

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

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

Agenda

- 12-1**
To receive apologies for absence
- 12-2**
To declare interests relevant to agenda items
- 12-3**
To approve the minutes of the 'Part 1' meeting on 28th November 2019

David Highton

David Highton

David Highton

 Board minutes 28.11.19 (Part 1).pdf (8 pages)


- 12-4**
To note progress with previous actions

David Highton

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

- 12-5**
Safety moment

Claire O'Brien / Peter Maskell

 Safety Moment for Trust Board December 2019 v1.pdf (4 pages)


- 12-6**
Report from the Chair of the Trust Board

David Highton

 Chair's report.pdf (1 pages)

- 12-7**
Report from the Chief Executive

Miles Scott





 Chief Executive's report December 2019 final.pdf (1 pages)

Staff experience

- 12-8**
Physician Associates and Advanced Clinical Practitioners
A presentation will be given at the meeting

Peter Martin / Jessica Plail / Gemma
Craig

The item has been scheduled for 10.15am

12-9 Integrated Performance Report for November 2019			Miles Scott
	IPR month 8.pdf	(35 pages)	
12-9.1 Safe (incl. update on progress with the Perinatal Mortality Review Tool (PMRT); and planned and actual ward staffing for November 2019)			Claire O'Brien
12-9.2 Safe (infection control)			Sara Mumford
12-9.3 Effective			Peter Maskell
12-9.4 Caring			Claire O'Brien
12-9.5 Responsive			Sean Briggs
12-9.6 Well-Led (finance)			Steve Orpin
12-9.7 Well-Led (workforce)			Simon Hart
Quality			
12-10 Quarterly mortality data			Peter Maskell
	Mortality Report for Trust Board.pdf	(9 pages)	
Planning and strategy			
12-11 Update on the Trust’s planning for 2020/21			Amanjit Jhund
	Update on the Trust’s planning for 2020-21.pdf	(10 pages)	
12-12 Approval of the Business Case for the expansion of car parking at Maidstone and Tunbridge Wells Hospitals N.B. The item will now be considered in the 'Part 2' Trust Board meeting			David Highton
Reports from Trust Board sub-committees			
12-13 Workforce Committee, 28/11/19 (including the Annual Report from the Guardian of Safe Working Hours)			Maureen Choong
	Workforce Committee, 28.11.19 (incl. GOSWH Annual Report).pdf	(30 pages)	
12-14 Patient Experience Committee, 02/12/19			Maureen Choong



Patient Experience Cttee Trust Board Report,
02.12.19.pdf

(1 pages)

12-15

Quality Committee, 05/12/19

Sarah Dunnett



Summary of Quality C'ttee, 05.12.19.pdf

(1 pages)

12-16

Finance and Performance Committee, 18/12/19

Neil Griffiths



Summary of Finance and Performance C'ttee
18.12.19.pdf

(1 pages)

12-17

To consider any other business

David Highton

12-18

To receive any questions from members of the public

David Highton

12-19

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: 30th January 2020, 9.45am, Pentecost/South rooms,
The Academic Centre, Maidstone Hospital***

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



FOR APPROVAL

Present:	David Highton	Chair of the Trust Board	(DH)
	Sean Briggs	Chief Operating Officer	(SB)
	Maureen Choong	Non-Executive Director	(MC)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Neil Griffiths	Non-Executive Director	(NG)
	Peter Maskell	Medical Director	(PM)
	David Morgan	Non-Executive Director	(DM)
	Claire O'Brien	Chief Nurse	(COB)
	Steve Orpin	Chief Finance Officer (from item 11-6)	(SO)
	Miles Scott	Chief Executive	(MS)
In attendance:	Richard Finn	Associate Non-Executive Director	(RF)
	Simon Hart	Director of Workforce	(SH)
	Amanjit Jhund	Director of Strategy, Planning & Partnerships	(AJ)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Jo Webber	Associate Non-Executive Director	(JW)
	Kevin Rowan	Trust Secretary	(KR)
	Rita Lawrence	Associate Director of Organisational Development (for item 11-8)	(RL)
Observing:	Maria Georgiou	Clinical Scientist, Health Physics	(MG)
	Daryl Judges	Assistant Trust Secretary	(DJ)
	Rita Lawrence	Associate Director of Organisational Development (for items 11-1 to 11-7)	(RL)
	David East	Ekim Consulting	(DE)

11-1 To receive apologies for absence

Apologies were received from Emma Pettitt-Mitchell (EPM), Non-Executive Director. It was also noted that Karen Cox (KC), Associate Non-Executive Director, would not be in attendance.

DH then welcomed RF and JW to their first Trust Board meeting since being appointed as Associate Non-Executive Directors.

11-2 To declare interests relevant to agenda items

DH declared that he remained the interim Chair of the Kent and Medway Sustainability and Transformation Partnership.

11-3 To approve the minutes of the 'Part 1' meeting of 31st October 2019

The minutes were approved as a true and accurate record of the meeting, subject to amendments to item 10-9.3 relating to stroke performance that were requested by PM. PM explained that the changes required were not straightforward so proposed that he liaise with KR to amend the minute. DH agreed. It was therefore confirmed that KR would liaise with PM to amend the minute.

Action: Liaise with the Medical Director to confirm the amendments required to the minute of item 10-9.3 at the 'Part 1' meeting on 31st October 2019 (Trust Secretary, November 2019 onwards)

DM then referred to the final paragraph of item 10-8 and noted that MS had stated that he would discuss the ideas he had on innovation with DM outside of the Trust Board meeting. MS acknowledged the prompt.

11-4 To note progress with previous actions

The circulated report was noted. The following actions were discussed in detail:

- **10-14 (“Consider, with the Executive Team, the points made at the Trust Board meeting on 31/10/19 regarding the resourcing of the Trust’s Freedom to Speak Up Guardian”).** DH proposed that the action be closed, on the basis of the action that was scheduled via the Executive Team Meeting. This was agreed.

11-5 Safety moment

COB referred to the relevant attachment and highlighted the key points therein, which included the importance of incident reporting and of the support provided to staff during and after incidents. PM added that a new system was being introduced to make it easier to report incidents, and promote incidents being resolved in real time.

RF noted that circa 55% of staff felt that “My organisation treats staff who are involved in an error, near miss or incident fairly” so asked when the next test of that would take place. COB confirmed that a staff survey was taking place at present and the results would be available in the spring of 2020. RF also noted the importance of culture. PM concurred and also highlighted the importance of improving the vacancy rate, to enable staff to have more time available.

MC commented that she was pleased at the work to make it easier to report incidents and provide a swifter response to those who reported incidents.

MS then noted that some Trust Board sub-committees had opted to remove the “Safety moment” item from their agendas and stated he felt that any decision to cease such items should be made by the Trust Board. MS elaborated that he would favour keeping “Safety Moment” items on the agendas, and although he was not in favour of duplication, he felt it would be possible to ensure that each sub-committee tailored its discussion on the subject. KR pointed out that the Finance and Performance Committee had been the first Trust Board sub-committee to remove “Safety Moment” items from its forward programme, so a precedent had already been set. DM added that the Audit and Governance Committee had felt the “Safety Moment” item just repeated the discussion held at the Trust Board meeting a few days earlier and it was important to not just pay lip service to the “Safety Moment”. The point was acknowledged. DH proposed that the issue raised by MS be considered at the Trust Board ‘Away Day’ on 04/12/19. This was agreed.

Action: Arrange for the scheduling of “Safety moment” items at Trust Board sub-committees to be discussed at the Trust Board ‘Away Day’ on 04/12/19 (in light of the recent decision by the Charitable Funds and Audit and Governance Committees to remove that item from their forward programmes) (Trust Secretary / Chair of the Trust Board, December 2019)

11-6 Report from the Chair of the Trust Board

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

- DH was pleased to welcome RF and JW to the Trust Board and he would consider which Trust Board sub-committees he would ask them to join in due course
- DH was also pleased to take part in the annual Staff Star Awards. One of the winners of the Chairman’s award was the Human Papillomavirus (HPV) team, who had acted very professionally to the loss of service arising from the Trust failing in a bid to win the tender for an expanded service

11-7 Report from the Chief Executive

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

- A Major Incident had occurred since the last Trust Board meeting, and a formal incident debrief would be held to identify any lessons to be learned. Both hospitals had responded amazingly well and the response was testament to the work done at the Trust by the Emergency Planning team. MS intended to report the formal lessons learned to the Trust Board once finalised
- Organisational Development (OD) work was continuing apace, which included the follow-up from a visit to Western Sussex NHS Foundation Trust

- The Trust had made two Clinical academic appointments for the new Kent and Medway Medical School (KMMS) and both appointees were consultants already employed within the Trust

DH referred to the KMMS and asked whether the scheduled General Medical Council (GMC) visit had occurred. MS confirmed that the visit would occur w/c 02/12/19.

Patient Experience

11-8 A patient's experience of the Trust's services

DH explained that the patients who had been scheduled to attend had to withdraw because of ill health. COB then explained the rationale for the item and introduced RL. RL then gave a presentation which covered "Why are we doing this work?"; "Components of the Discovery Phase"; "MTW culture change team"; and "Progress to date" (which noted that an all staff behaviour survey would 'go live' w/c 02/12/19).

DH referred to the intention to issue another staff survey, but noted that the national NHS staff survey would only close on 29/11/19, so asked if all staff would be surveyed again. RL confirmed that would be the case. DH asked how survey fatigue among staff would be addressed. RL acknowledged that was a risk and confirmed that a deferral of the next survey had been considered, but it was determined that it was better to issue the survey before Christmas. RL added that the next survey was only 10 questions long and was anonymous.

RL then continued with the presentation, which covered the "Workforce Diagnostic"; the "Patient Experience Diagnostic"; the "Behaviour survey"; "Culture conversations"; the "Culture and outcomes dashboard"; and the "Timeline", which included that the draft findings of the diagnostic phase would be presented to the Trust Board in February 2020, with the formal findings being presented to the Trust Board in March 2020.

DH noted the importance of presenting the Trust's various change programmes as a coherent approach, rather than them being perceived to be disparate and unconnected. DH added that the change team was therefore an important resource in testing such perceptions. SO agreed and extolled the value of engaging with the change team, adding that he had held conversations with some junior members of the team, to try and explain the relationship between the various change-related strands. SO also stated that Western Sussex NHS Foundation Trust appeared to be better at presenting a coherent approach, and it was acknowledged that the Trust needed to do more to achieve that end. MC concurred and noted the importance of the 'how' and not just the 'why'.

NG then emphasised the importance of ensuring change was sustainable and asked RL whether that had been considered. RL emphasised the need for the leadership programme to become part of the core business of all managers. SO added that Western Sussex NHS Foundation Trust regarded transformation as a core aspect of its functions.

RF then noted the importance of the link between leadership and culture, but appealed for any changes identified before the presentation of the findings to just be implemented i.e. rather than wait until the presentation. SO agreed and confirmed that approach would be applied.

Integrated Performance Report

11-9 Integrated Performance Report for October 2019

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

- There was continuing good performance and progress in some of the key areas that had been identified at the beginning of the year, including complaints response time and cancer access standards
- There was however more operational pressure than at the same time in 2018

11-9.1 Safe (incl. planned and actual ward staffing for October 2019)

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

- The 'safe staffing' figures were at their best for the year, and the Trust hoped to have no vacancies early in the next year
- The rate of falls was better for the month but the Trust was above its trajectory. The falls team was preparing for a Quality Committee 'deep dive' meeting on the subject on 05/12/19
- The number of open incidents had increased in October, and the Divisions reported on that metric at the 'main' Quality Committee
- Duty of Candour compliance continued to be an area of focus

11-9.2 Safe (infection control)

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

- There had been four cases of CDI for the last month and some focused work would take place with particular wards
- E Coli infections had increased. Lord North Ward had a problem but other wards had also seen an increase. Many cases were related to the urinary tract, which was disappointing given the work that had been undertaken previously

DH referred to the latter point and noted that there had been a major emphasis on hydration, which should help with Urinary Tract Infections (UTIs). SM agreed and noted that a review would be held to identify whether any further action was required.

11-9.3 Effective

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

- The Summary Hospital-level Mortality Indicator (SHMI) remained unchanged from the level previously reported and the Mortality Surveillance Group had been asked to investigate the increase. PM hoped to be able to report the outcome at the next Trust Board meeting
- The Hospital Standardised Mortality Ratio (HSMR) was assuringly low
- Stroke performance had been discussed at the last Trust Board meeting and the adverse impact on the problems in accessing data had been highlighted. As it was now known that complete data would not be obtained for some time, it was proposed that stroke data be reported one month behind. PM then gave further details of the stroke performance and the cover that was in place following the transfer of the service from Tunbridge Wells Hospital (TWH) to Maidstone Hospital (MH)

SB asked whether PM had started to hear of any concerns regarding stroke care at other local providers, as SB had received requests for support from such providers. PM explained that he was aware that the stroke services at all other local Trusts faced challenges and the one major concern regionally was the lack of a 24/7 thrombectomy rota. PM added that although such a service was being developed at William Harvey Hospital, that would not be ready any time soon.

DH noted the Judicial Reviews into the decision regarding the Hyper Acute Stroke Units (HASUs) would be held w/c 02/12/19 and asked what the impact of the delays had been on consultant staffing. PM explained that there were challenges and he was unable to attend the Trust Board 'Away Day' on 04/12/19 as he would be at a stroke conference aiming to recruit consultant stroke physicians from out of the area.

PM then explained that the Trust had been commended at the recent Getting It Right First Time (GIRFT) visit for having a stable level of emergency readmissions despite the continued increase in the number of Same Day Emergency Care (SDEC) patients.

11-9.4 Caring

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

- Complaints response performance had been at the highest monthly level for the year but that would not be sustained for November and COB was investigating the reasons for that
- The Friends and Family Test (FFT) response for October had been very poor. COB was therefore working hard with the Divisional teams to address the causes

11-9.5 Responsive

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

- The Trust faced enormous challenges in relation to Emergency Department (ED) attendances, which continued to increase, and the record busiest day had occurred three times in the recent past. Despite that, the Trust was the ninth best performing Trust in the country on the A&E 4-hour waiting time target. The reduced vacancy rate had however been a great positive. PM and SB had also been promoting the need to have more senior decision makers at the 'front door' whilst also improving discharges, although this had been adversely affected by staffing shortages in community services
- Ambulance handover performance had improved markedly although it was acknowledged that more action was needed. Thanks should be given to the ED team for the improvement in the face of continuing challenges

SDu noted SB's reference to short staffing in Kent Community Health NHS Foundation Trust (KCHFT) and asked whether all avenues, including financial, had been explored to address such shortages. SB explained that the support provided by KCHFT had previously been very good but some challenges had emerged in recent weeks. SB added that such challenges were being explored by SB and his colleagues.

MC asked about surgical cancellations. SB acknowledged that 14 patients had had to be cancelled on the day of their surgery, which was acknowledged to be terrible for such patients, although the Trust's level of cancellations was far lower than some other organisations.

SB then reported the latest position on Referral to Treatment (RTT) performance, noting that the final position for the month was 84.2%, as the timetable of the data production meant that the data within the Integrated Performance Report was not finalised at the point it was submitted to the Trust Board. SB also highlighted the current status with regards to RTT funding from commissioners and noted that SO was closely involved in discussions to resolve the current issues. SB then explained the plans to address some of the issues in outpatients.

SB then highlighted that the Trust had achieved the required target in relation to the two-week, 31-day and 62-day Cancer waiting time targets, and the cancer team would soon attend the Executive Team Meeting to discuss the sustainability of the performance. SB also noted that the Trust would soon be visited by the NHS' Chief Operating Officer / Chief Executive of NHS Improvement.

11-9.6 Well-Led (finance)

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

- The month's surplus was £1.5m, but that was below the planned level of surplus. The Provider Sustainability Fund (PSF) for October had therefore not been assumed and had not been included in the month's position.
- The reasons for the adverse variance included a higher than planned usage of temporary nursing staff. Work was therefore taking place to set a new trajectory, with the primary goal to reduce agency-sourced temporary nursing staff and the secondary goal to reduce the usage of Bank-sourced temporary nursing staff
- The other reason related to the Trust's management of the contract for the Primary Provider for Planned Care, in terms of the cost of patients exercising their choice to receive treatment via an independent sector provider
- The year-end forecast would be considered again at the next Finance and Performance Committee meeting. There was little flexibility as the Trust headed into the winter period and there was genuine concern regarding the delivery of the year-end financial position

COB then provided further context regarding the supernumerary status of the new overseas nursing recruits, noting that some had required more support than others so it was not always feasible to adhere to the supernumerary timescales that had originally been envisaged. The point was acknowledged.

SB asked SO whether he expected the aforementioned resourcing issues with West Kent Clinical Commissioning Group (CCG) to be resolved by the time of the next Trust Board meeting, as it the

Trust Board may need to make decisions to reduce activity if required. SO explained the situation and stated that he was confident that the cancer-related funding would be received, but was less confident in the receipt of the RTT-related funding, given the CCG's financial position. SO added further details of the liaison with West Kent CCG, but pointed out that some external support may be required to resolve the issues. SB noted that the operational team had been asked to model the impact of the Trust not receiving the funding, and SB emphasised that the absence of the funding could have an adverse impact on RTT performance.

11-9.7 Well-Led (workforce)

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

- Vacancies had reduced significantly due to influx of overseas nursing staff. There had been some delays in obtaining objective structured clinical examination (OSCE) places, but the challenges were being overcome. Pastoral care continued to be provided to the overseas recruits, but such staff continued to face challenges, for example when they moved out of accommodation that had been provided by the Trust
- Medical staffing challenges continued
- There were higher levels of long-term sickness absence in some areas but support was being provided
- The Trust had now achieved a 50% response rate for the national NHS Staff Survey, which was a significant improvement on the rate that had been achieved over the last few years

RF noted that staff turnover had increased over the past six months and asked if the reasons were known, including via staff exit interviews. SH explained that the Trust had recently changed the method of reporting staff turnover, which had affected historical comparisons, but noted that higher turnover was usually focused on areas with more junior banded staff, such as Facilities. SH added that very little information was provided via staff exit interviews and it was acknowledged as an area of weakness.

11-10 Proposals regarding the Board Assurance Framework 2019/20

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

- When the Board Assurance Framework (BAF) had been reviewed by the Trust Board in September 2019, it was agreed that KR should consider how the Trust Board's sub-committees could be more directly involved in the oversight of the BAF
- A meeting was subsequently held with MC and some proposals were agreed, which were then discussed with DH and submitted to the Audit and Governance Committee on 05/11/19. The Committee supported the proposals so these had been submitted to the Board, for approval
- The Trust Board should bear in mind that the proposals would make the BAF process more complicated

MC referred to the latter point and stated that she did not intend for the process to become more complex or bureaucratic and as the intention was to use the Trust Board sub-committees more actively. The point was acknowledged.

MS confirmed his support for the proposals, as did DM. A discussion was then held on the issue and DH confirmed that he was content that the proposals would increase the level of scrutiny and oversight applied to the BAF. DM asked whether there were any implications for the Trust's Annual Report and Accounts. KR confirmed there would be no implications as the Trust's External Auditors were not specifically interested in the BAF as part of their year-end work. KR also emphasised that BAF was just a report that was not markedly different from other reports submitted to the Trust Board and/or other forums, and should not be considered to be any different. The point was acknowledged.

AJ then stated that objectives 6 ("Establish functioning Digestive Diseases Unit by October 2019") and 7 ("Build new AMU to enable a new Hyper Acute Stroke Unit (HASU) by winter 2019") were both strategic objectives and should therefore be overseen by the same sub-committee. AJ elaborated that both objectives should either therefore be overseen by the Finance and Performance Committee or the Patient Experience Committee. KR proposed that both objectives

be overseen by the Finance and Performance Committee and not the Patient Experience Committee. DH acknowledged the proposal but instead stated that that a decision need not be taken at that time.

The proposals regarding the BAF 2019/20 were approved, subject to the amendment arising from AJ's comment.

Assurance and Policy

11-11 7 Day Services board assurance self-assessment

SM referred to the relevant attachment and highlighted the key points therein, which included the areas of non-compliance. PM added further context to the non-compliant areas, and explained that apart from Medicine, the Trust would be compliant by March 2020. PM added that the Trust was one of a very large number of Trusts that would not be able to achieve Clinical Standard 8. PM explained that he was not however aware of the consequences of not complying with Clinical Standard 8 by the stated deadline.

MS asked PM to clarify that he did not disagree with the content of Clinical Standard 8, as MS' understanding was that the basis of the standards was to shift the balance of the provision of care to be more consultant led, which reflected the Trust's current workforce planning. PM confirmed that he believed it was the right thing to do and elaborated on the Trust's approach.

PM then highlighted the challenges associated with implementing the standards in the Medicine and Emergency Care Division.

SO then remarked that he was concerned that improvement initiatives such as this often did not properly consider the benefits that would be achieved from implementation, and he was therefore keen that plans expanded on such benefits. PM explained the process by which the document had been developed but acknowledged SO's point. SO elaborated on the need to strengthen the case and not adopt a defensive approach. The point was acknowledged.

DH summarised that there was consensus that it was considered important to develop full 7 Day Services, regardless of the national requirement, and that the Trust Board was supportive of implementing that as soon as possible. DH added that SO had proposed that more ambition be demonstrated and that more thought be given to the benefits. NG noted that the general points raised by SO had also been considered by the Finance and Performance Committee.

COB then asked whether "consultant" meant "doctor", or whether nurse consultants could be incorporated into the standard. SM explained that NHS Improvement's definition of "consultant" was limited to medical staff. DH stated that he supported the Trust leading the way on that issue and explaining its approach if it considered it to be correct.

11-12 Ratification of Standing Orders, Standing Financial Instructions & Reservation of Powers and Scheme of Delegation (annual review)

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

- The full documents had not been submitted as part of the formal Trust Board 'pack' for the meeting, but had been made available to Trust Board members as supplementary reports via the Trust's online meetings portal. The changes were however described in the brief report
- The changes had been approved by the Audit and Governance Committee in November 2019

Questions were invited. None were received. The revised Standing Orders, Standing Financial Instructions & Reservation of Powers and Scheme of Delegation were ratified as submitted.

Reports from Trust Board sub-committees

11-13 Charitable Funds Committee, 29/10/18 (incl. approval of revised Terms of Reference and approval of the Annual Report & Accounts of the Charitable Fund, 2018/19)

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

- Revised Terms of Reference had been agreed and were submitted for approval
- The Charitable Fund Annual Report and Accounts for 2018/19 had been agreed and were submitted for approval
- The need for a more strategic approach on charitable funds had been considered and DM had since discussed that issue with MS, who was supportive of adopting a more strategic approach

Questions were invited. None were received. The revised Terms of Reference were approved as submitted.

The Annual Report and Accounts of the Charitable Fund, 2018/19 were also approved as submitted.

11-14 Audit and Governance Committee, 05/11/19 (incl. approval of revised Terms of Reference)

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

- Revised Terms of Reference had been agreed and were submitted for approval
- The Trust Board was asked to authorise the write off of the loss of circa £350k relating to the collapse of Carillion
- SB had attended and DM found that to be helpful

The Trust Board duly authorised the write off of the loss relating to the collapse of Carillion. The revised Terms of Reference were also approved as submitted.

11-15 Quality Committee, 13/11/19

SDu referred to the relevant attachment and highlighted the key points therein, which included the significant delays in letter typing of outpatient clinic letters, particularly in Trauma & Orthopaedics. SDu added that the issue had been referred back to the Divisions to resolve but she thought the Trust Board should be made aware. SB acknowledged the issue and explained the factors involved, along with the actions being taken in response.

11-16 Finance and Performance Committee, 26/11/19 (incl. Quarterly progress update on Procurement Transformation Plan)

NG referred to the relevant attachments and highlighted that the case for the reconfiguration of complex elective inpatient gastrointestinal surgery from MH to TWH had been reviewed and supported. NG also noted that SB would give a presentation on outpatients at the Committee's next meeting, in December 2019.

DH also drew attention to the Procurement Transformation Plan, for which progress was noted.

11-17 To consider any other business

KR asked that the Trust Board delegate the authority to the 'Part 2' Trust Board meeting scheduled for later that day to approve the case for the reconfiguration of complex elective inpatient gastrointestinal surgery from MH to TWH; and to make a decision regarding the Audit and Governance Committee as Auditor Panel's recommendation regarding the current contract for external audit. The requested authority was duly delegated.

11-18 To receive any questions from members of the public (please note that questions should relate to one of the agenda items)

No questions were posed.

11-19 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

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

Trust Board Meeting – December 2019

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
11-5	Arrange for the scheduling of "Safety moment" items at Trust Board sub-committees to be discussed at the Trust Board 'Away Day' on 04/12/19 (in light of the recent decision by the Charitable Funds and Audit and Governance Committees to remove that item from their forward programmes)	Trust Secretary / Chair of the Trust Board	December 2019	There was insufficient opportunity for the issue to be discussed at the Trust Board 'Away Day' on 04/12/19. The Trust Board is therefore asked to consider the matter, taking into account the briefing enclosed in Appendix 1

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
11-3	Liaise with the Medical Director to confirm the amendments required to the minute of item 10-9.3 at the 'Part 1' meeting on 31 st October 2019	Trust Secretary	December 2019	The relevant minute was amended to "PM then highlighted the latest position for emergency readmissions; noted the status of the Trust's newly introduced quality governance arrangements; and explained the reasons for the reduction in performance on stroke care, which included the recent non-submission of data to the Sentinel Stroke National Audit Programme (SSNAP). A discussion was then held on the stroke performance".

Actions not yet due (and still 'open')

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

¹

Not started

On track

Issue / delay

Decision required

Appendix 1: Briefing in relation to “Safety Moment” items at Trust Board sub-committees

Situation

- It was agreed at the Trust Board meeting on 28/11/19 that the scheduling of “Safety moment” items at Trust Board sub-committees should be discussed at the Trust Board ‘Away Day’ on 04/12/19 (in light of the recent decision by the Charitable Funds and Audit and Governance Committees to remove that item from their forward programmes).
- However, as there was insufficient opportunity for the issue to be discussed at the Trust Board ‘Away Day’ on 04/12/19, the Trust Board is asked to consider the matter at its ‘Part 1’ meeting on 19/12/19.

Background

- “Safety Moment” items were introduced to the agenda of Trust Board meetings in May 2015, following the agreement, at a “Patient Safety Think Tank” session held with the Trust Board on 29/04/15, of the principle that “Safety” should feature as the first item at Committee meetings.
- The consideration of “Safety Moment” items was not included within the Terms of Reference of any Trust Board sub-committee (which are required to be approved by the Trust Board), and the principle noted above was applied differently by the six Trust Board sub-committees, based on the preference of each Committee and/or its Chair:
 - The Finance Committee (as it was then) introduced a “Safety Moment” item in the same month (May 2015), following the then Chair’s confirmation that he wanted to apply the principle noted above. However it was then agreed at the Finance and Performance Committee on 26/03/19 (as part of the “Future Finance and Performance Committee meetings – discussion” item) that the current “Safety moment” item should be replaced with a “Finance or performance moment”.
 - The Charitable Funds Committee introduced a “Safety Moment” in July 2015, following the then Committee Chair’s confirmation that he wanted to apply the principle noted above. It was then agreed at the Charitable Funds Committee Meeting on 29/10/19 that the ‘Safety Moment’ was no longer required as it was a duplication of information
 - The Audit and Governance Committee introduced a “Safety Moment” item in May 2016, at the request of the then chair. It was then agreed at the Audit and Governance Committee Meeting on 05/11/19 that the ‘Safety Moment’ was no longer required as it was a duplication of information
 - The Quality Committee has never featured a “Safety Moment” item, on the basis that it discusses safety-related items regularly as part of most of its items
 - The Workforce Committee has never featured a “Safety Moment” item
 - The Remuneration and Appointments Committee has never featured a “Safety Moment” item

Assessment

- The “Safety Moment” items have developed since their introduction from being an unscripted verbal item that was allocated to different members of the relevant Committee to its current form (in which a written report is produced, following an agreed schedule/programme)
- “Safety Moment” items clearly align more closely with the remit of some Trust Board sub-committees more than others
- The Trust Board has hitherto been content to leave the decision on whether (or not) to have a “Safety Moment” item at each Trust Board sub-committee with that sub-committee

Recommendation

- The Trust Board is asked to continue to leave the decision on whether (or not) to have a “Safety Moment” item at each Trust Board sub-committee with that sub-committee

Trust Board meeting – December 2019

Safety moment	Chief Nurse / Medical Director
<p>The Safety Moment for December has focused on Learning Disability Awareness.</p> <p>The enclosed report contains a summary of the key messages that have been shared each week.</p>	
<p>Which Committees have reviewed the information prior to Board submission?</p> <ul style="list-style-type: none">▪ N/A	
<p>Reason for submission to the Board (decision, discussion, information, assurance etc.) ¹</p> <p>Information and discussion</p>	

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Treat me well

Simple adjustments make a big difference

People with a diagnosis of autistic spectrum condition often function day to day by having fixed and rigid routines. Any change to these routines such as attending hospital can be extremely distressing for the individual.

We can minimise the distress caused by implementing "Reasonable Adjustments". Reasonable adjustments are simple changes that make a big difference.

Patient story

A gentleman attended hospital in an emergency; due to his autism he would only take his medication with a hot meal. Unfortunately his medication often arrived after his hot meal. This resulted in him missing vital oral medication.

A small adjustment of ensuring food and medication were delivered at the same time would have resolved the patient's "poor compliance with medication". Always read and act on information contained in people's hospital passports.

Ask **ME** what would help me in hospital, if I am not able to tell you talk to my family or carer.



Week Two 09/12/2019

Avoidable Deaths

1200 people with a learning disability die avoidably in the NHS every year. This means that if the person had received person centred care they would not have died.

The National LeDeR program conducts independent Mortality Reviews of all deaths of people with learning disabilities who died within the NHS. LeDeR has found the following contributing factors:

- Missed assessments/tests
- Poor management of epilepsy
- Delays in giving fluid or nutrition
- Poor bowel monitoring leading to untreated constipation
- Poor recognition of carer of families valuable role in care delivery
- Poor application of the Mental Capacity Act (2005)



How to prevent avoidable deaths

- Make time to listen to the patient and/or their family/carers and act on information provided.
- Make 'reasonable adjustments' for people with learning disabilities.
- Closely monitor and record oral intake.
- Accurately monitor and record urine output and bowel monitoring.
- Make referrals to appropriate teams in a timely manner, including to the learning disability liaison nurse. Learning Disability liaison nurse can help with missed assessments, communication difficulties, behaviour that challenges and creative reasonable adjustments.

Week Three 16/12/2019

End of Life Care for People with Learning Disabilities

One of the most important elements of providing good end of life care is communication, communication with both the patient who is dying and their family. This is no different for a patient who has a diagnosis of learning disabilities.

Please see below some of the "do's" and "don'ts" when providing end of life care to a person with a learning disability:

Do:

- Complete the individualised care plan for the dying patient and involve the person in decisions as much as they are able to be and want to be (even if they lack capacity).
- Ask the patient their views and feelings and find out if they have already completed an advanced care plan.
- Support the person to make decisions and be involved in their care by using easy read information. Please click here for Macmillan's easy read information and scroll down to end of life care:
<https://www.macmillan.org.uk/information-and-support/resources-and-publications/other-formats/easy-read.html>
- Ask the person's views on organ and tissue donation.
- Regularly assess the patient and look for non-verbal cues that may indicate pain or distress.
- Treat carer's/relatives as experts in the person's usual presentation, listen to them and act on information.
- Allow 'open' visiting for patient's relatives and/or carer's.
- Bereaved family or friends may also have learning disabilities; the community learning disability team can support people with bereavement. Referrals can be made by contacting the following number 03000 410 333.



Don't:

- Keep information secret and not tell the person that they are dying.
- Assume a person's distress or behaviour is related to their learning disability; always make attempts to identify other environmental or physical causes.

Week Four 23/12/2019

Hospital Passport

The hospital passport is a document used to communicate information to health professionals about a person with a diagnosis of learning disability.

The hospital passport contains important information about a person's risk behaviours, moving and handling and eating and drinking guidance. Equally as important it provides guidance on how to communicate with the individual and how to reduce the occurrence of behaviour that challenges.

The hospital passport is usually completed in the community either by the individual, a nurse, a carer or family member. Please read and act upon information contained in the patient's hospital passport.

Staff were reminded to contact Philippa Harris, Learning Disability Liaison Nurse for further advice

Maidstone and Tunbridge Wells NHS Trust

Hospital Passport

For people with learning disabilities coming into hospital

My name is:

If I have to go to hospital this book needs to go with me, it gives hospital staff important information about me.

It needs to hang on the end of my bed and a copy should be put in my notes.

This passport belongs to me. Please return it when I am discharged.

Nursing and medical staff please look at my passport before you do any interventions with me.

Things you must know about me

Things that are important to me

My likes and dislikes

Maidstone and Tunbridge Wells NHS Trust

Kent County Council
kent.gov.uk

The January Patient Safety Calendar is focused around complaints.

Report from the Chair of the Trust Board

Chair of the Trust Board

NHS Providers' Chair/Chief Executive network

I attended the NHS Providers' Chair/Chief Executive network on 03/12/19 where many key areas were discussed - patient safety over the winter; progress on the NHS Long Term Plan; the financial outlook for this financial year and next; digital; workforce and the People Plan; future capital requirements and the "Rebuild the NHS" campaign.

Royal visit

I was delighted to be part of the welcoming party to meet HRH Princess Anne when she visited Maidstone Hospital on 11/12/19 to formally open the new Helipad. This event allowed us to pull together to present some of our hard working teams and feel a sense of pride in MTW. Thanks to John Weeks (Director of Emergency Planning, Response and Communications) and the organising team for such a well planned and executed event.

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.

Date of AAC	Title	First name	Surname	Department	Potential/Actual Start date
06/12/2019	Dr	Naami	Macddy	Radiology	TBC
12/12/2019	Dr	Jennifer	Turner	Medical Oncology	TBC
12/12/2019	Dr	Anthi	Zeniou	Medical Oncology	TBC
12/12/2019	Dr	Maria	Karina	Clinical Oncology	TBC
12/12/2019	Dr	Samuel	Chan	Clinical Oncology	TBC

Which Committees have reviewed the information prior to Board submission?

N/A

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

Information

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Report from the Chief Executive

Chief Executive

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

1. MTW was honoured to welcome Her Royal Highness The Princess Royal this month to officially open the new helipad at Maidstone Hospital. Thanks to a generous £300,000 donation from the HELP Appeal we have been able to construct an all-weather helipad that can operate 24 hours a day, seven days a week. A commemorative plaque was unveiled by Her Royal Highness, who also spent time meeting with and talking to some of our staff.
2. Our first ever Christmas charity appeal is now in full swing. It's a good opportunity to allow people to give something back to their local hospital and help raise money to support our children's services. Some of our wonderful young patients & their families are backing our new campaign. A huge thank you to everyone who has given so generously so far. Anyone wishing to donate can text MTWKIDS with the amount to 70085 or visit www.justgiving.com/campaign/mtwkids
3. Building work on the purpose-built £8m Acute Assessment Unit is now nearing completion and is set to open early in the new year. The new unit will allow us to undertake further assessment and monitoring on patients with urgent medical and surgical conditions who have been referred by their GP or Emergency Department (ED).
4. A huge thank you to the 51% of staff who completed the NHS Staff Survey 2019 - that's 1,000 more than last year. This is our best response ever & will help us better understand their views. We have a clear ambition to improve further the staff experience & the feedback will be used to help make the changes everyone wants to see, ensuring MTW becomes a great place to work.
5. MTW has won the Hospice UK Innovation in Dying Matters Award for the comedy evening we held during Dying Matters Week. Thank you to our Palliative Care and Chaplaincy teams for organising this event.
6. We have recently launched our [Patient Experience Strategy, Making it Personal](#), to help us meet our patient care goals. This sets out what we'll do over the next 3 years to improve the experience of our patients. As a Trust we're doing more than ever to involve our patients, listen to their feedback and take action on what they tell us. This strategy builds on the good work we've implemented to allow us to be consistently excellent with our approach and delivery.
7. Best wishes to Jacqui Slingsby, Divisional Director of Nursing and Quality for Surgery, on her retirement. She leaves after 35 years of service in the NHS.
8. I am delighted to confirm that we have met all eight national cancer standards in October. This is the first time we've achieved this in over five years and is testament to the excellent work we've put in place to turn our cancer performance around in such a short space of time. Thank you to our staff for their hard work, effort and drive to introduce quality improvements, which have enabled us to be in this positive position.
9. 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:
 - a. Review and update on the implementation of the Electronic Patient Record programme.
 - b. Performance updates on cancer, Referral to Treatment (RTT) and Emergency Department.
 - c. Update on staff flu vaccination programme.
 - d. Review of work to achieve our ambition to become an outstanding provider of care.
 - e. Discussion around improving staff facilities and amenities.
10. Finally, I would like to wish our staff, patients, carers and their families, and all those we work with, a very happy and healthy Christmas and New Year.

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

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Integrated Performance Report, November 2019

**Chief Executive /
Members of the Executive Team**

Enclosed is Integrated Performance Report for month 8, 2019/20 (which includes an update on progress with the Perinatal Mortality Review Tool (PMRT); and the planned and actual ward staffing for November 2019).

Which Committees have reviewed the information prior to Board submission?

- Finance and Performance Committee, 18/12/19 (in part)

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

Review and discussion

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Integrated Performance Report

November 2019

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Appendices (Page 16 onwards)

- Finance Report
- Safe Staffing Report

Scoring for Performance Wheel

Scoring within a Domain:

Each category within the Balanced scorecard is given an overall RAG rating based on the rating of the KPIs within the domain on a YTD basis that appear on the balance scorecard (below) :

Red = 3 or more red KPIs within the domain

Amber = 2 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

Note: Detailed dashboards and a deep dive into each CQC Domain are available on request - mtw-tr.informationdepartment@nhs.net

Performance Wheel and Executive Summary

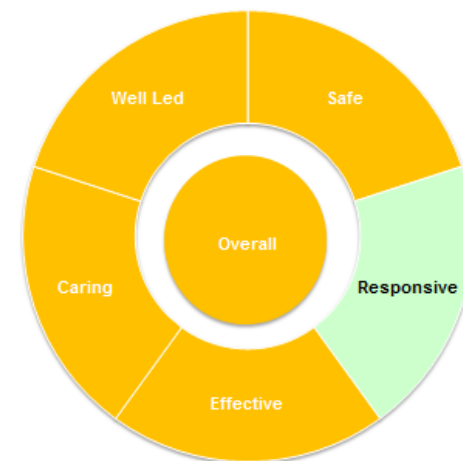
Previous Month (Oct-19)



Current Month (Nov-19)



2019/2020 Year to date



Executive Summary

The Trust has achieved the National Cancer 62 Day FDT Standard of 85% for three consecutive months. All Cancer Waiting Times Targets were achieved in October.

Nursing vacancies are being filled through local and overseas recruitment. This, along with normal levels of annual leave led to a further increase in both the overall and nursing staff fill rate which is the highest level reported so far this year. There has been a further improvement in the rate of Falls and SIs reported.

Despite an increase per working day in elective activity in November, activity levels remain below plan YTD (particularly for Outpatients). Performance for the Referral to Treatment (RTT) standard has decreased to below trajectory in October at 84.12%. The non-admitted waiting list and backlog is showing an increasing trend for some key areas which is directly impacting on performance. The monthly position for November is currently unavailable, so the finalised position for October has been reported in this version of the report.

Achievement of the A&E 4 hour standard has been impacted by the continued high level of A&E Attendances. Non-elective patient flow has also been impacted by the an increase in admissions, Delayed Transfers of Care and average length of Stay (LOS) continuing to remain above plan. This has resulted in there being less beds available for patients requiring an admission from A&E, leading to an increase in the use of escalated beds.

Performance Wheel and Executive Summary

Items for Escalation

- **C.Diff:** the number of cases of C.Diff increased in November and is now 1 above the maximum trajectory YTD.
- **E.Coli:** the number of cases of E.coli decreased to 4 cases reported in the month, which equates to a rate of 19.6 per 100,000 occupied beddays. This is below the phased trajectory of 20.1 as at November, reducing to 19.0 by the end of the year.
- **Falls:** Achieved the trajectory for the 3rd consecutive month and is now achieving the trajectory YTD with no Serious Incidents relating to Falls reported.
- **Safe Staffing:** Nursing Safe Staffing fill rate increased in November to 101.4% which is the highest level reported so far this year, above the average of last year and is above the target of 93.5%.
- **Stroke:** Performance against the metrics that constitute the Best Practice Tariff has been impacted by a combination of data completeness and validation, as well as annual and compassionate leave, although performance improved slightly for all three indicators in October. The expectation is that compliance with the tariff will improve as the consultant stroke rota is fully filled along with improvements in the timeliness of data capture and validation.
- **A&E Attendances:** are currently showing an annualised growth of 9.78%. November was the second busiest month ever.
- **A&E 4 hour Standard:** performance decreased further in November to a score of 87.32% against an agreed trajectory of 92.16% and has been below plan now for the last four consecutive months.
- **Referral to Treatment (RTT) Incomplete Pathway (October):** Performance decreased in October and is now below trajectory at 84.12%. The Trust Waiting List has increased to 31,828 and the backlog has increased to 5,053 due to the increase in the OP Backlog. The November position is currently not available.
- **Cancer 2weeks (2ww):** Performance against the 2ww and 2ww breast symptoms targets have been achieved for two consecutive months (93.0% and 94.1% respectively in October) despite the increased number of incoming referrals. November is also expected to achieve both targets.
- **Cancer 62 Day:** Performance against this target has been achieved for three consecutive months (85.8% in October). However, this remains extremely challenging with November expected to be above 80% and close to the 85% target
- **Diagnostics Waiting Times <6 weeks:** Achieved the 99% national target in November. Performance is now consistently being sustained once again.
- **Finance:** The Trust was breakeven in November which was £0.7m adverse to plan. The Trust delivered the pre PSF plan in November but did not recover the overspend in October therefore the Trust was not eligible for PSF funding (£0.7m in month). In order to deliver the November plan the Trust released the remainder of old year provisions (£1.7m) and capitalised £0.4m EPR project costs that were previously charged to revenue. Without the release of old year provisions and the capitalisation of EPR revenue costs the Trust would have been £0.6m adverse to forecast. The main adverse movement to forecast related to a reduction in Radiotherapy income due to a 15% reduction in activity between months and £0.1m pressure relating to the escalation of 2 wards (part way through the month).
- **Workforce (various):** Substantive recruitment has taken place and staffing fill rates have increased to the highest level recorded so far this year at 81%. Agency and bank usage decreased, reflecting the decrease in demand for temporary staffing. Short –term sickness levels remained at the same high level as last month and the overall sickness rate increased further to 3.7% (highest level so far this year and above the target). The staff turnover rate has increased slightly from 11.7% to 11.9% in November. 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 13.2%.

Summary Scorecard

Safe		Curr Month		Year to Date		Year End		Change on Prev Mth	Responsive		Curr Month		Year to Date		Year End		Change on Prev Mth		
ID	Key Performance Indicators	Plan	Actual	Prev Yr	Plan	Curr Yr	Plan		FOT	ID	Key Performance Indicators	Plan	Actual	Prev Yr	Curr Yr	Plan		FOT	
S1	Rate C-Diff (Hospital only)	20.1	29.4	22.8	24.0	24.6	22.4	22.4	↓	R1	Emergency A&E 4hr Wait	92.2%	87.3%	92.5%	91.0%	91.7%	90.1%	↔	
S2	Number of cases C.Difficile (Hospital)	4	6	37	39	40	55	55	↓	R2	Emergency A&E >12hr to Admission	0	0	2	0	0	0	→	
S3	Number of cases MRSA (Hospital)	0	0	3	0	1	0	1	→	R3	Ambulance Handover Delays >30mins	369	492	2709	4008	4428	5484	↔	
S4	Rate of E. Coli Bacteraemia	20.1	19.6	30.8	22.2	33.9	21.5	21.5	↑	R4	RTT Incomplete Pathway (October)	85.6%	84.1%	81.0%	84.1%	86.7%	83.7%	↔	
S5	Rate of Hospital Pressure Ulcers	0.90	0.6	1.2	0.9	0.6	0.9	0.6	→	R5	RTT 52 Week Waiters (New in Month)	8	5	49	41	96	41	↔	
S6	Rate of Total Patient Falls	6.00	5.04	6.31	6.00	5.98	6.00	5.93	↑	R6	% Diagnostics Tests WTimes <6wks	99.0%	99.0%	99.4%	99.0%	99.0%	99.0%	→	
S7	Number of Never Events	0	0	1	0	1	0	1	→	R7	Cancer two week wait	93.0%	93.0%	86.5%	93.0%	93.0%	93.0%	→	
S8	Number of New SIs in month	12	6	123	96	89	144	137	↑	R8	Cancer two week wait-Breast Symptoms	93.0%	94.1%	83.1%	94.1%	93.0%	94.1%	↔	
S9	SIs not closed <60 Days Monthly Snapshot	24	11	-	24	11	24	11	↑	R9	Cancer 31 day wait - First Treatment	96.0%	97.5%	96.2%	97.5%	96.0%	97.5%	↔	
S10	Overall Safe staffing fill rate	93.5%	101.4%	97.1%	93.5%	95.3%	93.5%	95.3%	↔	R10	Cancer 62 day wait - First Definitive	85.0%	85.8%	62.6%	85.8%	85.0%	85.8%	↔	
Effective		Curr Month		Year to Date		Year End		Change on Prev Mth	Responsive - Flow		Curr Month		Year to Date		Year End		Change on Prev Mth		
ID	Key Performance Indicators	Plan	Actual	Prev Yr	Plan	Curr Yr	Plan		FOT	ID	Key Performance Indicators	Plan	Actual	Prev Yr	Curr Yr	Plan		FOT	
E1	Hospital-level Mortality Indicator (SHMI)	Band 2	1.0348	1.0244	1.0244	1.0348	Band 2	Band 2	→	R11	Average LOS Non-Elective	6.40	6.89	6.94	6.91	6.40	6.91	↔	
E2	Standardised Mortality HSMR	Lower conf <100	92.7	102.4	100.0	92.7	Lower conf <100	92.7	→	R12	Theatre Utilisation	90.0%	86.2%	91.3%	86.6%	90.0%	86.6%	↔	
E3	% Total Readmissions	14.1%	14.4%	13.6%	14.1%	14.8%	14.1%	14.8%	↔	R13	Primary and Non-Primary Refs	16,457	14378	127,137	129924	199,052	195752	↔	
E4	Readmissions <30 days: Emergency	14.7%	15.0%	14.1%	14.7%	15.3%	14.7%	15.3%	↔	R14	Cons to Cons Referrals	4,291	5366	48,398	49269	51,898	66,432	↑	
E5	Readmissions <30 days: Emergency (excl SDE)	14.0%	14.2%	13.8%	14.0%	14.7%	14.0%	14.7%	↔	R15	OP New Activity	18,696	18419	143,150	149630	226,133	224414	→	
E6	Readmissions <30 days: Elective	6.8%	7.4%	7.1%	6.8%	7.6%	6.8%	7.6%	↔	R16	OP Follow Up Activity	28,675	27867	213,179	225906	346,845	340616	↔	
E7	Stroke: Best Practice (BPT) Overall %	50.0%	36.5%	50.0%	50.0%	39.0%	50.0%	39.0%	↔	R17	Elective Inpatient Activity	614	618	4,307	4761	7,426	7217	↑	
E8	Nat CQUIN: % Dementia Screening	90.0%	98.4%	99.8%	90.0%	93.4%	90.0%	93.4%	↔	R18	Day Case Activity	4,151	4007	29,854	32143	50,210	48748	↑	
E9	Nat CQUIN: % Dementia Risk Assessed	90.0%	97.3%	90.3%	90.0%	104.7%	90.0%	104.7%	↔	R19	Non Elective Activity (inc Maternity)	5,541	5552	42,460	44068	67,606	66603	↔	
E10	Nat CQUIN: % Dementia Referred to Specialist	90.0%	100.0%	98.6%	90.0%	99.0%	90.0%	99.0%	↔	R20	A&E Attendances : Type 1	12,691	14178	103,110	112927	159,252	169466	↔	
Caring		Curr Month		Year to Date		Year End		Change on Prev Mth	Well-Led		Curr Month		Year to Date		Year End		Change on Prev Mth		
ID	Key Performance Indicators	Plan	Actual	Prev Yr	Plan	Curr Yr	Plan		FOT	ID	Key Performance Indicators	Plan	Actual	Prev Yr	Curr Yr	Plan		FOT	
C1	Single Sex Accommodation Breaches	0	0	35	0	0	0	0	→	W1	Surplus (Deficit) against B/E Duty	783	24	1,535	2,228	6,897	6,897	→	
C2	Rate of New Complaints	3.92	2.25	2.19	2.96	2.38	2.93	2.55	↔	W2	CIP Savings	2,108	1,812	8,160	14,585	22,329	22,329	↔	
C3	% complaints responded to within target	75.0%	74.0%	75.0%	75.0%	63.6%	75.0%	67.5%	↔	W3	Cash Balance	30,444	28,428	8,566	28,428	3,000	3,000	→	
C4	IP Resp Rate Recmd to Friends & Family	25.0%	19.5%	24.5%	25.0%	16.3%	25.0%	16.3%	↑	W4	Capital Expenditure	2,390	197	3,140	2,199	14,448	15,557	→	
C5	IP Friends & Family (FFT) % Positive	95.0%	95.7%	93.7%	95.0%	95.3%	95.0%	95.3%	↔	W5	Finance use of Resources Rating	2	3	3	3	2	3	→	
C6	A&E Resp Rate Recmd to Friends & Family	15.0%	2.3%	21.2%	15.0%	8.7%	15.0%	8.7%	↔	W6	Staff Turnover Rate (%)	10.0%	11.9%	9.2%	11.9%	10.0%	11.9%	↔	
C7	A&E Friends & Family (FFT) % Positive	87.0%	88.7%	91.0%	87.0%	87.6%	87.0%	87.6%	↔	W7	Vacancy Rate (%)	8.0%	8.5%	10.7%	11.5%	8.0%	11.5%	↔	
C8	Mat Resp Rate Recmd to Friends & Family	25.0%	12.0%	11.8%	25.0%	23.1%	25.0%	23.1%	↔	W8	Total Agency Spend	964	1,075	15,497	12,971	15,471	16,258	↔	
C9	Maternity Combined FFT % Positive	95.0%	97.8%	99.1%	95.0%	94.7%	95.0%	95.0%	↔	W9	Statutory and Mandatory Training	90.0%	86.6%	87.1%	86.1%	90.0%	90.0%	↔	
C10	OP Friends & Family (FFT) % Positive	84.0%	84.2%	84.1%	84.0%	82.5%	84.0%	84.0%	↔	W10	Sickness Absence	3.3%	3.7%	3.4%	3.4%	3.3%	3.4%	↔	
Target Indicator Key:										Change on Previous Indicator Key:									
On or above Target										Significant improvement on Previous (>5%)				↑	Deterioration on previous (<5%)				↔
Review and Corrective Action required										Improvement on previous (<5%)				↔	Significant deterioration on previous (>5%)				↓
Significantly below target - urgent action required										No Change				→					
KPI Used in Performance Wheel Scoring																			

Headlines

Safe:	Positives:	Challenges:
<p>Lead Director(s): Claire O'Brien/ Peter Maskell</p>	<p>Infection Control: Compliance in MRSA Screening for the Elective pathway remains above target.</p> <p>The number of gram negative blood stream infections and MSSA cases continue to remain lower than the levels reported in the previous year.</p> <p>In November the number of cases of E.Coli decreased to 4 cases reported equating to a rate of 19.6 per 100,000 occupied beddays which is below the phased trajectory of 20.1 as at November reducing to 19.0 by the end of the year.</p> <p>Falls: The level of Falls has improved further this month to the lowest level reported so far this year with 103 Falls reported equating to a Rate of 5.04 per 1,000 occupied bed days, therefore achieving the trajectory for both the month and YTD. There were no Serious Incidents relating to Falls in November.</p> <p>Serious Incidents (SIs): The number of SIs reported decreased to 6 in November and remains below the maximum limit.</p> <p>Incidents: The rate of incidents that were severely harmful reduced further in November to 0.27 which is below the limit of 1.23. There has been a reduction in the number of incidents open for more than 45 days.</p> <p>Safe Staffing: This has increased in November to 101.4% which is the highest level reported so far this year, above the average of last year and is above the target of 93.5%.</p>	<p>Infection Control: There were 6 cases of C.difficile reported in November. Year to date the Trust is now slightly above trajectory with 40 cases reported against a maximum limit of 39.</p> <p>Performance for MRSA Screening in Non- Elective pathways dipped further at 90.8% in November.</p> <p>Incidents: Incidents of Abuse towards Staff decreased in November to 33 which is 72% of all incidents of aggression reported (22 in October).</p> <p>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.</p>

Headlines

Effective:	Positives:	Challenges:
<p>Lead Director(s): Peter Maskell</p>	<p>Mortality: The Risk Adjusted Hospital Standardised Mortality Rate (HSMR) and SHMI are both continue to remain within acceptable limits. The HSMR has been below 100 for the last seven reporting periods.</p> <p>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 3.4%</p> <p>Patients with Dementia: The percentage of patients screened for Dementia increased in October to 98.4% against the 90% national target and remains above target YTD (93.4%). The percentage of those that were risk assessed or referred to a specialist were required both continue to remain significantly above target.</p>	<p>Emergency Readmissions (Non-Elective): Following discussion with the Medical Director it was decided to show the rate of emergency readmissions within 30 days of discharge (non-elective) excluding SDEC (those on a same day emergency care pathway) as well as the total rate of emergency readmissions within 30 days of discharge (non-elective) due to the increased use of short stay units. Performance is monitored against local targets based on improving to above the average of last year. Performance has improved for both indicators in November but both remain slightly above the target (average of last year).</p> <p>Emergency readmissions (Elective): The level or emergency readmissions within 30 days of discharge for those who were originally admitted on an elective pathway has increased and is slightly above the target.</p> <p>Stroke: Performance against the metrics that constitute the Best Practice Tariff has been impacted by a combination of data completeness and validation, as well as annual and compassionate leave, although performance improved slightly for all three indicators in October. The expectation is that compliance with the tariff will improve as the consultant stroke rota is fully filled along with improvements in the timeliness of data capture and validation.</p> <p>Access to Stroke Consultant (14hrs): The new service provided at Maidstone will enable compliance with the 14 hr standard to improve, however until the consultant week rota is fully staffed the full potential will not be reached.</p> <p>Time on a stroke ward (90%): With full and timely data input and the known adequate capacity on the stroke units at Maidstone Hospital there is potential to achieve the target for patients spending 90% of their time on a Stroke Ward. Achievement of the target will only be hampered by any winter pressures.</p>

Headlines

Caring:	Positives:	Challenges:
<p>Lead Director(s): Claire O'Brien/ Peter Maskell</p>	<p>Complaints: The overall number of complaints received has remained fairly consistent month on month.</p> <p>Friends and Family Survey: The Percentage positive performance for November was above plan in all four areas. Both Maternity and Outpatients saw an increase in performance to 97.8% and 84.2% respectively.</p> <p>Outpatient response rate increased to 6.7% in November which is the highest monthly response rate so far this year.</p> <p>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</p> <p>VTE Risk Assessment: The Trust continues to consistently achieve the 95% National Target for patients receiving a VTE Risk Assessment</p>	<p>Complaints Response Rate: Following the significant increase in performance seen in October, performance dropped in November to just below the target at 74%.</p> <p>Despite the increase in performance in October, YTD the percentage of complaints responded to within target is 63.6% which remains below the 75% target.</p> <p>Friends and Family: Following the large decrease in response rates seen last month due to it being the first month of reporting following the process change, this has increased back to previous levels of Inpatients at (19.5%). Maternity has increased but not back to previous levels at 12%. A&E response rate remains extremely low at 2.3% as only one site has currently being captured.</p> <p>FFT “walkabout” across both sites took place on 20th November 2019 with Trust and FFT provider staff. Additional services included in hierarchy for reporting and encouraged to use electronic options for feedback. In house poster to be designed and shared to raise awareness and encourage feedback.</p>

Headlines

Responsive:	Positives:	Challenges:
Lead Director(s): Sean Briggs	<p>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 43.5 per day so far this year – or around 9.4% of all A&E attendances</p> <p>A&E admissions (SDEC): The percentage of patients that are zero LoS (excluding Clinical Decision Unit (CDU) patients) is 26.1% YTD, compared to 22.1% for the same period last year.</p> <p>Ambulance Handovers: Ambulance handovers have improved over the past two months against their spike in September. 30-60 minute reduced to 11% in November, whilst over 60 minute delays reduced to 1.4%.</p> <p>Outpatient Efficiency: DNA Rates for both New and Follow Up have remained fairly consistent this year and are just above the target level of 5% for the Trust.</p>	<p>ED Attendances: The past 52 weeks have been 9.78% busier than the preceding 52, and 2019/20 attendance is forecast to be 8.7% higher than 2018/19. November recorded the 2rd busiest month ever.</p> <p>4 hour Emergency Access Standard: A&E performance has been extremely challenging over the last three months with a score of 87.32% against a trajectory target of 92.16% in November. Whilst performance has struggled across both sites there have been particular issues that have impacted on the Maidstone site performance over the last four months which have caused more breaches than expected.</p> <p>Emergency Admissions from A&E to a main Ward: Whilst the overall % of A&E Attendances that are then admitted onto a main ward is lower than last year YTD (18.9% compared to 20.8%) the numbers have shown an increase over the last three months are now above the average and 2 per day more than for the same period last year.</p> <p>Beds: Delayed Transfers of Care (DTC) increased to 4.76% in November which is above plan and higher than last year. This, along with non-elective average length of stay (LOS) remaining slightly above plan has meant that bed occupancy increased further to 96.1% in November as there has been an increased use of escalated beds (5% of total occupancy). Many of the available beds are specialist or paediatric beds not available for general acute admissions.</p> <p>New Outpatient Activity: Activity is 1.1% below plan YTD. However, for the main RTT Specialties this is 9% below plan YTD. Specialties furthest from plan remain ENT, Gastroenterology, Ophthalmology and Trauma & Orthopaedics which is directly impacting on their achievement of their RTT Trajectories.</p> <p>Outpatient Efficiency: The ERS Unavailable Slot %age remained high in Oct-19 at 25.5%. Separate meetings have taken place with the specialities in order to implement a plan. Cancellation of outpatient appointments with less than 6weeks notice continues to be an area of concern at 15.1% YTD.</p>

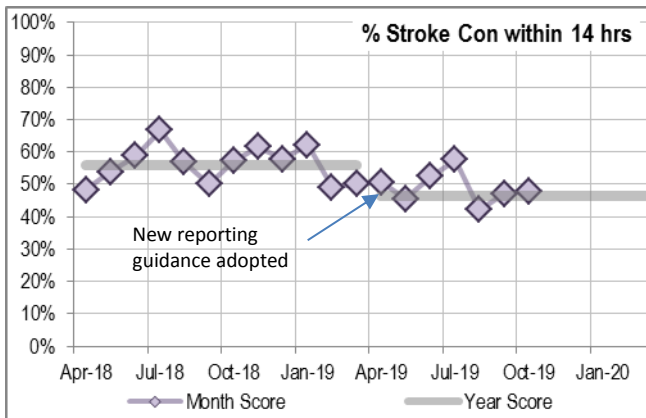
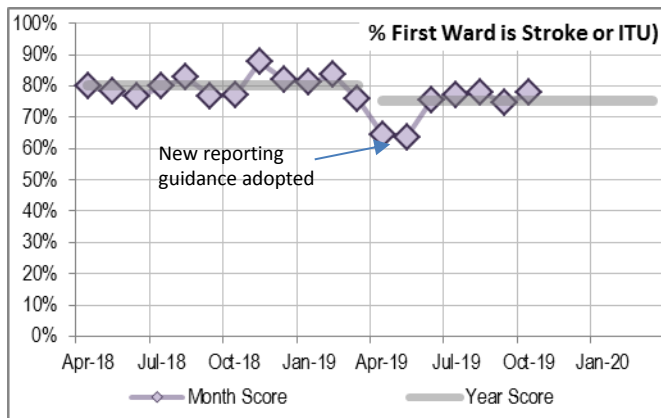
Headlines

Responsive:	Positives:	Challenges:
<p>Lead Director(s): Sean Briggs</p>	<p>Inpatient Efficiency (Last minute cancellations): The rate of last minute reportable cancellations remains below the 0.8% maximum limit at 0.6% YTD</p> <p>Inpatient Efficiency (Theatre Utilisation): Utilisation has remained constant in November at 86.2%.</p> <p>Diagnostic Waiting Times <6weeks: Following the decrease in performance over the last four months, previous issues have now been resolved and the Trust has therefore achieved the national target of 99% in November.</p> <p>Cancer Waiting Times: The Trust has achieved the 62 day standard for the 3rd consecutive month at 85.8% in October and all Cancer Waiting Times Standards were achieved.</p> <p>The Trust has successfully achieved both the 2ww and the Breast Symptoms standards for the 2nd consecutive month at 93% and 94.1% respectively which required all services to work on additional capacity requirements following the increased number of incoming referrals from October 2019</p>	<p>Outpatient Utilisation: The monthly utilisation figures have been averaging 65%. Although there are several data quality issues with the OP Utilisation figures resulting in them being understated performance remains below plan.</p> <p>Elective Activity: Overall activity increased by 16 cases per working day in November compared to October but remains 4.9% below plan YTD (DC is 4.8% below plan and IP are 5.9% 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 above plan.</p> <p>RTT Incomplete Pathway (October): Performance decreased in October and is now below trajectory at 84.12%. The Trust Waiting List has increased to 31,828 and the backlog has increased to 5,053 due to the increase in the OP Backlog. November performance is not available at the time of reporting.</p> <p>The Trust is still reporting some 52 week breaches on a monthly basis (5 reported for October). All patients will have a harm review by the managing Consultant. One low harm has been found with the outcome being prolonged discomfort for the patient. No harm has been found for all of the others that have been completed</p> <p>Due to the lower levels of outpatient activity undertaken YTD 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.</p> <p>The Elective and Outpatient New Activity remain lower than plan YTD (-5%) and (-9%) for RTT Specialties respectively, which has led to an increase in the RTT Waiting List and backlog for some specialties, particularly for the non-admitted pathway</p> <p>Cancer Waiting Times: Despite the achievement of the 62 Day target for the 3rd consecutive month, this remains a challenge for the Trust. November is expected to be above 80% and close to the 85% target. Ongoing work continues to ensure sustainable processes and active management of the 62 day PTL and backlog</p>

Headlines

Well Led:	Positives:	Challenges:
<p>Lead Director(s): Steve Orpin/ Simon Hart</p>	<p>Finance: The Trust is forecasting to meet its control total by the end of the year.</p> <p>CIP delivery has under-performed by £0.3m in month 8. The Trust has delivered £14.6m savings YTD which is £0.5m favourable to plan (3.5% over performance).</p> <p>The Trust's overall capital programme is forecast to outturn at £14.7m (excluding donated assets and PFI Lifecycle). This includes the use of £6.4m of asset sale funding (capital resource approved recently by DHSC); the recently notified £2.1m of national Diagnostic Funding to purchase two CT scanners, a MRI and Mammography equipment, and £1.25m of national funding for the Electronic Prescribing Medicines programme (EPMA).</p> <p>Vacancy Rate: The Trust vacancy rate continues to show a gradual downward trend from a high of 13.3% in April to 8.5% in November (-4.8%). This downward trend has also been seen in both the Nursing (-7.1%) and Medical and Dental (-8%) Staff Groups.</p> <p>Staff Appraisals: The 2019/20 appraisal cycle is overall at 91.8% with Estates and Facilities, Women's, Children's and Sexual Health, Diagnostics and Clinical Support and Medical and Emergency Care all achieving in excess of 90%.</p> <p>Annual Leave and Staff Fill Rate: Annual Leave has reduced back to 6.7% in November and therefore with the reduction in vacancy rate the overall staffing fill rate has also increased to 81% which is the highest level reported YTD.</p>	<p>Finance: Breakeven in Month 8 which was £0.7m adverse to plan.</p> <p>Variances within forecast of £7.5m are mitigated by £1.9m additional income opportunities, Divisional Recovery plan (£4.6m) and further capitalisation of EPR project costs (£1m). The level of divisional run rate improvement required is £1.2m for the remaining 4 months and represents a risk to the position.</p> <p>Medical staffing pay overspent YTD by £1.9m mainly within Medicine and Emergency Division (£1.6m) and Paediatrics (£0.6m). Substantive recruitment has taken place and controls on temporary bookings have been improved which should reduce agency spend.</p> <p>Nursing vacancies are being filled through local and overseas recruitment; this should see a reduction in temporary staffing spend which is assumed in the forecast. However the Trust has opened 2 escalation wards earlier than planned which would increase the number of staff required.</p> <p>Shortfall year to date relating to private patient income. Private In patient's beds at TWH have opened in October but as yet we have not seen the expected increase in private patient income. There has also been escalation of NHS patients into these beds.</p> <p>If the I&E forecast moves adversely this will reduce the level of cash available.</p> <p>Sickness Rate: The overall sickness rate has increased to 3.7 %, above the maximum limit of 3.3%. YTD this is slightly above target at 3.4%.</p>

Escalation: Stroke Best Practice Indicators



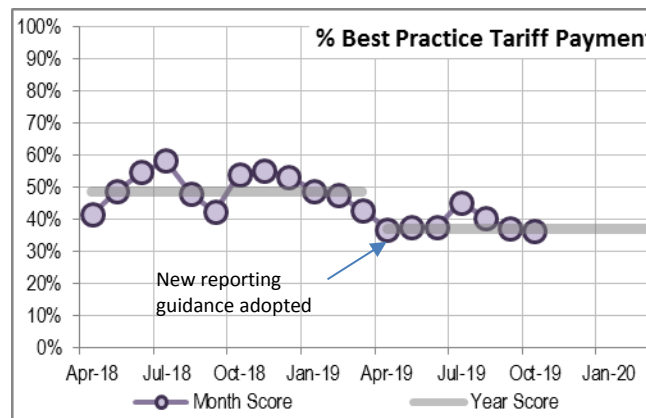
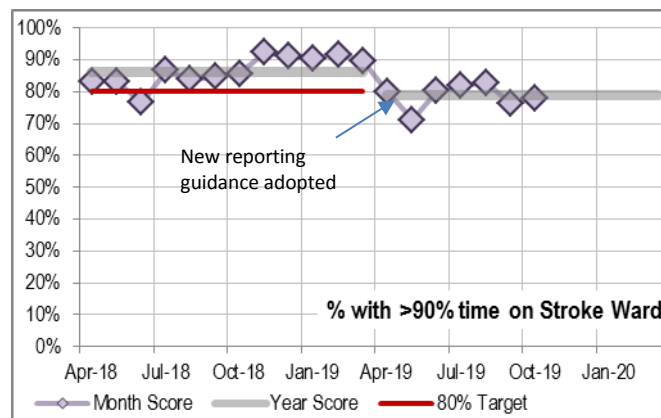
Data is now reported one month behind (October) to allow time for the data to be fully captured and validated. The timeliness of data capture and reporting is being addressed with the service.

There are 3 main stroke indicators that constitute Stroke Best Practice Tariff.

1. First Ward must be a Stroke Ward (or ITU): last year averaged 80.2%, but this year has reduced to 77.8%

2. Stroke Consultant within 14 hrs: Performance has been lower in Aug, Sep and Oct due to a combination of annual & compassionate leave, and data quality & completeness. The validated position to the end of Oct is 47.6%, 49.1% YTD.

3. 90% of Spell on Stroke Ward. Changes in the guidance means that this metric is now calculated differently to the reported results last year. In 2018/19, we would have scored 86.2% under the new methodology, but this year is reported at 78.7%.



Summary:

There are three stroke indicators that constitute Stroke Best Practice tariff, 39% of patients this year have qualified by meeting all three indicators. In 2018/19, the percentage passing all 3 tests & qualifying for a Best Practice Tariff payment would have been 50% YTD. This year is currently at 39%.

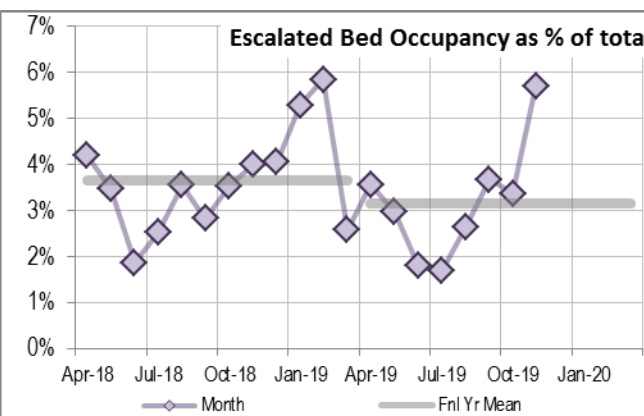
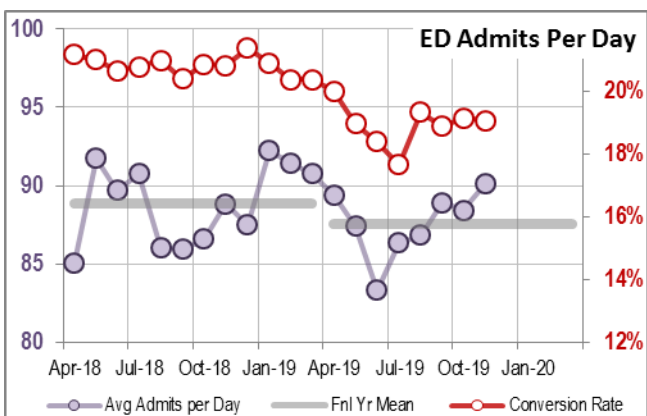
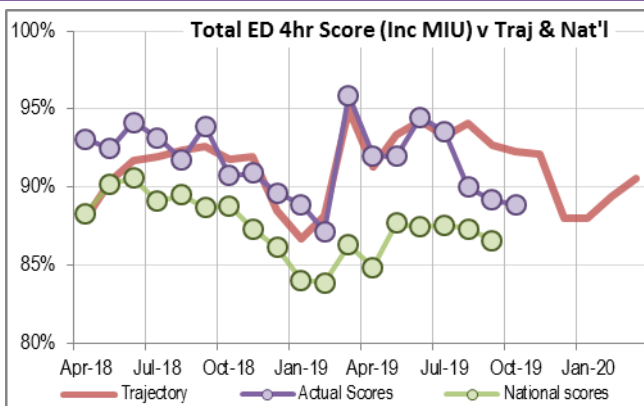
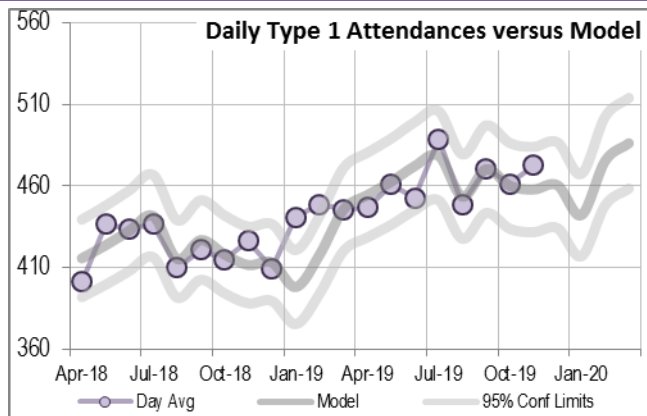
Actions:

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

Assurance:

1. BPT data now sent fortnightly
2. Action plan now in place to monitor and validate data.
3. ED teaching by CNS team for early recognition of Stroke symptoms and early referral to Stroke to avoid transfer to CDU. It is not clinically appropriate for any suspected or confirmed stroke to go 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 8.7% increase on that for 2019/20

November was 3.2% higher than expected at 472.6 per day. This represents the 2nd busiest month ever at a time when we expect attendances to be easing off into the winter.

4 Hr Time in Department: Performance has been down for four months now, coming in at 87.32% against an agreed trajectory of 92.16% for November

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 3.2%, which is a small improvement on last year. However, this has spiked early this year (in November to over 5% of total the 96.1% total occupancy) which is similar to the level that was not seen until January last year.

ED admits per day to main IP Ward: 2018/19 averaged 88.9 per day. Or 20.8% of attendances. This year we average 87.6 against much higher attendances, so the percentage is now 18.9%.

Ambulance Handovers: Last year, 9.9% of ambulances were delayed 30-60 mins, and 1.5% were delayed > 60. This year so far it's 11.9% delayed 30-60 mins and 1.41% >60. November is improved at 11.0% / 1.24% 1.5%

Summary:

Type 1 attendances are currently showing an annualised growth of 9.78% (last 52 weeks v preceding 52). November was the 2nd busiest month ever. Both sites have had difficulties over the last four months but there have been particular issues that have impacted on the Maidstone site performance over the last four months which have caused more breaches than expected. YTD, the average Time in Department is now higher than last year at 3h29m. The non-elective average LOS and DTOC are remaining fairly static and above plan which has meant that bed occupancy rose to 96.1% in November as there has been an increased use of escalated beds (5% of total in November).

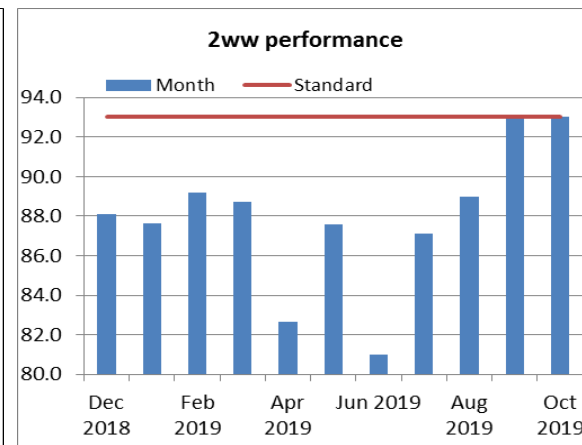
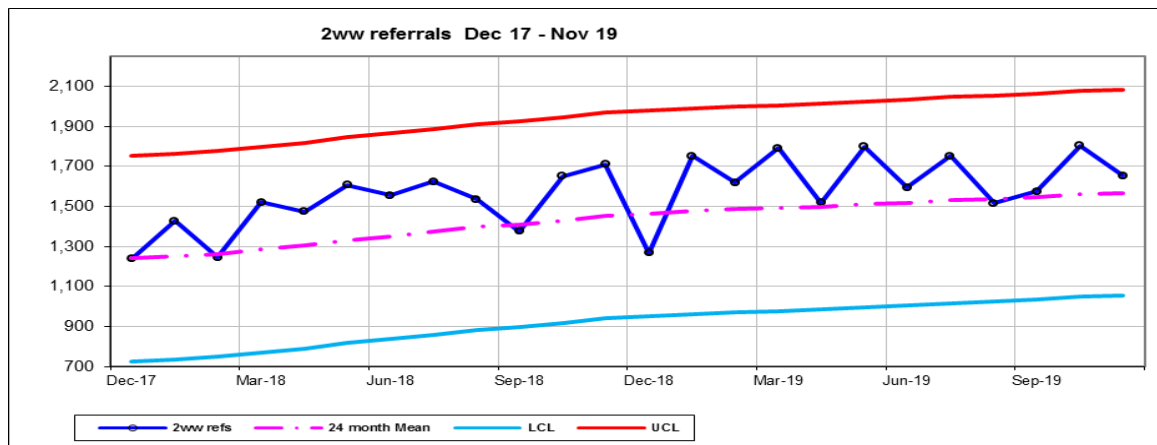
Actions:

SDEC running 7 days per week. Commencing trial of Medical Consultant in ED in Jan to support SDEC streaming. Ambulance handover plan in place with increased SECAMB / CCG/ MTW working. Improvement seen in handover performance. Development of 10 weeks to Christmas to improve flow and ED Performance, good results around EDN completion earlier in the day. Increase in GP slots planned which will enable more patients to be streamed to this service. New ED Consultant appointed, nursing planned to be fully recruited by June 2020. EDPs supporting "hello" nurse on ongoing trial.

Assurance:

Work continuing to ensure all departments within Trust feel a part of the 4Hour Access Standard –Increased profile on ambulance handovers. Focused bed meetings on actions. NHSI visited and commended us on our processes for ambulance handover and provided some recommendations to us and SECAMB for further improvement. Multi-professional Huddle embedded daily at 08.30. Continued focus on staff provision and demand analysis. Winter escalation wards are open to support flow and maintain ED Performance. Maintaining top 20 ED performance in the country consistently.

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 - Nov)	397	157	25	146	361	53	15	146	209	1671	158	555
% change last 12 mths	15.9%	11.1%	47.2%	18.9%	16.6%	9.8%	229.3%	0.4%	0.9%	29.6%	12.5%	14.8%

Demand: Following the increase of referrals received in October (1803) this decreased again in November to 1655 referrals – which remains in line with the monthly average over all.

Overall, Haematology had a slight increase of 2% from last month and Lower GI had an increase of 3% from October to November. All other tumour sites had a reduction of referrals between October and November, with Lung recording the largest reduction in referrals of 54%

2 Week Wait (2WW) Performance:

For the second consecutive month, both the 2ww standard and the Breast Symptoms 2ww standard were achieved in October – with reportable totals of 93.0% for 2ww performance and 94.1% for Breast Symptoms. Breast, Gynae, Haematology, and Head & Neck all achieved the 2ww standard, with Lung, Lower GI, Upper GI and Urology achieving between 88% and 92%

The current unvalidated position for November is 90.8% with 107 first seen breaches being reviewed and we are expecting to hit the target again in November.

Summary:

The Trust has successfully achieved both the 2ww and the Breast Symptoms standards for the second consecutive month, which required all services to work on additional capacity requirements following the increased number of incoming referrals from October 2019

Actions:

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

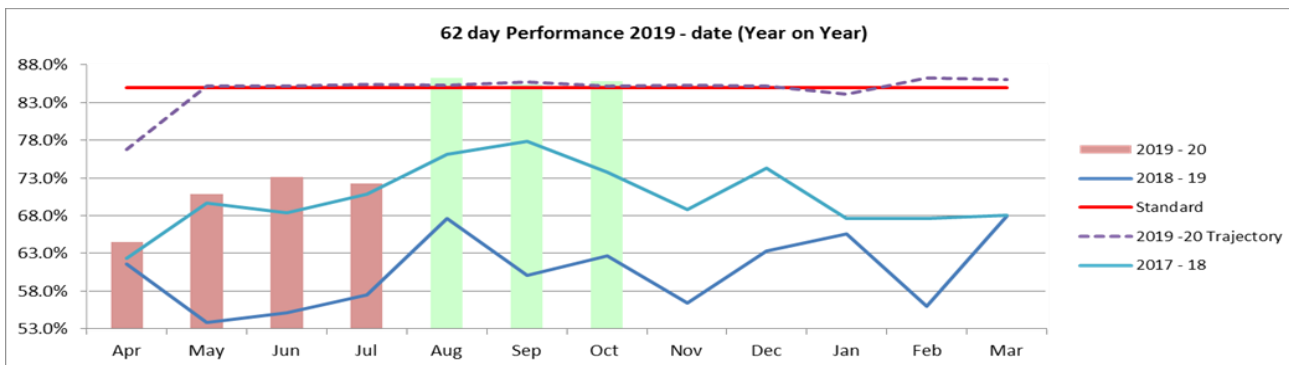
Assurance:

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.

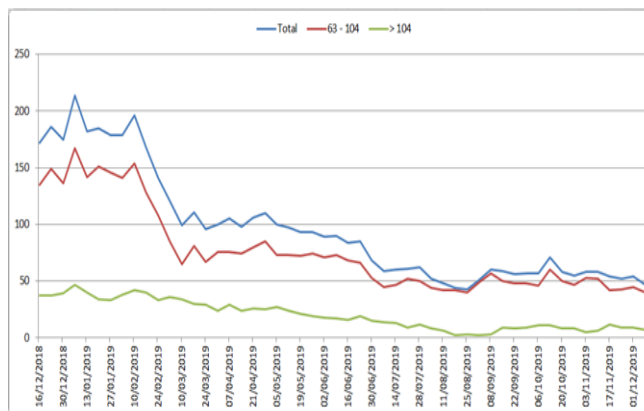
Escalation: Cancer Waiting Times – 62 Day



Trust Performance: The Trust is reporting an achievement of 85.8% for the overall 62 day standard for October 2019 – which is an achievement of the 62 day standard for the 3rd consecutive month (August to October 2019). The current position for November 2019 is not yet fully validated and the breaches for this period are being reviewed.

Of particular note – for the CWT reporting month of October 2019 – all reportable CWT targets have been achieved – (First seen for 2ww & breast symptoms, 31d FDT, 62d FDT & screening, as well as all 3 x 31d Subsequent treatment standards – Surgery, Drug and Radiotherapy)

62 Day Performance						
October 2019	All reportable patients			MTW only patients		
	Total	Breach	%	Total	Breach	%
Breast	20.5	0.5	97.6	20	0	100.0
Gynae	14.5	3.0	79.3	10	3	70.0
Haematology	2.0	1.0	50.0	2	1	50.0
Head & Neck	1.0	1.0	0.0	1	1	0.0
Lower GI	10.5	1.0	90.5	10	1	90.0
Lung	10.5	1.0	90.5	8	1	87.5
Other	0.0	0.0		0	0	
Upper GI	15.5	2.5	83.9	13	2	84.6
Urology	31.5	5.0	84.1	27	3	88.9
TOTAL	106.0	15.0	85.8	91	12	86.8



Tumour Specific Performance: Breast, Lower GI and Lung all reported above 90% for the 62d standard in October. Upper GI and Urology were also above the 62 day standard with 83.9% and 84.1% respectively. Gynae reported below target at 79.3% with Haematology at 50% with 2 treatments over the month

Conversion rates for 2ww referrals: The overall conversion rate remains at 8%. This varies across the different tumour sites with the highest remaining as Lung converting an average 23.22% of referrals received and the lowest from 2ww referrals is Head & Neck at 2.6%

The total backlog has dropped below 4% from the beginning of December and is currently 3.9% of the overall PTL.

The number of patients on the backlog above Day 104 has been maintained at 7 or 8 per day from the beginning of December 2019.

Summary:

The continued management of the 62 day PTL has enabled the Trust to achieve the 62 day standard for the third consecutive month.

All departments continue to work in setting up sustainable processes for ongoing achievement of the Cancer standards.

In October ALL CWT targets were achieved (for the first seen standard and both the first definitive and subsequent treatment standards)

Actions:

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.

Assurance:

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.

Appendices

REVIEW OF LATEST FINANCIAL PERFORMANCE

- The Trust was breakeven in November which was £0.7m adverse to plan. The Trust delivered the pre Provider Sustainability Fund (PSF) plan in November but did not recover the overspend in October therefore the Trust was not eligible for PSF funding (£0.7m in month). In order to deliver the November plan the Trust released the remainder of old year provisions (£1.7m) & capitalised £0.4m Electronic Patient Record (EPR) project costs that were previously charged to revenue.
- Without the release of old year provisions and the capitalisation of EPR revenue costs the Trust would have been £0.6m adverse to forecast. The main adverse movement to forecast related to a reduction in Radiotherapy income due to 15% reduction in activity between months and £0.1m pressure relating to the escalation of 2 wards (part way through the month).
- The Trust's normalised run rate (excluding PSF and MRET funding) in November was £2.8m deficit which was £2.2m adverse to plan.
- In November the Trust operated with an EBITDA surplus of £2.5m which was £0.9m adverse to plan
- The Trust's year to date surplus including PSF was £2.2m which was £2m adverse to plan. The key variances to budget were: Underperformance in Private Patient Income (£1.5m net), RTT Income reserve (£2.3m), £0.1m overspend against outsourcing, overspends within expenditure budgets (£2.9m) and PSF slippage of £1.5m. These pressures have been partly offset by release of prior year provisions (£3.5m) and release of £4m of reserves.
- The key current month variances are as follows:
 - Income adjusted for pass-through items is £1.8m adverse to plan, the main pressures relate to non-delivery of PSF (£0.8m), under delivery within clinical income (£0.9m) due to non-delivery of RTT risk reserve £0.3m & slippage within Daycase (£0.2m), Oncology fractions (£0.2m) & Adult Critical Care (£0.3m) as well Private Patient Income slippage (£0.3m).
 - Pay budgets adjusted for pass-through items and release of reserves/old year provisions overspent by £0.1m in November. The key overspends in the month were within Medical staffing (£0.3m) and Nursing (£0.2m) due to high level of temporary staffing usage. The pressure within Nursing and Medical staffing is predominantly within the Medical and Emergency division.
 - Non Pay budgets adjusted for pass through items and release of reserves / old year provisions overspent by £0.7m in November. The main pressure related to higher than planned outsourcing costs relating to patient choice activity (£0.8m).
- The closing cash balance at the end of November 2019 was £28.4m which is slightly lower than plan of £30.4m. Within the original cash plan for November the Trust was expecting £2m from NHSI relating to qtr 3 PFI support funding, this has been received in December.
- The Trust has just received approval to convert the proceeds from the asset sales in 2018/19 to capital totalling £6.3m for 2019/20, with the remaining £2m being carried forward to 2020/21 as per the original plan.
- The Trust's overall capital programme is forecast to outturn at £14.7m (excluding donated assets and PFI Lifecycle). This includes the use of £6.4m of asset sale funding (capital resource approved recently by DHSC); the recently notified £2.1m of national Diagnostic Funding to purchase two CT scanners, a MRI and Mammography equipment, and £1.25m of national funding for the Electronic Prescribing Medicines programme (EPMA).
- The Trust has also been notified of agreement of an additional Health System Led Investment (HSLI) ICT capital fund of £500k through the STP route – it is awaiting the formal letter of approval. In addition there are some cyber funding bids that the Trust has submitted following notification of funds to bid against
- The Trust is forecasting to deliver the planned surplus including PSF and MRET of £6.9m however this includes £7.5m of risks to the financial position.
- To mitigate these overspends the Trust is focusing on identifying further £4.5m of CIPs/Divisional recovery plans, Divisions have been asked to develop recovery plans by the 19th December for review by the Chief Finance Officer. The Trust is also in discussion with commissioners for an additional £1.9m additional income as well as planning on capitalising a further £1m of EPR project costs.
- The Trust has potential additional unmitigated risks of £2.2m which if materialised would require further recovery actions.

Trust Board Finance Report

Month 8
2019/20

Trust Board Finance Report for November 2019

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1a. Dashboard

November 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	39.7	41.2	(1.5)	0.3	(1.8)	■	330.1	334.7	(4.5)	1.0	(5.6)	■	498.0	501.0	(3.0)	■
Expenditure	(37.2)	(37.9)	0.7	(0.3)	0.9	■	(307.2)	(309.9)	2.7	(1.0)	3.7	■	(460.4)	(463.2)	2.8	■
EBITDA (Income less Expenditure)	2.5	3.4	(0.9)	0.0	(0.9)	■	23.0	24.8	(1.8)	0.0	(1.8)	■	37.6	37.8	(0.2)	■
Financing Costs	(2.5)	(2.6)	0.1	0.0	0.1	■	(20.4)	(20.9)	0.6	0.0	0.6	■	(31.4)	(32.0)	0.6	■
Technical Adjustments	0.0	0.0	0.0	0.0	0.0	■	(0.4)	0.4	(0.7)	0.0	(0.7)	■	0.7	1.1	(0.3)	■
Net Surplus / Deficit (Incl PSF and MRET)	0.0	0.8	(0.7)	0.0	(0.7)	■	2.2	4.2	(2.0)	0.0	(2.0)	■	6.9	6.9	0.0	■
CIPs	1.8	2.1	(0.3)		(0.3)	■	14.6	14.1	0.5		0.5	■	22.3	22.3	0.0	■
Cash Balance	28.4	30.4	(2.0)		(2.0)	■	28.4	30.4	(2.0)		(2.0)	■	3.0	3.0	0.0	■
Capital Expenditure	0.2	2.4	2.2		2.2	■	2.2	7.2	5.0		5.0	■	15.6	14.4	(1.1)	■
Capital service cover rating							4	3	■				4	4	■	
Liquidity rating							3	3	■				4	4	■	
I&E margin rating							2	1	■				1	1	■	
I&E margin: distance from financial plan							2	1	■				1	1	■	
Agency rating							4	3	■				4	3	■	
Finance and use of resources rating							3	2	■				3	3	■	

Summary:

- The Trust was breakeven in November which was £0.7m adverse to plan. The Trust delivered the pre PSF plan in November but did not recover the overspend in October therefore the Trust was not eligible for PSF funding (£0.7m in month). In order to deliver the November plan the Trust released the remainder of old year provisions (£1.7m) and capitalised £0.4m EPR project costs that were previously charged to revenue.
- Year to date the Trust is £2m adverse to plan, the key variances to budget were: Underperformance in Private Patient Income (£1.5m net), RTT Income reserve (£2.3m), £1.2m CIP slippage, £0.1m overspend against outsourcing, overspends within expenditure budgets (£2.9m) and PSF slippage of £1.5m. These pressures have been partly offset by release of prior year provisions (£3.5m) and release of £4m of reserves.
- The Trust has spent £5m more (67%) than the YTD agency ceiling set by NHSI (£11.8m per annum)
- The Trust has delivered £14.6m savings YTD which is £0.5m favourable to plan (3.5% favourable)

Key Points:

- The Trusts normalised run rate in November was £2.8m deficit pre PSF which was £2.2m adverse to plan (pre PSF).
- Without the release of old year provisions and the capitalisation of EPR revenue costs the Trust would have been £0.6m adverse to forecast. The main adverse movement to forecast related to a reduction in Radiotherapy income due to a 15% reduction in activity between months and £0.1m pressure relating to the escalation of 2 wards (part way through the month).
- The main pressures in the month related to £0.9m underperformance in clinical income mainly associated with Daycases (£0.2m), Oncology Fractions (£0.2m) and Adult Critical Care (£0.2m) as well as £0.8m overspend against outsourcing budgets, continued pressures within Medical staffing (£0.3m) and nursing overspend (£0.3m). These pressures were offset by £1.7m release of old year provisions and £0.4m capitalisation of EPR project costs.

Risks:

- The Trust is forecasting to deliver the planned £6.9m surplus including PSF. In order to deliver the financial plan the Trust must deliver £7.5m of mitigations in the remaining 4 months to offset risks to the financial position. These risks and mitigating actions are shown in section 4.

1b. Summary Income & Expenditure (Exceptional Items)

Income & Expenditure November 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	39.2	40.0	(0.8)	0.3	(1.0)	322.0	326.3	(4.3)	1.0	(5.3)
Expenditure	(38.9)	(37.9)	(1.0)	(0.3)	(0.8)	(310.0)	(309.9)	(0.1)	(1.0)	0.9
Trust Financing Costs	(2.5)	(2.6)	0.1	0.0	0.1	(20.4)	(20.9)	0.6	0.0	0.6
Technical Adjustments	0.0	0.0	0.0	0.0	0.0	(0.4)	0.4	(0.7)	0.0	(0.7)
Net Revenue Surplus / (Deficit) before Exceptional Items	(2.2)	(0.5)	(1.7)	0.0	(1.7)	(8.7)	(4.1)	(4.5)	0.0	(4.5)
Exceptional Items	1.7		1.7		1.7	3.5		3.5		3.5
Net Position	(0.5)	(0.5)	0.0	0.0	0.0	(5.2)	(4.1)	(1.0)	0.0	(1.0)
PSF and MRET Funding	0.5	1.3	(0.8)	0.0	(0.8)	7.4	8.3	(0.9)	0.0	(0.9)
Net Revenue Surplus / (Deficit) Incl PSF, MRET and Exceptional Items	0.0	0.8	(0.7)	0.0	(0.7)	2.2	4.2	(2.0)	0.0	(2.0)

Key messages:

The Trust position before exceptional items was £1.7m adverse to plan in the month, the Trust released £1.7m remaining old year provisions to help mitigate other budget pressures.

Income:

Income YTD net of pass-through related costs and exceptional items is £5.3m adverse to plan. The main pressures relate to under delivery of Private Patient income (£2.3m) and slippage within Cancer and RTT recovery plan funding (£3m).

Expenditure:

Expenditure budgets net of pass-through and exceptional items are £0.9m favourable, the key favourable variances relate to: release of reserves (£4m), underspends relating to Cancer recovery plans (£0.7m), and Private Patient activity underperformance (£0.9m). The key pressures within expenditure budgets relate to Medical Staffing (£1.9m), CIP slippage (£1m), Nursing overspend (£0.6m) and drug overspend (£0.8m).

Reserves: The Trust has released £4m of reserves held to offset YTD pressures and has issued reserves to fund agreed business cases. The Trust has now fully committed its contingency reserves and therefore any net developments requiring investment will need to be offset by additional savings.

PSF: The Trust delivered the pre PSF plan in November but did not recover the overspend in October therefore the Trust was not eligible for PSF funding (£0.7m in month, £1.5m YTD). The Trust will be able to deliver the PSF for quarter 3 if the overspend (£0.5m) is recovered in December.

2a. Income & Expenditure

Income & Expenditure November 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	31.2	32.2	(0.9)	0.0	(0.9)	257.9	260.4	(2.5)	0.0	(2.5)	390.1	390.0	0.1
High Cost Drugs and Devices	3.9	3.7	0.2	0.2	0.1	31.4	30.3	1.2	1.2	(0.1)	45.2	45.2	0.0
Total Clinical Income	35.2	35.9	(0.7)	0.2	(0.9)	289.4	290.7	(1.3)	1.2	(2.6)	435.2	435.1	0.1
PSF and MRET	0.5	1.3	(0.8)	0.0	(0.8)	7.4	8.3	(0.9)	0.0	(0.9)	14.4	13.8	0.6
Other Operating Income	4.0	4.1	(0.1)	0.1	(0.2)	33.4	35.6	(2.3)	(0.2)	(2.1)	48.4	52.0	(3.7)
Total Revenue	39.7	41.2	(1.5)	0.3	(1.8)	330.1	334.7	(4.5)	1.0	(5.6)	498.0	501.0	(3.0)
Substantive	(20.4)	(21.4)	1.0	(0.0)	1.0	(158.7)	(168.2)	9.5	0.4	9.0	(241.4)	(254.1)	12.7
Bank	(1.3)	(0.8)	(0.5)	0.0	(0.5)	(9.9)	(6.8)	(3.1)	0.0	(3.1)	(14.5)	(10.2)	(4.3)
Locum	(1.2)	(0.7)	(0.5)	0.0	(0.5)	(7.6)	(5.9)	(1.7)	0.0	(1.7)	(12.0)	(8.4)	(3.7)
Agency	(1.1)	(1.0)	(0.1)	0.0	(0.1)	(13.0)	(10.6)	(2.4)	0.3	(2.7)	(17.8)	(15.5)	(2.4)
Pay Reserves	0.6	(0.1)	0.7	0.0	0.7	(0.1)	(1.7)	1.6	0.0	1.6	(0.5)	(2.0)	1.6
Total Pay	(23.3)	(23.9)	0.6	(0.0)	0.6	(189.3)	(193.1)	3.8	0.7	3.1	(286.2)	(290.1)	3.9
Drugs & Medical Gases	(4.7)	(4.3)	(0.4)	(0.2)	(0.2)	(36.5)	(34.2)	(2.2)	(1.5)	(0.7)	(54.2)	(51.4)	(2.8)
Blood	(0.2)	(0.2)	(0.0)	0.0	(0.0)	(1.6)	(1.5)	(0.1)	0.0	(0.1)	(2.3)	(2.2)	(0.1)
Supplies & Services - Clinical	(2.9)	(2.8)	(0.0)	0.0	(0.1)	(22.4)	(22.7)	0.3	0.3	0.0	(33.3)	(33.9)	0.7
Supplies & Services - General	(0.5)	(0.4)	(0.1)	(0.0)	(0.1)	(3.5)	(3.5)	0.0	(0.0)	0.0	(5.2)	(5.3)	0.2
Services from Other NHS Bodies	(0.6)	(0.5)	(0.1)	(0.0)	(0.1)	(5.6)	(5.7)	0.1	0.6	(0.4)	(7.8)	(7.5)	(0.3)
Purchase of Healthcare from Non-NHS	(1.1)	(0.3)	(0.9)	(0.0)	(0.8)	(10.6)	(7.0)	(3.6)	(0.1)	(3.5)	(14.8)	(8.7)	(6.1)
Clinical Negligence	(1.5)	(1.5)	(0.0)	0.0	(0.0)	(11.7)	(11.7)	0.0	0.0	0.0	(17.6)	(17.6)	0.0
Establishment	(0.4)	(0.3)	(0.1)	0.0	(0.1)	(2.4)	(2.2)	(0.2)	0.0	(0.2)	(3.5)	(3.4)	(0.2)
Premises	(1.9)	(2.2)	0.3	(0.0)	0.3	(16.9)	(16.8)	(0.1)	0.1	(0.2)	(26.4)	(26.0)	(0.4)
Transport	(0.1)	(0.1)	0.0	(0.0)	0.0	(1.0)	(1.1)	0.0	(0.0)	0.0	(1.6)	(1.6)	0.0
Other Non-Pay Costs	(0.6)	(0.8)	0.3	(0.0)	0.3	(6.2)	(5.4)	(0.7)	(1.1)	0.4	(8.0)	(7.2)	(0.8)
Non-Pay Reserves	0.5	(0.6)	1.0	0.0	1.0	0.4	(4.9)	5.3	0.0	5.3	0.4	(8.2)	8.6
Total Non Pay	(13.9)	(14.0)	0.1	(0.3)	0.3	(117.9)	(116.8)	(1.1)	(1.7)	0.7	(174.2)	(173.1)	(1.1)
Total Expenditure	(37.2)	(37.9)	0.7	(0.3)	0.9	(307.2)	(309.9)	2.7	(1.0)	3.7	(460.4)	(463.2)	2.8
EBITDA	2.5	3.4	(0.9)	0.0	(0.9)	23.0	24.8	(1.8)	0.0	(1.8)	37.6	37.8	(0.2)
	0.0	0.0	0.0	%		7.0%	7.4%	40.2%	0.0%	32.8%	7.5%	7.5%	7.8%
Depreciation	(1.0)	(1.1)	0.1	0.0	0.1	(8.7)	(8.9)	0.2	0.0	0.2	(13.1)	(13.5)	0.4
Interest	(0.1)	(0.1)	0.0	0.0	0.0	(0.9)	(1.1)	0.1	0.0	0.1	(1.4)	(1.6)	0.2
Dividend	(0.1)	(0.1)	0.0	0.0	0	(1.1)	(1.1)	0	0.0	0	(1.6)	(1.6)	0
PFI and Impairments	(1.2)	(1.2)	0.0	0.0	0.0	(9.6)	(9.9)	0.2	0.0	0.2	(15.4)	(15.4)	0.0
Total Finance Costs	(2.5)	(2.6)	0.1	0.0	0.1	(20.4)	(20.9)	0.6	0	0.6	(31.4)	(32.0)	0.6
Net Surplus / Deficit (-)	(0.0)	0.8	(0.8)	0.0	(0.8)	2.6	3.9	(1.2)	0.0	(1.2)	6.2	5.8	0.4
Technical Adjustments	0.0	0.0	0.0	0.0	0.0	(0.4)	0.4	(0.7)	0.0	(0.7)	0.7	1.1	(0.3)
Surplus/ Deficit (-) to B/E Duty Incl PSF and MRET	0.0	0.8	(0.7)	0.0	(0.7)	2.2	4.2	(2.0)	0.0	(2.0)	6.9	6.9	0.0
Surplus/ Deficit (-) to B/E Duty Excl PSF and MRET	(0.5)	(0.5)	0.0	0.0	0.0	(4.6)	(4.1)	(0.5)	0.0	(0.5)	(7.0)	(7.0)	0.0

Commentary

The Trust was breakeven in November which was £0.7m adverse to plan. The Trust delivered the pre PSF plan in November but did not recover the overspend in October therefore the Trust was not eligible for PSF funding (£0.7m in month). The Trust will be able to deliver the PSF for quarter 3 if the overspend (£0.5m) is recovered in December.

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 November by £0.9m and adverse to plan £2.5m year to date. The key favourable variances are in A&E (£0.4m) and Electives (£0.3m) offset by Day Cases (£0.2m) Oncology Fractions (£0.2m), Adult Critical Care (£0.2m) and the AIC adjustment (£0.6m).

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 £0.2m adverse to plan in November by £0.2m. The main pressures in month were Private Patient Unit activity below planned levels (£0.3m) partly offset by £0.1m Education and Research income over performance.

Pay budgets adjusted for pass-through items and release of reserves/old year provisions overspent by £0.1m in November. The key overspends in the month were within Medical staffing (£0.3m) and Nursing (£0.2m) due to high level of temporary staffing usage. The pressure within Nursing and Medical staffing is predominantly within the Medical and Emergency division.

Non Pay budgets adjusted for pass through items and release of reserves / old year provisions overspent by £0.7m in November. The main pressure related to higher than planned outsourcing costs relating to patient choice activity (£0.8m).

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)

		Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Change between Months
Revenue	Clinical Income	35.5	33.1	32.4	30.6	34.5	35.2	36.4	34.3	37.9	36.3	35.9	38.2	35.2	(3.0)
	STF / PSF	1.3	1.3	0.0	0.0	12.8	0.9	0.9	1.5	1.0	1.0	1.0	0.5	0.5	(0.0)
	High Cost Drugs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(0.0)
	Other Operating Income	4.1	4.3	4.7	4.4	5.3	4.1	4.1	4.6	4.5	3.9	4.1	4.2	4.0	(0.2)
	Total Revenue	40.8	38.6	37.1	35.0	52.6	40.2	41.4	40.4	43.4	41.2	41.0	42.9	39.7	(3.2)
Expenditure	Substantive	(18.9)	(18.7)	(18.8)	(18.7)	(19.9)	(20.1)	(19.5)	(19.3)	(19.7)	(19.9)	(19.6)	(20.2)	(20.4)	(0.1)
	Bank	(1.1)	(1.2)	(1.2)	(1.3)	(1.4)	(1.3)	(1.1)	(1.1)	(1.2)	(1.3)	(1.2)	(1.2)	(1.3)	(0.0)
	Locum	(0.8)	(1.0)	(0.9)	(0.7)	(1.1)	(0.8)	(0.9)	(0.9)	(0.9)	(1.0)	(1.1)	(0.8)	(1.2)	(0.3)
	Agency	(1.7)	(1.7)	(1.9)	(2.1)	(1.4)	(1.6)	(1.7)	(1.5)	(1.9)	(1.8)	(1.8)	(1.7)	(1.1)	0.6
	Pay Reserves	(0.2)	(0.2)	(0.1)	(0.2)	(0.2)	(0.3)	(0.3)	(0.3)	(0.3)	0.7	(0.1)	(0.1)	0.6	0.7
	Total Pay	(22.7)	(22.8)	(23.0)	(23.0)	(23.9)	(24.2)	(23.5)	(23.1)	(23.9)	(23.3)	(23.9)	(24.1)	(23.3)	0.7
Non-Pay	Drugs & Medical Gases	(4.8)	(4.2)	(3.9)	(4.5)	(4.5)	(4.6)	(4.6)	(4.2)	(4.7)	(4.5)	(4.4)	(4.8)	(4.7)	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	(3.0)	(3.1)	(3.0)	(2.8)	(2.7)	(2.7)	(2.7)	(2.8)	(3.0)	(2.6)	(2.8)	(2.9)	(2.9)	0.1
	Supplies & Services - General	(0.5)	(0.5)	(0.5)	(0.4)	(0.5)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.5)	(0.1)
	Services from Other NHS Bodies	(1.3)	(0.9)	(0.9)	(0.2)	(3.2)	(1.0)	(0.8)	(0.7)	(0.6)	(0.6)	(0.8)	(0.5)	(0.6)	(0.1)
	Purchase of Healthcare from Non-NHS	(0.2)	(0.3)	(0.3)	(0.4)	(0.5)	(1.5)	(1.7)	(1.6)	(1.2)	(1.2)	(1.1)	(1.1)	(1.1)	(0.0)
	Clinical Negligence	(1.3)	(1.5)	(1.5)	(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)	(0.2)	(0.2)	(0.3)	(0.3)	(0.3)	(0.3)	(0.4)	(0.3)	(0.4)	(0.1)
	Premises	(1.5)	(1.8)	(2.6)	(1.9)	(2.3)	(2.3)	(2.2)	(2.4)	(1.9)	(2.1)	(1.9)	(2.2)	(1.9)	0.3
	Transport	(0.1)	(0.1)	(0.2)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	0.0
	Other Non-Pay Costs	(0.4)	(0.3)	(1.0)	(1.5)	1.8	(0.5)	(0.5)	(0.7)	(1.2)	(1.0)	(1.0)	(0.7)	(0.6)	0.1
	Non-Pay Reserves	0.0	0.0	0.0	0.0	0.0	(0.5)	(0.4)	(0.4)	0.7	0.1	0.4	0.0	0.5	0.5
	Total Non Pay	(13.6)	(13.2)	(14.3)	(13.9)	(14.0)	(15.4)	(15.4)	(15.4)	(14.3)	(14.4)	(14.3)	(14.8)	(13.9)	0.9
	Total Expenditure	(36.3)	(36.0)	(37.3)	(36.9)	(38.0)	(39.6)	(38.9)	(38.5)	(38.3)	(37.7)	(38.1)	(38.8)	(37.2)	1.6
EBITDA	EBITDA	4.5	2.6	(0.1)	(1.9)	14.7	0.5	2.5	1.9	5.1	3.6	2.8	4.1	2.5	(1.6)
Other Finance Costs	Depreciation	11%	7%	0%	-6%	28%	1%	6%	5%	12%	9%	7%	9%	6%	
	Interest	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.0)	(1.1)	(1.0)	0.1
	Dividend	(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
	PFI and Impairments	(0.1)	(0.1)	(0.1)	(0.1)	0.5	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	0.0
	Total Other Finance Costs	(1.2)	(1.2)	(1.2)	2.7	7.9	(1.2)	(1.2)	(1.2)	(1.2)	(1.2)	(1.2)	(1.3)	(1.2)	0.1
Net Surplus / Deficit (-)	Net Surplus / Deficit (-)	2.0	0.1	(2.6)	(0.5)	21.9	(2.0)	(0.1)	(0.7)	2.5	1.0	0.5	1.4	(0.0)	(1.4)
Technical Adjustments	Technical Adjustments	0.0	0.0	0.0	0.0	(0.2)	0.0	0.0	(0.6)	0.0	0.0	(0.0)	0.1	0.0	(0.1)
Surplus/ Deficit (-) to B/E Duty Incl pSF	Surplus/ Deficit (-) to B/E Duty	2.0	0.1	(2.6)	(0.5)	21.7	(2.0)	(0.1)	(1.3)	2.6	1.0	0.4	1.5	0.0	(1.5)
Surplus/ Deficit (-) to B/E Duty Excl STF	Surplus/ Deficit (-) to B/E Duty	0.8	(1.1)	(2.6)	(0.5)	8.9	(2.9)	(1.0)	(2.8)	1.5	0.0	(0.6)	1.0	(0.5)	(1.5)

3a. Cost Improvement Plan

Savings by Division

	Current Month		
	Actual	Original Plan	Variance
	£m	£m	£m
Cancer Services	0.08	0.13	(0.05)
Diagnostics and Clinical Support	0.37	0.25	0.12
Medicine and Emergency Care	0.44	0.52	(0.07)
Surgery	0.38	0.67	(0.29)
Women's, Children's and Sexual Health	0.19	0.21	(0.01)
Estates and Facilities	0.12	0.17	(0.05)
Corporate	0.11	0.18	(0.06)
Total	1.70	2.12	(0.42)
Internal Savings Plan stretch	0.11	(0.01)	0.12
Total	1.81	2.11	(0.30)

Savings by Subjective Category

	Current Month		
	Actual	Original Plan	Variance
	£m	£m	£m
Pay	0.81	0.47	0.34
Non Pay	(0.29)	0.38	(0.67)
Income	1.29	1.25	0.04
Total	1.81	2.11	(0.30)

Savings by NHSI RAG

	Current Month		
	Actual	Original Plan	Variance
	£m	£m	£m
Green	1.30	1.38	(0.08)
Amber	0.33	0.25	0.08
Red	0.19	0.48	(0.29)
Total	1.81	2.11	(0.30)

Year to Date

	Actual	Original Plan	Variance
	£m	£m	£m
	£m	£m	£m
Cancer Services	0.78	0.97	(0.20)
Diagnostics and Clinical Support	2.19	2.12	0.06
Medicine and Emergency Care	2.65	3.44	(0.80)
Surgery	3.16	5.48	(2.32)
Women's, Children's and Sexual Health	1.66	1.68	(0.02)
Estates and Facilities	1.23	1.74	(0.51)
Corporate	0.98	1.38	(0.39)
Total	12.65	16.82	(4.16)
Internal Savings Plan stretch	1.93	(2.74)	4.67
Total	14.59	14.08	0.51

Year to Date

	Actual	Original Plan	Variance
	£m	£m	£m
	£m	£m	£m
Pay	4.80	2.76	2.04
Non Pay	(0.84)	1.13	(1.97)
Income	10.63	10.19	0.44
Total	14.59	14.08	0.51

Year to Date

	Actual	Original Plan	Variance
	£m	£m	£m
	£m	£m	£m
Green	11.53	10.17	1.36
Amber	2.39	1.67	0.72
Red	0.67	2.24	(1.57)
Total	14.59	14.08	0.51

Forecast (Risk Adjusted)

Forecast	Additional Savings	Revised Forecast	Original Plan	Variance
	£m	£m	£m	£m
	£m	£m	£m	£m
Cancer Services	1.08	0.04	1.11	1.45
Diagnostics and Clinical Support	2.95	0.08	3.03	3.11
Medicine and Emergency Care	4.43	0.14	4.57	5.46
Surgery	5.23	0.20	5.43	8.15
Women's, Children's and Sexual Health	2.41	0.06	2.48	2.56
Estates and Facilities	1.88	0.06	1.93	2.30
Corporate	1.33	0.05	1.38	2.09
Total	19.30	0.63	19.93	25.12
Internal Savings Plan stretch	2.40		2.40	(2.79)
Total	21.70	0.63	22.33	0.0

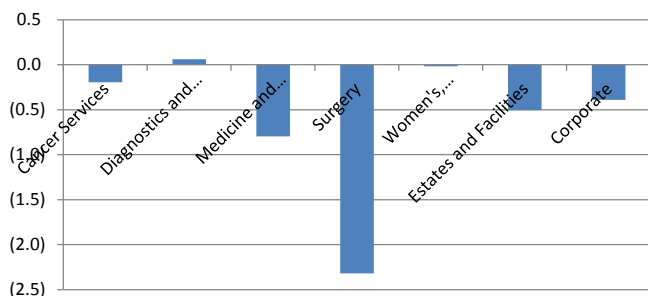
Forecast (Risk Adjusted)

Forecast	Additional Savings	Revised Forecast	Original Plan	Variance
	£m	£m	£m	£m
	£m	£m	£m	£m
Pay	7.15	0.13	7.28	4.58
Non Pay	(1.23)	0.07	(1.16)	2.54
Income	15.78	0.43	16.21	15.20
Total	21.70	0.63	22.33	0.00

Forecast (Risk Adjusted)

Forecast	Additional Savings	Revised Forecast	Original Plan	Variance
	£m	£m	£m	£m
	£m	£m	£m	£m
Green	16.19		16.19	14.33
Amber	3.86		3.86	3.08
Red	1.65	0.63	2.28	4.92
Total	21.70	0.63	22.33	0.00

YTD Month Variance £m



Comment

The Trust was adverse to plan in the month by £0.3m which was mainly relating to slippage within Operational efficiency (£0.5m) partly offset by over performance in workforce (£0.3m).

The Trust is £0.5m favourable YTD which is mainly due to over performance within workforce savings (£2.4m) and Best use of Resources (£0.5m) offset by slippage within patient flow (£2.4m).

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

The divisions are currently forecasting to deliver £21.7m savings in 2019/20 which is £3.4m short of the internal stretch target of £25.1m and £0.6m short of the internal savings target.

The Divisions CIP forecast is an improvement of £0.4m compared to last months forecast. This is mainly due to £0.5m increase in additional workforce savings mainly within Cancer (£0.3m) and Diagnostics (£0.2m) partly offset by £0.1m reduction associated with Prime Provider CIP to reflect the higher than planned costs for November.

4a. Year End Forecast Run Rate £m

Year End Forecast November 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	38.2	35.2	35.3	37.1	34.5	37.0	433.3	435.1	(1.8)
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	0.1	0.1	0.1	0.2	0.2	0.2	1.7	5.1	(3.4)
Other Operating Income	4.0	4.0	4.4	4.4	3.8	3.9	4.1	3.9	3.6	3.6	3.6	3.6	46.7	47.0	(0.3)
Total Revenue	40.2	41.4	40.4	43.4	41.2	41.0	42.9	39.7	39.5	41.3	38.8	41.4	491.1	501.1	(10.0)
Substantive	(20.1)	(19.5)	(19.3)	(19.7)	(19.9)	(19.6)	(20.2)	(20.4)	(21.1)	(21.1)	(21.3)	(21.7)	(243.9)	(254.2)	10.3
Bank	(1.3)	(1.1)	(1.1)	(1.2)	(1.3)	(1.2)	(1.2)	(1.3)	(1.2)	(1.2)	(1.2)	(1.2)	(14.7)	(10.2)	(4.5)
Locum	(0.8)	(0.9)	(0.9)	(0.9)	(1.0)	(1.1)	(0.8)	(1.2)	(1.2)	(1.2)	(1.1)	(1.1)	(12.2)	(8.4)	(3.8)
Agency	(1.6)	(1.7)	(1.5)	(1.9)	(1.8)	(1.8)	(1.7)	(1.1)	(1.5)	(1.4)	(1.3)	(0.9)	(18.0)	(15.6)	(2.5)
Pay Reserves	(0.3)	(0.3)	(0.3)	(0.3)	0.7	(0.1)	(0.1)	0.6	(0.1)	(0.1)	(0.1)	(0.1)	(0.5)	(2.0)	1.6
Total Pay	(24.2)	(23.5)	(23.1)	(23.9)	(23.3)	(23.9)	(24.1)	(23.3)	(25.0)	(25.0)	(25.0)	(24.9)	(289.2)	(290.3)	1.1
Drugs & Medical Gases	(4.6)	(4.6)	(4.2)	(4.7)	(4.5)	(4.4)	(4.8)	(4.7)	(4.6)	(4.6)	(4.6)	(4.6)	(54.7)	(51.4)	(3.3)
Clinical Supplies	(3.2)	(3.1)	(3.2)	(3.5)	(3.0)	(3.2)	(3.4)	(3.4)	(3.2)	(3.2)	(3.2)	(3.3)	(38.9)	(39.3)	0.4
Purchase of Healthcare from Non-NHS	(1.5)	(1.7)	(1.6)	(1.2)	(1.2)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(14.9)	(8.7)	(6.2)
Other Non-Pay Costs	(5.6)	(5.6)	(5.9)	(5.7)	(5.8)	(5.9)	(5.5)	(5.2)	(5.9)	(6.0)	(5.9)	(5.6)	(68.8)	(67.1)	(1.7)
Non-Pay Reserves	(0.5)	(0.4)	(0.4)	0.7	0.1	0.4	0	0.5	0.0	0.0	0.0	0.0	0.4	(6.5)	6.9
Total Non Pay	(15.4)	(15.4)	(15.4)	(14.3)	(14.4)	(14.3)	(14.8)	(13.9)	(14.8)	(14.9)	(14.7)	(14.5)	(176.9)	(172.9)	(3.9)
Other Finance Costs	(2.6)	(2.6)	(2.5)	(2.6)	(2.6)	(2.4)	(2.6)	(2.5)	(2.6)	(2.6)	(2.6)	(3.4)	(31.4)	(32.0)	0.6
Technical Adjustments	0.0	0.0	(0.6)	0.0	0.0	(0.0)	0.1	0.0	0.0	0.0	0.0	1.0	0.7	1.1	(0.4)
Surplus/ Deficit (-) to B/E Duty	(2.0)	(0.1)	(1.3)	2.6	1.0	0.4	1.5	0.0	(2.9)	(1.1)	(3.5)	(0.4)	(5.6)	6.9	(12.5)
Surplus/ Deficit (-) to B/E Duty Excl PSF	(2.9)	(1.0)	(2.2)	1.5	0.0	(0.6)	1.0	(0.5)	(3.4)	(1.6)	(4.0)	(0.9)	(14.5)	(7.0)	(7.5)
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	0	2.6	1.6	1.6	1.6	7.5	0	7.5
Revised Forecast Including Mitigations	(2.9)	(1.0)	(2.2)	1.5	0.0	(0.6)	1.0	(0.5)	(0.8)	0.0	(2.3)	0.7	(7.0)	(7.0)	(0.0)
Variance by month	0.0	0.0	0.0	0.0	0.0	0.0	(0.5)	0.0	0.5	(0.3)	(0.1)	0.3			
Variance by Quarter			0.0			0.0			0.0			(0.1)			

5a. Balance Sheet

November 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	Reported	November Plan	Variance	October Reported	Full year Plan	Revised FOT
Property, Plant and Equipment (Fixed Assets)	286.7	290.9	(4.2)	287.3	307.6	309.7
Intangibles	2.4	3.0	(0.6)	2.7	2.8	2.8
PFI Lifecycle	0.0	0.0	0.0	0.0	0.0	0.0
Debtors Long Term	1.7	1.4	0.3	1.7	1.4	1.4
Total Non-Current Assets	290.8	295.3	(4.5)	291.7	311.8	313.9
Current Assets	0.0	0.0	0.0	0.0	0.0	0.0
Inventory (Stock)	8.2	7.9	0.3	7.9	7.8	7.8
Receivables (Debtors) - NHS	21.0	29.0	(8.0)	23.2	24.7	24.7
Receivables (Debtors) - Non-NHS	14.5	12.8	1.7	14.3	9.2	9.2
Cash	28.4	30.4	(2.0)	30.3	3.0	3.0
Assets Held For Sale	0.0	0.0	0.0	0.0	0.0	0.0
Total Current Assets	72.1	80.1	(8.0)	75.7	44.7	44.7
Current Liabilities						
Payables (Creditors) - NHS	(6.1)	(5.5)	(0.6)	(5.2)	(5.1)	(5.1)
Payables (Creditors) - Non-NHS	(43.3)	(40.9)	(2.4)	(44.8)	(31.2)	(32.0)
Deferred Income	(14.1)	(10.0)	(4.1)	(17.6)	(2.6)	(2.6)
Capital Loan	(2.2)	(2.2)	0.0	(2.2)	(2.2)	(2.2)
Working Capital Loan	0.0	(16.9)	16.9	0.0	(26.1)	(26.1)
Other loans	(0.4)	(0.4)	0.0	(0.4)	(0.4)	(0.4)
Borrowings - PFI	(5.4)	(5.4)	0.0	(5.4)	(5.3)	(5.3)
Provisions for Liabilities and Charges	(1.5)	(1.5)	0.0	(1.5)	(1.5)	(1.5)
Total Current Liabilities	(73.0)	(82.8)	9.8	(77.1)	(74.4)	(75.2)
Net Current Assets	(0.9)	(2.7)	1.8	(1.4)	(29.7)	(30.5)
non-current liabilities: Borrowings - PFI > 1yr	(183.5)	(183.9)	0.4	(184.0)	(182.2)	(182.2)
Capital Loans	(6.9)	(7.7)	0.8	(6.9)	(6.6)	(6.2)
Working Capital Facility & Revenue loans	(26.3)	(26.2)	(0.1)	(26.2)	0.0	0.0
Other loans	(1.3)	(1.3)	0.0	(1.3)	(1.3)	(1.3)
Provisions for Liabilities and Charges- Long term	(1.0)	(1.0)	0.0	(1.0)	(1.0)	(1.0)
Total Assets Employed	70.9	72.5	(1.6)	70.9	91.0	92.7
Financed By:						
Capital & Reserves						
Public dividend capital	211.8	211.8	0.0	211.8	213.2	215.2
Revaluation reserve	31.8	31.8	0.0	31.8	46.2	46.2
Retained Earnings Reserve	(172.7)	(171.1)	(1.6)	(172.7)	(168.4)	(168.7)
Total Capital & Reserves	70.9	72.5	(1.6)	70.9	91.0	92.7

Commentary:

The overall working capital within the month results in a decrease in Debtors of £6.3m against plan with an increase in creditors of £8.6m compared to the revised plan submitted in May. The cash balance held at the end of the month is lower than the plan by £2m.

Non-Current Assets -

Capital additions for 2019/20 based on the plan submitted on 15th May are £14.8m with depreciation of £13.5m. Included within the capital additions are £0.4m donated assets. The planned spend for November was £2.4m with actual spend of £0.3m.

Current Assets -

Inventory of £8.2m is in-line with the planned value of £7.9m. The main stock balances are pharmacy £2.8m, TWH theatres £1.4m, Materials Management £1m and Cardiology £1m.
 NHS Receivables have decreased from October's position by £2.2m to £21m. Of the £21m reported balance, £9.2m relates to invoiced debt of which £2.5m is aged debt over 90 days. Invoiced debt over 90 days has increased by £0.4m from the reported October position of £2.5m. The remaining £11.8m 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 £0.2m to £14.5m from the reported October position of £14.3m. Included within the £14.5m balance is trade invoiced debt of £2.1m and private patient invoiced debt of £1m. Also included within the £14.5m are prepayments and accrued income totalling £9.6m. Prepayments primarily relate to rates & annual service maintenance contracts, which will reduce throughout the year as they are expensed.

The closing cash balance at the end of November 2019 was £28.4m which is slightly lower than plan of £30.4m. Within the original cash plan for November the Trust was expecting £2m from NHSI relating to qtr 3 PFI support funding, this has been received in December.

In December the Trust received confirmation from NHSI that the proceeds from the asset sales in 2018/19 which have been carried forward can now be used to fund capital projects. The cash release against these projects has been built in from January to March.

The Trust is using the cash forecast to invest available funds weekly in the National Loans Funds which currently earns an interest rate of 0.70% compared to the RBS rate of 0.64%.

Current Liabilities -

NHS payables have increased from October's reported balance by £0.9m to £6.1m. Non-NHS trade payables have remained the same at £43.3m giving a combined payables balance of £49.4m.

Of the £49.4m combined payables balances, £10.8m relates to actual invoices of which £5m are approved for payment and will be released when they fall due, the remaining balance of payables of £38.6m relates to uninvoiced accruals.

The Balance of £5m approved invoices at the end of November shows 96% are within 0-30 days outstanding.

Deferred income of £14.1m primarily is in relation to £8.4m advance contract payment received from WKCCG, Health Education England mth 9 funding £1m and NHSE £0.6m.

Non current liabilities:

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.

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.

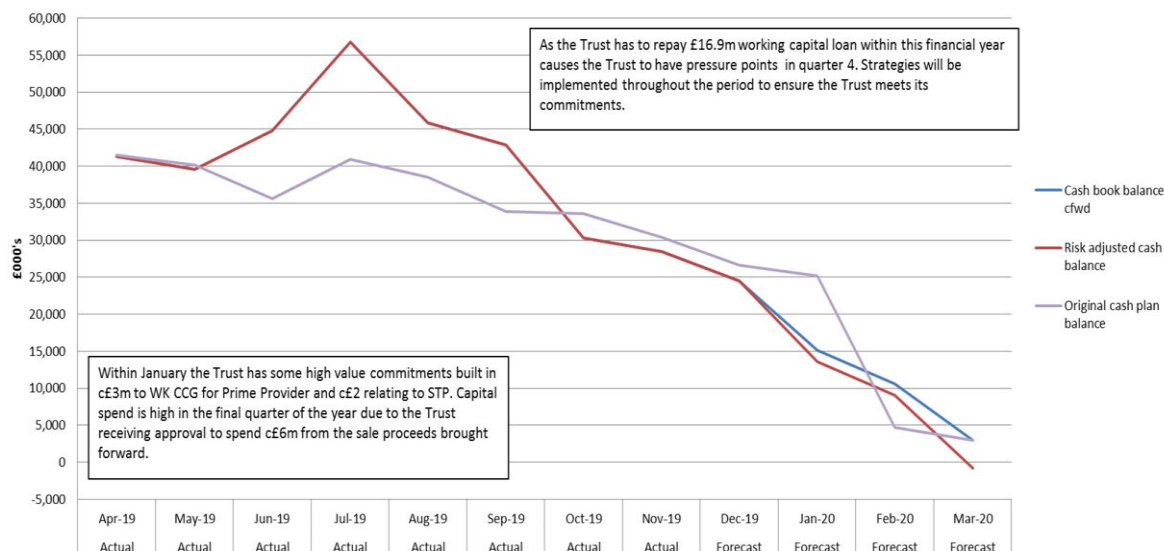
Forecast outturn:

The public dividend capital increases by the end of the financial year by £3.4m. £1.3m is in relation to ICT - EPMA project and £2.1m for Diagnostic funding to purchase an MRI and 2 CT scanners, the funding for both the projects are 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 buildings and land assets totalling £14.4m.

5b. Cash Flow

Risk adjusted cash flow 2019/20



Information on loans:

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 investment loan

Capital investment loan	2.02%	12.000	1.20	0.06	15/09/2020
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
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Commentary

The blue line shows the Trust's cash position for 2019/20 and the purple line shows the original plan values. The red risk adjusted line shows the position if the relevant risk items are not received.

The cash balance of £28.4m is lower than the plan of £30.4m. The cash flow original plan is based on the I&E original plan, during the year as the I&E forecast position gets revised the cash flow forecast also gets revised. There are differences between the I&E and the cash flow, where the I&E can spread costs over the life of the contract but the cash will be impacted at the time it is paid.

For the first seven months of 2019/20 the Trust had higher cash balances than the original cash plan expectation due to:
The Trust receiving £8.4m PSF bonus in July as a result of achieving the financial position in 2018/19.

The Trust has received income on a monthly basis from CCG's relating to Prime Provider contracts, however the Trust is carrying forward the cash c£3.8m as we are waiting for invoices to be received, with the main invoice of c£2m from WK CCG for May and June activity. The capital plan expected to have spent £7.3m up to the end of November but has only spent £2.8m therefore the remaining project costs have been phased over the last quarter of the financial year.

Due to the Trust having surplus cash as result of the items above, the Trust was able to repay the working capital loan earlier in the year than the plan of February - the loan was for £16.9m. The Trust has just received approval to convert the proceeds from the asset sales in 2018/19 to capital totalling £6.36m for 2019/20, with the remaining £2m being carried forward to 2020/21 as per the original plan.

The Trust is planning on delivering the agreed year-end cash limit of £3m.

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. In qtr 4 the Trust has planned to receive PDC funding of £3.37m, £1.25m relates to ICT - EPMA project and £2.1m for Diagnostic equipment. If the funding is not received the capital expenditure will not be spent.

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	2,008	441	1,567	6,588	2,550	-4,038	2,420
ICT	2,630	1,609	1,021	4,103	6,274	2,171	3,535
Equipment	2,063	150	1,913	3,163	6,139	2,976	3,287
PFI Lifecycle (IFRIC 12)	419	0	419	594	594	0	594
Donated Assets	-150	643	-793	400	900	500	935
Total Including Donated Assets	6,970	2,842	4,128	14,848	16,457	1,609	10,771
Less donated assets	150	-643	793	-400	-900	-500	0
Total Excluding Donated Assets	7,120	2,199	4,921	14,448	15,557	1,109	

The Trust's overall capital programme is forecast to outturn at £14.7m (excluding donated assets and PFI Lifecycle). This includes the use of £6.4m of asset sale funding (capital resource approved recently by DHSC); the recently notified £2.1m of national Diagnostic Funding to purchase two CT scanners, a MRI and Mammography equipment, and £1.25m of national funding for the Electronic Prescribing Medicines programme (EPMA).

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

Nov-19		DAY				NIGHT				TEMPORARY STAFFING		Bank / Agency Demand: RN/M (number of shifts)	Bank / Agency Demand: RN/M (number of shifts)comparison of previous month	WTE Temporary demand RN/M	Temporary Demand Unfilled -RM/N (number of shifts)	Temporary Demand Unfilled RM/M comparison of previous month	Overall Care Hours per pt day	Nurse Sensitive Indicators					Financial review		
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 (number of shifts)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	119.8%	71.6%	-	100.0%	96.0%	96.7%	-	-	29.4%	59.4%	126	→	8.83	13	↓	8.8	35.0%	76.2%	3	0	Increased RN fill rate supporting SPNs within the department.	134,289	136,541	(2,252)
MAIDSTONE	Cornwallis (M) - NS959	125.8%	156.0%	-	100.0%	102.4%	103.8%	-	-	34.8%	14.1%	45	↑	2.83	2	↘	6.6	18.9%	100.0%	1	0	Increased fill rate during the day to support surgical bed management / operational flow.	80,888	128,037	(47,149)
MAIDSTONE	Culpepper Ward (M) - NS551	100.6%	78.6%	-	-	101.7%	100.0%	-	-	16.8%	27.4%	62	↓	4.38	9	↗	7.5	57.9%	90.9%	1	0		113,018	106,778	6,240
MAIDSTONE	John Day Respiratory Ward (M) - NT151	101.7%	121.1%	-	-	116.0%	105.2%	-	-	33.6%	39.4%	119	→	8.07	9	↗	6.6	43.8%	92.9%	5	3	Increased fill rate at night to support enhanced care needs through the month	132,265	151,681	(19,416)
MAIDSTONE	Intensive Care (M) - NA251	98.1%	130.6%	-	-	94.3%	-	-	-	14.0%	21.4%	70	↑	4.71	4	→	26.0			0	0	Increased csw fill rate due to support escalated dependency within the month	163,371	176,078	(12,707)
MAIDSTONE	Pye Oliver (Medical) - NK259	107.4%	101.0%	-	-	100.4%	101.1%	-	-	20.2%	64.0%	97	↓	6.22	12	↓	6.0	10.9%	83.3%	4	0		119,314	112,754	6,560
MAIDSTONE	Chaucer Ward (M) - NS951	116.9%	118.4%	-	-	105.9%	126.7%	-	-	45.5%	22.6%	150	↗	9.69	34	↓	6.9	No resp	No resp	4	0	Increased fill rate to support dependency requirements on the ward	165,185	167,480	(2,295)
MAIDSTONE	Whatman Ward - NK959	88.9%	99.8%	-	100.0%	163.3%	187.0%	-	-	50.2%	38.8%	157	↗	11.23	37	↑	7.3	60.3%	93.2%	3	0		95,747	132,889	(37,142)
MAIDSTONE	Lord North Ward (M) - NF651	99.0%	106.9%	-	-	98.9%	113.3%	-	-	21.0%	4.6%	39	↓	2.73	9	↗	7.1	59.0%	91.3%	1	0	Increased CSW at night to to enhanced care needs across 8 episodes of care.	88,181	94,035	(5,854)
MAIDSTONE	Mercer Ward (M) - NJ251	108.7%	104.6%	-	100.0%	112.2%	96.7%	-	-	22.8%	63.1%	94	↘	6.17	8	↘	6.2	50.0%	100.0%	1	0		119,487	108,892	10,595
MAIDSTONE	Edith Cavell (M) - NS459	0.0%	0.0%	-	-	0.0%	0.0%	-	-	0.0%	No hours	No Demand	↓	No Demand	No Demand	↓	-	Closed	Closed	-	0		-6,836	3,726	(10,562)
MAIDSTONE	Acute Medical Unit (M) - NG551	93.3%	91.3%	-	-	147.2%	200.0%	-	-	46.0%	46.6%	167	↑	11.14	34	↓	7.7	No resp	No resp	4	0	Increased fill rate at night due to ongoing escalation	117,548	153,677	(36,129)
TWH	Ward 22 (TW) - NG332	126.1%	116.4%	-	100.0%	118.8%	116.0%	-	-	41.9%	33.9%	148	↑	10.30	37	↓	6.5	No resp	No resp	13	1	6 falls above threshold. Increased fill rates to support enhanced care requirements during the month	129,106	153,364	(24,258)
TWH	Coronary Care Unit (TW) - NP301	127.1%	78.8%	-	-	99.0%	-	-	-	38.0%	34.0%	97	↓	5.97	14	↓	11.4	54.5%	90.9%	0	0	Reduced CSW fill rate due to lack of available temporary staff for unregistered shifts.	69,979	70,921	(942)
TWH	Ward 33 (Gynae) (TW) - ND302	101.2%	99.2%	-	-	100.0%	103.3%	-	-	15.1%	12.2%	38	↓	2.29	8	↓	10.2	14.6%	100.0%	1	0	1 fall above threshold	81,468	89,405	(7,937)
TWH	Intensive Care (TW) - NA201	115.0%	100.1%	-	-	111.7%	96.7%	-	-	8.5%	0.0%	53	↑	3.53	6	↘	28.7			1	0	1 fall above threshold. Increased fill rate to support unit escalation throughout the month.	190,571	196,760	(6,189)
TWH	Acute Medical Unit (TW) - NA901	86.8%	90.0%	-	100.0%	109.9%	103.3%	-	-	35.0%	46.6%	237	↓	16.94	44	↓	7.7	9.4%	93.3%	8	2	2 falls above threshold. Reduced fill rate due to vacancies and lack of available temporary cover.	184,662	190,392	(5,730)
TWH	Surgical Assessment Unit (TW) - NE701	97.5%	85.4%	-	-	100.0%	100.0%	-	-	19.9%	2.3%	19	↘	1.21	2	↘	10.3			1	0	1 fall above threshold. Escalation throughout the month	61,157	62,731	(1,574)
TWH	Ward 32 (TW) - NG130	100.1%	104.1%	-	-	97.8%	104.4%	-	-	19.6%	23.7%	58	↑	3.74	2	↗	7.2	No resp	No resp	0	0		-7,699	-6,110	(1,589)
TWH	Ward 10 (TW) - NG131	106.8%	94.1%	-	100.0%	102.5%	140.5%	-	100.0%	37.1%	30.3%	144	↑	9.51	26	↑	11.9	No resp	No resp	0	0	Considered action to alter skill mix and increase CSW fill rate to support staffing levels.	115,442	106,636	8,806
TWH	Ward 11 Winter Escalation 2019 TW	21.3%	10.6%	-	-	18.3%	13.3%	-	-	0.0%	No hours	No Demand	↓	No Demand	No Demand	↓	0.9	No resp	No resp	3	0	Winter escalation ward opened as part of winter plan to support capacity and operational flow	119,152	134,536	(15,384)
TWH	Ward 12 (TW) - NG132	122.1%	123.5%	-	100.0%	116.7%	93.3%	-	-	32.0%	40.3%	146	↑	8.98	29	↑	7.3	20.3%	93.3%	10	0	4 falls above threshold.	124,066	137,688	(13,622)
TWH	Ward 20 (TW) - NG230	186.0%	97.4%	-	-	134.4%	100.0%	-	-	38.9%	45.5%	110	↓	7.81	9	↘	6.6	No resp	No resp	9	1	2 falls above threshold. Increased fill rate due to enhanced care needs and RMN requirements throughout the month.	112,116	135,094	(22,978)
TWH	Ward 21 (TW) - NG231	106.9%	144.3%	-	100.0%	95.3%	128.3%	-	-	31.3%	47.0%	116	↓	7.74	9	↓	6.7	21.7%	100.0%	4	1	Increased CSW fill rate due to enhanced care needs throughout the month	144,590	156,468	(11,878)
TWH	Ward 2 (TW) - NG442	115.6%	132.4%	-	100.0%	101.4%	109.4%	-	-	32.2%	42.1%	133	↑	8.58	26	↑	8.1	147.1%	88.0%	6	0	Increased fill rate to support SPN's on the ward. Bed occupancy between 26 - 30 throughout the month due to escalation	116,959	128,666	(11,707)
TWH	Ward 30 (TW) - NG330	102.1%	107.4%	-	100.0%	106.7%	100.0%	-	-	37.2%	14.7%	116	↓	7.22	27	↓	6.3	No resp	No resp	6	0	1 fall above threshold. 27 unfilled shifts however, reduction in demand for temporary staffing.	118,756	144,213	(25,457)
TWH	Ward 31 (TW) - NG331	123.8%	112.1%	-	100.0%	95.9%	101.1%	-	-	33.2%	33.2%	142	↓	8.66	15	↓	7.1	No resp	No resp	7	3	1 fall above threshold. Increased fill rate during the day to support enhanced care on 4 occasions and supporting SPN's on the ward	130,352	146,141	(15,789)
Crowborough	Crowborough Birth Centre (CBC) - NP775	95.2%	96.1%	-	-	90.6%	96.7%	-	-	18.4%	0.0%	39	↑	2.37	1	↗		81.8%	100.0%		0		67,938	68,183	(245)
TWH	Midwifery (multiple rosters)	91.6%	56.4%	-	-	96.1%	72.0%	-	-	15.1%	8.9%	481	↓	27.57	39	↓	20.6	12.0%	98.2%	0	0		686,082	709,537	(23,455)
TWH	Hedgehog Ward (TW) - ND702	99.1%	74.6%	-	-	104.0%	-	-	-	38.5%	52.5%	212	↑	13.81	18	↓	8.9	7.6%	100.0%	0	0		204,328	216,794	(12,466)
MAIDSTONE	Maidstone Birth Centre - NP751	100.1%	89.9%	-	-	98.5%	100.9%	-	-	17.0%	0.0%	35	→	2.00	0	↓		112.9%	97.1%	0	0		72,476	62,288	10,189
TWH	SCBU (TW) - NA102	82.7%	321.9%	-	-	95.9%	-	-	-	15.7%	3.5%	106	↑	6.22	8	↗	13.3				0	Bed occupancy between 9 -18 during the month. Unit in black escalation across 4 recorded days, Red on 6 days and Amber across 9 days. Increased CSW fill rate as these numbers are inclusive of B4 Nursery Nurses which increase the fill rate of unregistered hours against a plan of 172.5. Roster to be realigned to reflect unregistered demand	179,169	182,391	(3,222)
MAIDSTONE	Short Stay Surgery Unit (M) - NE751	99.2%	85.8%	-	-	151.4%	-	-	-	35.6%	36.8%	66	↑	4.34	5	↗	8.0			1	0	1 fall above threshold	43,595	50,966	(7,371)
TWH	Short Stay Surgical Unit (TW) - NE901	154.9%	139.0%	-	-	169.0%	294.5%	-	-	101.3%	26.3%	167	↗	10.46	34	↑	7.0			0	0	Increased fill rate to support unit escalation throughouth the month	81,887	95,969	(14,082)
MAIDSTONE	Accident & Emergency (M) - NA351	80.8%	42.9%	-	-	102.2%	145.2%	-	-	20.4%	25.3%	204	↓	13.10	54	↓		No resp	No resp	3	0	MH - Reduced day fill rate due to vacancies and lack of available temporary staff across 54 shifts. Increased CSW fill rate at night to support department requirements.	199,253	213,451	(14,198)
TWH	Accident & Emergency (TW) - NA301	83.7%	88.2%	-	100.0%	91.4%	91.9%	-	-	40.1%	51.0%	445	↓	31.02	84	↓		4.5%	88.7%	3	0	TWH - Reduced fill rate due to vancancies and lack of available temporary staff across 84 shifts.	330,750	384,451	(53,701)
MAIDSTONE	Maidstone Orthopaedic Unit (M) - NP951	95.3%	90.8%	-	-	88.5%	-	-	-	23.3%	8.3%	44	↓	2.92	2	↘				1	0	1 fall above threshold. Ward closed over one weekend. Staff relocated to support safe staffing	43,805	47,698	(3,893)
MAIDSTONE	Foster Clarke Winter Escalation 2019	44.4%	56.7%	-	-	77.7%	58.3%	-	-	0.0%	No hours	No Demand	↓	No Demand	No Demand	↓	7.1			1	0	Winter escalation ward opened as part of winter plan to support capacity and operational flow	0	7,348	(7,348)
MAIDSTONE	Peale Ward (M) - NE959	110.8%	122.5%	-	100.0%	100.0%	96.7%	-	-	13.4%	27.6%	35	↑	2.24	4	↘	7.9	56.9%	97.6%	2	0	1 fall above threshold. Increased fill to support episode of enhanced care and to support surgical bed management.	81,233	35,905	45,328
																						Total Established Wards	5,003,650	5,394,451	(390,801)
																						Additional Capacity beds	40,411	47,128	(6,717)
																						Cath Labs	0	0	0
																						Whatman	3,112,657	2,829,947	282,710
																						Other associated nursing costs	8,156,718	8,271,526	(114,808)

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%

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

Ward name	Main 2 Specialities on each ward		Day								Night								Day				Night				Care Hours Per Patient Day (CHPPD)			
	Speciality 1	Speciality 2	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 non-registered nurses/ care staff (%)	Average fill rate registered 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
			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	1,999	2,323	1,558	1,096	0	0	226	216	1,368	1,110	660	639	0	0	0	0	118.8%	71.8%	No data	100.0%	96.0%	96.7%	No data	No data				
Coronwall	100 - GENERAL SURGERY	101 - UROLOGY	1,399	1,508	158	871	0	0	96	96	968	992	319	331	0	0	0	0	125.8%	156.0%	No data	100.0%	102.4%	103.8%	No data	No data				
Culpepper (inc) CCU	320 - CARDIOLOGY	300 - GENERAL MEDICINE	1,653	1,663	1,392	1,094	0	0	0	0	1,320	1,343	330	330	0	0	0	0	100.6%	78.0%	No data	No data	101.7%	100.0%	No data	No data				
John Day	140 - RESPIRATORY MEDICINE	340 - GENERAL MEDICINE	2,217	2,254	1,888	1,439	0	0	0	0	1,650	1,614	660	695	0	0	0	0	101.7%	121.1%	No data	No data	116.9%	105.4%	No data	No data				
Intensive Treatment Unit (ITU)	192 - CRITICAL CARE MEDICINE		3,364	3,303	455	236	0	0	0	0	2,812	2,651	0	69	0	0	0	0	98.1%	130.6%	No data	No data	94.3%	No data	No data	No data				
Pay Oliver	301 - GASTROENTEROLOGY	300 - GENERAL MEDICINE	1,572	1,688	1,464	1,478	0	0	0	0	990	994	990	1,001	0	0	0	0	107.4%	101.0%	No data	No data	100.4%	101.1%	No data	No data				
Chaucer	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1,935	2,262	1,829	2,165	0	0	0	0	1,320	1,388	990	1,254	0	0	0	0	116.9%	118.4%	No data	No data	105.9%	126.7%	No data	No data				
Lord North	170 - MEDICAL ONCOLOGY	800 - CLINICAL ONCOLOGY	1,695	1,677	606	648	0	0	0	0	1,080	1,088	960	480	0	0	0	0	90.0%	106.9%	No data	No data	98.9%	133.1%	No data	No data				
Mercer	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1,580	1,717	1,398	1,461	0	0	96	96	990	1,111	660	638	0	0	0	0	108.7%	104.6%	No data	100.0%	112.2%	96.7%	No data	No data				
Edith Cavell	300 - GENERAL MEDICINE		125	0	87	0	0	0	0	0	99	0	33	0	0	0	0	0	0.0%	0.0%	No data	No data	0.0%	0.0%	No data	No data				
Urgent Medical Admissions Unit (UMAU)	180 - ACCIDENT & EMERGENCY	300 - GENERAL MEDICINE	2,367	2,152	1,328	1,211	0	0	0	0	990	1,458	330	660	0	0	0	0	93.3%	91.3%	No data	No data	147.2%	200.0%	No data	No data				
Ward 22	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	1,566	1,974	1,496	1,742	0	0	48	48	990	1,177	1,309	1,518	0	0	0	0	126.1%	116.4%	No data	100.0%	116.8%	116.0%	No data	No data				
Connery Care Unit (CCU)	320 - CARDIOLOGY	300 - GENERAL MEDICINE	1,166	1,482	360	284	0	0	0	0	990	980	0	0	0	0	0	0	127.1%	78.8%	No data	No data	99.0%	No data	No data	No data				
Gynaecology/Ward 33	502 - GYNAECOLOGY	100 - GENERAL SURGERY	1,507	1,526	713	707	0	0	0	0	990	990	330	341	0	0	0	0	101.2%	99.2%	No data	No data	100.0%	103.1%	No data	No data				
Intensive Treatment Unit (ITU)	192 - CRITICAL CARE MEDICINE		1,285	1,779	560	360	0	0	0	0	2,429	2,937	330	319	0	0	0	0	115.0%	100.1%	No data	No data	111.7%	96.7%	No data	No data				
Medical Assessment Unit	180 - ACCIDENT & EMERGENCY	300 - GENERAL MEDICINE	1,183	2,763	1,154	1,210	0	0	161	161	2,070	2,276	1,035	1,070	0	0	0	0	88.8%	90.0%	No data	100.0%	109.9%	103.1%	No data	No data				
SAU	180 - ACCIDENT & EMERGENCY	100 - GENERAL SURGERY	1,063	1,055	867	314	0	0	0	0	660	660	330	330	0	0	0	0	97.5%	85.4%	No data	No data	100.0%	100.0%	No data	No data				
Ward 32	300 - GENERAL MEDICINE		2,065	2,068	1,437	1,495	0	0	0	0	990	968	990	1,014	0	0	0	0	100.1%	104.1%	No data	No data	97.8%	104.4%	No data	No data				
Ward 10	100 - GENERAL SURGERY		2,201	2,350	1,205	1,134	0	0	108	108	1,320	1,353	627	881	0	0	33	33	106.8%	94.1%	No data	100.0%	102.5%	140.1%	No data	100.0%				
Ward 14	100 - GENERAL SURGERY		758	385	758	80	0	0	0	0	660	123	660	80	0	0	0	0	21.3%	10.6%	No data	No data	16.3%	13.3%	No data	No data				
Ward 12	320 - CARDIOLOGY	301 - GASTROENTEROLOGY	1,965	2,400	1,446	1,787	0	0	40	40	990	1,155	1,260	1,282	0	0	0	0	122.1%	123.5%	No data	100.0%	116.7%	93.3%	No data	No data				
Ward 20	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	914	1,699	1,653	1,611	0	0	0	0	990	1,331	1,287	1,287	0	0	0	0	186.0%	97.4%	No data	No data	134.4%	100.0%	No data	No data				
Ward 21	140 - RESPIRATORY MEDICINE	302 - ENDOCRINOLOGY	2,399	2,351	954	1,377	0	0	156	156	1,650	1,579	660	847	0	0	0	0	106.9%	144.3%	No data	100.0%	95.3%	128.1%	No data	No data				
Ward 2	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1,851	2,140	1,736	2,297	0	0	36	36	988	1,002	979	1,071	0	0	0	0	115.6%	132.4%	No data	100.0%	101.4%	109.4%	No data	No data				
Ward 31	110 - TRAUMA & ORTHOPAEDICS		2,018	2,060	1,376	1,478	0	0	56	56	990	1,056	1,188	1,188	0	0	0	0	102.1%	107.4%	No data	100.0%	106.7%	100.0%	No data	No data				
Ward 30	110 - TRAUMA & ORTHOPAEDICS		1,957	2,422	1,490	1,670	0	0	188	188	1,320	1,246	990	1,001	0	0	0	0	121.8%	112.1%	No data	100.0%	95.9%	101.1%	No data	No data				
Birth Centre (Cromborough)	501 - OBSTETRICS		816	771	445	332	0	0	0	0	714	647	345	314	0	0	0	0	95.2%	96.1%	No data	No data	90.6%	96.7%	No data	No data				
Midwifery Services (with/just natal & Delivery Suite)	501 - OBSTETRICS		21,212	19,442	7,380	4,166	0	0	0	0	5,481	5,265	2,818	2,044	0	0	0	0	91.6%	56.4%	No data	No data	96.1%	72.0%	No data	No data				
Hedderley	420 - PAEDIATRICS		2,999	2,973	460	396	0	0	0	0	2,135	2,219	0	219	0	0	0	0	99.1%	74.6%	No data	No data	104.0%	No data	No data	No data				
Birth Centre	501 - OBSTETRICS		811	812	356	320	0	0	0	0	657	647	323	326	0	0	0	0	100.1%	89.9%	No data	No data	98.5%	100.9%	No data	No data				
Neonatal Unit	420 - PAEDIATRICS		4982	3,174	158	507	0	0	0	0	2,113	2,216	0	284	0	0	0	0	82.7%	121.9%	No data	No data	95.9%	No data	No data	No data				
MDU	100 - GENERAL SURGERY		1,142	1,132	947	469	0	0	0	0	491	481	0	31	0	0	0	0	99.2%	91.8%	No data	No data	111.4%	No data	No data	No data				
Peake	100 - GENERAL SURGERY		1,189	1,118	533	653	0	0	150	150	660	660	330	319	0	0	0	0	110.8%	122.5%	No data	100.0%	100.0%	96.7%	No data	No data				
SSU	100 - GENERAL SURGERY		1,127	1,746	500	695	0	0	0	0	462	781	231	480	0	0	0	0	154.9%	139.0%	No data	No data	169.0%	294.5%	No data	No data				
Whitman	100 - GENERAL MEDICINE		2,001	1,779	1,383	1,361	0	0	80	80	660	1,078	324	606	0	0	0	0	88.9%	99.8%	No data	100.0%	103.1%	187.0%	No data	No data				
MDU			913	871	759	689	0	0	0	0	660	584	0	11	0	0	0	0	95.3%	90.8%	No data	No data	88.5%	No data	No data	No data				

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST
Women's and Children's
Perinatal Mortality report
December 2019

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

Division: Women's and Children's

Specialty: Maternity

1. Introduction

All perinatal deaths are reported to MBRRACE which is a national organisation that collates information and produces reports on learning from deaths. It is the expectation that all perinatal deaths are reviewed in a multidisciplinary forum using the Perinatal Mortality Review Tool. This tool was introduced in 2018 and from December 2018, all eligible cases are reviewed using this questionnaire.

The tool supports:

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

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

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

2. Overview:

	Stillbirths	Neonatal Deaths	National SB rate per 1000	MTW SB rate	National NND rate per 1000	MTW NND rate
2017	13	8	3.74	2.97	1.67	1.82
2018	7	3				
2019	13	4				

The stillbirth rate for the UK in 2017 was 3.74 per 1,000. The rate of neonatal mortality for babies born at 24 weeks gestational age or later in the UK is 1.67 deaths per 1,000 live births.

The stillbirth rate at MTW for the 2017 was 2.97 per 1000 and 1.82 per 1000 for Neonatal Death.

There is no national data for 2018 as yet.

3. 2019 cases

Date	Case type	SI declared	PMRT COMPLETED
02/1/19	25 Stillbirth	No	complete
30/1/19	Term IUD	Yes	complete
22/2/19	26+6 IUD	No	complete
30/4/19	Term IUD at home	Yes	complete
30/4/19	Term IUD reduced FM	Yes	complete
01/5/19	22+1 NND (extreme prem)	No	complete
28/5/19	IUD 25+1	No	complete
30/5/19	IUD at 27w mother with severe morbidity	Yes	complete
13/6/19	36w IUD	No	complete
25/07/2019	22 NND extreme prem	No	complete
5/8/2019	27+4 NND/ SB	No	Under review
28/08/2019	38+1 IUD	Yes	complete
10/09/2019	38+0 IUD	No	complete
12/09/2019	31+1 IUD	No	complete
17/09/2019	34+2 stillbirth	No	complete
7/11/19	22+5 NND (extreme prem)	No	complete
29/11/19	30 stillbirth	No	Under review

4. Learning from cases

Learning	Action	Completed
To ensure that IOL is offered on the third episode of Reduced Fetal Movements	Communicate to Triage staff that Reduced Fetal movements must be recorded even though it may not be the primary reason for attending.	√
Referrals for scans and/or further investigations were not undertaken when required	There was some confusion by the community midwife as to whether mother was on a serial scan pathway or fundal height measurement pathway. Feedback has been given to the midwife.	√
A mother had pregnancy complications recognised as requiring specific birth planning advice but the advice wasn't given	Communication around birth place planning for when antibody levels are detected was not consistent. This had no impact on the outcome but the SOP says that 0.2 or above needs to be delivered in an obstetric centre. Women need to be referred to consultants for discussion if women want to deliver at the birth centre but are not suitable on the birth	√

Learning	Action	Completed
	place assessment. Send memo to community midwives and birth centre staff.	
The mother presented with reduced fetal movements and there is no evidence that during her antenatal care she had been given written information about what to do if she experienced a change in fetal movements	Communication to all community and antenatal staff to ensure that written information is given to all women at booking and documented. Documentation of fetal movements discussion at every subsequent antenatal appointment	√
The mother had a malpresentation breech or transverse lie during her pregnancy which was not managed according to national or local guidelines	Ensure midwives are clear that malpresentation at 36w requires an obstetric review.	√
Gap & Grow guidance for antenatal scanning not always followed as per guidance	Ensure there is clarity amongst all community midwives regarding timing of scans for women on the Gap and Grow pathway. Recommend the community team reviews GAP Grow guideline and ensures that their techniques meet best practice guidance Attendance at face to face Gap & Grow teaching sessions for all community midwives. Frequency of face to face sessions to be agreed with lead Gap & Grow midwives and obstetrician There is also the opportunity for E learning	√
Adequate documentation of review of ultrasound scans.	If ultrasound scans are carried out for women thought to have underlying risk factors then there needs to be clear documented evidence that there has been reviewed and any appropriate action taken. Community midwives are to ensure that there is documented evidence that scan results have been reviewed either by themselves if normal or appropriate obstetric referral if necessary.	
Apparent capacity issues in obstetric antenatal clinics and lack of clarity amongst midwives over how to escalate this if necessary	Review of process followed to obtain antenatal clinic review appointments Review of agreed process of escalation if difficulty experienced by community midwife in obtaining obstetric review appointment. Involvement of assistant General Manager in this review	
No actual documentation that fetal movements were discussed during first telephone call to Triage. Identified that workload within this clinical area may have impacted on this omission in documentation	Highlight amongst all staff the importance of accurate recording of all aspects of telephone conversations on E3 systems. Review of workload on Triage is already ongoing A review of Triage workload is already underway as a Task and Finish group as this area is often extremely busy, receiving 8000 calls per month. Processes and staffing within this area is undergoing review.	√
Distress caused by having to wait until following morning for repeat scan when this was unnecessary	Ensure all medical staff and senior midwifery staff are aware that this is not part of the process if an IUD has already been confirmed.	√

Learning	Action	Completed
	Particularly important out of normal working hours Clear communication of process to medical staff and senior midwives.	
The mother should have had an interpreter at every visit and especially at booking. However it was not clear on the referral what language was spoken by the mother and so the midwife would not have known to book one. It is unclear whether the mother understood the information about smoking cessation as she declined intervention. It is documented that she was waiting for a prescription for aspirin at 20w which suggests that she had not fully understood that process for obtaining aspirin and the importance of taking it from 12 weeks. Every effort should be made by the maternity service to ensure that an interpreter is present or that language line	Matrons to be aware of the case and cascade to teams the importance of booking a face to face interpreter. It is difficult when no language is specified on the booking however the appointment should be rebooked with an interpreter is necessary	
The mother had investigations on the antenatal ward and was discharged before the results were available. There is no pathway for ensuring the results are communicated to the woman until the next contact with a health professional who would be relied upon to look up them up.	The Antenatal ward should formulate a robust system for following up test results and communicating them to the women	

5. Summary

Families continue to be supported by the bereavement midwives. The actions from learning are tracked at a Directorate meeting and CLIPA to ensure that they are completed.

The case of the baby born on the 5th August is currently classified as a Neonatal Death/Stillbirth on the above table. The baby was born in very poor condition and was resuscitated by the Neonatal Team. There was a heartbeat for 10 minutes. The doctor declared the baby had died at 40 minutes of age. The Coroner has classified this as a Stillbirth as the post-mortem examination declared that the baby had not breathed and therefore could not be classified as a neonatal death. This is very unusual. Unfortunately this has caused much distress to the mother who desperately wanted the acknowledgment that her baby had lived. She is now contributing to a working party which is drawing up documentation on developing national guidance on signs of life.

Work has begun to embed the standards of the National Bereavement Care Pathway (NBCP) within our care of bereaved parents across the areas of A/E, Screening, Gynae, Maternity, NNU and Paediatrics. We were the first Trust to register following the pilot scheme. The aim is to improve bereavement care and reduce variability in provision for families after miscarriage, ectopic pregnancy, molar pregnancy, termination for fetal anomaly, stillbirth, neonatal death or sudden infant death. We are conducting a gap analysis to identify where areas we need to concentrate on. It is apparent that the Trust should be able to offer bereavement counselling to parents but this is not currently possible.

Quarterly mortality data

Medical Director

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

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

This report is based upon the Trust's most recent data, published by Dr Foster for the period of September 2018 to August 2019.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information, assurance and discussion

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

Mortality Surveillance Report

HSMR Current Performance

The standard HSMR calculation uses a 12 month rolling view of our performance. The latest results of this are shown below in Fig. 1. The 12 months September 2018 to August 2019 show our HSMR to be 92.7, which is an increase compared to last month's position of 92.5.

Figure 1. Rolling 12 Month view

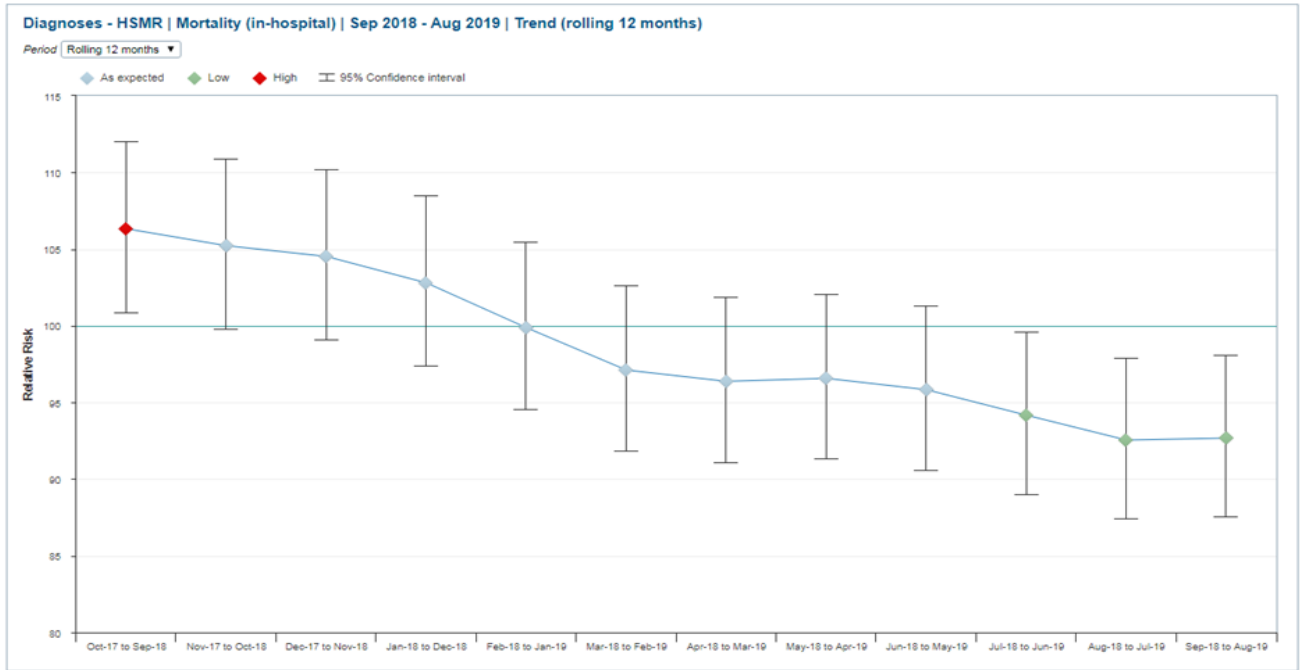
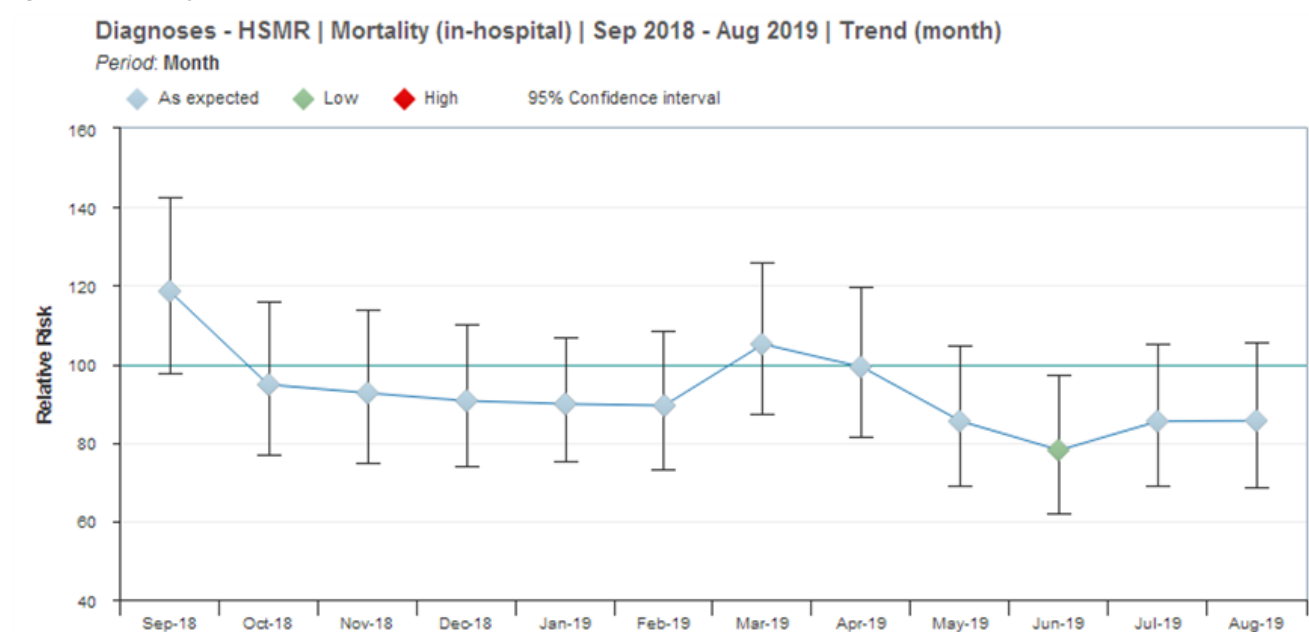


Figure 2 shows a monthly view of our HSMR performance. The latest month should be viewed with caution as this often shows a false position due to the lag in coding activity. Viewing the previous month, so July 2019 in this case, shows that the Trust's position has increased to 85.1 from 78.0 in June 2019.

Figure 2. Monthly view



Benchmarking

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

Figure 3. Benchmarking against all non-specialist trusts (September 2018 – August 2019)

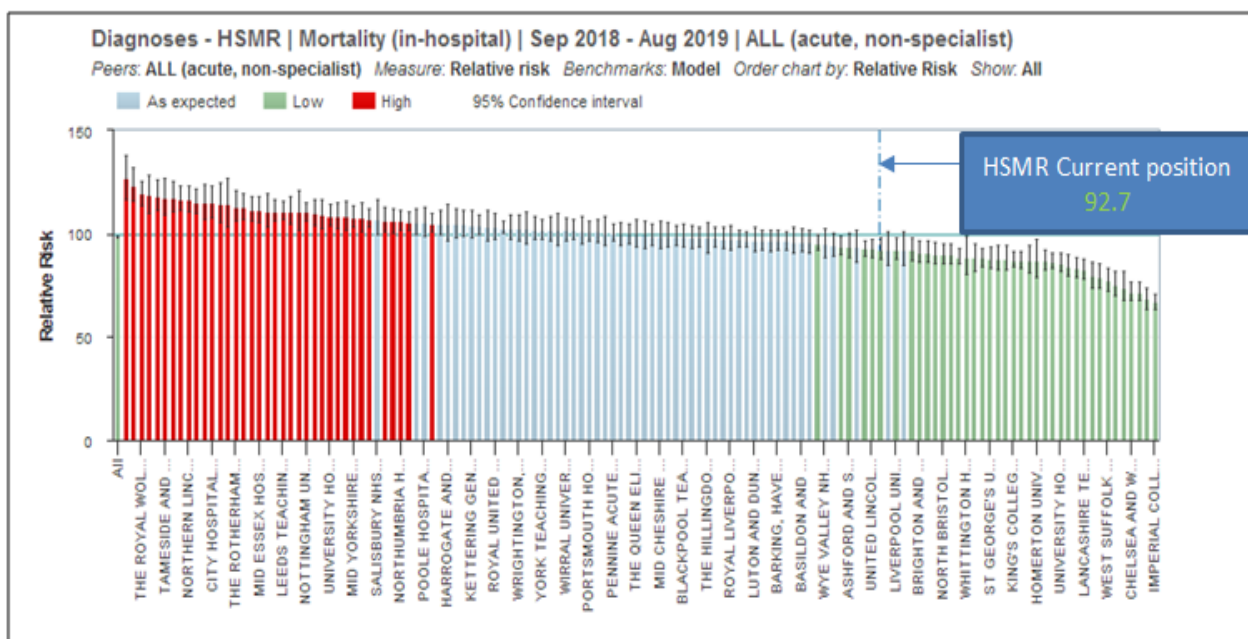
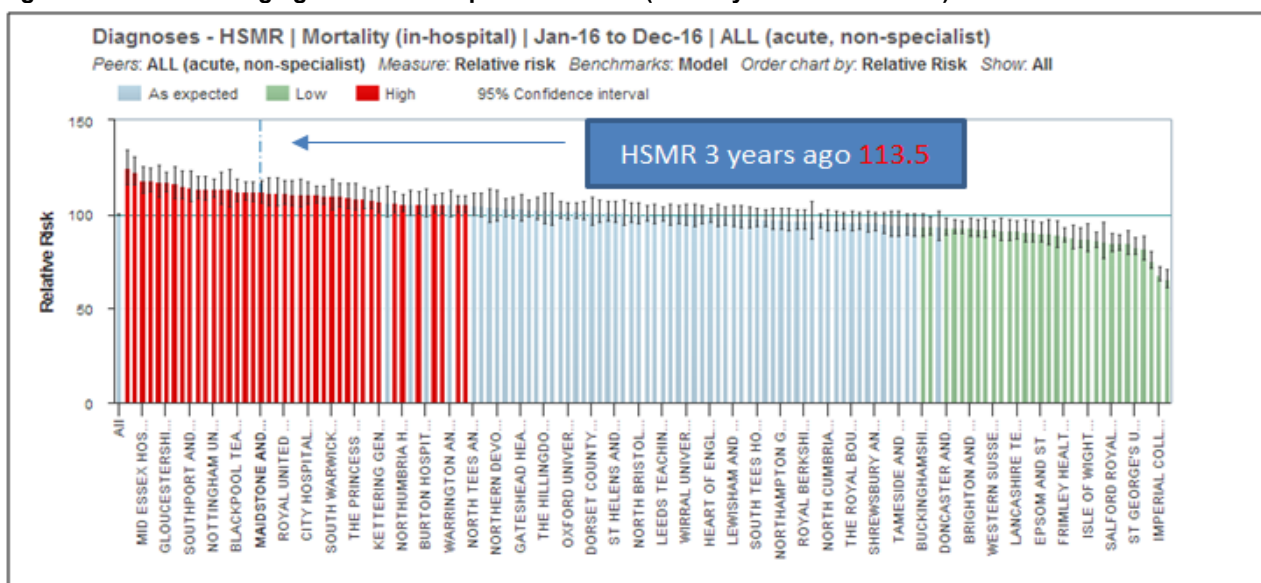


Figure 4. Benchmarking against all non-specialist trusts (January - December 2016)

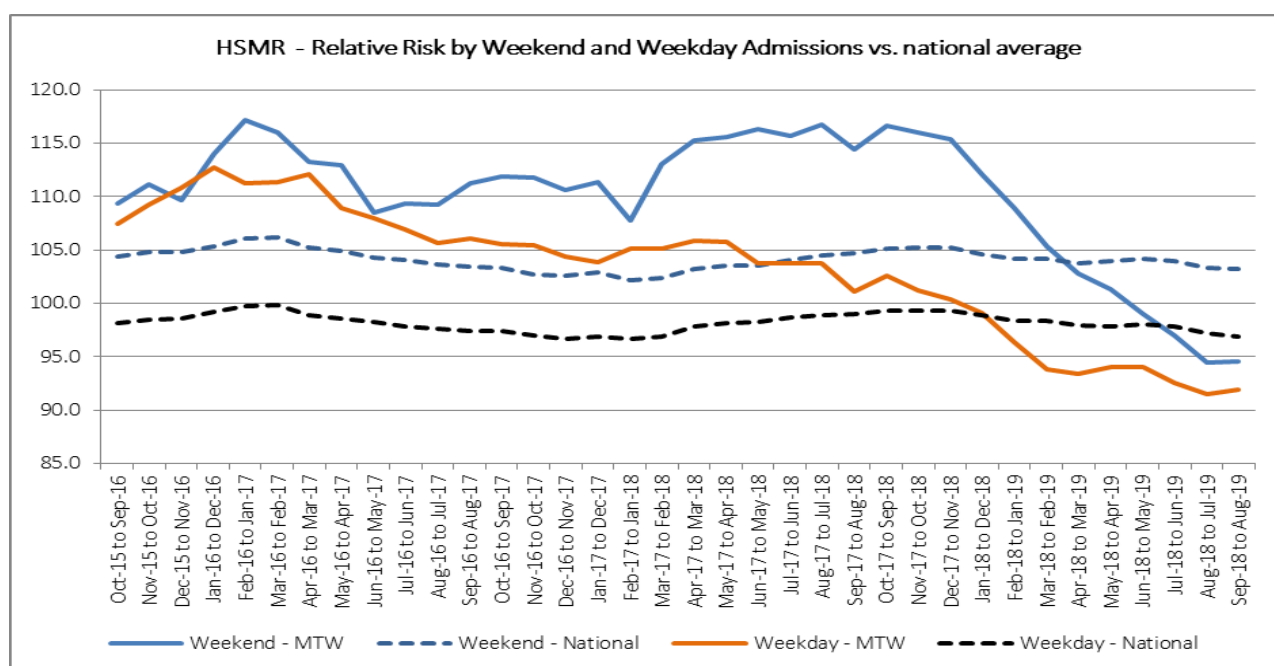


Understanding and Improving upon HSMR

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

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

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



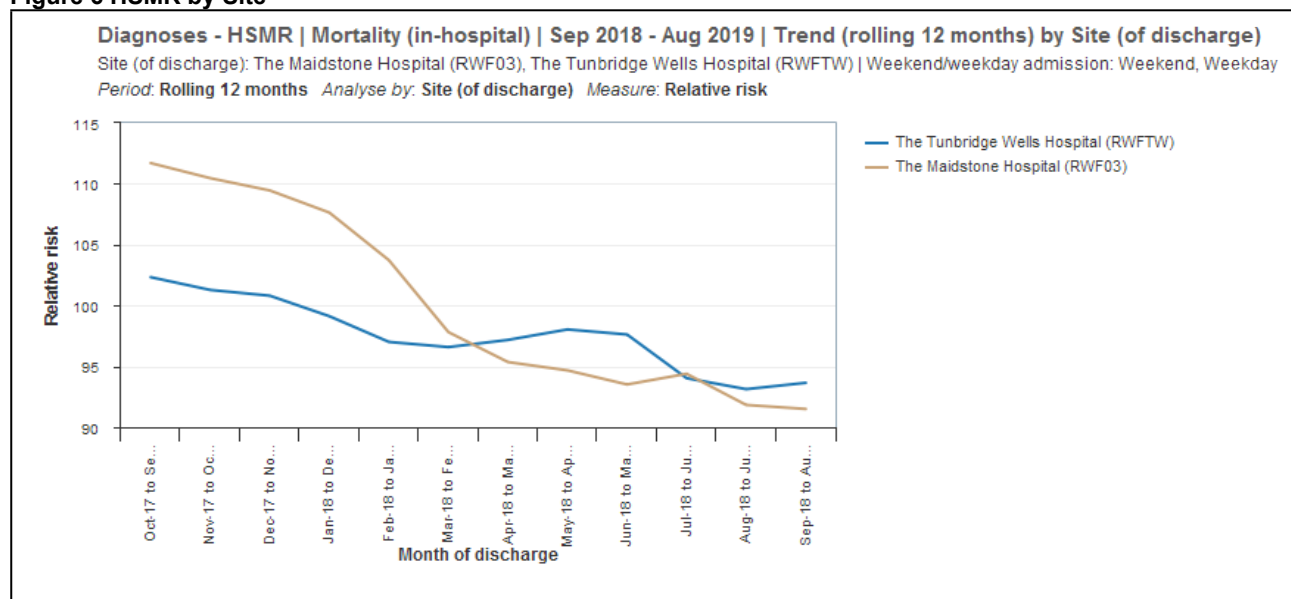
The Seven Day Services programme is focused around reducing variation in performance and mortality forms part of the scope of this work. The latest period has a HSMR of 94.6 (94.5 last month) for weekends and 91.89 (91.49 last month) for weekday admissions, both the weekday & weekend rates are significantly lower than where the Trust was at the beginning of the year.

Further investigation of the Weekday Relative Risk for the current rolling 12 month period shows Respiratory Medicine (123.3 – 165 deaths) as being ‘red’.

The site split of the Weekday deaths for September 2018 – August 2019 is Maidstone – 89.3 (no significant change from last month of 89.4) & TWH – 93.8 (an increase from 93.3 last month).

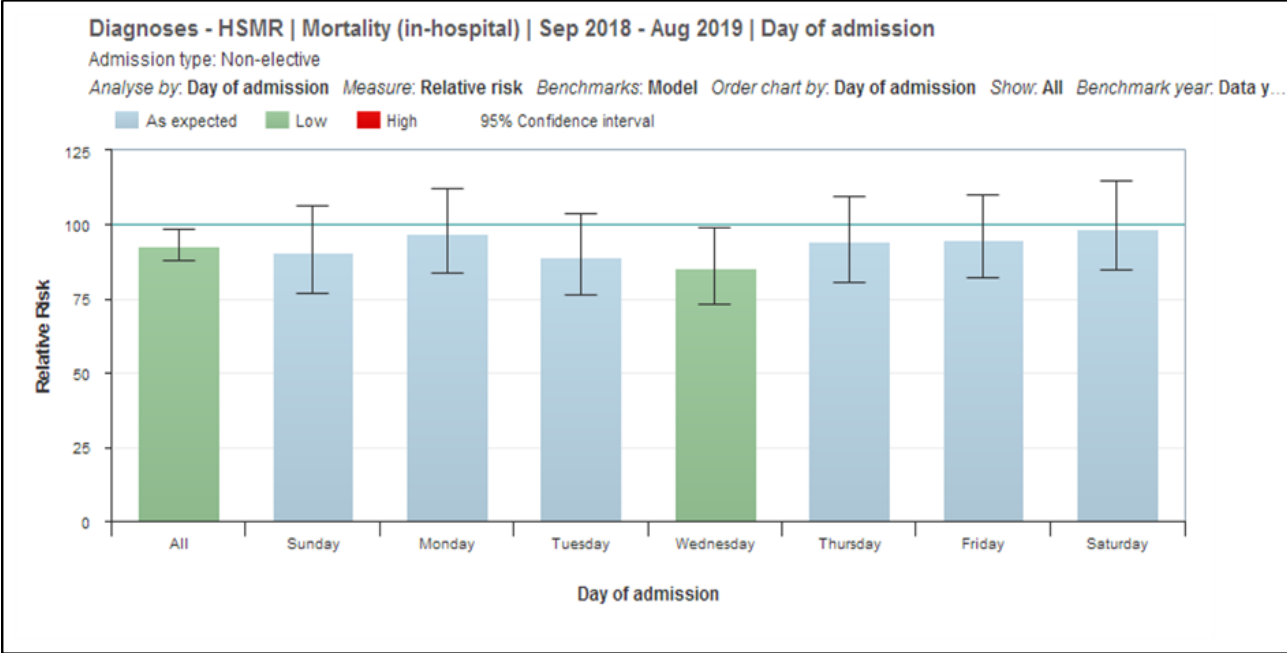
Fig. 6 shows the HSMR split by site. The HSMR at the Maidstone site has decreased to 91.5 from 91.8 last month; the Tunbridge Wells site has increased to 93.6 from 93.1 last month.

Figure 6 HSMR by Site



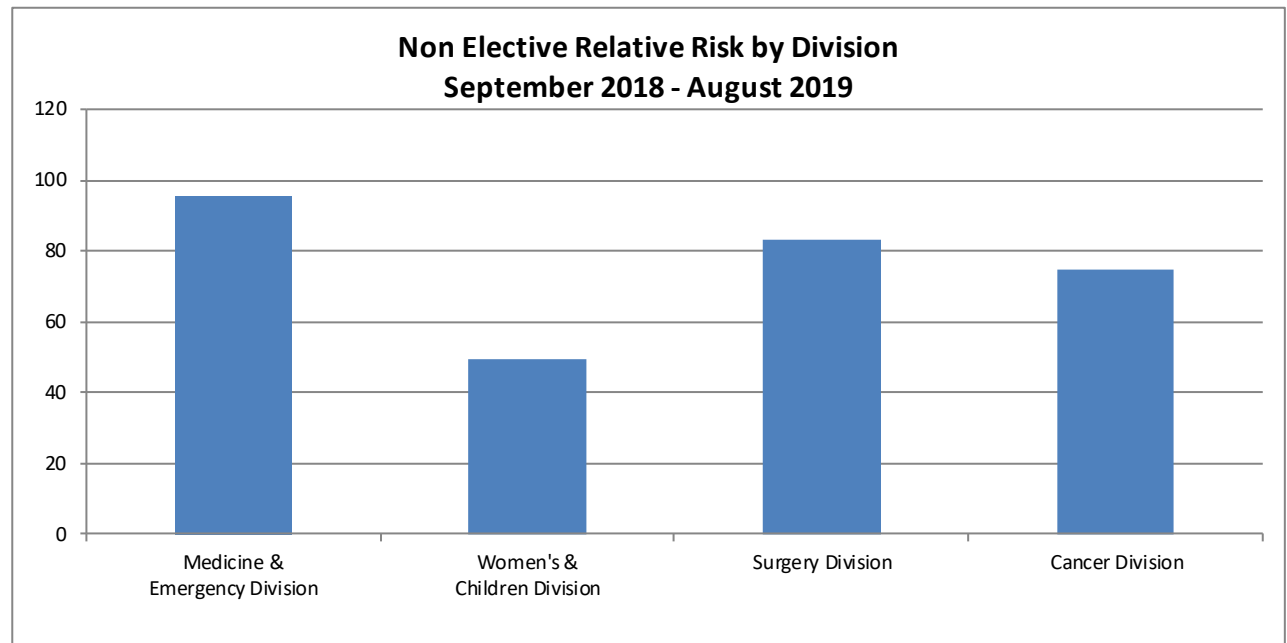
The latest analysis shows that patients admitted to the Trust any day of the week has an ‘as expected’ or ‘low’ level of relative risk of death, previously Saturdays had a high relative risk.

Figure 7 Relative Risk by Day of Admission



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

Figure 8 Divisional Non Elective Relative Risk



Summary Hospital-Level Mortality Indicator (SHMI)

SHMI is a measure of mortality and performance which includes all deaths in hospital regardless of diagnosis, in addition to all those individuals who die within 30 days of discharge from hospital. SHMI published by HSCIC for the period July 2018 – June 2019 shows SHMI as 1.0323 which is banded as level 2 “as expected.”

CUSUM (CUMulative SUM control chart) Alerts

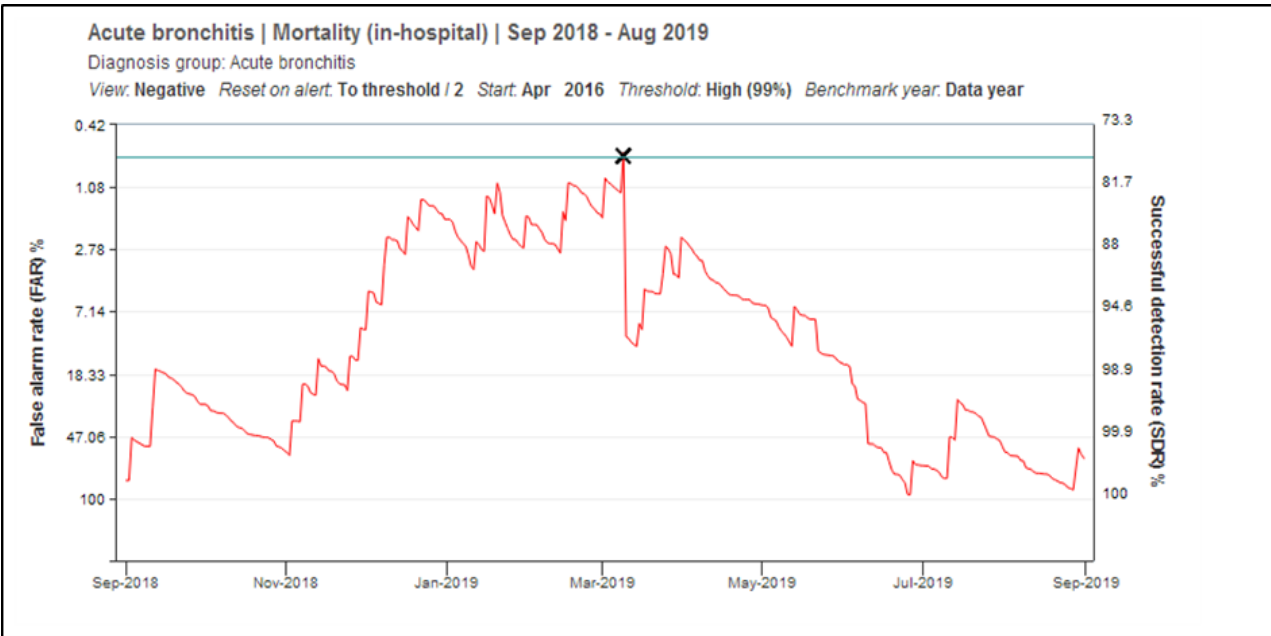
A further element of the work undertaken by the Mortality Surveillance Group is to review the CUSUM alerts. This is a method of identifying areas where there are an unexpected cumulative number of mortalities which have been following treatment for a specific diagnosis; this can be both due to more and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

Figure 9 Diagnosis with negative CUSUM Alerts

Relative risk & CUSUM alerts										
Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend	LOS	Readm.	Peers
All Diagnoses	1 4	116728	1446	1589.1	1.2	91.0				
HSMR (56 diagnosis groups)	6	38982	1215	1311.0	3.1	92.7				
Acute and unspecified renal failure	1	456	69	47.0	15.1	146.9				
Acute bronchitis	1	1154	34	20.5	2.9	165.8				
Chronic ulcer of skin		235	16	9.0	6.8	177.3				
Multiple sclerosis	1	34	2	0.2	5.9	979.2				
Parkinson's disease	1	70	5	1.3	7.1	374.2				
Peritonitis and intestinal abscess		30	9	3.5	30.0	253.8				
All Procedures	1	76312	920	1013.6	1.2	90.8				
Rest of Miscellaneous operations	1	4917	28	16.6	0.6	168.5				

Figure 10b shows the CUSUM alert for Acute Bronchitis which has shown as having a red relative risk of 165.8 in September 2018 - August 2019, the patient level backing data for these alerts is currently being audited by the coding department.

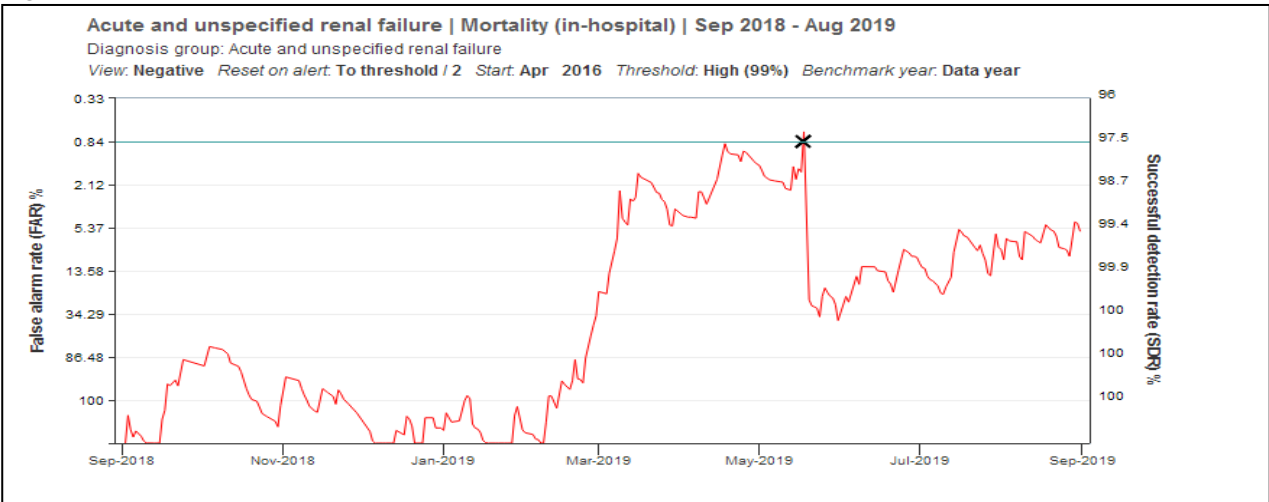
Figure 10a Acute Bronchitis CUSUM Alert



The majority of these patients are not patients with bronchitis but actually patients with chest infections, chest sepsis or pneumonia. All these conditions sit within this coding group and lack of clarity of the clinical condition has negatively impacted on the ability of the coders to code correctly. The lead for coding is working with one of our Respiratory Consultants to consider future actions required.

Figure 10b shows the CUSUM alert point for Acute and unspecified renal failure which has shown as having a red relative risk of 146.9 in September 2018 - August 2019, the patient level backing data for these alerts has been supplied to the coding department for further review.

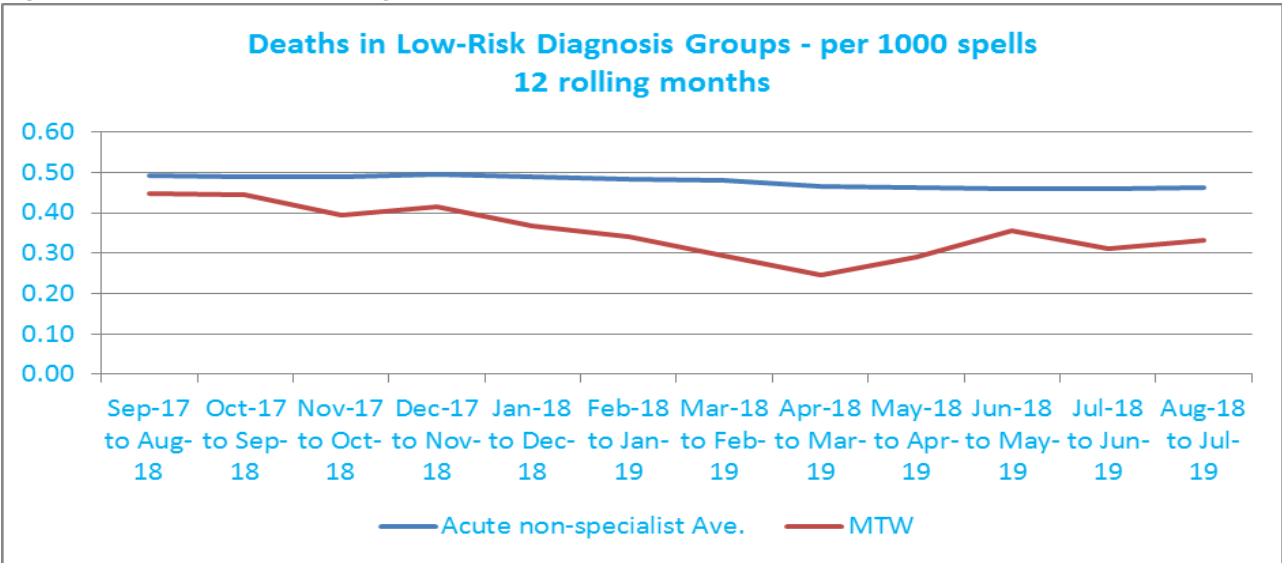
Figure 10b Acute & Unspecified Renal Failure



Deaths in Low Risk Diagnosis Groups

MTW is now below the Acute, Non Specialist Trusts average when looking at deaths in low risk diagnosis groups. The current average is 0.33 which is below the national average of 0.46. This is a metric used by the CQC in their insight report and MTW was flagged as being consistently worse than average for this measure, hence its inclusion in this report.

Figure 11 Deaths in Low Risk Diagnosis Groups



There were 15 deaths in a low risk group in the last 12 months, these deaths breakdown as follows.

Diagnosis group	Total
Other connective tissue disease	3
Oesophageal disorders	2
Multiple sclerosis	2
Open wounds of extremities	1
Alcohol-related mental disorders	1
Essential hypertension	1
Osteoarthritis	1
Other diseases of bladder and urethra	1
Other nervous system disorders	1
Transient cerebral ischaemia	1
Viral infection	1
Total	15

The Mortality Surveillance Group (MSG):

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

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

Trust	2018/19 YTD	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	2019/20 YTD
No of Deaths	1600	142	121	95	128	114	135	133	868
No of Completed Reviews	1363	121	98	83	111	99	112	84	708
%age completed reviews	85.2%	85.2%	81.0%	87.4%	86.7%	86.8%	83.0%	63.2%	81.6%
No of Un-reviewed Deaths	237	21	23	12	17	15	23	49	160

The table above shows the results for 2018/19 & April - October 2019 as at 14th November 2019.

During 2018/19, 60 deaths had an SJR completed; this equates to 3.8% of the trust deaths.

During April - October 2019, 20 deaths have had an SJR completed which equates to 2.3% of the total deaths to date.

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

The Mortality Steering group is responsible for supporting the Trust in providing assurance that all hospital associated deaths are proactively monitored, reviewed, reported and where necessary, investigated. In addition it is to ensure that lessons are learned and actions implemented to improve outcomes.

Each Directorate has a nominated Mortality Lead with the key objective of ensuring that the Mortality review process is embedded locally and that deaths that have raised concern are fed-back to the Group from the Directorate and in addition that learning from the Directorates to the MSG and vice versa is sustained.

Learning from Mortality Reviews includes the need for:-

- Improved documentation in regard to decision making re ceiling of care and plan for palliation.
- Prompt senior oversight of decision making re End of Life Care (EOLC), to include review of DNACPR form signed by Consultant lead
- Sensitive DNACPR discussions with relatives should be carried out by senior members of medical team who are responsible for making the decision and not delegated to juniors.
- When a patient is receiving End of Life Care the requirement for any invasive investigations such as blood tests need to be justified as they may not affect management.
- Consent for high risk surgical procedures must include the risk of death.
- Prompt referral to palliative care team when decision made for EOLC.
- Documentation of best interest discussions.
- Importance of contemporaneous and legibility of documentation.
- Improved documentation with particular records of thought processes leading to decision making, including elimination of possible diagnoses.

Medical Examiner Process Implementation Working Group

In addition to the Mortality Surveillance Group there is also a requirement for all Acute Trusts in England to begin setting up medical examiner offices, as such this Working Group became instrumental in July 2019.

The purpose of the medical examiner system is to:

- Provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths
- To ensure the appropriate direction of deaths to the coroner
- Provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased
- Improve the quality of death certification
- Improve the quality of mortality data

The Working group to date have:-

- Mapped the current roles of the Bereavement services team to prevent duplication of work and to also identify key development requirements for those staff who could be considered at risk
- Developed Job Descriptions for the Medical Examiner and Medical Examiner Officer roles
- Worked with PMO and Deputy Medical Director to determine number of PA's that would be required to undertake the role of Medical Examiner
- Liaised with Chief Coroner and Regional Medical Examiner to ensure key requirements are understood
- Worked with Deputy Director of Finance to consider funding options in regard to Part 2 monies
- Worked with Estates to consider options to create further desk space to support additional staff

Next Steps for both MSG and Medical Examiner project groups:-

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

Trust Board meeting – December 2019

Update on the Trust's planning for 2020/21	Director of Strategy, Planning and Partnerships
The enclosed report provides an update on the Trust's planning for 2020/21.	
Which Committees have reviewed the information prior to Board submission? <ul style="list-style-type: none">▪ Finance and Performance Committee, 18/12/19	
Reason for submission to the Board (decision, discussion, information, assurance etc.) ¹ Review and discussion	

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

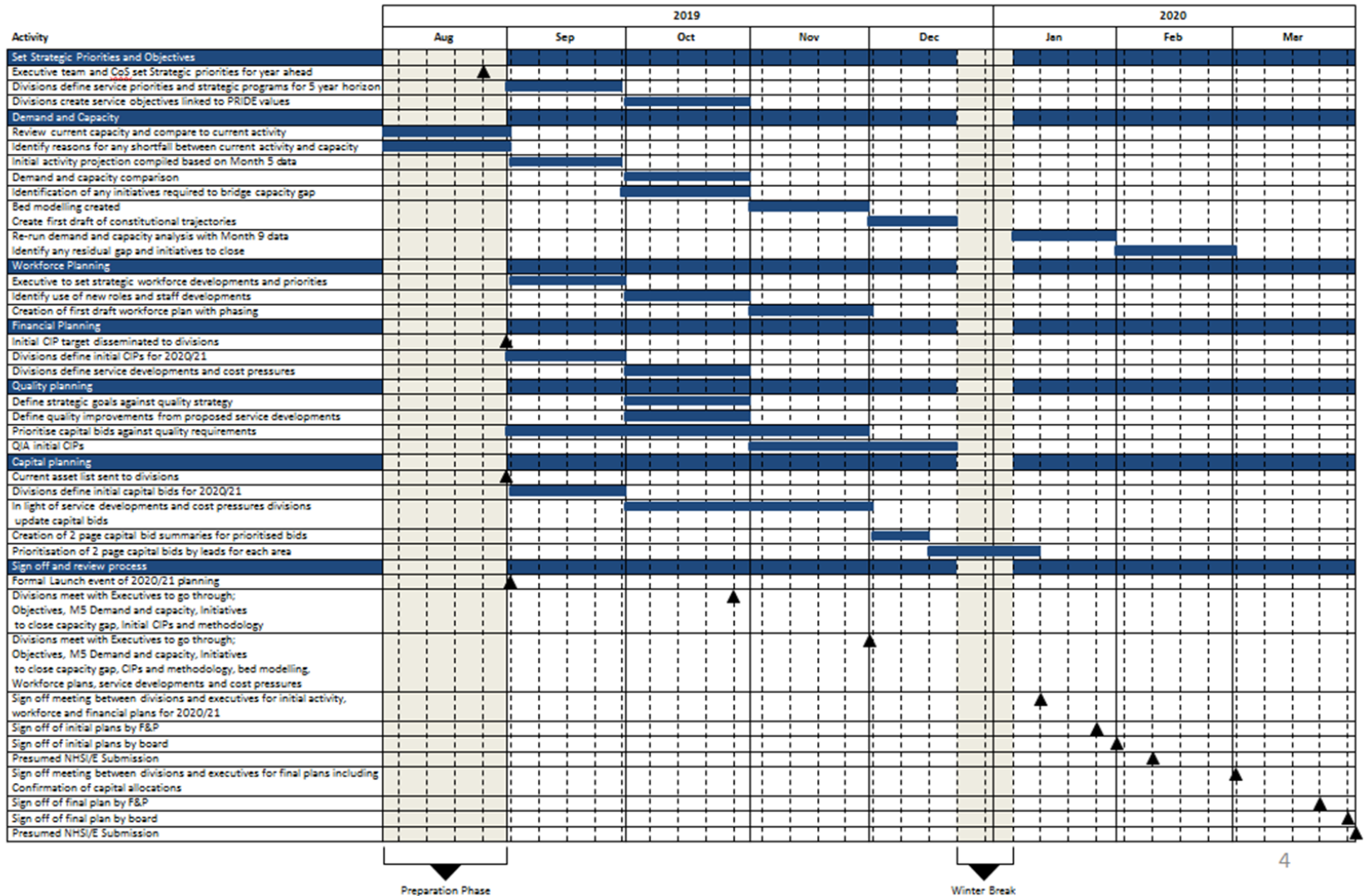
Update on 20/21 planning

13th December 2019

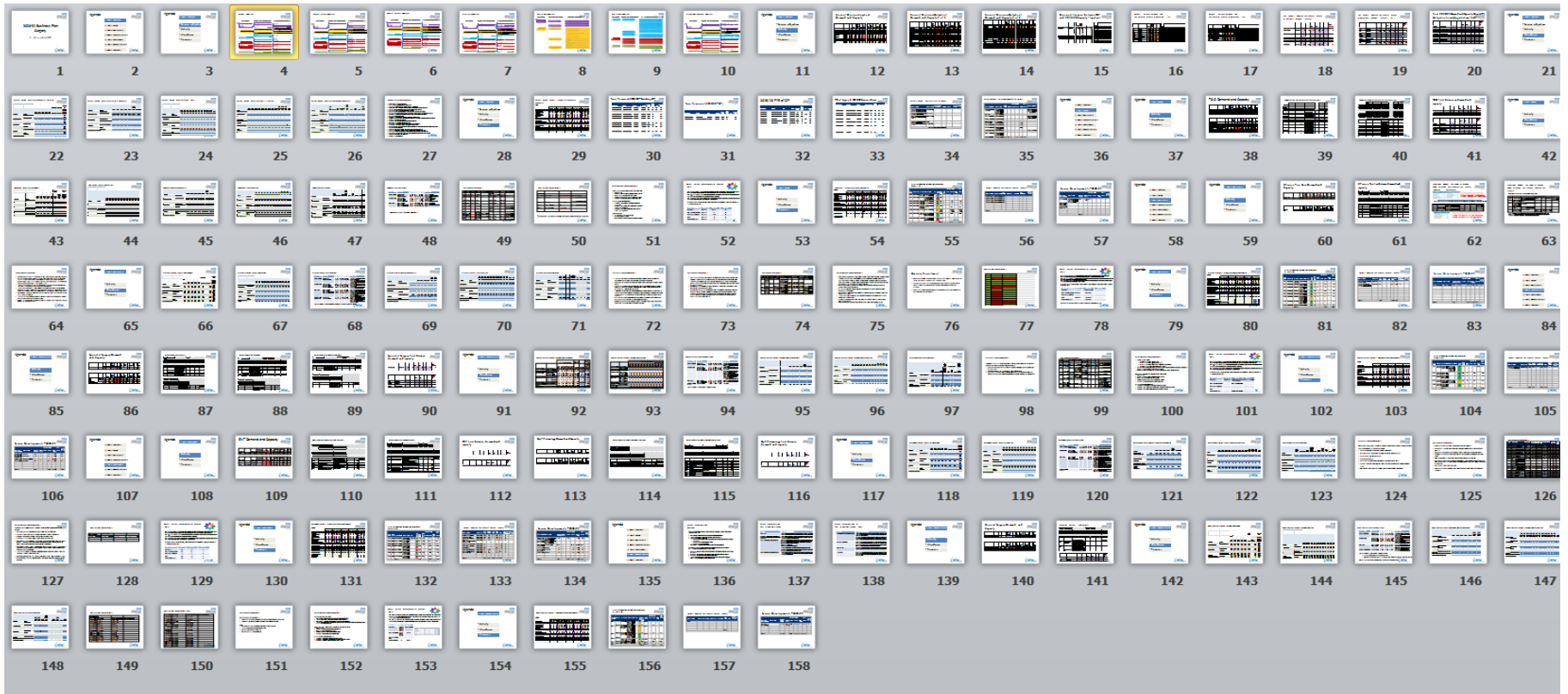
Following the 19/20 planning cycle we worked with teams to identify areas of improvement for 20/21 planning

Feedback	Response
Divisions and directorates reported being unsure of the final decision regarding funding service developments and capital bids	This year we will have a formal sign off session at which formal approval or rejection of service developments and capital programmes will take place. If any circumstances inhibit formal sign off at this stage (e.g. due to capital resource limit for example) then a clear timeline and decision point for final sign off will be communicated
Sequentially tackling demand and capacity then workforce and then finance slowed the process down and did not give enough time to CIP formulation e.t.c.	Divisions will parallel process construction of their plans this year beginning workforce and CIP planning at a much earlier stage
Lack of clarity on why activity numbers change and lack of sign off on final numbers	Clearer guidance will be accompanied by a dedicated sign off of activity numbers not just for the first submission but also for the second submission.
Lack of scrutiny of corporate business	Dedicated review meetings will be held with each corporate area, Chiefs of Service will also sit on the panel alongside the remaining executives for these panels to ensure that corporate areas are held to the same standard as the divisions
Lack of transparency between service developments and CIPs between divisions	Business plans to be shared between divisions to ensure transparency
Lack of communication during process and afterwards especially on capital	Regular monthly communication throughout with clear indication of next decision points, support available and key next steps

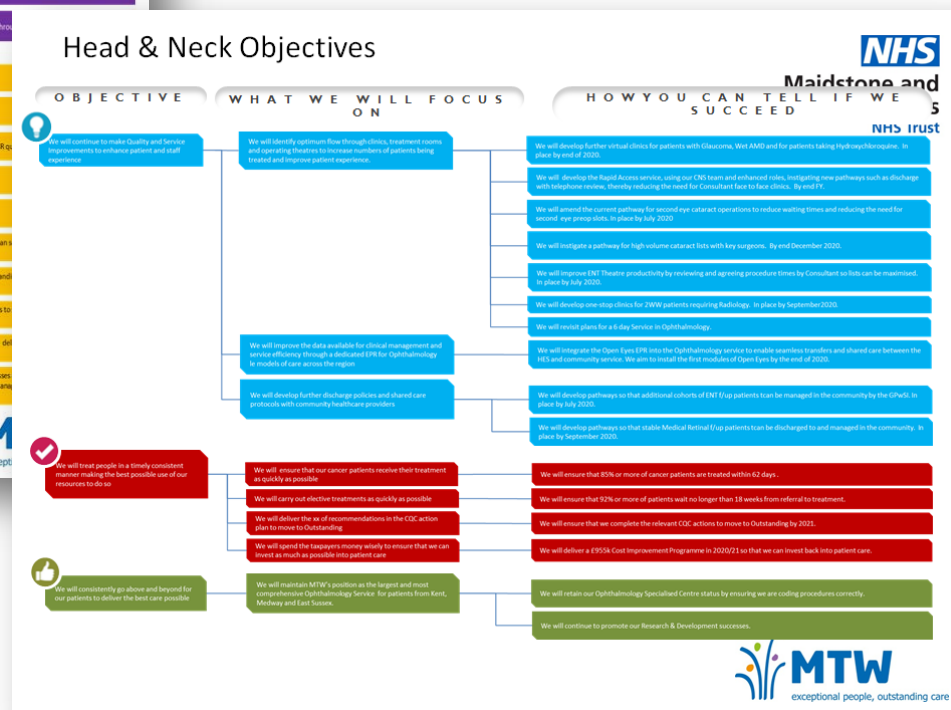
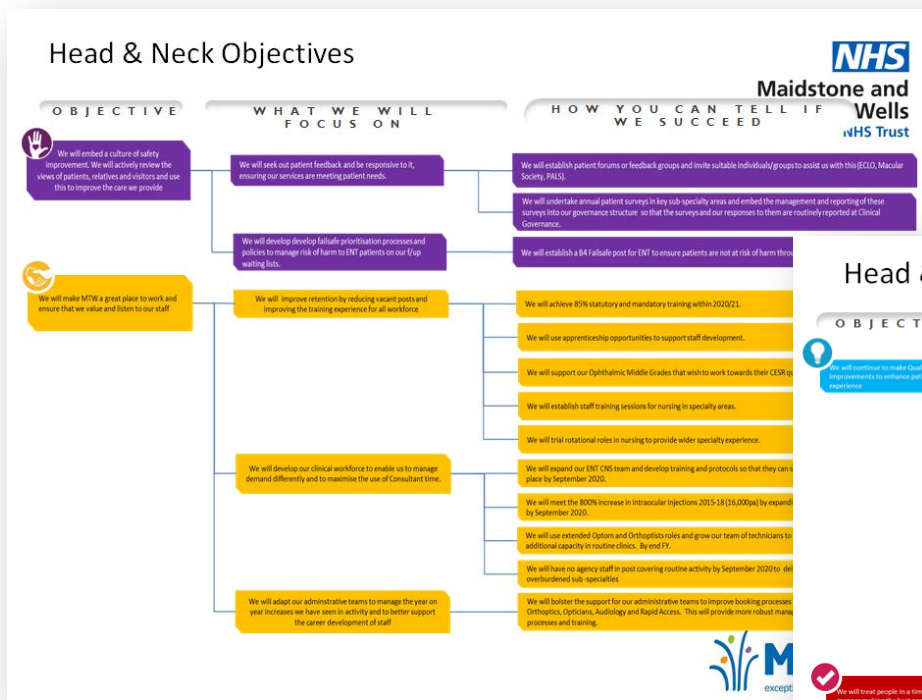
In response to the feedback from the 2019/20 planning round we are developing in parallel the different elements of the plan this year



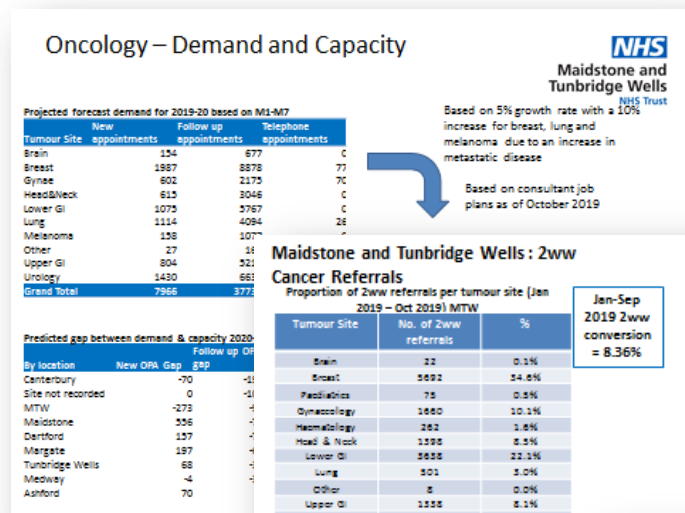
Divisional business plans are currently in excess of 100 pages – Surgery example



Divisions have been embedding QSIR methodology in their business plans – e.g. using driver diagrams to define objectives



Divisions have again been using the IMAS – IMAT models to model demand and capacity but this year we have extended D&C analysis to additional areas



Oncology demand and capacity is being modelled across the Kent and Medway sites as well as by Tumour site

Maidstone and Tunbridge Wells : 2ww Cancer Referrals

Proportion of 2ww referrals per tumour site (Jan 2019 – Oct 2019) MTW

Tumour Site	No. of 2ww referrals	%
Brain	22	0.1%
Breast	5692	24.6%
Paediatrics	75	0.3%
Gynaecology	1660	10.1%
Haematology	262	1.8%
Head & Neck	1596	8.5%
Lower GI	3658	22.1%
Lung	501	3.0%
Other	8	0.0%
Upper GI	1556	8.1%
Urology	1782	10.8%
Totals	27	0.8%
Total	14473	100%

Jen-Sep 2019 2ww conversion = 8.36%

National: Trend in Cancer Referrals



Two week wait demand and capacity is being modelled to identify specific requirements to meet the standard

National: Projected cancer incidence

- There were an estimated 2.5 million people living with cancer in the UK in 2015 and is expected to rise to 4 million by 2030 (Macmillan cancer support).
 - More than three times as many older people (aged 65 and over) will be living with cancer by 2040 (Macmillan cancer support).
 - This is particularly important considering an
- | Age Group | 2018 | 2030 | 2040 | % change |
|-----------------|---------|---------|-------|----------|
| Age 0-15 | 12,200 | 35,400 | 3,200 | 10.0% |
| Age 16-64 | 105,900 | 108,200 | 6,300 | 6.1% |
| Age 65 and over | 35,600 | 38,300 | 6,800 | 21.5% |

Pathology Activity October 2019

Blood Transfusion	GP	Hospital/ Inpatient	Total
2018/19	1,911	11,064	12,975
2019/20	1,982	10,559	12,541
% change	4%	-5%	-3%
Immunology			
2018/19	2,502	1,804	4,306
2019/20	2,918	2,006	4,924
% change	17%	11%	14%

DEXA D&C and Pathology is being calculated for DCSS in addition to main imaging modalities

First draft of workforce plans (including in all areas a trajectory on QSIR training) are being scrutinised by execs

Surgical Division Workforce Plan 20/21

WdGrpParent	WdGrpCat
ABC/Sen Man Staff	ABC/Sen Man Agency
	ABC/Sen Man Bank
	ABC/Sen Man Substantive
ABC/Sen Man Staff Total	
Medical Staff	Consultants
	Medical Agency
	Medical Locums
	Other Medical Grades
Medical Staff Total	
Nursing	Nurse Agency
	Nurse Bank
	Nurse Substantive - Trained
	Nurse Substantive - Untrained
Nursing Total	
Scientific Therap & Tech Staff	STT Agency
	STT Bank
	STT Substantive
Scientific Therap & Tech Staff Total	
Grand Total	

Surgical Division Workforce 20/21 £ Phasing

WdGrpCat	Sum of Workforce Plan £ 20/1	Sum of Workforce Plan £ 20/2	WdGrpParent
ABC/Sen Man Agency	0	0	
ABC/Sen Man Bank	7,394	7,394	
ABC/Sen Man Substantive	492,207	492,207	
500,201		500,201	
Consultants	1,295,854	1,295,854	
Medical Agency	129,830	129,830	
Medical Locums	98,435	98,435	
Other Medical Grades	1,302,471	1,302,471	
2,926,590		2,926,590	
Nurse Agency	82,465	82,465	
Nurse Bank	106,222	106,222	
Nurse Substantive - Trained	1,801,880	1,801,880	
Nurse Substantive - Untrained	449,542	451,542	
2,539,309		2,491,530	
STT Agency	18,978	18,978	
STT Bank	24,755	24,755	
STT Substantive	303,379	303,379	
346,112		346,112	
5,002,005		5,071,807	

Surgical Division Workforce Bridging between years

WdGrpParent	WdGrpCat
ABC/Sen Man Staff	ABC/Sen Man Agency
	ABC/Sen Man Bank
	ABC/Sen Man Substantive
ABC/Sen Man Staff Total	
Medical Staff	Consultants
	Medical Agency
	Medical Locums
	Other Medical Grades
Medical Staff Total	
Nursing	Nurse Agency
	Nurse Bank
	Nurse Substantive - Trained
	Nurse Substantive - Untrained
Nursing Total	
Scientific Therap & Tech Staff	STT Agency
	STT Bank
	STT Substantive
Scientific Therap & Tech Staff Total	
Grand Total	

Divisional Retention Plan – 2020/21

- Complete 1:1's on a regular basis
- Carry out team meetings on a regular basis
- Ensure engagement and attendance
- Complete all staff appraisals and performance reviews
- Ensure individual objectives are set
- Ensure there is clear direction towards the future
- Managers share information with staff
- Managers need to be available for staff
- Support on-going training for staff
- Offer mentorship programs
- Support statutory and mandatory training
- PDN providing clinical and competitive
- Supervision for overseas nurses
- Encourage staff to engage and attend
- Buddies assigned to each overseas nurse
- Use apprenticeship opportunities to support staff
- Provide staff training sessions for staff
- Use new roles to create opportunities
- Team building/away day
- Communication – team brief/division
- Staff engagement – 'back to the floor'
- Ensure staff have a work/life balance
- Through the staff survey, act on any feedback
- Communicate the 'you said, we did' message
- Celebrate achievements

Quality, Service Improvements & Redesign (QSIR)



QSIR Fundamental - A one day programme offers participants an introduction to a range of tried and tested service improvement tools and approaches that give them the confidence and skills to start on their improvement journey

QSIR Practitioner - A four day programme (spread over four months) aimed at providing you with the know-how to design and implement more efficient and productive services and processes.

QSIR College - Develops candidates to a level where they are assessed and accepted as associate members of the QSIR Teaching Faculty and go on to skill up other staff in their local systems

Provide the Trajectory by workforce group of the number of staff undertaking QSIR training in 2020/2021

Workforce Group	QSIR F	QSIR P	QSIR C
Medical	All staff	6/15	0
Nursing & Midwifery	All staff	13	0
Healthcare Scientists	All staff	3/6	0
AHP	All staff	0	0
Admin & Clerical	All staff	5	1

NHS
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NHS Trust

Specialist Surgery for example have identified £244k of their £350k target with credible plans for identifying the remaining CIPs

Description	Division	Sub-division	Pay / Non Pay / Income	4000 or more Increase in Revenue Reduction in Expense
Reduced Nursing Agency / Bank Signature (net of Triangulation costing)	ACANCERPRG	ONCOLOGY	Pay	11
Reduced Nursing Agency / Bank Signature (net of Triangulation costing)	ACANCERPRG	DCLNHQIM	Pay	104
Cancer Services Deep Dive Signature	ACANCERPRG	ONCOLOGY	Income	
Cancer Services Deep Dive Signature	ACANCERPRG	DCLNHQIM	Income	
Reduced Medical Agency / Bank Signature	ACANCERPRG	ONCOLOGY	Pay	0
Reduced Medical Agency / Bank Signature	ACANCERPRG	DCLNHQIM	Pay	0
Radiology Fluorine - ad hoc to Clinic	ACANCERPRG	ONCOLOGY	Income	
Radiology Consumables	ACANCERPRG	ONCOLOGY	Non Pay	56
Electronic Medical Records	ACANCERPRG	ONCOLOGY	Pay	22
IT - Hardware / Operating sys	ACANCERPRG	ONCOLOGY	Income	
ITM - KCHPT Additional Support	ACANCERPRG	ONCOLOGY	Income	
ITM - KCHPT Additional Support	ACANCERPRG	DCLNHQIM	Income	
ITM - Insurance Companies for Manufacturers	ACANCERPRG	ONCOLOGY	Income	
Medical Physics - PMG Income	ACANCERPRG	ONCOLOGY	Income	
Medical Physics - Nuc Inv	ACANCERPRG	ONCOLOGY	Income	
Diagnostic Income	ACANCERPRG	ONCOLOGY	Income	
Medical Physics - KIMS/Spine Operation of Contracts	ACANCERPRG	ONCOLOGY	Income	-10
Nursing - Effort upon consultants Improvement of prescribing on line in their favor to decrease waste of drug and chair time	ACANCERPRG	DCLNHQIM	Non Pay	
Radiography - Bulk purchase of Consumables for MTW and East Lain	ACANCERPRG	ONCOLOGY	Non Pay	
Implement GO - Admin Reduction	ACANCERPRG	DCLNHQIM	Pay	0
Additional Training Support Income	ACANCERPRG	ONCOLOGY	Income	62
Additional BMT Income	ACANCERPRG	DCLNHQIM	Income	-18
Radiography Temp Agent Reduction	ACANCERPRG	ONCOLOGY	Pay	25
Admin and Clinical Roles Reduction	ACANCERPRG	ONCOLOGY	Pay	0



MTW
exceptional people. outstanding care.



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Forecast activity profile for Wells Suite: PP & NHS

PP & DC

	April	May	June
Amb/Onc/OPD	35	35	35
Diagnostic/OPD (not NHS)	30	30	30
Imaging	30	30	30
Consultation	4	4	4
Pathology (Preval)	5	5	5
Oncology	5	5	5
Sub Total PP & DC	139	139	139

NHS

	April	May	June
Amb/Onc/OPD	35	35	35
Diagnostic/OPD (not NHS)	30	30	30
Imaging	30	30	30
Consultation	4	4	4
Pathology (Preval)	5	5	5
Oncology	5	5	5
Sub Total NHS	139	139	139

Grand Total

	April	May	June
PP & DC	139	139	139
NHS	139	139	139
Grand Total	278	278	278

NB: Activity levels at average of 72 pcm Consultant Survey declared volumes

Forecast activity profile for Wells Suite: PP & NHS

PP & DC

	April	May	June
Amb/Onc/OPD	35	35	35
Diagnostic/OPD (not NHS)	30	30	30
Imaging	30	30	30
Consultation	4	4	4
Pathology (Preval)	5	5	5
Oncology	5	5	5
Sub Total PP & DC	139	139	139

NHS

	April	May	June
Amb/Onc/OPD	35	35	35
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Consultation	4	4	4
Pathology (Preval)	5	5	5
Oncology	5	5	5
Sub Total NHS	139	139	139

Grand Total

	April	May	June
PP & DC	139	139	139
NHS	139	139	139
Grand Total	278	278	278

NB: Mix/profile of PP and NHS can be. This will be dependent on PP growth than shown, or more due to slower growth/priorities/seasonal demand pressures

Forecast activity profile for Wells Suite: PP & NHS

PP & DC

	April	May	June
Amb/Onc/OPD	35	35	35
Diagnostic/OPD (not NHS)	30	30	30
Imaging	30	30	30
Consultation	4	4	4
Pathology (Preval)	5	5	5
Oncology	5	5	5
Sub Total PP & DC	139	139	139

NHS

	April	May	June
Amb/Onc/OPD	35	35	35
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Oncology	5	5	5
Sub Total NHS	139	139	139

Grand Total

	April	May	June
PP & DC	139	139	139
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Forecast activity profile for Wells Suite: PP & NHS

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Amb/Onc/OPD	35	35	35
Diagnostic/OPD (not NHS)	30	30	30
Imaging	30	30	30
Consultation	4	4	4
Pathology (Preval)	5	5	5

Summary report from Workforce Committee, 28/11/19 (including the Annual Report from the Guardian of Safe Working Hours)	Committee Chair (Non-Exec. Director)
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The Workforce Committee met on 28th November 2019.

The key matters considered at the meeting were as follows:

- The actions from previous meetings were reviewed
- The Committee noted the presentation of the current workforce indicators and discussed the particular challenges around turnover and the importance of obtaining a sufficient volume of exit interview data to be able to identify underlying trends. The need for additional leaver data as well as the reasons why people stayed would be of especial importance in the context of the retention programme for the forthcoming year.
- The Committee reviewed the progress of the Overseas Nurses Recruitment Programme. Whilst acknowledging the success of the programme to date the committee focused on the need to ensure that the Trust received the full benefit of the additional staff through reduced use of bank and agency which was not yet fully apparent. The need to have a comprehensive retention programme for all nursing staff & the overseas nurses in particular was highlighted so as to ensure that the improved nursing position was maintained. Access to career progression & affordable accommodation would be central to the work of the Trust
- The Committee noted the report from the Trust Health & Safety Committee. In particular the Committee discussed the need to improve the DNA rates in Occupational Health and the work to manage water hygiene.
- The Committee noted the review of Trust employment relations processes in light of the Abdullah report and the actions taken to assure itself that its disciplinary processes were compliant with the guidance. All Trusts have been asked to review their employment relations processes by NHS Improvement (NHSI) /NHS England (NHSE) in light of the findings of this report. The Trust met the recommendations set out, although there continued to be challenges in finding managers with sufficient time to be able to investigate allegations within the required time frames. MTW employment relations cases are reviewed by a panel of Staff Side and Staff Network chairs on an annual basis to identify any issues of concern, their report is shared with the Workforce Committee.
- The Committee noted the annual report of the Guardian for Safer Working (which had been enclosed in full in Appendix 1). The key issues being raised by junior medical staff continued to relate to additional hours worked. One fine had been issued as a result of issues with a rota which had been addressed. The appointment of the two Chief Registrars in Medicine was a welcomed additional resource to resolving issues early at a local level. Issues remained with some Clinical Supervisors responding promptly to exception reports but this had improved over the year.
- The Committee noted the updates provided on progress against the Exceptional People, Outstanding Care programme and the procurement of a senior leadership programme and would continue to regularly monitor progress against these two workstreams

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

- The Committee noted the annual report of the Guardian for Safer Working (which had been enclosed in full in Appendix 1)

Which Committees have reviewed the information prior to Board submission?

N/A

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

Information and assurance

Appendix 1

WORKFORCE COMMITTEE – November 2019

11/11/19

GUARDIAN FOR SAFE WORKING – ANNUAL REPORT 2018 - 2019

MATT MILNER, GUARDIAN
FOR SAFE WORKING

Summary / Key points

Annual report from the Guardian for Safe Working for the period October 2018 – October 2019.

Points to be noted:

- The 2016 Terms & Conditions of service for doctors in training were updated from August 2019 (see attached)
- All of the doctors in training are now on the updated contract.
- In the past year no work schedule reviews have taken place.
- 1.5 hours of department fines have been incurred over the period.
- Exception report responding from Clinical Supervisors is good in general, however the new 7 day completion time and resolution will be challenging.
- The Trust has 359 doctors in training.
- In total 198 exception reports were raised in the period October 2018 – October 2019.

Which Committees have reviewed the information prior to Workforce Committee submission?

None

Reason for receipt at the Workforce Committee (decision, discussion, information, assurance etc.)

- Information
- Assurance

Annual Report:

1. In August 2016 the new Terms & Conditions of Service (TCS) for doctors in training were first introduced and in August 2019 these were updated. Changes to the contract included:
 - 7 day deadline for Clinical Supervisors to respond to Exception Reports.
 - Payment for additional hours worked to be made in the same month.
 - Changes to break allowances on nightshifts.
 - A maximum of 72 hours worked in any 168 hour period.
 - A Facilities & Rest Charter set a maximum of 4 long day shifts in a row.

Further details are included in the attached document.

The Trust currently has 359 doctors in training.

2. At induction our doctors in training receive a presentation from the Guardian for Safe Working Hours providing information on the Contract Terms & Conditions, method and reasons raising Exception Reports, the review process for Exception Reports and how outcomes from reports raised are dealt with.
3. It was reiterated to the Doctors in Training that the Trust welcomes appropriate Exception Reports and that unless the Guardian is made aware of issues regarding safe working conditions he is unable to deal with these or to make improvements.
4. Two SPRs in Medicine have been welcomed into the posts of Chief Registrars. They have been giving support to the Guardian by highlighting and identifying possible resolutions with issues that may not necessarily reach the Guardian via the Exception Reporting or Junior Doctor Forum route.

The Guardian will be holding monthly meetings with the Chief Registrars to discuss Exception reports and other matters arising.

Attendance at the Junior Doctors forum has improved during the last year with trainees from a range of specialities attending this has been helped by the Chief Registrars engaging with doctors in training.

5. Exception reports – during the period October 18 – 19 a total of 198 Exception Reports were raised. The reasons given for raising reports remains similar to previous years. The majority of reports filed are again from FY1/FY2 doctors and mainly relate to extra hours worked.

The reasons given for the additional hours are staff shortages due to annual leave and sickness, volume of clinic work needing attending to and attending to patients who become more unwell towards the end of the doctors shift. Also attending compulsory departmental training is highlighted as a challenge.

The Guardian is assured that Exception Reports are rarely raised relating to inadequate supervision. However several have been raised from an FY1 unable to contact the on call Surgical Registrar regarding patient care.

6. One issue that still remains is delays in Clinical Supervisors responding to Exception Reports in the appropriate time frame. Although this is a small proportion of the reports it still requires follow up by the Guardian.

The reasons for the delays include doctors in training assigning the incorrect Clinical Supervisor on the DRS4 system or when the correct Clinical Supervisor has been assigned they delay responding to the report.

It has been reiterated to Clinical Supervisors what their duties and response times are in relation to Exception Reports. A copy of the NHS Employers Doctors in Trainee Terms & Conditions fact sheet has been recirculated to supervisors and they have been made aware of the requirement to respond to Exception Reports with the 7day deadline.

The Guardian is aware that the timeframe is difficult due to clinical commitments and finding time to meet and discuss reports with trainees to resolve issues.

7. A further challenge with the updated Terms & Conditions is the requirement for trainees to have 3 x 30 minute breaks whilst working a long night shift; this may mean speciality registrar is working in isolation without senior cover available.

Speciality managers will need to establish the best way to accommodate the requirement for breaks in to the rotas safely.

8. The Trust now has five Physician Associates in post within T&O, Haematology and Surgery departments with appointments having been made also in Obs & Gynae and Frailty areas. This will help support doctors in training with their everyday workload and fill in on a short term basis to cover sick leave and other temporary absences.

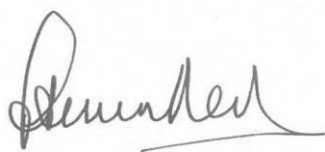
Scope and status

This framework agreement is adopted by the Joint Negotiating Committee Juniors (JNC(J)) following agreement with all constituent parties.

This framework is adopted following the confirmation of the relevant funding received from the Department of Health and Social Care and NHS England on 10 June 2019.

It is intended that this agreement covers all NHS employers in England employing doctors in training.

This framework document sets out a four-year agreement covering the years from 1 April 2019 to 31 March 2023. It sets out both the pay investment that will be made and the amendments to the 2016 junior doctors contract that employers, the British Medical Association (BMA) and the Department of Health and Social Care (DHSC) are agreeing to implement over the period of the agreement and going forward.



Steven Ned
Joint Negotiating Committee (Juniors)
Management side co-chair
Joint Director of Workforce with Rotherham
and Barnsley Hospital NHS Foundation Trusts



Jeeves Wijesuriya
Joint Negotiating Committee (Juniors)
Staff side co-chair
UK Junior Doctors Committee chair
British Medical Association

FRAMEWORK AGREEMENT: AMENDMENTS TO 2016 JUNIOR DOCTORS CONTRACT

Context for the 2018 contract review

The new junior doctor contract¹ was introduced in England without the BMA's agreement in 2016. The intention of the negotiations on this new contract was to introduce for doctors in training new and improved safe working arrangements, more support for their education and a new modernised pay system. The BMA and NHS Employers agreed during negotiations on this contract to jointly commission in August 2018 a review of its efficacy, to identify any areas for improvement to the contract terms. In 2018, the BMA Junior Doctors Committee, NHS Employers and DHSC agreed to take forward the contract review with the intention of negotiating changes to the contract that would be put to a new referendum of the BMA Junior Doctor membership. Members will be asked to consider whether they accept the 2016 contract, including the amendments that have been negotiated. If members vote to accept the amended contract, it will be collectively agreed.

The changes set out in this framework document represent the outcomes of this review.

To note:

- NHS Employers has agreed these changes in negotiations on behalf of employers.
- The BMA Junior Doctors Committee will now put this agreement to their membership with their endorsement.
- This will mean that, subject to confirmation of the collective agreement, all doctors in training in England will move to the new terms from August 2019.
NB: This will put the junior doctors' contract onto the same basis as all national NHS pay contracts with changes agreed in partnership between staff and employer representatives.
- The parties together support the amended contract and are committed to partnership working to ensure that the contract effectively supports the delivery of high-quality patient care by supporting recruitment and retention and enabling high quality training for the NHS's future consultants and GPs.

¹ This covers doctors and dentists in approved postgraduate training programmes under the auspices of Health Education England (HEE)

- In future, the Joint Juniors Negotiating Committee (JNCJ) made up of the BMA and employer representatives will become the vehicle through which any further changes are agreed collectively.
- The Government has agreed to the changes set out in this document.

Equalities Impact Assessment

The Secretary of State has an Equality duty under s.149 of the Equality Act 2010 to consider the impact of any changes in relation to the protected characteristics. A comprehensive equalities impact assessment on the proposed amendments to the contract is being carried out in line with the Secretary of State's public sector Equality Duty, and the DHSC will publish this analysis. In line with best practice the department has engaged with the BMA and NHS Employers as key stakeholder in this process, who are content with the approach taken and methods used.

In light of how seriously the BMA takes equality and diversity, they will commission an independent review of the draft equalities impact assessment as part of this stakeholder engagement, to ensure that it addresses members' equalities concerns and to analyse the outcome for members.

Overview of pay

Context: 2016 Contract Funding and Transitional Arrangements

- The 2016 contract was based on planned changes being implemented on a cost neutral basis.
- On introduction, doctors below ST3 in 2016 moved onto the new nodal point payment system.
- Doctors at ST3 and above continued to be paid increments and banding supplements until 2022 to enable them to complete training under the old payment system given their expectations.
- There was an expectation that some savings would be released to enable additional investment in the 2016 contract to be made in future years.
- Provision was made for a senior decision makers allowance to be paid to the most senior doctors in training, reflecting the level of responsibility they took on.
- It was the intention for this allowance to be paid to those senior trainees who are responsible in the out of hours period for making decisions about patient care with light touch consultant telephone supervision, and all parties recognised the importance of rewarding these senior trainees who are working at close to consultant level

- However, the partners agreed that it would be more appropriate to introduce a 5th Nodal point onto the pay structure to recognise this position for senior trainees in the later years of their training.

2018 Review: financial context and additional investment

Extensive analytical work has been carried out on the contract implementation; this has identified that the contract for doctors in training will be recurrently cost neutral. However, there are not expected to be any savings.

In response to this position the Government and NHS England have agreed to make available a pay envelope which supports further investment into the contract.

The proposed investment is over 4 years and consists of a total of 2.3% in 2019/20 and 3% in each of the three years 2020/21, 2021/22 and 2022/23. Of this total investment, junior doctors will receive an annual pay uplift of 2%.

	18/19	19/20	20/21	21/22	22/23
NP1 - F1	£27,146	£27,689	£28,243	£28,808	£29,384
NP2 - F2	£31,422	£32,050	£32,691	£33,345	£34,012
NP3 - ST1-2	£37,191	£37,935	£38,694	£39,467	£40,257
NP4 - ST3-5	£47,132	£48,075	£49,036	£50,017	£51,017
NP5 - ST6-8	£47,132	£48,075	£52,036	£56,077	£58,398

*Values based on 2% uplift per annum.

**NP5 includes additional investment of £3k in 20/21, £3k in 21/22, and £1.2k in 22/23 on top of the 2% uplifts to salaries

***Note that these represent substantive pay values and increases may be implemented part way through the year.

The remaining investment (around £90 million) will be used to fund other specific changes which are set out in detail in the pay and transitional arrangements section. These cover the following:

- **A new nodal point 5:** This will be introduced for trainees at ST6 and above through a staggered approach and will replace the Senior Decision Makers allowance as set out in the 2016 terms and conditions of service (see paras 5 and 5.1 for details)
- **Weekend allowance uplift** to ensure those working the most frequent weekends are remunerated more fairly (see paras 7 and 7.1)

- **An enhanced rate of pay for shifts that finish after midnight and by 4am** (see paras 6 and 6.1)
- **An LTFT allowance** to recognise the additional costs LTFT doctors incur throughout training (see paras 1 and 1.2)
- **Changes to the academic flexible pay premium** (see paras 13 and 13.1)
- **Extension of Section 2 transitional pay protection** (see paras 9 and 9.1)

Equalities, LTFT, and flexible training

1. LTFT allowance

1.1 Any doctor who is training less-than-full time will be paid an annual allowance of £1,000 for as long as they continue to train less-than-full-time. This is a fixed amount which will apply to any LTFT trainee regardless of their LTFT percentage and will be paid on top of their usual salary/any other pay elements. The allowance will be spread out over the year and paid in monthly instalments. This will come into effect from December 2019.

1.2 Those trainees who are already in receipt of the £1,500 transitional LTFT allowance will continue to receive this as per Schedule 14, but will not receive the £1,000 permanent allowance on top of this. Once their entitlement to the transitional £1,500 allowance ends, they will then receive the £1,000 allowance.

2. Shared parental leave and adoption leave

2.1 The 2016 contract shares a number of common schedules with the NHS Staff Handbook. As a result of negotiations via the NHS Staff Council, with full BMA involvement, shared parental leave will now be available as an enhanced occupational benefit as opposed to the basic statutory entitlement. This means that the rate of pay will be equivalent to that for occupational maternity leave, and doctors who rotate between different employers will be eligible to receive both this occupational pay and the statutory pay where relevant. There is also clarity that rotating doctors are eligible for occupational adoption leave and pay, and a requirement to receive time in lieu when a keeping in touch (KiT) or shared parental leave in touch (SPLiT) day is worked on a day of paid leave. Breaks in service while on approved OOP (out of programme), on an honorary contract or in a placement with a non-NHS employer in a crown dependency will now be disregarded so they don't affect eligibility for maternity, adoption and shared parental leave.

3. Champion of flexible training

3.1 Employers and/or host organisations will be required to appoint a champion of flexible training. The following principles shall be taken into account in appointing to the role:

- a) It is the employer's responsibility to appoint the champion of flexible training
- b) The appointment panel for the champion shall include the medical director or a nominated deputy, the director of HR/workforce or a nominated deputy, and two doctors in training, nominated by the junior doctors' forum (JDF) or equivalent. At least one and if at all possible both of the doctors in training must be based in the appointing employer (or host organisation, if appropriate) and at least one of the doctors in training must work LTFT.
- c) The panel should reach consensus on the appointment.
- d) The recruitment process for the appointment of the champion should otherwise follow local recruitment processes.
- e) Employers / host organisations can choose to act collaboratively to make and share the appointment across a number of employers.
- f) Employers must ensure that the Champions have sufficient resources to undertake their responsibilities.
- g) Other non-hospital employers with fewer than 10 trainees (this could include but is not limited to public health, occupational health medicine and palliative care) must contract with the champion of flexible training at a neighbouring NHS trust to offer support to LTFT trainees as and when required.

3.2 Where an employer is unable to appoint to the post they must ensure that alternative arrangements to support less than full time trainees are in place. These arrangements should be jointly produced with the Local Negotiating Committee (LNC) or JDF and are intended to be interim arrangements with the aim of appointing a champion in the future.

Those champions who have already been appointed in post through local recruitment processes prior to the publication of the updated TCS will not be expected to reapply for the position and will continue as champions.

4. Good rostering guidance

4.1 Selected principles encapsulated within the GRG guidance will be contractualised and employers must continue to adhere to them when designing work schedules.

4.2 The following sections relating to non-resident on-call working (found on pages 17 to 21 of the GRG) will be included in the contract:

- Calculating prospective hours
- Predictable and unpredictable work
- NROC design process
- Exception reporting for NROC
- Effective management of rotas

4.3 The following principles pertaining to LTFT working patterns will be included in the contract:

- Each LTFT doctor must have a personalised (*read as 'bespoke'*) work schedule built for them to ensure they are working the correct proportion of hours and shift types, included in the full-time template for their LTFT percentage, and are being paid correctly.
- Study leave should be prospectively sought for all teaching, courses and educational opportunities that fall on non-working days and where study leave approval is granted it must be compensated with TOIL, or payment if the trainee prefers.
- Unless agreed, a normal day, long day or twilight shift should not be rostered on a non-working day in a fixed working pattern.
- It should be highlighted to the doctor the individual pro-rata entitlement to study leave and annual leave (inclusive of pro-rated public holidays) to ensure the earliest opportunity to allow the planning of leave. This should be specified in the work schedule.
- All attempts should be made, where possible, to facilitate set working day patterns where requested by the doctor in line with the statutory right to request flexible working, provided that service needs can be met.
- Where a doctor is working LTFT for health reasons, recommendations made by occupational health must be factored into the design of the roster.

4.4 The parties also agreed that the JNC(J) will look at the last principle in more detail, including how best to ensure reasonable adjustments are made for all trainees with disabilities (LTFT or full-time) in a timely way. The JNC(J) should refer to GMC guidance on supporting doctors with health issues or disabilities in medical education and training and relevant findings of the GMC's Health and Disability Review.

4.5 The following principles related to cover arrangements and leave (found on pages 10, 14 and 15 of the guide) will be included in the contract

- Additional clarity on emergency and unforeseen circumstances where doctors may be required to provide cover for colleagues
- There being no requirement to pay back shifts missed due to sick leave
- A mechanism should be in place for planning and submitting leave requests prior to a doctor starting in a post and the duty roster being issued
- A rota should not be so restrictive in its design that it gives the appearance that fixed leave is incorporated into the rota
- Job interviews for NHS, public health, academic, NHS commissioned community health and hospice appointments should be considered professional leave, with time off accommodated appropriately and should not require annual or study leave for these interviews to take place

- Where at all possible, a roster should be designed to have at least two, if not three, consecutive weeks without out-of-hours duties, to be able to grant requests for longer periods of leave

Pay and transitional arrangements

5. Fifth nodal point

5.1 The 2016 contract provided for a senior decision makers' allowance to be introduced. The parties agreed that instead of an allowance, a fifth nodal point will be introduced for trainees at ST6 and above in order to recognise the significant high service contribution these trainees make. This will be introduced through a staggered approach from October 2020 as follows:

- In October 2020 the value will be £3,000.
- In October 2021 the value will increase to £6,000.
- In April 2022 the value will increase to £7,200.

6. Shifts ending after midnight and by 4am

6.1 Where a shift ends after midnight and by 4am, the entirety of the shift will attract an enhancement of 37% of the hourly basic rate. This change will come into effect in December 2019.

7. Weekend frequency allowance

7.1 The weekend frequency allowance rates for those working 1 in 2, 1 in 3, and 1 in 6 weekends will be uplifted in order to ensure these trainees are not paid less per hour for working more intense frequencies. The rate for those working 1 in 2 weekends will be **15%** of their basic salary; for those working 1 in 3 weekends it will be **10%** of their basic salary, and for those working 1 in 6 it will be **5%** of their basic salary. This change will come into effect in December 2019.

8. Annual pay uplifts

8.1 There will be an annual pay uplift of 2% over the next four years. The DDRB terms of reference allow them to make further pay recommendations or observations should one of the parties request it, or indeed where they consider it appropriate.

9. Transitional pay protection

9.1 Trainees who are currently in receipt of 'Section 2' transitional pay protection under Schedule 14 will have their pay protection extended until 2025. This means that those trainees who would otherwise lose their pay protection due to the four-year cut-off period or the 2022 end date would continue to be paid under the 2002 payscales until 2025. The parties will review this 2025 end date at a future JNC(J), balancing the position of trainees who may remain in type 2 protection with the responsibility to consider issues of equal pay and the equality duty and allowing for extension of this

date it if there remain trainees who are still pay protected under Section 2. As is currently the case, these trainees will continue to be paid according to the 2002 contract payscale.

10. Pay protection on changing specialty

10.1 When a trainee switches into an identified hard-to-fill specialty, pay protection will be based on what they would have earned had they not switched, provided that they have achieved an Outcome 1 or 2 at their most recent ARCP. If a trainee switches half-way through the year without an Outcome 1 or 2 at their most recent ARCP, their pay protection will not be based on the next salary point but the salary for the grade they are currently on.

10.2 For example, a trainee who switches from ST2 in paediatrics into GP training without having completed the year and/or attained an Outcome 1 or 2 will be pay protected at their ST2 salary in their first year of GPST (GPST1). They will need to successfully progress onto the second year of GPST (GPST2) in order to receive the ST3 salary and continue to progress through the pay system as though they had not switched.

10.3 The contract will provide for the JNCJ to agree to extend pay protection to additional specialties, that currently do not receive a flexible pay premia, where there is clear evidence that the specialty has difficulties in recruiting and where the JNCJ agree that pay protection may help address the issues. The JNCJ will consider if any additional specialties should be eligible for pay protection on an annual basis. Once a specialty has been classed as hard-to-fill by the JNCJ, this designation will be reviewed every three years in order to determine whether or not it still constitutes a hard-to-fill specialty. If the parties agree at the JNCJ that this specialty should no longer be deemed hard-to-fill, those trainees who are already training in that specialty will continue to be pay protected until they complete their training.

11. Pay protection on re-entering training from a career grade – non-shortage specialties

11.1 The parties recognise that the clause limiting pay protection to hard-to-fill specialties does not encourage SAS doctors to re-enter training. Doctors who are employed under SAS national terms and conditions of service currently are not eligible for pay protection if they return to training in any specialty that isn't classed as hard to fill, unless the return is due to circumstances related to disability. The parties commit to exploring a time limited arrangement to provide pay protection for SAS doctors re-entering training, pending the planned reform of arrangements informed by the SAS Strategy. Funding issues will need to be fully considered. The parties will undertake work through JNC(SAS) to propose an approach.

12. Individualised and rota averaged pay

12.1 The parties are committed to the introduction of individualised pay. The parties recognise the dependencies with work NHS Improvement and England are leading on Workforce Development Systems, including the aim of having universal e-rostering by 2021 as in the Long Term Plan. DHSC will

commission NHS Improvement and England to establish a Working Group, involving NHS Employers and the BMA, to develop a work programme and timeline with contingencies to ensure individual pay functionality can be implemented effectively and as soon as is practicable, coming together to review progress towards this in 2020.

Flexible pay premia

13. Academic FPP

13.1 The parties agree that the eligibility criteria for the academic flexible pay premium should reflect more closely the way in which academic careers progress during training. The following changes will be made to the eligibility requirements for non-integrated academic pathways, set out under the 'other academic pathways' heading in Schedule 2 of the terms and conditions of service:

- The criteria for eligibility will now apply to research undertaken during core and run through training programmes, as well continuing to apply during higher training programmes.
- The criteria for eligibility will continue to apply to research undertaken as part of an approved out of programme activity for research (OOPR) that has been approved by the postgraduate dean. In addition, eligibility will be extended to doctors who have undertaken research on a less than full-time basis whilst continuing to undertake training also on a less than full-time basis.
- The criteria for eligibility will continue to require a trainee to return to the same training programme upon completion of the research, but will now also cover instances where a trainee returns to a different programme (provided that programme is related to their research qualification).
- Where a doctor returns to employment on a different training programme, the presumption will be that the research qualification is related to that programme. If an employing organisation is in disagreement over the relationship between the research qualification and the new programme, this will be escalated to the relevant post graduate dean to validate whether the premium should be removed.

This change will come into effect in December 2019.

Safety and rest limits

14. Maximum of 72 hours work in any 7 consecutive day period

14.1 The reference period for this rule will be measured as a maximum period of 72 hours work in any consecutive period of 168 hours, rather than calendar days referenced from midnight to midnight. This reflects the interpretation outlined in Good Rostering Guide produced by the BMA and NHS Employers.

15. Rest after night shifts

15.1 The 46-hours of rest currently required after working 3-4 consecutive night shifts will be applied to any number of rostered night shifts. For example, if two consecutive night shifts or a single night shift are rostered, 46-hours of rest will also apply at the conclusion of either of those shifts.

16. Weekend frequency exemption for nodal point 2

16.1 All trainees will be covered by the maximum weekend frequency rule and definition. The exemption to the maximum weekend frequency rule that could be applied for one placement in foundation year two will no longer be in operation,

17. Maximum 1 in 2 weekend frequency

17.1 All reasonable steps should be taken to avoid rostering trainees at a frequency of greater than 1 in 3 weekends. Authorisation for a rota using a pattern greater than 1 in 3 should require a clearly identified clinical reason agreed by the clinical director and be deemed appropriate by the guardian of safe working. Such rotas should be co-produced with junior doctors, agreed via the JDF and reviewed annually. Trainees that wish to work in excess of 1:3 weekends by undertaking additional work, for example as a locum, are able to agree to do so but must not work at a frequency of greater than the maximum 1 in 2 weekend limit.

18. Maximum of 8 consecutive shifts rostered or worked over 8 consecutive days

18.1 The maximum number of consecutive shifts that can be rostered or worked will be reduced to seven as standard over a period of time. The arrangements to alter existing rotas to meet this provision should commence as soon as is reasonably practicable but, in any event, must have concluded by 5 August 2020 as set out in the implementation timetable.

18.2 Employing organisations and trainees can agree through local processes and in consultation with those affected by the rota, to maintain or increase this limit to eight. Agreements will be on a rota by rota basis and must be reviewed annually as per the original process and additionally reviewed if requested via a work schedule review. Any disagreement on a change to a working pattern must be escalated to the guardian of safe working and the JDF, and where necessary further escalated through the work schedule review appeals processes. Any affected trainee may request a work schedule review in accordance with schedule 5.

18.3 For the purpose of this rule where a shift, such as a night shift, results in work occurring across two separate days as part of one shift, the work on each day is counted independently toward the maximum consecutive limit.

19. Maximum of 5 consecutive long day shifts

19.1 The maximum number of consecutive long day shifts that can be rostered or worked will be reduced to four as standard over a period of time. The arrangements to alter existing rotas to meet this provision should commence as soon as is reasonably practicable but, in any event, must have concluded by 5 August 2020 as set out in the implementation timetable.

19.2 Employing organisations and trainees can agree through local processes and in consultation with those affected by the rota, to maintain or increase this limit to five. Agreements will be on a rota by rota basis and must be reviewed annually as per the original process and additionally reviewed if requested via a work schedule review. Any disagreement on a change to a working pattern must be escalated to the guardian of safe working and the JDF, and where necessary further escalated through the work schedule review appeals processes. Any affected trainee may request a work schedule review in accordance with schedule 5.

20. Breaks

20.1 The parties remain committed to addressing fatigue, in particular in relation to night working, and to ensuring that trainees are supported to take their contractually entitled breaks.

20.2 Any doctor that works a night shift (a shift that attracts the 37% hourly pay enhancement) of twelve or more hours in duration will now receive a third 30-minute paid break. Furthermore, the review and mitigation of missed breaks and other safety critical breaches should be a standing item on JDF agendas.

Leave

21. Calculation of annual leave

21.1 The parties are jointly committed to addressing the inequities and inconsistencies that can occur in relation to how annual leave is calculated and applied. While every endeavour has been made to find an agreeable solution within the timeframe of this review, it is felt that greater time and resource is needed to achieve the desired outcome. A dedicated joint working group will be convened via the JNC(J) for this purpose.

22. Leave for life changing events

22.1 The clause requiring that employers must allow annual leave to be taken for life-changing events has been amended to make clear that this clause relates only to annual leave and should not be conflated with other forms of leave, and to remove the example of a wedding day, to prevent the misinterpretation of this clause that a wedding is the only type of event that can be considered life-changing. It is also supplemented by guidance to clarify that it is for doctors to define what events

are life-changing for them, and that the default assumption is that these requests will be approved – with an escalation process including the guardian where this is necessary.

23. Study leave and mandatory training

23.1 The terms and conditions of service will now be explicit to ensure that study leave is not used by employers for statutory and mandatory training that is a requirement to work in that trust or departmental setting. By doing this, study leave will remain preserved for training or other opportunities that are required to progress through the postgraduate training programme of the specific curriculum that the doctor is enrolled in. The required statutory and mandatory training activities of the doctor will now be sent to doctors alongside their work schedule, which will then be able to be arranged during the placement.

23.2 The contract will have a specific provision to ensure that any time required outside of the work schedule is either paid or given back as time off in lieu, thereby ensuring that trainees will always will always have recognition for this activity, regardless of when it is completed.

24. Prospective cover for study leave

24.1 Employing organisations locally determine the processes for how study leave is managed and taken. Where trainees are required to provide internal cover for colleagues on the rota when they take study leave or if shifts attracting an enhanced rate of pay or an allowance are required to be swapped for study leave, prospective cover is in operation. This must be factored into the calculation of the average weekly hours of work and pay for that rota. Where employing organisations have alternative arrangements for covering study leave where internal cover or swaps are not required, prospective cover does not apply.

Locum work

25. National locum rates

25.1 NHS Improvement will continue to work collaboratively with employing organisations in line with their national mandate to reduce expenditure on temporary staffing and agency locums. The parties acknowledge that this work is extraneous to the national terms and conditions for doctors in training, and therefore the national locum rates outlined in the pay circular and referenced in the terms and conditions of service will be removed. NHS staff banks continue to have the authority to set the rates of payment they offer for locum work.

26. The locum clause

26.1 It is agreed that greater clarity within the terms and conditions of service is necessary to reflect the intended process for undertaking locum work. If trainees wish to do work additional to their work schedule, they will continue to be required to offer their spare time to the service of any NHS

staff bank, for work commensurate to their current grade and competencies. Activities such as; event and expedition medicine, work for medical charities, non-profits, humanitarian and similar organisations, or sports and exercise medicine do not fall under the scope of additional work as a locum.

26.2 The parties are committed to longer term work with NHS Improvement to review the efficacy of current staff bank processes and to make recommendations on improvements that can be made to the benefit of both trainees and employing organisations.

Guardian fines

27. Breaches that attract a financial penalty

27.1 Guardian fines will be extended to include breaches of:

- The minimum non-resident on-call (NROC) overnight continuous rest of five hours between 22:00 and 07:00
- The maximum 13-hour shift length
- The minimum 11 hours rest between resident shifts
- The minimum 8 hours total rest per 24-hour NROC shift

27.2 Where a fineable breach arises that may cause a further breach to occur, for example in the next consecutive shift, it is intended that systems and processes will be developed to mitigate against the further breach occurring or against future occurrences.

28. Rates of the guardian fine

28.1 The total rate of the guardian fine will be based on a 4x multiplier of the 2019 NHSI locum rates, rather than the standard hourly rate paid to the doctor. The apportionment of the fine monies will continue to be paid at a rate of 1.5x the hourly locum rate to the doctor and the remaining funds paid into the guardian fine pot to be disbursed via agreement at JDFs.

Exception reporting

29. What can be exception reported

29.1 The parties agree that the terms and conditions of service should provide greater clarity on the types of activity that can be exception reported. While it is not possible to outline an exhaustive list within the contract, there are a number of overarching principles and examples of activities that will provide a useful steer to trainees and employers which will be included as set out below.

29.2 Exception reporting is the mechanism by which trainees can guarantee compensation for all work performed and uphold agreed educational opportunities, this includes but is not limited to:

- All scheduled NHS work under this contract (e.g. any patient facing and non-patient facing activities that your team or supervisor requires you to do as part of your employment)
- Any activities required for the successful completion of ARCP and any additional educational or development activities explicitly set out in the agreed personalised work schedule
- Activities that are agreed between the doctor and their employer, such as quality improvement or patient safety tasks directly serving a department or wider employing organisation, or their doctors (e.g. attending a JDF, activities related to rota management, delivering teaching, or setting up training programmes)
- All professional activities that doctors are required to fulfil by their employer (e-portfolio, induction, e-learning, Quality Improvement and Quality Assurance projects, audits, mandatory training / courses)

Unless required by your employer or agreed with the educational supervisor, this does not include occasions where an individual may choose to undertake educational activities for personal development or career enhancing purposes which are outside of contractual requirements, the agreed personalised work schedule or are not an essential activity to pass ARCP.

30. Reviewal process for exception reports

30.1 Since the adoption and roll out of exception reporting some organisations have adopted different processes for who reviews exception reports further to agreement with their trainees. This has resulted in individuals other than the educational supervisor being nominated as the reviewer/actioner for certain types of exception report. To reflect this existing practice, the reviewal process for exception reports should be a locally agreed process, which is jointly agreed by; the Guardian, the JDF, and the Joint Local Negotiating Committee. Regardless of the process that is agreed, all reports should be copied to a trainee's educational supervisor irrespective of whether the educational supervisor is required to action all types of report.

31. Response time for educational supervisors

31.1 The terms and conditions of service will mirror the response times referenced in the exception reporting flowcharts produced by NHS Employers and the BMA. In line with this, the educational supervisor (or other nominated reviewer) must respond to exception reports within 7 days of a report being submitted in order to review the report and discuss the reasons with the trainee, and progress to agreeing an appropriate outcome.

31.2 The guardian of safe working will have the authority to action any exception reports that have not been responded to.

32. Pre-authorisation for additional hours of work

32.1 Doctors in their professional judgement may consider that it is necessary to work beyond the hours set out in their work schedule, in order to secure patient safety. The parties acknowledge that doctors will endeavour to seek approval for this with their clinical manager before or during the event but recognise that this will not always be possible and fully support that doctors should be empowered to exception report whenever pre-authorisation is not possible. Once an exception report has been submitted it will continue to be subsequently validated by the clinical manager, and an outcome agreed within 7 days, to allow for payment for the additional hours worked.

33. Payment for exception reports

33.1 Payment must be made for approved exception reports within a month, or within the next available payroll, of a report being approved for payment and agreed by all parties. There should be no additional administrative burden, such as submitting additional forms outside of the exception reporting process, to receive payment for an approved exception report.

34. Conversion of untaken time off in lieu (TOIL) into pay

34.1 Where TOIL is agreed by all parties as the outcome of an exception report, there will be a 4-week window from the outcome being agreed for the trainee and rota manager to discuss and allocate the TOIL to a future shift in their working pattern before the end of that placement. In the instances where this does not occur, the TOIL should automatically be converted to pay after that 4-week period. At the end of a placement, any untaken TOIL will be converted into pay.

35. Automatic acceptance of exception reporting outcomes

35.1 To ensure prompt payment the doctor should formally accept the exception reporting outcome presented by the employer as soon as is practicable. Where agreed outcomes are not formally closed on the system following discussion with the relevant supervisor these will automatically be accepted and closed at the end of the trainee's rotation. Exception reports for trainees with extenuating circumstances will be automatically be accepted and closed at four weeks.

35.2 The parties will produce supporting guidance for trainees and employing organisations to assist in defining examples of extenuating circumstances, such as long-term sickness or maternity leave

Work scheduling

36. Induction

36.1 Generic work schedules must account for the local trust induction required to be undertaken prior or at the start of the placement. This must be reflected as hours of work and paid accordingly.

37. Host and lead employer responsibilities

37.1 As the number of lead employers grow and the lead/host employer relationship normalises for many trainees, it has been agreed that the educational roles of both of these organisations will be clarified by guidance from NHS Employers and the BMA. This guidance, albeit not in the contract, will instruct both host and lead employers of their educational responsibilities towards trainees, and providing assurances for trainees about which of these two groups will be responsible for their work scheduling.

38. Personalised work scheduling meetings and off-site educational supervisors

38.1 Trainees must be able to meet with their Educational Supervisor in the 4 weeks following their start date. It is important that this meeting takes place to personalise the trainee's work schedule, but for a variety of other educational reasons, such as reviewing the curriculum requirements of the post. Even if their allocated Educational Supervisor is off site, trainees will now have the opportunity to meet with them and must be released from clinical duties to do so.

39. Exception reporting for missed personalised work scheduling meetings

39.1 In the event that this does not happen within the first 4 weeks of their new jobs, doctors or dentists in training will now be able to file an exception report, which will be sent to the Director of Medical Education and Educational Supervisor (for trainees working in non-hospital settings, including – but not limited to – GP and Public Health trainees, this will be sent to the Head of School instead of the Director of medical Education).

40. Code of practice

40.1 The parties have agreed that the requirements for the provision of information from employing organisations to trainees at 8 weeks and 6 weeks prior to commencement in post, as contained within the Code of Practice will be made contractual. This will come into effect following the collaborative development of the legal mechanisms and processes to enact it.

Guardian of safe working hours

41. Administrative time and support

41.1 The parties are committed to ensuring that discussions and reviewal of the administrative time and support available to the guardian are undertaken on a comprehensive and inclusive basis.

41.2 It is agreed that employing organisations shall seek to engage with all parties involved in performance management of the guardian to assess and make recommendations to set time commitment and administrative support required for the role, taking into consideration the number of rotas and the number of doctors in training for whom the guardian will have responsibility. This will be an annual process.

GP trainees

42. Supernumerary status of GP trainees

42.1 The terms and conditions of service will reflect the longstanding principle contained in the previous contractual arrangements for GP trainees prior to 2016, that trainees in general practice settings are supernumerary to the workforce of the practice.

43. Additional mileage/expenses for GP trainee home visits

43.1 GP trainees that are required to use their personal vehicle on the possibility of a home visit being required on any working day shall be eligible for reimbursement for the cost of mileage and associated costs from their home to the principal place of work.

Facilities

44. Too tired to drive home provisions

44.1 Where a trainee feels too tired to drive home following a night shift, a long late shift or attending work at night when non-resident on-call, employing organisations are already required cover the cost of an appropriate rest facility or alternative arrangements for the trainee's safe travel home. This provision will now also provide for reasonable expenses to be paid for the trainee's return journey to work, either to begin their next shift or, where they have left their personal vehicle at work, to collect the vehicle.

45. Payment for accommodation when non-resident on-call

45.1 Emergency response requirements may necessitate that trainees working non-resident on-call must be able to travel back to work within a specified time and/or must be based within a specified distance from their workplace. Where it necessary to be resident in order to maintain a safe response time for the management of time critical conditions and a trainee is based outside of these, and as a result must obtain accommodation to be resident during the on-call duty period, employers will provide this without charge. If appropriate on-call accommodation is not available, the hospital must make alternative accommodation arrangements. In this circumstance, any extra cost incurred may not be passed onto the doctor.

Commitment to future work

46. Working groups

46.1 The parties remain committed to the ongoing maintenance of the 2016 terms and conditions of service through future meetings of the Joint Negotiating Committee for Junior Doctors (JNCJ) and to

continue make improvements for the benefit of trainees and employers. There are a number of areas where longer term and more dedicated review were felt necessary.

46.2 The parties agree that the JNCJ will commission further thematic working groups to review the following:

- Health and wellbeing of doctors in training
- Non-resident on-call
- Annual leave
- Recruitment and retention of trainees in general practice, and pay parity with hospital medicine

47. Supporting guidance

47.1 In addition to the above, the parties have also agreed to jointly produce and/or update guidance on a number of areas.

Item
Guidance on champion of flexible training
Less than Full Time templating tool
Less Than Full Time work schedule
2005 flexible training guidance
Good rostering guidance
Guidance on exception reporting
Guidance on improving access to breaks being taken within shifts
Best practice guidance on reducing fatigue during night shifts, and appropriate facilities
Guidance on Non-Resident On-Call, building on that in the Good Rostering Guidance
Guidance on the impact of regular work at maximum shift limits and technological solutions such as consultant led and/or digital handover
Update the Good Rostering Guidance in relation to workforce planning and tools
Guidance on the minimum number of doctors required to roster sustainable, training-compatible rotas
Guidance on generic work schedules
Guidance on personalised work schedules
Guidance on work schedule reviews, to supplement flowcharts
Guidance on visibility of exception reporting payment on payslips
Guidance on best practice for exception reporting in non-hospital settings
Guidance on administrative support for guardians

Guidance for guardians and the Junior Doctor Forum on the use of fine money
Guidance on best practice for the guardian role in non-hospital settings
Guidance for employing organisations in relation to the Follett principles and ensuring that joint academic/NHS appointments are covered by honorary contract arrangements
Guidance in conjunction with relevant stakeholders on ascertaining expected hours of work for public health trainees
Guidance on the exceptional Flexible Pay Premia
Guidance on educational requirements of every postgraduate training programme by training grade
Update the NHS Employers factsheet for Educational Supervisors
Continue to work with Academy of Medical Royal Colleges on recognition of transferrable competencies framework
Guidance on use of recognition of transferrable competencies for Health Education England and Employers
Guidance on use of educational exception reporting, including the need for Director of Medical Education reports to the board
Guidance on protections for trainees who undertake Out of Programme activities

Framework Agreement: amendments to the 2016 junior doctors contract

Outline Implementation Timetable

This implementation timeline should be read in conjunction with the published [framework agreement](#). The framework agreement sets out both the pay investment that will be made and the amendments to the 2016 junior doctors' contract following negotiations between NHS Employers, the British Medical Association (BMA) and the Department of Health and Social Care (DHSC)

We are working with software providers to ensure the appropriate software updates are made to give effect to the relevant provisions.

Updated terms and conditions for the 2016 contract and implementation support materials will be published in due course.

For queries:

Employers can contact doctorsanddentists@nhsemployers.org

Junior doctors **who are BMA members** can contact: support@bma.org.uk or on 0300 123 1233.

Date	Proposed implementation
1 April 2019 (backdated)	<p><u>Annual pay uplifts</u></p> <ul style="list-style-type: none"> Annual 2% uplift applied during the period 2019/20 to 2022/23. Backdated to 1 April in 2019/20 ESRresponse: system updates in place by September 2019
7 August 2019 (first Wednesday in August)	<p>Amended 2016 contract is introduced</p> <p><u>Pay and transitional arrangements</u></p> <ul style="list-style-type: none"> Trainees who are currently in receipt of 'Section 2' transitional pay protection under Schedule 14 will have their pay protection extended until 2025.

Framework Agreement: amendments to the 2016 junior doctors contract

- Pay protection for changing specialty clause is updated to reflect the agreed method of calculating pay protection for those moving into hard-to-fill specialties.

Leave

- Leave for life changing events

Safety and rest limits

- Breaks for night shifts
- Weekend frequency exemption for nodal point 2
 - FY2 rotas using the weekend frequency exemption will be risk assessed at the point of commencement in August. Where no significant risks are identified that would render the service unworkable, rotas will be amended to a maximum frequency of 1 in 2 weekends, using local rota change processes, in line with the Good Rostering Guide.
 - Where significant risks are identified that would render the service unworkable, the existing rotas will remain in place until no later than December 2019.

Employers notified of 12-month timeframe to commence the process to alter existing rotas and will need to start consultation with trainees to reduce:

- The maximum number of consecutive shifts rostered or worked over 8 consecutive days reduced from 8 to 7
- The maximum number of consecutive long day shifts rostered or worked reduced from 5 to 4

Arrangements to alter existing rotas to meet this provision should commence as soon as is reasonably practicable but, in any event, must have concluded by 5 August 2020

Locum work

2. Locum clause clarification

Framework Agreement: amendments to the 2016 junior doctors contract

	<p><u>Facilities</u></p> <ul style="list-style-type: none"> h) Too tired to drive home provisions i) Payment for accommodation when non-resident on-call <p><u>GP Trainees</u></p> <ul style="list-style-type: none"> j) Supernumerary status of GP trainees k) Additional mileage/expenses for GP trainee home visits <p><u>Guardian fines</u> (as per amended pay circular)</p> <ul style="list-style-type: none"> l) Rates of guardian fines <p><u>Exception reporting</u></p> <ul style="list-style-type: none"> m) What can be exception reported n) Pre-authorisation for additional hours of work <p><u>Work scheduling *</u></p> <ul style="list-style-type: none"> o) Personalised work scheduling meetings and off-site educational supervisors p) Exception reporting for missed personalised work scheduling meetings <p><i>Due to the short notice with the implementation of this provision. For trainees commencing on 7 August, it may not be possible to arrange a meeting with their educational supervisor within the 4-week time frame. In this situation the trainee must arrange a meeting with the clinical lead as soon as its practicable to do so</i></p>
Oct 2019	<p>Pay and Transitional Arrangements</p> <ul style="list-style-type: none"> 5. Pay protection clause for those on 2002 terms and conditions is updated to reflect pay protection arrangements for those moving onto the updated 2016 TCS. <p><i>The parties have committed to ensure that an agreement in this regard will be reached by early October 2019. Trainees who remain on the 2002 TCS should not be moved onto the updated 2016 terms until pay protection arrangements have been finalised and a transition date agreed.</i></p>

Framework Agreement: amendments to the 2016 junior doctors' contract

	<p><u>Safety Limits</u></p> <p>5 Maximum of 72 hours work in any consecutive 168-hour period</p> <p><u>Work scheduling</u> <i>[Recommended to issue for Oct 2019, or at the trainees next scheduled rotation]</i></p> <p>6 Host and lead employer responsibilities (guidance) 7 Mandatory training requirements to be sent with generic work schedule 8 Generic work schedules to be sent to include the local trust induction required to be undertaken prior or at the start of the placement.</p> <p><u>Safety limits</u> <i>[Recommended to be reflected in rotas for Oct 2019 rotations. To be included in rotas for Dec 2019 rotations and all other rotas to be updated no later than Feb 2020]</i></p> <p>9 Rest after night shifts 10 Maximum 1 in 3 weekend frequency</p> <p><u>Exception reporting</u></p> <p>11 Review process for exception reports locally</p> <p><u>Agreed sections of the Good Rostering guidance</u></p> <p>12 NROC 13 LTFT principles</p>
Dec 2019	<p><u>Pay</u></p> <ul style="list-style-type: none"> Weekend frequency allowance An enhanced rate of pay for shifts that finish after midnight and by 4am <p><u>Exception reporting</u></p> <ul style="list-style-type: none"> Response time for educational supervisors

Framework Agreement: amendments to the 2016 junior doctors' contract

	<p><u>Guardian of safe working hours</u></p> <p>6. Administrative time and support</p> <p><u>Guardian fines</u></p> <p>7. Breaches that attract a financial penalty</p> <p><u>Flexible Pay Premia</u></p> <p>8. Academic FPP</p> <p><u>Less Than Full Time</u></p> <p>9. LTFT Allowance</p> <p><u>Flexible training</u></p> <p>10. Champion of flexible training</p> <p><u>Exception reporting</u> <i>[Software systems to be updated for Dec 2019 and payment for validated reports made in the next available payroll. The submissions of reports in Dec 2019 after go-live may not be resolved in time for Jan 2020 payroll and may be carried into Feb. It is recommended that these are processed earlier, where possible]</i></p> <p>11. Payment for exception reports 12. Conversion of untaken time off in lieu (TOIL) into pay 13. Automatic acceptance of exception reporting outcomes</p>
Feb 2020	<p><u>Leave</u></p> <p>11. Study leave and mandatory training 12. Prospective cover for study leave</p>
5 August 2020	<p><u>Code of practice</u></p> <p>14. 8/6-week notification provisions, with supporting caveats</p> <p><i>Changes to be in place by June 2020, for doctors rotating from 5 August 2020, requiring notifications at 8 and 6 weeks prior to this date, and all future rotation dates applicable.</i></p>



Framework Agreement: amendments to the 2016 junior doctors’ contract

October 2020	<p>Introduction of the fifth nodal point</p> <p>18. 1 October 2020 the value will be £3,000 [£52,036]</p> <p>19. 1 October 2021 the value will increase to £6,000 [£56,077]</p> <p>20. 1 April 2022 the value will increase to £7,200 [£58,398]</p>
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Additional provisions

20 Enhanced shared parental leave and child bereavement leave introduced from 1 April 2019.

**Summary report from the Patient Experience Committee,
02/12/19**
**Committee Chair
(Non-Executive Director)**

The Patient Experience Committee (PEC) met on 2nd December 2019.

The key matters considered at the meeting were as follows:

- The status of actions raised at previous meetings was noted, which included agreement that previous actions relating to the response to the Cancer Patient Experience Survey 2017 should be superseded by a new action for a progress report to be provided by the Divisional Director of Nursing & Quality (DDNQ), Cancer Services to the Assistant Trust Secretary for dissemination to PEC members.
- The DDNQ, Cancer Services agreed to liaise with the West Kent Cancer Action Group on how the Trust's response to the national cancer survey can be more inclusive of the wider population
- The Chief Nurse gave a presentation on the feedback gathered from the PEC Workshop on 04/09/19, with Committee members agreeing to take into consideration which patient groups should be a future focus of the Committee going forward to optimise effectiveness
- The Chief Nurse gave a presentation on the feedback from patient engagement events and forward programme of patient engagement work outlining the Trust's Patient Experience Strategy and vision, highlighting the concerns raised by patients and carers from surveys and events with Trust's priorities to address the key issues
- The Chair reported on the future of the Committee, and it was agreed that a draft 'Compact' / Code of Conduct would be provided by the Interim Patient Experience Lead to be circulated by the Assistant Trust Secretary and all members invited to submit comments to the Chair by 31/01/20 ahead of the next PEC Meeting
- The following actions were raised under "any other business":
 - a. For the Committee Chair to liaise with the Chief Operating Officer over the Trust's reported use of two pages of paper when sending patients a copy of the letter to their GP following care or treatment at the Trust
 - b. For the Complaints and PALS Manager to investigate the signage in relation to the 'red route' areas at Maidstone Hospital to determine whether drivers are notified of penalty notices
 - c. For the Chief Nurse to investigate the concerns raised at the meeting in relation to the League of Friends shop staff at Maidstone Hospital having to respond to queries arising from the 5pm closure of the main reception desk (and the reported planned relocation of the security desk)

In addition to the actions noted above, the Committee agreed: N/A

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

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

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

Summary report from Quality Committee, 05/12/19 Committee Chair (Non-Exec. Director)

The Quality Committee met on 5th December (a Quality Committee 'deep dive' meeting).

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

- A **review of patient falls** was undertaken, for which the Falls Prevention Practitioner and Deputy Chief Nurse attended. The presentation covered "Inpatient Falls – the big picture"; "Falls rate comparison by years"; "Monthly Falls Rate and Falls Numbers"; and "Falls by Site for 2019", and a discussion was held on whether the 6.1 falls rate achieved last year, against the target rate of 6.0, was regarded as a failure, or was so close to the target that it was considered a success. A query was also raised as to whether a falls rate of 6.0 was the correct target to aim for. This was confirmed as appropriate, although the team was challenged to be more ambitious when setting the objectives for 2020/21, given the increased levels of staffing that the Trust had been able to achieve.
- The presentation also included the findings from the National Audit Inpatient Falls 2017, which included poor performance for the "Measurement of lying and standing blood pressure" indicator (which had since been area of focus).
- Falls-related Serious Incident (SIs) were also discussed and the Associate Director, Quality Governance agreed to check and confirm what proportion of the 19 patients aged over 75 that had experienced a falls-related SI during 2019/20 had been subject to a falls risk assessment.
- The three **items scheduled for the next meeting in February 2020** were noted and confirmed ("Update on the implementation of the Trust-wide action plan for diabetes"; "Review of the Critical Care Outreach service"; and "Outcome of the review of radiology incidents and complaints involving concerns in relation to unreported plain X-rays that was requested at the Quality Committee 'deep dive' meeting on 14/08/19")

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

- The Chief Nurse should check and confirm whether the Estates and Facilities department undertake audits of the existence and functioning of emergency call bells within the public toilets at the Trust's hospitals

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

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

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

Information and assurance

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

Summary report from the Finance and Performance Committee, 18/12/19	Committee Chair (Non-Exec. Director)
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The Finance and Performance Committee met on 18th December 2019.

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

- The “performance moment” focused on **Outpatients**, and the Chief Operating Officer gave a presentation. A number of areas for improvement were identified so it was agreed that the Committee should apply further scrutiny to progress and that an “Update on outpatient services” should be submitted every two months, from February 2020
- The **month 8 financial performance** was reviewed, which noted that the Trust remained on plan for the year (due to the application of flexibility during quarter three); and also noted that formal recovery plans had been asked for all areas across the Trust, which would be reviewed on 19/12/19. The updated forecast for the 2019/20 year-end was also discussed
- The monthly **update on Wells Suite income** was given and progress noted (which included that no cases had been cancelled, despite the pressures faced by the Trust)
- The **month 8 non-finance related performance** was discussed, which included the A&E 4-hour (for which the Trust continued to feature in the top 10 of Trusts nationwide), Referral to Treatment (RTT) and cancer waiting time targets
- An **update on the Winter Plan** was presented and the Committee noted the range of actions planned over the coming weeks to improve patient flow
- An **update on the implications of implementing IFRS 16 (Leases) from 2020/21** was noted and it was agreed that a summary of the initial data collection on the impact (that Trusts need to submit on 15/01/20) should be submitted to the Committee in January 2020
- An **update on the Trust’s planning submissions for 2020/21** was given by the Director of Strategy, Planning and Partnerships, and the Committee noted the improvements from the 2019/20 planning process (although the variability in the development of Divisional plans was also acknowledged, as was the need for further triangulation)
- The **case for additional car parking capacity** was reviewed in detail (for which the Director for Estates & Facilities attended). The Committee agreed that the Case could be recommended for approval by the Trust Board, subject to further clarification of the risks, which would be considered at the Trust Board meeting on 19/12/19 (a separate item has been scheduled for the ‘Part 2’ Trust Board meeting). It was also agreed that the Chief Executive should prepare a brief presentation focusing on the risks associated with the Case, to support the Trust Board’s review
- The reports submitted for the **post-project review of approved Business Cases, recent findings from relevant internal audit reviews and use of the Trust Seal** were noted
- It was confirmed that the **“finance moment” at the January 2020** meeting should be on cash management

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

- The Trust Secretary should liaise with the Director of Strategy, Planning and Partnerships to schedule the Committee’s consideration of the 2020/21 plan for the West Kent Integrated Care Partnership
- The Trust Secretary should schedule an “Update on the implementation of the Electronic Patient Record (EPR)” item at the Committee’s meeting in January 2020
- The Trust Secretary should defer the “Update on IT strategy and related matters (six-monthly)” item from the Committee meeting in January 2020 to the meeting in February 2020

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

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

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

Information and assurance