NHS
Maidstone and Tunbridge Wells NHS Trust

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

27 February 2020, 13:00 to 15:30
Lecture Rooms 1 and 2, The Education Centre, Tunbridge Wells Hospital

Agenda

02-1
To receive apologies for absence

David Highton

02-2
To declare interests relevant to agenda items

David Highton

02-3
Minutes of the 'Part 1' meeting of 30th January 2020

David Highton

Board minutes 30.01.20 (Part 1).pdf (9 pages)

02-4
To note progress with previous actions

David Highton

Board actions log (Part 1).pdf (3 pages)

02-5
Safety moment

Claire O'Brien / Peter Maskell

Safety Moment.pdf (4 pages)

02-6
Report from the Chair of the Trust Board

David Highton

Chair's Report.pdf (1 pages)

02-7
Report from the Chief Executive

Miles Scott

Chief Executive's report February 2020.pdf (3 pages)

02-8
Integrated Performance Report for January 2020

Miles Scott

IPR month 10.pdf (39 pages)

02-8.1
Safe (incl. planned and actual ward staffing for January 2020)

Claire O'Brien

02-8.2
Safe (infection control)

Sara Mumford

02-8.3
Effective

Sean Briggs

02-8.4
Caring

Claire O'Brien

02-8.5
Responsive

Sean Briggs

02-8.6
Well-Led (finance)

Steve Orpin

02-8.7
Well-Led (workforce)

Simon Hart

Board Assurance Framework (BAF)

02-9
Proposed amendment to objective 6 in the Board Assurance Framework for 2019/20

Kevin Rowan

Proposed amendment to BAF objective 6.pdf (1 pages)

Planning and strategy

02-10
Stroke service update

Peter Maskell / Sean Briggs

Stroke Service Update.pdf (33 pages)

02-11
Mid-winter review

Sean Briggs

Winter Plan Update Trust Board February 2020 FINAL.pdf (9 pages)

02-12
Update on the Trust's 2020/21 plan (incl. details of the first submission of the Trust's 2020/21 operating plan)

Amanjit Jhund

Update on the Trust's 202021 plan.pdf (20 pages)

02-13
The Kent and Medway Strategy Delivery Plan, 2019/20 to 2023/24

Amanjit Jhund

The Kent and Medway Strategy Delivery Plan, 2019-20 to 2023-24.pdf (105 pages)

02-14
Review of the Business Case for the Kent & Medway Vascular Programme

Simon Brooks-Sykes

Please note that the Senior Strategic Development Manager & Programme Manager for the Kent and Medway Vascular Network will attend for this item

Please note that the appendices have been made available via the "Documents" section of the Admincontrol system

The item has been scheduled for 2:45pm

Review of the Business Case for the Kent & Medway Vascular Programme.pdf (55 pages)

Reports from Trust Board sub-committees

02-15
Workforce Committee, 30/01/20

Emma Pettitt-Mitchell

Workforce committee summary January 2020.pdf (1 pages)

02-16
Quality Committee, 06/02/20

Sarah Dunnett

Summary of Quality C'ttee, 06.02.20.pdf (1 pages)

02-17
Finance and Performance Committee, 25/02/20

Please note that the report will be issued after the meeting

Neil Griffiths

02-18
To consider any other business

David Highton

02-19
To receive any questions from members of the public

David Highton

02-20
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: 26th March 2020, 9.45am, Pentecost / South Rooms, The Academic Centre, Maidstone Hospital

MINUTES OF THE TRUST BOARD MEETING ('PART 1') HELD ON THURSDAY 30TH JANUARY 2020, 9.45A.M, AT MAIDSTONE HOSPITAL

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	David Highton	Chair of the Trust Board	(DH)
	Sean Briggs	Chief Operating Officer	(SB)
	Maureen Choong	Non-Executive Director	(MC)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Neil Griffiths	Non-Executive Director	(NG)
	Peter Maskell	Medical Director	(PM)
	David Morgan	Non-Executive Director	(DM)
	Claire O'Brien	Chief Nurse	(COB)
	Steve Orpin	Chief Finance Officer	(SO)
	Emma Pettitt-Mitchell	Non-Executive Director	(EPM)
	Miles Scott	Chief Executive	(MS)
In attendance:	Karen Cox	Associate Non-Executive Director	(KC)
	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)
	Vicki Belton	Health Play Specialist, Paediatric Gastroenterology (for items 01-6 to 01-8)	(VB)
	Ellie Hudson	Patient's relative (for item 01-8)	(EH)
	Christian Lippiatt	Head of Occupational Health & Freedom to Speak Up Guardian (for items 01-13 and 01-15)	(CL)
	Jackie Tyler	Lead Matron, Children's Services (for items 01-6 to 01-8)	(JT)
	John Weeks	Director of Emergency Planning & Communications (for items 01-12, 01-13, 01-15 and 01-16)	(JWe)
Observing:	Naomi Butcher	Team Leader in Cancer Services	(NB)
	Pam Croucher	Public member of the Patient Experience Committee	(PC)
	Robin Harmer	External Account Manager, Ocura Healthcare Furniture	(RH)

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

01-1 To receive apologies for absence

No apologies were received.

01-2 To declare interests relevant to agenda items

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

01-3 To approve the minutes of the 'Part 1' meeting on 19th December 2019

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

01-4 To note progress with previous actions

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

- **12-5 ("Arrange for an easy-read version of the SWAN end of life care campaign leaflet to be produced").** COB reported that the End of Life Steering Committee had met on 28/01/20

and it had been agreed that an easy-read version of the leaflet would be developed. It was therefore confirmed that the action could be closed.

01-5 Safety moment

COB referred to the relevant attachment and highlighted the key points therein, which included that staff had been made aware that it was both appropriate and acceptable to apologise when things went wrong. COB also stated that the concept of seeing every complaint as a gift had also been encouraged, as well as emphasising the need to ensure that the achievement of the complaints response target should be considered in context, so that work did not cease once the response had been sent, and that lessons were learned. PM added that there was a need to change the culture in relation to complaints, although there had been some progress in the regard, and acknowledged the validity of seeing complaints as a gift.

KC referred to the change programmes in place in the Trust and asked whether the Trust monitored details of the location and themes involved in complaints. COB confirmed that such details were monitored and made specific reference to the complaints Annual Report.

DM asked why complaints were categorised by risk level. COB replied that the Trust was required to apply such ratings and explained the criteria for applying a 'red' rating. DM asked for clarification that that the rating was therefore, in effect, a rating of seriousness rather than risk. COB confirmed that was correct.

01-6 Report from the Chair of the Trust Board

DH referred to the relevant attachment and highlighted the key points therein, which included details of the Consultant appointments that had been made, as well as noting that that he had unveiled the plaque at the new League of Friends courtyard garden that was referred to in MS' report under item 01-7.

01-7 Report from the Chief Executive

MS referred to the relevant attachment and highlighted the key points therein, which included the work that would commence regarding improvements in estates and facilities, for which a report would be submitted to the Trust Board in March 2020.

Patient Experience

01-8 A patient's experiences of the Trust's services

DH welcomed EH to the meeting and explained that the Trust Board considered it important to hear patients' stories. DH also noted that EH had been the public face of the Trust's Christmas charity "Kid's appeal". JT then introduced EH and explained that she was the mother of a child that was receiving regular treatment at the Riverbank Unit at Maidstone Hospital (MH). EH then reported the following points:

- Her son, Finley, had a very rare condition, Diamond Blackfan Anaemia, and had to undergo regular blood transfusions at the Riverbank Unit
- The staff at the Riverbank Unit often went 'above and beyond' their required duties. Dr Kisat responded very swiftly to any queries EH posed, including via text message
- EH only had minor issues for improvement as on the whole she had nothing but praise for the service

DH noted that Finley's care involved other hospitals and asked whether the liaison between the Trust and those hospitals worked well. EH confirmed that was the case.

PM asked about the holistic care that was provided to Finley. EH described how this manifested and reiterated her comments that she was really pleased with the care provided by the Trust.

MS asked how EH found the transition between the children's services at the Riverbank Unit and the services at Tunbridge Wells Hospital (TWH), noting that there would be occasions when Finley would need care and treatment at TWH. EH replied that there were some issues with the transition

between the two hospitals, but on the whole the relationship worked well. MS commented that EH's circumstances illustrated the importance of continuing to have the Riverbank Unit at MH. EH then gave details of the charges that were applied when she had to attend TWH and MS committed to investigate the issues raised.

Action: Arrange for the car parking fee issue raised by the person presenting at the "Patient Experience" item at the Trust Board meeting on 30/01/20 to be investigated (Chief Executive, January 2020 onwards)

MC asked how Finley felt about the Trust's service. EH noted that Finley was only 2½ years old, but confirmed that he was pleased with the service.

COB then commended EH for attending and noted that Dr Kisat would have liked to be at the meeting, to support EH, but was unable to do so. COB then emphasised the importance of continuity of care.

DH asked EH to elaborate on the minor issues she felt needed to improve, noting that he presumed the car parking issue EH had described was one such issue. EH confirmed that was the case and noted that delays in transfusions were frustrating.

DH then thanked EH for attending, and for being the public face of the Trust's Christmas charity "Kid's appeal".

Integrated Performance Report

01-9 Integrated Performance Report for December 2019

01-9.1 Safe (incl. planned and actual ward staffing for December 2019)

COB referred to the relevant attachment and highlighted the key points therein, which included the increase in the total number of falls at MH, and the continued high number at TWH. COB elaborated on the work being undertaken in response, which included the additional staff member that had started in post in the falls prevention team.

COB then reported the latest position on the occurrence of hospital-acquired pressure ulcers and explained how the Trust had responded, which included the additional staff training that would be delivered by the Tissue Viability team. COB also reported the latest position regarding Serious Incidents (SIs), including the completion of SI investigations.

COB then referred to the safe staffing data and highlighted the key points therein. DH commented that he assumed the use of agency staff would reduce once the overseas nursing staff completed their supernumerary periods and asked COB for further details. COB confirmed that the aim was to support the overseas nurses to end their supernumerary periods but noted that the level of staff who had passed their objective structured clinical examination (OSCE) in recent weeks had reduced, so such staff would continue to be supported. SH added further details on the plans to support such individuals and ultimately reduce the use of temporary staff. SO noted that the data from January 2020 indicated that the use of agency staff had reduced, which aligned with the Trust's expectations. SB however cautioned against being over optimistic on the issue.

SDu remarked that it felt like the Trust was moving into a staffing position that it had not been in for several years, and asked what messages had been given to staff in relation to expected performance. COB confirmed that the expectation from Matrons had been communicated, and elaborated on the details. SDu emphasised the importance of ensuring there were clear messages on priorities. The point was acknowledged.

MC noted the bureaucratic burden that was placed on nursing staff and asked COB whether she was confident that nurses had sufficient capacity, and time, to undertake all their expected duties. COB gave her perspective and noted the introduction of a leadership programme for Matrons.

MS then referred to SDu's comment regarding priorities, acknowledged the point, and emphasised the need for further integration between projects.

01-9.2 Safe (infection control)

SM referred to the relevant attachment and highlighted the key points therein, which included that there had been only one case of c-diff (which meant the Trust was one case below trajectory), along with the latest details of flu cases.

SM then gave details of the Trust's response to the Novel Coronavirus (2019-nCoV), noting that two patients had been suspected of having the virus but neither had needed to be tested. SM added that an isolation pathway had been established in the Emergency Department (ED) and discussions had taken place at the STP level, which had noted that GPs did not have the facilities to adequately respond to suspected cases. SM added that one member of staff had been expected to return from China on 31/01/20, but it had been confirmed that they would not return to work and would self-isolate themselves for two weeks, in accordance with the national guidance. SM concluded that the Trust was as prepared as it could be.

01-9.3 Effective

PM referred to the relevant attachment and highlighted the key points therein, which included the latest position on readmissions, for which PM noted that he was working with the Trust's Associate Director of Business Intelligence. DH asked for confirmation that the increase in elective readmissions had triggered the 'red' rating in the "Effective" domain. PM confirmed that was correct.

01-9.4 Caring

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

01-9.5 Responsive

SB referred to the relevant attachment and highlighted the key points therein, which included the continued high number of attendances at the ED, although the Trust continued to be within the top five performing Trusts in the country for ED 4-hour waiting time target performance, which was 91% for January. SB commended the performance, which staff considered to be a greater achievement than achieving the 95% target in March 2019. SB also noted that the improved performance on patient flow had enabled a strong performance on ambulance handovers.

SB then noted that every cancer access target had been achieved in November 2019 and reported that the same would be the case for December 2019. SB commended NB, who was observing the Trust Board meeting that day, for her role in the achievement.

DH noted that at a recent national event, the NHS' Chief Operating Officer had asked for the Trust's improvement on cancer to be developed into a case study, which demonstrated the national recognition that had been obtained.

DM then referred to the forecast bed numbers required, as stated within the winter plan, and asked how the actual situation compared to the forecast. SB explained that the forecast in the winter plan had been erroneous, particularly for the attendances and performance in December 2019, although the situation in January 2020 was more closely aligned with the plan. SB elaborated on the aspects of the winter plan that had worked well, along with those that had not worked so well. MS then gave details of the bed numbers compared to those in the winter plan and DH added further context, including the Trust's comparative position.

DM asked how the potential replacement of the ED 4-hour waiting time target would affect the Trust. DH explained his understanding of the potential change and MS stated that even if the change occurred, it was likely that the Trust would need to continue to measure the ED 4-hour waiting time target target, to provide some historical context to any new measure.

SB then reported the final data for performance on the Referral to Treatment (RTT) waiting time target and explained the actions being taken to achieve the expected year performance of 86.7%.

NG added that the Finance and Performance Committee meeting on 28/01/20 had acknowledged the continued hard work and achievement of the various targets, but asked how the clinically led organisational changes had affected the Trust's performance on such targets. SB replied that he believed the changes had made a real difference and illustrated his point with some recent examples.

DH then noted that he and SO had attended an NHSE/I South East Leadership Summit on 23/01/20, which prioritised the need to focus on eradicating the number of patients who waited more than 52 weeks for treatment and asked SB for an update. SB gave details of the Trust's continuing data quality project and confirmed that the only patients that waited longer than 52 weeks at the Trust were those who were unknown to the Trust at the time and who were only recognised as having waited more than 52 weeks after that point i.e. such waits were related to a data quality issue, not to capacity issues.

01-9.6 Well-Led (finance)

SO referred to the relevant attachment and highlighted the key points therein, which included that the Trust had delivered its financial plan for quarter 3, so the Trust was eligible for the Provider Sustainability Fund (PSF) for that quarter, which meant the Trust was now on track to deliver its year-end surplus of £6.9m.

SO then reported that Divisions had been asked to set their own recovery plans, and the only request beyond that was for Divisions to deliver such plans.

EPM referred to the number of amber ratings on the "Performance Wheel" and asked how such ratings aligned with the confidence that the Members of the Executive Team had indicated in relation to the year-end performance. DH pointed out that the Board Assurance Framework (BAF) ratings reflected a confidence rating against a narrower set of objectives, and there was therefore no direct relationship between the ratings in the BAF and the ratings in the "Performance Wheel". KR confirmed that was correct and that that was how the process was intended to work. A discussion was then held during which DH suggested that the revised Integrated Performance Report be reviewed in due course, to ensure the process worked as effectively as intended. DH continued that would like to see the review completed by the Trust Board meeting in March 2020. This was agreed. SO however noted that a simple change that could be made was to include the forecast "Performance Wheel" within the Integrated Performance Report.

Action: Arrange for the revised Integrated Performance Report to be reviewed, in response to the comments made at the Trust Board meeting on 30/01/20 and to determine whether it was operating as effectively as intended (Chief Finance Officer, March 2020)

01-9.7 Well-Led (workforce)

SH referred to the relevant attachment and highlighted the key points therein, which included the latest position on the staff flu vaccination campaign and the work taking place on staff turnover.

RF challenged the choice of workforce Key Performance Indicators (KPIs) currently listed under the "Well Led" domain and proposed that the aforementioned review of the Integrated Performance Report consider whether there were more appropriate measures of leadership that should be monitored under that domain. DH concurred. The proposal was therefore agreed.

Action: Ensure that the review of the revised Integrated Performance Report that was requested at the Trust Board meeting on 30/01/20 consider the appropriateness of the current workforce-related Key Performance Indicators in the "Well-Led" domain (Chief Finance Officer / Director of Workforce, March 2020)

Planning and strategy

01-10 Briefing on the current situation in relation to the stroke service

PM referred to the relevant attachment and highlighted the key points therein, which included that the outcomes of the Independent and Judicial Reviews had not yet been issued. PM also commented on the Trust's current stroke performance and made reference to the situation at other local trusts, including Medway NHS Foundation Trust (MFT). SB added that the report included a

risk assessment that related to how the Trust would manage the impact of a deterioration of MFT's stroke service, but SB made it clear that the assessment was not an attempt to prejudge the outcome of the Independent Review or Judicial Review. The point was acknowledged.

PM then gave further details of the Trust's current performance and noted that this compared favourably with other local Trusts. SB also commended the staff for maintaining the rating on the Sentinel Stroke National Audit Programme (SSNAP) and for sustaining their morale in the face of significant change. COB then commented further on the current situation regarding nursing staff.

DM then referred to the risk of the Trust losing the £200k of capital expenditure that had been allocated to the Hyper Acute Stroke Unit (HASU). SO gave assurance that the expenditure would be allocated to another capital scheme, rather than be lost, if there continued to be no outcome from the aforementioned Independent and Judicial Reviews.

01-11 Approval of the Trust's Corporate Strategy and Clinical Strategy and key choices and implications for the supporting strategies

AJ referred to the relevant attachment and highlighted the key points therein, which included the progress with completing the three remaining supporting strategies (the financial strategy, the estates and facilities strategy and the people strategy). AJ then gave details of the engagement that had been taken, and was planned, in relation to the strategy, which included plans to print hard copies of the strategy, once approved.

DH noted that it had now been announced that Wilf Williams had been appointed as the successor to Glenn Douglas as Accountable Officer of the eight Kent and Medway Clinical Commissioning Groups (CCGs) and asked that this be reflected in the engagement work. AJ agreed.

Action: Ensure that the external engagement on the Trust's clinical strategy included the incoming Accountable Officer for the eight Kent and Medway Clinical Commissioning Groups (Director of Strategy, Planning and Partnerships, January 2020 onwards)

JW noted the omission of East Sussex from the engagement plans, noting that many such patients' local hospital was TWH. AJ acknowledged the omission and agreed to address this.

Action: Ensure that the external engagement on the Trust's clinical strategy included representatives from East Sussex (Director of Strategy, Planning and Partnerships, January 2020 onwards)

RF highlighted the need to be consistent when referring to the names of the supporting strategies, noting that the report that had been submitted referred to both a "People Strategy" and a "Workforce Strategy". The point was acknowledged.

RF also proposed that the "Workforce Strategy" be renamed to reflect the fact that it was also an organisational strategy. This was agreed.

Action: Consider renaming the "Workforce Strategy" as the "Workforce and Organisational Strategy", to reflect the strategy's intended scope (Director of Workforce / Director of Strategy, Planning and Partnerships, January 2020 onwards)

MC noted the plans to print hard copies of the strategy documents and appealed for AJ to recognise the need for summary versions, given the likelihood of the full document being read. AJ acknowledged the point.

The strategies were then approved as submitted.

01-12 Update on the Trust's 2020/21 plan

AJ referred to the relevant attachment and highlighted the key points therein, which included the current timescales for the submission of the plan. SO added further details.

DH then gave details of the messages that had been given at the aforementioned NHSE/I South East Leadership Summit he and SO had attended, which included the themes of digital and RTT transformation. DH continued, noted the discussions that were taking place regarding the required levels of hospital bed capacity, and stated that he believed such a focus was not in keeping with

the spirit of the NHS plan. DH therefore proposed that the Trust's plan for 2020/21 contain some aspirations that were related to improved non-hospital services, including capacity in such services. A discussion was then held on the issue during which support was given to DH's proposal.

01-13 Kent County Council's five year plan consultation

AJ referred to the relevant attachment and highlighted the key points therein, which included that the consultation would close on 17/02/20. AJ also highlighted the feedback that had been received to date, which had informed the content of the "potential feedback" boxes in the report.

RF proposed that the Trust's response should make it very clear that the infrastructure associated with housing developments should be introduced before the houses were developed. DH confirmed the Trust Board's support for that to be included in the Trust's response.

Action: Ensure that the Trust's response to Kent County Council's five year plan consultation included the point that the infrastructure associated with new housing developments should be introduced before the houses were developed (Director of Strategy, Planning and Partnerships, January 2020 onwards)

01-14 Approval of the Business Case for the 'Ive Programme'

SO referred to the relevant attachment and highlighted the key points therein, which included the background to the programme, noting that it had been named after Jony Ive, who had designed the iPhone for Apple. SO added that the Business Case had been considered and supported by both the Executive Team Meeting and Finance and Performance Committee and was submitted for approval. DH confirmed that the Finance and Performance Committee had recommended option 5 when it considered the Business Case on 28/01/20.

RF asked about integration and also asked how the programme would be implemented, as it would take time, effort and training. SO confirmed that the programme would include elements of integration and elaborated on the details, which included the application of single sign-on for end users and the link with the Electronic Patient Record (EPR). SO then acknowledged the challenges of implementation but noted that such considerations would be undertaken once the Business Case was approved. DH also noted that some applications would only work on a Windows 10 environment. The point was acknowledged.

RF stated that he would like to see the Business Case within the context of a wider strategy. DH pointed out that the Trust Board had recently approved an IT strategy and noted that the strategy could be shared with RF.

Action: Circulate the IT Strategy that was approved by the Trust Board in July 2019 (Trust Secretary, January 2020 onwards)

SO added that the next Finance and Performance Committee meeting was scheduled to consider an "Update on the IT strategy and related matters" report and proposed that that report be made available to all Trust Board members. This was agreed.

Action: Ensure that all Trust Board Members received the report submitted for the "Update on IT strategy and related matters" item at the Finance and Performance Committee meeting on 25/02/20 (Trust Secretary, February 2020)

The Business Case for the 'Ive Programme' was approved as submitted.

Assurance

01-15 Quarterly report from the Freedom to Speak Up Guardian

CL referred to the relevant attachment and highlighted the key points therein, which included the details of a Case Review from the National Guardian's Office and details of how the Trust compared with the issues identified for the Trust covered by the Review.

DH asked when the findings from the latest NHS staff survey would be received. SH replied that the Trust had been advised that it would receive an embargoed version of the survey findings by the end of 31/01/20.

SO proposed that the recommendations from the National Guardian's Office's Case Reviews be included in future the Freedom to Speak Up Guardian reports, along with details of any action/s required by the Trust in response. This was agreed.

Action: Ensure that the recommendations from the Case Reviews published by the National Guardian's Office were included in future quarterly reports from the Freedom to Speak Up Guardian (along with the details of any action/s required by the Trust in response) (Freedom to Speak Up Guardian, April 2020)

SO noted the reduction in concerns reported and asked if CL planned further promotion of the role. CL noted that the Freedom to Speak Up policy, which was in the final stages of ratification, would provide an opportunity to promote the Guardian role further.

SDu asked whether the significant employee relations issues that were reported to the 'Part 2' Trust Board meeting were triangulated against concerns raised by the Freedom to Speak Up Guardian. SH confirmed that such triangulation occurred.

EPM noted that she had recently met with the Associate Director of Organisational Development and asked for a comment on the staff's seeming reluctance to attend the feedback sessions that had been recently scheduled. A discussion was then held and DH confirmed that the Exceptional People Outstanding Care programme would be discussed at the Trust Board Seminar in February, so there would be an opportunity to discuss that issue at the Seminar.

01-16 Emergency Planning Annual Report, 2019

JWe referred to the relevant attachment and gave a presentation which illustrated the key emergency planning events that had occurred through 2019, which included the inclement weather faced by some staff at the start of 2019, the detailed preparations that were undertaken for the UK's EU exit, the development and opening of the new Helipad at MH, the Emergency Preparedness awards ceremony, the emergency planning exercises that were undertaken in June and October 2019, the Emergency Planning team's visit time Salisbury District Hospital (who had responded to the Novichok nerve agent incident in 2018), the heatwave that took place in July 2019, the use of video clips in Emergency planning training, and the Major Incident that occurred in November 2019. JWe also noted that the Trust was compliant with all relevant national emergency planning guidance.

MS then commented that the Trust was very lucky to have JWe and his team, which was the most practical emergency planning team MS had encountered throughout his time in the NHS. SB echoed MS' commendation and pointed out that the Trust was recognised by national bodies as being the best practised emergency planning Trust in the country.

Reports from Trust Board sub-committees

01-17 Quality Committee, 15/01/20

The circulated report was noted. Questions were invited. None were received.

01-18 Finance and Performance Committee, 28/01/20

The circulated report was noted. Questions were invited. None were received.

01-19 To approve revised Terms of Reference for the Remuneration & Appointments Committee

KR referred to the circulated report and invited questions or comments. None were received.

The revised Terms of Reference were approved as submitted.

01-20 To consider any other business

KR asked the Trust Board to delegate the authority to the 'Part 2' Trust Board meeting scheduled for later that day to approve the Strategic Outline Case for the provision of oncology services in East Kent. The requested authority was duly granted.

01-21 To receive any questions from members of the public (please note that questions should relate to one of the agenda items)

PC asked whether the acoustics of the rooms that were used for Trust Board meetings at TWH could be improved, as it was difficult to hear proceedings from the "Public Gallery". MS confirmed that the issue would be investigated.

Action: Explore the feasibility of improving the sound quality in the room used for Trust Board meetings at Tunbridge Wells Hospital, to enable the proceedings to be properly heard in the "Public Gallery" (Trust Secretary, January 2020 onwards)

01-22 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.

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]
01-14b	Ensure that all Trust Board Members received the report submitted for the "Update on IT strategy and related matters" item at the Finance and Performance Committee meeting on 25/02/20	Trust Secretary	February 2020	The report will likely not be available until 24/02/20, but it will be circulated as soon as it is provided
01-21	Explore the feasibility of improving the sound quality in the room used for Trust Board meetings at Tunbridge Wells Hospital, to enable the proceedings to be properly heard in the "Public Gallery"	Trust Secretary	January 2020 onwards	This issue is being explored, and it is likely that additional systems will need to be purchased, as the functionality of the existing systems is insufficient to address the issue

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
01-8	Arrange for the car parking fee issue raised by the person presenting at the "Patient Experience" item at the Trust Board meeting on 30/01/20 to be investigated	Chief Executive	February 2020	It has been agreed that the person should have free car parking on both the Maidstone and Tunbridge Wells sites whether they bring their son for his regular appointments.
01-11a	Ensure that the external engagement on the Trust's clinical strategy included the incoming Accountable Officer for the eight Kent and Medway Clinical Commissioning Groups	Director of Strategy, Planning and Partnerships	January 2020 onwards	A Meeting has been scheduled with the Accountable Officer for the eight Kent and Medway Clinical Commissioning Groups to discuss Clinical Strategy
01-11b	Ensure that the external engagement on the Trust's clinical strategy included representatives from East Sussex	Director of Strategy, Planning and Partnerships	January 2020 onwards	Meeting requested with Executive Director of Strategy for Sussex and East Surrey to begin engagement with East Sussex on the Trust's Clinical Strategy

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

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
01-11c	Consider renaming the "Workforce Strategy" as the "Workforce and Organisational Strategy", to reflect the strategy's intended scope	Director of Workforce / Director of Strategy, Planning and Partnerships	January 2020 onwards	The document was amended and a discussion held with the Associate Director of Organisational Development and the Director of Workforce
01-13	Ensure that the Trust's response to Kent County Council's five year plan consultation included the point that the infrastructure associated with new housing developments should be introduced before the houses were developed	Director of Strategy, Planning and Partnerships	January 2020 onwards	The point that the infrastructure associated with new housing developments should be introduced before the houses were developed was included in the Trust's feedback to the Kent Count Council's five year plan consultation
01-14a	Circulate the IT Strategy that was approved by the Trust Board in July 2019	Trust Secretary	February 2020	The IT Strategy was circulated to all Trust Board Members on 19/02/20

Actions not yet due (and still 'open')

Ref.	Action	Person responsible	Original timescale	Progress
01-9.6	Arrange for the revised Integrated Performance Report to be reviewed, in response to the comments made at the Trust Board meeting on 30/01/20 and to determine whether it was operating as effectively as intended	Chief Finance Officer	March 2020	An item has been scheduled for the Trust Board in March 2020
01-9.7	Ensure that the review of the revised Integrated Performance Report that was requested at the Trust Board meeting on 30/01/20 consider the appropriateness of the current workforce-related Key Performance Indicators in the "Well-Led" domain	Chief Finance Officer / Director of Workforce	March 2020	An item has been scheduled for the Trust Board in March 2020
01-15	Ensure that the recommendations from the Case Reviews published by the National Guardian's Office were included in	Freedom to Speak Up Guardian	April 2020	The request will be incorporated into the next quarterly report from the Freedom to Speak Up

Ref.	Action	Person responsible	Original timescale	Progress
	future quarterly reports from the Freedom to Speak Up Guardian (along with the details of any action/s required by the Trust in response)			Guardian

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Safety Moment **Chief Nurse / Medical Director**

The Safety Moment for February has been focussed on Infection Prevention.

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

Which Committees have reviewed the information prior to Board submission?
- Finance and Performance Committee, 25/02/20

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

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

Week One 07/02/2020

Management and Prevention of UTIs' Week 1: Skip the Dip
Improving the management of urinary tract infections in older people is part of this year's antimicrobial resistance (AMR) CQUIN. To achieve this target we are required to review the antibiotic prescriptions for patients who are being treated for a lower UTI and see if they are compliant with national guidance in terms of diagnosis and choice of agent.

One element of this is to review if dipsticks are used to diagnose lower urinary tract infections. Our initial review found a considerable number of dipsticks are being used to diagnose UTIs. Therefore we need to raise awareness that National Guidelines no longer recommend using urine dipsticks to diagnose urinary tract infections (UTIs) in older people (Over 65).

Bacteria in the urine can be normal in older people. This is called asymptomatic bacteriuria and is not harmful and does not require antibiotics and if given may cause harm.

In order to minimise the risk of antibiotic resistance it is important that antibiotic are not prescribed just based on a positive dip.

To further raise awareness of this guidance 'To Dip or Not to Dip' posters have been put up in the sluices of every ward and stickers have been placed on the lids urine analysis bottles stating; 'Suspected UTI in over 65s? DO NOT PERFORM URINE DIPSTICK'.

Week Two 14/02/2020

Diagnosis and management of suspected Lower Urinary Tract infections in men and women over 65.
We continued with the same theme 'Improving the management of urinary tract infections in older people' in the second week

We know that a considerable number of patients are being prescribed co-amoxiclav inappropriately to treat a UTI. To help support clinicians in the diagnosis and management of lower urinary tract infections a simple flow chart has been developed and circulated to staff which included the follow information:

If a patient over the age of 65 presents with urinary signs and symptoms abnormal temperature and non-specific signs of infections first think sepsis or exclude pyelonephritis.

To diagnose a possible UTI check for the following new signs and symptoms:
- New onset Dysuria alone

Or two or more:
- Temperature 1.5^0C above the patient's normal
- Frequency and urgency
- Incontinence
- Delirium
- Supra pubic pain
- Visible Haematuria

If a UTI is likely, do not perform a dip stick.
- Send an MSU before starting antibiotics
- Start empirical antibiotics – do not prescribe broad spectrum antibiotics such as co-amoxiclav
- Consider previous urine culture and susceptibility results
- Review the choice of antibiotics when microbiological results are available
- If urinary catheter present consider changing or removing

Week Three 21/02/2020

Be like HOUDINI and make that urinary catheter disappear….

The general rule is that all urinary catheters should be removed with the exception of some factors - HOUDINI is an acronym—each letter represents a different factor a nurse should consider when removing a urinary catheter. It is an easy way to help nurses remember the protocol, and the clear criteria help ensure nurses only remove the catheter when appropriate.

Haematuria – clots and heavy
Obstruction – mechanical urology
Urology/gynaecology/perianal surgery/prolonged surgery
Decubitus ulcer – to assist the healing of a perianal/sacral wound
Input output monitoring
Nursing at the end of life
Immobilisation due to unstable fracture/neurological deficit

If there is no indication, make the catheter disappear!

Catheter maintenance top tips:
- Remove post operatively within 24 hours.
- Assess the need for the catheter daily if an inpatient (at planned intervals for others) and document.
- Advise/provide peri-urethral care with soap and water, 3 times a day and after each bowel movement.
- Use an aseptic non-touch technique.
- Use the smallest size catheter possible.
- Document insertion and rationale.
- Label bag with the date inserted.

Every patient discharged with a long term catheter must have a urinary Catheter passport.

- Catheter passports provide documented information regarding patients' urinary catheter. It is held by the patient so that it can be taken between hospital and community teams
- Who needs one?
- All patients who require a long term urinary catheter (Urethral or Supra pubic) require one
- When should it be given?
- On discharge from an inpatient ward or when seen in clinic is a long term catheter is required

Week Four 28/02/2020

Maintain good hydration to prevent UTIs

Good hydration can assist in preventing and treating:
- Urinary tract infections
- Headaches
- Constipation
- Dizziness – this can lead to falls
- Confusion
- Kidney stones
- Poor oral health
- Pressure ulcers/skin conditions

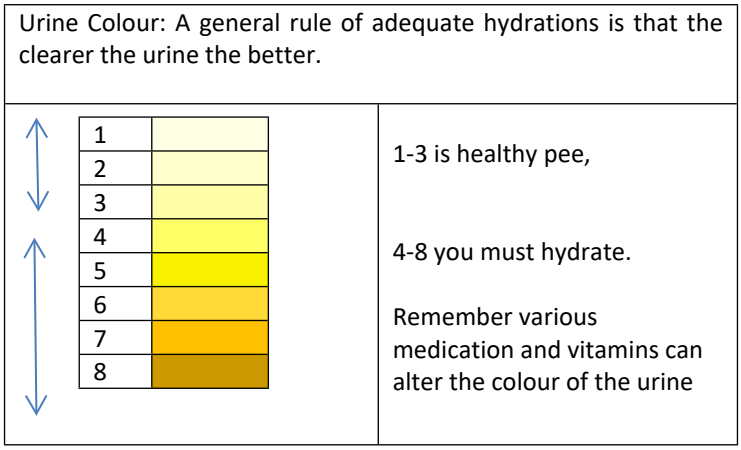
Common causes of dehydration include:

- The elderly have a reduced thirst so they may not know that they are thirsty
- Unable to communicate (cannot say that they are thirsty)
- Pre-existing medical conditions e.g. diabetes, stroke
- Dementia
- Cognitive impairment
- Medication e.g. diuretics
- Illness
- Fear of incontinence due to drinking
- Mobility and dexterity
- Excessive fluid loss

How can you help?

- Patients should drink around 1500-2000mls - 6-8 glasses each day
- Offer drinks regularly throughout the day.
- Encourage sips of fluids little and often in people with poor mouth control and/or excessive saliva as they are likely to lose more fluids
- Ensure drinking water is visible and easily accessible
- Where needed assist patients to have their drinks
- Offer a choice of cups and drinks
- Maintain accurate fluid balance charts

Check the urine colour: A general rule of adequate hydrations is that the clearer the urine the better.



The March Patient Safety Calendar is focussed around MCA/DOLS.

NHS Maidstone and Tunbridge Wells NHS Trust

Report from the Chair of the Trust Board **Chair of the Trust Board**

Consultant appointments

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

Date of AAC	Title	First name	Surname	Department	Potential/Actual Start date
29/01/2020	Dr	Heleni	Mastoroudes	Obs and Gynae	May 2020
14/02/2020	Dr	Isabel	Woodman	Histopathology	May 2020

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

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

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

Report from the Chief Executive **Chief Executive**

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

1. The latest national Staff Survey was published on 18 February. Many more staff than ever before completed the survey at MTW, (51%). This gives us a really reliable picture of how our staff are feeling and what we must address to ensure that MTW is a great place to work.

   Key messages from each section of the survey for MTW are:

   - Equality, Diversity & Inclusion: scores are up from last year, but still not what they were four years ago. Staff with disabilities do not always have sufficient adjustments in place at work.
   - Health & Wellbeing: What really stands out is the proportion of staff who report feeling unwell with stress at some point in the last year; some 40%. While this is not new and is not different to similar trusts across the NHS, it is a priority for us to address.
   - Immediate Managers: Staff report some improvement in support and engagement from their managers. This is a priority area for further development.
   - Morale, Team Working & Engagement: Year on year improvement is reported against this range of indicators. Significantly the proportion of staff who would recommend MTW as a place to work and as a place to receive treatment has increased and is now above the average for similar trusts.
   - Bullying & Harassment: While year on year changes are positive, the numbers of staff experiencing harassment and bullying at work, especially from patients and relatives or from other colleagues are not acceptable. We must take action to address these findings and also root out any individual instances of harassment, bullying or abuse from managers.
   - Quality of Care & Safety Culture: Staff report continuing improvements in quality and safety at MTW. This is welcome and will encourage us to make further efforts in these areas.

   We are determined to ensure that MTW becomes the best place to work it can possibly be. These results will inspire a comprehensive programme of action and improvement across the organisation.

2. I would like to thank staff across the trust for the incredible effort that has been put into preparations to keep staff, patients and the public safe from the potential spread of coronavirus. We now have a fully functioning community assessment and testing service up and running in partnership with SE Coast Ambulance, Kent Community Healthcare and West Kent CCG. On our two hospital sites we have coronavirus 'pods' in operation so that possible patients can be assessed away from the Emergency Department to minimise potential spread of the virus.

   Happily the number of patients requiring testing so far has been relatively small and no-one has yet tested positive for the virus in our hospitals. The risk to the general public is moderate. Everyone is being reminded to follow Public Health England advice, which is available, along with the latest information about coronavirus infections, at www.gov.uk/coronavirus and www.nhs.uk

   This has been a great example of multi-disciplinary and multi-agency working. I received a letter from Kent Police thanking MTW staff for their support and excellent collaborative multi-agency working in putting national plans in place to respond to the coronavirus

infection. Within the trust I would particularly like to highlight the outstanding work of our Emergency Planning, Infection Prevention & Control, Estates & Facilities and Emergency Department teams. Many individuals have gone 'above and beyond' to have everything ready ahead of schedule.

3. To mark the 200th birth year of pioneering nurse Florence Nightingale, 2020 has been designated 'International Year of the Nurse and Midwife' by the World Health Organisation (WHO). To celebrate MTW is inviting patients, past and present, as well as family members, to get involved by sharing their stories about how our nurses and midwives have had a positive impact or made an extraordinary contribution to their life. These tales will be shared throughout the year to help highlight the work carried out by MTW nurses and midwives 24 hours a day, seven days a week. Share your story via social media or download a form via our website.

   We are also creating videos celebrating nursing at our Trust now as well as in the past; sharing photos and experiences of nurses past and present via social media channels; awarding a special gold 'chief nurse' badge each month during 2020 to a nurse or midwife who has gone the extra mile; and handing out special anniversary pin badges in May to mark International Day of the Nurse / Midwife.

4. Preparation work has now started on the construction of two car park decks to increase the number of car parking spaces at the Trust. The improvements will see 175 additional spaces at Tunbridge Wells Hospital and 200 spaces at Maidstone Hospital. The work is expected to finish at the end of March 2020.

5. The first phase of the roll out of a new and improved care model for those who are pregnant has now taken place. Continuity of Carer was introduced by MTW in the Crowborough and High Weald area of north east Sussex. The new model, which is part of the national Maternity Transformation Programme, means those who register their pregnancy in Crowborough will now be cared for by the same team of six to eight midwives. This consistency in care means people will see a familiar face throughout their pregnancy, labour and post-birth. We hope to roll out Continuity of Carer to our other birth centre soon.

6. Thank you to local company Yesss Electrical who have gifted a Visualite sensory and wellbeing light display worth more than £3k to Riverbank children's ward at Maidstone Hospital. Children undergoing treatment or waiting to go down for day surgery can now gaze up at blue skies, white floating clouds and rays of golden sunshine. Visualite wellbeing lighting solutions are designed to provide a calming and therapeutic effect in a healthcare space.

7. MTW hosted a special information event this year to mark World Cancer Day this month. Dozens of people visited the Kent Oncology Centre for a behind-the-scenes tour of one of our state-of- the-art Linear Accelerator machines, with a rare opportunity to talk to some of our expert radiographers, clinical nurse specialists and physicists. Staff, patients and visitors also wrote their personal pledges to help commitment to a cancer-free world, which are now on display on a special pledge tree in the centre. The event also brought together partner agencies including Macmillan, Involve and Look Good, Feel Better to showcase what local support networks are in place for those living with cancer and their friends and family.

8. MTW has been developing further its staff health and wellbeing programme with a visit from an Indian street food van to thank staff for their hard work over the winter period, the launch of a new staff choir at Tunbridge Wells Hospital as well as acupuncture clinics to promote relaxation. More developments will be taking place in the future.

9. The Trust hosted a series of events at the beginning of the month to mark National Apprenticeship Week, 3 – 7 February. MTW's Apprenticeship Team hosted drop in

sessions and attended an Apprenticeship Fair at Maidstone Leisure Centre to promote the range of apprenticeships available at the Trust. MTW currently has 140 apprentices working towards various qualifications in subjects such as healthcare science, nursing, midwifery, HR and PR and communications. More information is available at https://www.mtw.nhs.uk/apprenticeships/

10. MTW was placed fifth in the country for its Emergency Department performance in January. This is a fantastic achievement in light of the unprecedented demand the NHS is facing with high levels of attendances and acutely unwell patients. Thank you to our staff for their support, hard work and determination to deliver quality improvements to the care we provide and to our partners who we are working with closely to deliver integrated services.

11. 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. Staff flu vaccination programme
    b. Update on MTW's Culture and leadership programme
    c. Performance updates on RTT, Cancer and Emergency Department national targets
    d. Focus review on improving the outpatient experience
    e. Apprenticeship programme and development of new apprenticeship opportunities

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, January 2020	**Chief Executive / Members of the Executive Team**

Enclosed is Integrated Performance Report for month 10, 2019/20.

Which Committees have reviewed the information prior to Board submission?

- Finance and Performance Committee, 25/02/20 (in part)

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

Review and discussion

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

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Integrated Performance Report

January 2020

MTW
exceptional people, outstanding care

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Maidstone and Tunbridge Wells NHS Trust

Contents

Appendices (Page 18 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

MTW
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Performance Wheel and Executive Summary

Previous Month (Dec-19)

Current Month (Jan-19)

2019/2020 Forecast Outturn

Executive Summary

The Trust has achieved the National Cancer 62 Day FDT Standard of 85% for five consecutive months. All Cancer Waiting Times Targets were achieved in January for the third consecutive month. In addition the Trust also achieved the trajectory for both the A&E 4hr standard and the Referral to Treatment (RTT) standard.

The Trust declared one Never Event in January for Wrong route administration of medication . The patient experienced no harm. Immediate actions are being supported and this is being fully investigated.

Despite the continued high level of A&E Attendances the A&E 4 hour standard improved significantly in January to 91.07% which is 3% above the trajectory of 88%.

There has been an increased use of escalated areas in January due to pressures with non-elective flow (12.2% of all occupied beds in January). We continue to move experienced staff from our core clinical areas to ensure our escalation areas have been safely managed.

The rate of Pressure Ulcers and Falls remained similar in January (slight reduction in Falls).

Activity levels increased for both elective and New Outpatient appointments in January but remained 4.5% below plan for the month and remain below plan YTD.

Performance for the Referral to Treatment (RTT) standard increased to 85.03% in January, which is therefore above the trajectory of 84.98%. The waiting list and backlog both decreased in January, however some key areas continue to show an increasing trend. The RTT recovery plan for Quarter 4 (January to March 2020) remains in place and is being closely monitored.

Performance Wheel and Executive Summary

Items for Escalation

- **Never Event:** One declared in January for the Trust. This is being investigated with immediate actions taking place. The patient did not experience any harm.

- **Infection Control:** With the 3 cases of C.Diff reported in January the Trust remains below the maximum trajectory YTD. Cases of E.Coli have increased in January with the rate now being above the threshold monthly and year to date. This has resulted in the forecast for the year showing an adverse position to plan. The February safety moment focused on reducing the risk of UTIs. The Trust will further promote the HOUDINI criteria through the distribution of staff information cards.

- **Falls:** The rate of Falls has reduced marginally from last month but remains slightly above the 6.0 maximum trajectory both month and YTD.

- **Pressure Ulcers:** Levels remained consistent in January with 15 hospital acquired pressure ulcers reported equating to a rate of 2.3 per 1,000 occupied beddays. In line with NHSi guidelines the Trust has changed the way that pressure ulcers are recorded to include Deep Tissue Injuries (DTIs). This coincided with the overall increase in pressure ulcers in both December and January which is being investigated.

- **Stroke:** Performance against the metrics that constitute the Best Practice Tariff has improved in December, but remains below the level the Trust aspires to achieve. 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 4 hour Standard:** A&E performance has improved significantly in January at 91.07% against a trajectory target of 88.00%. Average time in department and average time to first treatment indicators are all improving. The Trust remains in the 10 best performing Trusts in England.

- **Referral to Treatment (RTT) Incomplete Pathway:** Performance increased to 85.03% in January which is therefore above the trajectory of 84.98%. The Trust Waiting List has decreased to 31,965 and the backlog has decreased to 4,785 due to an increase in both the elective and new outpatient activity.

- **Cancer 2weeks (2ww):** Performance against the 2ww and 2ww breast symptoms targets have been achieved for four consecutive months (94.7% and 94.4% respectively in December). January is also expected to achieve both targets.

- **Cancer 62 Day:** Performance against this target has been achieved for five consecutive months (87.3%) with January expected to achieve .

- **Diagnostics Waiting Times <6 weeks**: Performance remained similar at 98.2% in January and therefore did not achieve the target. This was caused mainly by capacity issues in Endoscopy which have improved in February.

- **Finance:** The Trust delivered the financial plan for January generating £1.7m surplus including PSF. The Trust was £1.4m better than previously forecasted, £1m related to RTT income support which was previous included in the month 12 position and £0.4m related to an underspends within pay budgets. Year to date the Trust is £0.1m favourable to plan, the key variances to budget were: Underperformance in Private Patient Income (£1.8m net), RTT Income reserve (£1.9m), £2.5m CIP slippage, £0.4m overspend against outsourcing and overspends within expenditure budgets (£2.5m). These pressures have been partly offset by release of prior year provisions (£3.5m), release of £3.6m of reserves, QIPP income adjustment (£1.3m) and £0.3m over performance within clinical income.

- **Workforce (various):** Following the decrease in the staffing fill rate seen last month due to the increase in both the sickness and annual leave rate over the Christmas/New Year period the fill rate is now back to previous levels at 78% in January. The nursing staff fill rate increased to 100.3%. The overall sickness rate continues to remain high at 3.9% and the Annual Leave rate has returned to previous levels at 10.5%. The Agency and bank usage remained similar to the previous month and continued delays in the availability of OSCE examinations and the length of supernumerary time for some overseas nurse recruits have contributed to a slower than expected reduction in nurse agency expenditure. The vacancy rate increased slightly to 9.0%, in January, slightly above plan.

Summary Scorecard

Safe		Curr Month		Year to Date			Year End		Change on Prev Mth
ID	Key Performance Indicators	Plan	Actual	Prev Yr	Plan	Curr Yr	Plan	FOT	
S1	Rate C-Diff (Hospital only)	18.3	13.7	22.5	23.0	21.4	22.4	21.1	↘
S2	Number of cases C.Difficile (Hospital)	4	3	46	47	44	55	52	↘
S3	Number of cases MRSA (Hospital)	0	0	3	0	1	0	1	→
S4	Rate of E. Coli Bacteraemia	18.3	32.0	28.4	21.5	31.6	21.5	29.6	↓
S5	Rate of Hospital Pressure Ulcers	*1.26*	2.3	1.4	1.3	1.6	1.3	1.6	→
S6	Rate of Total Patient Falls	*6.00*	6.50	*6.26*	6.00	6.11	*6.00*	6.08	↗
S7	Number of Never Events	*0*	1	1	0	2	0	2	↓
S8	Number of New SIs in month	12	11	138	120	113	144	137	↑
S9	SIs not closed <60 Days Monthly Snapshot	24	3	-	24	3	24	3	↑
S10	Overall Safe staffing fill rate	93.5%	100.3%	97.0%	93.5%	96.1%	93.5%	96.1%	↗

Effective		Curr Month		Year to Date			Year End		Change on Prev Mth
ID	Key Performance Indicators	Plan	Actual	Prev Yr	Plan	Curr Yr	Plan	FOT	
E1	Hospital-level Mortality Indicator (SHMI)	Band 2	1.0249	1.0391	1.0391	1.0249	Band 2	Band 2	→
E2	Standardised Mortality HSMR	Lower conf <100	91.7	102.3	100.0	91.7	Lower conf <100	91.7	→
E3	% Total Readmissions	14.1%	14.8%	13.6%	14.1%	14.8%	14.1%	14.8%	↗
E4	Readmissions <30 days: Emergency	14.8%	15.3%	14.1%	14.8%	15.4%	14.8%	15.4%	↗
E5	Readmissions <30 days: Emergency (excl SDE	14.0%	13.9%	13.9%	14.0%	14.8%	14.0%	14.8%	↗
E6	Readmissions <30 days: Elective	6.8%	8.1%	7.1%	6.8%	7.7%	6.8%	7.7%	↗
E7	Stroke: Best Practice (BPT) Overall %	50.0%	46.9%	50.0%	50.0%	41.0%	50.0%	41.0%	↗
E8	Nat CQUIN: % Dementia Screening	90.0%	99.1%	99.8%	90.0%	95.2%	90.0%	95.2%	↘
E9	Nat CQUIN: % Dementia Risk Asssessed	90.0%	100.0%	93.5%	90.0%	101.7%	90.0%	101.7%	↑
E10	Nat CQUIN: % Dementia Referred to Specialist	90.0%	100.0%	99.1%	90.0%	99.1%	90.0%	99.1%	→

Caring		Curr Month		Year to Date			Year End		Change on Prev Mth
ID	Key Performance Indicators	Plan	Actual	Prev Yr	Plan	Curr Yr	Plan	FOT	
C1	Single Sex Accommodation Breaches	0	0	35	0	0	0	0	→
C2	Rate of New Complaints	3.92	2.20	2.23	2.93	2.32	2.93	2.42	↗
C3	% complaints responded to within target	75.0%	80.4%	82.8%	75.0%	67.1%	75.0%	68.4%	↗
C4	IP Resp Rate Recmd to Friends & Family	25.0%	16.0%	18.7%	25.0%	16.3%	25.0%	16.3%	↘
C5	IP Friends & Family (FFT) % Positive	95.0%	96.3%	93.5%	95.0%	95.5%	95.0%	95.5%	→
C6	A&E Resp Rate Recmd to Friends & Family	15.0%	1.9%	5.4%	15.0%	8.4%	15.0%	8.4%	↓
C7	A&E Friends & Family (FFT) % Positive	87.0%	87.2%	90.5%	87.0%	87.5%	87.0%	87.5%	→
C8	Mat Resp Rate Recmd to Friends & Family	25.0%	20.1%	37.6%	25.0%	22.2%	25.0%	22.2%	↗
C9	Maternity Combined FFT % Positive	95.0%	96.9%	95.8%	95.0%	95.5%	95.0%	95.5%	↘
C10	OP Friends & Family (FFT) % Positive	84.0%	83.6%	84.4%	84.0%	82.6%	84.0%	82.6%	↗

Responsive		Curr Month		Year to Date		Year End		Change on Prev Mth
ID	Key Performance Indicators	Plan	Actual	Prev Yr	Curr Yr	Plan	FOT	
R1	Emergency A&E 4hr Wait	88.0%	91.1%	92.1%	90.6%	91.7%	90.5%	↑
R2	Emergency A&E >12hr to Admission	0	0	2	0	0	0	→
R3	Ambulance Handover Delays >30mins	369	362	3763	5011	4428	5749	↑
R4	RTT Incomplete Pathway	85.0%	85.0%	81.1%	85.0%	86.7%	85.5%	↗
R5	RTT 52 Week Waiters (New in Month)	8	5	61	62	96	62	↘
R6	% Diagnostics Tests WTimes <6wks	99.0%	98.2%	99.1%	98.2%	99.0%	99.0%	↗
R7	Cancer two week wait	93.0%	94.7%	88.1%	94.7%	93.0%	94.7%	↗
R8	Cancer two week wait-Breast Symptoms	93.0%	94.4%	58.3%	94.4%	93.0%	94.4%	↘
R9	Cancer 31 day wait - First Treatment	96.0%	99.5%	97.2%	99.5%	96.0%	99.5%	↗
R10	Cancer 62 day wait - First Definitive	85.0%	87.3%	63.3%	87.3%	85.0%	87.3%	↗

Responsive - Flow		Curr Month		Year to Date		Year End		Change on Prev Mth
ID	Key Performance Indicators	Plan	Actual	Prev Yr	Curr Yr	Plan	FOT	
R11	Average LOS Non-Elective	6.40	6.89	6.94	6.87	6.40	6.87	↗
R12	Theatre Utilisation	90.0%	86.4%	91.3%	86.4%	90.0%	86.4%	↗
R13	Primary and Non-Primary Refs	17,241	15684	157,139	165054	199,052	197968	→
R14	Cons to Cons Referrals	4,495	6124	59,103	62262	51,898	70,844	→
R15	OP New Activity	19,586	18676	176,457	186129	226,133	223521	↘
R16	OP Follow Up Activity	30,038	26591	265,325	281548	346,845	338897	↘
R17	Elective Inpatient Activity	643	599	5,217	5925	7,426	7153	↘
R18	Day Case Activity	4,349	4151	36,779	40018	50,210	48320	→
R19	Non Elective Activity (inc Maternity)	5,726	5952	53,455	55927	67,606	67010	↗
R20	A&E Attendances : Type 1	12,641	13941	129,462	141428	159,252	170038	↘

Well-Led		Curr Month		Year to Date		Year End		Change on Prev Mth
ID	Key Performance Indicators	Plan	Actual	Prev Yr	Curr Yr	Plan	FOT	
W1	Surplus (Deficit) against B/E Duty	1,696	1,720	- 896	5,987	6,896	6,896	→
W2	CIP Savings	2,045	1,781	10,266	17,983	22,329	22,329	→
W3	Cash Balance	25,209	17,669	7,956	17,669	3,000	3,000	→
W4	Capital Expenditure	1,490	539	5,855	4,771	14,448	16,128	→
W5	Finance use of Resources Rating	2	3	3	3	2	3	→
W6	Staff Turnover Rate (%)	10.0%	12.6%	8.9%	12.6%	10.0%	12.6%	↘
W7	Vacancy Rate (%)	8.0%	9.0%	10.7%	11.1%	8.0%	11.1%	↘
W8	Total Agency Spend	1,362	1,618	19,145	16,109	17.738	18.574	↘
W9	Statutory and Mandatory Training	90.0%	85.3%	87.1%	86.0%	90.0%	86.0%	↘
W10	Sickness Absence	3.3%	3.9%	3.4%	3.5%	3.3%	3.5%	→

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

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

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

Headlines

Safe:	Positives:	Challenges:
Lead Director(s): **Claire O'Brien/** **Peter Maskell**	**Infection Control**: Compliance in MRSA Screening for the Elective pathway remains above target YTD and was 100% compliance in January There were three cases of C.difficile reported in January against a maximum trajectory of 4. The Trust is therefore back on trajectory with 44 cases against a maximum limit of 47 **Serious Incidents (SI)s:** SIs open at the end of the month decreased further which is the lowest number reported so far this year. Performance for those being closed within the 60 day target also improved further in January to 3 SIs currently open that have passed their breach date for closure. **Safe Staffing**: This has increased to 100.3% in January largely due to the need to ensure safe staffing levels in the higher use of escalated areas.	**Never Event:** The Trust declared one Never Event in January for Wrong route administration of medication. The patient experienced no harm. Immediate actions are being supported and this is being fully investigated. **Infection Control**: Cases of E.Coli have increased in January with the rate now being reported above the threshold monthly and year to date. The February safety moment focused on reducing the risk of UTIs. The Trust will further promote the HOUDINI criteria through the distribution of staff information cards. **Falls:** The level of Falls has reduced slightly in January to 142 equating to a Rate of 6.50 per 1,000 occupied bed days. The rate is now slightly above trajectory YTD at 6.1. As part of the NHSi project focussing on Lying and Standing Blood Pressure (LSBP) rollout across all inpatient areas has been completed. The Falls Group will be monitoring the impact of the Falls Training and the NHSI project. **Pressure Ulcers (Hospital Acquired):** In line with NHSi guidelines the Trust has changed the way that pressure ulcers are recorded to include Deep Tissue Injuries (DTIs). The number of hospital acquired pressure ulcers reported has remained the same in January with 15 reported equating to a rate of 2.3. This was across both sites of the Trust. A Study day has been booked in May for the Tissue Viability Champions who are working on action plans to embed the learning from the NHSI collaborative work which the Trust engaged in to support improvements in practice. The average rate of all pressure ulcers (including those who already had a pressure ulcer on admission) is 23.5 so far this year compared to an average of 16.7 last year **Duty of Candour:** The Deputy Patient Safety Manager has completed an audit for 2018/19 – Q1 & 2, actions have been delegated to the Patient Safety Leads. Individuals within the Patient Safety Team now have clearly defined roles and responsibilities for the management of Duty of Candour and compliance is monitored through the Patient Safety KPI's.

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Headlines

Effective:	Positives:	Challenges:
Lead Director(s): **Peter Maskell**	**Mortality:** The Risk Adjusted Hospital Standardised Mortality Rate (HSMR) and SHMI both continue to remain within acceptable limits. The HSMR has been below 100 for the last eight reporting periods, being reported at 91.7 for the 12 months to October 2019. The latest SHMI published for the period September 2018 – August 2019 is reported at 1.0249 which is banded as level 2 "as expected". **Patients with Dementia**: The percentage of patients screened for Dementia remained similar in January at 99.1% against the 90% national target and remains above target YTD (95.2%). The percentage of those that were risk assessed or referred to a specialist where required both continue to remain significantly above target and were both at 100% compliance for January.	**Emergency Readmissions:** 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 improved slightly for both indicators in January and both remain slightly above the target (average of last year). YTD, Non Elective readmission is 15.4% compared to 14.6% for the equivalent period last year, but excluding the contribution from SDEC, the rate has not changed significantly. **Emergency readmissions (Elective):** The level or emergency readmissions within 30 days of discharge for those who were originally admitted on an elective pathway has decreased and is slightly above the target. However this year is showing a 1% increase on last year. This is being investigated further to see if there are any underlying trends. **Stroke**: Performance against the metrics that constitute the Best Practice Tariff has improved in December, but remains below the level the Trust aspires to achieve. 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. Performance against the indicator for the Stroke Ward being the First Ward for Stroke patients decreased in January. This has been investigated and actions put in place to address any areas of concern.

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Headlines

Caring:	Positives:	Challenges:
Lead Director(s): **Claire O'Brien/** **Peter Maskell**	**Complaints:** The overall number of complaints received has remained fairly consistent month on month. Performance for the percentage of complaints responded to within their target date increased further in January to 80.4% (above the 75% target). YTD performance is 67.1%. Divisional performance increased to 82.7% for January and is at 82.4% YTD which is above the 75% target. **Friends and Family Survey:** The Percentage positive performance for January was above plan in all areas with the exception of Outpatients which was slightly below plan. **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	**Friends and Family:** Response rates continue to fluctuate for all four areas and all areas remains below plan YTD. Extra IPads have been sourced to be used in identified areas for electronic submission to increase response rates. Also, there is currently a trial of Volunteers in the Maidstone Emergency Department to assist patients with completing the FFT. An in-house poster has also been developed and rolled out to raise awareness.

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Headlines

Responsive:	Positives:	Challenges:
Lead Director(s): **Sean Briggs**	**4 hour Emergency Access Standard:** A&E performance has improved significantly in January at 91.07% against a trajectory target of 88.00% in January. Average time in department and average time to first treatment indicators are all improving. **Ambulance Handovers:** Although higher than the Trust would like them to be YTD, handover delays have been cut significantly in January, with 30-60 minute delays under 10% for the first time since Mar-19, and just 13 delays over 60 minutes in January compared to an average of 55 per month Apr-19 to Dec-19	**ED Attendances:** The past 52 weeks have been 9.2% busier than the preceding 52, and 2019/20 attendance is forecast to be 9.1% higher than 2018/19. January was 0.5% higher than expected at 449.7 per day **Beds and Escalated Areas**: Due to the continued high level of emergency admissions from A&E (highest ever in December at 93.4 per day with a slight reduction in January at 92.5 per day) and the flow indicators remaining below plan the level of escalated areas has increased to a high of 12.3% of the total bed occupancy. In January. Many of the available beds are specialist beds not available for general acute admissions. **Inpatient Efficiency (Theatre Utilisation):** Theatre Utilisation with TAT has increased back to 86.4% in January but remains below plan. The activity equated to 80.9 elective cases per working day, an increase from 69.3 in Dec-19. **Cancellation of outpatient appointments with less than 6weeks notice:** This continues to be an area of concern at 14.7% YTD. However, Jan-20 saw an improvement to 12.9%, the lowest rate it's been all year. **Outpatient Utilisation:** The monthly utilisation figures have been averaging 67.7%. Although there are several data quality issues with the OP Utilisation figures resulting in them being understated performance remains below plan.

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Headlines

Responsive:	Positives:	Challenges:
Lead Director(s): **Sean Briggs**	**RTT Incomplete Pathway:** Performance increased to 85.03% in January and is therefore above the trajectory of 84.98%. The Trust Waiting List has decreased to 31,965 and the backlog has decreased to 4,785 due to an increase in both elective and new outpatient activity. **Cancer Waiting Times:** For a third consecutive month the Trust has achieved all reportable Cancer Waiting Times standards, including 87.3% for the 62 day standard, 94.7% for the 2ww and 94.4% for the Breast 2ww standard. The 62 day standard has now been achieved for five consecutive months and both the 2ww and Breast 2ww standards have been achieved for four consecutive months.	**New Outpatient Activity:** Activity is 1.3% below plan YTD. However, for the main RTT Specialties this is 9.2% below plan YTD. Specialties furthest from plan remain ENT, Gastroenterology, Ophthalmology, and Trauma & Orthopaedics which is directly impacting on their achievement of their non-admitted RTT Trajectories and led to an increase in the RTT Waiting List and backlog in some specialties. **Elective Activity:** Overall activity increased in January but was still 4.8% below plan and is now 4.5% below plan YTD (DC is 4.5% below plan and IP are 4.4% below plan YTD). 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 remains above plan. Some of the speciality initiatives submitted in the speciality business plans have not been funded. The RTT recovery plan from January– March 2020 remains in place and is being closely monitored. **RTT Incomplete Pathways (52 week breaches):** The Trust is still reporting some 52 week breaches on a monthly basis (5 new reported for January). All patients will have a harm review by the managing Consultant. **Diagnostic Waiting Times <6weeks:** The Trust did not achieve the national target in January at 98.2% against the target of 99%. This was caused mainly by capacity issues in Endoscopy which have improved in February.

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Headlines

Well Led:	Positives:	Challenges:
Lead Director(s): **Steve Orpin/** **Simon Hart**	**Finance**: The Trust has delivered the year to date financial plan resulting in full PSF payment. The Trust is forecasting to meet its control total by the end of the year. The Trust's overall capital programme is forecast to outturn at £15.6m (excluding donated assets and PFI Lifecycle). This includes the use of £6.4m of asset sale funding (capital resource approved in November 2019 by DHSC); the £2.1m of national Diagnostic Funding notified in December 2019 to purchase two CT scanners, a MRI and Mammography equipment, £1.25m of national funding for the Electronic Prescribing Medicines programme (EPMA) and additional funding expected for cyber risk issues.	**Finance:** The Trust is implementing financial recovery plans and currently has £1.2m of additional mitigations to deliver the plan. Medical staffing pay overspent YTD by £2.4m mainly within Medicine and Emergency Division (£2.4m) and Paediatrics (£0.8m). Substantive recruitment has taken place, controls on temporary bookings and review of bank rates have been implemented which should reduce agency spend. 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. 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. If the I&E forecast moves adversely this will reduce the level of cash available. **Vacancy Rate:** The overall Trust vacancy rate remained similar in January at 9%, but remains slightly above plan. The rate remains 4% lower that at the beginning of the financial year. **Sickness Rate:** The overall sickness rate has remained the same at 3.9% in January, above the maximum limit of 3.3% and just below the upper control limit. YTD this is slightly above target at 3.5%. 82.4% of frontline staff have received flu vaccinations against a CQUIN target of 80% (to be achieved by the end of February) The Trust target is 85% **Annual Leave and Staff Fill Rate:** Following the increase in annual leave and subsequent decrease in the fill rate due to the Christmas and New Year period these have returned to previous levels in January.

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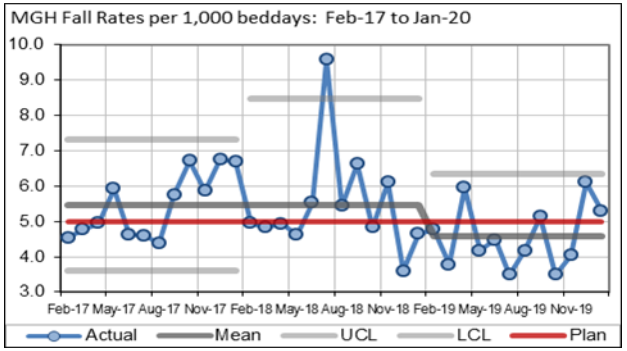
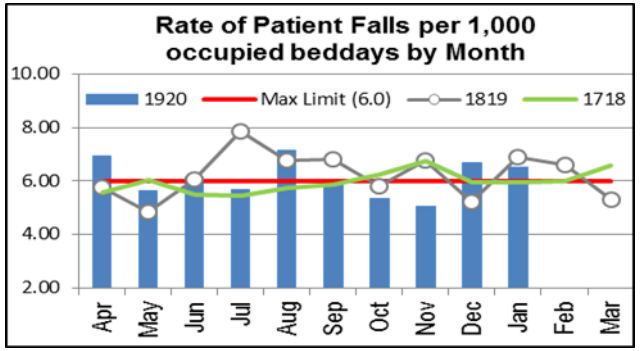
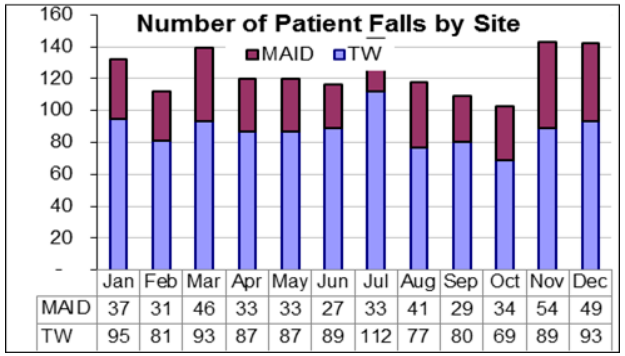
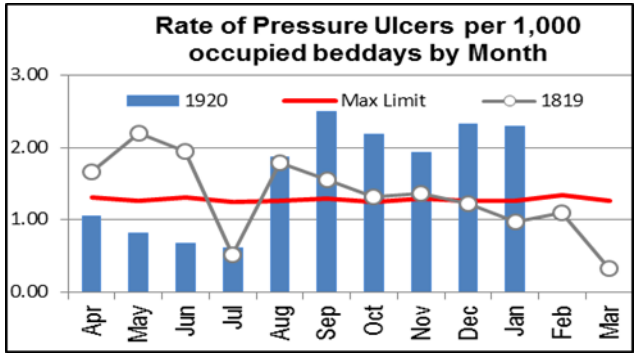
Escalation: Harm Free Care







	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
MAID	37	31	46	33	33	27	33	41	29	34	54	49
TW	95	81	93	87	87	89	112	77	80	69	89	93



Falls: The level of Falls has reduced slightly in January to 142 equating to a Rate of 6.50 per 1,000 occupied bed days. The rate is now slightly above trajectory YTD at 6.1. Following the increase in the numbers reported for the Acute & Geriatric Directorate at Maidstone last month this has reduced in January but remains higher than usual at 30 which has led to the overall rate of Falls at Maidstone remaining high at 5.29. The number reported for TWH increased slightly in January equating to a rate of 7.39 and YTD this remains above trajectory at 7.1 against 6.30.

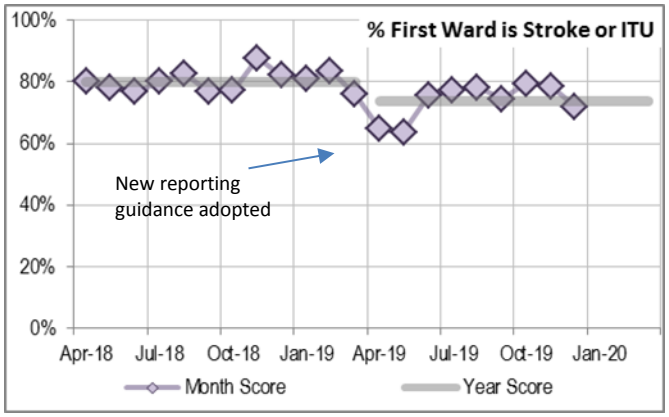
Pressure Ulcers: The level of hospital acquired pressure ulcers (HAPU) has remained the same in January with 15 reported equating to a rate of 2.3 against a maximum limit of 1.3. The increase was on both sites of the Trust. In line with NHSi guidelines the Trust has changed the way that pressure ulcers are recorded to include Deep Tissue Injuries (DTIs). The average rate of all pressure ulcers (including those who already had a pressure ulcer on admission) is 23.5 so far this year compared to an average of 16.7 last year.

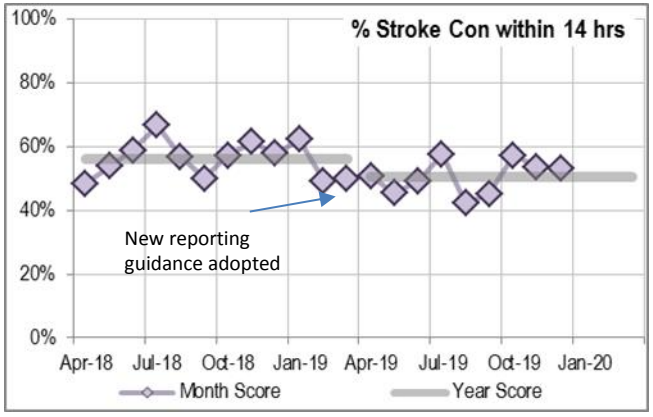
Severity of Falls: Of the 142 Falls reported, 116 resulted in no harm, 23 resulted in low harm and 3 resulted in moderate harm

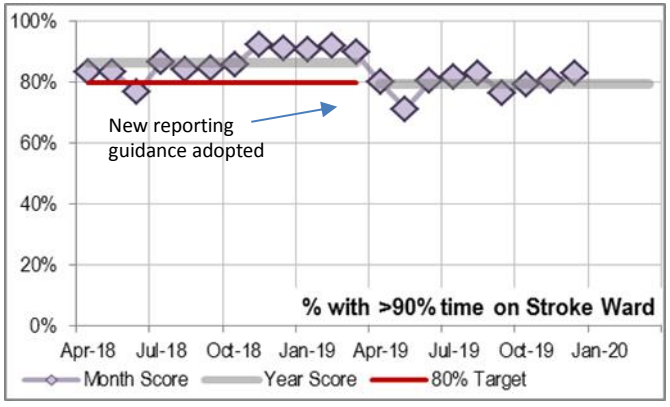
SIs: There were two Serious Incidents relating to Falls declared in January (both SIs occurrence in December but declared in January)

Summary:	Actions:	Assurance:
The level of Falls has reduced slightly in January to a rate of 6.50 per 1,000 occupied bed days but remains slightly above trajectory for both the month and YTD. There were 2 Serious Incidents relating to Falls declared in January. The level of hospital acquired pressure ulcers (HAPU) has remained the same in January with 15 reported equating to a rate of 2.3 against a maximum limit of 1.3. The rate of all pressure ulcers remains higher this year than last year.	As part of the NHSi project focussing on Lying and Standing Blood Pressure (LSBP) rollout across all inpatient areas has been completed. LSBP is one of the three high impact actions for CQUIN CCG7. Additionally ,the moving and handling facilitator has been recruited and is offering bespoke training in the clinical areas to support staff. A Study day has been booked in May for the Tissue Viability Champions who are working on action plans to embed the learning from the NHSI collaborative work which the Trust engaged in to support improvements in practice.	Wards on the Falls project is monitored through spot audit monthly. This is to monitor progress, sustainability as well as opportunity to identify if further support required. The Falls Group will be monitoring the impact of the Falls Training and the NHSI project The Tissue Viability Team, with support of the Directorate Matrons will be undertaking a 'Deep Dive' review of the Hospital Acquired Pressure Ulcers to identify any themes / trends and significant learnings that can be shared with all. Raised awareness of the role of the Link nurses for tissue viability at ward level. To enhance provision of education from the tissue viability team

Escalation: Stroke Best Practice Indicators







Data is reported one month in arras (Dec-19) 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 three main stroke indicators that constitute Stroke Best Practice.

1. First Ward must be a Stroke Ward (or ITU): last year averaged 80.2%. January performance decreased to 71.9% and YTD the position is 73.6% to end of Dec.

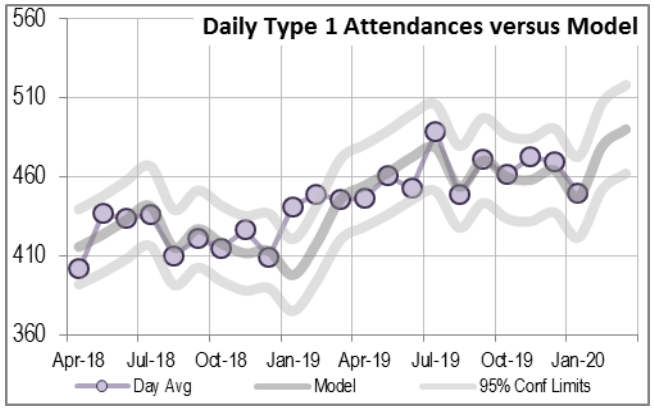
2. Stroke Consultant within 14 hrs: Performance remains similar in January at 53.1%. The YTD position to the end of Dec is 50.5%

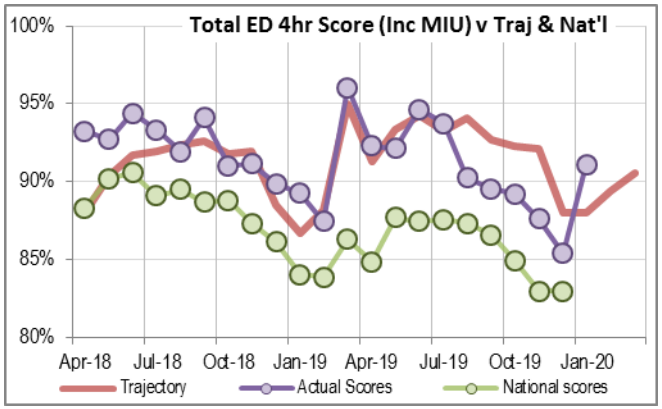
3. 90% of Spell on Stroke Ward. Changes in the guidance means that this metric is now calculated differently to the reported results last year. In 2018/19, we would have scored 86.2% under the new methodology. January increased to 82.8% and YTD the position is 79.5%.

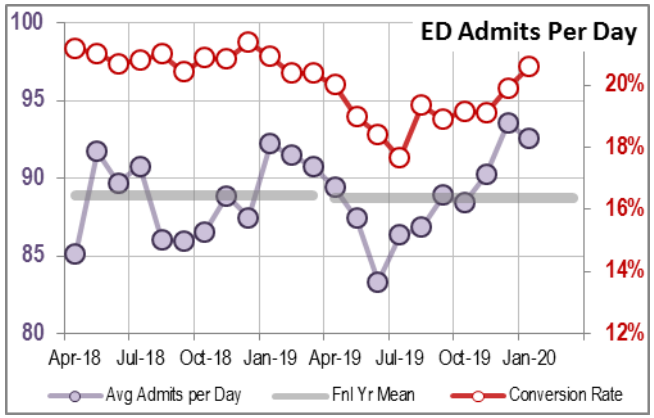
% Best Practice Tariff : The percentage of patients passing all 3 of these tests has improved over the last 2 months but remains 41% YTD.

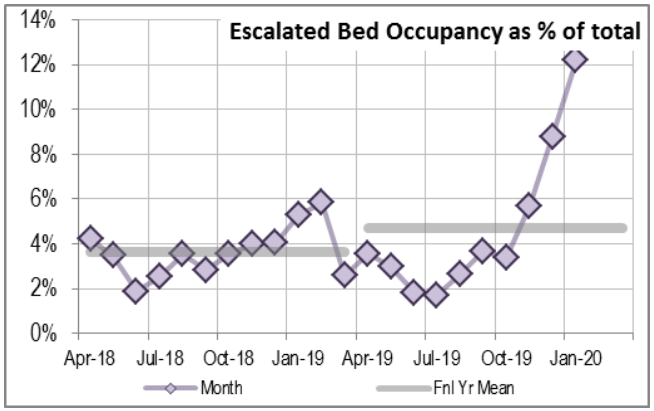
Summary:	Actions:	Assurance:
There are now three stroke indicators that constitute Stroke Best Practice. a) Admitted direct to a stroke or intensive treatment ward, b) See a stroke consultant within 14 hours of arrival (or their stroke if that happens on-site), c) Spend 90% of their spell on a stroke ward. 40.0% 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 48.8%. This year it is 41.0% so far.	1.Stroke CNS team to monitor compliance against BPT and investigate non-compliance 2. Current monitoring of these BPT targets have shown that any patient that is transferred to CDU before Stroke ward fails this target. 3. Time to Stroke Consultant impacted by number of patients being admitted out of hours and over weekend. 4. 90% spell on Stroke currently not always achieved due to increased capacity issues on the MGH Site, Stroke patients being moved to other wards once their stroke pathway is complete and minimal Stroke patients chosen to move during rehab stage. 5. Breach meetings to be commenced with Stroke Matron and CNS team to discuss actions for stroke patients who were admitted to other wards first or were transferred to Stroke after the 4 hour target.	1. BPT report completed monthly by CNS and shared with relevant teams. Latest report to be presented at Clinical Governance when agenda space available. CNS team continue with monthly coding validation. 2. 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 conformed stroke to go to CDU. 3. We are covering about 80% of weekends with stroke consultants and have full time cover during the week. We will need to recruit one further stroke consultant to get up to 100%. When a stroke consultant is not available, all stroke patients are reviewed by a Consultant Physician. 4. Daily identification of the patients most suitable to move to outlying wards at board round involving the whole MDT continues. 5. First meeting to commence this month and decision will then be taken regarding ongoing frequency of the meetings.

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 9.1% increase on that for 2019/20

January was 0.5% higher than expected at 449.7 per day.

4 Hr Time in Department: Performance had been down for five consecutive months but January was 3.13% above target at 91.13% against an agreed trajectory of 88.00%. We are consistently in the 10 best performing Trusts in England

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 4.7%, with much of that seen in the past 10-12 weeks. Escalated beds tends to spike in January / February, but this year is higher than normal

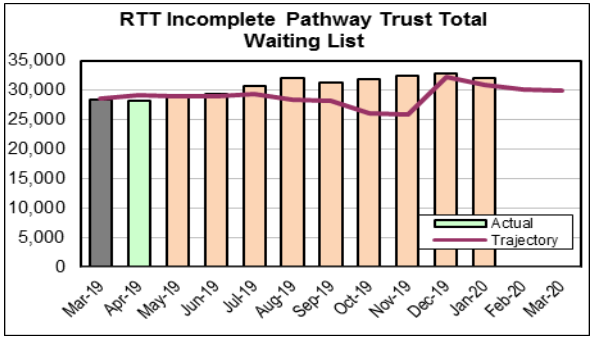
ED admits per day to main IP 2018/19 averaged 88.9 per day, or 20.8% of attendances. This year we averaged 88.2 against much higher attendances, so the percentage is now 19.1%. Dec saw the highest ever daily rate of 93.5. Jan fell back slightly to 92.5

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 11.8% delayed 30-60 mins and 1.35% >60. Jan was 9.0% / 0.34%

Summary:	Actions:	Assurance:
Performance was 3.13% above target in January. YTD, the average Time in Department is now significantly improved on the same period last year at 3h33m. The non-elective average LOS and DTOC have both shown a slight improvement but remain above plan which has meant that bed occupancy was 93.7% in January and there has been an increased use of escalated beds (12% of total in January). Ambulance handovers have improved dramatically in January, showing their best delay rates since March.	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. New ED Consultant in place with additional ED consultant starting March. Nursing planned to be fully recruited by June 2020. EDPs supporting "hello" nurse on ongoing trial on both sites. Further developing the GP in ED service to enable more patients to be streamed. Delay to RAP build at Maidstone due to delay on AMU build.	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. Working with A&E Delivery Board on monthly basis to support region wide issues/ actions. System call put in on a daily basis where required when system is tight. Audit run in both EDs to identify opportunity for GP flow Winter escalation wards are open to support flow and maintain ED Performance. Maintaining top 10 ED performance in the country consistently. Regular site meetings/ winter huddles to support decision making.

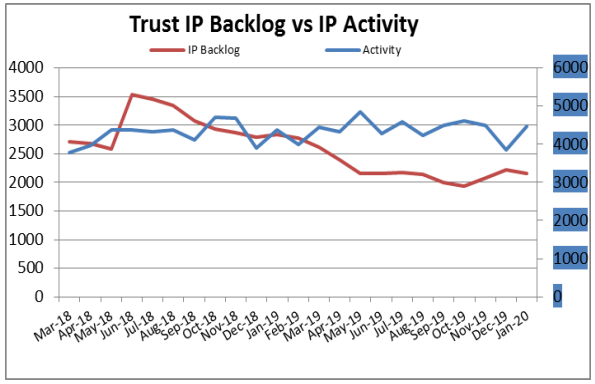
Escalation: RTT Incomplete Pathways

Trust	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
Trajectory Total WL	28508	29152	28932	28908	29273	28433	28261	25964	25959	32154	30956
Actual Total Waiting List	28412	28268	29027	29269	30705	32085	31344	31828	32446	32725	31966
Actual IP Waiting List	6494	6045	6037	5978	6102	6009	5780	5742	5932	6113	6154
Actual OP Waiting List	21918	22028	22518	22606	23616	24893	24291	24880	25173	25235	24682
Trajectory Backlog	4146	4806	4578	4622	5089	4576	4543	3536	3740	5379	4648
Actual Total Backlog	4797	4510	4305	4163	4430	4868	4910	5052	5192	5257	4784
Actual IP Backlog	2611	2391	2157	2156	2158	2135	2004	1932	2079	2220	2153
Actual OP Backlog	2186	2119	2148	2006	2272	2721	2861	3045	3049	2931	2571
Trajectory % Performance	85.5%	83.5%	84.2%	84.01%	82.61%	83.9%	83.9%	86.4%	85.6%	83.3%	85.0%
Actual Total % Performance	83.1%	84.0%	85.2%	85.8%	85.6%	84.8%	84.3%	84.1%	84.0%	83.9%	85.03%

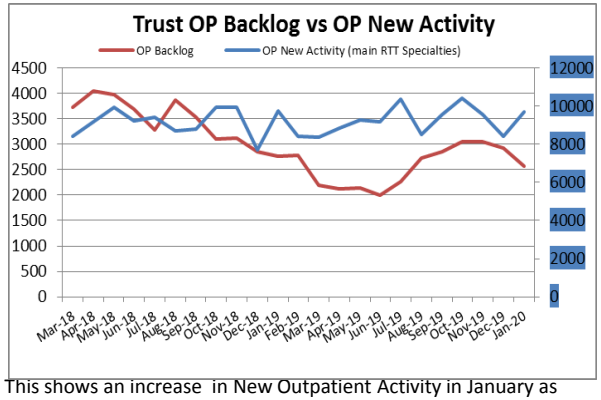


RTT performance increased to 85.03% in January and is therefore above the trajectory of 84.98%. The overall waiting list and backlog (patients who have been waiting over 18 weeks) have both decreased.

For the Trust the OP backlog is now slightly above plan and the IP Backlog is below plan. The OP Waiting List is now below plan but the IP Waiting List is slightly above plan which has meant that the overall Waiting List is slightly above plan.



This shows an increase in Elective Activity in January as well as the RTT admitted backlog which decreased in January due to the increase in activity levels



This shows an increase in New Outpatient Activity in January as well as the RTT non-admitted backlog which decreased in January due to the increase in activity levels.

RTT by Specialty: All specialties saw an improvement in performance in January with the exception of T&O, Cardiology and Diabetes which saw a small decrease. All Specialties were above their recovery trajectory for January.

All Specialties saw a reduction in both their IP and OP Backlog with the exception of T&O.

Ophthalmology, ENT and Neurology OP Backlog account for the biggest proportion of the Trust OP Backlog (22%, 19% and 10% respectively)

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

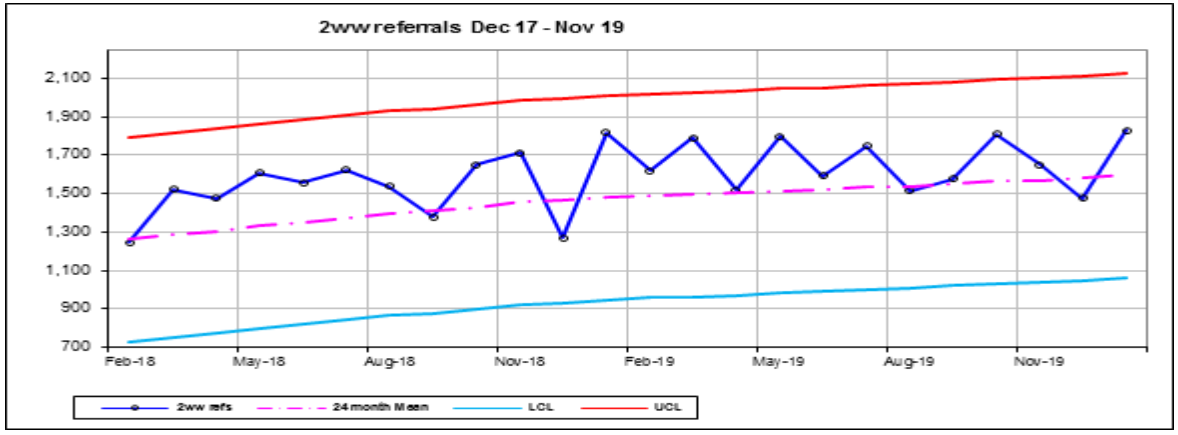
RTT 52 week Breaches: 6 reported for January (5 new for January). All patients will have a harm review by the managing Consultant. 52 Week Panel established.
RTT Data Quality: This has become business as usual and is monitored weekly at the Access Performance meeting.

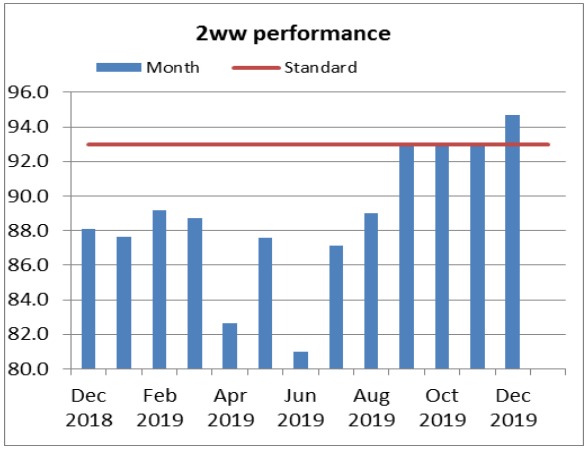
Diagnostics <6weeks: Performance remained similar at 98.2% in January, therefore not achieving the target.

Theatre Utilisation: Theatre Utilisation with TAT has remained consistent for this financial year, averaging 86.5%. There was an increase in Theatre activity in Jan-20 which also equated to an increase of an average of 11.6 elective cases per working day.

Summary:	Actions:	Assurance:
Performance increased to 85.03% in January and is therefore above the trajectory of 84.98%. The Trust Waiting List has decreased by 760 to 31,918 and the backlog has decreased by 481 to 4,786 due to an increase in both elective and outpatient new activity.	Some of the speciality initiatives submitted in the speciality business plans have not been funded. RTT recovery plan from Jan – March 20 has been implemented. Review operational plan for RTT data quality project.	Weekly monitoring of the specialty plans for activity, diagnostics, and theatre scheduling, backlog and waiting list size, through the Access Performance meetings and specialty meetings. All patients over 40 weeks monitored daily ensure treatment occurs before 52 weeks. This has become business as usual and is monitored weekly at the Access Performance meeting.

Escalation: Cancer Waiting Times – 2 Weeks





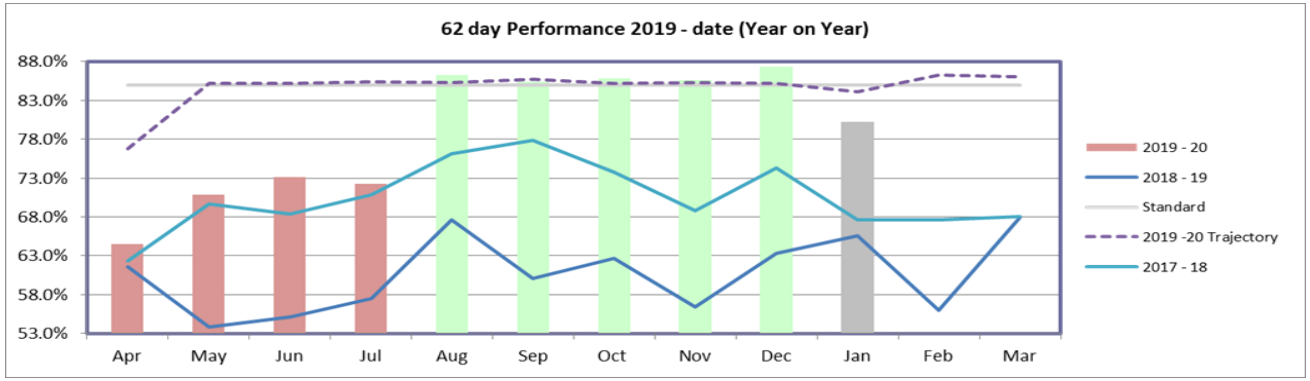
2ww GP referrals to MTW	Breast	Childre n	Gynae	Haem	Head & Neck	Lower GI	Lung	Other (inc	Upper GI	Urology	Total	BSYM	Breast total
2017	319	4	119	9	109	261	47	8	139	154	1164	165	404
2018	343	9	141	17	123	310	48	4	146	207	1289	141	484
2019	393	14	157	26	146	359	53	5	145	208	1659	155	548
2020 (Jan - Jan)	450	25	193	17	150	389	68	7	156	235	1829	139	589
% change last 12 mths	14.6%	76.5%	23.1%	-35.0%	3.0%	8.5%	27.5%	35.5%	7.3%	12.8%	10.2%	-10.5%	7.5%

Demand: As expected, numbers of referrals increased in January 2020, with 1829 2ww referrals (excluding screening) , which is an increase of 19% over December and the highest number of 2ww referrals received in a single month over the previous 4 years. Haematology referrals had a 35% decrease in January from the overall average for 2019, but all other tumour sites noted an increase in January, with 23.1% for Gynae and 76.5% for Children's referrals (which had 25 received). Breast had the greatest number of referrals received in January with 450 for 2ww and 139 for Breast Symptoms.

2 Week Wait (2WW) Performance:
The Trust is maintaining the achievement of the 2ww standard reporting 94.7% for December 2019 and 94.4% for Breast Symptoms
Overall, the majority of tumour sites achieved the standard for first appointment within 14 days, except for Children's cancers, Lung and Urology (excluding Testicular). There has been a significant improvement in Lower GI, reporting over 93% for the first time this year, with 93.8%
The current un-validated position for January is 92.6% with 89 first seen breaches being reviewed.

Summary:	Actions:	Assurance:
The Trust is maintaining achievement of the 2ww standard for both suspected cancer and Breast Symptom referrals, with the majority of tumour sites reporting an achievement of the standard. The number of referrals has increased again in January 2020, with receipt of 1829 referrals, which is the highest number of referrals in the past 48 months Overall there has been a 28.7% increase of 2ww referrals received between 2018 and 2019.	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. During the first week of go live, booking days reduced from 10-14 to 7-10. Nurse triage twice a day has reduced the pathway time by one day and ensured complete utilisation of clinic space. The lung team have set up a new one-stop clinic process, which has allowed for 2ww patients to be scanned and then seen in clinic within the same day.	A 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 2ww action log monitors transformation and development, and holds services to account. 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: For a 5th consecutive month, the Trust has achieved the 62 day standard, reporting 87.3% for December 2019. This is a significant improvement from last year where the Trust reported 56.4% for November 2018.

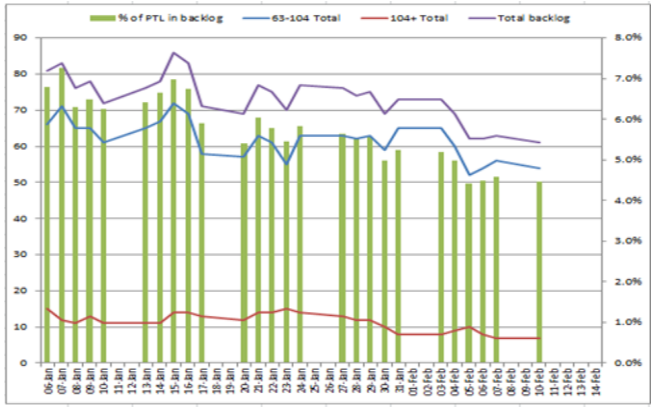
Tumour Specific Performance:
Progressing from the best 2ww performances in August & September, Breast has reported 100% over 21 first definitive treatments for December 2019.
Gynaecology and Urology have achieved the 62d Standard with Upper GI reporting just below the target at 84.6%.

Lung, Haematology, Head & Neck and Lower GI have reported below target at 60%, 71.4%, 72.7% and 76.9% respectively

The current, unvalidated position for January is 80.2%.

Conversion rates for 2ww referrals: The overall conversion rate has not changed from previous months and remains at 8%. With variations across the different tumour sites,

62 Day Performance						
December 2019	All reportable patients			MTW only patients		
	Total	Breach	%	Total	Breach	%
Breast	21.0	0.0	100.0	21	0	100.0
Gynae	8.5	1.0	88.2	5	1	80.0
Haematology	7.0	2.0	71.4	6	1	83.3
Head & Neck	5.5	1.5	72.7	3	1	66.7
Lower GI	6.5	1.5	76.9	6	1	83.3
Lung	7.5	3.0	60.0	5	2	60.0
Other	2.0	0.0	100.0	2	0	100.0
Upper GI	6.5	1.0	84.6	6	1	83.3
Urology	26.0	1.5	94.2	21	1	95.2
TOTAL	90.5	11.5	87.3	75	8	89.3



PTL Backlog- For the beginning of February 2020, the 62 day PTL backlog is being maintained at less than 5% of the total backlog. There are currently 61 patients in the backlog, 10 of which are over 104 days. The majority of the patients over 104 days are between Lower GI and Upper GI.

Summary:	Actions:	Assurance:
For a third consecutive month the Trust has achieved all reportable Cancer Waiting Times standards, including 87.3% for the 62 day standard The Cancer Team are continuing to actively validate all breach and high risk pathways and specific attention is being paid to Interprovider Transfers to ensure that all patients referred are valid and ready for treatment PTL Backlog:- For the beginning of February 2020, the 62 day PTL backlog is being maintained at less than 5% of the total backlog.	Action plans for each pathway have been 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. A new lung MDTC has been recruited, in addition to the navigator role, to provide more support at the treatment end of the pathway. 'All options' clinic for the prostate pathway and doubling the number of brachytherapy lists each week.	Daily huddles with each tumour site team are in place Additional funding has been secured from the CCG and Cancer Alliance to support proposed actions and posts required to continue cancer pathway improvements. Harm reviews are conducted for all patients treated over 104 days. Daily PTLs with GMs and DDOs for all tumour sites with endoscopy, radiology, pathology and oncology presence. Weekly cancer performance meeting to review breach risks and outstanding tumour site issues.

Appendices

Safe		2018/19	2019/20	Q2			Q3			Q4			Q1			Q2			Q3			Q4	YTD	FOT	YTD Var from Plan
ID	Key Performance Indicators	Outturn	Target	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan			
S1	Rate of Cdifficile per 100,000 beddays	22.8	22.4	35.5	39.2	46.4	19.2	15.1	9.7	32.1	19.9	28.4	44.6	0.0	25.6	14.8	29.6	35.1	19.6	29.4	4.7	13.7	21.4	21.1	-6.8%
S2	CDifficile (Post 72hrs) - Hospital	56	55	7	8	9	4	3	2	7	4	6	9	0	5	3	6	7	4	6	1	3	44	52	-3
S3	MRSA Bacteraemia (Post 48hrs) Hospital	3	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	1
S3.1	% Elective MRSA Screening	98.0%	98.0%	98.7%	98.5%	98.7%	99.0%	99.0%	99.0%	98.0%	99.0%	98.0%	99.0%	99.1%	99.0%	99.0%	99.0%	99.0%	98.9%	99.4%	98.8%	100.0%	100.0%	100.0%	2.0%
S3.2	% Non-Elective MRSA Screening	93.1%	95.0%	No data	No data	No data	93.0%	95.2%	95.0%	86.0%	92.5%	93.1%	89.0%	92.0%	90.0%	92.3%	95.0%	92.9%	91.6%	90.8%	94.1%	92.3%	92.3%	92.3%	-2.7%
S4	Rate of E. Coli Bacteraemia per 100,000 beddays	28.1	21.5	35.5	34.3	15.5	24.0	50.3	24.3	13.8	19.9	33.2	29.8	14.1	35.8	19.8	34.5	55.1	63.5	19.6	14.0	32.0	31.6	29.6	10.1
S4.1	MSSA Bacteraemia (Post 48hrs)	19	19	2	5	0	1	0	1	2	0	2	1	3	0	4	1	6	0	3	6	1	25	27	8
S4.2	E. Coli Bacteraemia (Post 48hrs)	69	52	7	7	3	5	10	5	3	4	7	6	3	7	4	7	11	13	4	3	7	65	73	21
S4.3	Cases of Gram Negative Bactareamia	113	113	10	10	7	11	12	9	5	8	11	8	4	7	8	8	14	16	5	6	7	83	102	-11
S4.4	Catheters inserted	1,160	225	222	No data	No data	310	209	No data	No data	No data	205	213	224	245	181	212	191	278	-	-	207	207	207	- 18
S5	Rate of Hospital Acquired Pressure Ulcers	1.32	1.26	0.51	1.79	1.56	1.31	1.36	1.23	0.97	1.09	0.32	1.05	0.81	0.68	0.61	1.86	2.49	2.19	1.93	2.32	2.29	1.63	1.59	0.4
S5.1	Rate of All Pressure Ulcers	16.5	16.0	18.6	15.1	15.8	18.2	16.5	17.2	16.5	18.6	14.4	23.0	20.9	23.7	22.1	22.5	24.3	27.6	21.9	20.9	23.8	23.1	23.1	7.1
S5.2	Pressure Ulcers Grade 2	49	36	1	5	2	4	2	4	3	1	0	1	1	1	1	1	4	5	0	6	6	26	32	- 4
S5.3	Pressure Ulcers Grades 3	3	-	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	-
S5.4	Pressure Ulcers Grades 4	3	-	0	1	0	0	0	0	2	0	0	0	0	0	0	0	0	0	1	1	0	2	2	2
S5.5	Pressure Ulcers Deemed "Un-gradeable"	13	24	2	4	3	0	0	0	-	-	0	3	0	1	0	2	4	4	3	5	2	24	28	4
S5.6	Pressure Ulcers DTIs	25	36	0	0	4	4	6	3	1	5	2	2	4	2	3	8	7	5	8	3	7	49	55	19
S5.7	Pressure Ulcers MASD	-	-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	-
S5.8	Pressure UlcersTotal	93	96	3	11	9	8	8	7	6	6	2	6	5	4	4	11	15	14	12	15	15	101	117	21
S6	Rate of Patient Falls	6.21	6.00	7.86	6.76	6.80	5.81	6.79	5.21	6.88	6.58	5.31	6.94	5.66	6.14	5.68	7.14	5.91	5.33	5.04	6.69	6.50	6.11	6.08	0.11
S6.1	Rate of Patient Falls TWH	6.75	6.30	6.90	7.53	6.90	6.38	7.18	6.19	8.29	7.73	6.28	7.48	6.53	7.14	7.11	9.03	6.44	6.58	5.75	7.09	7.39	7.06	6.98	0.76
S6.2	Rate of Patient Falls MH	5.31	5.05	9.57	5.44	6.62	4.84	6.11	3.60	4.64	4.76	3.78	5.96	4.18	4.48	3.49	4.18	5.13	3.49	4.04	6.11	5.29	4.65	4.69	-0.35
S6.3	Falls resulting in "No Harm"	1,170	1,116	122	93	97	99	97	82	115	102	89	93	92	97	78	119	93	90	78	117	116	973	1159	43
S6.4	Falls resulting in "Low Harm"	312	300	39	35	29	18	34	22	31	26	16	37	21	20	30	19	20	19	22	22	23	233	283	- 17
S6.5	Falls resulting in "Moderate Harm"	33	24	7	5	2	2	3	2	2	2	6	6	3	2	3	2	2	0	3	0	3	24	28	4
S6.6	Falls resulting in "Severe Harm"	22	24	0	5	3	2	1	1	3	1	1	2	4	1	5	5	3	0	0	4	0	24	28	4
S6.7	Falls resulting in "Death"	2	-	0	0	1	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	1	1	1
S6.8	Total Number of Patient Falls	1,525	1,464	155	138	132	121	135	107	150	132	112	140	120	120	115	145	118	109	103	143	142	1255	1499	35
S6.9	Total Number of Patient Falls TWH	1,033	996	87	97	85	84	90	79	111	95	81	93	87	87	89	112	77	80	69	89	93	876	1042	46
S6.10	Total Number of Patient Falls MH	492	468	68	41	47	37	45	28	39	37	31	46	33	33	27	33	41	29	34	54	49	379	457	- 11
S7	Never Events	1	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1	2	2	2
S8	Number of New SIs in month	154	144	11	18	17	19	11	5	10	8	8	17	15	8	9	17	7	10	6	13	11	113	137	- 7
S8.1	Serious Incidents rate	0.63	0.59	0.56	0.88	0.88	0.91	0.55	0.24	0.46	0.40	0.38	0.84	0.71	0.41	0.44	0.84	0.35	0.49	0.29	0.61	0.50	0.55	0.56	0.00
S8.2	Number of Open Sis	87	95	96	96	110	97	90	104	87	81	85	97	99	93	84	83	80	82	62	59	48	48	48	- 47
S9	SIs not closed <60 Days Monthly Snapshot		24										57	50	52	39	21	31	25	11	11	3	3	3	- 21
S10	Overall Safe staffing fill rate	96.8%	93.5%	95.8%	94.3%	95.0%	99.2%	99.5%	95.3%	98.0%	95.8%	95.5%	94.8%	94.2%	94.0%	94.4%	93.4%	92.5%	97.4%	101.2%	98.1%	100.3%	96.1%	96.1%	2.6%
S11	Safety Thermometer % of Harm Free Care	97.4%	95.0%	98.2%	98.3%	97.6%	97.3%	97.5%	98.4%	97.9%	98.5%	97.4%	97.5%	98.5%	98.0%	97.8%	98.3%	82.8%	85.7%	88.5%	89.3%	86.7%	86.7%	86.7%	-8.3%
S11.1	Safety Thermometer % of New Harms	2.6%	3.0%	1.8%	1.7%	2.4%	2.6%	2.3%	1.6%	2.1%	1.5%	2.6%	2.4%	1.5%	1.9%	2.3%	1.7%	8.8%	6.5%	5.6%	5.4%	7.4%	7.4%	7.4%	4.4%
S12	Number of Central Alerting System Alerts Overdue	8	12	0	2	0	1	1	0	1	1	1	1	2	1	0	1	1	1	1	1	5	14	16	4
S13	Medication Errors - Low Harm	86	72	8	10	3	2	8	3	6	6	17	7	4	12	12	8	8	9	5	13	4	82	94	22
S13.1	Medication Errors - Moderate Harm	11	12	1	3	0	0	1	1	0	4	1	3	0	1	1	0	0	0	1	0	0	6	8	-4
S13.2	Medication Errors - Severe Harm	4	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
S14	Number of Incidents reported in month	11,737	11,700	1,083	1,088	950	1,026	1,033	850	1,084	947	939	954	934	886	945	950	969	1130	1104	1121	1209	10202	12152	452
S14.1	Rate of Incidents that are Harmful	1.01	1.23	1.11	1.10	1.47	1.07	0.77	0.47	1.01	0.53	0.96	1.05	1.39	1.13	1.38	1.89	1.03	0.71	0.27	0.89	0.33	0.97	0.96	-0.26
S14.2	Number of Incidents open >45 days	1,931	1,931	2,273	1,959	1,515	2,135	1,469	2,095	2,046	2,205	1,416	1448	1931	2025	1940	1478	2844	2946	1665	2088	1724	1724	1724	-207

Effective		2018/19 Outturn	2019/20 Target	Q2			Q3			Q4			Q1			Q2			Q3			Q4	YTD	FOT	YTD Var From Plan
ID	Key Performance Indicators			Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan			
E1	Hospital-level Mortality Indicator (SHMI)	Band 2	Band 2	1.0440	1.0219	1.0219	1.0371	1.0244	1.0244	1.0391	1.0391	1.0391	1.0391	1.0296	1.0235	1.0165	1.0224	1.0363	1.0412	1.0348	1.0331	1.0249	1.0249	1.0249	Band 2
E2	Standardised Mortality HSMR		Lower Confidence <100	106.70	105.80	104.80	103.70	102.40	103.30	102.30	101.20	99.40	96.30	97.20	92.70	93.10	91.50	91.50	91.70	92.70	91.00	91.70	91.7	91.7	-8.3
E2.1	Crude Mortality	1.00%	1.00%	0.94%	0.90%	1.14%	0.88%	0.77%	1.02%	1.25%	1.11%	1.07%	1.01%	0.85%	0.70%	0.86%	0.82%	0.99%	0.86%	0.94%	0.99%	1.09%	0.91%	0.91%	-0.1%
E3	% Total Readmissions	14.12%	14.12%	14.20%	14.14%	13.65%	14.54%	13.97%	15.29%	14.39%	14.66%	14.75%	14.89%	13.51%	14.96%	15.16%	14.65%	15.43%	14.66%	15.46%	14.81%	Data runs one month behind	14.83%	14.83%	0.7%
E4	Readmissions <30 days: Emergency	14.75%	14.75%	14.80%	14.67%	14.29%	15.34%	14.81%	16.06%	14.84%	15.30%	15.38%	15.54%	14.27%	15.33%	15.88%	15.13%	16.11%	15.26%	16.10%	15.27%		15.43%	15.43%	0.7%
E5	Readmissions <30 days: Emergency (excl SDEC)	13.99%	13.99%	15.07%	13.68%	13.04%	14.08%	13.81%	14.31%	14.59%	14.23%	14.45%	15.20%	13.86%	14.10%	14.81%	14.99%	16.12%	14.73%	15.12%	13.95%		14.75%	14.75%	0.0%
E6	Readmissions <30 days: Elective	6.77%	6.77%	7.00%	8.06%	6.08%	5.64%	5.99%	5.96%	8.04%	6.58%	7.43%	7.73%	5.34%	10.21%	6.58%	9.00%	7.12%	7.66%	8.05%	8.06%		7.68%	7.68%	0.9%
E7	Stroke: Best Practice Tariff Overall %	43.1%	50.0%	58.3%	48.1%	42.3%	54.3%	55.4%	53.3%	49.1%	47.5%	43.1%	36.9%	37.9%	34.4%	45.5%	40.6%	35.3%	44.4%	46.4%	46.9%		41.0%	41.0%	-9.0%
E7.1	Stroke BPT Part 1: First Ward	75.9%	80.0%	80.0%	82.7%	76.9%	77.1%	87.7%	82.2%	81.1%	83.6%	75.9%	64.6%	63.6%	75.4%	77.3%	78.1%	74.5%	79.4%	78.6%	71.9%		73.6%	73.6%	-6.4%
E7.2	Stroke BPT Part 2: Cons <=14 Hours	50.0%	58.0%	66.7%	56.8%	50.0%	57.1%	61.5%	57.8%	62.3%	49.2%	50.0%	50.8%	45.5%	49.2%	57.6%	42.2%	45.1%	57.1%	53.6%	53.1%		50.5%	50.5%	-7.5%
E7.3	Stroke BPT Part 3: 90% Time on Stroke Ward	89.7%	80.0%	86.67%	83.95%	84.62%	85.71%	92.31%	91.11%	90.57%	91.80%	89.66%	80.0%	71.2%	80.3%	81.8%	82.8%	76.5%	79.4%	80.4%	82.8%		79.5%	79.5%	-0.5%
E7.4	% TIA <24hrs	64.7%	60.0%	29.2%	65.2%	63.2%	66.7%	70.6%	58.3%	91.7%	61.9%	42.1%	60.6%	53.3%	54.5%	57.7%	51.9%	36.4%	71.4%	70.8%	68.2%		58.1%	58.1%	5.2%
E8	Nat CQUIN: % Dementia Screening	98.8%	90.0%	99.6%	100.0%	99.8%	99.6%	99.8%	100.0%	100.0%	99.8%	98.8%	94.3%	92.3%	84.4%	91.0%	95.5%	98.7%	98.4%	98.8%	99.6%	99.1%	95.2%	95.2%	-5.9%
E9	Nat CQUIN: % Dementia Risk Asssessed	98.7%	90.0%	94%	96%	90.0%	95.5%	100.0%	99.0%	100.0%	100.0%	98.7%	98.2%	93.9%	92.2%	96.4%	89.6%	700.0%	97.3%	96.2%	82.1%	100.0%	101.7%	101.7%	0.5%
E10	Nat CQUIN: % Dementia Referred to Specialist	100.0%	90.0%	98%	100%	98.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.1%	100.0%	100.0%	96.2%	100.0%	100.0%	100.0%	98.0%	100.0%	100.0%	99.1%	99.1%	-2.6%
E10.1	NE LOS for Patients with Dementia												7.5	8.9	8.0	9.5	9.0	9.1	8.3	9.1	8.3	8.8	8.7	0.0	0.0
E10.2	Readmissions <30 Days for Pt with Dementia												21.0%	20.9%	22.3%	30.0%	28.0%	23.2%	22.4%	22.1%	21.2%	0.0%	22.4%	22.4%	-1.5%
E11	C-Section Rate (elective or non-elective)	27.9%	25.0%	26.9%	28.8%	24.0%	29.7%	30.2%	26.5%	31.3%	29.5%	27.0%	31.1%	32.3%	27.5%	28.6%	27.5%	29.6%	30.8%	29.3%	27.8%	25.2%	15.1%	29.0%	-9.9%
E11.1	% Mothers initiating Breastfeeding	82.2%	78.0%	79.14%	84.02%	81.74%	77.72%	83.50%	80.45%	84.37%	84.01%	85.19%	83.3%	83.8%	79.3%	82.6%	80.9%	80.5%	81.5%	84.9%	80.0%	83.7%	82.1%	82.1%	4.1%
E11.2	% Stillbirths Rate	0.17%	0.47%	0.20%	0.19%	0.20%	0.00%	0.20%	0.00%	0.42%	0.23%	0.21%	0.48%	0.39%	0.21%	0.00%	0.22%	0.83%	0.00%	0.21%	0.47%	0.22%	0.30%	0.30%	-0.2%

Caring		2018/19 Outturn	2019/20 Target	Q2			Q3			Q4			Q1			Q2			Q3			Q4	YTD	FOT	YTD Var from Plan
ID	Key Performance Indicators			Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan			
C1	Single Sex Accommodation Breaches	35	0	5	12	0	10	8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
C2	Rate of New Complaints	2.30	2.93	1.93	1.67	2.22	2.84	2.41	2.34	2.39	2.04	3.17	2.28	2.21	2.71	2.27	2.51	1.85	2.93	2.25	2.01	2.20	2.32	2.42	-0.61
C3	% complaints responded to within target	75.7%	75.0%	73.3%	62.8%	54.3%	65.3%	75.0%	66.7%	82.8%	73.3%	75.7%	66.7%	37.5%	45.7%	65.4%	65.1%	71.4%	85.4%	74.0%	80.0%	80.4%	67.1%	68.4%	-7.9%
C3.1	Total Open Complaints	149	140	155	137	144	139	129	129	130	120	149	155	173	154	134	149	132	143	145	127	125	125	125	- 15
C3.2	Number of new complaints received	564	720	38	34	43	59	48	48	52	41	67	46	47	53	46	51	37	60	46	43	48	477	597	- 123
C3.3	Number of Nursing Complaints	107	108	8	5	7	9	13	12	10	12	10	5	9	11	7	10	5	5	9	2	7	70	88	- 20
C3.4	Number of Medical Complaints	353	336	24	21	26	41	32	32	31	23	43	30	26	33	31	26	23	39	22	28	34	292	348	12
C3.5	Number of Complaints open 60-90 days	182	180	15	18	11	12	10	11	13	12	19	14	25	18	16	22	13	9	10	13	6	146	176	- 4
C3.6	Number of Complaints open >90 days	349	348	36	37	43	29	25	20	19	18	20	30	33	33	27	32	24	24	25	23	29	280	338	- 10
C4	% IP Response Rate Friends & Family	17.9%	25.0%	19.5%	18.7%	20.1%	15.3%	24.5%	19.6%	18.7%	18.2%	17.9%	18.7%	20.4%	16.5%	16.0%	15.4%	16.6%	8.0%	19.5%	17.1%	16.0%	16.3%	16.3%	-8.7%
C5	IP Friends & Family (FFT)% positive	94.8%	95.0%	94.2%	95.9%	93.8%	94.2%	93.7%	93.9%	93.5%	95.6%	94.8%	94.2%	95.6%	96.7%	95.1%	93.9%	94.0%	98.5%	95.7%	96.5%	96.3%	95.5%	95.5%	0.5%
C6	% A&E Response Rate Friends & Family	8.9%	15.0%	12.1%	8.1%	12.3%	4.2%	21.2%	12.9%	5.4%	7.6%	8.9%	11.0%	14.6%	12.3%	9.6%	10.1%	9.1%	0.8%	2.3%	12.1%	1.9%	8.4%	8.4%	-6.6%
C7	A&E Friends & Family (FFT) % positive	92.0%	87.0%	89.4%	92.6%	90.9%	91.4%	91.0%	89.9%	90.5%	91.3%	92.0%	81.2%	86.1%	91.6%	91.5%	88.1%	85.7%	96.4%	88.7%	87.3%	87.2%	87.5%	87.5%	0.5%
C8	% Maternity Combined Q2 Response Rate	20.3%	25.0%	27.0%	9.9%	43.8%	18.2%	11.8%	23.9%	37.6%	26.2%	20.3%	20.1%	6.0%	45.5%	44.5%	33.4%	17.3%	7.8%	12.0%	16.3%	20.1%	22.2%	22.2%	-2.8%
C9	Maternity Combined FFT % Positive	98.4%	95.0%	93.5%	98.0%	92.1%	95.0%	99.1%	90.4%	95.8%	96.5%	98.4%	93.8%	97.1%	94.2%	94.0%	93.6%	94.7%	97.0%	97.8%	99.7%	96.9%	95.5%	95.5%	0.5%
C10	OP Friends & Family (FFT) % Positive	81.2%	84.0%	85.2%	81.7%	83.9%	82.7%	84.1%	84.2%	84.4%	84.3%	81.2%	82.5%	82.5%	81.5%	82.1%	83.0%	81.3%	82.3%	84.2%	82.2%	83.6%	82.6%	82.6%	-1.4%
C10.1	OP Friends & Family (FFT) Response Rate	68.5%	68.0%	66.2%	66.2%	67.4%	68.6%	68.8%	67.4%	69.0%	68.5%	68.5%	49.3%	62.5%	56.9%	55.4%	56.5%	51.3%	59.0%	67.7%	48.8%	59.2%	56.7%	56.7%	-11.3%
C11	VTE Risk Assessment (%)	96.4%	95.0%	97.2%	95.4%	96.1%	96.9%	97.2%	96.5%	97.2%	97.4%	96.4%	97.0%	96.9%	97.1%	97.3%	96.7%	96.7%	96.9%	95.9%	95.6%	96.4%	96.7%	96.7%	1.7%

Responsive		2018/19 Outturn	2019/20 Target	Q2			Q3			Q4			Q1			Q2			Q3			Q4	YTD	FOT	YTD Var From Plan
ID	Key Performance Indicators			Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan			
R1	A&E % 4hrs Arrival to Exit - Trust (Inc MIU)	92.09%	91.67%	93.16%	91.79%	93.93%	90.75%	90.93%	89.6%	88.91%	87.16%	95.85%	92.29%	92.16%	94.65%	93.73%	90.27%	89.54%	89.24%	87.63%	85.41%	91.07%	90.61%	90.50%	-1.4%
R1.1	A&E % 4hrs Arrival to Exit - Maidstone	95.07%	95.23%	94.41%	93.42%	97.17%	96.26%	95.21%	92.22%	92.87%	90.80%	97.81%	94.35%	94.00%	95.95%	96.79%	89.89%	92.96%	90.34%	89.04%	86.17%	91.05%	92.06%	92.42%	-3.4%
R1.2	A&E % 4hrs Arrival to Exit - TWells	86.25%	85.08%	88.79%	86.60%	88.45%	82.33%	84.05%	83.58%	81.32%	78.91%	92.60%	87.11%	87.30%	91.10%	88.36%	86.15%	81.83%	83.91%	81.78%	79.61%	87.80%	85.44%	84.91%	-0.2%
R1.3	A&E Conversion Rate	20.8%	20.8%	20.8%	21.0%	20.4%	20.9%	20.8%	21.4%	20.9%	20.4%	20.4%	20.0%	19.0%	18.4%	17.7%	19.4%	18.9%	19.2%	19.1%	19.9%	20.6%	19.2%	19.2%	-1.7%
R1.4	A&E Left without being Seen Rate (%)	2.8%	2.8%	3.4%	3.2%	2.5%	2.3%	2.4%	2.5%	2.6%	3.3%	2.4%	2.8%	2.4%	2.5%	2.8%	2.8%	2.8%	2.4%	2.7%	3.2%	2.0%	2.6%	2.6%	-0.1%
R1.5	A&E Time to Assessment 15 mins	95.3%	95.0%	95.9%	94.9%	97.0%	95.2%	95.9%	95.3%	94.7%	91.5%	95.2%	94.5%	90.0%	92.0%	90.9%	89.0%	87.0%	87.4%	88.4%	76.0%	89.2%	88.3%	88.3%	-6.7%
R1.6	A&E Time to Treatment 60 mins	55.9%	55.9%	53.5%	54.7%	57.5%	55.4%	58.1%	55.3%	56.7%	52.9%	57.2%	55.7%	56.4%	58.9%	58.8%	58.1%	57.8%	60.1%	57.3%	51.0%	60.1%	57.4%	57.4%	1.5%
R1.7	A&E Unplanned Re-Attendance Rate (%)	8.0%	8.0%	8.3%	8.7%	7.6%	8.4%	8.1%	8.1%	7.8%	8.3%	8.0%	8.3%	8.5%	8.4%	8.3%	8.7%	9.1%	8.3%	8.8%	8.5%	8.4%	8.5%	8.5%	0.5%
R1.8	A&E Average Time in Department (Hours)	0.14	0.16	0.14	0.14	0.13	0.15	0.14	0.15	0.15	0.16	0.13	0.14	0.14	0.13	0.14	0.15	0.15	0.15	0.16	0.17	0.15	0.15	0.15	-0.09
R2	A&E 12hr Breaches	2	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2	0	2
R3	Ambulance Handover Delays >60mins	596	540	22	60	31	67	82	70	74	83	13	57	59	26	42	56	77	57	50	75	14	513	603	14.0%
R3.1	Ambulance Handover Delays >30mins	4,487	4,428	250	400	284	486	442	441	613	444	280	494	531	384	528	490	581	508	492	641	370	5019	5757	36.0%
R4	RTT Incomplete Pathway	83.12%	86.67%	80.4%	79.4%	79.7%	80.67%	81.01%	81.61%	81.10%	81.29%	83.12%	84.05%	85.17%	85.78%	85.57%	84.83%	84.34%	84.12%	84.00%	83.91%	85.03%	85.03%	83.74%	0.0%
R4.1	RTT Incomplete Admitted Backlog	2,606	2,315	3,434	3,348	3,065	2,930	2,867	2,779	2,829	2,781	2,606	2391	2157	2156	2171	2135	2004	1932	2079	2224	2153	2224	2399	-8.1%
R4.2	RTT Incomplete Non-Admitted Backlog	2,182	872	3,298	3,911	3,578	3,200	3,235	2,886	2,781	2,807	2,182	2119	2148	2007	2259	2733	2906	3120	3113	3042	2631	3042	2447	196.2%
R4.3	RTT Specialties Not Achieved Nat Target	9	0	11	12	10	10	9	9	9	9	9	9	10	9	9	11	11	12	11	11	11	104	104	104
R4.4	RTT Incomplete Total Backlog	4,788	3,186	6,732	7,259	6,643	6,130	6,102	5,665	5,610	5,588	4,788	4510	4305	4163	4430	4868	4910	5052	5192	5266	4784	5266	4846	52.7%
R5	RTT 52 Week Waiters (New in Month)	8	96	6	4	8	8	11	5	7	8	8	6	10	3	3	6	8	5	14	2	5	62	62	-18
R6	% Diagnostics Tests WTimes <6wks	99.2%	99.0%	99.7%	99.6%	99.4%	99.5%	99.4%	99.1%	99.1%	99.5%	99.2%	99.1%	99.1%	98.7%	98.5%	96.5%	98.7%	99.3%	99.1%	98.0%	98.2%	98.2%	99.0%	-0.8%
R7	*Cancer two week wait	88.7%	93.0%	82.3%	76.4%	78.0%	86.5%	90.0%	88.1%	87.6%	89.2%	88.7%	82.6%	87.6%	81.0%	87.1%	89.0%	93.1%	93.0%	93.0%	94.7%	Data runs one month behind	94.7%	94.7%	1.7%
R8	*Cancer WT - Breast Symptons 2WW	73.2%	93.0%	67.5%	58.5%	71.3%	83.1%	81.7%	58.3%	69.4%	74.7%	73.2%	56.4%	65.2%	63.4%	81.7%	91.5%	98.2%	94.1%	95.2%	94.4%		94.4%	94.4%	1.4%
R9	*Cancer 31 day wait - First Treatment	96.1%	96.0%	97.9%	96.2%	95.1%	96.2%	96.8%	97.2%	95.9%	96.2%	96.1%	96.5%	96.0%	96.8%	97.7%	97.2%	96.4%	97.5%	97.2%	99.5%		99.5%	99.5%	3.5%
R9.1	*Cancer 31 day - Subs Treatment - Surgery	92.9%	94.0%	96.4%	96.2%	82.4%	92.0%	79.4%	100.0%	82.4%	96.0%	92.9%	87.1%	96.3%	96.7%	100.0%	86.2%	95.8%	97.0%	96.7%	85.7%		85.7%	85.7%	-8.3%
R9.2	*Cancer 31 day - Subs Treatment - Drugs	99.0%	98.0%	100.0%	99.1%	98.7%	99.3%	98.7%	98.3%	96.7%	98.2%	99.0%	100.0%	100.0%	100.0%	98.9%	100.0%	99.0%	100.0%	100.0%	100.0%		100.0%	100.0%	2.0%
R9.3	*Cancer 31 day Subs Treatment Radio	92.8%	94.0%	95.4%	97.6%	93.7%	98.2%	96.7%	99.2%	90.5%	94.5%	92.8%	92.5%	91.4%	94.3%	93.1%	93.4%	92.7%	95.0%	95.3%	97.3%		97.3%	97.3%	3.3%
R10	*Cancer 62 day wait - First Definitive	67.9%	85.0%	57.5%	67.7%	60.1%	62.6%	56.4%	63.3%	65.6%	56.0%	67.9%	64.5%	70.9%	73.1%	72.2%	86.3%	85.4%	85.8%	85.6%	87.3%		87.3%	87.3%	2.3%
R10.1	*Cancer 62 day wait - First Definitive - MTW	72.8%	85.0%	59.3%	70.9%	65.1%	63.8%	58.8%	65.6%	69.2%	58.8%	72.8%	68.6%	80.4%	80.0%	78.4%	90.1%	88.9%	86.8%	90.5%	89.3%		89.3%	89.3%	4.3%
R10.2	*Cancer WT - 62 Day Screening Referrals	74.4%	90.0%	79.5%	83.7%	69.0%	88.2%	97.3%	84.8%	80.6%	55.2%	74.4%	84.6%	87.8%	94.7%	80.0%	89.7%	91.7%	95.3%	94.9%	94.1%		94.1%	94.1%	4.1%
R10.3	*Cancer WT - 62 Day Cons Specialist	82.4%	85.0%	61.5%	76.5%	40.0%	86.4%	72.2%	69.2%	64.0%	86.7%	82.4%	100.0%	41.7%	67.7%	65.5%	56.3%	55.6%	55.0%	41.7%	54.5%		54.5%	54.5%	-30.5%

Well-Led		2018/19 Outturn	2019/20 Target	Q2			Q3			Q4			Q1			Q2			Q3			Q4	YTD	FOT	YTD Var From Plan
ID	Key Performance Indicators			Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan			
W1	Surplus (Deficit) against B/E Duty	12,006	6,897	574	82	- 1,014	3,075	2,030	136	- 2,567	- 457	13,359	- 2,001	- 71	- 1,272	2,569	1,036	407	1,535	24	2,039	1,720	5,987	6,896	2.2%
W2	CIP Savings	13,825	22,325	1,200	1,151	917	1,221	1,151	678	1,428	986	2,574	725	1,012	1,291	1,868	3,882	1,792	1,728	1,812	1,847	1,781	17,983	22,329	-1.2%
W3	Cash Balance	10,405	3,000	18,207	14,126	13,493	12,640	8,566	12,766	7,956	10,625	10,405	41,294	39,537	44,793	56,821	45,854	42,824	30,327	28,428	23,239	17,669	17,669	3,000	-29.9%
W4	Capital Expenditure	19,185	14,448	327	365	82	547	1,106	2,420	295	430	12,900	358	45	380	149	250	442	378	197	2,033	539	4,771	16,128	-53.5%
W4.1	Income	465,038	502,732	41,154	38,606	36,805	40,695	40,821	38,634	37,148	34,981	44,309	40,150	41,400	40,363	43,400	41,228	40,971	42,902	39,701	44,349	43,346	417,809	501,934	-0.3%
W4.2	EBITDA	28,347	37,810	2,998	2,515	1,545	5,533	4,475	2,603	- 104	- 1,934	6,386	540	2,452	1,895	5,133	3,575	2,838	4,063	2,465	5,071	4,177	32,209	38,222	1.9%
W5	Finance use of Resources Rating	3	2	4	4	4	3	3	3	3	4	3		3	3	3	3	3	3	3	3	3	3	3	1
W6	Staff Turnover Rate	9.1%	10.0%	9.9%	9.7%	9.39%	9.09%	9.22%	9.10%	8.90%	8.86%	9.12%	9.54%	9.79%	10.14%	10.79%	10.89%	11.43%	11.7%	11.9%	12.3%	12.6%	12.61%	12.61%	2.6%
W7	Vacancy Rate (%)	10.0%	8.0%	10.3%	11.1%	10.65%	9.63%	9.57%	10.83%	10.33%	10.26%	9.99%	13.31%	13.27%	13.11%	12.60%	11.97%	10.40%	9.1%	8.5%	8.3%	9.0%	11.06%	11.06%	3.1%
W7.1	Contracted WTE	5,153	5,479	5,049	5,069	5,064	5,148	5,017	5,124	5,139	5,145	5,153	5,147	5,105	5,122	5,169	5,219	5,323	5,393	5,425	5,444	5,472	5,472	5,472	-0.1%
W7.2	Establishment WTE	5,670	6,134	5,617	5,627	5,628	5,632	5,631	5,685	5,684	5,684	5,670	5,906	5,891	5,921	5,972	6,016	6,033	6,065	6,031	6,117	6,134	6,134	6,134	0.0%
W7.3	Substantive Staff Used	5,012	5,597	4,907	4,937	4,949	4,996	5,036	5,002	4,995	5,009	5,012	4,998	5,019	5,032	5,040	5,101	5,152	5,240	5,285	5,357	5,364	5,364	5,364	-4.2%
W7.4	Worked WTE	5,826	6,134	5,597	5,732	5,654	5,688	5,631	5,733	5,747	5,784	5,826	5,623	5,808	5,667	5,733	5,938	5,810	5,927	6,014	6,126	6,072	6,072	6,072	-1.0%
W7.5	Vacancies WTE	517	656	568	558	564	483	614	561	545	539	517	758	786	799	803	797	710	672	606	673	662	662	662	0.9%
W8	Total Agency Spend	22,651	18	2,113	2,072	1,901	1,787	1,734	1,747	1,901	2,097	1,408	1,649	1,655	1,531	1,852	1,770	1,786	1,653	1,075	1,520	1,618	16,109	19	0
W8.1	Nurse Agency Spend	- 9,434	- 4,369	- 853	- 847	- 822	- 823	- 661	- 728	- 862	- 860	- 963	- 577	- 563	- 468	- 474	- 612	- 641	- 706	- 473	- 649	- 628	- 5,790	- 5,790	32.5%
W8.2	Medical Locum & Agency Spend	- 19,052	- 13,982	- 1,567	- 1,585	- 1,517	- 1,261	- 1,456	- 1,806	- 1,663	- 1,674	- 1,933	- 1,656	- 1,699	- 1,718	- 1,957	- 1,886	- 1,902	- 1,573	- 1,484	- 1,740	- 1,685	- 17,300	- 17,300	23.7%
W8.3	Bank Staff Used	500	305	338	448	383	372	365	416	433	442	500	332	511	356	426	574	392	426	502	529	467	467	467	53.0%
W8.4	Agency Staff Used	277	232	310	302	277	271	229	270	283	286	277	249	241	243	233	229	234	226	196	206	210	210	210	-9.6%
W8.5	Overtime Used	36	No data	42	46	46	49	-	45	37	47	36	45	37	35	35	33	33	35	32	34	30	30	30	No data
W8.6	Temp costs & overtime as % of total pay bill	No data	12.0%	16.6%	18.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	16.0%	16.1%	15.9%	17.1%	18.2%	17.8%	0	0	0	0	16.3%	16.3%	4.3%
W9	Statutory and Mandatory Training	83.3%	90.0%	89.0%	85.8%	82.9%	No data	No data	No data	No data	No data	83.3%	83.5%	84.5%	86.1%	87.2%	88.9%	85.8%	86.4%	86.6%	85.8%	85.3%	86.0%	86.0%	-4.0%
W10	Sickness Absence	3.6%	3.3%	3.2%	3.3%	3.4%	3.4%	3.4%	3.9%	3.4%	3.8%	3.6%	3.1%	3.5%	3.3%	3.2%	3.5%	3.4%	3.6%	3.7%	3.9%	3.9%	3.5%	3.5%	0.2%
W11	Staff FFT % recommended work	82.2%	57.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	82.2%	82.2%	82.2%	53.3%	53.3%	53.3%	72.2%	72.2%	72.2%	72.2%	72.2%	72.2%	72.2%	72.2%	72.2%	15.2%
W11.1	Staff Friends & Family (FFT) % rec care	89.0%	80.0%	78.2%	78.2%	78.2%	78.2%	78.2%	78.2%	89.0%	89.0%	89.0%	75.3%	75.3%	75.3%	77.8%	77.8%	77.8%	77.8%	77.8%	77.8%	77.8%	77.8%	77.8%	-2.2%
W12	Appraisal Completeness	92.0%	95.0%	76.5%	82.6%	84.7%	86.2%	88.1%	90.2%	91.0%	92.1%	92.0%	2.6%	11.7%	26.7%	78.2%	87.4%	89.8%	91.1%	91.8%	91.8%	90.5%	90.5%	90.5%	-4.5%

REVIEW OF LATEST FINANCIAL PERFORMANCE

- The Trust delivered the financial plan for January generating £1.7m surplus including PSF. The Trust was £1.4m better than previously forecasted, £1m related to RTT income support which was previous included in the month 12 position and £0.4m related to an underspends within pay budgets.
- The Trust's normalised run rate (excluding PSF and MRET funding) in January was £0.6m deficit which was £0.9m adverse to plan.
- In January the Trust operated with an EBITDA surplus of £4.2m which was £0.1m adverse plan.
- Year to date the Trust is £0.1m favourable to plan, the key variances to budget were: Underperformance in Private Patient Income (£1.8m net), RTT Income reserve (£1.9m), £2.5m CIP slippage, £0.4m overspend against outsourcing, overspends within expenditure budgets (£2.5m). These pressures have been partly offset by release of prior year provisions (£3.5m), release of £3.6m of reserves, QIPP income adjustment (£1.3m) and £0.3m over performance within clinical income.
- The Trust was £1.4m better than the month 9 forecast, the main movements to forecast were: £1m RTT income support which was previous included in the month 12 position, £0.3m improvement within Medical pay budgets mainly within Surgery Division (£0.2m) and £0.2m benefit associated with Energy costs due to actual charges being less than estimated meter readings.
- The key current month variances are as follows:
    - Income adjusted for pass-through items is £0.2m favourable to plan, over performance within Clinical Income (£0.5m) is partly offset by underperformance within Private Patients (£0.3m). Clinical Income over performance in January is due to £0.7m RTT income support (over performance compared to planned value for January) partly offset by underperformance within Neonatal critical care activity (£0.2m).
    - Pay budgets adjusted for pass-through items underspent by £0.1m in January, Medical staffing pressures (£0.3m) were offset by (£0.3m) underspend within STT staff group. The pressure within Medical staffing is predominantly within the Medical and Emergency division (£0.3m) and Womens and Childrens Division (£0.1m).
    - Non Pay budgets adjusted for pass through items and release of reserves overspent by £0.8m in January. 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 January 2020 was £17.7m which is lower than plan of £25.2m. The variance relates to YTD agency spend which is higher by c£3.2m compared to the cash plan and High Weald's monthly January contractual SLA payment was not received by the Trust until the beginning of February.
- The Trust received authorisation in November 2019 to use £6.4m of asset sale resource brought forward from 2018/19 for critical equipment and estates backlog schemes that could be delivered in this financial year. The Trust's bid for national EPMA capital funding was approved at a level of £1.25m. The Trust also received approval in early December from NHSE/I to the allocation of funding from the national Diagnostic Equipment Fund covering two CT scanners, a MRI and Mammography equipment in this financial year (£2.1m) as well as £578k HSLI funding. In January confirmation has been given of further funding relating to managing Cyber risk (£427k). All of the additional external funding will need to be drawn down before the cut-off date of 9th March.
- The overall capital programme FOT is £15.6m (excluding donated and PFI Lifeycle). This includes Internally Generated capital of £4.85m, £6.4m asset sales, and the external funding sources detailed above. The internally generated capital of £4.85m has reduced in year by c.£0.4m as a result of forecast underspend on depreciation resulting from the initial reduction in the overall programme value (removal of some external financing items) and slippage in the timing of schemes due to the original planning issues around the national capital position. Overall £14.4m is already spent or committed (excluding donated and PFI Lifeycle) e.g. ICT;

EPR/EPMA £5.28m, Infrastructure £0.7m, Equipment; £0.9m general equipment, £2.1m CTs x 2, MRI & Mammography, £1.8m equipment from asset sales (includes balance of costs for Diagnostics) and Estates; £2.7m for backlog, Linac enabling and additional schemes from the asset sale.

- The Trust is forecasting to deliver the planned surplus including PSF and MRET of £6.9m however this includes £1.2m of risks to the financial positon.
- To mitigate these overspends the Trust is focusing on identifying identify revenue costs that could be capitalised (£0.1m) and additional income opportunities (£1.1m) from CCGs including additional RTT and Cancer support.

Maidstone and Tunbridge Wells NHS Trust

Trust Board Finance Report

Month 10
2019/20

Maidstone and Tunbridge Wells NHS Trust

Trust Board Finance Report January 2020

Maidstone and Tunbridge Wells NHS Trust

1a. Dashboard

January 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	43.3	42.7	0.7	0.4	0.2		417.8	418.3	(0.5)	1.6	(2.1)		501.9	501.1	0.9	
Expenditure	(39.2)	(38.4)	(0.8)	(0.4)	(0.3)		(385.6)	(386.7)	1.1	(1.6)	2.7		(463.7)	(463.2)	(0.5)	
EBITDA (Income less Expenditure)	4.2	4.3	(0.1)	(0.0)	(0.1)		32.2	31.6	0.6	(0.0)	0.6		38.2	37.8	0.4	
Financing Costs	(2.5)	(2.6)	0.1	0.0	0.1		(25.4)	(26.4)	1.1	0.0	1.1		(31.4)	(32.0)	0.6	
Technical Adjustments	0.0	0.0	0.0	0.0	0.0		(0.9)	0.7	(1.5)	0.0	(1.5)		0.0	1.1	(1.0)	
Net Surplus / Deficit (Incl PSF and MRET)	**1.7**	**1.7**	**0.0**	**(0.0)**	**0.0**		**6.0**	**5.9**	**0.1**	**(0.0)**	**0.1**		**6.9**	**6.9**	**(0.0)**	
CIPs	1.8	2.0	(0.3)		(0.3)		18.0	18.2	(0.2)		(0.2)		22.3	22.3	(0.0)	
Cash Balance	17.7	25.2	(7.5)		(7.5)		17.7	25.2	(7.5)		(7.5)		3.0	3.0	0.0	
Capital Expenditure	0.5	1.5	1.0		1.0		4.8	10.3	5.5		5.5		16.1	14.4	(1.7)	
Capital service cover rating							4	3					4	4		
Liquidity rating							4	3					4	4		
I&E margin rating							1	1					1	1		
I&E margin: distance from financial plan							1	1					1	1		
Agency rating							4	3					4	3		
Finance and use of resources rating							3	3					3	3		

Summary:

- The Trust delivered the financial plan for January generating £1.7m surplus including PSF. The Trust was £1.4m better than previously forecasted, £1m related to RTT income support which was previous included in the month 12 position and £0.4m related to an underspends within pay budgets.
- Year to date plan the Trust is £0.1m favourable to plan, the key variances to budget were: Underperformance in Private Patient Income (£1.8m net), RTT Income reserve (£1.9m), £2.5m CIP slippage, £0.4m overspend against outsourcing and overspends within expenditure budgets (£2.5m). These pressures have been partly offset by release of prior year provisions (£3.5m), release of £3.6m of reserves, QIPP income adjustment (£1.3m) and £0.3m over performance within clinical income.
- The Trust has delivered £18m savings YTD which is £0.2m adverse to plan.

Key Points:

- The Trusts normalised run rate in January was £0.6m deficit pre PSF which was £0.9m adverse to plan (pre PSF).
- The Trust was £1.4m better than the month 9 forecast, the main movements to forecast were: £1m RTT income support which was previous included in the month 12 position, £0.3m improvement within Medical pay budgets mainly within Surgery Division (£0.2m) and £0.2m benefit associated with Energy costs due to actual charges being less than estimated meter readings.

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 £1.2m of mitigations in the remaining 2 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 January 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	41.9	41.3	0.7	0.4	0.2	404.2	407.2	(3.0)	1.6	(4.6)
Expenditure	(39.2)	(38.4)	(0.8)	(0.4)	(0.3)	(388.4)	(386.7)	(1.7)	(1.6)	(0.1)
Trust Financing Costs	(2.5)	(2.6)	0.1	0.0	0.1	(25.4)	(26.4)	1.1	0.0	1.1
Technical Adjustments	0.0	0.0	0.0	0.0	0.0	(0.9)	0.7	(1.5)	0.0	(1.5)
Net Revenue Surplus / (Deficit) before Exceptional Items	**0.3**	**0.3**	**0.0**	**(0.0)**	**0.0**	**(10.4)**	**(5.2)**	**(5.2)**	**(0.0)**	**(5.2)**
Exceptional Items	0.0		0.0		0.0	4.8		4.8		4.8
Net Position	**0.3**	**0.3**	**0.0**	**(0.0)**	**0.0**	**(5.6)**	**(5.2)**	**(0.4)**	**(0.0)**	**(0.4)**
PSF and MRET Funding	1.4	1.4	(0.0)	0.0	(0.0)	11.6	11.0	0.6	0.0	0.6
Net Revenue Surplus / (Deficit) Incl PSF, MRET and Exceptional Items	1.7	1.7	0.0	(0.0)	0.0	6.0	5.9	0.1	(0.0)	0.1

Key messages:
Year to date the Trust position before exceptional items is £5.2m adverse to plan , the Trust has benefited by £4.8m of exceptional items relating to release of old year provisions (£3.5m) and QIPP adjustment (£1.3m).

Income:
Income YTD net of pass-through related costs and exceptional items is £4.6m adverse to plan. The main pressures relate to under delivery of Private Patient income (£2.9m) and slippage within Cancer and RTT recovery plan funding (£2.6m).

Expenditure:
Expenditure budgets net of pass-through and exceptional items are £0.1m adverse, the key favourable variances relate to: release of reserves (£3.6m), underspends relating to Cancer recovery plans (£0.7m), and Private Patient activity underperformance (£1.2m). The key pressures within expenditure budgets relate to Medical Staffing (£2.4m), CIP slippage (£2m), Nursing overspend (£0.4m) and drug overspend (£0.8m).

Reserves: 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 received £0.6m bonus PSF relating to 2018/19 which is treated as a technical adjustment and therefore does not contribute to the delivery of the 2019/20 control total.

2.a Income & Expenditure

Income & Expenditure January 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	33.9	33.4	0.5	0.0	0.5	325.1	325.7	(0.6)	0.0	(0.6)	392.3	390.0	2.3
High Cost Drugs and Devices	4.1	3.7	0.4	0.4	0.0	39.5	37.7	1.8	1.9	(0.1)	45.2	45.2	0.0
Total Clinical Income	**38.1**	**37.2**	**0.9**	**0.4**	**0.5**	**364.6**	**363.4**	**1.2**	**1.9**	**(0.7)**	**437.5**	**435.1**	**2.3**
PSF and MRET	1.4	1.4	(0.0)	0.0	(0.0)	11.6	11.0	0.6	0.0	0.6	14.4	13.8	0.6
Other Operating Income	3.9	4.1	(0.2)	0.0	(0.3)	41.6	43.8	(2.2)	(0.3)	(1.9)	50.0	52.1	(2.0)
Total Revenue	**43.3**	**42.7**	**0.7**	**0.4**	**0.2**	**417.8**	**418.3**	**(0.5)**	**1.6**	**(2.1)**	**501.9**	**501.1**	**0.9**
Substantive	(20.5)	(21.5)	1.0	(0.0)	1.1	(200.0)	(211.1)	11.1	0.4	10.7	(241.7)	(254.2)	12.5
Bank	(1.2)	(0.9)	(0.4)	0.0	(0.4)	(12.4)	(8.5)	(3.9)	0.0	(3.9)	(14.7)	(10.2)	(4.5)
Locum	(1.1)	(0.6)	(0.4)	0.0	(0.4)	(9.8)	(7.2)	(2.6)	0.0	(2.6)	(11.7)	(8.4)	(3.3)
Agency	(1.6)	(1.4)	(0.3)	(0.1)	(0.2)	(16.1)	(13.2)	(2.9)	0.2	(3.1)	(18.8)	(15.8)	(3.0)
Pay Reserves	(0.1)	(0.1)	(0.0)	0.0	(0.0)	(0.3)	(1.8)	1.6	0.0	1.6	(0.5)	(2.0)	1.6
Total Pay	**(24.5)**	**(24.5)**	**(0.0)**	**(0.1)**	**0.1**	**(238.6)**	**(241.8)**	**3.2**	**0.6**	**2.6**	**(287.3)**	**(290.6)**	**3.3**
Drugs & Medical Gases	(4.8)	(4.3)	(0.5)	(0.5)	(0.0)	(45.9)	(42.8)	(3.1)	(2.2)	(0.8)	(55.1)	(51.4)	(3.7)
Blood	(0.2)	(0.2)	(0.0)	0.0	(0.0)	(2.0)	(1.9)	(0.1)	0.0	(0.1)	(2.4)	(2.2)	(0.1)
Supplies & Services - Clinical	(2.6)	(2.8)	0.2	0.1	0.1	(28.1)	(28.4)	0.3	0.4	(0.1)	(33.7)	(33.9)	0.3
Supplies & Services - General	(0.5)	(0.5)	(0.0)	0.0	(0.0)	(4.5)	(4.4)	(0.0)	0.0	(0.0)	(5.4)	(5.3)	(0.0)
Services from Other NHS Bodies	(0.5)	(0.5)	0.0	0.2	(0.1)	(6.5)	(6.7)	0.1	0.8	(0.7)	(7.5)	(7.6)	0.0
Purchase of Healthcare from Non-NHS	(1.3)	(0.4)	(0.8)	0.0	(0.8)	(13.1)	(7.7)	(5.4)	(0.1)	(5.3)	(15.7)	(8.6)	(7.2)
Clinical Negligence	(1.5)	(1.5)	(0.0)	0.0	(0.0)	(14.6)	(14.7)	0.0	0.0	0.0	(17.6)	(17.6)	0.0
Establishment	(0.3)	(0.3)	(0.0)	(0.0)	(0.0)	(3.1)	(2.8)	(0.3)	0.0	(0.3)	(3.6)	(3.4)	(0.3)
Premises	(2.3)	(2.4)	0.1	0.0	0.1	(20.9)	(21.5)	0.5	0.1	0.5	(25.6)	(26.1)	0.5
Transport	(0.2)	(0.1)	(0.0)	0.0	(0.0)	(1.3)	(1.3)	(0.0)	(0.0)	0.0	(1.8)	(1.6)	(0.1)
Other Non-Pay Costs	(0.7)	(0.6)	(0.1)	(0.1)	0.1	(7.4)	(6.6)	(0.8)	(1.2)	0.4	(8.5)	(7.5)	(1.0)
Non-Pay Reserves	0.0	(0.4)	0.4	0.0	0.4	0.4	(6.1)	6.5	0.1	6.5	0.4	(7.5)	8.0
Total Non Pay	**(14.7)**	**(14.0)**	**(0.7)**	**(0.3)**	**(0.4)**	**(147.0)**	**(144.8)**	**(2.2)**	**(2.2)**	**0.0**	**(176.4)**	**(172.7)**	**(3.7)**
Total Expenditure	**(39.2)**	**(38.4)**	**(0.8)**	**(0.4)**	**(0.3)**	**(385.6)**	**(386.7)**	**1.1**	**(1.6)**	**2.7**	**(463.7)**	**(463.2)**	**(0.5)**
EBITDA	**4.2**	**4.3**	**(0.1)**	**(0.0)**	**(0.1)**	**32.2**	**31.6**	**0.6**	**(0.0)**	**0.6**	**38.2**	**37.8**	**0.4**
	0.0	*0.0*	*(0.0)*	*%*		*7.7%*	*7.6%*	*-130.1%*	*0.0%*	*-29.8%*	*7.6%*	*7.5%*	*45.8%*
Depreciation	(1.1)	(1.1)	0.0	0.0	0.0	(10.9)	(11.2)	0.3	0.0	0.3	(13.1)	(13.5)	0.4
Interest	(0.1)	(0.1)	0.0	0.0	0.0	(1.2)	(1.3)	0.2	0.0	0.2	(1.4)	(1.6)	0.2
Dividend	(0.1)	(0.1)	0.0	0.0	0	(1.3)	(1.3)	0	0.0	0	(1.6)	(1.6)	0
PFI and Impairments	(1.2)	(1.2)	0.0	0.0	0.0	(12.0)	(12.6)	0.6	0.0	0.6	(15.3)	(15.4)	0.0
Total Finance Costs	**(2.5)**	**(2.6)**	**0.1**	**0.0**	**0.1**	**(25.4)**	**(26.4)**	**1.1**	**0**	**1.1**	**(31.4)**	**(32.0)**	**0.6**
Net Surplus / Deficit (-)	**1.7**	**1.7**	**(0.0)**	**(0.0)**	**(0.0)**	**6.8**	**5.2**	**1.7**	**(0.0)**	**1.7**	**6.9**	**5.8**	**1.0**
Technical Adjustments	0.0	0.0	0.0	0.0	0.0	(0.9)	0.7	(1.5)	0.0	(1.5)	0.0	1.1	(1.0)
Surplus/ Deficit (-) to B/E Duty Incl PSF and MRET	**1.7**	**1.7**	**0.0**	**(0.0)**	**0.0**	**6.0**	**5.9**	**0.1**	**(0.0)**	**0.1**	**6.9**	**6.9**	**(0.0)**
Surplus/ Deficit (-) to B/E Duty Excl PSFand MRET	**0.3**	**0.3**	**0.0**	**(0.0)**	**0.0**	**(5.0)**	**(5.2)**	**0.1**	**(0.0)**	**0.1**	**(7.0)**	**(7.0)**	**(0.0)**

Commentary

The Trust delivered the financial plan for January generating £1.7m surplus including PSF. The Trust was £1.4m better than previously forecasted, £1m related to RTT income support which was previous included in the month 12 position and £0.4m related to an underspends within pay budgets.

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 above plan in January by £0.5m and adverse to plan by £0.6m year to date. The key favourable variances before AIC adjustment are in Non-Electives (£0.4m), and Other income (£2.1m) offset by Day Cases (£0.2m), Adult Critical Care (£0.2m) and Neonatal Critical Care (£0.2m).

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 £0.3m adverse to plan in January. The main pressures in month were Private Patient Unit activity below planned levels (£0.3m).

Pay budgets adjusted for pass-through items underspent by £0.1m in January, Medical staffing pressures (£0.3m) were offset by (£0.3m) underspend within STT staff group. The pressure within Medical staffing is predominantly within the Medical and Emergency division (£0.3m) and Womens and Childrens Division (£0.1m).

Non Pay budgets adjusted for pass through items and release of reserves overspent by £0.8m in January. 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)

		Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Change between Months
Revenue	Clinical Income	32.4	30.6	34.5	35.2	36.4	34.3	37.9	36.3	35.9	38.2	35.2	37.1	38.1	0.9
	STF / PSF	0.0	0.0	12.8	0.9	0.9	1.5	1.0	1.0	1.0	0.5	0.5	2.8	1.4	(1.4)
	High Cost Drugs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Other Operating Income	4.7	4.4	5.3	4.1	4.1	4.6	4.5	3.9	4.1	4.2	4.0	4.4	3.9	(0.5)
	Total Revenue	**37.1**	**35.0**	**52.6**	**40.2**	**41.4**	**40.4**	**43.4**	**41.2**	**41.0**	**42.9**	**39.7**	**44.3**	**43.3**	**(1.0)**
Expenditure	Substantive	(18.8)	(18.7)	(19.9)	(20.1)	(19.5)	(19.3)	(19.7)	(19.9)	(19.6)	(20.2)	(20.4)	(20.8)	(20.5)	0.3
	Bank	(1.2)	(1.3)	(1.4)	(1.3)	(1.1)	(1.1)	(1.2)	(1.3)	(1.2)	(1.2)	(1.3)	(1.3)	(1.2)	0.1
	Locum	(0.9)	(0.7)	(1.1)	(0.8)	(0.9)	(0.9)	(0.9)	(1.0)	(1.1)	(0.8)	(1.2)	(1.1)	(1.1)	0.1
	Agency	(1.9)	(2.1)	(1.4)	(1.6)	(1.7)	(1.5)	(1.9)	(1.8)	(1.8)	(1.7)	(1.1)	(1.5)	(1.6)	(0.1)
	Pay Reserves	(0.1)	(0.2)	(0.2)	(0.3)	(0.3)	(0.3)	(0.3)	0.7	(0.1)	(0.1)	0.6	(0.1)	(0.1)	0.0
	Total Pay	(23.0)	(23.0)	(23.9)	(24.2)	(23.5)	(23.1)	(23.9)	(23.3)	(23.9)	(24.1)	(23.3)	(24.8)	(24.5)	0.4
Non-Pay	Drugs & Medical Gases	(3.9)	(4.5)	(4.5)	(4.6)	(4.6)	(4.2)	(4.7)	(4.5)	(4.4)	(4.8)	(4.7)	(4.6)	(4.8)	(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)	(2.8)	(2.7)	(2.7)	(2.7)	(2.8)	(3.0)	(2.6)	(2.8)	(2.9)	(2.9)	(3.0)	(2.6)	0.4
	Supplies & Services - General	(0.5)	(0.4)	(0.5)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.5)	(0.5)	(0.5)	0.0
	Services from Other NHS Bodies	(0.9)	(0.2)	(3.2)	(1.0)	(0.8)	(0.7)	(0.6)	(0.6)	(0.8)	(0.5)	(0.6)	(0.5)	(0.5)	0.0
	Purchase of Healthcare from Non-NHS	(0.3)	(0.4)	(0.5)	(1.5)	(1.7)	(1.6)	(1.2)	(1.2)	(1.1)	(1.1)	(1.1)	(1.2)	(1.3)	(0.0)
	Clinical Negligence	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.4)	(1.5)	(0.0)
	Establishment	(0.3)	(0.3)	(0.2)	(0.2)	(0.3)	(0.3)	(0.3)	(0.3)	(0.4)	(0.3)	(0.4)	(0.4)	(0.3)	0.1
	Premises	(2.6)	(1.9)	(2.3)	(2.3)	(2.2)	(2.4)	(1.9)	(2.1)	(1.9)	(2.2)	(1.9)	(1.8)	(2.3)	(0.5)
	Transport	(0.2)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.2)	(0.0)
	Other Non-Pay Costs	(1.0)	(1.5)	1.8	(0.5)	(0.5)	(0.7)	(1.2)	(1.0)	(1.0)	(0.7)	(0.6)	(0.6)	(0.7)	(0.0)
	Non-Pay Reserves	0.0	0.0	0.0	(0.5)	(0.4)	(0.4)	0.7	0.1	0.4	0.0	0.5	0.0	0.0	0.0
	Total Non Pay	(14.3)	(13.9)	(14.0)	(15.4)	(15.4)	(15.4)	(14.3)	(14.4)	(14.3)	(14.8)	(13.9)	(14.4)	(14.7)	(0.2)
	Total Expenditure	(37.3)	(36.9)	(38.0)	(39.6)	(38.9)	(38.5)	(38.3)	(37.7)	(38.1)	(38.8)	(37.2)	(39.3)	(39.2)	0.1
EBITDA	EBITDA	(0.1)	(1.9)	14.7	0.5	2.5	1.9	5.1	3.6	2.8	4.1	2.5	5.1	4.2	(0.9)
		0%	*-6%*	*28%*	*1%*	*6%*	*5%*	*12%*	*9%*	*7%*	*9%*	*6%*	*11%*	*10%*	
Other Finance Costs	Depreciation	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.0)	(1.1)	(1.0)	(1.1)	(1.1)	0.0
	Interest	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.0)
	Dividend	(0.1)	(0.1)	0.5	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	0.0
	PFI and Impairments	(1.2)	2.7	7.9	(1.2)	(1.2)	(1.2)	(1.2)	(1.2)	(1.2)	(1.3)	(1.2)	(1.2)	(1.2)	0.0
	Total Other Finance Costs	**(2.5)**	**1.4**	**7.2**	**(2.6)**	**(2.6)**	**(2.5)**	**(2.6)**	**(2.6)**	**(2.4)**	**(2.6)**	**(2.5)**	**(2.5)**	**(2.5)**	**0.0**
Net Surplus / Deficit (-)	Net Surplus / Deficit (-)	(2.6)	(0.5)	21.9	(2.0)	(0.1)	(0.7)	2.5	1.0	0.5	1.4	(0.0)	2.6	1.7	(0.9)
Technical Adjustments	Technical Adjustments	0.0	0.0	(0.2)	0.0	0.0	(0.6)	0.0	0.0	(0.0)	0.1	0.0	(0.5)	0.0	0.6
Surplus/ Deficit (-) to B/E Duty Incl pSF	Surplus/ Deficit (-) to B/E Duty	(2.6)	(0.5)	21.7	(2.0)	(0.1)	(1.3)	2.6	1.0	0.4	1.5	0.0	2.0	1.7	(0.3)
Surplus/ Deficit (-) to B/E Duty Excl STF	Surplus/ Deficit (-) to B/E Duty	(2.6)	(0.5)	8.9	(2.9)	(1.0)	(2.8)	1.5	0.0	(0.6)	1.0	(0.5)	(0.8)	0.3	1.1

3a. Cost Improvement Plan

Savings by Division

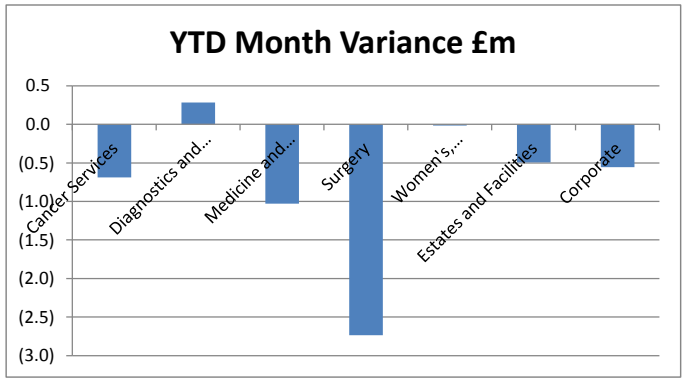
	Current Month			Year to Date			Forecast (Risk Adjusted)				
	Actual	*Original Plan*	*Variance*	*Actual*	*Original Plan*	*Variance*	*Forecast*	*Additional Savings*	*Revised Forecast*	*Original Plan*	*Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Cancer Services	(0.01)	0.12	(0.13)	0.52	1.21	(0.69)	0.56	0.06	0.62	1.45	(0.8)
Diagnostics and Clinical Support	0.41	0.25	0.17	2.90	2.62	0.28	3.30	0.13	3.43	3.11	0.3
Medicine and Emergency Care	0.35	0.50	(0.15)	3.43	4.46	(1.03)	4.13	0.23	4.36	5.46	(1.1)
Surgery	0.40	0.67	(0.27)	4.08	6.82	(2.74)	5.15	0.34	5.49	8.15	(2.7)
Women's, Children's and Sexual Health	0.19	0.21	(0.02)	2.08	2.10	(0.01)	2.46	0.11	2.57	2.56	0.0
Estates and Facilities	0.12	0.14	(0.02)	1.53	2.02	(0.49)	1.80	0.10	1.90	2.30	(0.4)
Corporate	0.09	0.18	(0.09)	1.18	1.73	(0.56)	1.33	0.09	1.42	2.09	(0.7)
Total	**1.56**	**2.06**	**(0.50)**	**15.73**	**20.96**	**(5.24)**	**18.74**	**1.04**	**19.78**	**25.12**	**(5.3)**
Internal Savings Plan stretch	0.22	(0.01)	0.23	2.26	(2.76)	5.02	2.54		2.54	(2.79)	5.3
Total	**1.78**	**2.04**	**(0.26)**	**17.98**	**18.20**	**(0.22)**	**21.29**	**1.04**	**22.33**	**22.33**	**(0.0)**

Savings by Subjective Category

	Current Month			Year to Date			Forecast (Risk Adjusted)				
	Actual	*Original Plan*	*Variance*	*Actual*	*Original Plan*	*Variance*	*Forecast*	*Additional Savings*	*Revised Forecast*	*Original Plan*	*Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Pay	0.67	0.45	0.22	5.85	3.68	2.17	6.73	0.21	6.94	4.58	2.4
Non Pay	(0.20)	0.34	(0.54)	(1.08)	1.83	(2.91)	(1.20)	0.12	(1.08)	2.54	(3.6)
Income	1.31	1.25	0.06	13.22	12.70	0.53	15.75	0.71	16.46	15.20	1.3
Total	**1.78**	**2.04**	**(0.26)**	**17.98**	**18.20**	**(0.22)**	**21.29**	**1.04**	**22.33**	**22.33**	**(0.00)**

Savings by NHSI RAG

	Current Month			Year to Date			Forecast (Risk Adjusted)				
	Actual	*Original Plan*	*Variance*	*Actual*	*Original Plan*	*Variance*	*Forecast*	*Additional Savings*	*Revised Forecast*	*Original Plan*	*Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Green	1.24	1.33	(0.10)	14.09	12.82	1.27	16.27		16.27	14.33	1.9
Amber	0.41	0.22	0.19	3.15	2.12	1.03	3.90		3.90	3.08	0.8
Red	0.13	0.49	(0.36)	0.75	3.26	(2.51)	1.11	1.04	2.15	4.92	(2.8)
Total	**1.78**	**2.04**	**(0.26)**	**17.98**	**18.20**	**(0.22)**	**21.29**	**1.04**	**22.33**	**22.33**	**(0.00)**



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 (£0.2m).

The Trust is £0.2m adverse to plan which is mainly due to over performance within workforce savings (£2.5m) and Best use of Resources (£0.8m) offset by slippage within patient flow (£3.6m).

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

The divisions are currently forecasting to deliver £21.3m savings in 2019/20 which is £3.8m short of the internal stretch target of £25.1m and £1m short of the internal savings target.

4a. Year End Forecast Run Rate £m

Year End Forecast January 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	37.1	38.1	34.5	37.5	436.6	435.1	1.4
PSF and MRET	0.9	0.9	1.5	1.0	1.0	1.0	0.5	0.5	2.8	1.4	0.5	0.5	12.6	13.8	(1.2)
Private Patients	0.1	0.1	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	1.5	5.1	(3.6)
Other Operating Income	4.0	4.0	4.4	4.4	3.8	3.9	4.1	3.9	4.3	3.8	3.6	4.3	48.4	47.0	1.3
Total Revenue	**40.2**	**41.4**	**40.4**	**43.4**	**41.2**	**41.0**	**42.9**	**39.7**	**44.3**	**43.3**	**38.8**	**42.5**	**499.1**	**501.1**	**(2.0)**
Substantive	(20.1)	(19.5)	(19.3)	(19.7)	(19.9)	(19.6)	(20.2)	(20.4)	(20.8)	(20.5)	(20.8)	(20.9)	(241.7)	(254.3)	12.5
Bank	(1.3)	(1.1)	(1.1)	(1.2)	(1.3)	(1.2)	(1.2)	(1.3)	(1.3)	(1.2)	(1.2)	(1.1)	(14.7)	(10.2)	(4.5)
Locum	(0.8)	(0.9)	(0.9)	(0.9)	(1.0)	(1.1)	(0.8)	(1.2)	(1.1)	(1.1)	(0.9)	(0.9)	(11.7)	(8.4)	(3.3)
Agency	(1.6)	(1.7)	(1.5)	(1.9)	(1.8)	(1.8)	(1.7)	(1.1)	(1.5)	(1.6)	(1.4)	(1.3)	(18.8)	(15.8)	(3.0)
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)**	**(24.8)**	**(24.5)**	**(24.4)**	**(24.3)**	**(287.3)**	**(290.6)**	**3.3**
Drugs & Medical Gases	(4.6)	(4.6)	(4.2)	(4.7)	(4.5)	(4.4)	(4.8)	(4.7)	(4.6)	(4.8)	(4.6)	(4.6)	(55.1)	(51.4)	(3.7)
Clinical Supplies	(3.2)	(3.1)	(3.2)	(3.5)	(3.0)	(3.2)	(3.4)	(3.4)	(3.5)	(3.1)	(3.3)	(3.2)	(39.0)	(39.3)	0.3
Purchase of Healthcare from Non-NHS	(1.5)	(1.7)	(1.6)	(1.2)	(1.2)	(1.1)	(1.1)	(1.1)	(1.2)	(1.3)	(1.3)	(1.3)	(15.7)	(8.6)	(7.2)
Other Non-Pay Costs	(5.6)	(5.6)	(5.9)	(5.7)	(5.8)	(5.9)	(5.5)	(5.2)	(5.1)	(5.5)	(5.5)	(5.6)	(67.1)	(65.9)	(1.1)
Non-Pay Reserves	(0.5)	(0.4)	(0.4)	0.7	0.1	0.4	0	0.5	0	0	0	0	0.4	(7.5)	7.9
Total Non Pay	**(15.4)**	**(15.4)**	**(15.4)**	**(14.3)**	**(14.4)**	**(14.3)**	**(14.8)**	**(13.9)**	**(14.4)**	**(14.7)**	**(14.7)**	**(14.8)**	**(176.5)**	**(172.7)**	**(3.8)**
Other Finance Costs	(2.6)	(2.6)	(2.5)	(2.6)	(2.6)	(2.4)	(2.6)	(2.5)	(2.5)	(2.5)	(2.5)	(3.5)	(31.4)	(32.0)	0.6
Technical Adjustments	0.0	0.0	(0.6)	0.0	0.0	(0.0)	0.1	0.0	(0.5)	0.0	(0.0)	0.9	0.0	1.1	(1.1)
Surplus/ Deficit (-) to B/E Duty	**(2.0)**	**(0.1)**	**(1.3)**	**2.6**	**1.0**	**0.4**	**1.5**	**0.0**	**2.0**	**1.7**	**(2.9)**	**0.8**	**3.9**	**6.9**	**(3.0)**
Surplus/ Deficit (-) to B/E Duty Excl PSF	**(2.9)**	**(1.0)**	**(2.2)**	**1.5**	**0.0**	**(0.6)**	**1.0**	**(0.5)**	**(0.8)**	**0.3**	**(3.4)**	**0.3**	**(8.1)**	**(7.0)**	**(1.2)**
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)**
Variance to Plan Excl PSF Pre Mitigations	0.0	0.0	0.0	0.0	0.0	0.0	(0.5)	0.0	0.6	0.0	(1.1)	(0.2)	(1.2)	0	(1.2)
Variance by Quarter			0.0			0.0			0.1			(1.3)			
Total Mitigations / Recovery Actions	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1.2**	**1.2**	**0**	**1.2**
Revised Forecast Including Mitigations	**(2.9)**	**(1.0)**	**(2.2)**	**1.5**	**0.0**	**(0.6)**	**1.0**	**(0.5)**	**(0.8)**	**0.3**	**(3.4)**	**1.5**	**(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	0.6	0.0	(1.1)	1.0			
Variance by Quarter			0.0			0.0			0.1			(0.1)			

5a. Balance Sheet

January 2020

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	January Plan	Variance	December Reported	Full year Plan	Revised FOT
Property, Plant and Equipment (Fixed Assets)	287.5	291.9	(4.4)	287.6	307.6	310.2
Intangibles	2.6	2.9	(0.3)	2.3	2.8	2.8
PFI Lifecycle	0.0	0.0	0.0	0.0	0.0	0.0
Debtors Long Term	1.8	1.4	0.4	1.8	1.4	1.4
Total Non-Current Assets	**291.9**	**296.2**	**(4.3)**	**291.7**	**311.8**	**314.4**
Current Assets	0.0	0.0	0.0	0.0	0.0	0.0
Inventory (Stock)	8.4	7.8	0.6	8.5	7.8	7.8
Receivables (Debtors) - NHS	33.3	27.9	5.4	25.0	24.7	24.7
Receivables (Debtors) - Non-NHS	13.1	11.4	1.7	13.5	9.2	9.2
Cash	17.7	25.2	(7.5)	23.2	3.0	3.0
Assets Held For Sale	0.0	0.0	0.0	0.0	0.0	0.0
Total Current Assets	**72.5**	**72.3**	**0.2**	**70.2**	**44.7**	**44.7**
Current Liabilities						
Payables (Creditors) - NHS	(5.4)	(5.5)	0.1	(5.8)	(5.1)	(5.1)
Payables (Creditors) - Non-NHS	(42.0)	(37.3)	(4.7)	(42.4)	(31.2)	(31.6)
Deferred Income	(14.1)	(6.0)	(8.1)	(12.6)	(2.6)	(2.6)
Capital Loan	(2.3)	(2.2)	(0.1)	(2.3)	(2.2)	(2.2)
Working Capital Loan	(12.3)	(16.9)	4.6	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	(1.6)	(1.5)	(0.1)	(1.5)	(1.5)	(1.5)
Total Current Liabilities	**(83.5)**	**(75.2)**	**(8.3)**	**(70.4)**	**(74.4)**	**(74.8)**
Net Current Assets	(11.0)	(2.9)	(8.1)	(0.2)	(29.7)	(30.1)
non-current liabilities: Borrowings - PFI > 1yr	(182.5)	(183.1)	0.6	(183.0)	(182.2)	(182.2)
Capital Loans	(6.9)	(7.7)	0.8	(6.9)	(6.6)	(5.8)
Working Capital Facility & Revenue loans	(14.1)	(26.1)	12.0	(26.4)	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	**75.1**	**74.1**	**1.0**	**72.9**	**91.0**	**94.0**
Financed By:						
Capital & Reserves						
Public dividend capital	211.8	211.8	0.0	211.8	213.2	216.2
Revaluation reserve	31.8	31.8	0.0	31.8	46.2	46.2
Retained Earnings Reserve	(168.5)	(169.5)	1.0	(170.7)	(168.4)	(168.4)
Total Capital & Reserves	**75.1**	**74.1**	**1.0**	**72.9**	**91.0**	**94.0**

Commentary:
The overall working capital within the month results in a increase in Debtors of £7.1m against plan with an increase in creditors of £4.6m compared to the revised plan submitted in May. The cash balance held at the end of the month is lower than the plan by £7.5m.

Non-Current Assets -
The FOT for 2019/20 capital additions are c£16.5m of which £0.9m relates to donated assets. The YTD spend up to and including January is £5.3m against a plan of £10.6m. 2019/20 is the fifth year in the current five year cyclical valuation period; a full valuation will be undertaken in March 2020 by the Trust's professional valuers Montagu Evans LLP, the FOT value includes an assumption of 5% increase in values.

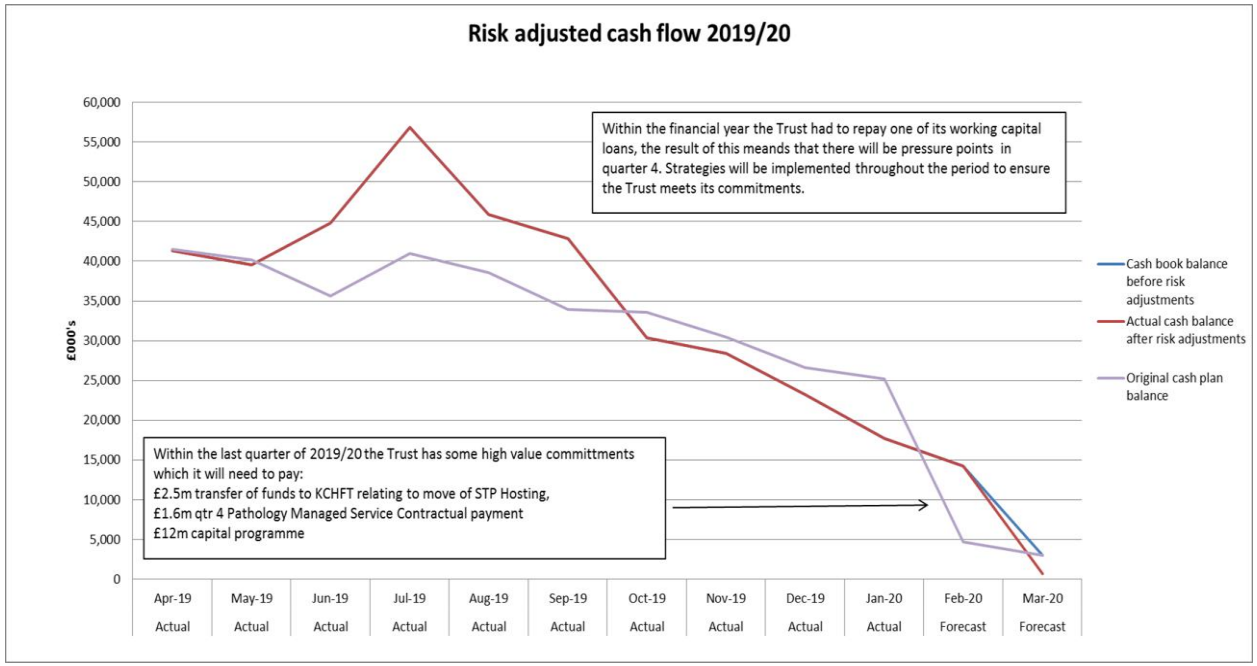
Current Assets -
Inventories of £8.4m is slightly higher that the planned value of £7.8m. The main stock balances are pharmacy £2.9m, TWH theatres £1.4m, Materials Management £1m and Cardiology £1.4m.
NHS Receivables have increased from the December's position by £8.3m to £33.3m. Of the £33.3m reported balance, £12.7m relates to invoiced debt of which £3.5m is aged debt over 90 days. Invoiced debt over 90 days has increased since the December's position of £2.5m. The remaining £20.6m relates to uninvoiced accrued income including quarter 3 PSF of £2.3m 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 has reduced by £0.4m to £13.1m from the reported December position of £13.5m . Included within the £13.1m balance is trade invoiced debt of £2.7m and private patient invoiced debt of £0.7m. Also included within the £13.1m are prepayments and accrued income totalling £7.6m. 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 January 2020 was £17.7m which is slightly lower than cash plan of £25.2m. Primarily th e variance relates to ytd agency spend which is higher by c£3.2m compared to the cash plan and High Weald delayed paying their monthly SLA until February of £2.1m
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 Janu ary 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 0.68% compared to the RBS rate of 0.64%.

Current Liabilities -
NHS payables have decreased from December's reported balance by £0.4m to £5.4m . Non-NHS trade payables have reduced slightly to £42m from £42.4m giving a combined payables balance of £47.4m .

Deferred income of £14.1m primarily is in relation to £4.7m advance contract payment received from WKCCG, and £2.1m from High Weald CCG and £1.9m relating to Maternity Pathway.

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 ene rgy 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 buildi ngs and land assets totalling £14.4m.

5b. | Cash Flow



Information on loans:

	Rate	Value £m's	19/20 Annual Repayment £m's	19/20 Annual Interest Paid £m's	Repayment Date
Revenue loans:					
Interim Revolving Working Capital Facility (IRWCF)	3.50%	12.132	0.00	0.43	19/10/2020
interim working capital loans	3.50%	13.990	0.00	0.49	18/03/2021
Capital loans:					
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

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 £17.7m is lower than the plan of £25.2m. Part of the variance relates to YTD agency spend is higher by c£3.2m compared to the cash plan; additionally High Weald CCG had a delay in approval of their monthly SLA invoice, therefore the Trust didn't receive the income until the start of February.

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 receives income on a monthly basis from CCG's relating to Prime Provider contracts, however the Trust was carrying forward the cash but as at mth 10 the majority of these invoices have been paid.

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 achieved the relevant targets to secure the qtr 3 PSF funding, this is forecast to be received in March. This item is risk adjusted just in case there is a delay in receiving the funds. Quarter 4 PSF will be included within 2020/21 cash flow.

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	3,818	638	3,180	6,588	2,600	-3,988	2,406
ICT	3,350	3,746	-396	4,103	7,292	3,189	6,671
Equipment	2,663	386	2,277	3,163	5,641	2,478	5,323
PFI Lifecycle (IFRIC 12)	419	0	419	594	594	0	594
Donated Assets	300	555	-255	400	900	500	900
Total Including Donated Assets	**10,550**	**5,326**	**5,224**	**14,848**	**17,028**	**2,180**	**15,893**
Less donated assets	-300	-555	255	-400	-900	-500	0
Total Excluding Donated Assets	**10,250**	**4,771**	**5,479**	**14,448**	**16,128**	**1,680**	

Following the recent announcements of new capital funding in 2019/20, the Trust reverted to the plan agreed in May 2019 but updated the use of the £6.4m asset sale resource to be applied to critical equipment and estates backlog schemes that could be delivered in this financial year. The Trust submitted a new business case for the CRL cover for this resource and this has now been approved. The Trust's bid for national EPMA capital funding was approved at a level of £1.25m. The Trust has also received approval in early December from NHSE/I to the allocation of funding from the national Diagnostic Equipment Fund covering two CT scanners, a MRI and Mammography equipment in this financial year (£2.1m) as well as £578k HSLI funding and more recently £427k Cyber Funding.

The overall capital programme FOT is £15.5m (excluding donated and PFI Lifeycle). This includes Internally Generated capital of £4.85m and £6.4m asset sales. The internally generated capital of £4.85m has reduced in year by c.£0.4m as a result of forecast underspend on depreciation resulting from the reduction in the overall programme value (removal of a external financing items) and slippage in the timing of schemes due to the planning issues around the national capital position)

Overall £14.8m is already spent or committed (excluding donated and PFI Lifeycle) e.g. ICT; EPR/EPMA £5.28m, Infrastructure £0.7m, Equipment; £0.9m general equipment, £2.1m CTs x 2, MRI & Mammography, £1.8m equipment from asset sales (includes balance of costs for Diagnostics) and Estates; £2.4m for backlog, Linac enabling and additional schemes from the asset sale.

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

Jan-20		DAY				NIGHT				TEMPORARY STAFFING								Nurse Sensitive Indicators					Financial review		
Hospital Site name	Health Roster Name	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Bank/Agency Usage	Agency as a % of Temporary Staffing	Bank / Agency Demand: RN/M (number of shifts)	Bank / Agency Demand: RN/M (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	104.7%	93.7%	-	100.0%	115.1%	88.7%	-	-	20.9%	49.6%	93	↑	6.39	18	↑	9.4	41.3%	94.7%	6	0	1 fall above threshold. Ward supporting SPNs. RMN requirements throughout the month.	126,934	129,151	(2,217)
MAIDSTONE	Cornwallis (M) - NS959	115.3%	155.0%	-	100.0%	102.0%	96.7%	-	-	20.9%	17.2%	28	↓	1.76	4	→	6.8	18.9%	94.1%	1	1	Increase fill rate to support surgical bed management.	124,053	90,871	33,182
MAIDSTONE	Culpepper Ward (M) - NS551	93.8%	78.6%	-	-	98.4%	100.0%	-	-	17.2%	18.5%	70	↗	4.84	3	↘	7.7	91.7%	97.0%	3	0	1 fall above threshold CCU and 1 fall above threshold Culpepper	113,018	108,302	4,716
MAIDSTONE	John Day Respiratory Ward (M) - NT151	95.7%	110.9%	-	-	100.6%	90.2%	-	-	27.4%	12.4%	72	↓	4.87	10	↘	6.2	40.4%	89.5%	3	2	Increased CSW fill rate to support enhanced care requirements.	132,265	136,194	(3,929)
MAIDSTONE	Intensive Care (M) - NA251	102.2%	87.5%	-	-	93.3%	-	-	-	6.8%	16.3%	40	↓	2.80	3	↗	31.6			0	0	Bed occupancy between 4 and 8. Staffing levels in line with patient dependency.	185,039	181,186	3,853
MAIDSTONE	Pye Oliver (Medical) - NK259	87.9%	112.1%	-	-	104.3%	95.7%	-	-	20.3%	66.2%	86	↓	5.68	8	↓	6.0	15.5%	88.9%	4	1	Reduced fill rate due to sickness during reporting period and ward supporting SPNs.	119,314	110,894	8,420
MAIDSTONE	Chaucer Ward (M) - NS951	111.8%	82.6%	-	-	108.1%	104.8%	-	-	30.2%	13.1%	82	↓	5.08	11	↘	6.7	0.0%	0.0%	10	4	4 falls above threshold. Increased RN fill rate reflective of SPN's induction on ward.	165,185	134,100	31,085
MAIDSTONE	Whatman Ward - NK959	87.4%	95.1%	-	100.0%	175.8%	151.5%	-	-	37.9%	35.8%	128	↑	8.97	15	↗	7.1	55.0%	95.5%	4	1	Increased fill rate at night due to ward escalation throughout the month. Bed occupancy between 19 - 25	92,372	119,323	(26,951)
MAIDSTONE	Lord North Ward (M) - NF651	106.7%	187.1%	-	100.0%	100.0%	113.2%	-	-	14.9%	6.2%	34	→	2.29	7	↘	8.0	89.5%	94.1%	2	0	Increased CSW fill rate to support increased dependency levels on ward and enhanced care.	88,181	104,115	(15,934)
MAIDSTONE	Mercer Ward (M) - NJ251	94.8%	108.8%	-	100.0%	100.0%	108.9%	-	-	23.1%	49.5%	79	↑	5.19	8	↗	6.2	92.3%	100.0%	3	0		119,487	108,913	10,574
MAIDSTONE	Acute Medical Unit (M) - NG551	93.7%	91.0%	-	-	134.4%	183.6%	-	-	39.4%	30.1%	166	↑	11.24	34	↗	8.7	5.6%	90.0%	6	0	2 falls above threshold. Increased fill rate at night due to ongoing escalation. Increase in demand for temporary staff throughout the month.	117,548	139,036	(21,488)
TWH	Ward 22 (TW) - NG332	105.8%	111.0%	-	100.0%	119.8%	103.0%	-	-	28.3%	26.6%	97	↓	6.72	25	↓	6.1	12.5%	100.0%	7	1	Increased fill rate to support enhanced care requirements across 21 days.	129,106	129,582	(476)
TWH	Coronary Care Unit (TW) - NP301	108.6%	120.7%	-	-	97.6%	-	-	-	25.0%	18.6%	57	↗	3.41	7	→	11.0	176.9%	95.7%	3	0	3 falls above threshold. Staff redeployment on occassions to support organisation safe staffing.	69,979	68,155	1,824
TWH	Ward 33 (Gynae) (TW) - ND302	97.2%	107.4%	-	-	100.0%	100.0%	-	-	15.5%	1.9%	47	↑	2.83	2	↓	11.9	17.1%	100.0%	1	0	1 fall above threshold. Increase in temprary staffing demand.	81,469	93,047	(11,578)
TWH	Intensive Care (TW) - NA201	107.7%	99.5%	-	-	103.7%	96.8%	-	-	9.9%	0.0%	65	↑	4.28	6	↘	30.7			0	0	Escalation reported on 11 episodes	206,692	210,071	(3,379)
TWH	Acute Medical Unit (TW) - NA901	91.0%	113.1%	-	100.0%	105.4%	105.3%	-	100.0%	39.9%	51.9%	281	↑	19.73	58	↓	8.4	18.2%	95.8%	10	0	4 falls above threshold. Increased demand in temporary staffing alongside active recruitment to vancacnies has improved fill rate. 58 unfilled shifts reported.	184,662	211,643	(26,981)
TWH	Surgical Assessment Unit (TW) - NE701	102.0%	109.3%	-	-	98.4%	100.0%	-	-	14.3%	0.0%	18	↓	1.18	1	↘	13.9	0.0%	0.0%	0	0	Unit escalation to support organisation capacity demands	61,157	59,427	1,730
TWH	Ward 32 (TW) - NG130	72.3%	78.1%	-	-	97.8%	72.0%	-	-	5.3%	3.7%	23	↓	1.28	2	↘	7.4	0.0%	0.0%	3	0	1 fall above threshold. Since move to ward 32 there is a bed base reduction to 20 beds which is reflected in reduction in fill requirements. Healthroster to be amended to reflect change in plan.	115,442	108,655	6,787
TWH	Ward 10 (TW) - NG131	101.2%	91.1%	-	100.0%	96.0%	120.9%	-	-	No Hours	17.1%	89	↓	5.65	5	↘	6.2	0.0%	0.0%	5	0	3 falls above threshold	119,152	146,236	(27,084)
TWH	Ward 11 (TW) Winter Escalation 2019 - NG144	118.5%	89.8%	-	-	105.4%	109.7%	-	-	78.7%	31.7%	191	↑	12.41	33	↓	5.2	0.0%	0.0%	10	1	6 falls above threshold	0	79,191	(79,191)
TWH	Ward 12 (TW) - NG132	117.0%	118.5%	-	100.0%	124.7%	97.6%	-	-	33.1%	46.0%	133	→	8.79	7	↓	7.4	20.5%	94.4%	4	0	Slight increase in fill rate reflective of skill mix adjustment to support staffing levels.	124,066	151,011	(26,945)
TWH	Ward 20 (TW) - NG230	103.9%	88.4%	-	-	107.5%	118.4%	-	-	23.7%	11.5%	44	↓	2.95	5	↘	5.5	54.2%	76.9%	15	0	8 falls above threshold. RMN requirements across 8 reported days.	112,116	110,129	1,987
MAIDSTONE	Foster Winter Escalation 2019 (M) - NR359	88.7%	79.1%	-	-	154.8%	75.0%	-	-	70.5%	41.8%	188	↑	13.44	18	↓	5.3	0.0%	0.0%	4	0	Increase in temporary demand requirements to support escalation area. 18 unfilled shifts and reported staff moves redeplyed to support levels. Bed occupancy between 21 and 28	148,543	106,322	42,221
TWH	Ward 21 (TW) - NG231	92.7%	104.2%	-	100.0%	110.3%	105.9%	-	-	20.1%	49.8%	112	↓	7.71	38	↗	6.3	32.3%	95.0%	6	3	Increased patient acuity reported with fluctating numbers of level 2 patients throughout the month.	144,590	132,863	11,727
TWH	Ward 2 (TW) - NG442	123.0%	102.9%	-	100.0%	115.5%	119.3%	-	-	26.3%	29.3%	95	↑	5.86	25	↘	7.6	80.7%	91.3%	10	0	3 falls above threshold. Increased fill rate and demand for temporary staff to support staffing requirements for bed occupancy between 26 - 30 due to escalation of AFU through the month.	116,959	130,540	(13,581)
TWH	Ward 30 (TW) - NG330	116.9%	135.8%	-	100.0%	106.7%	109.8%	-	-	41.1%	11.1%	91	↓	5.53	11	↓	7.6	27.4%	95.7%	8	1	3 falls above threshold. Increased fill rate due to enhanced care requirements reported throughout the month.	118,756	149,231	(30,475)
TWH	Ward 31 (TW) - NG331	116.5%	96.9%	-	100.0%	99.2%	102.2%	-	-	27.1%	21.8%	110	↘	6.83	9	↓	6.9	35.2%	100.0%	7	0	1 fall above threshold. Increased fill rate to support skill mix and SPNs transition to ward.	144,652	150,506	(5,854)
Crowborough	Crowborough Birth Centre (CBC) - NP775	90.2%	96.9%	-	-	97.3%	100.0%	-	-	7.2%	0.0%	15	↓	0.93	0	↓					0		67,938	70,284	(2,346)
TWH	Midwifery (multiple rosters)	92.9%	57.2%	-	-	99.1%	71.4%	-	-	13.6%	9.4%	438	↑	24.88	35	↓	26.2	50.9%	96.9%	0	0	Reduced fill rate due to lack of available temporary staff. Delivery suite prioritised to ensure safe staffing levels. 35 unfilled shifts across the midwifery rotas which is imroved in month reporting period.	671,782	703,182	(31,400)
TWH	Hedgehog Ward (TW) - ND702	103.6%	91.0%	-	-	117.5%	-	-	-	41.5%	49.7%	204	↑	13.70	11	↓	10.2	3.0%	88.9%	1	0	1 fall above threshold. RMN requirements report across 22 days. Bed occupancy between 16 - 27.	161,550	203,832	(42,282)
MAIDSTONE	Maidstone Birth Centre - NP751	103.7%	No Hours	-	-	97.3%	92.7%	-	-	15.7%	0.0%	34	↘	1.78	0	↓		0.0%	0.0%	0	0		72,406	73,647	(1,241)
TWH	SCBU (TW) - NA102	77.6%	306.1%	-	-	93.6%	-	-	-	12.8%	0.0%	91	↑	5.15	10	↑	18.9				0	RN fill rate ialigned to bed occupancy between 7 -13 throughout the month. Amber escalation across 2 days and red escalation for 1 day. Increased CSW fill rate as these numbers are inclusive of 84 Nursery Nurses which increase the fill rate of unregistered hours against a plan of 172.5. Roster to be realigned to reflect unregistered demand.	179,171	163,363	15,808
MAIDSTONE	Short Stay Surgery Unit (M) - NE751	92.8%	75.1%	-	-	126.0%	-	-	-	24.4%	25.0%	49	↓	3.35	4	↘	11.1	0.0%	0.0%	0	0	Ward closed for bank holiday and 1 x Sunday only otherwise open including additional weekend lists. Increased fill rate to support additional activity.	43,595	49,668	(6,073)
TWH	Short Stay Surgical Unit (TW) - NE901	164.3%	101.3%	-	-	154.0%	265.0%	-	-	81.9%	24.0%	147	↓	8.94	15	↓	7.8	0.0%	0.0%	2	0	2 falls above threshold. Increased fill rate due to ongoing escalation	162,043	94,990	67,053
MAIDSTONE	Accident & Emergency (M) - NA351	80.2%	121.0%	-	-	98.5%	157.8%	-	-	25.5%	19.9%	197	↘	12.52	36	↓		0.5%	100.0%	2	0	MH - Reduced day fill rate due to vacancies and lack of available temporary staff across 36 shifts. Increased CSW fill rate at night to support department requirements.	195,340	210,939	(15,599)
TWH	Accident & Emergency (TW) - NA301	89.0%	86.1%	-	100.0%	90.8%	91.3%	-	-	36.5%	48.6%	420	↓	29.31	70	↓		3.2%	85.5%	7	0	TWH - 1 fall above threshold. Reduced fill rate due to vacancies and lack of available temporary staff across 70 shifts.	358,568	395,491	(36,923)
MAIDSTONE	Maidstone Orthopaedic Unit (M) - NP951	91.6%	93.7%	-	-	95.3%	-	-	-	46.7%	23.9%	80	↑	5.56	7	↘	15.6	0.0%	0.0%	1	0	1 fall above threshold	43,805	45,857	(2,052)
MAIDSTONE	Peale Ward (M) - NE959	111.7%	120.9%	-	100.0%	100.1%	103.3%	-	100.0%	18.0%	22.2%	50	↑	3.03	8	↗	8.1	23.4%	93.3%	2	0	1 fall above threshold. Bed occupancy between 11 - 13. Increased fill supporting SPNs onto ward.	81,233	76,862	4,371
																						Total Established Wards	5,216,935	5,409,948	(193,013)
																						Additional Capacity beds Cath Labs	40,411	39,221	1,190
																						Whatman	0	-830	830
																						Edith Cavell (M) - NS459	-6,836	-1,762	(5,074)
																						Ward 32 (Wells Suite) (TW) - PP010	-7,699	-1,246	(6,453)
																						Other associated nursing costs	3,353,513	3,153,423	200,090
																							8,596,324	8,598,754	(2,430)

RAG Key

Under fill / Overfill

Green: Greater than 90% but less than 110%

Amber Less than 90% OR greater than 110%

Red Less than 80% OR greater than 130%

RAG Key

↓ Reduction of greater than 5

↑ Increase of greater than 5

→ Remains equal to Or less than a difference of 5

Only complete sites your organisation is accountable for			Day								Night								Day				Night				Care Hours Per Patient Day (CHPPD)			
Ward name	Main 2 Specialties on each ward		Registered Nurses/Midwives		Non-registered Nurses/Midwives (Care Staff)		Registered Nursing Associates		Non-registered Nursing Associates		Registered Nurses/Midwives		Non-registered Nurses/Midwives (Care Staff)		Registered Nursing Associates		Non-registered Nursing Associates		Average fill rate - registered nurses/ midwives (%)	Average fill rate - non-registered nurses/midwives staff (%)	Average fill rate - Registered nursing associates (%)	Average fill rate - trainee nursing associates (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - nursing associates (%)	Average fill rate - trainee nursing associates (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours												
Acute Stroke	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	2,074	2,172	1,392	1,304	0	0	216	216	1,386	1,595	682	605	0	0	0	0	104.7%	93.7%	No data	100.0%	115.1%	88.7%	No data	No data				
Cornwallis	100 - GENERAL SURGERY	101 - UROLOGY	1,234	1,423	662	1,025	0	0	96	96	1,012	1,032	341	330	0	0	0	0	115.3%	155.0%	No data	100.0%	102.0%	96.7%	No data	No data				
Culpepper (incl CCU)	320 - CARDIOLOGY	300 - GENERAL MEDICINE	1,740	1,632	1,488	1,170	0	0	0	0	1,364	1,342	341	341	0	0	0	0	93.8%	78.6%	No data	No data	98.4%	100.0%	No data	No data				
John Day	340 - RESPIRATORY MEDICINE	300 - GENERAL MEDICINE	2,011	1,923	1,498	1,661	0	0	0	0	1,705	1,715	671	605	0	0	0	0	95.7%	110.9%	No data	No data	100.6%	90.2%	No data	No data				
Intensive Treatment Unit (ITU)	192 - CRITICAL CARE MEDICINE		3,253	3,324	171	149	0	0	0	0	2,852	2,661	0	0	0	0	0	0	102.2%	87.5%	No data	No data	93.3%	No data	No data	No data				
Pye Oliver	301 - GASTROENTEROLOGY	300 - GENERAL MEDICINE	1,667	1,465	1,531	1,716	0	0	0	0	1,023	1,067	1,023	979	0	0	0	0	87.9%	112.1%	No data	No data	104.3%	95.7%	No data	No data				
Chaucer	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	2,100	2,348	1,911	1,579	0	0	0	0	1,364	1,474	1,364	1,430	0	0	0	0	111.8%	82.6%	No data	No data	108.1%	104.8%	No data	No data				
Lord North	370 - MEDICAL ONCOLOGY	300 - CLINICAL ONCOLOGY	1,767	1,884	542	1,014	0	0	76	76	1,116	1,116	371	420	0	0	0	0	106.7%	187.1%	No data	100.0%	100.0%	113.2%	No data	No data				
Mercer	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1,660	1,575	1,535	1,669	0	0	36	36	1,023	1,023	682	743	0	0	0	0	94.8%	108.8%	No data	100.0%	100.0%	108.9%	No data	No data				
Edith Cavel	300 - GENERAL MEDICINE		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	No data	No data	No data	No data	No data	No data	No data	No data				
Urgent Medical Ambulatory Unit (UMAU)	180 - ACCIDENT & EMERGENCY	300 - GENERAL MEDICINE	2,667	2,498	1,508	1,373	0	0	0	0	1,023	1,375	342	627	0	0	0	0	93.7%	91.0%	No data	No data	134.4%	183.6%	No data	No data				
Ward 22	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	1,605	1,699	1,501	1,667	0	0	96	96	891	1,067	1,364	1,406	0	0	0	0	105.8%	111.0%	No data	100.0%	119.8%	103.0%	No data	No data				
Cornary Care Unit (CCU)	320 - CARDIOLOGY	300 - GENERAL MEDICINE	1,202	1,306	362	437	0	0	0	0	1,023	998	0	0	0	0	0	0	108.6%	120.7%	No data	No data	97.6%	No data	No data	No data				
Gynaecology/Ward 33	502 - GYNAECOLOGY	100 - GENERAL SURGERY	1,555	1,511	752	807	0	0	0	0	1,023	1,023	341	341	0	0	0	0	97.2%	107.4%	No data	No data	100.0%	100.0%	No data	No data				
Intensive Treatment Unit (ITU)	192 - CRITICAL CARE MEDICINE		3,440	3,706	372	370	0	0	0	0	2,728	2,829	341	330	0	0	0	0	107.7%	99.5%	No data	No data	103.7%	96.8%	No data	No data				
Medical Assessment Unit	180 - ACCIDENT & EMERGENCY	300 - GENERAL MEDICINE	3,337	3,038	1,414	1,599	0	0	160	160	2,139	2,254	1,058	1,115	0	0	12	12	91.0%	113.1%	No data	100.0%	105.4%	105.3%	No data	100.0%				
SAU	180 - ACCIDENT & EMERGENCY	100 - GENERAL SURGERY	1,119	1,142	372	407	0	0	0	0	682	671	341	341	0	0	0	0	102.0%	109.3%	No data	No data	98.4%	100.0%	No data	No data				
Ward 32	300 - GENERAL MEDICINE		2,151	1,556	1,521	1,188	0	0	0	0	1,023	1,001	1,023	737	0	0	0	0	72.3%	78.1%	No data	No data	97.8%	72.0%	No data	No data				
Ward 10	100 - GENERAL SURGERY		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	No data	No data	No data	No data	No data	No data	No data	No data				
Ward 11 (TW) Winter Escalation 2019 - NG144	100 - GENERAL SURGERY		1,134	1,344	1,132	1,017	0	0	0	0	1,023	1,078	1,023	1,122	0	0	0	0	118.5%	89.8%	No data	No data	105.4%	109.7%	No data	No data				
Ward 11 (TW) - NG131	100 - GENERAL SURGERY		2,273	2,301	1,275	1,161	0	0	92	92	1,364	1,309	682	825	0	0	0	0	101.2%	91.1%	No data	100.0%	96.0%	120.9%	No data	No data				
Ward 12	320 - CARDIOLOGY	301 - GASTROENTEROLOGY	2,049	2,398	1,465	1,736	0	0	96	96	1,023	1,276	1,364	1,331	0	0	0	0	117.0%	118.5%	No data	100.0%	124.7%	97.6%	No data	No data				
Ward 20	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	917	952	2,000	1,768	0	0	0	0	1,023	1,100	1,078	1,276	0	0	0	0	103.9%	88.4%	No data	No data	107.5%	118.4%	No data	No data				
Foster Winter Escalation 2019 (M) - NR359			1,661	1,473	1,431	1,131	0	0	0	0	682	1,056	1,012	759	0	0	0	0	88.7%	79.1%	No data	No data	154.8%	75.0%	No data	No data				
Ward 21	340 - RESPIRATORY MEDICINE	302 - ENDOCRINOLOGY	2,280	2,115	938	977	0	0	216	216	1,705	1,881	682	722	0	0	0	0	92.7%	104.2%	No data	100.0%	110.3%	105.9%	No data	No data				
Ward 2	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1,622	1,995	1,760	1,810	0	0	72	72	922	1,065	990	1,181	0	0	0	0	123.0%	102.9%	No data	100.0%	115.5%	119.3%	No data	No data				
Ward 30	110 - TRAUMA & ORTHOPAEDICS		2,056	2,403	1,440	1,955	0	0	54	54	990	1,056	1,353	1,485	0	0	0	0	116.9%	135.8%	No data	100.0%	106.7%	109.8%	No data	No data				
Ward 31	110 - TRAUMA & ORTHOPAEDICS		2,007	2,337	1,544	1,496	0	0	194	194	1,364	1,353	1,023	1,045	0	0	0	0	116.5%	96.9%	No data	100.0%	99.2%	102.2%	No data	No data				
Birth Centre (Crowborough).	501 - OBSTETRICS		803	725	357	346	0	0	0	0	743	723	357	357	0	0	0	0	90.2%	96.9%	No data	No data	97.3%	100.0%	No data	No data				
Midwifery Services (ante/post natal & Delivery Suite)	501 - OBSTETRICS		22,519	20,914	7,558	4,320	0	0	0	0	5,429	5,380	2,602	1,859	0	0	0	0	92.9%	57.2%	No data	No data	99.1%	71.4%	No data	No data				
Hedgehog	420 - PAEDIATRICS		2,907	3,011	315	287	0	0	0	0	2,185	2,567	0	219	0	0	0	0	103.6%	91.0%	No data	No data	117.5%	No data	No data	No data				
Birth Centre	501 - OBSTETRICS		863	896	0	6	0	0	0	0	686	668	333	309	0	0	0	0	103.7%	No data	No data	No data	97.3%	92.7%	No data	No data				
Neonatal Unit	420 - PAEDIATRICS		4,138	3,212	171	524	0	0	0	0	2,400	2,247	0	253	0	0	0	0	77.6%	306.1%	No data	No data	93.6%	No data	No data	No data				
MSSU	100 - GENERAL SURGERY		1,239	1,150	769	578	0	0	0	0	506	638	0	10	0	0	0	0	92.8%	75.1%	No data	No data	126.0%	No data	No data	No data				
Peale	100 - GENERAL SURGERY		1,238	1,383	518	626	0	0	192	192	682	683	330	341	0	0	11	11	111.7%	120.9%	No data	100.0%	100.1%	103.3%	No data	100.0%				
SSSU	100 - GENERAL SURGERY		1,388	2,288	528	535	0	0	0	0	495	762	253	671	0	0	0	0	164.8%	101.3%	No data	No data	154.0%	265.0%	No data	No data				
Whatman	300 - GENERAL MEDICINE		2,106	1,840	1,430	1,359	0	0	92	92	682	1,199	341	517	0	0	0	0	87.4%	95.1%	No data	100.0%	175.8%	151.5%	No data	No data				
MOU			881	807	781	732	0	0	0	0	682	650	0	11	0	0	0	0	91.6%	93.7%	No data	No data	95.3%	No data	No data	No data				

Proposed amendment to objective 6 in the BAF for 2019/20 **Trust Secretary**

The 12 objectives in the Board Assurance Framework (BAF) were approved by the Trust Board on 23/05/19, which included the objective (number 6) to "Establish functioning Digestive Diseases Unit by October 2019".

When the January update of the BAF was reviewed by the Executive Team Meeting on 21/01/20, the title of objective 6 was considered to be too narrow as the objective pertained to the wider reconfiguration of surgical services. It was acknowledged that the title reflected the initial intention and timescale although it was now expected that the Unit would be established by the end of 2019/20.

It was noted that the Trust Board would need to approve any proposed amendment to the title of objective 6, so it was agreed that the Director of Strategy, Planning and Partnerships should propose an alternative title, to be considered by the Trust Board.

At the Executive Team Meeting on 04/02/20 it was then confirmed that the Trust Board should be asked to approve a proposed amendment of the title of objective 6 from "Establish functioning Digestive Diseases Unit by October 2019" to "Implement the planned surgical reconfiguration by the end of 2019/20".

The Trust Board is therefore asked to consider and approve this proposed amendment.

Which Committees have reviewed the information prior to Board submission?

- The Executive Team Meeting, 04/02/20

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

To consider and approve a proposed amendment to the title of BAF objective 6

[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

Stroke Service Update **Chief Operating Officer / Medical Director**

The paper aims to update the Board on the following areas related to the Maidstone and Tunbridge Wells (MTW) stroke service:

1. Judicial and Independent progress

The outcome of the Judicial Reviews was received on 21st February 2020. The judge has just handed down her ruling in the High Court and has ruled in our favour of the JCCCG decision on the configuration of HASU/ASU developments in Kent and Medway on all grounds. There is no news at the time of writing regarding the outcome of the Independent Review.

The Independent Review process does not allow for appeal, however the Judicial Review process does and the STP are aware that there is likely to be an appeal to one or both of the Judicial Reviews. In the meantime the network will continue with the HASU/ASU development programme.

2. Estates Phasing

The estates team have plans drawn up and a contactor ready to start work on the surveys on the MTW stroke development.

The phasing of the work for the development of the new HASU/ASU has been reviewed again by the estates team and there are 2 options for a go live date assuming work can commence in April 2020. The phasing shows that the new go live date would be the beginning of August 2021 if winter capacity could be used for the stroke decant. If this is not possible or there is no other winter escalation plan or capacity available the go live date would move to November 2021.

A work around is possible for HASU/ASU and rehabilitation for a short period over 2 clinical areas which may allow the HASU/ASU to go love earlier than December 2021 however this is dependent on Darent Valley Hospital's go live. This is due to the impact on the change in flows in West Kent to spread the stroke workload appropriately as set out in the DMBC. We await Darent Valley Hospital's confirmation of go live

The STP will request capital to be brought forward to allow MTW and Dartford and Gravesham NHS Trust (Darent Valley Hospital – DVH) to commence estates work early in 2020/21 however the STP does not anticipate any capital being available until well into quarter 1. They have however confirmed that should any Trust commit funding early in 2020/21 to allow estates work to commence this will be reimbursed as part of the programme. The Trust would seek to risk assess any expenditure and would require confirmation of the process for reimbursement form NHSE.

Which Committees have reviewed the information prior to Board submission?

- Exec Team Meeting – 25/02/20

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

1. Note the JR outcome – information
2. Note the IR position
3. Confirm early release of Trust capital/funding in April 2020/21 to enable estates work to commence in April 2020 – discussion/decision
4. Support exploring options for winter capacity to allow the building work to progress over the winter or accept the extended delay to delivery of the HASU/ASU – discussion/decision

[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

Subject: **The Maidstone and Tunbridge Wells Stroke Service Stroke Service**

To: **Trust Board**

From: **Sean Briggs, Chief Operating Officer, Maidstone and Tunbridge Wells NHS Trust**

Date: **27th February 2020**

Purpose: **Stroke HASU/ASU Development Update – Phasing of Estates Programme**

This update includes:

1. Judicial and Independent Reviews Update
2. Estates Phasing

1. Judicial and Independent Reviews Update

The outcome of the Judicial Reviews was announced on 21st February 2020. The JCCCG decision regarding the configuration of the HASU/ASU services in Kent and Medway was challenged on eight grounds. The judge considered but denied permission for a judicial review on six of the grounds. She granted permission for the remaining two. After consideration of the legal arguments on these two she dismissed the claims, which means the network can move forward with the implementation of the three new hyper acute stroke units at Darent Valley Hospital, Maidstone Hospital and William Harvey Hospital. A copy of the judgement is embedded at the end of the document. The outcome of the Secretary of State referral and the subsequent Independent Reconfiguration Panel review is not yet know but the outcome is anticipated in the near future.

The Independent Review process does not allow for appeal, however the Judicial Review process does and the STP are aware that there is likely to be an appeal to one or both of the Judicial Reviews. In the meantime the network will continue with the HASU/ASU development programme.

The outline business case has been submitted to NHSE and the STP is completing the full business case and will request early release of some capital to allow the three identified HASU sites to progress with enabling and estates work. The aim is to submit the full business case in April 2021 with the hope of release of capital in quarter 1 of 2020/21.

The STP has confirmed verbally that should any of the Trusts commit any local capital to commence estates this is not at risk and will be reimbursed as part of the programme. Should the Trust opt to do this then a full risk assessment would be undertaken prior to allocation of local capital and commencement of work including written confirmation of the reimbursement process by NHSE.

2. Estates Phasing and Timeline

It was anticipated that MTW could still meet the April 2021 deadline for delivery however having reviewed this with the estates team the earliest the estates work could be finished is August 2021 (table 1). This assumes:

- The Trust agrees to use £200k of current capital to start the survey and planning process, noting that any capital allocated would be reimbursed by stroke programme. This would go into 2020/21 capital programme.
- The STP is successful in securing early release of capital for Q1 of 2020/21 and this is confirmed.
- The full capital requirement of £6.24m for the HASU/ASU build is phased over the programme as previously set out.
- The Trust is able to manage the winter months in 2020/21 by switching escalation beds from Foster Clark to Edith Cavell. This assumes Edith Cavell is not allocated for other use going forward. If this is not possible other solutions for winter capacity will need to be explored.

If the winter escalation cannot be managed without using Foster Clark and no other decant area can be identified to allow the stroke estates work to continue, the building work will stop over winter and delay the HASU/ASU build completion for a further three months to November 2021 (table 2)

In terms of service delivery the Trust has previously confirmed that a 'work around' to deliver the HASU/ASU and rehabilitation across different clinical areas would be possible for a short period of time to prevent delay to the go live. This is not ideal as it splits the clinical pathway for patients which will be critical to maintain throughput, but is a possibility for a short period and can be explored further as the programme progresses. However this may not have merit as MTW cannot go live with the HASU/ASU until Darent Valley Hospital (DVH) is also ready to do so. This is due to the change in flows required to ensure both HASU/ASUs take the right patients to spread the workload effectively in West Kent. DVH have indicated that the timescale are likely to be challenging due to the confines of site development of their PFI although they have not confirmed their possible start date.

Table 1

Stroke HASU/ASU/Rehab – Estates Timeline (using previously allocated winter capacity for decant over winter 2020/21)

Item	Phase	Weeks	Start date	End date
1	Planning and design work Detailed design work and quantum of costs Design review and mobilisation	10 12 8	April 2020	September 2020
2	Alteration and modification works to vacated AMU	14	September 2020	December 2020
3	Relocation to stroke service from ASU and Chaucer ward to modified AMU and Foster Clark	2	December 2020	December 2020
4	Alteration and modification works to existing ASU and Chaucer ward	24	January 2021	July 2021
5	Relocation of stroke services to newly developed area	4	July 2021	August 2021

Table 2

Stroke HASU/ASU/Rehab – Estates Timeline (stop development in December 2020 to allow for winter escalation)

Item	Phase	Weeks	Start date	End date
1	Planning and design work Detailed design work and quantum of costs Design review and mobilisation	10 12 8	April 2020	September 2020
2	Alteration and modification works to vacated AMU	14	September 2020	December 2020
	PAUSE FOR WINTER ESCALATIONTO FOSTER CLARK			
3	Relocation of stroke service from ASU AND to modified AMU and Foster Clark	2	April 2021	April 2021
4	Alteration and modification works to existing ASU and Chaucer	24	April 2021	October 2021
5	Relocation of stroke services to newly developed area	4	October 2021	November 2021

The Board is asked to:-

1. Note the changes in completion of the estates programme and the impact on potential go live.
2. Confirm the use of capital early in 2020/21 financial year to allow the programme to commence. This is predicated on confirmation of early release of capital and reimbursement of any capital spend earlier than released by NHSE
3. Note the differing go live dates depending on the Trusts review of winter escalation

Neutral Citation Number: [2020] EWHC 372 (Admin)

Case No: CO/1908/2019 & CO/1926/2019

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 21st February 2020

Before :

MRS JUSTICE FARBEY

- -

Between :

THE QUEEN ON APPLICATION OF A	**First Claimant**
-and-	
THE QUEEN ON APPLICATION OF MARION KEPPEL	**Second Claimant**

- and –

(1) SOUTH KENT COASTAL CCG **(2) WEST KENT CCG** **(3) MEDWAY CCG** **(4) BEXLEY CCG** **(5) CANTERBURY COASTAL CCG** **(6) SWALE CCG** **(7) ASHFORD CCG** **(8) DARTFORD GRAVESHAM & SWANLEY CCG** **(9) THANET CCG** **(10) HIGH WEALD LEWES HAVENS CCG**	**Defendants**
(1) KENT COUNTY COUNCIL **(2) MEDWAY COUNCIL**	**Interested Parties**

- -

- -

David Blundell & Hannah Gibbs
(instructed by **Leigh Day**) for the **First Claimant**
Jenni Richards QC & Annabel Lee
(instructed by **Irwin Mitchell LLP**) for the **Second Claimant**
Fenella Morris QC & Benjamin Tankel
(instructed by **Capsticks**) for the **Defendant**
David Lock QC & James Neill
(instructed by **Medway Council**) for the **Second Interested Party**
The first Interested Party did not appear and was not represented

Hearing dates: 3, 4 and 5 December 2019
Written submissions: 30 January 2020

- -

Approved Judgment

Judgment Approved by the court for handing down.

MRS JUSTICE FARBEY :

Introduction

1. This is an application for judicial review of the decision of the defendants taken on 14 February 2019 to de-commission acute stroke services at Queen Elizabeth the Queen Mother Hospital (QEQM) in Thanet, Kent. Following a review of stroke services and a public consultation, the defendants have decided to establish three hyper-acute stroke units (HASUs) in Kent at Darent Valley Hospital, Maidstone Hospital and William Harvey Hospital respectively. The defendants have decided that the stroke unit at QEQM will not become a HASU and so it will close down.

2. The first claimant is a 59-year old man granted anonymity in these proceedings by order of Thornton J dated 31 May 2019. He has lived in Thanet for six years, currently residing in Westgate-on-Sea. He is a committee member of Save our NHS in Kent (SONiK) which has campaigned against the closure of the QEQM stroke unit. He was diagnosed with autism and Generalised Seizure Disorder three years ago. He has been told by doctors that he is at increased risk of stroke owing to a number of health conditions and lifestyle factors (for example, smoking from an early age).

3. The second claimant is a life-long resident of Ramsgate in Thanet. She has complex health needs and is at high risk of suffering a stroke. She regularly attends QEQM for hospital appointments. Her husband was successfully treated at QEQM for stroke in 2016. The claims are supported by SONiK. Ms Carly Jeffrey, a SONiK committee member, has provided a detailed witness statement.

4. The defendants are the Clinical Commissioning Groups (CCGs) responsible for commissioning healthcare services in Kent. In 2017, they formed a Joint Committee of Clinical Commissioning Groups (JCCCG) to consider how best to commission services in order to meet the needs of the people in their area for stroke treatment.

5. The interested parties are local authorities. The first interested party has taken no part in the proceedings. The second interested party - which represents the population in Medway in Kent - supports the claim and, like the claimants, invites the court to quash the decision. Its interest in the proceedings derives from its public health functions and duties under section 2B of the National Health Service Act 2006 which requires it to take such steps as it considers appropriate for improving the health of the people in its area. As a public health authority for an area affected by the defendants' decision, the second interested party was consulted and expressed its views to the defendants on the relevant issues prior to the decision.

6. By order of Sir Wyn Williams sitting as a Judge of the High Court, the claim was listed for a "rolled-up" hearing in order that the application for permission to apply for judicial review and the substantive claim be heard at the same time. I heard oral submissions over the course of three days. Mr David Blundell and Ms Hannah Gibbs appeared on behalf of the first claimant. Ms Jenni Richards QC and Ms Annabel Lee appeared on behalf of the second claimant. Ms Fenella Morris QC and Mr Benjamin Tankel appeared on behalf of the defendants. Mr David Lock QC and Mr James Neill appeared on behalf of the second interested party.

7. Following the hearing, the Court of Appeal handed down judgment in *R (Nettleship) v NHS South Tyneside CCG and anr* [2020] EWCA Civ 46 which touches on similar issues. I received written notes on *Nettleship* on behalf of the claimants and the defendants. No party requested a further oral hearing. I am grateful to counsel for their oral and written submissions.

Factual background

Social deprivation and risk of stroke

8. At the heart of this case are the concerns of the claimants and the second interested party about health inequalities for socially deprived people living in Thanet. I have received competing evidence about social deprivation in Thanet including a detailed witness statement from Dr David Whiting who is employed by the second interested party as a public health consultant. He gives evidence on the distribution of areas of deprivation within Kent and the relationship between deprivation and stroke incidence, challenging the defendants' analysis. Subject to limited exceptions which do not apply here, it is not the function of the court to make findings of fact in judicial review proceedings. In terms of what is relevant and material to the issues of law which I must decide, the following analysis suffices.

9. According to information published by Public Health England, Thanet is one of the 20% most deprived areas in England. The Indices of Deprivation 2015 show that it continued to rank as the most deprived part of Kent. There is a connection between social deprivation and poor health. Life expectancy for both men and women in Thanet is lower than the average in England. There is evidence before me, however, that Thanet is not the only deprived area in Kent. There are other pockets of deprivation in urban, coastal and estuarial areas.

10. In general, people from more deprived areas have an increased risk of stroke. People from the most economically deprived areas of the United Kingdom are around twice as likely to have a stroke and are three times more likely to die from a stroke than those from the least deprived areas. A number of lifestyle factors in deprived communities (such as obesity, physical inactivity and an unhealthy diet) contribute to that increased risk. Priorities in Thanet include reducing early death from a number of causes including stroke.

Access to emergency treatment for stroke

11. Thanet lies on the north-eastern edge of Kent. If the stroke unit at QEQM closes, stroke sufferers who live in Thanet will have to travel further to be treated for stroke. Their families and carers will have to travel further in order to visit them. The claimants and second interested party are concerned that the burden of increased journey times will be borne by a group of people more likely than others to suffer stroke and (save for patients conveyed by ambulance) less able to afford the travel costs.

12. It is not in dispute that stroke patients need timely treatment. The defendants' evidence shows that recovery from a stroke is significantly influenced by:

    i. Seeing a stroke consultant within 24 hours;

ii. Having a brain scan within 1 hour of arriving at a hospital;

iii. Being seen by a stroke-trained nurse and one therapist within 72 hours of admission; and

iv. Being admitted to a dedicated stroke unit.

13. As at April 2017, the Royal College of Physicians assessed that around 80% of people having a stroke in England arrived at hospital by ambulance. National, non-mandatory guidelines from NICE (1 May 2019) recommend the admission of everyone suspected of stroke "directly to a specialist stroke unit" and the administration of emergency thrombolysis (clot-busting treatment for which around 20% of patients are eligible) if "treatment is started as soon as possible within 4.5 hours of onset of stroke symptoms".

14. The Royal College of Physicians National Clinical Guideline for Stroke (2016) contains recommended clot-busting treatment times:

i. Patients with acute ischaemic stroke, regardless of age or stroke severity, in whom thrombolytic treatment can be started within 3 hours of known onset should be considered for such treatment.

ii. Patients with acute ischaemic stroke under the age of 80 years in whom thrombolytic treatment can be started between 3 and 4.5 hours of known onset should be considered for it.

iii. Patients with acute ischaemic stroke over 80 years in whom thrombolytic treatment can be started between 3 and 4.5 hours of known onset should be considered for it on an individual basis. In doing so, treating clinicians should recognise that the benefits of treatment are smaller than if treated earlier, but that the risks of a worse outcome, including death, will on average not be increased.

15. Local written standards in Kent stipulate that the care of people with suspected stroke should aim to minimise time between a call to emergency services and the administration of thrombolysis, for the proportion of patients who need it. This “call to needle” time should be less than 120 minutes. In practical terms, this means:

i. The time from a 999 call to the ambulance service to bringing a patient to the hospital door should be as short as possible and less than 60 minutes; and

ii. The time from arrival at the hospital door to thrombolysis should be as short as possible and less than 60 minutes.

16. The defendants have since at least July 2015 regarded both these 60-minute targets as "key clinical targets". Current standards of best practice indicate that, in cases where clot busting treatment is necessary, it should be administered within 4.5 hours from the onset of a patient's symptoms. The defendants' evidence is that its 120-minute "call to needle" timeframe is "well within the national 4.5 window and therefore optimises the clinical benefits available to patients."

17. Speed of treatment is not the only factor relevant to clinical outcomes in this field of medicine. The defendants' evidence makes plain that there is a connection between recovery from stroke and the kind of stroke service which CCGs provide. The 2016 Clinical Guideline says that thrombolytic treatment should only be administered within a well-organised stroke service with:

    i. Processes throughout the emergency pathway to minimise delays to treatment, to ensure that thrombolysis is administered as soon as possible after stroke onset;

    ii. Staff trained in the delivery of thrombolysis and monitoring for post-thrombolysis complications;

    iii. Specialist nursing staff. A minimum of six thrombolysis-trained staff should be available at any time of day or night;

    iv. Immediate access to imaging and re-imaging;

    v. Protocols in place for the management of post-thrombolysis complications.

18. National guidelines state that patients with a suspected transient ischaemic attack ("TIA"; also known as a mini-stroke) should be given aspirin and assessed urgently by a neurological specialist or at an ASU. I do not need to deal separately with TIA which did not form the subject of discrete submissions before me.

The pre-consultation decision-making process

19. On the current model in Kent and Medway, hospital stroke services are provided by four hospital trusts across six acute hospital sites. The average number of stroke patients treated across the catchment area is 3,010. East Kent Hospitals University NHS Foundation Trust (EKHUFT) provides stroke services in QEQM in Margate and William Harvey Hospital in Ashford.

20. As set out in the witness statement of Mr Glenn Douglas (the relevant Accountable Officer for the defendants and a member of the defendants' Joint Committee of CCGs), the decision to close QEQM's stroke unit has been years in the making. In 2014, the Kent and Medway Sustainability and Transformation Partnership (STP) launched a Stroke Services Review. The impetus for the Review was that poor Sentinel National Audit Programme (SSNAP) scores – indicating poor services- were recorded across all hospital sites in the area. In July 2015, the Review published a Case for Change. That document takes into consideration the National Stroke Strategy 2007 which says that the key to successful outcomes for stroke patients is treatment in a "high quality stroke unit with rapid access to diagnostics, specialist assessment and intervention."

21. The Review recognised the importance of effective primary prevention and rehabilitation but the 2015 Case for Change focused on improving treatment and care in the hyper-acute/acute phase. The aim of the Review was, therefore, to ensure the delivery of clinically sustainable, high quality, hyper-acute/acute stroke services for the next ten to fifteen years, that are accessible to Kent and Medway residents 24 hours a day, seven days a week.

22. The Review was not designed to prioritise the needs of socially deprived groups within Kent. The objective of designing a new service was to take into consideration the needs of all Kent and Medway residents who experience stroke as well as the needs of their families. For reasons that should not require elaboration, the Review proceeded on the basis that patients should be given the best possible chance of survival and the risk of disability should be minimised.

23. The 2015 Case for Change nevertheless considered the "stroke profiles" for the relevant CCGs based on data provided by Public Health England. East Kent (where Thanet is located) had the highest prevalence of risk factors. Stroke prevalence in Thanet was 2.7% compared with the 2.0% national average. Deprivation levels in Thanet were considered.

24. The Kent and Medway Stroke Programme Board was established in January 2015. It comprised NHS commissioners and service providers from across Kent and Medway as well as patient, local authority and Stroke Association representatives. The Programme Board provided an oversight function in relation to the Review. The Board was supported by (among other bodies) a Patient and Public Advisory Group. Public involvement was therefore engrained within the Review. NHS England also played its role in the work of the Review, providing oversight and assurance in relation to the defendants' statutory duties.

25. In November and December 2015, the defendants held three "People's Panels" aimed at patients and members of the public which considered the case for change in detail. The defendants' evidence is that the panels questioned and challenged the emerging proposals for improving future stroke care and voted on different aspects of stroke services, providing their view on what they, as patients and carers, valued most. There is no reason for this court to go behind that evidence.

26. The Review confirmed that the specialist HASU/ASU model based on national guidance was expected to bring a number of benefits to patients in Kent and Medway:

    i. Improved care and outcomes, ensuring that patients will be given the best possible chance of survival and minimising disability from stroke;

    ii. Access to 24-hour, 7-day specialist care, regardless of where in Kent and Medway the patient resides;

    iii. Sustainable stroke services for all residents;

    iv. High performance against national best practice, assisted by a minimum of 500 patients per annum to maintain workforce experience;

    v. A specialist workforce; and

    vi. Consistency of stroke care for Kent and Medway residents regardless of where they live.

27. Following the Review, the defendants started working on a plan to reconfigure stroke services and establish HASUs/ASUs. In March 2016, the defendants ran a "challenge session" with (among others) patient and public representatives to test the work to date

and the emerging options. In September and October 2016, there was a further series of events involving people who had suffered a stroke, their carers, and members of the public.

28. In 2017, "listening events" were held in every CCG area in Kent and Medway. Attendees included Stroke Association representatives, stroke survivors and carers. A further workshop was held in Ashford which was publicised to the wider public. There were a further 15 focus groups. Efforts were made to include those with protected characteristics under the Equality Act 2010 and other "seldom heard" groups.

29. In January 2018, the defendants received a pre-consultation Integrated Impact Assessment (IIA) compiled by independent consultants. This detailed report contained a health impact assessment, a travel and access impact assessment, and an equality impact assessment. The latter assessed the impact of change on groups with protected characteristics under section 149 of the Equality Act and on deprived communities. There is an express reference to the Equality Act 2010. There is no express reference to duties to socially deprived groups who fall outside the 2010 Act but it is plain that the purpose of considering deprived communities was to assist the defendants to meet those duties. The impact on journey times was assessed and was described in a manner that has not been challenged by the claimants or second interested party.

30. The IIA was reviewed by a bespoke Task and Finish Group which focused on the defendants' equality duties and its health inequalities duties. The Group comprised representatives from CCGs, local authorities and patient representatives.

31. In relation to stroke treatment, the defendants published a Pre-Consultation Business Case (PCBC) on 24 January 2018. The PCBC sets out in detail how the defendants developed their proposals for change to stroke services.

32. The PCBC shows that a decision was taken to develop stroke services at existing acute hospitals in Kent and Medway (of which there are seven) rather than to develop new sites. A theoretical long list of 127 options was reached. The next stage was to filter those options to a realistic and manageable medium list for detailed consideration. In order to achieve this, five criteria were deployed which were "hurdle criteria" in the sense that they each had to be surmounted before an option could progress to the medium list. Whether the services would be accessible to patients and carers was one of the hurdle criteria.

33. In relation to the accessibility criterion, the key question was whether the population would be able to access services within a window of 120 minutes from "call to needle." In applying that timeframe, clinicians developed a proxy measure for journey time, namely that 95% of the confirmed stroke population would have door-to-door access to a stroke unit (i.e. from arrival of an ambulance to reaching the unit) within 60 minutes at peak travel times. There is no challenge to the defendants' modelling of travel times.

34. Clinicians recommended that there should be three HASUs as it would not be possible to staff more than three units. An additional fourteen consultants would be needed to staff four or more units, which would be challenging against the background of national shortages in stroke consultants.

35. Application of the hurdle criteria led to a medium list of thirteen options, each containing three hospitals. QEQM featured in seven of the medium list options. A shortlist of five options was then drawn up for public consultation. All the medium list options were considered to be acceptable as having met the hurdle criteria. The evaluation of the remaining options therefore sought to weigh the advantages and disadvantages in accordance with specified evaluation criteria.

36. These evaluation criteria were developed by clinicians but with involvement from patients and the public. Draft criteria were developed and then tested in July and August 2017 with the involvement of: eight focus groups; support groups run by the Stroke Association; an online and paper survey; and a stakeholder event with an open invitation to members of the public. Quality, access and workforce were the top-rated criteria across all these forms of public involvement. Patient choice came last.

37. The finalised criteria were as follows:

    i. Quality of care for all;

    ii. Access to care for all;

    iii. Workforce;

    iv. Ability to deliver; and

    v. Affordability and value for money.

38. All seven of the medium list options which contained QEQM were ranked poorly or very poorly on quality of care. The five options that went forward to public consultation were ranked highest on quality. The claimants emphasise that options including QEQM failed to pass the evaluation criteria because QEQM cannot provide adequate co-dependent services, described in some of the documents as clinically "desirable" rather than as key to the viability of stroke services.

39. In March 2018, the STP published a general Case for Change, not limited to stroke services. It concluded that there was insufficient focus on ill-health prevention across the whole of the Kent and Medway health system. It identified those particular areas with a higher level of deprivation. It noted that higher levels of deprivation were linked to a number of health problems which could be reduced by a greater focus on prevention. It noted that stroke was "by far the worst performing service, failing to meet at least 67% of standards across…Kent and Medway."

Public consultation

40. The defendants' public consultation ran for 11 weeks from 2 February to 13 April 2018. The consultation document ("Improving Urgent Stroke Services in Kent and Medway") stated: "We are consulting on the proposal to establish hyper acute stroke units; whether 3 is the right number; and 5 potential options for their location." It set out the five shortlisted options but also said: "We would welcome your comments on all the options or other options you think we should consider". I shall return to the effect of this broader request for comments and to the details of the public consultation below.

41. The results of the public consultation were collated by an independent research consultancy in a report in summer 2018. SONiK's voice was expressly included in the report. It was noted that SONiK wanted stroke services to stay at QEQM. SONiK is referenced in the report as opposing the current proposals on the grounds that the defendants had failed to identify alternatives; failed to publicise the proposals adequately; failed to consult; and failed to provide adequate information.

42. The report set out residents' concerns over the reality of stated travel times: the key concern was whether the modelled travel times are realistic, in light of the risk of gridlock on the roads, increased traffic during summer months, increases in population, the poor state of roads and road closures. The impact of location on patients' families, who would be forced to travel long distances on hospital visits, was firmly raised.

43. The report sets out how members of the public expressed the view that residents of Thanet would live too far from any of the defendants' proposed options. Written responses to the consultation "centred around the desire for an option closer to Thanet." Many people "did not feel any option is suitable, and expressed a desire for…QEQM…to be reconsidered as one of the options." All options were "perceived to leave East Kent (particularly Thanet) at a disadvantage with little or no choice."

44. The report highlighted that all the proposed options were seen as leaving East Kent at a disadvantage:

> " one of the key areas of concern is that no options under consideration include an East Kent hospital, and in particular that Thanet is a long way from any hospitals under consideration."

45. The report states:

> "Across all strands of the consultation, the desire to maintain services at QEQM and consider the needs of the residents of Thanet has been made clear".

46. Key areas of concern regarding the decision-making process included the omission of QEQM from the shortlist. The report sets out how a significant proportion of people responded to the consultation by saying that Thanet should not have been excluded.

47. The report contains a section entitled: "Need: areas of deprivation and elderly populations will be least well served". It records:

> "Residents are particularly concerned East Kent has no HASU option yet has both higher proportions of elderly residents and some of the most deprived areas in the country - both of which are linked to higher incidences of stroke."

48. In summary, the report makes clear that respondents to the consultation raised questions as to why QEQM had not been prioritised and included in the options, given the levels of deprivation in Thanet and the distance that residents of Thanet would need to travel to any of the hospitals included in the proposed options.

49. The defendants were therefore aware from the public consultation that members of the public wanted a HASU in Thanet. Mr Douglas says in his second witness statement that an informal workshop discussed this issue on 28 June 2018. The workshop comprised members of the JCCCG and representatives from the consulting CCGs. The defendants further discussed the number of HASUs and the question of locating a HASU at QEQM at a formal meeting on 28 August 2018.

Post-consultation decision-making

50. Following the consultation, in September 2018, a further independent IIA was published, taking into account the findings of the public consultation. In support of the IIA, eight interviews were undertaken with "equality leads"; three interviews were undertaken with community groups; and five focus groups were undertaken with groups considered to have a disproportionate need for stroke services. A focus group in Margate covered the Thanet CCG and sought the views of those suffering social deprivation.

51. The defendants reviewed and updated the evaluation criteria and methodology. A "preferred option workshop" was held in September 2018. Attendees included local councils, expert advisors, clinical professionals and observers.

52. Mr Douglas in his witness statement sets out the careful methods adopted at the workshop to ensure evidence-based, robust and non-partisan decision-making. The unanimous view of participants was that "Option B" was the preferred option, i.e. Darent Valley Hospital, Maidstone General Hospital and William Harvey Hospital. Option B was the strongest option across metrics relating to quality, access, workforce, implementation and value for money.

53. On 22 January 2019, the decision-making business case (DMBC) for the review of urgent stroke services in Kent and Medway was published. This detailed and evidence-based document (which took account of groups protected by equality law and those from deprived communities) recommended Option B and concluded;

> "As part of the work to shortlist options, …EKHUFT… concluded that it would not be possible to run two Hyper Acute Stroke Units because it would be very difficult to deliver due to recruitment issues and the risks around staff relocation. Of the sites run by the trust, the William Harvey Hospital was identified as the best option for a hyper acute stroke unit. This was because of the existence of other services that are desirable to have located alongside a hyper acute stroke unit."

54. The claimants therefore emphasise that QEQM fell out of the equation because it cannot provide "desirable" as opposed to clinically necessary services.

The decision under challenge

55. The defendants' decision was taken at a committee meeting on 14 February 2019. The proposals were discussed including the evaluation criteria, increased travel times, workforce concerns, viability of four sites and the implementation process. The

committee agreed that Option B should be implemented. NHS England support the decision.

56. Under the proposed new configuration, the nearest HASU to the first claimant's home will be WHH, approximately 37.5 miles away whereas QEQM is approximately 3.6 miles away. The second claimant will have to travel 36.7 miles to WHH.

Legal framework

57. If a public authority withdraws a benefit previously afforded to the public, it will usually be under an obligation to consult the beneficiaries of that service before withdrawing it: *R (LH) v Shropshire Council* [2014] EWCA Civ 404, [2014] PTSR 1052, para 21.

58. In *R v Brent London Borough Council, Ex parte Gunning* (1985) 84 LGR 168, the court summarised the salient features of a fair consultation:

    i. It must be undertaken at a time when proposals are still at a formative stage;

    ii. The proposer must give sufficient reasons for any proposal to permit of intelligent consideration and response;

    iii. Adequate time must be given for consideration and response; and

    iv. The product of consultation must be conscientiously taken into account in finalising any statutory proposals.

59. In *R (Moseley) v Haringey London Borough Council* [2014] UKSC 56, [2014] 1 WLR 3947, Lord Wilson (at para 25) endorsed the *Gunning* principles. He also advanced (at para 24) two purposes of the duty to consult which he took from the judgment of Lord Reed in *R (Osborn) v Parole Board* [2014] AC 1115, paras 67 and 68:

    i. A fair consultation "is liable to result in better decisions, by ensuring that the decision-maker receives all relevant information and that it is properly tested";

    ii. It avoids "the sense of injustice which the person who is the subject of the decision will otherwise feel".

60. Lord Wilson added (at para 24) that the duty to consult affected members of the public has an important democratic value. In another well-known passage, he held at para 27:

> "Sometimes, particularly when statute does not limit the subject of the requisite consultation to the preferred option, fairness will require that interested persons be consulted not only upon the preferred option but also upon arguable yet discarded alternative options."

61. Even when the subject of the requisite consultation is limited to the preferred option, fairness may nevertheless require "passing reference to be made to arguable yet discarded alternative options" (para 28).

62. Section 3 of the National Health Service Act 2006 sets out duties of CCGs as to the commissioning of health services. It provides in so far as relevant:

> "(1) A clinical commissioning group must arrange for the provision of the following to such extent as it considers necessary to meet the reasonable requirements of the persons for whom it has responsibility –
>
> (a) hospital accommodation,
>
> (b) …
>
> (c) medical, …nursing and ambulance services,
>
> (d) …
>
> (e) such other services or facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as the [CCG] considers are appropriate as part of the health service,
>
> (f) such other services or facilities as are required for the diagnosis and treatment of illness."

63. Section 14R of the same Act lays down a duty on CCGs as to improvement in quality of healthcare services. It provides in so far as relevant:

> "(1) Each clinical commissioning group must exercise its functions with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness.
>
> (2) In discharging its duty under subsection (1), a clinical commissioning group must, in particular, act with a view to securing continuous improvement in the outcomes that are achieved from the provision of the services
>
> …".

This duty is owed to everyone (irrespective of personal characteristics).

64. Section 14T sets down duties as to reducing inequalities between patients in accessing healthcare services and in the outcomes achieved by such services:

> "Each clinical commissioning group must, in the exercise of its functions, have regard to the need to—
>
> (a) reduce inequalities between patients with respect to their ability to access health services, and
>
> (b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services."

65. The duty is to "have regard" to the need to reduce inequalities. In December 2015, NHS England published guidance to assist decision-makers including CCGs in discharging the duty ("Guidance for NHS commissioners on equality and health inequalities legal duties"). It mentions a "move towards greater investment in health and health care where the level of deprivation is higher". CCGs should look at "how the outcome is distributed across society by area of deprivation and by different groups, rather than by focusing on average outcomes for all people". Achieving universal healthcare may require targeting specific population groups and by ensuring that "the quantity and quality of services in deprived areas is adequate."

66. Section 14V deals with the duty on CCGs as to patient choice:

> "Each [CCG] must, in the exercise of its functions, act with a view to enabling patients to make choices with respect to aspects of health services provided to them."

67. Section 14Z2 concerns duties on CCGs to involve and consult the public in planning and developing healthcare services including proposals for change. It provides in so far as relevant:

> "(1) This section applies in relation to any health services which are, or are to be, provided pursuant to arrangements made by a clinical commissioning group in the exercise of its functions ("commissioning arrangements").
>
> (2) The clinical commissioning group must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways)—
>
> (a) in the planning of the commissioning arrangements by the group,
>
> (b) in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and
>
> (c) in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.
>
> …"

68. The duty in section 14Z(2)(b) to involve and consult the public in relation to changes in the provision of health services extends only to proposals for change. There is no duty to consult on options which the CCGs deem to be unviable, unrealistic or unsustainable as they do not represent proposals for change: *Nettleship*, para 56.

69. The public sector equality duty (PSED) is contained in section 149 of the Equality Act 2010 which provides:

> "(1) A public authority must, in the exercise of its functions, have due regard to the need to—
>
> (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
>
> (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
>
> (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.
>
> …
>
> (3) Having due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to—
>
> (a) remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;
>
> (b) take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;
>
> (c) encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.
>
> …"

70. Public bodies must therefore have "due regard" to the factors and considerations set out in section 149. That duty is an integral and important part of the mechanisms for ensuring the fulfilment of anti-discrimination legislation: *R (Bracking) v Secretary of State for Work and Pensions* [2013] EWCA Civ 1345, para 26.

The grounds for judicial review

71. The claimants and the second interested party raised lengthy grounds of challenge. Although not every ground was supported by each of them, it is convenient to set out the grounds compendiously:

> **Ground 1:** The defendants misunderstood or failed to discharge the health inequality duty under section 14T of the Act. The defendants' decision to close the QEQM stroke unit means that the most deprived areas to the east of Kent including Thanet will experience an increase in travel times to hospital by ambulance. Only 81.3% of those

from the most deprived quintile of the population will be able to access stroke services within 45 minutes compared to 92.4% of the general population. Of Thanet's population, 17% will not be able to access a HASU in 60 minutes.

Ground 2: The defendants failed to consider and failed to make sufficient inquiries into whether and how stroke prevention measures could mitigate the effects of the decision to remove stroke services from QEQM. The grounds for judicial review contend that: "Given how critical prevention was deemed to be to the decision, it was irrational for the [defendants] to proceed to [a] final decision without adequately considering and making sufficient inquiry into the matter of prevention".

Ground 3: The defendants "failed to make sufficient inquiry into workforce recruitment issues" when deciding that it was not viable to have a HASU at QEQM.

Ground 4: The defendants failed to discharge their duty as to patient choice under section 14V of the 2006 Act.

Ground 5: The defendants' consultation was unlawful. It breached the common law duty of consultation and/or section 14Z2 of the 2006 Act.

Ground 6: The defendants failed to have due regard to the PSED under section 149 of the Equality Act 2010.

Ground 7: The defendants failed to conduct sufficient inquiry into the impact of increased travel times to the reconfigured hospital services before making the decision, in breach of its duty to inform itself of essential information.

Ground 8: The decision was unlawful as the defendants failed to consider its effect on patient flows from outside the Kent and Medway area and/or it was *Wednesbury* unreasonable to support an option which will support NHS services for patients outside the defendants' area in preference to a configuration which will provide services to patients predominantly within the defendants' own areas.

The interpretation of section 14T(a)

72. In making their submissions on the defendants' duties as to reducing health inequalities, the case presented to me by the claimant and second interested party was essentially that the time needed for patients and their families to reach a hospital (whether by ambulance or otherwise) was the key to access to health services under section 14T(a). They appeared to want to interpret "the ability to access health services" under section 14T(a) as meaning the ability to arrive at a hospital building. At any rate, they did not seem to propose or deploy in their submissions an interpretation of section 14T(a) that went beyond physical access to a hospital.

73. In my judgment, Parliament did not intend such a limited approach. The key point about access to health services is the ability to receive medical treatment for the purpose of avoiding death and (if possible) to make a recovery to good health. I agree with Ms Morris that the "ability to access health services" in section 14T(a) means the ability to take advantage of and benefit from a health service. Shorter journey times may be relevant but they are not determinative of access to health services.

Competing statutory duties

74. As Ms Morris submitted, the particular duties on which the claimants and interested party rely are part of a suite of high level duties under the 2006 Act. The range and scope of these duties may be understood from the exposition of Green J as he was then in *R (Hutchinson) v Secretary of State for Health and Social Care* [2018] EWHC 1698 (Admin), paras 28-45. They include (for example) the duty to exercise functions effectively and economically (section 14A); the duty to promote integrated health services (section 14Z1); and the duty to assist in ensuring the continuous improvement in the quality of primary medical services (section 14S).

75. The 2006 Act therefore imposes a number of different duties relating to a wide range of factors, reflecting the complexity of decision-making in an advanced healthcare system such as the NHS. The defendants' decision was therefore multi-factorial, involving the allocation of limited resources between competing needs. The 2006 Act duties engage socio-economic interests and do not all pull in the same direction. In balancing the competing factors, the 2006 Act clearly involves the exercise of substantial discretion, judgment or assessment (*R (Pharmaceutical Services Negotiating Committee & another) v Secretary of State for Health* [2018] EWCA Civ 1925, [2019] PTSR 885, para 81).

76. Neither the written nor oral submissions on behalf of the claimants or second interested party took this approach on board. Their approach comprised a commentary on selected parts of the documents in order to highlight to the court what was said to be a lack of reference to the particular duties that they wished to emphasise. Ms Morris was able to deal with this approach by making a list of key references to documents in the hearing bundle showing where the defendants dealt with the issues of health inequalities arising from economic deprivation as well as a list of references to the defendants' consideration of travel times.

77. The important point, however, is that the defendants considered health inequalities but did not rate them as a key evaluative criterion in determining the location of HASUs. Parliament intended CCGs to enjoy a broad discretion when choosing how to commission (*Hutchinson*, para 94). In the absence of a public law error, there is no reason for this court to interfere.

The scope of judicial review

78. As Ms Richards emphasised, QEQM was the only hospital in Kent and Medway that was not included in any of the proposed, shortlisted options set out in the consultation paper. Under the defendants' proposals, people who live in Thanet will be unable to attend their local hospital for a serious medical condition. However, judges in judicial review applications are concerned to supervise decision-makers so that they do not step outside the powers which our elected Parliament has given to them. It is an axiom of the law of judicial review that the court does not concern itself with the merits of executive action.

79. The supervisory nature of the court's jurisdiction is an important constitutional principle. It delineates the respective democratic functions of judges and those who are elected, or delegated by Parliament in legislation, to take decisions on behalf of the public. The principle should not be undermined by invitations to the court to cherry-

pick evidence or to interpret the defendants' decision-making documents and the consultation documents like a statute. By going down these routes, the submissions on behalf of the claimants and the second interested party strayed into the merits of the decision.

Professor Rudd's evidence

80. This impermissible approach was particularly marked by the challenge to the evidence of Professor Tony Rudd. He is the National Clinical Director for Stroke with NHS England. He has overseen the Review since its inception. Among other positions, he chairs the Intercollegiate Stroke Working Party at the Royal College of Physicians which has been responsible for developing the National Clinical Guidelines for Stroke and running SSNAP.

81. Professor Rudd has provided a witness statement on behalf of the defendants. He says that the new model of care for stroke services in Kent and Medway is fully supported by NHS England and is in line with stroke services across the rest of the country. He himself has clinically validated the decision under challenge. It will deliver what is established best practice based on national and international evidence.

82. Professor Rudd says that the defendants' decision will enable a full seven-day a week stroke service in Kent and Medway with specialist staff available round the clock. Patients will be admitted directly to the new HASUs rather than waiting in the emergency department before they see a stroke specialist. They will have brain scans and clot busting drugs, where appropriate, within two hours of calling for an ambulance. Evidence from HASU services in Greater Manchester, London and Northumberland demonstrates that patients living in those areas have better stroke services than in Kent. In Northumberland, some patients travel over 60 miles (which takes more than an hour) to reach the only HASU. There has been no increase in deaths since the HASU was established. Patients receive treatment faster and spend fewer days as in-patients before going home.

83. Professor Rudd confirms:

> "The evaluation process identified that three was the optimal number of HASUs for Kent and Medway, based primarily on the number of staff needed to run more than three units, and the numbers of patients each unit would see. These two criteria are critical to the quality of high-power acute stroke care (intensive support and care in the critical 72 hours after a stroke). When units do not have round-the-clock, seven day a week expert teams, patient outcomes are likely to suffer. When units do not see the minimum of 500 confirmed strokes (and ideally at least 600) the staff do not hone their skills and build expertise, and patient outcomes suffer".

84. Dealing with the claimants' case that stroke services ought to be situated at QEQM as an area of high deprivation, Professor Rudd says:

> "There is no evidence to show that the location of hyper acute stroke units improves deprivation or reduces health inequalities…"

85. Dealing with the claimants' case that deprived communities are those with highest need for stroke services, he says:

> "There is no evidence to show that HASUs should be sited in areas of highest incidence or prevalence."

86. Professor Rudd deals with the important factors in deciding the location of stoke services:

> "a. Access: can the population reach the unit within a specified timeframe?
>
> b. Availability of co-dependent and co-adjacent services: does the hospital site have the necessary co-dependent services for a HASU, and how many of the desirable services are also available at the site?
>
> c. Workforce: are the staff available to provide 24/7 care to stroke patients?"

87. The claimants and second interested party made observations and comments about Professor Rudd's statement with a view to undermining it. There was in my judgment no proper, public law reason to go behind what Professor Rudd has said. Others may take a different clinical view or reach a different conclusion on the merits of how the Review was conducted. That is not relevant in the absence of a properly formulated challenge on recognised judicial review grounds.

88. Professor Rudd's clinical opinion was attacked on the grounds that it failed to take into consideration that each minute of travel time to hospital counts in accessing successful treatment for stroke. Mr Lock led the criticism on the basis of a quotation from a journal article cited in the literature review carried out for the defendants as part of their evidence-based approach. The journal article is one among very many sources considered in the literature review and it states that "the odds of treatment decrease by 2.5% for every minute of transfer time." This led to somewhat trenchant submissions that, in achieving good outcomes for stroke patients in Thanet, every minute counts.

89. Ms Morris produced the underlying journal article which showed that the research underpinning the 2.5% statistic related to delays in hospital-to-hospital transfer of stroke patients in or around Chicago in 2010. The 2.5% statistic was plucked out of the wealth of evidence considered by the defendants without regard for context or the facts. It does not engage any point of public law.

90. Similarly, in pressing their case for the shortest possible travel times to hospital, the claimants and second interested party emphasised evidence from the Stroke Association that a person loses an estimated 1.9 million neurons every minute a stroke is untreated. I do not doubt that that statistic has force but, as a judge, I am bound to consider it within the framework of judicial review principles. Professor Rudd deals with travel

times in his witness statement. He says that the model of care under the proposed new HASUs will be that:

> "the 20% or so of patients who need clot busting treatment will receive it within 120 minutes of calling 999".

91. He accepts that he may be wrong about this but goes on to say that it is:

> "important to stress that travel time is just one aspect of stroke care and it is not the critical factor in improving outcomes for patients".

In his view, the most important factor in saving lives and reducing disability is round-the-clock care on fully staffed units. On conventional principles of public law, Professor Rudd's conclusions are unimpeachable.

92. The claimants and second interested party drew my attention to the SSNAP Acute Organisational Audit 2016 which states: "Outcomes are better the earlier thrombolysis is administered." I have no reason to doubt that that is the case – but it is inapt to take this information out of context and to treat it like a part of a statute giving rise to duties on health authorities. What is required is a "fair and straightforward reading of the documents as a whole, in their full context": *R (Pharmaceutical Services Negotiating Committee & another) v Secretary of State for Health* [2018] EWCA Civ 1925, [2019] PTSR 885, para 79.

93. By focusing on travel times and by asking the court to dig deeper into individual pieces of the evidence which they regard as relevant to health outcomes, the submissions on behalf of the claimants and second interested party ignore the wider context. The defendants took a multi-factorial decision which was quality assured both clinically and procedurally. I have not read or heard submissions which raise any public law argument as to why I should enter into the arena and determine a factual issue, or why I should reject Professor Rudd's analysis.

94. The travel time data used by the defendants is taken from a nationally recognised data source called Basemap which allows for congestion, tourist traffic, accidents, bad weather and any other factors that affect journey times. South East Coast Ambulance NHS Foundation Trust compared their actual blue light journey times and found that they were somewhat less than the Basemap times. The defendants therefore have a very high level of confidence that the travel times are adequate. This court has no reason to conclude otherwise. There are no grounds for concluding that the defendants were irrational in their approach to the risk that the 120-minute target may be missed on account of unpredicted journey times.

The grounds of challenge: analysis and conclusions

95. **Ground 1:** Mr Blundell submitted that vague references to health inequalities in the documents before the court were inadequate to discharge the duty to have regard to the need to reduce inequalities in relation to access to services and outcomes (i.e. the two limbs of section 14T). I reject that submission. It is plain from any reasonable reading of the documents that the defendants had in mind inequality arising from social deprivation when formulating and taking their decision. Mr Douglas confirms in his

witness statement that deprivation was considered but discarded as an evaluation criterion as it was not a sufficient differentiating criterion between the options on the medium list. There is no good reason to go behind what Mr Douglas has said and no reason to consider that the defendants did not take into consideration the evidence in relation to impacts on socially deprived communities in Thanet.

96. In my judgment, this part of Mr Blundell's argument amounts upon analysis to a disagreement with the weight given to the impact of travel times on deprived communities. Weight was a matter for the defendants to determine and it does not raise a hard-edged question of law.

97. Mr Blundell submitted that the defendants were wrong to take a "whole population average" approach by which Mr Blundell meant that the defendants focused on average travel times to HASUs across the whole population rather than on travel times in deprived areas such as Thanet.

98. I do not discern any real public law challenge here. In my judgment, the defendants took into consideration all relevant factors including the impact on travel times for deprived communities. Nothing in section 14T obliged them to reach any fixed conclusion. They were not obliged to cite section 14T or quote it in a formulaic manner. They were obliged to perform the obligation which it stipulates: that is what they did.

99. Mr Blundell submitted that the defendants had misunderstood their section 14T duty by relying on the fact that longer travel times for deprived communities will be mitigated by rapid treatment once at the HASU. This submission fails to take on board Professor Rudd's evidence that factors other than travel time lead to improved clinical outcomes and save lives.

100. Mr Blundell criticised the defendants' conclusion that the positive health aspects from the proposed changes, including improved clinical outcomes, are likely to be experienced disproportionately by socially deprived patients because of their higher propensity to require stroke services. He submitted that it would render the purpose of section 14T meaningless if the duties it imposes could be satisfied by making generic improvements to universal services and claiming that socially deprived communities are the beneficiaries as the most frequents service users.

101. In response to this part of Mr Blundell's argument, Ms Morris submitted that, as a matter of logic, health inequality stands to be reduced if all people in Kent have access to improved stroke services. Those from deprived communities use stroke services disproportionately and so they (as opposed to other sections of the community) will be the greater beneficiaries of improvements brought about by the introduction of the new model.

102. I set aside whether this conclusion is, strictly speaking, one of logic. However, in my judgment, it is reasonable for the defendants to take the view that improved stroke services will benefit those from deprived communities in Thanet and elsewhere in Kent to a greater degree than others and so play a part in reducing health inequalities. It is right that other groups will benefit too, such as older people and frail people who may suffer strokes but who may not suffer social deprivation. However, as Ms Morris submitted, nothing about section 14T mandates the defendants to locate stroke services in areas of high deprivation.

103. Mr Lock submitted that the section 14T duty is a legal duty requiring CCGs to give particular focus to the needs of certain patients in preference to others. The duty requires positive action in favour of socially deprived people and against other cohorts of patients. It is a duty of positive discrimination.

104. Both Mr Lock's and Mr Blundell's submissions ringfence one particular aspect of the multi-factorial, broad-brush assessment which the defendants were obliged to undertake. The duty under section 14T is to have regard to the need to reduce health inequalities. As I have mentioned, the terms of section 14T do not mandate a particular outcome. Section 14T does not oust other duties. The defendants in this case had regard to health inequalities. There was no breach of section 14T.

105. For these reasons, while the arguments before me warrant permission to apply for judicial review, the challenge on ground 1 is dismissed.

106. **Ground 2:** Mr Blundell submitted that the defendants failed adequately to consider whether, how and when stroke prevention measures were required in order adequately to mitigate the impact of the closure of the unit at QEQM. The failure to make sufficient inquiries into steps needed to prevent stroke breached the duty of inquiry in *Secretary of State for Education and Science v Tameside Metropolitan Borough Council* [1977] AC 1014.

107. In my judgment, this ground of challenge cannot succeed. The decision under challenge was at no stage contingent on putting in place measures to prevent or reduce the number of people who suffer stroke. The PCBC has a section on prevention but does not link prevention strategies to the proposed reconfiguration. The DMBC described a number of initiatives that may reduce stroke, such as reduction in smoking rates, improvements in diabetes detection and addressing obesity. It stated that staff and organisations in health and social care will need to work together to deliver these initiatives and "embed prevention in all aspects of service delivery." However, the DMBC makes plain that the defendants' focus was on hospital stroke services. It does not say that initiatives to prevent stroke must be developed before the proposals can safely go ahead. Initiatives relating to prevention are (as Ms Morris submitted) part of a parallel but different strategy to reduce stroke in deprived communities.

108. Mr Blundell's skeleton argument sets out a number of disconnected parts of the evidence which discuss ways of mitigating the negative impacts of the defendants' decision. He highlights, for example, that the Senior Responsible Officer for the Review is recorded as having told the Medway Council Health Scrutiny Committee on 12 March 2019 that the defendants had recognised that improvements delivered by HASUs would not address health inequalities and had therefore made a commitment to the development of a prevention Business Case. Those words are taken out of context. In the same paragraph of the minutes of the Scrutiny Committee meeting, the Officer is recorded as saying that the existing stroke units in Medway and Thanet were among the worst rated in the country and that the proposals would result in improved outcomes for patients regardless of where they lived.

109. Mr Blundell asked the court to give weight to a meeting of the JCCCG on 20 December 2018 at which "mitigations and responses" to a projected rise in stroke incidence was discussed, such as maximising bed resource. This has little or nothing to do with the decision under challenge.

110. None of the passages on which Mr Blundell relies – individually or together - raise a question of public law. There is no reason to go behind Professor Rudd's evidence that the review was concerned with the provision of acute stroke services and was not concerned with prevention. Decisions about prevention are a further and different strand of work to improve stroke services. I shall refuse permission to apply for judicial review on this ground.

111. **Ground 3:** Mr Blundell went on to criticise the defendants for relying on confirmation from East Kent Hospitals University NHS Foundation Trust (EKHUFT) that it would be unable to recruit enough staff for two HASUs. He submitted that the defendants had failed in their duty of inquiry to interrogate or investigate the Trust's position in this regard and failed to make adequate inquiries as to why a HASU within QEQM (whether it amounted to a fourth stroke unit or otherwise) could not attract or deploy an adequate skilled workforce.

112. As part of the work to shortlist options, EKHUFT concluded that it would not be possible to run two HASUs owing to recruitment issues. Of the sites run by EKHUFT, it identified that William Harvey Hospital was the better option because it could offer other services that are desirable to have alongside a HASU. Mr Blundell submitted that, even if the defendants were entitled to take into consideration the existence of desirable services at William Harvey Hospital, they were required to make further inquiries in relation to workforce recruitment.

113. This ground does not reflect what actually happened. The defendants carried out detailed workforce modelling of their own which was presented in the DMBC. The methodology for the modelling cannot be impugned on public law grounds and no attempt was made to impugn it. Mr Blundell did not identify any further inquiries which ought to have been carried out.

114. The defendants developed and circulated a questionnaire to individual Trusts about their willingness and ability to deliver the necessary changes to support the service reconfiguration. QEQM completed the questionnaire. There is no reason to go behind either the information provided by QEQM or the information provided by EKHUFT. Nor can the defendants be criticised for consulting EKHUFT whose views were a relevant factor to be considered.

115. Professor Rudd's unchallenged view is that:

> "It would be, in my view, and based on the current availability of specialist stroke workforce, an impossible task to recruit the additional 14 consultants required to safely staff four HASUs in Kent".

In my judgment, the claimants have failed to raise any arguable point of law on workforce issues. I shall refuse permission to apply for judicial review.

116. **Ground 4:** The next ground of challenge is that the defendants failed to discharge their duty to consider patient choice under section 14V of the 2006 Act on the erroneous basis that it was not relevant to a decision about the configuration of acute services. The defendants erroneously conflated the need to consider patient choice when it comes to commissioning services with the different question of whether an individual patient

can establish a legal right to choose a secondary care provider for elective referrals. The defendants "shut their eyes" to the question of patient choice.

117. In his witness statement, Mr Douglas confirms that HASUs are for patients who require urgent treatment following a stroke. Such patients are mostly conveyed by a blue light ambulance to the nearest service. Patient choice does not arise for such urgent cases. The PCBC shows that choice most commonly came last in the ranking of evaluation criteria by stakeholders and the public before the public consultation. In my judgment, the defendants were not under any legal duty to consult further or give any further consideration to patient choice in these circumstances. I refuse permission to apply for judicial review on this ground.

118. **Ground 5:** Ms Richards took the lead in making oral submissions on ground 5 which concerns the fairness of the consultation process. I shall grant permission to apply for judicial review on this ground.

119. Ms Richards emphasised that all options put forward for public consultation involved the closure of stroke services at QEQM which is the only hospital in Kent and Medway currently providing stroke services which was not included in any of the potential options for a HASU. There was, in consequence, no effective public consultation as to the future of stroke services at QEQM. It followed that the defendants' public consultation breached the statutory duty of public involvement and consultation in section 14Z2 of the 2006 Act and breached the common law duty to consult.

120. Ms Richards submitted that the defendants were under a statutory duty to involve the public and a common law duty to consult specifically on QEQM because there is a well-established stroke service there. QEQM passed the hurdle criteria and was part of a clinically viable set of options. The closure of the stroke unit would deprive the residents of Thanet of a stroke service. A local stroke service is significant and important to a deprived community such as Thanet. Consultation about QEQM would have led to better decision-making and would have respected the democratic principle outlined in *Moseley*.

121. Ms Richards submitted that the evaluation criteria (which is where options containing QEQM failed) did not have clear-cut answers and so the views of consultees should have been sought. There is no evidence that consultation on QEQM would have been unduly onerous. The failure to consult on QEQM has given rise to a feeling of injustice as the various witness statements from Thanet stroke campaigners have explained. Consultation specifically on QEQM could have made a real difference because it would have led to better public information about options containing QEQM which would in turn have led to more effective public scrutiny. This case can be distinguished from *Nettleship* because options containing QEQM were realistic and viable (having surmounted the hurdle criteria).

122. The defendants had a statutory duty in section 14Z2 to involve and consult the public on proposals for change. I am in no doubt that they met their duty. The defendants built public involvement into their decision-making process There was significant public involvement across the various stages by which they reached the new three-HASU model.

123. Having involved the public in the development of evaluation criteria, the application of those criteria produced a short list of proposals for change. Those criteria were rational and were applied rationally. The options put to the public in the formal public consultation were the proposals for change within the meaning of section 14Z2. In my judgment, the effect of *Nettleship* is that a decision-maker need only consult on proposals for change: it does not need to consult on arguable yet discarded options. Passing reference will suffice.

124. Ms Richards submitted that *Nettleship* stands for the proposition that all "realistic and viable options" should have been the subject of full public consultation (see *Nettleship* para 60). On the facts of this case, I am not persuaded that the lack of clinically desirable services at QEQM could make a stroke service "realistic and viable". The evidence shows that many key services for stroke patients are not available at the QEQM site. The DMBC makes clear that options which included William Harvey Hospital (the other EKHUFT site) were evaluated more highly because it has all major emergency services and the location of a HASU there would be consistent with it becoming a major emergency centre. It is not the function of this court to assess the clinical pros and cons of the evaluation criteria which ruled out QEQM or to criticise the evaluation criteria for giving weight to the existence of co-adjacent services. I do not understand the court in *Nettleship* to mean that every clinically viable option must be the subject of public consultation – even those which are inferior in some important respect. It seems to me that such a wide approach was expressly disavowed (see para 59).

125. There was in any event more than passing reference to QEQM in the consultation document. I have been provided with the questionnaire that accompanied the consultation paper. It is plain from the questionnaire that the defendants did not exclude the public from expressing their views not only about the proposed options but also about any other option. The questionnaire expressly asked for views on (among other things) the potential advantages or disadvantages of the proposed changes; any other criteria that the defendants should consider in their decision-making; any other ways as to how and where specialist urgent stroke services should be located; anything else that should be taken into consideration; any other comments in relation to the proposals; and any comments on the way that the consultation had been run.

126. It is not in dispute that, during the consultation period, 701 telephone interviews took place; 2,240 online surveys were completed; 334 paper surveys were returned. Listening events took place in 28 locations across Kent and Medway including Thanet. Those events generally consisted of an unstructured question and answer session in plenary followed by group table discussions on various issues including other options falling outside those discussed in the consultation paper. Members of the consultation team took questions and comments at a further five meetings of local groups.

127. Engage Kent were commissioned to hold sessions with community groups who experience barriers to accessing services or who are under-represented in healthcare decision-making. The target groups were BAME communities, people whose liberty is restricted, homeless people and those less likely to participate in civic activities as a result of health, substance misuse or older age. An additional 171 people took part in these events.

128. Engage Kent undertook other "public focussed conversations" with 94 residents selected by the weighting of relevant factors that could increase the risk of stroke. Rural communities were targeted for street surveys (116 in total). A random sample of 61 shoppers in Margate was surveyed over a two-hour period on one day.

129. Emails and letters were sent to the consultation team from individuals and others. The defendants' Facebook presence reached 169,496 people and its Twitter presence reached over 200,000 people. Comments made by the public on Facebook and Twitter were considered and reviewed by theme.

130. SONiK responded to the consultation in detail. Its objections to the proposals were (among other things) that they would not improve stroke services, would endanger the lives of those who would lose services in a local hospital, and had been formulated without adequately considering alternatives or consulting the public. It accused the defendants of having already closed their minds to alternatives and criticised the decision not to locate a HASU at QEQM. The SONiK response dealt with the list of desirable co-adjacent services, asserting that they had been "used to simply eliminate hospitals".

131. It is therefore plain that those who wanted to respond to the consultation were able to do so and to give their views about QEQM. That is what residents of Thanet did. The preference of many residents for a stroke service in Thanet was a key theme to emerge from the consultation and decision-makers responded by giving it further consideration. In my judgment, the consultation was fair and adequate.

132. I also accept Ms Morris' submission that residents of Thanet are not losing a service in the sense that they will forever be deprived of stroke treatment. Their service will continue albeit in a different place. In the context of access to NHS services for life-threatening illness, I do not accept that the physical relocation of a service which would thereby stand to be enhanced amounts to the withdrawal of a benefit requiring fuller consultation process than happened here.

133. I need to deal specifically with the claimants' sense of injustice which has formed one of the foundations of their claim for judicial review. It should not be belittled. Nevertheless, it seems to me that the purpose of section 14Z2 is to promote and ensure the democratic imprimatur of a key public service – upon which the court touched in *Moseley*. By the time of the publication of the PCBC, the following groups had been involved in the development of proposals for change: the public; patients; service users; carers; voluntary organisations; community groups; and volunteers working at affected organisations. The court was not provided with any concrete submissions as to who else ought to have been involved.

134. Public involvement was not haphazard but was an inherent aspect of the processes deployed by the defendants for effecting change. A "communications and engagement lead" had been appointed for the Review. An independent review by Healthwatch Kent had scrutinised pre-consultation engagement and concluded that the public had been involved in shaping and developing the case for change. Healthwatch Kent deemed the two-year period of patient and public involvement to meet standards of good practice. The PCBC itself made plain that local health services should be created in partnership with citizens and communities.

135. The PCBC also made plain that the focus of public engagement should be on equality and narrowing inequalities. While there are no references to sections of statutes, it is plain that the PCBC had in mind the PSED and the section 14T duty.

136. The PCBC set "objectives for engagement" with stakeholders including:

> "To ensure the patient, staff and stakeholder voice is represented by engaging identified audiences in the design and implementation of the plans and proposals at each stage".

The purpose of such public involvement was to:

> "Help meet statutory duties and best practice guidance".

137. The defendants adopted a number of principles that would underpin the public consultation. Those principles included:

> "We will cover the geography, demography and diversity of Kent and Medway and our boundary populations, including the working population, silent majority, seldom heard, people who are mostly well, and people who aren't, and those with protected characteristics, to gather a fair representation of views and feedback."

138. The defendants took into consideration that the IIA had highlighted groups which may have a disproportionate need for stroke services including deprived communities. The defendants were not only concerned to engage those groups in the consultation exercise but to target the views of those with protected characteristics and those in deprived communities:

> "**We also made a commitment to ensuring we targeted**…the needs of seldom heard groups and others with special requirements. These groups include, for Kent and Medway and in our neighbouring CCG areas, for example: the young, the working well, **those in deprived communities**, those in more rural communities, …. We also **committed to seeking views** on the proposals from those representing **the nine protected characteristics**: age, disability, gender reassignment, marriage and civil partnership, pregnancy race, religion and belief, sex and sexual orientation" (emphasis added).

139. Statutory duties (such as the PSED or the section 14T duty) mean that it is lawful for some voices (such as those with protected characteristics or those from deprived communities) to be specifically sought or targeted in the process of public involvement and consultation – which is what happened here. I accept Ms Morris' submission that, once that is done, the sense of injustice felt by particular claimants or particular interest groups will need to be viewed in the context of the more general democratic process which the 2006 Act promotes. It will be harder for individuals to argue that their own particular sense of injustice should prevail when the wider democratic exercise has been performed.

140. I have considered a number of other arguments relating to the consultation which were raised by Mr Blundell and/or by Ms Richards. They are not arguable. The public consultation provided a "fair opportunity for those to whom the consultation was directed adequately to address the question in issue": *R (Keep the Horton General) v Oxfordshire CCG and others* [2019] EWCA Civ 646, para 66. For these reasons, this ground does not succeed and is dismissed.

141. **Grounds 6 and 7:** These grounds were advanced by the second claimant and may be taken together. As originally pleaded in the Claim, the point of Ground 6 seems to have been that the IIAs made no reference to the section 149 duty and that there was no evidence that the defendants had due regard to the duty in form or substance. Put in these broad and unqualified terms, that submission goes nowhere.

142. Ms Richards did not seek to advance Ground 6 as pleaded. Nor did she seek to advance Ground 7 (which concerns the defendants' failure to make proper inquiries into increased travel times) as a discrete ground of challenge. Instead, she narrowed the focus of her submissions in order to concentrate specifically on increased travel times for patients, their families and carers. She submitted that the defendants had (a) failed to discharge the PSED and (b) failed to conduct sufficient inquiry into the increased travel times that these groups would face if the unit at QEQM closes.

143. Ms Richards submitted that the defendants had breached the PSED because they failed to have due regard to eliminate discrimination in relation to two characteristics protected by section 149(7), namely age and disability. A third factor – race – was advanced in Ms Richards' skeleton argument but not pursued orally.

144. Ms Richards submitted that the PSED applied to the decision as to where to locate HASUs. The September 2018 IIA had identified a number of negative impacts in relation to longer journey times. The increased stress and anxiety of making an unfamiliar journey to a hospital as well as increased travel costs are likely to affect older and disabled people disproportionately. Older and disabled patients are more likely to be affected by barriers to travel as they are more reliant on family and carers who may be inhibited from travelling if the journey is longer and more costly.

145. Ms Richards submitted that the minutes of the 14 February 2019 meeting, at which the defendants' decision was taken, make no reference in form or substance to the section 149 duty. She was however bound to accept that the DMBC was before the defendants at the February meeting and that it contained a section on equalities implications based on the IIAs. However, as I understood her submission, she challenged the IIAs as failing to refer to the statutory objectives of section 149 and as failing to consider the retention of stroke services in QEQM.

146. The short answer to Ms Richards' submissions is that they fail to acknowledge the breadth of the evidence that founded the defendants' decision. There can be no suggestion that those attending the 14 February meeting were inadequately briefed about the extensive procedures and evidence-gathering that led to the preferred option.

147. The defendants carried out two, full IIAs which dealt expressly and in a focused way with the impact of the recommended options upon those with protected characteristics. They addressed in substance the key questions required by section 149. The IIA dealt in detail with the negative impacts of the defendants' proposals on groups with protected

characteristics under equality law. The DMBC, which was supplied to attendees of the February 2019 meeting, cited the negative impacts, as set out in the IIA, so that decision-makers had evidence of equality impacts before them. The PSED was not breached.

148. Ms Richard further submitted that the PSED required a comparative IIA for every option on the medium list before it could progress to the short list. As Ms Morris emphasised, there is no authority for that proposition and it would not, in the circumstances of this case, provide an answer that would be material to the location of HASUs.

149. Ms Richards submitted that the Travel Advisory Group (which has been established and which will consider how to mitigate longer travel times for friends, family and carers) amounted to post-decision mitigation whereas some form of other or further inquiry ought to have been carried out prior to the decision. No concrete suggestion for further inquiry was advanced and no challenge was raised to the defendants' conclusions about travel times.

150. In reaching their decision, the defendants considered evidence about peak hour driving times for the public (which would include family, friends and carers of stroke patient) across all thirteen of the medium list options. In short, the maximum times both in the seven options that included QEQM and in options that did not include QEQM was 67 minutes. Given that travel times over 60 minutes would apply to less than 1% of the population, the defendants concluded that maximum travel times would not differentiate between options. It is not irrational or otherwise unlawful for the defendants not to rely on a non-differentiating factor when selecting options for the short list. In any event, the documents before the defendants at the time of their decision conclude that travel difficulties for visitors and carers would be outweighed by better clinical outcomes for patients. The defendants were entitled as a matter of law to adopt a model for stroke services that prioritised clinical outcomes.

151. The defendants have taken into consideration (for example in the PCBC) that access to public transport is "extremely important" for friends, relatives and carers. The Transport Advisory Group is designed to tackle increased journey times. There was no duty on the defendants to await its conclusions before taking a decision. Given the defendants' compliance with the PSED and the ample evidence demonstrating that the defendants took journey times into consideration, I do not see what this ground adds to the claim.

152. Grounds 6 and 7 raise no arguable error of law. Permission to apply for judicial review is refused.

153. **Ground 8:** This ground was advanced by the second interested party but Mr Lock did not pursue it in his skeleton argument or orally. I shall refuse permission to apply for judicial review.

Summary

154. In summary, permission to apply for judicial review is granted on grounds 1 and 5 but refused on other grounds. The claim is however dismissed.

NHS Maidstone and Tunbridge Wells NHS Trust

Update on Winter Plan **Chief Operating Officer**

The enclosed report provides an update on the Trust's Winter Plan that was approved at Trust Board in September 2019. This report is submitted in line with the recommendations from the Internal Audit carried out in Summer 2019 on Winter Pressures 18/19, which stated progress against delivery of the Winter Resilience Plan should be reported to the Trust Board during the winter period.

The report covers the winter period up to and including week ending 9th February 2020.

Which Committees have reviewed the information prior to Board submission?

- None

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

1.0 Introduction

The Winter Plan for 19/20 was presented at Trust Board in September 2019. This paper provides an updated position against the Winter Plan.

In summary, winter pressures started earlier than predicted, necessitating the need for additional beds to be opened sooner than planned. December's attendance in ED was 1.2% above model and was the 2nd highest monthly attendance ever recorded. The annualised growth (last 52 weeks compared to preceding 52 weeks) for December was 10.72%, the highest annualised growth seen in the 15 years of monitoring. Emergency Department (ED) performance achieved 85.07% against a target of 87.99%. This was the Trust's worst performance for three years however the Trust remained in the Top 20 nationally during this period.

January saw an improvement in flow across both sites. The higher than planned level of escalation (some unfunded) across both sites continued but did support achievement of 91.13% for the monthly performance. This put the Trust in 5th place nationally for the ED access standard in January.

There has been no adverse weather this winter so far and cases of Flu and Norovirus have been limited to date. Coronavirus testing has put some challenge into the system over the past 3 weeks and is expected to continue to have an impact although it is difficult to predict the significance at the current time. Additional staff have been required to support the Assessment Pod model on both sites and this is under regular review.

The predicted activity contained within the Winter Plan has been revised to include actual activity up until the end of January and predicted for February, which is detailed in the bullet points below each paragraph.

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

- **Winter of 19/20 now expected to be 8.0% busier than 2018/19 (Dec, Jan & Feb)**
- **Upper and lower confidence limits now 7.2% and 8.8%**
- **Annual ED growth now at 9.15%**

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

- **This winter has averaged 890 per week (01-Dec-19 to 10-Feb-20), and peaked at 919 per week. This represents 27.7% of arrivals, and a 9.9% increase on the equivalent period last year. So far, we have avoided any cold snaps, which tend to send more elderly patients in with neck of femur fractures and respiratory illnesses.**

Emergency admissions: We have a model based on historical data, but over the past 2 years, emergency admissions have been driven more by increased use of Clinical Decision Units and Same Day Emergency Care (SDEC) pathways, which are driving an increase in zero Length of Stay (LOS) admissions.

- **Non-zero admissions up 3.1% so far this winter**
- **Zero LOS admissions up 9.6% so far this winter**

Non-elective LoS (excluding zero): Historically, there is a tendency for the average, non-zero LoS to increase by 0.5-1.0 days in the depths of winter. For 19/20 a reduction of 0.5 day LOS was required and for this to be maintained through winter as a key component in managing patient flow and bed capacity. NE LoS has come down from a peak of just over 8.0 days in early 2017 to an average of 6.7 days in 2019/20 Q2. We would expect the winter to average around 7.0 to 7.2 days (probably peaking higher in Jan), compared to 7.0 over last winter.

- **Average LOS so far this winter is 6.8 days which is 0.2 to 0.4 days less than modelled**

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

- **January DToC 5.0% which equates to 1083 lost bed days (513 Maidstone and 570 Tunbridge Wells)**

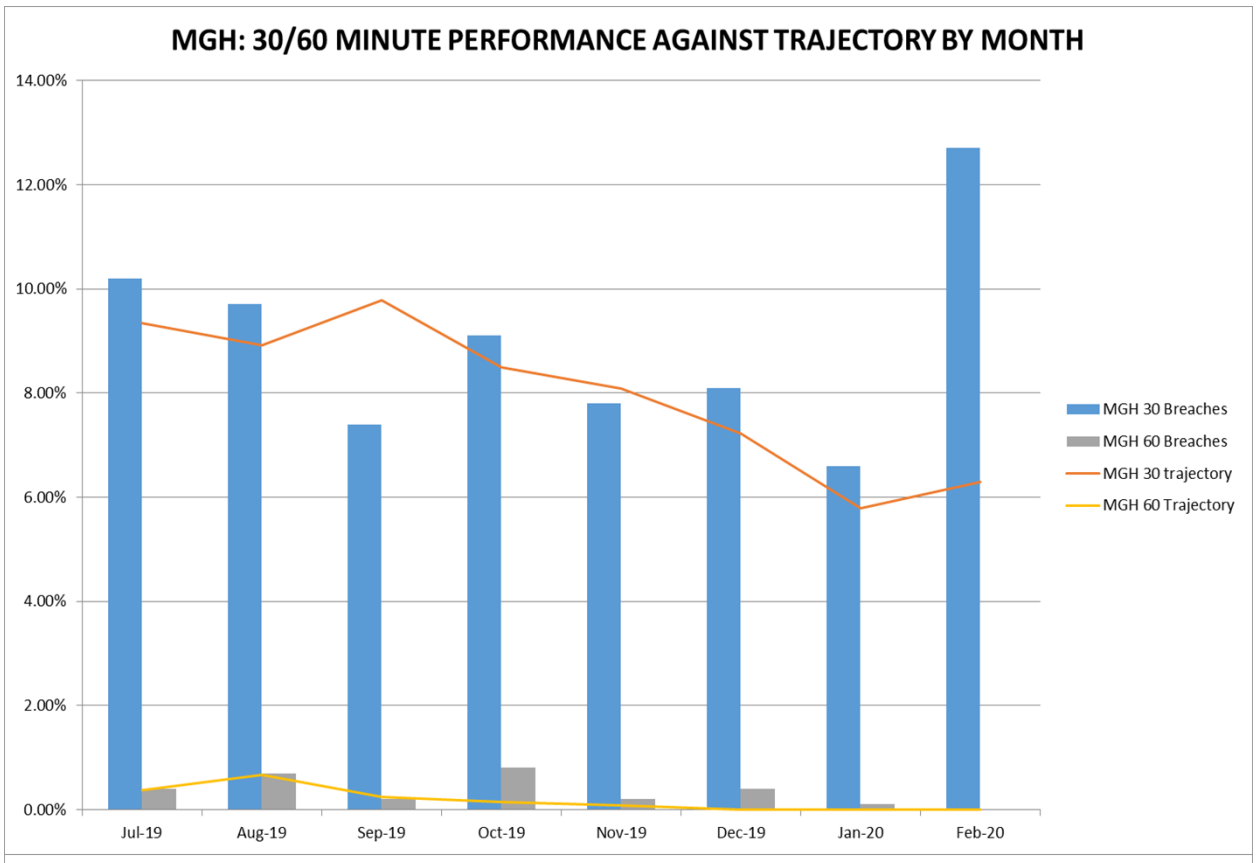
Elective activity: Elective work has not been adversely impacted on by non-elective escalation.

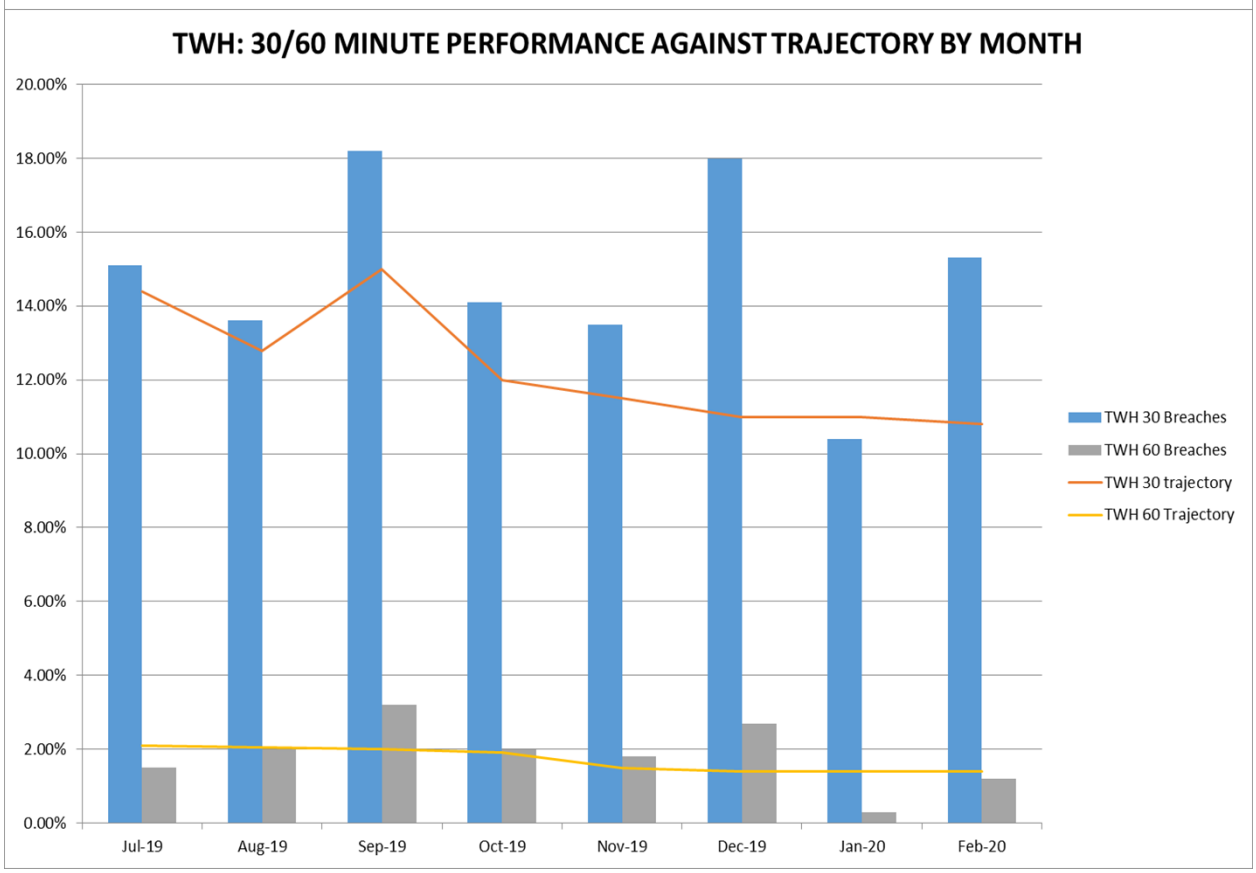
- **January saw an increase of 400 operations carried out compared with January 2019**

Hospital @ Home: This service has not reached the planned occupancy levels despite the change in model (discharge into community care). This is due to a lack of referrals from MTW but also workforce gaps within KCHFT which, at times, has led to a number of referrals being declined on the day.

Winter Huddle: Continues at 08.30 each morning and has had surgical representation although this requires further embedding.

Ambulance delays: Significant improvement has been made in the reduction of ambulance handover delays. January saw Tunbridge Wells Hospital met both the 30 minute and 60 minute trajectory. Maidstone Hospital did not achieve these standards but performance showed an improvement on previous months. February has seen deterioration in 30 minute handover delays at both sites. 60 minutes delays on both sites remains on track against trajectory as of 10th February.


MGH: 30/60 MINUTE PERFORMANCE AGAINST TRAJECTORY BY MONTH
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
MGH 30 Breaches
MGH 60 Breaches
MGH 30 trajectory
MGH 60 Trajectory


TWH: 30/60 MINUTE PERFORMANCE AGAINST TRAJECTORY BY MONTH
20.00%
18.00%
16.00%
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
TWH 30 Breaches
TWH 60 Breaches
TWH 30 trajectory
TWH 60 Trajectory

OPEL status: The Trust has remained at OPEL 3 (Operating Pressures Escalation Level Red) despite all neighbouring Trusts escalating into OPEL 4 (Operating Pressures Escalation Level Black) for prolonged periods of time. West Kent system conference calls have taken place as required over winter and are chaired by West Kent CCG.

Same Day Emergency Care (SDEC): SDEC units continue to deliver an improved zero day LOS in line with assumptions.

2.2.2 Zero LoS Admissions Percentage	1718 Baseline : Wk Avg	15.9%		
	1819 Baseline : Wk Avg	21.7%	36.1%	on 1718
	1920 Forecast : Wk Avg	22.1%	2.1%	on 1819
	Last 12-24 Months : Wk Avg	21.5%		
	Last 12 months : Wk Avg	21.9%	1.9%	on previous
	Last 6 weeks : Wk Avg	23.1%	5.6%	on last 12 months
	Last week	22.2%	1.4%	
	2.2 as a percentage of 2.1. CDU & Maternity excluded			

Length of Stay: Non elective length of stay has ranged from 6.65 days to 7.15 days

2.3 Length of Stay	1718 Baseline : Wk Avg	7.46		
	1819 Baseline : Wk Avg	7.05	-5.5%	on 1718
	1920 Forecast : Wk Avg	6.87	-2.5%	on 1819
	Last 12-24 Months : Wk Avg	7.13		
	Last 12 months : Wk Avg	6.91	-3.1%	on previous
	Last 6 weeks : Wk Avg	7.11	2.9%	on last 12 months
	Last week	6.84	-0.9%	on last 12 months
	Average LoS, excluding Zeroes and all maternity activty			

Long Length of Stay (Stranded patients): LLOS >21 days has seen a peak during the latter part of January and early February. This has been driven by a lack of capacity, both in the community and more significantly in social care, particularly around large packages of domiciliary care. The issues have been escalated and additional Home First capacity is being arranged to support flow.

2.4.1 Seven Day Stranded	1718 Baseline : Wk Avg	#DIV/0!		
	1819 Baseline : Wk Avg	313.38	#DIV/0!	on 1718
	1920 Forecast : Wk Avg	310.11	-1.0%	on 1819
	Last 12-24 Months : Wk Avg	313.05		
	Last 12 months : Wk Avg	310.78	-0.7%	on previous
	Last 6 weeks : Wk Avg	336.95	8.4%	on last 12 months
	Last week	323.71	4.2%	on last 12 months
	Average LoS, excluding Zeroes and all maternity activty			

2.4.2 Fourteen Day Stranded	1718 Baseline : Wk Avg	#DIV/0!		
	1819 Baseline : Wk Avg	184.84	#DIV/0!	on 1718
	1920 Forecast : Wk Avg	179.41	-2.9%	on 1819
	Last 12-24 Months : Wk Avg	#DIV/0!		
	Last 12 months : Wk Avg	180.13	#DIV/0!	on previous
	Last 6 weeks : Wk Avg	198.64	10.3%	on last 12 months
	Last week	184.14	2.2%	on last 12 months
	Average LoS, excluding Zeroes and all maternity activty			

2.4.3 Twenty One Day Stranded	1718 Baseline : Wk Avg	#DIV/0!		
	1819 Baseline : Wk Avg	119.47	#DIV/0!	on 1718
	1920 Forecast : Wk Avg	114.30	-4.3%	on 1819
	Last 12-24 Months : Wk Avg	119.61		
	Last 12 months : Wk Avg	114.77	-4.0%	on previous
	Last 6 weeks : Wk Avg	129.83	13.1%	on last 12 months
	Last week	114.86	0.1%	on last 12 months
	Average LoS, excluding Zeroes and all maternity activty			

2.0 Actions Being Taken

Quality, performance and demand are reviewed weekly by the Chief Operating Officer and the senior operational team. Any variation from plan is reviewed and where possible, corrective actions put into place. 'Lessons Learnt' is a standing agenda item at this forum to ensure the Winter Plan for 20/21 reflects any unforeseen issues that have arisen this winter along with the mitigation put into place.

The action plan below details the work currently being undertaken to ensure patients receive safe and effective care during the winter period.

	Action	Expected Output	Lead	Timeframe
1.	SDEC provision being reviewed at TWH with a planned change to service to provide a joint 7/7 medical, surgical and ortho ambulatory service being scoped	• Less patients waiting in ED overnight • Support a reduction in ambulance handover delays • Improved joint working between medicine and surgery • 2 side rooms on AMU released back into bed stock	Divisional Directors of Operations for Planned Care and Medicine & Emergency Care	End of February
2.	Refresh of Board Rounds - 3 month project	• Audit of current practice • Senior lead allocated per specialty • Video being produced to support understanding and 'how to' approach • Improved overview of capacity for next 24 hours • Improved flow	Deputy Chief Operating Officer Director of Nursing & Quality, Medicine & Emergency Care Trust Discharge Manager	Completed Completed Completed End of April Beginning of March
3.	Escalation of social care and community capacity issues	• Improved availability of large packages of care • Improved availability of community beds and Rapid Response	CEO	Completed
4.	Senior decision maker in ED	• Decreased admissions • Support a reduction in ambulance handover delays • Improved patient care / experience	Chief of Service, Medicine & Emergency Care Director of Operations,	End of February

			Medicine & Emergency Care	
5.	Ensuring control room response when risk of dipping below 90%	• Increased ‘grip and control’ on challenging days • Improved flow • Maintain ED performance >90%	Deputy Chief Operating Officer Director of Nursing & Quality, Medicine & Emergency Care Director of Operations, Medicine & Emergency Care	Ongoing

The table below, which was included in the Winter Plan, has been updated (to week ending 9.02.2020) to show Actuals versus Plan.

Winter Model & Plan versus Actual

			06-Oct-19	13-Oct-19	20-Oct-19	27-Oct-19	03-Nov-19	10-Nov-19	17-Nov-19	24-Nov-19	01-Dec-19	08-Dec-19	15-Dec-19	22-Dec-19	29-Dec-19	05-Jan-20	12-Jan-20	19-Jan-20	26-Jan-20	02-Feb-20	09-Feb-20
Total Type 1 ED		Model	3,285.9	3,252.8	3,215.6	3,185.8	3,176.6	3,198.0	3,218.6	3,228.2	3,219.5	3,221.8	3,236.5	3,256.3	3,244.5	3,202.6	3,134.7	3,105.9	3,116.6	3,166.1	3,199.9
		Actual	**3,309**	**3,359**	**3,292**	**3,064**	**3,135**	**3,286**	**3,400**	**3,341**	**3,275**	**3,442**	**3,442**	**3,293**	**3,067**	**3,054**	**3,174**	**3,140**	**3,078**	**3,278**	**3,300**
		% +/-	0.7%	3.3%	2.4%	-3.8%	-1.3%	2.8%	5.6%	3.5%	1.7%	6.8%	6.3%	1.1%	-5.5%	-4.6%	1.3%	1.1%	-1.2%	3.5%	3.1%
Non Elective Admissions																					
Medical	CDU & SDEC	Model	497.9	498.1	499.4	499.5	500.6	465.8	467.1	468.8	464.0	460.3	458.4	456.8	451.2	445.2	439.7	438.1	438.3	442.4	446.0
		Actual	469	469	500	472	473	487	498	489	488	530	529	455	502	473	553	464	515	545	486
	Non Zero	Model	346.4	347.2	348.4	350.7	359.7	375.9	376.2	378.0	382.1	391.6	399.5	408.8	413.7	415.6	411.2	403.7	397.9	394.1	393.9
		Actual	374	376	349	355	360	363	406	380	366	404	396	398	386	395	413	386	377	347	322
	Total	**Model**	**844.3**	**845.3**	**847.8**	**850.2**	**860.3**	**841.7**	**843.3**	**846.8**	**846.1**	**851.8**	**857.8**	**865.6**	**864.9**	**860.7**	**850.9**	**841.8**	**836.3**	**836.5**	**839.9**
		Actual	**843**	**845**	**849**	**827**	**833**	**850**	**904**	**869**	**854**	**934**	**925**	**853**	**888**	**868**	**966**	**850**	**892**	**892**	**808**
Surgical		Model	184.6	185.2	185.7	186.4	188.2	179.0	181.8	185.2	183.6	177.4	170.6	169.4	172.9	175.1	176.5	175.2	175.5	176.9	179.2
		Actual	181	182	182	180	164	197	159	154	161	161	175	170	152	149	179	152	168	126	157
T & O		Model	62.6	58.1	58.1	57.4	59.3	51.2	50.3	49.3	50.0	50.6	52.4	52.1	51.4	50.2	50.6	51.7	51.5	50.0	48.2
		Actual	45	52	41	45	58	57	43	38	49	41	38	56	44	40	49	47	61	45	50
Gynae		Model	12.8	13.2	13.5	13.4	13.2	13.9	13.9	13.6	12.7	11.9	11.6	11.4	11.2	11.5	12.7	14.0	14.6	14.8	14.6
		Actual	12	19	14	16	12	15	14	9	8	7	8	9	8	17	16	10	7	13	14
Paeds		Model	49.2	49.5	49.3	49.2	49.4	69.8	71.4	71.5	70.7	69.5	67.7	63.9	60.4	58.6	60.4	63.3	65.2	65.2	64.8
		Actual	54	67	52	51	56	58	62	68	73	82	75	63	69	55	68	53	68	63	49
Oncology & Other		Model	2.5	2.6	2.7	2.7	2.9	2.6	2.7	3.1	3.4	3.6	3.8	3.9	3.8	3.6	3.5	3.7	4.0	4.4	5.0
		Actual	5	8	4	1	5	10	1	8	2	6	6	12	6	3	3	5	3	8	5
Total NE		**Model**	**1,156.0**	**1,153.9**	**1,157.0**	**1,159.3**	**1,173.3**	**1,158.2**	**1,163.4**	**1,169.5**	**1,166.5**	**1,164.9**	**1,163.9**	**1,166.3**	**1,164.6**	**1,159.7**	**1,154.6**	**1,149.7**	**1,147.1**	**1,147.7**	**1,151.6**
		Actual	**1,140**	**1,173**	**1,142**	**1,120**	**1,128**	**1,187**	**1,183**	**1,147**	**1,147**	**1,231**	**1,228**	**1,164**	**1,167**	**1,133**	**1,281**	**1,117**	**1,199**	**1,146**	**1,082**
		% +/-	**-1.4%**	**1.7%**	**-1.3%**	**-3.4%**	**-3.9%**	**2.5%**	**1.7%**	**-2.0%**	**-1.6%**	**5.7%**	**5.5%**	**-0.2%**	**0.2%**	**-2.3%**	**10.9%**	**-2.9%**	**4.5%**	**-0.1%**	**-6.0%**
Elective Admissions																					
Medical		Planned	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	3.0	4.0	6.0	6.0	6.0	6.0	6.0
		Actual	10	11	8	7	8	10	7	9	14	8	12	9	7	6	11	7	10	10	3
Surgical		Planned	67.0	67.0	67.0	67.0	67.0	67.0	67.0	67.0	67.0	67.0	67.0	67.0	40.0	54.0	67.0	67.0	67.0	67.0	67.0
		Actual	60	59	58	41	55	56	63	64	74	63	67	57	22	42	62	63	63	71	63
T & O		Planned	44.0	44.0	44.0	44.0	44.0	44.0	44.0	44.0	44.0	44.0	44.0	44.0	26.0	35.0	44.0	44.0	44.0	44.0	44.0
		Actual	30	27	28	25	25	25	32	27	41	32	24	26	6	14	25	23	27	19	16
Gynae		Planned	19.0	19.0	19.0	19.0	19.0	19.0	19.0	19.0	19.0	19.0	19.0	19.0	12.0	16.0	19.0	19.0	19.0	19.0	19.0
		Actual	5	13	15	6	15	11	11	10	19	17	13	16	1	6	13	14	16	10	16
Paeds		Planned	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	4.0	5.0	6.0	6.0	6.0	6.0	6.0
		Actual	3	1	2	1	-	6	1	1	2	2	1	1	-	1	1	3	1	3	2
Oncology & Other		Planned	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	2.0	3.0	4.0	4.0	4.0	4.0	4.0
		Actual	7	5	5	2	2	2	3	1	5	4	4	3	1	2	5	1	4	1	1
Total EL		**Planned**	**146.0**	**146.0**	**146.0**	**146.0**	**146.0**	**146.0**	**146.0**	**146.0**	**146.0**	**146.0**	**146.0**	**146.0**	**87.0**	**117.0**	**146.0**	**146.0**	**146.0**	**146.0**	**146.0**
		Actual	**115**	**116**	**116**	**82**	**105**	**110**	**117**	**112**	**155**	**126**	**121**	**112**	**37**	**71**	**117**	**111**	**121**	**114**	**101**
		% +/-	**-21.2%**	**-20.5%**	**-20.5%**	**-43.8%**	**-28.1%**	**-24.7%**	**-19.9%**	**-23.3%**	**6.2%**	**-13.7%**	**-17.1%**	**-23.3%**	**-57.5%**	**-39.3%**	**-19.9%**	**-24.0%**	**-17.1%**	**-21.9%**	**-30.8%**

Update on the Trust's 2020/21 plan (incl. details of the first submission of the Trust's 2020/21 operating plan)	**Director of Strategy, Planning and Partnerships**

Enclosed is an update on the Trust's 2020/21 plan (Incl. details of the first submission of the Trust's 2020/21 operating plan).

Which Committees have reviewed the information prior to Board submission?

- Finance and Performance Committee, 25/02/20
- Exec Team Meeting (ETM), 25/02/20

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

Review and discussion

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

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NHS Trust

2020/21 Operational Plan

MTW
exceptional people, outstanding care

This year although we are not required to produce a provider narrative document we will have to still produce trajectories and template submissions (Activity, finance and workforce) as usual

Maidstone and Tunbridge Wells NHS Trust

STP/single CCG planning responsibilities

- Co-ordination of process
- Ownership of short system operational statement. Key components include:
  - Updates to system programmes and critical milestones – Faye Rye + system programme leads + ICP contributions
  - Financial position of the system and ICPs, level of risk, source of efficiencies – Ivor Duffy + Finance Group
  - System approach to quality; provider narratives – Paula Wilkins/Sarah Vaux + Directors of Nursing
  - Workforce summary tables – Rebecca Bradd + HRDs
- Completion of STP 'plans on a page' – supports the system operational statement and wider STP programme planning Development of system/single CCG performance trajectories
- Development of single CCG activity, finance and workforce trajectories
- Development of trajectories for system priorities/programmes (cancer, MH, LD & autism) – led by system leads working with CCG, ICP and provider colleagues
- Facilitate high level 'check and challenge role' for critical provider level trajectories (e.g. RTT, A&E, 92% occupancy)
- Aggregation of trajectories to support check and challenge

Providers planning responsibilities

- Provider trajectories – trajectories need to be submitted by individual organisations but should be developed as an ICP footprint to take account of partner contributions and system working – e.g., impact of Local Care.
- Provider activity, finance and workforce trajectories
- Contribution to short system operational statement

ICPs planning responsibilities

- Completion of ICP planning templates – supports both operational planning and longer term ICP planning.
- Discussion of relevant trajectories as an ICP – to capture impact of partnership working and to seek agreement across partners
- Contribution to short system operational statement

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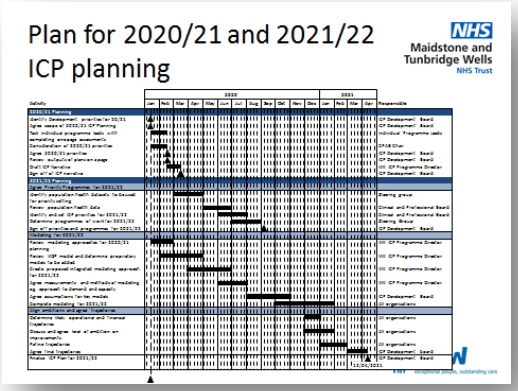
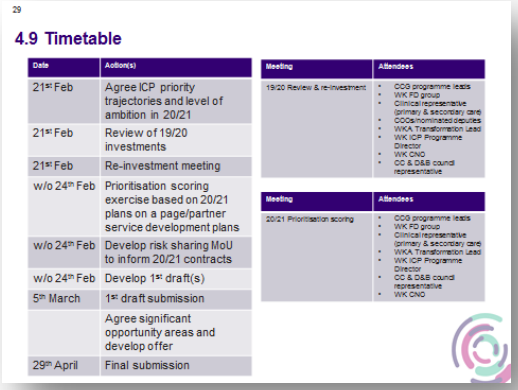
Within the ICP Development Board we have developed the scope for planning in 2020/21 including the joint prioritisation process to balance our trajectory ambitions against the system financial envelope

Maidstone and Tunbridge Wells NHS Trust

- In the January ICP Development Board we focused on defining the 2 year plan for creating an integrated approach to planning including defining the scope for 2020/21 versus 2021/22 planning for the ICP
  - For 2020/21 will focus on an evolution of existing planning processes with additional focus on joint investments determined by clinical priorities and joint prioritisation
  - 21/22 will see the development of an integrated and aligned approach to planning from the very start of the process
- To achieve this aim we will have to define the modelling approaches, data sources and key assumptions during the summer of 2020



- In February the ICP development board held a discussion on the system finances led by the finance directors from across the system.
- To determine the key priorities and investments for 2020/21 it was agreed that a joint prioritisation exercise would be undertaken involving partners from across the system (this is scheduled for Friday the 21st of January)
- This joint prioritisation exercise will be informed by the clinical priorities set by the clinical and professional board as well as a consideration of the wider determinants of health



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4.9 Timetable

Date	Action(s)
21st Feb	Agree ICP priority trajectories and level of ambition in 20/21
21st Feb	Review of 19/20 investments
21st Feb	Re-investment meeting
w/o 24th Feb	Prioritisation scoring exercise based on 20/21 plans on a page/partner service development plans
w/o 24th Feb	Develop risk sharing MoU to inform 20/21 contracts
w/o 24th Feb	Develop 1st draft(s)
5th March	1st draft submission
	Agree significant opportunity areas and develop offer
29th April	Final submission

Meeting	Attendees
19/20 Review & re-investment	• CCG programme leads • WK FD group • Clinical representative (primary & secondary care) • CCGs nominated deputies • WKA Transformation Lead • WK ICP Programme Director • WK CNO • CC & D&B council representative

Meeting	Attendees
20/21 Prioritisation scoring	• CCG programme leads • WK FD group • Clinical representative (primary & secondary care) • WKA Transformation Lead • WK ICP Programme Director • CC & D&B council representative • WK CNO

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We will have to ensure that we agree the template submissions for the 5th of March

DATE	DEADLINE
19th Feb	• Initial trajectories due to STP to support STP/ICS Partnership Board deep dive
24th Feb	• STP/ICS Partnership Board – extraordinary meeting on planning and contracting deep dive
25th Feb	• First draft workforce returns due to STP
27th Feb	• Updated trajectories due to STP; Initial draft system narrative statement (NHSE/I exceptions based template)
2nd March	• First draft activity and finance returns due to STP – to be discussed at 2nd March FAM meeting
5th March	• Shadow K&M CCG GB – submitted plans shared for familiarisation, not sign off (sign off not necessary for initial submission) • First draft submission to NHSE/I
11th March	• Second draft trajectories due to STP to facilitate show & tell/check and challenge sessions
w/c 16th March	• Internal 'show and tell/check and challenge sessions' on key trajectories – sessions diarised for A&E and RTT – others TBC
w/c 23rd March	• NHSE/I joint system/regional exec meetings to discuss first draft submissions
30th March	• Second draft activity, workforce and finance returns due to STP • Second draft system narrative statement • Any changes to trajectories arising from the 'check and challenge session' • (whether or not NHSE/I require an interim submission, we will run an internal check point to support 2nd April CCG GB)
2nd April	• Inaugural K&M CCG Governing Body – update on planning position and steps to finalisation
9th April	• Potential interim submission to NHSE/I • Inaugural K&M CCG Finance and Performance Committee – detailed review of planning position and steps to finalisation
27th March	• Deadline for 20/21 contract signature
24th April	• Final trajectories due to STP; Final activity, workforce and finance returns to STP; Final draft system narrative statement
TBC late April	• STP/ICS Partnership Board endorsement
29th April	• Final submission to NHSE/I
30th April	• K&M CCG Governing Body endorsement
March/April	• Publication of the People Plan and national LTP Implementation Plan • Publication of local Five Year Plans

For our activity modelling we have built upon the foundations that we laid in the 2019/20 business planning round

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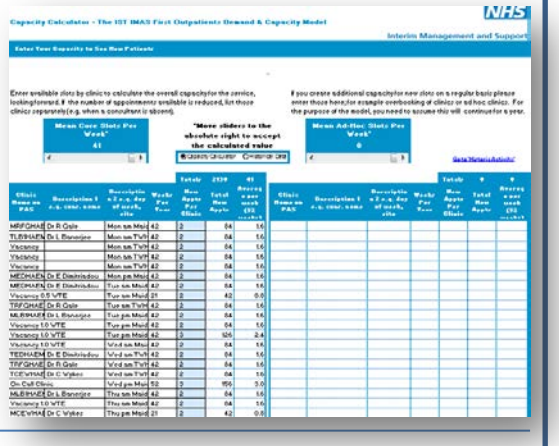
Demand and capacity planning

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



Improvement potential

- In order to identify their improvement initiatives for 20/21 a variety of sources from internal data and expertise to the model hospital and GIRFT were used to identify improvements
- Divisions and directorates have sized their improvement initiatives by individual lever to ensure that we can accurately forecast the levels of activity that we can deliver next year in house and the levels to be outsourced under our prime provider contract
- This has also allowed us to accurately forecast the implications on our waiting list and backlog and therefore likely RTT profile for 20/21

Initiatives	Demand management/ Productivity improvement or New ways of working	Size of initiative
Theatre Utilisation (Foot Non Fractures)	TWH	48 slots
Review of job plan when recruiting new Substantive Foot and Ankle consultant	One additional list/month of 5 patients (assumed in post by May 2019)	50 slots
Theatre Utilisation (Knee, Lower Limb and Hip Comb)	MOU, Maidstone	252 slots
Funded Knee WLI		40 slots
Upper Limb Shoulder Fellow	Two additional lists of 6 patients	456 slots
Theatre Utilisations (Shoulder Non Fractures)	TWH	49 slots
Funded Shoulder WLI		30 slots
New Hand and Shoulder Consultant from Sept 19	Using budget from Spine Consultant retiring in Sept 19, Full year effect = 266 appts	Half year effect = 133 slots

Bottom up bed modelling

- LoS identified by POD and specialty
- Detailed calculation of bed requirement built from specialty specific demand and capacity work converted into bed days and therefore bed requirement

Top down bed modelling

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

Tunbridge Wells Hospital
Summary

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

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

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

Our proposed RTT trajectory is in line with our 5 year plan submission and proposes a reduction in waiting list in line with operational plan guidance however we will need to commit to eliminating 52 week waits

NHS Maidstone and Tunbridge Wells NHS Trust

Long term plan trajectory

Referral to Treatment				As at 31 March 2019	As at 30 June 2019	As at 30 Sept 2019		Y1	Y2	Y3	Y4	Y5
Number of incomplete RTT pathways <=18 weeks	*i*	+		23,616	25,106			20,794	20,794	20,794	20,794	20,794
Number of incomplete RTT pathways Total	*i*	+		28,413	29,269			23,980	23,980	23,980	23,980	23,980
Referral to treatment Incompletes - Performance % (92% standard)				**83.1%**				**86.7%**	**86.7%**	**86.7%**	**86.7%**	**86.7%**
Number of incomplete RTT pathways >52 weeks	*i*	+		2	6			10	5	5	5	5

Proposed 2020/21 operational plan trajectory including Jan – Jan reduction in waiting list

		Jan-20	Baseline	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
RTT	Total Patients Waiting	31,965	30,000	31,065	31,267	32,163	32,560	32,152	32,346	31,611	31,468	31,349	30,293	30,063	30,355
	>18 weeks waits:	4,785	4,000	4,258	4,207	4,888	5,145	5,098	5,253	4,774	4,702	4,622	4,052	3,904	4,048
	Peformance %	85.03%	86.7%	86.3%	86.5%	84.8%	84.2%	84.1%	83.8%	84.9%	85.1%	85.3%	86.6%	87.0%	86.7%

		Baseline	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Total	Q1	Q2	Q3	Q4
Diagnostics	Total Patients Waiting	6,508	6070	6119	6355	6774	6313	6271	6650	6511	6420	6420	6240	6508	76,651	18,544	19,358	19,581	19,168
	Patients waiting >6wks	50	61	61	64	68	63	63	67	65	64	64	62	65	767	185	194	196	192
	Peformance %	0.8%	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%	1.0%	1.0%	1.0%	1.0%

For ED we have reduced our trajectory (88%) from that submitted in the Long Term Plan (92%) due to the increased pressures we have faced over the past year

Maidstone and Tunbridge Wells NHS Trust

Long term plan trajectory

		Expected		Out-turn	Y1 Actual	Y1 Actual if possible	Y1 Q3 and Q4 reforecast plan based on Q1/Q2 performance	Y1 Plan as per 19/20 Op Plan	Y2 Plan	Y3 Plan	Y4 Plan	Y5 Plan
Accident and Emergency		Sign		31/03/2019 March 2019	Q1 As at 30 June 2019	Q2 As at 30 Sept 2019	31/04/2020	31/04/2020	31/04/2021	31/04/2022	31/04/2023	31/04/2024
Accident and Emergency - >4 hour wait	*i*	+		15,561	3,684	4,375	9,620	17,680	17,174	17,920	18,702	19,524
Accident and Emergency - Total Patients	*i*	+		189,120	51,312	53,642	100,863	205,816	214,671	223,995	233,777	244,046
Accident and Emergency - Performance % (95% standard)		+		**91.8%**	**92.8%**	**91.8%**		**91.4%**	**92.0%**	**92.0%**	**92.0%**	**92.0%**

Proposed 2020/21 operational plan trajectories

		Baseline	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Total	Q1	Q2	Q3	Q4
A&E Type 1, Type 3 (inc Crowb)	Total Patients Seen	208,556	17,493	18,693	18,603	19,499	18,248	18,392	18,295	17,180	17,769	17,260	16,339	19,237	217,007	54,789	56,138	53,244	52,836
	>4hr Wait	17,323	2,109	1,860	1,631	1,948	1,708	1,908	1,972	2,034	3,069	3,158	2,395	2,248	26,041	5,600	5,564	7,075	7,801
	Peformance %	91.69%	87.94%	90.05%	91.23%	90.01%	90.64%	89.62%	89.22%	88.16%	82.73%	81.71%	85.34%	88.31%	88.00%	89.78%	90.09%	86.71%	85.23%

		Baseline	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Total	Q1	Q2	Q3	Q4
Ambulance Handover delays	Number of arrivals	3,867	3,704	3,839	3,711	3,874	3,783	3,671	3,883	3,897	4,147	4,124	3,648	3,994	46,277	11,254	11,329	11,927	11,767
	Delays 30-30 mins	348	333	342	327	337	325	312	326	323	415	371	299	320	4,030	1,002	974	1,064	990
	Delays >60mins	25	24	18	1	1	1	1	1	1	1	1	1	0	53	43	4	4	3

Cancer trajectories maintain our ambition to maintain performance against the 85% standard but are reliant on additional investment for sustainability (1/2)

NHS
Maidstone and Tunbridge Wells

Proposed 2020/21 operational plan trajectory

		Baseline	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Total	Q1	Q2	Q3	Q4
	Total Patients Seen	1,421	1,494	1,459	1,520	1,617	1,393	1,399	1,578	1,476	1,535	1,491	1,535	1,678	18,173	4,472	4,409	4,589	4,704
Cancer	>2 week wait	76	105	102	106	113	98	98	110	103	107	104	107	117	1,272	313	309	321	329
2WW (93%)	Peformance %	94.65%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.00%	93.00%	93.00%	93.00%

		Baseline	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Total	Q1	Q2	Q3	Q4
	Total Patients Seen	108	176	171	145	189	152	118	164	157	117	190	163	188	1,930	492	459	438	541
Cancer 2WW Breast	>2 week wait	6	12	12	10	13	11	8	11	11	8	13	11	13	135	34	32	31	38
(93%)	Peformance %	94.44%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%

		Baseline	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Total	Q1	Q2	Q3	Q4
	Total Patients Seen	191	237	235	232	230	224	233	211	224	200	228	222	224	2,699	703	686	635	674
Cancer 31 Day First	>2 week wait	1	9	9	9	9	9	9	8	9	8	9	9	9	108	28	27	25	27
(96%)	Peformance %	99.48%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%

		Baseline	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Total	Q1	Q2	Q3	Q4
	Total Patients Seen	21	32	28	31	30	30	25	35	31	22	25	32	30	354	92	86	88	88
Cancer 31 Day Surgery	>2 week wait	3	2	2	2	2	2	2	2	2	1	2	2	2	21	6	5	5	5
(94%)	Peformance %	85.71%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%

		Baseline	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Total	Q1	Q2	Q3	Q4
	Total Patients Seen	76	108	108	105	92	78	102	94	103	80	105	78	96	1,148	321	271	277	279
Cancer 31 Day Drugs	>2 week wait	-	1	1	1	1	1	1	1	1	1	1	1	1	11	3	3	3	3
(98%)	Peformance %	100.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%

		Baseline	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Total	Q1	Q2	Q3	Q4
	Total Patients Seen	220	320	257	259	334	284	244	252	243	231	338	285	290	3,336	835	863	725	913
Cancer 31 Day Radio	>2 week wait	6	19	15	16	20	17	15	15	15	14	20	17	17	200	50	52	44	55
(94%)	Peformance %	97.27%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%

Cancer trajectories maintain our ambition to maintain performance against the 85% standard but are reliant on additional investment for sustainability (2/2)

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Maidstone and Tunbridge Wells

Proposed 2020/21 operational plan trajectory

		Baseline	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Total	Q1	Q2	Q3	Q4
Cancer 62 days (85%)	Total Patients Seen	90.5	126.8	124.2	124.7	120.5	118.9	107.9	111.1	131.0	94.8	117.4	139.4	140.4	1,457	376	347	337	397
	>62 day wait	11.5	19.0	18.6	18.7	18.1	17.8	16.2	16.7	19.7	14.2	17.6	20.9	21.1	219	56	52	51	60
	Peformance %	87.29%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%

		Baseline	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Total	Q1	Q2	Q3	Q4
Cancer 62 day Screening (90%)	Total Patients Seen	17.0	13.6	21.5	19.9	15.7	15.2	18.9	22.5	20.4	17.8	21.5	18.9	22.0	228	55	50	61	62
	>62 day wait	1.0	1.4	2.1	2.0	1.6	1.5	1.9	2.3	2.0	1.8	2.2	1.9	2.2	23	6	5	6	6
	Peformance %	94.12%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%

		Baseline	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Total	Q1	Q2	Q3	Q4
Cancer 62 day Upgrade (85%)	Total Patients Seen	11.0	6.8	12.6	16.2	15.2	8.4	14.1	10.5	6.3	11.5	11.5	8.4	15.2	137	36	38	28	35
	>62 day wait	5.0	1.0	1.9	2.4	2.3	1.3	2.1	1.6	0.9	1.7	1.7	1.3	2.3	21	5	6	4	5
	Peformance %	54.55%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%

		Baseline	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Total	Q1	Q2	Q3	Q4
Cancer Faster Diagnosis 28 Days	Total Patients	1,529.0	1,670	1,630	1,664	1,806	1,546	1,516	1,742	1,633	1,651	1,681	1,698	1,865	20,102	4,964	4,868	5,026	5,245
	>28 days or no date	990.0	870.9	780.1	716.6	699.1	558.0	457.8	479.8	449.3	435.8	428.9	423.6	420.5	6,720	2,368	1,715	1,365	1,273
	Peformance %	35.25%	47.84%	52.13%	56.94%	61.29%	63.90%	69.81%	72.46%	72.49%	73.61%	74.49%	75.05%	77.46%	66.57%	52.30%	64.77%	72.84%	75.73%

We will require additional investment in order to ensure that:

- Cancer performance is sustainable for our patients and our staff (£4.71m recurrent funding from 2019/20 plus £0.52m additional funding)
- Compliance with the 28 day faster diagnostic standard (£0.56m funding excluding diagnostic MRI capacity which is in the process of being assessed)

The new 92% bed occupancy standard will be a critical measure of success for the system, we believe that our systems currently inaccurately report this and have based the trajectory on operational intelligence

Maidstone and Tunbridge Wells NHS Trust

Proposed 2020/21 operational plan trajectories

	Average Daily Number	Baseline	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Total	Q1	Q2	Q3	Q4
G&A Beds Open and daily bed occupancy	Open and Available	738	654	650	642	641	647	655	651	671	692	716	716	716	8,051	1,946	1,943	2,014	2,148
	Occupied	693	648	644	636	635	641	649	644.49	668	691	716	716	716	8,002	1,927	1,924	2,003	2,148
	% Bed Occupancy	93.9%	99.1%	99.0%	99.0%	99.0%	99.0%	99.1%	99.0%	99.5%	99.8%	100.0%	100.0%	100.0%	99.4%	99.03%	99.03%	99.44%	100.00 %

	Baseline	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Average Daily Number of Long Stay patients >21 Days	90	90	88	82	82	84	84	79	77	82	88	85	80

- In terms of the 92% occupancy target the system is currently reporting a bed occupancy of 93.9%. However this is thought to be a false position as operational observation and direct data collection places bed occupancy at 98%-100%.
- Work has been undertaken to re-baseline bed occupancy led by Lynn Grey and in conjunction with NHSE/I
- MTW is not unique in this regard and work is underway nationally to review methodology of bed occupancy measurement
- From initial work it is thought that there will need to be additional investment into Community and Primary care however this is still to be worked through in light of the re-baselining.

NHS
Maidstone and Tunbridge Wells
NHS Trust

2020/21 Financial Plan

MTW
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2020/21 Financial Plan

Maidstone and Tunbridge Wells NHS Trust

Financial Improvement Target

The Trust has received a Financial Improvement Target (FIT) of a surplus of £0.568m. The FIT replaces the Control Total used in 2019/20.

The PSF has been replaced by Financial Recovery Fund (FRF). The Trust won't receive any FRP as it is on plan to meet it's 2019/20 Control Total.

The Trust will receive MRET of £6.2m which gives a £5.632m deficit pre MRET.

Financial Plan

The financial plan proposes to meet the Financial Improvement Target however this includes a CIP target for 20/21 of £23.7m which is 4.8% of 19/20 turnover. In addition the underlying position includes £1.8m roll over of 19/20 CIP schemes.

Breakeven and Surplus Trust Scheme

The Trust has the opportunity of a reward payment of 0.5% of relevant income if a breakeven position is achieved in 20/21 and at the end of 21/22 if financial performance is maintained. This is estimated at £2.26m per year based on 0.5% of clinical income. The reward payment is not included in the plan figures.

Movement from Long Term Plan

The movement and key variances from the Long Term Plan submitted in November 2019 to the current draft plan are explained on the next slide.

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Movement between Long Term Financial Plan and Current Plan

Maidstone and Tunbridge Wells NHS Trust

	Long Term Plan £000		Current Plan £000		Difference £000	
2019/20 Forecast	6,460		6,460		0	
Technical adjustments	435		435		0	
Total Including Technical Adjustemnt	**6,896**		**6,896**		**0**	
Less PSF Income	-7,651		-7,651		0	
2019/20 FOT Excluding PSF		**-755**		**-755**		**0**
Non Recurrent (Non CIP)	-5,935		-6,844		-909	
Non Recurrent CIP	-5,255		-5,592		-337	
FYE of 2019/20 CIP	4,544		1,794		-2,750	
FYE of Business Cases	*-3,006*		-6,518		-3,512	
Other Adjustments	0		-637		-637	
Total Recurrent	**-9,652**		**-17,797**		**-8,145**	
Underlying Deficit		**-10,407**		**-18,552**		**-8,145**
2020/21 Inflation (Net)	*-5,870*		-8,615		-2,745	
2020/21 Contingency Reserve	-5,000		-5,000		0	
Demographic Growth and WLSS	0		1,367		1,367	
2020/21 Cost Pressures	-2,404		-4,131		-1,727	
Total New 2020/21 Pressures	**-13,274**	**-23,681**	**-16,380**	**-34,932**	**-3,106**	**-11,251**
Control Target		0		568		0
Total Variance to Control Total		**-23,681**		**-35,500**		**-11,251**
2020/21 Planning Review				11,800		
2020/21 CIP				23,700		
Revised Variance to Control Total				**0**		

Key Variances from LTP

The overall plan as adversely moved by £11.3m, £8.1m due to deterioration of underlying deficit and £3.1m due to new pressures resulting from updated planning assumptions.

Non Recurrent Non CIP: 19/20 FOT has an additional £0.9m of non recurrent items

FYE CIP: Reduction due to revision of Prime Provider delivery

FYE Business Case: The Trust Board has approved the Ive Business Case for IT improvements. This has a revenue impact of £2.2m in 2020/21. Additional Car parking (£0.8m) and Medical E Rostering software (£0.3m).

Inflation and Pay Award: Modelling shows the impact of the pay AFC award to be 3.98% which is 1% or £2.9m higher than the LTP assumption of 2.9%.

Demographic Growth: The current plan assumes the cost of the growth will be at a marginal rate of 70%.

Cost Pressures (£1.7m): IFRS16 revenue impact £0.7m, Rota Compliance £0.5m, Pathology STP £0.4m and Endoscopy Scope Review £0.4m

Summary I&E Table

Maidstone and Tunbridge Wells NHS Trust

	2019/20 Budget	Month 9 2019/20 FOT	2020/21 Plan (Incl Inflation) and Directorate identified CIP	Movement between 2020/21 Plan and 2019/20 forecast outturn
Clinical Income	431.9	434.9	451.0	16.1
Education Training & Research	10.9	11.1	11.2	0.1
Other Income	35.7	36.9	31.8	-5.1
Commercical Income	3.4	3.6	3.5	0.0
Private Patients	5.1	1.6	2.9	1.3
MRET	6.2	6.2	6.2	0.0
Total Income	**493.3**	**494.3**	**506.7**	**12.4**
Medical Staff	-86.8	-90.1	-89.9	0.2
Nursing	-100.1	-99.4	-108.0	-8.6
Scientific and Technical Staff	-45.4	-43.6	-49.0	-5.4
A&C/Sen Man Staff	-41.6	-39.7	-44.5	-4.8
Support Staff	-14.7	-14.4	-15.5	-1.1
Pay Reserves including Apprenticeship levy	-2.0	-1.2	-1.2	0.0
Total Pay	**-290.7**	**-288.2**	**-308.0**	**-19.8**
Drugs & Medical Gases	-51.4	-54.8	-57.8	-3.0
Supplies and Servcies	-39.3	-38.9	-41.0	-2.1
Purch healthcare from non NHS	-8.6	-15.3	-18.7	-3.4
Clinical Negligence	-17.6	-17.6	-20.1	-2.5
Premises	-26.1	-25.6	-31.4	-5.8
Other Non Pay	-22.4	-23.9	-21.7	2.1
Reserves	-7.3	0.0	-5.5	-5.5
Total Non Pay	**-172.6**	**-176.1**	**-196.3**	**-20.2**
Other Finance Costs	-31.9	-31.1	-32.5	-1.4
Technical Adjustments	1.1	0.3	1.1	0.8
Total Deficit Including MRET Income	**-0.8**	**-0.8**	**-29.0**	**-28.2**
Other Adjustments				
Planning Review Challenges			11.8	
CIP 'Areas of Focus' and STP Schemes			9.1	
Unidentified CIP			8.6	
Total Other Adjustments	**0.0**	**0.0**	**29.5**	
Total Surplus Including Other adjustments	**-0.8**	**-0.8**	**0.6**	
Control target Total	-0.8	-0.8	0.6	
Variance to Control Total	**0.0**	**0.0**	**0.0**	

Divisions have identified £6m of CIP which is incorporated into the plan, further benefits relating to 'Planning review challenges' (£11.8m), finalisation of 'CIP Areas of Focus' savings (£9.1m) and identification of £8.6m unidentified CIP is required to deliver the control total.

Movements between Outturn and plan

Income increase of £12.4m between years

- Clinical Income is forecasted to increase by £16.1m between years. This is mainly due to:
  - Increase in Tariff £7.1m
  - Growth including waiting list steady state £9.8m
  - FYE of business cases £3m
  - less Non recurrent RTT Income support (£1.5m)
  - Loss of Cytology Income (£0.5m)
  - Reduction in Sussex Stroke activity (£0.6m).
- The level of private patient income at the Wells Suite has been based upon 10 In Patient beds
- Reduction in other income (£5.1m) relates to:
  - STP (cease hosting Oct 19) £2.5m
  - Non recurrent income of £0.6m received in 2019/20
  - Reduction in donated asset income (£0.7m) which is offset by a technical adjustment
  - Loss of £0.7m provider to provider Pathology income

Pay £19.8m Increase between years

- Inflation (£11.3m)
- 2019/20 Non recurrent benefits (£3.3m)
- FYE of agreed business cases (£5m)
- Cost Pressures (£0.5m)
- STP reduction in cost £0.3m

Non Pay £20.2m increase

- FYE of business cases (£4.5m)
- Growth reserve (£7.8m)
- Inflation (£2.4m)
- Reserves (£5.5m)
- CNST (£2.5m)
- 2019/20 Non Recurrent benefits (£1m)
- STP reduction in cost £2.2m

Other Finance £1.4m increase

- Depreciation and PDC increase (£1.4m)

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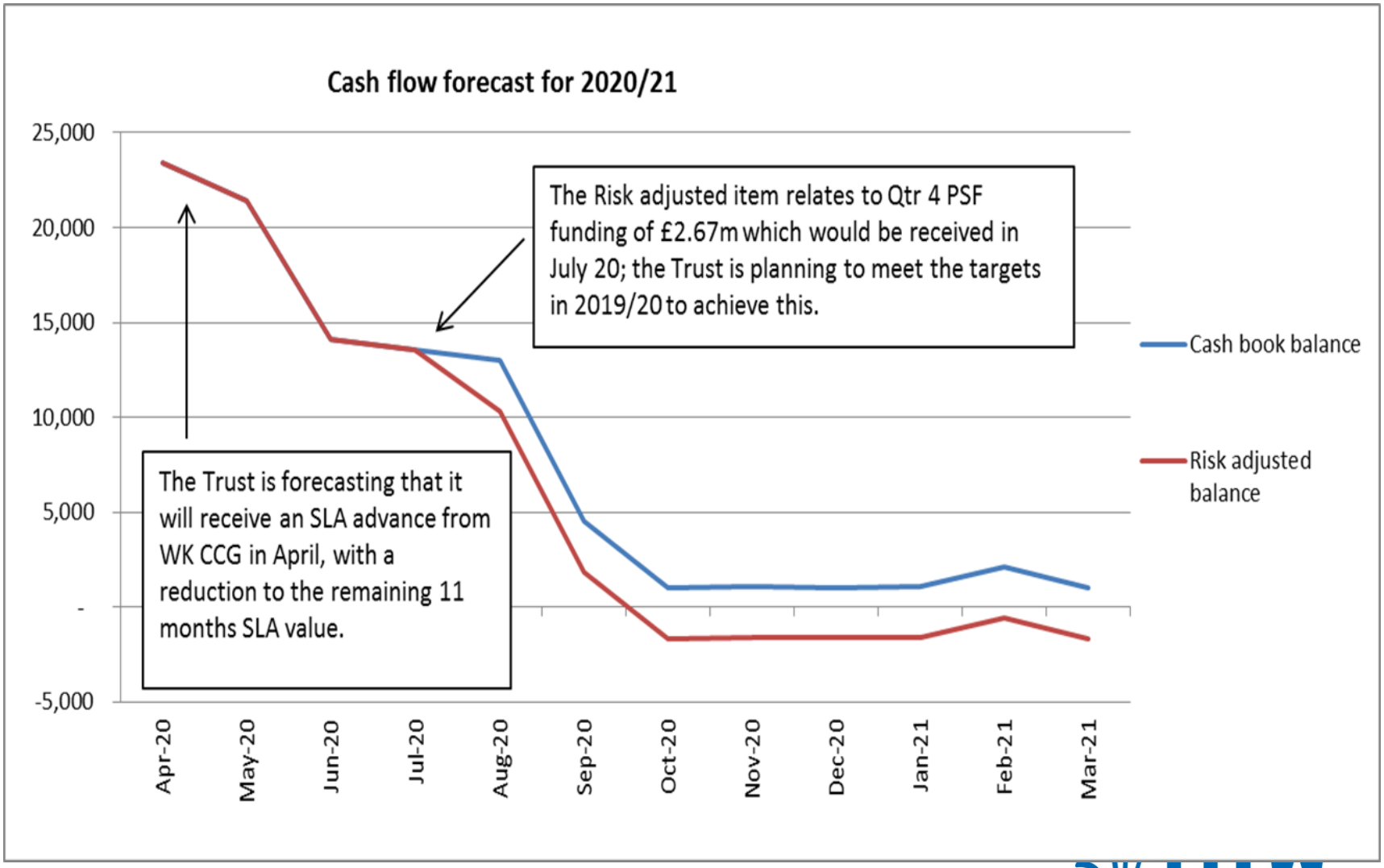
Capital planning

Draft Capital Spend Plan - all figures £000	2020/21
Estates	
Backlog maintenance	634
Backlog maintenance - funded from asset sale 18/19	1,000
Estates Projects - other renewals	306
Subtotal - internally generated funds	**1,940**
ICT	
ICT - Infrastructure	500
ICT - EPR (excluding EPMA)	651
Subtotal - internally generated funds	**1,151**
Equipment	
Trustwide equipment	2,486
Trustwide equipment - funded from asset sale 18/19	1,000
Subtotal - internally generated funds	**3,486**
Externally financed projects	
TWH - Lifecycle (IFRIC 12 PFI capital)	976
Salix Energy infrastructure - Economisers	167
Linac replacement programme - PDC	1,730
Critical Medical Imaging replacement - Loans	2,350
HASU Stroke - STP bid PDC - pending outcome	6,245
Pathology LIMS	3,200
ICT infrastructure	900
Anaesthetics Machines - critical replacment	2,000
Subtotal - external finance	**17,568**
Total Capital Spend Plans	**24,145**

- The draft capital plan is as per the LTP submission in October 2019
- It assumes:
  - The £2m cash carried forward from assets sales will be available to use to support backlog/equipment – this will be subject to a NHSE/I & DHSC case
  - External funding can be secured for a number of projects e.g. linac replacement, pathology cases
- Further work on the plan needs to take account of:
  - The resource base taking into account the different additional funding sources received in 2019/20 for relatively short lifed assets – this will increase the internally generated resource going forward
  - The impact of Clinical, Estates and Financial Strategies for 2020/21 onwards
  - Prioritisation of Business Planning proposals from the Divisions
  - The impact of IFRS 16 capitalisation of leases and how this plays into the funding position
  - The review of the EPR capital funding required for 2020/21

Cash flow forecast for 2020/21

Maidstone and Tunbridge Wells NHS Trust



Cash flow additional notes

Maidstone and Tunbridge Wells NHS Trust

Cash flow assumptions

- The cash flow forecast is driven by the I&E plans and therefore any changes to the I&E position or monthly phasing of income , costs or CIPs will impact on the cash flow
- The opening cash balance is £3m which includes £2m carry forward from the asset sale in March 2019, to fund 2020/21 in year capital projects. It is assumed this will be utilised in 2020/21.
- In April the Trust is expecting to have an advance on its contract with WK CCG of c.£23m with the remaining contract balance released over the following 11 months (as in 2019/20).
- It is assumed that 2019/20 Qtr 4 PSF funding will be received in July 2020 on the basis of achieving the relevant targets in 2019/20. There is no PSF funding in 2020/21 but MRET funding of £6.2m (same value as 2019/20) is still being received which is not linked to targets.
- The 2020/21 capital programme is based on the long term capital plan value of c.£24m – this is a work in progress and does not at this stage include IFRS 16 leased capital impacts.
- The Trust is assuming that the working capital revenue loans are converted to PDC therefore there is no plan to repay them in 2020/21. This was notified to the Trust by NHSE/I on the 3rd February 2020.
- The loan interest associated to the working capital revenue loans has also been removed, but the PDC dividend value has increased due to the increase in PDC value from the conversion of the loans to PDC.
- The Trust still has the existing capital loans for which principal and interest are paid out in September and March.
- No additional working capital loans are forecast to be required within 2020/21 on the basis of delivering the planned I&E position
- The Closing cash balance will return to the £1m baseline value at 31st March 2021.

Risks

- The cash flow forecast is based on the I&E planned position therefore if during the year the position moves adversely from plan the Trust will require additional financing to ensure it can meet its commitments

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Key Risks

Maidstone and Tunbridge Wells NHS Trust

Contract Negotiations

Contracts have not yet been finalised with commissioners. The main risks for West Kent and Surrey and Sussex CCGs relates to the additional activity to maintain RTT performance and Cancer performance. Details provided in separate paper. The current income assumptions don't include any commissioner QIPP.

The change in commissioner landscape from 8 CCGs in Kent and Medway to one Kent and Medway Commissioner means a change to the existing relationships between Trust and CCG staff.

Further Planning Review

There is further planning review work to complete to ensure a sustainable underlying financial plan for the 20/21 financial year

CIPs

The Divisions have currently identified £6.0m, with further areas of focus identified as £9.1m. More work is required to ensure full delivery of our plan.

Business cases and Services developments

Business cases and Services developments to be cost neutral or funded via contingency reserve. Currently, no costs associated with service developments have been included in the plan.

Capital funding

The impact and funding approach to IFRS 16 capitalised leases remains a risk, along with the potential for Trust lease schemes in 2019/20 to fall into 2020/21 if delayed in completion.

There are a number of externally funded schemes in the plan which carry risk where funding is not yet agreed.

Cash

The cash position reflects the planned I&E phasing and surplus – changes to that position will impact on the Trust's liquidity and if significant might lead to a requirement for working capital support

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Next Steps

Maidstone and Tunbridge Wells NHS Trust

Contract Negotiation
Contract negotiations will continue with the commissioners and financial assumptions will need to align to performance trajectories agreed.

Further Planning review
The finance team is working with Divisions on the following;
- Review of underlying position
- Review of Workforce Phasing
- Exploring non recurrent benefits

CIP generation
The transformation team is working with the Divisions to ensure;
- Project plans are in place for identified CIPs
- Areas of focus are scoped for opportunity for further CIPs

Triangulation of Finance, Activity and Workforce
The triangulation of Finance (Income and Expenditure), Activity and Workforce plans will continue; particularly areas of change such as the prime provider model introduced in 19/20.

Financial Budget Sign Off
A budget will need to be approved by the Trust Board at the end of March even though the final planning submission is not until 29th April.

Capital
The sources of funding need to be firmed up (internal and external assumptions). High level prioritisation of key Trust capital requirements needs to be agreed. The impact of IFRS 16 needs to be further assessed and understood, including the approach to resourcing.

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The Kent and Medway Strategy Delivery Plan, 2019/20 to 2023/24	**Director of Strategy, Planning and Partnerships**

In January 2018, the NHS published its Long Term Plan for the next 10 years. All systems across England were required to develop a local five year plan in response to the NHS Long Term Plan over the summer and autumn of 2019.

Enclosed for information is the draft Kent and Medway five year plan, subject to final discussion with NHS England/NHS Improvement. The plan sets out the continued transformation of the local system, building on all of the work to date under the Kent & Medway Sustainability and Transformation Partnership (STP). It sets out a commitment to become a high performing Integrated Care System (ICS), delivering high quality services, improving the overall health and wellbeing of the population, investing in prevention and embedding prevention through the ICS, and working to address health inequalities. The plan was developed with widespread engagement of staff from across the system, discussed at system forums and informed by four public engagement events.

The plan is a technical document and once it has been finalised with NHS England/NHS Improvement, a shorter, more digestible, public facing summary will be published. Following the endorsement of the plan at the STP/ICS Partnership Board on 4th November, Clinical Commissioning Group Governing Bodies and provider Boards are asked to support and endorse the plan.

Detailed implementation will be addressed through annual operational planning

Which Committees have reviewed the information prior to Board submission?

- N/A

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

To support and endorse the enclosed Kent and Medway Strategy Delivery Plan, 2019/20 to 2023/24

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

Transforming health and social care in Kent and Medway

DRAFT

Bringing the NHS Long Term Plan to life in Kent and Medway

Kent & Medway Strategy Delivery Plan 19/20 to 23/24

Submission to NHS England and NHS Improvement

Transforming health and social care in Kent and Medway is a partnership of all the NHS organisations in Kent and Medway, Kent County Council and Medway Council. We are working together to develop and deliver the Sustainability and Transformation Plan for our area.

Medway Council Serving You

Kent County Council kent.gov.uk

NHS

Foreword (1/2)

I am delighted to present this five year **Strategy Delivery Plan** for the health and care system in Kent and Medway. This plan describes our priorities and actions over the next five years to continuously improve the health and wellbeing of our population, and to address the challenges of our health and care system. We have engaged widely in developing this plan, focusing on what matters most to local people. However, this plan reflects the current status of our system and over the next six to nine months, there will be significant changes in the way that services are organised, not least the merger of our existing eight Clinical Commissioning Groups to form a single CCG for Kent and Medway. Such changes will prompt us to reflect on this Plan and to launch a refreshed vision and strategy as we move closer to becoming an Integrated Care System.

In the summer of 2018, the government announced increased funding for the NHS in England resulting in the publication of a **Long Term Plan for the NHS** in January 2019; setting out guidelines for how the increased investment should be spent in local systems. The Plan signals a need for more integrated services, an increased focus on prevention and more targeted action on the biggest killers and disablers of our population. We welcome this set of national priorities as it accords with our own in Kent and Medway.

We are a system comprised of partners from across the NHS, local authorities, the voluntary sector and patient groups with a shared goal of achieving **'Quality of Life, Quality of Care'**. By providing high quality personalised care we will support people to live their best lives - helping people to look after their physical health, mental health and wellbeing; preventing avoidable illness; and supporting people with complex needs to best manage their health and look after their independence.

In Kent and Medway, we have a number of **structural challenges** with the way our services are organised and delivered, impacting both clinical and financial sustainability. We are working together as a system to implement long term solutions to these challenges, in a phased approach. In 19/20, we launched our system wide Workforce Transformation Strategy which aims to **make Kent and & Medway a great place to live, work and learn**. This has seen the creation of the Kent and Medway Medical School, an exciting collaboration of partners that will attract and train future doctors from 2020. We are also developing the Kent and Medway Academy for Health and Social Care to focus on system wide solutions to strategic challenges such as creating fulfilling lifelong careers in health and care.

Our first clinical priority area is the development of a network of hyper acute stroke units to ensure that providers can consistently deliver high quality services. This will result in more people surviving a stroke and improved quality of life and independence for people who have had a stroke. At a place level, our East Kent transformation programme is assessing two potential options that propose using our hospitals differently in the future to improve standards, with a single centre for specialist services and separating planned and emergency care, to benefit both types of services. This will be subject to formal consultation before a final decision is made.

Foreword (2/2)

Over the next five years we will look at options in relation to vascular and other more specialist services as well as looking at the options to improve care through networking of services across Medway, North Kent and West Kent.

Since the creation of the K&M Sustainability and Transformation Partnership in 2016 we have made **great strides in integration** including the implementation of system wide programmes for transforming primary care, creating multi-disciplinary teams to support people with complex needs, and prevention across the life course. In September 2019, our CCGs unanimously agreed to merge to become a single CCG across K&M in a move which will enable a focus on improving population health, commissioning at scale, and removing unwarranted variation.

This plan includes explicit commitment of all partners to invest in **population health and prevention,** ensuring that prevention is part of every single health and care pathway. Across the system we are tackling the **underlying drivers of health inequalities**. By taking positive action on underlying issues, such as smoking, obesity and alcohol consumption, we will reduce deaths and disability caused by cardiovascular disease, stroke, diabetes, respiratory disease and some cancers such as lung and colon. We know that the burden of issues such as smoking and obesity does not affect our population equally and that in areas of deprivation these issues contribute to inequalities. Additionally, we know that feeling lonely has a major impact on both our physical and mental health. Together, we need to do more to tackle **deprivation and social isolation**.

In this plan, you will see our priorities and actions to improve outcomes for all major conditions. This is underpinned by an overriding principle that our care pathways focus on the person and their needs and goals, not just a condition. This plan includes also explicit commitments to:

- Continue to improve our **cancer services** and ensure that more cancers are diagnosed earlier at stages 1 and 2 and that more people survive cancer
- Focus on our population's **mental health**, expand mental health services and better look after the physical health of people with severe mental illness
- Ensure that children, young people and adults with **SEND, Learning Disabilities and autism** and their families and carers receive the care and support they need and deserve

This plan is a call to arms for a fundamental change in the way that care is delivered in Kent and Medway and that enables all of us to lead our best lives.

Glenn Douglas

Contents (1/3)

Contents (2/3)

Section one

Introduction

Introduction continued

Our vision for Kent and Medway

Three years ago, we created the Kent and Medway Sustainability and Transformation Partnership, bringing together over 19 partners from health, local authorities, voluntary sector and patient groups across Kent and Medway to work together to transform and improve services. Our vision for 'Quality of Life, Quality of Care' is the driver behind all of our transformation and improvement initiatives. We are pleased that the ethos of the NHS Long Term Plan is firmly reflected in our own vision. Our vision is informed by the Joint Health and Wellbeing Strategies of our two authorities Kent County Council and Medway Council*.

In Kent and Medway, we want to create a population where people are supported to live well and stay well, recognising that our health is impacted by everything around us – our living environment, our working environment, our families and communities – and that good health is a combination of good physical health, good mental health and our overall wellbeing. We want to create vibrant, strong communities where people support one another across the generations.

Over the summer of 2019, our Sustainability and Transformation Partnership has been working across the Kent and Medway system with staff, clinicians and our population to develop this five year Strategy Delivery Plan. Our Plan sets out the strategic objectives and priorities for Kent and Medway and how we will implement the NHS Long Term Plan locally. The Long Term Plan itself was developed with extensive engagement of the people who know best what needs to change – with staff and patients from across the county.

Delivering this plan over the next five years and beyond requires significant investment, some of which will come from dedicated Long Term Plan funding and some of which will need to be met from our baseline funding. This requires us to make decisions about what to do when. This task will continue beyond the publication of this plan and will be tackled as part of each year's operational and financial planning. We also have a significant need for capital investment and will continue to work closely with national bodies on how this requirement will be met.

*https://www.kent.gov.uk/__data/assets/pdf_file/0014/12407/Joint-health-and-wellbeing-strategy.pdf https://www.medway.gov.uk/.../2369/health_and_wellbeing_strategy_2012.pdf

Introduction continued

Our approach to developing this plan

The Kent and Medway Strategy Delivery Plan 19/20-23/24 has been developed in collaboration with a wide network of local experts from across health and social care. Every stage of its creation has been clinically led, with contributions from a range of GPs and clinical specialists. Our system wide STP Clinical and Professional Board have provided input to the plan at their meetings in August, September and October. Additionally, we have utilised a range of system forums and boards to discuss and develop the proposals in this plan (see right).

Whilst this is a Kent and Medway level plan setting out system level ambitions, work has been performed with colleagues in our localities to ensure the plans are locally owned. We have brought together clinicians, commissioners, service managers and finance professionals to discuss the proposals as they have developed and to ensure that they are underpinned by realistic finance and workforce assumptions.

The plan builds on the progress and achievements of the Kent & Medway Sustainability and Transformation Partnership over the past three years, recognising that we have already made significant progress in areas such as the plans for reconfiguration of stroke services to improve outcomes for people who have had a stroke, the East Kent transformation programme to develop a system for East Kent that will consistently deliver high quality care into the future, collective commitment across all partners to implement more joined up care closer to home in 'Local Care', fewer people smoking than ever before, and improved performance against cancer waiting standards. Our plan builds on this strong foundation, using the NHS Long Term Plan as a helpful framework against which to review our progress to date and to identify additional areas of focus.

System forums involved in the development of this plan

Health and Wellbeing Boards
STP Non-Executive Directors Oversight Group
STP/ICS Partnership Board
STP Clinical and Professional Board
STP Finance Group
STP Patient and Public Advisory Group
CCG Governing Bodies
Provider Boards
Local Care Board
Primary Care Board
Digital Workstream Group
Dementia Improvement Board
Cancer Strategy Delivery Group
Joint Committee of CCGs for Cancer
Joint Committee of CCGs for Stroke
Mental Health Improvement Board
Local A&E Delivery Boards
Prevention Workstream Group
Local Maternity System Board
Diabetes Oversight Group Board
Workforce Board
HR Directors Group

Most importantly of all, we have held four engagement events across Kent and Medway to discuss our NHS Long Term Plan response and test our thinking with the public, as well as undertaking targeted engagement activity on specific priority areas, including surveys and focus groups with seldom-heard groups. As well as these events, we have conducted staff briefings, and discussed the plan as it progresses with wider stakeholders, for example district and borough councils, MPs, and Health and Wellbeing Boards for Kent and Medway.

Introduction continued

Implementing this strategy delivery plan

Delivering through our new Integrated Care System framework

We will become an Integrated Care System by 2021 which will enable us to go further and faster in areas such as making decisions collectively and driving integration. In September 2019, our Clinical Commissioning Groups unanimously agreed to merge to become a single CCG across Kent and Medway in a move which will enable a focus on improving population health, commissioning at scale, and removing unwarranted variation. The merger was approved by NHS England and NHS Improvement on 21st October 2019.

Our Integrated Care Partnerships, comprising Primary Care Networks, will be empowered to design and deliver their local services in a way that achieves improved outcomes for local people. Our Primary Care Networks are bringing together GP practices and developing expanded primary care teams to build a resilient primary care for the future and provide more community based care.

This new way of organising ourselves, to drive integration and a focus on population health, is a very different landscape. We recognise that the governance arrangements of the Sustainability and Transformation Partnership need to change as we move to become an Integrated Care System with a more formal set of structures than have existed under the STP. We will initiate a governance review working with system partners on the principles to guide the development of options and recommendations for ICS governance, including the arrangements for clinical and patient representation, accountabilities for quality governance, patient safety and outcomes. We will need to look at the accountabilities that should reside with Integrated Care Partnerships (ICPs) and the accountability relationship between the single CCG and the ICPs.

Keeping our strategy live

In Kent and Medway, we believe it is important that this strategy remains a live, dynamic process. This Strategy Delivery Plan has been prepared according to a national timetable for all systems across England to prepare five year plans in response to the national NHS Long Term Plan by Autumn 2019. We recognise that the contents of this plan reflect a point in time and that the coming year will see significant change for Kent and Medway as we make further strides in becoming an Integrated Care System, including the planned merger of our CCGs by April 2020, accelerated development of our four Integrated Care Partnerships and the bedding down of our 42 Primary Care Networks (PCNs). We have developed a Primary Care Strategy led by Primary Care professionals and we recently held our first conference of the Clinical Directors of the 42 PCNs. Over the next 6 to 12 months our ICPs and PCNs will develop considerably in their leadership and working arrangements including partnership working.

As such, we are proposing to develop a refreshed vision for our Integrated Care System in spring/summer 2020. This will be part of a wider Organisational Development programme which we will start to implement now to support us in the changes we need to make to become an Integrated Care System by 2021. We will also need to produce a commissioning strategy for the new Kent and Medway single CCG. Additionally, our ICPs will be developing, for the first time, their operational plans in early 2020. Consequently, we intend to launch a new ICS vision in spring/summer 2020 that will build on all of the work to date but will look further ahead to the next five to ten years. Our strategic objectives and priorities will be further refined as we develop a Kent and Medway Population Health Outcomes Framework. In light of all this, we aim to develop a Strategy Delivery Plan refresh in late 2020. This refresh will take account of any additional targeted funding awarded to Kent and Medway to support the implementation of the Long Term Plan.

We will monitor whether the priorities and actions set out in this plan are having the intended impact on our patients and our population. We will identify the interventions which have greatest impact and we will ensure that they are implemented across our geography.

Section two

Summary of our Strategy Delivery Plan

Needs of our population

In summer 2019, Kent County Council and Medway Council jointly produced a Kent and Medway Health Needs Assessment, the results of which have directly informed the setting of priorities in this plan. We have unacceptable differences across Kent and Medway in the underlying drivers of poor health (such as smoking and obesity) which results in health inequalities. There is a clear link between health inequalities and deprivation and that as a system we need to do more to tackle deprivation.

Causes of preventable ill-health

Smoking - 15% of people in Kent and 14.7% of people in Medway smoke, which is higher than the national average.
Obesity – Obesity is rising and directly contributes to many serious illness, such as diabetes. In Medway, obesity levels are higher than the national average for both adults and reception year children. While in Kent, levels are similar to the national average, we have high levels of obesity in Thanet and Dover.
Alcohol and substance misuse –There are an estimated 17,053 dependent drinkers across Kent and Medway, approximately 378,000 adults who drink more than 14 units a week, contrary to department of health guidelines, and approximately 7000 opiate and/or crack cocaine users. Rates of death and harm linked to alcohol and substance misuse are generally higher in areas of deprivation

Major health conditions

Smoking, obesity and alcohol and substance misuse directly impact on the levels of death and disability caused by major health conditions such as cardiovascular disease, stroke and diabetes.

- The estimated prevalence of *cardiovascular disease* in K&M is lower than the national average but it is still a significant cause of disability
- There are at least 123,000 people with diabetes of which around 90% are adults with *type 2 diabetes* which is amenable to actions on diet and physical activity
- *Stroke* prevalence is around the national average although rates are higher in some areas. Stroke is the largest cause of severe disability
- Rates of *respiratory disease* are generally lower than national average but we have pockets where under 75s mortality due to respiratory disease is significantly higher – in Dover, Thanet, Swale and Medway
- The number of people over the age of 65 with a diagnosis of *dementia* in Kent and Medway is estimated to be 23,375, with 14,298 (61.17%) having a confirmed diagnosis. Some dementia is preventable, with good management of cardiovascular health.

To improve the health of our population against these major conditions, our plan includes both preventative actions and targeted interventions delivered in Primary Care aimed at people at high risk.

In 2017, 4,893 people died from *cancer* in Kent and Medway, accounting for 29% of all deaths and 40% of deaths for under 65s. Over recent years, cancer mortality rates for Medway have remained consistently higher than the England average. While mortality rates in Kent are in line with national average, they have been increasing in recent years. There is more to be done on prevention, screening, and earlier diagnosis. Continued action on smoking, diet and physical activity will reducing the risks of developing specific types of cancer including lung and colon cancer.

Multi-morbidity and frailty

Approximately 20% of the Kent and Medway population have more than one long term condition, known as ‘multi-morbidity’, rising to 40% in over 50s and 70% in over 85s. There is a strong link between multi-morbidity and deprivation, with around 21% of people living in the most deprived areas having multiple conditions compared to 16% in the most affluent areas.

People with multiple conditions are more likely to become frail – and frailty doesn’t just affect the elderly. Identifying frailty risk early enables earlier intervention and maximises quality of life and independence.

In Kent & Medway, we are taking a population health approach to managing the overlap between frailty and multi-morbidity by identifying people at risk and supporting them with integrated multi-disciplinary teams.

Needs of our population

Mental health

We all have mental health and we will all experience challenges with our mental health at some point in our lives. Since 2014, rates of severe depression have increased in Kent and Medway and suicide rates are higher than both the national average and regional neighbours, particularly in men. The co-existence of mental health problems like depression or anxiety with other problems such as obesity, smoking, alcohol misuse and poor self-care is also increasing. People with severe mental health illness are more likely to have a physical health condition and die on average 15 years earlier than people with no mental illness.

There is an urgent need to take a population health approach to looking after the mental health and emotional wellbeing of our population. We need targeted action on expanding services and ensuring that people can access the right support. We need to focus on improving the physical health of people with mental illness and recognise that good health is a combination of physical health, mental health and wellbeing.

Dementia

Currently, only just over 61% of individuals over the age of 65 in Kent and Medway suspected to have dementia have a diagnosis. We need to ensure that people receive a timely diagnosis and receive the appropriate support to ensure they remain as independent as possible, for as long as possible.

Healthy start in life

Obesity in pregnancy, low birth weight and rates of breastfeeding are amongst some of the most relevant issues in Kent and Medway where we could have a positive impact on giving babies a healthier start in life.

One in five pregnant women in Kent and one in four pregnant women in Medway were obese in 2017, a 1% and 2% increase from 2015. 3% of pregnant women in K&M were morbidly obese.

Low birth weight is associated with a number of different factors, one of which is smoking. While the rate of smoking in pregnancy has been falling, there is more to do to reduce from the current rate of 14.2% to the Local Maternity System (LMS) target of 6% by 2022.

- Rates of breastfeeding in the first 48 hours of life differ significantly across Kent and Medway, with Maidstone and Tunbridge Wells NHS Trust reporting highest rates and Dartford and Gravesham NHS Trust reporting the lowest.

Children and young people

There are a wide range of needs for children in Kent and Medway:

- Around 13% of children and young people aged 5 to 19 years are estimated to have a mental health condition and there is particular concern for looked after children
- 1 in 5 primary school children are obese or overweight
- The rate of teenage pregnancies is above regional average
- Children in early years do not have adequate vaccination coverage
- The number of children with life-limiting conditions has increased in recent years, while the rate of deaths is declining owing to advances in diagnosis and care. The need for palliative and end of life care is growing year on year
- Rate of children with SEN type autism is higher than national average
- Rate of children and adults with SEND, LD or autism receiving physical health checks varies significantly across Kent and Medwayand this unwarranted variation must be reduced
- In early 2019, Ofsted and the Care Quality Commission (CQC) conducted a joint inspection of services for children and young people in Kent with special educational needs and/or disabilities (SEND) which identified a number of weaknesses. Kent County Council and the NHS are committed to working together to address these weaknesses

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Summary of our population needs

What people have told us

In developing our plan we have drawn on extensive previous engagement with local people, as well as carrying out specific and targeted engagement activity to inform the development of the strategic priorities set out in this document. You can read all about these events in our Strategy Delivery Plan Engagement Document. In summary terms, here are main things that local people want to see in their services:

For prevention

- Helping people improve their health and make healthier lifestyle choices
- Recognising and tackling the wider determinants of health
- Making the most of community resources to improve health and wellbeing

For mental health

- Improving quality and how care is organised, including communication between different services and with patients
- Making it easier to access care, including improving awareness among all NHS staff and having more mental health staff in front-line services
- NHS, schools, employers and councils and communities working together to raise awareness of mental health problems and to improve mental health and wellbeing

For Dementia

- Better information about post diagnostic services, activities and carer support
- Better access to technology that could give reminders and provide additional security and peace of mind
- Access to a wider range of activities and activities which are aimed specifically at men

For cancer

- Improving how cancer services are currently organised
- Getting a quick referral and diagnosis
- Communication within the NHS and with patients and their families, and raising awareness to support earlier diagnosis and help prevent cancer

For primary and community based care

- Getting enough of the right staff, with the right skills in primary and community care
- Making it easier to access the right care quickly and close to home
- Making sure primary and local care is well planned, consistent and joined up

For children and young people

- Improving current services and communication within the NHS and with social care
- Working with parents, families and schools to raise awareness of and prevent mental health problems and to better support children with mental health needs
- Taking a more proactive approach to targeting families who don't take up vaccinations, working with them to understand and overcome concerns

For digital transformation

- Encouraging and helping people to use digital technology, including NHS staff, where appropriate, without losing face to face contact
- Making better use of digital technology to improve health and quality of care
- Making better use of digital technology to connect different health and care services

Our system challenges

Geographical and demographic challenges

Kent and Medway is a large geographical area (1,368 square miles) including many towns, villages and rural areas, surrounded on three aspects by water and in close proximity to London. The county has a very long coastline particularly in the south and east of the county; and more urban and light industrial towns in the north and west. It is a major transitory route for the continent through the port of Dover and the Channel Tunnel in Folkestone. Transport across the county can be challenging both by road and public transport. We have pockets of high levels of deprivation, particularly in our coastal areas and in parts of Medway, driving significant differences in health outcomes as referenced earlier in our description of population needs. Close proximity to London has an impact on our ability to recruit and retain staff. Adopting a range of approaches to tackle this and to make K&M a great place to live, work and to learn is a pivotal strand of our Workforce Transformation Strategy (see right for more detail on workforce challenges).

The population of Kent and Medway in 2018 was estimated to be approximately 1.85 million people, an increase of 0.8% from the previous year. Most of this growth was from the Kent area, where growth was higher than both the national average and that of the South East. The population is expected to increase to 2.1 million by 2031 with local authority housing forecasts indicating that some 178,600 housing units are planned by 2031. In north Kent, there will be significant concentrated population growth from the Ebbsfleet Healthy New Town, with 15,000 new homes including a high number of young families. Whilst the significant population growth in Kent increases demand for services, it also provides an opportunity to recruit and train more people in health and care skills.

As with the rest of England, we also have an ageing population. The number of older people is growing quickly. Growth in the number of over 65s is over four times greater than those under 65; an ageing population means increasing demand for health and social care, for example, there are currently around 14,000 people living with dementia in K&M.

Workforce challenges

It is recognised by national regulators that Kent and Medway has some of the most difficult workforce challenges across the South East and that we have made significant progress since the inception of the Kent and Medway STP to tackle these issues. We have developed a system wide Workforce Transformation Strategy and underpinning the Strategy is a set of plans for short, medium and long term solutions, recognising that growing future workforce supply to the numbers required is a long term endeavour.

We have shortages in general practice that are amongst the worst in the country. This is exacerbated by the age profile of our staff with 25% of GPs and 55% of general practice nurses approaching retirement. Transforming out of hospital care including implementing new models of community based care is a significant strand of our long term strategy and this will require us to address challenges in community staffing including in community nursing and Allied Health Professionals. We have shortages of key mental health professional workforce including psychiatrists and nurses. There are specific concerns in relation to the cancer workforce required by 2022 including specific gaps in gastroenterology, histopathology, and clinical and diagnostic radiology. There are shortages of skilled social care workforce providing direct care and support in our local communities, with over half of all vacancies in Kent and Medway being within social care. These shortages can directly impact the quality of care that is provided to patients as well as increasing the workload and strain for our staff.

We are tackling our workforce challenges through implementation of a system wide strategy, working at a system level on areas best addressed collectively (for example, by promoting life long careers and attracting young people into health and care professions) as well as working at an organisational level on targeted local recruitment, retention and best place to work schemes aligned to system wide principles. We will adopt system ways of working to ensure that all components of the system work together collaboratively to grow our workforce for the future.

https://www.kent.gov.uk/data/assets/pdf_file/0018/80145/GIF-Framework-full-document.pdf

Our system challenges

Acute services sustainability

Across Kent and Medway we have a number of structural challenges with how our services are organised and delivered which can impact the quality of our services. Resolving these structural challenges is also the key to long term clinical and financial sustainability of our services, alongside actions to build the workforce for the future and to deliver streamlined and efficient services.

These challenges need to be addressed in a phased approach and our first clinical priority has been to implement a new model for **stroke services** in response to our providers continuously struggling to meet quality standards. Following a review of services in 2014, a proposal was developed to establish a network of hyper acute stroke units and acute stroke units operating 24 hours a day, 7 days a week. This change will mean that more people survive a stroke and, for those who have had a stroke, improved quality of life and independence. Over the next five years, we will look at the case for change for other specialist services, starting with vascular services. Our goal will be to identify where services are not consistently delivering high quality care, to assess the case for change and to develop a set of options for change which will be rigorously analysed and subjected to engagement with our population.

At a place level, the delivery of services in **East Kent** is not sustainable. In 2016, clinicians and leaders in East Kent published a case for change setting out the reasons why change is needed – long waits to see a GP, long waits in A&E, challenges with attracting and retaining enough staff to deliver services and the need to deliver services differently moving more care closer to home. Our East Kent transformation programme was established to steer the work to develop new models of care in East Kent and a series of options for the future configuration of urgent, emergency and acute medical care. Through an appraisal process, this has resulted in the shortlisting of two potential options that propose using our hospitals differently in the future to improve standards, with a single centre for specialist services and separating planned and emergency care, to benefit both types of services. This will be subject to formal consultation before a final decision is made.

The capital requirements in East Kent are a pressing cause for concern, with significant backlog maintenance to ensure that conditions for patients and staff are safe and appropriate. Regardless of which option is the confirmed option, the issues of the current hospital estate will need to be addressed.

The implementation of **Local Care** has been continuing at pace in East Kent and this will be a key part of the solution for East Kent; under either option. Local Care teams are providing joined up, personalised care close to home which focuses on keeping people well, avoiding unnecessary hospital admissions, and maintaining wellness and independence.

Whilst we do not believe major service reconfiguration is required in the same way as is being pursued in East Kent, in our other areas – West Kent, Medway & Swale, Dartford, Gravesham and Swanley – we need to conduct a needs assessment of the services that require more networking between acute providers or consolidation in order to ensure services are sustainable and able to deliver the best outcomes. In Medway and Swale specifically, we will utilise the newly formed Integrated Care Partnership to look at the clinical and financial viability of services into the longer term.

You can read more about our approach to challenges of acute services sustainability in Section 3

Our system challenges

Diagnostic services

Improving diagnostics in healthcare is a global objective of effective healthcare systems. We need to continuously improve how quickly and accurately we diagnose conditions and illnesses. In Kent and Medway, we have particular challenges affecting our diagnostics capacity and processes associated with both workforce challenges and availability of diagnostic equipment.

In particular, shortages of radiologists impact our diagnostic services. However, our broader workforce challenges impact the availability of our consultants and other clinical professionals to support diagnostics.

There are examples across K&M of patients requiring diagnostic support via an emergency admission but not being able to access an MRI, CT or ultrasound in the evenings/weekends as well as long waits for particular types of investigations such as neurological investigations.

In East Kent, our transformation programme is tackling challenges of access to diagnostics. This will also need to be considered as part of the work that needs to be undertaken in other parts of the county as we look at the need to network services between hospitals or to consolidate provision of services. Additionally, within our cancer programme we are implementing a range of improvements to support early diagnosis.

However, the work on diagnostics now needs to span beyond East Kent and cancer to a wider diagnostics review that will encompass both a speciality view and a geographical view.

Options will need to include consideration of networked models as well as the potential major diagnostic centre in the Kent and Medway geography. Digital will need to play a significant role in the transformation of diagnostic services, with increasing levels of automation to speed up processes and free up staff time as well increased use of artificial intelligence to support earlier and more accurate diagnosis.

Quality challenges

All of the challenges described - workforce, acute system sustainability and diagnostics – are all inextricably linked and all compound to affect the quality of our services at times. Quality services are services that are safe, effective, and provide as positive a patient experience as possible.

Two of the acute trusts have been in special measures for quality in recent years and as a system we struggle to meet the constitutional targets of A&E four hour waiting times, cancer waiting times, and 18 week referral to treatment standard. Some of our acute trusts still report higher than expected cases of MRSA and C difficile. Many of our patients receive excellent care, but there are also examples of where care has fallen short of the required standard. It is this variation in quality of care that our five year plan will tackle.

Despite support and continued improvement projects, the quality of care across the Kent and Medway geography remains challenged. The only solution is to work together as a system to enhance the care for our population in relation to both prevention and intervention and prioritise the development of new models of care to keep people well for longer.

We also know that we need a greater focus on recognised Quality Improvement methodologies and a cultural change in the way we approach improvement. Quality Improvement must be at the heart of system and organisational culture, with a focus on identifying the root causes of issues, improving processes, measuring and sustaining that improvement.

Our system challenges

Financial position and investment

Delivering this plan requires significant investment, some of which will come from dedicated Long Term Plan funding and some of which will need to be met from our baseline funding. This requires us to make decisions about what to do when. This task will continue beyond the publication of this plan and will be tackled as part of each year's operational and financial planning.

Kent and Medway is a financially challenged system, and as previously described in this chapter, some of the key reasons for this include growing demand for services combined with how some of our services are currently configured. By ensuring that our services are both clinically and financially sustainable we will drive a route to long term financial balance. Additionally, we also know that there are significant opportunities for productivity and efficiency across Kent and Medway, for example, in pathology, back office functions and our use of temporary staffing. In terms of care delivery, by reducing unwarranted variation and streamlining care pathways to remove unnecessary delays we will both improve patient outcomes and experience while also releasing valuable staff time to reinvest in the improvements set out in this plan.

You can read about more about our approach to driving efficiency and productivity in section 5.

We have a significant need for capital investment. Whilst we are doing all that we can to utilise existing estate and to move care closer to home, there remain instances where we will require new buildings and where we need to maintain our current buildings. The investment required for the East Kent transformation and to implement our Local Care model of care closer to home is a significant element of our capital requirement. We will continue to work with national bodies as to how this requirement will be met to support delivery of this plan.

You can read about our estates strategy in section 6.

Our five strategic objectives

To meet the needs of our population and to address our system challenges we will focus on five strategic objectives:

What our K&M Health Needs Assessment says

- **Cancer** is the number one cause of premature death
- **Cardio Vascular Disease** is the biggest cause of disability
- **Stroke** is the single largest cause of complex disability
- 90% of adults with **diabetes** have preventable type 2 diabetes
- Higher levels of **respiratory disease** in areas of deprivation
- **Frailty** and **multi-morbidity** are rising
- **Health inequalities** between most and least deprived areas

What people have told us they want to see

Prevention – healthier lifestyle choices

MH – quality and ease of access to services
Cancer – increased efforts to raise awareness to prevent and diagnose cancer earlier as well as quicker referral and diagnosis
Children and Young People – better support for children and young people with MH problems as well as improving vaccination rates
Primary and community care – easier access to the right staff and bringing care closer to home
Digital transformation –Better use of digital services to connect health and care services and improve health and quality of care.

Our system challenges

- Long coastline and proximity to London
- Workforce challenges particularly in primary care, social care, mental health and cancer
- Acute services sustainability challenges
- Quality challenges

1) **Improving care quality experience -** This strategic objective covers a wide range of delivery priorities including developing our ICS accountability framework for quality and *Delivering integrated care closer to home* (expanded primary care and community care services). We are *transforming urgent and emergency care* to ensure that A&E is only used for serious urgent care needs and emergencies. We also know that resolving a number of *structural challenges* that impact the clinical and financial sustainability of our services is critical. Lastly, this objective includes a number of *specific priorities to improve care and outcomes* for a number of clinical and service areas.

2) **An increased focus on population health and prevention -** This strategic objective includes developing our approach to population health management to improve overall population outcomes. Prevention will be embedded throughout the ICS and at the start of every care pathway. Our approach to prevention follows the life course as well as targeted actions on priority areas of smoking, obesity, alcohol, MH, health protection, cancer and other major conditions

3) **Driving financial balance, efficiency and productivity –** This strategic objective covers our actions to address our financial challenges including meeting the government's four tests for best use of taxpayers' investment in the NHS

4) **Transformation of our workforce and infrastructure –** This strategic objective starts with our Workforce Transformation Strategy and the actions being taken to address our workforce challenges. Digital transformation is a critical enabler to improving care quality and transformation and to providing the infrastructure to support population health management. Our estates strategy is aligned to our clinical strategies to deliver a fit for purpose estate for the future, with a significant capital requirement.

5) **A new Integrated Care System delivery model** – This strategic objective is about a new way of organising ourselves, in line with national policy, that will better enable integration of services, put an end to unwarranted variation and drive a focus on population health.

Our strategic planning framework

Our strategic planning framework has been informed by our STP programmes, the Kent and Medway Health Needs Assessment, listening to what local people want, and the national priorities as set out in the NHS Long Term Plan.

Principles cutting across our strategic objectives

- A relentless focus on driving out unwarranted clinical variation
- Adopting a 'health in all policies' approach across all partners in the development of new policies to consider the impact on population health
- Promoting self management, self care and citizen activation

Strategic objectives	1. Improving care quality and patient experience (Section 3 of this plan)	2. Increased focus on population health and prevention (Section 4 of this plan)	3. Driving financial balance, efficiency and productivity (Section 5 of this plan)	4. Transformation of our workforce and infrastructure (Section 6 of this plan)	5. A new integrated care system delivery model (Section 7 of this plan)
Delivery Priorities	• Implementing an ICS quality framework and quality priorities • Delivering more care outside of hospital including resilient primary care and community care • Addressing clinical and financial sustainability of acute services • Transforming urgent and emergency care • Transforming outpatients and ensuring timely planned care • Improving services and care outcomes for cancer, MH, maternity and neonatal, children and young people, LD and autism, stroke, CVD, diabetes, respiratory disease, end of life care	• Implementing population health management (PHM) including a K&M outcomes framework informed by this Strategy Delivery Plan • Developing capacity and capabilities for PHM • Embedding prevention throughout the system and in every pathway • Supporting more people to stop smoking and preventing children and young people from ever starting to smoke • Taking a place based approach to tackle obesity • Identifying people at risk of alcohol and substance misuse in the commnity and supporting them with targeted interventions • Tackling health inequalities at a place based level	• Deliver against financial trajectories for the 5 year period • Achieve success in bidding for targeted funding from national bodies to support the delivery of our plan • Deliver c12m productivity savings in 19/20 • Continue to explore opportunities to delivery productivity savings of c£53-90m by 23/24 through areas such as: ○ Continued implementation of best practice processes *(GIRFT, Right Care, Model hospital)* ○ Delivering a single pathology service for Kent & Medway ○ Developing a collaborative 'bank' for medical and nursing staff across K&M	• Implementing the K&M Workforce Transformation Strategy • A step change in digitally enabled care including online guidance to support self-care • Creating the infrastructure to enable integrated datasets • Implementation of the K&M Shared Care Record • Completing and implementing the K&M analytics strategy • Delivery of our K&M estates strategy including success in national bidding rounds for funding	• A system commissioner to commission at scale and drive a focus on population health • Development of Integrated Care Partnerships to deliver high quality integrated care and tackle local health inequalities • Development of Primary Care Networks to create a resilient primary care and expanded community care delivering personalised anticipatory care • Development of innovation, research, and quality improvement • Expanded joint working between the NHS, local authorities, voluntary sector, and wider partners

By doing all of this we will achieve for the population:

- Increase in healthy life expectancy
- Improved wellbeing and resilience
- Reduced health inequalities

Our priorities for the population of Kent and Medway by 2023/24

By delivering the priorities across our five strategic objectives, we will deliver improved outcomes and benefits for the population. The below is a set of priorities for the population that have been identified through the development of this plan. This will be supplemented with a K&M Population Health Outcomes Framework to be developed in early 2020. *Please note that the below is not exhaustive and does not cover all of the benefits and outcomes described in this plan – you will find these within individual chapters.*

A good start in life for babies, children and young people

- Less than 6% of women will smoke during pregnancy
- Increased breastfeeding rates by providing more support for more wom en who choose to breastfeed and through promotion of benefits
- Some 2000 women will receive perinatal MH support
- Increase vaccination uptake
- Around 16,000 children and young people accessing mental health services
- Reduced gap in rates of obesity for reception year children between the most and least deprived areas
- Reduced waiting times for children and their families for autism spectrum disorder assessments
- Children with complex needs will be supported by a community based multi-disciplinary team

Good health and wellbeing for working age adults

- Even more people will have received psychological therapies for common MH problems (c60,000)
- A reduction in the age incidence of stroke
- More people will survive stroke and those who do will have better quality of life and independence
- Around 6,500 people will have been supported by the Diabetes Prevention Programme
- A lower rate of diabetic complications
- A lower rate of premature mortality and disability from CVD
- Less than 12% of population will smoke
- A reduced gap in obesity levels between the most and least areas
- More people will be supported by Alcohol Care Teams

Good health and wellbeing for people who are frail and/or have multiple conditions conditions

- More people with complex needs (including people with MH conditions and people with complex LD or autism) will have been supported by a multi-disciplinary team, supporting them to stay well
- Some 30,000 people will have benefited from a social prescribing referral
- At least 30,000 people will have benefited from a care and support plan
- Incidence of falls in older people and frail people will reduce
- Reducing levels of premature mortality for people with mental health conditions and for people with LD or autism
- More people with LD or autism will receive community based care
- More people will receive a timely diagnosis for dementia and be guided to the right care and support
- Nearly 80% of people with LD and autism will have had a physical health check

Across our population

- c61% of cancers will be diagnosed earlier at stages 1 and 2 leading to more people surviving cancer
- 70% to 100% of our general hospitals with a major ED will have liaison psychiatry services in place to support people with a mental health need
- Following a successful Mental Health Wellbeing campaign, more people will know their 'five a day' for the mind
- More people will report that they feel comfortable discussing mental health and that they have been able to access the right services through a 'no wrong door' approach
- Suicide will reduce by 10%
- More people will have received urgent care and advice outside of A&E settings
- Almost all of our population will have been able to access online consultations
- Carers will report they feel better supported by a range of different resources

Our strengths and opportunity areas

We have set strategic objectives and priorities to address our challenges and the needs of our population. It is important to recognise that in delivering on our strategic objectives and priorities, we will build and capitalise on our key strengths and achievements including:

- Our GP leaders unanimously voting to merge our existing CCGs to create a single CCG across K&M to commission at scale, put an end to unwarranted variation and drive population health management
- Our ambitious and driven Primary Care Network clinical directors
- Our commitment to meeting the national investment standard in Mental Health and the progress in achieving parity of esteem between physical and mental health
- Our improved cancer performance for treating patients within 62 days of referral, taking us to the second best performing cancer alliance in the country for this standard.
- Our commitment to embedding prevention throughout the ICS and in every pathway
- Our work on the Kent Integrated Dataset which has enabled us to develop a detailed understanding of our population
- Our track record of coming together to agree future direction, for example, our collective commitment to the Local Care model and our Primary Care strategy owned and led by Primary Care professionals
- Our track record of partnership working with the STP comprising over 19 partnership organisations – see slide 98 for list of members

As we continue to implement our strategic objectives and priorities, we will actively target themes where we know that there are opportunities to be further exploited including:

- Further development of our long term digital strategy including the role that digital will play in transforming how people look after their health and wellbeing and in transforming how care is delivered and experienced. We recognise that we have many pockets of innovation and excellence across Kent and Medway. We now need to develop a long term strategy which drives consistent application of high impact digital tools and solutions
- A greater focus on identifying and spreading innovation, irrespective of which part of the system is the instigator. This will be reliant on the ability to evaluate impact effectively and to adopt a change management model which enables innovation to be swiftly implemented and spread
- Further integration of our primary and community care strategies via joined up implementation plans, with a focus on the overall population health outcomes to be achieved
- Further integration of mental health services into our care models for prevention, PCN working and community based care, urgent and emergency care and planned care – this will ensure that mental services are not seen and experienced as standalone services but are integrated with services for physical health
- A focus on developing capacity and capability for quality improvement within our Integrated Care Partnerships, including Primary Care Networks, such that we continuously improve our care delivery
- Opportunities to ‘build for health and wellbeing’ from the outset in the context of Ebbslfeet Healthy New Town. This exciting development provides opportunities to innovate and to learn from this experience for the wider benefit of Kent and Medway.

These areas will be revisited as part of our strategy refresh in 2020

Section Three

Strategic Objective 1) – Improving care quality and patient experience

Section Three

Strategic Objective 1) – Improving care quality and patient experience

Our approach to quality

Strategic Objective 1) – Improving care quality and patient experience

Our approach to quality

A single national definition of what we mean by 'quality' was first introduced following Lord Darzi's review of the NHS in 2008/09 - care that is safe, clinically effective, and that provides as positive an experience for patients as possible. All three dimensions must be present to deliver a high quality service. This is the definition adopted in Kent & Medway.

Developing a system approach to quality

We are developing an ICS quality framework to enable organisations to have a common definition and approach to quality, with shared and aligned programmes to achieve quality improvement and prevent duplication. This chapter sets out the guiding principles to the approach whilst the strategy is developed across the ICS. The quality framework will be overseen by the Kent and Medway Clinical and Professional Board.

A significant step in system working for quality is the establishment of a new Nursing and Clinical forum to bring together the senior nursing leaders from providers, commissioners and education across Kent and Medway. The forum is currently defining its purpose but aims to provide nursing and clinical advice and guidance to the Clinical and Professional Board. The forum will provide strategic direction to areas such as workforce and quality strategy as well as supporting the transitional arrangements and developments as the system establishes an Integrated Care System and Integrated Care Partnerships. This strategy recognises that Primary Care Networks (PCNs) are at differing levels of maturity and therefore the quality support offered needs to flex and be tailored to their individual needs. An Allied Health Professional Cabinet has also been set up to look at the priorities across AHP disciplines.

Our proposed strategic quality priorities for the next five years

- We will implement new ICS governance arrangements for quality assurance which will include safeguarding,Infection prevention and control (IPC) and patient safety
- We will invest in developing our capacity and capabilities for quality improvement across the system, utilising recognised Qi methodologies to continually drive improvement
- We will further develop our quality framework to increase the focus on early warning signs
- We will work both within and across ICPs to support quality improvement by learning from complaints and incidents and to identify and spread good practice
- We will invest in developing our workforce, introducing new roles as well as ensuring a culture that allows the leaders of the future to be identified, developed and supported to achieve

Strategic Objective 1) – Improving care quality and patient experience

Our approach to quality continued

K&M Quality Priorities for 19/20 and 20/21

The below priorities have been developed and signed off the Nursing and Clinical Forum:

- To ensure clinical quality, leadership and accountability are clearly understood across all commissioned services
- To ensure mechanisms are in place and working well to provide assurance on the quality of all commissioned services, ensuring local needs and variations are addressed
- To promote an open and transparent culture between commissioners and provider organisations across each ICP and the ICS to identify and implement areas of best practice and learning
- To support the care sector improving the quality of care delivered
- To ensure that people have a positive and safe experience of care and that the individual is at the centre of care
- To ensure that a competent workforce is in place to deliver the transformations both in and out of hospital
- To reduce variation in all aspects of quality including outcomes related to premature deaths in both physical and mental health settings
- To ensure robust Quality Assurance and Improvement Framework developed to support emerging Primary Care networks and new models of care

As a result of adopting the Darzi definition of quality, our priorities are necessarily broad and span areas outside of the scope of traditional CCG quality functions. Delivering on these quality principles will require actions from functions and organisations across the system; in particular there is a significant role for digital transformation and workforce transformation to drive quality. Our ICPs will need to be at the forefront of driving continuous improvement in services and using evidence and data effectively.

Safety

In order to achieve our priorities we will need to ensure that we foster a standardised process across the system in safeguarding, care planning, investigating and quality assurance to reduce risk to patients and enable comparison of themes, trends and promote shared learning. Providers across K&M have described the following areas for action to directly improve clinical outcomes:

- Reducing falls, ensuring the 3 high impact interventions are carried out
- Reducing the number of pressure ulcers that are acquired whilst under our care
- Ensuring nutritional assessments are embedded reducing concerns and incidents relating to nutrition and hydration optimising health for recovery

In addition there are work streams across providers aimed at

- Ensuring that healthcare associated infections are reduced, including the prescribing and management of antibiotics and promoting good antimicrobial stewardship
- Prioritising the reduction to the length of stay and support the prevention of re admissions
- Improved quality of care for the deteriorating patient, promoting early recognition, response and appropriate escalation in all areas of care; including the sepsis pathway. All stakeholders in the systems are working to create a safety culture that embraces ‘lessons learned’ and recognises human factors that influence clinical practice and decision making. In order to achieve this there will need to be good governance and peer review of serious incidents to seek assurance that learning has embedded, by reviewing progress of completion and effectiveness of actions. Primary care will be support to adopt safety tools such as ECLIPSE live and PINCER.
- We will ensure Quality Impact/Combined Impact assessments are completed and reviewed when implementing change including monitoring of potential risks.

Strategic Objective 1) – Improving care quality and patient experience

Our approach to quality continued

Safety continued

- Develop digital ways of working to improve the interoperability between the systems to ensure seamless data sharing which will support more time to care and reduce risk (see digital chapter)
- Support leadership and quality development in the care sector
- Deliver the Kent and Medway workforce Plan as an integral part of safety

Actions to ensure compliance with National Patient Safety Strategy

The strategy aims to commit to a continuous improvement of person/ patient safety by building on the foundations of a patient safety culture and patient safety system. This includes the delivery of three strategic aims: Insight, Involvement and Improvement.
We will:

- Provide leadership to local systems and within 5 years we will have created a coalition of resources to support the ICPs to have developed, implemented plans and evaluated outcomes aligned with the NHS Long Term Plan. This will include leadership support to the care sector
- Set the ambition for delivering the strategy locally to ensure alignment with regional priorities and have delivered these within the 5 years
- Ensure the establishment of acute trust-based medical examiner scrutiny of all deaths in acute hospitals by April 2020, and all deaths by April 2021
- all deaths in acute settings are scrutinised by medical examiners by
- Support work with the emerging PCNs to develop their role in safety improvement, with a fully matured system within 5 years
- Ensure that delivery of the strategy achieves the right balance between assurance and improvement within ICP and Care settings.
- Encourage uptake of the new patient safety curriculum and training with this being fully embedded within 5 years
- Encourage the implementation of early warning systems and within 5 years have an established system that recognises these and is able to respond to prevent poor quality
- Incorporate insights from pilot site systems into plans to implement the awaited Patient Safety Incident Response Framework (PSIRF) by summer 2021
- Improve patient involvement in patient safety by ensuring that patient representatives are members of safety-related committees throughout the system by April 2021

At a strategic level the system commissioner will:

- Support STP/ICS across Kent and Medway to implement features of the NHS Patient Safety Strategy with it being fully embedded by 21/22
- Share learning within and across the systems including non-NHS providers and the Care Sector; escalating concerns from PSIRF

The system commissioner will work with regulators to:

- Encourage contribution to the patient safety specialist network
- Deliver the Patient Safety Improvement programme through the improvement programmes for maternity and neonatal safety, medicines safety and mental health safety improvement programme
- Support the replacement of the National Reporting and Learning System (NRLS) and Strategic Executive Information System (StEIS) with the new Patient Safety Management System (PSIMS) by March 2021

Strategic Objective 1) – Improving care quality and patient experience

Our approach to Quality continued

Effectiveness

To ensure that care is effective we will need to continue to work to improve the flow of patients through whichever pathway of care best meets their needs, with effective and seamless transfer and care across and between providers, delivering timely and safe treatment through both emergency and planned pathways. There will need to be continued work to reduce mortality rates; improve the care and treatment patients receive following a stroke and to see this reflected in the published national data (HSMR, SHIMI, SSNAP).There will be work to develop and expand shared care protocols and improved drug monitoring, including medicines management in the care sector.

To improve outcomes for women and babies the achievement of the Better Births agenda will be prioritised and the outcomes monitored. So that the system is better enabled to identify and evidence improvements in outcomes of care, quality improvement methodologies and digital solutions will be adopted.

Experience

We will ensure that there are excellent public and patient engagement plans to improve the way we engage and receive feedback from patients ensuring vulnerable groups and those with complex needs are given the opportunity to respond. The intelligence gathered from all groups will be utilised in the co-design and co-production of patient pathways across the system through the use of the ESTHER philosophy as set out in the Workforce plan.

To directly improve the experience for the person /patients we will:

- Improve the transition of care for children and young people to adult services
- Ensure timely decision making for the provision of End of Life Care
- Make personalised care a priority, including consent and capacity assessments to ensure collaborative decision making and the use of ESTHER cafes to include the person's experience in MDTs, risk assessment, and focus on the patients' needs
- To support the experience for patients we will ensure that staff feel valued through good staff engagement and appraisals and learning from new models of care. We will support the development of staff to strengthen the NHS, social care and care sector pool of talent, develop new and enhanced roles to improve pathways of care and raise staff morale and encourage retention and progression. It is our aim to improve the staff survey results to reflect that staff want to work for the NHS, social care and the care sector and for organisations to be recognised as outstanding employers

Strategic Objective 1) – Improving care quality and patient experience

Quality Governance

As we transition towards a system commissioner as part of the ICS with four ICPs across Kent and Medway, the current governance arrangements will need to develop. Specific attention is being given how the care sector and non-NHS providers are involved and represented, they are part of the emerging quality structures of all four ICPs. Recruitment to a single Chief Nurse across the system commissioner will commence following the appointment of the Accountable Officer in late 2019. This post will be crucial to the design and development of the new governance arrangements.

The Nursing and Clinical and Professional forum will be instrumental in identifying the appropriate soft and hard intelligence required to develop datasets, dashboards, thresholds and statistical analysis tools that are used across the system. It is envisaged that the current routes for quality escalation of concerns to the K&M Quality Surveillance Group will be replaced with a quality oversight group which will include all key stakeholders will review emerging safety concerns.

Safeguarding teams across K&M are working collaboratively across the ICS footprint to ensure there is sufficient expert capacity to effectively safeguard both children and adults. The collaborative approach to safeguarding is delivered through each member of the team leading on portfolios that align to national safeguarding directives, legislative requirements and local need.

Operational safeguarding will be delivered from within the ICPs (including the PCNs and Social Care) achieving the frontline objectives of the Kent and Medway Boards & Partnerships, providing performance, audit & experiential data as evidence of achievement & sustainability.

Designated nurses/professionals within the system commissioner will provide a strategic overview of the safeguarding governance of the ICPs and provide a valuable expert resource to the system and partners to ensure that learning is shared and that national programmes are appropriately delivered at the local level. External scrutiny will be achieved through the national safeguarding team and the local safeguarding boards and partnerships.

Quality assurance

We will take an approach to quality assurance that focuses on an objective overview of how well the whole system operates in order to prioritise activity and identify gaps, weaknesses and strengths against known risks. This approach, embedded in a culture of mutual respect, will allow partners to hold each other to account on the evidence available, and support the ongoing development of a culture of constructive challenge and improvement. Benchmarking tools and audits will be used to help identify areas for improvement.

By adopting the “Three Line of Defence” methodology used in a range of national and local assurance models, our approach focuses on developing assurance across partnerships that supports the management of risk and provides an understanding of both the operational delivery of services and the effectiveness of the system in meeting the needs of our population.

This methodology will provide a balance between the frontline, the organisational and the system oversight, using early warning indicators and a dashboard to help us to identify and track good or poor system performance and focus on new issues or risks. Success and the impact will be measured against defined outcome measures which will be developed during 2020/21.

Strategic Objective 1) – Improving care quality and patient experience

Quality Assurance continued

The **first** tier of assurance will take place at the local ICP operational level, coming from those delivering the frontline services, assuring that performance is monitored, risks identified and addressed, and objectives are achieved.

- Development of dashboards that incorporate an early warning mechanism
- System/peer assurance process, shared quality committee process
- Agreed escalation process and threshold
- Consistency of approach (policy, process, procedure) within the system
- ICP and safeguarding quality forums
- Care Sector Registered Managers Network to develop quality improvement mechanisms supported by the Design and Learning Centre (DLC) Learning
- Hub feeding back into the Local Workforce Action Board.

The **second** tier of assurance will be at a strategic level via the Clinical Commissioning Group and giving an overview of the activity and quality of care being delivered to the population, including that care is delivered in line with set expectations and standards.

- Agreed system quality metrics and KPIs
- Adapted QSG approach to strategic system assurance
- Consistency of approach (policy, process, procedure) across ICPs
- Agreed escalation process and threshold

The **third** tier of assurance will be of an independent nature and will provide assurance of the whole system, highlighting gaps, weaknesses and strengths. This assurance approach will be in development during 2019/20 and fully embedded in 2020/21

Quality Improvement

There is commitment across our system to embed quality improvement in how we manage change, and organisations have trained staff in a variety of complementary methodologies including Quality, Service Improvement and Redesign (QSIR), Lean / Six Sigma, Dartmouth Clinical Microsystems, and General Practice Improvement Leaders (GPIL).

As we develop our integrated care system we will build on this capacity and capability across all settings of health and social care, ensuring that more people are trained and empowered to take forward these evidence-based approaches to continuous improvement.

Embedding QI is a critical part of the development of our ICPs, where we aim to build teams that can support this work across their locality with a range of skills including data and analysis, change management and quality improvement. The care model framework set out in our clinical and professional vision takes exactly this approach, starting with understanding the needs of a particular cohort, designing and testing interventions to meet these needs, and evaluating the impact. These approaches will help us address our unwarranted variation alongside programmes such as GIRFT and RightCare.

The impact of any planned service change or improvement will be assessed by the application of a Combined Impact Assessment. This tool, which will be agreed for use across Kent and Medway, will combine an assessment on quality alongside our obligations under the Equality Act (2010) to undertake impact assessments against the protected characteristics.

Section three

Strategic Objective 1) – Improving care quality and patient experience

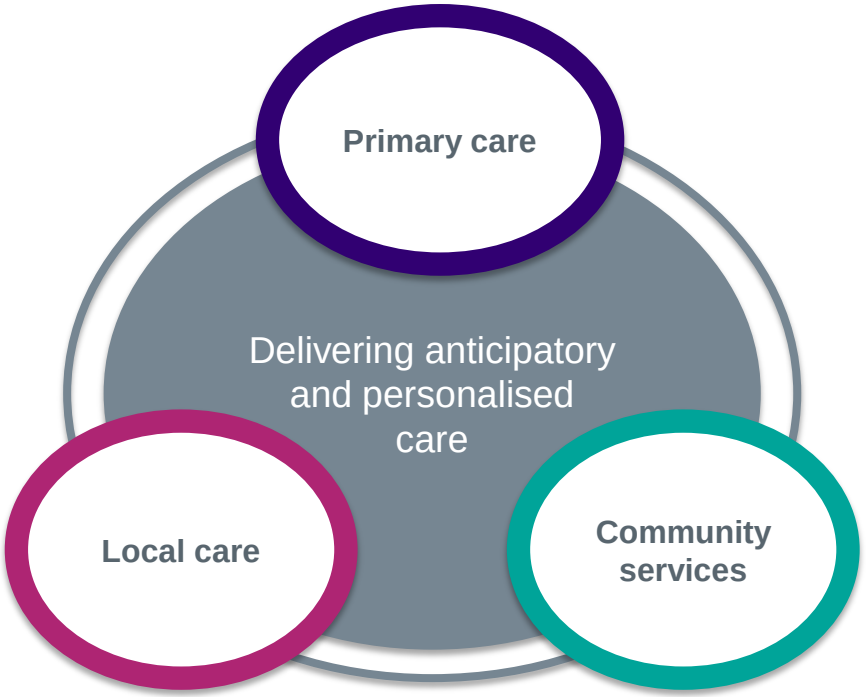
A new model of integrated care closer to home

Strategic Objective 1) – Improving care quality and patient experience

A new model of integrated care closer to home

Primary and community based care

Our approach to transforming out of hospital and expanding primary and community based care is made up of three strands: building a resilient Primary Care, implementing our Local Care model of multi-disciplinary team working and investing in our Community services. None of these areas are exclusive of the others and over time we see the boundaries between these areas blurring even further. We are organising ourselves around the person and their needs, rather than around organisations and services. By bringing together all of these strands in how we deliver care, we will deliver care that is more anticipatory and personalised. We are implementing specific initiatives to support personalised care, in line with national policy, but personalised care in Kent and Medway is a consistent ethos that underpins our strategies and plans for primary care, wider community services and Local Care – and indeed more broadly across all of the clinical and service areas outlined in this plan. It means focusing on the whole person and their needs and goals, focusing on 'total health' - physical health, mental health and wellbeing, supporting people to look after their health and wellbeing, and empowering people in decisions about their health and care. By doing this, we will fundamentally change patient experience and long term outcomes. The creation of a single CCG across Kent and Medway will create further opportunities to strengthen the delivery of personalised care through new commissioning strategies.



Primary Care – We are investing in primary care through delivery of our primary care strategy, including strengthening core general practice, and the development of 42 Primary Care Networks across K&M, implementing new roles and digitally innovations to meet our workforce challenges. Over time, PCNs will take on increasing responsibilities for improving the overall health of local populations

Community services – We are investing in community services to ensure that more people receive the right care they need at home with multi-disciplinary teams providing crisis response and reablement. We are rolling out the renowned Buurtzorg model of self-managed teams, proven to focus on the needs of the patient

Local Care - We are completing the roll out of MDTs for adults and older people with complex needs across Kent and Medway, utilising the successful MDT principles we have developed locally. MDTs span competences from across health, social care and voluntary sector. Over the next five years, we will roll out MDT working for children with complex needs, people with co-occurring conditions, and for people with learning disabilities and autism.

Mental health support and services span all strands, however, we recognise that we have more to do to integrate our mental health pathways and ensure 'no wrong door' for access MH support or services.

Strategic Objective 1) – Improving care quality and patient experience

A new model of integrated care closer to home

Primary and community based care

One of the five major practical changes set out in the NHS Long Term Plan is to "boost out-of-hospital care, and finally dissolve the historic divide between primary and community health services." The 2016 Kent & Medway Case for Change set out the challenges facing out-of-hospital care, including:

- 30% of patients in acute hospital beds would be better looked after in an alternative setting
- 12% of admissions through A&E are avoidable through more consistent decision making at the front door, or through better health and social care provision in the community
- 25% of community hospital patients would be better cared for at home or in other community setting
- There is wide variation in whether people would recommend their GP practice to a friend – between 68% and 84% (national average 78%)

The 2018 Case for Change refresh supported this stating, 'that a priority area for focus is avoiding hospital admissions for people with long term conditions and supporting their carers'.

Additionally, we know that primary care is the bedrock of out of hospital care and that we have significant workforce challenges in primary care in K&M. Our shortages in GPs are amongst the worst in the country and we have a significant volume of GPs approaching retirement.

This has led to the dedicated establishment of programmes across Kent and Medway for Primary Care and Local Care**.**

Our primary care strategy

We have undertaken significant engagement and co-design to develop a single primary care strategy for Kent and Medway, led in partnership with the Kent Local Medical Committee. This strategy is owned by primary care, including our new PCN Clinical Directors, with a commitment from all partners to ensure that we deliver it.

Our vision for primary care is to have healthy people, happy communities, and valued colleagues. We have set out what we hope primary care will look like in five years time, and a realistic set of phased improvement priorities over the next five years to achieve this. We have undertaken detailed work to understand the affordability of these and where we need to make further investment as a system to deliver them.

Our priority themes are based on what we heard from primary care:

- Care redesign for patients and communities
- Workforce and workload
- Digital
- Estates
- Finance and contracts
- Communications and engagement
- Primary care networks
- Measurable implementation plans

You can read more in our Primary Care Strategy

Strategic Objective 1) – Improving care quality and patient experience

A new model of integrated care closer to home continued

Primary and community based care continued

Development of primary care networks

Our development of primary care networks (PCNs) begins with stabilising core general practice, the bedrock of PCNs, and this is a focus in our primary care strategy. It then builds on what local areas have already been doing to support primary care at scale – we are not starting from scratch. Building successful PCNs means creating expanded primary and community care teams. As part of our primary care strategy, we have co-designed a consistent support offer for our PCNs. This is being coordinated centrally but delivered locally, maximising the resource that we already have in the system.

In September 2019 we brought all of our PCN Clinical Directors together to discuss this support offer, their development, and allocation of the PCN Development Funding that we have been given as a system. These Clinical Directors have also contributed directly to the phasing of priorities for primary and local care. Our PCN development offer builds on the national maturity matrix and will enable everyone working in a PCN to be able to do four things:

- Take care of you e.g. personal leadership development
- Take care of your colleagues e.g. developing effective teams
- Take care of your community e.g. care transformation projects, population health management
- Get the basics right e.g. IT, governance, financial flows

Our commitment to additional investment in primary and local care means that PCNs will be able to access significant support to put them in the best position to deliver all of the national requirements across the next five years, as well as work in partnership across their ICP on our wider ambitions for local care and improved population health.

As they evolve, ICPs are working with their PCNs to develop plans for what can be done in partnership, which includes the involvement of community providers. This year, we have allocated funding to PCNs for three things:

- Clinical Director leadership development: we are excited by the number of new leaders who have chosen to step up as Clinical Directors, and will ensure they get significant individual support to develop in these roles. In addition to funding, Clinical Directors have access to support from our Training Hubs who are running dedicated programmes, as well as coaching and mentoring
- Primary care network development: every PCN has received some funding for development and delivery of a local plan that helps build network maturity, backed by dedicated support from local CCG teams. We have not been prescriptive on what we expect from these plans, allowing networks the freedom and headspace to work on local priorities in partnership
- Service improvement projects: in 19/20 we are focusing on improving data quality and coding to enable PCNs to have an accurate baseline for improvement. In addition to this, we are providing access to support from central teams trained in quality improvement methodology. Through this we will build the capacity and capability to run service improvement projects targeted at improving on system priorities where we know we have significant unwarranted variation; or targeted at areas that will put PCNs in a stronger position to deliver the new service specifications

Our PCN leaders are visionary and ambitious, however we must recognise that there is a gap between what they are currently able to deliver with the resources and time that they have had available, and the much wider five year vision. More funding is part of the solution, but is not the only thing we need to do to bridge this gap. In partnership with the Kent Local Medical Committee (LMC), we will continue to provide backfill to release clinical time for all of our Clinical Directors to come together and work with us on designing the future.

Strategic Objective 1) – Improving care quality and patient experience

A new model of integrated care closer to home continued

Primary and community based care continued

Our Local Care model

Our Local Care model has been the cornerstone of our STP since its creation. Our Multi Disciplinary Team (MDT) model of personalised care ensures that the needs and preferences of the individual are honoured for optimal functional health and quality of life. We have been rolling out MDTs across Kent & Medway for adults and older people with complex needs and frailty, aligned to the 42 Primary Care Networks. Our agreed 'MDT Framework for Primary Care Networks ensures consistency and quality of the delivery of personalised care across all 42 PCNs.

Some considerable engagement with a range of stakeholders has led to the development of eight key interventions which will deliver holistic personalised care, and align to the national Universal Personalised Care agenda:

- Care and support planning with community navigation and case management
- Self-care and management
- Healthy living environment
- MDTs, integrated coordinated as close to home as possible
- Single point of access
- Rapid response
- Discharge planning and reablement
- Access to expert opinion and timely access to diagnostics

By doing this, we are intending to have a positive impact on the following:

- Unnecessary A&E attendances and patient admissions
- Reducing long length of stay
- Positive outcomes for patient activation, independence and wellbeing

We have made significant progress on this ambition and have MDTs in place within each PCN to deliver integrated health and care services close to where people live. This is something we must continue to drive; integrated working at scale and pace to make personalised care the norm.

Over the next five years we will deliver an integrated health and social care model of personalised care to all frail elderly patients and adults with complex needs that focuses on delivering high quality, outcome-focused, person centred, coordinated care that is easy to access and that enables people to stay well and live independently for as long as possible in their home setting.

We will transform local services to deliver proactive care and support, focused on promoting health and wellness rather than care and support that is solely reactive to ill health. Core to the model of care is the philosophy of health and care services working together to promote and support independence, utilising statutory, voluntary and, where appropriate, independent sector services to deliver the right care, in the right place, at the right time.

Over the next five years the MDT approach will expand to provide services for children with complex needs and people with learning disabilities and autism. These MDTs will include a broader range of staff than those already in place, be aligned to the PCNs and comprise of staff working across health, local authority, voluntary and care sectors.

Extensive engagement has been undertaken across the system to develop an agreed 'MDT Framework for Primary Care Networks', including links to our 'top tips' for MDT working.

Strategic Objective 1) – Improving care quality and patient experience

A new model of integrated care closer to home continued

Primary and community based care continued

Our Local Care model

The Multi-Disciplinary Team (MDT)

The concept is to prevent duplication from multiple services, prevent the patient having to repeat themselves, to co-ordinate the patient's care, to put the patient at the very centre of their care, to identify any unmet need gaps and work as a team to address the patient in a cohesive way.

The patient is at the **centre of the plan of care** and is involved in the decision making process and the planning of their anticipatory **care management plan**.

Social prescribing

About 30% of the referrals from the MDT meetings are for social prescribing, as a way to improve outcomes for people; keeping people well, independent and resilient by connecting them to community based support, services, resources and assets. Across K&M we have agreed a set of principles for rolling out social prescribing and community- based support to meet the needs of local populations. We are developing a business case for a single IT platform to facilitate better coordination of social prescribing.

By 23/24 some 30,000 people will have benefited from a social prescribing referral.

Care planning

Our model of integrated case management (ICM) supports shared decision making and care planning. The focus is to drive personalisation, help people to maintain independence, provide care closer to home and build community resilience. Our ICM approach aims to build relationships between health and social care professionals to improve health and wellbeing outcomes for patients at high risk of future emergency admission to hospital.

ICM is initially aimed at the top 3% of the population with the highest risk stratification scoring or severe frailty. The service aims to reduce unnecessary hospital admissions, reduce avoidable A&E attendance, and facilitates early discharge from in-patient beds.

By 23/24, at least 30,000 people will have benefited from a care and support plan

Strategic Objective 1) – Improving care quality and patient experience

A new model of integrated care closer to home continued

Primary and community based care continued

While our Local Care model is the heart of out of hospital services, there is a significant transformation agenda taking place within community services more broadly.

Of note is our implementation of the Buurtzorg model of care. Founded in the Netherlands in 2006/07, Buurtzorg is a unique district nursing system and involves small teams of nursing staff and other community staff providing a range of personal, social and clinical care to people in their own homes in a particular neighbourhood. The model has garnered international acclaim for being entirely nurse-led with both the RCN and The King's Fund welcoming the remarkable success of the Buurtzorg model. A significant reason why Buurtzorg has managed to provide excellent patient-centred care been due to its approach of putting patient self-management at the heart of its operation.

The model focuses on personalisation; it starts from the patient perspective, and works outwards to create solutions that enable improved independence and quality of life. The model empowers individuals and encourages self-reliance. There's an emphasis on small teams of staff working with each individual and their families and carers to access all the resources available in their social networks and neighbourhood to support them to be more independent. The nursing teams have a flat management structure, working in 'non-hierarchical self-managed' teams. This means they make all the clinical and operational decisions themselves. Aspects of the Buurtzorg model are in stark contrast to historical provision in England where 'health' and 'social care' have typically been provided by two entirely separate teams. People requiring care at home are often seen by multiple staff members on a given day and may not see the same care worker or nurse again. The Buurtzorg model provides continuity of staffing.

The types of benefits to patients of this care model include increased levels of wellbeing and independence ; more confidence to self care with less reliance on health and social care services. Patients feel more empowered, supported and reassured through continuity of staff and wider engagement with their local communities.

The types of benefits to staff include higher levels of job satisfaction through deeper more meaningful relationships with both patients and colleagues as well as a sense of trust, autonomy and control.

Kent County Council, Kent Community Health NHS Trust and Medway Community Healthcare are now implementing the Buurtzorg model across Kent and Medway through the Transforming Integrated Community Care (TICC) project, a four year health and Europe research project that that aims tocreate systemic change in health & social care, providing services better suited to our ageing population and addressing holistic needs.

TICC will enable us to implement new ideas and practice quickly; increase staff productivity, recruitment, retention creating a blueprint for successful transfer of social innovative service models in health and social care from one country to another benefitting all public/private services. We have an ambitious roll out plan across the County starting with our test and learn community nursing team s in Ashford, Charing, Edenbridge and Medway and a domiciliary-care led team of occupational therapists, enablement support and care workers based in the Ashford town area.

Strategic Objective 1) – Improving care quality and patient experience

A new model of integrated care closer to home continued

Primary and community based care continued

Key progress to date

Significant progress has been made across K&M in the delivery of our local care model to support all 42 PCNs; with each one having an aligned multi-disciplinary team, working to deliver integrated case management, for adults with complex needs and frailty. To date, all are achieving their agreed trajectories of personalised anticipatory care plans, helping individuals to stay well and supported in the community.

To augment this 'Frailty Pathways' have been developed including bespoke frailty units to support 'hot frailty clinics' for step up step down crisis care; we are working with our NHSE/I lead to ensure links with the reconfiguration of 111 in terms of a seamless crisis response and single point of access.

Consistency in delivery and quality

For 2019/20 we have an agreed deliverables framework for local care. Across local and primary care we are presently working on an aligned outcomes framework.

Our 'Primary Care Strategy' has been well received, having been co-designed with primary care colleagues. It also includes an agreed support offer for PCN development.

To ensure consistency and quality we have worked with key stakeholders across the system to develop an 'MDT Standards Framework for PCNs', including 'top-tips' for MDTs, which we have now shared both locally and nationally (mentioned on page 28).

We have also agreed a K&M 'Quality Standard' for Primary Care; a set of consistent local enhanced services for key delivery priorities.

Social prescribing

There has been an additional investment of £15m, across health and local authority into social prescribing in 2019/20. There is a collective agreement, longer term, to align contracts and link with the new social prescribing posts within each PCN.
To support this we have agreed to move to a full business case for the provision of one social prescribing platform across K&M.

Supporting carers

This has also been a key focus and we have engaged a wide range of stakeholders to co-design an 'app' to support anyone in a caring role (paid or unpaid); building on the award winning 'Stop Look Care' booklet from Brighton and Hove CCG. Stage 1 of the development provides the fundamental elements in caring for someone and also how to access support for the individuals who care. Stage 2 will provide a comprehensive directory of services and access for on-line training resources, free of charge, to all care agencies.
We are pleased the app is in the final stages of the NHS Digital Pathfinder programme, hoping for national roll out.

Sharing learning

To date we have hosted two K&M wide conferences for local care in 2018 and 2019 (the 2019 conference was attended by 200 people across 45 different health and care organisations). We also held a K&M wide conference for PCN Clinical Directors in September 2019 to co-design our support offer to PCNs.

Strategic Objective 1) – Improving care quality and patient experience

A new model of integrated care closer to home continued

Transforming urgent and emergency care

Nationally, and across Kent and Medway (K&M), we have an urgent and emergency care (UEC) system under significant pressure, but also one in the midst of profound change. The Long Term Plan sets out actions to ensure patients get the care they need, fast, and to relieve pressure on Emergency Departments (ED) New service channels such as Urgent Treatment Centres (UTCs) are being designated across England.

For those that do need hospital care, emergency admissions are increasingly being treated through same day emergency care (SDEC) without need for an overnight stay. This model will be rolled out across all acute hospitals and nationally the ambition is to increase the proportion of acute admissions typically discharged on day of attendance from a fifth to a third. Building on hospitals' success in improving outcomes for major trauma, stroke and other critical illnesses conditions, new clinical standards will ensure patients with the most serious emergencies get the best possible care. In partnership with local councils' further action to cut delayed hospital discharges will help free up pressure on hospital beds.

In Kent and Medway, delivery against the four hour A&E standard is challenged. We have a specific set of priorities for transforming UEC (see right) that are complimented by our work to create a resilient primary care for the future and to implement our Local Care model. The transformation of UEC in Kent and Medway is dependent on all of these transformations coming together in a whole system approach to materially change how and where patients receive care. This level of change will take time to realise its full impact and is affected by the scale of workforce challenges across K&M. However, we are making good progress and our plans are supported by national bodies.

Urgent and Emergency Care will be led by the four Local A&E Delivery Boards (LAEDBs) geographically based around the four Integrated Care Partnerships in Kent.

Our strategic priorities for UEC are:

- **Urgent Treatment Centres (UTCs)** that are primary care led, open at least 12 hours per day every day, offering appointments that can be booked through 111 or GP referral, and are equipped to diagnose and deal with the most common ailments for which people attend ED
- **High Intensity User (HIU) services** will support patients who frequently attend A&E to resolve the reasons for their attendances, linking in with existing networks of support service including those from the third sector
- **Same Day Emergency Care (SDEC) units** will support each ED by providing rapid assessment and care to allow the majority of patients to return home the same day
- **Reducing delayed transfers of care (DTOC) and length of stay (LOS)** – improved hospital flow will have a positive impact on ED. Ensuring appropriate LOS and avoiding DTOCs involves a multi-faceted, system wide approach, working with primary care, community care and local authorities
- **Quality improvement initiatives in ED** aimed at streamlining processes and ensuring good access to expert opinion and diagnostics. Additionally, quality improvement initiatives aimed at improving flow throughout a hospital can help to release clinician time to support ED.
- **Embed a single multidisciplinary Clinical Assessment Service** within the newly commissioned 111 service to provide specialist services from a range of different professionals, encompassing physical and mental health
- **Developing our emergency care pathways for Mental Health**, including alternatives to ED such as crisis cafes and sanctuaries

Taking these actions will stem the rising increase in demand in EDs and ensure that EDs deliver safe and effective services, however, as a system it will remain challenging to consistently meet the four hour waiting standard over the five year period.

Strategic Objective 1) – Improving care quality and patient experience

A new model of integrated care closer to home continued

Improving planned care

Delivery across Kent & Medway against the national referral to treatment time standard has been challenged through 2018-2019. Recruitment and retention of key clinical staff has been, and remains, a critical challenge.

Delivery of reduced waiting times and improved pathways of care are key priorities shared by all partners within Kent & Medway. Providers and commissioners are working together to achieve national Referral to Treatment (RTT) expectations and those outlined in the national Long Term Plan. Delivery in ICPs will be enabled by key shared work across workforce, digital development and estates. ICPs will agree jointly-owned demand and capacity plans, incorporating utilisation of Independent Sector (IS) capacity. Continuous improvement in Emergency and Non-Elective Care management across Kent will enable more effective, planned and reliable use of NHS and IS Elective Care capacity.

In this context, CCGs and Trusts in Kent & Medway have been increasingly looking to work more collaboratively using a mix of approaches. These have varied across ICPs, from using new contract models such as an Aligned Incentives Contract (AIC) or large-scale Prime Provider contracts, to developing joint plans between CCGs and providers for outpatient transformation. Local partners are continuing to use these contract models and plans to focus on redesign of whole clinical pathways, better use of technology and expansion of collaborative contract models that encourage joint working. All four ICP areas have plans, agreed by providers and the CCGs, focused on the key Elective Care aims across Kent & Medway:

- Improving performance against 18 week Referral to Treatment (RTT), including working towards the utilisation of capacity alerts and the delivery of the 26 week programme
- Reducing the inconsistencies
- Addressing workforce pressures
- Ensuring the application of the Kent and Medway Referral and Treatment criteria (RATC) is applied consistently across all providers

Aside from speciality specific approaches, there are three main areas where we are working as a system:

Workforce - In each ICP, providers will cease to compete with one another for key clinical staff but will act collaboratively. Furthermore, providers across the ICS will recruit on consistent rates for permanent, temporary and locum staff.
Transforming outpatients - ICPs are working with local providers to manage waiting lists through their Transforming Outpatients workstreams which have seen the introduction of a number of one stop shop approaches and an increase in non-face to face follow-up clinics to improve use of capacity. In support of this a number of telephone clinics, nurse led clinics and the introduction of virtual clinics utilising Skype and video technology have been introduced. ICPs will also look to maximise their approach to offering advice and guidance functionality.
Right Care and Getting It Right First Time (GIRFT) - All the ICP systems are working collaboratively to agree opportunities identified through these national programmes and through Outpatient Transformation projects to ensure that shared, jointly-owned delivery projects are established. The opportunities, areas of focus and projects are specific to ICPs. ICPs are reviewing speciality patient pathways across a spectrum of planned care areas including, Ear, Nose and Throat (ENT), Neurology, Urology, Gynaecology and Gastroenterology.

Despite taking these actions, our performance against referral to treatment times and diagnostic waiting times remains challenged over the five year period. We intend to re-cast our diagnostic waiting times projection as part of a dedicated diagnostics review across Kent and Medway, which will drive up performance. In terms of referral to treatment time, we will initiate further work at both a system and an ICP level to identify further local opportunities as well as system level opportunities to treat patients across ICP areas. This will require system level oversight and assurance to track delivery and impact of initiatives.

Section Three

Strategic Objective 1) – Improving care quality and patient experience

Acute services sustainability

Strategic Objective 1) – Improving care quality and patient experience

Acute services sustainability

East Kent Transformation Programme

We are working with our patients, public and other stakeholders to look at how we develop local care and options for changing the way our hospitals in east Kent are organised (covering a broad range of services including emergency care, planned care, outpatients). The four East Kent CCGs have delegated authority for taking forward the transformation programme to a joint committee, which is supported by a robust programme infrastructure. We are taking forward this change programme because:

- We know that the way that our acute hospitals in East Kent are set up makes it difficult to provide consistently good care. For example people spending too long waiting in A&E and waiting too long for treatment. The current configuration of services is also not financially sustainable. By making changes we can improve the quality of care and establish a more sustainable model of care.
- We also know many people, including complex elderly frail patients, are often treated in the acute hospital setting when their needs are better met in an alternative setting of care. Both data analysis and bed audits undertaken by clinical teams have identified that this could be as many as one in three acute hospital beds being used to support individuals whose needs could be met through an alternative care model.
- We expect GPs, community staff, mental health, social care and other professionals to be working together in local teams everywhere in East Kent to provide more joined-up care for people with complex health needs. This is facilitated by the development of Primary Care Networks and the East Kent Integrated Care Partnership. In terms of acute care, all three main hospitals in East Kent are equally important for future care and need to be used so they provide care by working together, not as separate entities.

In order to achieve this change, we identified a long list of possible options for the roles of the three hospitals and assessed these against hurdle criteria, which were developed with clinicians, patients and the public, and other stakeholders. This resulted in two options emerging for the reconfiguration of hospital services as a medium list:

- **Option 1:** A major emergency centre at the William Harvey Hospital in Ashford, an emergency centre at the Queen Elizabeth the Queen Mother Hospital in Margate, and an integrated care hospital at the Kent and Canterbury Hospital.
- **Option 2**: A major emergency centre at the Kent and Canterbury Hospital with the other two hospitals becoming integrated care hospitals

The detailed evaluation of the above two options is now in the process of being finalised. Both options were considered against five criteria:

- Clinical sustainability
- Accessibility
- Strategic fit
- Ease of implementation
- Financial sustainability.

The outcome of the evaluation will be presented to NHS England in a pre-consultation business case, seeking approval to move to public consultation in February. Ahead of submitting the business case, the proposal will be submitted in November to the South East Coast Clinical Senate for their consideration in order to inform NHS England's assurance process.

Strategic Objective 1) – Improving care quality and patient experience

Acute services sustainability

Stroke services

Kent and Medway providers have continuously struggled to meet the quality standards of the national Stroke Sentinel National Audit Programme (SSNAP). Most scores are below average and although there have been some improvements since June 2014, this has been slow and is inconsistent. This indicated a clear need to improve the quality of stroke care in Kent and Medway. We have significant challenges in workforce and our stroke services are not configured in line with evidence based national best practice.

The Kent and Medway Stroke Review was instigated in 2014 by local healthcare professionals, including senior doctors, nurses and care professionals. The national guidance for stroke states that the quality of a stroke unit is the single biggest factor that can improve a person's outcome following a stroke, and developing these is the main objective of the stroke review. Successful stroke units, both hyper-acute stroke units (HASUs) and acute stroke units (ASUs), are built around a stroke-skilled multi-disciplinary team that is able to meet the collective needs of the patient. The proposal was, therefore, to establish HASUs and ASUs operating 24 hours a day, 7 days a week, to care for all stroke patients across the Kent and Medway area. This will deliver many benefits for patients, most notably more people will survive stroke and have improved quality of life and independence.

Following the development of options, options appraisal and public consultation, the Joint Committee for stroke agreed that three HASU/ASUs would be established at Darent Valley Hospital, Maidstone Hospital and William Harvey Hospital. We are committed to the proposals agreed by the joint committee following consultation and we are endeavouring to implement these proposals as soon as possible, pending the outcome of legal challenges.

Acute services sustainability

Vascular

Approximately 13,000 patients in Kent and Medway receive vascular treatment each year, (about 2,600 specialised and 11,400 non-specialised) currently delivered by six hospitals, of which only two are specialised vascular centres providing the full range of complex vascular care.

The national standards state there should be 24-hour access to specialist care and a minimum catchment population of 800,000 to ensure doctors treat enough different types of vascular cases to remain expert. However, there is only a small pool of the specialist surgeons and interventional radiologists available and neither of our 2 vascular centres have sufficient skilled staff. Both centres serve a population of less than 800,000 as patients from Tunbridge Wells and Dartford, Gravesham and Swanley access services in London.

A long list of possible options has been considered for Vascular services in K&M. A clinical review of those options has been undertaken and the recommended option is for a single vascular arterial centre supported by other non arterial sites in K&M. The single arterial centre would be located at one of the two current vascular centres in east Kent and Medway.

Activity numbers are being finalised and will be presented to commissioners and the Joint Health Overview and Scrutiny Committee (JHOSC) A formal consultation is being planned for early 2020. This will also be linked to the wider reconfiguration work being undertaken in East Kent.

Section Three

Strategic Objective 1) – Improving care quality and patient experience

Delivering the NHS Long Term Plan in clinical and services areas

Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

Cancer

The NHS Long Term Plan sets two bold ambitions nationally for improving cancer outcomes – that by 2028:

- 55,000 more people each year will survive cancer for five years or more
- 75% of people will be diagnosed at an early stage (stage one or two)

In 2017, 4,893 people died from cancer in Kent and Medway. The mortality rate from all cancers has been falling over time locally and nationally. However, cancer remains the leading cause of premature death in Kent and Medway, accounting for 29% of all deaths and 40% of deaths in those aged under 65-years in 2017. There were 10,359 new cases of cancer registered in 2016/17, the majority of which were in people under 75 years of age. This is a 13.5% rise from 9,127 in 2011/12.

In Kent & Medway, our overall 1-year survival rate across all tumours is 71.7% which is below the national average, and our 5-year survival rate is 46.7% also below the national average (CADEAS, 2019). The key to improved survival rates is to diagnose cancer earlier and, in Kent and Medway, our current early stage diagnosis rate is 51.8% with the expectation nationally that we achieve 75% by 2028.

The Kent and Medway Cancer Alliance brings together clinicians and managers from health, social care and other services to transform the diagnosis, treatment and care for cancer patients. These partnerships enable care to be more effectively planned across local cancer pathways. In advance of the anticipated establishment of a single CCG from April 2020, our existing CCGs have set-up a joint committee of clinical commissioning groups (JCCCG) to make joint decisions. It is the publicly-accountable governance forum driving forward our collective strategy for improving cancer care and outcomes.

Since the first meeting of the Joint Committee in March 2018, the following progress and improvements have been made:

- Significant improvement with 62 day cancer performance across K&M – the Cancer Alliance position has moved from 19 out of 19 alliances to 2nd out of 19 alliances for the latest reported month August 2019 (83.8%)
- Progress with implementation of streamlined diagnostic pathways in line with national recommendations for lung, colorectal and prostate Cancer which means patients are getting diagnosed faster
- Initiated a pilot in Dartford in July 2019 to support patients presenting with vague and indeterminant symptoms accessing diagnostic tests quicker
- In partnership with the South East London Cancer Alliance, we are working to improve cross-boundary issues and tertiary referrals to ensure safer and faster diagnosis for patients in the transfers of care
- As a result of the alignment of the STP with the Cancer Alliance, we have established a clear reporting and governance structure to ensure that timely decisions and clinical priorities are discussed appropriately
- Focused work with clinicians in our priority Tumour Site Specific Groups (TSSGs) to streamline patient pathways and improve services for our patients
- Agreed stratified pathway protocols for breast, prostate and colorectal cancer to support the personalised care agenda

Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

Cancer continued

Our strategic priorities for improving cancer care and outcomes are:

- Prevention – as over half of cancers can be prevented, prevention is a critical focus of our cancer strategy, with a focus on smoking prevention, diet, obesity, alcohol consumption, and HPV vaccination
- Screening – we will focus on increased uptake of screening programmes to support early diagnosis, in particular bowel due to the current variation across our CCG geographies and the strong evidence base that early diagnosis of bowel cancer has a significant impact on survival rates
- Earlier and faster diagnosis – we have a multi-faceted approach including awareness campaigns, a primary care education strategy, reviewing and improving our diagnostic service provision (for both cancer and diagnostics broadly, recognising that issues with diagnostics do not just impact patients with cancer but with a wide range of conditions).
- Treatment and care – our strategy includes a number of strands to ensure that patients can access appropriate and specialist treatment, including specialised surgical care available alongside modern radiotherapy and chemotherapy services
- Personalised care and support – we will ensure that all patients have access to personalised care including a care plan, access to health and wellbeing information and support, stratified pathways of care, and provision of psychological support

By 2023/24, Kent and Medway will have:

- Significantly increased uptake and coverage of the National Cancer Screening Programmes
- Networked Diagnostic Services for streamlined turnaround and reporting of tests
- Implemented the Faster Diagnosis Standard so that patients get a diagnosis of cancer within 28 days of referral by a GP (85%)
- Implemented Targeted Lung Health Checks based on national piloting and recommendations
- Established a Radiotherapy Network with colleagues at Guys & St Thomas's NHS Trust which has fully implemented the new national service specifications
- Ensured that all cancer patients will have access to personalised care, including needs assessment, a care plan and health and wellbeing support and provision
- Extensive genomic testing available to patients who are newly diagnosed with cancers
- Developed plans with ICPs to improve early cancer diagnosis of patients in their localities and significantly increased the number of people diagnosed at stages 1 & 2 – by 23/24 c61% of cancers will be diagnosed at stages 1 & 2

Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

Mental Health

We all have mental health and, just like our physical health, our mental health goes up and down over time. We experience different things in life, our circumstances change, and we move through different stages of life. In fact, over half of us will have a problem with mental health during our lifetime and about a quarter of us do at any one time. So, just like we look out for our body, we need to look out for our mind.

Common mental health problems, such as depression and anxiety, are increasing both nationally and here in Kent and Medway. The co-existence of mental health problems with other issues such as smoking and alcohol misuse is also increasing. People with a serious mental health illness die on average 25 years earlier than people without a mental illness.

Prevention, early diagnosis and support for children is essential, because half of all lifetime mental disorders start by the age of 14 and 75% by the mid-20s . Our work to help prevent MH problems in children and provide earlier diagnosis and support, needs to be linked to a wider set of actions on deprivation, adverse childhood events and other risk factors for MH problems in children. The NHS and education will need to work even more closely in the future, including mental health support teams in schools.

In Kent and Medway, specialist mental health services for adults and older people are delivered by Kent and Medway NHS and Social Care Partnership Trust (KMPT) and for children and young people by North East London NHS Foundation Trust (NELFT). Additionally, KCC and Medway Council provide MH social work and AMHP provision, as well as commissioned social care mental health services. We also have a range of IAPT providers and additional primary care mental health practitioners. These providers are coming together to form a K&M Mental Health Collaborative.

Since 2016, we have had in place a system programme for Mental Health within our Kent and Medway Sustainability and Transformation Partnership. This programme has focused on delivering the Five Year Forward View for Mental Health, promoting mental wellbeing, and integrating physical and mental health care. Our Mental Health Workstream Oversight Group meets monthly and comprises a wide range of partners including Healthwatch, CCG commissioners, Local Authority social care mental health and public health representatives, KMPT and NELFT.

Progresses and successes to date include:

- A reduction in the rate of death by suicide
- A higher than the national target number of CYP with a diagnosable mental illness accessing specialist mental health services
- We significantly expanded specialist community perinatal mental health services, serving pregnant women and new mums
- A higher than the national expected proportion of people recovered after receiving IAPT / primary care psychological therapies
- Nearly ¾ of people referred with suspected first episode of psychosis engaged with the Early Intervention in Psychosis service within two weeks of referral
- All adults who were acutely unwell were placed in local acute inpatient mental health beds, except women needing psychiatric intensive care
- All CCGs met the Mental Health Investment Standard for 2019/20
- We have secured so far in 2019/20 c£5m Central Transformation Funding for local community crisis care services, Liaison Mental Health Services, and schools-based Mental Health Support Teams

Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

Mental Health continued

Our Plan

We will support Kent and Medway's population to have good habits for looking after our minds as a normal part of living a healthy life. Where children, young people and adults have problems with their mental health or a mental health illness, we will ensure that the right mental health care is simple to access, close by. Our overriding principle for mental health support is 'no wrong door' – that staff across health and social care will feel comfortable talking to a person about mental health and be able to signpost to the right care and support.

We are taking up the big challenges to give mental health equal priority to physical health, address equity of health outcomes for people with a mental illness, reduce the treatment gap in mental health care, and have excellent mental health services.

Our strategic priorities are:

- Improving the mental health and wellbeing of the population including developing resilience – we will implement a Mental Health Wellbeing Campaign
- Ensuring 'no wrong door' for accessing mental health support – through partnership working and integration we will ensure that anyone who needs support for their mental health needs will be able to access it
- Developing a working collaborative of K&M Mental Health service providers to optimise the mental health contribution to PCNs and ICPs
- Developing and implementing a Mental Health Impact Assessment to carve mental wellbeing into local NHS policy, pathways redesign and complex change delivery at the outset
- Increasing the proportion of children and young children accessing timely support for their mental health or in relation to a mental illness
- Improving mental health service outcomes for young people aged 18-25 years
- Working to increase and sustain positive outcomes for people with common mental health illness
- Transforming core community mental health services so that people with lived experience report them as 'services without borders'
- Addressing the inequity in health outcomes for people with severe mental illness, especially targeted actions for improved physical health
- Enhancing urgent and emergency pathways for people with a mental illness, including community-based alternatives to A&E and more tailored NHS 111 and Ambulance services
- Ensuring that 75% to 100% of our general hospitals with an A&E department have on-site liaison mental health services that satisfy national 'Core 24' standards
- Improving dementia diagnosis rates and the range of services available to support people with dementia and their families and carers
- Increasing community support (including out of hours) to ensure that people with dementia can remain in their usual place of residence at a time of crisis. This will include support to care homes

To support the transformation of mental health services, CCG planned investment this year is £278m and will continue to meet Mental Health Investment Standard in future years.

Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

Maternity and neonatal

Giving babies and children a healthy start in life is one of our key priorities. Our approach to maternity and neonatal care includes a focus on prevention and promoting healthy behaviours, continuously improving neonatal care, and supporting women during pregnancy and beyond.

- The rate of smoking in pregnancy in Kent and Medway is 14.2%, with the aim to reduce this to 6% by 2022. Stopping smoking is the single most important change a woman can make to avoid unnecessary complications. Smoking in pregnancy is associated with a wide range of problems, including complications during labour, increased risk of stillbirth, miscarriage, premature birth, low birthweight and sudden unexpected death in infancy. It also increases the risk of infant mortality by 40%
- One in five pregnant women in Kent and one in four in Medway were obese in 2017, a 1% and 2% increase from 2015. Obesity during pregnancy impacts on the infant's weight in childhood and increases the infant's predisposition to type 2 diabetes in childhood
- Infant mortality has been decreasing in Kent and Medway over the past 15 years, however, over the last six years in Kent this has increased from 3.5 per 1000 to 3.8 per 1000 while rates in Medway remain unchanged at 3.7
- 1 in 3 women will experience urinary incontinence after childbirth, 1 in 10 faecal incontinence, and 1 in 12 pelvic organ prolapse. Physiotherapy is the most cost effective intervention for preventing and treating these conditions. There is a commitment across Kent and Medway to improve access to postnatal physiotherapy, ensuring that all women have access to multidisciplinary pelvic health clinics and clear referral pathways when required
- UK breastfeeding rates at 6-8 weeks compare unfavourably with other countries in Europe. In Kent and Medway we have variation in breastfeeding rates across the county. We will develop and implement a tailored breastfeeding strategy to ensure that women have the advice, information and support they need, when they need it, and ultimately improve local rates of breastfeeding initiation and continuation. Improving the UK's breastfeeding rates would have a profoundly positive impact on child health.

In February 2016 the national Better Births Maternity Review* set out a compelling future for maternity services: *we should work together across organisational boundaries in larger place-based systems to provide a service that is kind, professional and safe, offering women informed choice and a better experience by personalising their care*. Achieving this requires local leadership and action and this is achieved by commissioners, providers and service users coming together to create a Local Maternity System (LMS) to deliver local transformation. The LMS is a collaborative of organisations and partners. The LMS Maternity System Transformation plan has been approved by the NHSE Regional Team and was endorsed by the K&M STP prior to submission. In addition, the 0-25 Health and Wellbeing Board in Kent and the Health and Wellbeing Board in Medway also endorsed the plan as the respective Boards are committed to improving health in pregnancy and early childhood.

Our strategic priorities for the next five years are:

- Safer maternity care
- Tackling smoking in pregnancy
- Delivering continuity of carer
- Improving perinatal mental health services
- Access to maternity records and digital support

* https://www.england.nhs.uk/mat-transformation/

Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

Maternity and neonatal continued

Safer maternity care

The second version of the national care bundle includes a greater emphasis on continuous improvement and addresses variation by bringing together *five* key elements of care based on best available evidence and practice in order to help reduce stillbirth rates. The priorities for the Kent and Medway LMS are:

- Reducing smoking in pregnancy
- Risk assessment, prevention and surveillance of pregnancies at risk of foetal growth restriction (FGR)
- Raising awareness of reduced foetal movement (RFM)
- Effective foetal monitoring during labour
- Reducing preterm birth from 8% to 6% by 2025

There is significant commitment in this second version of the Saving Babies' Lives Care Bundle to meet the national ambition of 50% reduction in stillbirth, maternal mortality, neonatal mortality and serious brain injury and a reduction in preterm birth rate, from 8% to 6%, by 2025.

Smoking during pregnancy

The new Tobacco Control Plan 2017-2022 defines an ambition to achieve a 'tobacco free generation' by 2022. To realise this vision, we must harness our efforts to ensure babies and children are not exposed to tobacco use. The Tobacco Control Plan seeks to further reduce maternal smoking in England to 6% or less by 2022. Our work will involve working with Public Health colleagues and our STP Prevention Programme on smoking cessation during pregnancy. We will target interventions in communities with the highest maternal rates.

Delivering of continuity of carer

Continuity of carer is associated with significant improvements in the safety, personalisation and experience of maternity care including:

- Seven times more likely to be attended at birth by a known midwife
- 16% less likely to lose their baby and 19% less likely to lose their baby before 24 weeks.
- 24% less likely to experience pre-term birth
- 15% less likely to have regional analgesia and 16% less likely to have an episiotomy

In K&M, the LMS are working to ensure that most (>51%) women are receiving continuity of carer by March 2021. All Trusts are developing and implementing Continuity of Carer pathways.

Perinatal mental health services

The NHS Long Term Plan includes a commitment to establish Maternity Outreach Clinics to integrate maternity, reproductive health, and psychology therapy for women experiencing mental health difficulties. This community based model of care will compliment specialist inpatient services and psychological therapy services. The LMS in K&M is bidding to national bodies to be an early implementer for this new community based care. By 23/24, some 2,000 women will receive perinatal MH support.

Access to maternity records and digital support

Three of our four Trusts have received funding from NHS Digital to enable women access to their own maternity records. The LMS is funding the development of electronic personal health records at the remaining Trust to ensure that all women have this option. The LMS will be participating in work at the level of Kent, Surrey and Sussex clinical network to ensure that women are guided to a small number of recommended apps to form their digital toolkit. Via this toolkit, women will be able to express their choices and receive personalised care.

Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

Children and young people (CYP)

Across Kent and Medway, whilst there are some exemplar services in place for CYP, there is not yet an over-arching strategic plan for the commissioning and delivery of Children's Services. As a result, the level of service delivery and clinical/care outcomes vary considerably and are a material contributory factor to the inequalities children and young people experience across the county.

Current challenges

- The recent CQC/Ofsted Inspection of services for children with Special Educational Needs and Disabilities in Kent identified areas of significant weakness. Medway's inspection also identified similar challenges
- There is a high number of women who smoke during their pregnancy (13.8% in Kent and 17.1% in Medway)
- Children in their early years do not have adequate vaccination coverage
- 1 in 5 primary school children are obese or overweight
- The rate of teenage pregnancies is above the regional average in Kent and Medway
- Around 10% of children and young people have a mental health issue and there is a particular concern for looked after children
- 12% of children in Kent and 17% of children in Medway have a special educational need
- There is minimal local provision of cancer care and hospice care for children

Action taken to date

A Joint Committee of K&M CCG's has been established to oversee improvements. The Joint Committee supported the immediate priorities to oversee the delivery of the Kent and Medway SEND action plans including the imminent Medway re-inspection and to support the development a Kent and Medway multi-agency plan for Children and Young People (0-25). They recognised that this will identify further system priorities and will be developed in line with the Long Term Plan.

We have produced SEND Improvement Plans which are agreed with CQC and Ofsted which focus on 5 areas of improvement:

1. Parental confidence, engagement and coproduction
2. Inclusive practice, outcomes, progress and attainment of children and young people
3. Quality of education, health and care plans
4. Joint commissioning and governance
5. Service provision

Next Steps

The development of a system-wide priorities document by December 2019 which will describe system:

- Principles
- Priorities
- Strategic Aims and Objectives
- Success Measures

Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

Learning disabilities and autism

The rate of children with the autism in Kent and Medway is significantly higher than the England average. It is also higher than Kent's statistical neighbour Essex. The rate of children with ASD known to schools is 19.7 per 1,000 in Kent and 20.5 per 1,000 in Medway. The prevalence of the primary SEN type ASD is much greater amongst children and young people with SEN support (9.7 % in Kent, 5.7% in England) and amongst children and young people with an Educational Health Care Plan (EHCP) at 39.7% in Kent, and 28.2% in England. We also know that 24.5% of the 14-18 year olds with a Learning Disability are prescribed hypnotic medication without having a diagnosis of a serious mental health disorder and 15.7% are prescribed anti-psychotics.

In February 2018, an analysis of Autism & ADHD data confirmed, within the adult population of Kent, 14,600 people are estimated as being undiagnosed for Autism (7,118) and or ADHD (7,482). Medway data for these cohorts showed within the adult population of Medway 8,061 people are estimated as being undiagnosed for Autism (1,001) and or ADHD (7,060).

Kent & Medway adult's data evidences a significant undiagnosed population when compared to expected prevalence rates for this cohort. Therefore, the demand for adult diagnostic service provision is unlikely to diminish over the next 5-10 years.

Only around 40% of our learning disability population across Kent and Medway, registered with a GP and aged over 14, years are accessing annual health checks and for our adults, aged 19 and older, 20.8 % with a Learning Disability are prescribed a hypnotic without having a diagnosis of a serious mental health disorder and 25% prescribed anti-psychotics.

Our service model for LD & Autism

Commissioning

Learning Disability services for Kent and Medway have been commissioned via a Section 75 Partnership Agreements between all Kent CCGs and Kent County Council, and between Medway Council and Medway CCG. There is also an established Integrated Commissioning Team for Kent Learning Disability, and an integrated Pooled Budget, which are hosted by Kent County Council. From 1st April 2019 the scope for the Kent Partnership Agreement was expanded to include Autism, and it was clarified that the current Section 75 Agreement is not age limited. We have also developed and agreed a plan to stop the over medication of people with a learning disability (STOMP).

Kent and Medway health and social care are currently working together to review and jointly commission a co-designed neuro developmental pathway, recognising the gaps in community service provision for people with autism that result in poorer outcomes for individuals and their families and have adverse economic consequences for the health and social care system.

For clients across Kent and Medway with Learning Disability or autism who are currently accessing in-patient care and are part of the previously named Transforming Care programme, there is a dedicated programme, with a system wide SRO to focus on recovery of the current inpatient numbers. Whilst the numbers of CYP inpatients is within acceptable limits, improvements to the admission and discharge processes are being made with specific reference to reducing both the number of inpatients and out of area admissions. The numbers for adult inpatients are far in excess of that expected for our population and a recovery plan is in place which focuses on discharge planning to deliver the 19/20 trajectory of 63 adults, reducing long lengths of stay and out of area placements, mobilisation and delivery of community and the forensic infrastructure business case and CTR/CeTR assessment capacity.

Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

Learning disabilities and autism continued

Learning disability and autism services are currently provided by a range of providers including:

- Kent & Medway NHS & Social Care Partnership Trust
- Kent Community Health NHS Foundation Trust
- Medway Community Healthcare
- East Kent Hospitals NHS Foundation Trust
- North East London NHS Foundation Trust
- Kent County Council has a well-established specialist adult social care 'Autistic Spectrum Conditions' (ASC) team covering Kent. Providing statutory assessments, care and support packages for those eligible under the Care Act 2014. The ASC team has recently redesigned its service in preparation for integration with health in 2020 and it is anticipated that the service will expand its specialisms to include other neurodevelopmental conditions such as ADHD. Medway have already changed their social care model of delivery to a generic function but retains specialisms amongst its workers
- The inpatient secure and non-secure capacity is provided by a range of NHS and private specialist providers. In addition, the PBS Framework enables access to 14 Providers who successfully showed, through the tender process, that they have, or are, developing the right approaches, competencies and capability to support people with the most complex needs. Providers with the right skills and organisational infrastructure are key to co-producing solutions for people with complex needs, particularly those with learning disability and/or autism within the remit of need defined by the Transforming Care Programme

Priorities for improvement

- To review and co-design a new neuro developmental pathway for Kent & Medway by April 2020
- To ensure people with Learning Disabilities access annual health checks and screening to support improved physical health by December 2020 with 80% people receiving
- To eliminate the back log of Learning Disabilities Mortality Reviews and to ensure learning informs future commissioning plans by October 2020
- To ensure the appropriate prescribing of anti-psychotic medications for people with Learning Disabilities by April 2020. The current uptake is low with the NHS plan target being 75%
- Provide more community based and forensic support for people with LD & autism who are at risk of, or are, accessing inpatient secure care by December 2020
- To significantly reduce the number of CYP and adults requiring in-patient secure care by 2025 in line with national expectations
- To better develop the specialist community care market via the PBS framework which is ongoing
- To ensure K&M delivers the necessary CTR/CeTR capacity
- To develop host commissioner arrangements for secure inpatient facilities by April 2020
- Provide more personalised care for people with LD & autism and their families, listening to their care needs and their life goals by working with clients and families with learned experience
- To work specifically with main stream education providers to enable them to provide timely support to people with autism and ADHD

Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

Stroke

Stroke prevalence across Kent and Medway is around the national average of 1.7% with some areas of higher prevalence. It is estimated that there are currently nearly 1.2 million adults across the area that have two or more unhealthy lifestyle behaviours, such as smoking and obesity, which increase their risk of avoidable disease and disability such as stroke. Each year, an average of 3,054 strokes are treated for patients in the Kent and Medway catchment area. Stroke care accounts for about 4.5% of total spending on healthcare in Kent and Medway with an average of £7,000 per year spent on people who have had a stroke, (compared to an average £2,700 per year for those who have not).

Kent and Medway providers have continuously struggled to meet the quality standards of the national Stroke Sentinel National Audit Programme. Most scores are below average and although there have been some improvements since June 2014, this has been slow and is inconsistent. This indicated a clear need to improve the quality of stroke care in Kent and Medway.

The Kent and Medway Stroke Review was instigated in 2014 by local healthcare professionals, including senior doctors, nurses and care professionals. The national guidance for stroke states that the quality of a stroke unit is the single biggest factor that can improve a person's outcome following a stroke, and developing these is the main objective of the stroke review. Successful stroke units, hyper-acute stroke units (HASUs) and acute stroke units (ASUs), are built around a stroke-skilled multi-disciplinary team that is able to meet the collective needs of the patient. The proposal was therefore to establish HASUs and ASUs operating 24 hours a day, 7 days a week, to care for all stroke patients across the Kent and Medway area. This will deliver many benefits for patients, most notably more people will survive stroke and with improved quality of life and independence.

Our five year strategic priorities for Stroke include:

- Taking a range of preventative actions on diet, physical exercise, obesity and smoking as outlined in section 5 of this plan
- Implementing targeted interventions in primary care such as detection and monitoring of Atrial Fibrillation (AF) to reduce the number of AF related strokes
- Developing a stroke prevention business case, that will incorporate both of the above
- Implementing the model of hyper acute stroke units and acute stroke units across K&M, in line with national policy
- Support the development and delivery of an intra-arterial thrombectomy centre for stroke patients within Kent and Medway (currently, thrombectomy is not consistently available and there is a need to travel outside of the county for intervention compromising the benefits associated with early recanulisation)
- Developing a rehabilitation business case to ensure that community services meet the national and local specifications and to reduce variation

Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

Diabetes

In Kent and Medway, there are at least 123,000 people with diabetes of which around 90% are adults are living with Type 2 diabetes. Approximately 75% of people with diabetes go on to develop cardiovascular disease. Prolonged exposure to raised blood glucose levels can also damage the eyes, kidneys and nerves. Diabetes is the leading cause of blindness in people of working age, the largest single cause of end stage renal failure and the second most common cause of lower limb amputation. This places a significant burden on health and social services. Life expectancy is reduced, on average, by more than 20 years in people with Type 1 diabetes and by up to 10 years in people with Type 2 diabetes. More recently, a greater number of children are being diagnosed with Type 2 diabetes, as a secondary condition to being overweight. Increasing physical activity, maintaining good diet and reducing the obesogenic environment are key strands of our prevention strategy (see section 4). These preventative actions will be critical to reducing the number of people who develop diabetes.

Current service provision

Historically, variation has existed in the commissioning arrangements for diabetes services across Kent and Medway which has led to variation in care and outcomes for people with diabetes. A key priority is addressing this variation in diabetes prevention, management, treatment and care/support, with a focus on achieving the three nationally recommended treatment targets. Addressing variation and meeting the national standards is the purpose of the Diabetes Oversight Group. This group membership comprises of STP diabetes Leads including Clinical, STP Prevention leads, 8 CCG commissioning leads, acute provider and community provider leads in diabetes, Public Health, Diabetes UK, voluntary sector and patient representative. The purpose of the group is to oversee the implementation of the NHS Long Term Plan for diabetes.

Our five year priorities

Kent and Medway's ambition for diabetes can be broken down into three overarching priorities:

- *Prevention of type 2 diabetes* – Increase referrals and attendance at the National Diabetes Prevention Programme (NDPP). We will work with practices and all partners across the STP to ensure there is sustained referrals and understand the barriers/issues to referral rates and subsequent attendance. We will also develop the opportunities to improve referrals through the Primary Care Networks. By 23/24, some 6,500 people will have been supported by the Diabetes Prevention Programme.
- *Reduce the variation in commissioning* – A Kent and Medway CCG would set Integrated Care Partnerships with clear standards to be achieved supplemented with national pathways and support people who are newly diagnosed to manage their own health by further expanding provision of structured education and digital self-management support tools. This will include expanding access to HeLP Diabetes an online self-management tool for those with type 2 diabetes. We will procure a K&M Diabetes Education Service that will increase access and attendance to structured education programmes
- *Reconfigure diabetes services* – Developing primary care/community services, improving interfaces between primary/community and secondary care ensuring resource/work force are aligned accordingly and developed and ensure diabetes alignment with the wider CVD LTP deliverables. We will enable more people to achieve the recommended diabetes treatment targets and drive down variation between CCGs and practices to minimise their risk of future complications

Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan in clinical and service areas

Cardiovascular disease (CVD)

The NHS Long Term Plan identifies cardiovascular disease as a clinical priority and the single biggest condition where lives can be saved by the NHS over the next 10 years. The Plan sets the ambition for the NHS to help prevent over 150,000 heart attacks, strokes and dementia cases over the next 10 years and outlines how we, and partners in the voluntary and community sector and in other national organisations, will meet this.

The national CVD Prevention programme has been set up to develop targeted interventions to optimise care by maximising diagnosis and treatment to minimise both individual risk factors, and population risk.

In K&M, although prevalence of CVD is lower than the England average, it is the biggest cause of premature mortality and a significant cause of disability in K&M. The number of hospital admissions in K&M for heart failure is increasing, particularly in Medway where the gap to England is also increasing.

Our five year priorities

1) A step change in our prevention efforts including rolling out the national CVDPrevent initiative

The chapter on prevention outlines our ambitions and plans to prevent or mitigate some of the risk factors for cardiovascular disease, smoking, obesity, alcohol, lack of activity and high salt consumption. Our aim is to ideally prevent bad habits forming but also to identify people whose habits or behaviours would benefit from and be amenable to an intervention that will decrease their future risks. Our approach is to work with people to understand their personal risks and what could be done to reduce these, taking a holistic person centred approach

2) Identification of patients at risk followed by targeted interventions

We will be supporting the HealthChecks programme to both ensure that it is being accessed and is accessible to those most at risk, and that those identified risks are then acted upon. We will also be working with pharmacists and pharmacies to support them in identifying patients at risk, for AF though the use of AliveCor, for BP through the use of BP monitoring and for Cholesterol through point of care screening.

We are already piloting an audit in primary care to support the CVDPrevent initiative in some parts of Kent & Medway. This provides prompts in the patients' clinical record which are visible during a consultation, reports at a practice level identifying individual patients and reports at a system level showing performance at a practice level. The plan is to have this aligned to the CVDPrevent rules once they are finalised and role out this support to primary care across the whole of Kent and Medway.

3) Monitoring the impact of interventions

The primary care CVDPrevent audit will also help us improve identification and management of patients with risk conditions, and allow us to monitor near real time improvements and the impact of interventions. We would use the Kent Integrated Dataset (KID) as a means of monitoring this on a near real time basis, and identifying where interventions should be targeted.

Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

Respiratory disease

Respiratory disease affects one in five people in England and is the third biggest cause of death, with hospital admissions for respiratory disease remaining a major factor in the winter pressures faced by the NHS.

Nationally, there is a correlation between incidence and mortality for respiratory disease with social deprivation due to higher levels of smoking, poor housing, and higher levels of air pollution. Kent and Medway is recognised as having several areas of high deprivation.

One in five people in England are affected by respiratory disease and only cancer and heart disease cause more deaths. For under-75 mortality due to respiratory disease, Kent on average, fares better than England, though areas such as Thanet and Medway are comparatively worse.

The three cornerstones of the Long Term Plan for respiratory are:

- Prevention
- Earlier diagnosis
- Pulmonary rehabilitation

Community Respiratory services are provided across Kent and Medway (with the exception of Dartford, Gravesham and Swanley) delivering care at home, in community clinics and in acute hospitals dependent on need. They also provide an "unwell service" which offers, where appropriate, same day appointment, helping to treat acute episodes promptly and preventing unnecessary admission to hospital.

There is some inconsistency in provision across Kent and Medway, for example community respiratory as above. There are also challenges in workforce, with a lack of staff and poor retention. There is a lack of access to smoking cessation services and poor standardisation and interpretation of spirometry.

Our ambition for respiratory

Key actions to achieve the ambitions for respiratory:

Reduction in smoking rates across all categories – including children, pregnant women, and older age, through better education to prevent initiation of smoking and improvement in smoking cessation services

Improvement in diagnosis and identification of respiratory disease by case finding, improvement in spirometry services and interpretation, as well as encouraging 'at risk but well' patients to engage with opportunistic spirometry, brought in via community screening sessions

Improved access to pulmonary rehabilitation services by increasing referral rates, including through QOF, increasing places for pulmonary rehabilitation courses and working towards alternative means of engaging patients who work or who are otherwise unable to attend courses

Ensuring 100% of patients within K&M are able to access community respiratory services, including during exacerbations, providing long-term management, psychological support, education and palliative care in addition to smoking cessation, pulmonary rehabilitation and pharmacological treatment.

Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

End of Life care in Kent and Medway

We live in an ageing society. In England around 500,000 people die each year. This will increase by 15% by 2035. The number of people with long term conditions (LTCs) is rising (by 2025 number of people with at least one LTC will rise from 15 million to 18 million; those with two or more LTCs will rise from 5 million to 6.5 million), leading to more complex end of life care for some of these patients.

In 2017, 46% of people died in hospital in England and 68% were admitted to hospital in the last 90 days of their life, with 7.4% of those having 3 or more admissions. Whilst data for Kent and Medway shows a downward trend with 43% dying in hospital, admittance to hospital in the last 90 days of life was higher than the national average in 6 out of 8 Kent and Medway CCGs.

End of Life and palliative care in Kent and Medway is provided by a variety of specialist, acute, community, primary care, and voluntary sector organisations. There are eight specialist hospices. Six of these (Pilgrims Hospice Canterbury, Pilgrims Hospice Margate, Pilgrims Hospice Ashford, Heart of Kent hospice, Hospice in the Weald, and Wisdom hospice) provide services solely for adults. Ellenor Hospice provides services for all ages and Demelza Hospice is a specialist children's hospice. Community care is provided by a range of NHS and voluntary organisations, and includes community nurses, district nurses, specialist nurses, health care and therapy assistants.

Our ambition is for everyone approaching end of life to receive high quality care that reflects their individual needs, choices and preferences. We strive to provide high quality and equitable end of life and palliative care to everyone, regardless of their life limiting condition, care setting, social circumstances, lifestyle choices, culture or religion.

Challenges for End of Life Care

The challenges in Kent and Medway reflect many of those experienced nationally. A lack of standardised care planning documentation and shared IT platforms can result in confusion among providers about treatment plans and ceilings of care, potentially leading to patients receiving poor care and ultimately a negative experience. Similar issues occur through the lack of a standardised electronic care record. There is a lack of standardised documentation both nationally and at a system level. This can create difficulties for patients and their carers, particularly at points of transfer of care. Patients at end of life frequently transfer between acute, primary and community sector as well as care homes and hospices.

There is a challenge to ensure all staff are adequately trained to enable them to identify and care for patients approaching the end of life and to ensure there is an understanding that end of life treatment encompasses the last 12 months of a person's life, rather than the last few weeks or days. In order to support this, it is vital end of life care is embedded into primary and community care. We need to address inequalities in end of life care, for those with learning disabilities, working with specialist commissioning to support prisoners, travellers, LGBTQ+ and the homeless.

End of Life care for children and Young People

Rates of life limiting and life threatening conditions (LLCs) amongst children and young people have significantly increased in K&M since 2014/15 whilst death rates from LLCs have been declining since 2008.The need for services is growing year on year owing to advances in diagnosis and management of LLCs. The national picture can also be seen in Kent and Medway where a complex and fragmented system is sometimes ill equipped to cope with this, particularly in the provision of 24 hour EOL care.

Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

End of Life care continued

Our priorities for the next five years

We recognise the need for a strategy and implementation plan for Kent and Medway and will be working with colleagues to establish this. In the development of the strategy we will consider the following areas:

- Expansion of services for children with life limiting conditions and terminal illness, in line with the national priority of the LTP and as indicated by our K&M Health Needs Assessment, reducing unwarranted variation and the delivery of care closer to or in the child's home
- Review of provision of home based EoL care, reflecting our commitment to support people to be cared for and die in their preferred place including support for their informal carers
- Standardisation of care and support planning and documentation across providers and wider organisations involved in a person's end of life care to include advance care planning and tools such as RESPECT
- Working more closely with voluntary sector to maximise the value that they can bring to EoL and bereavement care

Section Four

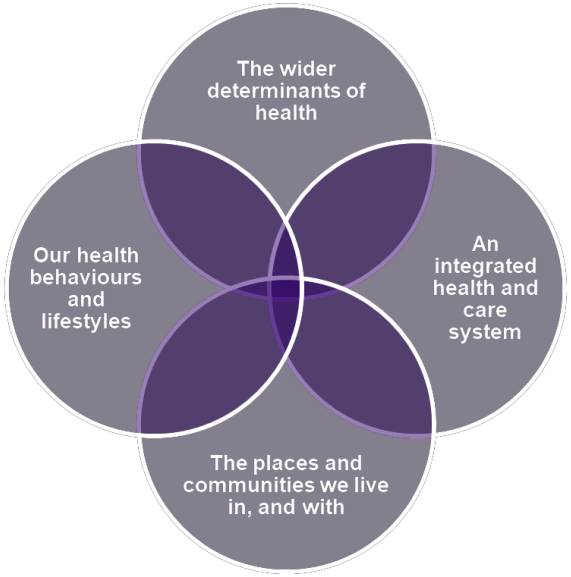
Strategic Objective 2) – An increased focus on population health and prevention

Strategic Objective 2) – An increased focus on population health and prevention

Our approach to population health

Population Health is an approach aimed at improving the health of an entire population. The concept of population health is not new: there is existing knowledge across the system and specific expertise within our Public Health teams. However, the term 'population health' helps to create a collective sense of responsibility across partner organisations and individuals, in addition to public health professionals. Population health management (PHM) uses data to guide the planning and delivery of evidence-based interventions to achieve maximum improvement of population health within the resources available.

The King's Fund defines population health as having four key pillars rooted in what drives our health, and what can improve and maintain it over time. Population health can only be delivered through a coherent, joined up system. A population health system recognises the interconnectedness of the four pillars of population health management, maximising the activity in the overlapping areas, as well as ensuring a balance of activity across the four pillars.



Defining population health management in Kent and Medway

The Kent and Medway system have been working on aspects of PHM for a number of years, such as the Kent Integrated Dataset (KID). This work has been further supported by the STP. However, a programme to develop a *Roadmap for Population Health Management in Kent and Medway* has now been established as part of the development towards an Integrated Care System. The programme will involve all parts of the Integrated Care System, including commissioners, ICPs, PCNs, upper tier Local Authorities as well as Public Health England and the Kent, Surrey and Sussex Academic Health Science Network.

Case studies from the NHSE/I Population Health Development Programme show that one of the first steps on the roadmap to embedding a PHM approach is to develop a consistent understanding and vision of PHM across place and system leadership. Nationally, PHM is defined as improving population health by *"…data driven planning and delivery of proactive care to achieve maximum impact. It includes segmentation, stratification and impactibilty modelling to identify local 'at risk' cohorts - and, in turn, designing and targeting interventions to prevent ill-health and to improve care and support for people with ongoing health conditions and reducing unwarranted variations in outcomes."*

Locally, we aim to develop a simplified definition that resonates with our stakeholders, patients and the public, and broaden its scope, recognising that clinical care and health behaviours account for only 50% of health outcomes. Our Kent and Medway definition, agreed with our local stakeholders, will reflect our collaborative approach to PHM, explicitly incorporating prevention and improving well-being. This definition will be underpinned by a vision and values statement, articulating our aims for PHM and aspirational future state.

Strategic Objective 2) – An increased focus on population health and prevention

Our approach to population health continued

Maturity and progress to date

An initial assessment against the population health management maturity matrix indicates that overall, Kent and Medway's arrangements are 'Developing' against the infrastructure, intelligence and interventions domains. In some areas of the Intelligence domain, we are 'Maturing', for example: the development of the Kent and Medway Care Record using linked data to segment and stratify the local population starting to map and understand the system's analytical workforce.

There is the potential to rapidly move to 'Maturing' overall once specific Infrastructure and Intelligence elements are agreed or established, e.g., joint data controller arrangements, linking remaining care datasets within Kent Integrated Dataset or its successor. As part of the programme, we will also consider the development of system-wide leadership behaviours (i.e. supporting action across the four pillars of population health) and workforce development requirements.

The maturity assessment will be adapted and continue to be tested with stakeholders to ensure that it accurately reflects our progress, in order to helpfully inform the development of our PHM arrangements.

Kent and Medway is one of the most advanced areas in the country in linking longitudinal patient and social care user data across a number health and care settings. This gives us an opportunity to understand in depth the health of the Kent and Medway population, including an ability to segment and stratify our population to identify "at risk" cohorts and assess the impact of proposed strategies. Whilst we have developed a range of leading edge approaches around the capture and linking of data we are yet to fully optimise the benefits and impact of these approaches. As part of becoming an Integrated Care System with a focus on population health management, we will need to develop and maximise our infrastructure and system architecture to enable full realisation of person level linked data.

Support for Primary Care Networks

The 2019/20 planning guidance states that 'STPs/ICSs must ensure that Primary Care Networks (PCNs) are provided with primary care data analytics for population segmentation and risk stratification…to allow Primary Care Networks to understand in depth their populations' needs for symptomatic and prevention programmes including screening and immunisation services'. Kent and Medway's Public Health Teams are in the process of drafting PCN health profiles to support local understanding of health and care needs. Medway Council's Public Health team is also producing PCN-level children and young people's profiles to support work on developing a system-wide, intelligence–led children and young people's strategic plan

Next steps

By April 2020, we plan to have an agreed Population Health Management Strategic Plan in place, which outlines our PHM arrangements at each level of the system, the infrastructure, intelligence and intervention capabilities that will support these arrangements and how we will continue to strengthen and enhance population health management during the lifetime of this Strategy Delivery Plan to become a 'thriving' population health system.

Our immediate priorities for 2019/20 are to:

Q3:

- Agree local PHM definition and supporting vision and values statement
- Establish population health management as a system-wide work programme, with agreed governance arrangements and dedicated resources
- Agree Analytics Strategy
- Complete PCN-level health and children & young people's profiles

Q4:

- Run further stakeholder workshops to inform strategic plan development

Strategic Objective 2) – An increased focus on population health and prevention

Our approach to prevention

The importance of prevention in impacting health and wellbeing

The Kent and Medway Health Needs Assessment, produced jointly by Kent County Council and Medway Council, sets out a compelling case for the role of prevention in supporting the needs of our population.

There are many major health conditions that are preventable and amenable to targeted interventions, particularly those that are linked with smoking, diet (including salt consumption), obesity, alcohol and substance misuse, and air pollution. Some headlines from the K&M Health Needs Assessment from a prevention perspective are shown below:

- **Cancer** - Cancer remains the leading cause of premature death in K&M. In 2017, 4,893 people died from cancer in K&M, accounting for 29% of all deaths and 40% of deaths for under 65s. Over recent years, cancer mortality rates for Medway have remained consistently higher than the England average. While mortality rates in Kent are in line with national average, they have been increasing in recent years. There is more to be done on prevention, screening and earlier diagnosis. Continued preventative action on smoking, diet and physical activity will reducing the risks of developing specific types of cancer including lung and colon cancer
- **Cardio Vascular Disease (CVD)** - CVD causes a quarter of all deaths in the UK and is the largest cause of premature deaths in deprived areas. It is the single biggest area where the NHS can save lives as CVD is largely preventable through lifestyle changes, particularly diet and exercise. The estimated prevalence of CVD in people of all ages is 9.9% in Kent and 8.3% in Medway and, although this is lower than the England average (9.5%), CVD is still the biggest cause of premature mortality and a significant cause of disability in Kent and Medway
- **Respiratory disease** - One in five people in England are affected by respiratory disease and only cancer and heart disease cause more deaths. There is a significant link between respiratory disease and deprivation, associated with smoking, poor living environments and air quality. While K&M fares better than England as a whole, we have pockets where under 75 mortality due to respiratory disease is significantly higher than the England average - in Dover, Thanet, Swale, and Medway
- **Stroke** is the fourth single leading cause of death and the single largest cause of complex disability. There is a strong evidence base for the case finding of atrial fibrillation and subsequent anti-coagulation treatment in the prevention of stroke. Unhealthy lifestyle choices such as smoking and obesity increase the risk of stroke.
- **Type 2 diabetes** is increasing in prevalence and is often associated with being overweight. It can have devastating effects on the eyes, kidneys, nerves, and limbs. In Kent and Medway, there are at least 123,000 people with diabetes of which around 90% of adults with Type 2 diabetes
- **Mental Health** – there is a strong case for prevention in Mental Health. Half of all lifetime mental disorders start by the age of 14 and 75% by the mid-20s . Efforts to positively impact the mental health and wellbeing of children need to considered alongside wider actions relating to deprivation and adverse childhood events such as family breakdown. Suicide rates in K&M are higher than the national average, particularly in men, and there are large co-occurrences with substance misuse and self-harm
- **Frailty and multi-morbidity** – Frailty doesn't just affect the elderly and having more than one long term condition increases a person's risk of becoming frail. Additionally, ageing does not necessitate becoming frail. Therefore, targeted action on maintenance of wellbeing and independence is essential. There also needs to be a greater alignment between interventions for frailty and dementia.

Strategic Objective 2) – An increased focus on population health and prevention

Our approach to prevention continued

Health Inequalities in Kent & Medway

Health inequalities are avoidable differences in the health and wellbeing of individuals due to factors such as, where they live and whether they have good quality employment. The past decade has seen mortality falling across Kent and Medway, however, the gap in deaths between the most and least deprived areas continues to increase, i.e. there are widening health inequalities. For example, over the last five years in Medway, life expectancy has increased by 2.6 years in Cuxton and Halling, while it has only increased by 0.3 years in Chatham Central, leading to an increase in the gap in life expectancy from 5.1 years to 7.4 years. In Kent, over a six-year period, female life expectancy has decreased by 0.5 years in Folkestone and Hythe and increased by 1 year in Sevenoaks. Male life expectancy in Canterbury has not changed, whilst male life expectancy in Thanet has improved by 1 year over the same time period.

In Kent and Medway, men living in the most deprived areas have, on average, a 7 to 8 year life expectancy gap when compared with men living in the least deprived areas. While the trend is similar for women, the absolute gap is smaller (4.4 years for Kent and 5.4 years for Medway). Cancer is the largest cause of premature mortality overall. But in the more deprived areas, an increasing proportion of deaths are caused by cardiovascular, respiratory and gastrointestinal (GI) disease.

Many inequalities are amenable to being reduced through earlier detection of disease and preventative measures, such as lifestyle modification and management of long-term health risks.

The causes of health inequalities are many and complex and although many of the wider determinants of health can be addressed at a strategic level, via national and regional interventions, there is a compelling argument for designing interventions at a local level where they can be informed by the local communities and local services. This is the reason for the utilisation of the Integrated Care Partnerships in addressing health inequalities. These new partnerships present a bridge between work at the individual level and at the regional and national level.

Profiles have been created for each of the Integrated Care Partnerships (ICPs) in the Kent and Medway Integrated Care System (ICS). The aim of the profiles is to allow comparison between each of the ICPs and identify priority areas to focus work.

Strategic Objective 2) – An increased focus on population health and prevention

Our approach to prevention continued

More action on prevention

A critical overarching theme throughout our five year plan is the importance of more action on prevention. To deliver prevention at scale, the NHS needs to work with other local partners, specifically local government, to maximise the use of resources to deliver better outcomes. Local government has a strong role to play to create the physical and cultural environment in which health can be protected and improved. In K&M, we have a compelling vision for joined up action on prevention between the NHS, local authorities, the voluntary sector and our communities. Prevention is everyone's responsibility and it is never too early or too late in the life cycle to focus on prevention.
The K&M Health Needs Assessment stresses the importance of these factors and the critical role of prevention in positively impacting outcomes. This has driven our proposed prevention strategic priorities:

Prevention across the life course:

- A strong start in life
- Working age adults
- Ageing well

Prevention across the system

- Reducing health inequalities
- Tackling modifiable disease risk factors by:
  - Stopping smoking
  - Reducing obesity
  - Reducing alcohol consumption
- Protecting health
  - Improved screening
  - Improved vaccination
  - Improved infection control
  - Reducing antimicrobial resistance (AMR)
- Improving chronic disease management and secondary prevention
  - Cardiovascular disease/stroke, respiratory disease, diabetes
- Improving mental health
- Improving air quality

Embedding Prevention across the system

Extending the reach of prevention across the system through all levels and in all pathways will be a priority over the 5 years of the strategic plan. Alongside the work on population health management, there is a clear opportunity to set clear ambitions and scope of work. To ensure consistency and consensus, a set of principles have been developed which are being proposed for the ICS as a commitment to drive prevention across the system:

- Prevention will be owned by the whole Kent and Medway system. All partners have a clear understanding of prevention and of their role within the system
- Prevention and its role in reducing health inequality and variation will be a priority across the system, making the best use of a proportionate approach
- All clinical pathways will begin with prevention
- Tackling prevention as an system will be a whole system approach. The wider determinants of health will be tackled alongside clinical health in a partnership approach making the most of partner specialisms
- There is parity in the importance of good physical health alongside mental wellbeing
- The system will take a life course approach embedding prevention alongside all life events. It's never too early or too late for prevention.
- Children and young people will be a priority, embedding prevention at the earliest opportunity. Schools and other education settings will be fully involved to shape the future of children and young people
- Systems thinking will underpin all work, using an intelligence led, evidence based approach to developing and evaluating interventions
- Interventions will be implemented at scale in a coherent and consistent way across the system to achieve the best outcomes
- Services will be co-commissioned to ensure prevention is fully embedded across the system. Every commission must be published with a section on prevention

Strategic Objective 2) – An increased focus on population health and prevention

Our approach to prevention continued

Current delivery priorities for 1920 into 20/21

- **NHS Health Check:** The NHS Health Check outreach programme introduced in 2019/20 is designed to increase the number of patients diagnosed with hypertension through a specific programme focused on vulnerable members of the population of Kent and Medway. This programme will overlap into the early stages of 20/21 and will enable identification of risk factors particularly for CVD
- **Obesity:** Kent and Medway provide a range of well established weight management services through 'OneYou Kent' and 'A Better Medway' respectively. Obesity prevalence is heavily influenced by the wider determinants of health and for this reason tackling obesity involves changing a complex system of interrelated factors and relationships at multiple levels for interventions to be effective. Equally, as is demonstrated in the data, prevalence of obesity is higher in disadvantaged communities leading to health inequality and the requirement for a place-based approach. In light of the publication of the guidance on the Whole Systems Approach to Obesity, the Prevention Workstream is currently reviewing the opportunity to embed the whole systems approach in our work to tackle obesity across K&M
- **Smoking cessation:** Services for smoking cessation are well developed across Kent and Medway and offer services to support people to quit smoking through the 'OneYou Kent' offer and the 'A Better Medway Programme'. The range of services available are designed to offer the service in a way that suits the needs of individuals. Services include digital and online services, face to face and telephone support. There is public facing 'walk in' provision in both central Chatham and Ashford offering convenient and approachable support. The number of adults across Kent and Medway who smoke continues to fall and the current trajectory will need to be maintained to meet the aspiration set out in the Tobacco Control Plan of 12% or less adults who smoke by 2022
- **Smokefree environments:** Achieving a Smokefree environment at each of our Trust sites is a key focus in 2019/20. Trusts have come together to develop consistency in policy and actions to facilitate full implementation of their Smokefree commitment. Actions are being implemented including wording in appointment letters, signage and speaker systems
- **Smoking during pregnancy:** Specialist smoking cessation midwives in each of the acute trusts have supported pregnant women in Kent to quit smoking since 2016. STP funding in the financial year 2019/20 has enabled extension of this service to Medway. Smoking cessation midwives have a key role in ensuring carbon monoxide testing of pregnant women at the time of booking and making referrals to stop smoking services as appropriate. The latest data for 2018/19 shows that 14.2% of women across Kent and Medway smoke during pregnancy, although this is falling, there is a steep trajectory to reach the Local Maternity System Target of 6% by 2022. It is intended that the work of the specialist midwives will continue into 2020/2021 alongside a range of services provided by Kent and Medway Public Health Teams
- **Reducing alcohol consumption:** Reducing alcohol consumption services across Kent and Medway fall under the following main areas
  - Identification and brief advice - Know your score ('OneYou Kent' campaign) and lower your drinking ('A Better Medway' campaign)
  - Making Every Contact Count training for frontline staff
  - The Blue Light project in Medway supports those facing severe and multiple disadvantage (substance misuser, involvement in the criminal justice system and homelessness) by way of a multi-agency team
  - Moving forward into 20/21 the Kent and Medway aspiration is to create better links between hospitals and treatment services and to ensure vulnerable dependant drinkers have access to MDT teams via local care

Strategic Objective 2) – An increased focus on population health and prevention

Our approach to prevention continued

Current delivery priorities for 1920 into 20/21

- **Air Quality:** The Kent and Medway Energy and Low Emissions Strategy Consultation sets out a clear vision for reducing emissions and, therefore, improving air quality across the footprint. The aim of the strategy is that by 2050 emissions in the county of Kent have been reduced to Net-Zero and it is benefiting from a competitive, innovative and resilient low carbon economy, where no deaths are associated with poor air quality. The outcome of the consultation and the strategy will guide the ongoing work through the lifetime of the plan.
- **Health Protection (including antimicrobial resistance):** The scope of the STP Prevention Workstream has been extended to include Health Protection. This strand of work includes oversight of antimicrobial resistance (AMR), outbreak control, infection prevention and control, sexual health and immunisation and screening (non-cancer). A Task and Finish Group has been set up to develop a work plan to guide the work of this strand through the period of the plan.

Section five

Strategic Objective 3) – Driving efficiency and productivity

Strategic Objective 3) – Driving financial balance, efficiency and productivity

Investing in the delivery of the Long Term Plan

Kent & Medway has been allocated £166m of Long Term Plan fair share funding over the five years. The categories of spend for each of these categories of investment are set out at high level in the table below. Throughout the development of this Strategy Delivery Plan, we have brought together clinicians, service managers, subject matter experts and finance professionals to continue to stress test the affordability of plans at a high level. Work will continue on this with each year's operational and financial planning to ensure that funding is allocated to the commitments outlined in this plan. Where required, the STP/ICS will make decisions regarding the prioritisation of initiatives.

	Plan 2019/20	Plan 2020/21	Plan 2021/22	Plan 2022/23	Plan 2023/24
LTP Funding Allocation Summary					
Mental Health	**1,604**	**1,732**	**6,278**	**12,640**	**17,009**
Children and Young People's services	-	84	1,926	2,984	4,928
Adult and older adult Crisis Resolution Home Treatment Teams and Crisis Alternatives	-	1,648	896	1,203	1,572
Serious Mental Health Issues	-	-	3,456	8,453	10,508
Primary Medical and Community Services	**12,952**	**14,366**	**16,474**	**21,160**	**25,506**
a) Primary Care	12,952	13,405	14,231	14,612	14,485
b) Ageing Well	-	961	2,244	6,548	11,021
Cancer	3,754	2,915	2,276	2,183	2,185
Other	1,226	1,305	3,020	4,396	13,252
LTP funding allocation, total	**19,536**	**20,318**	**28,048**	**40,379**	**57,952**

The NHS Long Term Plan implementation framework states that targeted funding will be available for selected systems to act as pilot or test sites in implementing certain aspects of the LTP earlier than other systems. The system is actively bidding for targeted funding in relation to a number of areas. These include PCN development, new Local Care models, diabetes, mental health, and Cancer innovation fund. Ageing Well funding will be applied to deployment of home-based and bed-based elements of the Urgent Community Response model, development of Community Teams, and Enhanced Health in Care Homes. 'Other' covers the LTP funding available to support implementation of the LTP for Prevention, CVD, Stroke & Respiratory, CYP & maternity, Learning Disabilities and Autism.

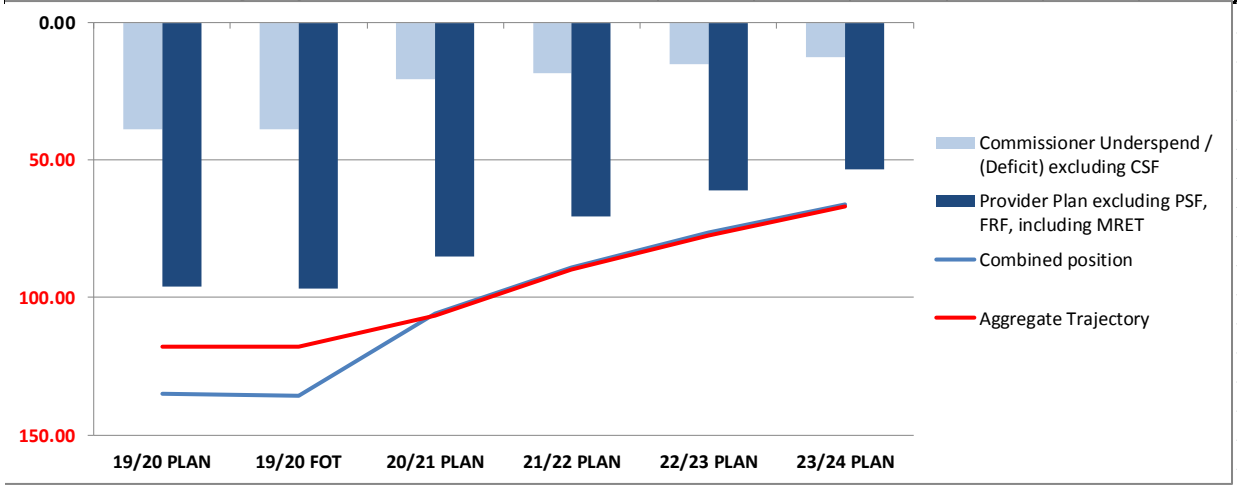
This does not represent the total funds that K&M will invest in these areas, as we anticipate receiving additional targeted funding through successful bids to national bodies as well as re-prioritising our baseline budget according to the priorities outlined in this plan. This will see a shift in investment over the next five years to prevention, out of hospital services and integrated care. Prioritisation and impact on other services will continue to be assessed through the 20/21 operational planning process

Strategic Objective 3) – Driving financial balance, efficiency and productivity

Delivering finance balance

The five year projections have been prepared with acknowledgement to financial improvement trajectories. Separate work is ongoing in respect of medium to long term financial planning to deliver long term clinical and financial sustainability through a range of measures including transforming out of hospital care, managing demand, reducing unwarranted variation, driving efficiency and productivity and making best use of capital. K&M STP has made significant progress in addressing a 19/20 £479m do-nothing financial challenge presented in October 2017. The current forecast is for a £135m net deficit in 19/20 (after sustainability funding). All organisations are forecasting financial balance against their trajectories for the 3 year period 2021/22 to 2023/24. However Dartford & Gravesham Trust and East Kent Hospitals Trust are currently forecasting plans adverse to their trajectories for 2020/21. To balance the system this pressure manifests in a £6m additional QIPP requirement in CCG plans and therefore delivering collectively above the expected trajectories by the £6m for the CCGs. Finance leaders have agreed to share this additional challenge across the system and have agreed to develop an appropriate approach to this. Through our Finance Group and Finance & Activity Modelling Group (FAM Group) we will conduct an exercise to confirm the £6m position and to understand the key opportunities across all four Integrated Care Partnerships. Additionally, work has been initiated to develop proposals for how income will be apportioned across the system for 20/21 and how we will move to alliance based contracts.

Aggregate Plan Position vs Trajectory (£m)	19/20 PLAN	19/20 FOT	20/21 PLAN	21/22 PLAN	22/23 PLAN	23/24 PLAN
Commissioner Underspend / (Deficit) excluding CSF	38.90	38.90	20.68	18.56	15.11	12.71
Provider Plan excluding PSF, FRF, including MRET	96.12	96.72	85.11	70.60	61.12	53.31
Combined position	**135.02**	**135.62**	**105.79**	**89.16**	**76.23**	**66.02**
Aggregate Trajectory	117.82	117.82	106.68	89.87	77.38	66.78
Combined distance to trajectory	**17.20**	**17.80**	**0.89**	**0.71**	**1.15**	**0.76**



The table and graph show the trajectory of the system is moving towards financial balance over the five year period. Contingent on achievement of agreed trajectories, the receipt of Financial Recovery Funding of £107.7m in 20/21 would take the system to an aggregate surplus position which continues through to 2023/24.

In line with the long term plan expectations, the number of organisations in deficit within Kent and Medway reduces over the planning period from 10 to 8 (of 12) organisations before FRF and from 3 to 0 after the application of FRF with all organisations planning to be in surplus from 2022/23 after FRF. Work is continuing across the system to the ambition of a quicker trajectory to financial balance.

Number of Deficit Organisations	Before FRF		After FRF	
	CCGs	Prov	CCG	Prov
2019/20	5	5	1	2
2020/21	4	5	0	1
2021/22	4	5	0	1
2022/23	4	5	0	0
2023/24	3	5	0	0

Strategic Objective 3) – Driving financial balance, efficiency and productivity

Driving efficiency and productivity

The K&M Productivity programme was established in 2016. The programme has focused on delivering efficiencies that are enabled by working in partnership at a 'system level'. A 'Productivity Executive Board' and 'Working Group' governance structure have been set up with finance and subject matter expert leads assigned to each workstream embedding a collaborative culture and ownership to deliver. A clear reporting structure and governance has been created with an Executive SRO. This programme has delivered savings of £1.2m in 2017/18, £2.9m in 2018/19, and forecast delivery of £11.67m of saving in 2019/20.

The key areas of focus for 19/20 delivery are:

- £8.99m in Bio-Similar switching
- £250k in continence formulary
- £1.86m in Temporary Staffing
- £555k in Pathology

These programmes of work align with the Carter Efficiency Guidance and the NHS Long Term Plan (LTP).

The STP will follow due process for "stress-testing" of all programmes ensuring the assumptions underpinning them are credible and the outcomes are deliverable.

The plans for 19/20 and the forward planning for the next 5 years, in line with the LTP, will support a trend towards achievement of financial balance. Model Hospital is supporting the STP to realise an opportunity of c £53m to c £90m over 5 years. Teams are completing a desktop exercise with Model Hospital against internal datasets to confirm a degree of confidence with the opportunity.

The Model Hospital opportunities include:

- **Developing a workforce to deliver 21st century healthcare -** This workstream focuses on maintaining agency staff in accordance with NHSI cap rates for Nursing, AHP and Admin staff and working in partnership with agencies for Medical locums making Kent & Medway NHS the best place to work. Alongside this, K&M STP are driving forward a technology driven collaborative bank system which embeds with existing banks systems. This will enable K&M to develop a new operating model for workforce which will override all workforce gaps and costs. Model Hospital demonstrates workforce holds an opportunity of c£16m - £26m."
- ***By 2023, K&M will align with the diagnostic imaging networks vision -*** to enable the rapid transfer of clinical images from care settings close to the patient to the relevant specialist clinician to interpret. The programme is currently undertaking a diagnostic review and will develop the initiatives in collaboration with the Cancer Alliance plan and the Elective Care Transformation and Digital plans.
- ***Tackle clinical variation across health improving providers' financial and operational performance*** – Kent & Medway recognises that further unwarranted clinical variation exists, particularly within Geriatric Medicine, Emergency Medicines and Orthopaedic & Spinal Surgery with an opportunity of c£11m – c£13m, c£10m- c£14m and c£8m – c£14m respectively. Kent & Medway have plans in place by utilising Rightcare, Model Hospital and GIRFT data and support from local and central NHSE/I to deliver opportunities where they exist.
- ***Estates and Facilities is a key priority with opportunity ranging from c£8.2m - £23.4m***- This workstream holds plans for a review of Linen & Laundry, Medical Records Storage and Transport. These plans are a stepping stone towards maximising best value within K&M's existing Estate. Capital planning has started and in many places is already in progress with regards to prioritisation, improving utilisation of clinical space, ensuring build and maintenance is done sustainably, improving energy efficiency and releasing properties now needed to support the government's target of building new homes.

Strategic Objective 3) – Driving financial balance, efficiency and productivity

Driving efficiency and productivity

- ***Further efficiencies in NHS admin costs across providers and commissioners both nationally and locally -*** Productivity will be part of this priority which sits with CCG and Providers at tackling reducing management costs. The STP recognises efficiency in consolidating corporate services, thereby reducing the cost and improving the quality of services. Focus areas are currently within scope; temp staffing such as developing a Collaborative Bank and reviewing structures across organisations such as HR and Legal. Further plans will include standardisation of internal procedures/processes (to reduce variation and enable prospects of pooling/sharing of resources) and pooling of high cost/specialist resource within a system to maximise utilisation

Areas which Model Hospital exclude but where the STP will realise opportunity are:

- In the future, a ***single pathology service in Kent and Medway*** will be established with a single Laboratory Information Management System, Managed Service Contract, referred diagnostic contract and standardised operating procedures; which, together with potential efficiency gains through strategic partnership/s and management/workforce redesign. This workstream is well established and a final business case (FBC) is currently being developed. The potential annual saving for this initiative across Kent and Medway is **£5.6 million annual saving** on current costs

- ***Delivering value from the £16bn spend on medicines-*** Kent & Medway Medications Optimisations Group have agreed a set of priorities which will deliver 'system level' working and 'local level' working for the next 5 years. The focus points are Workforce, System Aseptic Review, Dispensing, Medicines Information, Centralised Stock Holding, 'Direct to ward', Vaccination Supply & Management and a centralised admin function, whilst other priorities will be maintained at a local partnership level such as Clinical Services, Educational & Training and Governance

- ***Improved efficiency in community health, mental health and primary care through integrated care models*** – productivity opportunity will hold a wider 'lens' focusing on the improved efficiency in the new partnership ways of working model. Keys focus points will be on supporting all Community staff, Primary Care Networks and Mental Health. The collaborative working of these priority STP workstreams will model and track the changes to ensure we are measuring improved productivity at a wider level

- ***Engage with local intelligence at a population health level-*** Kent & Medway is committed to **achieving cash releasing productivity growth**. Productivity will continue to plug into national support and datasets and initiate further work with Public Health Intelligence to gain a niche understanding of the population needs. By triangulating all of these sources, productivity growth will accelerate and impact benefits realisation in specific areas of deprivation.

Strategic Objective 3) – Driving financial balance, efficiency and productivity

Reducing growth in demand through integration and prevention

We have set out in sections 3 and 4 of this plan our plans for prevention and integrated services. The full financial impact of these new models of care is not yet fully quantified, in line with the LTP implementation framework statement that all not systems will be in a position to quantify this as part of the Strategy Delivery Plan. Understanding the impact of prevention and integration on the cost of services is necessarily complex. Work has started across our ICPs to understand the medium term cost impact of key interventions being taken in Local Care and Primary Care (i.e. integrated care). However, more work is required on this. Understanding the impact of prevention would need to be evaluated over a longer term timeframe (potentially in excess of 10 years). We will look to learn from NHSE/I and more advanced Integrated Care Systems as to the most appropriate method for long term financial planning of this nature.

Making best use of capital investment

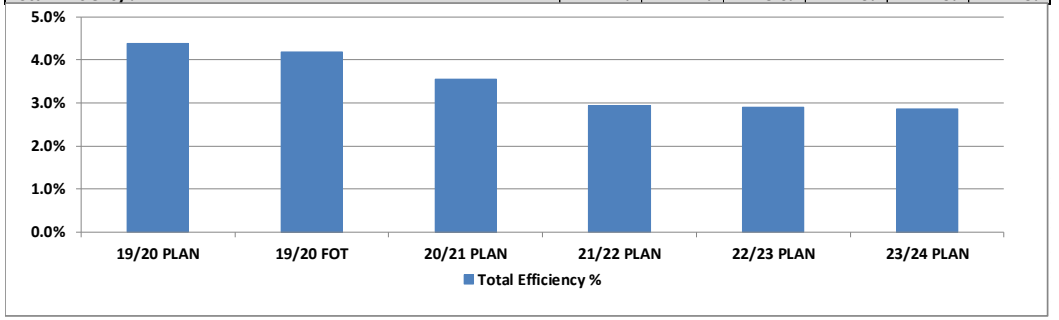
The K&M Estates Strategy contains 117 projects, with capital investment values varying from under £500k to £363m. The suite of projects totals
£821m. The STP have an agreed assurance and governance process for the Programme Management of all Capital projects. The STP has initiated programme management of the disposals programme with regular reporting from the property owners and escalation of blockers and issues. The estates workstream is embedded as an enabler into all other workstreams – including the Estate/Capital requirement to deliver the services.

Please see Section 6 for details of our estates strategy

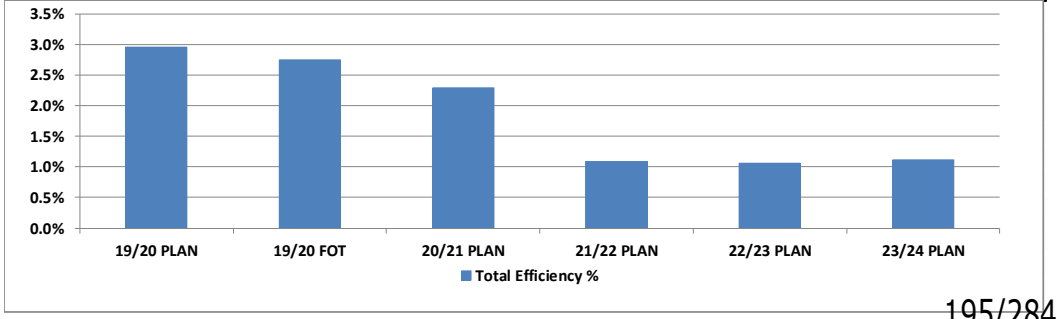
Achieving cash-releasing productivity growth of at least 1.1% per year

Through all of the efficiency and productivity schemes, the organisations within Kent and Medway are planning on delivering in excess of 1.1% cash releasing productivity growth. The profiling of the efficiencies required and planned show the higher ask in the first two years of the plan.

Aggregate PROV Efficiencies (£m)	19/20 PLAN	19/20 FOT	20/21 PLAN	21/22 PLAN	22/23 PLAN	23/24 PLAN
TOTAL schemes	94.47	90.12	78.34	66.22	66.94	68.03
Baseline for calc	2,158.49	2,150.74	2,205.79	2,249.66	2,310.84	2,375.36
Total Efficiency %	**4.4%**	**4.2%**	**3.6%**	**2.9%**	**2.9%**	**2.9%**



Aggregate Commissioner Efficiencies (£m)	19/20 PLAN	19/20 FOT	20/21 PLAN	21/22 PLAN	22/23 PLAN	23/24 PLAN
TOTAL schemes	82.54	76.74	66.40	32.47	32.88	36.03
Recurrent allocation	2,786.17	2,783.88	2,895.22	2,983.40	3,104.08	3,222.87
Total Efficiency %	**3.0%**	**2.8%**	**2.3%**	**1.1%**	**1.1%**	**1.1%**



Section Six

Strategic Objective 4) – Transformation of critical enablers

Strategic Objective 4) – Transformation of our workforce and infrastructure

Making K&M a great place to live, work and learn

In Kent and Medway, we know that at the heart of our health and care services are our people and that is why we are committed to making Kent and Medway a great place to live, work and learn. The workforce transformation strategy focuses on our commitment to work together to prioritise actions that will have the biggest impact on addressing our workforce challenges. We strongly believe this focus will support the system-wide transformation needed to provide the people of Kent and Medway with a better quality of life and a better quality of care. We have developed the strategy with the aims for our:

Workforce to work together across health and social care, enjoy their work, learn in their jobs and be empowered, engaged and developed to be good at what they do.

Employers to work together to attract and retain the right supply of health and social care workforce through talented and capable leadership and the offer of attractive, flexible and interesting careers

Population to have the skills and support to help them manage their own health and care with confidence and, where needed, with the right support to achieve their health, social and community outcomes and goals

To deliver this ambition and address critical workforce challenges we will develop a **Kent and Medway Academy for Health and Social Care** working collectively to:

- **Promote Kent and Medway** as a great place to work
- **Maximise supply** of health and social care workforce
- Create **lifelong careers** in health and social care
- **Develop our system leaders** and encourage culture change
- **Improve workforce wellbeing, inclusion and address workload** to increase retention

As set out in the interim NHS People Plan, and aligned to our transformation plan, we need more staff working across health and social care over the next five years; system actions identified in our strategy will both address existing shortages and deliver the improvements set out in the Long Term Plan.

Our workforce context

In Kent and Medway we employ around 78,141 FTE workforce across Kent and Medway in over 350 careers across health and social care organisations.

	Workforce (FTE) March 19 (actual)*
Acute	18,960
Community	5,372
Mental health	3,175
Primary care	4,030
Ambulance (Total SECAMB)	3,427
CCG (* 19/20 FOT)	619.
Social care (* 2018)	31,700
Pharmacy (* 2017)	2,012
Dentistry	1,086
Ophthalmology (* 2018)	414
Vacancies	7,346
Total	78,141.

It is recognised that across K&M, there have been long term workforce challenges with workforce supply for most staff groups being behind national growth averages, except for pharmacists and health visitors.

Strategic Objective 4) – Transformation of our workforce and infrastructure

Some of workforce challenges include:

- Limited pipeline of skilled and qualified workforce in Kent and Medway
- Limited system digital capability and digital skills of our workforce hindering new ways of working and creating inefficiencies
- Trust shortage of key specialty workforce and staff groups including consultants (61.79 FTE by 20/21), adult, community and mental health nursing, junior doctors and allied health professionals
- Shortage of GP and primary care workforce is exacerbated by the primary care age profile – 25% of GPs and 55% of general practice nurses approaching possible retirement. In order to meet the retirement gap, we would need to increase the GP workforce to 222.4 full–time equivalent (FTE) and grow our nursing workforce to 287.9 FTE
- Not enough stroke workforce to provide hyper acute stroke services on the current sites. The revised workforce gap analysis across the preferred sites will require an estimated additional 135.5 FTE to 264 FTE staff, including the filling of a range of new and enhanced roles
- Shortages of key mental health professional workforce including, psychiatrists and nurses, and a required total growth in the mental health practitioner workforce by 2024 of 1577 FTE
- Significant unregistered and non- statutory workforce for intellectual disabilities supporting a complex and extremely diverse group of people with support required being highly individualised with the potential for variability in terms of workforce engagement and development support
- A 90 FTE gap between forecast supply and demand in cancer workforce by 2022. Particular areas of concern are: Gastroenterology, histopathology, clinical and diagnostic radiology amounting to 84% of the identified gap.
- Shortage of skilled social care workforce providing direct care and support in local communities, with over half of all vacancies in Kent and Medway within social care – estimated vacancy rate of 8.7%.

The Kent and Medway Local Workforce Board (LWAB) which oversees the delivery of the workforce transformation plan have identified five key strategic system workforce risks:

- Collective inability to attract, recruit and retain sufficient numbers of high quality staff may result in a continued dependency on temporary staff and unsafe staffing levels, affecting quality of care, costs and may also impact on the health and wellbeing of staff
- Limited national and regional supply of workforce will not meet demand in Kent and Medway which may result in an increased vacancies now and in the future
- Reliance on temporary staffing may lead to quality issues and impact on the improvement plan for financial sustainability
- Lack of consistent funding alignment for growth in workforce expected may result in not achieving expected growth in workforce
- Should there be a deterioration of staff engagement due to lack of workforce confidence, this may lead to worsening morale and subsequent increase in turnover.
- Limited system digital capability and digital skills of our workforce hindering new ways of working and creating inefficiencies

The Workforce Transformation plan aims to mitigate these risks and address our system wide workforce challenges. Key actions include activities to attract, recruit and retain the right staff, actions to maximise current supply through workforce redesign, using digital and new and enhanced roles, investment in cross sector apprenticeships, a collaborative approach for harmonising temporary staffing costs and agency conversion, working with our partners to identify recurring workforce funding streams.

We have been working together as a workforce board to understand the collective challenges and opportunities in Kent and Medway. We successfully supported our universities to campaign for a **medical school for Kent and Medway** to increase our supply of potential doctors and attract wider professionals into the county.

Strategic Objective 4) – Transformation of our workforce and infrastructure

Our Transformation Strategy
To deliver our ambition and address critical workforce challenges we will develop a **Kent and Medway Academy for Health and Social Care** working collectively to:

- **Promote Kent and Medway** as a great place to work through social media, a dedicated website, and recruitment campaigns for roles such as GPs and primary care. We are developing a joint attraction offer and will undertake joint international recruitment activities; maximising the use of apprenticeships including health and care rotations and streamlining the recruitment process through the implementation of staff passports

- **Maximise supply** of health and social care workforce acknowledging that we have a limited workforce supply. We will launch a Kent & Medway Academy and introduce a Kent & Medway Medical School in 2020, undertake redesign through competency workforce planning, maximise the use of current skills through new and enhanced roles such as care navigation and through the use of social prescribing, introduce a skills hub and improve the digital capability of our staff

- Create **lifelong careers** in health and social care by providing work experience, pre-employment health and care courses, promoting careers through school
- and employment events. We are also supporting flexible and part time working and using new technologies to support staff such as our Help4Carers app

- **Develop our system leaders** and encourage culture change. We have been working together to introduce an OD toolkit for local care team collaboration, introducing a Kent and Medway Talent Board for hard-to-recruit roles and senior roles across health and social care, developing our own leaders of the future from the existing workforce, and equip current leaders with the skills they need to help transform our local systems. These actions will be supported by the introduction of a system OD strategy later this year

- **Improve workforce wellbeing, inclusion and address workload** to increase retention through Best Place to work retention programmes, by developing programmes which support staff with health and wellbeing activities, staff resilience projects, professional development and retirement planning. We are working on the implementation of an inclusion strategy and improving rostering in all our organisations

Our workforce transformation strategy provides an overview of our work to date including:

- A Kent and Medway Medical School which will have 500 students by 2025, with a focus on growing our future workforce aligned to our care models
- Kent and Medway social care recruitment campaign
- Launching the 'Take a Different View' website and social campaign for hard to recruit roles
- Upskilling education programmes for health and care in the community
- Supported 237 individuals through pre-employment and Prince Trust courses and engaged with 8900 individuals through careers activities Launched an OD toolkit for multidisciplinary team working
- Invested in system leadership development programmes
- Investment in retention programmes for GPs

Our workforce transformation plan identifies key activities that are being undertaken between 19/20 to 21/22 for our STP priority areas. These include:

- Ensuring cross system placement readiness for the Kent and Medway Medical School, with 100 medical students starting in September 2020
- Working with education partners to increase the number of trainee placements
- Working with PCNs and ICPs to undertake localised workforce planning and redesign including promotion of career development and new and enhanced roles
- Developing our health and social care staff to be digitally ready through training, access to education platforms and use of digital champions
- Working together to recruit a number of international doctors enrolling onto the Kent and Medway Global Learners Programme by March 2021. This would make a difference to hard to recruit areas such as interventional radiology, surgery, Anaesthetics, ED and Elderly Care including Stroke

Strategic Objective 4) – Transformation of our workforce and infrastructure

- Implementation of our primary care workforce plan through our Training Hubs with a focus on developing multidisciplinary learning and working within PCNs, retention of our workforce (at all career stages), workforce redesign including introduction of new roles, OD and leadership development and primary care recruitment campaigns
- Working with providers to implement the stroke workforce plan including actions on recruitment, workforce redesign, introduction of new and enhanced roles and upskilling through the stroke competency framework and education programme and retention
- Growing the mental health workforce with an expansion target for growing the workforce by 2021 of 498 WTE - we are currently over performing and would meet this target
- Investment in community learning disability and neuro-developmental teams, introduction of a Positive Behaviour support team and attractive pay rates for providers on the PBS framework
- Co-production of a Kent and Medway workforce plan, building on sessions being run to identify key actions to address the shortage of hard to recruit roles and a Kent and Medway recruitment campaign
- Social care sector recruitment campaign, continued sector engagement and events to develop a care sector workforce strategy, rollout of ESTHER coaching, supporting new roles including apprenticeships and introduction of the Help4Carers app

Delivery of the Workforce Transformation plan is monitored through the Workforce Board with progress reported to the Partnership Board. The Workforce Board has four key workstream groups which include engagement from primary care, social care, HR Directors and Directors of Nursing. The implementation plan is being updated to include actions up to 23/24 with a revised workforce monitoring dashboard.

Responding to the Interim People Plan

In Kent and Medway we recognise the importance of the national, regional, local system and organisational actions needed to address the workforce challenge and welcome the recommendations made as part of the Interim People Plan, focused on four key themes of:

- Making the NHS the best place to work
- Improving leadership culture
- Holistic approach to workforce transformation and workforce growth – ‘more people, working differently’
- Changing the workforce operating model within the context of ICS working

We have reviewed our transformation plan against the key local system recommendations from the Interim People Plan and are encouraged that these recommendations, in the most part, are already underway or planned as part of our activities.

Making the NHS the best place to work to Improve workforce wellbeing, inclusion and address workload.

We have a number of organisational and system initiatives to improve retention including two Trust providers on the Best Place to Work scheme and a number undertaking the NHSE/I retention programmes, Training Hubs leading retention initiatives for the ‘First Five, Last Five’ programmes for primary care (£192,850 awarded by NHSE/I) and local authorities working with the care sector to develop a workforce strategy for the wider care sector utilising support and expertise from Skills for Care. Shared inclusion and health and wellbeing commitments and activities will be further developed using best practice from our organisations and from the wider health and care systems.

Strategic Objective 4) – Transformation of our workforce and infrastructure

Improving leadership culture to Develop our system leaders and encourage culture change. We have programmes underway to support the leadership development within primary care, social care providers and system leaders through Practice Manager and Registered Manager development programmes, *Leading through Kent and Medway* system leadership programme and the development of Communities of Practice. Clinical Director and PCN development offers are planned for later this year.

- We are developing an ICS OD strategy, including working with our system leaders to develop shared values and behaviours and bring together the system plans and actions.

Holistic approach to workforce transformation and workforce growth – 'more people, working differently', alignment to promote Kent and Medway and maximise supply. Working together to grow the workforce supply by promoting Kent and Medway whilst also using our current workforce differently. Examples of this include:

- Buurtzorg community teams
- Local and system workforce redesign (using competency based system workforce planning)
- Upskilling current staff (for example, care navigation and stroke competency framework)
- Maximising new and enhanced roles (such as Nurse Associates, apprenticeships, Advanced Clinical Practitioners, Physician Associates)
- Digital (upskilling, improved rostering, shared systems and use of telecommunications to reduce inefficiency)
- Empowering our population and their carers to self- care and self-management through the use of technology such as the Help4Carers app and training and support for self- monitoring
- Changing the workforce operating model within the context of ICS working- including the development of a Kent and Medway Academy for health and social care to create lifelong careers in health and social care. In Kent and Medway we have been developing our operating model for workforce for the future including the development of a Kent and Medway Academy and Workforce Board.
- We have been working together to develop our strategic approach to key challenges in primary care, social care and, more recently, the nursing challenge, led by senior system leaders from health and social care and overseen by LWAB. The Academy will build on the workforce transformation plan and the good relationships we have with partners such as HEE and NHSE/I. There will be a focus on workforce planning, career development, work experience, engagement with education, role development and redesign, and workforce assurance. The Academy will also play a key role in engagement and development of a network of volunteers and peer support.
- Part of our evolving governance arrangements will be localising workforce activities where these are best undertaken at an integrated care partnership, primary care network or organisational level whilst continuing to share learning and best practice.

Strategic Objective 4) – Transformation of workforce and our infrastructure

Delivering a digital transformation

Digital must be regarded as a golden thread running throughout our plan. This includes utilising digital technology to enable service transformation, to harness the power of modern technology and approaches to allow health and care to be delivered in new ways not previously possible. Delivery needs to be enacted through a strong and mature platform that keeps our data both secure and accessible. We need to ensure that digital care delivery is safe and seamless as we become ever more reliant on technology for both every day delivery of health and care and long term strategic planning. We can use digital to keep our population healthier for longer, intervene earlier when needed and to enable the use of our NHS resources more effectively in caring for our population.

Kent and Medway is committed to learning from best practice from other areas and to gain maximum advantage from national products and solutions, such as the NHS App and NHS Login. For example, the STP is linked into the Global Digital Exemplar (GDE) and local health care record programmes and is seeking to apply learning from the GDE blueprints, where appropriate, to STP priorities.

The Kent and Medway digital strategy has the ambition to help people achieve the best possible health and well-being outcomes, living independent and fulfilling lives in their own homes and communities by using digital innovation and technology. The digital workstream aims to co-design solutions; working proactively with all relevant stakeholders to deliver the right solutions and outcomes. The Kent and Medway digital strategy contains seven core components as detailed in the table opposite.

Digital strategy core components	Vision
Universal care record	Health and care professionals have immediate access to all relevant information about a patient's care, treatment, diagnostics and previous history, for all patients across Kent & Medway, with each digital footprint area determining their own delivery approach. This will be delivered through the Kent and Medway Care Record (More information on slide 74)
Universal Care Professional Access	Health and care professionals can operate in the same way independent of their geographic location. This is the infrastructure layer and includes providing HSCN connections to all sites with GovRoam access to support sharing of information, and meeting cybersecurity standards
Universal transactional services (eCare Navigation)	Health and care professionals can access a common directory of services and make arrangements for the appropriate referral to the next stage of the care pathway
Shared management information	Health and care professionals have the management information they require to run an efficient and effective service for patients e.g. details of bed occupancy and compliance with targets
Online patient services	Patients can access their own medical and social care records online and use other online services e.g. book a GP appointment or ask a clinician a question.
Expert systems	Health and care professionals and patients have access to knowledge bases to support the care processes
Personal digital healthcare	Patients can use personal technology to support their healthcare e.g. a device can automatically send data to alert their GP. This can be collated and used to inform population health management

Strategic Objective 4) – Transformation of workforce and our infrastructure

Delivering a digital transformation continued

This strategy is delivering:

- A digital infrastructure based on care/clinical themes and their associated outcome measures (cross reference to clinical transformation sections)
- County wide processes for sharing data safely and securely
- Focus on data quality and consistent coding

The development of digital maturity with care provider organisations is based on creating core capabilities across the organisation covering

- Administration
- Records Assessments and Plans
- Transfers of Care
- Medicines management
- Order communications and results management
- Remote and assistive care
- Decision support
- Clinical and business intelligence
- Asset & resource optimisation

Our actions for the next five years cover three broad categories:

1) Deliver today's requirements
2) Transformation to support tomorrow
3) Underpin the future

Kent and Medway Care Record

We are developing the Kent and Medway Care Record (KMCR) to achieve the following:

- Enable health and care professionals involved in an individual's care to view near real-time electronic patient records currently held in numerous Provider point of care systems. A view of an individual's KMCR will be accessed via an integrated solution
- Enable a citizen to access their own consolidated record and to receive support and guidance to promote self-care
- Support the use of the rich dataset to drive intelligence, both in terms of near real time operational management of the Health and Social Care system plus longer term strategic planning and population health management (utilising depersonalised subset of data)

KMCR facilitates the NHS Long Term Plan aspiration to provide a Local Health Care Record for Kent and Medway. Subject to business case approval, the Kent and Medway Care Record will deliver a significant transformational change for the health and social care system in terms of shared information between providers and with citizens. This will provide a better patient experience and improve clinical safety as all relevant information will be available in one place. KMCR will also provide a platform for Kent and Medway citizens to access their health and care records and provide a consolidated platform to support population health intelligence.

The KMCR will initially prioritise the needs of Urgent and Emergency Care settings where patient data is required instantaneously, then extend to other areas including care homes. The development of specific KMCR requirements, including design and mobilisation, will be led by our Citizen User Group and Clinical Reference Group.

The specification that has underpinned the KMCR procurement has been based on national best practice. We continue to discuss our plans for the KMCR with NHSE/I to ensure that all national best practice is utilised.

Strategic Objective 4) – Transformation of workforce and our infrastructure

Developing a digital transformation continued

Future digital structures and priorities

The merger of our CCGs provides an opportunity to review and invest in digital leadership through the establishment of a Chief Information Officer (CIO) at a system level. This role is key in reviewing and agreeing a refreshed digital strategy and implementation plans for K&M.
With the imminent merger of the eight CCGs, there is an opportunity to develop extended capability in a range of functions including digital. We are moving to develop integrated management structures in order to streamline, remove duplication and pool talent.

It is suggested that Kent and Medway needs to improve its digital planning and delivery capability to ensure that digital developments are able to support strategic and delivery aspirations. The new leadership and management structures would be pivotal to this. Guidance from NHSE/I emphasises the need to establish either Chief Clinical Information Officers (CCIO) or Chief Information Officers (CIO) as board level appointments. Regardless of the specific approach adopted, both clinical and technical leadership is required

Through this approach we need to focus on:

- **Oversight of the system architecture:** Ensure oversight and coherence of enterprise architecture services, solutions architecture and design, application and data architecture, architecture and information governance, and assurance and consulting
- **Strategic development and planning:** Understanding the challenges, issues and opportunities of the emerging digital landscape in Kent and Medway and developing system strategies and associated plans that align opportunities to local requirements
- **Technology Architecture:** Ensuring focused Information Management &Technology (IM&T) expertise and advice is in place to ensure all significant IT investments have a solid business case and are consistent with established IT architectural standards
- **IM&T Programme & Project Management:** Scalable and adaptable delivery of digital initiatives to ensure significant commitments are delivered within time and budget constraints and to agreed specification. This can be through delivery of an intelligent customer role linked to the commissioning of external support or through the direct management of internal resources as agreed with the CCG or system
- **Digital Procurement, Contract & Vendor Management Services:** Managing 3rd party suppliers end-to-end to ensure high quality and compliant service provision as well as ongoing value for money
- **Systems Accreditation & Testing:** Providing assurance that updated or new externally provided systems meet the business / contractual specifications and that the inter-operability of systems is assured
- **Information governance and cyber security:** Strengthen our resilience and ensure the ongoing safeguarding of data
- **Business Intelligence:** Our system has a strong focus on population health intelligence and we are developing a K&M health and care analytics strategy to build on our extensive experience with linked data sets, most notably the Kent Integrated Data set (KID). The strategy is due for completion in autumn 2019 and will cover the following themes:
    - Understanding and predicting the health needs of the population and understanding the impact of interventions on population health, reducing health inequalities, improving patient experience, efficiency, and workforce wellbeing
    - Examining the wider determinants of health and the impact of work across the system
    - Supporting the shift from reactive care to anticipatory care
    - Providing information and intelligence for our citizens
    - Driving innovation by working with research and industry partners
    - Developing whole system demand and capacity intelligence for integrated care management
    - Developing intelligent business support for clinicians and care teams

Strategic Objective 4) – Transformation of workforce and our infrastructure

Developing a digital transformation continued

Across Kent and Medway we harnessing technology to transform services and personalise care. We have outlined some examples of the innovations being tested, piloted and implemented across Kent and Medway. Through our Digital Transformation Group we will evaluate the cost and benefits of various innovations and we will look to spread the most impactful innovations.

Supporting cancer diagnosis using technology

Darent Valley Hospital are harnessing machine learning and use of artificial intelligence (AI) software to identify abnormal chest x-rays. If an abnormality is detected AI will be able to detect this within 40 seconds allowing patients requiring further investigations to be fast tracked for a CT scan.

There is opportunity to adopt AI supported diagnostic technology for other tumour groups as this area of work develops. Using AI we can ensure that we can support early diagnosis through a more efficient turnaround of x-rays for those patients on a cancer pathway. We will evaluate the impact of this pilot and consider its further application across Kent and Medway.

Kent and Medway is the only cancer alliance nationally that has a networked cancer information system across all of its providers, the next phase of this journey is to develop a integrated cancer care record for patients in Kent and Medway. The benefit of this solution would mean that no matter which hospital, GP surgery or clinic you are at, your full care record relating to your cancer diagnosis and treatment will be available to the relevant clinician. The system will draw a diagnostic scan, blood tests and reports from the various local systems through IT interfaces to allow it to be seen in one place.

We are currently looking to implement a network diagnostic service where scans can be reported by a clinician remotely irrespective of where a scan was performed, removing unnecessary delays.

Unlocking the future of digital primary care

Kent and Medway is embarking on an exciting period of change with additional digital functionality being made available for practices and patients.

Over the next few years we will be embarking on a transformational change in how patients service their primary care needs:

- Underpinning online consultations as a core element of the primary care offer, enabling patients to access primary care at their convenience, and where deemed clinically appropriate, rollout of these services will start in 2019 / 20.
- Using digital technology to enable practices to operate at scale and develop patient facing models of care that are utilising technology such as apps an wearables.
- Wider integration between providers and system suppliers to join up pathways and patient journeys. Creating seamless and safe handoffs between systems allowing patients to flow between care settings.

There is significant investment that is being made in primary care and a fundamental change in the way we are harnessing technology to improve patient access and experience.

Strategic Objective 4) – Transformation of workforce and our infrastructure

Developing a digital transformation continued

Digital Primary Care First East Kent Digital First Unscheduled Care Accelerator

Moving to a digital based primary care sector is a key aspiration of the STP and we are fortunate to have one of the national digital accelerator projects within the county; the East Kent Digital First Unscheduled Care Accelerator (EK UCA). This will deliver agreed outcomes within our unscheduled care pathways. This will ensure patients and professionals can access appropriate services in a timely and consistent manner, reducing unwarranted variation around experience (patient and professional). It is expected that the solutions that are being implemented in East Kent will be extended to the rest of the county

East Kent was awarded accelerator funding due to two specific challenges:

- **GP to patient ratio** – East Kent has some of the lowest GP to patient ratios in England, currently **1:2520** in Thanet. The NHSE mean is **1:1724**.
- **Significantly higher ageing and associated acuity** in the Thanet locality, which places additional unscheduled demand pressure on the unscheduled care pathway, particularly around care homes.

Phase 1: Funding will develop and test new ways of working enabled by Digital First solutions. Margate Primary Care Network (PCN) (4 GP Practices / 17 Care Homes) and Hythe (8 GP Practices) will be our original test of change sites. East Kent will adopt a Quality Improvement Making Data Happen approach and focus on three areas of the unscheduled care pathway

- **Patient access (on the day primary care demand) -** Ensuring patients flow down the right channels via the NHS App (where possible) to the appropriate whole system professional in a safe and timely manner
- **Digitally enabling Care Homes** – Ensure a more proactive approach with rapid response by appropriate professionals delivered in a more effective manner, reducing GP visits enabling GPs to have more capacity for continuity of care around complex patients. This will also ensure the right step up in care – when required.
- **UEC/111 interoperability** – The ability to ensure that professionals can have safe and timely access to almost real time information to make the right pathway decisions. The ability to directly book patients to the appropriate professional e.g. GP practice or Urgent Treatment Centre

We will build on learning from our online consultation partner e Consult around efficient delivery of 'on the day' GP services, a PCN hub based approach to maximise on efficient and effective use of GP time. The aim being that GPs focus on the patients that need their expertise – between **20-30%** of daily demand. The other **70%** channel shifting to administration support, social prescribing, practice pharmacists and nursing staff. This will also impact positively on Emergency Department walk-ups.

Our core aim is to:

Enable the East Kent Unscheduled Care system to use their time more effectively to reduce unwarranted variation in health outcome and patient, carer and workforce experience.

A core requirement is to blueprint our approach and spread it in a prioritised manner – based on findings from our QI Making Data Happen platform for example conveyance (over 75s) rate per 1000 GP practice patients or demand and capacity work using operational data to both baseline the current position and measure improvement.

We fully understand that this system transformation requires appropriate levels of business change management and programme management. This is not about product – it's about digitally enabling new models of care that can spread and sustain on a local and national basis.

Strategic Objective 4) – Transformation of workforce and our infrastructure

Developing a digital transformation continued

Avoiding unnecessary visits to hospital by channel shifting

There are a number of pilot solutions in place across Kent & Medway to utilise video conferencing solutions to provide virtual consultations, including the Attend Anywhere project at Maidstone & Tunbridge Wells.

It is our ambition to extend these pilots across the whole of Kent and Medway leading to the provision of up to 30% of follow-up outpatient appointments virtually by the end of the long term plan period.

- Use of online advice and guidance services to provide specialist clinical advice to generalists
- The use of remote monitoring telehealth devices to support safe, early discharge
- Supporting self-care by the provision of online information to patients, removing the need for unnecessary follow-up appointments

Unlocking the future of digital mental health care

The future of Mental Health provision will benefit from digital technology and solutions in a number of areas, these include:

- The adoption of a population health intelligence approach to looking at the mental health and emotional well-being of our population
- The provision of online services to support direct access to a range of IAPT services
- Making crisis care plans available to care professionals that need them across the urgent care pathway
- Supporting the “no wrong door” aspiration through the provision of a shared care record (KMCR) Patient access to their records, including their care plan, is expected to become available in year two of this development and will facilitate the provision of data by patients from wearables, home hospital devices, and Internet of Things (IoT) devices.
- Provision of online advice and guidance between care professionals
- The use of video-conferencing as an option for consulting with patients
- We have identified a range of artificial intelligence applications covering patient engagement, administration support, alert management, coding and classification, predictive forecasting, record summarisation, and information governance. There is much work still to do on this agenda but already we can see opportunities and benefits across the board from patient safety, through quality improvement, clinical outcomes, productivity, satisfaction, and sustainability.

Strategic Objective 4) – Transformation of workforce and our infrastructure

Developing a digital transformation continued

Supporting digital maternity

Better Births Maternity Review set out a digitally enabled future for the provision of maternity services and it is our ambition to meet this aspiration by providing every woman with access to her personal health record to support her through her pregnancy. We anticipate that this will be delivered through the citizen access component of the Kent and Medway Care record and will be accessed through the NHS App utilising NHS Login.

We will further support this by the provision of apps to provide targeted and relevant information to women throughout their pregnancy.

Through the Local Maternity System (LMS) maternity services will be well represented within web resources for Kent & Medway, providing a single point of access and directory of services for women and families accessing maternity and neonatal services. The first iteration of this website is planned to go live in April 2020, and development of the resource to meet the needs of a modern maternity service will be ongoing, with innovation, development and maintenance being handed over as business as usual by March 2021.

East Kent Hospitals University Foundation Trust have an advancing digital maternity transformation programme underway, with colleagues from maternity, IT and business intelligence working well together to deliver benefits for the service. Kent & Medway LMS will support the spreading of this best practice across the footprint. The MOMA app being developed in East Kent will be developed and adopted across Kent & Medway in line with the Better Births vision for women to have a digital tool for maternity. This work also forms part of the personalisation and choice workstream as the app becomes a digital Personal Health and Support Plan for the maternity journey. It will enable clinicians to tailor care to each woman based on what is important for her.

Community Services

Supporting the wider partnership arrangements for the delivery of health and social care services to patients, we will develop digital solutions in the following areas:

- Preventing ill health:
  - Signposting patients to information via smartphone apps and other digital resources
  - Supporting patients with self management of long-term conditions through wearable technology, online support services and tailored apps
- Integrating services:
  - Sharing patient data and information across the care management team through the KMCR and supporting technologies
  - Providing online support, guidance and training for clinicians on condition specific issues
- Delivering high quality care at home and in the community:
  - Providing teams with live, interactive resourcing tools that will allow teams to respond to real-time patient demands
  - Supporting teams to undertake remote consultations and liaison with patients and carers
- Developing sustainable services:
  - Provide digitally enabled services to remove duplication, speed patient access to services and reduce complexity
  - Supporting digital access for clinicians and patients to clinical information and service access points

Strategic Objective 4) – Transformation of our workforce and infrastructure

Our estates strategy

The Kent & Medway STP (K&M STP) fully acknowledge the importance of having the right estate to deliver its clinical aspirations and intentions. This includes ensuring the estate is future proofed to meet the demands of the large housing growth which will occur over the next 10 years within Kent and Medway resulting in an additional c. 400,000 or c.23% increase in population by 2031 according to Kent & Medway Growth & Infrastructure Plan 2018.

This population growth, combined with the aging population within Kent and Medway will have a significant impact on the demand for services, the location the services are required to be delivered from and how the services are delivered. In response to this, the system submitted a forward thinking Estates Strategy in July 2019 to NHS I focusing on how the estate will be an enabler to the K&M STP objectives, how the accessibility of the estate will improve to the benefit of the patient and how we will ensure that the estate is fit for purpose and future proofed. Following a review and roundtable discussion with NHS I, the Estates Strategy for Kent and Medway has now been rated as 'Good'.

The Strategy focuses on the transformation of how the estate is viewed and used – to shift perspective from individually owned properties to a shared, co-located estate which can be used by all organisations within the STP. This alignment of the estate will focus primarily on opportunities that will benefit the patient, by making the services more accessible and in fit-for purpose facilities. Through shared costs and improved utilisation of the estate – paying particular adherence to the Carter Metrics and ERIC/model hospital data - it is hoped that revenue saved can be re-invested either into the estate to improve its condition and capacity and/or patient services.

Within the Primary/Local estate, the system will undertake locality reviews to seek to utilise the existing estate to its full potential – by reducing void spaces and increasing shared desk spaces, open to all organisations, including the Local Authorities. Through working with the digital workstreams and the Kent and Medway Care Record, we will seek to improve connectivity within all buildings regardless of organisation – to allow more time spent on work productivity and less time on travelling to siloed office locations.

We will also be working closely with the new ICP's in their development of Primary Care Networks, and with the Acute Trusts as clinical service requirements and locations are agreed for out of hospital services to best serve patient needs. An example of which may be Cancer or Integrated Urgent Care Services, as the locations to deliver these will impact on the development of the PCN's, the size of the estate necessary and any requirements on the accessibility of the estate. Emphasis will be on utilising the existing estate in the most efficient way to reduce void costs, with shared clinical service space throughout the day wherever possible to reduce the amount of void space/redundant rooms when a service is not running.

As demonstrated in the Estates Checkpoint Submission contained within the appendices, the K&M STP have a robust disposals pipeline working towards the £85.4m Naylor Fair Share target that was allocated. Currently, organisations within K&M have delivered £51m of receipts, with an additional £28m of properties on our disposals pipeline to be delivered within the Naylor timescales. Through the locality reviews that are being undertaken, it is expected that currently unknown disposal opportunities will arise from a reduction in void spaces/improved utilisation within the current estate – which will enable other properties to be sold.

Strategic Objective 4) – Transformation of our workforce and infrastructure

Our estates strategy continued

Although the existing estate will be used whenever possible, there will also be instances where a new build is required, or significant capital required to tackle backlog maintenance issues to ensure continuity of services. Therefore, we will continue to work on developing its capital projects pipeline and prioritisation of projects for different funding amounts. By regularly updating and understanding the priority of each project, resources and internal assurance can be given to business cases to be developed in line with strategic need or greatest impact. This will ensure that they are available or close to completion for future capital bidding rounds as they become available, and that the capital expenditure is efficiently targeted to projects with the best return to the system.

A high level summary of our mid/long term capital investment requirement broken down per STP clinical initiative shows investment of:

- Stroke services Reconfiguration - £27.7m
- East Kent Acute Redesign - Option 1 = £351m, Option 2 = £363m Acute bids - £224m (excluding the EK Redesign)
- Local Care including primary care
- £211m Mental Health - £31m

Without this integrated health system approach and without additional capital investment, there is a risk that the current estate may not able to meet the patient needs now and also in the future, which will have an impact on the patients health and wellbeing. It is imperative that the K&M Estate has sufficient pro-active investment to the housing and population growth, so it has the resilience to provide the additional clinical services that will be required, as well as appropriate environments for staff to deliver services from before and during the housing growth, not after.

Section Seven

Strategic objective 5) A new Integrated Care System delivery model

Strategic objective 5) A new Integrated Care System delivery model

An Integrated Care System for Kent and Medway

To achieve 'Quality of Life, Quality of Care' we know that we need to organise our system differently to remove duplication and enable collaboration and integration. We are creating an Integrated Care System to support the delivery of joined up and personalised care, to drive consistency of services, and to address unwarranted variation.

- **Primary care networks (PCNs):** GP practices working as networks, as outlined in the NHS Long Term Plan and enabled through the new GP contract. PCNs will enable delivery of primary care at scale, with an extended primary care team. We will have 42 Primary Care Networks in K&M, all of which have a Clinical Director who is responsible for leading the PCN's development.
- **Four integrated care partnerships (ICPs):** Partnerships of NHS providers and other key partners working together to deliver joined up care by collaborating within their local geography. They will determine and secure the delivery of care through integrated working, operating across populations of around 250,000 to 700,000. Our four ICPs are:
  - East Kent Integrated Care Partnership
  - Dartford, Gravesham and Swanley Integrated Care Partnership
  - Medway and Swale Integrated Care Partnership
  - West Kent Integrated Care Partnership
- **One Single system commissioner:** The establishment of a single K&M CCG covering our population of circa 1.8 million. A single CCG would not simply be a coming together of the current CCGs with the same responsibilities but would set strategic direction, establish the financial framework for the system and have an assurance function. Its focus would be on population needs as outlined in the table below.

This signals significant transformation of health and social care commissioning and provision to drive collaboration and integration. The development of strong relationships and partnerships across providers in different settings and sectors form a critical part of the success of delivering this change. The ability to work as a whole system, both commissioning and provision, will strategically strengthen the planning of services in response to population needs and expected outcomes, as well as the management of resources and its deployment. It is anticipated that the ability to work as a system will also offer opportunities to preside over key activities such as financial arrangements and incentives, in line with single control totals.

Benefits for patients arising from Primary Care Networks:

- Extended access to primary care at different practices/facilities outside of traditional opening hours and with more care, advice and support offered outside of the GP's consulting room
- Patients discover a new confidence in primary care teams – recognising that sometimes the most effective help and support is found outside of the consulting room and with a pharmacist, social prescriber, nurse or mental health professional
- You'll only need to tell your story once – shared records will mean that patients no longer have to tell their story to multiple individuals or teams
- Prevention and early intervention are key drivers to help people stay well, prevent avoidable illness, and to make the right decisions for their health and wellbeing
- Joined-up care for those with complex conditions, treating the whole person and what's important to them will be the cornerstone of care
- By creating bigger, more integrated teams allows professionals to work under the primary care 'umbrella', rather than in isolation, offering more holistic and personalised care. With other highly qualified health professionals able to focus on care and support to patients, GPs will have more time to deal with the complex cases that need their attention and focus on bringing their medical knowledge and expertise where it is most needed.

Strategic objective 5) A new Integrated Care System delivery model

Benefits of creating Integrated Care Partnerships

- ICPs will work together rather than in competition with each other to deliver local care. We expect their role will include:
  - Focusing on the specific health needs and challenges of their local population and developing and delivering services that improve the health and wellbeing of local people
  - Driving integration by breaking down barriers between organisations, enabling more joined-up working, less duplication and a more seamless experience for patients
  - Assuring and overseeing the quality of care and services that local people receive, reporting on performance and ensuring that the highest quality standards are adhered to
  - Local clinicians and teams at the forefront of designing and delivering patient pathways that deliver the highest quality care and best patient outcomes with the support of local people
  - Making best use of available budget and managing contracts with local providers to ensure that care and support represents true integration and value for money.

Benefits of creating a Kent and Medway CCG

- The Kent and Medway CCG would focus on health needs of the whole population and would set out what integrated care partnerships need to do to meet them
- The CCG could also commission some specialist services for the whole of Kent and Medway, for example, cancer care and children's services
- The CCG would set the standard of what we want to see for everyone in Kent and Medway, how funding flows and hold the whole system to account

To achieve ICS status by April 2021, we need to deliver the following:

Key actions for remainder of 19/20

- Develop ICS system model and governance structure for transition including the agreement of ICS system functions and interim operating model
- Confirm future ICS leadership arrangements that includes the appointment of the permanent Accountable Officer and senior management team for single CCG, building upon current joint working arrangements
- Confirm future functions and roles across ICPs, CCG and ICS responsibilities.
- Appoint Independent Chair for ICS and CCG Clinical Chair
- Develop the Medium Term Financial strategy across K&M system (links to merger application)
- Approval of the K&M Analytics Strategy

Actions for 20/21

Merger of 8 CCGs into single CCG by April 2020

- Further development of future financial allocations
- Develop a long term strategic approach to embedding prevention in all policy, commissioning and delivery of services
- An agreed Population Health Management Strategy outlining our PHM arrangements at each levels of the system, including the infrastructure, intelligence and intervention capabilities

The table overleaf shows our K&M position against the key national components of an integrated Care System.

Key requirements for an ICS from the LTP implementation framework	Kent and Medway current position
A partnership board, representing commissioners, trusts, primary care networks, and – with the clear expectation that they will wish to participate - local authorities, voluntary and community sector and other partners	• Recently undergone a major STP/ICS Partnership Board governance refresh, resulting in the streamlining of our governance ensuring alignment to clinical forums and Health and Wellbeing Boards • System Transformation Executive Board will oversee the delivery of the system commissioner, ICPs and PCNs across Kent and Medway and has broad representation from across the sectors • Developed, and have in place, joint working relationships with both of our upper tier Local Authorities and we are continuing to develop our ways of working with the voluntary sector
A non-executive chair (locally appointed, but subject to approval by NHS England and NHS Improvement) and arrangements for involving non-executive members of boards/ governing bodies	• A NEDs Oversight Group that sits alongside the STP/ICS Partnership Board and successfully received funding from NHS Confederation to be a pilot site for effective NED / Lay member engagement • A System Commissioner Governance Oversight Group made up of CCG Lay members to oversee the development of a single CCG. The STP currently has an interim chair and we will recruit a permanent independent chair for the ICS
Sufficient clinical and management capacity drawn from across their constituent organisations to enable them to implement agreed system-wide changes	• A clear system transformation infrastructure in place with good clinical leadership and close working with Local Govt • A single Accountable Officer structure across the 8 CCGs with direct reports holding portfolios with shared responsibility • Shared leadership by way of a senior management team across the 8 CCGs to enable joint working • Dedicated PMO capacity within the STP working on large scale change programmes across the system • We will be appointing a Kent and Medway Chief Nursing Officer and Chief Financial Officer
Full engagement with primary care, including through a named accountable Clinical Director of each primary care network	• Developed primary care strategy that is owned by primary care professionals, including our PCN Clinical Directors. • We have worked directly with the Clinical Directors through surveys, workshops and 1:1s to understand what support they want and need to develop their roles within ICPs and the ICS, as well as to develop their own PCN. This directly contributed to how we allocated our PCN development funding and to the design of our support offer, which is centrally coordinated but delivered within ICP footprints • Appointed a Senior Primary Care Advisor to sit on our System Transformation Executive Board to support the design and development of PCN representation
Clinical leadership aligned around ICSs to create clear accountability to the ICS. Cancer Alliances will be made coterminous with one or more ICS, ICSs and Health and Wellbeing Boards will also work closely together	• An established Clinical and Professional Board (CPB) has a specific mandate through its terms of reference to promote clinical and professional engagement and leadership in the delivery of STP programmes and the transition to an integrated care system • Each of the four ICPs has established local clinical and professional boards to build on this model and lead the delivery of our clinical and professional vision. As we transition to an ICS we will use the CPB to support the development of these local arrangements as well as advising on the design of an ICS that remains as firmly clinically and professionally led as our STP has been since its inception. This will ensure that we continue to provide care model frameworks and support and challenge at system level, while enabling local programmes and pathways to be developed within ICPs • Through the Kent and Medway Cancer alliance (which is already coterminous with our STP), we have a strong focus on improving cancer performance against national standards and preparing to meet new standards for faster diagnosis and diagnosis at stages 1 & 2

Strategic objective 5) A new Integrated Care System delivery model

The case for a K&M system commissioner through a single Clinical Commissioning Group

Our eight clinical commissioning groups (CCGs) have successfully applied to become a single commissioner with effect from 1 April 2020. This will enable the NHS in Kent and Medway to build on, and accelerate, joint working to address some of our key local challenges, unlocking short and long term benefits for the people who use our services and for our workforce.

A single clinical commissioning group will:

- Free up staff and GP time to improve care for local people
- Have less complex structures and a clearer framework for clinical decision making
- End duplication of committees, meetings and effort, saving time and money, not just for the clinical commissioning group, but also the for the NHS trusts and other organisations that provide NHS services and partners, such as social care
- Enable faster decision making, meaning improvements to patient care can happen sooner
- Agree health outcomes for Kent and Medway, reducing unacceptable difference in health and life expectancy – these will be delivered by integrated care partnerships and will be tailored to their local populations
- Use detailed data to achieve a bird's eye view of the health of specific groups or communities, underpinning the development of health outcomes
- Reduce the number of buildings needed for staff in the longer term and IT running costs
- Improve staff recruitment and retention through a joined-up approach to workforce issues and opportunities
- Use its substantial buying power to increase value for money for the taxpayer
- Continue to involve local people in shaping health and care services
- Accelerate clinically-led innovation

The GPs who chair the current CCGs led the drive to create a single CCG, after rigorously assessing all the possible options for a system commissioner. They undertook extensive engagement including with the GPs who make up our current CCGs, staff, patients, the public, health and social care partners, local authorities and MPs.

A recurring theme has been concern about the potential loss of local input into a single CCG. To address this concern, the following has been integral to the proposed design of a single CCG:

- The new CCG will always be GP-led, with a GP governing body majority including a GP from each current CCG until at least April 2022 and clinical representation or leadership as appropriate on all committees
- A full and robust development programme for primary care networks enabling effective leadership within the emerging integrated care system
- Strong local patient and public representation running from the CCG governing body to individual primary care networks, linking all patient and public involvement forums, and creating a citizens' panel and an insight bank, to significantly strengthen the use of patient experience and insight across the system
- GP members and governing bodies of the existing eight CCGs all approved the merger. NHSE/I approved the merger application in October 2019
- We have also developed a 'One Team' model which sets out how health and social care will work together in a more joined-up way, drawing expertise together from across organisations to address the key challenges, and improve quality of life and quality of care for patients

Strategic objective 5) A new Integrated Care System delivery model

ICS Organisational Development

We have been working as a system to develop our organisational development (OD) approach through our System Leadership and OD group. We have developed a set of OD activities to support PCNs and to enable our CCG teams to transition to a single system commissioner. We are scoping the OD needs of our ICPs. An OD strategy that brings these elements together to support Kent and Medway to transition to an ICS is to be developed, building on current and future system OD needs, activities and actions. This will support us as a system to have an agreed set of system priorities, a common language, development of our system leaders to lead this change and a shared OD methodology to transform our system. As the new system will be evolving over the next five years, with different parts developing at different rates, this strategy itself is emergent and will adapt and change as new elements of the system develop and mature.

Immediate priorities are focused on the development of the ICS OD strategy, transition plan for the system commissioner, and the clinical leadership and development offer for the PCNs.

- Development of the ICS OD strategy
- Undertaking development of our senior leaders with the objective of co-producing a vision, values, behaviours and strategic direction and prioritising strategic activities for the ICS
- Implement the senior leadership structure that is aligned to the delivery of the vision of the ICS including appointment to the permanent AO/system leader
- Developing cohorts of leaders (including clinical leaders) in system working, building on the Leading across Kent and Medway pilot
- Implement the Workforce and OD plan for the CCG
- Rollout of the PCN development offer including clinical leadership development, rollout of the OD toolkit to support team collaboration
- Scoping of OD needs with ICPs
- Develop new models of care that work effortlessly across boundaries

ICS Operating Model

As the Integrated Care System develops, there will be a number of functions that we will need to operate at a system level. These functions will include:

- **System Planning:** This year has seen the development of a System Operating Plan for 19/20 and the creation of this five year Strategy Delivery Plan 19/20 to 23/24. There is further work to do on our long term outcomes and benefits, linked with future operational planning at all levels of the ICS
- **System Resilience:** In 18/19, Kent and Medway were asked to provide some support to winter planning at a system level; this was expanded to also lead on EU Exit planning for the system. We have established a team at a Kent and Medway level to lead on system resilience and planning
- **Assurance and delivery:** With the changes at NHSE/I, and the expectation that ICSs will take more of a responsibility for assurance, STPs/ICSs will be invited to join the regulators' system assurance meetings and Intensive Support work with ICPs in 19/20
- **Quality:** The NHSE/I feedback on the SOP noted the lack of a Quality strategy at a Kent and Medway level. We have set out in Chapter 4a) Our approach to quality how this is being addressed

NHSE/I will be rolling out a "one team" approach with STPs/ICSs on delivering national programmes in 19/20. In some areas, the STP has pre-existing programmes and already works with NHSE/I, but STPs/ICSs will take on more responsibility for overseeing national programmes across systems. This will include Primary Care, Cancer, Mental Health, Continuing Healthcare, Maternity, Learning Disabilities and Autism, Digital, Diabetes, Variations and New Pathways, Urgent and Emergency Care, Elective.

In Kent and Medway, we have developed an interim operating model which describes the integrated working arrangements across the emergent ICS and outlines the key relationships between commissioners, healthcare providers (including PCNs) and local authorities - the key partner organisations within the new system. It reflects the need to focus on the system and sub-systems rather than the individual organisations, drawing expertise together from across organisations in order to address the key challenges, and realise opportunities for patient through integration of care delivery.

Strategic objective 5) A new Integrated Care System delivery model

Specialised commissioning

As we move to become an Integrated Care System, we will continue to work with NHSE/I to plan and deliver specialised services as locally as possible and to join up care pathways from primary care through to specialised services with the overall goal of improving patient outcomes and experience. We will work with NHSE/I to understand the national parameters within which ICS can take on more responsibility and the associated resource implications.

We will support NHSE/I to repatriate services that are currently being provided outside of the South East where it is in the best interests of patients and supports sustainability of South East providers. This will be in support of the drive to move care closer to home.

We will work with NHSE/I on the implementation of Long Term Plan commitments as outlined elsewhere in this plan:

- Improving bowel, breast and cervical screening uptake
- Implementing the HPV vaccination programme for boys
- Roll out of FIT 120
- Roll out of HPV Primary Screen in the cervical screening programme
- Taking forward the findings of Sir Mike Richards review into Cancer screening
- Designing screening and vaccination programmes to support a reduction in health inequalities
- Improvements in child immunisation levels
- Implementation of the digital child health record ‘e-book’

Specific areas for Kent and Medway include:

- *Mechanical Thrombectomy* – the geography of Kent makes it important to have a mechanical thrombectomy centre in Kent to ensure equitable access. Currently it is envisaged that it will be at William Harvey site based on analysis conducted by NHSE/I. It is important looking ahead that there is a joined up approach to planning all vascular intervention which would include thrombectomy for stroke and vascular services

- *Kent and Medway Vascular Network* – continuing to drive the establishment of a vascular network across Kent and Medway to secure the long-term provision of vascular services and support equity of access for all patients in Kent and Medway (as outlined earlier in this plan on page 41)

- *Clinical Frailty* – East Kent have successfully achieved a place in the National Clinical Frailty Pilot for Vascular services. The improvement work developed at this site will be used as an exemplar for other specialised service teams to improve their services for people with frailty, as well as shaping national policy

- *Cardiology* – We will work closely with specialised commissioning colleagues to establish an appropriate network to improve the outcomes and experience of people accessing these services and ensure fast access to life-saving stroke treatments

- *Enhanced Supportive Care* - Promote the expansion of Enhanced Supportive Care, and take a leadership role in sharing learning, to enable patient choice and informed decision-making. Specialised Commissioning have pump-primed investment in Maidstone and Tunbridge Wells NHS Trust to achieve this.

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Strategic objective 5) A new Integrated Care System delivery model

Innovation

As we move to become an ICS, we will need to consider where leadership and capability for research and innovation should sit, with a need to consider innovation alongside our approach to quality improvement and digital given the close interactions between these areas.

In order to spread innovation faster and wider, Kent and Medway STP supported the establishment of the Innovation Collaborative. The collaborative consists of the Kent Sussex and Surrey AHSN, and the Design and Learning Centre who have a remit to accelerate the uptake of health and social care innovations in Kent and Medway. The Design and Learning Centre was initially developed as part of the NHS Integrated Care Pioneer Programme which aimed to explore new and innovative ways of delivering health and social care in an integrated way. The Innovation Collaborative seeks to identify, select and support the adoption of innovations that improve clinical outcomes, deliver better patient experiences, drive down the costs of care and stimulate wealth creation locally and regionally.

In line with the ambitions of the Long Term Plan, the Kent and Medway STP Clinical and Professional Board (C&PB) set a challenge for the collaborative to find new and innovative ways to support people with a number of conditions including asthma, cardio vascular disease, chronic obstructive pulmonary disease and diabetes. The group will report back to the Clinical and Professional Board during Q4 of 2019/20.

Key deliverables for the Innovation Collaborative in 19/20 are:

- Organising user / citizen innovation sessions to support programmes such as Local Care and Digital
- Evaluation and Research Network supporting the Clinical & Professional Board including the link with ARC and the Health Analytics Board
- ESTHER training and briefing sessions for Dartford Gravesham and Swanley and Swale
- ESTHER and Buurtzorg: EU management and implementation of the new models of care
- Care Sector Workforce : facilitating conferences and engagement
- Medication Innovation programme : digital MAR sheets and joint pharmacy programme
- International and national funding applications including for the Innovation Lab, Workforce Academy, Digital innovation supporting health and social care

Future arrangements for innovation will be considered as part of the wider ICS operating model design

Strategic objective 5) A new Integrated Care System delivery model

The role of the voluntary sector and volunteers

In Kent and Medway, we are committed to working closely with the voluntary sector, recognising the invaluable and under exploited role of the voluntary sector to support new models of care.

Social isolation has a major impact on both physical and mental health and as a system we are committed to working with our communities, with the voluntary sector, volunteers and local businesses to continue to find new and innovative ways to tackle loneliness and isolation. We also recognise that there is a significant role for business, community, voluntary sector organisations and volunteers to support prevention. As we embed prevention across all of our pathway, we will actively consider new and expanded ways of working with these organisations and individuals.

As part of the Kent and Medway STP, the local care model for older people and adults with long-term conditions has been developed. Through this new model, new roles for care navigators, case managers and peer supporters are being developed. Peer supporters will usually be volunteers, with similar conditions or challenges to give the patient the support they need. They might also act as mediators. Some of our volunteers already provide a sign-posting role by staffing information desks, but the new local care model provides opportunities for the role of peer supporters to be further developed and recruited.

Through the Home First scheme, the NHS and social care in Kent is working more closely together to get more people home from hospital safely and sooner. Part of this involves commissioning and partnering with organisations, such as Age UK, to provide a meet and greet service for patients returning home from hospital. We will explore opportunities for volunteers to form part of a befriending scheme to help tackle social isolation among patients who are returning home from hospital and support sign-posting as part of the multidisciplinary team.

Befriending services are in place across much of our geography, mainly for isolated older people, delivered by local organisations including Age UK, carers' organisations, volunteer bureaux and community groups. Most are specific to a geographical location such as isolated rural areas or to a specific client group, for example phone befriending for carers, or visits to people with dementia. Arrangements for funding of befriending services by KCC are moving from grants to contracts and as a result, a number of befriending services are forming a Kent-wide consortium to tender for this work. We will explore way of working with any future consortium to help build befriending into our care pathways. We will support promotion of the befriending scheme to increase referrals from our staff.

We will utilise local business and community networks to promote volunteer recruitment and create corporate fundraising and volunteering opportunities for local businesses. A good example of where this has already worked well is where Maidstone Lions supported Kent Community Health Foundation Trust's charity 'i care' to launch a sensory room in Maidstone

Volunteers make a unique and valuable contribution to patients, carers, visitors and staff. As well as having a positive impact on healthcare services and the volunteer, volunteering is widely recognised as a powerful tool for promoting healthy communities. Volunteers are an essential resource in helping us achieve our vision,

In Kent and Medway we recognise that volunteering can help to:

- Improve quality of life: The Royal Voluntary Service, in May 2012, found volunteering in later life decreased depression and social isolation and boosted quality of life.
- Improve an individual's ability to cope with ill health: Volunteering can help people come to terms with their illness and provide a form of distraction to one's own problems

Strategic objective 5) A new Integrated Care System delivery model

- Lead a healthier life: Smokers who volunteer in stop-smoking services, often give up and students who binge-drink, drink less when volunteering.
- Improve mental health: Volunteering helps people to improve self-esteem and gives a sense of purpose. This can be vital for people who might be isolated.

Across Kent and Medway, provider Trusts utilise the valuable service of volunteers in over 37 different types of roles many of which are patient focused including volunteers who assist with mealtimes, ward exercise rehabilitation, ward trolley rounds, reception and admin support, hospital shops, and governors. Additionally, we have a vibrant network of volunteers in primary care carrying out activities such as volunteer driving.

We are developing and innovative and integrated youth volunteering offer in partnership with Pears Foundation and NHSI/E during 20/21 and 21/22 that increases the number of young people aged 16-25 actively participating in volunteering within the sector and widens the breadth of volunteering opportunities available to young people, building a cross sector network that works together to embed this work within the wider health and care volunteering and career development system. We are also working in partnership with the Princes to Trust to support Young People aged 16-30 yrs old into health and care careers and planning to expand these type of employability model with other voluntary sector organisations to widen participation and diversify our workforce.

As we become an Integrated Care System, there is an opportunity to look at ways of engaging and partnering with business, community, and voluntary sector organisations as a system, to support and augment the work that is happening with individual organisations and at a local level.

Section Eight

Monitoring delivery of this plan

Monitoring delivery of this plan

Governance

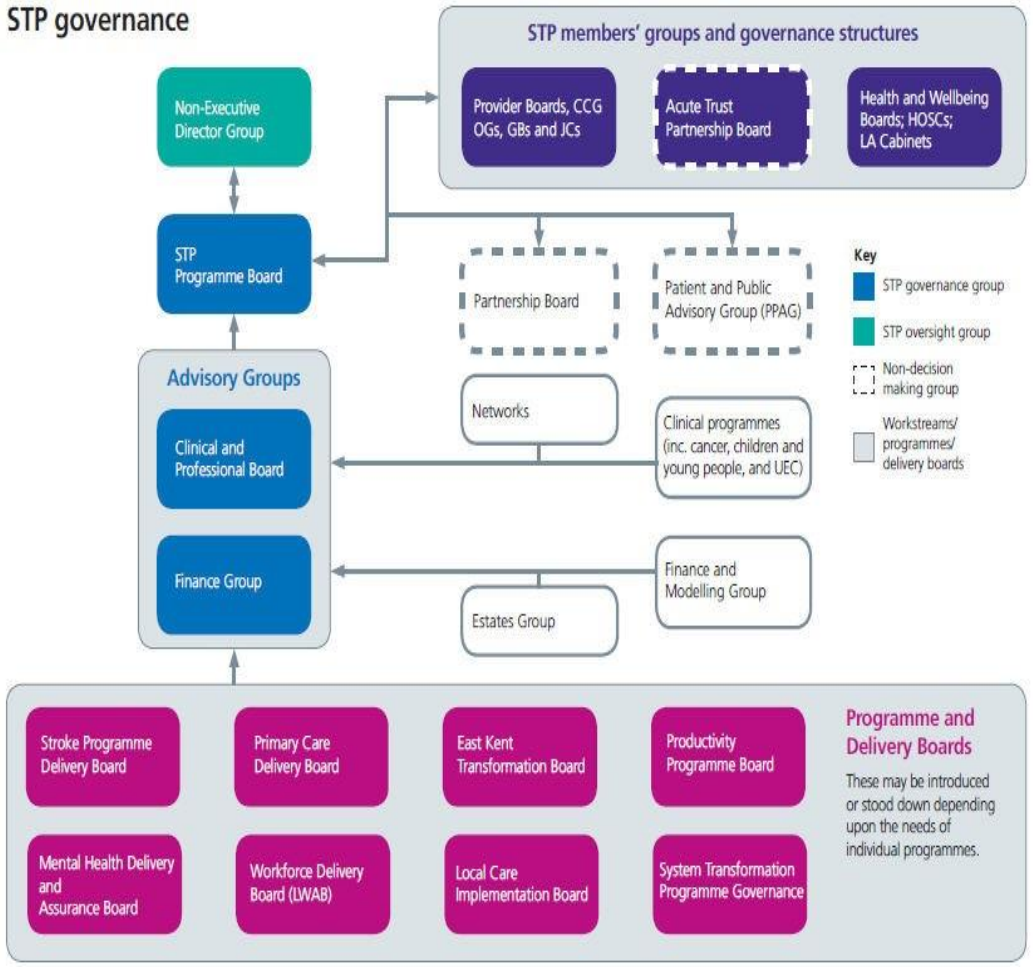
Our Kent and Medway Sustainability & Transformation Partnership (STP) has established system governance to support delivery of our STP Programmes and provide the foundation for delivery of the Strategy Delivery Plan (see governance structure right). In 2018, the STP refreshed the system governance with individual Programme Boards set up to support delivery, and a Non-Executive Director Group established with membership from NHS commissioners and providers as well as the Local Authorities to support oversight and connection to statutory organisations and their Boards and Committees.

However, as we move to become an Integrated Care System, we will need to transition to a new set of ICS governance arrangements, ascertaining what is required at the system level and what will need to operate at the level of the Integrated Care Partnerships.

In the immediate future, we will continue to utilise our existing STP governance, individual organisational governance, and ICP partnership boards. Our existing arrangements are already changing incrementally to support the move to an ICS, for example with the STP Programme Board evolving into an ICS Partnership Board.

Alongside the creation of new governance for a single CCG, a wider governance review will be instigated to look at the levels of accountability between the CCG and the ICPs including where accountabilities sit for quality governance and quality assurance (as outlined in section three of this plan on 'Our approach to Quality'). Additionally, a key focus of the new governance arrangements will be the importance of clinical leadership, GP representation and patient representation. It is likely that we will need to develop and evaluate a series of options for the future ICS arrangements.

Once new arrangements are agreed, we will ensure a smooth transition from the existing legacy STP arrangements to the ICS governance model.



Monitoring delivery of this plan

Supporting delivery

The established system governance and programme delivery is supported by a PMO team that has been set up as part of the STP team, and has been in place since 2017. The PMO team lead the management of the STP programmes with SROs and workstream leads and ensures an appropriate programme management approach is used. The PMO team also manage the system governance to support the focus on delivery and oversight. As we move to become an ICS, the emergent Integrated Care Partnerships will provide the infrastructure for partners to work together on delivery as well as the local governance to track progress with the delivery of plans.

Assurance

Kent and Medway's vision for an Integrated Care System will support delivery and ensure appropriate monitoring across the different levels of the system. NHSE/I are supporting this model with assurance focusing on the ICP level in 2019/20 with the STP invited to attend assurance discussions. The Single Oversight Framework for providers and the CCG Improvement and Assessment Framework are also being brought together to support the move to partnership working. To support further integration, NHSE/I are also inviting STP and ICS leaders to join their South East region Senior Leadership Team meetings every quarter. These are complemented by six-monthly meetings with each STP or ICS leadership team. NHSE/I are also establishing a "One Team" approach with STPs/ICSs for national programmes that will provide a direct linkage between national and STP programmes and an operating model that supports a whole system approach.

Risk management

The STP has established a risk management approach that is led by programmes and tracked and monitored through the STP. Every STP workstream has a programme board that manages programme risk or escalates to our STP/ICS Partnership Board where required.

As part of our ICS development we are designing a new approach to monitoring system risks across Primary Care Networks, Integrated Care Partnerships and across K&M as a system. This will build on the STP risk management policy that has been signed off by all organisations for monitoring the STP programme. We will report on these risks in our 20/21 System Operating Plan and individual ICP and organisational plans.

Monitoring delivery of this plan

Future engagement on our plans

The STP has engaged with patients, public, and a range of partners and stakeholders to develop and deliver plans since 2016. Our approach was to build on the extensive engagement work already undertaken, which gives us a good understanding of local issues, attitudes, and concerns and has informed our work. To support the development of the Strategy Delivery Plan, listening events were held in each of the ICP areas, as well as targeted engagement with seldom heard groups.

The Kent and Medway STP's Patient and Public Advisory Group (PPAG) has been regularly involved in the development of engagement plans, as well as playing an important role in co-producing and critiquing the actual plans. PPAG members sit on existing STP workstreams representing the patient voice and feed into the co-design of the plans from those workstreams.

As the STP evolves into an ICS, and to support the delivery of plans, we have co-designed a new model of patient and public involvement to ensure that patients continue to have a voice at every level. This includes the creation of a new patient group, supplemented by patient, client and carer-led task and finish groups. These will be drawn together for time-limited focused pieces of work as the workstreams and overall programme of transformation require.

In addition, two new systems will be set up to support these groups. We will launch a virtual citizen's panel - a network of people representative of the Kent and Medway population to ensure a public perspective can be sought on all work programmes. Plus an insight bank to collate and link all the existing intelligence on patient experience gathered by NHS trusts, Healthwatch Kent and Healthwatch Medway, CCG, ICPs and local authorities. Supplementary groups are also being established at ICP and PCN level to ensure patients have a voice at every level.

While not losing the range of groups and mechanisms we have to support our engagement, we will be using these new groups to facilitate and help monitor our progress. We will continue to share our progress against the ambitions we have set out with our audiences and seek their views on how effective we are being and where we can improve so that the voice of patients and the public remains at the heart of everything we do.

Monitoring delivery of this plan

Next steps

The Strategy Delivery Plan builds on the work of the STP as well as the System Operating Plan for 19/20 to provide a plan for the next five years for Kent and Medway. Following approval of Kent and Medway's Strategy Delivery Plan, we will ensure that this is comprehensively built into programmes with the appropriate governance in the system to monitor progress and support delivery. This will also be hardwired into the development plan for the Integrated Care System in Kent and Medway. Detailed actions for the coming year will be set out in the System Operating Plan for 20/21, which will provide further granularity on plans in the next financial year.

The development of Kent and Medway's plans do not stop with our Strategy Delivery Plan. Significant pieces of strategy and plans in development include a shared children's plan, a system wide analytics strategy, a refreshed Digital strategy and an End of Life Care strategy and implementation plan. Additionally, we know that the creation of a single CCG and the development of our Integrated Care Partnerships, including our Primary Care Networks, creates an opportunity to refresh our system vision.

We intend to launch a new ICS vision in spring/summer 2020 that will build on all of the work to date but will look further ahead to the next five to ten years. Our strategic objectives and priorities will be further refined as we develop a Kent and Medway Population Health Outcomes Framework. Additionally, we will develop a commissioning strategy for the new single Kent and Medway CCG. In light of all this, we aim to develop a Strategy Delivery Plan refresh in late 2020. This refresh will take account of any additional targeted funding awarded to K&M to support the implementation of the Long Term Plan.

Annex 1 – STP partners

Members of STP Programme Board

1. Ashford CCG
2. Canterbury and Coastal CCG
3. Dartford and Gravesham NHS Trust
4. Dartford, Gravesham and Swanley CCG
5. East Kent Hospitals University NHS Foundation Trust
6. Kent and Medway NHS and Social Care Partnership Trust
7. Kent Community Health NHS Foundation Trust
8. Kent County Council
9. Maidstone and Tunbridge Wells NHS Trust
10. Medway CCG
11. Medway Community Healthcare CIC
12. Medway Council
13. Medway NHS Foundation Trust
14. South East Coast Ambulance Service NHS Foundation Trust
15. South Kent Coast CCG
16. Swale CCG
17. Thanet CCG
18. West Kent CCG
19. Healthwatch Kent and Medway

Review of the Business Case for the Kent & Medway Vascular Programme	**Director of Strategy, Planning and Partnerships**

The enclosed report provides information on an NHS England / Improvement led programme to review the provision of vascular surgical services across Kent and Medway.

Vascular surgical services in Kent and Medway are currently provided by Medway Foundation NHS Trust (MFT) and East Kent Hospitals University NHS Foundation Trust at Kent and Canterbury Hospital (K&CH).

A number of reviews of vascular surgery have been undertaken since 2014, led by NHS England Specialised Commissioning. These reviews have concluded that an acute inpatient vascular service should be commissioned from one single acute Trust. In the interim, until the longer-term transformation programme is delivered, all inpatient vascular surgery is to be centralised at the K&CH. This new model of care will mean that there will be no inpatient vascular surgical care provided at MFT.

Outpatient service provision, diagnostics for vascular surgery and day case surgery will remain unchanged in terms of their location but EKHUFT will become the host provider Trust for the Kent and Medway Vascular Surgical Service.

The vascular surgical team who are currently employed by MFT will transfer over to EKHUFT under TUPE arrangements. This includes five consultant vascular surgeons, one ST Registrar, two Vascular Nurse Specialists and three supporting administrative staff. Other teams that provide a supporting service for the vascular surgical service will continue to provide these services under a number of service level agreements.

At Maidstone Hospital, outpatients and diagnostic services will continue to be provided as at present. The hospital will have access to Vascular Consultant opinion with consultant presence two days per week. A Vascular Consultant will also be available on a planned ad-hoc arrangement to support with elective gynae-oncology, orthopaedic and obstetric surgical cases where it is considered necessary to have a vascular specialist on site. The current Service Level Agreements that exist between MTW and MFT will be transferred to EKHUFT and will be reviewed after six months of go-live.

The proposed reconfiguration of vascular services in Kent and Medway constitutes a significant change in the delivery of services and therefore a public consultation is required to seek the views and opinions of our stakeholders. The pre-consultation business case is being prepared by NHS E South East Spec Com and this is required to be approved prior to commencement of a public consultation. This assurance process can only commence however once the provider organisations are signed up to the business case and agree on the preferred option. Once all NHS providers and NHS E are in agreement with the proposals set out in this business case the Programme Management Team will secure the agreement of the Kent County Council Health Overview and Scrutiny Committee and of the Medway Health Overview and Scrutiny Committee. This will enable a proposed six week public consultation to commence (currently scheduled for April and May 2020). Analysis of the consultation feedback and responses will then be undertaken to allow the NHS organisations to make an informed decision on their proposals for the reconfiguration of vascular services in Kent and Medway.

The current programme of work shows that the Kent and Medway Vascular Network could go live in summer 2020 subject to NHS England Specialised Commissioning approval.

Which Committees have reviewed the information prior to Board submission?

- Executive Team – 18/02/20
- Business Case Review Panel – 17/02/20

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

Decision to approve the recommended preferred option

[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

Final Approval Level:

SERVICE DEVELOPMENT BUSINESS CASE

Title:	**Kent and Medway Vascular Surgery Programme**				
Care Group:	Surgery and Anaesthetics Care Group	**Specialty/ Department:**	Vascular Surgery		
Project Manager:	Simon Brooks-Sykes	**Financial Lead:**	Elisa Llewelyn	**HR Partner:**	Karl Woods

**** ALL SECTIONS MUST BE COMPLETED***

Section 1 - Executive Summary

1.	**What is the issue/s that needs to be resolved? (Include Timescales)**

Vascular Surgical services in Kent and Medway are currently provided by two NHS Trusts: Medway Foundation NHS Trust and East Kent Hospitals University NHS Foundation Trust.

In March 2013, the National Service Specification (NSS) for Specialised Vascular Services was issued for adoption from October 2013. The report states "There is a strong evidence base that suggests that mortality from elective aneurysm surgery is significantly less in centres with a high caseload than in units that perform a lower number of procedures".

In December 2014, NHS England Specialist Commissioning initiated a review of the vascular service provided by the current providers in Kent and Medway. This was followed by the publication of a detailed Case for Change for Vascular Surgery in Kent and Medway[1] which articulated the need to reconfigure the local Vascular services across Kent and Medway in order to meet the NSS and Vascular Society's Provision Of Vascular Surgery standards (VS POVs).

The main issues that were identified by the review included:

- The lack of a vascular network across Kent and Medway.
- The number of people served by both East Kent Hospitals University NHS Foundation Trust (EKHUFT) and Medway NHS Foundation Trust (MFT) is below the 800,000 minimum which is recommended by the Vascular Society.
- At both trusts, the total number of some of the core index procedures is either borderline or below the recommended numbers.
- The number of consultants is currently lower than required. Consequently there is concern about being able to staff the vascular surgical and interventional radiology rotas 24/7 at both sites.

Neither hospital was able to fully meet the service specification criteria or achieve the requirements of the VS POVs on its own.

In early 2015, NHS England South (South East) granted derogation (a temporary exemption) to both

[1] See appendix 1

	Kent and Medway Trusts so that they could continue to provide vascular surgical services even though they did not fully meet the national specification (EKHUFT now treats the minimum number of core index procedures). Both Trusts were tasked with working together to find a sustainable, efficient and effective longer-term solution for vascular surgical services. In 2015/16, further work was undertaken as part of the Kent and Medway Sustainability and Transformation Partnership to plan for the longer-term future of vascular surgical services. This work concluded that in the longer-term (as part of the STP) a single inpatient vascular centre should be created in east Kent. Such a centre would serve a population of over 1.4 million, would allow the consolidation of skilled staff and resources to achieve the requirements of the national specification and would enable the service to meet the needs of the VS POVs. In July 2018, NHS England led a further review of vascular services in Kent and Medway and recommended that the arterial hub should be located at Kent and Canterbury Hospital in Canterbury ahead of its final location being determined under the East Kent STP. The GIRFT vascular lead and the Vascular Society of Great Britain and Ireland agreed with this recommendation. In March 2019, the South East Regional Medical Director and Chief Clinical Information Officer (CCIO) also concluded that the arterial hub should be established at Canterbury. It was acknowledged that whilst the future location of the unit will be determined through the East Kent transformation programme this should not detract from the need to ensure delivery of a high quality, sustainable service in the interim. It is NHS England's intention to implement the recommendations of this review and to commission acute inpatient vascular services in the interim period from a single inpatient arterial hub in Kent and Medway (located at the Kent and Canterbury Hospital) by the end of 2019/20. The longer-term future of the service would be determined by the east Kent STP and under the two shortlisted options it would either remain at K&CH or relocate to the William Harvey Hospital in Ashford. EKHUFT has been supporting MFT's inpatient vascular surgical services over recent months as MFT has been unable to provide sustainable on-call rotas within the service. In January 2020, MFT implemented an emergency move of all elective and non-elective AAA surgery to Kent and Canterbury Hospital. This emergency move remains in place and therefore no AAA surgery can be undertaken at MFT. This business case articulates the reason why the preferred option for the interim arterial centre should be located at Kent and Canterbury Hospital until such time as the longer-term transformational programme is implemented.
2.	**What are the options to address the issue/s?**
	A number of possible options have been evaluated and this produced a short-list of two options. Following extensive public and patient engagement a detailed options appraisal was undertaken to produce a recommended preferred option. Details of each of the options and the preferred option are outlined in section 3 of this business case.
3.	**What is the financial impact of the Options?**
	It is assumed that the clinical and operational model of both options, namely whether the services were based at EKHUFT or MFT would be broadly similar and therefore it is likely that the costs of providing the model would not vary significantly between the options. The estimated impact of the service moving to EKHUFT has the following impact on each Trusts bottom line. This modelling assumes that EKHUFT will be paid MFT's Market Forces Factor for all the transferred patients.

	EKHUFT	MFT
Income	£4,439,295	-£4,439,295
Expenditure	£4,362,116	-£3,564,127
Change in Trust Position	**£77,179**	**-£875,168**

The above table has assumed the likely amount of pay and non-pay cost MFT will be able to avoid through TUPE, staff redeployment, reduction in agency nursing and allied health professionals and reductions in variable non-pay expenditure. However, it should be noted that MFT will be left with stranded costs which will deteriorate the financial position of the Trust and commissioners are asked to support the Trust through this transition (typically 3 years). EKHUFT financial position is estimated to be a small improvement in its bottom line.

4. What are the details of the preferred option?

The preferred option is a network model that works across a number of sites with a single acute inpatient arterial centre supported by an enhanced non-arterial centre and a number of outpatient sites.

The model will be structured as follows:

- **Single Arterial Centre (Hub) –** This will be located at the Kent and Canterbury Hospital in Canterbury, East Kent. The Arterial Centre will be the single hospital within the network that provides all inpatient care for both elective and emergency vascular surgery, providing all types of vascular surgery and vascular interventional radiology. This Arterial Centre will be the only hospital in Kent and Medway that has on site a 24/7, full, year-round specialist vascular team to manage all acute inpatient elective and emergency vascular surgery. The Arterial Centre will also be the managerial centre for the Kent and Medway Vascular Network. The Arterial Centre will also fulfil all the components of care available in an enhanced non-arterial vascular centre. This reflects the national recommendation for best practice. All vascular inpatient care will take place in the single Arterial Centre, this will include recovery from surgery until the patient is fit to either return home or to be transferred to rehabilitation care closer to their place of residence. This is mainly the case for patients requiring amputations although some other North Kent patients may wish to return to Medway Hospital for further rehabilitation closer to home. The Arterial Centre will also provide a comprehensive vascular diagnostic and outpatient ambulatory care service for the local population.

- **Enhanced non-arterial vascular centre (Enhanced Spoke) -** Medway Hospital (MFT) will be the Enhanced non-arterial vascular centre and will form an integral part of the Networks solution model of care. This will be resourced to provide local vascular services that do not require a 24/7 workforce presence and inpatient based vascular interventions. It will have an enhanced weekday presence of a specialist vascular team to support other acute services within the hospital. This hospital will have interventional radiology (IR) services to support day case vascular interventions. This IR service will also support the IR needs of non-vascular services. Day-case services will be provided to support activity within the vascular network e.g. renal access surgery and on-going fistula management support interventions and it will offer a comprehensive vascular diagnostic and outpatient ambulatory care service.

- **Non-enhanced non-arterial hospitals (Spokes) -** Locally across Kent and Medway, the Network model will be supported by Non-enhanced non-arterial hospitals. Hospitals that provide acute care services (typically medicine, surgery, obstetrics), that at times will require on site vascular advice and will require direct contact links to the arterial vascular centre for 24/7 support for vascular advice and patient management. These sites will not have a daily specialist vascular presence, however, the ability to offer full vascular diagnostics and outpatient services for the local population will be available. The Non-enhanced non-arterial hospitals will deliver all out of hospital care and will be delivered through the existing Kent and Medway hospitals' buildings at these sites. These hospital sites, which include Maidstone Hospital, Sheppey Hospital, William Harvey Hospital, Queen Elizabeth The Queen Mother Hospital and Dover Hospital will deliver a range of services that seek to keep care as close to

home as possible for patients and will include:

- Outpatients clinics; i.e. multi-disciplinary clinics, condition specific clinics, one stop shop clinics, nurse led and consultant clinics;
- Pre- and post-operative care;
- Ongoing monitoring and management of vascular conditions e.g. Peripheral vascular disease;
- Diagnostics and tests; and
- Day surgery where appropriate

In summary therefore, the preferred option would see EKHUFT becoming the host provider Trust for the Kent and Medway Vascular Surgical Service. In the interim, until the longer-term transformation programme is delivered, all inpatient vascular surgery would be centralised at the Kent and Canterbury Hospital in Canterbury. There would be no inpatient vascular surgical care provided at MFT.

Outpatient service provision, diagnostics for vascular surgery and day case surgery would remain unchanged in terms of their location but EKHUFT will become the provider of all of those services.

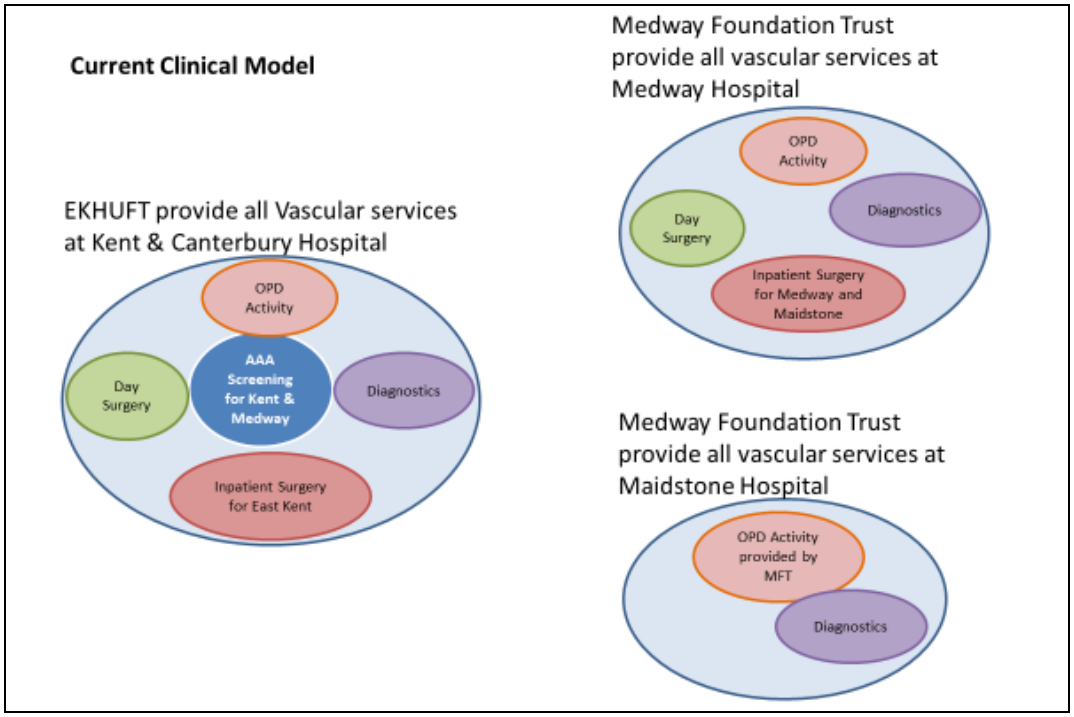
The vascular surgical team who are currently employed by Medway Hospital NHS Foundation Trust will all transfer over to East Kent Hospitals University NHS Foundation Trust under TUPE arrangements. This includes 4 consultant vascular surgeons, 1 ST Registrar, 2 Vascular Nurse Specialists and 3 supporting administrative staff. Other teams that provide a supporting service for the vascular surgical service will continue to provide these services under a number of service level agreements. Details of staff transferring and their clinical commitments are provided at Appendix 2.

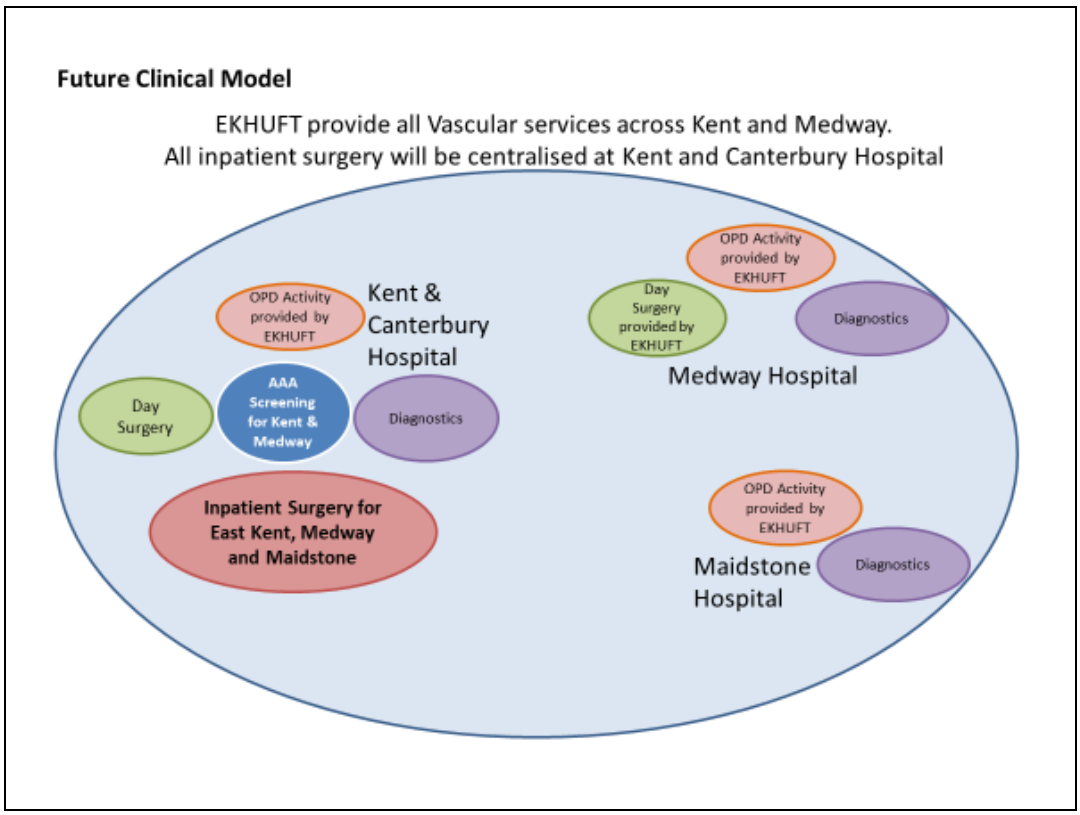
Some members of Medway Hospital's anaesthetic team and interventional radiology team have expressed a desire to continue to participate in the provision of vascular surgical care at K&CH but do not wish to formally transfer their employment to K&CH. Arrangements are being made for those staff to participate in the vascular network using honorary contracts and service level agreement to remunerate them for their time. All appropriate clinical governance arrangements have been set in place to support this activity.

At Maidstone Hospital, outpatients and diagnostic services will continue to be provided as at present. The hospital will have access to Vascular Consultant opinion with consultant presence 2 days per week. A Vascular Consultant will also be available on a planned ad-hoc arrangement to support with elective gynae-oncology, orthopaedic and obstetric surgical cases where it is considered necessary to have a vascular specialist on site. The current Service Level Agreements that exist between MTW and MFT will be transferred to EKHUFT and will be reviewed after the Network has been operational for 6 months.

The detailed clinical model and clinical pathways have been produced and formally approved by the Network Steering Group and can be found at Appendix 3.

The two Venn diagrams below show the scale of the proposed changes.





Under the preferred option, EKHUFT will become the lead provider organisation for all vascular services in Kent and Medway.

Detailed analysis of the activity data has produced a definitive set of procedures which relate to inpatient care. The proposed move of all inpatient vascular surgical activity under the preferred option will therefore impact around 400 inpatient cases per year.

Outpatient activity will continue to be provided in its current locations.

Site	OP New	OP Follow Up	Grand Total
EKHUFT	3,641	3,651	7,292
MFT	1,458	1,270	2,728
MTW	1,856	1,616	3,472
Total	6,955	6,537	13,492
Outpatient activity at MFT, MTW and EKHUFT			

Detailed Financial Analysis

Impact on EKHUFT				Impact on Medway FT		
Income	**Activity**	**Income**		**Income**	**Activity**	**Income**
Adult Critical Care	584	£651,744		Adult Critical Care	584	-£651,744
Daycase	213	£232,329		Daycase	213	-£232,329
Elective Inpatient	141	£722,554		Elective Inpatient	141	-£722,554
Emergency Inpatient	250	£1,142,929		Emergency Inpatient	250	-£1,142,929
Excess Beddays	212	£58,398		Excess Beddays	212	-£58,398
OP FA	2,942	£640,523		OP FA	2,942	-£640,523
OP FU	2,548	£253,130		OP FU	2,548	-£253,130
OP Procedure	709	£97,776		OP Procedure	709	-£97,776
Stents		£597,035		Stents		-£597,035
Unbundled Radiology	803	£42,879		Unbundled Radiology	803	-£42,879
Total Income	**8,403**	**£4,439,295**		**Total Income**	**8,403**	**-£4,439,295**
Expenditure				**Expenditure**		
Pay Costs	**WTE**	**Expenditure**		**Pay Costs**	**WTE**	**Expenditure**
Admin & Management	6.50	£208,634		Admin & Management	4.00	-£128,390
Outpatient Services	1.00	£24,436		Outpatient Services	1.00	-£24,436
Admissions Area	4.80	£148,420		Admissions Area		
Allied Health Professionals	9.24	£349,701		Allied Health Professionals	6.60	-£249,786
Critical Care Nurses	10.84	£368,825		Critical Care Nurses	10.84	-£368,825
Medical Staff	7.00	£941,933		Medical Staff	6.00	-£807,371
SCP	1.00	£54,916		SCP	1.00	-£54,916
Sonographer	1.00	£63,949		Sonographer	1.00	-£63,949
Remove Locum Sonographer		-£23,816				
Specialist Nursing	5.26	£251,356		Specialist Nursing	4.00	-£191,145
Theatre	0.46	£22,078		Theatre	3.68	-£176,624
Ward	17.26	£535,783		Ward	17.26	-£535,783
Travel Costs		£77,000				
Total Pay Costs	**64.36**	**£3,023,214**		**Total Pay Costs**	**55.38**	**-£2,601,225**
Variable Non Pay Costs				**Variable Non Pay Costs**		
Drugs		£120,218		Drugs		-£120,218
Other Non Pay Costs		£64,917		Other Non Pay Costs		-£64,917
Pathology		£1,395		Pathology		-£1,395
Radiological Services		£6,628		Radiological Services		-£6,628
Supplies		£724,842		Supplies		-£724,842
MTW Outpatient Clinic Recharges		£106,950		MTW Outpatient Clinic Recharges		-£106,950
Medway FT Outpatient Clinic Recharges		£150,500		Medway FT Outpatient Clinic Recharges		£150,500
Total Non Pay Costs		**£1,175,450**		**Total Non Pay Costs**		**-£874,450**
Additional Support Services Costs				**Additional Support Services Costs**		
Pharmacy		£20,292		Pharmacy		-£20,292
Pathology		£30,599		Pathology		-£30,599
Radiology		£13,125		Radiology		-£13,125
Outpatient Services	1.00	£24,436		Outpatient Services	1.00	-£24,436
Total Support Services Costs	**1.00**	**£88,452**		**Total Support Services Costs**	**1.00**	**-£88,452**
Equipment		75000		Equipment		
Total Costs		**£4,362,116**		**Total Costs**		**-£3,564,127**
Profit/(Loss)		**£77,179**		**Profit/(Loss)**		**-£875,168**

Implementation plan and timescales

The proposed reconfiguration of vascular services in Kent and Medway constitutes a significant change in the delivery of services and therefore a public consultation is required to seek the views and opinions of our stakeholders. The pre-consultation business case is being prepared by NHS E South East Spec Comm and this is required to be approved prior to commencement of a public consultation. This assurance process can only commence however once the provider organisations are signed up to the business case and agree on the preferred option. Once all NHS providers and NHS E agree with the proposals set out in this business case the Programme Management Team will secure the agreement of the Kent County Council Health Overview and Scrutiny Committee and of the Medway Health Overview and Scrutiny Committee. This will enable a proposed six-week public consultation to commence (currently scheduled for April and May 2020). Analysis of the consultation feedback and responses will then be undertaken to allow the NHS organisations to make an informed decision on their proposals for the reconfiguration of vascular services in Kent and Medway.

The current programme of work shows that the Kent and Medway Vascular Network could go live in the summer of 2020.

Section 2 - Case for Change Summary

1.	What is the issue/s that needs to be resolved?

1.1 Introduction

Vascular Surgical services in Kent and Medway are currently provided by two NHS Trusts: Medway Foundation NHS Trust and East Kent Hospitals University NHS Foundation Trust. However, the current configuration of specialised vascular surgery across Kent and Medway is not sustainable and needs to change.

The NHS England service specification which references the recommendations of the Department of Health, VSGBI, the Royal College of Radiologists, NCEPOD and NICE recommends a minimum population of 800,000 in order to maintain safe activity levels stating that "vascular services need to be organised to allow reasonable volumes of elective activity to exist alongside an acceptable consultant emergency on-call rota thus ensuring appropriate critical mass of infrastructure and patient volumes."

The review of vascular service in 2015/16 led by the South East Regional Medical Director, recommended that the arterial centre should be located at Kent and Canterbury Hospital in Canterbury ahead of its final location being defined and coming to fruition under the East Kent STP. Professor Mike Horrocks (GIRFT vascular lead) and Jonothan Earnshaw (VSGBI) agree with this recommended model.

In March 2019, the South East Regional Medical Director and Chief Clinical Information Officer (CCIO) also concluded that the arterial centre should be established at Canterbury[2]. He acknowledged that the future location of the unit will be determined through the East Kent transformation programme but this should not distract from the need to ensure delivery of a high quality, sustainable service in the interim. It is therefore NHS England's intention to implement the recommendations of the review by the end of 2019 and to commission vascular services from a single inpatient arterial hub in Kent and Medway.

1.2 What are specialist vascular services?

Vascular disease affects veins and arteries. It may cause blood clots, artery blockages and bleeds which can lead to strokes, amputations of limbs and conditions that might threaten life if left untreated.

NHS England South (South East) commission (plan and pay for) specialised treatment in Kent and Medway, Surrey and Sussex.

NHS England has led a review to look at this small but very important part of specialised services in Kent and Medway. Specialised vascular services are types of treatment for:

- aortic aneurysms – a bulge in the artery wall that can rupture (treatment may be planned or as an emergency)
- carotid artery disease, which can lead to stroke
- arterial blockages, which can put limbs at risk

The types of treatment that might be required include:

- complex and potentially high risk bypass surgery to the neck, abdomen or limbs
- balloon or stent treatment to narrowed or blocked arteries
- blood clot dissolving treatments to the limbs
- stent grafts of varying complexity to treat aneurysms.

[2] Please see Appendix 4

All these treatments are highly specialised and need a skilled team available 24 hours a day, every day of the year, to provide this service and support patients.

The review looked at both emergencies and planned specialist vascular treatment. It included both patients treated in Kent and Medway hospitals and people living in Kent and Medway who go to London for their treatment. This review did not look at varicose vein surgery, heart disease, heart surgery or the management of the common types of stroke.

1.3 Why has NHS England reviewed specialist vascular services in Kent and Medway?

Vascular services are a specialised area of healthcare which, evidence has shown, will benefit from organisation into larger centres covering a population that is big enough for there to be significant volumes of activity in all areas of service, with a robustly staffed workforce able to deliver services 24 hours a day, 365 days of the year.

There is an opportunity in Kent and Medway to ensure that excellence in patient care and outcomes can be provided and that resource is always available for the vascular service to continue to improve on the type and standards of care provided.

Establishing a vascular service of excellence will offer the opportunity for a much improved and comprehensive service to patients. In particular, the right model of care could deliver more local care to Kent and Medway residents and the type of care could include more complex procedures. Such a centre will be better able to embrace new technology and innovation in practice. A regional centre of excellence is most likely to be the place that patients would choose for their specialist care and where other clinicians are most likely to refer their patients to. Such centres are most likely to be able to attract the highest calibre workforce and offer sustainability.

The training boards will look to centres of excellence to be involved in training the future generation of vascular clinicians. This not only benefits the service but invests in the future provision of excellence in patient care. Suitably sized centres with the appropriate population could offer opportunity for quality audit and research.

The vision of the clinical teams in Kent and Medway is to develop and deliver a model of care for vascular services that offers all of these benefits.

2. How frequently does the issue occur?

Vascular surgical services in Kent and Medway have been the focus of intensive reconfiguration works for the past 6 years. The services do not comply with the national service specification or meet the needs of the VS POVs. Kent and Medway is three or four years behind many other parts of the country where vascular services have already been reconfigured to achieve compliance and deliver more sustainable care.

Based on the activity for 2018/2019 and the 2019/20 year to date activity, the following conclusions can be drawn about the expected levels at the single arterial inpatient centre. The data used comes from the NAC Dataset provided by NHSE using the Total Sum of Unique Patients.

Total All Activity	2019/20 (Full Year)
Validated Inpatient Procedures	814
Other IP Procedure 107 Activity	292
EKHUFT Validated DC Procedures	8
Other EKHUFT DC Procedure 107 Activity	28
MFT Validated DC Procedures	14
Other MFT DC Procedure 107 Activity	8

Total Activity	**1,164**

There are a further 440 non-validated day cases within the dataset that are not included in the above table

Under the preferred option, the growth in inpatient activity (from present state) is shown in the table below

Activity	2018/19	2019/20 (FYE)	Total (12-month average)
EKHUFT Current Total	680	740	700
EKHUFT New Total	1066	1142	1091
% Change	*57%*	*54%*	*56%*

Procedures

The table below shows the total number of inpatient procedures that took place in 2019/20 at EKHUFT and at MFT. The activity undertaken at MFT includes patients admitted from the Maidstone catchment area.

Procedure Type	EKHUFT 2019/20 (Full Year)	MFT 2019/20 (Full Year)
Open Aortic Aneurysm	52	10
EVAR Aortic Aneurysm	54	20
Subclavian Artery	0	4
Lower Limb - Reconstruction Surgery	48	48
Lower Limb - Amputation (Major)	78	66
Lower Limb - Amputation (Minor)	70	98
Emergency Femoral Artery	0	2
Elective Iliac Artery Ops	4	0
Carotid Endarterectomy	32	10
IR - Angioplasty	270	94
Renal Access	128	46
Total inpatient activity	**736**	**398**

Detailed analysis of the activity data has produced a definitive set of procedures which relate to inpatient care.

Outpatients

The following data from 2018/19 is for Vascular Outpatients, split by New and Follow Up. It also shows the breakdown by each site where activity has been delivered.

Site	OP New	OP Follow Up	Grand Total
EKHUFT	3,641	3,651	7,294
MFT	3,314	2,886	6,200
Total	6,955	6,537	13,494

Table 7 Outpatient activity at MFT and EKHUFT

	In 2018, Maidstone and Tunbridge Wells NHS Trust approached EKHUFT with an invitation to provide vascular surgical services across west Kent. Following discussions with west Kent CCG, this development has been temporarily been put on hold pending the outcomes of the EKHUFT and Medway Vascular Network. If the network achieves the aims and objectives that have been set out then MTW may look to join the Kent and Medway Vascular Network.
3.	**What is the severity of the issue - Strategically? (Scope & Risk)**
	1.4 Vascular Society of Great Britain and Ireland (VSGBI) In 2012 VSGBI published a series of recommendations describing how vascular services should be organised to deliver the best outcomes for patients (Provision of Vascular Services, 2012). VSGBI quality improvement frameworks (QIFs) are also in place for both abdominal aortic aneurysm (AAA) repair and lower limb amputation. The NHS AAA Screening Programme has made adopting the AAA QIF mandatory for providers treating patients referred from the programme. In light of these recommendations NHS England, as the commissioners of specialist vascular services, published a national service specification for the provision of vascular services in July 2013. This specification sets out both the essential components of a specialist vascular service and the clinical outcomes that the service should achieve. A clinical reference group, chaired by Professor Matt Thompson, has developed the national service specifications[3]. Reporting outcomes of all vascular surgical procedures to the new National Vascular Registry has been mandatory since April 2015 The national service specification, the Vascular Society guidance and a range of research papers culminate in the conclusion that to achieve the best outcomes for patients an arterial centre needs to provide complex aortic endovascular procedures from a dedicated vascular hybrid theatre. This must be supported by 24/7 vascular surgery and 24/7 interventional radiology, bringing together the expertise and experience of key clinicians in these techniques to provide both elective endovascular procedures and emergency procedures such as endovascular repair for ruptured abdominal aortic aneurysm. Indeed being able to perform interventional radiology procedures in a dedicated hybrid theatre has the potential to significantly reduce the length of recovery and the risk of surgical complications and lower the risk of mortality compared to conventional open repairs. To achieve the guidance and to deliver resilient and sustainable vascular services NHS England are re-organising vascular services into networks. Since the publication of the national service specification NHS England, South-South East have been reviewing vascular services across Kent, Surrey and Sussex to determine the work needed to ensure local vascular providers comply with the best practices outlined in the service specification. The key elements of which are that providers of vascular services should: • Serve a minimum population of at least 800,000 people to ensure an appropriate volume of procedures. • Ensure that highly experienced staff are treating sufficient numbers of patients to maintain competency. • Have 24/7 on site vascular surgery and interventional radiology on-call rotas that are staffed by a minimum of 6 vascular surgeons and 6 interventional radiologists (individually undertaking a minimum number of interventions). • Provide access to cutting edge technology including a hybrid operating theatre for endovascular (minimally invasive) aortic procedures. • Provide a dedicated vascular ward and nursing staff. • Have a specialist team to manage patients with vascular disease that includes vascular surgeons, interventional radiologists, specialist nurses, vascular scientists, diabetes specialists, stroke

[3] . A copy of the national service specification for vascular services can be found at: http://www.england.nhs.uk/commissioning/spec-services/npc-crg/group-a/a04/

physicians, cardiac surgeons, orthopaedic surgeons, and emergency medicine amongst other specialties to provide a comprehensive multi-disciplinary service.
- Care of patients will be managed through regular multi-disciplinary team meetings, which will occur at least once a week.
- Provider networks will work towards the aim of all leg amputations being undertaken in arterial centres by 2015.

Central to national recommendations is the requirement for arterial surgery to be delivered out of fewer, higher volume specialist arterial surgical centres to improve clinical outcomes (in particular mortality rate) and deliver a range of other benefits to patients.

The emphasis on high volume specialist units particularly relates to concerns regarding the risks or poorer outcomes associated with a low numbers of cases each year. Hence there has been national recognition of the need for reconfiguration proposals to deliver sufficient activity per consultant to maintain the highest surgical standards.

Medway Foundation Trust and East Kent Hospitals University Trust are the two current arterial centres in Kent and Medway. However only one, the Kent and Canterbury Hospital, is currently able to meet the service specification criteria.

In January 2020, MFT's vascular surgical services were extremely fragile and it was becoming increasingly difficult to run robust on-call rotas for AAA Surgery. This had been an ongoing issue which EKHUFT had been supporting with since August 2019. On the 6th January 2020, MFT implemented an emergency move of all elective and non-elective AAA surgery to Kent and Canterbury Hospital. This has helped stabilise the vascular surgical services at MFT and was the first step towards consolidation of inpatient vascular surgical services in Kent and Medway.

1.5 Kent and Medway Health Needs Assessment

The current K&M population is 1,817,400. (2016 ONS Data). The population of Kent is projected to increase by 125,800 by 2026 and will grow by around 14% by 2035. The population of Medway is projected to increase by just under 15%, reaching around 317,529 by 2035. This represents an increase of just over 40,500 people.

Kent and Medway faces a number of demographic challenges these include pockets of significant growth in over 65 year olds in some areas (by 2035 the ONS thinks over 65s will make up more than a quarter of the area's residents), areas of deprivation and a significant variation of mortality across its wards.

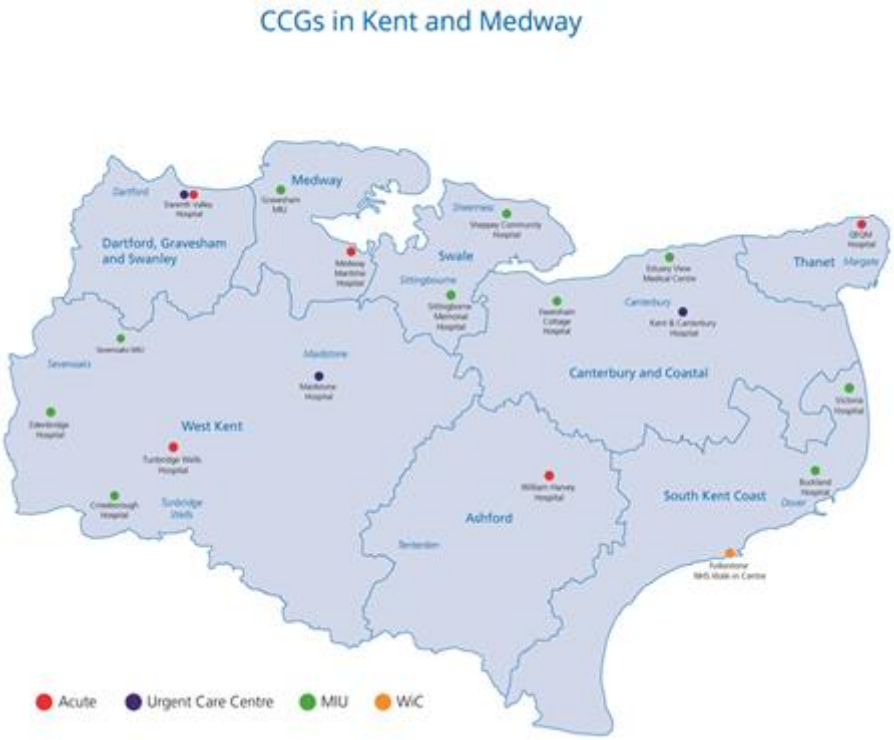
Cardio Vascular Disease (CVD) is a key cause for premature death in Kent and Medway. Key concerns are the high prevalence of diabetes, hypertension, obesity and smoking.
The non-modifiable factors for CVD relate to;
- Age
- Male gender
- Ethnicity
- Family History.

The modifiable features include;
- Diabetes
- Smoking
- Hypertension
- Obesity
- Physical Inactivity
- Cholesterol levels
- Alcohol.

Across Kent and Medway, the highest prevalence for hypertension is in South Kent Coast and Thanet CCGs followed by, Dartford/Swanley & Gravesham (DGS) CCG. Diabetes prevalence is highest in Swale and Thanet CCGs followed by South Kent Coast and Medway CCGs. Medway CCG has the highest level of obesity followed by Swale CCG.

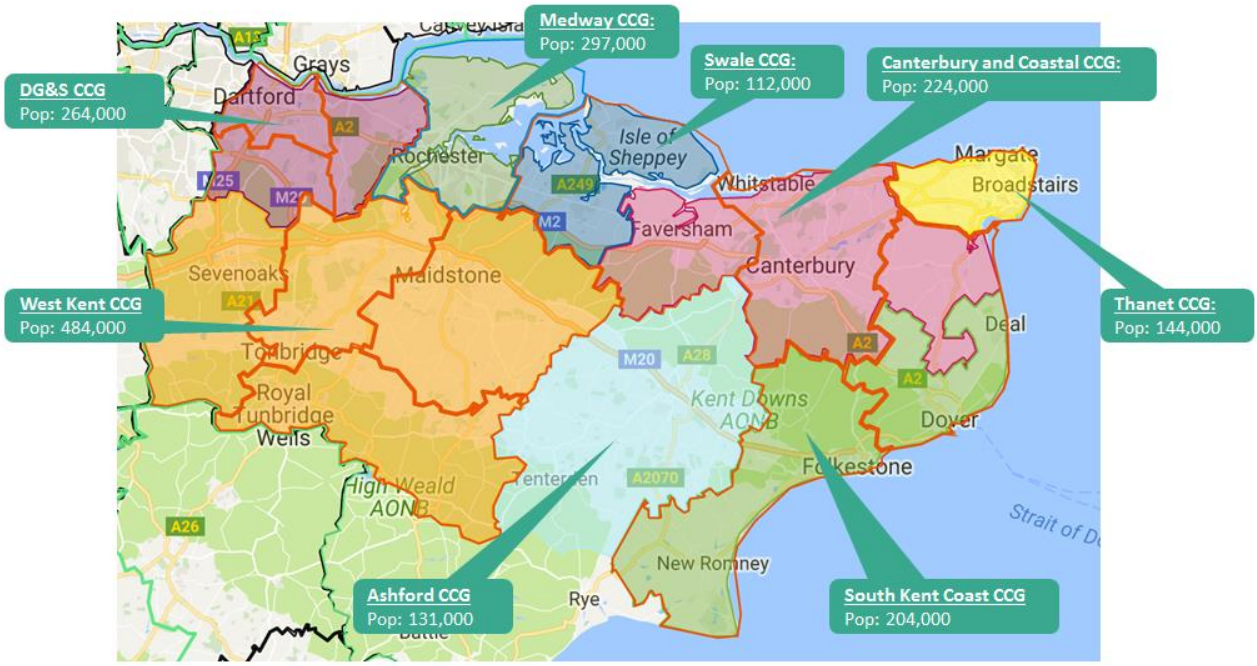
As noted there is a variance across Kent and Medway in relation to deprivation with key pockets across the North Kent and East coastal areas in particular South Kent Coast, DGS, Thanet and Swale. There are however specific wards in CCG areas with high levels of deprivation including Medway and West Kent CCGs.

Map of Kent and Medway with CCGs and Acute Hospital Sites



In Kent and in Medway, about 1,200 people need specialist acute inpatient vascular care each year.

1.6 Kent and Medway Clinical Commissioning Groups



Notes: CCG footprints are designated by background colours; District Council boundaries shown in red outline
Source: NHS England GP List Size Data (January 2017)

Figure 1: Map of Kent and Medway CCGs footprint

North Kent CCGs	**Population**
Dartford & Gravesham and Swanley CCG	264,000
Medway CCG	297,000
Swale CCG	112,000
East Kent CCGs	
Ashford CCG	131,000
Canterbury & Coastal CCG	224,000
Thanet CCG	144,000
South Kent Coast CCG	204,000
West Kent CCG	
West Kent CCG	484,000
Total	**1,860,000**

There are two main local authorities serving Kent and Medway, these are:

- Kent County Council; and
- Medway Council

The recommended population base (National Service Specification and Vascular Society guidance) needed for an adequate number of cases for a viable centre is 800,000.

If all the Kent population's vascular surgery requirements were cared for within Kent and Medway (i.e. including the population currently flowing into London from west and north Kent) then the total network population would exceed 1,600,000. This would be enough to support two vascular arterial centres i.e. 800,000 per centre. However, the population flowing into London for vascular surgery equates to almost 50% of the West Kent population and 94% of the North Kent population (Dartford and Gravesham). As a consequence, the population data illustrates that the current combined catchment area for EKHUFT and MFT vascular surgical services is around 1.4 million.

1.7 Specification Standards

The National Specification for Vascular services notes that the overarching aim of elective and 24/7 emergency vascular services is to provide evidence-based models of care that improve patient diagnosis and treatment and ultimately improve mortality and morbidity from vascular disease. Key features of the national specification include:

- All Trusts delivering vascular services must belong to a provider vascular network
- Arterial surgery should be delivered in an arterial centre
- The pathway for vascular services to include; Diagnosis /Assessment /Outpatient activity / In patient activity / Day case activity / Rehabilitation care.
- Non-arterial surgery and day care should receive specialist vascular care locally with agreed protocols including emergency transfers to the arterial centre.
- Adequate population volumes; A minimum population of 800,000 but for a world class service a larger catchment area will be required.
- Adequate volumes of core Vascular procedures. (> 60 AAA procedures, > 50 Carotid Endarterectomies and commensurate lower limb procedures)
- 24/7 arterial surgery
- 24/7 Interventional radiology available
- Acceptable on call rota requirements, i.e. consultants being on call no more frequently than every six weeks.
- A minimum of six Arterial surgeons and six Interventional radiologists.
- Provision of Vascular surgery by specialist vascular surgeons.
- Provision of Vascular Interventional Radiology by specialist IR consultants.
- Provision of Vascular service by a specialist multi-disciplinary team (MDT).

The following table represent the status of the current services measured against the national specification of Medway Foundation Trust, East Kent Hospitals University Foundation Trust and Guys and St. Thomas' Hospitals Trust (the main London provider for K&M).

Required	Medway FT	East Kent Hospitals	St Thomas' Hospital	Comments
24/7 MDT	No	No	Yes	
6 vascular surgeons. **On call rota (1:6)**	No 1:5*	No 1:4	Yes 1:10	 *includes a locum
On call Vascular Interventional radiology	Yes	Yes*	Yes	*Recruitment underway
AAA screening	Through K&M screening programme	EKHUFT delivers the K&M screening programme	Yes	
Outpatient assessment	Yes	Yes	Yes	
Diagnostics	Yes	Yes	Yes	
In patient non arterial services	Yes	Yes	Yes	
Elective and emergency arterial services	Yes	Yes	Yes	

Day case surgery	Yes	Yes	Yes	
Planning Population currently served;	505,569	682,106	450,687 from Kent (plus South London)	Kent Population treated in London: 450,687 Kent population treated outside Kent or London: 86,417
Risk adjusted Mortality rates; AAA/CE (NVR data September 15)	4.6%/ 4.0%	1.1%/ 1.0%	0.6%/ 3.5%	All within national tolerance

Table 3 Status of the current services measured against the national specification

Details of the current clinical pathways for patients requiring vascular treatment are provided at Appendix 1.

1.13 The Vascular Society

The Vascular Society published guidance on the Provision of Vascular services (2012). The primary objective of the society guidance is to *"provide all patients of vascular disease with the lowest possible elective and emergency morbidity and mortality rates in the developed world. This will be achieved by modernising services to deliver world class care from a smaller number of high volume hospital sites."*

Key recommendations of the Vascular Society guidance[4] include:

- Recognition that it is no longer acceptable:
  1. For emergency vascular care to be provided by generalists who do not have a specialised elective vascular practice.
  2. To provide elective or emergency vascular cover outside a fully centralised service or a formalised modern clinical network with a designated single site for all arterial interventions providing a 24/7 on-site service.
  3. For the vascular specialist to be providing emergency general surgical cover. In addition, vascular surgeons should not be expected to provide elective general surgical services. (N.B. Occasionally some surgeons will undertake specific procedures to maintain competencies directly related to local service needs, but this should be the exception.)
- Networks, involving arterial intervention at more than one site, often result in a reduction in the quality of care and increased mortality for patients in out of business hours. For this reason, current strategies for the provision of vascular care require that all arterial interventions should be performed on a larger volume hospital site, with intervention provided at these hospitals by vascular surgeons and interventional radiologists from both the central and network hospital sites. This allows for 24/7 patient care and the timely treatment of any complications, which may occur.
- Services should be organised in a model that allows reasonable elective activity alongside acceptable on call consultant arrangements. This should result in small units creating a modern clinical network where a designated single centre performs all elective and emergency arterial interventions.
- Facilities must be set up for 24/7 provisions, supported by 24/7 critical care, dedicated vascular wards and endovascular theatre.
- Minimum procedure volumes are recommended; > 60 AAA procedures per unit with a minimum population of 800,000. Minimum 10 per surgeon.
- Hospitals providing vascular services should know and audit their AAA mortality aiming for elective mortality of 3.5% (by the end of 2013) and should regularly review the mortality morbidity rates of

[4] The full document can be found at:
http://www.england.nhs.uk/wp-content/uploads/2013/06/a04-spec-vascu-adult.pdf

the Specialists.

- Specialists undertaking aortic interventions should submit their activity to the National Vascular Register
- Specialist vascular centres should provide dedicated nursing care of vascular in-patients, combining aspects of general surgical nursing, critical care, limb and wound assessment, tissue viability, wound care, rehabilitation, care of the disabled and care of the elderly.
- This care should be provided in a ward dedicated to the care of vascular patients is essential to ensure an appropriate skill mix of nurses who have been specially trained in the care of vascular patients
- Emergency assessment and treatment should be available within one hour of travel to a recognised vascular unit in most locations in the UK. 95% of patients should be triaged, referred and have arrived at the vascular unit within two hours arrival at the spoke hospital.

Vascular services are a specialised area of healthcare, which evidence has shown, will benefit from organisation into larger centres covering a population that will facilitate significant volumes of activity in all areas of service with a robustly staffed workforce able to deliver services 24 /7, 365 days of the year. The vision of the clinical teams in Kent and Medway is to develop and deliver a model of care for vascular services that will deliver all of this.

1.14 Aims and Objectives

The overarching aim of this programme is to provide evidence-based models of care that improve patient diagnosis and treatment, and ultimately improve mortality and morbidity from vascular disease. The service will deliver this aim by:-

- Improving the patient experience, providing equality of access to the full range of vascular diagnostics and interventions and ensuring that patients are receiving a high quality of service, with access to the most modern techniques;
- Developing and sustaining the resilience of vascular services and the workforce providing those services;
- Improving mortality and morbidity rates for people with vascular disease and improving survival rates following hospitalisation;
- Improving complication rates following a vascular admission (short and long term).
- Reducing mortality rates by preventing death from ruptured abdominal aortic aneurysm, stroke, lower limb ischaemia and vascular trauma;
- Providing early intervention and treatment to achieve regional reductions in the incidence of stroke due to carotid artery disease and leg amputation due to peripheral arterial disease;
- Supporting other services to control vascular bleeding and manage vascular complications; and
- Working jointly with the diabetic and podiatry service to optimise care, minimise tissue loss and prevent amputation.

1.15 Travel Times Analysis

The Vascular Society recommends that services should be arranged to minimise transfer times and to transfer vascular emergencies to the vascular unit without delay. The key priority is to transfer the patient to a vascular unit, even if the travel time is beyond the hour, as evidence shows that this improves patient outcomes.

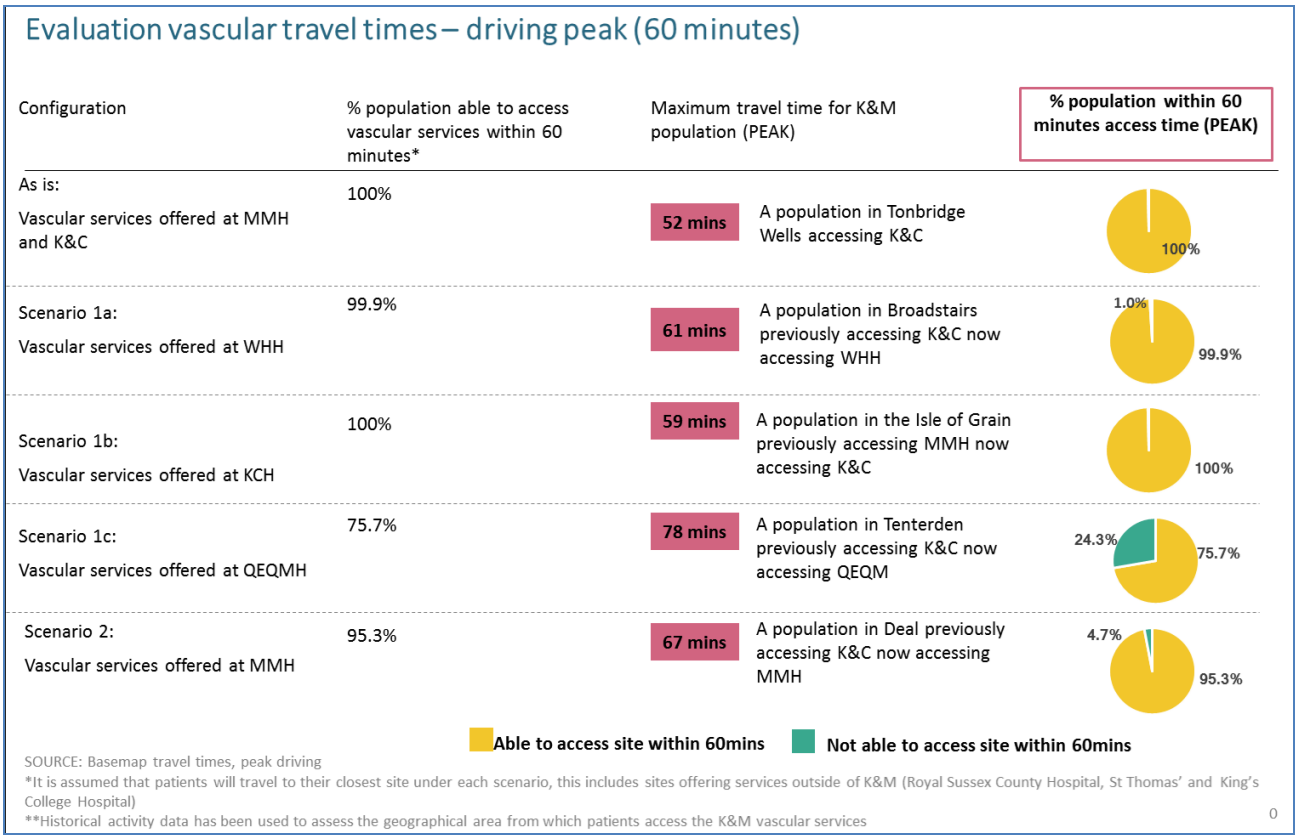
In January 2015, a detailed travel analysis was commissioned as part of the vascular service review in Kent & Medway (see appendix 5 for the detailed report). The results of the report showed the travel time to Medway Maritime and Kent & Canterbury hospitals and concluded that:

- Medway Maritime is the most accessible site within 30 minutes to the population of Kent and Medway
- Medway Maritime and Kent & Canterbury are equally accessible within 45 minutes
- London hospitals are accessible within 60 minutes by ambulance only to areas in the western quarter of Kent.
- A service centred on Medway Maritime would be slightly over 60 minutes by ambulance (62

minutes) from the east coast around Thanet which has a high number of admissions of circulatory disease (n = 1,699).

- A service centred on Kent & Canterbury would be over 60 minutes by ambulance from Tunbridge Wells, but this area has lower number of admissions than around Thanet (n = 796).

A further analysis of vascular patient travel times was also undertaken by Carnell-Farrar in July 2017[5]. The analysis showed that 100% of patients from across Kent and Medway are currently able to access vascular services provided at either MMH or K&CH within 60 minutes.



The analysis also showed that having the Single Arterial Centre located at QEQMH would provide poor access for patients requiring vascular surgery. If the Centre was located at QEQMH then around 25% of the Kent and Medway population would fall outside of the 60-minute travel time window. As a result, around 5% of the population would be transferred to one of the London tertiary centres for the care.

Travel time analysis that has been undertaken has demonstrated that establishing the Vascular Centre at WHH or at K&CH would allow the best access for patients from across Kent and Medway allowing 99.9% and 100% of the population able to reach these respective sites within 60 minutes.

Having the Single Arterial Centre located at Medway Maritime Hospital would provide slightly lower levels of access; allowing 96.5% of the population to reach the centre within 60 minutes.

4.	**What is the severity of the issue - Financially? (Scope & Risk)**
	The financial impact of maintaining the current clinical and operational model is difficult to cost due to the number of unknown variables which will arise from the deterioration of Vascular services on each site due to the unsustainable pressures currently experienced by the services with staff stretched across unsustainable rota schedules. However it is likely that services would lose substantive medical staff who would be replaced by expensive locums and so ultimately the do nothing option will increase

[5] Carnell-Farrar Travel times analysis is provided at Appendix 6

	costs in both organisations with no corresponding improvement in patient care.
5.	**What are the risks to the Trust of maintaining the current position – Qualitative?**
	There are many risks associated with maintaining the status quo. The service would continue to be unsustainable and this would threaten the viability of the existing vascular services. These sustainability issues relate to the fragility of specialist workforce (Consultant surgeons, IR Consultants and specialist nurses and the wider multi-disciplinary team) being spread too thinly across the county and having insufficient patients to treat. In turn, this means that our staff become less skilled and less experienced in treating sufficient numbers of patients to maintain competencies. Maintaining the status quo also means that having 24/7 on site vascular surgery and interventional radiology on-call rotas staffed by the right number of staff continues to be impossible. We would continue to be unable to have a specialist team to manage patients with vascular disease that includes vascular surgeons, interventional radiologists, specialist nurses, vascular scientists, diabetes specialists, stroke physicians, cardiac surgeons, orthopaedic surgeons, and emergency medicine amongst other specialties to provide a comprehensive multi-disciplinary service. Staying as we are also means that staff are also unable to develop their skills and expertise and this impacts on the ability to manage patients' conditions and recovery. Having services fragmented as they are at present means that services are less productive and less efficient as there is unnecessary duplication and waste. It also inhibits opportunities for training, research and innovation and this all impacts on patient care. Although K&CH has a dedicated vascular ward and nursing staff, this is not the case in Medway where vascular patients are cared for on general surgical wards. Under the status quo this would continue. Patients requiring major amputations should be treated in arterial centres that have all the necessary skills and resources to manage their care. This is not in place at the moment therefore at times patients do not receive a high quality of service, with access to the most modern techniques. It is also difficult to make improvements to mortality and morbidity rates for people with vascular disease and improving survival rates following hospitalisation in the way services are currently configured. Making improvements to complication rates following a vascular admission (short and long term) is also extremely difficult. Staying as we are would also mean that reducing mortality rates by preventing death from ruptured abdominal aortic aneurysm, stroke, lower limb ischaemia and vascular trauma is almost impossible. Providing early intervention and treatment to achieve regional reductions in the incidence of stroke due to carotid artery disease and leg amputation due to peripheral arterial disease and supporting other services to control vascular bleeding and manage vascular complications also continues to be extremely difficult and fragile. Maintaining the status quo would also mean that working jointly with the diabetic and podiatry service to optimise care, minimise tissue loss, prevent amputation, standardise methods and promotion of best practice across the clinical teams continues to be challenging. It also means that opportunities to reduced length of stay for patients and improving pathway links with community providers to support timely repatriation of patients following surgery remains almost impossible. In summary therefore, if the status quo continues there is a real risk that Kent and Medway's vascular surgical services fall over and patients would have to travel to London to receive all of their vascular care. The risk associated with this is that the London providers would be unable to cope with the additional demand and patients would suffer.

Section 3 – Option Appraisal

The outputs from the Review clearly demonstrated that there is a need to address the provision and configuration of the Vascular services in Kent and Medway to ensure sustainable and quality service accessible to all Kent and Medway residents.

The scope for the scheme is to reconfigure the existing Specialised Commissioned in-patient vascular services in Kent and Medway. With this in mind, an original long list of seven options was generated using the options framework.

Option 1 – Two Kent and Medway Hubs with Current London Pathway
No Change to the current configuration and patient flows. Kent and Medway surgical services provided at East Kent Hospitals University NHS FT (EKHUFT) and Medway Foundation Trust (MFT) and Guy's and St Thomas' NHS Foundation Trust (GSTH).

Option 2 – No Kent and Medway Hubs
No arterial surgical centre in Kent and Medway. All arterial surgery takes place in London. All Kent and Medway providers are network spokes.

Option 3 – Two Kent and Medway Hubs without London
The two vascular surgery centres in Kent and Medway become hub centres and no patients are referred to GSTH, expect for highly specialised procedures.

Option 4 – One Kent and Medway Hub, no London Pathway
One vascular surgery centre in Kent and Medway becomes the hub centre and no patients are referred to GSTH, expect for highly specialised procedures.

Option 5 – One Kent and Medway Hub with London Pathway
One vascular surgery centre in Kent and Medway becomes the hub centre. Patients continue to be referred to GSTH.

Option 6 - Networked Kent and Medway Hubs, no London Pathway
The two current vascular surgery centres provided all arterial surgery for Kent and Medway with no referral to GSTH, except for highly specialised procedures. The two surgical and IR teams network to provide Hub services including surgical cover at both sites 24/7.

Option 7 - Networked Kent and Medway Hubs with London Pathway
The two current vascular surgery centres provided arterial surgery for Kent and Medway with the current referral pathway to GSTH remaining. The two surgical and IR teams network to provide Hub services including surgical cover at both sites 24/7.

The Vascular Review Programme Board formally agreed the scope of the reconfiguration and noted that this would not include the current patient flows into GSTT (July 2016). Patient and Clinical choice will remain for both GSTT and the new proposed K&M collaboration.

The options appraisal tested each option against a set of criteria from the national specification and the Vascular Society Provision of Vascular Services. These included:

a. Minimum population volumes;
b. Minimum procedures undertaken;
c. Minimum staffing numbers for consultant surgeons and interventional radiologist;
d. Specialist facilities including dedicated hybrid theatres and wards;
e. Targets for key outcomes measures; and
f. To work within a network, using a hub (in-patient unit) and spoke (out-patient and diagnostic units) delivery model.

The ability to meet the aforementioned criteria and the quality and safety issues of each option was reviewed within the context of:

a. Delivering a safe sustainable staffing rota and availability;
b. Travel Times;
c. Essential co-dependencies; and
d. Current activity and possible impact of future population growth

Short-listed options

The option appraisal process was agreed through the Programme Advisory Board and undertaken by the Clinical Reference group. The Clinical Reference Group appraised the long list of options and determined that two options should be short listed:

- **Option 5 – One Kent and Medway Hub with London Pathway**

- **Option 7 – Networked Kent and Medway Hubs with London Pathway**

These two options were reviewed in detail against the national specification and Vascular Society guidance. The review was undertaken by the Clinical Reference Group and included consideration for workforce, job planning, travel times, patient transfers, emergency and non-emergency take and patient safety and experience.

Further analysis identified that Option 7 would;
- not deliver the required volume of activity at the two arterial centres
- not resolve the derogation or deliver the national specification in a sustainable manner; and would
- require the closure of in-patient support at one site on certain periods potentially leaving post-surgical patients without consultant cover.

Option 5 was assessed as being the only option able to deliver the national specification requirements and was the only option able to create a sustainable centre of excellence in Kent and Medway. To achieve this, the clinical model will operate as a network across Kent and Medway with a single arterial centre (hub) and a more diverse, multi-site model for non-arterial centres. One of the non-arterial centres would become an enhanced non-arterial centre providing mainly outpatient and day-case services for the local population. Under this option, appropriate patients will continue to be referred from Kent and Medway to GSTH.

This preferred model for the future of vascular services in Kent and Medway required further clarification in relation to which hospital site becomes the single arterial centre (hub) and which site becomes the non-arterial centre.

Medway Foundation Trust has a single inpatient site, however in East Kent there were three possible sites that could potentially host either an AC or an Enhanced NAC: QEQMH, WHH and K&CH.

A site-based analysis was therefore undertaken to ascertain which of the East Kent Hospital sites would be most suited to become a Vascular Centre (either AC or NAC). This analysis considered:
- Whether the site has the necessary clinical adjacencies to support either an AC or a NAC;
- Existing estates constraints specific to the site in question
- Any possible flows of activity that may result from creating either an AC or a NAC at that site.

Following completion of the analysis of the long-listed options and the subsequent identification of the short-listed options, the options for more detailed analysis were as follows:

Option 5A - Single Arterial Centre at Kent and Canterbury Hospital and Enhanced Non-Arterial Centre at MFT

Option 5B - Single Arterial Centre at Medway, and Enhanced Non-Arterial Centre at EKHUFT

Under both short-listed options, patients would still have the opportunity to access the London tertiary

centres for their treatment under patient choice.

In order to take forward the development of the recommendation and model of care, the Chief Executive Officers at EKHUFT and MFT worked together to agree the Kent and Medway Vascular Clinical Network arrangements[6]. This formal collaboration agreed the development of the Network through a Network Board with a number of key work streams and sub-groups.

The purpose of the sub-groups was to develop the clinical model and the governance arrangements (both clinical and information governance). The Finance work stream group provided the overarching support for the development of this business case as part of a Network solution. This group provided on-going financial and information support as required once the Network was up and running.

The Network solution has been jointly developed by the clinicians from MFT and EKHUFT in accordance with the national specification and Vascular Society guidance. It seeks to deliver the ambition providing world class vascular services across Kent and Medway which is both clinically and financially sustainable for the future. The detailed clinical model and clinical pathways have been produced and formally approved by the Network Steering Group and can be found at Appendix 3.

Further development of the Vascular Surgical model will take place alongside the Kent and Medway Sustainability and Transformation Partnership (STP). The permanent solution for the Vascular Surgical model will form part of the business case for the STP once the Pre-Consultation Business Case has been approved and the Public Consultation for the STP has been completed. However, the East Kent Transformation Programme is likely to take around 7 years to deliver therefore NHS England has recommended that an interim arterial hub should be located in Canterbury at the Kent and Canterbury Hospital until such time as the longer-term transformation programme materialises.

Numerous Public and Patient Engagement events have been held over the last four years and the information gathered from the Events has been used to help inform these decisions. See Appendices 7 & 8

Details of the two preferred options for the interim arterial network model are now provided below alongside the do-nothing option.

Short-listed Options

Do nothing	Maintain the current position
Summary of Option	Under this option acute inpatient vascular surgical services would remain as they currently are, provided at both Medway Maritime Hospital in Gillingham and at Kent and Canterbury Hospital in Canterbury. Neither hospital would become a single arterial centre for Kent and Medway.
Activity Impact (Demand & Capacity)	Under this option neither acute inpatient hospital site would serve the minimum population levels and therefore both hospitals would struggle to treat sufficient number of clinical cases required by the national service specification. Consequently, both Trusts would remain under Commissioner derogation. This is not a position that NHS England is prepared to let continue.
Workforce Impact	The workforce would continue to be split across two inpatient sites with Medway Hospital not seeing the necessary levels of activity. This option also does nothing to improve the current intensity of on-call commitments and consequently does nothing to improve the recruitment opportunities. Consultants will continue to have to cover unsustainable on-

[6] See Appendix T

	call rota commitments. At Medway Hospital, the Vascular surgical service will continue to struggle to secure junior doctors support (Jnr Doctors have been temporarily removed from the service due to lack of supervision and oversight. These have been replaced by substantive doctors to support the service for the immediate future).
Income Impact	None – although income may decrease if substantive staff are lost
Cost Impact (Revenue)	Likely increase in costs due to loss of substantive staff as a result of unsustainable rota scheduling
Benefits of Implementation	NHS England, the Vascular Society and GIRFT have all concluded that this option is not sustainable and must not continue. There are no benefits to maintaining the status quo.
Quality & Safety Impact	This option will not support the sustainable delivery of evidence-based models of care that aim to improve patient diagnosis and treatment. Ultimately there will be no ability to improve mortality and morbidity from vascular disease across Kent and Medway. The way vascular surgical services are currently configured in Kent and Medway is inconsistent with the need to deliver services as part of a vascular network. This option would mean that arterial surgery would not be delivered in an arterial centre serving a large enough population. As a consequence, clinicians would not undertake adequate volumes of core Vascular procedures to maintain their skills. Consultants would continue to have to participate in unacceptable on call rotas, which is unsustainable.
Risks of Implementation	NHS England, the Vascular Society and GIRFT have all concluded that this option is not sustainable and must not continue. There are no benefits to maintaining the status quo.

Option 5A	**Preferred Option:** **Single Arterial Centre at Kent and Canterbury Hospital and Enhanced Non-Arterial Centre at MFT**
Summary of Option	Under this option, the single Arterial Centre will be based at the Kent and Canterbury Hospital in Canterbury, East Kent. The Arterial Centre will be the single hospital within the network that provides all inpatient care for both elective and emergency vascular surgery, providing all types of vascular surgery and vascular interventional radiology. This Arterial Centre will be the only hospital in Kent and Medway that has on site a 24/7, full, year round specialist vascular team to manage all acute inpatient elective and emergency vascular surgery. The Arterial Centre will also be the managerial centre for the Kent and Medway Vascular Network. Medway Hospital (MFT) will be the Enhanced non-arterial vascular centre and will form an integral part of the Networks solution model of care. This will be resourced to provide local vascular services that do not require a 24/7 workforce presence and inpatient based vascular interventions. It will have an enhanced weekday presence of a specialist vascular team to support other acute services within the hospital. This hospital will have interventional radiology (IR) services to support day case vascular interventions. This IR service will also support the IR needs of non-vascular services. Day-case services will be provided to support activity within the vascular network e.g. renal access surgery and on-going fistula management support interventions and it will offer a comprehensive vascular diagnostic and outpatient ambulatory care service. The Network model will be supported by Non-enhanced non-arterial hospitals. Hospitals that provide acute care services (typically medicine, surgery, obstetrics), that at times will require on site vascular advice and will require direct contact links to the arterial vascular

centre for 24/7 support for vascular advice and patient management. These sites, which include Maidstone Hospital, William Harvey Hospital and Queen Elizabeth The Queen Mother Hospital will not have a daily specialist vascular presence, however, the ability to offer full vascular diagnostics and outpatient services for the local population will be available. The Non-enhanced non-arterial hospitals will deliver all out of hospital care and will be delivered through the existing Kent and Medway hospitals' buildings at these sites. These hospital sites will deliver a range of services that seek to keep care as close to home as possible for patients and will include:

- Outpatients clinics; i.e. multi-disciplinary clinics, condition specific clinics, one stop shop clinics, nurse led and consultant clinics;
- Pre- and post-operative care;
- Ongoing monitoring and management of vascular conditions e.g. Peripheral vascular disease;
- Diagnostics and tests; and
- Day surgery where appropriate

Patients would still have the opportunity to access the London tertiary centres for their treatment under patient choice.

Activity Impact

(Demand & Capacity)

The clinical model will see the creation of a vascular network across Kent and Medway with a single arterial inpatient centre (hub) at K&CH, an enhanced non-arterial centre at MFT providing outpatient, day-case surgery and diagnostic services, and a number of supporting sites that will provide outpatient services and diagnostics for their local population.

Based on the activity for 2018/2019 and the 2019/20 year to date activity, the following conclusions can be drawn about the expected levels at the single arterial inpatient centre. [7]

Total All Activity	2019/20 (Full Year)
Validated Inpatient Procedures (K&CH & MFT)	814
Other IP Procedure 107 Activity (K&CH & MFT)	292
EKHUFT Validated DC Procedures	8
Other EKHUFT DC Procedure 107 Activity	28
MFT Validated DC Procedures	14
Other MFT DC Procedure 107 Activity	8
Total Activity	**1,164**

There are a further 440 non-validated day cases within the dataset that are not included in the above table.

All inpatient procedures that will be undertaken at K&CH once the network goes live

Under the preferred option, the growth in inpatient activity (from present state) is shown in the table below. The day case activity shown above will stay in its current location. It will not all move to K&CH.

Activity	2018/19	2019/20 (Full Year Effect)	Total (12-month average)
EKHUFT Current Total	680	740	700
EKHUFT New Total	1,066	1,142	1,091
% Change	*57%*	*54%*	*56%*

[7] The data used comes from the NAC Dataset provided by NHSE using the Total Sum of Unique Patients.

The figure of 1,091 (in the above table) has been used to calculate the theatre capacity required in the future.

Procedures

The number of procedures shown in the table below have been agreed by NHS England Specialised Commissioning working in conjunction with the Business Intelligence Team and Consultants at EKHUFT. The table shows the number of procedures undertaken at EKHUFT and MFT in 2019/20.

Procedure Type	EKHUFT 2019/20 (Full Year)	MFT 2019/20 (Full Year)
Open Aortic Aneurysm	52	10
EVAR Aortic Aneurysm	54	20
Subclavian Artery	0	4
Lower Limb - Reconstruction Surgery	48	48
Lower Limb - Amputation (Major)	78	66
Lower Limb - Amputation (Minor)	70	98
Emergency Femoral Artery	0	2
Elective Iliac Artery Ops	4	0
Carotid Endarterectomy	32	10
IR - Angioplasty	270	94
Renal Access	128	46
Total inpatient activity	**736**	**398**

The total number of procedures figure does not match the figure shown for inpatient activity because a number of patients will have had more than one procedure during their inpatient stay.

Detailed analysis of the activity data has produced a definitive set of procedures which relate to inpatient care. The proposed move of all inpatient vascular surgical activity from MFT to K&CH will therefore impact around 400 cases per year.

Beds

At K&CH, the number of occupied bed days has risen to a high of nearly 6,000 bed days in 2018/19. This means on average the vascular surgical inpatient activity occupied around 20 beds (at 85% occupancy).

The demand and capacity modelling shows that the move of 400 inpatient vascular cases per year from MFT to K&CH. Working on 85% bed occupancy this activity would require around 11 beds. Therefore, the proposed arterial hub at Kent and Canterbury Hospital will require a total of 31 inpatient beds.

Current funded beds at K&CH	20
Additional beds needed	11
Total beds required (85% occupancy)	31

Table 4 Vascular inpatient bed current and future required

The current dedicated Vascular inpatient ward at Kent and Canterbury Hospital is Kent Ward. Kent Ward currently has 20 funded inpatient beds and 3 unfunded inpatient beds.

It also has a 6 bedded area which is currently allocated for day case surgery and admissions. In the future, these 6 beds would become inpatient beds dedicated for inpatient Vascular Surgery and the unfunded beds would be appropriately funded taking the total number of funded inpatient beds from 20 to 29.

It is recognised that the LOS at Medway is higher than that of EKHUFT, as such it is not expected that the gap in beds required will be sought through efficiencies in the system. It is unknow at present if the increased requirement for repatriation or the growth in amputations requiring 2 beds spaces will affect EKHUFT LOS. As such, the business case is looking to fund converting the 6 bedded trolley bay on Clarke (adjacent ward) into an inpatient space to accommodate peaks in demand.

The 12 trolley bay spaces will be re-provided in the former Ambulatory Care area located between the Urgent Treatment Centre and the Radiology department.

The graph below shows the average length of stay for vascular patients at MFT and at EKHUFT. Average length of stay for Medway patients is around 2 days longer than for patients at K&CH.

EKHUFT will be looking to repatriate patients that have had a major limb amputated back to MFT for their ongoing rehabilitation once they no longer need to be under the direct care of the Vascular surgical team. The clinical pathway for these patients enables them to be repatriated under Medway Hospital's diabetic team. This would also help to free up inpatient bed capacity at the arterial centre. A robust process must be in place to ensure the timely transfer of these patients.

The demand and capacity modelling uses the following data and assumptions:

- Data taken from NHSE NAC dataset.
- Theatre and bed capacity provided internally and using the same totals as the initial internal piece of work.
- Percentages of theatre splits from the initial internal work.
- The additional demand and capacity is based on the methodology used in the initial work using an 'as is percentage growth' method.

Theatres

Table below shows the theatre capacity required for all vascular activity. Currently weekly theatre capacity equates to 7 sessions and in the future the service will require 11 sessions. These additional 4 sessions will be provided through the move of some general surgical main theatre sessions from the K&CH site to QEQM (2.5 sessions). The additional IR theatre sessions will be created with the opening of the second IR theatre. The capacity will temporarily be created through elongated days until both theatres are in use.

Main **Theatre**	**Sessions**[8]
Current annual Capacity	364
Current weekly Capacity	7
Capacity Growth (annual)	203.49
New Total Capacity required (annual)	567.49
New Total Theatre capacity Required (per week)	4
Weekly Total sessions required	11

[8] **Activity modelling assumptions:**
That all sessions have been entered onto Theatreman.
That all activity under IR and Vascular that currently takes place in KCH theatre 6 is appropriate.
An all-day session counts as two sessions.
This does not include cancelled sessions.
This is an average figure and it is assumed variation can be absorbed within operational working practices.

Theatre 6 (EVT) and Interventional Radiology

	Theatre 6 (Joint Vascular and IR)	Theatre 6 (Vascular-related IR)	Theatre 6 (IR)	Total
Current annual utilisation	104	139.88	358.8	602.68
Current weekly capacity	2	2.69	6.9	8.9
Capacity annual growth	58.14	30.23	-	88.37
New total annual capacity required	162.14	170.11	-	332.25
New weekly total capacity required	3.13	3.27	-	6.4
Weekly capacity Gap to fill	1.13	0.58	-	1.71

Table 6 Theatre 6 and Interventional Radiology

According the theatre utilisation dashboard[9], KCH theatre six (EVT) was used on average 2 sessions a week for vascular activity. Interventional Radiology activity used 6.9 (7) sessions a week, of which 2.69 sessions was Vascular-related IR activity. Rounding up, therefore theatre six (EVT) was utilised for a total of 8.9 (9) sessions a week. The unused sessions is for MDT and is used ad-hoc when required.

The analysis shows that 2 (1.71) extra sessions will be needed in theatre six to accommodate activity which will be moving from MFT. Therefore an average of 10.61 sessions a week will be needed to accommodate all activity from EKHUFT and MFT. Of course, a proportion of that activity will be done either at weekends or out of hours.

ITU / Critical Care

HDU bed activity is not indicated separately on the Trusts PAS system. It is anticipated that an additional 2 HDU beds are required. There is sufficient bed space for 2 additional beds in critical care which will be funded as part of this business case.

Outpatients

The following data[10] from 2018/19 is for Vascular Outpatients, split by New and Follow Up. It shows the breakdown by Trust of where OPD activity has been delivered. This outpatient activity will continue to be provided in its current locations and it will not change as a result of the creation of the Kent and Medway Vascular Network model.

Site	OP New	OP Follow Up	Grand Total
EKHUFT	3,641	3,651	7,292
MFT	1,458	1,270	2,728
MTW	1,856	1,616	3,472
Total	6,955	6,537	13,492

Table 7 Outpatient activity at MFT and EKHUFT

[9] weekly data between week commencing 31/12/18 and 30/12/2019 (53 weeks)

[10] The OPD data has come from the Dr Foster

<table>
<tr><td>Workforce Impact</td><td>The vascular surgical team who are currently employed by Medway Hospital NHS Foundation Trust will all transfer over to East Kent Hospitals University NHS Foundation Trust under TUPE arrangements. This includes 4 consultant vascular surgeons, 1 ST Registrar, 2 Vascular Nurse Specialists and 3 supporting administrative staff. Other teams that provide a supporting service for the vascular surgical service will continue to provide these services under a number of service level agreements. Details of staff transferring and their clinical commitments are provided at Appendix 2.

Some members of Medway Hospital's anaesthetic team and interventional radiology team have expressed a desire to continue to participate in the provision of vascular surgical care at K&CH but do not wish to formally transfer their employment to K&CH. Arrangements are being made for those staff to participate in the vascular network using honorary contracts and service level agreements. All appropriate clinical governance arrangements have been set in place to support this activity.</td></tr>
<tr><td>Income Impact</td><td>As the service is embedded there should be an increase in the volume of patients seen and treated as waiting lists are reduced to expected levels. This is not expected to result in a material increase in cost to commissioners on an annual basis. However, MFT are left with considerable stranded costs which commissioners are asked to fund.</td></tr>
<tr><td>Overall Service Level Impact (SLR Profitability)</td><td>
<table>
<tr><th></th><th>EKHUFT</th><th>MFT</th></tr>
<tr><td>Income</td><td>£4,439,295</td><td>-£4,439,295</td></tr>
<tr><td>Expenditure</td><td>£4,362,116</td><td>-£3,564,127</td></tr>
<tr><td>Change in Trust Position</td><td>£77,179</td><td>-£875,168</td></tr>
</table>
</td></tr>
<tr><td>Benefits of Implementation</td><td>Under this option, service would become sustainable and viable. The specialist workforce (Consultant surgeons, IR Consultants and specialist nurses and the wider multi-disciplinary team) will all be located on a single site meaning that they will have sufficient patients to maintain their specialist skills. There would be 24/7 on site vascular surgery rotas staffed by the right number of specialist staff.

The option will enable the service to have a specialist team to manage patients with vascular disease that includes vascular surgeons, interventional radiologists, specialist nurses, vascular scientists, diabetes specialists, stroke physicians, cardiac surgeons, orthopaedic surgeons, and emergency medicine amongst other specialties to provide a comprehensive multi-disciplinary service.

Staff will be better able to develop their skills and expertise. Productive and efficiency will improve as there will be less duplication and waste. It also supports opportunities for training, research and innovation and this all impacts on improvements in patient care.</td></tr>
<tr><td>Quality & Safety Impact</td><td>All vascular inpatients will be treated on a dedicated vascular ward by dedicated vascular nursing staff.

Patients requiring major amputations will be treated in this single arterial centre which will have all the necessary skills and resources to manage their care and access to the most modern techniques. There will also make it easier to make improvements to mortality and morbidity rates for people with vascular disease and improving survival rates following hospitalisation.

The preferred option will also enable early intervention and treatment to achieve regional</td></tr>
</table>

	reductions in the incidence of stroke due to carotid artery disease and leg amputation due to peripheral arterial disease. The preferred option also will enable working jointly with the diabetic and podiatry service to optimise care, minimise tissue loss, prevent amputation, standardise methods and promotion of best practice across the clinical teams. It also means that opportunities to reduced length of stay for patients and improving pathway links with community providers to support timely repatriation of patients following surgery will be more possible. The above costing also includes a number of service enhancements that will improve the service offering to patients in Kent and Medway and ensure that services are more timely and sustainable. The Vascular Nurse Practitioners are vital to the running of the Vascular services across Kent and Medway. The VNP deliver independent clinics alongside the vascular surgeon teams, support the vascular doctors and ward staff. The team are responsible for delivering a large amount of the vascular outpatient activity, pre-assessment, supporting inpatients and the emergency pathways. The teams are skilled in the assessment of the acute and chronic vascular patients. This includes undertaking a physical assessment, recording of a health history, interpretation of Doppler assessments and planning appropriate treatment. The current VNP teams are at risk of losing their workforce over the next 2-5 years through retirement with no clear plan on training and replacing the highly skilled staff. The business case included the funding to support recruitment for two full time band 6 in a development posts to train up with the required competencies to become a band 7 in the future. The EKHUFT Vascular Department currently pay an agency sonographer to run an all-day clinic once a week at KCH. The role is highly specialised and we do not currently have the skills within the Trust to support this activity. The vascular team often require specialist ultrasound scans at other times through the week but are unable to access them. The business case includes the funding to recruit a full-time vascular sonographer to the department. This removes the agency costs of £426 per day which is currently paid. The sonographer would run all day clinics at WHH, QEQM and K&CH. The clinics would comprise of the routine vascular scans, AAA surveillance patients and inpatients awaiting scans which often see delays to their treatment and/or discharge. This post will also support a reduction to the departmental costs. Ultrasound scans can be carried out on some patients post EVAR surgery instead of CT scans. The reduction CT scans is likely to be around 10 per month. This also provides a health benefit to the patient as they will not be exposed to further radiation. There is a potential to develop a peripheral arterial duplex scan service, similarly a specialist post carotid surgery scan service. The Vascular service will see a reduction of trainee doctors over the coming years due to the changes in the training programme. As a Vascular hub we must ensure there is a safe, stable and sustainable workforce in place to deal with the demand. The addition of two Associate Specialist posts will future proof the on-call and activity required of the middle grade doctor tier. This will also guarantee the service does not need to use high cost locums at times of trainee shortages. The current outpatient waiting times at Medway for Vascular services are at unsustainable levels in order to achieve 18weeks. By combining resources, we will be able to address the long waiting times and improve the referral to treatment performance. Inpatient services will need to be reconfigured on the Kent and Canterbury site in order to support the increase in vascular inpatient activity. Kent ward will remove the trolley bay to create an additional 6 beds, the space is currently used for vascular theatre admissions. Clarke ward will also lose their Urology admission area to facilitate another additional 6 beds required for vascular inpatients. The expansion of the bed base must be supported by a new admissions area on site for Vascular and Urology patients. This

	admission unit will create streamlined processes for theatre admissions, reducing delays to theatres, improved communication pathways and saves time for medical teams as patients are all in one place. This will allow the ward staff to concentrate on high acuity patients on the ward and discharges.
Risks of Implementation	MFT staff choose not to TUPE resulting in EKHUFT having to employ costly locum and agency staff.

Option 5B	**Single Arterial Centre at Medway, and Enhanced Non-Arterial Centre at K&CH**
Summary of Option	Under this option, the single Arterial Centre will be based at Medway Hospital. The Arterial Centre will be the single hospital within the network that provides all inpatient care for both elective and emergency vascular surgery, providing all types of vascular surgery and vascular interventional radiology. This Arterial Centre will be the only hospital in Kent and Medway that has on site a 24/7, full, year-round specialist vascular team to manage all acute inpatient elective and emergency vascular surgery. The Arterial Centre will also be the managerial centre for the Kent and Medway Vascular Network. Under this option, Kent and Canterbury Hospital will be the Enhanced non-arterial vascular centre and will form an integral part of the Networks solution model of care. This will be resourced to provide local vascular services that do not require a 24/7 workforce presence and inpatient based vascular interventions. It will have an enhanced weekday presence of a specialist vascular team to support other acute services within the hospital. This hospital will have interventional radiology (IR) services to support day case vascular interventions. This IR service will also support the IR needs of non-vascular services. Day-case services will be provided to support activity within the vascular network e.g. renal access surgery and on-going fistula management support interventions and it will offer a comprehensive vascular diagnostic and outpatient ambulatory care service. The Network model will be supported by Non-enhanced non-arterial hospitals. Hospitals that provide acute care services (typically medicine, surgery, obstetrics), that at times will require on site vascular advice and will require direct contact links to the arterial vascular centre for 24/7 support for vascular advice and patient management. These sites will not have a daily specialist vascular presence, however, the ability to offer full vascular diagnostics and outpatient services for the local population will be available. The Non-enhanced non-arterial hospitals will deliver all out of hospital care and will be delivered through the existing Kent and Medway hospitals' buildings at these sites. These hospital sites will deliver a range of services that seek to keep care as close to home as possible for patients and will include: • Outpatients clinics; i.e. multi-disciplinary clinics, condition specific clinics, one stop shop clinics, nurse led and consultant clinics; • Pre- and post-operative care; • Ongoing monitoring and management of vascular conditions e.g. Peripheral vascular disease; • Diagnostics and tests; and • Day surgery where appropriate Patients would still have the opportunity to access the London tertiary centres for their treatment under patient choice.
Workforce	The vascular surgical team who are currently employed by EKHUFT will all transfer over

Impact	to Medway NHS Foundation Trust under TUPE arrangements. This includes 3 consultant vascular surgeons, 2 ST Registrar, 5 Vascular Nurse Specialists and 6 supporting administrative staff. Other teams that provide a supporting service for the vascular surgical service will continue to provide these services under a number of service level agreements.
Income Impact	Additional cost to commissioners of MFT providing service due to higher MFF = £250k
Overall Service Level Impact (SLR Profitability)	Data not available

Section 4 | Options scoring process

A set of Evaluation Criteria was developed as part of the STP against which all future proposed clinical models are being and will be evaluated. The full evaluation criteria were developed by the STP hospital care work-stream. These have built on patient, public and carer insight over recent years around what is important to people about local services, with clinical leadership and involvement in the design and thinking, and some on-going testing and discussion with wider stakeholder audiences and groups across Kent and Medway.

The development and progress of the design phase for the evaluation criteria has regularly been reported to the STP Clinical Board, the Patient and Public Advisory Group (or its predecessor arrangement the Patient and Public Engagement Group) and onwards to the STP Programme Board.

The evaluation criteria model consisted of 6 elements, each with a set of sub-criteria against which each of the short-listed options were evaluated. The evaluation criteria were used to evaluate the two shortlisted options for Vascular Surgical services in Kent and Medway.

	Criteria	Sub-criteria	Evaluation question
1	Quality of care for all	Clinical effectiveness and responsiveness	Does the option provide improved delivery against clinical and constitutional standards, access to skilled staff and specialist equipment, comparison of current clinical quality of sites?
		Patient experience	Which option would provide a better experience for patients using patient experience surveys and looking at the quality of the buildings and facilities?
		Clinical co-dependencies	What are the clinical co-located services required for vascular and other services that required vascular inputs?
		Clinical outcomes	Which option would provide a better clinical outcomes for patients using mortality rate and re-admission rates?
		Safety	What is the expected impact on excess mortality, serious untoward incidents and patient harm?
2	Access to care for all	Distance and time to access services	Do any options keep to a minimum the increase in the average or total time it takes people to get to hospital by ambulance, car (at off-peak and peak times) and public transport?
		Service operating hours	What is the ability of model to facilitate 7 day services and improved access to care out of hours?
		Patient choice	Which options would give people in Kent the greatest choice of hospitals for each service under consideration across the greatest number of trusts?
3	Affordability and value for money	Profit/Loss	What is the Profit/Loss of the options?
		Affordability to commissioners	What is the affordability to commissioners?
		Capital cost to the system	Which options would have the lowest capital costs (cost of buildings and equipment)?
		Meet license conditions	Does the option meet regulatory requirements e.g. surpluses generated by each Foundation Trust?
4	Workforce	Scale of impact	What is the potential impact on current medical and non medical staff and retraining / relocation required?
		Sustainability	What is the likelihood of each option to be sustainable from a workforce perspective, facilitating 7 day services and taking into account recruitment challenges and change in what work force does i.e. ability to ensure sufficient people with the right skills in the right places?
		Impact on local workforce	What is the potential impact on staff attrition due to change?
5	Deliverability	Expected time to deliver	How easy will it be to deliver change in 3-5 years?
		Co-dependencies with other strategies	How well does each align with other strategic changes and provide a flexible platform for the future?
6	Research and Education	Disruption to education & research	Which options best fit with current research and education to minimise disruption in these areas?
		Support current & future education & research delivery	Which options best support current and developing research and education?

Table: Evaluation criteria used to evaluate the short-listed options

On 15th August 2017 an evaluation process was undertaken to appraise the remaining two options using the evaluation criteria. The evaluation process was undertaken by the following representatives from MFT and EKHUFT:

- K&M Lead Vascular consultant
- Deputy chief Executive and the Director of Strategic Development and Capital Planning - EKHUFT
- Director for Surgical Services MFT
- Medical Director MFT
- Consultant Interventional Radiologist and Deputy Vascular Network Lead MFT
- Divisional Director for Surgical Services EKHUFT

- Senior Strategic Development Manager and Programme Manager for the Kent and Medway Vascular Network – EKHUFT
- Deputy Chief Nurse and Deputy Director of Quality EKHUFT
- General Manager Surgery – EKHUFT
- General Manager for Emergency Surgical Services – MFT

The evaluation criteria were examined to allow a comprehensive evaluation of the two options enabling the team to score each of the options against the criteria. The analysis for each option was completed by analysing each evaluation criteria in details through the sub-criteria which were measured via specific evaluation questions.

The outputs of the option evaluation process are shown in the table below.

Scoring of each option against the criteria

Criteria	Sub-criteria	Scores OPTION A	Scores OPTION B	Rationale
1 Quality of care for all	• Clinical effectiveness and responsiveness	+2	+2	Clinical effectiveness , patient experience and clinical outcomes were not clear differentiators between the two options even when compared as part of the National Vascular Registry. The GIRFT report did not highlight patient experience as an issue so is also not a differentiator. Creating the single arterial centre would improve all of these metrics regardless of which option was implemented
	• Patient experience	+1	+1	
	• Safety	+2	+2	
	• Clinical co-dependencies	+2	0	Clinical co-dependencies at EKHUFT would be better under the STP plans and it was felt that clinical outcomes could also be improved if the Centre was in East Kent due to having all the correct clinical adjacencies present.
	• Clinical outcomes	+2	+1	
2 Access to care for all	• Distance and time to access services	0	-1	It was felt that having the centre at MFT would provide slightly poorer access for patients than at present. Having the centre in East Kent would not improve or worsen distance and access times.
	• Service operating hours	0	0	Service operating hours would be improved regardless of which option was selected.
	• Patient choice	+1	+1	Patient choice was not considered to be a differentiator between the two options
3 Affordability and value for money	• Profit/Loss	-2	-2	It was agreed that further work needed to be undertaken on the affordability elements of the business case.
	• Affordability to commissioners	+1	0	A lower EKHUFT Market Forces Factor was considered to be beneficial against affordability to commissioners.
	• Capital cost to the system	-1	-1	Capital cost to the system was the same for both options and therefore not a differentiator
	• Meet license conditions	0	0	Neither option would make meeting the license conditions any easier or worse.

4	Workforce	• Scale of impact • Sustainability • Impact on local workforce	+1 +2 -1	+1 +2 -1	It was felt that medical staff would mainly be moving under the preferred option therefore the impact would be relatively small and similar under each option. Both options would provide opportunities to improve training, recruitment and retention and help the service become more sustainable; similar under each option. There may be a negative impact on local staffing as people may chose not to move with the service but this would be the same under each option
5	Deliverability	• Expected time to deliver • Co-dependencies with other strategies	+1 +2	+1 +1	It was felt that each option should be delivered within the same timescale (between 3 to 5 years). Therefore there was no difference between the two options It was felt that EKHUFT was further forward with its development of a clinical strategy under the STP with a clear emerging preferred option defined and timelines prescribed for public consultation. Vascular services form part of that strategy. MFT are not so well advanced with their plans under the STP
6	Research and Education	• Disruption to education & research • Support current & future education & research delivery	0 +2	0 +2	Neither option will have and disruptive impact on research and education therefore both options scored 0. Both options should enhance future education and research delivery but again, no differentiation between the two options.
		Total scores	**15**	**9**	**CONCLUSION** - Option A scores higher than Option B. The preferred option is therefore to create a single Arterial Centre at a site in East Kent identified as the Major Emergency Centre (MEC) with specialist services, and to create an Enhanced Non-Arterial Centre at MFT.

Table: Scoring of the short-listed options using the evaluation criteria

The conclusion from the options appraisal process identified Option 5A as the preferred option - Single Arterial Centre at the Kent and Canterbury Hospital with an Enhanced Non-Arterial Centre at MFT.

Section 5 | Travel impact on affected patients under the preferred option

A travel analysis has been undertaken using the postcodes of patients currently accessing inpatient vascular care at Medway Hospital. Postcodes have been taken from the dataset provided by NHS England Specialised Commissioning.

Patients that currently receive inpatient care at Medway Hospital will, in the future, need to travel further to receive their inpatient care at Kent and Canterbury Hospital.

The table below shows the difference in travel times for this group of patients. The analysis shows the average time it currently takes for vascular inpatients to access Medway hospital alongside the average travel time for the same patients (from the postcodes of Medway patients) to access Kent and Canterbury Hospital.

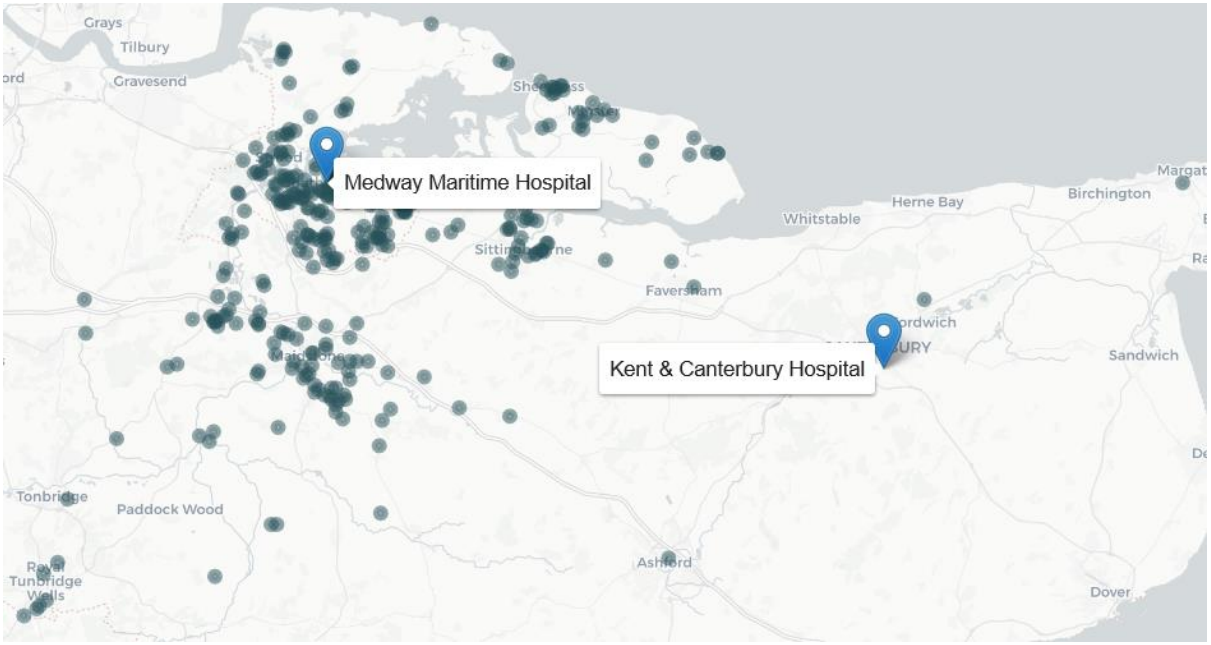
		Range	
Travel Time Analysis	**Average Time (minutes)**	**Min Time (minutes)**	**Max Time (minutes)**
MFT Driving AM Peak Time	21.95	3.49	90.55
K&CH Driving AM Peak Time	43.87	16.11	88.49

For the group of patients analysed (patients who are currently accessing inpatient vascular care at Medway Hospital) the average travel time will increase from 22 minutes to 43 minutes.

Patients are currently spending between 4 minutes and 91 minutes (the range) travelling to Medway Hospital in peak time for their inpatient vascular care. Using the same set of patients, the travel time range would be between 16 minutes and 88 minutes to travel to K&CH.

Currently, patients from the Maidstone area of west Kent that require vascular surgical care receive their care at Medway Maritime Hospital. The average travel time for those patients to access MFT is around 32 minutes. In the future, under the preferred option, these patients will have an average travel time of around 53 minutes.

The map below shows that not all of these patients originate from the Medway area. There are 7 patients whose postcodes are closer to Canterbury than Medway therefore the time taken for these patients to get to Medway is currently longer than it would be for them to get to Canterbury in the future.



Map 1 Originating postcode of patients accessing MFT for their inpatient vascular treatment (2018/19)

In the future, 60% of the patients' postcodes (from those patients currently receiving inpatient care at MFT) will be able to access K&CH in under the 43 minutes average travel time.

Distance data

		Range	
Distance Analysis	**Average Distance**	**Max Distance**	**Min Distance**
MFT Driving Distance	14.7 km	69.1 km	5.8 km
K&CH Driving Distance	48.3 km	91.7 km	8.9 km

The average distance travelled by patients who are currently accessing their inpatient vascular care at Medway is currently 14.7 km. Some patients are travelling 70 km for their care whilst others travel just 5.8 km.

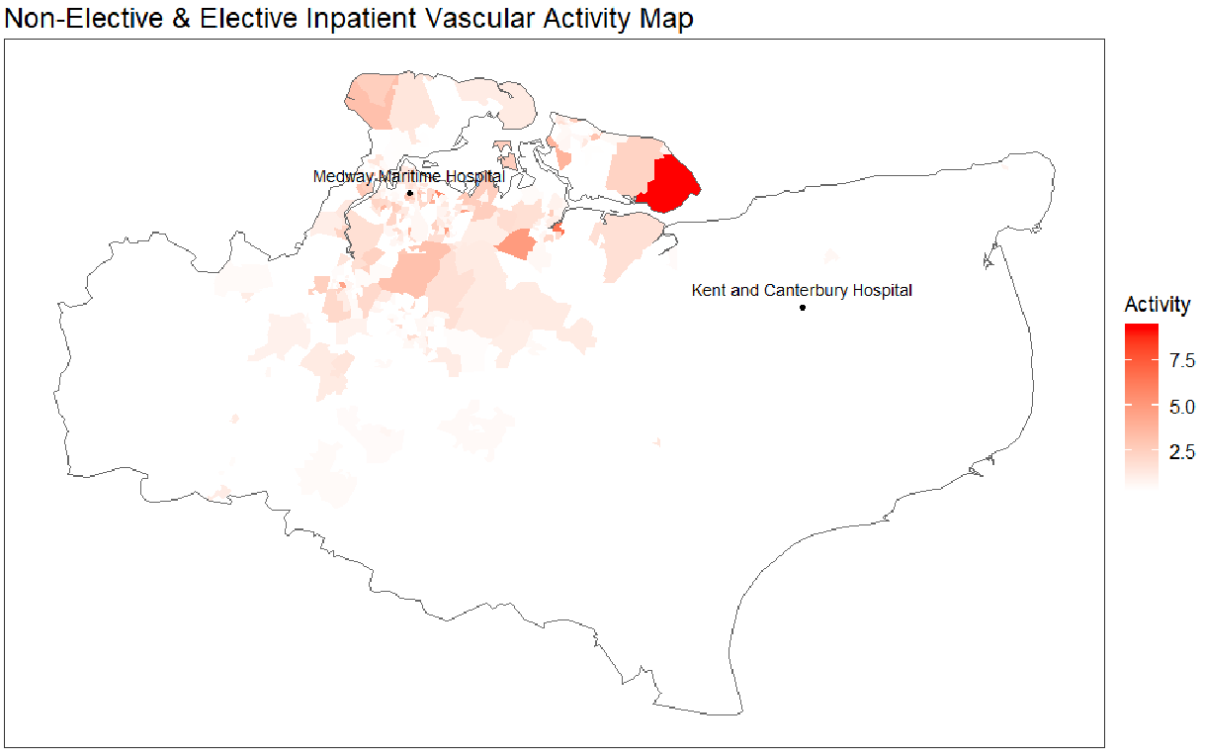
In the future, the average distance that patients will need to travel to access inpatient care at Canterbury is 48.3 km.

The analysis of the current patient data (patients who are currently accessing their inpatient vascular care at Medway) shows that the maximum travel distance in the future would be 91.7 km and the minimum distance would be 8.9 km. There are 7 postcodes that are closer to K&CH than they are to Medway and for these patients the travel distance would be much shorter than at present.

It is important to note that the majority of the cohort of patients on which this analysis focuses are predominantly patients who are currently accessing vascular inpatient care at their local hospital in Medway. It is therefore only natural that the distance and time taken to travel to K&CH in the future will be longer (as it is not their local hospital).

Heatmap

The heatmap below provides information about the number of patients that are currently accessing their vascular inpatient care at Medway.



Map 2 Heatmap showing originating postcodes of patients accessing MFT for their inpatient vascular treatment (2018/19)

Section 6 – Workforce requirement and support

This section gives an overview of the combined workforce demand for the vascular service upon go live. Vacancies at the time of this report are highlighted alongside recruitment strategies to support supply of labour to deliver the service. In line with Our NHS People plan we will support all affected colleagues to ensure achievement of the best place to work now and as part of a new model.

Risks and issues are included in this section for consideration and readiness. An engagement plan is proposed to support the transition and integration of staff in both organisations. Timescales to support the transfer are provided to address the preferred and minimum legislative requirements for transfer of service.

Table 1a below shows the TUPE workforce for go-live:

Consultant	Current Employing Organisation	Staff Group	Band	weekly hours	Service	Base
1	MFT	Medical and Dental	Consultant	47.392	Vascular	MMH
2	MFT	Medical and Dental	Consultant	48.012	Vascular	MMH
3	MFT	Medical and Dental	Consultant	46.844	Vascular	MMH
4	MFT	Medical and Dental	Consultant	48.392	Vascular	MMH
5	MFT	Medical and Dental	Consultant-recharge GS	48.368	Vascular 50% and Surgery 50%	MMH
	MFT	Medical and Dental	STR Higher	40	Vascular	MMH
	MFT	Nursing and Midwifery (Registered)	AfC 8a	37.5	Vascular	MMH
	MFT	Nursing and Midwifery (Registered)	AfC 7	37.5	Vascular	MMH
	MFT	Administrative and Clerical	AfC 4	37.5	Vascular	MMH
	MFT	Administrative and Clerical	AfC 4	37.5	Vascular	MMH

		MFT	Administrative and Clerical	AfC 3	37.5	Vascular	MMH	

Possible implications associated with TUPE:

1. Change of base/location – this will attract a four-year excess mileage payment (where applicable); at the time of writing and based on the current information available this will amount to circa £77,000 over the four years (high level assumptions made).

2. Both organisations operate on national terms and conditions and there is no impact on pay on either side.

3. Both organisations are Foundation Trusts with freedoms to set Supporting Programme Activity (SPA) outside national terms and conditions of service.

4. Some consultants at MFT have additional programmed activities (APA) – discussion on how this will be treated should be considered; it is therefore recommended that timescales for TUPE activities detailed in the key stages of the consultation process are observed.

5. Assess impact of on-call service – identify all rotas that eligible staff participate in on-call duties especially those outside vascular service, if applicable.

6. The job planning cycle for MFT runs from Nov/Dec for a 12-month period therefore this means that current job plans have been agreed until Nov/Dec 2020; however job planning is an activity that can be reopened when required.

7. Deanery doctors' placements will be transferred to EKHUFT following liaison with Kent, Surrey and Sussex Health Education England deanery (KSSHEE) – one-post at Specialty Registrar (Higher) level (StR H).

8. Administrative and clerical staff currently in scope for TUPE will need the proposed base/location assessed to determine if TUPE falls within the test of suitable alternative employment. For clarity, if the chosen base/location remains MFT then all admin staff will TUPE if the base is to transfer to Kent and Canterbury Hospital (KCH) then assessment of return mileage from current home addresses to KCH needs to be considered to determine if TUPE applies.

9. Organisational Development package to support staff transferring: it is recommended that a supportive bespoke organisational development programme is put in place prior to the transfer to align cultural approach. This programme should commence ahead of the consultation exercise and continue during this challenging period for staff and also include the onboarding upon transfer – estimated costs circa £5k. To be delivered by an external party.

Recruitment Strategies:

A number of strategies will be deployed to address existing vacancies identified in the table above. These will include targeting potential candidates locally, nationally and internationally. Some of the existing routes at present include:

1. Use of existing NHS Jobs platform, advertising on BMJ;

2. Working alongside Sustainability and Transformation Partnership (STP) to tap into the Global Learners Initiative to source candidates internationally;

3. Other international recruitment avenues – Medical Training Initiative (MTIs),Trust Clinical Fellow (CTFs);

4. Recruitment and retention initiatives to be considered;

5. EKHUFT will advertise for Vascular consultation posts ahead of TUPE transfer; current MFT employees are welcome to apply ahead of TUPE if preferred.

Key stages of the consultation process:

The two proposed timescales below meet legislative timescale requirements; however, the preferred timescale outline mitigates potential liabilities associated with Programmed Activity (PA) change.

PREFERRED TIMESCALES

Go live minus 6 months	Go live minus 3 months	Go live minus 1 month	Go live
• Receipt of decommissioning letter; • Receipt of letter of measures; • Notification of and engagement with relevant unions/staff side colleagues; • With the above 2 in place launch consultation for 30 calendar days; • All activities associated with consultation to be completed (Outcome, 1-2-1 meetings etc.).	• Give notice period to remove PAs that are MFT centric.	• Employee Liability Information (DD) submitted. • OH records transferred securely and with consent.	• Employees transfer.

MINIMUM TIMESCALES

Go live minus 3 months	Go live minus 1 month	Go live
• Receipt of decommissioning letter; • Receipt of letter of measures; • Notification of and engagement with relevant unions/staff side colleagues; • With the above 2 in place launch consultation for 30 calendar days; • All activities associated with consultation to be completed (Outcome, 1-2-1 meetings etc.).	• Employee Liability Information (DD) submitted; • OH records transferred securely and with consent.	• Employees transfer with the liability of lieu of notice of PA change.

Possible Risks:

High-level risks associated with the delivery of the vascular service post go-live are provided below along with possible mitigations.

ID	Risk	Mitigation
1	In the event that EKHUFT advertise for vascular consultant posts ahead of TUPE and current MFT consultants apply and are successful, the service at MFT may be at risk given reduced capacity; alternatively if applicants are external to MFT then consideration needs to be given to avoid a possible situation of having excess vascular consultants in post for the network – this may result in a possible redundancy situation.	Monitor vacancies detailed in tables above on a monthly-basis to help inform recruitment strategies.
2	In the event that that the letter of measures informs that APAs will not be accommodated, some consultants may find this unattractive resulting in a decision to resign (and therefore not TUPE).	Early discussion with stakeholders on how APAs will be treated ahead of TUPE.
3	In the event that the base/location for administrative staff changes from MFT there is a possibility that this staff group may not TUPE on the grounds of it not being considered suitable alternative employment.	The base/location for admin staff to remain MFT, this will allow for service continuity from this staff group.
4	There is a possibility that none of the staff eligible for TUPE transfers across to EKHUFT (through resignations). Under TUPE legislation employees may choose to resign from their current post at any time including a day before the date of TUPE transfer. The network needs to bear this in mind in planning for the service delivery.	The network needs to work up a scenario with this possibility. Consideration may also be given to explore temporary workforce in readiness for this eventuality.
5	Recruitment strategies deployed may not yield candidates.	Exploration of temporary workforce should be considered by host/employing organisation and associated funding included in the business case.
6	Lack of frequent communication to staff directly affected, resulting in dis-engagement and possible resignations.	Robust communication and organisational development supportive programme throughout process.

Section 7 | Impact on Trusts within the Network

The preferred option is a network model that works across a number of sites with a single acute inpatient arterial centre supported by an enhanced non-arterial centre and a number of outpatient sites.

The model will be structured as follows:

- **Single Arterial Centre (Hub) – This will be located at the Kent and Canterbury Hospital in Canterbury, East Kent.**

The Arterial Centre will be the single hospital within the network that provides all inpatient care for both elective and emergency vascular surgery, providing all types of vascular surgery and vascular interventional radiology. This Arterial Centre will be the only hospital in Kent and Medway that has on site a 24/7, full, year round specialist vascular team to manage all acute inpatient elective and emergency vascular surgery. The Arterial Centre will also be the managerial centre for the Kent and Medway Vascular Network. The Arterial Centre will also fulfil all the components of care available in an enhanced non-arterial vascular centre. This reflects the national recommendation for best practice. All vascular inpatient care will take place in the single Arterial Centre, this will include recovery from surgery until the patient is fit to either return home or to be transferred to rehabilitation care closer to their place of residence. This is mainly the case for patients requiring amputations although some other North Kent patients may wish to return to Medway Hospital for further rehabilitation closer to home. The Arterial Centre will also provide a comprehensive vascular diagnostic and outpatient ambulatory care service for the local population.

- **Enhanced non-arterial vascular centre (Enhanced Spoke) – Medway Hospital.**

Medway Hospital (MFT) will be the Enhanced non-arterial vascular centre and will form an integral part of the Networks solution model of care. This will be resourced to provide local vascular services that do not require a 24/7 workforce presence and inpatient based vascular interventions. It will have an enhanced weekday presence of a specialist vascular team to support other acute services within the hospital. This hospital will have interventional radiology (IR) services to support day case vascular interventions. This IR service will also support the IR needs of non-vascular services. Day-case services will be provided to support activity within the vascular network e.g. renal access surgery and on-going fistula management support interventions and it will offer a comprehensive vascular diagnostic and outpatient ambulatory care service.

The vascular surgical team who are currently employed by Medway Hospital NHS Foundation Trust will all transfer over to East Kent Hospitals University NHS Foundation Trust under TUPE arrangements. This includes 5 consultant vascular surgeons, 1 ST Registrar, 2 Vascular Nurse Specialists and 3 supporting administrative staff. Other teams that provide a supporting service for the vascular surgical service will continue to provide these services under a number of service level agreements. Details of staff transferring and their clinical commitments are provided at Appendix 2.

Some members of Medway Hospital's anaesthetic team and interventional radiology team have expressed a desire to continue to participate in the provision of vascular surgical care at K&CH but do not wish to formally transfer their employment to K&CH. Arrangements are being made for those staff to participate in the vascular network using honorary contracts. All appropriate clinical governance arrangements have been set in place to support this activity.

- **Non-enhanced non-arterial hospitals (Spokes) – Maidstone Hospital, William Harvey Hospital, Queen Elizabeth The Queen Mother Hospital**

Locally across Kent and Medway, the Network model will be supported by Non-enhanced non-arterial hospitals. Hospitals that provide acute care services (typically medicine, surgery, obstetrics), that at times will require on site vascular advice and will require direct contact links to the arterial vascular centre for 24/7 support for vascular advice and patient management. These sites will not have a daily specialist vascular

presence, however, the ability to offer full vascular diagnostics and outpatient services for the local population will be available. The Non-enhanced non-arterial hospitals will deliver all out of hospital care and will be delivered through the existing Kent and Medway hospitals' buildings at these sites. These hospital sites will be provided with a range of services that seek to keep care as close to home as possible for patients and will include:

- Outpatients clinics; i.e. multi-disciplinary clinics, condition specific clinics, one stop shop clinics, nurse led and consultant clinics;
- Pre- and post-operative care;
- Ongoing monitoring and management of vascular conditions e.g. Peripheral vascular disease;
- Diagnostics and tests; and
- Day surgery (where appropriate)

The preferred option would see EKHUFT becoming the host provider Trust for the Kent and Medway Vascular Surgical Service. In the interim, until the longer-term transformation programme is delivered, all inpatient vascular surgery would be centralised at the Kent and Canterbury Hospital in Canterbury. There would be no inpatient vascular surgical care provided at MFT.

Outpatient service provision, diagnostics for vascular surgery and day case surgery would remain unchanged in terms of their location but EKHUFT will become the provider of all of those services.

At Maidstone Hospital, outpatients and diagnostic services will continue to be provided as at present. The hospital will have access to Vascular Consultant opinion with consultant presence 2 days per week. A Vascular Consultant will also be available on a planned ad-hoc arrangement to support with elective gynae-oncology, orthopaedic and obstetric surgical cases where it is considered necessary to have a vascular specialist on site. The current Service Level Agreements that exist between MTW and MFT will be transferred to EKHUFT and will be reviewed after the first 6 months of the Network go-live date. All costs for diagnostics undertaken on vascular patients at Maidstone Hospital by the Kent and Medway Vascular Network will need to be charged to EKHUFT.

The detailed clinical model and clinical pathways have been produced and formally approved by the Network Steering Group and can be found at Appendix 3.

Section 8 – Benefits Summary of Options			
Target Indicator	**Option**	**Option 5A**	**Option 5B**
	Do Nothing	Preferred	Alternative
SERVICE DELIVERY			
The expected benefits that have been identified will be achieved through the delivery of this vision for Vascular Surgery across Kent and Medway and include:			
• Development of skills and expertise so that patients are better able to manage their condition and recovery;	No	Yes	Yes
• Improved access to outpatient clinics at non-enhanced non-arterial centres;	No	No	No
• Improved sustainability of the existing vascular services;	No	Yes	Yes
• A sustainable specialist workforce (Consultant surgeons, IR Consultants and specialist nurses and the wider multi-disciplinary team);	No	Yes	Yes
• A more productive and efficient service (minimisation of duplication and waste);	No	Yes	Yes
• Improved opportunities for training, research and innovation;	No	Yes	Yes
• Ensure that highly experienced staff are treating sufficient numbers of patients to maintain competency.	No	Yes	Yes
• Have 24/7 on site vascular surgery and interventional radiology on-call rotas that are staffed by a minimum of 6 vascular surgeons and 6 interventional radiologists (individually undertaking a minimum number of interventions).	No	Yes	Yes
• Provide access to cutting edge technology including a hybrid operating theatre for endovascular (minimally invasive) aortic	Yes	Yes	Yes

procedures. • Provide a dedicated vascular ward and nursing staff.	Only at 1 site	Yes	Difficult and costly to deliver due to estate pressures
• Have a specialist team to manage patients with vascular disease that includes vascular surgeons, interventional radiologists, specialist nurses, vascular scientists, diabetes specialists, stroke physicians, cardiac surgeons, orthopaedic surgeons, and emergency medicine amongst other specialties to provide a comprehensive multi-disciplinary service.	No	Yes	Yes
• Care of patients will be managed through regular multi-disciplinary team meetings, which will occur at least once a week.	Yes	Yes	Yes
• Provider networks will work towards the aim of all leg amputations being undertaken in arterial centres	No	Yes	Yes
• Improving the patient experience, providing equality of access to the full range of vascular diagnostics and interventions and ensuring that patients are receiving a high quality of service, with access to the most modern techniques;	No	Yes	Yes
• Developing and sustaining the resilience of vascular services and the workforce providing those services;	No	Yes	Yes
• Improving mortality and morbidity rates for people with vascular disease and improving survival rates following hospitalisation;	No	Yes	Yes
• Improving complication rates following a vascular admission (short and long term).	No	Yes	Yes
• Reducing mortality rates by preventing death from ruptured abdominal aortic aneurysm, stroke, lower limb ischaemia and vascular trauma;	No	Yes	Yes
• Providing early intervention and treatment to achieve regional reductions in the incidence of stroke due to carotid artery disease and leg amputation due to peripheral arterial disease;	No	Yes	Yes

• Supporting other services to control vascular bleeding and manage vascular complications; and	No	Yes	Yes
• Working jointly with the diabetic and podiatry service to optimise care, minimise tissue loss and prevent amputation.	Yes	Yes	Yes
QUALITY INDICATORS			
• Continued improvement of the clinical outcomes, in particular lower limb amputation, working towards achieving the best rather than average performance;	No	Yes	Yes
• Standardised methods and promotion of best practice across the clinical teams	No	Yes	Yes
• Clear lines of accountability and clinical governance across the network that puts clinicians and patients at the heart of performance monitoring and service development;	No	Yes	Yes
• The creation of a transparent and effective vascular network, that benefits from shared clinical expertise and clear effective pathways of care;	No	Yes	Yes
STRATEGIC BENEFIT			
• Reduced length of stay for patients and more effective pathway links with community providers to support timely repatriation of patients following surgery.	No	Yes	Yes
• Serve a minimum population of at least 800,000 people to ensure an appropriate volume of procedures.	No	Yes	Yes
SAVINGS (CIP)			

• Affordability for Commissioners	Yes	Yes	No as MFT has a higher MFF which Commissioners would need to pay for all EKHUFT activity
OTHER			
• Distance to access services	Yes	Yes	No (Medway arterial centre would provide poorer access for some of the population)

Section 9 Equality analysis

The NHS England Specialised Commissioning team has undertaken a high level analysis of the equality impact that changes to the provision of vascular surgical services will have.

People with diabetes are at a higher risk of vascular disease. Prevalence of diabetes is caused by a number of factors such as an ageing population, obesity and low levels of activity.

Another important factor for diabetes is the changing ethnic mix of the population. People from black and minority ethnic communities are six times more likely to develop the disease, suffer from a 50% increased risk of heart disease and have much higher levels of kidney disorders. The care of people with diabetes can also be complex with 25% of people suffering from three or more other long-term conditions.

NHS England now has an accessible information standard which needs to be considered/adhered to in the engagement[11]

Group	Evidence
Age	Patients using vascular services tend to be older. Although there is an increasing prevalence of older people using online services it will be important for the communications and engagement process to consider the needs of older people by producing some documentation in print/large print to allow for age-related changes in vision.
Disability	• Because a proportion of patients accessing vascular services have diabetes it is likely that some will have visual impairment beyond the usual age-related changes in vision. This means that the consultation will need to be available in alternative formats. These patients may be unable to drive and may have difficulties accessing public transport, consideration needs to be given to whether they will be able to attend meetings. • Arterial disease in some patients requires lower limb amputation which will also affect accessibility to attend meetings • Patients with chronic mental health problems and learning disability (particularly Down's syndrome) are at increased risk of diabetes and arterial disease. There will be a requirement for easy read versions of documentation
Gender reassignment (including transgender)	No impact
Marriage and civil partnership	No impact
Pregnancy and maternity	No impact

[11] https://www.england.nhs.uk/wp-content/uploads/2015/07/access-info-upd-er-july-15.pdf

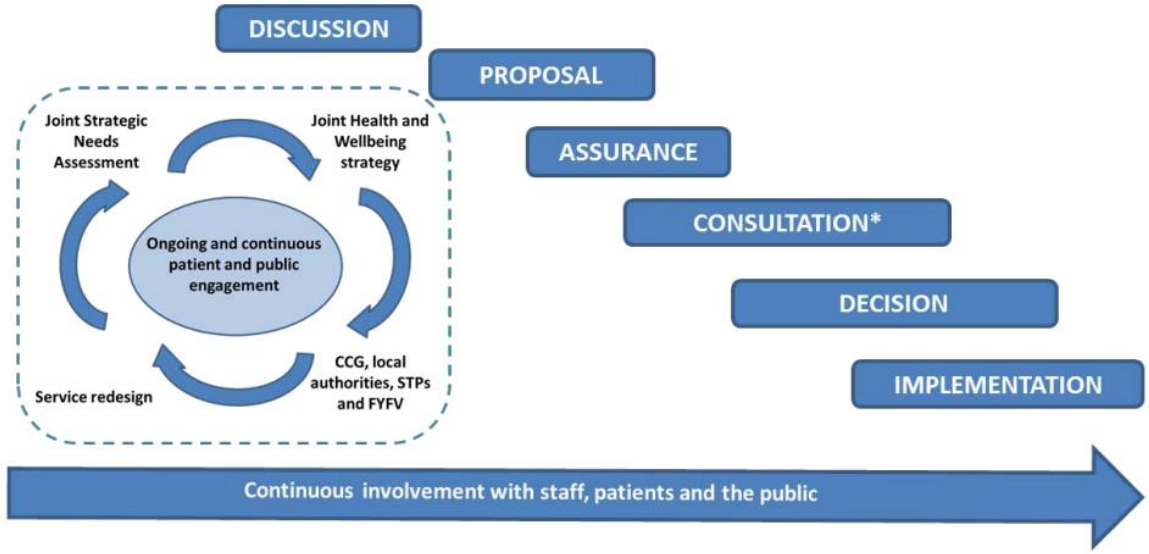
Race	Diabetes is more common in people of South Asian origin with earlier onset of significant arterial complications. People of Afro-Caribbean origin are more prone to high blood pressure which may be more difficult to control than in other groups, hence increased incidence of renal disease and stroke. Narrative content of the communications does not need to be adjusted but appropriate images this group can identify with should be used in any design. It will also be appropriate to make translations available for people whose first language is not English.
Religion or belief	Patients whose religion or belief does not allow blood transfusion or particular blood products will have complications relating to accessing vascular services.
Sex	Vascular disease is more likely to affect men than women. Narrative content of the communications does not need to be adjusted but appropriate images this group can identify with should be used in any design.
Sexual orientation	No impact
Carers	As vascular patients tend to be older and may already have disabilities (or develop a disability as a result of vascular surgery/amputation) they may already have a carer or may need the support of a carer. The consultation will seek to engage with carers to understand the impact of the proposals and possible solutions such as community transport for visitors.
Other identified groups.	Parts of Medway CCG have areas of socio economic deprivation. Smoking, obesity and low levels of activity are more common in areas that have socio economic deprivation. As these lifestyle risk factors are also linked to prevalence of diabetes (and therefore risk of vascular disease) the communications and engagement must consider the communications needs of this group. A review by Ofcom indicates that socio economic deprivation influences access to ICT (put in full) which can itself be a form of social exclusion. However, more recent research by Public Health England for the One You campaign shows people aged 40-60 in lower socio economic groups are heavy users of mobile communications including text messaging and digital social media such as Facebook. The mix for the campaign needs to take these preferences into account.

Section 10 – Implementation Plan

The Kent and Medway Vascular Surgery Network Programme has been led and Programme Managed by NHS England South East Specialised Commissioning.

The detailed analysis of the activity data highlighted that only a small proportion of the vascular activity that is undertaken at MFT and EKHUFT is commissioned by Specialised Commissioning and, indeed, that a large proportion of the activity is commissioned by the Clinical Commissioning Groups across Kent and Medway. Nevertheless, NHS England South East Specialised Commissioning have confirmed that they wish to continue to lead the proposed reconfiguration of vascular services in Kent and Medway and the CCGs have confirmed that they are happy for NHS E to do so. [12]

These commissioning arrangements are important as the NHS must abide by NHS England's Assurance Processes as set out in "Planning, assuring and delivering service change for patients (March 2018)". This assurance process requires commissioners and their local partners to develop clear, evidence based proposals for service change and to undertake assurance to ensure they can progress with due consideration for the government's four tests of services change and NHS England's test for proposed bed closures. The service change process has several phases as shown in the diagram below.



*Public consultation may not be required in every case. A decision about whether public consultation is required should be made taking into account the views of the local authority.

The proposed reconfiguration of vascular services in Kent and Medway constitutes a significant change in the delivery of services and therefore a public consultation is required to seek the views and opinions of our stakeholders. The pre-consultation business case is being prepared by NHS E South East Spec Com and this is required to be approved prior to commencement of a public consultation. This assurance process can only commence however once the provider organisations are signed up to the business case and agree on the preferred option. Once all NHS providers and NHS E are in agreement with the proposals set out in this business case the Programme Management Team will secure the agreement of the Kent County Council Health Overview and Scrutiny Committee and of the Medway Health Overview and Scrutiny Committee. This will enable a proposed six week public consultation to commence (currently scheduled for April and May 2020). Analysis of the consultation feedback and responses will then be undertaken to allow the NHS organisations to make an informed decision on their proposals for the reconfiguration of vascular services in Kent and Medway.

The current programme of work shows that the Kent and Medway Vascular Network could go live in the summer of 2020.

[12] See Appendix 9

Section 11 – Recommendations	
1.	It is recommended that approval is given for the preferred option to be implemented.
2.	

Section 12 – sign off		
EKHUFT Sign-Off		
Divisional Decision Board	Date:	
Medical Devices Group	Date:	
Strategic Investment Group	Date:	
CPMT	Date:	
Finance & Investment Committee	Date:	
Trust Board	Date:	

MFT Sign-Off		
Divisional Decision Board	Date:	
Medical Devices Group	Date:	
Strategic Investment Group	Date:	
CPMT	Date:	
Finance & Investment Committee	Date:	
Trust Board	Date:	

MTW Sign-Off		
Divisional Decision Board	Date:	
Medical Devices Group	Date:	
Strategic Investment Group	Date:	

Case Ref:

CPMT	Date:	
Finance & Investment Committee	Date:	
Trust Board	Date:	

APPENDICES

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from Workforce Committee, 30/01/20	Committee Chair (Non-Exec. Director)

The Workforce Committee met on 30th January 2020.

- **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 committee reviewed and noted the two relevant targets from the Board Assurance Framework and agreed with the current assessment of the likelihood of those targets being met.
  - The Committee reviewed the Workforce committee Risk register. It was agreed to close the general risk about the recruitment of clinical staff in light of progress on nurse recruitment and open a new risk specific to consultant recruitment
  - The Guardian for Safer Working presented his quarterly report to the committee. The committee noted the increase in the numbers of exception reports submitted compared to previous quarters and the actions taken by directorates to address issues raised. The committee noted the very small amount of fines issued by the Guardian when compared to other acute Trusts.
  - The committee received an update on the progress of the Culture and Leadership diagnostic assessment and noted the importance of the evidence from this piece of work being closely tied to the findings of the National Staff Survey when formulating plans to change and develop the culture and working environment of the Trust
  - The committee reviewed the progress of the proposed senior leadership programme. It noted the impact of the Culture and Leadership diagnostic on the initial specification and endorsed the proposal to work with an identified supplier to develop a programme that encompassed the original intentions for a senior leadership programme as well as the need to ensure that such a programme was fully part of the wider work on cultural change
  - The committee noted the conclusions and actions of the most recent Health and Safety committee
  - The committee reviewed and noted the report on the OSCE ready pilot programme and supported its continuation as per the recommendations of the report, subject to the appropriate procurement process.

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

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

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

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

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from Quality Committee, 06/02/20 Committee Chair (Non-Exec. Director)

The Quality Committee met on 6th February 2020 (a Quality Committee 'deep dive' meeting).

1. **The key matters considered at the meeting were as follows:**
   - An **update on the implementation of the Trust-wide action plan for diabetes** was given, for which the Clinical Lead in Diabetes & Endocrinology and his colleagues attended. The presentation covered what had been done to close the actions from the Quality Committee 'deep dive' meeting in October 2019, as well as progress with each action in the action plan (which included the actions arising from the diabetes-related "Preventing Future Deaths" report the Trust had been issued by HM Coroner). Following a discussion on the steps to ensure the correct doses of insulin were administered, the Clinical Lead agreed to consider the introduction of some clinical guidance on the administration of insulin, to support the planned audit of such administration by providing a standard against which practice could be compared. They also agreed to ensure that appropriate engagement and liaison occurred with the Site Manager team on the recommendation in the diabetes Trust-wise action plan regarding the Trust's failure to administer correct doses of insulin.
   - A **review of the Critical Care Outreach service** was also undertaken, and members of the Outreach Team gave an assuring presentation which covered "7 core elements of Comprehensive Critical Care Outreach (NoRF 2019)"; "Patient Track and Trigger"; "Rapid response"; "Education training and support"; "Patients Safety and Clinical Governance"; and "Audit and evaluation, monitoring of patient outcome and continuing quality care".
   - The three **items scheduled for the next meeting in April 2020** were noted and confirmed ("Update on the plans for the strategic development of Ophthalmology Services"; "Follow-up review of quality/clinical outcomes within the Urology 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:** N/A

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

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

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

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