Maidstone and Tunbridge Wells NHS
NHS Trust

TRUST BOARD MEETING

Formal meeting, to which members of the public are invited to observe. Please note that questions from members of the public should be asked at the end of the meeting, and relate to one of the agenda items

10.30am – c.1pm WEDNESDAY 29TH JUNE 2016

THE ACADEMIC CENTRE, MAIDSTONE HOSPITAL

A G E N D A – PART 1

Ref.	Item	Lead presenter	Attachment
6-1	To receive apologies for absence	Chairman	Verbal
6-2	To declare interests relevant to agenda items	Chairman	Verbal
6-3	Minutes of the Part 1 meeting of 25th May 2016	Chairman	1
6-4	To note progress with previous actions	Chairman	2
6-5	Safety moment	Chief Nurse	Verbal
6-6	Chairman's report	Chairman	Verbal
6-7	Chief Executive's report	Chief Executive	3
6-8	Integrated Performance Report for May 2016	Chief Executive	
	▪ Safe / Effectiveness / Caring	Chief Nurse	
	▪ Safe / Effectiveness (incl. HSMR)	Medical Director	
	▪ Safe (infection control)	Dir. of Infect. Prevention and Control	4
	▪ Well-Led (finance)	Director of Finance	
	▪ Effectiveness / Responsiveness (incl. DTOCs)	Chief Operating Officer	
	▪ Well-led (workforce)	Dir. of Workforce	
6-9	The impact of the new Acute Medical Unit at Tunbridge Wells Hospital on patient flow	Chief Operating Officer	5
	Quality items		
6-10	Planned & actual ward staffing for May 2016	Chief Nurse	6
6-11	Approval of Quality Accounts, 2015/16	Chief Nurse	7
	Other matters		
6-12	Findings of the national inpatient survey 2015	Chief Nurse	8
	Assurance and policy		
6-13	Update on the review of Medical rotas	Medical Director	Verbal
6-14	Responsible Officer's Annual Report 2015/16	Medical Director	9
	Reports from Board sub-committees (and the Trust Management Executive)		
6-15	Audit and Governance Committee, 25/05/16	Committee Chairman	10
6-16	Charitable Funds Committee, 23/05/16	Committee Chairman	11
6-17	Quality Committee, 13/06/16	Committee Chairman	12
6-18	Trust Management Executive, 15/06/16	Committee Chairman	13
6-19	Patient Experience Committee, 16/06/16	Committee Chairman	14
6-20	Finance Committee, 27/06/16	Committee Chairman	15 (to follow)
6-21	**To consider any other business**		
6-22	**To receive any questions from members of the public**		
6-23	To approve the motion that in pursuance of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public now be excluded from the meeting by reason of the confidential nature of the business to be transacted	Chairman	Verbal

Date of next meetings:

- 20th July 2016, 10.30am, Education Centre, Tunbridge Wells Hospital
- 28th September 2016, 10.30am, Academic Centre, Maidstone Hospital
- 19th October 2016, 10.30am, Education Centre, Tunbridge Wells Hospital
- 30th November 2016, 10.30am, Academic Centre, Maidstone Hospital
- 21st December 2016, 10.30am, Education Centre, Tunbridge Wells Hospital

Anthony Jones,
Chairman

Maidstone and Tunbridge Wells NHS
NHS Trust

MINUTES OF THE MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST BOARD MEETING (PART 1) HELD ON WEDNESDAY 25TH MAY 2016, 10.30 A.M. AT TUNBRIDGE WELLS HOSPITAL

FOR APPROVAL

Present:	Anthony Jones	Chairman of the Trust Board	(AJ)
	Avey Bhatia	Chief Nurse	(AB)
	Sylvia Denton	Non-Executive Director	(SD)
	Glenn Douglas	Chief Executive	(GD)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Angela Gallagher	Chief Operating Officer	(AG)
	Alex King	Non-Executive Director	(AK)
	Jim Lusby	Deputy Chief Executive	(JL)
	Steve Orpin	Director of Finance	(SO)
	Paul Sigston	Medical Director	(PS)
	Steve Tinton	Non-Executive Director	(ST)
In attendance:	Richard Hayden	Director of Workforce	(RH)
	Jim Lusby	Deputy Chief Executive	(JL)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Sharon Beesley	Clinical Director, Cancer & Haematology (for item 5-9)	(SB)
	David Fitzgerald	General Manager, Cancer & Haematology (for item 5-9)	(DF)
	Kevin Rowan	Trust Secretary	(KR)
Observing:	Hannah Alland	Digital Communications Officer	(HA)
	Karen Carter-Woods	Risk and Governance Manager, Women's, Sexual Health and Paediatric Directorates	(KCW)
	Saheel Mukhtar	Urology Registrar	(SMu)
	Claire O'Brien	Deputy Chief Nurse	(COB)
	Richard Hallett	Vice-President, The Friends of Crowborough Hospital	(RHa)

5-1 To receive apologies for absence

Apologies were received from Kevin Tallett (KT), Non-Executive Director.

5-2 To declare interests relevant to agenda items

There were no declarations of interest.

5-3 Minutes of the Part 1 meeting of 27th April 2016

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

5-4 To note progress with previous actions

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

- Item 9-8i ("Ensure the Trust Board receives the outcome of the planned review of Medical rotas being led by the Medical Director"). AJ asked for an update. PS reported that he had been asked to refrain from reviewing any rotas until new Junior Doctor contract had been issued. AJ asked PS for a date when the review would be completed. PS stated that he could provide an update to each Trust Board meeting. ST queried whether the previous work on reviewing rotas had stopped. PS confirmed this was the case, and clarified that he was not allowed to review the rotas until the new Junior Doctor contract had been issued. AJ asked when the Junior Doctors would vote on the contract. RH replied that this would be the end of June or early July
- Item 3-8i ("Arrange for Trust Board Members to visit the new Acute Medical Unit at Tunbridge Wells Hospital"). AJ noted a visit had been arranged for 1pm that day

5-5 Safety moment

KR referred to the 2 'Never Events' that occurred in 2015/16, that were noted in the Trust's Governance Statement within Attachment 16 (which would be discussed under item 5-21), and proposed that the Trust engaged Internal Audit to undertake an advisory review, to collate the processes in place to prevent the occurrence of other relevant Never Events. KR added that he had discussed the matter with AB and SO, and understood that there was sufficient contingency within the Internal Audit plan for 2016/17 to enable the work to be undertaken at no additional cost. AJ commended the proposal, which was agreed.

Action: Request that Internal Audit undertake an 'advisory' review of the processes the Trust has in place to prevent the occurrence of relevant 'Never Events' (Trust Secretary, May 2016 onwards)

5-6 Chairman's report

AJ reported that the Annual Report from 2015/16 gave a good summary of the Trust, and of the situation across the NHS, given the number of Trusts with financial- & pressure-related difficulties.

5-7 Chief Executive's report

GD referred to the circulated report and highlighted the following points:

- The Trust was engaging with the work being undertaken for the Sustainability and Transformation Plan (STP), which was now being portrayed as 'delivering the Five Year Forward View (5YFV)'. Broadly, the work was being divided among East Kent and West Kent although there was some overlap between the two. The 'A21/A229 corridor' was the term being used to describe the region from Medway in the north to Hastings in the south, and this area represented the focus of the work for the Trust
- Page 2 of report contained an error, in that GD did not actually attend the Emergency Planning session at the Kent County Showground, but other Executive colleagues had attended
- Kent was, in general, a high user of antibiotics, but the Trust had managed to curtail its use of antibiotic medication without affecting its Sepsis rate
- In addition to the awards listed in the report, a Chief Executive's special award had been given to the Gynaecology Ward, as GD had been proud of their care, particularly in relation to the compassion showed during a recent tragic case

AJ suggested that GD notify the Gynaecology Ward that the Trust Board echoed GD's congratulations. The suggestion was acknowledged.

SDu asked what the process was for the STP group that GD chaired to report back to the Trust Board. AJ replied that one of the mechanisms was to use the Trust Board 'away day' on 20/06/16. GD continued that the STP had a milestone at the end of June, in which a draft report would be prepared. GD added that this would be reviewed by the Chief Executive of NHS England and the wider NHS hierarchy, and a decision would be made as to which options would be pursued. GD therefore stated that a report was likely to be able to be submitted to the Trust Board in July.

5-8 Integrated Performance Report for April 2016

GD referred to the circulated report and highlighted that the performance report would be subject to a number of changes over the course of the coming months, to make the report more user-friendly. GD then invited AG to commence the reporting of the key points, on the basis that operational performance affected a number of key indicators.

Effectiveness / Responsiveness (incl. DTOCs)

AG referred to the circulated report and highlighted the following points:

- A&E 4-hour waiting time target performance was at 91% against the agreed trajectory of 86%
- There had been an increase in elective activity, so a reduction in patients waiting over 18 weeks was expected

- Performance on the Cancer 62-day first definitive treatment target was much better for Trust-only patients for March (data was reported 1 month in arrears), but efforts continued to improve the pathways for all Tumour Sites. Directorates met regularly to review systems and processes
- The rate of Delayed Transfers of Care (DTOCs) was at 5-5.5%, and although this was not reducing, it was being stabilised
- Improvements in Stroke continued

AJ asked how the Trust's 91% performance on the A&E 4-hour waiting time target compared with others. AG answered that nationally, the Trust was circa 30th - 35th out of the 100+ Trusts, and the Trust was the leading local performer. AJ asked when the trajectory intended to return performance to 95%. AG replied that the internal trajectory led to that performance in September/October, but NHS Improvement had asked the Trust to submit a trajectory that resulted in performance below the 95% level. ST asked what was preventing the 95% performance being achieved earlier (than September/October). AG replied that this was a combination of volume, capacity, recovering from the Trust's position in Quarters 3 and 4 of 2015/16, and the need to balance 4-hour wait performance against the need to undertake elective activity. AG added that the Trust was maintaining its 4-hour wait trajectory in addition to undertaking elective activity. ST asked why the A&E 4-hour waiting time target was rated 'green'. AG explained that this was because performance was in accordance with Trust's agreed trajectory.

Safe (infection control)

SM then referred to the report and highlighted the following points:

- There had been 2 cases of Clostridium difficile in April, which was 1 below the Trust's trajectory
- MRSA screening performance had reduced to 93% as a result of a new Outpatient clinic being established, and a disagreement as to whether patients at the clinic required screening. This had however now been resolved, and the patients were being screened. Performance was therefore expected to improve in the long-term

ST noted that SO had expressed concern at the challenge posed by a CQUIN target related to antibiotic prescribing, and asked how that challenge was being met. SM replied that the Trust's Antimicrobial Stewardship Group was overseeing performance, and explained the Trust was required to reduce the usage of Meropenem and Tazocin. SM continued that a holistic view of the patient was required, which focused on prevention; but the issue was being actively monitored, and awareness was being raised via the Antimicrobial Pharmacists. SM added that to address the aspect of the target a documented review of prescriptions be carried out within 72-hours, a simple system was being established to enable Junior Doctors to record the existence of such reviews on the Drug Chart. SM also reported that Junior Doctors were frequently reminded of the need to do these reviews, and audits were undertaken monthly. ST asked what barriers needed to be overcome to achieve the required performance. SM replied that the greatest barrier to reducing usage was that the baseline year that had been chosen was a year in which the Trust had seen a significant drop in usage, and the Trust was therefore required to reduce usage by more than 1%. SM emphasised that the key to success was education and awareness. PS added that senior decision-making and challenge as to whether prescriptions were really needed was also important. AJ cautioned against the target being met at the expense of necessary prescribing. The point was acknowledged.

Safe / Effectiveness (incl. HSMR)

PS then referred to the circulated report and highlighted that the Summary Hospital-level Mortality Indicator (SHMI) rate was higher, but this was reflective of the SHMI data being 6-months in arrears, and the rate as of that day was within the expected range. PS added that there were no specific areas felt to be a concern.

Safe / Effectiveness / Caring

AB then referred to the circulated report and highlighted the following points:

- A supplementary report (Attachment 5) covered some issues, but the main issue to report related to falls. A target falls rate of 6.2 had been set, and AB was confident this would be

achieved. AB had asked SM to support this achievement, in terms of applying the same approach that had led to success within infection prevention and control
- The Friends and Family Test (FFT) response rate in A&E had not been good in April, but AB had asked the newly-appointed Deputy Chief Nurse to review whether all appropriate processes were in place

AJ referred to patient falls, and asked whether lessons learned from liaison with other Trusts had been introduced. AB replied that the approach applied by Brighton and Sussex University Hospitals NHS Trust, which had been discussed at a Quality Committee 'deep dive', had largely been adopted, and it was also intended to provide more senior support to the falls-related issues. AJ asked whether it was scheduled to review falls again at the Quality Committee. KR confirmed this was not currently scheduled. SDu proposed that this be scheduled for 1 year from when the Quality Committee 'deep dive' had met previously i.e. January 2016. This was agreed.

Action: Schedule a follow-up review of Patient Falls for the Quality Committee in January 2017 (Trust Secretary, May 2016 onwards)

Well-Led (finance)

SO then referred to the circulated report and highlighted the following points:
- The Trust's position was marginally adverse to plan for the month
- April saw a rise in elective activity, and day case activity was on plan
- There had been an increase in the capturing of non-elective activity data
- Outpatient activity had been adversely affected by the Junior Doctors' strike
- 90% CQUIN performance had been planned for but at month 1, 75% performance was forecast
- Expenditure was less than the planned position, and Agency expenditure was below plan
- Nurse Agency expenditure reduced from March to April, and this was expected to reduce further, although this was still higher than the same point in the previous year
- There had been an increase in substantive staffing
- CIP performance was slightly behind plan, and the phasing of aspects of the Plan needed to be reviewed, and reported back to the Finance Committee
- Attachment 4 contained a supplementary report on finance, in the form of a slightly-revised pack. This was a sub-section of the revised full pack submitted to the Finance Committee, and comments on the format and content were very welcome

AJ noted that income had increased by 8% from the previous year, and asked why a 10% increase had been forecast. SO highlighted that Easter had occurred in April in 2015/16, which was not the case for 2016/17. SO added that there had also been an increase in prices. GD added that the Trust's taking over the contract for High Weald Maternity services was also important.

AJ then noted the 8% increase in income could be used as a synonym for activity, but Agency expenditure had increased by 43%. SO clarified that the 43% increase only referred to Medical Locums, and added that improvements had been seen in Surgical areas. SO also emphasised that that largest increase had been in Locum, not Agency, usage, which was lower cost. PS added that a number of Medical appointments had been made recently. AJ acknowledged the challenges involved in recruitment, but remarked that the increased in Locum expenditure had not been explained. PS stated he was not surprised by the increase. AJ suggested the issue be reviewed further. ST replied that the Finance Committee had discussed the issue in detail on 23/05/16.

SO then continued, and highlighted that there had been a greater increase in activity than in cost base, albeit in relation to the Nursing workforce. SO added that the Trust was where it expected to be in terms of medical staffing.

SD then referred back to the Cancer waiting times reported by AG, and in particular the 2-week and 62-day waits, and asked when the Trust's performance would return to the required levels. AG replied that the 62-day wait standard would be met from October 2016 (i.e. the beginning of Quarter 3). AG continued that the 2-week wait performance would be at the required 93% level, and be stable, by the end of June 2016. AG added that majority of reasons for non-compliance with the 2-week wait target was patients changing their original appointments, and work had been undertaken with GPs to address this. AG pointed out that the 2-week wait target had been met in

February, and had only been missed by circa 2 appointments in March. GD added that the larger issue was that GPs were referring patients on the 2-week wait pathway without informing such patients that they were on a Cancer pathway, and such patients often then changed their appointment. GD added that AG had undertaken significant work with GPs to address this.

Well-led (workforce)

RH then referred to the circulated report and highlighted the following points:

- There was 1 error on the dashboard that was circulated: the "Vacancy %" should be 11.3% (and not 12.9% as reported)
- There had been an increase in sickness absence. No particular pattern was evident, but there had been a large spike in sickness for staff from the Kent and Medway Health Informatics Service (KMHIS) in the immediate period before KMHIS was closed in March 2016
- A new Head of Employee Relations had been appointed, who had been asked to focus on reducing sickness absence

SDu asked whether any analysis had been done to assess whether there was an association between the recent increase in sickness absence and staff recruited from overseas, given the significant upheaval that such staff experienced. RH replied that this had not been reviewed in detail, but agreed to investigate the matter.

Action: Investigate whether there is an association between the recent increase in sickness absence and staff recruited from overseas (Director of Workforce, May 2016 onwards)

AB gave assurance that support had been provided to the Nurses that had previously joined from the Philippines, as well as those that had joined from the EU. AB also reported that a recruitment day had been held on 21/05/16, and had been very successful; and added that a waiting list was now in place for staff wanting to work within Maternity. AB noted that further recruitment days would be held in the future.

Presentation from a Clinical Directorate

5-9 Review of the Kent Oncology Centre

AJ welcomed SB and DF to the meeting. SB gave a presentation highlighting the following points:

- The Oncology Centre was based on 2 hospital sites: Maidstone Hospital (MH, which had 6 Linear Accelerators (LinAcs)) and Kent & Canterbury Hospital (K&C, which had 3 LinAcs)
- The MH site opened following the closure of the Radiotherapy Centres at St Williams Hospital, Rochester; and Pembury Hospital in 1993. The service was then centralised to MH under the name of the "Mid Kent Oncology Centre"
- The Calman Hine report (1989) recommended that Cancer treatment be provided closer to home. MH and K&C started to work closer together in 1996, and merged in 1999
- In 1993, when the Centre was opened, there were 3 LinAcs and 5 Oncologists (based at MH). In 1999, after the merger with K&C, 4 Oncologists and 3 LinAcs were added to the 'establishment', and by that time, MH had 7 Oncologists.
- In 2005, the 'new build' at MH added 3 more LinAcs, and there were currently 9 LinAcs (6/3) and 25 WTE Oncologists across Kent and East Sussex employed by the Trust

DF then continued, and highlighted the following points:

- The current Cancer Services included Chemotherapy Units at each provider site (Darent Valley Hospital, Medway NHS Foundation Trust, East Kent Hospitals University NHS Foundation Trust (EKHUFT, which had 3 sites); Hastings; Tunbridge Wells Hospital (TWH) & MH
- Outpatient clinics were also undertaken at each provider site, with the Oncologists employed by the Trust
- The Radiotherapy activity at MH and K&C was the Trust's, and there were SLA recharges between the other providers and the Trust for the Oncologists

AJ asked whether it made sense for Chemotherapy to be organised separately from other aspects of the service. SB replied that she understood this was largely a historic arrangement, and was unsure of the rationale, but speculated that it may have been related to the existence of block contracts. SB continued that the problems with the arrangement had become apparent once the

Payment by Results (PbR) contract had been introduced. AJ asked whether it made more clinical sense to have all services operated in the same way. GD stated that the arrangements involved some real anomalies, and the original rationale was now largely passé. GD added that the anomalies did not make it easy to manage the service, particularly in relation to investment and efficiencies, and acknowledged that the situation needed to be addressed. ST remarked that he understood the financial aspects were in the process of being addressed. SO clarified that the current focus was to achieve a more equitable recompense for the Trust, and did not aim to resolve the overarching issue of a devolved service across multiple providers.

ST queried whether the dispersed nature of the service was best for patients. SB stated that it was best for patients to be treated near their homes, and this was what patients wanted, but the Trust's lack of governance and influence over Chemotherapy at EKHUFT was unsatisfactory, and was not effective. DF added that the Outpatient arrangements were more of a concern. PS summarised that the Trust was unable to be as responsive as it wished. ST asked what action was therefore being taken. AJ stated that he expected this to be addressed via the Trust's strategic work, and via the overall review of services in Kent and Sussex. AJ continued that such work would achieve some output by the end of June, as GD had reported under item 5-7. SB stated that the aforementioned financial issues were being addressed at Executive level, but commissioners needed to be supportive of further changes. SB continued that the state of the 1937 building at K&C needed to be borne in mind, in relation to potential future locations, and this may involve relocating the service within EKHUFT, or considering alternative sites. SB added that the Trust had offered to provide the staff for the Chemotherapy Unit at the William Harvey Hospital in Ashford, but this had been declined.

DF then continued, and highlighted the following points:

- Other challenges included LinAc replacements, which had a 10-year lifespan. This included both 'wear and tear' aspects and technological advances. EKHUFT's strategic intent about the K&C site was also awaited, and thus far, there had been a delayed upgrade to the oldest LinAc
- Cancer waiting times standards posed a further challenge, particularly in relation to inter-provider transfers
- The future direction of the service focused on the Satellite Oncology Unit at TWH; the potential repatriation of Outpatient activity to the Trust; the potential creation of smaller satellite Units at other providers (i.e. EKHUFT and Darent Valley Hospital); and consideration of a mobile Chemotherapy service to enable some Chemotherapy to be delivered closer to patients' homes

AJ referred to the latter point, and noted that a mobile Unit had been considered for years, and he had discussed this with SB's predecessor as Clinical Director. SB clarified that the arrangement now being proposed was different to that proposed previously. GD asked for further details of potential locations. SB replied that Crowborough, Sevenoaks and Sittingbourne Hospitals were being considered. JL confirmed that discussions were underway in relation to these sites.

ST reiterated his earlier query as to how the issues discussed would be addressed, and asked GD whether this was part of STP, as AJ had indicated. GD confirmed this was not the case, as decisions by Specialist Commissioners (i.e. NHS England) would be required, and opined that such decisions were likely to be a low priority at the present time. ST asserted that he still did not have a sense of what was trying to be achieved, how this was intended to be achieved, and what timescales were involved. JL stated that an important next step was to be able to describe the Trust's own views on the future, and not allow the frustration of external inertia to affect the Trust's strategy. ST expressed full support for that approach. JL proposed that the issue be discussed further at the Trust Board 'away day' on 20/06/16. This was agreed.

AJ then asked SB and DF why the Trust's Cancer performance had deteriorated since the previous year. SB replied that there had been a year on year increase in demand, in terms of referrals from GPs. SB added that much additional Cancer pathway activity had been absorbed into existing clinics over the years, and when this was combined with the departure of some of the established Multidisciplinary Team (MDT) Coordinators, which affected performance monitoring, a 'tipping point' had been reached. AG pointed out that the majority of the Cancer waiting time

breaches were not under the direct remit of the Cancer and Haematology Directorate, which was why much of the work to address the issues were focused on the MDT leads.

AJ thanked SB & DF for attending, and noted that the level of interest from the Board reflected the fact that the Kent Oncology Centre was regarded as one of the 'jewels in the Trust's crown'.

Quality Items

5-10 Supplementary Quality and Patient Safety report

AB referred to the circulated report and highlighted that Appendix 1 contained a Safety Improvement Plan that was prepared in response to the Trust's participation in the national "Sign Up To Safety" campaign. AB added that the format of the Plan, which had been submitted for comment and approval, was largely prescribed.

The Trust Board approved the Safety Improvement Plan as circulated.

5-11 Quality Improvement Plan: closure report / next steps

AB referred to the circulated report and highlighted the following points:

- It was time to cease submission of the monthly reports, as although there were 3 'green' rated areas, there was sufficient assurance to propose the reporting process be 'closed'
- The document which outlined the in-house process to assess future compliance was also enclosed. The process had been tested out in practice with Critical Care & Paediatrics, and the report of the former assessment would be submitted to the Trust Management Executive (TME). The report of the Paediatrics assessment would be shared with Trust Board Members

AJ asked for AB to provide confirmation at the next Trust Board meeting that Compliance actions 9 and 14 had been 'closed'. AB replied that of the 3 'green' rated areas, action 6 under Compliance action 9 was progressing according to plan, but the other 2 'green' rated actions would take longer than a month to conclude. AJ therefore proposed that AB report the closure of these 3 actions to the Trust Board on an exception basis. This was agreed.

AB then asked for comments on the aforementioned in-house process. SDu stated that it was a good idea to focus on areas that had not been criticised by the Care Quality Commission (CQC) at their last inspection. SDu added that the process provided potential opportunities to cross-fertilise and improve learning and 'upskilling' from staff moving between areas. AJ concurred.

AJ then highlighted that the CQC had indicated that their future inspection process was likely to focus on A&E and Critical Care, although full inspections may still occur. AJ elaborated that he understood that the CQC's future plans had been limited by reductions in their budget.

5-12 Staffing (planned and actual ward staffing for April 2016; & 6-monthly review of Ward & non-Ward areas)

AB referred to the circulated report (Attachment 7) and highlighted the following points:

- Some areas had levels of Enhanced Nursing care, and some Wards had patients with complex mental health needs
- The only area with an "Overall RAG Status" of 'amber' was Ward 2, which was due to a number of reasons. Ward 2 used to be Ward 22, and the number of beds had increased as part of the change. The Ward also employed some overseas Nurses, who took time to settle
- The 'Care Hours per Patient Day' data template was expected to be released to Trusts on 01/06/16, and therefore this data was likely to be submitted to the next Trust Board meeting

AB then referred to Attachment 8 and highlighted the following points:

- The report was submitted to the Trust Board twice per year
- An integrated approach had been taken when developing the report, involving the Finance and Human Resources departments
- The data was based on Ward rosters, and was therefore 'bottom up'
- There had been many changes over the last year which had been added to establishments and budgets

- The Ward Manager and Matron for each area had been involved, to ensure they fully understood and agreed the establishments and budgets
- The only new change related to Pye Oliver Ward, for which there had been an uplift of an additional Clinical Support Worker at night

AJ asked whether totals for the data were available, to enable the overall movement to be assessed. SO agreed to provide these to Trust Board Members.

Action: Circulate, to Trust Board Members, the totals for the data provided in the Appendices to the 'Nurse establishment review' report submitted to the Trust Board on 25/05/16 (Director of Finance, May 2016)

AJ asked whether the data in the report was included in the Trust's business Plan. SO gave assurance that the establishments had been in the Plan approved by the Trust Board, and noted there had been an overall increase. AB elaborated that most of the increases were for the new Acute Medical Unit at TWH and for the inclusion of previous escalation areas into the bed-base.

AJ clarified that there was no saving, and no changes beyond those reported. SO confirmed that no saving was being reported. AB gave assurance that following the review, she believed the staffing levels on Wards were safe.

SDu then referred back to Attachment 7, and in particular the "Intensive Treatment Unit (ITU)" at MH, and asked for an explanation of the data, in terms of comparison with the ITU at TWH. PS explained that the ITU at TWH did not involve set dependency levels. AB added that a detailed review was undertaken with each area that exceeded budget, and it may only take a few additional staff to lead to the position reported in Attachment 7. GD suggested that the inclusion of income data would help, for ITU and potentially SCBU. AJ proposed that this therefore be included in future reports. This was agreed to be considered.

Action: Consider including details of income for 'ITU' within future 'planned and actual ward staffing' reports submitted to the Trust Board (Director of Finance / Chief Nurse, May 2016 onwards)

5-13 Safeguarding adults update (annual report to Board)

AB referred to the circulated report and highlighted the following points:

- The full Annual Report had been reviewed at the TME and Quality Committee, and was available to all Trust Board Members if required
- The Report gave assurance that the correct policy and procedures were in place, and that staff were aware of such processes
- The need for additional resource was being explored with Kent Community Health NHS Foundation Trust (KCHFT), and a shared post to respond to patients with learning difficulties was being explored

AJ invited queries or comments. None were received.

Planning and strategy

5-14 Discussion of the assumptions underlying the 2016/17 Winter and Operational Resilience Plan (incl. how elective activity will be increased)

AG referred to the circulated report and highlighted the following points:

- The report contained a very early iteration of the outline of the Trust's Plan
- The Plan was due to be submitted to the TME in June, so detailed work was underway
- The delivery plan for 2016/17 had recently been submitted and all performance trajectories had now been agreed, which would be reflected in the next iteration
- A risk assessment had also been undertaken, and the Plan needed to reflect the outcome
- An assessment of the bed configuration needs across both main hospital sites was underway. The assessment of Surgical beds was complete and the focus was now on Medical beds

AJ remarked that the report was very interesting, particularly in relation to the assumptions, and asked why 95% of variation in demand had been assumed. AG stated that NHS Improvement had

asked Trusts to use that level as the basis for their initial planning, but further in-house discussions would be held, and the Trust's assumptions would be based on what was expected following that.

AJ then referred to Tonbridge Cottage Hospital (TCH), and stated that he had received assurance that the 8 beds at that site would be available to the Trust. AG replied that the beds were available to patients who required 'slow stream rehabilitation'. AJ asked whether the Trust had rights to the beds and that the beds could therefore be included in the Trust's bed-base. AG replied that this was not the case, as the beds were managed by KCHFT. AJ asked whether the Trust could determine the patients that were admitted to TCH. GD clarified that the Trust could transfer its patients there if there was space. AJ asked whether this could be done without question. AG answered that the admission criteria were very clear, but the turnaround of the beds was very low. AG reiterated that the beds were occupied with patients referred by the Trust, but the beds were not managed by the Trust. AJ asked for clarification that the Trust's bed-base had, in effect, been increased by such beds. GD stated that the bed-base within the wider system had been increased, but the beds were accessible to the Trust.

SDu then highlighted that the previous winter had not been notable for any epidemics etc., but had still involved unprecedented levels of demand, and asked why the occupancy levels listed in the report had been assumed. AG acknowledged the validity of the point, but clarified that the levels in the report had been suggested to the Trust as a starting point, and these would be refined by further in-house discussions, which would include the occupancy levels seen during the previous winter. SDu suggested that the plans include a 'down-side'. GD agreed this was sensible.

AJ asked what level of staffing was being aimed for in the Plan. AG replied that such detail was not yet available, but an associated workforce plan would be developed, as well as an activity plan. AG added that the recruitment of substantive staff would continue.

Assurance and Policy

5-15 Update on the review of Medical rotas

This was covered under item 5-4.

Reports from Board sub-committees (and the Trust Management Executive)

5-16 Audit and Governance Committee, 05/05 & 25/05 (incl. Audit & Gov Cttee Annual Report for 2015/16)

ST referred to the circulated report and highlighted the following points:

- There was nothing of significance to report from the meeting held on 05/05/16
- The outcome of the meeting held earlier that day, in relation to the Annual Report and Accounts for 2015/16, would be covered under items 5-21, 5-22 and 5-23

5-17 Quality Committee, 11/05/16 (incl. SIs)

SDu referred to the circulated report and highlighted the following points:

- It was agreed to liaise with Age UK to ensure that the Trust's patient survey methodology was appropriate in relation to encouraging participation from elderly patients
- There was an open invitation for a representative from the Human Resources department to attend the meeting
- The Stroke performance was included as an Appendix, but the Committee had expressed frustration at the lack of progress with the Kent Medway Stroke Review

GD referred to the latter point, and noted there was a meeting on 27/05/16 to discuss options. AJ commended the improved Stroke performance, particularly at MH.

5-18 Trust Management Executive, 18/05/16

GD referred to the circulated report and noted that it was the first meeting at which the Trust's 2 new Clinical Directors had been present.

AJ noted that the Trust's Chief Pharmacist was due to retire at the end of May. SM reported that the Chief Pharmacist was responsible for some important statutory roles, and gave assurance that all of these would be undertaken by the Head of Pharmacy at MH until the new Chief Pharmacist started in post.

5-19 Finance Committee, 23/05/16 (to incl. approval of business cases)

ST referred to Attachment 15 and invited comments or queries. None were received.

ST then referred to Attachment 14, highlighted that the Business Case had been circulated and approved virtually, and invited queries or comments. AJ asked why Option 3 ("Replace existing system delivering additional functionality to support the medical workforce as part of the initial deployment") had not been chosen. PS replied that selecting Option 3 in the absence of an agreed Junior Doctor contract would delay the implementation of the system.

The Business Case was formally approved as circulated.

5-20 Charitable Funds Committee, 23/05/16

ST reported the following points:

- There was nothing of significance to report, but the principle was agreed that expenditure should be promoted among those areas that were not subject to traditional fundraising campaigns, or made the most requests for funding
- The Committee discussed the circumstances under which staff events could be funded from charitable purposes, and these would be reflected in a revised Charitable Funds Policy

SDu suggested that Trust Board Members remind staff that charitable funds were available for expenditure, during any visits they undertook to Wards. GD welcomed this, and added that the Leagues of Friends also held significant amount of funding.

AJ referred to the latter point, and noted that Viscountess De L'Isle of Penshurst Place had now retired, and had been replaced as the President of The League of Friends of TWH by Lady Mills.

SDu added that it was suggested at the Committee that a more structured approach to applying for funds be introduced.

Annual Report and Accounts

5-21 Approval of Annual Report, 2015/16 (including Governance Statement)

ST referred to the circulated report and highlighted the following points:

- The Committee had reviewed the Annual Report over 2 meetings. Much of the content was prescribed, and the Board's particular attention was drawn to the Governance Statement
- There were no issues arising from the Annual Report or Accounts, apart from the wording in the External Auditors' opinion that related to the Value for Money conclusion. The Auditors had been asked to use alternative wording, and they had agreed to consider this. It had been agreed that the Auditor's response would be reviewed, and a decision as to what, if any, action was required would be made at that point

ST then recalled that the wording for his biography in the Report required minor amendment, and agreed to provide this to KR.

Action: Provide the Trust Secretary with details of the amended wording for the biography of the Chair of the Finance Committee listed in the Trust's draft Annual Report for 2015/16 (Chair of Finance Committee, May 2016)

KR then highlighted that there was an error on page 39, as the Director of Workforce had been stated to have voting rights at the Trust Board. KR confirmed this would be corrected.

SDu asked whether the individuals featured in the photographs within the Report were completely representative of the workforce and the population the Trust represented. It was agreed to review

the ethnicity of the individuals in the photographs, and consider whether a more ethnically-diverse range of individuals should be featured.

Action: Review the ethnicity of the individuals featured in the photographs within the Trust's draft Annual Report for 2015/16, and consider whether a more ethnically-diverse range of individuals should be featured (Trust Secretary, May 2016)

The Annual Report for 2015/16 was approved, subject to the aforementioned amendments; and the outcome of the Auditor's consideration of the request to amend the wording in their opinion.

5-22 Approval of Annual Accounts, 2015/16

ST noted that the External Auditors had commended the work of the Finance Team in preparing and submitting the Accounts. AJ commended SO. SO clarified that his team deserved the credit.

A further report (Attachment 17a) was then tabled. ST referred to that report and highlighted that it contained additional disclosures which had been discussed at the Audit and Governance Committee held earlier that day.

The Annual Accounts for 2015/16, including the additional disclosures within Attachment 17a, were approved.

5-23 Approval of Management Representation Letter, 2015/16

ST referred to the circulated Letter and highlighted that the Audit and Governance Committee had reviewed this at its meeting earlier that day and agreed to recommend that the Trust Board approve the Letter.

The Management Representation Letter for 2015/16 was approved as circulated.

Other matters

5-24 The scheduling of Finance Committee & Board meetings

AJ referred to the circulated report and highlighted that it outlined the options following the discussion that had been held at the Board meeting in March 2016.

AJ asked for comments or queries, noting that his preference was for the status quo.

ST remarked that he did not feel strongly about any of the options.

AJ then asked SO his intentions in relation to enabling the monthly financial information to be available more quickly at the end of each month. SO replied that he had a personal objective to reduce the 'close down' date, and expected significant improvements by the end of 2016/17.

In the absence of any further views, AJ proposed that the meetings remain as currently scheduled. This was agreed.

5-25 To consider any other business

GD reported that the Paediatric A&E department had opened that day. AJ welcomed this, and suggested Trust Board Members may wish to visit. KR pointed out that the Quality Committee had already agreed that a formal visit should be arranged for Committee members.

5-26 To receive any questions from members of the public

There were no questions.

5-27 To approve the motion that in pursuance of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public now be excluded from the meeting by reason of the confidential nature of the business to be transacted

The motion was approved.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – June 2016

6-4 Log of outstanding actions from previous meetings — Chairman

Actions due and still 'open'

Ref.	Action	Person responsible	Original timescale	Progress [1]
9-8i (Sep 15)	Ensure the Trust Board receives the outcome of the planned review of Medical rotas being led by the Medical Director	Trust Secretary / Medical Director	September 2015 onwards (but then extended to March 2016)	It was agreed at the Board on 25/05/16 that the Medical Director would provide an update to each Trust Board, from June 2016 onwards. A verbal update has therefore been scheduled for the June 2016 Trust Board meeting.
5-12i (May 16)	Circulate, to Trust Board Members, the totals for the data provided in the Appendices to the 'Nurse establishment review' report submitted to the Trust Board on 25/05/16	Director of Finance	May 2016	In progress
5-12ii (May 16)	Consider including details of income for 'ITU' within future 'planned and actual ward staffing' reports submitted to the Trust Board	Director of Finance / Chief Nurse	May 2016 onwards	The matter is still being considered

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
3-27i (Mar 16)	Arrange for the Patient Experience Committee to receive a presentation from the Integrated Discharge Team	Trust Secretary	June 2016	A presentation was given at the Patient Experience Committee meeting in June 2016
4-9i (Apr 16)	Submit a report to the Trust Board, in June 2016, on the impact of the new Acute Medical Unit at Tunbridge Wells Hospital on patient flow	Chief Operating Officer	June 2016	A report has been submitted to the June 2016 Board meeting
5-5 (May 16)	Request that Internal Audit undertake an 'advisory' review of the processes the Trust has in place to prevent	Trust Secretary	May 2016	A request was made, and the Audit Planning Memorandum (APM) has been approved by the

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

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
	the occurrence of relevant 'Never Events'			Chief Nurse
5-8i (May 16)	Schedule a follow-up review of Patient Falls for the Quality Committee in January 2017	Trust Secretary	May 2016	The item has been added to the forward programme for the 'main' Quality Committee in January 2017
5-8ii (May 16)	Investigate whether there is an association between the recent increase in sickness absence and staff recruited from overseas	Director of Workforce	June 2016	The sickness absence data for March and April 2016 has been reviewed, and there is no significant statistical variation. In March 2016 the rate was 0.5% higher whereas in April 2016 it was 1.0% lower. Furthermore there was no significant variation in reasons for the absence. The monthly analysis will continue to ensure that the Trust monitors the position carefully and takes appropriate action if and when needed to support its Nursing workforce.
5-21i (May 16)	Provide the Trust Secretary with details of the amended wording for the biography of the Chair of the Finance Committee listed in the Trust's draft Annual Report for 2015/16	Chair of Finance Committee	May 2016	The information was provided (and the Annual Report was subsequently amended to reflect that the individual in question was "Interim Vice Chair" of the School of Orient and African Studies London University (and not a "Board member and Audit Committee Chair" as was originally listed))
5-21ii (May 16)	Review the ethnicity of the individuals featured in the photographs within the Trust's draft Annual Report for 2015/16, and consider whether a more ethnically-diverse range of individuals should be featured	Trust Secretary	May 2016	A review was undertaken and some of the photographs were replaced with photographs showing a more ethnically-diverse range of individuals

Actions not yet due (and still 'open')

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting - June 2016

6-7	Chief Executive's update	Chief Executive

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

1. Since our last Board meeting, I have continued to maintain our organisational focus on the delivery of safe, high standards of care for patients, while working closely with our wider partners on a long-term vision to provide sustainable health and social care services throughout Kent and Medway.

   I have continued to promote, to our staff, the importance of maintaining clinically safe, high quality services for patients in our care. Some of my key messages to our staff since our last Board meeting have focused on:

   - The latest trends from our clinical governance reviews around incidents relating to tourniquets and maintaining dignity during moving and handling of patients
   - Sharing our three to five year Safety Improvement Plan with staff to help build a patient safety culture in our Trust that is well–led, has a good organisational safety framework at its centre and sees measurable improvements over the coming years.
   - Raising the profile of antimicrobial use, in line with best national practice, to reduce inappropriate prescribing and tackle the long-term consequences of over use.

   We are keenly aware, and continue to be creative and innovative in addressing, the shared challenges faced by the NHS of seeing patients in a timely way within our finite budgets.

2. MTW, alongside partners NHS West Kent CCG and NHS High Weald Lewes and Havens CCG, have been chosen as Maternity Choice and Personalisation Pioneers by NHS England.

   We are just one of seven areas across the country to be successful in spearheading new ways of opening up choice in maternity care.

   It means that over the next 18 months, notional budgets will be introduced for pregnant women living in west Kent and the Crowborough area. They will be able to use the funding to pick who provides their care while they are expecting and when they give birth, depending on what is most important to them. Congratulations to the maternity team for all their hard work. This is fantastic news for the Trust and I welcome the opportunity to be at the forefront of this new initiative.

3. Our dedicated children's A&E at Tunbridge Wells Hospital has now been open a month and is providing emergency care to patients under the age of 16. With up to 1,500 or so paediatric A&E attendances every month (14% of all people seen in our A&Es are under 16), I have no doubt this will be a very busy and beneficial facility which will provide a much more pleasant environment for young people and their families.

4. The results of the most recent national inpatient survey show that patients continue to rate our hospitals highly at a time when demand for NHS services is at unprecedented levels. We received an overall good response from patients who were asked by the Care Quality Commission to rate over 70 areas of their care, covering eight key standards. Overall patients rated their care, and staff, highly and found MTW's hospitals to be clean and safe. The majority of patients said they felt well looked after while in hospital locally, and had trust and confidence in the doctors and nurses, who treated them with respect and dignity.

5. The new patient transport service is due to be launched across Kent and Medway on 1 July. There are tough new measures in place to raise standards with more emphasis on customer care and getting patients home from hospital promptly. The new service will be provided by G4S.

6. Kent Oncology Centre was recently given a state-of-the-art bladder scanner by the Prostate Cancer Support Association Kent. It cost £7,500 and was handed over by Terry Laidlaw (Chairman of the PCSA) and Graham Edwards (the original founder and current fundraising manager) to Christine Richards our Head of Radiotherapy Services. I would like to personally thank PCSA for their support.

7. Congratulations to our recent staff and team of the month award recipients. Our most recent awards for outstanding endeavour have been presented to the junior doctors in medicine, Ann Forster in Patient Transport, and the Gynae ward, who I also gave a special award to for the way in which they went above and beyond for one of their patients. In all instances, our colleagues showed the highest levels of hard work and professionalism.

8. Our new Perinatal Mental Health Nurse, Hellen Robinson, along with representatives from partner agencies, have held an event to give advice and information to our hospital visitors. It is important that we help raise awareness and understanding of perinatal mental health - it is known that babies' earliest experiences of relationships will lay down foundations that influence their future social, emotional and cognitive development.

9. Yet more members of our staff have received national recognition for their endeavours and are using their own time to help improve health services in other countries.

   Dr Rema Jyothirmayi has been awarded the 2016 Oncology Registrars' Forum Trainer Award (by the Royal College of Radiologists).This award is presented annually to a UK-based consultant clinical oncologist who has made an outstanding contribution to clinical oncology teaching and training at a local, regional or national level.

   Dr Mike Coutts, consultant histopathologist travelled to Chisinau, Moldova on behalf of the Royal College of Pathologists to work with the Moldovan Government, the Moldovan Society of Pathology, the International Cervical Cancer Prevention Association and the United Nations Population Fund to help with the introduction of a cervical screening programme. He visited six hospitals, the Ministry of Health, the UN office and met lots of people. Progress was made in reorganising pathology in the country and in improving training and organisation for all steps of the cervical screening pathway, including in histopathology. Later this year Mike will be welcoming two Moldovian pathologists to Maidstone to train in cervical and gynaecological pathology with him.

   Junior Sister Marta Barreiro in Ophthalmology has travelled to the Bolivian Amazon to work with the charity Andean Medical Mission to help in the provision of eye services. The charity travels to remote areas where access to health services does not exist. It is great to see our staff doing so much to improve people's lives wherever they may be.

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – June 2016

6-8	**Integrated Performance Report for May 2016**	**Chief Executive**

The enclosed report includes:

- The 'story of the month' for May 2016, which includes the latest position on Delayed Transfers of Care (DTOCs)
- Quality Exception Report
- Work Force update
- The Trust performance dashboard
- Integrated performance charts; and
- Financial performance overview and Finance Pack.

Which Committees have reviewed the information prior to Board submission?

-

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

Discussion and scrutiny

[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

'Story of the month' for May 2016

Responsiveness

At the end of month 2 the Trust is delivering within the agreed performance trajectories for the emergency 4 hour standard and 18 week referral to treatment, but underperforming on the cancer 62-day first definitive treatment (FDT) standard.

1. 4 hour standard, non-elective activity and LOS

We achieved 91% against a trajectory of 86.6% for the 4 hour standard in May. A number of projects and improvement action plans remain in place to achieve a consistent and sustainable improvement across both sites and these are focused on reducing LOS and delivering the ambulatory model for acute medicine. The level of non-elective activity has been much higher than plan throughout the winter and remains above last year's level by 7.6% (600 more admissions YTD). The non-elective length is 7.2 days at the end of May against the internal phased target of 7.2, bed occupancy is above 95% and DTOC rate is at 5.3%.

Trust delayed transfers of care	3.2%	4.5%	3.4%	4.8%	4.1%	4.4%	4.8%	4.2%	3.6%	4.1%	3.4%	6.0%	5.5%	4.8%	6.8%	7.9%	7.1%	7.9%	6.6%	5.7%	6.0%	5.0%	5.8%	5.6%	5.5%	5.3%

Row Labels	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Grand Total
A : Awaiting Assessment	8	6	2	3	5	7	3	2		11	17	17	15	6	15	21	15	17	15	10	5	7	3	8	1	6	225
B : Awaiting Public Funding		2		2	7	7	6	1		1	3	2	2		1	1	4	8	7	3	1			1	1	1	61
C : Awaiting Further Non-Acute NHS Care	18	38	40	46	31	33	30	25	19	21	18	28	32	34	39	48	33	30	20	6	3	8	15	18	17	13	663
Di : Awaiting Residential Home	2	2		9	4		1	6	10	5	3	6	18	1	11	27	28	26	22	16	21	15	15	27	32	20	327
Dii : Awaiting Nursing Home	3	3	2	9	2	20	13	16	8	17	12	30	40	21	38	90	57	52	56	40	73	53	80	73	58	67	933
E : Awaiting Care Package	2	11	9	6	8	8	13	26	15	11	18	10	7	7	20	16	27	17	32	26	43	28	36	36	28	24	484
F : Awaiting Community Adoptions	7	8	3	6	7	2	7	8	6	9	1	8	1	11	2	1		1	13	9	8	14	5	13	8	7	165
G : Patient of Family Choice	36	39	44	36	59	32	46	47	36	39	47	60	60	44	44	45	16	43	26	22	31	12	12	22	13	9	920
H : Disputes						1							2	1			1	3	1	1		1				3	14
I : Housing		2	6	2				2		2		1	3	4	3	1		1	13	12	9	3	5	1			70
Grand Total	**76**	**111**	**106**	**119**	**123**	**110**	**119**	**133**	**94**	**116**	**119**	**162**	**180**	**129**	**173**	**250**	**181**	**198**	**205**	**145**	**194**	**141**	**171**	**199**	**158**	**150**	**3862**

2. Cancer 62 day FDT

Performance is below trajectory for April, largely due to issues in one tumour group where the volume of referrals continue to grow and the delays occur in the pre-diagnosis stage of the pathway prior to a decision to treat being confirmed. Clear actions have been agreed with the specialty, some of which are deliverable internally but some that need additional staff and resource which is being progressed. A follow-up cancer summit was held in June to review actions and improvement plans that were agreed in January and much progress has been achieved, particularly in breast and lung cancer. The cancer delivery plan is monitored on a weekly basis with the relevant managers.

3. RTT and elective activity.

The Trust is on target to deliver the agreed RTT trajectory by the end of July and the improvement reflects the increase in the level of elective and day case activity undertaken year to date. Progress is maintained with all specialties supported by outsourcing in orthopaedics and the number of patients in the over 18-week backlog is gradually reducing in all specialties.

Quality exception report

It is encouraging to see a significant reduction in the rate of patient falls this month and the sustained reduction in falls causing serious harm. There remains absolute focus on this as our number one patient safety priority with a programme of improvements to sustain this position.

Complaints response times dropped in May but we are back on track for June.

Workforce

Despite the increase in budget establishment this year as a result of the opening of the new ward at Tunbridge Wells Hospital, transfer of Crowborough birthing centre to the Trust, permanent establishment of Foster Clarke and Whatman wards and impact of other agreed business cases, the vacancies percentage has improved (1.3% reduction) on the same period last year and is 0.3% better than the reported position last month. The Trust now employs 5,089.1 whole time equivalent substantive staff representing a net increase of 220.7 WTE against the same month last year. However the Trust will continue to focus attention on recruitment and establishment reviews in order to reduce the vacancy number further. Although the dependence upon temporary staff remains higher than planned, further work is ongoing to ensure we reduce our dependence upon expensive agency and interim workers. The use of bank staff was 332.7WTE in May 2016 which was similar to the amount used last month (333.3 WTE) but represented a significant improvement (+61.0 WTE) on the same period last year.

Sickness absence in the month was 4.2%, representing 0.1% improvement on last month and 0.3% deterioration on the same period last year (3.9%). Sickness absence management remains a key area of focus for the HR and operational management teams. A review of the sicknesses absence data for March and April 2016 showed no significant statistical variation in the sickness absence rate for the international nurse recruits. In March 2016 the rate was 0.5% higher whereas in April 2016 it was 1.0% lower. Furthermore there was no significant variation in reasons for the absence. The monthly analysis will continue to ensure that the Trust monitors the position carefully and takes appropriate action if and when needed to support our nursing workforce.

Statutory and mandatory training compliance figure is 0.3% lower than the same period last year. However this is as a result of the figure being rebased to include all subjects and is above the Trust 85% target. Actions are in place to improve compliance further.

TRUST PERFORMANCE DASHBOARD **Position as at:** **31 May 2016**

Governance (Quality of Service): **2.0** **Amber/Red** Based on TDA 2014/15 Methodology

Finance: **TDA** **Amber**

	Safe	Latest Month		Year to Date		YTD Variance		Year End		Bench Mark
		Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/ *Limit*	Forecast	
'1-01	*Rate C-Diff (Hospital only)	4.85	9.1	5.0	9.2	4.2	- 4.6	11.5	10.2	
'1-02	Number of cases C.Difficile (Hospital)	1	2	2	4	2	- 2	27	25	
'1-03	Number of cases MRSA (Hospital)	0	0	0	0	0	0	0	0	
'1-04	Elective MRSA Screening	98.0%	99.0%	98.0%	99.0%		1.0%	98.0%	99.0%	
'1-05	% Non-Elective MRSA Screening	97.0%	97.0%	97.0%	97.0%		2.0%	95.0%	97.0%	
'1-06	**Rate of Hospital Pressure Ulcers	3.0	2.2	1.9	2.5	0.6	- 0.5	*3.0*	2.6	3.0
'1-07	***Rate of Total Patient Falls	7.2	5.5	6.8	6.2	- 0.6	- 0.0	*6.2*	6.2	
'1-08	***Rate of Total Patient Falls Maidstone	5.7	5.2	5.8	5.7	- 0.1			6.3	
'1-09	***Rate of Total Patient Falls TWells	8.0	5.8	7.3	6.5	- 0.8			7.2	
'1-10	Falls - SIs in month	5	0	6	1	- 5				
'1-11	Number of Never Events	0	0	0	0	0	0	*0*	0	
'1-12	Total No of SIs Open with MTW	20	22			2				
'1-13	Number of New SIs in month	10	8	13	16	3	- 4			
'1-14	**Serious Incidents rate	0.48	0.36	0.32	0.37	0.04	0.31	*0.0584 - 0.6978*	0.37	*0.0584 - 0.6978*
'1-15	Rate of Patient Safety Incidents - harmful	1.22	0.13	1.40	0.36	- 1.04	- 0.87	*0 - 1.23*	0.36	*0 - 1.23*
'1-16	Number of CAS Alerts Overdue	1	0			-1	0	*0*		
'1-17	VTE Risk Assessment	95.3%	95.5%	95.3%	95.3%	0.0%	0.3%	95.0%	95.3%	95.0%
'1-18	Safety Thermometer % of Harm Free Care	97.0%	96.6%	96.8%	96.5%	-0.3%	1.5%	95.0%		93.4%
'1-19	Safety Thermometer % of New Harms	2.18%	3.23%	2.30%	3.44%	1.14%	0.4%	*3.00%*	3.44%	
'1-20	C-Section Rate (non-elective)	10.2%	12.4%	10.2%	13.8%	3.66%	-1.2%	*15.0%*	13.8%	

	Effectiveness	Latest Month		Year to Date		YTD Variance		Year End		Bench Mark
		Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/ *Limit*	Forecast	
2-01	Hospital-level Mortality Indicator (SHMI)******	Prev Yr: Oct 13 to Sept 14		-	105.0	105.0	5.0	*Lower confidence limit to be <100*		100.0
2-02	Standardised Mortality (Relative Risk)	Prev Yr: Oct 13 to Sept 14		110.1	102.0	- 8.1	2.0			100.0
2-03	Crude Mortality	1.1%	1.4%	1.2%	1.3%	0.1%				
2-04	****Readmissions <30 days: Emergency	11.9%	11.8%	11.9%	11.8%	-0.1%	-1.8%	*13.6%*	11.8%	14.1%
2-05	****Readmissions <30 days: All	10.9%	11.1%	10.9%	11.1%	0.2%	-3.6%	*14.7%*	11.1%	14.7%
2-06	Average LOS Elective	3.2	3.0	3.3	3.2	- 0.1	- 0.0	*3.2*	3.2	
2-07	Average LOS Non-Elective	7.4	7.2	7.5	7.5	- 0.0	0.7	*6.8*	6.8	
2-08	******New:FU Ratio	1.28	1.27	1.31	1.24	- 0.06	- 0.27	*1.52*	1.24	
2-09	Day Case Rates	82.8%	83.6%	83.4%	84.6%	1.1%	4.6%	80.0%	84.6%	82.2%
2-10	Primary Referrals	8,375	8,951	17,376	18,460	6.2%	5.7%	104,825	104,825	
2-11	Cons to Cons Referrals	3,197	2,529	6,593	5,232	-20.6%	-26.1%	40,698	40,698	
2-12	First OP Activity	10,650	12,081	22,014	23,598	7.2%	0.3%	144,940	144,940	
2-13	Subsequent OP Activity	20,409	23,086	42,824	45,676	6.7%	-2.7%	279,695	279,695	
2-14	Elective IP Activity	654	688	1,276	1,318	3.3%	-10.4%	8,755	8,755	
2-15	Elective DC Activity	3,016	3,309	6,155	6,674	8.4%	-7.2%	44,937	44,937	
2-16	Non-Elective Activity	3,911	4,104	7,716	8,301	7.6%	9.1%	45,985	45,985	
2-17	A&E Attendances (Inc Clinics. Calendar Mth)	13,764	14,797	28,512	27,570	-3.3%	0.1%	163,967	163,967	
2-18	Oncology Fractions	5,334	5,646	10,823	11,932	10.2%	4.1%	70,642	70,642	
2-19	No of Births (Mothers Delivered)	502	482	982	984	0.2%	0.3%	5,888	5,904	
2-20	% Mothers initiating breastfeeding	81.1%	76.6%	80.1%	74.1%	-6.1%	-3.9%	78.0%	78.0%	
2-21	% Stillbirths Rate	0.0%	0.21%	0.20%	0.10%	*-0.1%*	*-0.4%*	*0.47%*	0.10%	0.47%

	Caring	Latest Month		Year to Date		YTD Variance		Year End		Bench Mark
		Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/ *Limit*	Forecast	
3-01	Single Sex Accommodation Breaches	0	0	0	0	0	0	0	0	
3-02	*****Rate of New Complaints	1.79	1.68	1.69	1.47	-0.2	0.15	*1.318-3.92*	1.56	
3-03	% complaints responded to within target	54.8%	58.1%	51.4%	65.0%	13.6%	-10.0%	75.0%	75.0%	
3-04	****Staff Friends & Family (FFT) % rec care	84.0%	83.3%	84.0%	83.3%	-0.7%	4.3%	79.0%	83.3%	79.2%
3-05	*****IP Friends & Family (FFT) % Positive	94.3%	95.7%	95.6%	96.2%	0.6%	1.2%	95.0%	96.2%	95.7%
3-06	A&E Friends & Family (FFT) % Positive	87.5%	91.8%	88.2%	91.1%	2.9%	4.1%	87.0%	91.1%	84.9%
3-07	Maternity Combined FFT % Positive	95.2%	93.5%	94.7%	93.8%	-0.9%	-1.2%	95.0%	95.0%	95.5%
3-08	OP Friends & Family (FFT) % Positive	77.7%	81.4%	77.4%	81.9%	4.5%			81.9%	

* Rate of C.Difficile per 100,000 Bed days, ** Rate of Pressure Sores per 1,000 admissions (excl Day Case), *** Rate of Falls per 1,000 Occupied Beddays, **** Readmissions run one month behind, ***** Rate of Complaints per 1,000 occupied beddays.

***** New :FU Ratio is only for certain specialties -plan still being agreed so currently last year plan

Delivering or Exceeding Target	
Underachieving Target	
Failing Target	

Please note a change in the layout of this Dashboard to the Five CQC/TDA Domains

******A&E 4hr Wait monthly plan is Trust Recovery Trajectory

	Responsiveness	Latest Month		Year/Quarter to Date		YTD Variance		Year End		Bench Mark
		Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/ *Limit*	Forecast	
4-01	******Emergency A&E 4hr Wait	90.9%	90.5%	91.5%	91.0%	-0.4%	5.2%	95.0%	95.0%	80.9%
4-02	Emergency A&E >12hr to Admission	0	0	0	0	0	0	*0*	0	
4-03	Ambulance Handover Delays >30mins	New	No data	New	No data				No data	
4-04	Ambulance Handover Delays >60mins	New	No data	New	No data				No data	
4-05	RTT Incomplete Admitted Backlog	523	1610	523	1610	1,087	60	401	401	
4-06	RTT Incomplete Non-Admitted Backlog	54	618	54	618	564	- 159	201	201	
4-07	RTT Incomplete Pathway	97.3%	91.0%	97.3%	91.0%	-6.3%	1.0%	92%	92.0%	
4-08	RTT 52 Week Waiters	0	0	3	0	- 3	0	*0*	0	
4-09	RTT Incomplete Total Backlog	577	2228	577	2228	1,651	- 222	602	602	
4-10	% Diagnostics Tests WTimes <6wks	99.9%	99.0%	99.9%	99.0%	-0.9%	0.0%	99.0%	99.0%	
4-11	*Cancer WTimes - Indicators achieved	6	3	6	3	- 3	- 6	9	9	
4-12	*Cancer two week wait	94.1%	91.3%	93.0%	91.3%	-1.7%	-1.7%	93.0%	93.0%	
4-13	*Cancer two week wait-Breast Symptoms	96.5%	83.3%	95.7%	83.3%	-12.4%	-9.7%	93.0%	93.0%	
4-14	*Cancer 31 day wait - First Treatment	98.9%	96.6%	98.8%	96.6%	-2.2%	0.6%	96.0%	96.6%	
4-15	*Cancer 62 day wait - First Definitive	82.4%	64.3%	81.9%	64.3%	-17.6%	-9.5%	85.1%	85.1%	
4-16	*Cancer 62 day wait - First Definitive - MTW	87.7%	68.1%	86.7%	68.1%	-18.6%		85.0%		
4-17	*Cancer 104 Day wait Accountable	5.5	14.0	5.5	14.0	8.5	14.0	*0*	14.0	
4-18	Delayed Transfers of Care	4.9%	5.3%	5.2%	5.4%	0.2%	1.9%	3.5%	3.5%	
4-19	% TIA with high risk treated <24hrs	80.0%	82.8%	79.5%	85.0%	5.5%	25.0%	60%	85.0%	
4-20	% spending 90% time on Stroke Ward	87.8%	86.7%	79.8%	84.5%	4.7%	4.5%	80%	84.5%	
4-21	Stroke:% to Stroke Unit <4hrs	52.2%	45.3%	52.2%	52.9%	0.8%	-7.1%	60.0%	60.0%	
4-22	Stroke: % scanned <1hr of arrival	45.7%	56.9%	44.4%	61.2%	16.7%	13.2%	48.0%	61.2%	
4-23	Stroke:% assessed by Cons <24hrs	76.1%	72.3%	73.4%	76.0%	2.6%	-4.0%	80.0%	80.0%	
4-24	Urgent Ops Cancelled for 2nd time	0	0	0	0	0	0	*0*	0	
4-25	Patients not treated <28 days of cancellation	0	1	0	3	3	3	*0*	3	

RTT Incomplete Pathway Monthly Plan is Trust Recovery Trajectory

**CWT run one mth behind, YTD is Quarter to date, Monthly Plan for 62 Day Wait First Definitive is Trust Recovery Trajectory*

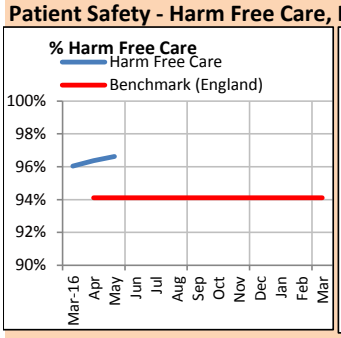
**** Contracted not worked includes Maternity /Long Term Sick* ***** Staff FFT is Quarterly therefore data is latest Quarter*

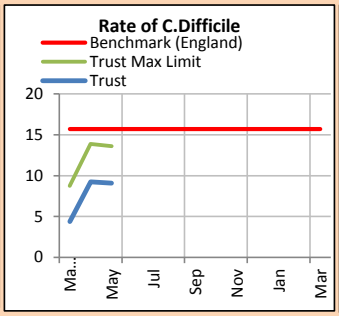
****** IP Friends and Family includes Inpatients and Day Cases* *******SHMI is within confidence limit*

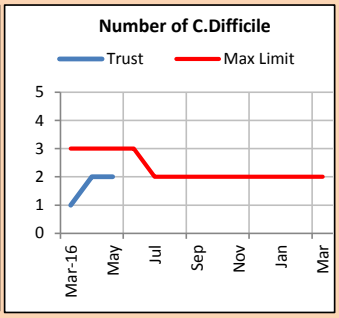
	Well-Led	Latest Month		Year to Date		YTD Variance		Year End		Bench Mark
		Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/ *Limit*	Forecast	
5-01	Income	32,245	34,118	62,990	67,309	6.9%	-1.6%	410,736	410,736	
5-02	EBITDA	146	(493)	638	(1,445)	-326.5%	314%	11,086	11,086	
5-03	Surplus (Deficit) against B/E Duty	(2,703)	(3,210)	(5,064)	(6,886)			(22,928)	(22,928)	
5-04	CIP Savings	1,657	1,453	3,056	2,679	-12.3%	-12.0%	23,076	23,076	
5-05	Cash Balance	16,816	5,881	16,816	5,881	-65.0%	-30%	1,000	1,000	
5-06	Capital Expenditure	647	102	647	182	-71.9%	-81.5%	*15,189*	15,189	
5-07	Establishment (Budget WTE)	5,552.6	5,830.1	5,552.6	5,830.1	5.0%	0.0%	5,837.3	5,837.3	
5-08	Contracted WTE	4,868.4	5,089.1	4,868.4	5,089.1	4.5%	-3.5%	5,427.1	5,427.1	
5-09	***Contracted not worked WTE	(98.5)	(99.3)	(98.5)	(99.3)			(100.0)	(100.0)	
5-10										
5-11	Bank Staff (WTE)	271.7	332.7	271.7	332.7	22.4%		254.8	254.8	
5-12	Agency & Locum Staff (WTE)	284.1	253.9	284.1	253.9	-10.6%		155.3	155.3	
5-13	Overtime (WTE)	72.5	46.4	72.5	46.4	-36.1%		64.4	64.4	
5-14	Worked Staff WTE	5,424.2	5,622.7	5,424.2	5,622.7	3.7%	-3.6%	5,801.7	5,801.7	
5-15	Vacancies WTE	684.2	639.7	684.2	639.7	-6.5%		408.6	408.6	
5-16	Vacancy %	12.3%	11.0%	12.3%	11.0%	-1.3%		8.5%	8.5%	
5-17	Nurse Agency Spend	(851)	(789)	(1,614)	(1,653)	2.4%				
5-18	Medical Locum & Agency Spend	(1,004)	(1,308)	(1,930)	(2,672)	38.4%				
5-19	Temp costs & overtime as % of total pay bill		17.0%		17.0%					
5-20	Staff Turnover Rate	9.4%	9.9%		9.9%	0.4%	-0.6%	*10.5%*	9.9%	8.4%
5-21	Sickness Absence	3.9%	4.2%		4.3%			*3.3%*	3.3%	3.7%
5-22	Statutory and Mandatory Training	87.2%	86.9%		86.9%	-0.3%	1.9%	85.0%	86.9%	
5-23	Appraisal Completeness	Not reported for Quarter 1								
5-24	Overall Safe staffing fill rate	103.3%	101.6%	103.4%	102.5%	-1.7%		93.5%	102.5%	
5-25	****Staff FFT % recommended work	58.8%	66.9%	58.8%	66.9%	8.1%	4.9%	62.0%	66.9%	62.9%
5-26	***Staff Friends & Family -Number Responses	393	305	786	305	-481				
5-27	*****IP Resp Rate Recmd to Friends & Family	26.7%	22.4%	27.3%	20.6%	-6.7%	-4.4%	25.0%	25.0%	24.9%
5-28	A&E Resp Rate Recmd to Friends & Family	9.3%	10.4%	8.0%	7.7%	-0.4%	-7.3%	15.0%	15.0%	13.3%
5-29	Mat Resp Rate Recmd to Friends & Family	12.4%	24.0%	15.2%	27.1%	11.9%	2.1%	25.0%	27.1%	24.6%

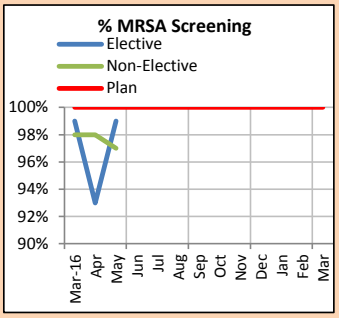
INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

Patient Safety - Harm Free Care, Infection Control

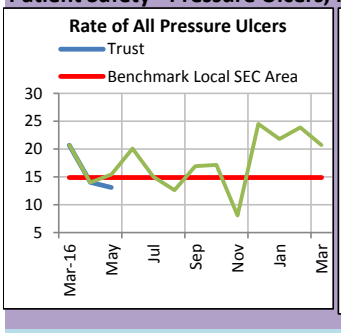


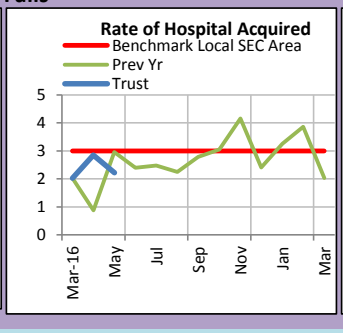


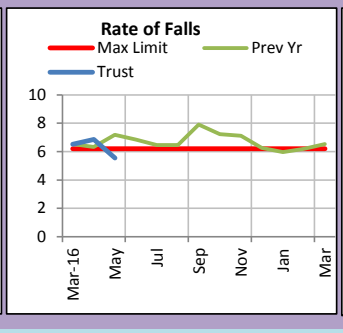


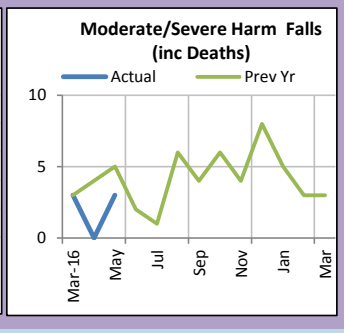


Patient Safety - Pressure Ulcers, Falls

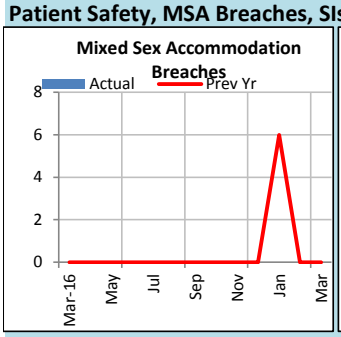


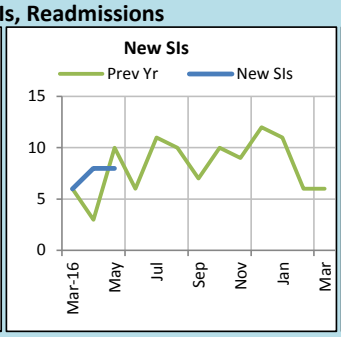


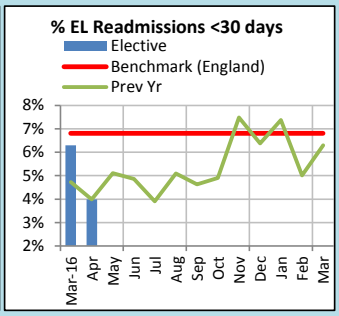


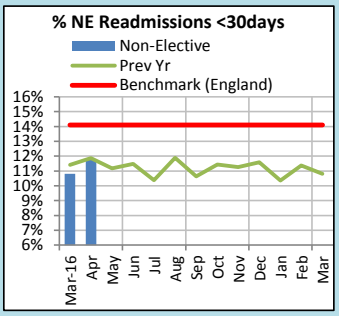


Patient Safety, MSA Breaches, SIs, Readmissions

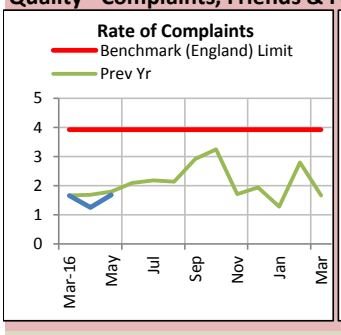


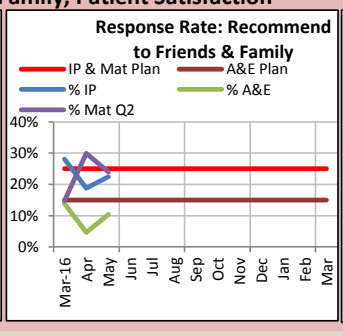


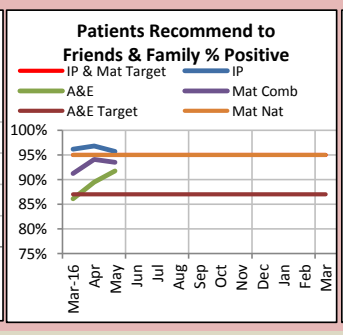


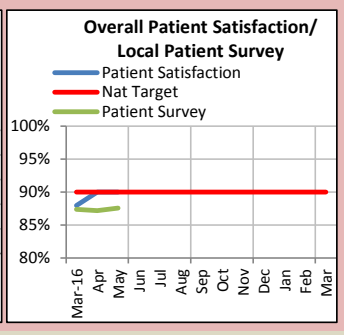


Quality - Complaints, Friends & Family, Patient Satisfaction

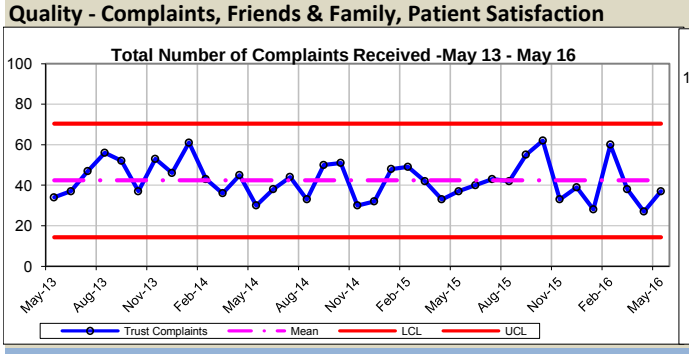


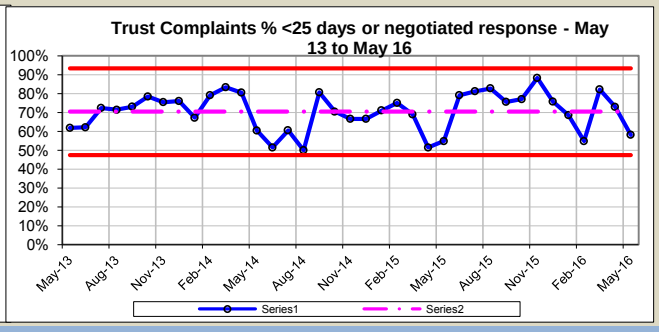




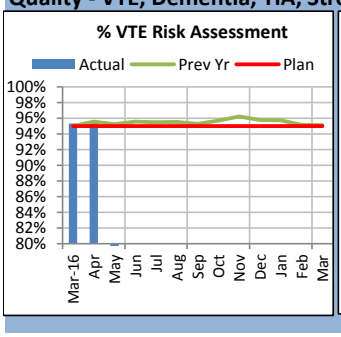


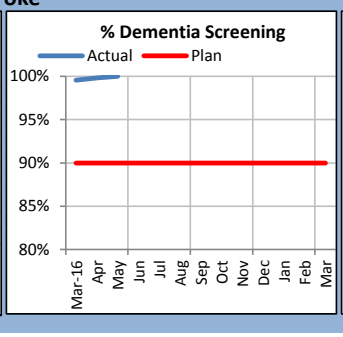
Quality - Complaints, Friends & Family, Patient Satisfaction

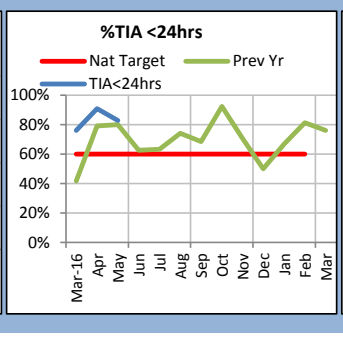


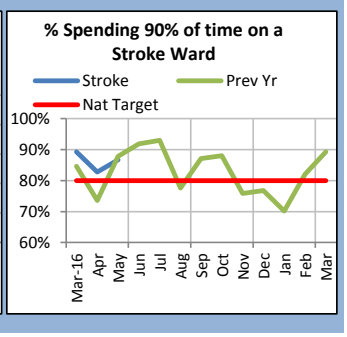


Quality - VTE, Dementia, TIA, Stroke



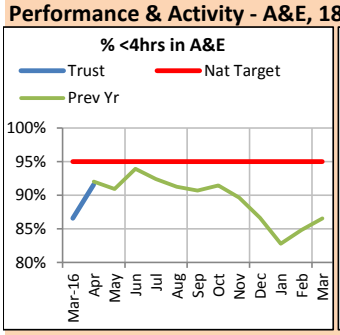


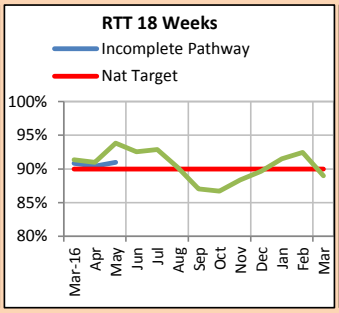


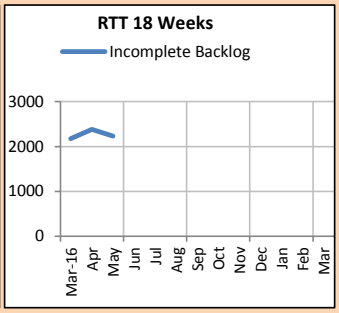


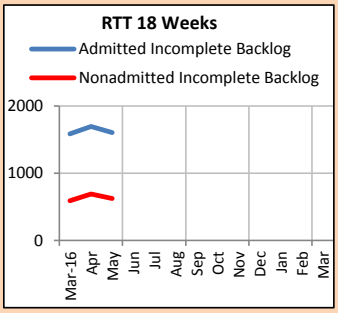
INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

Performance & Activity - A&E, 18 Weeks

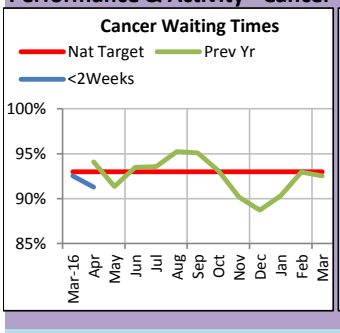


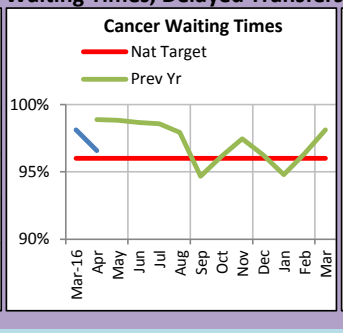


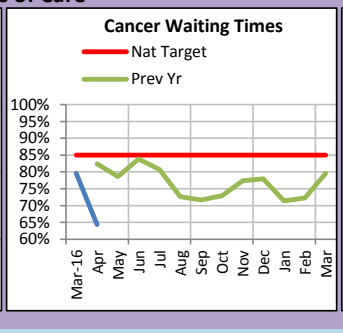


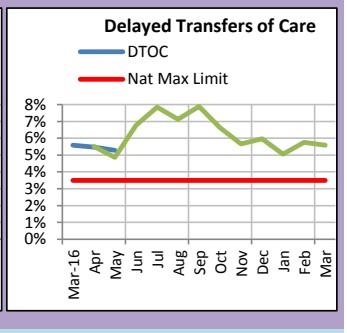


Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care

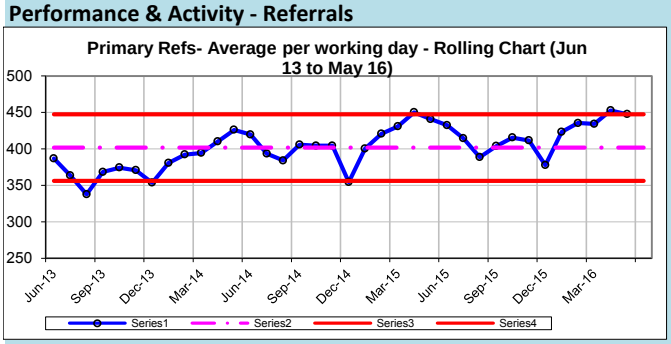


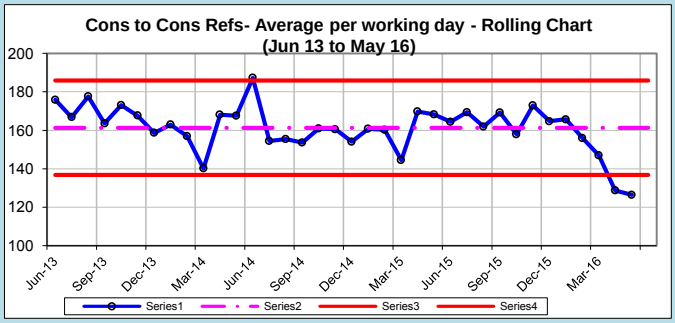




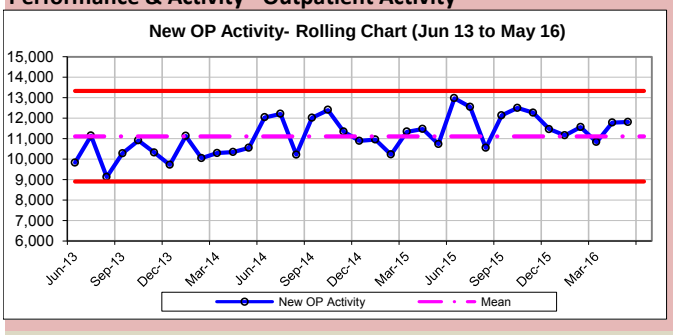


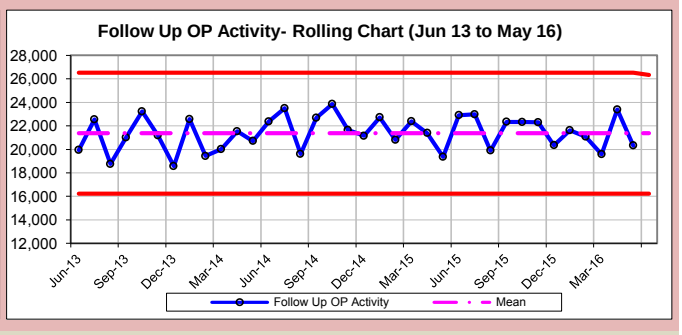
Performance & Activity - Referrals



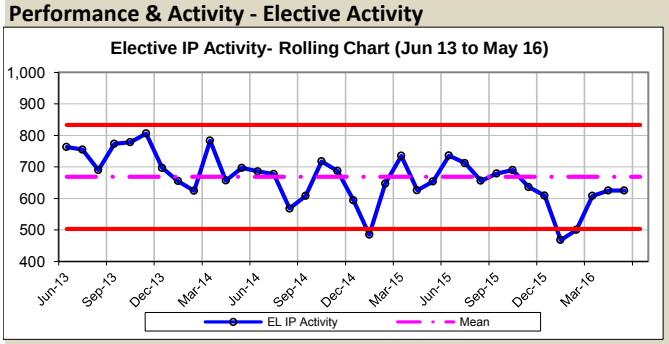


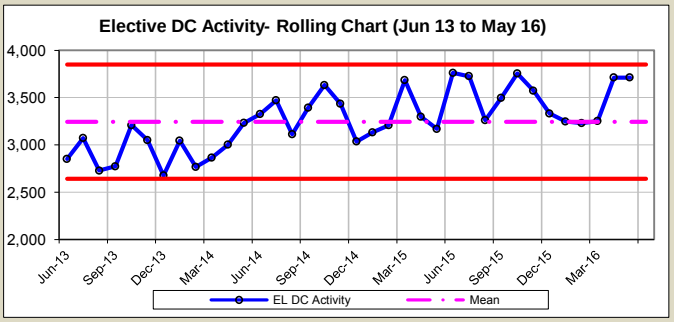
Performance & Activity - Outpatient Activity



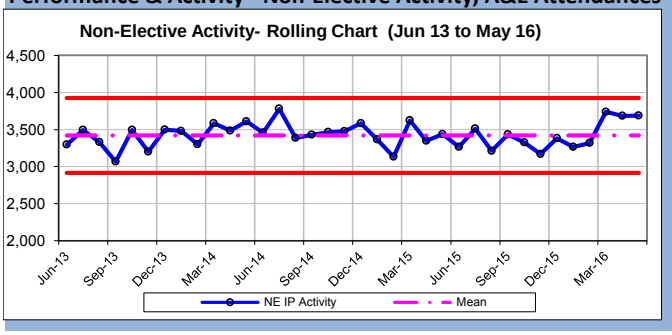


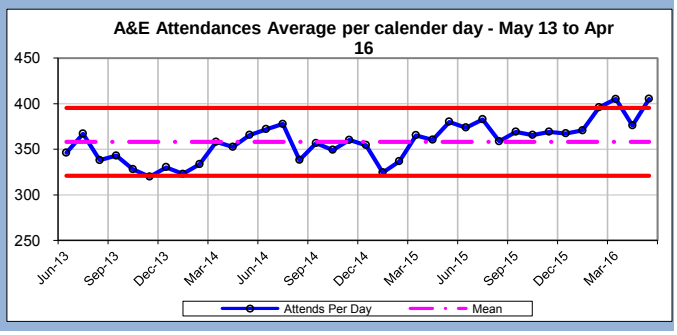
Performance & Activity - Elective Activity





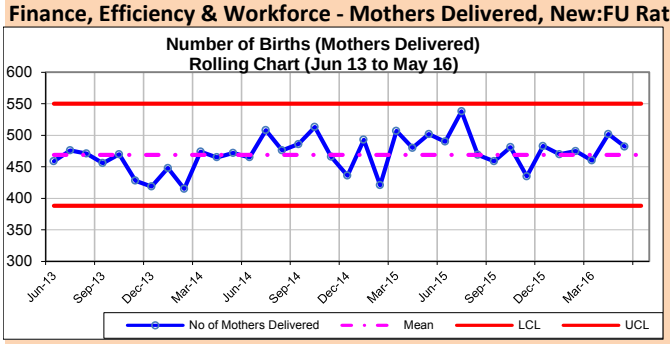
Performance & Activity - Non-Elective Activity, A&E Attendances

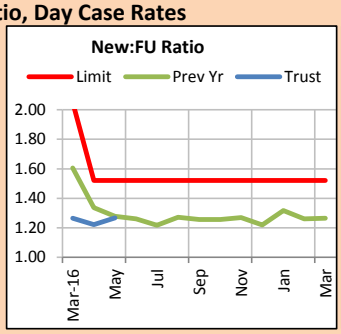


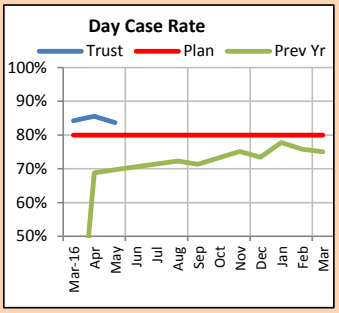


INTEGRATED PERFORMANCE REPORT ANALYSIS - FINANCE, EFFICIENCY & WORKFORCE

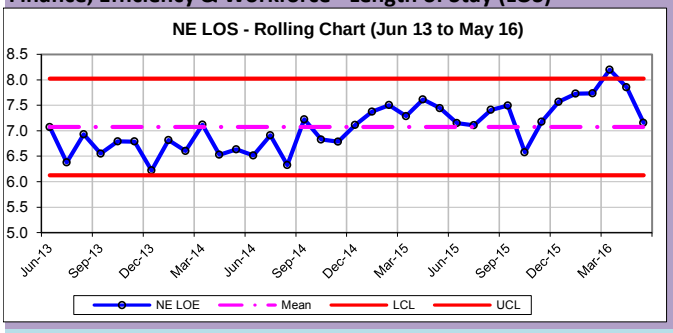
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates

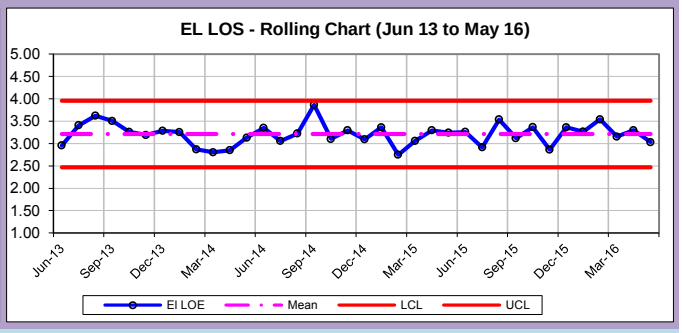




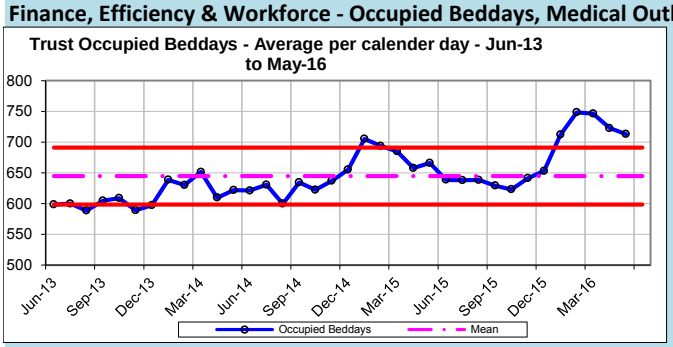


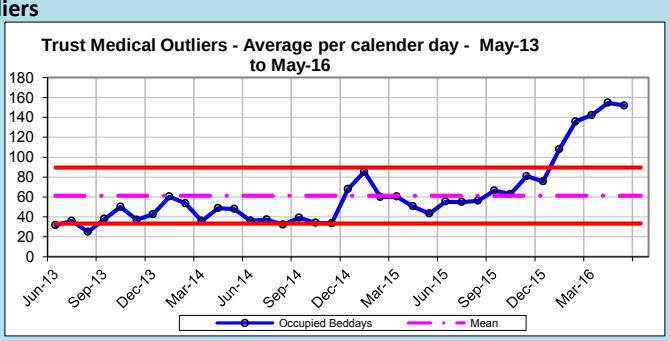
Finance, Efficiency & Workforce - Length of Stay (LOS)



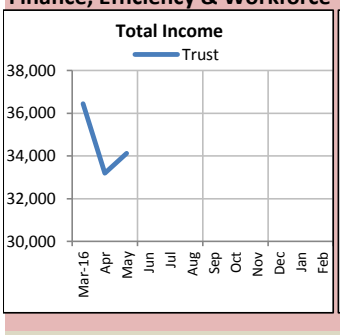


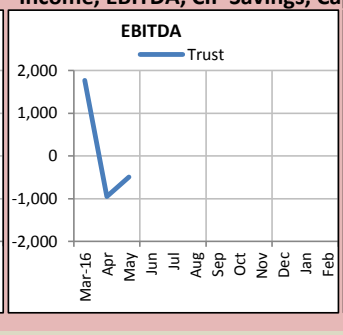
Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

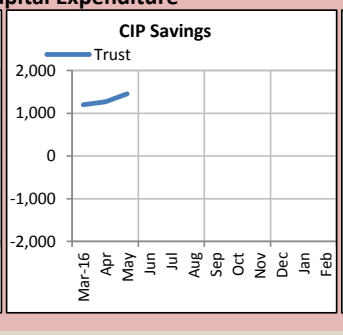


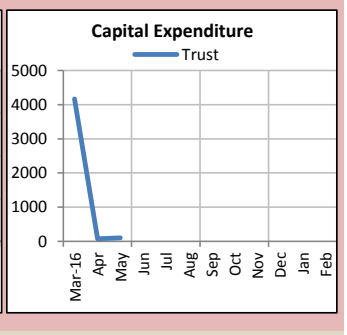


Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure

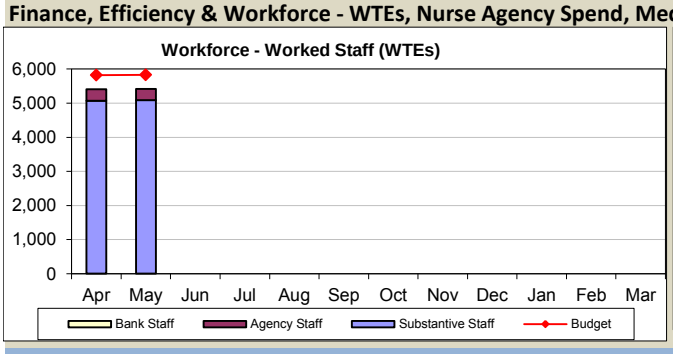


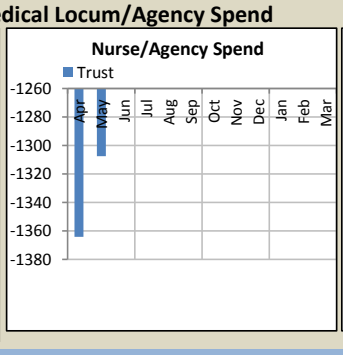


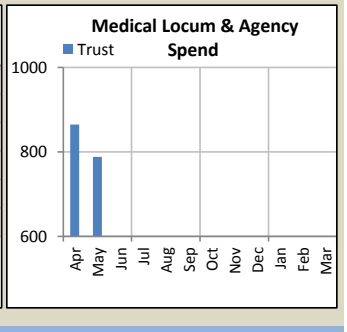




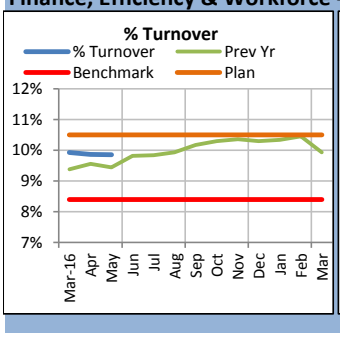
Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend

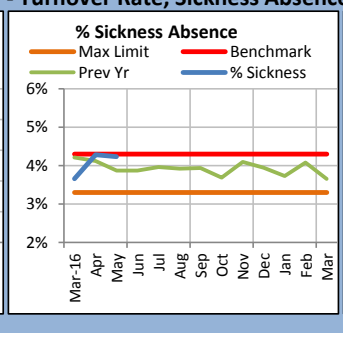


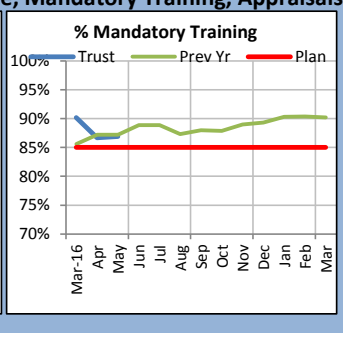




Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals







Appraisal Data not reported for Quarter 1

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board – June 2016

6-8 Review of Latest Financial Performance **Director of Finance**

Summary / Key points

- The Trust had an adverse variance against plan at the end of May 2016 of £0.9m
- The Trust's net deficit to date (including technical adjustments) is £6.9m against a planned deficit of £5.8m, therefore £1.1m adverse to plan.
- The key drivers of the variance in the month are as follows:
    - Total income is adverse to plan by £0.4m, with the main driver Clinical income, £1.5m adverse. Elective income is £0.7m adverse, which is offset by a £0.1m favourable variance in Non Elective activity (net of Non Elective Threshold). Fines and contract penalties are £0.7m in month, £0.6m adverse to plan. RTT and A&E fines are £0.4m in month with an increase in the 30 day readmission penalty for May.
    - Pay underspent by £0.4m, corporate areas underspent by £0.2m due to vacancies and nursing underspent by £0.2m. Medical and STT agency increased month on month.
    - Non Pay is overspent by £1m. Drugs is £0.6m adverse, however this is offset by a favourable high cost drugs variance of £0.3m. Other non-pay costs are £0.3m adverse due to consultancy spend.
- The CIP performance in May delivered efficiencies of £1.45m which was £0.03m adverse to plan.
- In May the Trust operated with an EBITDA deficit of £0.5m which was £1m adverse to plan.
- T&O is adverse to plan by £1.3m YTD, £1.2m under performance on income and £0.1m overspend on pay.
- The Trust held £5.9m of cash at the end of May, a decrease of £4.5m from the end of April. The Trust is currently forecasting to draw down of £2m in July at 3.5% interest and a further £8m in September.

Reason for circulation to Trust Board

To note the Mays position and actions needed to deliver the £22.9m annual plan

Maidstone and Tunbridge Wells NHS Trust

Trust Board Finance Pack

Month 2
2016/17

Maidstone and Tunbridge Wells NHS Trust

Trust Board Pack for April 2016

mtw

Executive Summary

Maidstone and Tunbridge Wells NHS Trust

1a. Executive Summary May 2016

Key Variances £m

	May	YTD		Headlines
Total Deficit	**(1.0)**	**(1.1)**	Adverse	The reported Trust position for May is a deficit of £3.2m which is £1m adverse to plan The main drivers were: Clinical Income, £1.5m adverse to plan, £0.7m relating to fines, £0.1m net non elective favourable and Elective £0.7m adverse. Other non pay costs were adverse by £0.3m relating to consultancy spend.
Pay	0.4	0.8	Favourable	Pay was £0.4m underspent, overspends on Medical (£0.1m) and Scientific and technical staffing (£0.1m) are offset by underspends on Nursing (£0.3m) and Admin and Clerical (Corporate) (£0.2m)
High Cost Drugs (Net)	0.3	0.5	Favourable	
Non Elective threshold	(0.5)	(0.9)	Adverse	Non Elective activity is £0.6m over plan in May (£1.5m YTD) however part of this income has been lost due to the non elective threshold
Contract Penalties & Challenges	(0.7)	(1.1)	Adverse	18 week RTT is the main driver of the penalties (£0.3m in month, £0.7m YTD). 30 day emergency readmission increased in month to £0.3m
KPMG	(0.3)	(0.3)	Adverse	
Daycase Activity	(0.5)	(0.6)	Adverse	Main driver is T&O which internal activity is 105 cases less than the same period last year
CIP	(0.0)	(0.4)	Adverse	CIP plan for May was £1.49m with a delivery of £1.45m, £0.03m adverse to plan, mainly back office and temporary staffing

Financial Forecast

Risks:
Unidentified CIPS (£3.3m) phased from 1st July 16 equating to a reduction in budget of £0.4m per month.

Ability to deliver elective activity (backlog) within financial envelope (tariff)

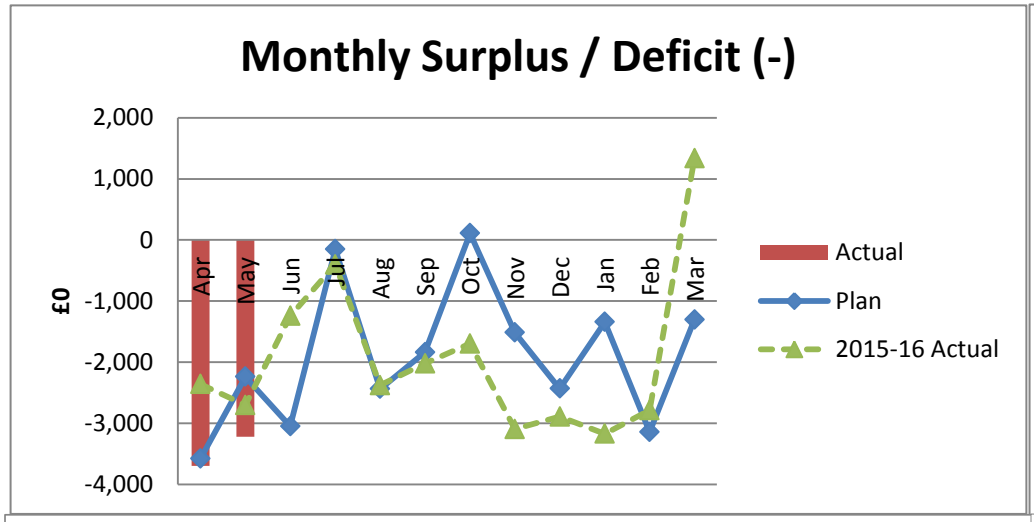
CQUINs are still being negotiated with the Commissioners, the main CQUINs with risk are: Flu vaccinations, Health and Well being and Antibiotic prescribing

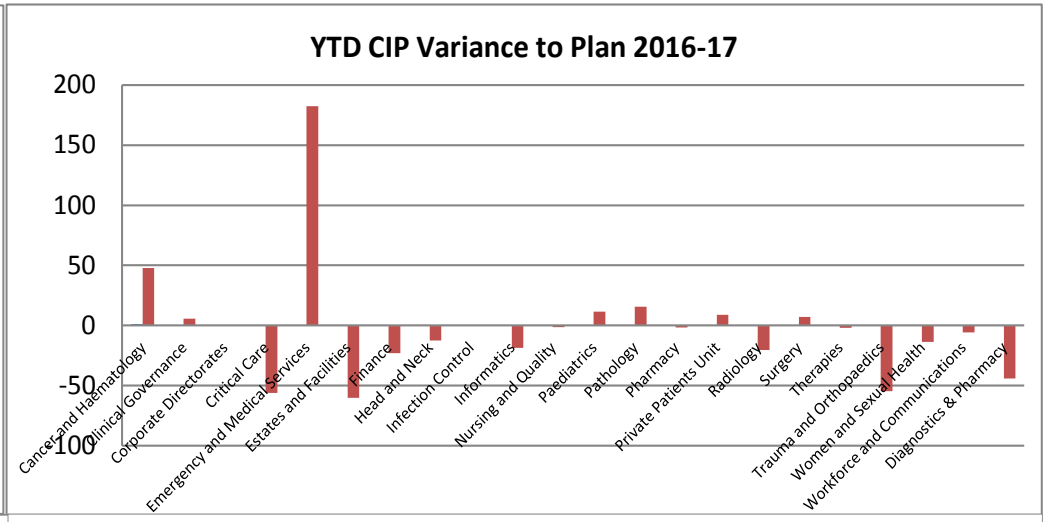
Opportunities:
Lord Carter efficiencies programme being led by the PMO team with clinicians and operational teams

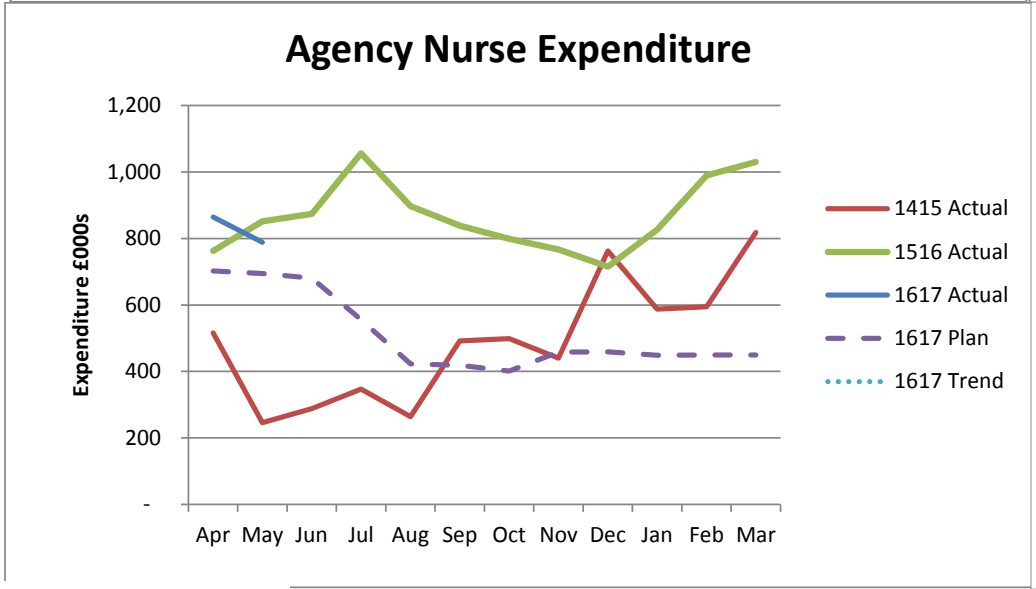
Unidentified savings workshops are taking place over the next month

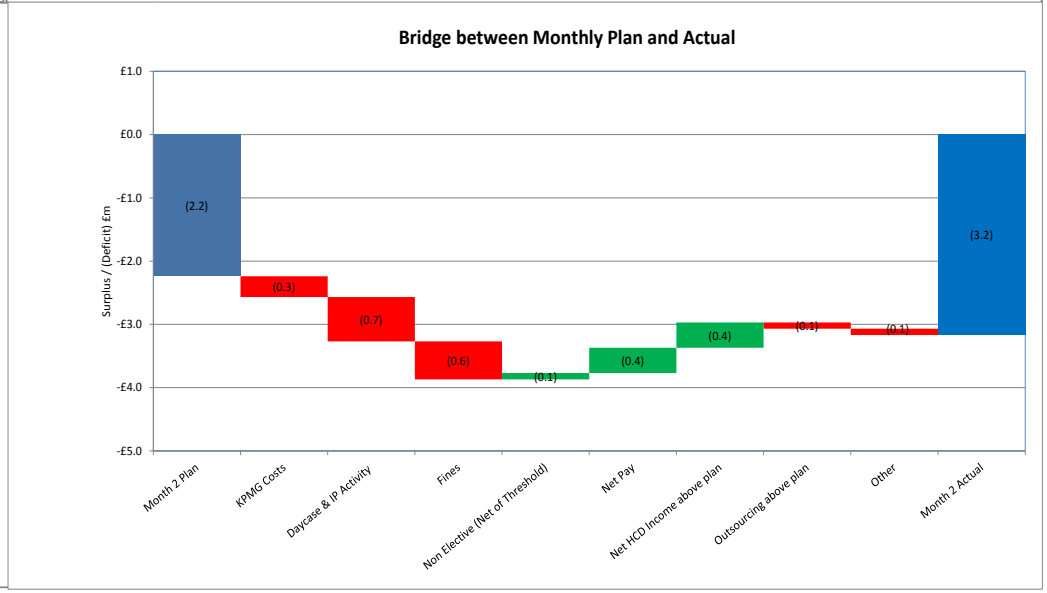
Maidstone and Tunbridge Wells NHS Trust

1b. Executive Summary KPI's May 2016









Financial Performance

Maidstone and Tunbridge Wells NHS Trust

2a. Consolidated Income & Expenditure

Income & Expenditure May 2016/17

		Current Month			Year to Date			Annual Forecast		
		Actual £m	*Plan* £m	*Variance* £m	*Actual* £m	*Plan* £m	*Variance* £m	*Actual* £m	*Plan* £m	*Variance* £m
Revenue										
	Clinical Income	27.7	29.1	(1.5)	54.2	56.9	(2.7)	344.3	344.3	0
	High Cost Drugs	2.6	1.7	0.9	5.4	3.8	1.6	21.2	21.2	0
	Other Operating Income	3.8	3.7	0.2	7.7	7.7	0.0	45.2	45.2	0
	Total Revenue	34.1	34.5	(0.4)	67.3	68.4	(1.1)	410.7	410.7	0
Expenditure										
	Substantive	(17.9)	(18.6)	0.7	(35.7)	(37.2)	1.4	(223.0)	(223.0)	0
	Bank	(0.8)	(0.9)	0.2	(1.6)	(1.9)	0.2	(11.9)	(11.9)	0
	Locum	(0.9)	(0.5)	(0.3)	(2.1)	(1.1)	(1.0)	(6.6)	(6.6)	0
	Agency	(1.6)	(1.4)	(0.2)	(2.9)	(2.8)	(0.1)	(13.5)	(13.5)	0
	Pay Reserves	0.0	(0.1)	0.1	0	(0.3)	0.3	2.1	2.1	0
	Total Pay	(21.2)	(21.6)	0.4	(42.4)	(43.2)	0.8	(253.0)	(253.0)	0
	Drugs & Medical Gases	(4.1)	(3.5)	(0.6)	(8.3)	(7.3)	(1.0)	(41.4)	(41.4)	0
	Blood	(0.2)	(0.2)	0.0	(0.4)	(0.4)	(0.0)	(2.2)	(2.2)	0
	Supplies & Services - Clinical	(2.7)	(2.7)	(0.1)	(4.9)	(5.3)	0.4	(31.6)	(31.6)	0
	Supplies & Services - General	(0.5)	(0.5)	(0.0)	(0.9)	(0.9)	0.0	(5.5)	(5.5)	0
	Services from Other NHS Bodies	(0.7)	(0.7)	0.0	(1.4)	(1.4)	(0.0)	(8.1)	(8.1)	0
	Purchase of Healthcare from Non-NHS	(0.7)	(0.6)	(0.1)	(1.5)	(1.3)	(0.2)	(7.7)	(7.7)	0
	Clinical Negligence	(1.5)	(1.5)	(0.0)	(3.0)	(3.0)	(0.0)	(18.2)	(18.2)	0
	Establishment	(0.3)	(0.3)	(0.1)	(0.6)	(0.6)	0.0	(3.4)	(3.4)	0
	Premises	(1.7)	(1.7)	(0.0)	(3.7)	(3.7)	(0.0)	(20.4)	(20.4)	0
	Transport	(0.2)	(0.1)	(0.1)	(0.3)	(0.3)	(0.0)	(1.6)	(1.6)	0
	Other Non-Pay Costs	(0.7)	(0.3)	(0.3)	(0.9)	(0.7)	(0.2)	(4.2)	(4.2)	0
	Non-Pay Reserves	(0.2)	(0.4)	0.2	(0.5)	(0.8)	0.4	(2.3)	(2.3)	0
	Total Non Pay	(13.4)	(12.4)	(1.0)	(26.3)	(25.6)	(0.8)	(146.6)	(146.6)	0
	Total Expenditure	(34.6)	(34.1)	(0.6)	(68.8)	(68.8)	0.0	(399.7)	(399.7)	0
EBITDA	**EBITDA**	(0.5)	0.5	(1.0)	(1.4)	(0.3)	(1.1)	11.1	11.1	0
		(0.0)	*0.0*	*0.0*	*-2.1%*	*-0.5%*	*98.4%*	*2.7%*	*2.7%*	
Other Finance Costs										
	Depreciation	(1.4)	(1.4)	(0.0)	(2.7)	(2.7)	0.0	(16.5)	(16.5)	0
	Interest	(0.1)	(0.1)	0.0	(0.1)	(0.1)	0.0	(1.3)	(1.3)	0
	Dividend	(0.3)	(0.3)	0.0	(0.6)	(0.6)	0	(3.4)	(3.4)	0
	PFI and Impairments	(1.1)	(1.1)	0.0	(2.3)	(2.3)	(0.0)	(27.0)	(27.0)	0
	Total Finance Costs	(2.8)	(2.8)	(0.0)	(5.7)	(5.7)	0.0	(48.2)	(48.2)	0
Net Surplus / Deficit (-)	**Net Surplus / Deficit (-)**	(3.3)	(2.4)	(1.0)	(7.1)	(6.1)	(1.1)	(37.1)	(37.1)	0
Technical Adjustments	**Technical Adjustments**	0.1	0.1	(0.0)	0.3	0.2	(0.0)	14.2	14.2	0
Surplus/ Deficit (-) to B/E Duty	**Surplus/ Deficit (-) to B/E Duty**	(3.2)	(2.2)	(1.0)	(6.9)	(5.8)	(1.1)	(22.9)	(22.9)	0.0

Commentary:

The Trust had a lower deficit in month than April however the deficit is not in line with plan (£1m adverse variance in month). The YTD deficit is £1.1m adverse.

The key drivers of this are clinical income (£1.5m in month, £2.7m YTD) due to the Trust continuing to manage non elective demand which is having a detrimental effect on elective activity. However there has been an improvement in elective activity in month 2 (see page 25). This variance includes fines of £0.8m in month and £1.4m YTD

In theory this Elective income is recoverable in line with the operational trajectory. This is therefore considered a timing variance at this stage.

The Trust has managed the adverse income variance with an underspend on pay (£0.8m) and non-pay underspent (£0.2m after excluding pass through drugs cost).

Pay is underspent YTD by £0.8m, overspends on Medical (£0.3m) and Scientific and Technical Staffing (£0.1m) offset by underspends on Nursing (£0.6m) and Admin and Clerical (£0.3m). Both medical and STT agency have increased from month1, although it should be noted that month 1 agency was acrrued within locum expenditure (staff flow).

Other non pay costs is adverse by £0.3m in month due to consultancy spend.

The Trust forecast remains unchanged at this stage in the year however the plan assumes unidentified savings will be delivered from July 16. Actions taken to rectify this position include:
- CIP gap closure programme
- NEL LoS reduction programme

Financial Performance

Maidstone and Tunbridge Wells NHS Trust

2b. Year to Date Variance by Directorate

Income & Expenditure May 2016/17

		Year to Date Variance by Directorate													
		Urgent Care	Diagnostics & Pharmacy	Surgery	Head and Neck	Critical Care	Trauma & Orthopaedics	Private Patient Unit	Cancer	Patient Admin	Paediatrics	Womens & Sexual Health	Estates & Facilities	Corporate	TOTAL
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Revenue															
	Clinical Income	412	(38)	7	(93)	128	(1,135)	(136)	(92)		(4)	(380)		(1,393)	(2,723)
	High Cost Drugs	(2)	(2)	(0)	0		(0)		0		0			1,588	1,583
	Other Operating Income	(105)	37	(5)	(3)	(7)	(15)	50	71	2	3	(21)	(60)	79	26
	Total Revenue	**305**	**(3)**	**2**	**(97)**	**121**	**(1,150)**	**(86)**	**(21)**	**2**	**(1)**	**(401)**	**(60)**	**274**	**(1,114)**
Expenditure															
	Substantive	599	57	83	30	169	(32)	42	(3)	7	71	91	18	289	1,420
	Bank	62	43	(37)	21	117	(7)	(19)	7	12	19	50	13	(33)	247
	Locum	(603)	(49)	(67)	(72)	(21)	(26)	4	(33)		6	(74)		(51)	(988)
	Agency	(138)	(36)	(29)	86	(55)	(24)	1	(14)	9	(13)	21	(0)	47	(145)
	Pay Reserves	108									(14)	41		128	263
	Total Pay	**28**	**15**	**(50)**	**65**	**211**	**(90)**	**28**	**(43)**	**27**	**69**	**129**	**30**	**379**	**798**
	Drugs & Medical Gases	14	(44)	(0)	(15)	26	5	(20)	(59)	(4)	11	29	(0)	(992)	(1,049)
	Blood	0	(14)								(0)			(6)	(20)
	Supplies & Services - Clinical	132	(63)	0	62	(61)	183	76	(32)	7	(16)	57	(37)	59	368
	Supplies & Services - General	15	4	6	1	23	3	(1)	(2)	(0)	1	7	(28)	4	34
	Services from Other NHS Bodies	56	(3)	(14)	(2)	(0)	2		(7)		5	(20)	1	(34)	(15)
	Purchase of Healthcare from Non-NHS	(22)	(116)	(11)	13	(7)	(243)	1	(3)		(5)	37	(19)	180	(196)
	Clinical Negligence													(0)	(0)
	Establishment	19	13	6	4	3	4	4	2	1	5	5	(38)	(25)	3
	Premises	(13)	1	5	2	20	1	3	1	(22)	(3)	(6)	11	(50)	(49)
	Transport	3	(2)	(0)	1	0	0	(0)	(1)	0	0	7	(57)	3	(44)
	Other Non-Pay Costs	252	120	(28)	(3)	(37)	27	(51)	(63)	3	(1)	(35)	(1)	(355)	(171)
	Non-Pay Reserves	(1)							8			6		347	360
	Total Non Pay	**456**	**(105)**	**(36)**	**63**	**(32)**	**(18)**	**12**	**(155)**	**(15)**	**(1)**	**87**	**(167)**	**(869)**	**(779)**
	Total Expenditure	**484**	**(90)**	**(87)**	**128**	**179**	**(108)**	**40**	**(198)**	**13**	**68**	**216**	**(136)**	**(490)**	**18**
EBITDA	**EBITDA**	**788**	**(93)**	**(85)**	**31**	**301**	**(1,258)**	**(46)**	**(219)**	**15**	**67**	**(185)**	**(197)**	**(215)**	**(1,096)**
Other Finance Costs															
	Depreciation													5	5
	Interest													1	1
	Dividend														
	PFI and Impairments													(6)	(6)
	Total Finance Costs	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Net Surplus / Deficit (-)	**Net Surplus / Deficit (-)**	**788**	**(93)**	**(85)**	**31**	**301**	**(1,258)**	**(46)**	**(219)**	**15**	**67**	**(185)**	**(197)**	**(215)**	**(1,096)**
Technical Adjustments	**Technical Adjustments**														
Surplus/ Deficit (-) to B/E Duty	**Surplus/ Deficit (-) to B/E Duty**	**788**	**(93)**	**(85)**	**31**	**301**	**(1,258)**	**(46)**	**(219)**	**15**	**67**	**(185)**	**(197)**	**(215)**	**(1,096)**

Expenditure Analysis

Maidstone and Tunbridge Wells NHS Trust

3a. Run Rate Analysis

Analysis of 13 Monthly Performance (£m's)

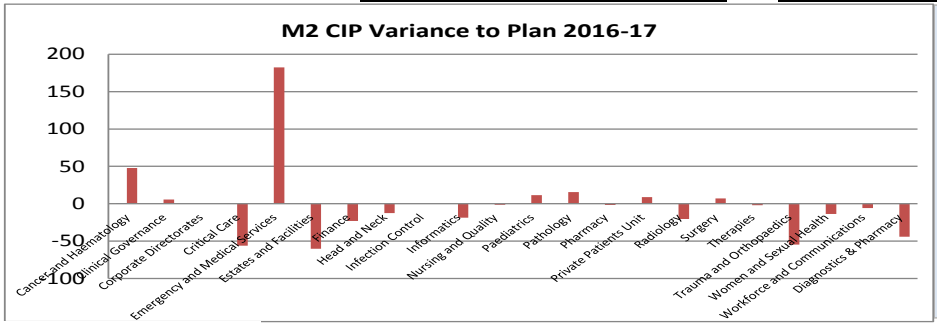
		May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
Revenue	Clinical Income	25.5	28.1	29.0	26.3	27.3	27.3	26.3	26.4	25.5	25.7	26.9	26.6	27.7
	High Cost Drugs	2.0	2.2	1.9	1.8	2.8	2.5	2.8	2.8	2.7	2.6	3.1	2.8	2.6
	Other Operating Income	4.7	3.9	4.3	4.1	4.3	4.3	4.1	4.0	4.0	4.6	6.5	3.8	3.8
	Total Revenue	**32.2**	**34.1**	**35.2**	**32.2**	**34.4**	**34.0**	**33.2**	**33.2**	**32.2**	**33.0**	**36.4**	**33.2**	**34.1**
Expenditure	Substantive	(17.3)	(17.1)	(16.8)	(17.0)	(17.1)	(17.0)	(17.5)	(17.4)	(17.3)	(17.7)	(18.1)	(17.8)	(17.9)
	Bank	(0.8)	(0.8)	(0.8)	(0.9)	(0.8)	(0.8)	(0.8)	(0.8)	(0.9)	(0.9)	(1.1)	(0.9)	(0.8)
	Locum	(0.6)	(0.6)	(0.7)	(0.8)	(0.8)	(0.8)	(0.6)	(0.9)	(1.0)	(0.7)	(0.6)	(1.2)	(0.9)
	Agency	(1.8)	(1.7)	(2.0)	(1.9)	(1.9)	(1.7)	(1.6)	(1.6)	(1.4)	(1.7)	(1.9)	(1.3)	(1.6)
	Pay Reserves	0	0	0	0	0	0	0	0	0	0	0	0	0
	Total Pay	(20.4)	(20.3)	(20.3)	(20.5)	(20.6)	(20.2)	(20.4)	(20.6)	(20.6)	(21.0)	(21.8)	(21.2)	(21.2)
Non-Pay	Drugs & Medical Gases	(3.4)	(3.4)	(3.2)	(3.1)	(4.2)	(3.7)	(4.0)	(4.1)	(4.1)	(3.9)	(4.0)	(4.3)	(4.1)
	Blood	(0.2)	(0.2)	(0.1)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)
	Supplies & Services - Clinical	(3.0)	(2.6)	(2.9)	(2.6)	(2.8)	(2.8)	(3.0)	(2.8)	(2.5)	(2.3)	(2.3)	(2.2)	(2.7)
	Supplies & Services - General	(0.5)	(0.4)	(0.5)	(0.5)	(0.4)	(0.4)	(0.5)	(0.4)	(0.6)	(0.4)	(0.7)	(0.4)	(0.5)
	Services from Other NHS Bodies	(0.4)	(0.2)	(1.0)	(0.6)	(0.8)	(0.4)	(0.5)	(0.6)	(0.7)	(0.6)	(0.7)	(0.7)	(0.7)
	Purchase of Healthcare from Non-NHS	(0.1)	(1.2)	(0.5)	(0.6)	(0.6)	(0.8)	(0.6)	(0.7)	(0.3)	(0.7)	(1.1)	(0.8)	(0.7)
	Clinical Negligence	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.5)	(1.5)
	Establishment	(0.2)	(0.4)	(0.3)	(0.4)	(0.3)	(0.4)	(0.4)	(0.3)	(0.3)	(0.4)	(0.4)	(0.2)	(0.3)
	Premises	(1.7)	(1.8)	(1.6)	(1.6)	(1.7)	(2.0)	(1.9)	(1.8)	(1.4)	(1.0)	(1.1)	(2.1)	(1.7)
	Transport	(0.1)	(0.1)	(0.2)	(0.1)	(0.1)	(0.2)	(0.2)	(0.1)	(0.0)	(0.1)	(0.2)	(0.1)	(0.2)
	Other Non-Pay Costs	(0.6)	(0.5)	(0.6)	(0.3)	(0.6)	(0.4)	(0.3)	(0.4)	(0.5)	(0.8)	(0.8)	(0.2)	(0.7)
	Non-Pay Reserves	0	0	0	0	0	0	0	0	0	0	0	(0.2)	(0.2)
	Total Non Pay	(11.7)	(12.2)	(12.4)	(11.2)	(13.1)	(12.7)	(13.0)	(12.8)	(12.0)	(11.8)	(12.9)	(12.9)	(13.4)
	Total Expenditure	(32.1)	(32.5)	(32.7)	(31.7)	(33.7)	(32.9)	(33.5)	(33.4)	(32.6)	(32.8)	(34.7)	(34.1)	(34.6)
EBITDA	EBITDA	0.1	1.6	2.4	0.5	0.7	1.1	(0.3)	(0.2)	(0.4)	0.2	1.8	(1.0)	(0.5)
		0%	*5%*	*7%*	*2%*	*2%*	*3%*	*-1%*	*-1%*	*-1%*	*1%*	*5%*	*-3%*	*-1%*
Other Finance Costs	Depreciation	(1.4)	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)	(1.4)	0.9	(1.4)	(1.4)
	Interest	(0.1)	(0.1)	(0.1)	(0.1)	(0.0)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)
	Dividend	(0.4)	(0.4)	(0.4)	(0.3)	(0.4)	(0.4)	(0.3)	(0.2)	(0.4)	(0.4)	0.1	(0.3)	(0.3)
	PFI and Impairments	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.2)	(1.1)	(1.4)	(14.2)	(1.1)	(1.1)
		(2.9)	**(2.9)**	**(2.9)**	**(2.9)**	**(2.9)**	**(2.9)**	**(2.9)**	**(2.8)**	**(2.9)**	**(3.2)**	**(13.2)**	**(2.9)**	**(2.8)**
Net Surplus / Deficit (-)	Net Surplus / Deficit (-)	(2.8)	(1.3)	(0.5)	(2.3)	(2.1)	(1.8)	(3.2)	(3.1)	(3.3)	(3.0)	(11.5)	(3.8)	(3.3)
Technical Adjustments	Technical Adjustments	(0.1)	(0.1)	(0.1)	0.0	(0.1)	(0.1)	(0.1)	(0.2)	(0.1)	(0.2)	(12.8)	(0.1)	(0.1)
Surplus/ Deficit (-) to B/E Duty	Surplus/ Deficit (-) to B/E Duty	(2.7)	(1.2)	(0.4)	(2.4)	(2.0)	(1.7)	(3.1)	(2.9)	(3.2)	(2.8)	1.3	(3.8)	(3.2)

Cost Improvement Programme

Maidstone and Tunbridge Wells NHS Trust

4a Directorate Performance

	Current Month			Year to Date			Plan				
	Actual	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*	*Fully developed*	*Plans in progress*	*Opportunity*	*Unidentified*	*Grand Total*
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Cancer and Haematology	0.34	0.30	0.05	0.54	0.59	(0.06)	2.32	0.17	0.03	0.00	2.52
Clinical Governance	0.01	0.00	0.01	0.02	0.01	0.01	0.04	0.00	0.00	0.00	0.04
Corporate Directorates	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.10	0.10
Critical Care	0.08	0.13	(0.06)	0.19	0.27	(0.08)	1.33	0.01	0.00	0.00	1.34
Emergency and Medical Services	0.40	0.22	0.18	0.65	0.43	0.22	2.01	0.96	1.04	1.74	5.75
Estates and Facilities	0.08	0.14	(0.06)	0.15	0.27	(0.12)	1.41	0.79	0.00	0.00	2.20
Finance	0.01	0.03	(0.02)	0.03	0.07	(0.04)	0.42	0.00	0.00	0.00	0.42
Head and Neck	0.08	0.09	(0.01)	0.13	0.18	(0.05)	0.91	0.11	0.01	0.00	1.03
Infection Control	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Informatics	0.01	0.03	(0.02)	0.05	0.06	(0.01)	0.35	0.00	0.00	0.00	0.35
Nursing and Quality	0.00	0.00	(0.00)	0.00	0.00	(0.00)	0.00	0.00	0.00	0.01	0.01
Paediatrics	0.05	0.03	0.01	0.09	0.07	0.02	0.78	0.04	0.05	0.00	0.87
Pathology	0.06	0.04	0.02	0.11	0.08	0.03	0.48	0.00	0.01	0.00	0.48
Pharmacy	0.00	0.00	(0.00)	0.00	0.00	(0.00)	0.00	0.03	0.00	0.00	0.03
Private Patients Unit	0.02	0.01	0.01	0.03	0.03	0.01	0.16	0.00	0.00	0.13	0.28
Radiology	0.02	0.04	(0.02)	0.07	0.07	(0.01)	0.45	0.08	0.00	0.00	0.53
Surgery	0.13	0.12	0.01	0.22	0.24	(0.02)	1.09	0.20	0.04	0.00	1.33
Therapies	0.00	0.00	(0.00)	0.03	0.00	0.03	0.09	0.00	0.00	0.00	0.09
Trauma and Orthopaedics	0.12	0.18	(0.05)	0.25	0.43	(0.19)	2.01	0.80	0.03	0.00	2.85
Women and Sexual Health	0.05	0.06	(0.01)	0.11	0.13	(0.02)	0.38	0.37	0.03	0.73	1.51
Workforce and Communications	0.01	0.01	(0.01)	0.01	0.02	(0.01)	0.07	0.11	0.00	0.00	0.18
Diagnostics & Pharmacy	0.00	0.05	(0.04)	0.03	0.09	(0.06)	0.56	0.00	0.01	0.62	1.18
Total	**1.45**	**1.49**	**(0.03)**	**2.68**	**3.04**	**(0.36)**	**14.84**	**3.67**	**1.25**	**3.32**	**23.08**



Critical Care: £80k slippage in procurement schemes to date (£57k in current month) in addition to slight slippage to plan in April on bowel screeing roll out, May target was achieved..

Estates and Facilities: A number of Directorate's schemes have had to be rephased due to outcomes from audit; such as Energy; this reflects the underperformance in month.

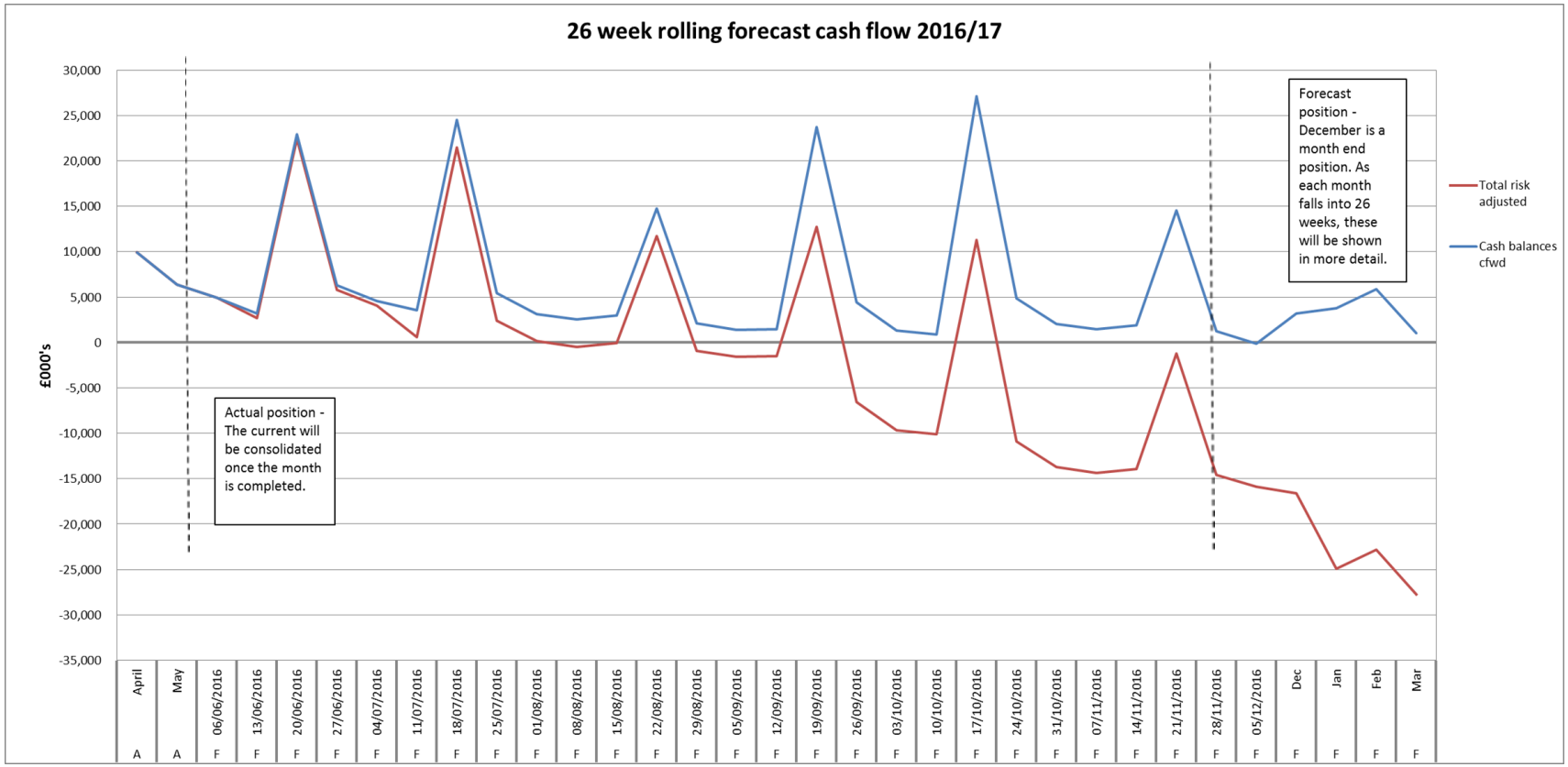
Finance: Unplanned extension of a consultancy contract has now to be rephased. Non recurrent underspend of £26k in May due to held vacancies but not included in month 2 numbers.

Diagnostics and Pharmacy: Current under delivery is due over spend in AHP agency staff. Procurement team currently investigating opportunities to take this workforce group via staff flow which will result in a saving this will be done in parallel with the recruitment campaign

Liquidity

Maidstone and Tunbridge Wells NHS Trust

5a. Cash Flow



Commentary:

The blue line shows the Trust's cash position from the start of April, after receiving a double block from WKCCG in April. The forecast shows £2m draw down expected in July (at 3.5% interest) and a further £8m required in September, the remaining balance (£12.9m) is forecast to be received in the second half of the year.

The red line demonstrates if external funding is unavailable and the impact on the Trust cash position.

The 15/16 cash draw down converted to a loan in the final quarter of last financial year. This is repaid on an interest only basis and full repayment will be made in February 2019.

This cash forecast is driven by the I&E position with adjustments for working capital movements therefore if elective activity does not improve cash support may be required sooner.

The Trust is undertaking a programme to reduce the requirement on funding lower interest payments.

Balance Sheet

Maidstone and Tunbridge Wells NHS Trust

5b. Balance Sheet

May 2016

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

	May			April	Full year	
£m's	**Reported**	**Plan**	**Variance**	**Reported**	**Plan**	**Forecast**
Property, Plant and Equipment (Fixed Assets)	348.0	347.6	0.4	349.2	335.5	335.5
Intangibles	3.1	1.7	1.4	3.2	1.5	1.5
PFI Lifecycle	0.0	0.0	0.0	0.0	0.0	0.0
Debtors Long Term	1.1	1.2	(0.1)	1.2	1.2	1.2
Total Non-Current Assets	**352.2**	**350.5**	**1.7**	**353.6**	**338.2**	**338.2**
Current Assets						
Inventory (Stock)	8.7	8.3	0.4	6.7	8.3	8.3
Receivables (Debtors) - NHS	27.2	6.2	21.0	34.5	21.1	21.1
Receivables (Debtors) - Non-NHS	13.5	9.9	3.6	13.5	10.0	10.0
Cash	5.9	8.4	(2.5)	10.4	1.0	1.0
Assets Held For Sale	0.0	0.0	0.0	0.0	0.0	0.0
Total Current Assets	**55.3**	**32.8**	**22.5**	**65.1**	**40.4**	**40.4**
Current Liabilities						
Payables (Creditors) - NHS	(5.2)	(5.0)	(0.2)	(5.6)	(5.0)	(5.0)
Payables (Creditors) - Non-NHS	(57.5)	(31.1)	(26.4)	(64.5)	(33.0)	(33.0)
Capital & Working Capital Loan	(2.2)	(2.2)	0.0	(2.2)	(2.2)	(2.2)
Temporary Borrowing	0.0	0.0	0.0	0.0	0.0	0.0
Borrowings - PFI	(4.8)	(4.8)	0.0	(4.8)	(5.0)	(5.0)
Provisions for Liabilities and Charges	(1.9)	(2.3)	0.4	(1.9)	(1.0)	(1.0)
Total Current Liabilities	**(71.6)**	**(45.4)**	**(26.2)**	**(79.0)**	**(46.2)**	**(46.2)**
Net Current Assets	(16.3)	(12.6)	(3.7)	(13.9)	(5.8)	(5.8)
Finance Lease - Non- Current	(202.3)	(202.5)	0.2	(202.8)	(198.2)	(198.2)
Capital Loan - (interest Bearing Borrowings)	(14.5)	(14.5)	0.0	(14.5)	(44.6)	(44.6)
Interim Revolving Working Capital Facility	(16.9)	(16.9)	0.0	(16.9)	(16.4)	(16.4)
Provisions for Liabilities and Charges	(1.4)	(1.4)	0.0	(1.4)	(0.7)	(0.7)
Total Assets Employed	**100.8**	**102.6**	**(1.8)**	**104.1**	**72.5**	**72.5**
Financed By						
Capital & Reserves						
Public dividend capital	(203.3)	(203.3)	0.0	(203.2)	(203.3)	(203.3)
Revaluation reserve	(53.8)	(53.8)	0.0	(53.8)	(53.8)	(53.8)
Retained Earnings Reserve	156.3	154.5	1.8	152.9	184.6	184.6
Total Capital & Reserves	**(100.8)**	**(102.6)**	**1.8**	**(104.1)**	**(72.5)**	**(72.5)**

Commentary:

The balance sheet remains relatively constant since April. Key movements from April to May are in working capital where the cash balance has reduced as stock has increased (cash outflow), debtors have decreased and creditors have decreased. As mentioned on the cashflow slide the Trust is putting a focus on increasing cash and will be looking at these working capital metrics.

Non-Current Assets

PPE - The value of PPE continues to fall as depreciation is greater than the current capital spend, this is due to capital projects being prioritised. This is in line with plan and is not creating an unsustainable backlog of maintenance or required replacements.

Current Assets

Inventory has risen since April due to £0.3m purchase of pharmacy drugs and £0.1m increase in cardiology stocks. Inventory reduction is a cash management and potential CIP being discussed.

NHS Receivables have fallen since April but are still significantly above plan. Work is ongoing to collect debtors but with the financial situation of many neighbouring NHS organisations this will be difficult. Of this £27.2m debt, £6.4m is over 90 days.

Trade receivables is also above plan (by £3.6m), included within this balance is trade invoiced debt of £1.1m and private patient invoiced debt of £1.4m.

Current Liabilities

Trade payables has decreased since April but remains significantly above plan. At present the Trust has a policy to pay approved invoices within 30 days but there are £9.1m of unapproved invoices, and £4.7m approved invoices at month end. £27.3m of accruals, including TAX, NI, Superannuation and PDC. Also included with trade payables is £24.6m of deferred income primarily relating to the advance received from WK and Medway CCG's in April of £18 million.

Capital Programme

Maidstone and Tunbridge Wells NHS Trust

6a. Capital Programme

Capital Projects/Schemes

	Current Month			Year to Date			Annual Forecast	Committed
	Actual	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*	*Plan*	
	£000	£000	£000	£000	£000	£000	£000	£000
Estates	0	100	-100	0	100	-100	9,384	1
ICT	158	651	-493	158	651	-493	2,671	1,037
Equipment	24	235	-211	24	235	-211	2,581	174
PFI Lifecycle (IFRIC 12)	0	0	0	0	0	0	552	552
Donated Assets	0	0	0	0	0	0	800	90
Total	**182**	**986**	**-804**	**182**	**986**	**-804**	**15,988**	**1,853**
Less donated assets	0	0	0	0	0	0	-800	-90
Contingency Against Non-Disposal	0	0	0	0	0	0	0	0
Adjusted Total	**182**	**986**	**-804**	**182**	**986**	**-804**	**15,188**	**1,764**

Commentary:

The total resource for the 2016/17 capital programme is £15.9m, including PFI lifecycle and donated assets, which has been approved by the Trust Board and prioritised by the relevant lead Directors.

The Estates projects include significant investment for Backlog Maintenance of £2m, the majority of which relates to deferred 2015/16 schemes, and a new electrical substation at Maidstone Hospital at a cost of c£2.6m. The OBC for the TWH Linac Bunkers has been approved by the Trust Board and has a capital value of c£7.3m phased over 2 years (£4m in 16/17), the case is due for submission to the NHSI once specialist commissioner support is obtained.

The list of equipment schemes currently exceed the funding available, a prioritisation process is in progress and expected to be finalised by beginning of July. This takes consideration of schemes that were deferred from 15/16. The Procurement Inventory project is underway and being implemented in early 2016/17.

There is a contingency allocation of £200k within the equipment schemes to allow for any emergency purchases within the year e.g. x-ray tube replacement.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – June 2016

6-9	**The impact of the new Acute Medical Unit at Tunbridge Wells Hospital on patient flow**	**Chief Operating Officer**

At the Trust Board meeting in April 2016, it was agreed that a report should be submitted to the Trust Board, in June 2016, on the impact of the new Acute Medical Unit at Tunbridge Wells Hospital on patient flow.

The requested report is enclosed.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Review and discussion

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

Update report: 'The impact of the new Acute Medical Unit at Tunbridge Wells Hospital on patient flow'

1. Introduction

Due to considerable operational pressures upon capacity and disruption to the flow of patients through the hospital it was agreed in the spring of 2015 that there was an organisational need to increase capacity for inpatient beds and assessment facilities at Tunbridge Wells Hospital to support the on-going growth in demand and activity. The assessment at the time showed a shortfall of 40 cored medical beds which increased to 61 during the winter period.

Following business case approval, a capital programme was launched and the new ward was opened in mid-March 2016 as an Acute Medical Unit with 16 assessment / ambulatory trolleys and 22 short stay medical beds.

This report outlines the impact of the new ward on patient flow and the benefits realised in its first 3 months of operation. It also highlights areas of concerns that continue in regards to patient flow for non-elective medical patients.

The shortfall in capacity resulted in a number of performance indicators not being met and operational bottlenecks:

- 4-hours ED access standard
- High volume of medical outliers
- Bed occupancy levels over 90%
- Reduction in elective activity particularly at TWH
- Detrimental financial impact relating to income from activity.
- High rate of operations cancelled and postponed operations

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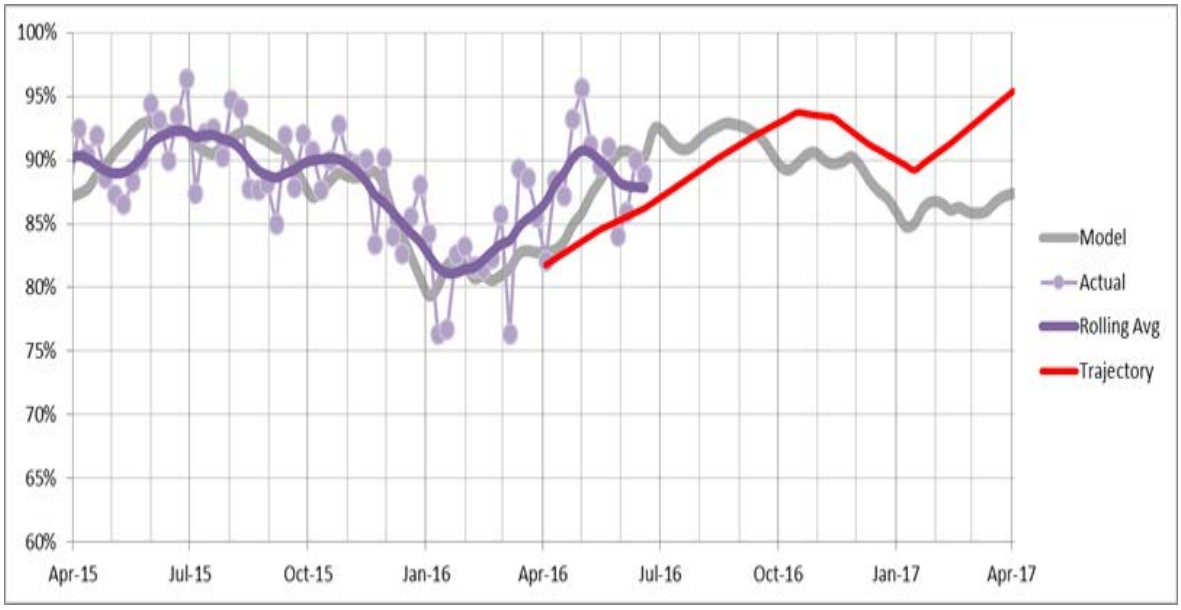
2. Emergency Demand

For context the level of attendance through both EDs remain higher that the modelling we have undertaken which is based on the last 12 months average weekly attendance, which is then up or scaled up or down for seasonal factors.

Winter 2015/16 saw the actual attendances diverge from the model in a way it's never done before, with the attendances in Jan & Feb being consistently 8-10% above the model. Attendances are currently close to the model, not because attendances have reduced, but because we are approaching peak attendance levels (they typically spike late June to mid-July), and the model has been up-lifted by the recent high attendances. Attendance so far this this year is 5.6% higher than last year, compared to the 1.5-2.0% annual growth we expect to see.



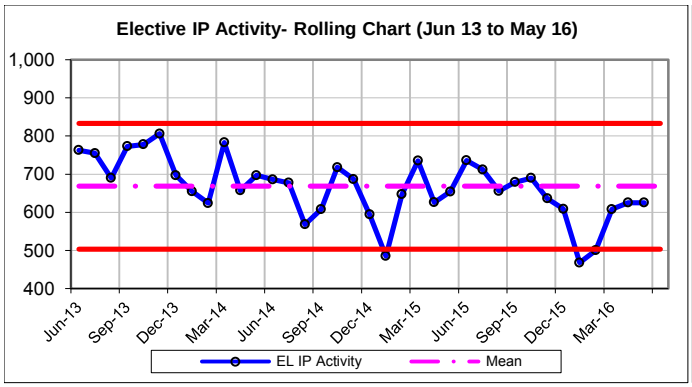
The Doctors strikes in April reduced attendances by an estimated 300-400.

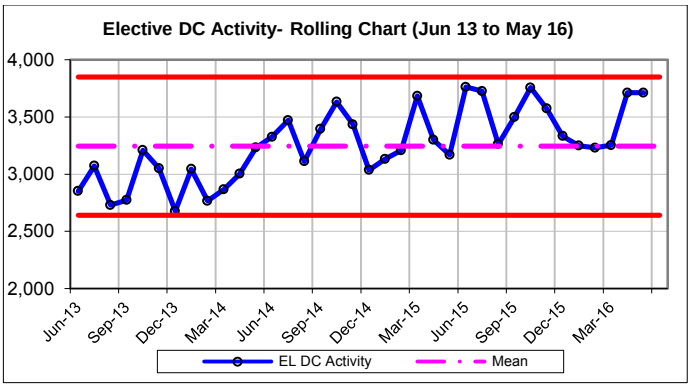
3. Outline of improvements in Q1 of 2016-17

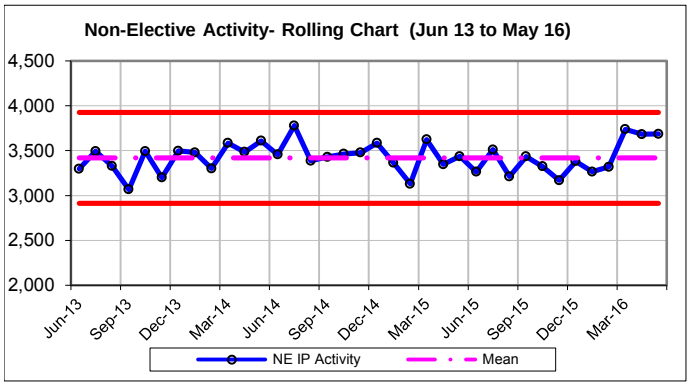
The attached tables below outline the improvements achieved in the overall management of patient flow in the Trust, particularly in relation to the reduction in cancelled operations, use of escalation beds and level of elective activity. The next steps are to fully establish the AMU as an assessment and ambulatory area that will facilitate the flow from the ED for emergency patients and enable earlier discharge from the medical and elderly care wards

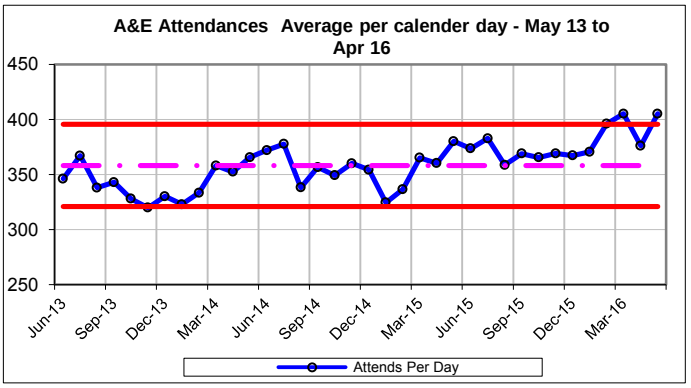
4. Conclusion

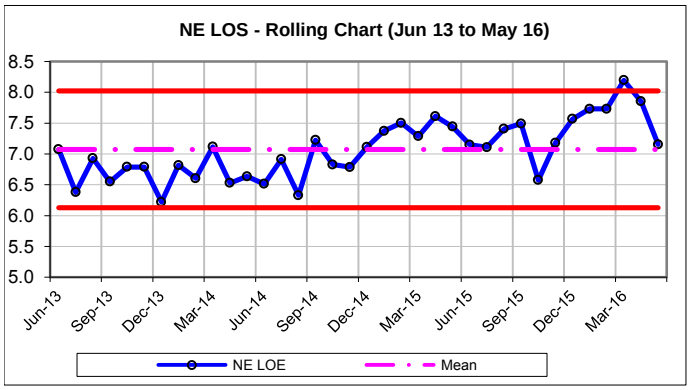
Although we continue to have key issues to address regarding the non-elective pathway including the increase in demand and the slower than needed pace on LOS we have made considerable improvement in the flow for elective activity, increasing both the elective and day case throughout for all specialties. The level of cancelled and postponed operations has reduced in Q1 compared to Q4 of 15-16 and the level of medical outliers in surgical beds has reduced considerably.

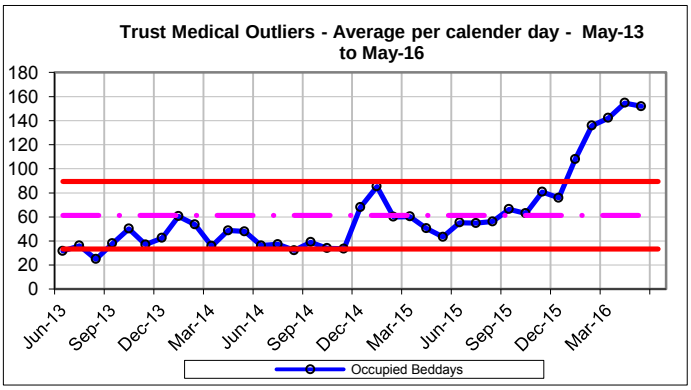

Elective IP Activity- Rolling Chart (Jun 13 to May 16)
1,000
900
800
700
600
500
400
Jun-13
Sep-13
Dec-13
Mar-14
Jun-14
Sep-14
Dec-14
Mar-15
Jun-15
Sep-15
Dec-15
Mar-16
EL IP Activity
Mean

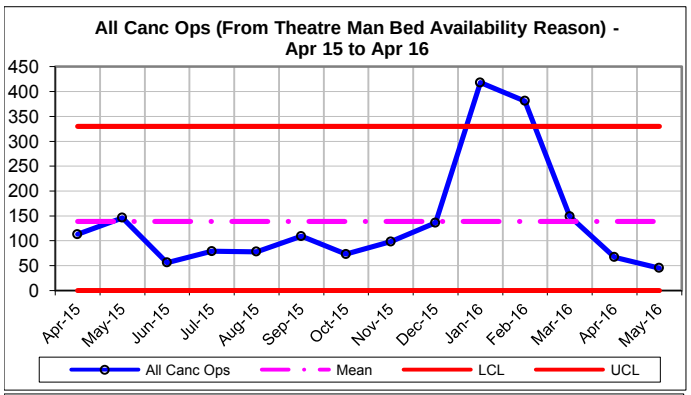

Elective DC Activity- Rolling Chart (Jun 13 to May 16)
4,000
3,500
3,000
2,500
2,000
Jun-13
Sep-13
Dec-13
Mar-14
Jun-14
Sep-14
Dec-14
Mar-15
Jun-15
Sep-15
Dec-15
Mar-16
EL DC Activity
Mean

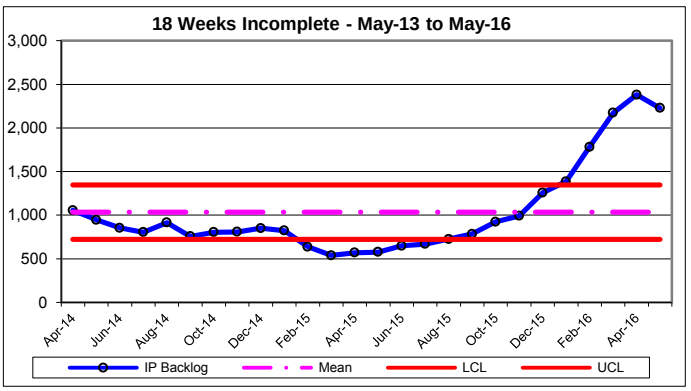

Non-Elective Activity- Rolling Chart (Jun 13 to May 16)
4,500
4,000
3,500
3,000
2,500
2,000
Jun-13
Sep-13
Dec-13
Mar-14
Jun-14
Sep-14
Dec-14
Mar-15
Jun-15
Sep-15
Dec-15
Mar-16
NE IP Activity
Mean

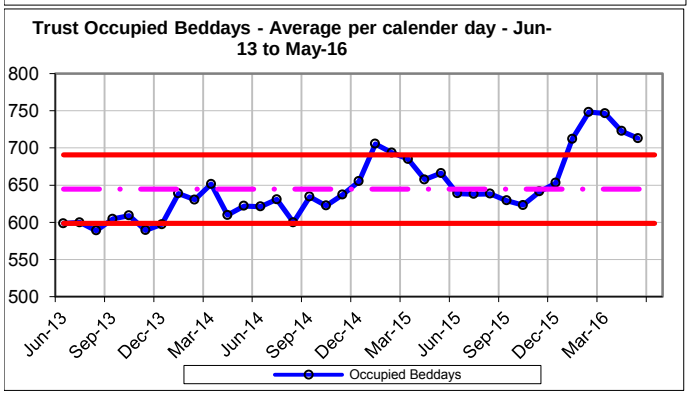

A&E Attendances Average per calender day - May 13 to Apr 16
450
400
350
300
250
Jun-13
Sep-13
Dec-13
Mar-14
Jun-14
Sep-14
Dec-14
Mar-15
Jun-15
Sep-15
Dec-15
Mar-16
Attends Per Day

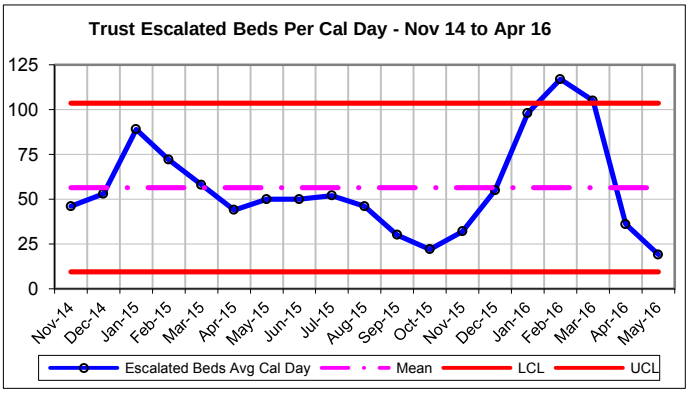

NE LOS - Rolling Chart (Jun 13 to May 16)
8.5
8.0
7.5
7.0
6.5
6.0
5.5
5.0
Jun-13
Sep-13
Dec-13
Mar-14
Jun-14
Sep-14
Dec-14
Mar-15
Jun-15
Sep-15
Dec-15
Mar-16
NE LOE
Mean


Trust Medical Outliers - Average per calender day - May-13 to May-16
180
160
140
120
100
80
60
40
20
0
Jun-13
Sep-13
Dec-13
Mar-14
Jun-14
Sep-14
Dec-14
Mar-15
Jun-15
Sep-15
Dec-15
Mar-16
Occupied Beddays


All Canc Ops (From Theatre Man Bed Availability Reason) - Apr 15 to Apr 16
450
400
350
300
250
200
150
100
50
0
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
May-16
All Canc Ops
Mean
LCL
UCL


18 Weeks Incomplete - May-13 to May-16
3,000
2,500
2,000
1,500
1,000
500
0
Apr-14
Jun-14
Aug-14
Oct-14
Dec-14
Feb-15
Apr-15
Jun-15
Aug-15
Oct-15
Dec-15
Feb-16
Apr-16
IP Backlog
Mean
LCL
UCL


Trust Occupied Beddays - Average per calender day - Jun-13 to May-16
800
750
700
650
600
550
500
Jun-13
Sep-13
Dec-13
Mar-14
Jun-14
Sep-14
Dec-14
Mar-15
Jun-15
Sep-15
Dec-15
Mar-16
Occupied Beddays


Trust Escalated Beds Per Cal Day - Nov 14 to Apr 16
125
100
75
50
25
0
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Escalated Beds Avg Cal Day
Mean
LCL
UCL

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – June 2016

6-10 Safe Staffing: Planned v Actual – May 2016 Chief Nurse

The attached paper shows the planned v actual nursing staffing as uploaded to UNIFY for the month of May 2016. This data is also published via the NHS Choices website and the Trust website as directed by NHS England and the National Quality Board.

Care Hours Per Patient Day
This now includes Care Hours Per Patient Day (CHPPD) as recommended in the Carter Report.

CHPPD has been recommended as a unified approach to reviewing and assessing staffing needs, and is widely used in North America, Canada and Australia as a triangulation tool when setting and reviewing staffing levels.

CHPPD is calculated by adding the hours of available registered nurses to the hours of available healthcare support workers during each 24 hour period and dividing the total by every 24 hours of in-patient admissions, or approximating 24 patient hours by counts of patients at midnight. NHS England have recommended the latter for the purposes of the UNIFY upload and subsequent publication.

Timescales for national publication have not yet been announced, as NHS England is currently reviewing a number of options. NHS England has given an assurance that Trusts will be informed of how the data will be published and Trusts will be provided with a briefing.

The Carter report reviewed c1000 wards across 25 trusts to gain some views on the range of CHPPD, as this figure will vary according to specialty, case mix and to some extent ward layout and co-adjacencies.

The Carter report indicated a range for CHPPD between 6.3 and 15.48. The median was 9.13.
Overall CHPPD for Maidstone Hospital for May was 8.3, and for Tunbridge Wells Hospital it was 9.4.

Planned vs. Actual
The fill rate percentage is the actual hours used compared to the hours set in the budgeted establishment. That is, the budgeted establishment sets out the numbers of Registered Nurses and Clinical Support Workers based on an average acuity and dependency (or planned case mix for elective units). When units are faced with increased acuity and/or dependency, in escalation or undergo a service change that is not currently reflected in the budget, this is represented by an 'overfill'. Financial and key nurse-sensitive indicators have also been included as an aid to triangulation of both efficient and effective use of staff.

This is evident in a number of areas where there has been an unplanned increase in dependency. A number of wards have required additional staff, particularly at night, to manage patients with altered cognitive states, increased clinical dependency or with other mental health issues. Notable in this respect are Stroke – Maidstone, John Day, Ward 10, and Ward 11.

Stroke – Maidstone had a number of patients with significant confusion and associated falls risks; cohort nursing was not possible in the early part of the month due to the need for side room nursing and gender split. Ward 10 had patients with mental health issues, confusion and high falls risks.

Ward 11 had a number of patients with tracheostomy, a number of patients transferred from ICU with new tracheostomy and 1 patient with a history of repeat falls.

All enhanced care needs are supported by an appropriate risk assessment, reviewed and

approved by the Matron.

Escalation areas account for the remainder of the over-fill. These areas remain the same; namely AMU (UMAU), and SAU.

A couple of areas had a fill rate less than plan. Where this occurred it was either due to decreased activity such as the ICU at Maidstone, or a considered risk such as CCU at Maidstone.

CCU at Maidstone is co-located with Culpepper ward, and as such staff move between the two areas as required during the course of a shift.

When the fill rate is only marginally over 100% by +/- 5% this is normally related to working patterns which required staff to work an additional shift periodically as long shifts result in a staff member either working over or under their contracted hours in any given month.

Accident & Emergency (A&E) Departments overall fill rates are good against planned staffing levels. TWH had additional support workers on at night to ensure fundamental aspects of care were maintained in escalated bays.

The RAG rating for the fill rate is rated as:
Green: Greater than 90% but less than 110%
Amber Less than 90% OR greater than 110%
Red Less than 80% OR greater than 130%

The principle being that any shortfall below 90% may have some level of impact on the delivery of care. However this is dependent on both acuity and dependency. Acuity is the term used to describe the clinical needs of a patient or group of patients, whilst dependency refers to the support a patient or group of patients may need with activities such as eating, drinking, or washing.

High fill rates (those greater than 110%) would indicate significant changes in acuity and dependency. This results in the need for short notice additional staff and as a consequence may have a detrimental impact on the quality of patient care.

The exception reporting rationale is RAG rated according to professional judgement against the following expectations:

- The ward maintained a nurse to patient ratio of 1:5 – 1:7
- Acuity and dependency within expected tolerances
- Workforce issues such as significant vacancy
- Quality & safety data
- Overall staffing levels
- Risks posed to patients as a result of the above

The **overall** RAG status gives an indication of the safety levels of the ward, compared to professional judgement as set out in the Staffing Escalation Policy. The arrow indicates improvement or deterioration when compared to the previous month. The thresholds for the overall rating are set out below:

The key underlying reasons for amber overall ratings are vacancy resulting in an adverse shift of the RN to CSW ratios and high levels of acuity and dependency.

RAG	Details
	Minor or No impact: Staffing levels are as expected and the ward is considered to be safely staffed taking into consideration workloads, patient acuity and skill mix. RN to patient ratio of 1:7 or better Skill mix within recommended guidance Routine sickness/absence not impacting on safe care delivery Clinical Care given as planned including clinical observations, food and hydration needs met, and drug rounds on time. OR Staffing numbers not as expected but reasonable given current workload and patient acuity.
	Moderate Impact: Staffing levels are not as expected and minor adjustments are made to bring staffing to a reasonable level. OR Staffing numbers are as expected, but given workloads, acuity and skill mix additional staff may be required. Requires redeployment of staff from other wards RN to Patient ratio >1:8 Elements of clinical care not being delivered as planned
	Significant Impact: Staffing levels are inadequate to manage current demand in terms of workloads, patient acuity and skill mix. Key clinical interventions such as intravenous therapy, clinical observations or nutrition and hydration needs not being met. Systemic staffing issues impacting on delivery of care. Use of non-ward based nurses to support services RN to Patient ratio >1:9 Need to instigate Business Continuity

Which Committees have reviewed the information prior to Board submission?

- N/A

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

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

May'16		Day		Night			Nurse Sensitive Indicators						Financial review		
Hospital Site name	Ward name	Average fill rate registered nurses/midwives	Average fill rate care staff (%)	Average fill rate registered nurses/midwives	Average fill rate care staff (%)	Overall Care Hours per pt day	FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	Overall RAG Status	Comments	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Acute Stroke	98.7%	117.7%	100.8%	212.9%	8.4	35.3%	88.9%	6	0		Increased need for CSW due to a number of confused patients under DoLS; Initially split between bay and side room. Ability to cohort into a bay occurred later in month.	128,741	126,535	2,206
MAIDSTONE	Romney	96.8%	93.5%	100.0%	100.0%	6.7	0.0%	0.0%	5	0			73,956	79,467	(5,511)
MAIDSTONE	Cornwallis	104.8%	90.3%	101.1%	100.0%	7.3	59.8%	92.9%	1	1			81,243	81,437	(194)
MAIDSTONE	Coronary Care Unit (CCU)	78.5%	N/A	100.0%	N/A	10.1	85.0%	94.1%	1	0		Low RN fill rate an accepted risk, as unit is co-located on Culpepper and staff are able to cross-cover during each shift as and when required. Early CHPPD would support this approach (HDU type area therefore would expect each patient to have between 10 to 12 hrs contact time according to acuity)	101,671	106,148	(4,477)
MAIDSTONE	Culpepper	111.3%	98.4%	100.0%	103.2%	6.4	68.8%	95.5%	2	0		Small increase in RN fill rate reflects the move in month between CCU and Culpepper			
MAIDSTONE	John Day	98.1%	102.4%	98.4%	117.7%	7.4	21.1%	93.3%	4	1		Enhanced care needs for 9 nights.	154,818	140,586	14,232
MAIDSTONE	Intensive Treatment Unit (ITU)	79.8%	N/A	75.8%	N/A	28.6	100.0%	100.0%	0	1		Low fill rate an accepted risk due to decreased activity and dependency. Appropriate levels of staffing for need is reflected in CHPPD (1:1 care over 24hrs)	164,622	164,628	(6)
MAIDSTONE	Pye Oliver	91.6%	100.0%	100.0%	116.1%	6.0	21.5%	94.1%	4	1		Enhanced care needs for 5 nights.	115,880	114,549	1,331
MAIDSTONE	Chaucer	92.0%	112.1%	99.4%	100.0%	6.6	43.9%	80.0%	6	0		Increased fill rate for CSW due to accepted shift in skill mix on a number of days. 1 bed space lost to accommodate bariatric patient.	140,995	135,788	5,207
MAIDSTONE	Lord North	103.9%	93.5%	98.9%	106.5%	7.4	80.6%	96.0%	1	0			88,633	97,989	(9,356)
MAIDSTONE	Mercer	100.0%	79.8%	98.9%	103.2%	6.4	5.4%	100.0%	3	0		Reduced fill rate in CSW days, an accepted risk.	98,102	111,612	(13,510)
MAIDSTONE	Edith Cavell (MOU)	94.4%	114.5%	100.0%	122.5%	8.2	0.0%		1	0		7 days/nights of enhanced care required for cognitively impaired patient.	62,248	66,972	(4,724)
MAIDSTONE	Urgent Medical Ambulatory Unit (UMAU)	97.8%	102.7%	126.9%	206.5%	12.6	5.8%	96.2%	2	0		Trolleys escalated over night throughout month.	118,588	131,128	(12,540)
TWH	Stroke (W22)	95.7%	93.5%	98.1%	98.9%	10.3	181.8%	95.0%	6	0			182,362	194,133	(11,771)
TWH	Coronary Care Unit (CCU)	98.9%	93.5%	100.0%	N/A	11.3	87.5%	95.2%	1	0			59,973	74,105	(14,132)
TWH	Gynaecology	90.9%	100.0%	100.0%	100.0%	10.9	40.9%	90.2%	0	0			65,125	61,840	3,285
TWH	Intensive Treatment Unit (ITU)	105.2%	100.0%	105.6%	N/A	29.0	0.0%	0.0%		1			179,172	191,309	(12,137)
TWH	Medical Assessment Unit	99.6%	102.4%	139.4%	102.2%	8.8	22.9%	94.9%	6	0		Ambulatory care bays escalated over night throughout month	166,176	212,364	(46,188)
TWH	SAU	113.7%	90.3%	103.2%	93.5%	8.9				0		Escalation on 4 days in month.	87,701	89,277	(1,576)
TWH	Ward 32	100.0%	100.0%	100.0%	100.0%	7.6	0.7%	0.0%	2	0			119,867	120,991	(1,124)
TWH	Ward 10	94.9%	136.3%	102.4%	217.7%	8.3	12.4%	100.0%	8	1		Enhanced care needs through out the month. RMN required over the last 9 days of the month. All cases supported by assessment and reviewed by Matron, ADNS and falls prevention practitioner. Patients cohorted where possible.	123,926	146,540	(22,614)
TWH	Ward 11	100.0%	121.5%	92.7%	167.7%	7.5	26.0%	100.0%	3	1		Enhanced care required for 4 nights for a trachy patient needs constant supervision to maintain tube placement. 3 nights to support transfer from ICU with post ICU confusion. 1 other patient high risk of falls, history of repeat falling.	125,797	133,571	(7,774)
TWH	Ward 12	85.0%	109.7%	94.4%	108.1%	6.4	1.2%	100.0%	8	0		7 episodes of short notice sickness, accepted risk. Further 3 episodes where bank/agency RN did not arrive.	118,382	112,728	5,654
TWH	Ward 20	114.7%	107.3%	125.0%	104.3%	7.6	27.8%	80.0%	8	0		Cohort nursing for high risk falls/confused states. RMN required throughout month.	126,170	152,612	(26,442)
TWH	Ward 21	104.3%	88.2%	89.7%	130.5%	6.5	29.6%	95.2%	4	2		RN:CSW ratio shift an accepted risk. EU staff awaiting NMC PIN counted in CSW numbers rather than RN numbers accounts some of the shift.	129,537	135,951	(6,414)
TWH↑	Ward 2	102.6%	101.6%	100.0%	104.3%	6.6	0.0%	0.0%	9	1	↑		102,243	120,577	(18,334)
TWH	Ward 30	91.8%	111.3%	97.6%	98.9%	7.3	13.4%	100.0%	3	1			119,528	120,856	(1,328)
TWH	Ward 31	98.9%	92.4%	98.4%	101.1%	6.6	93.5%	93.1%	8	0			124,655	129,241	(4,586)
TWH	Ante-Natal	103.2%	87.1%	101.6%	96.8%	9.9	24.0%	93.5%	0	0			630,506	647,035	(16,529)
TWH	Delivery Suite	96.4%	90.3%	93.5%	93.4%	30.5			0	0					
TWH	Post-Natal	98.6%	98.9%	96.0%	94.6%	9.1			0	0					
TWH	Gynae Triage	104.8%	103.2%	95.2%	106.5%				0	0			12,406	11,860	546
TWH	Hedgehog	109.1%	84.9%	111.3%	164.5%	10.3	5.7%	84.2%	0	0		Escalation to Woodlands overnight. Focus on ensuring staff available for night.	206,899	204,857	2,042
TWH	Birth Centre	100.0%	100.0%	95.2%	100.0%	84.5			0	0			62,136	63,154	(1,018)
TWH	Neonatal Unit	104.3%	71.0%	101.1%	90.3%	13.9			0	0			166,950	160,099	6,851
MAIDSTONE	MSSU	125.0%	83.3%	95.0%	N/A	17.8	0.0%	0.0%	0	0		Increased throughtput, requiring RN support to cover, and change in skill mix.	43,316	44,095	(778)
TWH	Peal	94.2%	122.6%	92.5%	N/A	8.4	27.9%	100.0%	1	0			87,098	84,366	2,732
TWH	SSSU	121.7%	95.0%	N/A	N/A	-	0.0%	0.0%	0	0		Escalated during month. Additional staff to ensure safe transit of patients through dept. including day recovery ward.	23,262	23,889	(627)
MAIDSTONE	A&E	97.5%	96.8%	100.0%	103.2%		9.6%	92.9%	0	0			197,499	199,370	(1,871)
TWH	A&E	102.2%	95.3%	106.5%	140.3%		11.2%	90.8%	6	0			294,412	326,552	(32,140)
												Total Established Wards	**4,884,595**	**5,118,208**	**(233,613)**
												Additional Capacity beds	175,984	140,486	35,498
												Other associated nursing costs	3,125,443	2,599,872	525,571
												Total	8,186,022	7,858,566	327,456

RAG Key

Underfill

Over fill

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - June 2016

6-11 Quality Accounts for 2015/16 Chief Nurse

The Trust is required by the Health Act 2009 to produce Quality Accounts of services provided by the organisation. The accompanying Regulations state that the Quality Accounts must be published by 30th June.

The final draft Quality Accounts for 2015/16 are therefore enclosed, for review and approval.

An earlier draft was reviewed at the 'main' Quality Committee on 11th May, whilst the latest versions were reviewed at the Trust Management Executive (TME) (on 15th June) and Patient Experience Committee (on 16th June).

The Quality Accounts are required to be externally audited, and the Auditors have provided an "unqualified" conclusion, which is explained in the "Independent Auditors' Limited Assurance Report comments on the 2015/16 Quality Account for Maidstone and Tunbridge Wells NHS Trust" on pages 78 to 80. It should be noted that the scope of the External Audit is referred to as "limited assurance", and therefore in this context the term "limited assurance" is not a negative term (which is the case when the term is used in the context of Internal Audit reviews).

The full report of the External Audit was reviewed at the TME on 15th June (and although one element of the Audit was incomplete at the date of that meeting, the final report was then circulated to TME members by email on 23rd June), and is scheduled to be reviewed at the 'main' Quality Committee on 6th July.

Which Committees have reviewed the information prior to Board submission?

- Quality Committee, 11/05/15 (earlier draft)
- Trust Management Executive, 15/06/16
- Patient Experience Committee, 16/06/16

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

Review and approval

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

Maidstone and Tunbridge Wells NHS Trust

Quality Accounts
2015/16

Quality Accounts

Providing safe, high quality health services and a good overall experience for our patients, staff and the public is at the centre of everything we do at Maidstone and Tunbridge Wells NHS Trust (MTW).

The Health Act 2009 requires all NHS healthcare providers in England to provide an annual report to reflect on standards of care and set priorities for improvement. These are called Quality Accounts.

Our Quality Accounts for 2015/16 highlight the progress we have made against key priorities for the year to improve services for our patients and present those areas that we will be focusing on as priorities for 2016/17.

We believe patients have a fundamental right to receive the very best care. This should be provided to them in the most appropriate setting, by teams of highly skilled and expert healthcare professionals who care passionately about the care they provide. We believe we have continued to make strong progress at MTW in providing patients the highest standards of care.

There are a number of national targets set each year by the Department of Health and locally, against which we monitor the quality of the services we provide. Through these Quality Accounts we aim to provide you with information on how effective our services are, how they are measured and where we aim to make improvements.

Index

Part One
Chief Executive's Statement


Glenn Douglas

Welcome to our Quality Accounts for 2015/16 which is an overview of the work we have undertaken to improve our patient experience and wellbeing.

We have continued to place our patients at the centre of everything we do during 2015/16 and I am proud to represent, through this report, the efforts of our dedicated teams of healthcare professionals.

As a Trust, it is our aim to become even more sensitive to the individual and collective needs of our patients. We are achieving this by being open and honest about our weaknesses, learning from our errors, and sharing best practice.

We were pleased to be rated `good' for openness and transparency during the year as part of a national review of the way hospitals learn from errors and improve patient care. We can and will do more to achieve the top rating of excellent.

We measure patient care in many ways as an organisation. This report sets out our performance against a number of national standards, for instance, and while we have met many of these we have struggled to achieve some for the reasons outlined below. While these are all important, and command our utmost attention, our Trust Board has been humbled, at times shamed, but ultimately inspired by the powerful stories our patients and their relatives have chosen to share with us, in person, at our public board meetings.

As a learning organisation, we have focused heavily on improving our clinical governance processes during 2015/16 and we will continue to do so in 2016/17 by looking at our human as well as our technological systems that measure our patient experience, and help us improve care outcomes.
From a human perspective, we have focused heavily on reviewing and improving the way we individually and collectively report and learn from incidents by embedding better processes for our staff to follow.
We have also introduced new technology at the frontline of patient care to protect our patients. We have invested heavily in new systems to help us better monitor patient vital signs in real-time, to provide earlier intervention for deteriorating patients. This is improving outcomes.

Our Quality Accounts also reflect upon our efforts to improve other aspects of patient safety including a major focus on falls prevention. We are committed to making further progress and improvements in this area during 2016/17. Other quality improvement initiatives that we have set out for 2016/17, focus heavily on further improving our patient experience monitoring systems, learning from patients and other organisations and showing our actions, sharing our successes, and reducing length of stay.

We know from experience that with commitment and focus, MTW can be among the best providers of healthcare. During 2015/16 we had the lowest rate of hospital-acquired Clostridium

difficile of all acute hospitals in the South of England and were among the best performing hospitals in the country. We will continue to do more to protect patients from avoidable infections. Other challenges require the combined efforts of every organisation and partner involved in health and social care.

Around 96,000 people were admitted to our hospitals in Maidstone and Tunbridge Wells for both urgent medical and surgical care and planned procedures in 2015/16. Sitting behind these figures are over 460,000 outpatient appointments, 340,000 images, and two million pathology tests.

137,000 A&E attendances – 8,000 more than the previous year

Our A&E departments saw over 137,000 people in 2015/16 which is 8,000 more patients than the previous year. In the last three years A&E attendances have risen by 10%. If you look back further, we are now seeing over 20,000 more A&E attendances a year than we did when our first Quality Accounts were published in 2009/10.

At the same time, we carried out 13,000 more planned procedures last year than we did in 2009/10.

One of single biggest challenges we faced in 2015/16 was patient flow and length of stay. Too many patients had their discharge from hospital delayed because of long waits for their ongoing care needs to be met. This reduced the number of beds available for patients coming into our hospitals for planned or emergency care and affected our ability to see all of our patients in a timely way. This also had an adverse impact on our finances, which are important part of maintaining patient care.

We opened a new acute medical unit at Tunbridge Wells Hospital towards the end of the year to help fast-track urgent medical care for patients coming through A&E. This will have a positive impact on patient care in 2016/17. We also providing more care in the community to help patients with chronic conditions better manage their health and avoid hospitalisation.
Patient flow through our hospitals is an on-going challenge, however, that we are unable to resolve alone. We are continuing to work closely with our partners on the improvements we all need to be part of during 2016/17.

By continuing to listen to our patients, our staff, and working closely with our stakeholders, we believe we can continue to make further care improvements for our patients in the year ahead. The information contained within this report represents an accurate reflection of our organisation's performance in 2015/16 and has been agreed by the MTW Trust Board.

Thank you for taking the time to read our Quality Accounts. If you have any comments or suggestions for our Trust, you can contact us in the following ways:

Follow us on Twitter: www.twitter.com/mtwnhs
Join us on Facebook: www.facebook.com/mymtwhealthcare
Become a member of our Trust: www.mtw.nhs.uk/mymtw

Glenn Douglas
Chief Executive

Part Two
Quality improvement initiatives

In this part of the report, we tell you about the areas for improvement in the next year in relation to the quality of our services and how we will intend to assess progress throughout the year. We call these our quality priorities and they fall into three areas: patient safety, patient experience and improvements in clinical effectiveness by focussing improvements in our governance structures.

The quality improvement priorities are only ever a small sample of the quality improvement work undertaken across the Trust in any one year. The initiatives selected in previous years will almost always continue into subsequent years, although the focus may change accordingly to need. By selecting new initiatives each year it ensures that a wide breath of areas are covered and prioritised each year.

We have chosen three quality priorities in 2016/17 which represent the views of our stakeholders, but are also in line with the Trust's overarching strategy for quality improvement. The quality priorities have been reviewed and agreed by the members of the Patient Experience committee, which include patient representatives and representative from Healthwatch Kent.

Quality Improvement Priorities 2016/17

NHS Improving Quality

Patient Safety
To improve the dissemination of learning from serious incidents and complaints to drive improvement across the organisation.
Key objectives will include:

- Central database to monitor all agreed actions agreed following Serious Incidents and Complaints reported to Learning and Improvement committee (SI panel)
- Actions agreed as a result of Serious Incidents and Complaints to be tested in practice through the internal assurance review programme and executive / non-executive walkabout.
- Improvements as a result of learning from Serious Incidents and Complaints to be shared in a staff monthly newsletter and on the intranet and website
- Improvements as a result of learning from the review of in-hospital mortalities.

Patient Experience
To improve the use of current feedback mechanisms and provide more innovative ways to receive and act upon feedback.
Key objectives will include:

- Friends & Family results to be clearly and consistently displayed within departments including actions and improvements as a result of qualitative feedback
- Positive feedback / plaudits to be gathered and shared in a more robust way with staff to ensure good practices are acknowledged and become drivers for improvement.

- Working with Healthwatch partner, consider and implement different ways of listening to staff and service users to drive improvements (such as listening events, better use of social media and technology)

Clinical Effectiveness
To improve the management of patient flow.
Key objectives will include:

- Sustained reduction in length of stay achieved through (but not exclusively) the full implementation of SAFER Discharge Bundle
- Sustaining ring-fenced beds for Stroke and Trauma and Orthopaedic patients
- Embedding the new pathway on AMU at Tunbridge Wells Hospital to further improve ambulatory care

We will monitor our progress against these subjects through our Directorate and Trust-level governance structures. This report and assurance of our progress against it will be presented at the Trust Management Executive (TME), Quality Committee and the Patient Experience Committee.

Our new ambulatory medical care ward at Tunbridge Wells Hospital opened at the beginning of 2016 following an investment of £3 million.

Patient Safety

sharing best practice with our staff

The organisation is committed to improve the reporting of incidents and the learning from them, together with the learning from complaints and claims in order to make sustained improvements to the services and care we deliver.

Aim/goal

To improve the dissemination of learning from serious incidents and complaints to drive improvement across the organisation.

Description of Issue and rationale for prioritising

Developing and improving care and as a result of lessons learnt from incidents, complaints and claims is at the heart of good governance. To maintain the momentum of change and sustain improvements already made the organisation wishes to continue this area of work as a priority. The organisation also recognises that cultural change takes time and continued prioritisation will enable these structural and process changes to influence and drive learning as a continual cycle of improvement.

Identified areas for improvement and progress during 2015/16

The following actions were undertaken in 2015/16

- The establishment of a triangulation group called CLIPA that brought together information and learning from complaints, legal services, incidents, PALS and audit. This group reports into Trust Clinical Governance Committee and shares learning via staff communication.
- The Incident reporting system (DATIX) was upgraded and reporting pages were streamlined and made more readily available for staff to use (via apps)
- We ran a patient safety culture conference in the summer of 2015 with multidisciplinary attendance
- A WHO accredited patient safety education course has been running since January 2015 available for all staff
- The Governance Gazette, a staff newsletter published monthly, has featured regular case studies for shared learning

Initiatives for further action for 2016/17

- Introduce a central database to monitor all agreed actions agreed following Serious Incidents reported to Learning and Improvement committee (SI panel).
    - Monitor SI action plans monthly at the Learning and Improvement committee (SI panel) via exception report
    - Ensure 90% actions are completed within designated timeframes and 100% actions completed within 1 year of a Serious Incident or Red complaint.
- Actions agreed as a result of Serious Incidents and Complaints to be tested in practice through the internal assurance review programme and executive / non-executive walkabout.
    - Testing in practice for all SI's and Red Complaints from previous 12 months to be included in internal assurance and included within the internal assurance review reports (100%)

- Improvements as a result of learning from all Serious Incidents and Red Complaints to be shared in a staff monthly newsletter and on the intranet and website (100% where disclosable)
- Improvements to in-hospital falls prevention with a reduction in falls rates to a target of less than 6.2 per 1,000 occupied bed-days by end of March 2017
- Improvements as a result of learning from the review of in-hospital mortalities.
    - By end of March 2017, 75% of all in hospital mortalities (excluding A&E only admissions) to be reviewed and submitted to the central database
    - Learning identified via individual mortality review process to be collated and reported at each Mortality Surveillance Group Meeting from August 2016 onwards. This learning to be fed back to departments via Directorate Clinical Governance Meetings.

Executive lead: Avey Bhatia, Chief Nurse
Board Sponsor: Avey Bhatia, Chief Nurse
Implementation lead: Jenny Davidson, Assc Director Quality Governance
Monitoring: Trust Clinical Governance Committee

Patient Experience

Aim/goal

To improve the use of current feedback mechanisms and provide more innovative ways to receive and act upon feedback.

Description of Issue and rationale for prioritising

Service user feedback is an important source of information to drive local improvements. Review of trends can indicate whether a service needs change or can indicate if a planned change has had the desired or expected outcome.

Identified areas for improvement and progress during 2015/16

Full implementation of FFT across all areas including children's services, out-patients and day care areas such as endoscopy.
Increased response rates across all areas.
Achievement on FFT for 2015/16 is (see p42/43 for further information):

Response Rate:

	Achieved	Plan	Benchmark
Maternity Services	19.8%	15.0%	23.4%
In-Patient Services	25.3%	30.1%	25.1%
Accident & Emergency	13.1%	20.0%	13.1%

Positive score – would recommend the service:

	Achieved	Plan	Benchmark
Maternity Services	94.7%	95.0%	95.5%
In-Patient Services	96.4%	95.0%	95.7%
Accident & Emergency	88.4%	87.0%	86.9%

Initiatives for further action for 2016/17

- Friends & Family results to be clearly and consistently displayed within departments including actions and improvements as a result of qualitative feedback
    - Set up a task and finish group by September 2016 to re-establish a process to consistently gather and display patient feedback.
    - 85% of areas will display their The FFT positive response rates and their actions to support improvements by March 2017
    - By March 2017 the Trust will achieve 25% response rates in FFT in all adult inpatient and Maternity Services and 15% response rate for Accident and Emergency services.

- Positive feedback / plaudits to be gathered and shared in a more robust way with staff to ensure good practices are acknowledged and become drivers for improvement.
    - Implementation of a new system which enables staff to upload plaudits and positive feedback.

- Working with Healthwatch Kent, consider and implement different ways of listening to staff and service users to drive improvements (such as listening events, better use of social media and technology)

    - The Trust will engage with Healthwatch to undertake at least one listening event per quarter and continue to facilitate and respond to 'Enter and View' visits at least twice per year.

Executive lead: Avey Bhatia, Chief Nurse
Board Sponsor: Avey Bhatia, Chief Nurse
Implementation lead: Claire O'Brian, Deputy Chief Nurse
Monitoring: Patient Experience Committee

Clinical Effectiveness

The Trust is committed to ensuring effective patient flows throughout the inpatient areas to allow patients to receive the right care at the right time in the most appropriate environment for their condition.

Aim/goal

To deliver safe and effective inpatient care with the minimum length of stay possible. This will include the on-going work around the reduction in bed occupancy rates, the reduction in transfers from Intensive Care Unit after 8pm, achieving the A&E 4 hour standard and achievement of the Stroke Indicators which are priorities for service users, commissioners and the Trust

providing safe and effective care for patients

Description of Issue and rationale for prioritising

Safe and effective care for patients remains at the heart of the Trust's objectives. In order to deliver this, there is a requirement to ensure good patient flow and availability of specialist inpatient beds when needed.

Identified areas of improvement and progress during 2015/16

- New ward opened at Tunbridge Wells Hospital in March 2016
- Implementation of Integrated Discharge Team
- Flexible use of inpatient capacity to manage non elective patient flow
- Implementation of **S**enior review, **A**nticipate, **F**low, **E**arly discharges, **R**eact to delays & waits (SAFER) Discharge Bundle
- Achievement of stroke ring-fenced bed on both sites
- Achievement of 80% of stroke patients spending at least 90% of their stay on a dedicated stroke ward

Initiatives for further action for 2016/17

- Sustained reduction in length of stay achieved through (but not exclusively) the full implementation of SAFER Discharge Bundle. To achieve the outputs and timeframes agreed at the **T**imely **E**ffective **S**afe (TES) Steering Group.
- Sustain one ring-fenced bed for Stroke patients at Maidstone at all times and two on the TWH site (90% by March 2017). Sustain one ring-fenced bed on W31 at TWH for fractured neck of femur patients at all times (90% by March 2017).
- Embed new ambulatory pathways on Acute Medical Unit (AMU) at Tunbridge Wells Hospital to achieve a 10% reduction (minimum) from March 2016 baseline in admitted patients from the medical take each day. The target is to be achieved by March 2017.

Executive lead: Angela Gallagher
Board Sponsor: Angela Gallagher
Implementation lead: Lynn Gray
Monitoring: LOS Steering Group

In this following section we report on statement relating to the quality of the NHS services provided as stipulated in the regulations

The content is common to all providers so that the accounts can be comparable between organisations and provides assurance that Maidstone and Tunbridge Wells Board has reviewed and engaged in national initiatives which link strongly to quality improvement

Statements relating to the quality of NHS services provided as required within the regulations

The Trust is registered by the Care Quality Commission to provide the following Regulated Activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983 (at both hospital sites) (this Regulated Activity was added during 2015/16)
- Diagnostic and screening procedures (at both hospital sites)
- Family planning services (at both hospital sites)
- Maternity and midwifery services (at both hospital sites)
- Surgical procedures (at both hospital sites)
- Termination of pregnancies (at Tunbridge Wells Hospital only)
- Treatment of disease, disorder or injury (at both hospital sites)

No conditions were applied to the registration.

The Nominated Individual for the Trust's Registration is Avey Bhatia, Chief Nurse.

During 2015/16 the Trust provided and/or subcontracted the full range of services for which it is registered (during 2015/16 the Trust provided and/or sub-contracted 101 NHS services). All the data available on the quality of care in these NHS services has been formally reviewed (with commissioners).

The income generated by the NHS services reviewed in 2015/16 represents 100% of the total income for the provider for the reporting period under all contracts, agreements and arrangements held by the provider for the provision of, or sub-contracting of, NHS services.

Reviewing standards

To ensure that we are providing services to the required standards the Trust supported a number of reviews of its services during 2015/16, undertaken by external organisations such as:

- NHS England – Framework of Quality Assurance (independent verification) – 2nd June 2015.
- NHS England – Local supervising group (statutory supervision of midwives) – 21st September 2015.
- NHS England peer review –Trauma services – 24th September 2015.
- Environment Agency (Radioactive substances regulation) – 14th July 2015.
- Counter terrorism security advisers (CTSA's) – April and October 2015.
- UKAS accreditation (clinical pathology accreditation (CPA/ISO 15189) – Histology and cytology – June 2015
- UKAS accreditation (clinical pathology accreditation (CPA/ISO 15189) – Blood sciences – August 2015
- UKAS accreditation (clinical pathology accreditation (CPA/ISO 15189) – Histopathology EQA scheme – Octobert 2015
- Medicines and Healthcare Products regulatory Agency (MHRA) – Transfusion – 5th October 2015.
- Health and Safety Executive (HSE) – Inspection of CL3 Laboratories – 14th September 2015.

- Kent police – counter terrorism crime and security Act annual inspection – September 2015.
- Standards Verifier for the Pearson's group (Diplomas in clinical healthcare support) – July and December 2015.
- Skills for Health (Quality improvement manager) – 10th June 2015.
- National cancer peer reviews – Haematology peer review – May 2015.
- National cancer peer reviews – Internal Validation – June 2015.
- National cancer peer reviews – Urology – 29th July 2015.
- CHKS (ISO 9001, CQC Peer review) – January 2016.
- ISO Accreditation 90001:2008 – EME services – 17th April 2015.
- NHS Protect (Qualitative assessment) – 17th August 2015.
- External audit as part of the Trust application to be ISO14001 registered (Estates) – June 2015.
- Pharmacy aseptic unit's regional quality assessments –May, November and December 2015.
- Patient led Assessments of the Care Environment (PLACE) – April and May 2015.
- Health Education Kent Surry and Sussex (HEKSS) Ophthalmology programme review – April and November 2015.
- Health Education Kent Surry and Sussex (HEKSS) Ophthalmology programme review – April 2015.
- General Medical council – Trainee and trainer survey – May 2015.
- Audit Commission – statutory audit of charitable funds – October 2015.
- Audit Commission – statutory audit of annual accounts – June 2015.

Internally we have the following reviews to assess the quality of service provision:

- Internal assurance reviews (CQC style)
- Internal PLACE reviews
- Infection Control including hand hygiene audits
- Trust Board member "walkabouts"

The outcomes of these are included within our triangulation process to review clinical areas and identify anywhere additional support and actions are required to maintain standards. Reports are scrutinised within identified committees within our governance structure and where necessary action plans are developed and monitored.

Hand hygiene audits to check service quality

Clinical Audit

This section of the Quality Account provides information about the Trust's participation in clinical audit. Identified aspects of care are evaluated against specific criteria to ascertain compliance and quality. Where indicated, changes are implemented and further monitoring is used to confirm improvement in healthcare delivery. Participation in national clinical audits, national confidential enquires and local clinical audit is mandated and provides an opportunity to stimulate quality improvement within individual organisations and across the NHS as a whole.

During 2015/16, MTW participated in 100% of relevant confidential enquiries and 100% of all relevant national clinical audits. During the same period, MTW staff successfully completed 149 clinical audits (local and national) of the expected 311 audits due to be completed (the audit programme had a total of 443 audits but not all were expected to complete within the timeframe). Whilst the majority of audits were undertaken and presented by staff at local meetings the Trust define a fully completed audit as being undertaken, presented with a written report and an action plan in place, submitted to the central audit team. A completeness exercise continues to assist staff to ensure all aspects of their audit have been fully completed and submitted as required.

The national clinical audits and national confidential enquiries that Maidstone and Tunbridge Wells NHS Trust participated in during 2015/16 are shown as follows-

National Clinical Audits for inclusion in Quality Accounts 2015/16	***Participation*** Y, N or NA	***No of cases submitted***	***% cases submitted***	***Comments***
Recruited patients during 2015/16 (Any period during 01/04/2015 to 31/03/2016)				
Acute Care				
Adult Critical Care Case Mix Programme (ICNARC) (CMP)	Y	489 (M) 613 (TW)	100%	
Emergency Laparotomy Audit (NELA)	Y	176	93.8%	Audit requirement 80% of relevant cases.
NAP 6 Perioperative anaphylaxis	Y	3	100%	Data collection still open and data being submitted
Use of Emergency oxygen (BTS)	Y	26	100%	
Procedural Sedation in Adults (CEM)	Y	66	100%	
Vital Signs in Children (CEM)	Y	100	100%	
VTE risk in lower limb immobilisation (CEM)	Y	100	100%	
Non-invasive Ventilation (BTS)	NA			No data collection in 2015/16
Severe Trauma (Trauma Audit & Research Network) TARN	Y	390	55.2%	Data input ongoing.
National Complicated Diverticulitis Audit (CAD)	NA			Audit not applicable to the Trust.
National Joint Registry (NJR)	Y	748	98%	
Blood transfusion				
(National Comparative Audit of Blood Transfusion Programme) - National Audit of Patient Blood Management in Scheduled Surgery 2015	Y	28	100%	
National Audit of the use of blood in Lower GI bleeding 2015	Y	11	100%	
National Comparative Audit of Red Cell and Platelet Transfusion in Adult Haematology patient 2016	Y	45	100%	

National Clinical Audits for inclusion in Quality Accounts 2015/16	*Participation* Y, N or NA	*No of cases submitted*	*% cases submitted*	*Comments*
Cancer				
Lung Cancer (NLCA)	Y	264		Data collection still open and data being submitted.
Bowel Cancer (NBOCAP)	Y	272		Data collection still open and data being submitted.
National Prostate Cancer Audit	Y	383		Data collection still open and data being submitted.
Oesophago-gastric cancer (NAOCG)	Y	138		Data collection still open and data being submitted.
Heart				
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Y	355	100%	Data collection still open and data being submitted.
Heart failure	Y	360	100%	Data collection still open and data being submitted.
Coronary angioplasty/ National audit of PCI	Y	263	100%	Data collection still open and data being submitted
Cardiac Rhythm Management (CRM)	Y	550	100%	
National Cardiac Arrest Audit (NCAA)	Y	26 (TW) 106 (M)	100%	Data collection still open and data being submitted
Adult Cardiac surgery	NA			MTW does not provide this service
Congenital heart disease (Paediatric cardiac surgery)	NA			MTW does not provide this service
Pulmonary Hypertension	NA			MTW does not provide this service
National Vascular Registry	NA			MTW does not provide this service.
Long Term Conditions				
Adult Asthma (BTS)	NA			No data collection in 2015/16
National (Adult) Diabetes Audit (NDA)	Y	3657	100%	
National Adult Diabetes Inpatient Audit (NaDIA)	Y	113	100%	
National Diabetes Footcare Audit	Y	33		Data collection still open and data being submitted
Inflammatory Bowel Disease (IBD) Programme - Biologic Therapy only	Y	80		
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Y	COPD = 109 Rehab = 23	100%	
Rheumatoid and early inflammatory arthritis	Y	50		
National Audit of Intermediate Care	NA			Audit not applicable to the Trust.
Chronic Kidney Disease in Primary Care	NA			MTW does not provide this service
Renal Replacement Therapy (Renal Registry)	NA			MTW does not provide this service
Older People				

National Clinical Audits for inclusion in Quality Accounts 2015/16	***Participation*** Y, N or NA	***No of cases submitted***	***% cases submitted***	***Comments***
Falls and Fragility Fractures Audit Programme (FFFAP) pilot	1. Y 2. NA 3. Y	1. Falls = 30 2. Fracture Liaison Service Database 3. National Hip Fracture Database = 485	1. 100% 2. N/A 3. 100%	2. MTW does not provide this service. This is a community service. 3. Data collection still open and data being submitted.
UK Parkinson's audit	Y	130	100%	
Sentinel Stroke National Audit Programme (SSNAP)	Y	1. Organisational Audit 2. Clinical Audit – 1198	1. N/A 2. 100%	1. Organisational data not collected this year 2. Data collection still open and data being submitted
Other				
Elective surgery (National PROMs Programme) Hip Replacement, Knee Replacement, Groin Hernia, Varicose Vein	Y	Hip: 259 Knee: 284 Groin: 320 Varicose: 15		
National Ophthalmology audit	Y			Registered to participate. Still awaiting software link from Royal College to enable data entry.
Mental Health				
Prescribing Observatory for Mental Health (POMH)	NA			MTW does not provide this service
Suicide and homicide in mental health (NCISH)	NA			MTW does not provide this service
Women's and Children's Health				
Neonatal Intensive and Special Care (NNAP)	Y	708	100%	All data submitted.
MBRRACE-UK; Perinatal Mortality Surveillance report; UK Perinatal Deaths for Births in 2013	Y	Stillbirth = 20 Neonatal = 1 Extended Perinatal = 21	100%	
MBRRACE-UK; Perinatal Confidential Enquiry; Congenital Diaphragmatic Hernia (CDH)	N/A			MTW is not a Level 3 Neonatal Unit
MBRRACE-UK; Perinatal Confidential Enquiry; Intrapartum stillbirths & Intrapartum related Neonatal deaths 2015	Y			Data collection still open and data being submitted.
MBRRACE-UK; Perinatal Confidential Enquiry; Antepartum stillbirth in term normally formed infants 2014	Y	Baby = 85 Woman = 85	100%	
MBRRACE-UK; Saving Lives, Improving Mother's Care	Y	0		No cases to report as no patients fitted this criteria
MBRRACE-UK; Maternal Saving Lives, Women with severe epilepsy	Y			Data collection still open and data being submitted.
MBRRACE-UK; Saving Lives, Women with artificial heart valves	N/A			MTW does not provide this service
Paediatric Inflammatory Bowel Disease. (Round 4) (IBD Programme)	Y	0	100%	MTW did not have any relevant cases during this round.
Paediatric Inflammatory Bowel Disease; Biologics Round 2 (IBD Programme)	Y	0	100%	MTW did not have any relevant cases during this round.

National Clinical Audits for inclusion in Quality Accounts 2015/16	*Participation* Y, N or NA	*No of cases submitted*	*% cases submitted*	*Comments*
National Paediatric Diabetes Audit (NPDA)	Y	TWH = 742 MGH = 839	100%	Data submitted, awaiting National report due May 2016
Paediatric Asthma (BTS)	Y	MTW = 27	100%	
UK Cystic Fibrosis Paediatric Registry	N/A			MTW does not provide this service
National Confidential Enquiries				
Adult Mental Health	Y	8	80%	Data collection still open and data being submitted.
Acute Pancreatitis	Y	8	100%	
Sepsis	Y	6	100%	
Gastrointestinal Haemorrhage	Y	8	100%	
Child Health Clinical Outcome Review Programme: Mental Health Conditions in Young People	Y	46 patient data submitted for selection	100%	Prospective data collection still open and data being submitted.

37 national audits were published in 2015/2016 with actions taken to address areas of non- or partial compliance. A number of improvements have been made in line with national recommendations, including-

1. **Trauma & Audit Research Network (TARN)**
   Rehabilitation Prescriptions have now been developed and implemented, these put in place a package of on-going post-op rehabilitation for up to 4 weeks and allows patients to return to their own home as opposed to temporary accommodation or community hospitals enabling earlier discharge from hospital and treatment in a more comfortable environment.
2. **Emergency Laparotomy Audit (NELA)**
   A system has been set up to ensure that Surgeons complete the pre-POSSUM predicted mortality tool before patients are accepted by theatres. This is to make sure that patients are admitted to the appropriate level of post-operative care on leaving theatres.
3. **Adult Community Acquired pneumonia.**
   A programme of continued education has been put in place for antibiotic prescribing in A&E and AMU nursing staff. This is to enable prompt administration of the first dose of antibiotics and chest x-rays requests when patients are admitted via A&E. Early treatment should produce better patient outcomes and reduce hospital length of stay.
4. **Mental Health (Care in Emergency Departments)**
   A mental health risk assessment proforma (SMART tool) has successfully been introduced and training on its use has been embedded into the A&E induction teaching programme which has input from the Consultant Liaison Psychiatrist. This tool aids clinical assessment and risk stratification and streamlines the referral pathway in a standardised way.
5. **Inflammatory Bowel Disease (IBD) programme – Biologic Therapy only.**
   Additional IBD Nurse Specialists have been appointed to increase capacity and enable 3 and 12 month follow-up appointments to be offered. This will enable regular monitoring of treatment progression.
6. **MBRRACE-UK Perinatal Confidential Enquiry programme**
   A Growth Analysis Protocol has been implemented from April 2016 which monitors growth from 24 weeks gestation by measuring the symphysis fundal height and plotting the measurements on a growth chart used for plotting fundal height and estimated fetal weight. This will aid early identification of fetal growth restriction which is associated with stillbirth, neonatal death and perinatal morbidity.
7. **NCEPOD – Sepsis Study**

A training package has been developed to be included on the trust mandatory training programme covering antimicrobial policies and prescribing, review and administration of antimicrobials. The trust Sepsis Group is working with the clinical coders to improve the accuracy of coding for patients diagnosed with sepsis. This will make it easier to identify patients for clinical audit, national reporting and shared learning.

Please see Appendix A for full details of progress against each of the reported national audit results 2015/16

Service Improvements

A number of service improvements have been made as a result of the **118** completed local clinical audits, across all Directorates, in 2015/16. Trust staff identified local areas of concern/interest, reviewed their practice and made recommendations for change. Staff actively use clinical audit as a quality improvement process to improve patient care and outcomes through the systematic review of the care they provide against explicit criteria. Improvements include:

Actions taken following local audits	Trust Actions
Radiology	GP's refer patients for lower limb ultrasound scan when deep vein thrombosis (DVT) is suspected. New practices were implemented for focused scanning of the proximal part of the lower limb. Doppler flow is not performed for these particular referrals and other causes of leg swelling, for instance, muscle tears are not offered. This has shortened the scanning time from 20 minutes down to 10 minutes per patient so that double the numbers of daily time slots are now available. Re-audit shows that there is a substantial improvement with more GP referred patients being scanned within the recommended time frames.
Radiology	Where a diagnosis of bone or soft tissue sarcoma is suspected, the reporting radiologist/ radiographer should attach the sarcoma reporting pre-set to the radiological report to raise the possibility of a sarcoma diagnosis in this rare rumour. Once diagnosed these patients should then be referred to the London sarcoma service. A reminder letter was sent to all radiologists/reporting radiographers/ sonographers that the pre-set exists and when it should be used. A re-audit was completed which led to the standard being met in all cases. There was no delay in referral to the appropriate sarcoma service therefore no delay in treatment.
Emergency and Medical Services – Elderly Care.	Low impact or fragility fractures are very common in people aged over 65. They include fractures of the hip, pubic rami, wrist and humerus. The Trust has employed Orthogeriatricians to improve care of patient admitted with hip fractures to aid the identification of osteoporosis and allow interventional treatment to potentially prevent further fractures. A Community Falls Service (run by Kent Community Health NHS Trust) has also been created. Patients presenting to the Emergency Departments at Maidstone and Tunbridge Wells NHS Trust with other fractures will be referred to the Falls Service for an osteoporosis assessment.
Midwifery	This audit of High risk twin pregnancies resulted in the Specialist Multiple Pregnancy Clinics being been introduced on both sides of the Trust. These new clinics review women who

Actions taken following local audits	Trust Actions
	were previously being seen for antenatal care as well as capturing newly referred women to the service. Re-audit results show there has been an improvement across all parameters. The care package includes: Early scanning and regular scanning programmes for MC and DC twins. Discussion and documentation of birth options. An agreed plan for the mode of delivery. Provision of twin specific information and support. Full blood count taken at 20-24 weeks as well as at 28/40 weeks. Aspirin is given if clinically indicated.
Surgery	Cancer patients have a sevenfold increased risk of developing VTE. For patients undergoing major abdominal surgery the risk of fatal VTE is double the baseline risk. Additional training was provided by the VTE nurse practitioner for junior doctors on the prevention of possible DVTs. Results show that there has been further improvement to patient care, chemical thromboprophylaxis is prescribed and administered in 100% of patients audited across both sites. The prescription of Anti-embolism stockings (AES) to reduce the risk of blood clots forming in the patients legs has also improved by 25% to 87% which suggests that our measures to improve prescription of AES were effective.
Anaesthetics	A new obstetric anaesthetic chart for caesarean section was developed and has substantially improved the overall quality of documentation for this group of patients. Tick boxes made recording of documentation easier, quicker and standardised the recording of information. The inclusion of the massive obstetric haemorrhage protocol on the anaesthetic chart has received really positive feedback The results were also made into a poster for presentation at the Royal College of Anaesthetists College Tutor meeting
Anaesthetics	Discontinuing medications peri-operatively may lead to adverse outcomes and the rate of non-surgical complications increases when patients do not receive certain regular medicines. Following the findings of the initial audit, the predominant reason for patients not receiving essential medications was because patients were perceived to be nil by mouth peri-operatively. A poster was produced to show which medications patients should receive prior to surgery and which should be omitted. A copy was put in surgical wards and a copy was placed onto all drugs trollies making it clearly visible whenever nurses did their drugs rounds. The re-audit has shown the proportion of medicines not given because patients were nil by mouth has considerably reduced suggesting that the key message of our educational campaign has been effective.
Acute Medicine	An audit of the Management of hypokalaemia (electrolyte abnormality) led to additional teaching sessions and distribution of Guidelines for Potassium replacement therapy on all wards, and informing staff of availability on Q-Pulse. Re-audit shows improvements in the management of hypokalaemia. Further action is required to update the trust guideline to allow for variations in acceptable treatment modalities for each severity cohort incorporating evidence-based guidelines such as cardiac monitoring.

Enhancing Quality and Enhanced Recovery Programme

Clinical teams across Kent Surrey Sussex (KSS) have agreed a number of key clinical interventions that should happen when a patient has been admitted across several pathways as part of the Enhancing Quality and Enhanced Recovery Programmes. For each pathway there are a number of performance measures to attain. These measures pulled together are regarded collectively as a 'care bundle'. Patients who receive the full 'care bundle' it has been clinical proven to improve patient outcome. Enhancing Quality pathways include Community Acquired Pneumonia, Heart Failure and Chronic Obstructive Pulmonary Disorder (COPD). Enhancing Recovery Programme includes three pathways; Orthopaedic, Gynaecology and Colorectal.

Enhancing Quality
Community Acquired Pneumonia
There have been several modifications to the Pneumonia pathway. The pathway was revised to bring it up to date with the latest clinical evidence. MTW performance is in line with KSS average for the Community Acquired Pneumonia Pathway; outcomes are mortality and 30-day readmission significantly below the regional average. Length of stay (LOS), however, is significantly higher than the KSS average.

Heart failure
The measures selected for Heart Failure were revised in April 2015, to align to the National Heart Failure Audit and support greater compliance with NICE guidelines and quality standards. MTW performance has been shown to be significantly above regional average with key outcomes mortality, Length of Stay (LOS) and 30-day readmission in line with regional average.

Chronic Obstructive Pulmonary Disorder (COPD).
The COPD pathway has been running since October 2014. MTW performance since implementation has been significantly above the regional average for KSS in this pathway, with approximately 75% of patients now receiving the full 'care bundle'. The pathway concerns the bundle of care provided at discharge and therefore 30-day readmission rate is the key outcome measure. MTW has the lowest rate of readmission and with all other measures in line with the regional average.

Enhanced Recovery Programmes
Enhancing Recovery Programme includes three pathways; Orthopaedic, Gynaecology and Colorectal surgery. All enhanced recovery pathways have the following measures in common; pre-operative assessment, planning and preparation before admission, reducing the physical stress of the operation by using minimally invasive techniques and preventing hyperthermia, structured approach to post-operative care. MTW adopted the care bundles swiftly, and has consistently performed at and above regional averages for each procedure care pathways. With orthopaedic and gynaecology both continuing to attain around 90% and above. Colorectal surgery is showing considerable improvement and is currently trending at regional average. Within all care pathways improvements have been seen in ensuring patients are given written and verbal explanation of their role in their recovery and discharge advice.

NICE Guidelines

The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care. NICE's role is to improve outcomes for people using the NHS by producing evidence based guidance and advice and monitor compliance through set quality standards and performance metrics.

MTW review all published guidelines produced by NICE to identify those which are relevant to the care we provide to our patients. Clinical audits are then undertaken on those guidelines identified as being relevant to assess the trusts compliance. These clinical audits focus on a number of key quality standards; that are designed to drive measurable service improvement to enhance practice and the care of patients. As at the end of 2015/16 there were **1107** published NICE guidance. Of those, **1007** (**91%**) have been evaluated. **337** (**33%**) of the evaluated guidance are relevant to the Trust. The breakdown is shown in the table below.

Guidance Type	Published	Evaluated	Relevant
Clinical Guidelines (NICE CGs)	232	199	102
Interventional procedures (NICE IPGs)	490	463	79
Technology appraisals (NICE TAs)	385	345	156
Totals	1107	1007	337

Audits of NICE Guidelines are an ongoing process of implementing change and measuring improvement until full compliance is achieved.

Please see Appendix C for full details of Trust compliance with guidance that has been audited and completed during 2015/16.

Research

Participation in clinical research

Maidstone and Tunbridge Wells NHS Trust understands the importance of being a research active organisation. Not only is it a central requirement within the NHS Constitution, it is also a patient priority. A June 2012 poll commissioned by the NIHR Clinical Research Network showed that 82% of the public think that it is important for the NHS to offer opportunities to take part in healthcare research

Participation in clinical research means patients get access to new treatments, interventions and medicines, and investment in research means better, more cost-effective patient care. In 2015/16, Maidstone and Tunbridge Wells NHS Trust played a key part in delivering the national research agenda despite the Trust recruiting only 500 patients to trials during the year against the NIHR requirement of 1250.

Patient Recruitment Leaders

MTW research teams achieved a number of UK and European ‘firsts’ during 2015, most notably the Rheumatology Research Team, led by Dr Mike Batley, being the first research team in the country to recruit a patient to an important trial involving rheumatoid arthritis patients. The breast cancer research team were the top recruiting team in the country for the Manta breast cancer study and second highest in Eurpoe. The ophthalmic research team Led by Mr Luke Membery won a highest recruiter award from the Moorfields hospital in 2015 and has put MTW in the top five of organisations for patient recruitment to ophthalmic trials.

2015 saw the development of the new Respiratory Research Team at Maidstone Hospital. The team, consisting of a new Lead Research Nurse and Research Associate recruited 18 patients to their first national portfolio study called Laser, looking at patients with allergic asthma. The team recruited the highest number of patients in the country.

Trust-Led Studies

The Trust has successfully delivered the first year of a three year study called BPOP (previously the BETTER study), working alongside researchers in local academic institutions and collegues from East Kent hospital. The study is the biggest study to be sponsored by MTW to date and is aiming to develop a pre and post exercise routine to improve outcomes for patients following abdominal surgery for cancer. The Surgical Research Team, led by Mr Haythm Ali, has enlisted the help from a number of MTW patients to design a new exercise regime with support from sports science experts.

The Surgical Research Team was successful in achieving National Portfolio status for the EPOP study late in 2015, increasing the study’s recognition across the Clinical Research Network.

Patient and Public Support

In the summer of 2015, MTW recruited a second Patient Research Ambassador, Judith Strutt. Judith has a special interest in diabetes, so is supporting the development of more studies in this area. Judith also supports diabetic patients who are participating in trials and who may wish to know more about joining a trial. It is anticipated that the trust will recruit many more specialist Patient Research Ambassadors year on year.

Judith Strutt – Patient Research Ambassador for Diabetes.

Increasing Patient Recruitment to Trials

The trust secured a number of high recruiting studies during 2015 to help deliver the increasing patient recruitment target for 2016/17 of 1455 patients. A number of registry studies have been opened in surgery, rheumatology, cardiology, haematology and hepatology, and studies looking at innovative ways of supporting patients in the community using technology.

New Look Research and Development Team

The central research and development department underwent a re-structure at the end of the financial year to free up existing staff to provide closer support to large recruiting national portfolio studies. This focus will help the trust to recruit a higher number of patients to trials, year on year, which in turn will help to deliver the NIHR annual recruitment target. The post holders also support hospital staff to develop their own 'in-house' research studies in preparation for inclusion onto the NIHR National Portfolio of studies. www.ukctg.nihr.ac.uk.

Denise Day, Research Governance Co-ordinator (centre) with new CTAs Kevin Bishop and Aimee Williams

The central governance team was also boosted by the recruitment to two new Clinical Trial Administrators to help support the growing number of trust research studies. The new central team provide support to clinical staff involved in research and have freed up the work of the oncology research team considerably to focus on patient recruitment.

Goals agreed with commissioners

CQUINS

This section describes how the Commissioning for Quality and Innovation (CQUIN) payment framework is used locally. The CQUIN framework aims to support a shift within the NHS to ensure that quality is the organising principle for all NHS services. It provides a means by which payments made to providers of NHS services depends on the achievements of locally agreed quality and innovation goals.

In 2015/16 2.5% of the contract value was dependent on achieving the CQUIN targets for CCGs and 2.4% was for NHS England in line with the CQUIN payment framework.

Further details of the agreed goals for 2015/16 and for the following 12 month period are available electronically at www.mtw.nhs.uk

Within the commissioning payment framework for 2014/15 quality improvement and innovation goals were set as indicated in the table below.

CQUINs	Target	*Achieved (local data)	RAG Rating
National CQUINs (CCGs)			
The percentage of patients with AKI treated in an acute hospital whose discharge summary includes each of the four key items	**90%**	94.7%	Green
The total number of patients presenting to emergency departments who met the criteria of the local protocol and were screened for sepsis.	**90%**	100%	Green
The number of patients who present to emergency departments with severe sepsis, and who received intravenous antibiotics within 1 hour of presenting:	**90%**	**73.5%**	Red
The proportion of patients aged 75 years and over screened for Dementia following an episode of emergency, unplanned care to hospital	**90%**	**98.7%**	Green
The proportion of those identified as potentially having dementia or delirium who are appropriately assessed	**90%**	**100%**	Green
To ensure that appropriate dementia training is available to staff through a locally determined training programme.	**90%**	**97%**	Green
To ensure that carers of people with dementia and delirium feel adequately supported	**20%**	**48%**	Green
Local CQUINs (CCGs)	**Target**	**Achieved**	
UEC - % of patients treated <60mins of arrival in A&E - 60% Target is Quarter 4 only	**60%**	**52%**	Red
Medication Safety Thermometer - Agreed new number of wards audited per month ie Q2 100% of patients on 4 Wards, Q3 100% of patients on 8 Wards, Q4 100% of patients on 10 Wards	**68%**	**Did not achieve Quarter 2 or Quarter 3**	Red
Stroke - Setting up Early Supported Discharge Teams at both sites – 10% reduction in length of stay by Quarter 4	**17.25**	**18.97**	Red
Implementation of HOUDINI Screening Tool for Catheter Associated Urinary Tract Infections (CAUTI) & Audits undertaken	**Implement, Audits Undertaken**	**Achieved**	Green
Reduction in CAUTI rate in Quarter 4 - 10% reduction from	**6.3%**	**3.0%**	

CQUINs	Target	*Achieved (local data)	RAG Rating
baseline			Green
NHS England CQUINs	**Target**	**Achieved**	
Clinical Utilisation Review - Installation and Implementation of software	**Implement**	**Implemented**	Green
Clinical Utilisation Review Installation – Review Impact	**Review**	**Not achieved**	Red
Clinical Utilisation Review - Reporting	**Report**	**Not achieved**	Red
Management of Oral Formulation of Systemic Anticancer Therapy (SACT) - 30% reduction from baseline in Oral SACT issued to patients but not taken by patients	**100%**	**100%**	Green
Oncotype DX: Eligible patients receiving a NICE DG10 compliant test with provision of monitoring data	**Eligible Patients**	**Achieved**	Green
Neonatal Unit Admissions - For all babies who are admitted to a neonatal unit for medical care at term a thorough and joint clinical review is undertaken	**95%**	**100%**	Green
Hepatitis C Networks - Year 1 - National Model of Specialised Hepatitis C Networks - developing a working group, map patient pathways and produce a plan to improve partnership working.	**Implement**	**Achieved**	Green

Commentary

In this section we highlight some of the CQUIN improvements and developments in 2015/16, including what we achieved and what challenged us.

National CQUINs:

The Trust successfully achieved the National CQUINs ensuring appropriate management after discharge for patients with AKI. More patients with dementia and delirium were identified early and supported to help them manage their condition and have a more positive experience with health and social care services. The Trust established a local protocol and ensured that appropriate emergency patients were screened for Sepsis. The Trust made significant progress in initiating intravenous antibiotics for those patients who have severe sepsis, red flag sepsis or septic shock within 60 minutes of presentation but for some patients this fell just outside the 60 minute timescale. The Trust will continue to embed this CQUIN in 2016/17 to further improve outcomes and patient experience.

Local CQUINs:

The Trust made significant improvements in the number of patients seen by a decision-making clinician within 60 minutes of arrival in the Emergency Department exceeding the national target of 50% at 51.4% for the year. However, the Trust failed to deliver the stretch target of 60% for Quarter 4 (52%) and this will remain an area of focus for next year.

The Trust developed a process for performing monthly audits of drug charts from relevant clinical areas and uploading this data to the national database, however this process was not fully implemented until November. This is now fully implemented within the Trust and the Trust will

continue to embed this CQUIN in 2016/17 continuing monthly audits and disseminating learning from themes linked to improvement opportunities.

Early Supported Discharge Teams attached to the Stroke Multidisciplinary Team have been successfully set up at both sites. The Trust made an improvement in reducing the Length of Stay for Stroke Patients but due to the slippage in the opening of the new ward at Tunbridge Wells and transferring Stroke patients from Tonbridge Cottage Hospital to Tunbridge Wells failed to achieve the 10% reduction. The Trust will continue to embed this CQUIN in 2016/17 to ensure a reduction in length of stay for stroke patients.

The Trust successfully implemented the HOUDINI Screening Tool for Catheter Associated Urinary Tract Infections (CAUTI) and audits were undertaken. The Trust exceeded the required 10% reduction in the CAUTI rate.

NHS England CQUINs:

The Trust successfully achieved all of the NHS England CQUINs with the exception of the Clinical Utilisation Review. This CQUIN was in three parts and due to the initial slippage in the installation and implementation of software was unable to achieve the review and reporting parts of the CQUIN. The Trust will continue to embed this CQUIN in 2016/17.

Statements from the CQC

The trust was inspected in October 2014 with the report published January 2015.
Overall the rating for the Trust was 'Requires Improvement'

Overall rating for this Trust	**Requires Improvement**
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Inadequate

The CQC inspection findings concluded with 1 enforcement notice and 18 compliance actions. The Trust welcomed the report and considered its findings to be fair. A Quality Improvement Plan was developed and progress was monitored at Board.
The enforcement notice relating to annual water sampling for legionella was responded to immediately with actions undertaken to address the issue and ensure governance is now place to prevent the risk of re-occurrence. The CQC visited Maidstone hospital on 30th June 2015 to review evidence submitted in practice and the enforcement notice was lifted by the CQC In September 2015.
There have been a number of substantial improvements over the 12months since the report was published. These include:

- A dedicated Staff engagement and Equality lead has been appointed
- Translation services have been fully reviewed and a new provider has been identified
- Consultant working patterns in ITU have been revised and are now compliant to ICU standards. This means there are twice daily ward rounds every day of the week.
- Critical Care outreach service implemented 24/7
- A full governance review has resulted in a revised governance committee structure for the Trust and a clear ward to board communication/ escalation process
- Paediatric Early Warning system has been implemented in paediatric services including paediatric A&E
- Water hygiene management is now fully compliant with statutory requirements with robust governance and management in place
- Consideration for privacy and dignity of patients in ITU regarding toilet facilities has been met

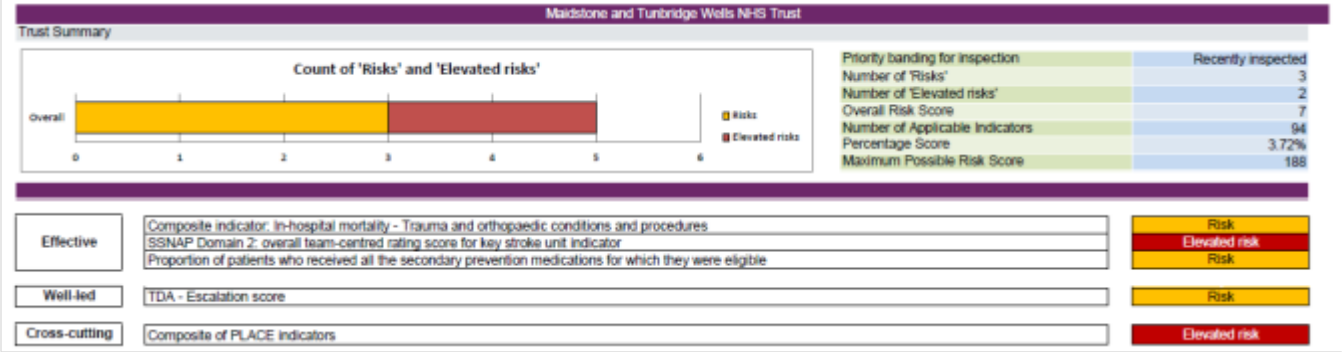
The monthly Quality Improvement Plan reports are published on our staff intranet and shared with commissioners and the CQC.

Intelligent Monitoring:

The CQC developed a new model for monitoring a range of key indicators about NHS acute and specialist hospitals in 2013. These indicators relate to the five key questions asked of all services. The indicators were used to raise questions about the quality of care. They will not be used on their own to make judgements. Judgements will always be based on the result of an inspection, which will take into account Intelligent Monitoring analysis alongside local information from the public, the Trust and other organisations.

Trusts are given a risk rating between 1 and 6, with Band 1 being the highest priority rating (or greatest risk) and 6 being the lowest priority (or lowest risk).

The rating was revised approximately every quarter. The last report (at the time of writing these Accounts) was published in May 2015 and the profile is given below. A banding was not given as the Trust had been recently inspected. However a percentage score of 3.72 % corresponds to a banding of 4.



No further reports have been issued or published on the CQC Website.

Improving data quality at MTW

Maidstone and Tunbridge Wells NHS Trust is committed to providing services of the highest quality.

Specifically, MTW needs to ensure its information is:

- Consistently captured;
- Recorded accurately;
- Securely shared within the boundaries of the law.

High quality information underpins the delivery of effective patient care and is essential to understanding where improvements need to be made.

During 2015/16 the Trust successfully completed the completeness and validity checks set out as part of the Information Governance Toolkit. The Trust uses the results of these checks to inform the workplan for the Data Quality Steering Group whose remit is to monitor performance against data quality standards. Recommendations and remedial actions are discussed and forwarded to appropriate areas.

Areas identified for improvement during 2015/16 were:-

- the use of the NHS Number within in the Trust as the primary identifier
- Continue an on-going program of data quality workshops for staff based on targeted areas for improvement.

NHS Number and General Medical Practice Code Validity
Data quality is also monitored for each submission the Trust is required to make throughout the year to the Health and Social Care Information Centre, Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient‘s valid NHS number was:
  98.9% for admitted patient care;
  98.4% for outpatient care; and
  96.0% for accident and emergency care.

The Trust has developed a data quality dashboard to assist service managers and clinicians.

Information Governance Toolkit

The Information Governance Toolkit is a performance tool produced by the Health and Social Care Information Centre. It draws together the legal rules and central guidance related to Information Governance. The Trust achieved a score of 72% satisfactory (Green in the toolkit grading scheme) against the Information Governance Toolkit Version 13, and achieved 8 of the 45 requirements at level 3. The remaining requirements were achieved at level 2 as required by the Operating Framework for England for 2011/12.

The Trust reviews its Information Governance Management Framework on an annual basis. This is to ensure that all the information the Trust holds is managed, handled, used and disclosed in accordance with the law and best practice. An action plan is developed each year to address the areas of weakness identified and progress against the action plan is monitored by the Information Governance Committee which is chaired by the Trust Data Protection Officer. The Trust Board is kept fully apprised of Information Governance issues affecting the organisation.

The Trust has an action plan in progress to continue to improve its compliance with the Information Governance standards.

Clinical Coding

Maidstone and Tunbridge Wells NHS Trust employs a team of appropriately qualified staff to code patient care episodes and associated clinical data. This coding it independently audited to ensure that the coding reflects the patient's diagnosis and treatment.

In 2015/16 a **Clinical Coding audit and process review** was undertaken by CHKS Ltd on behalf of MTW which was released in February 2016. The audit resulted in eight recommendations and the Trust has developed an action plan to address the issues identified.

Errors may occur when a clinical coder translates the written information provided by a clinician regarding a patient's diagnosis and treatment into standard codes. These codes are nationally and internationally recognised and are used by healthcare professionals and researchers to check on the outcomes of a patient's diagnosis and treatment and compare it to other patients and organisations in other parts of the country and abroad.

Part Three

Update on improvement initiatives 2015/16

Patient Safety

To improve the system of incident reporting and learning lessons from incidents, complaints and claims

Aim/goal

To make the process of reporting incidents quicker, easier and more accessible for all staff
To engage all staff groups to report incidents
To improve the current system of sharing the learning from incidents, complaints and claims

Action	Update
Incident reporting process to be developed to be easier, quicker and more accessible for all staff	*Datix improvement group established, DATIX upgrade completed March 2015. Reporting page reviewed and process now quicker and easier. DATIX app currently been rolled out on tablets and iPhone for improved access*
To develop a programme of staff engagement events identifying and engaging staff groups who currently are low reporters of incidents	*Clinical Governance Roadshow week undertaken in November 2015. This included patient safety awareness and how to report incidents. Associate Director Quality Governance attended Directorate Clinical Governance meetings to update staff*
To publish a summary of learning from every serious incident in our Governance newsletter	*Learning from SI's published in Governance Gazette,*
To implement a methodology for triangulating lessons from incidents, complaints and claims more effectively in order to identify overarching themes and organisational learning	*Complaints, Legal, Incidents, PALS, Audit (CLIPA) weekly meeting re-established in September 2015. Data on emerging themes and trends reviewed. Monthly report for Trust Clinical Governance Committee*
To review the current communication pathways for lessons learnt from incidents, complaints and claims and, with the informatics and communication teams consider and implement more effective ways to get messages of learning to staff and the public.	*Improvements made to information on the Trust intranet, input into communication team to provide learning, themes and trends via their forums and communication pathways (such as Glenn's newsletter)*

To improve the patient safety culture within the organisation to ensure the organisations and all staff are responsive to learning

Aim/goal

To engage all staff in developing a 'just' culture that is understood, practiced and owned by everyone

Action	Update
To implement an engagement campaign called 'Step up to Safety' with the aim of raising awareness and engaging staff sign up to a 'just' culture	*Clinical Governance Roadshow week undertaken in November 2015. This included patient safety awareness and a challenge to staff to share how they provide safe and quality care on a day to day basis. Leaflet disseminated to staff. Associate Director Quality Governance attended Directorate Clinical Governance meetings to update staff*
To host a patient safety culture focussed conference for MTW staff	*Conference hosted on 3rd July 2015 with over 60 attendees and positive feedback*
To engage staff is making a patient safety film that is then used to educate staff on the importance of 'just' culture and accountability.	*Financial constraints have prevented the completion of a tender process to fund an external company to produce a film. Alternatives are under consideration*

To improve patient flow through the Trust

Aim/goal

To have effective flow throughout the hospital, that enables patients to be cared for in the right environment by the right staff at the right time.

Action	Update
50% reduction in delayed transfers of care from MTW in the next 12 months	*The DTOC rate since November has ranged from 3.9% to 6.1%. Around 50% of these are related to waiting for Nursing Homes. Care Home availability continues to be a significant issue for the health economy as a whole as similar DTOC levels are experienced in the Community Hospitals, reducing patient flow from the acute sites.* *West Kent is recognised as an outlier for DTOC and as a result, a visit was undertaken in February by Ian Wilson, national expert, and his recommendations are being reviewed by health and social care partners.*
Review of wards at MTW to improve efficiency and flow through ward location and co-adjacencies	*Service redesign continues to be reviewed. The Trust has joined the National Programme for Ambulatory Emergency Care (AEC) with the expectation that up to 20% of the medical take can be treated on ambulatory pathways.*
Creation of additional capacity at the Tunbridge Wells Hospital (30-39 bed unit)	*The new Acute Medical Unit is due to opened in March 2016 with the addition of 38 bed spaces.*

To improve the quality of Stroke care

Aim/goal

The Trust intends to continue work on the improvements the stroke service by ensuring access to a stroke bed within 4hrs of attendance to Emergency Department, ensuring a CT (computerised tomography) scan within an hour of arrival at the hospital and the provision of a 7 day Transient Ischaemic Attack (TIA) service. These will have significant impact on the safety of patients requiring stroke care.

Action	Update
Ensure that patients are admitted to stoke bed within 4 hours of arrival, with a measure of MTW achieving a position in the upper quartile of Sentinel Stroke National Audit programme[1] (SSNAP) national data set.	*From Oct – Dec data* *TWH:37.9% - SSNAP level E* *MDGH:55.1%- SSNAP level D* *National: 59.8% - SSNAP level D*
Ensure that a CT scan is performed in under an hour of arrival, with a measure of MTW achieving a position in the upper quartile of SSNAP national data set.	*TWH: 59.3% - SSNAP level A* *MDGH: 57.1%- SSNAP level A* *National: 48.2% SSNAP level A*
Provision of a high risk TIA service 7 days /week (daytime)	*Currently a 5 day service remains operational. Strategic and directorate discussions regarding ability to provide a 7 day service taking place.*

Patient Experience

Meeting the needs of our clients with due regard to their cultural and linguistic backgrounds

Aim/goal

To meet the needs of all clients with due regard for their cultural and linguistic background.
To ensure our services meet these needs effectively by undertaking a review of the linguistic translation services and improving the service

Action	Update
Recruitment of an Equality and Diversity lead for the Trust	*Staff Engagement and Equality lead recruited who will lead on Equality and Diversity (commenced in post April 2016)*
Implement the tender process for linguistic translation and adopt an efficient system that meets patients and service needs	*Tender process completed and new provision of linguistic translation implemented June 2016 with new provider*
Implement a staff flag project, where staff who speak other languages wear a flag of this country on their name badge	*This will be part of the work plan for the Staff Engagement and Equality lead over the coming year*

[1] The Sentinel Stroke National Audit Programme (SSNAP) aims to improve the quality of stroke care by auditing stroke services against evidence-based standards, and national and local benchmarks. Building on 15 years of experience delivering the National Sentinel Stroke Audit (NSSA) and the Stroke Improvement National Audit Programme (SINAP), SSNAP is pioneering a new model of healthcare quality improvement through near real-time data collection, analysis and reporting on the quality and outcomes of stroke care.

Development of an Equality and Diversity awareness programme for all staff	*An awareness programme is in place* *Staff Engagement and Equality lead will review this programme in the coming months and recommend improvements, as necessary*
Development of a MTW Equality and Diversity strategy	*This forms part of the Workforce Strategy that was approved by the Trust Board in September 2016*

Fully implement Friends and Family Test for Outpatient Services and improve learning and action taken in response to Friends and Family test

Aim/goal

The aim is to expand the friends and family test to service users at all MTW outpatient departments and use this information to improve learning and implement improvements.

Action	Update March 2016
Include outpatient services in overall Friends and Family report	*Fully implemented.*
Establish a robust feedback loop where learning and improvements can be identified and changes implemented	*Feedback loop has been developed to enable with further work to continue this work to enable change and improvement planned in the coming year*
Triangulate results with themes from incidents and complaints, identify areas of good practice and where development should be focussed	*Dependent on the above. Intention is to stay with I Want Great Care. Revised service will enable benchmarking and trend analysis*
Ensure results, learning and changes are publically displayed in outpatient areas and kept up to date and improve response rates	*In progress; detailed analysis is dependent on supplier and support transcribing free text from out-patient returns (OP is an automated telephone service).*

The ensure meaningful patient and public involvement in all service improvements

Aim/goal

The aim is to undertake a review of current patient and public involvement processes, identify effective practice, identify areas for improvement and implement a cohesive approach and strategy.

Action	Update
Review of all patient and public involvement activities in the Trust including all local and national patient experience surveys to identify good practice and areas for development.	*Engagement with HealthWatch Kent strengthened. Regular meetings with HWK to identify trends and themes.* *HealthWatch have a designated representative on the Patient Experience Committee, undertake a number of 'enter and view' visits and have been involved in the planning of the new ward at Tunbridge Wells Hospital.*
Include service user representation at meetings where service improvement is on the agenda.	*Process in place. Recent examples include stroke strategy consultation and new ward development programme at TWH – plus as above.*
Conclude review of Patient Experience Committee.	*Review completed. Refined core committee membership to enable it to provide an 'assurance' function.*
Focus on Children Services feedback.	*FFT includes parents, children and young people.*

	Patient Stories are heard at Public Trust Board

Ensure clinical governance frameworks and processes throughout the Trust and at speciality level are effective

Aim/goal

To undertake an organisational review of Ward to Board clinical governance framework, processes and culture in order to identify effective practice and areas of improvement. To implement changes where required and measure improvements.

Action	Update
An external supported review of organisational clinical governance to identify good governance and culture, identify areas for improvement and implement new governance framework within the organisation.	*External governance review that included cultural element completed August 2015 with full report*
Establishment of a consistent organisational governance framework that supports effective Directorate level clinical governance.	*External governance review completed and committee structure amended.* *Clinical Governance framework developed with clear ward to board flow and clarity over reporting and support for Directorate clinical governance*
Establishment of a system of intelligent monitoring that will enable more effective measurement of quality and safety.	*Internal assurance process developed in relation to CQC domains. Pilot commenced April 2016*

Review and improve the effectiveness of Morbidity and Mortality meetings and reviews

Aim/goal

The aim is to further develop our existing mortality review process and demonstrate how this process can lead to care and service improvements through openness and shared learning

Action	Update
Review of current governance process against new CQC Well – led Domain	*Included in the external governance review completed August 2015*
In collaboration with Directorate leads and external partners agree an improved mortality review process that is documented as a standard operating procedure	*Establishment of revised Mortality review process and Trust Mortality Surveillance group January 2016.*
Review membership of the Trust Mortality Review Group to ensure representation within and external to the organisation	*Trust Mortality Surveillance group has membership in line with NHS England recommendations. The Clinical Commissioning Group is a member of the Trust Mortality Surveillance Group.*
With data analysts and informatics department, consider ways of automating the Mortality Review process that would make for a more timely and efficient process	*Support from Health Informatics department established. Automated mortality review process considered but not currently achievable due to changes to central patient data systems, however this will be consider & included in longer term plans*
With data analysts, consider and implement a triangulation system to ensure the data is being	*Triangulation system established in revised Mortality review process with data reported March 2016*

used more effectively in proactive risk management	*onwards*
Publication of summary reports on the intranet to demonstrate transparency and ensure shared learning across the organisation	*This will commence once data flow is established through the new Mortality review process. Expected May / June 2016. The Clinical Commissioning Group is a member of the Trust Mortality Surveillance Group.*

To ensure that systems and processes as well as, support for our staff is in place to discharge our responsibility to be honest, open and truthful in all dealings with patients and the public.

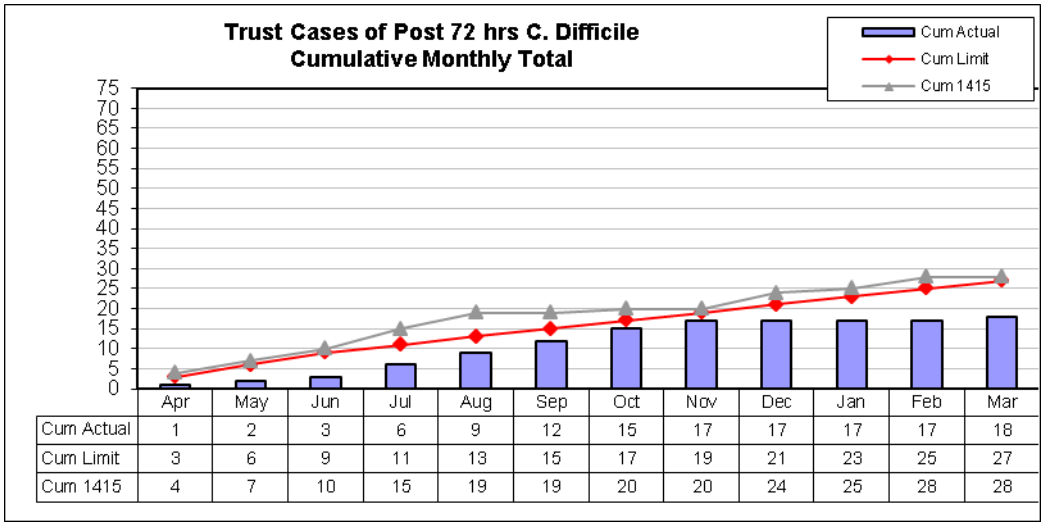
Aim/goal

The aim is to ensure all systems and processes follow the requirements and the essence of the statutory duty of candour.
To implement a support system for staff to discharge their responsibilities to be honest, open and truthful in al dealings with patients and public

Action	Update March 2016
To update the 'Being Open' Policy to include the Duty of Candour requirements	*Policy reviewed and Duty of Candour requirements explicit*
To further extend the training programme in place for all staff	*Training continues as part of the wider patient safety training program*
To further develop resources to assist and support staff when undertaking duty of candour in the clinical setting	*Patient Safety manager commenced in post September 2015 and further staff recruitment achieved. The better resourced patient safety team will be able to provide improved support and guidance for clinical staff as well as maintain a central database for assurance*
Along with the 'Cultural change' programme and 'Step up to Safety' campaign, implement a strategy to further embed the 'Honest and open' culture	*Quality strategy has been integrated into the Trust Clinical Strategy as Quality and culture underlies all future improvements.*
Develop a more robust support process for patients, relatives / carers and staff who have been affected by an incident that causes harm	*Included in the revised 'Being Open' policy and included in the revised 'Serious Incident' policy. Planning with Human resources to implement improved staff support when traumatic event occur.*
To implement an internal assurance process to provide continuous evidence of meeting the statutory requirements	*Audit undertaken on Duty of Candour requirements shows an improving trend. Further work is being undertaken and another audit is planned for later in 2016.*

Review of Quality Performance

Infection Control – C.Difficile Cases – The Trust exceeded this standard with 18 cases against a maximum of 27 cases for the year. The number of CDifficile cases throughout 2015-16 was 9 fewer than the number reported for 2014-15 – 36% reduction

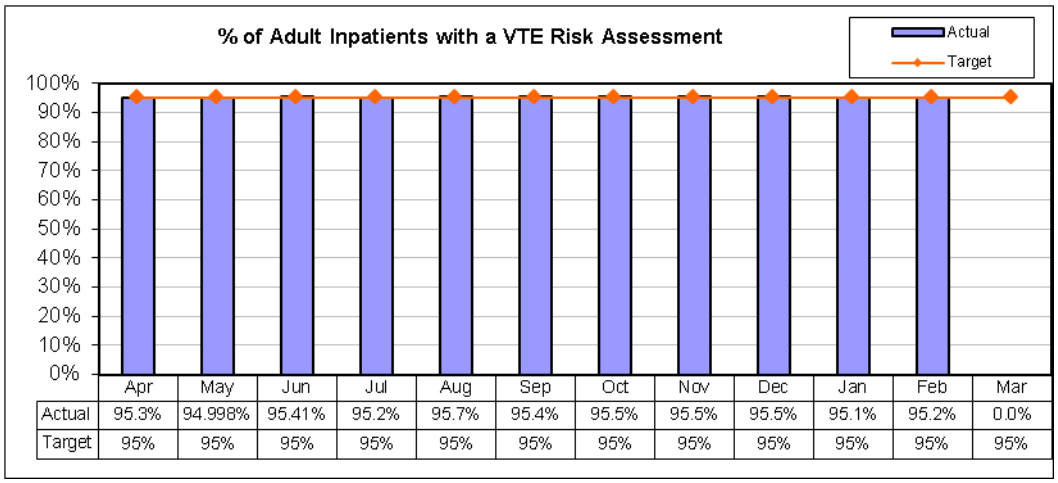


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cum Actual	1	2	3	6	9	12	15	17	17	17	17	18
Cum Limit	3	6	9	11	13	15	17	19	21	23	25	27
Cum 1415	4	7	10	15	19	19	20	20	24	25	28	28

Infection Control – MRSA Cases – The Trust under-achieved the standard, with 1 case of avoidable post 48 hr MRSA bacteraemia through the year against a Trust standard of zero avoidable.

Prevention of blood clots or venous thromboembolism (VTE)

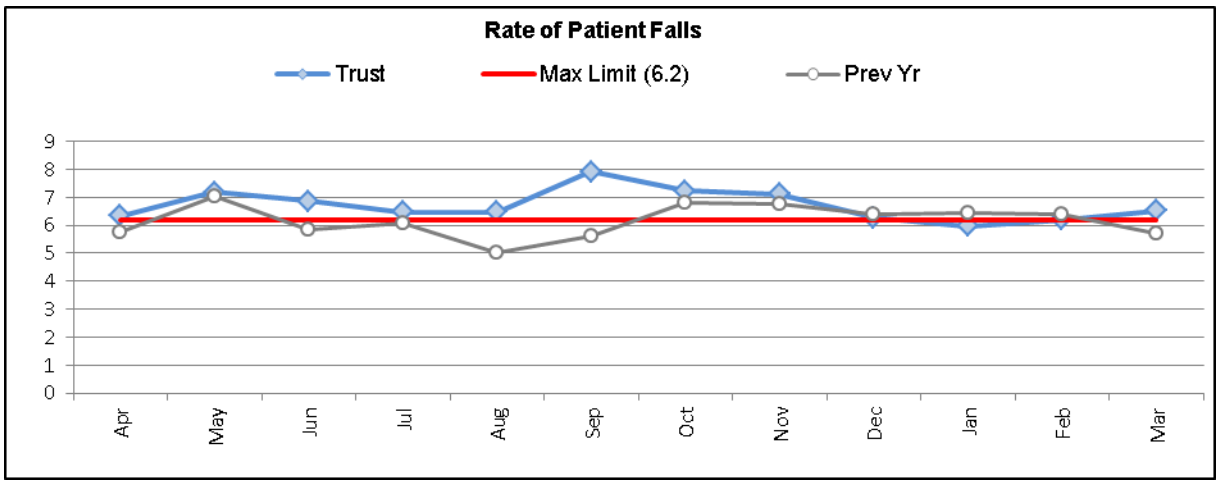
% Patients VTE Risk Assessment – The Trust ensured that 95% of patients were given a VTE Risk Assessment in 2015-16.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	95.3%	94.998%	95.41%	95.2%	95.7%	95.4%	95.5%	95.5%	95.5%	95.1%	95.2%	0.0%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Reducing the number of patient falls

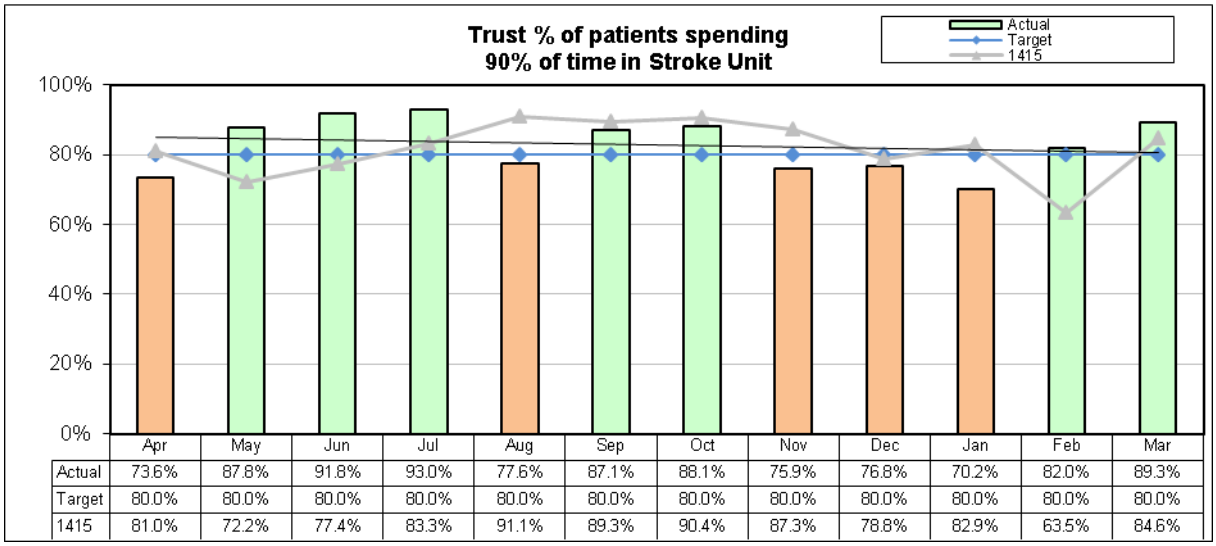
Rate of Falls – The Trust's rate of Falls per 1,000 Occupied Beddays is above the Trust internal improvement target of 6.2 at 6.69 for the year (6.16 for the previous year)



CLINICAL EFFECTIVENESS
Continue our focus on improving care for patients who have had a stroke

Also see update summary in part 3

80% of patients spending 90% of time on in Stroke Unit - The Trust achieved this standard of 80% of stroke patients to spend 90% of their time on a dedicated stroke ward in 2015-16 at 82.4%.

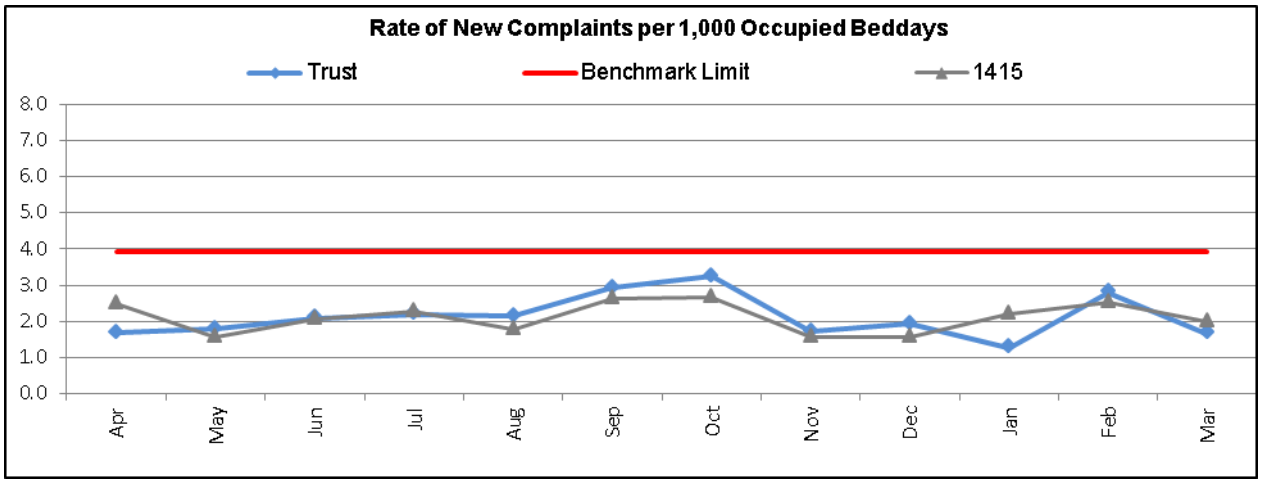


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	73.6%	87.8%	91.8%	93.0%	77.6%	87.1%	88.1%	75.9%	76.8%	70.2%	82.0%	89.3%
Target	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
1415	81.0%	72.2%	77.4%	83.3%	91.1%	89.3%	90.4%	87.3%	78.8%	82.9%	63.5%	84.6%

PATIENT EXPERIENCE

Complaints management

Rate of New Complaints- The Trust's rate of New Complaints per 1,000 episodes is below the national benchmark of 6.26 at 2.11 for the year (4.08 for the previous year). The number of new complaints received in 2015-16 is a 5.8% increase (+28) from the previous year.



Complaints report summary

(Regulation 18 of the Local Authority, Social Services and NHS Complaints (England Regulations 2009). Presented and discussed at MTW Quality Committee 8th July 2015

The Trust has a statutory duty to investigate and respond to complaints in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 (the regulations). This statutory obligation is further supported by the Trust's values – PRIDE – which highlight the importance of being customer focused and striving for continuous improvement. While complaints are often considered to have a negative connotation, we recognise that they are also valued methods of feedback and can highlight shortfalls in current practice or policy**.**

The central complaints team provide regular reports on the learning and service improvements arising from complaints. These are submitted to the Clinical Governance Committee on a regular basis and examples of the learning from complaints are also reported to the Patient Experience Committee. Case studies and key messages from complaints are regularly included in the Trust's Governance Gazette, produced monthly.

Patient Surveys

National Patient Surveys

During 2015 the Trust undertook two National Surveys. Although they are led by Picker Europe and the CQC we have been undertaking these in house. The surveys were the following:

- Women's Experience of Maternity Services
- Adult Inpatient Survey

The Maternity Department survey runs bi-annually and was previously run in 2013. The Inpatient Survey is run on an annual basis.

As stated in last year's Quality Accounts, the Trust aimed to improve the experience of patients across the organisation through focusing on key areas that were highlighted. Below are the questions that were focused on. This year's results are compared with those of the previous year where possible.

Adult Inpatient Survey 2015

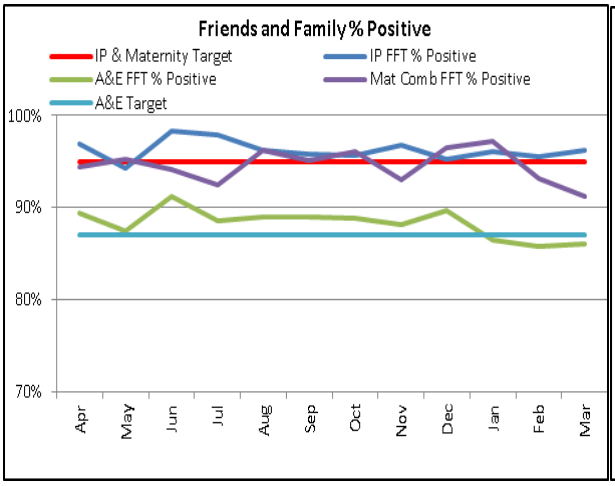
Focus questions from National Inpatient Survey		National Inpatient Survey	
		2015	2014
1	Were you involved as much as you wanted to be in decisions about your care and treatment?	91.7%	87.5
2	Did you find someone on the hospital staff to talk to about your worries and fears?	46.9%	47.3
3	Were you given enough privacy when discussing your condition or treatment	95.8%	95.6
4	Did a member of staff tell you about medication side-effects to watch for when you went home?	39.3%	42.0
5	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	69.1%	71.4

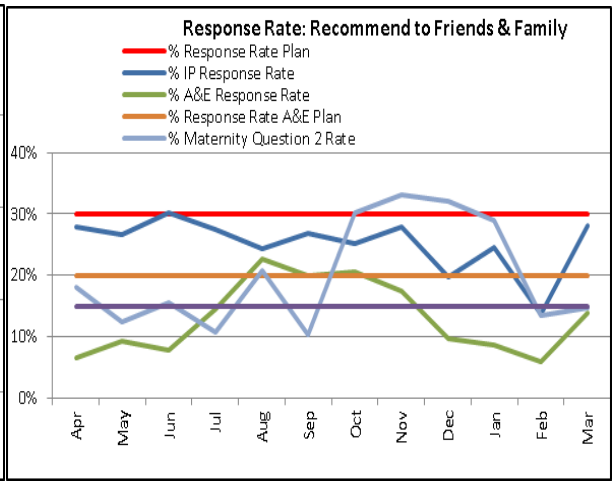
Friends and Family

The Inpatient and A&E positive response rates (96.4%, 88.4% respectively) have exceeded the Trust Plan and national benchmarks indicating that patients would recommend the Trust to their Friends and Family.
The Maternity positive response rate is just below the 95% target at 94.7%

Inpatient and A&E response rates have not met the planned Trust rate, but have exceeded the national benchmarks. Maternity response rate is above the 15% Trust target.

MTW Friends and Family scoring





Staff Survey 2015

This section outlines our most recent staff survey results for indicators KF19 (percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months) and KF27 (percentage believing that the trust provides equal opportunities for career progressions or promotion) for the Workforce Race Equality Standard.

KEY FINDING 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
This is reported at 22% which is a 1% decrease from the 2014 survey findings and is 4% lower than the National 2015 average for acute Trusts

The unweighted scores for KF 25, 26 and 21 split between White and BME staff is as follows:
White 21% (2014 findings – 23%) (National average for acute Trusts – 25%)
BME 25% (2014 findings – 23%) (National average for acute Trusts – 28%)

KEY FINDING 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion
This is reported at 86% which is a 1% decrease from the 2014 survey findings and is 1% lower than the National 2015 average for acute Trusts

The unweighted scores for KF 25, 26 and 21 split between White and BME staff is as follows:
White 89% (2014 findings – 90%) (National average for acute Trusts – 89%)
BME 71% (2014 findings – 78%) (National average for acute Trusts – 75%)

With the appointment of the new Staff engagement and Equality lead, the Trust plans to review the current Equality and Diversity approach and develop an up to date Equality and Diversity awareness programme for all staff. We will be working with a partner Trust to create a plan for delivering department/staff group specific training. Further, the Trust will be working with Stonewall to complete the Equality Index for 2016, we will utilise their materials to deliver appropriate training for the support of LGBT staff, set up an LGBT staff network and provide a mentoring scheme for LGBT staff.

Working with a partner Trust, we will conduct a review of all existing Trust practices in relation to Equality and Diversity requirements and complete the EDS2. We will develop links with local support groups and communities to engage them in the improvement plan for the Trust with assistance from Healthwatch and build a BME forum.

A new translation service for both language and British Sign Language has been agreed with a new provider and will go live on 1 June 2016. This new service will be more allow more ready access to staff and patients as it has a wider choice of forms of communication including telephone based interpreting, video-link and face to face interpreting.

Learning from Serious Incidents / Never Events

To ensure there is a system of learning from incidents and never events we have a robust reporting, investigation and learning process in place. We report all serious incidents centrally to a national system and identify trends and themes to help reduce risks going forward.

All serious incidents are assigned a lead investigator independent of the area where the event occurred and undergo a root cause analysis using recognised investigative tools. Action plans are developed to share learning across the organisation to prevent a similar event occurring. All serious incidents and never events are reported to an executive led panel to ensure a robust investigation has been undertaken and all learning outcomes identified.

The Trust declared 99 serious incidents in 2015/2016 compared to 118 the previous year.

Actions and learning from serious incidents are key to improving patient care and ensuring patients are safe and provided with high quality care. In 2015/2016 learning and actions included:

- All patients should have their follow up appointments booked directly following their Outpatient consultation unless discharged
- A Standard Operating Procedure has been written for Cancer and Haematology to ensure there is a robust appointment system in place to provide continuity of services after 17.00 hours
- All spinal surgery stopped for patients with a Body Mass Index greater than 35
- A review of the pre-assessment process relating to anaesthetic reviews ensuring this is completed prior to the surgery date
- A post take ward round checklist has been developed to ensure all essential actions have been completed including thrombosis risk assessments and prophylactic treatment prescribed
- Undertaking of lying and standing blood pressure on patients at high risk of falls to identify any postural instability
- Further training on moving and handling for patients post fall
- Post fall checklist for completion by medical and nursing staff
- Paediatric Early Warning System (PEWS) charts implemented that alert staff to a child with deteriorating observations and symptoms.
- Revised checklist implemented for inpatients attending radiotherapy to ensure all patient risks are identified to the department to allow plan of care to be implemented whilst in the department
- An awareness to staff that mortuary viewing should only occur out of hour if it is an emergency

Never Events

There were 2 Never Events during 2015/2016, a full root cause analysis was undertaken and presented to the Executive led panel and findings shared with the Trust Development Authority to ensure wider learning.

The first Never Event was a retained specimen bag during a laparoscopic procedure. This piece of equipment had been adapted by the surgeon to meet the needs of the patient and was not part of the theatre count. Actions included all equipment that enter the sterile field must be included in the theatre count. It is recognised that at times equipment may need to be adapted to meet individual patient’s needs this must be risk assessed, discussed with the whole theatre team prior to surgery and the rationale clearly documented within the patients’ healthcare records.

The second Never Event related group O Fresh Frozen Plasma being issued in error of the universal group of AB Fresh Frozen Plasma which should have been issued. The main action was that only the universal group fresh Frozen Plasma is now held within the organisation for emergency use until type specific is available.

Duty of Candour

From April 1st 2015 all registered providers were required to meet the new Regulation 20: Duty of Candour. The aim of this regulation is to ensure that providers are open and transparent with people who use services and other "relevant persons" (people acting lawfully on their behalf) in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology.

In 2015 the Trust ran a number of training events for staff outlining the duty of candour requirements. This was supplemented by articles in staff newsletters and postcard prompts. The trust has subsequently undertaken an audit to review compliance. This audit reviewed the 3 elements required to meeting in the regulations and showed good compliance with offering the first apology but identified that improvement is still required in communicating the outcome of the investigation to the relevant person. An action plan to address issues had been developed and there is on-going scrutiny of this statutory requirement at a senior level in the organisation. Duty of Candour guidance is included in the 'Being Open' policy.

'Sign up to Safety' Safety Improvement Plan

MTW developed and agreed safety pledges in 2015 and have since developed a Safety Improvement plan that will be rolled out over the next 1-3 years.

The following safety improvement domains have been identified are needed focused improvement as a result of a review of the data from legal services over claims against MTW through the NHS Litigation Authority data in the last 5 years, a review of the tends and themes from Serious Incidents and feedback from the CQC: Handover / communication, fetal assessment and identification of deviations from the norm (CTG interpretation), Patient decision making and informed consent & In patient falls. These claims are from the '*low value, high volume'* (Failure / delay diagnosis; Failure to obtain informed consent), *'high value, high volume'* (Handover communication, Failure to monitoring or respond to abnormal fetal heart rate, obstetric)

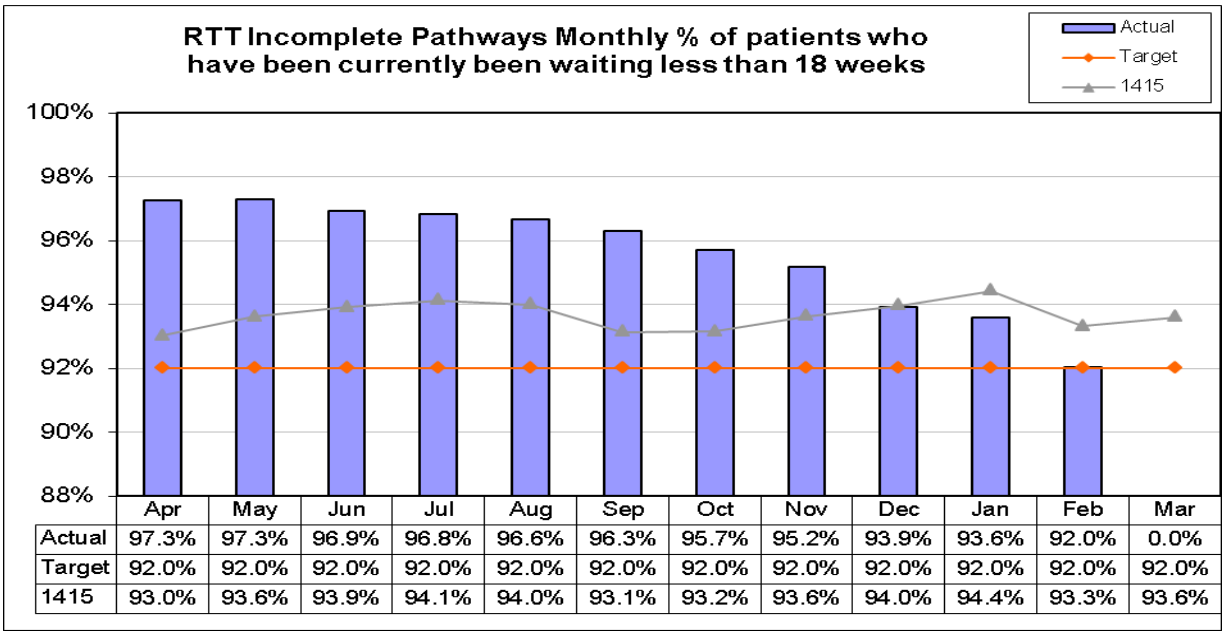
These safety improvement domains will form the heart of the Safety Improvement Plan:

- To improve communication during the handover process
- To improve the effectiveness of identifying and act upon deviations from normal during labour and birth
- To improve the quality of patient involvement in decision making and standards of obtaining informed consent
- To reduce the number of In Patient Falls

The Safety Improvement plan will follow the Plan, Do, Study, Act (PDSA) 90 day cycle supported by the NHS England Sign up to Safety Campaign.

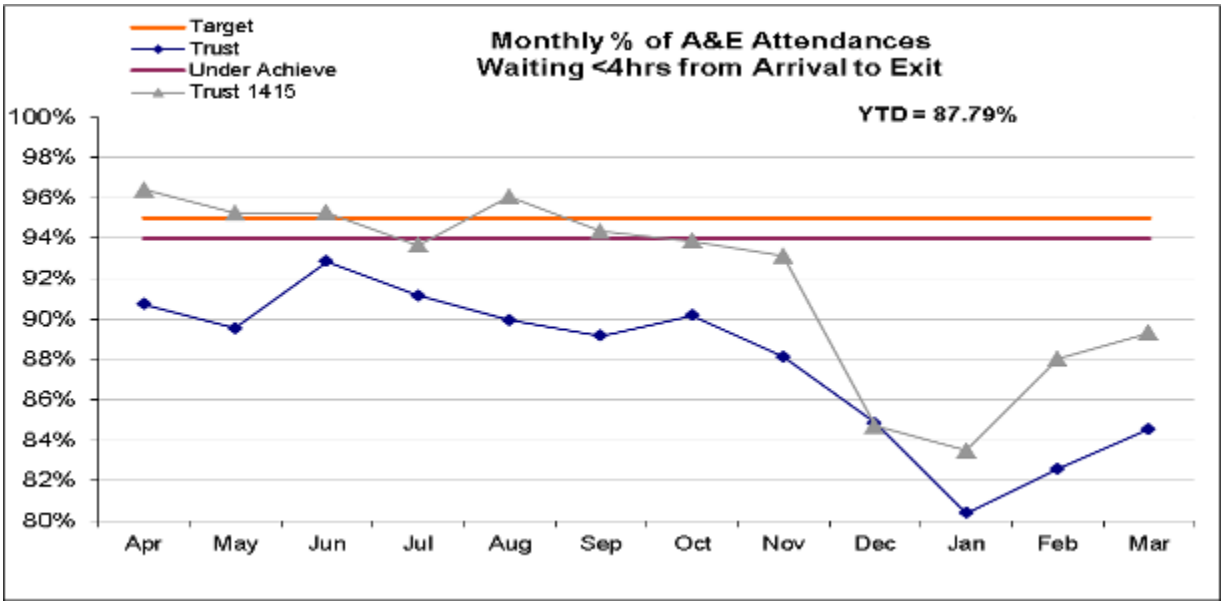
Other Quality Monitoring and Improvement Measures

18 weeks standard – The Trust achieved this standard at an aggregate Trust level, ensuring at least 92% of patients on an Incomplete Pathway had been waiting less than 18 weeks from April 2015 to February 2016, however under-achieved the target in March 2016 due to high levels of emergency activity. The Trust also ensured that at least 90% of admitted patients were treated in hospital following GP referral in 18 weeks and 95% of non-admitted patients were seen within the same period.

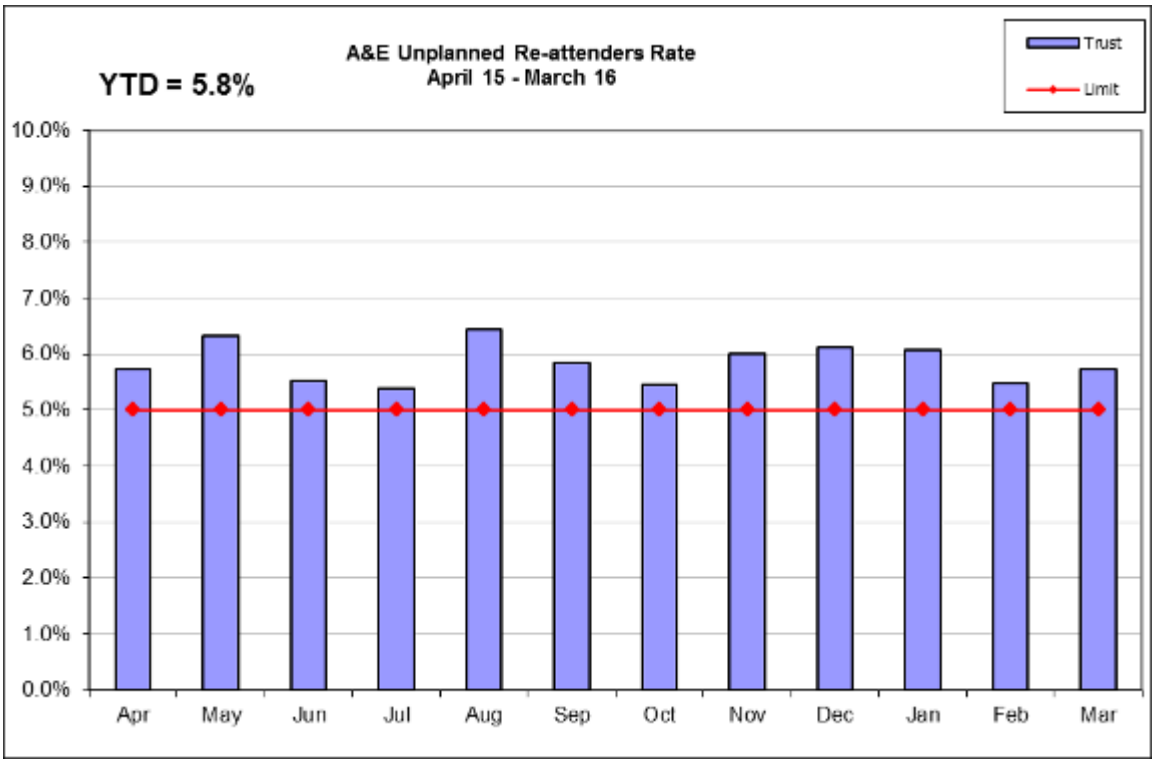


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	97.3%	97.3%	96.9%	96.8%	96.6%	96.3%	95.7%	95.2%	93.9%	93.6%	92.0%	0.0%
Target	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%
1415	93.0%	93.6%	93.9%	94.1%	94.0%	93.1%	93.2%	93.6%	94.0%	94.4%	93.3%	93.6%

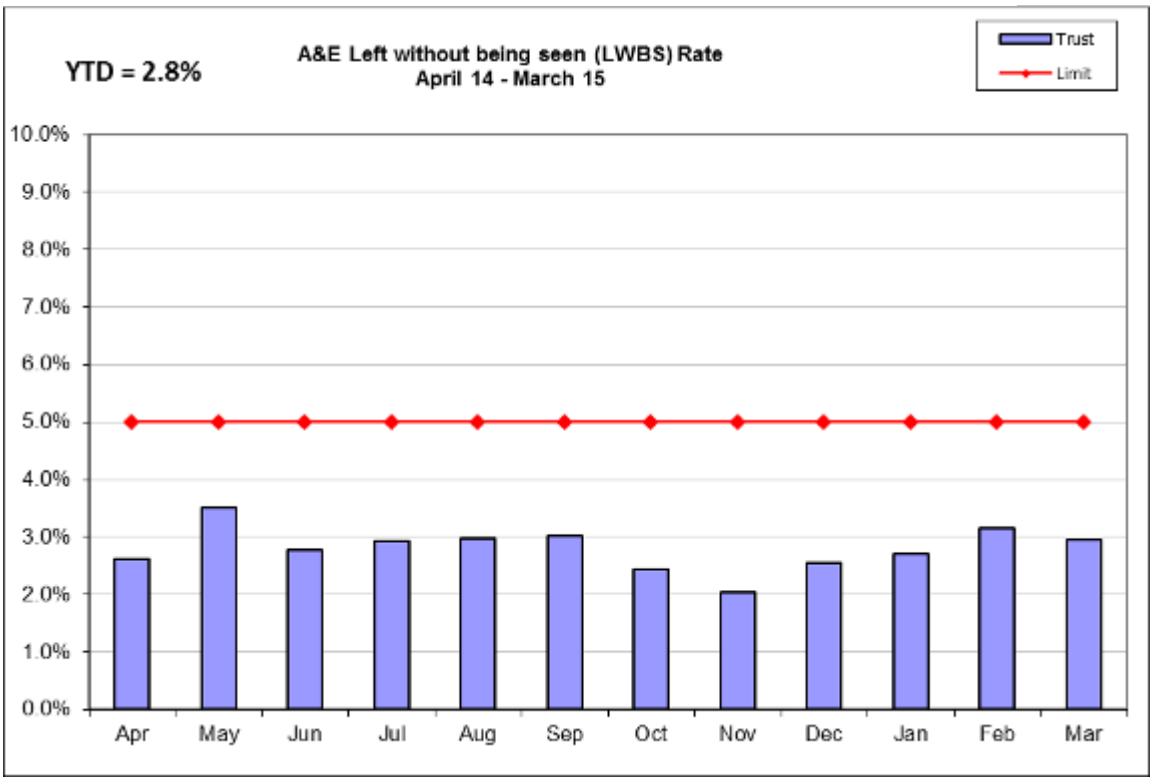
Emergency 4 hour access – Due to the extremely high level of demand the Trust did not achieve this standard of 95% of patients being seen, treated, admitted or discharged within 4 hours of arrival in its A&E departments in 2015-16 at 87.8%.



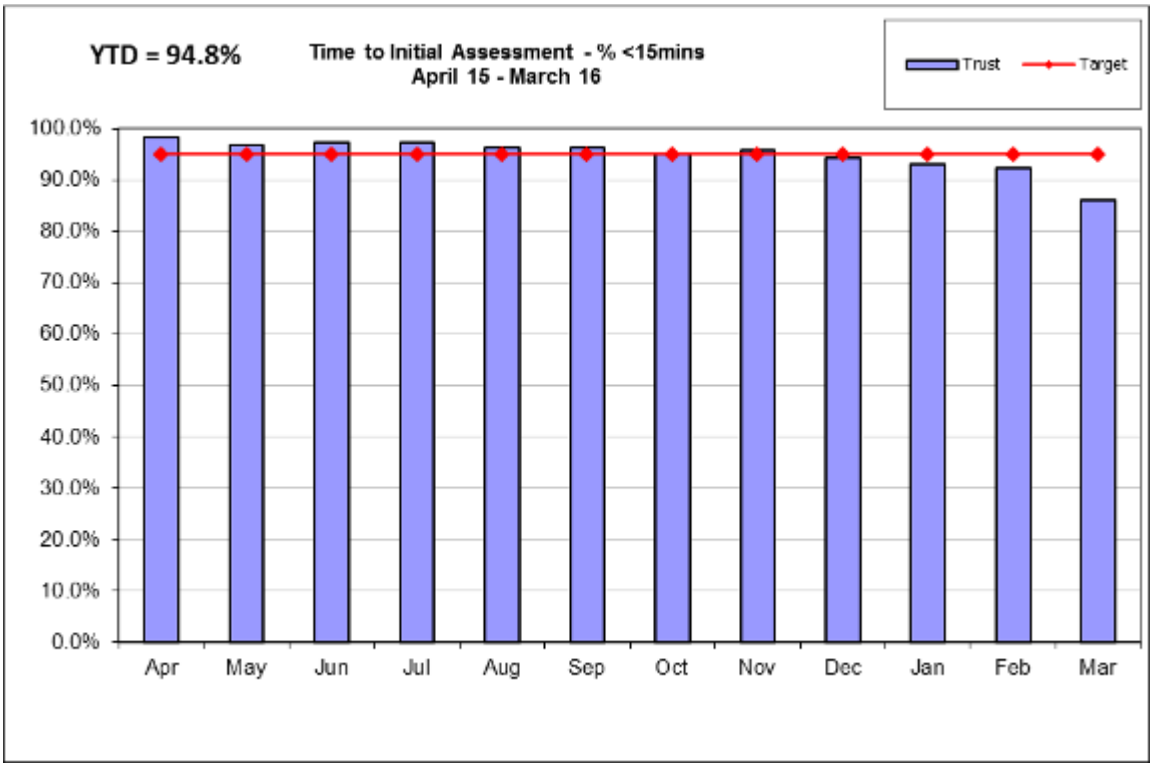
A&E Unplanned Re-attendance Rate – The Trust did not achieve this standard of less than 5% unplanned re-attendance rate at 5.8%.



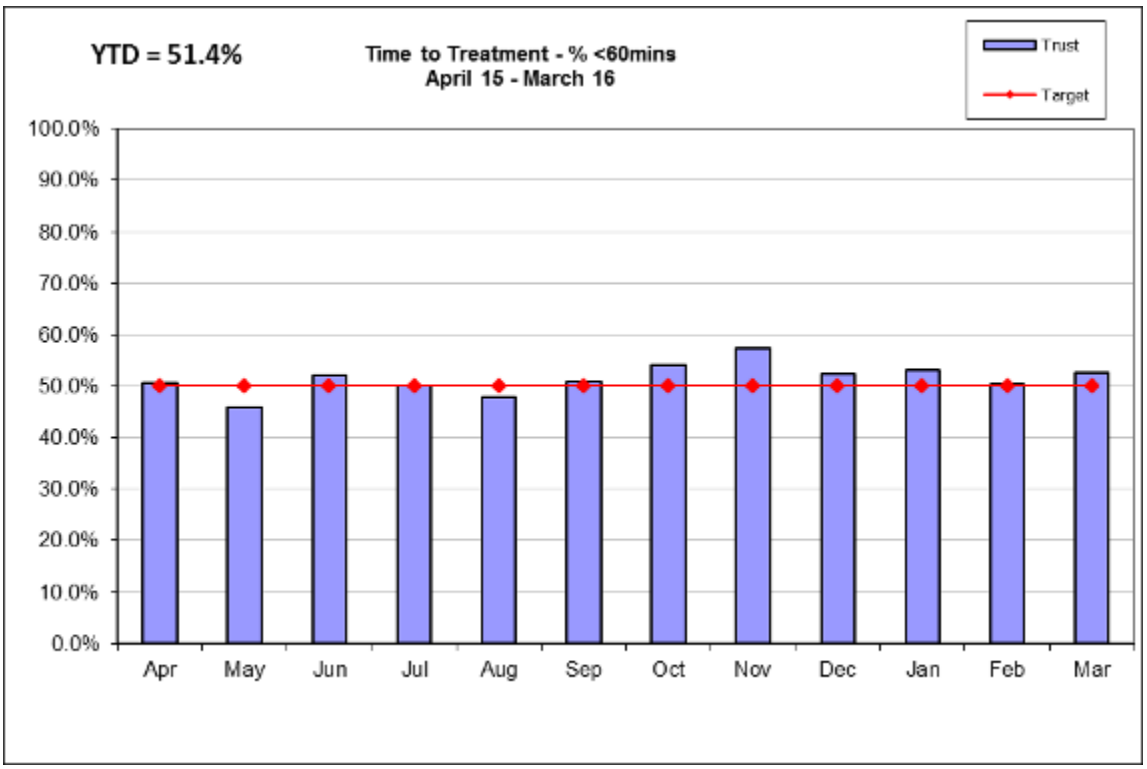
A&E Left without being Seen Rate – The Trust achieved this standard, of less than 5% of patients leaving its A&E Departments without being seen at 2.8%.



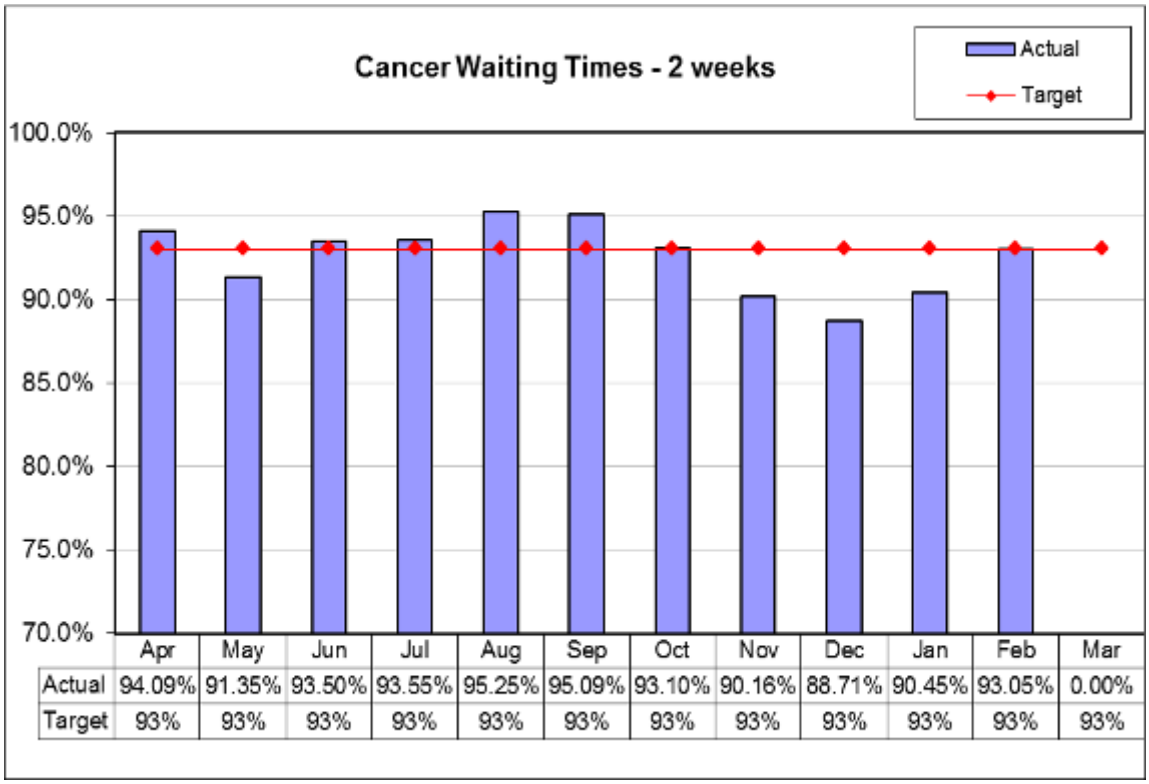
A&E Time to Initial Assessment <15 minutes – The Trust did not achieve this standard of 95% of patients arriving in its A&E Departments being assessed within 15 minutes of arrival at 94.8%.



A&E Time to Treatment <60 minutes – The Trust achieved this standard of 50% of patients arriving in its Emergency Departments being treated within 60 minutes of arrival at 51.4%.

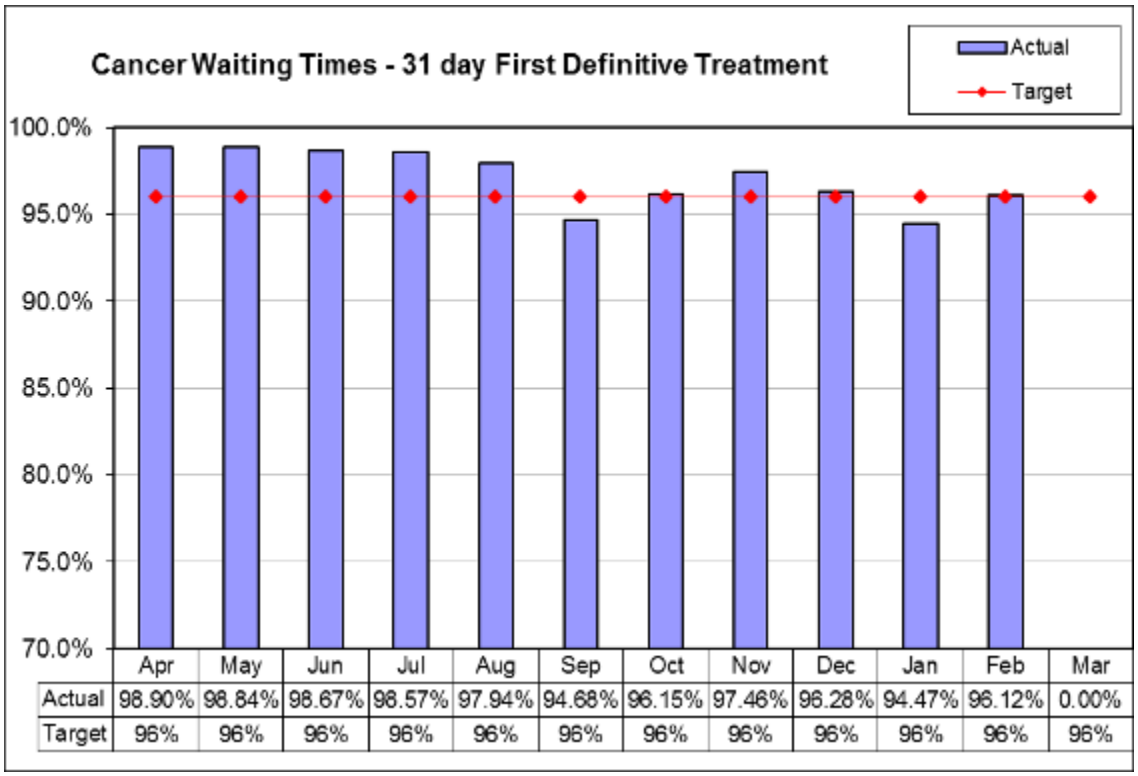


Cancer Waiting Time Targets - 2 weeks from referral – The Trust did not achieve this standard of ensuring that 93% of patients with suspected cancer were seen within two weeks.



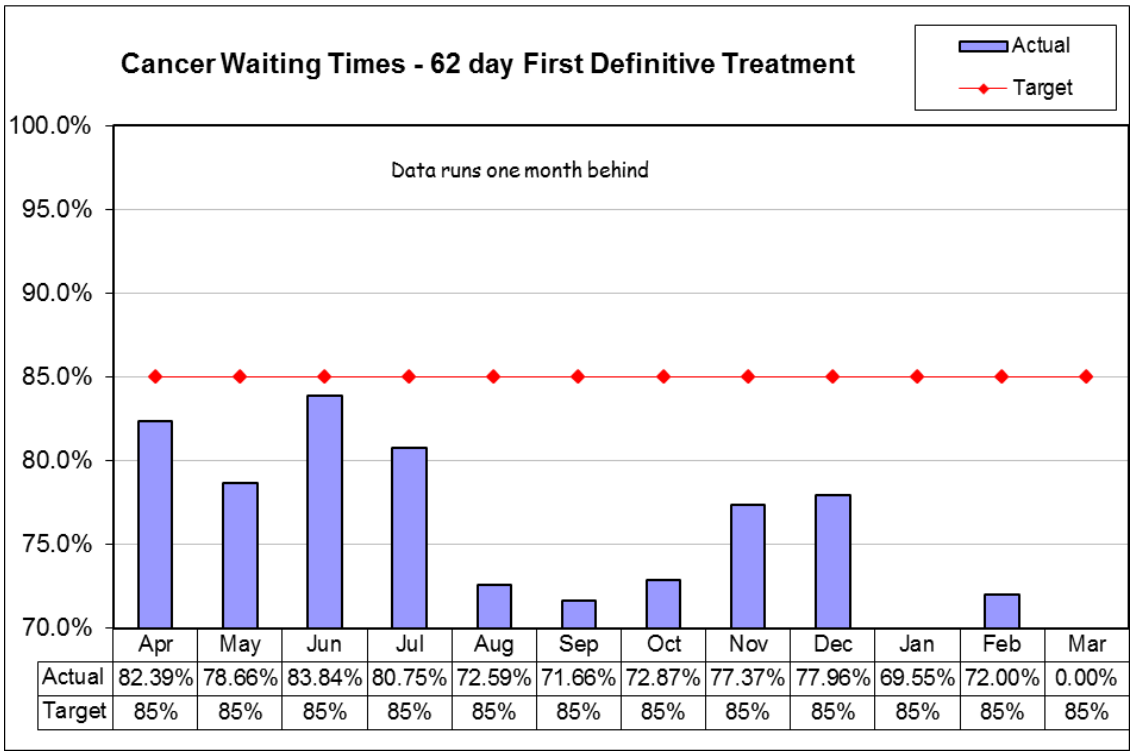
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	94.09%	91.35%	93.50%	93.55%	95.25%	95.09%	93.10%	90.16%	88.71%	90.45%	93.05%	0.00%
Target	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%

Cancer Waiting Time Targets – 31 Day First Definitive Treatment – The Trust did not achieve this standard of ensuring that 96% of patients who needed to start their treatment within 31 days did so.



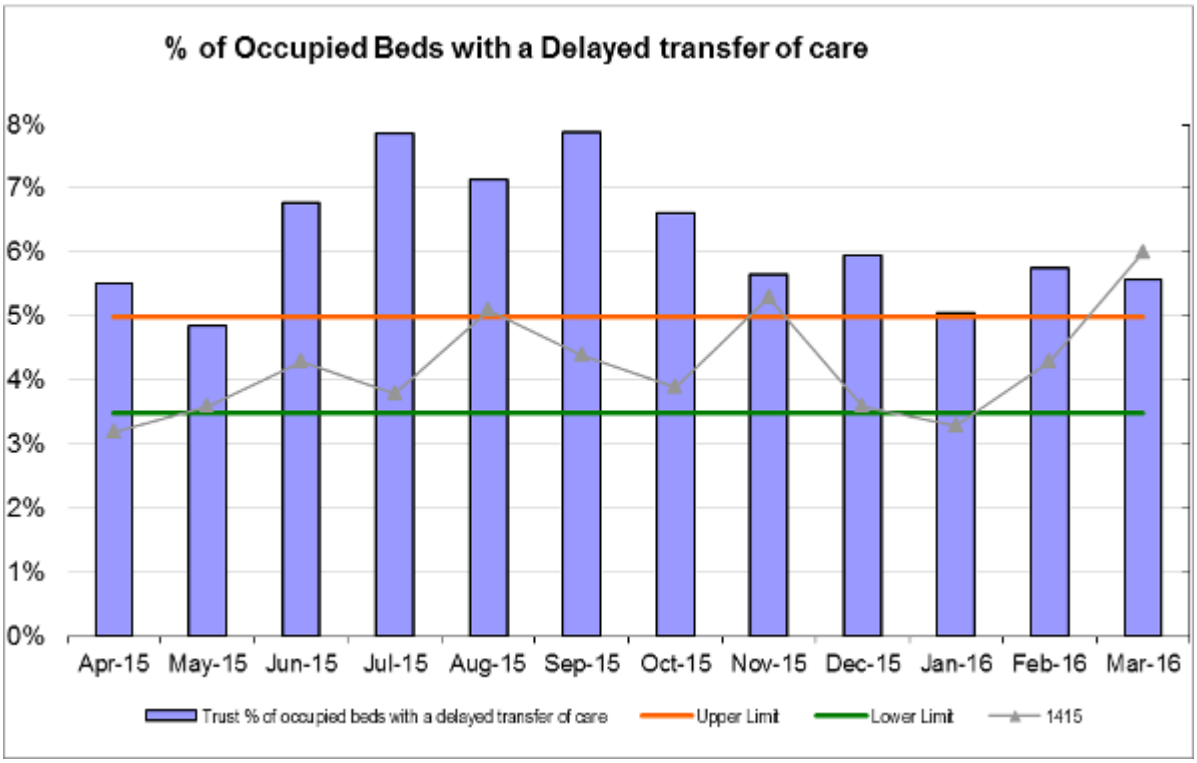
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	98.90%	98.84%	98.67%	98.57%	97.94%	94.68%	96.15%	97.46%	96.28%	94.47%	96.12%	0.00%
Target	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%

Cancer Waiting Time Targets – 62 day First Definitive Treatment – The Trust did not achieve this standard of 85% of patients who needed to start their first definitive treatment within 62 days did so.

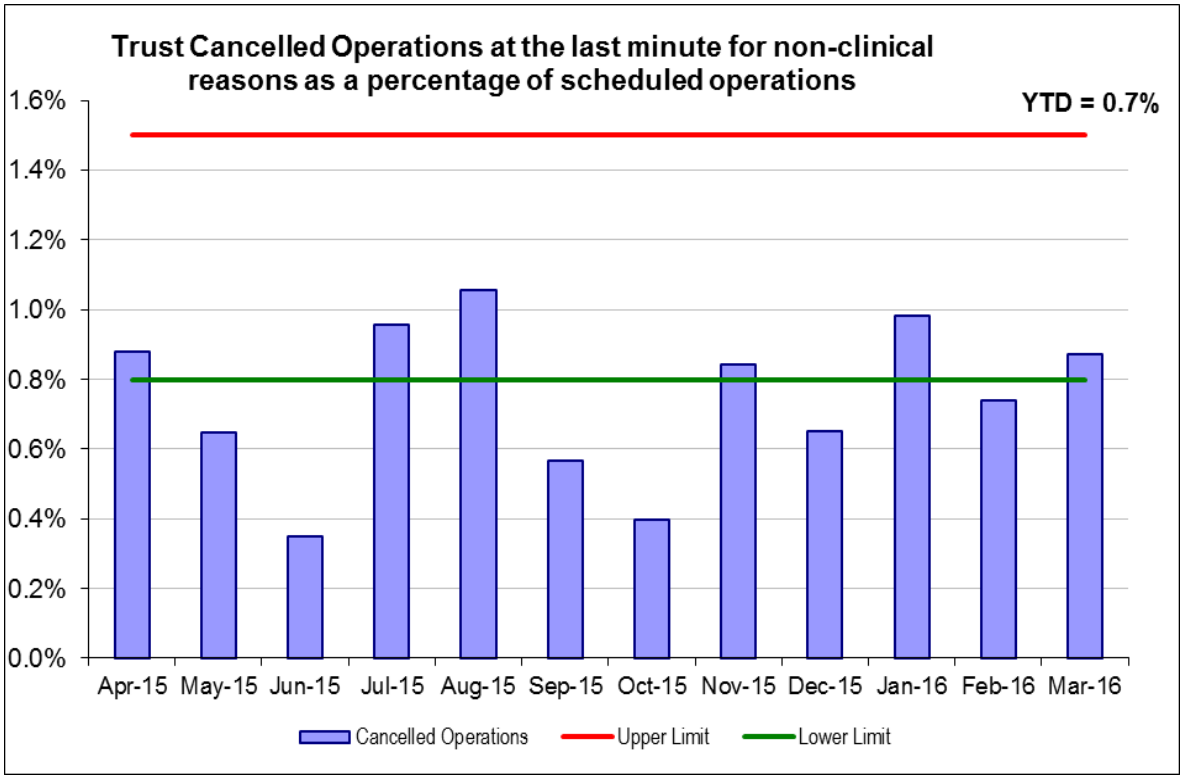


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	82.39%	78.66%	83.84%	80.75%	72.59%	71.66%	72.87%	77.37%	77.96%	69.55%	72.00%	0.00%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

Delayed transfers of care – The Trust did not achieve this standard of Delayed transfers of care remaining below the national limit of 3.5% for the year at 6.2%.



Cancelled operations – The Trust achieved the cancelled operations national standard of 0.7% for the seventh year running.



National Indicators

There are a variety of national indicators highlighted within the Outcomes Framework that each Trust is required to report on.
Maidstone and Tunbridge Wells NHS Trust considers that this data is as described for the following reasons:-

The Trust has achieved level 2 for the Information Governance Toolkit. As part of this process audits of clinical coding and non-clinical coding have been undertaken as well as completing the "completeness and validity checks".

In addition three key indicators are selected and audited each year as part of the Trust's assurance processes. This is over and above the indicators audited as part of the audit of these quality accounts.

The NHS Outcomes framework has 5 domains:

1. Preventing people from dying prematurely
2. Enhancing the quality of life for people with long-term conditions
3. Helping people to recover from episodes of ill health or following injury
4. Ensuring that people have a positive experience of care
5. Treating and caring for people in a safe environment and protecting them from avoidable harm

Domain	**Prescribed data requirements** **The data made available to the National Health Service Trust or NHS foundation Trust by the Health and Social Care Information Centre with regard to —**	**2015/16 local and national data**	**2014/15 local and national data**	**National average**
1 & 2	(a) the value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period; and (b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period. *The palliative care indicator is a contextual indicator.	100.30 Jul 14 – Jun 15 *(Better)*	101.50 Jul 13 – Jun 14 (Worse)	100
3	PROMS			
	i) groin hernia surgery	No data available	0.084	0.084
	ii) varicose vein surgery		N/A	N/A
	iii) hip replacement surgery		0.464	0.437
	iv) knee replacement surgery		0.320	0.315
	during the reporting period *(See below for explanation of reporting data)*		(Apr 14 to Mar 15)	(Apr 14 to Mar 15)
3	the percentage of patients aged— i) 0 to 14; and (ii) 15 or over, readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.***1**	**Trust** 10.4% **Elective** 5.3% **Non-Elective** 11.2%	**Trust** 10.9% **Elective** 5.5% **Non-Elective** 11.6%	(Q1 13/14 position) **Elective:** 6.81% **Non-Elective** 14.10%
4	the percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.	82.9	77	79 (2015/16)

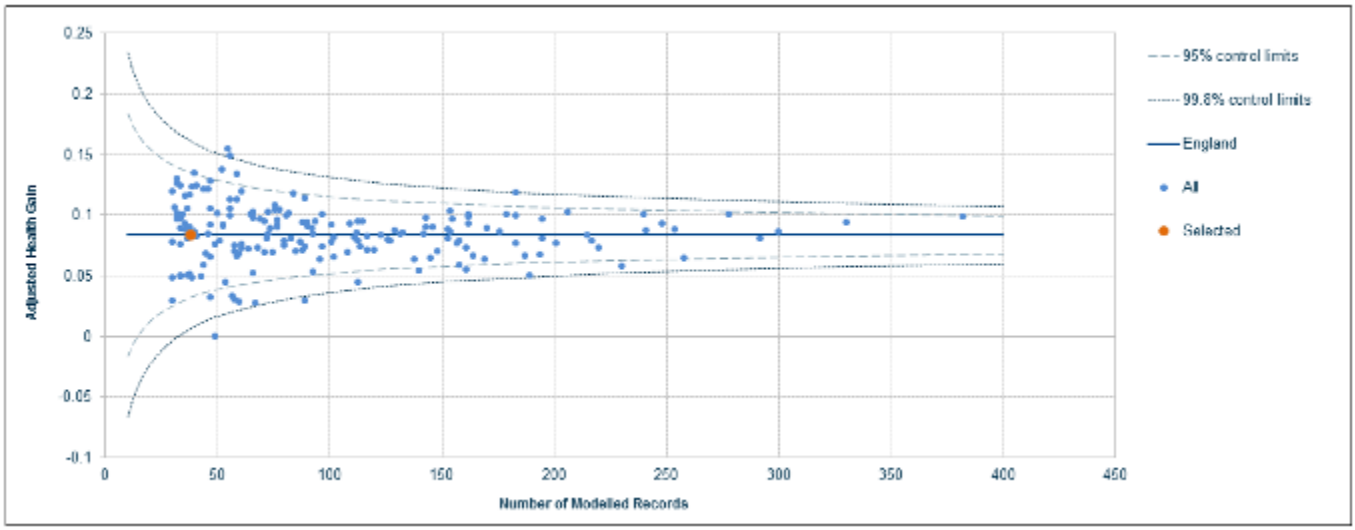
Domain	Prescribed data requirements **The data made available to the National Health Service Trust or NHS foundation Trust by the Health and Social Care Information Centre with regard to —**	2015/16 local and national data	2014/15 local and national data	National average
5	the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period	95.3%***2**	95.5%	96.0% (Jan 2015)
5	the rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.	7.4 ***3**	12.0	15.5
5	The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, The number and percentage of such patient safety incidents that resulted in severe harm or death. *(See below for explanation of reporting data)*	6911 1.2%	6173 1.6%	

*1 Local and national data is based on 30 day re-admission.
*2 Q4 not yet published so taken from local data.
*3 Figure based on local data as national data not published at time of report. National denominator figure derived from HES data, local denominator derived from KH03 return.

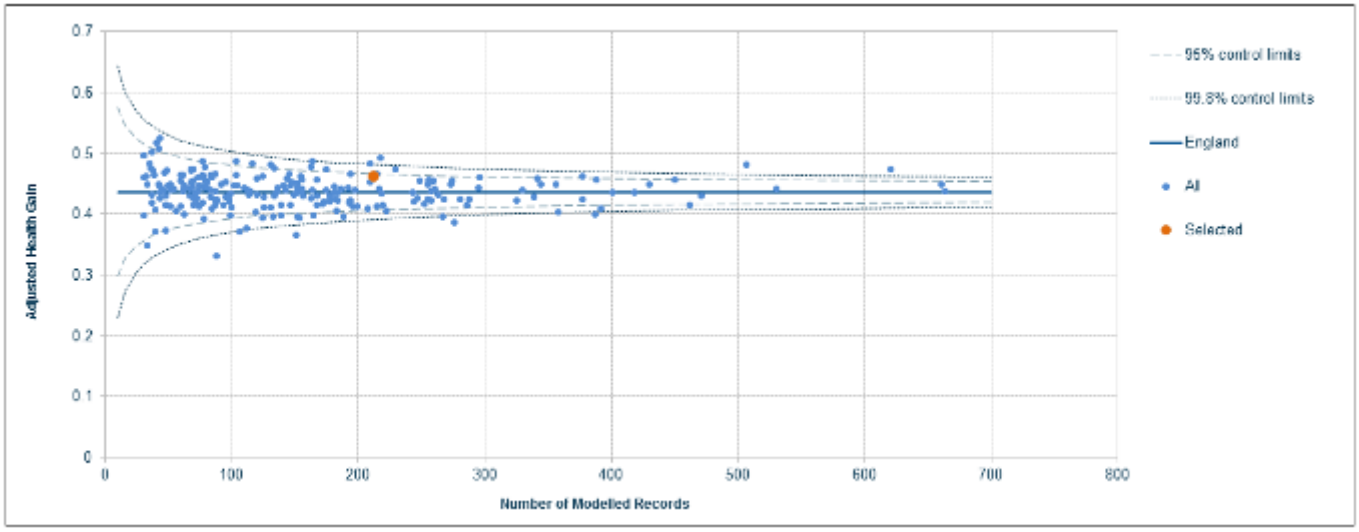
Patient Reported Outcome Measures (PROMs)
The NHS asks patients about their health and quality of life before they have an operation, and about their health and the effectiveness of the operation afterwards. Data is collected in the form of a patient questionnaire. This helps to measure and improves the quality of care.

There are four surgical procedures for which PROMs data is captured: Groin hernia, Hip replacement, Knee replacement and Varicose veins. Results are uploaded on the Health and Social Care Information Centre (HSCIC) from which the graphs below are provided. Data published in February 2016 (based on April 2014 to March 2015) shows all 3 surgical procedures showing an improvement in health gain following an operation (note that there was insufficient data for varicose veins surgery)

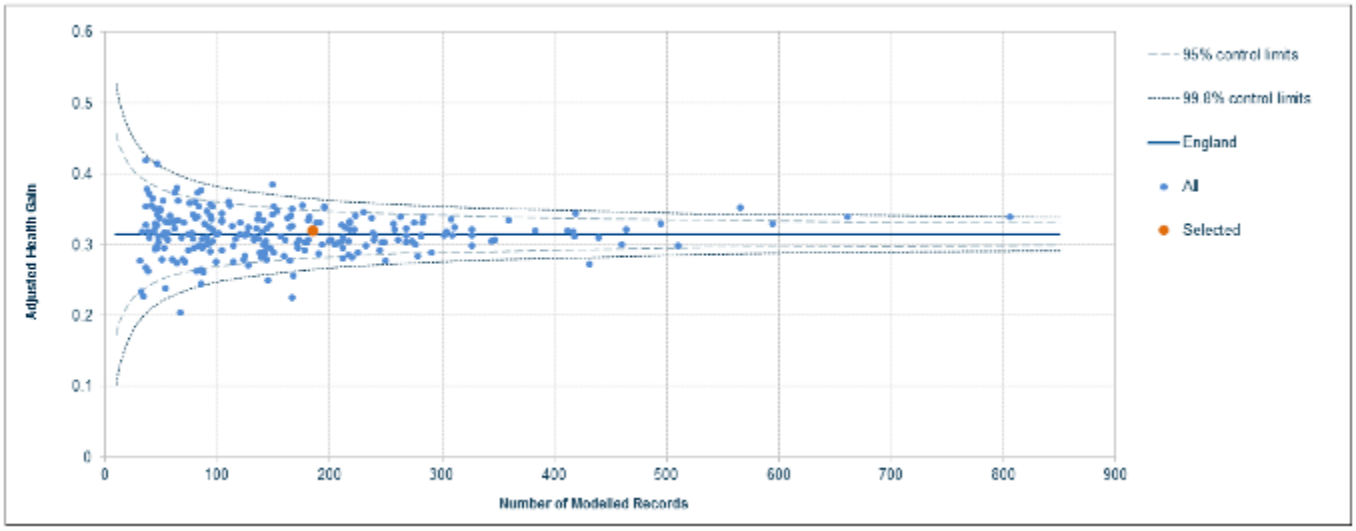
Groin Hernia – 38 returns of which 25 reported an improvement in health following the procedure.



Hip Replacement – 211 returns of which 194 reported an improvement in health following the procedure.



Knee Replacement – 185 returns of which 155 reported an improvement in health following the procedure.



Patient Safety Incidents

The proportion of patient safety incidents which resulted in severe harm or death for 2015/16 was 1.2% (1.6% 2014/15). This is calculated by dividing the number of serious and catastrophic incidents reported by Maidstone and Tunbridge Wells NHS by the total number of patient safety incidents 6911 (6173 for 2014/15)

How performance compares with the national average for this indicator where the data is available and meaningful:

The latest report from the National Reporting and Learning System (NRLS), which was published in March 2016 and covers the period of 01/04/15 to 30/09/15, provided a reporting rate of 26.02 compared to 22.9 the same time last year. The rate of incidents reported is per 1,000 bed days. This places the Trust within the lowest 25% of reporters

Improving performance
Maidstone and Tunbridge Wells NHS Trust is taking the following actions to improve performance, and so the quality of its services. Monitoring and actions to further improve include the following:

Mortality data
A Trust Mortality Surveillance Group, established in its current form in January 2016, meets monthly to review mortality data, identify trends and share learning. New process of triangulating data, an improved mortality review form and processes for patient notes access have been implemented. The group reports bi-monthly into Trust's Clinical Governance Committee and is chaired by the Medical Director.

Cdifficile
We have a rolling programme of audits to ensure three key indicators are reviewed every year in relation to Cdifficile, 18 week referral to treatment and A&E four-hour waits.

Serious Incidents
Serious incidents involving severe harm and death are investigated using Root Cause Analysis methodology and monitored via an executive-led panel which meets monthly. This group reviews all serious incident investigations and considers the root causes of incidents to identify learning and ensure that actions can be put in place to mitigate the risk of recurrence of similar events. The learning is disseminated across the Trust through Directorate and Trust clinical governance committees.

Scrutiny
Along with the key priorities for the year these indicators are scrutinised by the relevant governance committees, Trust Management Executive and the Quality Committee.

Additional areas of significant improvement during 2015/16

This section will provide a summary update on the initiatives we prioritised last year:

Infection control

The Trust has seen a further significant improvement in C. difficile rates during the last year. Building on the improvements made in previous years a reduction of 34% overall in hospital attributable cases with a rate of infection of 7.4 cases per 100 000 bed days was achieved. Antimicrobial stewardship has been a key focus with compliance audit data fed back through clinical governance meetings and ongoing review of antimicrobial guidance to ensure that antimicrobial prescribing is optimal and appropriate in all cases.

Complaints management

In 2015 the clinical governance team undertook a review of how to better support the Directorate staff and improve the management of the complaints process. In response to this review and its recommendations we rolled out a pilot programme which was evaluated very positively by staff and showed improvements in the timeliness of complaint responses (74% of all complaints are responded to within 25 working days). The new process includes early contact with complainants to discuss concerns and agree the outcomes they are seeking, central co-ordination of requests for information and compiling a response in conjunction with the department involved. This new system means clinical staff are able to spend more time providing direct care and implementing any changes that arise from complaints.

Following the success of the pilot, this programme has now been extended across the Trust to incorporate all Directorates.

New ward (Acute Medical Unit) and integrated stroke unit at Tunbridge Wells Hospital

The opening a new ward on the Tunbridge Wells Hospital site is a key milestone in work to improve patient flow and ultimately the patient experience.
This project was completed in a comparatively short period of time and demonstrated excellent team work across the whole health economy.
This has enabled us to bring stroke rehabilitation on the main hospital site, so improving the overall experience for patients suffering stroke, the opportunity to develop our frail elderly service and enhance our acute ambulatory care service.

Part 4
Appendices A, B and C

Appendix A

37 National reports were published where the topic under review was relevant to the trust in 2015/16 with action to be taken in 2015/16

National Report Published April 2015 to March 2016	*Report received*	
Acute Care		
National Cardiac Arrest Audit (NCAA)	Yes	Report received June 2015. Cumulative data quality reports published each quarter. Results reviewed awaiting action plan.
Adult Critical Care Case Mix Programme (ICNARC) (Round 2) (CMP)	Yes	Report April 2015. Requested national assessment to be completed.
Emergency Laparotomy Audit (NELA)	Yes	Clinical report received. October 2015. With specialty for assessment and action plan. Results show improvement on all fronts. Surgeons are completing the pre-POSSUM booking passes and consultant surgeon attendances in line with national average. Consultant Anaesthetist attendance is below national average. Mortality below national average.
Severe Trauma (Trauma Audit & Research Network) TARN	Yes	Themed reports published 3 times per year. Latest report received December 2015. Rehab prescription developed in conjunction with TARN database.
National Joint Registry (NJR)	Yes	Report received September 2015. With specialty for assessment.
Adult Community Acquired Pneumonia	Yes	Report received December 2015. Continued education for frontline staff in the need for prompt chest x-ray request. Ensure PGD for antibiotic prescribing in place for A&E and AMU nursing staff to ensure prompt administration of first dose antibiotics. Continued education of doctors in the need for combined antibiotic prescribing for patients with moderate or high severity CAP (CURB65 score 305).
Fitting child (care in emergency departments)	Yes	Report received June 2015 and with specialty for review and action plan development.
HQIP National SAMBA 15 (Society for Acute Medicine Benchmarking Audit)	Yes	Report received October 2015. Training programme to ensure patients should have an Early Warning Score documented and they are seen within 4 hours of arrival by a competent decision maker,
Mental health (care in emergency departments)	Yes	Report received June 2015. Mental health risk assessment proforma (SMART tool) successfully introduced. Mental Health awareness now embedded into A&E induction teaching programme.
Use of Emergency Oxygen (BTS)	Yes	Report received January 2016 and with specialty for review and action plan development.
Blood transfusion		
(National Comparative Audit of Blood Transfusion Programme) National comparative audit of blood transfusion of patient information and consent 2014	Yes	Report received October 2015 and with specialty for review and action plan development
Audit of patient blood management in	Yes	Published October 2015 and with specialty for

National Report Published April 2015 to March 2016	*Report received*	
scheduled surgery		review and action plan development.
National Comparative Audit of blood transfusions: use of Anti-D 2012	Yes	Report received October 2015 and with specialty for review and action plan development
Cancer		
Lung Cancer (NLCA)	Yes	Report received December 2015 and with specialty for review and action plan development
Bowel Cancer (NBOCAP)	Yes	Report received December 2015 and with specialty for review and action plan development
Head & Neck Cancer (DAHNO)	Yes	Report received December 2015 and with specialty for review and action plan development
National Prostate Cancer Audit	Yes	Report received November 2015 and with specialty for review and action plan development
Oesophago-gastric cancer (NAOCG)	Yes	Report received December 2015 and with specialty for review and action plan development
Heart		
Acute coronary syndrome or Acute myocardial infarction (MINAP) 2014-15	N/A	Report publication date delayed until July 2016
Heart failure 2013-14	Yes	Report received November 2015 and with specialty for review and action plan development
Cardiac Rhythm Management (CRM) 2014-15	N/A	Report publication date delayed until May 2016
Coronary angioplasty/ National audit of PCI 2014	N/A	Report publication date delayed until April 2016
Adult Cardiac surgery	NA	MTW does not provide this service
Congenital heart disease (Paediatric cardiac surgery)	NA	MTW does not provide this service
Pulmonary Hypertension	NA	MTW is not a Specialist PH centre.
National Vascular Registry	NA	MTW does not provide this service.
Long Term Conditions		
National (Adult) Diabetes Audit (NDA)	Yes	Report received February 2016 and with specialty for review and action plan development.
Inflammatory Bowel Disease (IBD) Programme - Biologic Therapy only	Yes	242-15/16 Report received September 2015. IBD specialist nurse to be recruited to assist with 3- and 12- month follow-up appointments, submission of patient data onto the IBD Biologics database and PROM forms completed.
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme – PULMONARY REHABILITATION	Yes	Report received October 2015. Discussion to take place with the CCG to obtain funding / staffing to extend the rehabilitation programme to include MRC2 patients.
HQIP National Diabetes Footcare audit	Yes	Report published March 2016. With specialty for review and action plan development,
Rheumatoid and early inflammatory arthritis	Yes	Report received January 2016 and with specialty for review and action plan development.
National Audit of Intermediate Care	NA	Audit not applicable to the Trust.
Chronic Kidney Disease in Primary Care	NA	MTW does not provide this service
Renal Replacement Therapy (Renal Registry)	NA	MTW does not provide this service
Older People		
Falls and Fragility Fractures Audit Programme (FFFAP) pilot	1. Falls	1. Report received November 2015 and with specialty for review and action plan development.
	2. Falls Liaison Service	2. N/A
	3. National Hip Fracture Database	3. Report received October 2015 and with specialty for review and action plan development
Older people (care in emergency departments)	Yes	Report received June 2015 and with specialty for review and action plan development.
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Report received January 2016 and with specialty for review and action plan development.

National Report Published April 2015 to March 2016	*Report received*	
UK Parkinson's	N/A	Report publication date delayed until end May 2016.
Other		
Elective surgery (National PROMs Programme) Hip Replacement, Knee Replacement, Groin Hernia, Varicose Vein	Yes	Report with specialties for review.
Mental Health		
Prescribing Observatory for Mental Health (POMH)	NA	MTW does not provide this service
Suicide and homicide in mental health (NCISH)	NA	MTW does not provide this service
Women's and Children's Health		
MBRRACE-UK; Perinatal Mortality Surveillance report; UK Perinatal Deaths for Births in 2013	Yes	Report received October 2015. All notes are reviewed at multidisciplinary mortality meetings. Learning identified and discussed at Risk Meeting, Clinical Governance Community Midwives team leaders meeting, Maternity Risk update. GAP (Growth Analysis Protocol) Project being implemented. Interpreters for Non English speaking patients. Kick Count being promoted by Community Midwives. This was the first time that many clinicians had used the Cause of Death & Associated Conditions (CODAC) system of death classification. In order to ensure accurate, consistent reporting it's recommended that the coding of the cause of death is undertaken by small local multidisciplinary teams. Cause of death to be checked by Bereavement Midwives or Maternity Clinical Risk Manager following post mortem/ all test reviewed.
MBRRACE-UK; Perinatal Confidential Enquiry; Congenital Diaphragmatic Hernia (CDH)	N/A	MTW does not provide this service
MBRRACE-UK; Perinatal Confidential Enquiry; Antepartum stillbirth in term normally formed infants 2014	Yes	Report received November 2015. Growth should be monitored from 24 weeks by measurement of the symphysis fundal height and plotting the measure on a growth chart. Growth Analysis protocol being implemented from April 2016
Paediatric Inflammatory Bowel Disease; Biologics Round 2 (IBD Programme)	Yes	Report received September 2015. The report has been discussed at MDT meetings and clinical governance. Education programme has been developed on the use of the Infliximab pro-forma that is filled out when patients come to the ward.
National Paediatric Diabetes Audit (NPDA) 2014	Yes	Report received January 2015. With specialty for action plan development
National Pregnancy in Diabetes Audit (NPID) 2014	Yes	Report received November 2015. With specialty for action plan development
Neonatal Intensive and Special Care (NNAP) 2014	Yes	Report received December 2015. New E3 Euroking maternity system downloads data direct to Badger interface. Badger training now included on new Drs induction programme by NNU staff
Paediatric Intensive Care (PICANet)	NA	MTW does not provide this service
National Confidential Enquiries		
Sepsis Study: 'Just Say Sepsis'	Yes	Report published November 2015. Report discussed and assessed at the Trust Sepsis Group Meeting: January 2016 The trust has a protocol that has been ratified and is available on Q-Pulse.

National Report Published April 2015 to March 2016	*Report received*	
		Shortfall was identified in training of F2's and Registrars on the management of sepsis. Training slots to be arranged with clinical tutors. The outreach team carry out mandatory training on sepsis and there is an e-learning package available. Standardised sepsis proforma to aid the identification, coding and treatment of sepsis are in use and available across the trust. A trial of the use of stickers is being implemented to improve the coding and documentation of patients diagnosed with sepsis. A&E has a triage process using PAR scoring to identify patients with suspected sepsis. Nerve Centre is also used to identify these patients and ensure appropriate treatment pathways are followed. The trust undertakes training on the management of Severe Sepsis and Infection control. Interventional radiology service is not available on a 24/7 basis. Consultant cover is available for Medical and Surgical services during the week. Registrar cover at weekends. Consultants are on call at home and have always been contactable when required. ITU opinions are sought and available when required. Urology – No Consultant cover currently provided for hospital at night. A training package is being developed to be included on the trust mandatory training programme on antimicrobial policies and prescribing. There is not currently 24/7 senior microbiology services, plans for implementing this are being reviewed. The trust provides rehabilitation in critical care and a 3 day follow up service on the wards but no formal post discharge follow-up is available due to limited resources. Patients who die with sepsis are discussed at M&M meetings, Autopsies are only done following a Coroner's opinion.
Gastrointestinal Haemorrhage Study: 'Managing the flow'	Yes	Report received July 2015 A Task and Finish Group has been set up to review service provisions in line with the recommendations of this national report. New pathway to be developed between Lower GI and Upper GI consultants to ensure continuity of care. A care pathway is to be developed to incorporate all elements of assessment, escalation of care, documentation and network arrangements. To establish the role of an on-call consultant who will be responsible for major GI bleeds to enable assessment within one hour of the diagnosis of a major bleed. A service to enable 24/7 access to an OGD within the optimal 24 hours is to be set up.

Appendix B

Updated actions on reports received during March 2014 to April 2015. These were awaiting review or had previously been reviewed and action plans developed. These reports have been reviewed and the table below shows which actions have been completed and implemented or where reviews are still outstanding.

National Annual reports published March 2014 - April 2015	Report Received	Improvements
Peri and Neonatal		
Neonatal Intensive and Special Care (NNAP) 2013	Yes	Report received October 2014. Doctors to document in medical notes; date & time conversation with parents, so the data can be entered easily on Badger. Badger training now included o new Drs induction programme for NNU staff.
Children		
National Paediatric Asthma Audit 2013	Yes	Report received April 2014. Asthma awareness training sessions have been implemented; these are attended by all clinical staff working within paediatrics. Patient information leaflets and written asthma plans have been developed and are now in use.
National Childhood Epilepsy 12	Yes	Report received December 2014. Business case for Paediatric Epilepsy Specialist Nurse awaiting finance and trust approval. This should enable children and young people to be seen within 2 weeks of presentation at hospital and reviewed at least annually as necessary.
MBRRACE-UK Saving Lives, Improving Mother's Care. Part of the Maternal infant and prenatal programme.	Yes	Report received December 2014. All the audit reports for this programme have been reviewed and assessed. Triage and Epilepsy Guidelines currently being developed.
National Pregnancy in Diabetes Audit 2013	Yes	Report received August 2014. Patient education sessions on the management of pregnancy with type 2 diabetes to be provided fortnightly by the Diabetes Specialist Nurse and Diabetes Midwife.
UK IBD Paediatric Audit	Yes	Report received August 2014. Guidelines for the management of acute ulcerative colitis are being used and teaching is taking place for nursing staff on the paediatric ward. All patients are now provided with at least annual reviews, but mostly every 3-6 months.
Acute Medicine		
CEM Severe Sepsis and Septic Shock in A&E	Yes	Report received August 2014. A staff training programme has been included on the new intake induction and forms part of the training that the trust Sepsis team delivers on recognition and recording of vital signs, the need to give and document oxygen administration, prompt IV fluid administration, taking and recording of vital signs, the need to take blood cultures before the patient leaves A&E, monitoring of urine output and prompt administration of antibiotics.
CEM Asthma in children in A&E	Yes	Report received January 2015 Staff training to include the need for nurses to monitor and record peak flow and GCS score. Additional triage training to include the need to give salbutamol promptly and prescribe appropriate steroids on discharge.
CEM Paracetamol overdose in adults in A&E	Yes	Report received January 2015 Induction and teaching programme on Toxicology and Poisoning to include information on the timing of measuring of plasma levels, the need for staggered overdose to be treated within one hour of arrival and

National Annual reports published March 2014 - April 2015	Report Received	Improvements
		patients arriving >8 hours after ingestion to be treated as per 2012 MHRA guidelines.
BTS Pleural Procedures 2014	Yes	Report received October 2014 Standardised proforma to be included in chest drain pack to be completed for each insertion and kept in patient notes. Regular teaching programme to be developed for chest drain insertions. Patients with chest drains to be cared for on appropriate specialty respiratory wards.
Acute Care		
National Cardiac Arrest Audit	Yes	Mandatory training sessions continue to be held and competency records maintained.
National Breast Screening Pathology	Yes	Report received October 2014. Standards met so no actions were required. Trust results were in line or above national results.
Long Term Conditions		
National Adult Diabetes Audit 2013	Yes	Report received January 2015 and with specialty for action plan development.
National Review of Asthma Deaths	Yes	Report received April 2014. All people with asthma are now provided with a personal asthma action plan that details their own triggers and current treatment.
National UK IBD Biologics 2013	Yes	Report received August 2014. The trust now participates in the biologics audit or the PANTS research project. Patients are entered on either of these projects depending on whether they fit the PANTS research criteria. New IBD database being set up to allow for monitoring of follow-up and disease activity.
National UK IBD 2012/13 Round 4	Yes	Report received June 2014 and with specialty for action plan development. Registered to us the new IBD national Biologics Therapy Registry. New Gastroenterologist employed from 2014 to increase capacity. This topic is now covered by the National UK IBD Biologics audit.
National Chronic Obstructive Pulmonary Disease (COPD)	Yes	Report received February 2015. Development of the Early Supported Discharge Service as per CCG commissioning is progressing. Business case to improve spirometry services has been drafted and is waiting trust approval.
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Report received December 2014 Fast track bed policy in place to ensure access to stroke unit within 4 hours of admission. Discharge delays discussed at SITREPS meeting. Speech and Language Therapy team carrying out annual dysphagia refresher training. Nursing competencies now include dysphagia awareness.
National Adult Diabetes Inpatient Audit (NaDIA)	Yes	Report received June 2014. Diabetes foot assessment form has been implemented and in use for any patients attending with diabetes. Clinical education sessions now include other clinical areas that do not specialise in diabetic care so that everyone has a general understanding of the management of the adult diabetic patient.
Elective Procedures		
Adult Critical Care Case Mix Programme (ICNARC)		Reports received June 2014. With specialty for action plan development.
National Emergency Laparotomy Audit (NELA) Organisational Report	Yes	The on-call teams now use predictor of mortality and morbidity both pre and post operatively for all emergency patients.
Cardiovascular Disease		

National Annual reports published March 2014 - April 2015	Report Received	Improvements
National Coronary Angioplasty 2012	Yes	Report received July 2014. Operators are regularly reminded to complete data fields for 'risk factors', creatinine levels and 'discharge date/status' on the cardiology IT system 'TOMCAT'.
MINAP 2013/14	Yes	Report received January 2014 Education of junior staff in the prompt prescription of appropriate secondary prevention medication and clear documentation of treatment decisions regarding medication. Ensure transfer of patients to specialist cardiology ward where possible.
Cardiac Arrhythmia 2013 (CRM)	Yes	Report received January 2015 Following implementation of new NICE guidelines, identification of patients suitable for ICD and CRT will be streamlined which will increase our submission numbers.
Heart Failure Audit 2013-14	Yes	Report publication was delayed and only received January 2016 currently with specialty for review and action plan development.
Cancer		
National Bowel Cancer (NBOCAP) 2014	Yes	Report Received March 2015. With specialty for review
National Lung (NLCA) 2014	Yes	Report Received March 2015. With specialty for review.
National Oesopho-Gastric (NAOGC) 2014	Yes	Received December 2014. With specialty for review.
Trauma		
Elective Surgery (PROMS)	Yes	Quarterly Reports received. With specialty for assessment.
National Joint Registry: Hip and knee replacements 2014	Yes	Report received September 2014. With specialty for action plan development.
Hip Fracture (National Hip Fracture Database) (NHFD) 2014	Yes	Report received September 2014. Trust-wide action plan produced from the Hip Fracture Working Group. Fast track bloods and diagnostics to enable fast track through Emergency Department to Ward. New patient information leaflets produced. Pressure damage and mortality reviews undertaken to ensure they remain within or below the NHFD national %.
Heavy Menstrual Bleeding Audit	Yes	National report received August 2014. Business case to extend the existing services to include a dedicated Menstrual Bleeding Clinic.
Sexual Health		
National audit of management of anogenital herpes	Yes	Report received December 2014. Patients are offered treatment at presentation of clinical symptoms began within the last five days. Counselling and support to be offered to patients with suspected clinical herpes. Delivery plan in place.

Appendix C

Summary of local audits undertaken during 2015/16 against NICE Guidelines

Audits of NICE Guidelines are an ongoing process of implementing change and measuring improvement until full compliance is achieved. The following table shows compliance against NICE Guidelines following local Trust audit and details the actions put in place to improve practice when partial or non-compliance was found. Changes will be implemented and a re-audit will be undertaken to identify whether these have led to improvements in practice.

Compliance has been assessed as: Fully compliant if all standards have been met. Partially compliant when >50% of the standards have been met. Non compliance is where less than 50% of the standards have been met.
CG = Clinical Guidelines TA = Technology appraisal IPG = Interventional Procedures Guidance

NICE Guidance	Compliance	Actions taken as a result of the audit/Evidence of compliance
NICE TA269; BRAF testing and the use of BRAF inhibitors in unresectable or metastatic melanoma	Partially compliant	Local guidelines to be developed for the management of vemurafenib associated rash. Patients who are BRAF positive should continue to be offered BRAF inhibitors unless they fit the exclusion criteria.
NICE TA145 Re-Audit: The use of cetuximab in the treatment of locally advanced squamous cell cancer of the head and neck	Fully compliant	No actions required as standards met.
NICE CG164 Audit: Identifications of Breast Cancer patients for genetic testing	Partially compliant	The referral pathway for genetic testing needs to be optimised to take into account the family history as well as phenotypical characteristics. To involve representatives from Guy's Genetic Unit when developing pathway.
NICE CG139; Central Venous Access Devices.	Partially compliant	To increase education concerning cannula insertion record documentation by bespoke ward based training to reinforce awareness of documentation requirements. Standard CVAD dressings are not efficacious. Obtain approval from IPCC to move to Tegaderm IV advanced CVC and PICC dressings as standard ward based stock. Visit wards at 3 monthly intervals for spot-checks and mini audits to provide feedback on improvements and provide local targeted education
NICE CG32 Re-audit: Use of Naso Gastric Tubes for Enteral Feeding	Partially compliant	We have increased our compliance from the last audit but we are still not reaching the required standards. NGT Competency framework to be updated to include NGT sticker completion
NICE CG094 - Early Management of Unstable Angina & NSTEMI in patients admitted to TWH only	Partially compliant	Educate colleagues in the need to calculate and record GRACE score and risk stratification of UA/NASTEMI patients to be reinforced. GRACE template to be added to the cardiology referral forms completed by the medical teams. Discuss the feasibility of having an ambulatory pathway for low risk UA/NSTEMI patients to be allowed home and recalled with 7-14 days for angiography
NICE TA120 - Heart Failure - cardiac resynchronisation - Do patients receiving CRTP/CRTD devices meet the criteria	Not compliant	Design a CRTP/CRTD insertion check list to be filed in the patients' notes to ensure all criteria are met prior to insertion. Where criteria are not met record should be made MDM discussion.
NICE TA94 Appropriate use of	Fully	All patients with a confirmed coronary artery disease

NICE Guidance	Compliance	Actions taken as a result of the audit/Evidence of compliance
statins in patients with ischaemic heart disease	compliant	met the standards of having a statin prescribed with a low acquisition cost. However, this audit highlights the need to improve documentation of medication decisions and discussion with patients.
(NICE CG146 Osteoporosis - fragility fracture) Osteoporosis prevention in older patients with fragility fractures	Not compliant	The main recommendation is that these results should be given to the CCG, who should consider commissioning a Fracture Liaison Service to proactively identify, investigate and treat the patients presenting to the hospital with a non-hip fracture, as, with the current system, less than half of patients discharged from A & E have an osteoporosis assessment following a low impact fracture.
NICE TA187 - Crohn's Disease and infliximab at Maidstone Hospital	Not compliant	All Biologic therapy cases to be discussed at IBD MDM before starting therapy and again at 12 months, add this criterion on the Pharmacy request form for Biologic therapy. Appoint an IBD nurse specialist to allow 3 month and 12 month reviews.
NICE CG141 Management of Upper GI Haemorrhage incorporating	Not compliant	Olympus to add drop-down box to report template that endoscopists can enter the Rockall score predicting mortality post-endoscopy. Ensure the FFP is given during resuscitation if INR >1.5 unless there is a documented clinical decision. Admitting clinicians to specify patient to be kept 'nil by mouth' if endoscopy requested. Add 'NBM' to proforma so patients aren't fed before OGD. Publicise the iSoft request forms can be used for expediency.
NICE CG165 Hepatitis B (chronic) (adults only)	Fully compliant	We are fully compliant with all the standards that we were able to measure against.
NICE CG92; VTE trustwide re-audit	Partially compliant	It will be the responsibility of the ward, unit and department to notify Doctors if the 24 hour risk assessment has not been done. Continue to monitor for any missed doses of chemical thromboprophylaxis. At every Mandatory Training and RN Induction programmes reinforce the importance of documentation and the need to prescribe AES.
NICE IPG254; Assessing the efficacy (sensitivity and specificity) and safety of Endobronchial Ultrasound (EBUS) guided transbronchial aspiration (TBNA) mediastinal lymphnode biopsies at Maidstone Hospital	Partially compliant	To procure the navigational EBUS system that would facilitate the accurate biopsy of lesions located in difficult to reach areas. Consultant to discuss with managers about the augmentation of our EBUS system with the navigational system. Preparation of cell blocks from needle-wash and preserving needle wash samples for further testing will facilitate the concentration of cells using ficol-hypaque or cytospin media, thus facilitating further phenotypic characterisation of abnormal cells for the diagnosis of lung cancers. .
NICE TA143 & 233 Ankylosing Spondylitis - Biologics	Partially compliant	Lack of documentation, diagnosis at another centre and delayed response were the main reasons for certain criteria not being fulfilled. These can be rectified and partially historic. We have recruited one more nurse specialist and this may allow more regular monitoring to meet the criteria for 3 monthly monitoring.
NICE CG15 - Management of Type 1 Diabetes in children and	Partially compliant	Contact diabetic team on every admission of children or young people with diabetes as soon as possible

NICE Guidance	Compliance	Actions taken as a result of the audit/Evidence of compliance
young people		Document all discussions with the child and carer, regarding the decision making process and the regimes offered Coeliac and Thyroid functions tests to be carried out on the ward, education to ward staff and Medical staff at their Induction
NICE NG1; Re-audit of the management of children with Gastro-Oseophageal reflux / disease in MTW	Not compliant	Clinicians should ensure that diagnosis is made as per the NICE guidelines and clearly classify the symptoms into Gastro-oesophageal Reflux or Gastro-oesophageal Reflux disease. Clinicians should consider not using Metaclopromide, Erythromycin or Domperidone in management of GORD Clinicians should recommend use of thickened formula as one of the steps in management of simple GOR. Clinicians should discuss cases with severe reflux or children with unusual presentations of reflux with the paediatric gastroenterology team before referring for pH study or Endoscopy
NICE CG99; Re-audit of Diagnosis & Management of Idiopathic Constipation in Secondary Care setting for children and young people	Not compliant	Constipation and management, included in teaching sessions to Paediatric Junior Doctors as part of their regular teaching programme Use the Information produced by the previous audit team and distribute them to Riverbank & Woodland Units
NICE CG112; Retrospective audit of quality of Neonatal "Feed and Wrap" MRI Scans	Not compliant	It is apparent that our current technique of 'feed and wrap' MRI scanning is not giving us good quality scans. Develop a new guideline to reflect the use of chloral hydrate sedation for routine neonatal MRI scans, to be available on Q-pulse. All babies requiring MRI scan should be sedated with chloral hydrate according to the dosing above. All babies must have oxygen available and saturation monitoring performed during and after the scan.
NICE CG55; Audit of Polycythaemia in the New born	Not compliant	Training of midwives and obstetric doctors of the need to not clamp and cut the baby's cord until 60 seconds following birth, or that cord milking is performed instead, if immediate resuscitation is required. Paediatricians to be proactive in encouraging appropriate delayed cord clamping
NICE CG176; Re-audit of Paediatric Neurological Documentation	Not compliant	All staff looking after children and young people to be trained in neurological assessment and the need for observations to be recorded competently and accurately. Band 6 Nurse to be identified to assist with supporting staff nursing patients with neurological conditions. Assess the current neurological observation chart to ensure it is fit for purpose.
NICE CG151; Re-audit of the Management of Febrile Neutropenia Patients (Paediatric Oncology Service)	Partially compliant	A clear referral pathway for the management of the unwell child undergoing chemotherapy needs to be developed. Consolidate febrile neutropenia guidance into a flow chart for the Unwell Oncology Child Increased ward based education for the immediate care of an unwell child who is receiving chemotherapy
NICE CG16; Re-audit of Management of paediatric Deliberate self-harm (DSH) (2/1415)	Not compliant	Education package for all ED medical staff, including psychiatric assessment (MSE) and risk assessment (statement of risk, use of Smart tool) and of the importance of notifying the Child Protection Nurse.

NICE Guidance	Compliance	Actions taken as a result of the audit/Evidence of compliance
NICE CG111 - An audit of MTW's management of Nocturnal Enuresis	Partially compliant	Detailed history should be taken as per the NICE guidelines and documented in the medical notes and clinic letters Alarms should be offered as a first line in all children above 5 years with bedwetting and parents should be counselled about the use of alarms and motivated to continue them if there is a response. Parents should be given information about the ERIC website. Leaflets could be designed for this purpose. Business case to be made for a specialist nurse led enuresis clinic, where these children could be assessed at 4 weeks following start of treatment. They could also act as a first port of contact for the management of these children including offering support to the families and children
NICE CG54; Re-audit of Urinary Tract Infection in children: diagnosis, treatment & long term management	Partially compliant	History taking and documentation of UTIs needs to be improved. Staff to be reminded of the flow chart which is readily available for use. Consultants to ensure that UTIs are treated with a 10 day course of antibiotics at the time of discharge.
NICE CG92: Extended VTE prophylaxis in oncology patients undergoing major abdominal surgery	Fully compliant	All patients evaluated undergoing major elective abdominal surgery for cancer are appropriately prescribed extended VTE prophylaxis on discharge
NICE IPG113; Audit: Surgical and patient reported outcomes following Dacryocystorhinostomy (DCR)	Fully compliant	General standards have been met therefore no clinical concerns or risks to patients To improve medical recording of pre-operative and post-operative assessment of patients with epiphora needing DCR, design a proforma which will be used in all theatres for pre-operative and postoperative assessment for patients.
NICE CG145; Management of spasticity in children and young people with non-progressive brain disorders: Paediatric Orthopaedic Patients	Not compliant	Whilst standards are not fully met the reaudit has shown there have been significant improvements managing spasticity as a result of the introduction of the proforma from the previous round. A new patient leaflet on botox treatment has been introduced to inform patients about the treatment process. Paediatricians will be copied into all clinic letters with the aim to improve communication between orthopaedic doctors and paediatricians. All new patients will be referred to physiotherapists to make sure that they receive a review by this team.
NICE CG3; Audit of Pre-Assessment Blood Tests and Investigations for Gynae Surgery	Partially compliant	To liaise with the anaesthetic department lead for pre-assessment, to review the current practice and consider changes to the pre-operative investigations protocols for gynaecology day case surgery
NICE IPG's 267, 280, 282, 283 & 284 - An audit of Prolapse Surgery Management (	Partially compliant	Laparoscopic apical prolapse surgery should be preferred method of surgical repair in younger, sexually active patients
NICE CG44; Audit of Intra-operative Novasure Failure Rate	Not compliant	All patients to have USS organised prior to “Novasure” procedure. Risk of failure of procedure to be documented on consent form as currently 10% risk of failing. Training session given by “Novasure” rep on troubleshooting if cavity assessment fails.
NICE CG129; Re-audit of Antenatal Care in Twin	Partially compliant	Guidelines to be available in the Multiple Pregnancy clinical room to ensure all staff are aware of the

NICE Guidance	Compliance	Actions taken as a result of the audit/Evidence of compliance
Pregnancies		guidelines for the management of multiple pregnancies. Relevant fetal cardiac referrals to be made by the Specialist midwife at the first twin antenatal clinic appointment. Assessment regarding the need for aspirin to be made by the Specialist midwife at the first twin antenatal clinic appointment. Specialist midwife to ensure a full blood count is taken between 20-24 weeks, this has been added to the proforma.
NICE CG110 - Audit of the management of pregnancy and complex social factors	Fully compliant	No actions required as all notes audited were fully compliant with the standards.
NICE CG70; Audit of the management of Induction of Labour	Partially compliant	The IOL guideline is currently being revised to clarify rational for induction at maternal request. Risks versus benefit of IOL particularly for primiparous women should receive greater consideration by consultants. A patient leaflet is being produced to inform women of the risks associated with IOL so that they are able to make a more informed decision.
NICE CG190; Re-audit of the management of retained placenta - Cycle 3	Not compliant	Produce Laminated pathway to be visible on delivery suite. Develop MROP checklist and operation notes to be used with every MROP to assist with meeting standards
NICE CG132; Post-operative Pain Management following Elective Caesarean Section	Partially compliant	Appropriate development of safe regime with input from pharmacy, obstetrics and anaesthetics and nurse specialists for patients self-medicate following C-section. Guideline to be written for safe self-administration of medications by obstetric patients on post-natal ward. Patient information leaflet to supplement patient medication self-administration framework
NICE CG154; Re-audit of Diagnosis & Management of Pregnancy of Unknown Location, Ectopic & Miscarriage within our trust	Partially compliant	Thorough documentation of standardised parameters in viewpoint to allow audit/investigation. A flowchart to be generated for the EPAC scanning room, stating the use of Viewpoint to inform those working out of hours. Registrars informed of the need to be available for review of initial bHCGs to ensure serial ones are carried out. Process to be established for EPAC histology reports to be reviewed by the Gynaecology Clinical Manager. Add EPAC to monthly teaching sessions, to include repetition of progesterone levels (Monday lunchtimes). Information regarding booking at EPAC for scans to be disseminated within other specialities and gynaecology.
NICE CG107; Re-audit of Hypertension in Pregnancy	Partially compliant	Develop a flow chart for postnatal management of Gestational Hypertension, PET and Chronic Hypertension to be displayed in postnatal wards.
NICE CG83 Rehabilitation After Critical Illness. Re-audit	Not compliant	ITU daily sheet to be adapted to include space to record NHS number, altering the order of two of the biochemistry sections, and increasing the size of the CXR analysis box. Re-design comprehensive clinical assessment forms and sheets for the problem lists and goals at the following intervals. Develop a patient/family/carer information leaflet to include: Patient diaries, Information on rehab pathway, Information about the differences between critical care

NICE Guidance	Compliance	Actions taken as a result of the audit/Evidence of compliance
		and ward based care, Named healthcare professional to co-ordinate rehab pathway, Critical care discharge summary. Physiotherapist contact card to be produced for patient/family/carer
NICE TA204:Denosumab for the prevention of Osteoporosis fractures in post-menopausal women – Criteria 2 only (Rheumatology)	Fully compliant in Rheumatology patients audited	Rheumatology fully compliant as standards are met but to share results with Medicine and Orthopaedics teams to ensure patients are appropriately treated in other specialties.

Part 5
Stakeholder feedback

1. West Kent Clinical Commissioning Group
2. Health Overview and scrutiny Committee – Kent County Council
3. Healthwatch Kent
4. Independent Auditors' Limited Assurance Report
5. Statement of Directors' responsibilities

West Kent Clinical Commissioning Group comments on the 2015/16 Quality Account for Maidstone and Tunbridge Wells NHS Trust

We welcome the Quality Account for Maidstone and Tunbridge Wells NHS Trust (MTW). MTW is the main provider of acute NHS services for the population in West Kent. As a CCG we work well with the staff at MTW with the aim of improving the quality and safety of the health care that we commission.

Patient Safety

Learning from incidents is essential and we look at how MTW intends to learn and share from serious incidents as part of our incident closure procedures. The incidents of falls are still of concern and the additional practices of having a thematic database and the use of a newsletter are welcome initiatives. Moreover, we are pleased to see that there will be more 'hands-on 'engagement from the leadership team. The CCG sits on the recently established Mortality Working Group and the focus is the interrogation of the causes of death that occur at MTW and the learning that can be taken from these.

Patient Experience

Listening to feedback from patients and their relatives is essential to enable improvements to care. Also, compliments need to be welcomed and conveyed to staff. The CCG is pleased to see that the Trust is committed to improving the response rates from the Friends and Family Test. Moreover, the Trust's commitment to include service user engagement will compliment other patient feedback mechanisms such as complaints and PALS.

Clinical Effectiveness

Effective patient flow is conducive to improved patient care and outcomes. We are working with all stakeholders to support MTW in reducing the length of stay and facilitating effective discharge. We are pleased to see that the Trust acknowledges the requirement to ensure that that the patient is in the appropriate area for their care. The Trust's commitment to improving ambulatory care is welcome.

Dr Steven Beaumont
Chief Nurse
NHS West Kent Clinical Commissioning Group
23 May 2016

Health Overview and Scrutiny Committee – Kent County Council comments on the 2015/16 Quality Account for Maidstone and Tunbridge Wells NHS Trust

Draft Quality Accounts were submitted to the Kent Overview and Scrutiny Committee, Kent County Council. The Chairman, Robert Brookbank, was unable to provide comment but requested that the committee receives a final version.

Healthwatch Kent comments on the 2015/16 Quality Account for Maidstone and Tunbridge Wells NHS Trust

Healthwatch Kent response to the Quality Account for Maidstone and Tunbridge Wells NHS Trust

As the independent champion for the views of patients and social care users in Kent we have read your Quality Accounts with great interest.

Our role is to help patients and the public to get the best out of their local health and social care services and the Quality Account report is a key tool for enabling the public to understand how their services are being improved. With this in mind, we enlisted members of the public and Healthwatch Kent staff and volunteers to read, digest and comment on your Quality Account to ensure we have a full and balanced commentary which represents the view of the public.

On reading the Account, it is pleasing to see that the length of the document has been reduced significantly from previous years allowing it to be more accessible to readers. We would still like to see a summary document be produced to let the public get a feel for the Trust's activities this past year without the need to digest the whole account which can be daunting to some. Overall the account was easy to follow and understand with minimal jargon which again was an improvement from previous years.

There seems to be a good awareness of issues facing the Trust, particularly with patient flow and discharge from hospital. We know that the Trust is actively trying to address these challenges. Healthwatch would be happy to get involved and help gather feedback from patients about their experiences of these areas.

It is positive to see Translation Services are being improved to help patients, who don't speak English as their first language and also those who might need to use a British Sign Language Interpreter, access services. We would like to hear more about how hard to reach groups have been listened to and how actions have been taking forward to improve their experience of using services provided by the Trust.

Healthwatch Kent would like to be kept informed about the new complaints process which will be implemented. We support the trust's desire to deal with more complaints within the specified 25 days and improve early communication with complainants.

Healthwatch Kent would like to take this opportunity to say that Maidstone & Tunbridge Wells NHS Trust have been very open with Healthwatch Kent and we have worked together on a number of projects this year including the opening of a new ward at Tunbridge Wells Hospital and talking to

patients about the A&E service. We would like to see the Trust do more engagement with the public and listen to their views of how services could be improved.

In summary, we would like to see more detail about how you involve patients and the public from all seldom heard communities in decisions about the provision, development and quality of the services you provide. We hope to continue and develop our relationship with the Trust to ensure we can support you with this.

Healthwatch Kent June 2016

Independent Auditors' Limited Assurance Report comments on the 2015/16 Quality Account for Maidstone and Tunbridge Wells NHS Trust

We are required to perform an independent assurance engagement in respect of Maidstone and Tunbridge Wells NHS Trust's Quality Account for the year ended 31 March 2016 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter
The indicators for the year ended 31 March 2016 subject to limited assurance consist of the following indicators:

- Percentage of patients risk assessed for venous thromboembolism (VTE): selected from the subset of mandated indicators based on discussion with the Trust.
- Rate of clostridium difficile infections: selected from the subset of mandated indicators based on discussion with the Trust.

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of directors and auditors
The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by DH in March 2015 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.
We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2015 to June 2016;
- papers relating to quality reported to the Board over the period April 2015 to June 2016;
- feedback from the Commissioners dated May 2016;
- feedback from Local Healthwatch dated June 2016;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated June
- 2015;
- the latest patient survey dated June 2016;
- the latest national staff survey dated 2015;
- the Head of Internal Audit's annual opinion over the trust's control environment dated May 2016;
- the annual governance statement dated May 2016;
- the Care Quality Commission's Intelligent Monitoring Report dated May 2015; and
- the results of the Payment by Results coding review dated December 2015.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the "documents"). Our responsibilities do not extend to any other information.
This report, including the conclusion, is made solely to the Board of Directors of Maidstone and Tunbridge Wells NHS Trust.
We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Maidstone and Tunbridge Wells NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed
We conducted this limited assurance engagement under the terms of the guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- analytical procedures;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations
Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information. The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.
In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Maidstone and Tunbridge Wells NHS Trust.

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

Grant Thornton UK LLP
Fleming Way
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Crawley RH10 9GT

Statement of Directors' responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- The Quality Accounts presents a balanced picture of the Trust's performance over the period covered;
- The performance information reported in the Quality Account is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- The Quality Account has been prepared in accordance with Department of Health guidance.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board

Date:

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – June 2016

6-12 Results of the National Inpatients Survey 2015 — Chief Nurse

Summary / Key points

This report provides an overview on the Trust results from the National Inpatients Survey (appendix 1) which was conducted in July 2015. The results have been published on the CQC website.

The report also includes a comparison of the Trust' results from the National Inpatients Survey over the past five years and a summary of the Trust scores compared with other nearby Trusts.

The key headlines from this report are as follows:

- The Trust surveyed patients who had an inpatient stay in both sites of the Trust in July 2015. The sample size for the audit was 1,250 patients with a response rate of 56.7% against a National average response rate of 47%
- The results demonstrate some slight improvement compared with the 2014 results in many of questions asked with notable and statistically significant improvements in the following key questions:
    - Did you ever share a sleeping area with patients of the opposite sex?
    - How would you rate hospital food?
    - Did you have confidence and trust in the doctors treating you?
    - After you used the call button, how long did it usually take before you got help?

There were no questions in this year's survey where the Trust saw any statistically significant reduction in the scores compared to the 2014 results. There are however some areas where there has been a slight reduction in our overall scores compared to last year's results which will be addressed in Trust wide and directorate level action plans. Those areas include the experience of patients and their families in relation to discharge planning and the wait for and explanations of medications at the point of discharge.

- Compared with other Trust Scores the Trust scored better than most other Trusts in the following question:
    - Were you ever bothered by noise at night by hospital staff?
- The Trust however scored worse than most other Trusts in the following question:
    - Were you told how you could expect to feel after you had the operation or procedure?

An action plan will be developed with the support of staff and volunteers to address all of the key areas where there is a requirement for improvement.

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive; Patient Experience Committee

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

For 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

1.0 Introduction

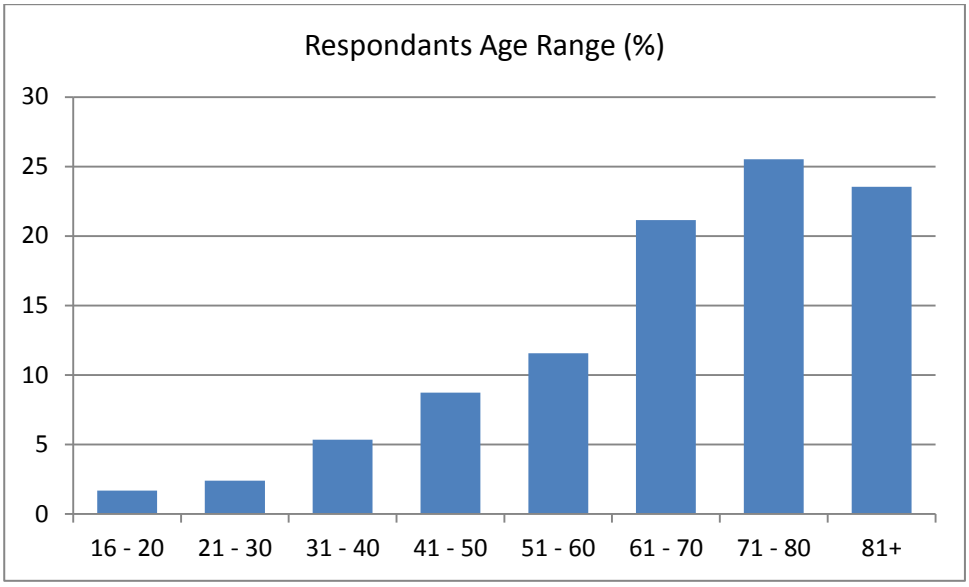
The Results from the 2015 National Inpatient Survey has been published on the CQC site.

As part of the survey the Trust surveyed adult patients (over the age of 16 years) who had an inpatient stay in both sites of the Trust in July 2015. The sample size for the audit was 1,250 patients (previously the sample size was 850 patients) with a response rate of 56.7% (709 patients completed a survey). This compares to a 47% response rate in all Trusts.

The demographic details of the patients who responded to the survey for MTW is as follows: 30.5% of patients were on a waiting list / or planned in advance and 67% of those who completed the survey were admitted as an emergency or urgent admission.

46% respondents were male and 54% respondents were female.

The youngest responder was **16** and the eldest was **100** years old. The table below demonstrates the age range of respondents.



There were 78 core questions (the same as 2014) but of those there were 4 new questions as follows:

- *Q31. In your opinion, did the members of staff caring for you work well together?*
- *Q56. Where did you go after leaving hospital?*
- *Q57. After leaving hospital, did you get enough support from health or social care professionals to help you recover and manage your condition?*
- *Q58. When you transferred to another hospital or went to a nursing or residential home was there a plan in place for continuing your care?*

2.0 Overall results

The results are attached to this report as appendix 2. There is some slight improvement compared with the 2015 results in many of the questions asked with notable and statistically significant improvements in the following key questions:

- Did you ever share a sleeping area with patients of the opposite sex?
- How would you rate hospital food?
- Did you have confidence and trust in the doctors treating you?
- After you used the call button, how long did it usually take before you got help?

Compared with other Trust Scores the Trust scored better than most other Trusts in the following question:

- Were you ever bothered by noise at night by hospital staff?

However compared with other Trust scores the Trust scored worse than most other Trusts in the following question:

- Were you told how you could expect to feel after you had the operation or procedure?

The attached document (appendix 2) demonstrates a comparison of the results of MTW over the past five years. The areas where there has been other improvements, (not statistically significant but none the less indicate some improvement) noted in this year's results are highlighted in green. Those key questions are as follows:

- 3. While you were in the A&E Department, how much information about your condition or treatment was given to you?
- 4. Were you given enough privacy when being examined or treated in the A&E Department?
- 8. In your opinion, had the specialist you saw in hospital been given all of the necessary information about your condition or illness from the person who referred you?
- 11. When you were first admitted to a bed on a ward, did you share a sleeping area, for example a room or bay, with patients of the opposite sex?
- 12. During your stay in hospital, how many wards did you stay in?
- 13. After you moved to another ward (or wards), did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?
- 25. Did you have confidence and trust in the doctors treating you?
- 26. Did doctors talk in front of you as if you weren't there?
- 38. Were you given enough privacy when discussing your condition or treatment?
- 55. How long was the delay?
- 72. Overall…(a greater number of respondents answered 10/10 for overall score)

The Trust scored less well compared to previous year's results in the following questions (highlighted in red in appendix 1)

- 54. What was the MAIN reason for the delay? (increase in delays waiting for medication and to see the doctor)
- 62. Were you told how to take your medication in a way you could understand?
- 65. Did the hospital staff take your family or home situation into account when planning your discharge?
- 69. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital? (e.g. services from a GP, physiotherapist or community nurse, or assistance from social services or the voluntary sector)

In summary it is encouraging to note that in many of the areas where there has been an improvement in the overall scores compared with national and local results. These results reflect some of the work that has been supported in the Trust to make improvements in the past year.

Some examples of the improvements include a review of menus and the process of meal delivery to patients which was undertaken in response to patient feedback and previous PLACE reviews. This would appear to have had a positive impact on some of the scores related to quality of food provided to Patients.

Another area of focus in the past year has been around the importance of staff responding to the nurse call bell promptly. There is increased staff awareness regarding the importance of responding to call bells as quickly as possible. The response times for nurse call bells has been monitored and reported to the Trust Patient Experience Committee and has remained within an agreed acceptable response time.

3.0 Comparison to other Trusts

The Trust has reviewed and compared the results from MTW and other local and neighbouring Trusts. A summary of the comparison is attached in appendix 3.

This summary demonstrates that MTW have scored higher than the other Trusts in 27 out of the 74 questions, highlighted in green. It is helpful to understand how local Trusts have scored as it does provide opportunities to share best practice from colleagues in other organisations which can help us to make improvements which can impact on the overall patient experience.

4.0 Next Steps.

In response to the results from the 2015 results, an action plan will be developed with engagement from both staff and volunteers who work with the Trust, which will enable some focus on some of the key areas where improvement is required.

Some initial discussions have been had relating to action required to support an improvement in the information given to patients regarding how they will feel after a procedure or operation. Some proposed actions include a review of patient information leaflets and a review of the pathway for patients who are admitted to hospital via an unplanned or emergency admission including clarifying information and communication provided to these patients.

This action plan and progress thereafter will be reported to the Trust Management Executive and the Patient Experience Committee.

Appendix 1

Patient survey report 2015

Survey of adult inpatients 2015

Maidstone and Tunbridge Wells NHS Trust

Survey of adult inpatients 2015

NHS patient survey programme
Survey of adult inpatients 2015

The Care Quality Commission

The Care Quality Commission is the independent regulator of health care and adult social care services in England. Our purpose is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care, and we encourage care services to improve. Our role is to register care providers, and to monitor, inspect and rate services. If a service needs to improve we take action to make sure this happens. We speak with our independent voice, publishing regional and national views of the major quality issues in health and social care.

Survey of adult inpatients 2015

To improve the quality of services that the NHS delivers, it is important to understand what people think about their care and treatment. One way of doing this is by asking people who have recently used health services to tell us about their experiences.

The thirteenth survey of adult inpatients involved 149 (one trust was excluded from the national results due to errors when drawing their sample) acute and specialist NHS trusts. Responses were received from 83,116 people, a response rate of 47%. Patients were eligible for the survey if they were aged 16 years or older, had spent at least one night in hospital and were not admitted to maternity or psychiatric units. Trusts sampled patients discharged during July 2015[1]. Trusts counted back from the last day of July 2015, including every consecutive discharge, until they had selected 1250 patients (or, for a small number of specialist trusts who could not reach the required sample size, until they had reached 1st January 2015). Fieldwork took place between September 2015 and January 2016.

Similar surveys of adult inpatients were also carried out in 2002 and annually from 2004 to 2014. They are part of a wider programme of NHS patient surveys, which cover a range of topics including A&E services, children's inpatient and day-case services, maternity services and community mental health services. To find out more about our programme and for the results from previous surveys, please see the links contained in the further information section.

The Care Quality Commission will use the results from this survey in our regulation, monitoring and inspection of NHS acute trusts in England. We will use data from the survey in our system of CQC Insight, which provides inspectors with an assessment of risk in areas of care within an NHS trust that need to be followed up. The survey data will also be included in the data packs that we produce for inspections. NHS England will use the results to check progress and improvement against the objectives set out in the NHS mandate, and the Department of Health will hold them to account for the outcomes they achieve. The NHS Trust Development Authority will use the results to inform quality and governance activities as part of their Oversight Model for NHS Trusts.

Interpreting the report

This report shows how a trust scored for each question in the survey, compared with the range of results from all other trusts that took part. It uses an analysis technique called the '**expected range**' to determine if your trust is performing 'about the same', 'better' or 'worse' compared with other trusts. For more information, please see the 'methodology' section below. This approach is designed to help understand the performance of individual trusts, and to identify areas for improvement.

A 'section' score is also provided, labelled S1-S11 in the 'section scores'. The scores for each question are grouped according to the sections of the questionnaire, for example, 'the hospital and ward,' 'doctors and nurses' and so forth.

This report shows the same data as published on the CQC website (http://www.cqc.org.uk/surveys/inpatient). The CQC website displays the data in a more simplified way, identifying whether a trust performed 'better', 'worse' or 'about the same' as the majority of other trusts for each question and section.

[1] 43 trusts sampled additional months because of small patient throughputs.

Standardisation

Trusts have differing profiles of people who use their services. For example, one trust may have more male inpatients than another trust. This can potentially affect the results because people tend to answer questions in different ways, depending on certain characteristics. For example, older respondents tend to report more positive experiences than younger respondents, and women tend to report less positive experiences than men. This could potentially lead to a trust's results appearing better or worse than if they had a slightly different profile of people.

To account for this, we standardise the data. Results have been standardised by the age, sex and method of admission (emergency or elective) of respondents to ensure that no trust will appear better or worse than another because of its respondent profile. This helps to ensure that each trust's age-sex-admission type profile reflects the national age-sex-admission type distribution (based on all of the respondents to the survey). Standardisation therefore enables a more accurate comparison of results from trusts with different population profiles. In most cases this will not have a large impact on trust results; it does, however, make comparisons between trusts as fair as possible.

Scoring

For each question in the survey, the individual (standardised) responses are converted into scores on a scale from 0 to 10. A score of 10 represents the best possible response and a score of zero the worst. The higher the score for each question, the better the trust is performing.

It is not appropriate to score all questions in the questionnaire as not all of the questions assess the trusts. For example, they may be descriptive questions such as Q1 asking respondents if their inpatient stay was planned in advance or an emergency; or they may be 'routing questions' designed to filter out respondents to whom following questions do not apply. An example of a routing question would be Q43 "During your stay in hospital, did you have an operation or procedure?" For full details of the scoring please see the technical document (see further information section).

Graphs

The graphs in this report show how the score for the trust compares to the range of scores achieved by all trusts taking part in the survey. The black diamond shows the score for your trust. The graph is divided into three sections:

- If your trust's score lies in the orange section of the graph, its result is 'about the same' as most other trusts in the survey.
- If your trust's score lies in the red section of the graph, its result is 'worse' compared with most other trusts in the survey.
- If your trust's score lies in the green section of the graph, its result is 'better' compared with most other trusts in the survey.

The text to the right of the graph states whether the score for your trust is 'better' or 'worse' compared with most other trusts in the survey. If there is no text the score is 'about the same'. These groupings are based on a rigorous statistical analysis of the data, as described in the following 'methodology' section.

Methodology

The 'about the same,' 'better' and 'worse' categories are based on an analysis technique called the '**expected range**' which determines the range within which the trust's score could fall without differing significantly from the average, taking into account the number of respondents for each trust and the scores for all other trusts. If the trust's performance is outside of this range, it means that it performs significantly above/below what would be expected. If it is within this range, we say that its performance is 'about the same'. This means that where a trust is performing 'better' or 'worse' than the majority of other trusts, it is very unlikely to have occurred by chance.

In some cases there will be no red and/or no green area in the graph. This happens when the expected range for your trust is so broad it encompasses either the highest possible score for all trusts (no green section) or the lowest possible for all trusts score (no red section). This could be because there were few respondents and / or a lot of variation in their answers.

Please note that if fewer than 30 respondents have answered a question, no score will be displayed for this question (or the corresponding section). This is because the uncertainty around the result is too great. A technical document providing more detail about the methodology and the scoring applied to each question is available on the CQC website (see further information section).

Tables

At the end of the report you will find tables containing the data used to create the graphs. These tables also show the response rate for your trust and background information about the people that responded.

Scores from last year's survey are also displayed. The column called 'change from 2014' uses arrows to indicate whether the score for this year shows a statistically significant increase (up arrow), a statistically significant decrease (down arrow) or has shown no statistically significant change (no arrow) compared with 2014. A statistically significant difference means that the change in the results is very unlikely to have occurred by chance. Significance is tested using a two-sample t-test.

Where a result for 2014 is not shown, this is because the question was either new this year, or the question wording and/or the response categories have been changed. It is therefore not possible to compare the results as we do not know if any change is caused by alterations in the survey instrument, or variation in a trust's performance. Comparisons are also not able to be shown if a trust has merged with other trusts since the 2014 survey, or if a trust committed a sampling error, in 2014. Please note that comparative data is not shown for sections as the questions contained in each section can change year on year.

Notes on specific questions

Please note that a variety of acute trusts take part in this survey and not all questions are applicable to every trust. The section below details modifications to certain questions, in some cases this will apply to all trusts, in other cases only to some trusts.

All trusts

Q11 and Q13: The information collected by Q11 "When you were first admitted to a bed on a ward, did you share a sleeping area, for example a room or bay, with patients of the opposite sex?" and Q13 "After you moved to another ward (or wards), did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?" are presented together to show whether the patient has ever shared a sleeping area with patients of the opposite sex. The combined question is numbered in this report as Q11 and has been reworded as "Did you ever share a sleeping area with patients of the opposite sex?" Please note that the information based on Q11 cannot be compared to similar information collected from surveys prior to 2006. This is due to a change in the question's wording and because the results for 2006 onwards have excluded patients who have stayed in a critical care area, which almost always accommodates patients of both sexes.

Q31: "In your opinion, did the members of staff caring for you well work together?" is a new question in 2015 and it is therefore not possible to compare with 2014.

Q53 and Q54: The information collected by Q53 "On the day you left hospital, was your discharge delayed for any reason?" and Q54 "What was the main reason for the delay?" are presented together to show whether a patient's discharge was delayed by reasons attributable to the hospital. The combined question in this report is labelled as Q54 and is worded as: "Discharge delayed due to wait for medicines/to see doctor/for ambulance."

Q55: Information from Q53 and Q54 has been used to score Q55 "How long was the delay?" This assesses the length of a delay to discharge for reasons attributable to the hospital.

Q56, Q57 and Q58: "Where did you go after leaving hospital?", “After leaving hospital, did you get enough support from health or social care professionals to help you recover and manage your condition? and “When you transferred to another hospital or went to a nursing or residential home, was there a plan in place for continuing you care?” are new questions in 2015 and it is therefore not possible to compare with 2014.

Q58: This question does not contribute to the Section score for 'Leaving hospital' (Section 9), though is displayed for trusts where 30 or more respondents answered this question. In the instances where 30 or more respondents answered this question, the question score is displayed for the trust. If the row for Q58 is blank, this means that less than 30 responses were received for this question.

Trusts with female patients only

Q11, Q13 and Q14: If your trust offers services to women only, a trust score for Q11 "Did you ever share a sleeping area with patients of the opposite sex?" and Q14 "While staying in hospital, did you ever use the same bathroom or shower area as patients of the opposite sex?" is not shown.

Trusts with no A&E Department

Q3 and Q4: The results to these questions are not shown for trusts that do not have an A&E Department.

Further information

The full national results are on the CQC website, together with an A to Z list to view the results for each trust (alongside the technical document outlining the methodology and the scoring applied to each question):
http://www.cqc.org.uk/inpatientsurvey

The results for the adult inpatient surveys from 2002 to 2014 can be found at:
http://www.nhssurveys.org/surveys/425

Full details of the methodology of the survey can be found at:
http://www.nhssurveys.org/surveys/833

More information on the programme of NHS patient surveys is available at:
http://www.cqc.org.uk/content/surveys

More information about how CQC monitors hospitals is available on the CQC website at:
http://www.cqc.org.uk/content/monitoring-nhs-acute-hospitals

Survey of adult inpatients 2015

Maidstone and Tunbridge Wells NHS Trust

Section scores

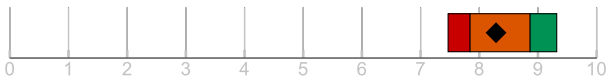
Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2015

Maidstone and Tunbridge Wells NHS Trust

The Emergency/A&E Department (answered by emergency patients only)

Q3. While you were in the A&E Department, how much information about your condition or treatment was given to you?



Q4. Were you given enough privacy when being examined or treated in the A&E Department?

Waiting list and planned admissions (answered by those referred to hospital)

Q6. How do you feel about the length of time you were on the waiting list?

Q7. Was your admission date changed by the hospital?

Q8. Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?

Waiting to get to a bed on a ward

Q9. From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?

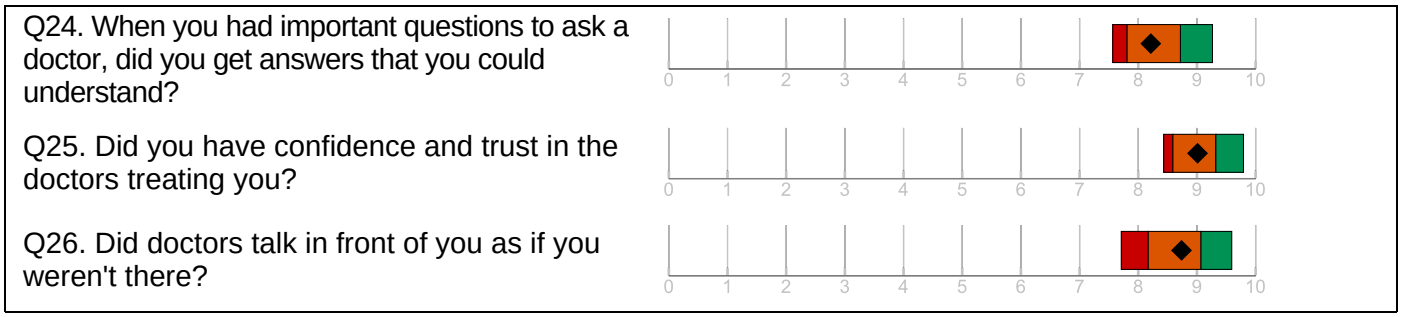
Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2015

Maidstone and Tunbridge Wells NHS Trust

The hospital and ward

Doctors



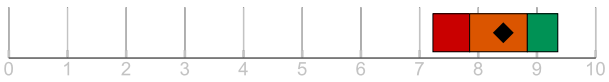
Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2015

Maidstone and Tunbridge Wells NHS Trust

Nurses

Q27. When you had important questions to ask a nurse, did you get answers that you could understand?



Q28. Did you have confidence and trust in the nurses treating you?

Q29. Did nurses talk in front of you as if you weren't there?

Q30. In your opinion, were there enough nurses on duty to care for you in hospital?

Care and treatment

Q31. In your opinion, did the members of staff caring for you work well together?

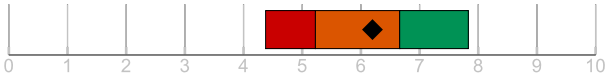
Q32. Did a member of staff say one thing and another say something different?

Q33. Were you involved as much as you wanted to be in decisions about your care and treatment?

Q34. Did you have confidence in the decisions made about your condition or treatment?

Q35. How much information about your condition or treatment was given to you?

Q36. Did you find someone on the hospital staff to talk to about your worries and fears?



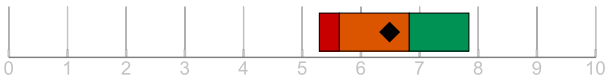
Q37. Do you feel you got enough emotional support from hospital staff during your stay?

Q38. Were you given enough privacy when discussing your condition or treatment?

Q39. Were you given enough privacy when being examined or treated?

Q41. Do you think the hospital staff did everything they could to help control your pain?

Q42. After you used the call button, how long did it usually take before you got help?

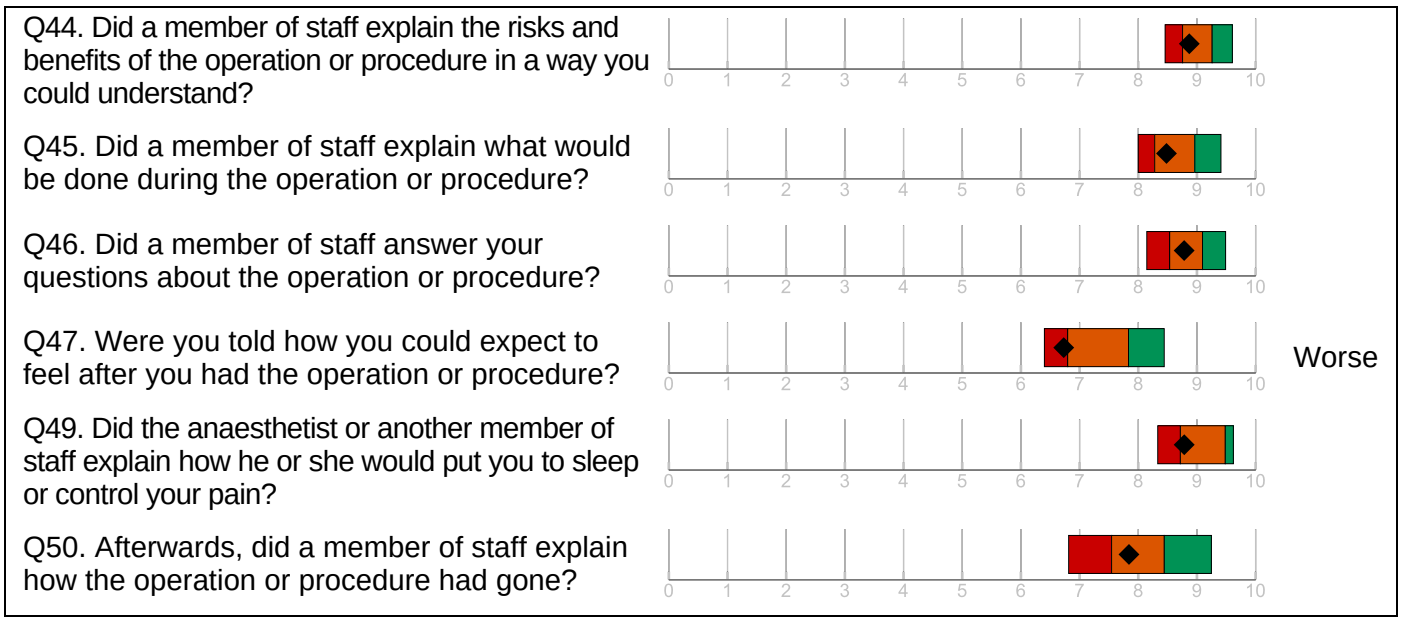


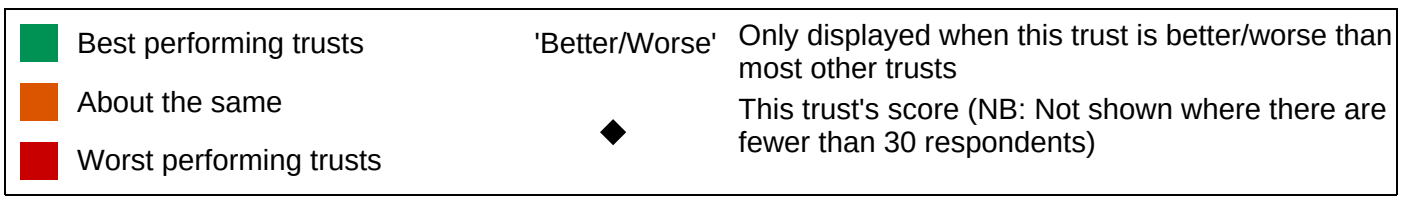
Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2015

Maidstone and Tunbridge Wells NHS Trust

Operations and procedures (answered by patients who had an operation or procedure)

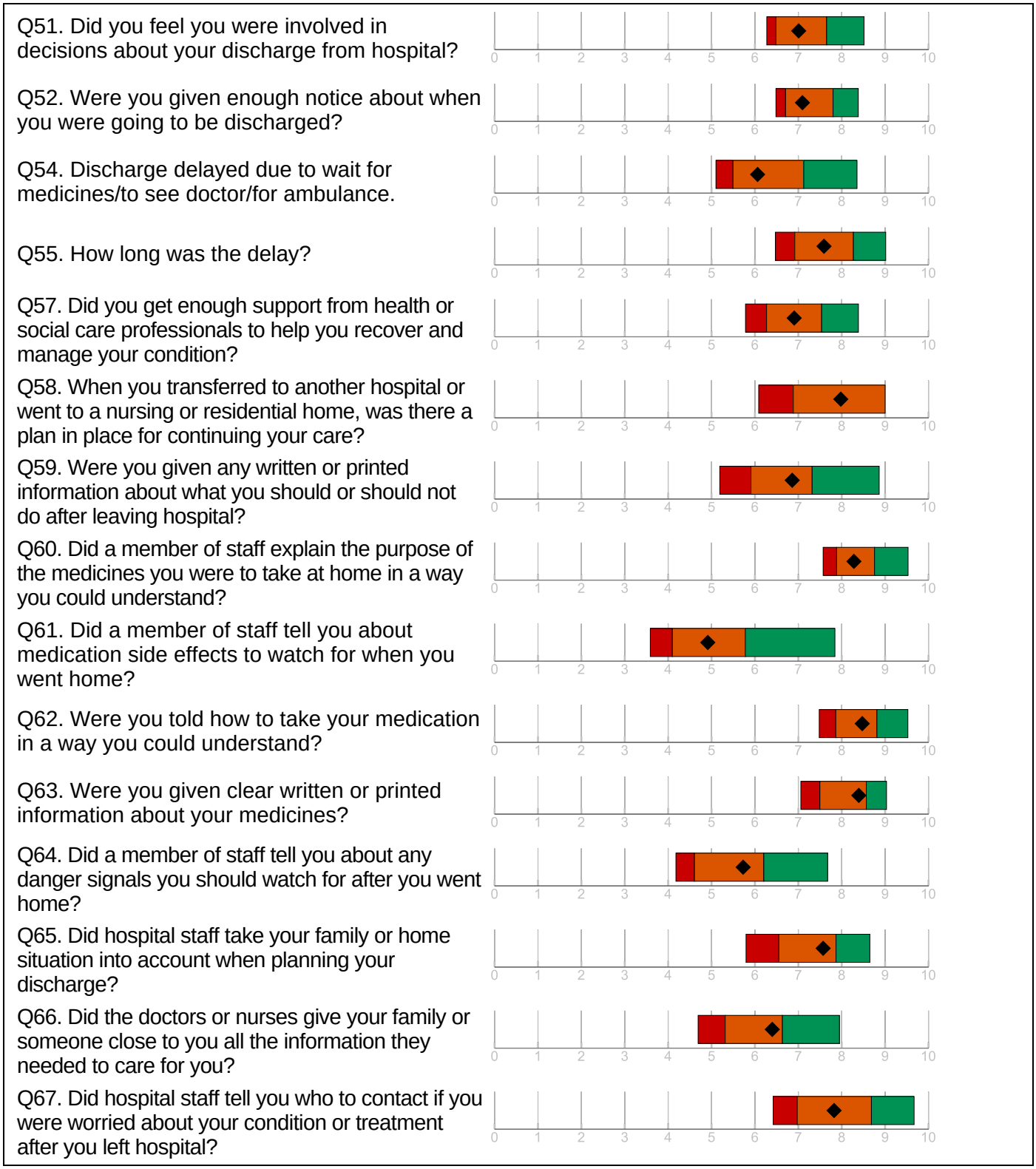


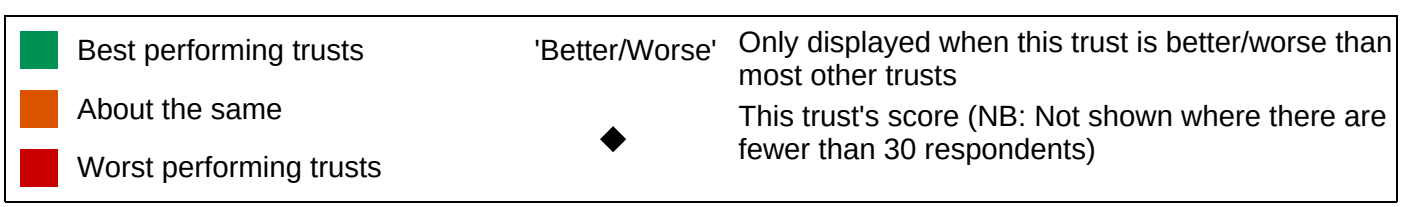


Survey of adult inpatients 2015

Maidstone and Tunbridge Wells NHS Trust

Leaving hospital

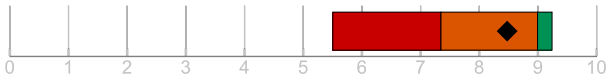




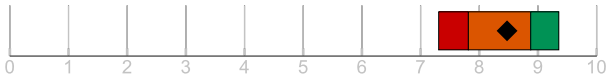
Survey of adult inpatients 2015

Maidstone and Tunbridge Wells NHS Trust

Q68. Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?



Q69. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?



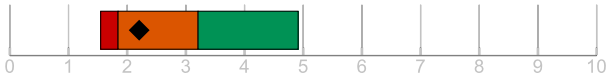
Overall views of care and services

Q70. Overall, did you feel you were treated with respect and dignity while you were in the hospital?

Q71. During your time in hospital did you feel well looked after by hospital staff?

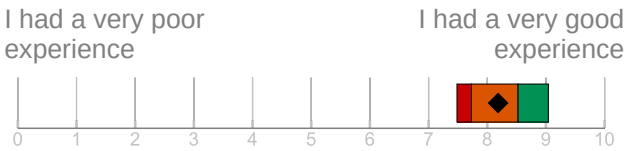
Q73. During your hospital stay, were you ever asked to give your views on the quality of your care?

Q74. Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?



Overall experience

Q72. Overall...



Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2015

Maidstone and Tunbridge Wells NHS Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2014 scores for this NHS trust	Change from 2014
The Emergency/A&E Department (answered by emergency patients only)							
S1	Section score	8.6	7.9	9.4			
Q3	While you were in the A&E Department, how much information about your condition or treatment was given to you?	8.3	7.5	9.3	395	8.3	
Q4	Were you given enough privacy when being examined or treated in the A&E Department?	9.0	8.1	9.5	419	8.8	
Waiting list and planned admissions (answered by those referred to hospital)							
S2	Section score	8.9	8.2	9.5			
Q6	How do you feel about the length of time you were on the waiting list?	8.2	6.9	9.4	217	8.6	
Q7	Was your admission date changed by the hospital?	9.1	8.5	9.9	230	9.1	
Q8	Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?	9.3	8.2	9.5	223	8.9	
Waiting to get to a bed on a ward							
S3	Section score	7.5	6.5	9.6			
Q9	From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	7.5	6.5	9.6	683	7.3	

↑ or ↓	Indicates where 2015 score is significantly higher or lower than 2014 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2014 data is available.

Survey of adult inpatients 2015

Maidstone and Tunbridge Wells NHS Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2014 scores for this NHS trust	Change from 2014
The hospital and ward							
S4	Section score	8.4	7.7	9.1			
Q11	Did you ever share a sleeping area with patients of the opposite sex?	9.3	7.9	9.8	545	8.9	↑
Q14	Did you ever use the same bathroom or shower area as patients of the opposite sex?	8.6	6.5	9.9	637	8.6	
Q15	Were you ever bothered by noise at night from other patients?	7.1	4.8	8.5	666	6.7	
Q16	Were you ever bothered by noise at night from hospital staff?	8.5	7.0	9.3	687	8.2	
Q17	In your opinion, how clean was the hospital room or ward that you were in?	9.2	8.2	9.7	691	9.1	
Q18	How clean were the toilets and bathrooms that you used in hospital?	8.9	7.7	9.5	664	8.7	
Q19	Did you feel threatened during your stay in hospital by other patients or visitors?	9.7	9.4	10.0	690	9.8	
Q20	Were hand-wash gels available for patients and visitors to use?	9.5	9.2	9.9	651	9.5	
Q21	How would you rate the hospital food?	5.8	4.5	7.9	658	5.4	↑
Q22	Were you offered a choice of food?	8.7	7.8	9.6	676	8.6	
Q23	Did you get enough help from staff to eat your meals?	7.2	5.9	9.2	169	7.2	
Doctors							
S5	Section score	8.7	8.1	9.5			
Q24	When you had important questions to ask a doctor, did you get answers that you could understand?	8.2	7.6	9.3	606	8.1	
Q25	Did you have confidence and trust in the doctors treating you?	9.0	8.4	9.8	680	8.7	↑
Q26	Did doctors talk in front of you as if you weren't there?	8.7	7.7	9.6	683	8.5	
Nurses							
S6	Section score	8.6	7.5	9.4			
Q27	When you had important questions to ask a nurse, did you get answers that you could understand?	8.4	7.2	9.4	612	8.3	
Q28	Did you have confidence and trust in the nurses treating you?	8.9	7.9	9.6	691	8.8	
Q29	Did nurses talk in front of you as if you weren't there?	9.2	8.0	9.6	685	9.0	
Q30	In your opinion, were there enough nurses on duty to care for you in hospital?	8.0	6.5	9.3	689	7.8	

↑ or ↓	Indicates where 2015 score is significantly higher or lower than 2014 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2014 data is available.

Survey of adult inpatients 2015

Maidstone and Tunbridge Wells NHS Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2014 scores for this NHS trust	Change from 2014
Care and treatment							
S7	Section score	8.0	7.2	8.9			
Q31	In your opinion, did the members of staff caring for you work well together?	9.0	8.0	9.7	654		
Q32	Did a member of staff say one thing and another say something different?	8.2	7.5	9.2	690	8.0	
Q33	Were you involved as much as you wanted to be in decisions about your care and treatment?	7.5	6.6	8.9	683	7.1	
Q34	Did you have confidence in the decisions made about your condition or treatment?	8.3	7.8	9.4	687	8.3	
Q35	How much information about your condition or treatment was given to you?	8.0	7.2	9.4	690	7.8	
Q36	Did you find someone on the hospital staff to talk to about your worries and fears?	6.2	4.4	7.8	390	6.2	
Q37	Do you feel you got enough emotional support from hospital staff during your stay?	7.5	6.1	8.8	412	7.3	
Q38	Were you given enough privacy when discussing your condition or treatment?	9.0	7.9	9.4	679	8.7	
Q39	Were you given enough privacy when being examined or treated?	9.6	9.1	9.9	686	9.5	
Q41	Do you think the hospital staff did everything they could to help control your pain?	8.5	7.6	9.4	415	8.2	
Q42	After you used the call button, how long did it usually take before you got help?	6.5	5.3	7.8	441	6.1	↑

↑ or ↓	Indicates where 2015 score is significantly higher or lower than 2014 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2014 data is available.

Survey of adult inpatients 2015

Maidstone and Tunbridge Wells NHS Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2014 scores for this NHS trust	Change from 2014
Operations and procedures (answered by patients who had an operation or procedure)							
S8	Section score	8.2	7.8	9.2			
Q44	Did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?	8.9	8.5	9.6	377	8.9	
Q45	Did a member of staff explain what would be done during the operation or procedure?	8.5	8.0	9.4	373	8.4	
Q46	Did a member of staff answer your questions about the operation or procedure?	8.8	8.1	9.5	315	8.7	
Q47	Were you told how you could expect to feel after you had the operation or procedure?	6.7	6.4	8.4	381	6.8	
Q49	Did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain?	8.8	8.3	9.6	319	8.8	
Q50	Afterwards, did a member of staff explain how the operation or procedure had gone?	7.8	6.8	9.2	380	7.6	

↑ or ↓	Indicates where 2015 score is significantly higher or lower than 2014 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2014 data is available.

Survey of adult inpatients 2015

Maidstone and Tunbridge Wells NHS Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2014 scores for this NHS trust	Change from 2014
Leaving hospital							
S9	Section score	7.3	6.1	8.4			
Q51	Did you feel you were involved in decisions about your discharge from hospital?	7.0	6.3	8.5	660	6.8	
Q52	Were you given enough notice about when you were going to be discharged?	7.1	6.5	8.4	681	7.1	
Q54	Discharge delayed due to wait for medicines/to see doctor/for ambulance.	6.1	5.1	8.4	643	6.3	
Q55	How long was the delay?	7.6	6.5	9.0	633	7.6	
Q57	Did you get enough support from health or social care professionals to help you recover and manage your condition?	6.9	5.8	8.4	362		
Q58	When you transferred to another hospital or went to a nursing or residential home, was there a plan in place for continuing your care?	8.0	6.1	8.8	34		
Q59	Were you given any written or printed information about what you should or should not do after leaving hospital?	6.9	5.2	8.9	664	7.0	
Q60	Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	8.3	7.6	9.5	502	8.2	
Q61	Did a member of staff tell you about medication side effects to watch for when you went home?	4.9	3.6	7.8	417	4.9	
Q62	Were you told how to take your medication in a way you could understand?	8.5	7.5	9.5	429	8.6	
Q63	Were you given clear written or printed information about your medicines?	8.4	7.1	9.0	478	8.4	
Q64	Did a member of staff tell you about any danger signals you should watch for after you went home?	5.7	4.2	7.7	508	5.5	
Q65	Did hospital staff take your family or home situation into account when planning your discharge?	7.6	5.8	8.6	422	7.4	
Q66	Did the doctors or nurses give your family or someone close to you all the information they needed to care for you?	6.4	4.7	7.9	450	6.5	
Q67	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	7.8	6.4	9.7	597	8.1	
Q68	Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?	8.5	5.5	9.2	192	8.9	
Q69	Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	8.5	7.3	9.4	334	8.7	

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Survey of adult inpatients 2015

Maidstone and Tunbridge Wells NHS Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2014 scores for this NHS trust	Change from 2014
Overall views of care and services							
S10	Section score	5.6	5.0	7.1			
Q70	Overall, did you feel you were treated with respect and dignity while you were in the hospital?	9.2	8.5	9.7	683	9.0	
Q71	During your time in hospital did you feel well looked after by hospital staff?	9.0	8.3	9.7	678	8.9	
Q73	During your hospital stay, were you ever asked to give your views on the quality of your care?	1.9	0.8	4.1	606	2.1	
Q74	Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	2.2	1.5	4.9	544	2.4	
Overall experience							
S11	Section score	8.2	7.5	9.0			
Q72	Overall...	8.2	7.5	9.0	657	8.1	

↑ or ↓	Indicates where 2015 score is significantly higher or lower than 2014 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2014 data is available.

Survey of adult inpatients 2015
Maidstone and Tunbridge Wells NHS Trust

Background information

The sample	This trust	All trusts
Number of respondents	703	83116
Response Rate (percentage)	57	47

Demographic characteristics	This trust	All trusts
Gender (percentage)	(%)	(%)
Male	46	47
Female	54	53
Age group (percentage)	(%)	(%)
Aged 16-35	6	6
Aged 36-50	12	10
Aged 51-65	20	24
Aged 66 and older	62	60
Ethnic group (percentage)	(%)	(%)
White	95	90
Multiple ethnic group	1	1
Asian or Asian British	1	3
Black or Black British	0	1
Arab or other ethnic group	0	0
Not known	3	5
Religion (percentage)	(%)	(%)
No religion	13	15
Buddhist	1	0
Christian	83	78
Hindu	0	1
Jewish	0	0
Muslim	0	2
Sikh	0	0
Other religion	1	1
Prefer not to say	2	2
Sexual orientation (percentage)	(%)	(%)
Heterosexual/straight	96	94
Gay/lesbian	1	1
Bisexual	0	0
Other	0	1
Prefer not to say	3	4

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Maidstone and Tunbridge Wells NHS Trust

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National Inpatient Survey 2015 results compared with previous results.

The following table contains the percentage results to the questions asked (not the problem scores)

Question	Answers	2015	2014	2013	2012	2011	2010
1. Was your most recent hospital stay planned in advance or an emergency?	Emergency or urgent	67.6	71.8	62.4	67.6	64.4	61.7
	Waiting list or planned in advance	30.5	26.6	35.3	30.2	32.8	34.6
	Something else	1.9	1.6	2.3	2.2	2.7	1.2
2. When you arrived at the hospital, did you go to the A&E Department (the Emergency Department / Casualty / Medical or Surgical Admissions unit)?	Yes	90.2	92.9	89.7	89.4	88.5	91.4
	No	9.8	7.1	10.3	10.6	11.5	4.6
3. While you were in the A&E Department, how much information about your condition or treatment was given to you?	Not enough	15.8	18.1	13.1	17.3	17.9	15.4
	Right amount	65.4	59.5	59.3	64.9	61.6	62.5
	Too much	0.0	0.0	0.5	0.3	0.3	0.0
	I was not given any information about my treatment or condition	7.7	5.1	10.1	7.3	8.8	11.2
	Don't know / Can't remember	11.2	17.2	17.1	10.2	11.4	7.5
4. Were you given enough privacy when being examined or treated in the A&E Department?	Yes, definitely	75.7	70.6	72.5	76.2	65.7	61.4
	Yes, to some extent	15.8	19.7	15.2	17.9	25.3	28.1
	No	2.0	1.8	1.5	1.9	2.9	4.5
	Don't know / Can't remember	6.6	7.9	10.8	4.1	6.1	2.6
5. When you were referred to see a specialist, were you	Yes	19.4	23.4	13.6	22.6	17.5	19.8

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Question	Answers	2015	2014	2013	2012	2011	2010
offered a choice of hospital for your **first hospital appointment**?	No, but I would have liked a choice	15.6	14.4	12.1	20.1	17.5	12.2
	No, but I did not mind	60.5	54.5	68.6	53.8	59.2	58.1
	Don't know / Can't remember	4.6	7.8	5.7	3.5	5.8	2.9
6. How do you feel about the length of time you were on the waiting list before your admission to hospital?	I was admitted as soon as I thought was necessary	75.9	78.8	74.8	70.9	69.5	70.9
	I should have been admitted a bit sooner	14.9	11.5	18.3	12.2	18.2	14.5
	I should have been admitted a lot sooner	9.2	9.6	6.9	16.9	12.3	5.8
7. Was your admission date changed by the hospital?	No	80.8	82.6	73.0	78.1	77.9	72.1
	Yes, once	14.3	13.4	23.4	17.6	15.9	16.3
	Yes, 2 or 3 times	4.5	4.1	3.6	3.7	5.3	2.3
	Yes, 4 times or more	0.4	0.0	0.0	0.5	1.0	0.6
8. In your opinion, had the specialist you saw in hospital been given all of the necessary information about your condition or illness from the person who referred you?	Yes, definitely	80.8	73.0	89.7	86.1	-	-
	Yes, to some extent	14.3	18.9	8.1		-	-
	No	4.5	3.8	1.5	7.7	-	-
	Don’t know / can’t remember	0.4	4.3	0.7	6.2	-	-
9. From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	Yes, definitely	14.0	17.6	13.3	21.1	16.9	22.2
	Yes, to some extent	24.4	22.7	19.1	25.6	28.4	24.5
	No	61.5	59.7	67.5	53.3	54.7	50.9
10. While in hospital, did you ever stay in a critical care area (Intensive Care Unit, High Dependency Unit or Coronary Care Unit)?	Yes	20.6	17.9	19.0	14.9	16.6	15.9
	No	73.0	75.5	75.6	79.5	79.3	77.1
	Don't know / Can't remember	6.4	6.6	5.5	5.6	4.1	4.9
11. When you were **first** admitted to a bed on a ward, did you share a sleeping area, for example a room or bay, with patients of the opposite sex?	Yes	7.9	12.4	10.1	12.6	22.2	35.0
	No	92.1	87.6	89.9	87.4	77.8	65.0
12. During your stay in hospital, how many wards did you stay in?	1	68.1	62.1	69.2	67.7	67.3	61.2
	2	24.2	27.2	24.1	24.0	22.6	30.6
	3 or more	6.4	8.1	4.4	7.6	8.9	6.8
	Don't know / Can't remember	1.3	2.6	2.3	0.6	1.3	0
13. After you moved to another ward (or wards), did you	Yes	3.5	9.0	6.3	9.0	15.3	30.6

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Question	Answers	2015	2014	2013	2012	2011	2010
ever share a sleeping area, for example a room or bay, with patients of the opposite sex?	No	96.5	91.0	93.7	91.0	84.7	69.4
14. While staying in hospital, did you ever use the same bathroom or shower area as patients of the opposite sex?	Yes	13.3	13.7	10.5	15.1	23.9	28.7
	Yes, because it had special bathing equipment that I needed	0.6	1.3	0.9	0.4	0.9	0.9
	No	79.0	73.8	82.3	74.8	58.4	53.5
	I did not use a bathroom or shower	4.2	5.9	2.3	4.7	9.8	8.6
	Don't know / Can't remember	2.9	5.3	4.1	4.9	7	6.5
15. Were you ever bothered by noise **at night** from **other patients**?	Yes	29.4	32.7	27.5	27.8	44.8	48.8
	No	70.6	67.3	72.5	72.2	55.2	49.8
16. Were you ever bothered by noise **at night** from **hospital staff**?	Yes	15.3	18.4	20.6	17.2	18.3	24.1
	No	84.7	81.6	79.4	82.8	81.7	74.3
17. In your opinion, how clean was the hospital room or ward that **you** were in?	Very clean	75.6	72.9	76.9	77.4	59.4	59.8
	Fairly clean	23.4	24.9	21.9	19.8	37.3	35.5
	Not very clean	1.0	2.2	0.9	1.9	2.7	3.5
	Not at all clean	0.0	0.0	0.3	0.9	0.6	1.2
18. How clean were the toilets and bathrooms that **you** used in hospital?	Very clean	67.5	63.4	71.0	70.8	48.3	45.3
	Fairly clean	26.9	29.1	22.7	22.4	37.7	41.8
	Not very clean	1.4	3.9	3.1	2.3	6.9	7.7
	Not at all clean	0.4	0.6	0.3	0.6	1.5	0.9
	I did not use a toilet or bathroom	3.7	3.0	2.8	3.8	5.6	3.3
19. Did you feel threatened during your stay in hospital by other patients or visitors?	Yes	3.3	2.2	1.7	1.7	4.2	4.9
	No	96.7	97.8	98.3	98.3	95.8	94.9
20. Were hand-wash gels available for patients and visitors to use?	Yes	88.8	91.4	89.2	91.0	91.1	94.4
	Yes, but they were empty	2.0	1.3	0.9	0.9	1.2	1.2
	I did not see any hand-wash gels	2.7	3.5	4.3	3.2	2.5	1.6
	Don't know / Can't remember	6.4	3.9	5.7	4.9	5.2	2.6
21. How would you rate the hospital food?	Very good	22.7	19.3	21.9	14.6	12.6	11.4
	Good	37.4	37.0	33.9	38.1	34.3	33.9

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Question	Answers	2015	2014	2013	2012	2011	2010
	Fair	24.9	23.7	27.1	28.4	30.6	35.5
	Poor	10.3	14.6	11.1	14.0	14.5	14
	I did not have any hospital food	4.7	5.4	6.0	4.9	8.1	4.2
22. Were you offered a choice of food?	Yes, always	80.9	79.7	74.4	75.6	72.9	68.5
	Yes, sometimes	12.3	13.0	14.9	16.5	17.1	21.3
	No	6.8	7.3	10.6	7.9	10	8.4
23. Did you get enough help from staff to eat your meals?	Yes, always	15.1	18.0	15.6	12.8	14.9	16.4
	Yes, sometimes	6.1	7.9	5.5	5.3	4.3	4.9
	No	3.8	4.4	3.5	4.9	5.7	5.8
	I did not need help to eat meals	75.0	69.7	75.4	77.0	75.1	70.6
24. When you had important questions to ask a doctor, did you get answers that you could understand?	Yes, always	60.2	58.0	63.9	57.8	57.8	55.6
	Yes, sometimes	23.2	27.0	20.6	26.4	25.7	28.5
	No	4.9	4.6	4.6	6.0	6.4	6.5
	I had no need to ask	11.7	10.5	10.9	9.8	10.1	8.6
25. Did you have confidence and trust in the doctors treating you?	Yes, always	82.0	76.3	79.7	79.0	75.2	73.6
	Yes, sometimes	14.6	19.3	16.6	15.9	20.9	21.3
	No	3.4	4.4	3.7	5.1	3.9	4.9
26. Did doctors talk in front of you as if you weren't there?	Yes, often	4.5	6.6	3.7	6.0	6.2	4.9
	Yes, sometimes	16.9	20.6	18.9	18.8	23.1	24.5
	No	78.6	72.8	77.4	75.3	70.7	69.6
27. When you had important questions to ask a nurse, did you get answers that you could understand?	Yes, always	62.7	62.3	61.1	61.1	56.8	57.7
	Yes, sometimes	22.4	23.6	20.7	24.9	27.3	28.7
	No	3.0	3.3	3.4	4.3	5.8	4.2
	I had no need to ask	11.9	10.8	14.8	9.8	10.1	8.6
28. Did you have confidence and trust in the nurses treating you?	Yes, always	79.9	78.7	77.1	73.5	69.6	71.5
	Yes, sometimes	17.2	17.8	20.6	23.1	27.1	24.8
	No	2.9	3.4	2.3	3.4	3.3	2.8

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Question	Answers	2015	2014	2013	2012	2011	2010
29. Did nurses talk in front of you as if you weren't there?	Yes, often	1.7	3.5	2.8	3.4	3.4	3
	Yes, sometimes	12.8	15.3	12.5	14.6	22.2	17.1
	No	85.5	81.3	84.7	82.0	74.4	78.5
30. In your opinion, were there enough nurses on duty to care for **you** in hospital?	There were always or nearly always enough nurses	67.0	63.3	64.0	61.6	55.7	54.9
	There were sometimes enough nurses	26.5	28.2	24.0	27.6	29.4	31.3
	There were rarely or never enough nurses	6.5	8.5	12.0	10.8	14.8	11.9
31. In your opinion, did the members of staff caring for you work well together?	Yes, always	76.9	-	-	-	-	-
	Yes, sometimes	15.3	-	-	-	-	-
	No	2.6	-	-	-	-	-
	Don't know / Can't remember	5.2	-	-	-	-	-
32. Sometimes in hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?	Yes, often	5.3	8.7	5.7	7.5	7.6	8.6
	Yes, sometimes	25.9	25.7	23.4	24.9	31.3	26.6
	No	68.8	65.6	70.9	67.6	61.1	63.6
33. Were you involved as much as you wanted to be in decisions about your care and treatment?	Yes, definitely	56.5	52.3	58.7	52.9	47.4	48.1
	Yes, to some extent	35.2	35.2	32.5	36.0	39.4	41.4
	No	8.3	12.5	8.8	11.1	13.2	9.6
34. Did you have confidence in the decisions made about your condition or treatment?	Yes, always	70.2	69.9	-	-	-	-
	Yes, sometimes	24.3	23.1	-	-	-	-
	No	5.5	7.0	-	-	-	-
35. How much information about your condition or treatment was given to **you**?	Not enough	20.1	23.2	15.8	20.5	24	23.4
	The right amount	79.6	76.5	83.4	79.3	74.9	76.2
	Too much	0.3	0.2	0.9	0.2	1.1	0
36. Did you find someone on the hospital staff to talk to about your worries and fears?	Yes, definitely	23.3	27.5	24.5	21.8	24.2	18.7
	Yes, to some extent	23.6	19.8	21.0	22.5	27.5	24.3
	No	10.3	13.8	12.4	14.3	15	13.3
	I had no worries or fears	42.8	38.9	42.1	41.3	33.3	42.3
37. Do you feel you got enough emotional support from	Yes, always	37.1	37.3	39.9	32.4	35.1	-

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Question	Answers	2015	2014	2013	2012	2011	2010
hospital staff during your stay	Yes, sometimes	16.5	17.4	15.6	19.2	18.9	-
	No	6.5	8.9	6.9	9.6	12.4	-
	I did not need any emotional support	39.9	36.4	37.6	38.8	33.6	-
38. Were you given enough privacy when discussing your condition or treatment?	Yes, always	83.9	78.6	85.9	78.5	70.2	65.4
	Yes, sometimes	11.8	17.0	11.5	19.2	21	22.2
	No	4.2	4.4	2.6	2.3	8.8	10.5
39. Were you given enough privacy when being examined or treated?	Yes, always	92.9	90.8	93.4	89.8	85.9	84.8
	Yes, sometimes	6.1	7.9	6.6	9.8	11.2	12.1
	No	1.0	1.3	0.0	0.4	2.9	2.3
40. Were you ever in any pain?	Yes	61.7	65.9	58.5	62.3	67.7	60.7
	No	38.3	34.1	41.5	37.7	32.3	38.1
41. Do you think the hospital staff did everything they could to help control your pain?	Yes, definitely	73.8	73.1	75.2	73.0	67.1	71.5
	Yes, to some extent	21.3	17.6	19.3	21.0	25.6	20.8
	No	4.9	9.3	5.4	6.0	7.4	5.8
42. How many minutes after you used the call button did it usually take before you got the help you needed?	0 minutes / right away	9.8	6.3	9.1	9.0	10.1	7.5
	1-2 minutes	27.0	25.4	22.9	21.4	20.6	17.3
	3-5 minutes	19.7	19.7	18.5	19.2	17	14.7
	More than 5 minutes	7.9	12.0	8.8	11.4	12	12.4
	I never got help when I used the call button	0.6	0.9	0.0	0.4	1.7	0.9
	I never used the call button	35.0	35.6	40.6	38.6	38.6	43.7
43. During your stay in hospital, did you have an operation or procedure?	Yes	56.7	58.8	62.5	55.5	60.5	60.7
	No	43.3	41.2	37.5	44.5	39.5	37.1
44. Beforehand, did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?	Yes, completely	77.4	75.4	83.7	73.8	70.6	73.8
	Yes, to some extent	15.5	14.6	10.7	18.4	17	16.9
	No	4.3	5.2	4.2	4.9	5.9	6.5
	I did not want an explanation	2.8	4.9	1.4	3.0	6.5	1.2
45. Beforehand, did a member of staff explain what	Yes, completely	70.2	66.5	73.5	64.9	64.3	65.4

Appendix 2

Question	Answers	2015	2014	2013	2012	2011	2010
would be done during the operation or procedure?	Yes, to some extent	20.7	23.7	19.5	26.1	21.3	22.3
	No	5.3	5.6	5.6	6.0	6.2	9.2
	I did not want an explanation	3.8	4.1	1.4	3.0	8.2	1.9
46. Beforehand, did a member of staff answer your questions about the operation or procedure in a way you could understand?	Yes, completely	64.2	63.2	70.9	60.2	57.5	60.4
	Yes, to some extent	14.1	15.6	11.7	22.3	23.3	19.2
	No	3.3	4.1	3.8	2.2	3.3	6.2
	I did not have any questions	18.4	17.1	13.6	15.2	15.9	13.1
47. Beforehand, were you told how you could expect to feel after you had the operation or procedure?	Yes, completely	50.9	51.9	57.7	52.4	54	50.4
	Yes, to some extent	29.6	28.8	24.4	28.1	26.5	27.7
	No	19.5	19.2	17.8	19.5	19.5	20
48. Before the operation or procedure, were you given an anaesthetic or medication to put you to sleep or control your pain?	Yes	83.9	81.5	90.7	85.0	84.7	85.4
	No	16.1	18.5	9.3	15.0	15.3	12.3
49. Before the operation or procedure, did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain in a way you could understand?	Yes, completely	79.0	75.3	86.8	79.2	70.9	82
	Yes, to some extent	13.2	11.3	9.5	11.7	16.8	11.3
	No	7.8	13.4	3.7	9.2	12.3	6.3
50. After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?	Yes, completely	66.1	63.0	67.4	62.5	64	56.9
	Yes, to some extent	22.3	24.0	20.9	21.2	22.7	29.6
	No	11.7	13.0	11.6	16.3	13.3	10.4
51. Did you feel you were involved in decisions about your discharge from hospital?	Yes, definitely	52.3	49.5	54.6	50.0	46.1	43.7
	Yes, to some extent	30.1	32.2	26.0	30.3	29.7	26.9
	No	15.1	15.5	14.6	17.5	15.1	17.1
	I did not need to be involved	2.5	2.8	4.9	2.1	9.1	10.5
52. Were you given enough notice about when you were going to be discharged?	Yes, definitely	54.1	53.6	56.4	52.4	-	-
	Yes, to some extent	32.9	33.1	33.0	33.8	-	-
	No	13.0	13.3	10.6	13.9	-	-
53. On the day you left hospital, was your discharge delayed for any reason?	Yes	42.5	43.0	39.0	42.1	46.4	49.1
	No	57.5	57.0	61.0	57.9	53.6	49.8

Appendix 2

Question	Answers	2015	2014	2013	2012	2011	2010
54. What was the **MAIN** reason for the delay? **(Tick ONE only)**	I had to wait for **medicines**	59.9	45.7	55.8	59.6	55.6	51.9
	I had to wait to **see the doctor**	18.4	12.9	15.5	17.2	20.3	19
	I had to wait for an **ambulance**	10.0	19.4	13.2	10.1	10.1	6.2
	Something else	11.7	22.0	15.5	13.1	14	13.3
55. How long was the delay?	Up to 1 hour	18.2	15.7	13.3	22.1	12.5	11.4
	Longer than 1 hour but no longer than 2 hours	26.8	27.2	25.2	23.9	37.1	25.2
	Longer than 2 hours but no longer than 4 hours	36.8	33.0	42.2	33.3	33	33.8
	Longer than 4 hours	18.2	24.1	19.3	20.7	17.4	26.2
56. Where did you go after leaving hospital?	I went home	88.5	-	-	-	-	-
	I went to stay with family or friends	4.7	-	-	-	-	-
	I was transferred to another hospital	3.4	-	-	-	-	-
	I went to a residential nursing home	2.4	-	-	-	-	-
	I went somewhere else	0.9	-	-	-	-	-
57. After leaving hospital, did you get enough support from health or social care professionals to help you recover and manage your condition?	Yes, definitely	32.5	-	-	-	-	-
	Yes, to some extent	15.1	-	-	-	-	-
	No, but support would have been useful	10.7	-	-	-	-	-
	No, but I did not need any support	41.8	-	-	-	-	-
58. When you transferred to another hospital or went to a nursing or residential home, was there a plan in place for continuing your care?	Yes, definitely	46.8	-	-	-	-	-
	Yes, to some extent	19.5	-	-	-	-	-
	No	24.7	-	-	-	-	-
	Don't know / can't say	9.1	-	-	-	-	-
59. Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?	Yes	67.1	66.8	76.3	62.5	67.8	62.4
	No	32.9	33.2	23.7	37.5	32.2	35
60. Did a member of staff explain the **purpose** of the medicines you were to take at home in a way you could understand?	Yes, completely	55.0	56.0	56.4	55.0	52.2	50.2
	Yes, to some extent	12.4	12.0	11.8	12.4	14	13.8
	No	7.1	9.1	5.2	6.2	6.8	8.4
	I did not need an explanation	12.4	10.9	11.8	11.6	11.9	9.8

Appendix 2

Question	Answers	2015	2014	2013	2012	2011	2010
	I had no medicines	13.0	12.0	14.7	14.8	15.1	15.7
61. Did a member of staff tell you about medication **side effects** to watch for when you went home?	Yes, completely	26.1	24.9	29.6	21.1	21.9	24.1
	Yes, to some extent	13.2	17.1	14.1	15.4	13.1	11.6
	No	29.2	30.2	29.6	31.9	35.2	38.6
	I did not need an explanation	31.6	27.7	26.8	31.6	29.8	25
62. Were you told how to **take** your medication in a way you could understand?	Yes, definitely	53.8	59.3	59.7	53.4	50.6	53.7
	Yes, to some extent	10.5	10.8	10.6	10.8	11.7	12.5
	No	6.2	6.8	5.5	6.4	8.6	8.8
	I did not need to be told how to take my medication	29.5	23.3	24.2	29.3	29.1	25
63. Were you given clear written or printed information about your medicines?	Yes, completely	60.4	58.1	62.1	50.7	62.9	65.6
	Yes, to some extent	10.1	11.4	11.0	14.3	15.6	17.3
	No	8.3	8.4	7.2	9.1	15.6	13.6
	I did not need this	18.7	19.4	15.5	22.9	-	-
	Don't know / Can't remember	2.6	2.7	4.1	3.0	5.9	2.6
64. Did a member of staff tell you about any danger signals you should watch for after you went home?	Yes, completely	33.4	32.3	33.5	27.7	26.2	23.6
	Yes, to some extent	16.0	16.0	17.3	16.9	17.6	15.4
	No	25.2	26.9	24.9	30.5	31.8	34.3
	It was not necessary	25.4	24.8	24.3	24.9	24.5	23.4
65. Did the hospital staff take your family or home situation into account when planning your discharge?	Yes, completely	39.2	46.0	44.5	38.2	-	-
	Yes, to some extent	14.4	13.4	14.7	14.5	-	-
	No	8.4	11.6	6.9	15.1	-	-
	It was not necessary	34.9	25.0	30.7	28.9	-	-
	Don’t know / can’t remember	3.1	4.0	3.2	3.2	-	-
66. Did the doctors or nurses give your family or someone close to you all the information they needed to help care for you?	Yes, definitely	34.7	38.2	39.4	30.4	28.1	23.1
	Yes, to some extent	16.4	17.1	12.6	14.7	17.5	17.3
	No	16.1	17.3	17.5	20.1	24	25.5
	No family or friends were involved	10.5	9.0	9.8	11.4	13.4	14.3

Appendix 2

Question	Answers	2015	2014	2013	2012	2011	2010
	My family or friends did not want or need information	22.3	18.4	20.7	23.4	17.1	17.1
67. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	Yes	69.1	71.4	73.6	65.3	58.7	69.9
	No	20.5	18.9	16.9	26.8	30.7	20.6
	Don't know / Can't remember	10.4	9.7	9.5	7.9	10.6	6.8
68. Did hospital staff discuss with you whether you would need any additional equipment in your home, or any adaptations to your home, after leaving hospital?	Yes	24.1	30.0	24.9	22.2	-	-
	No, but I would have liked them to	4.6	4.0	2.3	5.8	-	-
	No, it was not necessary to discuss it	71.4	65.9	72.8	72.0	-	-
69. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital? (e.g. services from a GP, physiotherapist or community nurse, or assistance from social services or the voluntary sector)	Yes	41.8	47.7	46.8	40.3	-	-
	No, but I would have liked them to	7.7	7.9	6.4	7.8	-	-
	No, it was not necessary to discuss it	50.5	44.4	46.8	51.9	-	-
70. Overall, did you feel you were treated with respect and dignity while you were in the hospital?	Yes, always	85.1	80.6	84.2	79.3	74.5	77.3
	Yes, sometimes	13.3	16.8	12.3	17.7	20.4	19.2
	No	1.6	2.6	3.4	3.0	5.1	2.1
71. During your time in hospital did you feel well looked after by hospital staff?	Yes, always	81.3	79.5	-	-	-	-
	Yes, sometimes	17.0	16.8	-	-	-	-
	No	1.8	3.7	-	-	-	-
72. Overall…	I had a very good experience (10)	25.3	7.8	30.4	24.5	-	-
	9	24.3	77.3	23.9	20.6	-	-
	8	25.5	1.8	20.9	18.9	-	-
	7	11.0	1.8	11.8	14.2	-	-
	6	5.0	1.8	3.2	3.4	-	-
	5	3.2	0.7	4.4	6.0	-	-
	4	2.4	0.4	1.8	0.9	-	-
	3	2.0	6.7	0.9	1.3	-	-
	2	0.5	0.4	1.5	1.7	-	-
	1	0.5	0.0	0.9	1.7	-	-
	I had a very poor experience (0)	0.5	1.4	0.3	6.9	-	-

Appendix 2

Question	Answers	2015	2014	2013	2012	2011	2010
73. During your hospital stay, were you ever asked to give your views on the quality of your care?	Yes	16.5	18.2	16.6	10.7	10.2	6.1
	No	71.9	71.8	70.9	81.4	82.3	86.4
	Don't know / Can't remember	11.6	10.0	12.6	7.9	7.4	5.8
74. Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	Yes	17.4	17.5	-	-	-	-
	No	62.4	61.1	-	-	-	-
	Not sure / Don't know	20.2	21.5	-	-	-	-

Appendix 3

Care Quality Commission National Inpatient Survey 2015

Question	Highest Trust score	Lowest Trust score	MTW	Medway	East Sussex Healthcare	Dartford & Gravesham	Brighton and Sussex	Surrey and Sussex	East Kent Hospitals
3.While you were in the A&E Department, how much information about your condition or treatment was given to you?	9.3	7.5	8.3	7.9	8.2	8.0	7.9	8.0	7.9
4.Were you given enough privacy when being examined or treated in the A&E Department? .	9.5	8.1	9.0	8.1	8.6	8.5	8.3	8.7	8.3
6. How do you feel about the length of time you were on the waiting list before your admission to hospital?	9.4	6.9	8.2	8.2	8.4	7.4	7.4	7.5	8.1
7. Was your admisssion date changed by the hospital?	9.9	8.5	9.1	9.2	9.5	9.0	8.9	8.6	9.2
8. In your opinion, had the specialist you saw in hospital been given all of the necessary information about your condition or illness from the person who referred you?	9.5	8.2	9.3	8.9	9.0	8.7	8.9	9.2	8.8
9. From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	9.6	6.5	7.5	6.5	8.2	7.1	7.6	7.1	7.7
11. When you were first admitted to a bed on a ward, did you share a sleeping area, for example a room or bay, with patients of the opposite sex?	9.8	7.9	9.3	8.1	7.9	8.9	8.3	9.4	9.0
14. While staying in hospital, did you ever use the same bathroom or shower area as patients of the opposite sex?	9.9	6.5	8.6	7.5	7.1	7.7	7.8	8.7	7.7
15. Were you ever bothered by noise at night from other patients?	8.5	4.8	7.1	5.9	6.0	5.6	6.1	5.2	5.8
16. Were you ever bothered by noise at night from hospital staff?	9.3	7.0	8.5	7.7	8.1	7.8	8.1	7.7	7.7
17. In your opinion, how clean was the hospital room or ward that you were in?	9.7	8.2	9.2	8.3	8.9	8.7	8.7	9.0	8.8
18. How clean were the toilets and bathrooms that you used in hospital?	9.5	7.7	8.9	7.8	8.4	8.2	8.4	8.3	8.2
19. Did you feel threatened during your stay in hospital by other patients or visitors?	10.0	9.4	9.7	9.7	9.8	9.8	9.6	9.5	9.5
20. Were hand-wash gels available for patients and visitors to use?	9.9	9.2	9.5	9.7	9.5	9.7	9.4	9.6	9.5
21. How would you rate the hospital food?	7.9	4.5	5.8	4.8	5.9	5.2	4.7	5.2	5.9
22. Were you offered a choice of food?	9.6	7.8	8.7	8.3	9.0	8.4	8.8	8.8	9.0
23. Did you get enough help from staff to eat your meals?	9.2	5.9	7.2	7.0	6.8	6.8	7.5	7.1	7.1
24. When you had important questions to ask a doctor, did you get answers that you could understand?	9.3	7.6	8.2	7.9	8.4	7.6	8.0	8.1	8.1
25. Did you have confidence and trust in the doctors treating you?	9.8	8.4	9.0	8.6	8.9	8.6	8.7	8.8	8.9
26. Did doctors talk in front of you as if you weren't there?	9.6	7.7	8.7	8.4	8.7	8.4	8.2	8.6	8.5
27. When you had important questions to ask a nurse, did you get answers that you could understand?	9.4	7.2	8.4	8.0	8.5	7.9	8.3	8.2	8.3
28. Did you have confidence and trust in the nurses treating you?	9.6	7.9	8.9	8.3	9.0	8.5	8.8	8.6	8.8
29. Did nurses talk in front of you as if you weren't there?	9.6	8.0	9.2	8.6	9.2	9.0	9.0	9.0	9.0
30. In your opinion, were there enough nurses on duty to care for you in hospital?	9.3	6.5	8.0	6.9	7.9	7.3	7.8	7.6	7.3
31. In your opinion, did the members of staff caring for you work well together?	9.7	8.0	9.0	8.2	8.9	8.6	8.8	8.7	8.6
32. Did a member of staff say one thing and another say something different?	9.2	7.5	8.2	7.8	8.2	7.8	7.8	8.0	8.1
33. Were you involved as much as you wanted to be in decisions about your care and treatment?	8.9	6.6	7.5	7.4	7.6	7.0	7.4	7.5	7.3
34. Did you have confidence in the decisions made about your condition or treatment?	9.4	7.8	8.3	8.0	8.4	7.9	8.2	8.4	8.1
35. How much information about your condition or treatment was given to you?	9.4	7.2	8.0	7.8	8.1	7.5	8.0	8.1	7.7
36. Did you find someone on the hospital staff to talk to about your worries and fears?	7.8	4.4	6.2	5.6	6.0	5.6	6.1	5.7	5.7

Question	Highest Trust score	Lowest Trust score	MTW	Medway	East Sussex Healthcare	Dartford & Gravesham	Brighton and Sussex	Surrey and Sussex	East Kent Hospitals
37. Do you feel you got enough emotional support from hospital staff during your stay	8.8	6.1	7.5	7.0	7.6	6.7	6.8	7.2	7.1
38. Were you given enough privacy when discussing your condition or treatment?	9.4	7.9	9.0	8.1	8.4	8.2	8.3	8.6	8.4
39. Were you given enough privacy when being examined or treated?	9.9	9.1	9.6	9.2	9.5	9.2	9.4	9.5	9.3
41. Do you think the hospital staff did everything they could to help control your pain?	9.4	7.6	8.5	7.9	8.5	7.9	8.2	8.0	8.0
42. After you used the call button, how long did it usually take before you got help?	7.8	5.3	6.5	5.8	6.2	5.7	6.3	6.2	6.0
44. Did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?	9.6	8.5	8.9	9.1	8.9	8.6	8.7	9.1	9.1
45. Did a member of staff explain what would be done during the operation or procedure?	9.4	8.0	8.5	8.4	8.1	8.4	8.5	8.7	8.5
46. Did a member of staff answer your questions about the operation or procedure?	9.5	8.1	8.8	8.7	8.8	8.5	8.6	8.8	8.9
47. Were you told how you could expect to feel after you had the operation or procedure?	8.4	6.4	6.7	6.8	7.1	7.0	7.0	7.4	7.1
49. Did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain?	9.6	8.3	8.8	9.1	9.0	8.8	8.9	9.0	9.0
50. Afterwards, did a member of staff explain how the operation or procedure had gone?	9.2	6.8	7.8	7.5	8.0	7.5	7.8	8.1	7.9
51. Did you feel you were involved in decisions about your discharge from hospital?	8.6	6.3	7.0	6.3	7.1	6.5	6.9	6.8	7.0
52. Were you given enough notice about when you were going to be discharged?	8.4	6.5	7.1	6.9	7.4	6.6	7.1	6.8	7.1
54. Discharge delayed due to wait for medicines/to see doctor/for ambulance.	8.4	5.1	6.1	5.7	7.3	6.0	6.6	6.1	6.3
55. How long was the delay?	9.0	6.5	7.6	7.0	8.4	7.4	7.9	7.7	7.4
57. Did you get enough support from health or social care professionals to help you recover and manage your condition?	8.4	5.8	6.9	7.1	7.0	6.6	6.5	6.9	6.9
58. When you transferred to another hospital or went to a nursing or residential home, was there a plan in place for continuing your care?	8.8	6.1	8.0	…	7.8	…	7.4	7.3	8.2
59. Were you given any written or printed information about what you should or should not do after leaving hospital?	8.9	5.2	6.9	6.4	6.2	6.4	6.8	6.0	7.2
60. Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	9.5	7.6	8.3	8.2	8.1	8.1	8.1	8.0	8.3
61. Did a member of staff tell you about medication side effects to watch for when you went home?	7.8	3.6	4.9	4.2	4.4	4.2	4.7	4.6	5.0
62. Were you told how to take your medication in a way you could understand?	9.5	7.5	8.5	8.1	8.2	7.8	8.4	8.3	8.4
63. Were you given clear written or printed information about your medicines?	9.0	7.1	8.4	8.1	7.5	7.8	7.8	8.1	7.9
64. Did a member of staff tell you about any danger signals you should watch for after you went home?	7.7	4.2	5.7	5.0	5.1	4.9	5.4	4.6	5.8
65. Did hospital staff take your family or home situation into account when planning your discharge?	8.6	5.8	7.6	6.8	7.2	6.9	7.5	6.6	7.3
66. Did the doctors or nurses give your family or someone close to you all the information they needed to care for you?	7.9	4.7	6.4	5.4	6.0	5.6	6.0	5.9	6.1
67. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the hospital?	9.7	6.4	7.8	7.4	7.6	7.4	8.0	7.7	8.0
68. Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?	9.2	5.5	8.5	8.2	8.5	8.0	8.1	8.3	8.7

Question	Highest Trust score	Lowest Trust score	MTW	Medway	East Sussex Healthcare	Dartford & Gravesham	Brighton and Sussex	Surrey and Sussex	East Kent Hospitals
69. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	9.4	7.3	8.5	8.4	8.3	8.0	8.2	8.1	8.3
70. Overall, did you feel you were treated with respect and dignity while you were in hospital?	9.7	8.5	9.2	8.7	9.2	8.8	9.1	9.1	9.0
71. During your time in hospital, did you feel wel looked after by hospital staff?	9.7	8.3	9.0	8.4	9.1	8.7	8.9	8.8	8.8
72. Overall…	9.0	7.5	8.2	7.6	8.2	7.8	8.1	8.0	8.0
73. During your hospital stay, were you ever asked to give your views on the quality of your care?	4.1	0.8	1.9	1.0	2.7	1.4	2.0	2.0	2.7
74. Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	4.9	1.5	2.2	2.0	2.4	1.6	2.5	2.9	2.3

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - June 2016

6-14 Responsible Officer's Annual Report 2015/16 — Medical Director

As a designated body, the Trust has responsibilities to provide a quality assured appraisal process to all doctors with a 'prescribed connection'. As Responsible Officer, the Medical Director must give assurance to the Trust Board that processes, compliance and monitoring of the medical appraisal and revalidation processes, as well as the ability of the Trust to respond appropriately to concerns raised about medical performance, meet national standards defined in legislation, by NHS England and by the GMC.

The appraisal year for doctors runs from 1st April to 31st March. In MTW medical appraisals are conducted between September and January.

The Board is asked review the report and approve the Statement of Compliance (Appendix F) confirming that the Trust, as a designated body, is in compliance with the regulations governing appraisal and revalidation.

Once approved, the Statement will then be signed by the Chief Executive, before being submitted to the higher-level Responsible Officer (by 30th September 2016).

Which Committees have reviewed the information prior to Board submission?

- N/A

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

1. To review the report and;
2. To approve the Statement of Compliance (Appendix F) confirming that the Trust, as a designated body, is in compliance with the regulations governing appraisal and revalidation

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

Maidstone and Tunbridge Wells NHS
NHS Trust

ANNUAL REPORT: MEDICAL APPRAISAL AND REVALIDATION AT MTW

1. Executive summary

Maidstone and Tunbridge Wells NHS Trust (MTW) is responsible for providing an annual appraisal to all doctors who have a prescribed connection. Of the **380** MTW doctors with such a connection, 350 completed an appraisal in the 2015/16 appraisal year ending 31.03.16. This is an overall appraisal rate of 92%. The rate varied with the grade of doctor: 97% consultants and 97% staff and associate specialists had an appraisal and 71% of the trust grade/locums and other grades had an MTW appraisal. As at 25th April 100% of connected doctors had submitted an appraisal where it was appropriate (ie excluding those which were not yet required).

Quality assurance processes of the medical appraisal process were expanded in 15/16 to include use of the NHS England tool for reviewing appraisal outputs and by the performance of an audit of a sample of the portfolios of supporting information of 20 MTW doctors.

The national phased roll out of the medical revalidation required MTW to assign 40% of our doctors for revalidation during year 3 (2015/16). The MTW advisory panel met monthly to advise the Responsible Officer (RO) about these recommendations as they fell due through the year. The RO made 114 positive revalidation recommendations, 26 deferral recommendations and one recommendation of 'non-engagement' to the General Medical Council (GMC).

2. Purpose of the report

As a designated body, Maidstone and Tunbridge Wells NHS Trust has responsibilities to provide a quality assured appraisal process to all doctors with a 'prescribed connection'. As Responsible Officer the Medical Director must give assurance to the Trust Board that processes, compliance and monitoring of the medical appraisal and revalidation processes, as well as the ability of the Trust to respond appropriately to concerns raised about medical performance, meet national standards defined in legislation, by NHS England and by the GMC.

The appraisal year for doctors runs from 1st April to 31st March. In MTW medical appraisals are conducted between September and January.

The purpose of revalidation is to give assurance to patients, employers, doctors and regulators that doctors are up to date, fit to practice and safe within their entire scope of practice (not just their NHS work). This paper seeks to give Board assurance that MTW meets its statutory requirements surrounding appraisal and revalidation of its doctors.

3. Background

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations2 and it is expected that provider Boards will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;

[2] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012'

- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

4. Governance Arrangements

The responsible officer has a defined overall responsibility for the management of all aspects of medical appraisal and revalidation. At MTW aspects of this are delegated to a deputy medical director who acts as the Trust's appraisal lead. Administrative support is provided by the Medical Director's personal assistant. Although systems for medical appraisal have been a requirement since 2001 these were overhauled at MTW in 2008. New systems of monitoring and quality assurance have evolved since then, as national guidelines have developed and clarity around the revalidation process has emerged.

Appraisers have been trained either internally or through external providers and updated annually, just prior to the commencement of the annual appraisal round.

Quality assurance processes are led by the appraisal lead. There is no designated HR lead for medical appraisal and revalidation processes.

The MTW 'Revalidation Advisory Group' met to assist the responsible officer with making and documenting revalidation recommendations for MTW doctors. The group has terms of reference and consists of the medical director, two deputy medical directors and the associate director of workforce. The group met monthly and triangulated the appraisal records, as well as any information about complaints, claims, incidents and disciplinary issues concerning the doctor whose revalidation is due. The RO may make one of 3 recommendations:

- A positive recommendation to revalidate
- A recommendation to defer revalidation for up to one year
- A notification that a doctor has not engaged adequately with the appraisal process.

Data about all doctors connected to MTW is kept on a spreadsheet which is regularly updated with information about previous appraisals and any concerns about their practice. This list is adjusted as doctors new to MTW establish a prescribed connection through a list held on the 'GMC connect' website. Changes are cross referenced with Medical Staffing, the Director of Medical Education and with clinical directorates to ensure that the link is appropriate and reflects the true employment status of the doctor.

Data on appraisal and revalidation processes is supplied to the regional team of NHS England on a quarterly basis by the appraisal lead.

Benchmarking also takes place through RO and Appraisal Lead attendance at Regional network meetings (3 times per annum) and through the appraisal lead's participation in RO appraisal for NHS England (South).

a. Existing Policy and Guidance

- MTW Appraisal and Revalidation Policy 2016
- MTW Management of concerns about the performance of doctors policy 2011
- MTW Back on track policy 2012
- NHS England appraisal policy 2014
- GMC: supporting information for appraisal and revalidation 2013

- GMC: framework for revalidation 2012

5. Medical Appraisal

a. Appraisal and Revalidation Performance Data

- 380 doctors connected to MTW as at the end of 15/16 on 31.03.16
- 350 doctors had a completed appraisal (92%)
- 240/243 consultants (97%); 56/91 SAS doctors (97%) and 51/72 of other doctors (71%) completed an appraisal.

(See also **Annual Report Template Appendix A;** Audit of all missed or incomplete appraisals audit)

b. Appraisers

79 MTW doctors are listed on the MTW list of approved appraisers, (13 SAS doctors and 66 consultants). No new appraisers were trained in 2015/16.

MTW appraisers attended one of four mandatory appraiser update sessions held in August and September 2015 by the appraisal lead. The content was determined by the action plan from the previous annual report and emphasised areas identified to have been poorly addressed in the 2014/15 appraisal round.

Appraisers received personal feedback about their performance in the 15/16 round with anonymised comments from their appraisees and structured comments from the Trust appraisal lead.

The appraisal lead attended 1 of the 3 regional appraisal leads networks. He also attended Regional update sessions for RO appraisal held by NHS England (South) and undertook 5 quality assured appraisals of Responsible Officers in South of England. The RO attended 1 of the 3 regional RO network meetings.

c. Quality Assurance

Outline of MTW quality assurance processes:

For the appraisal portfolio:

- Review of 5% of MTW medical appraisal folders to provide assurance that the appraisal inputs: the pre-appraisal declarations and supporting information provided is available and appropriate.
- Review of appraisal folders to provide assurance that the appraisal outputs: PDP, summary and sign offs are complete and to an appropriate standard -by whom and sign offs. An MTW defined checklist is used to ensure that appraisal outputs meet minimum standards required for certification of completion.
- Review of appraisal outputs to provide assurance that any key items identified pre-appraisal as needing discussion during the appraisal are included in the appraisal outputs -by whom and sign offs. A flag is used on the appraisal spreadsheet to identify any pieces of information that the RO has asked the doctor to discuss at appraisal, to ensure a written reflection is present.

For the individual appraiser:

- An annual record of the appraiser's participation in update meetings
- 360^0 feedback from doctors for each individual appraiser. A standard questionnaire is sent out to each appraisee upon receipt of the appraisal output. This is collated on a

spreadsheet and used to feedback to appraisers in an anonymised format at the close of the appraisal round.

- Scores from the NHS England QA toolkit were given to appraisers so they could benchmark their own skills

For the organisation:

- Feedback about Trust processes is sought from all doctors completing an appraisal
- Scrutiny of all the appraisal outputs by the appraisal lead and RO permits an overview of themes, risks and concerns to be formulated.

(See **Annual Report Template, Appendix B;** Quality assurance audit of appraisal inputs and outputs)

d. Access, security and confidentiality

The MTW appraisal system is paper based. The appraisal forms are a modified version of the national Medical Appraisal Guide ('MAG') forms produced by the NHS Revalidation Team in 2012 and are reviewed and adapted following each appraisal round.

The Medical Director's office holds spreadsheet information about MTW doctors on shared Q drive in the clinical governance section. These are password protected documents.

Portfolios of supporting information are held by the doctor and shared with the appraiser prior to the appraisal meeting. At completion of the appraisal the portfolio is returned to the doctor who is required to keep until completion of the relevant revalidation cycle. The completed appraisal forms are held in the Medical Director's office for 6 years.

Doctors are reminded of their information governance responsibilities not to include patient or colleague identifiable information in their appraisal portfolios. At the close of the appraisal round appraisers are reminded of their responsibility not to retain any paper or electronic record of the appraisals they have undertaken. No appraisal related information governance breaches were notified in the 2015/16 cycle.

e. Clinical Governance

Medical appraisals are evidence based through the requirement for doctors to produce a portfolio of supporting information to demonstrate they are up to date in their entire scope of practice. Designated bodies are expected to assist this process by the provision of corporate data to support individual doctor's appraisals. This process is immature. The following data sources are available:

- Dr Foster data
- Results of clinical, network based and national clinical audits
- Workload and productivity data is available in some specialties but may be team based or consultant based, so not applicable to other grades.
- Data about income generation for the Trust by clinical teams
- Clinical governance meeting information, attendance and contribution at clinical governance meetings.
- Complaints, litigation and claims data.
- Information about participation in statutory and mandatory training
- A doctor may be directed by the RO to bring information and evidence of personal reflection about a specific complaint, incident, claim, coroner's inquest or disciplinary issue to his appraisal and its inclusion is monitored.

6. Revalidation Recommendations

114 MTW doctors were given a positive revalidation recommendation in the 15/16 year (18%). 26 doctors were deferred and 4 doctors were remained on hold because of on-going GMC investigations. A single 'non-engagement' notification was made.

The common cause of deferral of revalidation was the absence of sufficient information on which to make a recommendation. Often this was the absence of formalised patient feedback through the MTW 360 appraisal system or poor evidence of participation in quality improvement activity. The solitary non-engagement recommendation triggered an investigation into the doctor for a breach of the MTW appraisal policy.

See **Annual Report Template Appendix C;** Audit of revalidation recommendations

7. Recruitment and engagement background checks

MTW detailed recruitment processes require the credentialing and performance of background checks. Fair recruitment and selection is part of the Trust's wider commitment to equality of opportunity in employment and effective recruitment, selection and appointment of staff are key elements in ensuring the Trust's workforce have the skills and capabilities to achieve its business aims.

The Trust's well-defined recruitment policy and procedure outlines recruiting personnel obligations and clear processes to ensure that the Trust selects the best person for the job, in a process which is fair, open and transparent, and compliant with legislation, best practice and NHS Employers Employment Standards, and NHSLA Frameworks. The policy applies to the recruitment and selection of all Trust medical staff, irrespective of the contractual status of the vacancy, clinical speciality, or seniority.

Employment checks are an on-going requirement for Trust staff, and will be applied in relation to internal moves and promotions within the Trust.

Professional registration and entitlement to work / remain in the United Kingdom are also monitored via monthly reports, and utilisation of on-line checking systems.

Equally relevant employment checks are carried out in relation to medical temporary staff who are utilised within the Trust via agencies in order to ensure that current / valid professional registration is in place, and checklists placed on file / available for audit.

Although no formalised system of language checking has been instigated, communication competency forms part of the interview process which is also attended by a member of the HR team.

See **Annual Report Template Appendix E**

8. Monitoring Performance

The Trust governance structures are in place and allow scrutiny of clinical performance throughout the organisation. Data on clinical outcomes, morbidity and mortality, readmissions and length of stay are regularly interrogated for clinical directorates allowing monitoring of clinicians performance.

9. Responding to Concerns and Remediation

Concerns regarding clinicians are handled under the umbrella of MHPS (maintaining high professional standards), and our Trust policies that encompass that national guidance. As appropriate, clinical or capability concerns are handled with advice from NCAS (National Clinical Advisory Service).

The Trust has a remediation policy, to address deficiencies of performance that are identified.

10. Risk and Issues

- There was small overall decline in appraisal rates at MTW (92% from 94% in 2014/15). The rates for substantive staff were static at 97% and the overall decline was due a fall in the appraisal rate of doctors in fixed term contracts from 41/54 (76%) in 2014/15 to 51/72 (71%) in 2015/16. This indicates an improvement in appraisal systems in identifying doctors linked to MTW on fixed term contracts who need an appraisal. The overall number of appraisals performed in the cycle increased from 338 in 2014/15 to 350 in 2015/16.
- The introduction of systems to ascertain the appraisal and revalidation status of doctors employed on fixed term contracts and other new appointees led to considerable improvement this area although the appraisal rate still lags behind that of substantive medical employees.
- A reliable consistent mechanism that provides appropriate summary of Trust governance information about an individual doctor is still lacking and was identified as a risk in last year's report. This would allow all MTW doctors to include a statement of significant complaints and incidents in their portfolio that can be discussed with the appraiser and reflections and learning documented at appraisal. Current systems largely rely on the doctor remembering to declare adverse episodes.
- 22% doctors took longer than 28 days to submit their completed appraisal (unchanged from 2014/15) but 28% doctors had their appraisal interview later than the last day of their assigned month (an increase from 25%).
- No doctors used the same appraiser for a 4th consecutive appraisal which has previously been an in issue.
- There was further improvement in the consistency with which doctors declared their entire scope of practice and the supporting evidence they present in non-NHS roles. This had been flagged to appraisers as an issue and a minor change to the appraisal forms help remind both parties of the need for appraisal to cover the whole scope of work.
- The NHS England tool for assessing the quality of appraisal summaries showed improvement in the overall quality of appraiser performance in 15/16. Particular weak area of documenting the reflective practice of doctors and the impacts this has on team working and improvements to patient care was identified as a theme requiring improvement.
- Improvements to the GMC Connect website have eased monitoring of the revalidation of doctors at the Hospice in the Weald. Changes to the GMC registration website allow easier identification of a doctor's responsible officer and designated body for revalidation.
- Notification of a selected appraiser to the RO office improved a little but this remains an onerous administrative problem.
- There was poor use of the appraisal deferral form from doctors who anticipated that they would have difficulty in doing a timely appraisal.
- The updated MTW appraisal and revalidation policy was approved in March 2016.
- Only the most recent appraisal is presented to the Revalidation Advisory Group whereas the appraisal record, with appraiser statements and PDPs for the whole revalidation cycle need to be reviewed. A paper based system makes this administratively very difficult.

11. Board Reflections

- MTW has a high rate of medical engagement with the statutory requirements around appraisal and revalidation.
- Appraisal rates are taken as a crude marker of the quality of appraisal systems in designated bodies by NHS England, GMC and the media.
- Regulatory bodies can take action against a Trust should they suspect that the systems in place lack assurance of quality.
- An NHS England independent verification visit in June 2015 indicated that the current appraisal and revalidation arrangements at MTW are ‘excellent’ and ‘good’ respectively.
- These systems are an administrative burden and represent a major commitment of time, effort and professionalism for our trained appraisers.

12. Corrective Actions, Improvement Plan and Next Steps for 16/17

- The trust will adopt the National ‘MAG’ Appraisal form which was published in April 2016. This is an interactive PDF that allows supporting information to be uploaded. This will bring MTW in line with national processes and allow a more paperless system in the trust. It will ease review of doctors’ portfolio information as part of our quality assurance mechanisms.
- The appraisal team will devise and set up a rolling dashboard of all appraisal outcomes for doctors connected to MTW. This will ease storage issues and improve the work of the Revalidation Advisory Group. The system will also help with early identification of late appraisals through automated email alerts
- The documentation of reflective practice will be a focus of learning for the appraiser update sessions that precede the 16/17 round.
- Medical staffing and clinical governance teams will build on the improving assistance and support to the Medical Director’s office so that the administrative burden of this process is minimised and appropriate assurance given.

13. Recommendations

The Board is asked to accept this report and to approve the statement of compliance confirming that the Trust as a designated body, is in compliance with the regulations governing appraisal and revalidation (Appendix F)

Annual Report Template Appendix A: Audit of all missed or incomplete appraisals audit

Doctor factors (total)	**Number**
Maternity leave during the majority of the ‘appraisal due window’	1
Sickness absence during the majority of the ‘appraisal due window’	1
Prolonged leave during the majority of the ‘appraisal due window’	0
Suspension during the majority of the ‘appraisal due window’	0
New starter – unknown previous appraisal history	19
Postponed due to incomplete portfolio/insufficient supporting information	0
Appraisal outputs not signed off by doctor within 28 days	77
Lack of time of doctor	0
Lack of engagement of doctor	8
Other doctor factors	0
Appraiser factors	
Unplanned absence of appraiser	0
Appraisal outputs not signed off by appraiser within 28 days	77
Lack of time of appraiser	0
Other appraiser factors (describe)	0
Organisational factors	
Administration or management factors	0
Failure of electronic information systems	0
Insufficient numbers of trained appraisers	0
Other organisational factors (describe)	0

Annual Report Template Appendix B: Quality assurance audit of appraisal inputs and outputs

Total number of appraisals completed		350
	Number of appraisal portfolios sampled (to demonstrate adequate sample size)	Number of the sampled appraisal portfolios deemed to be acceptable against standards
Appraisal inputs	17	17
Scope of work: Has a full scope of practice been described?	17	17
Continuing Professional Development (CPD): Is CPD compliant with GMC requirements?	17	16
Quality improvement activity: Is quality improvement activity compliant with GMC requirements?	17	14
Patient feedback exercise: Has a patient feedback exercise been completed? (in this appraisal or within this revalidation cycle)	17	11
Colleague feedback exercise: Has a colleague feedback exercise been completed?	17	11
Review of complaints: Have all complaints been included?	17	15
Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?	17	15
Is there sufficient supporting information from all the doctor's roles and places of work?	17	14
Is the portfolio sufficiently complete for the stage of the revalidation cycle (year 1 to year 4)? Explanatory note: For example • Has a patient and colleague feedback exercise been completed by year 3? • Is the portfolio complete after the appraisal which precedes the revalidation recommendation (year 5)? • Have all types of supporting information been included?	17	17

Appraisal Outputs		
Appraisal Summary	17	17
Appraiser Statements	17	17
PDP	17	17

Comments:

The standard was felt to be acceptable in all case and excellent in a few.
The following themes were detected:

1. Some portfolios were poorly structured making it very difficult to find specific pieces of information. Use of the national MAG form would address this as portfolio information can be embedded in the form. Alternatively the use of a contents page and divider tabs to indicate each section in a paper portfolio would be useful.
2. Governance sign off from independent providers could not be found in 2 instances where the doctor's scope of work included private practice.
3. Documented reflective practice was not evident in a number of portfolios.
4. The forms for the current and previous appraisal need to be found in the portfolio.
5. The most recent 360 MSF should be present in the portfolio even if this was not conducted in the current year.
6. Failure to anonymise patient information was an issue in two portfolios where lists of identifiable patients were included in order to show workload in outpatient and A&E settings. These were an unnecessary inclusion and the same information could have been more effectively summarised in some overall workload data without the information governance breach.
7. It was felt that in a couple of instances the portfolio was padded with unnecessary inclusions such as very out of date information about the doctor's practice. The portfolio information should be restricted to the period since the previous appraisal (with the exception of the 360 MSF).

Annual Report Template Appendix C: Audit of revalidation recommendations

Revalidation recommendations between 1 April 2015 to 31 March 2016	
Recommendations completed on time (within the GMC recommendation window)	141
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	141
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	N/A
No responsible officer in post	N/A
New starter/new prescribed connection established within 2 weeks of revalidation due date	N/A
New starter/new prescribed connection established more than 2 weeks from revalidation due date	N/A
Unaware the doctor had a prescribed connection	N/A
Unaware of the doctor’s revalidation due date	N/A
Administrative error	N/A
Responsible officer error	N/A
Inadequate resources or support for the responsible officer role	
Other	N/A
Describe other	N/A
TOTAL [sum of (late) + (missed)]	0

Annual Report Template Appendix D: Audit of concerns about a doctor's practice

Concerns about a doctor's practice	High level	Medium level	Low level	Total
Number of doctors with concerns about their practice in the last 12 months Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern	0	0	0	0
Capability concerns (as the primary category) in the last 12 months	1	0	0	0
Conduct concerns (as the primary category) in the last 12 months	2	0	0	0
Health concerns (as the primary category) in the last 12 months	0	0	0	0
Remediation/Reskilling/Retraining/Rehabilitation				
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2014 who have undergone formal remediation between 1 April 2014 and 31 March 2015 *Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice* *A doctor should be included here if they were undergoing remediation at any point during the year*				0
Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)				
Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)				
General practitioner (for NHS England area teams only; doctors on a medical performers list, Armed Forces)				
Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)				
Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)				
Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc) All DBs				
Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc.) All DBs				
TOTALS				

Other Actions/Interventions	
Local Actions:	0
Number of doctors who were suspended/excluded from practice between 1 April and 31 March: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included	0
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included Less than 1 week 1 week to 1 month 1 – 3 months 3 - 6 months 6 - 12 months	
Number of doctors who have had local restrictions placed on their practice in the last 12 months?	0
GMC Actions: Number of doctors who:	
Were referred to the GMC between 1 April and 31 March	0
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March	
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March	
Had their registration/licence suspended by the GMC between 1 April and 31 March	
Were erased from the GMC register between 1 April and 31 March	
National Clinical Assessment Service actions:	
Number of doctors about whom NCAS has been contacted between 1 April and 31 March:	1
For advice	1
For investigation	
For assessment	
Number of NCAS investigations performed	0
Number of NCAS assessments performed	0

Annual Report Appendix E: Audit of recruitment and engagement background checks

Number of new doctors (including all new prescribed connections) who have commenced in last 12 months (including where appropriate locum doctors)	
Permanent employed doctors	23
Temporary employed doctors	305
Locums brought in to the designated body through a locum agency	Not available
Locums brought in to the designated body through 'Staff Bank' arrangements	65
Doctors on Performers Lists	
Other Explanatory note: This includes independent contractors, doctors with practising privileges, etc. For membership organisations this includes new members, for locum agencies this includes doctors who have registered with the agency, etc.	
TOTAL	393

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NHS England INFORMATION READER BOX

Directorate		
Medical	Operations	Patients and Information
Nursing	Policy	Commissioning Development
Finance	Human Resources	

Publications Gateway Reference:	**01142**
Document Purpose	Guidance
Document Name	A Framework of Quality Assurance for Responsible Officers and Revalidation, **Appendix E - Statement of Compliance**
Author	NHS England, Medical Revalidation Programme
Publication Date	4 April 2014
Target Audience	All Responsible Officers in England
Additional Circulation List	Foundation Trust CEs , NHS England Regional Directors, Medical Appraisal Leads, CEs of Designated Bodies in England, NHS England Area Directors, NHS Trust Board Chairs, Directors of HR, NHS Trust CEs, All NHS England Employees
Description	The Framework of Quality Assurance (FQA) provides an overview of the elements defined in the Responsible Officer Regulations, along with a series of processes to support Responsible Officers and their Designated Bodies in providing the required assurance that they are discharging their respective statutory responsibilities.
Cross Reference	The Medical Profession (Responsible Officers) Regulations, 2010 (as amended 2013) and the GMC (Licence to Practise and Revalidation) Regulations 2012
Superseded Docs (if applicable)	Replaces the Revalidation Support Team (RST) Organisational Readiness Self-Assessment (ORSA) process
Action Required	Designated Bodies to receive annual board reports on the implementation of revalidation and submit an annual statement of compliance to their higher level responsible officers (ROCR approval applied for).
Timings / Deadline	**From April 2014**
Contact Details for further information	england.revalidation-pmo@nhs.net http:// www.england.nhs.net/revalidation/

Document Status

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Appendix F – Statement of Compliance

Designated Body Statement of Compliance

The Board of Maidstone and Tunbridge Wells NHS Trust (MTW) has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Comments: Dr Paul Sigston, Medical Director fulfils these requirements for MTW.

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Comments: Changes introduced in 15/16 have ensured improved and more prompt inclusion in the appraisal process for all doctors linked to MTW.

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Comments: 79 medical appraisers are recognised by the Trust for this role.

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

   Comments: annual update sessions are held by the appraisal lead and there are strong quality assurance systems that permit feedback of performance to appraisers.

5. All licensed medical practitioners[3] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Comments: The MTW appraisal form is an adaptation of the national MAG form

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

[3] Doctors with a prescribed connection to the designated body on the date of reporting.

Comments: The Trust is looking to build on existing systems to ensure doctors have access to data and supporting information relevant to their practice

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

Comments: These areas are covered by existing Trust processes

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

Comments: At MTW RO to RO communication is triggered by the recruitment of any new doctor establishing a prescribed connection to MTW. There is regular contact between MTW's RO and ROs at local independent providers. Ad hoc communication is conducted as circumstances dictate.

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[4] have qualifications and experience appropriate to the work performed; and

Comments: Monitoring of these processes will be conducted in 16/17 to provide improved assurance.

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Comments: Yes – see actions emerging from the annual report.

Signed on behalf of the designated body

Name: Glenn Douglas,
Chief Executive

Signed: _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

[4] Doctors with a prescribed connection to the designated body on the date of reporting.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting - June 2016

6-15	Summary report from Audit and Governance Committee, 25/05/16	Committee Chair (Non-Executive Director)

The Audit and Governance Committee met for a short time on 25th May 2016. Immediately after the 'main' meeting, the Committee reconvened as the "Auditor Panel" (in November 2015 the Board appointed the Audit and Governance Committee as the Trust's Auditor Panel, to advise on the selection, appointment and removal of External Auditors from 2017/18). A summary report from the "Auditor Panel" has been submitted to the Part 2 Trust Board meeting, due to commercial confidentiality.

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

- The Counter Fraud Annual Report for 2015/16 was reviewed and discussed. It was noted that there had been an increase in referrals, which indicated that the referral process was working well. There had been 12 new cases, with 4 cases carried forward. A number of cases had been prosecuted.
- The final draft Annual Report and Annual Accounts for 2015/16 (including the Governance Statement) was reviewed, and the Committee agreed to recommend that these be approved by the Trust Board, subject to the minor amendments that were discussed at the meeting. Trust Board Members will be aware that these were duly approved on 25/05/16
- The Audit Findings Report ('Report to those charged with governance') from the External Auditors was reviewed. The wording of the qualified 'except for' Opinion was discussed in detail, and the External Auditors agreed to consider amending the wording of the "Basis for qualified value for money conclusion" section of their Opinion for 2015/16 in light of the discussion. Trust Board Members will be aware that the outcome of this matter was discussed at the Part 2 Trust Board meeting on 25/05/16
- The 2015/16 Draft Management Representation Letter was reviewed, and it was agreed to recommend that this be approved by the Trust Board (and it was, on 25/05/16)
- The External Audit fee letter for 2016/17 was received, and it was noted that the fee would be £79,569 (excluding any mandated audit of the Quality Accounts)

2. The Committee agreed that (in addition to any actions noted above):

- N/A

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

- N/A

Which Committees have reviewed the information prior to Board submission?

- N/A

Reason for 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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – June 2016

6-16	Summary report from Charitable Funds Committee, 23/05/16	Committee Chairman (Non-Executive Director)

The Charitable Funds Committee met on 23rd May 2016.

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

- The income, expenditure and balance sheet, at quarter 4, 2015/16 were reviewed, along with fund transactions over £1k and the balances by individual fund. It was noted that total income for 2015/16 was £1.44m, of which £1.14m was in respect of legacy income and £291k in respect of income from donations. Total income was noted as significantly higher than for the previous year (£154k), but clarification was requested of how the level of non-legacy funding/income from donations compared with previous years.
- Total expenditure for 2015/16 was £767k, and increased expenditure was likely in the current year, as orders were made against legacy funding.
- The one occasion of expenditure refused was notified, and was confirmed as appropriate.
- Investment strategy was reviewed and it was agreed that the role and performance of the Charities Aid Foundation (CAF) should be reviewed in relation to fund performance and investment mix. The committee agreed that a low risk strategy was appropriate, but that consideration should be given to further investment in Equities once the outturn of short term spending was clearer.
- A revised proposal for the management and administration fee for 2016/17 (of £36,383.44, including an audit fee of £3,360) was approved. It was noted that the proposed audit fee was less than the for the previous year as the audit would be based on an independent review.
- Further revisions to the Policy and Procedures for Charitable Funds were proposed and agreed in respect of more explicit provisions on closure of infrequently used funds and clarification of processes related to the use of charitable funds for staff benefits/social events.

2. In addition to the actions noted above, the Committee agreed that…

- Consideration should be given to what further actions might be taken to ensure wider application of charitable funds to previously 'neglected' areas.
- The existing arrangement by which the salary of a Diabetes Nurse was paid from charitable funds (by the League of Friends) should be reviewed to establish if it would be more appropriately processed through Exchequer funding.
- The Chairman should write to departments that had not yet submitted expenditure plans.
- Three Charitable Funds Committee meetings were to be scheduled for 2017, to take place in February, June and October.

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

- N/A

Which Committees have reviewed the information prior to Board submission?

- N/A

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

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Trust Board Meeting - June 2016

6-17	Summary report from Quality Committee, 13/06/16	Committee Chair (Non-Executive Director)

A Quality Committee 'deep dive' meeting was held on 13th June 2016.

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

- A review of the actions agreed from previous meetings
- A review of Paediatric Care (with a focus on the non-elective pathway for children at both hospital sites (for which several members of the Children's Services team attended) was held. The Committee received a detailed presentation, focusing on the Team's position against the national service standards within the Royal College of Paediatrics and Child Health, "Standards for Children and Young People in Emergency Care Settings" and against recommendations from the Care Quality Commission inspection report (October 2014). The presentation also highlighted the pathways for paediatric patients at both sites and provided detailed statistics on attendance trends. It was noted that Paediatric attendances were increasing year on year at both sites, but those at Tunbridge Wells Hospital were growing more quickly.
- The Committee received assurance from the "Review of Paediatric Care" that compliance had been achieved against the relevant standards within the Royal College of Paediatrics and Child Health, "Standards for Children and Young People in Emergency Care Settings" (including the categories: Environment in emergency care settings; Management of the sick or injured child and Staffing and Training)
- The Committee received assurance from the "Review of Paediatric Care" that recommendations from the Care Quality Commission report (October 2014) had been implemented (including the categories of PEWS; Clinical governance; Topical anaesthetics and Risk register).
- The Committee were assured of progress in the presenting department and commended the team on their achievements to date
- Potential issues for review at future 'deep dive' meetings were discussed

2. The Committee agreed that:

- A "Review of End of Life Care" should be firmly scheduled for the Quality Committee 'deep dive' meeting in August 2016
- A "Review of Women's services" should be firmly scheduled for the Quality Committee 'deep dive' meeting in October 2016
- A "Surgery Review" should be scheduled for a Quality Committee 'deep dive' meeting in early 2017"

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

- N/A

Which Committees have reviewed the information prior to Board submission?

- N/A

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

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Trust Board meeting – June 2016

6-18 Summary of the Trust Management Executive (TME) meeting, 15/06 Chief Executive

The TME has met once since the last Board meeting. The key items covered were as follows:

- In the **safety moment**, the Chief Nurse reported that inpatient falls would be the number one safety priority for 2016/17, with the aim being to achieve a rate of 6.2 falls per 1000 Occupied Bed Days. It was noted that the initiative would be managed along similar lines to the approach applied to Infection Prevention and Control
- The key issues highlighted via the **reports from the Clinical Directors (CD)** were as follows:
  - Staffing was again reported to be a concern for a number of Directorates
  - Performance against the Cancer waiting tine targets remained an issue for Surgery, and a further Cancer Summit was scheduled for 16/06/16
  - The impact of the implementation of the Growth Assessment Protocol (GAP) had not been fully considered by the Maternity Department, and further work was being undertaken to mitigate the risks posed
  - Haematology clinic capacity remained an issue for Cancer, but a Business Case had been submitted to aim to enable the activity to be managed in a more stable way. It was also noted that some concern had been raised from 2 recent Cancer Peer Reviews, but assurance was given that the necessary action would be undertaken
  - Children's services reported that the new Children's A&E at Tunbridge Wells Hospital had been successful thus far, and the backlog of Electronic Discharge Notifications (EDNs) that had developed within the Directorate had been largely cleared
  - Critical Care gave an update on a risk involving Ophthalmic Microscopes, but the Chief Operating Officer pointed out that the equipment was number one priority on the Trust's equipment replacement programme
  - Diagnostics and Pharmacy reported that turnaround times for Histopathology reporting had deteriorated recently. The Directorate's report also included a discussion of the Trust's response to the national shortage of Cefuroxime
  - Emergency and Medical Services expressed concerns at the access to Psychiatric inpatient facilities. The Chief Operating Officer acknowledged the validity of the issue, and confirmed that the issue had been escalated to Commissioners.
- The **performance for month 2**, 2015/16 was reported, as was the latest position regarding **infection prevention and control**
- The report of the recent meetings of the **Trust Clinical Governance Committee** (a formal sub-committee of TME) was noted
- The Chief Nurse presented the findings from the **2015 National NHS Inpatient Survey**, and it was highlighted that, overall, the survey was positive
- An update on the **Kent and Medway Sustainability and Transformation Plan** (STP) was given
- The Chief Operating Officer presented the first iteration of the **winter & operational resilience plans**, and it was noted that monthly reports would be submitted to TME from July onwards
- An update on the **implementation of the SAcP (replacement PAS+)** was reported, and it was noted that the new date for implementation was likely to be in October 2016
- It was noted that no **Business Cases** had been approved since the last TME meeting, but a number of cases that had been submitted had been returned to the Directorate for further work
- Two **replacement Consultant posts were approved** (for a Consultant Breast Radiologist and a General Paediatrician with interest in Diabetes)
- An update on the **Internal Audit plan for 2015/16** (including outstanding actions) was noted
- Updates were received on the work of the TME's main **sub-committees** (Procurement Strategy Committee, Clinical Operations and Delivery Committee, Health & Safety Committee, and Policy Ratification Committee). The report from the Procurement Strategy Committee included a request to approve the proposed **Procurement Strategy** 2016-19 (which was heeded). The Health & Safety Committee report included assurance on the latest **water quality testing**
- The Director of Workforce submitted a report on the process for undertaking **Disclosure and**

Barring Scheme (DBS) checks (which was requested following an issue raised at a previous TME meeting)

- The Committee reviewed the **draft Quality Accounts 2015/16**, and received the report of the **External Audit of the Quality Accounts**, which reported an Unqualified conclusion
- The **Environmental Policy and Procedure** was approved, and it was noted that Carole Jones had been appointed as the **Clinical Director for the new Head & Neck Directorate** (which had separated from Surgery)

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

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Trust Board Meeting - June 2016

6-19	Summary report from Patient Experience Committee, 16/16/16	Committee Chair (Non-Executive Director)

The Patient Experience Committee met on 16th June 2016.

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

- A report on the CIP workstream on cancelled and missed appointments (see Section 3)
- The latest position on the Trust's new translation service, implemented on 1st June 2016
- The latest performance of the Trust's Stroke services
- In accordance with Board action 3-27i, a presentation by the Integrated Discharge Team
- An update on Complaints and PALS contacts, including a review of the Complaints and PALS Annual Report 2016 (which incorporated a review of the complaints and concerns received by the Trust; a review of performance in responding to complaints and a summary of the learning and action taken in response to complaints received in 2016-15).
- An update from Healthwatch, including recommendations from visits to Maidstone and Tunbridge Wells A&E departments in February 2016, and confirmation that plans were now underway to finalise arrangements for a enter and view visit to Outpatients
- A review of the Quality Accounts 2015/16 prior to their submission to Trust Board, which included a review of performance against Patient Experience priorities for 2015/16, and notification of 2016/17 priorities. These were: To improve the use of current feedback mechanisms and provide more innovative ways to receive and act upon feedback.
- Review of the Patient Led Assessments of the Care Environment (PLACE) Action Plan, including an update on the mealtime support being given to patients
- Notification of recent/planned service changes, which included updates on the opening of the AMU and Paediatric A&E at Tunbridge Wells Hospital and the offer of new complementary therapies for those suffering from secondary breast cancer
- An update on work from the West Kent Clinical Commissioning Group, including details of the new Kent and Medway patient transport service provided by G4S from 1st July 2016
- An update on Communications and Membership
- Findings from the national Maternity Survey 2015, which noted that the Trust scored better than average in parts of the ante natal; labour care and post natal surveys and did not perform worse than any other Trust in any of the questions
- Findings from NHS Inpatient Survey 2015, prior to consideration by Trust Board, noting that there were no questions in this year's survey where the Trust saw any statistically significant reduction in the scores
- Findings from the local patient survey, noting that: Overall satisfaction had remained stable at 90% for the last two months of the current year; complaints relating to nursing care have reduced over the past three months and satisfaction with involvement in care and decisions had remained positive. A reduction in positive responses relating to medication side effects on discharge from hospital and provision of support from staff to eat meals was also noted
- An update from the Patient Information and Leaflets Group (PILG)
- A report from the Quality Committee meetings on 02/03/16, 13/04/16, and 11/05/16

2. The Committee agreed to:

- The Chief Nurse to investigate the feasibility of introducing new name badges for all staff to reflect recommended typography (black type on yellow background) and a 50% increase in size
- The Head of Staff Engagement and Equality to submit a report on the new Trust translation service to the Patient Experience Committee in September 2016, to reflect the outcome of evaluation to date
- The Deputy Chief Nurse to consider how the PLACE assessment process might be used to assess whether the recommendations from the Healthwatch visits to A&E (Maidstone and

Tunbridge Wells Hospitals) have been addressed

- The Deputy Chief Nurse to report to the Patient Experience Committee in September 2016 on the status / future plans for the Care Assurance Audit Programme, in the light of the ongoing review with Healthwatch
- The Head of Communications to consider providing early notification to Patient Experience Committee members of major media stories in advance of their publication
- The Deputy Chief Nurse to submit a report to the Patient Experience Committee meeting in September 2016 with a proposed response to the issues raised by the survey questions: "Did a member of staff tell you about medication side effects to watch for when you went home?" and "Were you told how to take your medication in a way you could understand?"
- The Trust Secretary to identify the reasons preventing card payments in the Maidstone Hospital car-park ticket machines (in light of card payments being accepted at the machines at Tunbridge Wells Hospital)
- The Trust Secretary to identify why the automated teller machine (ATM) at Maidstone Hospital incurs a charge (in light of no charge being levied for the ATM at Tunbridge Wells Hospital)
- The Chief Nurse to investigate what can be done to improve shelving and mirror positioning in Tunbridge Wells Hospital patient bathrooms, ensuring the needs of wheelchair users are considered

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

The Committee noted the strategic and financial significance to the Trust of cancelled and missed appointments. An overall decrease in DNAs (2015/16: 7.39%; 2014/15: 7.64) was reported as a result of on-going work-streams, which equated to a saving of £0.53m. The reported equivalent target for 2016/17 was £0.9m and the Trust was currently slightly ahead of this. The Committee heard how text messages were currently sent to patients 2 days before appointments and that consideration was being given to sending an additional text message 7 days before the appointment in order to allow for greater reutilisation of cancelled slots. The Director of Finance reported that, as part of the CIP for 2016/17, updates on this issue would be made to the Finance Committee and Trust Board. The Patient Experience Committee considered that the matter was of sufficient strategic and financial significance to draw to the attention of the Trust Board via this report.

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 and to note the information under Section 3

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

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Trust Board Meeting – June 2016

6-20	Summary report from Finance Committee, 27/06/16 (incl. revised Terms of Reference)	Committee Chairman (Non-Executive Director)

The Finance Committee met on 27th June 2016.

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

- The "Safety Moment" invited the initial response to the outcome of the EU referendum, and it was agreed to arrange for the workforce-related risks arising from the outcome to be recorded within the Trust's Risk Register
- The annual review of the Committee's Terms of Reference was undertaken, and a number of minor amendments were agreed. The revised Terms of Reference are enclosed at Appendices 1 (as a 'clean' version) and 2 (as a 'track changes'), for approval
- The month 2 financial performance for 2016/17 was reviewed; and it was agreed that the Director of Finance should reconsider amending the budget for High Cost Drugs (to avoid having to report the associated expenditure for each future month as "Favourable"). The Director of Finance also agreed to provide Committee members with a working illustration of the impact of the non-elective activity threshold (which was reported as "Adverse"))
- The latest quarterly update on Service Line Reporting (SLR) was received, and it was agreed that consideration should be given as to whether the Trust's approach to the allocation of CNST charges should be amended (based on the approach taken to such allocation at other NHS Trusts). It was also agreed that the outcome of the SLR-related 'deep dive' to be undertaken with Ophthalmology should be reported to the Committee in September 2016
- A review of the Trust's Business Case process was undertaken, which focused on the 'next steps' to be taken to improve the process
- The Committee was notified of the changes that had been made to the Outline Business Case (OBC) for Linear Accelerator (LinAc) bunker capacity, which was reviewed at the Committee in February, and approved by the Trust Board in April 2016. The Committee expressed its contentment with the changes made.
- The Director of Finance submitted a "Finance Department Improvement Plan" outlining the details of the 30 workstreams and 8 objectives intended to improve the finance function
- The Trust's approach to its Reference Costs submission was reviewed and agreed
- The latest breaches of the external cap on the Agency staff pay rate were reported, as were the recent findings from relevant (i.e. finance-related) Internal Audit reviews
- The Committee's forward programme was reviewed, and some amendments were agreed

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

- The Chair of the Audit and Governance Committee would provide the Director of Finance with a Case Study of the application of the 'stop, start, simplify' approach with which he had been involved
- The Director of Finance should submit a report to the Finance Committee in July 2016 on the actions that had been / were being taken to improve the Trust's liquidity position
- The recommendation from KPMG that the Trust amend its creditor payment terms should be discussed at the 'Part 2' Trust Board meeting on 29/06/16
- The Trauma and Orthopaedics Directorate should be arranged to present to the Trust Board in the autumn of 2016; and the outcome of a 'deep dive' into Emergency Medicine should be provisionally scheduled to be reported to the Committee in November 2016
- The financial implications of the Kent and Medway Sustainability and Transformation Plan should be provisionally scheduled for discussion at the Finance Committee in August 2016
- The financial forecast for 2016/17 should be listed on the agenda of the July 2016 Committee meeting
- The Medical Director's opinion should be obtained as to whether the current frequency of "Update on IT strategy and related matters" reports to the Committee was adequate, in the light of current IT developments

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

- The Committee agreed a number of minor amendments to its Terms of Reference, which have been submitted for approval
- The Committee agreed that KPMG's recommendation that the Trust amend its creditor payment terms should be discussed at the 'Part 2' Trust Board meeting on 29/06/16

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
2. To approve the Committee's revised Terms of Reference (see Appendices 1 and 2)

Appendix 1: Revised Terms of Reference ('clean' version)

FINANCE COMMITTEE

Terms of Reference

1. Purpose

The Trust Board has established the Committee to provide the Trust Board with:

- Assurance on the effectiveness of financial management, treasury management, investment and capital expenditure and financial governance
- An objective assessment of the financial position and standing of the Trust
- Advice and recommendations on all key issues of financial management and financial performance
- Assurance on Information Technology performance and business continuity
- Advice and recommendations on all aspects of informatics, including Information Technology and telecommunications

2. Membership

Membership of the Committee is as follows:

- The Committee Chair - a Non-Executive Director appointed by the Trust Board
- The Committee Vice-Chair - a Non-Executive Director appointed by the Trust Board
- The Director of Finance
- The Medical Director
- The Chief Operating Officer[1]
- The Chief Executive[1]
- The Deputy Chief Executive [1]

Members are expected to attend all relevant meetings.

3. Quorum

The Committee shall be quorate when one Non-Executive Director and two Executive Directors are present. If the Director of Finance cannot attend a meeting, their representative will attend.

For the purposes of being quorate, any Non-Executive Director (including the Chairman of the Trust Board) may be present; and any other Executive Director may be present in place of the Medical Director, should the latter be unable to attend the meeting.

4. Attendance

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

The Committee Chair may also invite others to attend, as required, to meet the objectives of the Committee.

5. Frequency of meetings

The Committee shall generally meet each month.

6. Duties

The Committee has the following duties:

Financial Management

- Review financial plans and strategies and ensure they are consistent with the Trust's overall vision and strategic goals
- Ensure a comprehensive budgetary control framework is in place and operating effectively

[1] N.B. Either the Chief Operating Officer, Chief Executive or Deputy Chief Executive should be present at each meeting

- Monitor financial performance against plan, and ensure corrective action is taken where appropriate
- Develop and monitor key financial performance indicators, and advise the Trust Board on action required to improve performance / address risks. Indicators will include:
  - Risk rating and associated financial ratios;
  - Other financial ratios;
  - Service Line profitability;
  - Efficiency and productivity measures;
  - Benchmarking information;
- Review and assess the Trust's Efficiency Savings Plan (formerly Cost Improvement Plan)
- Obtain assurance that all Efficiency Savings Plan initiatives and business cases have been subject to a Quality Impact Assessment, and to liaise with Quality Committee as appropriate to ensure the robustness of the process

Treasury Management

- Approve the Trust's detailed treasury management policies, processes and controls
- Approve external funding and borrowing arrangements, including approval of working capital facilities and capital investment loan applications (within delegated authority, or review of such applications if the value exceeds the Committee's delegated authority)
- Approve relevant benchmarks for measuring performance e.g. Better Payment Practice Code (BPPC)
- Ensure proper safeguards are in place for security of the Trust's funds by ensuring approved bank mandates are in place for all accounts, which are updated regularly for changes in signatories and authority levels;
- Monitor compliance with treasury management policies and procedures
- Specify and review detailed treasury reporting requirements
- Review the cash flow and balance sheet of the Trust, ensuring effective cash management plans are in place

Capital Expenditure and Investment

- Review the Trust's capital plan ensuring its alignment to strategic priorities
- Review and assess the financial implications of the PFI contract for Tunbridge Wells Hospital, including any options for re-financing
- Review business cases above the threshold set-out in the Reservation of Powers and Scheme of Delegation, for capital and service development and advise the Trust Board on the financial implications of the proposals
- Regularly review investment criteria, and the investment appraisal and approval process

Financial Governance, Reporting, Systems and Function

- Review and assess arrangements for financial governance
- Review and agree financial policies
- Ensure financial reporting to Trust Board meets the requirements of the Board
- Review and assess the effectiveness of financial information systems, and agree and monitor development plans, including the development of Service Line Reporting
- Review and assess the capacity and effectiveness of the finance function and ensure development plans are in place to meet the current and future requirements of the Trust (including the requirements of Foundation Trust status)
- Assess the organisational awareness and adherence to financial management disciplines and controls and promote congruence between quality patient care and the achievement of financial objectives.
- Review and approve the Trust's approach to its Reference Cost submission/s

Procurement

- To monitor performance against the Trust's Procurement Strategy

Informatics (including Information Technology)

- Review informatics strategies and plans and ensure they are consistent with the Trust's overall vision and strategic goals

- Review plans and proposals for major development and investment in Information Technology, and advise the Trust Board accordingly, paying particular attention to the financial implications and risks of the proposals

Assurance and Risk

- Assure itself on (i) the identification of principal risks associated with the financial performance and financial management of the Trust, and Information Technology, (ii) the effective management of those risks and (iii) the escalation to the Trust Board of matters of significance

7. Parent Committees and reporting procedure

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

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

8. Sub-Committees and reporting procedure

The Finance Committee has no standing sub-committees, but may establish fixed-term working groups, as required, to support the Committee in meeting the duties listed in these Terms of Reference.

9. Emergency powers and urgent decisions

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

10. Administration

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

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

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

11. Review of Terms of Reference and monitoring compliance

The Terms of Reference of the Committee will be reviewed and agreed by the Finance Committee at least annually, and then formally approved by the Trust Board.

History

- Terms of Reference agreed by Finance Committee, May 2013
- Terms of Reference reviewed and agreed by Finance Committee, May 2014 (with a minor additional to duties agreed at the June 2014 Finance Committee)
- Terms of Reference approved by Trust Board, July 2014
- Terms of Reference (revised) agreed by Finance Committee, June 2015
- Terms of Reference (revised) approved by Trust Board, July 2015
- Terms of Reference (minor revision) agreed by Finance Committee, September 2015
- Terms of Reference (minor revision) agreed by Trust Board, September 2015
- Terms of Reference (reviewed and revised) agreed by Finance Committee, June 2016

Appendix 2: Revised Terms of Reference ('tracked changes' version)

FINANCE COMMITTEE

Terms of Reference ('tracked changes' version)

1. Purpose

The Trust Board has established the Committee to provide the Trust Board with:

- Assurance on the effectiveness of financial management, treasury management, investment and capital expenditure and financial governance
- An objective assessment of the financial position and standing of the Trust
- Advice and recommendations on all key issues of financial management and financial performance
- Assurance on Information Technology performance and business continuity
- Advice and recommendations on all aspects of informatics, including Information Technology and telecommunications

2. Membership

Membership of the Committee is as follows:

- The Committee Chair - a Non-Executive Director appointed by the Trust Board
- The Committee Vice-Chair - a Non-Executive Director appointed by the Trust Board
- The Director of Finance
- The Medical Director
- The Chief Operating Officer[2]
- The Chief Executive[1]
- The Deputy Chief Executive [1]

Members are expected to attend all relevant meetings.

3. Quorum

The Committee shall be quorate when one Non-Executive Director and two Executive Directors are present. If the Director of Finance cannot attend a meeting, their representative will attend.

For the purposes of being quorate, any Non-Executive Director (including the Chairman of the Trust Board) may be present; and any other Executive Director may be present in place of the Medical Director, should the latter be unable to attend the meeting.

4. Attendance

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

The Committee Chair may also invite others to attend, as required, to meet the objectives of the Committee.

5. Frequency of meetings

The Committee shall generally meet each month.

6. Duties

The Committee has the following duties:

Financial Management

- Review financial plans and strategies and ensure they are consistent with the Trust's overall vision and strategic goals
- Ensure a comprehensive budgetary control framework is in place and operating effectively

[2] N.B. Either the Chief Operating Officer, Chief Executive or Deputy Chief Executive should be present at each meeting

- Monitor financial performance against plan, and ensure corrective action is taken where appropriate
- Develop and monitor key financial performance indicators, and advise the Trust Board on action required to improve performance / address risks. Indicators will include:
  - Risk rating and associated financial ratios;
  - Other financial ratios;
  - Service Line profitability;
  - Efficiency and productivity measures;
  - Benchmarking information;
- Review and assess the Trust's Efficiency Savings Plan (formerly Cost Improvement Plan)
- Obtain assurance that all Efficiency Savings Plan Cost Improvement Plan initiatives and business cases have been subject to a Quality Impact Assessment, and to liaise with Quality & Safety Committee as appropriate to ensure the robustness of the process

Treasury Management

- Approve the Trust's detailed treasury management policies, processes and controls
- Approve external funding and borrowing arrangements, including approval of working capital facilities and capital investment loan applications (within delegated authority, or review of such applications if the value exceeds the Committee's delegated authority)
- Approve relevant benchmarks for measuring performance e.g. Better Payment Practice Code (BPPC)
- Ensure proper safeguards are in place for security of the Trust's funds by ensuring approved bank mandates are in place for all accounts, which are updated regularly for changes in signatories and authority levels;
- Monitor compliance with treasury management policies and procedures
- Specify and review detailed treasury reporting requirements
- Review the cash flow and balance sheet of the Trust, ensuring effective cash management plans are in place

Capital Expenditure and Investment

- Review the Trust's capital plan ensuring its alignment to strategic priorities
- Review and assess the financial implications of the PFI contract for Tunbridge Wells Hospital, including any options for re-financing
- Review major or contentious business cases above the threshold set-out in the Reservation of Powers and Scheme of Delegation, for capital and service development and advise the Trust Board on the financial implications and risks of the proposals
- Regularly review investment criteria, and the investment appraisal and approval process

Financial Governance, Reporting, Systems and Function

- Review and assess arrangements for financial governance
- Review and agree financial policies
- Ensure financial reporting to Trust Board meets the requirements of the Board
- Review and assess the effectiveness of financial information systems, and agree and monitor development plans, including the development of Service Line Reporting
- Review and assess the capacity and effectiveness of the finance function and ensure development plans are in place to meet the current and future requirements of the Trust (including the requirements of Foundation Trust status)
- Assess the organisational awareness and adherence to financial management disciplines and controls and promote congruence between quality patient care and the achievement of financial objectives.
- Review and approveal of the Trust's approach to its Reference Cost submission/s

Procurement

- To monitor the Trust's adherence to 'Better Procurement, Better Value, Better Care' metrics
- To approve the Trust's Procurement Strategy, and monitor performance against the Trust's Procurement Strategy

Informatics (including Information Technology)

- Review informatics strategies and plans and ensure they are consistent with the Trust's overall vision and strategic goals
- Review plans and proposals for major development and investment in Information Technology, and advise the Trust Board accordingly, paying particular attention to ~~on its alignment to the Trust's overall vision and strategy as well as~~ the financial implications and risks of the proposals

Assurance and Risk

- Assure itself on (i) the identification of principal risks associated with the financial performance and financial management of the Trust, and Information Technology, (ii) the effective management of those risks and (iii) the escalation to the Trust Board of matters of significance

7. Parent Committees and reporting procedure

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

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

8. Sub-Committees and reporting procedure

The Finance Committee has no standing sub-committees, but may establish fixed-term working groups, as required, to support the Committee in meeting the duties listed in these Terms of Reference.

9. Emergency powers and urgent decisions

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

10. Administration

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

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

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

11. Review of Terms of Reference and monitoring compliance

The Terms of Reference of the Committee will be reviewed and agreed by the Finance Committee at least annually, and then formally approved by the Trust Board.

History

- Terms of Reference agreed by Finance Committee, May 2013
- Terms of Reference reviewed and agreed by Finance Committee, May 2014 (with a minor additional to duties agreed at the June 2014 Finance Committee)
- Terms of Reference approved by Trust Board, July 2014
- Terms of Reference (revised) agreed by Finance Committee, June 2015
- Terms of Reference (revised) approved by Trust Board, July 2015
- Terms of Reference (minor revision) agreed by Finance Committee, September 2015
- Terms of Reference (minor revision) agreed by Trust Board, September 2015
- Terms of Reference (reviewed and revised) agreed by Finance Committee, June 2016