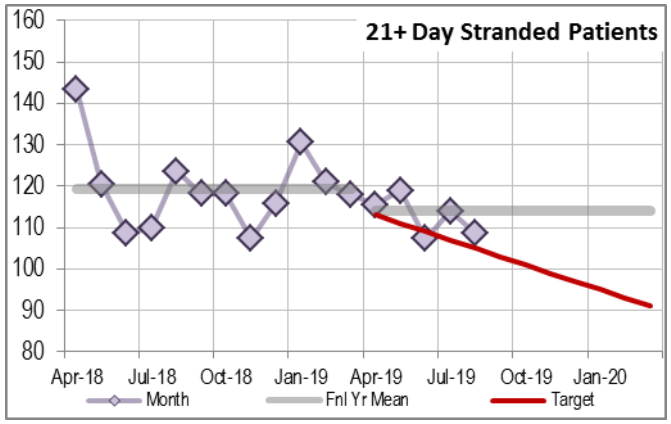
Escalated Bed Occupancy. Last year, escalated beds were an average of 3.6% of our total occupancy, rising to 5.8% in Feb-19. So far this year, we are at 2.5%, which is an improvement on last year. Aug was 2.6%

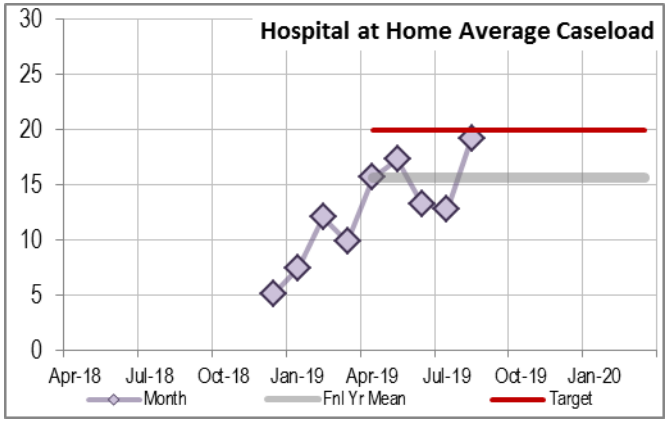
Non Elective Length of Stay (LoS) is something the Trust is actively trying to reduce, as it feeds directly into bed occupancy. Last year the Trust averaged 7.05 days. This year so far it's marginally lower at 7.02, but this difference is too low to be statistically significant.

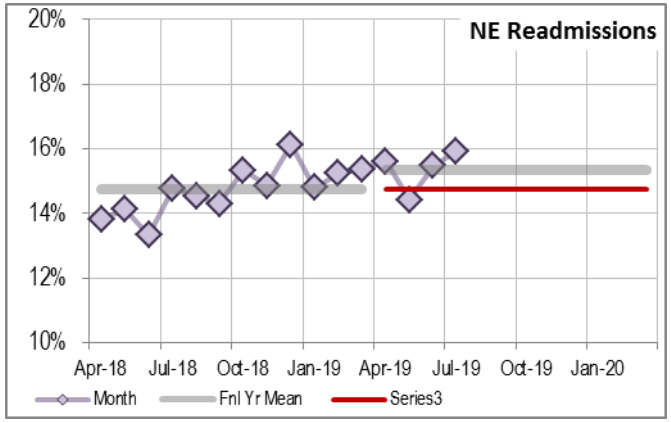
Summary:	Actions:	Assurance:
25.6% of all Non-elective (NE) admissions are now zero LoS (not counting CDU patients). Bed occupancy is consistently between 92% and 95%, but escalated beds are a significant improvement on the same period last year. Non-Elective length of stay (LoS) was 7.05 days last year, and is almost exactly the same YTD	LOS: Continue to use Clinical Utilisation Review (CUR) to identify delays in flow, including red and green days. Achievement of Q4 CQUIN for CUR. 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	Aug-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 4.30% 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 112.8, and Aug was 108.5

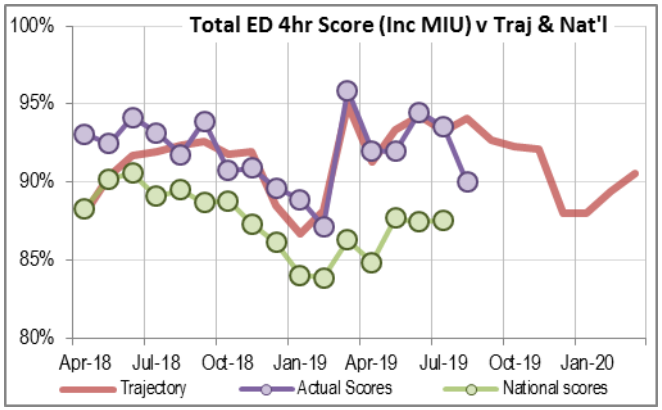
Hospital at Home is an average of the daily snapshot of patients on the H@H scheme. The intention is to run at around 20 patients. Every patient on the scheme effectively frees up a bed. This year we average 15.7, and Aug was 19.3

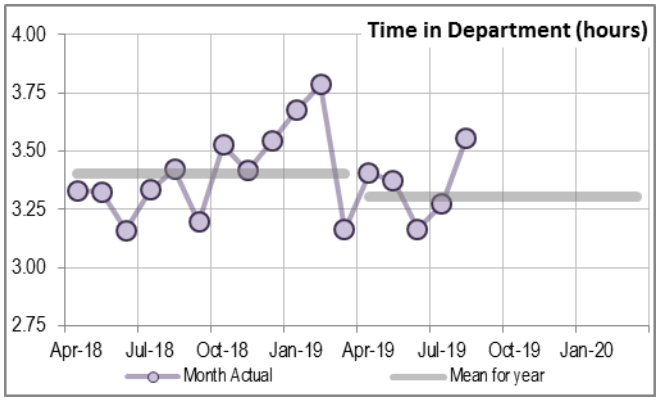
NE Readmissions. Averaged 14.7% in 2018/19, rising steadily through the year. This year's rate (to 30-July) is 15.2%. The latest month is generally prone to slight (~0.2%) undercounting. This is the official 30 day Readmission key performance indicator, with cancer and Mental Health patients excluded

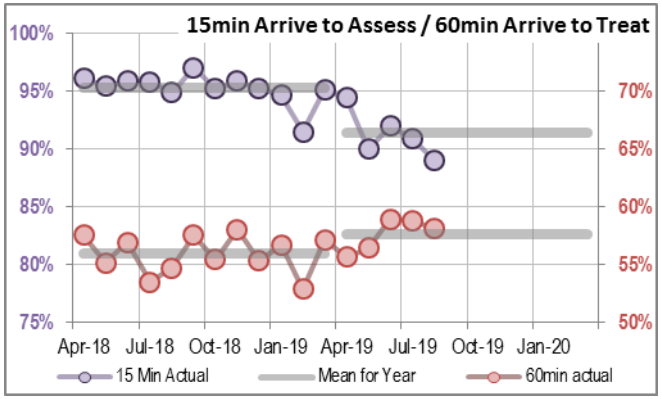
Increasing use of short stay units applies upward pressure on readmission rates by capturing in the count patients who would otherwise have gone home from ED

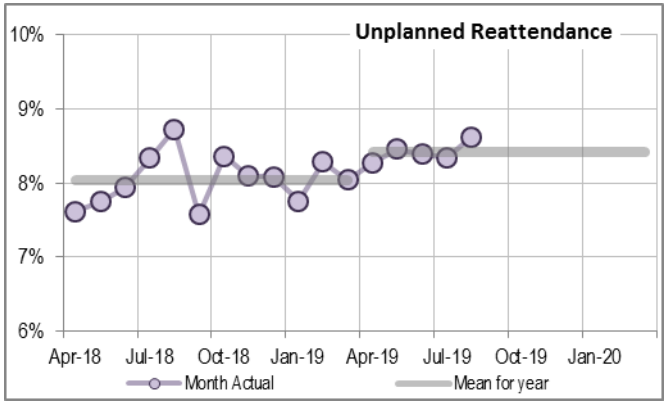
Summary:	Actions:	Assurance:
DToC has been coming down over time, but MFFD has been back over 14% for 5 months now. Stranded patients averages 112.8 so far this year compared to 119.5 last year, and the Hospital at Home scheme has effectively freed up 10-20 beds. Readmissions continues to rise, and is 15.1% so far this year, but much of this is a feature of increased SDEC. Staffing levels have created issues internally and externally over the summer period.	Long length of stay walk about and senior escalation to impact the 21+. DTOC remains stable with daily sign off Concern over level of POC available in community , community services such as rapid response are 'holding' waiting for long term double handed packages Capacity commissioned for Pathway 1 via HILTON insufficient for demand	- Daily sign off of Delayed transfer of Care at team leader level - Daily review of 21+ numbers - Long length of stay walk arounds have commenced on 'long stay Tuesday' initiative. Escalation call to execs on Thursday morning to highlight issues

Responsive	A&E Performance Indicators	Aug-19









4 Hr Time in Department: Performance took a hit in August, coming in at 90.02% against an agreed trajectory of 94.05%, one of the worst monthly scores against trajectory for some time. Around 2/3 of the excess breaches occurred at Maidstone, and are related to workforce issues, and a heightened state of infection control in UMAU

Total Time in Department averaged 3^{h} 24^{m} for Type 1 attendances through 2018/19, but have reduced significantly over the past couple of months. YTD the Trust are $3^{h}21^{m}$.and Aug was $3^{h}33^{m}$

15 minute arrival to assessment performance was 95.35% for 2018/19, but is averaging 91.37% so far this year

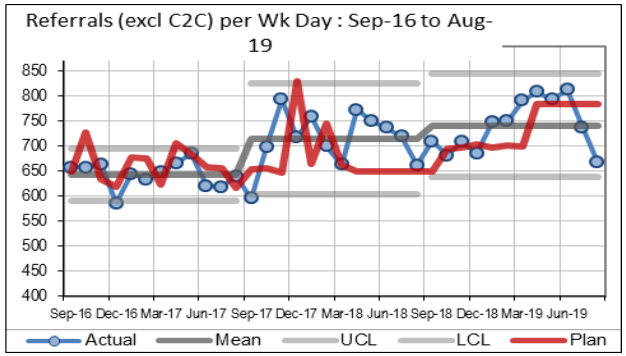
60 minute time to treatment averaged 55.89% for 2018/19, and are slightly higher this year at 57.60%

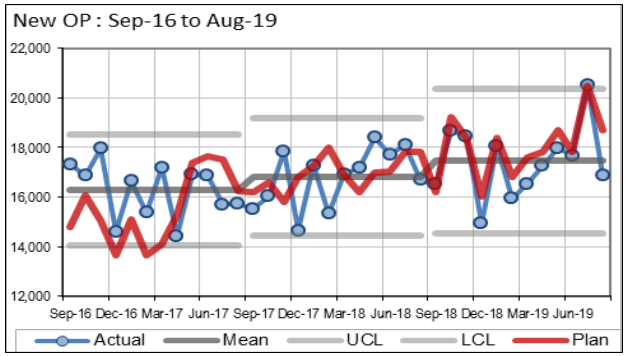
Unplanned re-attendance rate is a second unplanned visit, arriving less than 168 hours since the last attendance conclusion. This averaged 8.04% in 2018/19, and is 8.42% so far this year

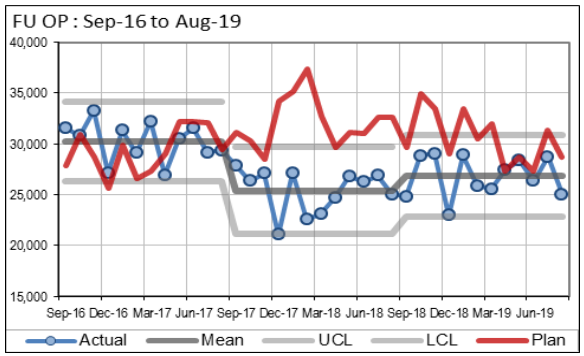
Ambulance Handovers: Last year, 9.6% of ambulances were delayed 30-60 mins, and 1.5% were delayed > 60. This year so far it's 12.3% delayed 30-60 mins and 1.3% >60.

Summary:	Actions:	Assurance:
Performance was just over 4 percentage points below target in August, mainly because of issues at Maidstone. YTD, the average Time in Department is slightly improved at 3h21m, 15 min pass rate is down at 91.37%, 60min pass rate is improved at 57.6%, and unplanned re-attendance rate is up slightly at 8.26%.	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	Aug-19







Referrals: The level of Referrals (excluding Cons to Cons Referrals) decreased in August to 667 per working day. This compares to 661 per working day in August last year. Referrals are always lower in the most recent month as there is an element of cashing up in the data and it is expected that the final total for August will increase. At the time of reporting last month referrals for July were 695 per working day but this has now increased by 43 to 738 per working day (+ 6%). Referrals are 2.7% below plan YTD. The level of referrals will need to be closely monitored over time to see if there is a decrease in demand.

The areas showing the biggest reduction per working day in August are Gynaecology, Ophthalmology, Surgery and Thoracic Medicine.

There has been a 2% reduction in Consultant to Consultant referrals YTD compared to the previous year.

New outpatient activity: Activity saw the expected decrease in August; however it was 18.7% below plan in August and is 5.2% below plan YTD. Activity decreased by an average of 89 per working day compared to July but remained at a similar level per working day to August last year. Activity in July and August has been adjusted slightly with an estimate of the activity being done in the Independent Sector but these are relatively small numbers. Overall all specialties saw a reduction in activity in August per working day compared to July. Surgery saw an 18% decrease, Ophthalmology saw a 15% decrease and T&O saw an 8% decrease.

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 around 9% below plan YTD

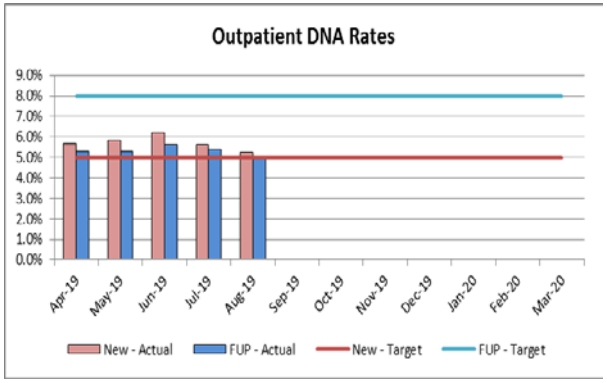
New Outpatient Activity by Specialty: The specialties furthest from plan YTD remain ENT (-27.3%), Gastroenterology (-32%), Ophthalmology (-17.2% and T&O (-10.3%) which is directly impacting on their achievement of their non-admitted RTT Trajectories. Gynaecology is 14.8% above plan YTD.

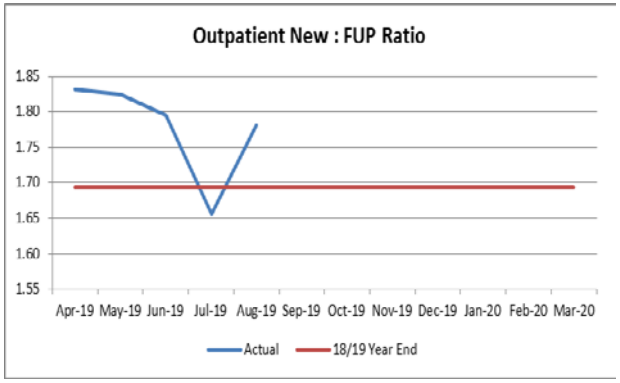
OP Follow Up Activity:
Follow up activity decreased in August and the number per working day was 102 lower than July, but 10 lower than August last year. Activity is now below the average. Activity was 16% below plan in August and 5.9% below plan YTD. As with the New OP Activity T&O, Gastroenterology, ENT, Ophthalmology and Cardiology are furthest from plan

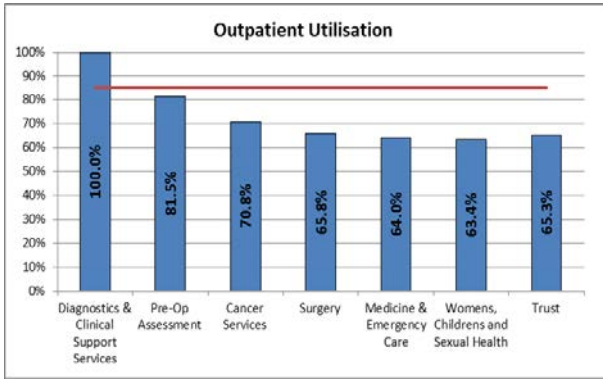
The key issues that contribute to lower than planned New Outpatient work remain:
Productivity challenges in Ophthalmology.

Summary:	Actions:	Assurance:
Referrals are 2.7% below plan. However the expected increase in demand can be seen for T&O, Gynaecology and General Surgery but has been offset by a decrease in demand for Ophthalmology. New Outpatient activity is 5.2% below plan YTD. However, for the main RTT Specialties this is 9% below plan YTD. Specialties furthest from plan remain ENT, Gastroenterology, Ophthalmology and Trauma & Orthopaedics.	Musculo-skeletal (MSK) pathway proposal agreed with Kent Community Healthcare Foundation Trust (KCHFT). Contracts have been exchanged. Go live date 30-09-19. The analysis shown to date demonstrates that the non AIC (Aligned Incentive Contract) referrals are down specifically from the Swale area in T&O, Ophthalmology and ENT.	Monitoring continues of the MSK pathway to ensure MTW can manage the referrals. Regular performance meetings with KCHFT to be scheduled. Yearly trends review and weekly monitoring has been implemented to understand the decrease.

Responsive	Elective Flow – Outpatient Efficiency	Aug-19







New DNA Rate: The New OP DNA Rate showed a downward trend during 2018/19 from a high of 6.7%, the YTD average for 2019/20 is 5.7% with August reducing to 5.3%. Dietetics & Paediatric Orthopaedics have seen a large increase in their Aug-19 DNA Rate; 12% & 19.2% retrospectively. There has been a significant improvement within Cardiothoracic Surgery, General Medicine, Pain Management, Rheumatology & Thoracic Medicine.

FUP DNA Rate: The Aug-19 FUP DNA Rate has reduced to 5% after increasing to 5.6% in Jun-19, with a YTD position of 5.3%; the reduction has been driven by an improvement in Dietetics (1.7%), Neurology (2.3%) & Vascular Surgery (8.5%). However as a Trust we remain below the 8% target.

New:FUP: The New:FUP rate is steadily improving, although Aug-19 (1.78) saw a slight increase from Jul-19 (1.66). The YTD New:FUP ratio for the Trust is 1.77.

Cancellations <6weeks of Outpatient Appointment: The cancellation of appointments <6weeks continues to be an issue at 15.7% YTD compared to a target of 8% with the majority of specialties higher than the target.

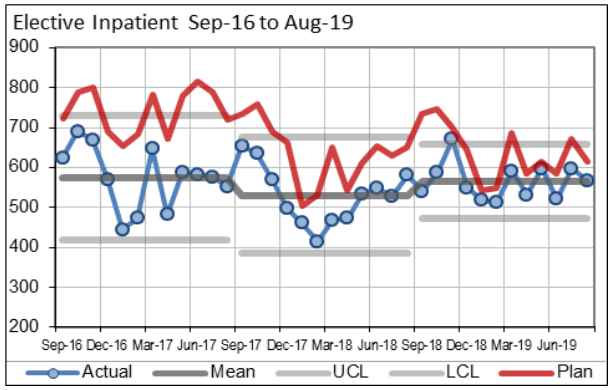
ERS Slot Unavailability: The ERS Unavailable Slot %age was remained high in Jul-19 (this runs 1 month behind) at 23.7%. There is a particular issue in T&O (13.7%), ENT (18%), Medical specialties (14.7%) and Gynaecology (34.7%).

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.

The monthly utilisation figures have been averaging 65%. T&O Directorate has the highest utilisation YTD at 74.2% & Urology/Gynae Onc/Breast/Vasc Surgery has the lowest at 49.6%. There are still a considerable amount of uncashed up appointments in July & August (713, 1067 retrospectively) which will affect the utilisation. YTD utilisation is 65.3%.

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 23.7% in July.	Appointment Slot Issues (ASI's) continue to be monitored with the relevant speciality. Speciality templates remain an issue and are ongoing from the changeover to Allscripts Patient Administration System (PAS) in Oct 17. All templates need changing.	Daily report is being circulated to the specialities. Weekly report circulated to the DOO and action plans requested. Plan to change the outpatient clinic templates is being explored.

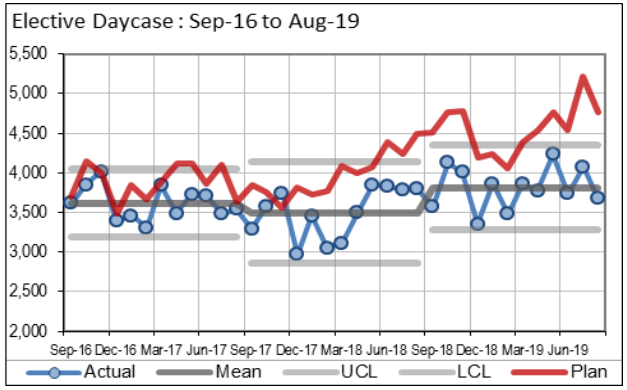
Responsive	Elective Flow – Inpatient Activity	Aug-19



Inpatient activity was 7.6% below plan in Aug-19 & YTD is 8.4% below plan. As expected there was a drop in the level of activity in August.

T&O is 33.4% below plan YTD (307 cases). Gynaecology, Urology & Paediatrics remain 27.4% (110 cases), 23.1% (114 cases) & 30.3% (41 cases) below plan YTD respectively. Cardiology & ENT are 22.3% & 13.8% above plan YTD respectively.

Trauma & Orthopaedics elective activity has been adjusted slightly with an estimate of the activity being done in the Independent Sector for July and August but these are relatively small numbers.



Daycase Activity also saw the expected decrease in August; however it was 11.3% below plan in August & 6% below plan YTD.

Cardiology saw a 37% decrease in daycase activity in August compared to July (decrease of an average of 1.8 cases per working day) from July.

Virtually all specialties saw a decrease in their August activity compared to July; however Paediatrics is above their YTD plan (159 cases). T&O, Ophthalmology, Cardiology & Urology are 45.7%, 30.4%, 28% & 25.9% below plan YTD but Surgery is now only 0.7% below plan YTD.

Total Elective Activity (IP and DC Combined):
Overall activity was 10.8% below plan in August & is 6.3% below plan YTD. Activity decreased in August by an average of 3.8 cases per working day compared to July.

T&O activity remains 41% below plan & Ophthalmology is 30% below plan YTD.

Surgery is now on plan YTD. Gynaecology remains 22% below plan, Urology is 25% below plan, Cardiology is 24% below plan and ENT is 12% below plan.

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

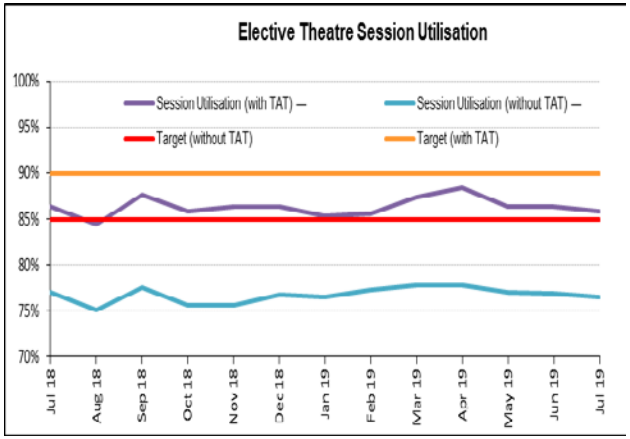
Key vacancies in consultant and trainee posts in a variety of specialties (Neurology & Endocrinology) Capacity issues in Ophthalmology.

Plans to improve efficiency have not all yet been fully realised in some areas. The T&O efficiency plan commenced 15/08/19 and the Ophthalmology plan is in progress.

Activity being done in the independent sector for the first quarter of the year has now been recorded on the PAS system. A new process has been implemented from 1st July to ensure capture of this data but there will be a time delay as to when this is available.

Summary:	Actions:	Assurance:
Overall activity decreased by around 3.8 cases per working day in August compared to July and is 6.3% below plan YTD (DC is 6% below plan and IP are 8.4% below plan). The specialties furthest from plan YTD remain T&O, Ophthalmology, Urology, Cardiology and Gynaecology which is directly impacting achievement of the RTT admitted pathway trajectories. General Surgery is now on plan.	Weekly monitoring of the specialty activity plans including non-AIC, AIC and Independent Sector (IS) activity. Specialities have devised activity plans to get back on track.	Weekly monitoring via -6-4-2 scheduling meeting, weekly monitoring at RTT Patient Targeted List (PTL) meeting, daily review at the elective bed meetings. Weekly monitoring at the divisional finance meeting

Responsive	Elective Flow – Inpatient Efficiency	Aug-19

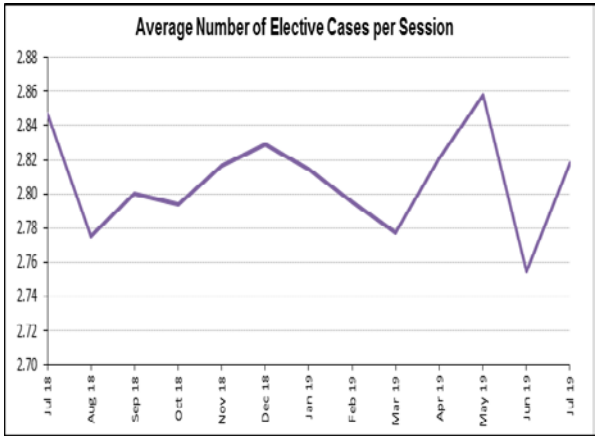


Utilisation with TAT has dropped slightly to 85.8% from 86.4%.

There was an increase in the number of elective theatre sessions that started within 15 minutes of the planned start time to 36% compared to 34% in Jul-19.

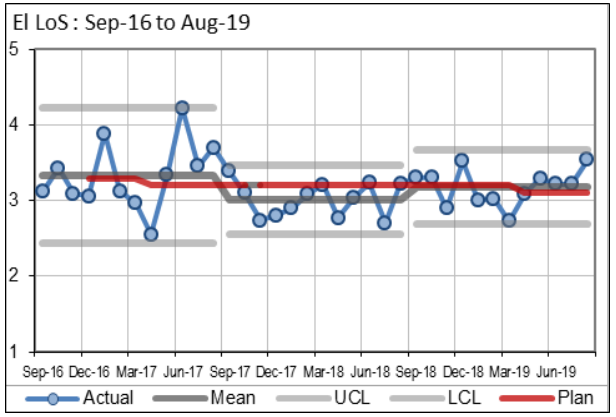
On day cancellations dropped to 6.3% from 6.5% in Jul-19. Aug-19 consisted of 73 hospital cancellations, 19 patient cancellations and 17 DNAs.

The rate of last minute reportable cancellations remains below the 0.8% maximum limit at 0.6% YTD, however for the month of August it rose to 1%. There have been 10 patients not re-scheduled within 28 days YTD.



There was a decrease in theatre activity in Aug-19 (1620 operations) with 103 less operations being completed compared to Jul-19. The decrease was predominantly in Ophthalmology (63 less operations).

The activity equated to 77.1 elective cases per working day, an increase from 74.9 in Jul-19.

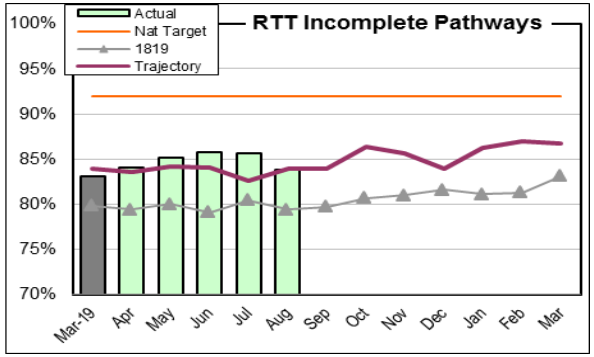


The Elective LOS has increased in August to 3.5 days against a plan of 3.1 days with the YTD position of 3.3 days.

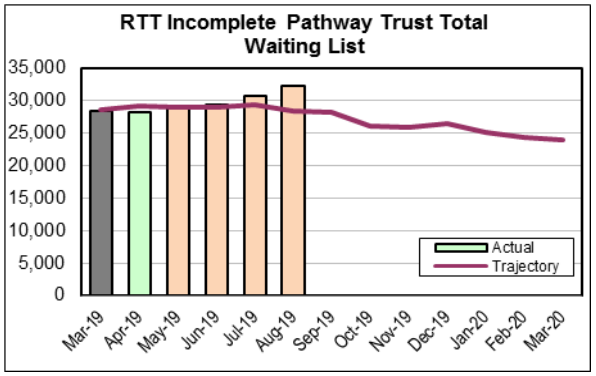
Area	YTD EL LOS
Trust	3.3
Surgical Specialties	3.0
T&O Directorate	2.9
Medical & Emergency Division	5.1

Summary:	Actions:	Assurance:
Theatre Utilisation with TAT has been decreasing since Apr-19 from 88.4% down to 82.7% in Aug-19. Following the 10% improvement in theatre sessions that started within 15 minutes seen in May-19 (38%), this has decreased down to 36% in Aug-19. There was a decrease in Theatre activity in Aug-19 however this equated to an increase of an average of 2 cases per working day.	Weekly monitoring of theatre scheduling. Specialities revisiting Consultant booking data to ensure procedure times are correct. Increase in cancellations both reportable and non-reportable.	Reviewed at weekly PTL meeting Procedure times to be agreed with Consultants and communicated to the booking teams. Cancellation task and finish group is being implemented

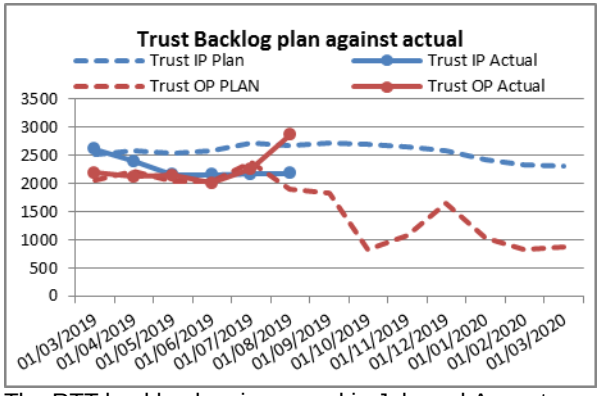
Responsive	RTT – Incomplete Pathway	Aug-19



RTT performance for the Trust decreased in August but remains above trajectory.



For the Trust the OP Waiting List and backlog are now above plan which has meant that the overall RTT Waiting List and Backlog are higher than plan.



The RTT backlog has increased in July and August. This has been mainly due to the OP (non-admitted pathway), although the IP (admitted pathway) backlog increased slightly in August.

Trust	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Trajectory Total WL	28508	29152	28932	28908	29273	28433
Actual Total Waiting List	28412	28268	29027	29269	30705	32257
Actual IP Waiting List	6494	6045	6037	5978	6102	6049
Actual OP Waiting List	21918	22223	22990	23291	24603	26208
Trajectory Backlog	4146	4806	4578	4622	5089	4576
Actual Total Backlog	4797	4510	4305	4163	4430	5045
Actual IP Backlog	2611	2391	2157	2156	2158	2185
Actual OP Backlog	2186	2119	2148	2007	2272	2860
Trajectory % Performance	85.5%	83.5%	84.2%	84.01%	82.61%	83.9%
Actual Total % Performance	83.12%	84.05%	85.17%	85.78%	85.57%	84.36%

RTT performance had shown an increasing trend since November 2019 to a high of 85.78% in June, but has dipped in both July and then again in August, however August remains above trajectory.

RTT by Specialty: All Specialties achieved their trajectory for August with the exception of Ophthalmology (-1.9%), Neurology (-14.5%), Rheumatology (-9.2%), Cardiology (-7.2%), Respiratory (-6%) and Gastroenterology (-2.0%), however Respiratory remains above the national target. General Surgery is now 4.2% above Trajectory, ENT and T&O are slightly above trajectory. Performance dipped in August for T&O, General Surgery and Gynaecology compared to July and there was a significant decrease for ENT (-3.2%). For Ophthalmology the non-admitted pathway performance is 4.7% below trajectory. All specialties saw an increase in both the OP Waiting List and Backlog due to the decrease in outpatient activity. Ophthalmology, ENT and Neurology OP Backlog account for the biggest proportion of the Trust OP Backlog (25%, 18% and 13% respectively)

RTT Backlog: The majority of the RTT backlog continues to be concentrated in surgical specialties as well as Neurology, Cardiology and Gastroenterology all of which saw an increase in August. These are being carefully monitored against forecasts and action plans on a weekly basis

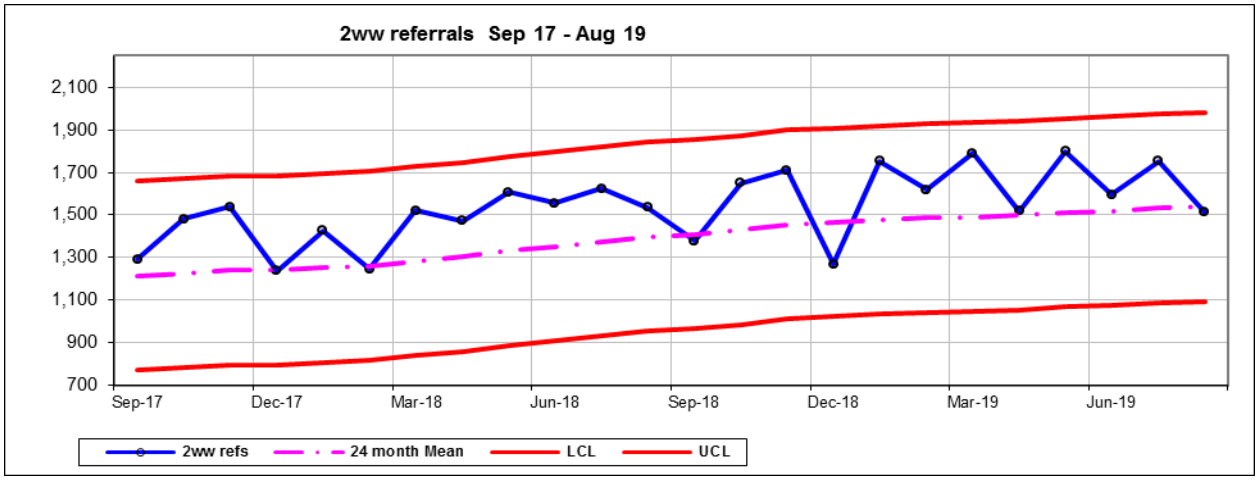
RTT 52 week Breaches: 7 reported for August (all new for August). All patients will have a harm review by the managing Consultant. No harm has been found as yet for the ones which have been completed. 52 Week Panel established.

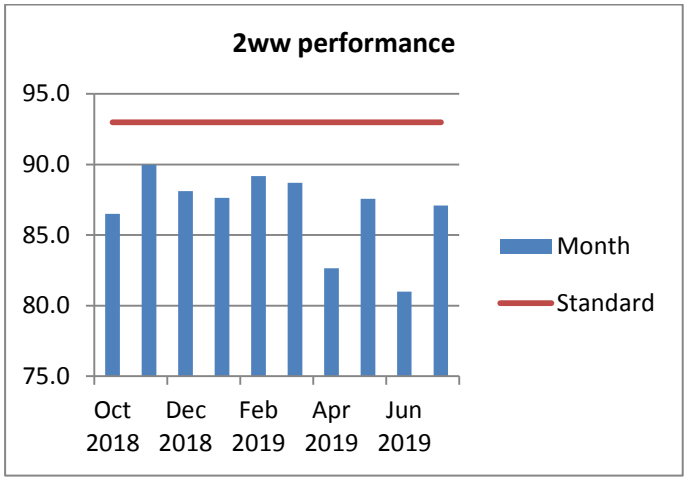
RTT Data Quality: Operational plan, risk assessment and QIA to be completed in order to review when the new reporting system can be implemented.

Diagnostics <6weeks: Performance dropped to 96.5% in August which is below the 99% target.

Summary:	Actions:	Assurance:
Performance decreased in August but remains above Trajectory at 84.36%. The Trust Waiting List has increased further to 32,257 which is therefore 3,824 (13%) higher than the Trust submitted Trajectory of 28,433 and the backlog has increased to 5,045 which is 469 higher (10%) than the submitted trajectory of 4,576 due to the increase in the OP Backlog.	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..	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)	Aug-19





2ww GP referrals to MTW	Breast	Gynae	Haem	Head & Neck	Lower GI	Lung	Other	Upper GI	Urology	Total	BSYM	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 - Aug)	397	160	26	144	357	55	1	144	192	1480	163	560
% change last 12 mths	15.8%	13.1%	50.7%	17.2%	15.4%	13.1%	-77.4%	-1.1%	-6.9%	14.8%	16.1%	15.8%

****Note – for August 2019 IPR report onwards, 2ww referral numbers include the Breast symptoms as well as Rare cancer (Acute Leukaemia, Childrens and Testicular), increase of approx. 180 – 200 for activity**

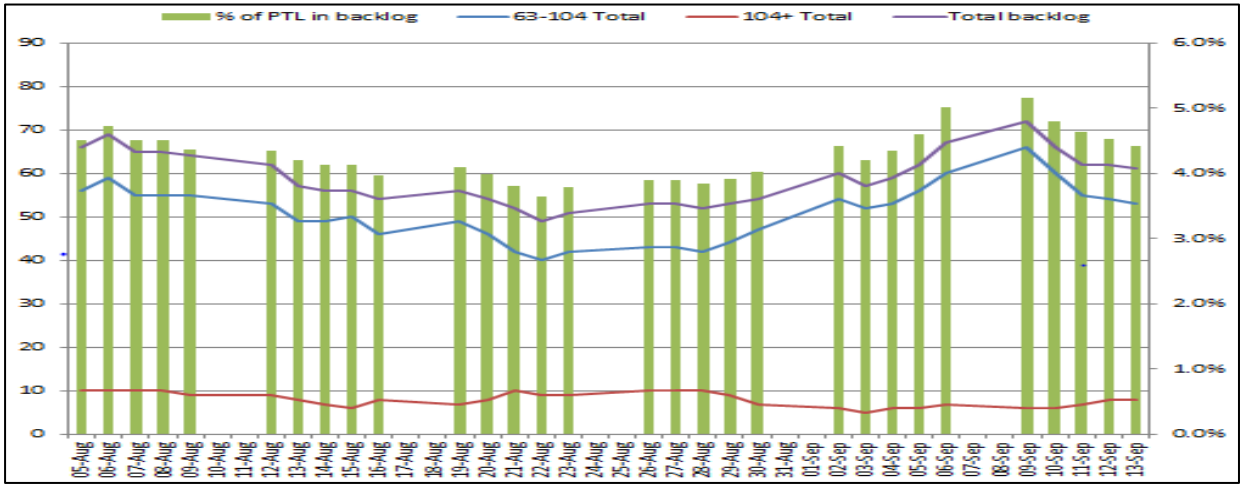
Demand: After a period of continued increased numbers of incoming 2ww referrals from January 2019 there was a decrease in referral numbers for June and August, likely related to the summer holiday period. This is expected to rise again through September, especially with the current Stand Up to Cancer campaigns. There has been a 50% increase in demand for Haematology 2ww referrals which remains a challenge with capacity

2 Week Wait (2WW) Performance:
Performance increased back up to 87.1% in July after a significant decrease in performance in June. August performance is currently being finalised but is estimated to be 86.9% for 2WW and 90.8% for 2WW Breast Symptoms

The majority of 2ww breaches in July were incurred in breast, Lower GI and urology and were among the lowest performing tumour sites along with haematology. Lung hit the 93% target for 2ww in July, and upper GI achieved 93.3 %

Summary:	Actions:	Assurance:
Continued increase of demand for 2ww referrals remains a challenge for clinic capacity, with specialities adding ad hoc clinics to meet demand. There has been a 50% increase in demand for Haematology 2ww referrals which remains a challenge with capacity and in July Haematology achieved 55.6% for the 2ww first seen appointment Following a decrease in June, performance increased back to previous levels in July but remains below target. The majority of breaches remain in the Breast tumour site.	The breast clinics have been re-mapped and additional capacity has been sourced to support the increase in demand in the long term. It has been agreed with the commissioners that Lower GI 2ww referrals that don't meet the criteria can be re-directed to an urgent but non-cancer pathway. Comms is going out to GPs and the new clinic will start in September. Gynae-oncology pathway re-instated for pelvic masses.	A new 2ww working group has been set up with involvement from General Managers across breast, urology, haematology and gynaecology. A new daily report has been developed to highlight any un-booked 2ww appointments and any appointments booked after 7, 10 and 14 days.

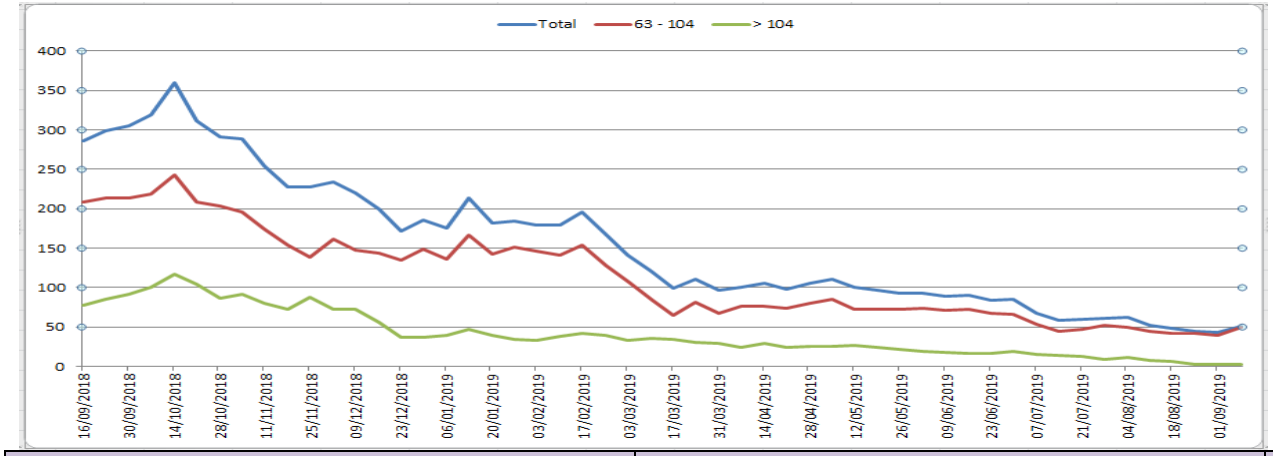
Responsive	Cancer Waiting Times – PTL / Backlog	Aug-19



The overall PTL is being maintained below a total of 1400 patients with a comparative backlog under 5% of the total overall PTL

With the increased capacity pressures through the summer holiday period there has been a slight increase in the overall backlog, but this would be expected to decrease through September with the Trusts aim to achievement of the 62 day standard

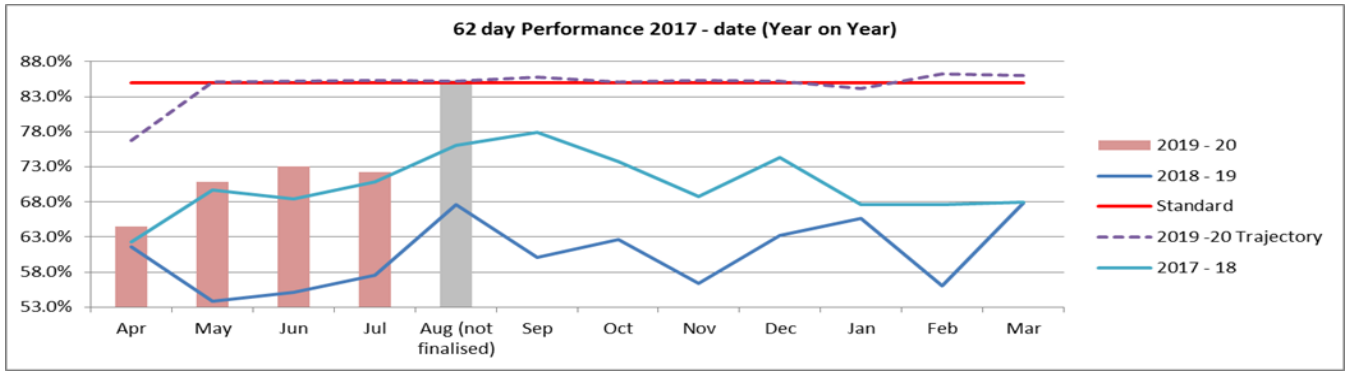
Lung currently 16% of their PTL in the backlog. Although Lower GI has a similar number of patients in their backlog, the overall % is 3% due to increased numbers being managed on current LGI pathways For Urology, the Prostate pathway has 10% of their PTL in backlog, whilst the other Urology sites (Haematuria, Urology and Kidney) have an overall total of 2 patients in their backlog



There has been a significant decrease in the backlog from August 2018 to March 2019.
The backlog has continued to be managed through August 2019, maintaining an overall % of less than 5% in the backlog. At the beginning of September there has been a slight increase in the number of patients going over 62 days, increasing to 66 on 9th September, however the patients of 104 days has not increased over this period and remains consistent at 6 patients.

Summary:	Actions:	Assurance:
The overalll backlog and those over 104 days has shown a significant downward trend and continues to decrease. There are now 57 patients in the backlog (6 of which are over 104). Backlog clearance continues and is expected to improve performance of the 62 Day Target.	Clinically led discussion to change the lung pathway to ensure patients are being treated within 62 days. Introducing new 'all options' clinic for the prostate pathway and brachytherapy review to reduce planning time and increase capacity.	Harm reviews are conducted for all patients treated over 104 days. This is being led by the clinical director for cancer performance. Daily PTLs with GMs and DDOs for all tumour sites with endoscopy, radiology, pathology and oncology presence. Weekly cancer performance meeting

Responsive	Cancer Waiting Times – 62 Day FDT	Aug-19



Trust Performance: The performance for July exceeded the forecast of 68% with an achievement of 72.2% for the overall 62 day target. The current validated (but not finalised) position for August is 85.3%, therefore achieving the national target of 85%.

Maintaining the improvement in the backlog position is driving up overall performance against the 62day standard.

62 Day Performance						
July 2019	All reportable patients			MTW only patients		
	Total	Breach	%	Total	Breach	%
Breast	23.5	5.5	76.6	23	5	78.3
Gynae	11.0	1.0	90.9	9	1	88.9
Haematology	10.0	4.0	60.0	9	3	66.7
Head & Neck	3.0	1.5	50.0	1	1	0.0
Lower GI	21.0	7.0	66.7	18	4	77.8
Lung	10.5	5.0	52.4	7	2	71.4
Other	2.5	0.0	100.0	2	0	100.0
Upper GI	8.5	2.0	76.5	8	2	75.0
Urology	25.0	6.0	76.0	20	3	85.0
TOTAL	115.0	32.0	72.2	97	21	78.4

The work implemented over the previous months with specific daily focus on the Cancer PTLs has resulted in a continued improvement in the overall performance of the 62 day standard. All Directorates have been proactive with dealing with escalations and work is continuing to ensure sustainable processes are in place to support the Trust with ongoing achievement of the 62 day standard going forward

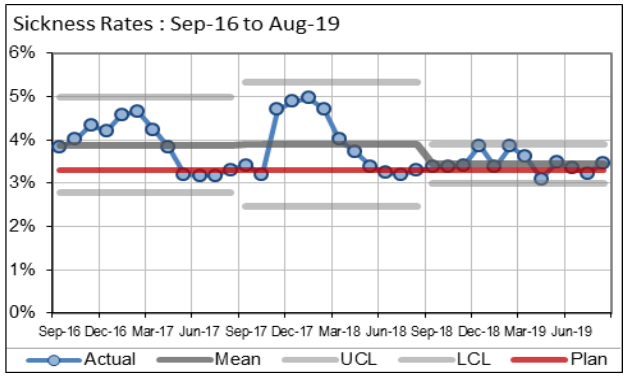
Tumour Specific Performance: Gynae has shown an increase in performance in July achieving 90.9% up from 80.0% in June. Haematology showed an increase from 30.8% to 60.0%, however performance has decreased across all other tumour specialities in July, with Head & Neck and Lung being the lowest achieving sites for July

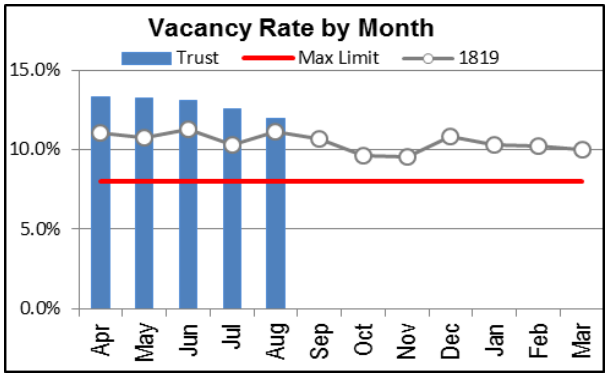
There was a marked under-performance in the Breast Tumour Site

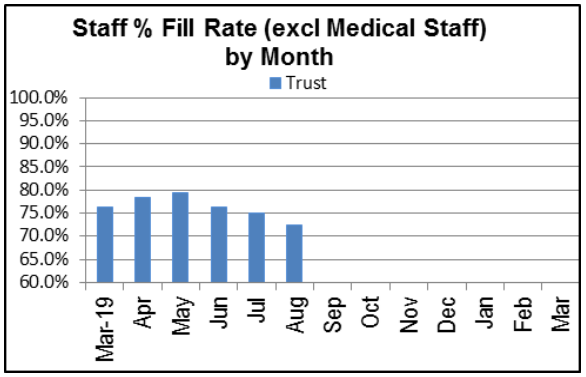
Conversion rates for 2ww referrals: The conversation rate for 2ww referrals remains at 8.1% for patients referred up to June 2019, which remains less than 2018 – likely due to the increased number of 2ww referrals, which are not converting to diagnosed pathways

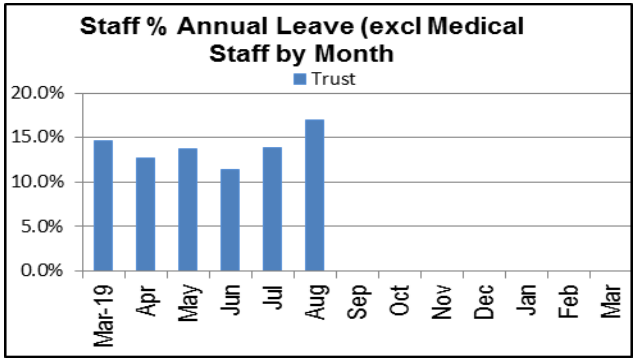
Summary:	Actions:	Assurance:
From April 2019 62 day performance has improved from 64.5% to 72.2 %. The current validated (but not finalised) position for August is 85.3% which is based on 111.5 treatments with 16.5 allocated breaches and this is therefore above the national target of 85%.	Action plans 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 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	Workforce	Aug-19









Annual Leave: As expected the level of Annual Leave has increased during July and August to a high of 16.9%.

Vacancy Rate: The overall vacancy rate has reduced slightly in August, however, both Nursing and Medical and Dental vacancies remain at a similar level to July.

	Vacancy %				
Staff Group	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**
Registered Nursing, Midwifery & HV	20.32%	19.86%	19.25%	19.25%	19.66%
Medical and Dental	16.55%	16.16%	15.59%	11.58%	11.25%
AHP	13.17%	14.48%	14.82%	13.68%	12.67%
Other ST&T	5.64%	10.92%	11.22%	9.70%	8.12%
Other	8.53%	8.39%	8.56%	8.93%	7.63%
Grand Total	**13.31%**	**13.27%**	**13.11%**	**12.63%**	**11.97%**

38 offers made via the Aryavarat pilot for OSCE ready nurses - expected to join August. 128 offers made in Kerala for nurses who will require OSCE support

Overall Staff Fill Rate (excluding Medical Staff): This has decreased over the last couple of months with a further 2.5% reduction in August to 72.3%

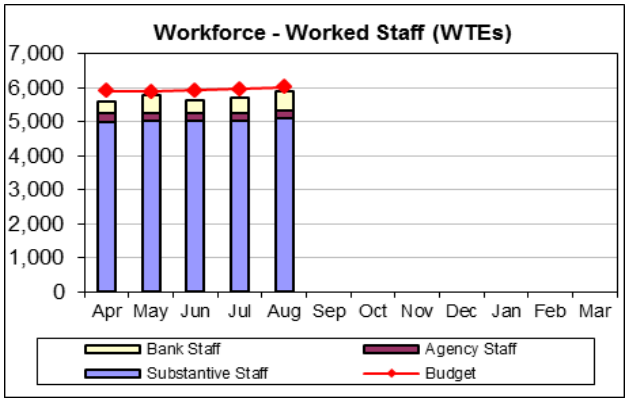
Turnover Rate: Due to the change in the calculation for turnover rate this will not be able to be accurately reported until March 2019.

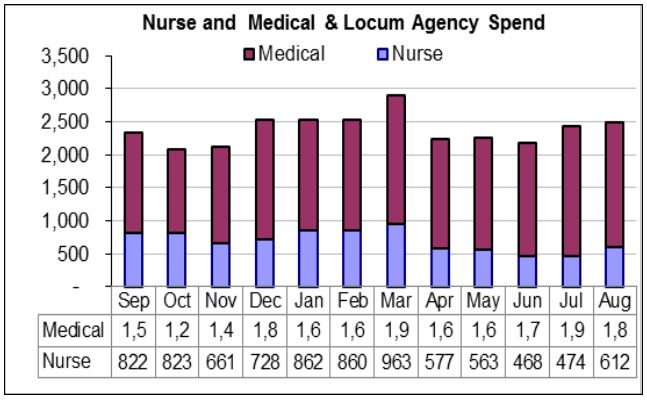
Sickness Rate: The overall sickness rate has become more stable over the last 12 months but has increased slightly to just above the maximum limit for August at 3.5%.

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

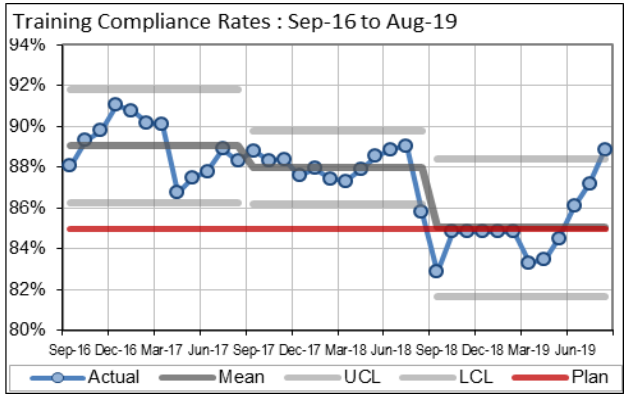
Summary:	Actions:	Assurance:
There has been a high level of annual leave and slghtly increased sickness in August. Whilst the use of bank staff did increase this was not at the same level of the reduction in substantive staffdue to the lack of availability of temporary staff in this Summer month which has meant that the overall staff fill rate (excluding medical staff) has decreased to 72.3% in August 2019. Vacancy rate has improved slightly but remains high.	Overseas Sykpe interviews have now been completed. 57 International nurses have arrived to date in 2019. Recruitment have been present at a range of events in Kent over the summer including 'Pub in the park' and 'war and peace' 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.

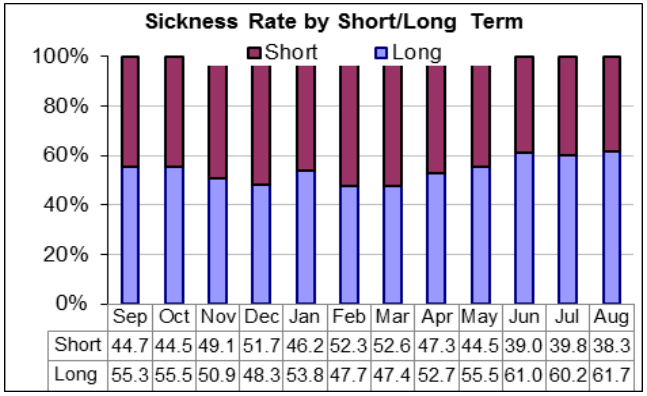
Well Led	Workforce	Aug-19





	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Medical	1,5	1,2	1,4	1,8	1,6	1,6	1,9	1,6	1,6	1,7	1,9	1,8
Nurse	822	823	661	728	862	860	963	577	563	468	474	612





	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Short	44.7	44.5	49.1	51.7	46.2	52.3	52.6	47.3	44.5	39.0	39.8	38.3
Long	55.3	55.5	50.9	48.3	53.8	47.7	47.4	52.7	55.5	61.0	60.2	61.7

Bank and Agency: The overall agency spend reduced in August but remained above plan. Following the reduction seen in the nurse agency spend over the last few months this increased again in August. Medical & Locum Agency Spend decreased during August.
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

Long Term Sickness: 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% (61.7% in August).

Mandatory Training: The areas that are below 80% compliance remain T&O, Operational Management and Sexual Health. Key areas of improvement this month are Information Governance (from 84% to 86.5%), Intermediate Dementia Awareness (from 84.5% to 87.4%) and Sepsis (from 86% to 88.4%)

Appraisals: Performance has improved further to 87.4% for August. The Cancer Division is furthest from plan at 77.8%; however this is a significant improvement from the 56% last month. All other Divisions are above 84%.

Summary:	Actions:	Assurance:
The overall agency spend reduced in August but remained above plan. Since April 2019 there has been a higher proportion of long-term sickness compared to short-term sickness. Mandatory Training compliance has continued the upward trend of improvement to to 88.9% for August, above the 85% target with Information Governance showing the biggest improvement. Appraisal Compliance has also increased to 87.4%.	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.

Appendix 2

Safe		2018/19 Outturn	2019/20 Target	Q1			Q2			Q3			Q4			Q1			Q2		YTD	FOT	YTD Var from Plan
ID	Key Performance Indicators			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug			
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	14.8	34.5	23.6	22.0	-3.4%
S2	CDifficile (Post 72hrs) - Hospital	56	55	1	1	4	7	8	9	4	3	2	7	4	6	9	0	5	3	7	24	54	-1
S3	MRSA Bacteraemia (Post 48hrs) Hospital	3	0	1	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	1	1	1
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%	99.0%	99.0%	1.0%
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%	92.3%	95.0%	95.0%	95.0%	0.0%
S4	Cases of Gram Negative Bacteraemia	113	113	7	9	14	10	10	7	11	12	9	5	8	11	8	4	7	8	7	34	97	-16
S4.1	MSSA Bacteraemia (Post 48hrs)	19	19	2	2	2	2	5	0	1	0	1	2	0	2	1	3	0	4	1	9	15	-4
S4.2	E. Coli Bacteraemia (Post 48hrs)	69	69	3	6	9	7	7	3	5	10	5	3	4	7	6	3	7	4	7	27	64	-5
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	181	212	212	212	- 13
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	0.34	0.15	0.51	0.36	0.64	- 0.5
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	22.1	22.5	22.4	22.4	6.4
S5.2	Pressure Ulcers Grade 2	49	36	7	11	9	1	5	2	4	2	4	3	1	0	1	1	1	1	1	5	26	- 10
S5.3	Pressure Ulcers Grades 3	3	-	2	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	-
S5.4	Pressure Ulcers Grades 4	3	-	0	0	0	0	1	0	0	0	0	2	0	0	0	0	0	0	0	0	0	-
S5.5	Pressure Ulcers Deemed "Un-gradeable"	13	24	0	2	2	2	4	3	0	0	0	-	-	0	3	0	1	0	2	6	20	- 4
S5.6	Pressure Ulcers Total	68	60	9	13	11	3	11	5	4	2	4	5	1	0	4	1	2	1	3	11	46	- 14
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	5.68	7.14	6.31	6.10	0.31
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	9.03	7.43	6.89	1.13
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	3.49	4.18	4.45	4.79	-0.55
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	78	119	479	1130	14
S6.4	Falls resulting in "Low Harm"	312	300	23	18	21	39	35	29	18	34	22	31	26	16	37	21	20	29	19	126	301	1
S6.5	Falls resulting in "Moderate Harm"	33	24	1	-	1	7	5	2	2	3	2	2	2	6	6	3	2	3	2	16	30	6
S6.6	Falls resulting in "Severe Harm"	22	24	2	3	0	0	5	3	2	1	1	3	1	1	2	4	1	5	5	17	31	7
S6.7	Falls resulting in "Death"	2	-	0	0	0	0	0	1	0	0	0	0	1	0	1	0	0	0	0	1	1	1
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	115	145	640	1494	30
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	88	112	467	1048	52
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	27	33	172	445	- 23
S7	Never Events	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	1	1	1
S8	Number of New SIs in month	154	144	13	20	14	11	18	17	19	11	5	10	8	8	17	15	8	9	17	66	150	6
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	0.44	0.84	0.65	0.61	0.00
S8.2	Number of Open Sis	96	95	92	103	100	96	96	110	97	90	104	87	81	85	97	99	93	84	83	83	83	- 12
S9	SIs not closed <60 Days Monthly Snapshot		24													57	50	52	39	21	21	21	- 3
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%	94.4%	93.4%	94.2%	94.2%	0.7%
S11	Safety Thermometer % of Harm Free Care	97.4%	95.0%	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%	97.8%	98.3%	98.3%	98.3%	3.3%
S11.1	Safety Thermometer % of New Harms	2.6%	3.0%	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%	2.3%	1.7%	1.7%	1.7%	-1.3%
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	0	1	5	12	0
S13	Medication Errors - Low Harm	86	72	5	12	6	8	10	3	2	8	3	6	6	17	7	4	12	12	8	43	85	13
S13.1	Medication Errors - Moderate Harm	11	12	0	0	0	1	3	0	0	1	1	0	4	1	3	0	1	1	0	5	12	0
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	0	0
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	945	950	4669	11494	-206
S14.1	Rate of Incidents that are Harmful	1.01	1.23	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	1.38	1.89	1.37	1.10	0.14
S14.2	Number of Incidents open >45 days	1,931	1,931	2,235	1,935	1,889	2,273	1,959	1,515	2,135	1,469	2,095	2,046	2,205	1,416	1448	1931	2025	1940	1478	1478	1478	-453

Effective		2018/19 Outturn	2019/20 Target	Q2			Q3			Q4			Q1			Q2		YTD	FOT	YTD Var From Plan
ID	Key Performance Indicators			Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug			
E1	Hospital-level Mortality Indicator (SHMI)	Band 2	Band 2	1.0440	1.0219	1.0219	1.0371	1.0244	1.0244	1.0391	1.0391	1.0391	1.0391	1.0296	1.0235	1.0165	1.0224	1.0224	1.0224	Band 2
E2	Standardised Mortality HSMR	Lower Confidence <100		106.70	105.80	104.80	103.70	102.40	103.30	102.30	101.20	99.40	96.30	97.20	92.70	93.10	91.50	91.5	91.5	-8.5
E2.1	Crude Mortality	1.00%	1.00%	0.94%	0.90%	1.14%	0.88%	0.77%	1.02%	1.25%	1.11%	1.07%	1.01%	0.85%	0.70%	0.86%	0.83%	0.85%	0.85%	-0.1%
E3	% Total Readmissions	14.11%	14.11%	14.22%	14.03%	13.66%	14.53%	14.01%	15.35%	14.34%	14.59%	14.75%	15.00%	13.66%	15.10%	15.21%	Data runs one month behind	14.74%	14.74%	0.6%
E4	Readmissions <30 days: Emergency	14.73%	14.73%	14.78%	14.55%	14.31%	15.34%	14.85%	16.13%	14.80%	15.23%	15.38%	15.62%	14.41%	15.47%	15.93%		15.15%	15.15%	0.4%
E5	Readmissions <30 days: Elective	6.84%	6.84%	7.52%	8.08%	6.08%	5.43%	6.00%	5.96%	8.02%	6.58%	7.43%	7.94%	5.42%	10.30%	6.32%		7.35%	7.35%	0.5%
E6	Stroke: Best Practice Tariff Overall %	43.1%	50.0%	58.3%	48.1%	42.3%	54.3%	55.4%	53.3%	49.1%	47.5%	43.1%	36.9%	37.9%	37.7%	45.5%	36.8%	39.0%	39.0%	-11.0%
E7	Stroke BPT Part 1: First Ward	75.9%	80.0%	80.0%	82.7%	76.9%	77.1%	87.7%	82.2%	81.1%	83.6%	75.9%	64.6%	63.6%	75.4%	77.3%	78.9%	71.7%	71.7%	-8.3%
E8	Stroke BPT Part 2: Cons <=14 Hours	50.0%	58.0%	66.7%	56.8%	50.0%	57.1%	61.5%	57.8%	62.3%	49.2%	50.0%	50.8%	45.5%	52.5%	56.1%	38.6%	48.9%	48.9%	-9.1%
E9	Stroke BPT Part 3: 90% Time on Stroke Ward	89.7%	80.0%	86.67%	83.95%	84.62%	85.71%	92.31%	91.11%	90.57%	91.80%	89.66%	80.0%	71.2%	80.3%	81.8%	86.0%	79.7%	79.7%	-0.3%
E10	% TIA <24hrs	64.7%	60.0%	29.17%	65.22%	63.16%	66.67%	70.59%	58.33%	91.67%	61.90%	42.10%	60.6%	53.3%	54.5%	57.7%	Mth behind	56.8%	56.8%	-3.2%
E11	C-Section Rate (elective or non-elective)	27.9%	25.0%	26.94%	28.79%	23.97%	29.65%	30.16%	26.48%	31.34%	29.52%	26.96%	31.08%	32.41%	27.53%	28.63%	27.35%	15.67%	29.41%	-9.3%
E11.1	% Mothers initiating Breastfeeding	82.2%	78.0%	79.14%	84.02%	81.74%	77.72%	83.50%	80.45%	84.37%	84.01%	85.19%	83.3%	83.8%	79.3%	82.6%	80.9%	82.0%	82.0%	4.0%
E11.2	% Stillbirths Rate	0.17%	0.47%	0.20%	0.19%	0.20%	0.00%	0.20%	0.00%	0.42%	0.23%	0.21%	0.48%	0.39%	0.21%	0.00%	0.22%	0.25%	0.25%	-0.2%

Caring		2018/19 Outturn	2019/20 Target	Q2			Q3			Q4			Q1			Q2		YTD	FOT	YTD Var from Plan
ID	Key Performance Indicators			Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug			
C1	Single Sex Accommodation Breaches	35	0	5	12	0	10	8	0	0	0	0	0	0	0	0	0	0	0	0
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	2.27	2.51	2.39	2.71	-0.54
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%	65.4%	65.1%	56.6%	67.4%	-18.4%
C3.1	Total Open Complaints	149	140	155	137	144	139	129	129	130	120	149	155	173	154	134	149	149	149	9
C3.2	Number of new complaints received	564	720	38	34	43	59	48	48	52	41	67	46	47	53	46	51	243	663	- 57
C3.3	Number of Nursing Complaints	107	108	8	5	7	9	13	12	10	12	10	5	9	11	7	10	42	105	- 3
C3.4	Number of Medical Complaints	353	336	24	21	26	41	32	32	31	23	43	30	26	33	31	26	146	342	6
C3.5	Number of Complaints open 60-90 days	182	180	15	18	11	12	10	11	13	12	19	14	25	18	16	22	95	200	20
C3.6	Number of Complaints open >90 days	349	348	36	37	43	29	25	20	19	18	20	30	33	33	27	32	155	358	10
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%	16.0%	15.4%	17.4%	17.4%	-7.6%
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%	95.1%	93.9%	95.1%	95.1%	0.1%
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%	9.6%	10.1%	11.5%	11.5%	-3.5%
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%	91.5%	88.1%	87.7%	87.7%	0.7%
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%	44.5%	33.4%	29.8%	29.8%	4.8%
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%	94.0%	93.6%	94.2%	94.2%	-0.8%
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%	82.1%	83.0%	82.3%	82.3%	-1.7%
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%	55.4%	56.5%	56.1%	56.1%	-11.9%
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%	97.1%	96.7%	Data runs one month behind	96.9%	96.9%	1.9%
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%	84.4%	91.0%		90.6%	90.6%	0.6%
C12.1	Nat CQUIN: % Dementia Risk Asssessed	98.7%	90.0%	94%	96%	90.0%	95.5%	100.0%	99.0%	100.0%	100.0%	98.7%	98.2%	93.9%	92.2%	96.4%		95.2%	95.2%	5.2%
C12.2	Nat CQUIN: % Dementia Referred to Specialist	100.0%	90.0%	98%	100%	98.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.1%	100.0%	100.0%	96.2%		98.5%	98.5%	8.5%
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%	92.0%	89.0%	89.0%	89.0%	-1.0%
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%	88.0%	84.0%	84.0%	84.0%	-6.0%
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%	95.0%	93.0%	93.0%	93.0%	3.0%
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%	98.0%	97.0%	97.0%	97.0%	7.0%
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%	91.0%	86.0%	86.0%	86.0%	-4.0%
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%	97.0%	98.0%	98.0%	98.0%	8.0%

Responsive		2018/19 Outturn	2019/20 Target	Q2			Q3			Q4			Q1			Q2		YTD	FOT	YTD Var From Plan
ID	Key Performance Indicators			Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug			
R1	A&E % 4hrs Arrival to Exit - Trust (Inc MIU)	91.86%	91.67%	93.16%	91.79%	93.93%	90.75%	90.93%	89.6%	88.91%	87.16%	95.85%	92.03%	91.96%	94.49%	93.55%	90.02%	92.42%	91.62%	-0.8%
R1.1	A&E % 4hrs Arrival to Exit - Maidstone	94.97%	95.23%	94.41%	93.42%	97.17%	96.26%	95.21%	92.22%	92.87%	90.80%	97.81%	94.24%	93.87%	95.81%	96.74%	89.62%	94.09%	94.26%	-2.0%
R1.2	A&E % 4hrs Arrival to Exit - TWells	85.80%	85.08%	88.79%	86.60%	88.45%	82.33%	84.05%	83.58%	81.32%	78.91%	92.60%	86.62%	86.94%	90.85%	87.98%	85.80%	87.62%	85.83%	-0.2%
R1.3	A&E Conversion Rate	20.8%	20.8%	20.8%	21.0%	20.4%	20.9%	20.8%	21.4%	20.9%	20.4%	20.4%	20.0%	19.0%	18.4%	17.7%	19.3%	18.9%	18.9%	-2.1%
R1.4	A&E Left without being Seen Rate (%)	2.8%	2.8%	3.4%	3.2%	2.5%	2.3%	2.4%	2.5%	2.6%	3.3%	2.4%	2.8%	2.4%	2.5%	2.8%	2.7%	2.6%	2.6%	-0.1%
R1.5	A&E Time to Assessment 15 mins	95.3%	95.0%	95.9%	94.9%	97.0%	95.2%	95.9%	95.3%	94.7%	91.5%	95.2%	94.5%	90.0%	92.0%	90.9%	89.0%	91.4%	91.4%	-3.6%
R1.6	A&E Time to Treatment 60 mins	55.9%	55.9%	53.5%	54.7%	57.5%	55.4%	58.1%	55.3%	56.7%	52.9%	57.2%	55.7%	56.4%	58.9%	58.8%	58.1%	57.6%	57.6%	1.7%
R1.7	A&E Unplanned Re-Attendance Rate (%)	8.0%	8.0%	8.3%	8.7%	7.6%	8.4%	8.1%	8.1%	7.8%	8.3%	8.0%	8.3%	8.5%	8.4%	8.3%	8.6%	8.4%	8.4%	0.4%
R1.8	A&E Average Time in Department (Hours)	3.40	3.26	3.33	3.42	3.19	3.53	3.42	3.54	3.68	3.79	3.16	3.41	3.38	3.17	3.27	3.56	3.35	3.35	0.03
R2	A&E 12hr Breaches	2	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
R3	Ambulance Handover Delays >60mins	596	540	22	60	31	67	82	70	74	83	13	57	59	26	42	56	240	555	6.7%
R3.1	Ambulance Handover Delays >30mins	4,487	4,428	250	400	284	486	442	441	613	444	280	494	531	384	528	490	2427	5010	31.5%
R4	RTT Incomplete Pathway	83.12%	83.90%	80.4%	79.4%	79.7%	80.67%	81.01%	81.61%	81.10%	81.29%	83.12%	84.05%	85.17%	85.78%	85.57%	84.36%	84.36%	89.12%	0.5%
R4.1	RTT Incomplete Admitted Backlog	2,606	2,315	3,434	3,348	3,065	2,930	2,867	2,779	2,829	2,781	2,606	2389	2154	2145	2136	2159	2159	1978	-19.3%
R4.2	RTT Incomplete Non-Admitted Backlog	2,182	872	3,298	3,911	3,578	3,200	3,235	2,886	2,781	2,807	2,182	2119	2149	2000	2250	2886	2886	886	51.7%
R4.3	RTT Specialties Not Achieved Nat Target	9	0	11	12	10	10	9	9	9	9	9	9	10	9	9	10	47	47	47
R4.4	RTT Incomplete Total Backlog	4,788	3,186	6,732	7,259	6,643	6,130	6,102	5,665	5,610	5,588	4,788	4508	4303	4145	4386	5045	5045	2863	10.2%
R5	RTT 52 Week Waiters (New in Month)	8	8	6	4	8	8	11	5	7	8	8	6	10	3	3	7	29	29	21
R6	% Diagnostics Tests WTimes <6wks	99.2%	99.0%	99.7%	99.6%	99.4%	99.5%	99.4%	99.1%	99.1%	99.5%	99.2%	99.1%	99.1%	98.7%	98.5%	96.5%	96.5%	99.0%	-2.5%
R7	*Cancer two week wait	88.7%	93.0%	82.3%	76.4%	78.0%	86.5%	90.0%	88.1%	87.6%	89.2%	88.7%	82.6%	87.6%	81.0%	87.1%	Data runs one month behind	84.6%	84.6%	-8.4%
R8	*Cancer WT - Breast Symptons 2WW	73.2%	93.0%	67.5%	58.5%	71.3%	83.1%	81.7%	58.3%	69.4%	74.7%	73.2%	56.4%	65.2%	63.4%	81.7%		67.1%	67.1%	-25.9%
R9	*Cancer 31 day wait - First Treatment	96.1%	96.0%	97.9%	96.2%	95.1%	96.2%	96.8%	97.2%	95.9%	96.2%	96.1%	96.5%	96.0%	96.8%	97.7%		96.7%	96.7%	0.7%
R9.1	*Cancer 31 day - Subs Treatment - Surgery	92.9%	94.0%	96.4%	96.2%	82.4%	92.0%	79.4%	100.0%	82.4%	96.0%	92.9%	87.1%	96.3%	96.7%	100.0%		94.9%	94.9%	0.9%
R9.2	*Cancer 31 day - Subs Treatment - Drugs	99.0%	98.0%	100.0%	99.1%	98.7%	99.3%	98.7%	98.3%	96.7%	98.2%	99.0%	100.0%	100.0%	100.0%	98.9%		99.7%	99.7%	1.7%
R9.3	*Cancer 31 day Subs Treatment Radio	92.8%	94.0%	95.4%	97.6%	93.7%	98.2%	96.7%	99.2%	90.5%	94.5%	92.8%	92.5%	91.4%	94.3%	93.1%		92.8%	92.8%	-1.2%
R10	*Cancer 62 day wait - First Definitive	67.9%	86.0%	57.5%	67.7%	60.1%	62.6%	56.4%	63.3%	65.6%	56.0%	67.9%	64.5%	70.9%	73.1%	72.2%		70.1%	70.1%	-15.2%
R10.1	*Cancer 62 day wait - First Definitive - MTW	72.8%	85.0%	59.3%	70.9%	65.1%	63.8%	58.8%	65.6%	69.2%	58.8%	72.8%	68.6%	80.4%	80.0%	78.4%		76.7%	76.7%	-8.3%
R10.2	*Cancer WT - 62 Day Screening Referrals	74.4%	90.0%	79.5%	83.7%	69.0%	88.2%	97.3%	84.8%	80.6%	55.2%	74.4%	84.6%	87.8%	94.7%	80.0%		87.4%	87.4%	-2.6%
R10.3	*Cancer WT - 62 Day Cons Specialist	82.4%	85.0%	61.5%	76.5%	40.0%	86.4%	72.2%	69.2%	64.0%	86.7%	82.4%	100.0%	41.7%	67.7%	65.5%		64.9%	64.9%	-20.1%

Well-Led		2018/19 Outturn	2019/20 Target	Q2			Q3			Q4			Q1			Q2		YTD	FOT	YTD Var From Plan
ID	Key Performance Indicators			Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug			
W1	Surplus (Deficit) against B/E Duty	12,006	8,429	574	82	- 1,014	3,075	2,030	136	- 2,567	- 457	13,359	- 2,001	- 71	- 1,272	2,569	1,036	261	6,897	19.3%
W2	CIP Savings	13,825	22,216	1,200	1,151	917	1,221	1,151	678	1,428	986	2,574	725	1,012	1,291	1,868	3,882	8,778	22,328	80.2%
W3	Cash Balance	10,405	3,000	18,207	14,126	13,493	12,640	8,566	12,766	7,956	10,625	10,405	41,294	39,537	44,793	56,821	45,854	45,854	3,000	18.9%
W4	Capital Expenditure	19,185	2,150	327	365	82	547	1,106	2,420	295	430	12,900	358	45	380	149	250	1,182	14,448	-46.2%
W4.1	Income	465,038	209,703	41,154	38,606	36,805	40,695	40,821	38,634	37,148	34,981	44,309	40,150	41,400	40,363	43,400	41,228	206,540	500,934	-0.8%
W4.2	EBITDA	28,347	14,542	2,998	2,515	1,545	5,533	4,475	2,603	- 104	- 1,934	6,386	540	2,452	1,895	5,133	3,575	13,594	38,392	4.5%
W5	Finance use of Resources Rating	3	2	4	4	4	3	3	3	3	4	3		3	3	3	3	3	3	0
W6	Staff Turnover Rate	9.1%	10.0%	9.9%	9.7%	9.39%	9.09%	9.22%	9.10%	8.90%	8.86%	9.12%	9.54%	9.79%	10.14%	10.79%	10.89%	10.89%	10.89%	0.9%
W7	Vacancy Rate (%)	10.0%	8.0%	10.3%	11.1%	10.65%	9.63%	9.57%	10.83%	10.33%	10.26%	9.99%	13.31%	13.27%	13.11%	12.60%	11.97%	11.97%	11.97%	4.0%
W7.1	Contracted WTE	5,153	5,405	5,049	5,069	5,064	5,148	5,017	5,124	5,139	5,145	5,153	5,147	5,105	5,122	5,169	5,219	5,219	5,219	-3.8%
W7.2	Establishment WTE	5,670	5,972	5,617	5,627	5,628	5,632	5,631	5,685	5,684	5,684	5,670	5,906	5,891	5,921	5,972	6,016	6,016	6,016	0.0%
W7.3	Substantive Staff Used	5,012	5,463	4,907	4,937	4,949	4,996	5,036	5,002	4,995	5,009	5,012	4,998	5,019	5,032	5,040	5,101	5,101	5,101	-7.5%
W7.4	Worked WTE	5,826	5,972	5,597	5,732	5,654	5,688	5,631	5,733	5,747	5,784	5,826	5,623	5,808	5,667	5,733	5,938	5,938	5,938	-1.3%
W7.5	Vacancies WTE	517	567	568	558	564	483	614	561	545	539	517	758	786	799	803	797	797	797	35.1%
W8	Total Agency Spend	22,651	15,559	2,113	2,072	1,901	1,787	1,734	1,747	1,901	2,097	1,408	1,649	1,655	1,531	1,852	1,770	8,457	16,258	0
W8.1	Nurse Agency Spend	- 9,434	- 2,478	- 853	- 847	- 822	- 823	- 661	- 728	- 862	- 860	- 963	- 577	- 563	- 468	- 474	- 612	- 2,693	- 2,693	8.3%
W8.2	Medical Locum & Agency Spend	- 19,052	- 7,209	- 1,567	- 1,585	- 1,517	- 1,261	- 1,456	- 1,806	- 1,663	- 1,674	- 1,933	- 1,656	- 1,699	- 1,718	- 1,957	- 1,886	- 8,916	- 8,916	21.8%
W8.3	Bank Staff Used	500	311	338	448	383	372	365	416	433	442	500	332	511	356	426	574	574	574	90.0%
W8.4	Agency Staff Used	277	199	310	302	277	271	229	270	283	286	277	249	241	243	233	229	229	229	14.5%
W8.5	Overtime Used	36	No data	42	46	46	49	-	45	37	47	36	45	37	35	35	33	33	33	No data
W8.6	Temp costs & overtime as % of total pay bill	No data	12.0%	16.6%	18.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	16.0%	16.1%	15.9%	17.1%	18.2%	18.2%	18.2%	6.0%
W9	Statutory and Mandatory Training	83.3%	90.0%	89.0%	85.8%	82.9%	No data	No data	No data	No data	No data	83.3%	83.5%	84.5%	86.1%	87.2%	88.9%	86.0%	86.0%	-4.0%
W10	Sickness Absence	3.6%	3.3%	3.2%	3.3%	3.4%	3.4%	3.4%	3.9%	3.4%	3.8%	3.6%	3.1%	3.5%	3.3%	3.2%	3.5%	3.3%	3.3%	0.0%
W11	Staff FFT % recommended work	82.2%	57.0%	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%	53.3%	53.3%	53.3%	-3.7%
W11.1	Staff Friends & Family (FFT) % rec care	89.0%	80.0%	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%	75.3%	75.3%	75.3%	-4.7%
W12	Appraisal Completeness	92.0%	95.0%	76.5%	82.6%	84.7%	86.2%	88.1%	90.2%	91.0%	92.1%	92.0%	2.6%	11.7%	26.7%	78.2%	87.4%	87.4%	87.4%	-7.6%

TRUST BOARD – SEPTEMBER 2019

NHS Maidstone and Tunbridge Wells NHS Trust

REVIEW OF LATEST FINANCIAL PERFORMANCE **CHIEF FINANCE OFFICER**

Summary / Key points

- The Trust's surplus including PSF and MRET funding was £1m in August which was in line with the plan.
- The Trust's normalised run rate (excluding PSF and MRET funding) in August was £0.9m deficit which was £0.9m adverse to plan.
- In August the Trust operated with an EBITDA surplus of £3.6m which was in line with plan.
- The Trusts surplus including PSF was £1m in August which was on plan. The key YTD variances against plan are: Underperformance in Private Patient Income (£0.9m net), RTT Income reserve (£1.4m), overspends within expenditure budgets (£1.1m) which is mainly within Medical staffing (£1.3m) and £0.6m EPR revenue pressure . These pressures have been offset by release of prior year provisions and back dated credit notes from NHS Property Services (£1.1m), over performance relating to clinical income (£0.7m) and release of £2.2m of reserves.
- The key current month variances are as follows:
  - Income adjusted for pass-through items is £0.6m adverse to plan, the main pressures relate to under delivery of Private Patient Income (£0.3m) and non-delivery of RTT risk reserve £0.3m.
  - Pay budgets adjusted for pass-through items underspent by £0.7m in August, although without the release of £1m of reserves the position would have been an overspend of £0.3m. Overspends within Medical staffing (£0.4m) and Nursing (£0.1m) were partly offset by underspends within Admin and Clerical (£0.1m) and Scientific and Technical staffing (£0.1m). The key pressures in Medical staffing were mainly within Emergency and Medicine directorate (£0.2m), Paediatrics (£0.1m) and Surgery Division (£0.1m).
  - Non Pay budgets adjusted for pass though items overspent by £0.2m in the month which includes £0.1m EPR funding pressure resulting from the EPR costs being charged to revenue pending confirmation of additional capital funding support.
- The Trust held £45.8m of cash at the end of August which is higher than the plan of £38.6m. This primarily relates to the Trust receiving PSF bonuses of £8.3m and £0.58m which were not included within the plan submission. The Trust had forecast to pay £1.5m Roche qtr 1 contract payment in July but the Trust is still waiting for an invoice therefore the expenditure is being carried forward. The Trust has also received income in respect of Prime Provider contracts but the expenditure won't be paid out until the Trust receives invoices from WK CCG totalling c£3m. As agreed the Trust repaid the single currency loan of £16.9m in August. The closing cash balance of the cash flow forecast is £3m which relates to the original planned carry forward of sale proceeds of £2m and £1m closing cash balance. The Trust has two working capital loans which are due to be repaid within 2020/21 totalling £26.1m. It is unlikely the Trust will generate enough cash surpluses to repay these loans, so it will need to apply to NHSI to defer the repayment. Currently NHSI are only allowing deferrals for a year, therefore the Trust will need to repay the balance in 2021/22.
- Following the recent announcements of new capital funding in 2019/20 it is not yet clear if the control total approach is to be implemented; therefore at this stage the Trust has retained the plan agreed in May 2019 but updated the use of the £6.4m asset sale resource to be applied to critical equipment and estates backlog schemes that could be delivered in this financial year. The Trust will need to submit a new business case for the CRL cover for this resource, along with the request for emergency capital for the CT scanner.
- Outside of the £6.4m asset sale funding, the Trust's internally generated capital is £4.85m for

the year. Of this £3.6m is already spent or committed e.g. £1.88m EPR, £0.4m equipment; £0.9m estates schemes. Therefore the Trust has £1.2m remaining that is not yet committed to cover all of its remaining capital requirements in 2019/20 (excluding donated asset funding). This includes a reduction of £350k related to the forecast underspend on depreciation (from the reduction in overall programme value and the timing slippages due to the issues around the national capital position) which results in a reduced level of available capital funding to spend.

- The Trust is forecasting to deliver the planned pre PSF deficit of £7m however this includes £8.6m of mitigations to offset the key variances to plan.

Reason for circulation to Trust Board

To discuss the August financial position

Maidstone and Tunbridge Wells NHS Trust

Trust Board Finance Report

Month 5
2019/20

Maidstone and Tunbridge Wells NHS Trust

Trust Board Finance Report for August 2019

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

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

3. Cost Improvement Programme
- a. Savings by Division

4. Year End Forecast
- a. Trust Forecast run rate

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

Maidstone and Tunbridge Wells NHS Trust

1a. Dashboard

August 2019/20

	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	41.2	42.1	(0.8)	(0.2)	(0.6)		206.5	208.5	(2.0)	0.4	(2.3)		500.9	503.2	(2.2)	
Expenditure	(37.7)	(38.4)	0.8	0.2	0.5		(192.9)	(195.5)	2.5	(0.4)	2.9		(462.5)	(465.4)	2.8	
EBITDA (Income less Expenditure)	3.6	3.6	(0.0)	0.0	(0.0)		13.6	13.0	0.6	(0.0)	0.6		38.4	37.8	0.6	
Financing Costs	(2.6)	(2.6)	0.0	0.0	0.0		(12.9)	(12.8)	(0.0)	0.0	(0.0)		(31.9)	(32.0)	0.1	
Technical Adjustments	0.0	0.0	0.0	0.0	0.0		(0.5)	0.0	(0.5)	0.0	(0.5)		0.4	1.1	(0.6)	
Net Surplus / Deficit (Incl PSF and MRET)	**1.0**	**1.0**	**0.0**	**0.0**	**0.0**		**0.3**	**0.2**	**0.0**	**(0.0)**	**0.0**		**6.9**	**6.9**	**0.0**	
CIPs	3.9	2.2	1.7		1.7		9.0	7.8	1.2		1.2		22.3	22.3	0.0	
Cash Balance	45.9	38.6	7.3		7.3		45.9	38.6	7.3		7.3		3.0	3.0	0.0	
Capital Expenditure	0.3	0.5	0.2		0.2		1.2	2.2	1.0		1.0		14.4	14.4	0.0	
Capital service cover rating							4	3					4	4		
Liquidity rating							3	3					4	4		
I&E margin rating							2	2					1	1		
I&E margin: distance from financial plan							1	1					1	1		
Agency rating							4	3					3	3		
Finance and use of resources rating							3	2					3	3		

Summary:

- The Trusts surplus including PSF was £1m in August which was on plan. The key YTD variances against plan are: Underperformance in Private Patient Income (£0.9m net), RTT Income reserve (£1.4m), £1.1m overspends within expenditure budgets mainly within Medical Staffing (£1.3m) and £0.6m EPR revenue pressure . These pressures have been offset by release of prior year provisions and back dated credit notes from NHS Property Services (£1.1m), over performance relating to clinical income (£0.7m) and release of £2.2m of reserves.
- The Trust has spent £3m more (56%) than the YTD agency ceiling set by NHSI (£11.8m per annum)
- The Trust has delivered £9m savings YTD which is £1.1m favourable to plan (14% favourable)

Key Points:

- The Trusts normalised run rate in August was £0.9m deficit pre PSF which was £0.9m adverse to plan (pre PSF).
- The Trust delivered the financial control target for August and therefore achieved the criteria for PSF funding.
- The main pressures (excluding CIP) in the month related to Medical Staffing (£0.4m), higher than planned outsourcing of elective work (£0.4m), Private patient unit slippage (Net = £0.2m) offset by release of £1.1m reserves.

Risks:

- The Trust is forecasting to deliver the planned £6.9m surplus including PSF. The actions to achieve this and the risks of non delivery are shown in section 4.

1b. Summary Income & Expenditure (Exceptional Items)

Income & Expenditure August 2019/20

	Current Month					Year to Date				
	Actual £m	*Plan* £m	*Variance* £m	Pass-through £m	*Revised Variance* £m	*Actual* £m	*Plan* £m	*Variance* £m	Pass-through £m	*Revised Variance* £m
Income	40.2	41.0	(0.8)	(0.2)	(0.6)	201.0	203.8	(2.7)	0.4	(3.1)
Expenditure	(38.6)	(38.4)	(0.2)	0.2	(0.4)	(193.9)	(195.5)	1.6	(0.4)	1.9
Trust Financing Costs	(2.6)	(2.6)	0.0	0.0	0.0	(12.9)	(12.8)	(0.0)	0.0	(0.0)
Technical Adjustments	0.0	0.0	0.0	0.0	0.0	(0.5)	0.0	(0.5)	0.0	(0.5)
Net Revenue Surplus / (Deficit) before Exceptional Items	**(0.9)**	**0.0**	**(0.9)**	**0.0**	**(0.9)**	**(6.2)**	**(4.5)**	**(1.7)**	**(0.0)**	**(1.7)**
Exceptional Items	0.9		0.9		0.9	1.1		1.1		1.1
Net Position	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**(5.1)**	**(4.5)**	**(0.5)**	**(0.0)**	**(0.5)**
PSF and MRET Funding	1.0	1.0	0.0	0.0	0.0	5.3	4.8	0.6	0.0	0.6
Net Revenue Surplus / (Deficit) Incl PSF, MRET and Exceptional Items	1.0	1.0	0.0	0.0	0.0	0.3	0.2	0.0	(0.0)	0.0

Key messages:
The Trust position before exceptional items was £0.9m adverse to plan in the month, the release of £0.9m back dated reserves helped the Trust to deliver the plan in the month.

Income:
Income YTD net of pass-through related costs and exceptional items is £3.1m adverse to plan. The Trust has over performed against non AIC contracts by £0.7m which is offset by under delivery of Private Patient Income (£1.5m) and Cancer and RTT recovery plan income (£1.9m).

Expenditure:
Expenditure budgets net of pass-through and exceptional items are £1.9m favourable, the key favourable variances relate to: release of reserves (£2.3m), underspends relating to Cancer recovery plans (£0.5m), Private Patient activity underperformance (£0.6m) and £0.2m CIP over performance. The key pressures within expenditure budgets relate to Medical Staffing (£1.3m) and EPR revenue pressure (£0.6m).

Reserves: The Trust has released £1.2m of reserves held to offset YTD pressures and has issued reserves to fund agreed business cases / developments such as overseas nurse recruitment which has left the Trust with £1.1m remaining in contingency reserves

PSF: The Trust delivered the financial control total in month 5 and therefore met the PSF criteria.

Maidstone and Tunbridge Wells NHS Trust

2a. Income & Expenditure

Income & Expenditure August 2019/20

	Current Month					Year to Date					Annual Forecast		
	Actual £m	*Plan* £m	*Variance* £m	Pass-through £m	*Revised Variance* £m	*Actual* £m	*Plan* £m	*Variance* £m	Pass-through £m	*Revised Variance* £m	*Actual* £m	*Plan* £m	*Variance* £m
Clinical Income	32.4	32.6	(0.2)	0.0	(0.2)	160.6	161.9	(1.4)	0.0	(1.4)	392.1	390.0	2.1
High Cost Drugs and Devices	3.9	3.8	0.1	0.0	0.1	19.5	19.0	0.5	0.6	(0.0)	45.2	45.2	0.0
Total Clinical Income	**36.3**	**36.4**	**(0.1)**	**0.0**	**(0.1)**	**180.1**	**181.0**	**(0.8)**	**0.6**	**(1.4)**	**437.3**	**435.1**	**2.1**
PSF and MRET	1.0	1.0	0.0	0.0	0.0	5.3	4.8	0.6	0.0	0.6	14.4	13.8	0.6
Other Operating Income	3.9	4.6	(0.7)	(0.3)	(0.5)	21.1	22.8	(1.7)	(0.2)	(1.5)	49.2	54.2	(5.0)
Total Revenue	**41.2**	**42.1**	**(0.8)**	**(0.2)**	**(0.6)**	**206.5**	**208.5**	**(2.0)**	**0.4**	**(2.3)**	**500.9**	**503.2**	**(2.2)**
Substantive	(19.9)	(21.0)	1.2	0.1	1.1	(98.5)	(104.2)	5.7	0.4	5.3	(245.4)	(253.4)	8.0
Bank	(1.3)	(0.8)	(0.5)	0.0	(0.5)	(6.1)	(4.4)	(1.7)	0.0	(1.7)	(14.0)	(10.2)	(3.8)
Locum	(1.0)	(0.7)	(0.3)	0.0	(0.3)	(4.5)	(3.7)	(0.8)	0.0	(0.8)	(11.7)	(8.4)	(3.3)
Agency	(1.8)	(1.3)	(0.5)	0.1	(0.5)	(8.5)	(7.3)	(1.1)	0.3	(1.4)	(16.3)	(15.7)	(0.6)
Pay Reserves	0.7	(0.3)	1.0	0.0	1.0	(0.5)	(1.4)	0.9	0.0	0.9	(1.1)	(3.5)	2.4
Total Pay	**(23.3)**	**(24.1)**	**0.9**	**0.1**	**0.7**	**(118.0)**	**(121.0)**	**3.0**	**0.6**	**2.4**	**(288.5)**	**(291.2)**	**2.7**
Drugs & Medical Gases	(4.5)	(4.3)	(0.2)	0.1	(0.3)	(22.6)	(21.4)	(1.2)	(0.7)	(0.5)	(54.5)	(51.3)	(3.2)
Blood	(0.2)	(0.2)	(0.0)	0.0	(0.0)	(1.0)	(0.9)	(0.1)	0.0	(0.1)	(2.3)	(2.2)	(0.1)
Supplies & Services - Clinical	(2.6)	(2.8)	0.2	(0.1)	0.3	(13.8)	(14.2)	0.4	0.1	0.3	(32.8)	(33.5)	0.7
Supplies & Services - General	(0.4)	(0.4)	0.0	0.0	0.0	(2.1)	(2.2)	0.1	0.0	0.1	(5.0)	(5.3)	0.3
Services from Other NHS Bodies	(0.6)	(0.8)	0.2	0.3	(0.1)	(3.7)	(4.0)	0.3	0.6	(0.3)	(7.8)	(9.0)	1.3
Purchase of Healthcare from Non-NHS	(1.2)	0.2	(1.4)	0.0	(1.4)	(7.2)	(5.9)	(1.3)	(0.1)	(1.3)	(14.3)	(11.4)	(3.0)
Clinical Negligence	(1.5)	(1.5)	(0.0)	0.0	(0.0)	(7.3)	(7.3)	(0.0)	0.0	(0.0)	(17.6)	(17.6)	(0.0)
Establishment	(0.3)	(0.3)	(0.0)	(0.0)	(0.0)	(1.3)	(1.4)	0.0	0.0	0.0	(3.2)	(3.4)	0.1
Premises	(2.1)	(2.1)	(0.0)	0.0	(0.0)	(10.9)	(10.5)	(0.4)	0.1	(0.5)	(26.0)	(26.1)	0.0
Transport	(0.1)	(0.1)	0.0	0.0	0.0	(0.6)	(0.7)	0.0	(0.0)	0.0	(1.5)	(1.6)	0.1
Other Non-Pay Costs	(1.0)	(0.8)	(0.2)	(0.1)	(0.1)	(3.9)	(2.9)	(1.0)	(1.0)	0.0	(9.0)	(6.0)	(3.0)
Non-Pay Reserves	0.1	(1.3)	1.4	0.0	1.4	(0.4)	(3.2)	2.7	0.0	2.7	0.0	(6.8)	6.8
Total Non Pay	**(14.4)**	**(14.3)**	**(0.1)**	**0.1**	**(0.2)**	**(74.9)**	**(74.5)**	**(0.5)**	**(1.0)**	**0.5**	**(174.1)**	**(174.2)**	**0.1**
Total Expenditure	**(37.7)**	**(38.4)**	**0.8**	**0.2**	**0.5**	**(192.9)**	**(195.5)**	**2.5**	**(0.4)**	**2.9**	**(462.5)**	**(465.4)**	**2.8**
EBITDA	**3.6**	**3.6**	**(0.0)**	**0.0**	**(0.0)**	**13.6**	**13.0**	**0.6**	**(0.0)**	**0.6**	**38.4**	**37.8**	**0.6**
	0.0	*0.0*	*0.0*	*%*		*6.6%*	*6.2%*	*-29.4%*	*0.0%*	*-24.8%*	*7.7%*	*7.5%*	*-26.0%*
Depreciation	(1.1)	(1.1)	0.0	0.0	0	(5.5)	(5.5)	0	0.0	0	(13.5)	(13.5)	(0.0)
Interest	(0.1)	(0.1)	0.0	0.0	0.0	(0.7)	(0.6)	(0.0)	0.0	(0.0)	(1.5)	(1.6)	0.1
Dividend	(0.1)	(0.1)	0.0	0.0	0	(0.7)	(0.7)	0	0.0	0	(1.6)	(1.6)	0
PFI and Impairments	(1.2)	(1.2)	(0.0)	0.0	(0.0)	(6.0)	(6.0)	(0.0)	0.0	(0.0)	(15.4)	(15.4)	0.0
Total Finance Costs	**(2.6)**	**(2.6)**	**0.0**	**0.0**	**0.0**	**(12.9)**	**(12.8)**	**(0.0)**	**0**	**(0.0)**	**(31.9)**	**(32.0)**	**0.1**
Net Surplus / Deficit (-)	**1.0**	**1.0**	**(0.0)**	**0.0**	**(0.0)**	**0.7**	**0.2**	**0.5**	**(0.0)**	**0.5**	**6.5**	**5.8**	**0.7**
Technical Adjustments	0.0	0.0	0.0	0.0	0.0	(0.5)	0.0	(0.5)	0.0	(0.5)	0.4	1.1	(0.6)
Surplus/ Deficit (-) to B/E Duty Incl PSF and MRET	**1.0**	**1.0**	**0.0**	**0.0**	**0.0**	**0.3**	**0.2**	**0.0**	**(0.0)**	**0.0**	**6.9**	**6.9**	**0.0**
Surplus/ Deficit (-) to B/E Duty Excl PSFand MRET	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**(4.5)**	**(4.5)**	**0.0**	**(0.0)**	**0.0**	**(7.0)**	**(7.0)**	**0.0**

Commentary

The Trusts surplus including PSF was £1m in August which was on plan .

Pass-through adjustments have been applied to account for: High Cost Drugs and devices, STP associated costs, and Research and Development costs.

Clinical Income excluding HCDs was adverse to plan in August by £0.2m and £1.4m year to date. The key favourable variances in Electives (£0.2m) and Day Cases (£0.1m) offset by adverse variances in Direct Access Radiology (£0.2m) and Adult Critical Care (£0.3m).

The Trust delivered the year to date PSF and MRET funding for month 5. The Trust received £0.6m additional bonus PSF in June relating to 2018/19, the bonus PSF is treated as a technical adjustment and therefore does not support the 2019/20 I&E position.

Other Operating Income excluding pass-through costs was adverse to plan in August by £0.5m. The main pressures in month were Private Patient Unit activity below planned levels (£0.3m) and £0.1m underperformance within Sexual Health income (offset by underspends in expenditure budgets) .

Pay budgets adjusted for pass-through items underspent by £0.7m in August, although without the release of £1m of reserves the position would have been an overspend of £0.3m. Overspends within Medical staffing (£0.4m) and Nursing (£0.1m) were partly offset by underspends within Admin and Clerical (£0.1m) and Scientific and Technical staffing (£0.1m). The key pressures in Medical staffing were mainly within Emergency and Medicine directorate (£0.2m), Paediatrics (£0.1m) and Surgery Division (£0.1m).

Non Pay budgets adjusted for pass though items overspent by £0.2m in the month which includes £0.1m EPR funding pressure resulting from the EPR costs being charged to revenue pending confirmation of additional capital funding support.

The Trust is currently forecasting to deliver the planned surplus of £6.9m including PSF and MRET funding.

Maidstone and Tunbridge Wells NHS Trust

2b. Run Rate Analysis

Analysis of 13 Monthly Performance (£m's)

		Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Change between Months
Revenue	Clinical Income	33.1	32.0	33.7	35.5	33.1	32.4	30.6	34.5	35.2	36.4	34.3	37.9	36.3	(1.6)
	STF / PSF	0.8	0.8	1.3	1.3	1.3	0.0	0.0	12.8	0.9	0.9	1.5	1.0	1.0	(0.0)
	High Cost Drugs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(0.0)
	Other Operating Income	4.7	3.9	5.7	4.1	4.3	4.7	4.4	5.3	4.1	4.1	4.6	4.5	3.9	(0.5)
	Total Revenue	**38.6**	**36.8**	**40.7**	**40.8**	**38.6**	**37.1**	**35.0**	**52.6**	**40.2**	**41.4**	**40.4**	**43.4**	**41.2**	**(2.2)**
Expenditure	Substantive	(18.5)	(18.9)	(17.6)	(18.9)	(18.7)	(18.8)	(18.7)	(19.9)	(20.1)	(19.5)	(19.3)	(19.7)	(19.9)	(0.2)
	Bank	(1.2)	(1.1)	(1.0)	(1.1)	(1.2)	(1.2)	(1.3)	(1.4)	(1.3)	(1.1)	(1.1)	(1.2)	(1.3)	(0.1)
	Locum	(0.7)	(0.7)	(0.6)	(0.8)	(1.0)	(0.9)	(0.7)	(1.1)	(0.8)	(0.9)	(0.9)	(0.9)	(1.0)	(0.1)
	Agency	(2.1)	(1.9)	(1.8)	(1.7)	(1.7)	(1.9)	(2.1)	(1.4)	(1.6)	(1.7)	(1.5)	(1.9)	(1.8)	0.1
	Pay Reserves	0.2	0.0	0.4	(0.2)	(0.2)	(0.1)	(0.2)	(0.2)	(0.3)	(0.3)	(0.3)	(0.3)	0.7	1.0
	Total Pay	(22.2)	(22.5)	(20.7)	(22.7)	(22.8)	(23.0)	(23.0)	(23.9)	(24.2)	(23.5)	(23.1)	(23.9)	(23.3)	0.7
Non-Pay	Drugs & Medical Gases	(4.3)	(4.4)	(4.4)	(4.8)	(4.2)	(3.9)	(4.5)	(4.5)	(4.6)	(4.6)	(4.2)	(4.7)	(4.5)	0.2
	Blood	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.0)
	Supplies & Services - Clinical	(3.0)	(2.8)	(3.1)	(3.0)	(3.1)	(3.0)	(2.8)	(2.7)	(2.7)	(2.7)	(2.8)	(3.0)	(2.6)	0.4
	Supplies & Services - General	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.4)	(0.5)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.0)
	Services from Other NHS Bodies	(0.7)	(1.1)	(0.8)	(1.3)	(0.9)	(0.9)	(0.2)	(3.2)	(1.0)	(0.8)	(0.7)	(0.6)	(0.6)	0.0
	Purchase of Healthcare from Non-NHS	(0.3)	(0.4)	(0.3)	(0.2)	(0.3)	(0.3)	(0.4)	(0.5)	(1.5)	(1.7)	(1.6)	(1.2)	(1.2)	(0.0)
	Clinical Negligence	(1.6)	(1.6)	(1.6)	(1.3)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	0.0
	Establishment	(0.4)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.2)	(0.2)	(0.3)	(0.3)	(0.3)	(0.3)	(0.0)
	Premises	(2.2)	(1.8)	(1.7)	(1.5)	(1.8)	(2.6)	(1.9)	(2.3)	(2.3)	(2.2)	(2.4)	(1.9)	(2.1)	(0.2)
	Transport	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.2)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	0.0
	Other Non-Pay Costs	(1.1)	(0.2)	(1.1)	(0.4)	(0.3)	(1.0)	(1.5)	1.8	(0.5)	(0.5)	(0.7)	(1.2)	(1.0)	0.2
	Non-Pay Reserves	0.5	0.6	(0.4)	0.0	0.0	0.0	0.0	0.0	(0.5)	(0.4)	(0.4)	0.7	0.1	(0.6)
	Total Non Pay	(13.8)	(12.7)	(14.5)	(13.6)	(13.2)	(14.3)	(13.9)	(14.0)	(15.4)	(15.4)	(15.4)	(14.3)	(14.4)	(0.1)
	Total Expenditure	(36.1)	(35.3)	(35.2)	(36.3)	(36.0)	(37.3)	(36.9)	(38.0)	(39.6)	(38.9)	(38.5)	(38.3)	(37.7)	0.6
EBITDA	EBITDA	2.5	1.5	5.5	4.5	2.6	(0.1)	(1.9)	14.7	0.5	2.5	1.9	5.1	3.6	(1.6)
		7%	*4%*	*14%*	*11%*	*7%*	*0%*	*-6%*	*28%*	*1%*	*6%*	*5%*	*12%*	*9%*	
Other Finance Costs	Depreciation	(1.0)	(1.2)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	0.0
	Interest	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	0.0
	Dividend	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	0.5	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	0.0
	PFI and Impairments	(1.2)	(1.3)	(1.4)	(1.2)	(1.2)	(1.2)	2.7	7.9	(1.2)	(1.2)	(1.2)	(1.2)	(1.2)	0.0
	Total Other Finance Costs	**(2.5)**	**(2.7)**	**(2.7)**	**(2.5)**	**(2.5)**	**(2.5)**	**1.4**	**7.2**	**(2.6)**	**(2.6)**	**(2.5)**	**(2.6)**	**(2.6)**	**0.0**
Net Surplus / Deficit (-)	Net Surplus / Deficit (-)	0.0	(1.1)	2.8	2.0	0.1	(2.6)	(0.5)	21.9	(2.0)	(0.1)	(0.7)	2.5	1.0	(1.5)
Technical Adjustments	Technical Adjustments	0.0	0.1	0.3	0.0	0.0	0.0	0.0	(0.2)	0.0	0.0	(0.6)	0.0	0.0	0.0
Surplus/ Deficit (-) to B/E Duty Incl pSF	Surplus/ Deficit (-) to B/E Duty	0.1	(1.0)	3.1	2.0	0.1	(2.6)	(0.5)	21.7	(2.0)	(0.1)	(1.3)	2.6	1.0	(1.5)
Surplus/ Deficit (-) to B/E Duty Excl STF	Surplus/ Deficit (-) to B/E Duty	(0.8)	(1.9)	1.8	0.8	(1.1)	(2.6)	(0.5)	8.9	(2.9)	(1.0)	(2.8)	1.5	0.0	(1.5)

3a. Cost Improvement Plan

Savings by Division

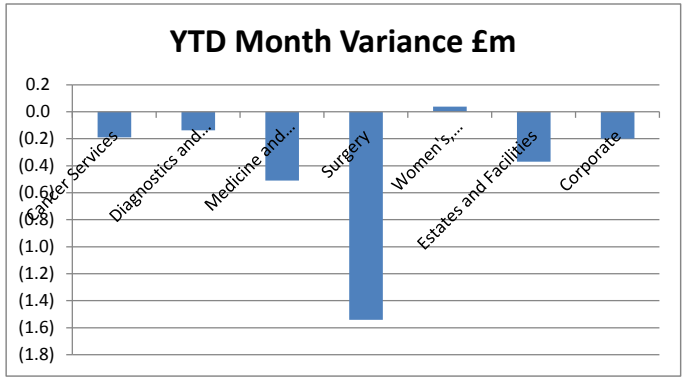
	Current Month			Year to Date			Forecast (Risk Adjusted)			
	Actual	*Original Plan*	*Variance*	*Actual*	*Original Plan*	*Variance*	*Forecast*	*Revised Forecast*	*Original Plan*	*Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Cancer Services	0.04	0.12	(0.08)	0.41	0.60	(0.19)	1.03	1.45	1.45	0.00
Diagnostics and Clinical Support	0.24	0.25	(0.01)	1.23	1.37	(0.14)	2.74	3.11	3.11	0.00
Medicine and Emergency Care	0.40	0.49	(0.09)	1.40	1.91	(0.51)	4.65	5.46	5.46	0.00
Surgery	1.30	0.69	0.61	1.91	3.45	(1.54)	5.95	8.15	8.15	0.00
Women's, Children's and Sexual Health	0.24	0.21	0.03	1.09	1.05	0.04	2.41	2.56	2.56	0.00
Estates and Facilities	0.12	0.36	(0.24)	0.82	1.19	(0.37)	1.88	2.30	2.30	0.00
Corporate	0.13	0.17	(0.04)	0.65	0.81	(0.20)	1.31	2.09	2.09	0.00
Total	**2.47**	**2.29**	**0.18**	**7.50**	**10.38**	**(2.91)**	**19.96**	**25.12**	**25.12**	**0.00**
Internal Savings Plan stretch	1.41	(0.10)	1.51	1.45	(2.62)	4.06	2.37	(2.79)	(2.79)	0.00
Total	**3.88**	**2.19**	**1.69**	**8.95**	**7.76**	**1.15**	**22.33**	**22.33**	**22.33**	**0.00**

Savings by Subjective Category

	Current Month			Year to Date			Forecast (Risk Adjusted)			
	Actual	*Original Plan*	*Variance*	*Actual*	*Original Plan*	*Variance*	*Forecast*	*Revised Forecast*	*Original Plan*	*Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Pay	0.63	0.38	0.25	2.53	1.42	1.11	6.81	7.81	4.58	3.22
Non Pay	1.96	0.39	1.57	(0.35)	(0.05)	(0.29)	(0.49)	(1.49)	2.54	(4.03)
Income	1.29	1.41	(0.13)	6.77	6.43	0.33	16.01	16.01	15.20	0.81
Total	**3.88**	**2.19**	**1.69**	**8.95**	**7.80**	**1.15**	**22.33**	**22.33**	**22.33**	**0.00**

Savings by NHSI RAG

	Current Month			Year to Date			Forecast (Risk Adjusted)			
	Actual	*Original Plan*	*Variance*	*Actual*	*Original Plan*	*Variance*	*Forecast*	*Revised Forecast*	*Original Plan*	*Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Green	3.50	1.58	1.92	7.43	5.92	1.49	16.67	16.67	14.33	2.34
Amber	0.31	0.24	0.07	1.29	0.93	0.36	3.83	3.83	3.08	0.75
Red	0.07	0.36	(0.30)	0.23	0.91	(0.68)	1.83	1.83	4.92	(3.10)
Total	**3.88**	**2.18**	**1.70**	**8.95**	**7.76**	**1.17**	**22.33**	**22.33**	**22.33**	**0.00**



Comment

The Trust was favourable to plan in the month by £1.7m which included £1.4m back dated savings relating to operational efficiency savings. The Trust is £1.2m favourable YTD which is mainly due to overperformance within workforce savings (£1.4m).

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 divisions are currently forecasting to deliver £22.3m savings in 2019/20 which is £2.8m short of the internal stretch target of £25.1m but delivers the planned savings target.

The CIP forecast includes the following key assumptions:
- Ward Closure from 1st October = £0.5m saving
- £0.6m savings to be identified by NHS supply chain starting from October.
- Independent sector costs reduce to excepted levels associated with patient choice activity.

Maidstone and Tunbridge Wells NHS Trust

4a. Year End Forecast Run Rate £m

Year End Forecast August 2019/20

Forecast Trend

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Budget	Variance
Clinical Income	35.2	36.4	34.3	37.9	36.3	36.1	38.0	36.0	35.6	37.3	34.7	37.3	435.1	435.1	0.0
PSF	0.9	0.9	1.5	1.0	1.0	0.5	0.5	0.5	0.5	0.5	0.5	0.5	9.0	13.8	(4.9)
Private Patients	0.1	0.1	0.2	0.1	0.1	0.2	0.3	0.4	0.3	0.4	0.4	0.4	2.9	5.1	(2.2)
Other Operating Income	4.0	4.0	4.4	4.4	3.8	4.0	3.6	3.6	3.6	3.6	3.6	3.5	45.9	49.1	(3.2)
Total Revenue	**40.2**	**41.4**	**40.4**	**43.4**	**41.2**	**40.8**	**42.5**	**40.5**	**40.0**	**41.8**	**39.1**	**41.7**	**492.9**	**503.2**	**(10.3)**
Substantive	(20.1)	(19.5)	(19.3)	(19.7)	(19.9)	(20.5)	(20.9)	(21.4)	(21.6)	(21.8)	(21.8)	(22.1)	(248.7)	(254.1)	5.4
Bank	(1.3)	(1.1)	(1.1)	(1.2)	(1.3)	(1.2)	(1.2)	(1.2)	(1.1)	(1.1)	(1.1)	(1.1)	(14.2)	(10.2)	(4.0)
Locum	(0.8)	(0.9)	(0.9)	(0.9)	(1.0)	(1.1)	(1.1)	(1.0)	(1.1)	(1.0)	(1.0)	(1.0)	(11.8)	(8.4)	(3.5)
Agency	(1.6)	(1.7)	(1.5)	(1.9)	(1.8)	(1.9)	(1.4)	(1.0)	(1.2)	(1.0)	(0.9)	(0.5)	(16.4)	(15.8)	(0.6)
Pay Reserves	(0.3)	(0.3)	(0.3)	(0.3)	0.7	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(1.1)	(2.0)	0.9
Total Pay	**(24.2)**	**(23.5)**	**(23.1)**	**(23.9)**	**(23.3)**	**(24.8)**	**(24.7)**	**(24.7)**	**(25.1)**	**(25.1)**	**(25.0)**	**(24.8)**	**(292.3)**	**(290.5)**	**(1.8)**
Drugs & Medical Gases	(4.6)	(4.6)	(4.2)	(4.7)	(4.5)	(4.5)	(4.6)	(4.6)	(4.6)	(4.6)	(4.6)	(4.6)	(54.5)	(51.4)	(3.1)
Clinical Supplies	(3.2)	(3.1)	(3.2)	(3.5)	(3.0)	(3.2)	(3.2)	(3.2)	(3.2)	(3.2)	(3.2)	(3.2)	(38.5)	(39.2)	0.7
Purchase of Healthcare from Non-NHS	(1.5)	(1.7)	(1.6)	(1.2)	(1.2)	(1.1)	(0.9)	(0.9)	(0.9)	(1.1)	(1.1)	(1.1)	(14.5)	(8.8)	(5.7)
Other Non-Pay Costs	(5.6)	(5.6)	(5.9)	(5.7)	(5.8)	(5.8)	(5.5)	(5.6)	(5.9)	(5.8)	(5.6)	(5.4)	(68.3)	(68.1)	(0.2)
Non-Pay Reserves	(0.5)	(0.4)	(0.4)	0.7	0.1	(0.0)	(0.2)	(0.0)	0.1	0.0	(0.1)	(0.3)	(0.9)	(7.3)	6.5
Total Non Pay	**(15.4)**	**(15.4)**	**(15.4)**	**(14.3)**	**(14.4)**	**(14.7)**	**(14.3)**	**(14.3)**	**(14.4)**	**(14.7)**	**(14.6)**	**(14.6)**	**(176.7)**	**(174.8)**	**(1.8)**
Other Finance Costs	(2.6)	(2.6)	(2.5)	(2.6)	(2.6)	(2.9)	(2.6)	(2.6)	(2.9)	(2.6)	(2.6)	(3.0)	(32.0)	(32.0)	0.0
Technical Adjustments	0.0	0.0	(0.6)	0.0	0.0	0.3	0.0	0.0	0.3	0.0	0.0	0.4	0.8	1.1	(0.3)
Surplus/ Deficit (-) to B/E Duty	**(2.0)**	**(0.1)**	**(1.3)**	**2.6**	**1.0**	**(1.2)**	**0.9**	**(1.1)**	**(2.1)**	**(0.5)**	**(3.0)**	**(0.3)**	**(7.2)**	**6.9**	**(14.1)**
Surplus/ Deficit (-) to B/E Duty Excl PSF	**(2.9)**	**(1.0)**	**(2.2)**	**1.5**	**0.0**	**(1.7)**	**0.3**	**(1.6)**	**(2.6)**	**(1.1)**	**(3.5)**	**(0.8)**	**(15.6)**	**(7.0)**	**(8.6)**
Mitigations / Recovery Actions	**0**	**0**	**0**	**0**	**0**	**1.1**	**1.2**	**1.1**	**1.1**	**1.0**	**1.1**	**2.1**	**8.6**	**0**	**8.6**
Plan Excluding PSF and MRET Funding	**(2.9)**	**(1.0)**	**(2.2)**	**1.5**	**0.0**	**(0.6)**	**1.5**	**(0.5)**	**(1.3)**	**0.3**	**(2.2)**	**0.5**	**(7.0)**	**(7.0)**	**(0.0)**
Revised Forecast Including Mitigations	**(2.9)**	**(1.0)**	**(2.2)**	**1.5**	**0.0**	**(0.6)**	**1.5**	**(0.6)**	**(1.5)**	**(0.1)**	**(2.4)**	**1.3**	**(7.0)**	**(7.0)**	**(0.0)**
Variance by month	0.0	0.0	0.0	0.0	0.0	0.0	(0.0)	(0.1)	(0.2)	(0.3)	(0.2)	0.8			
Variance by Quarter			0.0			0.0			(0.3)			0.3			

Maidstone and Tunbridge Wells NHS Trust

5a. Balance Sheet

August 2019

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

£m's	August Reported	August Plan	Variance	July Reported	Full year Plan
Property, Plant and Equipment (Fixed Assets)	288.4	288.9	(0.5)	289.2	307.6
Intangibles	2.8	3.1	(0.3)	2.9	2.8
PFI Lifecycle	0.0	0.0	0.0	0.0	0.0
Debtors Long Term	1.6	1.4	0.2	1.6	1.4
Total Non-Current Assets	**292.8**	**293.4**	**(0.6)**	**293.7**	**311.8**
Current Assets	0.0	0.0	0.0	0.0	0.0
Inventory (Stock)	7.8	7.8	0.0	7.8	7.8
Receivables (Debtors) - NHS	16.8	30.9	(14.1)	20.4	24.7
Receivables (Debtors) - Non-NHS	14.2	13.2	1.0	14.9	9.2
Cash	45.8	38.6	7.2	56.8	3.0
Assets Held For Sale	0.0	0.0	0.0	0.0	0.0
Total Current Assets	**84.6**	**90.5**	**(5.9)**	**99.9**	**44.7**
Current Liabilities					
Payables (Creditors) - NHS	(5.6)	(4.6)	(1.0)	(5.3)	(5.1)
Payables (Creditors) - Non-NHS	(50.3)	(46.6)	(3.7)	(47.3)	(31.1)
Deferred Income	(21.0)	(16.0)	(5.0)	(24.1)	(2.6)
Capital Loan	(2.6)	(2.2)	(0.4)	(2.2)	(2.2)
Working Capital Loan	0.0	(16.9)	16.9	(17.3)	(26.1)
Other loans	(0.4)	(0.4)	0.0	(0.4)	(0.4)
Borrowings - PFI	(5.4)	(5.4)	0.0	(5.4)	(5.3)
Provisions for Liabilities and Charges	(1.5)	(1.5)	0.0	(1.5)	(1.5)
Total Current Liabilities	**(86.8)**	**(93.6)**	**6.8**	**(103.5)**	**(74.3)**
Net Current Assets	(2.2)	(3.1)	0.9	(3.6)	(29.6)
non-current liabilities: Borrowings - PFI > 1yr	(185.0)	(185.3)	0.3	(185.5)	(182.2)
Capital Loans	(8.0)	(7.9)	(0.1)	(8.0)	(6.6)
Working Capital Facility & Revenue loans	(26.2)	(26.1)	(0.1)	(26.2)	0.0
Other loans	(1.5)	(1.5)	0.0	(1.5)	(1.3)
Provisions for Liabilities and Charges- Long term	(0.9)	(1.0)	0.1	(0.9)	(1.0)
Total Assets Employed	**69.0**	**68.5**	**0.5**	**68.0**	**91.1**
Financed By:					
Capital & Reserves					
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	(174.6)	(175.1)	0.5	(175.6)	(168.4)
Total Capital & Reserves	**69.0**	**68.5**	**0.5**	**68.0**	**91.1**

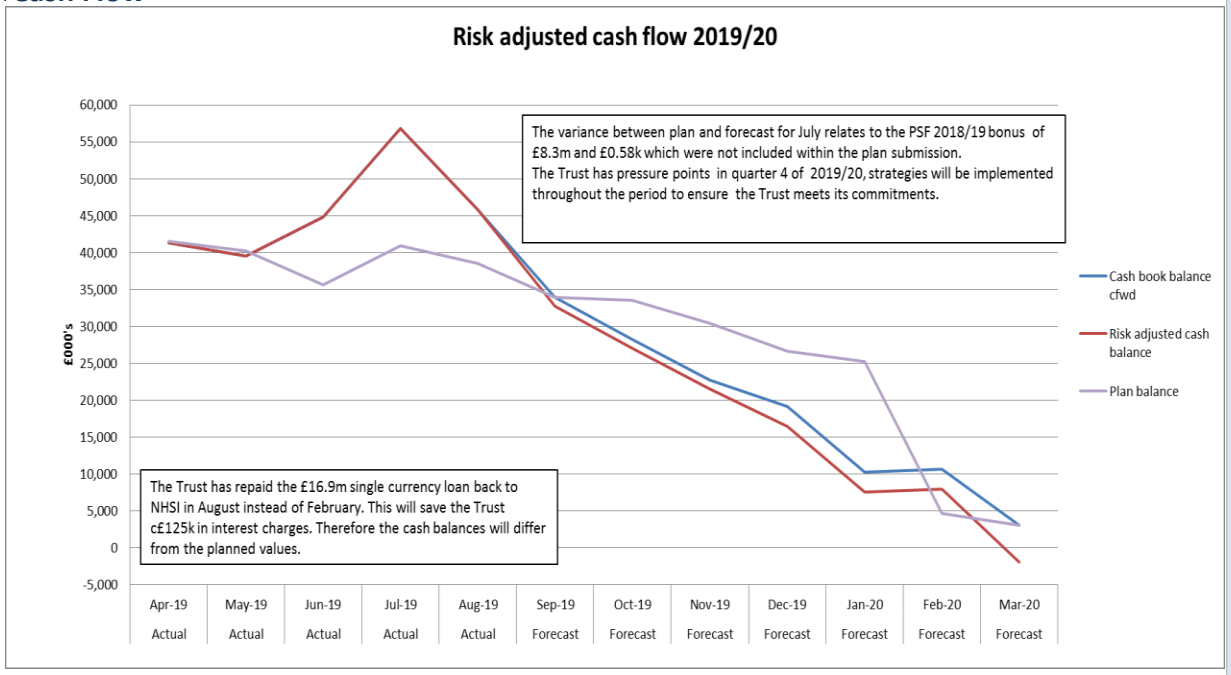
Commentary:
The overall working capital within the month results in a decrease in Debtors of £13.1m against plan with an increase in creditors of £9.7m compared to the revised plan submitted in May. The cash balance held at the end of the month is higher than the plan by £7.2m.

Non-Current Assets -
Capital additions for 2019/20 based on the plan submitted on 15th May are £14.8m with depreciation of £13.5m. Included within the capital additions are £0.4m donated assets. The planned spend for August was £0.6m with actual spend of £0.3m.

Current Assets -
Inventory of £7.8m is in-line with the planned value of £7.8m. The main stock balances are pharmacy £2.6m, TWH theatres £1.4m, Materials Management £1m and Cardiology £1.2m.
NHS Receivables have decreased from July's position by £3.6m to £16.8m. Of the £16.8m reported balance, £7.2m relates to invoiced debt of which £2.2m is aged debt over 90 days. Invoiced debt over 90 days has slightly increased by £0.3m from the reported Julys position of £1.9m. The remaining £9.6m relates to uninvoiced accrued income including quarter 1 PSF of £1.2m, months 4 and 5 PSF £1m and work in progress - partially completed spells £2.7m. Due to the cash pressures of many neighbouring NHS bodies regular communication is continuing and arrangements are being put in place to help reduce the level of debt.
Non NHS Receivables have decreased by £0.7m to £14.2m from the reported July position of £14.9m . Included within the £14.2m balance is trade invoiced debt of £1.8m and private patient invoiced debt of £0.58m. Also included within the £14.2m are prepayments and accrued income totalling £10.3m. Prepayments primarily relate to rates & annual service maintenance contracts, which will reduce throughout the year as they are expensed. The Trust is currently using a company called Patient Billing Ltd which are supporting the PPU department with improving the quality of invoices and debt collecting.
The cash balance of £45.8m is higher than the plan of £38.6m. The main increase is due to the Trust receiving PSF bonus from 2018/19 of £8.3m and an additional £0.58m which were not included within the plan submission. Additionally the Trust has received £1.3m of over performance from 2018/19 which was also not included within the plan. The Trust had forecast to pay £1.5m Roche qtr 1 contract payment in July but the Trust is still waiting for an invoice so the value is being carried forward. The Trust has also received income in respect of Prime Provider contracts but the expenditure wont be paid out until September c£3m. The closing cash balance of the cash flow forecast is £3m which relates to £2m proceeds from asset sales being carried forward and £1m closing cash balance.

Current Liabilities -
NHS payables have slightly increased from July's reported balance by £0.3m to £5.6m. Non-NHS trade payables have also increased by £3m giving a combined payables balance of £55.9m.
Of the £55.9m combined payables balances, £12.2m relates to actual invoices of which £6.7m are approved for payment and will be released when they fall due, the remaining balance of payables of £43.7m relates to uninvoiced accruals.
The Balance of £6.7m approved invoices at the end of August shows 91.6% are within 0-30 days outstanding. Deferred income of £21m primarily is in relation to £14.7m advance contract payment received from WKCCG, £1.1m Health Education Income, £1.9m maternity pathway with CCG's and £0.7m NHS England m6 support.
The Trust has 2 working capital loans totalling c£26.1m. The two loans are due to be repaid in 2020/21, £12.132m which is due to be repaid in October 2020 and the remaining £13.99m loan is based on a phased repayment plan throughout 2020/21 and are in non-current liabilities.
Other loans for both current and non current liabilities relate to the Salix loan which has been taken out to improve the energy efficiency of the Trust.
The public dividend capital increases by the end of the financial year by £1.5m. This is in relation to ICT - EPMA project expected to be received in quarter 4.
The increase between years for the revaluation reserve relates to the Trust forecasting a 5% increase in values on its building and land assets totalling £14.4m.

5b. Cash Flow



Information on loans:

	Rate	Value £m's	19/20 Annual Repayment £m's	19/20 Annual Interest Paid £m's	Repayment Date
Revenue loans:					
Interim Revolving Working Capital Facility (IRWCF)	3.50%	12.132	0.00	0.43	19/10/2020
interim working capital loans	3.50%	13.990	0.00	0.49	18/03/2021
Capital loans:	0.00%	0.000	0.00	0.00	00/01/1900
Capital investment loan					
Capital investment loan	3.91%	11.000	0.73	0.19	15/09/2025
Capital investment loan	4.73%	6.000	0.24	0.16	15/09/2035
Other loans:					
Salix loan (interest free)	0.00%	2.217	0.37	0.00	2024/25

Commentary

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 are not received.

The Trust's cash flow is based on the Income & Expenditure (I&E) plan and working capital adjustments from the Balance Sheet. If the I&E starts to move away from the plan, this will adversely effect the Trust's cash position.

The closing cash balance at the end of August 2019 was £45.8m which is slightly higher than plan of £38.6m. The main reason is the Trust receiving £8.3m and £0.58m PSF bonus relating to 2018/19 which was not included within the cash plan.
The Trust has also received income relating to prime provider contracts but the Trust is waiting for the CCG to invoice the Trust for c£3m expenditure which the Trust has forecast to pay out in September.

The Trust has repaid the single currency loan of £16.908m on the 12th August instead of February 2020, this will save the Trust c£125k in interest.

The cash flow balances in quarter 4 are low so strategies will need to be implemented to ensure its commitments are met. it is also important that the I&E remains to plan as if either of the income or expenditure adversely moves this will have a negative impact on the cash position.

The risk adjusted items relate to:

PSF funding which is received if certain targets are met. The cash flow has three quarters included as the income is received in arrears. Quarter 4 will be included within 2020/21 cash flow.

Within quarter 3 the Trust has external loan capital financing of £0.85m, if the funding is not received the capital expenditure will not be spent.

The Trust has planned to receive PDC funding of £1.48m in quarter 4, the £1.48m relates to ICT - EPMA project. The funding is not received the capital expenditure will not be spent.

2020/21 pressures:

The Trust has two working capital loans which are due to be repaid in the next financial year totalling £26.122m. It is likely that the Trust will not have enough surplus cash to repay the total loan value in 2020/21. Therefore, the Trust will need to request the approval from NHSI to defer potentially both of these loans. Currently the deferral of loan repayments is only given for a year, therefore they will need to be repaid in 2021/22, so the Trust needs to generate cash surpluses in order to facilitate these repayments going forward.

5c. Capital Programme

Capital Projects/Schemes

	Year to Date			Forecast			*Committed & orders raised
	Plan	*Actual*	*Variance*	*Plan*	*Actual*	*Variance*	
	£000	£000	£000	£000	£000	£000	£000
Estates	265	222	43	6,588	3,588	-3,000	926
ICT	1,570	916	654	4,103	3,967	-136	2,292
Equipment	363	44	319	3,163	5,949	2,786	358
PFI Lifecycle (IFRIC 12)	0	0	0	594	594	0	594
Donated Assets	-75	378	-453	400	900	500	870
Total Including Donated Assets	**2,123**	**1,560**	**563**	**14,848**	**14,998**	**150**	**5,039**
Donated Assets	75	-378	453	-400	-900	-500	0
Total Excluding Donated Assets	**2,198**	**1,182**	**1,016**	**14,448**	**14,098**	**-350**	

The figures above reflect the resubmitted capital plan in May 2019 following the request from the NHSI/E CFO to reduce capital plans given the national overcommitment on capital (CDEL). The Trust reviewed its proposals for externally financed schemes and agreed to reduce or defer £3.5m of projects in to 2020/21 to support the national position. The Trust has retained £850k in relation to a potential emergency capital loan for a replacement CT scanner.

In July there was a further national review on a STP patch basis to reduce the capital resource level to a given control total allocated to each patch. The Trust agreed to defer £6m of the asset sale funding earmarked for 2019/20 with a view to the entire £8m resource being agreed across the two years 2020/21 and 2021/22 (£4m each year). As a result of this process the Trust confirmed the arrangement for purchasing the modular AMU as an operating lease (revenue) rather than capital in this year by the deadline of 19th July. Following the recent announcements of new capital funding in 2019/20 it is not yet clear if the control total approach is to be implemented; therefore at this stage the Trust has retained the plan agreed in May 2019 but updated the use of the £6.4m asset sale resoruce to be applied to critical equipment and estates backlog schemes that could be delivered in this financial year. It is expected that the Trust will need to submit a new business case for the CRL cover for this resource, along with the request for emergency capital for the CT scanner.

Outside of the £6.4m asset sale funding, the Trust's internally generated capital is £4.85m for the year. Of this £3.6m is already spent or committed e.g. £1.88m EPR, £0.4m equipment; £0.9m estates schemes. Therefore the Trust has £1.2m remaining that is not yet committed to cover all of its remaining capital requirements in 2019/20 (excluding donated asset funding). This includes a reduction of £350k related to the forecast underspend on depreciation (from the reduction in overall programme value and the timing slippages due to the issues around the national capital position) which results in a reduced level of available capital funding to spend.

The Trust has also retained its bid for EPMA funding of £1.48m which is subject to central decision making; and is expecting resource cover of £300k to honour the carry forward of the HSLI funding into this financial year, which supported the 2018/19 national position.

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. It will also capitalise many existing service contracts reliant on a key asset or assets onto the balance sheet e.g. managed service contracts, as the new standard is about the "right to use" and an asset and exercise control over it, rather than ownership, or the balance of risks and rewards.

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

Appendix 4

Planned and actual ward staffing July 2019

RAG Rating

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

Jul-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	102.1%	81.4%	96.8%	117.5%	32.2%	43.9%	107	↓	7.49	6	↓	7.8	17.1%	100.0%	1	0	2	Enhanced care requirements across 10 ocassions Short term sickness reported.	147,455	141,778	5,677
MAIDSTONE	Cornwallis (M) - NS959	79.9%	83.1%	75.6%	48.4%	15.9%	20.7%	36	↓	2.32	0	↓	6.9	26.7%	97.5%	0	0	2	Reduced RN fill rate in line with bed occupancy range between 12 - 19 throughout the month and supporting bed management for operational flow. Altered skill mix at night to support staffing levels during the day	80,888	74,791	6,097
MAIDSTONE	Culpepper Ward (M) - NS551	104.7%	98.7%	103.0%	100.0%	20.8%	24.9%	69	↑	4.87	3	↘	7.9	60.0%	95.8%	1	0	0		112,018	108,814	3,205
MAIDSTONE	John Day Respiratory Ward (M) - NT151	89.3%	124.4%	100.1%	135.3%	51.8%	48.6%	180	↗	12.52	6	↓	6.6	34.6%	88.9%	6	1	2	1 fall above threshold Reduced RN fill rate due to vacacnices and 6 unfilled shifts. Increased CSW fill rate to support with enhanced care requirements throughout the month.	132,002	159,899	(27,897)
MAIDSTONE	Intensive Care (M) - NA251	90.1%	81.7%	85.6%	-	4.7%	8.1%	31	↓	1.93	7	↘	35.6			0	0	5	Reduced fill rate in line with low bed occupancy.	163,371	145,021	18,350
MAIDSTONE	Pye Oliver (Medical) - NK259	89.0%	91.9%	103.3%	98.9%	25.1%	59.8%	107	↓	7.39	14	↘	5.6	25.0%	76.5%	3	1	7	Redcued RN fill rate due to lack of availble temporary staff. 14 unfilled RN shifts reported.	118,990	110,266	8,724
MAIDSTONE	Whatman Ward - NK959	109.6%	95.9%	146.7%	128.7%	58.4%	46.8%	143	↑	9.88	7	↓	7.6	1.1%	100.0%	6	0	5	Increased fill rate due to weekend and night escalation throughout the month. Enhanced care requirements recorded on 3 occassions and ward supporting SPN.	92,372	115,930	(23,558)
MAIDSTONE	Lord North Ward (M) - NF651	100.7%	122.8%	99.7%	109.5%	23.9%	6.5%	48	↓	3.28	10	→	7.3	35.6%	100.0%	3	0	4	1 fall above threshold Increased fill rate at night due to enhanced care requirements.	88,181	104,091	(15,910)
MAIDSTONE	Mercer Ward (M) - NJ251	93.6%	104.9%	97.9%	129.0%	24.9%	41.0%	74	↗	4.93	7	↗	6.1	66.7%	90.0%	5	0	2	Increased CSW fill rate at night due to enhanced care needs	114,987	112,169	2,818
MAIDSTONE	Edith Cavell (M) - NS459	100.3%	110.3%	99.2%	122.8%	24.1%	26.5%	49	↑	3.30	1	↓	7.7	3.3%	100.0%	0	0	2	Some increased fill rate due to enhanced care requirements and to support ward move for deep clean.	85,229	81,382	3,847
MAIDSTONE	Acute Medical Unit (M) - NG551	90.1%	98.4%	129.9%	196.8%	33.4%	48.9%	146	↗	9.44	33	↘	9.0	0.0%	0.0%	2	0	4	Increased fill rate at night due to continued escalation throughout the month	117,548	140,474	(22,926)
TWH	Ward 22 (TW) - NG232	71.2%	94.0%	87.8%	109.2%	38.6%	37.6%	255	↗	15.18	78	↑	9.1	110.0%	100.0%	1	0	10	Reduced RN fill rates due to vacancies and lack of available temporary staff. 78 reported unfilled shifts across the month.	152,739	144,486	8,253
TWH	Coronary Care Unit (TW) - NP301	96.9%	83.9%	98.4%	-	34.9%	35.3%	83	↑	4.89	9	↗	10.5	107.7%	92.9%	0	0	3	Reduced CSW fill rate due to redeployment of staff to support safe staffing across organisation	69,051	67,179	1,872
TWH	Ward 33 (Gynae) (TW) - ND302	103.2%	95.6%	101.1%	100.0%	14.7%	20.7%	47	↓	2.97	13	↓	12.1	42.9%	94.4%	0	0	0	EGAU closed on one occassions due to staffing shortages.	81,469	84,344	(2,875)
TWH	Intensive Care (TW) - NA201	98.9%	98.6%	98.0%	86.5%	4.3%	0.0%	26	↘	1.82	4	↘	30.2			1	0	2	1 fall above threshold Short term sickness reported during the month	192,375	190,176	2,199
TWH	Acute Medical Unit (TW) - NA901	81.6%	96.3%	103.6%	95.6%	36.4%	43.8%	276	↑	19.57	69	↓	8.6	3.8%	100.0%	5	0	7	Reduced fill rate due to vacancies and lack of available temporary staff across 69 shifts	184,569	197,447	(12,878)
TWH	Surgical Assessment Unit (TW) - NE701	93.3%	96.8%	100.0%	97.5%	33.2%	5.2%	34	↘	2.38	7	↗	15.0			0	0	2		61,157	62,788	(1,631)
TWH	Ward 32 (Wells Suite) (TW) - PP010	95.4%	80.0%	100.1%	95.9%	41.9%	35.9%	113	↘	7.68	13	↓	6.1	73.7%	89.3%	10	1	7	4 falls above threshold Redcued CSW fill rates at night due to lack of available temporary staff. Enhanced care requirements throughout the month	135,069	133,496	1,573
TWH	Ward 10 (TW) - NG130	87.9%	111.3%	105.4%	121.5%	44.0%	29.2%	163	↑	10.10	34	↑	6.3	0.0%	0.0%	3	0	9	1 fall above threshold RMN and enhanced care requirements throughout the month increasing fill rate CSW fill rate. Reduced RN due to unfill rate of 34.	115,442	134,785	(19,343)
TWH	Ward 11 (TW) - NG131	93.2%	91.8%	102.4%	130.6%	37.4%	26.6%	148	↗	9.63	24	→	6.1	0.0%	0.0%	7	0	3	3 falls above threshold Considered action to alter skill mix and increase CSW fill rate to support staffing levels.	119,878	134,924	(15,046)
TWH	Ward 12 (TW) - NG132	88.1%	104.7%	111.7%	91.1%	44.3%	35.1%	168	↑	11.00	36	→	6.1	47.5%	96.4%	11	0	5	5 falls above threshold	127,510	121,315	6,195
TWH	Ward 20 (TW) - NG230	80.7%	113.5%	101.0%	130.2%	44.5%	18.3%	117	↘	8.28	16	↗	5.9	65.7%	78.3%	19	0		12 falls above threshold Increased CSW fill rate at night to support enhanced care requirements throughout the month. Reduced RN fill rate with lack of available temporary staff.	112,116	106,229	5,887
TWH	Ward 21 (TW) - NG231	86.3%	106.3%	96.1%	104.8%	27.9%	53.9%	148	↑	9.40	37	↓	6.0	17.5%	100.0%	4	0	10	Reduced RN fill rate due to lack of available temporary staff with 37 unfilled shifts. Redeployment of staff on occasion to support staffing across the trust.	143,977	137,961	6,016
TWH	Ward 2 (TW) - NG442	89.8%	101.6%	106.7%	109.8%	32.8%	41.6%	132	↘	9.00	18	↓	7.1	23.7%	77.8%	10	0	7	3 falls above threshold. Redcued RN fill rate due to lack of available temporary staff, AFU escalation on 4 occassions and enhanced care requirements across 10 episodes.	114,505	126,200	(11,695)
TWH	Ward 30 (TW) - NG330	89.5%	89.8%	100.0%	128.0%	40.3%	25.1%	147	↓	9.44	33	↑	6.0	1.0%	100.0%	11	0	14	6 falls above threshold Reduced fill rates due to lack of available temporary staff and enhanced care requirements throughout the month	118,756	126,778	(8,022)
TWH	Ward 31 (TW) - NG331	91.5%	79.2%	110.6%	97.9%	46.8%	52.4%	217	↑	14.23	38	↑	6.5	9.9%	100.0%	6	1		RMN requirements across 13 days / nights. Reduced fill rates due to lack of available temporary staff	130,352	142,322	(11,970)
Crowborough	Crowborough Birth Centre (CBC) - NP775	98.2%	100.0%	96.3%	100.0%	8.6%	0.0%	19	↗	1.02	0	↓		91.4%	94.0%		0			67,938	72,197	(4,259)
TWH	Midwifery (multiple rosters)	81.7%	74.0%	93.7%	87.0%	15.7%	15.8%	508	↑	29.98	83	↑	21.6			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.	671,836	689,475	(17,639)
	Midwifery Services - Specialist Midwives - NF102	127.0%	No Hours	No hours	No Hours	2.3%	0.0%	2		0.10	0		15.3									
	Midwifery MSW (TW)	No hours	86.8%	No hours	87.0%	30.8%	0.0%	No Demand		No Demand	No Demand		21.6									
	Midwifery Services - Delivery Suite - NF102	106.1%	No Hours	94.3%	No Hours	26.6%	36.3%	192		12.25	28		15.3									
	Midwifery Services - Antenatal Ward - NF102	108.1%	60.0%	102.7%	No Hours	29.7%	15.4%	124		6.97	14		21.6									
	Midwifery Services - Management - AY451	54.5%	No Hours	No hours	No Hours	0.0%	No hours	No Demand		No Demand	No Demand		15.3									
	Community Midwifery Services - NJ160	74.6%	41.1%	No hours	No Hours	2.6%	0.0%	39		1.85	2		21.6									
	Midwifery Services - Antenatal Clinic - NF102	64.7%	95.7%	No hours	No Hours	6.7%	0.0%	15		0.81	2		15.3									
	Midwifery Services - Postnatal Ward - NF102	74.0%	101.4%	82.8%	No Hours	20.7%	12.9%	136		8.01	37		21.6									
TWH	Hedgehog Ward (TW) - ND702	92.2%	49.5%	97.7%	-	14.1%	31.7%	131	↑	8.36	21	↗	15.3	9.4%	96.4%	0	0	2	Reduced CSW fill rate due to lack of paediatric cover. Fluctuating bed occupancy during the month between 12- 24	199,670	196,776	2,894
MAIDSTONE	Maidstone Birth Centre - NP751	93.7%	93.8%	99.4%	100.0%	14.3%	0.0%	23	↑	1.30	3	↗		90.0%	100.0%	0	0			69,611	61,406	8,205
TWH	SCBU (TW) - NA102	83.4%	65.5%	105.1%	-	15.5%	3.2%	121	↑	7.02	17	↑	11.5				0	4	Cot occupancy fluctuating between 12 - 21 beds. Amber escalation recorded on 4 days, Red escalation recorded on 13 days and Black escalation recorded on episodes across 12 days.	187,339	178,891	8,448
MAIDSTONE	Short Stay Surgery Unit (M) - NE751	96.3%	87.6%	95.5%	-	15.3%	16.4%	32	↑	1.81	6	↗	14.9			0	0	0	Unit closed on one ocassion. Supported Sunday list and increased theatre list.	43,595	48,269	(4,674)
TWH	Short Stay Surgical Unit (TW) - NE901	89.9%	112.6%	115.2%	226.1%	54.8%	23.1%	112	↑	7.06	22	↓	8.2			0	0	7	Escalated on 29 days throughout the month. Redcued RN fill rate due to lack of available temporary staff across 22 shifts	81,233	80,605	628
MAIDSTONE	Accident & Emergency (M) - NA351	82.1%	112.5%	96.6%	100.0%	24.7%	29.9%	226	↗	14.27	42	↑		6.3%	92.5%	2	0		MH- Reduced RN fill rate across the month with 42 unfilled shifts reported. TWH - Reduced fill rate across the month due to vacancies and lack of available temporary with 104 unfilled shifts.	81,887	63,387	18,500
TWH	Accident & Emergency (TW) - NA301	76.8%	89.8%	94.3%	93.6%	38.9%	55.0%	463	↑	32.19	104	↑		12.8%	91.1%	5	0			200,715	209,958	(9,243)
MAIDSTONE	Maidstone Orthopaedic Unit (M) - NP951	72.6%	60.9%	82.3%	-	27.9%	32.7%	52	↓	3.64	5	↓				0	0	8		345,494	339,972	5,522
MAIDSTONE	Peale Ward (M) - NE959	93.1%	97.6%	101.6%	103.2%	8.4%	2.3%	20	↘	1.10	1	→	8.1	67.7%	93.2%	0	0	4		43,693	45,768	(2,075)

		Budget £	Actual £	Variance £
Total Established Wards		**5,105,017**	**5,191,746**	**(86,729)**
Additional Capacity beds	Cath Labs	40,411	41,392	-981
	Whatman	0	-13,659	13,659
	Foster Clark	0	-298	298
Other associated nursing costs		2,911,577	2,665,829	245,748
Total		8,057,005	7,885,011	171,994

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%

RAG Key

↓	Reduction of greater than 5
↑	Increase of greater than 5
↗→	Remains equal to Or less than a difference of 5

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		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	Bank / Agency Dc WTE Temporary Temporary Demand Unfilled
	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									
Acute Stroke	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	2,066	2,110	1,819	1,480	1,419	1,374	693	815	102.1%	81.4%	96.8%	117.5%					
Cornwallis	100 - GENERAL SURGERY	101 - UROLOGY	1,706	1,363	1,263	1,050	1,353	1,022	341	165	79.9%	83.1%	75.6%	48.4%					
Culpepper (incl CCU)	320 - CARDIOLOGY	300 - GENERAL MEDICINE	1,596	1,671	1,119	1,105	1,364	1,405	341	341	104.7%	98.7%	103.0%	100.0%					
John Day	340 - RESPIRATORY MEDICINE	300 - GENERAL MEDICINE	2,300	2,054	1,207	1,502	1,705	1,707	682	923	89.3%	124.4%	100.1%	135.3%					
Intensive Treatment Unit (ITU)	192 - CRITICAL CARE MEDICINE		3,107	2,798	173	141	2,829	2,423	0	12	90.1%	81.7%	85.6%	No data					
Pye Oliver	301 - GASTROENTEROLOGY	300 - GENERAL MEDICINE	1,648	1,467	1,557	1,432	1,012	1,045	1,023	1,012	89.0%	91.9%	103.3%	98.9%					
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	1,786	1,799	600	737	1,112	1,109	372	408	100.7%	122.8%	99.7%	109.5%					
Mercer	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1,635	1,531	1,548	1,624	1,034	1,012	682	880	93.6%	104.9%	97.9%	129.0%					
Edith Cavel	300 - GENERAL MEDICINE		1,332	1,335	979	1,080	1,033	1,024	338	415	100.3%	110.3%	99.2%	122.8%					
Urgent Medical Ambulatory Unit (UMAU)	180 - ACCIDENT & EMERGENCY	300 - GENERAL MEDICINE	2,509	2,262	1,289	1,268	1,023	1,329	341	671	90.1%	98.4%	129.9%	196.8%					
Stroke/Ward 22	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	2,475	1,761	1,920	1,805	1,705	1,497	1,023	1,117	71.2%	94.0%	87.8%	109.2%					
Cornary Care Unit (CCU)	320 - CARDIOLOGY	300 - GENERAL MEDICINE	1,201	1,164	368	308	1,023	1,006	0	11	96.9%	83.9%	98.4%	No data					
Gynaecology/Ward 33	502 - GYNAECOLOGY	100 - GENERAL SURGERY	1,569	1,620	752	719	1,023	1,034	341	341	103.2%	95.6%	101.1%	100.0%					
Intensive Treatment Unit (ITU)	192 - CRITICAL CARE MEDICINE		3,555	3,515	372	367	2,726	2,671	341	295	98.9%	98.6%	98.0%	86.5%					
Medical Assessment Unit	180 - ACCIDENT & EMERGENCY	300 - GENERAL MEDICINE	3,490	2,847	1,574	1,516	2,139	2,217	1,070	1,022	81.6%	96.3%	103.6%	95.6%					
SAU	180 - ACCIDENT & EMERGENCY	100 - GENERAL SURGERY	1,119	1,044	372	360	681	681	341	333	93.3%	96.8%	100.0%	97.5%					
Ward 32	300 - GENERAL MEDICINE		1,672	1,595	1,853	1,482	1,023	1,025	1,364	1,309	95.4%	80.0%	100.1%	95.9%					
Ward 10	100 - GENERAL SURGERY		2,130	1,873	1,500	1,669	1,023	1,078	1,023	1,243	87.9%	111.3%	105.4%	121.5%					
Ward 11	100 - GENERAL SURGERY		2,293	2,136	1,368	1,256	1,353	1,386	682	891	93.2%	91.8%	102.4%	130.6%					
Ward 12	320 - CARDIOLOGY	301 - GASTROENTEROLOGY	2,027	1,786	1,354	1,417	1,023	1,143	1,364	1,243	88.1%	104.7%	111.7%	91.1%					
Ward 20	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1,284	1,036	1,666	1,891	1,023	1,034	1,023	1,332	80.7%	113.5%	101.0%	130.2%					
Ward 21	340 - RESPIRATORY MEDICINE	302 - ENDOCRINOLOGY	2,292	1,977	1,151	1,223	1,694	1,628	682	715	86.3%	106.3%	96.1%	104.8%					
Ward 2	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1,951	1,753	1,764	1,792	1,001	1,068	1,022	1,122	89.8%	101.6%	106.7%	109.8%					
Ward 30	110 - TRAUMA & ORTHOPAEDICS		2,108	1,885	1,403	1,260	1,024	1,024	1,023	1,309	89.5%	89.8%	100.0%	128.0%					
Ward 31	110 - TRAUMA & ORTHOPAEDICS		2,168	1,984	1,780	1,409	1,363	1,507	1,023	1,002	91.5%	79.2%	110.6%	97.9%					
Birth Centre (Crowborough).	501 - OBSTETRICS		863	848	357	357	743	716	357	357	98.2%	100.0%	96.3%	100.0%					
Midwifery Services (ante/post natal & Delivery Suite)	501 - OBSTETRICS		23,043	18,820	5,743	4,250	5,684	5,328	2,324	2,023	81.7%	74.0%	93.7%	87.0%					
Hedgehog	420 - PAEDIATRICS		5,494	5,067	660	327	2,325	2,271	0	0	92.2%	49.5%	97.7%	No data					
Birth Centre	501 - OBSTETRICS		822	770	380	356	682	677	333	333	93.7%	93.8%	99.4%	100.0%					
Neonatal Unit	420 - PAEDIATRICS		4,153	3,465	165	108	2,386	2,506	0	0	83.4%	65.5%	105.1%	No data					
MSSU	100 - GENERAL SURGERY		1,108	1,067	584	512	506	483	0	0	96.3%	87.6%	95.5%	No data					
Peale	100 - GENERAL SURGERY		1,352	1,258	746	728	671	682	341	352	93.1%	97.6%	101.6%	103.2%					
SSSU	100 - GENERAL SURGERY		1,649	1,483	600	676	506	583	253	572	89.9%	112.6%	115.2%	226.1%					
Whatman	300 - GENERAL MEDICINE		1,762	1,932	1,261	1,210	682	1,001	341	439	109.6%	95.9%	146.7%	128.7%					
				81,074	41,240	38,410	47,889	47,692	21,082	22,999									
			-91,261	0	0	0	47,889	47,692	21,082	22,999									

RAG Rating

Red	Less than	**80%**		
Amber	Between	**80%**	and	**90%**
Green	Between	**90%**	and	**100%**
Red	Greater than	**100%**		

Aug-19	DAY				NIGHT				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	Nurse Sensitive Indicators						Financial review		
Health Roster Name	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Bank/Agency Usage	Agency as a % of Temporary Staffing							FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	QuESTT Score	Comments	Budget £	Actual £	Variance £ (overspend)
Stroke Unit (M) - NK551	85.1%	86.0%	-	100.0%	105.5%	129.0%	-	-	41.7%	45.9%	162	↑	11.23	32	↑	7.5	87.8%	93.0%	0	0		Reduced RN fill rate due to 32 unfilled shifts and lack of available temporary staff	147,455	144,467	2,988
Cornwallis (M) - NS959	94.5%	124.7%	-	-	91.8%	80.5%	-	-	36.1%	11.3%	52	↑	3.41	3	↗	5.9	37.4%	91.2%	3	0	2	Bed occupancy range between 13-19 throughout the month	80,888	89,777	(8,889)
Culpepper Ward (M) - NS551	95.9%	93.9%	-	-	100.1%	132.3%	-	-	29.4%	20.0%	88	↑	6.03	8	↗	7.6	86.1%	100.0%	0	0	0		112,018	119,118	(7,100)
John Day Respiratory Ward (M) - NT151	87.4%	136.0%	-	-	98.1%	112.9%	-	-	42.6%	51.7%	159	↓	11.08	13	↑	6.4	33.8%	100.0%	5	0	5	Reduced RN fill rate due to 13 unfilled shifts. Increased CSW fill rate to support enhanced care requirements across 12 occasions	132,124	143,886	(11,762)
Intensive Care (M) - NA251	92.6%	95.0%	-	-	92.8%	-	-	-	10.6%	3.4%	53	↑	3.64	4	↗	26.5			0	0	8	Bed occupancy range between 5-8 over the month. Unfilled shifts reported but staffin in line with occupancy	163,371	163,927	(556)
Pye Oliver (Medical) - NK259	87.0%	95.3%	-	-	99.1%	103.2%	-	-	27.8%	52.3%	122	↑	8.25	29	↑	5.7	16.7%	81.8%	6	2	7	1 fall above threshold. Redcued RN fill rate due to lack of available temporary staff across 29 shifts.	116,290	111,607	4,683
Whatman Ward - NK959	87.3%	88.3%	-	100.0%	159.0%	174.2%	-	-	56.5%	42.9%	166	↑	11.56	18	↑	7.3	43.0%	76.5%	6	0	5	Increased fill rate at night due to ward escalation through the month	92,372	116,737	(24,365)
Lord North Ward (M) - NF651	91.8%	105.5%	-	-	99.5%	100.0%	-	-	18.7%	3.3%	34	↓	2.13	8	↘	6.9	No resp	No resp	4	0	4	2 falls above threshold	88,181	101,149	(12,968)
Mercer Ward (M) - NJ251	96.6%	99.0%	-	100.0%	102.6%	109.6%	-	-	26.7%	55.5%	107	↑	7.01	15	↑	6.1	30.4%	100.0%	4	1	0	Ward supported with increased demand for 105 temporary demand witn 15 unfilled across the month.	114,987	115,428	(441)
Edith Cavell (M) - NS459	99.8%	104.8%	-	-	107.5%	138.7%	-	-	25.4%	24.0%	63	↑	4.10	9	↑	5.8	123.3%	86.5%	2	2	6	Increased CSW fill rate to support increased acuity on the ward and enhanced care requirements.	85,229	80,456	4,773
Acute Medical Unit (M) - NG551	86.3%	93.3%	-	-	125.7%	200.0%	-	-	38.8%	37.7%	147	↗	9.60	46	↑	8.2	No resp	No resp	2	0	4	Reduced RN fill rate recorded due vacnacnies and lack of available temporary staff across 46 shifts throughout the month. Increased fill rate at night due to continued escalation throughout the month	117,548	146,849	(29,301)
Ward 22 (TW) - NG232	58.0%	86.9%	-	-	74.8%	105.4%	-	-	31.4%	28.3%	244	↓	14.62	113	↑	9.4	26.7%	100.0%	6	0	7	Reduced RN fill rate due to 113 unfilled shifts across the month. Bed occupancy decreasing gradualy in line with for ward closure.	165,535	133,719	31,816
Coronary Care Unit (TW) - NP301	90.7%	117.8%	-	-	97.0%	-	-	-	31.1%	40.9%	85	↗	4.99	23	↑	10.9	32.4%	100.0%	2	0	3	Increased CSW fill rate to support staffing levels - bed occupancy between 6-8 throughout the month.	70,485	66,954	3,531
Ward 33 (Gynae) (TW) - ND302	92.1%	79.4%	-	-	97.8%	106.5%	-	-	15.2%	8.2%	43	↘	2.60	14	↗	10.5	10.0%	100.0%	3	0	0	Reduction in CSW fill rate due to unfilled shifts and supporting patient escort requirements.	81,468	86,049	(4,581)
Intensive Care (TW) - NA201	108.8%	99.3%	-	-	104.9%	93.5%	-	-	10.6%	4.4%	86	↑	5.73	24	↑	27.8			0	0	2	Escalation supported on 14 days throughout the month	192,375	205,167	(12,792)
Acute Medical Unit (TW) - NA901	70.6%	104.5%	-	100.0%	92.6%	101.0%	-	100.0%	35.1%	43.7%	291	↑	21.14	120	↑	7.8	15.5%	94.3%	13	0	12	7 falls above threshold. Increase demand for RN's but 120 unfilled shifts imapcting on reduction in fill rate	184,569	179,469	5,100
Surgical Assessment Unit (TW) - NE701	89.3%	77.4%	-	-	96.8%	96.8%	-	-	38.5%	4.4%	48	↑	3.34	10	↗	13.2			0	0	0	Ward escalated on 14 occassions across the month. 10 unfilled RN shifts.	61,157	68,073	(6,916)
Ward 32 (Wells Suite) (TW) - PP010	91.2%	93.1%	100.0%	100.0%	116.0%	97.0%	-	-	41.0%	38.0%	137	↑	9.56	29	↑	6.3	5.6%	100.0%	15	0	6	9 falls above threshold. Increased fill rate at night supported by 10x RMN's due to enhanced care needs	120,069	135,207	(15,138)
Ward 10 (TW) - NG130	90.0%	106.5%	-	-	105.3%	114.0%	-	-	44.4%	23.3%	171	↑	10.22	35	↗	6.2	75.9%	98.4%	3	0	3	1 fall above threshold. Enhanced care and RMN requirements during the month across 17 episodes	115,442	130,181	(14,739)
Ward 11 (TW) - NG131	94.5%	115.3%	-	100.0%	102.4%	124.2%	-	-	45.2%	32.6%	187	↑	11.87	42	↑	6.5	7.5%	100.0%	3	0	5	Considered action to alter skill mix and increase CSW fill rate to support staffing levels.	119,514	138,836	(19,322)
Ward 12 (TW) - NG132	77.5%	109.8%	-	100.0%	104.1%	91.1%	-	-	42.7%	32.2%	157	↓	10.31	50	↑	12.4	11.7%	100.0%	7	2	7	1 fall above threshold	127,510	126,984	526
Ward 20 (TW) - NG230	86.0%	98.2%	-	-	95.6%	124.5%	-	-	37.9%	26.3%	114	↘	8.05	20	↗	5.4	No resp	No resp	10	0		3 falls above threshold. Increased CSW fill rate at night to support enhanced care requirements throughout the month. Reduced RN fill rate with lack of available temporary staff.	112,116	112,070	46
Ward 21 (TW) - NG231	88.9%	104.5%	-	100.0%	95.5%	111.3%	-	-	23.5%	53.5%	123	↓	7.89	33	↘	6.1	4.7%	100.0%	11	2	10	5 falls above threshold Skill mix adjustment throughout the month to support staffing levels. 33 unfilled RN shifts.	143,977	124,752	19,225
Ward 2 (TW) - NG442	85.6%	90.9%	-	100.0%	98.9%	103.4%	-	-	29.9%	39.4%	125	↓	8.80	29	↑	6.7	51.6%	90.9%	20	0	5	13 falls above threshold. Redcued RN fill rate with 29 unfilled shifts. AFU escalted overnight x1. Enhanced care requirement across 6 occasions.	112,497	115,320	(2,823)
Ward 30 (TW) - NG330	88.6%	83.7%	-	-	103.2%	121.5%	-	-	43.0%	20.3%	155	↑	10.11	36	↗	5.8	No resp	No resp	11	1	15	6 falls above threshold. 36 unfilled RN shifts	118,756	136,938	(18,182)
Ward 31 (TW) - NG331	79.9%	85.7%	-	100.0%	96.8%	94.6%	-	-	43.7%	47.4%	227	↑	14.54	61	↑	6.2	No resp	No resp	6	2		Redcued RN fill rate with 61 unfilled shifts across the month. Impacted by sickness, vacancies and lack of available temporary staff	130,352	144,298	(13,946)
Crowborough Birth Centre (CBC) - NP775	100.2%	90.5%	-	-	96.1%	93.8%	-	-	13.5%	0.0%	28	↑	1.51	1	↗					0			67,938	76,469	(8,531)
Midwifery (multiple rosters)	83.4%	67.6%	-	-	90.4%	81.5%	-	-	15.3%	16.3%	531	↑	30.85	113	↑							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.			
Midwifery Services - Specialist Midwives - NF102	137.3%	-			-	-			0.0%	No hours	No Demand		No Demand	No Demand											
Midwifery MSW (TW)	-	89.6%			-	81.5%			26.2%	0.0%	No Demand		No Demand	No Demand											
Midwifery Services - Delivery Suite - NF102	101.8%	-			92.8%	-			23.5%	33.7%	197		11.90	45											
Midwifery Services - Antenatal Ward - NF102	98.4%	100.0%	-	-	85.8%	-	-	-	26.9%	11.7%	121		7.07	22		20.8	71.4%	93.6%	0	0			683,454	677,992	5,462
Midwifery Services - Management - AY451	58.2%	-			-	-			0.0%	No hours	No Demand		No Demand	No Demand											
Community Midwifery Services - NJ160	80.2%	27.9%			-	-			2.9%	0.0%	38		1.77	3											
Midwifery Services - Antenatal Clinic - NF102	66.4%	82.6%			-	-			2.4%	0.0%	6		0.32	0											
Midwifery Services - Postnatal Ward - NF102	72.5%	56.2%			89.8%	-			27.1%	20.8%	169		9.78	43											
Hedgehog Ward (TW) - ND702	86.5%	54.4%	-	-	94.9%	-	-	-	18.0%	31.0%	175	↑	11.11	36	↑	14.6	0.4%	100.0%	1	0	10	1 fall above threshold. Staff in line with bed occupancy range between 12 - 21 throughout the month. RMN requirements on 5 occasions	199,670	196,916	2,754
Maidstone Birth Centre - NP751	97.7%	95.9%	-	-	97.3%	100.3%	-	-	14.0%	0.0%	21	↘	1.27	1	↘		78.9%	100.0%	0	0			72,548	63,245	9,303
SCBU (TW) - NA102	84.8%	69.1%	-	-	100.7%	-	-	-	14.2%	3.5%	104	↓	5.80	7	↓	11.2				0	6		186,228	181,746	4,482
Short Stay Surgery Unit (M) - NE751	76.7%	84.8%	-	-	93.2%	-	-	-	19.6%	17.2%	31	↘	2.09	3	↘	12.2			1	0	0	1 fall above threshold. Fill rate in line with ward closure on ocassions and.	43,595	42,293	1,302
Short Stay Surgical Unit (TW) - NE901	107.6%	136.4%	-	-	129.5%	212.0%	-	-	65.7%	20.3%	135	↑	8.16	28	↗	7.7			0	0		Increased fill rate to support ward escalation throughout the month across 29 days / nights	81,887	76,749	5,138
Accident & Emergency (M) - NA351	76.1%	114.0%	-	-	96.1%	100.0%	-	-	26.8%	34.3%	259	↑	16.95	70	↑		0.0%	100.0%	2	0		MH - Reduced RN fill rate due to vacancies and lack of available temporary staff with 70 unfilled shifts. TWH- Redcued RN fill rate due to vacancies and lack of available temporary staff across 121 shifts	199,253	203,589	(4,336)
Accident & Emergency (TW) - NA301	76.7%	72.2%	-	100.0%	90.7%	91.6%	-	100.0%	38.9%	50.8%	482	↑	33.79	121	↑		19.8%	88.1%	1	0			338,994	337,512	1,482
Maidstone Orthopaedic Unit (M) - NP951	74.0%	79.6%	-	-	92.6%	-	-	-	41.4%	36.9%	92	↑	6.18	24	↑	12.6			1	0	3	1 fall above threshold. Reduced fill rate due to a combination of lack of available temporary staff across 24 shifts. Ward closed on BH. Staff moves to support safe staffing .	43,693	41,219	2,474
Peale Ward (M) - NE959	99.3%	118.2%	-	-	99.9%	96.8%	-	-	14.7%	10.0%	45	↑	2.83	8	↑	8.0	1.1%	100.0%	0	0	7	bed occupancy fluctates between 8-13 throughout the month. CSW supported ward clerk duties on 3 days	81,233	77,692	3,541
																						Total Established Wards	**5,104,778**	**5,212,837**	**(108,059)**
																						Additional Capacity beds Cath Labs	40,411	42,605	(2,194)
																						Whatman	0	802	(802)
																						Other associated nursing costs	2,965,081	2,987,581	(22,500)
																							8,110,270	**8,243,825**	**(133,555)**

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%

RAG Key

↓ Reduction of greater than 5

↑ Increase of greater than 5

↗→ Remains equal to Or less than a difference of 5

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 Nurses/Midwives		Non-registered Nurses/Midwives		Registered Nursing Associates		Non-registered Nursing Associates		Registered Nurses/Midwives		Non-registered Nurses/Midwives		Registered Nursing Associates		Non-registered Nursing Associates		Average fill rate - registered nurses/ midwives (%)	Average fill rate - non-registered nurses/midwives staff (%)	Average fill rate - Registered nursing associates (%)	Average fill rate - trainee nursing associates (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - nursing associates (%)	Average fill rate - trainee nursing associates (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
	Specialty 1	Specialty 2	Total monthly	Total monthly	Total monthly	Total monthly	Total monthly	Total monthly	Total monthly	Total monthly	Total monthly	Total monthly	Total monthly	Total monthly	Total monthly	Total monthly	Total monthly	Total monthly												
Acute Stroke	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	1,982	1,686	1,619	1,393	0	0	108	108	1,397	1,474	682	880	0	0	0	0	85.1%	86.0%	No data	100.0%	105.5%	129.0%	No data	No data				
Cornwallis	100 - GENERAL SURGERY	101 - UROLOGY	910	859	885	1,104	0	0	0	0	1,108	1,018	341	275	0	0	0	0	94.5%	124.7%	No data	No data	91.8%	80.5%	No data	No data				
Culpepper (incl CCU)	320 - CARDIOLOGY	300 - GENERAL MEDICINE	1,573	1,508	1,119	1,051	0	0	0	0	1,351	1,352	341	451	0	0	0	0	95.9%	93.9%	No data	No data	100.1%	132.3%	No data	No data				
John Day	340 - RESPIRATORY MEDICINE	300 - GENERAL MEDICINE	2,269	1,983	1,208	1,642	0	0	0	0	1,706	1,673	682	770	0	0	0	0	87.4%	136.0%	No data	No data	98.1%	112.9%	No data	No data				
Intensive Treatment Unit (ITU)	192 - CRITICAL CARE MEDICINE		3,217	2,979	195	185	0	0	0	0	2,880	2,671	0	23	0	0	0	0	92.6%	95.0%	No data	No data	92.8%	No data	No data	No data				
Pye Oliver	301 - GASTRODENTEROLOGY	300 - GENERAL MEDICINE	1,586	1,380	1,527	1,456	0	0	0	0	1,023	1,014	1,022	1,055	0	0	0	0	87.0%	95.3%	No data	No data	99.1%	103.2%	No data	No data				
Chaucer	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	No data	No data	No data	No data	No data	No data	No data	No data				
Lord North	370 - MEDICAL ONCOLOGY	800 - CLINICAL ONCOLOGY	1,772	1,627	660	696	0	0	0	0	1,112	1,106	372	372	0	0	0	0	91.8%	105.5%	No data	No data	99.5%	100.0%	No data	No data				
Mercer	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1,622	1,567	1,410	1,396	0	0	119	119	1,023	1,050	681	746	0	0	0	0	96.6%	99.0%	No data	100.0%	102.6%	109.6%	No data	No data				
Edith Cavel	300 - GENERAL MEDICINE		1,329	1,326	976	1,023	0	0	0	0	1,023	1,100	341	473	0	0	0	0	99.8%	104.8%	No data	No data	107.5%	138.7%	No data	No data				
Urgent Medical Ambulatory Unit (UMAU)	180 - ACCIDENT & EMERGENCY	300 - GENERAL MEDICINE	2,301	1,985	1,344	1,253	0	0	0	0	1,023	1,286	341	682	0	0	0	0	86.3%	93.3%	No data	No data	125.7%	200.0%	No data	No data				
Stroke/Ward 22	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	2,471	1,434	1,926	1,674	0	0	0	0	1,705	1,276	1,023	1,078	0	0	0	0	58.0%	86.9%	No data	No data	74.8%	105.4%	No data	No data				
Cornary Care Unit (CCU)	320 - CARDIOLOGY	300 - GENERAL MEDICINE	1,216	1,103	359	422	0	0	0	0	1,023	992	0	33	0	0	0	0	90.7%	117.8%	No data	No data	97.0%	No data	No data	No data				
Gynaecology/Ward 33	502 - GYNAECOLOGY	100 - GENERAL SURGERY	1,543	1,420	630	500	0	0	0	0	1,023	1,001	341	363	0	0	0	0	92.1%	79.4%	No data	No data	97.8%	106.5%	No data	No data				
Intensive Treatment Unit (ITU)	192 - CRITICAL CARE MEDICINE		3,414	3,716	376	373	0	0	0	0	2,727	2,860	339	317	0	0	0	0	108.8%	99.3%	No data	No data	104.9%	93.5%	No data	No data				
Medical Assessment Unit	180 - ACCIDENT & EMERGENCY	300 - GENERAL MEDICINE	3,390	2,393	1,289	1,347	0	0	288	288	2,137	1,978	1,058	1,069	0	0	12	12	70.6%	104.5%	No data	100.0%	92.6%	101.0%	No data	100.0%				
SAU	180 - ACCIDENT & EMERGENCY	100 - GENERAL SURGERY	1,124	1,004	372	288	0	0	0	0	682	660	341	330	0	0	0	0	89.3%	77.4%	No data	No data	96.8%	96.8%	No data	No data				
Ward 32	300 - GENERAL MEDICINE		1,646	1,501	1,723	1,603	24	24	108	108	1,023	1,187	1,364	1,323	0	0	0	0	91.2%	93.1%	100.0%	100.0%	116.0%	97.0%	No data	No data				
Ward 10	100 - GENERAL SURGERY		2,138	1,925	1,494	1,591	0	0	0	0	1,023	1,078	1,023	1,166	0	0	0	0	90.0%	106.5%	No data	No data	105.3%	114.0%	No data	No data				
Ward 11	100 - GENERAL SURGERY		2,296	2,169	1,347	1,552	0	0	20	20	1,364	1,397	682	847	0	0	0	0	94.5%	115.3%	No data	100.0%	102.4%	124.2%	No data	No data				
Ward 12	320 - CARDIOLOGY	301 - GASTROENTEROLOGY	2,013	1,559	1,222	1,342	0	0	96	96	1,023	1,065	1,364	1,243	0	0	0	0	77.5%	109.8%	No data	100.0%	104.1%	91.1%	No data	No data				
Ward 20	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1,271	1,092	1,653	1,623	0	0	0	0	1,023	978	1,023	1,274	0	0	0	0	86.0%	98.2%	No data	No data	95.6%	124.5%	No data	No data				
Ward 21	340 - RESPIRATORY MEDICINE	302 - ENDOCRINOLOGY	2,265	2,014	1,035	1,082	0	0	102	102	1,705	1,628	682	759	0	0	0	0	88.9%	104.5%	No data	100.0%	95.5%	111.3%	No data	No data				
Ward 2	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1,906	1,632	1,641	1,492	0	0	114	114	1,023	1,012	1,022	1,056	0	0	0	0	85.6%	90.9%	No data	100.0%	98.9%	103.4%	No data	No data				
Ward 30	110 - TRAUMA & ORTHOPAEDICS		2,096	1,856	1,395	1,167	0	0	0	0	1,022	1,055	1,023	1,243	0	0	0	0	88.6%	83.7%	No data	No data	103.2%	121.5%	No data	No data				
Ward 31	110 - TRAUMA & ORTHOPAEDICS		2,248	1,796	1,637	1,403	0	0	188	188	1,364	1,320	1,023	968	0	0	0	0	79.9%	85.7%	No data	100.0%	96.8%	94.6%	No data	No data				
Birth Centre (Crowborough).	501 - OBSTETRICS		826	827	357	323	0	0	0	0	737	708	357	335	0	0	0	0	100.2%	90.5%	No data	No data	96.1%	93.8%	No data	No data				
Midwifery Services (ante/post natal & Delivery Suite)	501 - OBSTETRICS		21,605	18,011	5,635	3,809	0	0	0	0	5,663	5,120	2,333	1,902	0	0	0	0	83.4%	67.6%	No data	No data	90.4%	81.5%	No data	No data				
Hedgehog	420 - PAEDIATRICS		5,366	4,640	615	335	0	0	0	0	2,359	2,239	0	0	0	0	0	0	86.5%	54.4%	No data	No data	94.9%	No data	No data	No data				
Birth Centre	501 - OBSTETRICS		836	817	379	363	0	0	0	0	677	659	355	356	0	0	0	0	97.7%	95.9%	No data	No data	97.3%	100.3%	No data	No data				
Neonatal Unit	420 - PAEDIATRICS		4,198	3,559	165	114	0	0	0	0	2,398	2,414	0	0	0	0	0	0	84.8%	69.1%	No data	No data	100.7%	No data	No data	No data				
MSSU	100 - GENERAL SURGERY		1,197	918	579	491	0	0	0	0	484	451	0	33	0	0	0	0	76.7%	84.8%	No data	No data	93.2%	No data	No data	No data				
Peale	100 - GENERAL SURGERY		1,233	1,224	702	830	0	0	0	0	682	682	341	330	0	0	0	0	99.3%	118.2%	No data	No data	99.9%	96.8%	No data	No data				
SSSU	100 - GENERAL SURGERY		1,318	1,418	528	720	0	0	0	0	484	627	242	513	0	0	0	0	107.6%	136.4%	No data	No data	129.5%	212.0%	No data	No data				
Whatman	300 - GENERAL MEDICINE		1,959	1,711	1,392	1,230	0	0	72	72	682	1,085	341	594	0	0	0	0	87.3%	88.3%	No data	100.0%	159.0%	174.2%	No data	No data				
			88,129	76,636	39,387	36,869					47,676	47,211	21,078	22,856																
			0	0	0	0					0	0	0	0																

Maidstone and Tunbridge Wells NHS Trust

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST
Women's and Children's
Perinatal Mortality Review Tool (PMRT) report
September 2019

Main author: Rachel Thomas, Deputy Head of Midwifery and Gynaecology

Division: Women's and Children's

Specialty: Maternity

Requirement for document: (*Why is this document necessary?*)	• Provide assurance that the service is meeting the requirement to report all eligible cases and review cases using the tool • Assure the board that relevant key indicators in the CNST incentive scheme is being met
Cross References / Associated Documents:	This report is in response to key clinical audit requirements as set by MBRRACE This report is supported by the maternity services commitment to investigating all cases of stillbirth over 22 weeks

1. Introduction

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

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

The tool supports:

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

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

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

2. Process

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

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

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

3. Eligible cases

The Trust has been required to report all perinatal deaths on the online database and review the care given using the Perinatal Mortality review tool from 12th December 2018. The maternity service started using the tool from January 2018.

There are currently 11 cases that fit the criteria to be reviewed using the PMRT model that will be included in the CNST incentive programme (assessed up to the 15th August 2019). Since the 15th August there have been 4 cases for review using the Perinatal Mortality Review tool.

Date	Case type	SI declared	RCA	On PMRT	Report completed Within 4 months of the death	Parents informed and consented to investigation
02/1/19	25 Stillbirth	No	No	Yes	PMRT tool completed but not within timeframe	Yes
30/1/19	Term IUD	Yes	Yes	Yes	PMRT tool completed Yes	Yes
22/2/19	26+6 IUD	No	No	Yes	PMRT tool completed Yes	Yes
30/4/19	Term IUD at home	Yes	Yes	Yes	PMRT tool completed Yes	Yes
30/4/19	Term IUD reduced FM	Yes	Yes	Yes	PMRT tool completed Yes	Yes
01/5/19	22+1 NND	No	No	Yes	PMRT tool completed Yes	Yes
28/5/19	IUD 25+1	No	No	Yes	PMRT tool completed Yes	Yes
30/5/19	IUD at 27w mother with severe morbidity	Yes	Yes	Yes	Unable to be completed until SI is complete	Yes
13/6/19	36w IUD	No	Yes	Yes	PMRT tool completed Yes	Yes
25/07/2019	22 IUD	No	No	Yes	PMRT tool completed Yes	Yes
5/8/2019	27+4 IUD	No	No	No		TBC
28/08/2019	38+1 IUD	Yes	Yes	Yes		Yes
10/09/2019	38+0 IUD	No	Yes	Yes		yes
12/09/2019	31+1 IUD	No	Yes	No		yes
17/09/2019	34+2 IUD	No	Yes	No		yes

the shaded rows represent cases that have been completed

4. **Progress against inputting data**

We have 11 cases that are eligible for PMRT review. 9 cases have been completed, 8 within the 4 month timeframe with one case in progress and another recently notified. Monthly meetings on the Tuesday of the second week continue.

5. Learning from cases

Learning	Action
To ensure that IOL is offered on the third episode of Reduced Fetal Movements	Communicate to Triage staff that Reduced Fetal movements must be recorded even though it may not be the primary reason for attending.
Referrals for scans and/or further investigations were not undertaken when required	There was some confusion by the community midwife as to whether mother was on a serial scan pathway or fundal height measurement pathway. Feedback has been given to the midwife.
A mother had pregnancy complications recognised as requiring specific birth planning advice but the advice wasn't given	Communication around birth place planning for when antibody levels are detected was not consistent. This had no impact on the outcome but the SOP says that 0.2 or above needs to be delivered in an obstetric centre. Women need to be referred to consultants for discussion if women want to deliver at the birth centre but are not suitable on the birth place assessment. Send memo to community midwives and birth centre staff.
The mother presented with reduced fetal movements and there is no evidence that during her antenatal care she had been given written information about what to do if she experienced a change in fetal movements	Communication to all community and antenatal staff to ensure that written information is given to all women at booking and documented. Documentation of fetal movements discussion at every subsequent antenatal appointment
The mother had a malpresentation breech or transverse lie during her pregnancy which was not managed according to national or local guidelines	Ensure midwives are clear that malpresentation at 36w requires an obstetric review.
Gap & Grow guidance for antenatal scanning not always followed as per guidance	Ensure there is clarity amongst all community midwives regarding timing of scans for women on the Gap and Grow pathway. Recommend the community team reviews GAP Grow guideline and ensures that their techniques meet best practice guidance Attendance at face to face Gap & Grow teaching sessions for all community midwives. Frequency of face to face sessions to be agreed with lead Gap & Grow midwives and obstetrician There is also the opportunity for E learning

Learning	Action
Adequate documentation of review of ultrasound scans.	If ultrasound scans are carried out for women thought to have underlying risk factors then there needs to be clear documented evidence that there has been reviewed and any appropriate action taken. Community midwives are to ensure that there is documented evidence that scan results have been reviewed either by themselves if normal or appropriate obstetric referral if necessary.
Apparent capacity issues in obstetric antenatal clinics and lack of clarity amongst midwives over how to escalate this if necessary	Review of process followed to obtain antenatal clinic review appointments Review of agreed process of escalation if difficulty experienced by community midwife in obtaining obstetric review appointment. Involvement of assistant General Manager in this review
No actual documentation that fetal movements were discussed during first telephone call to Triage. Identified that workload within this clinical area may have impacted on this omission in documentation	Highlight amongst all staff the importance of accurate recording of all aspects of telephone conversations on E3 systems. Review of workload on Triage is already ongoing A review of Triage workload is already underway as a Task and Finish group as this area is often extremely busy, receiving 8000 calls per month. Processes and staffing within this area is undergoing review.
Distress caused by having to wait until following morning for repeat scan when this was unnecessary	Ensure all medical staff and senior midwifery staff are aware that this is not part of the process if an IUD has already been confirmed. Particularly important out of normal working hours Clear communication of process to medical staff and senior midwives.

6. Summary

The maternity service at Maidstone Tunbridge Wells NHS Trust aims to embed the use of the PMRT tool into the risk process as standard. The requirement by CNST incentive scheme mandates that all eligible cases from December 2018 should be inputted on the database within 4 months of each death. 50% of the cases need to be complete within 4 months of the death. Up to the 15th August, of the 11 cases reported, 8 were completed within the four month timeframe which equates to 73%.

Review of Board Assurance Framework (BAF) 2019/20 **Trust Secretary**

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

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

Objectives for 2019/20, and summary of year-to-date position

The objectives in the BAF were approved by the Trust Board on 23/05/19. The latest summary rating of the 12 objectives from the person responsible for empowering our staff (in terms of the confidence of achievement by year-end is as follows):

Objective (measure of success)	Confidence[2]
1. Reduce our falls rate while in hospital to 6 per 1'000 bed days	Amber
2. Reduce E. coli blood stream infections to 21.5 per 100'000 bed days by March 2020	Amber
3. Improve complaints performance to 75% across all divisions and directorates by March 2020	Amber
4. Improve our vacancy rate to 9% by March 2020	Amber
5. Achieve staff engagement score of ≥ 7.2 within 2019/20	Amber
6. Establish functioning Digestive Diseases Unit by October 2019	Red
7. Build new AMU to enable a new Hyper Acute Stroke Unit (HASU) by winter 2019	Green
8. Ensure that 85% or more of cancer patients are treated within 62 days	Amber
9. Ensure that 86.7% or more of patients wait no longer than 18 weeks from referral to treatment	Green
10. Ensure that 91.67% or more of people presenting to our Accident and Emergency Departments wait no longer than 4 hours	Green
11. Deliver a surplus of £6.9m in 2019/20 so that we can invest back into patient care	Green
12. Ensure that our Hospital Standardised Mortality Ratio (HSMR) is <100	Green

Review by the Trust Board

This is the second time during 2019/20 that the Trust Board has seen the populated BAF. Trust Board members are asked to review and critique the content, by considering the following prompts:

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

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

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

Review by other forums

The full BAF was reviewed at the Executive Team Meeting on 06/08/19 and by the Audit and Governance Committee on 07/08/19 (it had previously been agreed, following a request by the Audit and Governance Committee, that the BAF should be considered by that Committee before being submitted to the Trust Board). The BAF entries for objectives 8 to 11 will be reviewed by the Finance and Performance Committee on 24/09/19.

[1] HM Treasury: Assurance frameworks

[2] This is the confidence of the person responsible for empowering our staff that the objective will be achieved by the end of 2019/20

In July 2018, the Board considered whether the other Board sub-committees should review the relevant objectives of the BAF and it was agreed that this was not necessary, as the Workforce and Quality Committees already reviewed the objectives as part of their routine business.

Additional aspects relating to the Risk Register

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

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting, 06/08/19
- Audit and Governance Committee, 07/08/19
- Finance and Performance Committee (objectives 8 to 11), 24/09/19

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

Review and discussion (taking into account the prompts listed on page 1)

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

Board Assurance Framework 2019/20

NHS Maidstone and Tunbridge Wells NHS Trust

PRIDE value/s Patient First ☒ Respect ☐ Innovation ☐ Delivery ☐ Excellence ☐

How will we deliver on this value in 2019/20?
We will embed a culture of safety improvement that reduces harm and enhances patient experience. We will actively seek out the views of patients, relatives and visitors and use this to improve the care we provide

What will success look like?
We will reduce the number of patients experiencing a fall while in hospital

Objective (measure of success) *Objective*

1 Reduce our falls rate while in hospital to 6 per 1,000 bed days

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

1. Increased demand and escalation of beds resulting in patients nursed in inappropriate areas.
2. Staffing; vacancies, unfilled shifts
3. Staff training on falls prevention and associated equipment

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

a. Revised pathways of care and improved patient flow (1)
b. Recruitment strategy: overseas and open days (2)
c. All patient facing staff have access to falls prevention training (3)
d. Falls prevention is a Commissioning for Quality and Innovation (CQUIN) target for 2019/20 (which is raising awareness of falls prevention) (3)
e. September in Falls Awareness Month, so actions are planned during that month (3)

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

1. Continuous monitoring of incidents to identify themes and trends and implement learning.
2. KPIs for Falls report to the divisional dashboards
3. Monthly performance report submitted to Trust Board

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

If "No", what other data is needed?

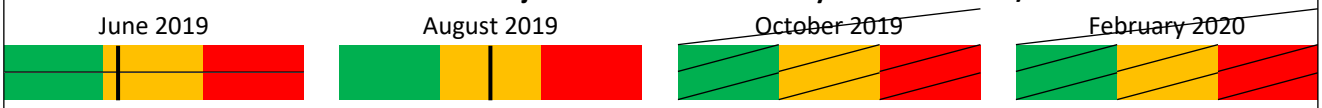
Does specific assurance exist on the data quality of the performance information? Yes ☒ No ☐

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

Person responsible for empowering our staff: Chief Nurse

Confidence that the objective will be achieved by the end of 2019/20[4]

June 2019 | August 2019 | October 2019 | February 2020



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

- The year to date rate (at the end of June 2019) is 6.24 per 1,000 occupied bed days
- Once the staffing fill rates have improved and the staff training is made mandatory (which is currently being discussed), the confidence rating will improve

[4] This is the confidence of the person responsible for empowering our staff that the objective will be achieved by the end of 2019/20. "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2019/20

NHS Maidstone and Tunbridge Wells NHS Trust

PRIDE value/s Patient First ☒ Respect ☐ Innovation ☐ Delivery ☐ Excellence ☐

How will we deliver on this value in 2019/20?
We will embed a culture of safety improvement that reduces harm and enhances patient experience. We will actively seek out the views of patients, relatives and visitors and use this to improve the care we provide

What will success look like?
We will reduce the number of patients acquiring an E. coli infection while in hospital

Objective (measure of success) *Objective*
2 Reduce E. coli bloodstream infections to 21.5 per 100,000 bed days by March 2020

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

1. A national heatwave causing an increased risk of dehydration and subsequent increase risk of Urinary Tract Infections (UTIs)
2. Non-compliance with antibiotic therapy for UTIs
3. Urinary catheters being inserted inappropriately and managed incorrectly
4. Non-compliance with antibiotic therapy for Endoscopic Retrograde Cholangiopancreatographies (ERCPs)
5. Poor compliance with Infection Prevention & control precautions

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

a. A hydration project has been introduced Trust-wide, to ensure that patients drink enough fluid to reduce the number of UTIs (1)
b. UTI Commissioning for Quality and Innovation (CQUIN) target being supported by the Infection Prevention and Control (IPC) Team reviewing antimicrobial prescribing for UTIs (2)
c. Root Cause Analysis (RCA) investigations are undertaken on E.coli bacteraemia related to catheters and ERCPs to identify any lapses in care for shared learning (2, 4)
d. Audit of compliance with the HOUDINI[5] protocol and catheter related UTIs with actions identified to improve documentation & reason for insertion (3)
e. UTI reduction working group to be held, supported by Consultant Urologist (1, 2, 3)
f. Urinary catheter passport re-launched (3)
g. Audit of ERCP prophylaxis completed with action to improve the administration of prophylaxis. Re-audit to be undertaken in 19/20 (4)
h. Mandatory IPC training is provided (face to face training includes hand hygiene training) (5)
i. Triangulation audits are undertaken by the IPC Team (5)
j. Ad hoc training focusing on key issues related to IPC, such as commode cleaning (5)
k. Attendance and participation in the Kent and Medway IPC improvement collaborative (1, 2, 3, 5)
l. 'Focus on' posters for promoting Hydration and avoiding Catheter Associated AUTIs (CAUTIs) / UTIs developed and shared (3)

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

1. Directorate performance reports presented to the Infection Prevention and Control Committee (IPCC) highlighting rates of infection, IPC issues and actions taken within each Directorate
2. Audit reports and action plan are presented to the IPCC and monitored through the governance team
3. Monthly board report from the Director of Infection Prevention and Control (DIPC)

Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*
If "No", what other data is needed? N/A

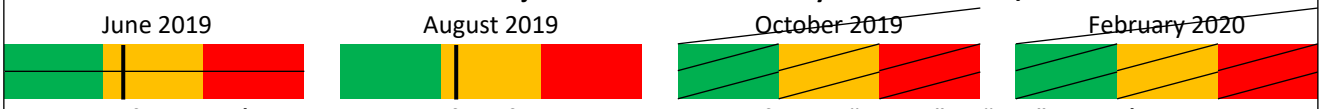
Does specific assurance exist on the data quality of the performance information? Yes ☒ No ☐

Details: E. coli data is reported on the national data capture system (DCS) & by the laboratory through the Telepath IT system. The IPC Team also collects the data which are reported through their ICNet system (which comes via Telepath). All these systems can be accessed in order to validate the data.

Person responsible for empowering our staff: Director of Infection Prevention and Control (DIPC)

Confidence that the objective will be achieved by the end of 2019/20[6]

June 2019 | August 2019 | October 2019 | February 2020



Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):
The causes of E. coli bacteraemia are often multifactorial therefore multiple interventions are required in order to

[5] Haematuria; Obstruction/Retention; Urology surgery; Damaged skin; Input/output, fluid monitoring; Nursing care end of life/comfort care; Immobility

[6] This is the confidence of the person responsible for empowering our staff that the objective will be achieved by the end of 2019/20. "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

have an impact on the rate. In keeping with the national picture our data shows that 50% of cases are related to the urinary tract therefore this is the main focus for interventions. Further planned actions include:

- Raising awareness on the wards of when to dip / not to dip and advising not to use this as an indicator to treat UTIs
- Promote improved antimicrobial prescribing in line with the Trust policy for treatment of UTIs – following the finding of the UTI CQUIN
- Cholecystitis pathway to be reviewed to ensure consistent antimicrobial prescribing
- Re-audit of prescribing prophylaxis antibiotics for ERCPs
- Continue to promote the urinary catheter passport and monitor use

Board Assurance Framework 2019/20

NHS Maidstone and Tunbridge Wells NHS Trust

PRIDE value/s Patient First ☒ Respect ☐ Innovation ☐ Delivery ☐ Excellence ☐

How will we deliver on this value in 2019/20?
We will embed a culture of safety improvement that reduces harm and enhances patient experience. We will actively seek out the views of patients, relatives and visitors and use this to improve the care we provide

What will success look like?
We will respond to complaints in a timely and consistent manner

Objective (measure of success) *Objective*
3 Improve complaints performance to 75% across all divisions and directorates by March 2020

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

1. Divisional performance failure to respond to complaints in a timely manner
2. Resource within complaints team
3. IT issues - age of computers (slow to respond)
4. Transition to Datix IQ Cloud, potential issues with functionality
5. Capital allocation for room expansion to be able to accommodate additional staff & provide computer
6. Serious Incident (SI) process: impact upon complaint response

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

a. Review of timeframes for each step of the complaints process (1)
b. Exception meetings held with Directorate leads by Chief Nurse and Assoc. Dir., Quality Governance (1)
c. Complaints closely monitored at Divisional Performance Reviews (DPRs) and Governance meetings (1)
d. Business Case approved for additional staff member (2)
e. Discussion with IT re timing of replacement of older computers (3)
f. Datix implementation group established to work through introduction of new system (4)
g. Concerns escalated to Executive leads (5)
h. Business Case approved for Patient safety team to improve on timeliness of SI investigations (6)
i. Review of pathway for complaints that are also SIs to identify key responsibilities/actions required (6)
j. Improvement trajectories have been developed for complaints responses that have exceeded the response date, and these trajectories will be monitored with the Divisions

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

1. Monthly Key Performance Indicators (KPIs)
2. Regular reports/updates to Directorates/Divisions
3. Complaints report to Patient Experience Committee

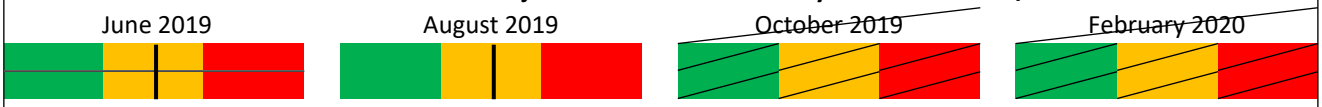
Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*
If "No", what other data is needed? N/A

Does specific assurance exist on the data quality of the performance information? Yes ☐ No ☒
Details: However, reviews undertaken by the Parliamentary and Health Service Ombudsman (PHSO) assure the quality of responses (for the complaints escalated to the PHSO), whilst the Trust also undertakes a complaints satisfaction survey.

Person responsible for empowering our staff: Chief Nurse

Confidence that the objective will be achieved by the end of 2019/20[7]

June 2019 | August 2019 | October 2019 | February 2020



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

- The year to date performance (at the end of June 2019) is 45.7%
- The Job Description for the new staff member is currently being finalised
- There is a lack of capital to provide new computer and the necessary estates work

[7] This is the confidence of the person responsible for empowering our staff that the objective will be achieved by the end of 2019/20. "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2019/20

NHS Maidstone and Tunbridge Wells NHS Trust

PRIDE value/s Patient First ☐ Respect ☒ Innovation ☐ Delivery ☐ Excellence ☐

How will we deliver on this value in 2019/20?
We will make MTW a great place to work and ensure that our staff feel valued and listened to

What will success look like?
We will reduce the number of vacant posts we have in the Trust

Objective (measure of success) *Objective*
4 Improve our vacancy rate to 9% by March 2020

What could prevent this objective being achieved? (including external factors) *Risks to objective*
1. A national shortage of certain staff groups
2. If there was a lack of clarity/focus on the key actions required
3. If there was a lack of capacity from professional groups to be able to support interviewing and professional development support of candidates at scale
4. If there was inefficiency of recruitment processes
5. If there was insufficient focus placed on retaining existing staff
6. If there was uncertainty over the status of vacancies
7. Uncertainty regarding Brexit i.e. the impact on the availability of European recruits

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*
a. The Trust Workforce Strategy 2015-20 and associated workplan ("Recruitment & Retention" is the first of 6 workforce priorities) (1, 2, 3)
b. Agreement of a qualified nurse recruitment plan for 2019/20 (2)
c. The establishment of the Nurse Recruitment and Retention Group (Chaired by the Chief Nurse) (3, 5)
d. Recruitment KPIs derived from the TRAC IT system identify areas where process can be improved (4)
e. New Roles and Apprentices group within the Workforce workstream of the Best Care Programme identifying additional apprenticeship roles within divisions (1)
f. Establishments and workforce requirements have been reviewed and agreed as part of the Business Planning process for 2019/20 (5, 6)
g. HealthRoster KPIs have been implemented in order to report on effective rostering of staff and usage of contractual hours & to challenge poor practice (5, 6)
h. Development of further international recruitment initiatives (7)

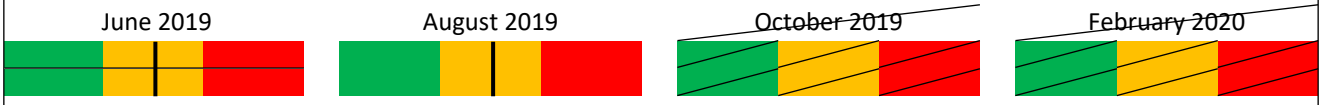
Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*
1. The Trust Performance Dashboard, which contains the "Vacancy Rate (%)" (as well as "Vacancies WTE")
2. Reports to the Workforce Committee (which includes a commentary on the latest issues regarding the vacancy rate)
3. Directorate performance dashboards
4. The 6-monthly review of Ward and non-Ward areas submitted to the Trust Board
5. The monthly Planned and Actual Ward Staffing reports to the Trust Board (re the establishments)
6. The Nursing recruitment plan (which is monitored via the Executive Team Meeting)

Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*
If "No", what other data is needed? N/A

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

Person responsible for empowering our staff: Director of Workforce

Confidence that the objective will be achieved by the end of 2019/20[8]



Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):
- The Trust vacancy rate at the end of June was 13.1%
- This increase is due to the increased establishment arising from Business and Workforce planning and a revised approach to vacancy calculation agreed by the finance and HR teams

[8] This is the confidence of the person responsible for empowering our staff that the objective will be achieved by the end of 2019/20. "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2019/20

PRIDE value/s	Patient First ☐	Respect ☒	Innovation ☐	Delivery ☐	Excellence ☐

How will we deliver on this value in 2019/20?
We will make MTW a great place to work and ensure that our staff feel valued and listened to

What will success look like?
We will improve how involved, motivated and satisfied our staff are

Objective (measure of success) *Objective*
5 Achieve staff engagement score of ≥ 7.2 within 2019/20

What could prevent this objective being achieved? (including external factors) *Risks to objective*
1. Failure to implement local staff engagement plans
2. Insufficient resource to deliver staff amenities programme
3. Lack of visibility of senior leaders on shop floor
4. Insufficient communication of actions and information to staff
5. Insufficient investment in clinical leadership
6. Staff are not empowered to influence or implement service changes

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*
a. All divisions have a staff engagement plan for 2019/20 reviewed within DPRs (1)
b. Trust engagement plan for 2019/20 agreed (1)
c. Executive and divisional leaders to have shop floor engagement identified in appraisal objectives (3)
d. Staff Amenities delivery group in place along with associated plan (2)
e. Retention and Engagement group set up chaired by Director of Workforce (1, 4)
f. Trust 'Thank you ' events (2, 3)
g. Senior leadership programme commissioned (5)
h. 'Exceptional People Outstanding Care' programme agreed by Trust Board (6)
i. The communications programme for the 2019 staff survey will commence in August (4)
j. Staff were provided with free ice creams and lolly ices during the heatwave in July 2019, which included personal delivery by members of the Trust Board (2, 3)

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*
1. National Staff Survey data
2. Divisional Performance reviews
3. Updates to the Workforce Committee
4. Minutes of the Engagement & Retention group

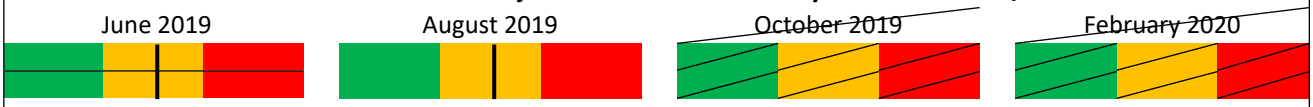
Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*
If "No", what other data is needed?

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

Person responsible for empowering our staff: Director of Workforce

Confidence that the objective will be achieved by the end of 2019/20[9]

June 2019 | August 2019 | October 2019 | February 2020



Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):
- The staff engagement score in the latest national NHS staff survey was 7.0

[9] This is the confidence of the person responsible for empowering our staff that the objective will be achieved by the end of 2019/20. "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2019/20

NHS Maidstone and Tunbridge Wells NHS Trust

PRIDE value/s Patient First ☐ Respect ☐ Innovation ☒ Delivery ☐ Excellence ☐

How will we deliver on this value in 2019/20?
We will continually improve the way we provide our services to ensure that our services meet the needs of the people we serve

What will success look like?
We will optimise the care across our two hospital sites

Objective (measure of success) *Objective*
6 Establish functioning Digestive Diseases Unit by October 2019

What could prevent this objective being achieved? (including external factors) *Risks to objective*
1. Failure to recruit staff in time for October
2. Any delays resulting in an overlap with winter
3. Failure to adequately identify and protect bed space

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*
a. Triangulation with Stroke move to ensure bed availability
b. A mitigation plan to deliver the Unit in March 2020 has been developed in case of failure to identify workforce plan in time to allow for recruitment prior to winter
c. Configuration timeline created with the Deputy Chief Operating Officer and Divisional Director of Operations for Medicine & Emergency Care to ensure that both original and mitigation plans do not affect winter planning
d. Agreement with Chief Operating Officer on a series of measures to protect digestive diseases bed stock

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*
1. Surgical reconfiguration steering group (Chaired by the Clinical Director for General Surgery)

Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*
If "No", what other data is needed? N/A

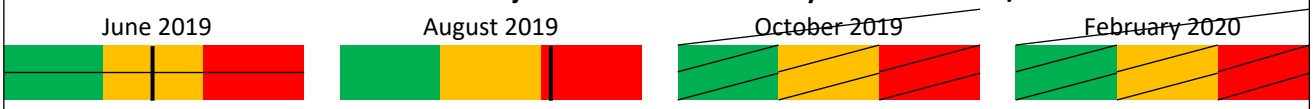
Does specific assurance exist on the data quality of the performance information? Yes ☐ No ☒

Details:

Person responsible for empowering our staff: Director of Strategy, Planning and Partnerships

Confidence that the objective will be achieved by the end of 2019/20[10]

June 2019 | August 2019 | ~~October 2019~~ | ~~February 2020~~



Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):
- It will not be possible to deliver the unit by October 2019 due to recruitment timelines
- As detailed above a mitigation plan is in place to deliver the unit by March 2020 (after the winter period)
- Despite the delay on delivery the service is confident this will be delivered before the end of FY19/20

[10] This is the confidence of the person responsible for empowering our staff that the objective will be achieved by the end of 2019/20. "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2019/20

PRIDE value/s	Patient First ☐	Respect ☐	Innovation ☒	Delivery ☐	Excellence ☐

How will we deliver on this value in 2019/20?
We will continually improve the way we provide our services to ensure that our services meet the needs of the people we serve

What will success look like?
We will work with partners to develop the best possible models of care across the region

Objective (measure of success) *Objective*
7 Build new Acute Medical Unit (AMU) to enable a new Hyper Acute Stroke Unit (HASU) by winter 2019

What could prevent this objective being achieved? (including external factors) *Risks to objective*
1. Capital funding to be released from NHS Improvement (NHSI)

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*
a. Following discussions and the Finance and Performance Committee and Trust Board in May and June 2019, it has been confirmed that the Trust will a hire (revenue-based) arrangement for the modular AMU building, and not a capital purchase.

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*
1. The reports submitted to the May 2019 Finance and Performance Committee and Trust Board ('Part 2') meetings
2. The minutes of the May 2019 Finance and Performance Committee and Trust Board ('Part 2') meetings

Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*
If "No", what other data is needed? N/A

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

Person responsible for empowering our staff: Chief Operating Officer

Confidence that the objective will be achieved by the end of 2019/20[11]

June 2019 | August 2019 | October 2019 | February 2020

Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):
- It has been confirmed that the Trust will a hire (revenue-based) arrangement for the modular AMU building

[11] This is the confidence of the person responsible for empowering our staff that the objective will be achieved by the end of 2019/20. "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2019/20

NHS Maidstone and Tunbridge Wells NHS Trust

PRIDE value/s Patient First ☐ Respect ☐ Innovation ☐ Delivery ☒ Excellence ☐

How will we deliver on this value in 2019/20?
We will treat people in a timely consistent manner making the best possible use of our resources to do so

What will success look like?
We will ensure that our cancer patients receive their treatment as quickly as possible

Objective (measure of success) *Objective*
8 Ensure that 85% or more of cancer patients are treated within 62 days

What could prevent this objective being achieved? (including external factors) *Risks to objective*
1. Oncology capacity shortfall due to workforce shortages.
2. Confirmation of Clinical Commissioning Group (CCG) funding into cancer to ensure we have sustainable plans in place
3. Increased service demand (higher than national average)
4. Pathway issues in Upper GI, Lung, Haematology and Head and Neck
5. Sustainable diagnostic capacity
6. Pension issues impacting additional sessions for clinicians and there flexibility to respond to increased demand

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*
a. Daily Patient Tracking List (PTL) meetings in place with all services
b. Weekly executive performance meeting in place
c. Cancer pathway transformation plan is now in place
d. Further support from NHSI on weekly issues
e. Additional funding currently in place for key services
f. Daily review of performance from executive level
g. A Cancer performance General Manager has been appointed

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*
1. Monthly reports to the Finance and Performance Committee and Trust Board
2. Weekly report to the Executive Team Meeting

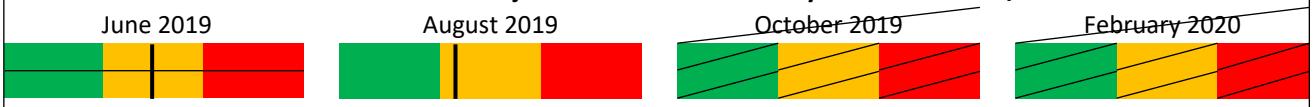
Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*
If "No", what other data is needed? N/A

Does specific assurance exist on the data quality of the performance information? Yes ☒ No ☐
Details: The 2018/19 Internal Audit "Assurance Review of Data Quality of Key Performance Indicators" published in May 2019 reviewed the data relating to the 62-day Cancer waiting time target and gave a conclusion of "Reasonable assurance". The report stated that "The figures reported to the Trust Board for Cancer 62 Day Wait, were found to be accurately reported based on the data available from the source data system"

Person responsible for empowering our staff: Chief Operating Officer

Confidence that the objective will be achieved by the end of 2019/20[12]

June 2019 | August 2019 | October 2019 | February 2020



Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):
- The year to date performance (at the end of May 2019) is 67.6%, but the rate for the month was 70.9%
- The quick progress in reducing the cancer backlog (which is key to hitting the 62-day performance) has been good
- Key capacity issues especially in oncology need to be resolved to be more confident at this point.
- There been a decrease in PTL in the last 6 months, and the backlog is currently (31/07/19) at 65, which is only 25 higher than the backlog considered to be sustainable in terms of delivery of the target (40)

[12] This is the confidence of the person responsible for empowering our staff that the objective will be achieved by the end of 2019/20. "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2019/20

PRIDE value/s	Patient First ☐	Respect ☐	Innovation ☐	Delivery ☒	Excellence ☐

How will we deliver on this value in 2019/20?
We will treat people in a timely consistent manner making the best possible use of our resources to do so

What will success look like?
We will carry out elective treatments as quickly as possible

Objective (measure of success) *Objective*
9 Ensure that 86.7% or more of patients wait no longer than 18 weeks from referral to treatment

What could prevent this objective being achieved? (including external factors) *Risks to objective*
1. RTT data quality programme could impact the total size of the waiting list.
2. CCG funding still relied upon to ensure we can achieve 86.7%.

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*
a. Data quality programme has been set up and is tracking progress on a weekly basis
b. On-going meetings with commissioners to track need for additional funding in place.

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*
1. The monthly reports to the Finance and Performance Committee and Trust Board

Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*
If "No", what other data is needed? N/A

Does specific assurance exist on the data quality of the performance information? Yes ☒ No ☐
Details: The 2018/19 Internal Audit "Assurance Review of Data Quality of Key Performance Indicators" published in May 2019 reviewed the data relating to the 18 Weeks RTT Incomplete Pathway and gave a conclusion of "Reasonable assurance".

Person responsible for empowering our staff: Chief Operating Officer

Confidence that the objective will be achieved by the end of 2019/20[13]

June 2019	August 2019	October 2019	February 2020

Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):
- Year to date performance (at the end of June 2019) is 85.8%.

[13] This is the confidence of the person responsible for empowering our staff that the objective will be achieved by the end of 2019/20. "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2019/20

PRIDE value/s	Patient First ☐	Respect ☐	Innovation ☐	Delivery ☒	Excellence ☐

How will we deliver on this value in 2019/20?
We will treat people in a timely consistent manner making the best possible use of our resources to do so

What will success look like?
We will review and treat patients in our accident and emergency room as quickly as possible

Objective (measure of success) *Objective*

10 Ensure that 91.67% or more of people presenting to our Accident and Emergency Departments wait no longer than 4 hours

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

1. Increased demand on services. For example May was our busiest every month as an organisation
2. Workforce shortages
3. Brexit

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

a. A flow programme is in place to transform same day emergency care (SDEC), Length of Stay (LOS) and out of hospital capacity, with a number of positive results so far (1)
b. Workforce group in place, and is focussing on international recruitment (2)
c. A Retention group is in place to ensure organisation supports current staff and any new ones joining (2)
d. A Brexit programme is in place working through all potential issues of a no-deal Brexit (3)

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

1. The monthly reports to the Finance and Performance Committee and Trust Board

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

If "No", what other data is needed?

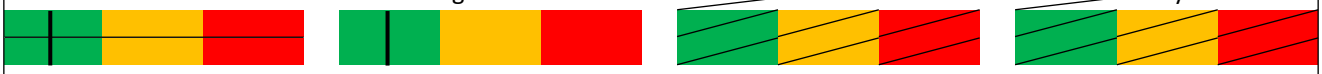
Does specific assurance exist on the data quality of the performance information? Yes ☒ No ☐

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

Person responsible for empowering our staff: Chief Operating Officer

Confidence that the objective will be achieved by the end of 2019/20[14]

June 2019 | August 2019 | October 2019 | February 2020



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

- Year to date performance (at the end of June 2019) is 92.8%, but was 94.5% for the month

[14] This is the confidence of the person responsible for empowering our staff that the objective will be achieved by the end of 2019/20. "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2019/20

PRIDE value/s	Patient First ☐	Respect ☐	Innovation ☐	Delivery ☒	Excellence ☐

How will we deliver on this value in 2019/20?
We will treat people in a timely consistent manner making the best possible use of our resources to do so

What will success look like?
We will spend the taxpayers money wisely to ensure that we can invest as much as possible into patient care

Objective (measure of success) *Objective*

11 Deliver a surplus of £6.9m in 2019/20 so that we can invest back into patient care

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

1. If there was a lack of senior leadership and commitment
2. If there were poor financial controls (or if good controls were poorly applied)
3. If there was a lack of commitment by managers
4. If the Cost Improvement Programme (CIP) schemes were not delivered (regardless of their RAG rating or identified value)
5. If the Trust's plans for 2019/20 had been developed without consideration of best practice elsewhere
6. If there was insufficient engagement with external stakeholders
7. If there is a change in the financial circumstances of commissioners, requiring them to take further action to manage demand
8. If the additional costs to improve Cancer are above the agreed funding
9. If the Trust is unable to access the CCG RTT risk reserve
10. If the upfront costs of overseas recruitment are not recouped through reduced agency by the end of the financial year.
11. If the Private Patient Income does not meet the level expected in the plan.

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

a. The Trust has signed up to its control total, and submitted a plan to achieve this (1)
b. Agreed Directorate budgets have been set (2)
c. A number of 'Grip and Control' measures have been implemented to ensure delivery (1, 2, 5)
d. The Performance Management Framework is now embedded (2, 3)
e. Action has been taken to engage with external stakeholders, including agreeing an Aligned Incentives Contract with West Kent CCG , which now includes Kent Community Health NHS FT (5,6) 6)
f. Delay investment to keep costs within CCG funding (8)
g. If unable to access risk reserve, activity will be limited within contract values (9)
h. The Trust has introduced a Best Care programme which seeks to bring a consistent approach to transformation and improvement across the Trust (1, 3, 4)
i. The 2019/20 CIP will be delivered by directorates, supported by the Best Care Workstreams(1, 3, 4)
j. The Trust has provided External Support to the Divisions to assist identification and delivery of CIP (4)
k. Working with private patient management to understand shortfall and develop recovery plan(11)
l. Monthly variance analysis with Divisions

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

1. The Monthly financial performance reports to the Best Care Programme Board, Finance and Performance Committee and Board
2. Monthly detailed Best Care Programme report to the Finance and Performance C'ttee & Trust Board
3. Monthly Divisional Performance Reviews

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

If "No", what other data is needed?

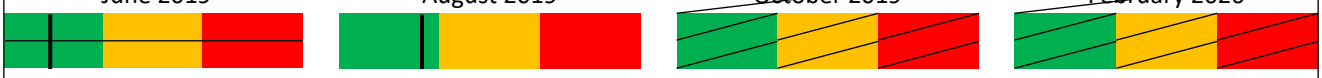
Does specific assurance exist on the data quality of the performance information? Yes ☒ No ☐

Details: The financial position is subject to annual external review via the annual audit of the financial accounts, which is reported to the Audit and Governance Committee and Board each May. In addition internal controls are in place to ensure financial reporting is accurate & complete. This is assured through an Internal Audit process which audits the components of finance reporting & underlying transactions

Person responsible for empowering our staff: Chief Finance Officer

Confidence that the objective will be achieved by the end of 2019/20[15]

June 2019 | August 2019 | October 2019 | February 2020



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

[15] This is the confidence of the person responsible for empowering our staff that the objective will be achieved by the end of 2019/20. "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

- At the end of June 2019, the Trust's deficit including PSF was £1.3m, which was on plan

Board Assurance Framework 2019/20

NHS Maidstone and Tunbridge Wells NHS Trust

PRIDE value/s	Patient First ☐	Respect ☐	Innovation ☐	Delivery ☐	Excellence ☒

How will we deliver on this value in 2019/20?
We will consistently go above and beyond for our patients to deliver the best care possible

What will success look like?
We will ensure that the number of patients that die in our hospital is as low as possible and remains below the level that would be expected

Objective (measure of success) *Objective*
12 Ensure that our Hospital Standardised Mortality Ratio (HSMR) is <100

What could prevent this objective being achieved? (including external factors) *Risks to objective*
1. Failure to recruit Medical Consultants to support the achievement of 7-day services
2. Failure to learn from mortality reviews
3. Weekend-related mortality worsening

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*
a. Business planning – Medicine & Emergency care (1)
b. Review of Medical rotas to enhance 24/7 site cover of services (1)
c. Investment in Datix Mortality Module (2)
d. Close monitoring of crude mortality is undertaken at the Mortality Surveillance Group (MSG)
e. Mortality reports to include shared learning (2)
f. Implementation of Medical Examiner and Medical Examiner Officers roles (2)
g. The MSG is actively monitoring the weekend-related mortality situation (3)

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*
1. Minutes and reports for the MSG
2. HSMR (& Summary Hospital-level Mortality Indicator (SHMI)) data reported the Trust Board
3. The mortality update reports to the 'main' Quality Committee and Trust Board
4. Actions taken by Learning from Deaths working group

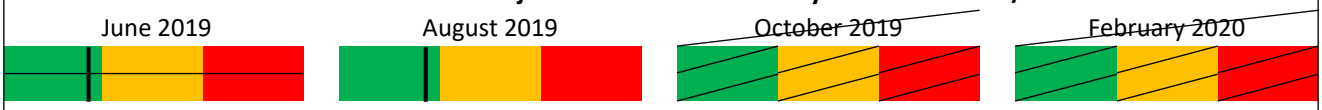
Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*
If "No", what other data is needed?

Does specific assurance exist on the data quality of the performance information? Yes ☒ No ☐
Details: Monthly assurance reports re quality of coding submitted

Person responsible for empowering our staff: Medical Director

Confidence that the objective will be achieved by the end of 2019/20[16]

June 2019 | August 2019 | October 2019 | February 2020



Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):
- The HSMR at the end of June 2019 was 92.7
- The SHMI at the end of June 2019 was also 1.0235 (which is within the expected range)

[16] This is the confidence of the person responsible for empowering our staff that the objective will be achieved by the end of 2019/20. "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

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

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

The latest review of red-rated risks at the Executive Team Meeting took place on 09/07/19, and the majority of those reviewed were rated as valid as submitted, though it was noted that some could be downgraded to amber by the next review. The status of the Risk Register as of 30/07/19 was as follows:

- 15 red-rated risks
- 78 amber-rated risks*
- 2 green-rated risks+

*Recent changes to the Trust risk grading matrix means there are currently seven ‘Amber 15s’ which will become ‘red’ when they are next saved/updated on the system. The Risk and Compliance Manager has asked that these ‘Amber 15s’ be reviewed in line with the newly published risk grading matrix and its associated guidance to confirm their rating.

+The change to the risk grading matrix has also resulted in fewer green-rated and more amber-rated risks.

The issues covered by most of the 15 current red-rated risks should be familiar to the Trust Board and its sub-committees, as these have been previously discussed at the Trust Board, Quality Committee, Finance and Performance Committee and/or Workforce Committee. These issues are as follows:

- Achieving the Cancer waiting time targets
- The cost pressures associated with the use of temporary staff
- Nursing staffing levels in Medicines and Emergency Care
- Medical staffing shortage in Surgery impacting on inability to deliver emergency & elective care
- Risk associated with failing to learn from incidents
- Lack of capacity to assess and treat within clinically recommended timeframes in the general Ophthalmic and Medical Retinal Service
- Increased risk of harm to patients and staff as a result of delays to psychiatric assessment in Emergency Department (ED) and Acute Medical Unit (AMU)
- Shortage of paediatric middle grade doctors on day shifts for paediatrics
- Shortage of radiotherapy therapeutic radiographers and consultant grade oncologists
- The effect of the UK’s EU exit arrangements on the Trust’s ability to carry out its key functions.
- Pathology LIMS (IT) system age and disaster recovery
- Data quality issues within the reporting system for Referral to Treatment (RTT)
- Lapses in service contract for the maintenance of endoscopes
- Risk associated with the age of the Toshiba 64 slice CT scanner

It should also be noted that the last bullet point relates to a red-rated risk that has not yet been validated via Executive Team Meetings (which validates red-rated risks every quarter). It is therefore possible that either the RAG rating and/or the risk score of these risks will be amended at the next validation (in October 2019).

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

NHS
Maidstone and Tunbridge Wells NHS Trust

Quarterly mortality data **Medical Director**

Summary / Key points

This report is submitted in line with guidance from the National Quality Board, March 2017. This stipulates that Trusts are required to collect and publish on a quarterly basis specified information on deaths. This should be through a paper and an agenda item to a public board meeting in each quarter to set out the Trust's policy and approach and publication of the data and learning points. This report also provides an update into the further actions that have subsequently been taken to understand and improve our Trust position, as a previous outlier, in regard to the Hospital Standardised Mortality Ratio (HSMR).

This report is based upon the Trust's most recent data, published by Dr Foster for the period of June 2018 – May 2019.

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

Information, assurance and discussion.

Mortality Surveillance Report

HSMR Current Performance

The standard HSMR calculation uses a 12 month rolling view of our performance. The latest results of this are shown below in Fig. 1. The 12 months June 2018 to May 2019 show our HSMR to be 91.5, which is a decrease compared to last month's position of 93.4.

Figure 1. Rolling 12 Month view

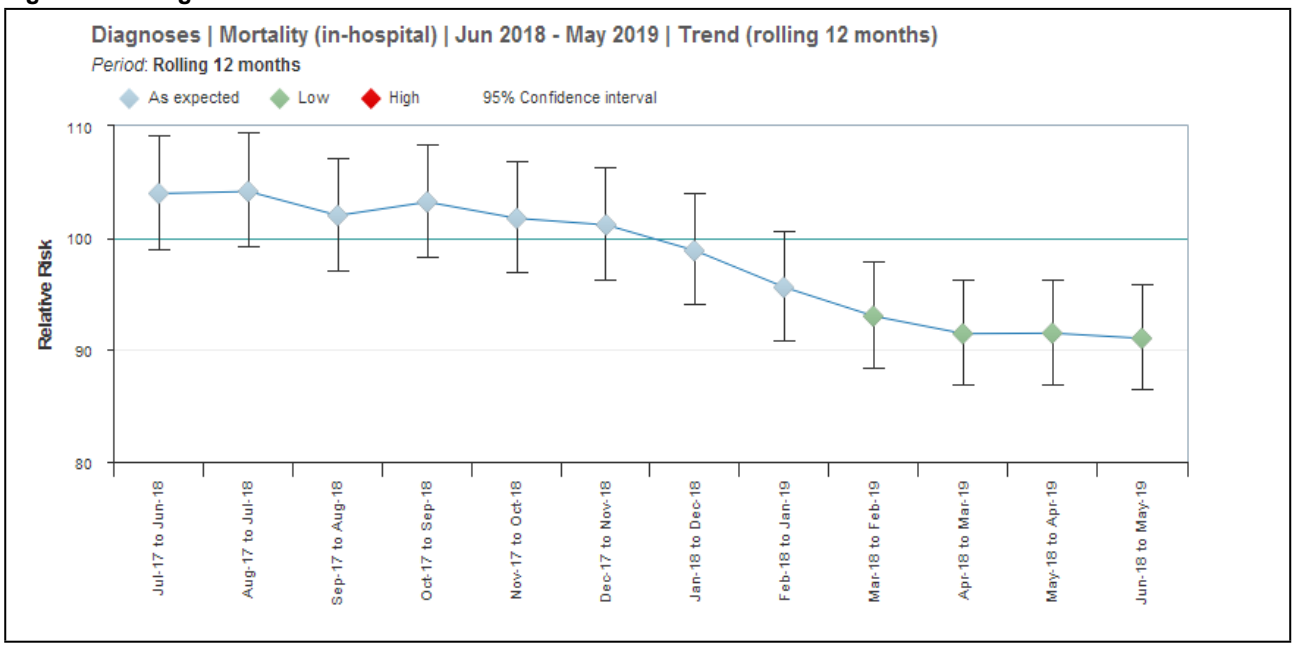
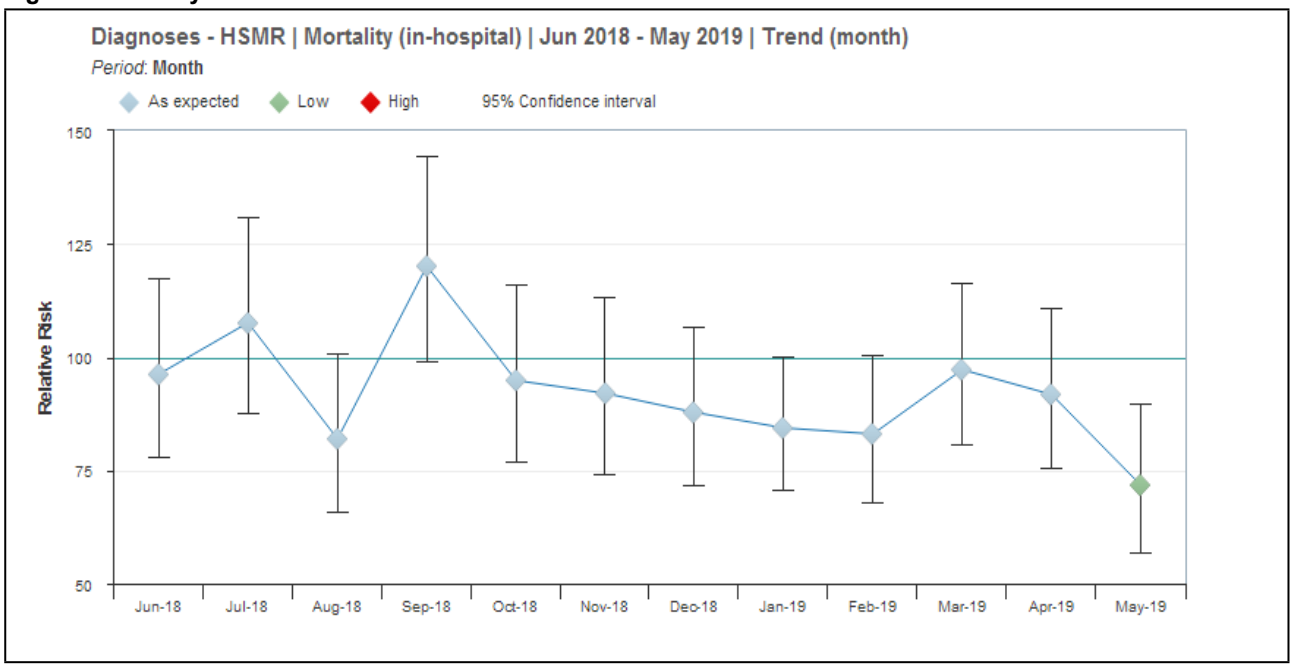


Figure 2 shows a monthly view of our HSMR performance. The latest month should be viewed with caution as this often shows a false position due to the lag in coding activity. Viewing the previous month, so April 2019 in this case, shows that the Trust's position has decreased to 91.8 from 97.2 in March 2019.

Figure 2. Monthly view



Benchmarking

Dr Foster enables us to benchmark our performance against our peers. There are various peer groups available e.g. GIRFT and Carter groups. Fig. 3 shows that the Trust is no longer a major outlier against this group.

Figure 3. Benchmarking against all non-specialist trusts (June 2018 – May 2019)

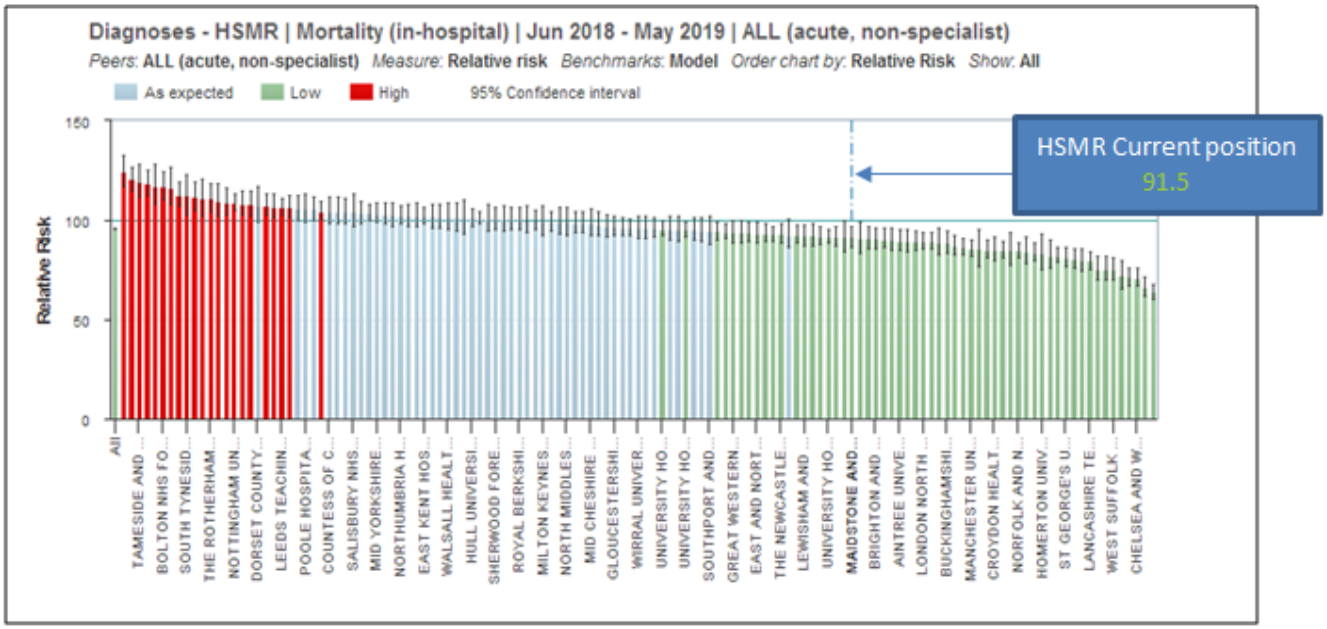
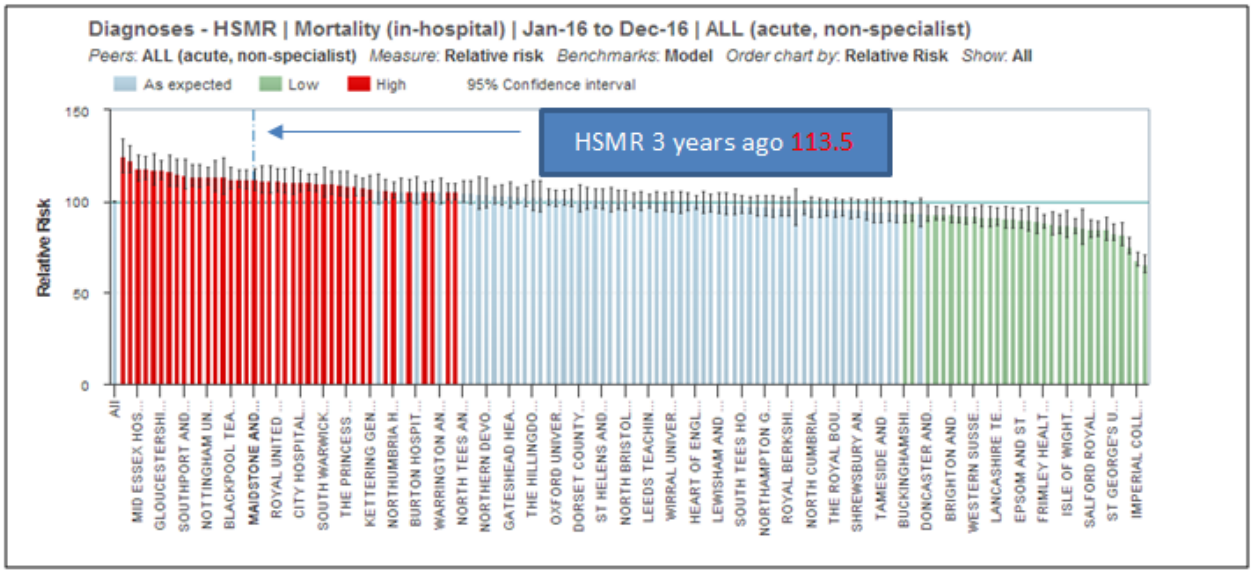


Figure 4. Benchmarking against all non-specialist trusts (January - December 2018)

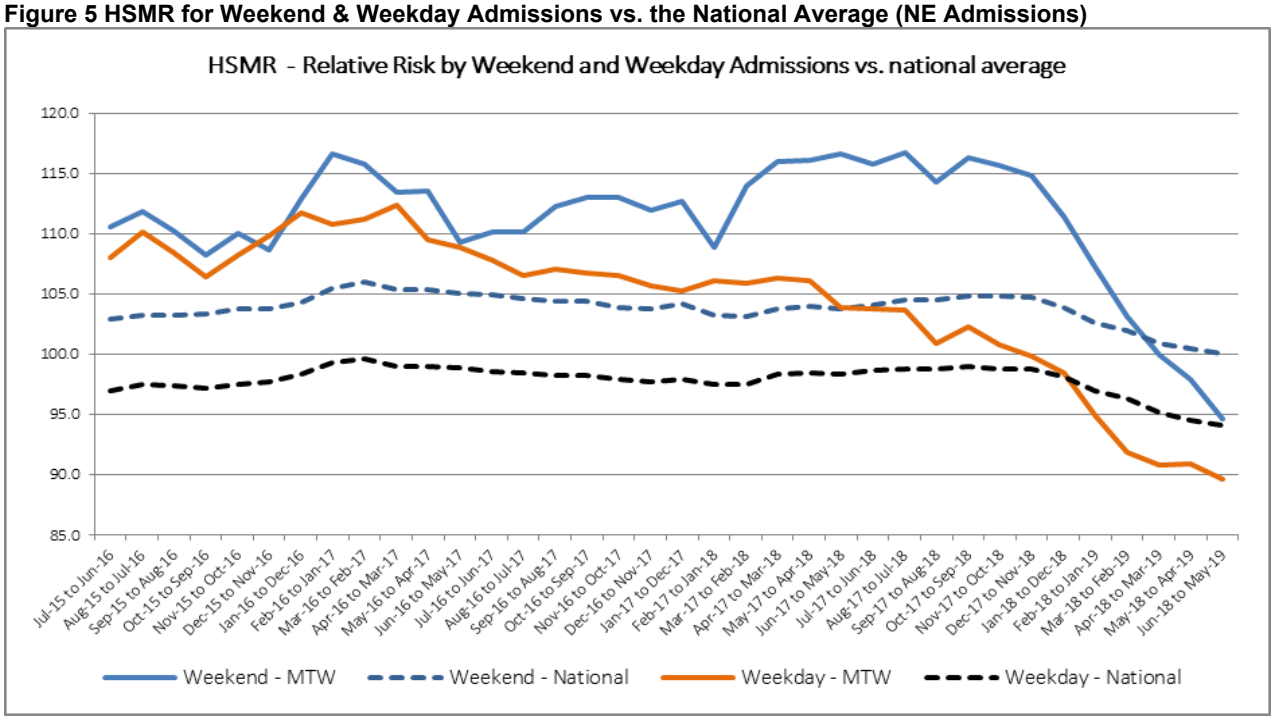


Understanding and Improving upon HSMR

It is evident from figures 1 – 4 that the Trust has made a sustainable reduction in our HSMR and are now in a much better position amongst our peers, having moved from a position of high relative risk to low relative risk has been the main objective of the Mortality Surveillance Group (MSG) during 2018/19 and now 2019/20.

A further concern that has become evident to the MSG has been in regard to an anomaly between the relative risk of mortality between weekday and weekend admissions. With the support of our Business Intelligence team and Dr Foster further analysis has been undertaken which is evidencing a gradual improvement since January – December 2018.

Figure 5 HSMR for Weekend & Weekday Admissions vs. the National Average (NE Admissions)

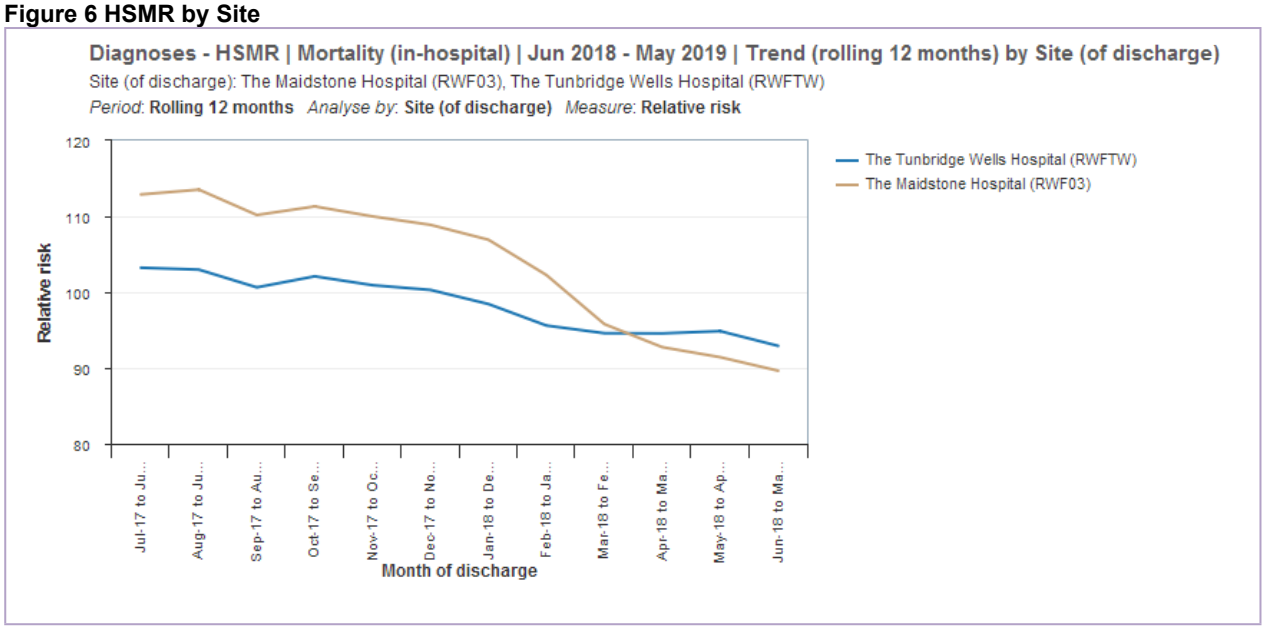


The Seven Day Services programme is focused around reducing variation in performance and mortality forms part of the scope of this work. The latest period has a HSMR of 94.7 (98 last month) for weekends and 89.7 (90.9 last month) for weekday admissions, both the weekday & weekend rate are significantly lower than the Trust position at the beginning of the year.

Further investigation of the Weekday Relative Risk for the current rolling 12 month period shows Endocrinology (157.4 – 34 deaths) & Respiratory Medicine (118.4 – 154 deaths) as being 'red'.

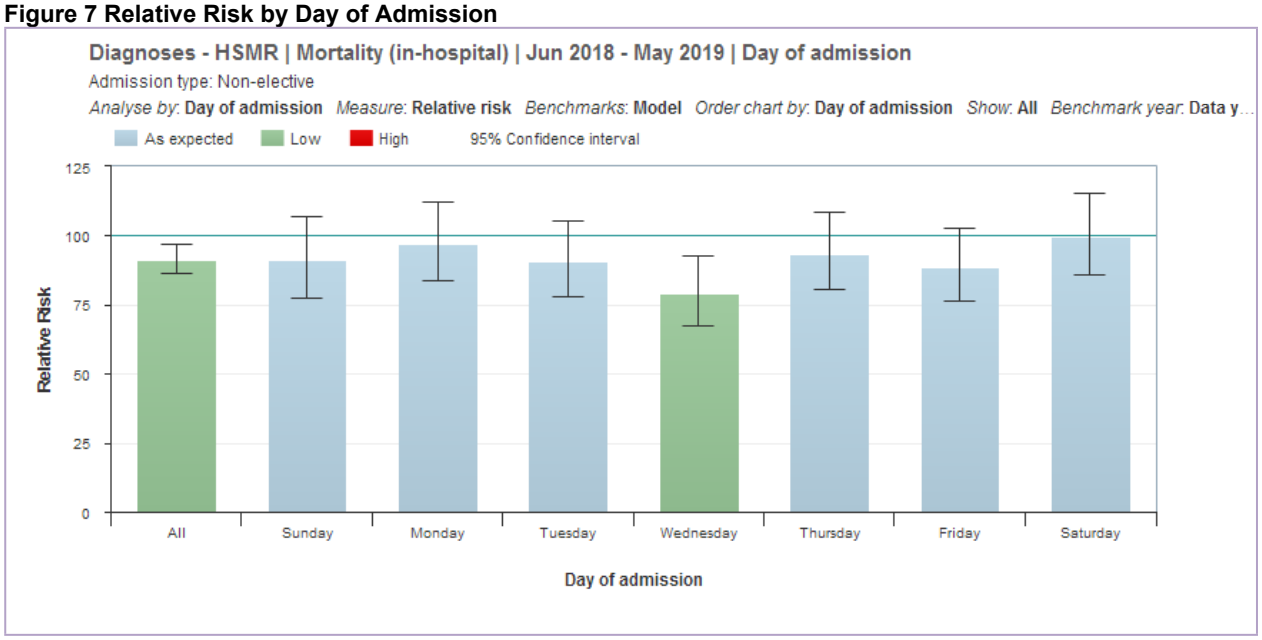
The HSMR at the Maidstone site has decreased to 89.6 from 91.4 last month; the Tunbridge Wells site has decreased to 92.9 from 94.9 last month.

Figure 6 HSMR by Site



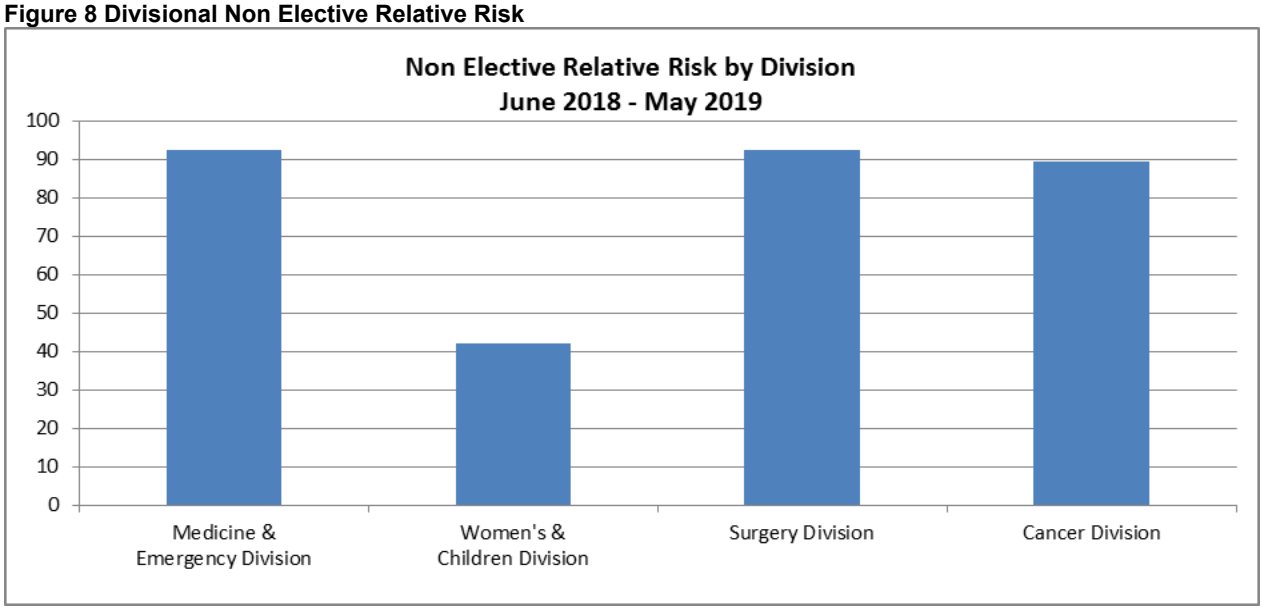
The latest analysis shows that patients admitted to the Trust any day of the week has an 'as expected' or 'low' level of relative risk of death, previously Saturdays had a high relative risk.

Figure 7 Relative Risk by Day of Admission



All four Divisions within the Trust have a non-elective relative risk within the expected range.

Figure 8 Divisional Non Elective Relative Risk



CUSUM (CUmulative SUM control chart) Alerts

A further element of the work undertaken by the Mortality Surveillance Group is to review the CUSUM alerts. This is a method of identifying areas where there are an unexpected cumulative number of mortalities which have been following treatment for a specific diagnosis; this can be both due to more and less than expected deaths. The below chart (Fig. 9) demonstrates the diagnosis groups where the Trust has received negative alerts when using A ‘high’ (99%) detection threshold over the past 12 months.

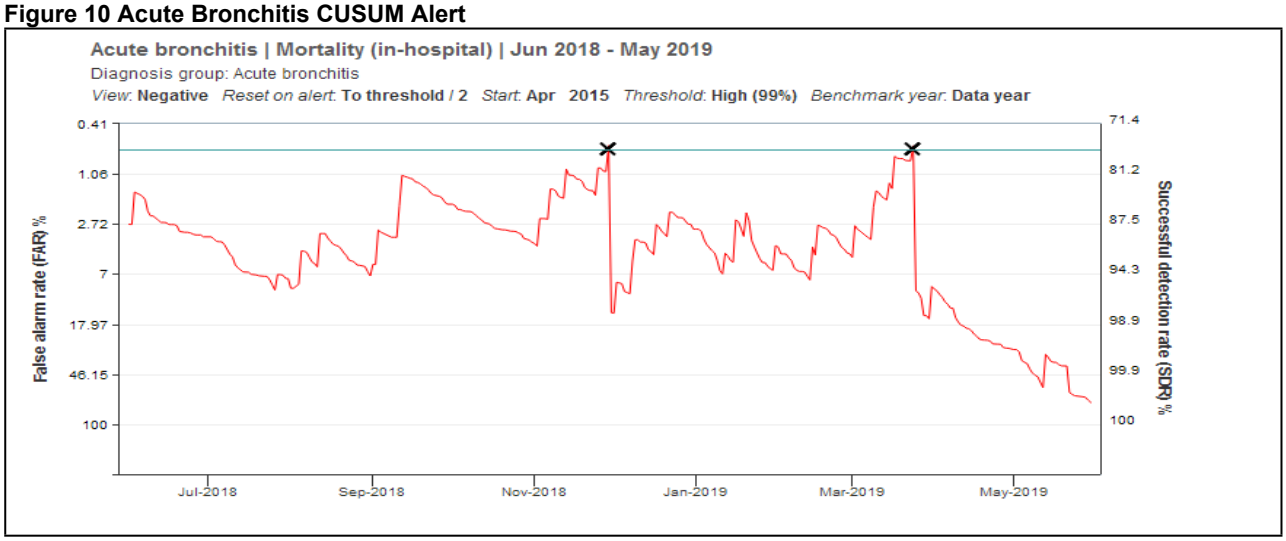
Figure 9 Diagnosis with negative CUSUM Alerts

Relative risk & CUSUM alerts

Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend	LOS	Readm.	Peers
All Diagnoses	2 5	116008	1476	1621.6	1.3	91.0				
HSMR (56 diagnosis groups)	7	38584	1228	1342.3	3.2	91.5				
Acute bronchitis	2	1167	35	22.4	3.0	156.0				
Essential hypertension	1	162	1	0.1	0.6	753.6				
Multiple sclerosis	1	30	1	0.3	3.3	383.0				
Other and ill-defined cerebrovascular disease	2	17	4	0.7	23.5	566.0				
Residual codes, unclassified	1 3	1307	27	12.8	2.1	211.1				
All Procedures	2	75913	920	1036.1	1.2	88.8				
Rest of Arteries and veins (diagnostic/minor)	1	228	14	9.4	6.1	148.5				
Rest of Miscellaneous operations	1	4807	23	14.4	0.5	159.7				

Figure 10 shows the 2 CUSUM alert points for Acute Bronchitis which has shown as having a red relative risk of 156 in May 2019, the patient level backing data for these alerts is currently being audited by the coding department.

Figure 10 Acute Bronchitis CUSUM Alert



Provisional findings suggest that two of the patients have been incorrectly coded, but the rest have been attributed to the quality of documentation. The majority of these patients appear to be patients with chest infections, chest sepsis or pneumonia and not bronchitis which sits within this coding group.

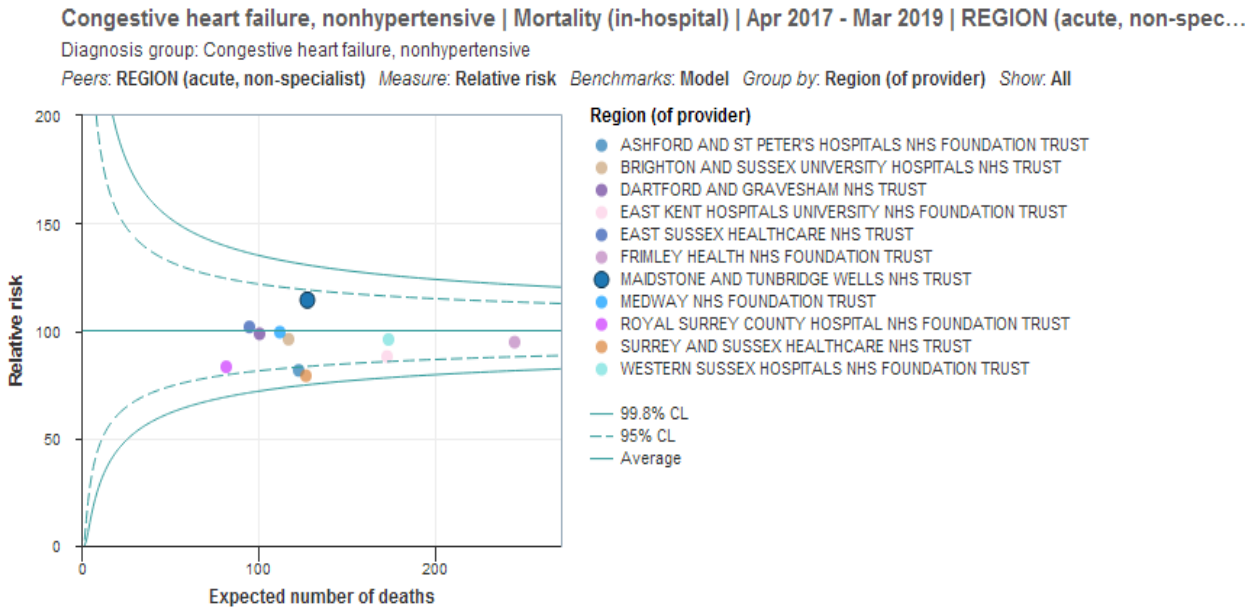
Congestive Heart Failure

A previous CUSUM alert identified in August 2018 for Congestive Heart Failure has also been investigated and the findings were discussed at the August 2019 Mortality Surveillance Group. The findings demonstrate that Congestive Heart Failure is now within acceptable limits with nothing significant evident for :-

- The day of admission
- Weekend vs. week day admission
- LOS
- Readmissions

During the period of April 2017- March 2019 (Fig 11) it is evident that MTW was above average, carrying a higher relative risk of deaths for Congestive Heart Failure when benchmarked over 24 months.

Figure 11 Congestive Heart Failure, non-hypertensive Apr 17 - Mar 2019



When looked at over the last 12 months we can see that MTW is now below average, carrying a lower relative risk of deaths for Congestive Heart Failure when benchmarked against the same group.

Figure 12 Congestive Heart Failure, non-hypertensive Apr 18 - Mar 2019

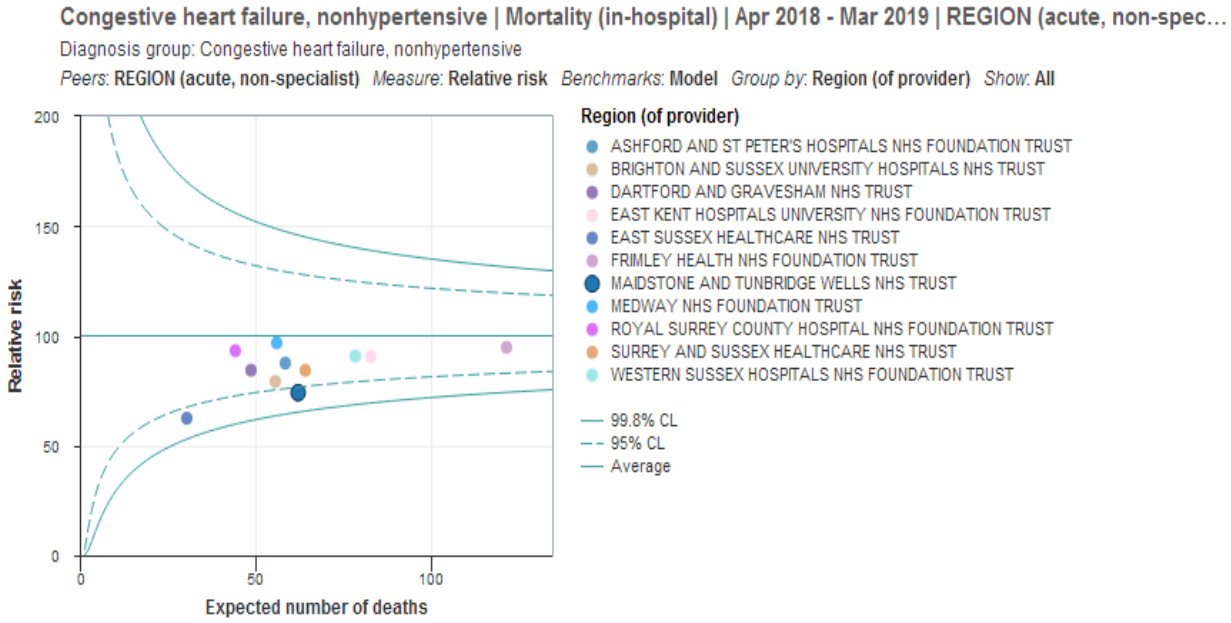
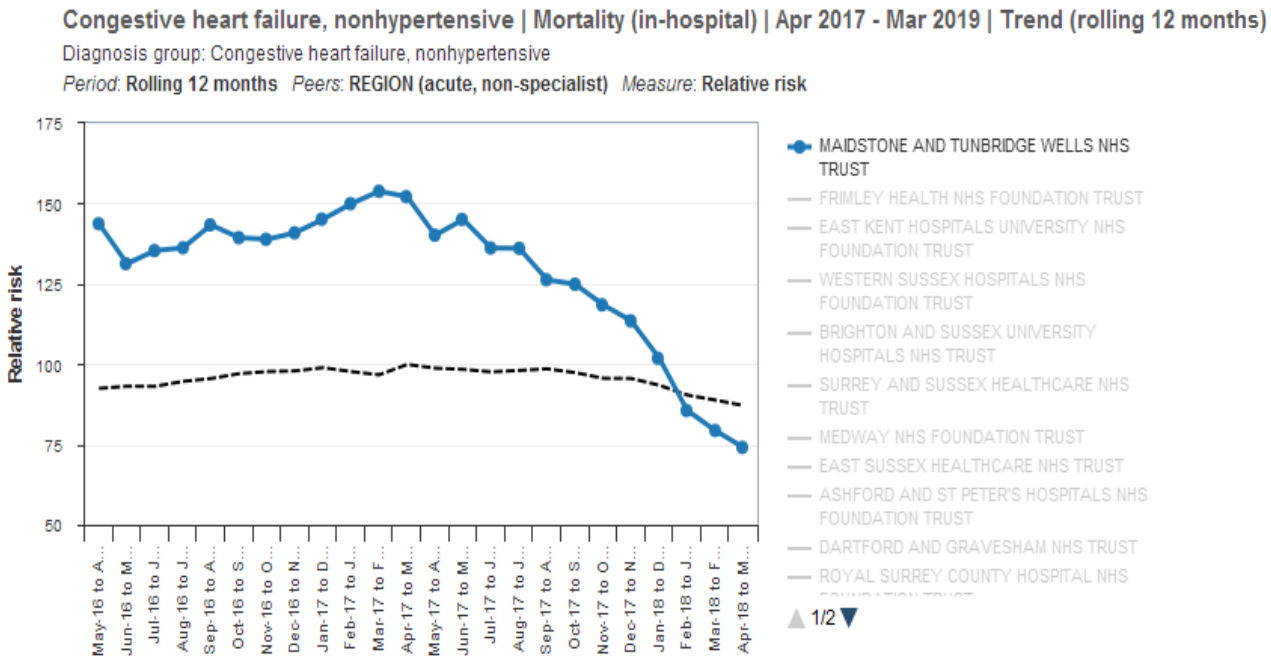


Figure 13 shows the reduction in the relative risk over the last 24 months, against our local peers as a group.

Figure 13 Congestive Heart Failure, non-hypertensive Apr 17 - Mar 2019 rolling 12 Months



In addition the information available from the Acute Heart Failure Quality & Patient Safety Collaborative (Kent, Surrey & Sussex Academic Health Science Network) demonstrates the increase in admissions to MTW (Figure 14) and the continued decline in crude mortality (Figure 15).

Figure 14 MTW - Heart Failure Admissions

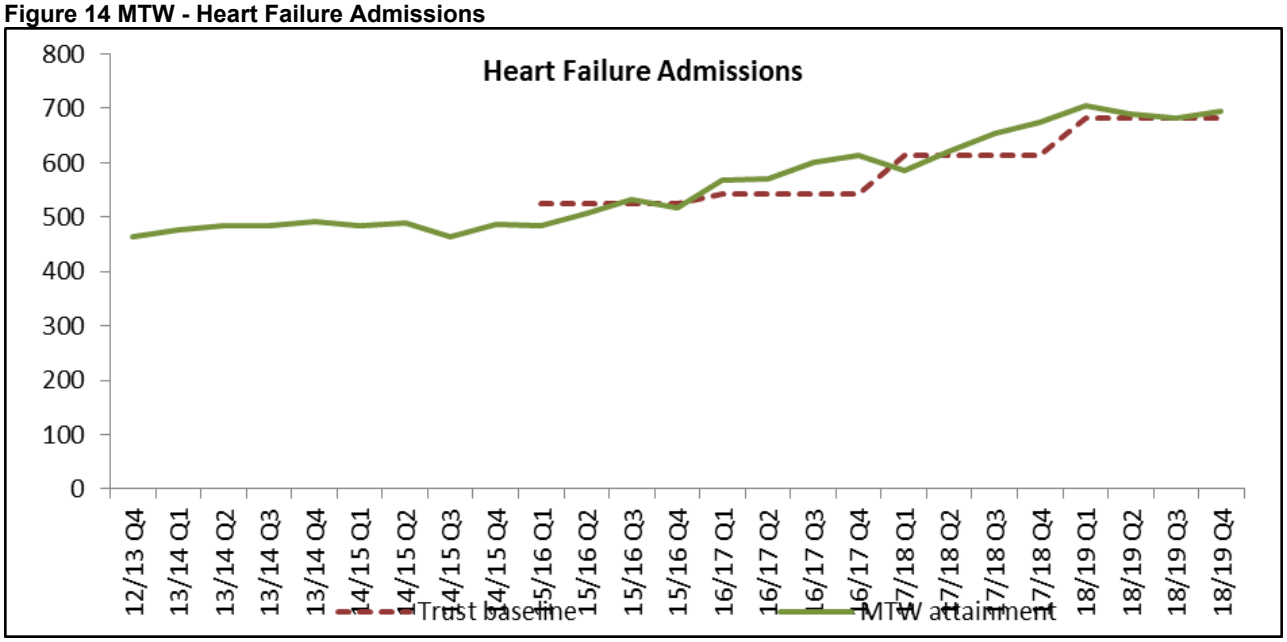
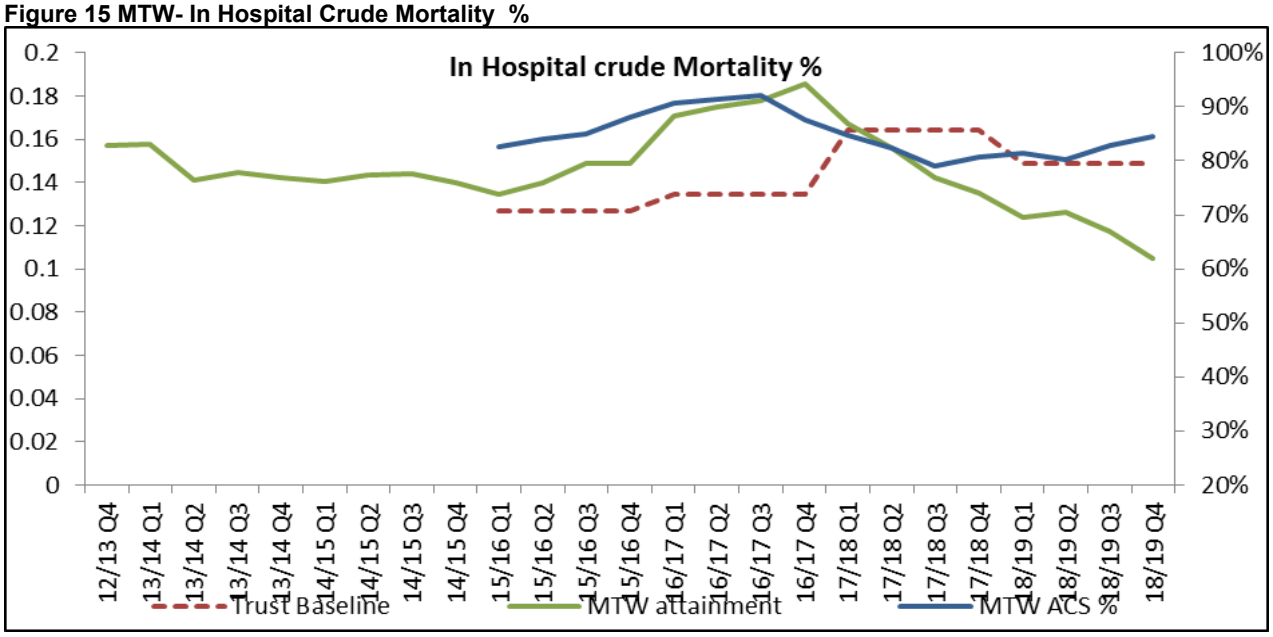


Figure 15 MTW- In Hospital Crude Mortality %



The Cardiology Specialist team have reported that the National Heart Failure audit outcomes clearly demonstrate that there has been an improvement in mortality associated with optimal care standards being provided to the patient (Appropriate Care Score –ACS%). The ACS (care standards) include; having input from a specialist, being looked after on a 'cardiology ward', having a cardiology follow-up and if the patient is confirmed to have left ventricular systolic dysfunction (LVSD), that they are discharged on the appropriate medications.

The delivery of improved patient outcomes are underpinned by:

1. Admitting teams continuing to make a referral to cardiology **and** the Heart Failure nurse as early as possible.
2. Access to inpatient echocardiogram (technician availability is crucial)
3. Daily access to cardiologist (via Cardiologist Of the Week rota)
4. Availability of Heart Failure Nurse specialist to see the patient (currently 0.8WTE per site)

The Heart Failure Specialist Nurse conducts a monthly audit to identify any patients who did not receive the required interventions to explore, understand and act upon variation, these are then presented to the Clinical Governance sessions on each site and to other Directorates were awareness needs to be raised. The Directorate believe that it has been through the raising of awareness that has resulted in the improvement in meeting all the care standards (ACS) but in also reducing the mortality rate. In addition to reviewing those patients who did not receive all of the required interventions they will also now include those patients who subsequently died of Heart Failure whilst in our care.

The Mortality Surveillance Group (MSG):-

The MSG has been operational in its current format since February 2016 and has made consistent progress in improving the reported positon of Mortality reviews, with acknowledgment that 90% compliance is this year's stretch target.

Figure 16 Trust Position of Mortality Reviews – (April - August 19)

Trust	2018/19 YTD
No of Deaths	1600
No of Completed Reviews	1363
%age completed reviews	**85.2%**
No of Un-reviewed Deaths	237

Apr-19	May-19	Jun-19	Jul-19	Aug-19	YTD
141	121	95	127	114	598
120	95	83	110	64	472
85.1%	**78.5%**	**87.4%**	**86.6%**	**56.1%**	**78.9%**
21	26	12	17	50	126

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

Learning from Mortality Reviews includes the need for:-

- Improved communication with patient and/or family re decision making for DNACPR
- Improved documentation in regard to decision making re ceiling of care and plan for palliation
- Prompt senior oversight of decision making re End of Life Care (EOLC), to include review of DNACPR form signed by Consultant lead
- Prompt referral to palliative care team when decision made for EOLC
- To not use abbreviations on the death certificate.
- Documentation of best interest discussions.
- Importance of contemporaneous and legibility of documentation.
- Improved documentation with particular records of thought processes leading to decision making, including elimination of possible diagnoses.
- Patients requiring ongoing intravenous fluids need routine blood tests to monitor their electrolyte balance
- Need for appropriate escalation for senior review.
- Importance of weekend handover to ensure clear instructions for continuity of care are provided.
- DNACPR to be kept on the first page of a patient's health records.
- Records of discussions with speciality teams to be recorded in notes.

Learning from Deaths Project Working Group (LFD).

The project group has been operational since May 2017 and was set up in response to the National agenda for learning from deaths. Following delivery of the main objectives (listed below) the Group has now been disbanded, effective from August 2019.

The objectives of the group which have now been completed include:-

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

Next Steps for the Mortality Agenda

There remain two central work objectives for Mortality to ensure that learning from patient deaths remains a key aspect of lessons learned and the governance agenda, these include:-

- Implementation of the Mortality Module – this will be delivered by the Datix Implementation Group and is envisaged to automate the mortality review process and become the repository for all documentation. In addition Datix IQ will be able to generate performance reports which will support the lessons learned agenda. This is anticipated to be functional from December 2019.
- Implementation of the Medical Examiner process and introduction of Medical Examiners and Medical Examiner Officer Roles. These roles are anticipated to support the relatives and loved ones of those who die in the care of MTW and improve their overall experience whilst supporting the critical review of the care being provided. These are expected to be in place from the 1st April 2020.

NHS
Maidstone and Tunbridge Wells NHS Trust

Briefing on the range of 'virtual' clinic / consultation IT systems used and / or planned for use at the Trust — **Chief Executive**

The enclosed report provides information on the digital transformation initiatives which are taking place within the Outpatient departments to improve services for both staff and patients.

Which Committees have reviewed the information prior to Board submission?
Outpatient Transformation Steering Group

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

Outpatient Digital Transformation Referrals

Electronic Referral System - fully rolled across the Trust in line with NHS digital guidelines. ERS under Outpatient Transformation moved to Business as usual December 2018

Kinesis Advice and Guidance for reduction in referrals
General Surgery, biochemistry, gynaecology, radiology orthopaedics, paediatrics, cardiology, ENT, Haematology, Neurology, Diabetes and endocrinology, rheumatology, microbiology, pain and urology.

Single Point of Triage through Referral Assessment Services (RAS) on ERS for MSK services, hip and knee, spinal, shoulder, foot & ankle, hand and wrist and pain management

RAS several exist to ensure the correct patient pathway

Virtual Fracture Clinic Triage

Next Steps for outpatient services

- Development of directory of services for all areas to reduce the RAS services
- Community gynaecology via GPwSI – reduce referrals to acute
- Scope new national virtual fracture clinic scheme

Outpatient Digital Transformation Appointments

Text messaging Services – used by all planned care, specialist medicine, paediatrics, gynaecology, sexual health and oncology services

Two way text messaging available at 7 days prior to appointment.

Next Steps for outpatient services

- Scope Patient booking portal (DrDoctor/Netcall)

Outpatient Digital Transformation Clinic Consultation

Virtual Clinics

Video Consultation Appointments (VCA Attend Anywhere)

18 month NHSI pilot from April 2019 of virtual OPD clinics being trialled in 5 areas, Sexual Health, ED, Cardiology, Gastroenterology & Hepatitis and Diabetes & Endocrinology – supported by JPMO transformation team

Telephone clinics -

Oncology: Radiotherapy/CNS/Consultant
Cardiology : Consultant and CNS Led
Respiratory: Consultant led
Diabetes and Endocrinology: Nurse Led IBD Pathway
Rheumatology: Consultant Led
Neurology: Consultant Led due to commence
Gynaecology: New physician associate role due to start; job plan includes telephone follow up clinics
ENT: integrated follow up pathway acute to primary care, primary care undertake telephone follow up clinics

Image Review Clinics -

Ophthalmology Optical Coherence Tomography (eye imaging) image follow up review (no patient 2nd attendance)

On-line testing –

Sexual health

Voice recognition (G2 Speech) – 3 specialities to be trialled – Urology, Neurology and Gastroenterology – supported by PMO transformation team

Next steps

- Bringing outpatient transformation, digital transformation and patient experience into one working group
- Ophthalmology virtual clinical test room – patient to attend for test only and consultant review of tests results non face to face, will expand use in other sub-specialities

NHS Maidstone and Tunbridge Wells NHS Trust

The Kent and Medway Sustainability and Transformation Partnership (STP): proposed establishment of a single NHS Clinical Commissioning Group; and update on the System Transformation Programme — **Chief Executive**

Establishing a single NHS Clinical Commissioning Group for Kent and Medway

The Kent and Medway STP is working towards merging the current eight Clinical Commissioning Groups (CCGs) to form a single CCG for the whole area, as part of the work to establish an Integrated Care System (ICS). Some slides explaining the plans in more detail are enclosed in Appendix 1. The STP needs to submit its merger application to NHS England and NHS Improvement in September 2019, and views from stakeholders will be included in the submission. Each organisation within the STP was therefore asked (in August 2019) to submit a letter of support before 27th September. Given that the Trust Board had previously discussed the potential merger (including at Trust Board 'Away Day' events), and had been supportive of the concept, the Chair of the Trust Board and Chief Executive agreed that a letter of support could be sent from the Chief Executive without formally asking the Trust Board to approve a letter. A letter of support will therefore be sent from the Trust to the STP before the requested deadline.

The Kent and Medway System Transformation Programme

The Kent and Medway System Transformation Programme focuses on the development of a Kent and Medway ICS. The intention is that the ICS will include a system commissioner, four place-based Integrated Care Partnerships (ICPs) and Primary Care Networks (PCNs) to deliver improved quality and provision of care and patient outcomes for the population.

A Programme Initiative Document (PID) was developed in June 2019 which describes the plans for the Programme in detail (including, among other things, the System Vision, Interim Operating Model for 2019/20 and initial Programme Governance arrangements. The PID has not been submitted to the Board, but is available to Trust Board Members on request from the Trust Secretary. There are 40 PCNs in Kent & Medway. These are now in place and have Clinical Directors appointed.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information

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

Transforming health and social care in Kent and Medway

Helping local people live their best life

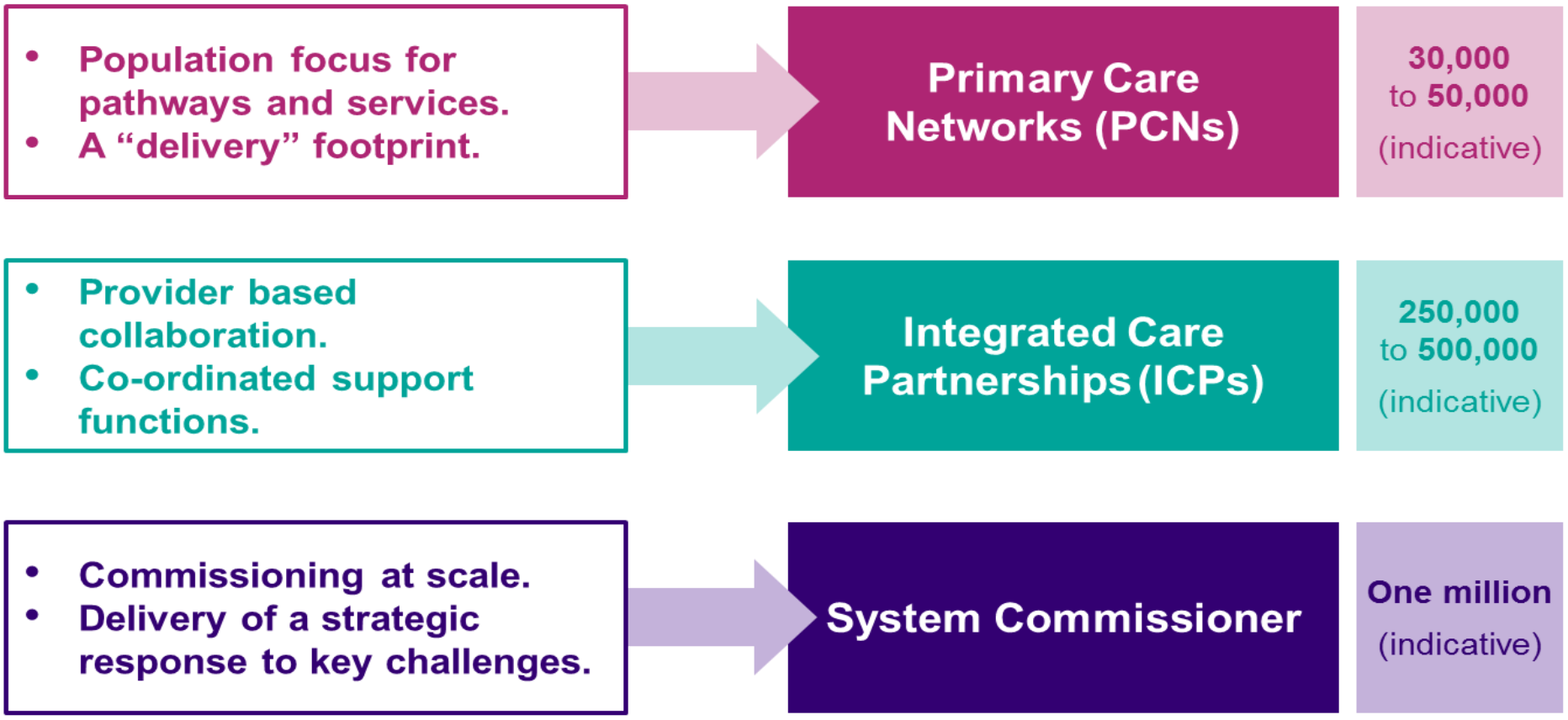
New ways of organising health and care services in Kent and Medway for benefit of everyone

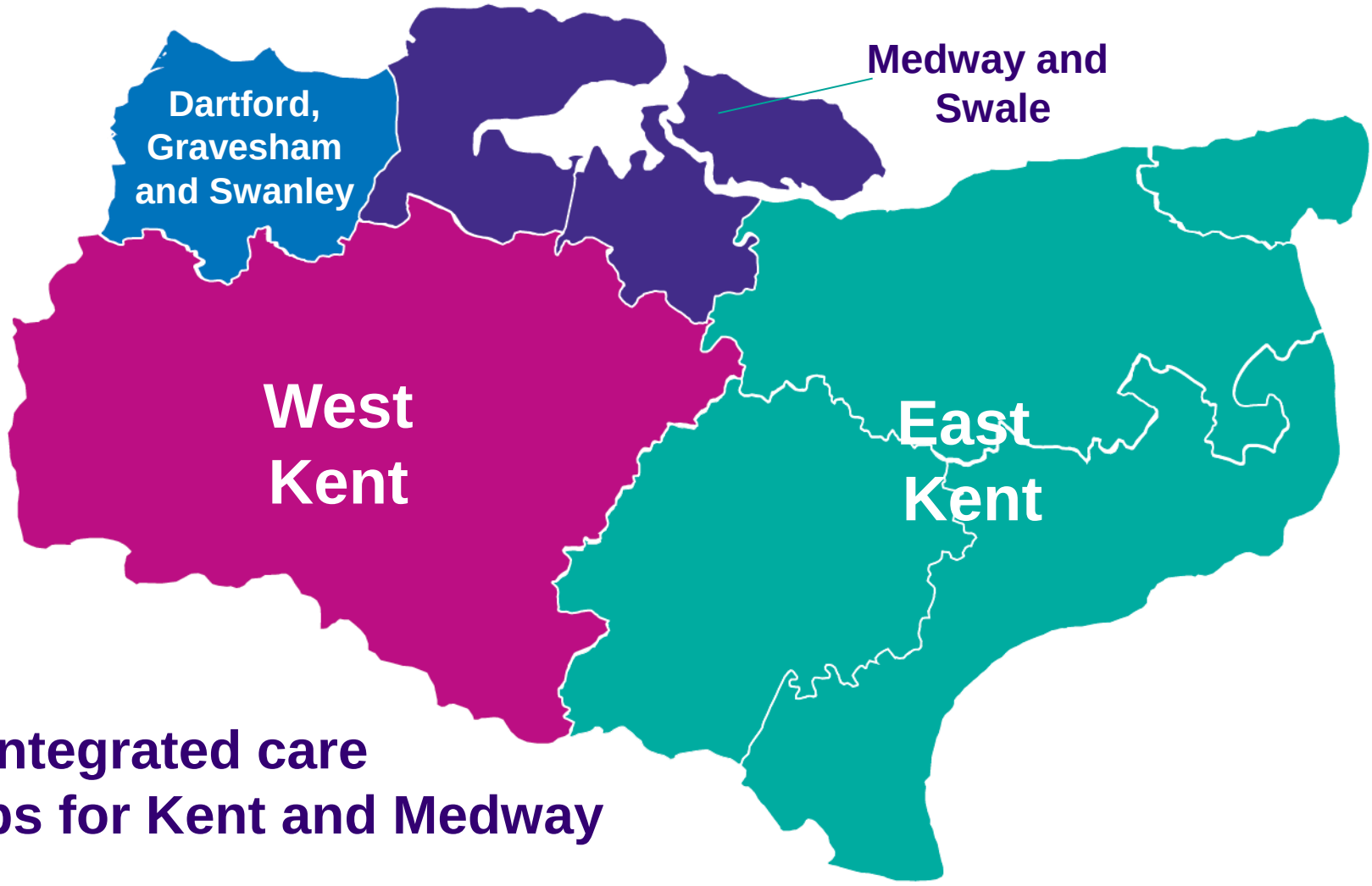
Quality of life, quality of care

Why change?

- The current structure of the NHS has not enabled **sustainable long term improvements to patient care**.
  - Average life expectancy across the county differs by more than 15 years
  - Fragmented services, e.g. children SEN, cancer services, etc
  - Varying performance across the county, elective and urgent care
  - Dementia diagnosis and treatment rates low and variable
- The **internal market** has pushed organisations to compete against each other rather than collaborate and integrate
- **Prevention** has consistently not been prioritised
- Significant **workforce** issues across the county
- Significant **financial challenges** across provider trusts and clinical commissioning groups (CCGs)

We and our partners are looking to move to an integrated care system (ICS)

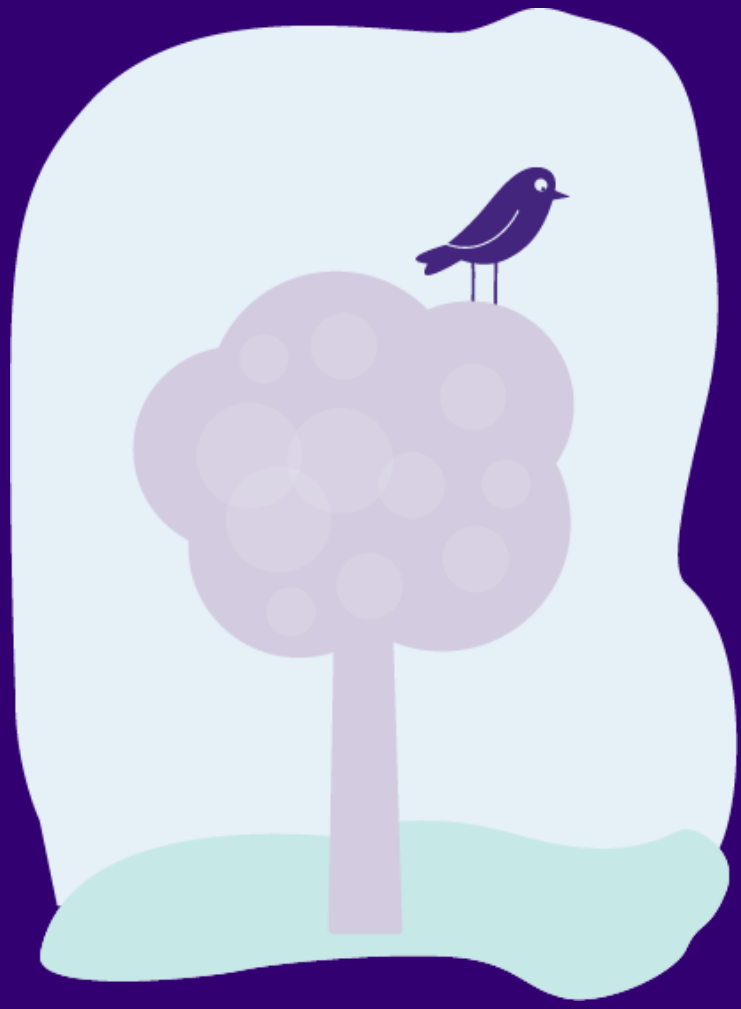




Proposed integrated care partnerships for Kent and Medway

Quality of life, quality of care

Why a single clinical commissioning group?



Why a single Kent and Medway CCG?

- National expectation that **each ICS will have a single CCG**
- Necessary move to **address major challenges** across the county and deliver Long Term Plan ambitions
- A single CCG will:
  - map health needs at county level
  - commission at scale – ambulance services, 111, specialist services etc
  - let contracts and provide leadership to the new integrated care partnerships, setting consistent outcomes for them to achieve
  - oversee the quality of services provided
  - commission GP practices
  - reduce fragmentation and duplication, saving time and cost
  - better deliver staff recruitment, including to new roles
  - strengthen the focus on righting health inequalities
- **Majority of current commissioning functions** will take place within ICPs
  Majority of staff will be local (ICP / PCN) facing.

So what does it mean for patients?

- Better **joined-up local services** with patients at the centre: **one service and one team**
- A joined-up focus for **population health** and the ability to **target resources** where most needed.
- **Providers working together** to deliver patient care
- **Improvement in access, experience and clinical/care outcomes**
- Ability of system to **move at pace** to improve services across Kent and Medway for patients.

Do we support a single CCG?

Review of the Kent and Medway STP Strategy Delivery Plan (and approval of relevant aspects)	**Director of Strategy, Planning and Partnerships**

The enclosed report contains the details of the Maidstone and Tunbridge Wells NHS Trust submission to form of the STP-wide Strategy Delivery Plan.

Which Committees have reviewed the information prior to Board submission?

- Finance and Performance Committee, 24/09/19

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

Review and discussion

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

NHS
Maidstone and Tunbridge Wells
NHS Trust

MTW 5 Year Plan (2019/20 to 2023/24)

20th September 2019

MTW
exceptional people, outstanding care

Contents

Maidstone and Tunbridge Wells NHS Trust

- **Activity**
- Workforce
- Finance
- Next steps

MTW exceptional people, outstanding care

Activity summary

NHS Maidstone and

Overview

- While there will be the submission of the STP led narrative document there will also be a template submission covering activity finance and workforce
- Although there will not be submitted trajectories for providers there will be STP level trajectories and the trajectories in this document have been constructed to inform that submission
- MTW and West Kent CCG activity projections currently do not align
- Alignment is close in all PODs (<1% difference) apart from ED
- West Kent CCG are using the whole systems partnership model while MTW uses it's proprietary modelling (which includes non-demographic growth as opposed to the WSP model which does not)
- For ED the Trust projects growth of 3.56% based on a best case scenario while the CCG WSP model projects ~1.5% (which is in line with MTW demographic growth projections)
- Work is underway to identify additional system interventions in both planned and urgent and emergency care to ameliorate growth and system meetings will continue to ameliorate any gap.

Difference between Trust Activity submission and West Kent CCG activity submission (excluding ED non demographic growth)

PODGrpCode4	PoD	19/20 Activity Plan	20/21 Forecast Activity	21/22 Forecast Activity	22/23 Forecast Activity	23/24 Forecast Activity	24/25 Forecast Activity	% Difference 20/21	% Difference 20/22	% Difference 20/23	% Difference 20/24	% Difference 20/25
Consultant Led First Outpatient Attendances		1	166	397	861	1,225	1,555	0.00%	0.08%	0.19%	0.42%	0.58%
Consultant Led Follow Up Outpatient Attendances		-1	252	878	2,075	2,818	3,500	0.00%	0.06%	0.20%	0.47%	0.63%
Total Consultant Led Outpatient Attendances		**-0**	**419**	**1,275**	**2,936**	**4,042**	**5,054**	**0.00%**	**0.07%**	**0.20%**	**0.45%**	**0.61%**
Total Outpatient Appointments with Procedures												
Elective Income - DC	DC	-2	66	80	165	269	392	0.00%	0.14%	0.17%	0.34%	0.56%
Elective Income - EL	EL	1	-10	-31	-34	-33	-33	0.01%	-0.14%	-0.41%	-0.45%	-0.43%
Elective Income Total		**-1**	**56**	**49**	**130**	**236**	**360**	**0.00%**	**0.10%**	**0.09%**	**0.24%**	**0.42%**
Non-Elective Income - 0 LOS	NEL 0 LOS	0	64	139	263	417	587	0.00%	0.23%	0.50%	0.93%	1.46%
Non-Elective Income - 1+ LOS	NEL 1+ LOS	-0	-60	-126	-162	-176	-153	0.00%	-0.18%	-0.36%	-0.46%	-0.49%
Non-Elective Income Total		**-0**	**3**	**13**	**101**	**240**	**434**	**0.00%**	**0.01%**	**0.02%**	**0.16%**	**0.37%**
A&E attendances (excl planned follow ups)	AandE	-0	209	-22	-121	73	302	0.00%	0.11%	-0.01%	-0.06%	0.04%
Type 1 A&E attendances (excl planned follow ups)	AandE excluding HRG: Type 3											

MTW exceptional people, outstanding care

MTW, KCH FT and WK CCG are working together on performance trajectories. There is a deep dive session with STP colleagues on 25th September to provide the STP with guidance on the potential trajectories, in light of this we have modelled the following for ED

Maidstone and Tunbridge Wells NHS Trust

Scenario 1 – Maintenance of current performance at 92%

Accident and Emergency			Out-turn 31/03/2019 March 2019	Y1 Actual Q1 As at 30 June 2019	Y1 Actual if possible Q2 As at 30 Sept 2019	Y1 Q3 and Q4 reforecast plan based on Q1/Q2 performance 31/04/2020	Y1 Plan as per 19/20 Op Plan 31/04/2020	Y2 Plan 31/04/2021	Y3 Plan 31/04/2022	Y4 Plan 31/04/2023	Y5 Plan 31/04/2024
Accident and Emergency - >4 hour wait	*i*		15,561	3,684	4,375	9,620	17,680	17,174	17,920	18,702	19,524
Accident and Emergency - Total Patients	*i*		189,120	51,312	53,642	100,863	205,816	214,671	223,995	233,777	244,046
Accident and Emergency - Performance % (95% standard)			**91.8%**	**92.8%**	**91.8%**	**90.5%**	**91.4%**	**92.0%**	**92.0%**	**92.0%**	**92.0%**

Scenario 1 – Achievement of 95% performance in 2020/21

Accident and Emergency			Out-turn 31/03/2019 March 2019	Y1 Actual Q1 As at 30 June 2019	Y1 Actual if possible Q2 As at 30 Sept 2019	Y1 Q3 and Q4 reforecast plan based on Q1/Q2 performance 31/04/2020	Y1 Plan as per 19/20 Op Plan 31/04/2020	Y2 Plan 31/04/2021	Y3 Plan 31/04/2022	Y4 Plan 31/04/2023	Y5 Plan 31/04/2024
Accident and Emergency - >4 hour wait	*i*		15,561	3,684	4,375	9,620	17,680	10,734	11,200	11,689	12,202
Accident and Emergency - Total Patients	*i*		189,120	51,312	53,642	100,863	205,816	214,671	223,995	233,777	244,046
Accident and Emergency - Performance % (95% standard)			**91.8%**	**92.8%**	**91.8%**	**90.5%**	**91.4%**	**95.0%**	**95.0%**	**95.0%**	**95.0%**

MTW exceptional people, outstanding care

For RTT we have modelled 2 distinct timeframes for recovery of the 92% standard one recovering the standard in 2020/21 and one in 2021/22

Maidstone and Tunbridge Wells NHS Trust

Scenario 1 – Achievement of 92% standard by end of 2020/21

			Out-turn 31/03/2019	Y1 Actual Q1	Y1 Actual if possible Q2	Y1 Q3 and Q4 reforecast plan based on Q1/Q2 performance 31/04/2020	Y1 Plan as per 19/20 Op Plan 31/04/2020	Y2 Plan 31/04/2021	Y3 Plan 31/04/2022	Y4 Plan 31/04/2023	Y5 Plan 31/04/2024
Referral to Treatment			As at 31 March 2019	As at 30 June 2019	As at 30 Sept 2019		Y1	Y2	Y3	Y4	Y5
Number of incomplete RTT pathways <=18 weeks	*i*		23,616	25,106			20,794	20,387	20,387	20,387	20,387
Number of incomplete RTT pathways Total	*i*		28,413	29,269			23,980	22,147	22,147	22,147	22,147
Referral to treatment Incompletes - Performance % (92% standard)			**83.1%**	**85.8%**			**86.7%**	**92.1%**	**92.1%**	**92.1%**	**92.1%**
Number of incomplete RTT pathways >52 weeks	*i*										
		NHSI forecasted 18/19 FOT	FOT FY 18/19	As at 30 June 2019	As at 30 Sept 2019		Y1	Y2	Y3	Y4	Y5
Number of completed admitted RTT pathways	*i*	40,360	28,175	2,687			33,548	34,051	34,528	35,011	35,501
Number of completed non-admitted RTT pathways	*i*	119,387	94,308	7,472			111,653	113,328	114,915	116,254	117,882
Number of New RTT pathways (clock starts)	*i*	183,605	152,568	12,211			179,847	182,545	185,101	187,692	190,320

Scenario 1 – Achievement of 92% standard by end of 2021/22

			Out-turn	Y1 Actual	Y1 Actual if possible	Y1 Q3 and Q4 reforecast plan based on Q1/Q2 performance	Y1 Plan as per 19/20 Op Plan	Y2 Plan	Y3 Plan	Y4 Plan	Y5 Plan
Referral to Treatment			As at 31 March 2019	As at 30 June 2019	As at 30 Sept 2019		Y1	Y2	Y3	Y4	Y5
Number of incomplete RTT pathways <=18 weeks	*i*		23,616	25,106			20,794	20,651	20,428	20,428	20,428
Number of incomplete RTT pathways Total	*i*		28,413	29,269			23,980	23,072	22,138	22,138	22,138
Referral to treatment Incompletes - Performance % (92% standard)			**83.1%**	**85.8%**			**86.7%**	**89.5%**	**92.3%**	**92.3%**	**92.3%**
Number of incomplete RTT pathways >52 weeks	*i*		12	6			10	5	5	5	5
		NHSI forecasted 18/19 FOT	FOT FY 18/19	As at 30 June 2019	As at 30 Sept 2019		Y1	Y2	Y3	Y4	Y5
Number of completed admitted RTT pathways	*i*	40,360	28,175	2,687			33,548	34,502	34,985	35,475	35,972
Number of completed non-admitted RTT pathways	*i*	119,387	94,308	7,472			111,653	113,802	115,395	117,011	118,649
Number of New RTT pathways (clock starts)	*i*	183,605	152,568	12,211			179,847	182,545	185,101	187,692	190,320

For Cancer (62 days) given the Trusts achievement of the standard we are forecasting this to continue over the 5 years

Maidstone and Tunbridge Wells NHS Trust

			MTW												
Standard	85%	E.B.12	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	FY
Monthly Diff. Tolerance	25%														
Cancer Waiting Times - 62 Day GP Referral	2015/16	Number Treated < 62 Days	23	17	16	18	23	21	19	24	20	15	19	18	233
		Total Number Seen	29	26	29	31	27	34	26	26	34	19	23	24	328
		%	**79.3%**	**65.4%**	**55.2%**	**58.1%**	**85.2%**	**61.8%**	**73.1%**	**92.3%**	**58.8%**	**78.9%**	**82.6%**	**75.0%**	**71.0%**
	2016/17	Number Treated < 62 Days	25	23	23	18	34	18	19	23	19	22	14	35	273
		Total Number Seen	33	30	32	28	40	27	33	30	25	37	21	41	377
		%	**75.8%**	**76.7%**	**71.9%**	**64.3%**	**85.0%**	**66.7%**	**57.6%**	**76.7%**	**76.0%**	**59.5%**	**66.7%**	**85.4%**	**72.4%**
	2017/18	Number Treated < 62 Days	31	14	22	22	18	0	2	21	24	32	20	18	224
		Total Number Seen	38	22	31	34	29	0	4	30	27	39	27	24	305
		%	**81.6%**	**63.6%**	**71.0%**	**64.7%**	**62.1%**		**50.0%**	**70.0%**	**88.9%**	**82.1%**	**74.1%**	**75.0%**	**73.4%**
	2018/19	Number Treated < 62 Days	21	24	25	33	30	25	21	22	24	23	31	22	301
		Total Number Seen	31	39	33	50	43	44	30	32	30	34	37	31	434
		%	**67.7%**	**61.5%**	**74.2%**	**65.3%**	**69.0%**	**55.8%**	**70.0%**	**68.8%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**69.4%**
	2019/20	Number Treated < 62 Days	26	29	25	36									116
		Total Number Seen	36	43	39	42									160
		%	**72.2%**	**67.4%**	**64.1%**	**85.7%**									**72.5%**
	2020/21 Plan	Number Treated < 62 Days	104	96	109	94	115	92	97	97	97	97	115	116	1,229
		Total Number Seen	125	115	130	113	137	110	116	116	116	115	137	138	1,468
		%	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**83.7%**
	2021/22 Plan	Number Treated < 62 Days	115	105	120	105	126	101	107	107	106	106	126	128	1,352
		Total Number Seen	135	124	141	123	148	119	126	126	125	125	148	150	1,490
		%	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**90.8%**
	2022/23 Plan	Number Treated < 62 Days	124	114	129	113	136	110	116	116	115	115	136	138	1,462
		Total Number Seen	146	134	152	133	160	129	136	136	135	135	160	162	1,718
		%	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.1%**
	2023/24 Plan	Number Treated < 62 Days	135	124	141	123	148	120	126	126	125	125	148	150	1,591
		Total Number Seen	159	146	166	145	174	141	148	148	147	147	174	177	1,872
		%	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**
	2024/25 Plan	Number Treated < 62 Days	149	137	156	136	162	132	139	139	138	138	162	166	1,754
		Total Number Seen	175	161	183	160	191	155	163	163	162	162	191	195	2,061
		%	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.1%**

MTW exceptional people, outstanding care

Contents

Maidstone and Tunbridge Wells NHS Trust

- Activity
- **Workforce**
- Finance
- Next steps

MTW exceptional people, outstanding care

Workforce (1/2)

Maidstone and Tunbridge Wells NHS Trust

Making the NHS the best place to work

- Our key priorities for 2020/21 will be to
- Develop a fully integrated health and wellbeing plan for the workforce
- Continue to invest in staff amenities
- Deliver the cultural diagnostic element of the Exceptional People Outstanding Care programme and associated action plans
- Implement an integrated leadership development programme that will support the culture of openness and engagement that MTW seeks
- Expand the Freedom to Speak Up role with additional FTSU champions

For 2021/2025 we will continue to develop our offer to staff to fulfil the Board objective of making MTW a great place to work. This will be achieved through the development of an integrated staff engagement strategy that will utilise the learning derived from the Exceptional People Outstanding Care cultural diagnostics work.

Improving the Leadership Culture

In 2020/21 we will launch a senior leadership programme that will compliment and support the embedding of the clinically led structure and embed and reinforce the associated trust leadership values. We will review our existing leadership programmes for aspiring and existing managers to ensure that these reflect the same values embodied in the senior programme and provide a framework of support for MTW leaders at each stage of their leadership progression.

For 2021/25 we will embed our leadership culture at all levels of the organisation. It will form a key part of our succession planning and internal development and will be incorporated into an integrated values based recruitment approach to the selection of any who aspire to a leadership position. Our leadership values will be recognised by all MTW staff who will be able to hold those in leadership positions to account to display the correct behaviours and uphold the values of the trust.

MTW exceptional people, outstanding care

Workforce (2/2)

Maidstone and Tunbridge Wells NHS Trust

Tackling the Nursing Challenge

On the basis of the current pipeline of nurse recruitment it is anticipated that the overall nurse vacancy rate will be reduced to c5% by the end of 2019/20

Our key priorities for tackling the nursing shortage in 20/21 will be

- Planning a reduced level of overseas recruitment compared with 19/20 to maintain overall nursing numbers
- Evaluation and possible extension of the OSCE ready programme
- Embedding the role of the Nurse Associate across the organisation
- Supporting the ongoing embedding of the overseas nurses recruited in 19/20 into the organisation
- Evaluating and extending the existing nurse retention programme

For 2021/2025 we will maintain the nursing levels reached in 2019/20 and at the same time reduce our reliance on overseas recruitment through the development of a strong pipeline of local candidates. These will be a combination of 3rd year students choosing MTW as their employer and a well-developed pipeline of nurses following an apprenticeship route to qualification.

Delivering 21st Century care

Over the last 12 months MTW has continued to expand its use of Physician Associates and has been able to introduce a number of Advance Clinical Practitioners across the organisation. Over the same period it had recruited two cohorts of Trainee Nurse Associates and expanded the number of apprenticeships that it uses.

In 2020/21 we will

- Ensure that the business and workforce plans of the organisation clearly set out plans to increase the number of new roles and new apprenticeships that will be developed to support service development
- Ensure that business and workforce plans for new roles include associated and budgeted training support
- Expand the numbers of apprenticeships taken on by the trust to fully utilise the apprenticeship levy
- Support clinicians to develop new roles alongside new clinical pathways

For 2021/2025 we will have a fully integrated approach to the deployment of Advanced Clinical Practitioners and other new roles across a wide range of clinical pathways clearly identified within annual workforce plans. These roles will operate on a pathway basis across the LCP.

MTW exceptional people, outstanding care

Contents

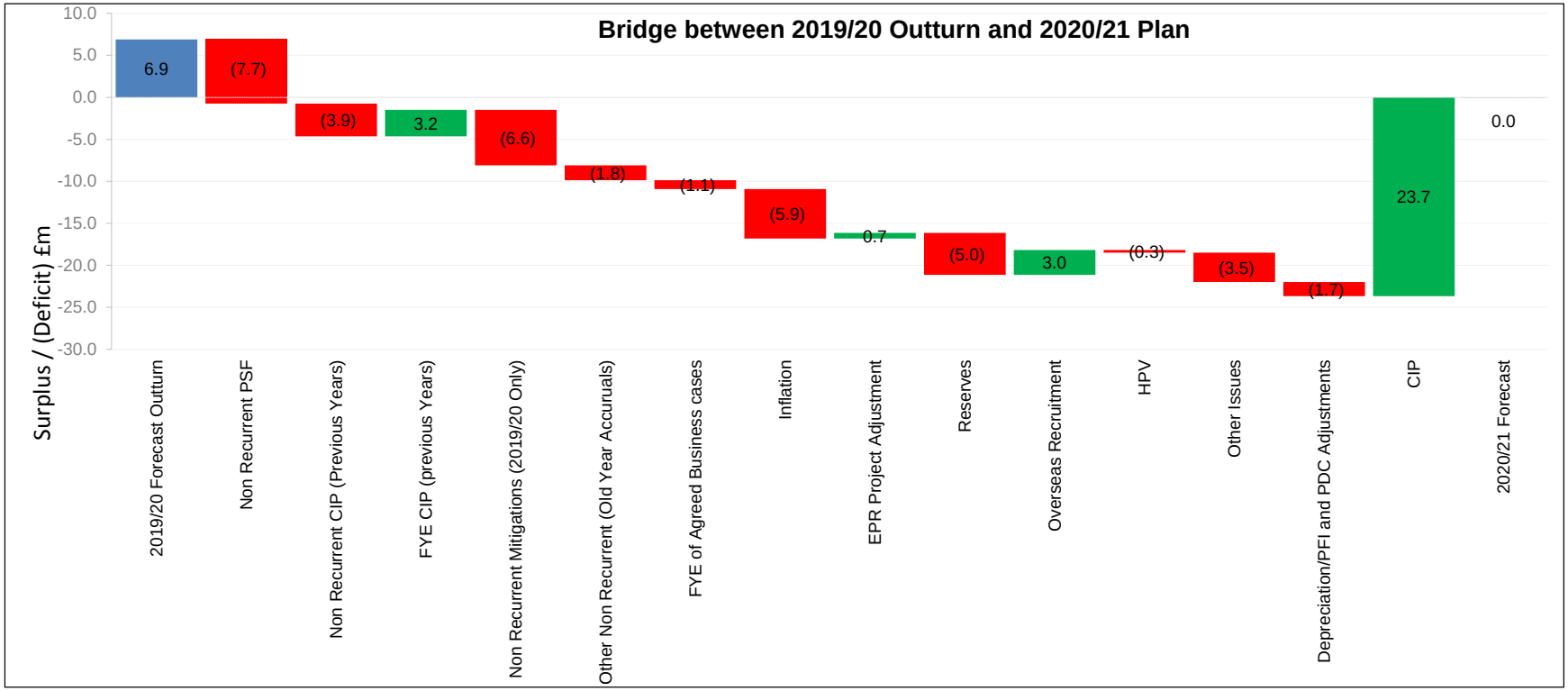
Maidstone and Tunbridge Wells NHS Trust

- Activity
- Workforce
- **Finance**
- Next steps

MTW exceptional people, outstanding care

Bridge between 2019/20 Outturn and 2020/21 Plan

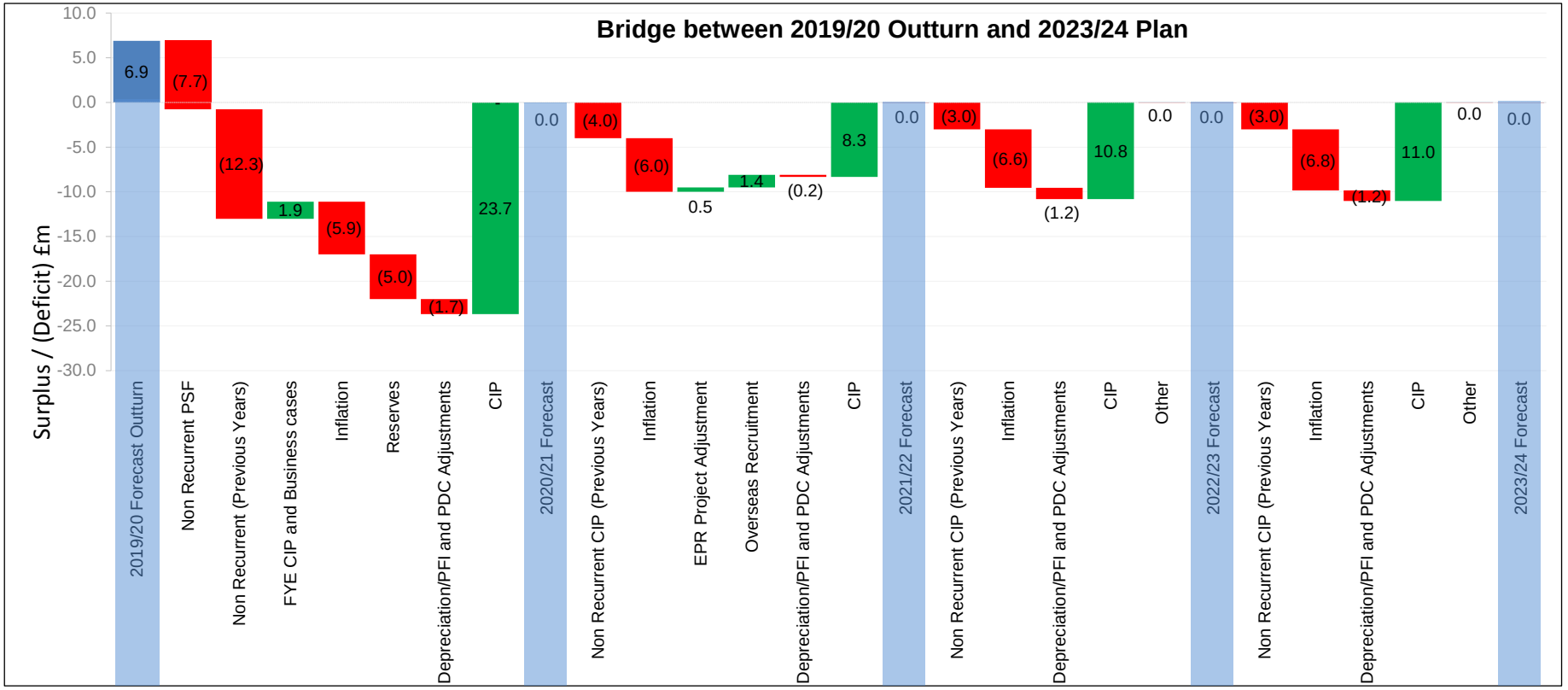
Maidstone and Tunbridge Wells NHS Trust



MTW exceptional people, outstanding care

Bridge between 2019/20 Outturn and 2023/24 Plan

Maidstone and Tunbridge Wells NHS Trust



MTW exceptional people, outstanding care

	2019/20 Budget	2019/20	2020/21	2021/22	2022/23	2023/24
SLA Income	431,922	434,726	451,342	464,761	477,679	491,262
Education Training & Research	10,897	10,487	10,442	10,442	10,442	10,442
Private Patients	6,081	4,211	4,212	4,212	4,212	4,212
Marginal Rate of Emergency Tariff Fund (MRET)	6,199	6,199	6,199	6,199	6,199	6,199
Provider Sustainability Fund (PSF)	7,651	0	0	0	0	0
Other Income	40,300	37,847	34,643	34,910	35,181	35,454
Total Income	**503,049**	**493,470**	**506,838**	**520,524**	**533,713**	**547,669**
Substantive and Bank	-272,821	-268,822	-274,010	-282,210	-287,653	-292,933
Agency	-15,683	-18,371	-18,365	-17,079	-16,336	-15,757
Pay Reserves	-2,497	0	0	0	0	0
Apprenticeship Levy	-1,025	-1,138	-1,171	-1,204	-1,229	-1,255
Total Pay	**-292,026**	**-288,332**	**-293,546**	**-300,493**	**-305,219**	**-309,945**
Clinical Negligence	-17,594	-17,594	-20,370	-22,509	-24,872	-27,484
Drugs	-51,370	-54,652	-57,643	-60,913	-64,067	-67,778
Purch healthcare from non NHS	-10,210	-14,486	-12,623	-12,925	-13,147	-13,373
Supplies and services	-41,208	-39,999	-39,243	-40,292	-40,985	-41,691
Premises	-20,218	-18,820	-18,726	-18,406	-18,433	-18,450
Depreciation and Impairments	-14,459	-14,094	-14,155	-13,721	-13,965	-14,204
Establishment	-2,813	-1,762	-1,883	-1,918	-1,945	-1,972
Other	-25,719	-28,094	-26,022	-25,868	-26,774	-27,700
Reserves	-4,201	0	-5,000	-5,000	-5,000	-5,000
Total Non Pay	**-187,792**	**-189,501**	**-195,665**	**-201,552**	**-209,189**	**-217,651**
Finance expense	-15,945	-15,898	-15,925	-16,028	-16,202	-16,372
Finance income	119	48	48	48	48	48
Other gains/(losses) including disposal of assets	0	8	8	8	8	8
PDC dividends payable/refundable	-1,596	-1,596	-2,890	-3,605	-4,221	-4,842
Total Finance Costs	**-17,423**	**-17,439**	**-18,760**	**-19,578**	**-20,368**	**-21,159**
Total Surplus (+) / Deficit Pre Technical Adjustments	**5,809**	**-1,802**	**-1,132**	**-1,099**	**-1,064**	**-1,087**
Technical Adjustments	1,088	1,048	1,132	1,098	1,064	1,086
Total Surplus (+) / Deficit Including Technical Adjustments	**6,897**	**-755**	**0**	**0**	**0**	**0**
CIP Target (Included in above numbers)			**23,667**	**8,326**	**10,812**	**11,041**

Draft STP Financial Trajectories

Maidstone and Tunbridge Wells NHS Trust

Provider	Financial Trajectory Pre Central Funding				
	2019/20	2020/21	2021/22	2022/23	2023/24
Provider	*Regional Input*				
Dartford and Gravesham NHS Trust	(8.2)	(6.5)	(4.8)	(3.0)	(1.2)
East Kent Hospitals University NHS Foundation Trust	(20.3)	(24.5)	(19.1)	(13.9)	(9.8)
Kent and Medway NHS and Social Care Partnership Trust	(6.0)	(5.4)	(4.6)	(3.6)	(2.6)
Kent Community Health NHS Foundation Trust	-	-	-	-	-
Maidstone and Tunbridge Wells NHS Trust	**(0.8)**	**-**	**-**	**-**	**-**
Medway NHS Foundation Trust	(43.7)	(43.7)	(42.8)	(41.7)	(40.5)
NHS Ashford CCG	(11.1)	(10.4)	(9.6)	(9.0)	(8.6)
NHS Canterbury and Coastal CCG	(10.1)	(9.1)	(8.0)	(6.9)	(5.9)
NHS Dartford, Gravesham and Swanley CCG	(5.0)	(0.7)	3.6	4.0	4.1
NHS Medway CCG	-	4.1	4.3	4.5	4.5
NHS South Kent Coast CCG	(9.5)	(9.4)	(9.4)	(9.4)	(9.4)
NHS Swale CCG	-	0.8	1.6	1.8	1.9
NHS Thanet CCG	(3.2)	(2.1)	(1.0)	(0.1)	0.6
NHS West Kent CCG	-	-	-	-	-
	(117.8)	**(106.7)**	**(89.9)**	**(77.4)**	**(66.8)**

The STP trajectories exclude PSF and FRF (Financial Recovery Fund) income. 2019/20 is the last year of PSF income and FRF will be allocated to system level if the system agrees to the trajectories. Organisations are able to negotiate different trajectories within the system but the system overall is expected to balance back to these trajectories.

MTW exceptional people, outstanding care

Key Assumptions

Maidstone and Tunbridge Wells NHS Trust

Baseline: The month 4 forecast has been used as the baseline of this modelling taking into account non recurrent items and FYE of CIP.

Stroke Reconfiguration: For planning purpose the modelling includes the full costs of running the new stroke service from April 2020. The additional step increase in costs (£5.9m per annum) has been incorporated with the assumption this will be funded via a 'Top up' to tariff therefore zero financial impact.

Cancer Recovery Funding: This modelling assumes the Full year effect of the cancer invest incurred in 2019/20 will be funded in full.

Activity Growth: Costs associated with delivering the activity growth assumptions has been incorporated into the plan based on the additional income levels (cost neutral).

Inflation: Inflation increases has been based upon national planning assumptions

CIPs Targets: The CIP target has been based on the Trust delivering the draft STP level financial trajectory

Reserves: Reserves of £5m have been incorporated within the plan to fund new service developments and cost pressures.

MTW exceptional people, outstanding care

Capital Spend Plan - all figures £000	2019/20	2020/21	2021/22	2022/23	2023/24
Estates					
Backlog maintenance	500	634	630	630	552
Backlog maintenance - funded from asset sale 18/19	1,212	1,000			
HASU - pending final approval					
AMU - funded 19/20 from £6m c/f asset sale 18/19	0	0			
AMU - funded from internal resources					
Pharmacy Outsourcing	150				
Estates Projects - other renewals		306	319	319	300
Linac estates work	373	0	375	375	375
Subtotal - internally generated funds	**2,235**	**1,940**	**1,324**	**1,324**	**1,227**
ICT					
ICT - Infrastructure	440	500	600	550	500
ICT - equipment funded from asset sale b/f	610				
ICT - HSLI (HISBI) funding b/f from 2018/19	300				
ICT - EPMA - pending funding approval	1,483				
ICT - EPR - funded from asset sale b/f	1,930				
ICT - EPR (excluding EPMA)	1,880	651	52		
Subtotal - internally generated funds	**6,643**	**1,151**	**652**	**550**	**500**
Equipment					
Trustwide equipment	894	2,486	1,484	1,313	1,466
Trustwide equipment - funded from asset sale 18/19	2,614	1,000			
Linac equipment and commissioning	250	0	250	250	250
Subtotal - internally generated funds	**3,758**	**3,486**	**1,734**	**1,563**	**1,716**
Externally financed projects					
TWH - Lifecycle (IFRIC 12 PFI capital)	594	976	1,239	1,270	1,301
Salix Energy infrastructure - Economisers	0	167			
Linac replacement programme - PDC	0	1,730	1,730	1,750	1,750
Critical Medical Imaging replacement - Loans	850	2,350			
Oncology Site replacement - East Kent - Loan		0	15,000	5,000	
HASU Stroke - STP bid PDC - pending outcome		6,245			
Subtotal - external finance	**1,444**	**11,468**	**17,969**	**8,020**	**3,051**
Total Capital Spend Plans	**14,080**	**18,045**	**21,679**	**11,457**	**6,494**

The capital plan is currently as per the 5 year plan submitted in the May NHSI Plans with two changes – inclusion of the stroke capital and increase in the planning assumption for the cost of the EK Oncology site replacement. The additional schemes included in the separate STP returns are not yet included in the working draft of the plan.

NHS
Maidstone and Tunbridge Wells
NHS Trust

Additional Capital schemes not in May NHSI Plan but in STP returns		20/21	21/22	22/23	23/24
		£'000	£'000	£'000	£'000
Theatres	STP capital PDC			20,000	
Pathology LIMS	STP capital PDC	3,200			
Cardiology suite centralised	Loan finance		7,300		
Rapid Diagnosic Centre (1 new MRI)	STP PDC			1,000	
Rapid Diagnosic Centre (Build for MRI)	STP PDC			1,700	
Kent Care Record	STP capital		1,100		
ICT infrastructure	£0.9m p.a. to 22/23 - Loan finance	900	900	900	830
Clinical applications	Loan finance			1,300	
Medical School accommod'n	Loan finance		21,000		
Car parking	Loan finance	6,000			
Anaesthetic machines replacemt	Emergency loan finance	2,000			
Ultrasound developments	Assume in internal equipment pot				
Radiology replacments	Emergency loan in 2020/21 plan £2,350				
incl 2nd CT	Emergency loan finance		2,300		
incl 1 MRI	Emergency loan finance			3,000	
incl 1 MRI and 1 CT	Emergency loan finance				3,000
TOTALS		**12,100**	**32,600**	**27,900**	**3,830**

The table above includes the additional capital schemes that the Trust has signalled in separate STP Workstream returns to be part of its strategic direction or critical infrastructure and equipment replacement. The funding source is a Trust assumption at this stage and therefore is a planning risk.

MTW
exceptional people, outstanding care

Cash

NHS
Maidstone and Tunbridge Wells NHS Trust

Creditors analysis:	19/20	20/21	21/22	22/23	23/24
NHS	5,139	4,639	4,639	4,639	4,639
Trade	33,397	36,132	38,396	39,648	40,248
Capital	1,708	1,708	1,708	1,708	1,708
Total Creditors outstanding	**40,244**	**42,479**	**44,743**	**45,995**	**46,595**

Loans due to be repaid	Value of loan	balance repaid 19/20	balance repaid 20/21	balance repaid 21/22	balance repaid 22/23	balance repaid 23/24	**balance of loan not paid**
	16,908	16,908					**0**
18/10/2020	12,132						**12,132**
18/09/2020	1,677		1,677				**0**
18/11/2020	558		558				**0**
18/01/2021	5,000						**5,000**
18/02/2021	2,765			2,765			**0**
18/03/2021	3,990						**3,990**
Balance of creditors if no element of loans repaid			**40,244**	**41,978**	**40,995**	**41,595**	

Impact and risks:

The main impact on the Trust's cash position relates to the ability to repay the working capital loans as they fall due in 2020/21. The Trusts planned I&E breakeven position for each of the next 5 years will not generate cash surpluses to enable repayment of the loans. This means that the Trust will need to annually apply to NHSI to defer the repayments of the loans. The only option for the Trust to repay any portion of the loans will be to stretch supplier payments. The table above shows an example of the impact to supplier payments if any element of loans are repaid. Stretching payments to suppliers holds a number of risks including interest charges, bad reputation, or supplier stop on supply of goods or services.

MTW
exceptional people, outstanding care

Next Steps

Maidstone and Tunbridge Wells NHS Trust

Before the final submission there will be a further review of the 20/21 financial position.

In addition further work will be done on the assumptions. In particular;

Impact of Hyper Acute Stroke
RTT trajectory cost
Cancer funding support
Activity Assumptions and the financial impact of growth
CIP Plan
Capital scheme inclusions and funding sources

MTW exceptional people, outstanding care

National Planning Inflation Assumptions

Maidstone and Tunbridge Wells NHS Trust

	2020/21	2021/22	2022/23	2023/24
AFC pay deal	2.90%	0.70%		
Pay and mix effects - AFC	n/a	2.10%	2.10%	2.10%
Pay and mix - other HCHS workforces	2.10%	2.10%	2.10%	2.10%
Tariff drugs	0.60%	0.60%	0.60%	0.60%
Other operating costs	1.80%	1.90%	2.00%	2.00%
Weighted inflation	**2.40%**	**2.40%**	**2.00%**	**2.00%**
Efficiency factor	-1.10%	-1.10%	-1.10%	-1.10%
Tariff uplift	**1.30%**	**1.30%**	**0.90%**	**0.90%**
Clinical Negligence Scheme for Trusts	10.50%	10.50%	10.50%	10.50%

MTW exceptional people, outstanding care

Contents

Maidstone and Tunbridge Wells NHS Trust

- Activity
- Workforce
- Finance
- **Next steps**

MTW exceptional people, outstanding care

Next steps

Maidstone and Tunbridge Wells NHS Trust

Activity

- Review baselines and impact on trajectories
- Agree initiatives to ameliorate growth
- Agree impact
- Remodel trajectories as appropriate

Workforce

- Continue to refine workforce requirements in light of activity and finance discussions

Finance

- Further review of the 20/21 financial position.
- Refine assumptions
  - Impact of Hyper Acute Stroke
  - RTT trajectory cost
  - Cancer funding support
  - Activity Assumptions and the financial impact of growth
  - CIP Plan
  - Capital scheme inclusions and funding sources

MTW exceptional people, outstanding care

Kent and Medway Strategy Delivery Plan 2019/20 to 2023/24	**Director of Strategy, Planning and Partnerships**

Enclosed is a report prepared by the Kent and Medway Sustainability and Transformation Partnership (STP) concerning the Kent and Medway Strategy Delivery Plan for 2019/20 to 2023/24.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Review and discussion

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

Transforming health and social care in Kent and Medway

Kent and Medway Strategy Delivery Plan 19/20 to 23/24

Bringing the NHS Long Term Plan to life in Kent and Medway

Our approach

Transforming health and social care in Kent and Medway is a partnership of all the NHS organisations in Kent and Medway, Kent County Council and Medway Council. We are working together to develop and deliver the Sustainability and Transformation Plan for our area.

Principles for our response to the NHS Long Term Plan

Our plan will show how Kent and Medway will deliver the improvements required over the next five years. It will be:

Built on the foundation of our work so far

- We will learn from and build on the work of the Kent and Medway Sustainability and Transformation Partnership from the past three years

Developed in partnership

- We are working with Kent County Council and Medway Council to develop our plan, as well as with all the NHS organisations across Kent and Medway, reflecting our commitment to joined up health and social care
- We can only deliver all of the LTP requirements by closer integration with local authorities. This is particularly evident in areas such as children and young people, learning disabilities and autism, and our out-of-hospital care model – 'local care'.
- We endeavour to embed prevention in all clinical and care pathways; taking a 21st century approach to prevention
- We are developing strong and vibrant communities where we are supporting people to live their best lives. This requires us to look beyond statutory services to the role of society, communities and individuals.

Principles for our response to the NHS Long Term Plan

Our plan will show how Kent and Medway will deliver the improvements required over the next five years. It will be:

Locally owned

- Our response will reflect the engagement, feedback and insight we have heard from our population, patients, staff and stakeholders.
- We have held four engagement events across K&M to discuss our NHS Long Term Plan response and test our thinking, as well as undertaking targeted engagement activity on specific priority areas, including surveys and focus groups with seldom-heard groups
- Our integrated care partnerships are involved in the plan development in multiple ways –
  - ICP delivery leads attending fortnightly planning meetings
  - ICP staff represented across our system groups and forums where the plan is being discussed
  - ICP finance leads are reviewing the proposed phasing of LTP implementation
- Our Primary Care Strategy is professionally-led with significant input from our GPs
- We held a Primary Care Network Clinical Directors conference on 18 September, where the five year plan was discussed

Principles for our response to the NHS Long Term Plan

Our plan will show how Kent and Medway will deliver the improvements required over the next five years. It will be:

Clinically-led

- All clinical areas of the plan are being developed by clinicians and health and care professionals
- Our plan will be developed with input from various clinical forums (for example Cancer Strategy Delivery Board)
- Our Clinical and Professional Board will have reviewed draft plan content at its August, September and October meetings
- Dr Peter Green, Clinical Chair of Medway CCG is supporting the whole plan development on behalf of the Clinical and Professional Board.

Realistic finance and workforce projections

- Our plan will be based on realistic finance and workforce projections to ensure that it is achievable and sustainable into the future
- We will need to triangulate the proposed phasing of LTP implementation recommended by clinical and operational colleagues with finance and workforce.
- Further discussions about the phasing of implementation and financing will be required where there isn't clear alignment.

Who is developing our plan?

- Over 60 people from across K&M are major contributors to our plan – across the Sustainability and Transformation Partnership, providers, commissioners, primary care, local authorities and voluntary sector
- Many of these individuals are working with a wider network to ensure sufficient clinical, financial, and partner input
- We are engaging with our system forums to seek feedback and input as we develop the plan, including:

Joint Health and Wellbeing Board	Digital workstream group
STP Programme Board	Dementia Improvement Board
STP Clinical and Professional Board	Cancer Strategy Delivery Group
STP Finance Group	Joint Committee of CCGs Cancer
STP Patient and Public Advisory Group	Mental Health Improvement Board
CCG Governing Bodies	Local A&E delivery boards
Provider Boards	Prevention workstream group
Local Care Board	Workforce Board
Primary Care Board	HR Directors Group

Bringing the NHS Long Term Plan to life in Kent and Medway

Our engagement context

- Since the Sustainability and Transformation Partnership was established in 2016 we have engaged on:

Local care

Building awareness and understanding across our communities, developing the 'Dorothy' model to bring this to life for local people

Transformation work in east Kent

Cutting across hospital, local and primary care, there has been a significant engagement effort which has informed the development of proposals

Stroke services consultation

A comprehensive public consultation across the whole of Kent and Medway reaching out across 2.2m people.

Prevention, access, healthy living support and self-care

Ongoing work across CCG areas and in partnership with local authorities and public health

We are building on what we have heard

Local people have told us they want…..

‘Older people and vulnerable people will worry about IT based services, we still need people on the end of a phone.’

Engagement with hard to reach on digital

‘When it comes to cancer care if that means travelling that’s fine. Care close to home that is not up to a high standard is worthless.’

Online survey, cancer

‘Specialist workers to talk to students about LGBTQ+ and sexuality as they are non-judgemental.’

Survey – what will make children’s services better?

‘Services in Kent and Medway to be as good as the best in the country’

‘People and doctors, coming together, that’s great team work – get the community involved’

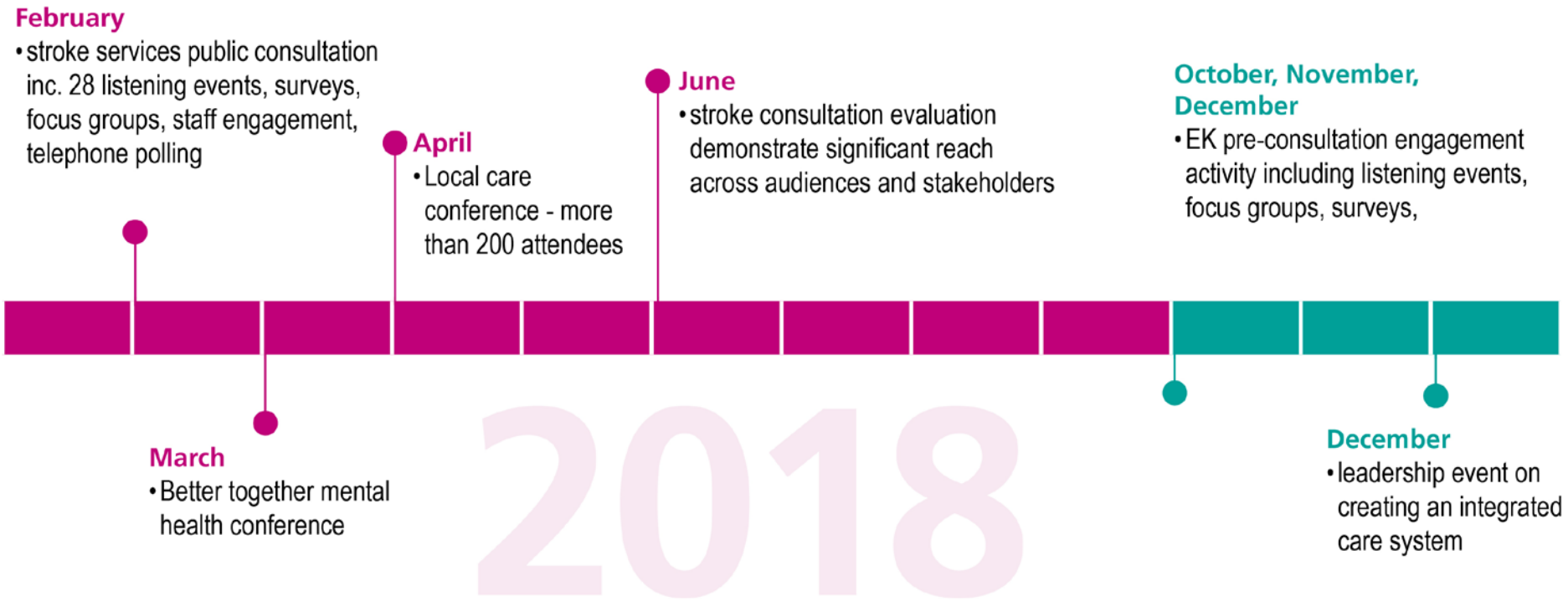
Online survey, system transformation survey

‘For staff - it will mean a better job satisfaction and work life balance.’

Benefits of ICS, online survey

Bringing the NHS Long Term Plan to life in Kent and Medway

Kent and Medway engagement overview 2018



Ongoing staff engagement: meetings and briefings, intranet, bulletins
Ongoing partner engagement – PPAG (monthly), CCGs lay members, Partnership Board (including local councils), MPs, HOSC, HASC,H&WBs, LMC, NHSE and NHSI
Ongoing media, social media, web and other content activity – sharing stories and information at each stage

Bringing the NHS Long Term Plan to life in Kent and Medway

Kent and Medway engagement overview 2019

January
- Kent and Medway welcomes LTP publication in joint NHS and local authority response

February
- East Kent public meeting on urgent treatment centres
- integrated care system event – 90 attendees including senior leaders, clinicians and patient representatives
- Primary care strategy develop-ment day with GPs , primary care staff and public/volunteers

March –
- Being Digital strategy launched (KCC and K&M STP)

April
- updates on the move towards an ICS in K&M for staff, professionals and stakeholders
- briefing district and borough councillors on the move towards K&M ICS

May
- Learn and share local care conference. More than 170 people from 40+ organisations
- Release the Pressure suicide prevention conference - Mental Health Awareness Week. 230 attendees.
- Healthwatch carried out engagement about children and young people's services to feed into our plans. A survey and outreach engagement visits to groups and services enabled nearly 300 people to share their views.

June
- publication of Helping local people live their best life and accompanying survey – patients and the public, staff and stakeholders
- Kent and Medway Cancer Alliance newsletter launched

July
- launch of children and young people's survey
- East Kent evaluation criteria workshop
- Patient information and support workshop for cancer services

July/August
- Briefing and follow-up meetings with MPs, district councils, MPs, Healthwatch on proposals for single commissioner
- series of workshops with patient and public advisory group to co-design what patient involvement looks like in ICS

August
- Engagement with Healthwatch members, plus members of public on ICS
- Briefing and webinar for all GPs across the system on proposals for single commissioner
- launch of cancer survey

September
- Four public events one in each ICP area to test early thinking, with voluntary sector and councillors
- Targeted engagement, through Healthwatch, with hard to reach on areas of inequalities
- Clinical directors conference with Local Medical Council (18 Sep)
- Commissioning and CCG staff away day on single CCG (13 Sep)
- LTP updates at AGMs across system
- mental health summit (Thanet)
- September – Westminster MP briefing (TBC)

October
- Chairs and NEDs briefing (28 Oct)

November
- Publish plan, summary and easy read versions* Note this is not an exhaustive list

Ongoing staff engagement: meetings and briefings, intranet, bulletins
Ongoing partner engagement – PPAG (monthly), CCGs lay members, Partnership Board (including local councils), MPs, HOSC, HASC,H&WBs, LMC, NHSE and NHSI
Ongoing media, social media, web and other content activity – sharing stories and information at each stage

Bringing the NHS Long Term Plan to life in Kent and Medway

Ongoing planned engagement activity

Patients and the public

- Four public-facing events in September – one in each integrated care partnership' area – to explore responses to priority areas
- Kent and Medway Patient and Public Advisory Group and GP surgeries' Patient Participation Group meetings and patient liaison meetings across K&M
- Surveys – children's services, cancer, ICS, single CCG
- Engage Kent commissioned to undertake targeted engagement with seldom-heard communities and groups across Kent and Medway
- Workstream engagement underway to inform development of specific priorities
- Further development of core materials (slide deck, script, Q&A etc) to support engagement
- Public meetings such as AGMs, boards

Staff and professionals

- Away day for CCG and STP staff to bring them up to speed with and discuss progress
- Further development of core materials to support engagement – to be circulated to all comms leads for internal comms use
- Meetings and briefings with leadership from across Kent and Medway
- Clinical directors conference – for Primary Care Network leaders
- Patient Participation Group chairs and GP practice managers' sessions
- Ongoing communications and engagement work with unions and staff side organisations and reps

Ongoing planned engagement activity

Other stakeholders

- Ongoing programme of 'business as usual' communications and engagement activities with a wide range of stakeholders.

  Examples include:

Healthwatch – volunteer meetings and sessions and business as usual activities
Chairs, NEDs briefing event – October 2019
Regular updates to HOSC/HASC and HWBs across Kent and Medway
Meetings and briefings with MPs, elected members and officers, with Westminster briefing planned for end of September
Voluntary and community sector organisations and representatives meetings and briefings

Update on the Trust's preparations for the UK's exit from the EU	**Chief Operating Officer / Head of Emergency Planning & Response**

The attached report is a summary of current preparations for EU Exit on October 31st.

It summarises risks and actions taken to manage continuity of service in the event of a worst case scenario. It has been compiled using current planning assumptions from NHS England and HM Government.

It relates to a dynamic and changing environment and therefore the Board should be aware that plans are constantly changing.

The Board should note that the NHS and the Trust in particular have a long history of responding to incidents and disruption.

The Trust like all NHS organisations has a legal responsibility to plan for the worst case scenario to ensure its core critical services can continue.

Using current planning assumptions there is a risk of disruption which should be mitigated as far as is practicable using the measures described.

Which Committees have reviewed the information prior to Board submission?
Executive Team Meeting, 17/09/19

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
The Board is asked to note the content

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

1. Current Situation

1.1 The Government have clearly stated it is HM Government Policy to leave the EU on October 31st 2019 either with a renegotiated deal or a no deal.

1.2 A public information campaign has started and sector specific guidance and workshops including NHS have been taking place.

1.3 EU Exit is still a major work stream for the Emergency Planning Team and has by definition delayed other projects.

2. Concurrent Risks

2.1 **EU Exit fatigue.** The repeat of preparations means it is possible that people underestimate the importance or impact of the risks.

2.2 **Winter.** The winter season brings additional risks including adverse weather and the increase in activity that occurs in non-elective attendances. Any adverse weather such as snow will also compound traffic and access issues.

2.3 **Flu Season**. If high levels of seasonal flu are present this will increase non elective admissions and compound staff shortages.

2.4 **Half Term** Although the Kent Half term will be over – the East Sussex Half term will be taking place. This is always a time when staffing is at a low point and divisions will need to factor this in.

3. Current Planning & Response Framework

3.1 The EPRR team are engaged in multi-agency planning & exercises with the Kent Resilience Forum and other NHS colleagues. Multi agency work streams are looking at a number of scenarios and access to NHS facilities has been raised at each one.

3.2 Local meetings with other stakeholders including local councils and companies continue.

3.3 The Trust will manage this in line with its standard incident management protocols. Additional on call incident commanders are available to ensure arrangements can work 24/7 if required.

4. **Trust Response**

4.1 It must be remembered that the Trust is a Category One responder under the civil Contingencies Act 2004. It has a legal duty to asses risk and plan accordingly. The Trust in common with other partner agencies has the planning assumptions from HM Government and must plan for a reasonable worst case scenario.

4.2 The overall strategic aim must be to maintain a safe level of care to our patients and ensure that our staff are looked after.

5. Workforce

5.1 **Workforce** – overall risk still remains although with additional nursing staff from overseas living locally this risk has improved. There seems to be no imminent risk of large scale exodus of domestics or other crucial staff with overseas backgrounds. The process of gaining UK citizenship has bedded in and is a more slick process than during the spring.

5.2 **Transport Disruption** – The trust experienced the extended Operation Stack in 2015 and it is clear that access for some groups of staff and patients that accessing the Maidstone Site may be difficult. Directorate Teams have identified staff in high risk disruption zones using postcode data and are in the process of identifying solutions. This can include:

- Working from home or another hospital base.
- using public transport where the trust can collect from a nearby rail station
- Changing shift and working hours or days.
- A number of hotel rooms have been booked across the Trust area and will available as a contingency if required and can be used by the Hospital Tactical Commander if required.
- A number of other contingencies including dedicated blue light vehicles remain available to the Hospital Tactical Commander if required.
- Divisional Directors can activate Business Continuity Plans to stand down some non-critical services and redeploy staff to support non elective services if required.
- The helipad at Maidstone Hospital should be completed and therefore is available for use by helicopters to move patients to other hospitals if required and to bring essential supplies if required in exceptional circumstances. The pad at Tunbridge Wells Hospital is also available 24/7.
- Bringing in supplies & laundry deliveries overnight when roads are quieter
- Using motorcycle couriers where needed for urgent blood samples

5.3 **Staff Welfare** – A high priority for the Trust must remain staff welfare particularly staff who have disrupted journeys to work or extend shift times to cover colleagues. The new arrangements to provide staff only access over night to the restaurant along with hot food are now in place. The Break Out room for Maidstone is also in use. Arrangements are in progress at Tunbridge Wells.

6. **Procurement** – National management is as in previous planning with additional ports of entry including air freight if required, risk assessment by Procurement indicates most of our supply is chain is resilient although some risk that unable to get next day delivery on some products may cause 72 hr delays in some isolated cases. Some spare parts are slightly higher risk but Estates are aware and are sourcing alternatives. Additional storage has also been procured. The close proximity to NHS Supply Chain warehouse makes things easier for MTW. The Board should be aware of the huge task undertaken by Procurement in risk assessing and investigating supply chains of thousands of suppliers.

7. **Medicines** – The previous stock management and shipment routes along with national co-ordination appears to have mitigated most issues – this will not stop local shortages unconnected with EU Exit which pharmacy are dealing with on a daily basis. The UK Government have reviewed medicines supply routes, stockpiles and supply chains. There is a clear message that medicines should be prescribed and dispensed as normal and any issues that cannot be managed locally with the usual local collaboration can be escalated and managed centrally. Advice to patients is being posted on nhs.uk.

8. Patients & service users

The Trust will communicate with patients using its website, social media channels and through its booking software that sends text messages out. In addition staff can phone those who do not receive text messages or who need a personal phone call. Where patients are on essential complex treatments and require daily treatment then the Trust has some hotel accommodation available to support this. Divisions will assess these requirements about 14 – 21 days prior to EU Exit when the case load is known. Where special advice is required such as Maternity or Oncology the divisions will ensure sufficient on the phone advice is available.

9. Planning

The Trust has a combined winter and EU Exit group co-chaired by the Deputy Chief Operating Officer and Head of EPRR meeting every two weeks with representation from divisions and essential partners including pharmacy, estates, communications and CCG. This group will also monitor local intelligence around Social Care, Nursing & Care homes to ensure the Trust is aware of any difficulties being experienced locally. The Trust is represented on a number of groups with multi agency partners and other NHS bodies and has fully engaged in EU Exit planning throughout.

10 **Conclusion**

This report summarises the current situation. This is a dynamic process.

The trust and the NHS are very good at withstanding disruption from whatever source and the organisation has a fantastic group of staff to assist. Even with the most effective planning and preparation if the worst case assumptions become reality then there will be disruption to services although as an organisation our critical services are believed to be resilient. Local NHS organisations have well practiced processes to collaborate and support each other along with our voluntary, local authority, emergency services and charity partners.

The Board should note that planning and response carry an additional cost burden for the organisation both in time, manpower and finance.

Approval of Emergency Preparedness, Resilience and Response (EPRR) Core Standards self-assessment	**Chief Operating Officer / Head of Emergency Planning & Response**

The enclosed report provides information on the Trust's statement of compliance with NHS England Core Standards on Emergency Planning Response & Recovery.

The Trust is fully compliant with the 64 Core Standards.

This year the "Deep Dive" relates to Climate Change and these standards do not contribute to the overall core standards rating. They are designed as an information gathering and status check for NHS England.

This year the deep dive falls into two parts –

- Emergency Response to severe weather
- Climate Change adaption

Our rating is as follows:

- Emergency Response to Severe weather - fully compliant with 14 of 15 – the outstanding standard is partially compliant and relates to IT remote working response. An action is highlighted for the Director of IT
- Climate change Adaptation – Not compliant with 4 of 5, partially compliant with 1 of 5

The responsibility for Climate change adaptation rests with the Director of Estates & Facilities and an action plan has been requested for presentation at the Resilience Committee.

Which Committees have reviewed the information prior to Board submission?
Trust Resilience Committee

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
The Board is asked to note and approve the submission.

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

1 Introduction

The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport accident. The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS-funded care, to show that they can deal with such incidents while maintaining services.

NHS England and Improvement has published NHS Core Standards for Emergency Preparedness, Resilience and Response arrangements. These are the minimum standards which NHS organisations and providers of NHS funded care must meet. The Accountable Emergency Officer in each organisation is responsible for making sure these standards are met

2 Statement of Compliance

As part of the national EPRR assurance process for this year Maidstone & Tunbridge Wells NHS Trust has been required to assess itself against these core standards. The outcome of this self-assessment shows that against 64 of the core standards which are applicable to the organisation the trust is fully compliant with 64 of these core standards

The overall rating is: Fully Complaint

. **NHS England and Improvement-South East EPRR Assurance Compliance Ratings:**
To support a standardised approach to assessing an organisation's **overall preparedness rating** NHS England and Improvement have set the following criteria:

Compliance Level	Evaluation and Testing Conclusion
Full	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

3. Areas to be considered

The Deep dive this year relates to climate change. The deep dive does not contribute to the Trusts overall rating but is intended as an indication of the NHS position. This section is split into two sections – that is Emergency Response to severe weather and the long term adaptation to climate change.

The standards on emergency response scored as follows:

Fully Compliant	Partially complaint	Non-compliant
14	1	0

The partial compliance relates to IT testing of working from home VPN connections.

The standards relating to long term adaptation of climate change

Fully Compliant	Partially compliant	Non-compliant
0	2	3

The responsibility for Long term adaptation planning rests with the Director of Estates & Facilities who has been requested to compile an action plan to highlight the actions required.

Conclusion:

The Trusts Emergency Preparedness remains strong and is an essential part of the organisation. The response by the organisation to climate change requires further assessment in conjunction with Estates & Facilities.

Please select type of organisation: **Acute Providers**

Publishing Approval Reference: 000719

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	14	14	0	0
Command and control	2	2	0	0
Training and exercising	3	3	0	0
Response	7	7	0	0
Warning and informing	3	3	0	0
Cooperation	4	4	0	0
Business Continuity	9	9	0	0
CBRN	14	14	0	0
Total	64	64	0	0

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Severe Weather response	15	14	1	0
Long Term adaptation planning	5	0	2	3
Total	20	14	3	3

Overall assessment:	Fully compliant

Instructions:
Step 1: Select the type of organisation from the drop-down at the top of this page
Step 2: Complete the Self-Assessment RAG in the 'EPRR Core Standards' tab
Step 3: Complete the Self-Assessment RAG in the 'Deep dive' tab
Step 4: Ambulance providers only: Complete the Self-Assessment in the 'Interoperable capabilities' tab
Step 5: Click the 'Produce Action Plan' button below

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below
1	**Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	• Name and role of appointed individual
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation	Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.
3	**Governance**	**EPRR board reports**	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board
4	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by: • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes.	Y	• Process explicitly described within the EPRR policy statement • Annual work plan

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	• EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group
6	**Governance**	**Continuous improvement process**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	• Process explicitly described within the EPRR policy statement
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document
9	**Duty to maintain plans**	**Collaborative planning**	Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.	Y	Partners consulted with as part of the planning process are demonstrable in planning arrangements
11	**Duty to maintain plans**	**Critical incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
12	**Duty to maintain plans**	**Major incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below
13	**Duty to maintain plans**	**Heatwave**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
14	**Duty to maintain plans**	**Cold weather**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
15	**Duty to maintain plans**	**Pandemic influenza**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
16	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases such as Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3 and PPE trained individuals commensurate with the organisational risk.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below
17	**Duty to maintain plans**	**Mass countermeasures**	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including arrangement for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. CCGs may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
18	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
19	**Duty to maintain plans**	**Mass Casualty - patient identification**	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below
20	**Duty to maintain plans**	**Shelter and evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
21	**Duty to maintain plans**	**Lockdown**	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
22	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
23	**Duty to maintain plans**	**Excess death planning**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below
24	**Command and control**	**On-call mechanism**	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.
25	**Command and control**	**Trained on-call staff**	On-call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf of the Chief Executive Officer / Clinical Commissioning Group Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.	Y	• Process explicitly described within the EPRR policy statement
26	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	Y	• Process explicitly described within the EPRR policy statement • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below
27	**Training and exercising**	**EPRR exercising and testing programme**	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement	Y	• Exercising Schedule • Evidence of post exercise reports and embedding learning
28	**Training and exercising**	**Strategic and tactical responder training**	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation	Y	• Training records • Evidence of personal training and exercising portfolios for key staff
30	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has a preidentified Incident Co-ordination Centre (ICC) and alternative fall-back location(s). Both locations should be annually tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.	Y	• Documented processes for establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards
31	**Response**	**Access to planning arrangements**	Version controlled, hard copies of all response arrangements are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and hard copies
32	**Response**	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans
33	**Response**	**Loggist**	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents. Key response staff are aware of the need for keeping their own personal records and logs to the required standards.	Y	• Documented processes for accessing and utilising loggists • Training records

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below
34	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for completing, signing off and submitting SitReps • Evidence of testing and exercising
35	**Response**	**Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'**	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y	Guidance is available to appropriate staff either electronically or hard c
36	**Response**	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Y	Guidance is available to appropriate staff either electronically or hard c
37	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work
38	**Warning and informing**	**Warning and informing**	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below
39	**Warning and informing**	**Media strategy**	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times.	Y	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'
40	**Cooperation**	**LRHP attendance**	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75% annually) Local Health Resilience Partnership (LHRP) meetings.	Y	• Minutes of meetings
41	**Cooperation**	**LRF / BRF attendance**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Y	• Minutes of meetings • Governance agreement if the organisation is represented
42	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate
46	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 ‘duty to communicate with the public’.
47	**Business Continuity**	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the comitmement to a Business Continutiy Management System (BCMS) in alignment to the ISO standard 22301.	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below
48	**Business Continuity**	**BCMS scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders
49	**Business Continuity**	**Business Impact Assessment**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	Y	Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support.
50	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Statement of compliance
51	**Business Continuity**	**Business Continuity Plans**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be reviewed regularly (at a minimum annually), or following organisational change, or incidents and exercises	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation
52	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below
53	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports
54	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectivness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans
55	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Organisational Evidence	Self assessment RAG **Red (not compliant) =** Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Severe Weather											
Domain: Severe Weather Response											
1	**Severe Weather response**	**Overheating**	The organisation's heatwave plan allows for the identification and monitoring of inpatient and staff areas that overheat (For community and MH inpatient area may include patients own home, or nursing/care home facility)	Y	The monitoring processes is explicitly identified in the organisational heatwave plan. This includes staff areas as well as inpatient areas. This process clearly identifies relevant temperature triggers and subsequent actions	Heatwave plan	Fully compliant				
2	**Severe Weather response**	**Overheating**	The organisation has contingency arrangements in place to reduce temperatures (for example MOUs or SLAs for cooling units) and provide welfare support to inpatients and staff in high risk areas (For community and MH inpatient area may include patients own home, or nursing/care home facility)	Y	Arrangements are in place to ensure that areas that have been identified as overheating can be cooled to within reasonable temperature ranges, this may include use of cooling units or other methods identified in national heatwave plan.	Heatwave plan	Fully compliant				
3	**Severe Weather response**	**Staffing**	The organisation has plans to ensure staff can attend work during a period of severe weather (snow, flooding or heatwave), and has suitable arrangements should transport fail and staff need to remain on sites. (Includes provision of 4x4 where needed)	Y	The organisations arrangements outline: - What staff should do if they cannot attend work - Arrangements to maintain services, including how staff may be brought to site during disruption - Arrangements for placing staff into accommodation should they be unable to return home	Cold Weather plan & accomodation & 4WD statement	Fully compliant				
4	**Severe Weather response**	**Service provision**	Organisations providing services in the community have arrangements to allow for caseloads to be clinically prioritised and alterative support delivered during periods of severe weather disruption. (This includes midwifery in the community, mental health services, district nursing etc)	Y	The organisations arrangements identify how staff will prioritise patients during periods of severe weather, and alternative delivery methods to ensure continued patient care	Trust only as matenity patients - Maternity triage has well rehearsed plans to bring in to hospital if required	Fully compliant				
5	**Severe Weather response**	**Discharge**	The organisation has polices or processes in place to ensure that any vulnerable patients (including community, mental health, and maternity services) are discharged to a warm home or are referred to a local single point-of-contact health and housing referral system if appropriate, in line with the NICE Guidelines on Excess Winter Deaths	Y	The organisations arrangements include how to deal with discharges or transfers of care into non health settings. Organisation can demonstrate information sharing regarding vulnerability to cold or heat with other supporting agencies at discharge	Contract with Age Concern , take home and settle, Fire service Safe & well visits, Heatwave Discharge Proforma,	Fully compliant				
6	**Severe Weather response**	**Access**	The organisation has arrangements in place to ensure site access is maintained during periods of snow or cold weather, including gritting and clearance plans activated by predefined triggers	Y	The organisation arrangements have a clear trigger for the pre-emptive placement of grit on key roadways and pavements within the organisations boundaries. When snow / ice occurs there are clear triggers and actions to clear priority roadways and pavements. Arrangements may include the use of a third party gritting or snow clearance service.	See plan	Fully compliant				
7	**Severe Weather response**	**Assessment**	The organisation has arrangements to assess the impact of National Severe Weather Warnings (including Met Office Cold and Heatwave Alerts, Daily Air Quality Index and Flood Forecasting Centre alerts) and takes predefined action to mitigate the impact of these where necessary	Y	The organisations arrangements are clear in how it will assesses all weather warnings. These arrangements should identify the role(s) responsible for undertaking these assessments and the predefined triggers and action as a result	EPRR Team on call 24/7	Fully compliant				
8	**Severe Weather response**	**Flood prevention**	The organisation has planned preventative maintenance programmes are in place to ensure that on site drainage is clear to reduce flooding risk from surface water, this programme takes into account seasonal variations.	Y	The organisation has clearly demonstratable Planned Preventative Maintenance programmes for its assets. Where third party owns the drainage system there is a clear mechanism to alert the responsible owner to ensure drainage is cleared and managed in a timely manner		Fully compliant				
9	**Severe Weather response**	**Flood response**	The organisation is aware of, and where applicable contributed to, the Local Resilience Forum Multi Agency Flood Plan. The organisation understands its role in this plan.	Y	The organisation has reference to its role and responsibilities in the Multi Agency Flood Plan in its arrangements. Key on-call/response staff are clear how to obtain a copy of the Multi Agency Flood Plan	in ICC	Fully compliant				
10	**Severe Weather response**	**Warning and informi**	The organisation's communications arrangements include working with the LRF and multiagency partners to warn and inform, before and during, periods of Severe Weather, including the use of any national messaging for Heat and Cold.	Y	The organisation has within is arrangements documented roles for its communications teams in the event of Severe Weather alerts and or response. This includes the ability for the organisation to issue appropriate messaging 24/7. Communications plans are clear in what the organisations will issue in terms of severe weather and when.	EPRR Team on call 24/7 using Social media, global e mails website & intranet	Fully compliant				

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Organisational Evidence	Self assessment RAG **Red (not compliant) =** Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
11	**Severe Weather response**	**Flood response**	The organisation has plans in place for any preidentified areas of their site(s) at risk of flooding. These plans include response to flooding and evacuation as required.	Y	The organisation has evidence that it regularly risk assesses its sites against flood risk (pluvial, fluvial and coastal flooding). It has clear site specific arrangements for flood response, for known key high risk areas. On-site flood plans are in place for at risk areas of the organisations site(s).	Trust does not have any estate in a flood risk zone nor has there been any issues including in the 2000 severe floods	Fully compliant				
12	**Severe Weather response**	**Risk assess**	The organisation has identified which severe weather events are likely to impact on its patients, services and staff, and takes account of these in emergency plans and business continuity arrangements.	Y	The organisation has documented the severe weather risks on its risk register, and has appropriate plans to address these.	see Risk Register in main core standards	Fully compliant				
13	**Severe Weather response**	**Supply chain**	The organisation is assured that its suppliers can maintain services during periods of severe weather, and periods of disruption caused by these.	Y	The organisation has a documented process of seeking risk based assurance from suppliers that services can be maintained during extreme weather events. Where these services can't be maintain the organisation has alternative documented mitigating arrangements in place.	see Example	Fully compliant				
14	**Severe Weather response**	**Exercising**	The organisation has exercised its arrangements (against a reasonable worst case scenario), or used them in an actual severe weather incident response, and they were effective in managing the risks they were exposed to. From these event lessons were identified and have been incorporated into revised arrangements.	Y	The organisation can demonstrate that its arrangements have been tested in the past 12 months and learning has resulted in changes to its response arrangements.	See exercise report	Fully compliant				
15	**Severe Weather response**	**ICT BC**	The organisations ICT Services have been thoroughly exercised and equipment tested which allows for remote access and remote services are able to provide resilience in extreme weather e.g. are cooling systems sized appropriately to cope with heatwave conditions, is the data centre positioned away from areas of flood risk	Y	The organisations arrangements includes the robust testing of access services and remote services to ensure the total number of concurrent users meets the number that may work remotely to maintain identified critical services	The system is tested but reports not available	Partially compliant	Director of IT to arrange testing & report to Resilience Committee	Director of IT		
Domain: long term adaptation planning											
16	**Long term adaptation planning**	**Risk assess**	Are all relevant organisations risks highlighted in the Climate Change Risk Assessment are incorporated into the organisations risk register.	Y	Evidence that the there is an entry in the organiations risk register detailing climate change risk and any mitigating actions	Separate heatwave & cold weather & flooding	Partially compliant	Director of Estates & Facilities to ensure risks on Climate change are reviwed and report back to Resilience Committee	Director of E&F		
17	**Long term adaptation planning**	**Overheating risk**	The organisation has identified and recorded those parts of their buildings that regularly overheat (exceed 27 degrees Celsius) on their risk register. The register identifies the long term mitigation required to address this taking into account the sustainable development commitments in the long term plan. Such as avoiding mechanical cooling and use of cooling higheracy.	Y	The organisation has records that identifies areas exceeding 27 degrees and risk register entries for these areas with action to reduce risk	Records - not on risk register as individual wards	Partially compliant	Director of Estates & Facilities to ensure hot areas are recorded on E&F risk register and report back to Resilience Committee	Director of E&F		
18	**Long term adaptation planning**	**Building adaptations**	The organisation has in place an adaptation plan which includes necessary modifications to buildings and infrastructure to maintain normal business during extreme temperatures or other extreme weather events.	Y	The organisation has an adaptation plan that includes suggested building modifications or infrastructure changes in future	Estates unable to produce plan	Non compliant	Director of Estates & Facilities to ensure plan produced and report back to Resilience Committee	Director of E&F		
19	**Long term adaptation planning**	**Flooding**	The organisations adaptation plans include modifications to reduce their buildings and estates impact on the surrounding environment for example Sustainable Urban Drainage Systems to reduce flood risks.	Y	Areas are identified in the organisations adaptation plans that might benefit drainage surfaces, or evidence that new hard standing areas considered for SUDS	Estates unable to produce plan	Non compliant	Director of Estates & Facilities to ensure plan produced and report back to Resilience Committee	Director of E&F		
20	**Long term adaptation planning**	**New build**	The organisation considers for all its new facilities relevant adaptation requirements for long term climate change	Y	The organisation has relevant documentation that it is including adaptation plans for all new builds	Estates unable to produce plan	Non compliant	Director of Estates & Facilities to ensure plan produced and report back to Resilience Committee	Director of E&F		

Overall assessment:										
Ref	**Domain**	**Standard**	**Detail**	**Evidence - examples listed below**	**Organisation Evidence**	**Self assessment RAG** **Red (not compliant) =** Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	**Action to be taken**	**Lead**	**Timescale**	**Comments**
15	**Severe Weather response**	**ICT BC**	The organisations ICT Services have been thoroughly exercised and equipment tested which allows for remote access and remote services are able to provide resilience in extreme weather e.g. are cooling systems sized appropriately to cope with heatwave conditions, is the data centre positioned away from areas of flood risk.	The organisations arrangements includes the robust testing of access services and remote services to ensure the total number of concurrent users meets the number that may work remotely to maintain identified critical services	The system is tested but reports not available	Partially compliant	Director of IT to arrange testing & report to Resilience Committee	Director of IT		
16	**Long term adaptation planning**	**Risk assess**	Are all relevant organisations risks highlighted in the Climate Change Risk Assessment are incorporated into the organisations risk register.	Evidence that the there is an entry in the organiations risk register detailing climate change risk and any mitigating actions	Separate heatwave & cold weather & flooding	Partially compliant	Director of Estates & Facilities to ensure risks on Climate change are reviwed and report back to Resilience Committee	Director of E&F		
17	**Long term adaptation planning**	**Overheating risk**	The organisation has identified and recorded those parts of their buildings that regularly overheat (exceed 27 degrees Celsius) on their risk register. The register identifies the long term mitigation required to address this taking into account the sustainable development commitments in the long term plan. Such as avoiding mechanical cooling and use of cooling higherachy.	The organisation has records that identifies areas exceeding 27 degrees and risk register entries for these areas with action to reduce risk	Records - not on risk register as individual wards	Partially compliant	Director of Estates & Facilities to ensure hot areas are recorded on E&F risk register and report back to Resilience Committee	Director of E&F		
18	**Long term adaptation planning**	**Building adaptations**	The organisation has in place an adaptation plan which includes necessary modifications to buildings and infrastructure to maintain normal business during extreme temperatures or other extreme weather events.	The organisation has an adaptation plan that includes suggested building modifications or infrastructure changes in future	Estates unable to produce plan	Non compliant	Director of Estates & Facilities to ensure plan produced and report back to Resilience Committee	Director of E&F		
19	**Long term adaptation planning**	**Flooding**	The organisations adaptation plans include modifications to reduce their buildings and estates impact on the surrounding environment for example Sustainable Urban Drainage Systems to reduce flood risks.	Areas are identified in the organisations adaptation plans that might benefit drainage surfaces, or evidence that new hard standing areas considered for SUDS	Estates unable to produce plan	Non compliant	Director of Estates & Facilities to ensure plan produced and report back to Resilience Committee	Director of E&F		
20	**Long term adaptation planning**	**New build**	The organisation considers for all its new facilities relevant adaptation requirements for long term climate change	The organisation has relevant documentation that it is including adaptation plans for all new builds	Estates unable to produce plan	Non compliant	Director of Estates & Facilities to ensure plan produced and report back to Resilience Committee	Director of E&F		

Responsible Officer's Annual Report 2018/19 — Medical Director

As a designated body, the Trust has responsibilities to provide a quality assured appraisal process to all doctors with a 'prescribed connection'. As Responsible Officer, the Medical Director must give assurance to the Trust Board that processes, compliance and monitoring of the medical appraisal and revalidation processes, as well as the ability of the Trust to respond appropriately to concerns raised about medical performance, meet national standards defined in legislation, by NHS England and by the GMC.

The appraisal year for doctors runs from 1st April to 31st March. In MTW medical appraisals are conducted between September and January.

The Board is asked to review the report and approve the Statement of Compliance (Appendix F) confirming that the Trust, as a designated body, is in compliance with the regulations governing appraisal and revalidation.

Once approved, the Statement will then be signed by the Chief Executive, before being submitted to the higher-level Responsible Officer (by 30th September 2019).

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

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

1. To review the report and;
2. To approve the Statement of Compliance (Appendix F) confirming that the Trust, as a designated body, is in compliance with the regulations governing appraisal and revalidation

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

ANNUAL REPORT: MEDICAL APPRAISAL AND REVALIDATION AT MTW

1. Executive summary

Maidstone and Tunbridge Wells NHS Trust (MTW) is responsible for providing an annual appraisal to all doctors who have a prescribed connection. Of the 411 MTW doctors with such a connection, 384 completed an appraisal in the 2018/19 appraisal year ending 31.03.19. This is an overall appraisal rate of 94.43%. The rate varied with the grade of doctor: 97% consultants and 93% staff and associate specialists had an appraisal and 84% of the trust grade/locums and other grades had an MTW appraisal. As at 31st May 2019, all doctors who had a prescribed connection to MTW had undertaken an annual appraisal unless a deferral had been agreed by the Deputy RO.

A random sample of the 19 portfolios of supporting information of MTW doctors were reviewed against NHS England standards to audit the information being submitted to the appraisal process.

The national phased roll out of the medical revalidation instigated in 2012 allocated all registered doctors to have been revalidated by March 2016. This resulted in a large drop in the numbers of doctors whose revalidation fell due in 2016 and 2017. During 2018/19, the MTW advisory panel met monthly to advise the Responsible Officer (RO) about these recommendations as they fell due through the year. The RO made 60 positive revalidation recommendations, 17 deferral recommendations and no recommendations of 'non-engagement' to the General Medical Council (GMC).

2. Purpose of the report

As a designated body, Maidstone and Tunbridge Wells NHS Trust has responsibilities to provide a quality assured appraisal process to all doctors with a 'prescribed connection'. As Responsible Officer the Medical Director must give assurance to the Trust Board that processes, compliance and monitoring of the medical appraisal and revalidation processes, as well as the ability of the Trust to respond appropriately to concerns raised about medical performance, meet national standards defined in legislation, by NHS England and by the GMC.

The appraisal year for doctors runs from 1st April to 31st March. In MTW medical appraisals are conducted between September and January.

The purpose of revalidation is to give assurance to patients, employers, doctors and regulators that doctors are up to date, fit to practice and safe within their entire scope of practice (not just their NHS work). This paper seeks to give Board assurance that MTW meets its statutory requirements surrounding appraisal and revalidation of its doctors.

3. Background

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations and it is expected that provider Boards will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

4. Governance Arrangements

The Responsible Officer has a defined overall responsibility for the management of all aspects of medical appraisal and revalidation. At MTW aspects of this are delegated to a deputy medical director who acts as the Trust's appraisal lead. The appraisal lead has been formally recognised as the Deputy RO. Administrative support is provided by the Medical Director's office. Although systems for medical appraisal have been a requirement since 2001 these were overhauled at MTW in 2008. New systems of monitoring and quality assurance have evolved since then, as national guidelines have developed and clarity around the revalidation process has emerged.

Appraisers have been trained either internally or through external providers and updated annually, just prior to the commencement of the annual appraisal round.

Quality assurance processes are led by the appraisal lead. There is no designated HR lead for medical appraisal and revalidation processes.

The MTW 'Revalidation Advisory Group' met to assist the responsible officer with making and documenting revalidation recommendations for MTW doctors. The group has terms of reference and consists of the medical director, the deputy medical director, chiefs of service and the newly appointed MTW appraisal lead. The group met approximately monthly and triangulated the appraisal records, as well as any information about complaints, claims, incidents and disciplinary issues concerning the doctor whose revalidation is due. The RO may make only one of 3 recommendations:

- A positive recommendation to revalidate
- A recommendation to defer revalidation for up to one year
- A notification that a doctor has not engaged adequately with the appraisal process.

Data about all doctors connected to MTW is kept on a spreadsheet which is regularly updated with information about previous appraisals and any concerns about their practice. This list is adjusted as doctors new to MTW establish a prescribed connection through a list held on the 'GMC connect' website. Changes are cross referenced with Medical Staffing, the Director of Medical Education and with clinical directorates to ensure that the link is appropriate and reflects the true employment status of the doctor.

Data on appraisal and revalidation processes is supplied to the regional team of NHS England on a quarterly basis by the appraisal lead.

Benchmarking of appraisal and revalidation processes also takes place through RO and Appraisal Lead attendance at Regional network meetings (3 times per annum).

a. Existing Policy and Guidance

- MTW Appraisal and Revalidation Policy 2016
- MTW Management of concerns about the performance of doctors policy 2011
- MTW Back on track policy 2012
- NHS England appraisal policy 2014
- GMC: supporting information for appraisal and revalidation 2013
- GMC: framework for revalidation 2012

5. Medical Appraisal

a. Appraisal and Revalidation Performance Data

- 411 doctors connected to MTW as at the end on 31.03.19
- 384 doctors had a completed appraisal (93.43%)
- 227/234 consultants (97%); 81/87 SAS doctors (93%) and 76/90 of other doctors (84%) completed an appraisal.

(See also **Annual Report Template Appendix A;** Audit of all missed or incomplete appraisals audit)

b. Appraisers

76 MTW doctors are listed on the MTW list of approved appraisers, (7 SAS doctors and 69 consultants). Four appraisers left and five new appraisers were trained in 2018/19.

MTW appraisers are invited to attend one of two appraiser update sessions held in the autumn by the appraisal lead prior to the start of the “appraisal season”. The content is determined by the gaps noted in previous reports and input form national guidance. All appraisers are given a collection of documents summarising the issues addressed, along with suggestions for the forthcoming appraisals.

Appraisers received personal feedback about their performance in the yearly round with anonymised comments from their appraisees.

The RO or the Deputy RO attended 3 of the 3 regional RO network meetings.

c. Quality Assurance

Outline of MTW quality assurance processes:

For the appraisal portfolio:

- Review of 5% of MTW medical appraisal folders to provide assurance that the appraisal inputs: the pre-appraisal declarations and supporting information provided is available and appropriate.

- Review of appraisal folders to provide assurance that the appraisal outputs: PDP, summary and sign offs are complete and to an appropriate standard -by whom and sign offs. An MTW defined checklist is used to ensure that appraisal outputs meet minimum standards required for certification of completion.
- Review of appraisal outputs to provide assurance that any key items identified pre-appraisal as needing discussion during the appraisal are included in the appraisal outputs. A flag is used on the appraisal spreadsheet to identify any pieces of information that the RO has asked the doctor to discuss at appraisal, to ensure a written reflection is present.

For the individual appraiser:

- An annual record of the appraiser's participation in update meetings and/or confirmation of receiving and assimilating the Deputy RO's update into their practice.
- 360^0 feedback from doctors for each individual appraiser. A standard questionnaire is sent out to each appraisee upon receipt of the appraisal output. This is collated on a spreadsheet and used to feedback to appraisers in an anonymised format at the close of the appraisal round.

For the organisation:

- Feedback about Trust processes is sought from all doctors completing an appraisal
- Scrutiny of all the appraisal outputs by the appraisal lead and RO permits an overview of themes, risks and concerns to be formulated.

(See **Annual Report Template, Appendix B;** Quality assurance audit of appraisal inputs and outputs)

d. Access, security and confidentiality

The MTW appraisal system is electronic. In MTW adopted the new national Medical Appraisal Guide ('MAG') forms produced by the NHS England in 2016. This is an interactive pdf which can be downloaded from the NHS England website and is available from the MTW RO office. Supporting information can be uploaded into the MAG form. Adoption of the form was not problematic and permitted a less paper based process compliant with national best practice.

The Medical Director's office holds spreadsheet information about MTW doctors on shared Q drive in the clinical governance section. These are password protected documents.

Portfolios of supporting information are held by the doctor and shared with the appraiser prior to the appraisal meeting. At completion of the appraisal the portfolio is returned to the doctor who is required to keep until completion of the relevant revalidation cycle. The completed appraisal forms are held on the Q drive in the clinical appraisal folder.

Doctors are reminded of their information governance responsibilities not to include patient or colleague identifiable information in their appraisal portfolios. At the close of the appraisal round appraisers are reminded of their responsibility not to retain any paper or electronic record of the appraisals they have undertaken. No appraisal related information governance breaches were notified.

August 2019

e. Clinical Governance

Medical appraisals are evidence based through the requirement for doctors to produce a portfolio of supporting information to demonstrate they are up to date in their entire scope of practice. Designated bodies are expected to assist this process by the provision of corporate data to support individual doctor's appraisals. This process is at present immature. The RO/Deputy RO keep a record (on the Q drive) of issues that they are aware of, but it remains the responsibility of the individual doctor to find the data and bring it to the appraisal. The following data sources are available:

- Dr Foster data.
- Results of clinical, network based and national clinical audits
- Workload and productivity data is available in some specialties but may be team based or consultant based, so not applicable to other grades.
- Data about income generation for the Trust by clinical teams.
- Clinical governance meeting information, attendance and contribution at clinical governance meetings.
- Complaints, litigation and claims data.
- Information about participation in statutory and mandatory training.
- A doctor may be directed by the RO to bring information and evidence of personal reflection about a specific complaint, incident, claim, coroner's inquest or disciplinary issue to his appraisal and its inclusion is monitored.

6. Revalidation Recommendations

60 MTW doctors were given a positive revalidation recommendation in the 2018/19 year, 17 doctors had deferred recommendations and there are no doctors 'on-hold' because of on-going GMC processes. No 'non-engagement' notifications were made.

The common cause of deferral of revalidation was the absence of sufficient information on which to make a recommendation. Often this was the absence of formalised patient feedback through the MTW 360 appraisal system or poor evidence of participation in quality improvement activity.

See **Annual Report Template Appendix C;** Audit of revalidation recommendations

7. Recruitment and engagement background checks

MTW detailed recruitment processes require the credentialing and performance of background checks. Fair recruitment and selection is part of the Trust's wider commitment to equality of opportunity in employment and effective recruitment, selection and appointment of staff are key elements in ensuring the Trust's workforce have the skills and capabilities to achieve its business aims.

Formal transfer of information from one RO to the next is becoming more widespread and has certainly improved the transfer of clinical governance information in both the NHS and the private sector.

The Trust's recruitment policy and procedure outlines recruiting personnel obligations and clear processes to ensure that the Trust selects the best person for the job, in a process which is fair, open and transparent, and compliant with legislation, best practice and NHS Employers Employment Standards, and NHSLA Frameworks. The policy applies to the recruitment and selection of all Trust medical staff, irrespective of the contractual status of the vacancy, clinical speciality, or seniority.

Employment checks are an on-going requirement for Trust staff, and will be applied in relation to internal moves and promotions within the Trust.

Professional registration and entitlement to work / remain in the United Kingdom are also monitored via monthly reports, and utilisation of on-line checking systems.

Equally relevant employment checks are carried out in relation to medical temporary staff who are utilised within the Trust via agencies in order to ensure that current / valid professional registration is in place and checklists placed on file / available for audit.

Although no formalised system of language checking has been instigated, communication competency forms part of the interview process which is also attended by a member of the HR team.

See **Annual Report Template Appendix E**

8. Monitoring Performance

The Trust governance structures are in place and allow scrutiny of clinical performance throughout the organisation. Data on clinical outcomes, morbidity and mortality, readmissions and length of stay are regularly interrogated for clinical directorates allowing monitoring of clinicians performance.

9. Responding to Concerns and Remediation

Concerns regarding clinicians are handled under the umbrella of MHPS (maintaining high professional standards), and our Trust policies that encompass that national guidance. As appropriate, clinical or capability concerns are handled with advice from NCAS (National Clinical Advisory Service).

The Trust has a remediation policy, to address deficiencies of performance that are identified.

10. Risk and Issues

- At MTW, the appraisal rate is reported as less than 100%, however this is due to a small number of late appraisals (i.e. after end of March 2019). We have a rigid rule that no doctor is allowed to miss out an appraisal in any year without the agreement of the RO/Deputy RO.
- Systems to ascertain the appraisal and revalidation status of doctors employed on fixed term contracts and other new appointees has led to considerable

improvement in this area although the appraisal rate still lags behind that of substantive medical employees.

- A reliable consistent mechanism that provides appropriate summary of Trust governance information about an individual doctor is still lacking and was identified as a risk in previous year's reports. This would allow all MTW doctors to include a statement of significant complaints and incidents in their portfolio that can be discussed with the appraiser and reflections and learning documented at appraisal. Current systems largely rely on the doctor remembering to declare adverse episodes and appraisers would much prefer to see a statement of such episodes provided by the trust to every doctor.
- There has been a major improvement in the consistency with which doctors declared their entire scope of practice and the supporting evidence they present in non-NHS roles.
- Doctors are required to present declarations from independent hospitals about current complaints or incidents. There is no effective means of monitoring compliance and this presents a risk to the RO's ability to have a complete knowledge of a doctor's performance.
- The weakest observed aspect of appraisals was documenting the reflection of the doctor. With the annual updates, it is hoped that this will improve.

11. Board Reflections

- MTW has a high rate of medical engagement with the statutory requirements around appraisal and revalidation.
- The RO/Deputy RO attend update training to keep the Trust at the forefront of effective appraisal and revalidation systems.
- Regulatory bodies can take action against a Trust should they suspect that the systems in place lack assurance of quality.
- These systems represent a major commitment of time, effort and professionalism for our trained appraisers.
- There is scope for improvement in the quality of medical appraisals.

12. Corrective Actions, Improvement Plan and Next Steps for 19/20

- MTW will continue to use the national MAG form for appraisal.
- The documentation of reflective practice will continue to be an area of focus.
- Medical staffing and clinical governance teams will build on the improving assistance and support to the Medical Director's office so that the administrative burden of this process is minimised and appropriate assurance given.
- Doctors need to value the appraisal process and understand how the MTW utilises the information that is gleaned from it. There needs to be renewed focus on appraisee training.
- The new appraisal lead will work with Chiefs of Service and Clinical directors to try to reduce the imbalance in the number of appraisals produced by individual appraisers and to recruit new appraisers

August 2019

13. Recommendations

The Board is asked to accept this report and to approve the statement of compliance confirming that the Trust as a designated body, is in compliance with the regulations governing appraisal and revalidation (Appendix F)

August 2019

Annual Report Template Appendix A: Audit of all missed or incomplete appraisals audit

Doctor factors (total)	**Number**
Maternity leave during the majority of the ‘appraisal due window’	2
Sickness absence during the majority of the ‘appraisal due window’	1
Prolonged leave during the majority of the ‘appraisal due window’	1
Suspension during the majority of the ‘appraisal due window’	2
New starter – unknown previous appraisal history	15
Postponed due to incomplete portfolio/insufficient supporting information	0
Appraisal outputs not signed off by doctor within 28 days	0
Lack of time of doctor	0
Lack of engagement of doctor	0
Other doctor factors	0
Appraiser factors	
Unplanned absence of appraiser	0
Appraisal outputs not signed off by appraiser within 28 days	0
Lack of time of appraiser	0
Other appraiser factors (describe)	0
Organisational factors	
Administration or management factors	0
Failure of electronic information systems	0
Insufficient numbers of trained appraisers	0
Other organisational factors (describe)	0

Annual Report Template Appendix B: Quality assurance audit of appraisal inputs and outputs

Total number of appraisals completed		384
	Number of appraisal portfolios sampled (to demonstrate adequate sample size)	Number of the sampled appraisal portfolios deemed to be acceptable against standards
Appraisal inputs		
Scope of work: Has a full scope of practice been described?	19	19
Continuing Professional Development (CPD): Is CPD compliant with GMC requirements?	19	19
Quality improvement activity: Is quality improvement activity compliant with GMC requirements?	19	18
Patient feedback exercise: Has a patient feedback exercise been completed? (in this appraisal or within this revalidation cycle)	19	17
Colleague feedback exercise: Has a colleague feedback exercise been completed?	19	17
Review of complaints: Have all complaints been included?	19	19
Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?	19	19
Is there sufficient supporting information from all the doctor's roles and places of work?	19	17
Is the portfolio sufficiently complete for the stage of the revalidation cycle (year 1 to year 4)? Explanatory note: For example • Has a patient and colleague feedback exercise been completed by year 3? • Is the portfolio complete after the appraisal which precedes the revalidation recommendation (year 5)? • Have all types of supporting information been included?	19	17

August 2019

Appraisal Outputs		
Appraisal Summary	19	19
Appraiser Statements	19	19
PDP	19	19

Comments:

A panel of 4 experienced appraisers reviewed the supporting information for 19 appraisals
The standards were variable, acceptable in all cases and excellent in a few. The was marked variation in the use of electronic vs paper evidence
The following themes were detected:

1. Good reflection observed with some examples of exceptional refection on negative feedback
2. Full scope of practice documented but not always supported by documentation
3. The timing of the Patient and colleague feedback is not planned to provide ideal feedback to the appraise an area that will be addressed in upcoming appraiser training
4. In some cases patient identification information was present in the supporting information. The importance of removing this information will be addressed in appraiser and appraisee training.

Annual Report Template Appendix C: Audit of revalidation recommendations

Revalidation recommendations between 1st April 2018 to 31st March 2019	
Recommendations completed on time (within the GMC recommendation window)	60
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	60
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	N/A
No responsible officer in post	N/A
New starter/new prescribed connection established within 2 weeks of revalidation due date	N/A
New starter/new prescribed connection established more than 2 weeks from revalidation due date	N/A
Unaware the doctor had a prescribed connection	N/A
Unaware of the doctor's revalidation due date	N/A
Administrative error	N/A
Responsible officer error	N/A
Inadequate resources or support for the responsible officer role	
Other	N/A
Describe other	N/A
TOTAL [sum of (late) + (missed)]	0

Annual Report Template Appendix D: Audit of concerns about a doctor's practice

Concerns about a doctor's practice	High level	Medium level	Low level	Total
Number of doctors with concerns about their practice in the last 12 months Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern				
Capability concerns (as the primary category) in the last 12 months				
Conduct concerns (as the primary category) in the last 12 months	4	1		5
Health concerns (as the primary category) in the last 12 months				
Remediation/Reskilling/Retraining/Rehabilitation				
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2019 who have undergone formal remediation between 1 April 2018 and 31 March 2019 *Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice* *A doctor should be included here if they were undergoing remediation at any point during the year*				
Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)				1
Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)				
General practitioner (for NHS England area teams only; doctors on a medical performers list, Armed Forces)				
Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)				
Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)				
Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc) All DBs				
Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc.) All DBs				
TOTALS				6

August 2019

Other Actions/Interventions	
Local Actions:	
Number of doctors who were suspended/excluded from practice between 1 April and 31 March: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included	2
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included Less than 1 week 1 week to 1 month 1 – 3 months 3 - 6 months 6 - 12 months	2 (3-6 months)
Number of doctors who have had local restrictions placed on their practice in the last 12 months?	2
GMC Actions: Number of doctors who:	
Were referred to the GMC between 1 April and 31 March	9
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March	10
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March	0
Had their registration/licence suspended by the GMC between 1 April and 31 March	0
Were erased from the GMC register between 1 April and 31 March	0
National Clinical Assessment Service actions:	
Number of doctors about whom NCAS has been contacted between 1 April and 31 March:	
For advice	5
For investigation	0
For assessment	0
Number of NCAS investigations performed	0
Number of NCAS assessments performed	0

Annual Report Appendix E: Audit of recruitment and engagement background checks

Number of new doctors (including all new prescribed connections) who have commenced in last 12 months (including where appropriate locum doctors)	
Permanent employed doctors	13
Temporary employed doctors	29
Locums brought in to the designated body through a locum agency	334
Locums brought in to the designated body through 'Staff Bank' arrangements (including doctors already employed by MTW but working bank shifts)	631
Doctors on Performers Lists	We do not hold this information
Other Explanatory note: This includes independent contractors, doctors with practising privileges, etc. For membership organisations this includes new members, for locum agencies this includes doctors who have registered with the agency, etc.	None
TOTAL	

A Framework of Quality Assurance for Responsible Officers and Revalidation

Appendix E - Statement of Compliance

Version 4, April 2014

THE NHS CONSTITUTION
the NHS belongs to us all

NHS England INFORMATION READER BOX

Directorate		
Medical	Operations	Patients and Information
Nursing	Policy	Commissioning Development
Finance	Human Resources	

Publications Gateway Reference:	**01142**
Document Purpose	Guidance
Document Name	A Framework of Quality Assurance for Responsible Officers and Revalidation, **Appendix E - Statement of Compliance**
Author	NHS England, Medical Revalidation Programme
Publication Date	4 April 2014
Target Audience	All Responsible Officers in England
Additional Circulation List	Foundation Trust CEs , NHS England Regional Directors, Medical Appraisal Leads, CEs of Designated Bodies in England, NHS England Area Directors, NHS Trust Board Chairs, Directors of HR, NHS Trust CEs, All NHS England Employees
Description	The Framework of Quality Assurance (FQA) provides an overview of the elements defined in the Responsible Officer Regulations, along with a series of processes to support Responsible Officers and their Designated Bodies in providing the required assurance that they are discharging their respective statutory responsibilities.
Cross Reference	The Medical Profession (Responsible Officers) Regulations, 2010 (as amended 2013) and the GMC (Licence to Practise and Revalidation) Regulations 2012
Superseded Docs (if applicable)	Replaces the Revalidation Support Team (RST) Organisational Readiness Self-Assessment (ORSA) process
Action Required	Designated Bodies to receive annual board reports on the implementation of revalidation and submit an annual statement of compliance to their higher level responsible officers (ROCR approval applied for).
Timings / Deadline	**From April 2014**
Contact Details for further information	england.revalidation-pmo@nhs.net http:// www.england.nhs.net/revalidation/

Document Status

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet

Appendix F – Statement of Compliance

Designated Body Statement of Compliance

The Board of Maidstone and Tunbridge Wells NHS Trust (MTW) has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Comments: Dr Peter Maskell, Medical Director fulfils these requirements for MTW.

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Comments: This is maintained on the GMC Connect website and regularly checked by the Revalidation Manager.

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Comments: 76 medical appraisers are recognised by the Trust for this role.

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

   Comments: annual update sessions are held by the appraisal lead and there are quality assurance systems that permit feedback of performance to appraisers.

5. All licensed medical practitioners[2] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Comments: The national MAG form is used at MTW and all medical practitioners complete an annual appraisal.

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

August 2019

Comments: The Trust provides some data to the individual practitioner but this is an area where the Trust will aim to provide more data and supporting information relevant to their practice

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

Comments: These areas are covered by existing Trust processes.

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

Comments: At MTW RO to RO communication is triggered by the recruitment of any new doctor establishing a prescribed connection to MTW. There is regular contact between MTW's RO and ROs at local independent providers. Ad hoc communication is conducted as circumstances dictate.

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[3] have qualifications and experience appropriate to the work performed; and

Comments: At MTW all mandatory pre-employment checks are carried out prior to start date to ensure that all licensed medical practitioners are qualified and experienced as appropriate for their role.

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Comments: Yes – see actions emerging from the annual report.

Signed on behalf of the designated body

Name: Miles Scott,

Chief Executive

Signed: _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

[3] Doctors with a prescribed connection to the designated body on the date of reporting.

NHS
Maidstone and Tunbridge Wells NHS Trust

Health & Safety Annual Report, 2018/19 (incl. agreement of the 2019/20 programme and Trust Board annual refresher training on Health & Safety, Fire safety, and Moving & Handling)	**Chief Operating Officer / Risk and Compliance Manager**

Summary / key points:

This report has been prepared by the Trust Competent Persons for the Board.

The Health and Safety Executive (HSE) advised that the Board should lead on health and safety and set the agenda. This performance report allows the Board to:

- Discuss and agree the Trust's health and safety objectives
- Agree the work programme for 2019/20
- Formerly delegate the management to the Health and Safety Committee.

This annual report provides:

- A review of the Trust's Health and Safety performance for 2018/19
- Assessment against objectives and KPIs set in the previous year
- Discussion of the key health and safety issues identified within the year
- Discussion document for the Board to determine the objectives and KPIs for 2019/20
- Identifies the strategy and action plan for the next year and going forward

The data shows that around 32% of reported injuries relate to staff, contractors and visitors and 68% relate to patients. There are many programmes and initiatives focused on patient safety so this report concentrates on issues relating to staff safety only.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

1. To discuss the report and note the role of the Board.
2. Information and assurance
3. To accept the work programme for 201920

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

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Health and Safety – Annual Board Report and Programme for 2019/20

Requested/ Required by: Trust Board and the Trust Management Executive

- Health and Safety at Work etc Act 1974.
- Management of Health and Safety at Work Regulations 1999.
- Workplace Health and Safety Standards 2013

Main author: Risk and Compliance Manager (Rob Parsons)
Contact Details: ext. 24581 rob.parsons@nhs.net

Other contributors: Head of Fire, Safety and Environment,
Occupation Health Manager,
Local Security Management Specialist,
Radiation Protection Adviser,
Falls Prevention Practitioner,
Vascular Access Specialist Practitioner

Document lead: **Chief Operating Officer**
(Board lead for Health and safety)

Directorate: Clinical Governance

Health and Safety – Annual Board Report and Programme for 2019/20

Requirement for document:	This annual report and programme is: • A review of the Trust's health and safety statistics and performance for 2018/19. • Assessment against objectives and KPI's set in the previous year. • Discussion of the key health and safety issues identified within the year. • Discussion document for the Board to determine the objectives and KPI's for 2019/20. • Identifies the strategy and action plan for the next year and going forward.
Cross references:	This report is in response to key health and safety legislation enacted under the Health and Safety at Work etc Act 1974. This report is supported by Trust key policies and procedures: • Health and Safety Policy and Procedure • Risk Management Policy and Procedure

Version Control:		
Issue:	**Description of changes:**	**Date:**
12	First annual Board report	May 2012
14	Second annual Board Report	May 2013
15	Third annual Board Report	May 2014
16	Fourth annual Board Report	May 2015
17	Fifth annual Board Report	July 2016
18	Sixth annual Board Report	August 2017
19	Seventh annual Board Report	August 2018
20	Eighth annual Board Report	August 2019

Contents

1. Executive Summary 4
2. Introduction....5
3. Review of Objectives and Programme set for 2018/19 5
4. Statistics for 2018/19....8
5. Benchmarking 12
6. Key Health and Safety Areas 13
7. Health and Safety Executive Inspections and Investigations in 2018/19 16
8. Summary and Conclusions 17
9. Objectives for 2019/20 18

Appendix A....23

1. Executive Summary

Introduction

The Health and Safety Executive (HSE) advised that the Board should lead on health and safety and set the agenda. This performance report allows the Board to:

- Discuss and agree the Trust's health and safety objectives
- Agree the work programme for 2019/20
- Formerly delegate the management to the Health and Safety Committee.

This annual report provides:

- A review of the Trust's health and safety statistics and performance for 2018/19.
- Assessment against objectives and KPI's set in the previous year.
- Discussion of the key health and safety issues identified within the year.
- Discussion document for the Board to determine the objectives and KPI's for 2019/20.
- Identifies the strategy and action plan for the next year and going forward.

Staff, contractor and visitor incident statistics make up 17.7% of the total incidents reported, which is dominated by patients incidents (82.3%). There are many programmes and initiatives for patient safety so this report concentrates on staff, contractor and visitor safety.

Highlights

- Specific objectives have been completed from 2018/19, though there remain a number of areas where ongoing objectives have been carried over.
- Overall reporting rates have increased by 26% compared with 2017/18.
- Injury rates have increased by 8% and the number of incidents reported under RIDDOR increased by 8% from 24 in 2017/18 to 26 in 2018/19.
- Sharps injuries increased by 8%, and this was the largest injury category (23%). There were more RIDDOR reportable dangerous occurrences from exposure to known blood borne viruses (BBV) than in previous years. There remains under reporting when compared with Occupational Health referrals.
- Violence, aggression and harassment incidents saw a 46% increase, with a 47% increase in injuries, when compared with 2017/18.
- There was a 10% increase in falls injuries, but a 16% decrease in the number of incidents.
- There has been a decrease in moving and handling injuries as well as injuries as a result of collisions, traps or being struck by something.
- Occupational ill health Datix reporting remains low.

Health and Safety Executive

HSE will not undertake proactive inspections or visits to health care organisations at the same frequency as higher risk industries. However, they will undertake proactive inspections in line with their own strategy and reactive visits based on intelligence.

2. Introduction

The Health and Safety Executive (HSE) advised the Board in 2012 that they should lead on health and safety and set the agenda. This performance report is to allow the Board to discuss health and safety and lead the strategy moving forward.

Health and Safety legislation requires the Trust Board to control the health and safety risks to their employees and others not in their employment. “Others” refers to contractors, volunteers, visitors and includes patients, and it is patients who generally suffer most harm in a clinical environment. There are numerous standards, requirements and bodies whose key role is to protect the safety of patients. This report and strategy will focus on the staff safety, which is a key element of patient safety.

Staff, contractor and visitor incident statistics make up 17.7% of the total incidents reported. This group, however, make up 32% of the total injuries. These have been divided into groups based on severity:

- Deaths to employees, contractors and visitors (deaths at work).
- Incidents and Injuries reportable to the HSE under the “Reporting of Injuries, Diseases and dangerous Occurrences’ Regulations 2013” (RIDDOR).
- All staff and visitor injuries.

The injuries have been divided into 7 types based on the categories used by the HSE in their national statistics. 92% of the total injuries fit into these categories. This allows for bench marking against all industry and the health sector:

- Falls (staff and visitor slips, trips and falls)
- Medical Sharps (needle stick injuries)
- Violence and abuse (includes physical assault and trauma).
- Struck by or collision with an object
- Moving and handling
- Contact with machinery and hot surface (includes hot liquids)
- Contact with a hazardous substance (includes biological agents)

Reporting rates are important as a reduction in injuries could be a result of improving standards or reduced reporting.

The Trust has an Occupational Health Service that undertakes health surveillance on staff to identify or prevent occupational diseases if they arise from employees work. They maintain records of referral of staff for workplace illness.

3. Review of Objectives and Programme set for 2018/19

In September 2018 the Trust Board agreed a programme for 2018/19:

Action	Leads	Progress and Comments
Health and Safety Management		
Improve the H&S audit systems in place to include active monitoring of compliance and review reminders to managers	Head of Fire, Safety and Environment	System has not been upgraded. Audit tool requirements have been simplified to encourage better compliance without affecting content.
Through training and manager awareness increase the number of RIDDOR incidents reported to HSE within required timescales.	Head of Fire, Safety and Environment	69% compliance, which is a decrease from 2017/18. The proportion of over 7 day injuries remains high which has had an effect on the % of reports submitted within HSE timescales.
Through training, communications and feedback raise awareness of what constitutes harm and no harm when	Head of Fire, Safety and Environment	There has been an increase in reporting rates for health and safety incidents and injury rates have also increased. Violence and

Action	Leads	Progress and Comments
reporting incidents, particularly violence and aggression and sharps/ splash incidents		aggression reporting and injury rates have both increased at around 45%. Sharps reports (+18%) have increased at a higher rate than injury rates (+7%)
Proactive accident and incident prevention by introduction of planned Health and Safety/ Fire Safety Inspections including all satellite areas	Head of Fire, Safety and Environment	Inspections are carried out as part of the Internal Assurance Assessment process. Quarterly inspections undertaken at MTW Laundry and Health Records.
Falls		
Continue with awareness and training to further reduce staff falls.	Falls Prevention Practitioner/ Risk and Compliance Manager/ Head of Fire, Safety and Environment	Falls prevention training sessions and Health and Safety awareness training and updates sessions provided to staff to raise awareness. Articles published in Governance Gazette to raise awareness and safety communications put out when snow and icy conditions are expected.
Slip, trip and falls incidents involving members of public. Investigations into incidents to be carried out by Head of Fire, Safety and Environmental wherever possible.	Head of Fire, Safety and Environment	Head of Fire, Safety and Environment has taken lead in investigating these types of incidents wherever possible. There was 1 RIDDOR incident involving a member of the public in 2018/19.
Environmental Hazards to be reviewed annually by departments and wards.	Departmental/ Ward Manager	Hazard Profile checklist should be completed annually in all departments and other relevant risk assessments reviewed periodically.
Radiation Protection		
Control of Electromagnetic Fields at Work Regulations 2016	Radiation Protection Advisor/ EME and Technical Services Manager	A risk assessment tool was developed and the majority of equipment in the Trust has been assessed and declared safe. The last phase of the project will continue to carry out more detailed assessments on the remaining small number of generic equipment types which have not been assessed.
Compliance with revised legislation: The Ionising Radiations Regulations 2017 and The Ionising Radiation (Medical Exposure) Regulations 2018	Radiation Protection Advisor	An action plan has been developed and is being monitored. Compliance with the previous regulations leads to compliance with much of the new regulation. The action plan is progressing and there are a number of points which have been completed. There are a variety of working groups completing other actions.
Violence and abuse		
To continue with the programme of access control upgrade at Maidstone Hospital and identify areas of weakness at TWH	LSMS	Wards at MGH identified as vulnerable and significant funding is needed to secure the wards. 2 wards at TWH require access control.
To continue with the programme of CCTV roll out at MGH and at TWH	LSMS	CCTV has been scoped for both sites. TWH ED and external areas of MGH are lacking in coverage. Funding is required to complete this task.
To continue with the education of the security team in relation to dementia, learning disabilities, MHA and MCA	LSMS and Corps of Security; Lead Nurse Dementia	Security staff are attending Trust training which is logged on matrix and toolbox talks have been attended by staff.
Moving and Handling		
External provider to review status of moving and handling assessments and training provision before Moving and	External moving and handling	External provider has begun reviewing assessments and training provision and will be reviewing Moving and Handling Policy and

Action	Leads	Progress and Comments
Handling objectives can be set	provider	Procedure
Sharps		
The Sharps/Splash working group will continue to use all means to change staff attitude and the embedded medical sharps culture	Head of Fire, Safety and Environment	The Sharps/Splash group stopped meeting in the second half of 2018/19. The Safety, Health and Risk Advisory Group (SHRAG), which will take over this work.
Analyse the injury data for 2017/18 and compare with previous data set. Highlight learning.	Risk and Compliance Manager	Ongoing analysis of data. Reported in previous Annual Report and in Section 6.4 below and to appropriate committees (Health and Safety Committee, Clinical Governance Committee, etc.)
Continue to review new safety devices in the market place across the Trust.	Vascular Access Specialist Practitioners (VASPs)	The trust standard safety Huber needles (Gripper Plus) were temporarily replaced with an alternative safety product (EZ Huber) to bridge the gap. These alternative devices have also been used at times of supply shortages of the standard Huber needles throughout the year. Education and training programmes were rolled out at the time. There have been no clinical issues/concerns with the safety products that the Trust currently procures.
Continue to respond to learning obtained from the analysis of reported injury data and to provide appropriate training updates as required	Vascular Access Specialist Practitioners	Communication circulated containing a personal perspective on effects of needle-stick injury. iPads have been provided in Occupational Health receptions to assist staff with reporting. Investigations into sharps/splash incidents are not always carried out with uniform rigor and can focus on actions taken after the incident rather than root cause of the incident. Recommendation made by Sharps/Splash Group that investigations would be better conducted by VASPs but this is not possible due to staffing resources.
Occupational Health		
Increase awareness of the need to report workplace stress and other ill health events on Datix	Head of Fire, Safety and Environment/ Risk and Compliance Manager	Reporting levels remain low and continued work is being carried out to raise awareness of need to report workplace stress and other ill health events.
Encourage staff and their managers to report work related stress and other ill health events through Datix.	Occupational Health Manager	As above.
Review and raise awareness of risk assessments that do or could identify the need for health surveillance	Occupational Health Manager	Discussions with department managers have continued alongside workplace visits to review and risk assess current working practices and hazard avoidance / removal processes. This has helped identify the need for continued surveillance and on which staff require it.
Reduce the gap between sharps / splash injuries reported on DATIX and the OH system.	Occupational Health Manager	Members of staff encouraged to report during statutory and mandatory training, OH attendance and provision of iPad in OH reception to assist in the facilitation of reporting.

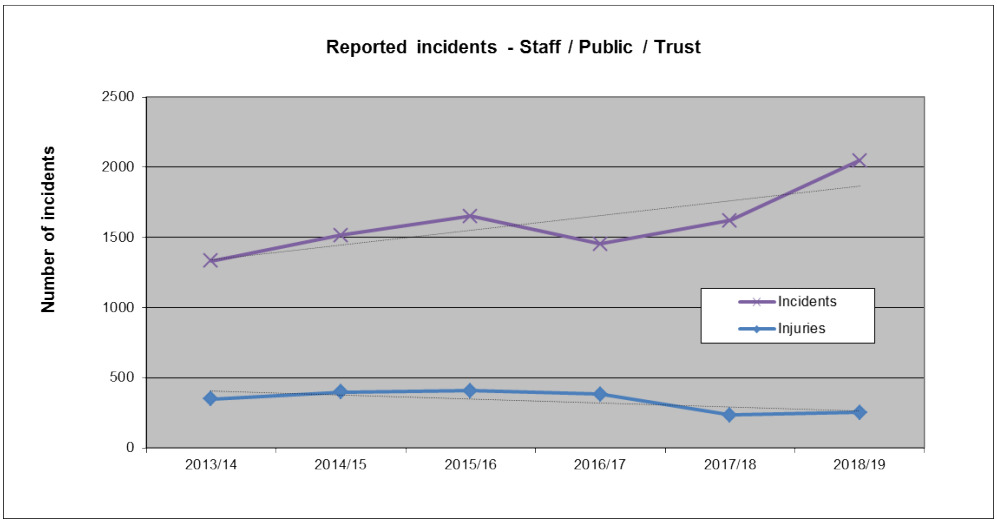
4. Statistics for 2018/19

The Datix incident database was interrogated for all non-patient injuries for the period of 01/04/18-31/03/19.

4.1. Reporting

There were 2049 staff/ public/ Trust incidents in 2018/19. This is a 26% increase from 1621 the previous year.

The ratio of reports to injuries has increased to approximately 8 reports for every injury from 7 reports per injury in 2017/18.



The total number of staff/ public/ Trust injuries increased by 8% from 234 to 251. This figure makes up 32% of total injuries.

4.2. Injuries

The data for 2018/19 has been compared with the data from previous 4 years.

The Trust submitted 26 RIDDOR reports in the year at an average of 2.17 per month. This is a slight increase from 24 the previous year. 69% of RIDDOR reports were submitted on time, lower than the 75% in 2017/18.

The increase in overall reporting rates (26%) is greater than the increase in injury rates at 8% and RIDDOR incidents (8%). When directly health and safety related incidents are isolated there has been an increase in 19% of number of incidents reported. These figures would suggest an improved reporting culture.

58% of RIDDOR reports were over 7 day injuries and this has been a factor in a larger proportion not being reported within the required timescales. Of these 15 incidents, 5 were trap/crush injuries involving doors, 4 were primarily caused by moving and handling (2 during patient handling, 2 non-patient handling), 3 were linked to violence and aggression, 2 were related to slips, trips and falls, with the other incident caused by another trap.

There has been an increase in the number of specified injuries, up to 5 from 3 in 2017/18. All were fractures as a result of slips, trips and falls and three involved wet floors reported in September and October. There was 1 RIDDOR incident involving members of the public, compared with none in 2017/18.

All six of the dangerous occurrences were reported as exposure to known blood borne virus (BBV).

RIDDOR Category	Year reported				
	2014/15	2015/16	2016/17	2017/18	2018/19
7 Day injury	25	16	20	16	15
Specified injury	6	10	14	3	5
Dangerous occurrences	1	1	3	4	6
Accidental death	0	0	0	1	0
	32	**27**	**37**	**24**	**26**

4.3. Categories of incidents resulting in injury

The eight largest categories make up 98.4% of all staff injuries. Five have increased and three have shown a decrease.

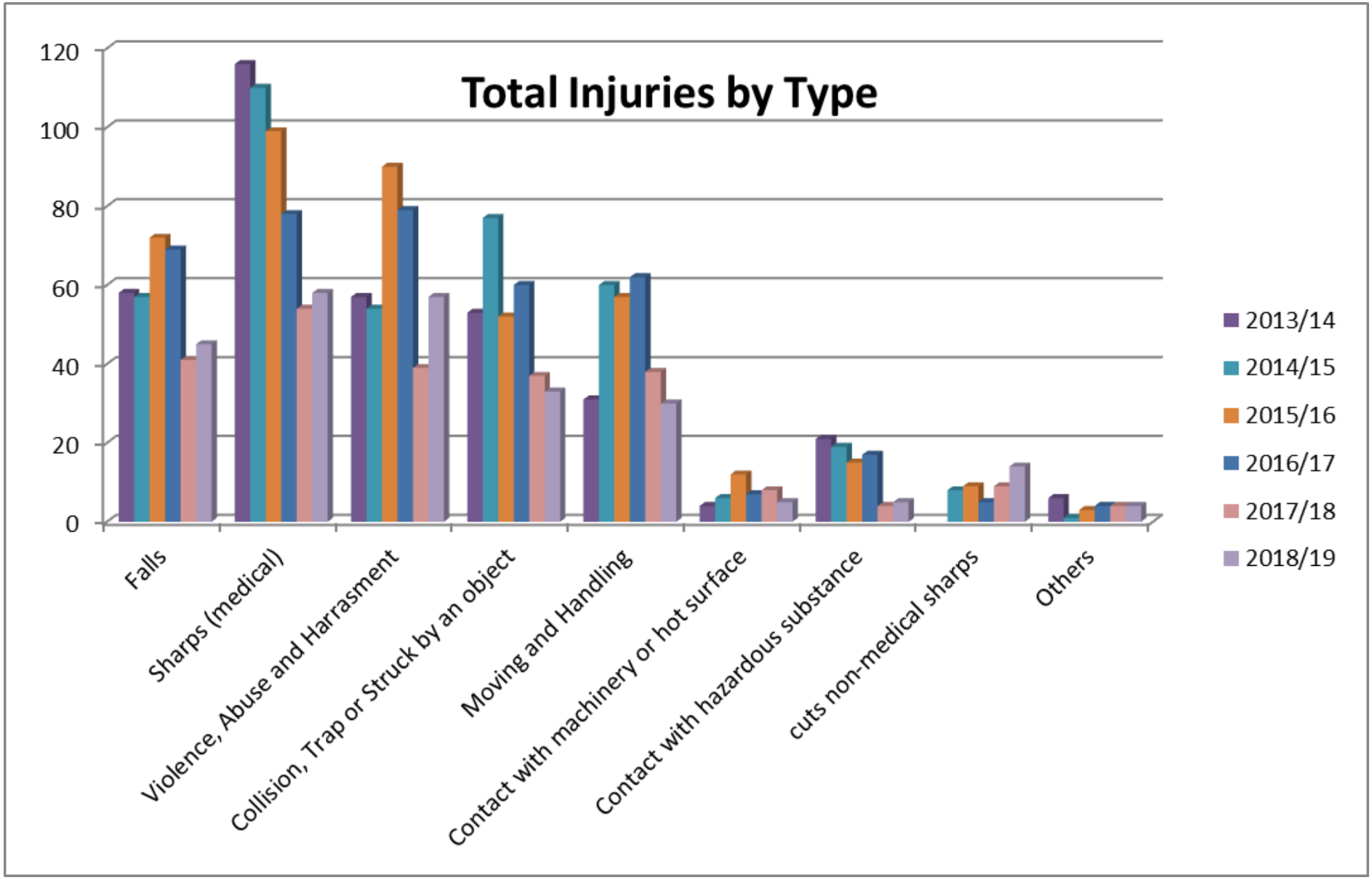
	2017/18	2018/19	% of total	Change
Falls	41	45	17.9%	**+10%**
Sharps (medical)	54	58	23.1%	**+7%**
Violence, abuse and harassment	39	57	22.7%	**+46%**
Collision, trap or struck by an object	37	33	13.1%	**-11%**
Moving and handling	38	30	12%	**-21%**
Contact with machinery or hot surface	8	5	2%	**-38%**
Contact with hazardous substance	4	5	2%	**+25%**
Cuts non-medical sharps	9	14	5.6%	**+56%**
Others	4	4	1.6%	**0%**
	234	**251**		

More detailed analysis is given in **Section 6** below.

Of the top five categories, the largest increase by type is injuries as a result of violence, abuse and harassment (+46%). There were less significant increases in falls (+10%) and sharps (+7) injuries. Moving and handling injuries saw the largest decrease (-21%) followed by collision, trap etc. (-11%).

Sharps remain the largest category with 58 injuries, though this is only just ahead of violence, abuse and harassment on 57. There does, however, remain a discrepancy between sharps injuries reported and occupational health attendances (see 6.4.3 below).

The chart below compares 2018/19 injuries by type with the previous five years:


Total Injuries by Type
120
100
80
60
40
20
0
Falls
Sharps (medical)
Violence, Abuse and Harrasment
Collision, Trap or Struck by an object
Moving and Handling
Contact with machinery or hot surface
Contact with hazardous substance
cuts non-medical sharps
Others
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19

4.4. Injuries by Division/ Directorate

The table below shows injuries by directorate/ specialty:

Division	Directorate	Total Injuries	Falls	Sharps (medical)	Violence, abuse and harassment	Collision, trap or struck by an object	Moving and handling	Contact with machinery or hot surface	Contact with hazardous substances	Cuts non-medical sharps	Others
Cancer Services	Haematology	2	2								
	Oncology	11	1	4			5			1	
		13	**3**	**4**			**5**			**1**	
Corporate Services	Corporate	4	2			2					
	Estates	15	4			4				5	2
	Facilities	10	5			2	2				1
	Nursing	6	3			2	1				
		35	**14**			**10**	**3**			**5**	**3**
Diagnostic and Clinical Support Services	Imaging	8		1	1	2	2		2		
	Outpatients	3	2					1			
	Pathology	10	3	6						1	
	Pharmacy	2	1				1				
	Therapies	3	1				2				
		26	**7**	**7**	**1**	**2**	**5**	**1**	**2**	**1**	
Medicines and Emergency Care	Acute Medicines and Geriatrics	35	3	6	21	1	3	1			
	Emergency Medicine	35	6	8	14	3	3		1		
	Medical Specialties	14	3	3	4	2		1			1
		84	**12**	**17**	**39**	**6**	**6**	**2**	**1**		**1**
Surgery	General Surgery	8	1	3	1	2				1	
	Head and Neck	3	1			1				1	
	Orthopaedics	13	2	4	5	1			1		
	Planned care coordination	12	1	2	3	2	2	1		1	
	Theatres and Critical Care	32	1	13	5	3	8			1	

Division	Directorate	Total Injuries	Falls	Sharps (medical)	Violence, abuse and harassment	Collision, trap or struck by an object	Moving and handling	Contact with machinery or hot surface	Contact with hazardous substances	Cuts non-medical sharps	Others
	Urology etc.	1				1					
		69	**6**	**22**	**14**	**10**	**10**	**1**	**1**	**4**	
Women's Children's and Sexual Health	Children's Services	10	1	1	3	2		1		2	
	Sexual Health	1		1							
	Women's Services	13	2	6		3	1		1		
		24	**3**	**8**	**3**	**5**	**1**	**1**	**1**	**2**	
		251	**45**	**58**	**57**	**33**	**30**	**5**	**5**	**13**	**4**

The size of the respective divisions and directorates and the activities undertaken has a clear influence on the number and nature of injuries that occur.

- 69.4% of injuries from violence abuse and harassment occur in the Medicines and Emergency Care Division. Acute Medicines and Geriatrics (36.8%) and Emergency Medicine (24.6%) were the two directorates with the most injuries.
- The Surgery Division (37.9%) had the most sharps injuries. Theatres and Critical Care (22.4%) was the directorate with most injuries, followed by Emergency Medicine (13.8%).
- Falls injuries were distributed across most directorates with Emergency Medicine (6), Facilities (5) and Estates (4) having the most.
- Corporate Services and Surgery were the divisions with the most collisions, trap, struck by etc. injuries, with 10 each.
- Surgery (10), and particularly the Theatres and Critical Care Directorate (8), had the most moving and handling injuries.
- The Estates directorate had the largest number of cut injuries (5). Again this is not surprising given the nature of the work carried out.

These figures are discussed in more detail in **Section 6** below.

4.5. Occupational ill health

5 incidents of occupational ill health were reported on Datix. This is an increase from 2017/18.

Ill health	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Skin and dermatitis	1	0	0	0	0	0
Work-related stress	0	0	1	0	1	3
Occupational respiratory disease	0	0	0	1	0	0
Environmental causes of ill health	0	1	0	3	1	2
Total occupational ill health	**1**	**1**	**1**	**4**	**2**	**5**
Others (not occupational)	2	2	6	10	5	8

To raise awareness the need to report work place ill health via Datix is stressed during statutory and mandatory health and safety training. Staff are advised at the point of assessment to report occupational ill health via Datix. In addition, the Occupational Health Team liaises with the Risk and Compliance Manager and Head of Fire, Safety and Compliance on cases of occupational ill health that require specialist advice and guidance. However, these measures alone will not significantly increase reporting and more work is required.

5. Benchmarking

The HSE uses accident rates to compare organisations. One measure is the number of RIDDOR reportable incidents per 100,000 employees. The HSE publish data for the health sector and for all industries. Data is based on total employee numbers rather than whole time equivalents.

	RIDDOR rate per 100,000 employees
All industries (2017/18)	263
Human health and social work (2017/18)	330
MTW 2013/14	232
MTW 2014/15	329
MTW 2015/16	324
MTW 2016/17	479
MTW 2017/18	358
MTW 2018/19	**370**

There has been a small increase in the Trust RIDDOR rate per 100,000 employees in line with the increase in the number of RIDDOR reportable incidents. The CCG has set risk levels; rates of <600 are rated as green, 600 to 660 as amber and >660 as red. **MTW is rated as green.**

Further comparison data was obtained from other local trusts. The Healthcare Risk Management Group (HRMG) has members from many trusts in the South East.

Type of Trust	Total RIDDORs	Employees	RIDDOR Rate (per 100,000 staff)	
MTW	26	7023	370	2018/19
Health sector (HSE national data)			330	2017/18
Acute and Community Trust 1	13	3860	336	2018/19
Acute and Community Trust 2	49	7200	680	2018/19
Community NHS Trust 1	17	5500	309	2018/19
Community NHS Trust 2	12	5060	237	2018/19
Hospices & Community Service	25	4250	588	2018/19
Private Healthcare Hospital	2	420	476	2018/19
Specialist NHS Trust	0	1236	0	2018/19
NHS Ambulance Service	69	3634	1898	2018/19
HMRG Average	**23.67**	**4242.55**	558	2018/19

MTW's RIDDOR rate is higher than the health sector average and lower than that of the HRMG. When the outliers (Specialist NHS Trust and NHS Ambulance Service) are discounted the RIDDOR rate reduces from 558 to 432. The variety of trusts providing data and the fact that no data was available from other acute NHS trusts makes direct comparison difficult, with the closest comparators the acute and community trusts. Benchmarking was only possible against organisations willing to share their data.

6. Key Health and Safety Areas

6.1 Falls

Falls account for 17.9% of staff/public/Trust injuries. The number of injuries from falls this year has increased by 10% to 45. Staff account for 75.6% of injuries and members of the public 24.4%. The overall number of slips, trips and falls incidents reported (including near misses and no harm incidents) decreased by 16% to 100.

Emergency Medicine is the directorate with the most slip, trip and fall injuries, with 6.

Estates and Facilities have 4 and 5 respectively for a total of 9. This is higher than last year when there were 7 though it is a significant improvement when compared to 24 in 2016/17.

7 of the RIDDOR incidents were related to slips, trips and falls. Three of these occurred in September and October 2018 and were linked to wet floors at both sites. Domestics were verbally briefed by supervisors to heighten mopping in areas identified to get wet during periods of rainfall. Risk assessment on mopping and drying was undertaken and controls implemented.

The number and severity of slips, trips and falls involving members of the public increased, with 38 incidents and 11 injuries compared with 26 incidents and 7 injuries in 2017/18. There was also 1 RIDDOR incidents compared with none in 2017/18.

Falls prevention is a key patient safety agenda item for the Trust. There is therefore a need to continue to focus on management of environmental hazards in the work place.

6.2 Violence and Abuse

Injuries from violence account for 22.7% of all injuries and was the second highest cause of injury in 2018/19 with 57 incidents. This is a 46% increase when compared with 2017/18. The number of incidents of violence, abuse and harassment reported (including near misses and no harm incidents) also increased significantly by 47% to 318, and this was by far the highest directly health and safety-related incident category by number of incidents.

The LSMS report on violence relates only to violence against staff. This was the requirement under NHS Protect and the reporting has continued as such. This year we have seen some particularly violent assaults on staff and an increase in sexual violence. Where there was capacity the individuals have been prosecuted through the criminal justice system. In the cases where the patient had no capacity, extra support was put in place. Verbal abuse towards staff has also increased. Reporting has increased which is encouraging as this is discussed at all conflict resolution sessions and toolbox talks. This allows the Trust to see a truer picture of events including threatening behaviour and assault. Datix shows there were 126 assaults on staff by patients and these were all related to the patient's capacity or mental health with the exception of ten people who had capacity and have been excluded and /or sentenced in court.

The LSMS provides monthly and bespoke training in relation to managing violence and aggression and provides a support function for post incident management.

Security support on wards has increased with a significant increase in cost to the Trust. The need for additional security officer numbers has been risk assessed and it has been determined than an increase from 3 to 4 officers per shift would provide greater support for staff and speedier response times. The requirement has been placed on the Trust risk register.

6.3 Moving and Handling

Moving and handling incidents account for 12% of staff injuries. There was a 21% decrease in injuries. 31 of the 38 moving and handling incidents resulted in injury, potentially indicating lower reporting of near misses and no harm incidents than the other categories.

Recent developments will see the external training provider review the Moving and Handling Policy and Procedure and the existing risk assessments and safe systems of work.

6.4 Sharps/ splash

6.4.1. Medical sharps

Injuries from medical sharps increased by 7%, from 54 to 58. The overall number of reported incidents (including near misses and those recorded as no obvious harm) increased by 18% to 112.

In 2017/18 there were four RIDDOR reportable sharps/ splash dangerous occurrences. In 2018/19 there were 6, with three needle stick injuries and three splash incidents where exposure to BBV was confirmed. To date there has been no HSE follow up on these incidents.

In May 2018 due to the loss of its CE marking (administrative issues), the trust standard safety Huber needles (Gripper Plus) were temporarily replaced with an alternative safety

product (EZ Huber) to bridge the gap. These alternative devices have also been used at times of supply shortages of the standard Huber needles throughout the year. Education and Training programmes were rolled out at the time.

The Sharps/Splash Group met in the first half of the year and undertook a number of actions in response to analysed sharps/splash injuries. First, a letter was circulated containing a personal perspective on the effects that receiving a needle-stick injury can have on your life and the health and well-being of your family. This was aimed at making the issue personal and addressing attitudinal concerns. Secondly, iPads were provided to the Occupational Health Department to encourage the reporting of sharps/splash injuries onto Datix, as there was a disparity between the number of staff attending Occupational Health for these injuries and the numbers being reported on Datix.

It was discussed that sharps/splash injuries are not being investigated with uniform rigor. The investigations often focus on the actions that the person has taken after the incident and not on the root cause of the incident itself. It was agreed that investigations would be better conducted by the Vascular Access Specialist Practitioners (VASPs) who could focus on the products, staff use of the products, staff working practices, training and educational concerns to get to the root cause of the incident. Unfortunately the Vascular Access Team cannot support this recommendation at this time due to insufficient staffing resources.

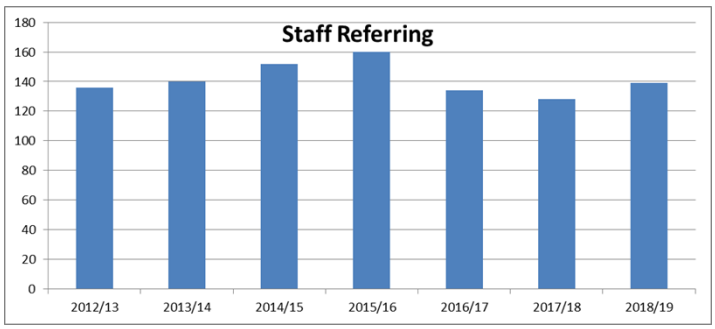
The sharps/splash group has now discontinued meeting.

6.4.2 Eye Splash Injury

While only 5 injuries were reported, there were 18 eye splash incidents in the Trust including near misses and those recorded as 'No obvious harm', a decrease from the 26 eye splash incidents reported in 2017/18. There were 3 'splash' incidents reportable under RIDDOR due to exposure to known BBV.

6.4.3 Sharps/ Contamination Injury Comparisons

Occupational Health reported that 139 staff had been referred following sharps/contamination injury. This was compared against Datix incidents and it was found that only 84 (60.4%) of those that attended occupational health had also completed a Datix form. This is a slight improvement from 2017/18 (58.6%).



When a Datix form was completed attendance at Occupational Health and/or the Emergency Department occurred in 94 out of 106 incidents (88.7%) where it would be expected.

There were also 2 incidents where no name was given on Datix and it was not possible to match with complete certainty and another incident where significant time elapsed between the Datix report and OH attendance.

Steps have been taken to improve reporting, including making iPads available to staff in the waiting room.

More education is required on the need to report sharps/ splash incidents accurately.

6.5 Collisions, Traps or Struck by and Object

These incidents occur when staff move around the workplace. It can be indicative of cramped conditions, bad housekeeping and rushing around and are often associated with moving and handling activities. In 2017/18 there were 37 injuries. This year this has decreased by 11% to 33 injuries.

The increase in number of RIDDOR incidents involving doors has been noticeable and has continued into the start of 2019. Governance Gazette articles have been published to highlight the hazard and need for continued vigilance and prompt reporting of defects.

6.6 Machinery, Hot Surfaces and Fluids

Burn/scald injuries have decreased, with 5 injuries compared with 8 in 2017/18.

7. Health and Safety Executive Inspections and Investigations in 2018/19

7.1 Trust Inspection

The CQC have taken over much of the day to day enforcement responsibility from the HSE for health and social care activities. RIDDOR reports are passed on to the CQC from the HSE.

There has been a gradual decline in the number of prosecutions of NHS Trusts and these have been limited to clear and significant health and safety breaches as well as breaches which occurred before the implementation of the memorandum of understanding with the CQC.

They will however undertake a limited number of inspections of NHS Trusts across the region with the focus on moving and handling practices and management of violence and aggression in line with their priorities and sector plans (see 7.3 below).

They may also undertake reactive visits based on intelligence. These include:

- RIDDOR incidents.
- Reports from other agencies such as CQC, MHRA, Environment Agency etc.
- Whistle blowing.

7.2 HSE Priorities for 2019/20

Across all sectors the HSE's priorities for 2019/20 include to:

- Focus on tackling ill health as part of the Health and Work programme
- Support the government's fundamental reform of the building safety system following the Grenfell Tower disaster
- Contribute to government-wide activities on the UK's departure from the EU
- Target inspections on specific issues and activities, including a sustained focus on work-related ill health
- Operate effective statutory schemes, ensuring the safe use of potentially harmful substances

- Provide assurance that duty holders are identifying and managing the major hazard risks they create

In the public sector the HSE will lead and engage with others to improve workplace health and safety by:

- Applying the Stress Management Standards through pilot exercises in healthcare, education, prisons and other areas
- Re-energising the control measure for tackling muscular skeletal disorders and identifying any emerging issues and solutions
- Providing direction and guidance to key stakeholders in health and social care on the management of violence and aggression in the workplace

8. Summary and Conclusions

- Specific objectives have been completed from 2018/19, though there remain a number of areas where ongoing objectives have been carried over.
- Overall reporting rates have increased by 26% compared with 2017/18.
- Injury rates have increased by 8% and the number of incidents reported under RIDDOR increased by 8% from 24 in 2017/18 to 26 in 2018/19.
- Violence, aggression and harassment incidents saw a 46% increase, with a 47% increase in injuries, when compared with 2017/18.
- Sharps injuries increased by 8%. This was the largest injury category (23%). There were more RIDDOR reportable dangerous occurrences from exposure to known blood borne viruses (BBV) than in previous years.
- There remains under reporting of sharps and splash incidents when compared with Occupational Health referrals.
- There was a 10% increase in falls injuries, but a 16% decrease in the number of incidents.
- There has been a decrease in moving and handling injuries as well as injuries as a result of collisions, traps or being struck by something, though there were 5 RIDDOR incidents involving trap/crush injuries in doors, a noticeable increase, and this trend has continued into the current year.

9. Objectives for 2019/20

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPI's
Health and Safety Management (Head of Fire, Safety and Compliance)					
Improve the H&S audit systems in place to include active monitoring of compliance and review reminders to managers	Continue to liaise with Synbiotix and reiterate requirements. Expected to continue throughout 2019/20.	Head of Fire, Safety and Environment	Risk and Compliance Manager	Progress will be monitored by lead and reported to the H&S committee.	Minimum of 75% compliance with aspiration towards 85% - 90%. This takes into consideration that this will be major revision of system.
Reduce the number of incidents and RIDDOR involving doors through improved awareness, reporting and monitoring.	Awareness campaign to reinforce vigilance and reporting to begin by end of Q2	Head of Fire, Safety and Environment	Risk and Compliance Manager	Active monitoring and monthly review of incidents	Reduction by at least 25% of injury and RIDDOR rates for incidents involving doors
	Scheduled audit programme of stairwells and corridors to be put in place by 31/08/19	Compliance Officer (Estates)	Statutory Compliance Manager	Audit findings	Audits completed as per plan.
Raise awareness to increase accuracy of incident reporting and quality of investigations for staff/Trust/Public incidents	Ongoing, and during statutory and mandatory training. As part of roll of Datix IQ cloud	Risk and Compliance Manager / Head of Fire, Safety and Environment	Patient Safety Team	Active monitoring when reviewed and before final approval	Reduction in % of incidents sent back to handler to be reviewed Qualitative judgement on accuracy and quality of incident reports and investigations
Promotion of revised risk assessment policy and procedure including changes to risk grading matrix and risk assessment	Throughout Q2 and into Q3 with targeted communication, refresher training, risk reporting and	Risk and Compliance Manager	Head of Fire, Safety and Environmental / Risk Leads	Review of documentation and assessments during inspections and liaison/ coaching of	Proportion of new risk assessments be completed using most appropriate documentation.

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPI's
documentation	liaison/ coaching			risk assessors	New and existing RAs graded and reviewed with reference to new grading matrix
Roll out of Datix IQ Cloud incident reporting	Roll out of all IQ Cloud modules within next 6 months	Interim Datix Project Manager	Patient Safety Team / Risk and Compliance Manager (for staff/Trust/public incidents)	Active monitoring and regular reporting on incident reporting	Incident reporting numbers remaining constant or increasing
Falls (Falls Prevention Practitioner)					
Continue with awareness and training to further reduce staff falls. Falls Prevention Awareness Week 23-29 September to promote falls prevention for patients and staff.	(The focus of the falls team is on reducing Patient falls) 23-29 September 2019	Falls Prevention Practitioner / Risk and Compliance Manager / Head of Fire, Safety and Environment	Risk Leads	Continue with regular refresher training. All falls will be investigated	Continue with awareness and training to further reduce staff falls.
Slip, trip and falls incidents involving members of public. Investigations into incidents to be carried out by Head of Fire, Safety and Compliance wherever possible.	Throughout the year	Head of Fire, Safety and Compliance	Risk and Compliance Manager	Progress will be monitored by lead, through RIDDOR panels and reported to the H&S committee	Objective measure of investigation quality
Environmental Hazards to be reviewed annually by departments and wards.	Annual review	Department/ward Manager	Risk and Compliance Manager	Monitored by Directorates, Divisions	Hazard profile checklist completed and relevant risk assessment in place.
Radiation Protection (Radiation Protection Advisor)					
Control of	Throughout the year	Radiation Protection	Risk and	Progress will be	Risk assessments and

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPI's
Electromagnetic Fields at Work Regulations 2016		Adviser / EME and Technical Services Manager	Compliance Manager	monitored by leads and reported to the H&S committee.	work plans have been developed for the remaining items of Medical Equipment to complete the assessment of the full Trust inventory. There is a process for assessment of new devices.
Continued compliance with revised legislation: The Ionising Radiations Regulations 2017 and The Ionising Radiation (Medical Exposure) Regulations 2018	Throughout the year	Radiation Protection Adviser	Risk and Compliance Manager	Progress will be monitored by lead and reported to the H&S committee.	Completion of objectives in accordance with the Trust action plan.
Violence and abuse (Trust Security Manager)					
Produce business case for funding for additional security officers	Lack of security personnel leaves the Trust vulnerable	Trust Security Manager	Director of E and F	Progress will be monitored by lead and reported to the H&S committee.	Additional security officers in place in order to reduce violence and aggression
CCTV has been placed on the risk register for MGH and TWH	Areas of weakness have been identified and a roll out programme costed. April 2020. Business case submitted	Trust Security Manager	Director of E and F	Progress will be monitored by lead and reported to the H&S committee.	CCTV installed in areas of weakness
To continue with the education of the security team in relation to dementia, learning disabilities, MHA and MCA	Provide 1:1 sessions and utilise Trust specialists. April 2020	Trust Security Manager and Corps of Security	Director of E and F	Progress will be monitored by lead and reported to the H&S committee.	All security staff trained in areas identified
Moving and Handling					
External provider to review status of moving and handling assessments, policies and procedures and training provision before Moving and Handling objectives can be set					

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPI's
Sharps/Splash (Sharps/Splash Working Group)					
The Safety, Health and Risk Advisory Group (SHRAG) will investigate strategies to change staff attitude and the embedded medical sharps culture	Throughout the year	Head of Fire, Safety and Environment	SHRAG members	SHRAG will report to the H&S Committee	Decrease sharp injuries this year.
Continue to review new safety devices in the market place across the Trust.	Ongoing in 2019/20	Vascular Access Specialist Practitioner	Procurement	The VASP will continue to report issues or concerns to the SHRAG and Medical Devices Committee	Compliance with the H&S (Sharp Instruments in Healthcare) Regulations 2013.
Continue to respond to learning obtained from the analysis of reported injury data and to provide appropriate training updates as required	Complete in 2019/20	Vascular Access Specialist Practitioner	Health Safety and Risk Leads	The VASP will continue to report issues or concerns to the SHRAG	Reduce injuries as a result of lack of training
Occupational Health (Occupational Health Manager)					
Raise awareness and encourage staff and their managers to report work related stress and other ill health events through Datix.	Complete throughout 2019/20	Occupational Health Manager / Head of Fire, Safety and Environment / Risk and Compliance Manager	Occupational Health Department	Reported to H&S Committee via Occupational health report.	Comparison of numbers referred to numbers reported.
Review and raise awareness of risk assessments that do or could identify the need for health surveillance	Continue throughout 2019/20, review previous assessments	Occupational Health Manager	Risk Leads and Risk and Compliance Manager	Reported to H&S Committee via Occupational health report.	New job roles / practices identified for health surveillance or PPE / risk avoidance where possible.

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPI's
Reduce the gap between sharps / splash injuries reported on DATIX and the OH system.	Complete throughout 2019/20	Occupational Health Manager	Risk Leads; Head of Fire, Safety and Environment / Risk and Compliance Manager	Reported to H&S Committee via OH reporting and DATIX reports.	Only 60.4% attending OH reported on DATIX. Aim to significantly reduce this figure.

Appendix A

2019/20 Training update - What does the Board need to know?

1. Health and safety

1.1. Health and safety law places duties on organisations and employers, and directors can be personally liable when these duties are breached – members of the board have both collective and individual responsibility for health and safety.

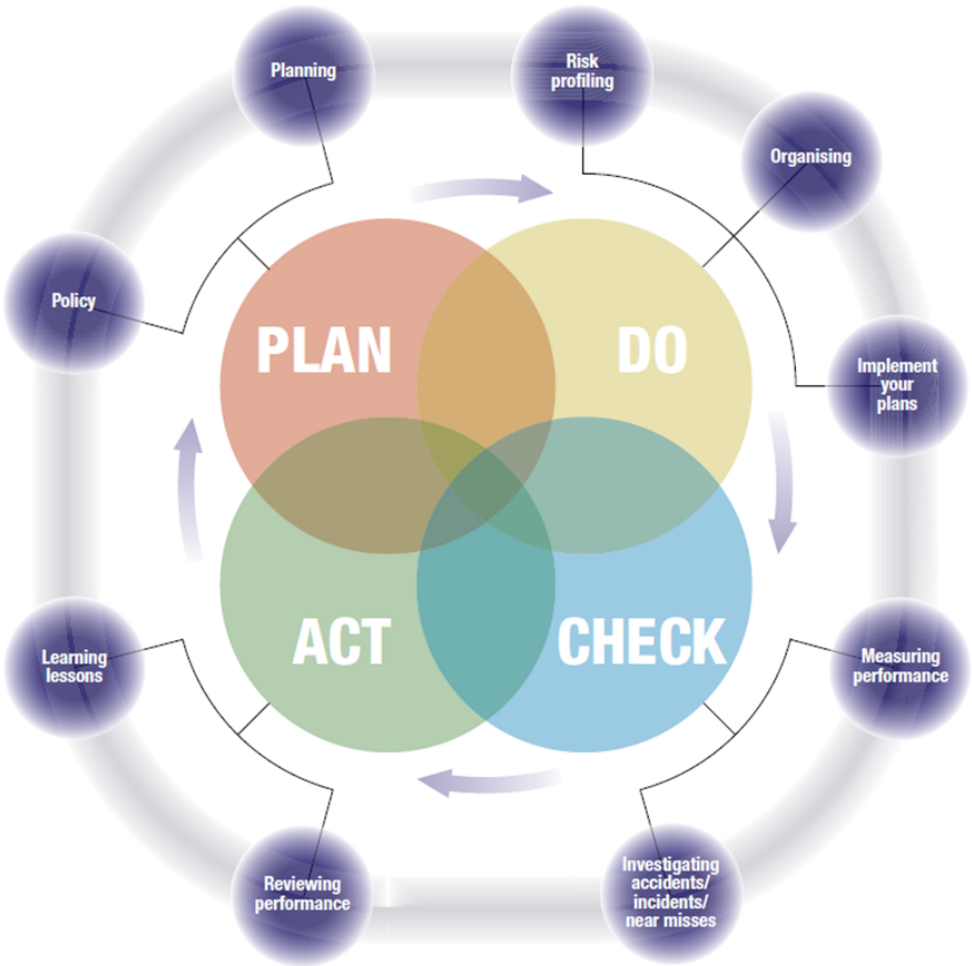
1.2. Addressing health and safety offers significant opportunities, including:

1.2.1. Reduced costs and reduced risks – employee absence and turnover rates are lower, accidents are fewer, the threat of legal action is lessened;

1.2.2. Increased productivity – employees are healthier, happier and better motivated.

1.3. Plan, Do, Check, Act

1.3.1. The HSE promotes the PDCA Cycle for Health and Safety Management, which integrates the key principles of POPIMAR from previous versions of HSG65:



1.3.2. As the cycle can be applied to all types of improvement projects, health and safety factors can and should be integrated so that potential impacts can be mitigated.

1.3.3. Common issues may be a lack of risk profiling and risk assessment prior to the implementation stage as well as not planning for how performance will be measured. Going from policy to implementation without sufficient engagement of competent persons, staff affected and other stakeholders can lead to clear and obvious hazards being overlooked, a lack of 'buy in' and other safety and quality issues. This will be exacerbated by not involving those affected in the 'check' stage with ad hoc, after the fact monitoring.

1.4. Healthcare prosecutions 2018/19

1.4.1. The number of prosecutions of NHS Trusts has decreased since the CQC has become the primary enforcement agency for health and safety offences in health and social care. Therefore the table below includes some private health and social care organisations. HSE prosecutions are generally historic (the incident took place before the memorandum of understanding with the CQC came into effect) and a high proportion of those are linked to mental health Trusts and providers.

Date	Organisation	Incident date(s)	Incident(s)	Penalty	Prosecuted by	Learning
July 2018	Argyle Care Group	October 2015	Resident with poor eyesight gained access to unsecured flight of stairs and fell	£16k fine + £9.5k costs	CQC	Care plan and falls assessments had not identified risks following deterioration in eyesight. Inadequate lock fitted.
November 2018	Hillgreen Care Limited	November 2015	Vulnerable resident allegedly sexually assaulted by another resident	£300k + £141k costs	CQC	Failure to provide one-to-one supervision required for resident with a history of committing sexual assaults

Date	Organisation	Incident date(s)	Incident(s)	Penalty	Prosecuted by	Learning
December 2018	Oxleas NHS Foundation Trust	July 2016	Patient attacked two health care workers with a knife	£300k fine + £28k costs	HSE	Procedures to keep knives locked up and out of reach of patients “ad hoc and inadequate”.
December 2018	Elysium Healthcare	March 2014	Patient died after opening a door and leaping from a moving minibus	£500k fine + £67.5k costs	HSE	Systems and procedures not in place including risk assessments
April 2019	The Priory Group (Private mental healthcare company)	November 2012	14 year old found unresponsive with a ligature in locked room	£300k + £66k costs	HSE	Failure to carry out suitable and sufficient ligature risk assessment and training in life support.

Whether the same kinds of incidents could take place at MTW need to be considered and, if they could, the further mitigation that is required. If the Trust is assured that suitable and sufficient controls are in place then these need to be monitored and maintained.

1.5. Revised Risk Assessment Policy and Procedure

The revised Risk Assessment Policy and Procedure v7.0 has been published and is now available on Q-Pulse.

The key changes are as follows:

- Changes to the Risk Grading Matrix and more detail in the associated guidance
- A slightly amended Risk Assessment Form
- An amended Hazard Profile Checklist and guidance
- An example of a more task-based risk assessment form

- Minor updates to the policy and other appendices

1.5.1. Changes to the Risk Grading Matrix

The Risk Grading Matrix has changed from this:

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

To this, new grading matrix:

	CONSEQUENCE/ SEVERITY				
LIKELIHOOD / PROBABILITY	Negligible 1	Minor 2	Moderate 3	Severe 4	Catastrophic 5
Highly Unlikely 1	Green 1	Green 2	Green 3	Green 4	Green 5
Unlikely 2	Green 2	Green 4	Green 6	Amber 8	Amber 10
Possible 3	Green 3	Green 6	Amber 9	Amber 12	Red 15
Likely 4	Green 4	Amber 8	Amber 12	Red 16	Red 20
Certain 5	Green 5	Amber 10	Red 15	Red 20	Red 25

There are no more Blue ratings with 1-4s becoming Green. Green 8s, 9s and 10s are now Amber. **Any Amber 15s become Red Risks.**

2. Moving and Handling

The Policy and Procedure for the Moving and Handling of Patients and Loads is due for review in July 2019. This is to be reviewed by TCR, the external training and consultancy provider.

Employers should apply the principles of **avoid**, **assess**, **reduce** with regards to moving and handling. They should avoid hazardous moving and handling as far as is reasonably practicable. Where it cannot be avoided then the task should be assessed and controls introduced to reduce the risk. Currently generic moving and handling risk assessments are overdue for review. Again, this is to be carried out by TCR.

In last year's report the need to guard against over-reliance on training as the primary control measure was discussed. Competent advice and guidance as well as an ongoing strategy to ensure that ergonomic principles are applied and the organisation is responsive to developments in the field are needed. The fundamental requirement under

health and safety law is to control reasonably foreseeable risks so far as is reasonably practicable. Therefore, the use of the external provider for consultancy and the plan to recruit a moving and handling coordinator are welcome in continued efforts to mitigate the risk.

While there is a downward trend for incident and injury rates, where injuries do occur they can keep staff away from their normal duties for more than seven days. Some of the recent crush/ trap RIDDOR reportable incidents discussed in **4.2** and **6.5** occurred whilst undertaking moving and handling activities, such pushing and pulling equipment while negotiating doors. Indeed, even open and closing a door or cupboard would be defined as moving and handling. Rapid access to advice and guidance post incident is important to prevent recurrence. However, reducing the number and severity of incidents through effective proactive risk assessment before the incident can occur is what the law requires.

3. Fire Safety

3.1. Board duties

Trust Board

The Trust Board has overall accountability for the activities of the organisation, which includes fire safety. The Trust Board should ensure that it receives appropriate assurance that the requirements of current fire safety legislation and the objectives of DH's Firecode are being met. The Trust Board discharges the responsibility for fire safety through the Chief Executive.

Chief Executive

The Chief Executive will, on behalf of the Board, be responsible for ensuring that current fire legislation is complied with. They will ensure that all agreements for the provision of care and other services by third parties include sufficient contractual arrangements to ensure compliance with the trust's fire safety policy.

The Chief Executive discharges the day-to-day operational responsibility for fire safety through the Director with fire safety responsibility.

Board Level Director (with fire safety responsibility)

The Director with fire safety responsibility is responsible for ensuring that fire safety issues are highlighted at Board level. This responsibility will extend to the proposal of programmes of work relating to fire safety for consideration as part of the business planning process.

This will include the management of the fire-related components of the capital programme and future allocation of funding.

At an operational level the Director with fire safety responsibility should be:

- assisting the Chief Executive with Board level responsibilities for fire safety matters;
- ensuring that the trust has in place a clearly defined fire safety policy and relevant supporting protocols and procedures;
- ensuring that all work that has implications for fire precautions in new and existing trust buildings is carried out to a satisfactory technical standard and conforms to all prevailing statutory and mandatory fire safety requirements;
- ensuring that all proposals for new buildings and alterations to existing buildings are referred to the Fire Safety Manager before building control approval is sought;
- ensuring that all passive and active fire safety measures and equipment are maintained and tested in accordance with the latest relevant legislation/standards, and that comprehensive records are kept;
- ensuring through senior management and line management structures that full staff participation in fire training and fire evacuation drills is maintained;
- ensuring that agreed programmes of investment in fire precautions are properly accounted for in the trust's annual business plan;
- ensuring that an annual audit of fire safety and fire safety management is undertaken, and the outcomes communicated to the Trust Board;
- fully supporting the Fire Safety Manager function.

In line with delegated authority, the Director with fire safety responsibility devolves day-to-day fire safety duties to the Fire Safety Manager.

References

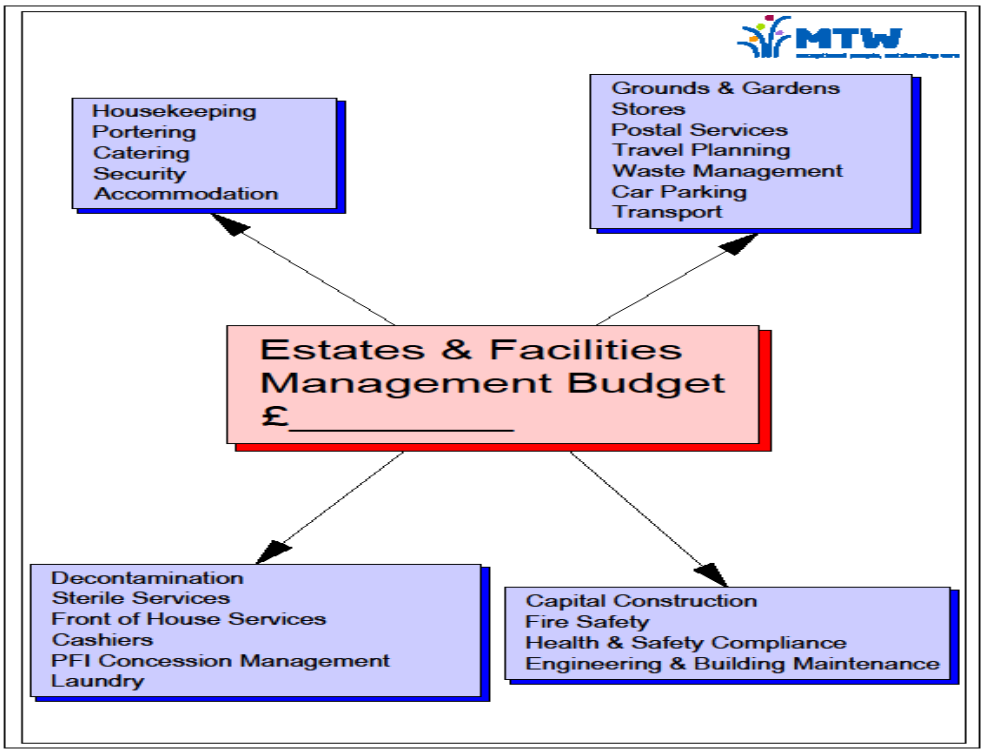
Health and Safety Executive (2013) *Managing for health and safety,* HSG65

Health and Safety Executive (2013) *Leading for health and safety at work*, INDG417(rev1)

Health and Safety Executive (2019) *HSE Business Plan, 2019/20*

Six monthly update on Estates and Facilities **Director of Estates and Facilities**

Introduction



The Estates & Facilities Directorate provides non-clinical services to underpin and support the clinical provision of two major acute hospitals in Kent.

The range of services provided and the work force employed are diverse with the Trust employing a large workforce with professional and vocational skills in the many different facets of Estates & Facilities management.

Overall the Estates & Facilities directorate employs 9.92% of the Trust work force and has an annual recurring budget of £27.5m and PFI costs of £25m.

This report is presented under three categories

1. Operational Functions
2. Estates & Facilities Development
3. Future Estates & Facilities management options.

The Trust Estates & Facilities cost sits within the norms of National NHS Trusts and is not an outlier in respect of overall benchmark costs.

The de

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

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

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

Six monthly update on Estates and Facilities

1. Operational Functions

There are national standards and specifications for the provision of NHS food to patients and also for the cleaning of the NHS Estate. These standards are subject to annual regulation by NHS monitoring and reporting mechanisms that are applied nationally to all NHS Trusts. The major regulating mechanism include the :

- Patient Led Assessment of the Care Environment (PLACE).
- The Estates Return Information Collection data (ERIC)
- The Premises Assurance Model (PAMS)

For day to day operations the Crown legislation in place for compliance is the Health & Safety at Work Act (1975) and its subordinate legislation. The Trust is also subject to compliance with the Regulatory Reform (Fire Safety) Order 2005. It is anticipated that there will be considerable changes of a more stringent Fire Safety regime arising out of changes in the Act from the 2017 Grenfell Tower disaster fire of June 2017.

Our fine food offering

2. Estates & Facilities Development

This year focus is being made on improving the internal and external environment, particularly at Maidstone Hospital. Facilities management improvement is being concentrated on a number of areas. There has been, and is this year, an increasing range of food products and offerings in the Trust. Taking into account allergens, special dietary requirements and the need to tackle head on the reduction in the use of plastics.

Transport

This financial year a new fleet of general transport vehicles has been introduced with lower carbon emissions and reduced operational costs. The fleet now contribute to cross site transportation which also allows other synergies to be obtained in clinical pathology functions.

Car Parking

Major car parking initiative is in train for this financial year. Capacity of car parking for visitors, patients and staff presents a significant pressure across both sites.

Potential car parking extensions are sought on both sites and the Trust is in constructive conversation with local authorities on extending the car parking with the provision of decks later this financial year.

Accommodation

The recruitment of nurses to fill Trust vacancies has required innovative solutions from the private accommodation sector in both the Maidstone and Tunbridge Wells areas. The directorate has gained skills in private accommodation sourcing and negotiation. Success in this area has also been due to close co-operative working with the Director of Nursing and the Director of Human Resources in finding suitable accommodation for overseas nursing.

Laundry

The Trust Laundry is subject to a long lease and is located at Parkwood, South of Maidstone. The Laundry provides all the Trusts linen and also contracts for linen at other Trusts.

Study is nearing completion on the Laundry efficiency in respect of financial costs and value for money. The report shall provide proposals for future options available to this Trust for laundry services including a sale or investment option for Trust management consideration.

The Laundry Team

Bus Transport

The Trust is currently trialling a mini bus shuttle service throughout the day seven days per week, between Tonbridge Railway station and the Tunbridge Wells Hospital. The service has been most successful and a similar provision is being explored between Tunbridge Wells train station and Tunbridge Wells Hospital.

An exciting provision eclipsing the existing service above is in negotiation with the major County bus operating provider. The possibility is being explored of a Trust employee open bus travel service across the County from one annual fixed charge. The offer on this matter is expected to be provided to the Trust within the next two weeks.

Grounds

The grounds and external environment at Maidstone Hospital have been identified as requiring considerable improvement. A programme of gardening developing the grounds. Plans are in place for the internal atria which at present are fallow.

At present Maidstone hospital grounds are subjected to an unacceptable level of visitors, patients and staff ignoring the Trust no smoking policy. The Trust is subject to pollution of the environment in its grounds with second hand smoke and littering of cigarette butts at both Maidstone and Tunbridge Wells hospitals. The Trust is now vigorously tackling this unacceptable behaviour by implementing the Trust Smoke Free policy and a number of changes approved by the Trust Executive and with the assistance of the Medical Director and Nursing Director going forward.

Plans are in place to create a patient friendly environment in the hospital atria's to improve patient experience and the ambience of Maidstone hospital. The Directorate acknowledges the assistance of the Trust League of Friends in this initiative.

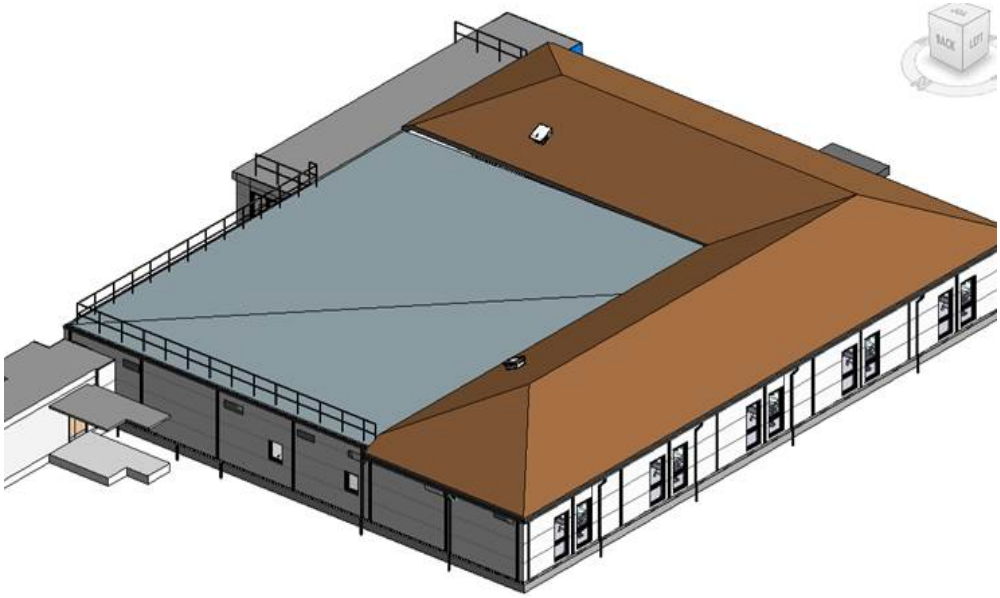
Capital Development and Estate Strategy

The Trust over many years has built a capability in health Estate construction, planning and discharging capital projects. The Trust directorate employs a number of professionally qualified engineers and building surveyors.

This year the major project being discharged is the Acute Medical Unit (AMU) at Maidstone hospital. The project is proceeding on time and within budget with the Certificate of Practical Completion for the building planned for January 2020.

Studies are now advancing for the provision of additional office accommodation and the inclusion of car parking decks to provide much needed car park spaces at both Tunbridge Wells Hospital and Maidstone Hospital, planned for a construction programme in this financial year.

The Trust has not had the benefit of a development control plan for either the Maidstone Hospital or Tunbridge Wells Hospital for a number of years. The Director of Estates and Facilities is working in conjunction with the Director of Strategy in the creation of a development control plan to assist decision making provision for the Trust Board and Executive in coming years.



3. Estates & Facilities Management into the future.

With the advent of the National Health Service post second world war it was government policy to employee people into a nationalised workforce in the NHS. Post 1970 brought about the

conceptual introduction of the private financial initiative (PFI) followed in the 1990's of the outsourcing into private companies of some or all Estates & Facilities management functions. The objective being to transfer risk to private companies and obtain an improved value for money service for health care trusts.

It is now common in Trusts to have a mix of private finance initiative provision, outsourced companies and directly employed staff providing the range of facilities management.

Some NHS Trusts have received approval from NHSI to develop and transfer pharmaceutical, Estates & Facilities and procurement functions into limited companies wholly owned by the Trust. The term commonly used is "Arms length" companies. The Trust currently utilises a mix of private finance initiative, estates services, directly employed estates staff at Maidstone Hospital and in house facilities staff at both Tunbridge Wells Hospital and Maidstone Hospital.

Going forward into the future in the NHS clinical services shall continue to be the subject of dynamic change in large acute hospital trusts and it is essential both for service continuity and value for money that Estates & Facilities functions should be provided at the highest standard and optimal cost by close working with the Director of Strategy, CEO and Finance Director.

The Maidstone and Tunbridge Wells NHS Trust real estate comprises of circa. 1980s "nucleus hospital" in Maidstone and 2011 PFI hospital which has a number of unique design concepts nationally including single beds.

Traditionally there has been a practice in the UK of building contemporaneous hospital designs specifically related to a period of clinical service delivery at that time. This conceptual concept does not match the constant change required in clinical provision and has resulted in this trust facing severe pressures with accommodation and the inefficiencies of poor clinical adjacencies, particularly at Maidstone Hospital.

The out turn objectives for 2019/20 financial year are:

1. Over the coming quarter a comprehensive and detailed study be undertaken of the entire estate accommodation matched against conceptual planning changes with clinical service delivery. The objective of the study being to offer solutions for consideration by the Trust Executive in maximising Estate efficiencies and improve clinical service delivery working in conjunction with the Director of Operations with a new accommodation policy.
2. The development and publication (subject to Trust Executive Officer approval) of a Estates strategy developed in conjunction with the Chief Executive Officer, Director of Strategy and Chief Operating Officer.
3. Proposed financial service delivery options for Estates & Facilities functions that are fit for purpose, affordable and match the Trust clinical service delivery obligations.
4. Develop a "can do attitude" for service delivery in the Directorate to meet the needs of patients, staff and the general public.

Doug Ward
Director of Estates & Facilities

Summary report from the Charitable Funds Committee, 23/07/19 | **Committee Chair (Non-Executive Director)**

Summary / Key points

The Charitable Funds Committee (CFC) met on 23rd July 2019.

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

- Under the Safety Moment, the Trust Secretary reported that the month's theme was Diabetes care and highlighted the key areas of focus for the month
- The draft Maidstone and Tunbridge Wells NHS Trust Charitable Fund Annual Report and Accounts 2018/19 were reviewed in advance of an independent examination and finalisation for approval at the CFC meeting in October 2019. It was agreed that the Chief Finance Officer/Head of Financial Services should review the accounting treatment of the property bequeathed to the Trust in 2004 and consider any necessary amendments to the Charitable Fund Report and Accounts 2018/19
- The financial overview at Month 3 was considered and it was noted that:
  - The fund balance stood at £986k, a decrease of £184k since 1st April 2019
  - Total year to date income was £184.6k with expenditure of £368.4k
  - 7 specific donations had been received exceeding £1k totalling £175k. The largest single donation was £150k to fund the new helipad at Maidstone Hospital
  - One request for expenditure had been refused during the period
  - An update was provided on the property bequeathed to the Trust in 2004 and it was agreed that the Chief Finance Officer/Head of Financial Services should recommend (for the Committee's approval ahead of its next meeting) a course of action on receipt of the independent evaluation of the property, that had been procured
  - The Committee accepted a recommendation from the Head of Financial Services that Social Impact Bonds were not an appropriate investment tool for charitable funds on the grounds that they conflicted with the fund's investment policy
- The Committee agreed that the proposed Management and Administration fee of £38,733 for 2019/20 should be revised to include the costs of the Fundraiser post (which were currently excluded) and that the name of the fee should be changed to include the word "support". It was agreed that this enabled the removal of the item scheduled for the CFC meeting in October to review the funding arrangements for the Trust's fundraiser. It was further agreed that the Finance and Fundraising functions should review current administrative roles and responsibilities within proposed management and administration charges and explore consolidation to help maximise efficiencies
- A fundraising update was provided for the period 19th March to 15th July 2019 and the Committee acknowledged the progress made in generating funds for the Trust. The charity's registration with the Donr and Amazon Smile charitable donation platforms was agreed. It was agreed in relation to the Amazon Smile platform that its functionality should be explored to confirm if it might be adapted to generate charitable donation suggestions based on postcode (i.e. local charities).
- The findings of the Association of NHS Charities Comparison Survey were noted and it was reported that this would be the last such report to be considered by the charity's membership of the Association would lapse in 2020

2. **In addition to the actions noted above, the Committee agreed that:** N/A

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

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

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

Summary report from the Finance and Performance Committee, 20/08/19 (incl. approval of revised Terms of Reference and quarterly progress update on Procurement Transformation Plan)	**Committee Chair (Non-Exec. Director)**

The Finance and Performance Committee met on 20th August 2019.

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

- Proposed amendments to the Committee's Terms of Reference (ToRs) were agreed (as part of the routine annual review); this was subject to the inclusion of additional content the Committee had requested for the "Performance" duties, which has now been actioned; the revised ToRs, with the proposed changes 'tracked', are shown in Appendix 1 for the Trust Board to approve
- The "Finance or performance moment" item was focused on Ophthalmic productivity. A number of issues were considered as part of the item and it was agreed that progress with the plans to improve ophthalmic productivity should be monitored via the Divisional Performance Reviews
- The month 4 financial performance was reviewed, which included the latest changes in relation to the national capital position. It was agreed to explore whether the costs of the design work that had been undertaken for the new Acute Medical Unit at Maidstone Hospital could be either a) established as an asset that could be paid for via capital funds, or b) incorporated into the costs for the establishment of the Hyper Acute Stroke Unit. The impending implementation of International Financial Reporting Standard (IFRS) 16 (Leases) was also noted and it was agreed that a report should be submitted to the Committee's meeting in September 2019 on the implications of implementing the Standard.
- The monthly update on Wells Suite income was given and it was confirmed that private patient services had now been formally transferred to the Surgery Division
- The month 4 non-finance related performance was discussed, which included the A&E 4-hour, Referral to Treatment (RTT) and 62-day Cancer waiting time targets.
- The West Kent Dermatology contract was discussed and the point was made that the Trust, as a Cancer Centre, should control all cancer activity, including dermatology. However it was agreed to investigate whether it was feasible for the Trust to receive the performance-related benefits from the contract if the Trust managed the contract on behalf of West Kent Clinical Commissioning Group (CCG) but the CCG remained the contract holder. It was also then confirmed that the Trust should take on the contract but the Committee should be notified of the final arrangements, once available.
- The latest quarterly progress update on the Procurement Transformation Plan was reviewed (circulated as Appendix 2) and it was agreed to check and confirm the extent of the Trust's use of the dispensing cabinet functionality of the Omnicell system
- The Committee reviewed a rejected Single Tender Waiver relating to Cost Improvement Programme (CIP) consultancy services (at the request of the Audit and Governance Committee) and assurance was given regarding the decision-making involved
- The standing "Breaches of the external cap on Agency staff pay rate" report was noted, as were the recent uses of the Trust's Seal
- It was confirmed that the subject of the "Finance or performance moment" at the meeting in September should focus on the winter plan

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

- The Trust Secretary should schedule a "Review of the format and content of the revised Integrated Performance Report" item at the Committee's meeting in October 2019
- The Trust Secretary should amend the order of the domains under the monthly "Integrated Performance Report" item on the 'Part 1' Trust Board agenda to reflect the order within the revised Integrated Performance Report

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

- The revised Terms of Reference are enclosed for Board approval

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
2. To approve revised Terms of Reference for the Finance and Performance Committee

Appendix 1: Revised Terms of Reference for the Finance and Performance Committee (for approval)

FINANCE AND PERFORMANCE COMMITTEE

Terms of Reference

NHS
Maidstone and Tunbridge Wells NHS Trust

1. Purpose

The Trust Board has established the Committee to provide the Trust Board with:

- Assurance on the effectiveness of financial management, treasury management, investment and capital expenditure and financial governance
- An objective assessment of the financial position and standing of the Trust
- An objective assessment of performance-related issues affecting the key operational targets and the Trust's financial position
- Advice and recommendations on all key issues of financial management, financial performance and operational performance
- Assurance on Information Technology performance (and IT-related business continuity)

2. Membership

Membership of the Committee is as follows:

- The Committee Chair - a Non-Executive Director or Associate Non-Executive Director appointed by the Trust Board
- The Committee Vice-Chair - a Non-Executive Director or Associate Non-Executive Director appointed by the Trust Board
- An Associate Non-Executive Director
- The Chief Finance Officer*
- The Chief Operating Officer*
- The Chief Executive*

Members are expected to attend all relevant meetings.

3. Quorum

The Committee shall be quorate when one Non-Executive Director or Associate Non-Executive Director and two Members of the Executive Team (see * above) are present. If a member of the Executive Team cannot attend a meeting, they should aim to send a representative in their place.

For the purposes of being quorate, any Non-Executive Director or Associate Non-Executive Director (including the Chair of the Trust Board) may be present; and any two Members of the Executive Team may be present (including any of those not listed in the Membership). Deputies representing Members of the Executive Team will count towards the quorum.

4. Attendance

All other Non-Executive Directors (including the Chair of the Trust Board), Associate Non-Executive Directors and Members of the Executive Team are entitled to attend any meeting of the Committee.

The Committee Chair may also invite others to attend, as required, to cover certain agenda items, and/or ensure the Committee meets its Purpose and complies with its Duties.

5. Frequency of meetings

The Committee shall generally meet each month, but the Committee Chair may schedule additional meetings, as required (or cancel any scheduled meetings)

6. Duties

The Committee has the following duties:

Financial Management

- Review financial plans and strategies and ensure they are consistent with the Trust's overall vision and strategic goals
- Ensure a comprehensive budgetary control framework is in place and operating effectively
- Monitor financial performance against plan, and ensure corrective action is taken where appropriate
- Develop and monitor key financial performance indicators, and advise the Trust Board on action required to improve performance / address risks.
- Review and monitor the Trust's Cost Improvement Programme (CIP)
- Obtain assurance that all ~~CIP schemes and Business Cases have been subject to a Quality Impact Assessment (QIA), and to liaise with the Quality Committee, as appropriate, to ensure the robustness of the process~~
- Monitor~~s~~ the delivery of the recommendations of the 'Lord Carter report' ("Operational productivity and performance in English NHS acute hospitals: Unwarranted variations")
- Ensure the Trust is actively engaged in and addresses all productivity opportunities presented as part of national initiatives

Treasury Management

- Review any significant (in the judgement of the Chief Finance Officer) proposed changes to the Trust's treasury management policies, processes and controls
- Approve external funding and borrowing arrangements, including approval of working capital facilities and capital investment loan applications (within the Committee's delegated authority), or to review such applications, and make a recommendation to the Trust Board if the value exceeds the Committee's delegated authority)
- ~~Ensure proper safeguards are in place for security of the Trust's funds by ensuring approved bank mandates are in place for all accounts, which are updated regularly for changes in signatories and authority levels;~~
- ~~Monitor compliance with treasury management policies and procedures~~
- Review the Trust's cash flow and balance sheet, to ensure effective cash management plans are in place

Capital Expenditure and Investment

- Review the Trust's capital plan ensuring its alignment to strategic priorities
- Review and assess the financial implications of the PFI contract for Tunbridge Wells Hospital, including any options for re-financing
- Review Business Cases for capital and service development above the threshold set-out in the Reservation of Powers and Scheme of Delegation, and make a recommendation to the Trust Board regarding the approval of such Cases
- Receive assurance on the effectiveness of the Trust's investment appraisal and approval process (via consideration of post-project reviews)

Financial Governance, Reporting, Systems and Function

- Review and assess the arrangements for financial governance
- Review and assess the effectiveness of financial information systems~~,~~ and monitor development plans, including the development of Service Line Reporting (SLR)
- Review and assess the capacity and effectiveness of the finance function and ensure development plans are in place to meet the current and future requirements of the Trust
- Assess the organisational awareness and adherence to financial management disciplines and controls and promote congruence between quality patient care and the achievement of financial objectives
- Review and approve the Trust's approach to its National Cost Collection return/s~~Reference Cost submission/s~~

Procurement

- ~~To m~~Monitor performance against the Trust's Procurement Strategy and Procurement Transformation Plan

Performance

- To M~~m~~onitor and review non-quality performance-related issues, particularly in relation to the key patient access targets
- Monitor and review the indicators within the Trust Performance Summary Scorecard (and associated information) prior to review by the Trust Board
- ~~To e~~Escalate performance-related issues to the Trust Board in the event of any concerns

Informatics (including Information Technology~~)~~

- Review Information Technology~~informatics~~ strategies and plans and ensure they are consistent with the Trust's overall vision and strategic goals
- Review plans and proposals for major development and investment in Information Technology, and advise the Trust Board accordingly, paying particular attention to the financial implications and risks of the proposals

Assurance and Risk

- Assure itself on (i) the identification of principal risks associated with the financial performance and financial management of the Trust, and Information Technology, (ii) the effective management of those risks and (iii) the escalation to the Trust Board of matters of significance

7. Parent Committees and reporting procedure

The Committee is a sub-committee of the Trust Board.

A summary report of each Committee meeting will be submitted to the Trust Board. The Chair of the Committee will present the Committee report to the next available Trust Board meeting

8. Sub-Committees and reporting procedure

The Committee has no standing sub-committees, but may establish fixed-term working groups, as required, to support the Committee in meeting the Purpose and/or Duties listed in these Terms of Reference.

9. Emergency powers and urgent decisions

The powers and authority which the Trust Board has delegated to the Committee may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted at least two Members of the Executive Team (see * in the above "Membership" section). The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the Committee~~, for formal ratification~~.

10. Administration

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

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

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

11. Review of Terms of Reference and monitoring compliance

The Terms of Reference of the Committee will be reviewed and agreed by the Committee at least annually, and then formally approved by the Trust Board.

History

- Terms of Reference agreed by Finance Committee, May 2013
- Terms of Reference reviewed and agreed by Finance Committee, May 2014 (with a minor additional to duties agreed at the June 2014 Finance Committee)
- Terms of Reference approved by Trust Board, July 2014
- Terms of Reference (revised) agreed by Finance Committee, June 2015

- Terms of Reference (revised) approved by Trust Board, July 2015
- Terms of Reference (minor revision) agreed by Finance Committee, September 2015
- Terms of Reference (minor revision) approved by Trust Board, September 2015
- Terms of Reference (reviewed and revised) agreed by Finance Committee, June 2016
- Terms of Reference (revised) approved by Trust Board, June 2016
- Terms of Reference (reviewed and revised) agreed by Finance Committee, June 2017
- Terms of Reference (revised) approved by Trust Board, June 2017
- Terms of Reference approved by Trust Board, October 2017 (to add Associate Non-Executive Directors to the membership)
- Terms of Reference agreed by the Finance and Performance Committee, April 2018 (to remove the Deputy Chief Executive from the membership, following the discontinuation of that post)
- Terms of Reference (revised) approved by Trust Board, May 2018 (to remove the Deputy Chief Executive from the membership, following the discontinuation of that post)
- Terms of Reference (reviewed and revised) agreed by the Finance and Performance Committee, July 2018
- Terms of Reference (revised) approved by the Trust Board, July 2018
- Terms of Reference agreed by the Finance and Performance Committee, August 2018 (to add a further Associate Non-Executive Director to the membership)
- Terms of Reference (revised) approved by the Trust Board, September 2018
- Terms of Reference (reviewed and revised) agreed by the Finance and Performance Committee, August 2019
- Terms of Reference (revised) approved by the Trust Board, September 2019

Appendix 2: Quarterly progress update on Procurement Transformation Plan

1. INTRODUCTION

1.1 The Procurement Transformation Plan (PTP) was originally approved by the Trust Board on the 19th October 2016. A refreshed PTP was submitted to NHSI on 11th May 2018 in line with the most current requirements.

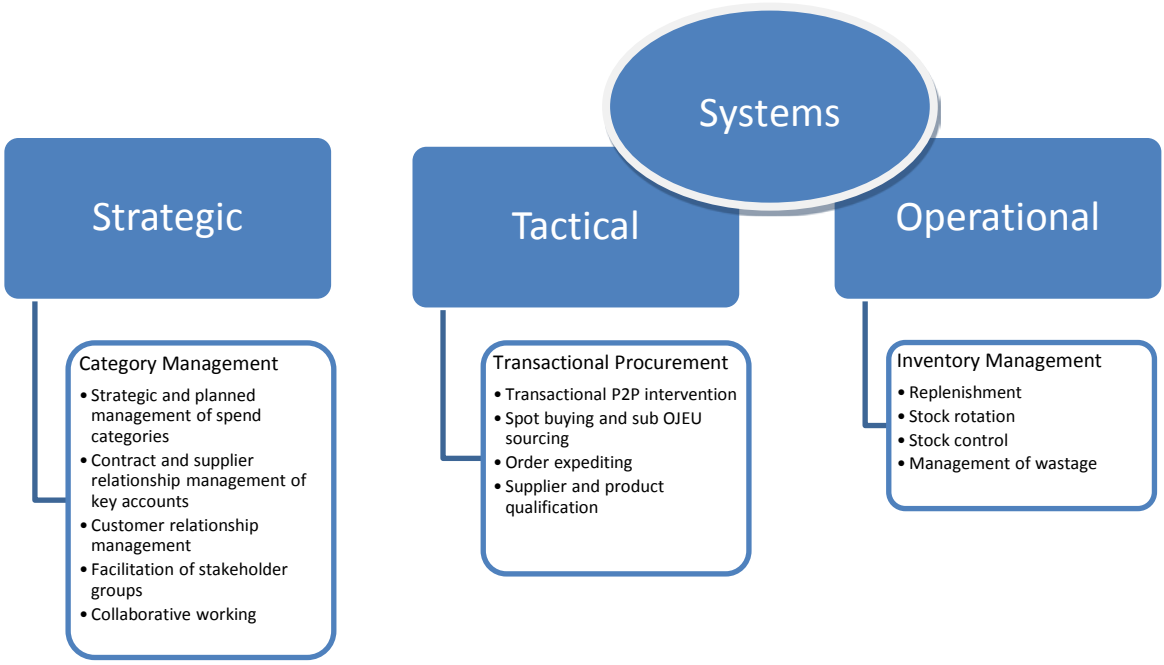
1.2 The PTP guidance from NHSI states that "Trusts will be asked to provide regular progress updates on their PTPs to their Trust's board and NHS Improvement. These will take place quarterly."

1.3 In January 2018, NHSI issued an amended set of procurement model hospital metrics. The model hospital has been updated with some of the new procurement metrics. This report reviews the latest quarterly performance against these metrics.

2. SUMMARY

2.1 Maidstone and Tunbridge Wells NHS Trust procurement team has been through a three year transformation programme. This programme was implemented as the Trust recognised the importance of the procurement function and the need to invest in this area. The business case for the transformation identified savings of £5million to be delivered in 3 years. The team delivered over £7million in the first three years thereby indicating the success of the transformation programme. The procurement team is now an integral part of every divisional CIP programme and expects to attend all CIP meetings and be involved in any new initiatives to ensure procurement are part of the planning to take forward new activity.

2.2 Maidstone and Tunbridge Wells NHS Trust (MTW) procurement team covers three key areas of procurement.



Strategic

2.3 Strategic procurement is a category management procurement function. The team covers all non-pay expenditure except for Pharmacy & Agency.

This team is focused on internal stakeholder relationship management; ensuring active and positive engagement throughout the procurement cycle all the way through to contract management stage. The team also covers external supplier management through the splitting of spend into discrete portfolios of categories. This allows a specialist focus on categories to

focus on value and total cost of ownership rather than exclusively price down savings initiatives.

Tactical

2.4 This is the more recognisable "purchasing" function managing purchase transactions with suppliers, unplanned sourcing activity and sub-OJEU or "tail" spend not managed through the strategic category management function. The team is also focused on catalogue management to ensure compliance with the Trust policy of No PO No Pay.

Operational

2.5 This function is more recognisable as the inventory management function responsible for the replenishment and distribution of goods throughout the organisation. This team is currently responsible for the Trust Omnicell inventory management system. They link with supplier change to identify product switches which support the Trust position on quality cost effective products.

Systems

2.6 This sits across the Tactical & Operational teams and covers the technology and manpower resource required to run and maintain the systems needed to drive efficient work practices which include Integra, Omnicell and GHX.

3. NEXT STEPS

3.1 **Strategic** – The Trust 2018/19 CIP target was £4.2million. The team identified the areas where these savings could be delivered by the end of March 2019, including £2.2million of roll-over savings that commenced in 2017/18. There was also a Kent & Medway STP work programme under the Productivity work-stream which was targeted to deliver £1m full year savings. This programme has been slow to get up to speed and has now been disbanded. The service has been re-branded as a support function to the other STP workstreams. Therefore the onus for delivering this number has fallen back on the internal team and is no longer expected to be delivered through the STP work stream. A full procurement work programme is monitored by the MTW Best Use of Resources Board, chaired by the Finance Director, on a monthly basis.

At year end we delivered £3.9m of in year savings. These delivered projects also represent a carry-over of £0.87m into 2019/20. As stated the STP savings have not materialised as expected and so the £1m projection has been added to the internal plan. Therefore the internal team has delivered £700k above the original target.

We have submitted a plan for 2019/20 which represents £2.9m of in-year savings which, with the additional £0.87m of carry-over gives a total plan of £3.77m.

3.2 **Tactical** – The team have implemented a full P2P system integrated with the finance system Integra2. This has the capacity to provide a full pathway from orders placed on the system, to the receipting of goods, invoicing and payment of the goods. This supports the work within the Trust on electronic purchase orders and catalogue management and we are working with our Catalogue Management provider to establish better catalogue pricing control and e-invoicing where possible with the ultimate aim of implementing a fully electronic PTP process. The system is now embedded so we will be looking at maximising its additional functionality and controls to drive quality data and opportunities.

3.3 **Operational** – The Trust has implemented an inventory management system, Omnicell within the high cost product areas such as Cardiac Cath Labs, Elective Theatres, Ophthamology and Short Stay Theatres. This is currently a mixed model of an open system (bar-code scanning) and closed system (automated cabinets).

3.4 **Systems** - The Omnicell system has enabled the Trust to monitor stock levels and identity the maximum and minimum stock levels to be held in each area. It also allows tracking of stock issued to patient level. A high level review of the way we use this system has been undertaken. This has identified that we are not realising the full benefits of an automated inventory

management system. Discussions are underway with the service provider to undertake an audit of how we are utilising the system. This will identify any existing functionality that we are not currently using, and make a recommendation of additional options (such as RFID tagging) which would improve the functionality and control. We currently have circa £60k of credit with Omnicell so it is hoped that we will be able to cover any improvements from this fund. We have already undertaken a small restructure of roles in the department and have therefore been able to employ a dedicated Omnicell manager with effect from March 2019. A review of how Omnicell was being utilised in Theatres at MGH has been undertaken in conjunction with the Theatre Manager. This project had the effect of reducing theatres' spend against budget by more than £100k. We will now be looking to replicate this work in all Omnicell areas (with the caveat that it does require the full support of the Theatre team to be effective).

4. TRUST PROCUREMENT PERFORMANCE (RAG rating against updated Carter targets)

MEASURES		PERFORMANCE		COMMENTARY (INCLUDING WHAT HAS BEEN IMPLEMENTED SINCE SUBMISSION OF ORIGINAL PTP AND CONSIDERATION AS TO WHAT SUPPORT IS REQUIRED)
		CARTER TARGET	CURRENT	
1	Monthly cost of clinical and general supplier per 'WAU'	**WAU (£350)**	**£304**	The Trust has seen continual increase in activity year on year. Fixed costs have been stretched to minimise the increase of costs and sustain a low WAU.
2	Total % purchase order lines through a catalogue	**80%**	**95.4%**	The Trust has fully implemented an electronic P2P system integrated with finance. This includes a catalogue which enables end user ordering. Focus will now be given to how we can convert non PO spend and bring areas outside of Integra on board (such as Estates)
3a	% of invoice value matched to an electronic purchase order	**90%**	**97.9%**	The Trust has a strict no PO no Pay policy. There is also a PO exemption list that is authorised within the Trust SFIs. This includes some services from other NHS organisations.
3b	% by count of invoices matched to an electronically generated purchase order	**90%**	**92.9%**	
4	% of spend on a contract	**90%**	**Not yet reported**	A review of how we record Contracted and Quoted spend through Integra will allow us to start measuring and reporting on this metric.
MEASURES		**PERFORMANCE**		**COMMENTARY (INCLUDING WHAT HAS BEEN IMPLEMENTED SINCE SUBMISSION OF ORIGINAL PTP AND CONSIDERATION AS TO WHAT SUPPORT IS REQUIRED)**

		CARTER TARGET	CURRENT	
5	Inventory Stock Turns	**NA**	**71 Days**	This number is in line with the previous quarter, but is still too high (our aim is to get down to 45 days). The expectation is that the new Omnicell Manager role will now create the time to focus on reducing this number.
6	NHS Standards Self-Assessment Score (average total score out of max 3)			Level 1 standard assessment was completed in December 2017. MTW have now received formal ratification of the assessment.
7	Purchase Price Benchmarking Tool Performance - % variance to median	**2.2%**	**2.1%**	This metric was previously reported as a £ figure, but is now reported as a % variance to median price within Model Hospital so this has been amended to align with the national metric.

5. Procurement Transformation Plan - Summary

1) People & Organisation :

People & Organisation

The team have undergone a transformation programme which structured the teams based on the three areas outlined within the executive summary. One post within the team has now been transformed into a development role and recruited to. The Apprenticeship scheme was not appropriate for this. A further operational role has been converted into an inventory systems manager role to support the improvement of Omnicell.

MTW has approached the local Christchurch Canterbury University and is now part of their graduate scheme where purchasing and supplies is one of the areas of study within the university. This is all part of the team succession planning and development as historically the team have struggled to fill posts within category management. We have received a work placement student through this scheme in the summer holiday period for the past 2 years, but in 2019/20 we will have 1 member of the Operational team off long term sick for at least 2 months and another on maternity leave for the year. Therefore the funding for this placement will unfortunately have to go towards Bank cover for the year. We do however intend to continue with the placement scheme when these pressures have subsided.

Continued development of the team is important and a training matrix has been developed identifying training for each member of the team and how this links to their procurement role. There is also a link to the procurement skills network and sharing learning through peers across the region. All members of the team have been offered the opportunity to study for their Level 4 CIPS through the Apprenticeship scheme. Three members of the team are currently studying for it. We will continue to offer this opportunity and will actively encourage staff members to develop via this route.

The Head of Category Management role has now been appointed to and the successful candidate started in the role on 1st February 2019. This has already seen an improvement in structured working and a skills assessment of the current Category Management team.

Next steps – There have been a number of internal changes to the team which is being driven by a clear desire to learn & develop better procurement skills. Whilst attendance on free-to-access procurement day-courses and the availability of the CIPS Level 4 qualification through the Apprenticeship scheme is useful, we have now started internal team development sessions to provide practical & bespoke support in areas such as strategy, specification development, key performance indicators, contract writing & contract management.

Following a year of staffing issues, the Inventory Management team now has a full complement of staff and is running smoothly which should allow us to improve the focus on resolving the Omnicell process issues.

With the National Category Towers going fully live on 1st April 2019, the need to repurpose some of the Category Management team may arise to avoid duplication. The team will need to put greater focus on developing alternative strategies for more efficient delivery of healthcare and better Contract Management. A skills assessment is being undertaken and we may require a further review of the department structure to meet the Trusts needs going forward.

Measures Implemented (200 words max)	All staff appraisals identify training needs and KPIs monitored on numbers of staff qualified. Three members of staff undertaking current CIPS training. Category management monitors the savings against monthly targets which have been built into the team's appraisals as objectives. A development role has been created for 2018/19. This post will be trained in Systems, Operations and Category Management for succession planning. Bespoke internal training has started. The Operational & Tactical team have commenced a project to improve automation of catalogue management and pave the way for true P2P invoicing.
Impediments and support (200 words max)	The Category Management team require upskilling, or modernising their knowledge base, particularly around commercial awareness & contract management, in order to meet the current challenges. Internal training run by ADoP & HoCM has now started. The Procurement team does not have an extensive training budget so identifying ways to access the Apprenticeship funding is key. We will continue to access free of charge PSD training when appropriate and introduce regular bespoke in-house training to support specific development needs. Temporary resource maybe required to undertake reviews of all Omnicell areas in order to maximise the benefits.

2) Processes, Policies & Systems :

The Procurement Strategy has been reviewed in November 2018. The strategy had been amended to take into consideration the impact of the significant changes to national policy and approach since it was agreed, and the effect on the regional STP and aligning the Trust objectives to support the changes in the national landscape.

Processes & Policies

Work is underway to improve the way we manage contracts and pricing through the catalogue which will have a direct impact on our ability to police the Trust's no PO no Pay policy. These improvements are focused on ensuring that any request for goods and services has followed the full trust processes and there is a clear audit trail of activity. It also ensures we have more complete usage data which in turn enables us to make better purchasing decisions.

MTW are key members of the Kent STP (along with Medway FT, Darenth Valley & East Kent FT, and the Community and Mental Health Trusts). The Productivity workstream for the STP has now been revised to a support function of the other workstreams rather than a workstream in itself. The Medway FT Head of Procurement has stepped down from leading on this and as yet no replacement has been appointed. The STP HOP's are therefore taking it in turns to chair monthly meetings. The collaboration has had a number of challenges around resource and skill

set, whilst East Kent's transition to a wholly owned subsidiary company has seen them become more distant from the group. The £1m savings target originally attributed to the STP work-streams for MTW has had to be brought back in-house for this financial year and there are no plans to include a STP specific savings number in our 2019/20 plans.

NHSSC have been approached to undertake the analysis on behalf of the STP to identify quick wins through commonality of product that could generate better pricing in the short term when our volumes are aggregated, or changes in supply route. However, East Kent have failed to provide written authorisation for their data to be analysed and shared and as such NHSSC are not prepared to undertake the work.

The national "Future Operating Model" goes fully live with its 'Buy Price = Sell Price' model on 1st April 2019. The Impact Statement from SCCL has identified £1.2m of Revenue savings for the Trust, but we will have our income top-sliced by £1.3m. They also project a Capital saving (based on our historical purchases) of a further £300k, so a net benefit to the Trust of £200k

Systems

The implementation of the Inventory management system (Omnicell) and the integrated procurement and finance system (Integra) has given the Trust the facility to get real time stock usage information. Work is being developed on how to utilise Omnicell more effectively to provide procedure level data to understand the cost of each patient and procedure variance. This also introduces disciplines that will be essential when Scan4Safety is implemented in the Trust.

Omnicell also allows us to report on our stock rotation efficiency by recording how many days of stock we hold on the shelves at any one time. This is a key metric of the model hospital that identifies areas in which we can remove waste. It is also a strong indicator of how effective our inventory management system is. Real time stock levels allow more accurate management of stock and comparison of usage across the departments.

The three-way match process flow built into Integra [Requisition, Authorise, Receipt] gives us the ability to auto-match our invoices against the orders to ensure we are paying the correct price and for the correct goods. However, this process is not currently functioning to its full capability and is requiring manual intervention and review to resolve invoice mismatches. A review of the whole Purchase to Pay process with Accounts Payable has therefore been established which will include the inputs from purchasing (price control), finance (invoice processing) & estates (receipting).

A review of how we can automate the management of our catalogues utilising GHX which in turn will facilitate true P2P e-invoicing has now commenced.

The Purchase Price Index and Benchmarking (PPIB) report is run each month which identifies the opportunities for the Trust. This is reviewed against the Trusts who are performing well in those areas. This validation process allows the buyers to focus on "quick win" opportunities and also opportunities for the category managers to include within their tenders. This work also identifies potential STP opportunities to be taken forward. Whilst this is a useful tool for like for like benchmarking of catalogue items, the Trust has also recently invested in an 'intelligent' analytical tool called Procurement Dashboard. This takes all of our spend data (not just that on PO) and reports opportunities for product switches. It also benchmarks the cost of services against our peers.

Measures Implemented (200 words max)	A Finance Improvement Project on the P2P process has started which will incorporate improvements in the use of Integra2. A review of how we manage catalogues and invoices has been undertaken with GHX. We believe there is an opportunity to re-configure the way we utilise this service which will remove significant manual input for both Procurement & Finance. A high level review of the Inventory Management system has been undertaken which has identified a number of historical set-up issues which need resolving and some work required on the governance of its use. The Procurement Dashboard tool has been purchased and a project is underway to undertake Contract Management discussions with our top 50 suppliers.
Impediments and support (200 words max)	A full review of the P2P process spans 3 departments. It should be possible to identify the points of the process that require improvement, but it may not be so easy to agree responsibility for resolving the issues. This has been recorded as a project with the Finance Improvement Plan but as yet we have not been able to fully engage with AP.

3) Partnerships :

Partnerships - Collaboration

Maidstone and Tunbridge wells NHS Trust is part of the Kent and Medway Sustainability transformation programme (STP) footprint. Part of the STP identifies the need for procurement across the region to work closer together and where possible identify resources that can be shared to achieve best value in the market.

The STP has explored and tested an outsourced and in-house solution for a shared service transactional procurement team, but this has now been rejected.

The SE regionals Heads of Procurement from Medway Foundation Trust, Dartford and Gravesham NHS Trust, East Kent Hospitals University NHS Foundation Trust, Kent Community Foundation Trust and Medway Community Healthcare, and Kent & Medway Social Care Partnership Trust have sought to work together as a region. East Kent have had to step back from engaging with the STP as it has focussed on setting up its arms-length wholly owned subsidiary which includes the Procurement service. The other Heads of Procurement meet every month to discuss opportunities for collaboration and have shared their procurement work plans.

The Heads of Procurement have shared the contacts across the region as well as identifying the skills of each of their staff, to outline what skills are available within the region. This has been instrumental for longer term discussions on how we work more closely together as there is significant skill shortage in procurement and specifically in the South East (SE) there is difficulty in attracting staff out of London.

Projects have failed to get off the ground due to lack of resource and the internal pressures that have impacted East Kent and at different times each of the Trusts .The drive towards national pricing predominantly on clinical products now means that the focus of the STP will need to switch towards the benefits of shared services rather than leveraging aggregated volume on common products.

Next Steps

MFT, MTW, DGT, KMPT & MCH have committed to move projects forward without EKUHT if they are unable to commit, whilst SCCL will identify quick wins across the whole STP in the

short term and any areas where aggregated volume can still drive better pricing (such as Orthopaedics and Cardiology). A number of areas that may benefit from a shared services model have been drawn up and these will be scoped further in the forthcoming HOP's meetings. The Future Operating Model is now live and we are taking steps to collaborate with the new towers on all new projects.	
Measures Implemented (200 words max)	The Trust led an STP tender for Orthopaedics. This was a key success for two of the Trusts and achieved savings in excess of £1million across the two Trusts. This tender has supported joint working and joint contract management meetings with the supplier. The model of this tender will support the STP going forward on how best to work together. The contract is due to renewal in 2020 and discussions are underway to see if there will be any benefits in East Kent joining us for a re-tender. The Trust is leading on STP projects for IT Hardware and Pathology Send Away Tests. The Trust led on the procurement for the Kent-wide HSCN network which delivered a 60% saving of circa £4m over 5 years across the patch.
Impediments and support (200 words max)	The creation of the East Kent wholly owned subsidiary is diluting the impact of STP collaborative projects, but the other members are committed to delivering what they can. The category towers will implement the national pricing (buy price = sell price) model with effect from 1st April 2019, so opportunities for benefitting from aggregated volumes will be limited. Whilst the focus changes towards shared services, these will typically be large and complex projects. The number of procurement staff who have the skills to run these is limited.

6. Risks and issues

The main risk to the procurement department is the shortage of key procurement skills within the team and the region. To deliver the CIP saving and ensure that the leads identified to support the Trust and the whole STP region, requires staff with good procurement knowledge and the ability to negotiate in the market. With the introduction of the 'Buy-Price=Sell-Price' model from the Category Towers, Procurement will need to adapt its focus to maintain its value to the Trust .Maidstone and Tunbridge Wells is very fortunate to have a Category Management team who are all MCIPS qualified but this does not necessarily mean that they all have the skills to think in a more innovative way about Procurement. There is also always the risk of losing staff to London where salaries and development opportunities are more attractive.

Appendix 1 – Procurement action plan

Procurement objective	Action
Procurement strategy	Staff qualifications. An internal target has been set for 50% of procurement team qualified to an appropriate level of CIPS accreditation. Training matrix has been pulled together to identify the training requirements of all staff and link this to their role. This will support the Trust in achieving the level 2 procurement standard. There are currently three members of the team training for the CIPS level 4 and this development opportunity remains open to all staff. Bespoke internal training sessions have been developed to provide focused development of the Category Management team.
Procurement workplan	Delivery of 2018/19 procurement workplan. This workplan covers tail spend and improvement of the trust position on contract spend. The 2019/20 plan has been submitted.
Procurement Savings	Achievement of agreed 2018/19 £4.2million – Delivered £300k behind target
Communication strategy	Communication to internal and external stakeholders. Focus on Trust policy to ensure adherence to spend restrictions as well as improved compliance. This is a key objective within the procurement strategy. Increase number of quarterly contract review meetings with key suppliers. Re-introduce the Procurement Strategy Committee to drive the strategy with the new Chiefs of Service
Policies, processes and systems	Policies are reviewed and updated annually or at times of significant change.
Spend controls	Percentage of invoiced expenditure captured electronically through Purchase orders (P2P systems). This is monitored at the Trust finance committee and audit committee to ensure compliance. Improved processes to increase non-clinical spend covered by PO are planned. Improved processes to develop true electronic P2P.
People and Organisation	Achievement of the procurement standard level 1 and training programme to support level 2. This has been achieved and now officially signed-off. Now we have received this we have 12 months to work towards level 2. We will therefore now start working towards this accreditation.
Collaboration	Alignment of procurement work plans across the region
	Pre-market engagement with suppliers now the norm.
	Discussions with private sector on ways in which we can work in partnership

5. RECOMMENDATION

5.1 It is recommended that the Finance and Performance Committee note and review the information in the report.

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from the Finance and Performance Committee, 24/09/19	**Committee Chair (Non-Exec. Director)**

The Finance and Performance Committee met on 24th September 2019.

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

- The "Finance or performance moment" focused on the **winter plan**, which was presented by the Deputy Chief Operating Officer. It was however noted that the plan, including the finances, was not yet finalised, and that further work would take place to enable the final plan to be submitted for the Trust Board's approval in October 2019
- The **month 5 financial performance** was reviewed, with the main focus of the discussion being the income variances relating to the under-delivery of private patient income and the non-delivery of the Referral to Treatment (RTT) risk reserve. The key aspects of the 2019/20 forecast were also discussed and it was agreed that the forecast should be the subject of the "Finance or performance" moment at the October 2019 Committee meeting
- The monthly **update on Wells Suite income** was given and it was agreed to check the implications of the loss on private patient activity so far this year and to confirm the actions to increase activity from October onwards. It was also agreed to check and confirm whether the data was available to allow the Wells Suite financial forecast for 2019/20 to be monitored weekly, via the Executive Team
- A **further review of the Surgery Division** was undertaken (following on from the July meeting) and it was noted that the Division was forecasting a £2.6m adverse variance to plan (after the planned mitigations). It was also confirmed that further reviews would not be scheduled, as the Division's performance would be overseen by Executive Team
- The **month 5 non-finance related performance** was discussed, which included the A&E 4-hour, RTT and 62-day Cancer waiting time targets. The achievement of the latter target for August was acknowledged and commended
- The Director of Strategy, Planning and Partnerships attended for a **review of the Kent and Medway Sustainability and Transformation Partnership (STP) Strategy Delivery Plan** and it was noted that individual providers would not be allocated performance trajectories, but the Trust had developed trajectories to inform the development of the STP-level trajectories that would be set. The same report has been submitted to the Trust Board
- The **timeline for the Trust's 2020/21 planning process**, and the associated guidance that had been issued to Divisions and Directorates, was reviewed
- A report was considered on **the implications of implementing International Financial Reporting Standard (IFRS) 16 (Leases) from 2020/21** and it was agreed to schedule further updates each quarter. It was also agreed to schedule a "The Trust's strategic approach to the implementation of IFRS 16 from 2020/21" item at the January 2020 meeting
- The latest six-monthly update on the **options being considered in relation to the PFI contract** at Tunbridge Wells Hospital was reviewed and it was agreed that the Chief Finance Officer should arrange for the formal reconsideration of the option to refinance the contract
- The latest **quarterly update on service tender submissions** was received, as was a report on the relevant aspects of the **Board Assurance Framework (BAF) and Risk Register**
- The **Breaches of the external cap on Agency staff pay rate** report was noted, but it was agreed to remove all future "Breaches…" items from the Committee's forward programme
- The Committee was notified of the **recent uses of the Trust Seal** and it was agreed that the Trust Secretary should check and confirm why three staff had been being transferred to the Trust from East Kent Hospitals University NHS Foundation Trust

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

- "Medical staffing" should be the subject of the "Finance or performance moment" at the November 2019 Committee meeting (with the Director of Workforce to lead on the item)

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

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

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

Summary report from Audit and Governance Committee, 07/08/19 (incl. the Annual Audit Letter for 2018/19)	**Committee Chair (Non-Executive Director)**

The Audit and Governance Committee met on 7th August 2019

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

- Progress with actions from previous meetings was noted
- The Safety Moment was focussed on Diabetes management and had been previously presented at the Trust Board meeting in July
- The updated Board Assurance Framework (BAF) 2019/20, as considered by the Executive Team Meeting (ETM) on 06/08/19, was received and the latest status of each objective noted. There was wider discussion about the agreement of objectives for the BAF going forwards and it was agreed to ensure that the feedback from the AGC consideration of the BAF was considered as part of the planning process for construction of the BAF 2020/21
- An update on progress with the Internal Audit plan for 2019/20 was reported and two outstanding general audit recommendations were noted. It was agreed that the Audit Manager, TIAA should provide the Chief Finance Officer with further details of the circumstances regarding the activity & income recording recommendation and the reported refusal of a business case for work to support delivery of the recommendation. It was further agreed to invite the Chief Operating Officer to the next AGC meeting to provide a response to the outstanding audit recommendations re discharge processes and activity and income reporting, but to withdraw the invite if the actions were closed in the interim to the satisfaction of internal audit
- The list of recent Internal Audit reviews, is shown below (in section 2)
- A Counter Fraud update was reviewed and it was agreed in respect of case lcfs0496#81726 (summary of reactive work), to confirm the status of action taken in response to the allegation that a subject had authorised a bank shift using a colleague's login details without authority. The Chief Finance Officer undertook to check and confirm the process in place for HR review of workforce-related counter fraud cases
- Under the External Audit 'Progress and emerging issues report', it was reported that the independent examination of the Trust's Charitable Funds Accounts was underway and that early discussions had been held with members of the Finance team about the Trust annual audit process for 2019/20
- The External Audit letter for 2018/19 was received and noted (Appendix 1)
- The response to the review/survey of External Audit service undertaken in March 2019 was noted
- The Chief Finance Officer provided a verbal summary of the latest financial position
- The Associate Director of Procurement attended for the review of the latest Single Tender Waivers data. It was agreed to arrange for the two rejected single tender waivers in the period 01/04/19 to 30/06/19 (relating to i. urgent access to international recruitment services and ii. CIP consultancy services) to be reviewed by the i. Workforce Committee and ii. Finance and Performance Committee, and the outcome to be reported to the AGC
- The latest details of gifts, hospitality and sponsorship declared were noted, which included an update on the process of reconciling information from the Association of the British Pharmaceutical Industry's "Disclosure" database for 2018 with declarations made by Trust staff for the same period. With respect to the declarations of gifts, hospitality and sponsorship received, it was noted that the declaration process for receipt of fees by staff for the delivery of a service was currently voluntary, but agreed to i. confirm if there was a process in place to ensure that staff were aware of their duty to declare all income sources to HMRC and ii. to consider the treatment of advisory fees received by Trust staff in the new "Management of Conflicts of Interest Policy" to ensure that it was clear that if staff were already in receipt of paid study leave, paid employment must not be undertaken during that period. It was further agreed to ensure that the consultation process for the Trust's new "Management of Conflicts of Interest Policy" included review by the Workforce

Committee

- Details of Payments for compensation under legal obligation were received and it was agreed to clarify if the learning from the Catering (LTPS) claim and Elderly Care (CNST) claim reported had been shared across Trust sites
- Details of the latest losses & compensations data were received
- In evaluating the conduct and outcomes of the meeting, it was agreed:
  - To consider inviting the owner of any limited assurance audit reviews to the next meeting of the AGC in November 2019;
  - For the Chair of the AGC and the Chief Finance Officer to raise the feedback and proposals received as part of the evaluation of the AGC meeting on 07/08/19 for wider discussion with Non-Executive Directors and the Executive Team, respectively and
  - For the Chair of the AGC to liaise with the Trust Secretary about the treatment and role of the Trust Risk Register in the context of the AGC's assurance responsibilities

- A discussion was held under Any Other Business about the process and considerations around the appointment of the Trust's External Auditor (related to the timelines of the current External Audit contract), and it was agreed to schedule a meeting of the Auditor Panel to follow the next AGC meeting on 05/11/19 and for the Chief Finance Officer to discuss the relevant issues with the incoming Chair of the AGC.

2. The Committee received details of the following Internal Audit reviews:

- "Data Quality of Key Performance Indicators" (which received a "Reasonable Assurance" conclusion)
- "Safeguarding Adults and Children" (which received a "Reasonable Assurance" conclusion)
- "Recruitment processes" (which received a "Reasonable Assurance" conclusion)

3. The Committee was also notified of the following "Urgent" priority outstanding actions from Internal Audit reviews:

- None

4. The Committee agreed that (in addition to any actions noted above):

- N/A

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

- N/A

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

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

Grant Thornton

The Annual Audit Letter for Maidstone and Tunbridge Wells NHS Trust

Year ended 31 March 2019

28 June 2019

Contents

Your key Grant Thornton team members are:

Darren Wells

Key Audit Partner

T: 01293 554120

E: Darren.J.Wells@uk.gt.com

Keith Mungadzi

Manager

T: 020 7728 2393

E: keith.Mungadzi@uk.gt.com

Section		Page
1.	Executive Summary	3
2.	Audit of the Accounts	5
3.	Value for Money conclusion	9
4.	Quality Accounts	13

Executive Summary

Purpose

Our Annual Audit Letter (Letter) summarises the key findings arising from the work we have carried out at Maidstone and Tunbridge Wells NHS Trust (the Trust) for the year ended 31 March 2019.

This Letter is intended to provide a commentary on the results of our work to the Trust and external stakeholders, and to highlight issues that we wish to draw to the attention of the public. In preparing this Letter, we have followed the National Audit Office (NAO)'s Code of Audit Practice and Auditor Guidance Note (AGN) 07 – 'Auditor Reporting'. We reported the detailed findings from our audit work to the Trust's Audit and Governance Committee as those charged with governance in our Audit Findings Report on 23rd of May 2019

Respective responsibilities

We have carried out our audit in accordance with the NAO's Code of Audit Practice, which reflects the requirements of the Local Audit and Accountability Act 2014 (the Act). Our key responsibilities are to:

- give an opinion on the Trust's financial statements (section two);
- assess the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (the value for money conclusion) (section three).

In our audit of the Trust's financial statements, we comply with International Standards on Auditing (UK) (ISAs) and other guidance issued by the NAO.

Our work

Materiality	We determined materiality for the audit of the Trust's financial statements to be £7.9m, which is 1.75**%** of the Trust's gross revenue expenditure.
Financial Statements opinion	We gave an unqualified opinion on the Trust's financial statements on 24 May 2019.
NHS Group consolidation template (WGA)	We also reported on the consistency of the financial statements consolidation template provided to NHS England with the audited financial statements. We concluded that these were consistent.
Use of statutory powers	We referred a matter to the Secretary of State, as required by section 30 of the Act on 15 May 2018 in relation to Maidstone and Tunbridge Wells NHS Trust's planned breach of its break-even duty for the three year period ending 31 March 2019.

Executive Summary

Value for Money arrangements	We were satisfied that the Trust put in place proper arrangements to ensure economy, efficiency and effectiveness in its use of resources.
Quality Accounts	We completed a review of the Trust's Quality Account and issued our report on this on 28 June 2019. We concluded that the Quality Account and the indicators we reviewed were prepared in line with the Regulations and guidance.
Certificate	We certified the completion of the audit of the financial statements of Maidstone and Tunbridge Wells NHS in accordance with the requirements of the Code of Audit Practice on 24 May 2019.

Working with the Trust

During the year we have delivered a number of successful outcomes with you:

- An efficient audit – we delivered an efficient audit with you in May, delivering the financial statements two days before the deadline, releasing your finance team for other work.
- Understanding your financial challenges – through the value for money conclusion we provided you with assurance on your operational and financial effectiveness.
- Sharing our insight – we provided regular audit committee updates covering best practice. We also shared our thought leadership reports.
- Providing training – we provided your teams with training on financial statements and annual reporting.

We would like to record our appreciation for the assistance and co-operation provided to us during our audit by the Trust's staff.

Grant Thornton UK LLP
2019

Audit of the Financial Statements

Our audit approach

Materiality

In our audit of the Trust's financial statements, we use the concept of materiality to determine the nature, timing and extent of our work, and in evaluating the results of our work.

We define materiality as the size of the misstatement in the financial statements that would lead a reasonably knowledgeable person to change or influence their economic decisions.

We determined materiality for the audit of the Trust's financial statements to be £7.9m, which is 1.75% of the Trust's gross revenue expenditure. We used this benchmark as, in our view, users of the Trust's financial statements are most interested in where the Trust has spent its revenue in the year.

The scope of our audit

Our audit involves obtaining sufficient evidence about the amounts and disclosures in the financial statements to give reasonable assurance that they are free from material misstatement, whether caused by fraud or error. This includes assessing whether:

- the accounting policies are appropriate, have been consistently applied and adequately disclosed;
- the significant accounting estimates made by management are reasonable; and
- the overall presentation of the financial statements gives a true and fair view.

We also read the remainder of the Annual Report to check it is consistent with our understanding of the Trust and with the financial statements included in the Annual Report on which we gave our opinion.

We carry out our audit in accordance with ISAs (UK) and the NAO's Code of Audit Practice. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Our audit approach was based on a thorough understanding of the Trust's business and is risk based.

We identified key risks and set out overleaf the work we performed in response to these risks and the results of this work.

Audit of the Financial Statements

Significant Audit Risks

These are the significant risks which had the greatest impact on our overall strategy and where we focused more of our work.

Risks identified in our audit plan	How we responded to the risk	Findings and conclusions
Improper revenue recognition	**As part of our audit work we have:** • evaluated the Trust's accounting policy for recognition income from patient care activities and other operating revenue for appropriateness and compliance with the DHSC Group Accounting Manual 2018/19; • updated our understanding of the Trust's system for accounting for income from patient care activities and other operating revenue, and evaluated the design of the associated controls; • reviewed the contracts with the Trust's main commissioners; • tested healthcare income from the Trust's main commissioners for the year to contract documentation and invoices billed; • reviewed the year end Agreement of Balances tool and followed up any significant discrepancies in intra-NHS income or receivables with Trust management;. • completed substantive testing of a sample of non-patient care income to ensure these items agree back to supporting documentation.	Our audit work has not identified any significant issues in respect of improper revenue recognition
Management override of internal controls	**As part of our audit work we have:** • evaluated the design effectiveness of management controls over journals; • analysed the journals listing and determined the criteria for selecting high risk unusual journals; • tested unusual journals made during the year and the accounts production stage for appropriateness and corroboration; • gained an understanding of the accounting estimates and critical judgements applied by management and considered their reasonableness.	Our audit work has not identified any significant tissues in respect of management override of controls.

Audit of the Financial Statements

Significant Audit Risks - continued

These are the risks which had the greatest impact on our overall strategy and where we focused more of our work.

Risks identified in our audit plan	How we responded to the risk	Findings and conclusions
Valuation of Property, Plant and Equipment	**As part of our audit work we have:** • reviewed management's processes and assumptions for the calculation of the estimate, the instructions issued to valuation experts and the scope of their work; • considered the competence, expertise and objectivity of any management experts used; • held discussions with the valuer about the basis on which the valuation is carried out and challenged the key assumptions; • reviewed and challenged the information used by the valuer to ensure it is robust and consistent with our understanding; • considered the reasonableness of the estimate and the adequacy of disclosure in the financial statements; • completed testing of revaluations made during the year to ensure they are input correctly into the Trust's asset register. • PPE NBV: -Going forward the Trust has agreed to undertake a review of the age of nil book value assets to check for existence and remove the asset from the Fixed Asset Register if no longer in use.	Our audit work did not identify any significant issues in respect of valuation of Property, Plant and Equipment..

Audit of the Financial Statements

Audit opinion

We gave an unqualified opinion on the Trust's financial statements on 24 May 2019.

Preparation of the financial statements

The Trust presented us with draft financial statements in accordance with the national deadline, and provided a good set of working papers to support them. The finance team responded promptly and efficiently to our queries during the course of the audit.

Issues arising from the audit of the financial statements

We reported the key issues from our audit to the Trust's Audit and Governance Committee on 23 May 2019.

Annual Report, including the Annual Governance Statement

We are also required to review the Trust's Annual Report, including the Annual Governance Statement. It provided these on a timely basis with the draft financial statements with supporting evidence.

Whole of Government Accounts (WGA)

We issued a group return to the National Audit Office in respect of Whole of Government Accounts, which did not identify any issues for the group auditor to consider.

Other statutory powers

We are also required to refer certain matters to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014. On 15 May 2018 we referred a matter to the Secretary of State under section 30(a) of the Local Audit and Accountability Act 2014 in relation to Maidstone and Tunbridge Wells NHS Trust's planned breach of its break-even duty for the three year period ending 31 March 2019.

Certificate of closure of the audit

We certified the completion of the audit of the financial statements of the Trust in accordance with the requirements of the Code of Audit Practice on 24 May 2019.

Value for Money conclusion

Background

We carried out our review in accordance with the NAO Code of Audit Practice, following the guidance issued by the NAO in November 2017 which specified the criterion for auditors to evaluate:

In all significant respects, the audited body takes properly informed decisions and deploys resources to achieve planned and sustainable outcomes for taxpayers and local people.

Key findings

Our first step in carrying out our work was to perform a risk assessment and identify the risks where we concentrated our work.

The risks we identified and the work we performed are set out overleaf.

Overall Value for Money conclusion

We are satisfied that in all significant respects the Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2019.

Value for Money conclusion

Value for Money Risks

Risks identified in our audit plan	How we responded to the risk	Findings and conclusions
Financial sustainability For 2018-19, the Trust was forecasting a deficit position of £1m before the delivery of £12.7m of Provider Substantiality Fund income from NHS Improvement and the delivery of £13.8m of CIPs against an original plan of £24.11m. At Month 9, the Trust was forecasting a deficit position of £1.0m pre-PSF.	**As part of our work we have:** • updated our understanding of the Trust's financial position; • considered any improvements to its financial arrangements; • Understood the financial plans for the year ahead.	Trusts are expected to plan to break even over a rolling three year cycle, achieving this within the political and operational environment in which they have to operate. The operating environment is complex; demand for the Trust's elective and emergency services is increasing; a national position of workforce shortages for key disciplines which are met by expensive agency staff; a high quality threshold demanded by the public and enforced by regulators and constrained financial resources within the health economy. The NHS Long Term plan sets out an ambition to return the provider sector to financial balance by 2020/21. A new financial framework is being established which will mean the end of the control total regime and Provider Sustainability Fund for all trusts which deliver against their recovery plans by 2021 at the latest. The Trust delivered a retained surplus of £20.3m including Provider Sustainability Funding for the year ended 31 March 2019. This is £8.6m favourable to the planned surplus of £11.7m agreed with NHS Improvement at the start of the year. The Trust's surplus for the year reduces the cumulative deficit to £37.9m. The Trust planned to achieve its agreed control total by delivering £24.1m cost improvement plan savings along with £7.4m non recurrent benefits. At the start of the financial year, all of the £24.1m saving schemes had been identified and a high proportion were assessed to be recurrent. Progress against the budget and savings plans was regularly monitored and scrutinised. At the year end, the Trust delivered £13.8m of CIPs. A significant proportion of these are recurrent savings. The slippage against target is largely related to two areas where the Trust was reliant on other parties. The better than expected year end surplus was achieved by two one off asset disposals. The Trust's financial planning and management arrangements have been appropriate during the year. In October, in recognition of the Trust's arrangements and progress, NHSI confirmed the Trust's exit from Financial Special Measures. In 2019/20, the Trust is forecasting to deliver a £6.9m surplus position which has been agreed with NHS Improvement. Along with robust budgetary control, this will require delivering £22.3m of CIPs. Based on the above, we are satisfied that the Trust has appropriate arrangements in place to ensure its financial sustainability.

Quality Accounts

The Quality Account

The Quality Account is an annual report to the public from an NHS Trust about the quality of services it delivers. It allows Trust Boards and staff to show their commitment to continuous improvement of service quality, and to explain progress to the public.

Scope of work

We carry out an independent assurance engagement on the Trust's Quality Account, following Department of Health (DH) guidance. We give an opinion as to whether we have found anything from our work which leads us to believe that:

- the Quality Account is not prepared in line with set DH criteria;
- the Quality Account is not consistent with other documents, as specified in the DH guidance; and
- the two indicators in the Quality Account where we have carried out testing are not compiled in line with DH regulations and do not meet expected dimensions of data quality.

Quality Account Indicator testing

We tested the following indicators:

- Percentage of patients risk-assessed for venous thromboembolism
- Rate of clostridium difficile infections

For each indicator tested, we considered the processes used by the Trust to collect data for the indicator. We checked that the indicator presented in the Quality Account reconciled to underlying Trust data. We then tested a sample of cases included in the indicator to check the accuracy, completeness, timeliness, validity, relevance and reliability of the data, and whether the calculation of the indicator was in accordance with the defined indicator definition.

Key messages

- We confirmed that the Quality Account had been prepared in line with the requirements of the Regulations.
- We confirmed that the Quality Account was consistent with the sources specified in the DH Guidance.
- We confirmed that the commentary on indicators in the Quality Account was consistent with the reported outcomes.
- Based on the results of our procedures, nothing came to our attention that caused us to believe that the indicators we tested were not reasonably stated in all material respects.

Conclusion

As a result of this we issued an unqualified conclusion on the Trust's Quality Account on 28 June 2019.

© 2019 Grant Thornton UK LLP. All rights reserved.

'Grant Thornton' refers to the brand under which the Grant Thornton member firms provide assurance, tax and advisory services to their clients and/or refers to one or more member firms, as the context requires.

Grant Thornton UK LLP is a member firm of Grant Thornton International Ltd (GTIL). GTIL and the member firms are not a worldwide partnership. GTIL and each member firm is a separate legal entity. Services are delivered by the member firms. GTIL does not provide services to clients. GTIL and its member firms are not agents of, and do not obligate, one another and are not liable for one another's acts or omissions.

Summary report from Quality Committee, 14/08/19 Committee Chair (Non-Exec. Director)

The Quality Committee met on 14th August (a Quality Committee 'deep dive' meeting).

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

- A **further review of progress in managing the Trust's response to the Care Quality Commission's report "A national review of radiology reporting within the NHS in England"** was presented by the Clinical Director, Imaging; Chief of Service, Diagnostics & Clinical Support; and General Manager, Imaging. The meeting heard that A&E & inpatient X sections were all reported within 24 hours, with the majority being reported within one to two hours. A&E chest X-rays were reported in 11 days, A&E skeletal tests were reported in two days, GP chest X-rays and skeletal tests were reported in one day, whilst oncology X sections were reported in 2.7 to 2.8 days. It was also reported that historically the Radiology Department did not provide formal reports for orthopaedic/fracture clinic/post-op X-rays; rheumatology outpatient limb X-rays; inpatient plain X-rays; and outpatient plain films, so it was agreed that the radiology incidents and complaints over the past three years should be reviewed to identify whether any involved concerns in relation to unreported plain X-rays
- A **review of the Trust's complaints process** was also presented by the Associate Director, Quality Governance. During the presentation it was agreed that the Associate Director would arrange for the introduction of a survey to enable staff involved in complaints investigations/responses to provide feedback on their experience. It was also agreed that they would a) check & confirm whether any action was taken in relation to the staff member who undertook the lacrimal probing and syringing procedure described in the ophthalmology complaint case study that was presented at the meeting & b) consider, with the Complaints & PALS Manager, whether the rate of complaints per 100 bed days Key Performance Indicator remained useful (i.e. given that not all complaints related to inpatient care)
- A **review of the Patient Safety Team and Serious Incident processes** was also presented by the Associate Director, Quality Governance. During the presentation it was agreed that the Associate Director would ensure that the Divisional reports submitted to the 'main' Quality Committee included details of compliance with national safety alerts. It was also agreed that they would confirm the timeline for the implementation of the upgrade to Datix Cloud IQ
- Under the "To consider any other business" item, the Chief Nurse reported the issues that had been identified as concerns in the latest letter arising from the Quality Surveillance Group process and also gave an update on the presentations that would be given at the CQC engagement events that would take place in September and December 2019.

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

- The General Manager for Radiology should provide the Chair of the Trust Board with a briefing on the status of the implementation of the new Radiology Information System (RIS), to enable them to raise any issues requiring escalation at the local provider Chairs' and Chief Executives' meeting on 19/08/19
- The General Manager, Radiology and Trust Secretary should liaise, to agree a date to schedule consideration of the review of radiology incidents and complaints involving concerns in relation to unreported plain X-rays that was requested at the meeting
- The Associate Director, Quality Governance should investigate whether it was possible to monitor the number of staff who viewed/read the Governance Gazzette (i.e. to indicate whether the publication was achieving its desired effect of sharing learning from complaints/incidents); and consider including another competition (with a prize) within the Gazzette, to promote the reading of the publication by staff
- A "Review of patient falls" should be scheduled for the 'deep dive' meeting on 05/12/19

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

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

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

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

Summary report from Quality Committee, 11/09/19	Committee Chair (Non-Executive Director)

The Quality Committee met on 11th September (a 'main' meeting). The meeting was observed by representatives from the Care Quality Commission.

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

- The Deputy Medical Director gave a brief 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 confirmed that the item would continue to be kept under scrutiny by the Quality Committee.
- An **update on Referral to Treatment (RTT) data quality** was noted, as the Chief Operating Officer was unable to attend the meeting. It was however agreed that a report should be submitted to the 'main' Quality Committee in November 2019 on the quality aspects of the programme. In addition, as the Medical Director confirmed that Divisions and Directorates were responsible for the work, it was agreed that the relevant aspects of the programme should be included within the Divisional reports to future 'main' Quality Committee meetings
- Each of the five **clinical Divisions then gave a report**. It was acknowledged that the meeting was in transition in relation to the reporting from the Divisions, and at the last meeting it had been agreed that Divisions could submit their report in any format (to allow them to consider how they wanted to report to the Committee). A range of formats were therefore deployed. Each Division reported on their key risks and issues, which included staffing challenges; ageing equipment; the action in response to a Preventing Future Deaths (PFD) report from HM Coroner (following the death of a patient with Type 1 diabetes); complaints response performance; and the implementation of the "Continuity of Care" pathway at Crowborough Birth Centre. The Diagnostics & Clinical Support Division also indicated a desire to introduce a Divisional 'Safety Moment' and the idea was commended.
- The Chief of Service for Medicine & Emergency Care gave the **latest update on mortality**, which included that the rate of completed mortality reviews was now consistently at circa 90%. An update was also given on the improvements expected from implementing the new Datix Cloud IQ service and the introduction of the Medical Examiner role
- The latest **update on Serious Incidents (SIs)** was given (which incorporated a report from the Learning & Improvement (SI) Panel), which highlighted the need for standards of documentation to be discussed by the Divisions
- Progress was reported on **implementing the Quality Strategy** and **Quality Accounts priorities 2019/20** which concluded that good progress had been made thus far. The latter item included an agreement that details of gram negative bacteraemias should be included within the Divisional reports to future 'main' Quality Committee meetings
- The **recent findings from relevant Internal Audit reviews** were noted. All of the completed reviews had received a "Reasonable assurance" conclusion
- The report of the **Quality Committee 'deep dive' meeting on 14/08/19** was noted
- Reports were received from the **Quality Committee's sub-committees** (i.e. the Complaints, Legal, Incidents, PALS, Audit (CLIPA) group; Infection Prevention and Control Committee; Drugs, Therapeutics and Medicines Management Committee; Safeguarding Adults Committee; and Safeguarding Children Committee), and the Chief Nurse reported that consideration was being given to merging the two safeguarding committees.

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

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

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

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

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

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from the Patient Experience Committee (workshop), 04/09/19	Committee Chair (Non-Executive Director)

At the Patient Experience Committee (PEC) meeting on 10/06/19, it was agreed that the time scheduled for the next PEC meeting on 04/09/19 should be used to hold a workshop to consider the developing role and remit of the Committee. It was further agreed that the agenda for the workshop would not include consideration of routine reports, unless items were of particular significance or time-critical (no such items were identified).

The workshop was comprised of 2 groups (1) patient representatives and (2) Trust staff / Non-Executive Directors). Group 1 was facilitated by Nicky Scott of Healthwatch Kent, and Group 2 by Non-Executive Directors, Maureen Choong and Emma Pettitt-Mitchell, respectively Chair and Vice Chair of the PEC. Both groups undertook the same exercises (which asked members to identify the current positive and negative aspects of the PEC and to consider the changes needed to deliver the desired objectives of the Committee). At the end of the session, the feedback from Group 1, patient representatives, was presented to Group 2, by Nicky Scott. During this time, Group 1 was invited to contribute to a session on the development of Patient Experience resource within the Trust (with the Trust's Head of Staff Engagement and Equality).

It is intended to consider the findings of the PEC workshop in more detail and to arrange a further meeting for key MTW staff involved in Patient Experience in October/November 2019 to discuss the feedback with Patient Experience colleagues from other Trusts. The outcome and proposals from this session will be presented at the PEC meeting on 02/12/19 and to the Trust Board in due course.

In addition to the actions noted above, the Committee agreed: N/A

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

- N/A

Which Committees have reviewed the information prior to Board submission?

- N/A

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

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