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 27TH MAY 2015

PENTECOST / SOUTH ROOMS, THE ACADEMIC CENTRE, MAIDSTONE HOSPITAL

A G E N D A – PART 1

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5-2	To declare interests relevant to agenda items	Chairman	Verbal	-
5-3	Minutes of the Part 1 meeting of 29th April 2015	Chairman	1	1-9
5-4	To note progress with previous actions	Chairman	2	10-11
5-5	Safety moment	Medical Director	Verbal	-
5-6	Chairman's report	Chairman	Verbal	-
5-7	Chief Executive's report	Chief Executive	3	12
5-8	Integrated Performance Report for April 2015 (incl. updates on recruitment and retention; and DTOCs)	Chief Executive	4	13-24
5-9	Theatre scheduling – issues and potential solutions	Chief Operating Officer	5	25-28
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5-18	Quality & Safety Committee, 13/05/15 (to incl. approval of revised Terms of Reference)	Committee Chair	13	122-130
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5-22	Approval of Ann. Report, 2014/15 (incl. Gov. Statement)	Chair of Audit and Governance Committee	17	166-224
5-23	Approval of Annual Accounts, 2014/15		18	225-273
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5-25	**To consider any other business**			
5-26	**To receive any questions from members of the public**			
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	Chairman	Verbal	-

Date of next meetings:

- 24th June 2015, 10.30am, The Academic Centre, Maidstone Hospital
- 22nd July 2015, 10.30am, The Education Centre, Tunbridge Wells Hospital
- 30th September 2015, 10.30am, The Academic Centre, Maidstone Hospital
- 21st October 2015, 10.30am, The 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 29TH APRIL 2015, 10.30 A.M. AT TUNBRIDGE WELLS HOSPITAL

DRAFT, FOR APPROVAL

Present:	Anthony Jones	Chairman (Chair)	(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)
	Steve Orpin	Director of Finance	(SO)
	Paul Sigston	Medical Director	(PS)
	Kevin Tallett	Non-Executive Director	(KT)
	Steve Tinton	Non-Executive Director (apart from item 4-17)	(ST)
In attendance:	Paul Bentley	Director of Workforce and Communications	(PB)
	Jim Lusby	Deputy Chief Executive	(JL)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Kevin Rowan	Trust Secretary	(KR)
	Stephen Smith	Associate Non-Executive Director	(SS)
Observing:	Gianna Pollero-Payne	Communications Manager	(GPP)
	Russell Davies	Trust Secretary, Dartford and Gravesham NHS Trust	(RD)
	Marion Smith	External Governance Adviser	(MS)

4-1 To receive apologies for absence

Apologies were received from Alex King (AK) Non-Executive Director.

AJ welcomed JL to his first Board meeting since joining the Trust as Deputy Chief Executive.

AJ noted that as a result of the findings from the last PLACE inspection regarding food, KR had arranged for Board members to sample the food being served on the wards at Tunbridge Wells Hospital (TWH) today. AJ noted that this would be made available after the Part 1 meeting.

4-2 To declare interests relevant to agenda items

There were no declarations of interest.

4-3 Minutes of the Part 1 meeting of 25th March 2015

The minutes were agreed as a true and accurate record of the meeting, subject to the following amendment:

- Item 3-3, Page 1: Replace “Item 2-7, page 3: Replace “KT stated that he believed the Trust’s plan worked, but only marginally…” with “KT stated that he believed the Trust’s plan worked, but only at the margins…””

Action: Amend the minutes of the Part 1 meetings of 25th March and 25th February 2015 (Trust Secretary, April 2015 onwards)

4-4 To note progress with previous actions

The circulated report was noted.

4-5 Chairman’s report

AJ reported that the Trust had been charged with Corporate Manslaughter, and the first hearing was scheduled for Sevenoaks Magistrates' Court on 01/05/15. AJ explained that the Trust would not be making any further comments in public, as the matter was sub judice. AJ added that two doctors had also been charged with Gross Negligence Manslaughter in relation to the same case.

4-6 Chief Executive's report

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

- Although he concurred with AJ's comments regarding the Corporate Manslaughter charge, he wished to acknowledge the tragic circumstances involved in the case, and note that the Trust's heartfelt feelings were with the Cappucini family
- The Capital programme and Estates Development plan had been launched, and work had already commenced
- GD had visited the new League of Friends shop at Maidstone Hospital, and had also been presented with a large donation cheque from the League
- An additional Ward was being planned for TWH
- The business case for a Linear Accelerator (LINAC) at TWH was also in development

AJ proposed that a formal letter of gratitude be sent from the Trust Board to the League of Friends of the Maidstone Hospital, following their most recent donation. This was agreed.

Action: Arrange for a formal letter of gratitude to be sent from the Trust Board to the League of Friends of the Maidstone Hospital, following their most recent donation (Trust Secretary, April 2015 onwards)

AJ highlighted that the LINAC at TWH would likely require additional car parking. GD acknowledged the point, and gave assurance that this was being investigated. GD also noted that planning permission had been granted for additional parking spaces at Maidstone Hospital.

SD asked whether the plans for the LINAC at TWH included other Cancer services, such as Chemotherapy. GD stated that this was not part of the current plans, but the intended facility would be able to be expanded to house such services in the future.

4-7 Reflection and response to the issues raised within the 'patient story' heard at the February 2015 Board meeting

AJ requested that PS also cover item 4-8. PS duly referred to the circulated reports (Attachments 4 and 5) and highlighted the following points:

- The report covered 3 areas: communication (and in particular the absence of ensuring that Mrs Wilcock was communicated with effectively); Medical Devices; and Patient Safety Culture
- In terms of Medical Devices policy and practice, work had been undertaken to revise and re-launch the policy. PS had recently discussed this with circa 30 Medical Directors from other Trusts, and had concluded that there was no better system in place at such Trusts
- In terms of patient safety culture, it had been acknowledged that there were opportunities to perform differently, and the work already being undertaken regarding culture would have a positive effect, although PS cautioned that this was a long-term initiative that would take years

SO added that the capital plan had been accelerated recently, to bring forward Medical Devices expenditure from the 2015/16 plan, and emphasised that the Medical Devices and Procurement Departments had been flexible, but also clear on the requirements that need to be met before purchases could be made.

SD asked whether the Medical Devices policy acknowledged the changes that can affect Devices, in terms of training and awareness in response to such changes. PS replied that relevant changes were responded to, and gave the example of a recent issue with Baxter pumps, where staff had been notified of a change, and trained appropriately.

KT asked how obsolescence was managed, and also asked about security considerations, both technical and physical. PS replied that many Medical Devices had a recommended life span, and therefore such devices were marked for replacement via the capital programme, unless the life span had been consciously extended by the Trust, for valid reasons. PS added that all Medical

Devices had safety mechanisms that triggered alarms when, for example, leads were removed. KT asked whether the extension of a recommended life span was recorded. AG confirmed this was the case.

AJ then asked for assurance that the 'hot dog' incident could not occur again. PS replied that one of the causes of the incident was that individuals had not used the safeguards within the Medical Devices policy. PS added that efforts to engage clinical staff with the Medical Devices Group had been made, so that such staff would not regard this forum as an obstacle that they needed to overcome in order to obtain the equipment they desired.

AJ asked for any further comments. AB remarked that culture was an important factor, and highlighted that the Board was scheduled to discuss this further after the Part 2 Board meeting.

AB also highlighted the concerns raised by Mrs Wilcox in terms of the lack of effective communication, and cautious behaviour from staff, and noted that the Trust's efforts in response to the Duty of Candour would have a positive effect. AJ stated that the presumption should be to always communicate, and not be cautious. PS acknowledged the point, but highlighted that he believed the staff involved had focused on their communication with Mr Wilcox.

4-8 The management of medical devices

This item was covered under item 4-7.

4-9 Integrated Performance Report for March 2015 (incorporating an update on recruitment & retention)

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

- The month had seen increased non-elective activity, and more non-elective patients with a higher acuity, which resulted in longer length of stay
- Social Services-related issues has affected the Trust's ability to perform, and represented probably the single biggest risk to the Trust's performance
- GD and AG had attended high-level meetings with Social Services, which had been inconclusive, and GD was not confident that the required action would be taken

GD added that AK had offered to undertake liaison with Social Services, on behalf of the Trust, but stated that more concerted action was required locally i.e. in the south of West Kent. GD elaborated that there appeared to be an unfair distribution of resources. GD then clarified that the issues he had highlighted did not reflect the level of commitment of the specific individuals from Social Services that were working with the Trust. GD summarised that this was the biggest single issue faced by the Trust, but gave assurance that it was receiving the attention it warranted.

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

- The 18-week referral to treatment target had been met in April, albeit via some outsourcing, but unless the aforementioned issues were addressed, the Trust would need to continue to outsource non-elective activity, and therefore lose the associated income streams
- The Trust had some over-52 week waits. Safety had not been compromised, but the Trust did not want such instances to occur. To this end, Internal Audit had been asked to review the Trust's processes, to ensure that there were no fundamental problems

GD highlighted that the Trust had no Clostridium difficile cases in March, and therefore finished the year on a positive note, but cautioned that the target for 2015/16 was even lower. GD commended SM and her colleagues. AJ concurred with GD's commendation, but stated that he understood that SM had some concerns regarding E. Coli. SM confirmed that this would be a focus for 2015/16.

SD asked whether there had been any review of how patients felt about the delayed discharges that had been experienced, and noted that such evidence would be powerful. AG answered that the number of times that a patient with a discharge plan became unfit while awaiting their discharge (for example, because of an infection) was routinely monitored.

ST asked whether performance against the A&E 4-hour waiting time target had been affected by the issues GD had raised. GD replied that the A&E department were performing very well, and therefore he was confident that the Trust did not have a problem in A&E and that the problem was therefore the inability to discharge patients in a timely manner, which in turn had a negative impact on the ability to admit patients from A&E.

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

- The turnover rate had increased in March, as a result of 120 staff leaving the Trust's payroll. Forty of these staff were from the Kent and Medway Health Informatics Service (KMHIS)
- There had been a net gain of 10 additional nurses in March, and the recruitment pipeline for the next 4 months was looking encouraging. Overseas recruitment trips were planned for May and September 2015

SDu then referred to the increased rate of Pressure Ulcers and Serious Incidents (SIs) and asked for an explanation. AB acknowledged that the number of Grade 2 Pressure Ulcers in March was the highest number since March 2014, but noted that the word "no" was missing from the sentence on page 17 of 141 (i.e. so that it should read "There is no specific reason or change in practice that would account for this increase…), as investigation of the cases had not identified any specific reasons for the increase. AB added that the figures for April had returned to expected levels.

AB then highlighted that the situation regarding patient falls had been a relative success story. SDu acknowledged such progress, but stated that she expected to see similar progress made with Pressure Ulcers. AB gave assurance that there was no complacency regarding Pressure Ulcers, but pointed out that the numbers involved were small. AB then expressed confidence that performance would be recovered through the continued focus that was being applied.

SO asked whether there had been any investigation of a link between Wards with higher temporary staffing and the occurrence of Pressure Ulcers. AB confirmed this had been investigated, but no evidence-based link could be identified.

SD commented that although the cause may be unknown, the Trust knew the action that should be taken to alleviate Pressure Ulcers, particularly on patients' heels, and suggested this be the focus of the Trust's efforts. AB acknowledged the point, and stated that she had met with Ward managers, to review the cases, and ensure they were aware there had been an increase. AJ requested that focus be maintained on the issue.

AJ then invited AG to highlight any further points, and requested that she also discuss the "Breaking the Cycle" report. AG referred to the circulated reports (Attachments 6 and 7) and highlighted the following points:

- The Trust implemented its "Breaking the Cycle" week ahead of the Easter break, to create some capacity ahead of Easter, but also to highlight the problems that the Trust faced
- West Kent Clinical Commissioning Group (CCG), Kent Social Services, and Kent Community Health NHS Foundation Trust were all involved in the initiative
- An action plan had been developed in response to internal issues, including electronic discharge notification, and Therapy services exhibiting reluctance to discharge patients to other services, even though these were available
- Actions relating to the wider system included the introduction of a 'discharge to assess' process, which was being led by Kent County Council (although neither AG nor GD were confident there would be a speedy response to the problem)
- In June, the Emergency Care Intensive Support Team (ECIST) would be on site, to address issues regarding system-wide delayed transfers of care

AJ noted that GD had identified Delayed Transfers of Care (and associated issues) as the main priority for the Trust, and therefore asked AG to continue to provide updates to future Board meetings.

Action: Provide an update to future Trust Board meetings on the level of Delayed Transfers of Care (and associated issues) (Chief Operating Officer, May 2015 onwards)

AJ asked whether the Trust Board could do anything to assist in the matter. GD stated that the key issue was the need for Social Services patients to be transferred to more appropriate services, and the CCG's acceptance of this need was paramount. GD added that AK's offer to liaise directly with Kent County Council was welcome, given the distribution of resources in South West Kent. AJ remarked that if action was not being taken by the time of the Board meeting in June 2015, the Board should consider formally writing a letter.

SDu commented that recent personal experience had highlighted the different perceptions between hospitals in terms of what action was within a patient's best interests, and elaborated that hospitals may tend to try to address clinical issues that extended beyond the principal reason for an admission. SDu noted that a GP from West Kent CCG had made a similar point at the 'Board to Board' meeting on 27/01/15, and suggested that GPs should be contacted soon after admission to provide a view on the holistic care of the patient. PS replied that the Trust was actively trying to recruit more Care of the Elderly Consultants, who were able to provide a more holistic view. AG added that the intention was to involve GPs more on Ward rounds, to provide such holistic input, and acknowledged that internal disagreements regarding fitness to discharge needed to be addressed. GD commented that the practice of contacting every GP for each admitted patient was a 'Gold Standard' to aim for, but would be very difficult to achieve. GD also pointed out that many emergency admissions were as a result of GP referrals. SDu asked whether given the difficulties, the aforementioned scheme could be piloted. PS replied that the full commitment of all GPs was required, and not just those within the higher management of the CCG. AG then reported that work was underway to introduce a Patient Tracking list System, to be able to monitor the detailed pathway of each patient, including the progress with addressing Social Care needs. AG added that a number of other initiatives were also being implemented through the Systems Resilience Group.

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

- The was one addendum to the circulated information in that the draft Accounts for 2014/15 that had been submitted to External Auditors showed a surplus of £157k, and not £163k
- The year-end position was £12.5m favourable to plan, but the most significant factor was the receipt of £12m of non-recurrent deficit support
- Agreement had been reached on all outstanding items relating to 2013/14 and 2014/15
- The overall financial position had been affected by the aforementioned capacity issues
- Cost Improvement Plan (CIP) delivery for the year was £23.8m
- The cash balance at year-end was £3.8m. Cash relating to Quarter 1 of 2015/16 had been received from Health Education England at the end of 2014/15, but the NHS Trust Development Authority had confirmed that the Trust was able to carry this forward into 2015/16
- The Trust had met all of its statutory duties for the year, subject to Audit

SO commended the operational teams across the Trust for their support in the achievement of the latter point. AJ also commended the team for achieving the results, particularly given the challenging context of the 2014/15 year, and the challenging financial environment across the NHS. ST also commended the performance.

4-10 'Breaking the cycle' update

This was covered under item 4-9

Additional quality items

4-11 Progress with the Quality Improvement Plan

AB referred to the circulated report and highlighted the following:

- AB had met with the Head of Hospital Inspections and their colleague from the Care Quality Commission (CQC) on 23/04/15, to review the actions taken in response to the water testing Enforcement Notice. The CQC had asked to see the evidence, and were assured by what they had seen. Those that visited the Trust on 23/04/15 would now investigate whether the Enforcement Notice could be lifted via a desk-top exercise, or whether a small team from the CQC needed to re-visit the Trust

- Other actions in the QIP had been reviewed and updated, and progress had been affected by the aforementioned capacity challenges

AJ commended the report's clarity, and invited questions from other Board members.

ST asked for further details of the criteria by which a "Green" rating was applied, and referred specifically to action CA2, noting that the rating was "Green", even though the action had not been completed by the "Action completion date". AB referred to action 2 on CA2 (ward rounds and risk assessment), and stated that the content of the "Evidence required" column was sufficient to enable the action, as worded, to be rated as "Green", even though there was an acknowledgement that further work was required in order to achieve the 'Gold standard'. AB also pointed out that there was an element of judgement in such ratings. ST retorted that the words used for the update for CA2 implied a delay, but the "Green" rating had led to his confusion, which prompted him to ask whether the rating was accurate. AB emphasised that she had been assured of sufficient evidence to warrant the "Green" rating, and highlighted that a "Green" rating represented "Assured / in progress".

AJ acknowledged that the date within the "Action completion date" needed to be re-set, to avoid any confusion. GD remarked that the ratings of some of the individual "Actions" could be reviewed, which may not lead to the overall "Compliance action" rating being affected. AJ suggested that future QIP Assurance Reports have a "Revised completion date" section added, but that the original date, as stated in the "Action completion date" column, be left. This was agreed.

Action: Add a "Revised completion date" section to future QIP Assurance Reports (Chief Nurse, April 2015 onwards)

ST stated that the Clinical Governance review currently being undertaken at the Trust was not referred to within the QIP, and suggested this be included. GD pointed out that the Clinical Governance review was not initiated as a specific response to the CQC inspection. ST acknowledged the point, but reiterated his proposal that this be included. AJ replied that the timings in the report already reflected the Trust's intentions, so it was agreed not to make reference to the Clinical Governance review in the QIP.

4-12 Safeguarding children update (annual report to Board)

AB referred to the circulated report and highlighted that the main risk was in compliance with Level 3 training.

AJ asked whether such training could be undertaken by e-learning. AB confirmed this was not possible, as a one-day face-to-face training session was required. AJ asked how the issue could therefore be addressed. AB replied that improvements had been made, and the standard of service being delivered was good, but the challenge was in releasing staff to attend the training, and efforts would continue to be made in this regard.

PB proposed that increasing the frequency of reporting on Level 3 training compliance would support these efforts. It was agreed that training compliance would be reported to the Trust Board via the Summary Report from the Workforce Committee, which reviewed mandatory training compliance in detail.

Action: Ensure that details of compliance with Level 3 Safeguarding Children Training is reported to future meetings of the Trust Board, via the Summary Report from the Workforce Committee (Director of Workforce and Communications / Chair of Workforce Committee, June 2015 onwards)

SDu then asked for details of the Trust's Safeguarding leads, and asked whether the CAS cards of A&E child patients were audited. AB confirmed that all CAS cards were retrospectively reviewed, and stated the Trust's Named Doctor was Dr Niki Pandya, whilst the Named Nurse was Jo Howe.

GD noticed that the report showed that Level 3 training was only "Recommended …", and was not therefore mandatory. GD also asked whether the Specialist Registrars in absolute need of such training had been targeted to ensure they had been trained. PS confirmed that this level of

identification had been undertaken. AB added that the guidance regarding the mandatory nature of Level 3 training was open to interpretation.

SDu asked for a comment on the liaison with Social Services, in light of the aforementioned problems regarding discharge. AB confirmed there were no concerns in relation to Safeguarding Children.

4-13 Safeguarding adults update (annual report to Board)

AB referred to the circulated report and highlighted that it contained details of the CQC's comments on Safeguarding, as well as the implications of The Care Act 2014.

ST asked whether the table on page 74 of 141 represented abnormal performance. AB replied that this was difficult to know definitively.

SDu noted that a patient had recently gone missing, and asked whether the Trust's policy had been applied effectively. AB replied that the investigation report of the incident had not yet been received.

4-14 Staffing (planned v actual ward staffing for March 2015; and 6-monthly review of Ward and non-Ward areas)

AB referred to Attachment 11 and highlighted that the RAG rating was "Amber" if a fill-rate was less than 90%. Questions were invited.

AJ noted that the "Average fill rate - care staff (%)" for the "Acute Stroke" unit at Maidstone Hospital was "187.1%", and asked for an explanation. AJ also noted that the rate for Mercer Ward was over 200%. AB confirmed that the figures were accurate, and stated that this would most likely be as a result of a patient being in receipt of 'Specialed' Nursing care.

AB then referred to Attachment 12, and highlighted the key recommendations.

AJ asked whether the recommendations had been reviewed by the Executive. SO confirmed that some areas had been identified within the business planning process. GD stated that the Executive Team had seen a draft version of the report, but it had not been considered at the Trust Management Executive (TME).

SD asked for confirmation that the Trust was safe and effective. AB replied that the report covered the distribution of staff on any given day, and stated that the Trust performed well in this regard. SD noted that skills were also important. AB concurred with the point.

KT commented that it would be useful to see some consideration as to whether changes in staffing affected quality of care. GD suggested that the Ward dashboard could be used to indicate a 'before' and 'after' situation.

SS referred to the recommendations in Attachment 12, and asked for clarification of the approval process. AB clarified that the recommendations for increased staffing would need to be subjected to business case review, but would be outside of the budgeted establishment.

Planning and Strategy

4-15 Update on the Trust's planning submissions, 2015/16 (incl. approval of the latest submission to the NHS Trust Development Authority)

SO referred to the circulated report and highlighted that it outlined the changes from previous versions reviewed at Finance Committee and Trust Board, but did not yet include the impact of the 2015/16 contracts.

AJ noted that the submission had been reviewed in detail at the Finance Committee on 27/04/15, and invited comments. None were received.

4-16 Update on 2015/16 contracts

SO referred to the circulated report and highlighted the following:

- Contractual values had now been agreed with Specialist Commissioning, thereby avoiding the need for arbitration. A value of £54.8m had been agreed, which included the final year of transitional support in its entirety
- The overall contractual value for 2015/16 was £202m, and therefore Commissioners had acknowledged the value of the out-turn for 2014/15
- Operationally and financially, all agreements were now in place, and the formalities now just needed to be completed

ST emphasised that in the light of the latter point, the onus was now very much on the Trust to deliver the contract. The point was acknowledged.

SDu asked whether the contract value purchased the same activity as in 2014/15. SO stated that generally this was the case, but there were some increases in births and non-elective activity.

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

4-17 Quality & Safety Committee, 12/04/15

SDu referred to the circulated report and invited queries or comments. None were received.

4-18 Trust Management Executive, 15/04/15

GD referred to the circulated report and highlighted that the configuration of the new Ward at TWH would be discussed at the next TME. GD elaborated that the options being considered were to have a single room environment or a Ward with bays.

AJ asked any Board member with a view on the configuration of the Ward to make this known to AJ and/or GD. AJ expressed his own preference for a Ward with bays.

4-19 Finance Committee, 27/04/15

ST referred to the circulated report and invited questions.

PB asked whether the request that a clearer illustration of the specific reductions in workforce within the Trust's 2015/16 plans be provided to Committee members needed to be submitted to the Workforce Committee. ST confirmed this was not necessary.

4-20 Patient Experience Committee – revised Terms of Ref.

SD referred to the circulated report and invited queries or comments.

KR highlighted three errors, on pages 122 and 123 (i.e. "Members may request a deputy to attend meetings in their place providing. Such a deputy will count towards the quorum" should read "Members may request a deputy to attend meetings in their place. Such a deputy will count towards the quorum"; "junior doctor" should read "junior doctors"; and "The frequency of reporting will depend on the frequency of each of the sub-committee" should read "The frequency of reporting will depend on the frequency of sub-committee meetings"), and noted these would be corrected in the final version.

KR then highlighted the proposed membership of the Director of Finance, and asked for opinions. SO stated that he would willingly attend, but queried whether he was the most appropriate Executive. ST asked whether it could be a representative of SO. AJ stated that it would be acceptable for SO to send a deputy from time to time, but he would like the Director of Finance to be a member of the Committee. PB proposed that the Medical Director attend instead. AJ stated that he would prefer membership to not just be limited to those with direct responsibility for the Committee's main subject matter.

AJ proposed that "All other Non-Executive Directors (including the Chairman of the Trust Board) and Executive Directors are welcome to attend…" be changed to "All other Non-Executive

Directors (including the Chairman of the Trust Board) and Executive Directors are entitled to attend...". This was agreed.

The Terms of Reference were approved subject to the amendments discussed.

Action: Amend the Terms of Reference for the Patient Experience Committee to reflect the changes made by the Trust Board (Trust Secretary, April 2015 onwards)

Assurance and policy

4-21 Approval of compliance oversight self-certification

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

The submission was approved as circulated.

4-22 To consider any other business

There was no other business.

4-23 To receive any questions from members of the public

No questions were received.

4-24 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 – May 2015

5-4 Log of outstanding actions from previous meetings — Chairman

Actions due and still 'open'

Ref.	Action	Person responsible	Deadline	Progress [1]
3-30 (Mar 15)	Arrange for an article raising awareness of the level of resource involved in the preparation of dosette boxes by pharmacy staff to be included with the Trust's staff magazine	Director of Infection Prevention and Control	March 2015 onwards	The Head of Pharmacy at Maidstone Hospital is preparing an educational article on the filling of dosette boxes for Ward staff and medical teams. The aim is for this to be completed in the next month.

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
2-13 (Feb 15)	Submit a report to the next Audit and Governance Committee responding to the concerns arising from the latest Internal Audit review of Consultant Job Planning	Medical Director	May 2015	A report was submitted to the Audit and Governance Committee on 6th May
3-15 (Mar 15)	Request that the Chief Pharmacist liaises with ward areas to raise awareness of the level of resource involved in the preparation of dosette boxes by pharmacy staff	Director of Infection Prevention and Control	May 2015	All ward Pharmacists are working with Wards to ensure that Ward staff know the practicalities and safe dispensing of dosette devices. A specific log-on for site practitioners to view the eDN Pharmacy Screen has been developed. This will alert them to eDNs which are also dosette devices. This will be shared at the eDN meeting held on 20/05/15
3-24 (Mar 15)	Arrange for the May 2015 Trust Board to discuss the assumptions underlying the 2015/16 Winter and Operational Resilience Plan, ahead of the Board's review of the Plan in June 2015	Chief Operating Officer	May 2015	A report has been submitted to the May 2015 Trust Board
3-7 (Mar 15)	Arrange for the 'main'	Chair of Quality	March 2015	The item was discussed as

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

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
	Quality & Safety Committee to undertake monitoring of Catheter Associated Urinary Tract Infections	& Safety Committee / Director of Infection Prevention and Control	onwards	part of the agenda of the 'main' Quality & Safety Committee held on 13/05/15, and updates will be provided at each 'main' Quality & Safety Committee during 2015/16
4-3 (Apr 15)	Amend the minutes of the Part 1 meetings of 25th March and 25th February 2015	Trust Secretary	April 2015 onwards	The minutes were amended
4-6 (Apr 15)	Arrange for a formal letter of gratitude to be sent from the Trust Board to the League of Friends of the Maidstone Hospital, following their most recent donation	Trust Secretary	April 2015 onwards	A letter from the Chairman of the Trust Board was sent on 06/05/15
4-9 (Apr 15)	Provide an update to future Trust Board meetings on the level of Delayed Transfers of Care (and associated issues)	Chief Operating Officer	May 2015 onwards	An update has been scheduled for the Trust Board, from May 2015 onwards, as part of the Integrated Performance Report item
4-11 (Apr 15)	Add a "Revised completion date" section to future QIP Assurance Reports	Chief Nurse	April 2015 onwards	A "Revised completion date" section has not been added. For Compliance Actions, new '"Actions" have been added, with completion dates which reflect the evolution of the situation. An example of a new action is Action 2b within Compliance Action 2 ("Second ward round at weekend in person")
4-20 (Apr 15)	Amend the Terms of Reference for the Patient Experience Committee to reflect the changes made by the Trust Board	Trust Secretary	April 2015 onwards	The Terms of Reference were amended

Actions not yet due (and still 'open')

Ref.	Action	Person responsible	Deadline	Progress
4-12 (Apr 15)	Ensure that details of compliance with Level 3 Safeguarding Children Training is reported to future meetings of the Trust Board, via the Summary Report from the Workforce Committee	Director of Workforce and Communications / Chair of Workforce Committee	June 2015 onwards	

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting - May 2015

5-7	Chief Executive's update	Chief Executive

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

1. I visited different wards and departments in our Trust this month, met with our clinical leads and looked at areas of our patient and staff experience as part of my efforts to be visible and accessible and understand our achievements and challenges first-hand. I spent time with staff involved in the £3 million development of our new respiratory ward at Maidstone Hospital to gain their views and visited our new admissions lounge to share the experiences patients have of this newly improved area. I was on our interview panels for new A&E and anaesthetic consultants and we are also interviewing for paediatric doctors as part of our commitment to patient care through further investment in frontline clinical staff.

2. We are opening a new Ambulatory Assessment Unit for medical patients at Tunbridge Wells Hospital this month. The Unit will provide fast-track diagnostic care and medical treatment for emergency patients, reducing the need for hospital admission and overnight stays. The Unit, which is similar to the Urgent Medical Ambulatory Unit at Maidstone, will support A&E at Tunbridge Wells and is part of our proactive plans to meet our changing patient needs.

3. Our nurses and junior doctors are among the first wave of clinical staff at the Trust to be equipped with mobile devices to record patient vital signs in real-time and have remote onsite access to these at any time. The move follows a successful ward trial and will be rolled out on all wards from now until the end of summer. The benefits are widespread and the possibilities unlimited, but most importantly, hospitals using this technology are seeing a marked improvement in patient outcomes.

4. We are privileged to have been chosen to take part in a national initiative to improve the experience of people diagnosed with secondary breast cancer. We are working with two of the UK's leading breast cancer charities to identify ways of enhancing and developing services for patients with secondary breast cancer. Part of this work involves asking patients how they would like to see our services enhanced and developed and pledging to make improvements.

5. We are continuing to provide more integrated care for patients with a new cardiac rehabilitation service. Our cardiac nurses are now providing improved inpatient and home provision advice, information and support for patients and carers during recovery from cardiac events.

6. I would like to place on record and publicly recognise the outstanding work of our League of Friends at Maidstone and Tunbridge Wells. Maidstone Hospital LoF raised and spent over £420,000 on new equipment for Maidstone in 2014/15, with a further £23,000 committed over the coming months. Tunbridge Wells LoF have donated over £132,000 at Tunbridge Wells.

7. Our thoughts as a whole are with all those who have lost loved ones in the devastating earthquakes to hit Nepal. We are proud to have wonderful links with Nepalese colleagues across the Trust and their families and our thoughts are with them and others at this sad time.

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 – May 2015

5-8	**Integrated Performance Report for May 2015** (incorporating an update on recruitment and retention)	**Chief Executive**

The key issues regarding performance in previous months in terms of non-elective activity continued into April. Whilst there was still a slight increase in A&E attendances, emergency admissions dropped to nearer normal levels allowing an improvement in the 4 hour wait target. March's severe spike in delayed transfers of care eased slightly in April but was still high at 5% (1080 beds days lost). The Trust continues to see a higher than usual number of patients over age 75 years who have a longer length of stay and we continue to see an impact from capacity issues at Kent Social Services. We remain focused on addressing issues that impact on length of stay particularly those that are within our own control to manage.

The continued use of escalation beds on both sites contributes to the significant numbers of agency staff being used as reported in the workforce section.

The Referral to Treatment (RTT) performance in April remained stable supported by outsourcing to private providers and our own activity levels have also improved. The 18 week backlog is moving towards a sustainable level and aggregate totals for all the RTT standards were met for the month.

The Trust has incurred a total of four 52 week breaches in April; all were identified by the Trust as a result of the review of systems undertaken following previous months breaches. The patients have now all been treated and they have not been adversely affected by the delays incurred. We have revised and improved our processes throughout the administration teams and increased the levels of training and monitoring that takes place.

The performance on cancer targets in March (reported a month in arrears) showed some improvement although the number of patients waiting over 62 days remains a key focus.

There was a single C Diff case in April and the rates for readmissions, complaints and falls remained stable despite the pressures on the Trust.

The enclosed report includes, as usual, the Trust performance dashboard; integrated performance charts; and financial performance overview.

Further details on recent recruitment and retention will be provided verbally at the meeting.

Which Committees have reviewed the information prior to Board submission?

- Executive Team, 19/05/15
- Trust Management Executive, 20/05/15

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

TRUST PERFORMANCE DASHBOARD **Position as at:** **30th April 2015**

Governance (Quality of Service): **2.0** **Amber/Red**

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

Responsible Committee: Quality & Safety

Delivering or Exceeding Target	
Underachieving Target	
Failing Target	

Please note a change in the layout of this Dashboard with regard to the Finance & Efficiency and Workforce Sections

Responsible Committee: Finance, Treasury & Investment ** Stroke & CWT run one mth behind*

	Patient Safety & Quality	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	Hospital-level Mortality Indicator (SHMI)	Prev Yr: July 12 to June 13		100.3	101.5	1.2	1.5	*100*		100
'1-02	Standardised Mortality (Relative Risk)	Prev Yr: April 13 to Mar 14		104.2	109.0	4.8	9	*100*		100
'1-03	Crude Mortality	1.3%	0.8%	1.3%	0.8%	-0.5%				
'1-04	Safety Thermometer % of Harm Free Care	97.1%	96.6%	97.1%	96.6%		1.6%	95.0%		94.0%
'1-05	*Rate C-Diff (Hospital only)	22.2	5.1	22.2	5.1	-17.1	-10.2	*11.5*	10.6	15.7
'1-06	Number of cases C.Difficile (Hospital)	4	1	4	1	-3.0	-2.0	*27*	25	27
'1-07	Number of cases MRSA (Hospital)	0	0	0	0	0	0	*0*	0	
'1-08	Elective MRSA Screening	99.0%	99.0%	99.0%	99.0%		1.0%	98.0%	99.0%	
'1-09	% Non-Elective MRSA Screening	98.0%	98.0%	98.0%	98.0%		3.0%	95.0%	98.0%	
'1-10	**Rate of Hospital Pressure Ulcers	1.9	0.9	1.9	0.9	-1.0	-2.1	*3.0*	0.8	3.0
'1-11	****Rate of Total Patient Falls	5.8	6.1	5.8	6.1	0.3	-0.1	6.20	6.1	
'1-12	****Rate of Total Patient Falls Maidstone	6.5	5.9	6.5	5.9	-0.6	-0.3	6.20	6.0	
'1-13	****Rate of Total Patient Falls Tunbridge Wells	5.1	6.3	5.1	6.3	1.2	0.1	6.20	6.2	
'1-14	Falls - SIs in month		1		1	1				
'1-15	MSA Breaches	0	0	0	0	0	0	0	0	
'1-16	Total No of SIs Open with MTW	23	55			32				
'1-17	Number of New SIs in month	7	3	7	3	-4	-7			
'1-18	Number of Never Events	0	0	2	0	-2	0	*0*	0	
'1-19	Number of CAS Alerts Overdue	2	1			-1	1	*0*		
'1-20	*****Readmissions <30 days: Emergency (Mar)	12.5%	11.4%	11.3%	11.7%	0.3%	-1.9%	*13.6%*	11.7%	14.1%
'1-21	*****Readmissions <30 days: Elective (Mar)	7.0%	4.7%	5.8%	5.5%	-0.3%	-0.8%	*6.3%*	5.5%	6.8%
'1-22	***Rate of New Complaints	4.6	3.61	4.6	3.61	-1.0	-2.65	*6.26*	3.30	6.26
'1-23	% complaints responded to within target	80.5%	51.4%	57.8%	51.4%	-6.4%	-23.6%	75.0%	75.0%	
'1-24	IP Resp Rate Recmd to Friends & Family	41.6%	27.9%	41.6%	27.9%	-13.7%	-2.1%	40.0%	45.1%	45.1%
'1-25	A&E Resp Rate Recmd to Friends & Family	18.4%	6.6%	18.4%	6.6%	-11.8%	-13.4%	20.0%	22.9%	22.9%
'1-26	Mat Resp Rate Recmd to Friends & Family	18.5%	18.1%	18.5%	18.1%	-0.4%	-1.9%	15.0%	24.5%	24.5%
'1-27	IP Friends & Family (FFT) % Positive	90%	97%	90%	97%	7%	2%	95%	95%	95%
'1-28	A&E Friends & Family (FFT) % Positive	92%	89%	92%	89%	-2%	2%	87%	89%	87%
'1-29	Maternity Combined FFT % Positive	88%	94%	88%	94%	6%	-1%	95%	95%	95%
'1-30	OP Friends & Family (FFT) % Positive	New	77.3%	New	77.3%	New			77.3%	
1-31	Five Key Questions Local Patient Survey	91.6%	88.8%			-2.8%		90%	90.0%	
1-32	VTE Risk Assessment (Feb)	95.6%	95.1%	95.6%	95.1%	-0.5%	0.1%	95%	95.1%	95%
1-33	% Dementia Screening	98.9%	95.5%	98.9%	95.5%	-3.4%	5.5%	90%	95.5%	
1-34	% TIA with high risk treated <24hrs (Mar)	41.7%	41.7%	72.2%	72.2%			60%	72.2%	
1-35	% spending 90% time on Stroke Ward (Mar)	84.6%	84.6%	81.8%	81.8%	0.0%	1.8%	80%	81.8%	
1-36	Stroke:% to Stroke Unit <4hrs (Mar)	New	47.2%	New	39.5%	New	New	55.0%	55.0%	
1-37	Stroke: % scanned <1hr of arrival (Mar)	New	53.8%	New	44.4%	New	New	43.0%	44.4%	
1-38	Stroke:% assessed by Cons <24hrs (Mar)	New	84.9%	New	73.3%	New	New	85.0%	85.0%	

Responsible Committee: Finance, Treasury & Investment

	Finance & Efficiency	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	Average LOS Elective	2.8	3.3	2.8	3.3	0.4	0.0	*3.3*	3.3	3.3
3-02	Average LOS Non-Elective	6.5	7.6	6.5	7.6	1.1	1.9	*5.7*	5.7	5.7
3-03	New:FU Ratio	1.64	1.53	1.64	1.53	-0.11	0.01	*1.52*	1.52	
3-04	Day Case Rates	83.4%	83.9%	83.6%	83.9%	0.3%	3.9%	80.0%	83.9%	82.19%
	Finance & Efficiency	**Latest Month**		**Year to Date**		**YTD Variance**		**Year End**		**Bench Mark**
		Plan	**Curr Yr**	***Plan***	**Curr Yr**	**From Prev Yr**	**From Plan**	**Plan**	**Forecast**	
3-05	Income	31,719	30,741	31,719	30,741	0.9%	-3.1%			
3-06	EBITDA	625	492	625	492	55.2%	-21.3%			
3-07	Surplus (Deficit) against B/E Duty	(2,361)	(2,357)	(2,361)	(2,357)					
3-08	CIP Savings	Data Not Available								
3-09	Cash Balance	20,067	20,034	20,067	20,034	24.0%	-0.2%			
3-10	Capital Expenditure	598	232	598	232	121.0%	-61.2%			
3-11	**Monitor Continuity of Service Risk Rating**									

	Performance & Activity	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	**Monitor Indicative Risk Rating**	**1.5**	**2.0**	**1.5**	**2.0**	**Amber/Red**		**Amber/Red**		
2-02	Emergency A&E 4hr Wait (SITREP Wks)	96.4%	90.1%	96.4%	90.1%	-6.3%	-4.9%	95%	95.0%	91.1%
2-03	Emergency A&E >12hr to Admission	0	0	2	0	-2	0	0	0	
2-04	***Ambulance Handover Delays >30mins	New	No data	New	No data				No data	
2-05	***Ambulance Handover Delays >60mins	New	No data	New	No data	`			No data	
2-06	18 week RTT - admitted patients	91.3%	91.0%	91.3%	91.5%	0.2%	1.5%	90%	91.5%	
2-07	18 week RTT - non admitted patients	96.6%	98.1%	96.6%	98.1%	1.5%	3.1%	95%	98.1%	
2-08	18 week RTT - Incomplete Pathways	94.8%	97.3%	94.8%	97.3%	2.4%	5.3%	92%	97.3%	
2-09	18 week RTT - Specialties not achieved	1	5	1	5	4	5	*0*	5	
2-10	18 week RTT - 52wk Waiters	0	5	0	5	5	5	*0*	5	
2-11	18 week RTT - Backlog 18wk Waiters	753	482	753	482				482	
2-12	% Diagnostics Tests WTimes <6wks	99.9%	99.93%	99.9%	99.93%	0.0%	0.9%	99.0%	99.93%	
2-13	Cancer WTimes - Indicators achieved	8	9	9	8	-1	-1	9	8	
2-14	*Cancer two week wait	94.0%	94.0%	94.0%	95.9%	1.9%	2.9%	93%	95.9%	
2-15	*Cancer two week wait-Breast Symptoms	96.4%	96.4%	96.4%	94.9%	-1.5%	1.9%	93%	94.9%	
2-16	*Cancer 31 day wait - First Treatment	100.0%	100.0%	100.0%	98.5%	-1.5%	2.5%	96%	98.5%	
2-17	*Cancer 62 day wait - First Definitive	86.6%	86.6%	86.6%	82.8%	-3.8%	-2.2%	85%	82.8%	
2-18	Delayed Transfers of Care	3.2%	5.5%	3.2%	5.5%	2.3%	2.0%	3.5%	3.5%	
2-19	Primary Referrals	8,665	8,847	55,024	60,758	10.4%	10.8%	104,172	104,172	
2-20	Cons to Cons Referrals	3,982	3,130	25,877	23,868	-7.8%	-4.5%	41,141	41,141	
2-21	First OP Activity	10,938	11,644	10,938	11,644	6.5%	-0.9%	146,918	146,918	
2-22	Subsequent OP Activity	20,564	20,962	20,564	20,962	1.9%	-0.8%	264,118	264,118	
2-23	Elective IP Activity	661	622	661	622	-5.9%	-2.7%	7,988	7,988	
2-24	Elective DC Activity	2,903	3,105	2,903	3,105	7.0%	0.7%	38,556	38,556	
2-25	Non-Elective Activity	3,958	3,818	3,958	3,818	-3.5%	-3.5%	*48,289*	48,289	
2-26	A&E Attendances (Calendar Mth)	10,692	10,942	10,692	10,942	2.3%	-1.8%	*135,922*	135,922	
2-27	Oncology Fractions	5,454	5,425	5,454	5,425	-0.5%	-7.8%	71,761	71,761	
2-28	No of Births (Mothers Delivered)	465	480	465	480	3.2%	0.9%	5,708	5,760	
2-29	Midwife to Birth Ratio	1:28	1.28	1.28	1.28	0.00	0.00	1.28	1.28	
2-30	C-Section Rate (elective & non-elective)	26.5%	29.2%	26.5%	29.2%	2.7%	4.2%	25.0%	25.0%	
2-31	% Mothers initiating breastfeeding	77.8%	77.1%	77.8%	77.1%	-0.8%	-0.9%	78.0%	78.0%	
2-32	Intra partum stillbirths Rate (%)	0.2%	0.4%	0.2%	0.4%				0.4%	

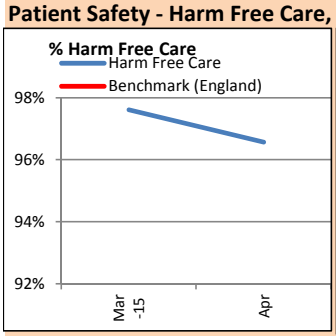
* Rate of C.Difficile per 100,000 Bed days, ** Rate of Pressure Sores per 1,000 admissions (excl Day Case), *** Rate of Complaints per 1,000 Episodes (incl Day Case), **** Rate of Falls per 1,000 Occupied Beddays, ***** Readmissions run one month behind.

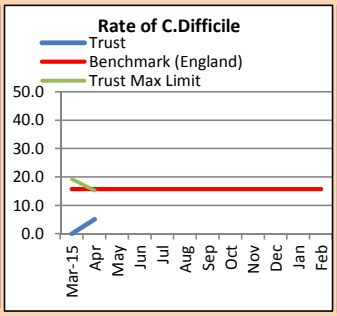
Responsible Committee: Workforce ** Contracted not worked WTE including Maternity/Long Term Sickness etc.

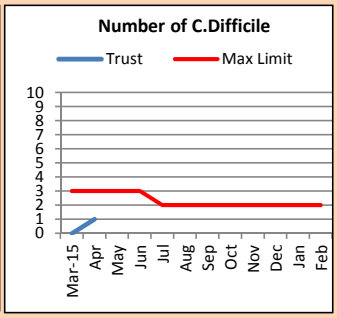
	Workforce	Latest Month		Year to Date		YTD Variance		Year End		Bench Mark
		Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/ Limit	Forecast	
4-01	Establishment (Budget WTE)	5,441.1	5,531.8	5,441.1	5,531.8	1.7%	0.0%	*0.0*	0.0	
4-02	Contracted WTE	4,924.7	4,922.2	4,924.7	4,922.2	-0.1%	-4.6%	*0.0*		
4-03	**Contracted not worked WTE		(110.7)		(110.7)					
4-04	Locum Staff (WTE)	17.2	19.5	17.2	19.5	13.3%				
4-05	Bank Staff (WTE)	298.1	308.0	298.1	308.0	3.3%				
4-06	Agency Staff (WTE)	96.2	268.8	96.2	268.8	179.4%				
4-07	Overtime (WTE)	71.7	89.0	71.7	89.0	24.1%				
4-08	Worked Staff WTE	5,319.0	5,509.2	5,319.0	5,509.2	3.6%	-1.3%	*0.0*		
4-09	Vacancies WTE	516.4	609.7	516.4	609.7	18.1%			0.0	
4-10	Vacancy %	9.5%	11.0%	9.5%	11.0%	16.0%			0.0%	
4-11	Nurse Agency Spend	(516)	(763)	(516)	(763)	47.9%			0	
4-12	Medical Locum & Agency Spend	(525)	(926)	(525)	(926)	76.4%			0	
4-13	Staff Turnover Rate	10.0%	9.6%		9.6%	-0.4%	-0.9%	*10.5%*	9.56%	8.4%
4-14	Sickness Absence	3.7%	4.1%		4.1%	0.5%	0.8%	*3.3%*	3.3%	3.7%
4-15	Statutory and Mandatory Training	86.2%	87.2%		87.2%	1.0%	2.2%	85.0%	85.0%	
4-16	Appraisals	Not reported until Quarter 1								

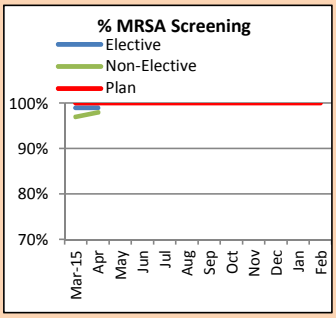
INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

Patient Safety - Harm Free Care, Infection Control

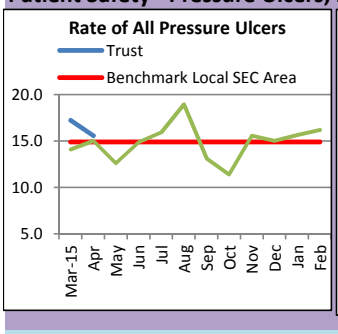


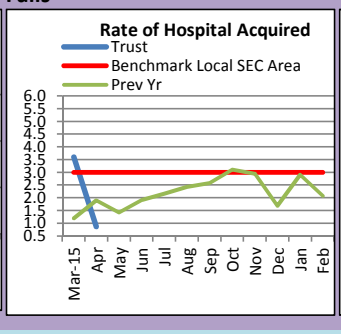


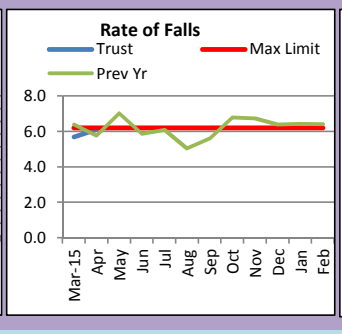


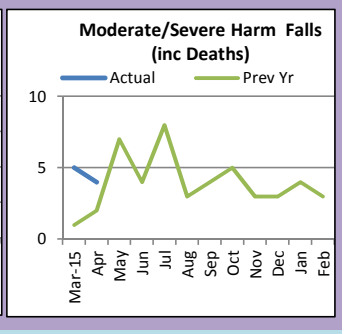


Patient Safety - Pressure Ulcers, Falls

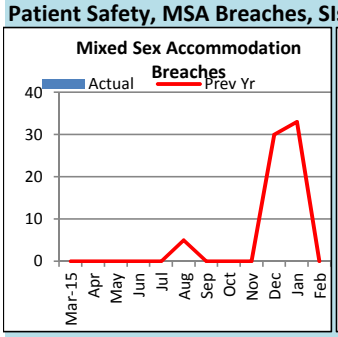


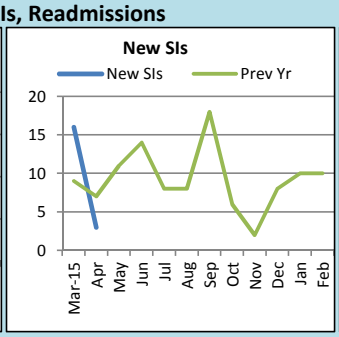


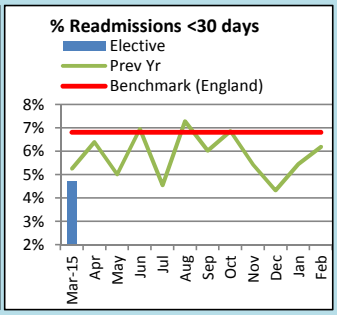


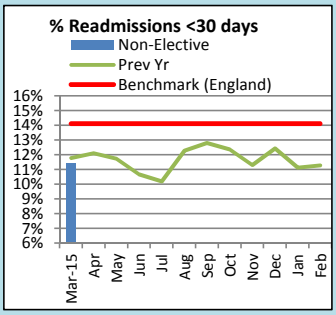


Patient Safety, MSA Breaches, SIs, Readmissions

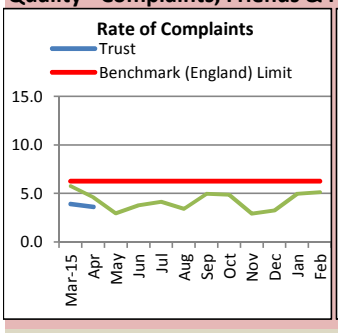


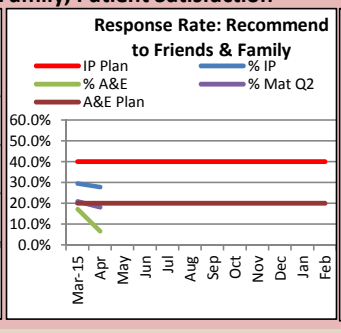


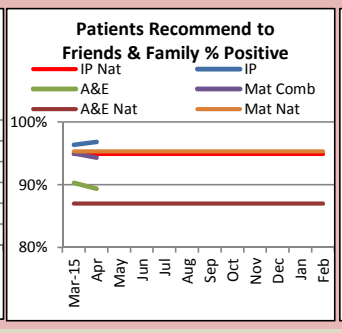


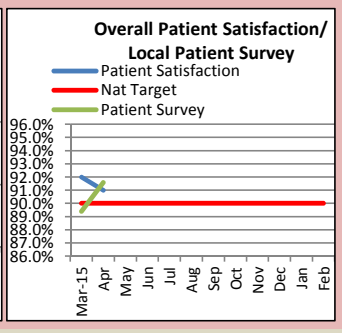


Quality - Complaints, Friends & Family, Patient Satisfaction

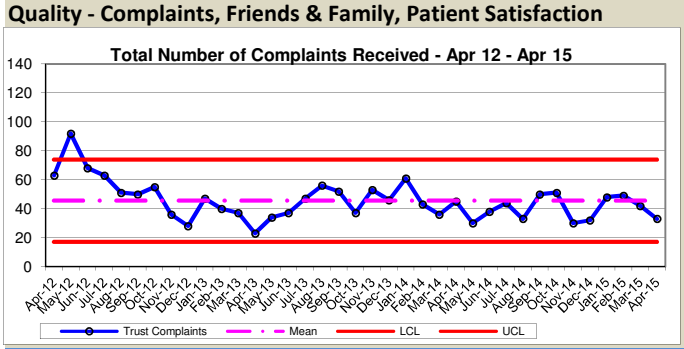


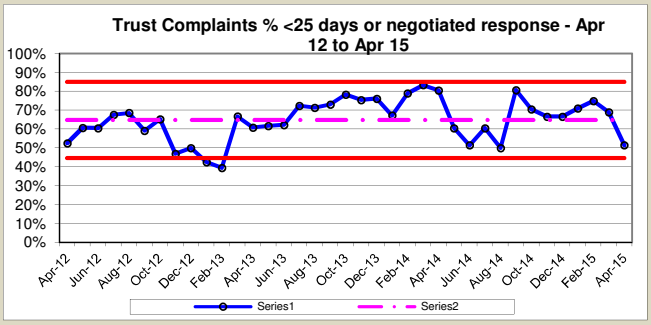




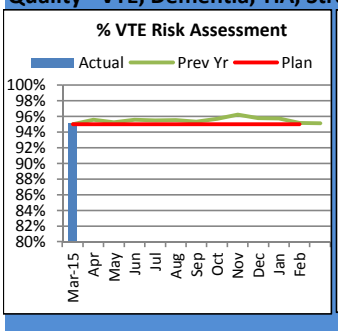


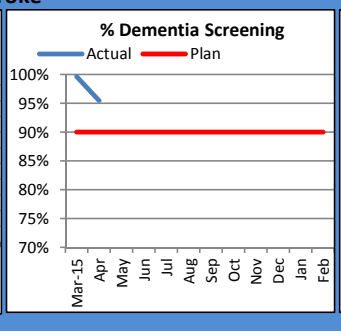
Quality - Complaints, Friends & Family, Patient Satisfaction

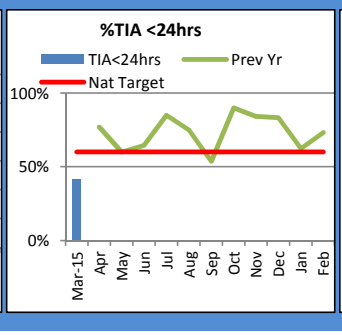


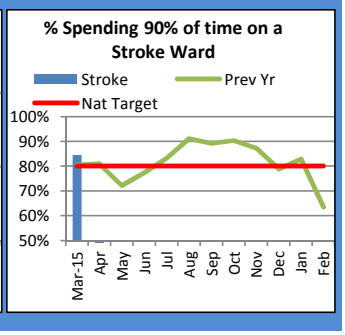


Quality - VTE, Dementia, TIA, Stroke



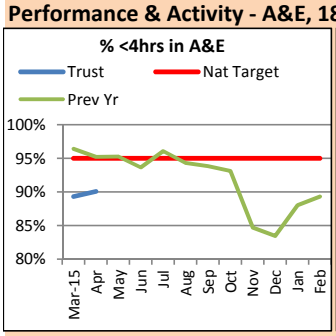


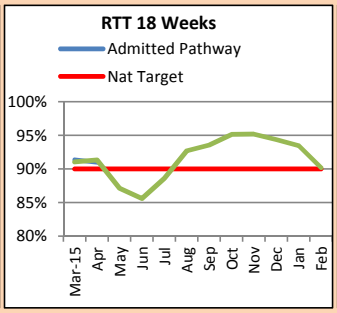


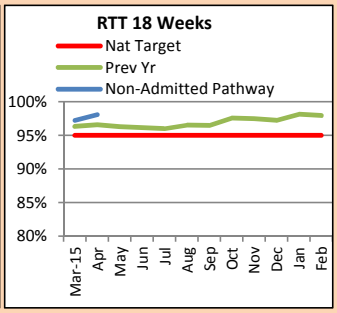


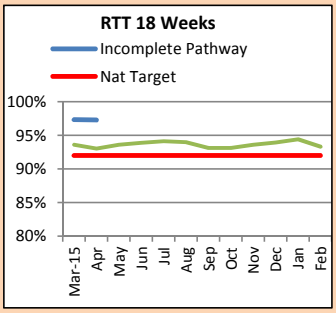
INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

Performance & Activity - A&E, 18 Weeks

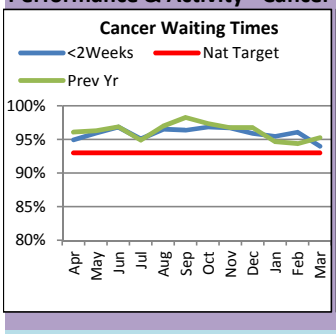


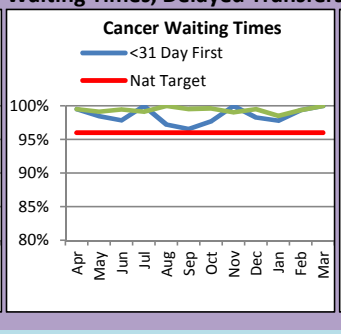


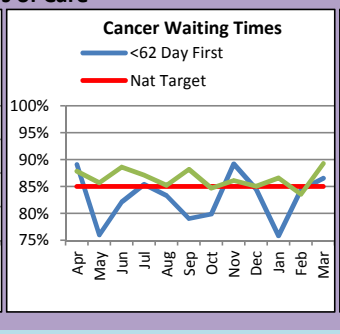


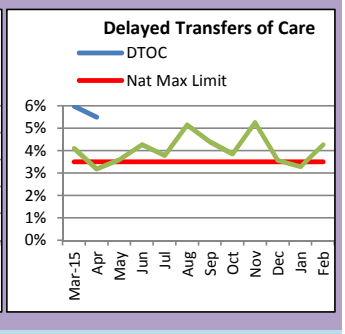


Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care

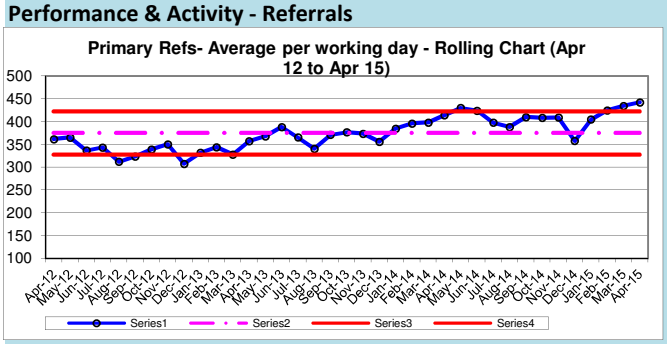


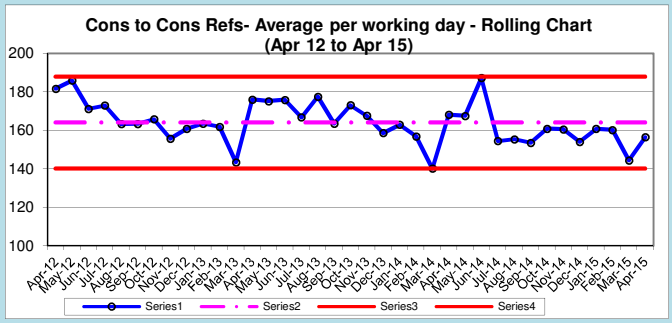




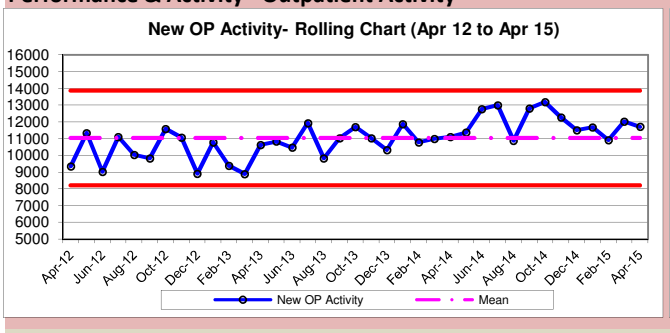


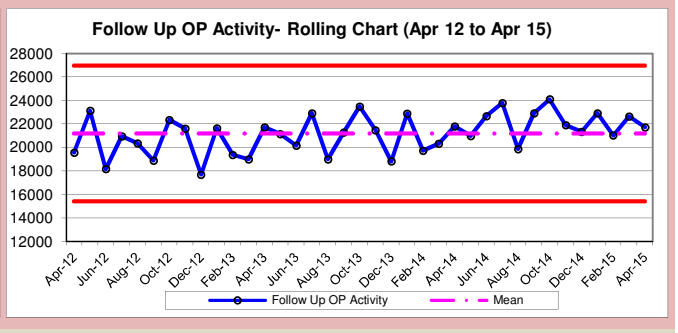
Performance & Activity - Referrals



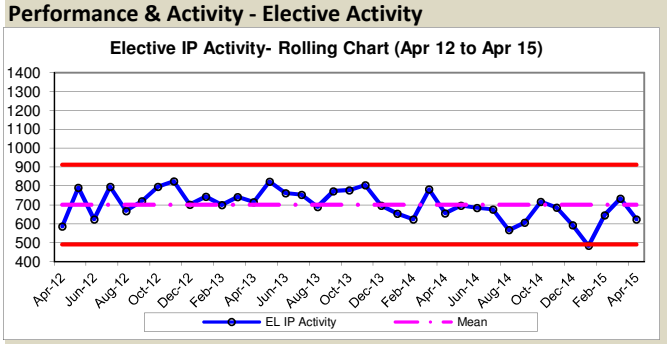


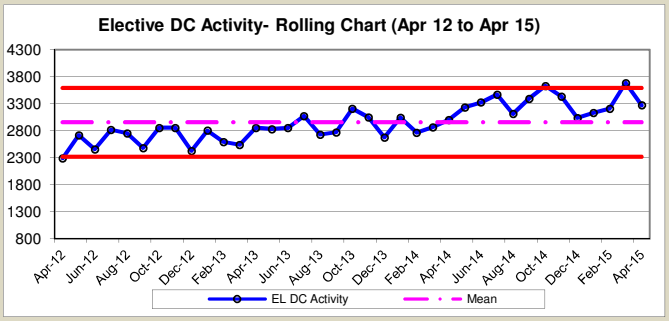
Performance & Activity - Outpatient Activity



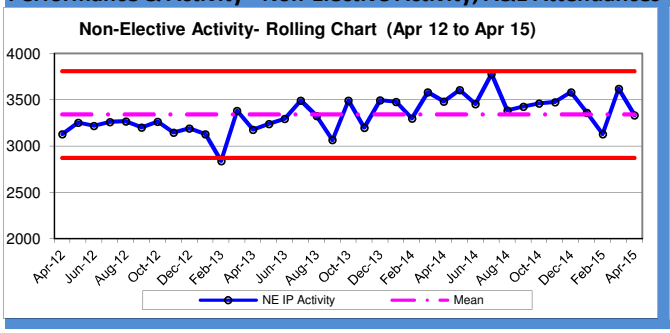


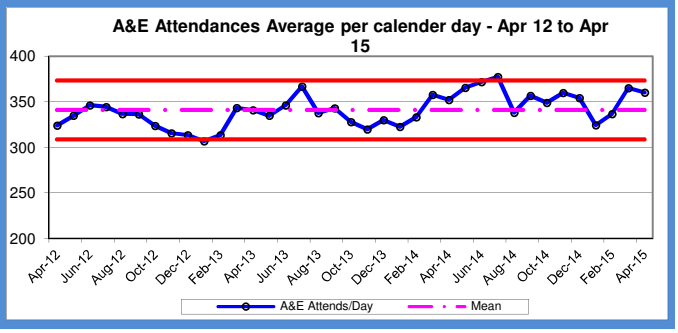
Performance & Activity - Elective Activity





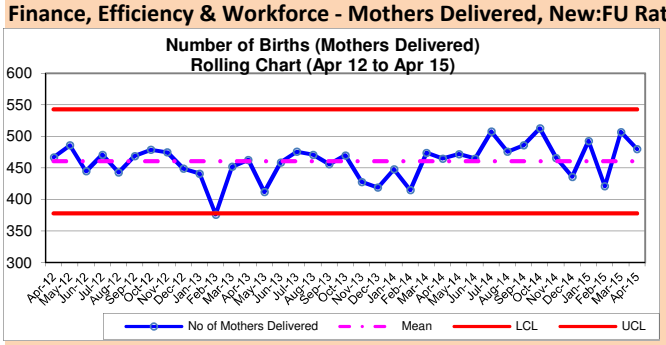
Performance & Activity - Non-Elective Activity, A&E Attendances

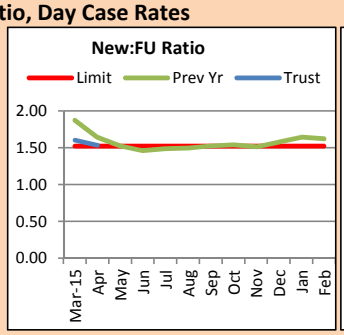


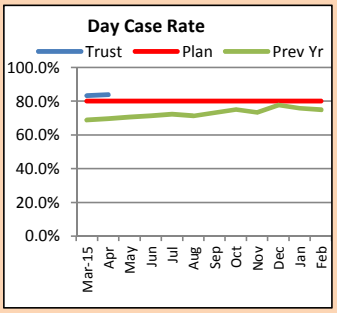


INTEGRATED PERFORMANCE REPORT ANALYSIS - FINANCE, EFFICIENCY & WORKFORCE

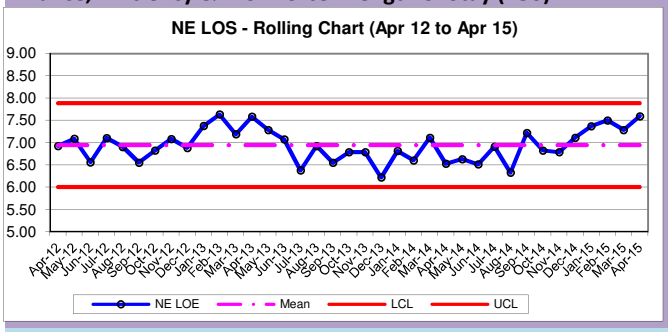
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates

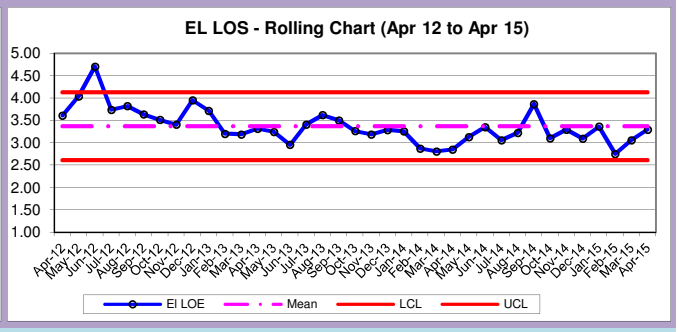




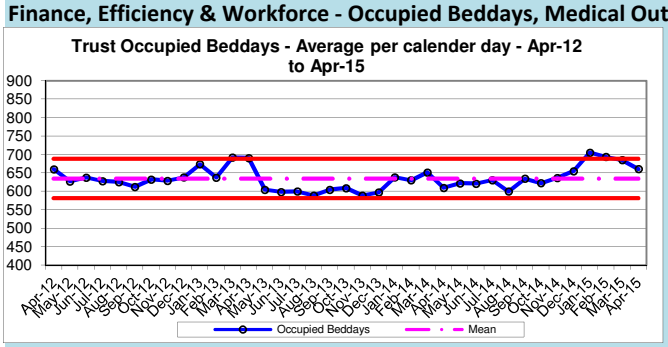


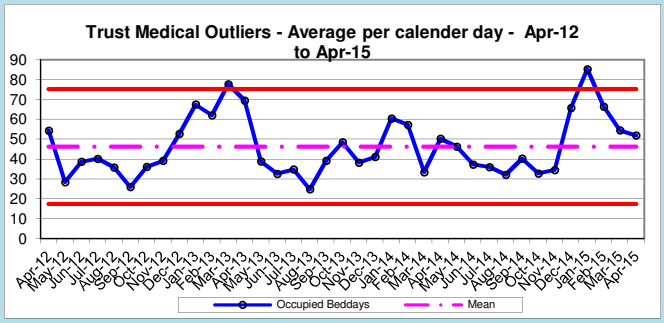
Finance, Efficiency & Workforce - Length of Stay (LOS)



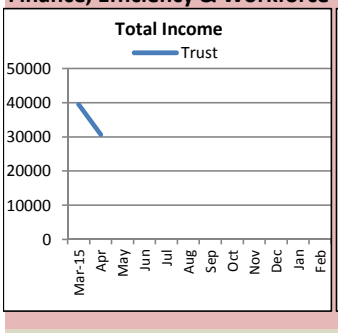


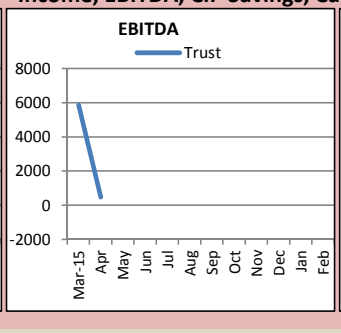
Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

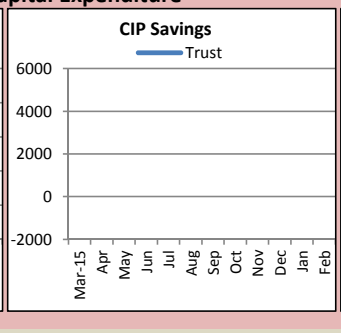


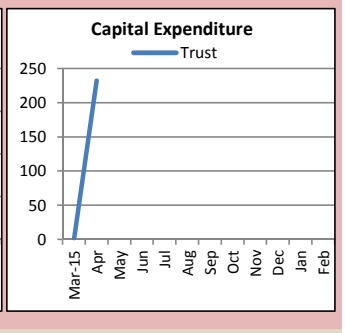


Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure

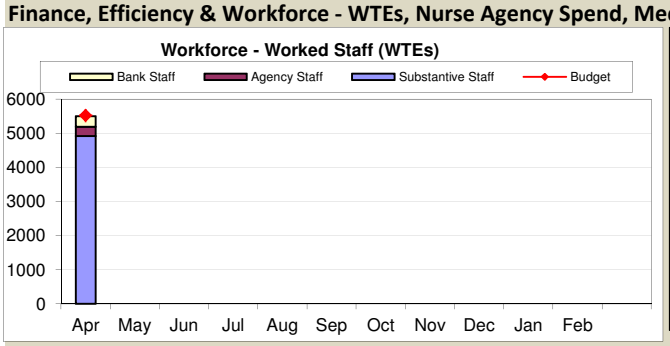


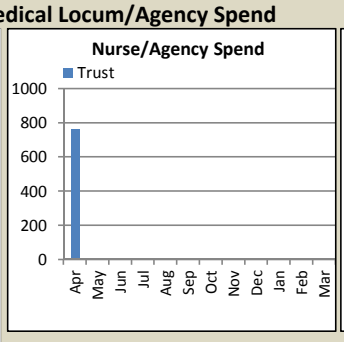


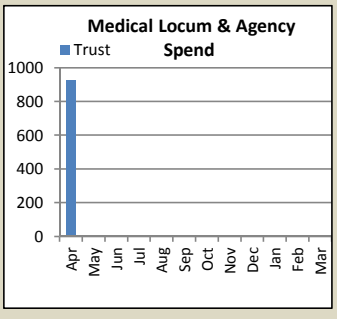




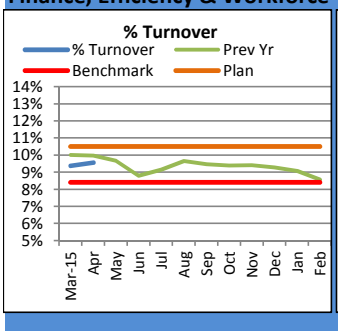
Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend

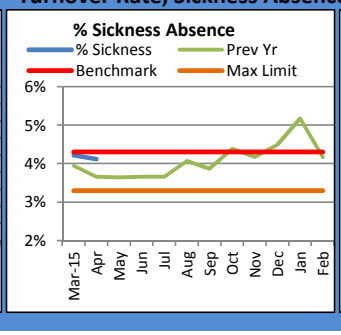


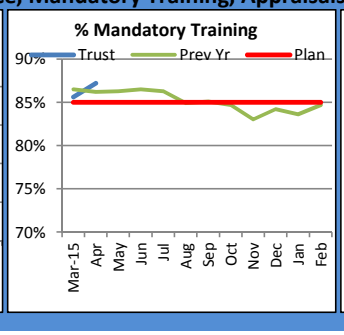


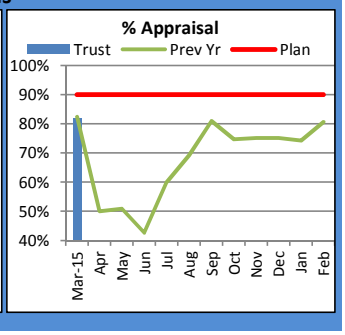


Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals









M1 Financial Performance Overview

1. Overview of the Financial Position at month 1 (2015/16)

1.1. This written summary provides an overview of the financial position at M1 of 2015/16. It should be read alongside the summarised finance pack, which has also been circulated to committee members.

\£m	Income	Expenditure	Position	Plan	Variance
Operating position	30.7	(31.6)	(0.9)	(0.9)	0.0
Finance costs, investments and dividends	0.0	(1.6)	(1.6)	(1.6)	(0.0)
Trust total	**30.7**	**(33.2)**	**(2.4)**	**(2.4)**	**(0.0)**

1.2. The Finance pack shows for Month 1 an in month deficit of £2,356k against an in month deficit plan of a £2,361k which reflects a small favourable variance of £4k. This also means that the contingency for month 1 has been consumed to support the position.

2. Operational financial performance month 1 (2015/16)

2.1. The operating position is effectively on plan but does carry some significant variances within that position. The high level variances become more apparent in the operational finance table below.

Income and Expenditure Summary for April (/£m)	Plan	Actual	Variance
NHS contract income	24.6	24.7	0.2
Non NHS contract patient care income	3.9	3.4	(0.5)
Total patient care income	**28.5**	**28.1**	**(0.3)**
Other income	3.3	2.6	(0.6)
Total operating income	**31.7**	**30.7**	**(1.0)**
Pay	(19.7)	(20.0)	(0.3)
Non pay	(12.9)	(11.6)	1.3
Total operating expenditure	**(32.6)**	**(31.6)**	**1.0**
Operating defcit	**(0.9)**	**(0.9)**	**0.0**

2.2. Patient care income is adverse to plan despite the higher than expected levels of activity as high cost drugs and devices costs charged is behind plan.

2.3. Pay expenditure is adverse to the plan by £0.3m in April. This reflects a £0.7m favourable variance from vacancies offset by a £1m over spend in agency, bank and locum staff.

2.4. The total year to date total income is £30.7m against a budget of £31.7m equates to an under performance of £1.0m.

2.5. As at month 1, the trust is reporting a £0.2m over performance against its SLA internal activity plans. There is a £0.2m underperformance on patient care activity which was offset by over performance non-patient care activity.

2.6. NHS patient income variances are outlined below:-

- **Elective inpatients** have a marginal £8k over plan at Month, while Daycase activity has an adverse variance of £0.1m. The underperformance is driven by the casemix of patients seen in the month which was not as rich as planned as well as the high incidence of uncoded activity which were valued at average prices.
- Outpatient follows ups have a £0.03m (1%) favourable movement against the internal plan as at Month 1. The Trust continues to see large volumes of follow up activity primarily in Surgical and Medical specialties, all of which are subject to CCG follow up SLA restrictions and are incurring penalties.
- Non elective inpatients are currently £0.1m (2%) below plan. The record levels of emergency demand previously experienced by the Trust are now showing signs of reduction. This is evidenced by the reduction in A&E attendances and admissions which have reduced the emergency threshold penalty levied under the NHS Standard contract.
- **Transitional Support – Cancer** -£0.3m – This refers to the transitional support received from NHS England to reduce the impact of the cancer tariff in 2015-16, this income has reduced by 50% in 2015-16 and will be removed completely in 2016-17. The Trust will have to take appropriate steps to reduce its expenditure base accordingly

2.7. Operating costs are £31.6m against a plan of £32.6m, a favourable variance of £1.0m. The budget included £0.2m of contingency phased into month 1.

2.8. Pay was overspent by £0.3m in the month. This reflects a variance for vacancies worth £0.7m more than offset by bank and agency overspends of £1.0m with nursing agencies exceeding plan by £0.5m.

2.9. Non pay costs are underspent by £1.3m in the month. A significant amount of the remaining underspend relates to rechargeable items and services such as high cost drugs and devices.

3. Other financial indicators for month 1 (2015/16)

3.1. EBITDA is a £0.7m surplus which is slightly ahead of plan.

3.2. The financing costs including those related to the PFI and deprecation totalled £3.1m, including PFI, depreciation and PDC which was broadly the plan for the month

3.3. CIPs will be reported for the first time in month 2.

3.4. Cash balances of £20m were held at the end of M1 which include the funds from double contract payments in April from the Trust's main commissioners

4. Conclusion

4.1. The consumption of the contingency for month 1 is an issue. Despite an apparent reduction in activity pressures in April pay costs especially for agency nurses remained high.

4.2. The Trust will require access to NHS finance (loans) later in the year in order to operate. The process of securing those loans has started with the TDA and with the submission of the plan.

4.3 The Board is requested note this report.

Maidstone and Tunbridge Wells NHS Trust

M01 Finance Pack

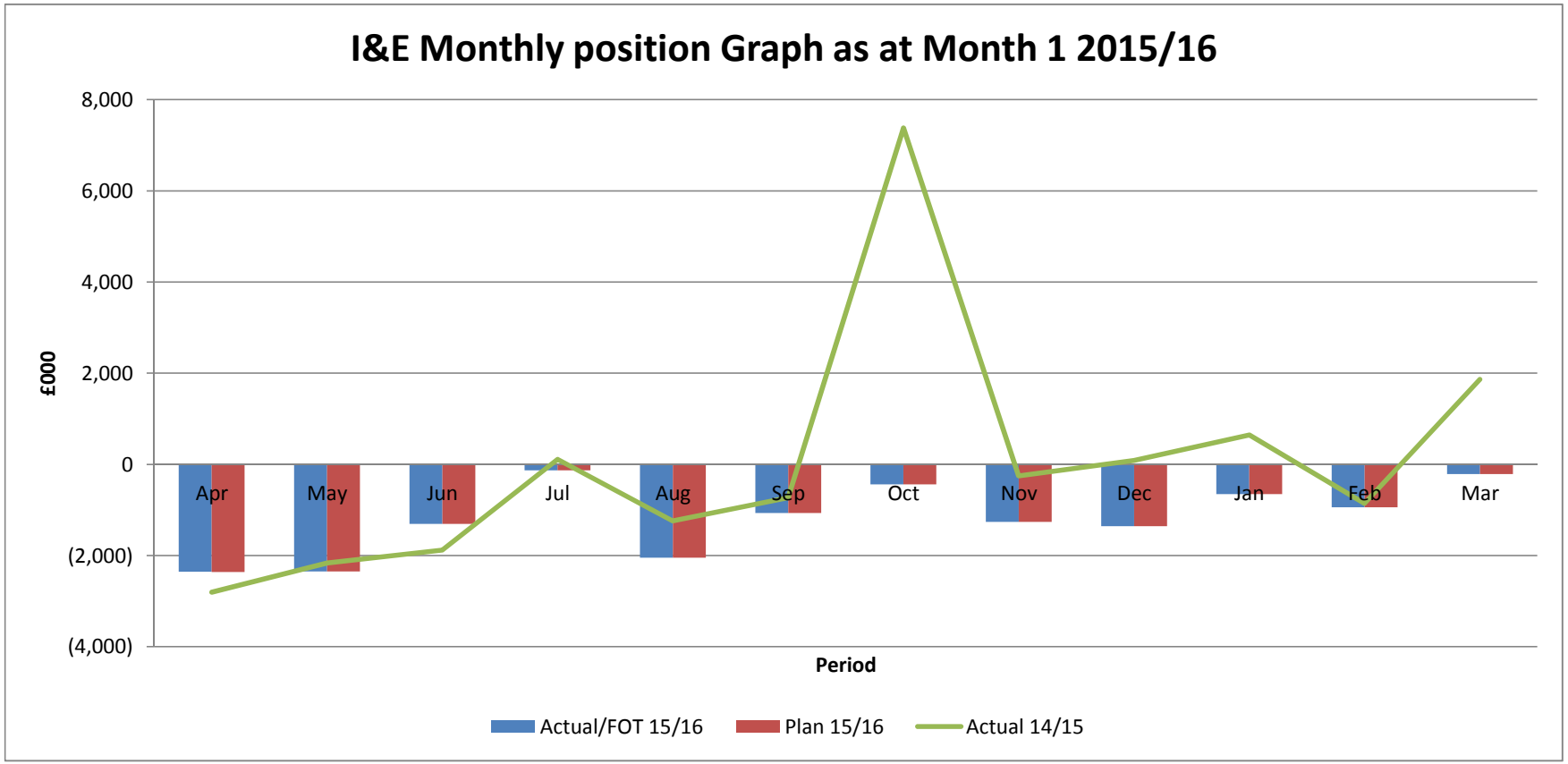
I&E Summary
I&E monthly trend graph
SLA position
CIP monthly graph
Cash Flow

Maidstone and Tunbridge Wells NHS Trust

Income and Expenditure Summary (/£m)	Annual Plan	April Plan	April Actual	April Variance
NHS contract income	306.3	24.6	24.7	0.2
Non NHS contract patient care income	54.7	3.9	3.4	(0.5)
Total patient care income	**361.0**	**28.5**	**28.1**	**(0.3)**
Other income	37.9	3.3	2.6	(0.6)
Total operating income	**398.9**	**31.7**	**30.7**	**(1.0)**
Pay	(226.6)	(19.7)	(20.0)	(0.3)
Non pay	(168.5)	(12.9)	(11.6)	1.3
Total operating expenditure	**(395.1)**	**(32.6)**	**(31.6)**	**1.0**
Operating defcit	**3.8**	**(0.9)**	**(0.8)**	**0.0**
Finance costs, investments and dividends	(19.3)	(1.6)	(1.6)	0.0
Retained Surplus/(Deficit) per accounts	**(15.5)**	**(2.5)**	**(2.5)**	**0.0**
IFRIC 12 and donated or government grants	1.4	0.1	0.1	(0.0)
Adjusted surplus/(deficit)	**(14.1)**	**(2.4)**	**(2.4)**	**0.0**

Maidstone and Tunbridge Wells NHS Trust

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual/FOT 15/16	(2,357)	(2,349)	(1,306)	(134)	(2,049)	(1,068)	(442)	(1,261)	(1,355)	(654)	(940)	(214)
Plan 15/16	(2,361)	(2,348)	(1,306)	(133)	(2,048)	(1,068)	(441)	(1,261)	(1,354)	(653)	(940)	(213)
Actual 14/15	(2,805)	(2,163)	(1,882)	111	(1,242)	(734)	7,380	(251)	84	646	(856)	1,867

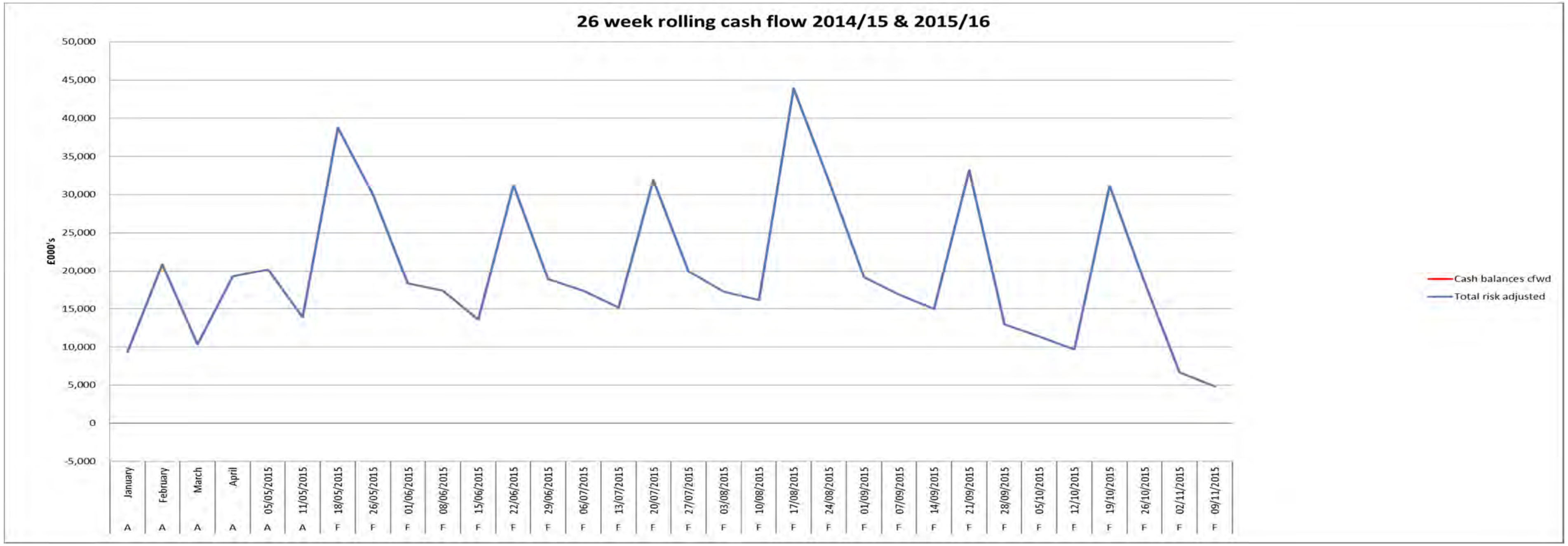


Maidstone and Tunbridge Wells NHS Trust

	Annual Plan	Phased plan (Month 1)	YTD Performance (Month 1)	Variance	% age Variance	FOT	FOT Variance	FOT % age Variance
	£'000	£'000	£'000	£'000	%	£'000	£'000	%
Daycase	33,682	2,695	2,586	-109	-4%	33,682	0	0%
Elective IP (in Excess days)	23,734	1,899	1,906	8	0%	23,734	0	0%
Non Elective IP (inc Excess days)	91,429	7,494	7,360	-134	-2%	91,429	0	0%
Non Elective Threshold	(2,485)	(204)	(220)	-17	8%	-2,485	0	0%
Outpatient New	24,673	1,974	1,957	-17	-1%	24,673	0	0%
Outpatient Follow up	30,623	2,450	2,475	25	1%	30,623	0	0%
Outpatient Unbundled imaging	9,028	722	707	-15	-2%	9,028	0	0%
Unbundled Imaging Threshold	0	0	0	0	0%	0	0	0%
Direct Access, A&E, other Direct	60,734	4,933	4,947	15	0%	60,734	0	0%
Maternity Pathway	11,064	907	907	0	0%	11,064	0	0%
Other NHS Clinical Income	11,895	1,859	1,936	77	4%	11,895	0	0%
CQUIN	5,888	471	478	7	2%	5,888	0	0%
CCG Reinvestment	0	0	0	0	0%	0	0	0%
Transitional support - Cancer	2,875	240	302	63	26%	2,875	0	0%
Challenge provision	(11,710)	(940)	(579)	362	-38%	-11,710	0	0%
Specialist Commissioning 70/30 Threshold	(1,173)	(96)	(150)	-54	56%	-1,173	0	0%
NHD Support	12,000	87	71	-16	-19%	12,000	0	0%
Cost of Change	4,000	57	57	0	1%	4,000	0	0%
Total	**306,258**	**24,546**	**24,741**	**195**	**1%**	**306,258**	**0**	**0%**

Maidstone and Tunbridge Wells NHS Trust

26 Week graphical presentation of cash balances up to w/c 9th November 2015, actuals at 15th May 2015



A	A	A	A	A	A	F	F	F	F	F	F	F	F	F	F	F	F	F
January	February	March	April	05/05/2015	11/05/2015	18/05/2015	26/05/2015	01/06/2015	08/06/2015	15/06/2015	22/06/2015	29/06/2015	06/07/2015	13/07/2015	20/07/2015	27/07/2015	03/08/2015	10/08/2015
9,392	**20,839**	**10,334**	**19,276**	**20,173**	**13,892**	**38,796**	**29,984**	**18,356**	**17,363**	**13,562**	**31,228**	**18,926**	**17,358**	**15,165**	**31,904**	**19,922**	**17,254**	**16,161**
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
9,392	**20,839**	**10,334**	**19,276**	**20,173**	**13,892**	**38,796**	**29,984**	**18,356**	**17,363**	**13,562**	**31,228**	**18,926**	**17,358**	**15,165**	**31,904**	**19,922**	**17,254**	**16,161**

F	F	F	F	F	F	F	F	F	F	F	F	F
17/08/2015	24/08/2015	01/09/2015	07/09/2015	14/09/2015	21/09/2015	28/09/2015	05/10/2015	12/10/2015	19/10/2015	26/10/2015	02/11/2015	09/11/2015
43,893	**31,807**	**19,150**	**16,880**	**14,964**	**33,217**	**12,961**	**11,368**	**9,675**	**31,202**	**18,616**	**6,661**	**4,828**
0	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
0	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
0	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
0	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
43,893	**31,807**	**19,150**	**16,880**	**14,964**	**33,217**	**12,961**	**11,368**	**9,675**	**31,202**	**18,616**	**6,661**	**4,828**

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - May 2015

5-9	Theatre scheduling	Chief Operating Officer

In March 2015, the Finance Committee received a presentation from the Clinical Director and General Manager for Trauma and Orthopaedics. The discussion of the issues raised during the presentation led to the Committee agreeing that a report on the issues (and potential solutions) relating to theatre scheduling should be submitted to the Trust Board. The enclosed report has been prepared in response.

The Theatre Utilisation Steering Board requested that the project team develop a new theatre master schedule, to deliver:

- Extra theatre capacity out of existing theatre estate
- Improved theatre utilisation
- Improve quality and patient experience by supporting new clinical pathways designed to improve quality of service and improving coordination between clinics and theatres.
- More flexibility, consistency and transparency in theatre planning.

Achievements

- Increased capacity for key specialities out of existing theatre estate.
- Many specialities have been moved to consistent theatres –which will reduce the need to move equipment between theatres and will develop sub specialism within the theatre teams.
- Theatre times have been standardised and increased to potentially 19:30 each evening.

Challenges

- Inadequate capacity to match demand in some specialties.
- Bed pressures, impacting on ability to maximise utilisation
- Lack of clinical leadership to support changes to job plans and working practises required to create more capacity within existing estate.
- Delays to moving to a 4 week rolling rota.

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive, 20/05/15

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

Introduction

The Theatre Utilisation is one of the CIP programmes for 2015/16 and an opportunity of £1.1m has been proposed. The project team report into the Theatre Utilisation Steering group, which membership consists of the Surgical and Anaesthetic CDs and is chaired by the Chief Operating Officer.

The Theatre Utilisation Steering Board requested that the project team develop a new theatre master schedule, to deliver:

- Extra theatre capacity out of existing theatre estate (currently inadequate theatre slots for new consultants).
- Improved theatre utilisation by moving to more efficient all-day lists and in some instances 2.5 session days and establishing a level of sub specialism in theatres.
- Improve quality and patient experience by supporting new clinical pathways designed to improve quality of service and improving coordination between clinics and theatres.
- More flexibility, consistency and transparency in theatre planning - A standardised theatre template that existing and new surgical lists, NHS or private can be accommodated. Each theatre would have the potential capacity to operate a combination of sessions during the week days and two sessions each day at the weekend:
    - 4 hour sessions either AM or PM (0830-1230 or 1330-1730)
    - 6 hour session- Extended Afternoon. (1330 -1930)
    - 9 hour session- All Day (0830-1730)
    - 11.0 hour Long Day (0830-1930)

This will provides a maximum of 73 hours per week per operating theatre, as opposed to the generally applicable, but with many exceptions (8hrs*5days) = 40 hours plus various unplanned or semi planned extra sessions.

Project Overview

The project team worked with GMs and CDs who in turn worked with their directorates and consultants to develop a schedule within the rules described above. In some specialities such as Gynae Oncology, Urology and UGI, long days were already established practice. This project has not increased the number of long day sessions but has introduced an extended afternoon of 6 hours, therefore one consultant can be operating in the morning and then another for the afternoon and into the evening, making the most of the time available. The new schedule went live on the 30th March 2015.

Achievements

- Theatre times have been standardised and increased to potentially 19:30 each evening.
- Many specialities have been moved to consistent theatres –which will reduce the need to move equipment between theatres and will develop sub specialism within the theatre teams.
- Increased capacity for key specialities out of existing theatre estate.

Challenges

- Delays to moving to a 4 week rolling rota. This was due to the EPR team being unable to support a change in outpatient clinics at the current time. (These would also need to change to avoid job plan clashes). It was suggested by the project group to coincide this with the implementation of the new PAS.
- Despite increases theatre space is still inadequate to match demand in some specialties.
- Bed pressures, to maximise benefit from increased theatres capacity – this is currently the rate limiting step.
- Lack of clinical leadership to support changes to job plans and working practises - e.g. long days but in particular weekend working.
- Continuing bed pressures due to increased usage of inpatient beds for NEL admissions is limiting theatre efficiency.

Speciality Achievement & Challenges

Trauma and Orthopaedics

- T&O theatre capacity has increased by over 3 sessions per week from approximately 32 session to 35.75 sessions per week and as a result T&O can now accommodate an additional 332 cases in 2015/16 compared to 14/15. The two appointed T&O consultants last year now have weekly sessions programmed into their timetable as opposed to backfilling other consultants' lists when available.
- Consolidated Maidstone sessions into one theatre, which reduced infection control risks and increases the flexibility of the use of the sessions.
- There are now only 7 half day sessions in the 5 week occurrence rota and 3 of those could be turned into extended afternoon sessions if the directorate can support them.
- There is the potentially for T&O to further increase capacity by increasing the number of extended afternoons, moving to long days (2.5 session days) or to weekend working. However there is resistance from the clinical team to progress this.
- Currently exploring an opportunity for T&O to 23 hour stay cases to Maidstone to mitigate the effect of inpatient cancellations at TWH.
- Currently exploring use of the Minor Ops theatres at TWH for appropriate cases.
- T&O were extremely disappointed to not move to a rolling 4 week rota –however staying on occurrences provided some short term problems and over all does not affect capacity.

Head and Neck

- The new ENT consultant when appointed has sessions already identified for their arrival.
- ENT are now generally in Theatre 1 at TWH reducing the need for equipment to move and providing more consistency in theatre team.
- The new Minor Operation Theatre at TWH was brought on line part way through 2014. Ophthalmology have been given exclusive access to this Theatre, increasing their capacity at TWH.
- Ophthalmology are yet to agree job plans for the revised start times –agreement will allow an additional case per session.
- Head and Neck are yet to fully embrace all the benefits of the new schedule as they still have predominantly half day sessions due to complication in job plans –their consultants run clinics across wide areas externally to the Trust. However the framework is in place for this to be challenged in the future.
- There is the potential for H&N to further increase capacity by increasing the number of extended afternoons or to weekend working in standard sessions. However there is little clinical support for this.

Surgery

- General surgery and Urology capacity and demand plans are now equal.
- The new schedule has allowed the introduction of the semi elective pathway –which has been introduced to improve patients' flows and reduce length of stay. The semi elective pathway has sessions at the beginning and end of each week. This will be reviewed in 3 month –to assess utilisation and check these are not underutilised.

Gynaecology

- Gynaecology have increased the number of sessions for their new consultant and a regular session for their long term locum.
- In addition they have increased the number of days that Gynae all days sessions and sessions of all day speciality (managed by two half day sessions by consultants) which reduced delays of changing speciality part way through the day.
- Gynaecology would like to further explore moving to long days for three of their consultants – however until the new anaesthetists are recruited Critical Care are unable to support this. The framework is in place to allow this on their commencement at the Trust.

Private Patients

- The PP unit has lost a number of underutilised and frequently left vacant sessions. These have been reallocated to specialities outsourcing activity.
- The Private Patient (PP) unit has 4 sessions dedicated to it in the 5 week occurrence schedule. In addition with the move to the 6-4-2 model of booking now winter pressures are easing, they will be given first refusal on all unused sessions.

Next steps

- The steering group has requested a review of the benefits of moving to a 4 week rolling rota prior to developing an implementation plan.
- The semi elective pathway will be reviewed in 3 months' time to ensure capacity is fully utilised.
- Further work is required with directorates to increase capacity by increasing the number of extended afternoons, moving to Long days (2.5 session days) and/or weekend working in standard sessions.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting - May 2015

5-11 CQC Quality Improvement Plan Assurance Report — Chief Nurse

Summary / Key points

The enclosed report provides the latest information on the progress being made against the delivery of the Quality Improvement Plan developed following the Care Quality Commission's inspection in October 2014.

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive, 20/05/15

Reason for receipt at 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

CQC Quality Improvement Plan

Assurance Report May 2015

This report is produced to provide staff, patients, stakeholders, the CQC and the board with an assurance against the Quality Improvement Plan developed and agreed in response the CQC inspection report that was published in February 2015. This is a monthly report (commenced April 2015 onwards), following which the main Quality Improvement Plan will be updated

The report will be submitted to the Trust Management Executive, the Trust Board, TDA and the CQC and will be shared with local commissioning groups. A summary will be published on the MTW intranet and MTW website.

The first section presents the progress of the Enforcement notice and Compliance action. The second section provides information about the progress on the 'Should do' actions to date.

Overview of progress to date

Enforcement action – Water testing Maidstone Hospital

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. Further information requested by the CQC has been submitted along with a request for the enforcement notice to be lifted. We are waiting for the CQC to review the information sent and advise on the next steps.

Compliance actions – Paediatrics

A validated paediatric early warning system has been identified and agreed for implementation at MTW. A paper version has been implemented in paediatric emergency department both sites, with intention to roll out to all paediatric departments in July 2015. This validated tool will also be used on Nervecentre (inpatient electronic recording system)

The Standard Operating Procedure (SOP) for the administration for topical anaesthetics for children has been completed and agreed. Training for senior staff to undertake PGD's is underway and due to be completed by the end of May. In the interim topical anaesthetic continues to be prescribed. Regular audits are undertaken to assess compliance.

Compliance actions – Critical care

Significant progress has been made in addressing the compliance actions against Critical Care. Morning wards rounds take place simultaneously at weekends and the second evening ward round takes place either in person or via telephone depending on acuity of patients. An agreement have been reached to enable the implementation of a second ward round at weekends consistently and to initiate an intensivist rota in line with the requirements of ICS standards. Recruitment for additional Consultants to support the rota continues.

Further work is ongoing to review the standard operating procedure for managing critically ill patients requiring ITU when capacity is challenging. There has been a significant improvement in reducing the number of ITU patients from ITU to wards out of hours (22.00 and 07.00).

The critical care outreach service is currently being recruited into, with a consultation paper to develop a 27/7 service being prepared for formal consultation.

Compliance action – meeting the needs of service users

An interim lead has been appointed in May who will lead the recruitment of a permanent Equality and Diversity lead and commence the work to meet the needs of service users with due regard to their cultural and linguistic background and any disability they may have.

Status of plan

Rating below relate to the progress of the enforcement/compliance action as a whole based on the date of **overall completion**. Some of the original actions, once completed have resulted in other actions being required which is simply an evolution of the situation for example compliance action 2, action 3b

The table below provides a summary of any issues arising.

KEY to progress rating (RAGB rating)

	Blue	Fully Assured
	Amber	More assurance required
	Green	Assured / in progress
	Red	Not assured

	Operational lead	Progress rating	Issues / Comments
Enforcement Notice – Water testing	Jeanette Rooke, Director of Estate & Facilities-		Action completed and evidence submitted to CQC for review. Request for enforcement notice to be lifted.
CA 1 - Paediatric Early Warning Scoring (PEWS) system	Jackie Tyler, Matron Children Services		None raised
CA 2 – ICU weekend cover	Daniel Gaughan General Manager, Critical Care		Significant progress with ward rounds at weekends, review and agreement on intensivist rota that will meet ICS requirements, expected full compliance by October 2015 with new rota. Risks assessed and mitigation in place in the meantime.
CA 3 – ICU consultant within 30mins	Daniel Gaughan General Manager, Critical Care		
CA 4 – ICU delayed admissions	Jacqui Slingsby Matron, Critical Care Directorate		None raised
CA 5 – ICU delayed discharges	Jacqui Slingsby Matron, Critical Care Directorate		None raised
CA 6 – ICU overnight discharges	Jacqui Slingsby Matron, Critical Care Directorate		Robust patient tracking in place, however continued concern in relation to patient flow at TWH which impedes patients having timely transfers (before 22.00hrs). Plan in place to create additional capacity at TWH

	Operational lead	Progress rating	Issues / Comments
CA 7 – Critical Care Outreach 24/7 service provision	Siobhan Callanan Associate Director of Nursing		None raised
CA 8 – ICU washing facilities	Jacqui Slingsby Matron, Critical Care Directorate		Improvements in facilities, action nearly completed
CA 9 – Cultural/linguistic needs	Richard Hayden Deputy Director of Workforce		None raised
CA 10 – CDU Privacy and dignity	Lynn Gray Associate Director of Nursing		Awaiting definitive decision on preferred option
CA 11 – Medical records	Wilson Bolsover Deputy Medical Director		None raised
CA 12 – Security staff	John Sinclair Head of Quality, Safety, Fire and Security		None raised
CA 13 – Incident reporting	Jenny Davidson Associate Director of Governance, Patient Safety and Quality		None raised
CA 14 – Joint management of children with surgery	Hamudi Kisat / Johnathan Appleby Clinical Directors		None raised
CA 15 – Children's Clinical governance	Karen Woods Risk and Governance Manager, Children and Women's Services		None raised
CA 16 – Incident reporting + lessons learnt	Jenny Davidson Associate Director of Governance, Patient Safety and Quality		Completed compliance action
CA 17 – Corporate clinical governance	Jenny Davidson Associate Director of Governance, Patient Safety and Quality		None raised
CA 18 – Topical anaesthetics	Jackie Tyler, Matron Children Services		None raised

Enforcement Notice

Enforcement Action			REF	Directorate	Issue Identified	Action /s	Lead	Date to be completed	Evidence Required	Outcome/success criteria	Delivery RATING
Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 – Cleanliness and Infection Control Cleanliness and infection control 12. (1) The registered person must, so far as reasonably practicable, ensure that – (a) Service users; (b) Persons employed for the purpose of the carrying on of the regulated activity; and (c) Others who may be at risk of exposure to a health care associated infection arising from the carrying on of the regulated activity, are protected against identifiable risks of acquiring such an infection by the means specified in paragraph (2). (2) The means referred to in paragraph (1) are (a) The effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of a health care associated infection; People who use services and others were not protected against the risks associated with health care associated infections because the trust had failed to ensure that an effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of health care associated infections, with specific regard to water quality and safety and more specifically, themanagement and control of Legionella. Regulation 12(1)(a)(b)(c)(2)(a)(c).	**Executive Lead: Glenn Douglas**	**Date compliance will be achieved by: January 2015**	**EN1**	Estates and Facilities Management	The annual water sampling for legionella was six months overdue at Maidstone Hospital	1. Internal Investigation undertaken 2. External review undertaken 3. Water Hygiene Management Action Plan developed and implemented 4. Governance around water hygiene management reviewed and new system of robust Governance implemented 5. Risk Assessments and Sampling testing undertaken 6. Authorised Engineer (Water) appointed 7. Estate Management and Audit review of processes with a number of new appointments have been made within the senior team of Estates Services ensuring Authorised Persons in each technical element. The planned preventative maintenance schedule is currently being reviewed to ensure all statutory requirements are incorporated. In addition a comprehensive schedule is being developed for audit purposes. The internal auditing will be triangulated by the inspections, risk assessments and annual report undertaken and issued by the Authorised Engineer (Water) who provides the independent assurance and validation.	Jeanette Rooke	Completed 14th January 2015	Report produced outlining Governance, testing results and audit processes External review report Certificates of sampling Ongoing Agenda and Minutes of meetings	Water hygiene Management is compliant with statutory requirements with robust governance and management in place	

Report submitted with all actions completed. Request for Enforcement notice to be lifted submitted with supporting evidence. RAGB = BLUE

Compliance action 1				CA1
Issue: *The PEWS system had not been validated and was not supported by a robust escalation protocol that was fit for purpose and was not standardised across the children's' directorate*				
Lead: *Hamudi Kisat, Clinical Director*		**Operational Lead: Jackie Tyler,** *Matron*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. PEWS chart reviewed in line with tertiary referral centres (Nottingham) or PEWS from National Institute for Innovation (used in other Trusts)	-Meeting with Nottingham Children's Hospital completed, authorisation given to adapt their PEWs paperwork - Awaiting final proof from Printers of new PEWs chart - Sepsis 6 incorporated - Chart will then go to relevant committees for approval.	1. Validated PEWS in place. 2. Revised escalation protocol in place 3. Staff competent and consistent in using PEWS and escalation. 4. 3 monthly audit of compliance 5. Evidence of communicatio n via meetings	31/6/15	
2. Escalation protocol reviewed alongside the PEWS chart review	Escalation protocol available in all areas for PEWs			
3. Once agreed, PEWS chart and escalation protocol implemented across Children's services directorate via teaching sessions, ward level meetings, A&E and Children's services Clinical Governance meeting	Paeds ED TWH now have PEWs score on Casualty care and current charts available in department Paeds ED MH trialling attachment of PEWs chart to casualty card – due to rolled out across sites July 15 Clinical skills facilitator in post to facilitate staff training			
PHASE 2 Electronic solution (Nervecentre) for PEWS and escalation implemented (brought forward within existing IT plan). NB excludes paediatric A&E	Senior nurse attendance at Nervecentre meetings Awaiting roll out of paperwork and trialling that before moving to electronic possibly September launch	6. Compliance audit from Nervecenter	31/12/15	
Action Plan running to time: Yes				
Evidence submitted to support update (list): Awaiting paper Pews documentation from printers and copy of ED casualty card from Maidstone and Tunbridge Wells NHS Trust				
Assurance statement :				
It has been identified that the introduction of a new PEWS chart to the wards must be done in a planned and controlled method. The trust is confident that in the interim, with the new escalation process in place, and the current PEWS tool, children who are at risk of deterioration are identified appropriately.				
Areas of concern for escalation:				
None				

Compliance action 2				CA2
Issue: *Contrary to the core standards of the Intensive Care Society: There was a lack of cover by consultants specialising in intensive care medicine at weekends; for example, one consultant covered more than 15 patients on two sites.*				
Lead: *Greg Lawton , Clinical Director*		**Operational Lead:** *Daniel Gaughan, GM*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Morning week-end ward rounds on both units implemented	Implemented January 2015	1. Anaesthetic electronic rota showing allocation of intensivists at weekends to site allocation 2. Business plan including risk assessment, mitigations and staffing analysis against core standards 3. TME Meeting minutes where business case considered and decision made 4. Audit of patients medical notes documenting weekend Consultant reviews	1/2/15	
2a. Second ward round at weekend is taking place at both units. Risk assessment undertaken with mitigations in place as required 2b. Second ward round at weekend in person	2a. Second ward round at weekends is taking place in person or by phone depending on acuity of patients. 2b. Agreement for amendments on rota to enable a 1-8 compliant rota to ensure a second ward round in person at weekends to occur consistently.		2a. 31/3/15 2b. 1/10/15	
3a. The rota for the intensivists reviewed in line with the requirements of the ICS core standards 3b. Rota fully meeting the ICS requirements	3a. Rota has been reviewed and agreement reached to meet ICS requirements. 3b. Decision made to implement a 1-8 compliant rota, implementation - September 2015.		3a. 31/3/15 3b. 1/10/15	
4. Business case for additional intensivists developed and considered	Final draft to be completed. Exec sign off and TME agreement June.		17/6/15	
5. Mitigation in place for non-compliance	Mitigation part of CQC intensivist risk assessment		30/6/15	
6. Recruitment achieved	Re advertising intensivists job June 2015		1/4/16	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list): Risk Assessment + Rota				
Assurance statement :				
Significant progress with agreement to change in intensivist rota				
Areas of concern for escalation:				
Appointment of suitability qualified intensivists				

Compliance action 3				CA3
Issue: *Contrary to the core standards of the Intensive Care Society: The consultant was not always available within 30 minutes. There was only one ward round per day when there should be two to comply with core standards.*				
Lead: *Greg Lawton , Clinical Director*		**Operational Lead:** *Daniel Gaughan, GM*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Travel times & distance for each consultant being reviewed to assess compliance with 30 minutes availability for each individual consultant.	This has now been assessed by the Clinical Director	1. Report from Clinical Director outlining each Consultant's travel distance and confirmation of each Consultants ability to respond within 30 minutes. 2. Any delays in responding to be reported as incidents (DATIX) 3. Audit of patients medical notes documenting weekend Consultant reviews	31/5/15	
2. Risk assessment to be undertaken where travel times exceed 30mins	This has been completed to support mitigation until new rota commences in September 2015		31/5/15	
3. Ward round compliance actions in CA2	3a. Second ward round at weekends is taking place in person or by phone following a risk assessment. 3b. Agreement for amendments on rota to enable a 1-8 compliant rota ensuring a second ward round in person at weekends		3a. 31/3/15 3b. 1/10/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list): Risk assessment				
Assurance statement :				
Fully compliant rota expected September 2015				
Areas of concern for escalation:				
Appointment of consultant intensivists.				

Compliance action 4				CA4
Issue: *Contrary to the core standards of the Intensive Care Society: Admissions were delayed for more than four hours once the decision was made to admit a patient to ICU*				
Lead: *Richard Leech, Clinical Director*		**Operational Lead:** *Jackie Slingsby, Matron & Lynn Gray, ADN emergency services*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Consider option of ringfencing ITU bed for admission	Discussion and agreement at TME: the ringfencing of ITU bed will be implemented where possible	1. Minutes of TME meeting where ringfencing option discussed 2. SOP for ITU admissions, transfers and discharges. SOP for managing critically ill patient when ITU is full 3. Site report documentation 4. Monthly performance data 5. DATIX IR1 completed for each patient who has a delayed admission to ITU due to inability to move wardable patients. Investigation into each occurrence with clear lessons learnt and changes implemented	20/5/15	
2. Standard Operating Procedure developed relating to ITU admissions	Operational Policy which incorporates admission policy reviewed and comments made. For approval at ICU meeting on 21/5/15		31/5/15	
3. Review SOP for managing critically ill patients requiring ITU, when ITU capacity is full (for e.g. in recovery)	Task and finish group of all stakeholders working on pathways for patients in escalation areas. Preliminary work re-visited and updated based on different scenarios		30/4/15	
4. ITU referrals & those patients requiring ITU will be identified and discussed at each site meeting and priorities escalated as appropriate.	Attendance at each site meeting by Shift leader/matron in place. Associate Director responsible for the site ensures ITU capacity and demand is discussed at each site meeting and plans put in place with clinical teams to transfer out as appropriate. ITU referrals will be consultant to consultant and raised to both the Clinical site team and Matron/Shift leader in ICU. Clinical priorities will be identified by the Consultant intensivist		1/4/15	
5. When no prospect of ITU capacity available on either site then arrangements for transfer to another unit will be made.	Consider escalation feasibility before any transfer. Critical care capacity within Trust reviewed before transfer outside of organisation. National Emergency bed service already in place.		1/1/15	
Action Plan running to time: **No**				
Evidence submitted to support update (list): Operational policy				
Assurance statement :				
Areas of concern for escalation:				
None				

Compliance action 5				CA5
Issue: *Contrary to the core standards of the Intensive Care Society: Discharges from the ICU were delayed for up to a week. Of all discharges, 82% were delayed for more than 4 hours*				
Lead: Greg Lawton*, Clinical Director*		**Operational Lead:** *Jackie Slingsby, Matron & Lynn Gray, ADN emergency services*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Standard Operating Procedure to be developed relating to ITU discharges	Operational Policy drafted. For agreement at next cross-site meeting 20/5/15.	1. SOP for ITU admissions, transfers and discharges. 2. Site report documentation. 3. Monthly performance data 4. DATIX incident report completed for each patient who has a delayed discharge from ITU Investigation into each occurrence with clear lessons learnt and changes implemented	31/5/15	
2. Transfers out of ITU to be followed up on a named patient basis at each site meeting	In place at site meetings		1/4/15	
3. To link in with Trust wide work around patient flow and delayed discharges improvement plan developed in line with D16 CQUIN and in collaboration with Chief Operating Officer and Clinical Site Management team	Monthly delayed discharge performance data captured on performance dashboard and within monthly unit reports. Performance against milestones reported at monthly CQUIN board. Incident forms completed for each delay, clinical site team identified as handlers.		30/5/15	
Action Plan running to time: Yes				
Evidence submitted to support update (list): Operational Policy, Delayed discharge list, ICU divisional dashboard, Site reports				
Assurance statement :				
Areas of concern for escalation:				

Compliance action 6				CA6
Issue: *Contrary to the core standards of the Intensive Care Society: Overnight discharges take place from the ICU.*				
Lead: Greg Lawton*, Clinical Director*		**Operational Lead:** *Jackie Slingsby, Matron & Lynn Gray, ADN emergency services*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. All ward fit patients to be identified to the site team at the earliest opportunity but by 1500 at the latest each day.	All patients deemed ward fit or likely to be fit are named at site meetings and entered on capacity handover form to the site team, together with any special requirements i.e. Side room needed, specialist ward etc. Displayed in site team on Comms board	1. Incident (DATIX) report to be raised on all post 2000hrs transfers. Review and identification of where lessons can be learnt and improvements made	1/3/15	
2. Transfer plans to be agreed and completed by 2000 hrs at the latest. **No patients to be routinely transferred from ITU after 2000.**	During April **7** patients at TWH (12 in March) and **0** at Maidstone (3 in March) were transferred to wards between 22:00 and 07:00, which is a significant improvement on March. Incident reports raised. Patients though deemed fit prior to these times were not able to be moved to a ward due to bed capacity issues.		1/3/15	
Action Plan running to time: Yes but capacity challenges continue to impact on delivery				
Evidence submitted to support update (list): Transfers out of hours spread sheet, ICU divisional dashboard, site reports				
Assurance statement :				
Robust Patient tracking in place				
Areas of concern for escalation:				
Concern in relation to patient flow at TWH continues, which impedes patients having timely transfers. Long term strategy for inpatient capacity at TWH in planning phase				

Compliance action 7				CA7
Issue: *The outreach service does not comply with current guidelines (National Confidential Enquiry into Patient Outcome and Death (NCEPOD) (2011))*				
Lead: *Greg Lawton, Clinical Director*		**Operational Lead:** *Siobhan Callanan, ADN planned care*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Business Case approved	Approved	1. Rota showing 24 hour / 7day cover 2. Review of service and performance data via Directorate Clinical Governance meetings	27/1/15	
2. Recruitment to posts	Currently 2.77 vacancies Further interviews to take place on 21st May 2015		1/9/15	
3. Implementation of a 24 hour 7 day out-reach service which will be fully integrated with critical care service	Consultation process underway		1/10/15	
Action Plan running to time: **Yes / ~~No~~**				
Evidence submitted to support update (list): Advert for outreach posts Draft consultation paper.				
Assurance statement :				
On track to deliver the plan, with good engagement across the teams and with support of the executive team				
Areas of concern for escalation:				
None				

Compliance action 8				CA8
Issue: *Improvements are needed in relation to the environment in the Intensive Care Unit with regards to toilet/shower facilities for patients.*				
Lead: *Greg Lawton, Clinical Director*		**Operational Lead:** *Jackie Slingsby, Matron*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Conversion of an existing toilet to a patient toilet & bathroom facility at Tunbridge Wells Hospital	Bathroom facility for patients have always been in place at TWH and contains a toilet within the shower room. The staff toilet which is co-located to the existing facility has been re-assigned and designated as a patient toilet, with appropriate signage	1. Photo of Toilet / shower facilities appropriate for patient use 2. Confirmation at Executive / Non Executive walkabout	1/4/15	
2. Provision of appropriate patient washing facilities within Critical Care at Maidstone Hospital	Shower room available and two designated patient toilets, one which has disabled access; all in use. Awaiting new shower chair delivery.		1/4/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list):				
Assurance statement :				
Photographs: Submitted with April update Non-Executive/Executive walk round at Maidstone – Avey Bhatia/Steve Tinton 13/4/15 at Tunbridge Wells – Paul Sigston 14/4/15				
Areas of concern for escalation:				
Outstanding action - New Shower chair ordered, awaiting delivery at Maidstone.				

Compliance action 9				CA9
Issue: *The provider did not ensure that care and treatment was provided to service users with due regard to their cultural and linguistic background and any disability they may have*				
Lead: *Richard Hayden, Deputy Director Human Resources*		**Operational Lead:** *Richard Hayden, Deputy Director Human Resources*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Appoint a dedicated lead for Equality and Diversity for Trust	Interim lead appointed during May 2015	1. Substantive E&D Lead Appointed 2. Training records against E&D awareness programme 3. New E&D Strategy 4. Detailed action plan for improvements 5. Evaluation of changes to service and feedback from staff (staff survey), patie nts, Healthwatch and community groups (with actions developed and monitored as required)	1/9/15	
2. Develop an E&D awareness programme for all staff			1/10/15	
3. Review and develop new E&D strategy for organisation, in collaboration with MTW staff and partner organisations			1/9/15	
4. Ensure current process for accessing translation services is communicated to all staff			1/2/15	
5. Identify an existing NHS centre of excellence and buddy with them to ensure best practice and learning implemented in a timely fashion			1/6/15	
6. Conduct a comprehensive review of all existing Trust practices in relation to E&D requirements - for example information, translation, clinical practices, food, facilities			1/4/16	
7. Develop links with local support groups and communities to engage them in the improvement plan for the Trust with assistance from Healthwatch			1/10/15	
8. Ensure appropriate organisational governance with assurance to Trust Board in relation to Equality and Diversity			1/9/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list):				
Assurance statement :				
Areas of concern for escalation:				
None				

Compliance action 10				CA10
Issue: *Dignity and privacy of patients was not being met in the Clinical Decisions Unit.*				
Lead: *Akbar Soorma, Clinical Director*		**Operational Lead:** *Lynn Gray, ADN emergency*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Options appraisal for addressing existing dignity and privacy issues in CDU (2 main options are Option 1: changing function of CDU or Option 2: provision of toilet facilities)	Options appraisal currently being developed to identify options to address privacy and dignity issues Meeting arranged with Estates Team to assist with development of proposals Report to Directorate Board	1. Options appraisal paper 2. Changes to CDU environment reviewed by link executives and reported at Standards Committee 3. Site report documentation	1/5/15	
2. Agree preferred option and implement	Report to Directorate Board		Option 1: 1/4/16 Option 2: 1/10/15	
3. Each patient to be tracked and discussed at each site meeting to ensure timeframes met and plan for discharge / transfer in place	Implemented at all site meetings and record of discussion to be recorded on site report documentation		1/4/15	
4. To link in with Trust wide work around patient flow and action TW30	Ensured outcomes are featured in the Escalation and Resilience policies.		30/5/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list): Yes				
Assurance statement :				
Compliance action 10 to ensure dignity and privacy of patients being met in Clinical Decisions Unit is progressing in line with agreed timeframes				
Areas of concern for escalation:				
Review of DSSA guidelines affecting options appraisal, financial and PFI constraints on estates work				

Compliance action 11				CA11
Issue: *The provider did not ensure that service users were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user.*				
Lead: *Paul Sigston, Medical Director*		**Operational Lead:** *Wilson Bolsover, Deputy Medical Director*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Reinforce requirements of Health Care Record keeping amongst multidisciplinary staff, including timely recording of actions undertaken by: 1a. Record Keeping champion for department who will be a source of information and support for record keeping standards 1b. Investigate the possibility of providing a name stamp for staff 1c. Staff involvement in record keeping audit	a) No progress at present. b) Legibility of names was not an issue (for junior doctors) so no major gains form this, which is perceived as difficult to implement. c) Audit will need to include the availability and completeness of the case records.	1. Minutes of Directorate Clinical Governance meetings 2. Staff audit pilot 3. Record keeping champion program and list 4. Report on name stamps for staff and recommendations 5. Induction programme for new doctors 6. Report from task and finish group on records	1a. 1/6/15 1b. 1/6/15 1c. 1/6/15	
2. Review induction programme for new Doctors to ensure adequate training provided.	a) Induction for trainees includes legibility of notes (15.4.15) b) Clinical Tutors asked to add in requirement to avoid loose papers (7.5.15) c) College tutors to be prompted about induction for non-training grades once (b) completed.		1/5/15	
3. Multidisciplinary Task and Finish group (sub-group of health records committee) to review current notes with fresh eyes and consider where improvements can be made	a) Discussed at CD Board (6.5.15). No perceived need to change the case note records ahead of implementation of electronic records.		1/6/15	
4. Record keeping audit to be included in case reviews at Directorate CG Meetings	Not commenced as yet		1/9/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list):				
Assurance statement :				
Work has commenced and is in progress				
Areas of concern for escalation:				
none				

Compliance action 12				CA12
Issue: *Contracted security staff did not have appropriate knowledge and skills to safely work with vulnerable patients with a range of physical and mental ill health needs.*				
Lead: *Jeanette Rooke, Director of Estates and Facilities*		**Operational Lead***: John Sinclair, Head of Quality, Safety, Fire & Security*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Provide documentation outlining the joint partnership with our contractor in regards to the provision of training.	Draft proposal sent to Interserve, awaiting confirmation-The General Manager for IFM is on compassionate leave so unable to confirm at present	1. Agreed documentation on joint partnership arrangements 2. Induction Attendance / compliance report on all existing security staff to Security Group 3. TNA document 4. Report on training compliance to Security Group 5. Certificates of training 6. Certificates of training	1/5/15 New date: 1/7/15	
2. All contractors to attend the Trust approved and agreed Induction Training and attend the Trust mandatory training	All Security Staff have completed the mandatory Trust training courses apart from two new starters who are currently going through registration processes.		1/4/15	
3. Contractors to be included on the Training Needs Analysis document outlining all requirements, frequency and levels	This can be evidenced by the attached email evidencing our L&D confirming a place on a requested course.		1/5/15	
4. Review compliance with all training requirements against existing security team	Security Contractor have 100% compliance rate in accordance with BSIA and ACS		1/5/15	
5. The Security Manager to provide training logs for the SMART Risk Assessment Training undertaken through one to one sessions with all security officers.	Security Manager has completed SMART Risk Assessment Training with 95% of the personnel deployed to both sites. The remaining employees will receive said training by the scheduled action completion date. SMART- Safeguarding Managing Risk Tool. Used to assess high risk patients-Two officers to complete-this is due to shift patterns		1/5/15 New date: 1/7/15	
6. All current security staff to be booked onto and attend Mental Health Awareness Training and dementia awareness training	All contracted Security Staff have been booked on Mental Health Awareness Training and Dementia Awareness Training courses provided by the Trust. All staff will have completed all above training by August 2015. Course feedback reviews will be undertaken to ascertain whether further higher level of training is required to provide the necessary support to meet the appropriate needs.		1/8/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list):				
Assurance statement :				
This action is being discussed at monthly SLA meeting, next due 18th May 15				
Areas of concern for escalation:				

Compliance action 13				*CA13*
Issue: *The process for incident reporting did not ensure that staff were aware of and acted in accordance with the trust quality and risk policy.*				
Lead: *Avey Bhatia, Chief Nurse*		***Operational Lead:*** *Jenny Davidson, Assc Director Governance, Quality and Patient Safety*		
Actions	***Monthly summary update on progress***	***Evidence required***	***Action completion date***	***Rating***
1. Staff leaflet on Trust Quality and Risk Policy, including incident reporting process to be produced in collaboration with staff and distributed to existing staff and new starters at induction	*Leaflet completed*	*1. Leaflet + audit of distribution and staff engagement through survey* *2. fully implemented intranet and web page* *3. Datix Staff survey + reporting figures / by profession* *4. Education presentation + staff survey* *5. Newsletter every month*	*1/5/15*	
2. Governance page to be developed on the intranet and MTW website with clear signposting to Incident Reporting section	*Allocated lead for this work. Will be arranging a task finish group starting May to achieve this task. Bolder reporting incident button already changed on intranet front page*		*Intranet 1/6/15* *Website 1/10/15*	
3. Incident reporting process currently under review, with full collaboration with clinical staff, to improve reporting process and investigate possibility of hosting reporting portal on mobile media	*Draft proposal written and plan is to undertake some collaborative work with staff over next month*		*1/6/15*	
4. Education / update program on Governance, Quality and Patient Safety including incident reporting and learning lessons from incidents to be rolled out to all medical and nursing staff over next year	*Identified within team and included in Governance team strategy, this work will be supported by internal recruitment to patient safety manager secondment*		*1/9/15*	
5. Continue to publish articles on Governance Gazette Newsletter relating to incident reporting and learning lessons. Encourage staff to write their own articles for publication.	*Aprils Governance Gazette is a focus on leaning from incidents relating to sharps*		*monthly*	
Action Plan running to time: ***Yes***				
Evidence submitted to support update (list): *draft proposal + Governance Gazette+ leaflet*				
Assurance statement :				
This action plan has been commenced and leads identified.				
Areas of concern for escalation:				
Patient safety team is awaiting recruitment of a 6month secondment Patient Safety Manager who will help implement some of these required changes. Recruitment expected June 2015				

Compliance action 14				CA14
Issue: *The clinical governance strategy within children's services did not ensure engagement and involvement with the surgical directorate*				
Lead: *Hamudi Kisat, Clinical Director & Johnathan Appleby, Clinical Director*		**Operational Lead:** *Hamudi Kisat, Clinical Director & Johnathan Appleby, Clinical Director*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Meeting between senior clinicians and managers Children's services directorate and Surgical directorates to establish clear roles and responsibilities of the care of children on the paediatric ward	Draft SOP completed following discussions/meetings with relevant teams	1. Minutes of joint meeting 2. Standard Operating Procedure 3. Audit of practice 4. MTW Clinical Governance Strategy 5. Agenda, Minutes and attendance records from CG meetings	1/5/15	
2. Standard Operating Procedure for care of children on surgical pathway on paediatric wards	Draft SOP completed –circulated for comment Patients now being admitted under surgical teams with paediatrician involvement		1/6/15	
3. Implementation of the SOP into routine daily practice	Awaiting for above actions to conclude		1/8/15	
4. Trust to develop a consistent approach to Clinical Governance through MTW Clinical Governance Strategy developed in collaboration with internal and external stakeholders	Awaiting feedback on outline of clinical governance approach in SOP		1/9/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list): draft SOP				
Assurance statement :				
This action plan is running to time currently				
Areas of concern for escalation:				
None				

Compliance action 15				CA15
Issue: *The children's directorate risk register did not ensure that risks are recorded and resolved in a timely manner.*				
Lead: *Hamudi Kisat, Clinical Director*		**Operational Lead:** *Karen Carter-Woods, Risk and Governance Manager*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. A full review of the directorate risks	Completed	1. Risk register shows children's section managed in a timely manner 2. Minutes of Directorate meeting / Clinical Governance meeting	1/5/15	
2. An update session for all senior nursing and medical staff on the purpose and process of the risk register	Update session carried out on the nurse update day 23rd April & at Clinical Governance meeting May 14th. Updates for junior staff will be continuing over next month		16/6/15	
3. Ensure review of risk register is standing agenda item at Directorate meetings / Clinical Governance meetings	Already standing agenda item at Directorate meetings Now standing agenda item at Paediatric Clinical Governance meeting		16/6/15	
Action Plan running to time: Yes				
Evidence submitted to support update (list): Directorate R&G report **(**March). Awaiting revised risk register				
Assurance statement :				
Heightened awareness of staff involvement in paediatric risks ongoing within the directorate				
Areas of concern for escalation:				
Nil				

Compliance action 16				CA16
Issue: *There were two incident reporting systems, the trust electronic recording system and another developed by consultant anesthetists and intensivists one for their own use. The trust could not have an overview of all incidents and potentially there was no robust mechanism for the escalation of serious incidents. Therefore opportunities were lost to enable appropriate action to be taken and learn lessons.*				
Lead: *Avey Bhatia, Chief Nurse*		**Operational Lead:** *Jenny Davidson, Assc Director Governance, Quality and Patient Safety*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Anaesthetic incident reporting pilot discontinued. Those involved in running this system, and other clinical staff fully engaged with the review on the DATIX system to improve reporting process	Confirmation e-mail from the lead for the anaesthetic pilot that this is discontinued. Meeting regarding Datix improvements due May	1. Written Confirmation from coordinator of system 2. Leaflet audit of distribution and staff survey 3. Newsletter article 4. Increased incident reporting through single reporting system from anesthetist and intensivists	1/2/15	
2. Staff leaflet to include reminder about rationale for single reporting system	Leaflet completed		1/5/15	
3. Reminders in Governance Gazette and via intranet and website about the SINGLE reporting system in the Trust.	In May's edition of the Governance Gazette		1/5/15	
4. Assc. Dir. Quality, Governance and Patient Safety to attend Anaesthetic CG meeting for discussion and update on reporting system	Attended Anaesthetic Clinical Governance meeting 14th May and updated attendees on reporting system		1/5/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list): e-mail confirmation + Governance Gazette + Leaflet + CG meeting minutes				
Assurance statement :				
This compliance action has been completed				
Areas of concern for escalation:				
None				

Compliance action 17				CA17
Issue: *There was a lack of engagement and cohesive approach to clinical governance. Mortality and morbidity reviews were not robust, not all deaths were discussed and there was no available documentation to support discussions.*				
Lead: *Paul Sigston, Medical Director*		**Operational Lead:** *Jenny Davidson, Assc Director Governance, Quality and Patient Safety*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Full review and collaborative process involving all stakeholders for developing and implementing a cohesive and comprehensive clinical governance system from ward to board	Draft CG strategy commenced. External consultant started Governance review in April 2015 and is reviewing current governance arrangements and will produce options /recommendations for improvements	1. CG strategy including clear CG process from ward to board 2. M&M review documentation of full review process and evidence of clear discussions and shared learning 3. Update outline and attendance	1/9/15	
2. Development of a MTW Clinical Governance Strategy	Will commence alongside review process above		1/7/15	
3. Mortality and morbidity review process to be reviewed in collaboration with stakeholders and developed with exploration of further use of technology and clinical governance processes to improve rigor, transparency and effectiveness	Initial review undertaken and areas identified to improve the process and flow of information. Initial meeting with health informatics to ascertain how IT can assist supporting the process.		1/8/15	
4. Update for staff involved at directorate and Trust level on their role in the mortality & morbidity review process	Will commence once review completed and new system in place		1/10/15	
Action Plan running to time: Yes				
Evidence submitted to support update (list): none				
Assurance statement :				
This action plan is running to time at present				
Areas of concern for escalation:				
None at present				

Compliance action 18				CA18
Issue: *The arrangement for the management and administration of topical anaesthetics was ineffective.*				
Lead: *Hamudi Kisat, Clinical Director*		**Operational Lead:** *Jackie Tyler, Matron*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Standard Operating Procedure for the administration of topical anaesthetics for children to be developed and implemented	Completed	1. SOP for children's services. 2. Audit of prescription charts. 3. Training records of staff undertaking PGD training	1/5/15	
2. Topical anaesthetics for children prescribed in all areas of the Trust	Audit to be undertaken to monitor compliance		1/6/15	
3. A number of key staff to undertake PGD training to facilitate appropriate timeliness of prescribing.	Training commenced for staff across both hospital sites		1/7/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list):				
Assurance statement :				
The actions for the management and administration of topical anaesthetic are nearly complete. The training of the majority of senior staff to use PGD's will take by the end of May.				
Areas of concern for escalation:				
None				

Should do actions

The following provides an update on 'should do' actions that are either due now or within the next 4 weeks.

REF	Service or Directorate	Issue Identified	Action/s	Operational leadership	Date to be completed	Evidence Required	Outcome/success criteria	**Summary update**
M10	Corporate	Develop robust arrangements to ensure that agency staff have the necessary competency before administering intravenous medicines in medical care services.	1. Add to agency booking checklist 2. Amend local induction checklist to include declaration by both manager and staff member 3. Communication to agencies that this now forms part of the Trust checklist	Richard Hayden, Deputy Director of Workforce / John Kennedy, Deputy Chief Nurse	1. 1/5/15 2. 1/5/15 3. 1/5/15	1. Booking form 2. Local induction checklist 3. Local audit findings	All agency staff that administer intravenous medicines are competent and have signed to confirm	**1. Agency booking checklist contains requirement** **2. Local induction checklist now includes declaration by both manager and staff member** **3. Agencies using checklist** **4. New contract in place from 1 June 15 with clearer reference to requirements**
M18	Corporate	Ensure that patients have access to appropriate interpreting services when required.	1. Survey of current service satisfaction via service leads and members of the patient experience committee (before and after any service change) 3. Identification of service users who can be invited to become involved in the evaluation of service needs in terms of the interpretation service 4. Engage assistance and involvement from Healthwatch	Jenny Davidson, Assc Director Gov, Quality and Pt Safety	1. 1/5/15 & 1/10/15 3. 1/5/15	1. Service leads survey results 2. Review report and outcome from tender process. 3. Service user group communications	1. Perceived improved service via survey 2. improved interpretation service as per continuous audit of performance reports 3. Service user group set up and effective at engaging in improvements	**Survey completed relating to service needs. Meeting with Healthwatch arranged that will facilitate the identification of service user groups**

REF	Service or Directorate	Issue Identified	Action/s	Operational leadership	Date to be completed	Evidence Required	Outcome/success criteria	**Summary update**
TW49	Corporate	Have clarity about the definition of what constitutes a Serious Incident Requiring Investigation (SIRI) or Never Event in relation to the retained swabs.	1. Staff leaflet on including incident reporting process and what constitutes an SI and Never event to be produced in collaboration with staff and distributed to existing staff and new starters at induction. 2. Review of SI policy and ensure clarity.	Jenny Davidson, Assc Director Gov, Quality and Pt Safety	1. 1/5/15 2. 1/5/15	1. Staff leaflet and SI policy 2. Intranet & Website 3. Education / update program and attendance 4. Newsletter article	Staff can articulate about the definition of what constitutes a Serious Incident (SI) or Never Event. In areas where swabs are used this will include in relation to the retained swabs	**Staff leaflet completed. SI policy under revision and will be completed ready for consultation June 2015**
TW28	Emergency and Medical Services	Make appropriate arrangements for recording and storing patients' own medicines in the CDU to minimise the risk of medicine misuse.	1. Development of Standard Operating Procedure in relation to arrangements for recording and storing pateints own medicines in the CDU 4. Use of checklist to ensure no drugs remain in CDU following transfer or discharge of patient	Claire Hughes, Matron A&E	1. 1/5/15 4. 1/5/15	1. Appropriate equipment in place to safely store patients' own drugs 2. Evidence of checklists completed to ensure no drugs remain on CDU following transfer or discharge of patient 3. SOP	No patient safety incidents relating to mismanagement of patients' own drugs in CDU	**Individual drugs cupboards purchased for both CDU's - awaiting delivery at TWH and installation at MH**

REF	Service or Directorate	Issue Identified	Action/s	Operational leadership	Date to be completed	Evidence Required	Outcome/success criteria	**Summary update**
M26	Emergency and Medical Services	Reduce delays for clinics and reduce patient waiting times.	1. Identify clinics in which there are high levels of DNA's , delays and waiting times.	Margaret Dalziel, Assc. Dir Operations	1. 1/5/15	1. Report on review of clinics DNA and templates 2. Appropriate booking of all clinic profiles 3.implementation of revised booking / reminder system 4. Feedback from Healthwatch	Reduced waiting times and delays	**Full scope of medical outpatients clinic structures and waiting times undertaken. In discussion with clinicians on clinic profile. To undertake an audit of waiting times in partnership with Healthwatch.**
M14	Emergency and Medical Services	Ensure within medical care services that patients' clinical records used in ward areas are stored securely.	2. Reinforce good housekeeping in relation to ensuring patient records are replaced in the notes trolley after use in clinical areas. 3. Remind office based staff about the need to minimise patient records being kept in offices and ensure office is secured when empty 4. Discuss (and minute) at following forums: • Ward Manager meetings • Quality & Safety Directorate Board • Clinical Governance 1/2 days • CAU meetings	Akbar Soorma, Clinical Director Lynn Gray, ADN Emergency care	2. 1/5/15 3. 1/5/15 4. 1/5/15	Report on current practice Results of spot audits Evidence of communication with staff and minutes of meetings	Adhere to record keeping guidelines and maintain patient confidentiality	**Scoping exercise undertaken. Assurance that appropriate equipment is being used in all area given. Minuted at all departmental meetings. Matron checks in place. CSP undertaking spot audits to ensure compliance. Reviewed monthly at Directorate Quality & Safety Board.**

REF	Service or Directorate	Issue Identified	Action/s	Operational leadership	Date to be completed	Evidence Required	Outcome/success criteria	**Summary update**
M16	Emergency and Medical Services	Review the ways in which staff working in medical care services can access current clinical guidance to ensure it is easily accessible for them to refer to.	1. All actions in conjunction with actions identified in M4. In addition: 2. Review of access and management of clinical guidance / protocols / documents	Donna Jarret, Director of Informatics Jenny Davidson Assc Dir, Gov, Quality, Patient Safety	2. 1/5/15	1. Report on review of current clinical guidance 2. Update on departments pages of intranet	Medical staff aware of where to find clinical guidelines	**Survey undertaken about staff access to clinical records. Data gathered about access across the organisation. Meetings arranged to consider document management service needs and option appraisal**
M3	Emergency and Medical Services	Make sure that a sufficient number of consultants are in post to provide the necessary cover for the ED	2. Advertise for 2 new substantive consultant posts (already approved)	Akbar Soorma, Clinical Director	2. 1/5/15	1. Consultant rota (planned and actual) showing necessary cover. 2. Confirmation of recruitment and start dates	Improved patient flow through ED by earlier senior intervention Sufficient number of consultants are in post to provide the necessary cover for the ED	**Consultant rotas changed from April to provide greater clinical presence and senior medical leadership. Interviewed and appointed one new consultant, other post has gone out again to advert.**

REF	Service or Directorate	Issue Identified	Action/s	Operational leadership	Date to be completed	Evidence Required	Outcome/success criteria	**Summary update**
M&TW6	Emergency and Medical Services	Review the way complaints are managed in the ED to improve the response time for closing complaints	2. Implement a revised process 3. Communicate the revised process to all ED staff and the central complaints team	Claire Hughes, Matron A&E	2. 1/5/15 3. 1/5/15	1. Documentation of agreed process and timeframes 2. Evidence of communication with staff 3. Audit of compliance with agreed process and timeframes 4. Minutes from monthly directorate clinical governance meeting and Standards Committee	Service delivered meets patients expectations All complaints responded to within 25 days	**Complaints structure within Directorate reviewed and plan to implement from mid - April. Monitoring of complaint management undertaken at monthly Directorate Quality & Safety Board.**
M9	Emergency and Medical Services	Ensure that medical care services comply with its infection prevention and control policies.	3. Audit local practice against infection prevention and control policies + actions developed where not compliant 3. Ensure IPPC is a standing agenda item at Directorate Clinical Governance meetings	Lynn Gray, ADN Emergency Care	3. 1/5/15 4. 1/5/15	1. Agenda and Minutes of ICC, Directorate Clinical Governance & Link Nurse Forums 2. Local audit + action plans where not complaint	IPPC rates below Trust trajectory and show evidence of continual reduction	**Review of IPCC prevalence at Directorate Quality & Safety Board. Actions taken for areas falling below expected standards of performance. Increased audits undertaken until performance at satisfactory level.**

REF	Service or Directorate	Issue Identified	Action/s	Operational leadership	Date to be completed	Evidence Required	Outcome/success criteria	**Summary update**
M19	Emergency and Medical Services	Ensure that the directorate of specialty and elderly medicine reviews its capacity in medical care services to ensure capacity is sufficient to meet demand, including the provision of single rooms.	1. Corporate review of demand and capacity requirements for 15/16 and beyond, with recommendations / plan 2. Review of operational Surge Plans to support management of peaks in demand, particularly over Bank Holiday periods, with recommendations / plan	Margaret Dalziel, Assc. Dir Operations Lynn Gray, ADN Emergency Care	1. 1/5/15 2. 1/5/15	1. Report on corporate demand and capacity review submitted to TME (+ minutes from meeting) 2. Report on Surge plans submitted to TME (+minutes from meeting)	Patients admitted under the care of Emergency & Medical Services are cared for within the designated bed base and in the most appropriate ward for their condition.	**Bed modelling exercise completed. New facility planned for TWH. Programme structure in place to develop options and deliver additional capacity early 2016.**
TW27	Emergency and Medical Services	Ensure the protocol for monitoring patients at risk is embedded and used effectively to make sure patients are escalated in a timely manner if their condition deteriorates.	1. Implement teaching for all relevant staff regarding use of PAR scores. 2. Ensure staff are aware of the relevant protocol for monitoring patients at risk + timely escalation communicated through team meetings and electronic reminders 3. Introduction of new cas card with the PAR scores on them.	Lynn Gray, ADN Emergency Care	1. 1/5/15 2. 1/5/15 3. 1/5/15	1. Audit showing compliance with observations recorded and escalated appropriately as needed 2. Education attendance lists 3. communication with staff 4. new CAS card 5. outline of new education programme	Deteriorating patients identified, escalated and treated without delay	**A&E documentation reviewed and changed to include PAR scoring. Roll-out included a teaching package for all staff. Audit to be undertaken in June.**

REF	Service or Directorate	Issue Identified	Action/s	Operational leadership	Date to be completed	Evidence Required	Outcome/success criteria	**Summary update**
TW29	Emergency and Medical Services	Respond to the outcome of their own audits and CEM audits to improve outcomes for patients using the service.	2. Ensure results presented and discussed at Directorate Clinical Governance meetings. 4. Specifically regarding the last CEM audit round – Symphony used to highlight high-risk patient groups for senior review and increased consultant cover will improve compliance. 5. Weekly review of pain scores and safeguarding questionnaires results by Clinical Leads and Clinical Director with performance issues addressed where necessary and extra support provided for individuals where required	Akbar Soorma, Clinical Director	2. 1/5/15 4. 1/5/15 5. 1/5/15	1. Communication to Clinical leads on their responsibilities and expectations on response / actions 2. Minutes of Directorate Clinical Governance Meetings with evidence of completed action plans and improvements in further audits 3. Weekly review documentation	Improved response to own audits and CEM audits to improve outcomes for patients	**Clinical Leads are taking this responsibility and have devised a new Consultant rota to ensure better Consultant presence on the shop floor from 6 weeks ago.**

REF	Service or Directorate	Issue Identified	Action/s	Operational leadership	Date to be completed	Evidence Required	Outcome/success criteria	**Summary update**
TW30	Emergency and Medical Services	Review the management of patient flow in the ED to improve the number of patients who are treated and admitted or discharged within timescales which meet national targets.	1. Undertake a diagnostic review to understand where delays are currently occurring. 2. Agree actions to improve these areas. 3. Clarify roles and responsibilities for all staff involved in patient flows within ED.	Claire Hughes, Matron A&E Emma Yales, General Manager	1. 1/5/15 2. 1/5/15 3. 1/5/15	1. Report on diagnostic review and action plan 2. Communication about clear roles and responsibilities of all staff 3. Sustained improvement seen in 4 Hour Access Target 4. Feedback reports from Healthwatch + response and actions	Improved patient care and experience Management of patient flow in the ED in relation to patients who are treated and admitted or discharged within timescales which meet national targets	**An audit of high risk patient groups and the impact on new ways of working will be carried out shortly in the next4-6 weeks.**
TW32	Emergency and Medical Services	Ensure there is strategic oversight and plan for driving improvement.	1. Review ED Strategy for 2015-2017 2. Ensure strategy is developed in collaboration with all relevant stakeholders including a multidisciplinary approach	Akbar Soorma, Clinical Director Cliff Evans Consultant Nurse	1. 1/5/15 2. 1/5/15	1. Documented ED Strategy in place including evidence of consultation with multidisciplinary staff 2. Evidence of communication of strategy to all relevant staff	Continuous and sustained improvement in all ED key performance areas	**Pain scores and safety questionnaires is carried out and individual performance issues addressed on a weekly basis.**

REF	Service or Directorate	Issue Identified	Action/s	Operational leadership	Date to be completed	Evidence Required	Outcome/success criteria	**Summary update**
TW34	Emergency and Medical Services	On the Medical Assessment unit the trust should ensure that point of care blood glucose monitoring equipment is checked. It should also consider how this checking should be managed to be integrated as part of an overall policy that forms part of a pathology quality assurance system.	2. Document daily checking of current blood glucose monitors in all ward areas.	Lynn Gray, ADN Emergency Care	2. 1/5/15	1. Business case and then procurement of BGM 2. Daily checking forms audit report + action log 3. Pathology Related Equipment Policy	Glucose Monitor equipment checked Minimised risk of inaccurate blood glucose readings being acted on	**Audit undertaken by junior doctors to compare results from near patient testing and lab. Results showed there was a clinically insignificant variation. Procurement of new blood glucose monitors is in progress.**
TW40	Emergency and Medical Services	Review the process for the management of patients presenting with febrile neutropenia to ensure they are managed in a timely and effective manner	1. Implement Rapid Assessment Treatment (RAT) process to identify patients early within their pathway.	Cliff Evans, Consultant Nurse	1. 1/5/15	1. Documented new pathway 2. Education update with attendance list 3. Audit results	Febrile neutropeanic patients are identified within first 30 minutes and put on the appropriate pathway	**Reviewing sepsis pathway and documentation. Audit of current provision undertaken in response to this. Screening process being adapted as a result. PGD written for nursing staff to enable commencement of IV antibiotics. Relaunch of sepsis screening pathway commenced including teaching for nursing and medical staff.**

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board - May 2015

5-12 Clinical Quality and Patient Safety Report — Chief Nurse

Summary / Key points

This report details the year end performance for the following areas:

- Facility acquired pressure ulcers
- Falls
- Complaints rate and percentage of complaints responded to on time.

The report also provides detail on DATIX patient safety incident reporting and the actions being taken to address the low reporting rates.

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

Quality Report

April 2015

The purpose of this report is to bring to the attention of the board any specific quality or patient safety issues that are either not covered within the integrated monthly performance report but require board level oversight or are covered but require greater detail.

The year-end performance against the key quality indicators is contained within the draft Quality Accounts 2014/15 (part three) previously circulated to board members for review and comment. The draft Quality Accounts have already been submitted and discussed at the Quality and Safety Committee and will be submitted to the June Trust Board for formal sign off prior to publication.

Therefore this report is intentionally brief highlighting only those quality indicators / areas of work which require further explanation or acknowledgement. Stroke performance is not discussed here as a detailed report was presented and discussed at the Quality and Safety Committee.

The Board is asked to note the contents of this report and make any recommendations as necessary.

Prevention of Facility Acquired Pressure Ulcers (FAPU)

The aim for 2014/15 was to achieve a reduction in category 3 / 4 pressure ulcers. During 2013/14 there were 8 category 3 / 4 pressure ulcers, in 2014/15 there were 3 (one of these was a category 4). The overall rate for FAPUs in 2013/14 was 2.4 per 1,000 admissions and for 2014/15 the rate was 2.5 per 1,000 admissions.

The majority of pressure ulcers are category 2's on patient's heels and this is the area where intense focus and continued education remains.

The increase seen in March 2015 (rate 3.6, 18 pressure ulcers) has not continued into April with a very low rate of 0.9 (4 pressure ulcers).

Falls Prevention

The aim for 2014/15 was to reduce the rate of falls from 7.2 per 1,000 occupied bed days to 6.75. A rate of 6.2 per 1,000 occupied bed days was achieved at March 2015. The number of falls reported in 2014-15 is a 9.8% reduction (-156) from the previous year. The strategy for 2015/16 is to develop a frailty response team, which would include the lead nurses for dementia, falls and pressure ulcer prevention and Matron for safeguarding adults working very closely together to manage patients and support staff. New initiatives specifically for the Maidstone site are under development to further reduce incidence of falls.

Complaints

For 2013/14 the rate of new complaints was 5.1 per 1,000 episodes. For 2014/15 the rate of new complaints was 4.6 against the national average of 6.26. Despite receiving below the national average number of complaints we have continued to struggle to improve our response times. Each of the directorates reported at the Quality and Safety committee their focus on improving their response times and the Chief Nurse and central complaints team are working closely to support the directorates.

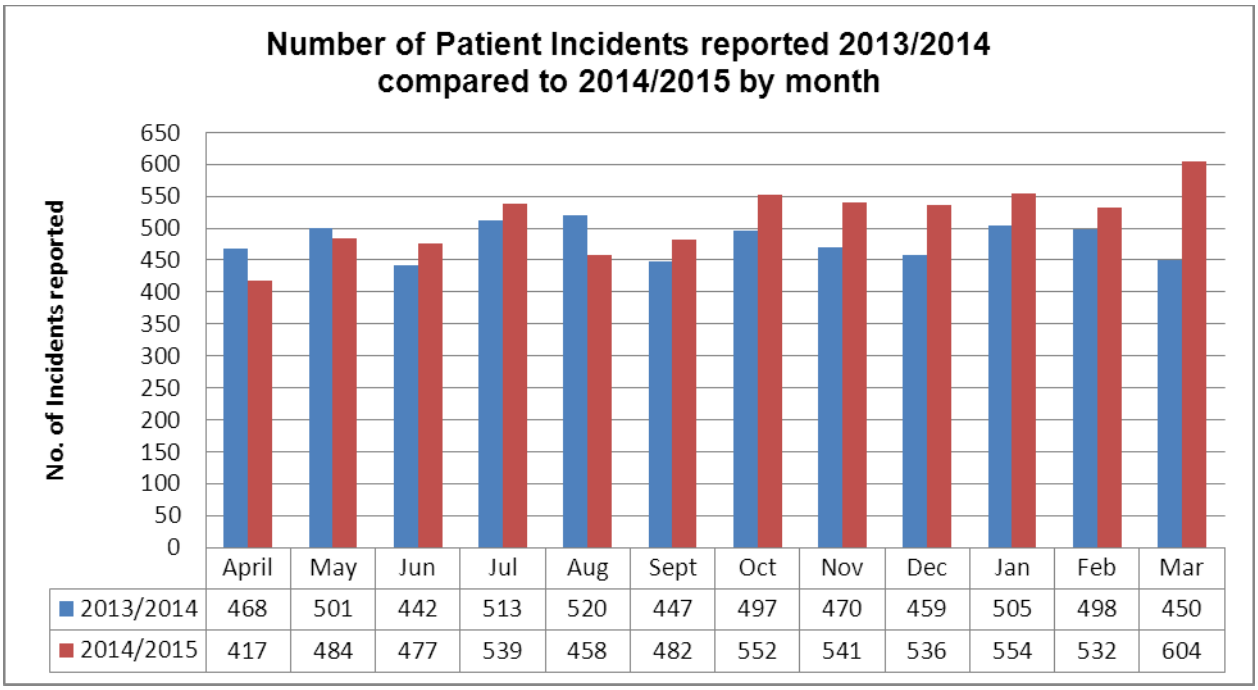
Maidstone and Tunbridge Wells NHS
NHS Trust

DATIX Incidents

A detailed report was presented at the May 2015 Quality and Safety committee meeting on DATIX incident reporting, showing the current position on 'open' incidents. A report published by the National Reporting and Learning System (NRLS) shows that Maidstone and Tunbridge Wells NHS Trust (MTW) are in the lowest 25% of reporters for 01 April 2014 to September 2014 (Appendix 1). The median reporting rate is 35.1 incidents per 1,000 beds days, MTW rate is 22.9. Appendix 2 shows the position for the previous 6 months (01 October 2013 to 31 March 2014) however the reporting rate is per 100 admissions and comparison is with large acute trusts only. MTW for this period had a reporting rate of 6.0 with the median reporting rate for the cluster being 6.93.

The graph below shows our reporting numbers for patient safety incidents for 2014/15 compared with 2013/14.

Graph 1 *Total 2013/14 = 5770, 2014/15 = 6176* ***increase 406 incidents***



	April	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2013/2014	468	501	442	513	520	447	497	470	459	505	498	450
2014/2015	417	484	477	539	458	482	552	541	536	554	532	604

We are aware that we have a low reporting rate, this was noted within the CQC inspection report and the 2014 staff survey published earlier this year. The question within the survey asks staff if they have reported errors, near misses or incidents within the last month. Our results show that we are in the bottom 20% of acute trusts and this has not changed from the previous 2013 staff survey. We have undertaken much work within the organisation with various groups of staff to really understand the reasons for this before proceeding to address the issues.

The main reasons given fall within the following areas:

- Cumbersome, time consuming reporting system
- Response / feedback to those who raise an incident
- Evidence of learning and change as a consequence of raising an incident
- Culture around understanding the importance of reporting to effect improvements in patient safety

Increasing DATIX incident reporting, ensuring timely investigations, learning and providing feedback are absolute priorities for 2015/16 and are integral within our Step up to Safety Campaign.

The Patient Safety Think Tank (PSTT) is working through a comprehensive plan to address each of the reasons listed above. Some of the actions that are already underway include:

- Upgrade of DATIX system
- Visibility of accessing DATIX from Staff Intranet – new big red button
- Specific CQUIN last year and carried forward into 2015/16 relating to increasing the number of medication errors that are reported including near misses
- Working through each and every DATIX field (with front line staff) for various incidents to make the reporting as slick and efficient as possible
- Exploring technology options with DATIX i.e. DATIX APP
- Education and training are on-going in terms of practical use of the system but also understanding the importance of reporting and creating a culture within the organisation which promotes and encourages reporting
- Raising awareness at directorate clinical governance meetings and within the monthly Governance Gazette
- New Patient Safety information leaflet developed for staff
- 'Step up to Safety' conference to celebrate good practice and reinforce key messages around patient safety

Graph 1 does show that reporting is increasing when comparing 2014/15 with 2013/14 and this remains an area of intense focus.

National Reporting and Learning System

Organisation Patient Safety Incident Report

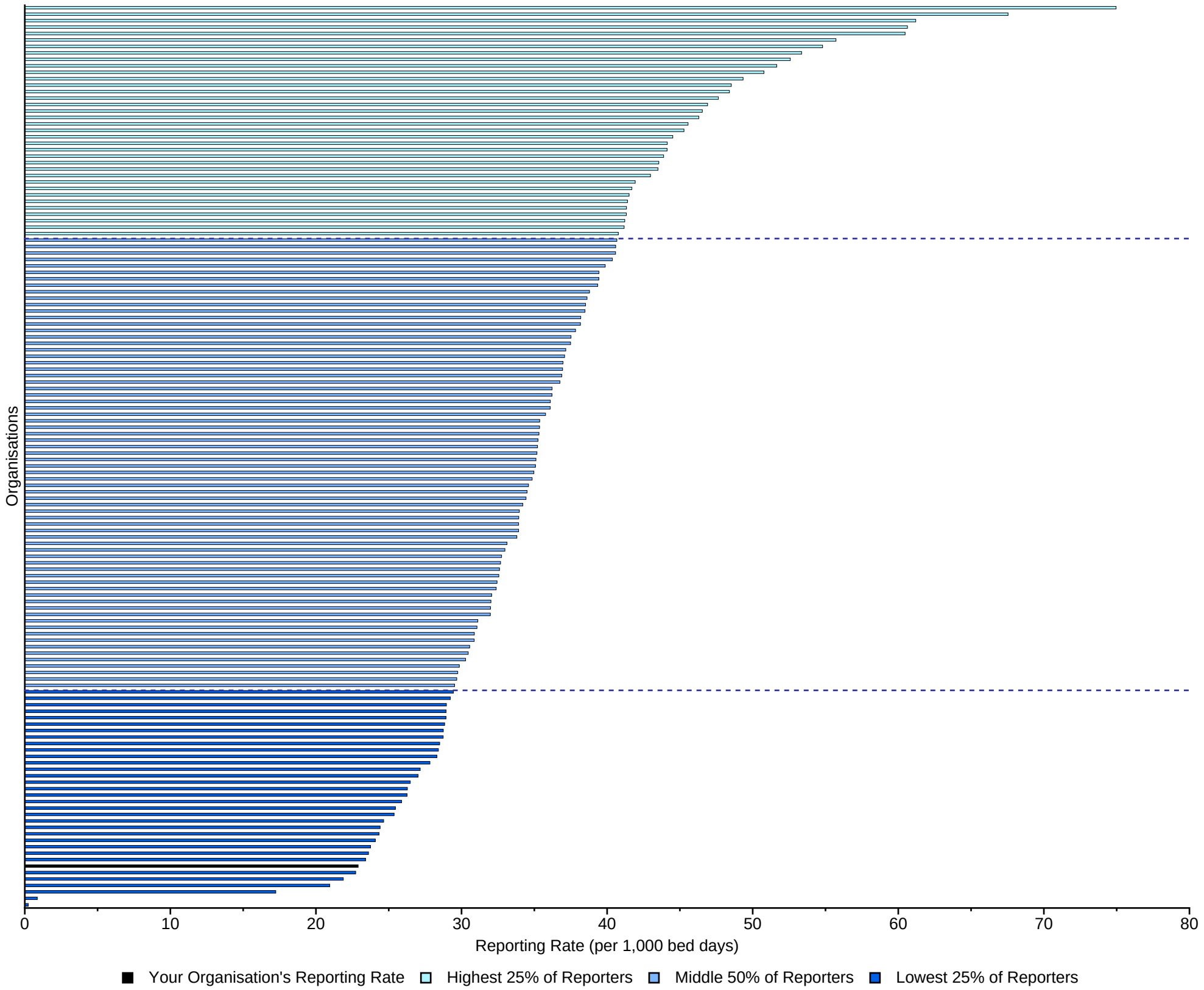
Reported incidents between 01 April 2014 to 30 September 2014

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST
Organisation type: Acute (non-specialist) organisation

Are you actively encouraging reporting of incidents?

The comparative reporting rate summary shown below provides an overview of incidents reported by NHS organisations to the National Reporting and Learning System (NRLS) occurring between 01 April 2014 to 30 September 2014. Your organisation reported 2,707 incidents (rate of 22.9) during this period.

Figure 1: Comparative reporting rate, per 1,000 bed days, for 140 Acute (non-specialist) organisations.



The median reporting rate for this cluster is 35.1 incidents per 1,000 bed days.

Organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problems are.

How regularly do you report?

Your organisation reported incidents to the National Reporting and Learning System (NRLS) in 6 out of the 6 months between 01 April 2014 to 30 September 2014.

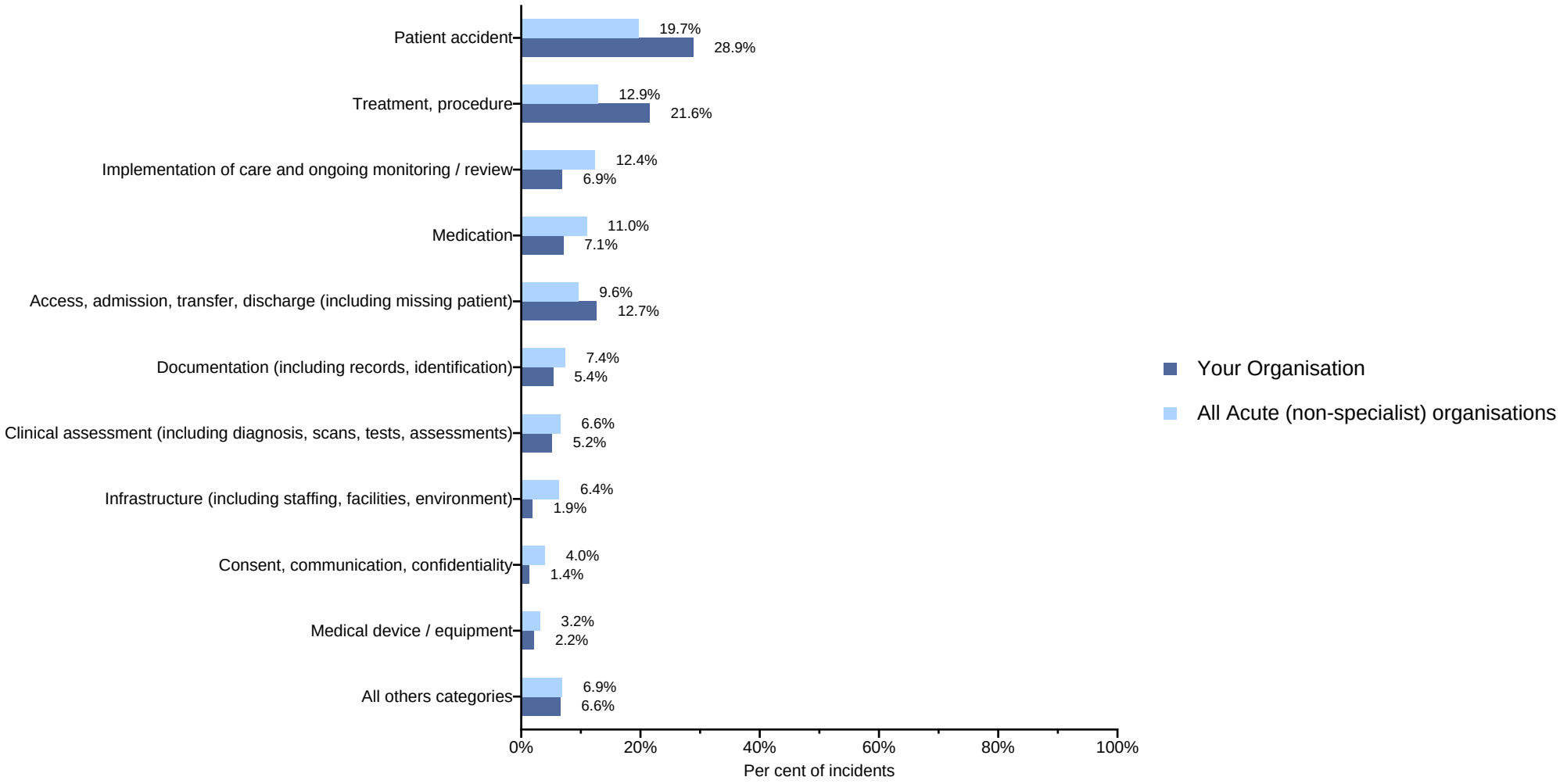
Report regularly: Incident reports should be submitted to the NRLS at least monthly.

Fifty per cent of all incidents were submitted to the NRLS more than 26 days after the incident occurred. In your organisation, 50% of incidents were submitted more than 16 days after the incident occurred.

Report serious incidents quickly: It is vital that staff report serious safety risks promptly both locally and to the NRLS, so that lessons can be learned and action taken to prevent harm to others.

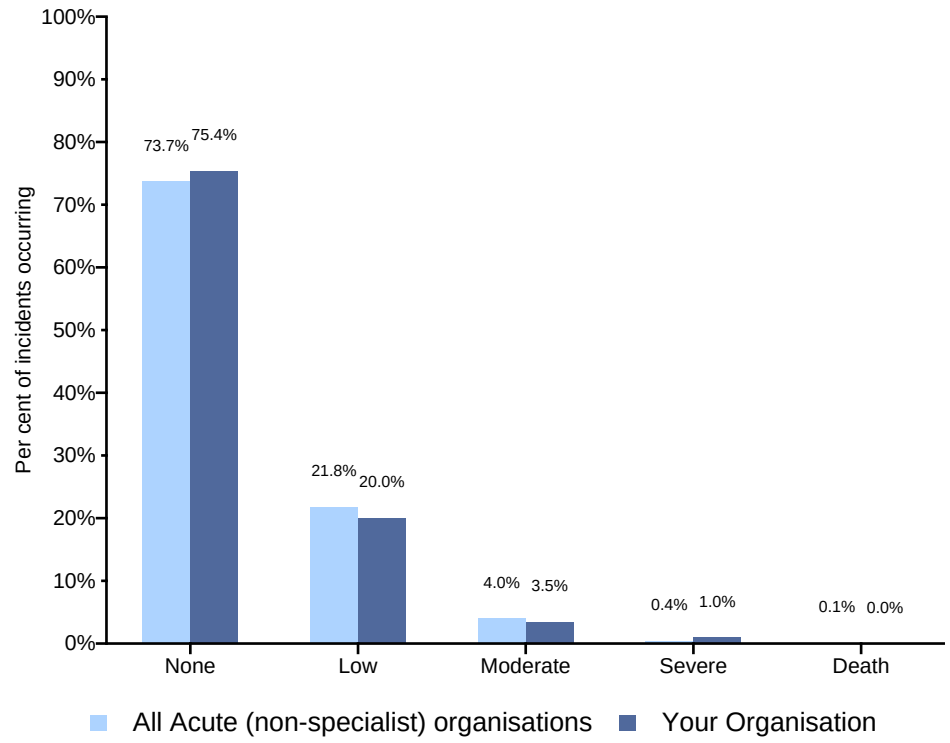
What types of incidents are reported in your organisation?

Figure 2: Top 10 incident types



If your reporting profile looks different from similar organisations, this could reflect differences in reporting culture, the type of services provided or patients cared for. It could also be pointing you to high risk areas. The response system is more important than the reporting system.

Figure 3: Incidents reported by degree of harm for Acute (non-specialist) Organisations



Degree of harm

	None	Low	Moderate	Severe	Death
Your figures:	2,041	541	96	28	1

Do you understand harm?

Nationally, 70 per cent of incidents are reported as no harm, and just under 1 per cent as severe harm or death.

However, not all organisations apply the national coding of degree of harm in a consistent way, which can make comparison of harm profiles of organisations difficult.

Organisations should record actual harm to patients rather than potential degree of harm.

Recognising and reporting incidents resulting in severe harm or death is an important sign of an organisation's reporting culture. If the numbers of incidents reported as severe harm or death are low compared with peers you should check that your reports reflect all incidents you are aware of through sources such as mortality review, inquests, litigation or complaints.

For further information on the reporting of serious incidents please see NHS England's guidance

http://www.nrls.npsa.nhs.uk/report-a-patient-safety-incident/about-reporting-patient-safety-incidents/

Further information for you

The NRLS helps the NHS to understand why, what and how patient safety incidents happen, learn from these experiences and take action to prevent future harm to patients. Alerts and other learning resources can be found at: www.england.nhs.uk/ourwork/patientsafety/psa/ and national data can be found at: www.nrls.npsa.nhs.uk/patient-safety-data/.

Reviewing the results of the NHS staff survey relating to incident reporting alongside this report will provide an important indicator of your reporting culture.

Ref: Yourdata_RWF_Apr2015

National Reporting and Learning System

Organisation Patient Safety Incident Report

Reported incidents between 1 October 2013 to 31 March 2014

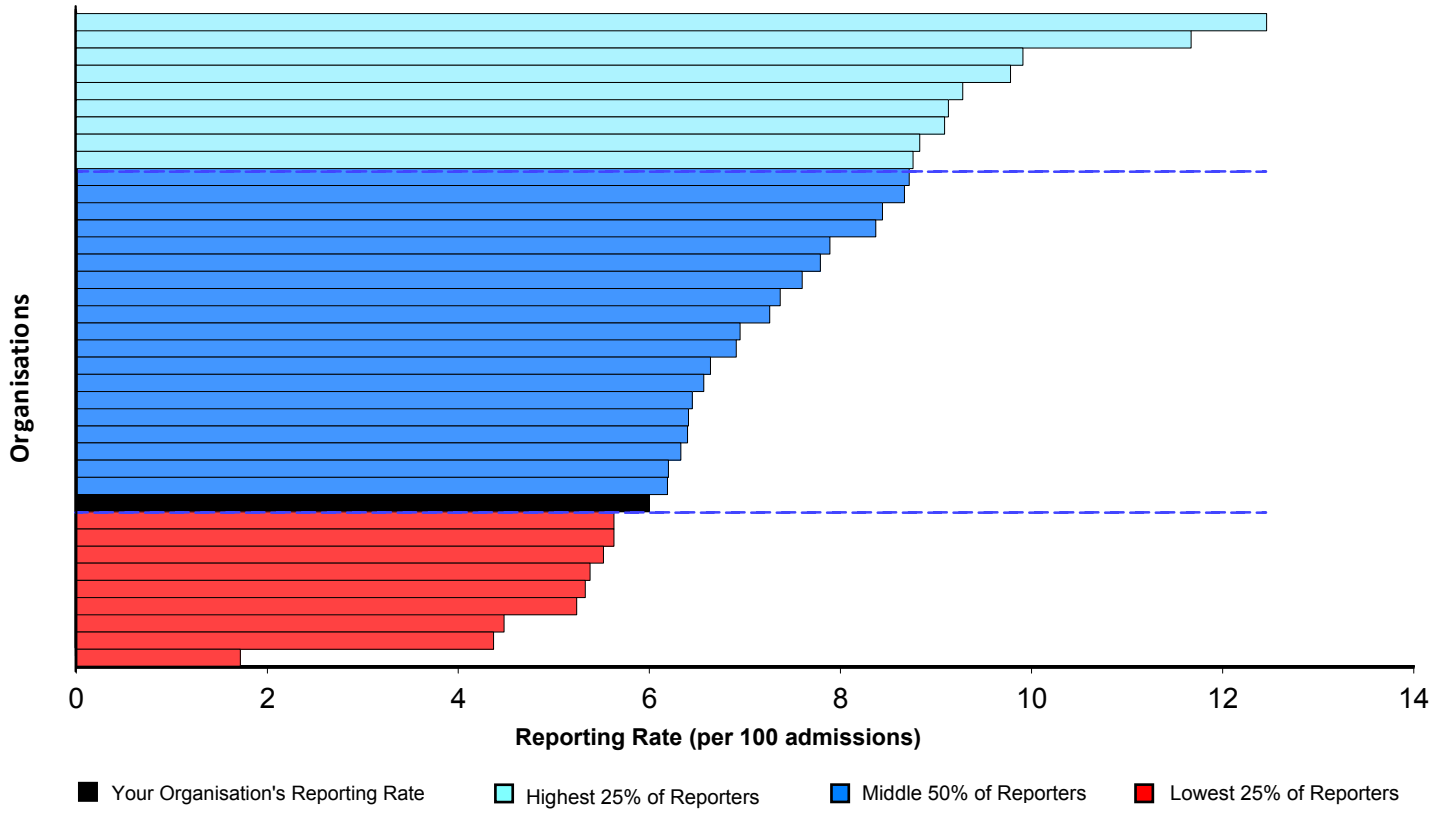
Maidstone and Tunbridge Wells NHS Trust

Organisation type: **Large acute organisation**

Are you actively encouraging reporting of incidents?

The comparative reporting rate summary shown below provides an overview of incidents reported by your organisation to the National Reporting and Learning System (NRLS) as ocurring between 1 October 2013 and 31 March 2014. 2,760 (Reporting rate of 6.00) incidents were reported during this period.

Figure 1: Comparative reporting rate, per 100 admissions, for 38 large acute organisations.



The median reporting rate for this cluster is 6.93 incidents per 100 admissions

Organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problems are.

How regularly do you report?

Your organisation reported incidents to the National Reporting and Learning System (NRLS) in 6 out of the 6 months between October 2013 and March 2014.

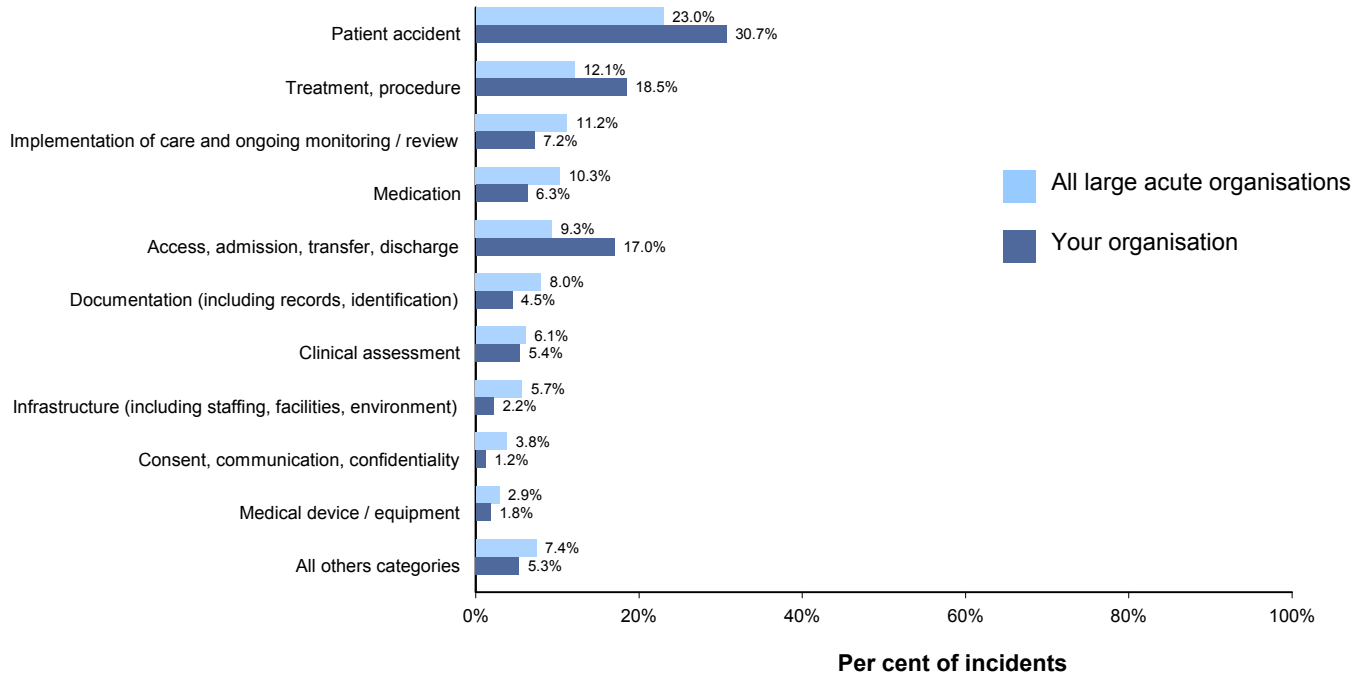
Report regularly: Incident reports should be submitted to the NRLS at least monthly.

Fifty percent of all incidents were submitted to the NRLS more than 28 days after the incident occurred. In your organisation, 50% of incidents were submitted more than 22 days after the incident occurred.

Report serious incidents quickly: It is vital that staff report serious safety risks promptly both locally and to the NRLS, so that lessons can be learned and action taken to prevent harm to others.

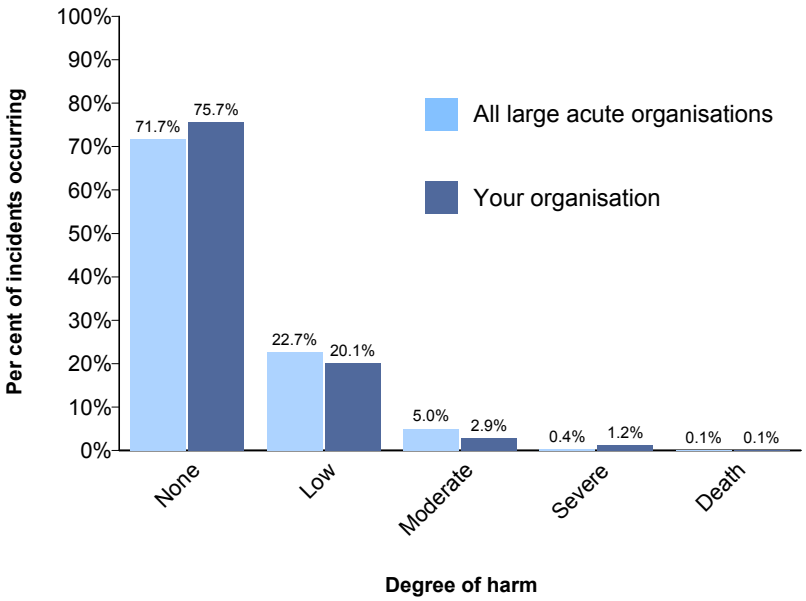
What type of incidents are reported in your organisation?

Figure 2: Top 10 incident types



If your reporting profile looks different from similar organisations, this could reflect differences in reporting culture, the type of services provided or patients cared for. It could also be pointing you to high risk areas. The response system is more important than the reporting system.

Figure 3: Incidents reported by degree of harm for large acute organisations



Your figures:	None	Low	Moderate	Severe	Death
	2,090	554	80	33	3

Do you understand harm?

Nationally, 69 per cent of incidents are reported as no harm, and just under 1 per cent as severe harm or death.

However, not all organisations apply the national coding of degree of harm in a consistent way, which can make comparison of harm profiles of organisations difficult.

Organisations should record actual harm to patients rather than potential degree of harm.

Further information

The NRLS helps the NHS to understand why, what and how patient safety incidents happen, learn from these experiences and take action to prevent future harm to patients. Alerts and other learning resources can be found at www.england.nhs.uk/ourwork/patientsafety/psa/ and national data can be found at: www.nrls.npsa.nhs.uk/patient-safety-data/.

Reviewing the results of the NHS staff survey relating to incident reporting alongside this report will provide an important indicator of your reporting culture.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board – May 2015

5-13 Safe Staffing: Planned V Actual - April 2015 **Chief Nurse**

Summary / Key points

The attached paper shows the planned v actual nursing staffing as uploaded to UNIFY for the month of April 2015. This data is also published via the NHS Choices website and the Trust website as directed by NHS England and the National Quality Board.

The report also includes some nurse sensitive indicators to support the professional judgement of safe delivery of care. Nurse sensitive indicators are those indicators that may be adversely impacted on if staffing levels are insufficient for the acuity and dependency of the ward. These indicators are supported by the Department of Health and latterly by the NICE review of ward staffing published in July 2014.

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'.

This can be seen for Mercer Ward, where there is an identified clinical need for an additional Clinical Support Worker at night. The current budgeted establishment is for 1 per night. When this is increased to 2 per night, the percentage shift is 200%.

When the fill rate is marginally over 100% for example Foster Clark where the fill rates are 108% and 102% for day and night respectively, this occurs when a small number of shifts are above the budgeted plan. In this case the ward had additional RN for 28 days on day shift. This addition is small compared to the budgeted plan where the ward was expecting to have for example 5 RNs on shift. Similarly the night shift required additional RN cover. The plan was for 4, but required an additional 1 RN per night for 3 nights. This can also be seen in escalation areas. UMAU for example required additional Clinical Support Workers at night for most of the month, as trolley bays which were planned to be closed at night were converted to beds at night.

The RAG rating for the fill rate is rated as:
Green: Greater than 90%
Amber Less than 90%
Red Less than 80%

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.

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 bout below:

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 receipt at 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

		Day		Night		Nurse Sensitive Indicators					
Hospital Site name	Ward name	Average fill rate - registered nurses/midw	Average fill rate - care staff (%)	Average fill rate - registered nurses/mid	Average fill rate - care staff (%)	FFT Response	FFT Score	Falls	PU - ward acquired	Overall RAG	Comments
MAIDSTONE	Acute Stroke	100.8%	85.8%	100.0%	216.7%	26%	80	9	0		Low CSW fill rate during the day off-set by increased presence of therapy staff. Night required one additional CSW above establishment due to dependency and confusional states.
MAIDSTONE	Romney	98.9%	103.3%	96.7%	105.0%			1	0		
MAIDSTONE	Cornwallis	91.7%	125.0%	106.7%	100.0%	29%	88	3	0		
MAIDSTONE	Coronary Care Unit (CCU)	98.9%	N/A	100.0%	N/A	76%	79	0	0		
MAIDSTONE	Culpepper	100.0%	98.3%	95.0%	113.3%	44%	67	2	1		
MAIDSTONE	Foster Clark	108.0%	120.0%	102.5%	110.0%	33%	90	2	1		
MAIDSTONE	Intensive Treatment Unit (ITU)	94.2%	N/A	93.8%	N/A	0%	100	1	0		
MAIDSTONE	John Day	80.0%	101.1%	102.2%	190.0%	12%	71	5	1		18 patients requiring 'specialling' at night. 10 day shifts with reduced RN cover
MAIDSTONE	Jonathon Saunders	97.5%	96.7%	100.0%	130.0%	21%	67	5	0		
MAIDSTONE	Lord North	97.3%	116.7%	96.7%	103.3%	42%	92	1	0		
MAIDSTONE	Mercer	95.0%	103.3%	92.2%	210.0%	11%	100	7	0		
MAIDSTONE	Pye Oliver	93.3%	170.0%	113.3%	180.0%	32%	73	5	0		
MAIDSTONE	Urgent Medical Ambulatory Unit (UMAU)	95.5%	100.9%	131.1%	200.0%	16%	68	2	0	↑	
TWH	Acute Stroke	95.6%	98.3%	95.6%	100.0%	88%	88	0	0	↑	
TWH	Coronary Care Unit (CCU)	92.2%	100.0%	100.0%	N/A	37%	94	0	0		
TWH	Gynaecology	101.9%	85.7%	100.0%	111.9%	13%	80	0	0		Support from Gynae Triage according to acuity & dependency. RN fill rate improved from last month.
TWH	Intensive Treatment Unit (ITU)	102.9%	100.0%	102.5%	40.0%	0%	0	0	0		CSW fill rate for night shift covered by Nurse-in-Charge. Acuity and skill mix was such that back fill not required.
TWH	Medical Assessment Unit	101.0%	143.3%	103.3%	126.7%	0%	0	10	0		
TWH	SAU	107.8%	123.3%	128.3%	150.0%	13%	80	0	0		
TWH	Ward 32	96.7%	86.7%	100.0%	100.0%	29%	78	0	0		CSW requirement cross covered by The Wells Suite as required.
TWH	Ward 10	97.1%	93.1%	80.0%	126.7%	17%	63	2	0		Increased number of confused patients/falls risks. Accepted risk in reduced of RNs at night to enable increase in CSW to meet dependency needs.
TWH	Ward 11	103.3%	116.7%	99.2%	143.3%	11%	50	4	0	↑	25 episodes of 1:1 care required during the month
TWH	Ward 12	88.6%	107.8%	75.6%	136.7%	71%	**44**	8	0		Some impact on care, with delays in delivering aspects of care. This is evident in the FFT score and call bell audit when compared with previews months. Ward under review by directorate.
TWH	Ward 20	98.2%	117.5%	96.7%	150.0%	33%	83	11	1		additional requirement for CSWs for cohorting of confused patients
TWH	Ward 21	92.5%	102.2%	92.7%	113.3%	100%	80	9	0	↑	
TWH	Ward 22	95.0%	105.6%	102.6%	98.9%	34%	74	8	0		
TWH	Ward 30	90.6%	120.5%	105.8%	97.7%	54%	61	6	0	↑	
TWH	Ward 31	99.5%	100.8%	102.5%	120.0%	100%	71	3	0	↑	
TCH	Stroke Rehab	98.0%	95.0%	100.0%	100.0%	53%	71	3	0		
TWH	Ante-Natal	100.0%	86.7%	100.0%	96.7%			0	0		Midwifery fill rate down for delivery suite. Unit to be viewed in totality as midwives move with women. 1:1 care in established labour was maintained
TWH	Delivery Suite	91.1%	116.7%	85.2%	98.3%			0	0		
TWH	Post-Natal	99.3%	84.0%	95.8%	100.0%			0	0		
TWH	Gynae Triage	96.7%	100.0%	96.7%	103.3%			0	0		
TWH	Hedgehog	101.7%	53.8%	108.3%	86.7%	0	0	0	0		Reviewing data collection for non registered staff day shift
MAIDSTONE	Birth Centre	98.3%	103.3%	100.0%	103.3%			0	0		
TWH	Neonatal Unit	100.6%	73.3%	100.0%	110.0%	0	0	0	0		Reviewing data collection for non registered staff day shift
MAIDSTONE	MSSU	121.2%	129.5%	111.4%	N/A	0	0	0	0		
MAIDSTONE	Chaucer	104.1%	149.2%	112.5%	158.3%	33%	13	5	0		Fill rates above plan, as in full escalation. FFT score being explored.
TWH	SSSU	100.0%	100.0%	N/A	N/A	0	0%	0	0		

Movement in overall RAG rating

↑ indicates an postive move compared to previous month

↓ indicates a negative move compared to previous month

no arrow indicates no change compared to previous month

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board – May 2015

5-14 National Patient Survey 2014 Chief Nurse

Summary / Key points

The National Patient Survey is conducted annually and is commissioned by the Care Quality Commission. The national survey involved 154 acute and specialist NHS Trusts, with a national response rate of 47%. Maidstone and Tunbridge Wells NHS Trust response rate was 56%.

The overall position remains unchanged from last year, with the Trust' being in the 'expected range' for all questions.

There is one statistically significant favourable shift which relates to patients being offered choice of food.

There are two statistically significant adverse shifts which relate to hospital specialists receiving sufficient information from the original referrer and privacy when discussing condition or treatment.

There are a number of other changes from last year but overall percentage numbers are small, but worthy of further consideration. Appendix 1 provides detail on scores over the last 5 years.

Question 68 *Overall I had a very good experience* on a scale of 1-10 (10 being very good experience) in the Trust 5 year comparator report is worth noting. Most of the respondents (score 77.3) awarding a score of 9 out of 10.

Which Committees have reviewed the information prior to Board submission?
- Trust Management Executive, 20/05/15

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 Trust National Inpatient Survey 2014

Respondents

850 questionnaires were sent to patients eligible for the survey, of which **471** returned a completed questionnaire, giving a response rate of **56%** (compared to **42%** in 2013). The response rate for all other Trusts was **47%**.

Key facts about the 471 inpatients who responded:

- **28%** of patients were on a waiting list/planned in advance and **72%** came as an emergency or urgent case.
- **42%** were male; **58%** were female.
- **10%** were aged 16-35; **12%** were aged 36-50; **17%** were aged 51-65 and **61%** were aged 66 and older.

Changes to the questionnaire

The 2014 inpatient questionnaire has been kept as similar as possible to the 2013 inpatient questionnaire to allow comparisons to be made between survey years. There are 70 core questions, the same number of questions last year.

Two questions carried in the 2013 inpatient questionnaire have been removed for the 2014 survey:

- Q65. Did you receive copies of letters sent between hospital doctors and your family doctor (GP)?
- Q66. Were the letters written in a way that you could understand?

Two new questions have been added for the 2014 survey:

- Q33. Did you have confidence in the decisions made about your condition or treatment?
- Q67. During your time in hospital did you feel well looked after by hospital staff?

A change to this year's survey is that free text comments do not need to be anonymised, as a statement has been added to the questionnaire stating that any information provided in the free text box will be shared. This will enable results to be looked at in full by trusts, the CQC and researchers.

Comparison with previous results:

The detail and comparison to previous years can be found in appendix 1. The results in the format that will be published on 21st May are attached in appendix 2.

Comparison with other trusts beyond 'expected range' cannot be undertaken until the results are released nationally.

Appendix 2 demonstrates where the Trust sits within an 'expected range'. Where a score is better than expected the marker will be in the green, where it is as expected it will be amber and worse than expected will be red.

Statistically significant changes:
A favourable change compared to last year's survey was seen in one question. This related to being offered a choice of food (Qu.22)

Adverse changes compared to last year's survey were seen in two questions. These related to information being provided to the specialist by the original referrer (Qu.8), and being given enough privacy when discussing your condition or treatment (Qu.37).

Other changes of note:

When comparing percentage scores (appendix 1) there some areas where there is some notable changes that are not noted as significant within the national report.

Question 12, number of ward moves, has shifted. Whilst overall the results are positive there is a notable change in the percentage of patients who were moved 3 or more times during their episode of care.

Question 15, disturbed by noise at night from patients; this has worsened compared to last year. It should be noted that noise from staff at night has improved.

Question 23, help to eat meals; this has remained broadly static with increases seen in all aspect of satisfaction. Scores have improved for both 'yes always' and 'yes, sometimes'; however there has also been an increase in the number who did not get the expected help.

Question 30, were there enough nurses on duty; this has improved slightly with a positive shift in the 'rarely or never enough' response.

Question 32, were you involved as much as you wanted in decisions about your care; this shows a similar shift as seen in Question 30.

Question 68 *Overall I had a very good experience* on a scale of 1-10 (10 being very good experience) in the Trust 5 year comparator report is worth noting. Most of the respondents (score 77.3) awarding a score of 9 out of 10.

Conclusion:

Overall there has been no significant change with the Trust falling within the 'expected range' but there are clearly areas that we need to focus on to improve the experience for our patients. We will review the report further focussing on specific questions where we want to focus our efforts this year.

The following table contains the percentage results to the questions asked, not the problem scores. **Appendix 1.**

Question	Answers	2014	2013	2012	2011	2010
1. Was your most recent hospital stay planned in advance or an emergency?	Emergency or urgent	71.8	62.4	67.6	64.4	61.7
	Waiting list or planned in advance	26.6	35.3	30.2	32.8	34.6
	Something else	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	92.9	89.7	89.4	88.5	91.4
	No	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	18.1	13.1	17.3	17.9	15.4
	Right amount	59.5	59.3	64.9	61.6	62.5
	Too much	0.0	0.5	0.3	0.3	0.0
	I was not given any information about my treatment or condition	5.1	10.1	7.3	8.8	11.2
	Don't know / Can't remember	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	70.6	72.5	76.2	65.7	61.4
	Yes, to some extent	19.7	15.2	17.9	25.3	28.1
	No	1.8	1.5	1.9	2.9	4.5
	Don't know / Can't remember	7.9	10.8	4.1	6.1	2.6
5. When you were referred to see a specialist, were you offered a choice of hospital for your **first hospital appointment**?	Yes	23.4	13.6	22.6	17.5	19.8
	No, but I would have liked a choice	14.4	12.1	20.1	17.5	12.2
	No, but I did not mind	54.5	68.6	53.8	59.2	58.1
	Don't know / Can't remember	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	78.8	74.8	70.9	69.5	70.9
	I should have been admitted a bit sooner	11.5	18.3	12.2	18.2	14.5
	I should have been admitted a lot sooner	9.6	6.9	16.9	12.3	5.8
7. Was your admission date changed by the hospital?	No	82.6	73.0	78.1	77.9	72.1
	Yes, once	13.4	23.4	17.6	15.9	16.3
	Yes, 2 or 3 times	4.1	3.6	3.7	5.3	2.3
	Yes, 4 times or more	0.0	0.0	0.5	1.0	0.6
8. In your opinion, had the specialist you saw in hospital been	Yes, definitely	73.0	89.7	86.1	-	-

Question	Answers	2014	2013	2012	2011	2010
given all of the necessary information about your condition or illness from the person who referred you?	Yes, to some extent	18.9	8.1		-	-
	No	3.8	1.5	7.7	-	-
	Don’t know / can’t remember	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	17.6	13.3	21.1	16.9	22.2
	Yes, to some extent	22.7	19.1	25.6	28.4	24.5
	No	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	17.9	19.0	14.9	16.6	15.9
	No	75.5	75.6	79.5	79.3	77.1
	Don't know / Can't remember	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	12.4	10.1	12.6	22.2	35.0
	No	87.6	89.9	87.4	77.8	65.0
12. During your stay in hospital, how many wards did you stay in?	1	62.1	69.2	67.7	67.3	61.2
	2	27.2	24.1	24.0	22.6	30.6
	3 or more	8.1	4.4	7.6	8.9	6.8
	Don't know / Can't remember	2.6	2.3	0.6	1.3	0
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?	Yes	9.0	6.3	9.0	15.3	30.6
	No	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	13.7	10.5	15.1	23.9	28.7
	Yes, because it had special bathing equipment that I needed	1.3	0.9	0.4	0.9	0.9
	No	73.8	82.3	74.8	58.4	53.5
	I did not use a bathroom or shower	5.9	2.3	4.7	9.8	8.6
	Don't know / Can't remember	5.3	4.1	4.9	7	6.5
15. Were you ever bothered by noise **at night** from **other patients**?	Yes	32.7	27.5	27.8	44.8	48.8
	No	67.3	72.5	72.2	55.2	49.8
16. Were you ever bothered by noise **at night** from **hospital staff**?	Yes	18.4	20.6	17.2	18.3	24.1
	No	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	72.9	76.9	77.4	59.4	59.8
	Fairly clean	24.9	21.9	19.8	37.3	35.5

Question	Answers	2014	2013	2012	2011	2010
	Not very clean	2.2	0.9	1.9	2.7	3.5
	Not at all clean	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	63.4	71.0	70.8	48.3	45.3
	Fairly clean	29.1	22.7	22.4	37.7	41.8
	Not very clean	3.9	3.1	2.3	6.9	7.7
	Not at all clean	0.6	0.3	0.6	1.5	0.9
	I did not use a toilet or bathroom	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	2.2	1.7	1.7	4.2	4.9
	No	97.8	98.3	98.3	95.8	94.9
20. Were hand-wash gels available for patients and visitors to use?	Yes	91.4	89.2	91.0	91.1	94.4
	Yes, but they were empty	1.3	0.9	0.9	1.2	1.2
	I did not see any hand-wash gels	3.5	4.3	3.2	2.5	1.6
	Don't know / Can't remember	3.9	5.7	4.9	5.2	2.6
21. How would you rate the hospital food?	Very good	19.3	21.9	14.6	12.6	11.4
	Good	37.0	33.9	38.1	34.3	33.9
	Fair	23.7	27.1	28.4	30.6	35.5
	Poor	14.6	11.1	14.0	14.5	14
	I did not have any hospital food	5.4	6.0	4.9	8.1	4.2
22. Were you offered a choice of food?	Yes, always	79.7	74.4	75.6	72.9	68.5
	Yes, sometimes	13.0	14.9	16.5	17.1	21.3
	No	7.3	10.6	7.9	10	8.4
23. Did you get enough help from staff to eat your meals?	Yes, always	18.0	15.6	12.8	14.9	16.4
	Yes, sometimes	7.9	5.5	5.3	4.3	4.9
	No	4.4	3.5	4.9	5.7	5.8
	I did not need help to eat meals	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	58.0	63.9	57.8	57.8	55.6
	Yes, sometimes	27.0	20.6	26.4	25.7	28.5
	No	4.6	4.6	6.0	6.4	6.5

Question	Answers	2014	2013	2012	2011	2010
	I had no need to ask	10.5	10.9	9.8	10.1	8.6
25. Did you have confidence and trust in the doctors treating you?	Yes, always	76.3	79.7	79.0	75.2	73.6
	Yes, sometimes	19.3	16.6	15.9	20.9	21.3
	No	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	6.6	3.7	6.0	6.2	4.9
	Yes, sometimes	20.6	18.9	18.8	23.1	24.5
	No	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	62.3	61.1	61.1	56.8	57.7
	Yes, sometimes	23.6	20.7	24.9	27.3	28.7
	No	3.3	3.4	4.3	5.8	4.2
	I had no need to ask	10.8	14.8	9.8	10.1	8.6
28. Did you have confidence and trust in the nurses treating you?	Yes, always	78.7	77.1	73.5	69.6	71.5
	Yes, sometimes	17.8	20.6	23.1	27.1	24.8
	No	3.4	2.3	3.4	3.3	2.8
29. Did nurses talk in front of you as if you weren't there?	Yes, often	3.5	2.8	3.4	3.4	3
	Yes, sometimes	15.3	12.5	14.6	22.2	17.1
	No	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	63.3	64.0	61.6	55.7	54.9
	There were sometimes enough nurses	28.2	24.0	27.6	29.4	31.3
	There were rarely or never enough nurses	8.5	12.0	10.8	14.8	11.9
31. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?	Yes, often	8.7	5.7	7.5	7.6	8.6
	Yes, sometimes	25.7	23.4	24.9	31.3	26.6
	No	65.6	70.9	67.6	61.1	63.6
32. Were you involved as much as you wanted to be in decisions about your care and treatment?	Yes, definitely	52.3	58.7	52.9	47.4	48.1
	Yes, to some extent	35.2	32.5	36.0	39.4	41.4
	No	12.5	8.8	11.1	13.2	9.6
33. Did you have confidence in the decisions made about your condition or treatment?	Yes, always	69.9	-	-	-	-
	Yes, sometimes	23.1	-	-	-	-

Question	Answers	2014	2013	2012	2011	2010
	No	7.0	-	-	-	-
34. How much information about your condition or treatment was given to **you**?	Not enough	23.2	15.8	20.5	24	23.4
	The right amount	76.5	83.4	79.3	74.9	76.2
	Too much	0.2	0.9	0.2	1.1	0
35. Did you find someone on the hospital staff to talk to about your worries and fears?	Yes, definitely	27.5	24.5	21.8	24.2	18.7
	Yes, to some extent	19.8	21.0	22.5	27.5	24.3
	No	13.8	12.4	14.3	15	13.3
	I had no worries or fears	38.9	42.1	41.3	33.3	42.3
36. Do you feel you got enough emotional support from hospital staff during your stay	Yes, always	37.3	39.9	32.4	35.1	-
	Yes, sometimes	17.4	15.6	19.2	18.9	-
	No	8.9	6.9	9.6	12.4	-
	I did not need any emotional support	36.4	37.6	38.8	33.6	-
37. Were you given enough privacy when discussing your condition or treatment?	Yes, always	78.6	85.9	78.5	70.2	65.4
	Yes, sometimes	17.0	11.5	19.2	21	22.2
	No	4.4	2.6	2.3	8.8	10.5
38. Were you given enough privacy when being examined or treated?	Yes, always	90.8	93.4	89.8	85.9	84.8
	Yes, sometimes	7.9	6.6	9.8	11.2	12.1
	No	1.3	0.0	0.4	2.9	2.3
39. Were you ever in any pain?	Yes	65.9	58.5	62.3	67.7	60.7
	No	34.1	41.5	37.7	32.3	38.1
40. Do you think the hospital staff did everything they could to help control your pain?	Yes, definitely	73.1	75.2	73.0	67.1	71.5
	Yes, to some extent	17.6	19.3	21.0	25.6	20.8
	No	9.3	5.4	6.0	7.4	5.8
41. How many minutes after you used the call button did it usually take before you got the help you needed?	0 minutes / right away	6.3	9.1	9.0	10.1	7.5
	1-2 minutes	25.4	22.9	21.4	20.6	17.3
	3-5 minutes	19.7	18.5	19.2	17	14.7
	More than 5 minutes	12.0	8.8	11.4	12	12.4
	I never got help when I used the call button	0.9	0.0	0.4	1.7	0.9

Question	Answers	2014	2013	2012	2011	2010
	I never used the call button	35.6	40.6	38.6	38.6	43.7
42. During your stay in hospital, did you have an operation or procedure?	Yes	58.8	62.5	55.5	60.5	60.7
	No	41.2	37.5	44.5	39.5	37.1
43. Beforehand, did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?	Yes, completely	75.4	83.7	73.8	70.6	73.8
	Yes, to some extent	14.6	10.7	18.4	17	16.9
	No	5.2	4.2	4.9	5.9	6.5
	I did not want an explanation	4.9	1.4	3.0	6.5	1.2
44. Beforehand, did a member of staff explain what would be done during the operation or procedure?	Yes, completely	66.5	73.5	64.9	64.3	65.4
	Yes, to some extent	23.7	19.5	26.1	21.3	22.3
	No	5.6	5.6	6.0	6.2	9.2
	I did not want an explanation	4.1	1.4	3.0	8.2	1.9
45. Beforehand, did a member of staff answer your questions about the operation or procedure in a way you could understand?	Yes, completely	63.2	70.9	60.2	57.5	60.4
	Yes, to some extent	15.6	11.7	22.3	23.3	19.2
	No	4.1	3.8	2.2	3.3	6.2
	I did not have any questions	17.1	13.6	15.2	15.9	13.1
46. Beforehand, were you told how you could expect to feel after you had the operation or procedure?	Yes, completely	51.9	57.7	52.4	54	50.4
	Yes, to some extent	28.8	24.4	28.1	26.5	27.7
	No	19.2	17.8	19.5	19.5	20
47. Before the operation or procedure, were you given an anaesthetic or medication to put you to sleep or control your pain?	Yes	81.5	90.7	85.0	84.7	85.4
	No	18.5	9.3	15.0	15.3	12.3
48. 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	75.3	86.8	79.2	70.9	82
	Yes, to some extent	11.3	9.5	11.7	16.8	11.3
	No	13.4	3.7	9.2	12.3	6.3
49. 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	63.0	67.4	62.5	64	56.9
	Yes, to some extent	24.0	20.9	21.2	22.7	29.6
	No	13.0	11.6	16.3	13.3	10.4
50. Did you feel you were involved in decisions about your discharge from hospital?	Yes, definitely	49.5	54.6	50.0	46.1	43.7
	Yes, to some extent	32.2	26.0	30.3	29.7	26.9

Question	Answers	2014	2013	2012	2011	2010
	No	15.5	14.6	17.5	15.1	17.1
	I did not need to be involved	2.8	4.9	2.1	9.1	10.5
51. Were you given enough notice about when you were going to be discharged?	Yes, definitely	53.6	56.4	52.4	-	-
	Yes, to some extent	33.1	33.0	33.8	-	-
	No	13.3	10.6	13.9	-	-
52. On the day you left hospital, was your discharge delayed for any reason?	Yes	43.0	39.0	42.1	46.4	49.1
	No	57.0	61.0	57.9	53.6	49.8
53. What was the **MAIN** reason for the delay? **(Tick ONE only)**	I had to wait for **medicines**	45.7	55.8	59.6	55.6	51.9
	I had to wait to **see the doctor**	12.9	15.5	17.2	20.3	19
	I had to wait for an **ambulance**	19.4	13.2	10.1	10.1	6.2
	Something else	22.0	15.5	13.1	14	13.3
54. How long was the delay?	Up to 1 hour	15.7	13.3	22.1	12.5	11.4
	Longer than 1 hour but no longer than 2 hours	27.2	25.2	23.9	37.1	25.2
	Longer than 2 hours but no longer than 4 hours	33.0	42.2	33.3	33	33.8
	Longer than 4 hours	24.1	19.3	20.7	17.4	26.2
55. Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?	Yes	66.8	76.3	62.5	67.8	62.4
	No	33.2	23.7	37.5	32.2	35
56. 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	56.0	56.4	55.0	52.2	50.2
	Yes, to some extent	12.0	11.8	12.4	14	13.8
	No	9.1	5.2	6.2	6.8	8.4
	I did not need an explanation	10.9	11.8	11.6	11.9	9.8
	I had no medicines	12.0	14.7	14.8	15.1	15.7
57. Did a member of staff tell you about medication **side effects** to watch for when you went home?	Yes, completely	24.9	29.6	21.1	21.9	24.1
	Yes, to some extent	17.1	14.1	15.4	13.1	11.6
	No	30.2	29.6	31.9	35.2	38.6
	I did not need an explanation	27.7	26.8	31.6	29.8	25
58. Were you told how to **take** your medication in a way you could understand?	Yes, definitely	59.3	59.7	53.4	50.6	53.7
	Yes, to some extent	10.8	10.6	10.8	11.7	12.5

Question	Answers	2014	2013	2012	2011	2010
	No	6.8	5.5	6.4	8.6	8.8
	I did not need to be told how to take my medication	23.3	24.2	29.3	29.1	25
59. Were you given clear written or printed information about your medicines?	Yes, completely	58.1	62.1	50.7	62.9	65.6
	Yes, to some extent	11.4	11.0	14.3	15.6	17.3
	No	8.4	7.2	9.1	15.6	13.6
	I did not need this	19.4	15.5	22.9	-	-
	Don't know / Can't remember	2.7	4.1	3.0	5.9	2.6
60. Did a member of staff tell you about any danger signals you should watch for after you went home?	Yes, completely	32.3	33.5	27.7	26.2	23.6
	Yes, to some extent	16.0	17.3	16.9	17.6	15.4
	No	26.9	24.9	30.5	31.8	34.3
	It was not necessary	24.8	24.3	24.9	24.5	23.4
61. Did the hospital staff take your family or home situation into account when planning your discharge?	Yes, completely	46.0	44.5	38.2	-	-
	Yes, to some extent	13.4	14.7	14.5	-	-
	No	11.6	6.9	15.1	-	-
	It was not necessary	25.0	30.7	28.9	-	-
	Don’t know / can’t remember	4.0	3.2	3.2	-	-
62. 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	38.2	39.4	30.4	28.1	23.1
	Yes, to some extent	17.1	12.6	14.7	17.5	17.3
	No	17.3	17.5	20.1	24	25.5
	No family or friends were involved	9.0	9.8	11.4	13.4	14.3
	My family or friends did not want or need information	18.4	20.7	23.4	17.1	17.1
63. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	Yes	71.4	73.6	65.3	58.7	69.9
	No	18.9	16.9	26.8	30.7	20.6
	Don’t know / Can’t remember	9.7	9.5	7.9	10.6	6.8
64. 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	30.0	24.9	22.2	-	-
	No, but I would have liked them to	4.0	2.3	5.8	-	-
	No, it was not necessary to discuss it	65.9	72.8	72.0	-	-
65. Did hospital staff discuss with you whether you may need	Yes	47.7	46.8	40.3	-	-

Question	Answers	2014	2013	2012	2011	2010
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)	No, but I would have liked them to	7.9	6.4	7.8	-	-
	No, it was not necessary to discuss it	44.4	46.8	51.9	-	-
66. Overall, did you feel you were treated with respect and dignity while you were in the hospital?	Yes, always	80.6	84.2	79.3	74.5	77.3
	Yes, sometimes	16.8	12.3	17.7	20.4	19.2
	No	2.6	3.4	3.0	5.1	2.1
67. During your time in hospital did you feel well looked after by hospital staff?	Yes, always	79.5	-	-	-	-
	Yes, sometimes	16.8	-	-	-	-
	No	3.7	-	-	-	-
68. Overall…	I had a very good experience (10)	7.8	30.4	24.5	-	-
	9	77.3	23.9	20.6	-	-
	8	1.8	20.9	18.9	-	-
	7	1.8	11.8	14.2	-	-
	6	1.8	3.2	3.4	-	-
	5	0.7	4.4	6.0	-	-
	4	0.4	1.8	0.9	-	-
	3	6.7	0.9	1.3	-	-
	2	0.4	1.5	1.7	-	-
	1	0.0	0.9	1.7	-	-
	I had a very poor experience (0)	1.4	0.3	6.9	-	-
69. During your hospital stay, were you ever asked to give your views on the quality of your care?	Yes	18.2	16.6	10.7	10.2	6.1
	No	71.8	70.9	81.4	82.3	86.4
	Don't know / Can't remember	10.0	12.6	7.9	7.4	5.8
70. Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	Yes	17.5	-	-	-	-
	No	61.1	-	-	-	-
	Not sure / Don’t know	21.5	-	-	-	-

Patient survey report 2014

Survey of adult inpatients 2014

Maidstone and Tunbridge Wells NHS Trust

Survey of adult inpatients 2014

National NHS patient survey programme
Survey of adult inpatients 2014

The Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England.

Our purpose is to make sure hospitals, care homes, dental and GP surgeries, and all other care services in England provide people with safe, effective, compassionate and high-quality care, and we encourage them to make improvements.

Our role is to monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety, and to publish what we find, including performance ratings to help people choose care.

Survey of adult inpatients 2014

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 twelfth survey of adult inpatients involved 154 acute and specialist NHS trusts. Responses were received from over 59,000 people, a response rate of 47%. People 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 were given the choice of sampling from June, July or August 2014. Trusts counted back from the last day of their chosen month, including every consecutive discharge, until they had selected 850 patients (or, for a small number of specialist trusts who could not reach the required sample size, until they had reached 1st January 2014). Fieldwork took place between September 2014 and January 2015.

Similar surveys of adult inpatients were also carried out in 2002 and from 2004 to 2012. 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 Intelligent Monitoring, 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' on page 5. 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 (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.

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 Q42 "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 2013' 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 2013. 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 2013 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 2013 survey, or if a trust committed a sampling error, either in 2014 or 2013. 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.

Q33: "Did you have confidence in the decisions made about your condition or treatment?" is a new question in 2014 and it is therefore not possible to compare with 2013.

Q52 and Q53: The information collected by Q52 "On the day you left hospital, was your discharge delayed for any reason?" and Q53 "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 Q53 and is worded as: "Discharge delayed due to wait for medicines/to see doctor/for ambulance."

Q54: Information from Q52 and Q53 has been used to score Q54 "How long was the delay?" This assesses the length of a delay to discharge for reasons attributable to the hospital.

Q67: "During your time in hospital did you feel well looked after by hospital staff?" is a new question in 2014 and it is therefore not possible to compare with 2013.

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):
www.cqc.org.uk/inpatientsurvey

The results for the adult inpatient surveys from 2002 to 2013 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/767

More information on the programme of NHS patient surveys is available at:
www.cqc.org.uk/public/reports-surveys-and-reviews/surveys

More information about how CQC monitors hospitals is available on the CQC website at:
http://www.cqc.org.uk/public/hospital-intelligent-monitoring

Survey of adult inpatients 2014

Maidstone and Tunbridge Wells NHS Trust

Section scores

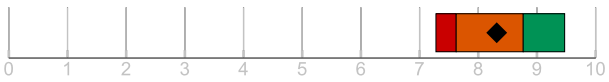
Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2014

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)

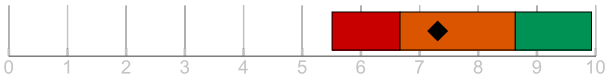
Q6. How do you feel about the length of time you were on the waiting list?

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?



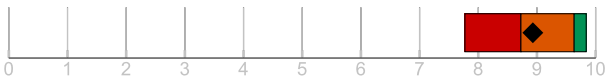
Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2014

Maidstone and Tunbridge Wells NHS Trust

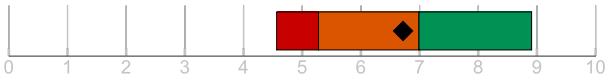
The hospital and ward

Q11. Did you ever share a sleeping area with patients of the opposite sex?



Q14. Did you ever use the same bathroom or shower area as patients of the opposite sex?

Q15. Were you ever bothered by noise at night from other patients?



Q16. Were you ever bothered by noise at night from hospital staff?

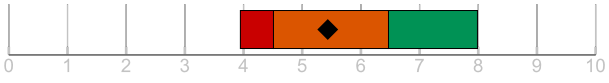
Q17. In your opinion, how clean was the hospital room or ward that you were in?

Q18. How clean were the toilets and bathrooms that you used in hospital?

Q19. Did you feel threatened during your stay in hospital by other patients or visitors?

Q20. Were hand-wash gels available for patients and visitors to use?

Q21. How would you rate the hospital food?



Q22. Were you offered a choice of food?

Q23. Did you get enough help from staff to eat your meals?

Doctors

Q24. When you had important questions to ask a doctor, did you get answers that you could understand?

Q25. Did you have confidence and trust in the doctors treating you?

Q26. Did doctors talk in front of you as if you weren't there?

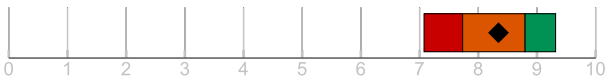
Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2014

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

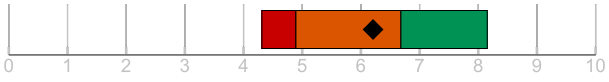
Q31. Did a member of staff say one thing and another say something different?

Q32. Were you involved as much as you wanted to be in decisions about your care and treatment?

Q33. Did you have confidence in the decisions made about your condition or treatment?

Q34. How much information about your condition or treatment was given to you?

Q35. Did you find someone on the hospital staff to talk to about your worries and fears?



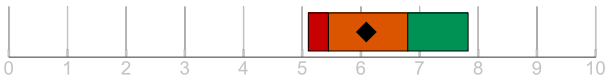
Q36. Do you feel you got enough emotional support from hospital staff during your stay?

Q37. Were you given enough privacy when discussing your condition or treatment?

Q38. Were you given enough privacy when being examined or treated?

Q40. Do you think the hospital staff did everything they could to help control your pain?

Q41. 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		

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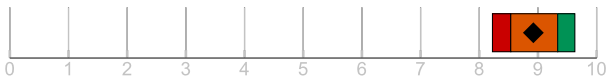
Operations and procedures (answered by patients who had an operation or procedure)

Q43. Did a member of staff explain the risks and benefits of the operation or procedure?



Q44. Did a member of staff explain what would be done during the operation or procedure?

Q45. Did a member of staff answer your questions about the operation or procedure?

Q46. Were you told how you could expect to feel after you had the operation or procedure?

Q48. Did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain?

Q49. Afterwards, did a member of staff explain how the operation or procedure had gone?

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		

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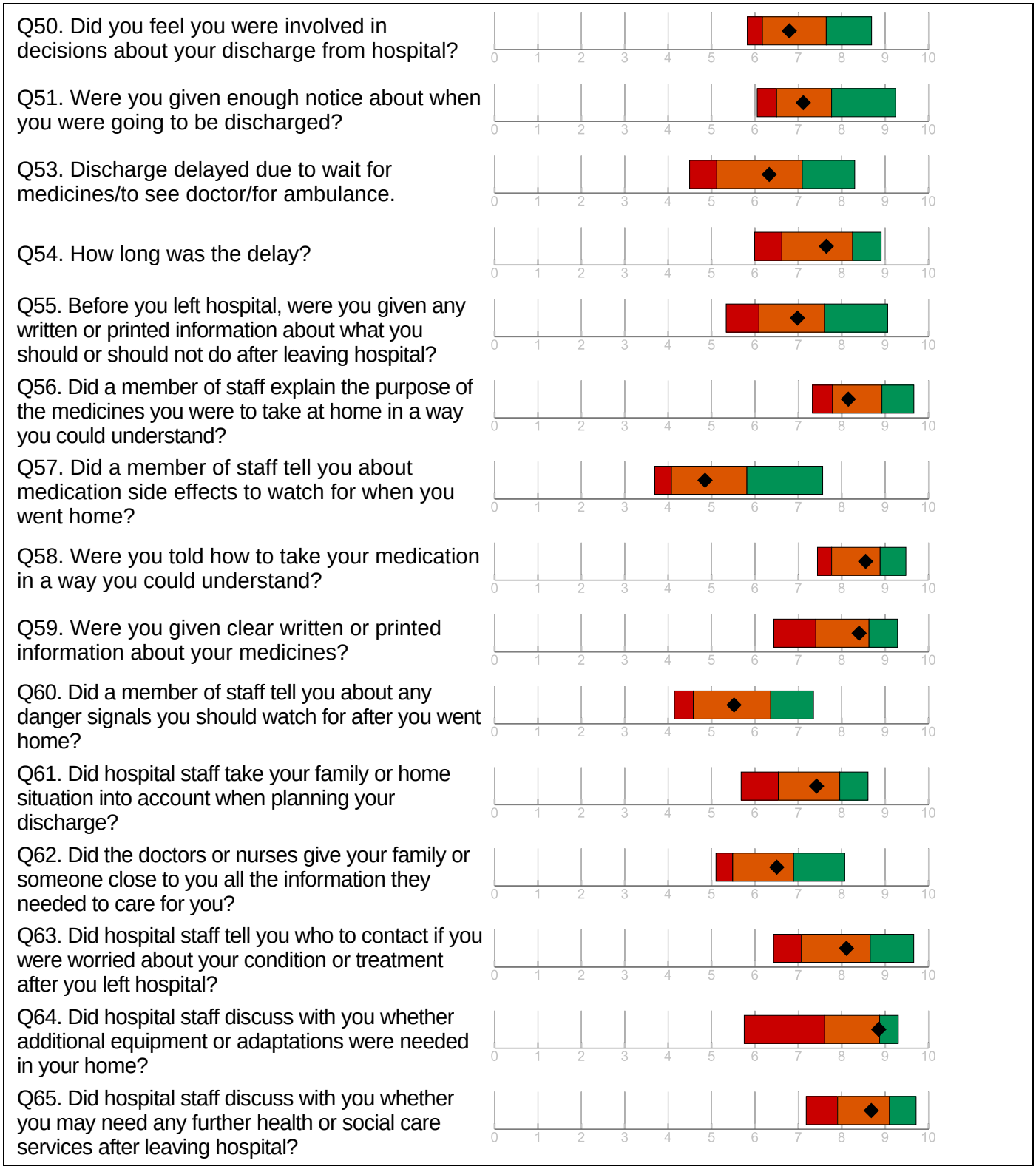
Maidstone and Tunbridge Wells NHS Trust

Leaving hospital



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		

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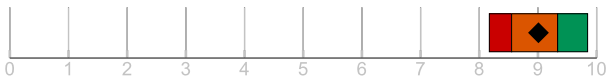
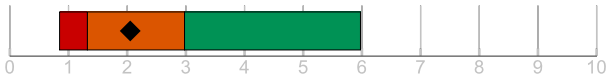
Overall views of care and services

Q66. Overall, did you feel you were treated with respect and dignity while you were in the hospital?

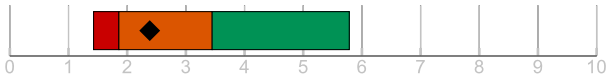


Q67. During your time in hospital did you feel well looked after by hospital staff?

Q69. During your hospital stay, were you ever asked to give your views on the quality of your care?

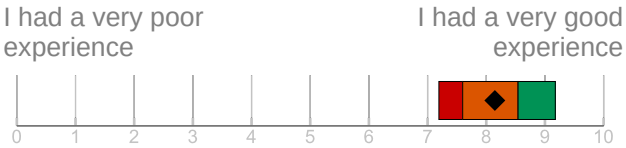


Q70. Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?



Overall experience

Q68. 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 2014

Maidstone and Tunbridge Wells NHS Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2013 scores for this NHS trust	Change from 2013
The Emergency/A&E Department (answered by emergency patients only)							
S1	Section score	8.5	7.7	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	7.3	9.5	263	7.9	
Q4	Were you given enough privacy when being examined or treated in the A&E Department?	8.8	7.9	9.6	302	9.0	
Waiting list and planned admissions (answered by those referred to hospital)							
S2	Section score	8.9	8.1	9.6			
Q6	How do you feel about the length of time you were on the waiting list?	8.6	6.8	9.5	126	8.4	
Q7	Was your admission date changed by the hospital?	9.1	8.5	9.9	135	9.0	
Q8	Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?	8.9	8.0	9.7	132	9.4	↓
Waiting to get to a bed on a ward							
S3	Section score	7.3	5.5	9.9			
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?	7.3	5.5	9.9	459	7.6	

↑ or ↓	Indicates where 2014 score is significantly higher or lower than 2013 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2013 data is available.

Survey of adult inpatients 2014

Maidstone and Tunbridge Wells NHS Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2013 scores for this NHS trust	Change from 2013
The hospital and ward							
S4	Section score	8.2	7.5	9.1			
Q11	Did you ever share a sleeping area with patients of the opposite sex?	8.9	7.8	9.8	382	9.0	
Q14	Did you ever use the same bathroom or shower area as patients of the opposite sex?	8.6	6.3	9.8	403	8.7	
Q15	Were you ever bothered by noise at night from other patients?	6.7	4.6	8.9	449	7.3	
Q16	Were you ever bothered by noise at night from hospital staff?	8.2	7.1	9.2	457	8.0	
Q17	In your opinion, how clean was the hospital room or ward that you were in?	9.1	7.9	9.7	465	9.2	
Q18	How clean were the toilets and bathrooms that you used in hospital?	8.7	7.3	9.5	450	9.0	
Q19	Did you feel threatened during your stay in hospital by other patients or visitors?	9.8	9.4	10.0	464	9.8	
Q20	Were hand-wash gels available for patients and visitors to use?	9.5	8.8	9.9	445	9.4	
Q21	How would you rate the hospital food?	5.4	3.9	8.0	435	5.6	
Q22	Were you offered a choice of food?	8.6	7.5	9.6	453	8.0	↑
Q23	Did you get enough help from staff to eat your meals?	7.2	5.9	9.4	138	7.4	
Doctors							
S5	Section score	8.4	7.8	9.5			
Q24	When you had important questions to ask a doctor, did you get answers that you could understand?	8.1	7.3	9.4	411	8.2	
Q25	Did you have confidence and trust in the doctors treating you?	8.7	8.2	9.8	455	8.8	
Q26	Did doctors talk in front of you as if you weren't there?	8.5	7.7	9.6	456	8.6	
Nurses							
S6	Section score	8.5	7.4	9.3			
Q27	When you had important questions to ask a nurse, did you get answers that you could understand?	8.3	7.1	9.3	411	8.3	
Q28	Did you have confidence and trust in the nurses treating you?	8.8	8.0	9.7	465	8.7	
Q29	Did nurses talk in front of you as if you weren't there?	9.0	7.6	9.7	459	9.0	
Q30	In your opinion, were there enough nurses on duty to care for you in hospital?	7.8	6.2	9.5	458	7.5	

↑ or ↓	Indicates where 2014 score is significantly higher or lower than 2013 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2013 data is available.

Survey of adult inpatients 2014

Maidstone and Tunbridge Wells NHS Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2013 scores for this NHS trust	Change from 2013
Care and treatment							
S7	Section score	7.7	6.8	8.9			
Q31	Did a member of staff say one thing and another say something different?	8.0	7.4	9.1	459	8.2	
Q32	Were you involved as much as you wanted to be in decisions about your care and treatment?	7.1	6.1	9.2	457	7.4	
Q33	Did you have confidence in the decisions made about your condition or treatment?	8.3	7.2	9.4	455		
Q34	How much information about your condition or treatment was given to you?	7.8	7.0	9.5	456	8.2	
Q35	Did you find someone on the hospital staff to talk to about your worries and fears?	6.2	4.3	8.2	278	6.0	
Q36	Do you feel you got enough emotional support from hospital staff during your stay?	7.3	5.7	9.0	292	7.6	
Q37	Were you given enough privacy when discussing your condition or treatment?	8.7	7.5	9.4	458	9.1	↓
Q38	Were you given enough privacy when being examined or treated?	9.5	9.0	9.9	457	9.6	
Q40	Do you think the hospital staff did everything they could to help control your pain?	8.2	7.3	9.3	300	8.2	
Q41	After you used the call button, how long did it usually take before you got help?	6.1	5.1	7.8	284	6.4	
Operations and procedures (answered by patients who had an operation or procedure)							
S8	Section score	8.2	7.7	9.2			
Q43	Did a member of staff explain the risks and benefits of the operation or procedure?	8.9	8.2	9.6	254	9.0	
Q44	Did a member of staff explain what would be done during the operation or procedure?	8.4	7.8	9.3	254	8.3	
Q45	Did a member of staff answer your questions about the operation or procedure?	8.7	7.8	9.6	222	8.7	
Q46	Were you told how you could expect to feel after you had the operation or procedure?	6.8	6.0	8.5	259	6.7	
Q48	Did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain?	8.8	8.2	9.6	212	9.0	
Q49	Afterwards, did a member of staff explain how the operation or procedure had gone?	7.6	6.7	9.0	262	7.6	

↑ or ↓	Indicates where 2014 score is significantly higher or lower than 2013 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2013 data is available.

Survey of adult inpatients 2014

Maidstone and Tunbridge Wells NHS Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2013 scores for this NHS trust	Change from 2013
Leaving hospital							
S9	Section score	7.3	6.1	8.3			
Q50	Did you feel you were involved in decisions about your discharge from hospital?	6.8	5.8	8.7	444	6.9	
Q51	Were you given enough notice about when you were going to be discharged?	7.1	6.1	9.2	459	7.2	
Q53	Discharge delayed due to wait for medicines/to see doctor/for ambulance.	6.3	4.5	8.3	413	6.5	
Q54	How long was the delay?	7.6	6.0	8.9	407	7.6	
Q55	Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?	7.0	5.3	9.1	452	7.5	
Q56	Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	8.2	7.3	9.7	347	8.4	
Q57	Did a member of staff tell you about medication side effects to watch for when you went home?	4.9	3.7	7.6	286	4.9	
Q58	Were you told how to take your medication in a way you could understand?	8.6	7.4	9.5	306	8.5	
Q59	Were you given clear written or printed information about your medicines?	8.4	6.4	9.3	312	8.3	
Q60	Did a member of staff tell you about any danger signals you should watch for after you went home?	5.5	4.1	7.3	333	5.5	
Q61	Did hospital staff take your family or home situation into account when planning your discharge?	7.4	5.7	8.6	318	7.8	
Q62	Did the doctors or nurses give your family or someone close to you all the information they needed to care for you?	6.5	5.1	8.1	323	6.4	
Q63	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	8.1	6.4	9.7	410	8.1	
Q64	Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?	8.9	5.8	9.3	152	9.1	
Q65	Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	8.7	7.2	9.7	252	8.8	

↑ or ↓	Indicates where 2014 score is significantly higher or lower than 2013 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2013 data is available.

Survey of adult inpatients 2014

Maidstone and Tunbridge Wells NHS Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2013 scores for this NHS trust	Change from 2013
Overall views of care and services							
S10	Section score	5.6	4.8	7.7			
Q66	Overall, did you feel you were treated with respect and dignity while you were in the hospital?	9.0	8.2	9.8	458	9.0	
Q67	During your time in hospital did you feel well looked after by hospital staff?	8.9	7.8	9.8	458		
Q69	During your hospital stay, were you ever asked to give your views on the quality of your care?	2.1	0.8	6.0	406	1.8	
Q70	Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	2.4	1.4	5.8	355	2.2	
Overall experience							
S11	Section score	8.1	7.2	9.2			
Q68	Overall...	8.1	7.2	9.2	442	8.2	

↑ or ↓	Indicates where 2014 score is significantly higher or lower than 2013 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2013 data is available.

Survey of adult inpatients 2014
Maidstone and Tunbridge Wells NHS Trust

Background information

The sample	This trust	All trusts
Number of respondents	471	59083
Response Rate (percentage)	56	47

Demographic characteristics	This trust	All trusts
Gender (percentage)	(%)	(%)
Male	42	47
Female	58	53
Age group (percentage)	(%)	(%)
Aged 16-35	10	6
Aged 36-50	12	11
Aged 51-65	17	23
Aged 66 and older	61	59
Ethnic group (percentage)	(%)	(%)
White	93	89
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	4	6
Religion (percentage)	(%)	(%)
No religion	19	16
Buddhist	0	0
Christian	77	78
Hindu	0	1
Jewish	0	0
Muslim	0	2
Sikh	0	0
Other religion	2	1
Prefer not to say	2	2
Sexual orientation (percentage)	(%)	(%)
Heterosexual/straight	93	94
Gay/lesbian	0	1
Bisexual	0	0
Other	1	1
Prefer not to say	5	4

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - May 2015

5-15 Confirmation of Trust's planning submissions, 2015/16 Director of Finance

Summary / Key points

- The enclosed report updates the Trust Board on the May 14th final plan submission
- The submitted financial plan delivers a deficit of £14.1m.
- The submitted financial includes a CIP target of £21.5m.

Which Committees have reviewed the information prior to Board submission?
- Trust Management Executive, 20/05/15

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

May Planning Submission

1. Purpose

1.1 Confirms the financial content of the submission and its consistency with previous reports to the Trust Management Executive, Finance Committee and Trust Board.

2. Executive Summary

2.1 The following table summarises the key performance indicators of the financial plan submitted to the TDA on the 14th May 2015.

Financial Metric	Score/value	Relevant RAG	Commentary
Total Turnover used in Financial Risk Ratings (Operating Revenue less Donated & Gov Grant Income - £0.2m)	**£398.7m**		
Surplus	**£(14.1)m**		
Key Metric **P1** - Planned Financial Performance -Adjusted Financial Performance Retained Surplus/(Deficit) as a percentage of Turnover (%)	**(3.5)%**	**RED**	Deficit generates a red
Key Metric **P2** - Is the Trust planning to access permanent PDC Other funding?	**Yes**	**RED**	Requirement for funding to achieve breakeven duty
Key Metric **P3** - Percentage of High Risk Efficiencies	**19.0 %**	**AMBER**	Ignores impact of schemes carried forward. Less than 10% generates a green
Key Metric **P4** - Percentage of Unidentified Efficiencies	**0.0 %**	**GREEN**	0% generates a green
Key Metric **P5** - Efficiencies as a % of Planned Spend	**4.2 %**	**GREEN**	As % of new schemes is between 3.8% and 5% (tariff efficiency and TDA assumed reasonable top limit of target)
Key Metric **P6** - Planned Underlying Financial Position	**(0.8)%**	**AMBER**	£(3.4)m of underlying deficit is between 0% and (2)% of turnover. Underlying surplus required for green and deficit of worse than (2)% (£7.6m) required for Red
Key Metric **P7** - Continuity of Services Risk Rating	**1.5**	**RED**	"Capital servicing" metric of submitted plan of scored a 1 reducing overall rating to a rounded 2, an overall rating of 3 required for a green
Key Metrics Overall RAG Rating		**RED**	Red P1 metric generates an overall red as would any 3 metrics of red

Table 1- schedule of key metrics

2.2 The deficit has increased by £0.7m as a result of the plan being amended to include additional non-recurrent costs the Trust expects to face in 2015/16.

2.3 The workforce submission was also made on the 14th of May and it demonstrated an expectation by the Trust that WTE would reduce by 278 (4.9%) as a result of service changes such as KPP and HIS plus the impact of CIPs. The workforce return does not have a set of reported KPI's but overall the movements are consistent with the financial submitted.

2.4 The activity templates were also submitted through Unify2 and are consistent with the income plans the trust submitted as part of the financials.

2.5 A written outline explanation of the plan was also submitted on the 14th May and this paper was the updated paper that was shared with the April Board.

3. Finances submitted

3.1 The final version of the plan was submitted on the 14th of May along with the Appendix A, the workforce schedule and a number of answers to specific questions raised by the TDA. At the point of this report being completed no feedback other than confirmation of receipt for all submissions has been received from the TDA.

3.2 The I&E plan submitted to the TDA is summarised below in table 2.

Income and Expenditure	**£m**
Revenue from patient care activities	361.4
Other operating income	37.5
Total income	**398.9**
Employee benefits	(226.6)
Other operating costs	(168.5)
Financing costs (loan interest, PDC)	(19.3)
Total costs	**(414.4)**
Retained surplus/(deficit)	**(15.5)**
Break even duty adjustments	
IFRIC 12 (PFI)	0.7
Impairements (exc IFRIC 12)	0.5
Donated/government grants	0.2
Total adjustments	**1.4**
Adjusted retained surplus/(deficit)	**(14.1)**

***Table 2 - summary of financial plan submitted*.**

Cash & Balance Sheet

3.3 The plan submitted generates a cash balance at 31st March 2016 of £2.1m as the Trust will require £13.8m of working capital loans and £6.5m capital investment loans.

4. Triangulation

4.1 The following table outlines the impact of areas of change on activity, income, costs and workforce.

	Activity growth change	Financial impact - income (£ms)	Total Expences (£ms)	Pay (£ms)	Non Pay (£ms)	WTE	
2014/15 OUTTURN		**402.9**	**402.7**	**236.8**	**165.9**	**5,722**	
Day case activity	754	0.7					
Elective Spells	254	0.7					
Non Elective Spells	981	1.8					
Outpatient FA	3,904	0.7					
Outpatient F-Up	3,029	0.3					
Outpatient Imaging	(1,507)	(0.2)					
A&E Attendance	5,607	0.6					
Critical Care	(169)	(0.2)					
Pathology	(1,155)	(0.0)					
Radiology	(553)	(0.0)					
Maternity Pathway	324	0.4					
Regular Attenders	(542)	(0.2)					
EIP Excess Bed Days	(25)	(0.0)					
NEIP Excess Bed Days	1,365	0.3					
Pre-Operative Assessments	(76)	(0.0)					
Ward Attenders	(193)	(0.0)					
Neo Natal	(115)	(0.1)					
Oncology Fractions	1,859	0.4					
Clinical PbR Growth	13,744	5.1	1.8	1.2	0.7	0	
Service Changes/Developments		4.7	4.1	(9.4)	13.5	(0)	KPP service change -259 WTE and -100 for cessation of HIS service +35 staff for quality investments per CQC +46 staff for new TWH NEL ward (funded from repatriated IS work in the plan).
CIPs		7.6	(13.9)	(7.5)	(6.4)	(0)	Majority of schemes skill mix based
		420.2	394.7	221.1	173.6	5,721	
NR		(23.6)	(4.0)	(2.3)	(1.7)		One off costs such as arrears and costs from prior periods. Also establishment of NEL pathway staff from temp to perm staff.
Tariff/Inflation		(1.3)	7.4	3.4	4.0		NHS tariff deflator less non NHS price increases
Cost Pressures			11.6	1.3	10.3		Majority of pay is pensions - remainder contingency against unit cost increase in new services.
Contract Changes		5.1	0.0				Rule and fine changes outside of tariff (mainly NEL threshold).
		(1.6)	0.0				£1.6m prior year settlement benefit
Restructure costs/redundancies			3.2	3.2	0.0		Net change in redundancies (£4m KPP in 2015/16 less £0.9m HIS in 2014/15)
2015/16 Plan		**398.7**	**412.9**	**226.6**	**186.2**	**5,721**	**£14.1m deficit**

5. Conclusion

5.1 The Board is asked to note plan submitted, the resultant RAG scores and the Annex A which was submitted as part of the return.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board - May 2015

5-16 Winter Plans – Discussion Paper **Chief Operating Officer**

Summary / Key points

This plan has been produced to ensure operational resilience for the winter period of 2015/16. Provision of sufficient inpatient bed capacity over the winter period to match fluctuations in demand for both non-elective and elective inpatients will provide a positive impact on quality, safety, and patient experience, and help the Trust deliver operational and financial plans.

Pressures in A&E at MTW are predominantly due to two factors, mismatch between demand and capacity for inpatient beds and lack of alignment of resource with demand within the Trust but also with our partners across the wider health economy, in particular Social Services, Community services, Mental Health and Ambulance Trusts.

The objectives of the 15/16 Winter plan are:
- Ensure patients go into the right bed first time
- Maintain key quality KPIs during the winter - Safeguard key clinical pathways to support patient safety including reducing HCAIs, Falls and pressures sores.
- Ensure delivery of A&E and RTT and Cancer standards during the winter period.
- Reduce delayed transfers DToCs to <2.5% during the winter period
- Maximise elective activity when non-elective activity is low & vice versa though flexible working
- Ensure all clinical areas have the right level of staff and skill mix required to maintain safe service and to deliver operational standards during the winter period.

This Plan sets out:
- the objectives of the 15/16 winter plans
- key pressures that arise from winter
- Demand and Capacity plans
- Planning and Implementation
- Risks and contingency plans
- Governance and Stakeholder engagements
- Next steps

The “planned escalation” beds outlined in this plan therefore represent a best attempt to balance elective and non-elective pressures within the resource limitation of the beds available. Significant inpatient bed pressures at TWH are likely to remain until commissioning of the new 39 bed ward in January 2015. These pressures will be partially mitigated by reductions in average NEL LOS but, to the extent those reduction are not delivered, the Trust will rely on use of “Contingency escalation” areas to manage the peaks in demand caused by increased admissions and delayed discharges. Implementation of LOS reduction programme therefore remains a vital part of the winter plan.

The objectives and the plan as a whole will be subject to further iterations taking into account changing situation and wider engagement with key stakeholders.

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

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
Discuss and support further development of the proposals outlined in the draft winter plan noting that it will be subject to further iterations.

[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

1.1 Introduction

This plan has been produced to ensure operational resilience for the winter period of 2015/16. Provision of sufficient inpatient bed capacity over the winter period to match fluctuations in demand for both non-elective and elective inpatients will provide a positive impact on quality, safety, and patient experience, and help the Trust deliver operational and financial plans.

The objectives of the 15/16 Winter plan are:

- Ensure patients go into the right bed first time
- Maintain key quality KPIs during the winter - Safeguard key clinical pathways to support patient safety including reducing HCAIs, Falls and pressures sores.
- Ensure delivery of A&E and RTT and Cancer standards during the winter period.
- Reduce delayed transfers DToCs to <2.5% during the winter period
- Across the Trust <30 patients that are MFFD occupying an acute hospital bed in any 24 hour period.
- Maximise elective activity when non-elective activity is low and vice versa though flexible working
- Ensure all clinical areas have the right level of staff and skill mix required to maintain safe service and to deliver operational standards during the winter period.

These objectives are based on experience and learning from last year and area designed to ensure focus although it is recognised that 14/15 winter was mild and that the Trust did not experience major outbreaks of infection.

The objectives and the plan as a whole will be subject to further iterations taking into account changing situation and wider engagement with within clinical teams and local health partners in particular, Kent Community services, South East Coast Ambulance Services, Kent Mental Health services and West Kent Social Services.

This Trust plan should be read in conjunction with the following Trust plans:

- Major Incident Plan;
- Pandemic Influenza Plan
- Trust Escalation policy and procedure for emergency admissions.
- Business Continuity Plans.

1.2 Key pressures that arise from winter

Pressures in A&E at MTW are predominantly due to two factors, mismatch between demand and capacity for inpatient beds and lack of alignment of resource with demand within the Trust but also with our partners across the wider health economy, in particular Social Services, Community services, Mental Health and Ambulance Trusts. These mismatches are much more pronounced and acutely felt in the winter months because of:

- Delayed discharges of medically fit patients due to lack of capacity in community / social care access to enablement / nursing home placements (biggest issue at TW)
- Delayed discharges due to pressure on medical staffing resulting from increased number of admissions (TWH), and medical outliers (MH)
- The tendency for a more complex case mix & more demand on emergency services.
- Increased demand for acute services due to higher levels of infection within the Community e.g. bronchopneumonia
- Higher levels of infection within the community with subsequent increase in demand for services, inability to discharge to community hospitals, residential or nursing homes.

- Bank Holiday impact on services
- Pressure on adult critical care and paediatric high dependency capacity across the network
- Unplanned absence of staff due to seasonal illnesses e.g. flu like symptoms and winter vomiting (Norovirus)
- Adverse weather resulting in difficulty in discharging patients and affecting staff
- Adverse weather resulting in difficulty in getting to and from work
- Pressure on A&E due to diverted demand if GPs when GPs are closed
- Unplanned staff absence due to seasonal flu, D&V outbreaks etc.

1.3 Demand and Capacity

1.3.1 Bed Modelling

Remodelling of "core" inpatient beds to ensure that there are enough speciality beds to meet Elective and Non-elective demand 85% of the time. This in turn helps ensure that patients are admitted to the right beds first time.

Funded and Escalation Bed stock

	Tunbridge Wells			Maidstone		
Directorate	**Funded**	**Total (Inc Esc)**	**Esc**	**Funded**	**Total (Inc Esc)**	**Esc**
Surgery	67			47	47	
Trauma & Orthopaedics	68					
Women's & Sexual Health	10					
Cancer & Haematology				18	18	
E&M Services	160			183	231	48
Grand Total	**305**	**0**	**0**	**248**	**296**	**48**

Additional "escalation" beds are required during winter months on top of core requirement.

	Tunbridge Wells			Maidstone		
Directorate	**Core Requirement**	**Winter Requirement**	**Winter Esc**	**Core Requirement**	**Winter Requirement**	**Winter Esc**
Surgery	75	76	1	48	51	3
Trauma & Orthopaedics	74	75	1	2	2	0
Women's & Sexual Health	10	11	1	1	1	0
Cancer & Haematology	2	2	0	18	18	0
E&M Services	184	203	19	217	245	28
Grand Total	**345**	**366**	**21**	**285**	**316**	**31**

Actions: The Programme Board is overseeing work to increase bed base and patient flow by:

1. Building a circa 39 inpatient bed facility – work in due to be completed in January 2016
2. Establish a 7 bed new ambulatory unit at TWH – May 2015
3. Reconfigure beds at Maidstone to reduce surgical bed base and increase medical bed base. Current programme to refurbish John Day/John Saunders at Maidstone is scheduled to be completed before by 1 December 2015.

1.3.2 Planned Escalation and Contingency Capacity

Priority	Planned Capacity Escalation & Demand Reduction at Tunbridge Wells	TWH Contingency Plans – allows room to manage fluctuations in demand		Planned Capacity Escalation & Demand Reduction at Maidstone Hospital	TWH Contingency Plans
1	New inpatient Ward 39 beds available in January	TWH Cardiac Catheter Lab – 3 (of 5) (includes 1 beds reserved for diagnostics)		*Chaucer – 12 Beds	*MH UMAU – 5 (of 8) beds
2	Minimise PPU to Cancer or Urgent Cases – 6 beds (estimate)	TWH Short Stay Surgery – 4 (of 8) beds		*Stroke Unit – 4 beds	MH Cardiac Catheter Lab – 3 (of 6) beds
3	*TWH Short Stay Surgery - 7 beds	TWH Ambulatory Unit – 4 (of) beds		*Whatman Ward -28 beds	MH Short Stay Surgery - 6 beds
4	TWH Cardiac Catheter Lab - 8 beds	TWH Recovery – 6 for Electives		Foster Clark - 28 beds	
5	*Ward 11 – 1 bed			Old MOU - 12 beds (tbc)	
6	Medical Divert to MH or Review Surgical transfers to TWH				
Total	**22**	**18 (26)**		**84**	**14 (20)**
Total Beds including Core	**326**			**332**	
Shortfall	**-39**			**+16**	

*Please note that these beds remain escalated since the winter.
+Please refer to updated Trust Escalation policy and procedure for emergency admissions for escalation triggers.

It must be noted that significant inpatient bed challenges at TWH are likely to remain until commissioning of the new 39 bed ward in January 2015. These pressures will be partially mitigated by medical divert to MH and/or reductions in average NEL LOS but, to the extent the NEL LOS reductions are not delivered, the Trust will rely on use of “Contingency escalation” areas to manage the peaks in demand caused by increased admissions and delayed discharges. Implementation of LOS reduction programme therefore remains a vital part of the winter plan. The “planned escalation” beds outlined in this plan therefore represent a best attempt to balance elective and non-elective pressures within the resource limitation of the beds available.

1.4 Planning and Implementation

1.4.1 Timetable:

May 2015	Discussion paper for TME	Deputy COO
June 2015	Consultations and engagement	Deputy COO
June 2015	Cost Winter proposals	Stuart Doyle
June 2015	Decision on escalation areas to be open for the winter finalised	TME
July 2015	Recruitment of staff for escalated areas	Directorates
August 2015	Receive plans from LHE partners	COO
October 2015	Test plans and agree contingency	COO
1 November	Implement plan	COO

1.4.2 Early winter escalation:

MTW winter escalation period to run from **01 November to 28 Feb 2016**, a month earlier than previous year to ensure a steady transition and to maintain patient safety, and maintain optimum patient flows. A success story of last winter was how key quality measures were maintained within acceptable standards despite the winter pressures. However some quality and patient experience measures including mortality, pressure ulcers, number of falls, some stroke SENTIL measures, NEL LOS and patient involvement in decisions about treatment deteriorated somewhat from October/November (*note link is not cause*). A&E conversion rates also increased from 26.7% in September to 28.6% in October and DToC peaked from 3.9% in October to 5.3% in November.

Recommendation for TME:

1. Approve winter period and allow Directorates to implement winter plans from 1 November 2015.

1.4.3 Maintain elective activity during the summer:

Directorates to plan to maintain elective activity in August and September. Robust planning of elective activity during the year is critical part of managing winter pressures proactively. Last year elective activity between August and September was more than 10% lower than in October and November.

1. **Recommendations for TME:** Support recruit fixed term locum consultants to extend consultant cover to from 0730 – 2330hrs seven days a week in A&E, Acute Medicine and Geriatric Medicine.

Directorate Actions:

1. Each directorate to review and publish agreed leave policy for each service area by end of June 2015 – policies must ensure delivery of safe service and of trust operational performance standards and balance staff well-being during the summer holidays and Winter months - CDs.
2. Directorates to finalise theatre schedules and staff rotas for August and September by end of June and identify locums and Bank/Agency staff required to maintain elective activity during these months where necessary – GMs & Matrons.
3. HR to work with operational managers to streamline the process for recruitment of locum staff and provide management training support where required – July 2015.

1.4.4 Maintain patient flow during the winter:

Other than bed capacity, pressures in A&E at MTW are also due lack of alignment of resource with demand within the Trust but also with our partners across the wider health economy, in particular Social Services, Community services, Mental Health and Ambulance Trusts.

Directorate Actions:

1. Recruit substantive staff to cover all escalation areas including for the winter period. The financial risk is mitigated the turnover rate and savings from reduction in Band and Agency spend. This is line with Trust 15/16 workforce plans – **GMs.**
2. Recruit fixed locum consultants to extend consultant cover to from 0730 – 2330hrs seven days a week - A&E, Acute Medicine and Geriatric Medicine
3. Complete comprehensive staffing plan (including therapies, diagnostics, pharmacy, phlebotomy, and transport) that ensures a/l is profiled to maintain capacity during December and especially first three weeks after Xmas.
4. Identify and communicate their Bank staffing needs for the period 1 Winter period by August 2015 - GMs.
5. Finalise schedule of outpatient clinics for the Winter period to support early senior review of all patients on wards including outliers – GMs/CDs/Outpatient Manager- August 2015.
6. Update the Trust Escalation policy and procedure for emergency admissions for escalation triggers to reflect learning points from 14/15 winter period and from breaking the cycle week.

HR Actions

1. Publish Bank recruitment incentives in place for the winter by September 2015 - **HR**
2. Establish a central team to manage staff sickness during the winter period to assist managers and allow them to focus on operational pressures – October 2015 - **HR**

SECAmb:

1. Institute daily site rep with HALOs and Clinical Operations Managers during the winter period to reduce inappropriate admissions / referrals to A&E and maintain close working relation with SECAmb– GM A&E
2. Develop plans to respond to the new SECAmb policy on handover of patients – A&E Matrons.

Social Services

1. Institute daily site rep during the winter period to proactively manage discharges of patients that are MFFD from acute trust. Daily review of shared PTL will help bring transparency and better coordination of discharges across the health economy
2. Agree robust plan for reducing DToC to <2.5% during the winter period. Between November and March 2015 DToC averaged 4.5% versus a target of 3.5%. This increase was especially felt at a time of heightened pressure for beds – **ADO for Emergency Medicine – June 2015.**
3. Increase case manager resources to adequately cover leave, training, sickness and fluctuations in demand.
4. Agree escalation pathway for operational staff to ensure transparency and visibility of issues at Executive levels
5. Agree plans for enhanced services during the winter period. Plans must support 7 day working.

Community services

1. Institute daily site rep during the winter period to proactively respond to bed pressures at acute trust. For example it was felt that community services a failed to adjust their admission criteria to support discharges from hospital when in high escalation which meant that beds existing beds were not utilised.
2. Share protocols on how admissions criteria into community beds will be flexed in response to heightened levels of escalation at the Trust.
3. Agree escalation pathway for operational staff to ensure transparency and visibility of issues at Executive levels
4. Agree plans for enhanced services during the winter period. Plans must support 7 day working.
5. Daily review and update of shared PTL to bring transparency and coordinate discharge planning across the health economy.

1.5 Risks & Contingency plans and Business Continuity

Risk Description	Impact	Likelihood	Risk Score (RAG)	Key controls in Place	Owner
Failure to recruit nursing and medical staff in a timely manner	5	5	25	Substantive recruitment to winter escalation beds International recruitment drive Engagement with LHE partners as outlined in Engagement plan below	HR
Failure to reduce the numbers DToC	4	5	20	Engagement with SS as outlined in Engagement plan below SS Winter Plans and contingency plans shared Plans tested	ADO for Medicine
Failure to reduce the number of MFFD patients occupying an acute bed	4	4	16	Engagement with LHE partners as outlined in Engagement plan below SS Winter Plans and contingency plans shared Plans tested	ADO for Medicine
Rise in NEL admissions above plan	4	3	12	Engagement with LHE partners as outlined in Engagement plan below	COO
Delays in commissioning of 39 bed ward a TWH	3	3	9	Proceeding with plans at risk	Programme Board
Financial risk of over spend of winter plans	3	3	9	Substantive recruitment to winter escalation beds to reduce Band and Agency spend Early recruitment decisions Maximise summer elective activity	DoF
Risks to delays in completion of planned refurbishment work	4	2	8	Close project management – initially allocated contingency has been spent.	Programme Board

1.6 Governance and Stakeholder Engagement Plan

Who?	How?	Other	Key message	Person responsible
Staff	Clinical Operations Group Meetings, Department & Ward meetings MTW winter planning e-mail address	Information of Intranet	Share improvement ideas Familiarise yourself with your role when in escalation Understand the agreed service leave policies and plan holiday well in advance to avoid disappointment Know where to find information Get your Flu vaccination	COO GMs and Matrons
Clinical Directors Site Leads Consultants	Directorate Management meetings Clinical Governance		Service Leave policies Involvement with escalation planning Roles when in escalated state	Clinical Directors
Executive Team	TME update paper		Plan, Risks and Mitigations Financial implications Recommendations/Decisions Monthly updates to TME Bi-monthly Progress updates to Board	COO
LHE partners (SS, KCHC, Mental Health, Local Hospices, SECAMB and West Kent CCG)	System Resilience Group meeting Daily Sitrep Urgent Care Board		Share learning Shared Planned Escalation plans for the Winter - What will each partner differently this winter? Test plans Share risks and contingency plans	COO
Patients	Trust Website	Posters Link to NHS Choices Information from NHS West Kent and Local GPs	Alternative providers Flu vaccination Visiting the hospital – Infection controls Did not attend (DNAs)	Comms teams

1.7 Next steps

- Further engagement with key stakeholders identified above
- Cost the Winter planning – taking into account cost of opening escalation areas, Agency and bank spend, loss of elective income due to drop in elective activity, potential loss of income from contractual penalties if operational performance standards are not delivered.
- Monthly management reports to TME and bi-monthly assurance reports to Trust Board.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - May 2015

5-17	Summary report from Audit and Governance Committee, 06/05/15	Committee Chairman (Non-Executive Director)

The Audit and Governance Committee met on 6th May 2015, and will meet on 27th May, to review the final Annual Report and Accounts for 2014/15 (before the Trust Board). A verbal report of the outcome of the meeting on 27th will be provided at the Trust Board on that date.

1. The key matters considered at the meeting on 6th May were as follows:

- The "RASCI" matrix (Responsible, Accountable, Support, Consult, Inform) that had been developed by the Director of Finance was reviewed (and commended)
- The Medical Director gave a response to the concerns arising from the latest Internal Audit review of Consultant Job Planning. The response noted that:
  - The relevant policy has been reviewed and reissued
  - There was no single point of contact for co-ordinating the process, as it was felt appropriate that Job Planning sits within Directorates
  - Job Plans were in place for all Directorates, and details of the Job Plans for the vast majority of Consultants were submitted to the Committee
- The Committee was informed of the processes in place to inform the development of the Board Assurance Framework (BAF) and Risk Register for 2015/16
- The Internal Audit Annual Report for 2014/15 (including the Head of Internal Audit Opinion) was received, as was an update on progress with actions from previous Internal Audit reviews. The overall Opinion was that "Reasonable assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk". The Committee discussed how an overall rating of "Substantial assurance" could be obtained
- The Counter Fraud Annual Report for 2014/15 was received, along with an update on the Counter Fraud work plan. The Work Plan for 2015/16 has since been circulated to Committee members, and will be formally approved at the meeting in August 2015
- A 'Progress and emerging issues report' was received from External Audit, which included an understanding of how the Committee gains assurance from management
- The External Audit fee letter for 2015/16 was received, and it was noted that the fee will be £75,069 (which compares to the £100,092 fee for 2014/15). The scale was set the Audit Commission prior to its closure
- Grant Thornton's "Benchmarking your annual report" report was received, and learning points for future year's Annual Reports were considered
- The draft Annual Report for 2014/15 (including the Governance Statement) was reviewed, and some proposed amendments were agreed
- The draft financial Accounts for 2014/15 were reviewed, and some queries were raised
- The Audit and Governance Committee Annual Report for 2014/15 was reviewed and agreed. The NHS Audit Committee Handbook recommends that the report be issued to all members of the Trust Board in advance of the meeting to agree the Annual Report and Accounts. The report is therefore enclosed, in Appendix 1
- The latest losses and compensations and single tender waivers data was reviewed
- The National Audit Office Local Audit Code was noted

2. The Committee received details of the following Internal Audit reviews:

- "Compliance with Nursing Rosters" (which received a Limited Assurance conclusion)
- "Budgetary Control and Financial Reporting" (which received a Reasonable Assurance conclusion)
- "Performance Related Incremental Pay" (which received a Reasonable Assurance conclusion)
- Core Financial Assurance – Financial Accounting and Non Pay (which received a

Reasonable Assurance conclusion)
- Information Governance Toolkit v12 (which received a Substantial Assurance conclusion)
- Local Registration Authority Management (which received a Limited Assurance conclusion)
- K&M HIS – Information Governance Toolkit v12 (which received a Reasonable Assurance conclusion)

3. **The Committee was also notified of the following "high" priority outstanding actions from Internal Audit reviews:**
   - A number of actions from the "Data Centre Facilities Review"; "Data Encryption Review"; and "Application Management Policies & Procedures" were noted. It was agreed to Invite the Managing Director of the Kent and Medway Health Informatics Service (KMHIS) and the Director of Health Informatics to provide an update on IT strategy and related matters to the Finance Committee in June 2015, and for this to include a response to the outstanding actions from Internal Audit reviews.
4. **The Committee agreed that:**
   - The Director of Finance should request that the Chief Nurse and Medical Director liaise direct with Internal Audit, to advise on the areas that would benefit most from the "CQC (carried forward from 14/15)" Internal Audit review
   - The Chief Operating Officer should be asked to review the "A season of major incidents: what is really causing the A&E crisis this winter?" report from Civitas
   - The draft Annual Report for 2014/15 (including the Governance Statement) should be amended to reflect the agreements made by the Audit and Governance Committee
   - The position should be established as to whether assurance had been received that an individual paid "off-payroll" during 2014/15 had paid the right amount of tax
5. **The issues that need to be drawn to the attention of the Board are as follows:**
   - None

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

Appendix 1:

Maidstone and Tunbridge Wells NHS
NHS Trust

Audit and Governance Committee Annual Report 2014/15

1. Introduction

This report summarises the key work areas of the Audit and Governance Committee during the period April 2014 to March 2015. The report supports the primary role of the committee in ensuring the adequacy and effective operation of the organisation's overall internal control system. The format of the report is informed by the guidance contained with the NHS Audit Committee Handbook (2014), and highlights work and outcomes in the following areas: Meetings and administration; 3. Governance, Risk Management and Internal Control, Internal Audit, External Audit, Audit and Governance Committee assessment; and Audit and Governance Committee statement / declaration.

2. Meetings and administration

During 2014/15, the Audit and Governance Committee met five times, on: 12/05/14, 28/05/14 (to recommend the approval of the Annual Accounts for 2013/14), 18/09/14, 20/11/14 and 12/02/15.

The membership of the Committee during 2014/15 was as follows:

- Sylvia Denton, Non-Executive Director
- Sarah Dunnett, Non-Executive Director
- Alex King, Non-Executive Director. Mr King joined the Board in September 2014
- Kevin Tallett, Non-Executive Director. Mr Tallett was the Chair of the Committee throughout 2014/15 (although Steve Tinton chaired the meeting held on 28/05/14 and Sarah Dunnett chaired the meeting held on 18/09/14).
- Steve Tinton, Non-Executive Director. Mr Tinton was the Vice Chair of the Committee throughout 2014/15

Attendance at each Audit and Governance Committee during 2014/15 is shown below:

	12/05/14	28/05/14	18/09/14	20/11/14	12/02/15
Sylvia Denton	-	✓	Apologies	✓	✓
Sarah Dunnett	Apologies	✓	✓[2]	✓	✓
Alex King	N/A	N/A	Apologies	✓	Apologies
Kevin Tallett	✓	✓[3]	-	✓	✓
Steve Tinton	✓	✓	Apologies	✓	✓

The Committee's Terms of Reference were reviewed and agreed at the Audit and Governance Committee meeting on 20/11/14, and approved by the Trust Board in December 2014. The Terms of Reference will next be reviewed at the November 2015 Audit and Governance Committee (and then be submitted for approval to the Trust Board in the same month).

The Terms of Reference deliberately do not incorporate clinical audit processes, as this is left to the oversight of the Quality & Safety Committee and its sub-committees.

3. Governance, Risk Management and Internal Control

a. Board Assurance Framework

The BAF is the document through which the Trust Board is apprised of the principal risks to the Trust meeting its objectives, and to the controls in place to manage those risks. In May

[2] The meeting on 18/09/14 was not quorate

[3] The meeting on 28/05/14 was chaired by Steve Tinton, as Kevin Tallett was chairing the Trust Board on the same day (and the Board was to approve the Annual Accounts, on the recommendation of the Audit and Governance Committee)

2014, the Committee agreed proposals for a revised Board Assurance Framework (BAF) format, and the revised BAF was reviewed at the Audit and Governance Committee at its meetings on 20/11/14 and 12/02/15. The functioning of the BAF (and Risk Register) has been subject to debate during 2014/15, particularly within the Audit and Governance Committee. However, the annual Internal Audit review of "Assurance Framework & Risk Management", undertaken at the end of 2014/15, concluded that the underlying processes are robust (although the final report of the review was not available at the time of producing this Statement), and in February 2015, the Audit and Governance Committee and Trust Board agreed a number of steps to strengthen the Trust's use of the BAF. These steps will be introduced during 2015/16, along with other measures to improve the BAF and Risk Register, following further discussion by the Board and its sub-committees.

b. Counter fraud

The Audit and Governance Committee has reviewed activity relating to counter fraud measures in 2014/15, via reports from the Local Counter Fraud Specialist (LCFS). The 2014/15 Counter Fraud Work Plan was approved at the meeting held on 12/05/14, which also received the Annual Report of Counter Fraud Activity for 2013/14.

c. Relationships with the Trust Board

The reporting from Committee to the Trust Board was strengthened in 2014/15 by the introduction of a written summary report of each meeting (previously, a verbal report from the Audit and Governance Committee Chair was just provided). The report is based on a template, and covers the key matters considered at the meeting; details of the Internal Audit reviews that were discussed; the "high" priority outstanding actions from Internal Audit reviews; and any issues that need to be drawn to the attention of the Board.

d. Head of Internal Audit Opinion (HoIA)

4. The Head of Internal Audit Opinion (HoIA) for 2014/15 states that "Reasonable assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk"

a. Governance Statement

The Governance Statement for 2014/15 was reviewed at the Audit and Governance Committee in May 2015, as part of the draft Annual Report and Accounts for 2014/15.

Based on this, the detailed work of the Audit and Governance Committee summarised above, and its Internal and External Auditor work programme, the Governance Statement is consistent with the view of the Audit and Governance Committee on the Trust's system of internal control, and the Committee supports the Trust Board's approval of the Statement, which is scheduled to take place in May 2015.

5. Internal Audit

The 2014/15 Internal Audit plan was agreed by the Audit and Governance Committee at its meeting on 12/05/14. The output from the plan is listed below.

Title	Report status	Assurance Level
Follow up on Consultant Job Plans	Final	Limited Assurance
Critical Financial Assurance – Payroll Arrangements	Final	Reasonable Assurance
Application Management Review	Final	Limited Assurance
Outpatient Clinic Maintenance	Final	Reasonable Assurance
Safeguarding Adults and Children	Final	Reasonable Assurance
Salary Overpayments	Final	Limited Assurance
Compliance with Nursing Rotas	Final	Limited Assurance
Information Governance Toolkit V12	Final	Substantial Assurance
Critical Financial Assurance – Financial Accounting & Non Pay	Final	Reasonable Assurance

Title	Report status	Assurance Level
Income Streams	Final	Reasonable Assurance
Budgetary Control and Financial Reporting	Final	Reasonable Assurance
Local Registration Authority	Final	Limited Assurance
Performance Related Pay	Final	Reasonable Assurance
Use of Temporary Medical Staff	Draft	Limited Assurance
Data Accuracy	Draft	Substantial Assurance
Assurance Framework and Risk Management Processes	Draft to be issued shortly	Reasonable Assurance

N.B. The above list does not include any reviews within the 2014/15 Plan that are not completed, or where the report has not yet been issued, at the time of this Annual Report

In 2015/16, the Committee will undertake a formal assessment of the performance of the Trust's Internal Auditor.

The Committee reviews the reliability and quality of clinical information systems via the Internal Audit process. In particular, an audit of data relating to Patient Access targets was included in the 2014/15 Plan, and will continue to be an annual feature of such Plans (in accordance with the NHS Trust Development Authority's expectations).

6. External Audit

On 18/09/14, the Audit and Governance Committee received the Annual Audit Letter for 2013/14. The "Key areas for Trust attention" were as follows:

- "The Trust: recorded a deficit of £12.4 million in its 2013/14 accounts (after allowable technical adjustments); delivered total savings of £23.5 million in 2013/14; demonstrated more robust assessment and monitoring of its financial position during the second half of the year".
- "The Trust's medium term position remains extremely challenging. As at June 2014, the Trust is predicting a £12.2 million deficit in both 2014/15 and 2015/16, after technical adjustments, in line with its two year financial plan. This plan includes delivery of c£22 million of recurrent CIPs each year".
- "The Trust is currently working on the development of a longer term five year financial recovery plan, in line timescales agreed with the Trust Development Agency (TDA). It is also actively focussing on the identification and implementation of further savings schemes, with a view to reducing its planned deficit for 2014/15"

The overall value for money conclusion within the Letter was that "On the basis of our work, which has highlighted the Trust's difficult financial position, and having regard to the guidance on the specified criteria published by the Audit Commission, we have issued a qualified "except for" conclusion in respect of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2014.".

The External Audit plan and fee for 2014/15 was approved by the Audit and Governance Committee on 12/02/15. The audit plan comprised: Audit of the financial statements; Reporting on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (i.e. a Value for Money conclusion); and external assurance on the Trust's Quality Account.

In 2015/16, the Committee will undertake a formal assessment of the performance of the Trust's external auditor.

7. Audit and Governance Committee assessment

The Committee agreed the approach for undertaking a self-assessment at its meeting on 20/11/14, and this assessment will be undertaken in early 2015/16. The findings will be discussed during that year, and any relevant actions will be agreed.

8. Audit and Governance Committee statement / declaration

The Audit and Governance Committee can confirm that:

- The Trust's Governance Statement for 2014/15 is consistent with the view of the Audit and Governance Committee on the Trust's system of internal control, and the Audit and Governance Committee supports the Trust Board's approval of the Statement
- The Committee has reviewed and used the Board Assurance Framework, and although there have been some views expressed to the contrary, the collective view of the Committee is that a) this is fit for purpose and; b) the 'comprehensiveness' of the assurances, and the reliability and integrity of the sources of assurance are sufficient to support the Trust's decisions and declarations
- The system of risk management in the Trust is adequate in identifying risks and allowing the Trust Board to understand the appropriate management of those risks
- There are no areas of significant duplication or omission in the systems of governance in the Trust that have come to the Audit and Governance Committee 's attention and not been adequately resolved
- There has been no major breakdown in internal control that has led to a significant loss in one form or another for 2014/15; and that
- There have been no major weakness in the governance systems that has exposed, or continues to expose, the Trust to an unacceptable risk

Kevin Tallett,
Chairman, Audit and Governance Committee, May 2015

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – May 2015

5-18	Summary report from the Quality & Safety Committee meeting, 13/05/15	Committee Chairman (Non-Executive Director)

The Quality & Safety Committee met on 13th May 2015.

The meeting on 13th May 2015 was a „main' meeting, and covered the following issues:

- Revised **Terms of Reference** (ToR) were reviewed and agreed, and the Trust Board is now asked to formally approve these. The revised ToR are enclosed. Proposed changes are „tracked', and if not self-explanatory, a comment of explanation is provided. A „clean' version (i.e. with the proposed changes accepted) of the ToR are also enclosed. The most significant change proposed is to change the Committee's title to "The Quality Committee", in recognition that "Safety" was one of the three tenets of the accepted definition of "Quality" (along with "Clinical Effectiveness" and "Patient Experience"). The Committee supported the change.
- The latest **Stroke care performance** was reported, and although improvements were noted, it was agreed to continue to receive an update on the latest performance at each meeting
- A report on the implementation of **"Intelligent fridges"**; and the problems with the provision of external internet access for the **Pharmacy robot at TWH** was received. It was noted that both issues were complex and multi-factorial, but were being addressed
- An **Audit of 'open' incidents** was received, and it was noted that the Trust's model for incident reporting was being reviewed by the Governance team. It was also noted that alternative models were being developed, and would be issued for consultation in the near future
- All the **Directorates** presented their reports. The key issue raised were as follows:
  - The report from **Surgery** highlighted that the relocation of inpatient Wards at Maidstone Hospital would result in a reduction of 15 Surgical beds. It was also noted that the investigation into the recent cases of Endophthalmitis (infection) had concluded, and that there had been no link to equipment. However, every single Cataract patient would now receive an Intracameral cefuroxime injection prior to treatment
  - **Trauma & Orthopaedics** highlighted that in response to Surgical Site Infections (SSIs) being above the national average, a Task Group had been established, and a number of actions taken. Although the initial signs were positive, it was agreed that surveillance of SSIs for hip and knee replacements should not be reduced from current levels. In addition, the Trust's response to the mortality alert from the Care Quality Commission (CQC) in relation to a particular sub-set of hip fractures was noted. The Committee heard that recent data suggested that the Trust was now at, or below, the national average for hip fracture mortality.
  - **Women's & Sexual Health** reported that the report of an external review into working relationships within the Obstetrics and Gynaecology Consultant body had now been received. Some issues clearly needed to be addressed, but at present, these had not had an impact on patient care.
  - **Cancer & Haematology** highlighted that the implementation of Chemotherapy E-prescribing was currently on hold, to enable some issues with the software to be resolved. NHS England had also been informed, and the company were being given the chance to assess and respond to the situation.
  - **Children's Services** reported that 24 candidates had applied for the new Consultant posts, and interviews would be held on 28/05/15. Prior to this, candidates would be invited to meet the Department. In addition, Ward Attender data was presented, and it was noted that numbers remained unchanged at the Riverbank Unit, but had increased by 5% for the Woodlands Unit
  - The incoming Clinical Director (CD) for **Critical Care** was welcomed to the meeting, and the outgoing CD was thanked for their contribution. It was reported that the Directorate's

response to the CQC's findings was continuing. WHO surgical checklist audit data was reviewed, and it was agreed that this should be validated and submitted to the next „main' Quality & Safety Committee. It was also noted that the latest crude mortality rate was rated as „red', but data from the Intensive Care National Audit & Research Centre (ICNARC) conflicted with the crude rate. It was agreed that the ICNARC data should be the data reported, for assurance.

  - The report from **Diagnostics, Therapies & Pharmacy** highlighted that Cellular Pathology reporting delays were being resolved. In addition it was noted that the Kent Pathology Partnership (KPP) had been paused for two months while the business case was revisited and reviewed (the Transfer of Undertakings (Protection of Employment) (TUPE) transfer of staff had been delayed in April 2015, and had been due to proceed from 01/07/15).
  - **Emergency & Medical Services** highlighted that Operational pressures and demand remained high. It was also reported that there were high vacancy rates in some areas, with reliance on temporary staff, and that the level of Delayed Transfers of Care was also a key issue.

- An update on the external **Clinical Governance Review** was provided. The Committee heard that the External Adviser would produce a report, with recommendations, in June
- The latest **Quality & Governance** report highlighted that there had been a decrease in all falls; the response rate for FFT had significantly improved; and the rate of complaints was lower than in previous years
- The latest **Serious Incidents** were considered, including the revised national Never Events Policy and Framework, and Serious Incident Framework
- The recent findings from relevant **Internal Audit reviews** were received
- The draft **Quality Accounts 2014/15** were reviewed and Committee members were invited to provide any suggested amendments or improvements to the document direct to the Associate Director of Governance, Quality and Patient Safety
- The latest situation regarding **Catheter Associated Urinary Tract Infections** was considered, and it was noted that a CQUIN target for a 10% reduction by Quarter 4 had been set. Further updates will be reported to each „main' meeting until the CQUIN was achieved
- A written report was received on the latest media coverage / **reputational risk** issues
- The minutes of the **Quality & Safety Committee 'deep dive'** held on 13/04/15 were received
- Reports were received from the latest meetings of the **sub-committees** i.e. Standards; Infection Prevention & Control; Clinical Governance; Patient Environment Steering Group and Safeguarding Children. There were no particular issues of concern raised, but the report from the Standards Committee included detailed outcomes data from the Dr Foster system. The Committee was assured that the data was being reviewed and investigated.

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

QUALITY COMMITTEE

TERMS OF REFERENCE

1. Purpose

The Quality Committee is constituted at the request of the Trust Board to oversee the implementation and management within the Trust of structures, systems and processes to enable delivery of the Trust's objectives relating to quality of care.

2. Membership

- Non-Executive Director (Chair) *
- Non-Executive Director (Vice Chair) *
- Non-Executive Directors *
- Chief Operating Officer *
- Chief Nurse *
- Medical Director *
- Director of Infection Prevention & Control (if not represented via a Clinical Director)
- Associate Director for Governance, Quality and Patient Safety *
- Risk and Compliance Manager
- Clinical Directorate representation – Clinical Directors (CD) or designated deputy (General Manager (GM) or Matron)

* Denotes those who constitute the membership of the 'deep dive' meeting (see below)

Members are expected to attend all relevant meetings, but will be required to attend at least 4 of the 'main' Quality Committee meetings (those who are also members of the 'deep dive' meeting will be required to attend at least 3 such meetings). Failure of a committee member to meet this obligation will be referred to the Chair of the Quality Committee for action.

3. Quorum

The Committee will be quorate when the following members are present:
- The Chair or Deputy Chair of the Quality Committee
- 1 other Non-Executive Director
- 2 Executive Directors
- 7 Clinical Directorate Representatives (i.e. CD, Matron or GM)
- 1 member of the MTW Governance Team

The 'deep dive' meeting (see below) will be quorate when the following members are present:
- The Chair or Vice Chair of the Quality Committee
- 1 other Non-Executive Director
- 2 Executive Directors

4. Attendance

<u>The following are invited to attend each main meeting</u>
- Internal Audit
- Complaints & PALS Manager
- The Chief Nurse from West Kent Clinical Commissioning Group (CCG)

Other staff may be invited to attend, as required, to meet the Committee's purpose and duties.

5. Frequency of Meetings

Meeting will be generally held every month, but will operate under two different formats. The meeting held on alternate months will be a 'deep dive' meeting, which will enable detailed

scrutiny of a small number of issues/subjects For clarity, the other meeting will be referred to as the 'main' Quality Committee.

Additional meetings will be scheduled as necessary at the request of the Chair.

6. Duties

6.1 To receive assurance on the delivery of quality of care across the Trust

6.2 To monitor the mitigations for significant risks relating to quality

6.3 To ensure that the Trust Risk Management Strategy and Policy is implemented consistently across the Trust, in relation to quality issues.

6.4 To approve, review and monitor the implementation of relevant policies and procedures.

6.5 To monitor the effectiveness of quality systems at a Corporate and Directorate level, and ensure that appropriate actions are taken.

6.6 To ensure that Directorates are identifying and managing their own quality issues effectively.

6.7 To receive reports about complaints claims and inquests, and the Trust's response.

6.8 To receive reports of Serious Incidents, and the Trust's response.

6.9 To receive progress reports on compliance with the Fundamental Standards (as defined by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

6.10 To ensure the Trust and its officers are working in partnership with external agencies for the effective management of risk across the health economy.

6.11 To oversee action in response to specific adverse circumstances (e.g. outbreaks of infection)

7. Parent committees and reporting procedure

The Quality Committee is a sub-committee of the Trust Board. The Committee Chairman will report activities to the Trust Board to next Trust Board meeting following each Quality Committee meeting.

Any relevant feedback and/or information from the Trust Board will be reported by Executive and Non-Executive members to each meeting of the Committee, by exception.

The Committee's relationship with the Patient Experience Committee is covered separately, below.

8. Sub-committees and reporting procedure

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

- Clinical Governance Committee
- Infection Prevention and Control Committee
- Mortality Review Group
- Patient Environment Steering Group
- Safeguarding Adults Committee
- Safeguarding Children Committee.
- Standards Committee

The Committee may also constitute 'Task & Finish' Groups to assist it in meeting its duties.

9. Patient Experience Committee

The Quality Committee may commission the Patient Experience Committee to review a particular subject, and provide a report. Similarly, the Patient Experience Committee may request that the Quality Committee undertake a review of a particular subject, and provide a report.

The Patient Experience Committee should also receive a summary report of the work undertaken by the Quality Committee, for information/assurance (and to help prevent any unnecessary duplication of work). The summary report submitted from the Quality Committee to the Trust Board should be used for the purpose. Similarly, a summary report of the Patient Experience Committee will be submitted to the Quality Committee.

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. Emergency powers and urgent decisions

The powers and authority of the Quality 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 Director members. The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the Quality Committee, for formal ratification.

12. Review of Terms of Reference

These Terms of Reference will be agreed by the Quality Committee and approved by the Trust Board. They will be reviewed annually or sooner if there is a significant change in the arrangements.

- Agreed by Quality and Safety Committee: 13 March 2013
- Approved by the Board: March 2013
- Agreed by the Quality & Safety Committee 'deep dive' meeting: 25th April 2014
- Terms of Reference (amended) agreed by the Quality & Safety Committee: 9th May 2014
- Approved by the Board: May 2014
- Terms of Reference (amended) agreed by the Quality & Safety Committee: 21st January 2015 (to remove reference to the Health & Safety Committee, which is a sub-committee of the Trust Management Executive)
- Revised Terms of Reference agreed by the Quality & Safety Committee, 13th May 2015
- Revised Terms of Reference approved by the Trust Board, 27th May 2015

Maidstone and Tunbridge Wells NHS
NHS Trust

QUALITY ~~& SAFETY~~ COMMITTEE

TERMS OF REFERENCE

1. Purpose

The Quality ~~& Safety~~ Committee is constituted at the request of the Trust Board to oversee the implementation and management within the Trust of structures, systems and processes to enable delivery of the Trust's objectives relating to quality of care ~~and patient safety~~.

2. Membership

- Non-Executive Director (Chair) *
- Non-Executive Director (~~Deputy~~ Vice Chair) *
- Non-Executive Directors *
- Chief Operating Officer *
- Chief Nurse *
- Medical Director *
- Director of Infection Prevention & Control (if not represented via a Clinical Director)
- Associate Director for Governance, Quality and Patient Safety *
- Risk and Compliance Manager
- Clinical Directorate r~~R~~epresentation – Clinical Directors (CD) or designated deputy (General Manager (GM) or Matron)

* Denotes those who constitute the membership of the „deep dive' meeting (see below)

Members are expected to attend all relevant meetings, but will be required to attend at least 4 of the „main' Quality ~~& Safety~~ Committee meetings (those who are also members of the „deep dive' meeting will be required to attend at least 3 such meetings). Failure of a committee member to meet this obligation will be referred to the Chair of the Quality ~~and~~ & Safety Committee for action.

3. Quorum

The Committee will be quorate when the following members are present:

- The Chair or Deputy Chair of the Quality ~~& Safety~~ Committee
- 1 other Non-Executive Director
- 2 Executive Directors
- 7~~8~~ Clinical Directorate Representatives (i.e. CD, Matron or GM)
- 1 member of the ~~Quality and~~MTW Governance Team

The „deep dive' meeting (see below) will be quorate when the following members are present:

- The Chair or Vice~~Deputy~~ Chair of the Quality ~~& Safety~~ Committee
- 1 other Non-Executive Director
- 2 Executive Directors

4. Attendance

The following are invited to attend each main meeting

- Internal Audit
- ~~Patient Safety and Risk Manager~~
- Complaints & PALS Manager
- ~~Clinical Audit and R&D Manager~~

Comment [RK1]: Is the title correct, given that "Safety" is one tenet of the accepted definition of "Quality" (along with "Clinical Effectiveness" and "Patient Experience"). Would the Committee be better named as the "Quality Committee"?

Comment [RK2]: If the title is changed to Quality Committee, this should be reflected throughout the ToR

Comment [RK3]: This change reflects the fact that there is now one less Clinical Directorate.

Comment [RK4]: This person could still be invited under the provision that "Other staff may be invited to attend to address issues of specific concern"

- ~~Director of Estates and Facilities Management~~
- ~~Director of Medical Education~~
- The Chief Nurse from West Kent Clinical Commissioning Group (CCG)

Other staff ~~members~~ may be invited ~~co-opted~~ to attend, ~~to address issues of specific concern at the discretion of the Chair.~~ as required, to meet the Committee's purpose and duties.

Comment [RK5]: These have never attended routinely, so should be removed, but they can still be invited under the provision that "Other staff may be invited to attend to address issues of specific concern"

5. Frequency of Meetings

Meeting will be generally held every month, but will operate under two different formats. The meeting held on alternate months will be a „deep dive' meeting, which will enable detailed scrutiny of a small number of issues/subjects For clarity, the other meeting will be referred to as the „main' Quality Committee.

Comment [RK6]: This affords some flexibility

~~The Chairman can call a meeting at any time if an urgent issue arises.~~Additional meetings will be scheduled as necessary at the request of the Chair.

6. Duties

6.1 To receive assurance on the delivery of quality of care across the Trust

~~6.1~~6.2 To monitor the mitigations for ~~identify~~ significant risks relating to gQuality ~~& Safety that the Trust Board need to consider in detail.~~

~~6.2~~6.3 To ensure that the Trust Risk Management Strategy and Policy is implemented consistently across the Trust, in relation to quality ~~and safety~~ issues.

~~6.3~~6.4 To ~~A~~approve, review and monitor the implementation of relevant policies and procedures~~.~~

~~6.4~~6.5 To monitor ~~and ensure~~ the effectiveness of quality ~~and safety~~ systems at a Corporate and Directorate level ~~in order to evaluate their impact and consequences~~, and ensure that appropriate actions are taken.

~~6.5 To identify significant risk that requires development of business cases and/or processes for consideration by the Trust Management Executive and/or sub-committees.~~

6.6 To ensure that Directorates ~~identify and~~ are identifying and managing their own quality ~~and safety risk~~ issues effectively~~.~~

6.7 To receive reports about ~~patient experience through~~ complaints~~,~~ claims and inquests~~and incidents made against the Trust in order to be assured of the Trust's good reputation and standing.~~, and the Trust's response

6.8 To receive reports of ~~to monitor against action plans arising from~~ Serious Incidents, and the Trust's response~~complaints and claims, to share learning and to ensure that actions have been completed.~~

6.9 To receive progress reports on compliance with the ~~Care Quality Commission's~~ Fundamental ~~Essential~~ Standards ~~for Quality and Safety~~ (as defined by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014~~.~~

6.10 ~~To receive, review and comment on reports from the Standards, Health & Safety, Infection Control, Clinical Governance Committee, Patient Environment Steering Group and Safeguarding Committees.~~

6.11 ~~To constitute „Task & Finish' Groups to undertake key work-streams on behalf of the Committee to meet identified needs.~~

6.12 To ensure the Trust and its officers are working in partnership with external agencies for the effective management of risk across the health economy.

6.13 To oversee action in response to specific adverse circumstances (e.g. outbreaks of infection)

7. Parent committees and reporting procedure

The Quality ~~& Safety~~ Committee is a sub-committee of the Trust Board. The Committee Chairman will report activities to the Trust Board to next Trust Board meeting following each Quality ~~and~~ & Safety Committee meeting.

Any relevant feedback and/or information from the Trust Board will be reported~~presented~~ by Executive and Non-Executive members to each meeting of the Committee, by exception.

The Committee's relationship with the Patient Experience Committee is covered separately, below.

8. Sub-committees and reporting procedure

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

- Clinical Governance Committee
- ~~Standards Committee~~
- ~~Clinical Governance Committee~~
- Infection Prevention and Control Committee
- Mortality Review Group
- Patient Environment Steering Group
- Safeguarding Adults Committee
- Safeguarding Children Committee.
- Standards Committee
- ~~Infection Prevention and Control Committee~~
- ~~Patient Environment Steering Group~~

The Committee may also constitute „Task & Finish' Groups to assist it in meeting its duties.

~~8. Audit and Governance Committee~~

~~The Audit and Governance Committee will provide an opinion on whether the Committee is fulfilling its function by reviewing performance against the Terms of Reference periodically (this opinion is likely to be informed via an Internal Audit review, as directed by the Audit and Governance Committee)~~

9. Patient Experience Committee

The Quality Committee may commission the Patient Experience Committee to review a particular subject, and provide a report. Similarly, the Patient Experience Committee may request that the Quality Committee undertake a review of a particular subject, and provide a report.

The Patient Experience Committee should also receive a summary report of the work undertaken by the Quality Committee, for information/assurance (and to help prevent any unnecessary duplication of work). The summary report submitted from the Quality

Comment [RK7]: This hasn't happened, and therefore the expectation should be removed. Removing this doesn't stop any such review being undertaken of course.

Comment [RK8]: This new section mirrors that within the revised Terms of Reference for the Patient Experience Committee

Committee to the Trust Board should be used for the purpose. Similarly, a summary report of the Patient Experience Committee will be submitted to the Quality Committee

~~9~~10. Administration

~~The Chair with the support of the Chief Nurse will:~~
- ~~Agree the Committee's annual programme~~
- ~~Set out the dates of planned meetings~~
- ~~Agree the key agenda items~~

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

~~The Committee shall be supported administratively by the Chief Nurse's Personal Assistant whose duties will include:~~
- ~~Call for papers from attendees and invitees at least 2 weeks before a meeting.~~
- ~~Collation and distribution of papers one week before the date of the meeting~~
- ~~Taking the minutes and circulation of draft minutes following the meeting.~~
- ~~Maintaining a record of meeting papers and minutes as a corporate file for the Trust.~~

11. Emergency powers and urgent decisions

Comment [RK9]: This section is now common in Board sub-committee ToR

The powers and authority of the Quality 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 Director members. The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the Quality Committee, for formal ratification.

~~10~~12. Review of Terms of Reference ~~and Monitoring Compliance~~

These Terms of Reference will be agreed by the Quality ~~and~~& Safety Committee and approved by the Trust Board. They will be reviewed annually or sooner if there is a significant change in the arrangements.

- Agreed by Quality and Safety Committee: 13 March 2013
- Approved by the Board: March 2013
- Agreed by the Quality & Safety Committee „deep dive' meeting: 25th April 2014
- Terms of Reference (amended) agreed by the Quality & Safety Committee: 9th May 2014
- Approved by the Board: May 2014
- Terms of Reference (amended) agreed by the Quality & Safety Committee: 21st January 2015 (to remove reference to the Health & Safety Committee, which is a sub-committee of the Trust Management Executive)
- Revised Terms of Reference agreed by the Quality & Safety Committee, 13th May 2015
- Revised Terms of Reference approved by the Trust Board, 27th May 2015

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – May 2015

5-19	**Summary of the Trust Management Executive (TME) meeting, 20/05/15**	**Chief Executive**

The TME met on 20th May 2015. The key points from the meeting were as follows:

- The Chief Operating Officer highlighted four areas of **safety** that required attention:
  - Sharps injuries
  - Eye splash injuries
  - Collision injuries
  - Use of the Trusts Chaperone Policy
- The **Directorate reports** highlighted the following:
  - There has been a 20% increase in Upper GI diagnostic referrals on last year
  - Progress had been made with the oncall rotas for Anaesthetists and Intensivists to comply with the ICS standards
  - There are problems recruiting middle grade doctors in a number of directorates
  - The Ambulatory Assessment Unit at Tunbridge Wells Hospital will be opened on 26/05/15 week
- The latest **performance, for month 1**, 2015/16 was reported (including the latest position regarding infection prevention and control). It was noted that performance on the A&E 4hr target was at 90.1% for month 1, the rate of patient falls was 6.1% which was a significant reduction and the rate of pressure ulcers graded at 3 or 4 had seen a reduction on the previous year.
- The Chief Operating Officer updated the Committee on progress with **Chemotherapy E-prescribing**
- An update was provided on **Theatre scheduling** detailing the issues and potential solutions.
- The Trust's **response to the NHS Staff Survey 2014** was provided.
- The Chief Nurse provided an update on the Plans to report on progress with **the Quality Improvement Plan** developed in response to the findings from the CQC's inspection
- The Director of Finance confirmed the **2015/16 planning submissions**
- The Deputy Chief Executive updated the Committee on progress being made with the **clinical strategy** including scenario modelling of the future local health economy
- An update was received on the MTW Programme Board detailing the **key estates projects** being undertaken
- The Committee approved the ward configuration of the new **Ward Development at Tunbridge Wells Hospital**
- The Committee received a briefing on "**GS1 & PEPPOL adoption plan**", which relates to bar-coding technology. The adoption plan will be submitted to the Trust Board in June 2015, for approval (all acute Trusts are required to produce a trust Board-approved adoption plan by the end of June 2015).
- The **recently-approved business cases** were noted, and the business case for replacement Echo machines at Maidstone Hospital was approved
- Updates were received on the work of the **TME's sub-committees** (Capital meetings; Policy Ratification Committee; Clinical Operations and Delivery Group; Health & Safety Committee, Information Governance Committee, and the Private Patient Board). The Health & Safety Committee report included assurance on water quality testing

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 - May 2015

5-20 Responsible Officer's Annual Report 2014/15 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 in quarter 3 (October –December).

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 2015).

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 **360** MTW doctors with such a connection, 338 completed an appraisal in the 2014/15 appraisal year ending 31.03.15. This is an overall appraisal rate of 94%. The rate varied with the grade of doctor: 97% consultants and 97% staff and associate specialists had an appraisal and 76% of the trust grade/locums and other grades had an MTW appraisal.

Quality assurance processes of the medical appraisal process were expanded in 13/14 to include use of the 'excellence' tool for reviewing appraisal outputs and by the performance of an audit of a sample of the portfolios of supporting information of 13 MTW doctors.

The national phased roll out of the medical revalidation required MTW to assign 40% of our doctors for revalidation during year 2 (2014/5). 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 130 positive revalidation recommendations and 38 deferral recommendations 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 in quarter 3 (October – December)

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;
- 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 which runs from October to December.

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

[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'

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 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 2012
- 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

- 360 doctors connected to MTW as at the end of 14/15 on 31.03.15
- 338 doctors had a completed appraisal (94%)

- 235/243 consultants (97%); 61/63 SAS doctors (97%) and 41/54 of other doctors (76%) completed an appraisal.

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

b. Appraisers

87 MTW doctors are listed on the MTW list of approved appraisers, (15 SAS doctors and 72 consultants). This also includes new appraisers who undertook training in 2014.

MTW appraisers attended one of four mandatory appraiser update sessions held in August and September 2014 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 14/15 round with anonymised comments from their appraisees and structured comments from the Trust appraisal lead.

The appraisal lead attended 2 of the 3 regional appraisal leads networks and 1 of 3 RO networks. He also attended Regional training sessions for RO appraisal held by NHS England (South) and undertook 5 quality assured appraisals of NHS Medical Directors in South of England. The RO attended 2 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 appraisal calibration events and 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 'excellence' 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 2014/15 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

130 MTW doctors were given a positive revalidation recommendation in the 14/15 year (18.6%). 38 doctors were deferred and 4 doctors were put on hold because of on-going GMC investigations. No 'non-engagement' notifications were made.

The common theme for deferral of revalidation was lack of formalised patient feedback through the MTW 360 appraisal system and poor evidence of participation in quality improvement activity.

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

7. Recruitment and engagement background checks

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

The Trust 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 Trust. 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 an overall improvement in appraisal rates and the quality of outputs and monitoring of medical appraisal at MTW.
- Enlarging the appraisal 'window' to include January and the allocation of doctors to one of 4 months eased the administrative burden
- 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. 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.
- An attempt to change the allocation of appraiser to a system of linking out-of-speciality did not meet with appraiser support and was abandoned. 30 doctors chose to have an appraiser who was not from their own speciality (9%).
- 22% doctors took longer than 28 days to submit their completed appraisal and 25% doctors had their appraisal interview later than the last day of their assigned month.
- Two consultants used an appraiser for a 4th consecutive appraisal contrary to Trust policy.
- One trust grade doctor had an appraisal with colleague who was not on the recognised list of MTW appraisers, contrary to Trust appraisal policy.
- There was some improvement in the consistency with which doctors declared their entire scope of practice and the supporting evidence they present in non-NHS roles.

- The ‘excellence’ tool for assessing the quality of appraisal summaries showed considerable improvement in the overall quality of appraiser performance in 14/15.
- Review of a random sample of appraisal portfolios of supporting information flagged issues on their structure presentation and organisation. Doctors provide insufficient evidence of personal reflection on the content of the portfolio.
- Although there was an impression of improvement of the quality of reflections on supporting information provided by doctors, they were not always present when required,
- Changes to the NHS England annual audit required modifications to local monitoring processes so that appraisals that took more than 28 days to be signed off were captured. This data showed that overall 26% of MTW appraisals fell into this category.
- Improvements to the GMC Connect website have eased monitoring of the revalidation of doctors at the Hospice in the Weald.
- There was very poor notification of the RO office of the appraisers selected for an individual’s appraisal in advance of the appraisal meeting.
- There was poor use of the appraisal deferral form from doctors who anticipated that they would have difficulty in doing a timely appraisal
- Two external reviews (Verita and Capsticks) flagged perceived issues with appraisal processes.

11. Board Reflections

- Appraisal rates are being 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 on June 2nd 2015 will make recommendations about our current appraisal and revalidation processes.

12. Corrective Actions, Improvement Plan and Next Steps for 15/16

- All doctors who had had 3 consecutive appraisals with the same appraiser will be identified and alerted to the need to change appraiser in the 15/16 round. Appraisers who have undertaken 3 consecutive appraisers will be similarly notified.

- The MTW appraisal forms will be modified to include explicit declarations around non-NHS work, to include private practice, educational and other roles which fall within their scope of practice.
- Guidance to doctors on the structure, content and presentation of their portfolio of supporting information will be issued in advance of the 15/16 round. The need for anonymisation of patient information will be emphasised.
- The ‘new starter’ form will be given to doctors by medical staffing, at appointment and/or at induction.
- Doctors will more actively asked to declare the name of their chosen appraiser at an early point in the appraisal round. Those who decline to nominate a suitable appraiser will be allocated one who may be from outside their speciality.
- Deferral of appraisal forms will be sought more actively from doctors known to be planning long term absence.
- Medical staffing and clinical governance teams need to provide consistent assistance and sustained support to the Medical Director’s office so that the administrative burden of this process is minimised and appropriate assurance given.
- The MTW appraisal and revalidation policy needs to updated.
- Monitoring of the high ‘late’ appraisal rate will be more rigorous and intervention will occur at an earlier point.
- The appraisal lead will investigate the suitability of alternatives to paper based systems to support the appraisal process.

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'	3
Sickness absence during the majority of the 'appraisal due window'	0
Prolonged leave during the majority of the 'appraisal due window'	0
Suspension during the majority of the 'appraisal due window'	0
New starter (after 1st July) – unknown previous appraisal history	10
Postponed due to incomplete portfolio/insufficient supporting information	0
Appraisal outputs not signed off by doctor within 28 days	87
Lack of time of doctor	0
Lack of engagement of doctor	1
Other doctor factors	12
Appraiser factors	
Unplanned absence of appraiser	0
Appraisal outputs not signed off by appraiser within 28 days	0
Lack of time of appraiser	0
Other appraiser factors (describe)	0
Organisational factors	
Administration or management factors	0
Failure of electronic information systems	0
Insufficient numbers of trained appraisers	0
Other organisational factors (describe)	0

Annual Report Template Appendix B: Quality assurance audit of appraisal inputs and outputs

Total number of appraisals completed		338
	Number of appraisal portfolios sampled (to demonstrate adequate sample size)	Number of the sampled appraisal portfolios deemed to be acceptable against standards
Appraisal inputs	20	18
Scope of work: Has a full scope of practice been described?	20	19
Continuing Professional Development (CPD): Is CPD compliant with GMC requirements?	20	19
Quality improvement activity: Is quality improvement activity compliant with GMC requirements?	20	15
Patient feedback exercise: Has a patient feedback exercise been completed? (in this appraisal or within this revalidation cycle)	20	13 (In 7/20 portfolios there was no evidence that 360 had been completed in the current cycle).
Colleague feedback exercise: Has a colleague feedback exercise been completed?	20	15
Review of complaints: Have all complaints been included?	20	20
Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?	20	20
Is there sufficient supporting information from all the doctor's roles and places of work?	20	19
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?	20	18

Appraisal Outputs	20	20
Appraisal Summary	20	20
Appraiser Statements	20	20
PDP	20	20

Comments:

The audit took a random sample of 6% of the 338 appraised doctors in the 2014/15 round. 20 portfolios were requested and all were received.

- The quality of the portfolios was very variable
- Some were very disorganised and this must have impeded effective appraisal.
- Personal reflections on supporting information were infrequent and of varying quality.
- Sometimes personal reflection was evident in the appraisal commentaries having been sought by the appraiser at interview.
- The paper based MTW system contributes to variability in the presentation of supporting information.
- Guidance to doctors is required on:
    - How to structure and subdivide their portfolio
    - The categories of information required
    - The need to anonymise all third party information
    - The need to provide information to evidence their non-NHS work
    - The requirement to include evidence of reflective practice
    - The need to avoid hand written information
    - The virtue of quality of information versus quantity (some of the portfolios were very bulky)

The review was conducted by The medical director / responsible officer and two deputy medical directors on

Annual Report Template Appendix C: Audit of revalidation recommendations

Revalidation recommendations between 1 April 2014 to 31 March 2015	
Recommendations completed on time (within the GMC recommendation window)	168
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	168
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	2	7	2	11
Capability concerns (as the primary category) in the last 12 months	0	3	0	3
Conduct concerns (as the primary category) in the last 12 months	2	4	0	6
Health concerns (as the primary category) in the last 12 months	0	0	2	2
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*				1
Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)				245
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)				64
General practitioner (for NHS England area teams only; doctors on a medical performers list, Armed Forces)				0
Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)				366
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)				1
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				31
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				707

Other Actions/Interventions	
Local Actions:	
Number of doctors who were suspended/excluded from practice between 1 April and 31 March: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included	3
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
1 week to 1 month	1
1 – 3 months	
3 - 6 months	1
6 - 12 months	
Number of doctors who have had local restrictions placed on their practice in the last 12 months?	1
GMC Actions: Number of doctors who:	
Were referred to the GMC between 1 April and 31 March	
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March	4
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March	1
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:	
For advice	3
For investigation	
For assessment	1
Number of NCAS investigations performed	
Number of NCAS assessments performed	1

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	14
Temporary employed doctors	284
Locums brought in to the designated body through a locum agency	Not available
Locums brought in to the designated body through 'Staff Bank' arrangements	32
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	330

For Providers – use of locum doctors:

Explanatory note: Number of locum sessions used (days) as a proportion of total medical establishment (days)

NB: this section may change as a result of the SCL Project

The total WTE headcount is included to show the proportion of the posts in each specialty that are covered by locum doctors

Locum use by specialty:	Total establishment in specialty (current approved WTE headcount)	Consultant: Overall number of locum days used	SAS doctors: Overall number of locum days used	Trainees (all grades): Overall number of locum days used	Total Overall number of locum (WTE) used
Surgery	128.65				10.82
Accident and Emergency & Specialty Medicine	209.8				18.68
Psychiatry	0				0

Locum use by specialty:	Total establishment in specialty (current approved WTE headcount)	Consultant: Overall number of locum days used	SAS doctors: Overall number of locum days used	Trainees (all grades): Overall number of locum days used	Total Overall number of locum (WTE) used
Obstetrics/Gynaecology	49.52				1.16
Children's	39				0.67
Diagnostics	52.67				3.56
Oncology	74.97				0.95
Trauma & Orthopaedic	47.41				4.97
Other	2				1.48
Total in designated body (This includes all doctors not just those with a prescribed connection)	673.67				39.15

A Framework of Quality Assurance for Responsible Officers and Revalidation

Appendix E - Statement of Compliance

Version 4, April 2014

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 14/15 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: 89 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 15/16 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 – May 2015

5-21	**Oversight Self-Certification, Month 1, 2015/16**	**Trust Secretary**

The enclosed schedule sets out the proposed oversight self-certification submission for month 1, 2015/16, based on performance as at 30th April. This submission must be sent to the NHS Trust Development Authority (TDA) by the end of May (i.e. by 29th).

A query has been raised with the TDA as to whether the monthly self-certification requirements for 2015/16 are the same as for 2014/15. A response has yet to be received, so it has been assumed that the requirements remain the same.

As Board members are aware, each month the Trust Board is required to self-assess against the questions contained in two self-certification documents under the TDA oversight process:
1. Monitor licence conditions; and
2. Board statements

The Trust is not required to provide supporting evidence (as listed in the "Evidence of Trust compliance" columns), and is just required to respond to each statement with "Yes" (i.e. compliant), "No" (i.e. not compliant) or "Risk" (i.e. at risk of non-compliance). If "No" or "Risk" is selected, a commentary on the actions being taken, and a target date for completion (in dd/mm/yyyy format), is required in order for the submission to be made.

The proposed self-assessment (and responses where required) for the latest submission are included in the "Latest assessment – Compliant?" column.

In relation to the Monitor licence conditions, there are some items which, as an aspirant Foundation Trust, the Board does not need to consider at the present time. These will however need to be understood and implemented as part of the trajectory to submit a Foundation Trust (FT) application. As had been agreed previously at the Board, the Trust will continue to declare non-compliance with such items, and the date by which the Trust will become compliant is proposed as 31/03/2017.

The evidence has been refreshed and updated from that reviewed at the Board in April 2015. Additions are highlighted, whilst deletions are shown as ~~struckthrough~~.

No change in compliant status is proposed from that agreed by the Board in April.

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

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
The Board is asked to:
1. Review the evidence presented to support the self-assessment (and amend if required); and
2. Approve the self-assessment for the forthcoming submission to the TDA

[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

Oversight Self Certification – Monitor Licence Conditions applicable to aspirant Foundation Trusts

General conditions

Condition	Evidence of Trust compliance / Commentary	Latest assessment – Compliant?
G4 – Fit and proper persons as Governors and Directors No unfit persons – undischarged bankrupts – imprisoned during last 5 years – disqualified Directors	All Trust Directors are "fit and proper" persons; confirmed through appointment process. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were approved by Parliament on 6th November 2014. The Regulations introduced a new requirement that Directors (or equivalent) of health service bodies be "fit and proper persons". The Care Quality Commission (CQC) will be able to insist on the removal of Directors that fail this test. Specifically, Directors should not be "unfit", which equates to not being an undischarged bankrupt; not having sequestration awarded in respect of their estate; not being the subject of a bankruptcy restrictions order; not being a person to whom a moratorium period under a debt relief order applies; not having made a composition or arrangement with, or granted a trust deed for, creditors; not being included in the children's barred list or the adults' barred list; and not being prohibited, by or under any enactment, from holding their office or position, or from carrying on any regulated activities[2]. In addition Directors need to be "of good character"[3], and have the health, qualifications, skills and experience to undertake the role. Finally, Directors should not have "been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity…". This latter restriction enables a judgement that a person is not fit to be a Director on the basis of any previous misconduct or incompetence in a previous role for a service provider. This would be the case even if the individual was working in a more junior capacity at that time (or working outside England). The Regulations apply to all Directors and "equivalents", which will include Executive Directors of NHS Trusts and Foundation Trusts. It is the responsibility of the provider and, in the case of NHS bodies, the chair, to ensure that all Directors meet the fitness test and do not meet any of the 'unfit' criteria. The Chair of a provider's board will need to confirm to the CQC that the fitness of all new Directors has been assessed in line with the new regulations; and declare to the CQC in writing that they are satisfied that they are fit and proper individuals for that role. The CQC may also ask the	Yes

[2] Regulated activities are listed in Schedule 1 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. They are: 'Personal care'; 'Accommodation for persons who require nursing or personal care'; 'Accommodation for persons who require treatment for substance misuse'; 'Treatment of disease, disorder or injury'; 'Assessment or medical treatment for persons detained under the Mental Health Act 1983'; 'Surgical procedures'; 'Diagnostic and screening procedures'; 'Management of supply of blood and blood-derived products etc'; 'Transport services, triage and medical advice provided remotely'; 'Maternity and midwifery services'; 'Termination of pregnancies'; 'Services in slimming clinics'; 'Nursing care'; and 'Family planning services'. Any provider carrying on any of these activities in England must register with the Care Quality Commission.

[3] In determining whether a Director is "of good character", consideration should be given as to whether the person has been convicted in the UK of any offence; or whether the person has been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals.

Condition	Evidence of Trust compliance / Commentary	Latest assessment – Compliant?
	provider to check the fitness of existing Directors and provide the same assurance to them, where concerns about such Director come to the CQC's attention. Although the Regulations will not, strictly speaking, be applied retrospectively, the Trust will likely need to ensure current Board members meet the Regulations' requirements for being "fit and proper". A proposed approach to the new Regulations was approved at the December 2014 Trust Board, and implementation has commenced (DBS checks are currently being processed for all Board members).	
G5 – Having regard to Monitor guidance – guidance exists or is being developed on: ▪ Monitors enforcement ▪ Monitors collection of cost information ▪ Choice and competition ▪ Commissioners rules ▪ Integrated Care ▪ Risk Assessment ▪ Commissioner requested services ▪ Operation of the risk pool	Monitor guidance is at varying degrees of progress through the consultation process. Trust response: **As an aspirant Foundation Trust, the guidance has not yet been fully reviewed and embedded. However the Trust will receive a summary of Monitor guidance requirements so that it can ensure compliance at a time appropriate to its foundation trust application trajectory.**	No Compliant by 31/03/2017
G7 – Registration with the Care Quality Commission	The Trust has full registration with the CQC. The Trust is registered to deliver the following regulated activities at both main hospital sites: 'Treatment of disease, disorder or injury'; 'Surgical procedures'; 'Diagnostic and screening procedures'; 'Maternity and midwifery services' and 'Family planning'. In addition, the Trust is registered to undertake 'Termination of pregnancies' at Tunbridge Wells Hospital.	Yes
G8 – Patient eligibility and selection criteria (for services and accepting referrals) ▪ Criteria are transparent ▪ Criteria are published	The Referral and Treatment Criteria (RATC) which apply from 1st April 20~~14~~15 are published on the West Kent CCG website ("Kent and Medway clinical commissioning groups' (CCGs') schedule of policy statements for health care interventions, and referral and treatment criteria").	Yes

Pricing conditions

Condition	Evidence of Trust compliance	Latest assessment – Compliant?
P1 – Recording of Information (about costs) to support the Monitor pricing function by the prompt submission of information	Trust response: **As an aspirant Foundation Trust, the requirement has not yet been fully reviewed and embedded. However the Trust will receive a summary of the Monitor pricing condition so that it can ensure compliance at a time appropriate to its foundation trust application trajectory** An action plan is required to ensure readiness to comply with all Monitor Pricing conditions at the required time (the Director of Finance will be responsible for leading on this).	No Compliant by 31/03/2017
P2 – **Provision of information** to Monitor about the cost of service provision	Trust response: **As an aspirant Foundation Trust, the requirement has not yet been fully reviewed and embedded. However the Trust will receive a summary of the Monitor information condition so that it can ensure compliance at a time appropriate to its foundation trust application trajectory**	No Compliant by 31/03/2017
P3 – Assurance report on submissions to Monitor. To ensure that information is of high quality, Monitor may require Trusts to submit an assurance report	Trust response: **As an aspirant Foundation Trust, the requirement has not yet been fully reviewed and embedded. However the Trust will receive a summary of the Monitor assurance reporting condition so that it can ensure compliance at a time appropriate to its foundation trust application trajectory**	No Compliant by 31/03/2017
P4 – Compliance with the national tariff (or to agree local prices in line with rules contained in the National tariff)	The Trust is compliant with the national tariff and where local tariffs are applied, are subject to negotiation and agreement with the CCG/Commissioners.	Yes
P5 – Constructive engagement concerning local tariff modifications The aim is to encourage local agreement between commissioners and providers where it is uneconomical to provide a service at national tariff; thereby minimising Monitors need to set a modified tariff.	The Trust is compliant with the national tariff and where local tariffs are applied, are subject to negotiation and agreement with the CCG/Commissioners.	Yes

Competition conditions

Condition	Evidence of Trust compliance	Latest assessment – Compliant?
C1 – Right of patients to make choices Providers must notify patients when they have a choice of provider, make information about services available, and not offer gifts/inducements for patient referrals. Choice would apply to both nationally determined and locally introduced patient choices of provider.	The Trust complies with the philosophy of patient choice, with regards to choice of provider. The Trust has not taken any actions to inhibit patient choice. The development of private patient services, the development of a birthing centre and the response to the KIMS private hospital are examples where the Trust has increased patient choice.	Yes
C2 – Competition Oversight Providers cannot enter into agreements which may prevent, restrict or distort competition (against the interests of healthcare users).	The Trust does not seek to inhibit competition.	Yes

Integrated care conditions

Condition	Evidence of Trust compliance	Latest assessment – Compliant?
IC1 – Provision of Integrated Care Trusts are prohibited from doing anything that could be regarded as detrimental to enabling integrated care. Actions must be in the best interests of patients.	The Trust does nothing to inhibit integration and positively advocates it where integration is in the patient's best interests.	Yes

Oversight Self Certification – Board Statements

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
For clinical quality, that: 1. the Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's oversight model (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients	▪ The Trust's integrated performance dashboard is reviewed monthly and includes the TDA's "routine quality & governance indicators" ▪ A "Clinical Quality & Patient Safety Report" report is submitted to the Trust Board ▪ The Quality & Safety Committee, and its sub-committees, provides a focus on quality issues arising from Directorates. A summary of each Quality & Safety Committee meeting is reported to the Board ▪ The Patient Experience Committee provides a patient perspective and input ▪ The Chief Nurse, a Board member, is accountable for quality ▪ There are dedicated complaints and Serious Incidents (SI) management functions ▪ Ongoing conduct of Family and Friends Test is reported through the Trust performance dashboard ▪ Patient stories are heard at Trust Board meetings ▪ SI report summaries are circulated to all Board members ▪ Board member visits to wards and departments enable triangulation of quality and other performance indicators. Pairings of NED and Executive Board members, to further promote such visits, have now been issued. Board members also participate in the conduct of Care Assurance Audits ▪ Systems investment (e.g. Q-Pulse, Symbiotix, Dr Foster) supports effective quality information/data management ▪ Quality Accounts have been developed in liaison with stakeholders ▪ Quality Impact Assessments conducted on all CIP initiatives ▪ Priority of patient care reflected in Trust values & embedded in staff appraisal The independent assessment of the Trust's Quality Governance Framework has largely endorsed the Trust's self-assessment and gave a validated score of 3.5; an action plan has been drafted to	Yes

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
	achieve further improvements. Further improvements include: - strengthening the processes through which learning is shared and embedded has been recognised, and - developing further benchmarks to support the assurance & target setting process The final report of the Trust's inspection by the Care Quality Commission in October 2014 was published in February 2015, and confirms that Trust's overall rating as 'Requires Improvement'. A Quality Improvement Plan has been developed in response, and has been submitted to the CQC. It ~~will be~~ is monitored via monthly reports to the Trust Management Executive and Trust Board.	
For clinical quality, that: 2. the board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements	The Trust has full registration with the CQC. The Trust is registered to deliver the following regulated activities at both main hospital sites: 'Treatment of disease, disorder or injury'; 'Surgical procedures'; 'Diagnostic and screening procedures'; 'Maternity and midwifery services'; and 'Family planning'. In addition, the Trust is registered to undertake 'Termination of pregnancies' at Tunbridge Wells Hospital. The final report of the Trust's inspection by the Care Quality Commission in October 2014 was published in February 2015, and confirms that Trust's overall rating as 'Requires Improvement'. A Quality Improvement Plan has been developed in response, and has been submitted to the CQC. It ~~will be~~ is monitored via monthly reports to the Trust Management Executive and Trust Board.	Yes
For clinical quality, that: 3. the board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.	The Medical Director is the responsible officer for medical practitioner revalidation. The Trust Board in May 2014 received the 2013/14 Annual Report from the Responsible Officer, and approved a 'statement of compliance' confirming that the Trust, as a designated body, was in compliance with the regulations governing appraisal and revalidation. The May 2015 Trust Board is scheduled to receive the 2014/15 Annual Report from the Responsible Officer.	Yes
For finance, that: 4. the board is satisfied that the trust shall at all times remain a going concern, as defined by the most up to date accounting standards in force from time to time	~~Trust response:~~ The Trust reported a deficit for 2013/14 and the financial situation is under ongoing review with the TDA. The Trust was recently awarded £12m of non-recurrent funding by the TDA for 2014/15. The Trust continues to operate as a going concern,	Yes

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
	and the 2014/15 financial accounts have been ~~are being~~ prepared on this basis. The External "The Audit Findings" report for 2014/15 states that "We have reviewed the Directors' assessment and are satisfied with managements assessment that the going concern basis is appropriate for the 2014/15 financial statements". The Trust achieved a small surplus in 2014/15, and the Trust Board will be asked to approve the 2014/15 Accounts in May 2015.	
For governance, that 5. the board will ensure that the trust remains at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times	The NTDA accountability framework aims to ensure that Trusts have a real focus on the quality of care provided. Under this framework, quality focus is achieved through: (i) Planning – the Trust conducts an annual process of service and budget planning and the Board reviews and agrees the IBP (ii) Oversight – the Trust participates fully in the oversight model (self-certification, review meetings) (iii) Escalation – The Trust welcomes support from the TDA and will cooperate fully with escalation decisions. ~~The Trust, has fully engaged with a risk summit of performance issues (c.diff, surgical trainees, A&E)~~ (iv) Development – the Trust will embrace the development model as appropriate. ~~The Trust has committed to development programmes for (i) Board members; (ii) Executive team, (iii) Clinical Directors and (iv) General Managers/Matrons.~~ (v) Approvals – the Trust is fully engaged in the FT application process and is awaiting dialogue with the TDA on the timetable towards authorisation. Trust values and priorities mirror the TDA's underpinning principles: ▪ local accountability – e.g. liaison with CCGs, Patient Experience Committee, patient satisfaction monitoring, whistleblowing & complaints management ▪ openness and transparency – e.g. embedded in Trust value on respect; duty of candour in Board Code of Conduct; open approach to Public Board meetings (which ~~now~~ take place each month) and both external &, internal communications channels; a growing membership	Yes

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
	▪ making better care easy to achieve – the Trust's stated priority, above all things, is the provision of high quality & safe care to patients (Patient First). ▪ an integrated approach to business – the Trust has adopted an integrated governance approach including an integrated performance dashboard.	
For governance, that: 6. all current key risks to compliance with the NTDA's Accountability Framework have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues in a timely manner.	See 5 above. In addition: ▪ The Trust monitors performance each month in accordance with the TDA Quality and Governance indicators. A Board Assurance Framework and ~~Board level~~ risk register, supported by an overall Risk Management Policy, are established and scrutinised by ~~accountable Executive Directors~~ various Committees ▪ Risks receive ~~ongoing~~ regular scrutiny and assurance ▪ Mitigating actions have agreed dates for delivery ▪ An annual Internal Audit plan is agreed and focuses on areas of key risk ▪ A professional Trust Secretary is employed ▪ A dedicated Risk Manager is employed ▪ The Trust fully participates in the TDA Oversight process ▪ The independent assessment of the BGAF & QGF was conducted in July 2013 and the positive results reported to the Trust Board in September 2013; a follow up review conducted in December 2103 re-affirmed the assessment.	Yes
For governance, that: 7. the board has considered all likely future risks to compliance with the NTDA Accountability Framework and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance	See 6 above. In addition: All risks are RAG rated according to severity and likelihood; mitigating actions are monitored and reported. Key risks to the Trust's agreed objectives are reported via the Board Assurance Framework.	Yes
For governance, that: 8. the necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations	The Board and its sub-committees are involved in the development of the Trust's annual plans, including specific aspects as required (financial, winter pressures, infection control, health and safety etc.). Key risks to the Trust's agreed objectives are reported via the Board Assurance Framework.	Yes

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
accepted by the board are implemented satisfactorily.	The Audit and Governance Committee, like all Board committees, provides a report to the Board following each meeting which is presented by the Committee Chair (a NED). The Board is fully engaged with the development of the IBP and the Clinical Strategy that underpins it.	
For governance, that: 9. an Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).	The Annual Governance Statement 2013/14 was agreed by the Trust Board in May 2014. The ~~guidance for the 2014/15 Governance Statement has now been issued, and the~~ 2014/15 draft Statement ~~has been agreed by the Trust Management Executive. It will be~~ was submitted to the NHS TDA (and the Trust's auditors) by the required deadline of 23rd April 2015, and the Trust Board in May 2015 will be asked to approve the final version.	Yes
For governance, that: 10. the Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward	Quality and governance indicators are monitored by the Board each month through the integrated performance dashboard. The Board is committed to achieving all targets and has set the vision of being in the best 20% of acute trusts nationally. Although the Trust did not meet the required performance (95%) in terms of the A&E 4 hour waiting time target for the 2014/15 year, the Board confirmed (in February 2015) that a compliance status of "Yes" was appropriate for the statement, on the basis that the Trust's plans were sufficient to deliver the 4-hour A&E waiting time target, even though the target would not actually be met.	Yes
For governance, that: 11. the trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit	The Trust has achieved IG toolkit level 2 for 2014/15 against all Requirements. The submission was approved by the Trust Board in March 2015	Compliant
For governance, that: 12. the board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.	A Trust Board Code of Conduct is in place which confirms the requirement to comply with the Nolan principles of selflessness, integrity, objectivity, accountability, openness, honesty and leadership. A register of Directors' interests is maintained and Board members are invited to declare any interests relevant to the agenda at the beginning of each Board meeting, and each Board sub-committee.	Compliant

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
	The Register of Directors' Interests was refreshed in March/April 2015, and features within the Annual Report for 2014/15, which the Trust Board will be asked to approve in May 2015. A new Non-Executive Director commenced in September 2014, which means that all formal Board positions are now filled substantively.	
For governance, that: 13. the board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.	▪ A launch session for the Board development programme for 2014 took place in December 2013, facilitated by Hay Group; this will synchronise with separate Executive Director, Clinical Director, General Manager/Matron development programmes. ▪ The Remuneration Committee reviews the performance of Executive Directors. ▪ The TDA has conducted a review of the Trust Board. ▪ The Trust continues to adhere to the Oversight process ▪ A proposed approach to the new 'fit and proper persons' Regulations was approved at the December 2014 Trust Board, and implementation has commenced (DBS checks are currently being processed for all Board members).	Compliant
For governance, that: 14. the board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan	▪ All Executive Director (and Clinical Director) positions are filled. ▪ The objectives of Executive Directors cascade from the Trust's corporate objectives which are agreed by the Trust Board. The Trust Board agreed the Trust's objectives for 2014/15 in September 2014, and agreed that these objectives should also apply for the 2015/16 year (subject to minor amendments regarding specific targets)	Compliant

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - May 2015

5-22	Annual Report 2014/15 (including Governance Statement)	Audit and Governance Committee Chairman

NHS Trusts are required by statute[1] to produce an Annual Report. The minimum content for such Annual Reports is prescribed by the Department of Health, through its „Manual for Accounts'. The Manual also states that "Beyond this [minimum content] however, the entity must take ownership of the annual report and ensure that additional information is included where necessary to reflect the position of the NHS body within the community and give sufficient information to meet the requirements of public accountability".

The draft Annual Report is required to be provided to the External Auditors, as part of their Audit of the financial accounts, and this was duly provided to Auditors on 23rd April 2015. The draft Governance Statement was provided to the NHS Trust Development Authority on the same date. Although the Governance Statement is included within the Annual Report, technically the Statement forms part of the Annual Accounts.

The draft Annual Report (including Governance Statement) was then reviewed by the Audit and Governance Committee on 6th May, and a number of amendments have since been made in response to comments received. Some accuracy errors have also been corrected (the exact details of these have been highlighted to the Audit and Governance Committee). The enclosed document also incorporates recent comments received from the Executive Directors and the Trust's Head of Communications.

The enclosed Annual Report therefore represents the final version, and has been submitted to review by the Audit and Governance Committee, which meets on 27th May, before the Trust Board.

The Audit and Governance Committee will be asked to review the Report in detail, and recommend that the Trust Board approves the document. The outcome of the Audit and Governance Committee's review will be provided verbally at the Trust Board on 27th May.

The final document will include the "Independent auditor's report to the Directors of the Trust", and the Annual Report and Accounts will be combined (the full Accounts will be inserted at the end of the Annual Report). It should also be noted that there may be further minor layout / design changes between now and the date that printed versions of the document will be produced (the Trust's Annual General Meeting, on 17th September 2015). However, such changes will be cosmetic, and the text will not be changed from that approved by the Board.

Which Committees have reviewed the information prior to Board submission?

- Audit and Governance Committee, 27/05/15

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [2]

To review and approve the Annual Report (including Governance Statement) for 2014/15

[1] The National Health Service and Community Care Act 1990

[2] 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 and Accounts 2014/15

taking pride

Patient First - Respect - Innovation - Delivery - Excellence

About this Annual Report

The National Health Service and Community Care Act 1990 requires NHS Trusts to produce an Annual Report. The content and format of such Annual Reports is required to follow the guidance issued by the Department of Health (in the form of a 'Manual for Accounts'). The specific requirements for Annual Reports for 2014/15 are that NHS bodies must publish, as a single document, the following:

The Annual Report comprising the: Strategic Report, Directors' report, Remuneration report' and Sustainability report;

- A statement of the Accountable Officer's responsibilities;
- A Governance Statement;
- The Audit Opinion and Report; and
- The Primary Financial Statements and Notes to the accounts

The Department of Health's guidance sets out the minimum content of the Annual Report. Beyond this however, the Trust is expected to take ownership of the Report and ensure that additional information is included where necessary to reflect the position of the Trust within the community and give sufficient information to meet the requirements of public accountability.

This document contains the content mandated by the Department of Health, but also includes details of events and developments that, when read with the mandated content, give an accurate picture of how the Trust performed during 2014/15. The document is divided into several sections:

- The "Strategic Report for 2014/15". This includes business information about the Trust; the Chairman and Chief Executive's report; Performance against the 2014/15 plans; and details of the Trust's staff;
- A summary of the Trust's Quality Accounts for 2014/15
- The "Sustainability Report for 2014/15". This follows the standard reporting format from the NHS Sustainable Development Unit
- The "Directors' Report for 2014/15". This includes details of the Trust Board; a Statement as to disclosure to auditors; Pension Liabilities, exit packages and severance payments; details of Directors' interests; the Trust's application of the 'Principles for Remedy' guidance; disclosure of "incidents involving data loss or confidentiality breaches"; details of the Trust's Health and Safety and Emergency Preparedness arrangements; and a review of financial performance for 2014/15 (including performance against the 'Better Payments Practice' and 'Prompt Payments' Codes, and details of Counter Fraud arrangements'); and staff sickness absence data
- The "Remuneration Report for 2014/15" (including details of 'off-payroll' engagements)
- The "Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust"
- The "Governance Statement for 2014/15"
- Independent auditor's report to the Directors of Maidstone and Tunbridge Wells NHS Trust and
- The Primary Financial Statement and Notes for 2014/15

The Annual Report was approved by the Trust Board of Maidstone and Tunbridge Wells NHS Trust on 27th May 2015.

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Maidstone and Tunbridge Wells NHS
NHS Trust

Strategic Report for 2014/15

taking Pride

About Maidstone and Tunbridge Wells NHS Trust

Maidstone and Tunbridge Wells NHS Trust (the Trust) is a large acute hospital Trust in the south east of England. The Trust was legally established on 14th February 2000[1], and provides a full range of general hospital services and some areas of specialist complex care to around 560,000 people living in the south of West Kent and the north of East Sussex.

The Trust's core catchment areas are Maidstone and Tunbridge Wells and their surrounding Boroughs, and it operates from two main clinical sites: Maidstone Hospital, and Tunbridge Wells Hospital at Pembury. The latter is a Private Finance Initiative (PFI) hospital [2] and provides wholly single bedded en-suite accommodation for in-patients. The Trust employs a team of over 5000 full and part-time staff.

In addition, the Trust provides specialist Cancer services to circa 1.8 million people across Kent, Hastings and Rother, via the Kent Oncology Centre, which is sited at Maidstone Hospital and at Kent and Canterbury Hospital in Canterbury. The Trust also provides Stroke Rehabilitation at Tonbridge Cottage Hospital, as well as providing Outpatient clinics across a wide range of locations in Kent and East Sussex.

[1] The Maidstone and Tunbridge Wells National Health Service Trust (Establishment) Order 2000
[2] The PFI Project Company is "Kent and East Sussex Weald Hospital Ltd" (KESWHL)

Chairman and Chief Executive's report

We would like to welcome you to our Annual Report for 2014/15. It remains our absolute aim to ensure safe, compassionate and sustainable health services are provided for patients in all areas and at every level of Maidstone and Tunbridge Wells NHS Trust (MTW).

During the year we maintained, and continued to deliver, safe, high standards of care, throughout prolonged periods of unprecedented demand for unplanned inpatient acute NHS care.

This was a key factor for MTW from October to March and it is testament to the skills and determination of our healthcare professionals, clinical leadership and organisational planning, that many hundreds of patients with higher levels of acuity and complex discharge needs, continued to receive good outcomes within a harm-free and caring environment.

For example, 96.7% of the inpatients we treated during 2014/15, as measured by the national Patient Safety Thermometer initiative, received harm-free care. Our clinical teams also achieved a 20% reduction in cases of Clostridium difficile. There are many other areas of good clinical practice and safer outcomes for patients covered in this report.

Despite our best efforts, due to the unprecedented demand for emergency care, we did not always consistently meet all of our waiting time standards during this time, and this is reflected in some areas of overall performance for the year. We have revised our 2015/16 planning in the light of this.

We are working with our partners throughout the local health economy, and taking a leadership role in meeting the changing needs of our patients during 2015/16. We do not envisage a reduction in unplanned admissions for year ahead and are therefore opening a new medical ward at Tunbridge Wells Hospital and a new elderly care ward at Maidstone, to better support flows of planned and unplanned patients through our hospitals.

The unprecedented increase in unplanned admissions, and longer lengths of stay associated with an increase in the age and acuity (and complex discharge needs) of our patients, had a financial consequence for MTW, increasing our cost base through the earlier opening, and longer use of, our escalation wards, and associated increase in agency staffing to support our clinical teams.

MTW achieved £23.8 million in efficiency savings without impacting on frontline patient services and care during 2014/15 and we ended the year with a small surplus. We managed this position by reducing costs, getting better procurement deals, cutting waste and bringing modern cost-effective systems into the NHS. We received £12 million in non-recurrent deficit funding from the Department of Health, by meeting our agreed improvement plan to steadily and sustainably return to financial balance.

We face a similar financial challenge in 2015/16 with efficiency savings needed totalling £23 million, and a planned deficit position of £13 million. This is in line with our long-term, and previously reported plans to steadily return to financial balance, while improving our patient experience by driving up the quality and safety of our services with low rates of infection, low rates of avoidable patient harms, and generally high levels of patient satisfaction.

We had our first full review by the Care Quality Commission (CQC), under its new `Chief Inspector of Hospitals' process in October 2014. Although we were disappointed to be rated as `Requires Improvement' we were pleased that inspectors found our staff to be caring and compassionate across all areas and saw the inspection as a positive opportunity to support improvements in patient care. At the same time, the CQC recognised there are many examples of good and excellent practice throughout our hospitals and that our

nurse staffing levels are good. It is our aim to ensure these areas of excellence are reflected throughout our organisation during 2015/16 both by sharing the good practice we have and by learning from others.

In January 2015, we received a high level of support from our partners in the local health economy at a Health Summit, which was arranged following the CQC inspection. We have a clear direction of travel to further improve patient care, which is supported by our partners, and we are working hard to achieve all of the improvements identified during our inspection.

We are strongly supporting the NHS Duty of Candour and are an open and honest organisation that seeks to learn both from its own mistakes and when things go wrong in other organisations. As part of our learning, we have benefited from having patients and patients' relatives share their experiences with us in person at our monthly public board meetings. We would like to thank these people again through our Annual Report, for sharing their powerful stories with us and helping us shape our journey of improvement.

Our overall high-level objectives for the year ahead, as part of our strategic plan, are:

- To transform the way we deliver services so that they continue to meet the needs of our patients
- To deliver services that are clinically viable and financially sustainable
- To actively work in partnership to develop a joint approach to future local health care provision

These objectives reflect our experience and endeavours both in 2014/15 and in the year ahead. We hope you enjoy our Annual Report.

Glenn Douglas, Chief Executive

27th May 2015

Anthony Jones, Chairman of the Trust Board

27th May 2015

Performance against our 2014/15 plans

The Trust's annual objectives for 2014/15 are covered under 3 themes, as follows:

- To transform the way we deliver services so that they meet the needs of patients;
- To deliver services that are clinically viable and financially sustainable; and
- To actively work in partnership to develop a joint approach to future local health care provision

The Trust's performance under each of these aims is outlined below.

To transform the way we deliver services so that they meet the needs of patients

The Trust performed excellently against the Department of Health objective of having no more than 40 Clostridium difficile cases, and had a total of 28 cases for the year, which was 7 cases (20%) fewer than for 2013/14. The Trust also reported only 1 case of MRSA bacteraemia, which was 2 fewer than 2013/14. The Trust also made positive steps towards increasing the level of clinical services that are available seven days a week.

The Trust made concerted efforts to improve the quality of its Stroke service, and was pleased to see that the latest data from the Sentinel Stroke National Audit Programme (SSNAP) showed that such efforts had resulted in improved ratings. The Trust also achieved the required standard of 80% of Stroke patients spending 90% of their time on a Stroke Ward, and we look forward to continuing to improve the delivery of our Stroke service in 2015/16.

To deliver services that are clinically viable and financially sustainable

One of the most significant challenges faced by the Trust during the year was in managing the sustained increase in clinical activity, which, when combined with increases in the acuity and complexity of patient's conditions, had an adverse impact on our ability to achieve the required performance against the 4-hour A&E waiting time target (the Trust's performance was 92% compared to the target of 95%). However, the Trust achieved the 95% target for patients being assessed in A&E within 15 minutes. Other notable achievements include achieving 8 out of 9 Cancer Waiting Time Targets; achieving the aggregate Trust level standards for all 3 pathways (admitted, non-admitted and incomplete) for the 18-week waiting time targets; and achieving the standard for operations cancelled at the last minute of below 0.8% for the sixth year running. The Trust also delivered its main financial target for the year, and returned a surplus of £157,000. This was a hard fought achievement, which included delivering efficiency savings of £23.8 million.

To actively work in partnership to develop a joint approach to future local health care provision

The Trust developed a new Strategy, 'Moving Forward -2015/16 to 2019/20' in the year, and continued to take a leading role with our stakeholders in the Local Health and Social Care economy with regards to tackling some of the system-wide issues that affected all providers during 2014/15. This role will continue to be important during 2015/16, and the Trust is committed to working with our partners to identify sustainable solutions.

Leading the way in Lung Cancer and Bronchial care

A service launched by the Trust at the start of October 2013 has progressed thanks to another generous donation by the Peggy Wood Foundation cancer charity. The Endobronchial Ultrasound (EBUS) can help with carrying out an accurate biopsy of lymph glands, via a bronchoscope with an ultrasound sensor tip and a processor, which assists in diagnosing and accurately staging Lung Cancer. It also helps in diagnosing other types of cancers.

With the donation of more equipment, a microscope, camera and HD monitor, the EBUS service is now complimented by a Rapid access Onsite Slide Evaluation (ROSE) service, which means Consultants performing the procedure should know immediately if an adequate sample has been taken from a patient's lymph glands, and results can be confirmed (with further testing) in a matter of days. Prior to the EBUS and ROSE services being introduced, patients had to travel to London, which sometimes resulted in a two to three week delay in examination and then further weeks lost waiting for results. EBUS and ROSE complement the Endoscopic Ultrasound (EUS) service already run by the Trust. MTW is the only Trust in Kent to provide both EBUS with ROSE techniques, as well as having EBUS and EUS on the same site for the investigations of lymph glands.

National recognition for Infection Control

Our Infection Prevention and Control Team were named as the top Acute Trust in the category of Infection Prevention Team of the Year at the Infection Prevention Society (IPS) annual meeting and awards event.

The IPS Awards are in their second year and recognise excellence, energy and results, in the field of infection prevention and control. The award ceremony took place in September in Glasgow and was attended by Dr Sara Mumford, Director of Infection Prevention and Control and members of the Infection Control team.

The Team were recognised for their clear focus, effective teamwork, leadership and their 'design and implementation of a rapid improvement programme which has had a dramatic impact on both infection and cross infection'.

Maternity services

In 2014, a total of 5,625 babies were born at Tunbridge Wells Hospital or the Maidstone Birth Centre (421 at the Birth Centre). That's around 187 school classes!

2014 was the busiest year ever for the maternity department at Tunbridge Wells Hospital. The team has continued to work to give the environment a more homely feel and two lounge areas have also been created for women and their partners to relax and to have somewhere to meet others. The Tunbridge Wells Hospital League of Friends kindly donated funds to purchase some telemetry units so that women needing to be monitored during labour can do so without having their movement restricted. The units can also be used in the birth pools, which has helped to offer more choice and has increased the number of women having water births.

For women having their labour induced, the process can often seem long and drawn out and the team wanted to improve the experience. As such, they have introduced the role of Induction Coordinator – this midwife cares for all of the women having an induction and liaises closely with the staff on the delivery suite to ensure safe prioritisation and improved communication to women so they can be kept up to date with what is going on.

Kangaroo Care (skin to skin contact) continues to be promoted by the maternity team across both sites and it is hoped that it will become standard for all mothers to use Kangaroo Care. The benefits of Kangaroo Care have been recognised internationally and a delegation from the Chinese Health Department visited recently to find out more (you can read more about this elsewhere in this Report).

Research has shown that giving birth in a Birth Centre is as safe for women with an uncomplicated pregnancy as it is in hospital. Most women giving birth at the Maidstone Birth Centre came from the local area; however several women travelled a considerable distance because they have heard of the excellent care and facilities on offer (the Birth Centre is available for anyone under the Trust's care to use, subject to them being deemed suitable). Since the Centre opened 3 years ago, more than 1,300 babies have been born there, and the Friends and Family Test and Maternity Survey show that these women are extremely happy with the care they receive.

There were several developments at the Centre in 2014, including a new technique being trialled to help relieve back pain during labour. Six midwives also completed a course enabling them to carry out 'first baby checks', and prevent women from needing to attend other hospital departments for such checks, and each month, the Centre receives around 1,000 calls requesting advice and support (which helps reduce pressure on other services both within the community and the hospitals).

Inspiring technology

Health Informatics is a key element and foundation to supporting the delivery of the Trust's vision. Through the creation, shaping, sharing and application of patient data and the deployment of appropriate technologies, Health Informatics can support service planning, the delivery of the Trust's clinical strategy, and decision-making to achieve desired outcomes for the quality of treatment and patient experience.

The Trust's Health Informatics strategy was approved by the Trust Board in September 2013 and is focused on delivering…**I**ntegrated systems to **S**upport our **P**atients **I**n **RE**al time – **INSPIRE**.

INSPIRE sets out how the Trust can maximise the benefit from the investment already made and exploit it further to enable staff to care for patients in a more responsive, safer way and support the wider Trust's clinical strategy and business plans. INSPIRE will:

- Give patients access to the information we hold about them and their treatment plans
- Give our clinical and operational staff a single and unified view of our patients
- Facilitate the delivery of integrated care in our locality by enabling the secure sharing of patient data
- Enable clinical services to go 'paperless' and reduce the burden of paper

Supported by a number of strategic and technical principles, a 5-year roadmap has been developed that will see the Trust achieve a fully integrated electronic patient record available to clinicians in the Trust, patients and commissioners by 2018. The INSPIRE strategy made good progress in 2014/15…

- The Trust was successful in obtaining £802,000 of funding from the "Safe Hospitals, Safer Wards" Technology Fund 1 for an Electronic Document Management system which will deliver an interactive view of patients medical history with access via PCs and mobile/handheld devices.
- The Trust was successful in obtaining £670,000 from the Nurse Technology Fund 2 for deployment of Nursing observations, including vital signs and Doctor handover, which will commence in summer 2015
- The Trust is leading the implementation of Chemotherapy e-prescribing across all 4 of the acute hospitals in Kent and Medway, which will reduce the risk in prescription errors, ensure easier visibility of patients chemotherapy treatment supporting shared care and meet the requirements of the NHS Standard Contract for Cancer Services

- The GP Kinesis 'Conferrals' system, which has been procured by our partners in West Kent Clinical Commissioning Group (CCG), has been introduced in a number of specialities. This will be a secure web-based software system that directly links GPs to hospital specialists for rapid access to expert advice on referral questions. The system will improve patient experience and pathway, reducing outpatient activity and unnecessary referrals, improve levels of service and reduce costs
- The Trust is working with West Kent CCG to implement a care pathway management system which will enable all providers of care to access a shared care record

Our staff

Although providing the best possible healthcare to our population is, and always will be, our primary focus, we take our responsibilities as an employer seriously. The year saw a reduction in our turnover rates (which measures how long our staff stay in post), increases in the number of permanent staff employed and a heightened level of satisfaction with the Trust as an employer. In 2014, the Trust took part in the 12th annual National NHS Staff Survey, and had a 51% response rate, which was in the highest 20% of acute Trusts. Overall, the survey showed a strong set of results since the 2013 survey and of the 29 key findings, 16 were better than national average, 8 were average, and 5 were worse than average, placing the Trust as one of the best hospital employers in Kent and Medway. The Trust scored highest in the country for the percentage of staff who felt they had been appraised (96%).

Whilst the overall results were good, there are some areas on which the Trust needs to focus:

- Address equality and diversity issues from the point of view of staff and patients
- Creating more meaningful engagement with staff
- Delivering a consistent shift in the prevailing leadership style and
- Shift emphasis to more strategic leadership rather than day-to-day leadership

Employee consultation (understanding and learning from the views of staff)

The Trust meets with local Trade Union representatives formally, via the Joint Staff Consultative Committee. A quarterly Open Staff Meeting system also operates, to cascade information to all staff, which involves a face-to-face meeting with two Executive Directors (including the Chief Executive) at both hospital sites. A weekly Chief Executive's update ("Glenn's update") is issued to all staff via email, enabling key messages to be given on matters of note. An in-house staff newsletter, "Pride", is also produced and distributed. The Trust also conducts 'Impressions' surveys throughout the year to ask staff their views. Three such surveys were undertaken in 2014/15.

The Trust has a range of support mechanisms for staff, beyond that provided by their line manager. This includes counselling services, and full Occupational Health services.

Equal opportunities

The Trust is committed to being an organisation within which diversity , equality and human rights are valued and appreciated, recognising that everyone is different, valuing the unique contribution that individual experience, knowledge and skills can make in delivering service goals and that this is visible at all levels of the organisation.

The Trust is committed to continuous development of services, which are open, equally accessible and meet the needs of all sections of the community served. We continue to strive to provide an environment in which people want to work and to be a model employer leading in good employment practices. The Trust is also committed to enabling each member of staff to achieve their full potential in an environment characterised by dignity and mutual respect.

The gender distribution of staff employed at the end of 2014/15 is as follows (the 2013/14 equivalent is in brackets):

	Male		Female	
Trust Board members *	9 (8)	64% (57%)	5 (6)	36% (43%)
Employees (head count)	1310 (1471)	24% (26%)	4164 (4141)	76% (74%)

* Includes non-voting Board members (refer to the 'Trust Board' section later in the Report for details)

Staff Sickness absence

This information is contained in the 'Financial performance' section below.

Disabled employees

The Trust has continued its commitments as a 'Two Ticks' Disability Symbol employer. The symbol is awarded in recognition of positive commitments regarding the employment, retention, training and career development of disabled people. In 2014/15 the Trust:

- Interviewed all applicants with a disability who met the minimum short-listing criteria
- Ensured there was a mechanism in place to annually discuss with disabled employees what we can do to ensure they develop and use their abilities
- Made every effort when employees become disabled to make sure they stay in employment
- Took action to ensure that all employees develop disability awareness and
- Reviewed the achievements against each of the 5 commitments to identify ways to continuously improve and maintain 'Two Tick' recognition

Education and Development

The Trust supported many hundreds of staff during the year to attain educational qualifications, from NVQ to Doctorate. We know that staff want the opportunity to develop to improve the service offered to our patients. We also know that medical staff in training like to come to the Trust, and when they do the developmental opportunities they receive are of the highest standard. This in turn provides the medical workforce of the future. We will continue to provide opportunities to all our staff in the years to come.

New eye treatment reduces hospital visits

A new long-lasting eye treatment for patients with vision loss has been introduced by the Trust. A tiny implant that slowly releases a drug is inserted into the eye and lasts for up to 3 years. Previously patients were required to have injections every month.

The implant is used to treat patients with diabetic macular oedema, a condition that affects some people with diabetes and causes damage to the light-sensitive layer at the back of the eye. It helps to reduce inflammation and the swelling that builds up in the macula as a result of the condition. The injection is administered in theatre by an eye specialist and helps to improve damaged vision or prevent it from getting worse, and the Trust expects to treat around 50 patients a year.

Integrated Sexual Health services

In February 2015, the Trust was awarded the £4.9m contract to provide integrated Sexual Health services for West Kent. Kent County Council (KCC), who commissions the service, put sexual health services in West Kent out to tender in September 2014. As well as maintaining the service at Maidstone, the Trust has gained services across North Kent, demonstrating the confidence that KCC have in our services.

mtw mtw.nhs.uk Sexual Health

The service is a 'hub and spoke' model developed in partnership with Kent Community Health NHS Foundation Trust and Brook Young People's services, and it will significantly increase the service provision within West Kent. The new service will consist of dedicated HIV and Young Persons' clinics in each district and help reduce the incidence of Sexually Transmitted Infections.

Free Wi-Fi

In early 2015, thanks to a very generous donation from the Maidstone Hospital League of Friends and the Tunbridge Wells League of Friends, both our hospitals were able to offer free public Wi-Fi for patients and visitors.

A NICE day at Maidstone Hospital

In January 2015, the Trust hosted the National Institute for Health and Care Excellence (NICE), who held its public Board Meeting at Maidstone Hospital. NICE holds their Board meetings every other month in a different hospital/area in the UK, and there was also a "Question Time" session, to enable anyone to ask questions of NICE and its procedures.

NICE

Maidstone and Tunbridge Wells NHS
NHS Trust

Summary of Quality Accounts for 2014/15

taking pride

Quality Accounts are intended to aid the public's understanding of what the Trust does well; identify where improvements in service quality are required; and list the improvement priorities for the coming year.

This section contains a summary of the Quality Accounts for 2014/15, but the full Quality Accounts, including full details of the improvement priorities for 2015/16, can be found on the Trust's website (www.mtw.nhs.uk), or the Trust's pages on the NHS Choices website (www.nhs.uk).

Performance against key priorities for 2014/15

Performance against the 2014/15 priorities, as stated in the 2013/14Quality Accounts, is detailed below.

Patient Safety: Reducing the number of avoidable harms with a focus on Hospital acquired infections, in particular MRSA, Clostridium difficile

- The Trust had 28 cases of Clostridium difficile (there were 35 in 2013/14). This is a 20% reduction. The rate of infection was 12 per 100,000 bed days (the national benchmark is 15.7)
- There was 1 case of unavoidable post-48 hour MRSA bacteraemia

Patient Safety: Reduce the rate of falls in the year from 7.2 per 1,000 occupied bed days to 6.75 per 1,000 occupied bed days

- The rate of falls was 6.2 per 1,000 occupied bed days at March 2015

Patient Safety: Reduce the incidence of category 2 pressure ulcers by 15% and to achieve zero incidence of hospital acquired category 3 and 4 pressure ulcers

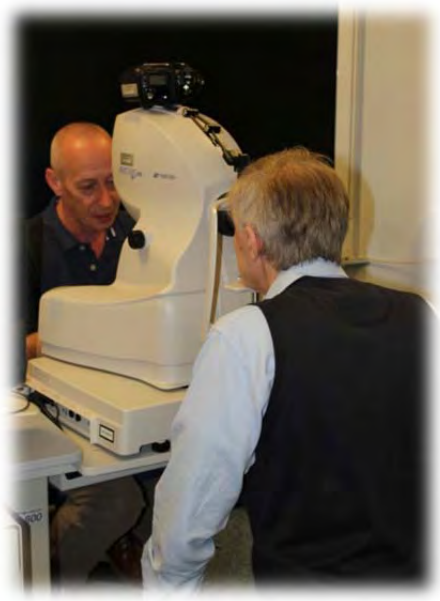
- 2014/2015 has seen a sustained reduction of facility acquired pressure damage (FAPD) of category 3 and 4. During 2014 there were no category 3 FAPD (compared to 8 in 2013/14); 1 category 4 FAPD which when investigated was found to be unavoidable.
- A prevalence audit in February 2015 confirmed that the Trust is continuing to maintain the reduction in FAPD

Patient Safety: Review and enhance the emergency care provision for children in our A&E Departments

- A revised Paediatric pathway has been agreed, and the Trust had recruited 8 Registered Sick Children's Nurses (RSCNs) to work across both sites and ensure implementation of the pathway

Clinical Effectiveness: To identify those patients with dementia with a view to ensuring that an effective care plan is in place to enable them to receive the best care possible throughout their pathway between the acute and community sectors

- Work continues with the Association for Alzheimer's and Dementia Support Services (ADSS) and the Dementia Buddy Scheme, which is now operating on both hospital sites. A Dementia Buddy coordinator is employed through ADSS and leads on the recruitment and training of volunteers. There are currently 53 volunteers, with 2 wards covered at Maidstone and 1 at Tunbridge Wells (although the intention is to expand this as more volunteers are recruited. A Day Room area has been developed between 2 wards at Maidstone Hospital for the Buddies to utilise, and during the year they have run lunch clubs, activity sessions and painting sessions
- In addition, the Estates and Facilities Department has been provided with the Kings Fund documentation on Enhancing the Environment for dementia patients in order to assist them in their planning and implementation of refurbishment and estate development



Clinical Effectiveness: Ensure all patients have their discharge from hospital planned to ensure there is a seamless transfer home with appropriate support in place and communication with all relevant parties, with particular focus on enhanced electronic discharge notification ensuring all agencies receive electronic notification, as appropriate

- Twice weekly conference calls with West Kent CCG, Kent Community Health NHS Foundation Trust, and Kent County Council are in place to discuss and monitor any delays in discharging patients
- Visits have also been made to service providers to start scoping the viability of telemedicine within Respiratory Medicine

Clinical Effectiveness: To ensure 80% of patients with a diagnosis of stroke receive 90% of their care on a dedicated stoke ward

- This objective was achieved, through actions coordinated by the Stroke Steering Group

Patient Experience: To improve our ward environments, with particular focus on day rooms and communal areas between wards at Tunbridge Wells Hospital

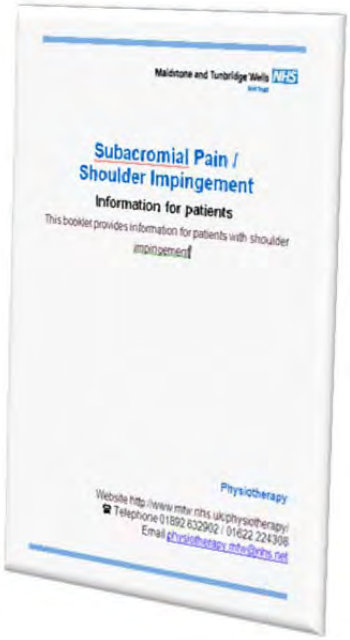
- Ward day rooms were included as part of refurbishment plans for Maidstone Hospital site, but the key focus for Maidstone Hospital in 2014 was the revision of way-finding and colour coding signage and hospital zones. Some investment has been made in furniture on both sites, and particular attention has been paid to maximising 'end of ward' space on the wards at Tunbridge Wells by creating small seating areas by the main window

- The links between the Patient Environment Steering Group (PESG) and the Dementia Steering Group remain strong, with clear understanding of the role both groups play in enhancing the environment for both patients living with Dementia and the wider population

Patient Experience: To improve management and actions in response to complaints to ensure each is used as an opportunity from which we can learn

- Complaints training (focusing on the investigation of complaints and drafting of complaint responses) was delivered by the central complaints team up until June 2014. One of the team objectives moving into 2015/16 is to review and re-launch the training programme, and the intention is to deliver a full day's training, allowing delegates to 'investigate' and 'respond' to a case study. Complaints and PALS case studies have been used in designing a new Trust-wide customer services training programme; the pilot is scheduled to take place in May 2015.
- An amalgamated PALS/Complaints report has been developed which combines the data captured to highlight recurring themes. This is submitted to the Clinical Governance Committee for review
- During 2014/15, the Trust Board agreed to hold meetings in public every month (previously this was every 2 months). A 'patient story' is normally heard at every other meeting, and in 2014/15, stories were relayed in person at the Board meetings in May, October and December 2014, and February 2015. Such stories provide invaluable first-hand experience of being a patient of the Trust, and are supplemented by visits of Board members to hospital areas (which are reported to the Board each quarter)

Patient Experience: To improve the quality of written information, particularly in relation to patient information leaflets & letters to GPs



- Extensive work has been carried out on the letters sent to patients to simplify the content. A standardised format is used by clinical secretaries and information is printed on the reverse
- The Patient Information and Leaflet Group reviewed the Department of Health guidance on leaflets. The Trust guidance was amended to allow more than 2 colours within leaflets that are printed within the Trust (core leaflets printed externally will still follow the 2 colour rule). This allows Directorates to adopt local colour stripes to highlight information by subject matter.

Patient Experience: To significantly improve our response rate for the Friends & Family Test (FFT), whilst maintaining our overall net promoter score

- The FFT now used routinely as part of the Directorate reports to Quality & Safety Committee, and FFT returns for A&E are noted at Site Operational meetings
- Consideration has been given to the use of IT and mobile technologies, and the implementation of 'NerveCentre' Vital Signs software will be considered for FFT feedback once the initial clinical care modules have been fully established.
- The use of text and voice activated technology is being established for Outpatients

Quality improvement priorities for 2015/16

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 10 quality priorities in 2015/16 which represent the views of our stakeholders, but are also in line with the Trust's overarching strategy for quality improvement. The priorities are aligned to the Quality Improvement Plan developed following the recent Care Quality Commission inspection and our Safety Improvement Plan. We have also considered internally generated data such as complaints, patient safety incidents and important national reports such as the Morecambe Bay Investigation, the Keogh Mortality Review, and the Berwick review into patient safety.

Patient Safety:

- To improve the system of incident reporting and learning lessons from incidents, complaints and claims
- To improve the patient safety culture within the organisation to ensure the organisations and all staff are responsive to learning
- To improve patient flow through the Trust

Patient Experience:

- To meet the needs of our patients with due regard to their cultural and linguistic background
- To review and improve linguistic translation services
- To implement Friends and Family Test (FFT) for Outpatient services and improve learning and action taken in response
- To ensure meaningful patient and public involvement in all service improvements

Clinical Effectiveness / Clinical Governance:

- To ensure clinical governance frameworks and processes across the Trust are effective
- To review and improve the effectiveness of Morbidity and Mortality meetings and reviews
- 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

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 and Safety Committee and the Patient Experience Committee. In addition we will provide an update on progress to our health care commissioners every 2 months.

Maidstone and Tunbridge Wells NHS
NHS Trust

Sustainability Report for 2014/15

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Sustainability has become increasingly important as the impact of peoples' lifestyles and business choices are changing the world in which we live. In order to fulfil our responsibilities for the role we play, the Trust has the following sustainability mission statement located in our sustainable development management plan (SDMP): "Working with the NHS Sustainable Development Unit (SDU), the Trust aims to provide a healthcare system that is as sustainable as it can be - it will consider all of the environmental impacts of providing this healthcare, not just carbon".

The Trust underwent a radical change between 2009 and 2012 which culminated with the opening of the new Tunbridge Wells Hospital, and the closure and disposal of the old hospitals it replaced. Maidstone Hospital has also changed significantly having considerable new estate added. Therefore 2012/13 is considered the base year against which to measure sustainability progress.

Policies

In order to embed sustainability within our business it is important to explain where in our process and procedures sustainability features. Sustainability is considered in the following areas: Travel, Procurement (environmental), Procurement (social impact) and Suppliers' impact. One of the ways in which an organisation can embed sustainability is through the use of an SDMP (although this has not been approved by the Board in the last 12 months) but the Trust does not currently use the Good Corporate Citizenship (GCC) tool or run awareness campaigns promoting sustainability.

Climate change brings new challenges to our business both in direct effects to the healthcare estates, but also to patient health. Examples of recent years include the effects of heat waves, extreme temperatures and prolonged periods of cold, floods, droughts etc. The Trust has identified the need for the development of a Board-approved plan for future climate change risks affecting our area.

Partnerships

The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner. Crucially for us as a provider, evidence of this commitment will need to be provided in part through contracting mechanisms. We have not currently established any strategic partnerships.

Performance

Organisation

Since the 2007 baseline year, the NHS has undergone a significant restructuring process, which is still continuing. Therefore in order to provide some organisational context, the following table may help explain how both the organisation and its performance on sustainability has changed over time.

Context info	2007/08	2012/13	2013/14	2014/15
Floor space (m^2)	109,896	124,635	134,453	138,533
Number of staff	3,969	4,376	4,604	4,797

Energy

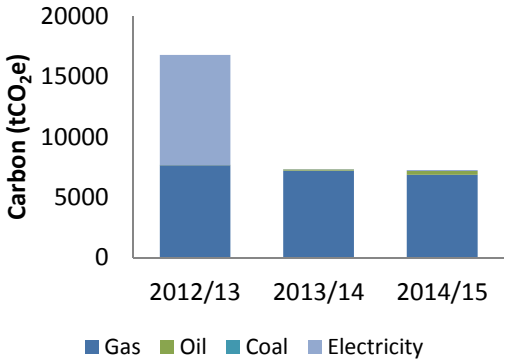
The Trust spent £3,849,104 on energy in 2014/15, which is a 2.4% increase on energy spend from 2013/14. Energy use is very similar to the previous year.

The number of patient contacts has increased from 2.5 million to 2.9 million. The number of degreed days (a measure of heating or cooling) is similar, yet there has been no increase in consumption.

Resource		2012/13	2013/14	2014/15
Gas	Use (kWh)	37,430,130	33,906,661	32,650,186
	tCO_2e	7,649	7,193	6,850
Oil	Use (kWh)	22,536	316,957	1,017,026
	tCO_2e	7	101	325
Coal	Use (kWh)	0	0	0
	tCO_2e	0	0	0
Electricity	Use (kWh)	21,260,601	21,804,450	22,090,528
	tCO_2e	9,126	47	83
Total energy CO_2e		16,782	7,341	7,258
Total energy spend		£3,463,985	£3,760,197	£3,849,104

N.B. tCO2e = Tonnes of CO2 equivalent. This is used to measure the equivalent CO2 concentration which causes the same level of absorption in the atmosphere for other greenhouse gases.

Carbon Emissions - Energy Use



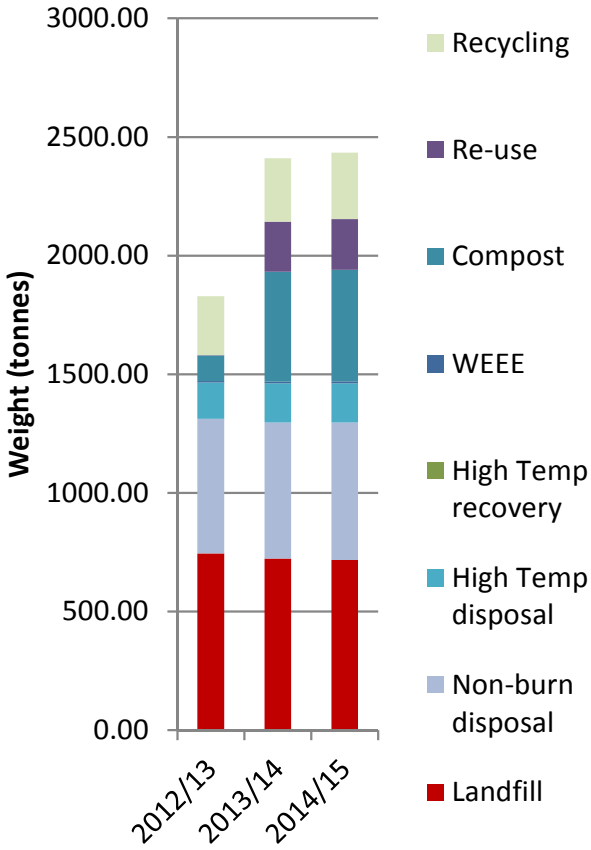
99.8% of the Trust's electricity use comes from renewable sources. Our supplier, EDF, provides our electricity for our hospitals and laundry that is Climate Change Levy (CCL) exempt as it is procured from green sources. There has been no investment into energy saving from capital projects. Regular energy awareness campaigns and audits have however been undertaken.

Waste

Much of the Trust's waste is now recycled, and volumes of waste reduced. Paper and cardboard is now recycled in more areas at Maidstone Hospital and the amount of recycling is increasing as more recycling bins are installed. The Trust waste management team have improved staff awareness, and increased recycling.

249	268	280
5.23	5.63	5.88
2	210	214
0.04	4.40	4.49
108	464	470
0.65	2.78	2.82
5	7	7
0.11	0.14	0.15
0	0	0
0	0	0
153	166	166
33.66	36.51	36.52
568	573	579
11.93	12.04	12.16
745	723	718
182.09	176.80	175.49
1830	2411	2434
14%	20%	20%
233.70	238.31	237.51

Waste Breakdown



N.B. WEEE is "Waste Electrical and Electronic Equipment"

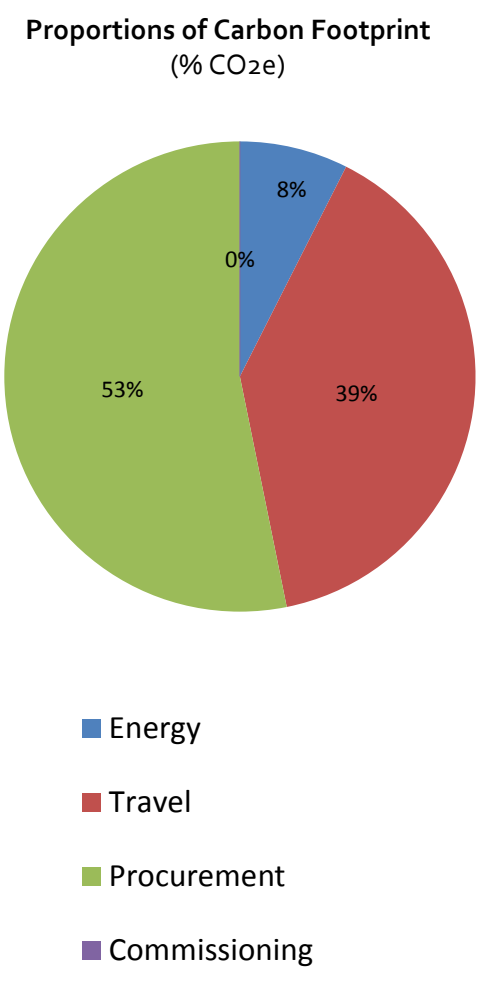
Water

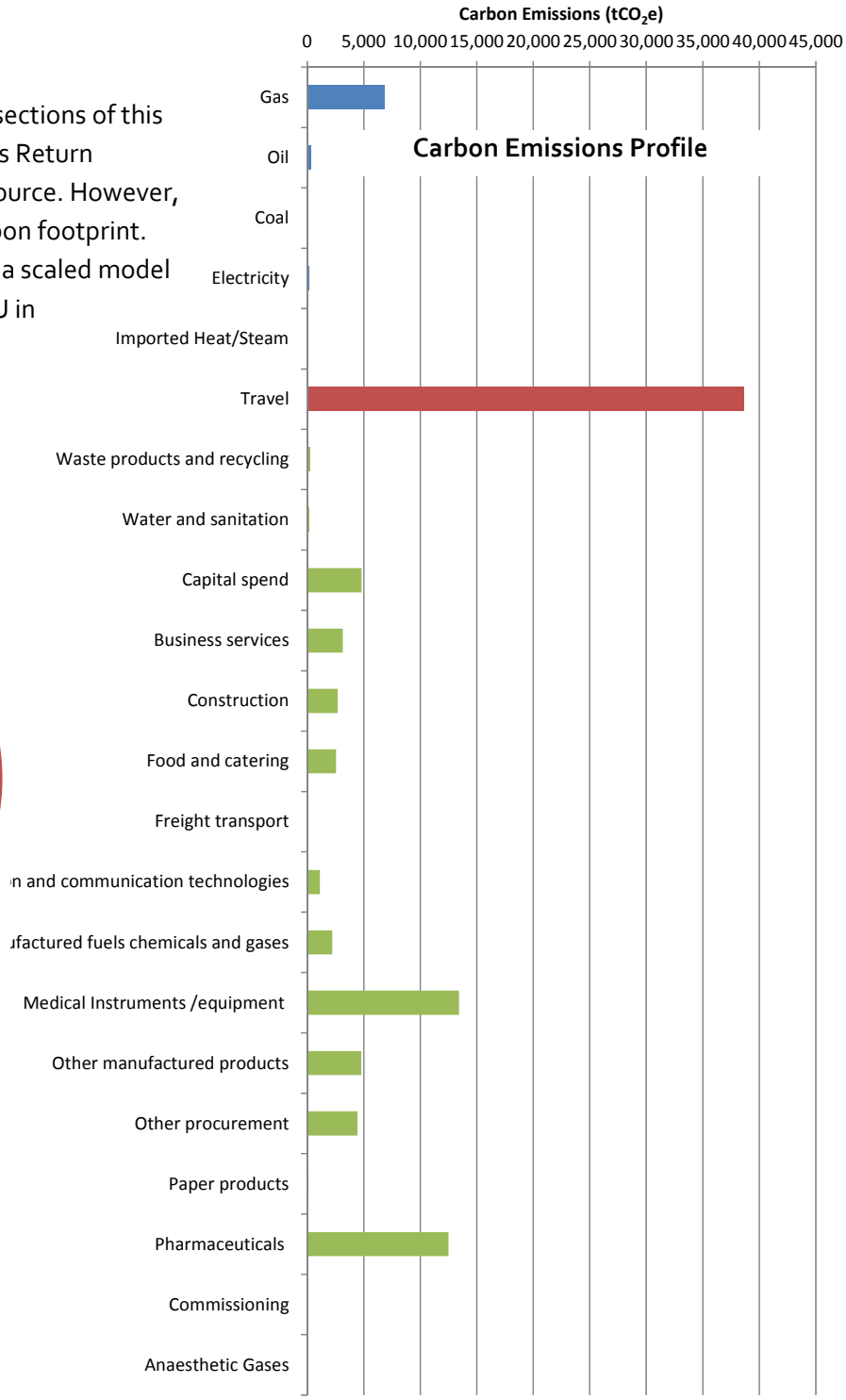
Despite providing more services, the Trust has managed to do so without an increase in water consumption. A specialist company was commissioned to carry out a water audit, and apart from some minor works required at the Laundry and some billing errors, there were no major problems.

Water		2012/13	2013/14	2014/15
Mains	m^3	160,368	167,248	167,216
	tCO_2e	146	152	152
Water & sewage spend		£504,538	£565,814	£578,482

Modelled Carbon Footprint

The information provided in the previous sections of this Sustainability Report uses the NHS Estates Return Information Collection (ERIC) as its data source. However, this does not reflect the Trust's entire carbon footprint. Therefore, the following information uses a scaled model based on work performed by the NHS SDU in 2009/10.





Maidstone and Tunbridge Wells NHS
NHS Trust

Directors' Report for 2014/15

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The Trust Board

The role of the Trust Board is to determine strategy and policy for the Trust, to monitor in-year performance against its plans and ensure the Trust is well managed and governed. The Trust Board comprises a Chairman, appointed by the Secretary of State, five other Non-Executive Directors, and eight other Directors (only five of whom have voting rights). The Non-Executive Directors bring a range of skills and expertise from outside the NHS. Their role is to hold Executive Directors to account. The Trust Board meets every month, in public. The times and venues are advertised on the Trust's internet site.

The Trust Board formally operates in accordance with its own Terms of Reference; the Trust's Standing Orders; Scheme of Matters Reserved for the Board and Scheme of Delegation; and Standing Financial Instructions.

Trust Board Members

At the end of 2014/15, the Trust Board had the following members:

Anthony Jones
Chairman*

Joined the Trust Board in March 2008, and was appointed Chairman in January 2009

Glenn Douglas
Chief Executive*

Became Chief Executive in October 2007

Paul Bentley
Director of Workforce and Communications
Joined the Board in February 2011

Avey Bhatia
Chief Nurse*

Joined the Board in July 2013

Sylvia Denton CBE
Non-Executive Director*
Joined the Board in March 2008

Sarah Dunnett OBE
Non-Executive Director*
Joined the Board in January 2014

Angela Gallagher
Chief Operating Officer*
Joined the Board in October 2011

Alex King MBE
Non-Executive Director*
Joined the Board in September 2014

* denotes Board members with voting rights

Sara Mumford
Director of Infection Prevention and Control
Joined the Board in November 2007

Steve Orpin
Director of Finance*
Joined the Board in April 2014

Paul Sigston
Medical Director*
Joined the Board in March 2010

Stephen Smith
Associate Non-Executive Director
Joined the Board in April 2012

Kevin Tallett
Non-Executive Director*
Joined the Board in June 2008

Steve Tinton
Non-Executive Director*
Joined the Board in April 2013

* denotes Board members with voting rights

The following persons also served on the Trust Board during 2014/15:

- Jayne Black, Director of Strategy and Transformation (joined the Board in September 2013 and left at the end of October 2014)
- Terry Coode, Director of Corporate Affairs (joined the Board in 2006 (as Director of Human Resources), became Director of Corporate Affairs in February 2011 and left in early April 2014)

Statement as to disclosure to auditors

Each Director can confirm that as far as they are aware there is no relevant audit information of which the Trust's auditors are unaware; and that they have taken all the steps that they ought to have taken as a Director in order to make themself aware of any relevant audit information, and to establish that the Trust's auditors are aware of that information.

Attendance at Board meetings

There were 11 Board meetings in 2014/15. Board members' attendance at each meeting is shown below:

Board member (see above for the time served on the Board during 2014/15)	April 2014	May 2014	June 2014	July 2014	September 2014	October 2014	November 2014	December 2014	January 2015	February 2015	March 2015
Anthony Jones, Chairman	✓	Apologies [3]	✓	✓	✓	✓	✓	✓	✓	✓	Apologies [4]
Glenn Douglas, Chief Executive	✓	✓	✓	✓	✓	✓	✓	Apologies [5]	✓	✓	✓
Avey Bhatia, Chief Nurse	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Angela Gallagher, Chief Operating Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Stephen Orpin, Director of Finance	✓	✓	✓	Apologies	✓	✓	✓	✓	✓	✓	✓
Paul Sigston, Medical Director	✓	✓	Apologies	✓	✓	✓	✓	✓	✓	✓	✓
Sylvia Denton, Non-Executive Director	✓	✓	✓	Apologies	✓	Apologies	✓	✓	✓	✓	✓
Sarah Dunnett, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Kevin Tallett, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Steve Tinton, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Alex King, Non-Executive Director[6]	N/A	N/A	N/A	N/A	✓	✓	✓	✓	Apologies	✓	Apologies
Paul Bentley, Director of Workforce and Communications	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Jayne Black, Director of Strategy & Transformation[7]	✓	✓	✓	✓	✓	✓	N/A	N/A	N/A	N/A	N/A
Sara Mumford, Director of Infection Prevention & Control	Apologies	✓	✓	Apologies	✓	Apologies	✓	✓	✓	✓	✓
Stephen Smith, Associate Non-Executive Director	-	✓	Apologies	Apologies	-	-	✓	Apologies	✓	✓	Apologies

[3] The meeting on 28th May 2014 was chaired by Kevin Tallett
[4] The meeting on 31st March 2015 was chaired by Kevin Tallett
[5] Paul Bentley represented the Chief Executive at this meeting
[6] Alex King joined the Board on 1st September 2014
[7] Jayne Black left the Trust at the end of October 2014

Directors' interests

The Trust Board and other committees routinely ask that any interests relevant to agenda items be declared at each meeting. In addition, a Register of Directors' interests is maintained. The interests recorded on the Register at the end of 2014/15 of those who served on the Trust Board during the year were as follows:

Director (see above for the time served on the Board during 2014/15)	**Details of modifiable interest**
Anthony Jones, Chairman	None
Glenn Douglas, Chief Executive	None
Avey Bhatia, Chief Nurse	None
Paul Bentley, Director of Workforce and Communications	▪ Mr Bentley's spouse is the Director and owner of Nishana Enterprises Ltd (company number 06671417), which contracts with a number of health organisations in the UK and overseas ▪ Non-Executive Director of NHS Innovations South-East Ltd (www.innovationssoutheast.nhs.uk / company number 05210174), which provides support to innovations in health. No equity is held in the company and Mr Bentley is the nominated Non-Executive Director from Maidstone and Tunbridge Wells NHS Trust
Jayne Black, Director of Strategy & Transformation	None
Terry Coode, Director of Corporate Affairs	None
Sylvia Denton, Non-Executive Director	▪ Trustee (unremunerated) of the PSP Association, a charity dedicated to the support of people with Progressive Supranuclear Palsy (PSP) and the related disease Cortico Basal Degeneration (CBD), and those who care for them (charity number 1037087)
Sarah Dunnett, Non-Executive Director	▪ Trustee of The Sevenoaks Almhouse Charity (charity number 226418) ▪ Governor of Sevenoaks School (www.sevenoaksschool.org / charity number 1101358) ▪ "Expert by Experience" inspector for the Care Quality Commission, on behalf of Age UK
Angela Gallagher, Chief Operating Officer	None
Alex King, Non-Executive Director	▪ Member of Kent County Council – Councillor for Tunbridge Wells Rural (Wards: Brenchley & Horsmonden, Capel, Goudhurst & Lamberhurst, Paddock Wood) ▪ Chairman of Kent County Council Policy and Resources Committee ▪ Vice-Chairman of Kent County Council Joint Transportation Board ▪ Chairman of King Partnership Ltd, which provides management and human resource consultancy services to clients in the UK and overseas (company number 02202346)
Sara Mumford, Director of Infection Prevention & Control	None
Stephen Orpin, Director of Finance	▪ Treasurer and Trustee of ECHO (Evelina Children's Heart Organisation), a charity providing support for children and young people with heart conditions who receive treatment at the Evelina Children's Hospital and the outreach clinics at local general hospitals attended by Evelina Cardiologists (www.echo-evelina.org.uk / charity number 1146494)
Paul Sigston, Medical Director	▪ Partner in a private practice LLP (Tunbridge Wells Group of Anaesthetists), which performs clinical work for Private and NHS patients. Mr Sigston is one of 14 partners ▪ Director of PKSigston Enterprises Ltd, which provides anaesthetic services to private patients (company number 07095783)
Stephen Smith, Associate Non-Executive Director	▪ Trustee of Combat Stress, the Veterans' Mental Health Charity (charity number 206002)
Steve Tinton, Non-Executive Director	▪ Lay Governor School of Orient and African Studies London University. ▪ Trustee of Educare Small School (www.educaresmallschool.org.uk) ▪ Member of the Independent Expert Oversight Advisory Committee of the World Health Organisation (effectively the audit committee of WHO), based in Geneva
Kevin Tallett, Non-Executive Director	▪ Enterprise & Corporate Change Director at EDF Energy PLC, an energy provider (company number 02366852)

N.B. Some Directors' notifiable interests changed during the year. Further details can be obtained from the Trust Secretary, who can be contacted via Maidstone Hospital, Hermitage Lane, Maidstone, Kent ME16 9QQ.

Pension Liabilities, Exit Packages and severance payments

Details of how the Trust treats Pension Liabilities are outlined in the Principal Financial Statements, along with details of Exit Packages agreed in 2014/15 (within Notes 10.6. and 10.4 & 10.5 respectively).

Board sub-committees

The Board has a number of sub-committees, to assist it in meeting its role and duties. Further details of these can be found in the 'Governance Statement' section later in the Annual Report.

The Trust's Management Structure

The Trust is organised into a number of Corporate and Clinical Directorates. At the end of 2014/15, the Clinical Directorates were as follows:

- Cancer and Haematology;
- Children's Services;
- Critical Care;
- Diagnostics, Therapies and Pharmacy;
- Emergency and Speciality Medicine; (this Directorate was formed in year via the amalgamation of Acute and Emergency Medicine and Speciality and Elderly Medicine Directorates)
- Surgery, General Surgery, Urology, Head & Neck and Gynae Oncology;
- Trauma and Orthopaedics; and
- Women's and Sexual Health

Each clinical area has a designated Clinical Director, General Manager and Matron, whilst Associate Directors of Nursing and Associate Directors of Operations also provide oversight. Corporate departments are each responsible to an Executive Director.

'Principles for Remedy'

The Trust applies the 'Principles for Remedy' guidance issued by the Parliamentary and Health Service Ombudsman as part of its complaints handling policy and procedure. Under the Trust's policy, financial remedy is only considered when a complaint is upheld and the complainant has clearly suffered a financial loss as a result of a service failure or breach of a Trust policy. In such circumstances, the Trust will consider paying a sum that restores the person to the position they would have been in prior to the circumstances which necessitated the complaint. The amount of financial remedy is agreed by the Legal Department and the Associate Director of Operations for the relevant Directorate. During 2014/15, the Trust made 9 such payments, totalling £2,741.67. Financial redress was also offered in a further 2 cases, but had not been finalised at the time of this Annual Report. This process excludes any claims for clinical negligence, which are pursued under the Trust's Claims Management Policy.

Radiographers achieve accreditation

The Society & College of Radiographers

Dan Miller, Radiotherapist; and Heather Dias, Macmillan Specialist Radiographer, both received the advanced practice accreditation from the Society and College of Radiographers during the year. The award recognises that these two therapy Radiographers are working at an advanced level within their specialist area. Heather specialises in Gynaelogical and Colorectal cancers and is also the Lead Radiographer for Brachytherapy. Dan, who trained at Addenbooke's in Cambridge, undertakes general radiography treatment for cancer patients and will soon be specialising in Head and Neck radiography work.

Disclosure of personal data-related incidents

During the year, the Trust had one Serious Incident Requiring Investigation involving personal data that met the criteria for reporting to the Information Commissioner's Office (a 'Level 2' severity incident), as follows:

Date (month)	Nature of incident	Nature of data involved	No. of people potentially affected	Notification steps
November 2014	Disclosed in Error (breach type B): Email sent to two healthcare colleagues with data attached that had not been anonymised	NHS Number; Name; Date of Birth; Address; Clinical condition; Planned investigations	c.3,250	Individuals not notified
Further action on information risk	As a result of this incident, a Root Cause Analysis was undertaken and a number of actions have been taken to strengthen processes and procedures within the Trust to better safeguard patient-level data. Staff members have been reminded of their responsibilities relating to confidentiality and data protection under the principles of the Data Protection Act 1998.			

The Trust also had the following severity 'Level 1'data-related incidents in the year:

Category	Nature of Incident	Total
A	Corruption or inability to recover electronic data	0
B	Disclosed in error	0
C	Lost in transit	0
D	Lost or stolen hardware	0
E	Lost or stolen paperwork	0
F	Non-secure disposal – hardware	0
G	Non-secure disposal – paperwork	0
H	Unloaded to website in error	0
I	Technical security failing (including hacking)	0
J	Unauthorised access/disclosure	3
K	Other	0

Policy on setting charges

The Trust has complied with HM Treasury's guidance on setting charges for information, as set out in Chapter 6 of HM Treasury's "Managing Public Money" guidance.

Stroke Unit donation

In October 2014, the Stroke Unit at Tunbridge Wells received a boost from the Inner Wheel Club of Tunbridge Wells, in the form of a cheque for £2,785. Each year the Inner Wheel Club chooses a charity to focus on and raise money for. As one of their own members (as well as members of their families), had been affected by Stroke, this year the club chose the Stroke Unit at Tunbridge Wells Hospital.

HRH The Countess of Wessex unveils First World War memorial stone

HRH The Countess of Wessex visited Tunbridge Wells Hospital in September 2014, to mark 100 years since the first casualties of the First World War were treated. Her Royal Highness unveiled a permanent memorial to the work of the hospitals during wartime. Her visit was a real success, thoroughly enjoyed by all those who attended.

After speeches in our Workhouse Chapel, Her Royal Highness unveiled the stone and spent time meeting staff and representatives from our partner agencies, including the police and ambulance service. She then came into the hospital to see the flags in the main entrance and to look at our World War One historical display in the main corridor. She met the Trauma team, before watching a decontamination demonstration outside (this is captured under the 'Emergency Preparedness' section overleaf).

It was a fantastic event, attended by other special guests as well as the Countess of Wessex. They included Baroness Emerton, Mr Bruno Mariën - Belgium Consul, the Mayor of Tunbridge Wells and many others.

Health & Safety performance

The Trust values its employee's health and safety. Having a fit and healthy workforce is essential in delivering a safe and efficient service for our patients. The Trust monitors accidents to staff and members of the public. A key measure in such monitoring is the number of injuries (reportable to the Health & Safety Executive (HSE)) per 100,000 employees. This is benchmarked against other similar Trusts in the south east and against the HSE's national statistics for the previous year. In 2014/15 the Trust's rate was 329, which was significantly below both the average for the health sector as a whole (436) and most acute Trusts in the South East (477).

The causes of injury are also monitored and compared with previous years. An annual programme is then agreed and delivered, informed by this analysis. This allows best practice to be adopted and continuous improvement to be made.

Emergency preparedness

The Trust has in place plans that are fully compliant with the requirements of the NHS Commissioning Board Emergency Preparedness Framework 2013 and associated guidance. As a Category One responder under the Civil Contingencies Act 2004, the Trust has specific statutory duties in relation to emergency planning and response. In addition, the organisation has other obligations as required by contracts and performance standards set by NHS England.

Throughout the year a continuous process of exercising, testing, training and assurance has taken place. There were no Major Incidents, although the Trust undertook a number of table-top and live exercises. The latter included:

- "Exercise Bell" – This exercise focused on testing actions highlighted as a result of Exercise Beacon, which took place in July 2014, and identified the learning and changes required in order to maintain a temporary switchboard service. It included relocating the switchboard to alternative accommodation whilst maintaining services.
- "Exercise Equinox" – This was a Trust-wide Communications Exercise activated by the South East Coast Ambulance service, and tested Trust-wide communications cascades
- "Exercise Harvest 1" – This exercise focused on the response to a Hazardous Materials Incident, and involved Kent Fire & Rescue Service, South East Coast Ambulance Service and Kent Police
- "Exercise Harvest 2" – This exercise focused on the response to a Hazardous Materials Incident and involved Kent Fire & Rescue Service , South East Coast Ambulance Service and Kent Police

The Trust (working in partnership with Kent Fire & Rescue Service Training School) held a series of four one-day sessions to provide innovative training and experience on the skills required to make decisions with partners and to practice the challenges of working with partner agencies. This included a practical multi-agency exercise with Police, Ambulance and Fire. The training was provided equally to Fire Brigade Commanders and Hospital Incident Managers. The sessions also provided experience in using the national decision-making model and understanding other agencies' needs. Excellent training was also provided by the Trust's Medical Physics Team so that managers and multi-agency partners understood the nature of the hazard particularly in a fire incident. The Trust has also supported a pilot national training course targeted at Silver Level Managers designed to meet the requirements of the National Occupational Standards where staff will understand the principles of command and control and crisis decision making.

Although Ebola and other Viral Haemorrhagic Fevers have been around for some time, the spread in parts of Africa and the increased potential for cases in the UK has led to an increase in awareness. Emergency Planning in partnership with the Infection Control Team has coordinated walk-through exercises in both Emergency Departments in the Trust to check on preparedness and have supported the Emergency Departments during suspected cases that have been seen in the Trust.

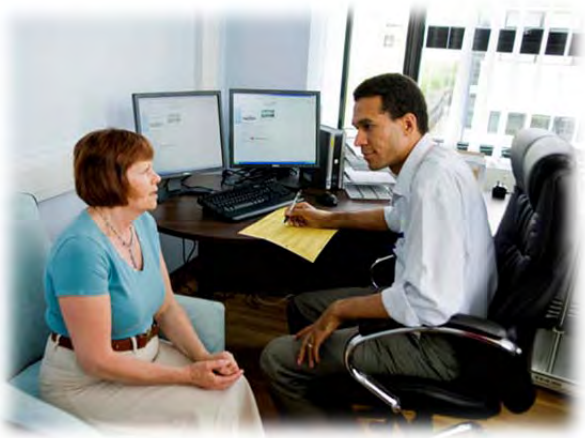
Chinese delegation visits

In February 2015, Tunbridge Wells Hospital welcomed five top Chinese healthcare professionals who wanted to see how we are encouraging new mothers to implement Kangaroo Care (skin to skin contact) with their babies from birth. The visit was requested by international charity, Save the Children, who were keen to find out more about our research and experience in Kangaroo Care. It is hoped that the visit will have an impact on maternity services in China and could change national policy in the country, now the benefits of Kangaroo Care have been seen first-hand.

During the visit, the delegates were given the opportunity to visit the post-natal ward to speak with new mothers using Kangaroo Care, attend theatre, meet key members of staff within the Trust and go to the neonatal unit where premature babies are cared for. They were impressed with what they saw. Kangaroo Care involves skin to skin contact between mothers and babies from birth. In low income settings it has been estimated to reduce perinatal mortality rates by up to 40% and there is an urgent need to accelerate its use on a global basis. It also has significant benefits for preterm babies in high income countries, and there are significant advantages for all babies, including helping mother and baby to bond and breastfeed successfully. Midwives from the Trust have developed a KangaWrap Kardi (which is similar to a wrap-over cardigan) for mothers who are having a caesarean section. This helps to facilitate immediate Kangaroo Care in the operating theatre as soon as the baby is born.

Local cardiology service a success

More than 130 cardiology patients have benefitted from a new service that was introduced by the Trust in 2013 - around 50 more patients than expected.



The Electrophysiology service, which comprises two Consultant Cardiologists, a Specialist Arrhythmia Nurse, outpatient clinics and the Cardiac Catheter Laboratory at Maidstone Hospital, is the first of its kind in Kent. The service has meant people no longer have to travel to London hospitals to receive specialist assessment and treatment. An Electrophysiology study (EPS) is a diagnostic test that is used to detect extra electrical pathways in the heart that could be causing abnormal heart rhythms. They treat patients from the age of 16 years and older. Ablation is a treatment that controls or corrects some abnormal heart rhythms, and is carried out at the same time as the EPS. Treatment with ablation has success rates of up to 95% and a very low risk of complications. Of those 130 patients who have received an EPS, around 80 per cent required ablation.

Financial performance in 2014/15

The Income & Expenditure out-turn for the year was a £0.2m surplus on an NHS breakeven duty basis, equating to an International Reporting Financial Reporting Standards (IFRS) deficit of £15m. Of the difference, £14.3m was in respect of impairment of Property, Plant and Equipment and £0.9m relating to the difference between the PFI 'on balance sheet' accounting and the off balance sheet equivalent (excluding relevant impairments).

In meeting the breakeven position the Trust had to deal with a number of significant pressures. These pressures included record demand for the Trust's A&E services and non-elective admissions which required the Trust to commission and staff additional beds on both hospital sites. Much of this activity had to be supported using more costly temporary staffing while only being funded at 30% of national tariff.

In order to deal with the issue of increased non-elective demand the Trust is planning to expand its capacity to assess and treat its non-elective patients by investing in an additional ward. The Trust is also looking to improve its ability to recruit and retain clinical staff in order to further reduce its reliance on temporary workers. This is more cost effective and provides better quality and patient experience. The Trust will continue to work with Clinical Commissioning Groups and other healthcare providers to develop more effective and efficient patient pathways.

The Trust needs to meet the continued requirement to become more efficient. In 2014/15 £23.8m of improvements were delivered whilst treating a higher number of patients and improving patient care. To assist with managing the in-year cost pressures of financing the PFI hospital, the Trust continued to receive central financial support from the Department of Health and the local commissioners. This totalled £16.3m in 2014/15 and will reduce to £12m in 2015/16. In 2014/15 the Trust received £12m of non-recurrent income from the Department of Health to support meeting its breakeven duty and provide sufficient cash.

Capital investments totalling £13.4m were made on medical equipment, IT and improvements to the estate which enhanced the patient experience and facilities.

The Trust's statutory (i.e. legal) duties

As an NHS Trust, the organisation has a number of statutory financial duties, which are explained below.

Breakeven duty

The statutory breakeven duty is formally measured over a three year period, or a five year period if agreed with the Department of Health. The requirement is to achieve breakeven on an income and expenditure basis. In 2014/15, the Trust has delivered a NHS breakeven duty surplus of £0.2m. This was the first year of a formal recovery plan to bring the Trust back into financial balance following a deficit in 2013/14.

Capital Cost Absorption Duty

The Trust is required to achieve a rate of return on capital employed of 3.5% and has met that target, achieving a return of 3.5% for the year to March 2015.

External Finance Limit (EFL)

The Trust is required to demonstrate that it has managed its cash resources effectively by staying below an agreed limit on the amount of cash drawn from the Department of Health. In 2014/15, the Trust met its target by managing the year end position to an under shoot against the EFL of £2.9m, actual closing cash balance £3.9m.

Capital Resource Limit

The Trust is expected to manage its capital expenditure within its agreed Capital Resource Limit (CRL). For 2014/15, the Trust's CRL was set at £13.4m which was underspent by £56k.

Capital Investment Loans

The Trust did not take out any additional loans in 2014/15, but did receive £1.1m of central funding for safer ward, safer hospital and nurse technology initiatives.

Better Payments Practice and Prompt Payments Codes

The Trust is required to pay its suppliers promptly in accordance with the Confederation of British Industry's Better Payments Practice Code (BPPC) and has also signed up to the Prompt Payments code. This requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. The Trust's BPPC performance over the last two years is reported below:

	2014/15 (number)	2014/15 (£'000)	2013/14 (number)	2013/14 (£'000)
Total bills paid in the year	104,523	182,738	101,715	183,587
Total bills paid within target	80,521	145,072	45,717	103,166
% paid within target	77%	79%	45%	56%

The Trust improved its cash-flow management in a difficult environment. This translated into higher achievement against the target than in 2013/14. Some delays in final funding settlements in the last quarter reduced the degree of compliance.

The Trust made six payments totalling £158.60 and two interest charges of £386.45 during the year under the 'Late Payment of Commercial Debts (Interest) Act 1998'.

Staff Sickness absence

The staff sickness absence for 2014/15 (and 2013/14) is reported below:

	2014/15	2013/14
Total days lost	43,881	42,116
Total staff years	4,962	4,990
Average working days lost	8.8	8.4

N.B. This data is provided via the Department of Health (DH) (as it is necessary to reconcile NHS Electronic Staff Record data with the 'Cabinet Office' data reported by central Government, to permit aggregation across the NHS). The data is based on the 2014 calendar year, due to timing difficulties with financial year data, but the DH considers this a reasonable proxy for the financial year.

Counter Fraud

The Trust has a range of Policies and Procedures in place to identify and respond to risks of fraud, including an "Anti Fraud, Bribery and Corruption Policy and Procedure"; "Standing Financial Instructions", "Risk

Management Policy and Strategy"; "Serious Incidents (SI) Policy and Procedure", and "Speak Out Safely (SOS) Policy and Procedure (formerly Whistle Blowing)" as well as Policies relating to, for example, employee verification checks. Such Policies are available to all staff via the Trust's Intranet. The Audit and Governance Committee also approves the programme of work for the Local Counter Fraud Specialist (LCFS), which aims to prevent, deter, and detect fraudulent activity. The LCFS is professionally accredited and acts as the first line of defence against fraud and corruption in the Trust. The LCFS works closely with NHS Protect and will refer all appropriate cases to the relevant NHS Protect Regional, Specialist, or National Proactive teams.

Accounting Issues

The accounts were prepared in accordance with guidance issued by the Department of Health and in line with International Financial Reporting Standards (IFRS). The accounts were prepared under the "Going Concern" concept.

External Auditors

The Trust's external auditors are Grant Thornton UK LLP. Their charge for the year was £132,000 (in 2013/14 this was £134,000) which includes the audit of the Quality Accounts. Grant Thornton UK LLP did not undertake any non-audit work for the Trust in 2014/15.

Looking forward to 2015/16

- The Trust is planning to deliver £21.5m of operational efficiencies in 2015/16 as it continues to deliver its Recovery Plan which is designed to ensure that resources deliver the best value for money without adversely impacting on patient services and the quality of care. The Plan shows that 2015/16 and 2016/17 will remain challenging years financially with a deficit expected as implementation of change is carried out against a backdrop of reducing tariffs and increasing demand

- The drivers of the deficit in 2015/16 include a reduction in financial support for the PFI from £16m to £12m (£4m); the national deflator on tariffs of 1.6% (£5.5m); change in tariff for the specialist cancer network; continued levels of non-elective activity that impact upon the ability of the organisation to run efficiently and effectively, and generate a reduced level of income through application of national tariff guidance; and other inflationary factors such as pay awards and the premium for the clinical negligence insurance scheme.
- Capital investment to improve buildings, medical equipment and IT infrastructure are planned for 2015/16 totalling £20.3m. This is planned to be funded via internally generated depreciation, disposal of assets and business cases for £6.5m of capital investment loans.
- In collaboration with East Kent Hospitals University NHS Foundation Trust, the Trust has established the Kent Pathology Partnership to develop centralised laboratory services for the major pathology specialities alongside local hot labs. This will be implemented in phases throughout the next 18 months.
- The outlook past 2015/16 sees the Trust continue to deliver on the long-term aims of improving quality, reducing cost and maintaining or increasing income.

Maidstone and Tunbridge Wells NHS
NHS Trust

Remuneration Report for 2014/15

taking Pride

In accordance with Section 234b and Schedule 7a of the Companies Act, as required by NHS Bodies, this report includes details regarding "senior managers" remuneration. In the context of the NHS, this is defined as:

"Those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments".

It is usually considered that the regular attendees of the entity's Board meetings are its "Senior Managers", and the Chief Executive has confirmed that the definition of "Senior Managers" only applies to the members of the Trust Board (refer to the 'Directors' Report' for further details).

The Trust Board has maintained a Remuneration Committee to advise and assist in meeting its responsibilities to ensure appropriate remuneration, allowances and terms of service for the Chief Executive, Directors and other key senior posts. Membership of the Committee comprises the Chairman of the Trust Board and all Non-Executive Directors.

The Chief Executive and Directors' remuneration is reviewed annually by the Remuneration Committee and decisions are based on market rates, national pay awards and performance. Reward is primarily through salary adjustment, although non-recurrent awards can be used to recognise exceptional achievements.

Pay rates for Non-Executive Directors of the Trust are determined in accordance with national guidelines, as set by the NHS Trust Development Authority (TDA). Remuneration for the Chairman of the Trust Board is also set by the TDA.

The Directors are normally on permanent contracts and subject to a minimum of 6 months' notice period; the Chief Executive's notice period is 6 months. Contract, interim and seconded staff will all have termination clauses built into their letters of engagement, which will be broadly in line with the above.

Termination arrangements are applied in accordance with statutory regulations as modified by Trust or National NHS conditions of service agreements, and the NHS pension scheme. The Remuneration Committee will agree any severance arrangements following appropriate approval from the TDA and Treasury as appropriate.

The figures included in the tables below show details of salaries, allowances, pension entitlements and any other remuneration of the Trust's 'Senior Managers' i.e. non-recurrent awards etc.

Salaries and allowances for the year ending 31st March 2015 (subject to audit)

Comparatives for the year ending 31st March 2014 are shown in brackets below the figure for 2014/15.

Name and title (alphabetical by surname) N.B. Dates of service are for the full 2014/15 year unless otherwise disclosed	(a) Salary (bands of £5,000)	(b) Taxable expense payments, and other benefits in kind, to the nearest £100	(c) Annual performance-related pay and bonuses (bands of £5,000)	(d) Long-term performance-related pay and bonuses (bands of £5,000)	(e) Other remuneration for other offices held alongside Senior Manager role (bands of £5,000)	(f) All pension-related benefits (bands of £2,500)	(g) TOTAL (columns a - f) (bands of £5.000)	(h) Payments or compensation for loss of office
	£000	£00 Λ	£000	£000	£000	£000	£000	£000
Anthony Jones, Chairman of the Trust Board	40 - 45 (40 - 45)	0 (0)	0 (0)	0 (0)	N/A	0 (0)	40 - 45 (40 - 45)	N/A
Glenn Douglas, Chief Executive	200 - 205 (200 - 205)	70 (70)	0 (0)	0 (0)	N/A	0 (27.5 - 30)	205 - 210 (235 - 240)	N/A
Paul Bentley, Director of Workforce and Communications	130 - 135 (130 - 135)	0 (0)	0 (0)	0 (0)	N/A	0 (7.5 - 10)	130 - 135 (135 - 140)	N/A
Avey Bhatia, Chief Nurse	110 - 115 (80 - 85)	0 (0)	0 (0)	0 (0)	N/A	25 - 27.5 (102.5 - 105)	135 – 140 (185 – 190)	N/A
Jayne Black, Director of Strategy & Transformation (until November 2014)	55 - 60 (50 - 55)	0 (8)	0 (0)	0 (0)	N/A	180 - 182.5 (125 - 127.5)	235 - 240 (175 - 180)	N/A
Terry Coode, Director of Corporate Affairs (until 11.04.14)	5 - 10 (90 - 95)	0 (0)	0 (0)	0 (0)	N/A	0 (10 - 12.5)	5 – 10 (105 - 110)	N/A Ω
Sylvia Denton, Non-Executive Director	5 - 10 (5 - 10)	0 (0)	0 (0)	0 (0)	N/A	0 (0)	5 - 10 (5 - 10)	N/A
Sarah Dunnett, Non-Executive Director	5 - 10 (5 - 10)	0 (0)	0 (0)		N/A	0 (0)	5 - 10 (5 - 10)	N/A
Angela Gallagher, Chief Operating Officer	115 - 120 (115 - 120)	0 (0)	0 (0)	0 (0)	N/A	0 (175 - 177.5)	115 - 120 (290 - 295)	N/A
Alex King, Non-Executive Director (from 01.09.14)	0 - 5 (N/A)	0 (N/A)	0 (N/A)	0 (N/A)	N/A	0 (N/A)	0 - 5 (N/A)	N/A
Ian Miller, interim Director of Finance (until 11.04.14)	20 – 25 Δ (180 - 185)	0 (0)	0 (0)	0 (0)	N/A	N/A	20 - 25 (180 – 185)	N/A
Sara Mumford, Director of Infection Prevention and Control	15 - 20 (15 - 20)	1 (0)	0 (0)	0 (0)	110 - 115 Ψ (115 - 120)	7.5 - 10 (0)	135 - 140 (130 - 135)	N/A
Steve Orpin, Director of Finance (from 14.04.14)	120 - 125 (N/A)	0 (N/A)	0 (N/A)	0 (N/A)	N/A	130 - 132.5 (N/A)	250 - 255 (N/A)	N/A
Paul Sigston, Medical Director	210 - 215 (150 - 155)	0 (0)	0 (0)	0 (0)	20 - 25 Ψ (50 - 55)	80 – 82.5 (47.5 - 50)	315 - 320 (250 - 255)	N/A
Stephen Smith, Associate Non-Executive Director	N/A Σ							
Kevin Tallett, Non-Executive Director	5 - 10 (5 - 10)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	5 - 10 (5 - 10)	N/A
Steve Tinton, Non-Executive Director	5 - 10 (5 - 10)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	5 - 10 (5 - 10)	N/A

Λ £ hundreds are used for taxable expense payments, and other benefits (column (b)). For this Trust, they relate to the non-cash benefit of a lease car. All other columns are in £ thousands.

Ω Relevant 'Payments or compensation for loss of office' were reported within the Trust's Annual Report and Accounts 2013/14.

Δ For comparative purposes this is the equivalent salary payment net of VAT; payments totalling £20,700 (plus VAT) were made for the secondment of Mr Ian Miller, as Interim Director of Finance; to a company he controls (Maxentius Limited).

Ψ Drs Sigston and Mumford hold clinical roles in the Trust alongside their responsibilities as Senior Managers.

Σ Mr Smith receives no remuneration for undertaking his role as Associate Non-Executive Director.

Pension benefits for the year ending 31st March 2015 (subject to audit)

Name and title Ψ (alphabetical by surname) N.B. Dates of service are for the full 2014/15 year unless otherwise disclosed	**(a) Real increase in pension at age 60 (bands of £2,500)**	**(b)** Real increase in pension lump sum at aged 60 **(bands of £2,500)**	**(c)** Total accrued pension at age 60 at 31st March 2015 **(bands of £5,000)**	**(d)** Lump sum at age 60 related to accrued pension at 31st March 2015 **(bands of £5,000)**	**(e)** Cash Equivalent Transfer Value Λ at 1st April 2014	**(f)** Cash Equivalent Transfer Value Λ at 31st March 2015	**(g)** Real increase in Cash Equivalent Transfer Value Σ	**(h)** Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Glenn Douglas, Chief Executive Ω	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0
Paul Bentley, Director of Workforce and Communications	0 - 2.5	0 - 2.5	45 - 50	140 - 145	771	824	32	0
Avey Bhatia, Chief Nurse	0 - 2.5	5 - 7.5	30 - 35	95 - 100	479	533	41	0
Jayne Black, Director of Strategy & Transformation (until November 2014)	7.5 – 10	22.5 - 25	45 - 50	135 – 140	578	876	165	0
Terry Coode, Director of Corporate Affairs (until 11.04.14)	0	0	10 – 15	35 – 40	273	276	0	0
Angela Gallagher, Chief Operating Officer	0 - 2.5	0 - 2.5	45 – 50	135 – 140	802	852	29	0
Ian Miller, interim Director of Finance (until 11.04.14)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Sara Mumford, Director of Infection Prev. and Control	0 - 2.5	0	35 - 40	70 - 75	511	553	28	0
Steve Orpin, Director of Finance (from 14.04.14)	5 – 7.5	17.5 - 20	35 - 40	105 - 110	391	511	105	0
Paul Sigston, Medical Director	2.5 - 5	12.5 - 15	45 - 50	140 - 145	746	868	102	0

Ψ As Non-Executive Directors do not receive pensionable remuneration; there are no entries in respect of pensions for Non-Executive Directors.

Λ A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008.

Σ Real Increase in CETV reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Ω Mr Douglas ceased payments into the NHS Pensions scheme in 2012/13.

Pay multiples (subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid Director in their organisation and the median remuneration of the organisation's workforce. The banded remuneration of the highest paid Director in the Trust in the financial year 2014/15 was £235,000 to £240,000 (in 2013/14, this was £200,000 to £205,000). This was 8.4 times the median remuneration of the workforce (in 2013/14, this was 7.3 times), which was £28,200 (in 2013/14, this was £27,900).

In 2014/15, no employees received remuneration in excess of the highest paid Director (in 2013/14 there was one employee). Remuneration ranged from £5,200 to £236,400 (in 2013/14, this was £6,000 to £208,000). The ratio of median remuneration to the highest paid Director for 2014/15 has increased slightly. The highest paid Director in the financial year 2014/15 was the Medical Director (in 2013/14 this was also the Medical Director).

Total remuneration includes salary, non-consolidated performance related pay and benefits in kind, but does not include severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. The calculations of the median pay included in this analysis is based on the month 12 remuneration on an annualised basis (remuneration divided by whole time equivalent multiplied by 12) and therefore is not necessarily the actual remuneration received by those individuals in the financial year.

Reporting relating to the review of tax arrangements of public sector appointees (not subject to audit)

As part of the Review of Tax arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23rd May 2012, the Trust in common with all public bodies, is required to publish information in relation to the number of 'off-payroll' arrangements meeting the specific criteria set by the Treasury. Individuals that are 'on-payroll' are subject to Pay As You Earn (PAYE), with income tax and employee National Insurance Contributions (NICs) deducted by the Trust at source. Individuals engaged to provide services to the Trust but who do not have PAYE and NICs deducted at source are 'off-payroll'.

All off-payroll engagements as of 31st March 2015, for more than £220 per day and lasting for longer than 6 months

	Number
Number of existing engagements as of 31st March 2015	6
Of which, the number that have existed…	
for less than 1 year at the time of reporting =	3
for between 1 and 2 years at the time of reporting =	3 Λ
for between 2 and 3 years at the time of reporting =	0
for between 3 and 4 years at the time of reporting =	0 Ω
for 4 or more years at the time of reporting =	0 Ω

Λ Two arrangements have been terminated at year-end, and the remaining arrangement will be terminated during 2015/16
Ω This reporting requirement has been in place since 2012, therefore the Trust has not recorded arrangements existing in earlier periods

All existing off-payroll engagements have at some point been subject to a risk based assessment, as to whether assurance was required that the individual is paying the right amount of tax. Where necessary, that assurance has been sought.

New off-payroll engagements between 1st April 2014 and 31st March 2015, for more than £220 per day that last longer than 6 months

	Number
Number of new engagements, or those that reached 6 months in duration, between 1st April 2014 and 31st March 2015	3 Θ
Number of new engagements which include contractual clauses giving the Trust the right to request assurance in relation to income tax and National Insurance obligations	3
Number for whom assurance has been requested	3
Of which…	
Assurance has been received	0
Assurance has not been received	3 Ψ
Engagements terminated as a result of assurance not being received	0

Θ Two of the three arrangements have been terminated, and the third arrangement will be terminated during 2015/16
Ψ Assurance regarding one of the arrangements will be obtained on 27th April 2015. Assurance for the other two arrangements will continue to be pursued.

Number of off-payroll engagements of Board members and/or senior officers with significant financial responsibility, during the year	1 Δ
Number of individuals that have been deemed "Board members and/or senior officers with significant financial responsibility", during the financial year. This figure includes both off-payroll and on-payroll engagements	16 Σ

Δ This arrangement ceased on 11th April 2014. The details of the exceptional circumstances that led to this arrangement were the resignation of the Trust's substantive Director of Finance in 2013/14, and the need to appoint an interim Director of Finance.
Σ This includes the Board members that left the Trust Board during 2014/15. Please refer to the 'Directors' Report' for further details.

Statement of Accountable Officer's responsibilities

The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the Trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers' Memorandum issued by the Chief Executive of the NHS Trust Development Authority. These include ensuring that:

- There are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- Value for money is achieved from the resources available to the Trust;
- The expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- Effective and sound financial management systems are in place; and;
- Annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Glenn Douglas, Chief Executive,

27th May 2015

Maidstone and Tunbridge Wells NHS
NHS Trust

Governance Statement for 2014/15

taking Pride

1. Scope of responsibility

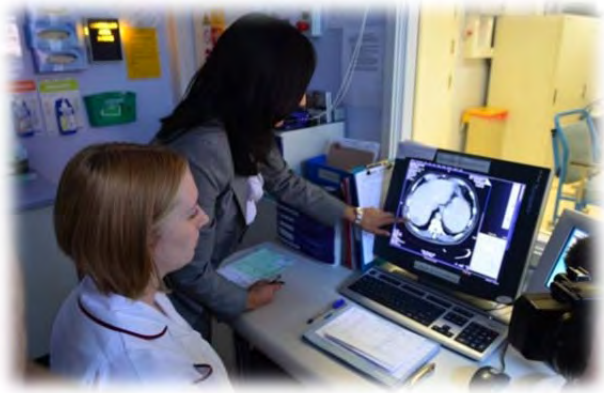
The Trust Board is accountable for internal control. As Accountable Officer, and as the Chief Executive, I have responsibility for maintaining a sound system of internal control and governance that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding quality standards, public funds and the organisation's assets. I acknowledge these and other responsibilities, as set out in the Accountable Officer Memorandum.

This statement describes the governance framework that has been in place for the period 1st April 2014 to 31st March 2015.

2. The governance framework of the organisation

The Trust Board

The Trust Board now meets in public every month (with the exception of August), and its agenda is focused around the key aspects of: quality; performance; planning and strategy; assurance; and reports from its sub-committees. A forward programme of agenda items is actively managed throughout the year to ensure the Board receives the information, and considers the matters it requires to perform its duties, efficiently and effectively. A key tenet of the information the Board receives at each meeting in public is an Integrated Performance report, which contains up-to-date details of performance across a range of indicators, including the national priorities set out in the NHS Trust Development Authority (TDA) Accountability framework for 2014/15. The Board also normally hears a 'patient story' at every other meeting, which provides invaluable first-hand experience of being a patient of the Trust. Such stories are supplemented by visits of Board members to wards and clinical areas (which are then reported to the Board each quarter). In 2014/15, the Trust paired each Executive and Non-Executive Director (NED) with particular Wards and Departments, as part of this programme of visits (though it is made clear that such pairings should not prevent Board members from visiting any area they wish).



In 2014/15, the following changes in personnel occurred within the Trust Board:

- Jayne Black (Director of Strategy & Transformation) left the Trust at the end of October 2014 (though Ms Black was not actually a formal/voting member of the Board)
- Alex King joined the Board as a Non-Executive Director on 1st September 2014
- Steve Orpin joined the Trust as Director of Finance on 14th April 2014

Board sub-committees and other key forums

The Board operates with the following sub-committees:

- The Audit and Governance Committee. This provides assurance to the Board in relation to the effectiveness of controls to minimise or mitigate the principal risks to the Trust; and its regulatory compliance obligations. The Committee is chaired by a NED, and all other NEDs (apart from the Chairman of the Trust Board) are members.
- The Charitable Funds Committee. This aims to ensure that the Maidstone and Tunbridge Wells NHS Trust Charitable Fund is managed efficiently and effectively in accordance with the directions of the Charity Commission and the wishes of donors. The Committee is chaired by a NED.

- The Finance Committee. This seeks assurance on the effectiveness of financial management, investment & capital expenditure and financial governance. The Committee is chaired by a NED.
- The Foundation Trust Committee. This oversees the development of the Trust in order to submit a successful application to become a NHS Foundation Trust. The Committee is chaired by the Chairman of the Trust Board, and although it remains a sub-committee of the Board, it did not meet in 2014/15.
- The Remuneration Committee. This sets appropriate remuneration and terms of service for the Chief Executive, other Executive Directors, and other senior employees. The Committee is chaired by the Chairman of the Trust Board.
- The Patient Experience Committee. This presents the patient and public perception of services, via engagement with a range of external stakeholders. The Committee is chaired by a NED.
- The Quality & Safety Committee. This provides assurance to the Trust Board that risks to achieving excellence in clinical and organisational operation are being effectively understood, managed and mitigated. The Committee is chaired by a NED, and in 2014/15, it was agreed to increase the frequency of meetings to monthly. A 'deep dive' meeting is therefore now held on alternate months, to enable certain subjects to be reviewed in detail, by a small membership of the 'main' Committee
- The Workforce Committee. This works to assure the Board that the Trust has the necessary strategies, policies and procedures in place to ensure a high performing and motivated workforce that is supporting business success. The Committee is chaired by a NED.

Attendance records are maintained for the Trust Board and its main sub-committees. The attendance record for the Board is reported within the body of the Trust's Annual Report.

The Board receives a summary report from each meeting of its sub-committees in a timely manner, supplemented by a verbal report from each sub-committee chair, which highlights the main subjects discussed, and draws attention to any matters requiring the Board's consideration and/or action. The Audit and Governance Committee also submits an annual report to the Board, in May, to inform the Board's consideration of the Annual Report and Accounts.

Although not a Board sub-committee, the Trust Management Executive (TME) oversees and directs the effective operational management of the Trust, including achievement of standards, targets and other obligations; and the identification, mitigation and escalation of assurance and risk issues. The TME meets monthly, and is chaired by the Chief Executive. Summary reports from each TME meeting are also received at the Trust Board.

In addition to the above committees, there are a range of other forums, structures and processes in place to oversee and manage any issues relevant to particular aspects of risk and governance. In this respect, the Trust has, for example, an Infection Prevention and Control Committee; a Standards Committee; a Health and Safety Committee; a Medicines Management Committee; an Information Governance Committee; a Clinical Governance Committee; Safeguarding Adults and Children Committees; and a Patient Environment Steering Group.

The Board assesses its effectiveness, and that of its sub-committees via a range of methods. The Terms of Reference of the Board and its sub-committees are reviewed regularly, to ensure the role and function of each reflects the Board's wishes. In addition, two Board 'away day' meetings were held, in May and October 2014, to enable reflection on the future clinical strategy of the Trust, and the Board's role in developing and

implementing that strategy. The Finance Committee undertook a self-evaluation in the year, and the findings were discussed at the March 2015 Finance Committee meeting. In early 2015/16, self-evaluation assessments of the Audit and Governance Committee and Trust Board will be issued, and the findings and response will be discussed later in 2015/16. At the end of the 2014/15, the Trust also engaged an external adviser to provide insight and advice into the Trust's governance structures, and this is likely to result in changes to such structures in 2015/16.

The Trust acts as host on behalf of the local health economy for the Kent and Medway Health Informatics Service (HIS). The HIS governance arrangements are underpinned by formal agreements with all HIS customers. There are explicit risk-sharing arrangements, which share risks or liabilities in a transparent and equitable way, and provide fair protection to the Trust as the host. These include explicit arrangements in respect of any member requiring exit. Each customer organisation has an individual Service Level Agreement to reflect the range of services they wish to commission. There is a regular HIS Board meeting which is attended by a senior representative of each customer organisation which acts as a decision-making forum, and which is chaired by the Trust's Chief Executive. During 2014/15, the Board has been apprised of the issues and risks associated with the HIS and its future.

In September 2014, the Board approved the Collaboration Agreement for the Kent Pathology Partnership (KPP). KPP is a contractual joint venture between the Trust and East Kent Hospitals University NHS Foundation Trust, which aims to create an efficient and innovative diagnostic service. The Chief Executives of both Trusts signed the Agreement on 24th October 2014, and work has continued to ensure that KPP comes into effect early within 2015/16. A substantive Managing Director started in post on 1st April 2015, and the Board will be updated with any significant developments regarding KPP during 2015/16.

To support the Trust's corporate governance framework, a Chartered Secretary is employed, as Trust Secretary. The post-holder supports the Trust Board in the discharge of its statutory functions and duties, and ensures that any issues regarding legal compliance, as well as best practice in corporate governance, are drawn to the Board's attention. To the best of my knowledge, the Board, and the wider organisation, has complied with its legal obligations during 2014/15, and is, in general, compliant with those aspects of the UK Governance Code considered to be relevant to the Trust.

Quality Governance

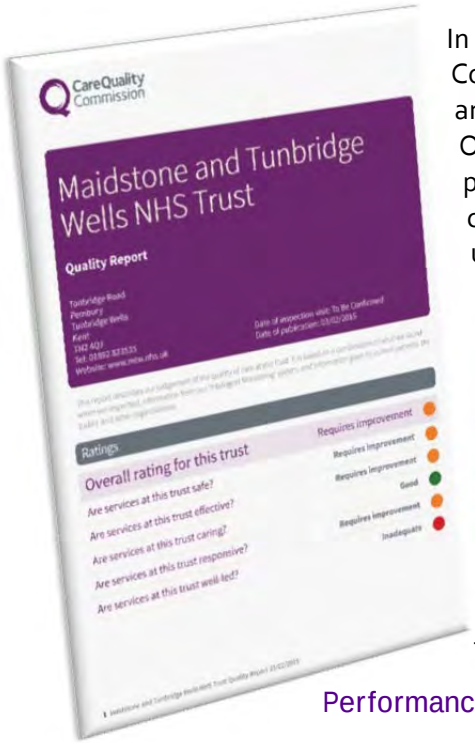
The Trust's Quality Governance arrangements are overseen by the Quality & Safety Committee, and its sub-committees, as described above; and on a number of associated systems and processes. The arrangements are described in detail within the Trust's annual Quality Accounts, which are reviewed by the Quality & Safety Committee, approved by the Trust Board, and published as a separate document. The Trust's Quality Accounts are also independently assessed by External Audit, with regards to whether the performance information reported therein is reliable and accurate. The audit of the 2013/14 Quality Accounts (which was concluded in 2014/15) resulted in an unqualified limited assurance report. The audit of the 2014/15 Quality Accounts will be available in the summer of 2015.

Clinical audit is supported by a central team, within the Governance Department, and is primarily overseen by the Standards Committee, a sub-committee of the Quality & Safety Committee which is chaired by the Medical Director.

The investigation of, and learning from, incidents and complaints is predominantly managed via Directorate governance meetings, but more significant incidents are discussed and monitored at a corporate level via the Serious Incident (SI) Panel. For clusters of incidents, Risk Summits are held, to identify root causes, and identify remedial action. SIs are also reported routinely to the Quality & Safety Committee and Trust Board.

Regrettably, two 'Never Events' occurred at the Trust in 2014/15, which were subject to Board-level scrutiny to ensure that lessons were learnt.

In August 2014, a Patient Safety Think Tank (PSTT) was established, to review, consider and propose developments to improve the patient safety culture within the Trust. Membership is from all areas of the organisation and involves junior and senior staff. The first aim of the PSTT was to establish the current position and to identify issues around the Trust's patient safety culture. A snapshot survey was therefore issued to all Trust staff, and the findings informed the development of a 'Roadmap' focusing on 3 areas: Reporting and Learning; Education and Support; and Human Factors: Leadership and Collaboration. The PSTT's output will continue to be reported to the Quality & Safety Committee and Trust Board in 2015/16.



In October 2014, the Trust was inspected by the Care Quality Commission (CQC) under its new 'Chief Inspector of Hospitals' process, and the reports of the inspection were published in February 2015. Overall, the Trust was given a rating of "Requires Improvement", which primarily related to concerns regarding Critical Care services, and clinical governance arrangements. However, the "Caring" domain was universally rated as "Good" across all areas. The Trust welcomed the inspection, and its findings, which largely reflected the Trust's position at that point. It was pleasing that the Quality Summit that was held in February, which involved a range of external stakeholders (including West Kent Clinical Commissioning Group (CCG), the TDA, and Healthwatch Kent) was supportive of the Trust and its efforts to improve. The Quality Improvement Plan developed in response to the inspection findings was discussed at the Trust Board and Quality & Safety Committee before being submitted to the CQC in March 2015. The TME and Trust Board will monitor progress with the Plan regularly during 2015/16. The full inspection reports are available on the Trust's website (www.mtw.nhs.uk).

Performance on national priorities

The Trust faced significant non-elective activity pressures throughout 2014/15, which were increased during the winter period, and which had adverse effects in a number of areas. Escalation beds had to be opened in far greater numbers than was expected, and the Trust was unable to achieve the required performance (95%) in relation to the A&E 4-hour waiting time target (which was one of the national priorities set out in the TDA Accountability framework for 2014/15). The Board was kept up to date with the extent of the pressures, which were compounded by a marked increase in the acuity and complexity of patients; and acknowledged the need to learn lessons from the experience. The Board recognises that although there is more the Trust can do to improve its effectiveness, the underlying causes relate to the functioning of the wider local health and social care economy, and efforts have been made during 2014/15 to work with our partners in West Kent CCG, High Weald Lewes Havens CCG and Social Services to develop solutions. At the end of 2014/15, the Trust launched 'Breaking the Cycle', a national initiative aimed at improving patient flow and producing a step change in patient safety, patient experience and performance. Together with health and social care partners, the Trust targeted the initiative on improving the non-

elective care pathway by dealing with issues relating to patient discharge. Work to improve patient flow and capacity will continue into 2015/16.

The Trust achieved all of the other national priorities set out in the TDA Accountability framework for 2014/15, with the exception of the following:

- "Referral to treatment waiting times of more than 52 weeks". Regrettably, 4 patients waited longer than 52 weeks, and although this is very low when compared with the overall number of patients treated within 52 weeks, the target is absolute
- "Proportion of patients receiving first definitive treatment for cancer within 62 days of referral by GP". The Trust has systems in place to monitor patients on a cancer pathway on a daily basis and a formal review occurs at the weekly Patient Tracking List (PTL) meeting. The key factors contributing to the underperformance have been related to delays in the diagnostic phase, capacity constraints in outpatients, and late referrals from other units. The cancer management team have a clear improvement plan in place to address the internal and external issues and regular reports are provided for both the TDA and the CCG regarding our progress
- "Patients waiting in A&E for more than 12 hours for a bed". Regrettably, two patients breached this target, though lessons have been learned from each following detailed investigations of the circumstances

The following processes are in place to ensure the quality and accuracy of elective waiting time data (and to manage the risks to such quality and accuracy):

- The Trust has a "Patient Access to Treatment Policy and Procedure", which encompasses Standard Operational Procedures for waiting list management at all stages of a referral to treatment pathway. The Policy also states the responsibilities of key staff, including those for auditing data quality. The Policy has recently been reviewed by the NHS Intensive Support Team (who were engaged to support the Trust with its non-elective patient pathways at the end of 2014/15), who confirmed that the Policy satisfied their standards
- Compliance with the above Policy is audited in two ways: firstly, an annual in-house audit of data quality in undertaken by the Information Team. The latest audit, in 2014/15, confirmed that the elective waiting time data is accurate (though some areas for improvement were identified). Secondly, the Trust's Internal Auditors (TIAA Ltd) have been commissioned to review the effectiveness of its process. At the time of writing this statement, the findings from this latter review are not yet available, but these will be reported to the Audit and Governance Committee in due course.

3. Risk assessment

Risks are identified, analysed and controlled in accordance with the Trust's Risk Management Policy and Strategy. The Trust has a Board Assurance Framework (BAF), and a Risk Register. The BAF is the document through which the Trust Board is apprised of the principal risks to the Trust meeting its objectives, and to

the controls in place to manage those risks. The BAF therefore differs from the Risk Register in that the latter can be considered a register of all risks that exist within the Trust, whilst the BAF only contains a sub-set of these risks (those that pose a direct threat to the achievement of the Trust's stated objectives). In addition to the Trust Board, the BAF and Risk Register are reviewed at the Audit and Governance Committee, and TME. The functioning of the BAF and Risk Register has been subject to debate during 2014/15, particularly within the Audit and Governance Committee. However, the annual Internal Audit review of "Assurance Framework & Risk Management", undertaken at the end of 2014/15, concluded that the underlying processes are robust (although the final report of the review was not available at the time of producing this Statement), and in February 2015, the Audit and Governance Committee and Trust Board agreed a number of steps to strengthen the Trust's use of the BAF. These steps will be introduced during 2015/16, along with other measures to improve the BAF and Risk Register, following further discussion by the Board and its sub-committees.

A number of new risks were identified in-year, but mitigated to an acceptable level. The risks recorded on the Trust Risk Register at the end of the 2014/15 year will be subject to a critical review, to ensure that the Risk Register entry accurately reflects the risk, within the context of the full scope of the Trust's operations. The 'red-rated' risks that remain following this will be reviewed by the TME in early 2015/6, to determine whether further action is required to address the risk, or whether the risk should either be accepted or have its 'red' rating moderated. In a related exercise, the Trust Board has identified that the key risks faced by the Trust for 2015/16 are as follows:

- Quality i.e. failure to provide care and treatment within the upper quartile; and the need to improve the standard of the Trust's clinical governance arrangements
- Capacity i.e. the need to increase inpatient capacity to cope with rising non-elective demand
- Staffing i.e. the need to reduce reliance on temporary staff and have the appropriate skill-mix
- Finances i.e. the need to deliver the financial plan for 2015/16
- Culture i.e. the need to enhance and sustain a high-performing culture
- Strategy i.e. the need for an updated cohesive strategy to deal with the instability and uncertainty in the wider health economy
- Reputation i.e. the potential impact on the Trust's future reputation as a result of the prosecution under the Corporate Manslaughter and Corporate Homicide Act 2007; and
- Senior workforce i.e. the need to ensure effective succession planning for key critical posts, to ensure the continual development of the Trust and its services

The Trust had one notifiable Information Governance Serious Incident Requiring Investigation (SIRI) in 2014/15. Data relating to children attending A&E was sent to two colleagues at the Clinical Commissioning Group (CCG), via NHS mail, as part of the CQUIN monitoring progress (the data used had originally been generated for another purpose). The CQUIN evidence was in the form of a Word document that contained other embedded documents, and one of these embedded documents was an Excel spreadsheet containing a graph showing performance. This file also contained the data used to generate the graph. The two CCG colleagues were not entitled to see this patient-level data, and this therefore represented a breach. A number of lessons have emerged following the Root Cause Analysis and an action plan has been developed to strengthen the Trust's safeguards to try to prevent a recurrence being possible. The incident was declared to the Information Commissioner's Office and Department of Health.

4. The risk and control framework

The Trust has in place a range of systems to prevent, deter, manage and mitigate risks and measure the associated outcomes. Some of these systems are described in the "The governance framework of the organisation" and "Risk assessment" sections above, and in addition to the Trust's Risk Management Policy and Strategy, a full range of risk management policies and guidance is made available to staff. This includes the procedures for incident reporting, managing complaints, risk assessment, investigation of incidents, health and safety, and 'being open' to staff and patients (to support the new statutory Duty of Candour). Additional advice on good practice can be obtained from a range of professional and specialist staff. The remit of the Trust's Governance Department includes clinical risk management; clinical governance; clinical audit; complaints; the Patient Advice and Liaison Service (PALS); staff health and safety; medico-legal service and claims handling; research and development; and the management of all clinical and non-clinical incident reporting. In addition, Directorates and sub-specialities have identified clinical governance and risk leads. There is a forum for clinical governance and risk management within each Directorate and within the majority of clinical sub-specialties.

Trust staff are involved in risk management processes in a variety of ways, including raising any concerns they may have (anonymously, if they so wish); being aware of their responsibility to report and act upon any incidents that occur; being involved in risk assessments; and attending regular training updates.

In-house support and advice on risk management and mitigation is available, primarily from the Governance and Estates and Facilities departments. This includes specific advice relating to patient safety, health and safety, finance, and information governance etc. Certain types of risk are also addressed via the engagement of external expertise. For example, the risk of fraud is managed and deterred via the appointment of a Local Counter Fraud Specialist (LCFS). Similarly, the Trust obtains advice from an external Dangerous Goods Safety Advisor (DGSA), and in 2014/15, the Trust appointed an Authorising Engineer to advise the Trust in relation to Domestic Water Hygiene Management, following concerns raised by the CQC during its October 2014 inspection. These concerns resulted in an Enforcement Notice being issued, but the necessary actions have been taken by the Trust, and the CQC has been asked to remove the Notice.

5. Review of the effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of risk management and internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the BAF and on the controls reviewed as part of the work of Internal Audit. The Head of Internal Audit Opinion for 2014/15 states that "Reasonable assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk".

Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control also provide me with assurance, via regular meetings and submission of reports to the committees referred to above. The BAF and Risk Register processes also provide me with evidence that the effectiveness of controls to manage the risks to the organisation have been reviewed, and scrutinised appropriately. Further evidence is provided by a range of sources including reports from Internal Audit (including Counter Fraud) and External Audit, and reports from external agencies, following

inspections and/or accreditation visits (including the CQC). The Audit and Governance Committee approves the Internal Audit plan for the year and receives details of the findings from each of the Internal Audit reviews that are undertaken. Although a number of the Internal Audit reviews completed in 2014/15 resulted in a 'significant assurance' conclusion, a number also led to a conclusion of 'limited assurance'. These reviews have been (or will be) considered at the Audit and Governance Committee, and actions to address the weaknesses identified in controls have been taken (or will be taken during 2015/16).

6. Significant issues

In addition to those referred to earlier in the Governance Statement, the following issues are considered significant, and warrant disclosure:

- The Trust ended 2014/15 with a £157,000 surplus, but the underlying challenges the Trust faces to its future financial viability remain, and the Trust's financial plan for 2015/16 shows a deficit of £13.4m
- In February 2014, the inquest into a patient who died at Tunbridge Wells Hospital in October 2012 after suffering a major obstetric haemorrhage due to complications following Caesarean Section, was adjourned, to allow the Police to investigate the death further. In April 2015, the Crown Prosecution Service authorised a charge against the Trust under the Corporate Manslaughter and Corporate Homicide Act 2007. The first hearing in the case is scheduled to take place in May 2015. The Trust Board will be kept updated with the development of the prosecution throughout 2015/16.
- In September 2014, the Trust pleaded guilty to breaches of the Health and Safety at Work etc. Act 1974, following a burn injury suffered by a patient in September 2012. The injury related to the use of a resistive polymer warming blanket, and resulted in significant burns to the patient's hip. The incident was investigated by the Health and Safety Executive (HSE), who concluded that a prosecution was warranted. The Trust's guilty plea arose in recognition of a number of failings in relation to procurement and training in medical devices, and a fine of £160,000 was imposed. Public apologies were made to the affected patient during the Trust's court appearances, and the patient attended the Trust Board in February 2015 to relay their experiences to Board members in person. The Trust has reviewed and amended its processes for procuring, training and maintenance of medical devices in response to the incident, with the aim of preventing recurrence.
- As was reported in the Governance Statement for 2013/14, in response to the findings from an Invited Review of Upper Gastrointestinal Cancer Resection practice from the Royal College of Surgeons, the Trust suspended Oesophago-Gastrectomy operations in 2013/14, and asked Guy's and St Thomas' NHS Foundation Trust to provide care and treatment for the patients requiring this service. The Clinical Advisory Group that the Trust established to ensure the recommendations of the Invited Review report were responded to systematically was disestablished in 2014, on the basis that the recommendations had been implemented, and in response to NHS England's intention to establish an Upper GI pathway Advisory Group. In November 2014, the Board approved a recommendation that the Trust not undertake Upper Gastrointestinal Cancer surgery in the future, but the Trust continues to liaise with NHS England in relation to its decisions on the future of the service for the patients of the Kent and Medway area

Glenn Douglas, Chief Executive

27th May 2015

Generous donation from League of Friends will benefit Rheumatology patients

Patients with Rheumatoid Arthritis will benefit from quicker diagnosis and more precise treatment thanks to a generous donation from the League of Friends.

The League of Friends at both Maidstone and Tunbridge Wells hospitals have funded the purchase of two new state-of-the-art ultrasound machines, at a cost of around £40,000 each - one for each hospital.

Rheumatoid Arthritis is an autoimmune disease where the immune system attacks the cells that line the joints, making them swollen, stiff and painful. Over time, this can damage the joint itself, the cartilage and nearby bone.

Rheumatoid Arthritis typically affects the joints symmetrically (both sides of the body at the same time) but this is not always the case. The small joints in the hands and feet are often the first to be affected

Specialist chair for Intensive Care

Maidstone's Intensive Care Unit (ICU) and Maidstone Hospital League of Friends have jointly purchased a brand new, specialist chair for patients.

The chair cost £3,740 and will help patients with severe weakness to sit up and get out of bed; as well as strengthening their posture and muscle activity, stimulating their respiratory muscles to aid the weaning process if they have been ventilated for a period of time, and boosting patient mood and morale. Some patients will even be able to go outside with the help of this specialist chair.

The chair is wheeled and fully adjustable so it can support a patient's head, torso and limbs. It can also be extended to almost flat and raised to tip forward to help a patient stand up with the physiotherapists during their rehabilitation, when they are well enough.

Independent auditor's report to the Directors of the Trust

This will be added once the auditors provide their report. This will be added once the auditors provide their report. This will be added once the auditors provide their report. This will be added once the auditors provide their report. This will be added once the auditors provide their report. This will be added once the auditors provide their report.

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Respective responsibilities of Directors and auditors

This will be added once the auditors provide their report. This will be added once the auditors provide their report. This will be added once the auditors provide their report. This will be added once the auditors provide their report.

Scope of the audit of the financial statements

This will be added once the auditors provide their report. This will be added once the auditors provide their report. This will be added once the auditors provide their report. This will be added once the auditors provide their report. This will be added once the auditors provide their report.

Opinion on financial statements

This will be added once the auditors provide their report. This will be added once the auditors provide their report. This will be added once the auditors provide their report. This will be added once the auditors provide their report.

Opinion on other matters

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Matters on which we report by exception

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Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Respective responsibilities of the Trust and auditors

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Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

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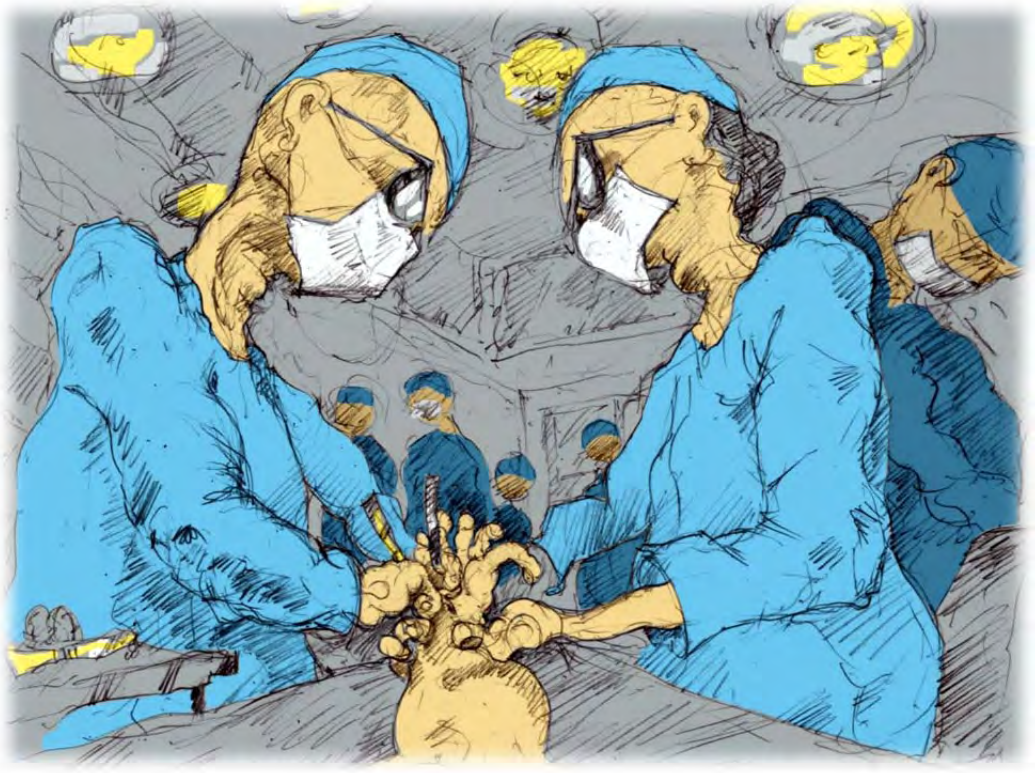
A handy sketch

At the end of 2014/15, one of our patients drew a sketch of an operation he underwent on his hand. The patient, Paul Bryan, was so pleased with how things went, he wrote a letter to a local newspaper to give praise and congratulations to the Surgical team, and all the Hospital staff, who Mr Bryan stated were extremely pleasant and helpful.



The newspaper printed the sketch (which is reproduced here), which shows the surgeon, James Nicholl, and his Registrar in the midst of the operation.

Thank you all for your continued support

The Trust continues to be very grateful to all those who make charitable donations[8] that support the Trust's work. Several significant purchases of equipment were only possible during 2014/15 because of the continued kindness of such donors. Thank you to all.

The Trust also would like to recognise the support and commitment to all our Volunteers, who work on the hospital wards, in offices and other departments, and meet and greet patients and visitors on their arrival.

Finally, the Trust also wishes to recognise and praise the undocumented hours given by a whole range of others from our communities, including those who give their time as lay members of Trust committees, and as fundraisers.

[8] To "Maidstone and Tunbridge Wells NHS Trust Charitable Fund". Charity No: 1055215. Please refer to the separate "Maidstone and Tunbridge Wells NHS Charitable Fund: Annual Report and Accounts for the year ended 31st March 2015' for further details

Maidstone and Tunbridge Wells NHS
NHS Trust

Primary Financial Statements and Notes for 2014/15

taking Pride

The Primary Financial Statements and Notes for 2014/15 will be inserted here and on the following pages, once finalised. The Primary Financial Statements and Notes for 2014/15 will be inserted here and on the following pages, once finalised. The Primary Financial Statements and Notes for 2014/15 will be inserted here and on the following pages, once finalised. The Primary Financial Statements and Notes for 2014/15 will be inserted here and on the following pages, once finalised. The Primary Financial Statements and Notes for 2014/15 will be inserted here and on the following pages, once finalised. The Primary Financial Statements and Notes for 2014/15 will be inserted here and on the following pages, once finalised. The Primary Financial Statements and Notes for 2014/15 will be inserted here and on the following pages, once finalised. The Primary Financial Statements and Notes for 2014/15 will be inserted here and on the following pages, once finalised. The Primary Financial Statements and Notes for 2014/15 will be inserted here and on the following pages, once finalised. The Primary Financial Statements and Notes for 2014/15 will be inserted here and on the following pages, once finalised. The Primary Financial Statements and Notes for 2014/15 will be inserted here and on the following pages, once finalised. The Primary Financial Statements and Notes for 2014/15 will be inserted here and on the following pages, once finalised. The Primary Financial Statements and Notes for 2014/15 will be inserted here and on the following pages, once finalised. The Primary Financial Statements and Notes for 2014/15 will be inserted here and on the following pages, once finalised. The Primary Financial Statements and Notes for 2014/15 will be inserted here and on the following pages, once finalised. The Primary Financial Statements and Notes for 2014/15 will be inserted here and on the following pages, once finalised. The Primary Financial Statements and Notes for 2014/15 will be inserted here and on the following pages, once finalised. The Primary Financial Statements and Notes for 2014/15 will be inserted here and on the following pages, once finalised. The Primary Financial Statements and Notes for 2014/15 will be inserted here and on the following pages, once finalised. The Primary Financial Statements and Notes for 2014/15 will be inserted here and on the following pages, once finalised. The Primary Financial Statements and Notes for 2014/15 will be inserted here and on the following pages, once finalised. The Primary Financial Statements and Notes for 2014/15 will be inserted here and on the following pages, once finalised. The Primary Financial Statements and Notes for 2014/15 will be inserted here and on the following pages, once finalised. The Primary Financial Statements and Notes for 2014/15 will be inserted here and on the following pages, once finalised. The Primary Financial Statements and Notes for 2014/15 will be inserted here and on the following pages, once finalised.

mtw.nhs.uk
Maidstone and Tunbridge Wells Hospitals

409,660 outpatient appointments
177,006 x-ray tests carried out
222 midwives
5,833 babies delivered
£23.8m of savings & efficiencies achieved
£390m of income 661 doctors
5,734 total employees
£13.4m spent on capital projects
129,045 A&E attendances
87,663 inpatient admissions
827,000 patient meals served
1609 nurses

Maidstone and Tunbridge Wells NHS Trust

Maidstone Hospital | Hermitage Lane | Maidstone | Kent ME16 9QQ

01622 729000 01622 226 416

www.mtw.nhs.uk

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taking pride

Patient First – Respect – Innovation – Delivery - Excellence

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - May 2015

5-23	**Annual Accounts 2014/15**	**Audit and Governance Committee Chairman**

The Annual Accounts for 2014/15 are enclosed.

The Accounts, along with the Auditors' findings, will be reviewed in detail at the Audit and Governance Committee on 27th May (before the Trust Board).

The Audit and Governance Committee will be asked to recommend that the Trust Board approves the Accounts, and a verbal update on the outcome of the Committee's review will be given at the Trust Board meeting.

Once approved, the Accounts will be signed, and submitted to the Auditors, who will in turn submit them to Department of Health, by the required deadline (12pm on Friday 5th June 2015).

Which Committees have reviewed the information prior to Board submission?

- Audit and Governance Committee, 27/05/15

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

To review and approve the Annual Accounts for 2014/15

[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

Details of Links

Name of Note		Linked to Form	subcodes	any other issues/notes
Statement of Comprehensive Income		TRU01	sc100-sc200	
Other Comprehensive Income		TRU01	sc250-sc330	Added additional row for 'Other Gains/losses' to template
Financial Performance for Year		TRU01	sc350-sc355	Rows do not match FMAs as IFRIC 12 rows reported on 1 line only in accounts
Statement of Financial Position		TRU02	sc100-sc490	Prior-year sc450-sc710
Statement of Changes in Taxpayers Equity		TRU03	sc100-sc350	
Statement of Cashflows		TRU04	sc100-sc640	
Note 1	Accounting Policies	N/A		
Note 2	XYZ pooled budget (optional)	N/A		
Note 3	Operating Segment	N/A		
Note 4	Income generation activities	TRU05	sc400-sc420	
Note 5	Revenue from patient care activities	TRU05	sc100-sc230	Calc to sum DH/other NHS spend not included.
Note 6	Other operating revenue	TRU05	sc250-sc370	Separate analysis of Finance/Operating lease in Other Operating Revenue not included
Note 7	Overseas Visitors Disclosure	TRU16	sc700-sc750	
Note 8	Operating Expenses	TRU06	sc100-sc430	Other' figure is different to FMAs as TRU06 includes change in discount rate in the 'Other' total, but this is shown on a separate row in accounts proforma. Accounts forms also exclude the DH requirement for an analysis of Depreciation and amortisation between gov/donated and other assets
Note 9	Operating Leases	TRU08	sc100-sc330	Analysis slightly diff format on TRU08
Note 10.1	Employee Benefits	TRU09	sc100-sc420	In 2012-13 there were rows for 'other post-employment benefits' and 'other employment benefits'. These are now included within the 'Salaries and Wages' row and prior year feeds to this row.
Note 10.2	Average Staff Numbers	TRU09	sc460-sc560	
Note 10.3	Staff Sickness absence and ill health retirements	TRU09	sc570-sc594	Sickness absence figures will be supplied separately after draft accounts deadline in Cabinet Office format
Note 10.4	Exit Packages	TRU10	sc100-sc270	
Note 10.5	Exit Packages Disclosures	TRU10	sc280-sc350	NEW table for 2013-14
Note 10.6	Pension costs (narrative disclosure)	N/A		
Note 11	Better Payment Practice Code	TRU09	sc600-sc670	
Note 12	Investment Revenue	TRU11	sc100-sc210	
Note 13	Other Gains and Losses	TRU11	sc211-sc300	
Note 14	Finance Costs	TRU11	sc310-sc420	
Note 15.1	Property, Plant and Equipment	TRU12	sc100-sc1090	
Note 15.2	Property, Plant and Equipment prior year	TRU12	sc630-sc1045	Prior year analysis of purchase/lease differs
Note 16	Intangible fixed assets	TRU13	sc100-sc390	
Note 16.2	Intangible fixed assets prior year	TRU13	sc480-sc840	Prior year analysis of purchase not linked
Note 17	Analysis of impairments and reversals	TRU14	sc100-sc960	
Note 18	Investment property	TRU15	sc100-sc190	
Note 19	Commitments	TRU15	sc200-sc220	
Note 19.2	Other Capital Commitments	TRU19	sc340-sc370	
Note 20	Intra-Government and other balances	TRU15	sc230-sc340	
Note 21	Inventories	TRU15	sc620-sc750	No Prior-year table on FMA or accounts for this
Note 22.1	Trade and Other Receivables	TRU16	sc200-sc490	
Note 22.2	Receivables past their due date but not impai	TRU16	sc500-sc530	No Prior_year table on FMA forms so will need to be completed manually
Note 22.3	Provision for impairment of receivables	TRU16	sc540-sc660	No Prior_year table on FMA forms so will need to be completed manually
Note 23	NHS LIFT investments	TRU21	sc450-sc570	
Note 24.1	Other Financial Assets - Current	TRU16	sc1400-sc141(	No prior year balances except closing and current year figures will have to be calculated
Note 24.2	Other Financial Assets - Non-current	TRU16	sc1240-sc139(	No prior year figures on FMA forms and 3 new rows introduced to table in current year
Note 24.3	Other Financial Assets - Non Current - Capita	N/A		Not linked as not on FMA forms. FReM requirement though
Note 25	Other current assets	TRU16	sc800-sc820	
Note 26	Cash and Cash Equivalents	TRU16	sc857-sc950	
Note 27	Non-current assets held for sale	TRU15	sc800-sc1030	
Note 28	Trade and Other Payables	TRU17	sc110-sc370	
Note 29	Other Liabilities	TRU17	sc400-sc480	
Note 30	Borrowings	TRU17	sc500-sc750	
Note 31	Other Financial Liabilities	TRU17	sc850-sc930	
Note 32	Deferred Revenue	TRU17	sc950-sc1030	
Note 33	Finance lease obligations as lessee	TRU18	sc100-sc320	
Note 34	Finance lease receivables as lessor	TRU18	sc330-sc810	
Note 35	Provisions	TRU19	sc100-sc250	
Note 36	Contingencies	TRU19	sc290-sc330	
Note 37	PFI and LIFT - additional information	TRU20	sc100-sc580	
Note 38	Impact of IFRS treatment - current year	TRU20	sc510-sc650	
Note 39	Financial Instruments: Financial Assets and L	TRU21	sc100-sc350	Note: Additional narrative disclosure required in accounts on Financial Risk Management
Note 40	Events after the end of the reporting period	TRU21	sc400	Note: Additional narrative disclosure required in accounts
Note 41	Related party transactions	N/A		
Note 42	Losses and special payments	TRU22	sc100-sc390	Prior-year is not linked for this Note as not on FMA forms
Note 43.1	Breakeven performance	TRU25	sc100-sc280	
Note 43.2	Capital cost absorption rate	N/A		
Note 43.3	External financing	TRU25	sc330-sc380	
Note 43.4	Capital resource limit	TRU25	sc545-sc600	
Note 44	Third party assets	n/A		

Data entered below will be used throughout the workbook:

Trust name	Maidstone and Tunbridge Wells NHS Trust
This year	2014-15
Last year	2013-14
This year ended	31 March 2015
Last year ended	31 March 2014
This year commencing:	1 April 2014
Last year commencing:	1 April 2013

Accounts 2014-15

Statement of Comprehensive Income for year ended 31 March 2015

	NOTE	2014-15 £000s	2013-14 £000s
Gross employee benefits	10.1	**(236,753)**	(227,421)
Other operating costs	8	**(162,190)**	(160,746)
Revenue from patient care activities	5	**359,435**	331,394
Other operating revenue	6	**43,875**	44,320
Operating surplus/(deficit)		**4,367**	(12,453)
Investment revenue	12	**48**	29
Other gains and (losses)	13	**(50)**	1,322
Finance costs	14	**(14,438)**	(14,286)
Surplus/(deficit) for the financial year		**(10,073)**	(25,388)
Public dividend capital dividends payable		**(4,881)**	(5,558)
Retained surplus/(deficit) for the year		**(14,954)**	(30,946)

Other Comprehensive Income

		2014-15 £000s	2013-14 £000s
Impairments and reversals taken to the revaluation reserve		**(6,158)**	(4,961)
Net gain/(loss) on revaluation of property, plant & equipment		**5,818**	6,732
Net gain/(loss) on revaluation of intangibles		**0**	0
Other gain /(loss)		**0**	0
Net gain/(loss) on revaluation of available for sale financial assets		**0**	0
Total other comprehensive Income	17	**(340)**	**1,771**
Total comprehensive income for the year*		**(15,294)**	(29,175)

Financial performance for the year

Retained surplus/(deficit) for the year	**(14,954)**	(30,946)
Prior period adjustment to correct errors and other performance adjustments	**0**	0
IFRIC 12 adjustment (including IFRIC 12 impairments)	**9,870**	10,573
Impairments (excluding IFRIC 12 impairments)	**5,241**	7,942
Adjustments in respect of donated gov't grant asset reserve elimination	**0**	57
Adjusted retained surplus/(deficit)	**157**	(12,374)

The IFRIC 12 adjustment relates to the difference in accounting for PFI between IFRS and UK Gaap of £0.9m and impairments relating to the PFI of £9m. Impairments on non PFI assets are £5.2m.

The notes on pages 5 to 46 form part of this account.

Statement of Financial Position as at 31 March 2015

	NOTE	31 March 2015 £000s	31 March 2014 £000s
Non-current assets:			
Property, plant and equipment	15	**371,921**	390,278
Intangible assets	16	**2,396**	1,366
Investment property	18	**0**	0
Other financial assets		**0**	0
Trade and other receivables	22.1	**1,227**	1,075
Total non-current assets		**375,544**	392,719
Current assets:			
Inventories	21	**6,519**	7,009
Trade and other receivables	22.1	**33,636**	37,661
Other financial assets	24	**0**	0
Other current assets	25	**0**	0
Cash and cash equivalents	26	**3,796**	1,287
Sub-total current assets		**43,951**	45,957
Non-current assets held for sale	27	**0**	0
Total current assets		**43,951**	45,957
Total assets		**419,495**	438,676
Current liabilities			
Trade and other payables	28	**(33,113)**	(31,734)
Other liabilities	29	**0**	0
Provisions	35	**(2,435)**	(1,996)
Borrowings	30	**(4,776)**	(4,772)
Other financial liabilities	31	**0**	0
DH revenue support loan	30	**0**	0
DH capital loan	30	**(2,174)**	(2,174)
Total current liabilities		**(42,498)**	(40,676)
Net current assets/(liabilities)		**1,453**	5,281
Total assets less current liabilities		**376,997**	398,000
Non-current liabilities			
Trade and other payables	28	**0**	0
Other liabilities	31	**0**	0
Provisions	35	**(1,944)**	(1,798)
Borrowings	30	**(208,034)**	(212,810)
Other financial liabilities	31	**0**	0
DH revenue support loan	30	**0**	0
DH capital loan	30	**(16,676)**	(18,850)
Total non-current liabilities		**(226,654)**	(233,458)
Total assets employed:		**150,343**	164,542
FINANCED BY:			
Public Dividend Capital		**199,548**	198,453
Retained earnings		**(111,941)**	(97,010)
Revaluation reserve		**62,736**	63,099
Other reserves		**0**	0
Total Taxpayers' Equity:		**150,343**	164,542

The notes on pages 5 to 46 form part of this account.

The financial statements on pages 1 to 4 were approved by the Board on 27th May 2015 and signed on its behalf by

Chief Executive: Date:

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2015

	Public Dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2014	**198,453**	**(97,010)**	**63,099**	**0**	**164,542**
Changes in taxpayers' equity for 2014-15					
Retained surplus/(deficit) for the year	0	(14,954)	0	0	**(14,954)**
Net gain / (loss) on revaluation of property, plant, equipment	0	0	5,818	0	**5,818**
Net gain / (loss) on revaluation of intangible assets	0	0	0	0	**0**
Net gain / (loss) on revaluation of financial assets	0	0	0	0	**0**
Net gain / (loss) on revaluation of available for sale financial assets	0	0	0	0	**0**
Impairments and reversals	0	0	(6,158)	0	**(6,158)**
Other gains/(loss)	0	0	0	0	**0**
Transfers between reserves	0	23	(23)	0	**0**
Reclassification Adjustments					
Transfers to/(from) other bodies within the resource account boundary	0	0	0	0	**0**
Transfers between revaluation reserve & retained earnings in respect of assets transferred under absorption	0	0	0	0	**0**
On disposal of available for sale financial assets	0	0	0	0	**0**
Reserves eliminated on dissolution	0	0	0	0	**0**
Originating capital for Trust established in year	0	0	0	0	**0**
New temporary and permanent PDC received - cash	0	0	0	0	**0**
New temporary and permanent PDC repaid in year	1,095	0	0	0	**1,095**
PDC written off	0	0	0	0	**0**
Other movements	0	0	0	0	**0**
Net recognised revenue/(expense) for the year	**1,095**	**(14,931)**	**(363)**	**0**	**(14,199)**
Balance at 31 March 2015	**199,548**	**(111,941)**	**62,736**	**0**	**150,343**

Balance at 1 April 2013	**182,068**	**(66,876)**	**62,140**	**0**	**177,332**
Changes in taxpayers' equity for the year ended 31 March 2014					
Retained surplus/(deficit) for the year	0	(30,946)	0	0	(30,946)
Net gain / (loss) on revaluation of property, plant, equipment	0	0	6,732	0	6,732
Net gain / (loss) on revaluation of intangible assets	0	0	0	0	0
Net gain / (loss) on revaluation of financial assets	0	0	0	0	0
Net gain / (loss) on revaluation of assets held for sale	0	0	0	0	0
Impairments and reversals	0	0	(4,961)	0	(4,961)
Other gains / (loss)	0	0	0	0	0
Transfers between reserves	0	812	(812)	0	0
Reclassification Adjustments					
On disposal of available for sale financial assets	0	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0	0
Originating capital for Trust established in year	0	0	0	0	0
New temporary and permanent PDC received - cash	32,385	0	0	0	32,385
	0	0	0	0	0
New PDC received/(repaid) - PCTs and SHAs legacy items paid for by DH					
New temporary and permanent PDC repaid in year	(16,000)	0	0	0	(16,000)
PDC written off	0	0	0	0	0
Transferred to NHS Foundation Trust	0	0	0	0	0
Other movements	0	0	0	0	0
Net recognised revenue/(expense) for the year	**16,385**	**(30,134)**	**959**	**0**	**(12,790)**
Balance at 31 March 2014	**198,453**	**(97,010)**	**63,099**	**0**	**164,542**

Statement of Cash Flows for the Year ended 31 March 2015

	NOTE	**2014-15 £000s**	2013-14 £000s
Cash Flows from Operating Activities			
Operating surplus/(deficit)		**4,367**	(12,453)
Depreciation and amortisation		**16,696**	17,480
Impairments and reversals		**14,250**	17,175
Other gains/(losses) on foreign exchange		**0**	0
Donated Assets received credited to revenue but non-cash		**0**	0
Government Granted Assets received credited to revenue but non-cash		**0**	0
Interest paid		**(14,431)**	(14,279)
Dividend (paid)/refunded		**(4,757)**	(5,753)
Release of PFI/deferred credit		**0**	0
(Increase)/Decrease in Inventories		**490**	1,764
(Increase)/Decrease in Trade and Other Receivables		**1,617**	(9,635)
(Increase)/Decrease in Other Current Assets		**0**	0
Increase/(Decrease) in Trade and Other Payables		**(2,843)**	(628)
(Increase)/Decrease in Other Current Liabilities		**0**	0
Provisions utilised		**(623)**	(292)
Increase/(Decrease) in movement in non cash provisions		**1,178**	596
Net Cash Inflow/(Outflow) from Operating Activities		**15,944**	(6,025)
Cash Flows from Investing Activities			
Interest Received		**48**	29
(Payments) for Property, Plant and Equipment		**(8,818)**	(14,671)
(Payments) for Intangible Assets		**(946)**	(135)
(Payments) for Investments with DH		**0**	0
(Payments) for Other Financial Assets		**0**	0
Proceeds of disposal of assets held for sale (PPE)		**0**	1,187
Proceeds of disposal of assets held for sale (Intangible)		**0**	0
Proceeds from Disposal of Investment with DH		**0**	0
Proceeds from Disposal of Other Financial Assets		**0**	0
Rental Revenue		**0**	0
Net Cash Inflow/(Outflow) from Investing Activities		**(9,716)**	(13,590)
Net Cash Inflow / (outflow) before Financing		**6,228**	(19,615)
Cash Flows from Financing Activities			
Gross Temporary and Permanent PDC Received		**1,095**	32,385
Gross Temporary and Permanent PDC Repaid		**0**	(16,000)
Loans received from DH - New Capital Investment Loans		**0**	0
Loans received from DH - New Revenue Support Loans (previously known as Working Capital Loans)		**0**	0
Other Loans Received		**0**	0
Loans repaid to DH - Capital Investment Loans Repayment of Principal		**(2,174)**	(2,174)
Loans repaid to DH - Working Capital Loans/Revenue Support Loans		**0**	0
Other Loans Repaid		**0**	0
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		**(4,772)**	(4,531)
Capital grants and other capital receipts (excluding donated / government granted cash receipts)		**2,132**	8,430
Net Cash Inflow/(Outflow) from Financing Activities		**(3,719)**	18,110
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**2,509**	(1,505)
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**1,287**	2,792
Effect of exchange rate changes in the balance of cash held in foreign currencies		**0**	0
Cash and Cash Equivalents (and Bank Overdraft) at year end		**3,796**	1,287

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2014-15 issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Movement of assets within the DH Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Treasury FReM. The FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the SOCNE/SOCNI, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Group are accounted for in line with IAS20 and similarly give rise to income and expenditure entries.

For transfers of assets and liabilities from those NHS bodies that closed on 1 April 2013, Treasury agreed that a modified absorption approach should be applied. For these transactions and only in the prior-period, gains and losses are recognised in reserves rather than the SOCNE/SOCNI.

1.4 Charitable Funds

For 2014-15, the divergence from the FReM that NHS Charitable Funds are not consolidated with bodies' own returns is removed. Under the provisions of IFRS 10 *Consolidated and Separate Financial Statements*, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entities' returns. In accordance with IAS 1 *Presentation of Financial Statements*, restated prior period accounts are presented where the adoption of the new policy has a material impact. The Charitable Funds for this Trust are not material for 2014-15 and have not been consolidated, see also policy note 1.32.

1.5 Pooled Budgets

The Trust does not have any pooled budgets.

1.6 Critical accounting judgements and key sources of estimation uncertainty

In the application of the NHS trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.6.1 Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below 1.6.2) that management has made in the process of applying the NHS trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

For 2014/15 the Trust has not identified any critical judgements that are required to be disclosed under IAS 1 paragraph 122. All the material judgements within this financial year relate to estimations and are disclosed in the relevant notes (see 1.6.2)

The accounts have been prepared on a going concern basis, in accordance with the guidance in the NHS Manual for Accounts. This defines the interpretation for the public sector context as being the anticipated continuation of the provision of the service in the future. Notes 5 (Revenue) and 26 (Cash) contain a reference in respect of future support and cash assumptions.

1.6.2 Key sources of estimation uncertainty

Key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year where arising, will be disclosed within the relevant note. The disclosure will include the nature of the assumption and the carrying amount of the asset/liability at the balance sheet date, sensitivity of the carrying amount to the assumptions, expected resolution of uncertainty and range of possible outcomes within the next financial year. The disclosure will also include an expectation of changes to past assumptions if the uncertainty remains unresolved.

Material areas including estimations within the 2014/15 accounts are as follows:

Property, Plant and Equipment valuation (see note 15.3)
Pension fund valuation (see note 10.6)
PFI (see note 37 and 38)

1.7 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the trust is from commissioners for healthcare services under local agreement (NHS Contracts). Revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period.

Interest revenue is accrued on a time basis, by reference to the principle outstanding and interest rate applicable.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The NHS trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The NHS trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.8 Employee Benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, *except for bonuses earned but not yet taken which, like leave earned but not yet taken is not accrued for at the year end, on the grounds of immateriality.

Notes to the Accounts - 1. Accounting Policies (Continued)

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.9 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.10 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives, where this would lead to a different depreciation profile. In respect of building and dwelling assets, the Trust has determined that it is appropriate to depreciate the component blocks of the two hospital sites and individual dwellings separately, as this takes into consideration the age and condition of the asset components and their differing depreciation profile and follows the external valuation schedules. The individual elements (e.g. walls, floors, lifts, heating etc) within these blocks are not deemed to be significant in relation to the block assets.

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Financial year 2014/15 is the final year in the 5 year cyclical valuation period. A full valuation was undertaken in September 2014 by Trust valuers Montagu Evans LLP. The lead relationship partner from Montagu Evans LLP is qualified to BSc MRICS. As the BCIS all in tender price index had increase by 4.05% from September to 31st March 2015 the Trust undertook a further desktop valuation at 31st March 2015 to update values to the balance sheet date. The results have been recorded in the property plant and equipment note.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value. The Trust will review annually, high value (over £100k) and long life (over 10 years) plant and machinery assets, to ensure these are held at the correct values and remaining useful lives. IT assets will also be subject to annual review.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income. Any residual balance in the revaluation reserve in respect to an individual asset is transferred to the retained earnings reserve on disposal of the asset.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.11 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the trust; where the cost of the asset can be measured reliably, and where the cost is at least £5000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.12 Depreciation, amortisation and impairments

Freehold land, assets under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the NHS trust expects to obtain economic benefits or service potential from the asset. This is specific to the NHS trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

Estimated useful lives for fixed assets are adopted as follows:	Years
Plant and Machinery	5 - 15
Furniture and Fittings	7 - 10
Information Technology	3 - 5
Vehicles	5 - 15

At each reporting period end, the NHS Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME). This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set.
AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1.13 Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.14 Government grants

The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.15 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.16 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the trust's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The NHS trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the NHS trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.17 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

Notes to the Accounts - 1. Accounting Policies (Continued)

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the NHS trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the NHS trust's Statement of Financial Position.

Notes to the Accounts - 1. Accounting Policies (Continued)

Other assets contributed by the NHS trust to the operator

Assets contributed (e.g. cash payments, surplus property) by the NHS trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the NHS trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

"A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured at the present value of the minimum lease payments, discounted using the implicit interest rate. It is subsequently measured as a finance lease liability in accordance with IAS 17.

"On initial recognition of the asset, the difference between the fair value of the asset and the initial liability is recognised as deferred income, representing the future service potential to be received by the Trust through the asset being made available to third party users.

The balance is subsequently released to operating income over the life of the concession on a straight-line basis."

1.18 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.19 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the NHS trust's cash management.

1.20 Provisions

Provisions are recognised when the NHS trust has a present legal or constructive obligation as a result of a past event, it is probable that the NHS trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates of -1.5% short term (1-5 years), -1.05% medium term (6-10 years) and +2.20% long term (over 10 years). 1.30% real (1.8% 2013-14) is the rate used for employee early retirements and injury benefits.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity. For 2014/15 the Trust has not recognised a restructuring provision.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.21 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the NHS trust'. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at note 35.

1.22 Non-clinical risk pooling

The NHS trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the NHS trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.23 Carbon Reduction Commitment Scheme (CRC)

CRC and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the NHS body makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.24 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.25 Financial assets

Financial assets are recognised when the NHS trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial assets at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the NHS trust's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

Notes to the Accounts - 1. Accounting Policies (Continued)

Held to maturity investments
Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Available for sale financial assets
Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition. The Trust has no financial assets available for sale.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques. The Trust has issued no loans, receivables are held at cost as this is believed to be not materially different to fair value for current asset, to the initial fair value of the financial asset.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the NHS trust assesses whether any financial assets, other than those held at ‘fair value through profit and loss’ are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset’s carrying amount and the present value of the revised future cash flows discounted at the asset’s original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced directly/through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.26 Financial liabilities
Financial liabilities are recognised on the statement of financial position when the NHS trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value. The Trust's liabilities are held at cost as this is not believed to be materially different to fair value in respect of current liabilities.

Notes to the Accounts - 1. Accounting Policies (Continued)

Financial guarantee contract liabilities
Financial guarantee contract liabilities are subsequently measured at the higher of:

The premium received (or imputed) for entering into the guarantee less cumulative amortisation.

The amount of the obligation under the contract, as determined in accordance with IAS 37 Provisions, Contingent Liabilities and Contingent Assets. The Trust has no financial guarantee contract liabilities.

Financial liabilities at fair value through profit and loss
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the NHS trust's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability. The Trust does not have any financial liabilities at fair value.

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.27 Value Added Tax
Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.28 Foreign currencies
The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the trust's surplus/deficit in the period in which they arise.

1.29 Third party assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. Details of third party assets are given in Note 44 to the accounts.

1.30 Public Dividend Capital (PDC) and PDC dividend [NHS trust only]
Public dividend capital represents taxpayers' equity in the NHS trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.31 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS Trust not been bearing their own risks with insurance premiums then being included as normal revenue expenditure. However, the note on losses and special payments is compiled directly from the losses and compensations register whish is prepared on an accruals basis.

1.32 Subsidiaries

Material entities over which the NHS trust has the power to exercise control are classified as subsidiaries and are consolidated. The NHS trust has control when it is exposed to or has rights to variable returns through its power over another entity. The income and expenses; gains and losses; assets, liabilities and reserves; and cash flows of the subsidiary are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the NHS trust or where the subsidiary's accounting date is not co-terminus.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Following Treasury's agreement to apply IAS 27 to NHS Charities from 1st April 2013, the Trust has established that as the Trust is the corporate trustee of the linked NHS charity - Maidstone and Tunbridge Wells NHS Charity (Charity registration 1055215), it effectively has the power to exercise control so as to obtain economic benefit. However the transactions are immaterial in the context of the group and transactions have not been consolidated. Details of the transactions with the charity are included in the related parties notes.

The Trust has no subsidiaries.

1.33 Associates

Material entities over which the NHS trust has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the NHS trust's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the NHS trust share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the NHS trust from the entity. The Trust has no Associates.

Associates that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'

1.34 Joint arrangements

Material entities over which the NHS trust has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture. The Trust has no Joint Arrangements.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the NHS body is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts. The Trust has no Joint Operations.

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method. The Trust has no Joint Ventures.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.35 Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SOCNE/SOCI on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

1.36 Borrowing Costs

Borrowing costs are recognised as expenses as they are incurred.

1.37 Accounting Standards that have been issued but have not yet been adopted

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2014-15. The application of the Standards as revised would not have a material impact on the accounts for 2014-15, were they applied in that year.

IFRS 9 Financial Instruments - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation
IFRS 15 Revenue from Contracts with Customers

2. Pooled budget

Maidstone and Tunbridge Wells NHS Trust does not have any pooled budgets.

3. Operating segments

Maidstone and Tunbridge Wells NHS Trust reports under a single segment of Healthcare. The Trust has considered the possibility of reporting two segments, relating to Healthcare and Non Healthcare Income, but this does not reflect the current Trust Board reporting practice which is reporting on both an aggregate Trust position and by directorate. Each of the significant directorates are deemed to have similar economic characteristics under the healthcare banner and can therefore be aggregated in accordance with the requirements of IFRS8. On this basis the potential requirement to report more than one segment is not applicable to the Trust at this time.

4. Income generation activities

The Trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care. The following provides details of income generation activities whose full cost exceeded £1m or was otherwise material.

Summary Table - aggregate of all schemes	**2014-15 £000s**	2013-14 £000s
Income	**4,155**	4,063
Full cost	**(2,630)**	(2,961)
Surplus/(deficit)	**1,525**	1,102
Car Parking		
Income	**2,184**	1,963
Full cost	**(1,773)**	(1,770)
Surplus/(deficit)	**411**	193
Catering		
Income	**1,491**	1,495
Full cost	**(613)**	(600) *
Surplus/(deficit)	**878**	895

* Prior year catering cost have been restated from £880k to £600k following a review of workings.

5. Revenue from patient care activities

	2014-15 £000s	2013-14 £000s
NHS Trusts	**1,314**	725
NHS England	**81,536**	74,633
Clinical Commissioning Groups	**254,097**	244,830
Foundation Trusts	**209**	161
Department of Health	**0**	0
NHS Other (including Public Health England and Prop Co)	**213**	0
Additional income for delivery of healthcare services	**12,000**	0
Non-NHS:		
Local Authorities	**1,767**	1,676
Private patients	**6,922**	8,076
Overseas patients (non-reciprocal)	**71**	3
Injury costs recovery	**1,224**	1,196
Other	**82**	94
Total Revenue from patient care activities	**359,435**	331,394

Injury cost recovery income is subject to a provision for impairment of receivables of 18.9% (15.8% 2013-14) to reflect expected rates of collection.

The £12m additional income for delivery of healthcare services received in 2014/15 relates to non-recurrent deficit funding is provided by the Department of Health.

Included within Revenue from NHS England for 2014/15 is £16.3m of financial support (2013/14 £20.8m):-

	2014-15 £000s	2013-14 £000s
Central Support for PFI scheme	**8,000**	8,000
NHS England support for PFI Scheme	**8,300**	12,810
	16,300	20,810

The 2015/16 plan includes £8m central PFI support and £4m local PFI support, with £8m central PFI support for 2016/17 and ongoing.

6. Other operating revenue

	2014-15 £000s	2013-14 £000s
Recoveries in respect of employee benefits	**0**	0
Patient transport services	**0**	0
Education, training and research	**11,077**	14,637
Charitable and other contributions to revenue expenditure - NHS	**0**	0
Charitable and other contributions to revenue expenditure -non- NHS	**0**	0
Receipt of donations for capital acquisitions - Charity	**455**	403
Receipt of Government grants for capital acquisitions	**0**	0
Non-patient care services to other bodies	**14,663**	13,058
Income generation	**4,155**	3,847
Rental revenue from finance leases	**0**	0
Rental revenue from operating leases	**23**	29
Other revenue	**13,502**	12,346
Total Other Operating Revenue	**43,875**	44,320
Total operating revenue	**403,310**	375,714

Other revenue includes £11.1m (£10.4m 2013/14) income for Health Informatics Services hosted by the Trust.

7. Overseas Visitors Disclosure

	2014-15 £000	2013-14 £000s
Income recognised during 2014-15 (invoiced amounts and accruals)	**71**	3
Cash payments received in-year (re receivables at 31 March 2014)	**0**	0
Cash payments received in-year (in respect of invoices issued 2014-15)	**42**	0
Amounts added to provision for impairment of receivables (re receivables at 31 March 2014)	**0**	0
Amounts added to provision for impairment of receivables (in respect of invoices issued 2014-15)	**0**	0
Amounts written off in-year (irrespective of year of recognition)	**14**	0

8. Operating expenses

	2014-15 £000s	2013-14 £000s
Services from other NHS Trusts	**2,065**	2,416
Services from CCGs/NHS England	**37**	67
Services from other NHS bodies	**31**	137
Services from NHS Foundation Trusts	**3,160**	4,478
Total Services from NHS bodies**	**5,293**	7,098
Purchase of healthcare from non-NHS bodies	**4,819**	3,434
Trust Chair and Non-executive Directors	**77**	70
Supplies and services - clinical	**72,155**	69,431
Supplies and services - general	**5,883**	5,437
Consultancy services	**2,234**	3,230
Establishment	**3,992**	4,080
Transport	**2,150**	2,395
Service charges - ON-SOFP PFIs and other service concession arrangements	**3,988**	3957 *
Business rates paid to local authorities	**0**	0
Premises	**16,201**	15,071 *
Hospitality	**0**	0
Insurance	**486**	377
Legal Fees	**443**	280
Impairments and Reversals of Receivables	**476**	173
Inventories write down	**0**	0
Depreciation	**16,043**	16,833
Amortisation	**653**	647
Impairments and reversals of property, plant and equipment	**14,250**	16,757
Impairments and reversals of intangible assets	**0**	418
Impairments and reversals of financial assets	**0**	0
Impairments and reversals of non current assets held for sale	**0**	0
Audit fees	**120**	134
Other auditor's remuneration	**12**	38
Clinical negligence	**10,692**	8,554
Research and development (excluding staff costs)	**0**	0
Education and Training	**910**	1,032
Change in Discount Rate	**23**	24
Other	**1,290**	1,276
Total Operating expenses (excluding employee benefits)	**162,190**	160,746
Employee Benefits		
Employee benefits excluding Board members	**235,900**	226,342
Board members	**853**	1,079
Total Employee Benefits	**236,753**	227,421
Total Operating Expenses	**398,943**	388,167

* PFI service charges have been disclosed separately for 2014/15, comparators have been restated separating this expenditure from the premises line.

**Services from NHS bodies does not include expenditure which falls into a category below

9 Operating Leases

The four main operating leases with values charged to operating expenses in year are disclosed below:-

Danwood - Lease of photocopiers and printers under a managed service arrangement £696k (£720k 2013/14). This arrangement is expected to complete in December 2017.

Ash Corporate Finance - Lease of the laundry land, buildings and equipment £323k (£283k 2013/14). The lease is for 25 years and contains an opt out clause in December 2020.

Roche Diagnostic Ltd - lease of equipment to support the pathology and clinical chemistry managed service £253k (£253k 2013/14). This arrangement completes in June 2017 with an option to extend for a further 3 years.

Telewest - lease of telephony equipment £510k (£616k 2013/14). This arrangement completes in 2015/16.

There are no purchase options or escalation clauses and there are no restriction imposed by the lease arrangements

9.1 Trust as lessee

	Land £000s	Buildings £000s	Other £000s	2014-15 Total £000s	2013-14 £000s
Payments recognised as an expense					
Minimum lease payments				**2,211**	2,329
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**2,211**	2,329
Payable:					
No later than one year	0	559	1,488	**2,047**	2,304
Between one and five years	0	1,532	1,184	**2,716**	3,571
After five years	0	471	0	**471**	564
Total	**0**	**2,562**	**2,672**	**5,234**	6,439
Total future sublease payments expected to be received:				0	0

9.2 Trust as lessor

	2014-15 £000	2013-14 £000s
Recognised as revenue		
Rental revenue	23	29
Contingent rents	0	0
Total	**23**	29
Receivable:		
No later than one year	23	23
Between one and five years	92	92
After five years	207	230 *
Total	**322**	345

* 2013/14 over 5 years restated following review of workings.

10 Employee benefits and staff numbers

10.1 Employee benefits

	2014-15		
	Total £000s	**Permanently employed £000s**	**Other £000s**
Employee Benefits - Gross Expenditure			
Salaries and wages	**194,306**	162,720	31,586
Social security costs	**14,117**	14,117	0
Employer Contributions to NHS BSA - Pensions Division	**29,284**	29,284	0
Other pension costs	**0**	0	0
Termination benefits	**1,023**	1,023	0
Total employee benefits	**238,730**	**207,144**	**31,586**
Employee costs capitalised	**(1,977)**	(707)	(1,270)
Gross Employee Benefits excluding capitalised costs	**236,753**	**206,437**	**30,316**

Employee Benefits - Gross Expenditure 2013-14	Total £000s	Permanently employed £000s	Other £000s
Salaries and wages	193,413	169,580	23,833
Social security costs	14,075	13,614	461
Employer Contributions to NHS BSA - Pensions Division	20,883	20,583	300
Other pension costs	2	2	0
Termination benefits	326	326	0
TOTAL - including capitalised costs	228,699	204,105	24,594
Employee costs capitalised	(1,278)	(555)	(723)
Gross Employee Benefits excluding capitalised costs	227,421	203,550	23,871

10.2 Staff Numbers

	2014-15			2013-14
	Total Number	**Permanently employed Number**	**Other Number**	Total Number
Average Staff Numbers				
Medical and dental	**668**	629	39	650
Ambulance staff	**0**	0	0	0
Administration and estates	**1,150**	1,045	105	1,175
Healthcare assistants and other support staff	**1,354**	1,190	164	1,322
Nursing, midwifery and health visiting staff	**1,580**	1,413	167	1,559
Nursing, midwifery and health visiting learners	**18**	18	0	18
Scientific, therapeutic and technical staff	**706**	666	40	662
Social Care Staff	**0**	0	0	0
Other	**0**	0	0	1
TOTAL	**5,476**	**4,961**	**515**	5,388
Of the above - staff engaged on capital projects	**34**	17	17	18

10.3 Staff Sickness absence and ill health retirements

	2014-15 Number	2013-14 Number
Total Days Lost	**43,881**	42,116
Total Staff Years	**4,962**	4,990
Average working Days Lost	**8.84**	8.44

	2014-15 Number	2013-14 Number
Number of persons retired early on ill health grounds	**3**	4
	£000s	£000s
Total additional pensions liabilities accrued in the year	**102**	51

10.4 Exit Packages agreed in 2014-15

Exit package cost band (including any special payment element)	**Number of compulsory redundancies**	**Cost of compulsory redundancies**	**Number of other departures agreed**	**Cost of other departures agreed**	**Total number of exit packages by cost band**	**Total cost of exit packages**	**Number of departures where special payments have been made**	**Cost of special payment element included in exit packages**
	Number	**£'s**	**Number**	**£'s**	**Number**	**£'s**		**£'s**
Less than £10,000	0	0	0	0	0	0	0	0
£10,000-£25,000	2	38,824	0	0	2	38,824	0	0
£25,001-£50,000	1	34,876	0	0	1	34,876	0	0
£50,001-£100,000	1	95,118	0	0	1	95,118	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Total number of exit packages by type (total cost	**4**	**168,818**	**0**	**0**	**4**	**168,818**	**0**	**0**

Redundancy and other departure costs have been paid in accordance with the provisions of the Trust. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

Compulsory redundancies were transacted in accordance with NHS Terms and Conditions.

Exit Packages agreed in 2013-14

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages by cost band	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£'s	Number	£'s	Number	£'s		£'s
Less than £10,000	0	0	1	9,669	1	9,669	0	0
£10,000-£25,000	2	34,941	0	0	2	34,941	0	0
£25,001-£50,000	0	0	0	0	0	0	0	0
£50,001-£100,000	1	64,884	1	78,519	2	143,403	0	0
£100,001 - £150,000	1	137,645	0	0	1	137,645	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Total number of exit packages by type (total cost	**4**	**237,470**	**2**	**88,188**	**6**	**325,658**	**0**	**0**

10.5 Exit packages - Other Departures analysis

	2014-15		2013-14	
	Agreements	**Total value of agreements**	Agreements	Total value of agreements
	Number	**£000s**	Number	£000s
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	2	59
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	1	29
Total	0	0	3	88

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognise in part or in full in a previous period

As a single exit packages can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 10.4 which will be the number of individuals.

The Remuneration Report includes disclosure of exit payments payable to individuals named in that Report.

10.6 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial reporting purposes. The valuation of the scheme liability as at 31 March 2015, is based on valuation data as 31 March 2014, updated to 31 March 2015 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pension website. Copies can also be obtained from The Stationery Office.

b) /full actuarial (funding) Valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The scheme Regulations allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee representatives as deemed appropriate.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pension (increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

The Trust participates in the National Employees Savings Trust (NEST) scheme as an alternative to those employees who are not eligible to join the NHS Pension Scheme. This came into effect in July 2013 for this Trust as part of the auto enrolment requirements introduced by the Government. NEST is a defined contribution scheme with a phased employer contribution rate, currently 1%. Trust contributions under the NEST scheme for the 2014/15 financial year totalled £4k (£2k 2013/14).

11 Better Payment Practice Code

11.1 Measure of compliance

	2014-15 Number	2014-15 £000s	2013-14 Number	2013-14 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**101,241**	**159,088**	98,706	164,115
Total Non-NHS Trade Invoices Paid Within Target	**78,674**	**129,327**	44,797	92,119
Percentage of NHS Trade Invoices Paid Within Target	**77.71%**	**81.29%**	45.38%	56.13%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**3,282**	**23,650**	3,009	**19,472**
Total NHS Trade Invoices Paid Within Target	**1,847**	**15,745**	920	**11,047**
Percentage of NHS Trade Invoices Paid Within Target	**56.28%**	**66.58%**	30.57%	56.73%

The Better Payment Practice Code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

11.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2014-15 £000s	2013-14 £000s
Amounts included in finance costs from claims made under this legislation	**0**	0
Compensation paid to cover debt recovery costs under this legislation	**0**	0
Total	**0**	0

The Trust made six late payment charges totalling £158.60 and two interest charges of £386.45 (£415.60 2013/14) during the year under the late payment of commercial debt act.

12 Investment Revenue

	2014-15 £000s	2013-14 £000s
Rental revenue		
PFI finance lease revenue (planned)	**0**	0
PFI finance lease revenue (contingent)	**0**	0
Other finance lease revenue	**0**	0
Subtotal	**0**	0
Interest revenue		
Bank interest	**48**	29
Other loans and receivables	**0**	0
Impaired financial assets	**0**	0
Other financial assets	**0**	0
Subtotal	**48**	29
Total investment revenue	**48**	29

13 Other Gains and Losses

	2014-15 £000s	2013-14 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	**(50)**	(55)
Gain/(Loss) on disposal of assets other than by sale (intangibles)	**0**	0
Gain/(Loss) on disposal of Financial Assets other then held for sale	**0**	0
Gain (Loss) on disposal of assets held for sale	**0**	1,377
Gain/(loss) on foreign exchange	**0**	0
Change in fair value of financial assets carried at fair value through the SoCI	**0**	0
Change in fair value of financial liabilities carried at fair value through the SoCI	**0**	0
Change in fair value of investment property	**0**	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	**0**	0
Total	**(50)**	1,322

14 Finance Costs

	2014-15 £000s	2013-14 £000s
Interest		
Interest on loans and overdrafts	**655**	718
Interest on obligations under finance leases	**0**	0
Interest on obligations under PFI contracts:		
- main finance cost	**11,416**	11,658
- contingent finance cost	**2,360**	1,903
Interest on late payment of commercial debt	**0**	0
Total interest expense	**14,431**	14,279
Other finance costs	**0**	0
Provisions - unwinding of discount	**7**	7
Total	**14,438**	14,286

15.1 Property, plant and equipment

2014-15	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:									
At 1 April 2014	**40,889**	**332,858**	**5,501**	**1,695**	**80,323**	**960**	**15,118**	**2,694**	**480,038**
Additions of Assets Under Construction	**0**	**0**	**0**	**6,386**	**0**	**0**	**0**	**0**	**6,386**
Additions Purchased	0	3,157	560	**0**	1,866	0	638	0	**6,221**
Additions - Non Cash Donations (i.e. physical assets)	0	0	0	0	0	0	0	0	**0**
Additions - Purchases from Cash Donations & Government Grants	0	0	0	0	418	0	37	0	**455**
Additions Leased	0	0	0	**0**	0	0	0	0	**0**
Reclassifications	0	56	0	(1,323)	0	0	530	0	**(737)**
Reclassifications as Held for Sale and reversals	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	(732)	0	0	0	**(732)**
Upward revaluation/positive indexation	0	5,818	0	0	0	0	0	0	**5,818**
Removal of accumulated depreciation/impairment following revaluation	(1,808)	(37,947)	(1,815)	0	0	0	0	0	**(41,570)**
Impairments/negative indexation	(501)	(10,283)	(1,213)	0	0	0	0	0	**(11,997)**
Reversal of Impairments	0	5,839	0	0	0	0	0	0	**5,839**
Transfers to NHS Foundation Trust	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	**0**
At 31 March 2015	**38,580**	**299,498**	**3,033**	**6,758**	**81,875**	**960**	**16,323**	**2,694**	**449,721**
Depreciation									
At 1 April 2014	**0**	**25,011**	**277**	**0**	**53,335**	**835**	**9,442**	**860**	**89,760**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reclassifications as Held for Sale and reversals	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	(683)	0	0	0	**(683)**
Removal of accumulated depreciation/impairment following revaluation	(1,808)	(37,947)	(1,815)	0	0	0	0	0	**(41,570)**
Impairments	1,808	20,787	1,443	0	109	0	1,138	0	**25,285**
Reversal of Impairments	0	(11,035)	0	0	0	0	0	0	**(11,035)**
Charged During the Year	0	6,194	148	0	7,346	47	2,034	274	**16,043**
Transfers to NHS Foundation Trust	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	**0**	0	0	0	0	**0**
At 31 March 2015	**0**	**3,010**	**53**	**0**	**60,107**	**882**	**12,614**	**1,134**	**77,800**
Net Book Value at 31 March 2015	**38,580**	**296,488**	**2,980**	**6,758**	**21,768**	**78**	**3,709**	**1,560**	**371,921**
Asset financing:									
Owned - Purchased	38,580	103,284	2,980	6,758	20,458	78	3,670	1,560	**177,368**
Owned - Donated	0	81	0	0	1,243	0	39	0	**1,363**
Owned - Government Granted	0	0	0	0	67	0	0	0	**67**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	193,123	0	0	0	0	0	0	**193,123**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2015	**38,580**	**296,488**	**2,980**	**6,758**	**21,768**	**78**	**3,709**	**1,560**	**371,921**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2014	29,585	30,919	1,900	0	680	13	0	2	**63,099**
Movements - Revaluation (LB&D), Transfer on disposal (P&M)	(500)	1,373	(1,213)	0	(23)	0	0	0	**(363)**
At 31 March 2015	**29,085**	**32,292**	**687**	**0**	**657**	**13**	**0**	**2**	**62,736**

Additions to Assets Under Construction in 2014-15

	£000's
Land	0
Buildings excl Dwellings	540
Dwellings	0
Plant & Machinery	5,846
Balance as at YTD	**6,386**

15.2 Property, plant and equipment prior-year

2013-14	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Cost or valuation:									
At 1 April 2013	38,433	328,726	4,202	2,646	80,222	960	29,258	3,052	**487,499**
Transfers under Modified Absorption Accounting - PCTs & SHAs	0	0	0	0	0	0	0	0	**0**
Transfers under Modified Absorption Accounting - Other Bodies	0	0	0	0	0	0	0	0	**0**
Additions of Assets Under Construction	0	0	0	1,576	0	0	0	0	**1,576**
Additions Purchased	2,098	2,124	1,827	0	1,676	0	1,194	18	**8,937**
Additions - Non Cash Donations (i.e. Physical Assets)	0	0	0	0	0	0	0	0	**0**
Additions - Purchases from Cash Donations & Government Grants	0	0	0	0	403	0	0	0	**403**
Additions Leased	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	578	0	(2,527)	887	0	945	0	**(117)**
Reclassifications as Held for Sale and Reversals	(121)	0	(390)	0	0	0	0	0	**(511)**
Disposals other than for sale	0	0	0	0	(2,865)	0	(16,279)	(376)	**(19,520)**
Revaluation	479	6,216	37	0	0	0	0	0	**6,732**
Impairments/negative indexation charged to reserves	0	(7,925)	(175)	0	0	0	0	0	**(8,100)**
Reversal of Impairments charged to reserves	0	3,139	0	0	0	0	0	0	**3,139**
Transfers to Foundation Trust	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	**0**
At 31 March 2014	**40,889**	**332,858**	**5,501**	**1,695**	**80,323**	**960**	**15,118**	**2,694**	**480,038**
Depreciation									
At 1 April 2013	0	6,331	162	0	47,679	730	19,820	939	**75,661**
Reclassifications	0	0	0	0	40	0	(40)	0	**0**
Reclassifications as Held for Sale and Reversals	0	0	(27)	0	0	0	0	0	**(27)**
Disposals other than for sale	0	0	0	0	(2,809)	0	(16,279)	(376)	**(19,464)**
Revaluation	0	0	0	0	0	0	0	0	**0**
Impairments/negative indexation charged to operating expenses	0	20,048	0	0	721	0	3,891	0	**24,660**
Reversal of Impairments charged to operating expenses	0	(7,903)	0	0	0	0	0	0	**(7,903)**
Charged During the Year	0	6,535	142	0	7,704	105	2,050	297	**16,833**
Transfers to Foundation Trust	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	**0**
At 31 March 2014	**0**	**25,011**	**277**	**0**	**53,335**	**835**	**9,442**	**860**	**89,760**
Net Book Value at 31 March 2014	40,889	307,847	5,224	1,695	26,988	125	5,676	1,834	**390,278**
Asset financing:									
Owned - Purchased	40,889	104,771	5,224	1,695	25,648	125	5,650	1,833	**185,835**
Owned - Donated	0	76	0	0	1,169	0	26	1	**1,272**
Owned - Government Granted	0	0	0	0	171	0	0	0	**171**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	203,000	0	0	0	0	0	0	**203,000**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2014	**40,889**	**307,847**	**5,224**	**1,695**	**26,988**	**125**	**5,676**	**1,834**	**390,278**

15.3 Property, plant and equipment

Within the financial year 2014/15, the Trust received donations to purchase medical equipment totalling £455k. The majority of these donations, £392k, were kindly donated by The League of Friends charities from both hospital sites and included supporting the purchase of a Holmium laser £270k. A further £57k was donated from the Maidstone and Tunbridge Wells Charitable Fund.

2014/15 was the final year in the Trust's 5 year cyclical valuation programme. A full valuation was carried out by Trust independent valuers Montagu Evans LLP at 30th September 2014 with further indexation applied by the Trust at 31st March 2015 to reflect the 4.05% increase in BCIS 'all in tender price' index since the date of the valuation.

The 30th September valuation resulted in a net impairment (reduction in value) of £24,857k across all categories of asset (Land, Build and Dwelling). The indexation at 4.05% increased values by £11,514k. The net change in valuation for 2014/15 is an impairment of £13,343k of which £13,003k has been recognised in the SoCI and the remaining £340k charged to reserves.

Specialised properties (main hospitals) have been valued based on Depreciation Replacement Cost (DRC). Existing Use Value (EUV) has been used as the basis of valuation for Land owner occupied and together with any non specialised buildings. Residential staff accommodation has been valued using Existing Use for Social Housing.

The adoption of EUV for 2014/15 as opposed to market value approach applied previously has resulted in a total impairment of £4,965k in respect of residential accommodation and associated land.

For 2014/15 the Trust commissioned, as part of the full valuation, a more detailed review of Trust external works, hard landscaping (roads, pathways etc) and soft landscaping/woodlands. In previous valuations this had been estimated at a percentage of the building costs, resulting in a disproportionately high value in particular at the Tunbridge Wells Hospital site. The 2014/15 value has been based on "hectares multiplied by build cost" which is a method consistent with that applied to the building valuation. This change in estimation has resulted in an impairment before indexation of £10,173k in external works asset across both sites.

The Trust carried out a fair value assessment of plant and machinery and IT tangible assets based on a valuation model as advised by Trust experts in the relevant asset classes. This resulted in impairments of £109k for Plant and Machinery and £1,138k IT tangible assets.

Economic lives of Non-Current Assets	Minimum Life	Maximum life
Property, Plant and Equipment		
Buildings exc Dwellings	1	60
Dwellings	28	33
Plant & Machinery	1	20
Transport Equipment	1	20
Information Technology	2	8
Furniture and Fittings	5	10

16.1 Intangible non-current assets

2014-15	IT - in-house & 3rd party software	Computer Licenses	Licenses and Trademarks	Patents	Development Expenditure - Internally Generated	Total
	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2014	**3,366**	**458**	**0**	**0**	**0**	**3,824**
Additions Purchased	946	0	0	0	0	**946**
Additions Internally Generated	0	0	0	0	0	**0**
Additions - Non Cash Donations (i.e. physical assets)	0	0	0	0	0	**0**
Additions - Purchases from Cash Donations and Government Grants	0	0	0	0	0	**0**
Additions Leased	0	0	0	0	0	**0**
Reclassifications	737	0	0	0	0	**737**
Reclassified as Held for Sale and Reversals	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
Revaluation & indexation gains	0	0	0	0	0	**0**
Impairments charged to reserves	0	0	0	0	0	**0**
Reversal of impairments charged to reserves	0	0	0	0	0	**0**
Transfer to NHS Foundation Trust	0	0	0	0	0	**0**
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	0	**0**
At 31 March 2015	**5,049**	**458**	**0**	**0**	**0**	**5,507**
Amortisation						
At 1 April 2014	**2,328**	**130**	**0**	**0**	**0**	**2,458**
Reclassifications	0	0	0	0	0	**0**
Reclassified as Held for Sale and Reversals	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
Revaluation or indexation gains	0	0	0	0	0	**0**
Impairments charged to operating expenses	0	0	0	0	0	**0**
Reversal of impairments charged to operating expenses	0	0	0	0	0	**0**
Charged during the year	529	124	0	0	0	**653**
Transfer to NHS Foundation Trust	0	0	0	0	0	**0**
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	0	**0**
At 31 March 2015	**2,857**	**254**	**0**	**0**	**0**	**3,111**
Net Book Value at 31 March 2015	**2,192**	**204**	**0**	**0**	**0**	**2,396**
Asset Financing: Net book value at 31 March 2015 comprises:						
Purchased	2,192	204	0	0	0	**2,396**
Donated	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	**0**
Finance Leased	0	0	0	0	0	**0**
On-balance Sheet PFIs	0	0	0	0	0	**0**
Total at 31 March 2015	**2,192**	**204**	**0**	**0**	**0**	**2,396**

Revaluation reserve balance for intangible non-current assets	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2014	0	0	0	0	0	**0**
Movements (specify)	0	0	0	0	0	**0**
At 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**

16.2 Intangible non-current assets prior year

2013-14	IT - in-house & 3rd party software	Computer Licenses	Licenses and Trademarks	Patents	Development Expenditure - Internally Generated	Total
	£000s	£000s	£000s	£000s	£000s	£000s
Cost or valuation:						
At 1 April 2013	4,304	495	0	0	0	4,799
Transfers under Modified Absorption Accounting - PCTs & SHAs	0	0	0	0	0	0
Transfers under Modified Absorption Accounting - Other Bodies	0	0	0	0	0	0
Additions - purchased	41	94	0	0	0	135
Additions - internally generated	0	0	0	0	0	0
Additions - donated	0	0	0	0	0	0
Additions - government granted	0	0	0	0	0	0
Additions Leased	0	0	0	0	0	0
Reclassifications	117	0	0	0	0	117
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	(1,096)	(131)	0	0	0	(1,227)
Revaluation & indexation gains	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0
Transfer to NHS Foundation Trust	0	0	0	0	0	0
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	0	0
At 31 March 2014	3,366	458	0	0	0	3,824
Amortisation						
At 1 April 2013	2,470	150	0	0	0	2,620
Reclassifications	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	(1,096)	(131)	0	0	0	(1,227)
Revaluation or indexation gains	0	0	0	0	0	0
Impairments charged to operating expenses	401	17	0	0	0	418
Reversal of impairments charged to operating expenses	0	0	0	0	0	0
Charged during the year	553	94	0	0	0	647
Transfer to NHS Foundation Trust	0	0	0	0	0	0
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	0	0
At 31 March 2014	2,328	130	0	0	0	2,458
Net book value at 31 March 2014	1,038	328	0	0	0	1,366
Net book value at 31 March 2014 comprises:						
Purchased	1,038	328	0	0	0	1,366
Donated	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0
Total at 31 March 2014	1,038	328	0	0	0	1,366

16.3 Intangible non-current assets

Economic lives of Non-Current Assets	Minimum Life	Maximum life
Intangible Assets		
Software Licences	3	5
Licences and Trademarks	0	0
Patents	0	0
Development expenditure	0	0
IT - in house & 3rd Party Software	2	7

17 Analysis of impairments and reversals recognised in 2014-15

	Total	Property Plant and Equipment	Intangible Assets	Financial Assets	Non-Current Assets Held for Sale
	£000s	£000s	£000s	£000s	£000s
Impairments and reversals taken to SoCI					
Loss or damage resulting from normal operations	**0**	0	0	0	0
Over-specification of assets	**0**	0	0	0	0
Abandonment of assets in the course of construction	**0**	0	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**	**0**	**0**
Unforeseen obsolescence	**0**	0	0	0	0
Loss as a result of catastrophe	**0**	0	0	0	0
Other	**0**	0	0	0	0
Changes in market price	**14,250**	14,250	0	0	0
Total charged to Annually Managed Expenditure	**14,250**	**14,250**	**0**	**0**	**0**
Total Impairments of Property, Plant and Equipment changed to SoCI	**14,250**	**14,250**	**0**	**0**	**0**
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve					
Loss or damage resulting from normal operations	**0**	0	0	0	0
Over Specification of Assets	**0**	0	0	0	0
Abandonment of assets in the course of construction	**0**	0	0	0	0
Unforeseen obsolescence	**0**	0	0	0	0
Loss as a result of catastrophe	**0**	0	0	0	0
Other	**0**	0	0	0	0
Changes in market price	**340**	340	0	0	0
Total impairments for PPE charged to reserves	**340**	**340**	**0**	**0**	**0**

Donated and Gov Granted Assets, included above	**£000s**
PPE - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	**0**
Intangibles - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	**0**

Changes in market price in respect of Property, Plant and Equipment relates to net impairments of £13,003k charged to the Statement of Comprehensive Income following the 5 year cyclical valuation at 30th September 2014 and indexation of 4.05% applied at 31st March 2015. The balance of £1,247k represents the fair value assessment of plant and machinery and IT tangible assets based on a valuation model as advised by Trusts experts in the relevant asset classes.

Further information in respect of the valuation is contained in Note 15.3.

18 Investment property

The Trust has no investment properties.

19 Commitments

Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2015 £000s	31 March 2014 £000s
Property, plant and equipment	**2,863**	2,895
Intangible assets	**105**	0
Total	**2,968**	2,895

20 Intra-Government and other balances

	Current receivables £000s	**Non-current receivables £000s**	**Current payables £000s**	**Non-current payables £000s**
Balances with Other Central Government Bodies	2,161	0	3,094	0
Balances with Local Authorities	277	0	27	0
Balances with NHS bodies outside the Departmental Group	0	0	10	0
Balances with NHS bodies inside the Departmental Group	23,843	0	5,098	16,676
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with Bodies External to Government	7,355	1,227	31,834	208,034
At 31 March 2015	**33,636**	**1,227**	**40,063**	**224,710**
prior period:				
Balances with Other Central Government Bodies	22,499	0	9,100	0
Balances with Local Authorities	313	0	14	0
Balances with NHS bodies outside the Departmental Group	0	0	2	0
Balances with NHS bodies inside the Departmental Group	6,777	0	3,694	18,850 *
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with Bodies External to Government	8,072	1,075	18,924	212,810 *
At 31 March 2014	**37,661**	**1,075**	**31,734**	**231,660**

* prior year comparators have been added to reflect the increase in disclosure for 2014/15, to include within the note the DoH capital loan (balances inside the departmental group) and the PFI liability (balances external to government).

21 Inventories	Drugs £000s	Consumables £000s	Work in Progress £000s	Energy £000s	Loan Equipment £000s	Other £000s	Total £000s	Of which held at NRV £000s
Balance at 1 April 2014	**2,975**	**609**	**0**	**69**	**0**	**3,356**	**7,009**	0
Additions	33,385	0	0	0	0	13,249	**46,634**	0
Inventories recognised as an expense in the period	(33,295)	0	0	(23)	0	(13,806)	**(47,124)**	0
Write-down of inventories (including losses)	0	0	0	0	0	0	**0**	0
Reversal of write-down previously taken to SOCI	0	0	0	0	0	0	**0**	0
Balance at 31 March 2015	**3,065**	**609**	**0**	**46**	**0**	**2,799**	**6,519**	**0**

22.1 Trade and other receivables	Current		Non-current	
	31 March 2015 £000s	31 March 2014 £000s	**31 March 2015 £000s**	31 March 2014 £000s
NHS receivables - revenue	**23,754**	27,922	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**0**	0	**0**	0
Non-NHS receivables - revenue	**3,568**	2,261	**0**	0
Non-NHS receivables - capital	**43**	2,175	**0**	0
Non-NHS prepayments and accrued income	**3,779**	3,529	**0**	0
PDC Dividend prepaid to DH	**89**	0	**0**	0
Provision for the impairment of receivables	**(971)**	(699)	**0**	0
VAT	**2,161**	1,355	**0**	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	**0**	0	**104**	87
Interest receivables	**0**	0	**0**	0
Finance lease receivables	**0**	0	**0**	0
Operating lease receivables	**0**	0	**0**	0
Other receivables	**1,213**	1,118	**1,123**	988
Total	**33,636**	37,661	**1,227**	1,075
Total current and non current	**34,863**	38,736		
Included in NHS receivables are prepaid pension contributions:	**0**			

The great majority of trade is with Clinical Commissioning Groups (CCG's) as commissioners for NHS patient care services. As CCG's are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

The movement in non NHS receivables - capital represents receipt of the proceeds due in respect of the sale of the Nurses Home and Oakapple site.

22.2 Receivables past their due date but not impaired	**31 March 2015 £000s**	31 March 2014 £000s
By up to three months	**3,353**	15,817
By three to six months	**2,618**	11,903
By more than six months	**5,364**	1,610
Total	**11,335**	29,330

The Trust does not hold any collateral against receivable balances.

22.3 Provision for impairment of receivables	**2014-15 £000s**	2013-14 £000s
Balance at 1 April 2014	**(699)**	(683)
Amount written off during the year	**204**	157
Amount recovered during the year	**184**	266
(Increase)/decrease in receivables impaired	**(660)**	(439)
Balance at 31 March 2015	**(971)**	(699)

The provision of receivables includes provision for all non-NHS invoices over three months overdue plus any other invoices that are deemed to be a specific risk. In addition 18.9% (15.8% 2013-14) of injury cost recovery debt has been provided in accordance with the guidance from the compensation recovery unit.

23 NHS LIFT investments

The Trust does not have any Lift investments

24.1 Other Financial Assets - Current

The Trust does not have any current financial assets.

24.2 Other Financial Assets - Non Current

The Trust does not have any non-current financial assets.

25 Other current assets

	31 March 2015 £000s	31 March 2014 £000s
EU Emissions Trading Scheme Allowance	**0**	0
Other Assets	**0**	0
Total	**0**	0

26 Cash and Cash Equivalents

	31 March 2015 £000s	31 March 2014 £000s
Opening balance	**1,287**	2,792
Net change in year	**2,509**	(1,505)
Closing balance	**3,796**	1,287
Made up of		
Cash with Government Banking Service	**3,763**	1,221
Commercial banks	**14**	49
Cash in hand	**19**	17
Liquid deposits with NLF	**0**	0
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**3,796**	1,287
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**3,796**	1,287
Patients' money held by the Trust, not included above, see note 44	**0**	1

For 2014/15 the Trust received £12m non-recurrent deficit support as cash. For 2015/16 the Trust plans include the requirement for a working capital facility of £12.3m. The Trust has advised the Trust Development Authority (TDA) that plans for 2016/17 will include a requirement for further working capital facility.

27 Non-current assets held for sale

	Land	Buildings, excl. dwellings	Dwellings	Asset Under Construction and Payments on Account	Plant and Machinery	Transport and Equipment	Information Technology	Furniture and Fittings	Intangible Assets	Financial Assets	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2014	0	0	0	0	0	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	0	0	0	0	0	0	0	0	0	**0**
Less assets sold in the year	0	0	0	0	0	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	**0**
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	0	**0**
Balance at 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Balance at 1 April 2013	1,022	0	478	0	0	0	0	0	0	0	**1,500**
Plus assets classified as held for sale in the year	121	0	363	0	0	0	0	0	0	0	**484**
Less assets sold in the year	(1,143)	0	(841)	0	0	0	0	0	0	0	**(1,984)**
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	**0**
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	0	**0**
Balance at 31 March 2014	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2014	0	0	0	0	0	0	0	0	0	0	0

The Trust currently has no assets held for sale

28 Trade and other payables

	Current		Non-current	
	31 March 2015 £000s	31 March 2014 £000s	**31 March 2015 £000s**	31 March 2014 £000s
NHS payables - revenue	**2,614**	5,272	**0**	0
NHS payables - capital	**320**	14	**0**	0
NHS accruals and deferred income	**0**	0	**0**	0
Non-NHS payables - revenue	**11,128**	8,594	**0**	0
Non-NHS payables - capital	**5,107**	1,169	**0**	0
Non-NHS accruals and deferred income	**12,590**	11,331	**0**	0
Social security costs	**38**	2,193	**0**	0
PDC Dividend payable to DH	**0**	0	**0**	0
VAT	**0**	0	**0**	0
Tax	**40**	2,380	**0**	0
Payments received on account	**0**	0	**0**	0
Other	**1,276**	781	**0**	0
Total	**33,113**	31,734	**0**	0
Total payables (current and non-current)	**33,113**	**31,734**		
Included above:				
to Buy Out the Liability for Early Retirements Over 5 Years	**0**	0		
number of Cases Involved (number)	**0**	0		
outstanding Pension Contributions at the year end	**3,016**	2,943		

29 Other liabilities

	Current		Non-current	
	31 March 2015 £000s	31 March 2014 £000s	**31 March 2015 £000s**	31 March 2014 £000s
PFI/LIFT deferred credit	**0**	0	**0**	0
Lease incentives	**0**	0	**0**	0
Other	**0**	0	**0**	0
Total	**0**	0	**0**	0
Total other liabilities (current and non-current)	**0**	**0**		

30 Borrowings

	Current		Non-current	
	31 March 2015 £000s	31 March 2014 £000s	**31 March 2015 £000s**	31 March 2014 £000s
Bank overdraft - Government Banking Service	**0**	0	**0**	0
Bank overdraft - commercial banks	**0**	0	**0**	0
Loans from Department of Health	**2,174**	2,174	**16,676**	18,850
Loans from other entities	**0**	0	**0**	0
PFI liabilities:				
Main liability	**4,776**	4,772	**208,034**	212,810
Lifecycle replacement received in advance	**0**	0	**0**	0
Finance lease liabilities	**0**	0	**0**	0
Other	**0**	0	**0**	0
Total	**6,950**	**6,946**	**224,710**	**231,660**
Total other liabilities (current and non-current)	**231,660**	**238,606**		

Borrowings / Loans - repayment of principal falling due in:

	31 March 2015		
	DH £000s	**Other £000s**	**Total £000s**
0-1 Years	2,174	4,776	**6,950**
1 - 2 Years	2,174	4,774	**6,948**
2 - 5 Years	8,096	15,739	**23,835**
Over 5 Years	6,406	187,521	**193,927**
TOTAL	**18,850**	**212,810**	**231,660**

The Department of Health loans totalling £29m were taken out to finance the Trust capital programme. The £11m loan received on the 15th March 2010 has a final repayment date of 15th March 2025 with a fixed interest rate of 3.91%, the further loan of £12m taken out on the 15th September 2010 has a final repayment date of 15th September 2020 with a fixed interest rate of 2.02%. The latest loan taken out on the 15th December 2010 has a final repayment date of 15th September 2035 at a fixed rate of 4.73%.

The PFI liabilities relate to the PFI contract that the Trust signed in March 2008. The contract is a standard form PFI contract with a concession that completes in 2042, when the building reverts to the Trust. Further information is set out in note 37.

31 Other financial liabilities

	Current		Non-current	
	31 March 2015 £000s	31 March 2014 £000s	**31 March 2015 £000s**	31 March 2014 £000s
Embedded derivatives at fair value through SoCI	**0**	0	**0**	0
Financial liabilities carried at fair value through profit and loss	**0**	0	**0**	0
Amortised cost	**0**	0	**0**	0
Total	**0**	0	**0**	0
Total other financial liabilities (current and non-current)	**0**	0		

32 Deferred revenue

	Current		Non-current	
	31 March 2015 £000s	31 March 2014 £000s	**31 March 2015 £000s**	31 March 2014 £000s
Opening balance at 1 April 2014	**1,340**	1,014	**0**	0
Deferred revenue addition	**28,855**	1,290	**0**	0
Transfer of deferred revenue	**(25,500)**	(964)	**0**	0
Current deferred Income at 31 March 2015	**4,695**	1,340	**0**	0
Total deferred income (current and non-current)	**4,695**	1,340		

33 Finance lease obligations as lessee

The Trust has not entered into any finance lease arrangements as lessee.

34 Finance lease receivables as lessor

The Trust has not entered into any finance lease arrangements as lessor.

35 Provisions

Comprising:

	Total	Early Departure Costs	Legal Claims	Other	Redundancy
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2014	**3,794**	416	700	2,599	79
Arising during the year	**1,267**	7	370	36	854
Utilised during the year	**(623)**	(17)	(363)	(164)	(79)
Reversed unused	**(89)**	0	(74)	(15)	0
Unwinding of discount	**7**	7	0	0	0
Change in discount rate	**23**	23	0	0	0
Balance at 31 March 2015	**4,379**	**436**	**633**	**2,456**	**854**
Expected Timing of Cash Flows:					
No Later than One Year	**2,435**	28	633	920	854
Later than One Year and not later than Five Years	**1,150**	90	0	1,060	0
Later than Five Years	**794**	318	0	476	0

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

As at 31 March 2015	95,510
As at 31 March 2014	83,662

Early departure costs relates to two ill health injury benefits calculated by current payment made by the NHS pension agency adjusted for average life expectancy using tables published by the National Statistics Office. Legal claims are estimates notified by the NHS Litigation Authority or the Trust's solicitors.

The provision for redundancy relates to potential costs associated with hosted Health Informatics Service

Other includes onerous contract provision £691k and provision for dilapidations of leased properties/equipment £1,765k.

36 Contingencies

	31 March 2015 £000s	31 March 2014 £000s
Contingent liabilities		
NHS Litigation Authority legal claims	**(45)**	(52)
Employment Tribunal and other employee related litigation	**0**	0
Redundancy	**0**	0
Other - Potential claim under the tenancy deposit scheme	**0**	(196)
Amounts recoverable against contingent liabilities	**0**	0
Net value of contingent liabilities	**(45)**	(248)
Contingent assets		
Contingent assets	**0**	0
Net value of contingent assets	**0**	0

37 PFI and LIFT - additional information

The trust signed a PFI project agreement on 26th March 2008 for the new Tunbridge Wells The Trust signed a PFI project agreement on 26th March 2008 for the new Tunbridge Wells Hospital at Pembury. The main building was handed over by the contractor in phases in December 2010 and May 2011 and recognised in the Trust's accounts accordingly. By joint agreement with the Trust's PFI partner the final phase of car parking & landscaping were completed and handed over early in January 2012, although contractual phasing and unitary payments were kept in line with the project agreement completion date of September 2012. The arrangement covers the provision of buildings, hard facilities management services and lifecycle replacement (building & engineering asset renewals). Under the project agreement the Trust has agreed expectations for the provision of these services and has termination options on default. The land remains the Trust's asset throughout the concession. The concession is due to run for 30 years until 2042 when the building will revert to the Trust. The annual unitary payment was contracted at £16.9m at 2005/06 prices, and is subject to an annual uplift by Retail Price Index which for the 2014/15 year was 2.7%.

The information below is required by the Department of Heath for inclusion in national statutory accounts

Charges to operating expenditure and future commitments in respect of ON and OFF SOFP PFI	**2014-15 £000s**	2013-14 £000s
Total charge to operating expenses in year - Off SoFP PFI	**0**	0
Service element of on SOFP PFI charged to operating expenses in year	**3,988**	3,957
Total	**3,988**	3,957
Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI		
No Later than One Year	**4,348**	4,132
Later than One Year, No Later than Five Years	**19,863**	18,888
Later than Five Years	**200,695**	209,417
Total	**224,906**	232,437

The estimated annual payments in future years will vary according to published RPI rates but are not expected to be materially different from those which the Trust is committed to make during the next year.

Imputed "finance lease" obligations for on SOFP PFI contracts due	**2014-15 £000s**	2013-14 £000s
No Later than One Year	**15,937**	16,188
Later than One Year, No Later than Five Years	**62,581**	62,981
Later than Five Years	**321,178**	336,714
Subtotal	**399,696**	415,883
Less: Interest Element	**(186,886)**	(198,301)
Total	**212,810**	217,582

Present Value Imputed "finance lease" obligations for on SOFP PFI contracts due Analysed by when PFI payments are due	**2014-15 £000s**	2013-14 £000s
No Later than One Year	**4,776**	15,640
Later than One Year, No Later than Five Years	**20,512**	55,890
Later than Five Years	**187,522**	191,829
Total	**212,810**	263,359

Number of on SOFP PFI Contracts	
Total Number of on PFI contracts	**1**
Number of on PFI contracts which individually have a total commitments value in excess of £500m	**0**

38 Impact of IFRS treatment - current year

The information below is required by the Department of Heath for budget reconciliation purposes

	2014-15 £000s	2013-14 £000s
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g. PFI / LIFT)		
Depreciation charges	**3,419**	3,714
Interest Expense	**13,776**	13,562
Impairment charge - AME	**9,009**	9,233
Impairment charge - DEL	**0**	0
Other Expenditure	**3,989**	3,957
Revenue Receivable from subleasing	**0**	0
Impact on PDC dividend payable	**(600)**	(365)
Total IFRS Expenditure (IFRIC12)	**29,593**	**30,101**
Revenue consequences of PFI / LIFT schemes under UK GAAP / ESA95 (net of any sublease revenue)	**(19,723)**	(19,528)
Net IFRS change (IFRIC12)	**9,870**	**10,573**
Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12		
Capital expenditure 2014-15	**145**	101
UK GAAP capital expenditure 2014-15 (Reversionary Interest)	**2,949**	2,773

39 Financial Instruments

39.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with commissioners and the way those commissioners are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust's treasury activity is subject to review by the Trust's internal auditors.

Currency risk
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk
The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the strategic health authority. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk
Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2015 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk
The Trust's operating costs are incurred under contracts with Commissioning Care Groups (CCG's), which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

39.2 Financial Assets

	At 'fair value through profit and loss' £000s	Loans and receivables £000s	Available for sale £000s	Total £000s
Embedded derivatives	0	0	0	**0**
Receivables - NHS	0	23,752	0	**23,752**
Receivables - non-NHS	0	6,262	0	**6,262**
Cash at bank and in hand	0	3,796	0	**3,796**
Other financial assets	0	0	0	**0**
Total at 31 March 2015	**0**	**33,810**	**0**	**33,810**
Embedded derivatives	0	0	0	0
Receivables - NHS	0	27,922	0	27,922
Receivables - non-NHS	0	7,486	0	7,486
Cash at bank and in hand	0	1,287	0	1,287
Other financial assets	0	0	0	0
Total at 31 March 2014	0	36,695	0	36,695

39.3 Financial Liabilities

	At 'fair value through profit and loss' £000s	Other £000s	Total £000s
Embedded derivatives	0	0	**0**
NHS payables	0	2,934	**2,934**
Non-NHS payables	0	24,797	**24,797**
Other borrowings	0	18,850	**18,850**
PFI & finance lease obligations	0	212,810	**212,810**
Other financial liabilities	0	0	**0**
Total at 31 March 2015	**0**	**259,391**	**259,391**
Embedded derivatives	0	0	0
NHS payables	0	5,286	5,286
Non-NHS payables	0	20,535	20,535
Other borrowings	0	21,024	21,024
PFI & finance lease obligations	0	217,582	217,582
Other financial liabilities	0	0	0
Total at 31 March 2014	0	264,427	264,427

40 Events after the end of the reporting period

In April 2015, the Crown Prosecution Service authorised a charge against the Trust under the Corporate Manslaughter and Corporate Homicide Act 2007. No estimate in respect of any potential financial impact for legal costs can be made at the date of signing the accounts.

41 Related party transactions

During the year none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Maidstone and Tunbridge Wells NHS Trust.

The Department of Health (DOH) is regarded as a related party. During the year Maidstone and Tunbridge Wells NHS Trust received £13.1m external financing (including capital £1.1m) and the Trust also has loans with the DoH, interest paid within the year of £655k, capital repayment of £2,174k and the balance outstanding is £18,850k. The Trust has transactions with other entities for which the Department is regarded as the parent department. The following entities of material transactions of more than £1m are:

£000's	2014-15 Receivables	2014-15 Payables	2014-15 Income	2014-15 Expenditure	2013-14 Receivables	2013-14 Payables	2013-14 Income	2013-14 Expenditure
Ashford CCG	0	0	876	0	249	0	1,328	0
Brighton & Sussex University Hospitals NHS Trust	0	14	2	24	5	6	5,619	27
Dartford & Gravesham NHS Trust	1,202	18	3,975	76	734	105	3,423	289
Dartford, Gravesham & Swanley CCG	220	0	3,681	0	264	0	3,351	0
East Kent University Hospitals Foundation Trust	2,418	1,190	5,899	1,980	4,066	1,782	5,477	2,550
Hastings and Rother CCG	115	0	905	0	283	0	1,099	0
Health Education England	68	0	9,157	2	97	0	3,675	0
High Weald Lewes Havens CCG	2,904	0	20,996	0	1,529	0	17,580	0
Kent and Medway NHS & Social Care NHS Trust	628	152	2,003	99	365	38	1,990	265
Kent Community NHS Trust (trf to FT status 1/3/15)	0	0	2,287	1,674	515	561	3,075	1,704
Kent Community NHS FT	728	657	733	105	N/A	N/A	N/A	N/A
Medway CCG	748	0	11,755	0	1,074	0	11,192	0
Medway NHS Foundation Trust	1,390	202	3,886	657	669	345	3,797	1,187
NHS England	6,463	60	82,705	65	1,988	5	75,202	0
NHS Pension Agency	0	3,016	0	29,284	0	144	0	21,082
Swale CCG	222	0	5,502	0	607	0	5,006	0
The NHS Litigation Authority	0	0	0	11,012	84	0	0	8,872
West Kent CCG	5,404	0	208,013	0	13,616	49	201,974	67

The Trust has not consolidated the Charitable funds that it controls on the grounds of materiality to the Trust (see policy notes 1.4 and1.32). The transactions between the Trust and the Charity (Maidstone and Tunbridge Wells NHS Charitable Fund - charity registration 1055215) are however material to the charity and therefore disclosed below. Please note this disclosure is based on the draft unaudited position of the charity.; the audited accounts of the charity will be available later this year.

	2014-15 £000	2013-14 £000
Total charitable resources expended with the Trust	**196**	611 *
Closing creditor (monies owed to the Trust by the charity)	**72**	102 *
Total income received by the Charity in the reporting period	**152**	638 *
Total Charitable Funds at end of the reporting period	**1,067**	1,094 *

* prior year comparitors have been restated following the completion of charitable funds accounts.

42 Losses and special payments

The total number of losses cases in 2014-15 and their total value was as follows:

	Total Value of Cases £s	**Total Number of Cases**
Losses	50,132	61
Special payments	11,532	36
Total losses and special payments	61,664	97

The total number of losses cases in 2013-14 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	55,810	77
Special payments	68,919	80
Total losses and special payments	124,729	157

Details of cases individually over £300,000

The Trust has no cases exceeding £300,000

43. Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

43.1 Breakeven performance	**2005-06 £000s**	**2006-07 £000s**	**2007-08 £000s**	**2008-09 £000s**	**2009-10 £000s**	**2010-11 £000s**	**2011-12 £000s**	**2012-13 £000s**	**2013-14 £000s**	**2014-15 £000s**
Turnover	241,329	243,218	272,939	297,888	311,889	322,176	345,101	367,391	375,714	**403,310**
Retained surplus/(deficit) for the year	1,696	(4,932)	131	143	(17,077)	(20,474)	(27,113)	(4,704)	(30,946)	**(14,954)**
Adjustment for:										
Timing/non-cash impacting distortions:										
2008/09 PPA (relating to 1997/98 to 2007/08)	0	0	(5,441)	0	0	0	0	0	0	0
Adjustments for impairments	0	0	0	0	17,266	21,430	23,646	2,610	17,175	**14,250**
Adjustments for impact of policy change re donated/government grants assets	0	0	0	0	0	0	324	182	57	**0**
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12*	0	0	0	0	0	754	3,443	2,041	1,340	**861**
Other agreed adjustments	0	0	0	4,952	0	0	0	**0**	0	**0**
Break-even in-year position	**1,696**	**(4,932)**	**(5,310)**	**5,095**	**189**	**1,710**	**300**	**129**	**(12,374)**	**157**
Break-even cumulative position	**1,887**	**(3,045)**	**(8,355)**	**(3,260)**	**(3,071)**	**(1,361)**	**(1,061)**	**(932)**	**(13,306)**	**(13,149)**

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

	2005-06 %	**2006-07 %**	**2007-08 %**	**2008-09 %**	**2009-10 %**	**2010-11 %**	**2011-12 %**	**2012-13 %**	**2013-14 %**	**2014-15 %**
Materiality test (I.e. is it equal to or less than 0.5%):										
Break-even in-year position as a percentage of turnover	0.70	-2.03	-1.95	1.71	0.06	0.53	0.09	0.04	-3.29	**0.04**
Break-even cumulative position as a percentage of turnover	0.78	-1.25	-3.06	-1.09	-0.98	-0.42	-0.31	-0.25	-3.54	**-3.26**

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have **not** been restated to IFRS and remain on a UK GAAP basis.

43.2 Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets and therefore the actual capital cost absorption rate is automatically 3.5%.

43.3 External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	2014-15	2013-14
	£000s	£000s
External financing limit (EFL)	**(5,490)**	11,513
Cash flow financing	**(6,228)**	19,615
Unwinding of Discount Adjustment *		7
Finance leases taken out in the year	**0**	0
Other capital receipts	**(2,132)**	(8,430)
External financing requirement	**(8,360)**	11,192
Under spend against EFL	**2,870**	321

* For 2014/15 onwards, the calculation of the Trust performance against the EFL has changed removing the requirement to adjust for unwinding of discount. For information, the value of unwinding discount in respect of provisions for 2014/15 is £7k

The underspend, agreed by the Trust Development Authority, has primarily resulted from a prepayment from Health Education England £2.5m.

43.4 Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2014-15	2013-14
	£000s	£000s
Gross capital expenditure	**14,008**	11,051
Less: book value of assets disposed of	**(45)**	(2,040)
Less: capital grants	**(122)**	0
Less: donations towards the acquisition of non-current assets	**(455)**	(403)
Charge against the capital resource limit	**13,386**	8,608
Capital resource limit	**13,442**	12,480
Underspend against the capital resource limit	**56**	3,872

44 Third party assets

The Trust held cash and cash equivalents which relate to monies held by the NHS Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2015	31 March 2014
	£000s	£000s
Third party assets held by the Trust	**0**	1

At 31st March 2015 the Trust held £244 on behalf of patients (2013-14 £1,147)

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - May 2015

5-24	**Management Representation Letter, 2014/15**	**Audit and Governance Committee Chairman**

The approval of the Letter of Representation from the Trust (management) is a formal part of the Annual Accounts process.

The Letter is drafted by the Trust's Auditors, using standard wording, following the completion of their Audit of the Annual Accounts.

The enclosed Letter is scheduled to be reviewed and agreed at the Audit and Governance Committee on 27th May (before the Trust Board meeting). A verbal update on the outcome of the Committee's review will be given at the Board on 27th May.

The Board is asked to approve the letter, which will then be signed by the Chief Executive (as Accountable Officer), and submitted to the External Auditors.

Which Committees have reviewed the information prior to Board submission?

- Audit and Governance Committee, 27/05/15

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

To review and approve the Management Representation Letter, 2014/15

[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

Chief Executive and Chairman's Office
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Grant Thornton UK LLP
Fleming Way
Manor Royal
Crawley
RH10 9GT

Dear Sirs

Maidstone and Tunbridge Wells NHS Trust
Financial Statements for the year ended 31 March 2015

This representation letter is provided in connection with the audit of the financial statements of Maidstone and Tunbridge Wells NHS Trust for the year ended 31 March 2015 for the purpose of expressing an opinion as to whether the financial statements give a true and fair view in accordance with International Financial Reporting Standards and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

We confirm that to the best of our knowledge and belief having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves:

Financial Statements

i As Trust Board members we have fulfilled our responsibilities under the National Health Services Act 2006 for the preparation of the financial statements in accordance with the Manual for Accounts and International Financial Reporting Standards which give a true and fair view in accordance therewith.

ii We have complied with the requirements of all statutory directions affecting the Trust and these matters have been appropriately reflected and disclosed in the financial statements.

iii The Trust has complied with all aspects of contractual agreements that could have a material effect on the financial statements in the event of non-compliance. There has been no non-compliance with requirements of the Care Quality Commission or other regulatory authorities that could have a material effect on the financial statements in the event of non-compliance.

iv We acknowledge our responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud.

v Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.

vi We are satisfied that the material judgements used in the preparation of the financial statements are soundly based, in accordance with International Financial Reporting Standards and the Manual for Accounts, and adequately disclosed in the financial statements. There are no other material judgements that need to be disclosed.

vii Except as disclosed in the financial statements:
   a. there are no unrecorded liabilities, actual or contingent
   b. none of the assets of the Trust has been assigned, pledged or mortgaged

c. there are no material prior year charges or credits, nor exceptional or non-recurring items requiring separate disclosure.

viii Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of International Financial Reporting Standards and the Manual for Accounts.

ix All events subsequent to the date of the financial statements and for which International Financial Reporting Standards and the Manual for Accounts requires adjustment or disclosure have been adjusted or disclosed.

x We have considered the adjusted misstatements, and misclassification and disclosures changes schedules included in your Audit Findings Report. The financial statements have been amended for these misstatements, misclassifications and disclosure changes and are free of material misstatements, including omissions.

xi In calculating the amount of income to be recognized in the financial statements from other NHS organisations we have applied judgement, where appropriate, to reflect the appropriate amount of income expected to be received by the Trust in accordance with the International Financial Reporting Standards and the Manual for Accounts.

xii Actual or possible litigation and claims have been accounted for and disclosed in accordance with the requirements of International Financial Reporting Standards and the Manual for Accounts.

xiii We acknowledge our responsibility to participate in the Department of Health's agreement of balances exercise and have followed the requisite guidance and directions to do so. We are satisfied that the balances calculated for the Trust ensure the financial statements and consolidation schedules are free from material misstatement, including the impact of any disagreements.

xiv We have no plans or intentions that may materially alter the carrying value or classification of assets and liabilities reflected in the financial statements.

xv We have prepared the accounts on a going concern basis and our assessment of the Trust's ability to continue as a going concern covers twelve months from the date of approval of the financial statements

Information Provided

xvi We have provided you with:
a. access to all information of which we are aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;
b. additional information that you have requested from us for the purpose of your audit; and
c. unrestricted access to persons within the Trust from whom you determined it necessary to obtain audit evidence.

xvii We have communicated to you all deficiencies in internal control of which management is aware.

xviii All transactions have been recorded in the accounting records and are reflected in the financial statements.

xix We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

xx We have disclosed to you all our knowledge of fraud or suspected fraud affecting the Trust involving:
a. management;
b. employees who have significant roles in internal control; or
c. others where the fraud could have a material effect on the financial statements.

xxi We have disclosed to you all our knowledge of any allegations of fraud, or suspected fraud, affecting the Trust's financial statements communicated by employees, former employees, regulators or others.

xxii We have disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing financial statements.

xxiii We have disclosed to you the identity of all of the Trust's related parties and all the related party relationships and transactions of which we are aware.

xxiv We have disclosed to you all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements.

Annual Report

xxv The disclosures within the Annual Report fairly reflect our understanding of the Trust's financial and operating performance over the period covered by the financial statements.

Annual Governance Statement

xxvi We are satisfied that the Annual Governance Statement (AGS) fairly reflects the Trust's risk assurance framework and we confirm that we are not aware of any significant risks that are not disclosed within the AGS.

Approval

The approval of this letter of representation was minuted by the Trust's Board at its meeting on 27th May 2015.

Yours faithfully

Name……Glenn Douglas……

Position……Chief Executive …….

Date……..

Signed on behalf of the Trust Board