Maidstone and Tunbridge Wells NHS Trust

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

31 October 2019, 09:45 to 13:00
Lecture Rooms 1 and 2, The Education Centre, Tunbridge Wells Hospital

Agenda

10-1
To receive apologies for absence

David Highton

10-2
To declare interests relevant to agenda items

David Highton

10-3
To approve the minutes of the 'Part 1' meeting of 26th September 2019

David Highton

Board minutes 26.09.19 (Part 1).pdf (11 pages)

10-4
To note progress with previous actions (incl. proposed amendment to the Workforce Committee's Terms of Reference)

David Highton

Board actions log (Part 1).pdf (4 pages)

10-5
Safety moment

Claire O'Brien / Peter Maskell

Safety Moment for Trust Board October 19 v1.pdf (4 pages)

10-6
Report from the Chair of the Trust Board

David Highton

Chair's report.pdf (1 pages)

10-7
Report from the Chief Executive

Miles Scott

Chief Executive's report.pdf (3 pages)

10-8
The implementation of the "MyPreOp" system

A presentation will be given at the meeting (at 10.15am)

Frances Staples / Lindsey Reynolds

10-9
Integrated Performance Report for September 2019

Miles Scott

IPR for month 6 (complete).pdf (62 pages)

10-9.1

Safe (infection control)

Sara Mumford

10-9.2
Safe (incl. planned and actual ward staffing for September 2019)

Claire O'Brien

10-9.3
Effective (mortality)

Peter Maskell

10-9.4
Effective

Sean Briggs

10-9.5
Caring

Claire O'Brien

10-9.6
Responsive

Sean Briggs

10-9.7
Well-Led (workforce)

Simon Hart

10-9.8
Well-Led (finance)

Steve Orpin

Quality items

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

Sara Mumford

DIPC annual Report to the Board.pdf (60 pages)

Planning and strategy

10-11
The winter plan

Sean Briggs

The winter plan.pdf (55 pages)

10-12
Update on the West Kent Integrated Care Partnership (ICP)

Amanjit Jhund

West Kent ICP Update.pdf (9 pages)

Assurance

10-13
Update from the Senior Information Risk Owner (SIRO) (incl. the current position on the Data Security and Protection Toolkit for 2019/20)

Claire O'Brien

Update from the SIRO.pdf (4 pages)

10-14
Quarterly report from the Freedom to Speak Up Guardian

N.B. The item has been scheduled for 12pm

Christian Lippiatt

FTSUG Board Report October 2019.pdf (4 pages)

Reports from Trust Board sub-committees

10-15
Workforce Committee, 26/09/19

Emma Pettitt-Mitchell

Workforce Committee summary, 26.09.19.pdf (1 pages)

10-16
Quality Committee, 03/10/19

Maureen Choong

Summary of Quality C'ttee, 03.10.19.pdf (1 pages)

10-17
Finance and Performance Committee, 29/10/19

The written summary report will be issued after the Committee meeting

Neil Griffiths

10-18
Charitable Funds Committee, 29/10/18

This will be a verbal update

David Morgan

10-19
To consider any other business

David Highton

10-20
To receive any questions from members of the public (please note that questions should relate to one of the agenda items)

David Highton

10-21
To approve the motion (to enable the 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

David Highton

Date of next meeting: 28th November 2019, 9.45am, Pentecost/South rooms, The Academic Centre, Maidstone Hospital

MINUTES OF THE TRUST BOARD MEETING ('PART 1') HELD ON THURSDAY 26TH SEPTEMBER 2019, 9.45A.M, AT MAIDSTONE HOSPITAL

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	David Highton	Chair of the Trust Board	(DH)
	Sean Briggs	Chief Operating Officer	(SB)
	Maureen Choong	Non-Executive Director	(MC)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Peter Maskell	Medical Director	(PM)
	Claire O'Brien	Chief Nurse	(COB)
	Steve Orpin	Chief Finance Officer	(SO)
	Emma Pettitt-Mitchell	Non-Executive Director	(EPM)
	Miles Scott	Chief Executive	(MS)
In attendance:	Karen Cox	Associate Non-Executive Director	(KC)
	Amanjit Jhund	Director of Strategy, Planning & Partnerships	(AJ)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Kevin Rowan	Trust Secretary	(KR)
	Kris Birney	Lead Theatre Practitioner, Practice and Development Practice Educator (for item 09-15)	(KB)
	Ritchie Chalmers	Lead Cancer Clinician (for the "Effective" and "Responsive" section of item 09-9)	(RC)
	Sarah Davis	Divisional Director of Operations, Surgery (for the "Effective" and "Responsive" section of item 09-9 and item 09-15)	(SDa)
	Julie Elphick	Emergency Planning Officer (for items 09-15, 09-16 and 09-17)	(JE)
	Alice Farrell	General Manager, Cancer Performance (for the "Effective" and "Responsive" section of item 09-9)	(AF)
	Katie Goodwin	Divisional Director of Operations, Cancer Services (for the "Effective" and "Responsive" section of item 09-9)	(KG)
	Suzanne O'Neil	Transformation Programme Director (for items 09-8 and 09-12)	(SON)
	Rob Parsons	Risk and Compliance Manager (for item 09-19)	(RP)
	Caroline Tsatsaklas	Joint Programme Management Office Lead (for items 09-8 and 09-12)	(CT)
	Charlotte Wadey	Divisional Director of Nursing and Quality, Cancer Services (for the "Effective" and "Responsive" section of item 09-9)	(CW)
	Doug Ward	Director of Estates & Facilities (for item 09-20)	(DW)
	John Weeks	Head of Emergency Planning & Response (for items 09-15, 09-16 and 09-17)	(JW)
Observing:	Niamh Ingram	NHS Graduate Management Trainee	(NI)

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

09-1 To receive apologies for absence

Apologies were received from Neil Griffiths (NG), Non-Executive Director. DH then welcomed KC and DM to their first meeting of the Trust Board following their appointment as Associate Non-Executive Director and Non-Executive Director respectively.

09-2 To declare interests relevant to agenda items

DH referred to items 09-13 and 09-14 and declared his role as interim Chair of the Kent and Medway Sustainability and Transformation Partnership (STP). It was also noted that although the Business Case for a patient tracking system was not intended to be discussed at the meeting, it would be appropriate to declare that NG was the Managing Director of TeleTracking Technologies International (the company that provided the preferred option in that Business Case).

09-3 To approve the minutes of the 'Part 1' meeting of 25th July 2019

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

09-4 To note progress with previous actions

The circulated report was noted. The following action was discussed in detail.

- **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").** SH reported that the company that provided free eye tests had been approached to consider whether they could provide free hearing tests, but if that was not feasible, alternatives would be considered. It was therefore agreed to leave the action open.

09-5 Safety moment

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

- Acute Kidney Injury (AKI) had been highlighted during the first week of the month and staff had been reminded of the importance of fluid balance
- The focus had then shifted to Sepsis, with the emphasis on early identification and escalation
- Other issues considered included blood cultures and escalation via the NEWS2 process

PM added that AKI had not always received the clinical significance it deserved, but the most striking aspect was the emphasis on staff speaking to relatives to encourage them to identify the signs, and for clinicians to listen to relatives.

09-6 Report from the Chair of the Trust Board

DH reported the following points:

- The Trust had made some consultant appointments, including in oncology, which would help, among other things, in the maintenance of the cancer access targets
- DH had undertaken the one-day Quality, Service Improvement and Redesign (QSIR) fundamentals course with SDu
- DH had attended the latest NHS Chairs and Chief Executive's update meeting, which AJ had also attended in MS' place. The meeting included presentations on the development of Primary Care Networks (PCNs) and EU Exit, and DH was pleased to see some national recognition of the potential particular impact of the latter on Kent
- DH had also attended the NHS Providers' "Leading Digital Transformation: the role of Provider Boards" event and he had relayed his observations from the day to MS

09-7 Report from the Chief Executive

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

- The Trust had met the 62-day Cancer waiting time target, which was a significant achievement, and augured well for future development of the Cancer Centre. The achievement had been very well received by patients and had been accomplished through the hard work of hundreds of staff, but SB should take particular credit
- The work to establish the Acute Assessment Unit (AAU) at Maidstone Hospital (MH) had started
- Members of the Executive Team had started to take a wide-ranging view of what it meant to be an 'outstanding' organisation, and not just focus on the achievement of external targets

DM referred to paragraph 6, and the statement that "Takeaway containers and cutlery are also made from fully compostable plant-based bio-plastics" and commented that compostable cutlery would only be beneficial if accompanied by appropriate collection arrangements as depositing such cutlery into recycling bins would be worse for the environment. MS acknowledged the point and stated that he would expect the group overseeing sustainability issues to consider the issue.

DH then referred to the development of the Integrated Care Partnership (ICP) in paragraph 11 and emphasised that the establishment of the ICP would likely have an impact on patient pathways ahead of the 'go live' date of April 2021. MS acknowledged the point.

Patient experience

09-8 Outpatient transformation

DH welcomed SON and CT to the meeting and explained that the patient scheduled to attend had been unable to do so, so an alternative presentation, which aligned with the "Patient experience' heading, had been scheduled. DH also explained that the item was closely linked to item 09-12. SON then gave a presentation which highlighted the following points:

- The Video Consultation Appointment (VCA) model, via the "attendanywhere" system, originated in Australia, but NHS Scotland had successfully trialled, and now used, the system to conduct non-face-to-face follow-up appointments in their outpatient departments
- An outpatient survey at the Trust revealed that a high proportion of patients were interested in video appointments. The Trust had therefore successfully bid to participate in a VCA pilot between April 2019 & December 2020. NHS Improvement (NHSI) would then gather evidence from the pilot to evaluate whether to implement the system as a national free NHS system
- The primary aim of the pilot was to reduce the need for patients to travel to hospital and take time off work or school, but there were a number of other potential benefits
- Various communications had raised awareness of the pilot and efforts had been made to seek patient and staff input, via a Co-Design Working Group

CT then continued, and highlighted the following points:

- The Co-Design Working Group's inaugural meeting had been held on 19/09/19. The governance structure also involved a VCA Project Group and a West Kent Alliance OPT Steering group
- The five specialties involved in the pilot were Sexual Health, the Emergency Department (ED), Diabetes/Endocrinology, Gastrointestinal/Hepatitis, and Cardiology
- The indicators that had been developed to be monitored during the pilot were a reduced Did Not Attend (DNA) rate; the conversion rate from face-to-face to non-face-to-face contacts and vice versa; and patient and staff satisfaction surveys

SDu referred to the list of indicators and asked if there was the potential to include some indicators on quality, to provide assurance that the system did not result in patient harm. SON replied by noting that work was underway in relation to developing quality indicators and the Trust was working closely with NHS Scotland in that regard. COB added further context from the Quality Impact Assessment (QIA) that had been completed and reviewed for the project.

PM asked if doctors had been trained in the new method of working i.e. in non-face-to-face consultations. SON acknowledged that this had not been the case and stated that she would ask the Project Group to consider whether such training was required.

Action: Ask the Video Consultation Appointment (VCA) Project Group to consider whether medical staff needed training in how to undertake non-face-to-face clinical consultations via the VCA system (Transformation Programme Director, September 2019 onwards)

CT then explained that VCA was offered to patients as a choice, whilst consultants could also decide to revert to a face-to-face consultation if they felt that was clinically appropriate.

MC referred to SDu's earlier point and noted that face-to-face consultations were not always without fault, so caution should be exercised before video consultations were held to a higher standard. The point was acknowledged. PM then described his experiences of using video consultations over the past nine years.

CT then continued, and highlighted the following points:

- NHSI had visited the Trust and had been so pleased with progress that they had asked the Trust to present at a national conference in October
- The equipment required to operate the system had now been delivered
- 'Next steps' had been set for the medium and long term, which included commencing the pilot clinic appointments

DM referred to the identification of risk and the consideration of unintended consequences and asked how the team had identified all the things that could go wrong with the system. SON replied

that the aforementioned liaison with NHS Scotland had been very important in that regard and the team had been able to learn lessons from NHS Scotland's experience.

MC opined that some patients may miss the social interaction involved in face-to-face consultations and suggested that some patient and career support groups be part of the consultation. The suggestion was acknowledged.

SB then commended the work that SON and CT had done to progress the project.

Integrated Performance Report

09-9 Integrated Performance Report for August 2019

MS referred to the relevant attachment and highlighted the following points:
- The report continued to develop, but comments on the format were still welcome
- The Trust's focus on key objectives was having the desired effect in many areas, but the progress that had been achieved needed to be continued, to manage the enduring increasing demand, as August and September had been very difficult months

COB then highlighted the following details regarding the "Safe" domain:
- There had been an increase in the number of falls and falls-related Serious Incidents (SIs). There had been a particular increase at Tunbridge Wells Hospital (TWH) so COB had asked the Business Intelligence team to review the falls over the past three years and consider whether there had been any themes, including if there was a link with the rate of Occupied Bed Days (OBDs). One Ward (22) had experienced a higher proportion of falls, and work had taken place in response. The causes had been multifactorial, but staffing was considered to be relevant
- It was national falls awareness week that week, and the Falls Prevention Practitioner had a display stand in place at TWH and MH

COB then described the further actions that had been taken, or were planned, in relation to falls, including the intended recruitment of a 0.8 Whole Time Equivalent (WTE) member of staff. PM also emphasised the importance of the multifactorial causes of falls and the need for all members of the multidisciplinary team, as well as representatives from multi-agencies, to be involved in falls prevention. PM also referred to the single room environment at TWH and noted that this was not always appropriate for frail elderly patients so the Trust may need to consider where the best location was to treat such patients. The point was acknowledged.

DH asked why the Trust was appointing to a 0.8 WTE post, as that would automatically reduce the interest from candidates seeking a full-time post. COB confirmed the 0.8 WTE post recruitment reflected the extent of available budget but stated that she would discuss DH's point with SO.

COB then continued, and highlighted the following points:
- The "Summary Scorecard" contained a larger number of 'red' rated indicators than previous months, which reflected some significant staffing-related challenges in August. However the staffing situation had now started to improve, particularly given the recent arrival of the first tranche of overseas nurses, many of whom were working supernumerary ahead of their objective structured clinical examinations (OSCEs). 11 of the 15 nurses that had taken their OSCEs thus far had passed
- Complaints response performance was below that required. However, there had been a good discussion at the last 'main' Quality Committee meeting and COB was hopeful of improvement

SM then highlighted the following details for Infection Control:
- The Trust had seen its first case of MRSA bacteraemia for 2019/20
- There had been a huge overall reduction in E. coli infections but this had been tarnished by Lord North's threefold increase in infections for the year to date. SM would however meet with CW on 27/09/19 to review the cases and ascertain what had happened

PM then confirmed that mortality performance would be covered under item 09-11. It was also noted that the key aspects of the "Caring" domain had been covered by COB's report under the "Safe" domain.

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

- The A&E 4-hour waiting time target, and wider patient flow, had been very challenging. However, a wide range of work was taking place (which SB described in detail)
- The Referral to Treatment (RTT) position and waiting list size stated in the report had been updated, as the data had not been finalised when the report had been issued. However, progress was being made on performance

SB then referred to the achievement of the 62-day Cancer waiting time target and stated that he wished to thank the other Members of the Executive Team that had contributed, particularly COB, SO, SH, AJ, and MS. RC, SDa, AF, KG and CW then introduced themselves and MS asked them to comment on how the achievement could be sustained. RC, KG and SDa described the factors that they believed had made the difference to performance, which included cultural change. RC added that further consideration was required in relation to the sustainability of the performance.

DH asked about the resilience of the clinical nurses operating the ‘straight to test’ process. CW explained that the business planning process included consideration of how to make the ‘straight to test’ nurse posts, which were currently funded by the Cancer Alliance, substantive.

MC also asked what would help sustain the performance. RC stated that there was a risk in removing the focus, so RC wanted to explore innovate ways of ensuring sustainability. MS noted that the question of sustainability should be addressed within the Trust’s 2020/21annual plan and that link needed to be clear to members of the Trust Board. The point was acknowledged.

KC asked how the team would create the ‘head space’ capacity to undertake the innovative thinking to which RC had referred. SB stated that the reduction of the Patient Tracking List (PTL) had already created some such capacity, as the review of patients on the PTL now took far less time than had been the case several months ago. RC added that the positive response to innovative ideas would also create an environment in which all staff could provide their contribution.

DH thanked RC, SDa, AF, KG and CW for their contribution to meeting the 62-day Cancer waiting time target and for attending the meeting.

SH then reported the following points for finance under the “Well Led” (workforce) domain:

- Overseas nurse recruitment continued, and the challenges, which included the identification of low-cost housing within the Tunbridge Wells area, were being addressed. This involved giving notice to staff who had been in Trust accommodation for more than six months, despite some such staff having lived in Trust accommodation for some years
- Overseas recruitment was continuing, albeit not at the same pace as before
- An electronic appraisal system had been used for first time and performance had improved from the same point in the previous year. Lessons had been learned from the use of the system and the documentation would be streamlined
- The staff flu vaccination campaign would start w/c 30/09/19, but vaccines would be provided to the Trust in three batches, which would be problematic

COB noted that although the Trust had done well in recruiting overseas nurses, the support such nurses required from their clinical colleagues was significant. COB added that support was also required for the latest batch of Nursing Associates. The points were acknowledged.

SO then reported the following points for finance under the “Well Led” (finance) domain:

- The Trust had a £1m surplus in month and a year to date surplus of £0.3m, both of which were in accordance with the plan
- The Cost Improvement Programme (CIP) position reflected the backdated release of reserves. £9m of the CIP had already been delivered and SO anticipated that the target of £22.3m would be achieved, although the stretch target of £25.1m would be pursued
- Work was taking place with Divisions on their individual financial positions, and their medical staffing costs in particular, and recovery plans had been requested

SDu asked whether the income from the Prime Provider contract for Planned Care had been reflected in the £9m of CIP delivery. SO confirmed that was the case. SDu asked whether that had

affected the ability to deliver cost-reduction CIP schemes. SO stated that he did not believe the receipt of the income had interfered with the message to ensure a tight cost base.

MC remarked that she was pleased to see the improvement in delivery of the CIP but cautioned against that having been achieved via heroic efforts, whilst highlighting the need for innovation. A discussion was then held on the issue and the approach taken at the Trust.

COB then highlighted the key points on the planned and actual ward staffing for July and August 2019 and the update on progress with the Perinatal Mortality Review Tool (PMRT).

09-10 Review of the Board Assurance Framework 2019/20

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

- As was intended, the Board Assurance Framework (BAF) had been considered at other forums before being considered by the Trust Board. The full BAF had therefore been reviewed at the Audit and Governance Committee and Executive Team Meetings in early August, whilst the objectives relevant to the Finance and Performance Committee had been reviewed at that Committee's meeting on 24/09/19. The performance described and confidence ratings therefore reflected the position at the time the report was produced, in late July
- The details in the report hopefully matched the Trust Board's understanding of the performance against the 12 objectives, but Trust Board members were invited to challenge this. The options available to the Trust Board were listed on page 1, but these were not intended to be exhaustive

DH noted the new Integrated Performance Report focused on the five domains and stated that there needed to be coherence between that report and the BAF. The point was acknowledged. MC asked whether it would be helpful for the Trust Board's sub-committees to be more involved in the oversight of the BAF. DH noted that some sub-committees already reviewed aspects of the BAF. MS noted that although that was the case, objectives were not allocated to the sub-committees to provide specific oversight. It was therefore agreed to consider how the Trust Board's sub-committees could be more directly involved in the oversight of the BAF.

Action: Consider how the Trust Board's sub-committees could be more directly involved in the oversight of the Board Assurance Framework (and the objectives therein) (Trust Secretary, September 2019 onwards)

DM commented that it was good practice for committee Terms of Reference to be reviewed annually, and also determine whether they had been met. KR concurred and explained the annual review process that was in place for the Trust Board's sub-committees.

DM then noted that the response to the question "Does specific assurance exist on the data quality of the performance information?" was often stated as "No". KR explained the background to that question and the responses in the report. DM asked whether a "No" response was acceptable. KR replied that it was acceptable under the current model but it was for the Trust Board to determine whether that should remain the case. DH highlighted that there was provision within the Internal Audit programme for additional work on data quality to be undertaken if that was deemed necessary.

Quality items

09-11 Quarterly mortality data

PM referred to the relevant attachment and highlighted the following key points:

- The Trust had moved from being a negative to a positive outlier on the Hospital Standardised Mortality Ratio (HSMR)
- Mortality data by Division showed that the Women's, Children's & Sexual Health Division was driving the very low mortality rates. However, the vast majority of deaths occurred within the Medicine and Emergency Care Division
- The CUmulative SUMmary CUSUM alerts had resulted in some 'deep dive' reviews
- PM was pleased to see that the Speech and Language Therapy service now had a fibreoptic endoscopic evaluation of swallowing (FEES) machine that assessed patients' ability to swallow

Planning and strategy

09-12 Briefing on the range of 'virtual' clinic / consultation IT systems used and / or planned for use at the Trust

MS referred to the relevant attachment and highlighted the work taking place to transform referrals, appointments and clinic consultations. MS emphasised that the Trust needed to embrace such transformation within its future plans. SON added that it may also be possible to undertake some non-face-to-face consultations beyond outpatients, including some day cases, to avoid the need for a clinic room to be found.

DH referred to the "Single Point of Triage through Referral Assessment Services (RAS) on ERS" for Musculoskeletal (MSK) services and asked whether Key Performance Indicators (KPIs) had been set for patients who needed hip and knee operations, as he was not convinced that physiotherapy triage added benefit to a patient's pathway, and such triage would therefore just delay the patient's operation for 12 weeks. MS acknowledged the point and agreed that the system needed to be monitored. DH reiterated the point that he would expect most GPs to be able to determine whether a patient needed hip or knee surgery. PM pointed out that there may be a more nuanced reason why it may be beneficial to delay some patients' surgery. SON added that the situation was often hampered by access to data, so work was taking place to address this.

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

The circulated report was noted.

09-14 Review of the Kent and Medway STP Strategy Delivery Plan (and approval of relevant aspects)

The circulated report was noted but DH proposed that the item be discussed in more detail in the 'Part 2' Trust Board meeting scheduled for later that day. This was agreed.

09-15 Presentation on the Emergency Planning live exercise held in June 2019

DH welcomed KB, JE, SDa and JW to the meeting. JE and KB then gave a presentation which highlighted the following points:

- "Exercise Boyles" had originated from the recognition that fire evacuation procedures needed review. The Kent Fire and Rescue Service were also keen to exercise the fire evacuation procedures at TWH
- A multiagency table-top exercise was undertaken with Kent Fire and Rescue service in October 2018. The outcomes from that had then contributed to a live simulation exercise in June 2019
- The scenarios involved in the live exercise were different in each theatre: a member of staff collapsed having been overcome by smoke; the anxious relatives of a child were in theatres screaming at responders; and an unstable patient needed to be relocated to a safe area to complete the life-saving surgery that was underway
- The values of the exercise reflected the Trust's PRIDE values, whist the teamwork that was required included Clinical Site Managers on-call managers and loggists; clinical staff from across all specialties in theatres; and colleagues from Kent Fire and Rescue, Kent Police, South East Coast Ambulance Service NHS Foundation Trust, Interserve, security and portering services all contributing to the overall response
- The outcomes from the exercise showed that staff valued the experience of the live simulation; and multi-agency partners valued working in a complex situation with clinically unstable patients. Command and control Joint Emergency Services Interoperability Principles (JESIP) had been applied; but the need for a loggist and for good quality communications had been recognised

A short film of the live exercise was then shown.

DH asked for details of the fire retardant times for theatres doors. JE replied that this was different per theatre, whilst KB elaborated that all doors had a 60 minute retardant time but some theatres had more than one door.

MC noted that she had been invited to be involved in the live exercise and it had reinforced the benefit of simulation training that involved smoke. MC also stated that it was very good to see the Trust's collaboration with the wider system.

JW then highlighted the liaison with external colleagues, which had enabled the live exercise to include staff making real 999 alarm calls. JW also noted that it was a genuine benefit to be able to run the exercise and many Trusts across the country had made approaches to understand how the Trust had managed this. JE added that she and KB intended to write a report of the exercise, with the aim of publishing this in some journals.

MS then presented KB with a Resilience Award for his contribution to resilience in theatres.

09-16 Update on the Trust's preparations for the UK's exit from the EU

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

- 'EU Exit fatigue' was an issue and needed to be overcome
- Transport was major risk, and potential mitigations included staff working from home or via Council and/or Fire Service offices
- Accommodation had been booked for staff and/or patients if required
- The Trust's Procurement Team had risk assessed all suppliers to ensure there was adequate supply chain resilience
- Staff welfare would be an issue during any period of disruption
- The Chief Pharmacist was managing medicine supply issues, but the normal supply chain remedies were being applied for the day-to-day medicine supply problems that occurred
- If the worst case scenario emerged, the some form of disruption would be unavoidable but the Trust was well placed to manage this

DH asked if JW had access to additional resources beyond those with the Emergency Planning Team. JW explained the approach and confirmed that he had full confidence that additional resources would be forthcoming should a request be made.

Assurance and policy

09-17 Approval of Emergency Preparedness, Resilience and Response (EPRR) Core Standards self-assessment

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

- The assessment had concluded that the Trust was fully compliant with the 64 Core standards
- A 'deep dive' review had been undertaken on the climate change standard, which showed the Trust was not compliant with 4 of the 5 standards, and partially compliant with the fifth standard. An action plan had therefore been requested for presentation at the Resilience Committee
- The final report from the Clinical Support Unit (CSU) had been published that day, and the report, which would be submitted to NHS England (NHSE), acknowledged the support the emergency planning team received from the Trust Board and individual Trust Board members

SB remarked that the achievement was also testament to JW and JE.

The EPRR Core Standards self-assessment was approved as circulated.

09-18 Responsible Officer's Annual Report 2018/19

PM referred to the relevant attachment and highlighted that the report contained two overall appraisal rates, but the correct figure was 93.43% (as stated on page 4 of 20), not 94.43% (as stated on page 2 of 20). PM also pointed out that no recommendations of 'non-engagement' had been made to the General Medical Council (GMC).

MC asked how the doctors that not been appraised were able to be revalidated. PM and SM explained the situation.

The Trust Board approved the Statement of Compliance confirming that the Trust, as a Designated Body, was in compliance with the regulations governing appraisal and revalidation.

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)

DH welcomed RP to the meeting. RP firstly noted that he was the Trust's Chartered Health and Safety individual, then referred to the relevant attachment and highlighted the following points:

- The report focused on staff incidents but there was some overlap with patient-related incidents
- Some of the objectives had been met but others had been carried forwarded into 2019/20
- There had been a significant increase in certain incidents
- Injury rates had increased and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)-related incidents had increased by 8%, from 24 to 26. The largest increase in incidents was for violence and aggression
- Sharps and violence and aggression incidents were the top two incident categories, although there remained underreporting of the former compared to the records for staff who attended the Occupational Health service for sharps incidents
- There had been an increase in incidents involving doors
- The Health and Safety Executive (HSE) did not inspect as much as they used to, but inspections still took place and RP had spoken with a counterpart in Sussex who had been subject to an inspection, to learn from their experience
- The report contained the objectives for 2019/20
- The "What does the Board need to know?" section included details of prosecutions and information about the new risk rating matrix

SDu asked whether the reported rate of manual handling incidents matched the number of manual handling-related Occupational Health referrals. RP noted that a comparison had not been done, so agreed to do this.

Action: Compare the reported number of manual handling-related staff incidents with the number of manual handling-related Occupational Health referrals (Risk and Compliance Manager, September 2019 onwards)

COB emphasised the need to consider what more needed to be done in response to violence and aggression. RP pointed out that the report contained details of the actions that had been taken.

MC then stated that she was unaware of any health and safety related information being considered at any Trust Board sub-committee. DH stated that he understood that the recent changes to the Trust's committee structure had made the Health and Safety Committee a sub-committee of the Quality Committee. KR clarified that the revised structure had not affected the Health and Safety Committee, which remained a sub-committee of the Trust Management Executive (TME). DH therefore asked that the Executive Team consider the appropriateness of the reporting arrangements/parent committee for the Health and Safety Committee.

Action: Consider the appropriateness of the reporting arrangements/parent committee for the Health and Safety Committee (Chief Executive, September 2019 onwards)

The Trust Board approved the Health and Safety work programme for 2019/20 as submitted.

09-20 Six-monthly update on Estates and Facilities

DH welcomed DW to the meeting. DW referred to the relevant attachment and highlighted the following points:

- The report contained details of the Trust's Estates Return Information Collection (ERIC)
- The Grenfell Tower Public Inquiry would likely result in recommendations to change fire arrangements and DW would expect there to be some implications for the Trust
- A positive meeting had been held with Arriva on 25/09/19 in relation to transport

- The Trust's Laundry team was extremely hard working. DW would prepare a report on the future of the laundry, which he would submit to MS, and probably the Trust Board, in due course
- DW was making efforts to improve the external and internal environment, noting that £22k per year was spent on picking up cigarette butts. Some new smoking-related posters would therefore be erected in the near future
- DW was undertaking a major study of the use of space, with SB and others, and the first phase had just been completed
- The future of the Trust's Estates and Facilities function was also being considered

Questions were invited. None were received.

[N.B. The meeting was adjourned at this point to enable the Trust Board to recognise and commend the charitable work undertaken by Sue Chapman from the Trust's Discharge Lounge]

Reports from Trust Board sub-committees

09-21 Charitable Funds Committee, 23/07/19

The circulated report was noted.

09-22 Finance and Performance Committee, 20/08/19 (incl. approval of revised Terms of Reference and quarterly progress update on Procurement Transformation Plan)

The circulated report was noted. The revised Terms of Reference for the Finance and Performance Committee were also approved as submitted.

09-23 Finance and Performance Committee, 24/09/19

DH referred to the relevant attachment and highlighted the key points therein. Questions were invited. None were received.

09-24 Audit & Governance Committee, 07/08/19 (incl. the Annual Audit Letter for 2018/19)

The circulated report was noted.

09-25 Quality Committee, 14/08/19 and 11/09/19

SDu referred to the relevant attachment and highlighted that the meeting had revealed that historically, Radiology not provide formal reports for certain specialties so it had been agreed that a 'spot check' should be undertaken to check that there had been good clinical decision making and no harm. SDu also noted that concerns had been raised regarding the introduction of the Radiology Information System (RIS), which illustrated the need to ensure clinicians were involved in the procurement of clinical IT systems. DH noted that the RIS had been subject to a multi-Trust procurement and value for money considerations would therefore have been relevant. The point was acknowledged.

09-26 Patient Experience Committee workshop, 04/09/19

MC referred to the relevant attachment and highlighted that there were likely to be some changes to the functioning of the Committee. Questions were invited. None were received.

09-27 To consider any other business

No other business was raised.

09-28 To receive any questions from members of the public

No questions were posed.

09-29 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.

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]
09-10	Consider how the Trust Board's sub-committees could be more directly involved in the oversight of the Board Assurance Framework (and the objectives therein)	Trust Secretary	September 2019 onwards	A meeting was held with the Non-Executive Director who raised the issue at the Trust Board meeting and some proposals were agreed, which the Non-Executive Director will discuss with the Chair of the Trust Board in the first instance. If the Chair Is supportive of the proposals, the Trust Secretary will discuss them with the Chair of the Audit and Governance Committee
09-19a	Compare the reported number of manual handling-related staff incidents with the number of manual handling-related Occupational Health referrals	Risk and Compliance Manager	September 2019 onwards	The requested analysis is being undertaken (but is not yet completed)
09-19b	Consider the appropriateness of the reporting arrangements/parent committee for the Health and Safety Committee	Chief Executive	September 2019 onwards	The issue was considered at the Executive Team Meeting on 01/10/19 and it was recommended that the Health and Safety Committee become a sub-committee of the Workforce Committee instead of the Trust Management Executive (TME). The Chair of the Trust Board and Chair of the Workforce Committee support the recommendation and the TME approved the first aspect of the change (to remove the Health and Safety Committee as being one of its sub-committees) on 16/10/19. The Trust Board is therefore asked to approve the required amendment to the Workforce Committee's Terms of Reference (which are enclosed in Appendix 1)

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

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
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	October 2019	This service is not available from the current supplier of the healthcheck service. The Trust will therefore include the provision of hearing tests within the re-tendering for that service. In the immediate term staff are being signposted to take advantage of the free hearing tests offered by Specsavers.
09-8	Ask the Video Consultation Appointment (VCA) Project Group to consider whether medical staff needed training in how to undertake non-face-to-face clinical consultations via the VCA system	Transformation Programme Director	October 2019	The Project Team has discussed the point with the Clinical Director for Outpatients and also raised it at a national NHSE/I sharing workshop on 08/10/19. The Clinical Directors view was that the Trust should learn from the clinicians who would pilot the system, to establish whether we need to do any additional training over and above the instructions provided in the manual (which has been embedded into the Standard Operating Policy). The project team will then reflect on that feedback before offering any training.

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

Workforce Committee

Terms of Reference

NHS
Maidstone and Tunbridge Wells NHS Trust

1 Purpose

The Workforce Committee is constituted at the request of the Trust Board to provide assurance to the Board in the areas of workforce development, planning, performance and employee engagement.

The Committee will work to assure the Board that the Trust has the necessary strategies, policies and procedures in place to ensure a high performing and motivated workforce that is supporting business success.

2 Membership

- Non-Executive Director (Chair)
- Non-Executive Director or Associate Non-Executive Director (Vice Chair)
- Chief Nurse
- Chief Operating Officer
- Director of Workforce
- Director of Medical Education (DME)

3 Quorum

The Committee shall be quorate when two members of the Executive Team and two Non-Executive Directors (or Associate Non-Executive Directors) are in attendance.

4 Attendance

All other Non-Executive Directors (including the Chair of the Trust Board and any Associate Non-Executive Directors) and members of the Executive Team are entitled to attend any meeting of the Committee.

Other staff, including members of the Human Resources Directorate, may be invited to attend, as required, to meet the Committee's purpose and duties.

5 Frequency of meetings

The Committee will meet every two months. The Chair can call a meeting at any time if issues arise.

6 Duties

To provide assurance to the Trust Board on:

- workforce planning and development, including alignment with business planning and development;
- equality and diversity in the workforce;
- employee relations trends e.g. discipline, grievance, bullying/harassment, sickness absence, disputes;
- occupational health and wellbeing in the workforce
- external developments, best practice and industry trends in employment practice;
- staff recruitment, retention and satisfaction;
- employee engagement
- terms and conditions of employment, including reward;
- organisation development, organisational change management and leadership development in the Trust;
- training and development activity in the Trust including prioritisation;
- reporting from the Guardian of Safe Working Hours (in relation to the Terms and Conditions of Doctors in Training)

- The Trust's Freedom to Speak Up Guardian (FTSUG) arrangements

To convene task & finish groups to undertake specific work identified by the Committee or the Trust Board.

To review and advise upon any other significant matters relating to the performance and development of the workforce.

7 Parent committees and reporting procedure

The Workforce Committee is a sub-committee of the Trust Board.

A summary report of each Workforce Committee meeting will be submitted to the Trust Board. The Chair of the Workforce Committee will present the Committee report to the next available Trust Board meeting.

8 Sub-committees and reporting procedure

The following Committees report to the Workforce Committee through their respective chairs or representatives following each meeting. The frequency of reporting will depend on the frequency of each of the sub-committees:

- Local Academic Board (LAB) (reporting to occur via the report from the DME)
- Senior HR meeting
- The Health and Safety Committee

9 Emergency powers and urgent decisions

The powers and authority which the Trust Board has delegated to the Workforce Committee may, when an urgent decision is required between meetings, be exercised by the Chairman of the Committee, after having consulted at least two Executive Director members. The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the Workforce Committee, for formal ratification

10 Administration

The Committee will be serviced by administrative support from the Trust Management Secretariat.

11 Review of Terms of Reference and monitoring compliance

The Terms of Reference of the Committee will be reviewed and agreed by the Workforce Committee at least annually, and then formally approved by the Trust Board. They will be reviewed annually or sooner if there is a significant change in the arrangements.

Terms of Reference agreed by Workforce Committee: 29th September 2016
Terms of Reference approved by Trust Board: 19th October 2016
Terms of Reference agreed by Workforce Committee: 30th October 2017
Terms of Reference approved by Trust Board: 29th November 2017
Amended Terms of Reference agreed by Workforce Committee: 25th January 2018 (to change the frequency of meetings from quarterly to every two months)
Amended Terms of Reference approved by Trust Board: 1st March 2018
Terms of Reference agreed by Workforce Committee: 28th March 2019
Amended Terms of Reference approved by Trust Board: 25th April 2019
Amended Terms of Reference approved by Trust Board, 31st October 2019 (to add the Health and Safety Committee as a sub-committee)

NHS
Maidstone and Tunbridge Wells NHS Trust

Safety moment **Chief Nurse / Medical Director**

The Safety Moment for October was focussed around Safeguarding Adults.

The enclosed report contains a summary of the key messages that have been shared each week.

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 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

The Safety Moment for October was focussed around Safeguarding Adults. A summary of the key messages that have been shared each week have been as follows:

Week One 07/10/2019

Safeguarding Adults
Awareness Week
7-11 October 2019

Noticing is not nosiness

Safeguarding Adults week ran from 7th – 11th October this year and we were delighted to promote the themes of PREVENTION and EMPOWERMENT.

The Care Act 2014 put Adult Safeguarding on a statutory footing and we all have duties within this Act to ensure that we follow the principles published in this act.

The six key principles that underpin all adult safeguarding work

1. Empowerment
2. Prevention
3. Proportionality
4. Protection
5. Partnership
6. Accountability

The Kent and Medway Safeguarding Adults Board (KMSAB) chose this year to focus Safeguarding Adults Awareness Week on the first two of the six principles from the Care Act 2014.

The safeguarding duties apply to an adult who is believed to:
- Be experiencing, or at risk of, abuse or neglect AND
- Has needs for care and support AND
- As a result of those care and support needs is unable to protect themselves from abuse/neglect

Karen Davies our Lead Matron for Adult Safeguarding talked about empowerment and prevention as part of our communication to staff. She said that these two principles could mean a number of things to different people, but here's what they mean to Karen in relation to Safeguarding Adults:

EMPOWER - the person, patient, friend or family member to make disclosures. Listen empathetically, believe their story, explain what you will now do, and explain what they should expect from the Safeguarding Adults process.

EMPOWER - the staff member to take the time to listen to the person, check the information, seek out advice, make that referral for safeguarding adults.

PREVENTION – it is better to take action before harm occurs, enable people:
- To recognise what abuse is so that they can be assisted to put preventative measures in place.
- To seek out help to prevent any harm or further harm,
- To make their own referrals if they can access support to prevent further harm,

Appropriate information sharing between agencies to support the prevention of harm to one or more adults at risk is vital. Support carers in their caring role to gain assistance to prevent abuse or neglect in the first place.

Another message that I would like to promote is for all Trust staff to '**THINK FAMILY'** in relation to Safeguarding. We all have duties to both safeguard adults and children alike. If you are concerned about an adult patient on your ward, that they are being abused in some way in the community – perhaps by a partner, friend, carer, neighbour also be curious about whether there are children or other 'adults (such as people with LD, Dementia, long term illness etc.) at risk' in that address.
Ask are there any children living with the person you are concerned about. Ask what are their names, DOB, and school. Ask what safety mechanisms are in place at the moment? Who is looking after them whilst the parent is in hospital?

Over the weeks in October watch out for Screensavers: Email Banners: MCA Competition (with a prize): Posters: New Internet and Intranet pages.

Week Two 14/10/2019

The Mental Capacity Act- Karen provided some thoughts to the Trust in relation to the Mental Capacity Act during week two as follows:

The Mental Capacity Act (2005) was full enacted in October 2007. I sit here and reflect on this landmark piece of legislation which hoped to change a culture of paternalism to that of a culture of autonomy. In other words instead of the Doctor Knows Best; the Patient Knows Best.

Recent audits of patient health care records indicate that in this Trust we know that we need to make improvements in the way in which we document the process of assessing a patient's ability to make a decision for themselves; be it an everyday decision or a decision for more complex matters.

Our training compliance with the Mental Capacity Act training is good 95% plus but on occasions our staff are not translating that into their practice.

As part of the Best Quality Board Work Streams we have set up a Mental Capacity Act Assessment working group to build a project to help practitioners to develop their confidence, competence and completion of their mental capacity assessments both for everyday decisions and for complex decisions.

The training delivery for this is being reviewed and revamped for the coming years in an endeavour to encourage practitioners to really embrace the ethos of the Mental Capacity Act and to place it at the heart of their practice when dealing with patients who have impaired decision making skills.

There is a competition launched for staff to design a Mental Capacity Assessment format for everyday decisions – please see the attached competition flyer for details of the competition. There are some great prizes. The competition will be judged by the Medical Director Dr Peter Maskell, Chief Nurse Claire O'Brien and Head of Legal Services Wendy Bates. Prize giving will be on the 25th November 2019.

Remember to adhere to the five statutory principles of the Mental Capacity Act (2005). Watch the following video by Baroness Findlay who is the national Champion for MCA to refresh your understanding of the statutory principles of the Mental Capacity Act (2005).
https://youtu.be/XiHCHcouxYA

My last thought is I wish this act was named the CONSENT to care and treatment act and then I think practitioner's would be more likely to adhere to these principles.

Week Three 21/10/2019

Pressure Ulcers and Raising Safeguarding Alerts

The Kent and Medway Safeguarding Adults Board (KMSAB) has adopted the use of the national Safeguarding Adults Protocol: Pressure Ulcers and the interface with a Safeguarding Enquiry.

The Trust need to follow the local authority's published policies and procedures. Therefore the Trusts new policy and procedures for:

1. The Prevention and Treatment of Pressure Ulcers and
2. The Safeguarding Adults at Risk Policy and Procedure

Include the National Protocol and the guidance tool for raising a safeguarding alert within them. If there is concern that a safeguarding alert might need to be raised in relation to a patient admitted with community acquired pressure ulcers, staff were guided to accessing the Adult Safeguarding Decision Guide for individuals with severe pressure ulcers which is an appendix of the Safeguarding Adults at Risk P&P.

The decision guide will help staff to decide whether the criteria for raising a safeguarding alert using the Kent Adult Safeguarding Alert Form (KASAF) has been reached.

The Trust is promoting the use of this for both hospital acquired and community acquired Pressure Ulcers and in the future the Trust will not be accepting a KASAF for Hospital Acquired Pressure Ulcers without the Decision Guide attached.

Week Four 28/10/2019

During the final week there was focus on the Deprivation of Liberty Safeguards (DoLS) with a Q&A approach, some of which are included as below:

Q = If a patient does not have the mental capacity to make the decision to be in hospital but is compliant with everything staff do – staff do not need to complete a DoLS application, that's right isn't it?
A = Not necessarily. What staff need to consider here is the 'Acid Test' – derived by the Supreme Court in Case Law, usually referred to as the Cheshire West case March 2014. If staff have a patient who is unable to make the decision to be admitted to hospital, or to remain in hospital, AND if staff have:

1. Continuous Supervision and control of the patient AND
2. The patient would not be free to leave

This will meet the criteria for a DoLS to be applied for. Back up the application with the Mental Capacity Assessment completed for this decision.

(Also consider – does the patient actually need to be kept in hospital? If not then make plans to discharge the patient appropriately and as safely as possible – most likely again in the patients Best Interests).

Q = Staff only need to complete a DoLS Application if the patient is trying to leave or saying that they want to go home.
A = No this is not the case, refer to Q&A above. The patient and conditions just need to meet the 'Acid Test' above.

Q = In the Emergency Department patients who lack mental capacity to consent to care and treatment in hospital do not need a DoLS to be applied for?
A = If the patient is in the emergency phase of receiving care and treatment to save life or preserve well-being, then staff are at liberty to make Best Interest decisions for those patients who lack capacity to consent to emergency care and treatment. Staff will not have to apply for a DoLS at this critical time.

If after the emergency treatment and investigations to preserve life have been completed; staff have a reasonable belief that the person lacks mental capacity, due to an impairment of brain or mind, the patient cannot make the decision to be admitted or remain in the ED; and staff have continuous supervision and control of the patient and staff would prevent the patient from leaving, a DoLS Form should be completed in ED. This must be backed up by the documented assessment of mental capacity.

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 two 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 Upper Gastrointestinal (GI)	13/10/19
06/08/2019	Dr	Meeta	Durve	Clinical Oncologist CNS and Lower GI	TBC
21/08/2019	Dr	Branimir	Penev	Urology	01/10/19
21/08/2019	Dr	Ian	Rudd	Urology	14/01/20
29/08/2019	Dr	Chak	Hin Szeto	Acute Medicine	TBC
29/08/2019	Dr	Arabella	Waller	Acute Medicine	TBC
29/08/2019	Dr	Juan	Simon- Turriate	Care of the Elderly	TBC
07/10/2019	Dr	Syed	Ahmed	Trauma and Orthopaedics	20/01/20

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

Report from the Chief Executive **Chief Executive**

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

1. I am delighted to confirm that we treated 86.34% of our cancer patients within 62 days in August. This put us in the top 20% of trusts nationally. This is a fantastic achievement and a vast improvement on our performance from just six months' ago when we were ranked as one of the worst performing trusts.

2. At the time of writing this report, the Trust continues to plan and prepare for the UK leaving the EU on 31 October. We have put well-tested contingencies in place that will allow patients to continue to access essential services in a range of circumstances. We are working in partnership with other agencies across Kent and the wider NHS on our EU Exit resilience planning and are confident that we are as prepared as we can be.

3. MTW welcomed five Chinese senior health delegates to Tunbridge Wells Hospital this month, who gave a presentation on how introducing Kangaroo Care (placing a baby skin-to-skin against a parent's chest) is contributing to the transformation of maternity services in China. A delegation of senior Chinese health officials initially visited MTW in February 2015 after international charity Save the Children requested a visit to see Kangaroo Care in action.

   The delegation was so impressed with what they saw that the Chinese Prematurity Intervention Programme invited three of our midwives to China in November 2015 to introduce the approach in their country and teach paediatric teams from 10 different hospitals. Kangaroo Care has been so successful it is now being rolled out nationwide.

   MTW's maternity team is a recognised innovator in this field and has been leading the way in the use of Kangaroo Care in a Transitional Care environment since 2009, influencing and developing clinical practice both within the UK and, now, overseas.

4. A new rainbow Pride pedestrian crossing has been unveiled at Maidstone Hospital this month – the first one of its kind in Kent. I joined members of our LGBT+ Network and Chair David Highton to officially open the crossing. The rainbow crossing is just one of the ways that MTW is helping to raise awareness of LGBT+ issues and show that the Trust is an open, inclusive and non-judgemental environment to its patients, staff and visitors.

5. We treated our first patient on our new Linear Accelerator (Linac) – the fourth Trubeam machine to be opened at Maidstone Hospital in four years, and the fifth overall, with our site at Canterbury home to the other. The Truebeam Linac machine treats cancer patients using the latest technology and with even greater accuracy, ensuring our patients receive the very highest standards of care.

6. Some of our staff have been busy getting active to help raise money for MTW's charity. Thank you to Fundraising Manager, Laura Kennedy, who ran the Royal Parks half marathon and raised £315; Bob Cook, who took on the Beachy Head trail marathon and has so far raised more than £600; and good luck to Stephen Crouch who has been chosen to represent MTW at next year's London Marathon. Stephen aims to raise £2,500 for our dedicated charity.

7. Thank you to the League of Friends at both hospital sites who have donated a combined amount of £80,000 to buy two state-of-the-art ultrasound machines. The new equipment will benefit up to 1,000 of our most critically ill patients who are admitted to our Intensive Care Units each year.

8. The Trust has opened a new Ophthalmology virtual suite, named after two members of MTW staff who have made a significant contribution to our Head and Neck services over the years. The Margaret Sullivan Suite will be run by a team of Clinical Nurse Specialist to help treat and care more of our patients with eye conditions associated with diabetes, glaucoma and Wet

Age-Related Macular Degeneration.

9. Our newly-renamed Cultural and Ethnic Minorities Network put on a range of fantastic events to celebrate & mark Black History Month. Our visitors, patients and staff were treated to several performances from a steel band, special international foods on offer in the hospital restaurants, a celebration of Diwali and information stands raising awareness about cultural issues.

10. More than 60 members of staff have been selected to form a culture change team as part of an 18-month ambitious culture and leadership programme. The culture change team attended two training days facilitated by the NHS Leadership Academy and NHS Improvement. They will now be conducting a series of engagement events and activities with staff to help make MTW a great place to work.

11. Congratulations to Dr Kate Stannard, a consultant anaesthetist, who has taken up a prestigious role as a National Examiner for the Royal College of Anaesthetists (RCoA). Examiners for the college are rarely selected from district general hospitals. Dr Stannard undertook a number of rigorous assessments and training days before being selected. She will help to deliver the practical conduct of the oral exam for candidates at the RCoA and will also review and write new questions for the examinations.

12. Our Infection Prevention and Control team held a series of events for staff to raise awareness of infection control during International Infection Prevention Awareness Week. The team celebrated a different theme each day, including hand hygiene, catheter care and staff hydration. They also visited wards and clinical areas to talk to patients about the importance of infection prevention.

13. HRH The Princess Royal will visit Maidstone Hospital on 11 December to officially open the new helipad, which was kindly funded by the HELP charity.

14. We welcomed a further 40 new international nurses to the Trust in October. The recruits come from India, Zimbabwe, Nigeria, Nepal and the Philippines, and join more than 100 nurses who have started working on our wards at MTW since July. So far, in total, nearly 400 nurses have been successfully recruited and will join us over the coming months.

15. MTW has been recognised for its work with dementia patients after winning an award at the Dementia Friendly Kent Awards 2019. Along with our fellow healthcare partners in the West Kent Emergency Services Dementia Group, which includes Kent Police, South East Coast Ambulance Service and Kent Fire and Rescue, the group took home the Community and Partnership Award. The partnership was recognised for its hard work in helping people with dementia in the community and helping reduce unnecessary hospital admissions.

16. Congratulations to our Costing Team, who picked up the Costing Award for the Kent, Surrey and Sussex brand from the Healthcare Financial Management Association (HFMA). The team have made significant improvements in costing processes and information, which has led to better information for services to use when making decisions about service delivery.

17. Proposals to merge eight clinical commissioning groups and form a single strategic Commissioner for Kent and Medway were approved by GP forums. An application has been submitted and agreed by NHS England.

18. 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:
    - Preparations for EU Exit
    - Review of Trust's no smoking policy
    - Performance updates on cancer, Referral to Treatment (RTT) and Emergency Department
    - Development of Advanced Clinical Practice policy and roles within the Trust
    - Ongoing development of the West Kent Integrated Care Partnership
    - Review of Trust's financial performance
    - MTW's winter plan and operational resilience during the coming season

- Update on the implementation of the Electronic Patient Record digital transformation programme

19. Congratulations to Jiselle Trajano, Clinical Site Manager, who was shortlisted in the Inspiring Diversity and Inclusion Lead category, and to Cathy Baker, midwife, who was nominated as Clinical Champion, for this year's National Black, Asian and Minority Ethnic (BAME) Awards.

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

NHS
Maidstone and Tunbridge Wells NHS Trust

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

Enclosed is Integrated Performance Report for month 6, 2019/20.

Which Committees have reviewed the information prior to Board submission?

- Finance & Performance Committee, 29/10/19 (in part)

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

Review and discussion

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

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Integrated Performance Report

September 2019

MTW
exceptional people, outstanding care

NHS
Maidstone and Tunbridge Wells NHS Trust

Contents

Appendices (Page 17 onwards)

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

Following the increased level of falls, SIs and Incidents seen last month these have reduced back to previous levels in September with 7 SIs being reported, which is the lowest number reported in any one month so far this year. Of these 2 were related to Falls.

Despite an overall increase in September, activity levels remain below plan YTD. Although the Trust continues to achieve the Referral to Treatment (RTT) Trajectory, the non-admitted waiting list and backlog is showing an increasing trend for some key areas and therefore achievement of the RTT Trajectory could be more challenging in future months.

Achievement of the A&E 4 hour performance has been impacted by the continued high level of A&E Attendances along with an increase in Delayed Transfers of Care. This resulted in there being less beds available for patients needing to be admitted to a bed from A&E.

The Trust Achieved the National Cancer 62 Day FDT Standard in August at 86.3%. All relevant departments across the Trust have worked hard to improve the overall 62 day performance and the teams were recognised for their achievement of this standard in August 2019. The September position is currently not fully validated, but is expected to be around 85%.

Items for Escalation

- **C.Diff:** the number of cases of C.Diff increased in September, but continues to achieve the trajectory YTD.
- **E.Coli:** the number of cases of E.Coli is increasing to a high of 11 in September equating to a rate of 55.1 per 100,000 occupied beddays
- **Falls:** Following the increase in the number and rate of Falls seen last month, which also led to an increase in SIs and incidents, this returned to previous levels in September, achieving the trajectory
- **Safe Staffing:** Nursing Safe Staffing fill rate decreased further in September to 92.6% but remains above the 93.5% target YTD.
- **A&E Attendances:** are currently showing an annualised growth of 8.75%. September recorded the 2nd highest daily attendances ever.
- **A&E 4 hour Standard:** performance decreased further in September to a score of 89.20% against a trajectory target of 92.70%.
- **Referral to Treatment (RTT) Incomplete Pathway:** performance remained similar in September, however, the RTT Trajectory was still achieved.
- **Cancer 2weeks (2ww):** Performance against the 2ww and 2ww breast symptoms has improved month on month but remain below target at 89% and 91.5% respectively. The validated but not finalised position for September is 93.1% for 2ww, 98.2% for Breast Symptoms, therefore both achieving the 93% national target. October is also expected to achieve.
- **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 86.3% in August, therefore achieving the national target of 85%. This has moved the Trust into 26th position out of 134 Trusts nationally.
- **Diagnostics Waiting Times <6 weeks:** Improvement in September but remains below the national 99% target for the fourth consecutive month.
- **Finance:** The Trusts surplus including PSF was £0.4m in August which was on plan, the main pressures in the month related to Medical Staffing (£0.2m), Private patient unit slippage (Net = £0.2m) offset by release of £0.2m reserves and vacancies of £0.5m in Nursing, Scientific and Technical staff and Admin and Clerical
- **Workforce (various):** Following the expected increase in Annual Leave in July and August this has reduced to previous levels in September. The overall staffing fill rate has increased back to previous levels, however, the nursing staff fill rate saw a reduction. Agency and bank usage decreased slightly in September, however this reflected the overall reduction in the demand for temporary staffing. Sickness levels reduced back to previous levels. Whilst the vacancy rate is showing a gradual downward trend (including vacancies in both Nursing and Medical and Dental Staff Groups) this remains 1.6% above plan with high vacancy levels in some key areas.

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)	25.8	35.1	24.7	24.7	22.4	22.4	↘
S2	Number of cases C.Difficile (Hospital)	5	7	30	30	55	55	↘
S3	Number of cases MRSA (Hospital)	0	0	2	1	0	1	↑
S4	Rate of E. Coli Bacteraemia	20.6	55.1	28.8	31.3	21.5	25.2	↓
S5	Rate of Hospital Pressure Ulcers	*0.90*	1.3	1.5	0.5	0.9	0.7	↓
S6	Rate of Total Patient Falls	*6.00*	5.91	*6.32*	6.24	*6.00*	6.00	↑
S7	Number of Never Events	*0*	0	1	1	0	1	→
S8	Number of New SIs in month	12	7	93	73	144	144	↑
S9	SIs not closed <60 Days Monthly Snapshot	24	31	-	31	24	31	↓
S10	Overall Safe staffing fill rate	93.5%	92.6%	96.3%	93.9%	93.5%	93.9%	↘

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	1.0363	1.0219	1.0363	Band 2	Band 2	→
E2	Standardised Mortality HSMR	Lower conf <100	91.5	104.8	91.5	Lower conf <100	91.5	→
E3	% Total Readmissions	14.1%	14.5%	13.6%	14.7%	14.1%	14.7%	↗
E4	Readmissions <30 days: Emergency	14.7%	15.0%	14.1%	15.3%	14.7%	15.3%	↗
E5	Readmissions <30 days: Elective	6.9%	8.5%	7.1%	7.6%	6.9%	7.6%	↘
E6	Stroke: Best Practice (BPT) Overall %	50.0%	21.2%	50.3%	36.5%	50.0%	36.5%	↓
E7	% TIA <24hrs	60.0%	No data	65.9%	56.8%	60.0%	56.8%	→
E8	Nat CQUIN: % Dementia Screening	90.0%	95.5%	99.8%	91.6%	90.0%	91.6%	↗
E9	Nat CQUIN: % Dementia Risk Asssessed	90.0%	89.6%	89.2%	94.2%	90.0%	94.2%	↓
E10	Nat CQUIN: % Dementia Referred to Specialist	90.0%	100.0%	98.2%	98.8%	90.0%	98.8%	↗

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	1.85	2.05	2.31	2.93	2.61	↑
C3	% complaints responded to within target	75.0%	71.4%	54.3%	58.8%	75.0%	67.0%	↑
C4	IP Resp Rate Recmd to Friends & Family	25.0%	16.6%	20.1%	17.2%	25.0%	17.2%	↗
C5	IP Friends & Family (FFT) % Positive	95.0%	94.0%	93.8%	94.9%	95.0%	94.9%	↗
C6	A&E Resp Rate Recmd to Friends & Family	15.0%	9.1%	12.3%	11.1%	15.0%	11.1%	↘
C7	A&E Friends & Family (FFT) % Positive	87.0%	85.7%	90.9%	87.4%	87.0%	87.4%	↘
C8	Mat Resp Rate Recmd to Friends & Family	25.0%	17.3%	43.8%	27.8%	25.0%	27.8%	↓
C9	Maternity Combined FFT % Positive	95.0%	94.7%	92.1%	94.2%	95.0%	94.2%	↗
C10	OP Friends & Family (FFT) % Positive	84.0%	81.3%	83.9%	82.2%	84.0%	82.2%	↘

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	92.7%	89.2%	93.1%	91.9%	91.7%	91.7%	↘
R2	Emergency A&E >12hr to Admission	0	0	1	0	0	0	→
R3	Ambulance Handover Delays >30mins	369	581	1781	3008	4428	5222	↓
R4	RTT Incomplete Pathway	83.9%	84.3%	79.7%	84.3%	83.9%	87.3%	↘
R5	RTT 52 Week Waiters (New in Month)	8	8	30	36	8	36	↘
R6	% Diagnostics Tests WTimes <6wks	99.0%	98.7%	99.4%	98.7%	99.0%	99.0%	↗
R7	Cancer two week wait	93.0%	89.0%	76.4%	89.0%	93.0%	93.0%	↗
R8	Cancer two week wait-Breast Symptoms	93.0%	91.5%	58.5%	91.5%	93.0%	93.0%	↑
R9	Cancer 31 day wait - First Treatment	96.0%	97.2%	96.2%	97.2%	96.0%	96.0%	↘
R10	Cancer 62 day wait - First Definitive	85.2%	86.3%	67.7%	86.3%	86.0%	86.3%	↑

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	6.60	6.67	6.94	7.05	6.40	7.05	↗
R12	Theatre Utilisation	90.0%	85.7%	91.3%	96.9%	90.0%	96.9%	↘
R13	Primary and Non-Primary Refs	16,457	14418	94,883	96360	199,052	196670	↘
R14	Cons to Cons Referrals	4,291	5380	35,929	36229	51,898	62,382	↘
R15	OP New Activity	18,696	18427	105,753	109136	226,133	223093	↗
R16	OP Follow Up Activity	28,675	26111	155,117	163659	346,845	338438	↘
R17	Elective Inpatient Activity	614	555	3,131	3363	7,426	7105	↗
R18	Day Case Activity	4,151	3937	21,945	23529	50,210	48832	↗
R19	Non Elective Activity (inc Maternity)	6,913	5424	31,646	32773	84,338	74942	↗
R20	A&E Attendances : Type 1	13,376	14125	77,456	84451	159,252	167691	↘

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	398	407	- 3,570	668	6,897	6,897	→
W2	CIP Savings	2,050	1,792	5,787	10,901	22,329	22,329	↘
W3	Cash Balance	33,931	42,824	13,493	42,824	3,000	3,000	
W4	Capital Expenditure	1,314	442	1,487	1,624	14,448	14,448	
W5	Finance use of Resources Rating	2	3	4	3	2	3	→
W6	Staff Turnover Rate (%)	10.0%	11.4%	9.4%	11.4%	10.0%	11.4%	↘
W7	Vacancy Rate (%)	8.0%	10.4%	10.7%	10.4%	8.0%	10.4%	↗
W8	Total Agency Spend	1,239	1,786	11,976	10,243	15,830	16,258	↘
W9	Statutory and Mandatory Training	90.0%	85.8%	82.9%	86.0%	90.0%	86.0%	↘
W10	Sickness Absence	3.3%	3.4%	3.4%	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 Performance Wheel Scoring	

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 September. Year to date the Trust remains on trajectory with 30 cases reported against a maximum limit of 30. Compliance in MRSA Screening for the Elective pathway remains 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. **Falls:** Following the increase in the number and rate of Falls seen last month this returned to previous levels in September, achieving the trajectory. The decrease was at the Tunbridge Wells (TWH) site which is the best performance for this site so far this year but remains slightly above trajectory. **Serious Incidents (SI)s:** The number of SIs reported decreased in September to 7 which is the lowest number reported so far this year. Of these 2 were related to Falls. **Incidents:** The rate of incidents that were severely harmful reduced back to previous levels in September (due to the decrease in Falls SIs) to 1.03 which is below the limit of 1.23. **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:** The overall number of cases of E.Coli reported is now slightly higher than the numbers reported in the previous year. The level reported for the Lord North Ward remains high. A deep dive is being undertaken. Performance for MRSA Screening in Non- Elective pathways dipped to below target at 92.9% in September. **Falls:** Despite the rate of Falls being below the maximum trajectory in September, YTD the rate remains slightly above at 6.2 against the maximum limit of 6.0. The rate of Falls for T&O continues to remain high **Incidents:** The number of incidents open for more than 45 days has more than doubled since last month. **Incidents of Abuse towards Staff:** Incidents increased in September to 35 which is 81% of all incidents of aggression reported (43 in September). **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 further decrease in the overall nursing fill rate indicator in September to 92.5% which is below the 93.5% target. This was impacted by the high vacancy levels along with a reduction in the use of temporary staff which was reflected in the reduction in the demand for temporary staffing during this month. There was an increase in demand on services. 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. It also does not reflect the contribution to care delivery that our overseas nurses are providing during their supernumerary time on their clinical areas awaiting registration.

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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 15.3%, 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. **Patients with Dementia:** The percentage of patients screened for Dementia increased in August to 95.5% against the 90% national target and remains above target YTD (91.6%).	**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 hours has dropped to 23.1% in September. The relocation of the Stroke service to Maidstone & subsequent disruption may have contributed to this. Percentage First Ward is down 9.0% at 71.2% and Percent with >90% of time on Stroke Ward is down 8.1% at 78.1% These have combined to cause the percentage of patients to meet all 3 Best Practice Tariff indicators to drop from 48.7% last year to 36.5% so far this year. Post re-configuration of Stroke services with seven day working will improve this target.

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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 although September was slightly below average in September. Divisional performance increased to 88.1% for September and is at 80.1% YTD which is above the 75% target. The number of overdue complaints has decreased in September to 58, below the average of 65 last year. **Friends and Family Survey:** The percentage of responses that were positive continues to remain fairly high in all areas but are slightly below target with the exception of A&E which remains consistently above target. **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:** Despite the increase in performance in September, YTD the percentage of complaints responded to within target it 58.8% which is below the 75% target. **Friends and Family:** The response rates continue to fluctuate across the four areas and remain below target YTD

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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 42.3 per day so far this year – or around 9.2% of all A&E attendances **A&E admissions** are reducing slightly despite higher attendances, and the percentage of patients that are zero LoS (excluding Clinical Decision Unit (CDU) patients) is 25.6% YTD, compared to 22.1% for the same period 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 **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 8.7% busier than the preceding 52, and 2019/20 attendance is forecast to be 7.7% higher than 2018/19. September recorded the 2nd highest daily attendances ever. **4 hour Emergency Access Standard:** A&E performance struggled again in September, with a score of 89.20% against a trajectory target of 92.70%. Unlike last month when the drop in performance was largely attributable to a significant decrease at Maidstone, September saw difficulties at both sites. **Ambulance Handovers:** 30-60 minute delays rose to 504 in Sept (13.9%), but still remains 66% higher than the equivalent period in 2018/19. Delays of more than 60 minutes are 51% higher than last year. **Beds**: Delayed Transfers of Care (DTOC) have increased in September along with the level of escalation beds used. This , along with non-elective average length of stay (LOS) remaining slightly above plan has meant that bed occupancy remains high at around 92-95% . Many of the available beds are specialist or paediatric beds not available for general acute admissions. **New Outpatient Activity:** New Outpatient activity is 2.7% below plan YTD. However, for the main RTT Specialties this is 10% below plan YTD. Specialties furthest from plan remain ENT, Gastroenterology, Ophthalmology, Cardiology and Trauma & Orthopaedics which is directly impacting on their achievement of their non-admitted RTT Trajectories. **Outpatient Efficiency:** The ERS Unavailable Slot %age remained high in Aug-19 (this runs 1 month behind) at 20.4%. There is a particular issue in T&O (13.8%), ENT (16.4%), Medical specialties (19.9%) and Gynaecology (41.9%).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 15.5% YTD.

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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 September was 84.34% against a target of 83.9%, therefore achieving the trajectory. Despite the increase in September the backlog remains 1,587 lower than the March 18 position. **Cancer Waiting Times:** Performance against the 2 week wait and 2 week wait breast symptoms has improved month of month but remain below the national target of 93% at 89% and 91.5% respectively. The validated but not finalised position for September is 93.1% for 2ww and 98.2% for 2ww Breast Symptoms, therefore both achieving the 93% national target. The 2WW team are also on track to achieve the 93% target in October with a 91.5% position at mid-point. The Trust continues to consistently achieve the cancer standards for 31 day First Definitive Treatment. The Trust succeeded with achievement of the 62day standard for August 2019 at 86.3%, therefore achieving the national target of 85%. This has moved the Trust into 26th position out of 134 Trusts nationally. All relevant departments across the Trust have worked hard to improve the overall 62 day performance and the teams were recognized for their achievement of this standard in August 2019. The September position is currently not fully validated, but is expected to be around 85%.	**Elective Activity:** Overall activity increased by around 12 cases per working day in September compared to August and is 6.2% below plan YTD (DC is 5.8% below plan and IP are 8.6% 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. **RTT Incomplete Pathway:** The Trust is still reporting some 52 week breaches on a monthly basis (9 reported for September). 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 YTD and a decrease in outpatient efficiency the Trust OP Waiting List and backlog are above trajectory which has meant that the overall RTT Waiting List and Backlog are higher than trajectory. The IP backlog has decreased slightly. The Elective and Outpatient New Activity remain lower than plan which has led to an increase in the RTT Waiting List and backlog for some specialties. **Diagnostic Waiting Times <6weeks:** Performance has increased to 98.7% in September but remains slightly below the 99% target . This is the fourth consecutive month that the Trust has not achieved the 99% target. The increase in performance is due to the issues in Endoscopy and Cardiology seen previously having now been resolved. **Cancer Waiting Times:** Despite the achievement of the 62 Day target in August, this standard remains a challenge for the Trust. Ongoing work continues to ensure sustainable processes and active management of the 62 day PTL and backlog. The overall 62 day performance continues to be at risk with incoming Specialist referrals for treatment being received at MTW late in the 62 day pathway. The Cancer Team are working on this position with the referring Trusts.

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Headlines

Well Led:	Positives:	Challenges:
Lead Director(s): **Steve Orpin/** **Simon Hart**	**Finance:** £0.4m surplus in Month 6 as planned and Year to Date a £0.7m surplus as planned. The Trust is forecasting to meet its control total by the end of the year. CIP delivery has over-performed by £0.3m in month 6. The Trust has delivered £10.9m savings YTD which is £1.1m favourable to plan (11% over performance). Favourable cash position at the end of month 6. Capital underspent against plan at the end of month 6 but all capital is committed in 19/20 **Vacancy Rate:** The Trust vacancy rate is showing a gradual downward trend from a high of 13.3% in April to 10.4% in September. This downward trend has also been seen in both the Nursing and Medical and Dental. **Sickness Rate:** The overall sickness rate has become more stable over the last 12 months. September was just above the maximum limit but YTD remains on plan. **Staff Appraisals:** The 201920 appraisal cycle is overall at 89.8% with Estates and Facilities, Women's, Children's and Sexual Health and Diagnostics and Clinical Support all achieving in excess of 90%. **Annual Leave and Staff Fill Rate:** Following the expected increase in Annual Leave in July and August this has reduced to previous levels in September and therefore the overall staffing fill rate (excluding medical staff) has also increased back to previous levels.	**Finance:** Medical staffing pay overspent YTD by £1.4m mainly within Medicine and Emergency Division (£1.1m) and Paediatrics (£0.5m). 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 £6.5m are mitigated by the expected release of the CCG RTT risk reserve, additional income opportunities, full delivery of the 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:** Whilst the Vacancy Rate is improving month on month this still remains a key challenge for the Trust particularly for the Nursing Staff Group at 18%. **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 **Staff Fill Rate (Excluding Medical Staff):** Whilst this has improved following the decrease seen last month this still remains a challenge for the Trust.

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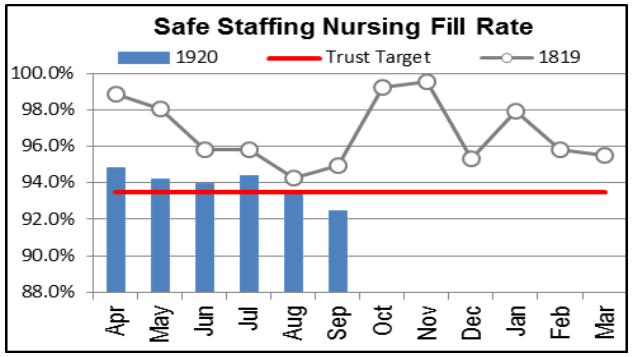
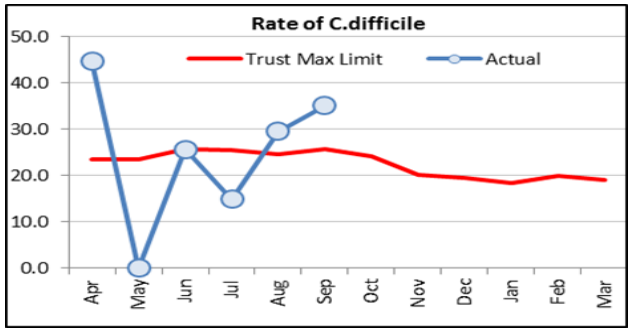
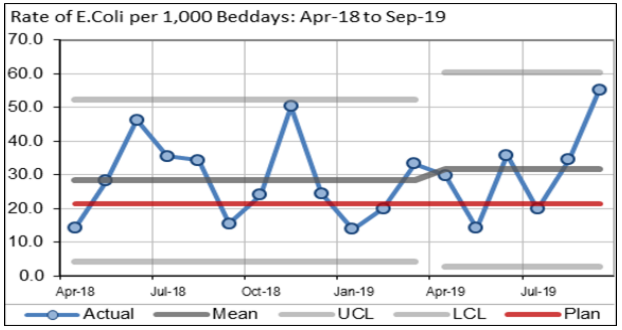
Escalation: Safe Staffing Rate and Infection Control



Safe Staffing Nursing Fill Rate: The nursing fill rate decreased further in September to below the Trust target at 92.5%. This was impacted by the high vacancy levels along with a lack of available temporary staff during this month and an increase in demand on services

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 September there were seven cases of C.Difficile reported equating to a rate of 35.1 per 100,000 occupied beddays. Year to date there have been 30 cases reported against a maximum limit of 30 year to date. In August there were 6 cases reported (instead of the 7 reported in this report as 1 was reported in error)

E.Coli Bacteraemia: Eleven cases reported equating to a rate of 55.1 against a phased target to 21.5 by the end of the year (38 cases reported YTD compared to 35 last year).

Of the 38 cases of E.Coli reported YTD, the biggest proportion remains for patients on the Lord North Ward at Maidstone Hospital with 13 (34%) compared to 6 (9%) for the same period in 2018/19. 4 reported in September 2019/20

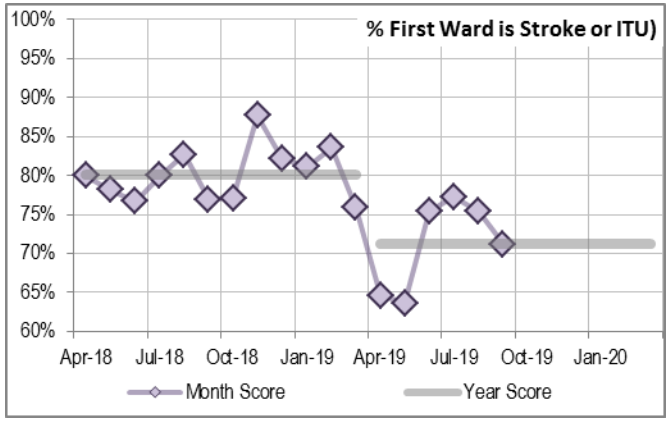
MRSA Bacteraemia: No cases of Hospital Acquired MRSA Bacteraemia were reported in September (1 YTD as reported last month).

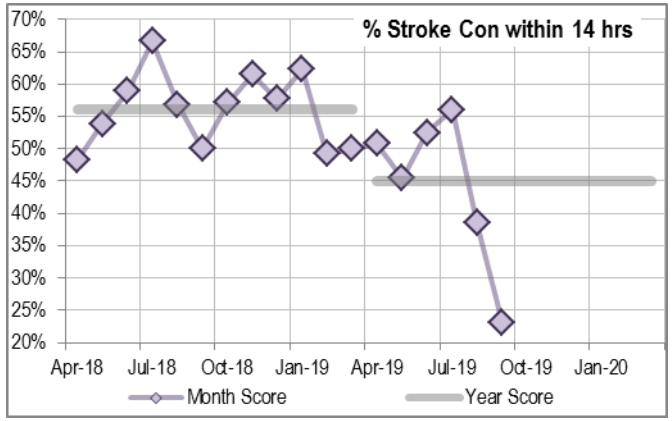
Following the improvement in compliance seen last month against the MRSA screening rate for the non-elective pathway this dipped to 92.9% in August. Compliance for the Elective pathway continues to remain above the 98% target at 99%.

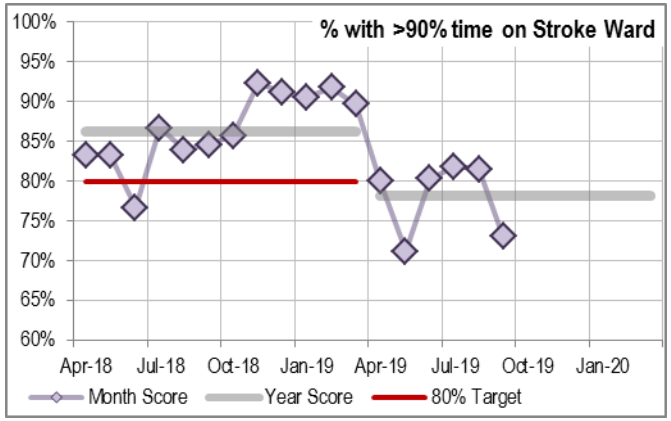
Infection Control Assurance: Routine cleaning Solution changed to Diff X across the Trust. HPV and UVC light cleaning remains in place for C diff cases, carriers and multi resistant organisms. Weekly C. difficile huddle held by DIPC and ICT. C. diff and MSSA review panels continue with DIPC and Chief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

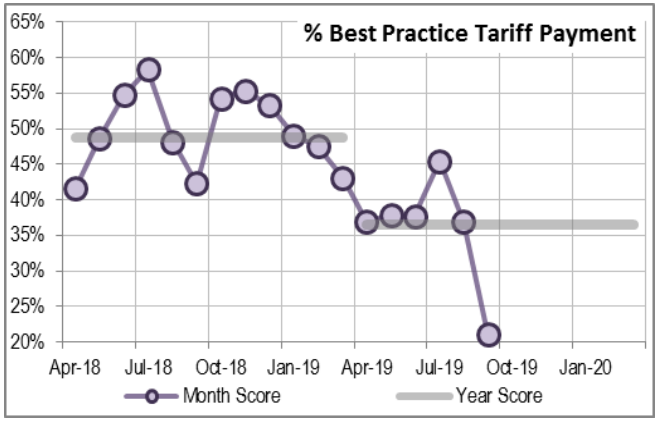
Summary:	Actions:	Assurance:
The Safe Staffing Fill Rate decreased further to 92.5% in September which is below the Trust target of 93.5%. This was impacted particularly in September by a lack of available temporary staff during this month (although this was reflected in a reduction in the demand for temporary staff) and an increase in demand on services. **Infection Control:** Despite an increase in cases reported in September, year to date the Trust remains on trajectory for cases of C.difficile	**Safe Staffing:** Weekly staffing meetings remain in place with the Staff bank, DDNQs and Chief Nurse to review staffing position and to identify key actions needed. Staffing levels reviewed and managed on a daily basis to support staffing levels across all areas. **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:** The Trust continues to support an ongoing programme and arrival of overseas nurses– whilst not registered as yet as they are being supported with their OSCE programme and they are providing support to our registered workforce to support care delivery whilst on the wards OSCE bookings are being made in advance of arrival to the UK. A further 31 overseas nurses joined the Trust in September with a further 51 due to start in October. 88 International nurses have arrived to date in 2019. A further 312 overseas nurses are due to join the Trust in the next few months.

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. This year we are 7% under YTD, but the difference is not yet statistically significant.

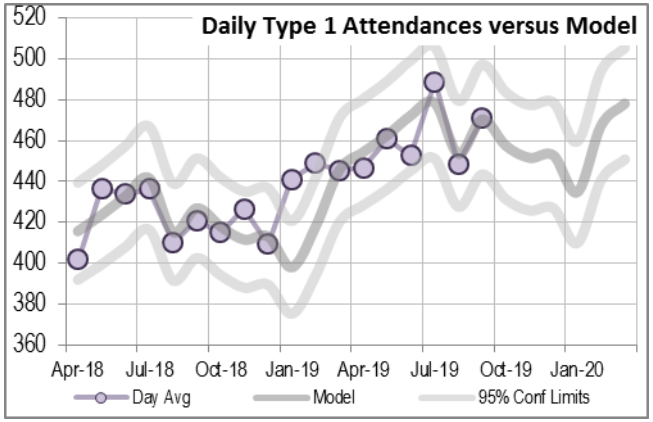
First Ward must be a stroke ward or ITU. Last year averaged 80.2%, but this year has dropped to 71.2% so far. Currently a lot of patients go to CDU first, and that is clinically appropriate until the Hyper Acute Stroke Unit comes online next year.

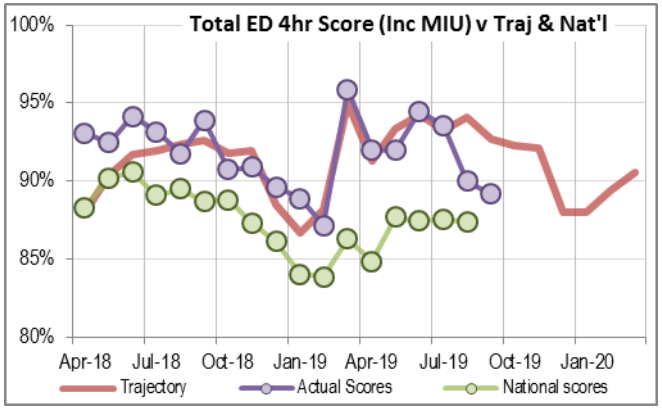
Stroke Consultant within 14 hrs. 2018/19 ran at 56.1%, but Sept has decreased to 23.1%. YTD we are 45.1%

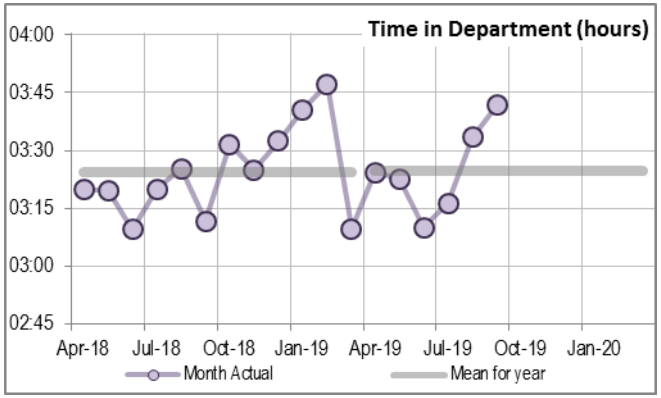
90% of Spell on Stroke Ward. This metric is now slightly different. The qualification is on HRG rather than Diagnosis code, the time is calculated in minutes rather than overnights, and we are no longer able to discount time spent in the Discharge Lounge. 2018/19 was 86.2%, but this year we are at 78.1%. 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 36.5% so far this year.

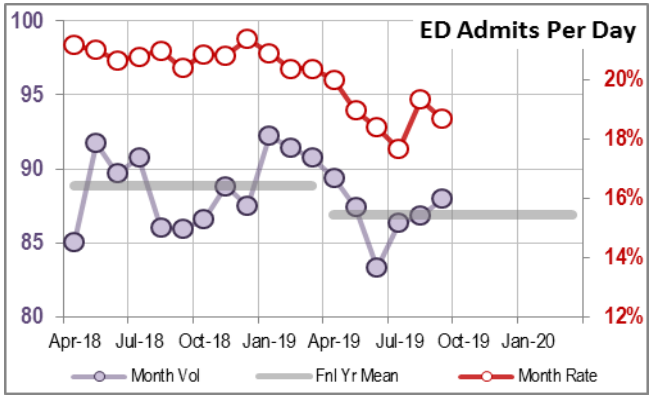
Summary:	Actions:	Assurance:
There are now three main stroke indicators that constitute Stroke Best Practice. a) admitted direct to a stroke or intensive treatment ward, b) See a stroke consultant within 14 hours of arrival or their stroke if that happens on-site, c) Spend 90% of their spell on a stroke ward. 36.5% of patients this year have qualified by meeting all three indicators. All three components are returning worse scores than last year.	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 7.6% increase on that for 2019/20

September was almost exactly as expected at 470.3 per day. This represents the 2nd busiest month ever

4 Hr Time in Department: Performance dropped again in September, coming in at 89.20% against an agreed trajectory of 92.70%. Unlike August where most of the problem was at Maidstone, this month, both sites struggled.

Total Time in Department averaged $3^h 24^m$ for Type 1 attendances through 2018/19. YTD the Trust is back at 3^h24^m.and Sep was 3^h41^m

ED admits per day to main IP Ward: 2018/19 averaged 88.9 per day or 20.8% of attendances. Numbers have increased over the last few months. This year we average 86.9 against much higher attendances, percentage is 18.9%.

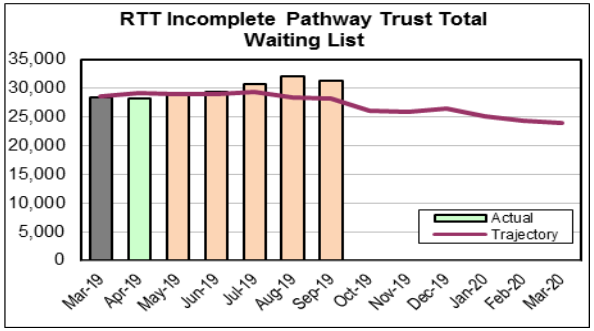
Ambulance Handovers: Last year, 9.6% of ambulances were delayed 30-60 mins, and 1.5% were delayed > 60. This year so far it's 12.5% delayed 30-60 mins and 1.3% >60. September spiked at 13.9%

Summary:	Actions:	Assurance:
A&E Attendances are currently showing an annualised growth of 8.75%. A&E performance struggled again in September, with a score of 89.20% against a trajectory target of 92.70%. Unlike last month when the drop in performance was largely attributable to a significant decrease at Maidstone, September saw difficulties at both sites. YTD, the average Time in Department is now the same as last year at 3h24m.	Weekend services now in place for AEC and Frailty through temporary cover at non consultant level, supported by GIM consultant rota. Ambulance handover plan in place which will also support at the front door during times of increased pressure. Continue to recruit a substantive workforce for the Emergency Departments. Identification of staff to support "hello" nurse on ongoing trial. Development of plan to support additional consultant sessions within Rapid Access Physiotherapy. Agreement to develop 7 bed Rapid Access Physiotherapy at Maidstone by Feb 2020 from Executives. Secure funding for trollies required to run efficient ED departments.	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. Increased profile on ambulance handovers. 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.

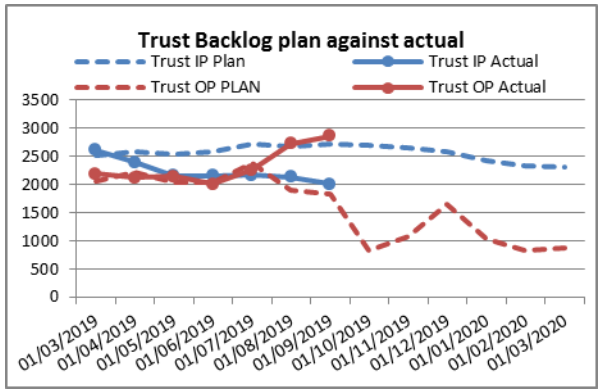
Escalation: RTT Incomplete Pathways

Trust	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Trajectory Total WL	28508	29152	28932	28908	29273	28433	28261
Actual Total Waiting List	28412	28268	29027	29269	30705	32085	31344
Actual IP Waiting List	6494	6045	6037	5978	6102	6009	5780
Actual OP Waiting List	21918	22032	22527	22619	23622	24898	24295
Trajectory Backlog	4146	4806	4578	4622	5089	4576	4543
Actual Total Backlog	4797	4510	4305	4162	4430	4857	4865
Actual IP Backlog	2611	2391	2157	2156	2158	2135	2004
Actual OP Backlog	2186	2119	2148	2006	2272	2722	2861
Trajectory % Performance	85.5%	83.5%	84.2%	84.01%	82.61%	83.9%	83.9%
Actual Total % Performance	83.12%	84.05%	85.17%	85.78%	85.57%	84.83%	84.34%

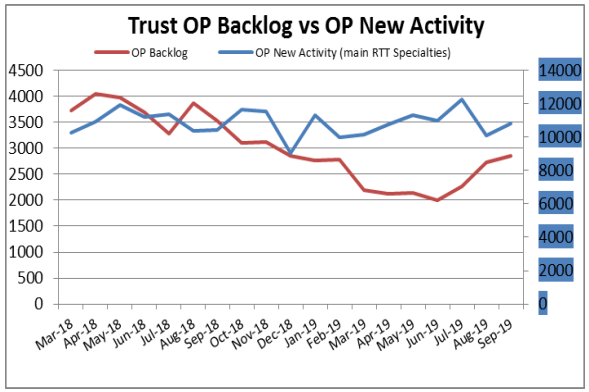
RTT performance decreased slightly in September and remains above trajectory



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 slightly further in September. This has been mainly due to the OP (non-admitted pathway).



This shows that despite an overall increase in New Outpatient Activity in September, following the significant decrease in August , the RTT non-admitted backlog increased in September due to lower activity levels in some areas.

RTT by Specialty: All Specialties achieved their trajectory for September with the exception of Ophthalmology (-1.4%), Neurology (-13.8%), Rheumatology (-8.3%), Cardiology (-7.2%), Respiratory (-5.5%) and Gastroenterology (-1.3%), however Respiratory remains above the national target. General Surgery is now 4.2% above Trajectory, ENT and T&O are around 2% above trajectory. Performance dipped in September for T&O and General Surgery compared to August and there was a significant decrease for Gynaecology (-5.9%). For Ophthalmology the non-admitted pathway performance is 5.4% below trajectory. All specialties saw an increase in the OP Backlog with the exception of Urology. Ophthalmology, ENT and Neurology OP Backlog account for the biggest proportion of the Trust OP Backlog (25%, 18% and 11% 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 September. These are being carefully monitored against forecasts and action plans on a weekly basis

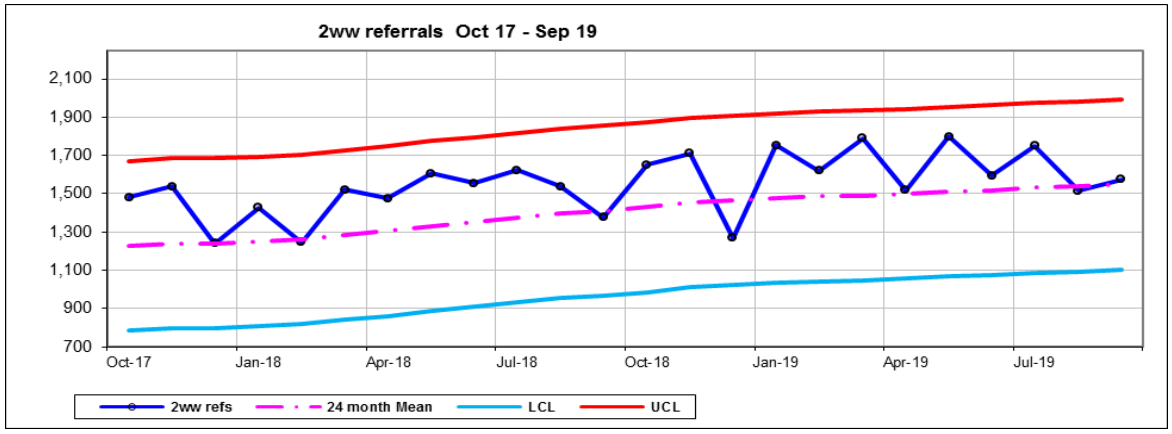
RTT 52 week Breaches: 9 reported for September (8 new for September). All patients will have a harm review by the managing Consultant. No harm has been found as yet for the ones which have been completed. 52 Week Panel established.

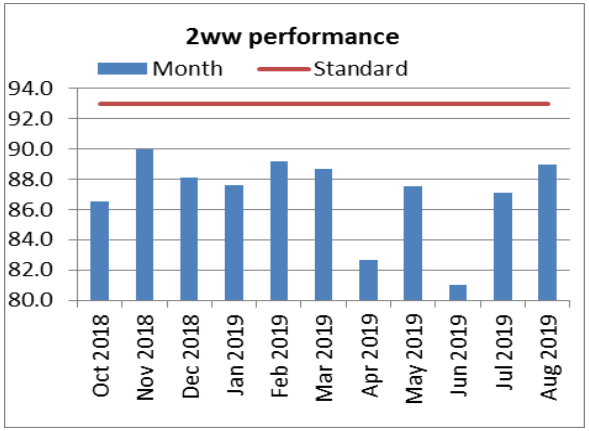
RTT Data Quality: Operational plan, risk assessment and QIA to be completed in order to review when the new reporting system can be implemented.

Diagnostics <6weeks: Performance increased to 98.7% in September due to the previous issues in Endoscopy and Cardiology having now been resolved. Performance remains slightly below the 99% target.

Summary:	Actions:	Assurance:
Performance increased slightly in September and remains above Trajectory at 84.34%. The Trust Waiting List has decreased further to 31,344 which is therefore 3,083 (11%) higher than the Trust submitted Trajectory of 28,261 and the backlog has increased to 4,865 which is 322 higher (7%) than the submitted trajectory of 4,543 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.	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





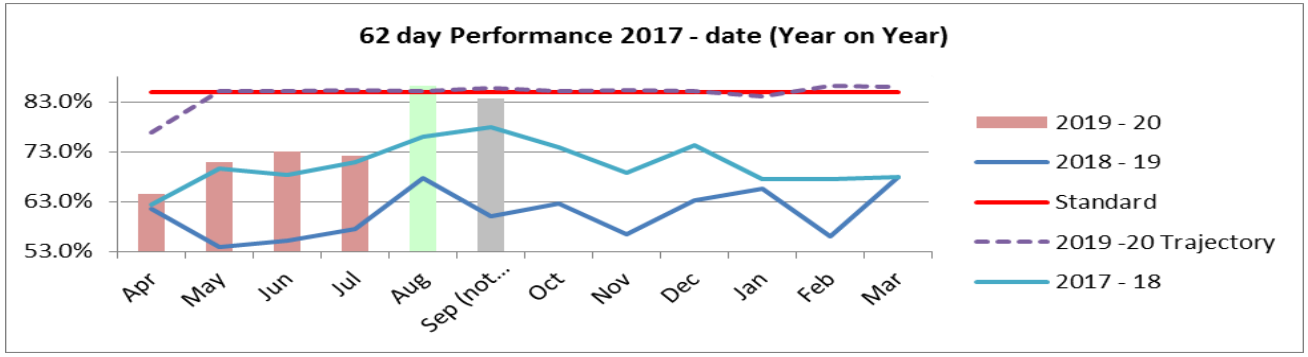
2ww GP referrals to MTW	Breast	Gynae	Haem	Head & Neck	Lower GI	Lung	Other	Upper GI	Urology	Total	BSYM	Breast total
2017	319	119	9	109	261	47	8	139	154	1164	165	404
2018	343	141	17	123	310	48	4	146	207	1289	141	484
2019 (Jan - Sep)	392	158	26	145	357	55	14	147	203	1657	157	549
% change last 12 mths	14.4%	11.7%	52.8%	18.3%	15.3%	12.9%	227.0%	0.5%	-1.8%	28.6%	11.8%	13.5%

Demand: Demand for 2ww referrals remains just over 1500 per month and has been in line with the expected growth over the last 24 months. The number of referrals has increased again through October – approximately a 7% increase in comparison to the same position in September – and is putting additional pressure on capacity. Breast, Lower GI, Urology and Upper GI remain the sites with the higher numbers of referrals

2 Week Wait (2WW) Performance:
2ww performance has continued to improve at 89% for August. The validated but not finalised position for September is 93.1% for 2ww and 98.2% for 2ww Breast Symptoms, therefore achieving the 93% national target. 2ww performance in all but one tumour group has improved in September compared to August. Breast remains the highest with 97.5% performance and only gynaecology and children's sit below 90% with current performance at 88.6% and 50% retrospectively. Children's cancer performance had reduced from 66.7% to 50% but a new process will be implemented at the end of October and anticipates all patients to be booked within their breach date. The 2WW team are on track to achieve the 93% target in October with a 91.5% position at mid-point.

Summary:	Actions:	Assurance:
After increased demand for 2ww referrals from January to July (peaking at 1799 referrals for May), the numbers of referrals for August and September has returned to just over 1500 per month. Following a period of reduced performance (Jun-19: 81%), new reporting and more robust referral management processes has resulted in a significant improvement in performance in September (93% -not finalised), therefore achieving the 93% national target. The target is also on track to be met in October 2019	Additional breast clinic capacity has taken breast to the best performing tumour group in August and September. Work has taken place to revise the LGI and UGI STT endoscopy booking process and ensure that patients are fully booked at point of telephone triage. Go live date is end of October. Appointment of a full-time 2WW coordinator will help to fill outstanding team vacancies. Identification of clinic space for children's cancer first seen appointments will allow the 2WW team to book directly into these slots	A new 2ww working group has been set up with involvement from General Managers across breast, urology, haematology and gynaecology. This group is focused on reducing patients booked past 7 days to ensure compliance with the 28 day standard. A report has been developed, and is reviewed daily, to highlight any un-booked 2ww appointments and any appointments booked after 7, 10 and 14 days. A new report to monitor patients unregistered on the system within 24 hours is in production to provide additional assurance that all patients with a 2WW referral are captured.

Escalation: Cancer Waiting Times – 62 Day



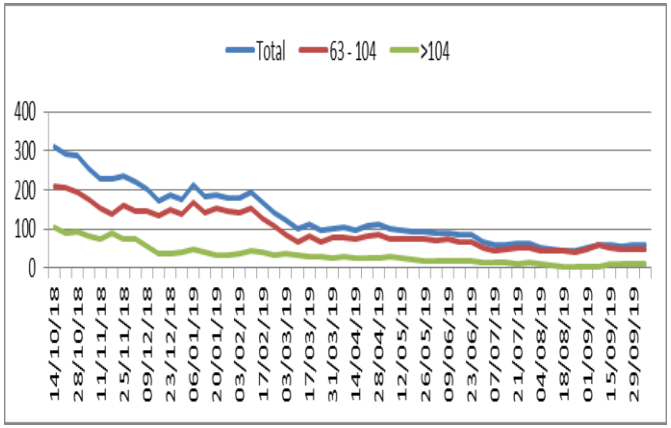
Trust Performance: The Trust succeeded with achievement of the 62day standard for August 2019 at 86.3%. This has moved the Trust into 26th position out of 134 Trusts nationally.
The September position is currently not fully validated, but is expected to be around 85%

The PTL is continuing to be managed with an overall % of less than 5% in the backlog. However, during the month of September, the number of patients from day 104 has increased to 10 and remains at this level through the beginning of October. Maintaining the improvement in the backlog position is driving up overall performance against the 62day standard.

Tumour Specific Performance: Breast, Head & Neck, Lower GI and Urology all reported above 90% for the 62d standard in August. Gynae and Upper GI were just below 85%, both with 83.3%
Lung continues to report below the national standard at 72.7% and Haematology is our lowest performing site at 66.7%
Both Lung and Haematology are below the current National Average of 78.5%

Conversion rates for 2ww referrals: The overall conversion rate remains at 8.2%. This varies across the different tumour sites with Lung converting an average 30.39% of referrals received and Head & Neck 2.68% for the first 7 months of 2019.

62 Day Performance						
August 2019	All reportable patients			MTW only patients		
	Total	Breach	%	Total	Breach	%
Breast	17.0	1.0	94.1	17	1	94.1
Gynae	12.0	2.0	83.3	9	1	88.9
Haematology	3.0	1.0	66.7	3	1	66.7
Head & Neck	2.5	0.0	100.0	0	0	
Lower GI	11.5	1.0	91.3	10	0	100.0
Lung	16.5	4.5	72.7	15	3	80.0
Other	2.0	1.5	25.0	0	0	
Upper GI	9.0	1.5	83.3	7	1	85.7
Urology	40.0	3.0	92.5	40	3	92.5
TOTAL	113.5	15.5	86.3	101	10	90.1



The overall 62 day performance continues to be at risk with incoming Specialist referrals for treatment being received at MTW late in the 62 day pathway (as seen in Lung, Gynae and Upper GI). The Cancer Team are working on this position with the referring Trusts

Summary:	Actions:	Assurance:
All relevant departments across the Trust have worked hard to improve the overall 62 day performance and the teams were recognized for their achievement of this standard in August 2019. Ongoing work continues to ensure sustainable processes and active management of the 62 day PTL and backlog. The overall backlog is being managed at less than 5% of the total PTL.	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 Daily PTLs with GMs and DDOs for all tumour sites with endoscopy, radiology, pathology and oncology presence. Weekly cancer performance meeting Harm reviews are conducted for all patients treated over 104 days. This is being led by the clinical director for cancer performance. Additional funding has been secured from the CCG and Cancer Alliance to support proposed actions and posts required to continue cancer pathway improvements.

NHS
Maidstone and Tunbridge Wells NHS Trust

Appendices

MTW
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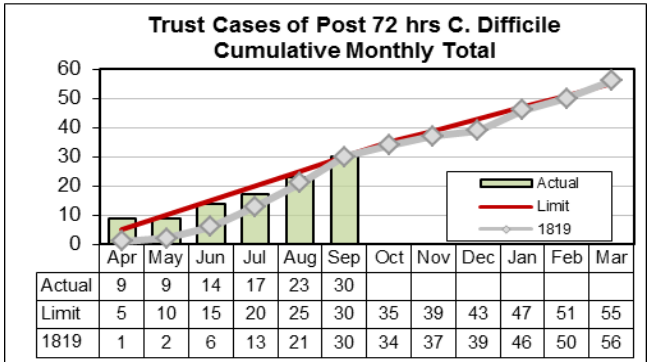
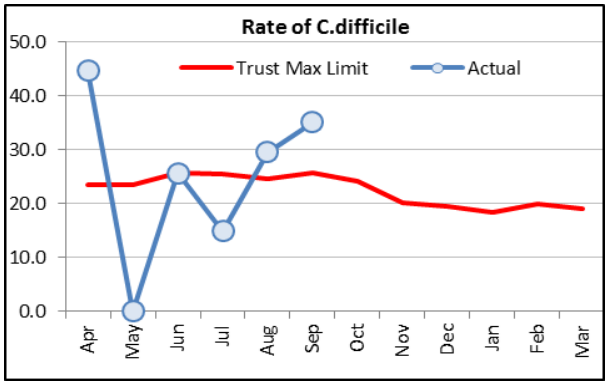
Safe	Infection Control	Sep-19



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	9	9	14	17	23	30						
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

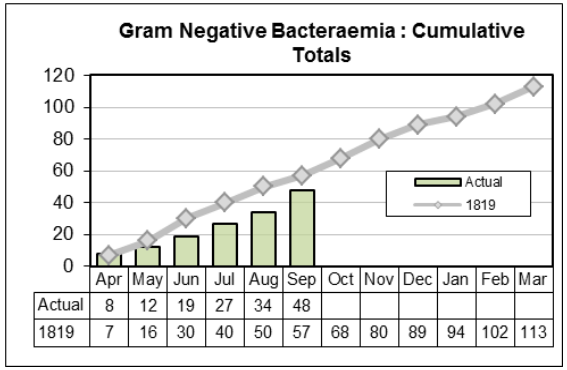
MSSA Bacteraemia	Apr	May	Jun	Jul	Aug	Sep	YTD
1516	0	3	2	4	4	0	13
1617	4	1	2	2	3	1	13
1718	2	0	0	3	0	2	7
1819	2	2	2	2	5	0	13
1920	1	3	0	4	1	6	15

MSSA: The number of MSSA cases reported during 1819 was a signficant reduction compared to previous years, however this redution was seen in the winter months from September to March. So far in 1920 the number of cases reported is slightly above the levels seen in 1819.



C.difficile: In September there were seven cases of C.Difficile reported equating to a rate of 35.1 per 100,000 occupied beddays. Year to date there have been 30 cases reported against a maximum limit of 30 year to date. In August there were 6 cases reported (instead of the 7 reported in this report as 1 was reported in error)

MRSA Bacteraemia: No cases of Hospital Acquired MRSA Bacteraemia were reported in September (1 YTD as reported last month) Following the improvement in compliance seen last month against the MRSA screening rate for the non-elective pathway this dipped to 92.9% in August. Compliance for the Elective pathway continues to remain above the 98% target at 99%.



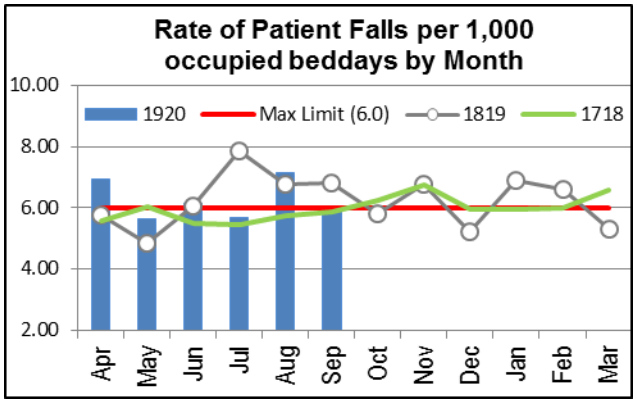
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	8	12	19	27	34	48						
1819	7	16	30	40	50	57	68	80	89	94	102	113

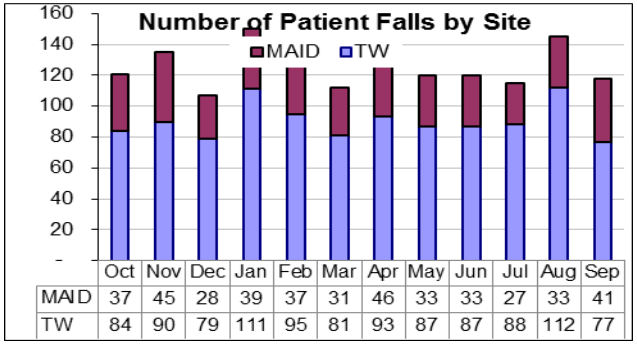
Gram Negative Bacteraemia (E.Coli, Klebsiella, Pseudomonas): The overall level of Gram Negative Bacteraemia blood stream infections remains significantly lower than the levels reported last year. In September there were 11 cases of E.Coli reported (38 YTD) and so far this year there have been 4 cases of Klebsiella and 2 cases of Pseudomonas reported.

Of the 38 cases of E.Coli reported YTD, the biggest proportion remains for patients on the Lord North Ward at Maidstone Hospital with 13 (34%) compared to 6 (9%) for the same period in 2018/19. 4 reported in September 2019/20

Summary:	Actions:	Assurance:
Despite an increase in cases reported in August and September year to date the Trust remains on trajectory for cases of C.difficile. Compliance for MRSA Screening for the Non-Elective Pathway dipped again in September to 92.9%. 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

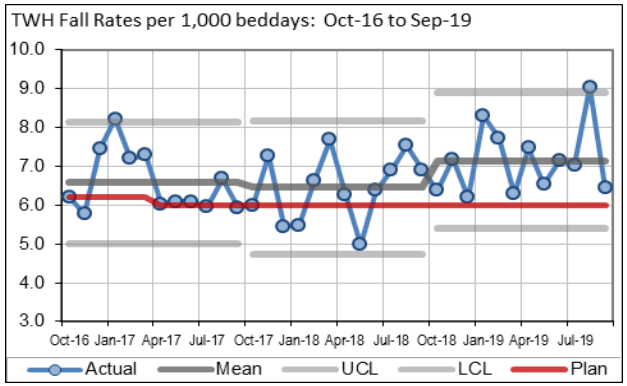
Safe	Harm Free Care	Sep-19





	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
MAID	37	45	28	39	37	31	46	33	33	27	33	41
TW	84	90	79	111	95	81	93	87	87	88	112	77

For September the rate of Falls decreased to 6.44 for Tunbridge Wells. Maidstone increased slightly to 5.13. YTD TWH is 7.3 and MH is 4.6



Severity of Harm 1920	Apr	May	Jun	Jul	Aug	Sep
No Harm	94	92	97	78	119	93
Low Harm	37	21	20	29	19	20
Moderate Harm	6	3	2	3	2	2
Severe Harm	2	4	1	5	5	3
Death	1	-	-	-	-	-
Total	140	120	120	115	145	118

SIs: The number of Falls Serious Incidents declared decreased back to previous levels with 2 declared in September (3 SIs reported for September but 1 declared in October)

Patients with Dementia: Falls for Patients with Dementia decreased slightly in September at 12 compared to 27 (unvalidated) in the previous year. YTD there have been 82 compared to 171.

Harm Free Care: The percentage of Harm Free Care remains above plan

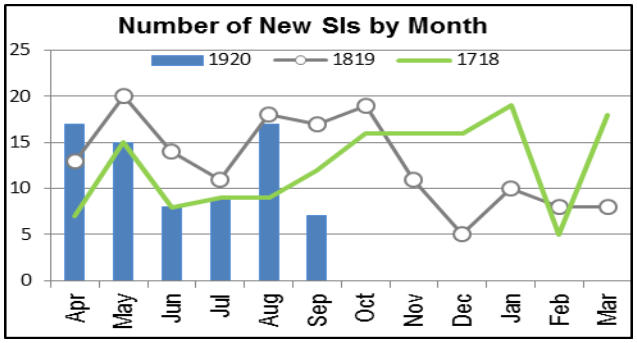
Falls: Following the increase in the number and rate of Falls seen last month this returned to previous levels in September with 118 Falls reported equating to a Rate of 5.91 per 1,000 occupied bed days, therefore achieving the trajectory. The decrease was at the Tunbridge Wells (TWH) site which is the best performance for this site so far this year but remains slightly above trajectory. Maidstone saw a slight increase in September.

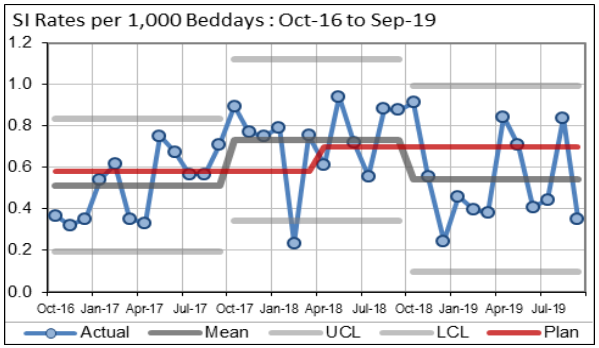
Falls by Division: Falls seen in the Medical and Emergency Care Division decreased in September and the rate of falls for both September and YTD remain lower than the previous year (6.8 compared to 7.3). The rate of Falls for T&O continues to remain high at 8.1 in September (8.4 YTD compared to 6.1 in the previous year).

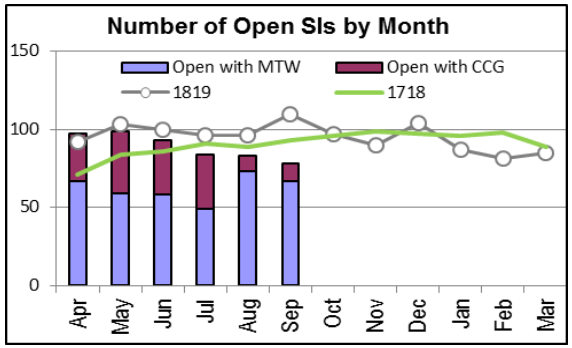
Pressure Ulcers: There were 8 hospital acquired pressure ulcers reported in September. YTD there have been 19 compared to 52 for the same period last year. The average number reported in 1819 per month was 6.

Summary:	Actions:	Assurance:
Following the increase in the number and rate of Falls seen last month this returned to previous levels in September with 118 Falls reported equating to a Rate of 5.91 per 1,000 occupied bed days, therefore achieving the trajectory. The decrease was at the Tunbridge Wells (TWH) site. The number of Falls that caused moderate or severe harm also decreased which resulted in 2 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)	Sep-19

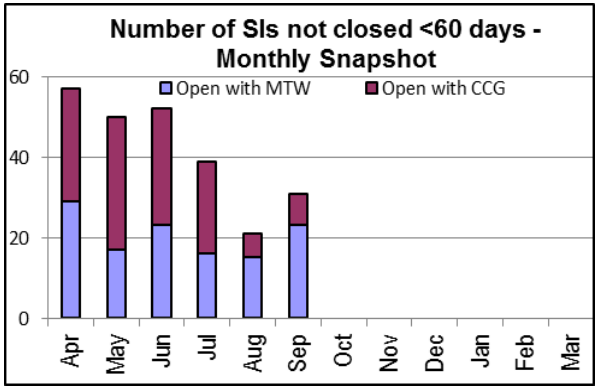






New SIs Category	Apr	May	Jun	Jul	Aug	Sep
Pressure Damage	1	1	-	-	-	-
Falls	3	6	1	3	7	2
Main	12	8	7	6	10	5
Total	16	15	8	9	17	7

SIs: The number of SIs reported decreased in September to 7 which is the lowest number reported so far this year. Of these 2 were related to Falls. YTD there have been 22 SIs reported relating to Falls (31% of the total SIs reported compared to 13 SIs (18%) for the same period last year) .
The rate of SIs reported per 1,000 beddays has decreased to 0.35 which is below the limit of 0.70



Downgraded SIs: In September 2 SIs were downgraded.

The number of SIs open at the end of the month is showing a slightly downward trend to 80 in September 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 was showing a downward trend but increased slightly in September to 31 (23 waiting for MTW and 8 waiting for the CCG). Of the 80 open 67 are waiting for closure by MTW and 13 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 but this is improving.

Summary:	Actions:	Assurance:
The number of SIs reported decreased in September to 7 which is the lowest number reported so far this year. Of these 2 were related to Falls. The number of SIs open at the end of the month is showing a slightly downward trend and remains lower than the previous year. Performance for those being closed within the 60 day target was showing a downward trend but increased slightly in September to 31 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 declaration of SI's. Use of the Governance Gazette to include SI figures month on month, case studies and patient safety alerts. Clinical Governance Objectives and action plan in place to monitor performance and compliance Improvement action plan for Patient Safety performance including improved performance for SI breach dates.	Our Band 2 Governance Assistant joined the team on the 30/09/2019. Our Band 3 Patient Safety Administrator joined the team on the 14/10/19. In addition we have successfully recruited to the Band 7 Deputy Patient Manager and she will join us on the 09/12/2019. Interviews will take place for the two Band 6 SI Investigators on 21/10/2019; if we are able to recruit successfully then the Patient team will be fully resourced.

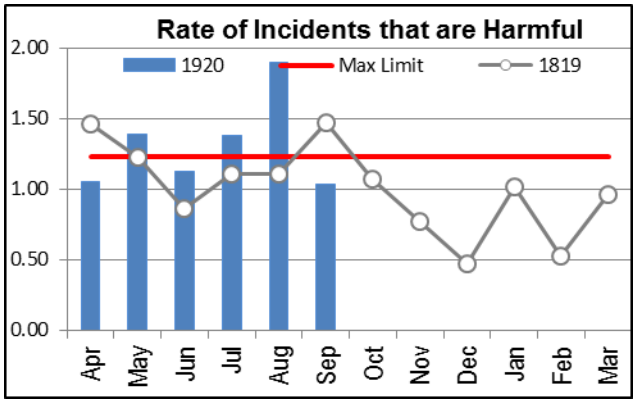
Learning from SIs and Falls Panels

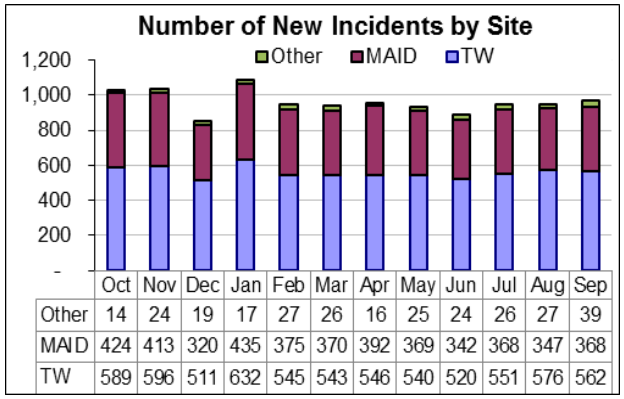
Learning from the Learning and Improvement Committees:

Care/Service Delivery Issue:	Learning:
Organisational improvement in completion of verbal and written format of Duty of Candour (DofC).	Consent procedure and requirements to be adhered in accordance with national guidance
All incident reporting to be Divisional responsibility regarding process and escalation	Datix reports to be reported on system and reviewed and escalated when required.
Consent procedure and requirements to be adhered in accordance with national guidance	Consent Policy to be reviewed - completed

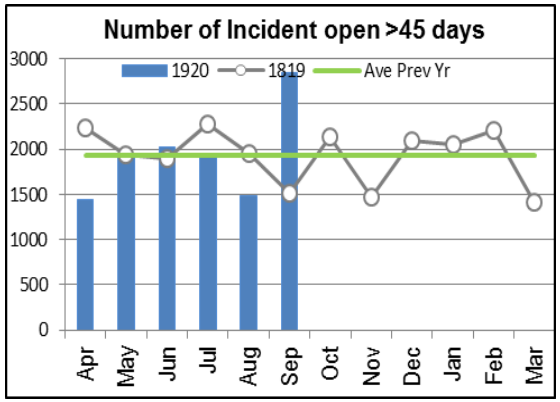
Learning from Falls Panel:	Learning:
Delay in medical team being notified and post fall medical review being undertaken in a timely manner	Post fall action, timely actions from staff to inform doctor of fall and review to be undertaken without delay.
Enhanced care assessment not undertaken for patient with increase restlessness to support decision making for level of monitoring required.	Enhanced care assessment to be carried out to support appropriate level of monitoring to be put in place for patient who become restless.
Patient with increased restlessness at night time moved out of the bay to staff base	Importance to promote sleep at night; avoid moving patient's bed to areas of light and noise (out of bay and next to staff base). Consider having staff in the bay instead.
Delay in medical team being notified and post fall medical review being undertaken in a timely manner	Post fall action, timely actions from staff to inform doctor of fall and review to be undertaken without delay.
Enhanced care assessment not undertaken for patient with increase restlessness to support decision making for level of monitoring required.	Enhanced care assessment to be carried out to support appropriate level of monitoring to be put in place for patient who become restless.

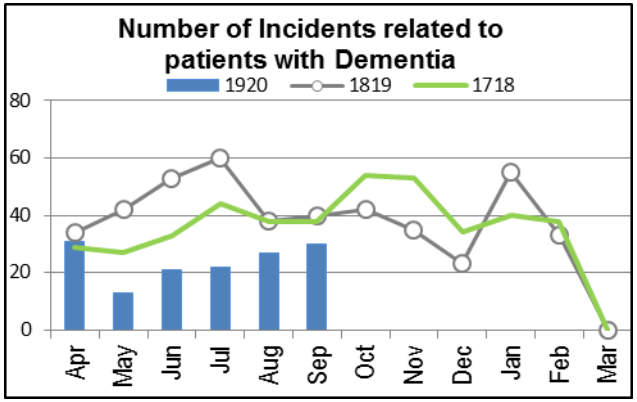
Safe	Incidents	Sep-19



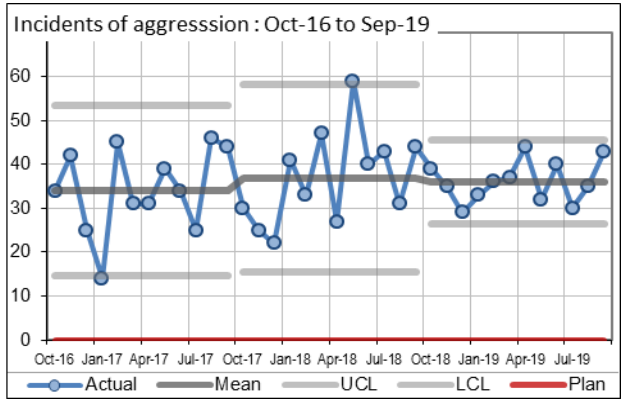


	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Other	14	24	19	17	27	26	16	25	24	26	27	39
MAID	424	413	320	435	375	370	392	369	342	368	347	368
TW	589	596	511	632	545	543	546	540	520	551	576	562





Incidents related to patients with Dementia increased in September but remain lower than last year.



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

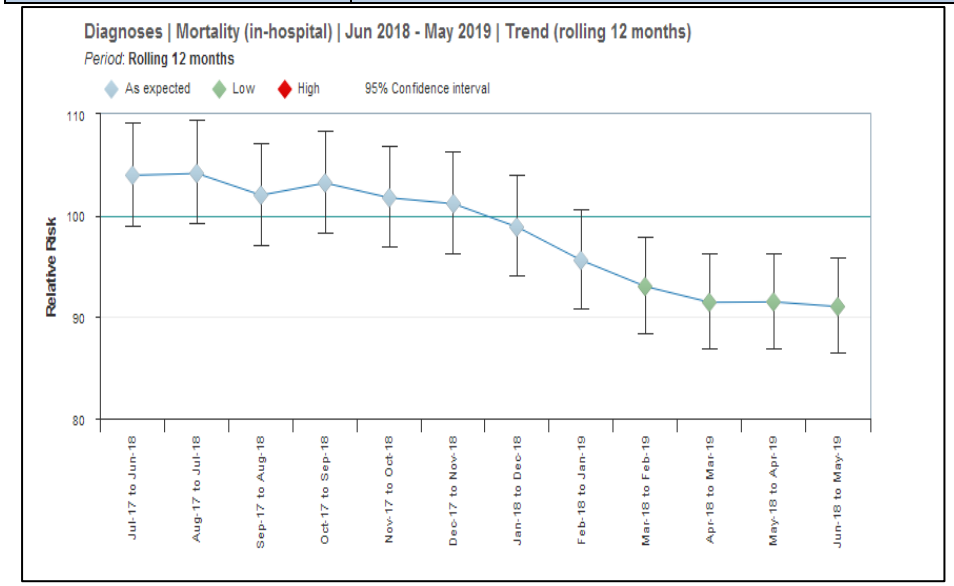
The number of incidents open for more than 45 days has significantly increased in September to 2844 which is over doubled since last month.

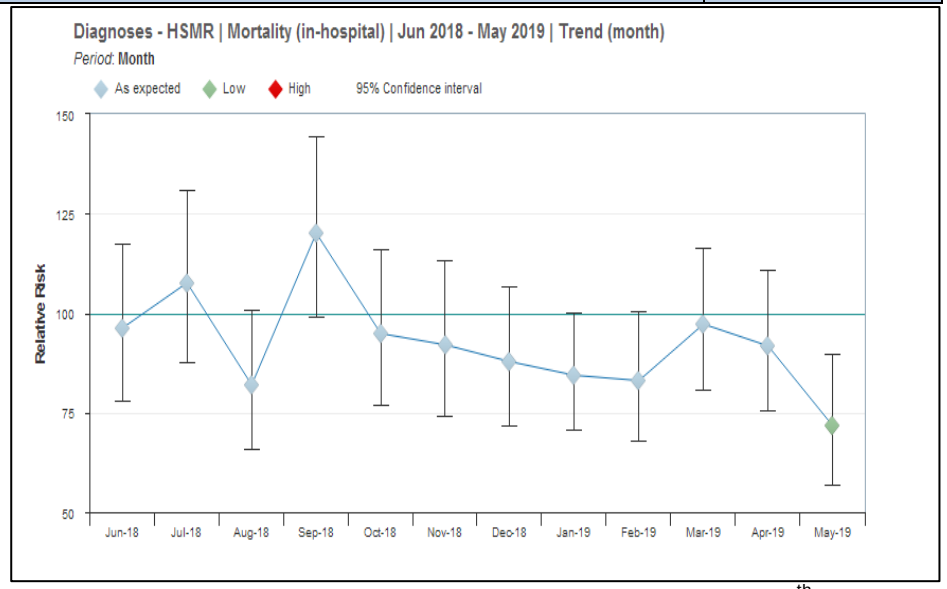
Incidents that are Severely Harmful: The rate of incidents that were severely harmful reduced back to previous levels in September (due to the decrease in Falls SIs) to 1.03 which is below the limit of 1.23.

Incidents of Abuse towards Staff: Incidents increased in September to 35 which is 81% of all incidents of aggression reported (43 in September). Similar to the average last year.

Summary:	Actions:	Assurance:
The rate of incidents that were severely harmful reduced back to previous levels in September (due to the decrease in Falls SIs) to 1.03 which is below the limit of 1.23. The number of incidents open for more than 45 days has significantly increased in September to 2844 which is over doubled since last month.	The monthly reports that are sent to the Directorates contain the number of open incidents and include the caveat that this must be reviewed and closed in a timely fashion. An improvement trajectory has been included within the Patient Safety Action plan. A “kick-off” meeting with Datix is yet to be organised. With the additional resource in the Patient Safety team; more hours will be allocated to the review and closure of incidents.	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 are overseen at Health & Safety Committee. The Patient Safety Manager attends CG Meetings. The Interim Datix Project Manager is facilitating ward based sessions to support with the closure of incidents

Effective	Mortality	Sep-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).

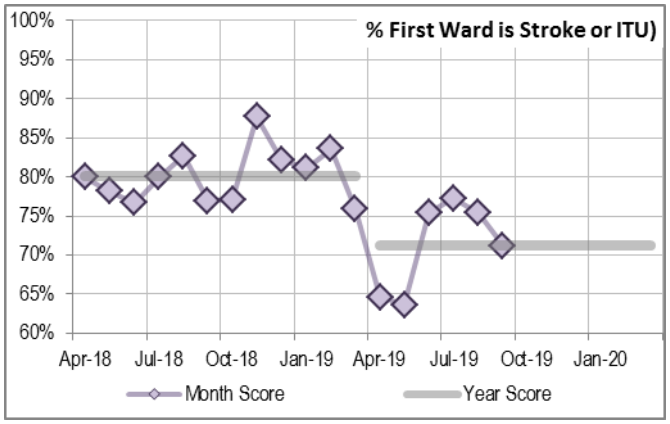
The Learning from Deaths working group was disbanded on the 11th September as its purpose and initial objectives have been delivered. Two new objectives remain, these include : –

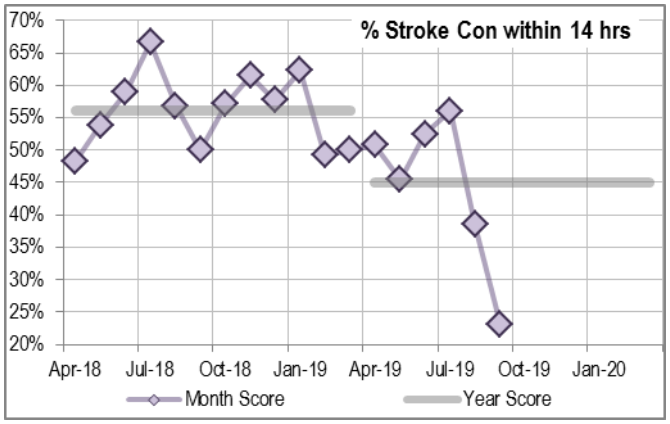
- The introduction of a Mortality Database, this is now being overseen by the Datix Implementation Working Group
- The introduction of the Medical Examiner and Medical Examiner officers role, this is now being overseen by the Medical Examiner Process implementation Working group.

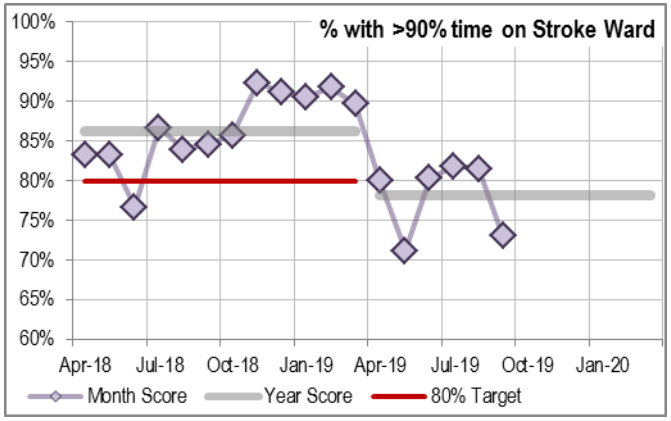
NB: There is a technical issue with Dr Foster therefore the September data is currently not available.

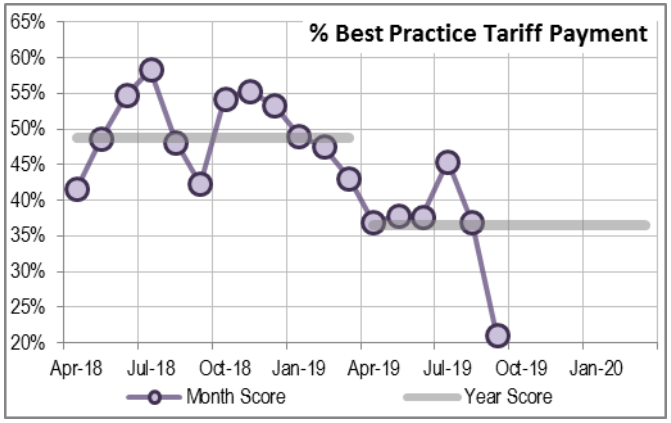
Summary:	Actions:	Summary:
The Risk Adjusted Hospital Standardised Mortality Rate (HSMR) and SHMI are both within acceptable limits and the Trust is no longer an outlier. The HSMR has been below 100 for the last three reporting periods. HSMR: Jun-18 – May-19 91.5 (86.4 – 96.8) SHMI: May 2018 - April 2019 103.63 (88.69 - 112.76)	**Mortality Review Audit –** 6 monthly review audit took place on the 4th October **Amber Care Bundle –** presentation at MSG to encourage its use for those critically ill patients and to promote having those 'difficult conversations' with patients and their families so that they are prepared for the worst potential outcome.	**Medical Examiner working group –** continues to meet on a monthly basis. JD's for both the ME and MEO roles are in the process of being finalised. Discussions with the Regional Medical Examiner and Lead Coroner for Kent & Medway are taking place to ensure that the proposed plans for MTW are in keeping with the National views.

Effective	Stroke Best Practice Indicators	Sep-19









There are now three main stroke indicators that constitute Stroke Best Practice. Last year, 823 patients came under this scheme. This year we are 7% under YTD, but the difference is not yet statistically significant.

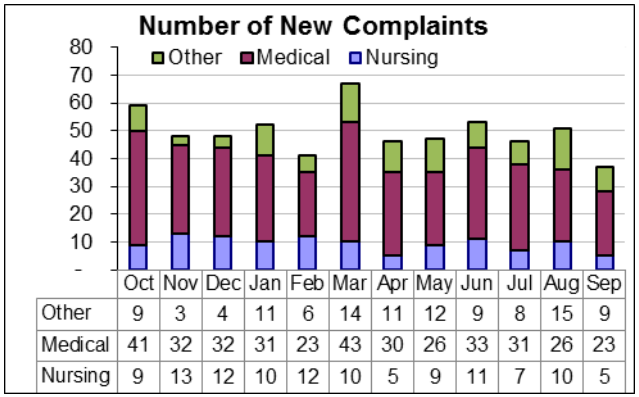
First Ward must be a stroke ward or ITU. Last year averaged 80.2%, but this year has dropped to 71.2% so far. Currently a lot of patients go to CDU first, and that is clinically appropriate until the Hyper Acute Stroke Unit comes online next year.

Stroke Consultant within 14 hrs. 2018/19 ran at 56.1%, but Sept has decreased to 23.1%. YTD we are 45.1%

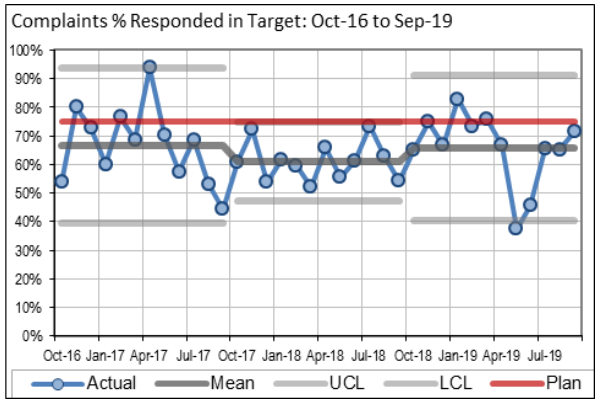
90% of Spell on Stroke Ward. This metric is now slightly different. The qualification is on HRG rather than Diagnosis code, the time is calculated in minutes rather than overnights, and we are no longer able to discount time spent in the Discharge Lounge. 2018/19 was 86.2%, but this year we are at 78.1%. 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 36.5% so far this year.

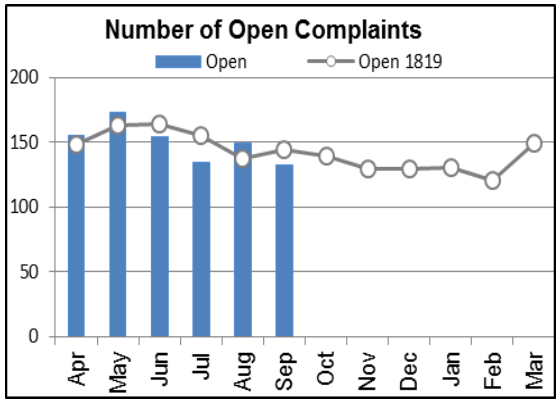
Summary:	Actions:	Assurance:
There are now three main stroke indicators that constitute Stroke Best Practice. a) admitted direct to a stroke or intensive treatment ward, b) See a stroke consultant within 14 hours of arrival or their stroke if that happens on-site, c) Spend 90% of their spell on a stroke ward. 36.5% of patients this year have qualified by meeting all three indicators. All three components are returning worse scores than last year.	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.

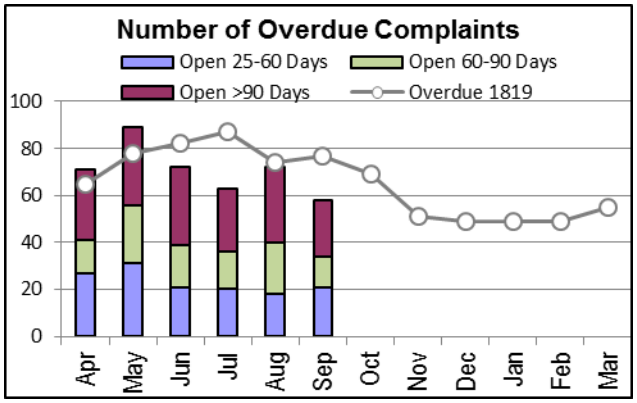
Caring	Complaints	Sep-19



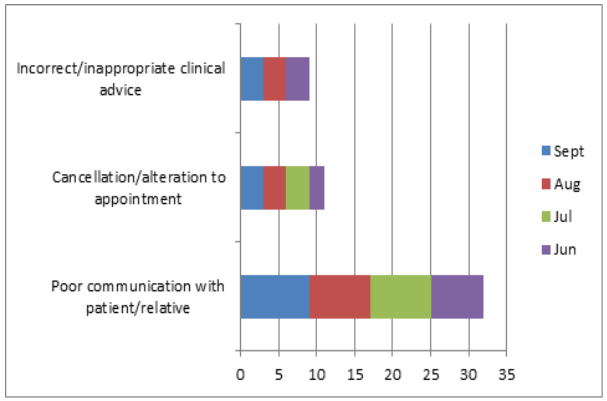
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Other	9	3	4	11	6	14	11	12	9	8	15	9
Medical	41	32	32	31	23	43	30	26	33	31	26	23
Nursing	9	13	12	10	12	10	5	9	11	7	10	5







Overdue complaints have decreased in September to 58, below the average of 65 last year. The decrease was broadly split between those open 60-90 days and >90 days.



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

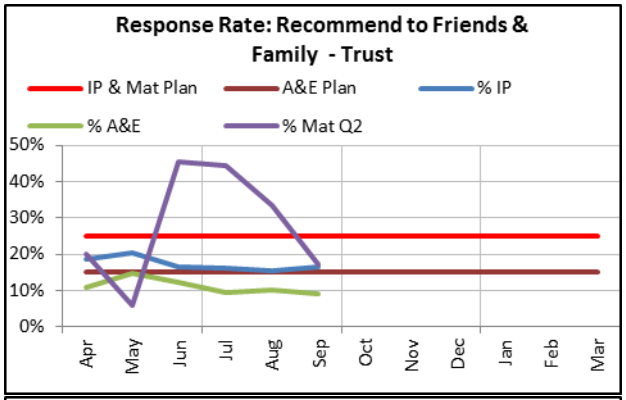
Open Complaints: The number of open complaints decreased in September. Of the 132 complaints currently open, the largest proportion is in both the Medical and Surgical Divisions, with the biggest increase being in T&O and Oncology. Of the complaints open more than 90 days, 8 have been open for more than 6 months (increase of 2 from last month)

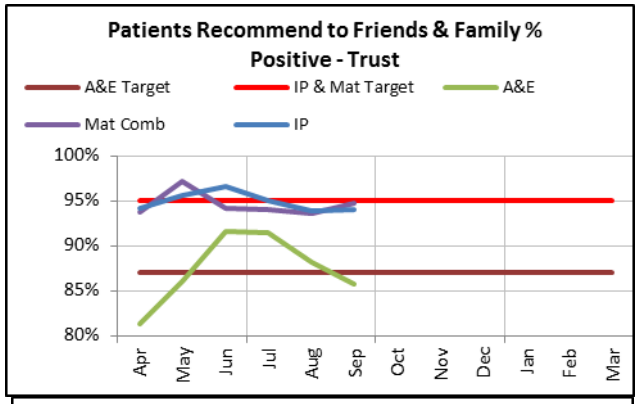
Themes of Complaints: The subject of complaints with the highest number remains poor communication with patients/relative, but numbers are decreasing month on month. Complaints about cancellations/alterations of appointments show a reducing trend, but features frequently in PALS concerns.

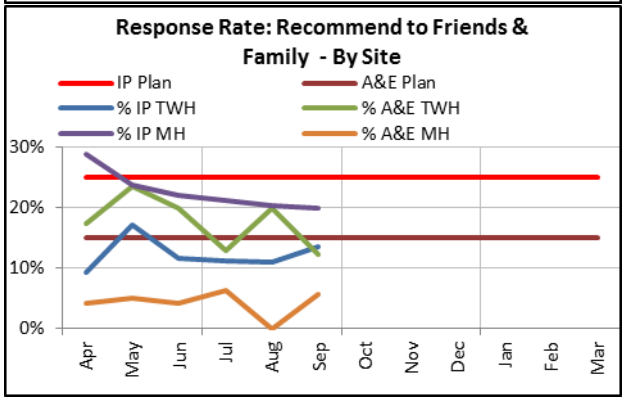
There were 22 compliments recorded in August, however not all compliments get recorded centrally.

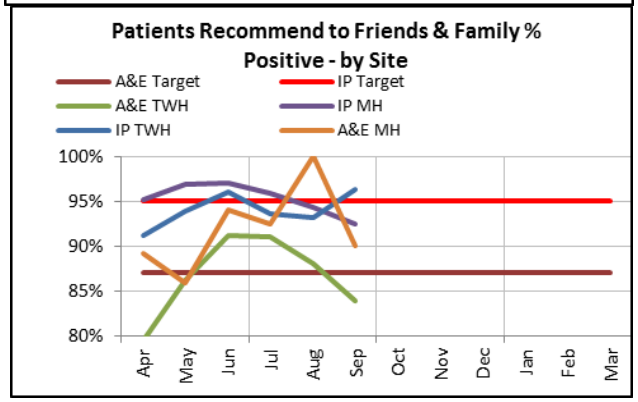
Summary:	Actions:	Assurance:
Performance increased to 71.4% in September but remains below the 75% target. YTD performance is 58.8%. Divisional performance increased to 88.1% for September and is at 80.1% YTD which is above the 75% target.	Interviews for Deputy Complaints and PALS Manager scheduled for 15 October Prospective weekly reports sent to all directorates to support achievement of response target.	Continued regular monitoring of all open complaints with reports to CN. Focused work with directorates to clear the complaints open over 6 months Learning published in the Governance Gazette.

Caring	Friends and Family Survey (FFT)	Sep-19









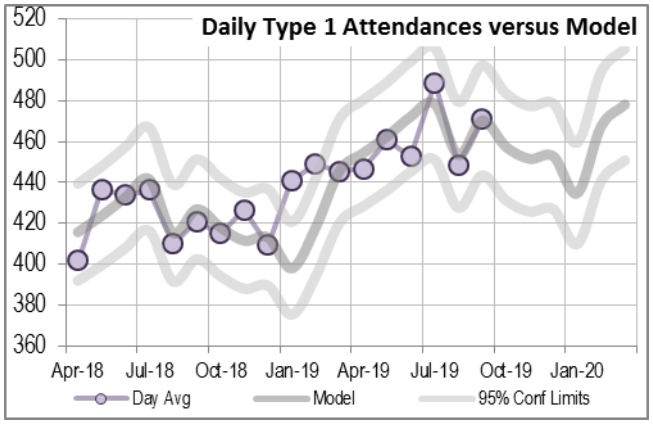
FFT Response Rates: There continues to be fluctuating consistency in the response rates with three of the four areas showing a reduction in the September response numbers. IP Response Rate increased by 1.2% but remains below target.

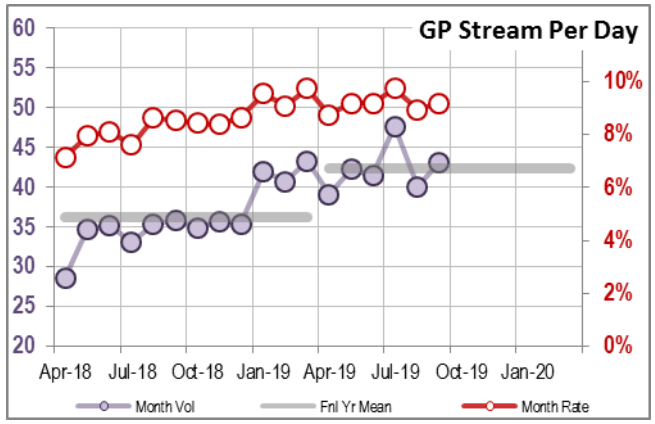
FFT By Site/Ward: The response rate for A&E continues to remain significantly lower at the Maidstone site (MH) and the response rate for Inpatients (IP) continues to remain lower at the Tunbridge Wells site (TWH)

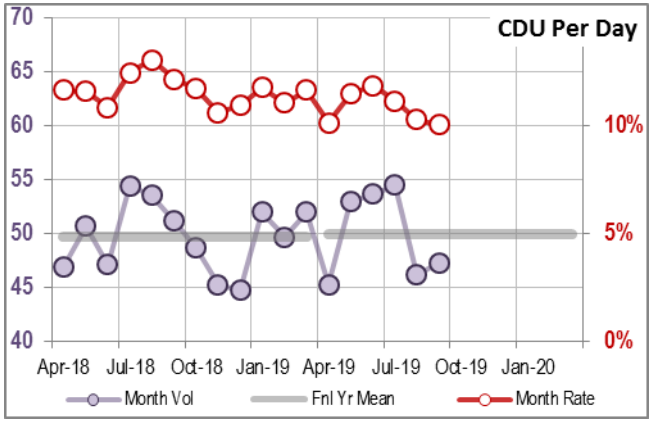
FFT Percentage Positive: The Friends and Family Test satisfaction rates have dipped below target for inpatients for September and YTD at 94.9% (MH is above target at 95.4% but TWH is below target at 94.2% YTD. Maternity performance for Q2 only (birthplace) has improved further in September but remains below plan YTD at 94.2%. The positive feedback rates for A&E remain above the national target across both sites so far during 19/20 despite a slight decrease in September. The positive feedback rate for OP decreased back to previous levels in September and remains slightly below target YTD.

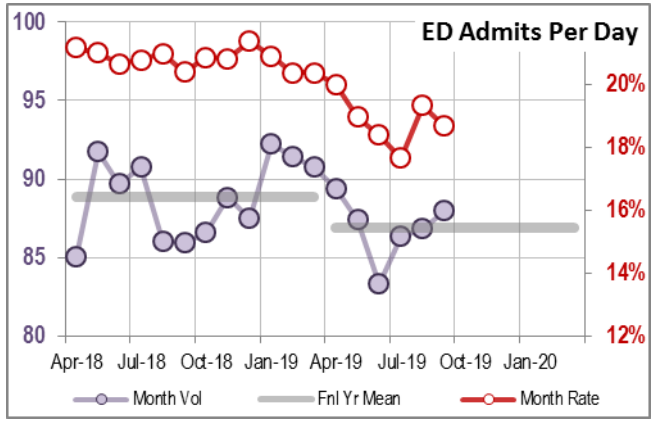
Summary:	Actions:	Assurance:
Response rates for September decreasd slightly for all areas with the exception of IP which saw a small increase (1.2%). We continue to see fluctuation in the maternity response rates. For the % positive,there was a slight increase for both Inpatients and Maternity in September, however all areas remain below target YTD with the exception of A&E.	Current contract ended with IWGC 30 September 2019. Implementation meetings with new provider IQVIA have continued on a regular basis in preparedenss for the transition for go live date. New survey cards approved with a decision to tranistion in a “like for like” service to minimise disruption in the first instance. Additional services now added who will be undertaking FFT with new provider. WeBex demonstration of new system provided and additional session will be arranged during go live.	Tranistion to new provider took place on the 30 September 2019. Surveys printed and received in Trust with procurement department leading on distribution. Trust wide communication informing FFT transition to new provider. Process for collection remains unchanged to minimise any disruption to service Additional Wewbex sessions available. IQVIA to attend Trust for “walkbout “ to all areas undertaking FFT now scheduled

Responsive	Non-Elective Flow: Into Hospital	Sep-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 7.6% increase on that for 2019/20

September was almost exactly as expected at 470.3 per day. This represents the 2nd busiest month ever

GP Stream: This averaged 36.3 per day (8.5% of arrivals) through 2018/19. So far this year it's 42.3 (9.2% of arrivals). A max of 66 slots are available per day across sites.

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 50.0 per day and 10.8% of attendances.

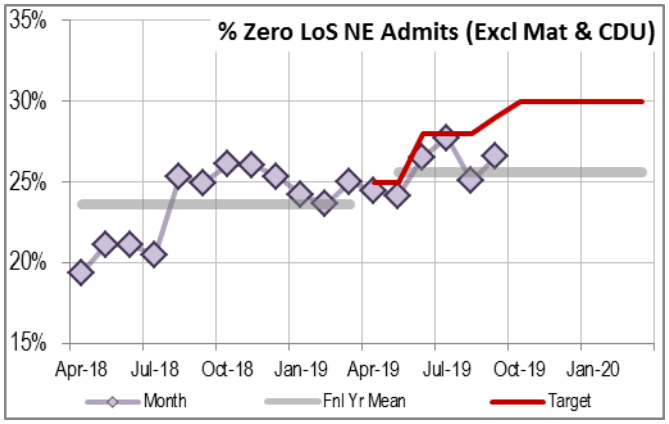
These patients are classed as NE admissions, but don't actually leave the ED, don't occupy a general or acute bed.

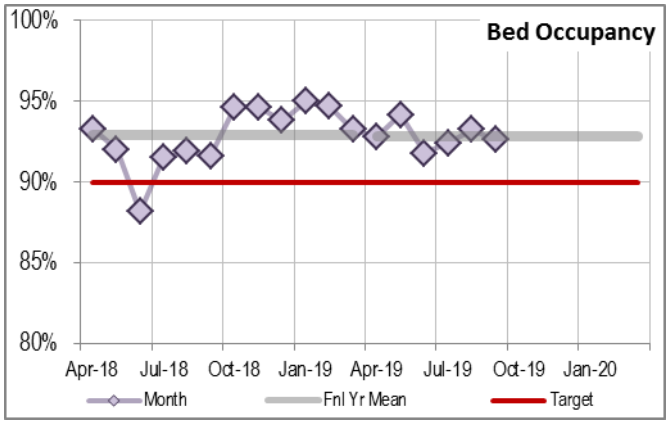
ED admits per day: This counts all patients leaving the Emergency Department to go into the main hospital. CDU patients only count here if they are transferred to another ward.

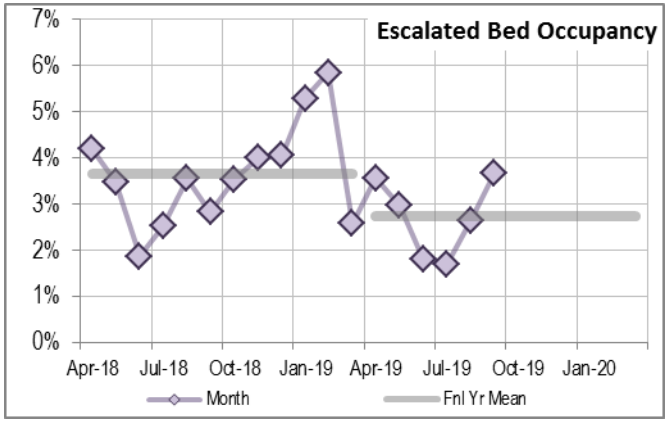
2018/19 averaged 88.9 per day. Or 20.8% of attendances. This year we average 86.9 against much higher attendances, so the percentage is now 18.9%.

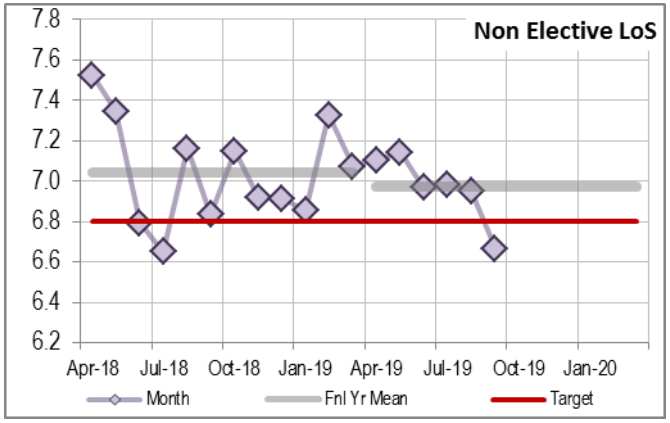
Summary:	Actions:	Assurance:
Type 1 attendances are currently showing an annualised growth of 8.75%. September was the 2nd busiest month ever. YTD, 9.2% of arrivals are streamed to GP, 61.2% are treated in ED, 10.8% are admitted to CDU but no further and 18.9% are admitted beyond CDU.	Weekend services now in place for AEC and Frailty through temporary cover at non consultant level, supported by GIM consultant rota. Improving processes for both AEC to increase referrals. Ambulance handover plan in place which will also support at the front door during times of increased pressure. Discussion system wide to support flow. Development of 10 weeks to Christmas to improve flow and hence the ED picture. Increase AEC on Maidstone site by improving referral process. Increase frailty services and AEC to 7 days a week.	Continued focus on daily management of capacity and patient flow. Work continuing to ensure all departments within Trust feel a part of the 4Hour Access Standard – Breach Bag concept embedded in ED and Ops Room, now rolled out to assessment units and IDT. Increased profile on ambulance handovers. Focused bed meetings on actions. Multi-professional Huddle embedded daily at 08.30

Responsive	Non-Elective Flow: Bed Management	Sep-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, 26.6% in September. Excludes clinical decision (CDU) only patients & Maternity. CDU patients are not generally receiving treatment.

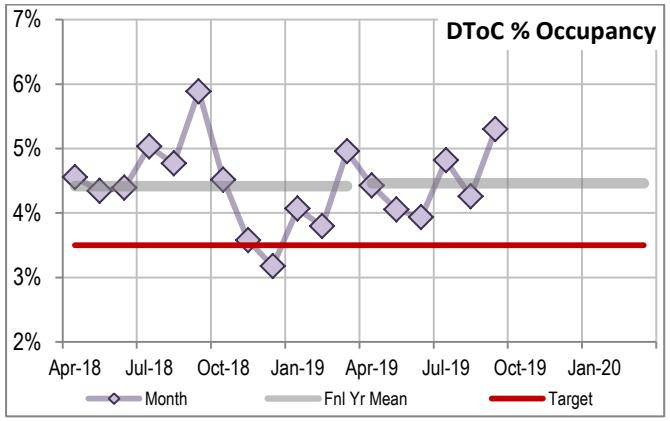
Bed occupancy averaged 92.9% last year (based on the 7am bed census). So far this year it's almost exactly the same. Bed occupancy tends to hit a minimum in late Spring / early Summer, but this has not happened this year. Many of the beds flagged as available on this census are paediatric, ITU or specialist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

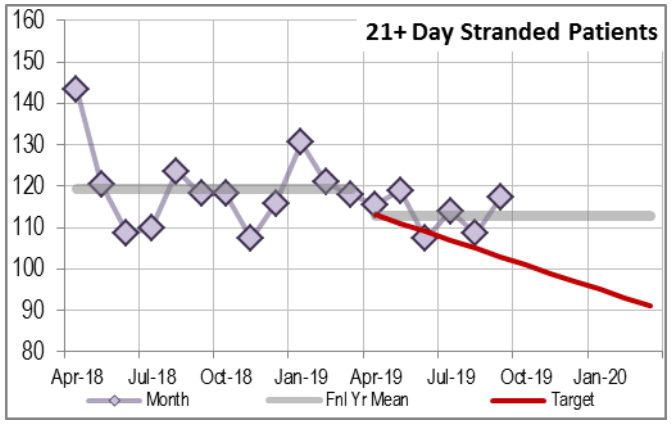
Escalated Bed Occupancy. Last year, escalated beds were an average of 3.6% of our total occupancy, rising to 5.8% in Feb-19. So far this year, we are at 2.7%, which is an improvement on last year. Sep was 3.7%

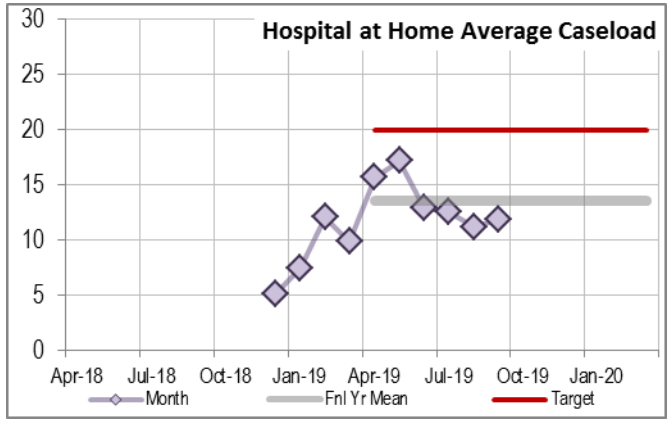
Non Elective Length of Stay (LoS) is something the Trust is actively trying to reduce, as it feeds directly into bed occupancy. Last year the Trust averaged 7.05 days. This year so far it's marginally lower at 6.97, but this difference is too low to be statistically significant.

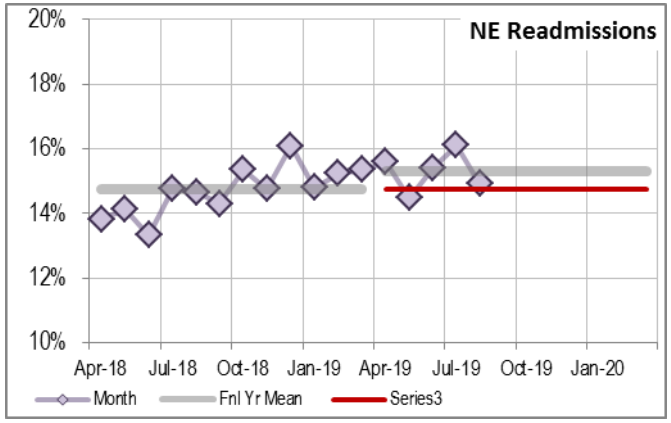
Summary:	Actions:	Assurance:
26.6% of all Non-elective (NE) admissions are now zero LoS (not counting CDU patients). Bed occupancy is consistently between 92% and 95%, but escalated beds are a significant improvement on the same period last year. Non-Elective length of stay (LoS) is marginally lower than last year at 6.97	LOS: Review of the LOS project has begun, with increased efficiency on Criteria Led Discharge, Discharge Lounge and SAFER training of overseas and new starter nurses. Continue to use Clinical Utilisation Review (CUR) to identify delays in flow, including red and green days. NOF project has had a soft launch, with 5 patients going to TCH for rehabilitation.	LOS reporting: % of non-elective take seen with 0 LOS Aug: 21.2, Sept: 24.6 Surgical 0 LOS Percent of Take: Aug: 38, Sept : 39.3 Non elective LOS in Medicine: Aug: 7.6 Sept 6.9.

Responsive	Non-Elective Flow: Out of Hospital	Sep-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 4.46% so far this year. September has spiked at 5.30%

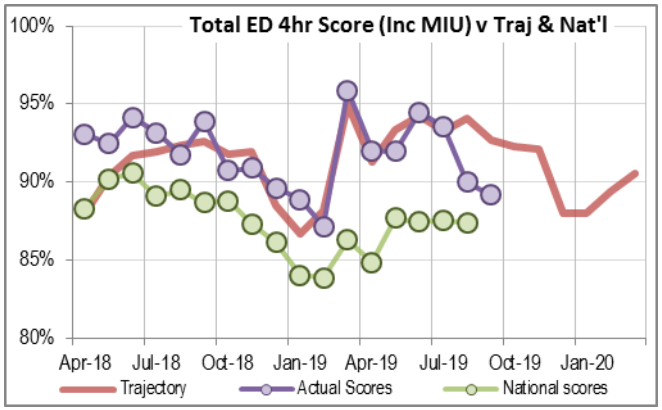
Stranded patients is a daily snapshot of the number of patients with a current LoS of 21 days or over. Last year, this averaged 119.5 patients. So far this year, we are at 113.5, and Sep was 117.3

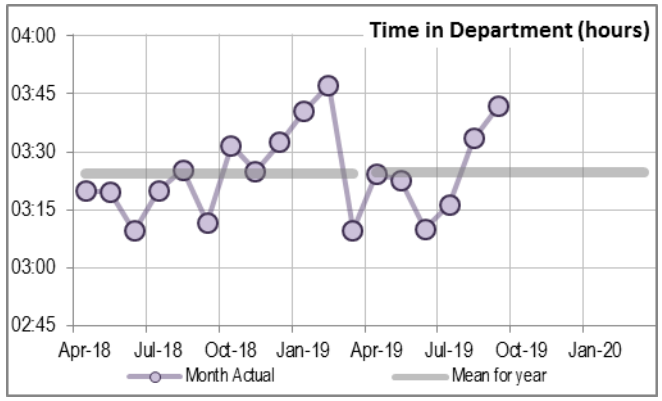
Hospital at Home is an average of the daily snapshot of patients on the H@H scheme. The intention is to run at around 20 patients. Every patient on the scheme effectively frees up a bed. This year we average 13.6, and Sep was 11.9

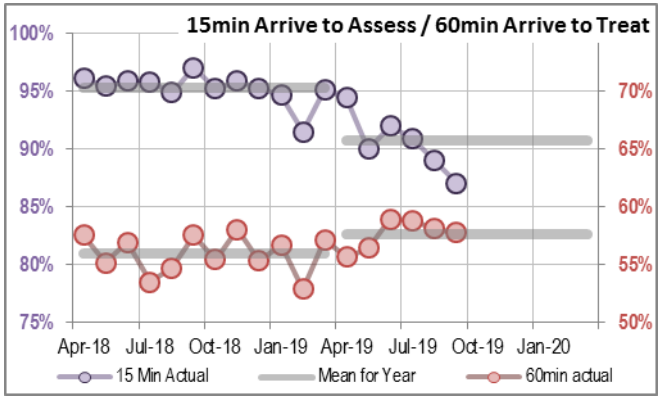
NE Readmissions. Averaged 14.7% in 2018/19, rising steadily through the year. This year's rate (to 31-Aug) is 15.3%. The latest month is generally prone to slight (~0.2%) undercounting. This is the official 30 day Readmission key performance indicator, with cancer and Mental Health patients excluded
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

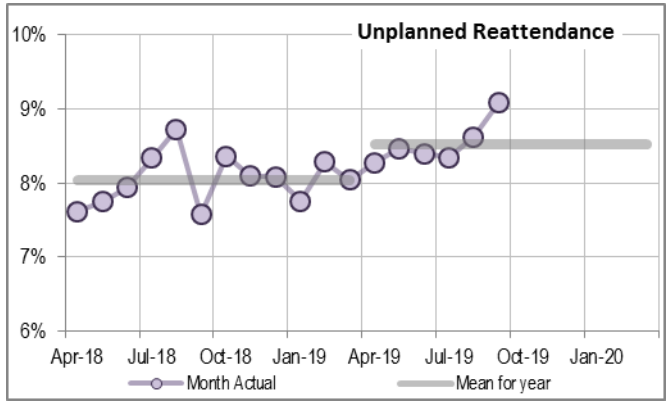
Summary:	Actions:	Assurance:
DToC had been coming down over time, but increased in September due to a reduction in exit pathways, especially POC. Stranded patient's average is 113.5 so far this year compared to 119.5 last year, and the Hospital at Home scheme has effectively freed up 10-20 beds. Readmissions continues to rise, and is 15.3% 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+. Medical input commenced 10/19 DTOC rose due to lack of POC and EMI care homes 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 escalation plan in place for winter	- Daily sign off of Delayed transfer of Care at team leader level - Daily review of 21+ numbers - Long length of stay walk-arounds on 'long stay Tuesday' initiative. Escalation call to execs on Thursday morning to highlight issues Discussion with social services for escalation plan for HILTON to 60 places for winter period

Responsive	A&E Performance Indicators	Sep-19









4 Hr Time in Department: Performance dropped again in September, coming in at 89.20% against an agreed trajectory of 92.70%. Unlike August where most of the problem was at Maidstone, this month, both sites struggled.

Total Time in Department averaged $3^{h}24^{m}$ for Type 1 attendances through 2018/19. YTD the Trust is back at $3^{h}24^{m}$.and Sep was $3^{h}41^{m}$

15 minute arrival to assessment performance was 95.35% for 2018/19, but is averaging 90.73% so far this year

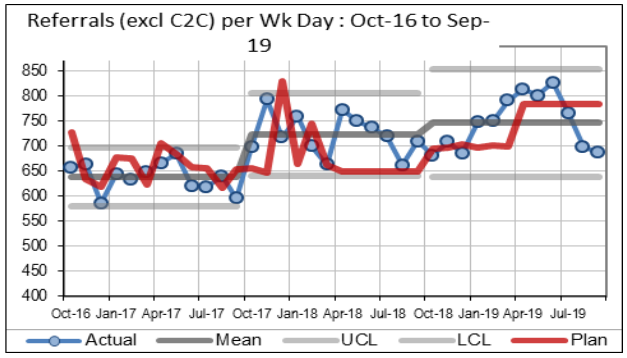
60 minute time to treatment averaged 55.89% for 2018/19, and are slightly higher this year at 57.62%

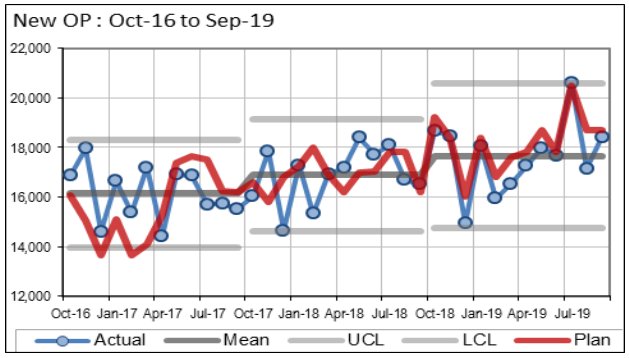
Unplanned re-attendance rate is a second unplanned visit, arriving less than 168 hours since the last attendance conclusion. This averaged 8.04% in 2018/19, and is 8.53% so far this year. Sep has spiked at 9.08%

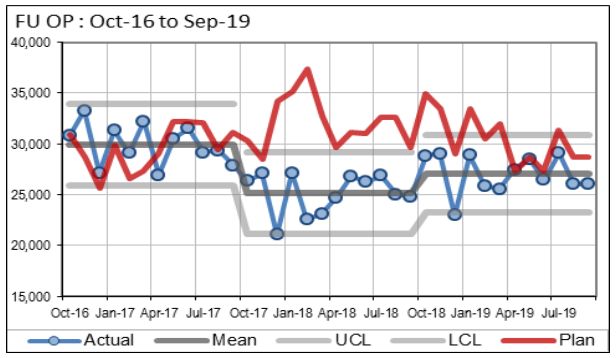
Ambulance Handovers: Last year, 9.6% of ambulances were delayed 30-60 mins, and 1.5% were delayed > 60. This year so far it's 12.5% delayed 30-60 mins and 1.3% >60. September spiked at 13.9%

Summary:	Actions:	Assurance:
Performance was 3.5 percentage points below target in September. YTD, the average Time in Department is now the same as last year at 3h24m, 15 min pass rate is down to 90.73%, 60min pass rate is improved at 57.6%, and unplanned re-attendance rate is up significantly at 8.52%.	Continue to recruit a substantive workforce for the Emergency Departments. Identification of staff to support "hello" nurse on ongoing trial. Development of plan to support additional consultant sessions within Rapid Access Physiotherapy. Agreement to develop 7 bed Rapid Access Physiotherapy at Maidstone by Feb 2020 from Executives. 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	Sep-19







Referrals: The level of Referrals (excluding Cons to Cons Referrals) decreased in September to 687 per working day. This compares to 710 per working day in September 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 September will increase. At the time of reporting last month referrals for September were 667 per working day but this has now increased by 43 to 710 per working day (+ 6%). Referrals are 2.4% below plan YTD. The level of referrals will need to be closely monitored over time to see if there is a decrease in demand.

There has been a 1% increase in Consultant to Consultant referrals YTD compared to the previous year.

New outpatient activity: Following the dip in Activity seen in August activity increased by 7% in September to above the average but remained 1.4% below plan in September and is 2.7% below plan YTD. Activity increased by an average of 61 per working day compared to August and was 52 per working day higher than September last year. Activity from July onwards 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 an increase in activity in September per working day compared to August except for Gynaecology, Breast Surgery and Care of the Elderly. Paediatrics saw a 22% increase, Ophthalmology saw a 19% increase, Gastroenterology saw a 16% increase and Rheumatology saw a 15% increase.

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 10% below plan YTD

New Outpatient Activity by Specialty: The specialties furthest from plan YTD remain ENT (-24.5%), Gastroenterology (-25.6%), Ophthalmology (-16.5%, Cardiology (-12%) and T&O (-11.2%) which is directly impacting on their achievement of their non-admitted RTT Trajectories. Despite the decrease in activity in September Gynaecology remains 14.4% above plan YTD.

OP Follow Up Activity:

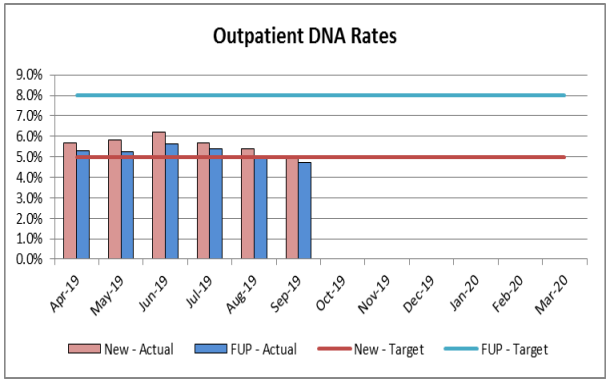
Follow up activity remained similar in September (the number per working day was 3 higher than August and September last year). Activity remains below the average. Activity was 8.9% below plan in September and 4.9% below plan YTD. As with the New OP Activity ENT and Urology are furthest from plan

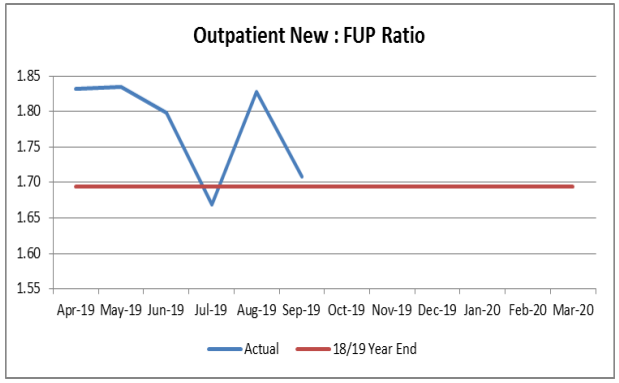
The key issues that contribute to lower than planned New Outpatient work remain:

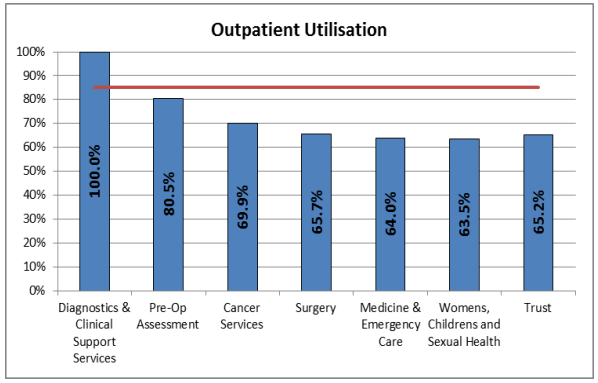
Ophthalmology is below the activity plan which is being investigated.

Summary:	Actions:	Assurance:
Referrals are 2.4% 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 2.7% below plan YTD. However, for the main RTT Specialties this is 10% 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) went live on 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 have been scheduled. Yearly trends review and weekly monitoring has been implemented to understand the decrease.

Responsive	Elective Flow – Outpatient Efficiency	Sep-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 5.6% with September reducing to 4.9%. Diabetes & Thoracic Medicine saw an increase in their Sep-19 DNA Rate; 14.7% & 10.5% retrospectively. There has been a significant improvement within Dietetics & Vascular Surgery.

FUP DNA Rate: The Sep-19 FUP DNA Rate has reduced to 4.7% after increasing to 5.6% in Jun-19, with a YTD position of 5.2%; the reduction has been driven by an improvement in General Medicine (1.3%) & Gynae Oncology (2.8%). As a Trust we remain below the 8% target.

New:FUP: The New:FUP rate is steadily improving, with Sep-19 reducing to 1.71 from 1.83 in Aug-19. The YTD New:FUP ratio for the Trust is 1.78.

Cancellations <6weeks of Outpatient Appointment: The cancellation of appointments <6weeks continues to be an issue at 15.5% YTD compared to a target of 8% with the majority of specialties higher than the target.

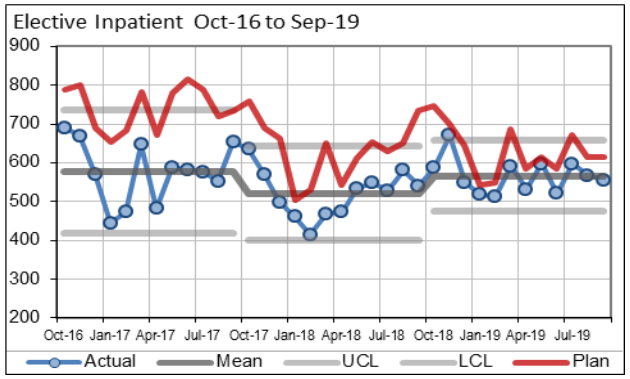
ERS Slot Unavailability: The ERS Unavailable Slot %age remained high in Aug-19 (this runs 1 month behind) at 20.4%. There is a particular issue in T&O (13.8%), ENT (16.4%), Medical specialties (19.9%) and Gynaecology (41.9%).

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 73.8% & Urology/Gynae Onc/Breast/Vasc Surgery has the lowest at 49.7%. There are still a considerable amount of uncashed up appointments in August & September (544, 1156 retrospectively) which will affect the utilisation. YTD utilisation is 65.2%.

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 20.4% in August.	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.

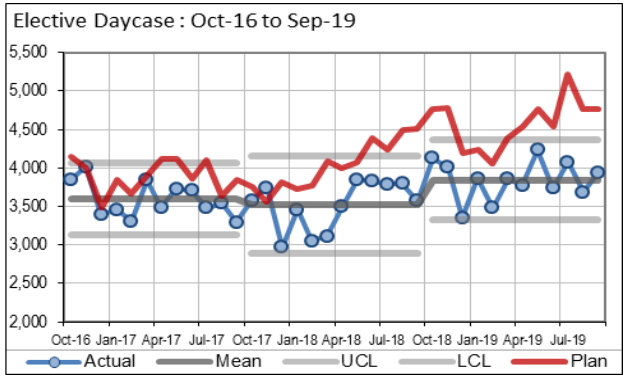
Responsive	Elective Flow – Inpatient Activity	Sep-19



Inpatient activity was 9.6% below plan in September & YTD is 8.6% below plan. This was a further 2% decrease in activity compared to August. Activity per working day in September was almost exactly the same as August and as September last year.

T&O is 33.2% below plan YTD. Gynaecology & Ophthalmology remain 28% below plan YTD, Paediatrics and 32% below plan and Urology is 20% below plan YTD. Cardiology & ENT are 17.6% & 6.8% 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 onwards but these are relatively small numbers.



Daycase Activity was 5.2% below plan in September and 5.8% below plan YTD. Activity increased in September as the number per working day was 12 higher than in August and 9 higher than September last year.

Gynaecology saw a 28% increase in day case activity in September compared to August.

Virtually all specialties saw an increase in their September activity compared to August except for Urology, Paediatrics and Care of the Elderly.

YTD T&O is 46% below plan, Ophthalmology is 28.7% below plan, Urology is 26.6% below plan, Gynaecology is 17% below plan and ENT is 16.1% below plan. Surgery is now 1.7% above plan YTD.

Total Elective Activity (IP and DC Combined):
Overall activity was 5.7% below plan in September & is 6.2% below plan YTD. Activity increased in September by an average of 12 cases per working day compared to August.

T&O activity remains 41% below plan & Ophthalmology is 29% below plan YTD.

Surgery is now on plan YTD. Gynaecology remains 21% below plan, Urology is 24% below plan, Cardiology is 21% below plan and ENT is 13% below plan.

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

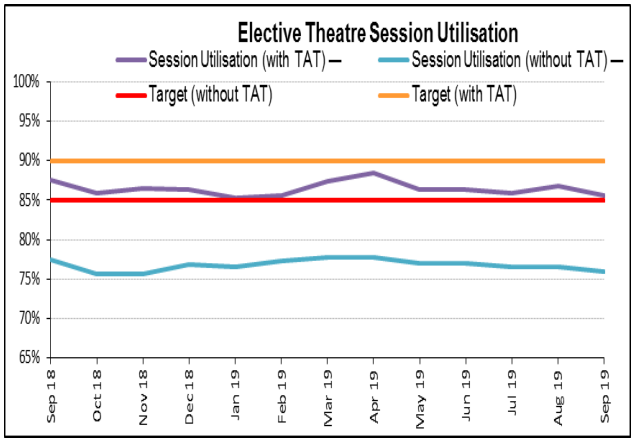
Key vacancies in consultant and trainee posts in a variety of specialties (Neurology & Endocrinology) Capacity issues in Ophthalmology.

The T&O efficiency plan commenced 15/08/19 and the Ophthalmology plan has been implemented and is progressing well.

The prime provider model activity is being closely monitored in order to assess if the data is being recorded accurately so that trends and activity numbers can be monitored.

Summary:	Actions:	Assurance:
Overall activity increased by around 12 cases per working day in September compared to August and is 6.2% below plan YTD (DC is 5.8% below plan and IP are 8.6% 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 within planned care.

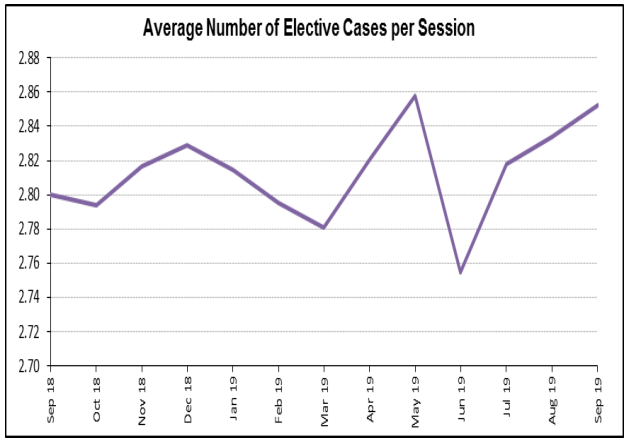
Responsive	Elective Flow – Inpatient Efficiency	Sep-19



Utilisation with TAT has dropped slightly to 85.7% from 86.9%.

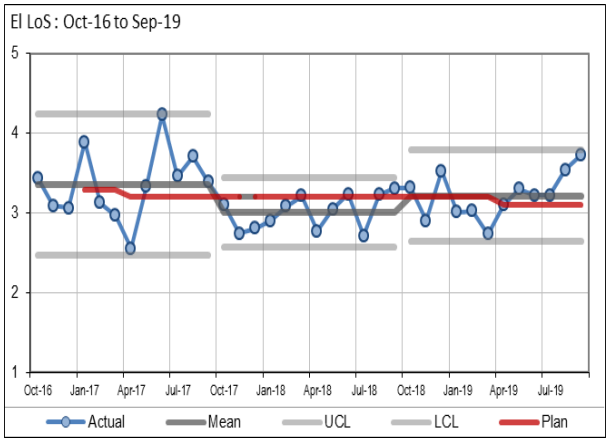
The number of elective theatre sessions that started within 15 minutes of the planned start time remained constant at 37%.

The rate of last minute reportable cancellations remains below the 0.8% maximum limit at 0.6% YTD. There have been 13 patients not re-scheduled within 28 days YTD.



There was an increase in theatre activity in Sep-19 (1637 operations) with 109 more operations being completed compared to Aug-19. The increase was predominantly in Ophthalmology (87 more operations).

The activity equated to 78 elective cases per working day, an increase from 73.9 in Aug-19.

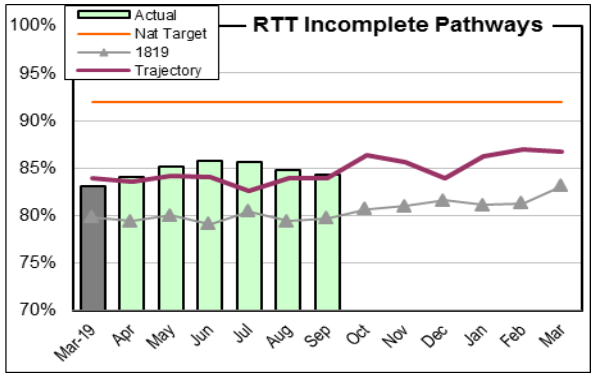


The Elective LOS has increased in September to 3.7 days against a plan of 3.1 days with the YTD position of 3.3 days.

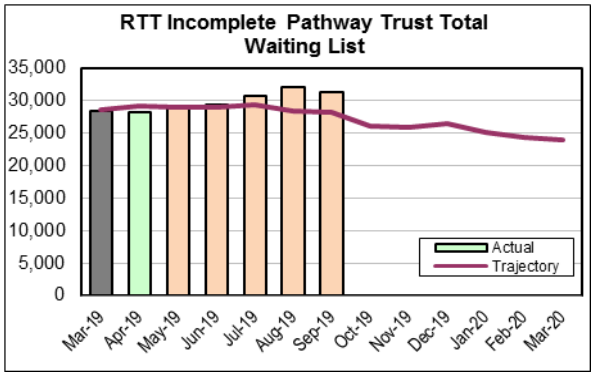
Area	YTD EL LOS
Trust	3.3
Surgical Specialties	3.0
T&O Directorate	3.0
Medical & Emergency Division	5.6

Summary:	Actions:	Assurance:
Theatre Utilisation with TAT has remained consistent for the last 5 months averaging 86%. The %age of theatre sessions that started within 15 minutes has remained consistant at 37% for the last 2 months. There was an increase in Theatre activity in Sep-19 however, this equated to a decrease of an average of 1 case 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 and is progressing well.

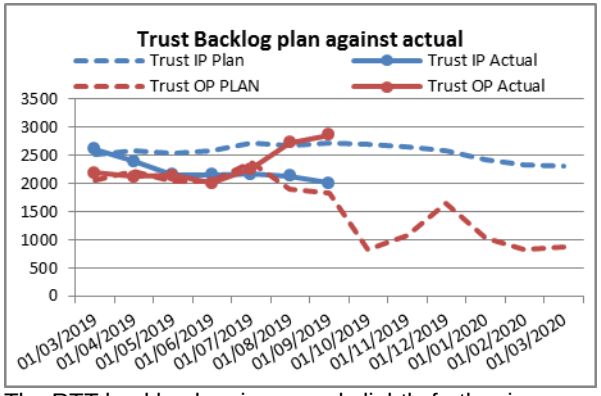
Responsive	RTT – Incomplete Pathway	Sep-19



RTT performance decreased slightly in September but remains above trajectory.



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



The RTT backlog has increased slightly further in September. This has been mainly due to the OP (non-admitted pathway).

Trust	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Trajectory Total WL	28508	29152	28932	28908	29273	28433	28261
Actual Total Waiting List	28412	28268	29027	29269	30705	32085	31344
Actual IP Waiting List	6494	6045	6037	5978	6102	6009	5780
Actual OP Waiting List	21918	22032	22527	22619	23622	24898	24295
Trajectory Backlog	4146	4806	4578	4622	5089	4576	4543
Actual Total Backlog	4797	4510	4305	4162	4430	4857	4865
Actual IP Backlog	2611	2391	2157	2156	2158	2135	2004
Actual OP Backlog	2186	2119	2148	2006	2272	2722	2861
Trajectory % Performance	85.5%	83.5%	84.2%	84.01%	82.61%	83.9%	83.9%
Actual Total % Performance	83.12%	84.05%	85.17%	85.78%	85.57%	84.83%	84.34%

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

RTT by Specialty: All Specialties achieved their trajectory for September with the exception of Ophthalmology (-1.4%), Neurology (-13.8%), Rheumatology (-8.3%), Cardiology (-7.2%), Respiratory (-5.5%) and Gastroenterology (-1.3%), however Respiratory remains above the national target. General Surgery is now 4.2% above Trajectory, ENT and T&O are around 2% above trajectory. Performance dipped in September for T&O and General Surgery compared to August and there was a significant decrease for Gynaecology (-5.9%). For Ophthalmology the non-admitted pathway performance is 5.4% below trajectory. All specialties saw an increase in the OP Backlog with the exception of Urology. Ophthalmology, ENT and Neurology OP Backlog account for the biggest proportion of the Trust OP Backlog (25%, 18% and 11% 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 September. These are being carefully monitored against forecasts and action plans on a weekly basis

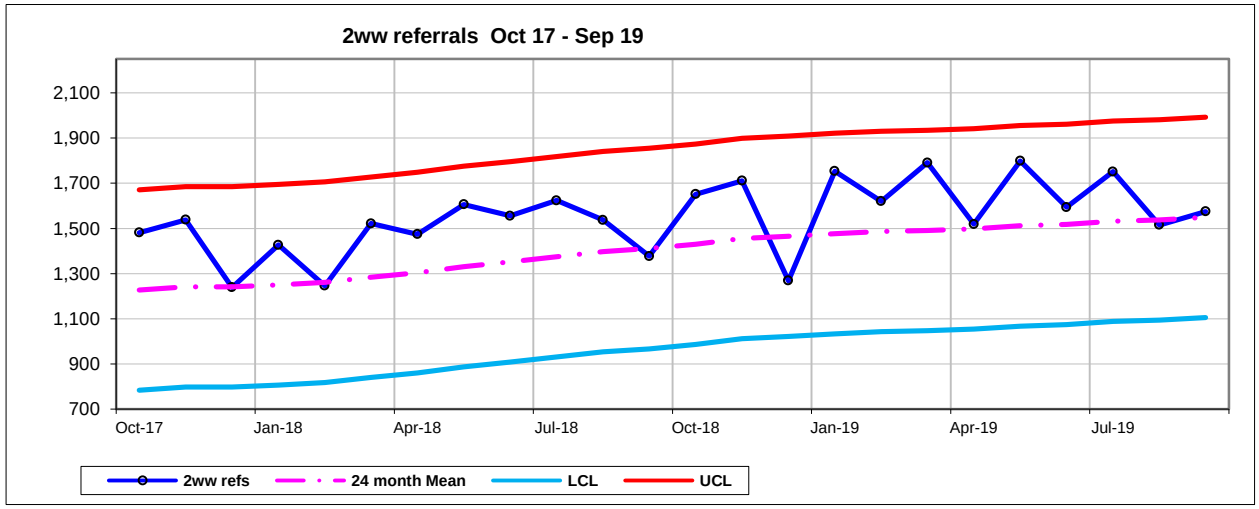
RTT 52 week Breaches: 9 reported for September (8 new for September). All patients will have a harm review by the managing Consultant. No harm has been found as yet for the ones which have been completed. 52 Week Panel established.

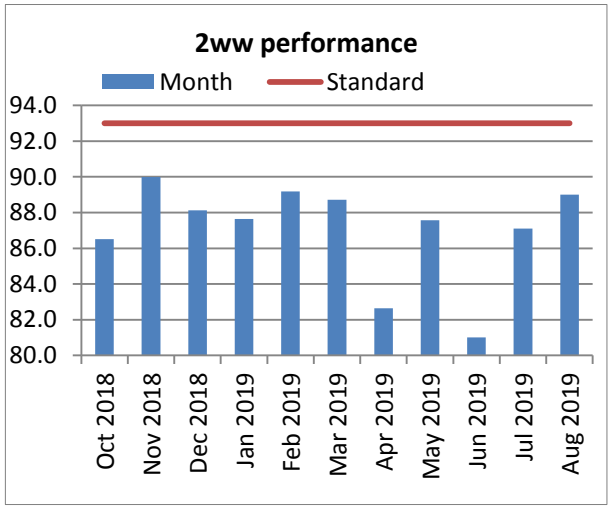
RTT Data Quality: Operational plan, risk assessment and QIA to be completed in order to review when the new reporting system can be implemented.

Diagnostics <6weeks: Performance increased to 98.7% due to the previous issues in Endoscopy and Cardiology having now been resolved. Performance remains slightly below the 99% target.

Summary:	Actions:	Assurance:
Performance increased slightly in September and remains above Trajectory at 84.34%. The Trust Waiting List has decreased further to 31,344 which is therefore 3,083 (11%) higher than the Trust submitted Trajectory of 28,261 and the backlog has increased to 4,865 which is 322 higher (7%) than the submitted trajectory of 4,543 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. ..	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)	Sep-19





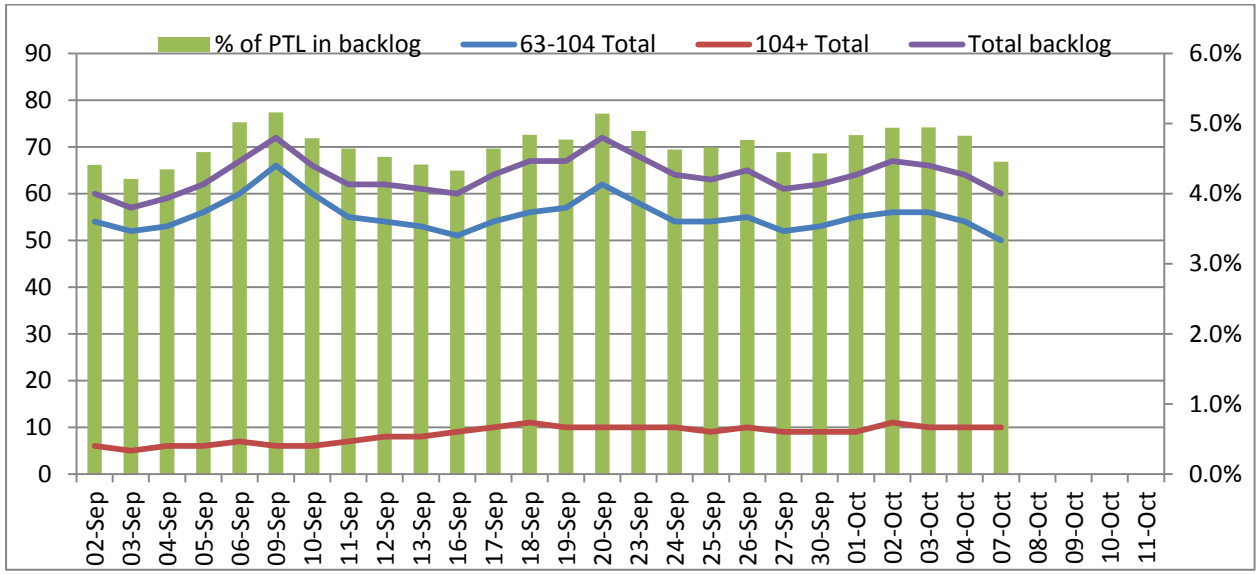
2ww GP referrals to MTW	Breast	Gynae	Haem	Head & Neck	Lower GI	Lung	Other	Upper GI	Urology	Total	BSYM	Breast total
2017	319	119	9	109	261	47	8	139	154	1164	165	404
2018	343	141	17	123	310	48	4	146	207	1289	141	484
2019 (Jan - Sep)	392	158	26	145	357	55	14	147	203	1657	157	549
% change last 12 mths	14.4%	11.7%	52.8%	18.3%	15.3%	12.9%	227.0%	0.5%	-1.8%	28.6%	11.8%	13.5%

Demand:
Demand for 2ww referrals remains just over 1500 per month and has been in line with the expected growth over the last 24 months. The number of referrals has increased again through October – approximately a 7% increase in comparison to the same position in September – and is putting additional pressure on capacity. Breast, Lower GI, Urology and Upper GI remain the sites with the higher numbers of referrals

2 Week Wait (2WW) Performance:
2ww performance has continued to improve at 89% for August. The validated but not finalised position for September is 93.1% for 2ww and 98.2% for 2ww Breast Symptoms, therefore both achieving the 93% national target.
2ww performance in all but one tumour group has improved in September compared to August. Breast remains the highest with 97.5% performance and only gynaecology and children's sit below 90% with current performance at 88.6% and 50% retrospectively. Children's cancer performance had reduced from 66.7% to 50% but a new process will be implemented at the end of October and anticipates all patients to be booked within their breach date.
The 2WW team are on track to achieve the 93% target in October with a 91.5% position at mid-point.

Summary:	Actions:	Assurance:
After increased demand for 2ww referrals from January to July (peaking at 1799 referrals for May), the numbers of referrals for August and September has returned to just over 1500 per month. Following a period of reduced performance (Jun-19: 81%), new reporting and more robust referral management processes has resulted in a significant improvement in performance in September (93.1% -not finalised), therefore achieving the 93% national target. The target is also on track to be met in October 2019	Additional breast clinic capacity has taken breast to the best performing tumour group in August and September. Work has taken place to revise the LGI and UGI STT endoscopy booking process and ensure that patients are fully booked at point of telephone triage. Go live date is end of October. Appointment of a full-time 2WW coordinator will help to fill outstanding team vacancies. Identification of clinic space for children's cancer first seen appointments will allow the 2WW team to book directly into these	A new 2ww working group has been set up with involvement from General Managers across breast, urology, haematology and gynaecology. This group is focused on reducing patients booked past 7 days to ensure compliance with the 28 day standard. A report has been developed, and is reviewed daily, to highlight any un-booked 2ww appointments and any appointments booked after 7, 10 and 14 days. A new report to monitor patients unregistered on the system within 24 hours is in production to provide additional assurance that all patients with a 2WW referral are captured.

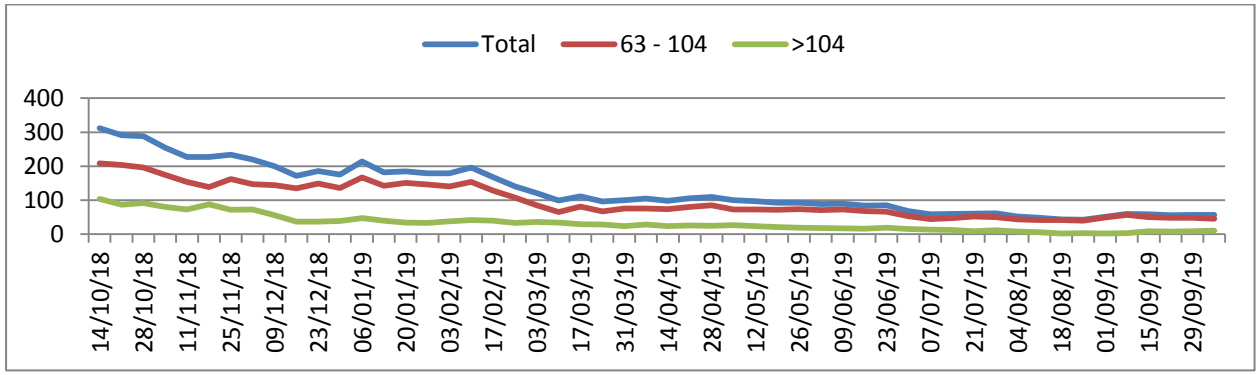
Responsive	Cancer Waiting Times – PTL / Backlog	Sep-19



Whilst the overall backlog remains at under 5% of the total PTL, the number of patients from day 104 has risen to 10 from mid-September, and remained at 10 through early October. The patients at day 104 are within Lung, Upper GI, Lower GI and Prostate – the majority of which have treatment planned within the next week

Lung has improved their overall position decreasing from 16% backlog to 11.8%. The Prostate pathway remains consistent with 9.1% of their PTL in the backlog and Upper GI at 10%

As expected the increased pressure following the summer holiday period increased the total PTL to over 1400 in mid-September, but this has returned to below 1350 before October.

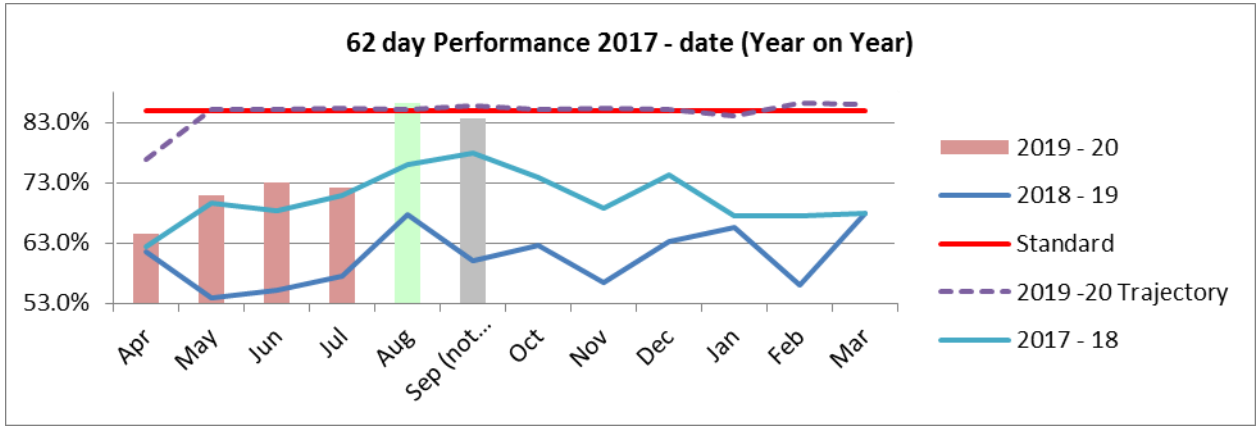


There was a significant decrease in the backlog from August 2018 to March 2019.
The PTL is continuing to be managed with an overall % of less than 5% in the backlog.

However, during the month of September, the number of patients from day 104 has increased to 10 and remains at this level through the beginning of October. This has largely been due to an increase in late specialist referrals in from other trusts and a couple of upgraded lung patients with complex comorbidities preventing treatment from commencing.

Summary:	Actions:	Assurance:
The overall backlog is being managed at less than 5% of the total PTL. There are a total of 60 patients in the backlog, 10 of which are over day 104 – which is a slight increase from 57 patients in September	Lung pathway changes have been agreed and are being implemented to reduce time to when a treatment decision is made. 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

Cancer Waiting Times – 62 Day FDT



Trust Performance: The Trust succeeded with achievement of the 62day standard for August 2019 at 86.3%. This has moved the Trust into 26th position out of 134 Trusts nationally.

The September position is currently not fully validated, but is expected to be around 85%

62 Day Performance						
August 2019	All reportable patients			MTW only patients		
	Total	Breach	%	Total	Breach	%
Breast	17.0	1.0	94.1	17	1	94.1
Gynae	12.0	2.0	83.3	9	1	88.9
Haematology	3.0	1.0	66.7	3	1	66.7
Head & Neck	2.5	0.0	100.0	0	0	
Lower GI	11.5	1.0	91.3	10	0	100.0
Lung	16.5	4.5	72.7	15	3	80.0
Other	2.0	1.5	25.0	0	0	
Upper GI	9.0	1.5	83.3	7	1	85.7
Urology	40.0	3.0	92.5	40	3	92.5
TOTAL	113.5	15.5	86.3	101	10	90.1

Gynae 62 day performance dropped from 90.9% in July to 83.3% in August, but all other tumour sites have shown an increased performance in August with 4 tumour sites achieving above the 85% standard.

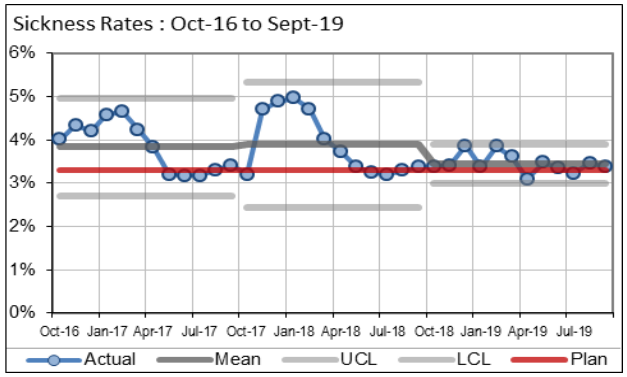
The overall 62 day performance continues to be at risk with incoming Specialist referrals for treatment being received at MTW late in the 62 day pathway (as seen in Lung, Gynae and Upper GI). The Cancer Team are working on this position with the referring Trusts

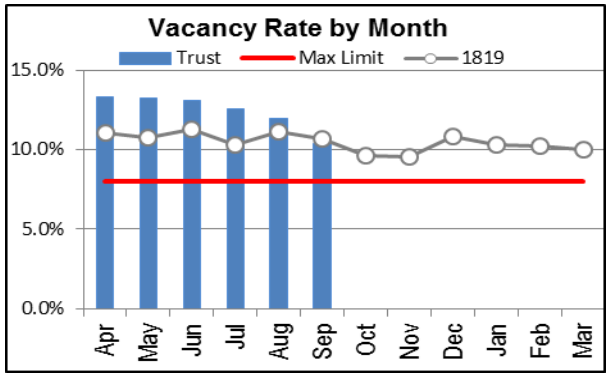
Tumour Specific Performance: Breast, Head & Neck, Lower GI and Urology all reported above 90% for the 62d standard in August. Gynae and Upper GI were just below 85%, both with 83.3% Lung continues to report below the national standard at 72.7% and Haematology is our lowest performing site at 66.7%
Both Lung and Haematology are below the current National Average of 78.5%

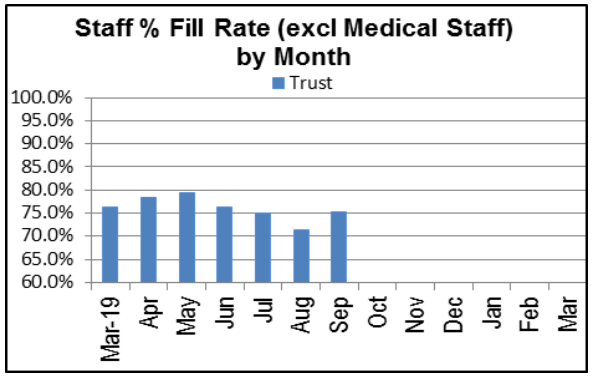
Conversion rates for 2ww referrals: The overall conversion rate remains at 8.2%. This varies across the different tumour sites with Lung converting an average 30.39% of referrals received and Head & Neck 2.68% for the first 7 months of 2019.

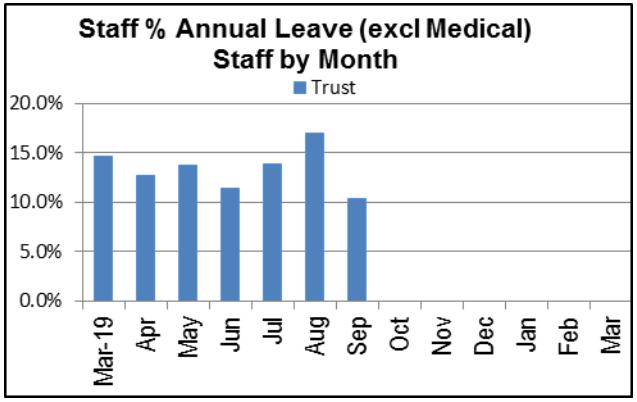
Summary:	Actions:	Assurance:
All relevant departments across the Trust have worked hard to improve the overall 62 day performance and the teams were recognized for their achievment of this standard in August 2019. Ongoing work continues to ensure sustainable processes and active management of the 62 day PTL and backlog	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	Sep-19









Annual Leave: Following the expected increase in Annual Leave in July and August this has reduced to previous levels in September at 10.4%.

Vacancy Rate: Overall vacancy rate has reduced by a further 1.6% across all staff groups. Both Nursing and Medical and Dental vacancy rate has reduced (-1.6% and -1.8% respectively)

	Vacancy %					
Staff Group	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**
Registered Nursing, Midwifery & HV	20.32%	19.86%	19.25%	19.25%	19.66%	18.03%
Medical and Dental	16.55%	16.16%	15.59%	11.58%	11.25%	9.44%
AHP	13.17%	14.48%	14.82%	13.68%	12.67%	11.35%
Other ST&T	5.64%	10.92%	11.22%	9.70%	8.12%	7.00%
Other	8.53%	8.39%	8.56%	8.93%	7.63%	6.12%
Grand Total	**13.31%**	**13.27%**	**13.11%**	**12.63%**	**11.97%**	**10.40%**

A further 31 overseas nurses joined the Trust in September with a further 51 due to start in October.

Overall Staff Fill Rate (excluding Medical Staff): Following the decreasing seen in August this has increased back to previous levels in September but remains low.

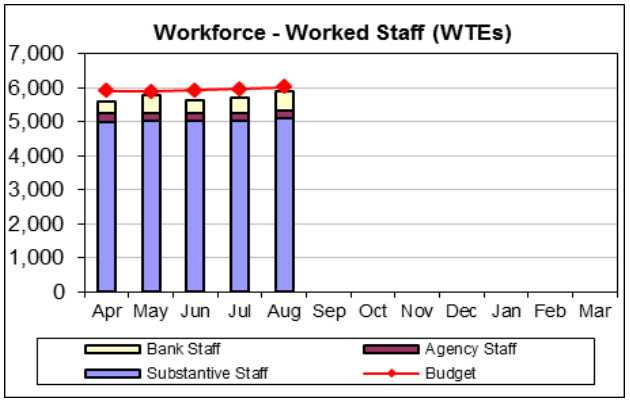
Turnover Rate: Due to the change in the calculation for turnover rate this will not be able to be accurately reported until March 2019.

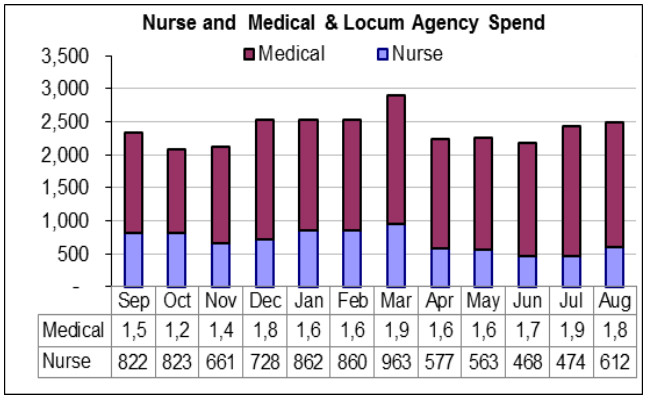
Sickness Rate: The overall sickness rate has become more stable over the last 12 months Although slightly above the maximum limit in September at 3.4%, YTD this is on target.

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

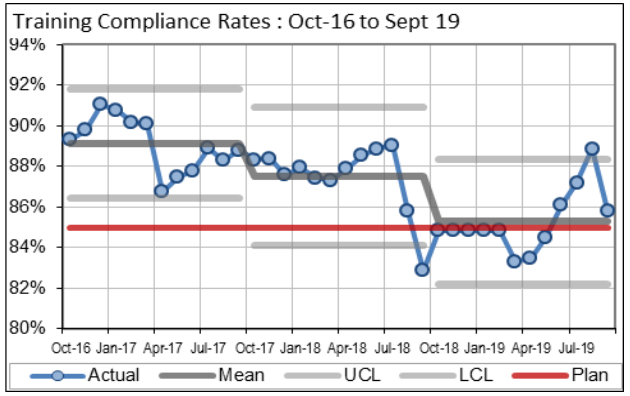
Summary:	Actions:	Assurance:
The Trust vacancy rate is showing a gradual downward trend from a high of 13.3% in April to 10.4% in September. This downward trend has also been seen in both the Nursing and Medical and Dental Staff Groups. Following the expected increase in Annual Leave in July and August this has reduced to previous levels in September and therefore the overall staffing fill rate has also increased back to previous levels.	88 International nurses have arrived to date in 2019. A further 312 overseas nurses are due to join the Trust in the next few months. Successful specialty doctor recruitment for paediatrics has reduced vacancies. Successful appointments for Consultants in COE and AMU and T&O.	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.

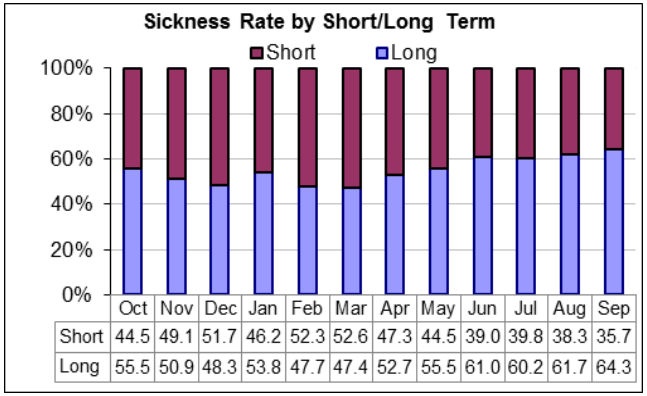
Well Led	Workforce	Sep-19





	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





	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Short	44.5	49.1	51.7	46.2	52.3	52.6	47.3	44.5	39.0	39.8	38.3	35.7
Long	55.5	50.9	48.3	53.8	47.7	47.4	52.7	55.5	61.0	60.2	61.7	64.3

Bank and Agency: The overall agency spend increased in September and remains above plan. Both the nurse and Medical & Locum agency spend increased further in September; however the level of bank staff used decreased and therefore the overall cost of temporary staff as a percentage of the total pay bill reduced.

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 51% in 1819 to an average of 59% (64.3% in September).

Mandatory Training: The areas that are below 80% compliance remain T&O, Operational Management Acute Medicine, Emergency Medicine, Surgery and Sexual Health. Key areas of improvement this month are SEPSIS for Paediatrics (from 71% to 85.5%), Safeguarding Children Level 2 (from 74.9% to 84.9%) and Basic Life Support (from 69.5% to 75.2%).

Appraisals: Performance has improved further to 89.8% for September. The Cancer Division is furthest from plan at 83.7%; however this is a significant improvement from the 77.8% last month. All other Divisions are above 85%.

Summary:	Actions:	Assurance:
The overall agency spend increased further in September and remains above plan. Since April 2019 there has been a higher proportion of long-term sickness compared to short-term sickness. Following the upward trend seen for Mandatory Training compliance this has decreased down by over 3% to 85.8% in September but remains above the 85% target with SEPSIS for Paediatrics showing the biggest improvement. Appraisal Compliance has increased further to 89.8%.	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 ePay expenses system has been rolled out as part of the new payroll contract. The National Staff Survey is now open and HRBPs are busy supporting divisions to boost our completion rate.	HR staff are working with line managers to ensure that all those on long term absence have a management plan in place. The flu vacination campaign has been launched with an aim to achieve a vaccination rate of 80% to hit the NHS target. Frontline clinical staff have been prioritised.

Safe		2018/19	2019/20	Q1			Q2			Q3			Q4			Q1			Q2			YTD	FOT	YTD Var from Plan
ID	Key Performance Indicators	Outturn	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep			
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	29.6	35.1	24.7	22.4	0.1%
S2	CDifficile (Post 72hrs) - Hospital	56	55	1	1	4	7	8	9	4	3	2	7	4	6	9	0	5	3	6	7	30	55	0
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	0	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%	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%	92.9%	92.9%	92.9%	-2.1%
S4	Rate of E. Coli Bacteraemia per 100,000 beddays	28.1	21.5	14.1	28.2	46.2	35.5	34.3	15.5	24.0	50.3	24.3	13.8	19.9	33.2	29.8	14.1	35.8	19.8	34.5	55.1	31.3	25.2	8.2
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	6	15	21	2
S4.2	E. Coli Bacteraemia (Post 48hrs)	69	52	3	6	9	7	7	3	5	10	5	3	4	7	6	3	7	4	7	11	38	62	10
S4.3	Cases of Gram Negative Bactareamia	113	113	7	9	14	10	10	7	11	12	9	5	8	11	8	4	7	8	7	14	48	104	-9
S4.4	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	191	191	191	- 34
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	1.34	0.53	0.68	- 0.3
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	24.4	22.8	22.8	6.8
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	4	9	27	- 9
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	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	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	4	10	22	- 2
S5.6	Pressure Ulcers Total	68	60	9	13	11	3	11	5	4	2	4	5	1	0	4	1	2	1	3	8	19	49	- 11
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	5.91	6.24	6.07	0.24
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	6.44	7.27	6.86	0.97
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	5.13	4.57	4.77	-0.43
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	93	572	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	20	146	296	- 4
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	2	18	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	3	20	32	8
S6.7	Falls resulting in "Death"	2	-	0	0	0	0	0	1	0	0	0	0	1	0	1	0	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	118	758	1490	26
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	77	544	1042	46
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	41	213	447	- 21
S7	Never Events	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	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	7	73	145	1
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	0.35	0.60	0.59	0.00
S8.2	Number of Open Sis	110	95	92	103	100	96	96	110	97	90	104	87	81	85	97	99	93	84	83	80	80	80	- 15
S9	SIs not closed <60 Days Monthly Snapshot		24													57	50	52	39	21	31	31	31	7
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%	92.6%	93.9%	93.9%	0.4%
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%	No data	98.3%	98.3%	-95.0%
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%	No data	1.7%	1.7%	-3.0%
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	1	6	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	8	51	87	15
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	0	5	11	-1
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	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	969	5638	11488	-212
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	1.03	1.31	1.11	0.08
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	2844	2844	2844	913

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	Sep			
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	1.0363	1.0363	1.0363	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	91.50	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%	1.00%	0.88%	0.88%	-0.1%
E3	% Total Readmissions	14.11%	14.11%	14.22%	14.14%	13.67%	14.56%	13.93%	15.31%	14.35%	14.59%	14.73%	15.00%	13.71%	15.04%	15.24%	14.49%	Data runs one month behind	14.75%	14.75%	0.6%
E4	Readmissions <30 days: Emergency	14.73%	14.73%	14.78%	14.67%	14.31%	15.36%	14.77%	16.09%	14.80%	15.23%	15.36%	15.60%	14.47%	15.42%	16.14%	14.99%		15.33%	15.33%	0.6%
E5	Readmissions <30 days: Elective	6.86%	6.86%	7.52%	8.06%	6.08%	5.66%	6.00%	5.96%	8.04%	6.58%	7.43%	7.94%	5.42%	10.30%	6.35%	8.54%		7.59%	7.59%	0.7%
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%	36.9%	21.2%	36.5%	36.5%	-13.5%
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%	75.4%	71.2%	71.2%	71.2%	-8.8%
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%	38.5%	23.1%	45.1%	45.1%	-12.9%
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%	81.5%	73.1%	78.1%	78.1%	-1.9%
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%	No data	Mth Behind	56.8%	56.8%	-3.2%
E8	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%	95.5%	Data runs one month behind	91.6%	91.6%	-3.9%
E9	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%	89.6%		94.2%	94.2%	0.4%
E10	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%	100.0%		98.8%	98.8%	2.8%

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	Sep			
C1	Single Sex Accommodation Breaches	35	0	5	12	0	10	8	0	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	1.85	2.31	2.61	-0.66
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%	71.4%	58.8%	67.0%	-16.2%
C3.1	Total Open Complaints	149	140	155	137	144	139	129	129	130	120	149	155	173	154	134	149	132	132	132	- 8
C3.2	Number of new complaints received	564	720	38	34	43	59	48	48	52	41	67	46	47	53	46	51	37	280	640	- 80
C3.3	Number of Nursing Complaints	107	108	8	5	7	9	13	12	10	12	10	5	9	11	7	10	5	47	101	- 7
C3.4	Number of Medical Complaints	353	336	24	21	26	41	32	32	31	23	43	30	26	33	31	26	23	169	337	1
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	13	108	198	18
C3.6	Number of Complaints open >90 days	349	348	36	37	43	29	25	20	19	18	20	30	33	33	27	32	24	179	353	5
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%	16.6%	17.2%	17.2%	-7.8%
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%	94.0%	94.9%	94.9%	-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%	9.1%	11.1%	11.1%	-3.9%
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%	85.7%	87.4%	87.4%	0.4%
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%	17.3%	27.8%	27.8%	2.8%
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%	94.7%	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%	81.3%	82.2%	82.2%	-1.8%
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%	51.3%	55.3%	55.3%	-12.7%
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%	95.7%	Mth behind	96.7%	96.7%	1.7%
C12	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%	91.0%	91.0%	91.0%	1.0%
C13	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%	84.0%	-6.0%
C13.1	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%	93.0%	3.0%
C13.2	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%	97.0%	7.0%
C13.3	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%	84.0%	84.0%	84.0%	-6.0%
C13.4	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%	91.0%	91.0%	91.0%	1.0%

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	Sep			
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%	89.20%	91.88%	91.07%	-1.3%
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%	92.64%	93.85%	93.84%	-2.2%
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%	81.33%	86.57%	84.91%	-1.1%
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%	19.4%	18.7%	18.8%	18.8%	-2.0%
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%	2.8%	2.7%	2.7%	2.7%	-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%	87.0%	90.7%	90.7%	-4.3%
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%	57.8%	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%	9.1%	8.5%	8.5%	0.5%
R1.8	A&E Average Time in Department (Hours)	0.14	0.14	0.14	0.14	0.13	0.15	0.14	0.15	0.15	0.16	0.13	0.14	0.14	0.13	0.14	0.15	0.15	0.14	0.14	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	0
R3	Ambulance Handover Delays >60mins	596	540	22	60	31	67	82	70	74	83	13	57	59	26	42	56	77	317	587	17.4%
R3.1	Ambulance Handover Delays >30mins	4,487	4,428	250	400	284	486	442	441	613	444	280	494	531	384	528	490	581	3008	5222	35.9%
R4	RTT Incomplete Pathway	83.12%	83.92%	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%	84.83%	84.34%	84.34%	87.26%	0.4%
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	2083	1992	1992	1905	-26.8%
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	2721	2916	2916	1659	60.1%
R4.3	RTT Specialties Not Achieved Nat Target	9	0	11	12	10	10	9	9	9	9	9	9	10	9	9	11	11	59	59	59
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	4804	4908	4908	3564	8.0%
R5	RTT 52 Week Waiters (New in Month)	8	8	6	4	8	8	11	5	7	8	8	6	10	3	3	6	8	36	36	28
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%	98.7%	98.7%	99.0%	-0.3%
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%	89.0%		85.4%	85.4%	-7.6%
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%	91.5%		71.6%	71.6%	-21.4%
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%	97.2%		96.8%	96.8%	0.8%
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%	86.2%		93.2%	93.2%	-0.8%
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%	100.0%	Data runs one month behind	99.8%	99.8%	1.8%
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%	93.4%		92.9%	92.9%	-1.1%
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%	86.3%		73.3%	73.3%	-12.0%
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%	90.1%		79.4%	79.4%	-5.6%
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%	89.7%		87.8%	87.8%	-2.2%
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%	56.3%		63.7%	63.7%	-21.3%
R11	Non-Elective LOS	6.90	6.40	6.56	6.95	6.70	7.04	6.83	6.80	6.71	7.22	6.75	7.10	7.14	6.97	6.98	6.92	6.67	7.05	7.05	45.0%
R11.1	Elective LOS	3.11	3.00	2.67	3.18	3.31	3.27	2.89	3.72	3.15	3.20	2.88	3.10	3.30	3.22	3.22	3.54	3.72	3.34	3.34	34.2%
R12	% Bed Occupancy	90.8%	90.0%	89.6%	90.5%	89.7%	92.8%	92.7%	91.2%	92.0%	93.4%	90.5%	92.0%	93.4%	90.1%	90.5%	91.6%	92.4%	91.7%	91.7%	1.7%
R12.1	Occupied Beddays Average Per Day	673	673	636	659	647	671	663	663	703	716	681	672	684	652	653	655	665	664	673	-0.1%
R12.2	Delayed Transfers of Care	4.4%	3.5%	5.0%	4.8%	5.9%	4.5%	3.6%	3.2%	4.1%	3.8%	5.0%	4.4%	4.1%	3.9%	4.8%	4.3%	5.3%	4.5%	4.5%	1.0%
R13	Theatre Utilisation (Elective)	90.5%	90.0%	86.4%	84.5%	87.6%	85.9%	86.5%	86.3%	85.5%	85.6%	87.0%	88.4%	86.3%	86.4%	143.7%	86.9%	85.7%	96.9%	96.9%	6.9%
R13.1	Day Case Rate	87.6%	87.1%	87.8%	86.8%	87.0%	87.9%	86.2%	87.5%	89.1%	88.4%	87.2%	87.7%	87.6%	87.8%	87.2%	86.7%	87.6%	87.4%	87.3%	0.3%
R13.2	Cancelled Operations (last minute)	0.7%	0.8%	0.6%	0.8%	0.8%	0.7%	0.6%	0.6%	0.7%	1.2%	0.7%	0.02%	0.00%	0.00%	0.00%	0.02%	0.00%	0.01%	0.01%	-0.8%
R13.3	Patients not treated <28 days of cancellation	26	0	4	2	0	6	2	0	1	2	1	4	3	1	2	1	2	13	13	13
R13.4	Urgent Ops Cancelled for 2nd time	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
R14	Outpatient Utilisation	#REF!	85.0%	65.4%	64.2%	65.1%	64.4%	66.2%	63.5%	66.3%	66.4%	64.5%	66.7%	65.4%	65.4%	66.1%	63.7%	63.2%	65.1%	65.1%	-19.9%
R14.1	Outpatient Follow Up : New Ratio	1.51	1.53	1.48	1.50	1.50	1.54	1.57	1.54	1.59	1.61	1.51	1.59	1.58	1.50	1.41	1.52	1.42	1.50	1.50	-3.4%
R14.2	Outpatient New DNA Rates	#REF!	5.0%	6.7%	6.4%	6.2%	6.4%	6.1%	5.7%	5.6%	5.0%	4.6%	5.7%	5.8%	6.2%	5.7%	5.4%	4.9%	5.6%	5.6%	0.6%
R14.3	Outpatient Follow Up DNA Rates	#REF!	5.0%	8.3%	7.9%	7.4%	7.8%	7.4%	6.5%	6.6%	6.4%	6.2%	5.3%	5.3%	5.6%	5.4%	5.0%	4.7%	5.2%	5.2%	0.2%

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	Sep			
R15	Primary Referrals	124,181	139,143	11054	9974	9815	11011	10832	8502	10794	9679	9973	11514	11455	10946	11435	9712	9244	64306	134425.1	-6.8%
R15.1	Non-Primary Referrals	63,092	59,909	5394	5205	4915	5209	5202	4833	5873	5040	5442	4766	5375	5598	6187	4954	5174	32054	62245	7.9%
R15.2	Cons to Cons Referrals	68,987	51,898	6349	6026	5399	6378	6091	4718	5987	5126	4758	6343	6255	5672	6765	5814	5380	36229	62382	40.7%
R16	OP New Activity	209,257	226,133	18278	16794	16615	18808	18590	15012	18294	16081	16719	17270	17987	17684	20620	17148	18427	109136	223093	-2.7%
R16.1	OP Follow Up Activity	316,538	346,845	26978	25111	24880	28933	29129	23078	29068	25966	25247	27458	28506	26438	29105	26041	26111	163659	338438	-4.9%
R17	Elective Inpatient Activity	6,171	7,426	521	568	527	554	622	460	450	435	519	531	597	521	597	567	555	3368	7110	-8.6%
R17.1	Day Case Activity	43,599	50,210	3749	3725	3523	4038	3871	3233	3692	3300	3520	3779	4236	3741	4079	3683	3937	23455	48758	-5.8%
R17.2	Total IP & DC Activity	49,770	57,636	4270	4293	4050	4592	4493	3693	4142	3735	4039	4310	4833	4262	4676	4250	4492	26823	55868	-6.2%
R18	Non Elective Activity (inc Maternity)	64,187	84,338	5344	5582	5245	5542	5272	5246	5749	5050	5682	5164	5564	5369	5917	5335	5424	32773	74942	-22.3%
R19	A&E Attendances : Type 1	155,838	159,252	13526	12707	12627	12861	12793	12684	13668	12567	13809	13401	14282	13577	15157	13909	14125	84451	167691	3.6%
R19.1	A&E Attendances : Total, inc MIU	191,157	195,883	16994	15716	15758	15766	15419	15316	16438	15277	16831	16642	17719	16925	18794	17330	17631	105041	206426	4.1%
R20	Oncology Fractions	65,671	67,260	5605	5379	4698	5648	5994	5059	5867	5292	6010	6694	6602	5685	6650	5834	5459	36924	70819	10.7%
R21	Number of Births (Mothers Delivered)	5,857	5,856	490	514	484	543	504	491	469	420	460	415	503	465	489	458	477	2807	5614	-4.1%

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	Sep			
W1	Surplus (Deficit) against B/E Duty	12,006	6,897	574	82	-1,014	3,075	2,030	136	-2,567	-457	13,359	-2,001	-71	-1,272	2,569	1,036	407	668	6,897	8.3%
W2	CIP Savings	13,825	22,328	1,200	1,151	917	1,221	1,151	678	1,428	986	2,574	725	1,012	1,291	1,868	3,882	1,792	10,901	22,329	11.1%
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	42,824	42,824	3,000	26.2%
W4	Capital Expenditure	19,185	14,448	327	365	82	547	1,106	2,420	295	430	12,900	358	45	380	149	250	442	1,624	14,448	-53.8%
W4.1	Income	465,038	502,732	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	40,971	247,511	500,362	-0.8%
W4.2	EBITDA	28,347	37,810	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	2,838	16,432	37,790	2.8%
W5	Finance use of Resources Rating	3	2	4	4	4	3	3	3	3	4	3		3	3	3	3	3	3	3	1
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%	11.43%	11.43%	11.43%	1.4%
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%	10.40%	10.40%	10.40%	2.4%
W7.1	Contracted WTE	5,153	-	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	5,323	5,323	5,323	-2.2%
W7.2	Establishment WTE	5,670	-	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	6,033	6,033	6,033	0.0%
W7.3	Substantive Staff Used	5,012	-	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	5,152	5,152	5,152	-7.0%
W7.4	Worked WTE	5,826	-	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	5,810	5,810	5,810	-3.7%
W7.5	Vacancies WTE	517	-	568	558	564	483	614	561	545	539	517	758	786	799	803	797	710	710	710	20.2%
W8	Total Agency Spend	22,651	15,679	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	1,786	10,243	16,258	0
W8.1	Nurse Agency Spend	-9,434	-2,487	-853	-847	-822	-823	-661	-728	-862	-860	-963	-577	-563	-468	-474	-612	-641	-3,334	-3,334	17.5%
W8.2	Medical Locum & Agency Spend	-19,052	-7,318	-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	-1,902	-10,818	-10,818	23.3%
W8.3	Bank Staff Used	500	-	338	448	383	372	365	416	433	442	500	332	511	356	426	574	392	392	392	32.3%
W8.4	Agency Staff Used	277	-	310	302	277	271	229	270	283	286	277	249	241	243	233	229	234	234	234	19.7%
W8.5	Overtime Used	36	No data	42	46	46	49	-	45	37	47	36	45	37	35	35	33	33	33	33	No data
W8.6	Temp costs & overtime as % of total pay bill	No data	0.0%	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%	17.8%	17.8%	17.8%	5.8%
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%	85.8%	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%	3.4%	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%	53.3%	#DIV/0!
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%	75.3%	#DIV/0!
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%	89.8%	89.8%	89.8%	-5.2%

Review of latest financial performance **Chief Finance Officer**

- The Trust's surplus including Provider Sustainability Fund (PSF) and MRET funding was £0.4m in September which was in line with the plan.
- The Trust's normalised run rate (excluding PSF and MRET funding) in September was £1.5m deficit which was £0.9m adverse to plan.
- In September the Trust operated with an EBITDA surplus of £2.8m which was £0.1m adverse plan.
- The Trusts surplus including PSF was £0.4m in September which was on plan. The key variances to budget were: Underperformance in Private Patient Income (£1.1m net), RTT Income reserve (£1.7m), overspends within expenditure budgets (£1.8m) and £0.3m EPR revenue pressure. These pressures have been offset by release of prior year provisions and back dated credit notes from NHS Property Services (£1.2m), over performance relating to clinical income (£0.9m) and release of £3.1m of reserves.
- The key current month variances are as follows:
  - Income adjusted for pass-through items is £0.5m adverse to plan, the main pressures relate to under delivery of Private Patient Income (£0.3m) & non-delivery of RTT risk reserve £0.3m
  - Pay budgets adjusted for pass-through items underspent by £0.4m in September, although without the release of reserves (£0.2m) the position would have been an underspend of £0.2m. Medical staffing (£0.2m) was the only staff group overspent in the month with Nursing (£0.1m), Admin and Clerical (£0.2m) and Scientific and Technical staffing (£0.2m) all underspending. The key pressures in Medical staffing continue to be within Emergency and Medicine directorate (£0.3m) and Paediatrics (£0.1m).
  - Non Pay budgets adjusted for pass through items overspent by £0.1m in the month which included a £0.3m year to date adjustment relating to the EPR project. However cumulatively the EPR project is £0.2m adverse to budget due to EPR costs being charged to revenue pending confirmation of additional capital funding support.
- The Trust held £42.8m of cash at the end of September which is higher than the plan of £33.9m. Within the cash plan the Trust had forecast expenditure of Qtr 1 and Qtr 2 Roche contractual payments relating to the managed service agreements totalling c£3.2m, the Trust has now received the invoices and these are expected to be paid in October. Additionally the Trust has received income in respect of prime provider contracts as part of the monthly SLA invoicing. The Trust is expecting invoices from WK CCG of c£2m for mth 2 and 3 expenditure, as soon as the Trust receives these invoices and they are approved, payment will be released to the CCG. 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 and the reversal of the capital control total reductions 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, estates backlog and IT schemes that could be delivered in this financial year. The Trust will be submitting a new application to NHSE/I for the CRL cover for this resource. The Trust has submitted the planned emergency capital case for the TWH CT scanner which is also being considered by NHSE/I under the heading of the recently announced £200m Diagnostic and Scanning equipment fund for this financial year. The Trust is in discussion with NHSE/I on other possibilities for bidding against this fund.

- The Trust is forecasting to deliver the planned surplus including PSF and MRET of £6.9m however this includes £6.5m of mitigations to offset the variances to plan.
- To mitigate these overspends the Trust is focusing on identifying further £4m of CIPs/Divisional recovery plans with monthly meetings taking place with Divisions and the CFO, COO and Director of Workforce. The Trust is also in discussion with West Kent CCG to access at least £1.5m additional income associated with the RTT access reserve. The Trust will also have to release the remaining £0.1m of reserves therefore any investment decisions where funding is not secured would have to be offset through additional savings.

Which Committees have reviewed the information prior to Board submission?
- Finance and Performance Committee, 29/10/19

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
To discuss the September financial position

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

Maidstone and Tunbridge Wells NHS Trust

Trust Board Finance Report

Month 6
2019/20

Trust Board Finance Report for September 2019

Maidstone and Tunbridge Wells NHS Trust

1a. Dashboard

September 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	41.0	41.4	(0.4)	0.0	(0.5)		247.5	249.9	(2.4)	0.4	(2.8)		500.4	503.2	(2.8)	
Expenditure	(38.1)	(38.4)	0.3	(0.0)	0.3		(231.1)	(233.9)	2.8	(0.4)	3.2		(462.6)	(465.4)	2.8	
EBITDA (Income less Expenditure)	2.8	3.0	(0.1)	(0.0)	(0.1)		16.4	16.0	0.4	(0.0)	0.4		37.8	37.8	(0.0)	
Financing Costs	(2.4)	(2.9)	0.5	0.0	0.5		(15.2)	(15.7)	0.5	0.0	0.5		(31.2)	(32.0)	0.8	
Technical Adjustments	(0.0)	0.3	(0.4)	0.0	(0.4)		(0.5)	0.3	(0.9)	0.0	(0.9)		0.3	1.1	(0.7)	
Net Surplus / Deficit (Incl PSF and MRET)	**0.4**	**0.4**	**0.0**	**(0.0)**	**0.0**		**0.7**	**0.6**	**0.0**	**(0.0)**	**0.0**		**6.9**	**6.9**	**0.0**	
CIPs	1.8	2.1	(0.3)		(0.3)		10.9	9.8	1.1		1.1		22.3	22.3	0.0	
Cash Balance	42.8	33.9	8.9		8.9		42.8	33.9	8.9		8.9		3.0	3.0	0.0	
Capital Expenditure	0.4	1.3	0.9		0.9		1.6	3.5	1.9		1.9		14.4	14.4	0.0	
Capital service cover rating							4	4					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	3					3	3		

Summary:

- The Trusts surplus including PSF was £0.4m in September which was on plan. The key variances to budget were: Underperformance in Private Patient Income (£1.1m net), RTT Income reserve (£1.7m), overspends within expenditure budgets (£1.8m) and £0.3m EPR revenue pressure . These pressures have been offset by release of prior year provisions and back dated credit notes from NHS Property Services (£1.2m), over performance relating to clinical income (£0.9m) and release of £3.1m of reserves.
- The Trust has spent £3.9m more (61%) than the YTD agency ceiling set by NHSI (£11.8m per annum)
- The Trust has delivered £10.9m savings YTD which is £1.1m favourable to plan (11% favourable)

Key Points:

- The Trusts normalised run rate in September was £1.5m deficit pre PSF which was £0.9m adverse to plan (pre PSF).
- The Trust delivered the financial control target for September and therefore achieved the criteria for PSF funding.
- The main pressures (excluding CIP) in the month related to Medical Staffing (£0.2m), higher than planned outsourcing of elective work (£0.5m), Private patient unit slippage (Net = £0.2m) offset by release of £0.4m reserves, £0.4m underspends within non medical pay budgets.

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 September 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	39.9	40.4	(0.4)	0.0	(0.5)	241.0	244.1	(3.2)	0.4	(3.6)
Expenditure	(38.5)	(38.4)	(0.1)	(0.0)	(0.1)	(232.1)	(233.9)	1.8	(0.4)	2.2
Trust Financing Costs	(2.4)	(2.9)	0.5	0.0	0.5	(15.2)	(15.7)	0.5	0.0	0.5
Technical Adjustments	(0.0)	0.3	(0.4)	0.0	(0.4)	(0.5)	0.3	(0.9)	0.0	(0.9)
Net Revenue Surplus / (Deficit) before Exceptional Items	**(1.0)**	**(0.6)**	**(0.4)**	**(0.0)**	**(0.4)**	**(6.9)**	**(5.2)**	**(1.7)**	**(0.0)**	**(1.7)**
Exceptional Items	0.4		0.4		0.4	1.2		1.2		1.2
Net Position	**(0.6)**	**(0.6)**	**0.0**	**(0.0)**	**0.0**	**(5.7)**	**(5.2)**	**(0.5)**	**(0.0)**	**(0.5)**
PSF and MRET Funding	1.0	1.0	0.0	0.0	0.0	6.4	5.8	0.6	0.0	0.6
Net Revenue Surplus / (Deficit) Incl PSF, MRET and Exceptional Items	0.4	0.4	0.0	(0.0)	0.0	0.7	0.6	0.0	(0.0)	0.0

Key messages:
The Trust position before exceptional items was £0.4m adverse to plan in the month, the release of £0.3m back dated reserves and £0.1m old year accruals helped the Trust to deliver the plan in the month.

Income:
Income YTD net of pass-through related costs and exceptional items is £3.6m adverse to plan. The Trust has over performed against non AIC contracts by £0.9m which is offset by under delivery of Private Patient Income (£1.8m) and Cancer and RTT recovery plan income (£2.4m).

Expenditure:
Expenditure budgets net of pass-through and exceptional items are £2.2m favourable, the key favourable variances relate to: release of reserves (£3.1m), underspends relating to Cancer recovery plans (£0.7m), Private Patient activity underperformance (£0.7m) and £0.4m CIP over performance. The key pressures within expenditure budgets relate to Medical Staffing (£1.8m) and EPR revenue pressure (£0.3m).

Reserves: The Trust has released £3.1m of reserves held to offset YTD pressures and has issued reserves to fund agreed business cases, the Trust has £0.1m remaining in contingency reserves.

PSF: The Trust delivered the financial control total in month 6 and therefore met the PSF criteria.

2a. Income & Expenditure

Income & Expenditure September 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	31.9	32.1	(0.2)	0.0	(0.2)	192.4	194.0	(1.6)	0.0	(1.6)	392.2	390.0	2.2
High Cost Drugs and Devices	4.0	3.8	0.2	0.2	0.0	23.6	22.8	0.8	0.7	0.0	45.2	45.2	0.0
Total Clinical Income	**35.9**	**35.9**	**(0.0)**	**0.2**	**(0.2)**	**216.0**	**216.9**	**(0.8)**	**0.7**	**(1.6)**	**437.4**	**435.1**	**2.2**
PSF and MRET	1.0	1.0	0.0	0.0	0.0	6.4	5.8	0.6	0.0	0.6	14.4	13.8	0.6
Other Operating Income	4.1	4.5	(0.4)	(0.1)	(0.3)	25.1	27.3	(2.1)	(0.3)	(1.8)	48.6	54.2	(5.6)
Total Revenue	**41.0**	**41.4**	**(0.4)**	**0.0**	**(0.5)**	**247.5**	**249.9**	**(2.4)**	**0.4**	**(2.8)**	**500.4**	**503.2**	**(2.8)**
Substantive	(19.6)	(21.2)	1.6	0.1	1.5	(118.1)	(125.4)	7.3	0.4	6.9	(245.0)	(253.6)	8.7
Bank	(1.2)	(0.8)	(0.5)	0.0	(0.5)	(7.4)	(5.2)	(2.1)	0.0	(2.1)	(13.4)	(10.2)	(3.2)
Locum	(1.1)	(0.8)	(0.3)	0.0	(0.3)	(5.6)	(4.4)	(1.2)	0.0	(1.2)	(11.0)	(8.4)	(2.7)
Agency	(1.8)	(1.2)	(0.5)	0.1	(0.6)	(10.2)	(8.6)	(1.7)	0.3	(2.0)	(17.3)	(15.8)	(1.5)
Pay Reserves	(0.1)	(0.3)	0.2	0.0	0.2	(0.6)	(1.7)	1.1	0.0	1.1	(1.1)	(3.5)	2.4
Total Pay	**(23.9)**	**(24.4)**	**0.5**	**0.1**	**0.4**	**(141.9)**	**(145.4)**	**3.5**	**0.7**	**2.8**	**(287.8)**	**(291.5)**	**3.7**
Drugs & Medical Gases	(4.4)	(4.3)	(0.2)	(0.2)	0.0	(27.0)	(25.7)	(1.4)	(0.8)	(0.5)	(53.7)	(51.3)	(2.4)
Blood	(0.2)	(0.2)	(0.0)	0.0	(0.0)	(1.2)	(1.1)	(0.1)	0.0	(0.1)	(2.4)	(2.2)	(0.1)
Supplies & Services - Clinical	(2.8)	(2.8)	(0.0)	0.0	(0.0)	(16.6)	(17.0)	0.4	0.1	0.3	(33.5)	(33.5)	0.1
Supplies & Services - General	(0.4)	(0.4)	0.0	(0.0)	0.0	(2.6)	(2.6)	0.1	0.0	0.1	(5.0)	(5.3)	0.3
Services from Other NHS Bodies	(0.8)	(0.7)	(0.1)	0.0	(0.1)	(4.4)	(4.7)	0.2	0.6	(0.3)	(7.9)	(8.9)	0.9
Purchase of Healthcare from Non-NHS	(1.1)	(0.5)	(0.6)	0.0	(0.6)	(8.3)	(6.4)	(1.9)	(0.1)	(1.9)	(14.0)	(9.9)	(4.1)
Clinical Negligence	(1.5)	(1.5)	0.0	0.0	0.0	(8.8)	(8.8)	0.0	0.0	0.0	(17.6)	(17.6)	0.0
Establishment	(0.4)	(0.3)	(0.1)	(0.0)	(0.1)	(1.7)	(1.6)	(0.1)	0.0	(0.1)	(3.5)	(3.4)	(0.1)
Premises	(1.9)	(2.1)	0.2	0.1	0.2	(12.8)	(12.5)	(0.2)	0.1	(0.3)	(26.5)	(26.1)	(0.4)
Transport	(0.1)	(0.1)	(0.0)	0.0	(0.0)	(0.8)	(0.8)	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)	(4.9)	(3.7)	(1.2)	(1.1)	(0.1)	(9.1)	(6.4)	(2.7)
Non-Pay Reserves	0.4	(0.3)	0.7	0.0	0.7	(0.0)	(3.4)	3.4	0.0	3.4	(0.0)	(7.5)	7.5
Total Non Pay	**(14.3)**	**(14.1)**	**(0.2)**	**(0.1)**	**(0.1)**	**(89.2)**	**(88.6)**	**(0.7)**	**(1.1)**	**0.5**	**(174.8)**	**(173.8)**	**(1.0)**
Total Expenditure	**(38.1)**	**(38.4)**	**0.3**	**(0.0)**	**0.3**	**(231.1)**	**(233.9)**	**2.8**	**(0.4)**	**3.2**	**(462.6)**	**(465.4)**	**2.8**
EBITDA	**2.8**	**3.0**	**(0.1)**	**(0.0)**	**(0.1)**	**16.4**	**16.0**	**0.4**	**(0.0)**	**0.4**	**37.8**	**37.8**	**(0.0)**
	0.0	*0.0*	*0.0*	*%*		*6.6%*	*6.4%*	*-18.2%*	*0.0%*	*-15.7%*	*7.6%*	*7.5%*	*0.7%*
Depreciation	(1.0)	(1.1)	0.1	0.0	0.1	(6.5)	(6.7)	0.1	0.0	0.1	(13.2)	(13.5)	0.3
Interest	(0.1)	(0.1)	0.1	0.0	0.1	(0.7)	(0.8)	0.0	0.0	0.0	(1.4)	(1.6)	0.2
Dividend	(0.1)	(0.1)	0.0	0.0	0	(0.8)	(0.8)	0	0.0	0	(1.6)	(1.6)	0
PFI and Impairments	(1.2)	(1.5)	0.3	0.0	0.3	(7.2)	(7.5)	0.3	0.0	0.3	(15.1)	(15.4)	0.3
Total Finance Costs	**(2.4)**	**(2.9)**	**0.5**	**0.0**	**0.5**	**(15.2)**	**(15.7)**	**0.5**	**0**	**0.5**	**(31.2)**	**(32.0)**	**0.8**
Net Surplus / Deficit (-)	**0.5**	**0.1**	**0.4**	**(0.0)**	**0.4**	**1.2**	**0.3**	**0.9**	**(0.0)**	**0.9**	**6.6**	**5.8**	**0.7**
Technical Adjustments	(0.0)	0.3	(0.4)	0.0	(0.4)	(0.5)	0.3	(0.9)	0.0	(0.9)	0.3	1.1	(0.7)
Surplus/ Deficit (-) to B/E Duty Incl PSF and MRET	**0.4**	**0.4**	**0.0**	**(0.0)**	**0.0**	**0.7**	**0.6**	**0.0**	**(0.0)**	**0.0**	**6.9**	**6.9**	**0.0**
Surplus/ Deficit (-) to B/E Duty Excl PSFand MRET	**(0.6)**	**(0.6)**	**0.0**	**(0.0)**	**0.0**	**(5.1)**	**(5.2)**	**0.0**	**(0.0)**	**0.0**	**(7.0)**	**(7.0)**	**0.0**

Commentary

The Trusts surplus including PSF was £0.4m in September 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 September by £0.2m and £1.6m year to date. The key favourable variances in A&E (£0.4m) Electives (£0.1m) and Day Cases (£0.1m) offset by a prior period adjustment £1.0m.

The Trust delivered the year to date PSF and MRET funding for month 6. 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 September by £0.3m. The main pressures in month were Private Patient Unit activity below planned levels (£0.3m) .

Pay budgets adjusted for pass-through items underspent by £0.4m in September, although without the release of £0.2m of reserves the position would have been an underspend of £0.2m. Medical staffing (£0.2m) was the only staff group overspent in the month with Nursing (£0.1m), Admin and Clerical (£0.2m) and Scientific and Technical staffing (£0.2m) all underspending. The key pressures in Medical staffing continue to be within Emergency and Medicine directorate (£0.3m) and Paediatrics (£0.1m), due to high temporary staffing usage. The temporary staffing usage within these areas represent c35% of the their total medical pay spend in the month which is c10% more than the Trust average. These two areas temporary medical spend represented 65% of the Trusts total temporary Medical spend.

Non Pay budgets adjusted for pass through items overspent by £0.1m in the month which included a £0.3m year to date adjustment relating to the EPR project. However cumulatively the EPR project is £0.2m adverse to budget due to 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.

2b. Run Rate Analysis

Analysis of 13 Monthly Performance (£m's)

		Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Change between Months
Revenue	Clinical Income	32.0	33.7	35.5	33.1	32.4	30.6	34.5	35.2	36.4	34.3	37.9	36.3	35.9	(0.4)
	STF / PSF	0.8	1.3	1.3	1.3	0.0	0.0	12.8	0.9	0.9	1.5	1.0	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	3.9	5.7	4.1	4.3	4.7	4.4	5.3	4.1	4.1	4.6	4.5	3.9	4.1	0.1
	Total Revenue	**36.8**	**40.7**	**40.8**	**38.6**	**37.1**	**35.0**	**52.6**	**40.2**	**41.4**	**40.4**	**43.4**	**41.2**	**41.0**	**(0.3)**
Expenditure	Substantive	(18.9)	(17.6)	(18.9)	(18.7)	(18.8)	(18.7)	(19.9)	(20.1)	(19.5)	(19.3)	(19.7)	(19.9)	(19.6)	0.2
	Bank	(1.1)	(1.0)	(1.1)	(1.2)	(1.2)	(1.3)	(1.4)	(1.3)	(1.1)	(1.1)	(1.2)	(1.3)	(1.2)	0.1
	Locum	(0.7)	(0.6)	(0.8)	(1.0)	(0.9)	(0.7)	(1.1)	(0.8)	(0.9)	(0.9)	(0.9)	(1.0)	(1.1)	(0.1)
	Agency	(1.9)	(1.8)	(1.7)	(1.7)	(1.9)	(2.1)	(1.4)	(1.6)	(1.7)	(1.5)	(1.9)	(1.8)	(1.8)	(0.0)
	Pay Reserves	0.0	0.4	(0.2)	(0.2)	(0.1)	(0.2)	(0.2)	(0.3)	(0.3)	(0.3)	(0.3)	0.7	(0.1)	(0.8)
	Total Pay	(22.5)	(20.7)	(22.7)	(22.8)	(23.0)	(23.0)	(23.9)	(24.2)	(23.5)	(23.1)	(23.9)	(23.3)	(23.9)	(0.6)
Non-Pay	Drugs & Medical Gases	(4.4)	(4.4)	(4.8)	(4.2)	(3.9)	(4.5)	(4.5)	(4.6)	(4.6)	(4.2)	(4.7)	(4.5)	(4.4)	0.1
	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	(2.8)	(3.1)	(3.0)	(3.1)	(3.0)	(2.8)	(2.7)	(2.7)	(2.7)	(2.8)	(3.0)	(2.6)	(2.8)	(0.2)
	Supplies & Services - General	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.4)	(0.5)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	0.0
	Services from Other NHS Bodies	(1.1)	(0.8)	(1.3)	(0.9)	(0.9)	(0.2)	(3.2)	(1.0)	(0.8)	(0.7)	(0.6)	(0.6)	(0.8)	(0.2)
	Purchase of Healthcare from Non-NHS	(0.4)	(0.3)	(0.2)	(0.3)	(0.3)	(0.4)	(0.5)	(1.5)	(1.7)	(1.6)	(1.2)	(1.2)	(1.1)	0.1
	Clinical Negligence	(1.6)	(1.6)	(1.3)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	0.0
	Establishment	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.2)	(0.2)	(0.3)	(0.3)	(0.3)	(0.3)	(0.4)	(0.1)
	Premises	(1.8)	(1.7)	(1.5)	(1.8)	(2.6)	(1.9)	(2.3)	(2.3)	(2.2)	(2.4)	(1.9)	(2.1)	(1.9)	0.2
	Transport	(0.1)	(0.1)	(0.1)	(0.1)	(0.2)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.0)
	Other Non-Pay Costs	(0.2)	(1.1)	(0.4)	(0.3)	(1.0)	(1.5)	1.8	(0.5)	(0.5)	(0.7)	(1.2)	(1.0)	(1.0)	(0.0)
	Non-Pay Reserves	0.6	(0.4)	0.0	0.0	0.0	0.0	0.0	(0.5)	(0.4)	(0.4)	0.7	0.1	0.4	0.3
	Total Non Pay	(12.7)	(14.5)	(13.6)	(13.2)	(14.3)	(13.9)	(14.0)	(15.4)	(15.4)	(15.4)	(14.3)	(14.4)	(14.3)	0.1
	Total Expenditure	(35.3)	(35.2)	(36.3)	(36.0)	(37.3)	(36.9)	(38.0)	(39.6)	(38.9)	(38.5)	(38.3)	(37.7)	(38.1)	(0.5)
EBITDA	EBITDA	1.5	5.5	4.5	2.6	(0.1)	(1.9)	14.7	0.5	2.5	1.9	5.1	3.6	2.8	(0.7)
		4%	*14%*	*11%*	*7%*	*0%*	*-6%*	*28%*	*1%*	*6%*	*5%*	*12%*	*9%*	*7%*	
Other Finance Costs	Depreciation	(1.2)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.0)	0.1
	Interest	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	0.0
	Dividend	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	0.5	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	0.0
	PFI and Impairments	(1.3)	(1.4)	(1.2)	(1.2)	(1.2)	2.7	7.9	(1.2)	(1.2)	(1.2)	(1.2)	(1.2)	(1.2)	0.0
	Total Other Finance Costs	**(2.7)**	**(2.7)**	**(2.5)**	**(2.5)**	**(2.5)**	**1.4**	**7.2**	**(2.6)**	**(2.6)**	**(2.5)**	**(2.6)**	**(2.6)**	**(2.4)**	**0.2**
Net Surplus / Deficit (-)	Net Surplus / Deficit (-)	(1.1)	2.8	2.0	0.1	(2.6)	(0.5)	21.9	(2.0)	(0.1)	(0.7)	2.5	1.0	0.5	(0.5)
Technical Adjustments	Technical Adjustments	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)	(0.1)
Surplus/ Deficit (-) to B/E Duty Incl pSF	Surplus/ Deficit (-) to B/E Duty	(1.0)	3.1	2.0	0.1	(2.6)	(0.5)	21.7	(2.0)	(0.1)	(1.3)	2.6	1.0	0.4	(0.6)
Surplus/ Deficit (-) to B/E Duty Excl STF	Surplus/ Deficit (-) to B/E Duty	(1.9)	1.8	0.8	(1.1)	(2.6)	(0.5)	8.9	(2.9)	(1.0)	(2.8)	1.5	0.0	(0.6)	(0.6)

3a. Cost Improvement Plan

Savings by Division

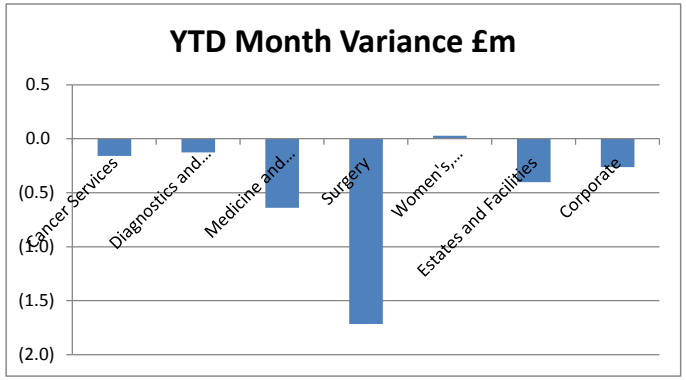
	Current Month			Year to Date			Forecast (Risk Adjusted)				
	Actual	*Original Plan*	*Variance*	*Actual*	*Original Plan*	*Variance*	*Forecast*	*Additional Savings*	*Revised Forecast*	*Original Plan*	*Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Cancer Services	(0.00)	0.13	(0.13)	0.57	0.73	(0.16)	0.78	0.04	0.83	1.45	(0.62)
Diagnostics and Clinical Support	0.27	0.26	0.01	1.50	1.63	(0.13)	2.62	0.10	2.72	3.11	(0.39)
Medicine and Emergency Care	0.37	0.50	(0.13)	1.77	2.41	(0.64)	4.45	0.17	4.62	5.46	(0.84)
Surgery	0.51	0.69	(0.17)	2.42	4.13	(1.71)	5.95	0.25	6.21	8.15	(1.94)
Women's, Children's and Sexual Health	0.20	0.21	(0.01)	1.29	1.26	0.03	2.41	0.08	2.49	2.56	(0.07)
Estates and Facilities	0.16	0.20	(0.03)	0.98	1.39	(0.40)	1.89	0.07	1.96	2.30	(0.34)
Corporate	0.11	0.17	(0.06)	0.76	0.98	(0.26)	1.31	0.06	1.38	2.09	(0.71)
Total	**1.62**	**2.15**	**(0.53)**	**9.28**	**12.53**	**(3.28)**	**19.42**	**0.78**	**20.20**	**25.12**	**(4.92)**
Internal Savings Plan stretch	0.17	(0.10)	0.27	1.62	(2.71)	4.33	2.13		2.13	(2.79)	4.92
Total	**1.79**	**2.05**	**(0.26)**	**10.90**	**9.81**	**1.05**	**21.55**	**0.78**	**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*	*Additional Savings*	*Revised Forecast*	*Original Plan*	*Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Pay	0.56	0.40	0.16	3.23	1.82	1.41	6.49	0.16	6.65	4.58	2.07
Non Pay	(0.04)	0.39	(0.43)	(0.38)	0.34	(0.72)	(0.78)	0.09	(0.69)	2.54	(3.24)
Income	1.27	1.25	0.01	8.05	7.69	0.37	15.84	0.53	16.37	15.20	1.17
Total	**1.79**	**2.05**	**(0.26)**	**10.90**	**9.85**	**1.05**	**21.55**	**0.78**	**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*	*Additional Savings*	*Revised Forecast*	*Original Plan*	*Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Green	1.35	1.44	(0.09)	8.93	7.36	1.55	16.29		16.29	14.33	1.96
Amber	0.37	0.24	0.13	1.66	1.17	0.49	3.58		3.58	3.08	0.51
Red	0.08	0.36	(0.28)	0.31	1.27	(0.96)	1.68	0.78	2.46	4.92	(2.46)
Total	**1.79**	**2.04**	**(0.25)**	**10.90**	**9.81**	**1.08**	**21.55**	**0.78**	**22.33**	**22.33**	**0.00**



Comment

The Trust was adverse to plan in the month by £0.2m which was mainly relating to slippage within Operational efficiency (£0.5m) and Ward closure (£0.2m) partly offset by overperformance in workforce (£0.5m).

The Trust is £1m favourable YTD which is mainly due to overperformance within workforce savings (£1.8m) and Best use of Resources (£0.3m) offset by slippage within patient flow (£1m).

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 October and not opened as part of winter escalation = £0.5m saving
- 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 September 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	35.9	38.1	36.2	35.7	37.3	34.7	37.3	435.2	435.1	0.1
PSF	0.9	0.9	1.5	1.0	1.0	1.0	0.5	0.5	0.5	0.5	0.5	0.5	9.5	13.8	(4.4)
Private Patients	0.1	0.1	0.2	0.1	0.1	0.1	0.3	0.3	0.3	0.4	0.4	0.4	2.8	5.1	(2.3)
Other Operating Income	4.0	4.0	4.4	4.4	3.8	3.9	3.6	3.6	3.6	3.6	3.6	3.5	45.8	49.1	(3.3)
Total Revenue	**40.2**	**41.4**	**40.4**	**43.4**	**41.2**	**41.0**	**42.5**	**40.7**	**40.0**	**41.8**	**39.1**	**41.7**	**493.3**	**503.2**	**(9.9)**
Substantive	(20.1)	(19.5)	(19.3)	(19.7)	(19.9)	(19.6)	(20.7)	(21.3)	(21.5)	(21.8)	(21.9)	(21.9)	(247.1)	(254.4)	7.3
Bank	(1.3)	(1.1)	(1.1)	(1.2)	(1.3)	(1.2)	(1.1)	(1.1)	(1.0)	(1.0)	(1.0)	(1.0)	(13.5)	(10.2)	(3.3)
Locum	(0.8)	(0.9)	(0.9)	(0.9)	(1.0)	(1.1)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(11.1)	(8.4)	(2.8)
Agency	(1.6)	(1.7)	(1.5)	(1.9)	(1.8)	(1.8)	(1.6)	(1.1)	(1.3)	(1.2)	(1.1)	(0.9)	(17.5)	(15.9)	(1.6)
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)	(3.5)	2.4
Total Pay	**(24.2)**	**(23.5)**	**(23.1)**	**(23.9)**	**(23.3)**	**(23.9)**	**(24.4)**	**(24.5)**	**(24.9)**	**(25.0)**	**(25.0)**	**(24.8)**	**(290.3)**	**(292.4)**	**2.0**
Drugs & Medical Gases	(4.6)	(4.6)	(4.2)	(4.7)	(4.5)	(4.4)	(4.5)	(4.5)	(4.5)	(4.5)	(4.5)	(4.5)	(54.2)	(51.4)	(2.8)
Clinical Supplies	(3.2)	(3.1)	(3.2)	(3.5)	(3.0)	(3.2)	(3.3)	(3.2)	(3.2)	(3.3)	(3.3)	(3.3)	(38.8)	(39.2)	0.3
Purchase of Healthcare from Non-NHS	(1.5)	(1.7)	(1.6)	(1.2)	(1.2)	(1.1)	(0.9)	(0.8)	(0.9)	(1.1)	(1.0)	(1.0)	(14.1)	(9.0)	(5.1)
Other Non-Pay Costs	(5.6)	(5.6)	(5.9)	(5.7)	(5.8)	(5.9)	(5.8)	(5.8)	(5.8)	(6.0)	(5.8)	(5.5)	(69.3)	(68.6)	(0.6)
Non-Pay Reserves	(0.5)	(0.4)	(0.4)	0.7	0.1	0.4	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.1)	(4.8)	4.7
Total Non Pay	**(15.4)**	**(15.4)**	**(15.4)**	**(14.3)**	**(14.4)**	**(14.3)**	**(14.6)**	**(14.4)**	**(14.4)**	**(14.9)**	**(14.6)**	**(14.5)**	**(176.5)**	**(173.0)**	**(3.6)**
Other Finance Costs	(2.6)	(2.6)	(2.5)	(2.6)	(2.6)	(2.4)	(2.6)	(2.6)	(2.6)	(2.6)	(2.6)	(3.1)	(31.2)	(32.0)	0.8
Technical Adjustments	0.0	0.0	(0.6)	0.0	0.0	(0.0)	0.0	0.0	0.0	0.0	0.0	0.7	0.3	1.1	(0.8)
Surplus/ Deficit (-) to B/E Duty	**(2.0)**	**(0.1)**	**(1.3)**	**2.6**	**1.0**	**0.4**	**1.0**	**(0.7)**	**(1.8)**	**(0.7)**	**(3.0)**	**0.0**	**(4.5)**	**6.9**	**(11.4)**
Surplus/ Deficit (-) to B/E Duty Excl PSF	**(2.9)**	**(1.0)**	**(2.2)**	**1.5**	**0.0**	**(0.6)**	**0.5**	**(1.3)**	**(2.3)**	**(1.2)**	**(3.6)**	**(0.5)**	**(13.4)**	**(7.0)**	**(6.5)**
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)**
Total Mitigations / Recovery Actions	**0**	**0**	**0**	**0**	**0**	**0**	**0.2**	**0.6**	**0.8**	**0.8**	**0.8**	**3.3**	**6.5**	**0**	**6.5**
Revised Forecast Including Mitigations	**(2.9)**	**(1.0)**	**(2.2)**	**1.5**	**0.0**	**(0.6)**	**0.8**	**(0.7)**	**(1.6)**	**(0.4)**	**(2.8)**	**2.8**	**(7.0)**	**(7.0)**	**(0.0)**
Variance by month	0.0	0.0	0.0	0.0	0.0	0.0	(0.8)	(0.2)	(0.2)	(0.7)	(0.5)	2.3			
Variance by Quarter			0.0			0.0			(1.2)			1.1			

5a. Balance Sheet

September 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	September Reported	September Plan	Variance	August Reported	Full year Plan
Property, Plant and Equipment (Fixed Assets)	288.1	289.5	(1.4)	288.4	307.6
Intangibles	2.7	3.0	(0.3)	2.8	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	**292.4**	**293.9**	**(1.5)**	**292.8**	**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	16.7	29.9	(13.2)	16.8	24.7
Receivables (Debtors) - Non-NHS	14.5	13.6	0.9	14.2	9.2
Cash	42.8	33.9	8.9	45.8	3.0
Assets Held For Sale	0.0	0.0	0.0	0.0	0.0
Total Current Assets	**81.8**	**85.2**	**(3.4)**	**84.6**	**44.7**
Current Liabilities					
Payables (Creditors) - NHS	(7.2)	(4.6)	(2.6)	(5.6)	(5.1)
Payables (Creditors) - Non-NHS	(51.2)	(44.8)	(6.4)	(50.3)	(31.1)
Deferred Income	(16.9)	(14.0)	(2.9)	(21.0)	(2.6)
Capital Loan	(2.2)	(2.2)	0.0	(2.6)	(2.2)
Working Capital Loan	0.0	(16.9)	16.9	0.0	(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	**(84.8)**	**(89.8)**	**5.0**	**(86.8)**	**(74.3)**
Net Current Assets	(3.0)	(4.6)	1.6	(2.2)	(29.6)
non-current liabilities: Borrowings - PFI > 1yr	(184.5)	(184.8)	0.3	(185.0)	(182.2)
Capital Loans	(6.9)	(6.9)	0.0	(8.0)	(6.6)
Working Capital Facility & Revenue loans	(26.2)	(26.2)	0.0	(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	**69.4**	**68.9**	**0.5**	**69.0**	**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	(174.2)	(174.7)	0.5	(174.6)	(168.4)
Total Capital & Reserves	**69.4**	**68.9**	**0.5**	**69.0**	**91.1**

Commentary:
The overall working capital within the month results in a decrease in Debtors of £12.3m against plan with an increase in creditors of £9m compared to the revised plan submitted in May. The cash balance held at the end of the month is higher than the plan by £8.9m.

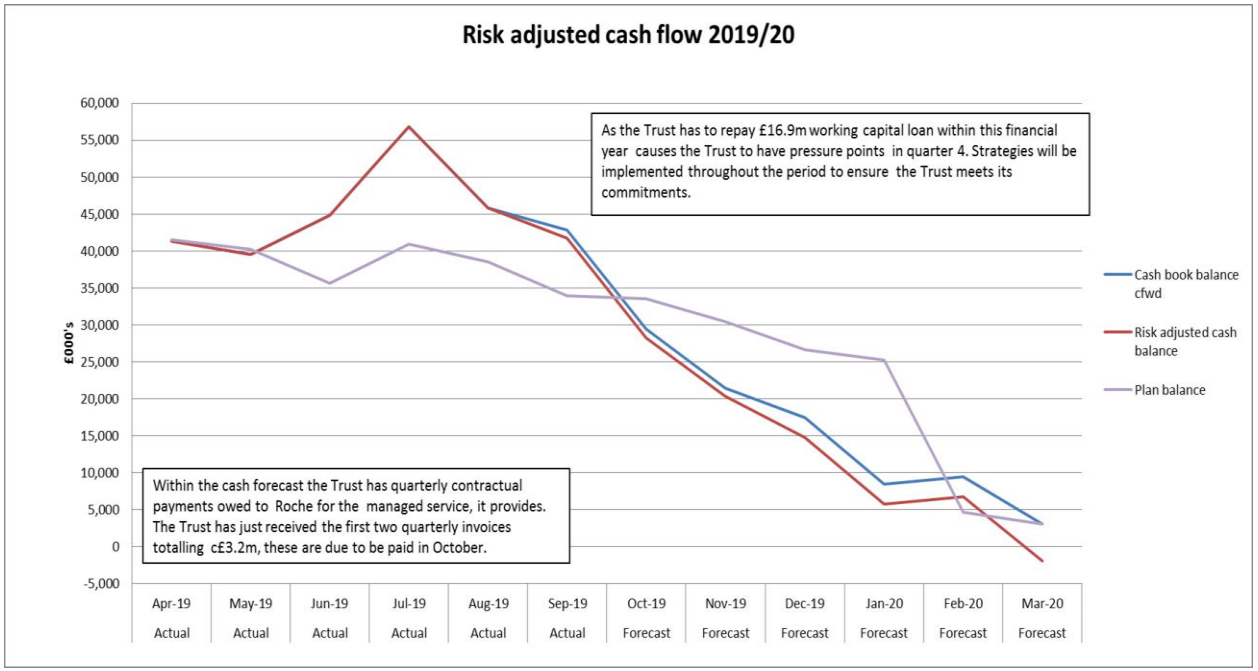
Non-Current Assets -
Capital additions for 2019/20 based on the plan submitted on 15th May are £14.8m with depreciation of £13.5m. Included within the capital additions are £0.4m donated assets. The planned spend for September was £1.3m with actual spend of £0.4m.

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 £1.1m.
NHS Receivables have slightly decreased from August's position by £0.1m to £16.7m. Of the £16.7m reported balance, £6.8m relates to invoiced debt of which £2.1m is aged debt over 90 days. Invoiced debt over 90 days has slightly decreased by £0.1m from the reported Augusts position of £2.2m. The remaining £9.9m relates to uninvoiced accrued income including quarter 2 PSF of £1.5m 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 increased by £0.3m to £14.5m from the reported August position of £14.2m. Included within the £14.5m balance is trade invoiced debt of £1.9m and private patient invoiced debt of £0.7m. Also included within the £14.5m are prepayments and accrued income totalling £10.6m. Prepayments primarily relate to rates & annual service maintenance contracts, which will reduce throughout the year as they are expensed.
The cash balance of £42.8m is higher than the plan of £33.9m. The main variance relates to the Trust forecasting two quarterly payments to Roche for the managed service contract totalling c£3.2m. The Trust has now received these invoices and these will be paid in October. Additionally the Trust has also received income in respect of Prime Provider contracts, the Trust is expecting invoices from WK CCG relating to mth 2 and 3 recharge of expenditure relating to Prime Provider totalling £2m, the Trust has these forecast to be paid in October. The Trust has already paid £1m to WK relating to mth 1 prime provider expenditure in September.
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 August's reported balance by £1.6m to £7.2m, this is primarily due to the Trust receiving an invoice from West Kent CCG for £1m relating to April Prime Provider recharge. Non-NHS trade payables have also increased by £0.9m giving a combined payables balance of £58.4m.

Of the £58.4m combined payables balances, £15.3m relates to actual invoices of which £8.3m are approved for payment and will be released when they fall due, the remaining balance of payables of £43.1m relates to uninvoiced accruals.
The Balance of £8.3m approved invoices at the end of September shows 82.5% are within 0-30 days outstanding.
Deferred income of £16.9m primarily is in relation to £12.6m advance contract payment received from WKCCG and £1.9m maternity pathway with CCG's.
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 September 2019 was £42.8m which is slightly higher than plan of £33.9m. The two main elements for the variances firstly relates to the cash forecast expecting two quarterly invoices from Roche totalling £3.2m, these invoices have now been received and will be paid in October.

Secondly the Trust has received income relating to prime provider contracts but the Trust is waiting for the CCG to invoice the Trust for c£2m expenditure which the Trust has forecast to pay out in October , although the Trust hasn't received the invoices yet.
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	475	551	-76	6,588	2,550	-4,038	926
ICT	1,930	1,045	885	4,103	3,967	-136	2,292
Equipment	613	47	566	3,163	7,037	3,874	446
PFI Lifecycle (IFRIC 12)	419	0	419	594	594	0	594
Donated Assets	-150	564	-714	400	900	500	870
Total Including Donated Assets	**3,287**	**2,207**	**1,080**	**14,848**	**15,048**	**200**	**5,127**
Less donated assets	150	-564	714	-400	-900	-500	0
Total Excluding Donated Assets	**3,437**	**1,642**	**1,795**	**14,448**	**14,148**	**-300**	

Following the recent announcements of new capital funding in 2019/20 and the reversal of the capital control total reductions 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, estates backlog and IT schemes that could be delivered in this financial year. The Trust will be submitting a new application to NHSE/I for the CRL cover for this resource. The Trust has submitted the planned emergency capital case for the TWH CT scanner which is also being considered by NHSE/I under the heading of the recently announced £200m Diagnostic and Scanning equipment fund for this financial year. The Trust is in discussion with NHSE/I on other possibilities for bidding against this fund.

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

Planned and actual ward staffing

Sep-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 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	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	Comments	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Stroke Unit (M) - NK551	89.7%	85.9%	-	100.0%	104.8%	108.5%	-	-	43.4%	55.1%	164	↗	11.37	9	↓	7.9	30.0%	93.3%	8	1	3 falls above threshold. Reduced RN fill rate due to unfilled shifts and lack of available temporary staff. Staff moved on 3 ocassions to support safe staffing	147,455	141,264	6,191
MAIDSTONE	Cornwallis (M) - NS959	114.3%	144.3%	-	-	102.5%	83.3%	-	-	28.6%	10.1%	33	↓	2.03	3	→	6.5	No resp	No resp	1	0		80,888	90,921	(10,033)
MAIDSTONE	Culpepper Ward (M) - NS551	100.3%	95.4%	-	-	104.2%	90.8%	-	-	22.0%	19.7%	73	↓	4.91	3	↓	7.7	48.9%	100.0%	0	0		113,018	112,070	948
MAIDSTONE	John Day Respiratory Ward (M) - NT151	88.5%	131.0%	-	-	102.8%	110.0%	-	-	39.0%	50.1%	150	↓	10.42	15	↗	6.4	48.5%	93.8%	4	0	RN reduced fill rate with 15 unfilled shifts. Increased CSW requirements due to enhanced care for high falls risk.	132,124	145,555	(13,431)
MAIDSTONE	Intensive Care (M) - NA251	90.9%	106.1%	-	-	83.3%	-	-	-	7.4%	30.8%	40	↓	2.62	2	↘	32.9			0	0	Reduced RN fill rate at night in line with reduced bed occupancy	163,371	166,864	(3,493)
MAIDSTONE	Pye Oliver (Medical) - NK259	87.7%	118.0%	-	-	122.3%	107.8%	-	-	35.2%	63.8%	165	↑	11.39	41	↑	6.3	33.3%	93.8%	10	2	5 falls above threshold. Reduced RN fill rate due to lack of available temporary staff on 41 ocassions. Increased fill rate at night due to RMN requirements	119,314	122,006	(2,692)
MAIDSTONE	Chaucer Ward (M) - NS951	59.5%	32.1%	-	-	75.8%	57.8%	-	-	26.8%	40.3%	120	↘	7.87	45	↑	6.0			4	1	Chaucer re opened and staffing requirements being aligned. EC ward staff moved to chaucer 23rd September	0	28,223	(28,223)
MAIDSTONE	Whatman Ward - NK959	81.1%	87.3%	-	100.0%	151.7%	149.6%	-	-	48.5%	40.0%	144	↓	9.95	19	↗	19.3	11.1%	84.6%	3	0	Reduced RN fill rate during the day due to 19 unfilled shifts against a demand of 144. Increased fill rate at night due to escalation of unit	102,496	110,905	(8,409)
MAIDSTONE	Lord North Ward (M) - NF651	96.6%	132.2%	-	-	98.8%	100.0%	-	-	21.1%	10.8%	50	↑	3.53	13	↗	6.9	28.1%	100.0%	1	0		88,181	100,893	(12,712)
MAIDSTONE	Mercer Ward (M) - NJ251	91.3%	108.8%	-	100.0%	98.9%	100.0%	-	-	21.9%	63.4%	94	↓	6.28	10	↘	5.9	60.0%	100.0%	3	1		119,487	107,579	11,908
MAIDSTONE	Edith Cavell (M) - NS459	71.3%	90.9%	-	-	81.4%	116.7%	-	-	33.0%	36.2%	73	↑	4.90	14	↗	6.4	100.0%	100.0%	2	1	Reduced fill rate in line with planned ward closure on 23rd September.	85,229	83,468	1,761
MAIDSTONE	Acute Medical Unit (M) - NG551	88.5%	87.7%	-	-	128.8%	190.0%	-	-	32.4%	43.3%	130	↓	8.45	41	↘	8.2	5.1%	100.0%	3	0	Reduced RN fill rate during the day due to lack of available temporary staff across 41 ocassions. Increased fill rate at night for escalation all throughout the month	117,548	137,250	(19,702)
TWH	Ward 22 (TW) - NG232	42.0%	69.8%	-	-	48.7%	66.9%	-	-	15.6%	29.1%	123	↓	7.49	55	↓	19.0	44.4%	100.0%	2	0	Ward closure as planned with reduced staff fill on reduction on bed base	165,535	127,397	38,138
TWH	Coronary Care Unit (TW) - NP301	103.0%	121.5%	-	-	95.7%	-	-	-	35.6%	37.9%	91	↑	5.46	16	↓	10.9	154.5%	98.0%	0	0		69,979	69,295	684
TWH	Ward 33 (Gynae) (TW) - ND302	94.0%	74.2%	-	-	98.9%	96.7%	-	-	18.7%	10.3%	58	↑	3.61	7	↓	10.0	23.4%	96.2%	0	0	Redcued CSW due to lack of available temporary cover	81,468	89,742	(8,274)
TWH	Intensive Care (TW) - NA201	105.3%	118.3%	-	-	98.4%	86.7%	-	-	4.8%	1.5%	41	↓	2.68	11	↓	27.6			0	0	Short term sickness during the month with unfilled shifts	190,571	201,259	(10,688)
TWH	Acute Medical Unit (TW) - NA901	80.6%	102.8%	-	100.0%	106.2%	97.1%	-	100.0%	44.0%	52.5%	327	↑	22.59	104	↓	7.8	6.5%	100.0%	11	0	5 falls above threshold	184,569	220,212	(35,643)
TWH	Surgical Assessment Unit (TW) - NE701	94.8%	83.3%	-	-	96.7%	96.7%	-	-	26.0%	1.9%	16	↓	1.14	6	↘	11.9			1	0	1 fall above threshold Escalated on 20 ocassions throughout the month	61,157	58,394	2,763
TWH	Ward 32 (Wells Suite) (TW) - NG332	103.7%	107.0%	100.0%	100.0%	119.0%	98.3%	-	-	35.4%	37.4%	123	↓	8.48	30	↗	6.4	No resp	No resp	9	0	3 falls above threshold. Increased fill rate at night due to RMN requirements on 12 ocassions	125,475	122,562	2,913
TWH	Ward 10 (TW) - NG130	88.4%	123.3%	-	-	101.6%	108.3%	-	-	36.8%	27.3%	131	↓	7.95	20	↓	6.4	No resp	No resp	1	0	Reduced RN fill rate with 20 shifts uncovered. Enhanced care requirements / RMN required across 14 ocassions	115,442	126,371	(10,929)
TWH	Ward 11 (TW) - NG131	97.1%	108.1%	-	-	94.9%	125.0%	-	-	39.3%	31.3%	149	↓	9.81	20	↓	6.3	No resp	No resp	4	0	Considered action to alter skill mix and increase CSW fill rate to support staffing levels.	119,152	128,367	(9,215)
TWH	Ward 12 (TW) - NG132	89.2%	112.8%	-	100.0%	108.9%	81.5%	-	-	44.3%	35.7%	155	↘	10.29	33	↓	6.0	74.2%	89.8%	6	0	33 unfilled RN shifts resulting in reduced day fill rate. Skill mix adjustment for CSW support increasing CSW fill rate during the day.	127,948	120,449	7,499
TWH	Ward 20 (TW) - NG230	88.0%	96.1%	-	-	98.7%	127.8%	-	-	38.2%	20.1%	93	↓	6.50	11	↓	5.4	110.0%	77.3%	14	4	7 falls above threshold. Redcued RN fill rate with 11 unfilled shifts. Enhanced care requirements throughout the month additional to plan unfilled due to lack of available temporary staff	112,116	105,311	6,805
TWH	Ward 21 (TW) - NG231	101.0%	105.2%	-	100.0%	107.9%	104.8%	-	-	32.3%	61.9%	175	↑	11.47	33	→	6.5	15.6%	91.7%	5	1	33 unfilled RN shifts throughout the month.	143,977	137,111	6,866
TWH	Ward 2 (TW) - NG442	102.0%	85.4%	-	100.0%	123.3%	127.4%	-	-	40.6%	51.6%	157	↑	10.74	28	↗	7.3	24.6%	100.0%	9	0	2 falls above threshold. Increased fill rate at night due to AFU esclation on 5 ocassions and increasing to weekend working. RMN requirements for half the month.	116,959	124,403	(7,444)
TWH	Ward 30 (TW) - NG330	85.3%	100.0%	-	100.0%	101.1%	115.5%	-	-	38.9%	17.1%	130	↓	8.14	41	↑	5.8	No resp	No resp	6	1	1 fall above threshold. Redcued RN fill rate with 41 unfilled shifts. Enhanced care requirements	118,756	122,160	(3,404)
TWH	Ward 31 (TW) - NG331	90.2%	93.1%	-	100.0%	97.5%	88.9%	-	-	44.2%	53.9%	222	↑	13.85	41	↓	6.3	No resp	No resp	8	1	2 falls above threshold	130,352	140,086	(9,734)
Crowborough	Crowborough Birth Centre (CBC) - NP775	85.9%	96.7%	-	-	98.7%	100.0%	-	-	8.7%	0.0%	21	↓	0.95	4	↗		34.3%	94.7%		0	Considered action to prioritise the night with Community teams support during the day	67,938	68,480	(542)
TWH	Midwifery (multiple rosters)	83.5%	73.1%	-	-	90.5%	73.0%	-	-	15.6%	10.4%	563	↑	32.22	136	↑	18.5			0	1	Reduced fill rate due to lack of available temporary staff. Delivery suite prioritised to ensure safe staffing levels.	686,083	676,910	9,173
TWH	Hedgehog Ward (TW) - ND702	59.4%	80.8%	-	-	81.2%	-	-	-	23.2%	31.2%	225	↑	14.42	55	↑	10.8	8.7%	100.0%	0	0	Bed occupancy range between 14 - 24 throughout the month. RMN requirements on 4 occasions. Recent consultation across paediatrics to change how teams works across speciality areas. Healthroster not yet in line with and is being worked on to reconfigure and match new way of working in teams. Staffing levels impacted by A/L over September with team changes resulting in an increase for temporary demand. RN fill rate therefore shows an anomaly which is as a result of team reconfiguration and NOT a representation of fill rate on HH. Numbers satisfactory during month maintaining safe staffing levels and service delivery	208,842	186,453	22,389
MAIDSTONE	Maidstone Birth Centre - NP751	90.4%	98.9%	-	-	94.5%	100.0%	-	-	12.6%	0.0%	22	↗	1.44	2	↗		44.7%	100.0%	0	0		72,476	63,509	8,967
TWH	SCBU (TW) - NA102	74.3%	354.3%	-	-	94.6%	-	-	-	10.3%	0.0%	75	↓	4.20	5	↘	14.8				0	Bed occupancy between 8 - 15 during the month. Unit Amber across 5 days. Planned Day unregistered was 157.5 hours and the actual were 558 hours. These are the numbers that make up the 354% fill rate. (157.5/558) These numbers are inclusive of 84 Nursery Nurses.	180,251	167,671	12,580
MAIDSTONE	Short Stay Surgery Unit (M) - NE751	91.5%	87.9%	-	-	107.9%	-	-	-	21.9%	16.7%	41	↑	2.59	10	↑	9.5			0	0	Increased fill rate due to ongoing escalation throughout the month	43,595	38,442	5,153
TWH	Short Stay Surgical Unit (TW) - NE901	103.3%	141.1%	-	-	142.6%	266.0%	-	-	74.2%	25.7%	151	↑	9.22	40	↑	6.9			1	0	1 fall above threshold Increased fill rate due to escalation throughout the month	81,887	74,412	7,475
MAIDSTONE	Accident & Emergency (M) - NA351	85.6%	100.6%	-	-	100.1%	96.7%	-	-	25.4%	27.7%	215	↓	13.45	27	↓		5.7%	90.0%	1	0	MH - Reduced RN fill rate due to vacancies and lack of available temporary staff with 27 unfilled shifts.	199,253	210,865	(11,612)
TWH	Accident & Emergency (TW) - NA301	80.1%	92.3%	-	100.0%	92.4%	96.6%	-	-	40.3%	61.6%	477	↓	32.46	96	↓		12.3%	83.9%	3	0	TWH - Redcued RN fill rate due to vacancies and lack of available temporary staff across 96 shifts	335,076	341,135	(6,059)
MAIDSTONE	Maidstone Orthopaedic Unit (M) - NP951	98.2%	91.9%	-	100.0%	94.2%	-	-	-	34.2%	27.6%	59	↓	3.99	7	↓				0	0		43,805	37,210	6,595
MAIDSTONE	Peale Ward (M) - NE959	106.6%	109.8%	-	100.0%	98.3%	100.5%	-	-	6.5%	35.2%	21	↓	1.36	3	↘	8.1	59.4%	95.1%	2	0	1 fall above threshold	81,233	67,369	13,864

Total Established Wards		5,133,006	5,172,575	(39,569)
Additional Capacity beds	Cath Labs	40,411	41,682	(1,271)
	Whatman	0	-802	802
Other associated nursing costs		3,036,983	2,874,493	162,490
		8,210,400	8,087,948	122,452

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 (Care Staff)		Registered Nursing Associates		Non-registered Nursing Associates		Registered Nurses/Midwives		Non-registered Nurses/Midwives (Care Staff)		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 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	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	1,943	1,742	1,563	1,342	0	0	132	132	1,397	1,464	704	764	0	0	0	0	89.7%	85.9%	No data	100.0%	104.8%	108.5%	No data	No data				
Cornwallis	100 - GENERAL SURGERY	101 - UROLOGY	1,037	1,185	731	1,054	0	0	0	0	968	993	330	275	0	0	0	0	114.3%	144.3%	No data	No data	102.5%	83.3%	No data	No data				
Culpepper (incl CCU)	320 - CARDIOLOGY	300 - GENERAL MEDICINE	1,501	1,506	1,080	1,031	0	0	0	0	1,287	1,341	330	300	0	0	0	0	100.3%	95.4%	No data	No data	104.2%	90.8%	No data	No data				
John Day	340 - RESPIRATORY MEDICINE	300 - GENERAL MEDICINE	2,188	1,935	1,191	1,561	0	0	0	0	1,639	1,685	660	726	0	0	0	0	88.5%	131.0%	No data	No data	102.8%	110.0%	No data	No data				
Intensive Treatment Unit (ITU)	192 - CRITICAL CARE MEDICINE		3,166	2,879	168	178	0	0	0	0	2,760	2,300	0	0	0	0	0	0	90.9%	106.1%	No data	No data	83.3%	No data	No data	No data				
Pye Oliver	301 - GASTROENTEROLOGY	300 - GENERAL MEDICINE	1,591	1,395	1,455	1,717	0	0	0	0	990	1,211	990	1,067	0	0	0	0	87.7%	118.0%	No data	No data	122.3%	107.8%	No data	No data				
Chaucer	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1,760	1,047	2,070	664	0	0	0	0	1,320	1,001	990	572	0	0	0	0	59.5%	32.1%	No data	No data	75.8%	57.8%	No data	No data				
Lord North	370 - MEDICAL ONCOLOGY	800 - CLINICAL ONCOLOGY	1,708	1,650	540	714	0	0	0	0	1,080	1,068	360	360	0	0	0	0	96.6%	132.2%	No data	No data	98.8%	100.0%	No data	No data				
Mercer	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1,566	1,431	1,425	1,550	0	0	48	48	990	979	660	660	0	0	0	0	91.3%	108.8%	No data	100.0%	98.9%	100.0%	No data	No data				
Edith Cavel	300 - GENERAL MEDICINE		1,233	879	950	864	0	0	0	0	946	770	330	385	0	0	0	0	71.3%	90.9%	No data	No data	81.4%	116.7%	No data	No data				
Urgent Medical Ambulatory Unit (UMAU)	180 - ACCIDENT & EMERGENCY	300 - GENERAL MEDICINE	2,312	2,046	1,324	1,161	0	0	0	0	1,001	1,289	330	627	0	0	0	0	88.5%	87.7%	No data	No data	128.8%	190.0%	No data	No data				
Stroke/Ward 22	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	2,406	1,010	1,851	1,291	0	0	0	0	1,650	803	990	662	0	0	0	0	42.0%	69.8%	No data	No data	48.7%	66.9%	No data	No data				
Cornary Care Unit (CCU)	320 - CARDIOLOGY	300 - GENERAL MEDICINE	1,153	1,187	360	438	0	0	0	0	990	948	0	9	0	0	0	0	103.0%	121.5%	No data	No data	95.7%	No data	No data	No data				
Gynaecology/Ward 33	502 - GYNAECOLOGY	100 - GENERAL SURGERY	1,501	1,410	645	478	0	0	0	0	990	979	330	319	0	0	0	0	94.0%	74.2%	No data	No data	98.9%	96.7%	No data	No data				
Intensive Treatment Unit (ITU)	192 - CRITICAL CARE MEDICINE		3,302	3,478	360	426	0	0	0	0	2,640	2,597	330	286	0	0	0	0	105.3%	118.3%	No data	No data	98.4%	86.7%	No data	No data				
Medical Assessment Unit	180 - ACCIDENT & EMERGENCY	300 - GENERAL MEDICINE	3,259	2,627	1,263	1,298	0	0	238	238	2,070	2,198	989	961	0	0	46	46	80.6%	102.8%	No data	100.0%	106.2%	97.1%	No data	100.0%				
SAU	180 - ACCIDENT & EMERGENCY	100 - GENERAL SURGERY	1,077	1,020	332	276	0	0	0	0	660	638	330	319	0	0	0	0	94.8%	83.3%	No data	No data	96.7%	96.7%	No data	No data				
Ward 32	300 - GENERAL MEDICINE		1,561	1,619	1,386	1,483	138	138	93	93	989	1,176	1,320	1,298	0	0	0	0	103.7%	107.0%	100.0%	100.0%	119.0%	98.3%	No data	No data				
Ward 10	100 - GENERAL SURGERY		2,058	1,820	1,449	1,786	0	0	0	0	990	1,006	990	1,072	0	0	0	0	88.4%	123.3%	No data	No data	101.6%	108.3%	No data	No data				
Ward 11	100 - GENERAL SURGERY		2,219	2,154	1,320	1,428	0	0	0	0	1,320	1,253	660	825	0	0	0	0	97.1%	108.1%	No data	No data	94.9%	125.0%	No data	No data				
Ward 12	320 - CARDIOLOGY	301 - GASTROENTEROLOGY	1,956	1,744	1,181	1,331	0	0	120	120	990	1,078	1,320	1,076	0	0	0	0	89.2%	112.8%	No data	100.0%	108.9%	81.5%	No data	No data				
Ward 20	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1,229	1,081	1,601	1,538	0	0	0	0	992	979	990	1,265	0	0	0	0	88.0%	96.1%	No data	No data	98.7%	127.8%	No data	No data				
Ward 21	340 - RESPIRATORY MEDICINE	302 - ENDOCRINOLOGY	2,208	2,230	1,065	1,121	0	0	48	48	1,650	1,781	660	692	0	0	0	0	101.0%	105.2%	No data	100.0%	107.9%	104.8%	No data	No data				
Ward 2	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1,808	1,844	1,626	1,388	0	0	72	72	990	1,221	967	1,232	0	0	0	0	102.0%	85.4%	No data	100.0%	123.3%	127.4%	No data	No data				
Ward 30	110 - TRAUMA & ORTHOPAEDICS		2,029	1,731	1,214	1,214	0	0	91	91	990	1,001	990	1,143	0	0	0	0	85.3%	100.0%	No data	100.0%	101.1%	115.5%	No data	No data				
Ward 31	110 - TRAUMA & ORTHOPAEDICS		2,053	1,851	1,597	1,487	0	0	115	115	1,320	1,287	990	880	0	0	0	0	90.2%	93.1%	No data	100.0%	97.5%	88.9%	No data	No data				
Birth Centre (Crowborough).	501 - OBSTETRICS		779	668	345	334	0	0	0	0	714	705	345	345	0	0	0	0	85.9%	96.7%	No data	No data	98.7%	100.0%	No data	No data				
Midwifery Services (ante/post natal & Delivery Suite)	501 - OBSTETRICS		20,520	17,132	5,439	3,979	0	0	0	0	5,472	4,951	2,258	1,649	0	0	0	0	83.5%	73.1%	No data	No data	90.5%	73.0%	No data	No data				
Hedgehog	420 - PAEDIATRICS		5,051	2,998	608	491	0	0	0	0	2,301	1,868	0	304	0	0	0	0	59.4%	80.8%	No data	No data	81.2%	No data	No data	No data				
Birth Centre	501 - OBSTETRICS		810	732	354	350	0	0	0	0	655	619	323	323	0	0	0	0	90.4%	98.9%	No data	No data	94.5%	100.0%	No data	No data				
Neonatal Unit	420 - PAEDIATRICS		3,984	2,961	158	558	0	0	0	0	2,288	2,165	0	200	0	0	0	0	74.3%	354.3%	No data	No data	94.6%	No data	No data	No data				
MSSU	100 - GENERAL SURGERY		1,113	1,019	524	461	0	0	0	0	462	499	0	42	0	0	0	0	91.5%	87.9%	No data	No data	107.9%	No data	No data	No data				
Peale	100 - GENERAL SURGERY		1,211	1,291	539	592	0	0	146	146	660	649	329	330	0	0	0	0	106.6%	109.8%	No data	100.0%	98.3%	100.5%	No data	No data				
SSSU	100 - GENERAL SURGERY		1,295	1,338	572	806	0	0	0	0	462	659	231	615	0	0	0	0	103.3%	141.1%	No data	No data	142.6%	266.0%	No data	No data				
Whatman	300 - GENERAL MEDICINE		2,000	1,622	1,368	1,194	0	0	99	99	660	1,001	330	494	0	0	0	0	81.1%	87.3%	No data	100.0%	151.7%	149.6%	No data	No data				
MOU			867	852	717	659	0	0	12	12	660	622	0	0	0	0	0	0	98.2%	91.9%	No data	100.0%	94.2%	No data	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																

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

The enclosed report provides a summary of infection prevention and control activity in the Trust between April 2018 and March 2019.

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

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

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

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

Maidstone and Tunbridge Wells NHS Trust

2018/19 Annual Infection Prevention and Control Report

and

2019/20 Healthcare Associated Infection Reduction Plan

2018/19 Annual Infection Prevention and Control Report and 2019/20 Healthcare Associated Infection Reduction Plan

Introduction

This is a two-part document; a report on the developments and performance related to Infection Prevention and Control (IPC) during 2017/18 and the broad plan of work for 2018/19 to reduce the risk of healthcare associated infections (HCAIs). The report outlines the challenges faced in-year and the Trusts approach to reducing the risk of HCAI for patients.

A zero tolerance approach continues to be taken by the Trust to all avoidable HCAIs. Good IPC practice is essential to ensure that people who use the Trust services receive safe and effective care. Effective IPC practices must be part of everyday practice and be applied consistently by everyone. The publication of the IPC Annual Report is a requirement to demonstrate good governance and public accountability

The report acknowledges the hard work and diligence of all grades of staff, clinical and non-clinical who play a vital role in improving the quality of patient and stakeholder experience as well as helping to reduce the number of infections. Additionally the Trust continues to work collaboratively with a number of outside agencies as part of its IPC and governance arrangements including commissioning CCGs, SECAMB, other local NHS Trusts and the members of the Kent and Medway STP HCAI and antimicrobial stewardship steering group and its subcommittees

Executive Summary

The annual report for Infection Prevention and Control outlines the Trust's IPC activity in 2018/19. In addition it highlights the role, function and reporting arrangements of the Director of Infection Prevention and Control (DIPC) and the Infection Prevention and Control Team (IPCT).

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

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

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

There are national contractual reduction objectives for *Clostridium difficile* infections and there are five other infections for which mandatory reporting to Public Health England is in place.

Clostridioides difficile infections

Meticillin Resistant *Staphylococcus aureus* (MRSA) bloodstream infections

Meticillin Sensitive *Staphylococcus aureus* (MSSA) bloodstream infections

Eschericia coli (E. coli) bloodstream infections

Klebsiella spp blood stream infections

Pseudomonas aeruginosa blood stream infections

The structure and headings of the report follows the ten criteria laid out in the 2015 edition of the Health and Social Care Act 2008; Code of practice in the prevention and control of infections and related guidance (also known as the Hygiene Code). A Trust compliance statement is available on the Trust website.

Compliance Criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them

Governance and Monitoring

1.1 IPC Governance

The Trust Board has collective responsibility for overseeing IPC arrangements in the Trust. The Chief Nurse is the executive lead for quality within the Trust

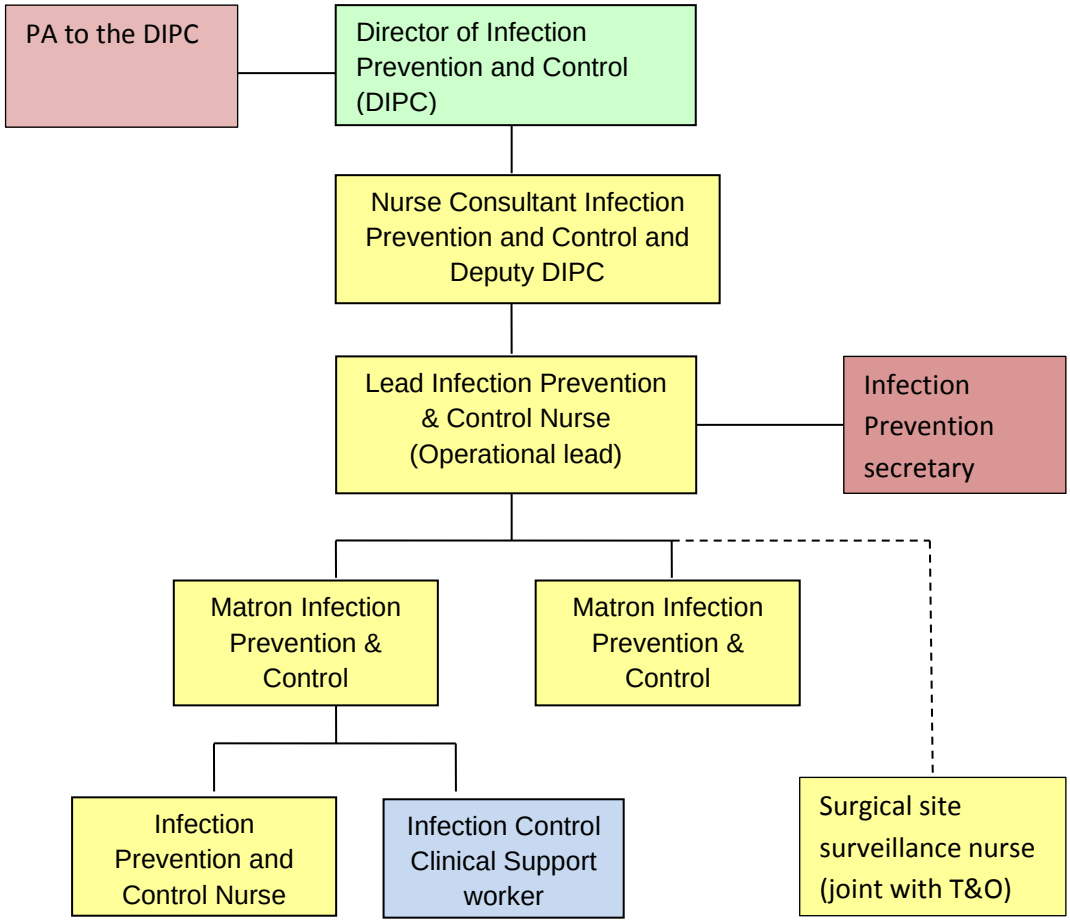
The Director of Infection Prevention and Control (DIPC) is a consultant microbiologist and reports directly to the Chief Executive Officer

The DIPC is supported by the Deputy DIPC (Nurse Consultant in Infection Prevention and Control) and the IPCT (Fig 1). The team welcomed Clair Taylor to her post as Infection Prevention and Control Matron this year

The DIPC delivers an Annual HCAI Reduction Report to the Board of Directors and the forthcoming HCAI Reduction Delivery Plan based on the national and local quality goals.

The Trust Board receives a monthly IPC report, more frequently or on an ad hoc basis if required. *C. difficile* and MRSA blood stream infection numbers and rates are detailed on the Board level dashboard together with MRSA screening rates.

Fig 1: Structure of the Infection Prevention and Control Team



Directorates report to the Infection Prevention and Control Committee on IPC matters. The structured reports delivered by the directorate representatives include ward audit results, triangulation audits provided by the infection prevention team and antimicrobial audits provided by the antimicrobial pharmacist. The reports are also used to feedback to directorate clinical governance meetings on infection prevention matters.

West Kent CCG is MTW's main commissioning organisation. IPC is a key element of quality commissioning and forms part of the joint commissioning quality schedule.

The *C. difficile* panel meets monthly on each hospital site and reviews root cause analysis reports from all Trust attributable cases of *C. difficile* and MSSA and MRSA blood stream infections. The panel reports to the main Learning and Improvement (Serious Incident) panel and also sends an annual summary report to the IPCC.

1.2 Infection Prevention and Control Committee

The Infection Prevention and Control Committee (IPCC) is chaired by the DIPC and meets bi-monthly. The committee has wide representation from services within the Trust and has external representation from West Kent CCG and Public Health England. The Chief Nurse is the Executive Director member of the committee

The IPCC reports to the Quality Committee, a sub-committee of the Board

The clinical Directorates report to the IPCC on all aspects of infection prevention and antimicrobial stewardship. Additional reports are received from estates and facilities, the vascular access team, the antimicrobial pharmacist, occupational health, risk manager and others as required.

The objectives of the IPCC include:

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

Healthcare Associated Infection Statistics and Targets

1.3 Surveillance

The IPCT undertakes continuous surveillance of target organisms and alert conditions. Patients with pathogenic organisms or specific infections, which could spread, are identified from microbiology reports or from notifications by ward staff. The IPCT advises on the appropriate use of infection control precaution for each case and monitors overall trends.

The IPCT uses the ICNet surveillance system.

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

The IPC team visit patients at regular intervals according to their infection or possible infection. Such infections/conditions are listed below:

1.3.1 Alert organisms

MRSA

Clostridioides difficile infection (CDI)

Group A *Streptococcus*

Salmonella spp

Campylobacter spp

Mycobacterium tuberculosis

Glycopeptide-resistant *Enterococci*

Multi-resistant gram negative bacilli e.g. expended spectrum beta-lactamase (ESBL)producers

Carbapenem resistant and Carbapenemase-producing Enterobacteriaceae (CRE/CPE)

Neisseria meningitidis

Aspergillus

Hepatitis A

Hepatitis B

Hepatitis C

Influenza

Norovirus

1.3.2 Alert Conditions

Measles

Mumps

Chicken pox and Shingles

Scabies

Two or more possibly related cases of acute infection e.g. gastroenteritis

HCAI Reduction Priorities for 2018/19

The national HCAI objectives for MTW for 2018/19 set by NHSE were:

- MRSA – a continued zero tolerance to all MRSA blood stream infections
- CDI – to have no more than 26 patients with Trust-attributable CDI.

In addition the HCAI action plan set out to:

- Reduce MSSA blood stream infection
- Reduce gram-negative blood stream infection

1.4 *Staphylococcus aureus*

All *Staphylococcus aureus* blood stream infections, whether sensitive to Meticillin (MSSA) or resistant to Meticillin (MRSA), are reported on a mandatory basis through the Public Health England (PHE) HCAI Data Capture System (DCS). The Trust's incidence of MSSA and MRSA cases is reported on the fingertips data base https://fingertips.phe.org.uk/profile/amr-local-indicators/data#page/0/gid/1938133070/pat/158/par/NT_trust/ati/118/are/RWF

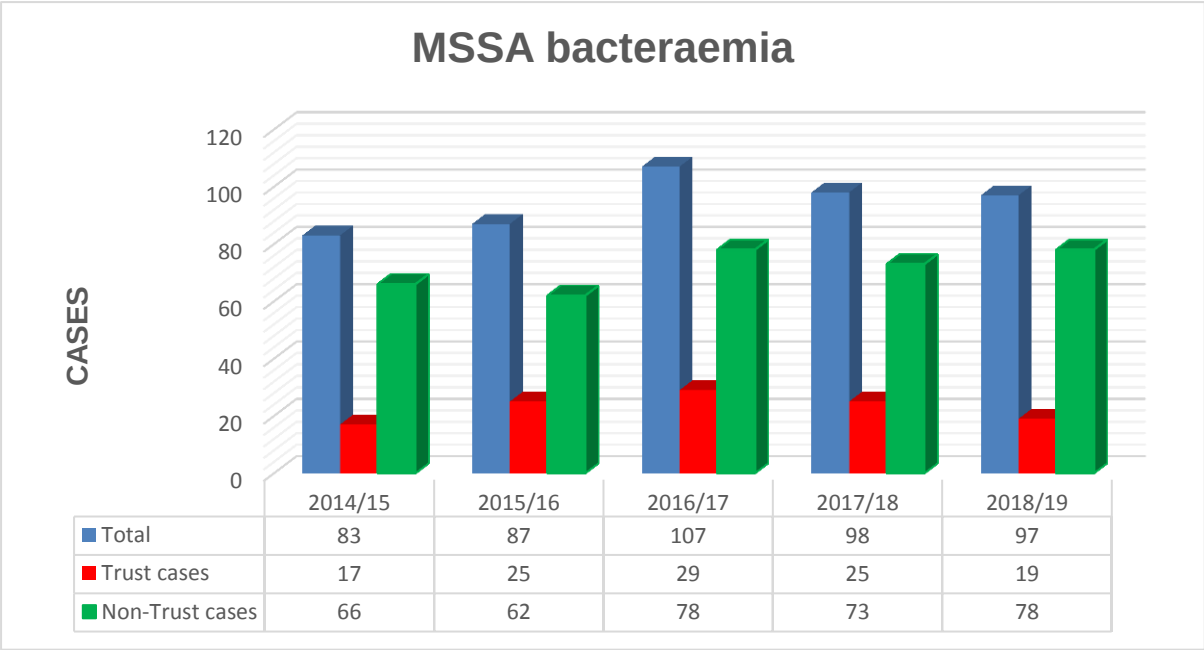
The incidence of these cases is reported publicly as acute Trust attributable or otherwise. The reduction of all avoidable blood stream infections including MSSA and MRSA continues to be an aim of the Trust

1.4.1 MSSA

There is no national objective set for MSSA bacteraemia.

All Trust-attributable (those occurring from day 2 after admission) cases of MSSA blood stream infection have a post – infection review including root cause analysis and presentation of the case at the Infection Control Review Panel.

Fig 2: MSSA bacteraemia cases



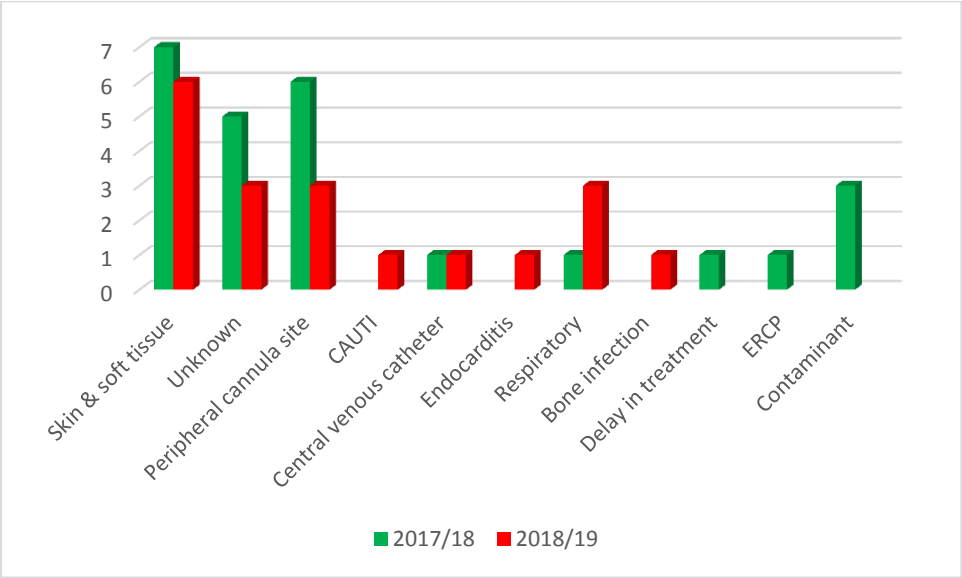
	2014/15	2015/16	2016/17	2017/18	2018/19
Total	83	87	107	98	97
Trust cases	17	25	29	25	19
Non-Trust cases	66	62	78	73	78

There was a 24% reduction in Trust-attributable cases in year. All of this reduction was at Maidstone Hospital where only 2 cases were seen for the year. Five cases were found to be avoidable including one contaminant, two peripheral cannula site infections, one

central venous catheter infection and one catheter associated urinary tract infection (CA-UTI)

Figure 3 shows the root causes of infections compared with 2017/18

Figure 3: MSSA bacteraemia provenance 2017/18-2018/19



1.4.2 MSSA screening

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

1.4.3 MRSA

There was no national HCAI objective for MRSA blood stream infections for 2018/19. However there was an expectation that no avoidable infections would be seen.

Cases are initially defined as non-trust apportioned if blood cultures are collected on the day of admission or the next day. All other cases are apportioned to the Trust. The national requirement for MRSA Post Infection Review (PIR) was withdrawn this year; however the Trust and WKCCG continued to use the process to apportion cases.

In line with the PIR process the Trust investigates every MRSA blood stream infection in collaboration with other care providers associated with the case. This process identifies lessons to be learned across the patient's pathway and determines the final assignment of the case to the CCG, Trust or Third Party.

The Trust has reported four non Trust apportioned cases and three Trust apportioned cases pre-PIR. The final assignment of cases is shown in Table 1. Following the PIR of all of the cases, none were finally assigned to the Trust.

Table 1: MRSA Apportionment and Final Assignment

Month	Apportioned		Final assignment		
	Non trust	Trust	CCG	Trust	Third Party
April	1	1	1		1
May	1		1		
June					
July					
August		1			1
September	1		1		
October	1		1		
November		1			1
December					
January					
February					
March					

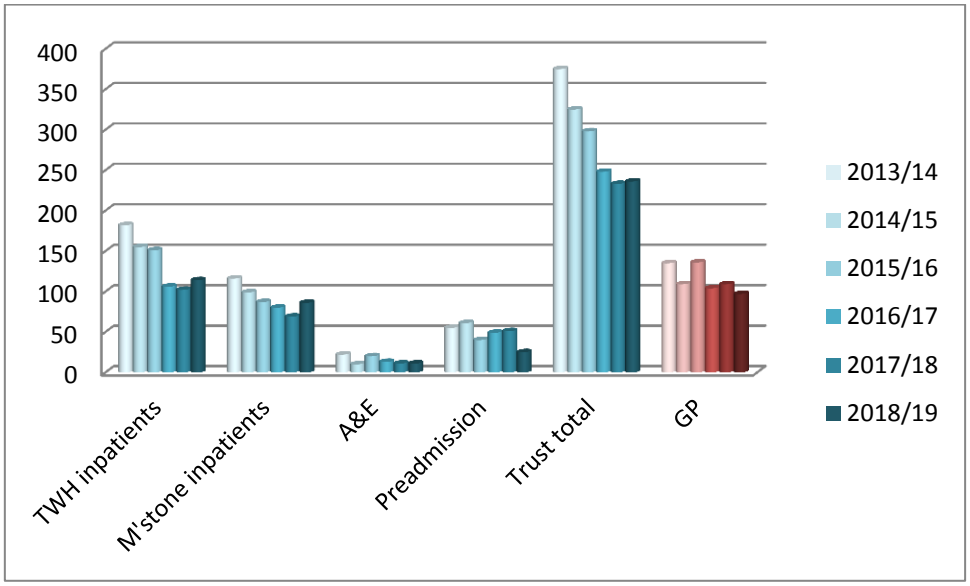
1.4.3 MRSA screening

The Trust continues to use a robust approach to screening the majority of patients, either pre-operatively or on admission. Since 2009, it has been Trust policy to screen all elective admissions (except for certain excluded groups) to comply with Department of Health policy. New guidance was published by the Department of Health in June 2014 (*Implementation of modified admission MRSA screening guidance for NHS* (2014). The guidance outlines a more focussed, cost-effective approach to MRSA screening. Following the publication of the guidance the screening at MTW was reviewed and revised. The revised policy was implemented in November 2014. As a consequence of this there has been no increase in the incidence of MRSA bacteraemia within the Trust and further revision has not been required

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

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

Figure 4: New MRSA colonisations 2013-19



Screening compliance is monitored on a monthly basis. During 2018/19 the elective MRSA screening was maintained at or above 97%. Non-elective screening compliance monitoring could not be completed for 9 months of the year due to IT technical issues.

The number of patients who may have acquired MRSA colonisation in hospital is also monitored. For 2018/19, 27 such cases were identified at Maidstone Hospital and 25 cases at TWH. There were five investigations into possible cross infection. None of these was found proven

1.4.4 Periods of Increased Incidence

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

When the PII is declared the following actions are taken:

Weekly audits of compliance with the *Control and Management of Meticillin Resistant Staphylococcus aureus (MRSA) including Screening and De-colonisation policy*

Weekly audits of antibiotic prescribing

The antibiograms of the MRSA isolates are examined for similarity. If the isolates are indistinguishable by antibiogram, they are sent to the reference laboratory for further typing and genetic finger printing.

Where cross infection is proven:

An incident investigation is initiated.

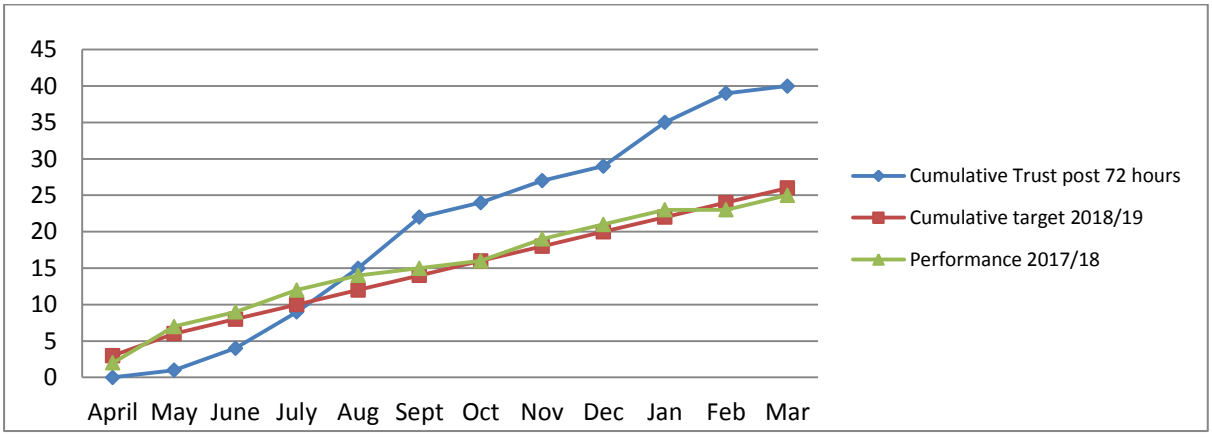
Ward staff may be screened if further cases are identified

1.5 *Clostridioides difficile* infection (CDI)

The CDI PHE objective for MTW for 2018/19 was no more than 26 cases, a reduction of one case on the previous year.

In total 40 Trust attributable cases were seen, a rate of 15.6 cases /100 000 bed days, an increase of 15 cases and a rate of 9.5/100 000 bed days in 2017/18

Figure 5: C. difficile performance against trajectory



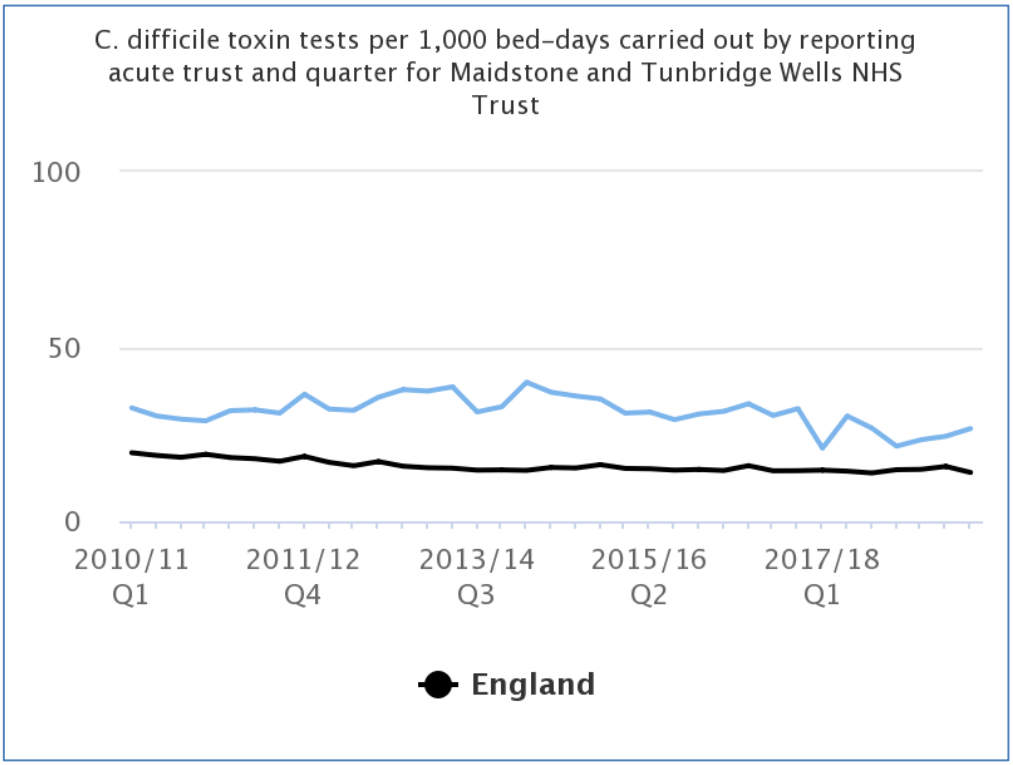
A Trust wide outbreak was declared in September 2018 in response to the increase in cases in June, July and August. Further details can be found at 1.12

1.5.1 Laboratory Diagnosis

C. difficile tests are processed on diarrhoea samples from all inpatients aged 2 years or over, all GP patients aged 65 and over and all other GP patients aged 2 and over where symptoms suggestive of C. difficile infection or antibiotic use are included on the request form, whether or not the test is specifically requested. During 2017/18, the microbiology laboratory processed 7345 samples for *C. difficile* on 4676 patients. Of these 1943 were GP patients, the others being inpatients in acute or community settings, MTW A&E or outpatient attenders.

For 2020/21, PHE is considering basing Trust objectives on not only the cases seen but also the relative rates of testing performed by individual trusts. MTW has a robust testing algorithm and a high rate of testing compared with other Trusts and the national rate as a result.

Figure 6: Laboratory testing compared with England average rate

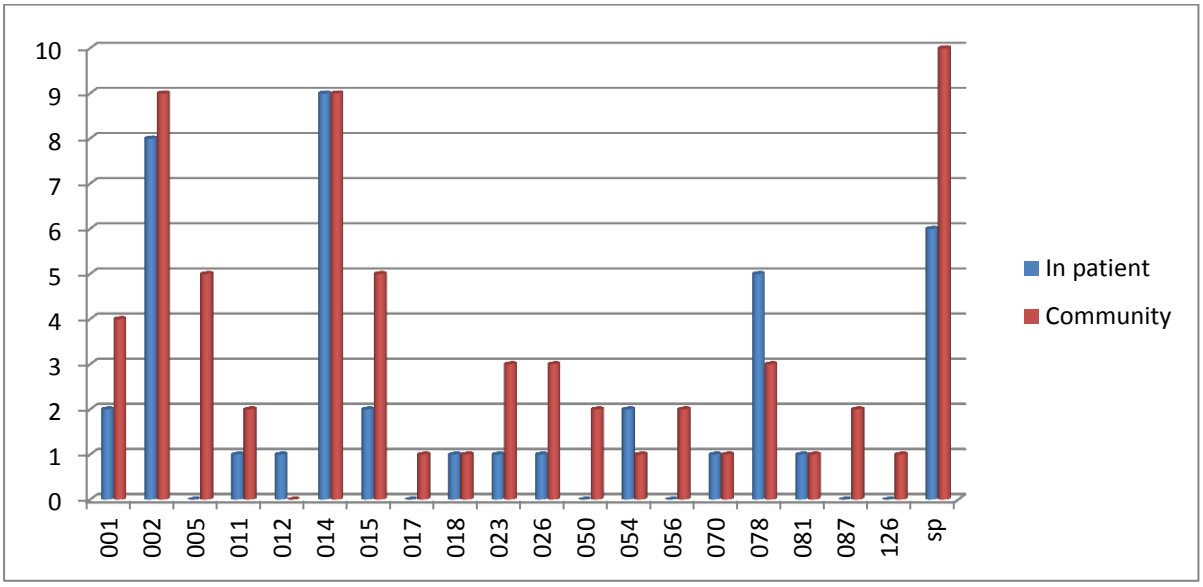


143 patients were newly identified as carriers of toxigenic *C. difficile* (157 in 2016/17). A treatment algorithm is in place to enable identified carriers at high risk to be treated to avoid progression to acute infection.

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

Typing of hospital cases tends to reflect those types prevalent in the community. Type 014 tends to be related to a higher rate of relapse. The 027 strain which caused the outbreak in 2005/6 has decreased in prevalence to background levels – no cases were seen this year. The monitoring of ribotypes will continue in order to detect any trends or cross infection and to give an early warning of any new epidemic strains emerging.

Fig 7: Ribotyping of *C. difficile* cases 2018/19



1.5.2 Case review

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

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

The panel considered all 40 hospital-attributable cases and a further six pre-72 hour cases where the patient had recent MTW admission.

Table 2: Outcomes of root cause analysis

Cross infection	Inappropriate antibiotics	Immuno-suppression	Community antibiotics	Appropriate antibiotics
1	9	3	1	32

Ten cases were found to be avoidable.

Twenty two cases were found to have lapses of care which may have affected their outcome. These include delayed stool sampling (10), Antibiotic guidance not followed (12), delay in isolation (1), cross infection (1). Two cases had more than one lapse of care.

Actions plans were developed in response to all identified issues. The wards are monitored by infection prevention team audits and antibiotic prescribing audits throughout the periods of increased incidence (PII) and are subject to spot checks after the PII has been stepped down to ensure that sustainable change has been made.

1.5.3 Periods of Increased Incidence

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

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

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

Weekly audits of antibiotic prescribing by the antimicrobial pharmacist

Weekly audit of the ward using the *C. difficile* High Impact Intervention audit tool until a score of >90% is achieved for three consecutive weeks and there have been no more cases during that time

If poor audit scores are seen, an escalation meeting is held between the ward manager, matron and infection prevention to assess the need for additional support and training from the IPT

Increased cleaning with throughout the ward with all single rooms decontaminated on discharge by either UV-C light or HPV fogging (depending on risk)

Daily review by the infection control team

When a PII is stepped down the ward is subject to random spot checks over the next month to ensure that improvement is sustained. If a ward fails a spot check, the PII is re-declared

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

Additional actions taken when an incident is declared include

Multidisciplinary investigation meeting held

Intensive infection prevention team support

During 2018/19, thirty two PIIs were declared for *C. difficile*, fifteen at Maidstone and seventeen at TWH. Eight wards had two PIIs during the year and two wards had three. Six PIIs were re-declared following a failed spot check audit. The PIIs lasted an average of five weeks with the longest period being 15 weeks. The majority of wards achieved the standard required in four weeks or less.

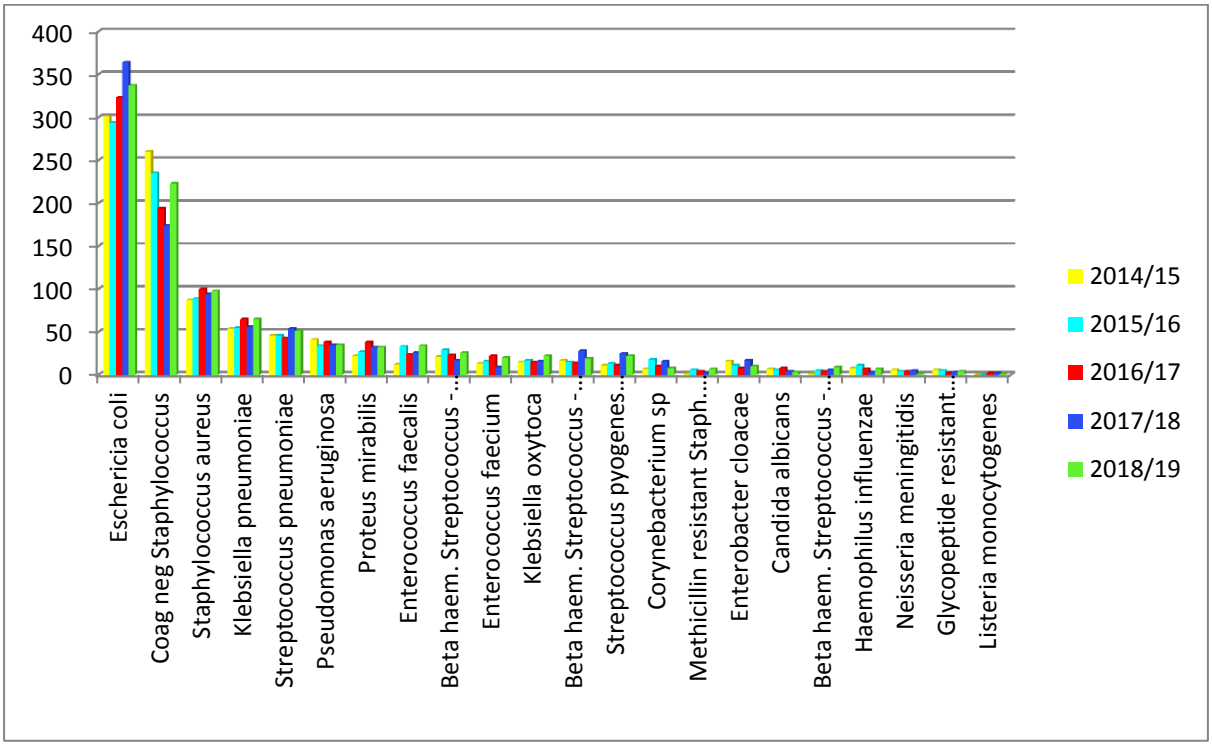
1.5.4 Non-Trust attributed CDI cases

There was a small increase in the number of patients with non-Trust attributable CDI from 73 cases in 2017/18 to 78 cases in 2018/19

1.6 Blood stream infections

A total of 1110 patients had positive blood cultures during 2018/19, a small decrease (20 patients) on the previous year. *E. coli* is the commonest organism causing blood stream infection in the Trust accounting for around 30% of all positive cultures.

Figure 8: Commonest significant isolates from Blood cultures 2014-2019



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

1.6.1 Gram negative blood stream infections

In June 2017, NHS Improvement set a national ambition to reduce healthcare associated gram-negative blood stream infections (healthcare associated GNBSIs) by 50% by March 2021. These include:

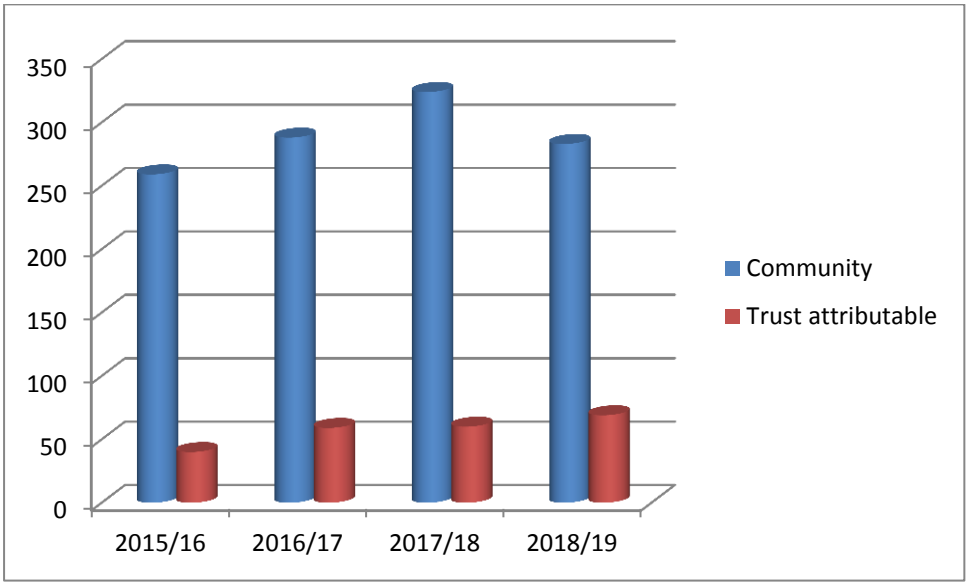
- *E. coli*
- *Klebsiella species*
- *Pseudomonas aeruginosa*

The Trust has been submitting *E. coli* surveillance data to PHE for many years and from April 2017 *Klebsiella species* and *Pseudomonas aeruginosa* data was also required

1.6.2 *Eschericia coli (E. coli)* bacteraemia

E. coli bacteria are frequently found in the intestines of humans and animals. There are many different types of *E. coli* and while some live harmlessly in the intestine, others may cause a variety of diseases. *E. coli* bacteraemia may be caused by primary infections such as urinary tract infections, biliary tract infections and others, spreading to the blood. The MTW rate of *E. coli* infections for 2017/18 was 23.0/100 000 bed days compared with an England rate of 22.2/100 000 bed days. *E. coli* is the commonest cause of bacteraemia (all sources) seen in MTW

Figure 9: *E. coli* bacteraemia 2015-2019



There has been a slow but constant increase in gram negative bacteraemia despite interventions such as improvements in urinary catheter management. The trend analysis suggests that about 38% of *E. coli* sepsis is due to urinary tract infection with 13% due to catheter associated UTI and 23% due to hepatobiliary sepsis.

Actions taken to reduce the rate of *E. coli* bacteraemia in 2018/19 include:

- Universal antimicrobial prophylaxis for ERCP patients implemented
- Hydration project – pilot on two wards to assess reduction in UTI in elderly patients
- Re-introduction of revised catheter passport across Kent and Medway
- High impact intervention including HOUDINI risk assessment for urinary catheters.
- Full root cause analysis undertaken where data collection raises concerns
- All interventions audited to assess impact
- All epidemiological data entered onto PHE Data Capture System to support the national ambition
- Lessons learned identified and shared through IPCC and clinical governance
- Participating in the national gram negative reduction support programme

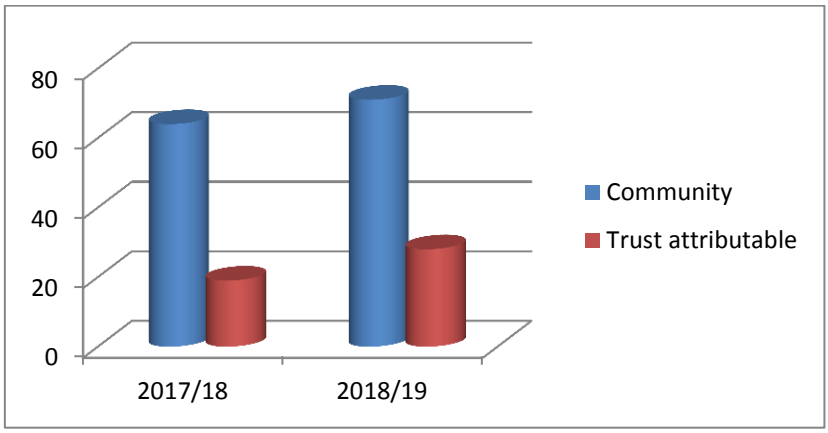
- DIPC and deputy DIPC working with the STP DIPC and colleagues across K&M STP which is a health economy pilot site for leadership in infection management in a project endorsed by NHSI Chief Nurse and Medical Director

Further measures are outlined in the HCAI reduction plan for 2019/20.

1.6.3 *Klebsiella* species bacteraemia

Klebsiella species are gram negative rod-shaped bacteria which are ubiquitous in the environment and are found in the human gut. Three main species cause the majority of human infection; *K. pneumoniae, K. oxytoca* and *K. aerogenes.* Common infections include pneumonia, wound infections and urinary and biliary tract infections. Numbers of infections have continued to rise both in the community and the hospital setting

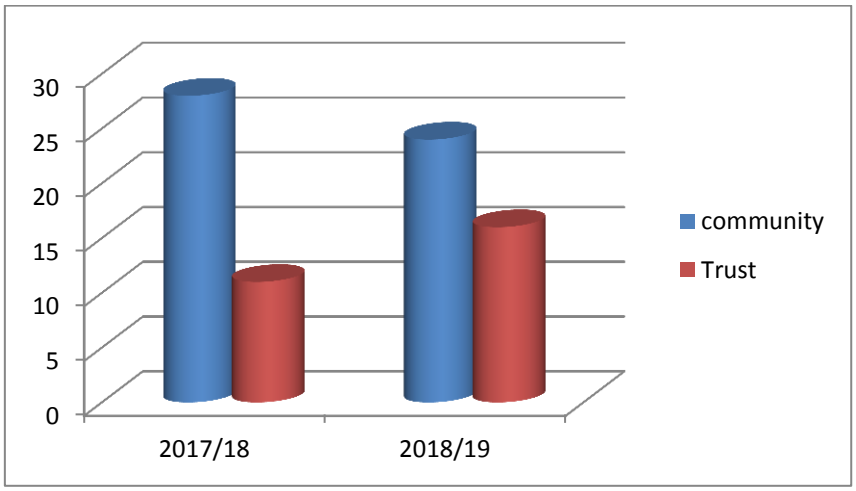
Figure 10: *Klebsiella* bacteraemia cases 2017-19



1.6.4 *Pseudomonas aeruginosa* bacteraemia

Pseudomonas aeruginosa is an opportunistic pathogen that rarely causes infection in healthy individuals. It can cause a wide range of infections, similar to other gram negative organisms.

Figure 11: *Pseudomonas aeruginosa* bacteraemia 2017-19



In a healthcare setting pseudomonas can contaminate devices that remain moist such as respiratory equipment and catheters but also ice-making machines and equipment with a water reservoir.

Cases of *Pseudomonas* bacteraemia are relatively low although still increasing at present.

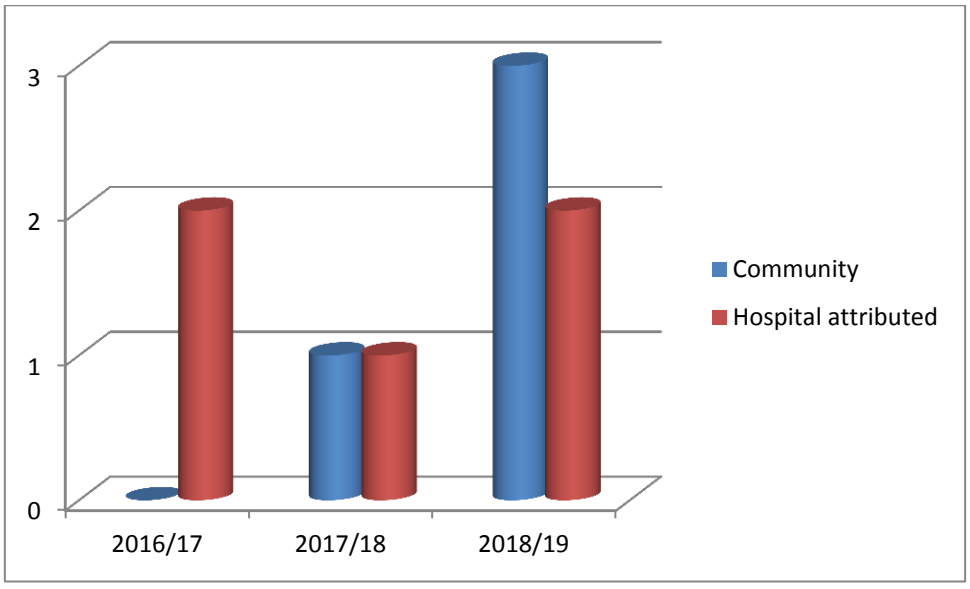
1.7 Glycopeptide resistant Enterococci (GRE)

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

A screening programme amongst haematology patients was put in place in March 2014 with all haematology patients screened on admission and discharge. The carriage rate amongst this cohort of patients has remained constant at around 20%. 25 carriers of GRE were newly identified from April 2018 – March 2019. Identification of carriers enables antibiotic regimens to be tailored to individual patients depending on their carrier status, improving patient safety.

Although the incidence of GRE infection has always been very low at MTW, with just five (three of which from one complex patient) blood stream infections recorded in 2018/19, it is known that other Trusts in the region have endemic GRE and patients can acquire long-term carriage of this organism.

Figure 12: GRE bacteraemia 2016-19

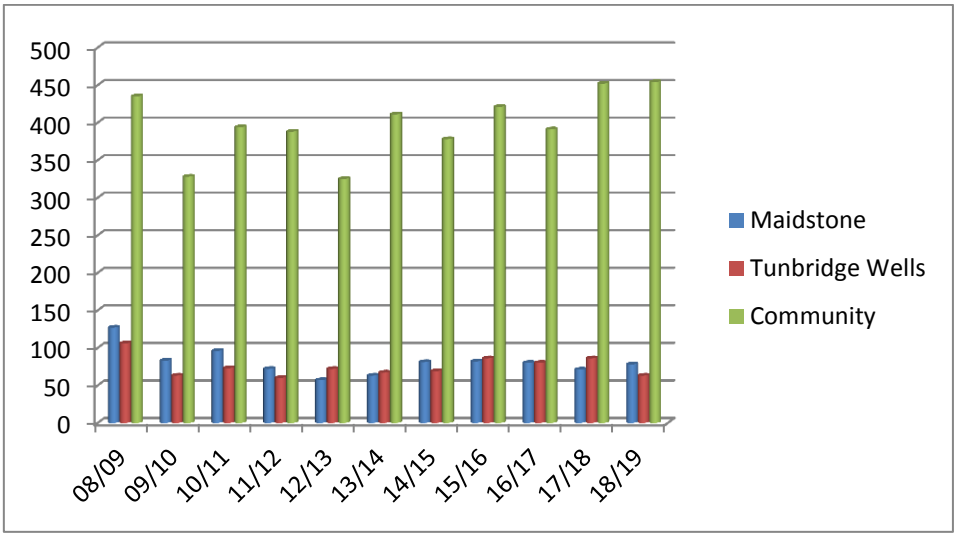


1.8 Extended Spectrum *Beta*-lactamase producing organisms (ESBLs)

ESBL organisms have the capability to produce enzymes which break down some of the more commonly used antibiotics. The numbers of patients developing infections with these organisms has been rising steadily over the last few years. A number of these organisms also have other mechanisms of resistance which can in some cases severely

restrict the choice of antibiotic and may lead to admission to hospital for intravenous antibiotics because there are no options for oral treatment.

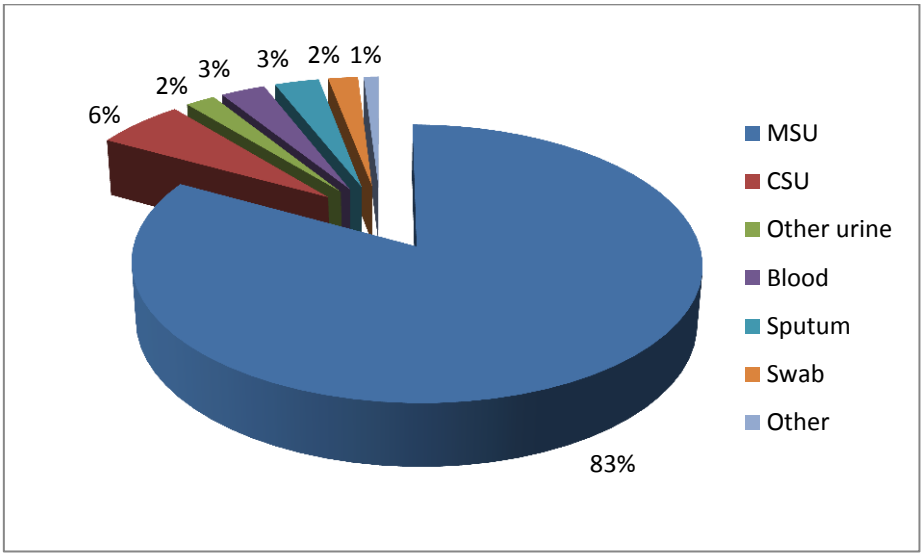
Figure 13: New ESBL isolates 2008-2019



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

There is no significant seasonal variation or trend in the number of cases seen. Most patients affected will carry the organism in their gut and as a result, urinary tract infections are the most commonly seen and account for more than 90% of cases. Long term catheterisation is recognised as a risk factor for carriage of ESBL organisms, likely due to the treatment of recurrent infection with broad spectrum antibiotics, selecting out resistant strains in the patient's gut forming a reservoir of infection

Figure 14: New ESBL isolates by specimen type 2018-19



1.9 Carbapenem resistant / Carbapenemase producing Enterobacteriaceae (CRE/CPE)

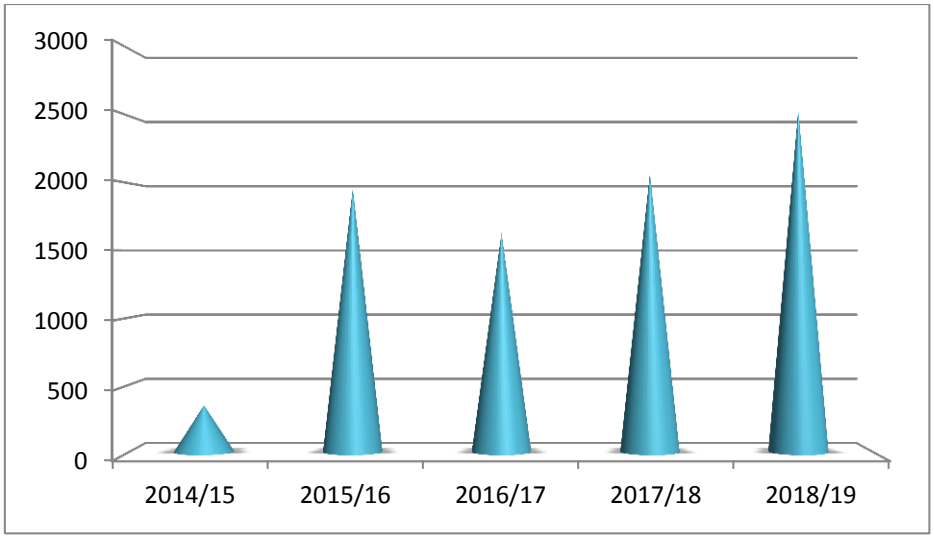
CPE and CRE are gram negative organisms found in the gut which are resistant to virtually every antibiotic including the Carbapenem group of antibiotics. They represent a major cross infection risk. Some of these organisms have the ability to transfer their resistance genes from one bacterium to another, even across species.

All Trusts have been required to have a screening programme for Carbapenem resistant organisms in place following a Patient Safety Alert in 2014. In 2018/19, 2548 CRE/CPE screening swabs were processed, around 500 more than the previous year.

Patients are identified as requiring screening by risk assessment – focussing on screening patients transferred in from healthcare abroad and patients who are transferred from (or have recently been in patients in) other UK hospitals and tertiary referral centres, including haematology patients and neonates.

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

Figure 15: CRE/CPE screens 2014-19



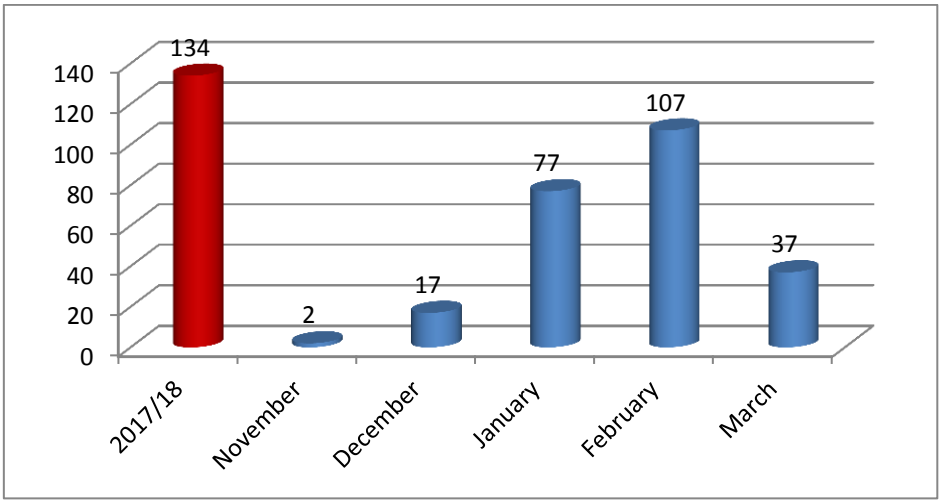
Four adult patients were identified as carriers on screening, three were transfers from other hospitals, two of which were outside the UK. One further adult was transferred to MTW as a known carrier. All necessary precautions were implemented according to the policy and there were no episodes of cross infection.

One new case was identified from a clinical sample with no risk factors identified.

1.10 Influenza

From November 2018 to March 2019, 240 patients with Influenza were admitted to the Trust. This is compared to 134 patients the previous year.

Figure 16: Influenza cases 2018/19



19 patients required ITU admission – a total of 261 days (average 13.7 ITU bed days).

All except one of the infections was due to Influenza A, the other being Influenza B.

Increased support and communications regarding identification and management of influenza was in place including:

- Daily side room reports including influenza patients
- Information shared at the site team meetings
- National reporting to NHS England on cases of flu.

The Trust is a Sentinel reporting site for influenza, reporting on all cases admitted to the Trust irrespective of level of care.

Untoward Incidents and Outbreaks

1.11 Norovirus

There were five ward based incidents due to norovirus in 2018/19. The table below provides a summary of the wards affected.

Table 3: Summary of Norovirus incidents 2018/19

Month	Ward	Patients affected	Staff affected	Bed days lost	Closure	Days closed
July 18	Chaucer	1	0	None	C Bay	2
July 18	Mercer	7	0	None	A Bay	6
July 18	Pye Oliver	11	3	16	Ward	6
Nov 18	TW20	17	2	None	1-10, 11-21	27
Nov 18	Chaucer	4	5	4	D bay	6

The TW20 incident was prolonged due to the case mix on the ward which included confused and wandering patients and high falls risk patients. Lessons learned from this incident include:

- High traffic through parts of the ward exacerbated the situation. Closing access routes reduced the spread of infection.
- Communication to relatives and visitors on restricted visiting was inconsistent leading to increased tension.
- Staffing levels and skill mix led to staff needing to cross from contaminated to non-contaminated areas when needed to care for patients.

Additional training for staff on the ward will be in place before the winter period to ensure that the lessons learned are implemented in any future outbreak.

1.12 *C. difficile*

A Trust wide outbreak was declared in September 2018 in response to the increase in cases in June, July and August. An outbreak management plan was developed and approved by the executives.

Four outbreak meetings were held on both sites over a four week period and a recovery plan was developed and implemented. Staff engagement was good and attendance at the outbreak meetings was high including representatives from NHSI, PHE and WKCCG. Trust wide communications were sent out and all doctors received emails from the Medical Director and the DIPC. Weekly infection control updates were sent to Board members, senior managers (managers, matrons and clinical directors) and other key staff.

It was noted that seven patients had died following their *C. difficile* diagnosis during the outbreak period. The mortality lead clinician undertook a review of these cases and concluded that in five cases there was no evidence that the infection influenced the patient's clinical course. In the remaining two cases, the conclusion was that although the infection complicated the management of the patients, both were seriously ill and the outcome was inevitable prior to the *C. difficile* diagnosis.

Further testing identified a single episode of cross infection on a ward at Maidstone hospital. A Serious Incident was declared and further investigation is carried out although no clear evidence of a route of cross infection was found.

Root cause analysis was completed on all cases. 22 cases were seen in total from May to September. Three cases were found to have been avoidable. Root cause and lapses of care identified are summarised below. Some cases had more than one lapse of care.

Table 4: Root Cause and Lapses of Care for outbreak cases

	Root Cause					Lapses of care			
	Appropriate antibiotics	Immuno-suppressed	Cross infection	CAHA	Inappropriate antibiotics	0	1	2	3
Avoidable			1		2			2	1
Unavoidable	16	2		1		9	9	1	

The learning from the outbreak was shared widely with clinical staff through face to face meetings, nursing meetings, junior doctor teaching and by email communications.

The criteria for closing the outbreak were agreed as a month with *C. difficile* rates at or below baseline levels. By the end of October both sites had had a period of over a month (37 days at TWH and 46 days at Maidstone) without a case of *C. difficile* and the rate returned to baseline for October.

Mandatory Surveillance of Surgical Site Infections in Orthopaedic Surgery

1.13 Surgical Site Infection

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

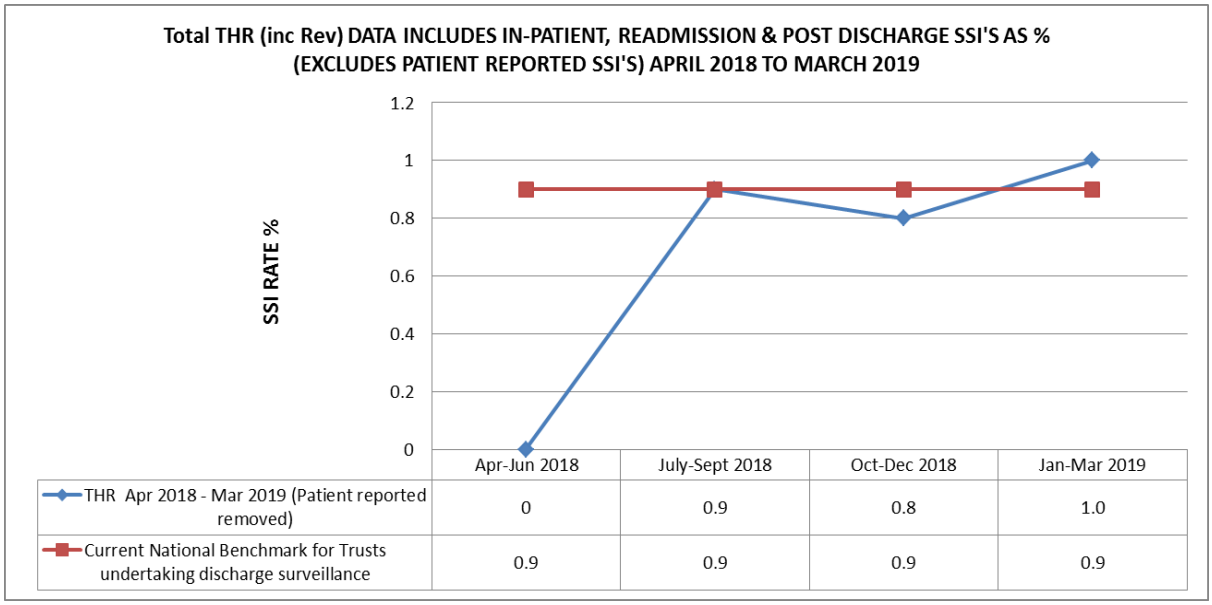
The surveillance scheme is coordinated by the Healthcare-associated Infection and Antimicrobial Resistance (HCAI & AMR) Department of the Communicable Disease Surveillance Centre (CDSC) at the Public Health England (PHE) in Colindale.

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

Patients are monitored for the first 60 days and infection rates monitored for up to one year post operatively. Monitoring is completed on inpatients and also by post-discharge surveillance through hospital readmission, outpatient review and patient discharge questionnaires. MTW completes the modules mandatory surveillance of elective total hip and total knee surgery, fractured neck of femur continuously throughout each year. Patient-reported SSIs are not included in the SSI performance data produced by PHE as no infection has been proven. However these infections are monitored and captured as part of the ongoing surveillance reports to PHE.

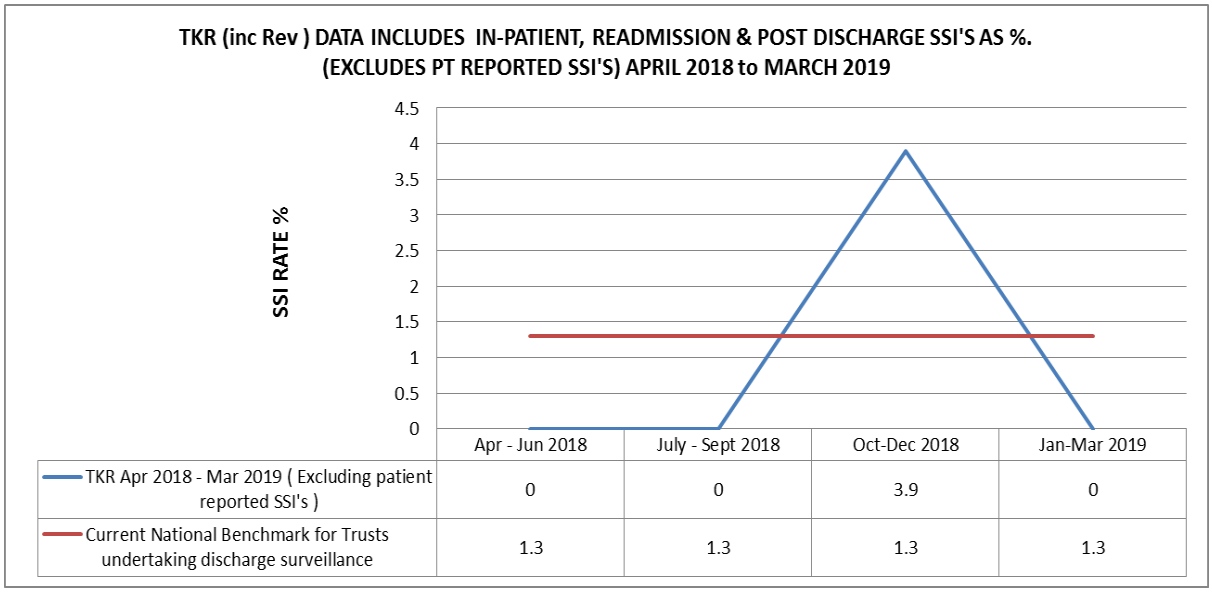
Further investigation is ongoing to determine if the pathway changes last year to comply with NICE guidance, which were initially successful in maintaining low levels of infection, are sustainably embedded

Fig 17: Results for elective hips and knees



	Apr-Jun 2018	July-Sept 2018	Oct-Dec 2018	Jan-Mar 2019
THR Apr 2018 - Mar 2019 (Patient reported removed)	0	0.9	0.8	1.0
Current National Benchmark for Trusts undertaking discharge surveillance	0.9	0.9	0.9	0.9

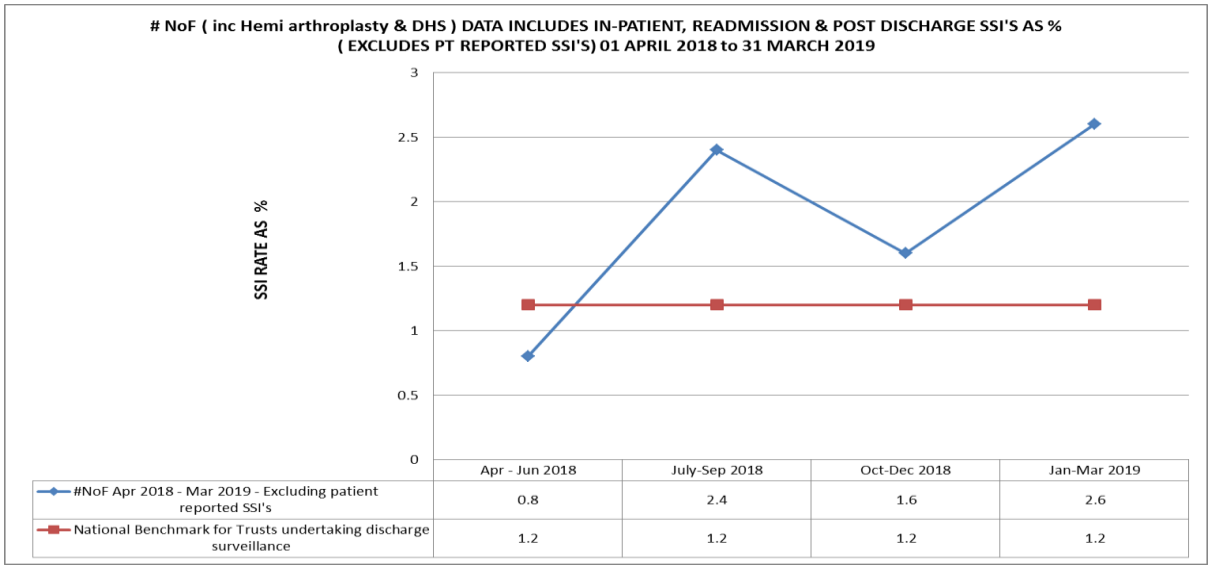
For the period Apr 2018 to Mar 2019 the overall SSI rate for elective hips remained equal to or below the national average. Due to winter pressures there was a reduction in activity on the TWH site during Q4. Despite there being a single case of infection in each of Q2-4, this resulted in a higher perceived percentage infection rate in Q4. The overall elective hip infection rate for 2018/19 is 0.7%.



	Apr - Jun 2018	July - Sept 2018	Oct-Dec 2018	Jan-Mar 2019
TKR Apr 2018 - Mar 2019 (Excluding patient reported SSI's)	0	0	3.9	0
Current National Benchmark for Trusts undertaking discharge surveillance	1.3	1.3	1.3	1.3

MTW was identified as a high outlier for elective total knee replacement for Q3, with a SSI rate of 3.9% (3 SSIs). The overall rate for the year 2018/19 was 1.1%, lower than the national average of 1.3%.

Figure 18: Results for repair of fractured neck of femur



The overall SSI rate for fractured neck of femur was 1.9%, above the national average of 1.2%.

Further work is being undertaken in this area to improve the infection rate including a case review to identify patient related risk factors and learning.

Compliance Criterion	What the registered provider will need to demonstrate
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

Refurbishment and New Builds

2.1 Estates

The Estates and Facilities Department ensure that the IPC Team have been regularly involved, consulted and engaged in the planning stage of numerous work projects. This has enabled the team to actively influence improvements to infection prevention and control in the built environment providing input in two broad aspects of work:

- Planning – The IPCT are asked for input in reviewing plans to ensure that any refurbishments or new builds offer the best facilities to reduce the risk of infections in line with any relevant Health Building Notes and Health Technical Memorandum
- Operation – The IPCT are asked to review methods to reduce the risk of any infections presented by the actual refurbishment/build process.

Estates report biannually to the IPCC on current and recently completed projects

Decontamination

2.2 Decontamination

The Decontamination Committee meets twice per year to consider all aspects of decontamination within the Trust. Sub-committees for each of the areas of responsibility have been formed to focus on departmental requirements and ensure ongoing HTM compliance and reporting back to the main committee

All decontamination and sterilisation of reusable surgical instruments is carried out off-site by an external provider. During the year the performance has been closely monitored and twice yearly reports are submitted to the IPCC. No major concerns have been raised and the service is compliant with HTM 01-01.

Decontamination and high level disinfection of flexible endoscopes is carried out in the endoscopy departments on both sites. The departments currently were re-inspected for JAG accreditation in February 2019 and have minor recommendations to complete before full ongoing accreditation is confirmed. Endoscopy is compliant with HTM 01-06.

The Trust laundry unit located off site at Parkwood continues to provide linen service to both of the Trust's hospital sites and Darent Valley Hospital, processing a total of over 7 million items per year. There are also a number of smaller community contracts. Annual audits are undertaken. The laundry is compliant with HTM 01-04

Cleaning arrangements

2.3.1 Monitoring

Domestic services repots to the IPCC three times per year, providing details of audits of cleaning standards. The audit programme is regularly reviewed with infection control and audits are carried out weekly, monthly or bi- monthly, depending on the risk level, with unannounced visits to wards & areas by Facilities Management to maintain a consistent approach.

During the *C. difficile* outbreak, all ward areas were escalated to high risk to enable monthly audits and this has been maintained since the closure of the outbreak.

All audits have shown good compliance with standards of cleanliness and achieved the target scores of 95-98% for very high risk areas and 85-95% for high risk areas. The high risk scores were consistently above 95% for the year.

The PLACE inspections for 2018 scored cleanliness at over 98.9% across the Trust, an increase over 2017.

2.3.2 Cleaning levels

The facilities department provide a very high level of support to the Infection Prevention and Control Team and are able to respond quickly to infection prevention issues such as urgent deep cleans and hydrogen peroxide (HPV) fogging.

A range of cleaning levels have been in place in the Trust for many years and these are regularly reviewed to ensure that they are fit for purpose and enable the most efficient turnaround times.

Table 5: Annual cleans for Maidstone and Tunbridge Wells Hospitals 2018-19

Tunbridge Wells

Level 2 Discharge Cleans	Level 3 - Steams	Level 3 – UV's	Level 4 - FOGs
21539	1682	750	340

Maidstone

Level 2 Discharge Cleans	Level 3 - Steams	Level 3 – UV's	Level 4 - FOGs
2507	7557	363	434

MTW

Level 2 Discharge Cleans	Level 3 - Steams	Level 3 – UV's	Level 4 - FOGs
24046	9239	1113	774

Discharge cleans at Maidstone are completed by nursing rather than facilities staff. Following the outbreak in September 2018 it was agreed that facilities would take over this function in a phased manner over 2019.

2.3.3 Deep Cleaning

The annual deep cleaning programme at Maidstone was completed in October 2018. The Estates department were able to combine the deep cleans with maintenance works and the LED lights replacement programme.

At TWH, all dirty utility rooms were fogged as part of the outbreak actions. A record is kept of all rooms fogged as part of discharge cleans and all rooms are either fogged or UVC (Ultra violet C) cleaned routinely during a Period of Increased Incidence of *C. difficile.*

To align cleaning standards with the National Standards of Cleanliness, a periodic schedule for deep clean will be implemented from 1st April 2019. This will be compiled in collaboration with Estates & Nursing to ensure every area is addressed throughout 2019/2020 so as a Trust we can demonstrate clear and measurable outcomes

2.3.4 Training

The IPC team delivered training sessions in correct handwashing/hygiene to all Portering staff across both sites.

Portering, domestic and catering staff are 99% compliant with Infection Prevention and Control training.

Water Safety

2.4 Water Safety

The quarterly Water Hygiene Steering Group (WHSG) meets to discuss the relevant water hygiene policies and procedures, plus improvement works being carried out within the MTW Trust.

Legionella water sampling is undertaken twice yearly at Maidstone Hospital. Legionella sampling at TWH is carried out on a quarterly basis by Interserve. Samples for both legionella and pseudomonas are taken from various outlets and supplies such as water tanks and calorifiers. The sampling points at Maidstone Hospital have been reviewed and reconfigured so that every water system within the hospital is tested over a period of a year. Positive counts are recorded on the resampling action tracker, and recommendations undertaken in a timely manner. Prompt action to rectify issues identified enables all areas to return to operational use. Until these works are completed, suitable control measures are in place to ensure safe water system. Works have included the removal of little used outlets, showers, and long dead legs. All works have been in agreement with Infection Control.

Compliance Criterion	What the registered provider will need to demonstrate
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

Antimicrobial Stewardship

3. Antimicrobial Stewardship Group (ASG)

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

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

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

- Ear nose and throat
- Acute and Emergency care – UTI, Community acquired pneumonia and cellulitis pathways
- ERCP prophylaxis
- Surgical guidelines for
    - Obstetrics and gynaecology
    - General surgery
    - Gastrointestinal surgery
    - Breast surgery
- Urosepsis
- Small intestine bacterial overgrowth (SIBO)
- Treatment and prophylaxis of seasonal influenza
- Use of probiotic tablets
- Prophylaxis for cardiac implants

In addition the group advised on updating the guidelines for management of infection in primary care in line with PHE recommendations, working collaboratively with the WKCCG antimicrobial pharmacist.

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

3.1 Antimicrobial Usage

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

Particular interest is taken in the prescribing of Piperacillin/Tazobactam (Tazocin) and Meropenem in the Trust. These are two broad spectrum antibiotics that are used in sepsis but are also associated with a higher risk of *C. difficile* infection. Meropenem is one of the Carbapenem antibiotics, resistance to which is becoming a significant problem nationally as discussed in section 1.9 of this report.

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

Fig 19: Total antimicrobial usage in defined daily doses (DDDs) per 1000 admissions compared with other England Trusts

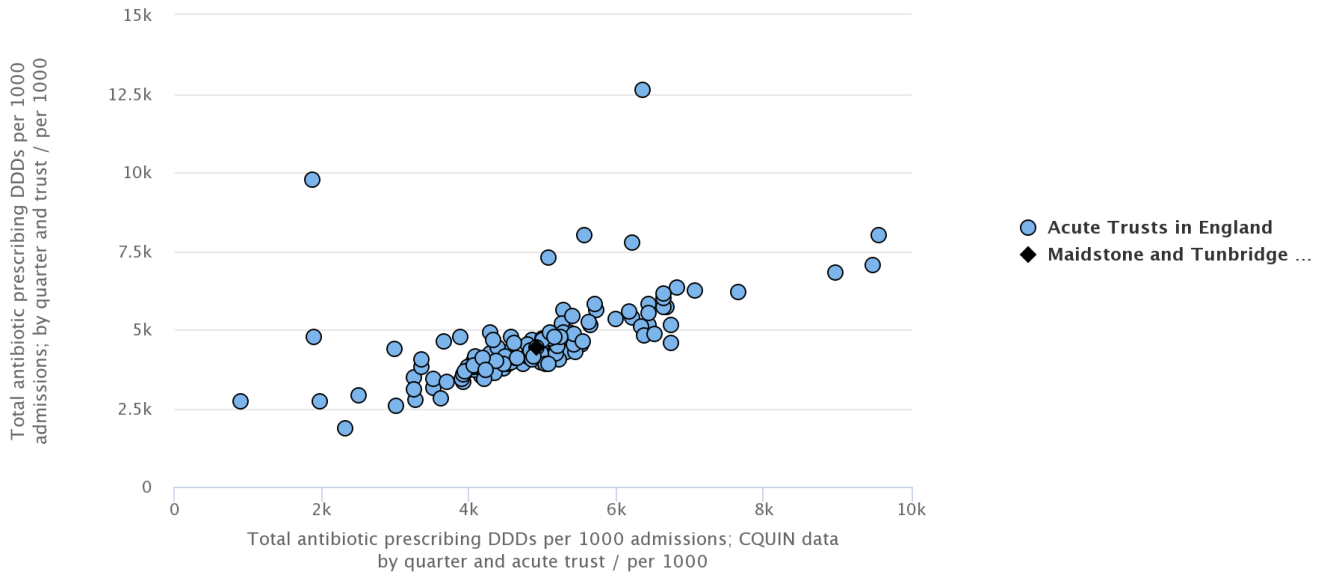
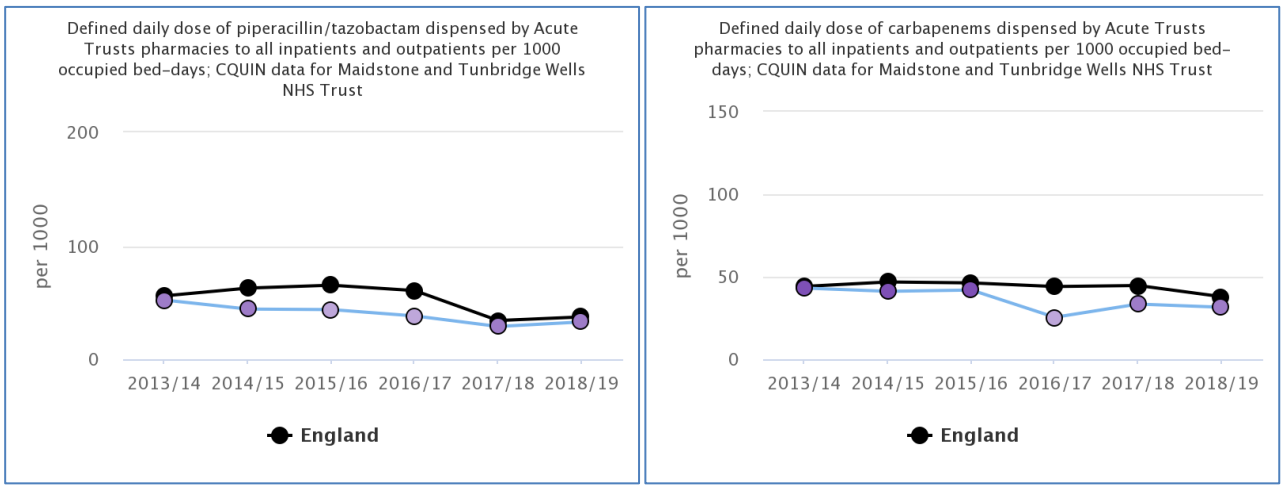


Fig 20: Piperacillin/Tazobactam & Carbapenem usage in DDDs/1000 admissions



3.2 Antimicrobial training and Education

A number of education sessions were delivered by the antimicrobial pharmacists and consultant microbiologists to medical staff and pharmacists. Education sessions include induction sessions for all new doctors, FY1 and FY2 teaching sessions and more advanced sessions for core medical trainees.

The team has also attended various clinical governance and directorate meetings to discuss topics including surgical prophylaxis, UTI management, audit results and the antimicrobial CQUIN.

In addition, antimicrobial information leaflets are issued to new locum doctors and FY1 as part of their induction welcome packs. An e-learning package for doctors of all grades, nurses, pharmacists and non-medical prescribers is currently under development.

3.3 Antimicrobial Audit

The pharmacists complete bi-monthly audits against the Antimicrobial prescribing policy. The audit results are reported to individual consultants, directorates and to the IPCC through the directorate triangulation reports. Following the introduction of the antimicrobial resistance and stewardship AMS CQUIN goals from NHS England evidence of 72 hours review is now included in this audit.

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

Table 6: Trust-wide bi-monthly antimicrobial prescribing audit 2018-19

Standards	April May	June July	Aug Sept	Oct Nov	Dec Jan	Feb Mar
% Patients with Allergy box completed	100%	99%	100%	100%	100%	100%
% Prescribed in line with guidelines	98%	100%	99%	100%	100%	100%
% with Indication documented in notes	96%	99%	94%	98%	97%	97%
% with indication documented on chart	82%	70%	79%	87%	88%	88%
% with duration documented on drug chart	76%	74%	60%	67%	80%	82%
% of Restricted antimicrobials approved by Microbiology	100%	100%	95%	100%	100%	100%
% of Patients prescribed Probiotics	83%	78%	88%	82%	88%	90%
Antibiotic review at 48-72 hours	90%	84%	82%	80%	83%	87%

3.4 Antimicrobial awareness

The Trust participated in both the European Antibiotic Awareness Day (EAAD) and the World Antibiotics Awareness week. This raised awareness amongst prescribers and nursing staffs within the Trust on the importance of applying antimicrobial stewardship to all antimicrobial prescriptions. Stalls were manned on both hospital receptions to raise awareness with the public and managed to get both staff and patients to sign-up as antibiotic guardians.

3.5 Reducing the Impact of Serious Infections (SEPSIS/AMR) CQUIN 2018/19

The CQUIN targets were based on 2017/18 data. The antimicrobial resistance (AMR) component of the CQUIN was split into two parts:

Part 2c – Antimicrobial review at 72 hours

Part 2d – Reduction in antibiotic consumption (measured in DDDs per 1000 admission)

Due to the winter pressures and increased acuity of patients seen, particularly with influenza related secondary bacterial infections, the overall target of 2% reduction in overall consumption was not achieved; however the reductions in carbapenems and piperacillin/tazobactam were reached.

Table 7: CQUIN outcome

Sepsis and AMR CQUIN Part 2c: Antibiotic review at 72 hours	
Q1: 83% of cases reviewed within 72 hrs (target 25%). Q2: 80% of cases reviewed within 72 hrs (target 50%) Q3: 96% of cases reviewed within 72 hrs (target 75%) Q4: 91% reviewed within 72 hrs (target 90%)	Achieved
Sepsis and AMR CQUIN Part 2d: Antibiotic consumption	
2% reduction in total antibiotic consumption	Not achieved
2% reduction in carbapenems	Achieved
1% reduction in piperacillin-tazobactam	Achieved

Compliance Criterion	**What the registered provider will need to demonstrate**
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.

The Trust provides all service users with information as required. This includes infection prevention information in the form of information leaflets, posters and resource folders for staff, and information leaflets and posters for patients and visitors.

In outbreak situations or infection prevention incidents, duty of candour is completed for all patients affected either directly or indirectly.

Staff are also provided with policies, clinical guidelines and care pathways for specific conditions.

There are Infection Prevention resources on the Trust intranet and Internet sites.

Information is provided to external partners as appropriate including:

- Notifications of *C. difficile* cases and gram negative blood stream infections to the relevant CCG HCAI lead
- Electronic discharge notifications include MRSA status
- Inter-hospital transfer forms include information relevant to IPC
- Patients identified as *C. difficile* carriers or with *C. difficile* infection are issued with a ‘green card’ which advises other healthcare providers of their diagnosis and the importance of prudent antimicrobial prescribing
- IPC information is shared with GPs for information on a case by case basis

The infection prevention team attend the site meeting at least daily to share information regarding IPC risks and concerns. A daily side room report is shared widely to ensure the safe isolation of infectious patients.

Compliance Criterion	What the registered provider will need to demonstrate
5	Ensure that people who have or develop and infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmitting the infection to other people.

The Infection Prevention Team provides a 7 day service and an on call microbiology service (laboratory and consultant) is available out of hours. The laboratory also provides 7 day working. The team regularly visit the wards and review patients with infectious diseases.

All urgent microbiology results are telephoned to clinicians to ensure prompt treatment and review.

Side rooms are actively managed by the Infection Prevention team and the Isolation Policy, including risk assessments for side room requirement and leaving doors open is available on the Trust intranet.

The IPT performs risk assessments for any potential infectious disease incident in the Trust. Contact tracing for both staff and patients is facilitated by the IPT working with Occupational Health where necessary.

Policies are also available for the management of patients with diarrhoea and a wide range of infectious diseases.

Patients are screened for MRSA, MSSA, GRE, CRE/CPE as appropriate (see Criterion 1).

An outbreak policy is in place and colleagues in Public Health England are available to assist with outbreak control if required.

Compliance Criterion	What the registered provider will need to demonstrate
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

Staff Development and Training

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

updates, link network and student training. Informal training is undertaken in the workplace on an ad hoc basis as the need arises.

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

For 2018/19 5331 staff members completed mandatory Infection Control training; a total of 85.3% of staff.

The team also participates in the induction training for junior doctors with the DIPC leading the infection control training. The consultant microbiologists provide training in antibiotic prescribing during induction training. In addition, training on infectious diseases and the use of antibiotics is provided as part of the post graduate educational programme.

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

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

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

The DIPC teaches on an infection control module for MSc students at the London School of Hygiene and Tropical Medicine and on the DIPC development programme and aspiring DIPC training course run by the Hospital Infection Society.

Within the IPT, one member completed the MSc in Infection Prevention and Control this year and one member has been awarded a Florence Nightingale Scholarship. Other members of the team are actively encouraged to pursue educational opportunities.

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

6.1 History

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

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

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

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

6.2 Key points

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

6.3 Hygiene Code compliance

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

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

There is a compliance statement on the Trust Website

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

Table 8: Hygiene code compliance criteria (2015)

Compliance criteria		**Examples of how we comply**
1	Systems to manage and monitor the prevention and control of infection.	• Governance and reporting structure • DIPC in post - reports to CEO • Infection prevention team • IPCC ToR • Annual work programme and action plan • Mandatory training • Link nurse network • Annual IC audit programme • IC policies and procedures in place • Side room management • Board level risk register • Outbreak policy • Surveillance systems • This report
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	• Director of Estates and Facilities reports to IPCC • Policies for decontamination, cleaning and laundry in place including record keeping processes • Cleaning processes agreed with Infection Prevention • Cleaning audits reported to IPCC • Deep clean programme • Hand hygiene facilities, signage and audit • JAG accreditation • Commode audits • Uniform policy
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	• Antimicrobial stewardship group meets monthly • Antimicrobial prescribing policy • Antimicrobial prescribing guidelines • Antimicrobial pharmacists in post • ASG reports to IPCC • 'Start smart then focus' in place • Antimicrobial training for doctors
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.	• Range of information leaflets for patients and relatives • Regular communication with CCG HCAI lead • EDN includes MRSA status • Switchboard messages on norovirus • IC messages on internet site for visitors and patients including

Compliance criteria		Examples of how we comply
		numbers of infections • Information for patients on antimicrobials • IC information shared with GPs on case by case basis • ICT attendance at daily site meetings
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	• Urgent microbiology results telephoned to clinicians • Isolation policy • Active side room management by ICT • Risk assessments carried out • Screening in place for MRSA, MSSA, GRE, CRE/CPE as appropriate • Diarrhoea policy • Reporting mechanism for notifiable disease to PHE in place
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	• Mandatory training for all staff and volunteers • Information provided to contractors • Temporary staff handbooks and competency • Bespoke training for certain groups of staff, eg porters, domestics • Handbooks for various staff groups • Exemplars of documentation provided to wards • IC resource folders on all wards – currently being converted to electronic format • Infection control responsibility included in all job descriptions • Facing to face ward based training for new nurses
7	Provide or secure adequate isolation facilities.	• Isolation policy • Negative pressure rooms available – A&E at TWH and John Day at Maidstone • Active management of side room provision • Clear isolation signage
8	Secure adequate access to laboratory support as appropriate	• Microbiology laboratory on Maidstone site • KPIs monitored • ISO 15189 accredited • All referral labs accredited • Telepath system interfaced with ICNET
9	Have and adhere to policies, designed for the individual's care and provider	• Standard infection control policy

Compliance criteria		Examples of how we comply
	organisations that will help to prevent and control infections.	• Policies for a range individual infections • Outbreak policy • Other policies in place to meet the requirements of the Code • Audit programme in place to monitor compliance with policies • All policies available on Trust intranet site
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	• Immunisation of staff policy in place • All staff can access on site occupational health services • Influenza vaccination offered to all staff and volunteers • Risk based screening for communicable diseases and assessment of immunity • OH arrangements in place in respect of blood borne viruses

6.4 Governance and Assurance

The Board receives assurance through the governance reporting structure described at 1.2, and directly from the DIPC who attends Board meetings to provide updates on infection control and new guidance relevant to the Trust.

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

6.5 National Priorities

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

Antimicrobial resistance – The next phase UK 5 year antimicrobial resistance strategy was published in 2019. The plan has been designed to ensure progress towards the 20-year vision on AMR, in which resistance is effectively contained and controlled. It focusses on three key ways of tackling AMR:

- Reducing the need for, and unintentional exposure to, antimicrobials
- Optimising use of antimicrobials
- Investing in innovation, supply and access

To support these aims there are actions across 15 ‘content areas’, ranging from reducing infection and strengthening stewardship to improving surveillance and boosting research. The plan also sets out four measures of success to ensure progress towards the 20-year vision. These include, among others, targets to:

- Halve healthcare associated gram-negative blood stream infections

- Reduce the number of specific drug-resistant infections in people by 10% by 2025
- Reduce UK antimicrobial use in humans by 15% by 2024
- Reduce UK antibiotic use in food-producing animals by 25% between 2016 and 2020 and define new objectives by 2021 for 2025
- Be able to report on the percentage of prescriptions supported by a diagnostic test or decision support tool by 2024

Reduction of antimicrobial use was the subject of a CQUIN for 2018-19. The Trust partially met the targets and further details can be found at section 3.5 in this report.

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

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

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

At MTW we have increased our data collection on epidemiology of these infections and active submit data to the national Public Health England database. See section 1.6 of this report for further information on the Trust's response to this target.

Apportionment of *C. difficile* infections

Public Health England is changing the definitions of C> difficile infections and changing the organisations to which they are apportioned. This is intended to recognise those cases where in-patient treatment has adversely affected patients after discharge. The new definitions to be implemented from April 2019 are as follows:

Hospital-onset healthcare-associated - Date of onset is ≥ 2 days after admission (where day of admission is day 1)

Community-onset healthcare-associated - Date of onset is < 2 days after admission and the patient was admitted to the trust in the 4 weeks prior to the current episode

Community-onset indeterminate association - Date of onset is < 2 days after admission and the patient was admitted in the previous 12 weeks, but not the previous 4 weeks prior to the current episode

Community-onset community-associated - Date of onset is < 2 days after admission and the patient had not been admitted to the trust in the previous 12 weeks prior to the current episode.

Unknown 3 months - The reporting trust answered "Don't know" to the question regarding admission in the 3 months prior to the current episode.

All unknown - The reporting trust did not provide any answer for questions on prior admission.

The new definitions will inevitably increase the number of healthcare associated cases seen. Only healthcare in acute Trusts counts towards the definitions. Community hospital care is not taken into account.

For 2020/21 it is likely that targets will be set taking into account the number of specimens examined for C. difficile. This is intended to remove bias associated with low testing Trusts.

Compliance Criterion	What the registered provider will need to demonstrate
7	**Provide or secure adequate isolation facilities**

Isolation Facilities

The Isolation policy is published on the Trust Intranet, together with the standard infection control policy which includes the use of personal protective equipment.

The Trust has a high proportion of single rooms although there is a disparity between the two sites with Tunbridge Wells Hospital having over 95% of beds in side rooms and Maidstone Hospital with 49 side room beds.

The target time for isolating patients with unexplained and potentially infectious diarrhoea (Pathway 1) is two hours. A rapid risk assessment is in place for all patients with diarrhoea

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

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

There are planned facilities in both Emergency Departments for isolating highly infectious individuals such as those suspected of having Ebola virus. The pathway for

these patients is practised regularly to ensure that staff are aware of the enhanced precautions and how to don and doff the protective suits.

Compliance Criterion	What the registered provider will need to demonstrate
8	**Secure adequate access to laboratory support as appropriate**

Laboratory Services

In house microbiology laboratory services are based at Maidstone Hospital The laboratory has ISO 15189 accreditation.

The laboratory is open 7 days a week and provides a 24 hour service with on call facilities from 6pm to 8am.

Advances in the laboratory during 2018/19 include introduction of Matrix-Assisted Laser Desorption/Ionisation – Time of Flight (MALDI-TOF) mass spectrometry for rapid identification of bacteria. This enables the microbiologists to give more timely and accurate advice to clinicians, targeting antimicrobial treatment more accurately.

Reference laboratory support is available at all times from both the Public Health England reference laboratories and other commercial laboratories which provide additional rapid diagnostics.

Compliance Criterion	What the registered provider will need to demonstrate
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections

The Trust has policies, guidelines and standard operating procedures in line with the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance. The documents are reviewed on a rolling programme and published on the Trust Intranet site.

The documents are monitored using a variety of audit tools to measure staff compliance with guidance.

Audit Programme

The infection control team have worked closely with the audit department to develop a comprehensive audit programme which monitors all aspects of infection control including compliance with infection control policies within the Trust. Audits are reported to the IPCC. Formal audits included:

- Audit of catheter associated urinary tract infections and compliance with the HOUDINI criteria.
- Re-audit of compliance with screening for Carbapenemase producing enterobacteriaceae (CPE).
- Audit of compliance with the documentation of the MRSA care bundle and decolonisation therapy
- Audit of antibiotic prophylaxis usage in ERCP patients developing post-procedure *E. coli* sepsis

Environmental audits were carried out in the following areas:

- Endoscopy
- Laundry facilities
- Crowborough birthing unit

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

The triangulation audits are conducted on:

- Bare below the elbows
- Hand hygiene including patient hand hygiene prior to meals
- Commode cleanliness
- MRSA decolonisation
- MRSA care pathway compliance
- MRSA non-elective screening
- Waste management

As part of the PII process additional audits are completed on

- Ward laundry management
- Decontamination of reusable devices

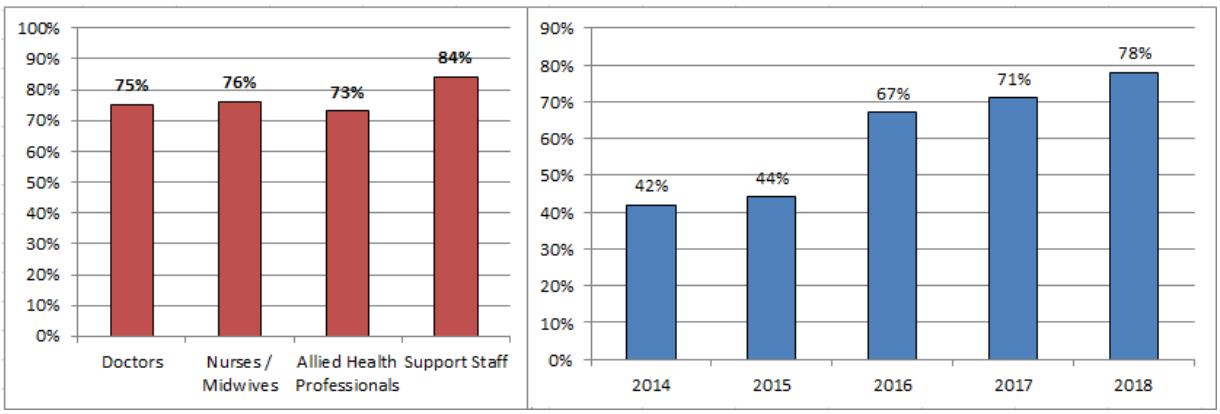
Compliance Criterion	What the registered provider will need to demonstrate
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

Occupational Health

The Occupational Health service provides pre-employment health assessments and assessment of immunity and provides vaccinations for new staff.

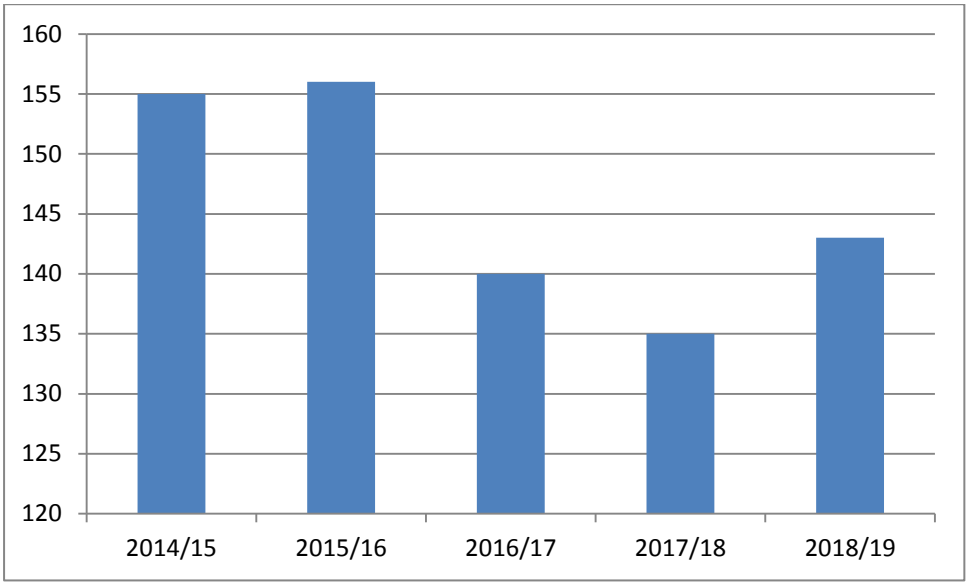
The Occupational Health department leads the seasonal flu vaccination campaign. For 2018/19 the CQUIN target was 75% of frontline staff vaccinated. The campaign was launched in September and used a peer vaccination programme to outreach into clinical areas. The Trust achieved a vaccination level of 78% which is the highest level achieved in recent years.

Fig 21: Vaccine uptake by staff group and 5 year comparison



There were 148 sharp/splash injuries in 2018/19 – a similar number to previous years. The occupational health department continues to review sharps injuries and examine ways to reduce the incidence with the Health and Safety team and the Sharps Working group.

Fig 22: Sharps and Splash injuries 2014-2019



Recommendations

The Trust Board is asked to note the progress in reducing healthcare associated infections and the Infection Prevention and Control Annual Work plan for 2019/20 (appendix 1)

APPENDIX 1

INFECTION PREVENTION AND CONTROL WORK PLAN 19/20

Healthcare associated infection Reduction Plan 2019-20

RAG RATING DEFINITION	
R	ACTIONS APPEARS UNACHIEVABLE NEEDS RE-BASELING / REASSESSING
A	SUCESSFUL DELIVERY OF PROJECT TIME AND THERE ARE NO THREATS TO DELIVERY
G	COMPLETED AND CLOSED NO FURTHER ACTIONS REQUIRED

Action No	**Date Identified**	**Source**	**Output** (What are we trying to achieve)	**Action** (How are we going to do it)	**By when**	**Work plan Quarter**	**Owner**	**Current Progress** (How are we doing)	**RAG Rating**
CULTURE AND ENGAGEMENT									
CE-001	Nov-17	APW	Improved attendance and engagement to the IPC Link workers programme and meetings	1) Monthly Link worker Meetings to be held on alternate sites 2) Revised link worker agreement to be implemented. 3) Link worker attendance to be monitored, fed back to divisions and monitored through IPCC 4) Summary report to be presented to IPCC	Mar-20	Q4	Jacqui Griffin (IPC Nurse)	• Monthly Link worker meetings are held on the TW and Maidstone hospital sites.	
CE-002	Feb-17	APW	Compliances with IPC practice and procedures	1) IPC team working with wards where non-compliances are identified, providing additional training and support	Mar-20	Q4	Lesley Smith (Nurse Consultant IPC)	• Every case of >72 hour CDI,> 48 hour MRSA	

Action No	Date Identified	Source	Output (What are we trying to achieve)	Action (How are we going to do it)	By when	Work plan Quarter	Owner	Current Progress (How are we doing)	RAG Rating
				2) findings from PII investigations followed up and monitored 3) Audit programme developed and available on the Q drive. Also see Audit and Surveillance section of this work plan				acquisitions, and MRSA & GRE bacteraemia is treated as a period of increased incidence (PII). The IPC team support the wards to achieve and maintain the 90% and above compliance on the high impact intervention audits. . • The IPC team complete a number spot checks after a ward comes off their PII to ensure that standards	

Action No	Date Identified	Source	Output (What are we trying to achieve)	Action (How are we going to do it)	By when	Work plan Quarter	Owner	Current Progress (How are we doing)	RAG Rating
								are being maintained.	
CE-003	Dec-17	APW	All medical devices and equipment to meet IPC requirements for use	1) IPC team to work with procurement to provide IPC advice on new products being considered	Mar-20	Q4	Lesley Smith (Nurse Consultant IPC)	•The infection Control team continue to review the cleaning requirement for equipment being purchased by the Trust	
CE-004	Apr-18	APW	Continue to raise the profile of Infection Prevention and control	1)IPC attendance at ward managers and Matrons meetings 2) IPC team to visit wards & department where possible 3) Participate in national and local initiatives to promote IPC. (Global Hand hygiene day, glove awareness week, International Infection Prevention week)	Mar-20	Q4	Lesley Smith (Nurse Consultant IPC)		
CE-005	Apr-19	APW	Develop process of gaining patient feedback / experience of	1) Process to be agreed 2) Discuss proposed process with patient representatives and seek agreement.	Oct-20	Q3	Lesley Smith (Nurse Consultant IPC)		

Action No	Date Identified	Source	Output (What are we trying to achieve)	Action (How are we going to do it)	By when	Work plan Quarter	Owner	Current Progress (How are we doing)	RAG Rating
			IPC						
CE-006	Apr-19	APW	Link worker conference to be held April 19	1) Venue to be agreed 2) speakers to be arranged 3)sponsors to be sourced 4)Agenda and invites to be sent 5)Evaluation to be undertaken	May-19	Qu 1	Claire Taylor (Infection Prevention Nurse) / Aly Barcroft (IPC Secretary)	Conference to be held on the 24th April in Maidstone academic centre. Agenda, speakers and sponsors have been agreed.	
SAFE, CLEAN ENVIRONMENT									
SCE-004	Oct-17	APW	Safe water systems	1) IPC representation at the Water Safety Meeting 2) All water sampling results to be sent to the IPC team for follow up 3) *Pseudomonas* risk assessment reviewed and updated	Mar-19	Q4	Lesley Smith (Nurse Consultant IPC)	• A member of the IPC team attends the Water Safety Group meeting. • *Pseudomonas* risk assessments have been completed and provided to	

Action No	Date Identified	Source	Output (What are we trying to achieve)	Action (How are we going to do it)	By when	Work plan Quarter	Owner	Current Progress (How are we doing)	RAG Rating
								Estates manager. These need to be further reviewed during 19/20	
SCE-005	Apr-19	APW	Alternative cleaning product to Difficil S to be introduced in June 19 as Clinimax have given notice that they are ceasing trading.	1) Meeting to be held to review alternative products 2) Trial to be undertaken involving Nursing and Domestic staff 3) Full evaluation to be undertaken prior to agreement and implementation in June	Jun-19	Qu 2	Lesley Smith (Nurse Consultant IPC)	1) Initial meeting held with E&F, Procurement , IPC to consider options. Agreed to identify 2-3 suitable products for trial	
SCE-006	Apr-19	Patient Safety alert	Estates and Facilities Patient safety Alert highlighted the risk of transmission of infection related to the use of portable fans	1) Meeting to be held to consider the finding and actions in response to the Alert 2) Trust risk assessment to be completed	May-19	Qu 1	Lesley Smith (Nurse Consultant IPC)	•Meeting held 5th February 19 which raised a number of concerns regarding the responsibilit y for the cleaning of fans and the use of tower	

Action No	Date Identified	Source	Output (What are we trying to achieve)	Action (How are we going to do it)	By when	Work plan Quarter	Owner	Current Progress (How are we doing)	RAG Rating
								Fans in the Trust. •Included on the IPCC agenda for discussion •Further meeting held March 19. Agreed actions included the cleaning of all the fans in the Trust and inventory to be developed. Alternative process for the cleaning of fans between each patient use to be agreed.	

Action No	Date Identified	Source	Output (What are we trying to achieve)	Action (How are we going to do it)	By when	Work plan Quarter	Owner	Current Progress (How are we doing)	RAG Rating
SURVEILLANCE & AUDIT									
SA-001	Apr-17	APW	Programme of audit to be developed and completed for 19/20	1) Audit programme to be developed and agreed at IPCC 2) HCAI provenance audit 3) Re-audit of compliance with the MRSA care bundle and decolonisation (second round) 4) Re-audit: Endoscopy Cleaning Policy for Infection Control 2019 5)Audit of the prescribing of prophylaxis for ERCPs 6) HOUDINI & CAUTI audit 7) Audit of compliance with the Policy and Procedure for the Assessment of Patients Presenting with Diarrhoea 8) Environmental audits 9) PII audits of MRSA and CDI	Mar-20	Q4	IPCT	• CSW is completing monthly triangulation audits with the findings being fed back to the ward at the time of the audit. The monthly finding are also sent to the matrons and presented at the IPCC	
SA-002	Apr-17	APW	Mandatory reporting of surgical site surveillance	1) SSS to be reported 6 monthly to IPCC 2) Quarterly reports to PHE 3) Feedback of findings to orthopaedic directorate 4) Proposed business case to increase SSS capacity once GIFT audit findings are known	Mar-20	Q4	Linda Baker (SSS Nurse)	QU 18/19 we were an outlier for TKR and NoF repairs. Working party to be convened and action plan to be developed.	

Action No	Date Identified	Source	Output (What are we trying to achieve)	Action (How are we going to do it)	By when	Work plan Quarter	Owner	Current Progress (How are we doing)	RAG Rating
SA-003	Apr-17	APW	No avoidable > 48 hour MSSA / MRSA bacteraemia	1) All pre and post 48 hours MSSA / MRSA bacteraemia to be reported on the DCS 2) RCAs to be completed on all > 48 hour MSSA/MRSA bacteraemia within 5 days and presented to the monthly panel for sign off 3) Trends and lessons learnt to be shared within the directorate	Mar-20	Q4	Lesley Smith (Consultant Nurse IPC)	There is no set limit for MSSA & MRSA however there is an expectation that we should have no avoidable infections.	
SA-004	Apr-17	APW	Gram negative reduction target - 10%, 15% & 20% reduction based on 2016 rates Local objective set for a reduction to 21.5 per 100,000 bed days (national rate 21.8)	1) Attend Kent and Medway HCAI Improvement group meetings with CCG 2) Local action plan to be updated 3) Catheter / HOUDINI audit report to be presented to IPCC 4) Audit of ERCPs 5) Continue to promote catheter passport 6) Report all > 48hr & <48 hr E.coli, Kelbsiella and Pseudomonas aeruginosa bacteraemia on the National Data Capture System 7) RCA is completed on all significant gram negative bacteraemia 8) 18/19 cases of > 48 hours to be reviewed to identify trends to	Mar-20	Q4	Lesley Smith (Consultant Nurse IPC)	Nurse Consultant attends Kent and Medway HCAI Improvement group and supports the HCAI improvement Group work plan. 67 > 48 cases reported in 18/19	

Action No	Date Identified	Source	Output (What are we trying to achieve)	Action (How are we going to do it)	By when	Work plan Quarter	Owner	Current Progress (How are we doing)	RAG Rating
				support 19/20 focused interventions **9**) Implement Hydration Project on all wards 10) Implement urinary catheter tools - https://improvement.nhs.uk/resources/urinary-catheter-tools 11) Cholecystitis pathway to be reviewed to ensure consistent antimicrobial prescribing. 12) Monitor trends against the national PHE fingertip data 13) Implement Kent and Medway catheter insertion and utilisation guidelines 14) Local working party to be developed					
SA-005	Apr-17	APW	*Clostridium difficile* Trust attributable infections to be within the Trust Limit of 55	1) Revised objective to be implemented which include the changes to the CDI reporting algorithm. • Hospital onset - healthcare associated • Community onset - healthcare associated •Community onset - indeterminate associated Community onset - community associated. 2) C diff policy to be updated to	Mar-20	Q4	Lesley Smith (Nurse Consultant IPC)	Revised reporting of CDI has been discussed at the IPCC in February and the Trust board. Email communication has been sent to ward	

Action No	Date Identified	Source	Output (What are we trying to achieve)	Action (How are we going to do it)	By when	Work plan Quarter	Owner	Current Progress (How are we doing)	RAG Rating
				reflect these changes 3) Monitor trends from the RCA & PIIs and act on findings 4) All RCAs are to be completed in 5 working days and presented to the monthly panel for agreement and sign off. 5) All samples to be sent for Ribotyping 6) changes to reporting to be communicated trust wide				managers and Matrons C diff policy has been updated and up loaded on the Q drive	
SA-006	Apr-19	APW	ICNet system upgrade planned for June 19. Alternative system or business case for upgrade to be agreed and implemented	1)Explore possibility of utilising the Sunrise system as an alternative it ICNET 2) Submit business case for ICNet Upgrade	Jul-19	Q2	Lesley Smith (Nurse Consultant IPC)	•Meeting held with Nancy Kirk and Suzanne Sutherland to explore the Sunrise system. It was agreed that the System would only provide about 70% of the functionality of the ICNet System and they would	

Action No	Date Identified	Source	Output (What are we trying to achieve)	Action (How are we going to do it)	By when	Work plan Quarter	Owner	Current Progress (How are we doing)	RAG Rating
								be unable to deliver this in the time frame. •Business case for ICNet upgrade developed and submitted April 19	
TRAINING & EDUCATION									
TE-001	Apr-17	APW	All training to be updated to reflect local and national guidelines	1) IPC Induction training to be updated	Jun-19	Q2	Claire Taylor (Infection Prevention Nurse)		
NATIONAL & LOCAL STANDARDS									
NLS-001	Apr-17	APW	Delivery of the local Antimicrobial Resistance Strategy	1) ASG to report to the IPCC 6 monthly 2) AMR CQUIN for lower urinary tract infections in older people to be delivered	Mar-20	Q4	Emmanuel Idowu, (Lead Antimicrobial Pharmacist)	• Antimicrobial Stewardship Group meets monthly and reports 6 monthly to the IPCC • Antibiotic audits are completed	

Action No	Date Identified	Source	Output (What are we trying to achieve)	Action (How are we going to do it)	By when	Work plan Quarter	Owner	Current Progress (How are we doing)	RAG Rating
								when there is a PII and bi monthly	
NLS-002	Apr-17	APW	Demonstrate Shared learning from lesson learned from RCAs and incidents	1) Lessons learnt from RCAs to be identified and shared 2) Trends to be monitored and reported for wider shared learning 3) Closing the loops of RCAs - Actions from RCAs to be monitored through the IPCC to ensure that all actions have been completed	Mar-20	Q4	Lesley Smith (Nurse Consultant IPC)	• Lessons learnt identified during RCA process and discussed at Panel • Findings from RCA are shared at Clinical Governance meetings	
NLS-003	Apr-17	APW	Support the Implementation of the Annual Flu plan	1) Peer vaccinators to recruited to support the 80% of frontline staff vaccination CQUIN 2) Adequate stock of viral swabs, masks and anti-viral medicines 3) Fit testing of front-line staff 4) Flu Campaign 5) Surveillance of flu cases 6) Timely raising awareness emails to be sent regarding signs and symptoms of flu and differential diagnosis	Mar-19	Q4	IPC Team	• The IPC team undertake surveillance of all flu cases	

Action No	Date Identified	Source	Output (What are we trying to achieve)	Action (How are we going to do it)	By when	Work plan Quarter	Owner	Current Progress (How are we doing)	RAG Rating
				7) business cases for in-house testing (PCR) machine to be submitted					
NLS-004	Apr-17	APW	Revise IPC policies due for update during 2018/19	1) Management of Group A Strep(Sept 18) IPCC approved - to go to PRC 2) Management of VHF (Sept 18) IPC and PRC approved - awaiting upload 3) Assessment of patients presenting with diahorrea (Feb 19) IPCC approved - to go to PRC - RRA to be finalised 4) Management of animal visitors (April 19) 5) Candida auris (New) (In progress) 6) Notification of Infection (New) (In progress) 7) Standards Precautions policy (July 19) 8) Policy for the Management of Scabies and Head Lice (July 19) 9) Policy and procedure for the care of patients with Transmissible Spongiform Encephalopathies (July 19) 10) Care and Management of patients with Norovirus (Sept 19) 11) Isolation Policy and Procedure (Aug 19)	Mar-20	Q4	IPC Team	•The Candida auris and notification of infection policies have both been drafted and needs approval from the DIPC before going to the IPCC meeting for approval.	

Action No	Date Identified	Source	Output (What are we trying to achieve)	Action (How are we going to do it)	By when	Work plan Quarter	Owner	Current Progress (How are we doing)	RAG Rating
				12) Control of Multi-resistant organisms (excluding MRSA & CPE) (Sept 19) 13) Environmental disinfection policy and procedure (Jan 20) 14) Control & management of CPE (April 20) 15) Care of patients with BBVs (April 20) 16) Decontamination of Mattresses (April 20)					
NLS-005	Apr-17	CCG	Deliver CCG KPIs	1) KPIs to be agreed 2) Agreed KPIs to be monitored through the IPCC meeting	Mar-20	Q4	Lesley Smith (Nurse Consultant IPC)	• KPIs for 19/20 to be approved.	
NLS-006	Apr-17	APW	Determine compliance with the code of practice the prevention and control of HCAIs	Self assessment tool for prevention and control of HCAIs to be completed and reviewed quarterly	Mar-20	Q4	Lesley Smith (Nurse Consultant IPC)	Compliance with Hygiene code continues to be reviewed. Policy for the reporting of infection to PHE remains outstanding. Further review required for 19/20	

Action No	Date Identified	Source	Output (What are we trying to achieve)	Action (How are we going to do it)	By when	Work plan Quarter	Owner	Current Progress (How are we doing)	RAG Rating
NLS-007	Mar-18	APW	Revise all IPC leaflets due of update during 18/19	All leaflets that require updating for 19/20 to be reviewed 1)ESBL and MSSA leaflets have been approved at IPCC and awaiting final approval by PILG 2) Hand hygiene leaflet 3) CPE	Mar-20	Qu4	Lesley Smith (Nurse Consultant IPC)	ESBL and MSSA leaflets awaiting final comments from PILG before being uploaded on Q pulse	
NLS-008	Apr-19	APW	Monitor areas of improvement and findings to be shared	IPC team to keep a record of change improvements	Mar-20	Qu 4	Lesley smith (Nurse Consultant IPC)		

The winter plan	**Chief Operating Officer**

The final version of the Trust's winter plan is enclosed, for review and discussion.

Which Committees have reviewed the information prior to Board submission?
Finance and Performance Committee, 29/10/19

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Winter Plan and Operational Resilience 2019/20

1.0 Introduction

Further to the paper which went to Trust Board in June, which offered our planning process for the winter 2019/20, this paper focuses on the details of the plan and progress towards delivery of them. The Plan is a result of outputs from the Seasonal Resilience & EU Exit Strategy Group, co-chaired by the Deputy COO and Director of Emergency Planning & Communications. Progress against this plan will be monitored through the weekly Forward Planning Meeting, chaired by the COO, which commences in late October.

2.0 Objectives

a. To ensure that there are plans in place to manage the modelled increase in activity scenarios and likely impact on bed capacity
b. Adopt and implement evidence-based best practice, to reduce the number of non-elective medical and surgical admissions by a combination of the extended use of Same Day Emergency Care (SDEC) pathways, reduced Medically Fit for Discharge (MFFD) patients and use of out of hospital capacity.
c. To ensure internal processes and systems are fit for purpose and resilient to meet the anticipated level of demand, in line with the Best Patient Flow delivery plans
d. Ensure delivery of all performance standards against agreed trajectories
e. Maintain and optimise patient flow through the hospitals to provide safe emergency and elective care
f. To ensure that all support services have plans to meet the demand scenarios concerning increased activity throughout the hospital
g. To ensure that there is appropriate, safe escalation plans in place which reduces the risk of medical outliers and negative impact on elective activity in surgery especially when escalation occurs in the surgical day unit and theatre recovery areas
h. To learn lessons from last year's winter plan and to apply ECIST principles

3.0 Operational Initiatives

Initiatives which worked well to manage flow & patient safety during Winter 2018/19 and which are included in the plan for 2019/20 with new initiatives:

- Daily safety huddle with good clinical engagement, involving a Planned Care clinician from November
- Dedicated 'outlier' medical teams on both sites
- Senior nurse to support medical post-take ward round at TW to signpost appropriate services to prevent admission
- Consistent approach by senior operational staff to site management and flow
- Same Day Emergency Care (SDEC) pathways established on both sites and working 7/7
- Surgical Flow Coordinator to support surgical flow & oversee escalation areas
- Increased establishment in ED to manage periods of overcrowding in line with Ambulance Handover plan
- Secure the capacity in the community to allow the flow of patients out of secondary care when medically fit
- Further improve inpatient flow through the 'Best Care' delivery programme, specifically 'Best Flow'
- To embed a clear understanding through the organisation of what all staff should do, if the organisation moves from OPEL 3 to OPEL 4 level. (Appendix 2 Operational Pressures Escalation Levels Framework**)** **OPEL 3 defined** as 'the local health and social care system is experiencing major pressures compromising patient flow and continues to increase. Actions taken in OPEL 2 have not succeeded in returning the system to OPEL 1. Further urgent actions are now required across the system by all A&E Delivery Board partners, and increased external support may be required. Regional teams in NHS E and NHS I will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally. National team will also be informed by DCO/Sub regional teams through internal reporting mechanisms' **OPEL 4 defined** as 'pressure in the local health and social care system continues to escalate leaving organisations unable to deliver comprehensive care. There is increased potential for patient care and safety to be compromised. Decisive action must be taken by the Local A&E Delivery Board to recover capacity and ensure patient safety. All available local escalation actions taken, external extensive support and intervention required. Regional teams in NHS E and NHS I will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally, and will be actively involved in conversations with the system'
- Develop a digitalised approach to information to allow improved availability and access to up to date information to assist in decision making
- Secure necessary staffing and reduction in vacancy levels
- Secure improved flow of patients into and out from the available ITU capacity
- Work with colleagues in other units to secure an improved flow of patients to and from tertiary centres

4.0 Capacity demand analysis

A key aspect of the plan is to understand and model the likely demand range across a number of key indicators. This modelling is based on previous activity experienced and refined on a monthly basis as we move towards the winter months. It will be important to understand likely levels but also upper limits, as appropriate delivery plans have been identified to mitigate the risk of these upper levels if they occur in a bad winter where numbers of scenarios come together. The areas to be modelled and included in our planning parameters:

1. **Total ED attendances per site:** An ED attendance model has been developed which uses historical trends to calculate expected attendances by month, week, day and even by hour. The model is currently showing that for type 1 attendances, the winter of 19/20 is expected to be around 3.3% busier than 1819 (with 2.3% and 4.3% as the upper & lower confidence limits). Annual growth in ED is currently around 7.0%. Note that the winter of 1819 was significantly busier than expected for an 8-10 week period

2. **Ambulance arrivals:** Ambulance arrivals usually run at 26-28% of total arrivals in the winter – more if the weather is poor. Last winter peaked at around 850-900 per week, and we would expect the coming winter to increase in line with ED attendances (3.3%). A cold winter could push this up by another 5% or so, bringing in more elderly patients with respiratory problems & fractures.

3. **Emergency admissions:** We have a model based on historical data, but over the past 2 years, emergency admissions have been driven more by increased use of Clinical Decision Units and SDEC pathways, which are driving an increase in zero LoS admissions. We expect non-zero admissions to increase at a similar or slightly lower rate to ED attendances (up to 5%), whilst zero LoS admissions are predicted to increase by 1 to 3% on 18/19

4. **Non-elective LoS (excluding zero):** Historically, there is a tendency for the average, non-zero LoS to increase by 0.5-1.0 days in the depths of winter. For 1920 we need to secure a 0.5 average day reduction in LoS & maintain it through winter as a key component in managing patient flow and bed capacity. NE LoS has come down from a peak of just over 8.0 days in early 2017 to an average of 6.7 days in 2019/20 Q2. We would expect the winter to average around 7.0 to 7.2 days (probably peaking higher in Jan), compared to 7.0 over last winter.

5. **DToC:** This has held fairly constant at around 28-32 patients per week (representing 3.9%- 4.8% of bed days) since the beginning of 2019. We are not expecting this to change significantly.

6. **Non Elective Bed Occupancy:** bed occupancy modelled, with 85th percentile figures have been rerun with both the latest activity (including winter & full year affect) and bed capacity, which will identify the bed capacity required per month for both Medicine & Emergency Care & Planned Care, per site for both elective & non-elective activity. This information has identified the shortfall in required beds when compared to physical bed availability within each of the hospitals. The outcome of this work has indicated a bed shortfall across sites of circa 168 beds in the worst week of winter (26th Jan). This level of shortfall offers a risk to the Trust in particular to the elective work flow and any additional planned activity associated with prime provider work. Further delivery of SAFER, SDEC pathways and best practice will help in reducing this capacity shortfall, however, there is still a shortfall and therefore pressure on the system and escalation across the health economy is expected.

Table 1 below shows the expected Non elective and Elective admissions per week across the winter period

		06-Oct-19	13-Oct-19	20-Oct-19	27-Oct-19	03-Nov-19	10-Nov-19	17-Nov-19	24-Nov-19	01-Dec-19	08-Dec-19	15-Dec-19	22-Dec-19	29-Dec-19	05-Jan-20	12-Jan-20	19-Jan-20	26-Jan-20	02-Feb-20	09-Feb-20	16-Feb-20	23-Feb-20	01-Mar-20	08-Mar-20	15-Mar-20	22-Mar-20	29-Mar-20
Type 1 ED		3,286	3,246	3,202	3,165	3,150	3,166	3,180	3,183	3,170	3,163	3,166	3,175	3,159	3,117	3,049	3,023	3,038	3,087	3,126	3,152	3,184	3,230	3,288	3,336	3,367	3,375
NE Admissions																											
Medical	0 LoS (inc CDU Only)	498	492	494	483	470	467	468	470	465	462	460	459	453	447	442	440	440	445	448	455	465	480	499	508	516	519
	Non-0	348	348	359	361	363	364	365	366	370	379	387	396	401	403	398	391	385	382	381	380	379	377	378	379	381	379
	Total	846	840	853	844	832	831	833	837	836	841	847	855	854	850	840	831	826	826	830	834	845	857	876	887	897	898
Surgical		177	176	172	170	168	168	170	173	171	165	158	157	160	162	163	161	161	162	164	166	166	168	169	170	167	163
T&O		57	55	50	49	49	47	46	45	45	46	47	47	46	45	45	46	46	45	43	42	43	44	45	45	46	47
Gynae		12	12	13	13	13	12	12	12	11	11	10	10	10	10	11	12	13	13	12	12	12	11	10	10	11	12
paeds		48	51	61	62	64	67	68	68	67	66	64	61	57	55	57	59	61	61	61	60	60	61	62	62	60	58
Oncology & Other		2	2	3	3	2	2	2	3	3	3	3	3	3	3	3	3	3	4	4	4	4	3	3	3	3	3
Total NE		**1,143**	**1,138**	**1,153**	**1,141**	**1,129**	**1,127**	**1,132**	**1,137**	**1,134**	**1,132**	**1,130**	**1,133**	**1,130**	**1,125**	**1,119**	**1,113**	**1,110**	**1,110**	**1,113**	**1,119**	**1,130**	**1,144**	**1,165**	**1,176**	**1,183**	**1,180**
Elective Admissions																											
Medical		6	6	6	6	6	6	6	6	6	6	6	6	3	4	6	6	6	6	6	6	6	6	6	6	6	6
Surgical		67	67	67	67	67	67	67	67	67	67	67	67	40	54	67	67	67	67	67	67	67	67	67	67	67	67
T&O		44	44	44	44	44	44	44	44	44	44	44	44	26	35	44	44	44	44	44	44	44	44	44	44	44	44
Gynae		19	19	19	19	19	19	19	19	19	19	19	19	12	16	19	19	19	19	19	19	19	19	19	19	19	19
Paeds		6	6	6	6	6	6	6	6	6	6	6	6	4	5	6	6	6	6	6	6	6	6	6	6	6	6
Oncology & Other		4	4	4	4	4	4	4	4	4	4	4	4	2	3	4	4	4	4	4	4	4	4	4	4	4	4
Total EL		**146**	**146**	**146**	**146**	**146**	**146**	**146**	**146**	**146**	**146**	**146**	**146**	**88**	**117**	**146**	**146**	**146**	**146**	**146**	**146**	**146**	**146**	**146**	**146**	**146**	**146**

Bed modelling has been undertaken to identify the funded bed capacity available per site by division and compared it to the bed capacity needed over the winter period per week to manage the expected activity in the table below. This is based on demand profile modelling through the year and latest LOS performance The shortfall in bed capacity is identified in the table below – for Medicine and Emergency Care this ranges from -52 to -168 beds across the winter weeks. Planned Care has sufficient capacity throughout the winter to meet demand.

Table 2

Funded Capacity		06-Oct	13-Oct	20-Oct	27-Oct	03-Nov	10-Nov	17-Nov	24-Nov	01-Dec	08-Dec	15-Dec	22-Dec	29-Dec	05-Jan	12-Jan	19-Jan	26-Jan	02-Feb	09-Feb	16-Feb	23-Feb	02-Mar	09-Mar	16-Mar	23-Mar	30-Mar
Planned Care (inc T&O)	total (Both Sites)	208	208	208	198	198	198	198	198	198	198	198	198	198	198	198	198	198	198	198	198		198	198	198	198	198
Urgent Care	total (Both Sites)	416	416	416	416	416	416	416	416	416	416	416	416	416	416	416	416	416	416	416	416	416	416	416	416	416	416
Cancer & Haem	total (Both Sites)	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18
Gynae	total (Both Sites)	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16
Private	TWH	0	0	0	0	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
Total	Grand Total	658	658	658	658	658	658	658	658	658	658	658	658	658	658	658	658	658	658	658	658	658	658	658	658	658	658
Planned Care (inc T&O)	Maidstone	63	63	63	63	63	63	63	63	63	63	63	63	63	63	63	63	63	63	63	63	63	63	63	63	63	63
Planned Care (inc T&O)	TWH	145	145	145	135	135	135	135	135	135	135	135	135	135	135	135	135	135	135	135	135	135	135	135	135	135	135
Urgent Care	Maidstone	242	242	242	242	242	242	242	242	242	242	242	242	242	242	242	242	242	242	242	242	242	242	242	242	242	242
Urgent Care	TWH	174	174	174	174	174	174	174	174	174	174	174	174	174	174	174	174	174	174	174	174	174	174	174	174	174	174
Cancer & Haem	Maidstone	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18
Gynae	TWH	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16
Private	TWH	0	0	0	0	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
Total Capacity	Grand Total	658	658	658	658	658	658	658	658	658	658	658	658	658	658	658	658	658	658	658	658	658	658	658	658	658	658
Demand NEL & EL Beds required																											
Planned Care (inc T&O)	Both sites	194	200	201	202	201	201	201	200	196	192	189	186	157	173	191	196	198	199	197	196	193	196	200	204	202	197
Urgent Care	Both sites	468	476	480	489	499	503	508	512	507	535	544	549	534	545	568	580	584	573	568	557	551	541	544	547	553	548
Cancer & Haem	Maidstone	14	14	14	14	14	14	13	13	13	14	14	14	10	11	13	13	13	14	14	14	14	14	14	14	14	13
Gynae	TWH	11	10	11	11	11	11	11	10	10	10	10	10	7	8	10	10	10	11	11	11	10	11	11	11	10	10
Total Demand		687	700	706	716	725	729	733	735	726	751	757	759	708	737	782	799	805	797	790	778	768	762	769	776	779	768
Capacity 'minus'Demand (Operational Plan) (Variance)																											
Planned Care (inc T&O)	total (Both Sites)	14	9	8	6	7	8	7	9	13	16	19	22	52	36	18	13	14	11	12	14	16	13	9	5	8	12
Urgent Care	total (Both Sites)	-52	-60	-64	-73	-83	-87	-92	-96	-105	-119	-128	-133	-118	-129	-152	-164	-168	-157	-152	-141	-135	-124	-128	-134	-137	-132
Cancer & Haem	total (Both Sites)	4	4	4	4	4	4	5	5	5	4	4	4	8	7	5	5	5	4	4	4	4	4	4	4	4	5
Gynae	total (Both Sites)	5	6	5	5	5	5	5	6	6	6	6	6	9	8	6	6	6	5	5	5	6	5	5	7	6	6
Total shortfall	Grand Total (variance)	-29	-42	-48	-58	-67	-71	-75	-77	-68	-93	-99	-101	-50	-79	-124	-141	-147	-139	-132	-120	-110	-104	-111	-118	-121	-110

Plans to close the GAP Phased benefits realisation of initiative to reduce bed capacity shortfall.	06-Oct	13-Oct	20-Oct	27-Oct	03-Nov	10-Nov	17-Nov	24-Nov	01-Dec	08-Dec	15-Dec	22-Dec	29-Dec	05-Jan	12-Jan	19-Jan	26-Jan	02-Feb	09-Feb	16-Feb	23-Feb	01-Mar	08-Mar	15-Mar	22-Mar	29-Mar
Medicine & Emergency Care winter bed requirement	468	476	480	489	499	503	508	512	507	535	544	549	534	545	568	580	584	573	568	557	551	541	544	547	553	548
Frailty TW 7dy/12hr	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7
Frailty MH 7dy/12hr	1	1	1	1	1	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
AEC TW 7dy/12hr	5	5	6	6	7	7	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8
AEC MH 7dy/12hr	3	3	4	4	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
Open Winter Escalation ward at TW	0	0	0	0	0	0	0	0	0	0	0	0	30	30	30	30	30	30	30	30	30	25	20	15	10	0
Open additional medical beds on Foster Clark at MH	0	0	0	0	0	0	0	0	0	0	0	0	10	18	18	18	18	18	15	10	5	0	0	0	0	0
Hospital @ Home benefit from new model	0	0	0	1	1	2	2	3	3	3	3	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
Move total 20 beds from Surgery to Medicine at TW	0	0	0	0	10	10	10	10	10	10	20	20	20	20	20	20	20	20	20	20	15	15	10	10	5	0
Move total of 6 beds from Surgery to Medicine at MH	0	0	0	0	0	0	0	0	6	6	6	6	6	6	6	6	6	6	6	6	6	3	0	0	0	0
Increase in Hilton capacity (KCC funded)	0	0	0	0	0	0	0	0	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9
Care Home pilot (via CHS)	0	0	0	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Falls service implemented in the community for urgent referrals	0	0	0	0	0	0	1	1	1	1	2	2	2	2	2	2	2	2	2	3	3	3	3	3	3	3
Manange 'Stranded Patients' through focussed LLOS process	2	2	2	3	3	3	3	4	4	4	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
Benefit in beds to Medicine & Emergency Care	18	18	20	22	35	39	41	43	58	58	70	72	112	120	120	120	120	120	117	108	103	90	77	72	62	47
Shortfall compared to bed requirement for Urgent Care	-34	-42	-44	-51	-48	-48	-51	-53	-33	-61	-58	-61	-6	-9	-32	-44	-48	-37	-35	-33	-32	-35	-51	-59	-75	-85

Phased benefits realisation of initiatives to reduce bed capacity shortfall	06-Oct	13-Oct	20-Oct	27-Oct	03-Nov	10-Nov	17-Nov	24-Nov	01-Dec	08-Dec	15-Dec	22-Dec	29-Dec	05-Jan	12-Jan	19-Jan	26-Jan	02-Feb	09-Feb	16-Feb	23-Feb	01-Mar	08-Mar	15-Mar	22-Mar	29-Mar
Planned Care (inc T&O) winter bed requirement	194	200	201	202	201	201	201	200	196	192	189	186	157	173	191	196	198	199	197	196	193	196	200	204	202	197
SDEC reduction in NELLOS (surg and T&O)	0	0	0	0	2	2	3	3	3	4	4	4	5	5	5	6	6	6	6	6	6	6	6	6	6	6
Hospital at Home benefit	0	0	0	2	2	3	3	4	4	4	4	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
Move total 46 bed from surgery to Medicine	0	0	0	-10	-10	-10	-10	-10	-16	-16	-26	-26	-26	-26	-26	-26	-26	-26	-26	-26	-21	-18	-10	-10	-5	0
Impact for Planned Care	0	0	0	-8	-6	-5	-4	-3	-11	-8	-18	-17	-16	-16	-16	-15	-15	-15	-15	-15	-10	-7	1	1	6	11
Available beds v bed requirement for planned care	14	8	7	-12	-9	-8	-7	-5	-7	-2	-9	-5	25	9	-9	-13	-15	-16	-14	-13	-5	-5	-1	5	10	12
Total capacity (+ / -) by week	**-20**	**-34**	**-37**	**-63**	**-57**	**-56**	**-58**	**-58**	**-40**	**-63**	**-67**	**-66**	**19**	**0**	**-57**	**-57**	**-63**	**-53**	**-49**	**-46**	**-37**	**-40**	**-52**	**-54**	**-65**	**-73**

Table 3 above identifies the phased plans to reduce the bed shortfall within Urgent and Planned Care

Assumptions relating to Table 3 are:

- SDEC operating 12hours a day/7 days a week on both sites
- H@H model changes to a 'discharge' model by November
- The NEL demand is within predicted parameters
- No significant changes to staffing levels (either within MTW or health and social care partners)
- No significant infection outbreaks (e.g. Norovirus)
- No significant adverse weather
- Stroke services across Kent and Medway continue to provide current services

Planned care – plans for activity over the winter period

TWH	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Total
No. of day cases	460	470	320	300	300	470	**2320**
No. of I/P done internally	150	150	100	0	0	100	**500**

5.0 What has the resilience plan already delivered in 2019

a. SDEC services (Acute Frailty, Surgical Assessment and Ambulatory Emergency Care) established on both sites
b. Delivered a reduction in LOS
c. Increased uses of Pathways 1,2,and 3
d. Established Hospital @ Home model
e. Improved ED performance in 18/19
f. Sustained approach to establishing SAFER bundle across the wards - n.b. SAFER is a practical tool to reduce delays for patients in adult inpatient wards (excluding maternity). The SAFER bundle blends five elements of best practice.

The SAFER patient flow bundle
S - Senior Review. All patients will have a senior review before midday by a clinician able to make management and discharge decisions. **A –** All patients will have an Expected Discharge Date (EDD) and Clinical Criteria for Discharge (CCD), set by assuming ideal recovery and assuming no unnecessary waiting.
F - Flow of patients to commence at the earliest opportunity from assessment units to inpatient wards. Wards routinely receiving patients from assessment units will ensure the first patient arrives on the ward by 10am.
E – Early discharge. 33% of patients will be discharged from base inpatient wards before midday.
R – Review. A systematic multi-disciplinary team (MDT) review of patients with extended lengths of stay (>7 days – also known as 'stranded patients') with a clear 'home first' mind set.

6.0 Key area within this year's plan

a. This includes a tactical approach this year similar to last year as we know this worked .The key aim of the following three components is to improve patient flow and in particular reduce LOS as we know LOS can increase over the winter period by up to 1 day.

b. Capacity plan -
   - Review case mix for elective work (day case and inpatient) to ensure 'best fit' with the Bed Modelling as detailed in Table
   - Pathway 3 – Continued use of pathway 3 and commercial beds The provision of on average 40 beds purchased in the community, has significantly helped in the flow of patients waiting for social services support and patients suitable for Pathway 3 (22 beds are occupied under the Pathway 3 scheme and a further 24 patients are being managed through the commercial bed scheme) It is recognised that this level of additional capacity is required through the year and will need to be enhanced over the winter period
   - Deliver consistently 30 patients on the H@H pathway
   - Focus on Long Length of Stay ward rounds to manage down the number of 'stranded patients' who have occupied a bed for longer than 14 nights
   - Comprehensive delivery of the SAFER bundle across all wards to secure a reduction in LOS for both medical and surgical Non Elective patients LOS
   - '10 Weeks of Christmas' approach to focus organisation on key areas for LOS reduction
   - Two Multi Agency Discharge Events being discussed at Local A&E Delivery Board to be held pre and post-Christmas with support from Director level partners across health and social care partners

c. Workforce plan – to ensure that we have maximised use of our available staff resource groups.
   - Additional medical teams
   - Additional OOH surgical team
   - Mobilisation of CNS and corporate nurses
   - Mobilisation of volunteers
   - Flue inoculation campaign

d. Escalation plan (to be mobilised during period / episodes of Overflow)

   - Planned opening of winter escalation ward for Medicine (aim to open 27th Dec)
   - Swing from surgery to medicine
   - Uses of assessment / ambulatory areas
   - Open closed capacity
   - Mobilise Additional staff

- Use day surgery areas
- Use of non IP areas
- Supported by the Boarding Guidelines

7.0 How is the Flow of patients going to be managed on a day to day basis?

Weekly Forward Planning meetings with the senior operational team, Chaired by COO, have been set up from October to manage and balance the expected weekly flow from both elective and non-elective activity in order to make any necessary adjustments to the plan and assure safe delivery of care.

In order to ensure grip and control for patients flow and safety, there will be a designated senior clinical member of staff allocated each day over the winter period. Daily site meetings will review the previous 24hrs and ensure that there are appropriate plans in place to manage the expected flow for the next 24rhs. The senior operational management team will be available on a daily basis (as they are now) to coordinate and mange necessary decision making

There will be clinical support identified on a day to day basis to help with decision making and ensure that there is excellent clinical involvement and ownership of the management of the patient flow through the hospitals. Clinical leadership from Medicine & Emergency Care is currently provided via the daily Huddle and the plan is to extend this practice to include surgery.

Through previous work with ECIP, a culture has developed of 'doing todays work today' demonstrated by ensuring that ED is cleared by Midday, of yesterday's work. Whilst challenging at times, this ambition will be refocussed on for the winter months as not only supports flow but patient safety. In addition the Boarding guidelines (appendix 1) has been reviewed and now approved which still moves patients from ED to the ward but swaps the sicker patient in a room and the less ill patient, into the designated boarding area on the ward.

Additional Medical teams to ensure appropriate clinical care for patients will be put into place for the winter within the Medicine & Emergency Care Division. This strategy has proved an essential element of the Winter Plan for the past 2 years.

More senior Specialty cover in ED will be delivered through changes to outpatient clinics, to create 'hot clinic' for urgent reviews and available to support ED.

8.0 Risk and Limitations

- Staffing – medical and nursing to manage escalated areas
- Impact of EU Exit
- Out of Hospital capacity to secure flow of patients out from hospital
- NEL rise above planned scenarios

- Stroke services in neighbouring trusts unable to provide current level of service impacting particularly at MH
- IP capacity and ability to mitigate the bed gap of circa 70 beds
- Financial implications and funding of necessary schemes not included in budget
- Impact on elective work, including prime provider activity

The full risk log is identified below with the financial risk being unable to be significantly mitigated

No.	Risk Title	Risk Description	Impact	Impact	Likelihood	Score	Response mitigating actions	Residual risk	Residual Likelihood	Residual score
1a	Significant rise in unplanned activity	unplanned activity continues to rise at both ED's leading to increased number of admissions (assuming same conversion rate as present) beyond the model	Poor patient experience, increased ambulance handover delays, lack of capity within ED's, reduced performanc e in 4 hour access, RTT and Cancer	4	4	16	Increase RAP staffing to support ambulance turnaround, increase hours in SDEC areas, improve LOS, use of OOH capacity	4	3	12
1b		increase in complex elderly patients which may cause an increase to LOS resulting in poor flow through the hospitals	beds not available in a timely way to absorb the numbers requiring admission	4	4	16	7 day working of the Acute Frailty Units on both sites is proven to reduce LOS and MFFD. Adherence to the SAFER principles will support flow	4	3	12

1c		limited number of escalation areas identified in the escalation policy due to the need to keep assessment areas flowing to support ED	pressure builds in ED	4	4	16	Escalation areas may still need to be used but with higher threshold triggers. To be reflected within updated escalation policy. The benefit of securing the flow of patients through the assessment areas will reduce the need for admission and therefore escalation areas opened.	4	3	12
2	Workforce vacancies	Despite positive moves to support recruitment across all professional groups this year, there remains significant areas of shortfall	patient experience, increase in LOS, poor flow, pressure builds in ED	4	4	16	On-going recruitment with pipeline in place over the winter months. All vacant shifts put out to Bank and Agency in advance. Good rostering management.	4	4	12
3	Financial impact of delivery	The cost of full escalation will cause pressure on elective work and therefore reduced income	Added financial pressure on the Trust	4	4	16	Develop comprehensive list of possible and likley costs associated with winter and prioritise costed initiatives to achieve maximum patient flow	4	4	16

4	Adverse weather	a. cold/snow/ice likely to causes higher ED attendances and admissions b. staff getting into workplace	May need to consider closing some areas to ensure safe levels of staffing for patients	4	3	12		4	3	12
5	Influenza	increased numbers of staff becoming ill with the flu	staffing shortages may cause areas to be closed compounding the bed pressures	4	4	16	Trust campaign to inoculate 90% of staff underway and reported on weekly. Peer vaccinators being used to ensure all areas are covered.	4	3	12

9.0 Key things which could significant impact the plans

- Even more NEL demand
- Impact of EU Exit
- Inability of neighbouring trusts to provide current stroke services
- Snow before Christmas
- Norovirus outbreak before Christmas (or after)
- Increased sickness among staff
- Flu in the community / staff

The plan covers these issues however, any one of them or a mixture of them occurring at a significant level, will affect the organisations ability to operate and add significant pressure to the Trust. These unusual events will be managed through control meetings identified in 7 above.

10.0 Plans

The following plans are based on the evaluation of last year and new initiatives. They focus on each Divisions individual plans in terms of the initiative, explanation of what is involved and the progress to date.

a. General- Cross Divisional Plans
b. Medicine & Emergency Care
c. Planned Care
d. W&C plans
e. Clinical Support & Diagnostics
f. Cancer Services
g. Estates and facilities plans

10.1 General - Cross Divisional plans

Initiative	Explanation of what it involves	Progress update	Lead
1.Capacity demand analysis	Understand levels of activity relating to different scenarios of growth	Detailed assessment of capacity and demand models has been undertaken. This has been undertaken for each site and for each division- urgent care, planned care and Women's and children identifying both non elective and elective activity. This has included Bed occupancy assessment and current performance of DToCs rates. and From the assessment of last year and current daily performance against 4hr targets, key capacity / demand and patient flow pressure points have been identified across the 7 day period and across holiday periods. This is being used to help in the clinical resource planning across these key periods within the winter plan This work has identified the level of risk concerning the upper limits of demand and the Divisions have include these scenarios within their winter plans. Implementation of the national best practice concerning patient flow and lessons learnt from last year have then been applied to reduce this capacity risk. Risk and quantified Impact on elective activity is understood and plans to mitigate this risk with use of the Independent sector are developing.	A Neild

2.Bed modelling	Understand - the beds numbers per specialty and per site , pressures and risks . Expected benefit from Best care programme initiatives. Confirm how the beds will be allocated and used over the winter period , considering urgent care demands, planned care needs (including prime provider work) And Private patient activity	• Bed modelling complete. • Shortfall in beds averages c.90 for Medicine & Emergency Care at TWH The Divisional plans to reduce the identified capacity shortfall include : • Extending the hours of operation of SDEC • To reduce the need to escalate into the SSSU which would affect day case activity, surgery have agreed to transfer 20 beds to medicine • Pathway 3 – Continued use of pathway 3 and commercial beds over the winter period. • Manage 'stranded patients' – ensuring that identified patients, progress on a daily basis with their care and treatment and do not sit in hospital waiting for decisions or tests etc. to take place. • Comprehensive delivery of the SAFER bundle across all wards to secure further reduction in LOS for both medical and surgical Non Elective patients LOS	COO, Deputy COO
3.TWH use of space review	Review the location of key departments to reflect current unmet needs, improve patients' pathways, consider clinical adjacencies and new ways of working at TWH	• Review and feasibility assessment of how the medical and surgical ambulatory patient service can be relocated to accommodate follow up patients after attending the AMU, is underway – possible solution is use of Wells Day Unit	Senior ops team

4.Escalation plan	Review of the escalation plan with clear triggers to be reviewed and agreed in September	e. Confirmed escalation will be required to reflect the bed modelling demand scenarios. Escalation plan (to be mobilised during period / episodes of Overflow) • Swing from surgery to medicine • Uses of assessment / ambulatory areas • Open closed capacity • Mobilise Additional staff • Use day surgery areas • Use of non IP areas • Supported by the Boarding Policy • Rebalance of Elective and NEL capacity	L Gray
5.Boarding Policy	To review the Boarding policy to ensure that it reflects best practice	Being finalised to reflect lessons learnt from last year . Each ward secure necessary screen to support the policy over the winter	S Foy
6.Securing temporary staff quickly	Review opportunity for a call off process to simplify and speed up the process of recruiting temporary staff, especially for last minute changes	The revised authorisation process for locum booking will facilitate this. Work is in progress to identify a call-off process for other staff groups	T Karlsson/R Bailey
7.Increased management cover over holiday period	Review opportunity for greater management cover over holiday periods e.g. more business as usual	As in previous years there will be full management cover over the winter period with an expectation that on site cover will be needed if significant pressure on the hospitals is experienced. This may involve a 7 day rota for the month of January	Senior ops group
8.CNS rostering	Review opportunity / impact to roster CNS's onto relevant specialty ward in a pre-planned way eg once a month over winter periods	Urgent Care: Respiratory, Cardiology CNS's to be based in ED to support early review & management of patients including admission avoidance. Jo Hockley to provide a rota from January for 6/52.	DDNQ's

9.Use of volunteers	Secure a clear plan as to how volunteers can support the wards when the hospital is in an escalated state	• Agreement reached on how the volunteers can be used in clinical areas(wards) • Non clinical departments have been asked to identify list of volunteers • Workshop dates for MTW non clinical staff and clinical non ward based staff being organised throughout October / November • Securing nominated leads for each area • Securing understanding with Site team / lead re coordination of volunteers at times of escalation Agreed that the role of volunteers in winter planning will need to mature with a phased approach	G Craig
10.IT sign on	Review opportunity to enable agency staff to have temporary login's to IT systems like Dr's have	Confirmed by Dir of IT that it is possible to undertake same process. Guidance notes on how to achieve the same process as to Dr's is being developed and will be distributed to all areas	N Sinclair
13.Incentives reward for staff	Policy developed –securing agreement for staff to undertake sessions with enhanced payment over difficult to fill shifts – need a clear policy agreed early Policy to allow - Flexibility for current staff to fill gaps in rotas in winter and be to be rewarded with an enhanced pay rates or be able to take time as annual leave later in the year	This work is in progress as part of the Best Workforce programme. Proposal being to be presented to the executive	Executives

15.Take action in a timely way associated with bad weather	Ensure plans are in plans for each specialty to understand which clinics should Pre cancel Outpatients and other activity due to the amber weather warning was the right thing to do by reducing traffic on the sites and potential for skips trips and falls.	• Plans in progress	Divisional management
17.Communications	Agree How we get 24-hour communications out to staff proactively when they need it. This is especially important when in OPEL 4 – consider Whats app groups , pre -set text messaging etc.	Divisions have developed wider leadership lists. Corporate list now exists of 350 leaders throughout MTW. Comms working with Emergency Planning and Response re use their new emergency text message service. Divisions securing mobile telephone numbers of operational teams. Comms developing guidance notes for Divisions to set up WhatsApp groups Looking at links with existing WhatsApp groups e.g. juniors doctors in order to secure timely key messages	Senior Operational Group
18.Communications	Division to confirm core messages to the public and staff before winter starts and when actions like the cancellation of appointments are carried out.	• Comms Department working with Divisions to proactively develop key messages for internal and external audiences • Comms exploring ways patient text reminder service can be used to convey winter messages • Comms working with KCHFT to develop patient and staff messaging to promote Home Frist and virtual ward schemes.	CommsTeam

20. Access to community beds	Pathway 3 and commercial beds –The provision of 30- 40 beds purchased in the community, will need to continue as it has significantly helped in the flow of patients waiting for social services support and pathway 3 type patients	Funding agreed and placement underway – Communication drive planned to promote better understating and access to all the community based services, specifically to encourage alternative to admission. • Communications team has contacted KCHFT communications department to develop staff and patient communications messages/materials to promote/explain use of Home First, Hospital @ Home other community-based services, specifically to encourage alternative to admission	D Hallam
21. Action when moving from Opel 3-4	To embed a clear understanding throughout the organisation of what staff can do when the organisation moves from Opel 3 to Opel 4 level. (Operational Pressures Escalation Levels Framework)	Each division is identifying within their local winter plans what actions they will be taking. Current plans include cancel all meetings, training sessions. Cancel OPD clinics of key staff to allow them to focus on inpatient flow , with a clear understanding and agreement of what and how they will be doing	Divisional management
22. Improved access to information	Develop a digitalised approach to information to allow improved availability and access to up to date information to assist in decision making.	As part of the Trust's Development of a digitalised approach to information, to allow improved availability and access to up to date information to assist in decision making, information dashboards via Shrewd and Smarties are now in place.	N Sinclair S Forsey – software J Jarvis – reporting
23. On Call Managers Forum	Session with ambulance trust held for all on call managers to prepare for the winter	Follow up session planned for December to ensure on call managers feel supported	Deputy COO
24. Daily Huddles	Continued use of the daily huddles with clinicians, clearly allowed improved ownership and understanding of the daily pressures across the trust and risk for the next 24hrs. Confirm if these need to change / added to for winter period	To continue and are being included within local divisional plans	LG/ST

25. Flu vaccination campaign	Workforce – reduce the risk of Flu outbreaks affecting both staffing and patients through a comprehensive flue vaccination campaign educating the staff as to benefits and need to have one eg move to a position in which staff are expected to have a flue vaccination	Programme to train additional staff to vaccinate has started. Flue vaccination Campaign started with information being sent out concerning vaccination programme for all staff .	C Lippiatt
26.Pts to tertiary centres	Work with colleagues in other units to secure an improved flow of patients to and from tertiary centres. Secure agreements with other units relating to time scales	Urgent Care: Use CUR to identify tertiary centre referrals – provision of electronic overview of patients waiting to go out/come in taking place	Site management team
27.Financial Planning for winter	A Financial assessment of the schemes and likely costs is being developed and a budget identified covering the winter period. All schemes requiring additional funding will be supported by a Business case which will go through the trust appraisal process	Each division is identifying costed specific schemes for winter above what is already within their budgets	All divisional leads
30.Staffing & Staff Welfare Planning	A review of HR policies - to ensure a consistent message about staff moving between sites and wards as well as personal preparedness for adverse weather	This is already being implemented and supported by division operational teams	T Karlsson/R Bailey
33. set up joint winter exercise workshop	Share and understand winter plans with colleagues within the trust and from outside.	Joint winter planning table-top scenario testing exercise undertaken on 1st October. In previous years this as worked well to allow better understanding of staff groups from across the sector to as to what is planned to occur and any risks there are still outstanding. This date has been brought forward, previous years as it will then allow any risk area to be mitigated prior to winter starting.	J weeks

10.2. Medicine & Emergency Care

Initiative	Explanation of what it involves	Progress update for 18/19 Winter	Implementation date & end date of scheme	Lead
1.Capacity demand analysis	Detailed plan to show demand & capacity by week from 1st Dec to 28th Feb for medicine. Current shortfall in beds for NEL medicine averaging 90 between Dec and March based on current demand levels and LOS across both sites but primarily focussed at TWH. Discussions ongoing with Planned Care to understand surgical capacity that could be 'given up' to medicine at TWH and potential impact this would have on elective income.		completed	Nick Sinclair
		Further work being undertaken to drill down to specialty level. Urgent Care Winter Workshop planned for 19th September with representatives from all specialties so activity and demand understood.	30.09.19	Senior Team
		Agreement on bed capacity available for NEL medicine on both sites from 1st Dec to 31st March	30.09.19	Lynn Gray
	Understand levels of activity relating to different scenarios of growth	Review data in line with above. Review resource requirements (primarily staffing) for ED and specialties if demand exceeds worst case scenario.	30.09.19	Nick Sinclair/Darren Palmer/Tim Hubbard
	Understand growth levels of respiratory patients (as most susceptible to illness over winter).	Respiratory team reviewing data and planning on how additional activity can be managed	30.09.18	Suzanne Bounds / Alan Dando / Dr Webster

2.Bed modelling	Understand the bed numbers per specialty and per site, pressures and risks. Expected benefit from Best Care programme initiatives.	Bed modelling complete – expected reduction of 20 beds in medicine as a result of AEC and Frailty working 7 days, 12 hours. Shortfall in beds circa 90 following improvement in LOS. Work underway to address shortfall (e.g. impact of virtual ward, increased Rapid Response etc.) Reviewing this at specialty level	30.09.19	Lynn Gray/Fiona Redman
	Confirm how the beds will be allocated and used over the winter period, considering urgent care demands, planned care needs (including prime provider work) and private patient activity	Discussions ongoing with senior teams across other Divisions.	30.09.19	Senior Ops Team
3. Use of 111	Use of the NHS 111 to be used as first point of triage for patients with an urgent medical concern. Aim is to reduce ED attendances by directing patient to the most appropriate place for their symptoms.	As part of the integration of 111 into the Urgent Treatment Centre (UTC) the provider of a UTC must be able to accept direct bookings from 111 into the appropriate clinical services. This is not currently possible into Symphony. The 111 tender has been put on hold and so no development work can progress until the new provider is chosen and we can then look to integrate the systems. We do however have a pathway for SECAmb to book directly into our GP in ED service where they cannot contact the patient's own GP. No timeline due to contract changes unknown to us.	TBC	Nick Sinclair

5. Maximise use of AEC and Ambulatory pathways	Best use of AEC and ambulatory pathways required to reduce >0 LoS admissions.	Lead AEC Nurse now in post across sites. Reviewing all pathways and considering an 'Exclusion Criteria' approach to AEC which has shown beneficial results in other Trusts. Awaiting decision on submitted Business Case for AEC to run 12hrs a day, 7 days a week to maximise productivity.	Work ongoing to drive better utilisation of pathways	John Clulow
6.Escalation plan	Review of the escalation plan with clear triggers to be reviewed and agreed in September	Confirmed escalation will be required to reflect the bed modelling demand scenarios. To be discussed at TME on 19.09.18	30.09.19	Lynn Gray
7.Boarding Policy	Review the Boarding policy to ensure that it reflects best practice and circulate	Boarding policy reviewed and completed	14.09.19 boarding guidlines v10.docx	Sally Foy
8. Physicians to support Emergency flow from ED	Senior decision-making at the front door is proven to reduce admission rates and LoS by ensuring correct management plans are implemented early in the patient's journey and that care is deliver in best place ('home' being the best place if possible)	Outpatient clinics have been blocked during January and February for Physicians so that a hot clinic approach can be adopted. Protocols to be circulated on how to use this service	15.11.19	Darren Palmer / Tim Hubbard
9. Reduction in Super Stranded patients	NHSI requirement that Trust demonstrates a 40% reduction in Super Stranded patients (based on last year's performance) by 31.3.20	Trajectory of no more than 112 has been set and weekly meetings taking place to monitor performance against plan.	1.12.19	Dawn Hallam / Fiona Redman
10.Increased management cover over holiday period	Review opportunity for greater management cover over holiday periods e.g. more business as usual	As in previous years there will be full management cover over the winter period with an expectation that on site cover will be needed if significant pressure on the hospitals is experienced. This may involve a 7 day rota for the month of January but would incur additional cost (costs submitted)	30.11.18	Lynn Gray

11. On call rota for January	Review the On Call Manager (Silver) rota for January.	• Consider the need to have a separate On Call Manager for each site over from 2nd January to 16th January as intensity of work increases • Change working hours on the day a manager is on call to start and finish later to ensure more senior presence during the evening to support flow and safety	30.10.18	Senior Ops Team
12. Annual leave management	Annual leave to be minimised over Christmas, New Year and January for all staff	All departments to monitor leave carefully to ensure sufficient staff in place over winter. Particular reference to be given to staffing levels from 21st Dec to 16th January. It is expected that no staff above Band 7 (including medical staff) take leave in the first 2 weeks of January	On going	Senior Divisional Team
13. Detailed operational plan for Urgent Care	Divisional detailed plan to be produced and published on Intranet covering 21st Dec to 16th January	Plan to include all rosters, on call managers, hot clinic profiles, contact numbers for all senior staff etc.	17th December	Nicola Scale
14.CNS rostering	Review opportunity / impact to roster CNS's onto relevant specialty ward in a pre-planned way e.g. once a month over winter periods	Urgent Care: Respiratory, Cardiology CNS's to be based in ED to support early review & management of patients including admission avoidance. Provide a rota from January for 6/52.	30.09.18	Jo Hockley

15. Take action in a timely way associated with bad weather	Ensure plans are in plans for each specialty to understand which clinics should Pre cancel Outpatients and other activity due to an amber weather warning as past experience has shown this is the right thing to do by reducing traffic on the sites and potential for slips trips and falls.	Urgent Care – plans to be included in the Urgent Care Winter Plan which will be published on the Intranet	15.11.18	Darren Palmer Tim Hubbard
17. Access to community beds	Pathway 3 and commercial beds –The provision of 30-40 beds purchased in the community, will need to continue as it has significantly helped in the flow of patients waiting for social services support and pathway 3 type patients.	Funding agreed and placement underway	ongoing	Dawn Hallam
18. Action when moving from OPEL 3-4	To embed a clear understanding throughout the organisation of what staff can do when the organisation moves from OPEL level 3 to OPEL level 4.	Each division is identifying within their local winter plans what actions they will be taking. Current plans include cancel all meetings, training sessions. Cancel OPD clinics for key staff to allow them to focus on inpatient flow, with a clear understanding and agreement of what will be achieved and how it will be monitored.	Delivered through Workshops, Site Meetings and departmental / ward meetings	Lynn Gray
20. Daily Huddles	Continued use of the daily huddles with clinicians, clearly allowed improved ownership and understanding of the daily pressures across the trust and risk for the next 24hrs. Confirm if these need to change / added to for winter period	To continue and are being included within local divisional plans Huddles to remain the same with addition of 5pm ED safety huddle. **Include Surgery** in huddle from Jan - March	1st December – end March 18/19. Unless pressure indicates earlier start date	Lynn Gray/Sarah Turner
21. Timely transfer of patients requiring tertiary centres	Work with colleagues in other units to secure an improved flow of patients to and from tertiary centres. Secure agreements with other units relating to time scales	Urgent Care: Use CUR to identify tertiary centre referrals – provision of electronic overview of patients waiting to go out/come in	ongoing	Sharon Melville / Elisa Cole

22.Financial Planning for winter	A Financial assessment of the schemes to support flow over winter with associated costs and risks has been developed and will be submitted to the Executives for consideration	As 1819 budgets set at outturn on previous year, additional costs over winter last year are included in budget however Division currently adverse to plan for pay. Each division is identifying specific schemes for winter and developing Business cases to support them	30.09.18	Claire Cheshire/Sally Foy /Lynn Gray
23. Review equipment needs	All specialties and departments to review need for additional equipment for the winter period	Ensure appropriate equipment is available to provide safe care (costs to be submitted)	30.09.19	Specialty teams
24. MADE events	Sector wide discharge event with senior support from partners to create capacity pre and post-Christmas. Agreed at LAEDB	Multi Agency Discharge Events to be discussed at LAEDB 14.10 19	20.11.19	Lynn Gray
25. Non - Emergency Patient transport	Provision of self-managed discharge and transfer service.	CCG contractor - G4S, now attending regular contract meetings with Trust Transport Manager and positioned 2 floor walkers on site. New Trust Transport Manager meeting daily.	ongoing	Sally Foy

10.3 Planned Care

Initiative / Plan Planned care	Explanation of what it involves	Progress update for 19/20 Winter	Implementation Date	Lead
1, Maintaining elective activity at Maidstone	All Theatre lists will run as normal in Main theatres, EEMU and MSSU – except lists cancelled due to AL	Activity to be reviewed weekly and a six week activity plan to be produced from 04/11/19 and signed off by DDO Surgery	Ongoing -6 week plan to be produced from 04/11/19	• T&O – Steph Parrick • H&N – Claire Hubert

Ensure elective activity continues at Maidstone to assist in maintaining cancer performance	MOU will be run 10 sessions per week and will not feature as part of escalation – this will involve elective Orthopaedic lists being moved in addition to those currently allocated to MOU to ensure it is fully utilised and maximum elective activity is maintained.			• Gen Surg & Urology – Jelan Pochin • Surgical Speciality – Dan Lyons • Gynae – Fiona Martin
	Robust 6-4-2 model in place – process to be expanded from 02/12/19 so that theatre lists not required due to leave will be given to the speciality dependent on the overall clinical and operational need and not offered out to the same speciality.	Process currently in place and will change from 02/12/19.	02/12/19	Daniel Gaughan
	Available theatre slots due to leave to be monitored at the weekly PTL meeting and designated by the DDO Surgery	Process currently in place and will change from 02/12/19.	02/12/19	Sarah Davis
2, Escalation plan for MH involving surgery To provide medical space without impacting surgical activity to support ED performance as part of the escalation plan.	Up to 6 IP beds will be offered towards winter escalation for Urgent Care to use as part of the wider escalation plan	To be included in the Trust escalation plan	To take effect from 02/12/19	Jacqui Slingsby/Sharon Page

3, Maintaining elective activity at TWH To maximise as much activity as possible to sustain the RTT position. Ensure elective activity will continue for those patients on a cancer pathway.	All Theatre lists to run as normal where possible with day case procedures being maximised – except lists cancelled due to AL	Activity to be reviewed weekly and a six week activity plan to be produced from 04/11/19 and signed off by DDO Surgery	Ongoing -6 week plan to be produced from 04/11/19	• T&O – Steph Parrick • H&N – Claire Hubert • Gen Surg & Urology – Jelan Pochin • Surgical Speciality – Dan Lyons • Gynae – Fiona Martin
	Additional CEPOD/Trauma lists to be provided when necessary in conjunction with elective demand.	Activity to be reviewed weekly and a six week activity plan to be produced from 04/11/19 and signed off by DDO Surgery	Plan to take effect from 04/11/19	Sarah Davis
	Robust 6-4-2 model in place – process to be expanded from 02/12/19 so that theatre lists not required due to leave will be given to the speciality dependent on the overall clinical and operational need and not offered out to the same speciality.	Process currently in place and will change from 02/12/19.	02/12/19	Daniel Gaughan
	Available theatre slots due to leave to be monitored at the weekly PTL meeting and designated by the DDO Surgery	Process currently in place and will change from 02/12/19.	02/12/19	Sarah Davis
4, Escalation plan for TWH involving surgery To provide medical space without impacting surgical	SSSU to convert 1-9 beds into chairs to ensure day case activity continues throughout winter. 6 x overnight beds will be required	To be included in the Trust escalation plan.	Plan to take effect from 02/12/19	Sarah Davis/Jacqui Slingsby/Sharon Page/ Sally Batley

activity to support ED performance as part of the escalation plan.	for 23 hour stay patients. This will release 9 beds for simple escalation. Up to 20 IP beds (this number includes the SSSU beds above) will be offered towards winter escalation for Urgent care to use as part of the wider escalation plan If SSSU remains fully escalated and it is likely that the site needs to use Recovery 1 or Holding bay for escalation then only 4 theatres will be open – 3 used for emergency work and the remaining one allocated to ENT, Gynae, Ortho for cancer work or 52-week breaches.			
	SSSU will be staffed to operate an admissions lounge process which again will help the flow of any elective activity that does take place.	Admission lounge is currently operational and will continue to function		Jacqui Slingsby/Sharon Page
5,Maximising elective activity before 23rd Dec across both sites Improve RTT position and reduce waiting times before heading into winter.	Ensure all existing sessions are fully utilised and pushed as much as possible to mitigate any loss of activity in Q4.	Weekly RTT monitoring in progress	21/10/19	Sarah Davis and Speciality GM's
6, Critical care capacity to meet peaks in demand within the Trust and within	Escalation for physical Critical Care capacity and patient dependency occurs on both the Tunbridge Wells	All escalation is dependent on a suitably trained workforce and staff are	Ongoing	Jacqui Slingsby

the local network. All escalation is dependent on a suitably trained workforce and staff are utilised flexibly across the site on a daily basis to accommodate the patients need. This may be supported by the Critical Care Outreach Service if required. Secure improved flow of patients into and out from the available ITU.	and Maidstone sites during peak demand periods. Whilst Maidstone ICU is currently staffed for a dependency of 7, 14 physical bed spaces are available within the ICU to admit patients. At Tunbridge Wells Hospital the ICU is currently staffed for a dependency of 7 although there are 9 physical bed spaces and with the colocation of Non-Elective Recovery provides the use of a maximum 2 further bed spaces, an ICU bedside workstation is in place to facilitate this. Both Intensive Care Units submit twice daily updates to the National NHS Directory of Services (DOS) online Critical Care bed capacity system and daily to the Emergency Bed Service. At TWH there are an additional 3.0 wte band 5 posts to help facilitate escalation into Recovery by providing a good core staff base to enable a critical care "staff bank" to function and cover when we need to escalate.	utilised flexibly across the site on a daily basis to accommodate the patient need. This may be supported by the Critical Care Outreach Service if required Secure improved flow of patients into and out from the available ITU Business continuity plan has been revisited and includes flexing up and down of ICU beds.	Ongoing	JacquiSlingsby/ Sharon Page
7, Close 10 surgical beds on Ward 10 in order to facilitate private patient capacity and move to Ward 32.	Ward 22 will become vacant on 11/10/19 following the stroke move. Ward 32 to move to Ward 22 leaving Ward 32 vacant. W10 to move to Ward 32 in collaboration with the private patients.	Plans to facilitate this move are currently in progress	23/10/19	Jacqui Slingsby/Sahron Page/Sally Batley
8,Implement a Consultant in SAU for Surgery and T&O	Recruit a Consultant from December –March to manage	Plans to facilitate this are currently in progress	02/12/19	Greg Lawton/Danny

	patient flow within the SAU.			Lawes
9, Flow Co-ordinator role to expand between Wards 30, 31 and SAU to assist with non-elective patient flow.	JD to be re-written to meet B4 criteria and post recruited into.	Plans to facilitate this are currently in progress.	02/12/19	Kelly Cushman
10,Consultant to attend site morning huddle	Recruit a Consultant from December –March to manage patient flow within the SAU and attend the morning site huddle	Plans to facilitate this are currently in progress	02/12/19	Greg Lawton/Danny Lawes
11, Increase use of Hospital at Home This will assist in reducing surgical admissions and LOS.	Patients to be identified either on an elective or non-elective pathway that can be discharged and mindfully watched at home by KCHFT. Surgical beds to be freed up for non-elective activity (expectation of up to 5-25 patients at any one time)	Planning in progress, pathways to be agreed with clinicians.	Ongoing	Jacqui Slingsby/ Sharon Page
12, Boarding Policy	Review the Boarding Policy with Urgent Care to ensure the policy reflects best practice and to circulate amongst the directorates	Once complete, ensure robust communication and set expectation of the ward staff.	Implemented	Jacqui Slingsby/Sharon Page
13, Escalation plan	Review of the escalation plan with clear triggers to be reviewed and agreed in September.	Confirmed escalation will be required to reflect the bed modelling demand.	27/09/19	Sarah Davis
		Ensure all directorates are aware of the triggers of escalation and the expectations to be set.	End of October	Jacqui Slingsby/Matrons
		To be an agenda item at Divisional Board		Sarah Davis

		Escalation guidelines for SSSU and theatre recovery/holding bay to be reviewed	End of October	Sabreena Stanton/Kris Birney/Lindsey Reynolds
		When SSSU, recovery or holding bay are escalated, consideration to triggers for extra catering, equipment and linen needs to be documented and understood by staff	End of October	Jacqui Slingsby/Matrons
14, Increased management cover over holiday period	Review opportunity for greater management cover over holiday periods e.g. more business as usual	Rota for management AL	October 2019	Zara Martin
		First two weeks of January separate rota to be implemented to ensure greater cover over a 12 hour period.	02/12/19	Zara Martin
15, Assurance to be given that staffs are 'FIT' tested.	ITU and theatre staff have completed FIT testing. Assurance plan to be implemented for the Surgical and T&O wards	Plan commenced	02/12/19	Jacqui Slingsby/ Sharon Page/ Sally Batley/ Kelly Cushman

10.4 Cancer Services

Initiative	Explanation of what it involves	Progress update for 19/20 Winter	Implementation date & end date of scheme	Lead
Capacity and Demand	Cancer services to understand demand and capacity at specialty level and ensure appropriate plans are in place to deliver safe care by individual teams.	Haematology Winter Workshop -TBC	October 2019	Senior Divisional Team
	Confirm how the beds will be allocated and used over the winter period, considering haematology demands and elective chemotherapy.	Pre-admission clinic to commence 26th September which will screen all elective patients to ensure they are fit and prepared for treatment.	26.09.18	Charlotte Wadey Stacy White
Chemotherapy Triage Phone	The Use of the chemotherapy triage phone will be the first point of triage for patients with an urgent SACT (Systemic anti-cancer treatment) concerns. Aim is to reduce ED attendances by directing patient to the most appropriate place for their symptoms, to include acute oncology assessment area, chemotherapy day units and GP's.	Re-training of all phone holders on patient s pathways. During working hours phone to be held by acute oncology who can monitor calls and sign post to appropriate place. Education of all departments within the division to ensure correct patient pathways followed.	Ongoing	Charlotte WADEY Janice Christie Karen McDonald Roz Yates

Maximise Ambulatory pathways	Oncology- Best use of ambulatory pathways required to reduce >0 LoS admissions.	Working with radiology to have protected slots for drainage of ascites early in the morning, can then be recovered by Acute Oncology to prevent admission.	October 2019	Senior Management Team

	Haematology- Best use of ambulatory pathways required to reduce LOS.	Increase establishment by 2 wte to ensure haematology ambulatory unit can be opened 5 days a week. Review business case for 2 wte band5/6 staff nurse	October 2019	
Boarding Policy	Circulate Boarding policy once agreed to Lord north Ward to ensure that it reflects best practice and circulate	Boarding policy to be shared with clinical teams on Lord North Ward	 boarding guidlines v10.docx	Nursing team
Review management and consultant cover over holiday period	Review opportunity for greater consultant cover over holiday periods e.g. more business as usual	Each triumvirate management team to review annual leave cover for their directorates to ensure full cover/support.	October 2019	Directorate management teams
On call rota	Consider supporting senior staff to train to support On Call Manager (Silver) rota.	• Consider who may be able to support on call rota with appropriate training/buddy	30.10.18	Senior Divisional Team
Annual leave management	Annual leave to be minimised over Christmas, New Year and January for all staff	All departments to monitor leave carefully to ensure sufficient staff in place over winter. Particular reference to be given to staffing levels from 21st Dec to 16th January. It is expected that no staff above Band 7 (including medical staff) take leave in the first 2 weeks of January	On going	Senior Divisional Team
CNS rostering	Review CNS rosters to ensure they are fully covered and where appropriate can support wards without having a impact on their workload	Matrons to discuss expectations on CNS to support wards during difficult periods. Ensure skills are updated where required.	30.09.18	Jo Hockley

All department have up to date winter plans for bad weather	Ensure plans are in plans for each directorate to understand which clinics should Pre cancel Outpatients and other activity due to an amber weather warning as past experience has shown this is the right thing to do by reducing traffic on the sites and potential for slips trips and falls.		15.11.18	GM's for each directorate Jenny Anderson Alice Ferral
Action when moving from OPEL 3-4	To embed a clear understanding throughout the division of what staff can do when the organisation moves from OPEL level 3 to OPEL level 4.	Each directorate within the division is to identify within their local winter plans what actions they will be taking. plans should include cancelling all meetings, training sessions. Cancel OPD clinics for key staff to allow them to focus on inpatient flow, with a clear understanding and agreement of what will be achieved and how it will be monitored.	Delivered through departmental / ward meetings/Team brief	Senior Management Teams
Daily Huddles	Continued use of the daily huddles within nursing, clearly allowed improved ownership and understanding of the daily pressures across the division including the trust and risk for the next 24hrs.	To continue and are being included within local directorate plans Huddles to remain the same at 8.30am.	On going	Matrons
Financial Planning for winter	Need an additional 2 wte band 5/6 for Chartwell to be able to open 5 days a week Require 1 wte band 5for the medical infusion unit to open 5 days a week.	Establish whether business cases are required.		

10.5 Clinical Support & Diagnostics

Diagnostics and Clinical Support	Explanation of what it involves	The likely benefit	Progress update
1. 7-day pharmacy service will be provided	The main challenge concerns staffing levels, however, these are currently being improved prior to winter	Allow improved discharge arrangements over the weekend	Chief Pharmacist is preparing proposal for increased establishment over winter to improve medicines reconciliation at admission point which will improve discharges. Business case for increasing the technical staffing for medicine management and reconciliation at TWH during winter period. The benefits expected are as follows: • Improved discharge times • Improve flow and throughout • Increase bed capacity • Improved medication safety through the timely completion of Medicines Reconciliation Cost submitted to finance £**50,724**
<u>Radiology</u> 2. No specific plans for changes to practice to support winter demand.	Previous years have shown that an increase in NEL demand does not increase demand on	Radiology. The only area this does increase demand for Radiology is additional trauma lists but these are relatively unplanned	
3. Plans to support Interventional patient recovery with use of bank nursing.	Employment of bank registered nurses to support the recovery of Interventional patients if nursing cover an issue on wards.	Continuation of Interventional Radiology service during winter pressures supporting compliance with 62 day cancer targets.	Bank nurses already in use but is dependent on where the patients will be recovered and staffing on those wards.
4. Increased phlebotomy service	To increase staffing x 1 per day on both sites	To ensure capacity increased to meet demand and assist in improving flow for NEL patients	GM for Pathology is preparing business case proposal for increasing phlebotomy support over winter. This was particularly effective last

			year in expediting discharges. Two four hour bank Phlebotomist shifts per site for the winter period to support increased discharges cost £5595 . To maintain competency of bank phlebotomists by incorporating a two 4 hour shifts per week at across both sites (8 hours in to total). 2. Provide a robust phlebotomy service to be called on in times of need to improve patient care and length of stay by having the best possible TAT of laboratory investigations. 3. Support clinical colleagues to direct their expertise to patient care rather than performing phlebotomy
5. Increase mortuary capacity	To increase mortuary capacity internally and by working with partner organisations	To increase mortuary capacity by 100 for the winter period to cope with the potential increase in demand	Temporary storage (Nutwells) will need to be used again in winter and order will be placed for increased capacity compared to last year. This will have a revenue impact. TWH – Internal unit (15 spaces) temporary storage now and then external unit (40 spaces) storage coming. Combined cost for both £22,500 Benefits are to improve deceased dignity by reducing the need to storage two remains in one space. Provide adequate storage over the Christmas period whilst the funeral directors and crematoriums are closed

Therapy Services Planning

Diagnostics and Clinical Support	Explanation of what it involves	The likely benefit	Progress update
6. Increase physiotherapy capacity	The main challenge concerns staffing levels. Recruitment to vacancies is improving but at any given time there are vacancies which we attempt to partially cover with agency staff (we only partially cover as we have to stay within financial envelope). Currently sourcing locums is difficult but this does tend to improve post-summer. Historically we have needed additional locums, above and beyond the financial envelope, over the winter in order to maintain flow and cover escalation beds. This has happened reactively. This year we would aim to plan for this and staff accordingly. <u>Summary of issue:</u> • Attaining staffing levels within current establishment and financial envelope • Maintaining flow/meeting demands over winter across both sites	Allow improved access to physiotherapy to improve flow in the hospital to discharge in Maidstone and Tunbridge Wells Hospitals.	• Agency requests against current establishment authorised and clinical manager continues to try to source locums Recruitment process with vacancies ongoing Skill mix reviews have been put in place and have improved recruitment • Recruit additional agency staff against winter pressures monies **2.00wte Band 7** Locum Physiotherapist **2.00wte Band 4** Locum Therapy Assistant Practitioner **From 12 weeks December 2019-February 2020** **Cost**: 2wte Band 7 Locum Physio £31032 2wte Band 4 Locum Assistant £16839 **<u>TOTAL £47871 for 12 weeks</u>**
2. Increase capacity in TADs and Urgent Care Therapy Teams	The TADS budget is planned to allow for an increase in staffing levels from December to March: • 1.00wte Band 6 locum Tunbridge Wells	Maintain standard response times for TADS and Urgent care Therapy seven days a week despite increased demand in winter to maintain patient flow	No additional funding is needed for TADS or UCT over the winter. Increased capacity will be dependent on successful recruitment of substantive and temporary staff.

	• 1.00wte Band 6 locum Maidstone Urgent Care therapy (A&E, AMU, AFU) have authorisation for 4.84wte additional Band 7 therapists to extend Acute Frailty Assessment to seven days a week at both hospital sites. So far only 1.00wte additional therapists has been appointed, 1.8wte of the existing Band 7 posts are about to become vacant and the team are carrying 2.00wte Band 6 vacancies.		
• Increase capacity in Occupational Therapy	Recruit additional agency staff against winter pressures monies 2.00wte Band 7 Locum Occupational Therapists and 2.00wte Band 4 Locum Therapy Assistant Practitioner From 12 weeks December 2019-February 2020. • To provide OT Cover to medical, and elderly care patients in escalation areas for discharge planning. • To provide and increase OT input to medical and elderly care patients requiring therapy input to reach goals for discharge home or to cottage hospitals. • To increase OT input to medical and elderly care	Would provide cover for 8 additional new patients to be seen on each site daily and 8 rehab sessions. This would impact on: • patient care and safety • patient flow • discharge planning • patient function and independence. • Improve access times to occupational therapy assessments Use of Band 2 Administrative staff would save clinical time currently spend in re-ordering equipment.	Due to long term difficulties with recruitment at all levels it would be unlikely to recruit to fixed term contracts. **Agency Cost:** • 2wte Band 7 Locum Physio £31032 • 2wte Band 4 Locum Assistant £16839 **TOTAL £47871 for 12 weeks** **Bank Staff Cost** • 2 wte Band 2 Admin staff £10.700.00 **TOTAL £10700 for 12 weeks**

	patients to maintain function whilst receiving medical treatment to ensure ready for discharge when medically fit. • To provide increased support to board rounds, bed meetings and sitrep meetings. • To facilitate movement around the hospital to cover medical outliers in all areas. Use Band 2 assistant admin staff to reorder equipment for the clinical team		
• Increase SALT team capacity	Additional staffing to contribute to the heightened Winter period activity. No additional reserve in current allocated budget, with cost pressures already identified for Macmillan SALT 2019/20.	Allow improved access to SALT in order to improve flow in the hospital to discharge in Maidstone and Tunbridge Wells Hospitals.	Recruit additional agency staff against winter pressures monies. Costings for Additional SALT staffing required to provide 5 day cover to Winter escalation wards from Dec 2019 – Feb 2020: 0.3wte Band 6 XR06/05 0.1 wte Band 4 XR04/04 **Total: £ 6,492**
• Increase Nutrition and Dietetic team Capacity	In absence of Clinical Manager for this area the detail for SALT has been utilised as a comparable service	Allow improved access to dietetic service in order to improve flow in the hospital to discharge in Maidstone and Tunbridge Wells Hospitals.	Recruit additional agency staff against winter pressures monies. Costings for Additional SALT staffing required to provide 5 day cover to Winter escalation wards from Dec 2019 – Feb 2020: 0.3wte Band 6 XR06/05 0.1 wte Band 4 XR04/04 **Total: £ 6,492**

10.6 Women's, Children's and Sexual Health

Initiative	Explanation of what it involves	Progress update for 19/20 Winter	Implementation date & end date of scheme	Lead
1.Capacity & demand analysis	Maidstone Plan to reduce Riverbank consultant cover by 2 hours per day Monday-Friday (From January 2020); with a range of 0-1 patients in these hours who would remain in ED and not transfer to Riverbank. Riverbank would remain open for elective patients with nursing and SHO cover.	Liaising with ED managers and Director of Strategy. Proposal being drafted	Jan 2020	Hamudi Kisat/Kym Sullivan
2.Bed modelling	**Assessment of Bed requirement** 8.2 beds are required for inpatients 3.4 beds for 0 length of stay	LOS reduction action plan to be agreed by Directorate. Agreement with surgery in regards to maximum surgical occupancy to be agreed. .	Ongoing	Divisional Triumvirate

3. RTT impact	RTT goals: • waiting list size to be <2268 by March 2018: • RTT backlog to be < 485 • RTT performance to be 80.2% NB: This does not included any changes as a result of surgical reconfiguration. Actions: Maximise booking % Validation Adhoc waiting list Reduction in elective lists will affect RRT activity level and backlog size. To plan extra lists to make up activity loss.	On plan	Ongoing	Fiona Martin

10.7 Estates & Facilities

Initiative	Explanation of what it involves	Progress update for 19/20 Winter	Implementation date & end date of scheme	Lead
1. Internal Facilities Staff bank	Increase staff bank pool across Facilities. Employees can work multi/cross-disciplinary. Better bank provision reduces the need for overtime and agency. Recruitment and retention remain a challenge in FM.	Increase staff bank pool across Facilities. Employees can work multi/cross-disciplinary. Better bank provision reduces the need for overtime and agency. Recruitment and retention remain a challenge in FM. Arrangements agreed and implemented. Bank staff now being routinely utilized and further bank recruitment remains ongoing.	ongoing	Sarah Gray (MGH) Helen Leith (TWH)

2. Catering - emergency food provision	Additional stock of food including frozen meals to be held in case of inclement weather/delivery failures. Min 5 days stock.	Ensure continuity of catering provision to staff and patients, for prolonged periods. Arrangements agreed and process for ordering and storing implemented.	11/10/2019 - 31/03/2020	Paul Rhodes
3. Inter-departmental management working and support incl daily/weekly duty manager and supervisor.	Management provision takes responsibility across the full range of Hotel Services. I.e. Zone managers now support catering and portering as well as domestics. Daily nominated 'Duty Facilities Manager', to avoid confusion during especially busy or periods of inclement weather. Assured senior FM attendance at bed and site meetings.	Increased management focus. Arrangements agreed and process implemented.	ongoing	Mona Kalsi (TWH), Abraham Adegoke (MGH)
		Continuity of Facilities management input across services and better resilience through winter when staffing comes under pressure. Review and monitor to ensure meets demand.	ongoing	Mona Kalsi (TWH), Abraham Adegoke (MGH)
		Improved staff attendance via sustained management presence. Weekly monitoring of sickness and absence throughout FM staff groups.	ongoing	Mona Kalsi (TWH), Abraham Adegoke (MGH)
4. 4 x 4 driver training	General Transport drivers to receive 4 x 4 training if applicable.	Readily available driver pool for driving 4 x 4 vehicles in inclement weather. Arrangements agreed and process implemented.	01/11/2019 - 31/03/2020	John Knight
5.A review of 4WD drive vehicles will be undertaken. A separate plan to ensure	The 4WD MOU is only for use once the trust has exhausted all business continuity plans. These plans include the provision of at least two internal 4WD with drivers by estates. It may be that a full external contract is a better way of delivering this essential business continuity.	Keep staff coming to work and maintain discharges of patients etc. Support to General Transport team function. Review current contract with Delta & Kent central to ascertain 4x4 availability.	01/10/2019 - ongoing	John Knight

the integrity of the 6X service will to be considered especially clear early morning communications to staff – especially those waiting in freezing conditions				
6.Winter Snow and Ice Procedure	Estates Team responsible for managing, implementing and carrying out the various aspects of maintaining the roads and pathways for the safe passage of patients, visitors and staff during periods of forecasted or unpredicted inclement weather i.e. frost, icy conditions and snow. Support from Facilities Management Team; esp. Grounds and Gardens.	Ensure safe access in and around the sites. Arrangements agreed and process implemented. Areas of site ranked for prioritisation. Winter planning meeting (EFM), held according to risk/likelihood. Create central file containing EFM Winter plans & Procedures.	ongoing	Peter Packard
7.Cleaning procedures to reduce down time	Cleaning-. Even with the new UV cleaning equipment, high levels of fogging still took place which meant that rooms were out of use for up to 4hrs. A review of the latest cleaning systems is planned to help reduce this downtime prior to next winter	Equipment trials are ongoing in some areas and new equipment has been delivered/ ordered for others; including capital bids for large items.	ongoing (capital plan 2019/20)	Darren Bulley

8.Any new fixed facilities required of for escalation areas	A review of temporary escalated areas to be reviewed to identify any need for fixed facilities	Timely readiness of escalation areas. Ongoing. Awaiting 2019/20 escalation plans.	ongoing	Sarah Gray (MGH) Helen Leith (TWH)
9.Rapid response teams	Rapid response teams to escalation areas - publish what can be expected and how feedback to control centres on progress is best done. Duty manager to be key in directing RRTs.	Faster turnaround of areas, by priority. Plans in place to cover winter period including improved communication. Ensure attendance (FM) at all bed meetings.		

11.0 Key performance indicators being monitored through Divisional performance meetings:

a. The number of times which OPEL 4 is initiated offers an insight into the pressure the trust is under during the winter period
b. ED performance - Performance for the Trust in line with the agreed trajectories
c. Ambulance Handover delays
d. Elective activity is in line with planning assumptions
e. Infection rates of patients and inoculation rates of staff
f. LOS – The Avg LOS needs to reduce by at least 0.5 days across all emergency admissions and not rise within the winter months. This is required to support Best flow and release the necessary bed capacity
g. Stranded patient numbers
h. Number of times the Boarding policy implemented
i. Numbers and types of Patient Complaints

12.0 Financial planning

The winter costs from last year have been already incorporated into the divisional budgets for this year. However, there is the need to understand the risk to the financial position concerning the necessary additional schemes identified by the divisions for this year, in order to manage the increased flow of patients this winter. A Financial assessment of the schemes is underway, in order to identify the level of financial risk to the Trust and if not supported, operational risk to performance and safety over winter . Each division has been asked to identify prioritised costed additional schemes which are not within their budgeted position. The table is being validated and offers a worst case scenario. The financial assessment included is currently forecasting that the Winter plan will have an adverse financial impact of c£3m to £3.5m; Finance and Directorate teams are working closely to finalise the financial assessment, based on the assessment completed to date it is likely prioritisation review will need to be completed to ensure costs are maintained within funded levels.

Maidstone and Tunbridge Wells NHS
NHS Trust

BOARDING GUIDELINES
August 2018

In the context of these guidelines, a boarded patient is defined as:

"A patient residing on a ward without an allocated bed space"

Purpose and rationale for these guidelines

The purpose of these guidelines is to ensure there are robust processes in place to provide assurance that patient safety is being maintained when the Trust is experiencing increased challenges managing demand and patient flow.

These new guidelines describes the process of risk sharing across the Trust when the Emergency Department (ED) has more patients than it can safely care for and supports the sites with maintaining patient safety, the provision of high quality care and a good patient experience.

Unlike many departments the ED must remain open. When all available patient care spaces are occupied, the risk of serious incidents happening not only increases with every new patient that arrives, but is concentrated in one area.

NHSI and our own MTW data shows that mortality increases for patients with avoidable long waits in ED. Allocating one extra patient (boarding) to suitable wards will share this risk across the Trust, Improve patient outcomes and reduces the risk in ED.

MTW's Emergency Departments (ED) sees between 360 and 460 patients per day depending upon the time of week, season or weather.

At Maidstone Hospital the department has the capacity to care for 22 adult patients in trolley or bed spaces across 3 areas (majors, resuscitation, minors - excludes pediatrics).

- 9 in majors
- 2 isolation cubicle
- 4 in Resuscitation

- 7 in minors
- Pediatrics in ED have 5 care spaces
- RAP 4 spaces

At Pembury Hospital the department has the capacity to care for adult patients in 33 trolley or bed spaces across 3 areas (majors, resuscitation, minors - excludes pediatrics).

- 18 in majors
- 1 isolation cubicle
- 6 in Resuscitation
- 8 in minors.
- Pediatrics in ED have 6 care spaces
- RAP 5 spaces

When these spaces are full and ambulances are unable to offload it is recognised that there will be times when the hospital needs to operate differently.

1. TRIGGERS FOR ACTIVATING PATIENT BOARDING

The Boarding of patients should be considered when a number of the following criteria are met.

- No care space in the ED
- The Trust escalation status is OPAL 3 or 4
- The ED escalation status is RED or BLACK
- More than 20 unplaced patients waiting for a bed at 8am
- Resus is full with level 2 dependency patients with incoming priority call and no immediate allocated bed space
- There are more than 3 ambulances being held for more than 45 minutes.

2. LEVELS OF BOARDING

LEVEL ONE -

Boarding against identified discharges will be considered when ED has 20-25 unplaced patients with decisions to admit (DTA's), plus 2 of the triggers above

LEVEL TWO -

Boarding patients on wards without identified discharges when DTA's are 25-30 and one of the above triggers.

LEVEL THREE-
Boarding of patients will occur when there are 35+ patients with a decision to admit unallocated at 08:00 hrs

Note: in the first instance
Matching boarded patients to their specialty will always be considered but may be overlooked at level 3 if the number of DTA's at 08.00 hrs is plus 35

3. ACTIVATING PATIENT BOARDING

The decision to escalate and activate patient boarding is not made by one individual alone but made together with the clinical teams, Chief Operating Officer, Operations Directors, and Associate Directors of Nursing. OOH the decision is made by the Executive Director on call following discussion with the on call manger.

This decision should be considered seven days a week and should be taken as early in the day as possible, ideally at the 09.00 site meeting, however this decision may need to be made earlier in line with the triggers for boarding (as above). These decisions should be reviewed hourly by the Site Director.

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4. TRANSFER OF BOARDED PATIENTS TO THE WARDS

The Site Director in conjunction with Associate Director of Nursing will decide, in conjunction with the Nurse in Charge of ED, Site Managers and the receiving ward, which patients are suitable to be moved to the wards. When a decision to board has been made it is the responsibility of the NIC of ED or senior site manager to ensure that the patient and family are aware that the patients will be boarding on a ward. There should be documentation in the notes that reflects the conversation.

5. CRITERIA FOR TRANSFERING BOARDED TO THE WARDS

- Only patients with a decision to admit (DTA) in ED or CDU will be moved to suitable wards for boarding.

- Where possible referred patients in ED should have a senior review and management plan documented by the on call registrar of the admitting team prior to transfer to the admitting ward.

- When transferring boarded patients it is the responsibility of ED staff to ensure that a comprehensive hand over is given to the nursing team. The patient must be escorted to the ward by a registered nurse.

- Only one patient per ward will be allocated. One ward named nurse (Registered or Support Worker dependent on the patient) must be allocated to care for the patient.

- Patients with cognitive impairment (e.g.delirium/dementia/mental health condition) should be given priority for a bed space.

- When the 'boarded' patient is bedded and the ward returns to its agreed bed base further patients can be admitted using the same criteria.

- The patient transferred from ED will be placed into the bed space and the patient awaiting discharge will be boarded outside the room. This allows treatments for the sickest patient to commence treatment without delay.

- The Infection control team should be made aware of any possible infection control risks.

- Screens should be available to maintain privacy and dignity of boarded patients.

- Patients requiring non – invasive ventilation should NOT be boarded, in this instance the patient who is mapped for discharge should be boarded to allow the patient requiring urgent intervention immediate access to a bed space.

- When boarded patients are on the wards any medications with the patient should be kept in a green pharmacy transfer medication bag and either locked in the wared drugs trolley or in a locked medicine cupboard in the clinical room.

- When boarding has been agreed, site matrons will be responsible for ensuring wards are safely staffed to receive one extra patient – this may mean moving staff from other areas.

- Tracking of boarded patients should be clearly visible in the site office and documented on the daily site reports which will be managed by site managers. An update on boarded patients will be provided at each site bed meeting so that appropriate plans can be put in place.

- Any patient boarded longer than 4 hours should be escalated to site managers and specialty matron. If there are any clinical concerns during the period of boarding these should be escalated to the site managers and matrons. An incident form should be completed when the period of boarding has exceeded 4 hours.

6. MONITORING OF COMPLIANCE WITH GUIDLINES

- The frequency of activation will be monitored by operational teams and recorded on site reports and on incident reports when boarding has exceeded 4 hours.
- Speed of transfer and the provision of the additional nursing support will be monitored by the Associate Directors of Nursing.
- Care of the additional patients on the ward will be monitored by the Senior Matron for the specialty.
- These guidelines will be reviewed at the weekly Chief Nurses Midwifery team meeting in relation to impact on provision of patient quality and safety.
- Impact on safety and care of existing patients on wards by reduced staff to patient ratios will be monitored by the Senior Matrons and reported through the Trust Clinical Governance Committee into the Quality Committee.

Appendix 2 **Operational Pressures Escalation Levels Framework (NHS England published 31st October 2016)**

Escalation status	**Status descriptor and triggers**	**Mitigating Actions**

Escalation status	Status descriptor and triggers	Mitigating Actions
Level Green: (Normal working) **OPEL One**	Demand for services within normal parameters - Trust is able to maintain patient flow and is able to meet anticipated demand within available resources	Maintain routine active monitoring of external risk factors including flu, weather Ensure all pressures are communicated regularly to all local partners
Level Amber: (Moderate Pressure) **OPEL Two**	Anticipated pressure in facilitating ambulance handovers within 60 minutes Insufficient discharges to create capacity for the expected elective and emergency activity Lack of beds across the Trust Opening of escalation beds likely (in addition to those already in use) ED patients with DTAs and no action plan Lower levels of staff available, but are sufficient to maintain services Infection control issues emerging Capacity pressures on intensive care and specialist beds	Undertake additional ward rounds to maximise rapid discharge of patients Clinicians to prioritise discharges and accept outliers from any ward as appropriate Implement measures in line with Trust Ambulance Handover Plan Notify CCG on-call Director to ensure the appropriate operational actions are taken Consideration given to elective programme including clinical prioritisation and cancellation of non-urgent elective inpatient cases
Level Red: (Extreme Pressure)	Actions at Amber failed to deliver capacity Significant deterioration in performance against the ED 4 hour target (e.g. a drop of 10% or more in the space of 24 hours) Patients awaiting handover from SECAMB within 60 minutes	ED senior clinical decision maker to be present in ED 24/7 where possible Contact on-take and ED on-call senior decision makers to offer support to staff and to ensure emergency patients are assessed rapidly

Escalation status	Status descriptor and triggers	Mitigating Actions
OPEL Three	significantly compromised Patient flow significantly compromised Unable to meet transfer from Acute Hospitals within 48 hours timeframe Awaiting equipment causing delays for a number of patients Significant unexpected reduced staffing numbers Serious pressures on intensive care capacity Problems reported with support services (IT, Transport, Estates, Pathology) that can't be rectified within 2 hours	Enact process of cancelling day cases and staffing day beds overnight if appropriate Open additional beds on specific wards, where staffing allows in line with escalation ladder (found at 6.1 of this document) ED to open an overflow area for emergency referrals, where staffing allows Notify CCG on-call Director so that appropriate operational actions can be taken to relieve the pressure Alert Social Services on-call managers to expedite care packages Active management of elective programme including clinical prioritisation and cancellation of non-urgent elective inpatient cases
Level Black: (Critical Pressure) **OPEL Four**	Actions at Red failed to deliver capacity No capacity across the trust Severe SECAmb handover delays Unable to offload ambulances within 120 minutes Emergency care pathway significantly compromised Unexpected reduced staffing	All actions from previous levels continue ED senior clinical decision maker to be present in ED 24/7, where possible Contact on-take and ED on-call Senior decision makers to offer support to staff and to ensure emergency patients are assessed

Escalation status	Status descriptor and triggers	Mitigating Actions
	causing compromises in service provision / patient safety Severe capacity pressures on intensive care beds Infectious illness, Norovirus, Severe weather and other pressures in Acute Trusts Problems reported with support services (IT, Transport, Estates, Pathology) that can't be rectified within 4 hours	rapidly Surgical senior clinical decision makers to be present on wards, in theatres and in ED 24/7, where possible Executive Director to provide support to site 24/7, where possible ***An Acute Trust wishing to divert patients from ED must have exhausted all internal support options before contacting the CCG and neighbouring trusts to agree a divert**

Update on the West Kent Integrated Care Partnership (ICP)	**Director of Strategy, Planning and Partnerships**

An update on the West Kent Integrated Care Partnership (ICP) is enclosed.

Which Committees have reviewed the information prior to Board submission?
Executive Team Meeting, 29/10/19

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

West Kent ICP Update

October 2019

In October the ICP development board will focus on establishing the new governance structures and agreeing the ICP functions and mapping resource to it

September

- Governance approach agreed in principle
- Agreement to engagement events.
- Engagement with PCNs (& District/ Borough Councils)
- Draft outline of ICP functions and guiding principles

October

- Establish and resource new governances (e.g. Steering Group, working groups)
- Visioning event with Shadow Board
- Agree initial ICP vision, functions and guiding principles

November

- ICP launch event with wide stakeholders – share vision, guiding principles and functions
- ICP contribution to ICS LTP signed off

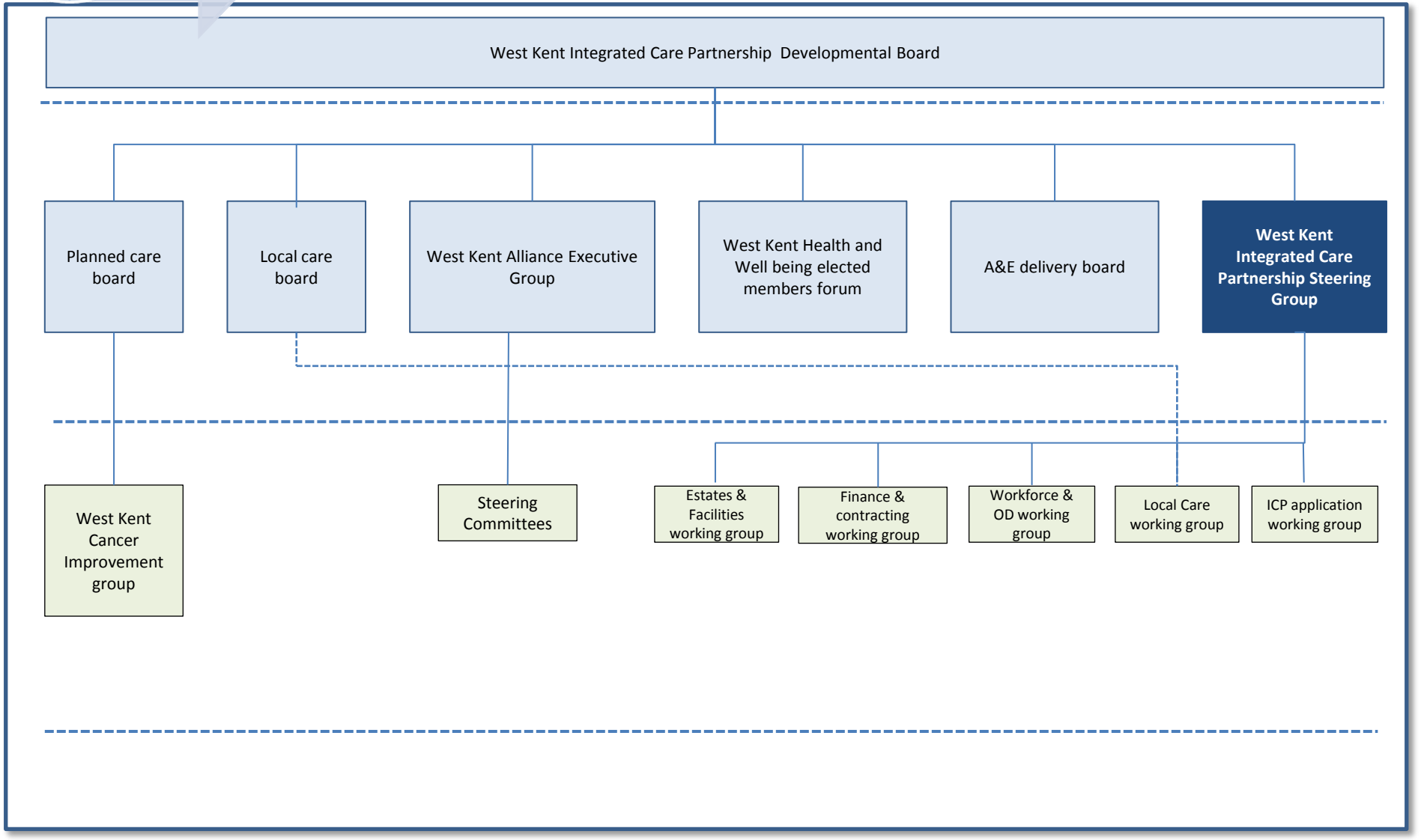
A three phased approach to transform the WK governance arrangements is proposed. Detail for each phase is shown on subsequent slides.

- Strategic commissioner established.
- Should CCG membership of the board end at this point?

Phase 1
Nov 2019

- ICP DB & WK IB reformed as WK ICP Development Board
- ICP Steering Group Established
- Developmental Leadership

A West Kent Developmental ICP Board, and Steering group are formed, replacing the existing WK ICP Development Board and WK IB.



Three options for membership were considered, 1. Organisational based 2. Sector based 3. Provider only development board with an extended partnership board. Option 3 was discounted as disadvantages relating to decision making and the joint health & care agenda were identified. Option 1 is shown below

Membership	Seats
Chair	1
SRO	1
GP	1
Maidstone & Tunbridge Wells NHS Trust	1
Kent & Medway NHS and Social Care Partnership Trust	1
Kent Community Health NHS Foundation Trust	1
West Kent CCG	1
Kent County Council	1
District & Borough Councils	1
GP Federation	1
PCN	4 (1 vote)

Indicates the leadership of the developmental board

Advantages

- Reflects ICP as collaboration of provider organisations
- Continuity of approach to development

Disadvantages

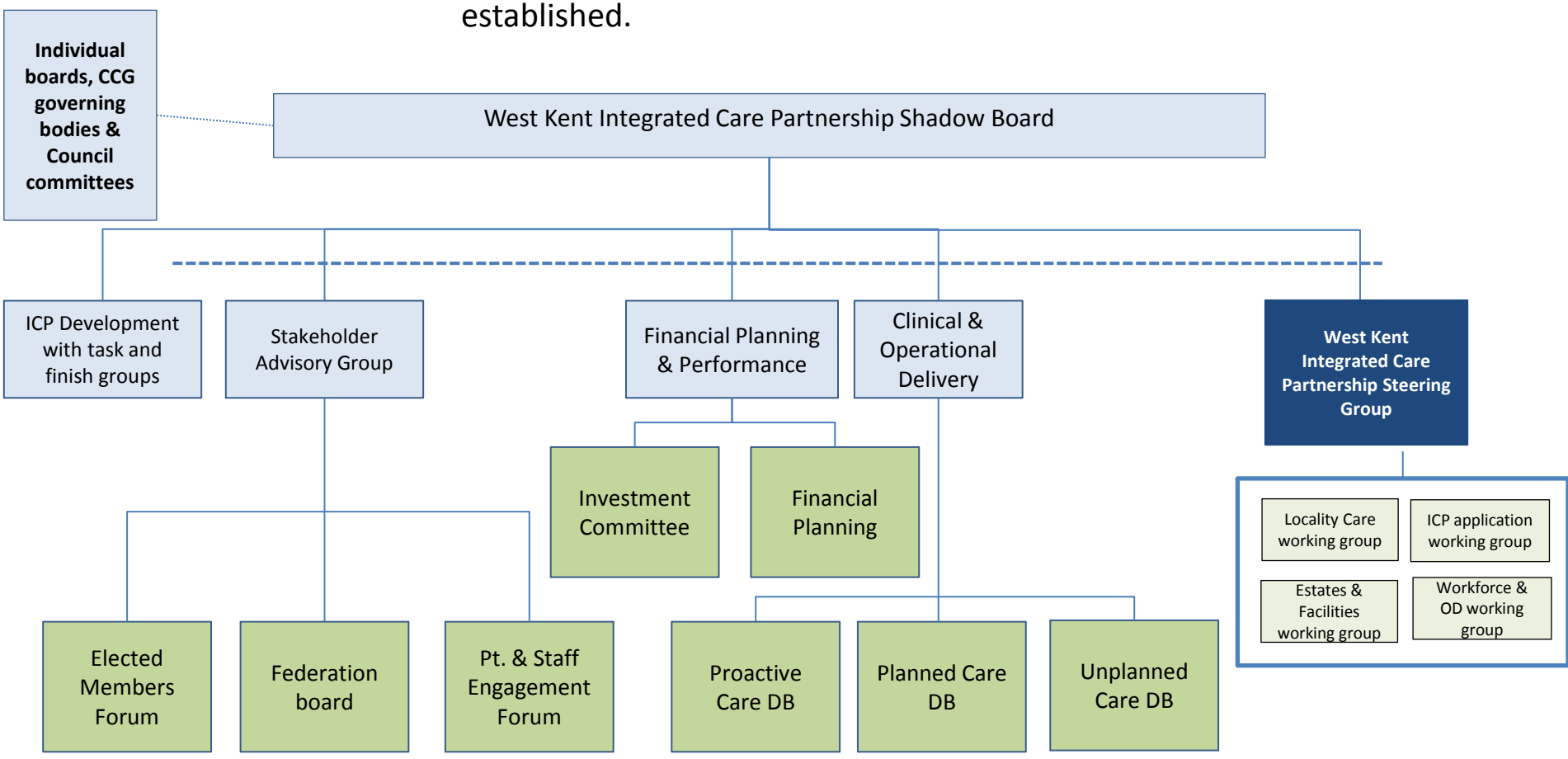
- Organisations rather than sectors of care e.g. acute care sector, are represented which means the views of a particular sector may not be fully reflected

Phase 2

April 2020

- Evolve the WK IB Groups and Committees into ICP Governance arrangements
- Shadow Board transitions to full running
- Transitional Leadership TBC

We will move to shadow running. The developmental leadership of the WK ICP Shadow Board will be revisited to reflect changes in commissioning, and the emerging requirements arising from ICP development. Over the phase 2 period the existing WK governance structures will move towards the anticipated ICP governance arrangements. A West Kent Finance and planning board will be established.



Phase 3

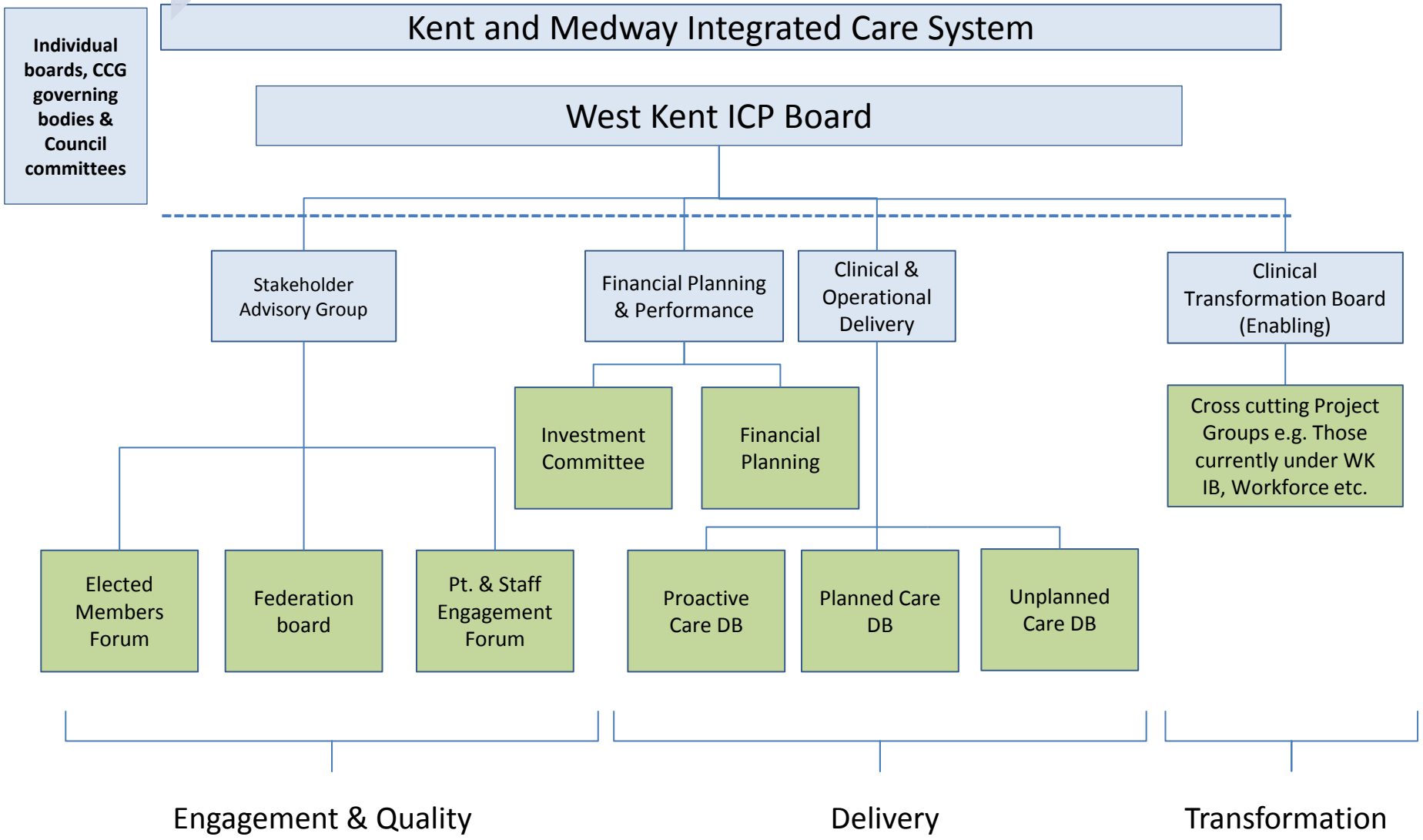
April 2021

ICS and ICP established

CP Governance ully operational

Formal ICP Leadership established

Following an open process the WK ICP leadership team will be established, and the formal governance arrangements are adopted. The governance model will need to be refreshed to align with the agreed organisational form. The next two slides show potential future governance models



* There will be clinical presence and leadership in every group, rather than a single clinical community forum approach

Building upon the baseline CCG functional mapping exercise. We wish to commission a piece of work to identify the population health priorities for West Kent & the skills and resources which reside within the CCG that will support the requirements and activities of an ICP. This will encompass:

- Mapping existing resources which align with proposed CCG functions transferring to ICP (and PCN) responsibility.
- Establish a process to identify the population health priorities for West Kent.
- Map the activities the ICP will require to deliver the identified population health priorities.
- Taking into account the existing programmes of work across West Kent, propose the new, and changes to established, programmes of work to align with the ICP activities and priorities.
- Propose which CCG functions transferring will be subject to change including cessation and identify the key skills and resource requirement to facilitate delivery through the lens of ICP activities
- Propose a timeline for resource transfer from commissioning to the developmental ICP which will leverage the ICP development

NHS
Maidstone and Tunbridge Wells NHS Trust

Update from the Senior Information Risk Owner (SIRO) (incl. the current position on the Data Security and Protection Toolkit for 2019/20)	**Chief Nurse (SIRO)**

The Trust Board will recall that in 2015 the Information Governance Alliance (IGA) published guidance for NHS Board members highlighting that ultimate responsibility for IG in the NHS rests with the Board of each organisation.

The enclosed update report aims to provide assurance of the work done in the first six months of this year in relation to the six key areas of responsibility.

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

The Trust Board will recall that in 2015 the Information Governance Alliance (IGA) published guidance for NHS Board members highlighting that ultimate responsibility for IG in the NHS rests with the Board of each organisation.

The Board will also recall that whilst ownership of Information Governance (IG) matters rests with the Board responsibility in MTW has been delegated to the Information Governance Committee (IGC) and that I have been tasked to represent the Board and Chair the Committee in my role as Senior Information Risk Owner (SIRO) and Board member responsibility for data and cyber security.

The responsibilities of the IGA have now been centralised in NHSX who will act as the single voice for matters of cross-system IG policymaking and advice. Until updated the existing guidance is still relevant. Relevant guidance advised that NHS Board members should seek assurance on the following:

1. Is the duty to share information for care introduced by the Health and Social Care (Safety and Quality) Act 2015 and promoted by the National Data Guardian[2] being effectively addressed? Are arrangements for integrated care working effectively?

2. Is the organisation's IG Toolkit assessment satisfactory? (For IG Toolkit read Data Security and Protection Toolkit). Is it a true reflection of performance? Has it been independently audited? Are there any known weaknesses or auditor recommendations and if so, how are they being addressed? Does the organisation have the capacity and capability to guarantee that plans for improved IG can be implemented?

3. Are the Board satisfied with the indicators of IG performance reported to it, e.g. are key roles filled? Are all staff trained in the basics? Are levels of missing or untraceable case notes acceptable etc.?

4. Are IG staff – IG managers, SIRO, Caldicott Guardian - trained appropriately? Are IG staff encouraged to participate in regional Strategic IG Network (SIGN)[3] meetings, contributing to and receiving support from the IGA[4]?

5. Are all significant IG Risks being managed effectively and considered at an appropriate level? Have there been any serious incidents requiring investigation reported? How confident is the organisation that all such incidents are reported? How many cyber-attacks have occurred and were they all successfully prevented?

6. Do the organisation's IG arrangements adequately encompass all teams and work areas, including hosted activity and contracted work that the organisation is legally accountable for?

This report aims to provide assurance of the work done in the first six months of this year in relation to the six key areas detailed above.

1. The Board are advised that the Information Governance Committee receives reports and presentations relating to proposed information sharing arrangements with partner organisations across health and social care. In addition the Caldicott Guardian is kept appraised and is asked to approve sharing for special projects, educational and research purposes.

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[2] Dame Fiona Caldicott, the National Data Guardian conducted a review of care sector information governance available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/192572/2900774_InfoGovernance_accv2.pdf

[3] SIGN groups meet regionally with their chairs meeting bi-monthly in a national meeting chaired by the IGA.

[4] The Information Governance Alliance (IGA) was established in July 2014 at the request of the National Data Guardian to support the Care Sector with authoritative advice and guidance on information governance issues, more details at IGA@nhs.net

2. The Board may recall that in the past I have reported on the publication of the National Data Guardian 10 Data Security Standards which are intended to apply to every organisation handling health and social care information.

   The 10 standards fall under three leadership obligations:
   1. People: ensure staff are equipped to handle information respectfully and safely, according to the Caldicott Principles.
   2. Process: ensure the organisation proactively prevents data security breaches and responds appropriately to incidents and near misses.
   3. Technology: ensure technology is secure and up-to-date.

   A number of assertions within the Data Security and Protection Toolkit, which replaced the IG Toolkit, fall under each standard against which the Trust must provide evidence which would indicate the level of maturity in that area.

   The Board are assured that a workplan has been developed, predicated upon the 10 data security standards, that will support the Trust in the development of policies and processes that will support the new 'statement of requirements' and annual 'statement of resilience'.

Workplan for 2019/20

Standard	Action
1. Personal Confidential Data	IG policies and procedures to be reviewed to ensure the meet relevant guidance in regard to data security and protection
	Privacy notices are reviewed and updated
	Access to information processes to be reviewed and updated to ensure statutory duties are being met.
	A Data Quality Dashboard to be developed to assess and improve data quality.
	The Trust will review and amend its processes to ensure it is able to uphold the National Data Opt-Out by March 2020.
2. Staff Responsibilities	Information asset registers to be reviewed and updated
3. Training	At least 95% of all staff complete their annual Data Security awareness training in the period 1 April to 31 March.
	Review specialist roles associated to data security and protection and ensure staff are appropriately trained or that the Trust has access to the necessary services.
4. Managing Data Access	Review systems access controls and undertake audits including log-in and password misuse.
5. Process Reviews	Analyse incidents and near misses to identify root causes in order that these may be addressed
	Systems vulnerabilities are identified during testing and technical solutions implemented to ensure issues cannot arise again in the same way.
6. Responding to Incidents	Anti-virus and other technical protection solutions are deployed and updated regularly.
7. Continuity Planning	A continuity plan in in place and tested once a year.
8. Unsupported Systems	Review all software & hardware to understand if it is supported and up to date. Where unsupported software and hardware are identified plans are put in place to manage the risks.
9. IT Protection	The Trust will continue to take steps to improve cyber security.
10. Accountable Suppliers	IT contracts are reviewed and suppliers held accountable for protecting the personal confidential data they process.

Each year the evidence that the Trust presents in support of its Toolkit submission is independently audited by the Trust's Internal Auditors (TIAA). In the year 2018/19 the Trust received 'Reasonable Assurance' as the audit opinion. Arrangements have already been put in place for the audit for 2019/20 to be conducted.

3. A number of key performance indicators are reviewed at the IGC as a standing agenda item. When indicators have shown that the Trust is not performing as we would wish actions have been agreed and regular updated received. IG KPIs are also monitored on a monthly basis as part of the Divisional Performance Review meeting for Health Informatics. There are currently no concerns to bring to the Board's attention.

4. With regard to staff who have roles and responsibilities associated to IG I can confirm that they have received training relevant to their role.

   The Head of Information Governance participates in a number of networks, the Kent Strategic IG Network, the Surrey and Sussex Strategic IG Network, the East of England Strategic IG Network and the Kent and Medway IG Partnership (a forum established for Local Authority, Borough Councils, Police, Fire and Health to foster collaboration and sharing of best practice).

   I and the Head of Information Governance attended an IG conference in July organised by the Sussex-wide Information Governance Group, which was very informative and contributed to our CPD and personal training.

5. IG risks fall within three categories, People, Technology and Processes. The risks are assessed and scored in line with the Trust Risk Management Policy and Procedure. High level risks are recorded on the Trust Risk Register.

   At each meeting the IG Committee receive detail of all incidents reported on Datix throughout the prior two months that have an IG element to them, i.e. The right information is not…
   - In the right place
   - At the right time
   - Accessible to those who need it can access it and
   - Understood

   There have been no serious incidents requiring investigation reported in the year to date. In relation to Cyber Risks the Board are advised that a technical group has been established which reviews Cyber Security within the Trust and advises the IG Committee on actions being taken. Processes have been put in place that enable to Trust to respond to Cyber risks in a timely manner. The Trust has joined a number of cyber related forum being led by NHS Digital. The Trust has achieved Cyber Essentials Plus accreditation, ahead of the March 2020 deadline proposed by NHS Digital.

6. The Trust's IG arrangements encompass all teams and work areas. The Head of IG meets regularly with the Trust Secretary (the Trust's Data Protection Officer (DPO)) who is able to provide further, independent, assurance to the Board in relation to the Trust's compliance with the General Data Protection Regulation (GDPR), other data protection laws, our data protection policies, awareness-raising, training, and audits.

NHS
Maidstone and Tunbridge Wells NHS Trust

Report from the Freedom to Speak Up Guardian — Freedom to Speak Up Guardian

Enclosed is the latest report to the Board by the Freedom To Speak Up Guardian (FTSUG).

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

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
The Trust Board is asked to read the report and discuss the content and recommendations

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

Board of Directors (Public)

Freedom To Speak Up Guardian Report

Action Requested / Recommendation

The Trust Board is asked to read the report and discuss the content and recommendations.

Summary

This is the second report to the Board by the Freedom To Speak Up Guardian (FTSUG) which now outlines and identifies trends, issues and the resource requirement to move the FTSU agenda forward.

Author; Christian Lippiatt, Freedom To Speak Up Guardian

Date; 21st October 2019

Freedom To Speak Up Non-Executive Director	Maureen Choong
Freedom To Speak Up Executive Lead	Simon Hart
Freedom To Speak Up Guardian	Christian Lippiatt

Introduction

The FTSU Agenda is to;

- Protect patient safety and the quality of care
- Improve the experience of workers
- Promote learning and improvement

By ensuring that;

- Workers are supported in speaking up
- Barriers to speaking up are addressed
- A positive culture of speaking up is fostered
- Issues raised are used as opportunities for learning and improvement

National Case Reviews

Brighton and Sussex University Hospital NHS Trust has recently had a case review conducted by the National Guardian's Office (NGO). In summary the NGO was looking for a culture of learning from and improving on concerns raised as well as a culture of speaking up. Issues had been raised with the NGO from former and existing BAME staff that their concerns had not been dealt with positively by the Trust.

BSUH had introduced a "weekly improvement huddle" to encourage speaking up/ raising concerns to then address them. It was acknowledged that there had been positive culture changes being made by a new leadership team, but there were concerns among staff that those senior leaders may leave before culture changes were embedded and established within the organisation.

What does this mean for MTW? As we embark on a major Trust wide cultural change programme, it provides a unique opportunity to embed "speaking up – business as usual" as a key theme to run throughout the Trust. This would undoubtedly serve to address and improve a broad range of aspects of hospital life and the services it delivers whilst also meeting expectations of best practice from both the NGO and CQC.

Themes / Issues

The issue of bullying and harassment continues to be a theme. The main issue here revolves around what is "the point". In concerns being raised, it appears focus is placed upon evidence; how much is there and is it irrefutable. However, "the point" is not can we prove beyond reasonable doubt that something did or did not happen. "The point" is; there is an individual, or a team of people who have been / are being significantly affected by another person's behaviour. The culture of the Trust would benefit from this shift towards recognising the affect upon staff and addressing it through a more mediated / resolutely method rather than investigatory, prove/disprove route.

Growing the Speaking Up Agenda

Releasing time to spend on FTSU concerns is still a significant challenge. The FTSUG role sits as a dual role within the Occupational Health Department. Following a review of the department, an additional Administration Assistant has been appointed and is working through the recruitment process. Recruitment of a Lead OH Nurse was unsuccessful and is being re-run at this time. Further to this a Mental Health Practitioner will be recruited, all of which will better support the Head of Department to release time for FTSU issues. Until this has all worked through, allocation of time for FTSU activities will be limited.

Re-Writing the Policy (Freedom to speak up: raising concerns policy and procedure)

The new policy has been ratified subject to some minor amendments. Once completed it will be widely publicised and used to further promote the agenda alongside who the Guardian and Ambassadors are.

Networking

The Guardian attends Regional and Local Network Meetings as well as internal networks, inductions and events where possible. The Guardian at MTW has been approached to take on the role of Regional Representative in 2020. This would be an opportunity to raise the profile of MTW in this forum as well as the speaking up agenda within the Trust, but will have to be considered against work pressures closer to the time.

Data Collection; Concerns Raised

'19/'20 Month	No. of contacts	Anonymous	All Open Cases
April	4	1	1
May	6	2	2
June	5	2	4
July	5	4	
August	6	2	
September	5	0	
October			
November			
December			
January			
February			
March			
Total	**31**	**11**	

Quarter	Month/Year	No. of Contacts
Q1	April-June '18	0
Q2	July-September '18	0
Q3	October-December '18	2
Q4	January-March '18	8
Total	**2018/19**	**10**

Quarter	Month/Year	No. of Contacts
Q1	April-June '19	15
Q2	July-September '19	16
Q3	October-December '19	
Q4	January-March '20	
Total	**2019/20**	**31**

Staff Group	Number
Estates & Facilities	3
Nursing	4
Midwifery	0
Medical	1
AHP's	1
Clinical Support	8
A&C	4
Unknown	10
Total	**31**

Theme	Number
Patient Safety	4
Bullying/ Harassment	12
Fraud	1
Health & Safety	5
Other	9
Total	**31**

Trust Board Meeting – October 2019

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from the Workforce Committee, 26/09/19	**Committee Chair (Non-Exec. Director)**

The Workforce Committee met on 26th September 2019.

The key matters considered at the meeting were as follows:

- The actions from previous meetings were reviewed,
- The Committee reviewed and agreed the risk register of the workforce committee
- The Committee noted the presentation of the current workforce indicators and discussed in detail the progress of the overseas recruitment campaign and the need to monitor retention of candidates both before and after they had started within the Trust
- The Committee noted and approved the contents and associated action plans for the Workforce Race Equality Standard and newly introduced Workforce Disability Equality Standard. Key areas for action related to tackling the incidence of bullying and harassment of staff by members of the public, equal career progression and for the Disability standard in particular, improving the basic data held by the trust of staff with a disability. The Committee noted the requirement to publish the data and associated action plans on the MTW internet page and agreed for their publication
- The Committee noted and endorsed the review of trust disciplinary cases by the Chair of Staff side and members of the Cultural & Ethnic Minority and LGBT networks in partnership with the HR department. The review was the second carried out in this way and identified no issues with the actions taken by the trust
- The Committee considered the issues for the trust as a result of the introduction of the taper on pensions relief and its impact on senior staff. The possible impact on Trust capacity was noted, in particular the risk to waiting list initiatives and additional winter capacity. The potential options open to the trust were discussed alongside the current government consultation on changes to the NHS pension scheme
- The Committee noted the report of the Director of Medical Education and in particular the greatly improved GMC Trainee survey. The previous red rating for clinical supervision had been removed and there was positive progress in all areas. The Director of Medical Education also noted that nearly all of the deanery posts had been filled as well as progress on improving facilities for junior doctors on both sites
- Further to a request by the Trust Audit and Governance Committee the Workforce committee reviewed a single tender waiver and associated procurement advice in relation to a pilot project for the recruitment of Objective Structured Clinical Examination (OSCE) ready nurses from India. It was noted that a full procurement exercise would be required at the end of the pilot project to ensure necessary compliance.

- **The issues that need to be drawn to the attention of the Board are as follows:**
  a. GMC Trainee survey
  b. Workforce Race Equality Scheme
  c. Workforce Disability Equality Scheme

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

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from Quality Committee, 03/10/19 Committee Chair (Non-Exec. Director)

The Quality Committee met on 3rd October (a Quality Committee 'deep dive' meeting). Regrettably, the meeting was not quorate, as only one Member of the Executive Team was present. A discussion was then held on the issue and it was agreed that the Executive Team should consider the quorum requirements outside of the meeting and agree a proposal, for discussion with the Chair of the Quality Committee.

1. **The key matters considered at the meeting were as follows:**
   - An **update from the diabetic team on the work to support the requirements of a recent Preventing Future Deaths (PFD) report from HM Coroner** was presented by the Consultant Physician & Leadership Tutor, Diabetes/Endocrinology Services and Divisional Director of Nursing & Quality, Medicine & Emergency Care. The presentation included a discussion on the "Trust Guideline for capillary blood glucose monitoring for inpatients and day cases with Diabetes Mellitus over the age of 18 years" and it was agreed that the content of "Algorithm for the Treatment and Management of Hypoglycaemia in Adults with Diabetes Mellitus in-Hospital" and "Hypoglycaemic episode - Treatment record" should be review in light of the comments made at the Committee, and that a random selection of nurses should be whether the guidance on the documentation was clear. It was also agreed to amend the content of "Algorithm for the Treatment and Management of Hypoglycaemia in Adults with Diabetes Mellitus in-Hospital" and/or "Hypoglycaemic episode - Treatment record" to ask staff to complete an incident form when appropriate. It was further agreed to schedule an "Update on the implementation of the Trust-wide action plan for diabetes" at the Quality Committee 'deep dive' meeting in February 2020, and for that update to include details of the staffing-related challenges and the actions being taken in response
   - A **review of the quality of the urology service** (safety, effectiveness / outcomes and patient and staff experience) was also presented, which included a claim that the Trust's regional Holmium Laser Enucleation of the Prostate (HoLEP) was probably the best in the world. Although some assurance was taken, it was agreed to schedule a follow-up review, focusing on quality & clinical outcomes, at the Quality Committee 'deep dive' in April 2020
   - A **review of the plans for strategic development of Ophthalmology Services** was also presented, and during the ensuing discussion it was agreed that the Director of IT whether it should be asked whether it was feasible for the 'Open Eyes' Electronic Patient Record for ophthalmology to be progressed on an STP-wide basis. It was also agreed to schedule an update on the plans for the strategic development of the services at the Quality Committee 'deep dive' meeting in April 2020

2. **In addition to the agreements referred to above, the meeting agreed that:**
   - A "Review of the Critical Care Outreach service" should be scheduled at the Quality Committee 'deep dive' meeting in February 2020 (to focus on an overview of the service, the use of the modified Early Warning System, activity & workforce (including the staff survey))

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