TRUST BOARD MEETING

Formal meeting, which is open to members of the public (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

Maidstone and Tunbridge Wells NHS Trust

10.30am – c.1pm WEDNESDAY 28TH JUNE 2017

LECTURE ROOMS 1 & 2, THE EDUCATION CENTRE, TUNBRIDGE WELLS HOSPITAL

A G E N D A – PART 1

Ref.	Item	Lead presenter	Attachment
6-1	To receive apologies for absence	Chair of the Trust Board	Verbal
6-2	To declare interests relevant to agenda items	Chair of the Trust Board	Verbal
6-3	Minutes of the Part 1 meeting of 24th May 2017	Chair of the Trust Board	1
6-4	To note progress with previous actions	Chair of the Trust Board	2
6-5	Safety moment	Chief Nurse	Verbal
6-6	Chairman's report	Chair of the Trust Board	Verbal
6-7	Chief Executive's report	Chief Executive	3
	Presentation from a Clinical Directorate		
6-8	Children's services	Clinical Director / Lead Matron, Children's Services / General Manager, Women's and Children's Services	Presentation
6-9	Integrated Performance Report for May 2017 ▪ Effectiveness / Responsiveness ▪ Safe / Effectiveness / Caring ▪ Safe (infection control) ▪ Well-Led (finance) ▪ Well-Led (workforce) ▪ Safe / Effectiveness (incl. mortality)	Chief Executive Chief Operating Officer Chief Nurse Dir. of Infect. Prev. & Control Director of Finance Director of Workforce Medical Director	4
6-10	Update on the Workforce Transformation Programme	Medical Director	5
	Quality items		
6-11	Planned and actual Ward staffing for May 2017	Chief Nurse	6
6-12	Approval of Quality Accounts, 2016/17	Chief Nurse	7
6-13	Quarterly mortality data	Medical Director	8
6-14	Findings of the national inpatient survey 2016	Chief Nurse	9
	Planning and strategy		
6-15	The 2017/18 Winter and Operational Resilience Plan	Chief Operating Officer	10
6-16	Kent and Medway Sustainability and Transformation Plan (STP) – Consideration of service models and hurdle criteria	Chief Executive	11
	Reports from Board sub-committees (and the Trust Management Executive)		
6-17	Audit and Governance Committee, 24/05/17	Committee Chair	12
6-18	Workforce Committee, 01/06/17 (incl. quarterly report from the Guardian of Safe Working Hours)	Committee Chair	13
6-19	Patient Experience Committee, 13/06/17	Committee Chair	14
6-20	Quality Committee, 14/06/17	Committee Chair	15
6-21	Trust Management Executive, 21/06/17	Committee Chair	16
6-22	Finance Committee, 26/06/17 (incl. revised Terms of Reference; and Business Case to reconfigure Theatre capacity at Tunbridge. Wells Hospital, for approval)	Committee Chair	17 (to follow) and 18
6-23	Charitable Funds Committee, 26/06/17	Committee Chair	Verbal
6-24	**To consider any other business**		
6-25	**To receive any questions from members of the public**		
6-26	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	Chair of the Trust Board	Verbal
	Date of next meeting: 19th July 2017, 10.30am, Academic Centre, Maidstone Hospital		

David Highton,
Chair

MINUTES OF THE TRUST BOARD MEETING (PART 1) HELD ON WEDNESDAY 24TH MAY 2017, 10.30A.M, AT MAIDSTONE HOSPITAL

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	David Highton	Chair of the Trust Board	(DH)
	Glenn Douglas	Chief Executive	(GD)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Angela Gallagher	Chief Operating Officer	(AG)
	Alex King	Non-Executive Director	(AK)
	Peter Maskell	Medical Director	(PM)
	Claire O'Brien	Interim Chief Nurse	(COB)
	Steve Orpin	Director of Finance	(SO)
	Kevin Tallett	Non-Executive Director	(KT)
In attendance:	Richard Hayden	Director of Workforce	(RH)
	Jim Lusby	Deputy Chief Executive	(JL)
	Sara Mumford	Director of Infection Prevention & Control	(SM)
	Kevin Rowan	Trust Secretary	(KR)
Observing:	Gemma Craig	Assistant Deputy Chief Nurse	(GC)
	Darren Yates	Head of Communications	(DY)
	Ian Courtney	EMIS Health	(IC)
	Pam Croucher	Healthwatch Kent Representative	(PC)
	David East	Member of the public	(DE)
	Ali Nobakht	Member of the public	(AN)

5-1 To receive apologies for absence

There were no apologies.

5-2 To declare interests relevant to agenda items

No interests were declared.

5-3 Minutes of the Part 1 meeting of 26th April 2017

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

5-4 To note progress with previous actions

The circulated report was noted.

5-5 Safety moment

COB reported that the focus for the month was Dementia and conveyed the following points:

- The focus of attention included screening patients over the age of 75 for Dementia. The target was to screen 90% of patients, and currently the rate was only at 45%. The screening assessment just required 3 simple questions to be asked, so work was taking place with the entire Multidisciplinary Team to improve compliance
- The next area of focus was falls related to Dementia. Eleven of the recent falls-related Serious Incidents (SIs) were associated with Dementia. The data collection for the National Falls Audit had recently been completed, as had an audit of bed rails, and the need to improve the assessment of mental capacity, as well as measuring patients' lying and standing blood pressure was acknowledged. The need to change behaviours was also accepted

DH asked how the Trust ensured that the issues identified in a month's Safety theme continued to be addressed, once the focus had shifted to another theme. COB confirmed that monitoring continued, and that Safety messages were cascaded through the Divisions, although the

effectiveness of the Safety Moment process needed to be assessed. KT pointed out that Safety Moments were intended to be an engagement tool. The point was acknowledged.

5-6 Chairman's report

DH reported the following points:

- He was pleased to have started at the Trust, and was very grateful to KT, AK and SDu in particular for their commitment since the previous Chair of the Trust Board had left
- The Trust Board currently had 2 Non-Executive Director (NED) vacancies, and the interviews for the first vacancy would conclude on 26/05/17. However, no appointment would be permitted during the current pre-election period, as appointments were required to be approved by the Cabinet Office. The advertisement for the second vacancy had also been postponed until after the General Election, but was intended to be issued soon after. It was therefore hoped to return to a full complement of NEDs as quickly as possible
- It was clear that the Trust faced another challenging year, and next Financial Special Measures (FSM) Review Meeting with NHS Improvement (NHSI) was scheduled for 07/06/17
- DH had been fortunate to undertake 3 visits to clinical areas, and had been genuinely impressed by what he had seen

5-7 Chief Executive's report

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

- The Trust was still experiencing significant increases in 'front-door' clinical activity. At the time the April 2017 Trust Board meeting had been held, the summer period appeared to have arrived, but this had now disappeared. So-called 'winter' pressures were however now experienced all year round, apart from some brief periods.
- The central NHS hierarchy's view of the A&E 4-hour and Cancer 62-day waiting time targets was that achievement was not negotiable. In particular, there would be no excuse for not achieving the latter target, but for the former, the expectation was more tempered, and related to Trusts achieving an improved position from 2016/17
- Staff were tired, but were showing remarkable resilience, and should be thanked for this. Staff would appreciate a visit from Trust Board Members
- The key aspect to draw from adverse incidents was whether the Trust learned from these, and the report contained 2 examples of where such learning had occurred
- Many staff lived in the Trust's local communities, and the situation described in section 3 of the report was the latest in a long series of examples where staff had applied their skills in the community, to improve people's lives

5-8 Integrated Performance Report for April 2017

DH referred to the circulated report and invited colleagues to highlight key issues. GD firstly noted that the context of performance was the aforementioned increasing activity. GD continued that the Trust only narrowly missed its trajectory for the A&E 4-hour waiting time target, but the Trust was increasingly unable to claim that its performance was adversely affected by the lack of action from other agencies. GD elaborated that the new Social Services funding had been received by Kent County Council (KCC) but agreement was still needed as to how this would be spent. GD added that only a proportion of the funding would therefore be available for 2017/18, and the funding only lasted for 3 years. GD concluded that the Trust therefore needed to judge itself on the actions it had taken, and the monthly Performance Report may need to be amended to accommodate this.

Effectiveness / Responsiveness (incl. DTOCs)

AG then highlighted the following points:

- There was now a new reality of increased activity, which had been apparent over the past 2 years. The Trust's efforts were being focused on elderly care, and in particular, non-elective admissions in elderly care. The specific focus was on assessment and frail elderly pathways. Plans were in place to manage via the introduction of an Elderly Frail Unit at Maidstone Hospital (MH), and this was aimed to be open by 05/06/17. De-escalation of MH had therefore taken place to accommodate the Unit, and enable the location to be deep-cleaned etc.

- The Trust was also taking the lead on the Home First programme, particularly in relation to the sourcing of capacity for Pathway 3 patients. This demonstrated that the Trust was taking responsibility for managing the patients presenting via the Emergency Department (ED)
- It was acknowledged that more Care of the Elderly Physicians needed to be appointed, along with more Elderly Care Ward staff, but plans were underway regarding this. Such actions were underpinned by the approach to Length of Stay (LOS), using the national SAFER bundle
- Delayed Transfers of Care (DTOCs) had improved in April (which was similar to the DTOCs seen in April 2016), but there had been more domiciliary care package capacity in the recent past, and the situation was being monitored closely

GD referred to the latter point, and noted that KCC had been trying to stimulate the domiciliary care market. GD added that there had been some disquiet at KCC in relation to NHS Specialist Commissioning devolving its current responsibility for the care of young persons with complex needs, and it had been mooted that some of the aforementioned Social Care funding would need to be allocated for this, but GD had been able to assist in resolving the situation. GD added that the Social Care funding therefore represented a real opportunity to have an impact.

AG then continued, and reported that a 6-week operational programme had been established, where front-line managers had been deployed to support efforts to overcome the constant tension between elective and non-elective capacity.

SDu remarked that it had been apparent from the discussions at the Finance Committee on 22/05/17 that the 38 breaches of the A&E 4-hour waiting time target had cost the Trust circa £200k, and this had prompted the need to link finance and performance more closely, as there were reduced opportunities, under the aligned incentives contract, to recover the adverse month 1 financial position. The point was acknowledged.

SDu also stated that it would be useful if the percentages quoted under the “key issues” section on page 2 of 21 were reported in absolute patient terms, for activity and the number of bed days lost etc. AG noted that the non-elective activity data was already reported within the Trust Performance Dashboard, which showed that 700 more non-elective patients had been admitted, but acknowledged the suggestion and agreed to undertake the required action.

Action: Ensure that the “key issues” listed in the introduction to future monthly Integrated Performance Reports report the relevant data in absolute patient terms (for activity, bed days lost etc.) rather than just percentages (Chief Operating Officer, May 2017 onwards)

KT stated that he welcomed the initiatives described by AG, but asked why the 6-week programme would not be in place for a longer period, given the new norm, and need for a new model. AG clarified that the 6-week period was essentially a diagnostic phase, but it was fully understood that it was no longer possible to just undertake an intensive piece of work that would enable the required performance to be achieved for the whole year. AG also noted that a dashboard had been developed to ensure the key aspects were monitored. JL added that the Divisional performance meetings had made it clear that the 6-week period was not the end of the process.

DH then referred to DTOCs and asked for confirmation that there was a national definition for these. AG explained that there were set criteria for DTOCs, and a meeting was held to confirm which cases met the criteria. DH asked whether the patients that did not meet the criteria were performance managed, and asked whether that number could be reported. AG agreed to arrange for the number to be reported within future Integrated Performance Reports.

Action: Arrange for the number of patients considered to be medically fit for discharge who did not meet the criteria for a “Delayed Transfer of Care” to be reported within future Integrated Performance Reports (Chief Operating Officer, May 2017 onwards)

DH then asked what the target date was for the establishment of a Frail Elderly Unit at Tunbridge Wells Hospital (TWH). AG confirmed this was likely to be mid-September 2017. DH asked if this could be expedited, noting the lost opportunity cost SDu had referred to in relation to the A&E 4-hour waiting time target breaches. AG acknowledged the point, but emphasised that there was less flexibility at TWH, as physical works were required for the planned Unit.

AG then continued, and highlighted the following points:

- The target for Referral to Treatment (RTT) had also been missed. The focus was on creating capacity, but circa 2 months of normal activity would see the Trust's performance recover. The Planned Care Division's specialities were focusing on their own aspects of the RTT plan. The Maidstone Orthopaedic Unit (MOU) was also working to very high occupancy, for Orthopaedic activity. The situation now needed to be replicated at TWH
- For Cancer, the Trust had underperformed on the 62-day waiting time target for over a year. The performance data was 1 month behind, so in March, the Trust achieved 71.9%. The Trust-only performance was however 82.5%, so there were still some issues in relation to patients referred from other Trusts. However, the 'straight to test' pathway for Lower Gastrointestinal (GI) Cancer was now very well established, and this would start to show benefit in the treatment pathway in the coming weeks
- Cancer Summits were held twice per year. Specific Summits had also been held for Breast, and Lower GI Cancer, and improvements had resulted following these. The next Summit would concentrate on Urology, where there had been diagnostic delays
- The Trust was focused on meeting the required standard of 62-day waiting time performance by the September/October 2017 deadline that had been agreed with NHSI. The Planned Care Division had also given a clear commitment to ensuring the target was achieved

GD stated that the central NHS hierarchy was of the view that the relatively small numbers of patients involved in the 62-day Cancer waiting time target should be manageable. DH asked what proportion of Cancer patients presented through the ED rather than via a referral. AG replied that she did not have access to the specific details, but this had been considered during the Cancer Peer Review process, and she believed the proportion was low.

DH then referred to the "MTW received breaches" on page 3 of 21, and asked whether this related to patients that had already breached the 62-day waiting time target before they had been referred. AG confirmed this was so, and noted that this also included patients that had not yet breached, but who had been referred late in their pathway, and therefore had no chance of being treated within 62 days. DH asked for confirmation that there was operational dialogue with the relevant hospitals. AG confirmed this was the case.

KT asked for more details of the delays in the diagnostic phase. AG explained the full scope of such delays, and confirmed that the absolute maximum turnaround for Radiology results was 2 weeks. AG also confirmed that work was underway to book patients in sequence, to ensure there was no delay. AG then gave details of the various actions being taken to try to reduce diagnostic delays. KT asked whether Cancer patients always knew, when they left after having a treatment, when their next treatment would be. AG confirmed that the majority of patients left knowing what their next treatment would be, even if the date of that treatment was not known.

Safe / Effectiveness / Caring

COB then reported the following points:

- The indicators in the 'Safe' domain were all rated 'green'
- Falls and pressure ulcers were lower than at the same point in 2016/17.
- The target falls rate for 2017/18 had been lowered from the target in place in 2016/17
- There had been 1 falls-related SI for April, and 2 thus far for May
- VTE risk assessment was 95.2%, which was positive, as this had been the subject of a recent Safety Moment
- The number of complaints had increased, but the response rate had improved tremendously, as a result of the efforts of the Central Complaints Team and Divisions
- The positive responses to the Friends and Family Test (FFT) were static, and it had been a struggle to achieve 95% in Maternity. New FFT cards had however been introduced, which had some quality-related questions, & it was hoped these would provide an opportunity to improve
- The FFT response rate was below target for inpatients, but better for Maternity

KT commended the complaints response, but referred to SDu's earlier remarks in relation to reporting data in absolute terms, and asked whether the absolute numbers were low. COB reiterated that there had been an increase in the complaints seen in the month.

Safe (infection control)

SM then highlighted the following points:

- The had been 2 Clostridium difficile cases, which was below the month's trajectory of 3
- There had been no cases of MRSA bacteraemia, and the second MRSA bacteraemia case from 2016/17 had now been removed from Trust's data, following a successful appeal
- MRSA screening was very high
- The enhanced epidemiology for gram-negative bacteraemias was going well

Well-Led (finance)

SO then highlighted the following points:

- The deficit was £1.3m for the month, which compared to a planned deficit of £1.1m. The variance to plan was attributed to the aforementioned A&E 4-hour waiting time target breaches. The month 1 deficit for 2016/17 had however been £3.7m, so there had been a clear improvement
- Cost Improvement Plan (CIP) performance was slightly behind plan, and slightly below the performance at the same point in 2016/17. However, the position was expected to recover for months 3 to. The position for March 2018 was expected to be positive as a result of a specific non-recurrent item
- The cash position was satisfactory and the Trust did not expect to ask for cash to support its liquidity during 2017/18
- Nurse Agency expenditure had reduced year-on-year. Medical Agency expenditure was however almost exactly the same as in 2016/17, so needed to improve

DH queried whether the month 2 CIP performance would be known by the FSM Review Meeting with NHSI on 07/06/17. SO confirmed this was the case.

Well-led (workforce)

RH then reported the following points:

- Sickness absence had improved, but continued to be the focus of the Human Resources (HR) and operational management teams
- Statutory and mandatory training compliance had reduced slightly, partly as a result of the subjects that require an annual update. There had however been a change in the way the data was reported, compared to last year, with the figure now being deduced from the 25 statutory and mandatory subjects. The next Workforce Committee meeting would review compliance against the 25 subjects within the programme

DH asked whether all 25 subjects in the programme were delivered via face-to-face training. RH confirmed that a variety of delivery methods were deployed and over the past 12 months the use of e-learning, which has been a method used by the Trust for a number of years, had increased. RH then continued, and highlighted the following points:

- Staff turnover was higher, and a detailed analysis would be submitted to the next Workforce Committee meeting, but there had been a significant increase in the number of retirements in March 2017 compared to previous years. A HR dashboard had been developed to ensure managers were aware of the age profile of their teams to help planning (although there was no longer a statutory retirement age)
- The staff FFT score, which related to the proportion of those who would recommend the Trust as a place to work, had reduced, but this needed to be considered in context. The issue would however be monitored, as the next survey was due in June 2017

At this point, KT referred back to "Oncology Fractions" indicator under the "Effectiveness" domain, and remarked that these had reduced from 2016/17. AG replied that there was no discernible reason for the reduction, but one of the Trust's Linear Accelerators (LinAcs) had recently been out of service for a while.

SDu then referred back to the staff FFT score, and commented that she had been impressed by the number of initiatives that had been launched which were designed to support staff during times

of considerable stress. COB noted that the issue was the subject of a CQUIN target for 2017/18, and this had helped to direct efforts.

Safe / Effectiveness (incl. Mortality)

PM then highlighted the following points:

- The steering group tasked with overseeing the implementation of the new policy changes regarding Mortality Reviews had held its first meeting. Dr Beesley, one of the new Deputy Medical Directors (and the person who would assume responsibility for mortality) had attended
- The Trust's Summary Hospital-level Mortality Indicator (SHMI) had reduced from 110 to 107, but this related to the use of NHS Digital's SHMI, rather than the SHMI produced by Dr Foster
- The Trust's latest Hospital Standardised Mortality Ratio (HSMR) was 108
- 48% of deaths had been reviewed across 2016/17, which was similar to the proportion reviewed in 2015/16. The aim was to review 100%.
- The deaths of fractured neck of femur patients were being reviewed (although these were already routinely reviewed). A 'deep dive' into the deaths was incomplete, but the Medical review of the deaths had identified a need for more Orthogeriatric Physicians, and the Planned Care Division had therefore agreed to relinquish some funding to enable Orthogeriatric review of relevant patients
- Other concerns that related to the higher than expected deaths pertained to Pneumonia and Congestive cardiac failure (CCF). Junior Doctor training was planned in response
- A written report would be required in the future. This would not be submitted to the June 2017 Trust Board meeting, but was expected for the meeting in July 2017
- Some queries had been raised with Dr Foster in relation to the rolling monthly mortality data

SDu then referred to the "Readmissions <30 days: All" data on page 5, and asked whether the "Bench Mark" level (14.7%) was set nationally. AG confirmed that this was locally-set, and was incorporated into the Trust's contract, as the national benchmark was 25%. SDu asserted that some patients were being readmitted quite often, and queried whether there should be a more ambitious target. PM explained that frail elderly patients were affecting the readmission rate, but there was a balance between the need to discharge patients quickly (and risk them being readmitted) and the risk of patients experiencing more health problems by staying in hospital. PM added that the new arrangements being planned for the ED meant that there was a higher likelihood that patients would be sent home, only to return. SDu pointed out that such patients would not however be admitted. PM retorted that some might. DH asked whether readmissions in the report only included patients who were readmitted with the same condition. AG confirmed this was not the case, and added that there had been an opportunity to address readmissions within Respiratory medicine, and a reduction had been seen for patients being managed under the Chronic Obstructive Pulmonary Disease (COPD) pathway.

Quality Items

5-9 Planned and actual Ward staffing for April 2017

COB referred to the circulated report and drew attention to the following points:

- 'Planned' levels of staffing meant those established within budget. The report also contained some Nurse-sensitive indicators, as well Care Hours Per Patient Day (CHPPD) date
- The Trust's nursing numbers tended to be higher than some other organisations, particularly at TWH, but this was considered to be related to the single-room environment at TWH
- Some Enhanced Care Nursing had been deployed, and some additional staff had been needed to meet escalation requirements. The rationale for additional staffing was included in the report
- The skill mix on Ward 21 had been reviewed to ensure the appropriate staff were deployed in accordance with patient need
- The "Overall RAG Status" was not applied scientifically, but 2 Wards were rated as 'amber'

SO noted that the far right hand side of page 4 of the report contained financial information, which showed that some areas were underspent, whilst some were overspent. SO continued that the latter had been discussed at the Divisional Performance Reviews held on 23/05/17, and Divisional

teams were focusing very clearly on the areas. SO summarised that overall, Nursing expenditure was broadly where it needed to be, although there were some areas of variance.

Assurance and policy

5-10 Update on the implementation of the PAS+ (incl. the outcome of the 3 assurance programmes)

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

- The Trust had been working to implement a new Patient Administration System (PAS) since late 2015, to change from the current iSoft PAS to an Allscripts PAS. The overall programme was rated 'red' as there was still no implementation date agreed with Allscripts
- The Programme had been reviewed on 10/05/17, and Allscripts had confirmed that the latest software ("CU8") was ready for full regression testing to commence on 25/05/17. The PAS Programme Board had then met on 23/05/17, to confirm that testing could start on that date.
- The regression testing would be completed by 26/06/17, which was next key date
- On commercial and legal matters, JL, AG and the Director of Health Informatics had met with members of the Allscripts management team to review the delays, and Allscripts inability to meet the agreed timescales, as well as the impact on the Trust's finances. Meetings were continuing, and a letter had been sent to Allscripts outlining the Trust's view that they had failed to meet one of the key contract milestones. The issues with Allscripts were being managed in parallel with the work to implement the Programme
- A three-pronged approach to gaining assurance had been taken, and all 3 assurance exercises were now complete. Allscripts had firstly been asked to produce a report to enable the Trust to have confidence that Allscripts could deliver the Programme. A new plan had subsequently been provided, and there were positive signs that enabled the Trust to have confidence in Allscripts' ability to deliver
- An internal review of how the PAS Programme Board had worked had also been undertaken, to see if the issues with Allscripts could have been anticipated, and managed differently. The report had been discussed at the Programme Board and Steering Group, and had provided positive assurance
- The third aspect was an independent health check undertaken by NHS Digital, who spent 3 days at the Trust reviewing documentation and interviewing staff. An overall rating of "AMBER RED"' was concluded, and the issues had been addressed via the Programme Board. The NHS Digital report had also been shared with Allscripts, and the aforementioned plan that Allscripts had submitted covered the issues raised in the report
- The plan led to a potential 'go live' date of 08/10/17, but this depended on the outcome of the testing, which would completed on 26/06/17

DH asked for confirmation that the Programme Board meeting held on 23/05/17 had agreed that the entry criteria for the CU8 software had been met. AG confirmed this was the case.

KT asked how the Programme Board had decided it was set up for success, given the lack of entry and exit criteria (as noted on page 4 of 4). AG replied that this had been determined during the Business Case phase, and included application of the experiences from other Trusts. AG added that the key aspect was the development of the software that Allscripts had inherited from Oasis (the supplier Allscripts had acquired), and it had only became apparent at a later date that the software was not mature enough for an effective Order Communications system.

KT also asked whether representatives from Allscripts attended the Programme Board. AG confirmed this was the case.

SDu remarked that she was concerned at the dichotomy between the Trust's own assessment and NHS Digital's "AMBER RED" rating. SDu also asked what the plan would be if the testing was not satisfactory after 26/06/17. AG confirmed that there had been a lot of development, as the testing had originally started on the "CU4" software. AG added that many steps had been taken to obtain assurance. SDu asked whether Allscripts had committed to the new timescales. AG confirmed that the timescales reflected the aforementioned plan submitted by Allscripts, but a decision would be made in June as to whether the October 2017 'go live' date was feasible. AG continued, and noted

that the Programme Board had regularly rated the Programme as 'red' (i.e. worse than NHS Digital's "AMBER RED" rating) because of the outstanding issues, and the "AMBER RED" rating related solely to the Order Communications system, which the Programme Board continued to rate as 'red'. AG also noted that the plan was not yet 'signed off', and was being regularly risk-assessed. SDu asked what 'sign off' meant for Allscripts. AG clarified that 'sign off' meant that the Trust accepted Allscripts ability to achieve the proposed 'go live' date of 08/10/17

SDu asked about the financial commercial considerations. AG reported the latest situation. KT noted that consideration needed to be given to taking Allscripts to court over the implementation of the whole system, and not just the breach of specific milestones, but suggested the issue be discussed further in the 'Part 2' Trust Board meeting scheduled for later that day. This was agreed.

DH then asked how the PAS Programme Board reported into the Trust Board. AG explained that a monthly update report on the implementation of the PAS was provided to the Trust Management Executive (TME). DH stated that he would welcome a separate, detailed briefing as part of his induction. This was agreed.

Action: Ensure the Chair of the Trust Board received a detailed briefing on the implementation of the PAS+ (Chief Operating Officer / Deputy Chief Executive, May 2017 onwards)

5-11 NHS Provider licence: Self-certification for 2016/17

KR referred to the report that had been circulated and highlighted the following points:

- The Health and Social Care Act 2012 introduced the concept of a Licence for providers of NHS services, and the NHS Provider License was subsequently introduced by Monitor in February 2013. Foundation Trusts were licensed from April 2013, with other providers being licensed from April 2014, but it was later confirmed that the Licence would not apply to NHS Trusts
- Despite this, in April 2017, NHSI had confirmed that NHS Trusts must undertake a self-certification against the NHS Provider Licence, on the basis that, despite their exemption, directions from the Secretary of State required NHSI to ensure that NHS Trusts complied with conditions equivalent to the Licence, as it deemed appropriate
- As NHSI's Single Oversight Framework (SOF) based its oversight on the Licence, NHS Trusts were legally subject to the equivalent of certain Provider Licence conditions, and must self-certify under these licence provisions
- The Trust Board was required to undertake the self-certification no later than 31/05/17 (for Licence condition G6) and 30/06/17 (for Licence condition FT4). Providers were required to then publish their G6 self-certification within 1 month
- NHS Trusts were not required to submit their self-certification declarations to NHSI, but NHSI would contact a select number of NHS Trusts (and Foundation Trusts) from July 2017, to ask for evidence that they had self-certified.
- If the Trust Board had been asked to self-certify in any other month, KR would have submitted a detailed report providing evidence to support a proposal that the Trust had complied with each relevant Provider Licence condition. However, as that day's Board meeting was due to consider the Annual Report and Accounts for 2016/17, which included the Governance Statement, KR felt that Attachment 14 provided sufficient supporting evidence to enable the Trust Board to undertake the required self-certification

GD referred to the latter point, and asked whether the Trust Board should therefore consider and approve the Annual Report for 2016/17 before considering the self-certification. KR replied that this was not necessary, as it was not essential that the content of the Annual Report, and the Governance Statement in particular, be approved before that content could be taken into account when considering whether the Board should self-certify against the relevant Licence conditions.

The Trust Board approved the proposed self-certification as circulated.

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

5-12 Audit and Governance Committee, 04/05/17 & 24/05/17 (incl. Audit and Governance Cttee Annual Report for 2016/17)

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

- At the Audit and Governance Committee meeting held earlier that day it had been agreed that the Annual Report, Accounts and Management Representation Letter for 2016/17 should be recommended for approval by the Trust Board. The Trust Board would be asked to approve the documents under items 5-16, 5-17 and 5-18
- The External Auditors had been very complementary about the audit and the Finance team
- The 'except for' Value for Money (VFM) conclusion was likely to be repeated each year until 2020/21, but SO would aim to ensure a positive outcome was achieved earlier than that date

The Audit and Governance Committee Annual Report for 2016/17 was noted.

5-13 Quality Committee, 03/05/17

SDu referred to the circulated report and highlighted that mortality would continue to be the focus of Quality Committee meetings until a detailed understanding of the situation was known.

5-14 Trust Management Executive (TME), 17/05/17

JL referred to the circulated report, and pointed out that the meeting had focused on a number of staffing appointments, but the challenging of requests to replace currently established Consultant posts was likely to become more commonplace.

DH noted that the 3 new Deputy Medical Directors had been appointed, and asked PM to comment. PM explained that Paul Sigston would focus on the Urgent Care Division, Sharon Beesley would focus on the Planned Care Division, and Sarah Flint would focus on the Women's, Children and Sexual Health Division, but the 3 individuals would also be involved in some aspect of corporate oversight.

5-15 Finance Cttee, 22/05/17 (incl. approval of the Business Case to replace 2 Linear Accelerators; and quarterly progress update on Procurement Transformation Plan)

SDu referred to the circulated report (Attachment 11) and highlighted the following points:

- The meeting was not quorate, which was regrettable given the amount of work involved
- The Committee agreed that the scope of Finance Committee should be extended to include performance, and therefore that a review should be undertaken to consider including this
- The recent increase in the use of Agency staffing and non-framework Agencies in particular had been noted, and it was agreed that the Workforce Committee should be asked to review this at its meeting w/c 29/05/17
- The Business Case for proposed LinAc replacements in 2017-2020 was reviewed and recommended for approval by the Trust Board

AK endorsed SDu's remarks regarding extending the role of the Finance Committee, on the basis that this would ensure the focus on performance was maintained after the Trust exited FSM. DH asked KT for his thoughts. KT stated that he agreed. DH then confirmed that he also concurred. It was therefore agreed that revised Terms of Reference (including membership) would be drafted, and submitted for approval to the Trust Board in June 2017, having first been agreed by the Finance Committee.

Action: Liaise with the relevant Trust Board Members and draft revised Terms of Reference (including membership) for the Finance Committee, to enable these to be submitted for agreement at the Finance Committee on 26/06/17, and approval at the Trust Board on 28/06/17 (Trust Secretary, May 2017 onwards)

DH then referred to the circulated Business Case for replacement LinAcs (Attachment 12). SO clarified that the despite the title on page 1 of the report ("…replace 2 Linear Accelerators), the Case was in fact to replace 3 LinAcs. DH acknowledged that the Finance Committee had reviewed the Case and invited questions or comments. GD remarked that he agreed with the approach being taken with East Kent Hospitals University NHS Foundation Trust.

SDu asked that the authors of the Case be commended, as it was very well written.

The Business Case for proposed LinAc replacements in 2017-2020 was approved as circulated.

SO then referred to the circulated quarterly progress update on the Procurement Transformation Plan (Attachment 13) and invited questions. DH pointed out that the "% of spend on a contract" of 43.91% in March 2017 was poor, when compared to the target of 90%, and asked for a comment. SO acknowledged the point, and gave assurance that actions would be taken to address this.

Annual Report and Accounts

5-16 Approval of the Annual Report, 2016/17 (incl. Governance Statement)

KT referred to the circulated Report (Attachment 14) and pointed out that the Audit and Governance Committee had received confirmation that the text highlighted in yellow within the Governance Statement on page 59 (i.e. "[N.B. The final findings of the 2016/17 Audit will be included here when available]") would be removed.

Attachment 14a, which had been circulated on 23/05/17, and which contained the details of errors that had been corrected within the "Salaries and allowance for the year ending 31st March 2017" and "Pension benefits for the year ending 31st March 2017" sections, was noted.

The Trust Board approved the Annual Report for 2016/17, subject to the reported amendments being made.

5-17 Approval of the Annual Accounts, 2016/17

SO referred to the circulated report (Attachment 15) and invited questions or comments. GD referred to the "Statement of Comprehensive Income for year ended 31 March 2017" (page 2) and queried why there was no subtotal of income and expenditure. SO confirmed that the format shown on that page had been in place for some time.

Attachment 15a, which had been circulated on 23/05/17, and which contained details of errors that had been corrected within the Notes to the Accounts (specifically in Notes 4 and 40.2) was noted.

The Trust Board approved the Annual Accounts for 2016/17, subject to the reported amendments being made.

5-18 Approval of the Management Representation Letter, 2016/17

The Trust Board approved the Management Representation Letter for 2016/17 as circulated.

5-19 To consider any other business

DH reported that the date of the September 2017 Trust Board meeting had been re-scheduled to 07/09/17, which was the same date as the Annual General Meeting. DH acknowledged that the re-scheduling may affect the reporting of the monthly information to the meeting, but this had been necessary because of pre-booked Annual Leave.

5-20 To receive any questions from members of the public

There were no questions.

5-21 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.

Trust Board Meeting – June 2017

NHS Maidstone and Tunbridge Wells NHS Trust

6-4 Log of outstanding actions from previous meetings — Chair of the Trust Board

Actions due and still 'open'

Ref.	Action	Person responsible	Original timescale	Progress [1]
4-8 (April 17)	Liaise with the Chief Operating Officer and Chief Executive to agree the wording for an activity-related key objective for the 2017/18 Board Assurance Framework, and submit this to the Trust Board, for approval	Trust Secretary	May 2017	Liaison has not yet occurred, but is intended to submit a proposed objective to the Trust Board in July 2017
5-10 (May 17)	Ensure the Chair of the Trust Board received a detailed briefing on the implementation of the PAS+	Chief Operating Officer / Deputy Chief Executive	May 2017 onwards	A date for the briefing is still being scheduled

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
5-8i (May 17)	Ensure that the "key issues" listed in the introduction to future monthly Integrated Performance Reports report the relevant data in absolute patient terms (for activity, bed days lost etc.) rather than just percentages	Chief Operating Officer	June 2017	The "The 'story of the month'" section of Integrated Performance Report submitted to the June 2017 Trust Board has been written to reflect the request
5-8ii (May 17)	Arrange for the number of patients considered to be medically fit for discharge who did not meet the criteria for a "Delayed Transfer of Care" to be reported within future Integrated Performance Reports	Chief Operating Officer	June 2017	The requested information has been added to the 'story of the month'" section of Integrated Performance Report submitted to the June 2017 Trust Board
12-8iii (Dec 16)	Arrange for the next Trust Board 'Away Day' to discuss the 'new normal' levels of clinical activity seen at the Trust	Trust Secretary	June 2017	The issue was discussed at the Trust Board 'Away Day' on 09/06/17
5-15 (May 17)	Liaise with the relevant Trust Board Members and draft revised Terms of Reference (including membership) for the Finance Committee, to enable these to be submitted for agreement at the Finance Committee on 26/06/17, and approval at the Trust Board on 28/06/17	Trust Secretary	June 2017	Liaison occurred and the Terms of Reference were reviewed and revised. They have been submitted to the Finance Committee on 26/06/17 (for agreement) and to the Trust Board on 28/06/17 (for approval)

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

Actions not yet due (and still 'open')

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

Trust Board meeting – June 2017

NHS
Maidstone and Tunbridge Wells NHS Trust

6-7 Chief Executive's report — Chief Executive

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

1. I am pleased to report that our £645,000 bid for national funding has been agreed to help improve patient flow through our Emergency Departments (EDs). We will now be moving forward at pace to transform our EDs on both sites to provide dedicated co-located areas for GP-led care. This clinically driven move will enable up to 20% of our A&E patients to be seen more appropriately by GPs working in the department. Within the next 4 months we plan to transfer the IC24 GP service at Tonbridge Cottage Hospital to Tunbridge Wells ED. We will be carrying out some building works at Tunbridge Wells Hospital (TWH) - which includes an extension at the front of A&E - to help make this happen. We will also be creating a dedicated area at Maidstone ED to provide a better GP-led service there.

   We will also be creating an assessment area for acute frailty at TWH. This will enable more of our elderly patients to be quickly streamed through the ED to see our elderly care physicians, facilitating our acute frailty model of care.

   This is very welcome news for our patients and clinical teams. I have thanked all of our clinical and non-clinical colleagues for their hard work in driving through our ultimately successful bid for national funding.

2. The Chaucer Acute Frailty Unit (CAFU) opened at Maidstone Hospital at the beginning of June. A multi-disciplinary team from many departments at MTW have worked together to set up these innovative new pathways, whereby patients are identified in A&E to see if they are suitable and then referred to the CAFU according to agreed criteria.

   The Unit offers 11 assessment spaces and 14 short-stay inpatient beds should patients need to stay for up to 48 hours. The pathway promotes national best practice, and supports rapid turnover and admission avoidance where it is safe and appropriate to do so. I have thanked all staff involved in getting the unit up and running.

3. It remains patently clear and evidently apparent that we must do all in our gift to continue to support and enable more of our frontline staff to implement the kinds of clinically-led changes that benefit our patients. It has never been more important to do so at this time of unprecedented demand for NHS care.

   We are going to do this through a new way of working called Listening into Action (LiA) that puts more of the ideas our staff have at the centre of our improvements.

   LiA has been adopted by other Trusts in recent years with noteworthy results. Care Quality Commission (CQC) results have significantly improved in a relatively short timeframe at a number of hospitals and staff are notably more engaged as Trusts pull together to fulfil their potential.

   LiA is about listening to colleagues' views and helping drive through their good ideas. This is very much a way of working that we wish to embed at every level of MTW. We have kick-started our LiA journey with 10 clinically-driven schemes that have come from our doctors and nurses to improve patient care. The clinical teams owning these changes will pioneer the LiA focused and effective way of making changes in the Trust over a 20 week period from the start of July. The 10 changes are:
   1. Reducing time to theatre for Fractured Neck of Femur patients
   2. Improving the patient pathway for those suffering from Inflammatory bowel disease (IBD)
   3. Improving access to Diabetes care for young adults

4. Shortening wait times in Ophthalmology through virtual clinics in Medical Retina
5. Shortening time to treatment for Oncology Prostate patients
6. Improving the use of GPs in A&E
7. Shortening wait times for Breast Clinic patients
8. Improving antenatal services at Maidstone Hospital
9. Streamlining the Pre Assessment process for the young, fit and well
10. Improving inefficient and frustrating IT systems for our junior doctors

We are also running a series of "Crowdfixing" events to give our staff the opportunity to talk about what matters most to them and what we can do together to tackle the issues raised.

Engaging and empowering staff is key to driving improvement in hospital care. This has been proven by Trusts and was strongly encouraged in a recent report by the CQC http://www.cqc.org.uk/drivingimprovement

4. The results for the 2016 National Inpatient Survey were published in June and provide us with a platform for further improvements this year. Looking at two key indicators, 97.4% of patient felts they were treated with respect and dignity, and 97.6% of patients felt well looked after by our staff. The full findings are described in a separate report on the June Trust Board agenda.

5. We helped celebrate international Volunteers' Week this month and gave our heartfelt thanks to over 400 volunteers who all give so much of their free time in our hospitals. Not only do our volunteers raise a massive amount of money for the Trust, to use in ways that benefit our patients, they enhance our workforce, brighten up our patients' days, offer a listening ear not only to patients, visitors and staff, guide our visitors through the hospitals, run errands, file and scan notes – the list is endless. We couldn't do what we do without them.

6. One of our midwives, Áine Alam, has received a prestigious Fellowship from the Royal College of Midwives (RCM) for her contribution to midwifery. This is an honour given to just a handful of midwives each year. Among many things, the Fellowship recognises Áine's contributions in many areas of midwifery including teaching and research. These include specialising in midwifery led care, multidisciplinary teamwork and teaching practices that are based on learning in the workplace. Congratulations to Áine.

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

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

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

Trust Board meeting – June 2017

Maidstone and Tunbridge Wells NHS Trust

6-9 Integrated Performance Report, May 2017	**Chief Executive / Members of the Executive Team**

The enclosed report includes:

- The 'story of the month' for May 2017 (including Emergency Performance (4 hour standard); Delayed Transfers of Care (DTOCs); Elective Activity / Referral to Treatment (RTT); and Cancer 62 day First Definitive Treatment)
- A financial commentary
- A workforce commentary
- The Trust performance dashboard
- An explanation of the Statistical Process Control charts which are featured in the "Integrated performance charts" section
- Integrated performance charts
- The Board finance pack

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive (TME), 21/06/17 (Trust performance dashboard)

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

Review and discussion

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

The 'story of the month' for May 2017

The key areas of focus remain as previously reported, emergency 4 hour standard, RTT and Cancer 62 day target.

1. Emergency Performance (4 hour standard)

Performance for the Trust for May was 86.93%, missing the Trust recovery plan of 90.85. 16/17 came in at 87.1%, which was in line with what was agreed as possible with NHSI. This year, we will be monitored against a new set of targets, where Q1, Q2 and Q3 must score 90% or above, then 95% in March 2018. The directorate management team and the Information Department have agreed a set of monthly targets to facilitate how we monitor and track this. The June target is set at 89.69%. Demand and capacity planning for 2017-18 (including winter resilience planning) is based on the new normal for non-elective activity using the parameters of attendances, admissions, age-profile and reason for admission as basis for planning.

The key issues for May are:

- A&E Attendances remain higher than last year & higher than long term trends, conforming closely to the MTW activity model.
- Non-Elective Activity was 4,153 discharges in May (16.2% higher than plan & 12.0% higher than May last year). 7,997 discharges YTD (12.5% up on plan & 8.3% up on last year). NE activity over the past 3 months has been at an all-time high.
- There were 1,364 bed-days lost (5.96% of occupied bed-days) due to DTOCs.
- Average number of Medically Fit for Discharge (MFFD) patients in May was 117, whilst the average weekly total on the delays snapshot for the dame period was 43. So typically, 74 MFFD (around 2/3) are not counted as DToCs
- Non-elective LOS was 7.58 days for May discharges after spiking at 8.68 in Jan. Average occupied bed days rose to 739 in May, up from April's 710

Focus remains on improving length of stay for all patients and establishing practice that is aimed at reducing the volume of patients that are admitted to inpatient beds and these are:

- Acute assessment facilities
- Ambulatory pathways across all specialties
- Frail elderly facilities & pathway

2. Delayed Transfers of Care

Count of Hospital ID	Column Labels																								
Row Labels	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
A : Awaiting Assessment	15	6	15	21	15	17	15	10	5	7	3	8	1	6	25	15	7	5	5	12	20	22	32	14	14	13
B : Awaiting Public Funding	2		1	1	4	8	7	3	1			1	1	1	8	12	25	21	5	3	6		4	3	1	3
C : Awaiting Further Non-Acute	32	34	39	48	33	30	20	6	3	8	15	18	17	13	11	10	8	10	14	6	23	8	13	16	17	21
Di : Awaiting Residential Home	18	1	11	27	28	26	22	16	21	15	15	27	32	20	37	21	33	43	34	19	21	30	24	35	21	8
Dii : Awaiting Nursing Home	40	21	38	90	57	52	56	40	73	53	80	73	58	67	65	67	69	83	69	63	112	78	77	76	57	70
E : Awaiting Care Package	7	7	20	16	27	17	32	26	43	28	36	36	28	24	39	41	41	76	58	51	89	49	30	38	35	39
F : Awaiting Community Adopti	1	11	2	1		1	13	9	8	14	5	13	8	7	12	4	6	10	8	5	7	9	10	13	6	8
G : Patient of Family Choice	60	44	44	45	16	43	26	22	31	12	12	22	13	9	19	19	10	16	20	16	14	9	19	28	6	10
H : Disputes	2	1			1	3	1	1		1				3	1	1				1			1	1	1	1
I : Housing	3	4	3	1		1	13	12	9	3	5	1			5	5	2	3	2	4	8	3	5	4	3	3
Grand Total	**180**	**129**	**173**	**250**	**181**	**198**	**205**	**145**	**194**	**141**	**171**	**199**	**158**	**150**	**222**	**195**	**201**	**267**	**215**	**180**	**300**	**208**	**215**	**228**	**161**	**176**
Trust Percentage Delays	5.5%	4.8%	6.8%	7.9%	7.1%	7.9%	6.6%	5.7%	6.0%	5.0%	5.8%	5.6%	5.5%	5.3%	6.2%	6.7%	6.7%	7.2%	7.9%	6.3%	8.1%	6.7%	7.1%	6.2%	5.6%	6.0%

For 2016/17, there were 17,781 bed days lost equating to a rate of 6.67 compared to 6.19 on 2015/16.

- Pathway 3 Home First for those patients requiring a care home facility is full at 10 beds. There has been a care manager in place to support flow through the beds
- There are 40+ patients being funded through the CCG commercial bed fund in private nursing homes, the vast majority of these are elderly patients with orthopaedic issues who are waiting healing in order to regain function. Many of these are coming to the end of their stay. If current levels of occupancy were maintained then the fund would be significantly overspent at year end
- Additional support for a Band 4 dedicated discharge resource for the MFFD wards is out at advert
- Enablement capacity has improved across the area
- CHS (an external agency to locate and facilitate discharge to nursing homes and private POC within 5 days for privately funded patients) again exceeded target in May
- Senior staff continue to lead the DTOC sign off meetings on Fridays with telephone attendance from the CCG, CHC and East Sussex leading to earlier identification of issues

Concerns raised about East Sussex DTOC as this appears to be rising whilst Kent is decreasing. Work with the information department to analyse trend specifically for East Sussex has shown that East Sussex is running at 3-4% higher than Kent. The DTOC is more volatile than Kent due to smaller numbers however there is sufficient concern that support services are not available within the East Sussex area.

3. Elective Activity / Referral to Treatment (RTT)

Performance: May performance shows the Trust continues to forecast non-compliance with the Incomplete RTT standards at an aggregate level – 87.6%

The Trust continues to be non-compliant at a speciality level for T&O, Gynae, ENT, Cardiology and Urology and the majority of the backlog is concentrated in these five-all of which are being carefully monitored against action plans put in place to reduce their longest waiters. All these specialities are trying to continue to reduce their backlogs despite cancellations by moving lists to Maidstone and focusing capacity on booking patients within the backlog to all available lists. Extra Saturday sessions are being planned when current escalation reduces.

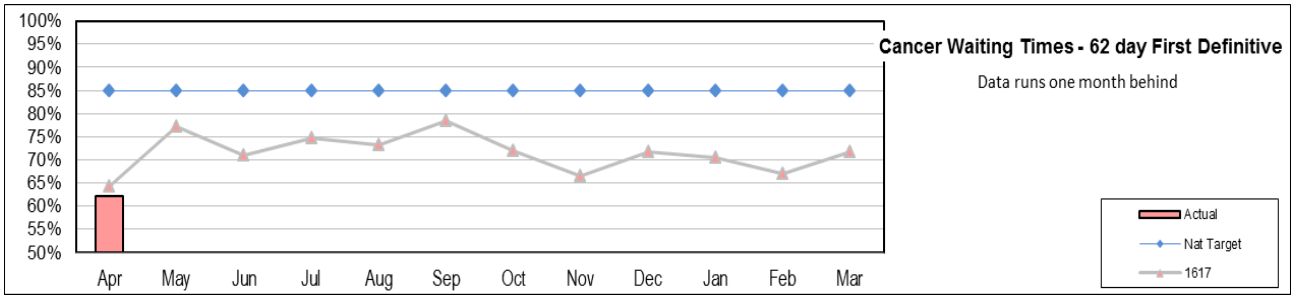
Operational teams are focused their recovery plans to increase elective activity and arrange extra clinics to ensure backlog does not grow further. The organisation continues to remain below the RTT performance trajectory submitted for 16/17. The Trust has now resubmitted the RTT trajectory for 17/18 which shows aggregate compliance by Nov 17.

	May-17	May-17 Trajectory	Variance from trajectory
RTT Backlog Incomplete	3,080	2,351	-729
RTT Waiting List	24,916	23,060	-1,856
RTT Incomplete performance %	87.6%	90.03%	-2.43

4. Cancer 62 day First Definitive Treatment

Performance for 62 day First Definitive Treatment (FDT) (data runs a month behind) - Apr-17: 62.3%, 2016/17 Q4: 69.7%, 2016/17 Full year: 71.5% (73.4% using new breach allocation policy) which is below the national target of 85%.

62 FDT for April: 34 breaches (under current allocation policy), 21 of these were MTW only patients. 18 patients from Other Trusts to MTW and 8 patients from MTW to elsewhere (1 patient = 0.5 breach). MTW received breaches: 3 patients from Medway, 1 patient from Darent Valley, 1 patient from East Sussex, 1 patient from QVH and 12 patients from East Kent (Patients shared across Trusts = 0.5 of a breach).



There are a number of remedial actions in place to achieve a sustainable improved performance.

- Straight to test triage clinics are now well established for colorectal referrals with increasing numbers of clinics per week & increasing numbers of patients being sent straight to test. This is reducing the length of pathways for these patients & will enable the number of breaches to be reduced
- The weekly cancer PTL meeting has been revised and an 11am “huddle” is taking place each day for the patients on days 40 to 61 for all the GMs to update on actions being taken.
- An Oncology PTL is now taking place weekly to replicate the main PTL meeting
- Dr Taylor is reviewing all the patients over 104 days currently on the PTL to ensure that there are no clinical risks to patients
- The MDT co-ordinators will be adding a cover sheet to the MDT list each week detailing the number of patients on the PTL for that tumour site in sections of days 0 – 20, 21 – 39, 40 – 62, over 62 and over 62, highlighting the number diagnosed and those undiagnosed.
- Resource to be reviewed to track cancer PTL and to ensure that all actions are being followed up on a daily basis.
- Lung one stop clinic to start from w/c 12th June

Oncology has implemented a new process to identify patients referred after day 38 where breaches can be avoided if the patient is treated within 24 days. Oncologists will reserve 1 new patient appointment per week & the process is being piloted to book the 24-day patients into these.

Financial commentary

- The Trust had an adverse variance against plan in May 2017 of £0.2m including Sustainability and Transformation Fund (STF), this is due to £0.2m shortfall against STF relating to non-achievement of the A&E trajectory target in May
- The Trust's net deficit (including technical adjustments) in May is £1.6m against a planned deficit of £1.4m, therefore £0.2m adverse to plan. The Trusts year to date net deficit (including technical adjustments) if £2.8m, £0.3m adverse to plan which is due to the non-achievement of the A&E trajectory.
- In May the Trust operated with an EBITDA surplus of £0.9m which was £0.2m adverse to plan and a reduction of £0.4m between months.
- The key variances in the month are as follows:
  - Total income was £1m favourable in the month, Clinical Income was £0.2m favourable which included an Aligned Incentive adjustment of a reduction of £0.2m, STF was £0.2m adverse in May due to missing the A&E trajectory and other operating income was £0.9m favourable, £1.25m favourable relating to STP (£0.9m) and PAS Allscripts (£0.35m) which is offsetting costs incurred, Private Patient income was £0.2m adverse to plan.
  - Pay was £0.5m favourable, all staff groups were underspent within the month, the largest underspending pay groups were Medical £0.2m and Scientific and Technical staffing £0.2m.
  - Non-Pay was overspent by £1.7m in the month which was mainly due to the STP (£1m) and PAS Allscripts (£0.35m) however this was offset by additional non clinical income. Clinical supplies and services are £0.5m overspent, £0.22m relating to non-delivery of Cost Improvement Plan (CIP) schemes.
- The CIP performance in May delivered efficiencies of £1m which was £0.3m adverse to plan, £0.4m adverse year to date.
- The Trust held £7.8m of cash at the end of May which is slightly lower than the plan value of £8.4m. Following the year end agreement of balances exercise the Trust is in contact with NHS organisations trying to collect all agreed values and escalating any items disputed.
- The Trust is forecasting a year end surplus of £6.3m which is £0.3m adverse to plan due to the YTD A&E STF trajectory slippage. In order to achieve this out-turn the Trust will need to deliver an additional £14.2m risk adjusted savings.

Workforce commentary

- At the end of May 2017, the Trust employed 5,084.1 whole time equivalent substantive staff, a 6.2 WTE reduction from the previous month. Overall temporary staffing is slightly higher than planned, but is lower than the corresponding period in the previous year and also continues to demonstrate a favourable shift from agency to bank.
- Sickness absence in the month (April) reduced by 0.6% to 3.2% compared to the previous month and represented a 1.0% improvement on the same period last year. However, sickness absence management remains a key area of focus for the HR and operational management teams.
- Statutory and mandatory training compliance has increased slightly to 87.5% from the previous month, and has remained consistently above the target percentage.
- Turnover has remained higher than target in May at 11.5%, and a detailed analysis of Trust Turnover was presented at the June Workforce Committee. Some areas have been identified for targeted investigation as a result of this analysis which will be progressed by the HR Business Partners in conjunction with the Divisional operational management teams.
- As identified last month, the 'Recommended Place to Work' indicator from the last quarterly pulse survey has fallen by 10% from the consistent response that the Trust has received over the past few years (circa 60%). This reduction was not mirrored in the recent published annual staff survey (February 2017) result of 63% for the Trust. The next quarterly pulse survey is due to close on 30th June. The Board will be provided with an update of the results in July 2017

TRUST PERFORMANCE DASHBOARD **Position as at:** **31 May 2017**

Delivering or Exceeding Target	
Underachieving Target	
Failing Target	

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

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

	Safe	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
'1-01	*Rate C-Diff (Hospital only)	9.09	21.8	4.6	15.8	11.3	2.3	11.5	11.5	
'1-02	Number of cases C.Difficile (Hospital)	2	5	2	7	5	1	27	27	
'1-03	Number of cases MRSA (Hospital)	0	0	0	0	0	0	0	0	
'1-04	Elective MRSA Screening	99.0%	98.5%	99.0%	98.5%		0.5%	98.0%	98.5%	
'1-05	% Non-Elective MRSA Screening	97.0%	97.0%	97.0%	97.0%		2.0%	95.0%	97.0%	
'1-06	**Rate of Hospital Pressure Ulcers	2.2	1.3	2.5	1.8	- 0.8	- 1.3	*3.0*	2.0	3.0
'1-07	***Rate of Total Patient Falls	5.3	5.94	6.0	5.75	- 0.2	- 0.3	*6.00*	5.72	
'1-08	***Rate of Total Patient Falls Maidstone	5.6	5.8	5.4	5.4	-			5.2	
'1-09	***Rate of Total Patient Falls TWells	6.2	6.0	6.0	6.0	-			6.1	
'1-10	Falls - SIs in month	0	5	1	6	5				
'1-11	Number of Never Events	0	0	0	0	0	0	*0*	0	
'1-12	Total No of SIs Open with MTW	22	35			13				
'1-13	Number of New SIs in month	8	17	16	24	8	4			
'1-14	***Serious Incidents rate	0.36	0.74	0.37	0.54	0.18	0.48	*0.0584 - 0.6978*	0.54	*0.0584 - 0.6978*
'1-15	Rate of Patient Safety Incidents - harmful	0.13	1.90	0.36	1.41	1.05	0.18	*0 - 1.23*	1.23	*0 - 1.23*
'1-16	Number of CAS Alerts Overdue	0	0			0	0	*0*		
'1-17	VTE Risk Assessment	95.6%	95.1%	95.4%	95.7%	0.3%	0.7%	95.0%	95.7%	95.0%
'1-18	Safety Thermometer % of Harm Free Care	96.6%	97.5%	96.5%	96.8%	0.3%	1.8%	95.0%		93.4%
'1-19	Safety Thermometer % of New Harms	3.23%	2.48%	3.43%	3.11%	-0.32%	0.1%	*3.00%*	3.11%	
'1-20	C-Section Rate (non-elective)	12.9%	15.0%	12.4%	13.9%	1.48%	-1.1%	*15.0%*	13.9%	

	Effectiveness	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
2-01	Hospital-level Mortality Indicator (SHMI)******	Prev Yr: July 14 to June 15		1.0260	1.0762	0.1	0.1	Band 2	Band 2	1.0
2-02	Standardised Mortality HSMR	Prev Yr: Apr 15 to Mar 16		106.1	108.7	2.6	8.7	Lower confidence limit		100.0
2-03	Crude Mortality	1.4%	1.2%	1.4%	1.2%	-0.2%		to be <100		
2-04	****Readmissions <30 days: Emergency	11.9%	12.2%	11.9%	12.2%	0.3%	-1.4%	*13.6%*	12.2%	14.1%
2-05	****Readmissions <30 days: All	11.2%	11.7%	11.2%	11.7%	0.4%	-3.0%	*14.7%*	11.7%	14.7%
2-06	Average LOS Elective	2.98	3.35	2.98	3.05	0.07	- 0.15	*3.20*	3.05	
2-07	Average LOS Non-Elective	7.20	7.64	7.20	7.54	0.35	0.74	*6.80*	6.80	
2-08	******FollowUp : New Ratio	1.62	1.51	1.63	1.53	- 0.10	0.01	*1.52*	1.52	
2-09	Day Case Rates	84.0%	86.6%	84.9%	87.3%	2.3%	7.3%	80.0%	87.3%	82.2%
2-10	Primary Referrals	9,321	9,073	18,953	16,838	-11.2%	-1.7%	109,314	109,314	
2-11	Cons to Cons Referrals	3,373	3,145	6,654	6,128	-7.9%	-10.9%	40,621	39,125	
2-12	First OP Activity	13,667	15,036	26,950	27,247	1.1%	-3.0%	165,729	165,729	
2-13	Subsequent OP Activity	27,249	27,571	53,857	50,520	-6.2%	-14.2%	351,502	351,502	
2-14	Elective IP Activity	704	574	1,324	1,050	-20.7%	-26.1%	8,144	8,144	
2-15	Elective DC Activity	3,673	3,867	7,447	7,308	-1.9%	-4.5%	43,859	43,859	
2-16	Non-Elective Activity	4,269	4,774	8,559	9,194	7.4%	7.0%	48,889	48,889	
2-17	A&E Attendances (Inc Clinics. Calendar Mth)	14,630	14,646	27,581	28,312	2.7%	4.4%	167,456	167,456	
2-18	Oncology Fractions	5,719	5,747	12,095	10,612	-12.3%	-12.9%	72,321	72,321	
2-19	No of Births (Mothers Delivered)	482	528	984	998	1.4%	0.2%	5,977	5,988	
2-20	% Mothers initiating breastfeeding	80.8%	80.8%	81.5%	80.3%	-1.2%	2.3%	78.0%	80.3%	
2-21	% Stillbirths Rate	0.4%	0.42%	0.21%	0.39%	*0.2%*	*-0.1%*	*0.47%*	0.39%	0.47%

	Caring	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
3-01	Single Sex Accommodation Breaches	0	0	0	0	0	0	0	0	
3-02	*****Rate of New Complaints	1.68	1.31	1.69	1.34	-0.4	0.02	*1.318-3.92*	1.33	
3-03	% complaints responded to within target	58.1%	70.4%	74.3%	79.1%	4.7%	4.1%	75.0%	79.1%	
3-04	****Staff Friends & Family (FFT) % rec care	87.2%	76.6%	87.2%	76.6%	-10.6%	-2.4%	79.0%	79.0%	
3-05	*****IP Friends & Family (FFT) % Positive	95.7%	95.5%	96.2%	95.4%	-0.8%	0.4%	95.0%	95.4%	95.8%
3-06	A&E Friends & Family (FFT) % Positive	91.8%	91.2%	91.1%	91.4%	0.2%	4.4%	87.0%	91.4%	85.5%
3-07	Maternity Combined FFT % Positive	93.5%	91.7%	93.8%	93.6%	-0.2%	-1.4%	95.0%	95.0%	95.6%
3-08	OP Friends & Family (FFT) % Positive	81.4%	84.2%	81.9%	84.1%	2.1%			84.1%	

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

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

***** *IP Friends and Family includes Inpatients and Day Cases* ******SHMI is at Band 2 "As Expected"*

	Responsiveness	Latest Month Prev Yr	Latest Month Curr Yr	Year/Quarter to Date Prev Yr	Year/Quarter to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
4-01	******Emergency A&E 4hr Wait	90.6%	87.0%	91.0%	87.0%	-4.0%	-2.1%	90.1%	90.1%	
4-02	Emergency A&E >12hr to Admission	0	0	0	0	0	0	*0*	0	
4-03	Ambulance Handover Delays >30mins	New	653	New	979					
4-04	Ambulance Handover Delays >60mins	New	73	New	93					
4-05	RTT Incomplete Admitted Backlog	1,550	2270	1,550	2270	720	738	1,259	1259	
4-06	RTT Incomplete Non-Admitted Backlog	777	810	777	810	33	42	631	631	
4-07	RTT Incomplete Pathway	91.0%	87.6%	91.0%	87.6%	-3.3%	-2.3%	92%	92.0%	
4-08	RTT 52 Week Waiters	0	0	0	0	-	0	*0*	0	
4-09	RTT Incomplete Total Backlog	2,229	3080	2,229	3080	851	780	1,890	1890	
4-10	% Diagnostics Tests WTimes <6wks	99.66%	99.5%	99.6%	99.5%	-0.1%	0.5%	99.0%	99.0%	
4-11	*Cancer WTimes - Indicators achieved	2	3	2	3	1	- 6	9	9	
4-12	*Cancer two week wait	91.3%	91.0%	91.3%	91.0%	-0.3%	-2.0%	93.0%	93.0%	
4-13	*Cancer two week wait-Breast Symptoms	78.4%	85.1%	78.4%	85.1%	6.7%	-7.9%	93.0%	93.0%	
4-14	*Cancer 31 day wait - First Treatment	96.6%	91.9%	96.6%	91.9%	-4.6%	-4.1%	96.0%	96.0%	
4-15	*Cancer 62 day wait - First Definitive	64.3%	62.3%	64.3%	62.3%	-2.0%	-10.3%	85.0%	85.0%	
4-16	*Cancer 62 day wait - First Definitive - MTW	68.1%	69.6%	68.1%	69.6%	1.5%		85.0%		
4-17	*Cancer 104 Day wait Accountable	14.0	9.0	14.0	9.0	-5.0	9.0	*0*	9.0	
4-18	*Cancer 62 Day Backlog with Diagnosis	New	83	New	83					
4-19	*Cancer 62 Day Backlog with Diagnosis - MTW	New	58	New	58					
4-20	Delayed Transfers of Care	5.3%	6.0%	5.4%	5.8%	0.4%	2.3%	3.5%	3.5%	
4-21	% TIA with high risk treated <24hrs	90.9%	77.8%	90.9%	77.8%	-13.1%	17.8%	60%	77.8%	
4-22	*******% spending 90% time on Stroke Ward	88.5%	81.5%	88.5%	81.5%	-7.0%	1.5%	80%	81.5%	
4-23	*******Stroke:% to Stroke Unit <4hrs	58.6%	60.3%	58.6%	60.3%	1.7%	0.3%	60.0%	60.3%	
4-24	*******Stroke: % scanned <1hr of arrival	62.7%	62.3%	62.7%	62.3%	-0.4%	14.3%	48.0%	62.3%	
4-25	*******Stroke:% assessed by Cons <24hrs	67.8%	71.0%	67.8%	71.0%	3.2%	-9.0%	80.0%	80.0%	
4-26	Urgent Ops Cancelled for 2nd time	0	0	0	0	0	0	*0*	0	
4-27	Patients not treated <28 days of cancellation	2	2	2	7	5	7	*0*	7	

RTT Incomplete Pathway Monthly Plan is Trust Recovery Trajectory

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

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

	Well-Led	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
5-01	Income	34,118	36,805	67,309	73,773	9.6%	2.6%	436,668	436,332	
5-02	EBITDA	(493)	913	(1,448)	2,221	-253.4%	-14.5%	38,055	38,055	
5-03	Surplus (Deficit) against B/E Duty	(3,213)	(1,603)	(6,906)	(2,831)			6,673	6,337	
5-04	CIP Savings	1,464	992	2,731	2,045	-25.1%	-14.9%	31,721	31,721	
5-05	Cash Balance	5,881	7,825	5,881	7,825	33.1%	-30%	1,000	1,000	
5-06	Capital Expenditure	103	143	182	180	-1.1%	-89.8%	*17,398*	17,398	
5-07	Establishment WTE	5,734.8	5,602.4	5,734.8	5,602.4	-2.3%	0.0%	5,602.4	5,602.4	
5-08	Contracted WTE	5,165.0	5,084.1	5,165.0	5,084.1	-1.6%	-0.5%	5,111.5	5,111.5	
5-09	Vacancies WTE	569.9	518.3	569.9	518.3	-9.0%	5.6%	490.9	490.9	
5-11	Vacancy Rate (%)	9.9%	9.3%	9.9%	9.3%	-0.7%	0.5%	8.8%	8.8%	
5-12	Substantive Staff Used	4,988.0	4,943.0	4,988.0	4,943.0	-0.9%	-3.3%	5,113.5	5,113.5	
5-13	Bank Staff Used	332.7	396.1	332.7	396.1	19.1%	18.8%	333	333.3	
5-14	Agency Staff Used	253.9	134.9	253.9	134.9	-46.9%	-13.3%	155.6	155.6	
5-15	Overtime Used	48.1	43.8	48.1	43.8	-9.0%				
5-16	Worked WTE	5,622.7	5,517.7	5,622.7	5,517.7		-1.5%	5,602.4	5,602.4	
5-17	Nurse Agency Spend	(789)	(651)	(1,653)	(1,259)	-23.8%				
5-18	Medical Locum & Agency Spend	(1,308)	(1,013)	(2,672)	(2,378)	-11.0%				
5-19	Temp costs & overtime as % of total pay bill	16.0%	13.7%	16.5%	14.5%	-2.0%				
5-20	Staff Turnover Rate	9.9%	11.5%		11.5%	1.6%	1.0%	*10.5%*	10.5%	11.05%
5-21	Sickness Absence	4.2%	3.2%		3.5%	-1.0%	0.2%	*3.3%*	3.3%	4.3%
5-22	Statutory and Mandatory Training	89.9%	87.5%		87.1%	-2.4%	2.1%	85.0%	87.1%	
5-23	Appraisal Completeness	Data not reported for Quarter 1.								
5-24	Overall Safe staffing fill rate	101.6%	98.9%	102.5%	98.5%	-4.0%		93.5%	98.5%	
5-25	****Staff FFT % recommended work	64.2%	53%	64.2%	53%	-11.7%	-9.5%	62.0%	62%	
5-26	***Staff Friends & Family -Number Responses	664	619	664	619	-45				
5-27	*****IP Resp Rate Recmd to Friends & Family	22.4%	23.3%	20.6%	23.5%	2.8%	-1.5%	25.0%	25.0%	25.7%
5-28	A&E Resp Rate Recmd to Friends & Family	10.4%	15.7%	7.7%	18.5%	10.8%	3.5%	15.0%	18.5%	12.7%
5-29	Mat Resp Rate Recmd to Friends & Family	24.0%	12.7%	27.1%	27.7%	0.6%	2.7%	25.0%	27.7%	24.0%

Explanation of Statistical Process Control (SPC) Charts

In order to better understand how performance is changing over time, data on the Trusts performance reports are often displayed as SPC Charts. *A*n SPC chart looks like this:

SPC is a type of charting that shows the variation that exists in the systems that are being measured. When interpreting SPC charts there are 4 rules that help to identify what the system is doing. If one of the rules has been broken, this means that 'special cause ' variation is present in the system. It is also perfectly normal for a process to show no signs of special cause. This means that only 'common cause ' variation is present.

Rule 1: Any point outside one of the control limits. Typically this will be some form of significant event, for example unusually severe weather. However if the data points continue outside of the control limits then that significant change is permanent. When we are aware of a significant change to a service such as Tunbridge Wells Hospital opening, then we will recalculate the centre and control lines. This is called a step change.

Rule 2: Any unusual pattern or trends within the control limits. The most obvious example of a cyclical pattern is seasonality but we also see it when looking at daily discharges where the weekends have low numbers. To qualify as a trend there must be at least 6 points in a row. This is one of the key reasons we use SPC charts as it helps us differentiate between natural variation & variation due to some action we have taken.

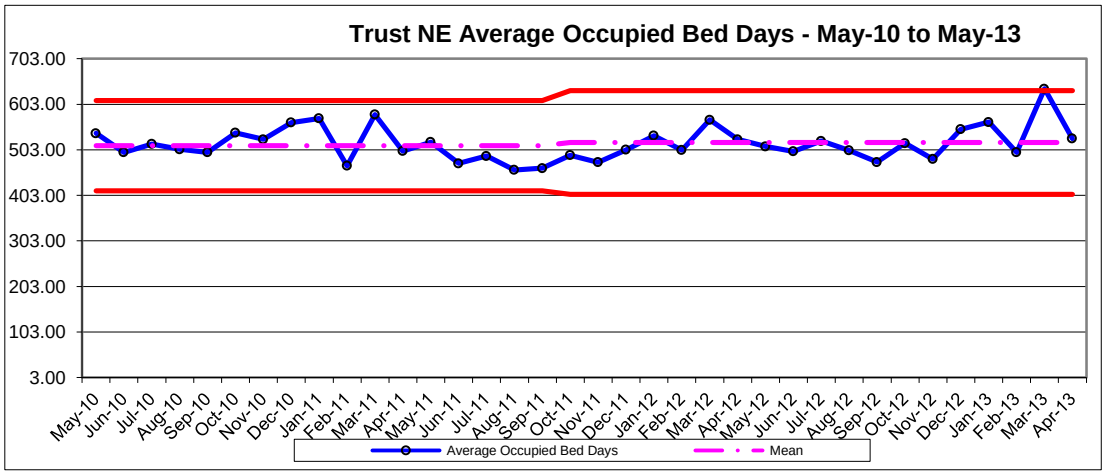
Rules 1 and 2 are the main reason for displaying SPC charts on our performance reports as it makes abnormally high or low values and trends immediately obvious. However there are two other rules that are also used to interpret the graphs.

Rule 3: A run of seven points all above or all below the centre line, or all increasing or decreasing. This shows some longer term change in the process such as a new piece of equipment that allows us to perform a procedure in an outpatient setting rather than admitting them. However alternating runs of points above the line then points below the line can also invoke rule 3.

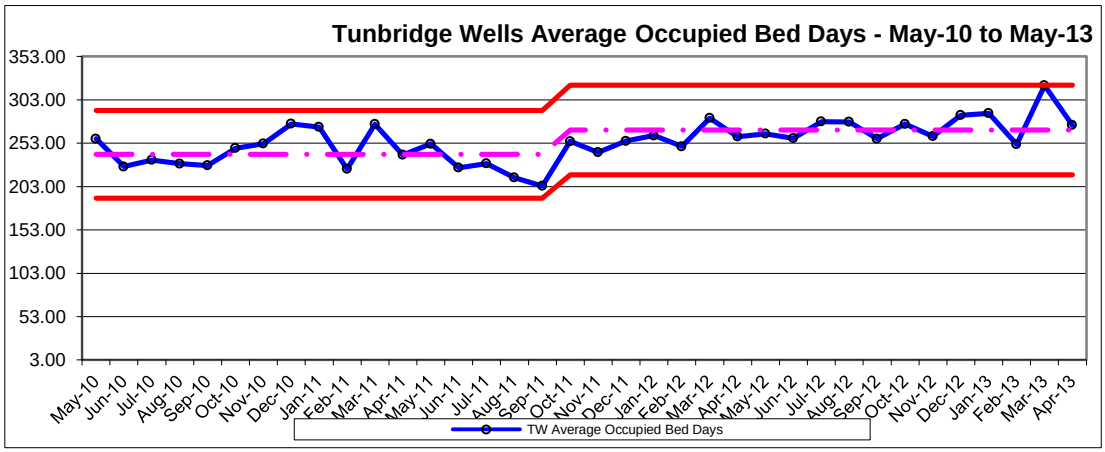
Rule 4: The number of points within the middle third of the region between the control limits differs markedly from two -thirds of the total number of points. This gives an indication of how stable a process is. If controlled variation (common cause) is displayed in the SPC chart, the process is stable and predictable, which means that the variation is inherent in the process. To change performance you will have to change the entire system.

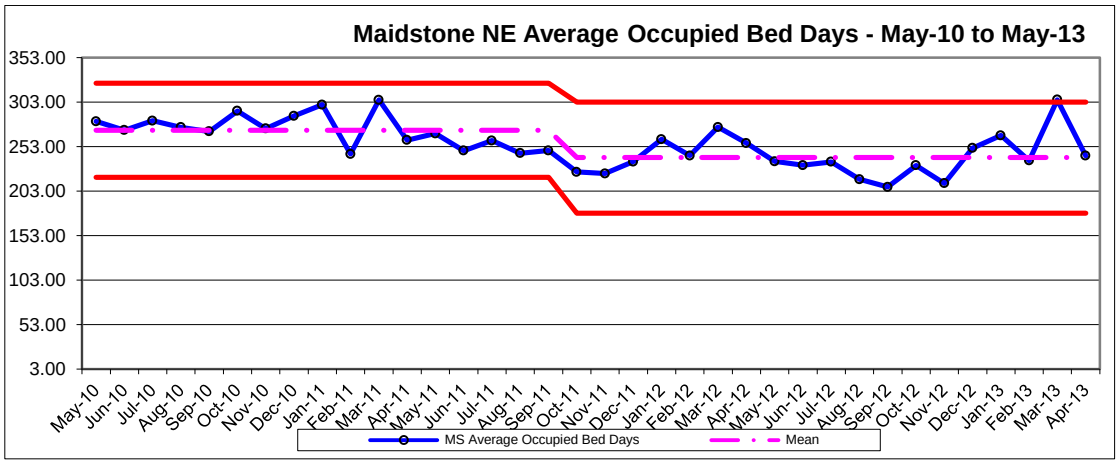
Changes to Control Lines

When there are known changes to the services we provide we reset the calculations as at the date of that change. For example you will see in the graph below that we have re-calculated the control lines from October 2011 onwards. This is to reflect the move of services to the new Tunbridge Wells Hospital in late September.



The change is not immediately obvious in the graph above if you look at just the blue line, but we know there were major changes to our inpatient beds. Looking at site level the change is more obvious:

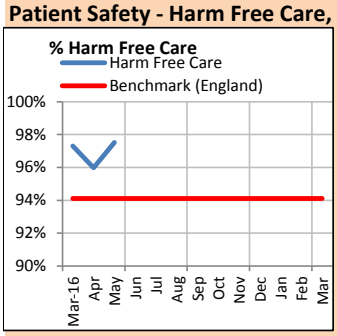


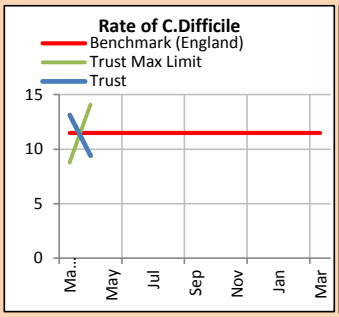


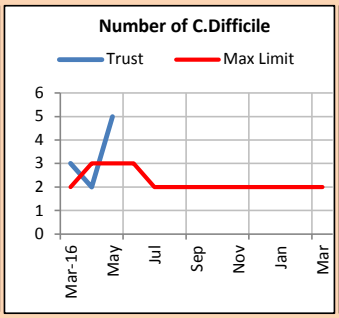
So in the examples given we have calculated a mean and control limits based on the data for May 2010 to September 2011 and then calculated them based on the period October 2011 to April 2013. The lines are all a result of the SPC calculations, only the date of the change is decided by the Information team based on a real life changes in process or service.

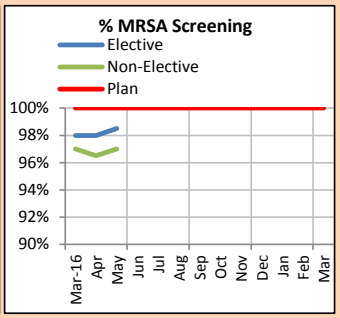
INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

Patient Safety - Harm Free Care, Infection Control

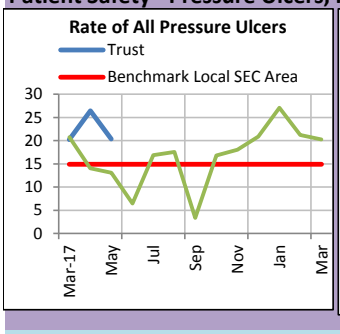


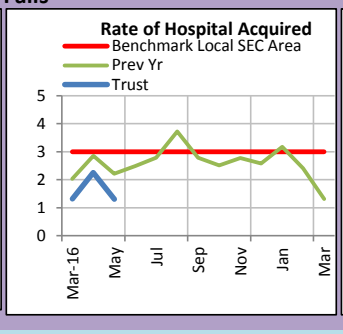


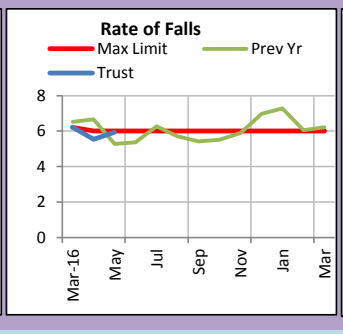


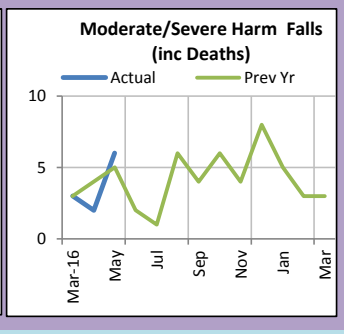


Patient Safety - Pressure Ulcers, Falls

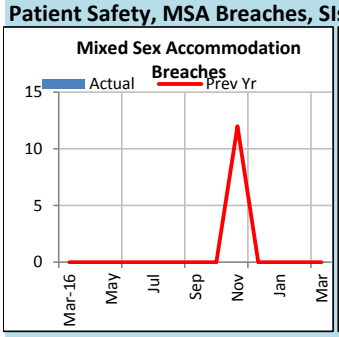


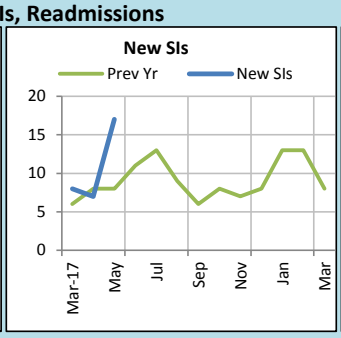


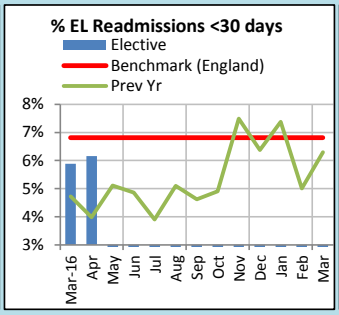


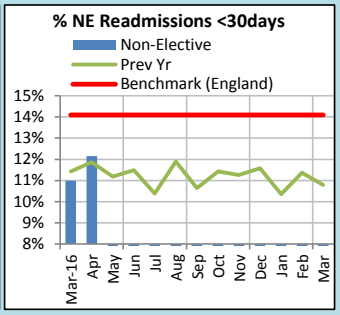


Patient Safety, MSA Breaches, SIs, Readmissions

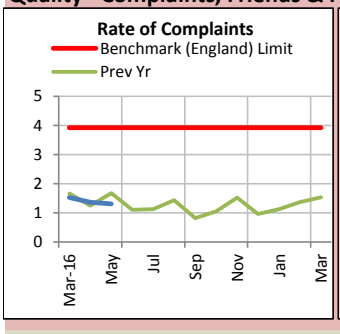


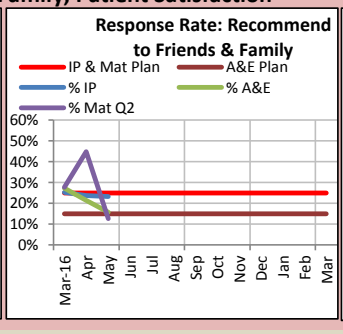


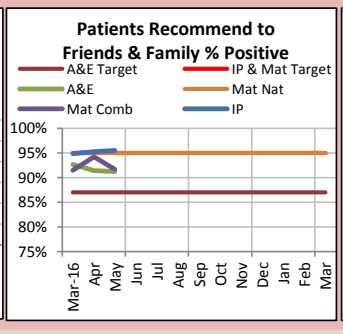


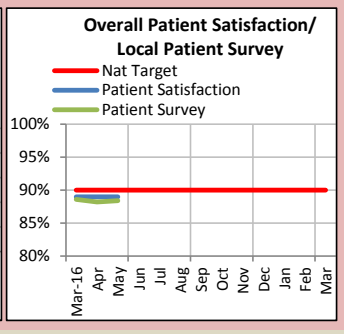


Quality - Complaints, Friends & Family, Patient Satisfaction

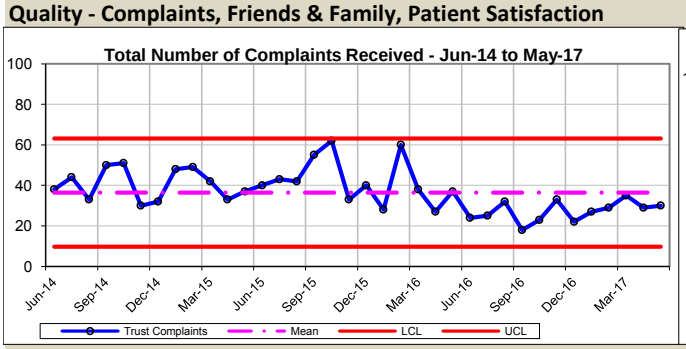


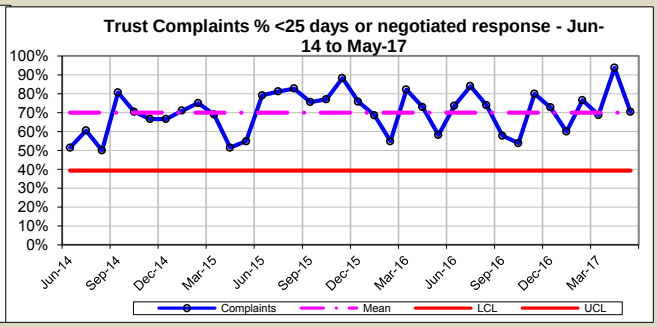




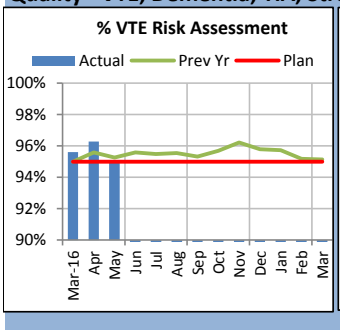


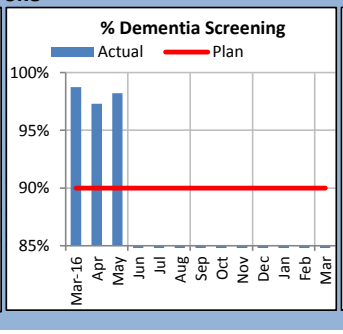
Quality - Complaints, Friends & Family, Patient Satisfaction

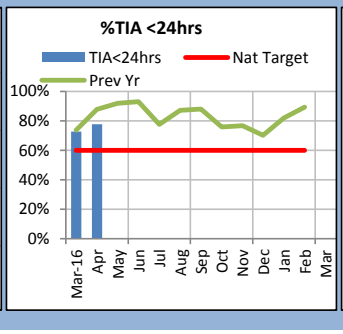


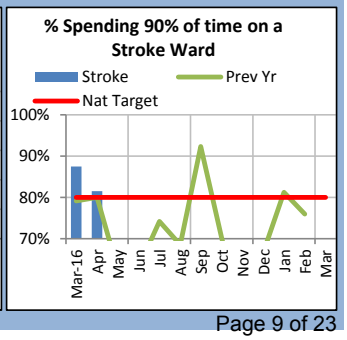


Quality - VTE, Dementia, TIA, Stroke



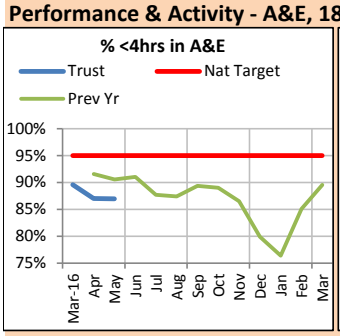


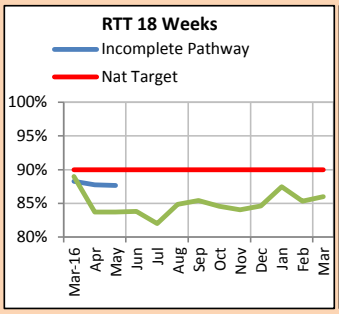


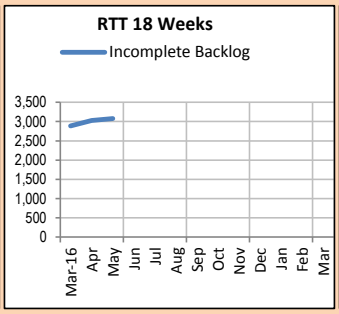


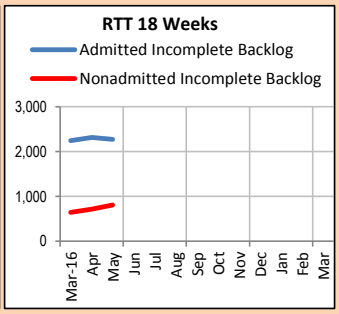
INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

Performance & Activity - A&E, 18 Weeks

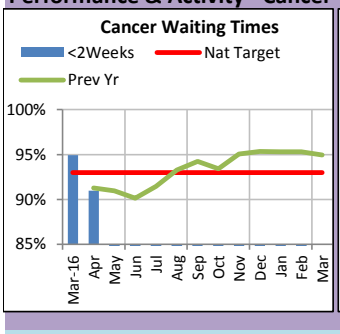


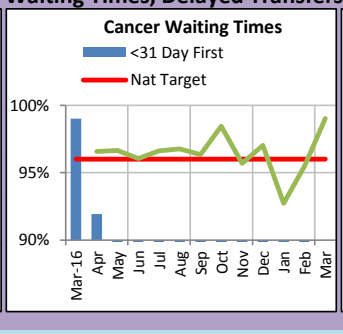


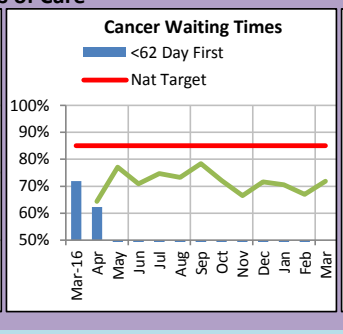


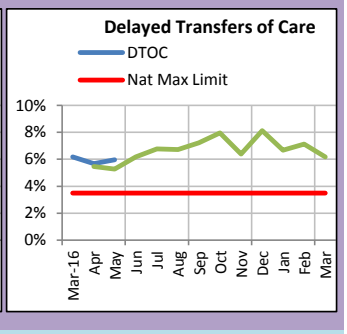


Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care

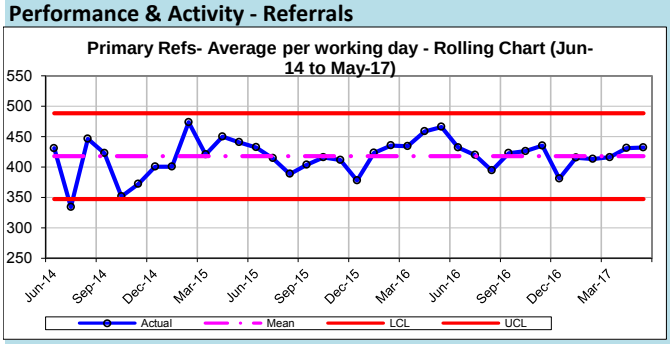


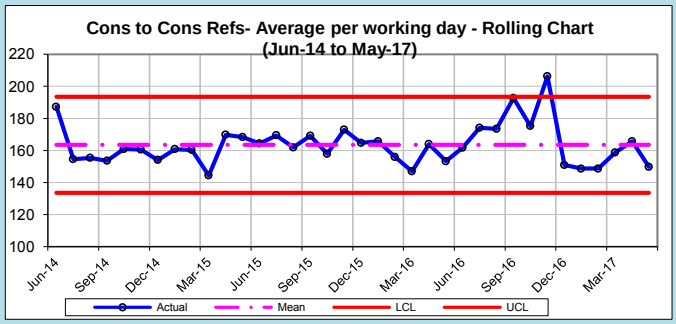




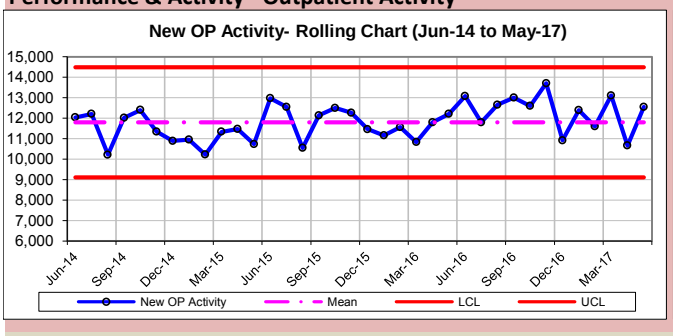


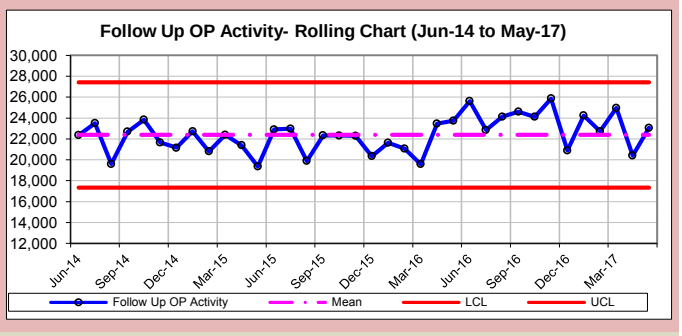
Performance & Activity - Referrals



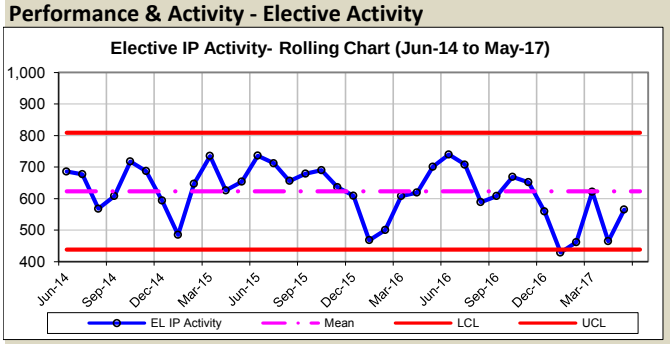


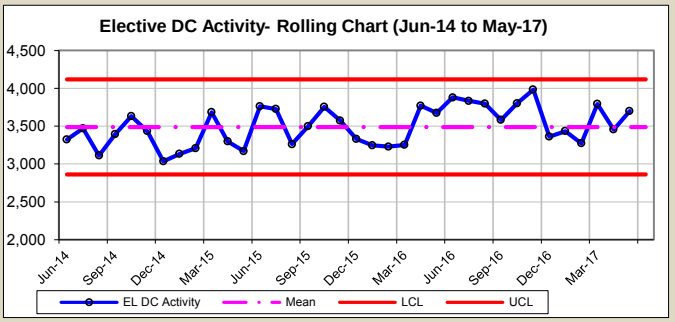
Performance & Activity - Outpatient Activity



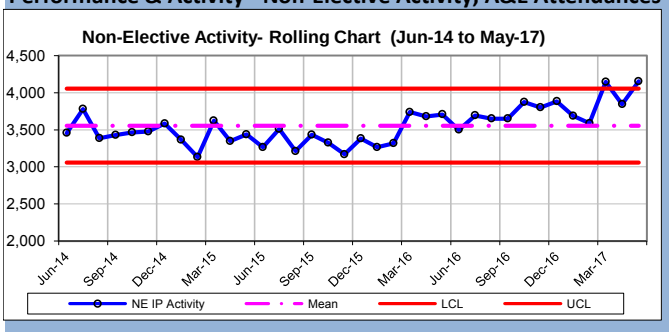


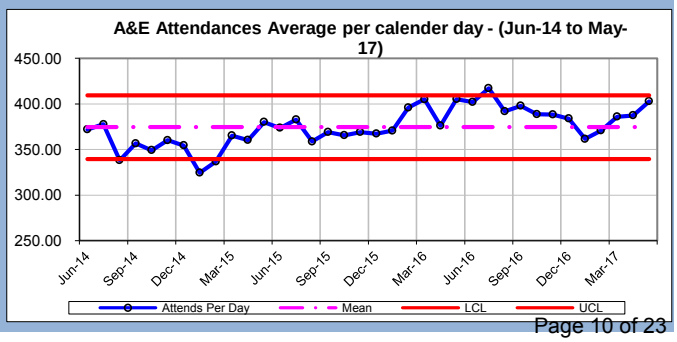
Performance & Activity - Elective Activity





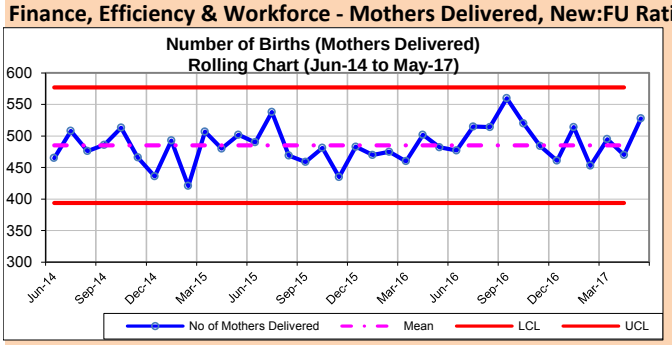
Performance & Activity - Non-Elective Activity, A&E Attendances

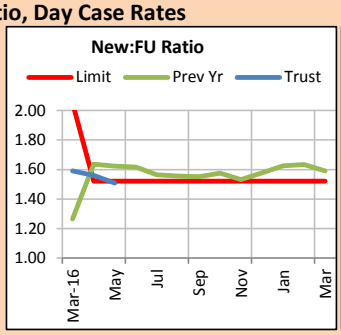


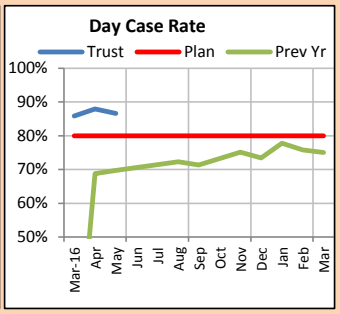


INTEGRATED PERFORMANCE REPORT ANALYSIS - FINANCE, EFFICIENCY & WORKFORCE

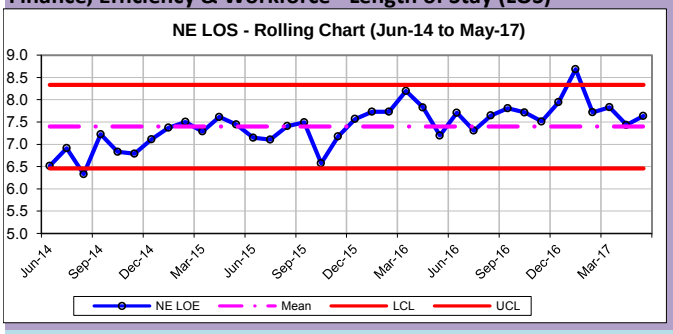
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates

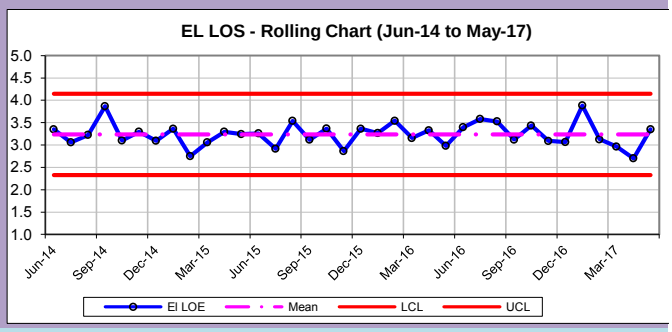




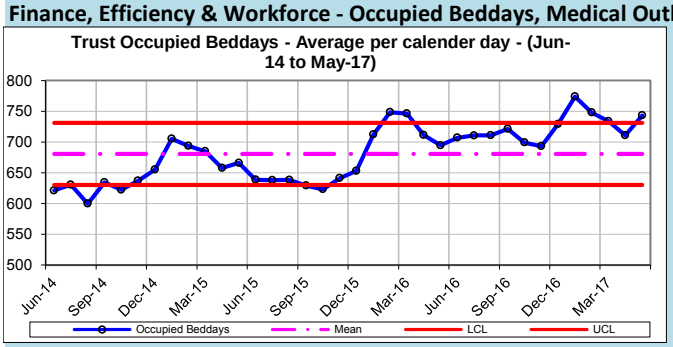


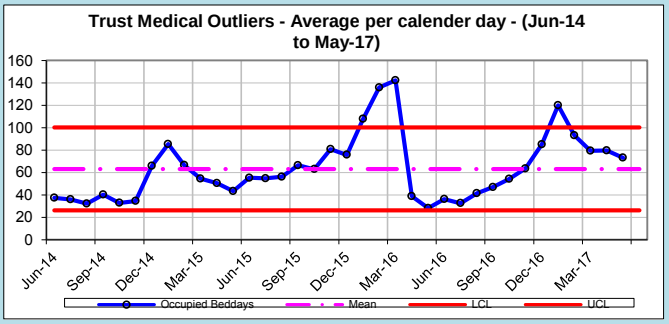
Finance, Efficiency & Workforce - Length of Stay (LOS)



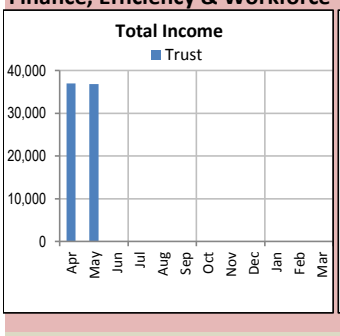


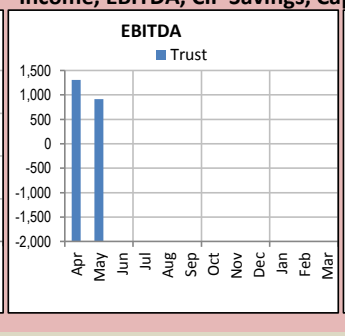
Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

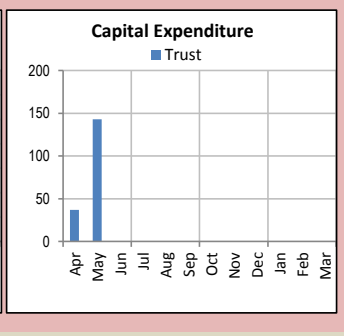




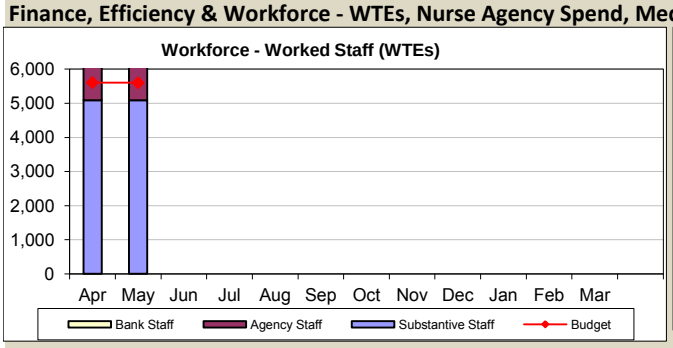
Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure

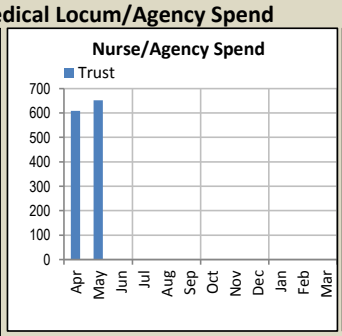


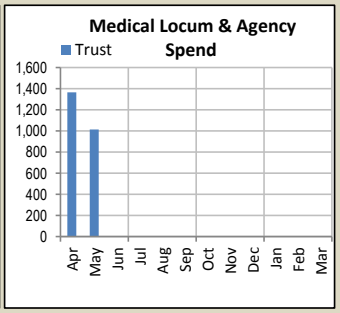




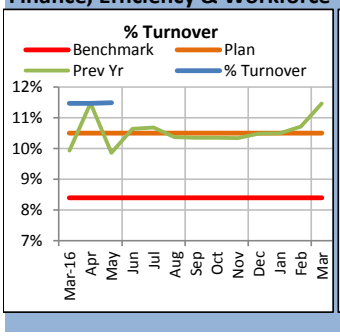
Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend

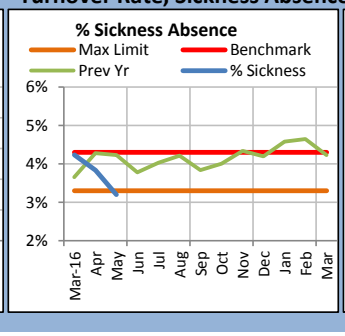


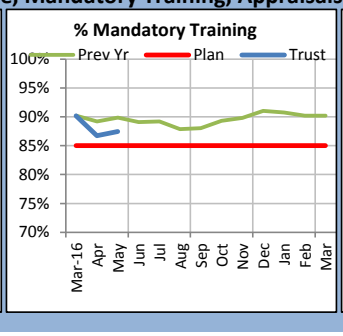


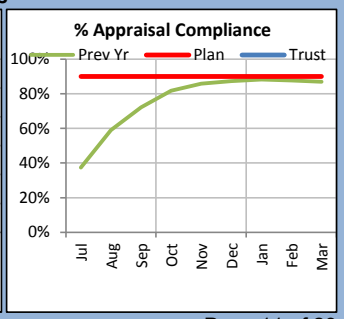


Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals









Maidstone and Tunbridge Wells NHS Trust

Trust Board Finance Pack

Month 2
2017/18

Maidstone and Tunbridge Wells NHS Trust

Content

Trust Board Finance Pack for May 2017

1.Executive Summary

1a. Executive Summary May 2017

Key Variances £m

	May	YTD		Headlines
Total Surplus (+) / Deficit (-)	(0.2)	(0.3)	Adverse	The Trusts deficit including STF was £1.6m in May which was £0.2m adverse to plan due to £0.2m slippage against STF income relating to the non achievement of the May A&E trajectory. The Trust was breakeven compared to the pre STF plan.
Clinical Income	0.2	0.3	Favourable	Clinical Income was favourable by £0.2m in the month, which included a reduction adjustment of £0.2m for the impact of the aligned incentive contract, leaving a £1.6m positive adjustment year to date. The key adverse variances in May were Elective & Day Cases (£0.4m), Regular Attenders (£0.2m) offset by favourable variances within Non-Electives (£0.2m) and High Cost Drugs (£0.4m). Due to the delay in completing contract baselines, a number of assumptions have been made to produce the income position. Please see activity and income slides.
Other Operating Income	0.9	1.9	Favourable	Other Operating Income £0.9m favourable in the month, £0.9m relating to STP costs (offset by additional costs), £0.35m PAS Allscripts income (offset by additional costs) and £0.2m adverse variance relating to private patient income (£0.13m relating to PPU (£0.27m YTD)).
Pay	0.5	0.6	Favourable	Pay was £0.5m favourable in the month, all staff groups are underspent to plan, A&C £0.14m favourable in month (£0.22m YTD), £170k underspend relates to corporate and estates and facilities directorates and clinical divisions £52k favourable to plan. STT staffing (£171k favourable YTD) which is mainly within Specialist Medicine £228k (mainly therapies) and Cancer (£130k favourable) partly offset by overspend within Critical care (£103k) which is offset by an underspend within the Nursing staff group. Medical £95k favourable and Nursing £47k favourable.
Non Pay	(1.7)	(2.9)	Adverse	Non Pay was overspent by £1.7m in May, £2.9m YTD. Pass though costs for STP, PAS Allscripts and drugs account for £1.5m (£2.6m YTD). The YTD position includes £0.1m connecting for health subsidy reduction (£0.6m per annum) within ICT.
Elective IP	(0.3)	(0.9)	Adverse	Elective Income was £0.3m adverse to plan in May, the Aligned Incentive contract adjustment relating to Elective activity was £0.2m therefore a net £0.1m adverse variance in the month. The continued pressure on Emergency Pathways contributed towards this.
Sustainability and Transformation Fund	(0.2)	(0.3)	Adverse	The Sustainability and Transformation fund is weighted 70% towards achieving the financial plan and 30% towards A&E access targets. The trust achieved the financial target in April and May but missed the A&E access trajectory.
CIP / FRP	(0.3)	(0.4)	Adverse	The Trust achieved £1m savings in May, this was £0.3m adverse to plan and has delivered £2m savings YTD (£0.4m adverse to plan).

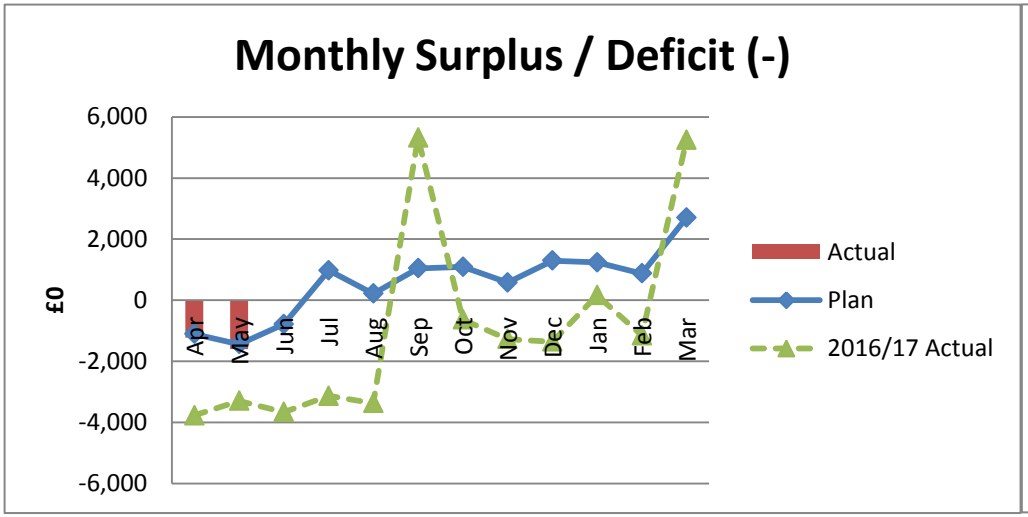
Risks:

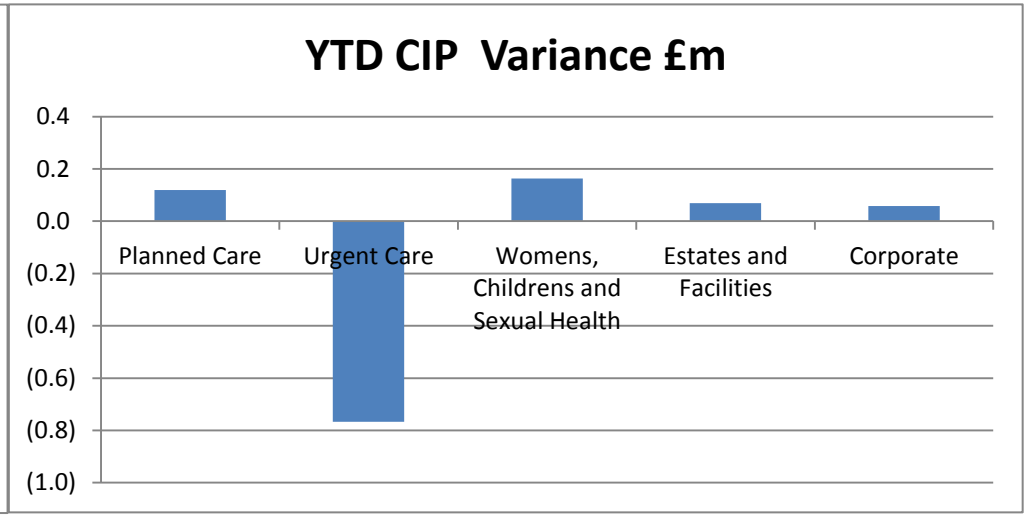
- The Trust has included over performance on a PbR basis for West Kent CCG relating to the cost risk share bucket. Discussion is on-going with the CCG about the application, access and use of the risk reserve, this will be reflected in the financial position in month 3 and will be retrospectively applied back to the beginning of the year.

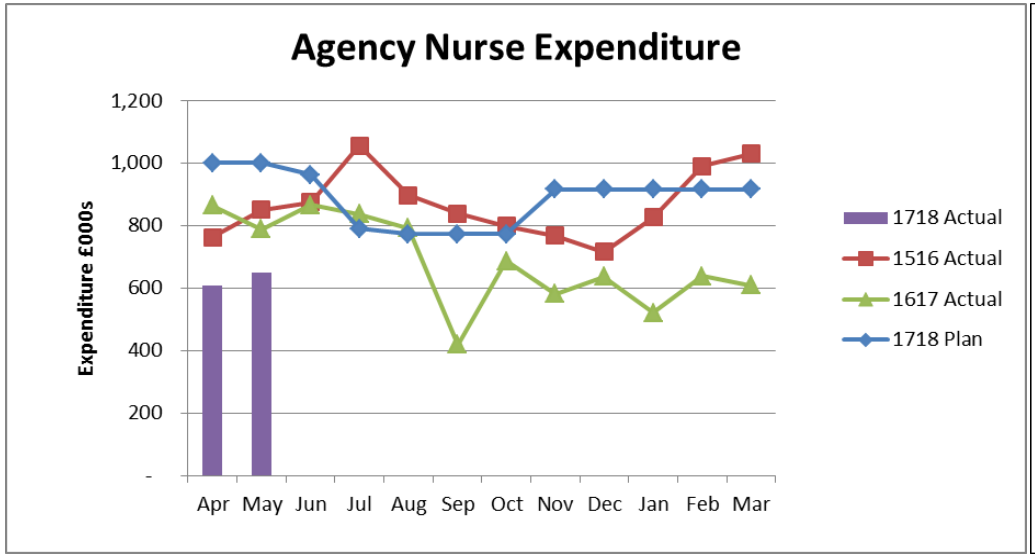
CQUINS: An assessment on system control totals and national risk profile will be made by NHS Improvement and NHS England on a quarterly basis, it is expected that the funds will be released and the Trust will be in a position to recognise the full 0.5%. Consideration of the Aligned Incentives contract impact will need to take place to ensure application of the national CQUIN guidance adhered to in full.

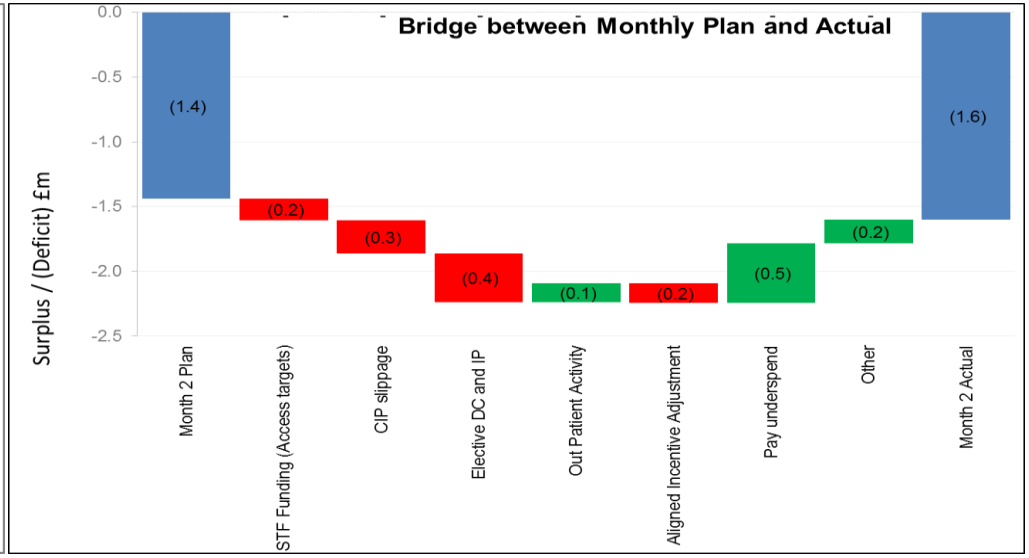
Maidstone and Tunbridge Wells NHS Trust

1b. Executive Summary KPI's May 2017









2.Income and Expenditure

Maidstone and Tunbridge Wells NHS Trust

2a. Income & Expenditure

Income & Expenditure May 2017/18

		Current Month			Year to Date			Annual Forecast		
		Actual £m	*Plan* £m	*Variance* £m	*Actual* £m	*Plan* £m	*Variance* £m	*Forecast* £m	*Plan* £m	*Variance* £m
Revenue										
	Clinical Income	31.8	31.6	0.2	63.8	63.5	0.3	381.9	381.9	0
	STF	0.4	0.6	(0.2)	0.8	1.1	(0.3)	10.8	11.2	(0.3)
	Other Operating Income	4.6	3.6	0.9	9.2	7.3	1.9	43.6	43.6	0
	Total Revenue	36.8	35.8	1.0	73.8	71.9	1.9	436.3	436.7	(0.3)
Expenditure										
	Substantive	(18.0)	(18.3)	0.4	(35.9)	(36.7)	0.8	(215.4)	(215.4)	0
	Bank	(0.9)	(0.6)	(0.3)	(1.8)	(1.2)	(0.6)	(6.1)	(6.1)	0
	Locum	(1.0)	(0.9)	(0.1)	(2.4)	(1.9)	(0.5)	(10.2)	(10.2)	0
	Agency	(0.8)	(1.3)	0.4	(1.7)	(2.6)	0.9	(13.3)	(13.3)	0
	Pay Reserves	(0.2)	(0.3)	0.0	(0.5)	(0.5)	0.0	(3.0)	(3.0)	0
	Total Pay	(21.0)	(21.4)	0.5	(42.2)	(42.9)	0.6	(248.1)	(248.1)	0
	Drugs & Medical Gases	(4.6)	(4.3)	(0.3)	(8.8)	(8.6)	(0.2)	(50.9)	(50.9)	0
	Blood	(0.2)	(0.2)	(0.0)	(0.5)	(0.4)	(0.0)	(2.5)	(2.5)	0
	Supplies & Services - Clinical	(2.8)	(2.3)	(0.5)	(5.3)	(4.6)	(0.7)	(23.7)	(23.7)	0
	Supplies & Services - General	(0.5)	(0.4)	(0.1)	(1.0)	(0.9)	(0.1)	(5.1)	(5.1)	0
	Services from Other NHS Bodies	(0.7)	(0.6)	(0.0)	(1.4)	(1.3)	(0.1)	(7.6)	(7.6)	0
	Purchase of Healthcare from Non-NHS	(0.5)	(0.9)	0.4	(1.0)	(1.8)	0.8	(7.9)	(7.9)	0
	Clinical Negligence	(1.7)	(1.7)	(0.0)	(3.4)	(3.4)	(0.0)	(20.6)	(20.6)	0
	Establishment	(0.3)	(0.3)	0.0	(0.6)	(0.6)	0.1	(3.7)	(3.7)	0
	Premises	(2.3)	(1.9)	(0.5)	(4.4)	(3.7)	(0.6)	(21.5)	(21.5)	0
	Transport	(0.1)	(0.1)	0.0	(0.2)	(0.2)	0.0	(1.4)	(1.4)	0
	Other Non-Pay Costs	(1.1)	(0.4)	(0.7)	(2.6)	(0.8)	(1.8)	(4.9)	(4.9)	0
	Non-Pay Reserves	(0.1)	(0.0)	(0.1)	(0.2)	(0.1)	(0.1)	(0.8)	(0.8)	0
	Total Non Pay	(14.9)	(13.2)	(1.7)	(29.3)	(26.5)	(2.9)	(150.5)	(150.5)	0
	Total Expenditure	(35.9)	(34.7)	(1.2)	(71.6)	(69.3)	(2.2)	(398.6)	(398.6)	0
EBITDA	**EBITDA**	0.9	1.1	(0.2)	2.2	2.6	(0.4)	37.7	38.1	(0.3)
		0.0	*0.0*	*(0.0)*	*3.0%*	*3.6%*	*-20.2%*	*8.6%*	*8.7%*	*100%*
Other Finance Costs										
	Depreciation	(1.2)	(1.2)	(0.0)	(2.4)	(2.4)	(0.0)	(14.8)	(14.8)	0
	Interest	(0.1)	(0.1)	0.0	(0.2)	(0.2)	0.0	(1.3)	(1.3)	0
	Dividend	(0.1)	(0.1)	0.0	(0.2)	(0.2)	0.0	(1.5)	(1.5)	0
	PFI and Impairments	(1.2)	(1.2)	(0.0)	(2.3)	(2.3)	(0.0)	(14.9)	(14.9)	0
	Total Finance Costs	(2.5)	(2.6)	0.0	(5.1)	(5.1)	0.0	(32.4)	(32.4)	0
Net Surplus / Deficit (-)	**Net Surplus / Deficit (-)**	(1.6)	(1.4)	(0.2)	(2.9)	(2.5)	(0.4)	5.3	5.7	(0.3)
Technical Adjustments	**Technical Adjustments**	0.0	(0.0)	0.0	0.1	(0.0)	0.1	1.0	1.0	0
Surplus/ Deficit (-) to B/E Duty	**Surplus/ Deficit (-) to B/E Duty Incl STF**	(1.6)	(1.4)	(0.2)	(2.8)	(2.5)	(0.3)	6.3	6.7	(0.3)
	Surplus/ Deficit (-) to B/E Duty Excl STF	(2.0)	(2.0)	0.0	(3.6)	(3.7)	0.0	(4.5)	(4.5)	0.0

Commentary

The Trusts deficit including STF was £1.6m in May which was £0.2m adverse to plan due to £0.2m slippage against STF income relating to the non achievement of the May A&E trajectory. The Trust was breakeven to the pre STF plan.

Clinical Income (Excluding STF) was £0.2m favourable in the month (£0.3m favourable YTD), which included a reduction of £0.2m aligned incentive adjustment (£1.6m positive YTD). The key adverse variances in May were Elective activity (DC and IP) £0.4m adverse to plan, Non Elective £0.26m adverse to plan in the month, Out Patients £0.4m favourable to plan and HCD income £0.4m favourable in the month.

STF income £0.2m adverse in month relating to non achievement of the May A&E trajectory, £0.4m YTD adverse to plan.

Other Operating Income £0.9m favourable in the month, £0.9m relating to STP costs (offset by additional costs), £0.35m PAS Allscripts income (offset by additional costs) and £0.2m adverse variance relating to private patient income (£0.13m relating to PPU (£0.27m YTD).

Pay was £0.5m favourable in the month, all staff groups are underspent to plan, A&C £0.14m favourable in month (£0.22m YTD), £170k underspend relates to corporate and estates and facilities directorates and clinical divisions £52k favourable to plan. STT staffing (£171k favourable YTD) which is mainly within Specialist Medicine £228k (mainly therapies) and Cancer (£130k favourable) partly offset by overspend within Critical care (£103k) which is offset by an underspend within the Nursing staff group. Medical £95k favourable and Nursing £47k favourable.

Non Pay was overspent by £1.7m in May, £2.9m YTD. Pass though costs for STP, PAS Allscripts and drugs account for £1.5m (£2.6m YTD). The YTD position includes £0.1m connecting for health subsidy reduction (£0.6m per annum) within ICT.

The Trust is forecasting a year end surplus of £6.3m which is £0.3m adverse to plan due to the YTD A&E STF trajectory slippage. In order to achieve this outturn the Trust will need to deliver an additional £14.2m risk adjusted savings.

3. Expenditure Analysis

3a. Run Rate Analysis

Analysis of 13 Monthly Performance (£m's)

		May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Change between Months
Revenue	Clinical Income	27.7	28.4	27.6	27.8	32.0	28.5	28.6	28.1	27.5	27.0	29.1	31.9	31.8	(0.1)
	STF					2.7	0.9	0.7	0.6	(0.0)	0.0	0.8	0.4	0.4	0.0
	High Cost Drugs	2.6	2.8	2.6	2.7	2.9	2.9	2.8	3.8	3.1	2.7	3.2	(0.1)	(0.0)	0.1
	Other Operating Income	3.8	3.6	4.0	3.6	3.7	4.0	3.9	3.9	4.5	3.9	8.4	4.7	4.6	(0.2)
	Total Revenue	**34.1**	**34.8**	**34.2**	**34.1**	**41.3**	**36.2**	**36.1**	**36.3**	**35.1**	**33.5**	**41.5**	**37.0**	**36.8**	**(0.2)**
Expenditure	Substantive	(17.9)	(18.1)	(17.9)	(17.9)	(18.1)	(18.0)	(18.1)	(18.1)	(17.6)	(17.8)	(17.3)	(17.9)	(18.0)	(0.1)
	Bank	(0.8)	(0.8)	(0.7)	(0.9)	(0.8)	(0.8)	(0.8)	(1.0)	(1.1)	(0.8)	(1.0)	(0.9)	(0.9)	0.0
	Locum	(0.9)	(1.0)	(1.1)	(1.1)	(0.8)	(0.9)	(0.5)	(1.9)	(1.1)	(0.9)	(1.6)	(1.4)	(1.0)	0.4
	Agency	(1.6)	(1.7)	(1.5)	(1.3)	(1.2)	(1.4)	(1.6)	(0.1)	(0.8)	(0.9)	(1.0)	(0.8)	(0.8)	0.0
	Pay Reserves	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(0.2)	(0.2)	0.0
	Total Pay	(21.2)	(21.6)	(21.3)	(21.2)	(20.9)	(21.1)	(20.9)	(21.1)	(20.5)	(20.5)	(20.8)	(21.3)	(21.0)	0.3
Non-Pay	Drugs & Medical Gases	(4.1)	(4.4)	(3.8)	(4.0)	(4.5)	(3.9)	(4.8)	(4.6)	(4.2)	(4.0)	(5.1)	(4.2)	(4.6)	(0.4)
	Blood	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	0.0
	Supplies & Services - Clinical	(2.7)	(2.7)	(2.7)	(3.0)	(2.7)	(2.7)	(2.6)	(2.8)	(2.7)	(2.5)	(3.1)	(2.6)	(2.8)	(0.2)
	Supplies & Services - General	(0.5)	(0.5)	(0.4)	(0.5)	(0.4)	(0.5)	(0.5)	(0.5)	(0.4)	(0.4)	(0.6)	(0.4)	(0.5)	(0.1)
	Services from Other NHS Bodies	(0.7)	(0.8)	(0.6)	(0.6)	(0.7)	(0.7)	(0.6)	(0.7)	(0.6)	(0.7)	(0.5)	(0.8)	(0.7)	0.1
	Purchase of Healthcare from Non-NHS	(0.7)	(0.8)	(0.9)	(0.9)	(0.6)	(0.8)	(0.7)	(0.7)	(0.8)	(0.5)	(0.5)	(0.5)	(0.5)	(0.0)
	Clinical Negligence	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.7)	(1.7)	(0.0)
	Establishment	(0.3)	(0.3)	(0.4)	(0.3)	(0.4)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.0)
	Premises	(1.7)	(1.9)	(1.9)	(1.7)	(1.2)	(1.7)	(1.4)	(1.8)	(1.8)	(1.7)	(1.7)	(2.0)	(2.3)	(0.3)
	Transport	(0.2)	(0.2)	(0.1)	(0.1)	(0.2)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.0)
	Other Non-Pay Costs	(0.7)	(0.6)	(0.4)	(0.2)	(0.3)	(0.3)	(0.9)	(0.9)	(1.2)	(0.7)	(0.5)	(1.5)	(1.1)	0.4
	Non-Pay Reserves	(0.2)	(0.4)	(0.4)	(0.4)	0.4	0.0	0.0	0.0	0.0	0.0	1.3	(0.1)	(0.1)	0.0
	Total Non Pay	(13.4)	(14.1)	(13.3)	(13.4)	(12.3)	(12.9)	(13.6)	(14.1)	(13.8)	(12.7)	(12.9)	(14.4)	(14.9)	(0.6)
	Total Expenditure	(34.6)	(35.7)	(34.6)	(34.6)	(33.1)	(34.0)	(34.5)	(35.2)	(34.3)	(33.2)	(33.7)	(35.7)	(35.9)	(0.2)
EBITDA	EBITDA	(0.5)	(0.8)	(0.4)	(0.5)	8.2	2.2	1.6	1.2	0.8	0.3	7.8	1.3	0.9	(0.4)
		-1%	*-2%*	*-1%*	*-1%*	*20%*	*6%*	*4%*	*3%*	*2%*	*1%*	*19%*	*4%*	*2%*	
Other Finance Costs	Depreciation	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(0.8)	0.8	(1.0)	(1.2)	(1.2)	(1.2)	(0.0)
	Interest	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.0)	(0.2)	(0.1)	(0.1)	(0.1)	0.0
	Dividend	(0.3)	(0.3)	(0.2)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	0.7	0.1	(0.1)	(0.1)	0.0
	PFI and Impairments	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.2)	(1.1)	(42.3)	(1.2)	(1.2)	(1.2)	0.0
		(2.8)	**(2.8)**	**(2.8)**	**(2.8)**	**(2.9)**	**(2.9)**	**(2.9)**	**(2.4)**	**(0.7)**	**(42.7)**	**(2.4)**	**(2.6)**	**(2.5)**	**0.0**
Net Surplus / Deficit (-)	Net Surplus / Deficit (-)	(3.3)	(3.7)	(3.2)	(3.3)	5.3	(0.6)	(1.3)	(1.2)	0.1	(42.4)	5.4	(1.3)	(1.6)	(0.4)
Technical Adjustments	Technical Adjustments	0.1	0.1	0.1	0.1	0.1	0.1	0.1	(0.0)	0.1	40.3	(0.1)	0.0	0.0	(0.0)
Surplus/ Deficit (-) to B/E Duty Incl STF	Surplus/ Deficit (-) to B/E Duty	(3.2)	(3.6)	(3.1)	(3.3)	5.4	(0.5)	(1.2)	(1.3)	0.3	(2.0)	5.3	(1.2)	(1.6)	(0.4)
Surplus/ Deficit (-) to B/E Duty Excl STF	Surplus/ Deficit (-) to B/E Duty	(3.2)	(3.6)	(3.1)	(3.3)	2.7	(1.4)	(1.9)	(1.9)	0.3	(2.0)	4.5	(1.6)	(2.0)	(0.4)

Maidstone and Tunbridge Wells NHS Trust

4. Cost Improvement Programme

4a. Current Month Savings by Directorate

	Current Month		
	Actual	*Original Plan*	*Variance*
	£m	£m	£m
Cancer and Haematology	0.1	0.1	(0.0)
Critical Care	0.1	0.1	(0.0)
Diagnostics	0.1	0.1	(0.0)
Head and Neck	0.0	0.0	0.0
Surgery	0.1	0.1	(0.0)
Trauma and Orthopaedics	0.4	0.3	0.1
Patient Admin	0.0	0.0	0.0
Private Patients Unit	0.0	0.0	(0.0)
Total Planned Care	**0.7**	**0.6**	**0.0**
Urgent Care	**0.0**	**0.5**	**(0.4)**
Womens, Childrens and Sexual Health	**0.1**	**0.0**	**0.1**
Estates and Facilities	**0.0**	**0.0**	**0.0**
Corporate	**0.1**	**0.1**	**0.0**
Total	**1.0**	**1.2**	**(0.3)**

Comment

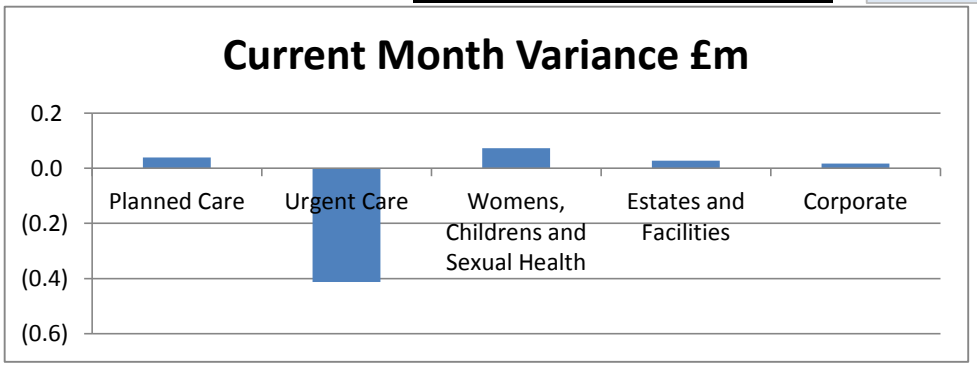
The Trust achieved £1m savings in May which was £0.26m adverse to plan.

The plan value is based upon the Trusts submitted plan to NHSI in December 16 and March 17. The Trust has a 'live' plan for monitoring the actuals and phasing of the CIP programme. Based upon the 'live plan the savings achieved in May were £0.3m below plan.

Planned Care: £33k favourable compared to original CIP planned phasing, however £190k adverse in May when compared to the 'live' plan. The main areas of slippage relate to Diagnostics (£90k adverse) mainly due to the delay in procurement savings (£70k) and Cancer £46k adverse due to £17k relating slippage in charging for private MDM appointments and £19k relating to 10% non pay saving.

Urgent Care: £0.4m adverse compared to the original plan however when compared to the 'live' plan the directorate are £55k adverse in the month which is mainly due to slippage against discretionary spending controls (£40k).

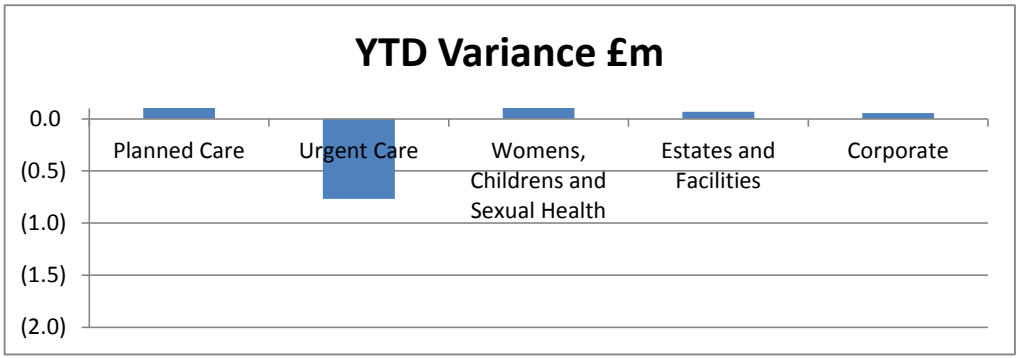
Womens, Childrens and Sexual Health: £0.1m favourable compared to the original plan however when compared to the 'live' plan the directorate have achieved the plan in the month (£121k).



Maidstone and Tunbridge Wells NHS Trust

4b. Year to Date savings by Directorate

	YTD		
	Actual	*Original Plan*	*Variance*
	£m	£m	£m
Cancer and Haematology	0.1	0.2	(0.1)
Critical Care	0.2	0.2	0.0
Diagnostics	0.1	0.1	0.0
Head and Neck	0.1	0.1	0.0
Surgery	0.1	0.1	(0.0)
Trauma and Orthopaedics	0.7	0.5	0.2
Patient Admin	0.0	0.0	0.0
Private Patients Unit	0.0	0.0	(0.0)
Total Planned Care	**1.4**	**1.3**	**0.1**
Urgent Care	**0.1**	**0.9**	**(0.8)**
Womens, Childrens and Sexual Health	**0.2**	**0.1**	**0.2**
Estates and Facilities	**0.1**	**0.0**	**0.1**
Corporate	**0.2**	**0.1**	**0.1**
Total	**2.0**	**2.4**	**(0.4)**



Comment

The Trust has achieved £2m savings YTD which is £0.4m adverse to plan.

The plan value is based upon the Trusts submitted plan to NHSI in December 16 and March 17. The Trust has a 'live' plan for monitoring the actuals and phasing of the CIP programme. Based upon the 'live plan the savings achieved YTD were £0.5m below plan.

Planned Care: £0.1m favourable compared to original CIP planned phasing, however £0.3m slippage YTD when compared to the 'live' plan. The main directorate adverse to plan is Diagnostics (£172k adverse) which is mainly due to procurement 10% savings target £170k and £26k delay in implementation of the new MLS contract.

Urgent Care: £0.8m adverse compared to the original plan however when compared to the 'live' plan the directorate are £64k adverse YTD which is mainly due to £80k slippage relating to discretionary spend controls.

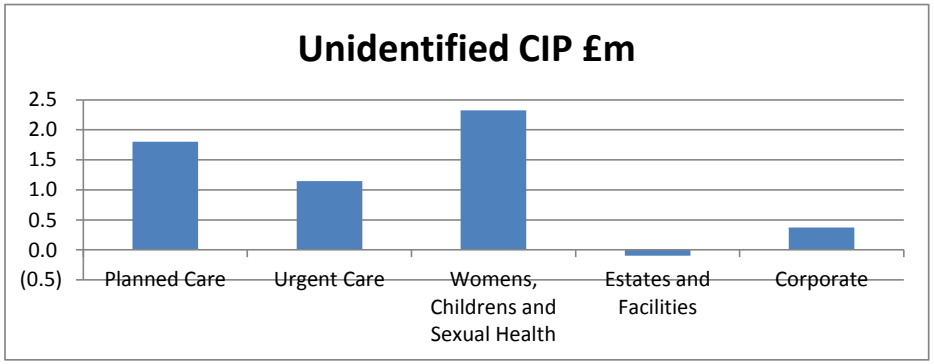
Womens, Childrens and Sexual Health: £0.2m favourable compared to the original plan however when compared to the 'live' plan the directorate are on plan and have achieved £244k savings YTD.

Maidstone and Tunbridge Wells NHS Trust

4c. Forecast savings by Directorate

Directorate Performance

	Forecast Savings					
	Actual Identified (Non Risk adjusted)	*Unidentified*	*Forecast*	*Plan*	*Variance*	*% Unidentified*
	£m	£m	£m	£m	£m	
Cancer and Haematology	1.7	0.3	2.0	2.0	0.0	13%
Critical Care	1.5	0.7	2.2	2.2	0.0	32%
Diagnostics	2.2	(0.1)	2.2	2.2	0.0	-3%
Head and Neck	1.1	(0.1)	1.0	1.0	0.0	-13%
Surgery	1.4	0.4	1.8	1.8	0.0	20%
Trauma and Orthopaedics	4.5	0.6	5.1	5.1	0.0	12%
Patient Admin	0.0	0.1	0.1	0.1	0.0	78%
Private Patients Unit	0.2	(0.0)	0.2	0.2	0.0	-26%
Total Planned Care	**12.7**	**1.8**	**14.5**	**14.5**	**0.0**	**12%**
Urgent Care	**7.7**	**1.1**	**8.9**	**8.9**	**0.0**	**13%**
Womens, Childrens and Sexual Health	**1.3**	**2.3**	**3.7**	**3.7**	**0.0**	**64%**
Estates and Facilities	**2.9**	**(0.1)**	**2.9**	**2.9**	**0.0**	**-3%**
Corporate	**1.5**	**0.4**	**1.9**	**1.9**	**0.0**	**20%**
Total	**26.2**	**5.5**	**31.7**	**31.7**	**0.0**	17%



The Trust has a £31.7m CIP plan for 2017/18 and has identified £26.2m (non risk adjusted) , £5.5m unidentified. The current forecasted risk adjusted identified savings is £17.5m, a shortfall of £14.2m.

Urgent Care Division have the largest risk adjusted shortfall to the target, £3.1m risk adjusted, £5.8m unidentified (65%).

Womens, Childrens and Sexual Health are the Division with the highest percentage identified with only 36% identified.

5. Balance Sheet and Liquidity

Maidstone and Tunbridge Wells NHS Trust

5a. Balance Sheet

May 2017

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

	May			April	Full year	
£m's	**Reported**	**Plan**	**Variance**	**Reported**	**Plan**	**Forecast**
Property, Plant and Equipment (Fixed Assets)	278.2	274.8	3.3	279.1	282.1	282.1
Intangibles	3.0	2.8	0.3	3.1	2.1	2.1
PFI Lifecycle	0.0	0.0	0.0	0.0	0.0	0.0
Debtors Long Term	1.5	1.2	0.3	1.5	1.2	1.2
Total Non-Current Assets	**282.7**	**278.8**	**3.9**	**283.7**	**285.4**	**285.4**
Current Assets						
Inventory (Stock)	7.3	8.3	(0.9)	8.1	8.3	8.3
Receivables (Debtors) - NHS	37.6	25.6	12.0	37.0	21.0	21.0
Receivables (Debtors) - Non-NHS	16.2	9.5	6.8	16.3	9.5	9.5
Cash	7.8	11.1	(3.3)	13.6	1.0	1.0
Assets Held For Sale	1.7	0.0	1.7	1.7	0.0	0.0
Total Current Assets	**70.7**	**54.4**	**16.3**	**76.7**	**39.8**	**39.8**
Current Liabilities						
Payables (Creditors) - NHS	(4.2)	(4.5)	0.2	(4.4)	(4.5)	(4.5)
Payables (Creditors) - Non-NHS	(69.1)	(36.5)	(32.6)	(73.9)	(13.6)	(13.6)
Capital & Working Capital Loan	(2.2)	(2.2)	0.0	(2.2)	(19.1)	(19.1)
Temporary Borrowing	0.0	0.0	0.0	0.0	0.0	0.0
Borrowings - PFI	(5.0)	(5.0)	(0.0)	(5.0)	(5.5)	(5.5)
Provisions for Liabilities and Charges	(1.8)	(1.1)	(0.7)	(1.8)	(1.3)	(1.3)
Total Current Liabilities	**(82.4)**	**(49.3)**	**(33.1)**	**(87.3)**	**(44.0)**	**(44.0)**
Net Current Assets	(11.7)	5.2	(16.8)	(10.5)	(4.2)	(4.2)
Finance Lease - Non- Current	(197.3)	(197.8)	0.5	(197.8)	(192.7)	(192.7)
Capital Loan - (interest Bearing Borrowings)	(12.3)	(12.3)	0.0	(12.3)	(10.2)	(10.2)
Interim Revolving Working Capital Facility	(29.0)	(29.0)	0.0	(29.0)	(16.1)	(16.1)
Provisions for Liabilities and Charges	(1.2)	(0.7)	(0.5)	(1.2)	(0.4)	(0.4)
Total Assets Employed	**31.2**	**44.2**	**(13.0)**	**32.8**	**61.8**	**61.8**
Financed By						
Capital & Reserves						
Public dividend capital	(205.0)	(205.0)	(0.0)	(205.0)	(208.6)	(208.6)
Revaluation reserve	(30.3)	(30.3)	0.0	(30.3)	(36.2)	(36.2)
Retained Earnings Reserve	204.1	191.1	13.0	202.5	182.9	182.9
Total Capital & Reserves	**(31.2)**	**(44.2)**	**13.0**	**(32.8)**	**(61.8)**	**(61.8)**

Commentary:
The balance sheet is £13m or 30% less than plan, primarily due to significant variations in current assets and current liabilities. Key movements to May are in working capital where receivables increase by 50% and payables increased by 100% over plan. The teams are continuing to focus on reducing the aged debtors and creditors and reviewing current processes to ensure improvement in working capital going forward.

Non-Current Assets (PPE)- The value of PPE has decreased from the April's position as assets are depreciated. The in-year capital programme has been prioritised and business cases are currently being prepared.

Current Assets - Inventory has decreased slightly from the reported April's position, mainly due to decrease in pharmacy stock from £3.6m to £3.1m. Materials management stock remains at £1m, whilst cardiology stocks decreased from £1.2m to £1.0m. Inventory reduction is a cash management strategy.

NHS Receivables has remained consistent with April reported position, remaining significantly higher than the plan value. Of the £37.6m balance, £15.2m relates to invoiced debt of which £3.3m is aged debt over 90 days. Debt over 90 days has remained consistent with April reported position. The remaining £22.4m relates to accrued income. Due to the financial situation of many neighbouring NHS organisations regular communication is continuing and "like for like" arrangements are being actioned.

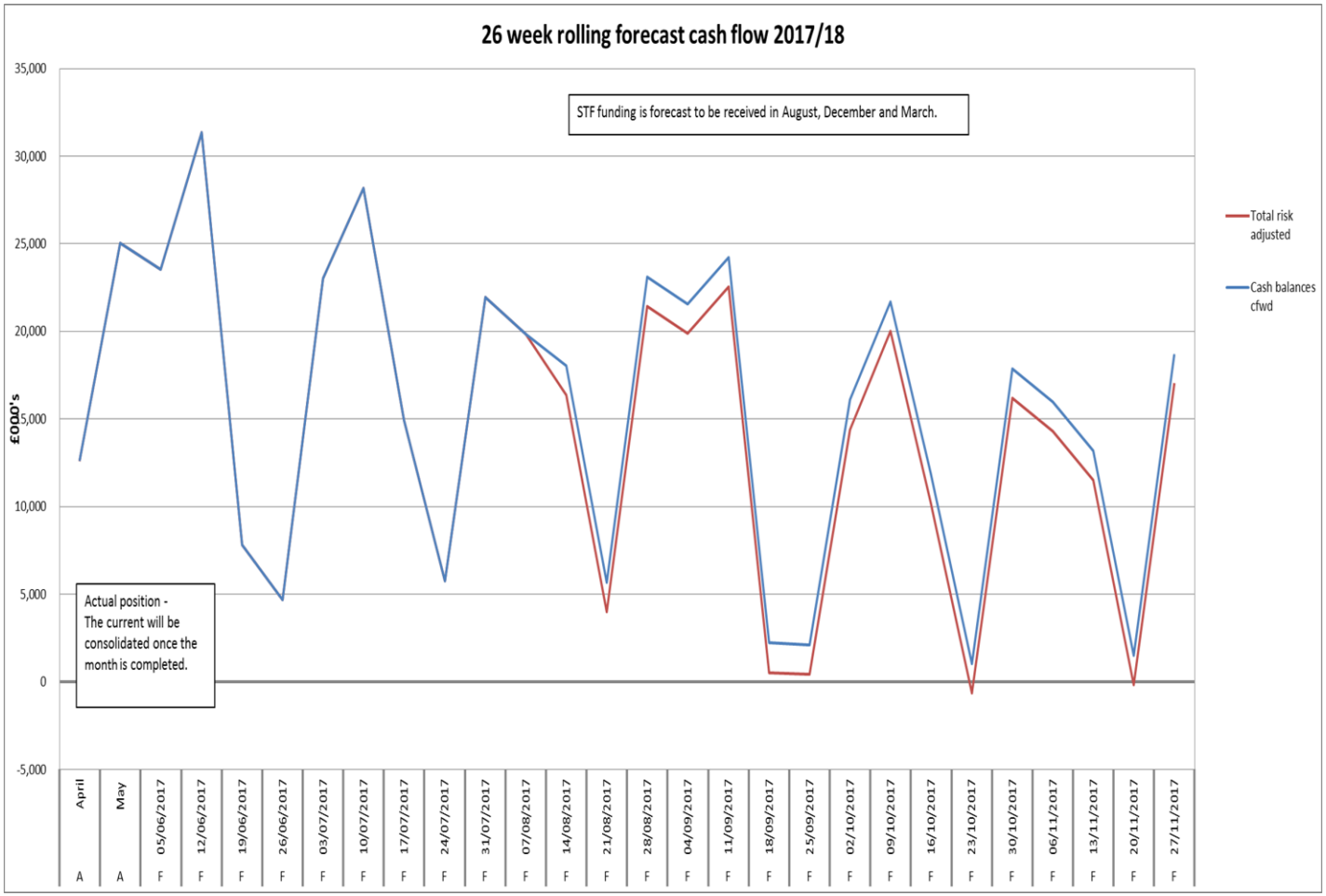
Trade receivables has remained consistent with April reported position, and is above plan by £6.8m. Included within this balance is trade invoiced debt of £2.8m and private patient invoiced debt of £0.6m which has decreased from £0.7 in April.

Current Liabilities -NHS trade payables has remained consistent with the April reported position and the plan of £4.5m. Non-NHS trade payables has decreased since April by £4.8m, although remaining significantly above plan of £36.5m.

Of the £69.1m trade creditor balances, £17.8m relates to invoices, £26.8m is deferred income primarily relating to double block from West Kent CCG, High Weald CCG and Medway CCG, and other funding for PAS AllScript and LDA. The remaining £24.5m relates to accruals, including TAX, NI, Superannuation, PDC and deferred income.

Maidstone and Tunbridge Wells NHS Trust

5b. | Cash Flow



Commentary

The blue line shows the Trust's cash position from the start of April, after receiving a double block from West Kent CCG, High Weald CCG and Medway CCG.

For 17/18 the Trust is assuming no receipt of external Revenue financing, compared to 2016/17 where the Trust received £12.1m IRWCF.

The risk adjusted items on the graph relate to STF funding for qtrs 1,2 and 3, along with £1.7m asset sales forecast for receipt in December. If this income is not received these will be mitigated by proposed strategies.

The other two risk adjusted items relate to capital funding for 2 linacs £3.6m and capital loan of £4m, these are mitigated by reducing the in year capital spend.

The cash flow is based on the Income and Expenditure plan along with working capital adjustments.

6. Capital

6a. Capital Programme

Capital Projects/Schemes

	Year to Date			Annual		
	Actual	*Plan*	*Variance*	*Plan*	*Forecast*	*Variance*
	£000	£000	£000	£000	£000	£m
Estates	38	600	562	8,873	8,873	0
ICT	113	450	337	1,664	1,664	0
Equipment	29	710	681	5,909	5,909	0
PFI Lifecycle (IFRIC 12)	0	0	0	502	502	0
Donated Assets	0	0	0	450	450	0
Total	**180**	**1,760**	**1,580**	**17,398**	**17,398**	**0**
Less donated assets	0	0	0	-450	-450	0
Asset Sales (net book value)	0	0	0	-1,727	-1,727	0
Contingency Against Non-Disposal	0	0	0	0	0	0
Adjusted Total	**180**	**1,760**	**1,580**	**15,221**	**15,221**	**0**

The Trust has an approved Capital Plan of £17.4m, which is made up by Capital resources of £14.8m depreciation; the Net Book Value of £1.7m for the proposed asset sales (Springs and Hillcroft properties); an estimate of donated assets of £0.45m; requested Central PDC funding for 2 Linacs of £3.6m ; and a proposed Salix loan of £4m for the Energy Infrastructure programme; less £7.7m of existing capital loan repayments.

The business case for Estates Backlog Maintenance programme of works has been approved and schemes are underway, with other Estates projects and renewals being prioritised by Estates Department. A major scheme for the Energy Infrastructure will be dependent on the successful application for a Salix loan. The ICT schemes have been prioritised and agreed with the Execs in May, the PAS replacement project is ongoing. The equipment schemes have been prioritised and the list is with the Execs for a final review and approval. Build work on Linac 1 bunker at Maidstone started in mid May, delivery of the Linac on site is due Jul/Aug, commissioning the equipment will start ready for clinical use by Dec17.

The additional PDC funding for the next 2 linacs is planned for the last quarter of the financial year, however the equipment will be put into storage until ready for delivery to the Trust in 18/19. The donated equipment is mainly made up of the remaining Cardiology legacies.

Trust Board meeting – June 2017

NHS Maidstone and Tunbridge Wells NHS Trust

6-10 Update on the Workforce Transformation Programme — Medical Director

The Trust Board meeting on 29/03/17 received an update on the Workforce Transformation Programme, and it was agreed that a further update report should be submitted to the Trust Board in June 2017.

A report is therefore enclosed which covers the following areas:

- The launch of the Workforce Transformation Steering Group and outputs to date
- Progress with the job planning review process
- Progress with the identification of an IT system to support job planning
- An update and overview of process for the completion of the Trauma & Orthopaedics (T&O) pilot
- An update on the capacity and demand analysis process (which will be part of the roll out of the full Trust-wide programme with the learning from the T&O pilot)

Which Committees have reviewed the information prior to Board submission?

- Finance Committee, 26/06/17

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

Information and assurance

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

1: SITUATION & BACKGROUND

This report sets out the progress made since the update to the Board on the 29th March 2017, and covers:

- The launch of the Workforce Transformation Steering Group. *This includes the outputs from the first two meetings of the Steering Group (in Working Group mode 18.5.17 and 15.6.17) and a forward look to the first meeting of the Full Workforce Transformation Steering Group on 29.6.17*
- Progress with the job planning review process
- Progress with the identification of an IT system to support job planning
- An update and overview of process for the completion of the T&O pilot
- An update on the capacity and demand analysis process *(which will be part of the roll out of the full Trust-wide programme with the learning from the T&O pilot)*

2: ASSESSMENT OF PROGRESS

2.1: Workforce Transformation Steering Group

The Workforce Transformation Programme Steering Group has been launched. The first meeting was held on 18th May 2017 (in Working Group format). The terms of reference (ToRs) are attached for reference (Appendix 1). As set out in the ToRs, there are two levels of Steering Group meetings – the Working Group (which meets monthly), and the Full Group, which includes the enhanced membership with a Lead Non-Executive Director and some of the Executive Team members (which meets quarterly). The focus of the agenda for the first meeting of the Steering Group was on the job planning review process (reviewing all revised documentation and principles contained therein). The Working Group held a further meeting on the 15th June 2017 to confirm all outputs from the Programme to date, for presentation to the Full Group on the 29th June 2017. At this meeting, the full group will receive presentations on the following:

- Job Planning Review process – full documentation set and revised principles
- Update on the demonstrations and proposal for the IT system to support job planning
- Outputs from the T&O Pilot for endorsement and confirmation of methodology for rollout
- An update on the further progress with the capacity analysis work

The Steering Group will be asked for their approval to the recommendations made in respect of the above, for release to the Executive Team for decision making and approval to proceed to the next stage in the programme.

2.2: Job Planning Review Process

A Trust-wide Clinical Lead was appointed in April 2017 together with a task and finish Review Group which has been established to oversee the following:

- Revised job planning policy and standards (including a PA Allocation document to ensure consistency and eliminate any unwarranted variation in the types of PAs awarded).
- Establishment of a Medical Job Planning Consistency Committee (MJPCC) (to provide a neutral vehicle for the review of all completed job plans for compliance and consistency with Trust and National requirements).
- Training for all CDs and General Managers
- IT system support demos and system recommendation
- Variation analysis of existing job plans

The review of the job planning process is now almost complete. It includes a revised Policy document and a detailed Job Planning Standards document to support the CDs and GMs in conducting the most effective job planning meetings with our Consultants and SAS colleagues. The revised documentation includes a set of principles that will be presented to the Full Steering Group on the 29th June for their endorsement. The documentation set was discussed with the CDs on the 7th June 2017 with which they were broadly in agreement and welcomed the plans for some firm and clear guidance to assist the process. A meeting was held between the Medical Director and the JMCC on the 25th May to introduce them to the concept of the revised policy and supporting documents. This was an initial introduction only & full discussion is yet to commence.

2.3: IT System Demonstrations

To support the revised job planning process, demonstrations were requested from two established medical workforce system suppliers (Skills for Health and Allocate). The demonstrations took place in May 2017 and a recommendation is being made to the Workforce Transformation Steering Group on 29.06.17 to seek their agreement to commence the production of a business case for presentation to the Executive Team in respect of the procurement and implementation of an e-job planning system. This was agreed in principle at the Steering Group (Working Group) meeting on 15.06.17.

2.4: T&O Pilot:

A detailed presentation containing the outputs and conclusion of the Pilot has been produced for the Workforce Transformation Steering Group, to be presented on the 29th June 2017. This will also contain the learning from the pilot and proposals for the methodology to inform the further rollout of the programme. The outputs for T&O include medical workforce productivity improvements (increased number of productive PAs), physical capacity expansion, increased income and service support mechanisms to protect elective flows.

2.5: Trust-Wide Rollout:

As stated above, the T&O Pilot has identified the methodology for the rollout of the full Trust-wide Programme. This includes a significant investment in capacity and demand analysis as outlined below:

2.5.1: Capacity and Demand Analysis: Learning from the Pilot:
For each service area, a bespoke capacity and demand analysis will need to be undertaken to identify the medical time required to deliver the service specifications which in turn, deliver the contracted activity. The analysis that was required to deliver the outputs from the T&O pilot is listed in Appendix 2. As can be seen, this was resource-intensive and required (in many areas) a zero-based level of analysis to properly build the database. For example, Trust-level templates had to be interrogated to accurately identify the number of clinical sessions each doctor is undertaking (using theatre timetables, out-patient clinic timetables etc) as job plans are out of date in many areas. The work listed in Appendix 2 is currently being timetabled for the Trust-wide rollout, pending approval to proceed.

2.5.2: Capacity & Demand Workshop:
A half day workshop was held on the 11th May 2017, at which the Trust's senior Business Analysts, Finance & Contracting Leads, PMO Leads, Workforce .Representative, Strategic Planning Leads were present. The session was facilitated by the Head of Delivery Development who is the Lead Manager for this Programme. An external Business Analyst was invited to attend to present a modelling methodology to support the event (copies of slide presentation available upon request).

The outputs from this workshop were:

- Confirmation of scope of exercise
- Agreement of methodology
- Estimate of resources required
- Estimate of timescales achievable

The capacity and demand elements of the exercise will be approached in two tranches, commencing with the capacity element. This will involve the production of a detailed job plan for each Consultant and SAS Doctor to determine our true workforce capacity for these staff groups. Analysis of the junior medical staff will not be included in this stage but will follow. This requires further discussion and scoping and will be informed by the Consultant and SAS Doctor exercise.

The process will then move into the demand analysis element of the programme to get a full picture of the medical workforce requirements of the Trust. It would be futile to identify our true workforce capacity and only crudely compare this to service demand. This would risk the

production of recommendations which could either under or over-staff service areas. This detailed work does not currently exist for all specialties and will require investment.

This work will be closely linked to the Job Planning review process outlined in section 2.3 above.

2.5.3: Methodology for Capacity Analysis:

The following steps outline the crude methodology being followed:

Step No	Action	Update
1	Letter from Medical Director to all CDs and General Managers, requesting copies of existing job plans/timetables and rotas, giving 3 weeks for completion and return	Sent 17.5.17 with deadline of 09.06.17. The Head of Delivery Development has also met with all GMs to brief them on the requirement.
2	Production of a detailed template onto which all existing data from the above, (plus all missing data which will be collected by the core team – *see step 5*) will be entered and analysed. The template will be complex as this will need to be similar to a job planning database tool.	Workshop held 19.05.17 with follow up meeting 26.5.17. Template in final draft format.
3	Establishment of Core Team to deliver this work led by a co-ordinator (*see 2.1.2(3)below)*	Established.
4	Interrogation of all initial baseline data from the Directorates (step 1) to identify gaps.	Commenced 12.06.17
5	Face to face meetings with the Directorates (CDs, GMs and individual Consultants/SAS Doctors) to populate all gaps and fully complete all consultant/SAS timetables onto the template.	Estimated as 3 month exercise. *Report on resource requirements submitted to Finance Committee in May and Executive Team on 6th June 2017.*
6	Analysis of the template to identify the productivity opportunity or deficit that the organisation has in Consultant and SAS Doctor PAs.	As above
7	Comparison to the Carter £11m productivity opportunity previously identified.	1 week (from completion of above)
8	Presentation to the Executive Team.	1 week (from completion of above)

3: Next Steps

- Endorsement of methodology from pilot exercise - Workforce Transformation Steering Group – 29.6.17 and Executive Team 04.07.17.
- Commencement of consultation on the revised job planning policy
- Business case for IT job planning support system
- Implementation of T&O pilot
- Timetabling of full rollout

Appendix 1

<table>
<tr><td>Title</td><td>Draft Terms of Reference
Workforce Transformation (WFT) Steering Group
REVISED @ 18.5.17</td></tr>
<tr><td>Date written</td><td>18th May 2017</td></tr>
<tr><td>Background/Context</td><td>This Steering Group will be part of the Trust's wider Transformation Programme. It has responsibility for overseeing the delivery of the Workforce Transformation pillar of the Programme, (initial focus on Medical Staff). It will link closely with three other Executive-led pillars of the Programme including Temporary Staffing, Culture and Engagement and Data Quality. The Group will have two memberships, one regular monthly membership and an enhanced quarterly membership that will involve Executive and non-Executive colleagues.

The Workforce Transformation Programme (Medical Staff) will ensure that the Trust has a robust and modern medical workforce that delivers safe, high quality and cost-effective healthcare services, satisfying all service delivery requirements. Areas for review as part of this work will include the following topics:

• Baseline analysis of existing workforce (initial pilots then rollout to each Directorate)
• Benchmarking (including the Carter metrics)
• Opportunities to introduce new and innovative roles
• Requirements of 7 day service programme (needs and opportunities)
• Temporary staffing/Locum usage
• Capacity and demand analysis (medical workforce staffing requirements)
• Job planning review (policy, process, content)
• Medical productivity</td></tr>
<tr><td>Purpose of the Steering Group</td><td>1. Provide the oversight, direction and timeline of the programme;
2. Resolve escalated issues/barriers to delivery and resolve obstacles that prevent progress;
3. Ensure the various workstream leads are provided the necessary support to deliver
4. Review the status of financial and quality risks and associated mitigating action plans;
5. Support and challenge workstream leads in delivering outputs
6. Monitor and drive workstream delivery
7. Adjust workstream plans to support delivery
8. Ensure that Quality Impact Assessment (QIA) is conducted as appropriate
9. Ensure that post-implementation evaluation is conducted for key outputs
10. Maintain a programme risk register
11. Provide updates to Trust groups and committees as required</td></tr>
<tr><td>Accountability and Reporting Responsibilities</td><td>1. Accountable to the Transformation Board (Exec Team meetings until established)
2. Monthly reports to the Transformation Board (“ “ “ “ “)</td></tr>
<tr><td>Membership (1) MONTHLY GROUP</td><td>The membership of the Steering Group will be:
<table><tr><td>Executive Sponsor and Chair – Peter Maskell</td></tr><tr><td>Sara Mumford – Trust Job Planning Clinical Lead</td></tr><tr><td>Lead Manager and Deputy Chair – Lynne Sheridan</td></tr><tr><td>Deputy Medical Director - TBC</td></tr><tr><td>Finance Lead – Sheila Stenson</td></tr><tr><td>PMO Sponsor – Suzanne O'Neil</td></tr><tr><td>PMO Lead – Abigail Hill</td></tr><tr><td>HR Lead – Ruth Bailey</td></tr><tr><td>Information Lead – Tracy Jardine/James Jarvis</td></tr><tr><td>Director of Operations – (co-opted based upon current review Directorates)</td></tr></table></td></tr>
</table>

Enhanced Membership (2) QUARTERLY GROUP	Non-Executive Director Lead – Sarah Dunnett Executive Director Lead (Operations) – Angela Gallagher Executive Director Lead (Workforce) – Richard Hayden Executive Director Lead (Finance) – Steve Orpin
Attendance	Chair – Executive Sponsor Deputy Chair - Lynne Sheridan The quorum - Chair or Deputy Chair, and at least 2 of the other group members, one to be Clinical and one to be Workforce.
Frequency of Meetings	The Steering Group will meet monthly, with an enhanced membership for quarterly meetings.
Programme Management & Administration	The Programme Management Office (PMO) shall ensure that appropriate programme management and administrative support is provided.
Duties	**Standard Agenda** 1. Review of previous actions 2. Overview of progress vs. plan (service, financial and milestones) 3. Resolution and decisions on escalated issues/barriers to delivery 4. Executive sponsor provides explanation of variance to plan of exceptional workstreams or initiatives 5. Review of schemes as appropriate (including new schemes) 6. Risks and issues 7. Documents for approval 8. Documents for decision 9. AOB / date of next meeting

Version Control: *Details of approved versions*		
Issue:	**Description of changes:**	**Date:**
Membership	Dr Sara Mumford added to membership as the Trust Clinical Lead for Job Planning	18.5.17

Appendix 2

Stage 1: Current State Analysis

	Analysis Area	Details
1	KPI metrics	Productivity Dashboard -rolling months. WAUs plus quality metrics
2	Required Productive Activity	Contract requirements, and aligned incentives plans, checked into demand and capacity plan *(see 8 below).*
3	Financial reconciliation	Review of Ledger versus current job plan reconciliation and verification of current establishment by all grades of medical staff.
4	Analysis of current job plans	Using meridian spreadsheets - review of DCC split into Theatres, outpatient, ward rounds, on call/pt admin/other, and SPAs -breakdown of total by consultants
5	Temp staffing spend	Analysis of current spend by month and expense type including, WLI, pp outsourced sessions and any other temp staffing spend. Also review of pipeline report for posts being recruited to.
6	Basic Sessions Timetable	Development of a basic timetable for all consultants detailing fixed sessions and standardised activities at a directorate level. Include Private Patients sessions consultant work externally.
7	Outpatients	Review of current templates down to clinic code. Review against Demand/capacity plans reviews.
8	Capacity & Demand	In-depth analysis of all units of activity undertaken (productive patient-facing and patient-related sessions) to deliver the contracted activity. This is measured against the total expected medical workforce availability in DCC PAs (Direct Clinical Care) for that service (using expected DCC to SPA ratios).
9	Spr/ Juniors rota	Review current rotas, analysis of gaps, banding reviews etc.
10	Other data sets	Waiting lists reports/ Theatre Dashboards/Service-specific Specific rotas (such as the Labour Ward rota that would apply in Women's Health)

Trust Board meeting – June 2017

NHS Maidstone and Tunbridge Wells NHS Trust

6-11 Planned and actual Ward staffing for May 2017 — Chief Nurse

The enclosed report shows the planned v actual nursing staffing as uploaded to UNIFY for the month of May 2017. This data is also published via the NHS Choices website and the Trust website as directed by NHS England (NHSE) and the National Quality Board.

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

The Carter report indicated a range for CHPPD between 6.3 and 15.48. The median was 9.13.
Overall CHPPD for Maidstone as remained stable at 7.7 (compared to 7.6 last month); there has been a decrease at Tunbridge Wells Hospital (TWH) to 8.9 (compared to 9.7 last month) this remains within the national average.

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

This is evident in a number of areas where there has been an unplanned increase in dependency. A number of wards have required additional staff, particularly at night, to manage patients with altered cognitive states, increased clinical dependency or with other mental health issues.

Wards in this category during April were Maidstone Stoke Unit, Wards 10, 20 and 32. Ward 2 also had a requirement for enhanced care however this was managed within existing available staff with a small addition to the CSW cohort at night.

All enhanced care needs are supported by an appropriate risk assessment, reviewed and approved by the Matron.

Escalation areas account for over-fill on Maidstone AMU (UMAU), and TWH AMU. Short Stay Surgery also had additional staff above their plan which is not directly reflected in the fill rate. This is because the staff are 'charged' to the SSSU however they are based in the Theatre holding bay to manage the displaced day surgical activity as a result of inpatient escalation requirements.

Ward 21 had a variation in the RN/CSW ratio. This was an accepted risk as unable to fill all shifts via bank/framework agency. The CSW numbers were increased to ensure overall numbers of staff on the ward were sufficient to respond to patient need. This was a considered decision based on acuity and skill mix with oversight by the directorate matron and the site practitioners.

Maternity manage staffing as a 'floor' with support staff moving between areas as required. Midwifery needs are assessed regularly by the Labour Ward Coordinator with midwives following women from delivery through to post-natal. This ensures that all women in established labour received 1:1 care from a Registered Midwife.

A number of wards will cross-cover each other. This enables a more efficient use of staff, and allows for safe redeployment of staff to escalated areas. For example Short Stay Surgery at TWH provide support to the escalated beds in Recovery. The ITUs will move staff between sites according to the acuity levels on each site.

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

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

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

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

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

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

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

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

RAG	Details
	Significant Impact: Staffing levels are inadequate to manage current demand in terms of workloads, patient acuity and skill mix. Key clinical interventions such as intravenous therapy, clinical observations or nutrition and hydration needs not being met. Systemic staffing issues impacting on delivery of care. Use of non-ward based nurses to support services RN to Patient ratio >1:9 Need to instigate Business Continuity

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Assurance

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

May'17		Day		Night		Overall Care Hours per pt day	Nurse Sensitive Indicators						Financial review		
Hospital Site name	Ward name	Average fill rate registered nurses/midwives	Average fill rate care staff (%)	Average fill rate registered nurses/midwives	Average fill rate care staff (%)		FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	Overall RAG Status	Comments	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Acute Stroke	93.5%	97.6%	98.4%	127.4%	747	26.8%	100.0%	8	0		Enhanced care needs for 15 nights (young traumatic head injury patient risk of absconding).	132,329	132,996	-667
MAIDSTONE	Foster Clark	93.0%	95.2%	98.9%	109.7%	828	30.9%	85.3%	13	0			109,824	94,367	15,457
MAIDSTONE	Cornwallis	108.6%	87.1%	104.3%	108.7%	513	40.4%	93.2%	0	0		CSW fill rate an accepted risk as able to cover from within rota with RNs plus RMN special for 7 days.	72,057	85,238	-13,181
MAIDSTONE	Coronary Care Unit (CCU)	100.0%	71.0%	100.0%	N/A	177	159.3%	100.0%	1	0		CSW fill rate an accepted risk as unit is co-located with Culpepper and staff move between units according to need.	103,725	109,380	-5,655
MAIDSTONE	Culpepper	100.0%	98.4%	100.0%	100.0%	399	63.4%	96.2%	0	1					
MAIDSTONE	John Day	93.3%	109.7%	113.9%	100.0%	924	55.1%	97.4%	4	0			127,486	135,678	-8,192
MAIDSTONE	Intensive Treatment Unit (ITU)	91.1%	N/A	91.9%	N/A	179	250.0%	100.0%	1	0		Decreased dependency for 15 days. Staff redeployed to TWH ICU.	174,246	165,643	8,603
MAIDSTONE	Pye Oliver	93.4%	98.7%	101.1%	100.0%	858	41.7%	91.4%	4	1			100,557	123,692	-23,135
MAIDSTONE	Chaucer	97.5%	97.1%	100.0%	98.2%	853	29.7%	81.8%	4	0		Relocated to Edith Cavel last week of the month.	135,000	117,576	17,424
MAIDSTONE	Lord North	94.8%	100.0%	98.9%	96.8%	503	119.4%	100.0%	2	0			101,914	93,503	8,411
MAIDSTONE	Mercer	111.3%	98.4%	98.9%	100.0%	773	50.0%	94.7%	5	0			101,227	106,506	-5,279
MAIDSTONE	Edith Cavell (MOU)	98.7%	98.9%	100.0%	97.3%	473	90.5%	100.0%	2	0		Ward relocated Chaucer last week of month.	54,355	78,355	-24,000
MAIDSTONE	Urgent Medical Ambulatory Unit (UMAU)	87.8%	91.2%	125.8%	187.1%	501	12.1%	100.0%	4	0		Trolley bay escalated overnight throughout the month	87,685	123,514	-35,829
TWH	Stroke/W22	86.6%	106.5%	98.1%	98.9%	633	127.3%	96.4%	10	0		RN x 2 and CSW x 2 moved to cover shortfall on other wards on 4 occasions in month	163,074	144,866	18,208
TWH	Coronary Care Unit (CCU)	99.0%	100.0%	97.8%	N/A	205	87.8%	100.0%	1	0			61,501	59,963	1,538
TWH	Gynaecology/ Ward 33	95.4%	97.1%	100.0%	106.5%	411	6.3%	100.0%	1	0			74,602	77,242	-2,640
TWH	Intensive Treatment Unit (ITU)	105.2%	93.5%	105.6%	96.8%	243	0.0%	0.0%	0	0		Increased dependency for 17 days. Supported by staff redeployment from Maidstone ICU	179,243	188,099	-8,856
TWH	Medical Assessment Unit	97.8%	91.1%	115.5%	103.2%	1014	10.9%	100.0%	8	0		Ambulatory bay escalated overnight	183,693	175,181	8,512
TWH	SAU	98.9%	90.3%	100.0%	96.8%	279			0	0			54,118	61,835	-7,717
TWH	Ward 32	95.7%	97.8%	101.1%	116.9%	833	35.9%	100.0%	10	0		20 episodes of enhanced care requiring additional support at night	130,237	125,682	4,555
TWH	Ward 10	94.4%	96.8%	83.9%	185.5%	886	38.4%	97.0%	1	0		20 nights requiring additional/enhanced observation overnight (cohorted approach to support 3 patients)	112,453	121,100	-8,647
TWH	Ward 11	95.9%	108.6%	88.7%	122.6%	881	44.2%	97.4%	2	0		RN:CSW ratio shift an accepted risk.	110,018	113,492	-3,474
TWH	Ward 12	90.4%	94.4%	98.9%	97.6%	914	13.5%	91.7%	5	1			122,915	114,617	8,298
TWH	Ward 20	97.8%	120.4%	100.0%	150.0%	925	33.3%	72.7%	14	1		Cohorting enhanced care/observation required thought the month.	106,680	111,186	-4,506
TWH	Ward 21	98.4%	100.0%	87.1%	125.8%	899	21.3%	94.7%	4	0		RN: CSW ratio shift an accepted risk as CSW required to support enhanced care needs.	133,012	140,720	-7,708
TWH	Ward 2	96.8%	94.8%	100.0%	117.7%	899	61.1%	86.4%	13	0		Enhanced care needs throughout the month, largely covered from within existing team, 7 nights required additional support	124,028	116,688	7,340
TWH	Ward 30	90.4%	91.3%	98.4%	98.4%	900	8.1%	100.0%	4	2			108,041	125,071	-17,030
TWH	Ward 31	91.4%	102.8%	96.8%	95.7%	896	0.0%	0.0%	4	0			129,736	151,375	-21,639
Crowborough	Birth Centre	95.2%	38.7%	100.0%	96.8%				0	0		MSW shortfall an accepted risk, as unit is co-located with other services at Crowborough Hospital.	85,997	55,431	30,566
TWH	Ante-Natal	98.4%	96.8%	100.0%	90.3%	294	12.7%	91.7%	0	0		Post-natal MSW shortfall an accepted risk, as staff move between areas to follow the woman/patient. All women in established labour received 1:1 care.	615,757	672,529	-56,772
TWH	Delivery Suite	100.7%	95.2%	95.7%	90.3%	298			0	0					
TWH	Post-Natal	98.6%	76.2%	101.6%	68.5%	643			0	0					
TWH	Gynae Triage	96.8%	103.2%	98.4%	90.3%				0	0			11,974	11,899	75
TWH	Hedgehog	101.1%	61.3%	103.9%	96.8%	546	0.0%	0.0%	2	0		CSW/Play therapy short fall an accepted risk as priority given to covering night. 15 nights of HDU x 2	214,824	176,561	38,263
MAIDSTONE	Birth Centre	96.8%	87.1%	100.0%	80.6%				0	0		MSW fill an accepted risk.	63,527	64,213	-686
TWH	Neonatal Unit	104.3%	80.6%	101.6%	100.0%	422			0	0		CSW fill rate an accepted risk.	167,377	174,503	-7,126
MAIDSTONE	MSSU	104.2%	97.8%	107.1%	N/A				0	0			40,769	38,065	2,704
MAIDSTONE	Peale	129.0%	34.7%	108.1%	87.1%	370	55.6%	97.5%	1	0		Rata variation as an on-going result of establishment changes. Anticipated resolution in coming months though staff movements.	70,239	72,832	-2,593
TWH	SSSU	100.0%	100.0%	100.0%	100.0%				0	0		Escalated throughout month. Additional staffing required to support day case activity via recovery and holding bay.	60,469	133,876	-73,407
MAIDSTONE	Whatman	97.8%	100.0%	98.9%	100.0%	895	85.2%	91.3%	7	1			90,069	88,278	1,791
MAIDSTONE	A&E	98.8%	93.5%	94.9%	96.8%		12.1%	89.8%	1	0			209,586	183,798	25,788
TWH	A&E	95.4%	92.5%	98.5%	85.5%		19.3%	92.1%	6	0			274,758	316,570	-41,812
												Total Establishment Wards	**4,999,102**	**5,182,122**	**(183,020)**
												Additional Capacity beds	39,307	32,728	6,579
												Other associated nursing costs	2,567,848	2,350,181	217,667
												Total	7,606,257	7,565,030	41,227

RAG Key

Under fill

Over fill

Trust Board meeting – June 2017

NHS Maidstone and Tunbridge Wells NHS Trust

6-12 Approval of Quality Accounts, 2016/17 Chief Nurse

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

The final draft Quality Accounts for 2016/17 are therefore enclosed, for review and approval.

An earlier draft was reviewed at the 'main' Quality Committee on 3rd May, whilst later versions were reviewed at the Patient Experience Committee (on 13th June) and Trust Management Executive (on 21st June).

The Quality Accounts are required to be externally audited, and the External Auditors have provided an "unqualified" conclusion, which is explained in the Auditor's draft opinion ("Independent Auditors' Limited Assurance Report comments on the 2016/17 Quality Account for Maidstone and Tunbridge Wells NHS Trust") which can be found at the end of the Quality Accounts document. At the time of circulation, the Audit work is being finalised (you will note that the detail of some of the information the Auditors review is missing) and it is expected that the External Auditors will sign off their report w/c 26th June. The full report of the External Audit is then scheduled to be reviewed at the 'main' Quality Committee on 5th July.

It should be noted that the scope of the External Audit is referred to as "limited assurance". However, this refers to the fact that the Audit only covers 'limited' aspects of the Quality Accounts. Therefore in this context, the term "limited assurance" does not have any negative connotation (which is the case when "limited assurance" is used in the context of Internal Audit reviews).

Which Committees have reviewed the information prior to Board submission?

- Quality Committee, 03/05/17 (initial draft)
- Patient Experience Committee, 13/06/17
- Trust Management Executive (TME), 21/06/17

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

Review and approval (for publication)

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

Maidstone and Tunbridge Wells NHS Trust

Quality Accounts
2016/17

Quality Accounts

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

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

Our Quality Accounts for 2016/17 highlight the progress we have made against key priorities for the year to improve services for our patients and present those areas that we will be focusing on as priorities for 2017/18.

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

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

Index

Part One
Chief Executive's Statement

Glenn Douglas

Welcome to our Quality Accounts for 2016/17 which provides a picture of patient care at Maidstone and Tunbridge Wells NHS Trust and sets out our quality priorities for the year ahead.

Demand for NHS hospital-based care reached unprecedented levels in West Kent and north East Sussex during 2016/17.

Our teams of highly skilled healthcare professionals at Maidstone and Tunbridge Wells hospitals provided over 800,000 episodes of care for our patients last year – that's around 50,000 more instances where patients required our help compared to the previous year.

We believe that the demand for our services will continue to grow for the foreseeable future and that is why we are working closely with our partners in health and social care, alongside our patients and the public, to create a Kent and Medway-wide health and social care plan to meet people's changing health needs.

We have an aging and increasingly elderly population and are seeing many more patients over the age of 65 being admitted to our hospitals in an emergency with complex care needs. More often than not, these patients require prolonged periods of hospitalisation and on-going care in the community. This is the `new norm' for the NHS locally and our quality priorities for the year ahead continue to build on our service improvements - from a patient safety, experience and clinical effectiveness perspective - for this important group of patients.

One of our priorities this year is to help more of our older patients retain their much-valued independence and return home after their hospital stay. This is important to them and it's important to us.

The growth in emergency hospital attendances, admissions and length of stay has had a clear impact on our ability to meet some of our waiting time standards all of the time. You will see from our Quality Accounts that we have not always consistently managed to see some of our emergency and elective patients as quickly as we would want to. Our quality priorities for 2017/18 continue to build upon our ongoing work to improve these areas of care.

At the same time we have maintained or improved key areas of patient safety during 2016/17. This is a testament to the efforts of our hardworking staff who have continued to put the safety of our patients first. There is still more we can do to improve the safety of our patients this year, and every year. Our Quality Accounts set out our priority areas to continue our patient safety improvements in an open and transparent way, based very much on an ethos of acknowledging when things have gone wrong, learning from our errors and sharing best practice.

While we will continue to look at every opportunity to enhance the care and experience that all of our patients have, 2016/17 was also a bumper year for babies. We delivered more babies than ever before last year and are delighted to see an increase in our birth rates at both Maidstone and Crowborough Birth Centres. We are one of few Trusts in the country to provide women with a full range of birth choices and are nationally piloting a birth choices project for the NHS.

The information contained within this report represents an accurate reflection of our organisation's performance in 2016/17 and has been agreed by the MTW Trust Board.

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

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

Glenn Douglas
Chief Executive

Part Two
Quality improvement initiatives

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

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

We have chosen three quality improvement priorities in 2017/18 which represent the views of our stakeholders, but are also in line with the Trust's overarching strategy for quality improvement. The quality priorities have been reviewed and agreed by the members of the Patient Experience committee, which include patient representatives and representatives from Healthwatch Kent.

Quality Improvement Priorities 2017/18

NHS Improving Quality

Patient Safety
To create reliable processes that will build a supportive environment to reduce avoidable harm.
Key objectives will include:

- We will demonstrate that we have embedded a safety culture within all departments undertaking invasive procedures with compliance with the WHO surgical safety methodology.
- We will improve the reporting of medication errors within the Trust and reduce the number of inappropriate omissions of doses of medication.
- We will reduce our observed rates of mortality to be in line with expected rates according to speciality.
- We aim to achieve consistent recognition and rapid treatment of sepsis in both our emergency and inpatient departments and ultimately reduce the number of avoidable deaths.
- We will improve the outcomes for expectant mothers and their babies in line with the Maternal and Neonatal Health Safety Collaborative.

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

- Implementation of the revised Friends & Family methodology to provide a more targeted focus on 5 questions relating to the patient's overall experience.
- To achieve consistent monthly response rates to the Friends and family test.
- To work with external partners such as Healthwatch, NHSI, CQC and the CCG to identify key themes of good practice and emerging issues that may give cause for concern. Activities may

include engagement with compliance Assurance, formal and informal PLACE assessments, engagement with service improvement initiatives and patient experience improvement groups
- Develop a framework to report and monitor the incidence of harm affecting those with cognitive impairment (dementia).

Clinical Effectiveness

To improve the management of patient flow.

Key Objectives will include:

- Avoiding unnecessary admissions to hospital through the increased use of ambulatory pathways of care for patients who attend our emergency departments.
- Work with our mental health partners to reduce the number of frequent attendances of patients in crisis attending our emergency departments.
- Improved access to ring-fenced beds for Stroke and fractured neck of femur patients.
- Development of pathways that will support the timely discharge of patients

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

Our newly refurbished phlebotomy room at Maidstone Hospital in Main Outpatient's Clinic 3.

Patient Safety

Maidstone and Tunbridge Wells NHS Trust is committed to the creation of an open and honest approach to patient safety which relies on both our staff feeling empowered to report incidents and raise concerns and our patients being welcomed to let us know when the care they receive falls short of expectations.

The evidence and information that is gathered from our incident reporting system, complaints, Patient Advice & Liaison service (PALs), inquests, legal claims, mortality reviews and clinical audit are all fundamental to the triangulation of key themes and trends which are then used to disseminate learning. Through this approach we aim to inspire our teams towards making a sustained and positive approach that ultimately improves the safety of our patient care.

Aim/goal

To ensure that all actions that we said we would undertake as a result of learning from incidents and complaints, as indicated in our action plans, have been undertaken and ensure that the learning from these has been disseminated and embedded into practice.

Description of Issue and rationale for prioritising

Embedding a positive and strong patient safety culture takes sustained time and effort to ensure that staff feel safe to raise concerns, empowered to make a difference and have faith that a fair and consistent approach will be taken when fault is discovered. Developing this culture relies on trust and a continuous approach to the developments we are making. In an effort to maintain the momentum of change we have chosen to continue with the dissemination of learning as a key priority for the coming year.

Identified areas for improvement and progress during 2016/17

The following actions were taken in 2016/17

- A central database is now in place that supports the patient safety team with the monitoring of actions previously identified and agreed at the Learning and Improvement committee (SI panel) for all serious incidents reported.
- The Trust's Internal Assurance Inspection process has, as part of their intelligence gathering process, identified actions that were previously agreed. Evidence for these actions were then investigated and collated during the course of these inspections. During 8 separate inspections we were able to evidence staff awareness and find evidence of practical actions being undertaken.
- The Governance Gazette has been published monthly and regularly features case studies to support shared learning.
- Launch of the Patient Safety Calendar in September 2016 with key safety initiatives identified and supported on a monthly basis. These have included communication, infection control, falls, pressure sores, medicines optimisation, Venous Thromboembolism (VTE) and incident reporting.
- Learning from Falls has also been evident with several safety initiatives undertaken this year, including falls as a safety calendar theme for the month of November 2016 and more recently the 'take 5' approach to patient assessment. We have also been successful in achieving our aim to reduce the number of patient falls this year to less than 6.2 per 1,000 occupied bed days achieving 6.07.
- Governance presentation to Directorates and Junior medical staff, on the importance of incident reporting and key learning themes that have been identified, given during the months of February and March 2017.

Initiatives for further action for 2017/18

Key objectives will include:

- We will demonstrate that we have embedded a safety culture within all departments undertaking invasive procedures with compliance with the WHO surgical safety methodology.
  - Agree a programme of audits on WHO compliance to all areas undertaking invasive procedures and monitoring of compliance.
  - Promotion of 'Human Factors' training and methodology.
- We will improve the reporting of medication errors within the Trust and reduce the number of inappropriate omissions of doses of medications.
  - Monthly reporting of medication safety incidents and raised awareness through Governance meetings and Medicines Safety News.
- We will reduce our observed mortality rates to be in line with expected rates according to speciality.
  - By the end of March 2018 every in hospital death will have been reviewed (in line with prevailing guidance)
- We aim to achieve consistent recognition and rapid treatment of sepsis in both our emergency and inpatient departments and ultimately reduce the number of avoidable deaths.
  - Through the work of the Sepsis Committee we aim to achieve the National CQUIN. This will be monitored monthly through the CQUIN Board and reported to the Patient Experience Committee.
- We will improve the outcomes for expectant mothers and their babies in line with the Maternal and Neonatal Health Safety Collaborative.
  - The work of the National Maternity Safety Improvement plans will be reported through the Maternity Board and the Key Performance Indicators (KPI's) will be monitored to inform their progress.

Executive lead: Claire O'Brien, Interim Chief Nurse
Board Sponsor: Claire O'Brien, Interim Chief Nurse
Implementation lead: Wendy Glazier, Associate Director Quality Governance
Monitoring: Trust Clinical Governance Committee

Patient Experience

NHS England publicise that good care is linked to positive outcomes for the patient and is also associated with high levels of staff satisfaction, however they also acknowledge the inconsistencies experienced by different patient groups. There is also an anxiety that those least likely to complain or speak out will experience the poorest care. Our 'Values' are therefore crucial in this objective to improve our patients' experience.

P– Patient First; We always put the patient first and at the centre of what we do.
R– Respect; We respect and value our patients, visitors and each other.
I – Innovate; We take every opportunity to improve service delivery.
D– Delivery; We aim to deliver high standards of quality and efficiency in everything we do.
E– Excellence; We take every opportunity to enhance our reputation and aim for excellence.

Aim/goal

To progress improvements made in capturing patient feedback which is essential for the assessment of our services and to help us make the necessary changes and improvements where necessary.

Description of Issue and rationale for prioritising

Service user feedback is one of the vital elements essential for improving and benchmarking the quality of care provided. It also provides an opportunity for services to reflect on their care, celebrate positive feedback and consider where and how to make local improvements.

This organisation relies on several methods of feedback both internal and external and will proactively work with all providers of data and information that relates to our service users to help apprise us of improvements that are required.

Identified areas for improvement and progress during 2016/17

The following actions were taken in 2016/17

- A task and finish group was established and a new contract engaged with 'Iwantgreatcare' to re-establish a process to consistently gather and display patient feedback.
- The Internal Assurance Inspections were also instrumental in ensuring that each area visited was displaying their feedback and able to demonstrate their local themes and trends.
- Achievement for Friends & Family for 2016/17 is:-
  (See Part 3, p39 for further detail)

Response Rate:

	Achieved	Plan	Benchmark
Maternity Services	26.6%	25.0%	24.0%
In-Patient Services	23.3%	25.0%	25.7%
Accident & Emergency	15.5%	15.0%	12.7%

Positive score – would recommend the service:

	Achieved	Plan	Benchmark
Maternity Services	93.6%	95.0%	95.6%
In-Patient Services	95.5%	95.0%	95.8%
Accident & Emergency	90.7%	87.0%	85.5%

- Each Directorate reports monthly to the Trust Clinical Governance Committee their plaudits and positive feedback. These are then shared with our Communications team to ensure that good practice and initiatives are publicised to promote learning throughout the organisation.
- Our new contract with 'Iwantgreatcare' has the capacity to extract personal feedback which staff can utilise during their appraisals and practice development plans.
- Healthwatch Kent have supported us with an Enter and View visit to our Outpatient departments in September 2016 and have remained instrumental in gaining external feedback. Formal reports are now being received on a quarterly basis, whilst informal communication occurs as necessary.

Patient Experience 2017/18

Key objectives will include:

- Implementation of the revised Friends and Family Test methodology to provide a more targeted focus on 5 questions relating to the patient's overall exp
- To achieve consistent monthly response rates to the Friends and Family Test.
- To work with external partners such as Healthwatch, NHSI, CQC and CCG to identify key themes of good practice and emerging issues that may give cause for concern. Activities may include engagement with compliance Assurance, formal and informal PLACE assessments, engagement with service improvement initiatives and patient experience improvement groups
- Develop a framework to report and monitor the incidence of harm affecting those with cognitive impairment (dementia).

Executive lead: Claire O'Brien, Interim Chief Nurse
Board Sponsor: Claire O'Brien, Interim Chief Nurse
Implementation lead: John Kennedy, Deputy Chief Nurse
Monitoring: Patient Experience Committee

Clinical Effectiveness

The Organisation is committed to the improvement of patient flow throughout the organisation by means of monitoring and benchmarking of patient data which supports the ethos of our patients' entitlement to the right care the first time in the most appropriate environment for their presenting condition.

Aim/goal

To deliver safe and effective care for patients by which-ever pathway of care best meets those needs. These options should include a variety of ambulatory pathways, onward referral to other provider organisations who are better able to meet their care needs and for those who are admitted in ensuring the minimum length of stay possible. This will include the on-going work around the reduction in bed occupancy rates, achieving the A&E 4 hour standard and achievement of the Stroke and Neck of Femur indicators which are priorities for service users, commissioners and this organisation.

Providing safe effective care

Description of Issue and rationale for prioritising

Safe and effective care for our patients remains at the heart of this organisation's objectives. For us to be able to deliver this there is a requirement to ensure good patient flow and the availability of specialist inpatient beds when needed.

Identified areas of improvement and progress during 2016/17

The following actions were taken in 2016/17

- Full implementation of **S**enior review, **A**nticipate, **F**low, **E**arly discharges, **R**eact to delays & waits (SAFER) Discharge Bundle.
- Improved accessibility to a stroke ring-fenced bed on both sites.
- Achievement of 80% of stroke patients spending at least 90% of their stay on a dedicated stroke ward.
- In support of right care, right place we have reviewed our bed stock for each clinical speciality. This has resulted in the re-opening of the Maidstone Orthopaedic Unit for elective orthopaedics. Whatman Ward and Ward 20 have been designated as medically fit wards for those patients awaiting onward care. Gynaecology ward has become Ward 33 to care for all surgical female patients.
- Flexible use of inpatient capacity to manage non elective patient flow during periods of increased demand.
- The reallocation of our previous Clinical Decision unit in the A&E Department to become the Rapid Assessment Triage to support the prompt assessment of all patients arriving by ambulance.
- Development of ambulatory pathways of care model in both Trauma & Orthopaedics and Gynaecology.

Initiatives for further action for 2017/18

Key Objectives will include:

- Avoiding unnecessary admissions to hospital through the increased use of ambulatory pathways of care for patients who attend our emergency departments.
    - Increase of specialities available on the ambulatory pathway model.

  - Development of frailty units on both the Tunbridge Wells and Maidstone hospital sites.
- Work with our mental health partners to reduce the number of frequent attendances of patients in crisis attending our emergency departments.
  - As part of the national CQUIN we aim to improve the pathways of care for patients with mental health needs by reducing the frequency of these attendances by 20%.
- Improved access to ring-fenced beds for Stroke and fractured neck of femur patients.
  - We will work with the speciality leads for both Stroke and Hip Fracture pathways of care to make sustained improvements in the national key performance indicators for each speciality and improve the standards of care.
- Development of pathways that will support the timely discharge of patients.
  - To work in partnership with our Community Trust and Social care partners to develop alternative models of care for our patients.
  - To improve the percentage of non-elective patients over 65 who return to their original place of residence by 2.5%.

Executive lead: Angela Gallagher, Chief Operating Officer
Board Sponsor: Angela Gallagher, Chief Operating Officer
Implementation lead: Lynn Gray, Director of Operations for Urgent Care
Monitoring: LOS Steering Group

Fergus was born three weeks early on 1 February 2016. Diagnosed with Down's Syndrome, his health took a turn for the worse one week after his birth. Here is his family's story …

"On the evening of Saturday 6 February, I noticed that Fergus had become unresponsive and I was struggling to rouse him. He was beginning to feel cool and I couldn't obtain a reading on the thermometer when trying to take his temperature. Recognising that there was a serious problem, and fearing the worst, we rushed him straight to A&E at Tunbridge Wells Hospital."

On arrival, specialist doctors immediately began to examine and treat Fergus. Once he was stabilised, ventilated, had an IV line in and was wrapped in an insulation blanket, Fergus was taken to theatre for x-rays. It was established that there was fluid on his left lung, which explained his difficulty breathing – in essence, Fergus was drowning. Fergus' condition was so serious it was decided to transfer him to the specialist children's hospital, Evelina, in London, where he was admitted to their intensive care unit. Following a scan of his heart, a drain was inserted into Fergus' left lung to commence draining of the fluid and lines were inserted into him to administer medication required to improve his vital signs.

Thankfully, Fergus started to improve, however a subsequent CAT scan indicated a build-up of air in the pleural space around the lung. Urgent treatment ensued to remove the air and stabilise his lung function. "The next target was to get Fergus off the ventilator and breathing independently. This took five days with Fergus initially doing well, but due to his slow progress, he was put on continuous positive air pressure (CPAP) to help support his breathing and enable this to continue." However, the cardiology team involved in Fergus' care found that his VSD (hole in his heart) was now considered to be of moderate size. So, on the day Fergus turned five weeks old he had open heart surgery.

Two weeks after the operation and the cardiology team signed him off and he was handed over to the respiratory team and transferred from the Paediatric Intensive Care Unit (PICU) to the High Dependency Unit (HDU) at the Evelina. Ten days later the family finally got the all clear and Fergus was discharged from hospital. The two-month ordeal was nearing an end and Fergus was coming home!

"We are eternally grateful to everyone who helped with Fergus during what was a really difficult time. We received nothing but the most caring, selfless and professional lifesaving NHS treatment – and it all started over a weekend. If it weren't for the amazing staff on duty that weekend, he would not have survived.

"The wonderful staff at the Evelina London Children's Hospital treated him and nursed him back to health, but the fast and thoughtful actions of the staff at Pembury Hospital undoubtedly saved his life."

They added: "When we look back now and think of all that the teams did for us, we feel so humbled and grateful. We were powerless and had to put our trust in the doctors. It was hard, but their expertise, knowledge and overall unfailing dedication and care saved our son."

For further patient experiences visit-
https://www.mtw.nhs.uk/?s=patient+first

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

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

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

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

- Assessment or medical treatment for persons detained under the Mental Health Act 1983 (at both hospital sites).
- Diagnostic and screening procedures (at both hospital sites).
- Family planning services (at both hospital sites).
- Maternity and midwifery services (at both hospital sites plus the Crowborough Birth Centre, which was added to the Trust's CQC registration in April 2016).
- Surgical procedures (at both hospital sites).
- Termination of pregnancies (at Tunbridge Wells Hospital only).
- Treatment of disease, disorder or injury (at both hospital sites).

No conditions were applied to the registration.

The Nominated Individual for the Trust's Registration is Claire O'Brien, Interim Chief Nurse (Avey Bhatia was the Trust's Chief Nurse and the nominated individual until February 2017).

During 2016/17 the Trust provided and/or subcontracted acute and specialised services to NHS patients through our contracts with Clinical Commissioning Groups, Kent County council and NHS England. The available data on the quality of care for all of these NHS services has been formally reviewed.

The income generated by the NHS services reviewed in 2016/17 represents 100% of the total income for the provider for the reporting period under all contracts, agreements and arrangements held by the provider for the provision of, or sub-contracting of, NHS services.

Reviewing standards

To ensure that we are providing services to the required standards the Trust supported a number of reviews of its services during 2016/17, undertaken by external organisations such as:

- General Medical Council (GMC) Trainee survey – 22nd March-11th May 2016
- Pearson Standards Verifier Visits – 4th April, 15th & 22nd June, 2016 and 31st January, 10th February, 2017
- NHS Protect Audit, Standard 24 – May 2016
- National Cancer Peer review – CUP- May 2016
- National Cancer Peer review – Anal – May 2016
- Kings Medical School Visit – 2nd June 2016
- Antenatal and Newborn Screening Quality Assurance visit – 14th June 2016
- Quality Surveillance – Acute Oncology – June 2016
- Quality Surveillance – Brain – June 2016
- Quality Surveillance – Urology –June 2016
- Quality Surveillance – Head and Neck – June 2016
- Quality Surveillance – Breast – June 2016
- Quality Surveillance – Colorectal – June 2016
- Quality Surveillance – Lung– June 2016

- Environment Agency (Radioactive substances regulation) – Tunbridge Wells hospital - 7th July 2016
- South East London, Kent & Medway review –Trauma services – 7th September 2016
- Healthwatch Kent – Enter and View of both outpatient departments – 28-29th September 2016
- Environment Agency (Radioactive substances regulation) –Maidstone hospital - 12th October 2016
- Quality Surveillance – Adult Chemotherapy – October 2016
- Southeast Coast Critical Care Network Visit – 21st October, 2016
- Counter Terrorism security advisers (CTSA's)- Pathology – 8th November 2016
- CHKS (ISO 9001:2008, CQC Peer Review) – February 2017
- Quality Surveillance – Paediatric – February 2017
- Counter Terrorism security advisers (CTSA's)- Radiology – 1st February 2017

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

- Internal assurance inspections (CQC style) with participation from our patient representatives
- Internal PLACE reviews
- Infection Control including hand hygiene audits
- Trust Board member "walkabouts"

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

Hand hygiene audits to check service quality

"The rooms at the hospital were also fantastic. The en-suite bathrooms really helped and the whole set-up gave me privacy and dignity. It's kept spotlessly clean and the attention to infection control is superb. I can't fault a thing and I would say to anyone who finds themselves in the awful position of needing to be admitted to hospital that this is the place you want to be."

For further Patient experiences visit- https://www.mtw.nhs.uk/?s=patient+first

Clinical Audit

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

During 2016/17, MTW participated in 100% of relevant confidential enquiries and 98% of all relevant national clinical audits (1 not submitted to – Ophthalmology). During the same period, MTW staff successfully completed **199** clinical audits (local and national) to action plan stage of the expected **371** audits on the programme to be undertaken. The remaining audits are at various stages of completeness and will be closely monitored through to completion.

The national clinical audits and national confidential enquiries that Maidstone and Tunbridge Wells NHS Trust participated in during 2016/17 are presented as follows-

National Clinical Audits for inclusion in Quality Accounts 2016/17	***Participation*** Y, N or NA	***No of cases submitted***	***% cases submitted***	***Comments***
Recruited patients during 2016/17 (Any period during 01/04/2016 to 31/03/2017)				
Acute Care				
Adult Critical Care Case Mix Programme (ICNARC) (CMP)	Y	TWH: 500 MAID: 513	100%	
Emergency Laparotomy Audit (NELA)	Y	122		Data collection ongoing.
NAP 6 Perioperative anaphylaxis	Y	3	100%	
Severe Sepsis and Septic Shock (care in Emergency Department)	Y	MGH: 50 TWH: 50	100%	
Society for acute medicine's benchmarking audit (SAMBA16)	Y	MGH: 33 TWH: 18	100%	
Moderate & Acute Severe Asthma – adult and paediatric (Care in emergency departments)	Y	MGH: 50 TWH: 50	100%	
Neurosurgical National Audit Programme	N/A			MTW does not provide this service
National Vascular Registry	N/A			MTW does not provide this service
Severe Trauma (Trauma Audit & Research Network) TARN	Y	545	99%	Data collection ongoing. Awaiting case notes.
National Complicated Diverticulitis Audit (CAD)	N/A			MTW does not provide this service
National Joint Registry (NJR)	Y	MTW: 506 (Knee: 213 Hip: 293)	100%	
Consultant Sign off (Care in the Emergency Department)	Y	MGH: 50 TWH: 50	100%	
BAUs Urology Audits: Radical prostatectomy audit	Y			Data collection ongoing
BAUs Urology Audits: Female Stress urinary incontinence audit	N/A			MTW does not provide this service
BAUs Urology Audits: Cystectomy	Y			Data collection ongoing
BAUs Urology Audits: Nephrectomy Audit	Y			Data collection ongoing
BAUs Urology Audits: Percutaneous	Y			Data collection ongoing

National Clinical Audits for inclusion in Quality Accounts 2016/17	***Participation*** Y, N or NA	***No of cases submitted***	***% cases submitted***	***Comments***
Nephrolithotomy (PCNI)				
BAUs Urology Audits: Urethroplasty Audit	N/A			MTW does not provide this service
ANS and BCN standards for intraoperative monitoring for spinal deformity surgery	N/A			MTW does not provide this service
Breast and cosmetic implant registry (BCIR)	N/A			Breast team will be doing this audit in 2017/18. N/A for 2016/17
Blood transfusion				
(National Comparative Audit of Blood Transfusion Programme) – Audit of red cell and platelet transfusion in adult haematology patients	Y	39	100%	
2017 National Comparative Audit of Transfusion Associated Circulatory Overload (TACO)	N/A			Data being collected 2017/18. Currently being collected
Audit of Patient Blood Management in Scheduled Surgery – Re-audit September 2016	Y	28	100%	
Serious Hazards of Transfusion (SHOT) UK. National haem vigilance scheme	N/A			
Cancer				
Lung Cancer (NLCA)	Y	1377	100%	
Bowel Cancer (NBOCAP)	Y	Patient: 310 Tumour: 310 Surgery: 238 Pathology: 173 Chemotherapy: 141		Final date for submission 15/05/17. Data collection ongoing
National Prostate Cancer Audit (NPCA)	Y	Diagnosis: 408 Symptoms: 419 Treatment: 547	100%	
Oesophago-gastric cancer (NAOCG)	Y	Patient: 116 HGD: 6 Tumour: 110 Chemo/Radio:75	100%	
Head and Neck Cancer 2015 (DAHNO)	Y	Patient: 80 Baseline A: 32 Baseline B: 80 Follow up: 0 Non-surgery: 68		
Heart				
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Y	TWH:216 MGH: 207	100%	Data collection still open and data being submitted
Heart failure	Y	TWH: 224 MGH: 254	100%	Data collection still open and data being submitted
Coronary angioplasty/ National audit of PCI	Y	MTW: 279	100%	Data collection still open and data being submitted
Cardiac Rhythm Management (CRM)	Y	MTW: 446	100%	Data collection still open and data being submitted
National Cardiac Arrest Audit (NCAA) 661	Y	TWH: 122 MGH: 105	100%	Data collection still open and data being submitted
National Chronic Obstructive Pulmonary Disease (COPD) Audit	Y	1.Pulmonary rehabilitation**:** 77 2.Secondary	100%	1.Data submitted 2.Data collection only opened Feb 17 data being submitted

National Clinical Audits for inclusion in Quality Accounts 2016/17	*Participation* Y, N or NA	*No of cases submitted*	*% cases submitted*	*Comments*
		care: 0		
Adult Cardiac surgery	N/A			MTW does not provide this service
Congenital heart disease (Paediatric and Adult cardiac surgery)	N/A			MTW does not provide this service
Pulmonary Hypertension	N/A			MTW does not provide this service.
Long Term Conditions				
Adult Asthma (BTS)	Y	MGH: 18 TWH: 10	100%	
National Adult Diabetes Inpatient Audit (NaDIA) 572	Y	MGH: 54 TWH: 64	100%	
National Diabetes Foot care Audit 622	N/A			Trust patient data currently submitted by the Community Podiatry Team. Will be brought back in house for 2017-18
Inflammatory Bowel Disease (IBD) Programme /IBD Registry	Y	MGH: 1 TWH: 0		Amalgamated old web portal with new on-line registry.
UK Cystic Fibrosis Registry (Adults + Paediatrics)	N/A			MTW does not provide this service
Renal Replacement Therapy (Renal Registry)	N/A			MTW does not provide this service
Endocrine and Thyroid National Audit	Y	MTW: 108	100%	
National Core Diabetes Audit (NDA)	Y	MTW: 3657	100%	
Chronic Kidney disease in Primary Care	N/A			MTW does not provide this service
Prescribing Observatory for Mental Health (POMH – UK) Prescribing antipsychotics for people with dementia	N/A			MTW does not provide this service
Prescribing Observatory for Mental Health (POMH – UK) Monitoring of patients prescribed lithium	N/A			MTW does not provide this service
Prescribing Observatory for Mental Health (POMH – UK) Rapid tranquilisation	N/A			MTW does not provide this service
Older People				
Falls and Fragility Fractures Audit Programme (FFFAP)	N/A N/A Y	1.Inpatient Fall (NAIF) 2.Fracture Liaison Service Database organisational data 3. National Hip Fracture Database 563		1. No data collection in 2016-17 2. MTW does not provide this service. This is a community service. 3. Data collection still open and data being submitted
National Audit of Dementia	Y	1.Organisational 2.Clinical data MGH: 50 TWH: 50	100%	
Sentinel Stroke National Audit Programme (SSNAP)	Y	1. Organisational 2. Clinical Data MGH: 322 TWH: 345	100%	1. Organisational data submitted 2. Data collection still open and data being submitted
Other				
Elective surgery (National PROMs Programme) Hip Replacement, Knee Replacement,		Hip: 393 Knee: 403 Groin: 433	100%	

National Clinical Audits for inclusion in Quality Accounts 2016/17	***Participation*** Y, N or NA	***No of cases submitted***	***% cases submitted***	***Comments***
Groin Hernia, Varicose Vein		Varicose: 0		
National Ophthalmology Audit	N			Registered to participate. Still awaiting software link from Royal College to upload data.
Smoking Cessation	Y	MGH: 50 TWH: 46	96%	Some notes unavailable
Learning Disability Mortality Review Programme (LeDeR)	N/A			Staged introduction across England
Mental Health				
Prescribing Observatory for Mental Health (POMH-UK)	N/A			MTW does not provide this service
Suicide and homicide and sudden unexplained death	N/A			MTW does not provide this service
Women's and Children's Health				
Neonatal Intensive and Special Care (NNAP) 67	Y	MTW: 669	100%	
MBRRACE-UK; National surveillance and confidential enquiries into maternal deaths	Y	MTW: 0	100%	At present none of our patients fulfil the criteria requirements.
MBRRACE-UK; Perinatal Mortality Surveillance	Y	Stillbirth: 16 Neonatal: 1 Extended Perinatal:17	100%	
MBRRACE-UK; Maternal morbidity and mortality confidential enquiries (cardiac (plus cardiac morbidity) early pregnancy deaths and pre-eclampsia)	N/A			MTW does not provide this service
MBRRACE-UK; Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths) 495	Y	Stillbirth: 22 Neonatal: 3 Extended Perinatal: 3 Intrapartum: 8	100%	
Paediatric Inflammatory Bowel Disease	Y	TWH: 0		At present none of our patients fulfil the criteria requirements.
National Maternity and Perinatal Audit (NMPA)	Y	11,659	100%	Organisational survey data also submitted
Paediatric Intensive Care (PICANet)	N/A			MTW does not provide this service
National Pregnancy in Diabetes Audit	Y	MTW: 16	100%	
Paediatric Pneumonia	Y	MTW: 36	100%	Data submission still open.
National Paediatric Diabetes Audit (NPDA)	Y	TWH: 131 MGH: 114	100%	
Paediatric Asthma (BTS)	Y	MTW: 27	100%	
National Confidential Enquiries				
Non Invasive Ventilation	Y	2	50%	
Heart Failure	Y	N/A	N/A	Patient data submitted to NCEPOD waiting for patient selection process for peer review.
Cancer in Children, Teens and Young Adults	Y	N/A	N/A	Patient data submitted to NCEPOD waiting for patient selection process for peer review.
Child Health Clinical Outcome Review Programme: Chronic Neuro-disability	Y	5	50%	Data collection still ongoing
Child Health Clinical Outcome Review Programme: Young Peoples Mental Health	Y	3	43%	Data collection still ongoing

41 national audits were published in 2016/2017 with actions taken to address areas of non- or partial compliance. A number of improvements have been made in line with national recommendations, including:-

Trauma & Audit Research Network (TARN)

Rehabilitation Prescriptions have now been developed and implemented; these put in place a package of on-going post-op rehabilitation for a maximum 4 weeks and allow patients to return to their own home, as opposed to temporary accommodation or community hospitals, enabling earlier discharge from hospital and treatment in a more comfortable environment. Highlighting the process of expediting patients to CT scan has led to a substantial improvement in patients with head injuries being scanned within the 60 minutes recommended in the NICE guidance, this enables a quicker diagnosis and where applicable, prompt transfer to King's College Hospital for specialist treatment.

Emergency Laparotomy Audit (NELA)

We have introduced an emergency laparotomy pathway comprised of 6 evidence based steps to improve care for these patients. This involves screening of patients using PAR scoring, lactate measurement and calculation of pre-operative risk; sepsis screening with early antibiotics where indicated; theatre within 6 hours of a decision to operate; goal directed fluid therapy in theatre, critical care for all patients postoperatively and consultant delivered care. Compliance with the bundle has steadily improved and there has been a significant reduction in mortality which sits comfortably below the national average (7.2% vs 11.1%).

MBRRACE-UK Saving Lives, Improving Mothers Care; Surveillance of Maternal Deaths 2012-2014

The Trust has invested in an outreach team which is now available 24/7. The maternity service has an excellent relationship with the outreach team and they review the HDU patients as a priority so that each woman is risk assessed to see if it is appropriate to continue care onsite. If the woman needs to be transferred to a tertiary unit, this will always be to a London Hospital which has obstetric services which would comply with the principle "one transfer to definitive care".

British Thoracic Society (BTS); National Paediatric Asthma Management 2015

Ongoing audit reviews demonstrate that the care of children with acute asthma continues to be efficient and effective; with initial assessments being performed on all asthma patients; and the provision of $Beta_2$ agonists being used as the first line treatment. Mild - moderate asthma patients, all receive salbutamol via MDI and spacer. Severe asthma patients (oxygen Saturation level <92%) all receive nebulisers. These interventions form part of the best treatment guidance advocated by the British Thoracic Society.

National Pregnancy in Diabetes Audit (NPID) 2015

The Midwifery Diabetic Team have improved early communication regarding specialist support by producing a clear pathway and implementing the diabetes in pregnancy pathway once pregnancy is disclosed by the woman to her GP. All women are seen within 1 week at the combined antenatal diabetic clinic and commence the pathway of 2 weekly visits once pregnancy disclosed. Women who have been identified to be part of the pathway benefit from being closely monitored which has the potential for reducing lasting effects on the baby. Women who attend for their diabetes appointments and are of childbearing age are offered family planning advice. MTW maintains a high level of research based practice.

Please see Appendix A for full details of progress against each of the reported national audit results 2016/17

Service Improvements

A number of improvements have been made as a result of the 147 completed local clinical audits, across all Directorates, in 2016/17, 51 of these were local re-audits. Trust staff identified local areas of concern/interest, reviewed their practice and made recommendations for change. Staff actively use clinical audit as a quality improvement process to improve patient care and outcomes through a systematic review against explicit criteria. Improvements include:

Actions taken following local audits	Trust Actions
Palliative Care Team	The decision to make a DNACPR order for a patient is an important and often challenging one. These results demonstrate evidence in improvement in a number of areas since the last audit in 2015, in particular the accurate use of patient identifiers and the number of records that include documentation of a conversation with the patient's next of kin. The audit also shows evidence of continued good practice in both completion of the section on clinical information regarding the reason resuscitation would not be appropriate and in obtaining an authorising signature. Cross boundary working has also positively progressed, with a rise in the presence of DNACPR forms brought in by patients from the community.
Tissue Viability	Pressure ulcers are a complex health problem arising from many interrelated factors. Prevention and treatment are paramount to ensure patient comfort and care. Actions from the previous round of the audit include: A Trust-wide education campaign to reduce the overall numbers of moisture associated skin lesions. Working with individual wards to raise knowledge of pressure damage prevention and treatment. A rapid review process of all category 2 ulcers by the Tissue Viability Service is in place. These actions have led to a sustained and continued improving picture in the reduction of pressure damage.
Infection Control Team	The Infection Prevention team developed a sticker to be placed in the patient notes on diagnosis of CDT (Clostridium Difficile associated diarrhoea) enabling a more consistent approach for the management of patients. This has been well evaluated as it is easy to see when in situ. If a patient is diagnosed over the weekend the sticker would be placed in the notes the next working day. This raises awareness to other health professionals. The audit shows that the care pathway is strongly embedded into everyday practice.
Ophthalmology	Actions from the previous round of this audit include the department hiring a clerk to call patients two weeks prior to surgery to confirm the patients' attendance and elicit any concerns. A TCI letter specifically reminded patients to stop their anti-platelet drugs as instructed at pre-assessment clinics. If patients cancel when contacted then this allows sufficient time to re-book another patient therefore reducing costs and optimising theatre time efficiency. Our results show a significant improvement in the rate of theatre cancellations and the new measures have consequently reduced costs and optimised theatre time efficiency. This is also beneficial to patients who can be slotted into any cancellations reducing their waiting times.
Paediatrics	Delay in treatment of children with suspected neutropenic sepsis can cause rapid deterioration and can potentially cause overwhelming sepsis and death. As a result of the last audit an Oncology Admission Proforma was introduced and has shown to have improved clinical response to a febrile oncology child as Medical and Nursing response times have improved and the percentage of antibiotics given within 1 hour has increased.
Cardiology	The cardiology team have introduced a new online request form which helps the clinicians (requesting the echo) to mention the appropriate indication by triaging the echo request according to British Society of Echocardiography (BSE) criteria. Since then the number of inappropriate referrals has significantly reduced. This has led to improvement in patient care now that we are prioritising and categorising all the echo's – this enables us to identify the truly urgent scans without any delay.

Actions taken following local audits	Trust Actions
Respiratory	Audits were carried out into the management of Pleural effusions. Following these audits a proforma was introduced which included all the initial steps in the management of pleural effusions according to BTS guidelines. Junior doctor education is carried out at every rotation in the use of this proforma and in the use of ultrasound guided aspiration. A new ultrasound machine is now available on the Respiratory wards. This ensures identification of a diagnosis swiftly and logically, to minimise unnecessary invasive investigations and minimise hospital stay.
General Surgery	Our previous audit found that only 32% of Barrett's Oesophagus cases with endoscopic diagnosis had a Prague classification. In our re-audit of the Barrett's specific list, we found that 100% had an appropriate classification therefore meeting our audit standard. In order for correct surveillance pathways to be allocated to patients, the diagnostic criterion needs to be met. In our first audit we highlighted a lack of defining Prague criteria at endoscopy and a suboptimal result in terms of quandrantic biopsies being taken (when the clinician was able). We can now demonstrate that the use of a Barrett's specific list will allow these standards to be met. This then allows the clinicians to make appropriate decisions with their patients regarding follow up

Enhancing Quality and Enhanced Recovery Programme

Clinical teams across Kent, Surrey & Sussex (KSS) agreed a number of key clinical interventions that should happen when a patient has been admitted across a number of clinical pathways as part of the Enhancing Quality (EQ) and Enhanced Recovery Programmes (ERP). The Enhancing Quality pathways include Community Acquired Pneumonia, Heart failure, Chronic Obstructive Pulmonary Disorder (COPD) and Fractured Neck of Femur. For each of these pathways there are a number of performance measures to attain that demonstrate compliance of the key quality indicators. These quality measures pulled together are regarded collectively as a ‘care bundle’. It has been clinically proven that delivery of the full ‘care bundle’ improves the patients’ outcomes.

Enhancing Quality
Community Acquired Pneumonia (CAP)
MTW performance is in line with KSS regional average for the Community Acquired Pneumonia Pathway; with key outcomes reported for mortality having decreased over the 6 years reported by 5% from 23% to 18% and also 30-day readmissions significantly below the regional average. Length of stay varies between 8 and 11.4 days which has been consistently in line with the regional average.

Heart failure
The measures selected for Heart Failure are aligned to the National Heart Failure Audit and support greater compliance with NICE guidelines and quality standards. Throughout the course of the heart failure programme, MTW’s performance for Length of Stay (LOS) and 30-day readmissions are in line with the regional average. The rates of Heart Failure Admissions range from 5.6 to 10.2 (per 1,000 Trust admissions); which is below average for heart failure admissions as a proportion of total Trust admissions. The Appropriate Care Sore performance score measures, the percentage of patients who receive the full care bundle. MTW performed above the regional average at 93%. Mortality rate for MTW heart failure patients has risen to 17%, this is reported as the highest in the region.

Chronic Obstructive Pulmonary Disorder (COPD).

MTW performance since implementation of the programme has been significantly above the regional average in this pathway, with approximately 75% of patients receiving the full 'care bundle'. In hospital mortality rates vary between 1.5% and 6%. MTW mortality is average for the region. Average length of stay is dispersed varying between 4 and 7.5 days which is longer than average, however the 30 day re-admission rates are below the regional average

Fractured Neck of Femur

The best practice tariff (BPT) for hip fracture came into effect in April 2010, meeting the commitment to High Quality Care for All, Lord Darzi's NHS Next Stage Review report. Meeting the BPT offers a financial incentive to improve care. The best practice measures have been selected in line with British Geriatrics Society (BGS) and National Institute for Health and Clinical Excellence (NICE) guidelines and are designed to ensure the patient recovers as quickly and as fully as possible. Compliance against standards are recorded on the National Hip Fracture Database (NHFD).

Maidstone and Tunbridge Wells NHS Trust is one of the busier hospitals with a higher number of hip fracture patients then most of the other participating hospitals within the region. NHFD monitoring compliance outcomes indicate MTW mortality rate, readmission rate and length of stay as average for the region.

TARN – The Trauma Audit and Research Network

TARN was established in 1988 after a number of recommendations were made for improvement in the care of trauma patients. Data is collected in order to monitor and compare Trauma Management in and between participating hospitals. Observations and interventions from the time of the accident, pre-hospital care, Emergency Department, ITU, imaging and operations are submitted together with diagnosis, past medical history and rehabilitation details. Participation is mandatory to maintain our status as a Level 2 trauma unit.

The Maidstone and Tunbridge Wells NHS Trust submit approximately 500 trauma patients per year to TARN, which is above regional numbers of 200 – 300 patients submitted. TARN use coding information to assess how many injuries meet TARN criteria for each hospital, and then report the number of expected submissions in comparison to the number received as a percentage. Submissions from Tunbridge Wells are now at 73%. Tunbridge Wells has led on the inclusion of Rehabilitation Prescriptions in TARN submissions, one of the only Trauma Units in the country to be undertaking this remit.

Emergency Laparotomy

The Emergency Laparotomy Collaborative (ELC) is led by the Kent, Surrey & Sussex Academic Health Science Network (KSS AHSN) with an aim to provide support in improving emergency laparotomy care and also to deliver quality improvement training. The Care Quality Score (CQS) performance score identifies the number of measures passed by each patient. MTW CQS performance was above average for the region. Admission rates across the region range between 0.7 to 3.4 admissions per 1,000 Trust admissions. MTW admissions are below average. Average length of stay is dispersed across Trusts and varies from 14 to 24 days, with MTW demonstrating an average of 20 days.

Enhanced Recovery Programmes (ERP)

Enhancing Recovery includes three elective pathways; Colorectal, Gynaecology and Orthopaedics. The aim for these pathways is to improve outcomes including reduced length of stay and readmission rates. All ERP Pathways have the following measures in common; pre-operative assessment; planning and preparation before admission; reducing the physical stress of the operation (by using minimally invasive techniques and preventing hyperthermia); a structured approach to immediate post-operative and peri-operative management (including pain relief, postoperative nutrition and early mobilisation). Making patients active in their own recovery and

planning means that the patients are better prepared to cope when they are back at home. Care Bundles when performed consistently and fully, have been clinically proven to improve patient outcomes.

The enhanced recovery project team continued its focus on increasing the numbers of patients going through each of the pathways and reviewed and reported each care programme monthly via the Trust Clinical Governance committee. This work continued until December 2016 when the national data collection process ceased.

Orthopaedics
The Appropriate Care Score (ACS) performance measures the percentage of patients who receive the full care bundle. MTW has historically performed in line with the regional average but performance has been variable over the last 12 reported months. Admission rates have ranged from 5.9 to 15.1 orthopaedic admissions per 1,000 Trust admissions, which can be explained by the periods of increased non-elective flow. MTW orthopaedic admissions are below average for the region. Length of stay for orthopaedic patients is largely consistent across Trusts with a regional average of 4.2 days.

Gynaecology
MTW ACS performance score measures have been consistently above the regional average throughout the course of the programme, although 2016 has seen considerable variation throughout the year with lower than average outcome noted for those receiving the full care bundle. MTW's rate of admission was above average for the region. Length of stay has decreased over the course of the programme by 1 day and is now an average of 3 days.

Colorectal
The ACS performance score measures the percentage of patients who receive the full care bundle. There is considerable variation between Trusts in performance over the last 12 months. MTW performance has historically been consistent with the regional average at 60% but has declined in recent months. Colorectal admission rates have remained consistent across Trusts, however MTW saw slightly higher than average admissions in the reported period at 2.5 admissions per 1,000 Trust admissions. MTW's length of stay was the highest in the region at 11.5 days.

NICE Guidelines

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

MTW review all published guidelines produced by NICE to identify those which are relevant to the care we provide to our patients. Clinical audits are then undertaken on those guidelines identified as being relevant to assess the Trust's compliance. These clinical audits focus on a number of key quality standards; that are designed to drive measurable service improvement to enhance practice and the care of patients. At the end of 2016/17 there have been **1204** NICE guidance documents disseminated to the specialty leads throughout the Trust. Of those, **1164** (**96.7%**) have been evaluated. **430** (**36.9%**) of the evaluated guidance are relevant to the Trust. The breakdown is shown in the table below.

Guidance Type	Published	Evaluated	Relevant
Clinical Guidelines (NICE CGs)	**253**	**223**	**102**
Interventional procedures (NICE IPGs)	**515**	**487**	**74**
Technology Appraisals (NICE TAs)	**436**	**387**	**159**
Totals	**1204**	**1097**	**335**

Please see Appendix C for full details of Trust compliance with guidance that has been audited and completed during 2016/17.

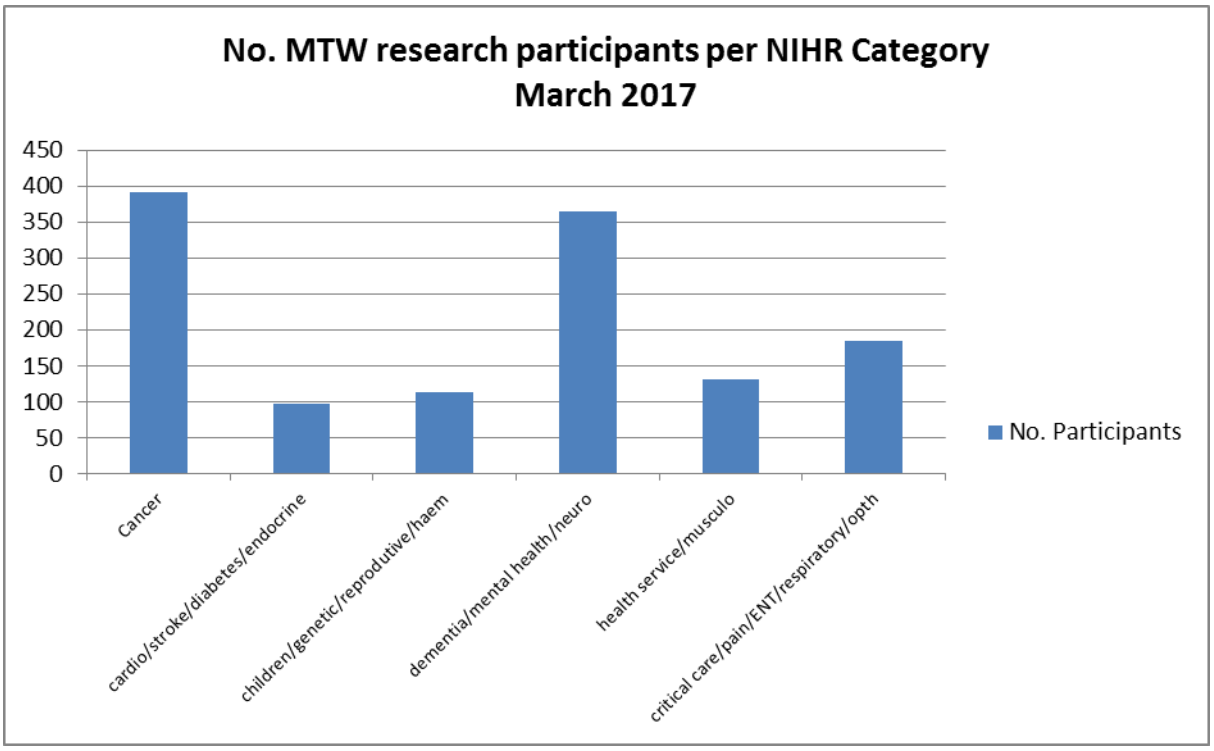
Research

Participation in clinical research

Maidstone and Tunbridge Wells NHS Trust (MTW) understands the importance of being a research active organisation. Not only is it a central requirement within the NHS Constitution, it is also a patient priority.

Participation in clinical research means patients can get access to new treatments, interventions and medicines and investment in research can mean better, more cost effective patient care.

In 2016/17 MTW played a key part in delivering the national research agenda by recruiting 1171 patients to studies that required a review by the National Research Ethics Service (NRES) from a total of 1535 people recruited to trials. MTW met its recruitment target of 1250 people, as set by the Kent, Surrey and Sussex Clinical Research Network (KSSCRN). Successful recruitment during the year was as a result of a full complement of delivery staff in all research teams and an improved, speedier expression of interest process to secure large recruiting studies early.



Recruitment by NIHR specialty grouping

The highest recruiting research areas in MTW during 2016/17 were oncology and mental health as they both ran high recruiting studies – DETECT-1 and the Self Declaration of Compassion Survey.

Trust Clinical Lead for Research and Development

During 2016, Maidstone and Tunbridge Wells NHS Trust successfully appointed a new Trust Lead for Research and Development, Mr Alastair Henderson, Consultant Urological Surgeon. Alastair took up the role in July 2016 and has already been instrumental in promoting research both within

and outside the organisation. He is Principle Investigator for the urology study, DETECT-1, the second largest recruiting study at MTW during 2016/17.

Mr Alastair Henderson
Trust Lead for Research & Development

Patient Public Involvement

The Research and Development Department believes patients and their carers' and relatives should be partners in research activity. During 2016, MTW's patients played a central part in research set up and delivery. The Elective Peri-Operative Isometric Exercise Programme (EPOP) surgical study (looked at designing an exercise regime to boost post-operative recovery) methodology and resulting exercise programme was developed by patients and clinicians working together. MTW also supported the National Institute of Health Research National Patient Survey, seeking the experiences of patients who have joined our trials. The results of this survey will be available in early May, 2017 and will inform how studies are delivered in the future.

"The trial at Maidstone Hospital was actually a very good experience. I was monitored very carefully and very frequently, which was time consuming but also helpful and reassuring. It was also very interesting to be part of a clinical trial and to feel like I was contributing to the development of medicines, and potentially helping people in the future."

For further patient's experiences visit-
https://www.mtw.nhs.uk/?s=patient+first

In January 2017, the Research and Development Manager and Research Patient Representatives from Maidstone and Tunbridge Wells NHS Trust and Kent Community Health Foundation Trust delivered a Patient and Public Involvement (PPI) workshop to staff across Kent and Medway. The workshop was part of a conference held at the University of Kent, developed and delivered by research staff from NHS organisations across Kent and Medway. The purpose of the workshop was to discuss cross-organisation working to promote PPI in research. Ideas from this workshop are shaping how the Trust works with their peers to that the needs of our patients remain central to the research that we undertake.

A Diverse Research Delivery Team.

During 2016/17 the research and delivery team has grown to meet increasing recruitment and diversity of studies. The research team has been boosted by the addition of an ophthalmic research practitioner who is medically trained. This Research Practitioner has a dual role by supporting the delivery of ophthalmic trials and preparing an MTW research project for adoption onto the National Portfolio of studies. A number of MTW nurses have also joined the research team, on a part time basis, to gain more knowledge and practical research experience. The research nurse role compliments our Trust's many nursing roles perfectly.

Research governance has been further strengthened by a junior governance officer joining the research governance team. This role has helped to expedite the set-up of trials across the organisation.

Research Nurse Wendy Milligan, Governance Officer Clare Calvert and Research Practitioner Dr Meriam Islam

Within oncology research, each tumour group now has a dedicated team of research nurses and a dedicated Clinical Trial Administrator to facilitate an efficient commencement and effective delivery of new trials. The new Haematology Lead Research Nurse, which was historically a dedicated oncology research role, has now been expanded to work across oncology and non-oncology research and has a team of delivery staff to support this.

The increase in delivery staff has enabled more patients to be recruited to studies at the Tunbridge Wells Hospital, particularly in haematology, critical care, trauma and orthopaedics and breast cancer. Increasing the number of studies opened at The Tunbridge Wells Hospital is a strategic aim for the forthcoming year.

Awarding excellence in research

The National Institute of Health Research awarded 10 consultants at Maidstone and Tunbridge Wells NHS Trust extra funding during 2016 for exceeding recruitment to trials, across a range of specialties. This additional funding has supported additional research nurse hours thereby increasing recruitment to trials and allowed a number of delivery staff to attend research conferences and participate in research training.

Goals agreed with commissioners

CQUINS

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

In 2016/17 2.5% of the contract value was dependent on achieving the CQUIN targets for CCGs and 2.0% was for NHS England in line with the CQUIN payment framework.

Within the commissioning payment framework for 2016/17 quality improvement and innovation goals were set as indicated in the table below.

CQUINs	Target	*Achieved (local data)	RAG Rating
National CQUINs (CCGs)			
Introduction of health and wellbeing initiatives; Physical Activities, Fast-Track Physio, Mental Health Initiatives such as Stress Management	Evidence of 3 initiatives promoted	100%	Green
Healthy Food for NHS Staff, visitors and patients; banning of a) price promotions b) advertising c) banning from checkouts of sugary drinks and foods (HFSS) d) Ensuring availability of healthy options	Delivery of four outcomes agreed with CCG	80%	Amber
Improving the uptake of flu vaccinations for frontline medical staff	65-74.9%= 80% >75%=100%	66.6%=80%	Amber
Timely identification and treatment for sepsis in emergency departments; percentage of eligible patients screened for sepsis.	90%	100%	Green
Sepsis ;% of eligible emergency patients with SEPSIS given intravenous antibiotics <60mins	Q1 = 65%, Q2 = 70%, Q3 = 75%, Q4 = 80%	Q1=71.4%, Q2=72.9%,Q3 =78.3%,Q4= 89%	Green
Timely identification and treatment for sepsis in acute inpatient settings; percentage of eligible patients screened for sepsis	Q1 establish baseline; Q2=55%;Q3=65 %Q4=70%	Q1 achieved; Q2=63.1%;Q3 =72.2%; Q4=77%	Green
Sepsis; 0% of eligible inpatients with SEPSIS given intravenous antibiotics <60mins	Q1 establish baseline; Q2=50%;Q3=55 %Q4=60%	Q1 failed; Q2=90%Q3=1 00%;Q4=100 %	Amber
SEPSIS % of eligible emergency patients or Acute Inpatients with SEPSIS reviewed <3 days	90%	100%	Green
Reduction in antibiotic consumption per 1000 admissions 1) total antibiotic consumption 2) Total consumption of carbapenem 3) total consumption of piperacillin-tazobactam	Reduction of 1% against baseline	100%	Green
Empiric review of antibiotic prescriptions	Q1 establish process; Q2=50%;Q3=75 %Q4=90%	Q1 achieved; Q2=72%Q3=8 5%;Q4=91%	Green

CQUINs	Target	*Achieved (local data)	RAG Rating
Local CQUINs (CCGs)	Target		
Medication Safety Thermometer; increased reporting of organisation medication errors and embed systems of learning from these errors and improving practice	100% of audits completed on 10 wards & demonstrate 2 areas of improvement	92%	Amber
Stroke Early Supported Discharge (ESD); to be supporting a fully functioning multi-disciplinary ESD team which has 7 day service coverage and has both quality and length of stay improvements for patients and carers; 10% reduction in LOS from 1516 baseline by Quarter 4 - Full Year; Carer Survey and Patient Experience Surveys carried out; Care Plan Audit Undertaken	20.2 LOS & audits submitted	100%	Green
Patient Flow; improving patient flow by using microsystems and a quality improvement programme; 4 microsystems identified in 4 wards and booklets submitted as evidence	16 microsystems evidenced	100%	Green
Domestic Abuse; Develop Training, Introduce a system to identify and flag on systems those who may be abused or other vulnerable patients, Introduce DASH Risk Assessment in A&E, Set up Domestic Abuse Champions, be involved in Kent Domestic Abuse Health Subgroup.	Identification of Eligible Patients	100%	Green
ED Hour to Access; arrival time in ED to contact with decision making clinician <60 mins	Q1 establish process; Q2=50%;Q3=55 %Q4=60%	100%	Green
NHS England CQUINs	**Target**		
Enhanced Supportive Care (ESC) Access for Advanced Cancer Patients; Audit of % of patients referred to Supportive Care Team out of total number of new diagnosis of incurable disease, Clinical Champion Nominated and engagement with National Peer Group	Establish process & audit	100%	Green
Clinical Utilisation Review (CUR) Installation and implementation; reduction in inappropriate hospital utilisation; Quarterly Reports on Progress and Delays pre go live, Quarterly data output reports post go live	Establish process and rollout of system	100%	Green
Activation System for Patients with Long Term Conditions (LTC's)- Chronic Obstructive Pulmonary Disease (COPD) and Irritable Bowel Syndrome (IBD) 1). Planning & Set Up - Year 1. 2). Team Building. 3). Elicitation of Activation information via the PAM. 4). Analysis & response	300 questionnaires	100%	Green
Adult Critical Care Timely Discharge; to reduce delayed discharges from Intensive Care to ward level care by improving bed management in ward based care, thus removing delays and improving flow. 30% reduction over the year in >24hr delayed discharges from Critical Care. 2014/15 baseline	30% reduction	50%	Amber

Commentary

In this section we highlight some of the CQUIN improvements and developments in 2016/17, including what we have achieved and what has challenged us.

National CQUINs:

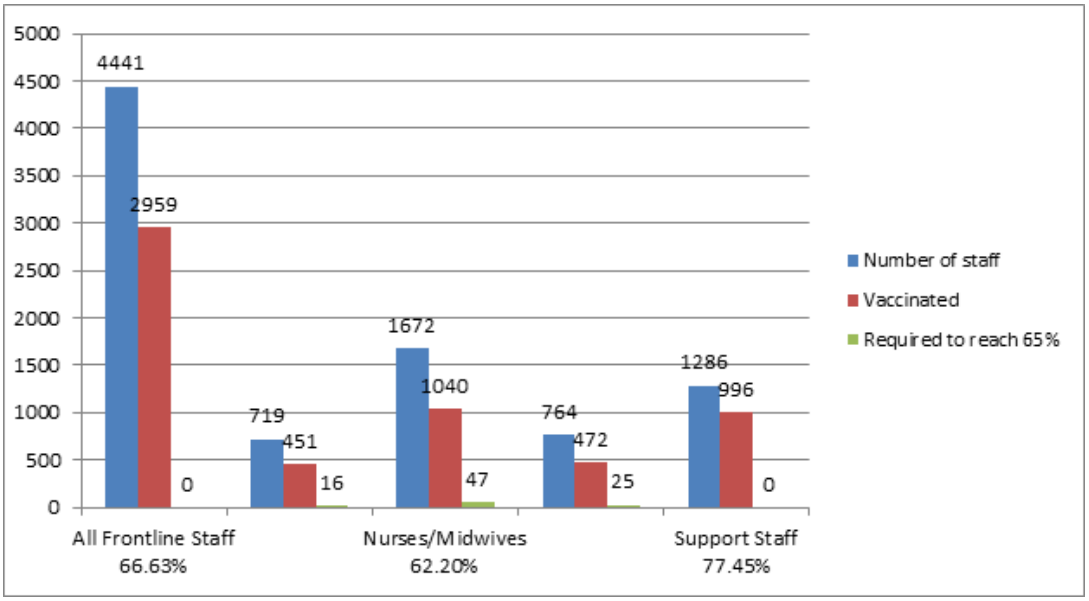
The Trust successfully achieved the National CQUIN to ensure the appropriate identification and management of patients, who attended Accident & Emergency or were later diagnosed with SEPSIS as an inpatient, with the exception of Quarter 1 for the identification of Sepsis in the inpatient category. This was due to a failure to identify any inpatients in the random sample which did not meet national guidance, hereafter we strengthened the processes and consistently achieved the stretch targets set. This work has been achieved through the co-ordination and multi-disciplinary team working of the SEPSIS committee and the enthusiasm of our staff. This agenda has ensured that the pathways and protocols for Sepsis have been reviewed and the introduction of a SEPSIS sticker to support our medical and nursing teams in its prompt treatment whilst improving patient outcomes.

"The one piece of advice I have for others is to be aware of the symptoms of sepsis. I knew nothing about it before this happened to me but the reality is, it kills more people than a lot of more widely understood illnesses. I am very keen to raise awareness of sepsis wherever I can – the more people who are aware of the condition, the more lives may be saved."

"I would like to take this opportunity to thank everyone involved in my care, but particular thanks must go to the paramedics, doctors and nurses that worked tirelessly to treat me, because they quite literally saved my life."

For further patient's experiences visit-
https://www.mtw.nhs.uk/?s=patient+first

Ensuring that our frontline staff were immunised for flu this year was particularly challenging as the maximum we'd previously achieved was 45% in 2015/16. The efforts made in collaboration with our Communications team helped to raise some competitive spirit within our workforce and thereby ensuring that 66.6% of our frontline staff were immunised for flu. This was a tremendous achievement with the additional benefits of reducing sickness and protecting and caring for our patients at the same time.



Frontline Staff Immunised for Flu Sept-Dec 2016

Local CQUINs:

The Trust has also made significant improvements in the number of patients seen by a decision-making clinician within 60 minutes of arrival in the Emergency Department exceeding the national target of 50% at 60.02% for the year. This was a target that we had failed to achieve last year so

this year our Emergency department team introduced several initiatives to ensure our patients were promptly seen and treated. These initiatives included a revised rapid assessment model and a review of the staffing model to complement the rising demand for emergency care at peak times and days of the week, all of which supported us in this achievement.

The Stroke Early Supported Discharge (ESD) Teams have worked successfully in collaboration with the Stroke Multidisciplinary Team in ensuring safe and effective discharge of our patients. This has been evidenced through our improvements in reducing the Length of Stay for Stroke Patients by 10% to an average 19.52 days and through the patient and carer's experience surveys that were undertaken. We also undertook an audit of the health and social care plan and made subsequent improvements to this document which we are confident will benefit our patient's further.

We have also worked collaboratively with West Kent CCG in regard to 'Improving Patient Flow' within four of our wards, two at Tunbridge Wells and two at Maidstone hospital. The CCG provided microsystem coaches to work with each multidisciplinary team to identify four areas of improvement that they each felt would benefit our patients and make further efficiencies in their pathways of care, these have included the establishment of 'Board Rounds' to expedite actions that will make the greatest impact on that patient's care, improving transfer times to the Discharge lounge on the day of discharge, improving pre-operative nutrition and improving communication between teams and specialities. Both the Trust and our Commissioners were complimentary of the benefits achieved through this collaboration and the insight that this gave them. This has also established firm grounds for future projects together to improve patient care.

NHS England CQUINs:

The Trust successfully achieved all of the NHS England CQUINs with the exception of the reduction in length of stay of less than 24hrs in Adult critical Care. This CQUIN concentrated on the Trust's ability to discharge medically fit patients to an acute ward within 24hrs. Due to a spike in activity in the summer of 2016, the Trust did not achieve the milestones set in Quarter 1 & 2, however we successfully achieved the milestones set in Quarter 3 & 4 and showed a remarkable improvement across the year, which also improved our effectiveness in patient flow and patient experience.

The CUR CQUIN has proved to be difficult to manage due to the prolonged delay in the installation of our new Patient administration system. However a decision was made in Q3 to install CUR onto the existing system and thanks to the great efforts made by our staff we were able to ensure that CUR was implemented across 400 beds by the end of March 2016.

Staff encountered numerous information technology (IT) issues in submitting the data to NHS England for the Long-term Conditions (LTC) CQUIN. However not only has the Trust met the milestone of 300 questionnaires for the LTC of Chronic Obstructive Pulmonary disease (COPD) and Irritable Bowel Disease (IBD), but it has met all other aspects of the CQUIN to the satisfaction of NHS England.

Statements from the CQC

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

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

The CQC inspection findings concluded with 1 enforcement notice and 18 compliance actions. The Trust welcomed the report and considered its findings to be fair. A Quality Improvement Plan was developed and progress was monitored at Board.

The enforcement notice relating to annual water sampling for legionella was responded to immediately with actions undertaken to address the issue and ensure governance is now in place to prevent the risk of re-occurrence. The CQC visited Maidstone hospital on 30th June 2015 to review evidence submitted in practice and the enforcement notice was lifted by the CQC In September 2015.

There have been a number of substantial improvements since the report was published. These include:

- The appointment of a dedicated Staff engagement and Equality lead.
- New provider of Translation services is in place.
- Consultant working patterns in ITU are fully compliant to ICU standards and include twice daily ward rounds every day.
- Critical Care outreach service is in place 24/7.
- A revised governance committee structure was implemented with a clear ward to board communication/ escalation process.
- Paediatric Early Warning system is utilised in paediatric services including paediatric A&E.
- Water hygiene management is now fully compliant with statutory requirements with robust governance and management in place.
- Shower and toileting facilities are in place for our patients in ITU.
- Review of the functionality of both Clinical Decision units in A&E so that privacy & dignity standards now meet compliance.

The Quality Improvement Plan was finally accepted and closed at Trust Board in May 2016, however ongoing work in terms of CQC preparedness and internal scrutiny via the Trust Internal Assurance inspections remains as part of our day to day business and is monitored through the Trust's Quality Committee.

Improving data quality at MTW

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

Specifically, MTW needs to ensure its information is:

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

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

The Trust develops a workplan for the Data Quality Steering Group annually which is influenced by national and contractual data quality standards as well as local initiatives for targeted improvements.

Recommendations and remedial actions are discussed and forwarded to appropriate areas.

Areas identified for improvement during 2016/17 were:-

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

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

- which included the patient‘s valid NHS number was (as at Month 11):
  99.1% (98.9% 15/16) for Admitted Patient Care;
  99.3% (98.4% 15/16) for Outpatient Care; and
  97.1% (96.0% 15/16) for Accident and Emergency Care.

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

Information Governance Toolkit

The Information Governance Toolkit is a performance tool produced by the NHS Digital (formerly the Health and Social Care Information Centre). It draws together the legal rules and central guidance related to Information Governance. The Trust achieved a score of 74% (72% in 2015/16) satisfactory (Green in the toolkit grading scheme) against the Information Governance Toolkit Version 14, and achieved 10 (8 in 2015/16) of the 45 requirements at level 3. The remaining requirements were achieved at level 2 as required by the Operating Framework for England for 2011/12.

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

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

Clinical Coding

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

In 2016/17 a **Clinical Coding audit and process review** was undertaken by Maxwell Stanley Ltd on behalf of MTW which was released in March 2017. The audit scored the Trust at Level 3 using the IG Toolkit's scoring mechanism. The recommendations within the audit report have been fed into an action plan to address the issues identified.

Attainment Levels	
0	Work has begun to develop the policies, procedures and/or processes that are necessary to become compliant
1	Work has begun to develop the policies, procedures and/or processes that are necessary to become compliant
2	there are approved and implemented IG policies and procedures in place that have been made available to all relevant staff
3	staff compliance and the effectiveness of the policies and procedures is monitored and assured

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

Part Three

Results and Achievements for the 2016/17 improvement initiatives

Patient Safety

Aim/Goal

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

Action	Update
Introduce a central database to monitor all actions agreed following Serious Incidents reported to Learning and Improvement committee (SI panel) ○ Monitor SI action plans monthly at the Learning and Improvement Committee (SI Panel) via exception report ○ Ensure 90% actions are completed within designated timeframes and 100% actions completed within 1 year of a Serious Incident or Red Complaint.	• *The Patient Safety team have developed and implemented a new monitoring database, with all new action plans being directly entered, upon agreement at the Learning & Improvement panel. The process of adding action plans that remain open is almost complete* ○ *Action plans that are overdue are escalated within the relevant Directorate to the Directorate leads and the AD for Quality Governance* ○ *The database that has been developed to support our actions plans currently does not include complaints, nor does it have the ability to statistically validate completion dates. This action therefore has not been achieved.* *Manual extraction of our data currently reports Serious Incidents to have reached a 42% completion rate for those actions that have reached their completion target dates. However the Complaints data is currently reporting 14.3% for entire action plans rather than individual actions which may have increased compliance.*
Actions agreed as a result of Serious Incidents and Complaints to be tested in practice through the internal assurance review programme and executive / non-executive walkabout. ○ Testing in practice for all SI's and Red Complaints from previous 12 months to be included in internal assurance and included within the internal assurance review reports (100%)	• *Patient Safety and Complaints teams provide information to the Inspection teams in regard to Actions that have previously been agreed for the area being visited to develop Key lines of Enquiry (KLOE's)* • *Eight internal Assurance Inspections have been undertaken this year and compliance with the Directorates previously agreed action plans have been positively tested in terms of staff knowledge or in actions demonstrated, these are then captured in the Directorate reports and reported to the Trust Clinical Governance Committee.*
Improvements as a result of learning from all	• *Governance Gazette is published monthly with*

Serious Incidents and Red Complaints to be shared in a staff monthly newsletter and on the intranet and website (100% where disclosable)	*each edition dedicating a section to learning from complaints and serious incidents.* • *Use of Chief Executives Newsletter to communicate key themes* • *Annual Complaints report published on Trust website* • *Governance presentations at Directorate Clinical Governance*
Improvements to in-hospital falls prevention with a reduction in falls rates to a target of less than 6.2 per occupied bed-days by end of March 2017	• *Establishment of the Falls Task & Finish Group chaired by the Chief Nurse* • *Policy & Procedure for Falls was reviewed and revised* • *Terms of reference for Slips, Trips and Falls group was reviewed* • *The Period of increase Incidence (PII) monitoring framework for falls was revised* • *Threshold for falls number on each ward/unit was set* • *Monthly falls data by ward sent out to all ward managers* • *Falls dashboard established.* • *Nursing assessment documents for falls prevention have been reviewed.* • *Screen saver with falls prevention message instigated* • *The cumulative position for 2016/17 was 6.07 per 1000 occupied bed days against a plan of 6.2 therefore objective delivered. (Further detail can be found on p53)*
Improvements as a result of learning from the review of in-hospital mortalities ○ By end of March 2017, 75% of all in hospital mortalities (excluding A&E only admissions) to be reviewed and submitted to the central database ○ Learning identified via individual mortality review process to be collated and reported at each Mortality Surveillance Group meeting from August 2016 onwards. This learning to be fed back to departments via Directorate Clinical Governance meetings.	• *Establishment of the Mortality Surveillance Group (MSG) and mortality review process.* • *Establishment of data reporting tool and monthly Directorate Reports produced* • *Deep dive into fractured neck of femurs undertaken with Directorate and Dr Foster to further understand anomalies in SHMI/HSMR data for MTW.* • *Submission of Mortality review data and learning identified has been formally recorded in the minutes of the MSG. In addition a six monthly review of learning was presented to the MSG and to the Trust Clinical Governance Committee for onward discussion at Directorate Clinical Governance Meetings.* • *Year-end percentage achieved for hospital mortality reviews undertaken is 43% against our plan of 75%. This action was not achieved but sustained improvement has been evidenced.* ○ *Quarter 1 = 29.67%* ○ *Quarter 2 = 50.67%* ○ *Quarter 3 = 60.67%* ○ *Quarter 4 = 31.0% (data collection ongoing)*

Patient Experience

Aim/goal

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

Action	Update
Friends & Family results to be clearly and consistently displayed within departments including actions and improvements as a result of qualitative feedback ○ Set up a task and finish group by September 2016 to re-establish a process to consistently gather and display patient feedback. ○ 85% of areas will display their FFT positive response rates and their actions to support improvements by March 2017 ○ By March 2017 the Trust will achieve 25% response rates in FFT in all adult inpatient and Maternity Services and 15% response rate for Accident & Emergency services.	• *The Friends & Family project group has been established and continues to lead the organisational approach to embedding the friends & family test into practice. The membership of this group includes a member of Healthwatch in addition to Trust staff.* • *Results over the last year have shown an inconsistency in response rates; whilst this can be largely attributable to increased operational pressures we acknowledge that further work is required.* • *There has been a renewed focus within the project team to reenergise the teams in practice as an opportunity to engage feedback from our patients.* • *'How we are doing' boards can be evidenced in each Ward/Department however ensuring that the FFT data remains current has been a challenge identified by the Quality Assurance Inspections.* • *Monthly agenda item for Nurse Education & Learning Forum (NELF)- ward managers are presenting their FFT to share learning and best practice and importantly to share the positive feedback that so many of our patients provide.* • *We achieved 26.6% for Maternity & 23.3% for Inpatients – objective partly met; A&E achieved 15.5% - objective met.* • *Implementation of our new contract with 'iwantgreatcare' has also supported a renewed focus and they have supported the organisation to undertake a case study on successes within our emergency departments which will then be shared across directorates to promote learning.*
Positive feedback / plaudits to be gathered and shared in a more robust way with staff to ensure good practices are acknowledged and become drivers for improvement ○ Implementation of a new system which enables staff to upload plaudits and positive feedback.	• *A section for feedback/plaudits is integrated within the Directorate reports which report initially to the Clinical Governance Committee.* • *Collaboration with the Communications team ensures that these are also publicised in the CEO's weekly update.* • *The 'iwantgreatcare' database also has a facility that enables us to extract individual feedback for our staff who can then use this as supportive evidence for their appraisals and revalidation.*
Working with Healthwatch Kent, consider and implement different ways of listening to staff	• *Patient representatives from Healthwatch continue to support the Trust in a number of patient focussed initiatives.*

and service users to drive improvements (such as listening events, better use of social media and technology) ○ The Trust will engage with Healthwatch to undertake at least one listening event per quarter and continue to facilitate and respond to 'Enter and View' visits at least twice per year.	• *They have also supported us on our Internal Assurance Inspections.* • *In September an 'Enter & View' visit was undertaken in our Outpatient department.* • *Healthwatch have also commenced a review of the discharge experience of our patients.*

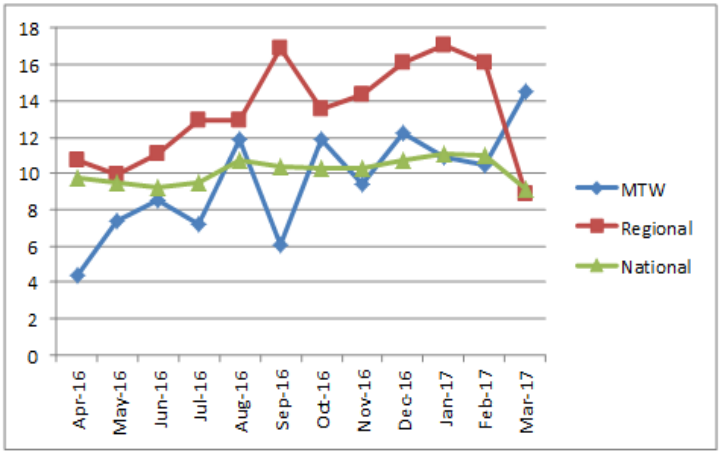
Clinical Effectiveness

Aim/Goal

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

Action	Update
Sustained reduction in length of stay achieved through (but not exclusively) the full implementation of SAFER Discharge Bundle. To achieve the outputs and timeframes agreed at the Timely Effective Safe (TES) Steering Group.	• *7.83 days reported for the Non-elective Length of Stay for Mar-17 against the Trust phased target of 6.8 days. For the year the average LOS was 7.72 days.* • *The Elective LOS is 2.97 days for March discharges against the phased target of 3.2. 3.29 for the year* • *Percentage delayed of occupied bed-days fell back from 7.11% in Feb to 6.17% in March (lowest level since June 16)* • *Full year attendances are 4.2% higher than last year, and A&E admissions 17.6% higher. Mar type 1 attendances were 4.7% down on last March.* • *Therefore despite higher attendances and admissions, LOS has remained stable from the previous year* • *Implementation of SAFER bundle across all wards – roll out over all medical and surgical wards on 2 sites over 18 weeks from March 16* • *Ongoing work to continue to implement SAFER through focus groups with junior doctors, weekly meetings with nursing staff, clinical governance sessions with Medical Director. Audit of SAFER on wards to identify gaps. Led by Clinical Lead CD for Diagnostics/ Infection Control* • *SOPs in place for Board rounds and criteria led discharges* • *Executive sponsor and Clinical lead, robust governance structure* • *Link into CCG A&E Delivery Board chaired by MTW Deputy Chief Executive* • *Home First pathway 1 rolled out to a number of*

	Maidstone wards, working with Local Referral Unit (LRU) • *Introduction of Clinical Utilisation Review (CUR) to identify patients which do not qualify for the acute sector* • *Electronic Discharge Notification (EDN) task and finish group led by CD for Diagnostics to simplify EDN process to be trialled early 2017* • *A&E performance for year-end was 87.1% (see p54 for further details).* • *We have also made significant improvements to our delays for patients waiting for transfer out of ITU during Quarter's 3 & 4 but failed to deliver the required reduction in Q1 & 2 (NHS England CQUIN).* • *Reduction in LOS for Stroke patients in Quarter 4 by 10% to achieve an average of 19.52 days (Local CQUIN)*

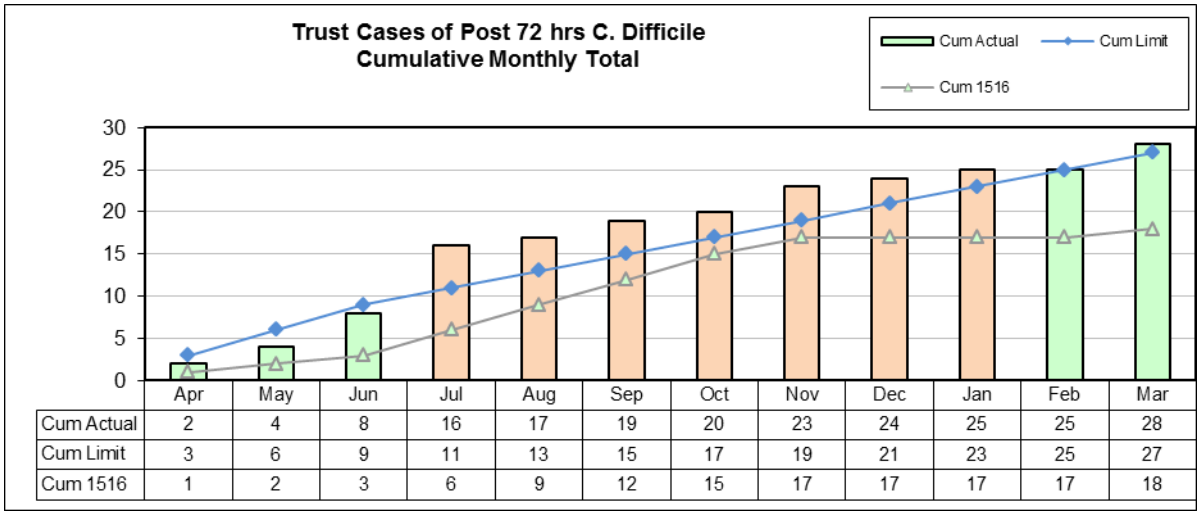
Sustain one ring-fenced bed for Stroke patients at Maidstone at all times and two on the TWH site (90% by March 2017). Sustain one ring-fenced bed on W31 at TWH for fractured neck of femur patients at all times (90% by March 2017).	• *The availability of ring fenced beds for Stroke and fractured neck of femur are reported at each site meeting. If ring fenced beds are not available, this becomes a priority for the Clinical Site team to achieve before the next site meeting.*
	• *The Sentinel Stroke National Audit Programme (SSNAP) also records the timeliness of admission to a Stroke Unit.* ***% patients direct admission to Stroke Unit <4hrs-60% target***
	  ○ *Trust 54.2% (↑5.7% 2015/16)*
	  ○ *TWH 50.1% (↑9.1% 2015/16)*
	  ○ *MGH 58.4% (↑3.6% 2015/16)*
	• *The National Hip Fracture Database (NHFD) has also started monitoring the time to Ward for Fractured Neck of Femur patients, although we are unable to define an achievement percentage it is evident that we did not achieve the 90% target. However in comparison to the regional and national averages, it is evident that as an organisation we continue to perform well as demonstrated in the graph below. (Data entry for March for all organisations is not currently complete).*
	 
	
	Average Time To Orthopaedic Ward 2016/17

Embed new ambulatory pathways on Acute Medical Unit (AMU) at Tunbridge Wells Hospital to achieve a 10% reduction (minimum) from March 2016 baseline in admitted patients from the	• *Ambulatory pathways across all specialties* • *T&O cellulitis ambulatory pathways set up* • *Embedding of surgical ambulatory pathways/ SAU* • *Escalation during winter months continues to be a barrier to full implementation*

medical take each day. The target is to be achieved by March 2017.	• *Medical ambulatory pathways being introduced gradually but escalation remains a problem.* • *Improved ED handover to specialties* • *Key stakeholders in fortnightly ED recovery task and finish group identifying actions to meet A&E standard and reduce admissions. ED recovery task and finish group reports into TES (Timely Effective Safe) Steering Group. Robust governance.* • *Due to the 4.2% increase in attendances that we experienced we were unable to achieve the planned reduction in patients admitted.*

Review of Quality Performance

Infection Control – Clostridium Difficile cases – The Trust did not achieve this standard with 28 cases against a maximum of 27 cases for the year equating to a rate of 10.5 CDifficile Case per 1,000 occupied beddays

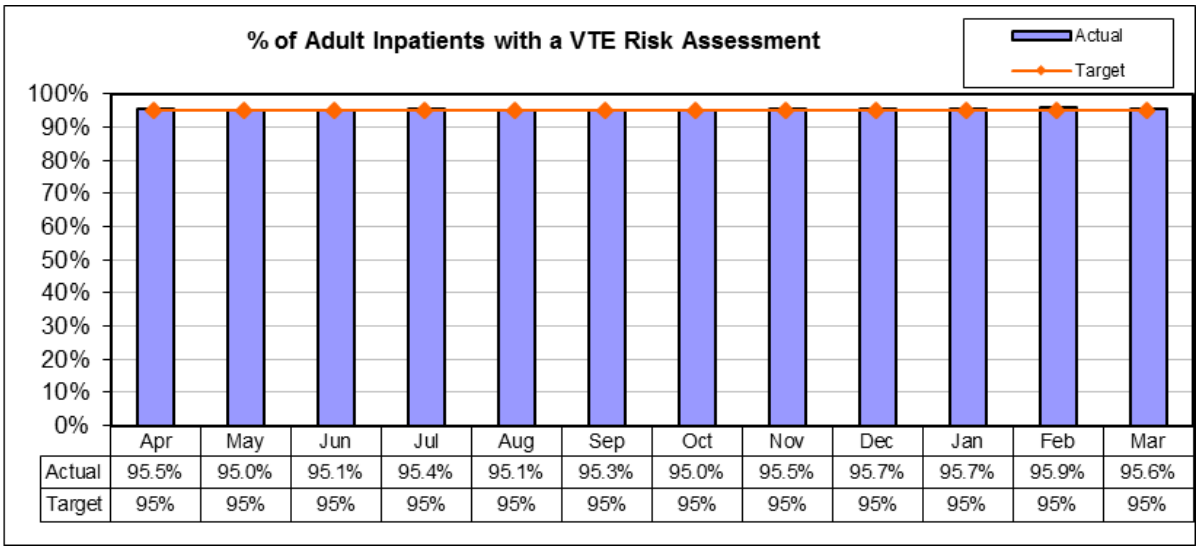


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cum Actual	2	4	8	16	17	19	20	23	24	25	25	28
Cum Limit	3	6	9	11	13	15	17	19	21	23	25	27
Cum 1516	1	2	3	6	9	12	15	17	17	17	17	18

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

Prevention of blood clots or venous thromboembolism (VTE)

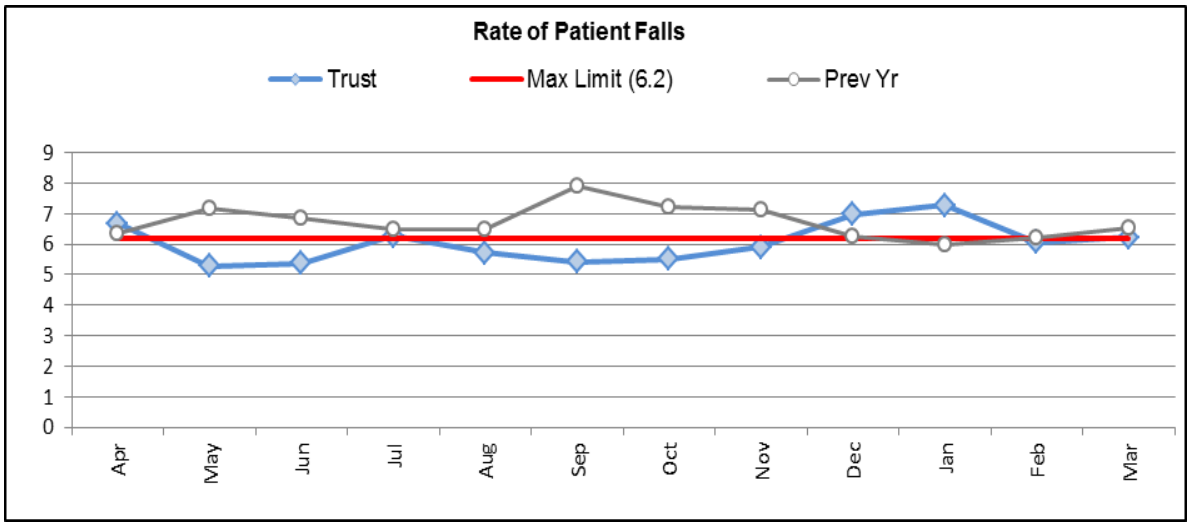
% Patients VTE Risk Assessment – The Trust ensured that 95% of patients were given a VTE Risk Assessment in 2016-17.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	95.5%	95.0%	95.1%	95.4%	95.1%	95.3%	95.0%	95.5%	95.7%	95.7%	95.9%	95.6%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

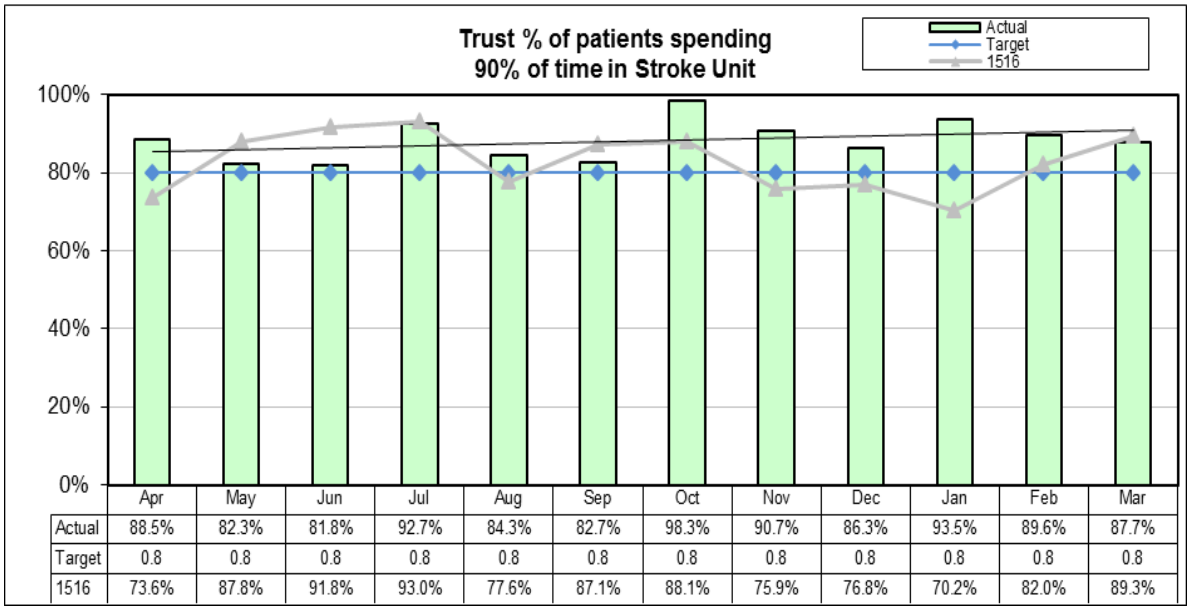
Reducing the number of patient falls

Rate of Falls – The Trust's rate of Falls per 1,000 Occupied Bed days is below the Trust maximum limit of 6.2 at 6.07 for the year (6.69 for the previous year). The number of falls reported in 2016/17 was 1613 (7 fewer than the previous year).



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

80% of patients spending 90% of time on the Stroke Unit - The Trust achieved this standard of 80% of stroke patients to spend 90% of their time on a dedicated stroke ward in 2016-17 at 82.4%.

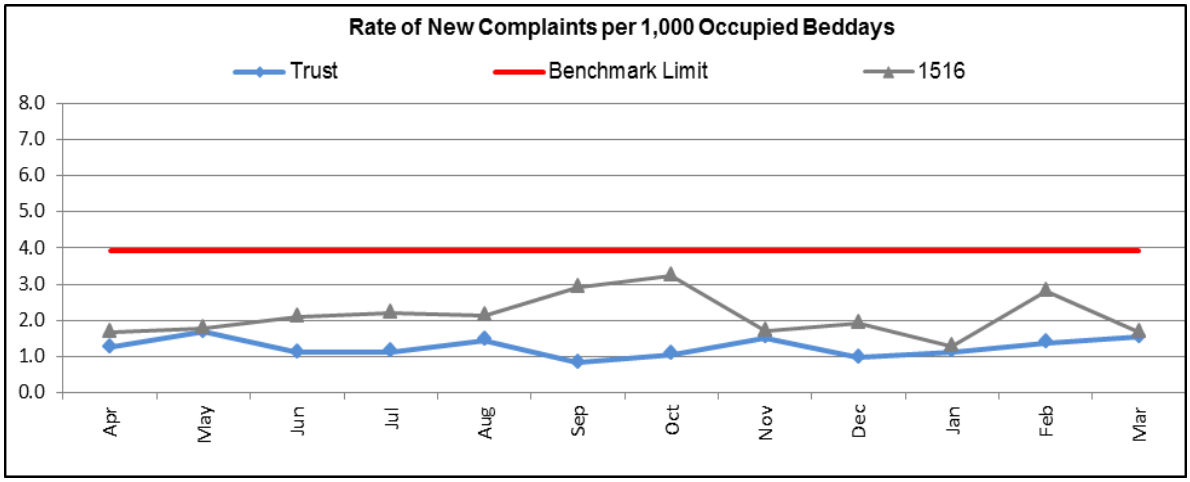


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	88.5%	82.3%	81.8%	92.7%	84.3%	82.7%	98.3%	90.7%	86.3%	93.5%	89.6%	87.7%
Target	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8
1516	73.6%	87.8%	91.8%	93.0%	77.6%	87.1%	88.1%	75.9%	76.8%	70.2%	82.0%	89.3%

PATIENT EXPERIENCE

Complaints management

Rate of New Complaints- The Trust's rate of New Complaints per 1,000 episodes is below the expected range of between 1.32 and 3.92 at 1.25 for the year (4.06 for the previous year). The number of new complaints received in 2016/17 is a 35% reduction (-178) from the previous year.



Complaints report summary

(Regulation 18 of the Local Authority, Social Services and NHS Complaints (England Regulations 2009). Presented and discussed at MTW Quality Committee in July 2016.

The Trust has a statutory duty to investigate and respond to complaints in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 (the regulations). This statutory obligation is further supported by the Trust's values – PRIDE – which highlight the importance of being customer focused and striving for continuous improvement. Whilst complaints are often considered to have a negative connotation, we recognise that they are also valued methods of feedback and can highlight shortfalls in current practice or policy. This feedback is essential in helping us to improve the quality of our services and the way in which we engage with our patients and their visitors**.** This includes being open and honest and saying sorry when it is required.

> As you will note from the opening and closing paragraphs of my original complaint, all that was sought was an acceptance by the Trust that certain care fell below an appropriate standard; an apology; and some reassurance that the Trust would perhaps learn from the experience. I believe that as a result of your efforts and this response, all three of these objectives have been achieved. …..in view of the above and in agreement with my siblings, I confirm that your response and apology bring this complaint to a satisfactory conclusion.
>
> Complainant

During 2016/17 we received 332 new complaints compared to 510 during 2015/16. The rate of complaints per 1,000 occupied bed-days was 1.25 for the year (lowest/highest decile range of 1.32 to 3.92). It is our aim to investigate and provide a full response to all formal complaints within an agreed timeframe of either 25 or 60 working days of the complaint being received, depending on the severity of the complaint. We responded to 69% of complaints within the agreed timescale against a target of 75%. Although we have seen some improvements in performance on a monthly basis we have been unable to consistently sustain this. We are confident in our complaints handling approach; however recruitment challenges have negatively impacted upon this performance standard that we know to be achievable. We remain optimistic that we can meet these standards in 2017/18.

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

Patient Surveys

National Patient Surveys

During 2016 the Trust undertook three National Surveys. Although they are led by Picker Europe and the CQC we have been undertaking these in house. The surveys were the following:

- Emergency Department Survey.
- Children and Young Persons Survey.
- Adult Inpatient Survey.

The Emergency Department survey runs bi-annually and was previously run in 2014. The Inpatient Survey is run on an annual basis. The Children and Young Persons Survey was a further survey added to the NHS Patient experience survey programme. This survey is still in the data collection stage.

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

Adult Inpatient Survey 2016

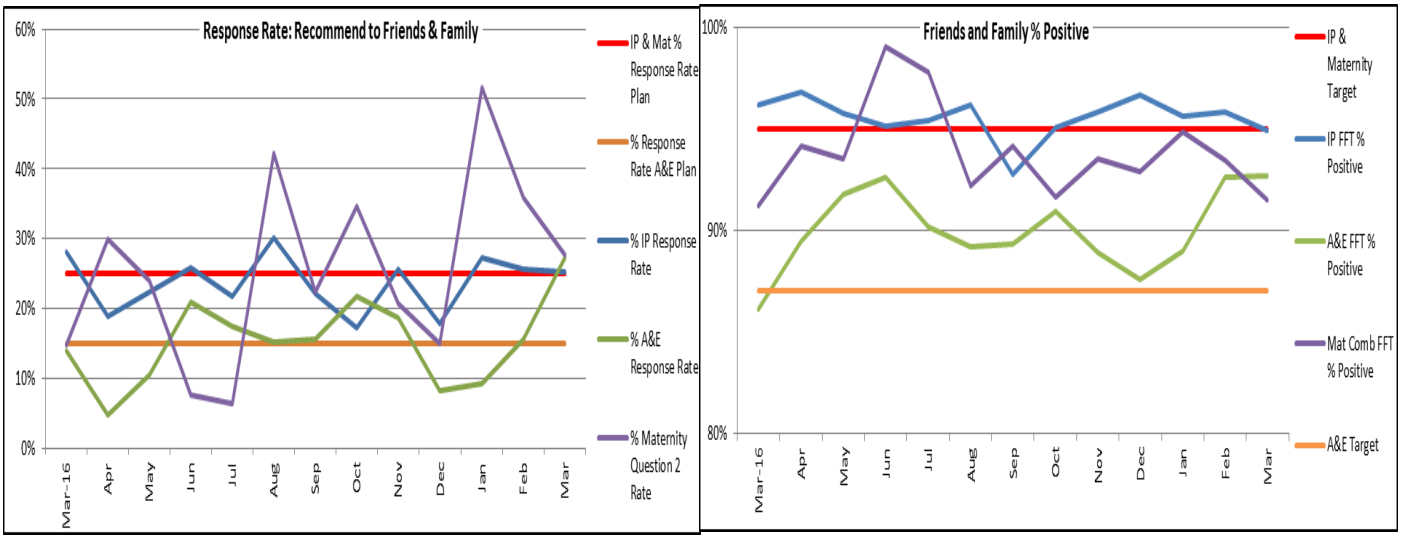
Focus questions from National Inpatient Survey		National Inpatient Survey	
		2016	2015
1	Were you involved as much as you wanted to be in decisions about your care and treatment?	91.0%	91.7%
2	Did you find someone on the hospital staff to talk to about your worries and fears?	47.7%	46.9%
3	Were you given enough privacy when discussing your condition or treatment	92.8%	95.8%
4	Did a member of staff tell you about medication side-effects to watch for when you went home?	39.4%	39.3%
5	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	66.3%	69.1%

Friends and Family

The inpatient and A&E positive response rates (95.5%, 90.7% respectively) have exceeded the Trust Plan indicating that patients would recommend the Trust to their Friends and Family. However the Inpatient positive response rate narrowly missed the national benchmark of 95.8% at 95.5%. Maternity did not meet either the Trust target of 95% and the national benchmark of 95.6% at 93.6%.

Maternity and A&E response rates however both exceeded the planned Trust rate and the national benchmarks at 26.6% and 15.5% respectively, whereas the Inpatient response rate did not achieve either at 23.3%.

MTW Friends and Family scoring



Staff Survey 2016

This section outlines our most recent staff survey results for indicators KF26 (percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months) and KF21 (percentage believing that the Trust provides equal opportunities for career progressions or promotion) for the Workforce Race Equality Standard.

KEY FINDING 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
This is reported at 25% which is a 3% increase from the 2015 survey findings and is the same as the National 2016 average for acute Trusts

The unweighted scores for KF 25, 26 and 21 split between White and BME staff is as follows:
White 25% (2015 findings – 21%) (National average for acute Trusts – 24%)
BME 21% (2015 findings – 25%) (National average for acute Trusts – 27%)

KEY FINDING 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion
This is reported at 90% which is a 4% increase from the 2015 survey findings and is 3% higher than the National 2016 average for acute Trusts

The unweighted scores for KF 25, 26 and 21 split between White and BME staff is as follows:
White 89% (2015 findings – 89%) (National average for acute Trusts – 88%)
BME 91% (2015 findings – 71%) (National average for acute Trusts – 76%)

The Trust appointed a new Head of Staff Engagement and Equality in April 2016 who has gone on to implement a new translation service providing a one stop shop for all translation services including written translation, face to face, British Sign Language, Deaf/Blind services. The telephone translation service is available 24 hours a day, 7 days a week, 365 days a year.

The Workforce Race Equality Standard (WRES) and Equality Delivery System (EDS2) have been completed and published and the Trust has obtained Level 2 Disability Confident Employer status which replaced the Positive about Disability "Two Ticks" scheme in July 2016. A Cultural Diversity Network has been set up to celebrate the diverse cultural backgrounds of Trust staff, to provide support and career development advice and guidance and drive forward the WRES action plan.

Working with Stonewall the Trust are Diversity Champions and the Stonewall Workplace Equality Index completed in September 2016 demonstrates an increased score from 2015. Transgender Awareness Workshops delivered internally have been well attended and a Transgender Policy to support staff undergoing gender transition has been written. An LGBT survey, created in collaboration with Great Ormond Street Hospital to assess how members of our LGBT community are treated at the Trust was undertaken in January 2017. As a result of this, an LGBT Network Group will launch at the beginning of May.

The Trust's intranet and website have dedicated Equality & Diversity areas and bespoke Diversity training sessions have been delivered to Trust staff.

The year ahead will see the launch of a Disability Network Group, the review of mandatory Equality & Diversity training and the update of the Equality & Diversity Policy. Workforce Equality Data needs to be improved to ensure that information we report on the protected characteristics of the Equality Act is a true representation of our workforce and role models for those characteristics need to be identified at senior levels of the organisation.

Learning from Serious Incidents / Never Events

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

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

The Trust declared 115 serious incidents in 2016/2017 compared to 99 the previous year.

Of these 115 Serious Incidents, following a robust investigation it was identified there was no significant learning for the Trust and all appropriate actions were already in place for 15 of these. These cases were discussed with our Commissioners who agreed with our findings and that these cases no longer met the Serious Incident criteria and these were subsequently downgraded by them bringing our total incidents reported down to 100 during 2016/17.

Actions and learning from serious incidents are key to improving patient care and ensuring patients are safe and provided with high quality care. In 2016/2017 learning and actions included:-

- Review/introduction of the WHO safety checklist for interventional procedures in the Cardiac Catheter Lab and Radiology
- Improved patient information and discharge advice for those undergoing Gastrostomy tube placement and Colposcopy
- Revised Doctor handbooks to ensure awareness of procedures within the Trust and sign posting to key departments and policies/guidelines
- The process in theatres has been reviewed to ensure all staff working in the area are aware of their roles and responsibilities during the WHO safety checklist and “time out” process
- Individualised induction information for temporary staff ensuring they are aware of our expectations of the care they provide.
- Amendment of our Critical Medications guidelines and posters identifying what these medications are and the effects of not receiving them
- Enhanced care guidance and risk assessments in particular for those with a high risk of falls – we have reduced our falls rate to 6.07 per thousand bed days against a threshold of 6.2 which we had set to achieve.
- We have improved feedback and shared learning from incidents – this includes teaching sessions with junior doctors, sharing monthly reports with new starters and all trainees, monthly safety moments with a different theme and attendance at Directorate Clinical Governance sessions.

Never Events

There were 4 Never Events during 2016/2017, a full root cause analysis was undertaken and presented to the Executive led panel and findings shared with NHS Improvement to ensure wider learning.

The first Never Event was identified in July 2016 when during an emergency surgical operation a central line was inadvertently inserted into the right carotid artery instead of the right internal jugular vein. The line had been inserted during the surgery due to the patient’s clinical condition.

During the procedure the ultrasound device used to check the positioning, had failed. Following the procedure it was evident that the patient had developed severe weakness in their left arm and leg and was diagnosed with a stroke as a result of this error. The patient was subsequently transferred to a specialist unit for vascular surgery. The patient is undergoing extensive rehabilitation as a result of this error. Actions taken as a result included the dissemination of details of the incident with key points of learning. The Trust guidance for Central line insertion was updated.

The second Never Event identified in August 2016 related to a patient that had the wrong side knee component inserted. Although this does not appear to have had a discernible effect on the patient it was identified that the standard checking process was not implemented by all staff involved in the procedure. Actions implemented include the introduction of an implant collection form for all primary hip and knee replacements. The Standard Operating Procedure has also been amended to highlight each individual's responsibilities during surgical procedures. This event also included personal reflection and learning for the individuals present during the surgery.

The third Never Event identified in November 2016 occurred when a patient underwent one procedure as per their consent and healthcare records but following this the surgeon undertook a further procedure which they had not consented to which has had an indeterminate impact on their plans for the future and caused psychological distress. It was identified that the surgeon did not fully participate in the "Time out" and was therefore not clear on the order of the list. Staff present also did not challenge a procedure being undertaken that had not been consented for. Actions taken have included the sole reliance on the electronic theatre list on the theatreman IT system, to ensure that this will now be the only available list to be referred to. There was also a lack of verification with the patient's consent form and no challenge was made when an additional piece of equipment was requested—the WHO checklist has been amended to make it explicit that the procedure the patient has consented for is read aloud by the operating surgeon and this is then written on the whiteboard within theatres as a visual confirmation.

The fourth Never Event identified in February 2017 relates to a mis-placed Nasogastric Tube, this incident remains under investigation.

Duty of Candour

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

During 2016/17 we have demonstrated an increased compliance with the 3 elements of meeting duty of candour for patients involved in a serious incident. During 2016/17 our database can evidence that 3% of our patients have no evidence of a verbal apology being given to them compared to 12% the previous year. In addition 3% of patients involved in a Serious Incident did not receive an initial duty of candour letter in 2016/17 compared to 27% the previous year. Communicating the outcome of the investigation to the relevant person has also showed improved compliance with 55% of the 75% required in 2016/17 already completed with the remaining 20% still open and under investigation. This is compared to 63% compliance against a figure of 90% the previous year. There is on-going education with departmental managers with all initial letters being reviewed by the central team in terms of quality and compliance and to ensure there is an identified person and relevant address to aid communication of the outcome. The central team are

also concentrating on moderate incidents to improve compliance and this requirement will continue in 2017/18.

‘Sign up to Safety’ Safety Improvement Plan

MTW developed and agreed safety pledges in 2015 and developed a Safety Improvement plan that was rolled out during 2015/16 with a completion delivery date predicted as 2018/19.

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

These safety improvement domains form the heart of this organisation’s Safety Improvement Plan:

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

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

Progress made against agreed improvements during 2016/17 include:-

Improve communication during the hand over process:

- ✓ The organisation has invested in ‘Nerve-centre’, which is an IT based solution for monitoring of our patients and enables the use of early warning triggers to enhance the escalation of deteriorating patients.
- ✓ The establishment of integrated discharge teams aligned to wards who facilitate timely intervention and exchange of information within the multi-professional team.
- ✓ Establishment of 'board' rounds to enhance decision making within the team for daily care planning and review of progress on care pathways.

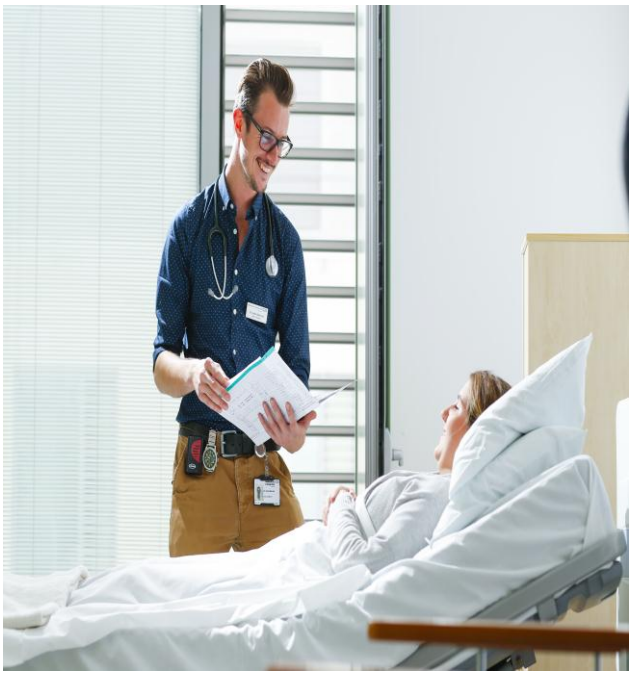
To improve the effectiveness of identifying and act on deviations from normal during labour and birth:-

- ✓ Implementation of a revised mandatory annual training programme using the PROMPT method of training: **PR**actical **O**bstetric **M**ulti-**P**rofessional **T**raining. PROMPT training helps develop the technical skills required in an emergency and also the non-technical skills, such as effective communication, calling for help effectively, team working, making the best use of the resources available, and delegation.
- ✓ In addition to the mandatory PROMPT training, the Trust provides access to High Fidelity Simulation Training for Obstetricians, Midwives, Anaesthetists and Theatre Practitioners.

- ✓ Increase in the number of consultants in Anaesthetics since 2012 with a trend towards a service that is increasingly consultant-delivered rather than simply consultant-led.
- ✓ The Trust now has increased Consultant cover in the maternity unit and increased Consultant Anaesthetist cover with one specifically designated to provide cover for the elective caesarean section list and a further Consultant Anaesthetist on duty for the Delivery Suite who has no other duties and is therefore available to attend emergencies.

To improve the quality of patient involvement in decision making and standards of obtaining informed consent:-

- ✓ Significant work has been undertaken within elective surgery to improve the consent process, including the implementation of a robust and timely availability of translation services.
- ✓ Further work is required for Urgent Care, End of Life Care and Medicines Management.
- ✓ The end of life steering group is looking at a number of initiatives to improve communication between patients and their families.
- ✓ A medications user group has also been established to improve patient involvement and engagement with strategies to understand and manage understanding of their medication regimes.
- ✓ The medicines information database (MAPS) has been fully implemented; this enables personalised production of medicines information at ward level.



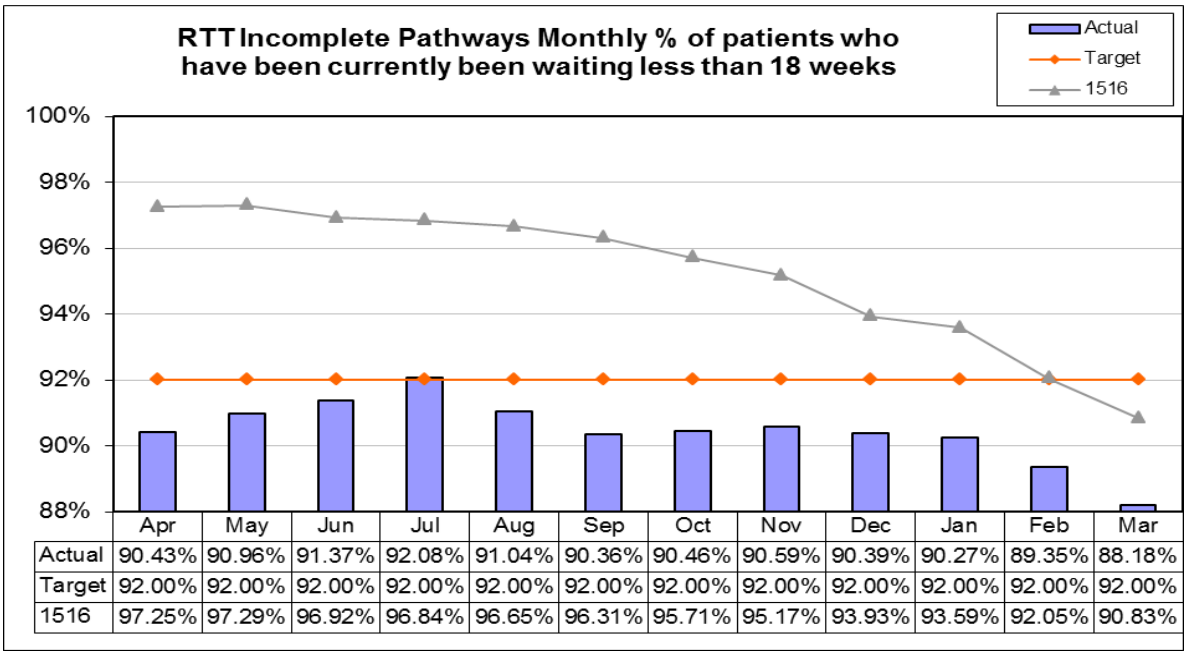
To reduce the number of patient falls:-

Significant work has been undertaken to reduce the number of falls culminating in a year end falls rate of 6.07 per 1000 bed days against an aim of 6.2. This was achieved through:-

- ✓ Establishment of the Falls Task & Finish Group which was chaired by the Chief Nurse.
- ✓ Terms of reference for Slips, Trips and Falls group was reviewed
- ✓ The Period of increase Incidence (PII) monitoring framework for falls was revised
- ✓ Threshold for falls number on each ward/unit was set and monitored by the Chief Nurse
- ✓ Monthly falls data by ward sent out to all ward managers
- ✓ Falls dashboard established.
- ✓ Nursing assessment documents for falls prevention have been reviewed.
- ✓ Safety Calendar Month of November focused on Falls Prevention
- ✓ Screen saver with falls prevention message instigated

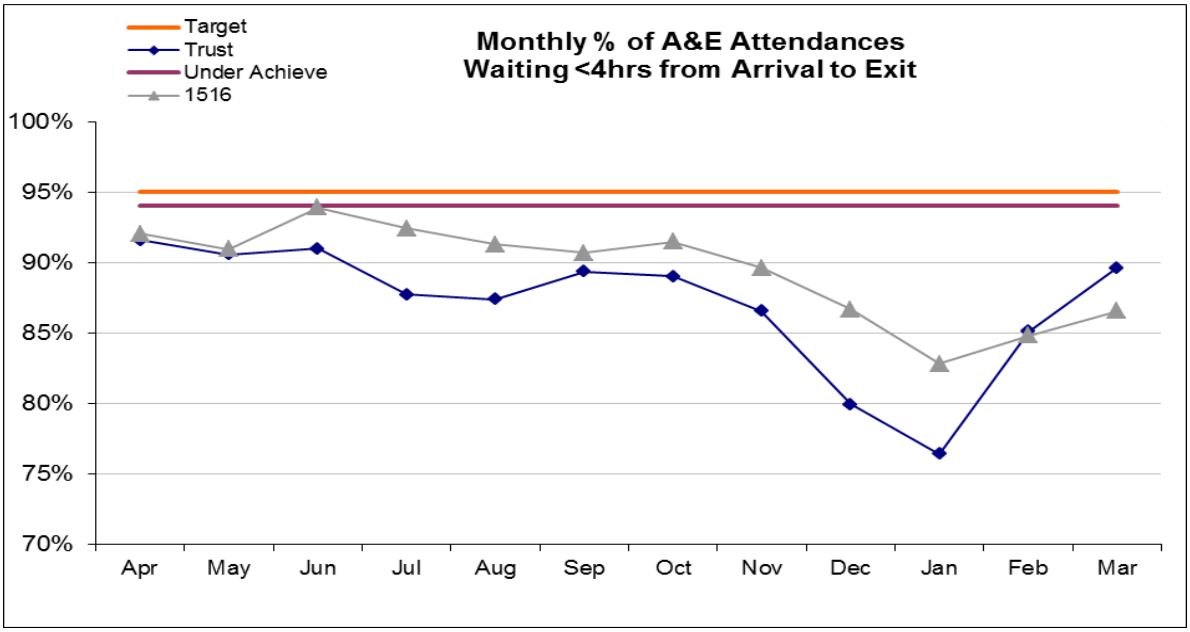
Other Quality Monitoring and Improvement Measures

18 weeks standard – The Trust did not achieve this standard at an aggregate Trust level of at least 92% of patients on an Incomplete Pathway had been waiting less than 18 weeks.

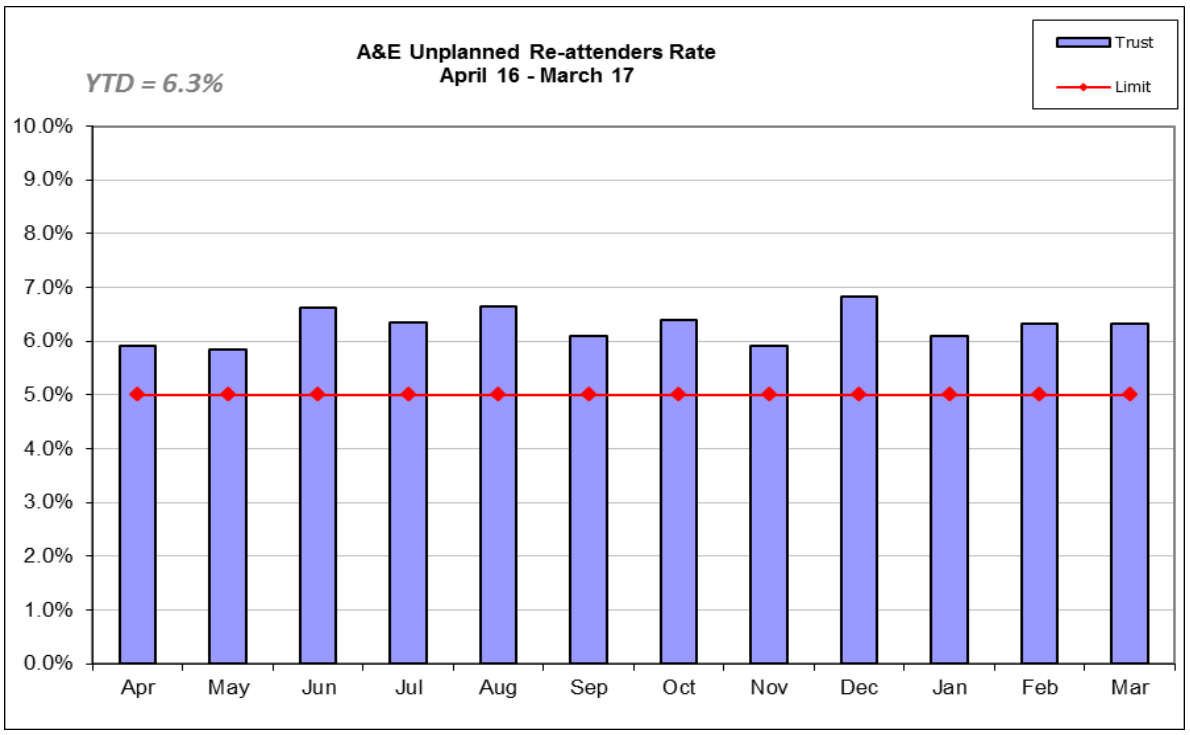


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	90.43%	90.96%	91.37%	92.08%	91.04%	90.36%	90.46%	90.59%	90.39%	90.27%	89.35%	88.18%
Target	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%
1516	97.25%	97.29%	96.92%	96.84%	96.65%	96.31%	95.71%	95.17%	93.93%	93.59%	92.05%	90.83%

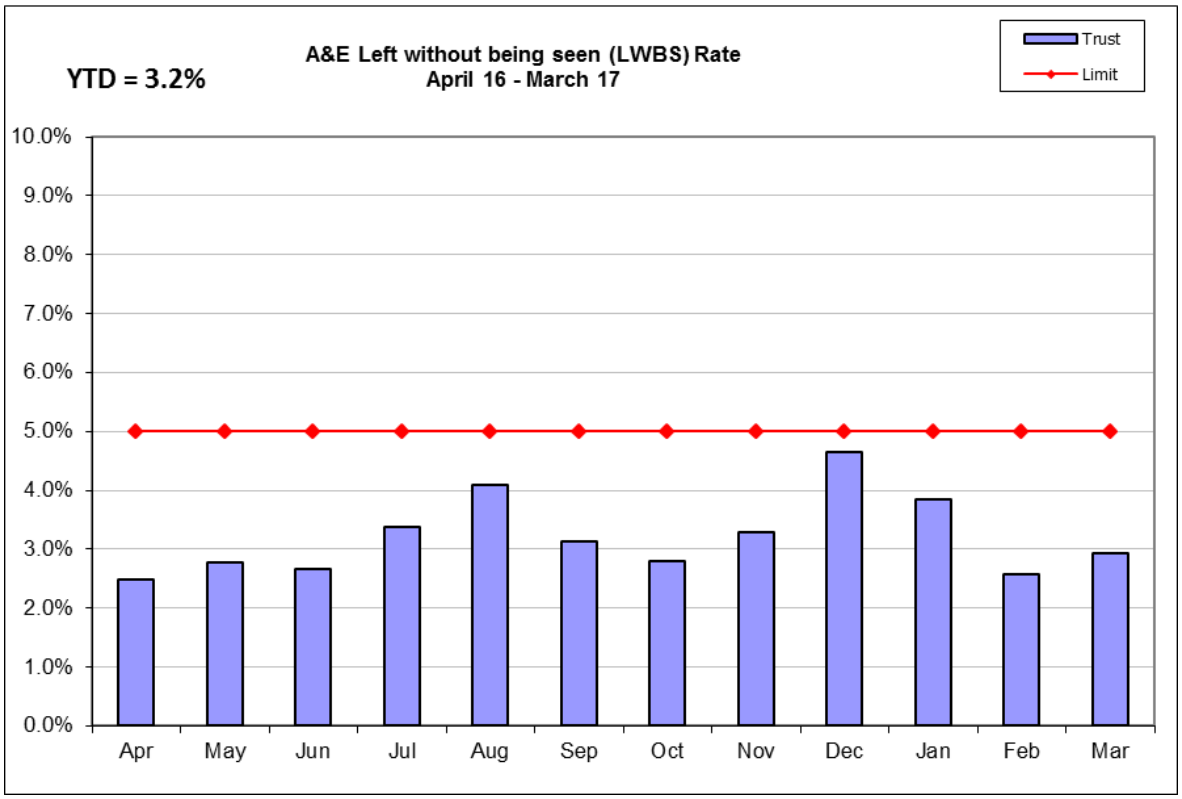
Emergency 4 hour access – The Trust did not achieve this standard of 95% of patients being seen, treated, admitted or discharged within 4 hours of arrival in its A&E departments in 2016-17 at 87.1%.



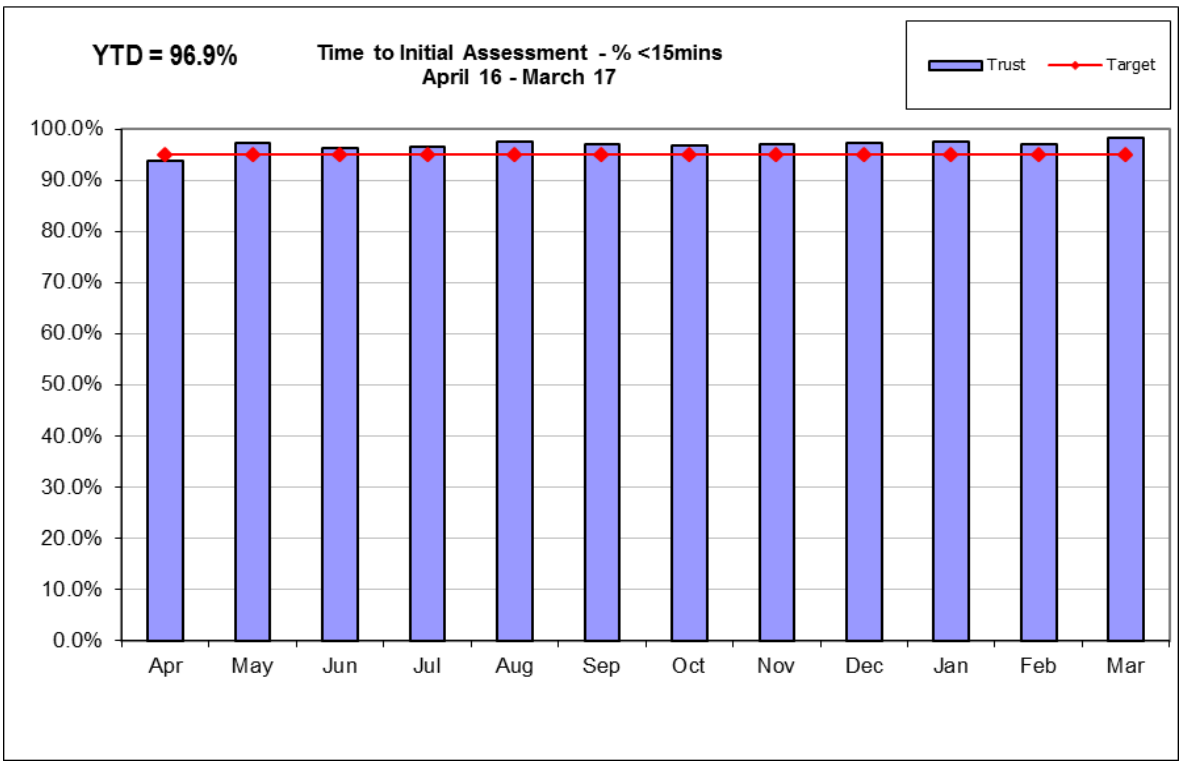
A&E Unplanned Re-attendance Rate – The Trust did not achieve this standard of less than 5% unplanned re-attendance rate at 6.3%.



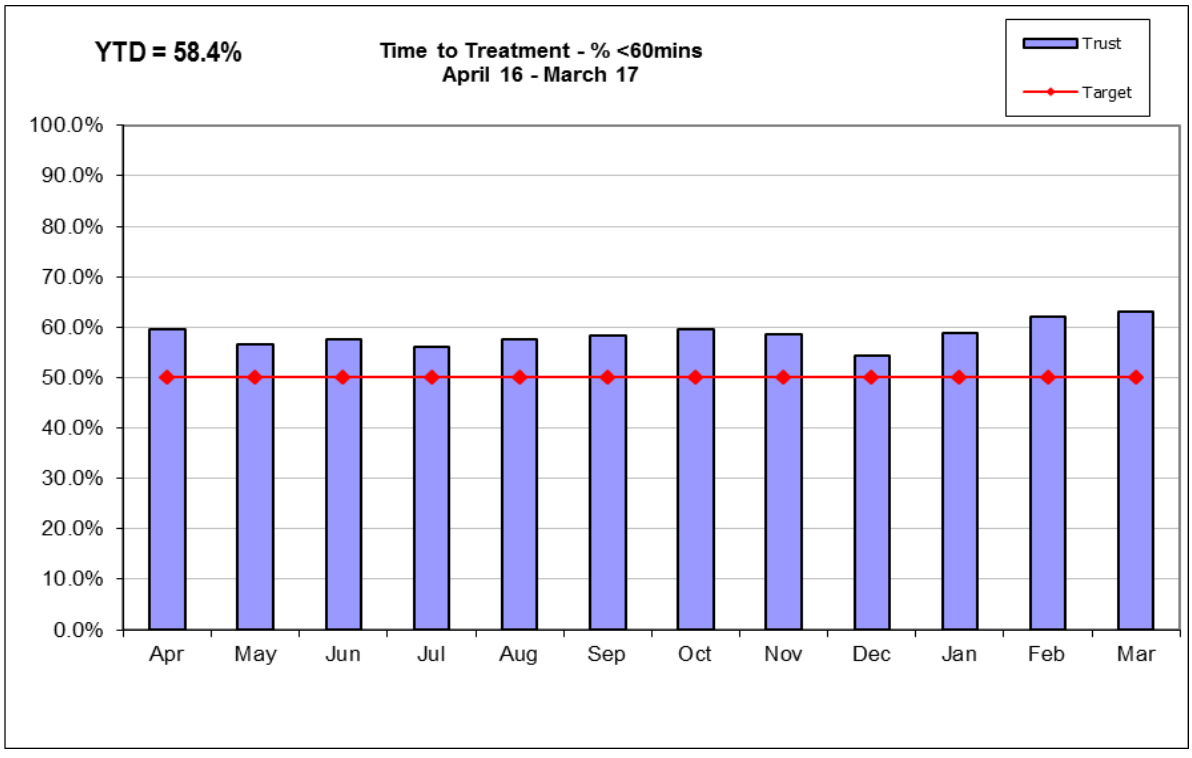
A&E Left without being Seen Rate – The Trust achieved this standard, of less than 5% of patients leaving its A&E Departments without being seen.



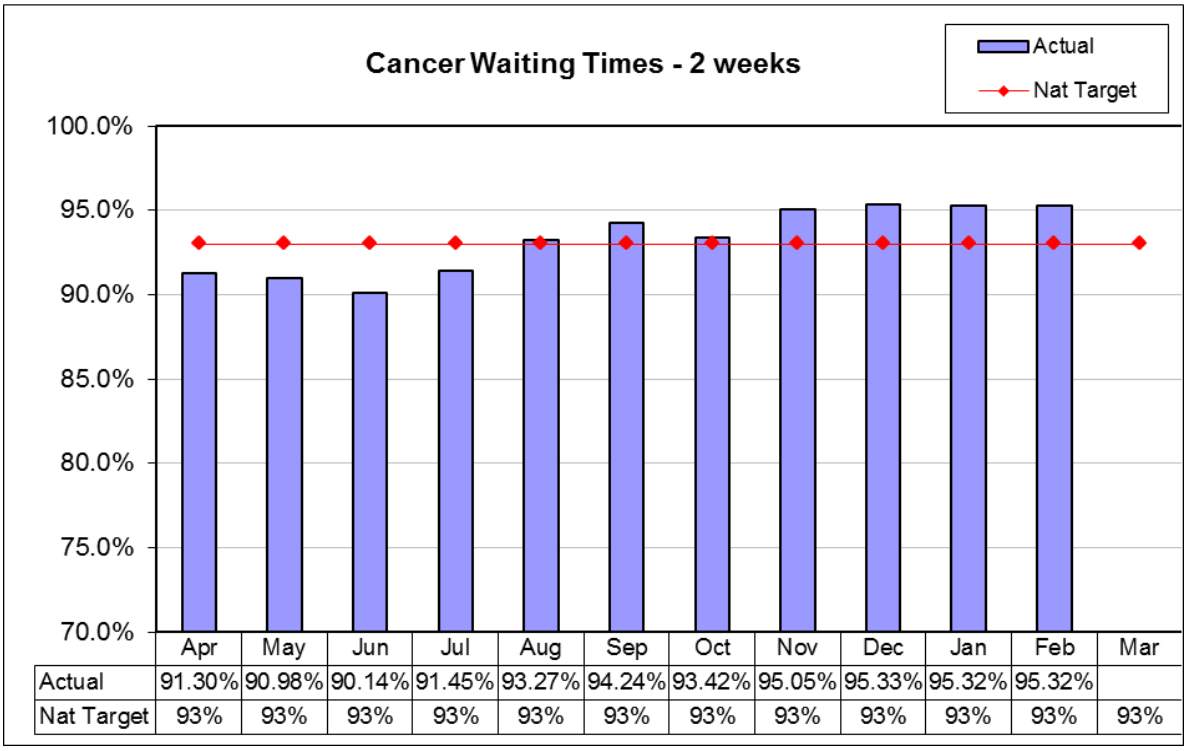
A&E Time to Initial Assessment <15 minutes – The Trust achieved this standard of 95% of patients arriving in its A&E Departments being assessed within 15 minutes of arrival.



A&E Time to Treatment <60 minutes – The Trust achieved this standard of 50% of patients arriving in its Emergency Departments being treated within 60 minutes of arrival at 58.4%. This is a 7% improvement on last year.

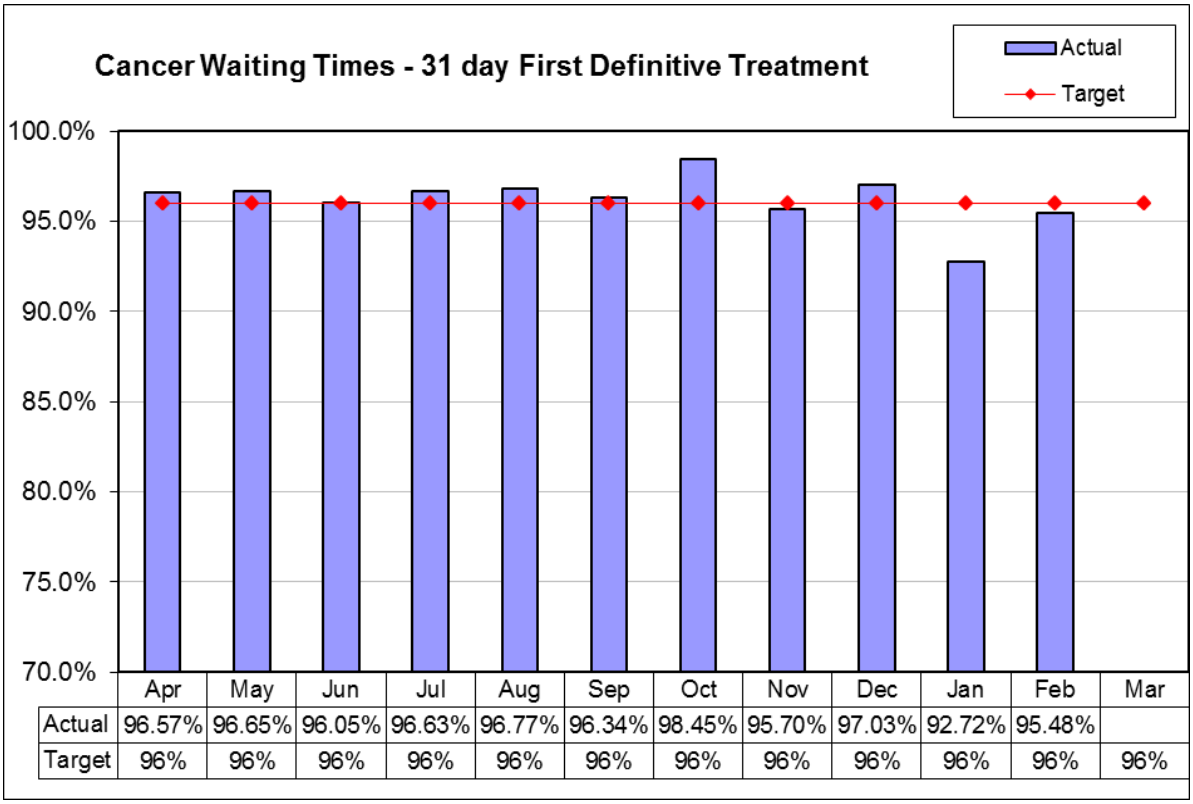


Cancer Waiting Time Targets - 2 weeks from referral – The Trust achieved this standard of ensuring that 93% of patients with suspected cancer were seen within two weeks.



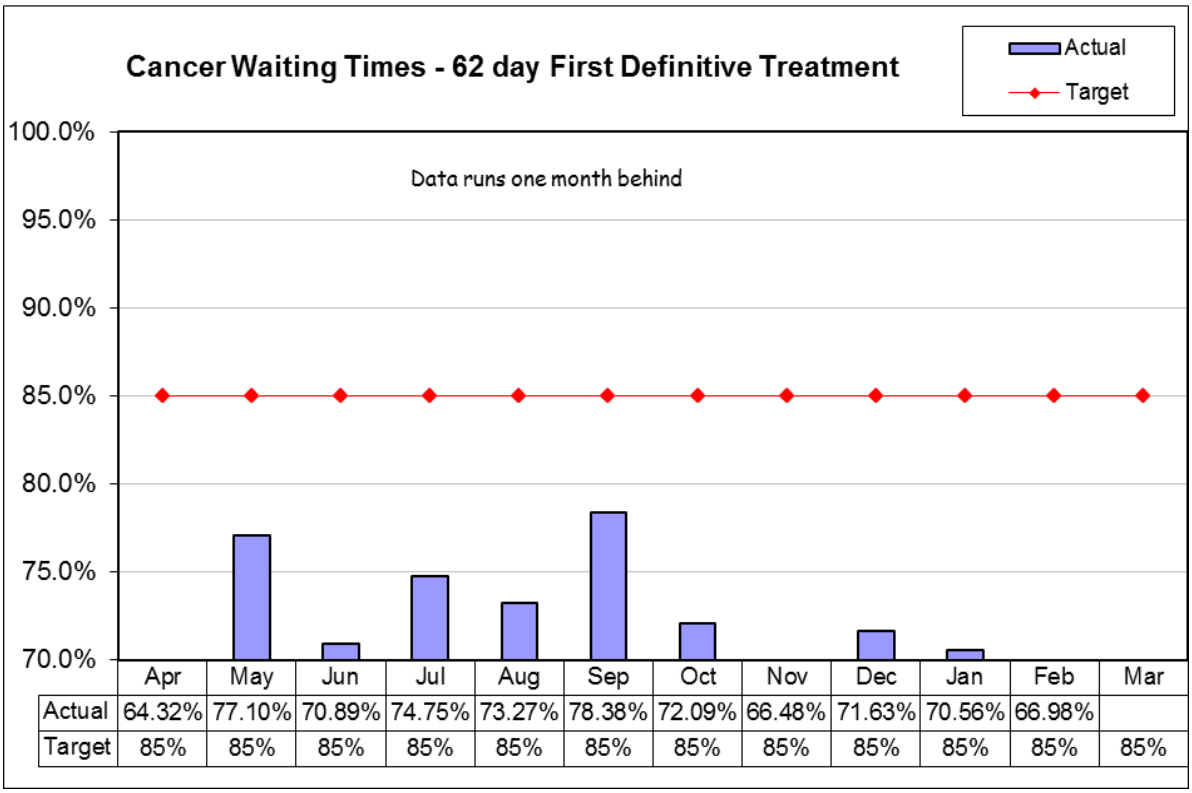
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	91.30%	90.98%	90.14%	91.45%	93.27%	94.24%	93.42%	95.05%	95.33%	95.32%	95.32%	
Nat Target	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%

Cancer Waiting Time Targets – 31 Day First Definitive Treatment – The Trust has achieved this standard ensuring that 96% of patients who needed to start their treatment within 31 days did so.



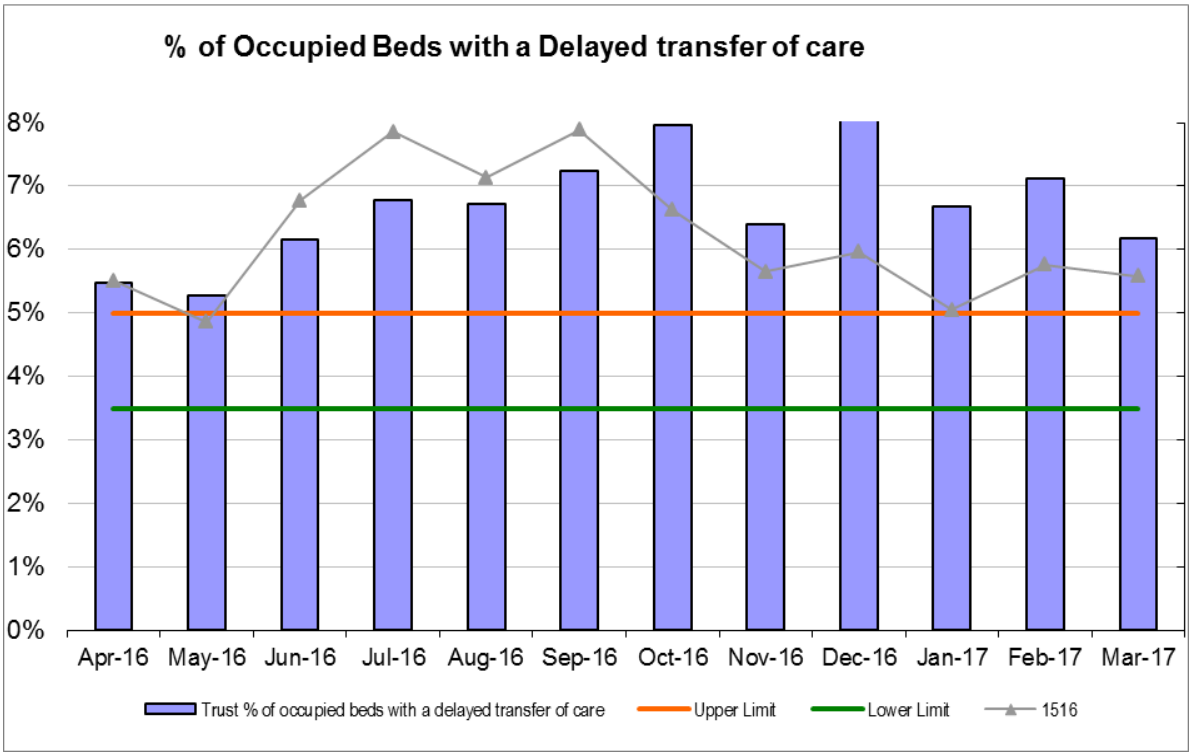
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	96.57%	96.65%	96.05%	96.63%	96.77%	96.34%	98.45%	95.70%	97.03%	92.72%	95.48%	
Target	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%

Cancer Waiting Time Targets – 62 day First Definitive Treatment – The Trust did not achieve this standard of 85% of patients who needed to start their first definitive treatment within 62 days doing so (expected 69%)

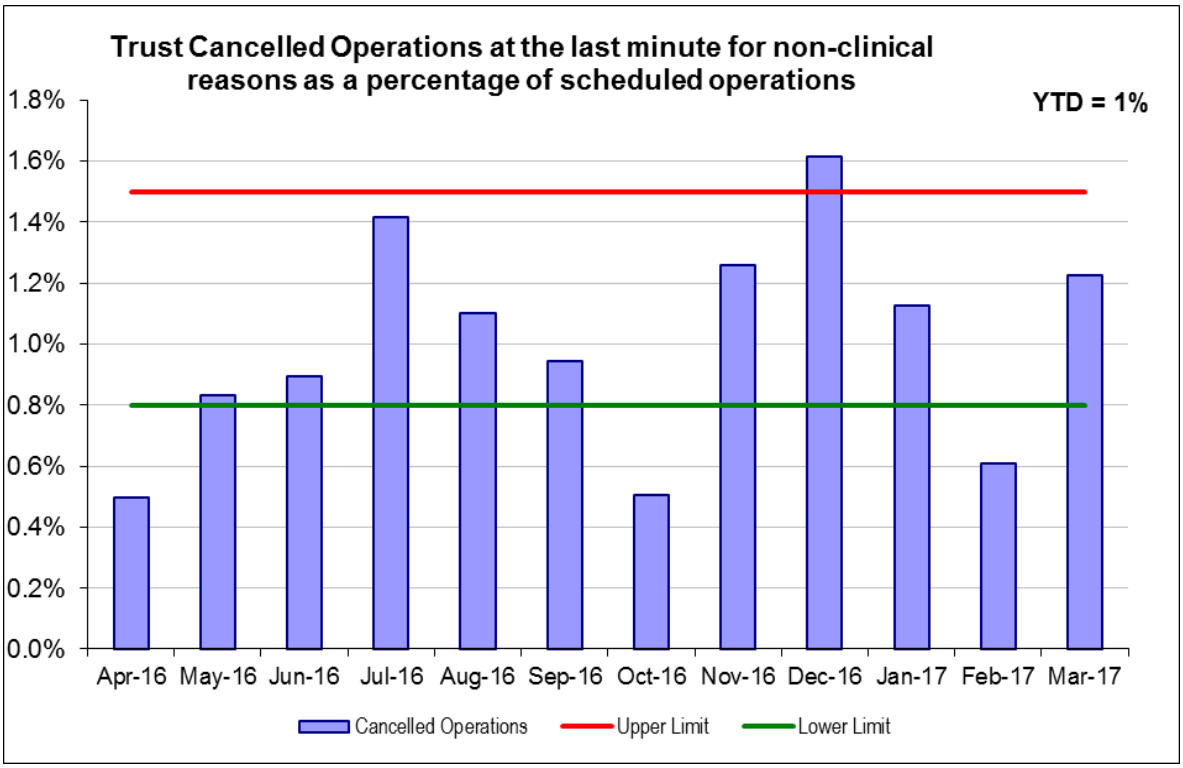


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	64.32%	77.10%	70.89%	74.75%	73.27%	78.38%	72.09%	66.48%	71.63%	70.56%	66.98%	
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

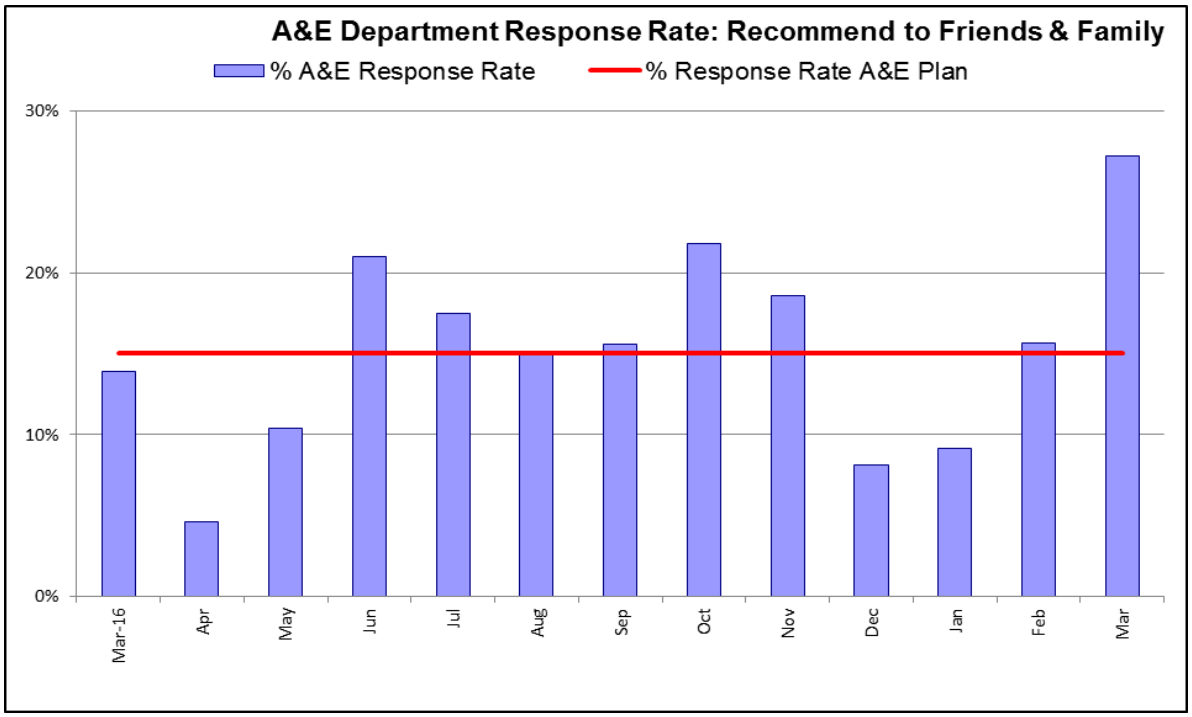
Delayed transfers of care – The Trust did not achieve this standard of Delayed transfers of care remaining below the national limit of 3.5% for the year at 6.67%.



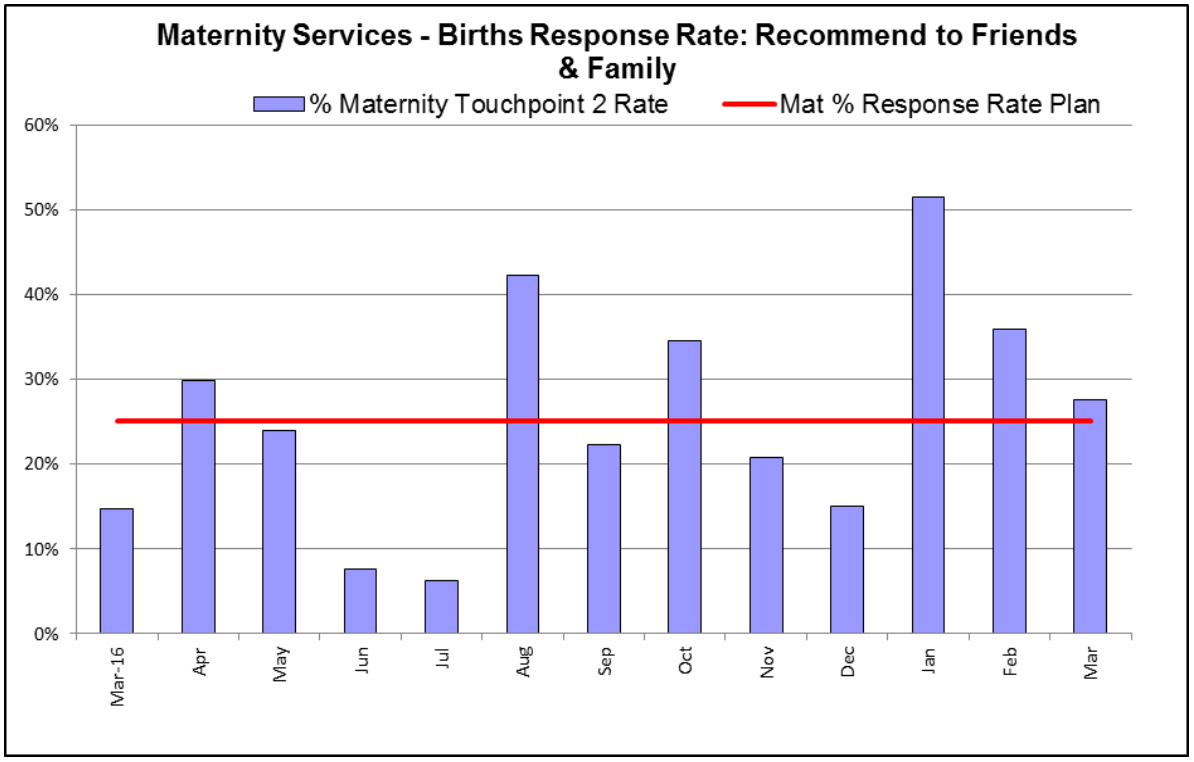
Cancelled operations – The Trust did not achieve this standard with 1% of operations cancelled at the last minute against the national maximum limit of 0.8%.



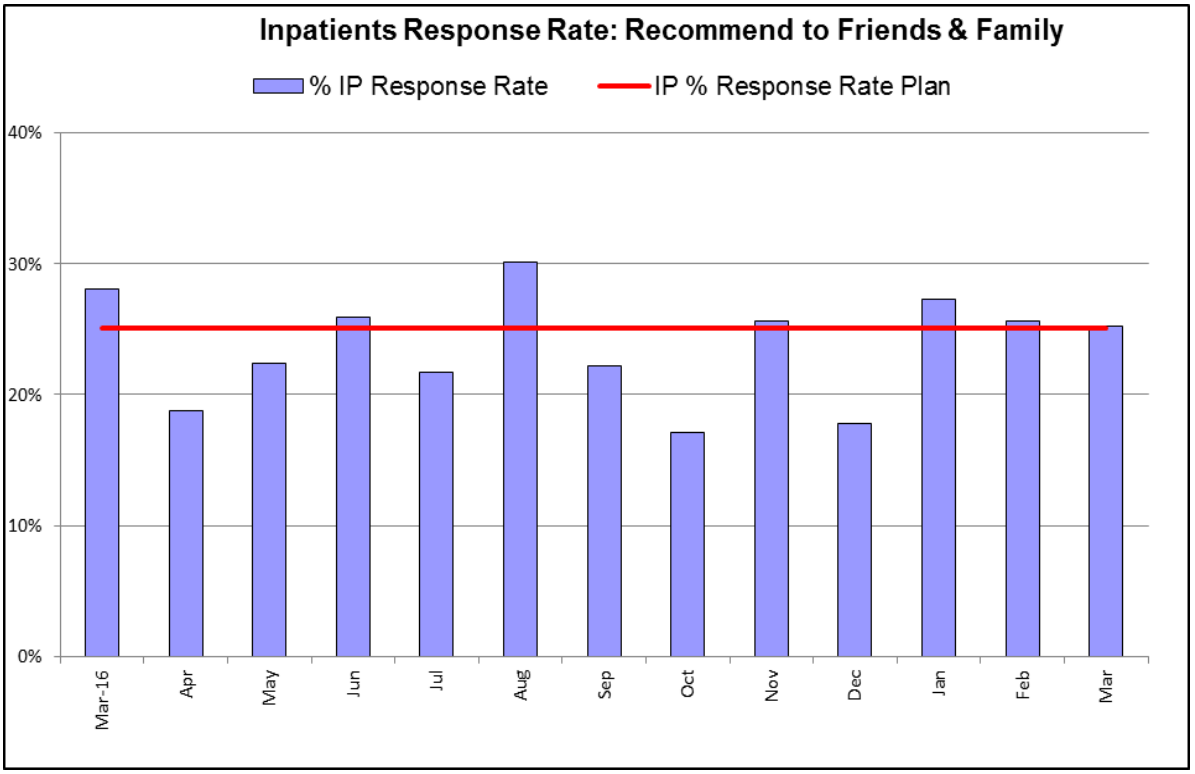
Friends and Family Test Response Rate A&E- The Trust achieved the target of 15% response rate for the Friends and Family Test given to patients in the A&E Departments at 15.5%. Of the responses received 90.7% were positive



Friends and Family Test Response Rate Maternity- The Trust achieved the target of 25% response rate for the Friends and Family Test given to patients after giving birth at 26.6%. Of all the responses received for patients accessing Maternity Services 93.6% were positive



Friends and Family Test Response Rate A&E- The Trust did not achieve the target of 25% response rate for the Friends and Family Test given to inpatients at 23.3%. Of the responses received 95.5% were positive



National Indicators

There are a variety of national indicators highlighted within the Outcomes Framework that each Trust is required to report on.

Maidstone and Tunbridge Wells NHS Trust considers that this data is as described for the following reasons:-

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

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

The NHS Outcomes framework has 5 domains:

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

Domain	**Prescribed data requirements** **The data made available to the National Health Service Trust or NHS foundation Trust by the Health and Social Care Information Centre with regard to —**	**2016/17 local and national data**	**2015/16 local and national data**	**National average**
1 & 2	(a) the value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period; and (b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period. *The palliative care indicator is a contextual indicator.	1.0762 (Band 2 – "As Expected" Oct 2015 – Sept 2016	1.026 (Band 2 – "As Expected" Jul 2014 – Jun 2015	100
3	PROMS			
	i) groin hernia surgery ii) varicose vein surgery iii) hip replacement surgery iv) knee replacement surgery during the reporting period (*See below for explanation of reporting data)*	0.074 No data available 0.442 0.337 (Apr 15-Mar 16)	0.084 N/A 0.464 0.320 (Apr 14-Mar 15)	0.088 N/A 0.438 0.320 (Apr 15-Mar 16)
3	the percentage of patients aged— i) 0 to 14; and (ii) 15 or over, readmitted to a hospital which forms part of	**Trust** 10.9% **Elective** 5.1%	**Trust** 10.7% **Elective** 5.4%	(Q1 13/14 position) **Elective:** 6.81%

Domain	Prescribed data requirements The data made available to the National Health Service Trust or NHS foundation Trust by the Health and Social Care Information Centre with regard to —	2016/17 local and national data	2015/16 local and national data	National average
	the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.***1**	**Non-Elective** 11.7%	**Non-Elective** 11.4%	**Non-Elective** 14.10%
4	The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.	82.2	83.1	79 (2015/16)
5	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period	95.4%***2**	95.3%	96.0% (Jan 2015)
5	The rate per 100,000 bed days of cases of C. Difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.	10.5 ***3**	7.4	15.5
5	The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, The number and percentage of such patient safety incidents that resulted in severe harm or death. *(See below for explanation of reporting data)*	7716 77 (0.99%)	6902 80(1.15%)	

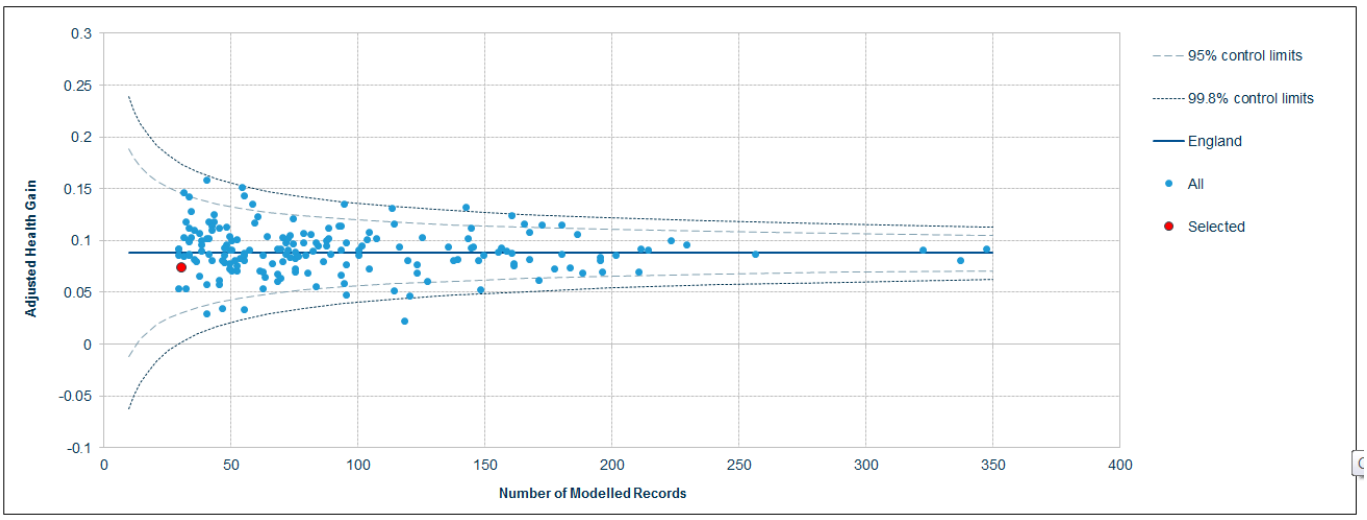
*1 Local and national data is based on 30 day re-admission.
*2 Q4 not yet published so taken from local data.
*3 Figure based on local data as national data not published at time of report. National denominator figure derived from HES data, local denominator derived from KH03 return.

Patient Reported Outcome Measures (PROMs)

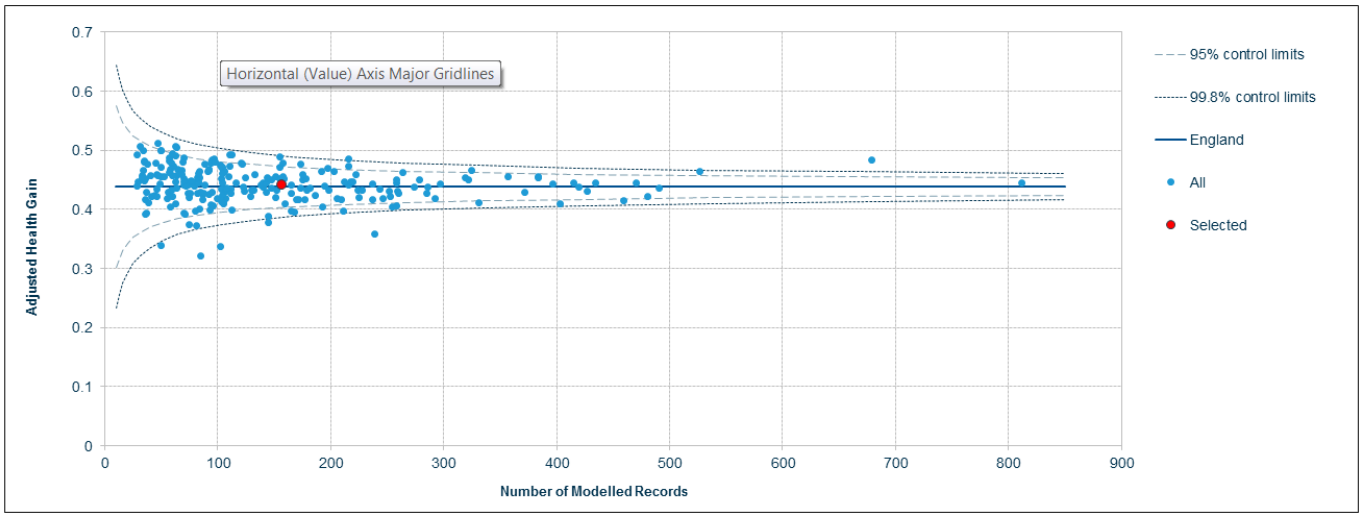
The NHS asks patients about their health and quality of life before they have an operation, and about their health and the effectiveness of the operation afterwards. Data is collected in the form of a patient questionnaire. This helps to measure and improves the quality of care.

There are four surgical procedures for which PROMs data is captured: Groin hernia, Hip replacement, Knee replacement and Varicose veins. Results are uploaded on the Health and Social Care Information Centre (HSCIC) from which the graphs below are provided. Data published in February 2017 (based on April 2015 to March 2016) shows all 3 surgical procedures showing an improvement in health gain following an operation (note that there was insufficient data for varicose veins surgery)

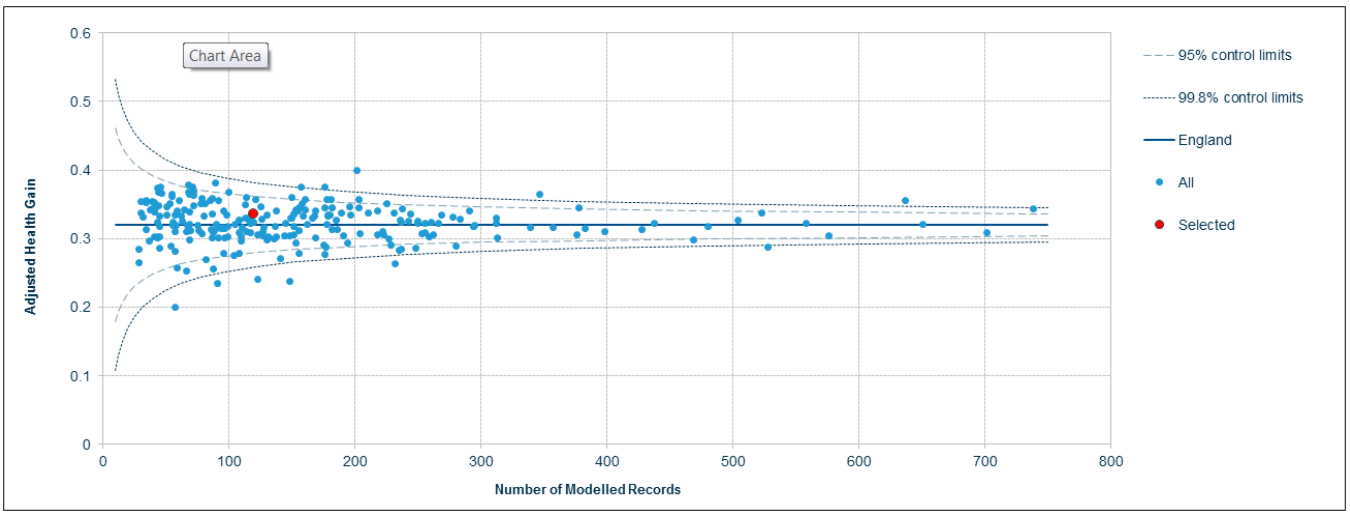
Groin Hernia – 31 returns of which 17 reported an improvement in health following the procedure.



Hip Replacement – 157 returns of which 140 reported an improvement in health following the procedure.



Knee Replacement – 120 returns of which 100 reported an improvement in health following the procedure.



Patient Safety Incidents

The proportion of patient safety incidents which resulted in severe harm or death for 2016/17 was 0.99% (1.15% 2015/16). This is calculated by dividing the number of serious and catastrophic incidents reported by Maidstone and Tunbridge Wells NHS by the total number of patient safety incidents 7716 (6902 for 2015/16).

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

The latest report from the National Reporting and Learning System (NRLS), which was published in March 2016 and covers the period of 01/04/16 to 30/09/16, provided a reporting rate of 26.23 compared to 26.02 the same time last year. The rate of incidents reported is per 1,000 bed days. This places the Trust within the lowest 25% of reporters and a position we continue to improve upon.

Improving performance

Maidstone and Tunbridge Wells NHS Trust also have several Divisional and Trust-Wide clinical operational groups which monitor the organisations key performance indicators. These clinical meetings ensure that indicators can be monitored and performance improved but also supports and enables our staff to have cross-directorate discussions and to share learning and overcome concerns. These meetings include:-

The Trust Mortality Surveillance Group; established in its current format in January 2016. This meets monthly to review all hospital related mortality data, identify trends and share learning. Following recent guidance from the National Quality Board in March 2017 and the CQC (Learning, Candour and accountability Report, December 2016) the Group is currently reviewing their aims and objectives to ensure these recommendations are met over the coming year. The Group reports bi-monthly into the Trust's Clinical Governance Committee and in addition supplementary reports have been submitted to the Quality committee and Trust Board. The chair of this Group is the Medical Director.

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

Maidstone and Tunbridge Wells NHS Trust meets the statutory requirement of having in place an Infection Prevention and Control Committee (IPCC), which is chaired by the Executive Lead for Infection Prevention and Control. In addition the Trust has a named Director for Infection Prevention and Control (DIPC) who also attends the Trust Board meetings. The IPCC sets the standards and monitors compliance against key infection prevention measures including those for Clostridium Difficile and MRSA. The IPCC receives Directorate reports and monitors their compliance via a monthly audit programme including standards for commode cleaning, hand hygiene, infection prevention training and Periods of Increased Incidence (PII). PII is an audit framework specifically used to check infection prevention standards in wards and departments where there may be concerns about practice, notably relating to any diagnosis of a Clostridium Difficile infection.

Each Division is required to undertake a regular Executive Performance review. These meetings monitor compliance through the Divisional dashboards. In particular Urgent Care have responsibility for the Accident & Emergency four-hour access standard and Planned Care

responsibility for the 18 week referral to treatment access standard. The Director of Operations and the Clinical Directors of these Divisions also work in collaboration with our commissioning teams to address non-compliance and to look at the implications of the wider health economy to ensure that our patient's needs are met.

Scrutiny

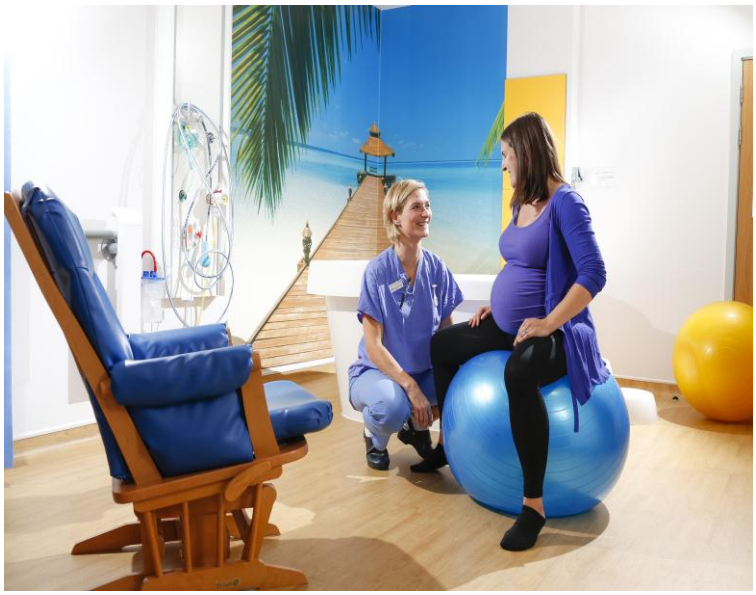
Along with the key priorities for the year these indicators are scrutinised by the relevant governance committees, Trust Management Executive and the Quality Committee.

Additional areas of significant improvement during 2016/17

This section will provide a summary update on further initiatives that were undertaken during the past year:

Maternity
It has been a busy, but exciting time for our Maternity services during the past year. We were delighted with the recent results of an independent review by NHS England which rated our Maternity services as having the lowest stillbirth and neonatal death rates in the whole country. We have also seen a 4% rise in the number of women choosing to have their baby at MTW, reflecting the good reputation of our services held by women and their families living locally.

There have been many different initiatives to improve our service throughout the year. We have achieved a 3% increase in the number of women with a straightforward pregnancy giving birth in an out of hospital setting, which is known to improve clinical outcomes for this group of women and also helps capacity issues at Tunbridge wells hospital. Maidstone Birth Centre has had a 20% increase in births throughout the year, Crowborough Birth centre, (which came under MTW management in April 2016), has seen a rise of 28% and Homebirths continues to be a popular choice for women. 13% of all births at MTW are now taking place in an out of hospital setting and we hope to see this increase further as more women understand the advantages of this model of care for women at low risk of complications.



There have also been numerous initiatives to improve care for women with a more complicated pregnancy, such as midwifery led antenatal clinics working in tandem with obstetricians to improve continuity of care, the 'Gap and Grow' antenatal program to improve the detection of babies at risk of growth problems in pregnancy, introducing 'out of hospital induction of labour' for appropriate women and the implementation of an enhanced recovery program for women having for women having an elective caesarean birth facilitating early discharge from hospital.

Two maternity initiatives from the past year have achieved national recognition by becoming finalists at national awards; The 'Kangaroo care at elective caesarean birth' project (HSJ Awards) and the MTW Better Births initiative (RCM awards) are examples of initiatives that have been highly rated by users of our service and demonstrate improvements in clinical outcomes.

During the year ahead we will continue to focus on improving our service in relation to safety, choice and continuity of care in line with the aims of the National Maternity Review.

Cancer Services
Thanks to the collaborative working between the Trust and Macmillan we have been able to support the expansion of the Colorectal Cancer Clinical Nurse Specialist team which has been instrumental in developing and implementing the “Straight to Test” pathway of care to facilitate an earlier diagnosis for our patients and streamline their journey. This also seeks to make further improvements with our cancer waiting targets.

A three month evaluation was undertaken at the Kent Oncology Centre’s chemotherapy day unit to trial an air tight sealing disposal system for cytotoxic waste management. This seeks to improve safety in the disposal and potentially reduces the amount of evaporated chemotherapy exposure for our patients and staff. This will also improve our environmental footprint. This will now be rolled out across the directorate.

We also undertook a trial and set-up an ambulatory haematology day unit. The intention was to ensure patients receive the right care in the right place at the right time and did not have to be unnecessarily admitted to an acute bed, thereby supporting our patients to spend as much time as possible in their home environments. With the implementation of the Ring fenced bed for our dedicated haematology in patient ward alongside ambulatory care this will also positively affect our hospitals length of stay and maximise our bed availability.

Neonatal
Our Neonatal team have taken advantage of the benefits of technology, for our new Mothers who are in the High dependency or Intensive care units and physically unable to visit their babies in the Neonatal unit, through the use of ‘facetime’ on IPads donated by previous parents. This helps to lessen their anxiety and supports that important interaction between a mother and her baby.

In addition we are supporting the Unicef Baby Friendly Initiative standards and are working towards Level 2 accreditation having identified 2 breast feeding leads and started staff training days. Our neonatal team also have regular BLISS (for babies born premature or sick) meetings which are attended also by a parent representative, work will be ongoing this year to continue to improve and reach the required standard required for accreditation.

The Trust Website has also been updated to support the parents of neonatal babies, and during the course of this year we appointed a Bereavement lead for parents whose baby has died. This service has also addressed the shortfall that we had previously identified for those parents who have had a baby at Tunbridge Wells hospital but who later dies in an out of area hospital.

End of Life Care (EoLC)
Several initiatives have been undertaken to improve EoLC within the Trust during 2016-2017. The Trust have mandated EoLC training for all registered clinical staff working within adult inpatient and emergency services on a three-yearly basis. Clinicians have the option of completing their training via the bespoke EoLC E-Learning package, developed within the Trust, or attending one of the mandatory training sessions. In addition, each adult ward has a named EoLC Palliative Care Clinical Nurse Specialist (CNS) to identify specific palliative and EoLC training needs and an identified "Ward Champion".

A survey of our bereaved relatives’ experience of care within MTW was undertaken between September 2016 until March 2017 to bench mark EoLC care and inform future service development. The first 100 completed surveys returned have now been analysed. Results identified that 83% of respondents rated the care for their relatives and friends in the last few days of life as good or excellent and 91% felt that that the patients were treated with dignity and respect. This will now be an ongoing Trust survey.

Following MTW's disappointing results from The National Care of the Dying Audit (2015) the audit was repeated internally by the EoLC and Palliative Care Team during 2016 using a more representative sample. Preliminary findings are favourable and have shown an improvement in all but one of the five indicators.

The individualised Care Plan for the Dying Patient documentation has been revised in consultation with clinicians and piloted on two wards and will be re-launched within the Trust in June 2017.

Review of Bed Capacity and speciality allocation to support the increased demand for admissions

During the course of the year we have reviewed our bed capacity based on the needs of our patients and as a result we have made every effort to redistribute our beds to meet the changing demand of our patients and thereby improve pathways of care for both planned and unplanned admissions by supporting the right care in the right place.

The Maidstone Orthopaedic Unit has transferred back to Orthopaedics to support the timely admission of orthopaedic patients waiting for elective procedures. We have also changed the criteria for admission to the Gynaecology ward which has since been renamed Ward 33 and now cares for female general surgical patients in addition to gynaecology patients. In addition three beds from the post-natal ward have been reallocated to Ward 33 increasing the general bed stock by three beds. The Private Patients Unit has also seen the conversion of three of its outpatient rooms back to patient bedrooms and 20 rooms on this unit have now been allocated to General Medicine from surgery. The Cardiac catheter (Cath) Lab recovery unit at Tunbridge Wells hospital has become the new home of the Surgical Assessment Unit. Cath lab patients will now be recovered in the pain room which has been redesigned to take three recliner chairs. In addition three of the rooms in the Coronary Care Unit have also been altered to accommodate 2 trolleys each, for Cath Lab recovery patients. These changes ensure that cardiac interventional surgery is not impeded due to the escalation of patients into these recovery beds whilst also ensuring that the surgical flow of patients from A&E can be assured of prompt assessment. In addition these changes have collectively meant that the Short Stay Surgical Unit can now open as a dedicated 23 hour stay day surgery unit, with an admissions lounge for elective patients. Interventional radiology patients are also being accommodated here, therefore ensuring prompt treatment.

In addition we have more recently reviewed those patients who are awaiting social care arrangements, who are deemed to be medically fit but who still require nursing care, and through this review of patient needs we have been able to reallocate our resources more efficiently with the creation of two medically fit wards. These are - Ward 20 at the Tunbridge Wells hospital and Whatman Ward at Maidstone hospital. These wards are also supported by activity co-ordinators and members of our Discharge team thereby ensuring that we can promote a more homely environment until arrangements can be made to support them out of hospital.

Our paediatric patients have also seen improvements with the longer opening hours of the Woodland Assessment unit and the conversion of some of Hedgehog's utility rooms into bedrooms; this has helped to reduce the number of out of area transfers due to a lack of capacity during periods of increased admissions.

We are confident that these considered reviews and redistribution of bed stock and resource has helped us as an organisation to make essential improvements in both the quality and effectiveness of our patients' treatment and care and also supported their timely discharge home by getting it right the first time.

Part Four
Appendices A, B and C

Appendix A

41 National reports were published where the topic under review was relevant to the Trust in 2016/17 with action to be taken in 2016/17

National Report Published April 2016 to March 2017	*Report received*	Date report due
Acute Care		
National Cardiac Arrest Audit (NCAA)	**Y**	**Summary report received for July 2016 for 2015/16 data.** Local reports with national comparative data. Reviewed and reported to the Trust's Resuscitation Committee. Data continues to be submitted to this audit however we have no current concerns identified.
Adult Critical Care Case Mix Programme (ICNARC) (CMP)	**Y**	**Report received June 2016.** Annual ICNARC Report for 1 April 2016 to 31 March 2016 was presented and discussed. Generally results were very encouraging for both Units when benchmarked against similar Units. Excellent SMR for both Units. Areas of concern were delayed admissions at TWH, delayed discharges on both sites. A business case to increase the dependency at TWH to 8 should improve delayed admissions considerably. High levels of high risk sepsis admissions on both sites were thought to be due to the case mix the Units see i.e. Emergency abdominal surgery at TWH and Haem/Oncology at Maidstone.
Emergency Laparotomy Audit (NELA)	**Y**	**5 July 2016** Report received and disseminated to team for review and assessment. Audit results regularly reviewed and assessed at clinical sessions. The Trust is in the top performing Trusts.
Severe Trauma (Trauma Audit & Research Network) TARN	**Y**	**27 July 2016 (Orthopaedic Injuries) / 29 December 2016 (Head & Spinal Injuries) March 2017 (Thoracic and Abdominal Injuries)** These are reviewed by the Clinical Lead for Trauma and discussed at Trauma Board. Any areas of underperformance are highlighted and actions for improvement identified. A report highlighted a lower than average percentage of patients with head injuries getting to CT scanning within 60 minutes of admission. Prioritising these patients for CT has led to improved results.
National Joint Registry (NJR)	**Y**	**Report received November 2016.** Annual NJR Report for 1 January to 31 December 2015. The report shows overall great compliance of 99% for the Trust. Our Trust is not an outlier.
Smoking Cessation	**Y**	**Comparative data received 7 December 2016.** The Trust is partially compliant. Patients are appropriately referred to Smoking Cessation Services. Need to ensure doctors are aware of the availability of Nicotine replacement Therapy and prescribe as necessary.
Vital Signs in children (care in the emergency department)	**Y**	**National report received 31 May 2016.** Site specific reports received June 2016. Both sites performed well in the taking and recording of vital signs with 97% compliance. Results for Maidstone were slightly better than TWH but this should show an improvement with the opening of a specific Paediatric ED.

National Report Published April 2016 to March 2017	*Report received*	Date report due
VTE Risk in lower limb immobilisation (care in emergency department)	**Y**	**National report received 31 May 2016;** site specific reports received June 2016. Both sites performed well Maidstone 97% and TWH 100%. Need to ensure there is evidence that patient information leaflets are being given to all patients.
HQIP National SAMBA 16 (Society for Acute Medicine Benchmarking Audit)	**Y**	**September 2016. Report received Jan 2017 with specialty for assessment.** The Trust is partially compliant. Trust-wide education to take place to ensure all patients admitted to AMU have an Early Warning Score (EWS) measured upon arrival at AMU and reviewed by a competent decision make within 4 hours.
Procedural sedation in Adults (Care in emergency department)	**Y**	**National report received 31 May 2016**; site specific reports received June 2016. The Trust is partially compliant. Implementation of new sedation proforma to ensure all relevant observations are taken and recorded.
UK Cystic Fibrosis Registry (Paediatric and Adult)	**N/A**	The Trust does not provide this service
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	**N/A**	The Trust does not provide this service
Use of Emergency Oxygen (BTS)	**Y**	**Report received May 2016.** Trust is partially compliant. Respiratory Clinical Nurse Specialists to continue drug prescription chart for all patients requiring emergency oxygen. Implementation of Nerve Centre database to allow for target parameters to be entered for each patient. Explore purchasing of ear SpO2 probes to ensure appropriate monitoring equipment is available in all clinical areas.
National Comparative Audit of Blood Transfusion Programme		
(National Comparative Audit of Blood Transfusion Programme) Red cell and platelet transfusion in adult haematology	**Y**	**Report received August 2016.** Haematological patients are high blood users and those with chronic BMF receive more blood than those with reversible BMF. Single unit red cell transfusions are uncommon and prophylactic single unit platelet transfusions would almost certainly be increased if counts were performed prior to transfusions of further units. Local hospital guidelines are frequently discrepant with national guidelines and contribute to inappropriate transfusion practice. Compliance is similar across all levels of care.
Use of blood in lower GI bleeding	**Y**	**Report received May 2016** with the speciality awaiting assessment completion
Audit of patient blood management in scheduled surgery	**Y**	**Report received January 2017.** Patient Blood management has not been integrated in surgical practice within the Trust. The Trust performs below national average on delivering the recommendations within PBM in surgical patients. The results are being discussed and managed at a Trust-wide level and there is a re-audit on the 2017/18 programme.
Serious Hazards of transfer (SHOT) UK. National haemovigilane scheme	**N/A**	No report available this year
Cancers		
National Cancer Diagnosis Audit	**N/A**	Primary Care Audit only
Lung Cancer (NLCA)	**Y**	**National Report received 25 January 2017.** With speciality for assessment, assessment should be completed by end April 2017

National Report Published April 2016 to March 2017	*Report received*	Date report due
Bowel Cancer (NBOCAP)	**Y**	**National Report received January 2017.** With speciality for assessment. Assessment due for completion end April 2017
Head & Neck Cancer (DAHNO)	**N/A**	**February 2017 –** No report from DAHNO yet.
National Prostate Cancer Audit	**Y**	**National Report received January 2017.** With speciality for assessment. Assessment due for completion end April 2017
Oesophago-gastric cancer (NAOCG)	**Y**	**National Report received January 2017.** With speciality for assessment. Assessment due for completion end April 2017
Urology		
BAUS Urology Audits: Female Stress Urinary Incontinence Audit	**N/A**	**No report available**
BAUS Urology Audits: Radical Prostatectomy Audit	**N/A**	**No report available**
BAUS Urology Audits: Cystectomy	**N/A**	**No report available**
BAUS Urology Audits: Nephrectomy Audit	**N/A**	**No report available**
BAUS Urology Audits: Percutaneous Nephrolithotomy (PCNL)	**N/A**	**No report available**
BAUS Urology Audits: Urethrolasty audit	**N/A**	The Trust does not provide this service
National Ophthalmology Audit	**Y**	**National report received May 2016** and reviewed by specialty**.** Plan to enter data for next round of the audit.
Chronic Kidney Disease in Primary Care	**N/A**	Primary Care Only
Renal Replacement Therapy (Renal Registry)	**N/A**	The Trust does not provide this service
Heart		
Acute coronary syndrome or Acute myocardial infarction (MINAP) 2014-15 data (202)	**Y**	**National report received 30 January 2017.** With Specialty for assessment. Should be available by mid-May.
Heart failure Audit 2014-15	**Y**	**National report received August 2016.** Performance at both sites is above national average. Both hospitals have a designated Heart Failure Nurse Service for inpatients, excellent echocardiogram services, cardiologist support for inpatient referrals and regular multi-disciplinary heart failure meetings.
National Cardiac Arrest Audit (NCAA) 661	**Y**	**National report received June 2016** There were no abnormal variants regarding age, sex or location. The Trusts survival to discharge rate is better than the predicted figures for similar hospitals.
Cardiac Rhythm Management (CRM) 2014-15	**Y**	**National report received 3 August 2016.** Overall performance on both sites was good with particularly good data on physiological (dual chamber) pacing for SSS. CRT and ICD implant rates are in line with national performance.
Coronary angioplasty/ National audit of PCI 2014	**Y**	**National report received 1 April 2016.** Radial access to be established as default access route for PCI, compliance increases year on year. Data completeness to be improved for patient diabetic status and renal function.
Adult Cardiac surgery	**N/A**	The Trust does not provide this service
Congenital heart disease (Adult cardiac surgery)	**N/A**	The Trust does not provide this service
Congenital heart disease (Paediatric cardiac surgery)	**N/A**	The Trust does not provide this service
Pulmonary Hypertension	**N/A**	The Trust does not provide this service
National Vascular Registry	**N/A**	The Trust does not provide this service

National Report Published April 2016 to March 2017	*Report received*	Date report due
National Pregnancy in Diabetes Audit 171	**Y**	**National report received 1 November 2016.** Our numbers were too small to be included in some of the analysis of this report. MTW were better than National and Regional results for Glucose Control, along with Folic acid supplement prior to pregnancy. However, we were lower with our Antenatal Care. MTW are to continue regular contact with local GP's and maintain the leaflets in the surgeries. Consider development of a preconception clinic.
National diabetes inpatient audit (NaDIA) 2016	**Y**	**National report received 8 March 2017.** With specialty for assessment
National Core Diabetes Audit (NDA) 2015-16 (573)	**Y**	**Report published 31 January 2017**. Downloaded April 2017, report missed due to double reporting by NDA. Currently with specialty for assessment.
Inflammatory Bowel Disease (IBD) Programme – IBD registry 2015-16	**Y**	**National report received 23 September 2016**, The Trust partially compliant. IBD specialist nurses now in place to assist with ensuring patients are followed up within appropriate timescale.
Rheumatoid and early inflammatory arthritis (NCAREIA) 2015-16	**Y**	**National report received 24 July 2016.** Overall the Trust is partially compliant. Poor GP referrals make it difficult to triage patients into appropriate ESYN (early synovitis) clinics. GP referral database (DORIS) is available but not always used. Additional clinic capacity required to ensure patients are seen within 3 weeks of referral. Advice line available for direct access to department. 24 hour answer phone service with calls returned within 48 hours.
Neurosurgical National Audit Programme	**N/A**	**Trust does not provide this service**
Falls and Fragility Fractures Audit Programme (FFFAP) pilot	**N/A**	**1. Inpatient Falls (NAIF) No report this year**
	N/A	**2. Fracture Liaison Service** MTW does not provide this service. This is a community service.
	Y	**3. National Hip Fracture Database Report due 3 September 2016.** Received and discussed within the team. An Ortho-Geriatrician has been appointed to enable joint care of patients with Orthopaedic Consultants on admission. Designated #NOF nurse to measure time taken for patient to be taken to theatre to identify areas where this patient journey can be shortened.
Sentinel Stroke National Audit Programme (SSNAP)	**Y**	**National report received October 2016** with specialty for assessment. Should be available by end May
UK Parkinson's	**Y**	**National report received August 2016.** The Trust is partially compliant. Need to allocate more time in clinics to allow for discussions re excessive daytime sleepiness and driving and anticipatory care planning to be had and documented. Need to be more aware of the management of bone health particularly in patients that have had a fall.
Elective surgery (National PROMs Programme) Hip Replacement, Knee Replacement, Groin Hernia, Varicose Vein	**Y**	**National Report received January 2017** MTW are to review the promotion of the PROMS questionnaires to patients in the pre-operative setting and reviewing the data that is being collected internally

National Report Published April 2016 to March 2017	*Report received*	Date report due
Mental Health		
Prescribing Observatory for Mental Health (POMH)	**N/A**	The Trust does not provide this service
Suicide and homicide in mental health (NCISH)	**N/A**	The Trust does not provide this service
Prescribing Observatory for Mental Health (POMH-UK): Prescribing anti psychotics for people with dementia	**N/A**	The Trust does not provide this service
Prescribing Observatory for Mental Health (POMH-UK): Monitoring of patients prescribed lithium	**N/A**	The Trust does not provide this service
Women & Children		
MBRRACE-UK; National Surveillance of perinatal deaths (Late foetal losses) 581	**Y**	**Report received May 2016** Each Cause of Death is checked by the Bereavement Midwives or Maternity Clinical Risk Manager before signing off. It's also discussed at Risk meeting if no post mortem performed.
MBRRACE-UK; National Surveillance and confidential enquiries into maternal deaths 719	**Y**	**Report received 7 December 2016** Plan to extend the Emergency Gynaecology Assessment Unit to 12 hours a day. A business case has been in place for the last 3 years for scanning at the weekend, but due to the financial situation this hasn't happened.
MBRRACE-UK; Maternal morbidity and mortality confidential enquiries (cardiac (plus cardiac morbidity) early pregnancy deaths and pre-eclampsia)	N/A	The Trust does not provide this service
Paediatric Inflammatory Bowel Disease; Biologics Round 2 (IBD Programme) 414	**Y**	**Report received September 2016.** Biological therapies are safe. Treatment rates for UC have increased substantially in the past year. Meeting with Pharmacy to switch patients already on Remicade to Biosimilars. New starters to only be prescribed Biosimilars.
National Paediatric Diabetes Audit (NPDA) 2015 64	**Y**	**Report received June 2016** A total of 119 children were included. Overall the Trust was higher on a number of treatment regimens and met the criteria best practice for children with adjusted percentage HbA1c .The remaining criteria indicates the Trust outcomes were slightly lower than the National average, remedial actions have been put in place to support improving outcomes.
Neonatal Intensive and Special Care (NNAP) 2015 90	**Y**	**Report received September 2016** Trust performance is in line with national figures. Need to list all babies<35 weeks and check whether steroids given on a monthly basis. Baby Friendly training starts April 2017 to be Baby Friendly Initiative compliant at Level 2 for all Neonatal Unit staff. Encourage all Dr's and NNU nursing staff and night staff to complete information on Badger information system.
Paediatric Asthma 65	**Y**	**Report received March 2016** The Trust is largely compliant with the national standards. More of our patients are given steroids and antibiotics than the national average Asthma awareness training sessions to be set up and new guidelines and information to be uploaded to intranet.
Paediatric Intensive Care (PICANet)	**NA**	
Confidential Enquiries		
NCEPOD: Acute Pancreatitis (Treat the Cause)	**Y**	**Report received 7 July 2016.** Trust mainly compliant with recommendations. A Business

National Report Published April 2016 to March 2017	*Report received*	Date report due
		Case for more dedicated theatre lists (hot lists) is being discussed to enable more timely access to theatres. Planning to reinstate the system of GP referral letter post-discharge advising of the need to refer patient to support services (Alcohol Support Services) as this service is provided by another Trust and will require referral by the patients GP.
NCEPOD: Treat as One (Adult Mental health in Acute hospitals)	**Y**	**Report received 26 January 2017** Report received and distributed. With specialty for assessment.

Appendix B

Updated actions on reports received during March 2015 to April 2016. These were awaiting review or had previously been reviewed and action plans developed. These reports have been reviewed and the table below shows which actions have been completed and implemented or where reviews are still outstanding.

National Report Published April 2015 to March 2016	*Report received*	
Acute Care		
National Cardiac Arrest Audit (NCAA)	Yes	The Trust continues to have a better than predicted survival to discharge rate for patients who have an in hospital cardiac arrest. To continue with training programmes.
Adult Critical Care Case Mix Programme (ICNARC) (Round 2) (CMP)	Yes	Report April 2015 Will continue to submit data and review the quarterly reports.
Emergency Laparotomy Audit (NELA)	Yes	Clinical report received. October 2015.Surgeons are completing the pre-POSSUM booking process passes and the consultant surgeons attendances are in line with the national average. Mortality rates continue to be better than national average.
Severe Trauma (Trauma Audit & Research Network) TARN	Yes	Themed reports published 3 times per year. Rehab prescription developed in conjunction with TARN database.
National Joint Registry (NJR)	Yes	Report received September 2015. With specialty for assessment. This was superseded by the next years report.
Adult Community Acquired Pneumonia	Yes	Report received December 2015. Continued education for frontline staff in the need for prompt chest x-ray request. Ongoing programme to ensure PGD for antibiotic prescribing, now in place for A&E and AMU nursing staff to ensure prompt administration of first dose antibiotics. Continued education of doctors in the need for combined antibiotic prescribing for patients with moderate or high severity CAP (CURB65 score 305).
Fitting child (care in emergency departments)	Yes	Report received June 2015. The Trust is partially compliant. Introduction of Paediatric ED and consultant Paediatrician for assessment of fitting children. Need to ensure blood glucose is taken as part of the initial assessment and documented in the patient's clinical record.
HQIP National SAMBA 15 (Society for Acute Medicine Benchmarking Audit)	Yes	Report received October 2015. Training programme to ensure patients should have an Early Warning Score documented and they are seen within 4 hours of arrival by a competent decision maker.
Mental health (care in emergency departments)	Yes	Report received June 2015. Mental health risk assessment proforma (SMART tool) successfully introduced. Mental Health awareness now embedded into A&E induction teaching programme.
Blood transfusion		
(National Comparative Audit of Blood Transfusion Programme)	Yes	Consent for transfusion is poorly delivered and documented. The Trust performs below national

National Report Published April 2015 to March 2016	*Report received*	
National comparative audit of blood transfusion of patient information and consent 2014		average on delivering information to patients regarding the risks and alternatives on blood transfusion, and is worse at documenting it. Rationale is better documented however 100% compliance is now required for which we fall short.
Audit of patient blood management in scheduled surgery	Yes	Patient Blood Management (PBM) has not been integrated in surgical practice within this Trust. The Trust performs below national average on delivering the recommendations within PBM in surgical practice. The timely identification and management of preoperative anaemia is lacking, as is identifying patients at increased surgical risk and thus there is a need to urgently address this. PBM intra-operative strategies need to be looked at and implemented and blood usage was often inappropriate and there is a need for the Trust to introduce a single unit transfusion policy with clearly defined transfusion triggers.
National Comparative Audit of blood transfusions: use of Anti-D 2012	Yes	Report received October 2015 and with specialty for final updates on assessment and action plan. Due for completion May 2017
Cancer		
Lung Cancer (NLCA)	Yes	Report received December 2015. With specialty for assessment. This was superseded by the next years report.
Bowel Cancer (NBOCAP)	Yes	The colorectal department is achieving consistently excellent clinical outcomes with mortality rates well below the regional and national average in one of the busiest departments in the country. There are no areas of clinical care identified within the audit where the department is an outlier.
Head & Neck Cancer (DAHNO)	Yes	Report received December 2015 and with specialty for review and action plan development
National Prostate Cancer Audit	Yes	This National Prostate Cancer Audit reports outcomes for patients diagnosed with Prostate Cancer in England between 2010 and 2013. Most of the results are presented by Cancer Network with some Trust specific data for patients diagnosed between 1 April 2014 and 31 July 2014. The Kent and Medway results show good data completeness (6th best in England), a low rate of potentially inappropriate radical treatment in cases of low risk prostate cancer (and by inference an acceptance of the role for active surveillance in these cases), an appropriate use of radical RT in cases of locally advanced prostate cancer, a low length of stay post radical prostatectomy with a low readmission rate.
Oesophago-gastric cancer (NAOCG)	Yes	Overall, the mortality from this surgery in the Trust was within the national expected figures: year and year survival figures were 80% and 50% (compared to ~75% and ~45% from the AUGIS data for national mortality). A review of other surgery carried out by the Trust assured the Trust Board that patients are receiving high quality and safe care. Patients requiring Oesphagectomy and Gastrectomy are receiving the majority of their care locally, but the major operation now takes place in Guys and St. Thomas's Hospital in collaboration with MTW's clinical cancer teams.
Heart		

National Report Published April 2015 to March 2016	*Report received*	
Acute coronary syndrome or Acute myocardial infarction (MINAP) 2014-15	N/A	National report received January 2017. This is now reported in the 2016/17 Quality Accounts Report.
Heart failure 2013-14	Yes	National report received November 2015. Performance at both sites is above the national average. Both hospitals have a designated Heart Failure Nurse Service for inpatients, excellent echocardiogram services, cardiologist support for inpatient referrals and regular multi-disciplinary heart failure meetings
Cardiac Rhythm Management (CRM) 2014-15	N/A	National report received August 2016. This is now reported in the 2016/17 Quality Accounts Report.
Coronary angioplasty/ National audit of PCI 2014	N/A	National report received August 2016. This is now reported in the 2016/17 Quality Accounts Report.
Adult Cardiac surgery	NA	MTW does not provide this service
Congenital heart disease (Paediatric cardiac surgery)	NA	MTW does not provide this service
Pulmonary Hypertension	NA	MTW is not a Specialist PH centre.
National Vascular Registry	NA	MTW does not provide this service.
Long Term Conditions		
National (Adult) Diabetes Audit (NDA)	Yes	Report received February 2016. There are encouraging trends of improvement in blood pressure control for people with type 1 and type 2 Diabetes and glucose control for type 1 Diabetes. People aged under 40 are much less likely to receive their care processes and those under 65 are less likely to achieve their treatment targets
Inflammatory Bowel Disease (IBD) Programme - Biologic Therapy only	Yes	National report received September 2015. IBD specialist nurses now recruited to assist with 3- and 12- month follow-up appointments, submission of patient data onto the IBD Biologics database and PROM forms completed.
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme – PULMONARY REHABILITATION	Yes	National Report received October 2015. Discussion has taken place with the CCG to obtain funding / staffing and extend the rehabilitation programme to include MRC2 patients as long as they have functional limitations due to breathlessness.
HQIP National Diabetes Footcare audit	Yes	Report published March 2016. The Trust is fully compliant. All patients are advised to check their feet regularly. Prompt referral to the podiatrist if any concerns about feet present. All patients admitted with diabetic foot problems are referred to diabetes foot MDT for review within 24 hours.
Rheumatoid and early inflammatory arthritis	Yes	Report received January 2016. Overall the Trust is partially compliant. Poor GP referrals make it difficult to triage patients into appropriate ESYN (early synovitis) clinics. GP referral database (DORIS) is available but not always used. Additional clinic capacity required to ensure patients are seen within 3 weeks of referral. Advice line available for direct access to department. 24 hour answer phone service with calls returned within 48 hours.
National Audit of Intermediate Care	NA	The Audit is not applicable to the Trust.
Chronic Kidney Disease in Primary Care	NA	MTW does not provide this service
Renal Replacement Therapy (Renal Registry)	NA	MTW does not provide this service
Older People		
Falls and Fragility Fractures Audit Programme (FFFAP) pilot	Yes	1. Falls- Report received November 2015. The Trust performed very well in the organisational aspects of this audit. Ongoing education to ensure lying and standing blood pressure is performed as

National Report Published April 2015 to March 2016	*Report received*	
		soon as practicable and appropriate actions taken if there is a substantial drop in blood pressure on standing.
	N/A	2. Falls Liaison Service
	Yes	3. National Hip Fracture Database- Report reviewed by department. Business plan for a second Ortho Geriatrician in place, interviews to take place.
Older people (care in emergency departments)	Yes	Report received June 2015. Overall the results from this audit are good. The one fundamental standard, 'that all patients over the age of 75 have at least one Early Warning Score' has already been addressed with the implementation of the Rapid assessments areas at both sites.
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Report received January 2016 and with specialty for review and action plan development.
UK Parkinson's	N/A	National report received August 2016. This is now reported in the 2016/17 Quality Accounts Report.
Other		
Elective surgery (National PROMs Programme) Hip Replacement, Knee Replacement, Groin Hernia, Varicose Vein	Yes	National Report received January 2017. MTW are to review the promotion of the PROMS questionnaires to patients in the pre-operative setting and reviewing the data that is being collected internally.
Mental Health		
Prescribing Observatory for Mental Health (POMH)	NA	MTW does not provide this service
Suicide and homicide in mental health (NCISH)	NA	MTW does not provide this service
Women's and Children's Health		
MBRRACE-UK; Perinatal Mortality Surveillance report; UK Perinatal Deaths for Births in 2013	Yes	Report received October 2015. All notes are reviewed at multidisciplinary mortality meetings. Learning identified and discussed at Risk Meeting, Clinical Governance Community Midwives team leaders meeting, Maternity Risk update. GAP (Growth Analysis Protocol) Project being implemented. Interpreters for Non English speaking patients. Kick Count being promoted by Community Midwives. This was the first time that many clinicians had used the Cause of Death & Associated Conditions (CODAC) system of death classification. In order to ensure accurate, consistent reporting it's recommended that the coding of the cause of death is undertaken by small local multidisciplinary teams. Cause of death to be checked by Bereavement Midwives or Maternity Clinical Risk Manager following post mortem/ all test reviewed. Continue processes and pathways already in place as now fully compliant
MBRRACE-UK; Perinatal Confidential Enquiry; Congenital Diaphragmatic Hernia (CDH)	N/A	MTW does not provide this service
MBRRACE-UK; Perinatal Confidential Enquiry; Antepartum stillbirth in term normally formed infants 2014	Yes	Report received November 2015. Growth should be monitored from 24 weeks by measurement of the symphysis fundal height and plotting the measure on a growth chart. Growth Analysis protocol being implemented from April 2016. GAP is now in place, with staff trained and aware of the policy.
Paediatric Inflammatory Bowel Disease; Biologics Round 2 (IBD Programme)	Yes	Report received September 2015. Education programme has been developed on the use of the Infliximab pro-forma that is filled out when patients

National Report Published April 2015 to March 2016	*Report received*	
		come to the ward. All new patient starters have a chest Xray, T-Spot and appropriate bloods prior to starting biologics. Guidelines followed. All Patients that start Biologics are followed up within 3 months of commencing Biologics and seen by the Nurse Specialist at each infusion to document Progress. PCDAI used to score patients progress. Steroids are always used as a last resort in patients with Crohn's disease.
National Paediatric Diabetes Audit (NPDA) 2014	Yes	Report received March2015. This was superseded by the next years report as the Assessment of Compliance for 2014 was never completed.
National Pregnancy in Diabetes Audit (NPID) 2014	Yes	Report received November 2015. Further liaising with primary care teams/GP surgeries regarding promotion of pre-conception care. Investigate the possibility of offering a pre-conception clinic facility within the maternity unit at MTW. Look at the possibility of creating a pre-conception advice page on the Trust website. Parts of the population are not accessing the care prior to pregnancy and this needs the primary carers to become involved. Encourage primary carers to use the available posters in the surgeries to improve uptake of pre-conception care.
Neonatal Intensive and Special Care (NNAP) 2014	Yes	Report received December 2015. New E3 Euroking maternity system downloads data direct to Badger interface. Badger training now included on new Drs induction programme by NNU staff
Paediatric Intensive Care (PICANet)	NA	MTW does not provide this service
National Confidential Enquiries		
Sepsis Study: 'Just Say Sepsis'	Yes	Report published November 2015. The Trust has a protocol that has been ratified and is available on Q-Pulse. Shortfall was identified in training of F2's and Registrars on the management of sepsis. Training slots to be arranged with clinical tutors. The outreach team carry out mandatory training on sepsis and there is an e-learning package available. Standardised sepsis proforma developed to aid the identification, coding and treatment of sepsis are in use and available across the Trust. A&E has a triage process using PAR scoring to identify patients with suspected sepsis. Nerve Centre is also used to identify these patients and ensure appropriate treatment pathways are followed. The Trust undertakes training on the management of Severe Sepsis and Infection control. A training package is included on the Trust mandatory training programme on antimicrobial policies and prescribing. The Trust provides rehabilitation in critical care and a 3 day follow up service on the wards but no formal post discharge follow-up is available due to limited resources. Patients who die with sepsis are discussed at M&M meetings, Autopsies are only done following a Coroner's opinion.
Gastrointestinal Haemorrhage Study: 'Managing the flow'	Yes	Report received July 2015 A Task and Finish Group has been set up to review service provisions in line with the recommendations of this national report. New pathway to be developed between Lower GI and Upper GI consultants to ensure continuity of

National Report Published April 2015 to March 2016	*Report received*	
		care. A care pathway is to be developed to incorporate all elements of assessment, escalation of care, documentation and network arrangements. To establish the role of an on-call consultant who will be responsible for major GI bleeds to enable assessment within one hour of the diagnosis of a major bleed. A service to enable 24/7 access to an OGD within the optimal 24 hours is to be set up.

Appendix C

Summary of local audits undertaken during 2016/17 against NICE Guidelines

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

Compliance has been assessed as: Fully compliant if all standards have been met. Partially compliant when >50% of the standards have been met. Non compliance is where less than 50% of the standards have been met.

CG/NG = Clinical Guidelines TA = Technology appraisal IPG = Interventional Procedures Guidance QS = Quality Standard PH = Public Health MPG = Medicines Practice Guidelines

NICE Guidance	Compliance	Actions taken as a result of the audit/Evidence of compliance
NICE CG132: Audit on Timing of Administration of Antibiotics for Caesarean Section	Fully compliant	No actions required as standards met.
NICE CG156: An audit of Perinatal Risks & Outcomes in	Partially compliant	Antenatal counselling regarding risks associated with an IVF pregnancy requires improvement. A leaflet is to be developed to be given in Gynaecology/Fertility clinics and used for counselling in Antenatal Clinics. All other standards were met.
NICE CG134: IVF Pregnancy Anaphylaxis	Partially compliant	The standards were not met on documentation of timings and advice given. We will monitor this as part of our regular departmental audits on documentation. All other standards were met.
NICE IPG 344: Assessment of departmental compliance with BSG Guidelines on Endoscopic classification and surveillance inpatients with Barrett's Oesophagus	Not compliant	Barrett's specific lists are now in place. Prague criteria should be stated for all endoscopic diagnoses. Quadrantic biopsies should be the minimum standard taken in patients with endoscopic diagnosis of Barrett's Oesophagus. BSG protocol, in addition to patient's preference and performance status, should be used to inform choices regarding endoscopic surveillance.
NICE CG144 & TA287: Diagnosis, management and follow-up of patients with PE (pulmonary emboli) at TWH	Partially compliant	Wells scores are inadequately utilised and documented in notes. Patients with unprovoked PEs, did not all have CT scans. PE proforma has been designed for junior doctors to complete and insert into clinical notes as guidance for investigating unprovoked PEs to include information for follow-up. eDNs to have automated proforma to provide more information for GPs follow-up
NICE CG144: Unprovoked pulmonary embolism follow-up	Partially compliant	Follow up of unprovoked PEs has to be carefully considered as it may be the first sign of a sinister pathology. All routine investigations are carried out, gender specific tests are not always done. A change has been made to the eDN to ensure follow up decision is always recorded and GP notified. A proforma has been created to list all investigations and management plans required.
NICE CG94: GRACE scoring in Acute Coronary Syndrome (ACS) Is it being assessed/done?	Not compliant	Assessment of future risk stratification of ACS is not always being carried out. Teaching sessions for staff working in A&E have been arranged. Cardiology team to calculate and document a GRACE score on initial assessment with all patients.
NICE TA249: Atrial fibrillation - dabigatran etexilate	Not compliant	Documentation of the process and reasoning behind the drugs prescription is poor and should be improved. Dabigatran is now rarely used in AF prophylaxis.

NICE Guidance	Compliance	Actions taken as a result of the audit/Evidence of compliance
		Alternative drugs, Rivaroxaban and Apixaban are now widely used. Re-audit of documentation of discussion with patients on the risks vs benefit with regards to this anticoagulant.
NICE CG 32: Re-audit: Use of the MUST screening for malnutrition at Maidstone and Tunbridge Wells NHS Trust 2016	Not compliant	Implemented actions: Increased MUST training. Update of MUST e-learning tool. Redevelopment of MUST tool to include action plan. Improvements shown since the last audit but still not reaching the required standard. Plans to include MUST in mandatory training for CSW's and RNs. The correct MUST tool to be used, contact the ward clerks to ensure correct ordering code is used.
NICE CG130: Hyperglycaemia in acute coronary syndrome (ACS)	Not compliant	Training for A&E clerking medical doctors / cardiology nurses of the importance of having blood glucose taken on admission. To consider including blood glucose as standard protocol for patients presenting with chest pain.
NICE QS63: Delirium: Re-audit	Partially compliant	Actions implemented: An additional clock was made available on Chaucer ward. Several teaching sessions were carried out to ensure doctors are aware of the need to carry out AMTS score for appropriate patients, act upon the score findings as necessary and communicate results to the GP. Education to ensure all doctors understand when to complete an AMTS. A new information leaflet for patients, family and carers is available and has been circulated to all staff. New junior doctor intakes are aware of the need to communicate results to GPs to enable further input from the community as necessary.
NICE QS90: Urinary tract infections in in-patients over 65 years	Partially compliant	The Trust is performing well in three areas. Less well in three others. Raise awareness of the over-diagnosis of UTIs and that the diagnosis should not be made on the basis of just a positive urine dip or urine culture. An Elderly Care liaison service commenced in October 2016, which may reduce the number of inappropriate diagnoses of UTI in medical admissions.
NICE CG169: Acute Kidney Injury and its management in Medical Patients (Re-audit)	Not compliant	Following the last round of the audit an AKI Care Pathway has been introduced. Improvements shown but standards not yet fully met. Doctors made aware of the need for clearer documentation of urinalysis and the need for USS of renal tract when assessing AKI patients.
NICE CG74: An audit of the use of antimicrobial prophylaxis for orthopaedic surgery at MTW NHS Trust	Partially compliant	Audit identified the need for both clarity and for post-surgical doses to be written up with clear 'post-induction' times. Clarification of terminology with a defined range of acceptable times could be of great use within the guidelines.
NICE CG92: Extended VTE prophylaxis in oncology patients undergoing major abdominal surgery: an audit in a district general hospital (T/Wells)	Not compliant	When patients are discharged from hospital LMWH is often not added to the TTO. To document '28 days of LMWH' in the post-operative instructions on the operation note. Review possibility of changing eDN software so the completing doctor actively considers the need for extended VTE prophylaxis
NICE MPG2: Re-audit of the use of PGDs for Sexual Health conditions in the hub GUM Clinic at MTW	Partially compliant	Template to aid documentation has been created and is in use. The audit demonstrated good PGD practices in the GUM clinic.
NICE CG124: Are we meeting the gold standard of care with regards to mobilisation of patients day one post repair of fractured NOF?	Partially compliant	Pain and anxiety were primarily the reasons why patients failed to mobilise in medically fit patients. A new Fracture NOF pathway has been developed to prompt appropriate analgesia. Education of nursing staff regarding MDT communication for referrals to physiotherapy, pain management and medical review where necessary.
NICE CG 179: Prevalence Audit March 2016	Partially compliant	Root cause analysis for all hospital acquired pressure damage is continuing and forms the basis for the serious incident review for hospital acquired category 3 and 4 pressure ulceration. The Trust will adopt a zero tolerance to moisture lesions. Education of all staff including Allied

NICE Guidance	Compliance	Actions taken as a result of the audit/Evidence of compliance
		Health professionals will continue to be a priority to accurately recognise pressure ulcers and deliver appropriate care. Ward based teaching will continue. Wards achieving zero prevalence will be published as good news events. A Trust-wide Action plan on prevention is in place.
NICE CG161: Audit: Compliance with the MTW NHS Trust 'Falls medication review stickers'	Not compliant	Falls Group Nurse to emphasise to the clerking ward staff the importance of attaching a yellow falls sticker onto a falls patient's drug chart. CSW/nurses/pharmacists to check the sticker for signature and date, if absent, they should remind the medical team to review. Falls Group Committee to emphasis to ward staff that a falls stickers must be placed on all patients aged 65 or older, regardless whether they have been admitted with a fall, so that their medications are reviewed and possibility of future falls reduced. Pharmacy team to pay particular attention to medicines that increase patients' risk of falls when reviewing medications, especially those patients admitted with a fall.
NICE CG 154: Early Pregnancy Assessment Clinic (EPAC) Performance Audit	Fully compliant	Consultant sessions presence in EPAC have increased due to additional weekly consultant sessions. All standards met so no actions required.
NICE CG140: Audit: Use of buprenorphine patches at Maidstone & Tunbridge Wells Hospital.	Not compliant	Pharmacy staff training on the use of when Butrans patches are appropriate to be prescribed will allow them to challenge prescriptions more.
NICE CG44: Re-audit of Intra-operative Novasure Failure Rate	Partially compliant	Following the previous audit a training session from the "Novasure" representative was undertaken for all clinical staff and this has reduced the risk of failure during the procedure. Medical staff to be made aware that all patients have USS organised before Novasure procedure. Another training session by "Novasure" representatives re trouble-shooting if cavity assessment fails; tips and techniques to overcome this.
NICE IPG156: Does breast papilloma follow-up at MTW breast unit detect any malignancies?	Fully compliant	Standards were met and no actions need to be taken
NICE CG37: Re-audit of the management of routine postnatal care of women and their babies	Partially compliant	Improvements demonstrated. Further re-audit to be carried out to assess whether the new E3 computer system resolves the problems with documentation in Postnatal care
NICE CG190: Management of delay in labour using Syntocinon	Partially compliant	A standardised document has been developed for use in vaginal examination timing and whether awaiting regular contractions before planning four hour examination.
NICE PH3: Audit of Prevention of Sexually transmitted infections & under 18 conceptions (Criteria 1-8 only Sexual Health)	Partially compliant	An Outreach team has been created and is currently in practice that focuses on change in behaviour of our patients. A 1:1 referral pathway within integrated sexual health for vulnerable groups clinics is now in place
NICE IPG 391: An audit on referral of patients with acute severe respiratory failure for extracorporeal membrane oxygenation (ECMO)	Fully compliant	An on line referral system will now allow direct access to referrals for auditing purposes.
NICE TA375: Biologic Therapy for Rheumatoid Arthritis	Partially compliant	There is a need to improve the area of provision of therapy within a reasonable range of time. Introduce a flowchart representing a graded procedure by which Biologics are prescribed and delivered to the patients in a more organized and timely manner, to ensure all appropriate data is recorded; one form to be completed for each patient.

Part Five

Stakeholder feedback

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

West Kent Clinical Commissioning Group comments on the 2016/17 Quality Accounts for Maidstone and Tunbridge Wells NHS Trust

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

Patient Safety
Learning from incidents and embedding change is essential. We look at how MTW intends to learn and share from serious incidents as part of our incident closure process, identifying themes and trends to help identify areas for greater scrutiny. It is pleasing to note the incidents of falls has declined and that work continues to reduce these further. It was disappointing for all concerned that the Trust exceeded the maximum number of cases of C-Diff this year by one. The CCG continue to support the embedding of a safety culture within the Trust and applaud their open and honest approach.

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

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

Paula Wilkins
Chief Nurse
West Kent CCG

5th May, 2017.

Health Overview and Scrutiny Committee – Kent County Council comments on the 2016/17 Quality Accounts for Maidstone and Tunbridge Wells NHS Trust

Draft Quality Accounts were submitted to the Kent Overview and Scrutiny Committee, Kent County Council. The Chairman, Mike Angell who responded:-

Thank you for the copy of Maidstone and Tunbridge Wells NHS Trust Quality Accounts 2016/17. The Kent HOSC will not be providing a statement this year as the Committee has not been reconstituted following the election on 4 May; it will be reconstituted on 25 May which is after the deadline for comments.

The Committee looks forward to receiving future copies of the Quality Accounts.

Received on the 9th May, 2017.

Healthwatch Kent comments on the 2016/17 Quality Accounts for Maidstone and Tunbridge Wells NHS Trust

Maidstone and Tunbridge Wells NHS Trust Quality Account Response

Healthwatch Kent is the independent champion for the views of patients and social care users in Kent. Our role is to help patients and the public get the best out of their local Health and Social Care services.
For several years now, local Healthwatch across the country have been asked to read, digest and comment on the Quality Accounts which are produced by every NHS Provider (excluding primary care and Continuing Healthcare providers).
As Healthwatch Kent has experienced cuts in resources along with everyone else, this year we have not been able to look at the report in detail.
However, we would like to support the Trust with a comment which reflects some of the work we have undertaken together in the past year.
We have seen that Maidstone and Tunbridge Wells values and understands our statutory role as a "critical friend". Some of our involvement with the Trust this year has included:

- Using our formal powers to Enter & View Outpatients services at both hospitals and talk to patients about their experience. Many of our recommendations following that visit have now been implemented including improved signage and layout.
- We are currently visiting both hospitals, care homes and people's homes to gather feedback from patients about their experience of being discharged from hospital.
- Being an active member of the Patient Experience Committee and supporting the group's development.
- Meeting regularly with the Chief Nurse to keep up to date with Trust activity
- Holding regular information stands at both Maidstone and Tunbridge Wells Hospitals, to talk directly to patients and hear their experiences of services.
- We have reviewed the Trust's engagement activities and encouraged the Trust to commit resource to engaging and involving local communities more in their work.
- Our volunteers regularly review patient leaflets.

We look forward to our continuing work with the Trust throughout the upcoming year.

Healthwatch Kent
15th May, 2017.

Independent Auditor's Limited Assurance Report to the Directors of Maidstone and Tunbridge Wells NHS Trust on the Annual Quality Account

We are required to perform an independent assurance engagement in respect of Maidstone and Tunbridge Wells NHS Trust's Quality Account for the year ended 31 March 2017 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the following indicators:

- Percentage of patients risk-assessed for venous thromboembolism (VTE)
- Rate of clostridium difficile infections

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

Respective responsibilities of directors and auditors

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

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

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

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

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

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

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

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2016 to June 2017;
- papers relating to quality reported to the Board over the period April 2016 to June 2017;
- feedback from Commissioners dated [XX/XX/20XX];
- feedback from Local Healthwatch organisations dated May 2017;
- feedback from Overview and Scrutiny Committee dated [**XX/XX/20XX**];
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated [XX/XX/20XX];
- the latest national patient survey dated [XX/XX/20XX];
- the latest local patient survey dated [XX/XX/20XX];
- the latest national staff survey dated [XX/XX/20XX];
- the latest local staff survey dated [XX/XX/20XX];
- the Head of Internal Audit's annual opinion over the trust's control environment dated 25/04/2017;
- the annual governance statement dated 25/5/2017; and
- any other relevant information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the "documents"). Our responsibilities do not extend to any other information.

This report, including the conclusion, is made solely to the Board of Directors of Maidstone and Tunbridge Wells NHS Trust.

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Maidstone and Tunbridge Wells NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included:

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

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

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

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

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our limited assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Maidstone and Tunbridge Wells NHS Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

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

Signature

Grant Thornton UK LLP
2nd Floor

St Johns House
Haslett Avenue West
Crawley
RH10 1HS

xx June 2017

Statement of Directors' responsibilities in respect of the Quality Accounts

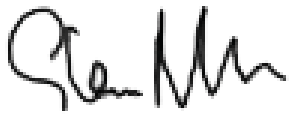
The directors are required under the Health Act 2009 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality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

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

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

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

By order of the Board



Date: 29/5/17

Trust Board meeting June 2017

NHS
Maidstone and Tunbridge Wells NHS Trust

6-13 Quarterly mortality data — Medical Director

This report is submitted in line with guidance from the National Quality Board, March 2017. This stipulates that Trusts are required to collect and publish, on a quarterly basis, specified information on deaths. This should be through a report and an agenda item to a public board meeting in each quarter to set out the Trust's policy and approach (by then end of Quarter 2) and publication of the data and learning points (from Quarter 3 onwards).

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

This report outlines the outcome of those investigations, their findings and further actions that are subsequently required.

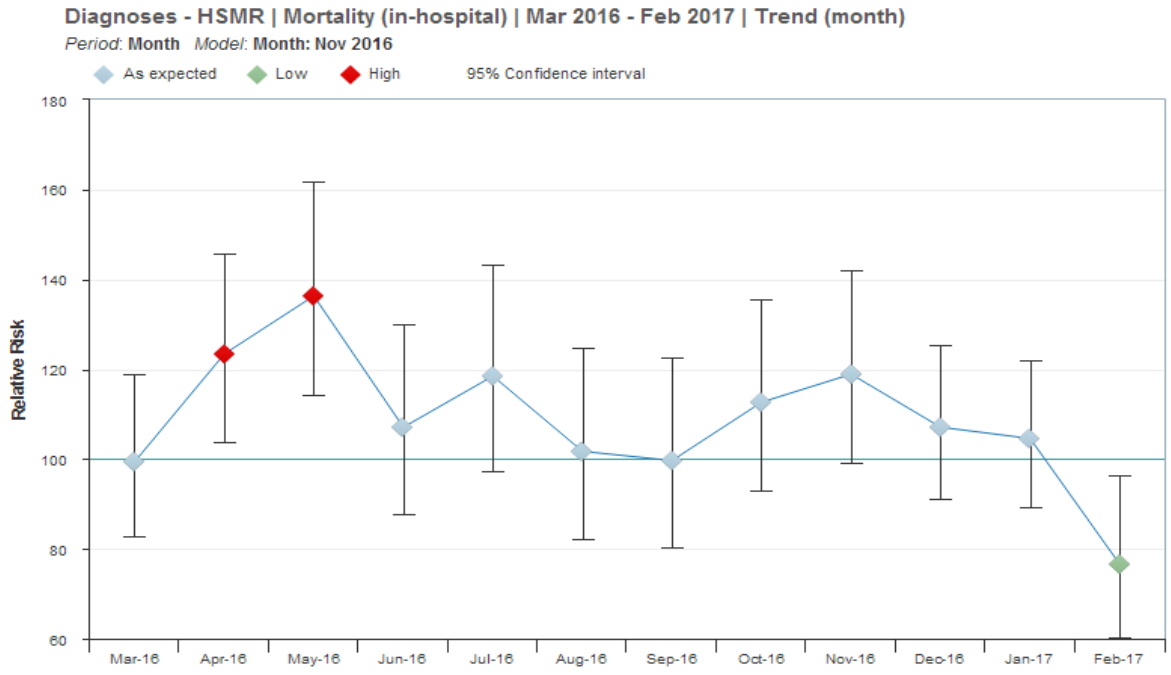
Which Committees have reviewed the information prior to Board submission?
- N/A

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

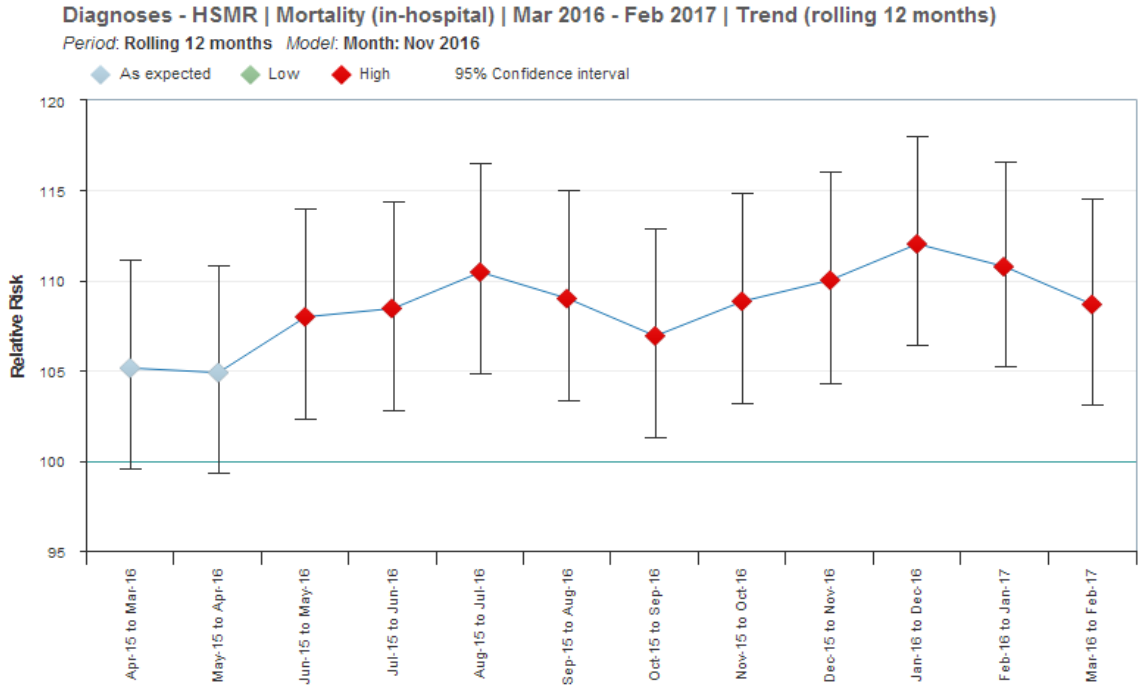
[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making;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

Current Position; Dr Foster

The Hospitalised Standardised Mortality Ratio (HSMR) is the most widely accepted indicator used as a measure of patient safety within an organisation, as such; we have attracted negative interest in being an outlier for this indicator. Despite the efforts that have been taken to understand the areas identified and to make redress, the most recent data from Dr Foster does little to give assurance of an improving picture. The first graph clearly demonstrates that month on month the HSMR has improved since the identified outlying months of April and May in 2016. As a word of caution the data for February is currently incomplete and is subject to change.



However graph two (below), which runs on a 12 month rolling average per point on the x-axis, does not provide the same level of assurance. The belief was that once we had moved past the outlying months of April and May 2016 that the HSMR data would return to an acceptable level, however Dr Foster do not have this same level of confidence and believe we will continue to remain an outlier.



'Investigating a high HSMR – best practice'

The guidance from Dr Foster recommends that we follow an investigation pathway:-

- Check coding- poor depth of coding can affect HSMR and it is recommended that coders and clinicians work more closely together
- Casemix- has something extraordinary happened? i.e. an abnormal run of severely ill patients in a short period of time.
- Structure- does our organisation and surrounding healthcare partners work differently to other trusts across the country.
- Process- at this point, consider is there a potential issue with quality of care.
- Individual or team- on occasion the investigation will lead you to an individual or team.

The Dr Foster report has consistently identified four 'red flags' – these include Congestive Heart Failure, Fractured Neck of Femur, Pneumonia and Non-Hodgkin's lymphoma. These are the four 'diagnoses' that have observed deaths greater than the levels that should be expected. Of these we have undertaken a 'Deep Dive' into Orthopaedics with a plan for Pneumonia agreed and Congestive Heart Failure and Non-Hodgkin's in development for next steps.

Coding Review

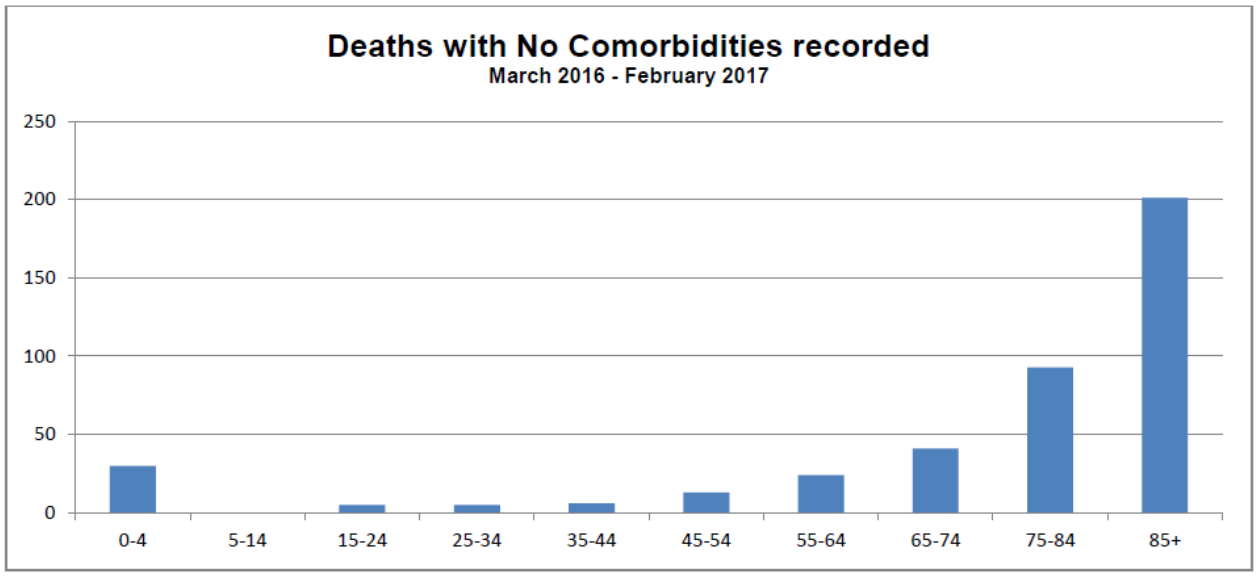
A coding review was carried out in February 2017. This report was commissioned prior to the deep dive into mortality but added to answer questions on accuracy and depth of coding in deceased patients. The following points should be noted.

- Overall coding accuracy was good
- Secondary diagnosis information was not always coded
- Information anomalies were apparent with the patients who had a death diagnosis of lymphoma
- Only accredited coders will now be allowed to code patients who have died
- Further work is needed to understand the role of miscoding in the trust's mortality data.

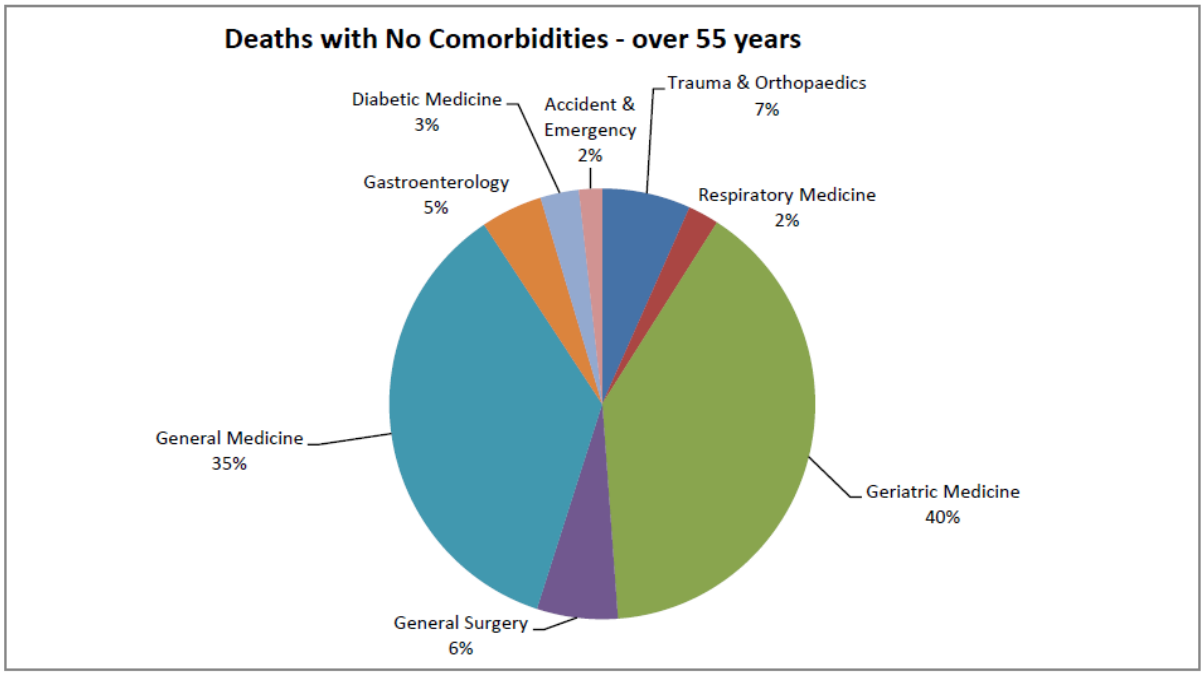
Casemix

There are various factors that influence the level of 'expected' deaths assigned to a Trust for the purposes of reporting the HSMR these include; Sex, Age, Diagnosis, type, time and month of admission, socio-economic factors, palliative care and diagnosis/procedure subgroups. One of the key factors is patients' co-morbidities (based on Charlson score) as this informs the Trust's casemix. Of the 1730 deaths recorded March 16 to February 17, 415 had no co-morbidities recorded (31.5%).

Deaths with a Charlson Score of zero recorded by age:-



Death (>55yrs) with a Charlson score of zero recorded by speciality (at diagnosis)



Targeted work with Specialist and Acute Medicine is required to address this potential under-reporting of co-morbidities as our coding team can only code against information that is recorded within the medical records. If the level of detail can be improved upon we can then ensure the 'expected' deaths assigned to the Trust are accurate.

Update on the Fractured Neck of Femur (NOF) Deep Dive

The timeframe was October 2015-September 2016, 48 deaths were identified by Dr Foster requiring further investigation. A sample of notes (circa 20) was reviewed by both Orthopaedic and geriatric consultants. 'Sampling' was necessary due to the availability of the medical notes. The ultimate objective of our deep dive was to determine if suboptimal care had been provided either by orthopaedic or geriatric specialities.

The Orthopaedic Directorate were initially challenged to reconcile the data produced by Dr Foster with that available from the National Hip Fracture Database (NHFD) as this had not previously identified any concerns with mortality data.

The total number of fractured NOF admissions using NHFD data for the time period, October 2015-September 2016, was 597 deaths. 39 deaths were reported on the NHFD database (Deaths within 30 days); 39/597 = 6.5%. For the same timeframe the 30 day Deaths National Average = 6.6%.The trust is not an outlier using the NHFD data and the trusts % 30 day mortality for this period remains under that of the national average.

Dr Foster identified 48 deaths, of which, one was miscoded as a fractured NOF (proximal shaft of femur fracture). Dr Foster has a Trust expected mortality rate of 36.8 patients (8.7%) – at present we are unclear as to the methodology of how this figure is arrived at and there is no indication of the total number of patients that Dr Foster has used for their calculations of mortality.

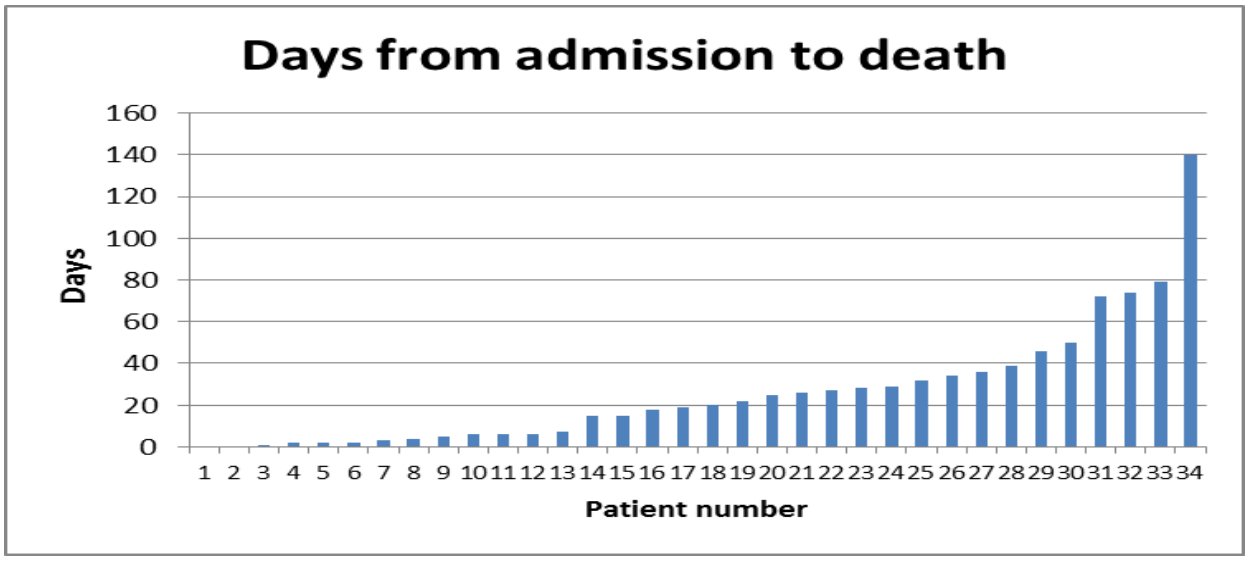
Different data collection forms were used on these reviews so data available to analyse varied.
- 9 Cases received only an orthopaedic review
- 11 cases were reviewed by both clinical teams
- 14 were reviewed solely by the medical consultant

In total: 34 sets of case notes received a review by a consultant team (71% 34/48)

Case mix: All patients (N=34)
7 (21% 7/34) patients did not have a procedure carried out
19 (56% 19/34) had some level of dementia recorded as a comorbidity
14 (79%15/19) were AMTS Graded as ≤5/10 (Severe) These patients tend to have poorer outcomes post-surgery due to decreased ability to rehabilitate.

Key Causes of death as recorded on the Death Certificates (n46):

Pneumonia Broncho pneumonia (4) Aspirational pneumonia (5) Hospital Acquired pneumonia (2) Pneumonia (5)	**Fractured NOF**	**Heart Disease**	**COPD**	**Ca**	**MI**
16	12	8	5	2	3



Patient with 140 days from admission to death was well at time of discharge from hip surgery but subsequently died at another hospital following an admission that required abdominal surgery.

Conclusions from the review include:-

- *Of the case notes reviewed, the clinical coding was considered to be correct.*
- *Pneumonia (Aspirational pneumonia, Community Acquired and Hospital Acquired pneumonia) were the most frequently occurring comorbidities and recorded cause of death.*
- *7 / 34 (20%) were not operated upon. These patients were considered to have been managed appropriately. Where possible, family and patients were involved in all discussions about care and outcomes. It is not known whether this is considered high because of the small number of case notes audited for this review and the lack of available data on all patients diagnosed with fractured NOF during this period., However we do know that 13/597 (2%) patients on the NHFD did not receive surgery.*
- *27 / 34 (79%) patients had surgery, of these 8 patients exceeded 48 hours from admission via A&E to time of procedure (33%), evidence suggests that >48 hours increases the mortality rate.*
- *Of the 34 reviews undertaken all deaths were classed as expected, however 2 patients, who both underwent surgery, were considered to have received some degree of suboptimal care, history of sepsis pre-operatively, delay in a Consultant review post-operatively (seen by junior member of the medical team) and the second patient developed surgical complications with lack of multi-disciplinary input re nutritional needs. These views will be further raised at the*

specialty mortality meetings. Any learning will be disseminated to relevant teams and presented at Clinical Governance.

Understanding the disparity in the HSMR for fractured NOF patients and the NHFD –

- NHFD focus on over 60's only – Dr Foster include all patients (so Dr Foster may have a slightly larger sample set)
- NHFD include deaths within 30 days of discharge following procedure – Dr Foster is not limited to 30 days post discharge (so Dr Foster has a greater sample set and all subsequent attendances are linked back to the primary diagnosis- referred to as super-spells)
- NHFD based on crude numbers whereas HSMR is a risk score made up of 12 factors including - Age, Sex, Method of admission (Elective or Non-Elective), Socio-economic deprivation, Diagnosis CCS subgroup, Co-morbidity, Source of admission, Number of emergency admissions in last 12 months, Palliative care, Year and Month of admission.

Understanding our HSMR and possible contributing factors –

- Time to surgery is considered a possible factor, as approximately a third of patients audited had not been operated on as per the standard, within 48hrs.
- The NOF Nurse reported delays due to theatre availability and sub-specialisation of surgeons and the associated rostering of operations.
- Data Quality – coding of the records audited was overall considered to be good.
- Coding of the reasons for procedures not taking place was highlighted as an area for improvement and requires a change in practice for consultants in their record keeping.
- Query over age profile >90+ year old patients – Dr Foster agreed that we appear to have a greater number of patients in this age range than our peers.
- Activity levels in this organisation were reported to be greater than our peers by our rotating Registrars and is supported by the greater than expected number of non-electives admitted to this organisation.

Actions taken

As a result of this review, and the data produced by the NHFD that had recognised the delay in patients being operated on within 48hrs, a Business Case was developed to support the funding of Theatre 6 at Tunbridge Wells Hospital in an effort to ensure that our patients receive surgery within the nationally recommended timeframes. The Directorate also have revised their workforce and now have a dedicated NOF nurse to monitor this pathway of care and work with the NHFD administrator to meet the parameters of care required.

In addition to the work undertaken with Orthopaedics support from Dr Foster has continued to gain greater understanding of ourselves as an organisation and to address the external scrutiny that being an outlier for HSMR brings.

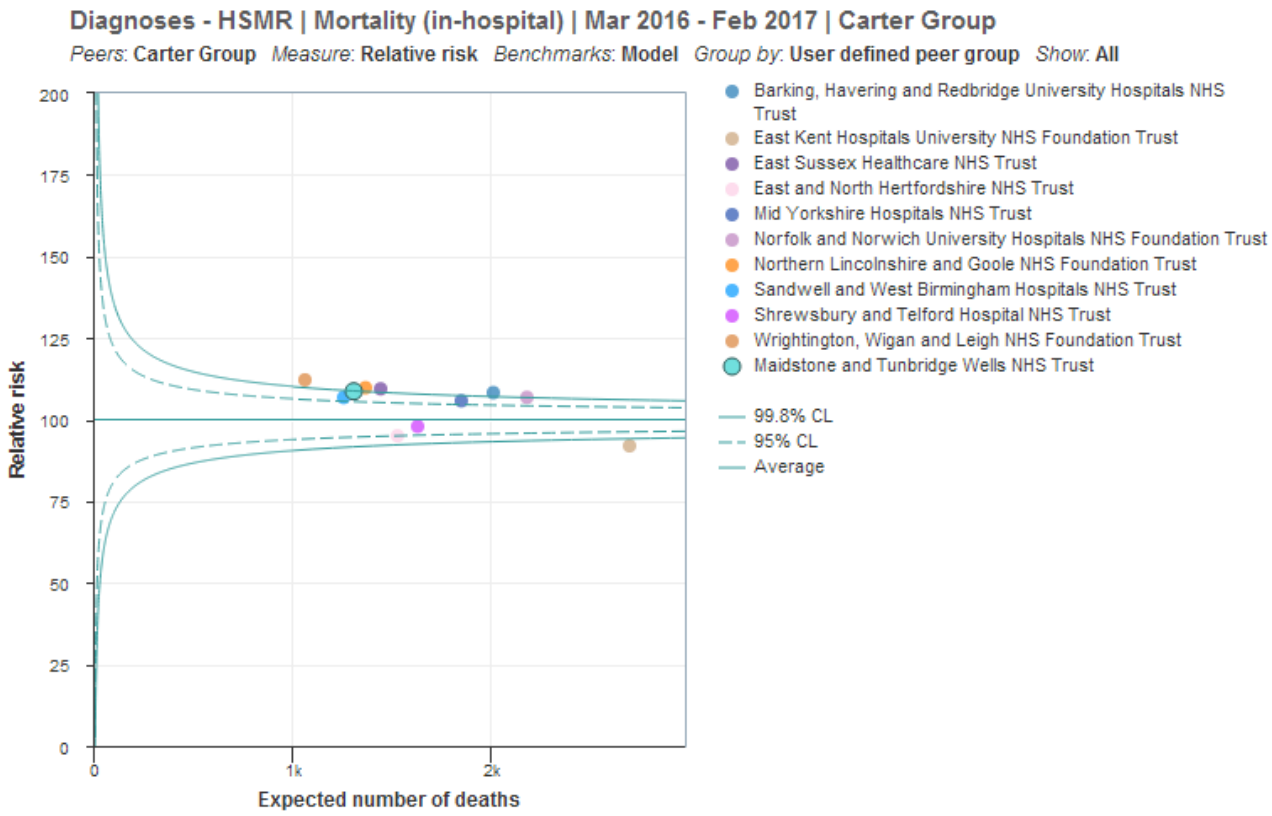
Organisational review of HSMR data:-

Mortality Data - Action Plan - Produced in January 2017

No.	Item	Action	Action Owner(s)	Original Deadline	Current Deadline	Status	Update
1	**Improve the visibility of mortality data within the Operations Directorate / Trust**	Design an internal Mortality dashboard by specialty and circulate to Ops managers monthly	James Jarvis	31/01/2017		Completed	Information Team has designed the new scorecards. Copies set to AG and PM. These have been circulated to Ops leads by AG.
		Share the Dr Foster standards dashboards with Ops managers e.g. CDs, Matrons and Directors of Ops, on a monthly basis.	James Jarvis	31/01/2017		Completed	Copies set to AG and PM. These have been circulated to Ops leads by AG
		Promote the use of the Dr Foster tools for services to self-serve to access mortality data.	James Jarvis / Dr Foster	31/03/2017	31/07/2017	Action Delayed	Training is being arranged for key staff with Dr Foster.
		Explore the inclusion of mortality review completeness on the EPR scorecards to raise the profile of the requirement to complete these and the associated benefits.	James Jarvis / Lynne Sheridan	31/03/2017		Completed	To be agreed by Jim Lusby as chair of the EPR Meetings and Exec Lead. Done - Jan-17 EPR Packs.
		Review the data supplied to the Mortality Surveillance Group in light of the recent deep dive and ensure this is appropriate to provide a focus on the key areas highlighted.	James Jarvis / Peter Maskell	28/02/2017		Completed	Dr Foster reports by Spec and Trust-level PLUS new scorecards sent to PM & AG.
2	**Verify the risk rating associated with Fractured NOF reported by Dr Foster**	Set up a half day session to review the relevant deaths with the lead consultant, Dr Foster and other internal supporting staff e.g. analysts and quality team.	James Jarvis / Wendy Glazier	28/02/2017		Completed	Session held - 1st Feb and follow up on the 8th Feb.
		Review the information reported from other sources e.g. the National Hip Fracture Data Base and try to reconcile to the Dr Foster data / understand the differences.	James Jarvis / Dr Foster	28/02/2017		Completed	Review of both data sources completed and the differences highlighted.
		Produce a report to explain the results of the audit and an action plan to address and issues found for either Ops, Information or third parties e.g. Dr Foster.	James Nichol	31/03/2017	21/04/2017	Completed	Results of the audit have been reported and shared.
3	**Ensure that mortality data is fed into the 7 Day Services project to reduce variation**	Provide baseline reports to the 7 Day Service programme board on mortality by day of the week by specialty, diagnosis and procedure - for Stocktake review for Clinical Directors Presentation.	James Jarvis	31/01/2017		Completed	Shared variety of Mortality reports with LS and PS for presentation to CDs.
		Set up and provide regular reports to the 7 Day Service programme board on mortality by day of the week by specialty, diagnosis and procedure.	James Jarvis / Lynne Sheridan	15/03/2017		Completed	JJ on Steering Group. Report added to Info Kiosk with Mortality by day of the week.
		Ensure reducing variation in mortality across the week is a key focus of the 7 Day Services programme.	James Jarvis / Lynne Sheridan	31/03/2017		Completed	JJ on Steering Group. Reports to included on the agenda.
4	**Ensuring the Trust's 'expected' level of mortality is as accurate as possible**	Review the resourcing of the Clinical Coding function and ensure this is in line with national benchmarks and produce a business case to cover any changes required.	Bernice Lloyd	31/01/2017		Completed	Business Plan went to Execs 31st Jan. Approved.
		Implement the plan when the business case has been finalised and approved.	Bernice Lloyd	31/03/2018		Action On Track	
		Provide guidance and training for Ops staff on the importance of clinical coding and the impact on mortality reporting.	Bernice Lloyd	31/03/2018		Action On Track	Ongoing training and support to staff.
		Provide focussed support for the Specialties identified as recording below expected levels of comorbidities.	Bernice Lloyd	31/03/2017	30/06/2017	Action Delayed	
		Monitor the levels of comorbidities recorded by specialty and highlight variation by exception.	James Jarvis	28/02/2017	30/06/2017	Action Delayed	Some adhoc reports have been produced, but need to agree a
		Ensure data quality for demographic data is as expected and monitor via DQ group.	James Jarvis	31/03/2018		Action On Track	Ongoing reporting and monitoring of DQ.
5	**Set up Early Warning Alerting**	Share mortality reports by specialty, diagnosis and procure to provide early warning alerting via the Dr Foster tools.	James Jarvis	28/02/2017		Completed	
		Set up the new Early Warning reporting on Dr Foster - using local data feeds, to provide more timely mortality reporting.	James Jarvis	31/03/2017		Completed	IG Committee have signed off the PIA. Data Sharing Agreement Signed. Information Team are working on data feeds.
		Once set up ensure the new Early Warning reports are shared with the Mortality Surveillance Group and other appropriate forums and managers / Ops staff.	James Jarvis	31/03/2017	31/07/2017	Action Delayed	The tool has been set up and access granted to the Trust. We can now look at how we use the new tool and share access / reports.

In addition we have benchmarked ourselves against comparator organisations:-

The Carter Peer Group-



	Super spells	Spells	Observed	Crude rate (%)	Expected	Expected rate (%)	Observed-expected	Relative risk	95% lower confidence limit	95% upper confidence limit
All	479263	480974	19025	3.969637	18333.84	3.825423	691.1645	103.7699	102.4	105.3
Norfolk and Norwich University Hospitals NHS Foundation Trust	67812	68064	2329	3.434495	2180.355	3.215293	148.6453	106.8175	102.6	111.3
Mid Yorkshire Hospitals NHS Trust	55822	55965	1956	3.503995	1849.47	3.313157	106.5296	105.76	101.2	110.6
East Kent Hospitals University NHS Foundation Trust	55740	55971	2484	4.456405	2701.055	4.845811	-217.0552	91.96406	88.4	95.7
Shrewsbury and Telford Hospital NHS Trust	53233	53715	1599	3.003776	1632.989	3.067626	-33.98944	97.91858	93.2	102.9
Barking, Havering and Redbridge University Hospitals NHS Trust	41318	41379	2178	5.27131	2011.939	4.869401	166.0609	108.2538	103.8	112.9
East Sussex Healthcare NHS Trust	38845	38908	1580	4.067448	1443.907	3.717098	136.0933	109.4254	104.1	115
Northern Lincolnshire and Goole NHS Foundation Trust	38705	38789	1501	3.878052	1367.511	3.533164	133.4889	109.7615	104.3	115.5
Sandwell and West Birmingham Hospitals NHS Trust	37895	38002	1339	3.533448	1254.115	3.309446	84.88536	106.7685	101.2	112.7
Maidstone and Tunbridge Wells NHS Trust	32999	33145	1422	4.309221	1308.552	3.965429	113.448	108.6697	103.1	114.5
East and North Hertfordshire NHS Trust	32816	32898	1449	4.415529	1524.774	4.646435	-75.77415	95.03047	90.2	100.1
Wrightington, Wigan and Leigh NHS Foundation Trust	24078	24138	1188	4.933965	1059.168	4.398904	128.8319	112.1635	105.9	118.8

A meeting was convened with Dr Foster on 14th June 2017 at which we gained a greater understanding of how the upper and lower confidence limits are set in relation to our demographics and patient profile. There were a number of areas for further action for the Information and Clinical Coding teams to follow upon. Most notable was the need to provide support and guidance to clinicians to improve the completeness of the record keeping associated with comorbidities, to enable these to be coded. Improving the quality of this aspect of our mortality data will help improve the accuracy of the 'expected' levels of mortality for patient profile. This will ensure an accurate picture of our mortality is reported in the future.

The Mortality Surveillance Group (MSG):-
The MSG has been operational in its current format since February 2016 and has made consistent progress in improving the reported positon of Mortality reviews, with acknowledgment that 100% compliance needs to be reached. The latest local position is:-

Position of Mortality Reviews – (Apr 16-Mar 17)

Trust	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD
No of Deaths	170	158	134	132	121	121	155	159	204	201	164	165	1884
No of Completed Reviews	52	47	41	57	65	74	101	119	128	132	92	51	959
%age completed reviews	**30.6 %**	**29.7 %**	**30.6 %**	**43.2 %**	**53.7 %**	**61.2 %**	**65.2 %**	**74.8 %**	**62.7 %**	**65.7 %**	**56.1 %**	**30.9 %**	**50.9 %**
No of Completed Reviews within agreed timescale	19	6	17	16	17	28	47	42	54	64	59	29	398
%age completed review within agreed timescale	**11%**	**4%**	**13%**	**12%**	**14%**	**23%**	**30%**	**26%**	**26%**	**32%**	**36%**	**18%**	**21%**
Unavoidable deaths, No Suboptimal Care	44	42	31	50	51	61	84	96	107	116	87	48	817
Unavoidable Death, Suboptimal care	5	4	6	4	10	11	11	12	11	11	2	0	87
Suboptimal care, possible Serious Incident	1	1	1	1	2	1	3	1	2	2	0	1	16
Suboptimal care, a Serious Incident	0	0	0	1	0	0	0	2	1	0	0	0	4
Unknown Classification	2	0	3	1	2	1	3	8	7	3	3	2	35
%age Unavoidable deaths, No Suboptimal Care	**85%**	**89%**	**76%**	**88%**	**78%**	**82%**	**83%**	**81%**	**84%**	**88%**	**95%**	**94%**	**85%**
%age Unavoidable Death, Suboptimal care	**10%**	**9%**	**15%**	**7%**	**15%**	**15%**	**11%**	**10%**	**9%**	**8%**	**2%**	**0%**	**9%**
%age Suboptimal care, possible Serious Incident	**2%**	**2%**	**2%**	**2%**	**3%**	**1%**	**3%**	**1%**	**2%**	**2%**	**0%**	**2%**	**2%**
%age Suboptimal care, a Serious Incident	**0%**	**0%**	**0%**	**2%**	**0%**	**0%**	**0%**	**2%**	**1%**	**0%**	**0%**	**0%**	**0%**

National Quality Board Dashboard- May- June 2017.
The Trust's method of Mortality reviews currently codes into 4 categories 0-3 as above. The New Dashboard (enclosed in Appendix 1) however codes in categories of 1-6. This will be addressed through the new Mortality Policy and review process that will be produced. It should also be noted that the new dashboard is still being refined, and Appendix 1 therefore contains some aspects that require further clarification and/or explanation. This will be worked on ahead of the next quarterly publication.

Next Steps:-
- Work with coding to disseminate learning to clinicians via Clinical Governance sessions
- Work with Bereavement service to support medical teams with Cause of Death and ensure that Comorbidities considered for part 2
- Review of patients coded with '0' co-morbidities
- Undertake Mortality review of Pneumonia
- Revise processes to meet the requirements issues by the National Quality Board in March 2017
    - Present new Dashboard (NQB) at Trust Board (quarterly)
    - Publish Mortality Strategy, Policy and new Mortality Review process- September 2017
    - Learning from Mortality reviews to be presented to Board- December 2017

NHS Learning from Deaths Dashboard Department of Health

Organisation	Maidstone and Tunbridge Wells NHS Trust
Financial Year	2017-18
Month	May

Learning from deaths dashboard V2.1, updated 08/03/2017

Learning from Deaths Dashboard

Purpose of the dashboard

This suggested dashboard is a tool to aid the systematic recording of deaths and learning from the care provided by NHS Trusts. Trusts may use this to record relevant incidents of mortality, deaths reviewed and lessons learnt to encourage future learning and the improvement of care.

Guidance on what should be recorded in individual fields is provided below, alongside instructions for completing and updating the dashboard. This guidance on individual fields complements the wider guidance provided in the National Framework on Learning From Deaths and separate methodology guidance on the Structured Judgement Review (SJR) as developed by the Royal College of Physicians (RCP). The dashboard is not prescriptive and Trusts may set their own definitions according to local goals and data availability, although minimum requirements are set out in the framework.

To update this dashboard - enter your data on the "Data" worksheet. The dashboard sheet is automatically updated.

Guidance on individual fields

Field No.	Field	Description of Field
Recording data on structured judgement reviews:		
1	**Total Number of Deaths in scope**	This must as a minimum include all adult inpatient deaths excluding maternity services. Where additional deaths are included (for example maternal deaths, deaths post-discharge or deaths of outpatients etc) the inclusion criteria should be made clear in this field, which can vary by trust. The total number of deaths in scope defined in this field must be used in all subsequent relevant fields in this work book. If a post-discharge period is being included in scope, (eg deaths within 30 days of discharge) then the death should be counted in the month where the death actually occurred rather than time of admittance or discharge. Note that where it has been identified that a patient has a learning disability the death should be recorded separately (see Data item 6, below).
2	**Total Number of Deaths Reviewed under the SJR methodology**	This is the total number of deaths for which the care provided to the patient has been reviewed by your Trust. This may be a combination of deaths reviewed under national and local minimum requirements and random sampling of all other deaths in scope.
3	**Total number of deaths considered to have more than a 50% chance of having been avoidable**	The Structured Judgement Review methodology, for use in relation to adult acute inpatient deaths, allows for reviewers to score a death as having a more than 50% chance of having been avoidable when this judgement is made in relation to the care provided by the trust conducting the review. This is the equivalent of a score of 3 or less. If using the RCP SJR then the number of such deaths scored in this way is equivalent to this field If not using RCP SJR, then the method used to judge whether a death was more likely than not to have been avoidable in relation to the care provided by the trust conducting the review (or another provider if appropriate) should be stated here including any definitions used. Note that if you are applying other methodologies to specific groups, such as learning disabilities patients, those methodologies may require a degree of judgement to determine whether the death was more likely than not to be avoidable. It may be appropriate to cross-reference those outputs with the processes for assessing structured judgement reviews, and if appropriate to include those outputs here. If the RCP SJR methodology is being used for structured judgement reviews Trusts are able to include monthly totals of reviewed deaths that were in each category 1 to 6. If the Trust is not using this methodology these fields can be either left blank or edited as appropriate.
Recording data on LeDeR reviews:		
4	**Total Number of Deaths in scope**	This must include all adult inpatient deaths for patients with identified learning disabilities. The total number of deaths in scope defined in this field must be used in all subsequent relevant fields. If a post-discharge period is being included in scope, (eg deaths within 30 days of discharge) then the death should be counted in the month where the death actually occurred rather than time of admittance or discharge.
5	**Total Deaths Reviewed Through the LeDeR Methodology**	Formally, the LeDeR review methodology should be applied to all of the deaths shown as 'in scope'. You should record the total number of deaths reviewed here.
6	**Total Number of deaths considered to have been potentially avoidable**	Record the total number of deaths for which review evidence leads to a conclusion that it is more likely than not that the death was potentially avoidable. This will require that a degree of judgement is applied to the outputs of the LeDeR review, and it may be appropriate to cross-reference these outputs with the processes for assessing structured judgement reviews

How to update the dashboard

To update this dashboard - enter your data on the "Data" worksheet. The dashboard sheet is automatically updated.

To update the dashboard with new data:
1. Enter data for appropriate month(s) in the Data tab. Note that the RCP1 to RCP6 and Trust comparison fields are optional and the dashboard will still function correctly if these fields are left blank.
- In the first 3 columns enter the data for your structured judgement reviews (number of deaths in scope, numbers reviewed, and numbers deemed potentially avoidable)
- You have the option of recording how many of the SJR reviews placed cases in each of the RCP1 to RCP 6 categories.
- For learning disabilities patients, enter the number of deaths in scope, numbers reviewed under the LeDeR methodology, and numbers deemed potentially avoidable

2. Change the month and year on the Front Sheet tab to the most recent month of data.
3. Change the data range on the time series charts as required by using the interactive dropdowns on the Dashboard tab (eg cell V4). Note that the time series charts are not linked to the front sheet selection and are driven entirely by the dropdowns.

Maidstone and Tunbridge Wells NHS Trust: Learning from Deaths Dashboard - May 2017-18

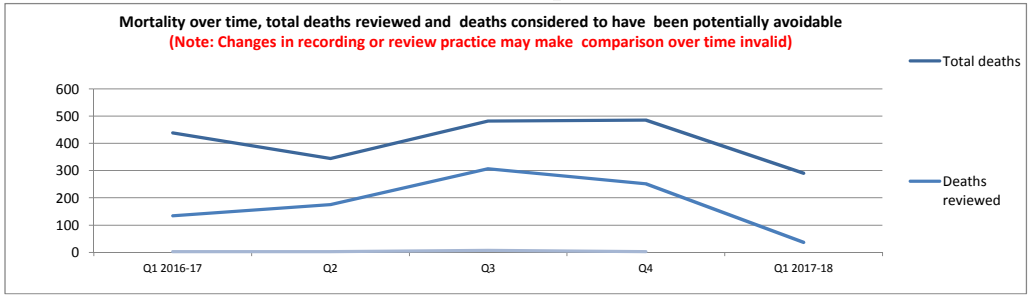
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
153	137	5	32	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
290	486	37	252	0	3
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
290	1752	37	868	0	16

Time Series: Start date 2016-17 Q1 End date 2017-18 Q1



Total Deaths Reviewed by RCP Methodology Score

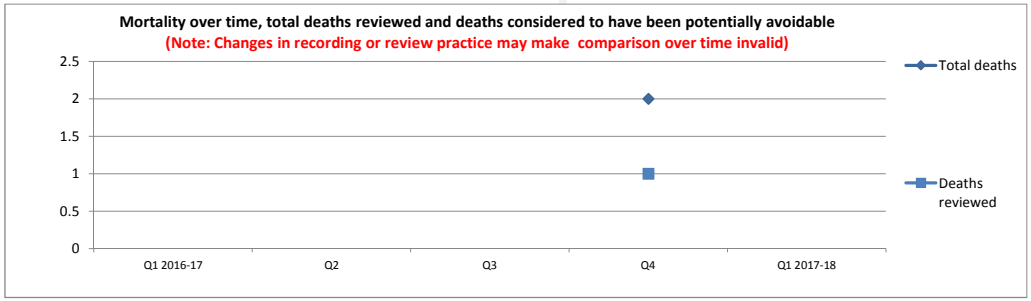
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	153	100.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	290	100.0%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	290	100.0%

Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	2	0	1	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
0	2	0	1	0	0

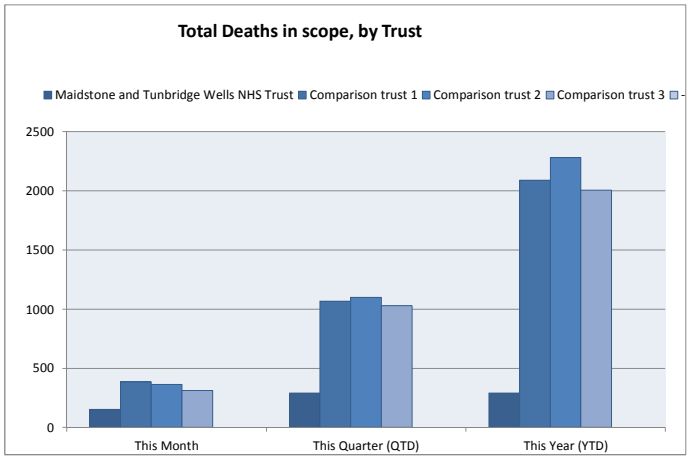
Time Series: Start date 2016-17 Q1 End date 2017-18 Q1

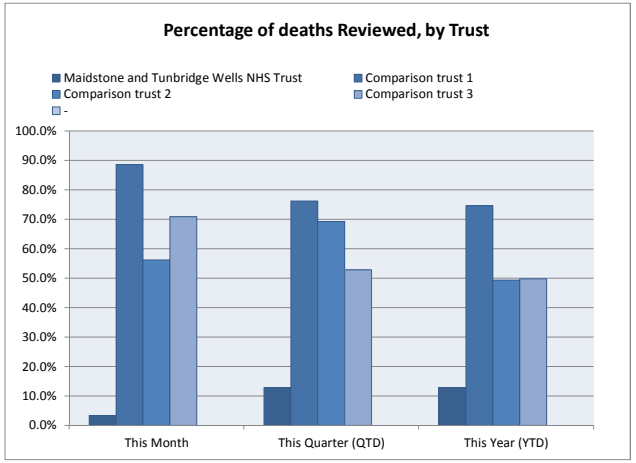


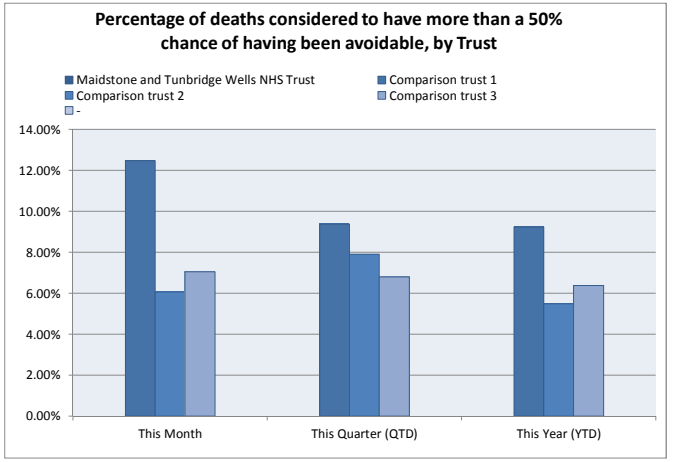
Maidstone and Tunbridge Wells NHS Trust: Learning from Deaths Dashboard - May 2017-18

Description:
Small differences in review practices can mean that comparisons between Trusts do not give a fair picture. It is open to Trusts to use data from other organisations to consider whether their own review processes are as comprehensive as others. Trusts are able to select their own peers or comparator organisations, and can use this locally to challenge themselves if their findings are very different. There is no central mechanism to provide you with data from other Trusts – this material is for local use and might be drawn, for example, from the dashboards published by other organisations

	Total Deaths in scope			Total Deaths Reviewed						Total number of deaths considered to have more than a 50% chance of having been avoidable (RCP <= 3)					
Organisation Name	This Month	This Quarter (QTD)	This Year (YTD)	This Month	This Month %	This Quarter (QTD)	This Quarter % (QTD)	This Year (YTD)	This Year % (YTD)	This Month	This Month %	This Quarter (QTD)	This Quarter % (QTD)	This Year (YTD)	This Year % (YTD)
Maidstone and Tunbridge Wells NHS Trust	153	290	290	5	3.3%	37	12.8%	37	12.8%	0	0.00%	0	0.00%	0	0.00%
Comparison trust 1	385	1067	2091	341	88.6%	813	76.2%	1558	74.5%	48	12.47%	100	9.37%	193	9.23%
Comparison trust 2	363	1100	2281	204	56.2%	761	69.2%	1124	49.3%	22	6.06%	87	7.91%	125	5.48%
Comparison trust 3	312	1029	2006	221	70.8%	543	52.8%	998	49.8%	22	7.05%	70	6.80%	128	6.38%
-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-







Trust Board meeting – June 2017

NHS Maidstone and Tunbridge Wells NHS Trust

6-14 Findings of the national inpatient survey 2016 — Chief Nurse

This report provides the results of the 2016 National Inpatient Survey which was published in June 2017 alongside a summary of proposed actions to be taken in response to the results. The month sample was fixed to July and will remain fixed for all future surveys. There were 84 core questions. The results reflected views from patients who had an inpatient stay at either site of the Trust. The sample size for the audit was 1,250 patients. The total number of patients who completed surveys for MTW was 601, which was a response rate of 48.5%. Nationally the response rate was 44%.

Key facts about the 601 responses

- **26.8%** of patients were on a waiting list/planned in advance and **70.9%** came as an emergency or urgent case.
- **41%** were male; **59%** were female.
- The youngest responder was **17** and the eldest was **104** years old
- **97.4 %** of patients felt they were treatment with respect and dignity
- **97.6%** of patients felt well looked after

The results from the survey provide an overview of assurance that the Trust has sustained levels in all areas consistently. There were 13 questions in which the Trust scored lower than in previous years. However, when compared with neighbouring acute Trusts, MTW is the only Trust to maintain similar levels in all areas in comparison to previous year's results.

Appendix 1 provides the comparison scores for our neighbouring trusts (indicating where we scored higher than our peers on 6 questions). Appendix 2 provides a 'one page' summary of the survey. The full survey report is enclosed at Appendix 3.

Key changes implemented since National Inpatient Survey 2015:

- There was a keen focus on 4 questions related to medications which MTW responded positively to identify areas where practice could be improved. The Patients and their Medicines group were formed and are actively progressing MAPPS (Medicines: a Patient Profile Summary), Engaging patients in their medicines, Pharmacy Survey and review of information**.**
- The re-launch of "I Want Great Care" for the Friends and Family Test (FFT) show significant achievement in A&E services for responses and will be used as a case study for learning
- Signage review of both sites with completion of the project to update signage.

Moving forward:

A separate action plan will be developed in response to the survey in collaboration with the Divisional and Directorate teams who will have ownership of agreed aspects to the plan. It is intended that local leads will be identified for proposed actions and that progress against agreed actions will be reviewed through appropriate forums but will include; the Chief Nurses Senior Management Meeting, the Nursing, Midwifery and Allied Health Care Professionals Group and, engagement with the Patient Representative Group.

It is proposed that the Listening into Action project, Development of Accessible Information, & the development of Corporate Quality Rounds in line with "Back to the Floor" evaluations, will form part of the action plan to improve on our responses. Triangulation of the FFT and Trust Inpatient survey will be promoted to provide timely data that assists in the monitoring of progress for action leads.

Which Committees have reviewed the information prior to Board submission?

- Patient Experience Committee, 13th June 2017
- Trust Management Executive (TME), 21st June 2017

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

Information and discussion

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

Appendix 1

Care Quality Commission National Inpatient Survey 2016

Question number	Survey question	Highest Trust score	Lowest Trust score	MTW	Medway	East Sussex Healthcare	Dartford & Gravesham	Brighton and Sussex	Surrey and Sussex	East Kent Hospitals	AVG
Section 1	**The Emergency/A&E Department**										
3	While you were in the A&E Department, how much information about your condition or treatment was given to you?	8.9	7.3	7.9	7.6	8.0	8.3	8.3	8.0	8.0	8.0
4	Were you given enough privacy when being examined or treated in the A&E Department?	9.4	7.8	8.7	7.8	8.4	8.6	8.6	9.0	8.1	8.5
Section 2	**Waiting List or Planned Admission**										
6	How do you feel about the length of time you were on the waiting list before your admission to hospital?	9.7	6.9	8.0	8.2	8.0	7.6	7.5	7.9	7.8	7.9
7	Was your admission date changed by the hospital?	9.7	8.2	9.0	9.3	9.4	9.0	8.9	8.9	9.0	9.1
8	In your opinion, had the specialist you saw in hospital been given all of the necessary information about your condition or illness from the person who referred you?	9.6	8.4	9.2	8.8	9.0	8.7	8.9	8.9	9.1	8.9
Section 3	**All Types of Admission**										
9	From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	9.6	5.8	6.5	6.1	7.5	7.1	7.5	7.1	7.4	7.0
Section 4	**The Hospital & Ward**										
11	When you were first admitted to a bed on a ward, did you share a sleeping area, for example a room or bay, with patients of the opposite sex?	9.8	8.6	9.1	8.6	9.1	8.6	8.7	9.2	8.8	8.9
14	Did you ever use the same bathroom or shower area as patients of the opposite sex?	9.8	6.2	7.8	7.4	7.3	7.7	7.6	8.8	7.5	7.7
15	Were you ever bothered by noise at night from other patients?	8.5	4.8	6.3	5.2	6.1	5.3	5.9	5.8	5.6	5.7
16	Were you ever bothered by noise at night from hospital staff?	9.2	7.1	8.0	7.1	7.8	7.8	8.0	7.8	8.1	7.8
17	In your opinion, how clean was the hospital room or ward that you were in?	9.7	8.2	9.0	8.2	8.9	8.7	8.8	9.1	8.7	8.8
18	How clean were the toilets and bathrooms that you used in hospital?	9.5	7.4	8.7	7.9	8.6	8.5	8.5	8.4	8.1	8.4
19	Did you feel threatened during your stay in hospital by other patients or visitors?	10.0	9.1	9.7	9.5	9.7	9.7	9.6	9.7	9.6	9.6
20	Did you get enough help from staff to wash or keep yourself clean?	9.2	7.0	8.4	7.4	8.2	8.2	8.1	7.5	8.3	8.0
21	If you brought your own medication with you to hospital, were you able to take it when you needed to?	8.8	6.0	7.3	6.8	7.6	7.2	7.0	7.4	7.7	7.3
22	How would you rate the hospital food?	7.7	4.5	6.1	4.8	6.0	5.1	4.6	5.5	5.7	5.4
23	Were you offered a choice of food?	9.5	7.7	8.5	8.5	9.1	8.5	8.9	8.8	9.1	8.8
24	Did you get enough help from staff to eat your meals?	9.3	5.5	7.2	6.4	7.3	8.2	7.2	6.5	7.3	7.2
Section 5	**Doctors**										
25	When you had important questions to ask a doctor, did you get answers that you could understand?	9.3	7.4	7.8	7.7	8.0	8.0	8.3	7.8	8.2	8.0
26	Did you have confidence and trust in the doctors treating you?	9.8	8.5	8.7	8.6	8.8	8.8	8.9	8.6	8.9	8.8
27	Did doctors talk in front of you as if you weren't there?	9.6	7.9	8.7	8.4	8.5	8.6	8.4	8.7	8.5	8.5
Section 6	**Nurses**										
28	When you had important questions to ask a nurse, did you get answers that you could understand?	9.3	7.4	8.2	7.5	8.4	8.3	8.3	8.1	8.3	8.2
29	Did you have confidence and trust in the nurses treating you?	9.5	8.2	8.7	8.2	8.9	8.8	9.0	8.9	8.8	8.8
30	Did nurses talk in front of you as if you weren't there?	9.7	8.1	8.9	8.6	9.0	9.0	8.9	9.2	8.9	8.9
31	In your opinion, were there enough nurses on duty to care for you in hospital?	9.0	6.4	7.8	6.4	7.6	7.3	7.7	7.5	7.2	7.4
32	Did you know which nurse was in charge of looking after you? (this would have been a different person after each shift change)	8.5	5.3	6.6	5.7	6.5	6.3	7.1	6.4	5.7	6.3
Section 7	**Your Care & Treatment**										
33	In your opinion, did the members of staff caring for you work well together?	9.5	7.9	8.5	7.9	8.7	8.6	8.7	8.7	8.6	8.5
34	Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?	9.1	7.4	7.9	7.4	8.0	7.7	8.1	8.0	8.1	7.9
35	Were you involved as much as you wanted to be in decisions about your care and treatment?	8.8	6.3	7.2	6.6	7.2	7.2	7.2	6.9	7.3	7.1
36	Did you have confidence in the decisions made about your condition or treatment?	9.5	7.4	8.1	7.7	8.2	8.0	8.3	8.2	8.2	8.1
37	How much information about your condition or treatment was given to you?	9.3	7.3	7.6	7.4	8.0	7.9	8.1	7.5	7.9	7.8
38	Did you find someone on the hospital staff to talk to about your worries and fears?	8.0	4.5	5.7	5.0	5.6	5.5	5.8	5.5	5.3	5.5
39	Do you feel you got enough emotional support from hospital staff during your stay?	8.8	6.1	6.9	6.3	7.3	7.1	7.2	6.9	6.8	6.9
40	Were you given enough privacy when discussing your condition or treatment?	9.4	7.9	8.5	7.9	8.5	8.5	8.5	8.7	8.1	8.4
41	Were you given enough privacy when being examined or treated?	9.9	9.2	9.4	9.3	9.5	9.4	9.4	9.6	9.3	9.4
43	Do you think the hospital staff did everything they could to help control your pain?	9.5	7.4	8.4	7.7	8.2	8.1	8.3	8.4	8.0	8.2
44	After you used the call button, how long did it usually take before you got help?	7.6	5.2	6.2	5.6	6.0	6.0	6.4	6.1	6.2	6.1
Section 8	**Operations & Procedures**										
46	Beforehand, did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?	9.7	8.2	9.0	8.8	9.2	8.8	8.9	8.7	8.9	8.9
47	Beforehand, did a member of staff explain what would be done during the operation or procedure?	9.2	7.9	8.7	8.7	8.6	8.3	8.4	8.2	8.7	8.5
48	Beforehand, did a member of staff answer your questions about the operation or procedure in a way you could understand?	9.5	8.1	8.8	8.8	8.9	8.6	8.6	8.6	8.9	8.7
49	Beforehand, were you told how you could expect to feel after you had the operation or procedure?	8.5	6.4	7.1	7.2	7.6	6.9	7.0	7.2	7.5	7.2
51	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?	9.5	8.7	9.1	9.4	8.9	9.1	9.0	9.1	9.1	9.1
52	After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?	9.0	7.2	7.8	7.5	7.9	7.6	7.6	8.0	7.9	7.8

Question number	Survey question	Highest Trust score	Lowest Trust score	MTW	Medway	East Sussex Healthcare	Dartford & Gravesham	Brighton and Sussex	Surrey and Sussex	East Kent Hospitals	AVG
Section 9	**Leaving Hospital**										
53	Did you feel you were involved in decisions about your discharge from hospital?	8.9	6.1	6.7	6.2	7.2	6.6	6.6	6.8	6.9	6.7
54	Were you given enough notice about when you were going to be discharged?	9.0	6.3	6.9	6.4	7.3	6.8	6.8	6.9	6.8	6.8
56	Discharge delayed due to wait for medicines/to see doctor/for ambulance.	8.2	4.8	6.0	5.6	7.4	6.1	6.4	6.2	6.7	6.3
57	How long was the delay?	9.1	6.2	7.4	7.1	8.4	7.5	7.9	7.6	7.8	7.7
59	After leaving hospital, did you get enough support from health or social care professionals to help you recover and manage your condition?	8.3	5.7	6.6	6.7	6.9	6.5	6.6	5.9	6.4	6.5
60	When you left hospital, did you know what would happen next with your care?	8.7	6.1	6.4	6.6	6.9	6.8	6.6	6.4	6.4	6.6
61	Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?	9.2	5.0	6.3	6.3	6.0	5.9	6.3	5.8	6.9	6.2
62	Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	9.6	7.6	8.0	7.8	8.0	8.1	8.4	7.7	8.3	8.0
63	Did a member of staff tell you about medication side effects to watch for when you went home?	7.7	3.5	4.8	4.0	4.4	4.6	4.5	4.2	4.8	4.5
64	Were you told how to take your medication in a way you could understand?	9.5	7.4	8.1	7.5	8.1	8.0	8.6	7.8	8.2	8.0
65	Were you given clear written or printed information about your medicines?	9.2	6.8	7.9	7.5	7.4	7.4	7.6	7.6	8.0	7.6
66	Did a member of staff tell you about any danger signals you should watch for after you went home?	7.6	4.0	5.2	4.8	5.6	4.9	5.3	4.7	5.8	5.2
67	Did hospital staff take your family or home situation into account when planning your discharge?	9.2	6.1	7.2	6.5	7.3	6.8	6.9	7.0	7.1	7.0
68	Did the doctors or nurses give your family or someone close to you all the information they needed to help care for you?	8.2	4.8	5.9	5.2	6.1	5.9	6.0	5.3	6.1	5.8
69	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	9.7	6.4	7.5	7.1	7.7	7.7	7.7	7.4	7.8	7.6
70	Did hospital staff discuss with you whether you would need any additional equipment in your home, or any adaptations made to your home, after leaving hospital?	9.5	4.5	8.6	7.7	8.0	8.5	7.5	8.3	7.9	8.1
71	Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital? (e.g. services from a GP, physiotherapist or community nurse, or assistance from social services or the voluntary sector)	9.3	6.8	8.1	8.2	8.1	7.9	8.2	7.4	8.0	8.0
Section 10	**Overall view of care and services**										
72	Overall, did you feel you were treated with respect and dignity while you were in the hospital?	9.8	8.5	9.0	8.5	9.0	9.0	9.0	9.0	9.0	8.9
73	During your time in hospital did you feel well looked after by hospital staff?	9.7	8.3	8.9	8.3	8.9	8.8	9.0	8.9	8.8	8.8
74	Overall...	9.2	7.4	8.0	7.4	8.0	7.9	8.0	8.0	8.0	7.9
75	During your hospital stay, were you ever asked to give your views on the quality of your care?	4.4	0.9	1.8	0.9	2.2	1.0	1.6	2.5	1.7	1.7
76	Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	5.0	1.4	2.1	1.5	2.4	1.4	2.8	2.8	2.2	2.2

NATIONAL INPATIENT S URVEY 2016

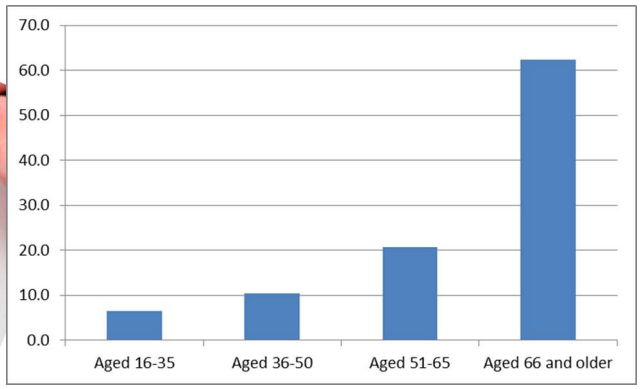
Sent to a data sample of 1250 adult inpatients (aged 16+)
41% male patients and 59% female patients

Returned Completed

601

48.5%

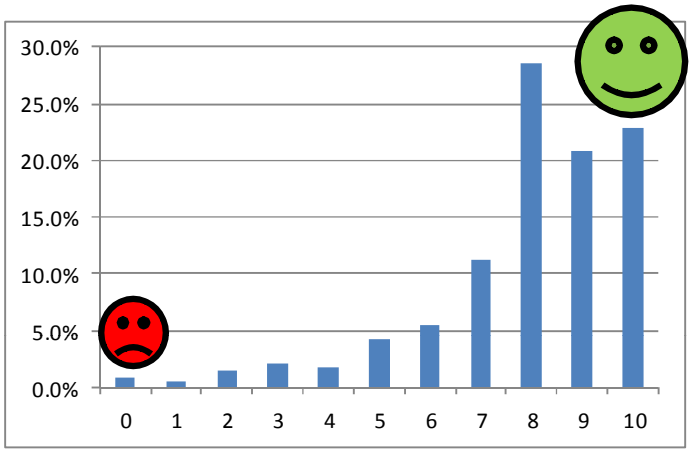
response rate



The youngest patient in the data sample was 17 years old and the oldest was 104

70.9% of patients were emergency or urgent admissions

26.8% of patients were waiting list or planned in advance



Overall…
I had a very poor experience (0)
I had a very good experience (10)

97.4% of patients felt they were treated with respect and dignity

97.6% of patients felt well looked after by hospital staff

79.5% of patients felt they were involved in their discharge from hospital

"patient comments"

Excellent care from start to finish - have no complaints about the NHS. All the staff work so hard!

All of the nurses during my 2 day stay were immensely helpful and friendly and made my stay in hospital much more comfortable. The doctor's consultant and the A&E admitting senior registrar treated my condition with exceptional skill and attention to detail for which I am very appreciative.

All very good, I have no complaints at all, I was always well cared for.

All tv's need to be working and have remotes

The delay in having my operation - which was put off three times because of "too many people in A&E requiring the recovery beds" There should be more beds available and nurses to look after those staying overnight?

I felt it was like a rush to send me home more than careful considera-tion as to whether I was ready/ should actually go.

mtw mtw.nhs.uk
Governance Team

Appendix 3

Patient survey report 2016

Survey of adult inpatients 2016

Maidstone and Tunbridge Wells NHS Trust

Survey of adult inpatients 2016

NHS patient survey programme
Survey of adult inpatients 2016

The Care Quality Commission

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

Survey of adult inpatients 2016

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 fourteenth survey of adult inpatients involved 149 acute and specialist NHS trusts. Responses were received from 77,850 people, a response rate of 44%. Patients were eligible for the survey if they were aged 16 years or older, had spent at least one night in hospital and were not admitted to maternity or psychiatric units. Trusts sampled patients discharged during July 2016[1]. Trusts counted back from the last day of July 2016, including every consecutive discharge, until they had selected 1250 patients (or, for a small number of specialist trusts who could not reach the required sample size, until they had reached 1st January 2016). Fieldwork took place between September 2016 and January 2017.

Similar surveys of adult inpatients were also carried out in 2002 and annually from 2004 to 2015. They are part of a wider programme of NHS patient surveys, which cover a range of topics including A&E services, children's inpatient and day-case services, maternity services and community mental health services. To find out more about our programme and for the results from previous surveys, please see the links contained in the further information section.

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

Interpreting the report

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

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

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

[1] 43 trusts sampled additional months because of small patient throughputs or data quality issues.

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 Q45 "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 2015' 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 2015. 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 2015 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 2015 survey, or if a trust committed a sampling error in 2015. Please note that comparative data are 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.

Q20: This question (Q20 in 2015 inpatient questionnaire), "Were hand-wash gels available for patients and visitors to use?" was removed from the 2016 survey because it was found there was very little differentiation between trusts, as well as the fact that there had been little movement over time.

Q20, Q21 and Q32: "Did you get enough help from staff to wash or keep yourself clean?", "If you brought your own medication with you to hospital, were you able to take it when you needed to?" and "Did you know which nurse was in charge of looking after you? (this would have been a different person after each shift change)" are new questions in 2016 and it is therefore not possible to compare with 2015.

Q55 and Q56: The information collected by Q55 "On the day you left hospital, was your discharge delayed for any reason?" and Q56 "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 Q56 and is worded as: "Discharge delayed due to wait for medicines/to see doctor/for ambulance."

Q57: Information from Q55 and Q56 has been used to score Q57 "How long was the delay?" This assesses the length of a delay to discharge for reasons attributable to the hospital.

Q60: "When you left hospital, did you know what would happen next with your care?" was part of the 2015 survey and was redeveloped for 2016 (Q58 in the 2015 inpatient questionnaire).

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?", 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?” and Q14 "While staying in hospital, did you ever use the same bathroom or shower area as patients of the opposite sex?" is not shown.

Trusts with no A&E Department

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

Further information

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

The results for the adult inpatient surveys from 2002 to 2015 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/935

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

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

Survey of adult inpatients 2016

Maidstone and Tunbridge Wells NHS Trust

Section scores

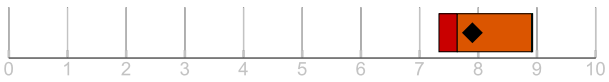
Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2016

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)

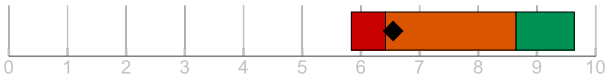
Q6. How do you feel about the length of time you were on the waiting list?

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?

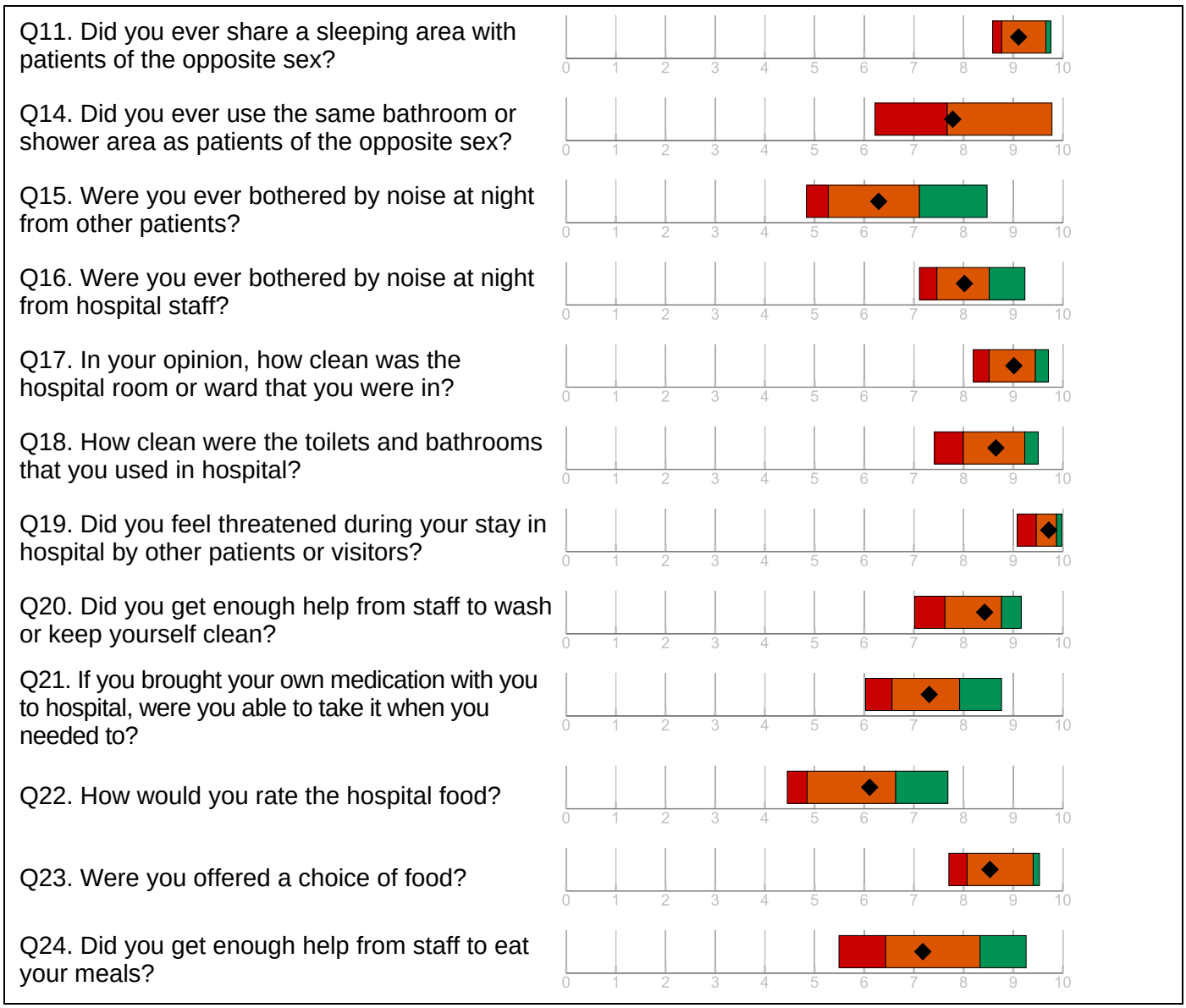


Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

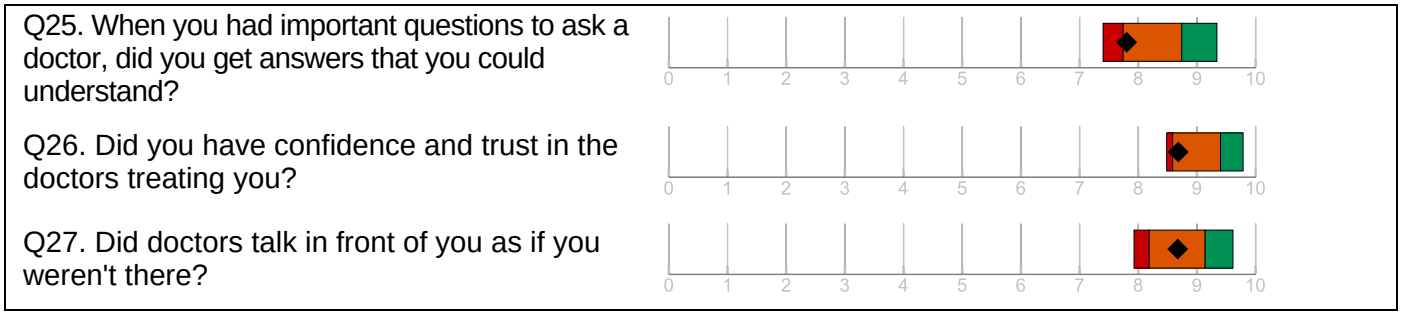
Survey of adult inpatients 2016

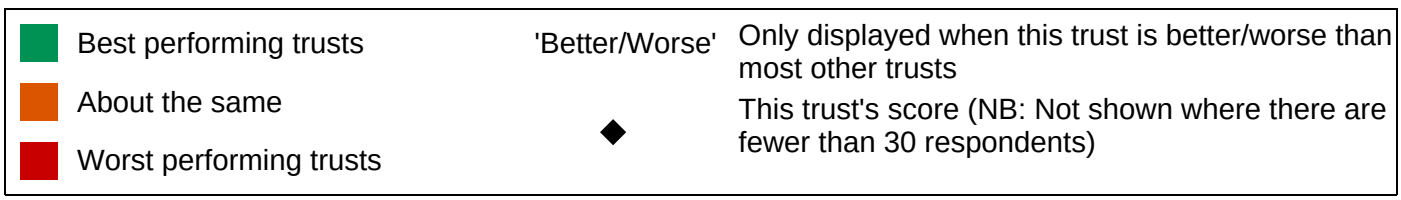
Maidstone and Tunbridge Wells NHS Trust

The hospital and ward



Doctors



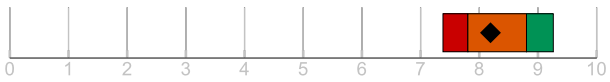


Survey of adult inpatients 2016

Maidstone and Tunbridge Wells NHS Trust

Nurses

Q28. When you had important questions to ask a nurse, did you get answers that you could understand?

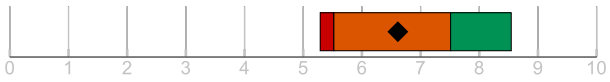


Q29. Did you have confidence and trust in the nurses treating you?

Q30. Did nurses talk in front of you as if you weren't there?

Q31. In your opinion, were there enough nurses on duty to care for you in hospital?

Q32. Did you know which nurse was in charge of looking after you? (this would have been a different person after each shift change)



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 2016

Maidstone and Tunbridge Wells NHS Trust

Care and treatment

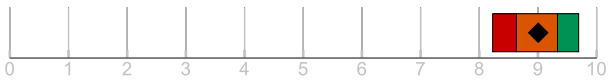
Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2016

Maidstone and Tunbridge Wells NHS Trust

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

Q46. Did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?



Q47. Did a member of staff explain what would be done during the operation or procedure?

Q48. Did a member of staff answer your questions about the operation or procedure?

Q49. Were you told how you could expect to feel after you had the operation or procedure?

Q51. Did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain?

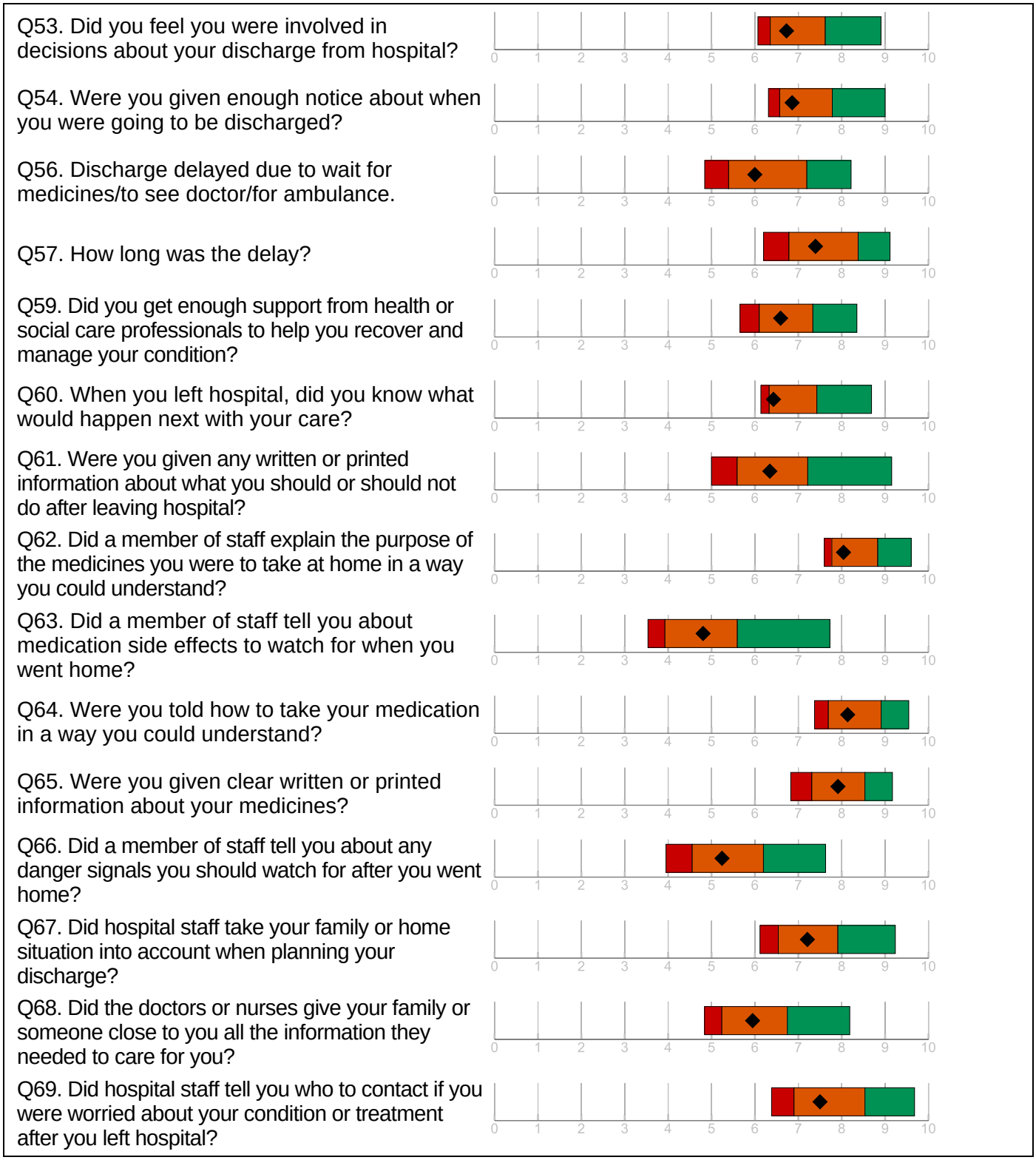
Q52. Afterwards, did a member of staff explain how the operation or procedure had gone?

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		

Survey of adult inpatients 2016

Maidstone and Tunbridge Wells NHS Trust

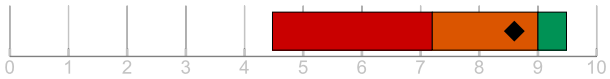
Leaving hospital



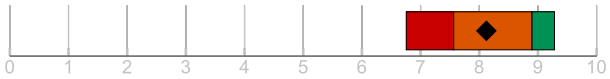
Survey of adult inpatients 2016

Maidstone and Tunbridge Wells NHS Trust

Q70. Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?



Q71. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?



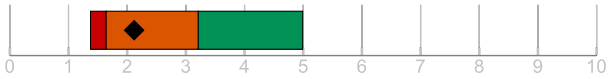
Overall views of care and services

Q72. Overall, did you feel you were treated with respect and dignity while you were in the hospital?

Q73. During your time in hospital did you feel well looked after by hospital staff?

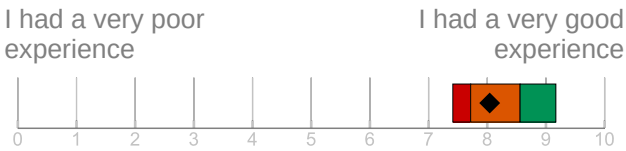
Q75. During your hospital stay, were you ever asked to give your views on the quality of your care?

Q76. Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?



Overall experience

Q74. 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 2016

Maidstone and Tunbridge Wells NHS Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2015 scores for this NHS trust	Change from 2015
The Emergency/A&E Department (answered by emergency patients only)							
S1	Section score	8.3	7.7	9.0			
Q3	While you were in the A&E Department, how much information about your condition or treatment was given to you?	7.9	7.3	8.9	361	8.3	
Q4	Were you given enough privacy when being examined or treated in the A&E Department?	8.7	7.8	9.4	392	9.0	
Waiting list and planned admissions (answered by those referred to hospital)							
S2	Section score	8.7	8.2	9.6			
Q6	How do you feel about the length of time you were on the waiting list?	8.0	6.9	9.7	170	8.2	
Q7	Was your admission date changed by the hospital?	9.0	8.2	9.7	171	9.1	
Q8	Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?	9.2	8.4	9.6	171	9.3	
Waiting to get to a bed on a ward							
S3	Section score	6.5	5.8	9.6			
Q9	From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	6.5	5.8	9.6	584	7.5	↓

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available.

Survey of adult inpatients 2016

Maidstone and Tunbridge Wells NHS Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2015 scores for this NHS trust	Change from 2015
The hospital and ward							
S4	Section score	8.0	7.3	9.0			
Q11	Did you ever share a sleeping area with patients of the opposite sex?	9.1	8.6	9.8	462	9.3	
Q14	Did you ever use the same bathroom or shower area as patients of the opposite sex?	7.8	6.2	9.8	498	8.6	↓
Q15	Were you ever bothered by noise at night from other patients?	6.3	4.8	8.5	583	7.1	↓
Q16	Were you ever bothered by noise at night from hospital staff?	8.0	7.1	9.2	578	8.5	↓
Q17	In your opinion, how clean was the hospital room or ward that you were in?	9.0	8.2	9.7	583	9.2	
Q18	How clean were the toilets and bathrooms that you used in hospital?	8.7	7.4	9.5	561	8.9	↓
Q19	Did you feel threatened during your stay in hospital by other patients or visitors?	9.7	9.1	10.0	582	9.7	
Q20	Did you get enough help from staff to wash or keep yourself clean?	8.4	7.0	9.2	350		
Q21	If you brought your own medication with you to hospital, were you able to take it when you needed to?	7.3	6.0	8.8	344		
Q22	How would you rate the hospital food?	6.1	4.5	7.7	561	5.8	
Q23	Were you offered a choice of food?	8.5	7.7	9.5	568	8.7	
Q24	Did you get enough help from staff to eat your meals?	7.2	5.5	9.3	118	7.2	
Doctors							
S5	Section score	8.4	8.0	9.5			
Q25	When you had important questions to ask a doctor, did you get answers that you could understand?	7.8	7.4	9.3	517	8.2	↓
Q26	Did you have confidence and trust in the doctors treating you?	8.7	8.5	9.8	580	9.0	↓
Q27	Did doctors talk in front of you as if you weren't there?	8.7	7.9	9.6	580	8.7	

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available.

Survey of adult inpatients 2016

Maidstone and Tunbridge Wells NHS Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2015 scores for this NHS trust	Change from 2015
Nurses							
S6	Section score	8.0	7.3	9.1			
Q28	When you had important questions to ask a nurse, did you get answers that you could understand?	8.2	7.4	9.3	525	8.4	
Q29	Did you have confidence and trust in the nurses treating you?	8.7	8.2	9.5	584	8.9	
Q30	Did nurses talk in front of you as if you weren't there?	8.9	8.1	9.7	582	9.2	↓
Q31	In your opinion, were there enough nurses on duty to care for you in hospital?	7.8	6.4	9.0	576	8.0	
Q32	Did you know which nurse was in charge of looking after you? (this would have been a different person after each shift change)	6.6	5.3	8.5	575		
Care and treatment							
S7	Section score	7.7	7.1	8.9			
Q33	In your opinion, did the members of staff caring for you work well together?	8.5	7.9	9.5	556	9.0	↓
Q34	Did a member of staff say one thing and another say something different?	7.9	7.4	9.1	580	8.2	↓
Q35	Were you involved as much as you wanted to be in decisions about your care and treatment?	7.2	6.3	8.8	576	7.5	
Q36	Did you have confidence in the decisions made about your condition or treatment?	8.1	7.4	9.5	575	8.3	
Q37	How much information about your condition or treatment was given to you?	7.6	7.3	9.3	581	8.0	
Q38	Did you find someone on the hospital staff to talk to about your worries and fears?	5.7	4.5	8.0	367	6.2	
Q39	Do you feel you got enough emotional support from hospital staff during your stay?	6.9	6.1	8.8	358	7.5	↓
Q40	Were you given enough privacy when discussing your condition or treatment?	8.5	7.9	9.4	581	9.0	↓
Q41	Were you given enough privacy when being examined or treated?	9.4	9.2	9.9	583	9.6	
Q43	Do you think the hospital staff did everything they could to help control your pain?	8.4	7.4	9.5	363	8.5	
Q44	After you used the call button, how long did it usually take before you got help?	6.2	5.2	7.6	393	6.5	

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Survey of adult inpatients 2016

Maidstone and Tunbridge Wells NHS Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2015 scores for this NHS trust	Change from 2015
Operations and procedures (answered by patients who had an operation or procedure)							
S8	Section score	8.4	7.9	9.1			
Q46	Did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?	9.0	8.2	9.7	316	8.9	
Q47	Did a member of staff explain what would be done during the operation or procedure?	8.7	7.9	9.2	318	8.5	
Q48	Did a member of staff answer your questions about the operation or procedure?	8.8	8.1	9.5	277	8.8	
Q49	Were you told how you could expect to feel after you had the operation or procedure?	7.1	6.4	8.5	320	6.7	
Q51	Did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain?	9.1	8.7	9.5	267	8.8	
Q52	Afterwards, did a member of staff explain how the operation or procedure had gone?	7.8	7.2	9.0	315	7.8	

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available.

Survey of adult inpatients 2016

Maidstone and Tunbridge Wells NHS Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2015 scores for this NHS trust	Change from 2015
Leaving hospital							
S9	Section score	6.9	6.3	8.5			
Q53	Did you feel you were involved in decisions about your discharge from hospital?	6.7	6.1	8.9	561	7.0	
Q54	Were you given enough notice about when you were going to be discharged?	6.9	6.3	9.0	576	7.1	
Q56	Discharge delayed due to wait for medicines/to see doctor/for ambulance.	6.0	4.8	8.2	536	6.1	
Q57	How long was the delay?	7.4	6.2	9.1	533	7.6	
Q59	Did you get enough support from health or social care professionals to help you recover and manage your condition?	6.6	5.7	8.3	333	6.9	
Q60	When you left hospital, did you know what would happen next with your care?	6.4	6.1	8.7	487		
Q61	Were you given any written or printed information about what you should or should not do after leaving hospital?	6.3	5.0	9.2	568	6.9	
Q62	Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	8.0	7.6	9.6	398	8.3	
Q63	Did a member of staff tell you about medication side effects to watch for when you went home?	4.8	3.5	7.7	336	4.9	
Q64	Were you told how to take your medication in a way you could understand?	8.1	7.4	9.5	351	8.5	
Q65	Were you given clear written or printed information about your medicines?	7.9	6.8	9.2	368	8.4	↓
Q66	Did a member of staff tell you about any danger signals you should watch for after you went home?	5.2	4.0	7.6	423	5.7	
Q67	Did hospital staff take your family or home situation into account when planning your discharge?	7.2	6.1	9.2	375	7.6	
Q68	Did the doctors or nurses give your family or someone close to you all the information they needed to care for you?	5.9	4.8	8.2	376	6.4	
Q69	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	7.5	6.4	9.7	519	7.8	
Q70	Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?	8.6	4.5	9.5	172	8.5	
Q71	Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	8.1	6.8	9.3	292	8.5	

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available.

Survey of adult inpatients 2016

Maidstone and Tunbridge Wells NHS Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2015 scores for this NHS trust	Change from 2015
Overall views of care and services							
S10	Section score	5.5	4.8	6.9			
Q72	Overall, did you feel you were treated with respect and dignity while you were in the hospital?	9.0	8.5	9.8	586	9.2	
Q73	During your time in hospital did you feel well looked after by hospital staff?	8.9	8.3	9.7	584	9.0	
Q75	During your hospital stay, were you ever asked to give your views on the quality of your care?	1.8	0.9	4.4	512	1.9	
Q76	Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	2.1	1.4	5.0	463	2.2	
Overall experience							
S11	Section score	8.0	7.4	9.2			
Q74	Overall...	8.0	7.4	9.2	564	8.2	

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available.

Survey of adult inpatients 2016
Maidstone and Tunbridge Wells NHS Trust

Background information

The sample	This trust	All trusts
Number of respondents	601	77850
Response Rate (percentage)	49	44

Demographic characteristics	This trust	All trusts
Gender (percentage)	(%)	(%)
Male	41	47
Female	59	53
Age group (percentage)	(%)	(%)
Aged 16-35	7	5
Aged 36-50	10	9
Aged 51-65	21	23
Aged 66 and older	62	63
Ethnic group (percentage)	(%)	(%)
White	94	90
Multiple ethnic group	0	1
Asian or Asian British	2	3
Black or Black British	0	1
Arab or other ethnic group	0	0
Not known	3	5
Religion (percentage)	(%)	(%)
No religion	16	16
Buddhist	0	0
Christian	79	77
Hindu	0	1
Jewish	0	0
Muslim	1	2
Sikh	0	0
Other religion	1	1
Prefer not to say	2	2
Sexual orientation (percentage)	(%)	(%)
Heterosexual/straight	95	94
Gay/lesbian	1	1
Bisexual	1	0
Other	1	1
Prefer not to say	4	4

Trust Board meeting – June 2017

NHS Maidstone and Tunbridge Wells NHS Trust

6-15 The 2017/18 Winter and Operational Resilience Plan Chief Operating Officer

This report identifies the objectives, governance and delivery structure to manage our clinical services safely and effectively all year but particularly responding to the unique operational pressures of the winter period. We have only just fully de-escalated all our areas following the unprecedented demand in winter 2016-17, where we saw a year on year rise of 14% in non-elective activity. This had a huge impact on our ability to maintain patient flow with prolonged escalation into elective beds and day surgery units on both sites (Maidstone for 2 full weeks in January & Tunbridge Wells throughout Dec – May).

Planning has already started for 2017-18 with changes already implemented and others in development. All changes that we expect to have a positive impact on patient flow need time to embed and mature before the full benefits can be realised.

The 2017 Operational Resilienc Group which includes E.D Improvement and Winter Planning has been set up to deliver the necessary changes, which is chaired by The Trust COO. This is an internal group and an external group is in the process of being established which bring together the operational leads from Kent Community Health NHS Foundation Trust (KCHFT), South East Coast Ambulance Service NHS Foundation Trust (SECAmb), Kent County Council (KCC) and West Kent Clinical Commissioning Group.

From our experience and evidence from elsewhere there are 4 consistent areas relating to urgent and emergency care where changes to practice will impact positively on flow, capacity and ability to maintain both elective and non-elective activity

- Pathway changes
- Workforce changes
- Activity & Demand Planning
- Sustainability

The above have been used to develop 9 workstreams who report into the Resilience Steering Group. These workstreams are already in place and have begun planning and implementing changes and are :

1. Ambulatory Emergency Care (AEC)
2. Acute Frailty Service (AFS)
3. Emergency Department (ED) improvement –
4. Workforce
5. Improving flow
6. Improving Patient Discharge
7. Activity and Demand - assessment and planning
8. Sustainability
9. Rapid Improvement weeks ->Intensive focus period

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive (TME), 21/06/17

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

Review and discussion

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

E.D Improvement, Winter Planning and Resilience (Operational Resilience)

We have only just fully de-escalated all our areas following an unprecedented winter period, where we saw a rise of 14% in non-elective activity, which affected our ability to undertake elective work and secure our Emergency Department (ED) waiting standards. It is important that we plan now, for how we will achieve the necessary performance Improvement throughout this year, in preparation for next winter. Anything we want to see happen differently will take time to deliver.

Planning parameters

For Winter 2017/18 the following predictions have been identified

1) Total A&E attendances : The model is predicting total weekly attendances of 2,600 to 2,800 per week between Nov-17 and Feb-18, rising to 2,900 a week by the end of march – around 5% higher than the winter of 16-17. Attendances have been running below model since the new year, possibly because the anomalously high attendances between Dec-15 and Apr-16 are causing the model to over-estimate.
   a. For Maidstone Hospital (MH), the projection is 1,200 to 1,300 between Nov-17 and Feb-18, rising to 1,350 by the end of Mar
   b. For Tunbridge Wells Hospital (TWH), it's 1,400 to 1,500 per week, rising to 1,550. Note that individual weeks can be up to 10% above or below projections

2) Ambulance arrivals are expected to be around 750-850 per week
   a. For Maidstone, we would expect 250-300 per week
   b. For TWH, we would expect 500-550

   These numbers will be higher if there is a protracted period of cold weather in the winter

3) Emergency admissions are more difficult to predict, as these no longer have a seasonal pattern. Emergency admissions are currently running at all time high of 900-950 per week, and this has been gradually rising from a low of 700-800 per week in late 2015. If the medium-term trend continues, then emergency admissions of 950-1,050 per week will be seen over the winter.
   a. For Maidstone, it's currently around 325-375 a week, up from 250-300 per week in late 2015. If this continues, we could see 375-425 per week in the coming winter
   b. For TWH, it's currently 525-575 a week, up from 450-500 in late 2015. This could rise to 575-625 if the trend continues.

   Current levels would probably be the low estimate, and the trend continuing would represent the high estimate

4) Non-elective LoS (excluding zero) has been fairly constant at 7.0 days for the last 2 years, with a tendency to rise by half a day or so in the depths of winter. This effect is usually only seen in Jan & Feb

5) Non Elective Bed Occupancy – bed occupancy modelled, with 85th percentile figures equals 679 beds occupied by non-elective patients. 384 at TWH and 295 at Maidstone based on last year (679 Total).
   a. If the non-elective activity trends continue, then winter admissions could be 5-10% higher than they are now.
   b. If the usual 10% increase in NE LoS manifests at the same time, then they increase to 442 and 339 – a total of 781

The overall impact on beds means that we need 339 at Maidstone and 442 at TWH. This means that we would be 36 short at Maidstone and 61 short at TW as a 'bad-case' scenario. Our plans will need to cover this scenario but also contingency plans if activity begins to rise considerably above our projections in autumn and beyond.

A worst case scenario, due to a few weeks of cold weather or a minor flu epidemic would raise this shortfall considerably to 45 at Maidstone and 68 at TWH.

If NE activity flattens off, then we would be 7 short at Maidstone and 29 short at TW. This is could be considered a best (or at least better) case scenario.

Additional beds are not available and therefore the focus is on ensuring that there is improved flow of patients through our available bed stock and use of appropriate escalation of areas. The escalation policy is being revised as part of winter planning process.

Areas of focus
Throughout last winter, there were 4 consistent themes relating to urgent and emergency care where improvement is needed now in preparation for next winter:

- Pathways
- Workforce
- Activity
- Sustainability

The plan includes the lessons learnt from how we managed last winter.

Pathways
Particularly for non-elective activity which focuses on the delivery of:

- Ambulatory pathways for all specialties
- Specialty units e.g. Frail elderly units (Bournemouth model) plus specialty doctors working in and supporting A&E and local GP units
- Acute assessment units

The Trust needs to ensure that we have a comprehensive front-door streaming model, so that A&E departments are free to care for the most urgent patients.

To understand what is required the Trust has undertaken a gap analysis re “streaming” to have clarity on where we are against what is expected.

Workforce
This is a key issue each year, as with higher demands we have to secure increased staffing to support escalated areas often with significant financial cost, particularly if we need to use agencies. Early planning and securing the necessary staff through overseas recruitment will help but often these staff take over 12 months to secure and settle into post.

To work collaboratively with KCHFT and other agencies to evaluate how best to support staff working in the community and social care sector, in order to help in moving patients out from hospital beds into community beds. The Trust will identify the feasibility of how they can utilise their staff expertise and experience in support care homes and in particular end of life plans.

Review how developing specialist nurse roles, such as an senior elderly frail nurse, would support the flow in the Acute Frailty Units, Acute Medical Units and specialty wards

Activity planning

a. **Non elective activity** : As in subsequent years it is likely that the trend of increased numbers of non-elective patients attending our A.E units will continue to rise, at least until there are greater alternatives set up for these patients to go to. The age profile of the patients is also increasing bringing added complexity to their treatment and subsequent discharge arrangements. Capacity and demand trajectory have demonstrated the likely winter demands and required capacity, generated through improved patient flow

b. Elective activity : The ability to undertake elective activity was again compromised this winter (although better than previous years) and when considering the parameters associated with the new Aligned Incentive contract, consideration should be made to profiling our contracted activity differently to avoid significant increases to our waiting list backlog in order to sustain RTT performance improvement

Sustainability
This falls into how best we can deliver our services and the configuration of our resources to achieve it the ever growing demands e.g.

a. Bed reconfiguration, escalation and de-escalation plans
The bed reconfiguration and escalation plan last year definitely helped in the management of our patients. We plan to asses if alternatives /additions would work better during the year prior to and then into winter, and see how we can best align non elective bed requirements with those of elective activity.

b. Bed stock and Future Use of space and facilities:
National best practice concerning elderly frail units, larger multispecialty assessment units and engaging the GP service in our front of house flow of E.D patients will be developed and implemented in a pashed way across our sites.

The change of use of theatres at TWH will be assessed through the Business Case process, following the decision to continue to use the of Maidstone Orthopaedic Unit (MOU) for elective orthopaedic work at Maidstone

c. Patient flow
Each site will need to secure the correct number of discharges a day to cope with the numbers of admissions. This can only be achieved through continued improvement in operational ways of working in terms of *admission avoidance schemes* , reducing LOS through *'SAFER'* and securing maximum benefit and growth in the three pathways associated with the *Home first programme*, to be fully in place by October

A focus on the *Red and Green days* system will also need to be applied .The philosophy of this approach is that the experience of a non value day adds to a poor patient experience, delays the patients' progress in recovery and creates an unnecessary longer length of stay. A Red day is a day when a patient is waiting for an action to progress their care or that an action could have been carried out in another setting.

This will be in addition to *On site Senior decision making, 7 days a week which* makes a difference to the flow of our patients and a work stream is already underway to identify how this can be implemented.

It is therefore vital that, together with our partners in local government, we ensure that the extra money made available for social care is in part used to support and free-up our acute hospital beds. We will be discussing with local adult social care departments how the flow can be significantly improved.

Contingency planning

Appropriate plans will be are in place to cover the following areas:
- Flu outbreaks affecting both staffing and patients – particularly to secure high inoculation rates amongst our staff and encourage risk patients to have their injections
- Infection outbreak – D&V affecting staff and patients
- Bad weather, resulting in increased patient numbers and staff getting into work
- Staff Loss to other trusts offering a more attractive work package

Impact of STP options, will need to be considered**,** future space requirements which may assist or compound our acute sites flow.

Governance
It is recognised that to improve patient flow the majority of above themes will need to work well and be fully embedded through the summer so that they are in place prior to next winter.

The 2017 E.D Improvement, Winter Planning and Resilience Steering Group (Operational Resilience) has been set up to deliver the above objectives, which is chaired by The Trust Chief Operating Officer. Progress highlight reports covering each of the themes are coordinated through the PMO office and distributed to the relevant audience and committees.

The 2017 E.D Improvement, Winter Planning and Resilience Steering Group will ensure that the plans developed will deliver operational resilience for the winter period 2017/18. The plans will need to demonstrate:

1. provision of sufficient inpatient capacity over the winter period to meet increased service demands for both non-elective and elective patients,

2. will positively impact on the quality of care delivered

3. support achievement of the Trust's operational and financial plans – based on agreed trajectories and standards

Delivery of the plan is through Nine workstreams .

These have been set up to report into the 2017 E.D Improvement, winter planning and Resilience Steering Group. Each of these workstreams has already begun planning and implementing changes. They include:

- **Ambulatory Emergency Care** (AEC)

Individual pathways covering National best practice, concerning the delivery of a range of ambulatory pathways are being developed along with an implementation time line. This covers both Medical and surgical pathways.

On the Maidstone site the acute ambulatory ward is being enhanced with an additional ambulatory unit which will focus on treatment and admission avoidance. This unit has recently moved into the Treatment suite on AMU. The Elective Medical Day Unit, which was recently run within the Treatment Suite, has moved to bay A on Chaucer.

At Tunbridge Wells the Rapid Improvement Week which has now developed into an Intensive focus period lasting 6 weeks, is created capacity with the Ambulatory unit in order to receive non elective ambulatory patients. An initial target has been set of 7 patients per day. Pathways to streamline the work and communication are being reviewed.

The surgical assessment unit at TWH – is focusing on the development of appropriate ambulatory pathways for Orthopaedics and surgical patients and ensuring that these are embedded during the summer months.

A project group has been set up to develop this work, with clinical engagement, which will report into the Winter Planning and Resilience Steering Group.

- **Acute Frailty Service** (AFS)

The focus for this work is currently on the Maidstone site. This model will then be adopted and transferred to the TWH site later in the year. The objective is to improve the patient pathway for the acute frailty cohort of patients, increase ambulatory pathways and ensure that the most appropriate patients are seen as inpatients within the Trust. The nationally recognised Bournemouth criteria has been adopted by the clinicians to identify the appropriate patients.

Edith Cavell was successfully de-escalated and 22 Chaucer (orthopaedic rehabilitation) beds have moved to Edith Cavell. The new Maidstone Acute Frailty Unit opened on 05/06/17 within Chaucer ward and consist of 14 beds , 6 trolleys and 5 chairs

Use of Ambulatory pathways and Frail Elderly units will have the following impacts

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a. The acute frailty unit will assess and treat acute elderly patients and through the ambulatory pathways reduce the need for admission or only admit up to 48 Hrs . The Average NE LOS for patients may actually increase as short stays become zero stays and are removed from the calculation.
b. Elderly frail patients who currently attend A.E will be moved to the new unit for assessment and treatment. This improved flow will help reduce waiting times in A.E.

The workgroup is also identifying the opportunities for a senior nurse workforce to support the elderly frail units to help cover the difficulty in recruiting to consultant posts. The feasibility of developing an integrated Elderly care unit, which covers the hospital and community services is being considered as this may also encourage recruitment as the geriatric team will work across and cover both services .

- **ED improvement** –

This workstream focuses on securing Internal professional standards concerning appropriate and safe reaction time and decision making to support patient flow through the department. This is supported by a newly developed breach report which is run and circulated on a weekly basis. The breach report identifies all delays and reasons for the delay. Directorates are then asked to identify actions plans on how to minimise delays in the future.

National best practice concerning comprehensive streaming of patients through the department with GP support along with admission avoidance plans, are being developed. A request for a Medical Coordinator to improve patient flow has been submitted for approval. This post would take all GP and A&E referrals and then allocate resource from the junior doctors appropriately.

Business cases for Enhance staffing for both doctors and nurses to cover 24 hrs within RAP process will be developed.

Improved flow through the unit will be supported with dedicated staff acting as flow coordinators and skilled in getting patients home particularly during the 8-11 period.

A focus on securing early corrective action from the E.D team to growing waiting times (over 2hrs) is now in place, based around what the delay is being caused by, and clear actions identified to prevent further slippage. The objective is for improved timely streaming of patients within E.D and securing safe but appropriate transfer of patients to AMU

A new policy is being developed in which there is acceptance of E.D Handover to specialist teams, rather than review of patients by the specialty team, prior to handover. This will help reduce delays

- **Improving flow** –

The focus is on reducing LOS, through the comprehensive adherence to SAFER principles which is recognised national best practice concerning the flow of patients through our hospital and particularly on planning for discharge of patients in a timely way. This is an ongoing process with audits of non-adhering wards followed by focused support to get them back on track. In addition ways of supporting junior doctors completing discharge letters in a timely ways to prevent delays is underway.

A key objective for the work stream is to prevent the half a day normal rise in LOS over winter period.

The work stream will also secure an understating of the reduction in LOS needed for planned care in order to give 15 beds to medicine over the winter period.

- **Improving Patient Discharge** – Delivery of the 'Home First Programme' pathways 1&3

  Implementation of Home First Pathway 1- a rapid access package of health and social care at an individual's usual place of residence that enables effective recovery and rehabilitation and uses trusted assessors to identify long term needs. The project involves three phases:

  Phase 1 – A proof of concept exercise to test the Home First Pathway 1 model,

  Phase 2 – Full implementation of Home First Pathway 1 to facilitate timely discharge from acute and community hospitals

  Phase 3 – Expansion of Pathway 1 to prevent unnecessary hospital admission or A&E attendance (i.e. acceptance of primary care referrals)

  Implementation of Home First Pathway 3 **–** Assessment of needs for long term residential or nursing care in a suitable sub-acute facility

  The process and procedures in respect of the Home First Pathway 3 Discharge Planning and Transfers have been identified. This pathway enables patients who are medically and therapy fit for discharge from acute hospital care and who require assessment of needs for potential long term residential of nursing care, to be transferred to a suitable sub-acute facility temporarily while the assessment and placement is undertaken. Initially this facility is provided at Westbank Nursing Home in Borough Green, where 10 beds have been sourced and at Burrswood,

  A model for Pathway 3 has now been identified and a Standing Operating Procedure has been developed as a guide to the processes to be used through proof of concept. This guide will be updated as the model develops through the proof of concept phase. QIA's have been signed off at Executive level. A project group working with healthcare partners continues to meet and the progress is reported into the Winter Planning and Resilience Steering Group.

  A Business Case for pathway 3 is being developed for additional beds in the community, which need to be secured prior to winter

  A review of bed capacity and best uses of beds at Tonbridge Cottage hospital and Sevenoaks hospitals to support patients with continuing health care needs is planned.

- **Activity and demand assessment and planning**. The focus of this work stream is to review the data available regarding the predicted NEL demand in order to identify opportunities for further reconfiguration of beds, use of theatres, and phasing of elective activity through the year in order to meet access standards as well as review the availability of rapid diagnostic support.

  1) Planned operations that were cancelled because of no bed or because an emergency patient took priority last year were as follows.
     a. Nov: 56
     b. Dec: 146
     c. Jan: 351
     d. Feb: 176
     e. Mar: 80

2) For two years in a row due to the considerable cancellations in Q4, the Trust has seen the RTT backlog grow by over 500 per year resulting in over 3,000 patients currently waiting over 18 weeks

Following this initial analysis the Planned Care Division is currently undertaking a review of how to phase activity through the year in order to reduce the pressure on bed availability for elective work over the winter period whilst minimising impact to RTT backlog size. The current options being considered

- Significant reduction in all elective activity at TW for the exception of cancer work between 23rd Dec and 18th Feb. This would result in only Theatre 5,6,7 and 8 being used for Trauma, CEPOD and cancer cases as it assumes Recovery 1 and 2 would be used for escalation.
- Reduce elective activity at MH between 23rd Dec to 14th January, as this assumes MSSU would be used for escalation.
- MOU unit would continue throughout as likely that the TWOU would have to cease for 8 weeks due to increased trauma during the winter period
- During this time consultants impacted by reductions in elective work would be expected to take leave or run outpatient clinics to reduce waits until theatres re-opens.
- Elective theatre would then be ramped up to ensure full utilisation of all theatres, including weekend working to catch up on lost activity over winter. This would effectively result in 12 month activity being undertaken in 10 months
- Alternatively Trust is seeking options to provide a further 12 spaces so that escalation into recovery 1 and 2 could be avoided and more elective activity could be done all year round. This would avoid build of backlogs which are harder to reduce. Options iinclude
  - Modular ward on site – this has already been discounted as not feasible at TW
  - Working with KCHT to open up beds at Sevenoaks
  - Exploring options to rent ward and theatre space from IS to continue elective work off site

In addition to mitigate the failure in securing alternatives, work is already progressing to re-open Theatre 6 at TWH to secure repatriation of Elective work (Orthopaedics), as well as increase theatre utilisation, weekend working and improving theatre availability for non-Elective trauma, so that the Trust can reduce its 18 week backlogs before December.

- **Workforce –**

Each Division are identifying and securing the specific winter workforce requirements. (NB this is in addition to the normal business as usual workforce planned requirements, which are managed separately, and has its own plan)**.**

A clear Temporary Staffing Policy, which supports the need for additional staff particularly during the winter period, is being developed.

To Secure AMU medical staffing 7 days a week in order to support decision making and to develop Ward based discharge co coordinators who will secure timely local discharge arrangements, in key areas such as AMU

Surgery to secure an RMO to support after care for additional ophthalmic patients on the Maidstone site

There are a number of specific things planned:

- 2 week radio campaign to encourage nurse recruitment

- 17 June - nursing open day
- Matrons investigating the poor take up of jobs by student nurses and directly encouraging student nurses to apply for posts.
- July – Irish recruitment process
- Company secured to head hunt for key nursing posts

- **Sustainability** – This involves:

1. A review of the escalation and de-escalation plans and policy documents, to ensure that that they reflect the needs and priorities of the organisation- with particular focus on the phasing of escalation and any areas in which escalation should not normally occur.

2. A review of the possible estates changes to support patient flow has been undertaken which has identified opportunities to convert non clinical space into clinical space and then reconfigure some departments which would help the Cardiac Catheter and Oncology day care services

The finance group will directly support the above workstreams in identifying and planning for the financial impact on the organisation.

Rapid Improvement weeks ->intensive focus for 6 week

A series of Rapid Improvement Weeks were originally set up, but after the initial week it soon realised that an intensive focus on patient flow was required of the next 6 weeks to secure improvement in the E.D performance. This focused approach has been supported by the unplanned care division who have embraced the initiative. With the first week the following was initially achieved:

- Reduction of medical outliers at Tunbridge Wells by over 50 %.
- Ring fenced 11 beds on ward 30 to support the orthopaedic pathway.
- Sustained the de-escalation of both recovery areas at Tunbridge Wells.
- Managed to start each day this week with medical assessment beds on each site.
- Closed Edith Cavell in preparation for the development of an Acute Frailty Unit at Maidstone.
- Trialled a different approach to surgical admissions on the Tunbridge Wells site.

A key learning from the initiative to date is the awareness from all staff in the patient flow pathways concerning the performance of E.D against the waiting time objective across each day , week and months performance.

Reporting - Each workstream lead is reporting progress against their plan at each Steering Group meeting via a standard progress highlight report. Update reports will be sent to TME. It is accepted that progress reports will be taken to the Divisional meetings and Clinical Operations and Delivery Committee and used to update the Urgent Care delivery plan for Kent and Medway.

Risk register – This has been compiled as part of the governance framework supporting the 2017 E.D Improvement, Winter Planning and Resilience Steering Group. Risks are being reviewed along with the appropriate mitigating actions at each meeting.

Initial key risks include:

- Staffing vacancies (particularly medical and nursing)
- Financial shortfall - including available capital money to deliver physical changes in A.E to support steaming of patients with GP services and the development of acute elderly frail services.

- Failure to achieve A&E, RTT and Cancer standards
- Unable to undertake planned elective activity due to unplanned escalation with continued high demands of none elective patients attending A.E

The workgroups will measure and monitor the impact and benefit of the initiatives in order to accurately reflect the level of risk and additional mitigating actions required for next winter

Engagement Plan - communication including internal and external stakeholder is being compiled and will be shared with staff and patient representatives. The aim is to ensure the identified work streams are understood by everyone who needs to use it, including wards and departments, and that all staff are aware of their roles within the plan particularly during escalation trigger points.

Communication and feedback concerning the improvement plans from the whole community will be shared e.g. – SECAmb working with MIUs to take patients to these units rather than hospital were appropriate.

The table below offers an initial summary of what has been achieved and what is planned over the forthcoming months:

Delivery plan	*Achievements to date*	*Future milestones for delivery*	*Timescale*
Ambulatory Emergency Care (AEC)	*Creation of capacity at Maidstone through reconfiguration* *Sign off of 10 non elective medical pathways* *Improved ambulatory flow to surgical/ gynae specialties* *Project group created with key stakeholders*	*Non acute ENT ambulatory pathways to increase* *Staffing in place to support Maidstone ambulatory unit* *Pilot of Medical Coordinator (B6) to control flow and direct medical resource* *Next 10 non elective medical pathways to be signed off*	*August 2017* *Sept 2017* *July 2017* *August 2017*
Acute Frailty Service (AFS)	*AFU set up at Maidstone 5.6.17 following agreement of clinical model* *Dashboard in place in monitor pathway changes* *Operational manager / project nurse in Urgent Care in place to support*	*Review of staffing at TW to support AFU at TW* *Space to be identified for TW AFU* *Set up integrated geriatric service, led by Med Dir*	*Sept 2017* *Sept 2017* *Nov 2017*
ED improvement –	*Project group set up with clinical leaders* *Breach report circulated to all specialties highlighting breach reasons on a daily*	*Review of handover delays* *PDSA cycles following identification of themes of breach reasons*	*July 2017*

Delivery plan	*Achievements to date*	*Future milestones for delivery*	*Timescale*
	basis *Pilot of extra doctor shift 18.00 – 2.00 TW to support reduction of delay to be seen by ED dr* *Dir Ops/ ADNS for Urgent Care supporting site flow continuously for one week rather than one day to increase continuity* *Rapid Improvement Week 22.5.17*		
Improving flow	*Embedding of SAFER* *Identification of Stranded Patient metric* *LOS targets set for 17/18* *Discharge Lounge pulling patients through more effectively, with increased staffing, offering improved pharmacy services etc*	*Review of 2 wards against new CUR (Clinical Utilisation Review) data identifying themes/ action plans for stranded patients* *EDN project group working with Telelogic on final simplified EDN to be piloted on 4 wards* *Rollout of electronic Day Before Actions forms on 2 wards* *Policy for nurse led discharge to be agreed* *Board Round video to be promoted*	*June 17* *July 17* *June 17* *Sept 17*
Improving Patient Discharge	A model for Pathway 3 has now been identified and a Standing Operating Procedure has been developed as a guide to the processes to be used through proof of concept. This guide will be updated as the model develops through the proof of concept phase. QIA's have been signed off Pathway 1, proof of	A Business case for pathway 3 is being developed for additional beds in the community, A review of bed capacity and best uses of beds at Tonbridge Cottage hospital and Sevenoaks hospitals to support patients with continuing health care needs is planned.	*July 17* *August 17*

Delivery plan	*Achievements to date*	*Future milestones for delivery*	*Timescale*
	concept has been secured and is in the process of being rolled out across all wards		
Activity and demand assessment and planning	Predicted NEL demand has been undertaken to quantify the planning parameters for this winter plan and which identifies three scenarios of bed pressure.	Following this initial analysis the Planned Care Division is currently undertaking a review of how to phase activity through the year in order to reduce the pressure on bed availability for elective work over the winter period whilst minimising impact to RTT backlog size	*July 17*
Workforce	*Focus on :* 2 week radio campaign to encourage nurse recruitment 17 June - nursing open day Matrons investigating the poor take up of jobs by student nurses and directly encouraging student nurses to apply for posts. July – Irish recruitment process in place Company secured to head hunt for key nursing posts	Develop a Temporary Staffing Policy, which supports the need for additional staff particularly during the winter period, is being developed. To Secure AMU medical staffing 7 days a week in order to support decision making Develop Ward based discharge co coordinators who will secure timely local discharge arrangements , in key areas such as AMU Surgery to secure an RMO to support after care for additional ophthalmic patients on the Maidstone site	*August 17* *October 17* *Sept 17* *Sept 17*
Sustainability	A review has been completed concerning the possible estates changes to support patient flow concerning the reconfigure of departments which would	A review of the escalation and de-escalation plans and policy documents	*Aug 2017*

Delivery plan	*Achievements to date*	*Future milestones for delivery*	*Timescale*
	help the Cardiac Catheter and Oncology day care services . The outcome identified that changes should occur but not until next spring as the focus of the estates department needs to secure changes to TWH E.D and elderly frail unit , if central funding becomes available.		
Rapid Improvement weeks -> intensive focus for 6 week	Cycle of Rapid Improvement weeks in place, incl. an intense operational focus for 6 weeks . Reduction of medical outliers at Tunbridge Wells by over 50 %. And creation of capacity to support AFU/ Ambulatory Care Ring fenced 11 beds on ward 30 to support the orthopaedic pathway. Sustained the de-escalation of both recovery areas at Tunbridge Wells. Managed to start each day this week with medical assessment beds on each site. Closed Edith Cavell in preparation for the development of an Acute Frailty Unit at Maidstone. Trialled a different approach to surgical admissions on the Tunbridge Wells site	*Scheduled for July 17th. Rapid Improvement dashboard to be reviewed*	

Trust Board meeting – June 2017

Maidstone and Tunbridge Wells NHS Trust

6-16	**Kent and Medway Sustainability and Transformation Plan (STP) – Consideration of service models and hurdle criteria**	**Chief Executive**

The enclosed report summarises the service models and hurdle criteria that have been developed through the Sustainability and Transformation Partnership (STP) and asks for support for these from Kent and Medway Clinical Commissioning Group (CCG) governing bodies, Trust Boards and Local Authority Committees.

The service models and hurdle criteria build on the Kent and Medway STP 'case for change', which was reviewed at the Trust Board in March 2017

The service models were developed by the local care and hospital care workstreams. These have built on patient, public and carer insight over recent years about what is important to people about local services, with clinical leadership and involvement in the design and thinking, and some ongoing testing and discussion with wider stakeholder audiences and groups across Kent and Medway.

The development and progress of the design phase has regularly reported to the STP Clinical Board, the Patient and Public Advisory Group (or its predecessor arrangement the Patient and Public Engagement Group) and onwards to the STP Programme Board. The draft service models have been presented to the South East Coast Clinical Senate and their feedback has been taken into account in preparing the final versions that are now being presented.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

The Trust Board is asked to consider the Kent and Medway:

- Local care model
- Emergency department service delivery model
- Acute medical service delivery model
- Stroke service delivery model
- Elective orthopaedic service delivery model
- Urgent care / elective orthopaedics and stroke hurdle criteria

[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

KENT AND MEDWAY SUSTAINABILITY PARTNERSHIP

Service Models and Hurdle Criteria

Introduction

1. This paper summarises the service models and hurdle criteria that have been developed through the Sustainability and Transformation Partnership (STP) and asks for support for these from Kent and Medway clinical commissioning group (CCG) governing bodies, trust boards and local authority committees.
2. This paper accompanies the detailed information on service models that covers:
    i. Local care model
    ii. Emergency department service delivery model
    iii. Acute medical service delivery model
    iv. Stroke service delivery model
    v. Elective orthopaedic service delivery model
    vi. Urgent care / elective orthopaedics and stroke hurdle criteri
3. The service models and hurdle criteria were developed by the local care and hospital care workstreams. These have built on patient, public and carer insight over recent years about what is important to people about local services, with clinical leadership and involvement in the design and thinking, and some ongoing testing and discussion with wider stakeholder audiences and groups across Kent and Medway. The development and progress of the design phase has regularly reported to the STP Clinical Board, the Patient and Public Advisory Group (or its predecessor arrangement the Patient and Public Engagement Group) and onwards to the STP Programme Board. The draft service models have been presented to the South East Coast Clinical Senate[1] and their feedback has been taken into account in preparing the final versions that are now being presented.

Context

4. Sustainability and Transformation Plans were proposed in the annual NHS planning guidance Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21 issued in December 2015[2]. This outlined the triple aim of the plans was to address health inequalities; quality failings and under-performance against NHS Constitution targets; and financial challenges.
5. The further development of Sustainability and Transformation Plans, and a further recognition that these arrangements are about collective system leadership through the change of name to Sustainability and Transformation Partnerships, was outlined in Next Steps on the Five Year Forward View[3] published in March 2017. The October STP

[1] Clinical Senates have been established to be a source of independent, strategi advice and guidance to commissioners and other stakeholders. This includes reviewing proposed changes through bringing together a range of health care professionals, with patients, to review proposals presented to them. This is also part of the NHS England service change assurance process.
[2] https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf
[3] https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf

submission outlined the key themes of transformation that are being pursued across Kent and Medway. These were identified as follows:

Care Transformation	System Leadership	Productivity	Enablers
• Prevention • Local (out-of-hospital) care • Hospital transformation • Mental health	• System / commissioning transformation • Communications and engagement	• CIPs and QIPP delivery • Shared back office • Shared clinical services • Procurement and supply chain • Prescribing	• Workforce • Digital • Estates

6. Work streams were established to take forward each of the above areas, comprising clinicians, leaders and practitioners from across Kent and Medway NHS and local authority organisations. They have been meeting since the autumn of 2016, and test and discuss their work with the programme's Patient and Public Advisory Group (including its precedessor the PPEG) and the programme's Partnership Board as part of an ongoing programme engagement infrastructure and as one strand of engagement activity

7. The STP Programme Board took stock of the progress being made by these work streams in February 2017. It was recognised that different parts of the Kent and Medway area were at different stages in relation to their readiness and development.

8. The STP stocktake concluded from an analysis of patient flows within Kent and Medway that there are negligible potential activity flows from East Kent to the rest of Kent and Medway. It was proposed that it is possible to consult on service changes in East Kent around urgent and emergency care alone, though the impact on future options in the rest of Kent and Medway will need to be considered. Therefore, two waves of public consultation are proposed but undertaken within a clear strategic framework for all of Kent and Medway:

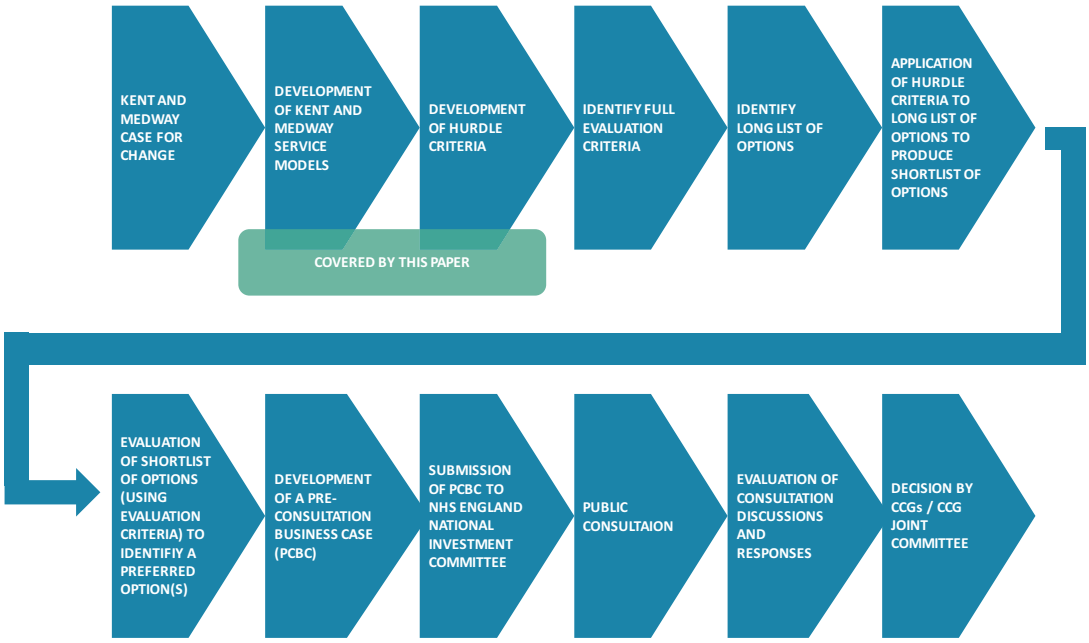
	Wave 1	Wave 2
Services in scope	• Acute stroke services across Kent & Medway • Vascular across Kent & Medway (if consultation is required) • Emergency services in East Kent (i.e. emergency departments and acute care) • Elective orthopaedics in East Kent	• Acute services in the rest of Kent & Medway

9. It had previously been hoped to consult on proposed wave 1 service changes in 2017 but a number of delays have been incurred, including the:

   - need to undertake more public engagement;

- need to put in place joint decision-making arrangements across the CCGs, which require a change to some of the CCG constitutions;
- impact of purdah due to the local and general election[4]; and
- not wishing to start any consultation too close to the Christmas holidays.

10. It is now envisaged that any required consultation would not take place until 2018.
11. In moving to consultation we are following a process that covers a number of stages as outlined in the following diagram (as outlined in the process diagram this paper covers the proposed service models and hurdle criteria):



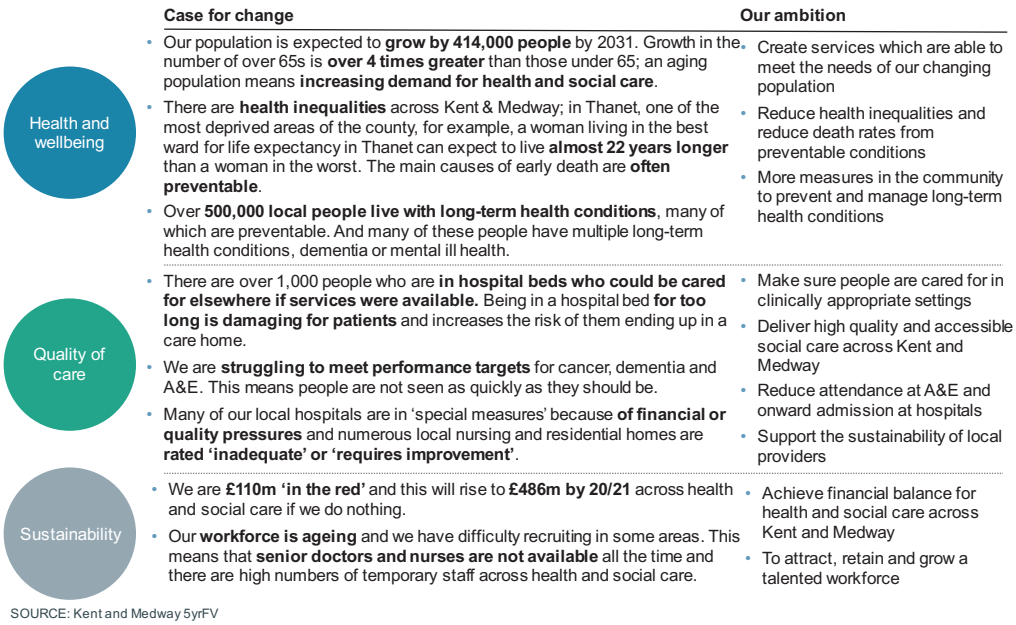
Case for change

12. The Kent and Medway STP Clinical Board has prepared a technical case for change[5] which has been used to prepare a more accessible public facing case for change to support engagement with patients, carers, local communities and stakeholders[6].
13. These documents outline the strategic rationale for why change is needed. Whilst there is much to be proud of about health and social care services in Kent and Medway there are several issues that we need to tackle; there are long waiting times for some services and the quality of care is not always as good as it could be. We also need to focus on reducing the need for health and social care, through self-management, ill health prevention and earlier diagnosis. The following provides a summary of the case for change:

[4] The term 'purdah' is used across central and local government to describe the period of time immediately before elections or referendums when specific restrictions on the activity of civil servants and other public bodies are in place in order to ensure there is no breach of Section 2 of the Local Government Act 1986 (this states to "not publish any material which, in whole or in part, appears to be designed to affect public support for a political party")

[5] http://kentandmedway.nhs.uk/wp-content/uploads/2017/03/Kent-Medway-Case-for-Change-technical-doc-FINAL-UPDATED.pdf

[6] http://kentandmedway.nhs.uk/wp-content/uploads/2017/04/Kent-Medway-Case-for-Change-UPDATED-APRIL-17.pdf



SOURCE: Kent and Medway 5yrFV

14. The position outlined in the case for changes provides further details of the challenges against the triple aims of STPs (as outlined in Point 4, namely:

    i. health inequalities – there continue to be significant health inequalities within Kent and Medway, with the main causes of early death often being preventable:

    ii. quality failings and under-performance of NHS Constitution targets – with large numbers of patients not supported in the most appropriate setting of care, widespread non-delivery of NHS Constitution targets and a significant number of organisations facing quality challenges; and

    iii. financial challenges – a net over-performance on £110m in 2015/16 on the NHS total system budget which is projected to rise to £486m by 2020/21.

15. The challenges outlined above, and in more detail in the case for change, impact detrimentally on the health and lives of the population we service and on the sustainability of NHS and social care services. The strategic remit of the STP is to address these challenges.

How our service models link together

16. Through developing our local care services we will be able to offer care closer to the patients home. It is recognised that many elderly patients are supported in acute hospital settings inappropriately, when there needs would be better met in a non-acute setting (e.g. outside of a hospital). This is outlined in the Kent and Medway Case for Change and it is well documented that supporting these patients in an acute setting has a detrimental impact on their long-term outcomes.

17. Whilst it is vital to develop our local care services, we also recognise that there will always be circumstances where individuals need to access secondary care. We are therefore developing revised models for emergency care, covering emergency departments (accident and emergency departments) and acute medical care, as well as for stroke care. However, our aim is to minimise reliance on secondary care, including facilitating discharge from the acute setting at the earliest opportunity.

18. Where it has been necessary for an individual to be admitted to acute care our Local Care and acute medical model will facilitate timely discharge, as outlined below for the elderly frail:

	1. Upon admission	2. Reduce time spent in a bed	3. Optimise the discharge process	4. Facilitate re-ablement and return to independence
Hospital care	• Assess patient for function and care needs on day 1 • Assessment needs to include cognition – early recognition of dementia/delirium	• Day 2 mobility plan • Work on mobility every day • Transparency within hospital to measure LOS >10 and medically fit • Trigger reviews of long stays • Early role of pharmacy in meds review	• Advance care plan • Discharge process run by community (below) • Early provision of discharge medication	• Enhanced transport offer
Interface	• Access to care record • Ownership retained by community teams • Direct link made between hospital team and community MDT to capture requirements • Planned day of discharge agreed by MDT • Determine social care means testing	• Daily MDT discharge meeting including community and care coordinators, nursing and medical team • Ensure assessment of care need has been made • Ensure funding decision is made	• Ensure rapid decision made about care packages required (e.g. within 2 hours) • Ensure care record reflects needed details of ongoing care	• Single point of access that works across CCGs in STP • Access to patient record • Better use of telemedicine and tele care to manage people out of hospital
Local care MDT	• Carers consulted by MDT about support needed	• Discussion with self-funders for care needs • Home environment assessed to see meets anticipated needs on discharge at the point of admission	• Discharge to assess • Care package in place (self/public) • Home modifications made • Carers prepared for requirements	• Support carers to reable • Provision of rapid response • Shift therapy workforce to out of hospital • Night sitting • Support individual decision making

19. We have also developed a revised elective orthopaedic service model. Whilst it is possible for elective orthopaedic services to operate on a standalone basis there are a number of interdependencies that need to be taken into consideration, in particular:

- the critical clinical service co-dependencies for orthopaedic elective work are anaesthetics and access to simple diagnostics, which need to be available on the same site; and
- the level of complexity of the procedures that can be undertaken is determined by access to Level 2 critical care facilities on site.

Service model for local care

20. The STP has prioritised the development of local (out-of-hospital) care. This is in recognition of the vital role these services play, including the current challenges they face as outlined in the case for change. This is also in response to what local people have said they want in recent years' insight work about more joined up services, better access to primary care and more support with staying well and managing their own care, and, importantly, in recognition that it is difficult to make change to the way hospital care is delivered without developing these services.

21. The Kent Integrated Dataset[7] has been used to interrogate spend and this has identified that approximately 32% of resources are used on 12% of the population, namely the elderly frail population, with multiple complex needs:

[7] Kent is one of the early implementers of the linked dataset initiative in England. The KID is possibly the largest linked dataset of its kind and one of the very few programmes with ambition to link data across the wider public sector. The Information Governance (IG) agreement behind the KID is that it can only be used for planning purposes, and cannot be used for informing direct patient care.

Spend per head, £
Population, Thousands
Spend, £ Millions

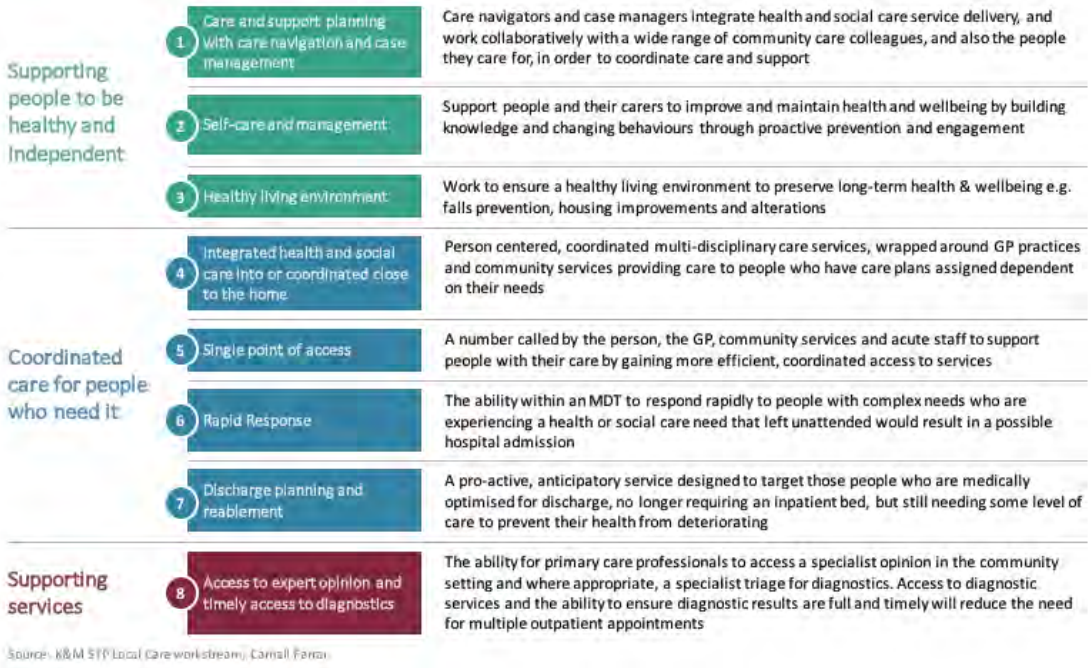
2015/16 population size, total spend and spend per head by condition and age band

Age	Mostly healthy		Chronic conditions (1-3)		Cancer		Neurological disorders		Dementia		Serious and enduring mental illness		Chronic conditions (4+)		Learning disability	
0-15	426		942		9,849		3,805						2,767		3,378	
	257.2	109.4	28.5	26.8	0.2	1.6	1.5	5.8					0.1	0.2	0.5	1.6
16-69	349		985		2,362		3,796		11,772		15,565		2,764		26,855	
	501.9	175.2	404.1	398.0	14.1	33.4	12.6	48.0	0.4	4.9	5.1	78.8	92.8	256.5	5.3	143.5
70+	1,901		1,782		2,420		4,262		7,681		24,943		4,576		42,310	
	21.8	41.4	79.1	141.0	8.5	20.6	4.1	17.6	3.6	27.8	0.5	12.3	84.8	388.2	0.4	15.7

Notes: KID data covers 55% of population and 32% of spend for scope area. Populations have been scaled to account for population registered to practices not flowing data into the KID. Spend has been scaled to match CCG data returns to account for data not included in the KID (e.g. non-PbR acute activity). Children's social care, CAMHS, prescribing costs and continuing care costs are not included. People registered to GP surgeries which flow into KID but had no activity in 2015/16 have been added to "mostly healthy" segments. KID data quality issues cause some people with long term conditions (incl. physical disability and SEMI) to be categorised erroneously as 'mostly healthy', artificially raising those segments' spend and populations.
Source: Kent Integrated Dataset; Carnall Farrar analysis; latest version as of 31/03/2017

22. Therefore, the focus of the work around local care has been on developing new service models to support this group of individuals but is now looking at how other groups of patients and users are now supported, e.g. children with complex needs, the mostly healthy with urgent care needs, adults with chronic conditions.

23. Our proposed service model for older people with complex needs model has been built around eight key interventions:

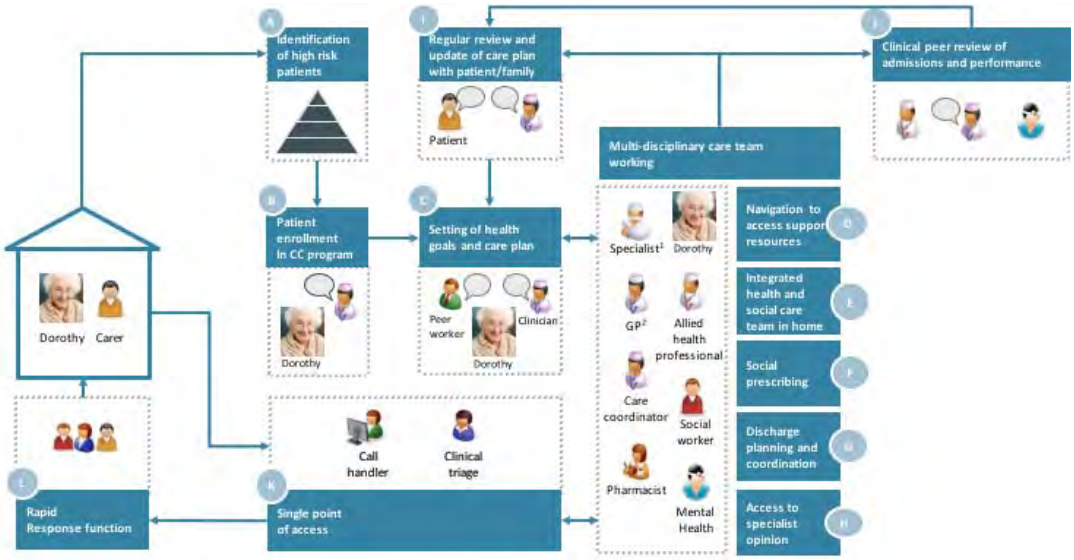


24. These interventions will be delivered through a revised service model that sees the integration of primary and community services working in multi-disciplinary teams. Key components of this working arrangement include:

PROCESS STAGE:		DESCRIPTION:
A	Identification of high risk patients	• Patients are identified through a monthly KID data refresh, highlighting their appropriateness to be cared for by the "older person complex care and support model", and are placed on their local MDT list to be assessed • Alternatively, patients are identified by clinicians in the community or in hospital care they are in contact with and are placed on their local MDT list to be assessed
B	Patient Enrollment in complex care programme	• Patients are informed of the older people with complex needs model and asked if they would like to enroll, informed of what the model requires and what the initial steps will be to ensure efficient inclusion
C	Setting of health goals and care plan	• There are two conversations, one with a peer and another with a clinical MDT member, ensuring personal goals and care and support needs are identified in partnership with the patient and their carers • Peer and clinical conversation outputs are captured in a care and support plan owned by the patient • The plan is used as the primary focus for the holistic care of an individual and is accessible to all teams interacting with the patients and by the patient themselves
D	Navigation to access support resources	• Case managers and care navigators support condition management, integration of services and care according to the patient's care plan and are supported by "social prescribing"
E	Integrated health and social care team in home	• MDTs deliver integrated care and support to both the patient and their carer
F	Social prescribing	• The MDT uses a highly accessible and user friendly digital directory of community resources for the patients, their carers and health and social care professionals, facilitating robust social prescribing practices • The MDT also work to empower people to become or remain highly engaged regarding their own health and wellbeing
G	Discharge planning and coordination	• The community MDT (led by the patients care navigator or case manager) in-reach into the hospital to assist with and speed up the discharge process using a patient's care and support plan to determine change in need and plan for additional care and support requirements in the community upon discharge
H	Access to specialist opinion	• MDT GPs, community nurses and consultants can access specialist healthcare professionals through various communication channels, who have time dedicated to answering questions regarding specific patients • MDT clinical staff have rapid access to diagnostic services (diagnostic and result) to quickly inform a clinical decision about a specific patient
I	Regular review and update of care plan with patient/ family/peer	• Annually, patients review their care plan with their peer supporter and with their CM/CN, ensuring their personal goals and care and support needs are still being fully and effectively addressed • The care and support plan is updated as a result of these reviews • MDTs meet regularly and when needed, to discuss and review the needs of specific individuals within the patient cohort

J	Peer review of admissions and performance	• Any admissions are clinically peer reviewed to understand the reasons and to learn for the future
K	Single point of access	• Patients with a care plan, their carer, the GP and community services have access to a single number (SPoA) that can be used when patients are experiencing an urgent health or social care need, and that provides individualised support through access to their care and support plan
L	Rapid response function	• The SPoA is used to access the MDT rapid response function, which guarantees a 2-hour response time when required, 24 hours a day • Patients receive and initial assessment by an MDT first responder who determines their short-term needs • When required, the patient and their carers will be supported for a short time period post-intervention, including a telephone and home visiting service • People requiring further clinical care will be transferred to the appropriate service quickly and efficiently

25. The above components of the service model are depicted below as a flow diagram that outlines the model of how it is intended that local care would be delivered:



1 Specialists in both inpatient or outpatient settings 2 Includes primary care physicians, advanced practice nurses, physicians assistants
Source: Carnall Farrar

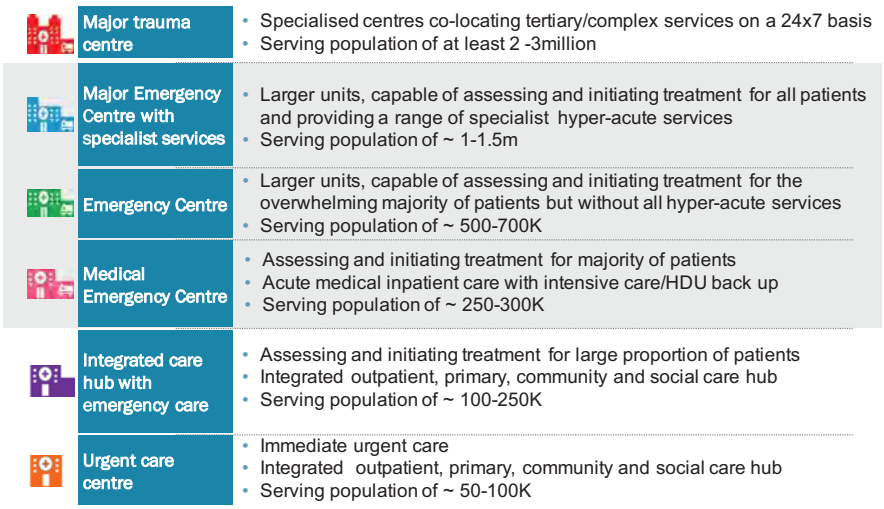
Emergency department clinical model summary

26. At present emergency department (ED) services are delivered at all seven acute hospitals sites in Kent and Medway. In 2015/16 there were 219,812 major emergency department attendances (including 254,441 adults and 57,507 children) and 311, 948 minor emergency department attendances (including 156,084 adults and 63,728 children). Emergency department attendances have grown by 3.6% per year over the last three years in Kent and Medway (the national average is 2.6%). Conversely, performance on the four-hour waiting target has deteriorated over the last two years; in

2015/16 on average 86% of people were discharged from emergency departments within four hours, compared to 92% nationally.

27. Some providers in K&M have amongst the worst patient satisfaction scores in the country. Patient stories show the current system is characterised by long waits, multiple contacts with health care professionals, and poor patient experience. A range of interventions are being developed to avoid emergency department attendances, as outlined in the previous section on our local care model. A new model for emergency departments will incorporate triage to the most appropriate pathway.

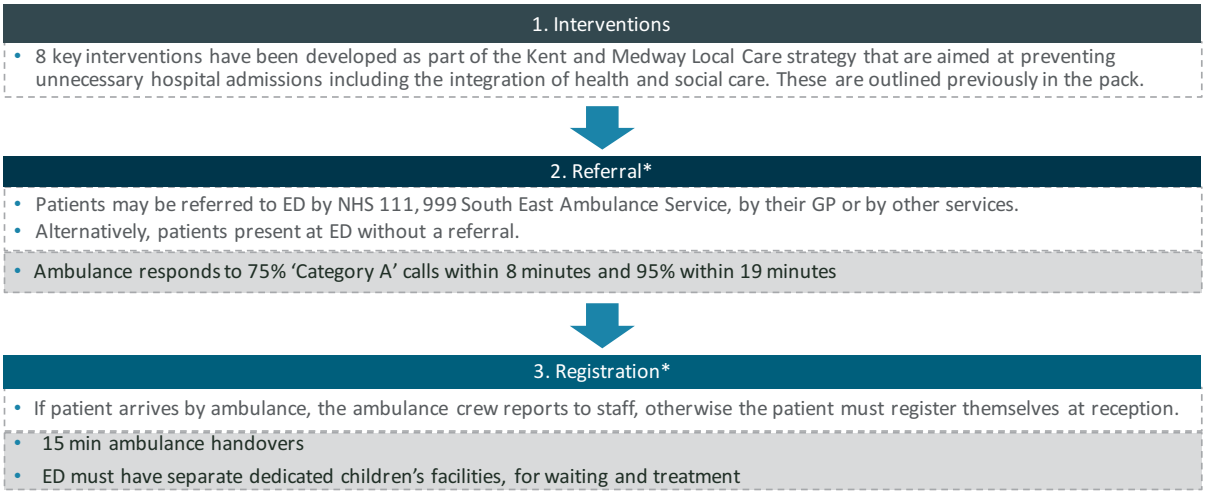
28. The models in the Keogh report have been used as a basis for developing building blocks of services (i.e. the service models we would see our current hospitals develop to become):



Source: Sir Bruce Keogh, Transforming Urgent and Emergency care services in England, End of Phase 1 Report, 2014

29. The South East Clinical Senate has undertaken work to understand the co-dependencies between services and these have been used to further describe the Keogh models.

30. The following diagram outlines the standard process that patients attending an emergency department would expect to experience:



4. Assessment

- Patients undergo a comprehensive** pre-assessment by a nurse or doctor before further actions are taken. This is called triage and will ensure people with the most serious conditions are seen first. Sometimes further tests need to be arranged before a course of action can be decided.
- No patient waits >12 hours on a trolley
- Presence of a senior ED doctor (ST4 or above) as a clinical decision maker 24/7

5a. Treatment or transfer

- Treatment or transfer: If situation is complicated, the patient my be seen by an ED doctor or referred to a specialist unit.
- 24/7 On site senior support within the core specialties
- Presence of a named paediatric consultant with a designated responsibility for paediatric care
- Availability of a surgeon at ST3 level or above, or a trust doctor with equivalent ability Interventional radiology services for highest acuity patients are available within one hour of referral

5b. Discharge*

- Discharge: If nurse or doctor feels situation is not a serious accident or emergency, the patient may be sent home and asked to refer themselves to a GP, referred to a nearby urgent care centre, minor injuries unit or referred to a GP on site.
- Consultant accredited in Emergency Medicine [CCT holder] on the Emergency Floor Consultant between 08:00 and 24:00, 7 days per week

* Category A calls relate to immediately life-threatening incidents

* Many places across Kent and Medway are introducing a first step based on the Barking, Having and Redbridge (BHR) 'Redirection' where the eyeball 'streaming' takes place by a GP or Consultant who in less than 4 minutes will assess the patient and redirect out to community services, GP's, Pharmacy, Minors/UCC, or hot clinics'. Those that remain go through the comprehensive triage.

** The detail of these aspects of the model is being developed as part of the local care work stream.

Acute medicine

31. At present acute medical care is delivered at all seven acute hospital sites in Kent and Medway and there were 115,626 medical admissions in 2015/16.

32. The population registered with GPs in Kent and Medway is 1.8 million (i.e. includes patients from outside the area registered with local GP practices). The population is forecast to grow over the next five years, with a majority of growth occurring in the elderly population. Partly linked to this there are rising numbers of emergency admissions and bed occupancy across Kent and Medway.

33. In a recent bed audit, there were 1,007 patients in hospital beds who are medically fit to leave their current setting of care (as at 22nd November 2016). The vast majority of patients who were medically fit for discharge were delayed for a reason outside of the control of the hospital.

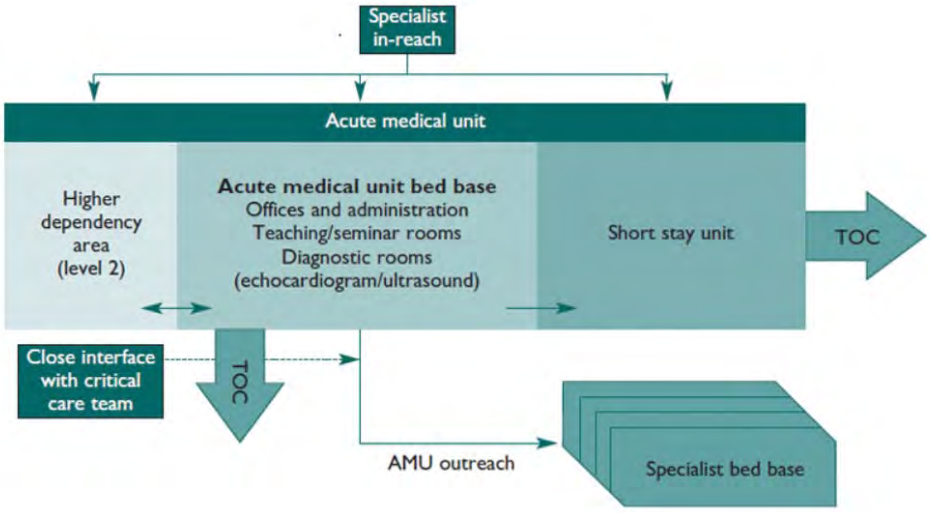
34. In line with national policy, the NHS aspires to provide seven day services but workforce constraints are challenging the delivering of this, including the inability to put in place 24/7 consultant cover in hospitals across Kent and Medway for those who need acute medicine.

35. The Kent and Medway acute medical care model is partially consolidated, but is still largely based on historic dispersal of services. Acute emergency medicine is currently delivered from seven sites using a variety of models. All Trusts aspire to deliver best practice models but constraints with capacity, estate and workforce only allow this to happen to varying degrees.

36. Our proposed service model covers:

- streaming to a fully functioning acute medical unit to reduce acute admissions;
- timely and appropriate discharge from the emergency department supported by schemes (e.g. such as occurs in the voluntary sector Take Home & Settle service in East Sussex);
- reduced non-elective length of stay, incorporating the NHS England pathway for people with dementia;
- Rapid Assessment Interface and Discharge (RAID) & Integrated Psychological Medicine Service (IPMS) models; and
- delivery of 7-day services in acute medicine to allow timely access to a senior specialist medical opinion.

37. The term Acute Medical Unit (AMU) has been defined by the Royal College of Physicians (RCP)[8] as 'a dedicated facility within a hospital that acts as a focus for Acute medical care for patients that have presented as medical emergencies to hospitals.' The report provides a detailed description of the rationale and requirements for an AMU but allows for local design. The structure of an AMU is schematically represented below:



38. Ideally an AMU should be co-located with other acute and emergency services as part of an emergency floor incorporating the ethos of Emergency Ambulatory Care. Strong clinical (medical and Nursing) and operational leadership is essential for an AMU to function successfully.

39. In delivering the acute medical take through an AMU a number of key principles need to be adopted:

- Assessment of acutely ill patients by competent clinical decision makers supported by appropriate levels of diagnostic support
- All areas follow the ethos of treating patients in an ambulatory model unless deemed otherwise by exclusion criteria
- Nominated medical, nursing and operational leads are in place working in the department on a regular basis

[8] Royal College of Physicians. *Acute medical care. The right person, in the right setting – first time.* Report of the Acute Medicine Task Force. London: RCP, 2007.

- Integration and collaboration of key acute services e.g. emergency department, critical care, AMU and key support services e.g. pharmacy and therapies
- Consistency of quality medical care 24 hours a day, 7 days a week
- Specialist medical in-reach when required in a timely way 7/7

Stroke services

40. In 2015/16 approximately 2,500 acute stroke patients were supported in the seven acute hospitals in Kent and Medway. Currently all of these hospitals provide acute stroke care and, following the immediate acute episode, patients are discharged without further rehabilitation or discharged back to their home with a community rehabilitation package or to a new home, such as a residential care home that is suitable for their needs
41. In 2015/16 only half of all patients were admitted within four hours and this performance is below national average. In addition, all of the hospitals:
    i. only provide five-day stroke consultant face-to-face cover;
    ii. none provide seven-day consultant ward rounds;
    iii. less than 50% of patients receive thrombolysis within 60 minutes; and
    iv. performance against Sentinel Stroke National Audit Programme (SSNAP) is variable and inconsistent.
42. Currently patient volumes are too small to deliver clinical sustainability hyper acute stroke units on all seven acute hospital sites. In particular, there are significant challenges that cannot be met with the current service model of all seven hospitals providing acute stroke care. We need to ensure there is 24/7 consultant availability with a minimum 6 trained thrombolysis consultant physicians on rota and consultant led ward round 7 days a week. This will be supported by a multi-disciplinary team including nurses, physiotherapists and occupational therapists.
43. In order to achieve the above we need to consolidate stroke services on fewer sites to ensure there are sufficient volumes of patients supported on each site to sustain the staffing numbers. For Kent and Medway this means delivering a combined hyper acute stroke unit and acute stroke unit service on a smaller number of sites. In practice for Kent and Medway this means developing hyper acute stroke units that support volumes of over 500 patients and less than 1500 confirmed stroke patients.
44. Alongside the acute stroke provision it is recognised that we need to develop robust early supported discharge and rehabilitation services.

Elective orthopaedics

45. There are 7,921 elective orthopaedic inpatient and 13,331 elective orthopaedic day case procedures undertaken in hospitals in Kent and Medway (plus 2,110 inpatient and 425 day case procedures in private hospitals under “choose and book arrangements”, which give patient a choice about where they receive treatment). The majority of the people having these procedures are older (with most procedures in the 64-69 age band).

46. In addition, Kent and Medway acute providers outsource approximately a further 2000 elective orthopaedic procedures each year to private hospitals and there are an additional 6,000 patients waiting for elective orthopaedic procedures across the area, with referral levels for elective procedures varying between CCGs and between practices. Some hospital waiting lists for planned care are long and growing. The number of cancellations on the day of the operation are increasing.

47. Right Care[9] analysis shows a potential significant opportunity in musculoskeletal elective bed days across the patient pathway, circa £8m compared to peers, and an additional £1.8m related to areas such as falls and primary care prescribing.

48. All acute hospital sites in Kent and Medway deliver a mixture of elective (planned) and non-elective (unplanned / emergency) orthopaedic services, with the exception of Kent & Canterbury Hospital which does not undertake any non-elective activity and Maidstone General Hospital which does not undertake any non-elective orthopaedic surgery.

49. Our proposed service model is based on:

- a focus on prevention and self-care and the benefit of a community-led integrated musculoskeletal (MSK) pathway;
- a set of principles including standardised approach, use of multi-disciplinary teams, one-stop services, senior support and better use of digital technology;
- a greater use of multi-disciplinary teams, consultant feedback, earlier discharge planning and ring-fenced elective beds; and
- consolidation of elective orthopaedic surgery onto fewer sites will lead to an improvement in outcomes.

50. The following diagram outlines our proposed service model:

[9] RightCare is an NHS England programme aimed at improving people's health and outcomes by promoting that the right person has the right care, in the right place, at the right time, making the best use of available resources. It uses data and evidence to highlight unwarranted variation to support quality improvement.

Hurdle criteria

51. As with the clinical models, the hurdle criteria have been developed through the hospital care workstream, with clnical and patient engagement, and then reviewed and signed-off by the STP Clinical Board, ahead of being approved at the STP Programme Board.

52. Through consideration of the service models we will identify a long list of options around potential service changes. As outlined in the process diagram at Point 11, these will be evaluated using the hurdle criteria. An option must meet the requirements of each of the hurdle critieria or it will be rejected. This means that through assessing the long list of options by applying the hurdle criteira to them, a short list of options will be generated. This shortlist of options will go forward to more detailed evaluation:

Criteria	Description in relation to application against long list of options for emergency care, acute medicine and elective orthopaedics	Description in relation to application against long list of options for stroke services
Is the potential configuration option clinically sustainable?	• Does it deliver key quality standards? • Does it address any co-dependencies? • Will the workforce be available to deliver it? • Will there be sufficient throughput or catchment population to maintain skills and deliver services cost effective?	• Does it deliver key quality standards? • Does it address any co-dependencies? • Will the workforce be available to deliver it? • Will there be sufficient throughput or catchment population to maintain skills and deliver services cost effectively?
Is the potential configuration option implementable?	• Will the option deliver financial and clinical sustainability within a medium-term timeframe by 20/21? This statement is based upon a system wide view, this may mean that some organisations have a net negative financial impact as well as some have a net positive impact.	• Will the option deliver financial and clinical sustainability within a medium-term timeframe by 20/21? This statement is based upon a system wide view
Is the potential configuration option accessible?	• Is the maximum travel time (by car) an average of one hour or less?	• Can the population access services within a window of 120 minutes from call to needle?[10]
Is the potential configuration option a strategic fit?	• Does it implement the outcome of other recent consultations or designation processes?	• Does it implement the outcome of other recent consultations or designation processes?

[10] Using 95% accessing services within 60 mins (off-peak) as a proxy

Is the potential configuration option financially sustainable?	• Must not increase the 'do nothing' financial baseline	• Must not increase the 'do nothing' financial baseline *(given the need for capital investment at any resulting sites which is of similar quantum, noting more at PFI sites, this will be considered in detail at evaluation stage)*

Summary

53. As indicated at the start of this paper it is envisaged that consultation will take place in two waves, with the first services that are intended to be consulted on being:

    i. Acute stroke services across Kent and Medway

    ii. Emergency services in East Kent (i.e. emergency departments and acute care)

    iii. Elective orthopaedics in East Kent

54. The next step will be to now:

    - agree a long list of options against each of the above services areas;
    - apply the hurdle criteria outlined in this document to the longlist of options to develop a shortlist of options;
    - agree full evaluation criteria; and
    - evaluate the shortlist of option using the full evaluation criteira.

55. The STP partner organisations are asked to consider the contents of this paper and indicate their support for:

    - the service models it outlines; and
    - the hurdle criteria that will be used to assess the long list of options.

56. The Governing Bodies of Clinical Commission Groups are asked to consider and formerly agree the service models and hurdle criteria.

Kent and Medway STP

Local Care Model

20th June 2017

Our vision for Local Care in Kent and Medway

Kent and Medway Local Care Vision

Our aim is to develop **holistic, patient-centered community and home-based care** across Kent and Medway resulting in:

- Wide ranging **proactive self-care and self-management measures** that reduce lifestyle risks and their causes
- Local people being given the **tools and information, services and support** needed to be accountable and responsible for their own care
- Connected care services, including **integrated health and social care**, resulting in patients being able to access services quickly and efficiently in a community setting where their needs are fully understood
- People **only attending hospital when essential**

Source: K&M STP Local Care workstream

We have agreed a set of key design principles to deliver this vision

Key design principles for Local Care

A. The Kent and Medway population as a whole is enabled and encouraged to be proactive regarding their own health and wellbeing and the Kent and Medway system is proactive in whole population prevention

B. Patients with long term care needs are supported to remain in their local communities through services wrapped around GP practices

C. If an urgent health need arises, the care a patient needs is provided within a community setting, as close to their place of residence as possible

D. If a stay in hospital is required there is a process from admission to discharge in order to minimise excessive length of stay and allow for a quicker patient recovery

E. Specialist services are available to patients and their local care service providers when there is necessary need

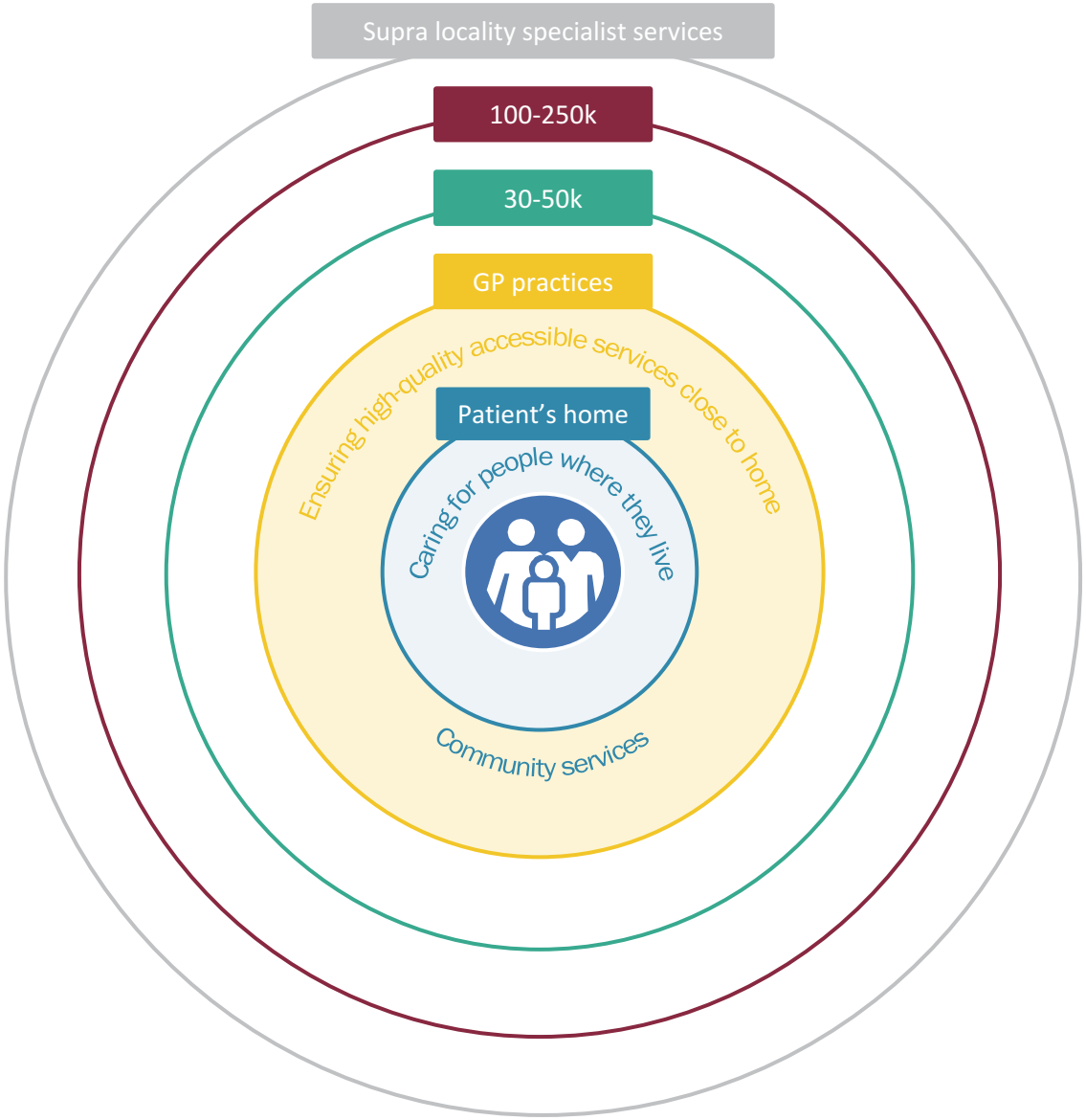
Priorities to delivery the strategy

- General Practice (GP) groupings (30-50k) will be at the heart of communities, supporting patients who need help accessing the services they require
- Patients are cared for by multi-professional health and social care teams that are developed around local natural geographical networks and communities
- Services groupings covering specific populations will facilitate an in-depth focus on local communities
- Improved working relationships with all providers, civil society, Healthwatch, and other patient representatives

Source: K&M STP Local Care workstream

Potential location and coverage of key services

ILLUSTRATIVE EXAMPLES



GP practices (practice population dependent)

- GP/GPSI
- Practice/ District Nurses
- Health care assistant
- Clinical pharmacist
- Physician associate
- MH professional / IAPT
- Receptionist
- Call handling service and clinical triage
- Out of hours service

Groupings to cover- 30-50k

MDT services:

- Care navigators/case managers
- Support navigation
- GP/GPSI
- Social care worker
- Physio
- Specialist dementia nurses
- Voluntary sector workers
- Domiciliary care workers
- Peer support worker
- Mental health worker
- Health coach
- Community/ hospital extensivist
- Rapid response
- Reablement

Additional services:

- Falls service
- Health and wellbeing services
- Directory of services and referral support
- Ambulatory Care
- Paramedic
- Midwife
- Community & Crisis
- Intermediate Care
- Optometrists
- Community Pharmacist
- Consultant outpatient clinics
- End of life care
- Out of hours service

Groupings to cover– 100-250k

- SECAmb 999
- NHS111 / OOH Model
- Consultant Hot Clinics
- Minor Injury Unit
- Learning Disability
- Autism and sensory services
- Hospices
- Continuing care
- Patient Transport
- Community Equipment and Assistive
- Technology Services
- Secondary Care Mental Health
- Diagnostics
- Call handling service and clinical triage

Source: K&M STP Local Care

Health and care professionals have developed a vision for Dorothy's care, which will become more consistent and simpler to access

Currently, Dorothy's care is…

Inconsistent and overlapped: Unfamiliar staff provide similar services and do not fully understand her health and care needs

Decided without her involvement: She feels excluded from all major care decisions and doesn't get to say what she would like

Difficult to access: There are multiple, confusing points of contact for different services when she has a health or care issue

Focused only on her health needs: She does not understand the wider community support available to her

Only assessed by a specialist when she visits the hospital: When she quickly needs diagnostic tests or an expert opinion, she has to travel to multiple outpatient appointments

Dorothy's care will be…

Consistent and well organised:
She is visited by friendly faces who are familiar with her needs

Decided with her: She is involved with all decisions made regarding her care and communication regarding decisions is clear

Simple to access: She has one phone number that she is confident can help her in any way required

Focused on her: Her wider health and social needs are understood and it is easy for her access any community support she needs

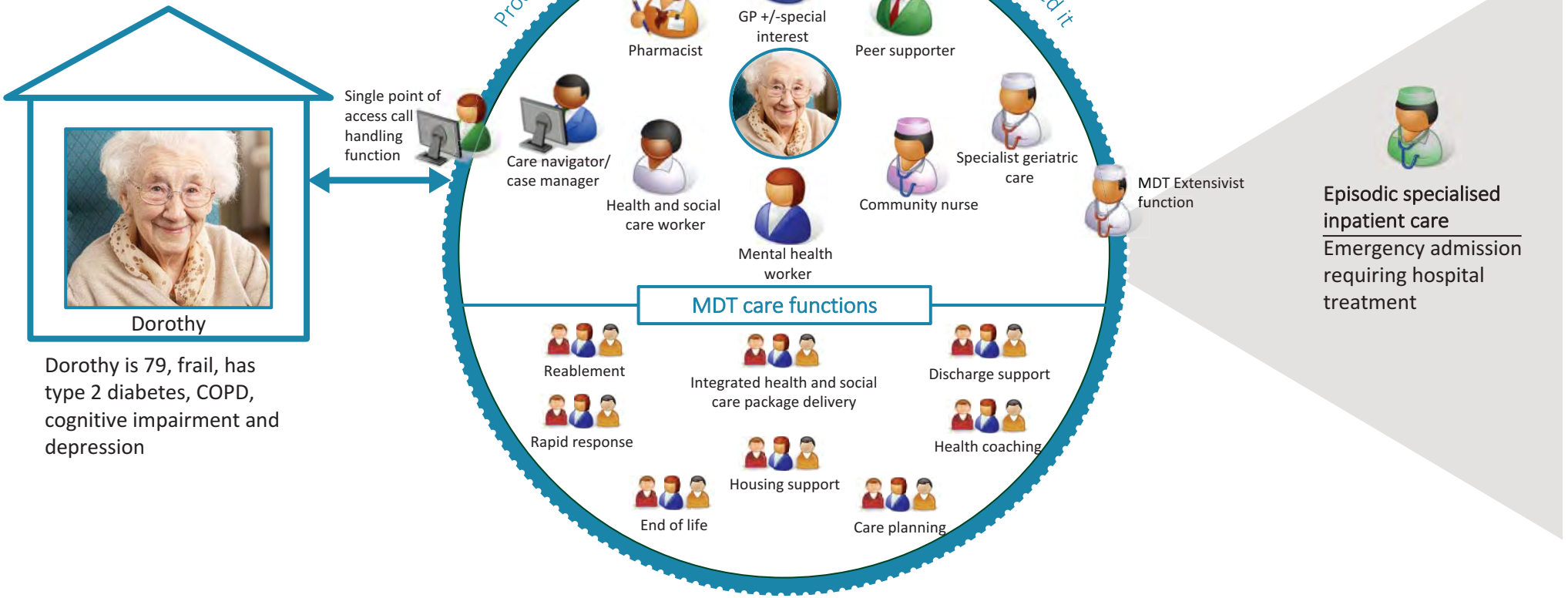
Assessed by an expert without her having to go to the hospital: She is quickly provided with the specialist opinion or diagnostic results needed without going to hospital

Source: K&M Local Care

K&M older persons complex care model will provide personalised, coordinated care

Supporting people to be healthy and independent

Self-care and self management	Ensuring healthy living environment	Care and support planning	Case Management & Care Navigation



Dorothy is 79, frail, has type 2 diabetes, COPD, cognitive impairment and depression

Supporting services

Diagnostics	Specialist opinion	Falls service	Housing services	Third sector

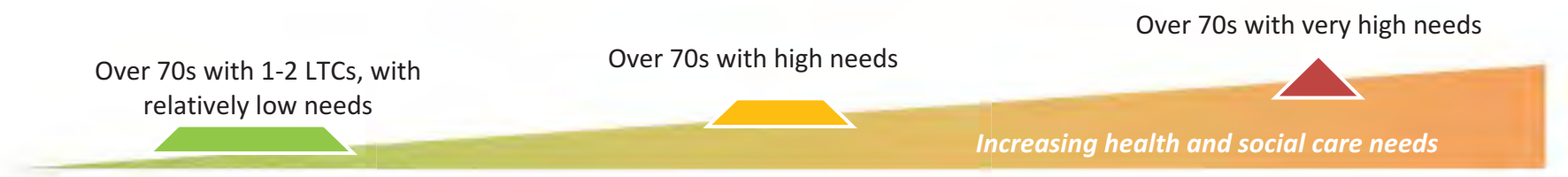
Source: K&M STP Local Care

Key elements of the older persons complex care model

Supporting people to be healthy and independent	1 Care and support planning with care navigation and case management	Care navigators and case managers integrate health and social care service delivery, and work collaboratively with a wide range of community care colleagues, and also the people they care for, in order to coordinate care and support
	2 Self-care and management	Support people and their carers to improve and maintain health and wellbeing by building knowledge and changing behaviours through proactive prevention and engagement
	3 Healthy living environment	Work to ensure a healthy living environment to preserve long-term health & wellbeing e.g. falls prevention, housing improvements and alterations
Coordinated care for people who need it	4 Integrated health and social care into or coordinated close to the home	Person centered, coordinated multi-disciplinary care services, wrapped around GP practices and community services providing care to people who have care plans assigned dependent on their needs
	5 Single point of access	A number called by the person, the GP, community services and acute staff to support people with their care by gaining more efficient, coordinated access to services
	6 Rapid Response	The ability within an MDT to respond rapidly to people with complex needs who are experiencing a health or social care need that left unattended would result in a possible hospital admission
	7 Discharge planning and reablement	A pro-active, anticipatory service designed to target those people who are medically optimised for discharge, no longer requiring an inpatient bed, but still needing some level of care to prevent their health from deteriorating
Supporting services	8 Access to expert opinion and timely access to diagnostics	The ability for primary care professionals to access a specialist opinion in the community setting and where appropriate, a specialist triage for diagnostics. Access to diagnostic services and the ability to ensure diagnostic results are full and timely will reduce the need for multiple outpatient appointments

Source: K&M STP Local Care workstream, Carnall Farrar

Different packages of care to reflect differing needs among older people



	Tier 1	Tier 2	Tier 3
Sub-segments	Over 70s with 1-2 LTCs, with relatively low needs	Over 70s with high needs	Over 70s with very high needs
Criteria for sub-segmentation	• Age 70+ with 1-2 well managed LTCs	• Age 70+ with 3+ LTCs and less than two AE appearances/NEL admissions per year • Stroke patients	• Age 70+ with dementia • Age 70+ with 3+ LTCs and at least two AE appearances/NEL admissions per year • End of life patients
Distribution in Kent	• **94,017** people • **6.2%** of the Kent population • **£227.2** of spend • **24,078** A&E attendances • **13,403** NEL admissions • **£2,415** spend per head	• **39,814** people • **3.9%** of the Kent population • **£149.5m** of spend • **13,313** A&E attendances • **8,135** NEL admissions • **£3,745** spend per head	• **19,858** people • **1.3%** of the Kent population • **£216.8m** of spend • **20,633** A&E attendances • **13,684** NEL admissions • **£10,919** spend per head
Salient features of care package for the sub-segment	• **No dedicated care-navigator, care planning carried out by peer or online;** once a year on average • **Support navigation provided** in order to ensure people are aware of the directory of services available • **Empowerment and education sessions** with general nurse; use of e-delivery for part of these sessions	• **Dedicated care-navigator for each person in this segment,** involved in annual care and support planning with MDTs, and regular care navigation for people • **Empowerment and education also managed by care navigator** • **Access to single point of access and rapid response services**	• **Most intense care package** in terms of appointments and care planning/case management • **Dedicated case manager,** involved in annual care and support planning with MDTs, and regular case management • **Access to single point of access and rapid response services**

Source: Kent Integrated Dataset, Carnall Farrar analysis

Care Models

1 Care and support planning in conjunction with care navigation and case management

Care navigators and case managers integrate health and social care service delivery, and work collaboratively with a wide range of community care colleagues, and also the people they care for, in order to coordinate care and support

Source: Birmingham Community Healthcare NHSFT, South Devon and Torbay CCG, King's Fund

Traits of successful care and support planning:

1. Identification of eligible people through predicted future needs and professional judgement
2. Use of trained peer workers to facilitate conversations to understand the holistic needs of people and their carers
3. Meeting of the local MDT when needed to to discuss the needs of the patient cohort and specific people within it
4. Use of care navigators to manage complex people (e.g. older with 3+ LTCs) supporting condition management, integration of services, adherence to their care plan and social prescribing
5. Use of case managers to manage high complexity people (e.g. End of life, older with dementia, older with 3+ LTCs) intensively supporting condition management, integration of services, adherence to their care plan and more supportive social prescribing
6. Enablement of self-management, self-care and activation

Source: Birmingham Community Healthcare NHSFT, South Devon and Torbay CCG, King's Fund

Case Management and Care Navigation

Care navigation (CN) concept (tier 2)

Care Navigation is for complex people (e.g. Older with 3+ LTCs, stroke) who require support to manage their conditions, access the care they need and to live independently, ensuring they stay out of hospital as much as possible. The key components of CN consist of:

- Facilitate the development and management of an anticipatory care and support plan in partnership with the person and their carer
- Coordination and integration of health and wellbeing services, holding other providers in the care and support plan to account
- Intermittent review of care and support plan and agreed outcomes in partnership with the person, evaluate outcomes and liaise with MDT
- Awareness of hospital admissions and assistance in discharge process
- Provide a central, continuous point of contact for the person, their carer, the MDT and range of health and social care staff involved
- Establishment of a relationship with the person to ensure familiarity and continuity
- Work towards improved self-management (and self-care)

Case management (CM) concept (tier 3)

Case Management is for very complex people (e.g. End of life, older with dementia, older with 3+ LTCs) who require intensive support to ensure they stay out of hospital as much as possible. The key components of CM consist of:

- Facilitate the development and management of an anticipatory care and support plan in partnership with the person and their carer
- Intensive coordination and integration of health and wellbeing services, holding other providers in the plan to account
- Frequent review of care and support plan and agreed outcomes in partnership with the person, evaluate outcomes and liaise with MDT
- Awareness of hospital admissions and assistance in discharge process
- Provide a central, continuous point of contact for the person, their carer, the MDT and range of health and social care staff involved
- Establishment of relationship with the person to ensure familiarity and continuity
- Work towards improved self-management (and self-care)

Care and support planning

- A person and their carer led process that develops a holistic plan that meets all of a person's needs and goals
- Created for people with high risk, complex needs identified through data analytics and professional opinion, who have agreed to have care navigation or case management (tier 2 and 3)
- A simple anticipatory care and support plan for independent and active older people (tier 1) created by the person in partnership with their GP
- A non-clinical, holistic approach is initially taken whereby peers are trained to be able to have conversations with a person and their carer in order to ensure their whole needs are fully understood and wishes taken into account when care is provided
- Peer-person conversation outcomes are taken to a multi-disciplinary team clinical meeting where a holistic care plan for how to meet the current/ future needs of the person are developed. The plan will include a package of care delivered by integrated health and social care services

Source: K&M STP Local Care

Care and support plan: *holistic, multi-disciplinary and trusted*

Concept

- A comprehensive plan to ensure the personalised, holistic care of an individual so that they get:

  "the care they need and no less; the care they want and no more"

- The *Care and Support Plan* is the primary focus for the holistic care of an individual and will be used by teams supporting people with Long Term Conditions and by the person themselves to ensure they have the care and support that is "just right" for them

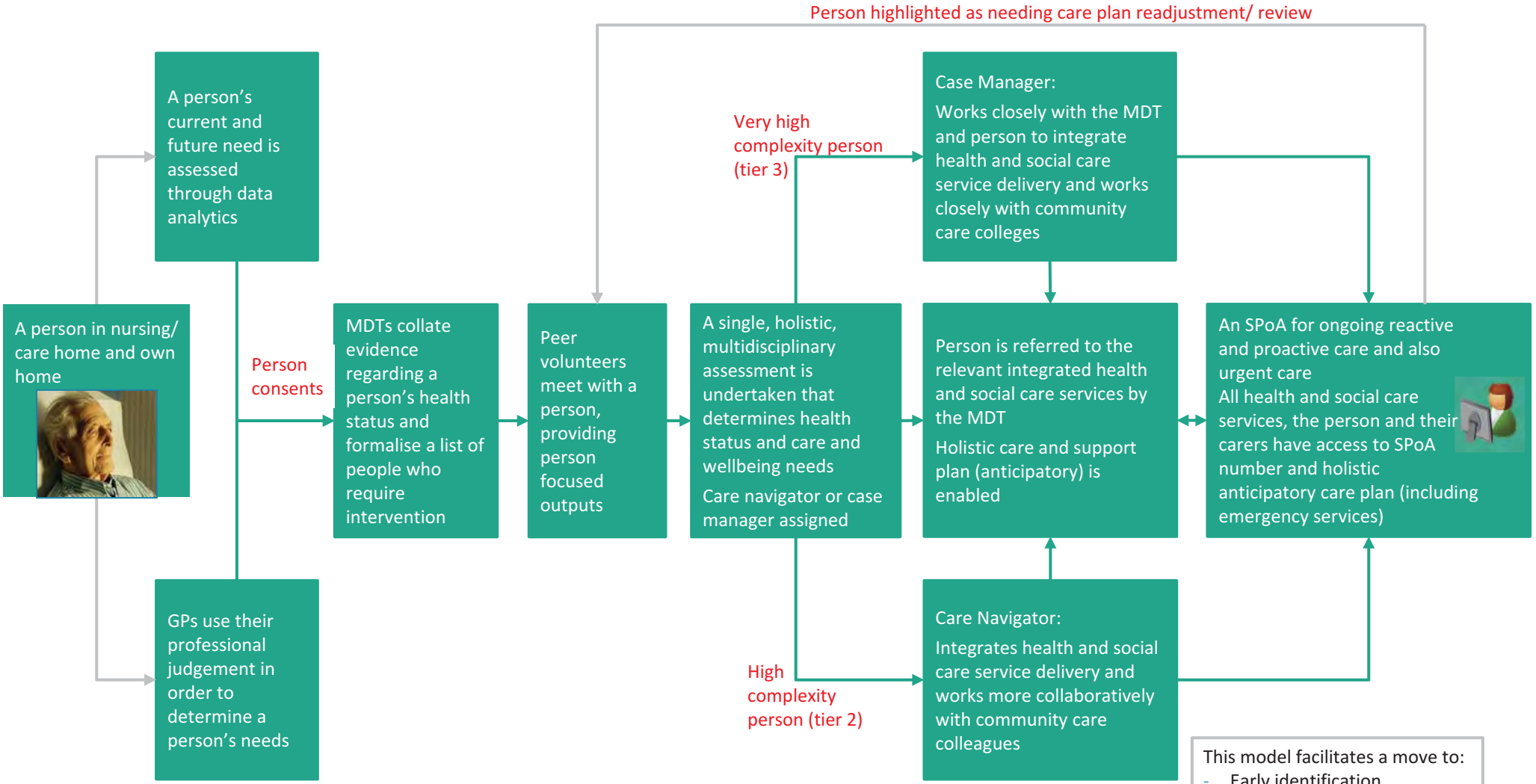
Components

- It should be created and updated in partnership with the person
- There is only one per person, and it is personalised and specific to that person
- The person (or their carer) should own it and be able to access and understand it
- The person should be able to add to and update aspects of the plan themselves
- It is the output of a collaborative "care planning" process, which aims to establish the holistic and individual needs of the person and that their care and support is aligned to their unique needs and preferences
- It is not just about medical interventions, but also covers personal goals and psychological, social and clinical needs
- It includes an anticipatory care plan for what actions to take when things get worse
- The trusted, holistic, multi-disciplinary care plan should give the overall summary view for caring for and supporting the person's needs and 'link' or 'signpost' other more detailed care plans held in other systems (e.g. an acute care plan in a hospital)

- *Note: Not to be confused with clinical record or a clinical plan*

Source: http://www.justaddspice.org; National Voices

Planned care approach to management of chronic conditions (Tiers 2 and 3)



Source: Carnall Farrar, K&M Local Care Workshop

Care coordination and planning– example pathway 1

Vera is 79, frail, has type 2 diabetes, COPD, early onset dementia and recently suffered a stroke. She lives with her husband Syd, who is also frail and often unwell himself

1

She visits her GP, Dr. Jones, as she has been feeling breathless over the last few days

2

Dr. Jones, assesses Vera and decides she more than meets the criteria for a care plan. Furthermore, the exacerbation of Vera's condition, along with the poor health status of her husband will require a short term care package to stabilise her. He gains the couples permission before taking further action

3

Dr. Jones calls the single point of access who arrange a short term package of care including a district nurse visit twice per week and a domiciliary worker visit once per day. The SPoA also contact the local (30-50k) MDT and request Vera be placed on the agenda for their next meeting

4

A peer support worker, with training to facilitate effective conversations, visits Vera and Syd. They discuss not only Vera's, but also Syd's ambitions for living independently, what they feel may help, including being more active, sociable and having a home they feel safer in

5

The couple are not IT literate and so an MDT health coach is also assigned to provide structured social prescribing. Through this support, Syd is assisted with accessing a local charity's respite care service

6

Vera is identified as being complex, needing a care navigator to assist her with her package of care and management of her conditions. After an initial introductory call, David her CN, will check in with Vera periodically, coordinate her care and monitor her overall progress. Vera can also call David if needed. She is also provided with the SPoA number incase David cannot be contacted

7

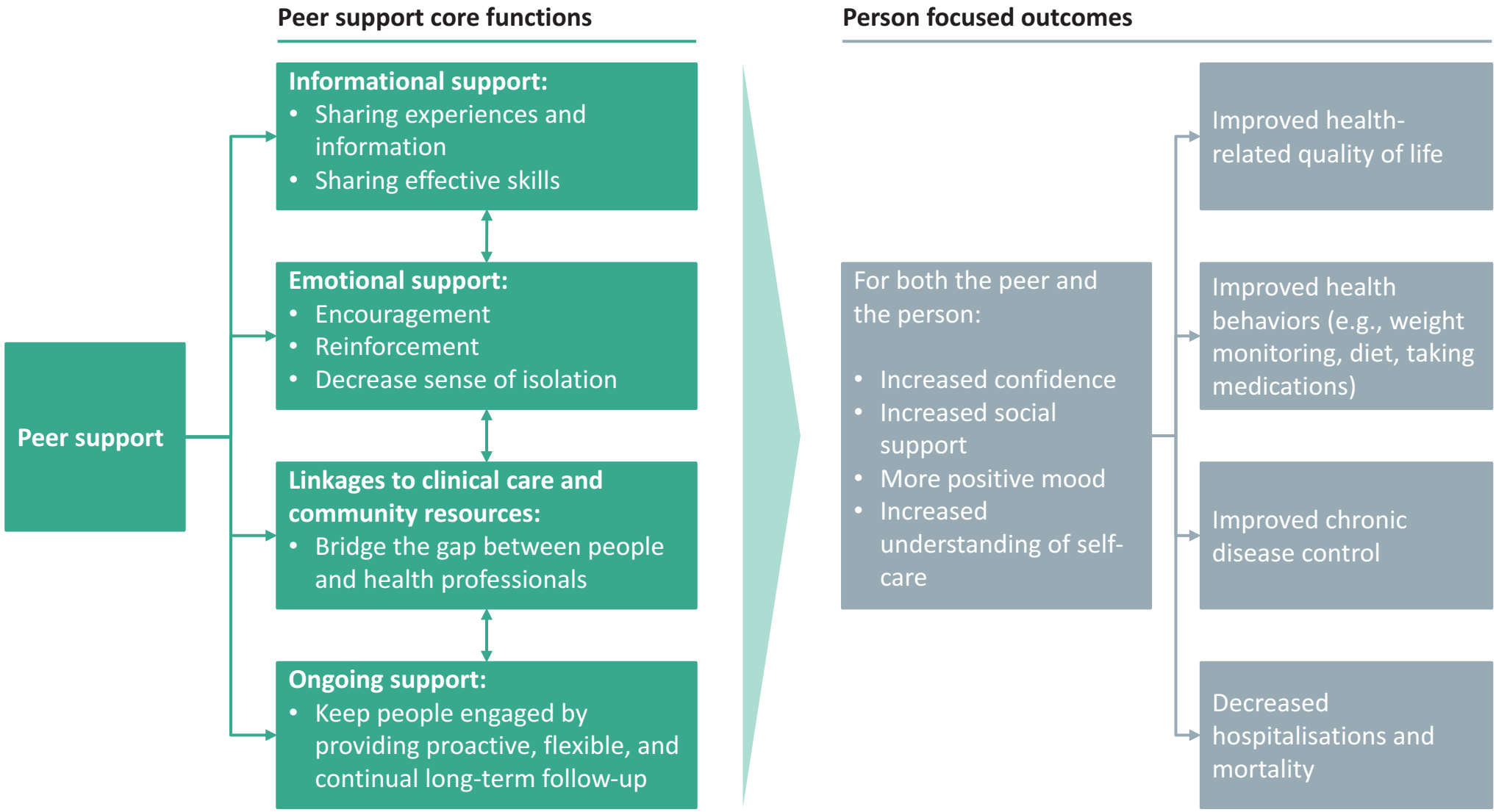
The MDT meet and using the peer conversation report, make a holistic plan. Vera's package of care is defined, including a dementia nurse, pharmacist, domiciliary care worker and falls prevention service. A shared electronic record is also created. Her care plan details these services, as well as the medication she must take and the self-management strategies she must follow

8

Vera is stable and Syd is less stressed and healthier. They are both able to live independently in the community

Source: K&M STP Local Care workstream

Peer support



Source: Homerton University Hospital NHS Foundation Trust; NESTA People Powered Health report, Peers for Progress website; Norris, S.L., Chowdhury, F.M., Van, Le K., et al. Effectiveness of community health workers in the care of persons with diabetes

Peer support

Concept

- The role of a peer supporter is usually a voluntary role
- Peer support relies on non-hierarchical, reciprocal relationships, which provide a flexible supplement to formal health system services for people with long term conditions. In addition, peer support fosters understanding and trust of health care staff among groups who otherwise may be alienated from or have poor access to health care

Components

- **Professional-led group visits with peer exchange:**
  - People who share the same condition are brought together with a health care provider or team of providers to address their self-management challenges
- **Peer-led face-to-face self-management programs:**
  - A person who shares the same condition as the participants leads an interactive conversation to enhance sharing and mutual encouragement
- **Peer coaches/ mentors:**
  - Individuals who have coped with the same condition meet one-on-one with people to listen, discuss concerns and provide support
- **Community health workers:**
  - Community members who work to bridge the gap between their respective communities and health care providers. They do not necessarily have a chronic condition, but they often share language, culture and community with the people who do. Oftentimes, the roles of community health worker and peer coach are merged
- **Support groups:**
  - Gatherings of people who share common experiences, situations, problems or conditions. In these gatherings, people are able to mutually offer emotional and practical support
- **Telephone-based peer support:**
  - Provided through regular phone calls that are either the sole form of an intervention or used to complement other modes of intervention
- **Web- and e-mail-based programs:**
  - These programs use the internet to mobilise peer support, including internet-based support groups and email reminders

Impact

- People who partner with a community health worker had more knowledge of their disease and better self-care skills than those who had no contact with a community health worker
- People connected with community health workers had fewer emergency room visits

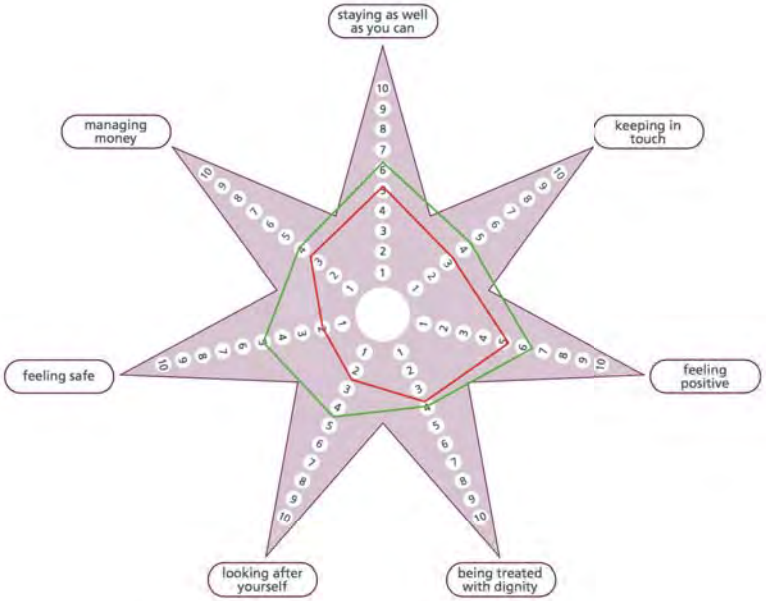
Source: Homerton University Hospital NHS Foundation Trust; NESTA People Powered Health report, Peers for Progress website; Norris, S.L., Chowdhury, F.M., Van, Le K., et al. Effectiveness of community health workers in the care of persons with diabetes

Outcomes star

Concept

Supporting people with initial and continued engagement with peer assessors and their care and support plan

- The star facilitates supported independence regardless of the circumstances of the person by highlighting the support needs of 7 aspects of an older persons life:
  - Staying as well as you can
  - Keeping in touch
  - Feeling positive
  - Being treated with dignity
  - Looking after yourself
  - Feeling safe
  - Managing money and personal administration



Elements

The ladder of change:

Each step on a area ladder has a score. Marking the most appropriate point that at person is at for each ladder gives a clear indication of the shape of a persons life:

- A full and rounded star reflects a full and rounded life
- Stars are completed again during a review and after changes in circumstances

Applicable as an element of care and support planning

Suitable for use in services where:

- There is an ongoing relationship between an older person and a health or social care worker
- The service aim is to maximise independence and well-being
- The service is holistic, focusing on the older persons life as a whole
- The Ladder of change reflects the services understanding of the steps needed to maximise independence and well being for an older person
- E.g. **Care management and case navigation**

Source: www.outcomesstar.org.uk

2 Support people and their carers to improve and maintain health and wellbeing by building knowledge and changing behaviours through proactive prevention and engagement

People with one or more LTCs should be enabled to ensure self management of their conditions is as effective as possible, limiting the need for other forms of care

The whole population are enabled to keep healthy and avoid developing new/other conditions and illnesses

Source: K&M STP Local Care workstream

Traits of successful support to people and their carers to improve and maintain health and wellbeing :

1. The ability to empower people to become or remain highly engaged regarding their own health and wellbeing
2. A highly accessible and user friendly directory of community resources for the people, their carers and health and social care professionals, facilitating robust social prescribing practices
3. Up to date and easily accessible digital and paper information and tools
4. Accessible and expansive services in a person's/carer's local community
5. Health and social care professionals (e.g. MDT health coaches) and a range of voluntary sector staff and volunteers that offer support to less engaged/ less able people and their carers
6. Parity of esteem enabled by integrated physical and mental health support

Source: Central London Community Healthcare NHS Trust; Sussex Community Trust and Brighton and Hove; Central and NW London Foundation Trust

Support people and their carers to improve and maintain health and wellbeing

Concept

- Proactive social prescribing of preventative information and tools, support and services to people and their carers to encourage self-management and self-care and to ensure carers avoid isolation, fatigue and stress
  - Ensuring these components are located in a well maintained and accessible directory of community resources
- Targeting people and their carers with a range of care complexities and levels of engagement:
  - **Complex, inactive people** will require preventative efforts to stop the development of additional conditions and the worsening of current ones with services and support including, and more expansive than, their local MDT
  - **Less complex, more active people** and the wider population will require more generalised support and signposting
- Integrated physical and mental health self-management strategies that provide information, services and support that encompass both physical and mental conditions and the impact they can have on each other
- It will be important that any voluntary sector organisations that people are referred into are well regulated

Components (examples)

Information and Tools:
- Healthy living app
- Health unlocked website
- Alzheimer's UK website
- Local authority health orientated campaigns
- Live it well website
- KCHFT 'my health check' app

Services:
- Smoking cessation
- Alcohol support
- Respite care
- Supported community walking
- Support navigation
- Local directory of services

Support:
- MDT staff e.g. health coaches and trainers
- Voluntary sector workers e.g. dementia support nurse
- Online and face to face peer support groups (including for carers)

Social prescribing

- Social prescribing facilitates access to a range of non-clinical interventions and activities which can impact positively on individual wellbeing and resilience
  - **Supported community referral** through a MDT/GP/ peer worker - deemed appropriate for less engaged people
  - **Sign posting** through a directory of services - provides an infrastructure for connecting people and the public to other community resources
- A GP social prescribing scheme saw results including:
  - GP appointments fall by 21%, while GP phone calls were cut by 6% and the number of GP home visits fell by 26%
  - A 23% reduction in A&E admissions amongst referred patients in the six months after

Source: Carnall Farrar, K&M Local Care Workshop, South Devon and Torbay CCG, Northumbria CCG; Health Education England (2016); Carers UK (2015) State of Caring; Price (2017) GP social prescribing can reduce appointments

Patient engagement

Concept

'Patient engagement' is a widely recognised concept. It describes the knowledge, skills and confidence a person has in managing their own mental and physical health

People with low levels of engagement:

- Are less likely to play an active role in staying healthy
- Are less likely to seek help when they need it
- Are less likely to follow a doctor's advice and manage their health when they are no longer being treated

Engagement as a healthcare tool

- The level of a persons engagement indicates the type of care needed i.e. case management, care navigation or a less intensive level of care and the type of social prescribing that will be most effective
- Case management, care navigation and support navigation can also facilitate increased levels of engagement in people:
  - Intervening to increase engagement can improve a person's engagement and health outcomes and is an important factor in helping people to manage their health
  - The ability to artificially create health triggers rapidly increased peoples engagement e.g. an alarming NHS health check or graphic advert

Impact

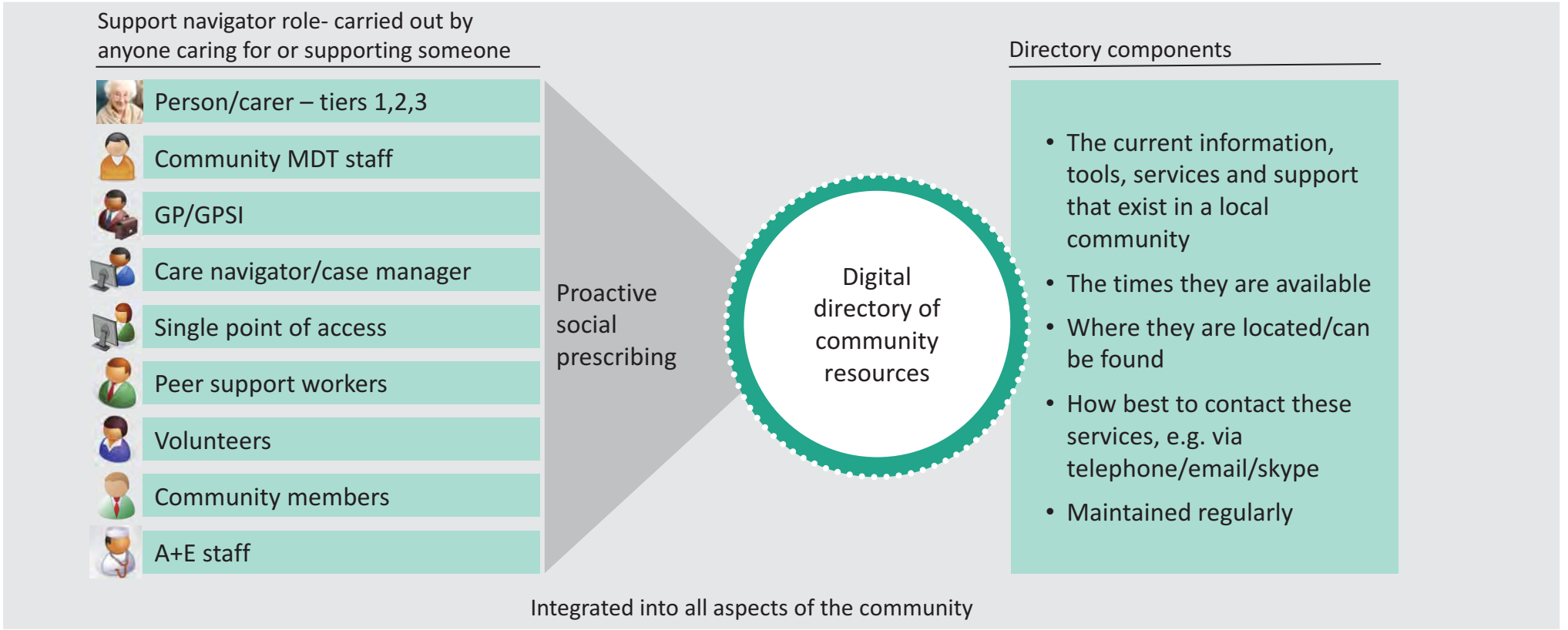
- Highly engaged people are more likely to adopt healthy behavior, to have better clinical outcomes and lower rates of hospitalisation, and to report higher levels of satisfaction with services
- People with low engagement levels are more likely to attend accident and emergency departments, to be hospitalised or to be re-admitted to hospital after being discharged. It is likely to lead to higher health care costs

Source: The King's Fund, 2014

Support Navigation

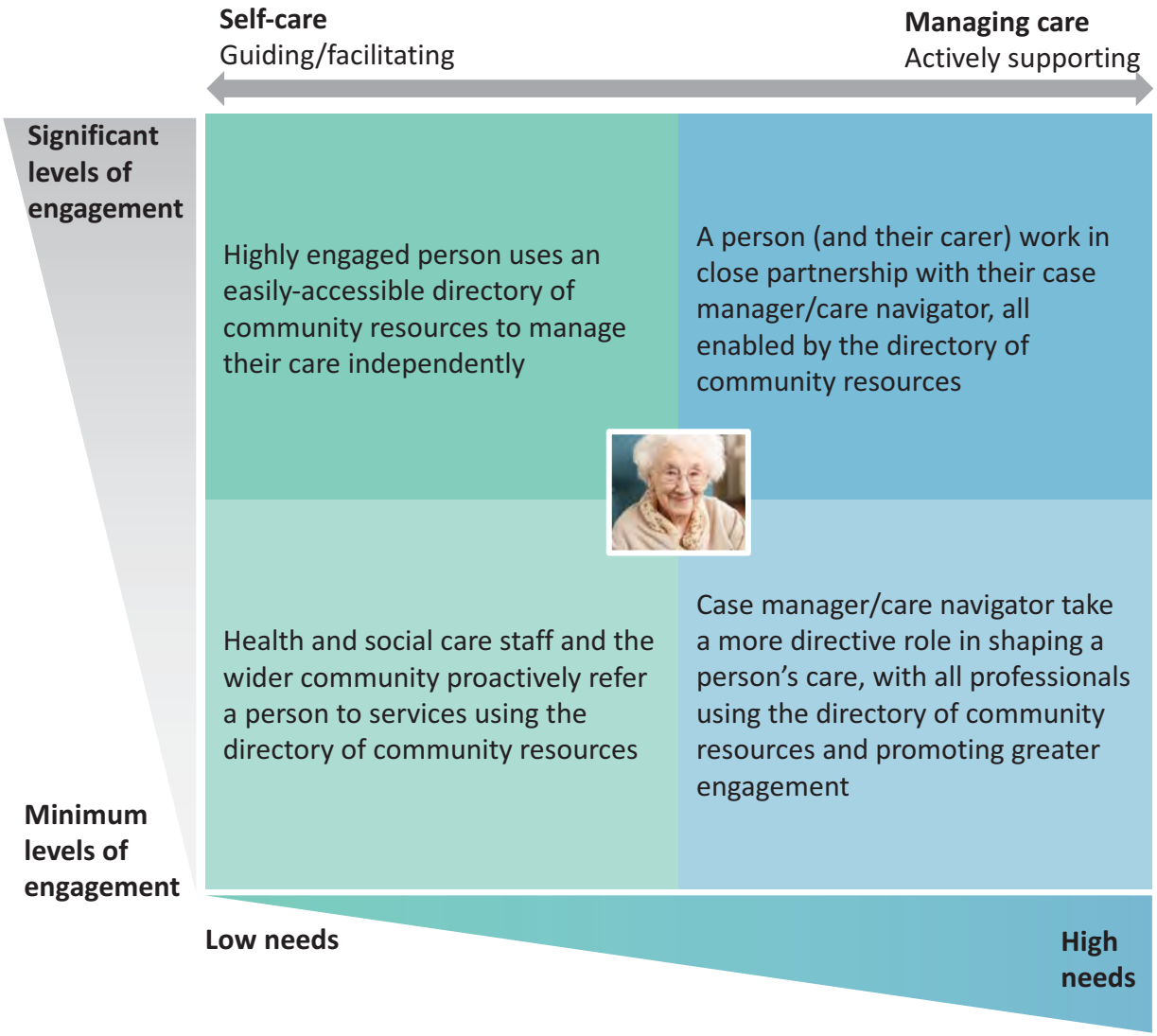
Concept

- Support Navigation is the basis of helping people understand the resources that are available to help them in the community, the ability to refer people to these services when necessary and the aim of engaging people to effectively self-care and self-manage
- Health and social care professionals, a range of other community members and older people with complex needs can all utilise a directory of services to help navigate and engage with the community resources available
- To gain a wide reach it is important to use schools and employers as an aggregator to ensure people in contact with older people with complex needs, as well as the older people themselves, are able to understand what care is available and accessible
- The digital directory of community resources will be more effective when maintained regularly and when users are confident it is comprehensive



Source: K&M STP Local Care workstream; Carnall Farrar

Significant levels of engagement make care more personalised and lessen the burden on the healthcare system



Greater engagement supports more personalised care and a more effective and efficient system

Source: K&M STP Local Care workstream; Carnall Farrar

Case example: Red Zebra- Connect Well

Concept

- Red Zebra has worked in partnership with the local multi-specialty Community Provider NHS scheme, the local Vanguard site, to establish a social prescribing service, enabling organisations and their client groups to work more closely with health services and access non-clinical services and activities in the community

Connect Well:

A web-based tool that enables both NHS professionals and the Red Zebra social prescribing service in the community to quickly and easily refer people to a range of local, non-medical support to maximise social, emotional or practical wellbeing. The aims and objectives include:

- Building strong social networks
- Exercising more
- Eating more healthily
- Feeling more supported and in control of lives
- Reduction in healthcare interventions for people identified by GP with a social prescribing need

Components

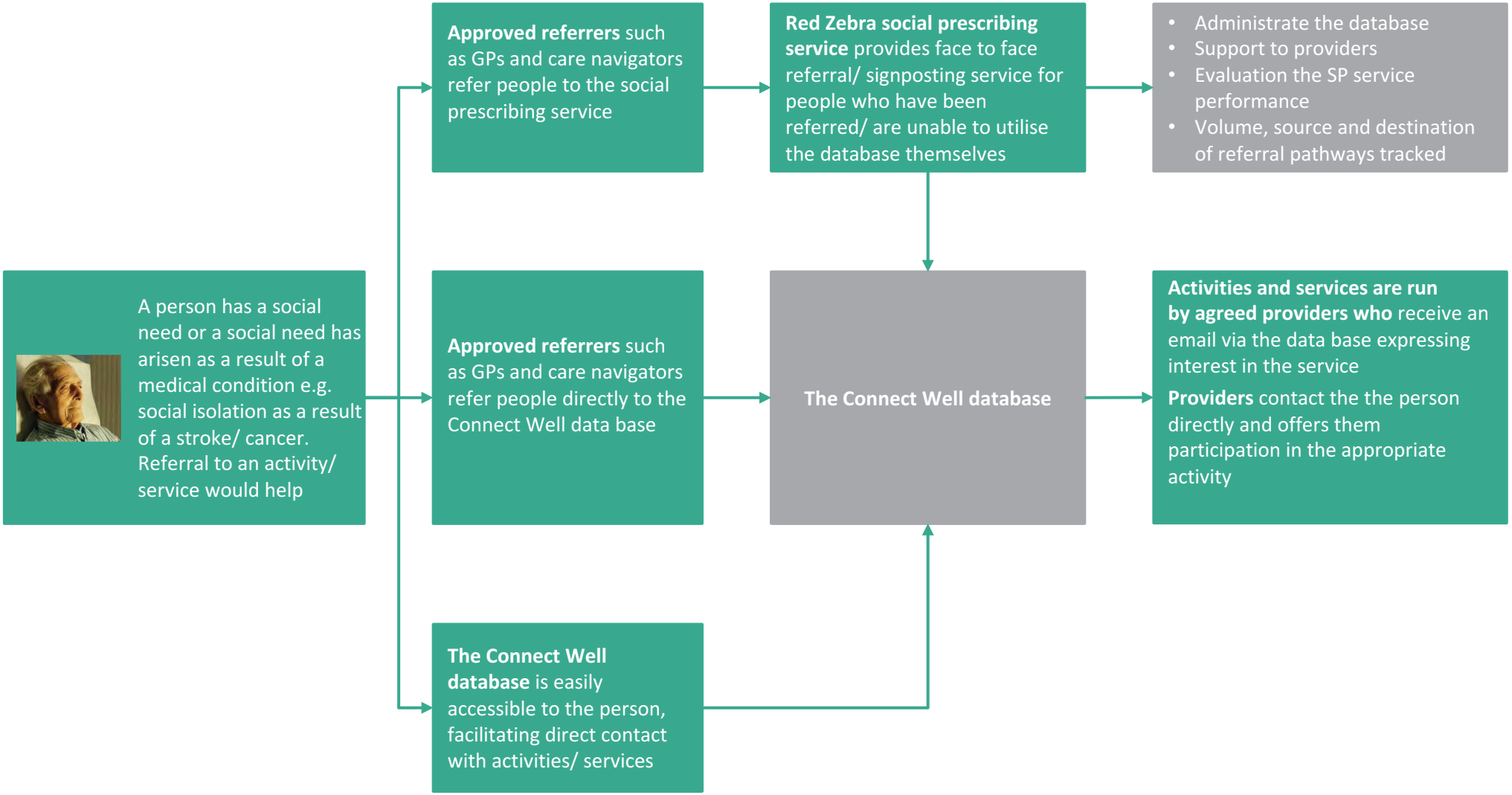
- Public carry out an internet search on the website and contact the relevant organisation, who will reply directly and accommodate the person in an activity/ service
- Red Zebra's social prescribing service offers face to face support for residents who are less activated or unable to access the website, to assist them in engaging with a community activity or service
    - This service can be accessed directly and confidentially through Connect Well or via a GP/ other healthcare professional referral using the Connect Well platform
- GPs/ other healthcare professionals can refer directly to the agreed providers using Connect Well as the directory of services

Supporting features:

- Reports that track and count referrals received by a given provider as well as by approved referrers
- Multiple accounts are supported, allowing GPs and other professionals outside of the health service to have an individual log-in
- All referrers using Connect Well receive Red Zebra training
- The team consists of 2 p/t social prescribing coordinators at a community location (face to face prescribing), a manager, an administrator and a CEO

Health: Kent Community Health NHS Trust; socialwelfare.bl.uk- Connect Well

Social prescribing process – Red Zebra Connect Well



Case example: Spice Credits and Time Banking systems

Concept

- A simple hour-for-hour based system: for every hour participants 'deposit', e.g. giving practical help and support to others, they are able to 'withdraw' equivalent support or attend an activity
- This concept facilitates the strengthening and building of communities and recruitment and engagement of volunteers through making use of the assets and resources that exist within a particular community or group that are traditionally overlooked

Components

Housing sector:
They work across a range of housing settings, including general needs housing and supported housing. Time Credits enable housing organisations to work with tenants on developing better financial resilience, digital inclusion, skills & employment

Health and social care:

Spice is currently working in partnership with local authorities, the NHS and service providers across England and Wales to deliver programmes aimed at improving health and care outcomes and to support system change and co-production. Our programmes focus on both broad-based community health and prevention, and improving specific outcomes for individuals with care needs and long-term conditions

Communities:

Our community programmes are delivered with a range of partners, from local authorities to community organisations. Time Credits increase levels of participation across a wide demographic. They also allow organisations to do more with their resources and reach out to more people who need their services. Time Credits encourage people to volunteer; through this, they make new friends, try new things, and ultimately begin to take on more responsibility, which leads to stronger networks

Case study: Chorley council: tackling social isolation among older people

Time Credits started trading in Chorley in August 2012. By June 2014 over 16,000 hours had been given by 900 people through a network of 48 local providers and community groups. A two year evaluation of Spice programmes from 2012-2014 showed that in Chorley:

- 70% of members know more people in their community
- 64% of members have shared their skills with others
- 57% of members said that earning and spending Time Credits helps improve their quality of life
- 40% of members feel healthier

Source: http://www.justaddspice.org

Support people and their carers – example pathway 1

1

Phillip is 68 and has mild dementia, COPD and depression and has a care plan. He lives with his wife Sarah who is healthy and well and who supports and cares for him full time. Phillip is a smoker and Sarah drinks more than she should do due to the emotional stress of caring for her husband. She has stopped going to her bridge club and visiting friends. The couple are also not active as Phillip needs lots of home care and Sarah cannot easily take him out

2

The MDT are aware of the potential health problems posed by the couple's smoking and drinking habits, as well as their isolation and the stress placed on Sarah as a full time carer. A health coach and dementia nurse from Alzheimers UK work to support the couple, providing a structured social prescribing service; signposting information and tools as well as supported community referral to services they would benefit from

3

Sarah is IT literate and has a laptop. She is provided with various tools and information by her dementia support nurse and through access to her local directory of services. These tools include an online peer support group run by the Alzheimer's society, the My Health Unlocked website and the details of a supported community walking group that included people with dementia and their carers

4

Phillip and Sarah are also both provided with smoke cessation and drinking support by the health trainer

5

The Alzheimer's society also provide respite care in the form of a sitter for Phillip once a week that allows Sarah to attend Bridge club and meet her friends

Through information and tools, support and services, Phillip and Sarah are stable, reduce activities that damage their health and become more active

Source: Carnall Farrar, Local Care workshops

Case examples: the voluntary sector and their impact on health and well being

Voluntary sector	Detail
Age UK	*Fit as a Fiddle* programme at a local level encouraged good health behaviors such as healthy eating and physical exercise. The final evaluation— based on interviews and before and after surveys of more than 800 beneficiaries—reports on a range of outcomes including statistically significant improvements in participants' wellbeing (as measured on the Warwick-Edinburgh Mental Wellbeing Scale) and the amount of strength and endurance activities participants undertook per week
The British Heart Foundation	Piloted the home administration of intravenous diuretics to heart failure patients. They found that 79% of interventions did not involve any hospital admission, whilst 63% achieved their target reduction in oedema (fluid retention), weight loss and/or other symptoms
The British Red Cross	*Support at Home* service offers short-term practical and emotional support at home aiming to help build people's confidence and regain their independence. Self-reported outcomes were measured before and after the intervention using a 5-point scale (based on 90 interviews with service users before their use of the service, 61 interviews at the end and 35 'retrospective' follow-up interviews). There were statistically significant increases in: wellbeing, ability to manage daily activities, participation in leisure activities and coping skills
DH, NHS England and **Macmillan Cancer Support Partnership**	The National Cancer Survivorship Initiative (NCSI) was. The NCSI comprised a number of pilots including assessment and care planning, stratified pathways and providing specialist services across seven pilot sites to support people living with and beyond cancer to return to work. An evaluation of the programme found that 38% of 320 participants went from 'not working to working' or from 'sick leave to full work or modified work'. In light of this success, the Living With and Beyond Cancer (LWBC) Programme was set up in June 2014
Rethink Mental Illness'	An evaluation of Crisis and Recovery Houses in Doncaster, Rotherham and North East Lincolnshire based on Outcomes Star data from 722 service users found statistically significant improvements in managing mental health, self-care, living skills, addictive behaviors, and self-esteem

Source: Bull et.al 2016. Untapped potential: Bringing the voluntary sector's strengths to health and care transformation

Existing Kent and Medway support services

Support at home services (free)	Detail
Alzheimer's & Dementia Support Services	A wide range of multicultural services to provide practical and emotional support to people with dementia, their carers, supporters and other relatives
Craegmoor	A provider of specialist community based support and enablement services
Kent Association for the Blind (KAB)	A range of help and support for people of all ages whose sight loss affects their daily lives
Voluntary Action Within Kent (VAWK)	Support for older people
Which? Elderly Care	Information for people looking after an elderly person
Equipment and changes to the home	KCC led service

Carer support	Detail
Carers space, Matter, Babble	Online communities
Carers Support - Ashford	Training courses, drop-in services, emergency care card, respite care and activity services
Involve- Maidstone and Malling	Range of carers support services incl home services, volunteering and older people support, emergency care card
Carers first- Dartford, Gravesham, Medway	Emotional and practical support, advice, information, guidance and offer statutory carers assessments, training, events, social groups, short break respite
Canterbury, Dover, Thanet	Training courses, drop-in services, emergency care card, respite care and activity services

Source: KCC

3 Work to ensure a healthy living environment to preserve long-term health & wellbeing

Support the wider determinants of physical and mental health, wellbeing, and independence, including a safe living environment, employment and other sources of fulfillment, and social inclusion

Source: K&M STP Local Care workstream

Traits of ensuring a healthy living environment to preserve long-term health & wellbeing:

1. Proactive identification of people whose living environment is not adequate and timely referral to universally and consistently available services to correct this
2. Proactive identification of people at risk of falling and timely referral to services that can reduce this risk
3. Housing associations working in partnership with health and social care organisations to deliver a range of initiatives that improve the living environment of older people
4. All health and social care professionals are aware of the significance of the home environment to older people's health, and work in collaboration with housing support services
5. Access to community services that enable social inclusion

Source: Carnall Farrar, K&M Local Care Workshop; Age UK

Work to ensure a healthy living environment to preserve long-term health & wellbeing

Concept

- That the living environment of a person and their carer is of the necessary standard to ensure that their conditions are not impacted, their overall health and wellbeing not effected and their independence maintained. This includes their place of residence and local community setting
- It is important to focus on transformation in the form of joint posts for housing, social care and health care and aim for integrated budgets, commissioning and wider sharing of expertise and knowledge

Components

Universally and consistently available:

- Preventative housing services targeting the proactively identified older population
  - Home assessment (as part of the holistic multidisciplinary assessment)
  - Digital enablers are used as much as possible e.g. home monitoring
- Falls prevention and home modification services
  - Falls assessment (as part of the holistic multidisciplinary assessment)
  - Home alterations
  - Falls prevention and balance classes run by health trainers or voluntary organisations
- Services in the local community that reduce the risk of isolation and social exclusion

K&M case example: Margate Task Force

Streetweeks

- Every home on a street is visited by the Task Force and advice is given on safety and health, allowing the team to gather information and identify suffering, risk and vulnerabilities through the completion of a “Your Home, Your Health” Survey.
- The information gained is acted upon quickly, both addressing problems early and gaining the trust of the community.

Resident Lead Partnerships

- Act as a focal point for the community, empowering residents to take responsibility for their own environment and safety
- Residents and service providers are brought together to address issues that affect the community and to establish sustained relationships

Source: Carnall Farrar, K&M Local Care Workshop; Reform.uk

Falls services

Concept

- Designed to both reduce falls in the community and hospitalisation as a result of falls and also assist those recovering from a fall
- There is an extensive evidence base for interventions to prevent falls, focusing on identifying and addressing risk factors such as postural instability, muscle weakness, visual impairment, home hazards or 'culprit' drugs
- Referral to services can be by the person themselves/ carers and community health and social care professionals

Components

Home modification:

- Frail older people are visited at home by a voluntary service/ local fire service etc., a trusted assessment is conducted, fall prevention actions are agreed and home adaptations are installed and hazards secured/removed as part of the person's holistic care and support plan if required

Exercise and balance classes:

- Frail older people are engaged in community exercise and balance classes run by voluntary organisations or health coaches

MDT/community falls care:

- MDT physios and podiatrists provide information and care regarding improving and maintaining good balance and strength and provide expert opinion to emergency services attending people who have fallen
- Pharmacists provide services regarding the impact of medication on balance

Case examples

Greenwich bespoke multidisciplinary falls team:

- Managed by a dedicated falls coordinator, operating across health and social care was put in place, more than 10 years ago, to reduce the number of falls occurring. The result was 57% reduction in falls from 2013/14 to 2014/15

Canterbury NZ community-based falls prevention service:

- Launched in 2012 with $1.5 million invested over three years, saving $17 million cost in reduced bed days alone
- Service helps people who have fallen in the past 12 months, who are worried about falling, or whose leg strength and balance could be improved
- Service includes: a home visit from a physiotherapist or registered nurse, who will conduct a falls assessment and draw up a personal falls prevention programme, a home hazard check and supervision by a registered nurse, physiotherapist or qualified instructor

Source: The Kings Fund 2014; National Institute for Health and Care Excellence 2013a; Cameron et al 2010; LGA report (2016); Better Care Fund Report (2014); Griffiths (2010)

Support people and their carers – example pathway 1

1 Martin is 80 has recently suffered a stroke, has COPD and depression and has a care plan. He lives alone in a bungalow that has not been renovated for 20 years

2 Martin has recently become a lot more unstable on his feet as a result of reduced physical activity and his COPD worsening. His district nurse Melissa, who visits Martin once a week, has noticed this and after discussing it at an MDT meeting and with Martin himself, decides to refer him to a falls service

3 Using the local directory of community resources, Melissa refers Martin to a local voluntary run falls service that works in partnership with the fire service. She passes on her evaluation of Martin's condition and the service assure her they will contact him within the next 48 hours

4 The local falls service call Martin at his home and they agree a member of the team will visit him to assess both his condition and his living environment (as part of a holistic multidisciplinary assessment)

5 A volunteer attends Martin's home and they determine that home modifications need to be made and that Martin would benefit from attending balance classes being run in the community

6 A voluntary team/ fire service team visit Martin, securing and removing hazards including repositioning furniture and installing hand rails and more accessible plug sockets

7 In addition, Martin is enrolled in his local balance class, run by a health coach from the MDT

Through home adaptations, attendance of balance classes and in conjunction with his care plan, Martin is more stable and is far more independent and secure in his home

Source: Carnall Farrar, Local Care workshops

Private rental housing initiatives

Concept

- There are too many properties in the private rental sector (PRS) in a bad state of repair, and too many inadequate landlords and letting agents
- Tenant security and housing quality need to be ensured throughout the housing system

Components

- Better use should be made by local authorities of existing powers, such as the use of selective licensing, improvement notices and hazard awareness orders, to persuade private landlords to maintain their property to a good standard
- Community housing agencies should be established by local authorities dedicated to working within the private rented sector and would be responsible for operating a system of landlord accreditation, tenant matching and other management services
- Working alongside housing management services there should be multi-agency PRS support teams supporting vulnerable (older) private tenants
- Councils who already have an accreditation system in place should ensure home improvement grants and loans are available to landlords to enable them to meet Decent Homes criteria

Case examples

Gateshead private rented sector team:

- A dedicated team working to improve property maintenance and housing conditions in the PRS. The team offers a range of services including:
  - General advice, guidance and support to tenants
  - Information and support to help landlords improve housing management and standards of property maintenance and repair
- Gateshead has also set up a PRS accreditation scheme, to promote and recognise good landlord management practices, improve standards in maintenance and repair, and ensure that every property has the relevant safety certificates in place

Newham Council's neighbourhood improvement zones:

- Introduced a system of compulsory licensing of privately rented property within defined neighbourhood improvement zones (NIZs) to improve resident problems through coordinating and focusing council services
- All privately rented property within the defined zone must be licensed, irrespective of size or occupancy. Any landlords who do not apply for and obtain a license are liable to prosecution and a fine

Source: IPPR North 2014; Newham Council 2013; Gateshead Council 2013

Housing associations

Concept

- When housing associations partner with health and social care organisations, they are able to apply their expertise in community services to improve health and well-being for the older population
- Health and social care outcomes and indicators give higher priority to preventative housing services for older people, designed to:
  - Improve the home environment
  - Promote independence
  - Reduce demand on the care system

Components

- Many housing associations have always provided care and support and are looking to work with health commissioners and providers in developing integrated models of health, care and support:
  - Health and social care services that automatically offer trusted home assessment services to older people as part of their holistic care and support plan, and implement actions as a result of it
  - Sheltered and care housing that act as hubs for the development of peripatetic home support that reaches out to all older people locally
  - Funding for housing support services that reduce the demand on health and social care
  - Health and social care professionals are trained as to the importance of an older persons home environment

Case examples

The 'Boilers on Prescription' project (18 month trial):

- Established by Gentoo (a Sunderland based housing association) in partnership with Sunderland CCG and Durham Darlington Easington and Sedgefield (DDES) CCG
- Allowed people with respiratory diseases (COPD) living in cold, damp homes to be 'prescribed' double glazing, boilers and insulation
- Reported a 60% reduction in the number of GP appointments needed by people taking part
- 30% reduction in A&E appearances
- 22% reduction in OP appointments

The Brighton and Hove Recovery College initiative:

- Sees a housing association working Sussex Partnership NHS Foundation Trust to provide community-based support to more than 9,500 people with mental health challenges

Source: The Kings Fund; National Housing Federation; Southdown.org, Gentoo, Age UK 2014

Case study: Dementia villages- De Hogeweyk, The Netherlands

Concept

- Frail older people with dementia, in need of nursing home care, will be happier if they can experience as 'normal' a life as possible, a life they recognise and understand and not as restrictive as a hospital or traditional care home
- They should be able to live with a small group of like-minded people, with whom they feel at ease, so they can satisfy the need for social contact and the mental health benefits that brings
- Hogeweyk intentionally allocates funding to encourage lifestyles and activities that reduce the need for physical therapy

Components

- The main accommodation is built around streets, squares, alleyways gardens and a park, within which the residents with dementia can move safely and securely
- The accommodation, for the 152 residents, is organised as 23 households, each made up of 6 or 7 residents. Each household has a kitchen, and dining and living areas. Bedrooms within each household are single occupancy. Occupants are split by personality type to ensure they integrate with other residents in their household
- Dedicated teams of six work in each house to ensure continuity of care and that a caregiver is on duty at all times
- Residents have to go 'outside' to reach the communal facilities which include shops, cafes a theatre and a pub, as well as for communal activities such as art classes
- Nursing staff merge with the residents. The facility has around 250 staff, (the equivalent of 170 full time), supplemented by the work of 140 volunteers
- The front end of the village focuses on managing the wellness and social aspects of care, decreasing the need for medications and for medical care
- A full time geriatric specialist assists residents with any medical needs. The village also employs a physical therapist

Source: Centre for Policy on Ageing, January 2016

Support people and their carers – example pathway 1

1

Graham is 79 and has mild dementia, COPD and depression and has a care plan. He lives alone in accommodation he owns but has not been able to maintain for over 15 years. The windows are single glazed, boiler does not meet regulations and there are no adaptations that a person with Graham's condition would need to ensure his safety and independence

2

The MDT are informed by the community nurse who visits Graham once a week that his health, particularly his COPD, is worsening due to his living conditions and that he is at an increasing risk of falling

3

The local housing association share a joint budget with the local CCG and Council, and have commissioned a home heating improvement service and a home modification service for those most at risk in their communities. The MDT are aware of these services and they are also listed in the digital directory of services. Graham is referred to them both

4

After a trusted assessment by a housing professional (part of the holistic multi-disciplinary assessment), they determine Graham needs double glazed windows, a new boiler and adaptations including hand rails, a stair lift and a personal alarm fob

5

Graham's community nurse also uses the local directory of services to refer Graham to a falls prevention service, an educational service that teaches him how to use his home adaptations and a community walks service

Through home improvements and adaptations and in conjunction with his care plan and community care package, Graham's COPD is stable, and he is far more independent and secure in his home

Source: Carnall Farrar, Local Care workshops

Kent and Medway falls prevention services

Support at home services (free)	Detail
Medway CCG Falls Prevention	Work is currently underway with the Kent Fire and Rescue Service (KFRS) to establish an effective referral pathway by which vulnerable older people who are identified as being at risk of a fall can receive appropriate support in the community. It is proposed that the service will commence early December 2016
DGS community-based falls prevention service	Aims to help people who have fallen in the past 12 months, who are worried about falling, or whose leg strength and balance could be improved - doctors or other health professionals can refer people to this service
Swale home safety assessment and handyperson service	Sees the borough council, the voluntary sector, the fire and rescue service, community health teams and the acute trusts working in partnership to support those over the age of 65 to remain living safely and independently within their homes

How can we learn from experience and scale up across Kent & Medway?

Source: Medway CCG, DGS CCG, Swale CCG

4 Bring integrated health and social care into or coordinate it close to the home

Person-centered, coordinated multi-disciplinary care services, wrapped around GP practices and community services providing care to people who have care plans assigned dependent on their needs

Source: K&M STP Local Care workstream

Multi-disciplinary team (MDT)

Concept

- An integrated health and social care team built around complex older people in a population of **30-50k**
- Multi-disciplinary teams will form the core of new models of care. These teams should bring together all of the relevant care professionals, volunteers, and other partners who provide care for a cohort of people with similar needs and deliver it in a **community / domiciliary setting**
- The vital role of an MDT is to facilitate joined-up care amongst care professionals and their partners. Effective discussion should result in a balanced care plan and care process that is supportive of a persons holistic needs
- For very high/ high risk people who are 70+ with multiple LTCs and complex needs, the MDT provide tailored care for the full needs of the individual
- There is future potential that an MDT can hold the budget for the people in their cohort

Components

- MDTs meet when needed, to discuss the needs of the cohort and specific people within it. In these meetings, they:
  - Review complex cases, acute admissions and people with a change in status (condition development/ change in housing situation)
  - Refer individuals to relevant services directly
  - Provide advice and opinions across disciplines
  - Direct individuals to self-care and self management resources and empower them to become more activated
- The MDT ensure the person and their carer are fully engaged in decisions about their care ('no decision without me')
- The MDT has to strongly advocate for the people under their care, ensuring they do not just get bounced around the health and social care system
- Care navigators and case managers are fully integrated in the MDT, working with the person, their carers, other professionals to integrate care
- Integrated informatics system across the MDT
- Delivery of care and support to both the person and their carer through:
  - Proactive, regular care and support e.g. navigation support and delivery of care
  - Episodic non-elective urgent services e.g. rapid response
  - Episodic planned care e.g. reablement

Staff

Professionals included should be able to effectively look after the physical, mental and social care and support needs of the individuals it covers and should therefore include: specialist care, primary generalist care, mental health care, community care, social care and voluntary sector providers

Staff: e.g. Geriatrician, psychogeriatrician, social care worker, dementia nurse, mental health worker, occupational therapist, community nurse, health coach, pharmacist, voluntary sector workers, GP/GPSI

An MDT extensivist: A GP or Physician with LTC expertise, functioning primarily in the community but able to follow a person into hospital

Source: Carnall Farrar, K&M Local Care Workshop, HomeFirst

5 Provide single point of access to secure any community and social care package

A number called by the person, their carer, the GP, community services and acute staff to support people with their care by gaining more efficient, coordinated access to services

Source: K&M STP Local Care workstream

Traits of successful single point of access:

1. Is the single front door for access to the MDT, utilising shared patient records and clinical input to aid with decision making

1. Helps solve a problem for a defined cohort such as an exacerbation of a long-term condition, a clinical query or change in social support (e.g. a carer becoming unwell)

2. Clear definition of who can call and what they will receive e.g. advice; referral and by when e.g. urgent assessment within 2 hours

3. Able to access services/information for the person across organisational boundaries

4. 24 hour accessibility

5. Has a clear entry point e.g. post discharge; once a person has a specific need for complex/integrated care, or once a crisis has begun

6. Allows referral of a new person to become part of the defined cohort e.g. complex needs

Source: Birmingham Community Healthcare NHSFT, South Devon and Torbay CCG, King's Fund

Single point of access

Concept

A number called by the peron, the GP, community services and acute staff to support people with their care by gaining more efficient, coordinated access to services across organisational boundaries

A service that is highly effective, allowing trust to be built with its users to ensure they have confidence in using it as their primary source of health and social care assistance

Components

Any person that requires discharge support, short term reablement, has a care plan or has been identified as needing urgent/anticipatory care, will have a single point of access service that can refer the person to their local MDT (30-50k) or to the specific community care services required. The SPoA ensures individuals with a care plan are quickly and efficiently referred with reference to their care plan. These people include end of life, older people with dementia, older people with 3+ LTCs and stroke
The key components of SPoA include:

- 24 hour availability
- The ability to triage a person to the rapid response service resulting in a response within 2 hours of referral
- Provision of a package of care for a person who requires discharge support or who needs short term reablement
- Access to a person's care plan
- Liaise with a person's carer, GP or member of the MDT as well as other care providers
- Ability to enable early exit where appropriate from 999/111 for those people with access to SPoA

Staff

- Clinical staff who lead the service
- Non-clinical call handlers using algorithms

Source: Carnall Farrar, K&M Local Care Workshop, South Devon and Torbay CCG, Northumbria CCG

Proposed SPoA model varies by population segment

Population	Who can contact?	What will they call for?	How will the call be dealt with?
Complex older people– under the care of an MDT	• The person themselves • Carer • GP • Hospital clinician	e.g. • Exacerbation of their condition • Clinical query • Change in carer status (e.g. illness) • To organise a package of care	• SPoA will determine who is the most appropriate member of the person's local MDT to attend to the query • The SPoA will contact this member who will in turn call back the person as soon as possible and determine the most appropriate course of action • As required the SPoA will also coordinate to ensure the required package of care is put in place
Complex older people– eligible for MDT care	• GP • Hospital clinician	e.g. • To ensure the local MDT are aware of a person that should be under their care • To organise a package of care	• The SPoA will contact the MDT to make them aware of the person who should then be discussed at the next MDT meeting • As required the SPoA will also coordinate to ensure that any required package of care is put in place
Other hospital inpatients who require a complex package of care in the community	• Hospital clinician	e.g. • To organise a package of care on hospital discharge	• The SPoA will coordinate to ensure the required package of care is in place when a person is discharged from hospital – this is not via a local MDT

Source: K&M STP Local Care workstream

Single Point of Access – example pathway 1 – a person with a care plan

1. John is 78. He lives alone with Parkinson's disease, type 2 diabetes, depression and walks with a stick. He has a care plan with support from a care navigator which has been in place for over a year and has kept his conditions stable

2. One morning his condition exacerbates beyond his own ability to manage and he feels he needs outside assistance

3. He calls the SPoA, a number he was provided to call for help before accessing another service

4. Upon taking the call, the SPoA call handler is automatically shown John's care plan details. After a short discussion with John he promises John he will be called back shortly

5. The SPoA call handler contacts the relevant member of the MDT that provides care for John to inform them of John's new needs

6. A nurse from John's MDT calls him back and together they agree a management plan for him

John's nurse calls him back a couple of days later to check that he is ok, he says his condition has improved and he is feeling more comfortable

Source: K&M STP Local Care workstream

Single Point of Access – example pathway 2 – a discharge patient

1 Vera is 79, frail, has type 2 diabetes, COPD, dementia and recently suffered a stroke. She lives with her husband who is also frail and often unwell himself. Although she fits the criteria for a care plan, currently she hasn't been identified by an MDT

2 After receiving care for her stroke she is now medically fit to be discharged from the hospital

3 She doesn't't have an anticipatory care plan but hospital staff have identified she has specific care needs upon discharge to ensure her condition continues to improve. She has limited mobility and her condition needs monitoring; her husband is not well enough to be her carer whilst she recovers

4 The acute discharger calls the SPoA and provides them with Vera's collated discharge support details gathered through a discharge support form, including the recommended community services she will require in the short term. The call handler uses this information to contact and coordinate the necessary services

5 An assessment within 24 hours determines Vera will require services for a period of 6 weeks including a domiciliary care worker to help with household tasks and provide personal care and a community nurse to provide continued care and an in-depth review of Vera's condition. Her husband will also be provided with carer support. The SPoA is contacted to arrange this

6 Vera can be discharged to her home with the appropriate care package in place

Vera recovers fully, her care package ends and she lives independently in the community

Source: K&M STP Local Care workstream

Single Point of Access – example pathway 3

1. Tony is 73, he has COPD, type 2 diabetes and depression

2. Tony's condition has exacerbated over the past few months and he has had a recent A&E visit. He visits his GP, Dr. Jordan, who identifies John as a person who should have a package of care and anticipatory care plan

3. Dr. Jordan is able to call the SPoA to set this up, along with a short-term package of care to ensure Tony is stabilised with the aim to avoid any further A&E visits

4. The call handler organises an urgent package of care to stabilise Tony by contacting and coordinating the necessary local community services. He is also placed on the MDT list in his local area to be discussed in their next meeting

5. The SPoA informs Dr. Jordan of the care package details that have been arranged, including a mental health worker and domiciliary care worker

Tony's condition stabilises and the MDT create an ongoing anticipatory care plan and package of care for him

Source: K&M STP Local Care workstream

Case Study: Birmingham Community Healthcare NHS Trust Adult Services SPoA

Concept

- 24-hour telephone service offering a single point of access for adult community health services
- Assists professionals in arranging the right care for urgent and non-urgent referrals and aims to prevent avoidable hospital admissions and manage long-term conditions effectively in the community, and palliative/end-of-life care in a person's own home
- The single point of access is supported by a comprehensive model of community care which proactively supports people in the community as the preferred action. The multidisciplinary teams include senior nurses with advanced clinical assessment, diagnostic and prescribing skills; care staff; physiotherapy and occupational therapy support; social workers; registered mental health nurses
- Available for any adult registered with a Birmingham GP

Components

Professionals – or people and carers known to the service – can call at any time of the day or night, seven days a week, to access coordinated care delivery including:

- Advanced assessment within two hours for people needing urgent health interventions and care who can remain at home
- Access to acute bed bureau for medical/surgical admissions
- Step-down to community nursing for longer term needs
- Four-hour response for people needing community nursing care, long-term condition management and treatment at home
- Provision of urgent equipment to avoid acute hospital admission
- Admission to community bed-based services, where appropriate
- Intravenous antibiotics
- Assessment for domiciliary therapy (physiotherapy and occupational therapy)
- Liaison with a person's GP to effectively manage clinical care at home and the wider health and social care system

Urgent calls will be dealt with by a senior nurse ensuring direct professional to professional contact

Impact

In a recent survey of 70 rapid response service patients, every respondent said they were treated in the most appropriate place to meet their needs and wishes and nearly all felt the initial response had been sufficiently prompt and just over two thirds felt they would have needed hospital admission had it not been for the rapid response team

Their urgent care bureau, accessed through the SPA phone number, has handled more than 15,000 calls since April 2016

Source: Birmingham Community Healthcare NHS Trust

6 Provide a rapid response ability to get a suitable health or social care worker to a person's home within 2 hours

The ability within an MDT to respond rapidly to people with a care plan who are experiencing a health or social care need that left unattended would result in a possible hospital admission

Source: K&M STP Local Care workstream

Traits of a successful rapid response ability:

1. The ability to react to a persons urgent needs in the community to prevent avoidable admissions
2. 2 hour response time from the initial referral of an individual
3. The ability to respond 24 hours a day is ensured through flexible MDT staff working hours
4. Initial assessment by first responder determining short term care needs
5. The person, their carers and their wider support network will be supported for a short time period post-intervention when required, including a telephone and home visiting service
6. People requiring further clinical care will be transferred to the appropriate service quickly and efficiently

Source: Central London Community Healthcare NHS Trust; Sussex Community Trust and Brighton and Hove; Central and NW London Foundation Trust

Rapid Response

Concept

- The ability within an MDT to respond rapidly to people with a care plan who are experiencing an urgent health or social care need that left unattended would result in a possible hospital admission
- The MDT, using a shared patient record, ensures all of a person's health, social care and other needs can be provided for

Components

Rapid response is for highly complex and complex people (e.g. End of life, older people with dementia, older people with 3+ LTCs, stroke) and other people who have a health or social care need in the community, ensuring they stay out of hospital as much as possible

The key components of the service:

- Response time of 2 hours or less
- 24 hour availability
- Staff that are able to work flexibly
- Staff with a range of abilities ranging from prescribing and physical assessment skills to domiciliary care
- Institute a package of care at home if deemed necessary, building upon what already exists, including nursing, therapies, domiciliary support and night sitting
- Liaising with the person's case manager/ care navigator regarding their progress and the package of care they are receiving
- Being responsible for the person for a short time period post-intervention when required, including a telephone and home visiting service
- Mental health service integration to ensure accuracy of a person's care
- People requiring further clinical care will be transferred to the appropriate service quickly and efficiently
- The response function is overseen by a senior clinician to reduce the risk placed on the responder e.g. a community geriatrician is able to confirm the decision made by a community nurse who has rapidly responded

Referrals:

- Accepts people with any types of infections e.g. chest infection, people who have had falls and people who are not managing at home
- It accepts referrals from health or social care professionals, such as GPs, nurses and social workers

Source: Carnall Farrar, K&M Local Care Workshop; Central London Community Healthcare NHS Trust; Woodward and Proctor (2016) Avoiding A&E through Rapid Response teams and See and Treat Models

Courses of action in an emergent health situation

Single point of access

Rapid response

Reablement
Integrated health and social care

A person has an urgent need in the community and the SPoA are contacted

Centrally held care plan and effective triaging are utilised

Call referred to rapid response

Resolved on the phone

Rapid response face to face assessment

Person receives immediate care in place of residence

Person receives immediate care and does not require further support

Their care record is updated

Person receives immediate care and is referred to other providers including a step-up process in the community

Person receives immediate care and is referred to the short term reablement team

Their care record is updated

Aim of reducing post 6pm hospital admission via community hospital/ specialist facilities admission

Person does not require immediate care in place of residence

Person referred to short term reablement team

Their care record is updated

Person not referred

SPoA arrange services

Care package delivered by community services for a defined time period

Source: Carnall Farrar, K&M Local Care Workshop, South Devon and Torbay CCG, Northumbria CCG

Rapid Response – example pathway 1

1. Doreen is 82, is frail, has type 2 diabetes, depression and COPD and has a care plan and care navigator. She has been suffering from increasing breathlessness since the middle of the night. Her daughter calls the SPoA at 4am to request assistance

2. The SPoA call handler triages the call to Doreen's local out of hours MDT staff using her care plan details. The MDT send the most appropriate rapid responder, a community nurse

3. The MDT responder arrives at Doreen's home within 2 hours of her daughter calling the SPoA

4. Doreen is assessed by the community nurse who identifies the symptoms as an exacerbation of her COPD. He stabilises Doreen and concludes that Doreen needs continued short term check-ups. He calls the SPoA who organise a health care assistant to attend Doreen's home frequently and ensure she fully recovers and her electronic record is updated

5. After 72 hours Doreen's health is as it was before her episode. Her care navigator calls both herself and her daughter to check on her condition and they agree that Doreen's care plan is sufficient and that no changes need to be made

Doreen continues to live independently in the community having avoided a hospital admission that may have resulting in a long-term worsening of her health condition

Source: K&M STP Local Care workstream

Rapid Response – example pathway 2

1. Doreen is 82, is frail, has type 2 diabetes, depression and COPD and therefore has a care plan and care navigator to assist her with the care package she receives. She has been suffering from increasing breathlessness since the middle of the night. Her daughter calls the SPoA to request assistance

2. The SPoA call handler triages the call to Doreen's local MDT team using her care plan details. The MDT send the most appropriate rapid responder, a community nurse. Doreens care navigator is also informed

3. The MDT community nurse responder arrives at Doreen's home within 2 hours of her daughter calling the SPoA

4. Doreen is assessed by the community nurse who identifies the side effects of worsening COPD and further discovers the onset of pneumonia. He stabilises Doreen and concludes that she needs escalated care in the community and should be admitted to a community hospital

5. The community nurse first responder calls single point of access who organise Doreen's transfer and contact her daughter and care navigator to inform them of the development

6. After two days Doreen is discharged from community hospital as her pneumonia was identified and treated early and her COPD was stabilised. She is picked up by her daughter and taken home. Her care navigator calls her and her daughter to check on her condition and they agree that Doreen's care plan is sufficient and that no changes need to be made

Doreen continues to live independently in the community having avoided a more severe worsening of her condition

Source: K&M STP Local Care workstream

Case Study: Birmingham Community Healthcare NHSFT: Arranging urgent assessments to avoid admissions

Components

- 24/7 phone line
- Any health professionals can telephone e.g. ambulance crew, GP OOH, Residential homes and people/ carers known to the service
- Service is for any person with a Birmingham GP
- Once referred, the service supports people to stay in community by coordinating care delivery including:
  - advanced assessments within two hours for patients needing urgent health interventions and care who can remain at home
  - access to acute bed bureau for medical/surgical admissions
  - step-down to community nursing for longer term needs
  - four-hour response for people needing community nursing care, long-term condition management and treatment at home
  - provision of urgent equipment to avoid acute hospital admission
  - admission to community bed-based services, where appropriate
  - intravenous antibiotics
  - assessment for domiciliary therapy (physiotherapy and occupational therapy)
  - liaison with a person's GP to effectively manage clinical care at home and the wider health and social care system

The SPoA and MDT interface

The rapid response ability is contactable through the SPoA and provided by the MDTs. These teams include: Senior nurses, care staff, physiotherapy and occupational therapy support, social workers, registered mental health nurses

Impact

- The SPoA, in conjunction with a rapid response service, MDT model, and discharge coordination resulted in:
  - 1,668 annual avoided admissions with an estimated cost saving of £4.5m
  - 3,758 bed days saved with an estimated cost saving of £751,600
  - 100% of urgent admission prevention assessments in patients' own homes have been delivered within two hours, seven days a week, for the previous 12 months
  - Patients have been transferred into the intermediate care facilities on average 5.8 days earlier than in previous years

Source: Birmingham Community Healthcare NHSFT

7 Discharge planning and reablement

A pro-active, anticipatory service designed to target those people who are medically optimised for discharge, no longer requiring an inpatient bed, but still needing some level of care to prevent their health from deteriorating. It is designed to reduce unnecessary prolonged hospital stays and patient re-admission

Source: K&M STP Local Care workstream

Traits of successful discharge planning for a person who has developed care needs that did not exist pre-admission:

1. Day one planning and a date for discharge set using a 'live' board to monitor patients progress
2. Enabling increased mobility whilst still in a hospital setting where appropriate
3. Detailed discharge planning ensuring a person's care needs are understood and catered for
4. Integrated community services accessed via a single point of access to ensure effective reablement and increased speed of discharge
5. Multiple defined discharge pathways to ensure people receive the correct support for their needs
6. Integration with any pre-existing services the person may have been receiving or live care plans

Source: HomeFirst, Carnall Farrar

Traits of successful discharge planning for people whose pre-admission care needs have not changed:

1. Identification of the person and initiation of anticipatory care plan processes to facilitate efficient discharge including acute services and the necessary integrated community care the patient will require

2. Day one planning and a date for discharge set using a ‘live’ board to monitor patients and dates

3. Effective communication with the care navigator or case manager

Source: HomeFirst, Carnall Farrar

Traits of a successful reablement service:

1. Integrated community services accessed via the SPoA to ensure effective reablement and increase speed of discharge and avoid repeat admission, utilising a shared assessment framework, single professional records and shared protocols
2. A 9am to 6pm service 7 days a week
3. Integration with the MDT rapid response ability to provide out of hours care
4. An assessment within 2 hours of returning home and the ability to organise a short term package of care
5. The production of a time limited (e.g. 6 weeks) individualised reablement care and support plan using relevant community services
6. Ensure referral to, and support from, other clinicians/professionals e.g. care navigators, to support people within their own environment

Source: HomeFirst, Carnall Farrar

Discharge planning

Concept

- Designed to target those people who are medically optimised, no longer requiring an acute hospital bed, but still needing some level of care in order for their health not to deteriorate
- A detailed, personalised, person centred assessment and plan that determines a person's needs and the short term services that will ensure they can be discharged to a home environment/ other community setting
- Integrated community services are accessed and organised via a single access point

Components

- Rapid identification of the needs of a person that ensures discharge can be facilitated as quickly as possible
- Day one planning and a date for discharge set using a 'live' board to monitor a person's progress
- Organisation of discharge services through a single point of access ensuring reduced discharge delays
- Communication with the person, their family and carers
- Engagement with care navigator or case manager
- Mobility assessment and plan to facilitate increased patient movement whilst in hospital and ensure patient is mobile enough to be discharged as soon as possible
- Discharge assistance provided by the community MDT in the hospital setting
- Referrals of people by their GPs in the afternoons and hospitals discharge in the mornings
- Pre-existing care plan re-instated if discharge support is not needed
- An effective interface between local and hospital care to determine the key priorities for care spanning the hospital and community settings e.g. community pharmacists delivering drugs to home for those recently discharged

Source: Carnall Farrar, K&M Local Care Workshop, HomeFirst

Reablement

Concept

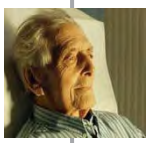
- Designed to reduce unnecessary prolonged hospital stays or inappropriate admission to acute inpatient care, long term residential/nursing care or NHS continuing health care for people by delivering a rehabilitation service/rapid response service
- A service provided to adults (18+) in their homes or initially in a short term care bed
- To maximise the opportunity for a person to have independence and resume/return to living at home or to longer term care when necessary

Components

- An expansive reablement service from 9am to 6pm
- Integrated community services accessed via a single access point to provide effective reablement and increase speed of discharge and avoid repeat admission, utilising a shared assessment framework, single professional records and shared protocol
- A take home and settle service that provides transportation and ensures essential needs met in a person's home
- Short term service to be in place and provided within 2 hours of a persons return to their place of residence
- A comprehensive multidisciplinary assessment within the person's own home/community facility
- Creation of a individualised care and support plan to aid recovery
- Time-limited support (recovery), enablement or rehabilitation packages finishing once set goals are reached
- Referral to and support from other clinicians/professionals such as specialist nurses in a person's home environment
- Utilisation of civil service staff as well as other community based workers to ensure the basic needs of a discharged person continue to be met

Source: Carnall Farrar, K&M Local Care Workshop, HomeFirst

Hospitalisation and discharge planning process



Patient in a hospital

Patient in A&E or

Day 1 discharge planning and date to discharge set

Mobility plan put in place including: physical therapy, occupational therapy or basic movement assistance provided by health care assistants

A&E and AMU forms completed by urgent care therapy team. Ward forms completed by nursing/ therapy staff

Discharge assessment form completed for patients

Patient discharged home without further services needed

Discharge assessment form identifies need for additional discharge support

Community MDT liaise with acute MDT

If the patient already has a package of care and there is no need to review it/ additional support is not necessary, the care package can be restarted by the SPoA and the MDT and the patient discharged without the involvement of discharge support

Discharge support form filled out determining if patient should be on path 1/2/3 and the care they need

Patient/ carer consent gained and SPoA contacted

Pathway 1, 2 and 3 patients identified and referred to SPoA

Pathway 1

Other services e.g. nursing care/ carer support/ MH

Next day therapy

Same day therapy

Social care

SPoA arranges short term community care package/ community hospital care that the discharge form requests for pathway 1 and 2 patients

Pathway 3 patients are allocated to an IDT case manager

Pathway 2

Community hospital rehabilitation

Pathway 3

Sub-acute facility

SPoA/IDT informs the patient referrer of the time services will begin

The patient is identified as medically optimised for discharge

If there is no service capacity the patient referrer is notified of the delay

Pathway 1 – Provision of care, reablement and or rehabilitation at usual place of residence.
Pathway 2 – Period of recovery and or rehabilitation in a community hospital
Pathway 3 – Assessment of needs for long term residential or nursing care in a suitable facility sub-acute facility

Note: Pathway 1,2 and 3 patient SPoA and IDT flows reflect future state
Note: Mobility planning and discharge coordination should occur simultaneously

Source: HomeFirst, Carnall Farrar

Community discharge care package and reablement process – Pathway 1 patients

Discharge support initial response

Patient discharged with 12 noon deadline and discharge support initial response deployed

Take home and settle service transports the patient to their place of residence and ensures essential needs are met

Nurse/ other care provider arrives at patients place of residence within 2 hours and patient needs assessed

Therapy team visit within 24 hours or sooner depending on clinical need/ risk

Outcomes of visit reported to SPoA and further short term services initiated if required

Constant review process as to whether the patient is fit to remain home

Short term care provider assesses the patient to determine what, if any, additional care is provided

Safe to remain at home?

Yes

No

Reablement

Reablement package ends and no additional care needed

Referred to MDT and long term care plan reinstated or created if necessary, care navigator or case manager assigned

Time limited integrated community service reablement package potentially including:

Social care worker
Mental health worker
Occupational therapist
District nurse
Pharmacist
Dementia nurse
Health coach

SPoA contacted who organise community services required as a result of the assessment output

Reablement/ rehabilitation required

Referred to MDT and long term care plan reinstated or created if necessary, care navigator or case manager assigned

No further services needed

Readmitted to acute hospital or referred to SPoA for transfer to community hospital or short term residential care

A daily meeting and conference call will take place including IDT, social care, nurses, reablement team, take home and settle and Rapid Response to review capacity, discuss existing discharge support patients and make decisions about next steps in assessment and care

Source: HomeFirst, Carnall Farrar, Age UK East Sussex

Discharge planning – example pathway 1

1. Harry is 80, lives alone in a poor standard of accommodation and is frail. He has had a bad fall, breaking his arm, a rib and becoming concussed. He is taken to A+E and then admitted for further care

2. Once stabilised in the hospital he is set a date for discharge. Mobilisation therapy is also organised to ensure he becomes active again as soon as possible

3. Harry's health is much worse than before he fell. He is considerably more frail, confused and has lost much of his confidence. A discharge support form is filled out and it is identified that he needs considerable discharge support with extensive community service use when he becomes medically fit to discharge

4. The acute discharger calls the SPoA and provides them with his discharge support form. The call handler organises the short term local community services in Harry's area that will include the 'Take home and settle service' and a service to be in place within 2 hours of his return home according to the Home first pathway 1. Harry has an electronic shared patient record that any service can access and that the SPoA use to coordinate services

5. Harry is passed medically fit for discharge and is returned home. Within 2 hours he is assessed by a member of the short term care service who determine his reablement care package including a physio, domiciliary care worker and a podiatrist for a 6 week period. He is also referred to the falls prevention service. The SPoA is called to organise the integrated community services required and his electronic record is updated

6. An assessment at the end of his 6 week care package determines that Harry will need an ongoing care package. He is referred to his local MDT through the SPoA and is provided with an ongoing domiciliary care package

Harry's health status has improved at the end of his 6 week reablement care package. His care plan now encompasses his care needs and he has regained confidence and some strength

Source: K&M STP Local Care workstream

Discharge planning – example pathway 2 – A care plan that can be reinstated

1 Helen is 82, is frail, has type 2 diabetes, hypertension and COPD and has a care plan and care navigator. She has a transient ischaemic attack (TIA) and is admitted to hospital with symptoms similar to a stroke

2 Once stabilised in the hospital she is set a date for discharge. Mobilisation therapy is also organised to ensure she becomes active again as soon as possible

3 Helen's care navigator visits both her and the ward staff and discuss her recovery and future care needs

4 Helen has been in the hospital bed for three days and has been determined as medically fit for discharge. The ward staff complete a discharge form and despite being mobile and able to manage her recovery at home she has no means of returning home. A discharge support form is filled out and the SPoA are informed that Doris will need the 'Take home and settle service'

5 The 'Take home and settle' service collect Helen from her ward bed and take her home, ensuring she has her prescribed medication, food in her cupboards and that her heating is on

6 The SPoA contact the local 'Take home and settle service'. Apart from this, Helen has no other needs. Her care navigator is informed she will be delivered home and her care plan and package of care are reinitiated

Helen continues to live independently in the community

Source: K&M STP Local Care workstream

Discharge planning – example pathway 3

1 Brian is 84, lives alone, has type 2 diabetes, COPD and recently suffered a stroke. He has a care plan and case manager due to the complexity of his care needs. He develops pneumonia and is admitted to hospital

2 Once stabilised in the hospital he is set a date for discharge. Mobilisation therapy is also organised to ensure he becomes active again as soon as possible

3 Acute staff begin initial discharge planning but identify that Brian's health is much worse then before he had pneumonia. He is considerably more frail, still weak and his condition unstable. A discharge form is filled out and it is identified that he needs considerable discharge support beginning with a period of community hospital rehabilitation

4 The acute discharger calls the single point of access and provides them with his discharge support form. The call handler organises Brian's transfer to a community hospital for an initial 6 week period. Brian is passed medically fit for discharge and is subsequently transferred to the designated community hospital

5 After a period of 3 weeks the community hospital can discharge Brian. They call the SPoA who organise a 6 week reablement community care package including a district nurse and domiciliary care worker

6 An assessment at the end of Brian's reablement care determines that Brian's needs have changed since he was admitted to hospital. His case manager calls the SPoA who place him on his local MDT's agenda for a revised package of care

Brian's condition is stable and he is able to continue living in the community with the assistance of his case manager and integrated care package

Source: K&M STP Local Care workstream

8 Access to expert opinion and timely access to diagnostics

The ability for primary care professionals to access a specialist opinion in the community setting and where appropriate, a specialist triage for diagnostics

Access to diagnostic services and the ability to ensure diagnostic results are complete will avoid the need for multiple outpatient appointments

Source: K&M STP Local Care workstream

Traits of successful access to expert opinion and timely access to diagnostics services:

1. Specialist healthcare professionals with time dedicated to answering GP, community nurse and consultant questions regarding specific patients
2. A directory of specialists, their contact details and availability
3. Use of various tools of communication through a variety of digital methods including record sharing systems, phone lines and video conferences
4. Rapid access to diagnostic services (diagnostic and result) regardless of who has requested it to quickly inform a clinical decision and where possible avoid an unnecessary outpatient appointment
5. Use of an electronic form to ensure efficiency of appointment bookings by highlighting when a person's full range of diagnostic tests is complete
6. A service that redirects patient flows through utilisation of senior clinical triage

Source: Carnall Farrar, K&M Local Care Workshop

Access to expert opinion and timely access to diagnostics

Concept

Need for access to specialist opinion

High levels of new outpatient appointments can result from the need for a specialist opinion that currently cannot be provided in the community effectively

Key levers to access specialist opinion without the need for an outpatient appointments:

30-50k service grouping
- **Common conditions** such as tier 2 and 3 high needs patients and other chronic condition patients, a specialist opinion can be accessed through the MDT, where a community geriatrician is known to primary care staff in their practice grouping. Avoids referrals and need for people to travel

100-250k service grouping
- **Rarer conditions** for a wider patient population such as degenerative neurological conditions, a specialist is contacted at more centralised localities e.g. hospital sites

Need for timely diagnostics

Follow up outpatient appointments can result from incomplete diagnostics or the need to follow up diagnostics:

Key levers to restrict follow up appointments are:

- The use of electronic health records that can be utilised by specialists to ensure all diagnostics are complete before an appointment is arranged
- The ability for specialists to review the diagnostics over the phone with the patient referrer
- The ChenMed model of closed file review allows specialists to to check that the diagnostic information is complete and that the referral is accurate before outpatient appointments are arranged

Note: It important to note that some diagnostics should still be triaged via a specialist e.g. CT/MRI scan and that this process does not simply allow open access to disgnostic tests

Patient population targeted

- Tiers 2 and 3 people (3+ LTCs) with complex needs
- Large surgical specialties including MSK, ophthalmology, general surgery and high volume medical specialties including respiratory, pediatrics

Impact

- Improved outcomes for people
- Reduced OP first appointments
- Reduced OP repeat appointments
- Improved referral pathway to the correct clinician

Source: Carnall Farrar, Chenmed, K&M Local Care Workshop

Courses of action to access expert opinion

Service grouping of 30-50k

A person (from tier 2/tier 3 with 3+LTCs and complex needs) visits their GP → A geriatrician within the local MDT is known by the GP and is contacted for advice → The community geriatrician provides the next steps for managing the person's holistic needs → The person does not need to be referred or have to travel to attend another appointment

A person (from tier 1 e.g. Osteoarthritis) visits their GP. The patient's condition is at a stage where specialist diagnostics +/- treatment need to be considered → A local MSK MDT (incorporating rheumatologists, orthopedic specialists and extended scope physiotherapists) operates at a 30-50k locality and the GP calls the ESP → The ESP advise that the person should have diagnostics → The ESP and the GP discuss the results of the diagnostics over the phone and an appointment with a rheumat-ologist is made → The person attends a reduced amount of OP appointments, travels less and goes to see the right clinician the first time

Service grouping of 100-250k

A person with a less common, more complicated single condition (e.g. motor neuron disease or cystic fibrosis) visit their GP. The person is at the stage where new specialist advice is required → The advice required is not able to be delivered at the 30k-50k service grouping . The hospital has specialist consultants who are available to be contacted → The GP contacts the specialist and gets the opinion/ advice of the specialist either by phone, email or digital methods → The person does not need to be referred or have to travel to attend another appointment

Source: Carnall Farrar, K&M Local Care Workshop

Access to timely diagnostics in the community – example pathway 1

1. Steven is 73, he has COPD, type 2 diabetes and depression
2. Steven has an exacerbation and he is feeling more breathless than usual over the last couple of months. He is worried so goes to visit his GP
3. Steven's GP, Dr. Jordan, discusses his condition with him and has concerns over the progression of his COPD and potential other contributing factors. Rather than referring him for a specialist outpatient appointment, Dr. Jordan is able to reach a respiratory physician, Dr. Adams, through a designated hotline to discuss Steven's condition
4. Dr. Adams advises Dr. Jordan on some diagnostics that he should have completed and he organises a chest X-Ray, ECG and some blood tests
5. An electronic health form is checked by Dr. Jordan and Dr. Adams when all of Steven's tests are completed
6. Dr. Jordan reviews the result and in parallel receives an explanatory email from Dr. Adams who has also reviewed the results and advises on an appropriate course of action
7. Dr. Jordan calls Steven to discuss the results and advises him of a change in his medication. He also arranges a follow up appointment for a couple of weeks later

Steven visits Dr. Jordan and as a result of the new medication regime his condition is much improved

Source: K&M STP Local Care workstream, Carnall Farrar

Access to expert opinion in the community – example pathway 2

1. Alice is 79, frail, has type 2 diabetes, COPD and recently suffered a stroke. She lives with her husband, Gerald, who is also frail and often unwell himself

2. After her recent stroke she was provided with an anticipatory care plan and placed under the care of the local MDT. Gerald was also given some carer support

3. Alice has been behaving a bit unusually and being forgetful, she calls the SPoA and as a result a GPSI, Dr. Lopez who is part of the local MDT calls Alice and Gerald

4. After the call Dr. Lopez decides that a more thorough assessment of Alice is required. She sets up an appointment with a community nurse to undertake an assessment. After this assessment she is referred to a psychogeriatrician who undertakes a more thorough dementia assessment

5. It is determined that Alice has early signs of dementia

6. As a result her care plan is updated to reflect this and additional support is put in place to help support her and her husband

Alice is able to continue living independently and as a result of her increased level of care, both herself and her husband have the confidence to manage her condition

Source: K&M STP Local Care workstream, Carnall Farrar

Emergency Department

Service delivery model

28 February 2017
Updated 13 June 2017

Introduction and purpose of service delivery model template

- A number of services have been prioritised as for early consideration by the K&M hospital care working group. This pack forms one of a series service delivery model templates for the priority services.
- The aim of this pack is to consider the key issues the service is facing within the hospital context, its current in-hospital model of care and aspirational future model among other relevant context.
- The pack follows the structure of:
  - A summary slide outlining key information from each section; then
  - Each section, with a summary slide up front followed by evidence slides
- The pack has been created with expert input from across Kent & Medway, and has been developed by the K&M Hospital care workstream before being signed off by the Clinical Board.

Note: The Acute care template includes paediatrics

This document has been updated to incorporate feedback from the SE Clinical Senate

Comment classification	Comment	Next steps
Can be incorporated into model easily	• There are comprehensive recommendations for rapid assessment and treatment models in emergency departments produced by NHS IMAS – to be taken into account	• Comment incorporated, no next steps
	• The ED model seemed to be purely about triage, which was considered somewhat limited in scope for a model to review	• Comment incorporated, no next steps
	• The ED requirements for imaging (e.g. USS, CT and MRI) should be stated	• Comment incorporated, no next steps
	• Are there any plans for rapid access to liaison psychiatry in the ED?	• Comment incorporated, no next steps
	• There was no mention of what would happen to those people presenting out of hours with substance and alcohol misuse issues and experiencing a mental health crisis	• Comment incorporated, no next steps
	• Reference should be made to specific emergency pathways that require different triage	• Comment incorporated, no next steps
	• More information required on the provision of support for self-management and carers	• Comment incorporated, no next steps
	• Further clarification on the senior decision maker on the 'front door' required	• Comment incorporated, no next steps
	• There was no information regarding the specific plans for ambulance handover within 15 minutes	• Comment incorporated, no next steps
	• There should be access for ED clinical staff to the summary care record.	• Comment incorporated, no next steps
Requires further work pre-PCBC	• There should be more detailed description as to how ED interacts with the frailty pathway	• CF to draft and incorporate into model
	• What impact will the changes have on patient experience for those accessing A&E, and on waiting times for assessment?	• CF to draft and incorporate into model
	• It is not clear that this specific ED model was discussed at patient events to ensure that patient experience and patient centred care have been adequately accounted for	• Steph Hood to ensure that it is discussed in pre-consultation events
	• There is no mention of any new or further developed workforce models for the EDs	• Workforce stream developing response
	• In the absence of modelling it was difficult to determine whether the ED capacity within K&M is sufficient	• Is underway in options appraisal
	• Regarding ambulance response time targets only red response times for 'category A' calls are shown, for which there are already in place targets and monitoring. As important are the more urgent 'green' calls	• CF to follow up with SECAmb
Requires further work post-PCBC	• There should be model developed for fracture management	• To develop further as part of model implementation

The STP outlined the aspiration for Hospital Care model which prevents ill health, intervenes earlier and delivers excellent, integrated care closer to home

Care Transformation workstreams

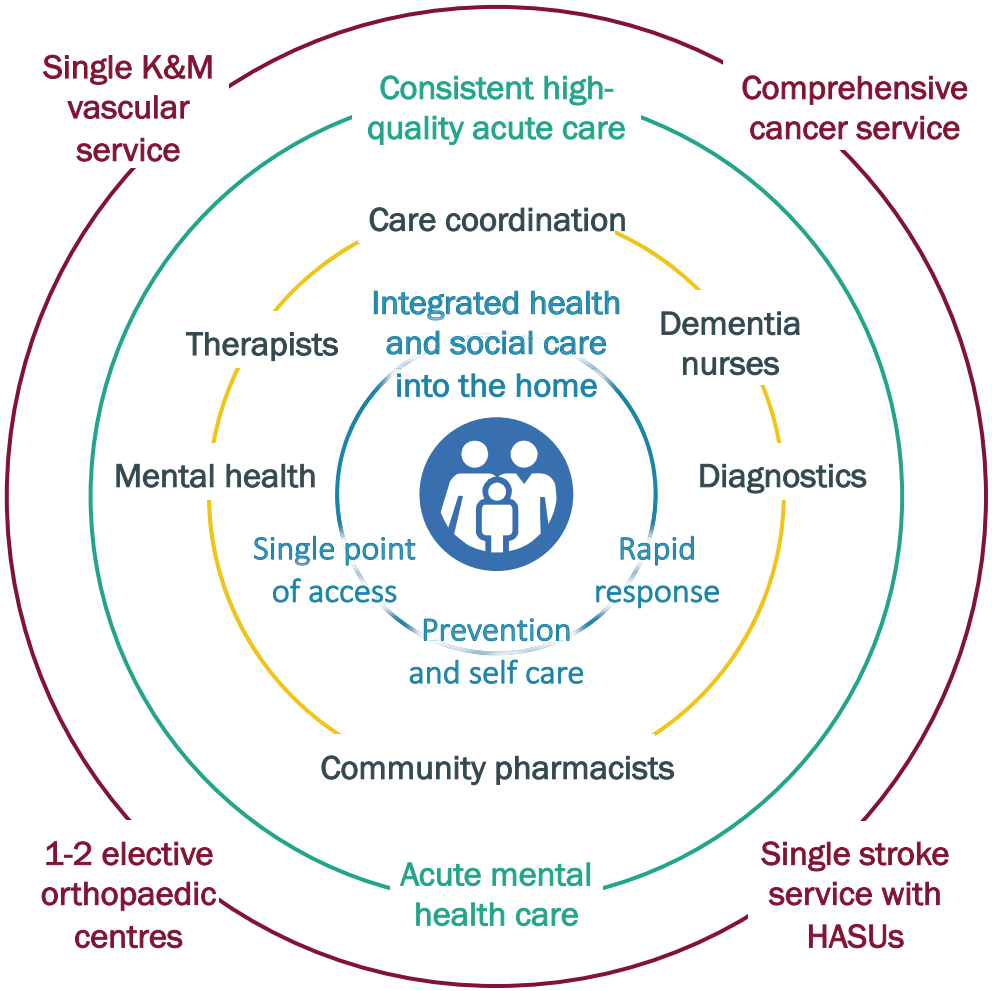
Prevention — Enlisting public services, employers and the public to support health and wellbeing

Local Care — A new model of care closer to home for integrated primary, acute, community, mental health and social care

Hospital Care — **Optimal capacity and quality of specialised, general acute, community and mental health beds**

Mental Health — Bringing parity of esteem, integrating physical and mental health services, and supporting people to live fuller lives

Kent and Medway Future Care Model



Source: K&M STP

The focus of this template will be on Hospital Care

Summary contents

1. **Who is the population being served?**
   - At present Emergency Department services, such as MIU or acute medical take, are delivered at all acute hospitals sites in K&M. However, the range of services and how they are organised are different at each site. For example, only three sites are trauma units.
   - In K&M in 2015/16 there were 219,812 major ED attendances (including 254,441 adults and 57,507 children) and 311, 948 minor ED attendances (including 156,084 adults and 63,728 children). Overall there were 105, 821 child attendances (>16) and 438,499 adult attendances (<16).
   - Compared to the general population, the majority of ED attendances were young (105,821 <15) or older (61,380>79) people.
2. **What are the issues in the case for change which need to be addressed?**
   - Across K&M, Emergency Department attendance has grown by 3.6% per year over the last 3 years (the national average is 2.6%). Alcohol misuse is an increasing cause of ED attendances.
   - The local ambulance service is stretched with increasing numbers of calls especially time critical calls; there has been a deterioration in response times over the last three years
   - Performance on the 4 hour waiting target has deteriorated over the last 2 years; in 2015/16 on average 86% of people were discharged from ED within 4 hours, compared to 92% nationally. Some providers in K&M have amongst the worst patient satisfaction scores in the country.
3. **What is the service delivery model today?**
   - Some local hospitals find it difficult to provide services for some seriously ill people - access to consultant cover or senior support is limited at weekends and 24/7 access to interventional radiology is not available across K&M. Recruitment to medical posts is becoming increasingly difficult.
   - Patient stories show the current system is characterised by long waits, multiple contacts with health care professionals, and poor patient experience.
4. **What is the proposed service delivery model for the future?**
   - The aspiration in K&M is to transform care and all parts of the patient pathway are being reviewed.
   - A range of interventions are being developed to avoid Emergency Department attendances. These include single point of access, care management and discharge planning.
   - A new model for ED will incorporate triage to the most appropriate pathway.
5. **What are the co-dependencies and building blocks?**
   - The models in the Keogh report have been used as a basis for developing building blocks of services.
   - The South East Clinical Senate has undertaken work to understand the co-dependencies between services and these have been used to further describe the Keogh models.
   - The models are Major Emergency Centre with specialist services, Emergency Centre, Emergency Medical Centre and Urgent Care Centre.
6. **What engagement has been undertaken?**
   - Over the last 2 years EKHUFT has engaged with key stakeholders internally and externally through a series of EKHUFT and East Kent Strategy Board events.
   - West Kent have not carried out engagement to date

Contents

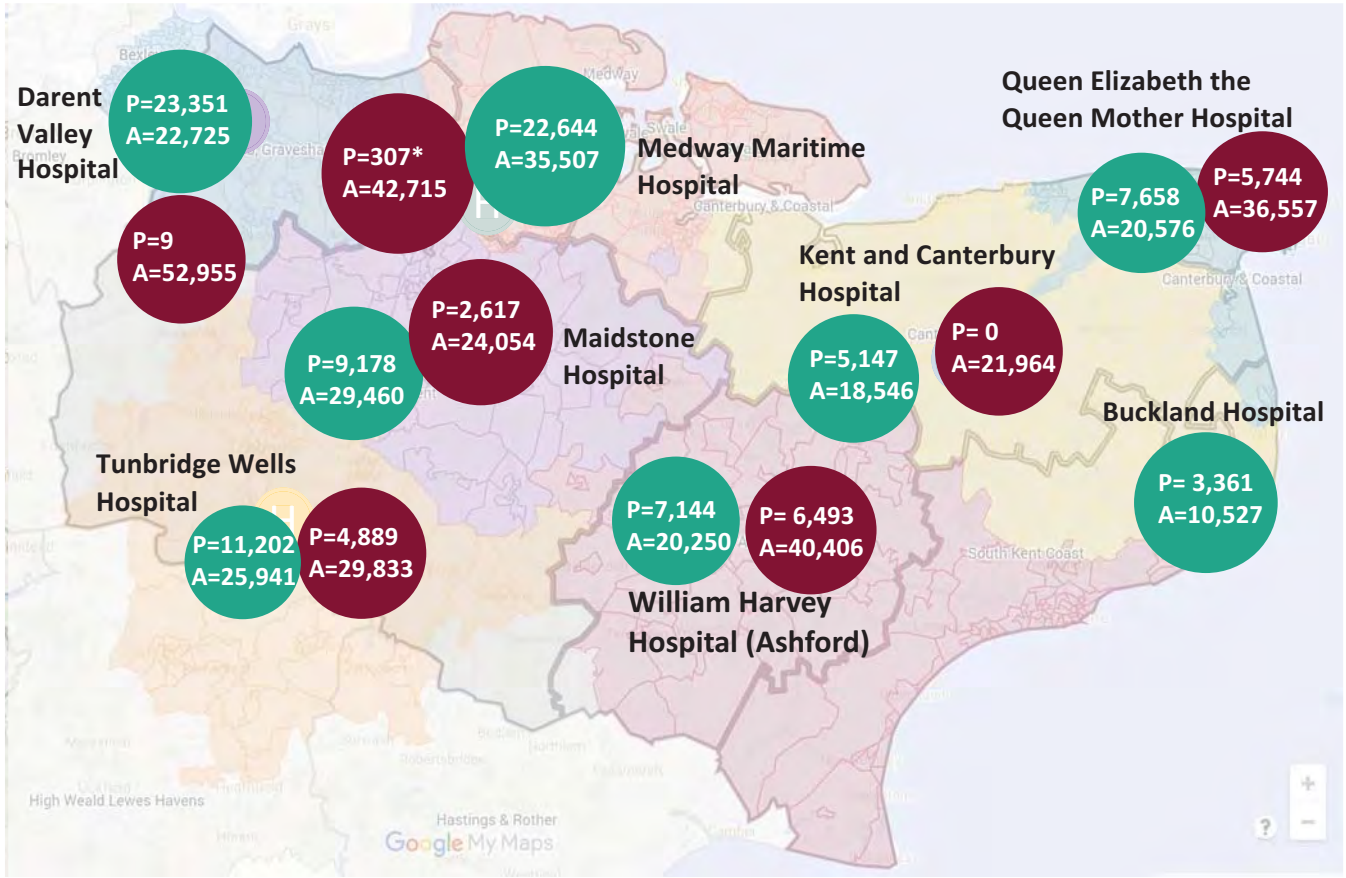
Who is the population being served: summary

1. **Who is the population being served?**
2. What are the issues in the case for change which need to be addressed?
3. What is the service delivery model today?
4. What is the proposed service delivery model for the future?
5. What are the co-dependencies and building blocks?
6. What engagement has been undertaken?

- At present Emergency Department services, such as MIU or acute medical take, are delivered at all acute hospitals sites in K&M. However, the range of services and how they are organised are different at each site. For example, only three sites are trauma units.
- In K&M in 2015/16 there were 219,812 major ED attendances (including 254,441 adults and 57,507 children) and 311, 948 minor ED attendances (including 156,084 adults and 63,728 children). Overall there were 105, 821 child attendances (>16) and 438,499 adult attendances (<16).
- Compared to the general population, the majority of ED attendances were young (105,821 <15) or older (61,380>79) people.

The following slides collate an evidence base to support the issue outlined here

Who is the population being served: activity by site



Minor patients

Major patients

A = Adult (≥16)

P= paediatrics (≤ 16)

	DVH	MFT	MGH	TWH	WHH	Buckland	K&C	QEQM
Total attendances	99,040	101,173	65,309	71,865	74,293	13,888	45,657	70,535

Note: Major ED in Maidstone Hospital excludes paediatrics. EKHUFT have minor activity only (A=10,527 and P =3,361) at Buckland Hospital. *MFT Major figures does not include PAU.

Source: Provider returns 2015/16

Who is the population being served: activity by Trust

	D&G	EKHUFT	MTW	MFT	K&M	England
Major ED attendances in 2015/16	46,084	111,164	61,393	42,066	222,857	14,960,805
Year on year growth (FY13/14 – FY15/16) (% per year)	-4.1%	+4.9%	+0.9%	+4.5%	+3.6%	+3.0%
Minor ED attendances	52,970	93,206[1]	75,781	57,395	1,118,207	7,355,96
Year on year growth (FY13/14 – FY15/16) (% per year)	+5.8%	-2.9%	+9.4%	+10.1%	+3.0%	+3.0%

Note: 1. Includes 13,888 minor activity at Dover. Please note that this does not included month to date (16/17) data which has demonstrated dramatic increase.
Source: Provider returns from trusts

Who is the population being served: 15/16 activity by age

Trust 15/16 ED activity by age segment: ED

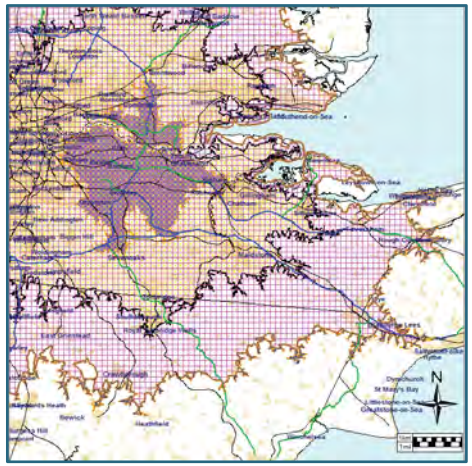
Age	EKHUFT	D&G	Medway	MTW	Total
0-15yrs	35,549	23,361	20,640	26,271	105,821
16-64yrs	114,429	54,401	60,010	76,659	305,499
65-79yrs	29,739	11,569	11,657	18,655	71,620
80+yrs	24,660	9,710	11,421	15,589	61,380

Source: Provided directly from DoS from each Trust
Note – EKHUFT data above includes Buckland Hospital

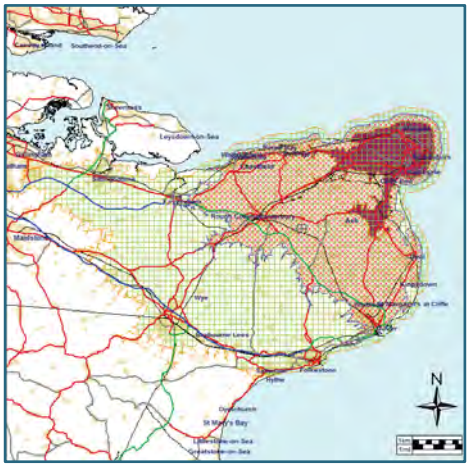
Isochrones depicting access times by car for emergency departments

15, 30 & 45 minutes travel times by car

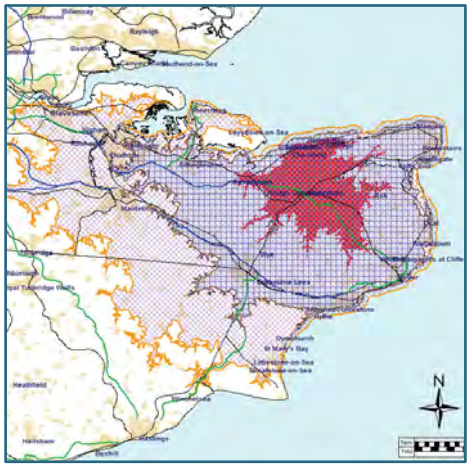
Darent Valley Hospital



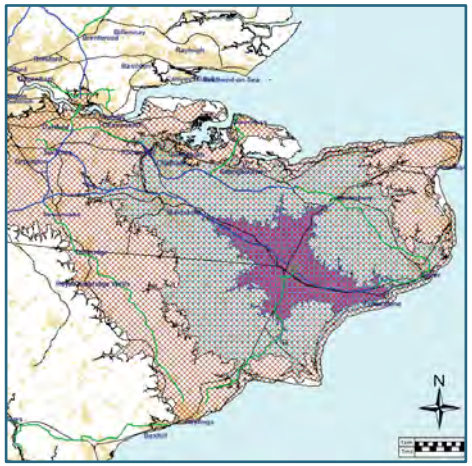
QEQM Hospital



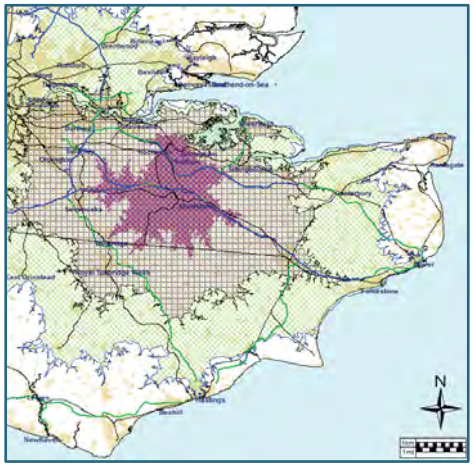
Kent and Canterbury Hospital



William Harvey Hospital

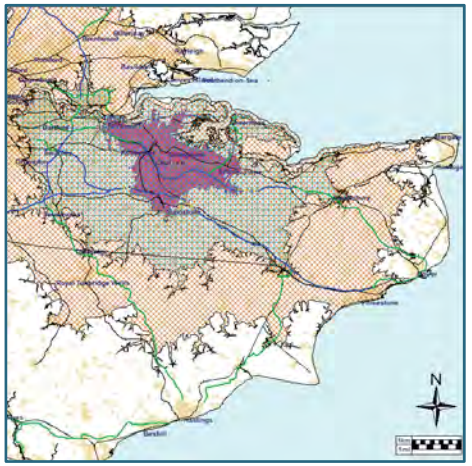


Maidstone Hospital



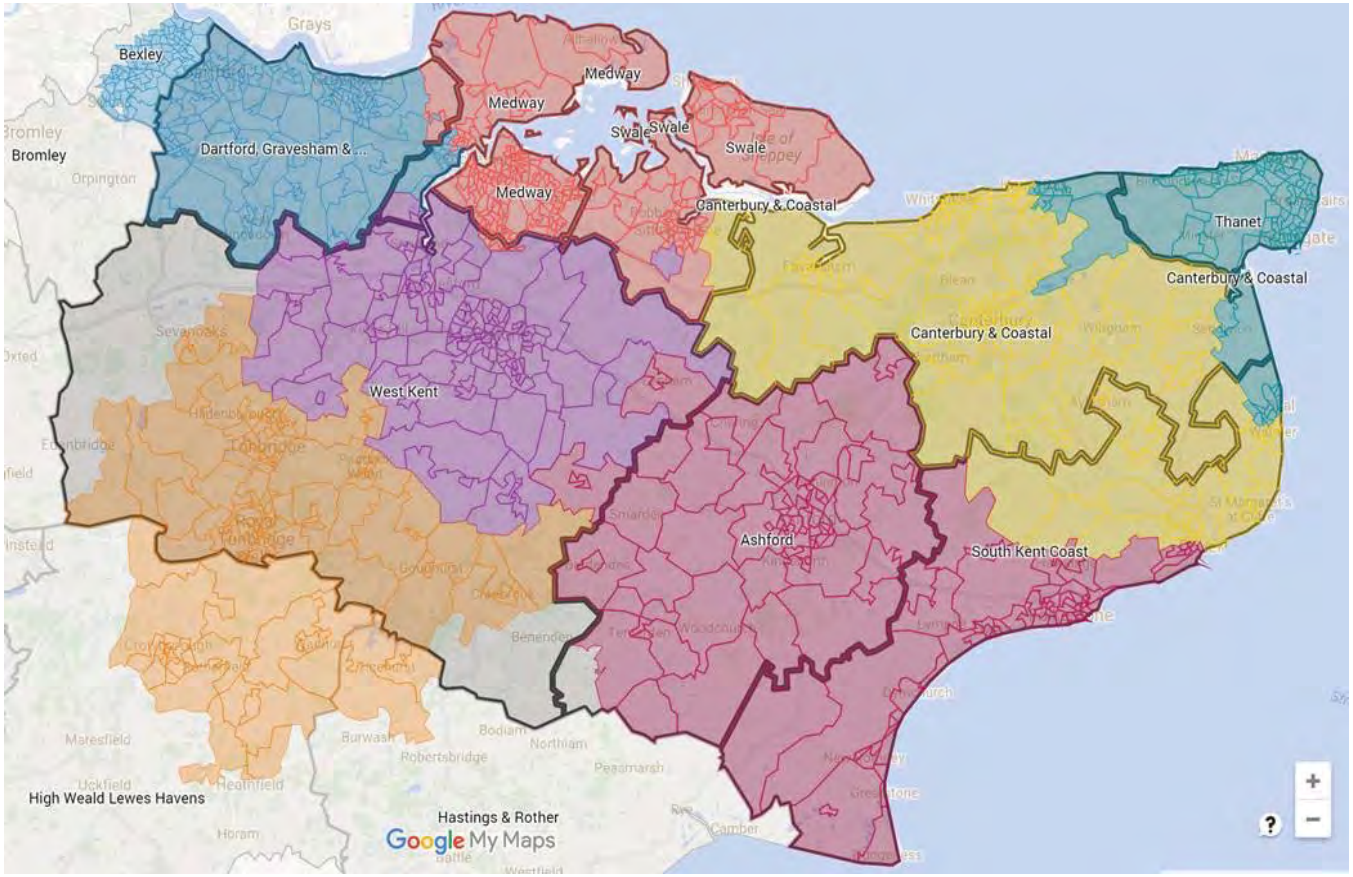
Tunbridge Wells Hospital

Medway Hospital



Source: SECamb (2017)

Map showing catchments for each hospital based on shortest travel time from each lower super output area (LSOA), car, off-peak

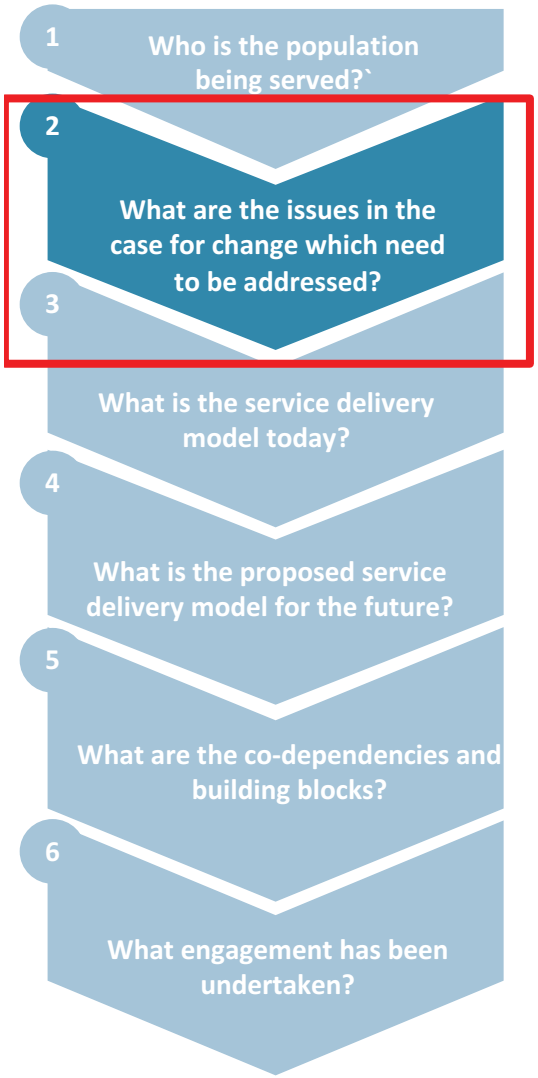


	Darent Valley	Maidstone	Tunbridge Wells	WHH	KCH	QEQM	MMH
People in catchment area, 2015, Thousands	**414**	**237**	**215**	**254**	**247**	**187**	**368**

SOURCE: ONS LSOA boundary, centroid and 2015 mid-year population data; Google Maps distance matrix; NHSE hospital site data; Carnall Farrar analysis

Contents

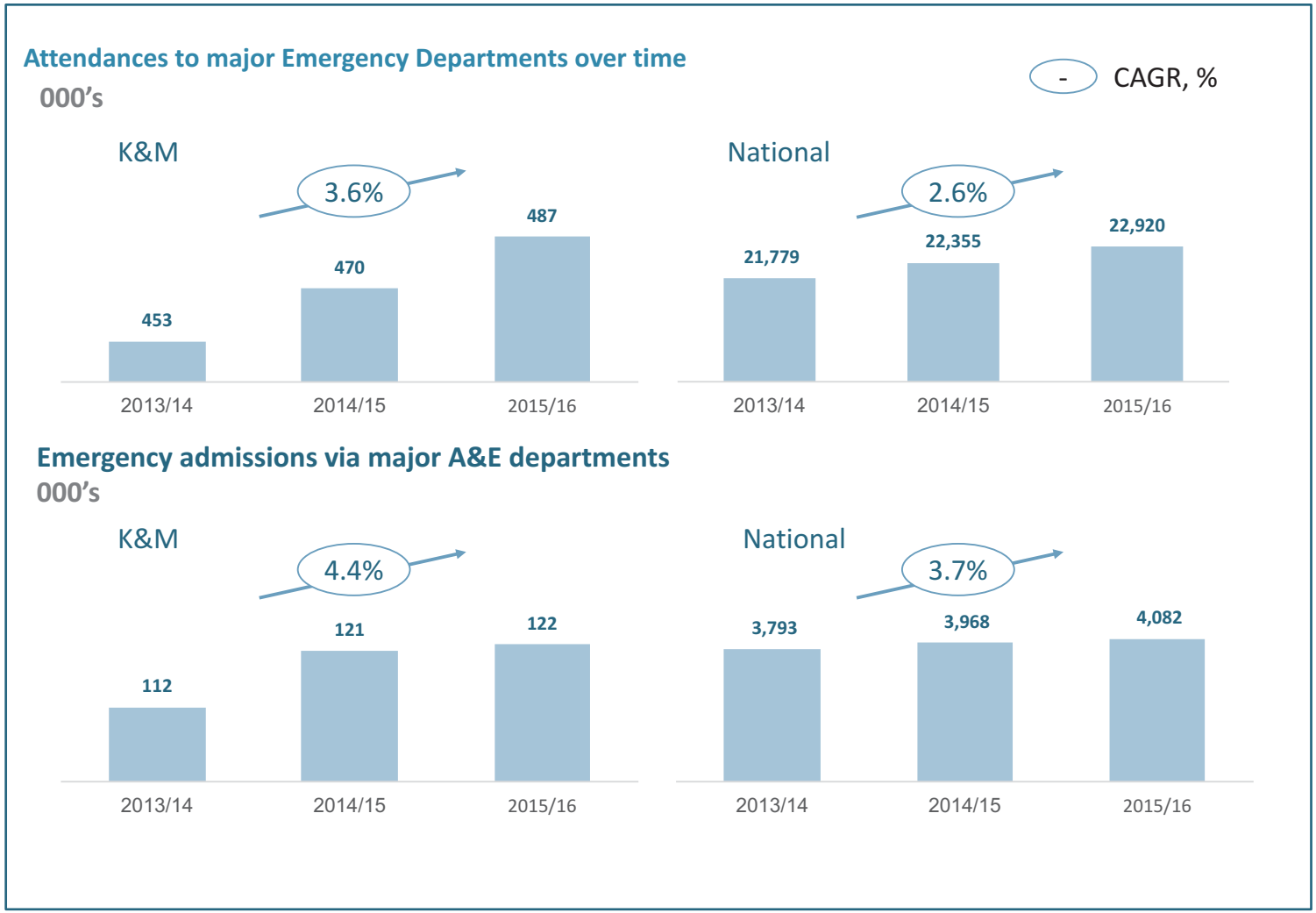
What are the issues in the case for change which need to be addressed?: Summary



- Across K&M, ED attendance has grown by 3.6% per year over the last 3 years (the national average is 2.6%). Alcohol misuse is an increasing cause of ED attendances.
- The local ambulance service is stretched with increasing numbers of calls especially time critical calls; there has been a deterioration in response times over the last three years
- Performance on the 4 hour waiting target has deteriorated over the last 2 years; in 2015/16 on average 86% of people were discharged from ED within 4 hours, compared to 92% nationally. Some providers in K&M have amongst the worst patient satisfaction scores in the country.
- Some local hospitals find it difficult to provide services for some seriously ill people - access to consultant cover or senior support is limited at weekends and 24/7 access to interventional radiology is not available across K&M. Recruitment to medical posts is becoming increasingly difficult.

The following slides collate an evidence base to support the issue outlined here

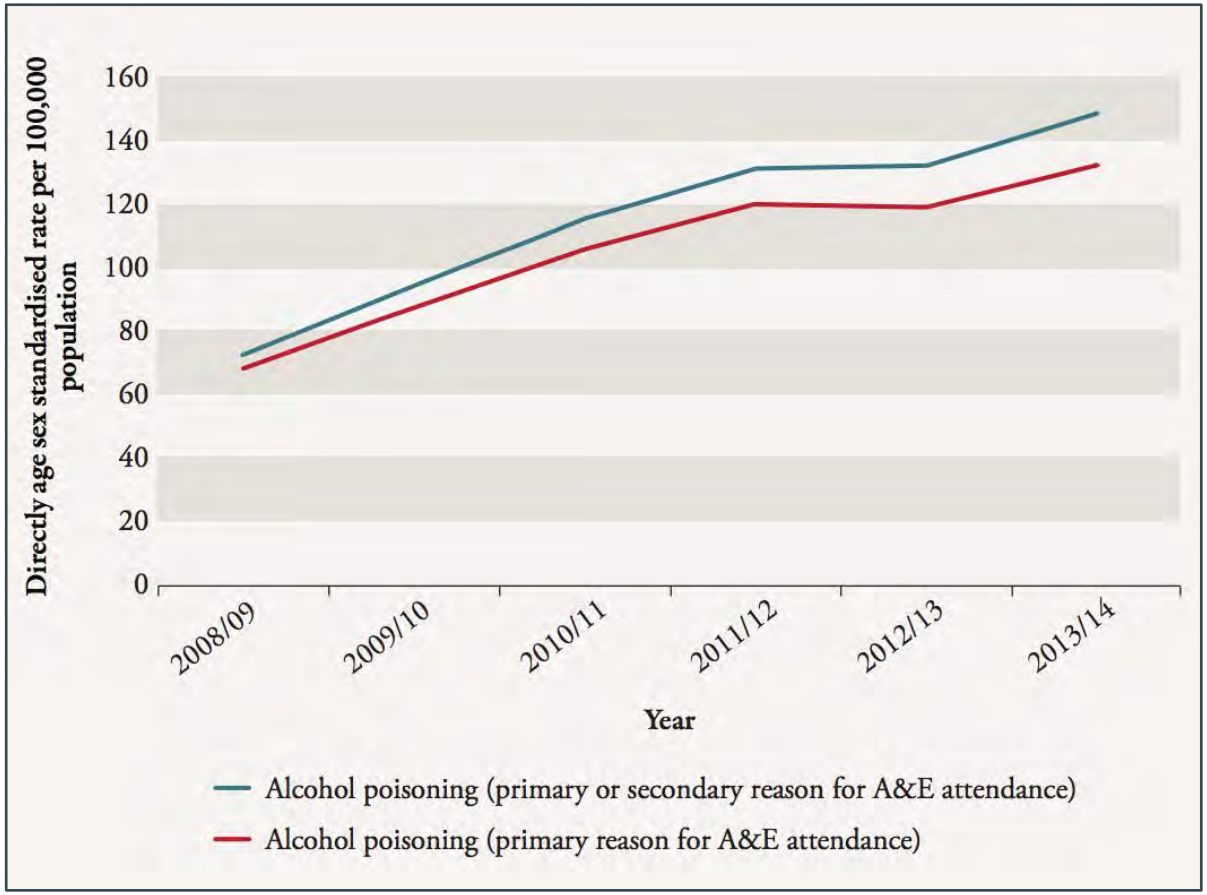
Attendances to major ED departments have risen by 3.6% per year over the last 3 years (the national average is 2.6%)



Source: NHS England, Quarterly ED activity data, Carnall Farrar analysis

Alcohol misuse is an increasing cause of attendance in ED

Directly age- and sex-standardised rates of ED attendances where alcohol poisoning has been recorded, per 100,000 population, 2008/09 to 2013/14

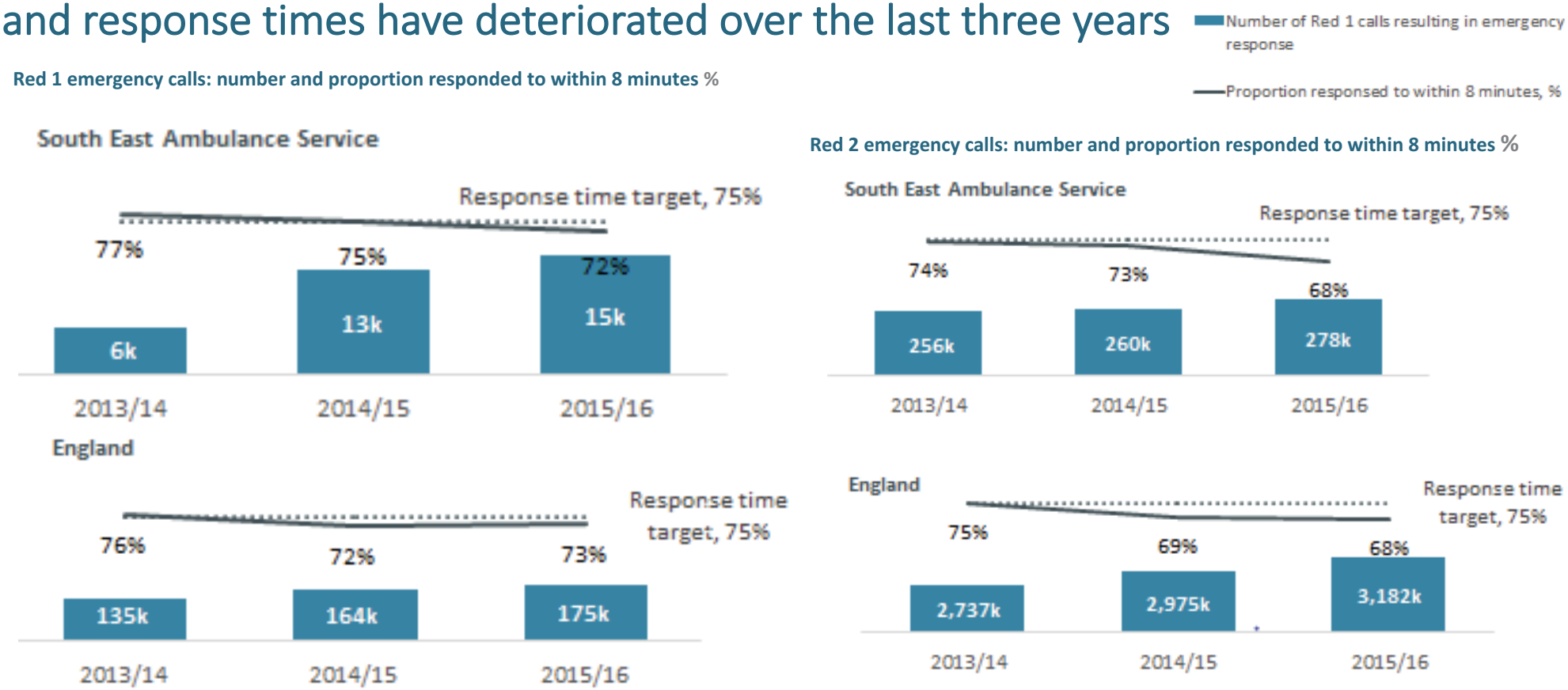


- A report by the Nuffield Trust found that from 2008/9 to 2013/14 (ie over six years), ED attendance rates likely to be due to alcohol poisoning doubled, from 72.7 per 100,000 of population to 148.8 per 100,000 – a 104.6% increase
- Three in four of those who attended ED due to likely alcohol poisoning arrived by ambulance. One in three were subsequently admitted to hospital overnight, in comparison to one in five of those attending ED for other reasons. This places potentially avoidable strain on ambulance trusts, ED and hospital services.

SOURCE: *Alcohol-specific activity in hospitals in England*, Nuffield Trust, December 2015. Claire Currie, Alisha Davies, Ian Blunt, Cono Ariti and Martin Bardsley.

The ambulance service is stretched: the number of Red 1 and Red 2 calls are rising, and response times have deteriorated over the last three years

Red 1 emergency calls: number and proportion responded to within 8 minutes %



- Between 2013 and 2015 the number Red 1 (serious and time critical) emergency calls to South East Ambulance Service rose by 148% - 5 times faster than the national average of 30%.
- Meanwhile the proportion of total calls responded to within the 8 minute target fell from 77% to 72% (the national target is 75%)

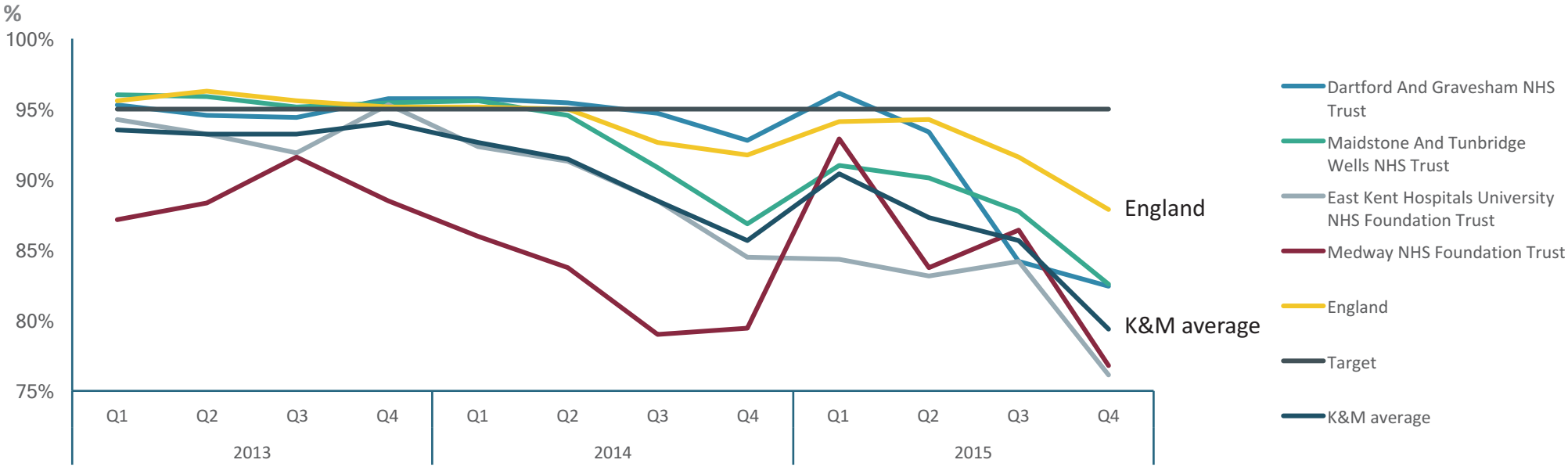
Red 2 emergency calls: number and proportion responded to within 8 minutes %

- Between 2013 and 2015 the number of Red 2 (serious, less time critical) emergency calls rose by 8%, compared to 16% nationally.
- Meanwhile the proportion of total calls responded to within the 8 minute target fell from 74% to 68% (the national target is 75%)

Note: Red 1 calls are the most serious/time critical; Red 2 calls are serious but less time critical
Source: NHS England, Ambulance Quality Indicators: time series annual data FY2013 and FY201 4 and monthly data for FY2015

There are long patient waiting times – nearly all providers have been breaching the 4 hour ED waiting time target for the last 3 years

Proportion of patients (type 1[1]) discharged from ED within 4 hours

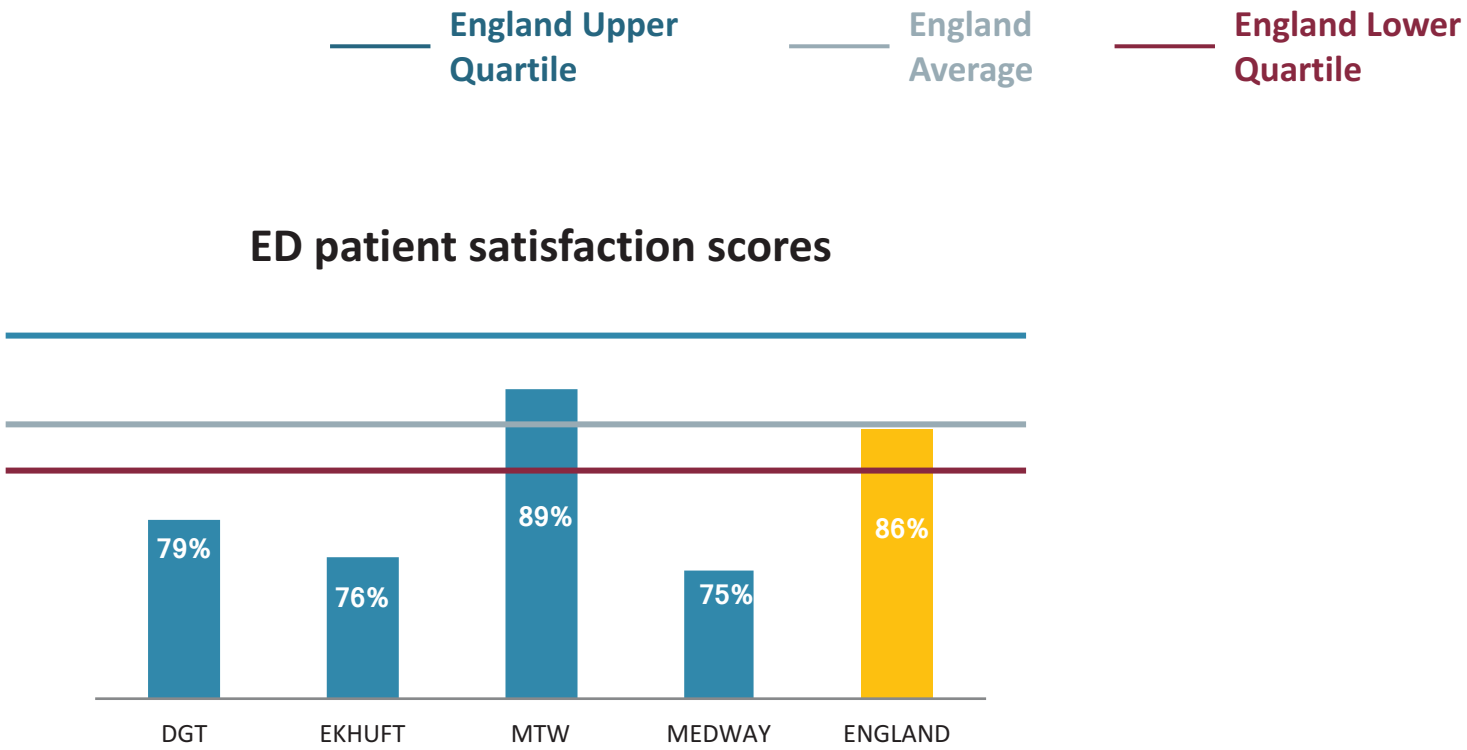


- All four trusts have consistently breached the waiting time target over the three years to 2016. Performance has also deteriorated over time.
- On average the proportion of patients discharged from major ED departments within 4 hours has fallen from 94% to 86% over the period. The national average in 2015/16 was 92%.
- In 2015/16, average performance ranged from 82% by EKHUFT to 89% by D&G.

Notes: [1] Type 1 reflects major ED attendances
[2] Kent and Medway average is weighted by the proportion of activity in each Trust

Source: NHS England, Quarterly ED activity data for FY2013 to FY2015, Carnall Farrar analysis

Several providers in K&M have some of the worst patient satisfaction scores in the country for ED



Note: The England average for ED was 86%

Source: Friends and Family Test, August 2016

Some local hospitals find it difficult to deliver services for some seriously ill people

Fully meets
Partially meets
Does not meet

Ref	Standard	Type	D&G	MH	TWH	Medway	QEQM	K&C*	WHH	Comments
ED5	ED must have separate dedicated children's facilities, for waiting and treatment.	Access								
ED6	Interventional radiology services for highest acuity patients are available within one hour of referral.	Access								**MTW:** Patients requiring Interventional radiology input are transferred to London **EKHUFT**: Networked from K&C - only partial due to gaps on rota and even though vascular picks up some gaps this is not a comprehensive rota **D&G**: Available at Kings and PCI at Ashford
ED1	A trained and experienced doctor (ST4 and above or doctor of equivalent competencies) in emergency medicine to be present in the ED 24 hours a day, seven days a week.	Workforce								
ED2	Consultant presence on the Emergency Floor of an accredited Consultant in Emergency Medicine [CCT holder] between 08:00 and 24:00, 7 days per week.	Workforce								**D&G**: DVH, Dartford consultant cover till 10PM **MTW**: Both sites have consultant presence until 22.00 **EKHUFT**: WHH & QEQM have consultant presence on site 08.00-22.00 with 9 hours of cover at weekends **Medway**: Medway has consultant cover to 22.00 5 days per week and 12.00-20.00 at weekends.
ED3	From 24.00 to 08.00, a consultant will be on-call and available to attend the hospital for the purposes of senior clinical decision making and patient safety within 30 minutes.	Workforce								
ED4	There must be on-site senior support at ST3+ level 24 hours per day within the core specialties in Acute Medicine, Critical care, Anaesthetics, General Surgery, Orthopaedics, paediatrics & Emergency Medicine.	Workforce								**D&G**: Orthopaedic Registrar available out of hours but not on site **MTW** - paediatrics and Orthopaedics are based at Tunbridge Wells
ED7	The ED to have a named paediatric consultant with a designated responsibility for paediatric care in the ED.	Workforce								**MTW**: Maidstone has a paediatric day ward Mon-Fri 09.00-19.00. paed consultant available via switch after this time. Paediatric ED at TWH staffed by Consultant 14.00-22.00 7 days a week. At Maidstone there are protocols for all sick children to be admitted to the paediatric day ward Mon-Fri 09.00-19.00. After these hours there is support via the paediatric team at TWH **EKHUFT**: A paediatric consultant has been employed by ED to provide specialist paediatric advice for both WHH and QEQM. This is a post that covers both sites. Clear protocols are in place for clinical referrals to the on-call paediatric teams and are available 24/7.

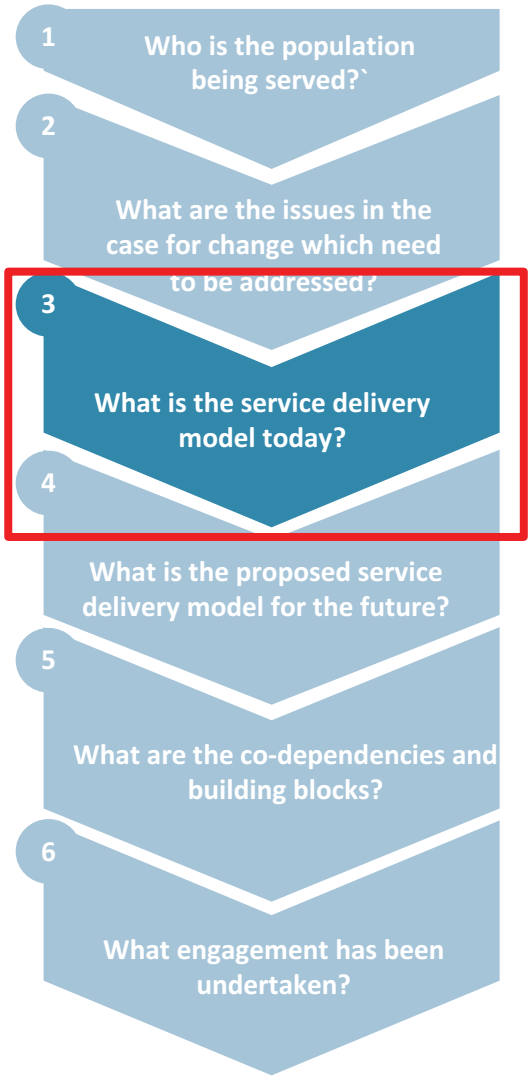
No

- *1 consultant team*
- *K&C also has a primary care led UCC supported by a MIU and AMU.*
- *There are also no in-patient paediatrics at K, general surgery and trauma patients. Protocols are in place with SECAMB if these patients should present to the front door, i.e. a referral service is in place to the children's ambulatory centre in hours and OOH protocols are in place for transfer to EDs*

Source: Trust data, Carnall Farrar, clinical standards audit (2016)

Contents

What is the service delivery model today?: Summary



- Patient stories show the current system is characterised by long waits, multiple contacts with health care professionals, and poor patient experience.

The following slides collate an evidence base to support the issue outlined here

Service delivery model today: Fracture management service, ED minors

Harry is 19 years of age and is a student studying in Ashford. Harry enjoys sports and whilst playing football he sustained a fall, resulting in pain in his left arm. Harry attends the minor injuries unit (MIU) at the WHH.

What can happen now to some patients:

- At the MIU Harry is seen by a junior doctor who works in the department. He is given an initial clinical assessment
- Harry is sent for an X-ray to confirm the diagnosis.
- The MIU junior doctor contacts the available orthopaedics junior doctor so that an orthopaedic clinical assessment can be made.
- Harry is given pain relief, his arm is then placed in a sling and he is told that he will be sent an appointment to attend fracture clinic at the WHH within the next 7 days.
- Harry is sent an appointment to attend the fracture clinic at the hospital within the given time frame and is seen by the Consultant Orthopaedic Surgeon, who confirms that no further treatment is required.
- Harry is then discharged from the fracture clinic, given advice and goes home.
- Harry is happy with this as the immediate pain in his arm has subsided and he now has full movement of his left arm.

Source: EKHUFT

Service delivery model today: Elderly frail person

Lucy is an 87 year old female who fits into the 'frail, elderly' category.

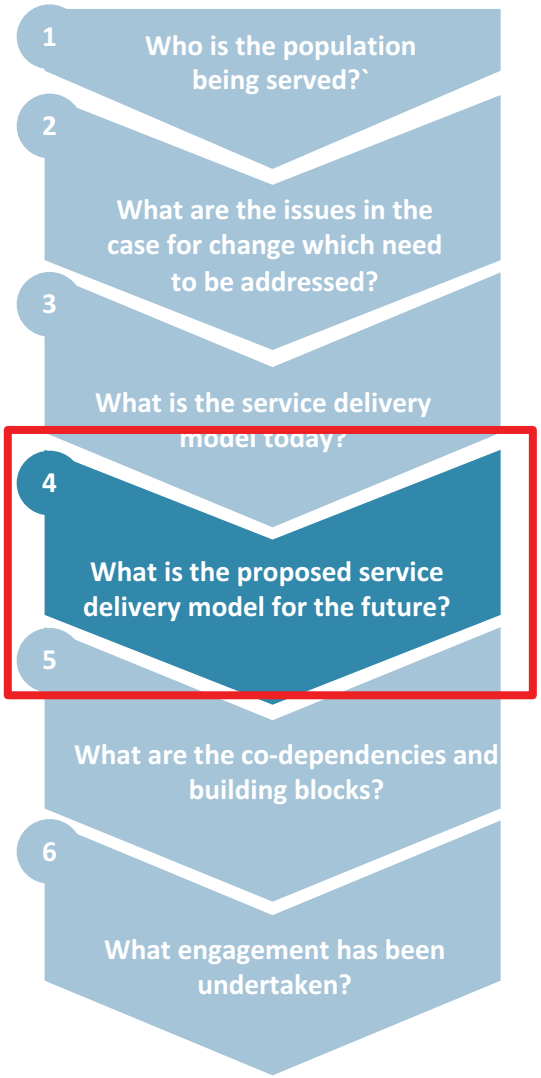
What can happen now:

- Lucy is an 87 year old woman is brought in by ambulance at 16.08. She has become very confused over the last two days and newly incontinent of urine. She had social service care twice daily prior to admission.
- Her observations showed a slightly raised temperature, a pulse rate of 105 and respiratory rate of 25. Her blood pressure was 105/74.
- The ED is very busy and there are no cubicle spaces when she arrives. A nurse practitioner comes to the ambulance to triage her after 12 minutes and identifies a possible urinary tract infection. After 40 minutes she is admitted to a cubicle in ED. A foundation doctor comes to see her after a further 25 minutes and agrees she has sepsis and puts in an intravenous canula, takes blood tests and prescribes antibiotics.
- She is placed on the admission list for the acute/general ward. The nurses are too busy to give the antibiotics immediately and she is taken to the clinical decision unit to make way for a new patient. Her antibiotics are finally given at 20.20 (3 hours beyond the sepsis protocol).
- She has become increasingly confused and difficult to manage. There are no beds for admission identified so she remains in ED until 02.45 when she is transferred to a surgical ward because there are no medical beds.

Source: Medway

Contents

What is the proposed service delivery model for the future?: Summary



- The aspiration in K&M is to transform care and all parts of the patient pathway are being reviewed.
- A range of interventions are being developed to avoid Emergency Department attendances. These include single point of access, care management and discharge planning.
- A new model for ED will incorporate triage to the most appropriate pathway.

The following slides collate an evidence base to support the issue outlined here

Aspirations for care in Kent and Medway (across all services)

It is the aspiration that patients in Kent and Medway:

1. Are supported to self-care where appropriate
2. Have easy access to advice when needed in person and using technology;
3. Can access care through most appropriate pathway
4. Are rapidly triaged to the most appropriate provider
5. Consistently receive care which is in line with best practice
6. Optimise experience and outcomes 7 days a week

Source: K&M Clinical Board, 2017

The local care model for the complex elderly designed a comprehensive care pathway

Supporting people to be healthy and independent

1. Care and support planning with care navigation and case management

Care navigators and case managers integrate health and social care ser[illegible]e delivery, and work much more collaboratively with a wide range of communit[illegible]agues in order to coordinate the care required for their patients

2. Self-care and management

Support people and their carers to improve an[illegible]y building knowledge and changing behaviours thr[illegible]nt

3. Healthy living environment

Work to ensure a health[illegible]being e.g. falls prevention, h[illegible]

Coordinated care for people who need it

4. Integrated health and social care into or coordinated close to the home

Patien[illegible]rapped around GP practices [illegible]ave care plans assigned dependent

5. Single point[illegible]

[illegible], community services and acute staff to support [illegible]g more efficient, coordinated access to services

[illegible] MDT to respond rapidly to complex patients who are experiencing a [illegible]l care need that left unattended would result in a possible hospital admission

A pro-active, anticipatory service designed to target those patients who are medically optimised for discharge, no longer requiring an inpatient bed, but still needing some level of care to prevent their health from deteriorating

Supporting services

[illegible]ess to expert opinion and timely access to diagnostics

The ability for primary care professionals to access a specialist opinion in the community setting and where appropriate, a specialist triage for diagnostics. Access to diagnostic services and the ability to ensure diagnostic results are full and timely will reduce the need for multiple outpatient appointments

The Local Care workstream is developing detailed models of care to avoid emergency admissions to hospital and support rapid discharge.

The focus of this document is triage within the hospital, but the model is part of a broader pathway, discrete elements of which are documented in the appendix

Source: K&M STP Local Care workstream, Carnall Farrar

A consistent service delivery model for ED is proposed

1. Interventions

- 8 key interventions have been developed as part of the Kent and Medway Local Care strategy that are aimed at preventing unnecessary hospital admissions including the integration of health and social care. These are outlined previously in the pack.

2. Referral*

- Patients may be referred to ED by NHS 111, 999 South East Ambulance Service, MDTs, by their GP or by other services.
- Alternatively, patients present at ED without a referral.

- Ambulance responds to 75% 'Category A' calls within 8 minutes and 95% within 19 minutes

3. Registration*

- If patient arrives by ambulance, the ambulance crew reports to staff, otherwise the patient must register themselves at reception.

- 15 min ambulance handovers - Emergency departments and assessment units should review their handover model to ensure it is not creating a bottleneck , guidance is as set out in the NHS Interim and Management Support guidance for improving ambulance handover
- ED must have separate dedicated children's facilities, for waiting and treatment

4. Assessment

- Patients undergo a comprehensive** pre-assessment by a nurse or doctor before further actions are taken. This is called triage and will ensure people with the most serious conditions are seen first. Sometimes further tests need to be arranged before a course of action can be decided.

- No patient waits >12 hours on a trolley
- In line with a rapid assessment and treatment model (RAT) decision to admit <2 hours
- Presence of a senior ED doctor (ST4+) as a clinical decision maker 24/7***
- 7 day access to diagnostic imaging
  Interventional radiology services for highest acuity patients are available within one hour of referral

5a. Treatment or transfer

- Treatment or transfer: If situation is complicated, the patient my be seen by an ED doctor or referred to a specialist unit.

- 24/7 On site senior support within the core specialties
- Presence of a named paediatric consultant with a designated responsibility for paediatric care
- Availability of a surgeon at ST3 level or above, or a trust doctor with equivalent ability Interventional radiology services for highest acuity patients are available within one hour of referral

5b. Discharge*

- Discharge: If nurse or doctor feels situation is not a serious accident or emergency, the patient may be sent home and asked to refer themselves to a GP, referred to a nearby urgent care centre, minor injuries unit or referred to a GP on site.
- Support for self-management and carers support

- Consultant accredited in Emergency Medicine [CCT holder] on the Emergency Floor Consultant between 08:00 and 24:00, 7 days per week
- The provision of written advice if necessary regarding ongoing self-management or carer-supported management

Category A calls relate to immediately life-threatening incidents

*Many places across k&M are introducing a first step based on BHR 'Redirection' where the eyeball 'streaming' takes place by a GP or Consultant who in less than 4 minutes will assess the patient and redirect out to community services, GP's, Pharmacy, Minors/UCC, or hot clinics'. Those that remain go through the comprehensive triage.

**The detail of these aspects of the model is being developed as part of the local care workstream

***Detailed later on

Source: NHS Choices, Urgent and emergency care services in England; NHS England, Ambulance Quality Indicators; NHS IMAS - Rapid Assessment and Treatment Models in Emergency Departments (June 2012); Improving Ambulance Handover – Practical Approaches, Interim Management and Support (2012); Carnall Farrar, clinical standards audit (2016)

Appropriate triage at the front door of the Emergency Department will be a key part of this new model*

Patient presents at Emergency Department

- On arrival, all patients who have not been referred by GP and accepted to the appropriate assessment unit will be sent direct to MIU or the GP led Urgent Care Centre (UCC) (with the exception of agreed conditions)[1]
- One of the most effective ways to manage emergencies is to have senior decision makers at the 'front door' (Nuffield Trust 2017, Shifting the balance of care). The clinical senate agreed this would mean having an ST4 doctor in place 24/7 for assessments. ***Note:*** *this may not be of sufficient seniority for some speciality areas and tasks.*
- All patients that self-present and require medical attention will be seen by an experienced health care professional

Senior decision maker available 24/7

- A health care professional is available to assesses the clinical acuity of patients 24 hours a day on a 7 day basis
- Detailed streaming guidelines will be used identify conditions that will go straight to resuscitation, ED, AMU, SAU, GP or other health and social care services
- Clinical streaming will include a combination of visual assessment, discussion with the patient and recording of initial vital signs.
- The clinician responsible for streaming will always be an experienced health care professional.
- There should be access for ED clinical staff to the summary care record.

Patients are referred to the correct health care practitioner with the appropriate range of skills required for their care

- Patients are seen in the correct stream within the UCC, or referred to another service to be seen by the most appropriate health care professional as required.

Note: some emergency pathways will require different triage, even pre-hospital, such as acute stroke, acute short term elevation MI, and major trauma, particularly if that hospital does not provide those acute services

[1] Exceptions are those with a GP referral that has been accepted by the clinician in charge and those being transferred for agreed specialist opinion.
*The detail of these aspects of the model is being developed as part of the local care workstream
Source: EKHUFT

The new model will follow the rapid assessment and treatment (RAT) model

- The aim of rapid assessment and treatment is to provide early senior assessment of undifferentiated 'majors' patients.
- The model has been implemented by a number of EDs, with considerable benefits to patient safety and satisfaction.
- The model also provides a means by which EDs can achieve 'time to assessment' and 'time to treatment' indicators.

Designing a rapid assessment and treatment model

1. Standards

An essential component of all models is 'internal professional standards' that define the times within which various interventions take place. Existing examples include:

- Arrival to RAT: <15 minutes
- RAT to decision to admit: < 2 hours
- Completion of imaging requests: < 1 hours

By setting and measuring such standards, bottlenecks can be identified and performance requirements clearly understood

2. Workforce

- RAT teams typically consist of a senior doctor (a consultant or a senior middle grade); a junior doctor; a qualified nurse; an Health Care Assistant (HCA) and sometimes a dedicated porter and clerical staff.
- In order to function effectively, RAT models depend on team-work and clear communication.

3. Equipment and tools

- The RAT team should be resourced with all necessary equipment (e.g. ECG machines) to help inform clinical decision-making and risk-management.
- Following assessment and initiation of treatment, patients are typically transferred to the care of the 'majors' team in the department. Hand-over using a Situation Background Assessment Recommendation (SBAR) or similar tools is important.

4. Infection control

- It is essential for any model to consider infection control (e.g. diarrhoea, MRSA, neutropenic sepsis) as these patients may need to by-pass RAT but still need immediate assessment

Source: NHS IMAS - Rapid Assessment and Treatment Models in Emergency Departments (June 2012)

The following steps will be used to develop a rapid assessment and treatment (RAT) model

1. Assemble a multidisciplinary team to design your local model of rapid assessment – including non-clinical support staff – and communicate your plans and intentions.
2. Use a "model for improvement" e.g. Plan, Do, Study, Act (PDSA) to test out your ideas and plans
3. Design rotas to avoid clinician exhaustion
4. Introduce a standard clerking proforma and documentation to support your model
5. Measure time to treatment and other metrics before and after implementation
6. Project-manage the implementation of your local model
7. Ensure rapid access to diagnostics
8. Allocate dedicated equipment to the RAT team
9. Design a system that can flex to demand
10. Introduce internal professional standards for response time to support speedy referral
11. Consider implementing rapid assessment into assessment units

Typically, RAT has three potential outcomes:

1. An intervention completely contained within the emergency department, with discharge home/to GP or follow up (including ambulatory emergency care).
2. Referral to an in-taking speciality for admission, with or without initial investigations.
3. Transfer to an alternative provider, service or facility.

implementation can be difficult, particularly in departments that have resource issues. Senior clinicians who lead RAT teams can find the intensity of work a challenge. Poor flow out of the ED can also present a challenge – rapidly assessing a patient to require admission can be frustrating if no bed is available.

Source: NHS IMAS - Rapid Assessment and Treatment Models in Emergency Departments (June 2012)

Consultant-liaison teams should be present in ED to allow rapid decisions about discharge or transfer for those patients presenting with mental health problems

- Mental health problems are the presenting feature in 5% of all emergency department attendances
- The Royal College of Psychiatrists London recommends that:
  - Emergency departments and acute medical and surgical units would benefit from a minimum of a 7-day, 12-hour-a-day on-site psychiatric service (with on call access for the other 12 hours)
  - Referrals from emergency departments or acute medical and surgical units will benefit from a response time of 1h where mental health assessment is needed for decisions about discharge or transfer from the unit
  - Consultant - liaison teams should cover Accident and Emergency and Medical Assessment Units to influence admissions to hospital when some older people with mental disorder might be better managed by diversion to an alternative service
- The UK Mental Health triage scale should be used to guide clinical decision-making in triage psychiatric screening assessments
- The London Mental Health Crisis Care Programme has defined an intoxication pathway as there is a need to clarify the different levels of intoxication and at what point individuals are transferred to an Emergency Department vs a Health Based Place of Safety. The term 'incapable' is being used as the trigger to send the individual to ED, case studies are being developed to assist with this decision making

UK Mental Health Triage Scale

Triage Code /description	Response type/ time to face-to-face contact	Typical presentations	Mental health service action/response	Additional actions to be considered
A Emergency	IMMEDIATE REFERRAL Emergency service response	Current actions endangering self or others Overdose / suicide attempt / violent aggression Possession of a weapon	**Triage clinician to notify ambulance, police and/or fire service**	Keeping caller on line until emergency services arrive / inform others Telephone Suppot.
B Very high risk of imminent harm to self or to others	WITHIN 4 HOURS Very urgent mental health response	Acute suicidal ideation or risk of harm to others with clear plan or means Ongoing history of self harm or aggression with intent Very high risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control Urgent assessment under Mental Health Act Initial service response to A & E and 'front of hospital' ward areas	**Crisis Team/Liaison/ face-to-face assessment AND/OR Triage clinician advice to attend a hospital A&E department** (where the person requires medical assessment/ treatment)	Recruit additional support and collate relevant information Telephone Suppot. Point of contact if situation changes
C High risk of harm to self or others and/or high distress, especially in absence of capable supports	WITHIN 24 HOURS Urgent mental health response	Suicidal ideation with no plan or ongoing history of suicidal ideas with possible intent Rapidly increasing symptoms of psychosis and / or severe mood disorder High risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control Overt / unprovoked aggression in care home or hospital ward setting Wandering at night (community) Vulnerable isolation or abuse	**Crisis Team/Liaison/ Community Mental Health Team (CMHT) face-to-face assessment**	Contact same day with a view to following day review in some cases Obtain and collate additional relevant information Point of contact if situation changes Telephone suppor; and advice to manage wait period
D Moderate risk of harm and/or significant distress	WITHIN 72 HOURS Semi-urgent mental health response	Significant patient / carer distress associated with severe mental illness (but not suicidal) Absent insight /early symptoms of psychosis Resistive aggression / obstructed care delivery Wandering (hospital) or during the day (community) Isolation / failing carer or known situation requiring priority intervention or assessment	**Liaison/CMHT face-to-face assessment**	Telephone suppor; and advice Secondary consultation to manage wait period Point of contact if situation changes

An exert from the UK Mental Health triage scale

SOURCE: Royal College of Psychiatrists & British Association for Accident and Emergency Medicine, 2004);https://ukmentalhealthtriagescale.org; Who cares wins: improving the outcome for older people admitted to the general hospital, Royal College of Psychiatrists(2005); Mental Health Crisis Care, Programme Update: Clinical Senate Council (May 2016)

Future service delivery model: Fracture management service, ED minors

Harry is 19 years of age and is a student studying in Ashford. Harry enjoys sports and whilst playing football he sustained a fall, resulting in pain in his left arm. Harry attends the minor injuries unit (MIU) at the WHH.

What will happen in future:

- When Harry arrives at the MIU reception desk with a suspected bone injury, Harry is asked to go to the fracture clinic and is seen by the duty doctor who is part of the consultant led trauma management team that day.
- Harry is sent for an X-ray to confirm the diagnosis and is given pain relief, his arm is then placed in a sling.
- Harry is then told that his X-ray and his medical records will be reviewed by the consultant T&O surgeon (assessed virtually) within 24 hours and will be contacted via phone to advise him on his treatment plan.
- The next day Harry is contacted by the Nurse who is supporting the virtual clinic and informs Harry that he has been clinically assessed virtually by the consultant orthopaedic surgeon and that he does not need to attend a follow up (face to face) fracture clinic.
- The nurse gives Harry advice on future management of his injury and a contact no if he is concerned.
- Harry is discharged and no further treatment is given.

Source: EKHUFT

Future service delivery model: Elderly frail person

Lucy is an 87 year old female who fits into the 'frail, elderly' category.

What will happen in future:

- The patient is assessed at home and identified as requiring medical intervention for a probable infection. A call to the Acute Medical Unit means she is accepted for direct admission to the unit from an ambulance car.
- She is seen within 20 minutes of arrival and all tests are performed. She starts her IV antibiotics within one hour and is admitted to the short stay admissions ward with a plan for discharge the following afternoon (24 hours). Her confusion resolves overnight as the antibiotics work (urinary tract infection).
- The following morning the frailty team assess her needs and call social services to restart her social care package. Transport is booked and her next of kin informed of the plan. Transport arrives and take the patient home at 17.30.

Source: Medway

Evidence base (1/2)

	Case study	Source/Publication	Date	Key Points
1	Urgent and Emergency Care review end of phase 1	Transforming urgent and emergency care services in England	November 2013	• Better self care • Right advice for Urgent Care • Highly responsive urgent care outside of hospital • Specialised emergency departments with the right facilities and expertise • Connecting all urgent and emergency services
2	Safer, faster, better; good practice in delivering urgent and emergency care	Transforming urgent and emergency care services in England	August 2015	• Demand management • Increasing community services • Ambulatory care • Acute medical assessment streaming • Frailty assessment • Integration with community and social services
3	The way ahead	Emergency Medicine Operational handbook	December 2011	• Workforce recommendations • Describes best clinical practice
4	Integrated care – taking specialist medical care beyond the hospital walls	A report to the Royal College of Physicians Future Hospital Programme	Feb 2016	• Improve patient care and experience through improved coordination

Evidence base (2/2)

	Case study	Source/Publication	Date	Key Points
5	Liaison psychiatry for every acute hospital	Royal College of Psychiatrists	December 2013	• Mental health problems occur in 5% of all emergency department attendances • Dementia in older adults and mental health problems associated with long-term physical conditions and medically unexplained symptoms in working-age adults account for disproportionate costs related to mental health needs in acute hospitals
6	Improving the outcome for older people admitted to the general hospital	Royal College of Psychiatrists	2005	• Service models for patients with dementia

Contents

What are the co-dependencies and building blocks?: Summary

1. Who is the population being served?`
2. What are the issues in the case for change which need to be addressed?
3. What is the service delivery model today?
4. What is the proposed service delivery model for the future?
5. **What are the co-dependencies and building blocks?**
6. What engagement has been undertaken?

- The models in the Keogh report have been used as a basis for developing building blocks of services.
- The South East Clinical Senate has undertaken work to understand the co-dependencies between services and these have been used to further describe the Keogh models.
- The models are Major Emergency Centre with specialist services, Emergency Centre, Emergency Medical Centre and Urgent Care Centre.

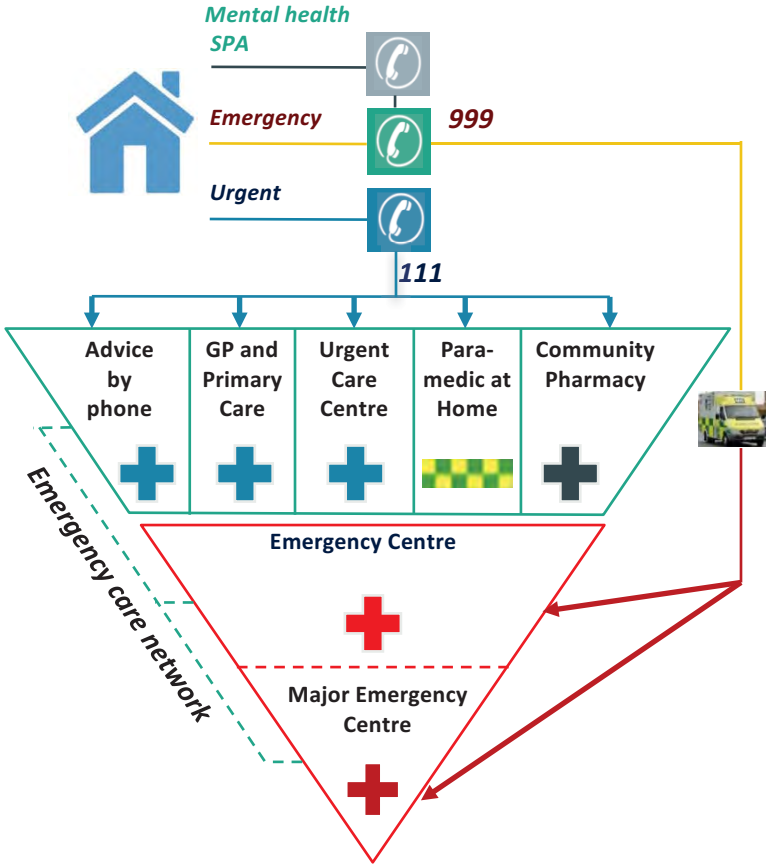
The following slides collate an evidence base to support the issue outlined here

Summary of building blocks of services

- The South East clinical senate has developed a list of co-dependencies between different services for urgent care
- The Keogh models have been used extensively locally to review and agree potential interdependencies
- Carnall Farrar have worked across a number of different health economies to define interdependencies and delivery models
- These three pieces of work have been used to develop proposed building blocks of services:
    1. Major emergency centre (with specialist services)
    2. Emergency centre
    3. Medical emergency centre
- These building blocks can be co-located or can be located on separate sites. The hurdle and evaluation criteria are used to determine how many of each are required and where they might be located.

The Keogh work in 2014 proposed a network of urgent care

- Major Emergency Centres (MECs) have a concentration of specialist expertise and services which are likely to fall within the remit of specialist commissioning. They provide support and coordination to a whole network for patients with specialist emergency care needs, and work in partnership with the other system components to ensure that patients are able to access specialist care in a timely way.
- An MEC includes specialist facilities that receive patients from Emergency Centres, or directly from an ambulance which has bypassed an Emergency Centre. Such facilities should include two or more specialist services such as major trauma, heart attack, critical care or stroke
- Emergency Departments that are integral to MECs will provide consultant presence over extended hours, immediate access to enhanced diagnostics, such as CT and MRI scanning and interventional radiology, and a wider range of facilities, as a result of the increased capabilities of the hospital in which they are located.



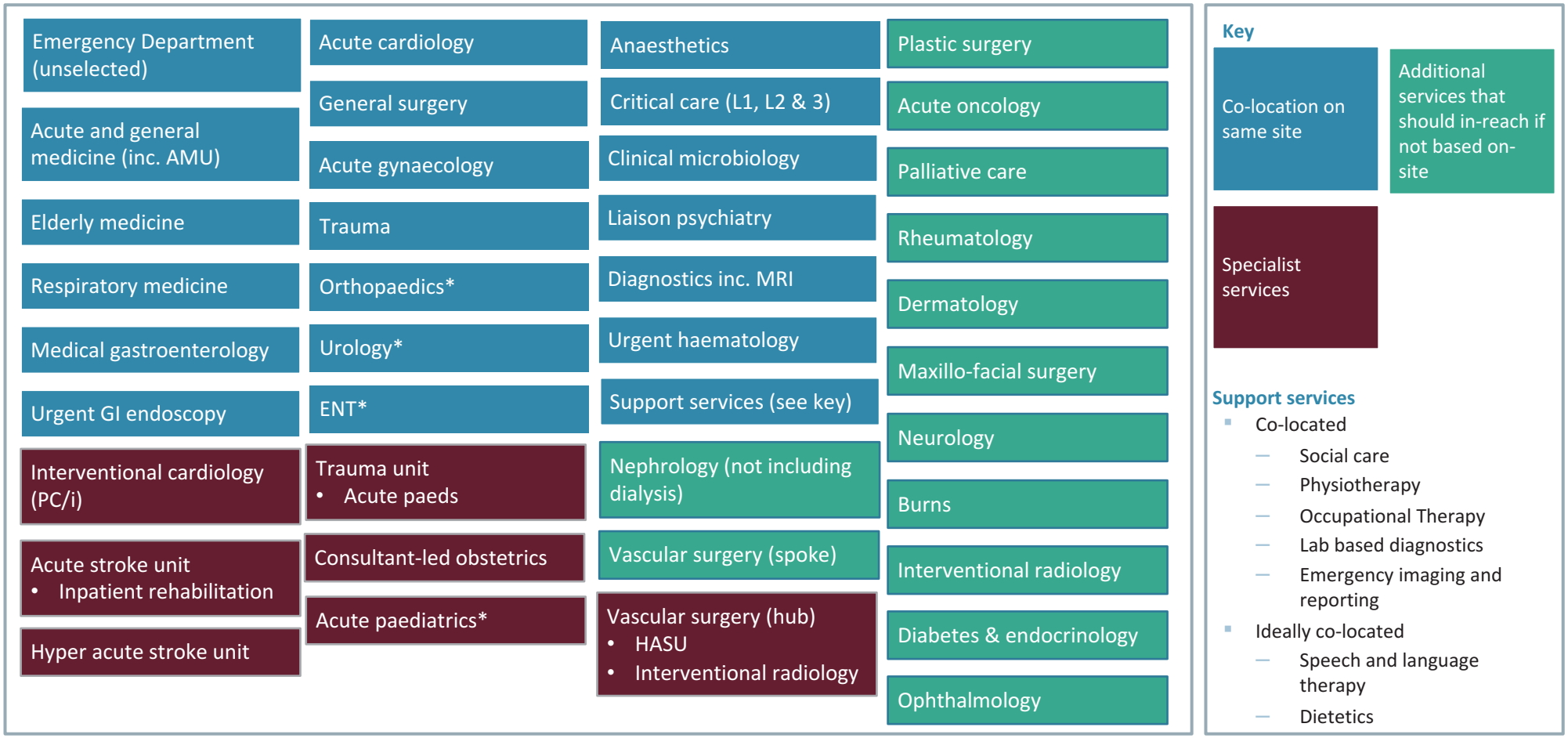
Source: Sir Bruce Keogh, Transforming Urgent and Emergency care services in England, End of Phase 1 Report, 2014

From the Keogh work, six different types of centres are proposed

	What	Services offered
Major trauma centre	▪ Specialised centres co-locating tertiary/complex services on a 24x7 basis ▪ Serving population of at least 2 -3million	▪ Neurosurgery, Cardiothoracic surgery ▪ Full range of emergency surgery and acute medicine ▪ Full range of support services, ITU etc
Major Emergency Centre with specialist services	▪ Larger units, capable of assessing and initiating treatment for all patients and providing a range of specialist hyper-acute services ▪ Serving population of ~ 1-1.5m	▪ Hyperacute cardiac, stroke , vascular services ▪ Trauma unit ▪ Level 3 ICU ▪ Moving towards 24x7 consultant delivered ED, emergency surgery, acute medicine, inpatient paeds ▪ Full obstetrics and level 3 NICU
Emergency Centre	▪ Larger units, capable of assessing and initiating treatment for the overwhelming majority of patients but without all hyper-acute services ▪ Serving population of ~ 500-700K	▪ Moving towards 24x7 consultant delivered ED, emergency surgery, acute medicine ▪ Level 3 ICU ▪ Inpatient Paeds and obstetrics with level 2/3 NICU
Medical Emergency Centre	▪ Assessing and initiating treatment for majority of patients ▪ Acute medical inpatient care with intensive care/HDU back up ▪ Serving population of ~ 250-300K	▪ Consultant led ED ▪ Acute medicine and critical care/HDU ▪ Access to surgical opinion via network ▪ Possibly paeds assessment unit and possibly midwife-led obstetrics
Integrated care hub with emergency care	▪ Assessing and initiating treatment for large proportion of patients ▪ Integrated outpatient, primary, community and social care hub ▪ Serving population of ~ 100-250K	▪ GP-led urgent care incorporating out of hours GP services ▪ Step up/step down beds possibly with 48 hour assessment unit ▪ Outpatients and diagnostics ▪ Possibly midwife-led obstetrics
Urgent care centre	▪ Immediate urgent care ▪ Integrated outpatient, primary, community and social care hub ▪ Serving population of ~ 50-100K	▪ As above but no beds

Source: Sir Bruce Keogh, Transforming Urgent and Emergency care services in England, End of Phase 1 Report, 2014

1. Major emergency centre (with specialist services)

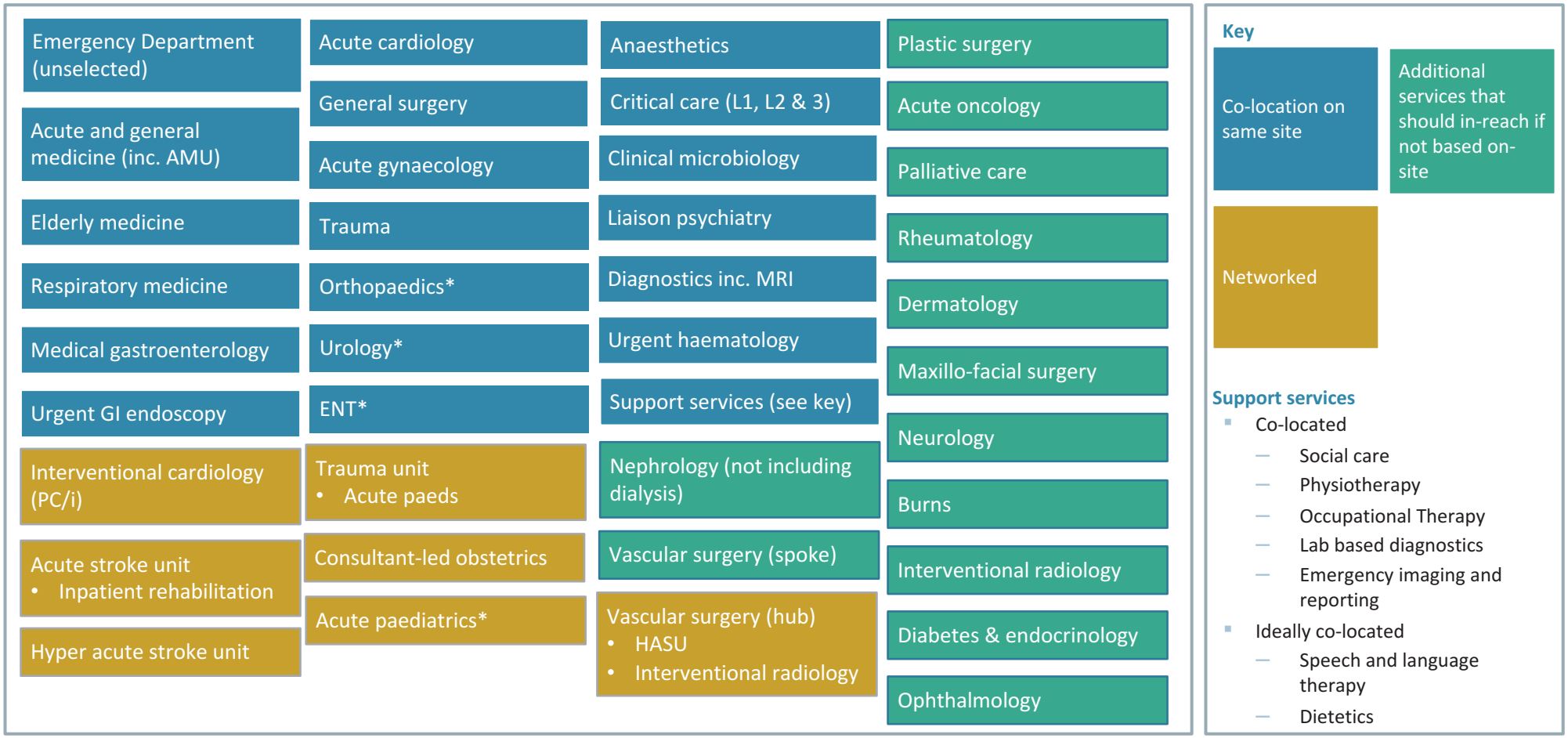


Source: [The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review December 2014], Carnall Farrar analysis

- In-reach may be sufficient depending on ED pathways (required for a trauma unit)

*Non-specialised paediatrics and paediatric surgery

2. Emergency centre

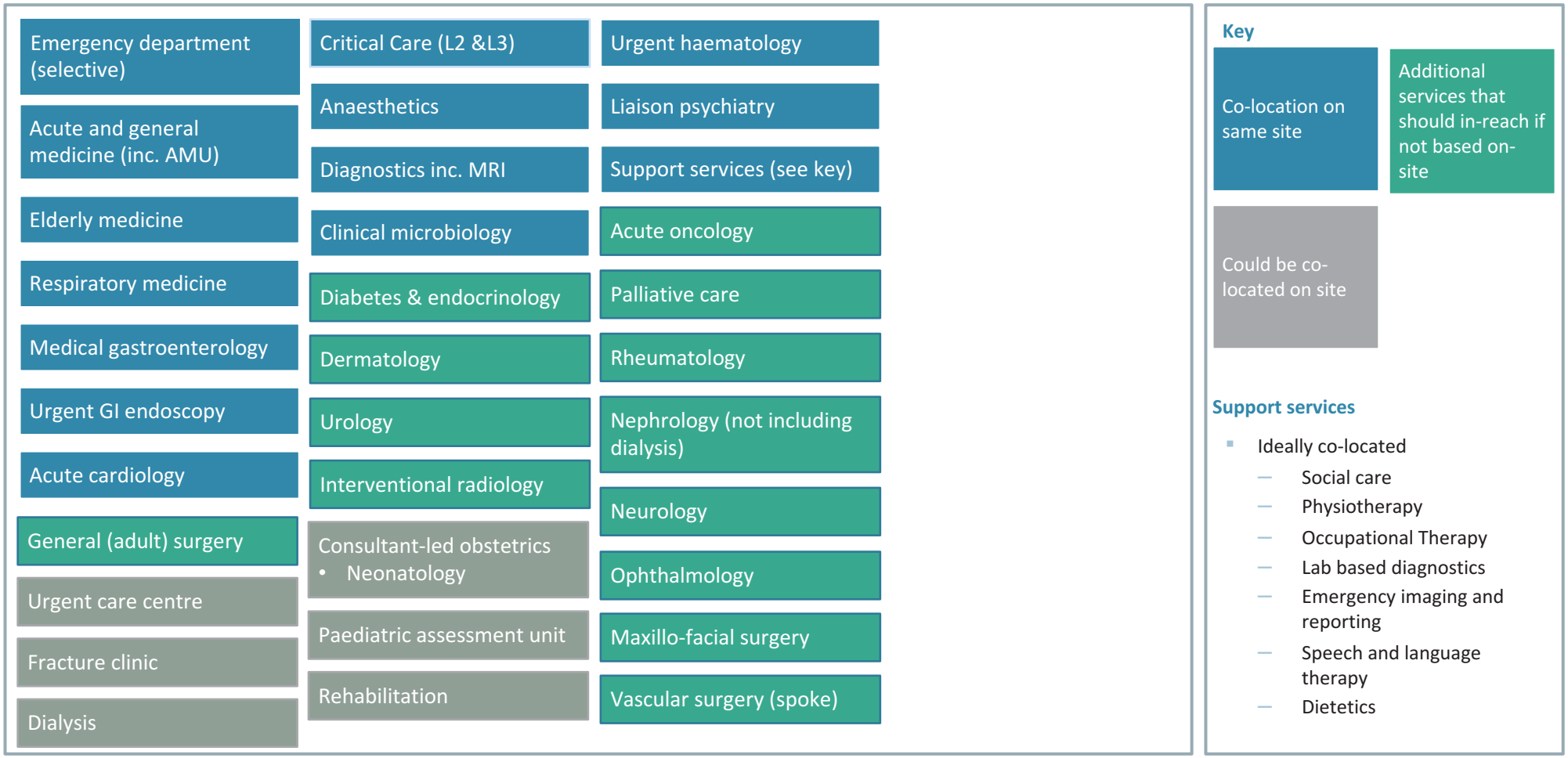


Source: [The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review December 2014], Carnall Farrar analysis

- In-reach may be sufficient depending on ED pathways (required for a trauma unit)

*Non-specialised paediatrics and paediatric surgery

3. Medical emergency centre



Source: [The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review December 2014], Carnall Farrar analysis

There are critical interdependencies for these building blocks

The work carried out by the south east coast clinical senate will govern co-dependencies when considering options for future acute service change

- It is proposed that the co-dependencies work carried out by the South East Coast Clinical Senate will be used to assess any impact of future acute services change
- The work undertaken by the SECCS provides generic advice about what services needed to be provided in the same hospital (either based there, or inreaching), and what could be provided on a networked basis
- The dependencies of eleven major acute hospital services were reviewed and the dependencies on a wide range of acute hospital based services assessed

CO-DEPENDENCIES DEFINITIONS: COLOUR KEY	
The colour describes the dependency of the service in the row, on the support service in the column. Note that both the Purple and Red dependencies describe column services that should not require the patient to move hospitals	
PURPLE	
Service should be co-located (based) in same hospital	
RED	
Service should come to patient (patient transfer not appropriate), but could be provided by visiting/inreach from another site (either physically, or via telemedicine links) if not based in the same hospital	
2	Within 2 hours
4	Within 4 hours
24	Within 24 hours
	Not specified
AMBER	
Ideally on same site but could alternatively be networked via robust emergency and elective referral and transfer protocols	
GREEN	
Does not need to be on same site. Appropriate arrangements are in place to obtain specialist opinion or care	

This resulted in a grid for identifying core groupings of services and the requirements for co-dependent service provision, as described in the rating scale

Source: South East Coast Clinical Senate (2014) The Clinical Co-Dependencies of Acute Hospital Services – A Clinical Senate Review

These interdependencies are outlined below

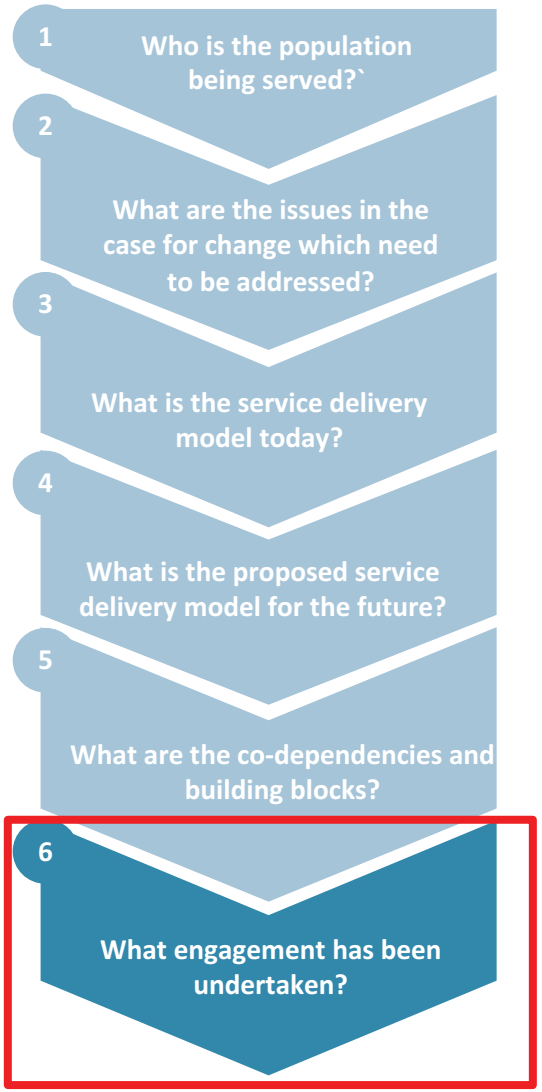
COLUMN TITLES: Clinical specialties and functions supporting the 11 major acute services in the rows

	ROW TITLES: The 11 major acute services whose dependencies on the specialties and functions in the columns is being described.	A&E /Emergency Medicine	Acute and General Medicine	Elderly Medicine	Respiratory Medicine (including bronchoscopy)	Medical Gastroenterology	Urgent GI Endoscopy (upper & lower)	Diabetes and Endocrinology	Rheumatology	Ophthalmology	Dermatology	Gynaecology	General Surgery (upper GI and lower GI)	Trauma	Orthopaedics	Urology	ENT	Maxillo-facial Surgery	Hub Vascular Surgery	Spoke Vascular Surgery	Neurosurgery	Plastic Surgery	Burns	Critical Care (adult)	Critical Care (paediatric)	General Anaesthetics	Acute Cardiology	Thoracic Surgery	Cardiac Surgery	Hyper-acute Stroke Unit	Acute Stroke Unit	Nephrology (not including dialysis)	Inpatient Dialysis	Acute Oncology	Palliative Care	Neurology	Acute Paediatrics (non-specialised paediatrics and paediatric surgery)	Neonatology	X-ray and Diagnostic Ultrasound	CT Scan	MRI Scan	Cardiac MRI	Nuclear Medicine	Interventional Radiology (including neuro-IR)	Clinical Microbiology/ Infection Service	Laboratory microbiology	Urgent Diagnostic Haematology and Biochemistry	Acute Inpatient Rehabilitation	Occupational Therapy	Physiotherapy	Speech and Language	Dietetics	Acute Mental Health Services
1	A&E (Emergency Medicine). Acute unselected take (including acute surgical patients)	X					2									2	2																																				
2	Acute Medical Take		X				2	24	24		24		4			12																		24		24																	
3	Acute (Adult) Surgical Take												X														4								24									4	4								4
4	Adult Critical Care (Intensive Care)											24	2	2		24	2							X											4									2	2								
5A	Major Trauma Centre																																																				4
5B	Trauma Unit																																											4									4
6A	Vascular Surgery (Hub)																		X																																		
6B	Vascular Surgery (spoke)																			X																																	
7A	Cardiology: Non-interventional																															24																					4
7B	Cardiology: Interventional - primary PCI for STEMI																															24																					4
7C	Cardiology: Interventional - PCI (non-STEMI) and devices																															24																					4
7D	Cardiology: Interventional - structural heart disease (including TAVI, MitraClips)																												4			24																					4
7E	Cardiac Surgery																																																				4
8A	Hyper-Acute Stroke Unit																													X		24																					
8B	Acute Stroke Unit						4																								X	24																					
9	Renal Services inpatient Hub					24		24	24		24					24																X		24	24	24																	4
10	Consultant led Obstetric Services		4		4	4		4				2	2			2				2		24					4					4				4								4	4					24			4
11	Acute (non-specialised) Paediatrics and Paediatric surgery																																				X								4								

Source: South East Coast Clinical Senate (2014) The Clinical Co-Dependencies of Acute Hospital Services – A Clinical Senate Review

Contents

What engagement has been undertaken?: Summary



- Over the last 2 years EKHUFT has engaged with key stakeholders internally and externally through a series of EKHUFT and East Kent Strategy Board events.
- West Kent have not carried out engagement to date

The following slides collate an evidence base to support the issue outlined here

Engagement to date

Over the last 2 years EKHUFT has engaged with key stakeholders internally and externally.

- Engagement commenced in 2014 with attendance at individual CCG groups so ideas could be exchanged between EKHFT clinicians and GPs around emerging issues and solutions
- Representatives of the executive team with relevant clinicians have met regularly with each CCG team to share any emerging thinking and gain feedback
- The EKHUFT case for change has been shared with GP members of CCGs and their responses incorporated

Key engagement events have been tabled on the next slides.

General engagement events to date (1/3)

Date	Type of engagement	Stakeholder group engaged	Description
January 2015 – current date	• Strategic meetings	Divisional and Medical Directors and heads of Nursing	• To keep them informed and gain feedback on every component of the strategy programme and latterly the STP
January 2015 – current date	• Open staff forums	All staff	• To keep them informed and gain feedback on every component of the strategy programme and latterly the STP
January 2015 – current date	• Staff forums for administration staff	All administration staff	• To keep them informed and gain feedback on every component of the strategy programme and latterly the STP
Spring 2015	• Focus Groups facilitated by Health Watch – 7 events in Thanet, Herne Bay, Canterbury, Ashford, New Romney and Folkestone and Tenterden. • Information shared in school book bags and at universities and train stations. Feedback forms given out and returned	Public. Over 1000 people contributed their thoughts some representing organisations	• To share the case for change
July 2015; Sept 2015; Dec 2015; July 2016; Nov 2016	• Clinical Forums for between 100 and 209 consultants and GPS at each event	Trust Consultants GPs CCG representatives	• To bring together the attendees to discuss the way forward in achieving an acute health system that is clinically and financially sustainable
January 2016	• Individual meetings with clinical leads • Sessions at the Quality and Innovation Hubs on al 5 EKHUFT sites	Consultants All staff	• To get feedback from staff about the evaluation criteria for option development

General engagement events to date (2/3)

Date	Type of engagement	Stakeholder group engaged	Description
Jan – Dec 2016	• Clinical engagement working groups	Consultants , GPs, nurses & AHP	• Clinical engagement in developing improvements in clinical pathways and promoting integration
4th February 2016	• EKSB engagement event • East Kent Clinical Forum • Monthly meetings	All health and social care organisations medical directors and clinical chairs	• Clinical input and approval of work done so far; discuss and develop the service area across east Kent
March 2016	• 3 day strategic event to identified innovative ways of working nationally and internationally, gain feedback and commitment to develop new pathways and ways of working	Divisional Clinical and management teams	• Identify new ways of working
7th April 2016	• EKSB engagement event • East Kent Patient & Public Engagement Group (PPEG) • Monthly meetings	Public and representatives of individual groups	• Share Care for Change and gain feedback
April – June 2016	• EK STP Task and Finish groups to identify current practice and issues and identify solutions for future clinical pathway planning across the health economy	EKHUFT Consultants and clinicians, GPs and CCG leads	• Design patient pathways for emergency care, planned care, Long term conditions (including frailty), paediatrics and maternity
April to June 2016	• EKSB engagement event • 6 Task & Finish Groups: 1. LTC & Frailty: 4 sessions 2. Planned and Specialist Care: 3 sessions 3. Maternity: 3 sessions 4. paediatrics: 4 sessions 5. Emergency & Urgent Care: 4 sessions 6. Mental Health: 2 sessions	Acute Care Consultants, Primary Care, Social Care and Community Health representatives	• Work stream sessions to build a shared vision for service areas in east Kent as well as share good practice from other areas

East Kent Strategy Board engagement to date (3/3)

Date	Type of engagement	Stakeholder group engaged	Description
July 2016	• EKSB engagement event • 4 Final Workshops for all Task & Finish groups: 1. LTC & Frailty 2. Planned and Specialist Care 3. Maternity & paediatrics 4. Mental Health	Acute Care Consultants, Primary Care, Social Care and Community Health representatives	• Share information about work done so far; discuss and refine the case for change and start to describe ambition for the service area across east Kent
27th July 2016	• EKSB engagement event • Presentation session	To all council leaders and Chief Executives	• To discuss the progress so far and future plans across east Kent
10th September 2015 – current date	• EKSB engagement event • Monthly meetings	All organisation CEO's, medical directors, accountable officers and clinical chairs (including KCC and NHSE)	• Develop strategy for the services area across east Kent
5th Sept 2016	• EKSB engagement event • Evaluation Criteria half day workshop	All organisation CEO's, medical directors, accountable officers and clinical chairs (including KCC and NHSE)	• To discuss the proposed evaluation criteria and evaluation process
15th Sept 2016	• EKSB engagement event • Discussion with MP • London based meeting		
Autumn 2016	• EKSB engagement event • 6 Focus groups facilitated by EKSB and supported by 'Curved Thinking'	Members of the Public and public groups	• To share the case for change

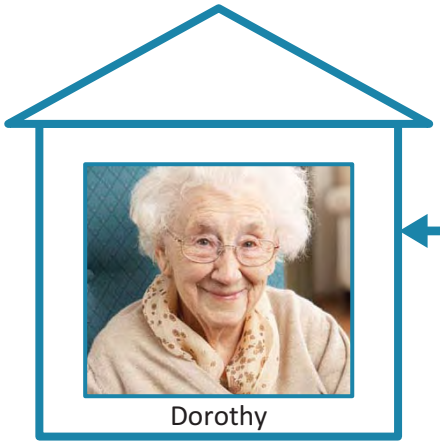
Contents

Appendix

The K&M older persons complex care model will provide personalised, coordinated care and a single point of access (1/2)

Supporting people to be healthy and independent

Self-care and self management	Ensuring healthy living environment	Care and support planning	Case Management & Care Navigation



Dorothy

Dorothy is 79, frail, has type 2 diabetes, COPD, cognitive impairment and depression

Single point of access call handling function

Proactive and continuing coordinated care for people who need it

Pharmacist

GP +/-special interest

Peer supporter

Care navigator/ case manager

Health and social care worker

Community nurse

Specialist geriatric care

MDT Extensivist function

MDT care functions

Reablement

Integrated health and social care package delivery

Discharge support

Rapid response

Health coaching

Housing support

End of life

Care planning

Episodic specialised inpatient care

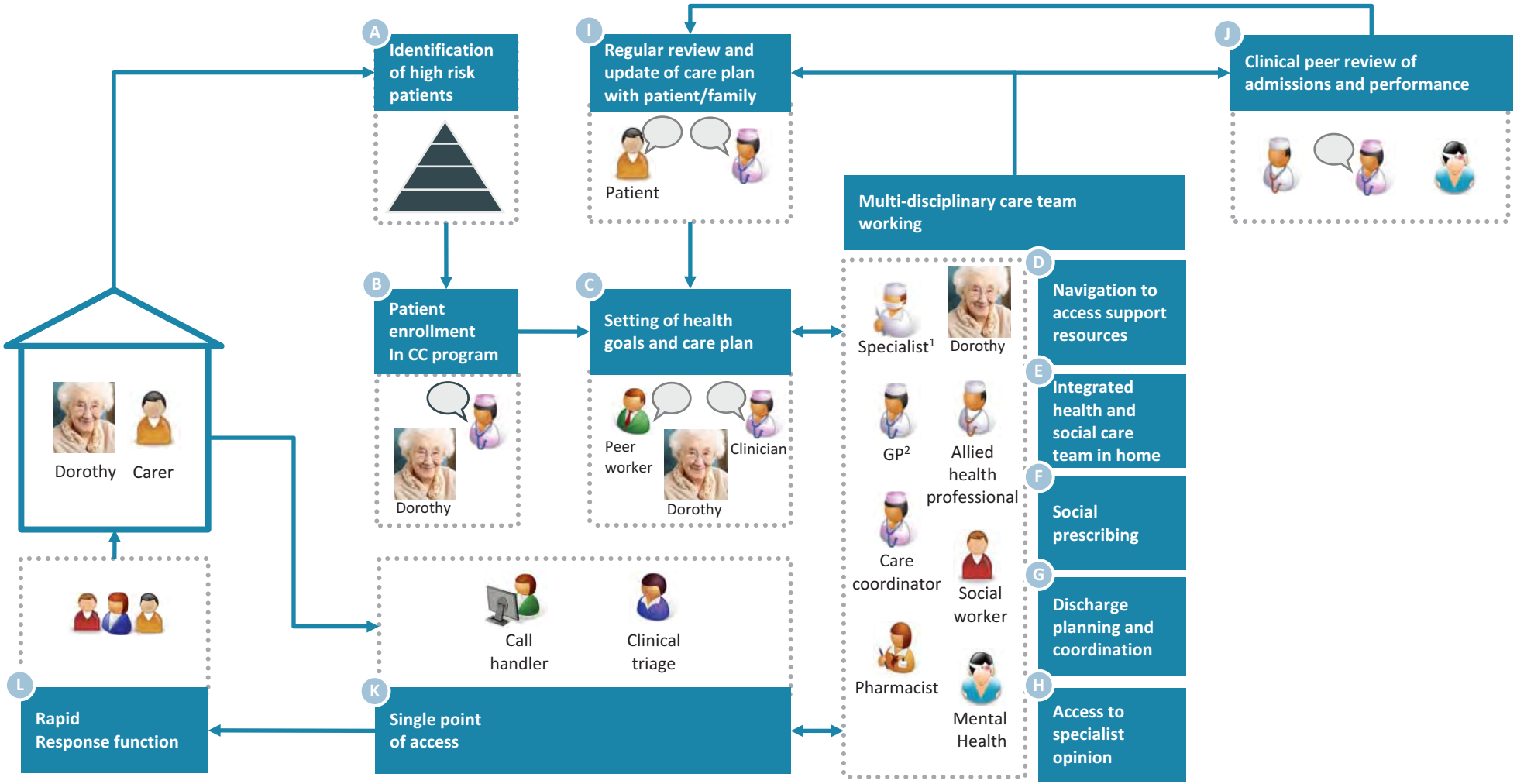
Emergency admission requiring hospital treatment

Supporting services

Diagnostics	Specialist opinion	Falls service	Housing services	Third sector

Source: K&M STP Local Care

The K&M older persons complex care model will provide personalised, coordinated care and a single point of access (2/2)



1 Specialists in both inpatient or outpatient settings 2 Includes primary care physicians, advanced practice nurses, physicians assistants
Source: Carnall Farrar

Acute medical care

Service delivery model

28 February 2017
Updated 13 June 2017

Introduction and purpose of service delivery model template

- A number of services have been prioritised as for early consideration by the K&M hospital care working group. This pack forms one of a series service delivery model templates for the priority services.
- The aim of this pack is to consider the key issues the service is facing within the hospital context, its current in-hospital model of care and aspirational future model among other relevant context.
- The pack follows the structure of:
  - A summary slide outlining key information from each section; then
  - Each section, with a summary slide up front followed by evidence slides
- The pack has been created with expert input from across Kent & Medway, and has been developed by the K&M Hospital care workstream before being signed off by the Clinical Board.
- The Acute medical care template focuses on the model for acute medicine in the acute hospital with future medical models using the assumptions made by local care about preventing acute hospital admission and facilitating appropriate timely discharge.

This document has been updated to incorporate feedback from the SE Clinical Senate

Comment classification	Comment	Next steps
Can be incorporated into model easily	• This was presented as a service delivery model for 'acute medical care'. The scope was not defined. What is included needs to be described	• Comment incorporated, no next steps
	• 'HOT' clinics are well described for COPD, but such clinics should be available for a wider range of specialties	• Comment incorporated, no next steps
	• If one of the intentions of the new model is to reduce admissions and reduce LoS, it would be useful to describe this ambition with the impact on bed numbers	• Comment incorporated, no next steps
	• The actual proposed local model of care for patients with dementia wasn't described further	• Comment incorporated, no next steps
	• The model needs to the 24/7 liaison psychiatry service	• Comment incorporated, no next steps
	• Seamless care between the community and hospital for patients should be a stated aim	• Comment incorporated, no next steps
	• There should be reference to ways in which patient self-management would be supported	• Comment incorporated, no next steps
Requires further work pre-PCBC	• It was not clear how acute care model fits in with the local care for the complex elderly and the ED model	• CF to draft and incorporate pathway
	• The involvement of and impact on the clinical services supporting acute medicine was not described.	• Task and finish group to discuss *
	• There should be more mention of pathways to enable more ambulatory (non-admitted) care	• Task and finish group to discuss *
	• Is there a SPoA for acute medicine? Who takes the calls/referrals?	• Task and finish group to discuss *
	• The need for and plans for electronic information sharing systems between the community and hospitals should be described	• IT group to develop response
	• Shortages in other key professions related to acute medical care (nurses and several of the allied health professions) should be acknowledged, and realistic models take this into account	• Workforce stream developing response
	• Review the risk that the increase in requirements for therapists in the community will deprive acute hospitals of these staff	• Workforce stream developing response
	• New models could specify roles of senior health care professionals that could fulfil medical duties	• Workforce stream developing response
Requires further work post-PCBC	• The ECIST from NHS Improvement have produced guidance that 'highlights a cluster of good practice tactics' – this should be reviewed and added	• To develop further as part of model implementation
	• The model could extend to medical inpatient standards and processes, such as the SAFER Patient Flow Bundle	• To develop further as part of model implementation
	• Reference should be made to the ECIST guidance on whole system priorities for the discharge of frail older people from hospital care	• To develop further as part of model implementation

***It is proposed that a 'task and finish group' comprised of 3-4 senior clinicians from across the trusts is convened to develop the models further with respect to these comments. It is proposed that they meet 1-2 times between June-July 2017**

The STP outlined the aspiration for Hospital Care model which prevents ill health, intervenes earlier and delivers excellent, integrated care closer to home

Care Transformation workstreams

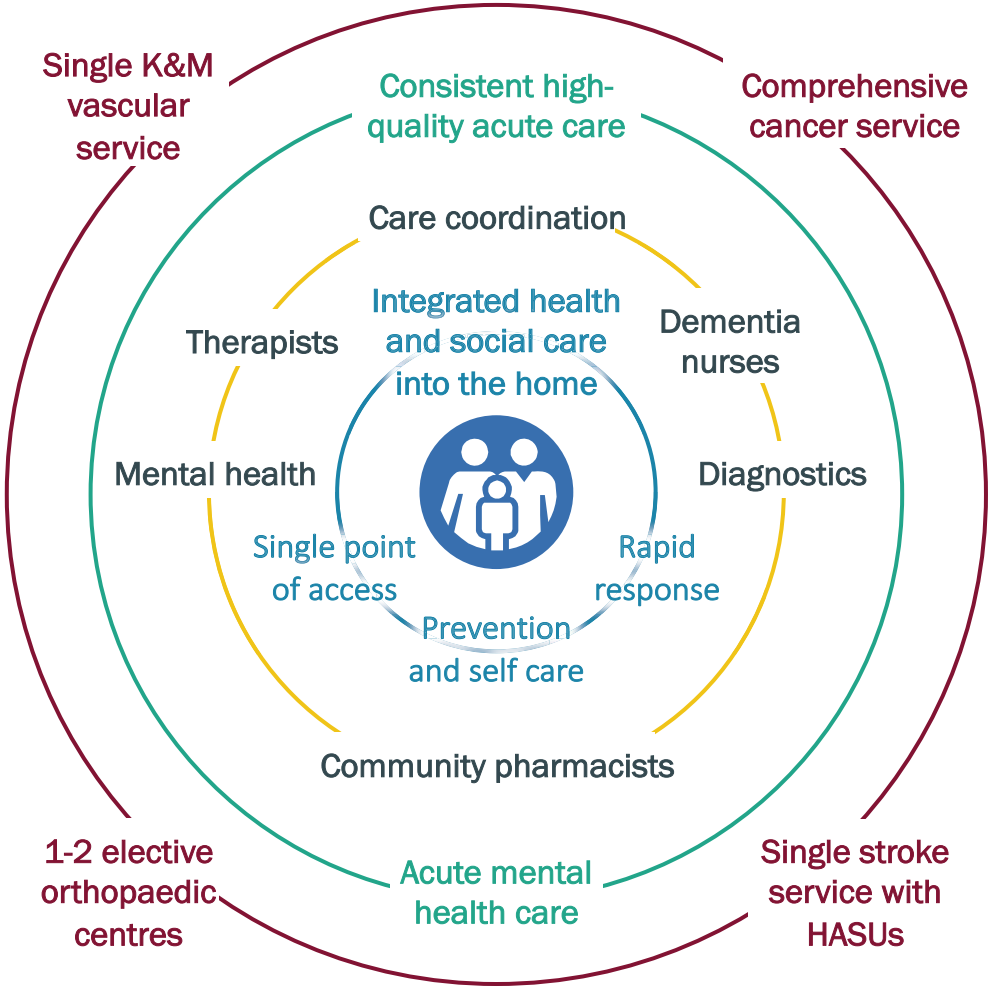
Prevention — Enlisting public services, employers and the public to support health and wellbeing

Local Care — A new model of care closer to home for integrated primary, acute, community, mental health and social care

Hospital Care — **Optimal capacity and quality of specialised, general acute, community and mental health beds**

Mental Health — Bringing parity of esteem, integrating physical and mental health services, and supporting people to live fuller lives

Kent and Medway Future Care Model



Source: K&M STP

The focus of this template will be on Hospital Care

Summary contents

1. Who is the population being served?
2. What are the issues in the case for change which need to be addressed?
3. What is the service delivery model today?
4. What is the proposed service delivery model for the future?
5. What are the co-dependencies and building blocks?
6. What engagement has been undertaken?

- The population of K&M is 1.8 million (2 million when including Bexley and East Sussex). The population is forecast to grow over the next 5 years, with a majority of growth occurring in the elderly population. Local providers also serve a proportion of neighbouring counties, increasing the population served.
- At present acute medical care is delivered at all 7 acute hospital sites and there were 115,626 medical admissions in K&M in 2015/16.
- Acute medical admissions tend to be older people.

- There are rising numbers of emergency admissions and bed occupancy across K&M. However, new models of care could reduce attendance and activity. A 15% opportunity has been identified in K&M.
- Excess length of stay in hospital increases the risk of hospital-acquired harm (and vice versa), particularly amongst the elderly. In a recent audit, there were 1,007 patients in hospital beds who are medically fit to leave their current setting of care*. In acute hospitals, the majority of these patients are over the age of 70 and were admitted as an emergency. However, the vast majority of patients who were medically fit for discharge were delayed for a reason outside of the control of the hospital.
- Workforce constraints prevent the delivery of 7 day services and 24/7 consultant cover across most hospitals in Kent & Medway for those who need acute medicine. All providers are having problems recruiting and retaining staff; this impacts on the ability to deliver safe, high quality services and extended hours.

- The K&M acute medical care model is partially consolidated, but is still largely based on historic dispersal of services. Acute emergency medicine is currently delivered from 7 sites using a variety of models . All Trusts aspire to deliver best practice models but constraints with capacity, estate and workforce only allow this to happen to varying degrees.

- There will be interventions along the pathway to improve outcomes. The Local Care workstream is developing detailed models of care to avoid emergency admissions to hospital and support rapid discharge. The focus of this pack is on the in-hospital pathway.
- Streaming to a fully functioning acute medical unit will be key to reducing acute admissions. Timely and appropriate discharge from A&E can also be supported by other schemes such as occurs in the voluntary sector Take Home & Settle service in East Sussex.
- The clinical model will also focus on reducing non-elective length of stay. This service model will incorporate the NHS England pathway for people with dementia, based on NICE guidelines. The Rapid Assessment Interface and Discharge (RAID) & Integrated Psychological Medicine Service (IPMS) models will be used for people with poor mental health.
- Trusts will increasingly need to deliver 7-day services in acute medicine to allow timely access to a senior specialist medical opinion. This will enable the new service delivery model to meet the standards set out in the case for change

- The models in the Keogh report have been used as a basis for developing building blocks of services.
- The South East Clinical Senate has undertaken work to understand the co-dependencies between services and these have been used to further describe the Keogh models.
- The models are Major Emergency Centre with specialist services, Emergency Centre, Emergency Medical Centre and Urgent Care Centre.
- The 'Future Hospital' and other best practice models are also used

- Over the last 2 years EKHUFT has engaged with key stakeholders internally and externally through a series of EKHUFT and East Kent Strategy Board events.
- West Kent have recently commenced an engagement program

Note: As at 22 November 2016

Contents

Who is the population being served: summary

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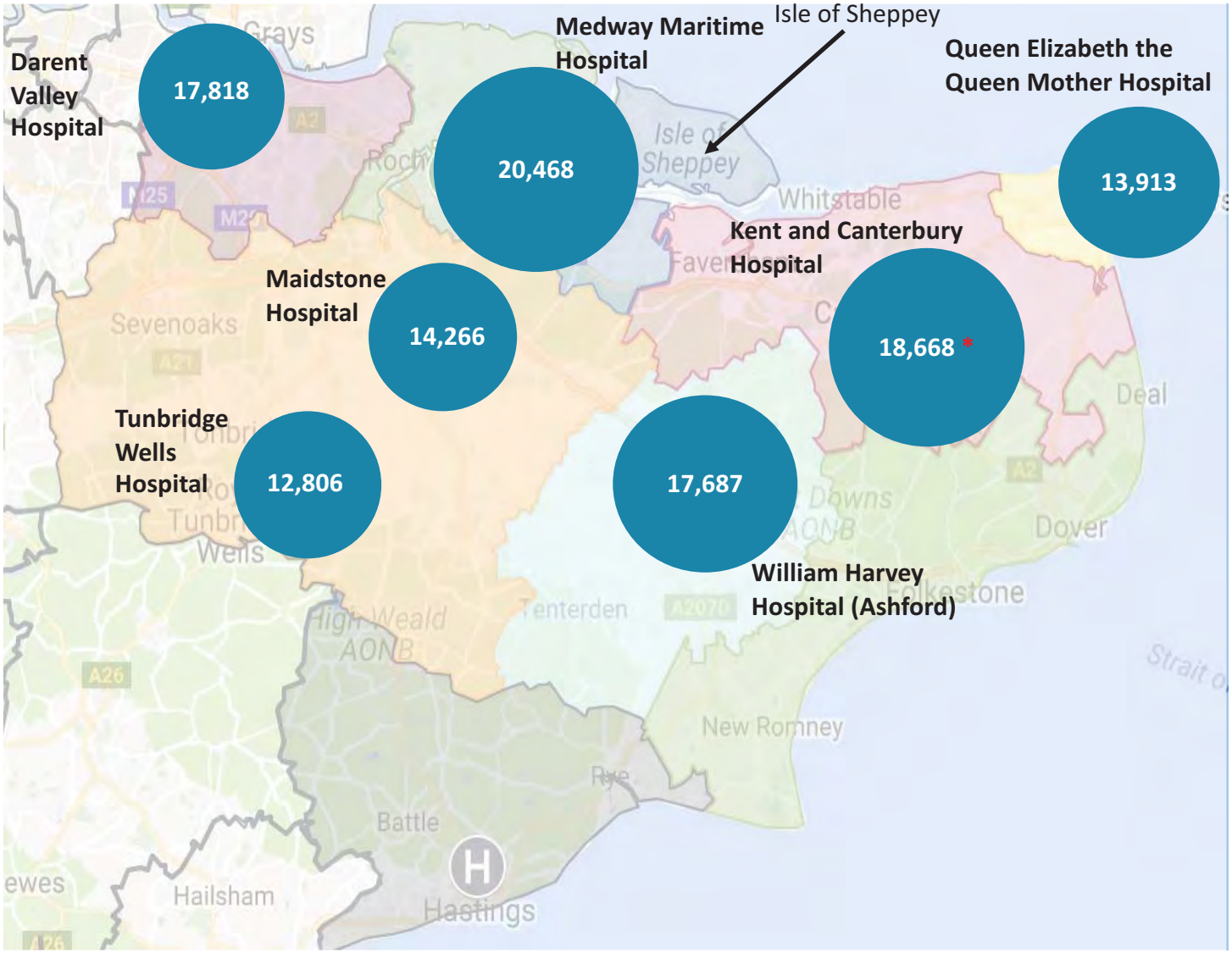
- At present acute care is delivered at all 7 acute hospital sites and there were 115,626 medical admissions in K&M in 2015/16.
- Acute medical admissions tend to be older people or people with more than one chronic condition.

The following slides collate an evidence base to support the issue outlined here

The below map of K&M shows acute care activity by site: 2015/16



Non-Elective medical admissions

***We have defined medical admissions as speciality codes:**
3*, 180, 400, 410, 430
The medical specialities considered in this document are:

- General Medicine
- Gastroenterology
- Endocrinology
- Clinical haematology
- Clinical physiology
- Clinical pharmacology
- Cardiology
- Dermatology
- Respiratory medicine
- Nephrology
- Neurology
- Clinical Nero-physiology
- Rheumatology
- Geriatric medicine
- Hepatology
- Geriatric medicine
- Diabetic Medicine
- Stroke medicine
- TIA
- Haemophilia
- Anticoagulant service
- A&E

NOTE: *The figure for Kent and Canterbury does not include A&E but the medical model at this time meant all medical attendances were admitted
Source: All data provided directly from each Trust separately, 2015/16

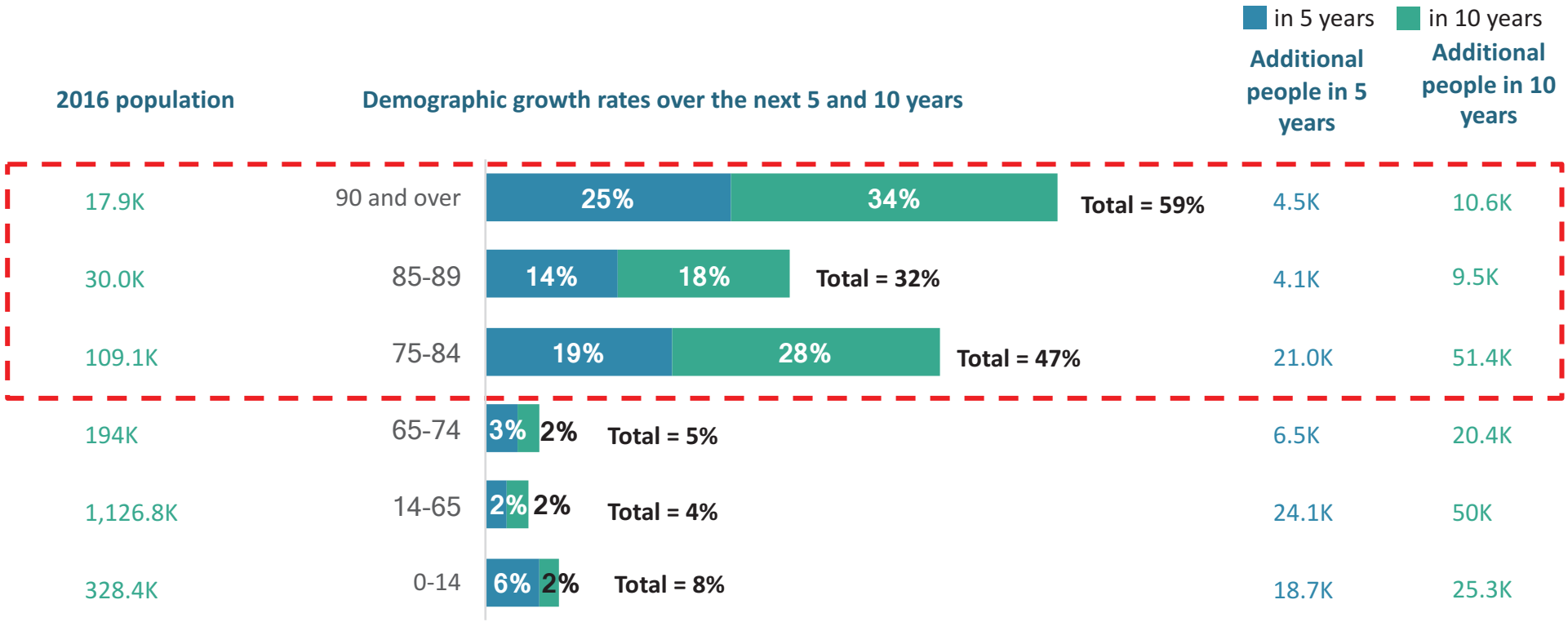
7 Day Quality standards

Below is how the Trusts in Kent and Medway currently perform against the Workforce 7 Day Quality standards in Kent & Medway

Ref	Standard	DGT	MH	TWH	Medway	QEQM	K&C	WHH
EM1	Consultant presence in the AAU 12 hours per day 7 days per week.							
EM2	Consultant acute physicians have no commitments other than to acute assessment when allocated to work within the AAU.							
EM3	Consultants from other specialties should commit sessions dedicated to acute medicine on the AAU with timely in reach to facilitate same day discharge. Including respiratory, cardiology, gastroenterology, geriatric medicine, diabetes & endocrinology and neurology.							
EM4	A doctor trained in the specialty of general internal medicine or acute internal medicine at level ST3 or above equivalent to SAS grade, or a registered healthcare professional with equivalent competences, should be immediately available at all times on the AAU. This healthcare professional must have up to date competences in ALS (Advanced Life Support).							
EM5	A consultant trained in general internal medicine or acute internal medicine or equivalent experience should be on call at all times and able to reach the AAU within 30 minutes. When on call for the unit, the consultant should not have other scheduled duties.							
EM8	The consultant acute physician admitting should work in blocks of more than 2 days and be present for 8 – 12 hours as day, 7 days per week.							
EM9	When functioning as the admitting consultant for emergency admissions, a consultant and their team are to be completely free from any other clinical duties or elective commitments.							
EM15	Single call access for mental health referrals to be available 24 hours a day, seven days a week with a maximum in person response time of 1 hour.							

Source: Trust data, Carnall Farrar, clinical standards audit (2016)

Over the next 10 years, Kent & Medway's population is forecast to increase, with a majority of growth occurring in the elderly population



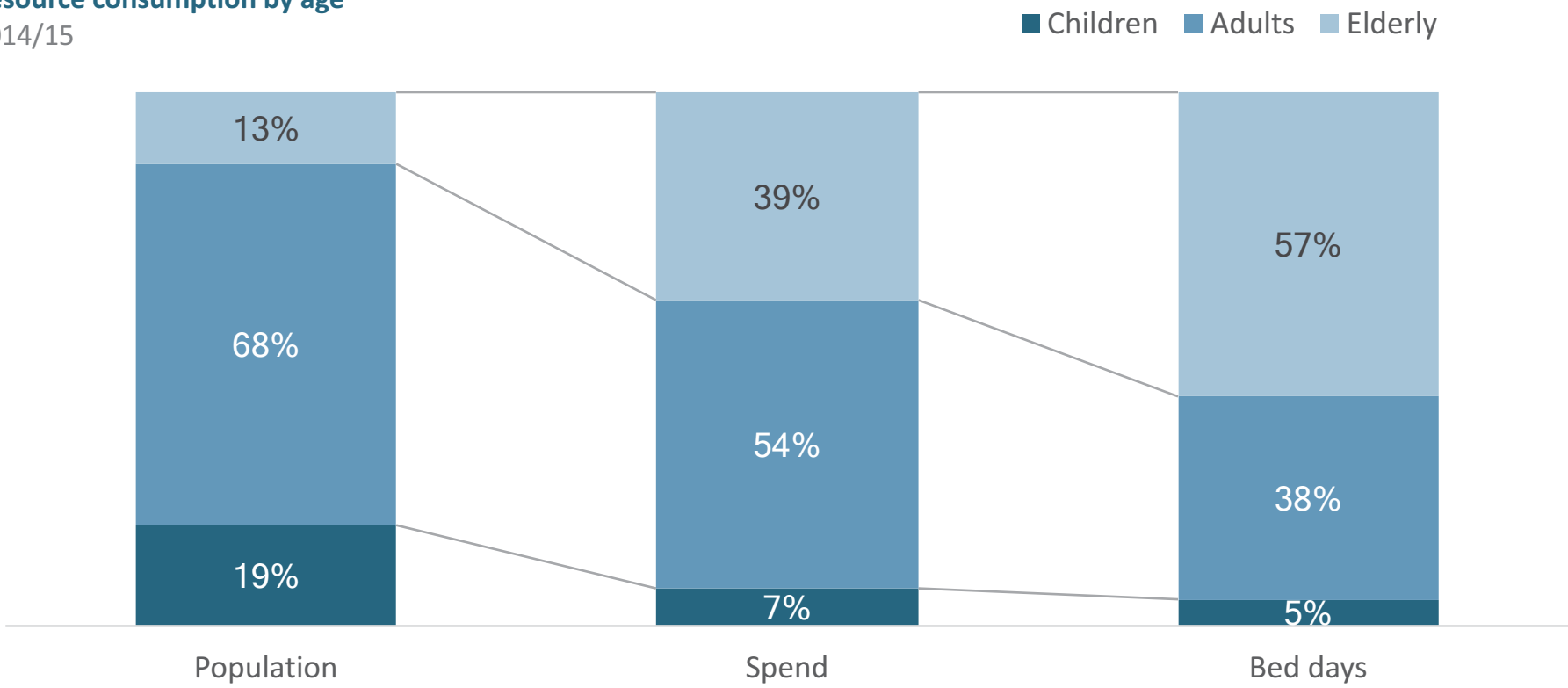
- Fastest growth is predicted in the **very elderly population** (90+)
- An ageing population implies an **additional 51,400 people** aged 75-84 by 2026
- **A growing elderly** population is likely to result in an increase in the number of people with **multiple long term conditions**
- If nothing changes, it is also likely lead to increased demand for **non-elective hospital beds**
- Note: This is demographic growth only and does not include growth in housing. From 2011 to 2021, planned housing developments are expected to bring an additional 136,620 people[2] in K&M.

1. The 85-89 age band is only a 5 year age gap
2. This number is estimated at 33% of that forecasted for 2031 (414,000)

Source: Office for National Statistics 2016.
Note: This excludes the Bexley and East Sussex population that Kent Trusts serve

A majority of hospital stays are elderly people - those aged 70+ comprise 13% of the population but account for 39% of total spend and 57% of all hospital bed days

Resource consumption by age
2014/15



- An **ageing population** is placing **greater burden** on the **system**.
- **More people** are predicted to be in **beds**, placing **greater strain** on **cost** and **resources**.

Source: Carnall Farrar analysis

Contents

What are the issues in the case for change which need to be addressed?: Summary

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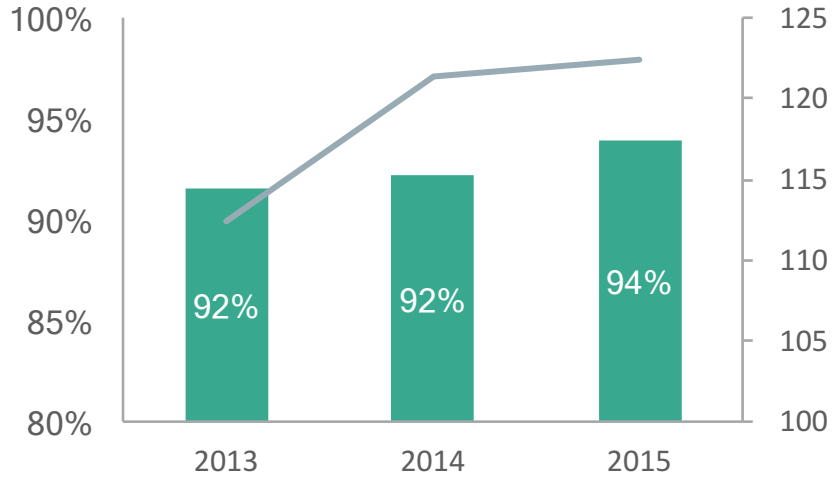
- There are rising numbers of emergency admissions and bed occupancy across K&M. However, new models of care could reduce non-elective activity and a 15% opportunity has been identified in K&M.
- Excess length of stay in hospital increases the risk of hospital-acquired harm (and vice versa), particularly amongst the elderly. In a recent audit, there were 1,007 patients in hospital beds who are medically fit to leave their current setting of care*. In acute hospitals, the majority of these patients are over the age of 70 and were admitted as an emergency. However, the vast majority of patients who were medically fit for discharge were delayed for a reason outside of the control of the hospital.
- Workforce constraints prevent the delivery of 7 day services and 24/7 consultant cover across most hospitals in Kent & Medway for those who need acute medicine. All providers are having problems recruiting and retaining staff; this impacts on the ability to deliver safe, high quality services and extended hours.

The following slides collate an evidence base to support the issue outlined here

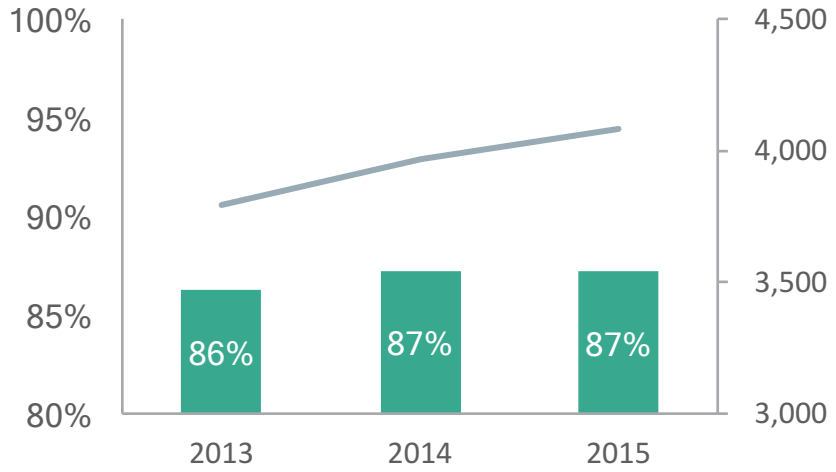
Emergency admissions and bed occupancy have been increasing across K&M in the last few years

Average overnight bed occupancy (%) and emergency admissions (k)

All acute Trusts in Kent and Medway



All Acute trusts in England

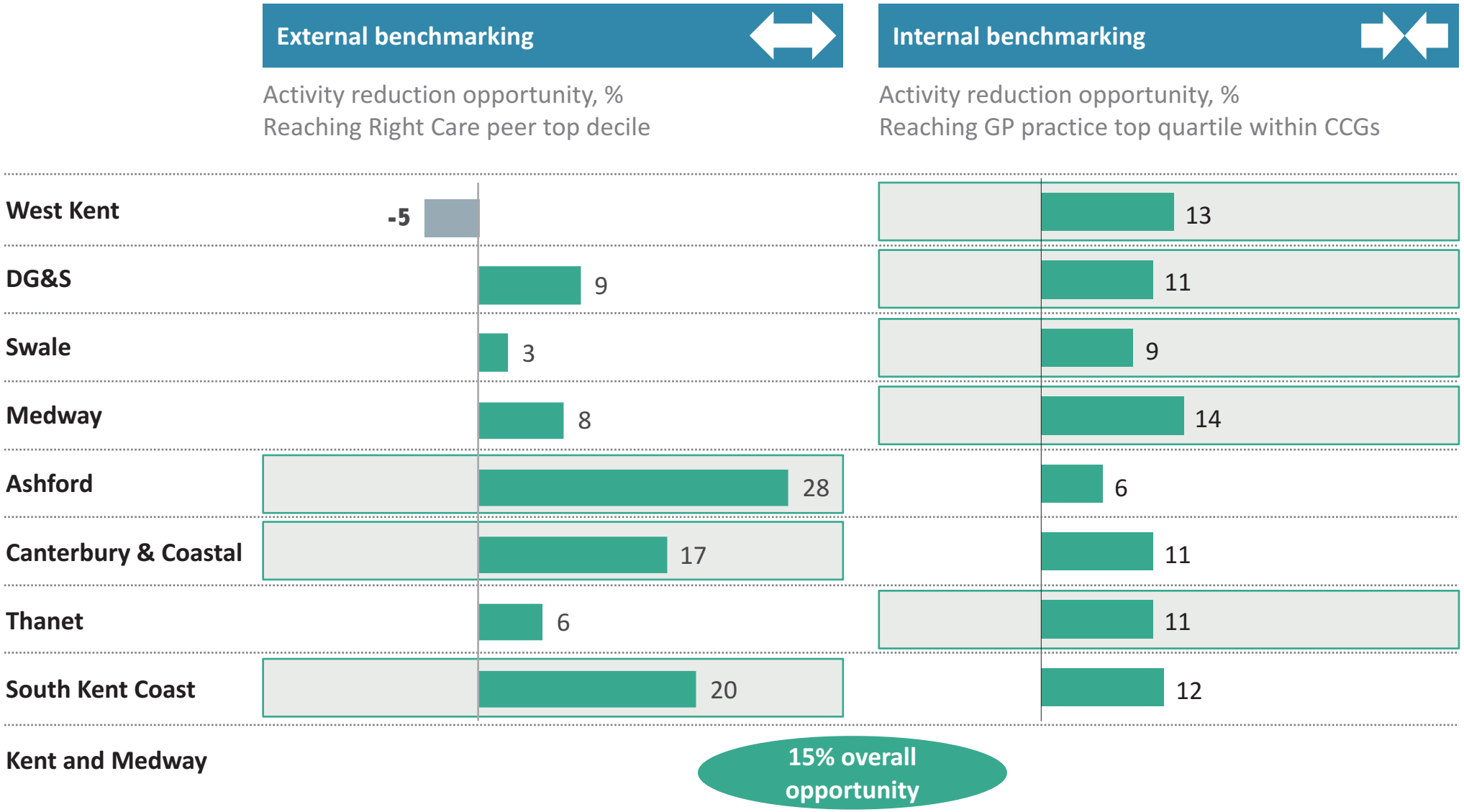


- Between 2013 and 2015, **emergency admissions rose by 8.9%** as across the four acute providers, **and bed occupancy rose by 2.2%.**
- On **average bed occupancy** was **94%** in 2015, compared to **87% nationally.**
- The **average bed occupancy** rate in England **grew** at a **slower rate** over the same period.

Note: The overnight bed occupancy rate is defined as the average daily number of beds occupied overnight that are under the care of consultants as a proportion of all available beds

Source: NHS England, quarterly data from FY2013-14 to FY 2015-16; Carnall Farrar analysis

However, benchmarking shows there is a 15% opportunity across K&M to reduce non elective admissions



Source: MAR data 2015/16, CCG SLAM data returns 2015/16, Right Care peer sets, Carnall Farrar analysis

International evidence suggests that 25-40% savings in non-elective spend are possible with the impact of integrated care

A review of the evidence base on integrated care shows a potential impact **of 25–40%** in cost reduction, for example

- 15–30% cost reduction through care coordination
- 50% reduction in acute admissions to hospital for patients with diabetes, through case-level care-planning and active disease management
- 23–40% reduction in admissions for CHD through best practice early management

Selected examples of integrated care

GENERALITAT VALENCIANA

- Significant cost reductions and higher levels of productivity
- 26% reduction in costs in districts with outsourced management
- 76% increase in hospital productivity
- 91% patient satisfaction rates

ChenMed Transforming Health Care Delivery for Seniors

- ChenMed has 30% fewer emergency admissions than other primary care networks in the same geography
- Compared to national averages for the population group, ChenMed reports 18% lower hospitalisation rate and 17% lower readmissions rates

NHS South Devon and Torbay Clinical Commissioning Group

- The number of patients with a care package in place within 28 days of assessment increased by 45%
- Non-elective inpatient bed use in over-65s population reduced by 29%; length of stay reduced by 19%
- Delayed transfers of care from hospital significantly reduced

CareMore It's what we do.™

- Reduction in A&E visits and unscheduled patient admissions
- 24% lower than avg hospitalisation; 38% shorter than avg hospital stays
- 60% lower than average amputation rate among diabetics
- 56% reduction in CHF hospital admits in 3 months
- 50% reduction in renal hospital admission rates in 5 months

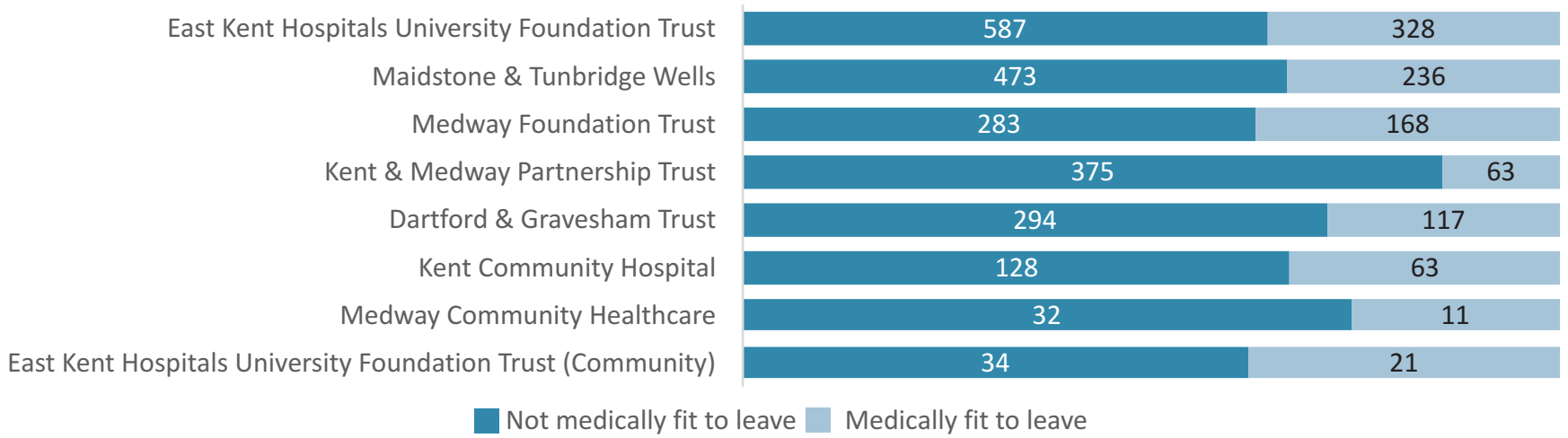
SOURCE: Dorling & Richardson, "McKinsey Evidence Base of Integrated Care", 2014

Excess length of stay in hospital increases the risk of hospital-acquired harm (and vice versa), particularly amongst the elderly

	Source	Study
Reduced mobility	National Audit Office (2016); Knight J, Nigam Y and Jones A (2009)	• One study has shown that older people can lose up to 5% of muscle strength per day of treatment in a hospital bed • Bedridden patients also at higher risk of developing pressure ulcers, deep vein thrombosis and catheterisation
Increased risk of infection	Lewis and Edwards (2015)	• There is an increased likelihood of acquiring a range of infections, such as pneumonia and urinary tract infections
Increased risk of falling	Collier R (2012)	• Older people are at higher risk of falling in hospital, where the environment is unfamiliar • If they fall they are more likely to have injuries, such as a broken bone
Dementia and delirium	Collier R (2012)	• Hospital stays often bring on or worsen episodes of confusion among patients with dementia
Loss of independence	Traub (2016)	• While at hospital older people are more likely to become reliant on the care of others (e.g. in bathing) • Prolonged bed stays therefore increase the likelihood that they will need to go to a nursing or residential home after discharge

In a recent audit, across the 3,213 beds audited in K&M, there were 1,007 patients in beds who were medically fit* to leave their current setting of care

Patients 'fit to leave' their current setting of care



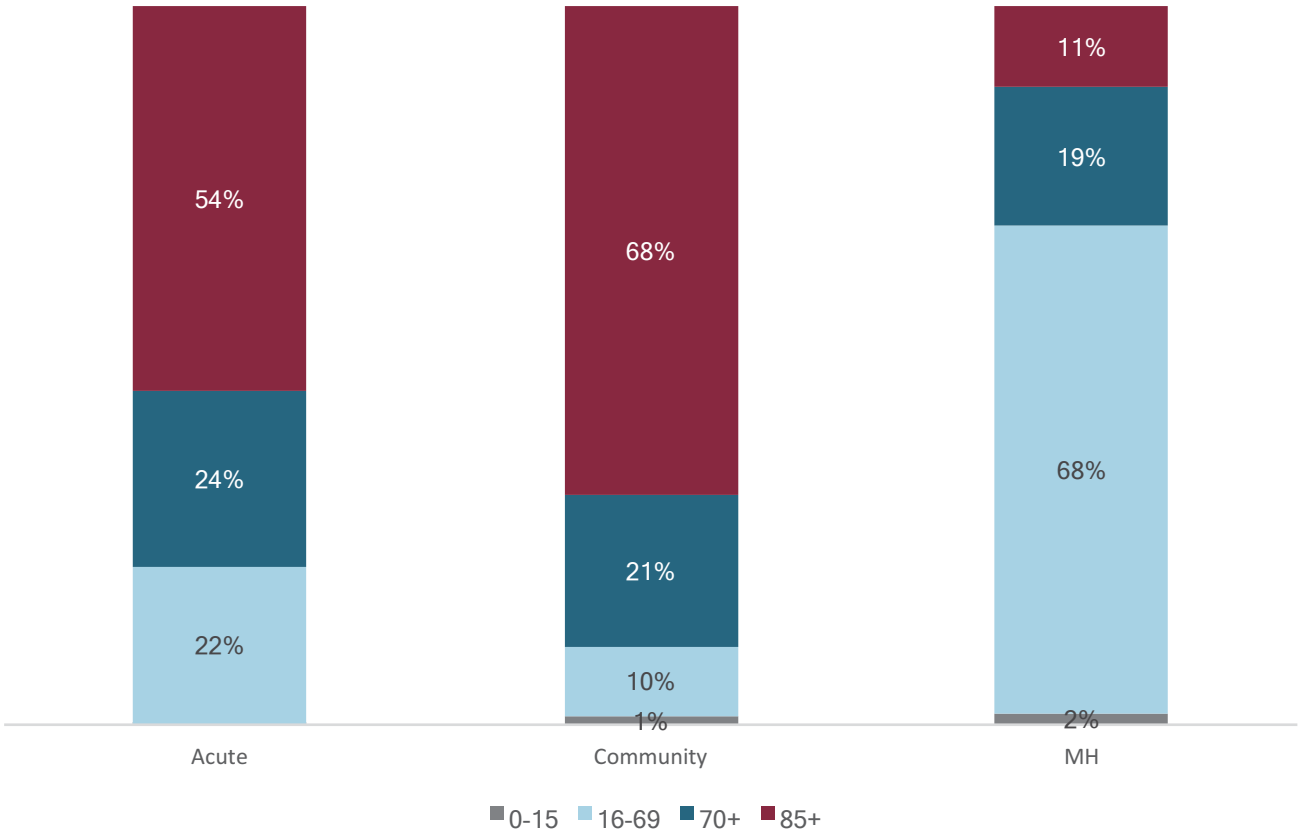
Trust Name	Occupied beds	Not fit to leave	Fit to leave	% fit to leave
East Kent Hospitals University Foundation Trust	915	587	328	35.8%
Maidstone & Tunbridge Wells	709	473	236	34.2%
Medway Foundation Trust	451	283	168	36.4%
Kent & Medway Partnership Trust	438	375	63	14.4%
Dartford & Gravesham Trust	411	294	117	28.5%
Kent Community Hospital	191	128	63	33.0%
Medway Community Healthcare	43	32	11	25.6%
East Kent Hospitals University Foundation Trust (Community)	55	34	21	38.2%
Total	**3,213**	**2,206**	**1,007**	**31.4%**

Note: As of 22 November 2016: * Medically fit means medically optimised and having no further requirement for medical input in the setting they are in. The bed audit was carried out over 1 day, and did not include the following beds: Level 2 beds (HDU); Level 3 beds (ICU); Maternity; Paediatrics; Neonatology; Day case beds; Forensic
Source: Carnall Farrar Analysis

Most delayed patients are older: 78% of acute patients and 89% of community patients who were medically fit* to leave the acute setting were over the age of 70

- The elderly (70+) make up a majority of patients currently in beds
- The very elderly (85+) are a large proportion of this age category, particularly in the community setting
- As expected, the age profile of medically fit patients is younger in the mental health provider setting

Proportion of patients 'fit to leave' – by age band

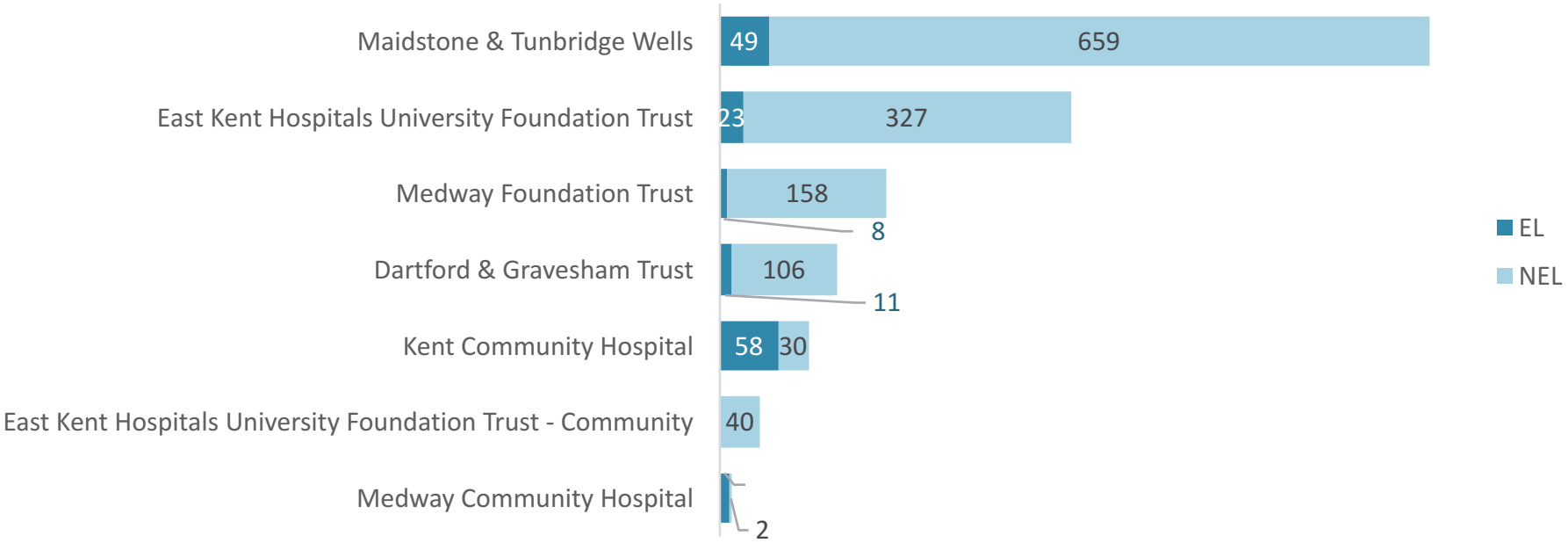


Source: Carnall Farrar Analysis

* Medically fit means medically optimised and having no further requirement for medical input in the setting they are in.

Most delayed patients are non-elective: 93% of patients in acute beds who were medically fit* to leave were admitted as non-elective patients

Acute/Community 'fit to leave' patients split by admission type



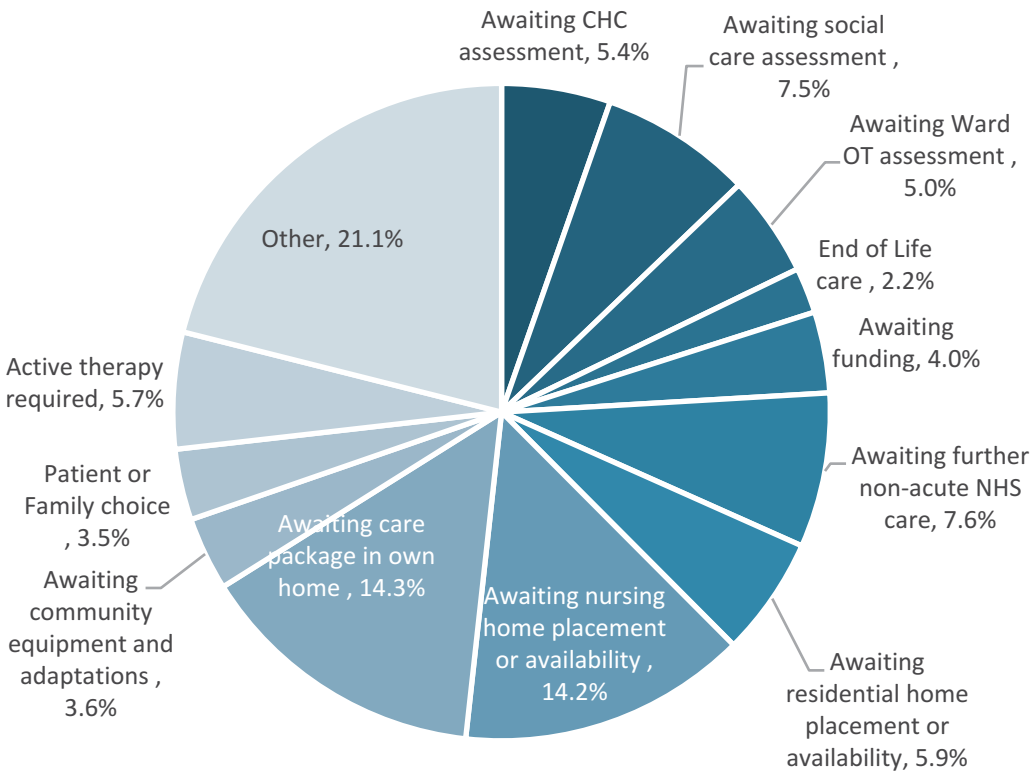
	Total Elective	Total Non-Elective	% Elective	% Non-Elective
Acute	91	1250	6.8%	93.2%
Community	67	72	48.2%	51.8%

Source: Carnall Farrar Analysis

** Medically fit means medically optimised and having no further requirement for medical input in the setting they are in.

However, the vast majority of patients who were medically fit for discharge were delayed for a reason outside of the control of the hospital

Reasons for delay – Acute & Community



- Of the 852 patients with a recorded 'reason for delay', 116 were awaiting nursing home placement
- 93 people were awaiting a care package in their own home
- The 'other' category includes:
  - Awaiting social care assessment bed (1.7%)
  - Safeguarding Issues (1.5%)
  - Non-weight bearing (1.4%)
  - Housing – patients not covered by NHS and Community Care Act (1.2%)
  - Disputes (0.9%)
  - Mental Health (0.4%)
  - Transport Issues (0.4%)
  - Waiting Investigation that could be done in an OP setting (0.1%)

Source: Carnall Farrar Analysis

Workforce constraints prevent the delivery of 7 day services and 24/7 consultant cover across most hospitals in Kent & Medway for those who need acute medicine

1	**Access to 7 day services is limited at weekends**	• Reviews for patients on specialist wards only available 5 days a week. Support services for discharge not available at weekends - pharmacy tends to be a 5 day service and is only available for 3 hours at the weekend (DVT, EKHUFT). • Pharmacy at EKHUFT is continually looking to increase hours of service but is constrained by workforce
2	**Consultant cover not available for a full 12 hours a day and acute physicians don't always work 7 days a week**	• Consultant cover is available 5 days of the week at EKHUFT. MFT has 7 day 12 hour cover in Acute Medicine • Some of these shortages are due to on-call/leave – senior cover is sometimes limited at DVT as a result
3	**Workforce constraints**	• Cross-covering for internal colleague absence interferes with dedicated Ambulatory care unit (ACU) or Acute Medical Unit (AMU) sessions at some Trusts • Most AMU do not have Acute Medicine specialists so specialists who do GIM have to fill in the gaps • Most Trusts have difficulty with recruiting sufficient junior medical staff and nursing staff

Source: Trust data, Carnall Farrar, clinical standards audit (2016)

Current workforce numbers in post K&M wide total 431

General Medicine; Number in post by site

	Status Quo						
	D&G	MMH	TW	MGH	K&C	QEQM	WHH
A&E Consultants	8 (2)	6.6	7.7	5.0	n/a	3	6
A&E middle grades	21.60	18	14.7	7.6	n/a	1	7
Acute Physician	3 (2)	5 (2)	2.0	1.0	1	3 (1)	2.5
HCOOP	6.2	5	3.4	2.0	4.5 (2.5)	4.5 (1.5)	6 (1)
Stroke	2	2*	2.5	1.9	2 (1)	3	3 (1)
Respiratory	5	5.43	2.0	1.0	3 (2)	4 (1)	4
Cardiology	4.8 (0.93)	4	3.0	4.0	3 (1)	5	5
Diabetes	3	3	2.0	2.0	1 (1)	2	2 (1)
Rheumatology	N/A	4	1.0	2.8	1	2	2 (1)
Gastroenterology	5	6.88 (1)	5.9	2.0	5 (1)	6	5
Medical middle grades	16	22.7	38.5	35.8	11	8	12
Total	**74.60**	**80.61**	**82.7**	**65.1**	**31.5**	**41.5**	**54.5**

430.51

SOURCE: NHS provider information- ESR total WTE in post (of which x WTE NHS locum)
*Stroke included in HCOOP for MMH

Across K&M there is an average 21% vacancy within general medicine posts; recruiting staff is an essential part of any future sustainability

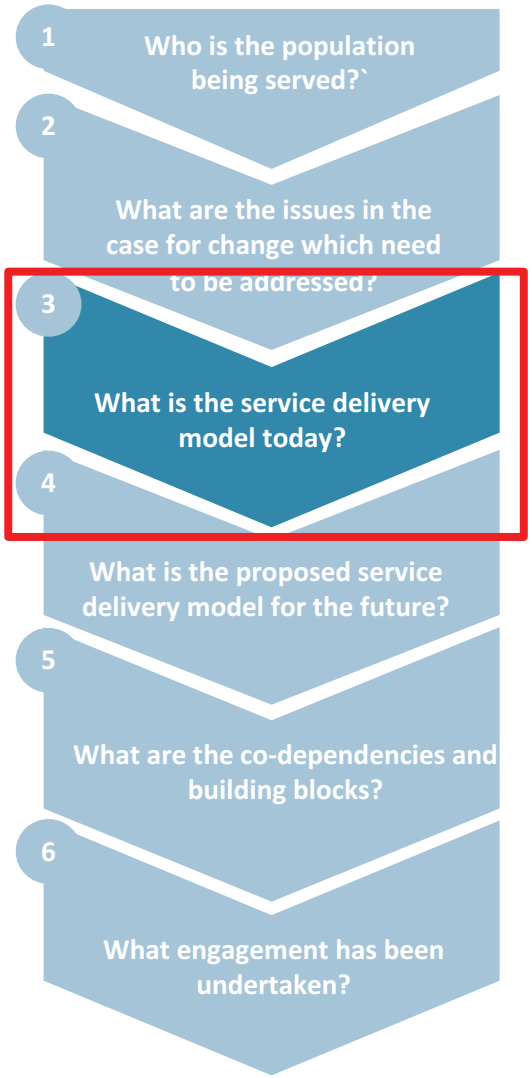
General Medicine; % Vacancy

	Status Quo						
	D&G	MMH	TW	MGH	K&C	QEQM	WHH
A&E Consultants	11.11%	17.50%	21.4%	0.0%	n/a	70%	40%
A&E middle grades	11.84%	43.75%	36.1%	30.9%	n/a	93%	50%
Acute Physician	0%	28.57%	0.0%	50.0%	67%	25%	37.5%
HCOOP	0%	30%	37.0%	50.0%	10%	10%	0%
Stroke	0%	n/a	0.0%	32.1%	33%	0%	0%
Respiratory	0%	36.86%	33.3%	66.7%	0%	0%	0%
Cardiology	19.06%	20%	0.0%	0.0%	0%	0%	16.7%
Diabetes	0%	31.82%	0.0%	0.0%	0%	0%	0%
Rheumatology	N/A	20%	0.0%	0.0%	0%	0%	0%
Gastroenterology	0%	0%	1.67%	33.3%	0%	0%	0%
Medical middle grades	15.30%	26.43%	11.5%	8.2%	15.4%	38.5%	7.7%
Total	9.60%	25.49%	18.3%	17.2%	14.9%	39%	21%

SOURCE: NHS provider information vacancy WTE as %

Contents

What is the service delivery model today?: Summary



- The K&M acute care model is partially consolidated, but is still largely based on historic dispersal of services
- Acute emergency medicine is currently delivered from 7 sites using a variety of models . All Trusts aspire to deliver best practice models but constraints with capacity, estate and workforce only allow this to happen to varying degrees.

The following slides collate an evidence base to support the issue outlined here

The K&M acute care model is partially consolidated, but is still largely based on historic dispersal of services

H Hospital

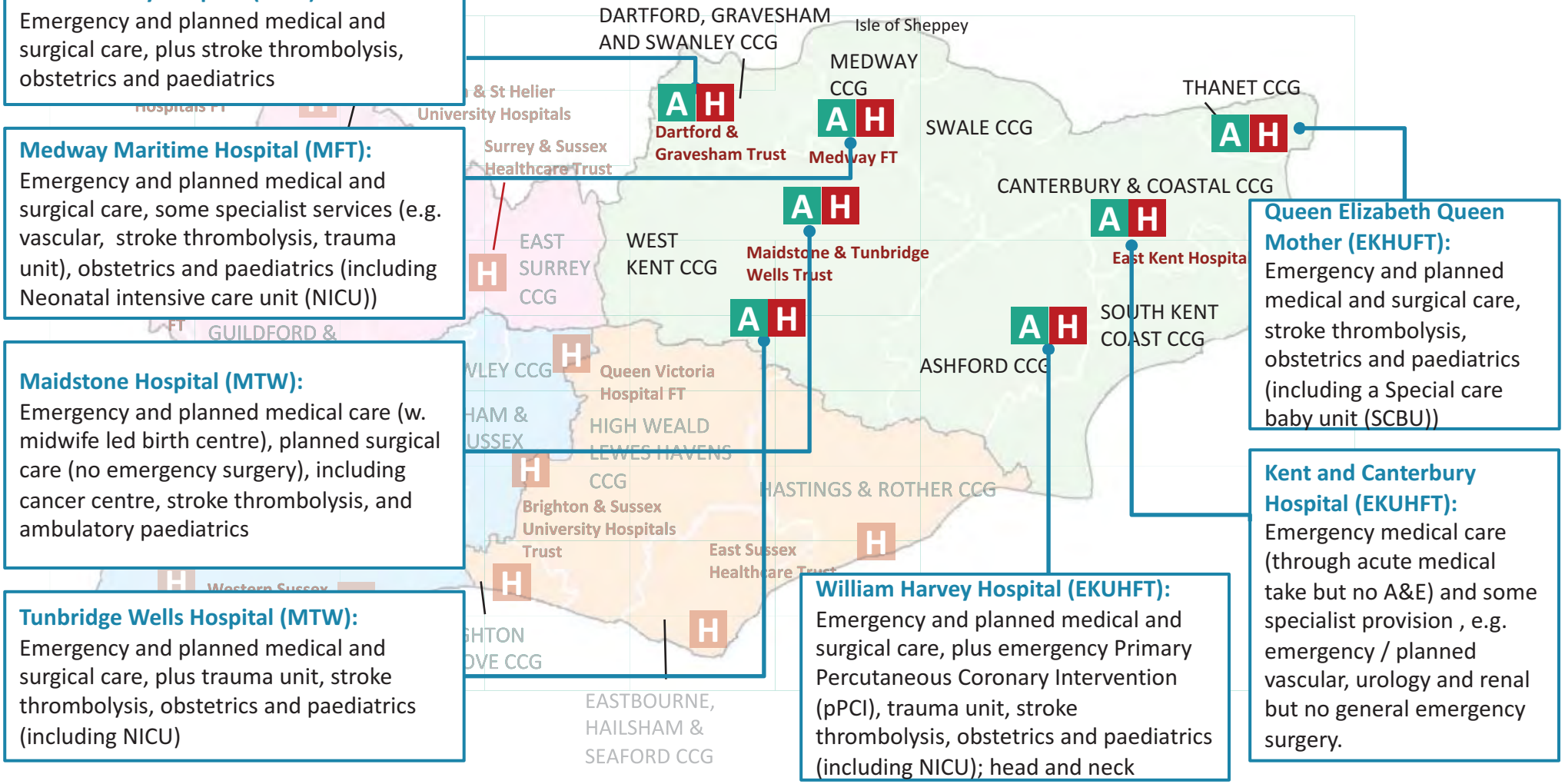
A Acute Medical Unit

Darent Valley Hospital (D&G):
Emergency and planned medical and surgical care, plus stroke thrombolysis, obstetrics and paediatrics

Medway Maritime Hospital (MFT):
Emergency and planned medical and surgical care, some specialist services (e.g. vascular, stroke thrombolysis, trauma unit), obstetrics and paediatrics (including Neonatal intensive care unit (NICU))

Maidstone Hospital (MTW):
Emergency and planned medical care (w. midwife led birth centre), planned surgical care (no emergency surgery), including cancer centre, stroke thrombolysis, and ambulatory paediatrics

Tunbridge Wells Hospital (MTW):
Emergency and planned medical and surgical care, plus trauma unit, stroke thrombolysis, obstetrics and paediatrics (including NICU)



Queen Elizabeth Queen Mother (EKHUFT):
Emergency and planned medical and surgical care, stroke thrombolysis, obstetrics and paediatrics (including a Special care baby unit (SCBU))

Kent and Canterbury Hospital (EKUHFT):
Emergency medical care (through acute medical take but no A&E) and some specialist provision , e.g. emergency / planned vascular, urology and renal but no general emergency surgery.

William Harvey Hospital (EKUHFT):
Emergency and planned medical and surgical care, plus emergency Primary Percutaneous Coronary Intervention (pPCI), trauma unit, stroke thrombolysis, obstetrics and paediatrics (including NICU); head and neck

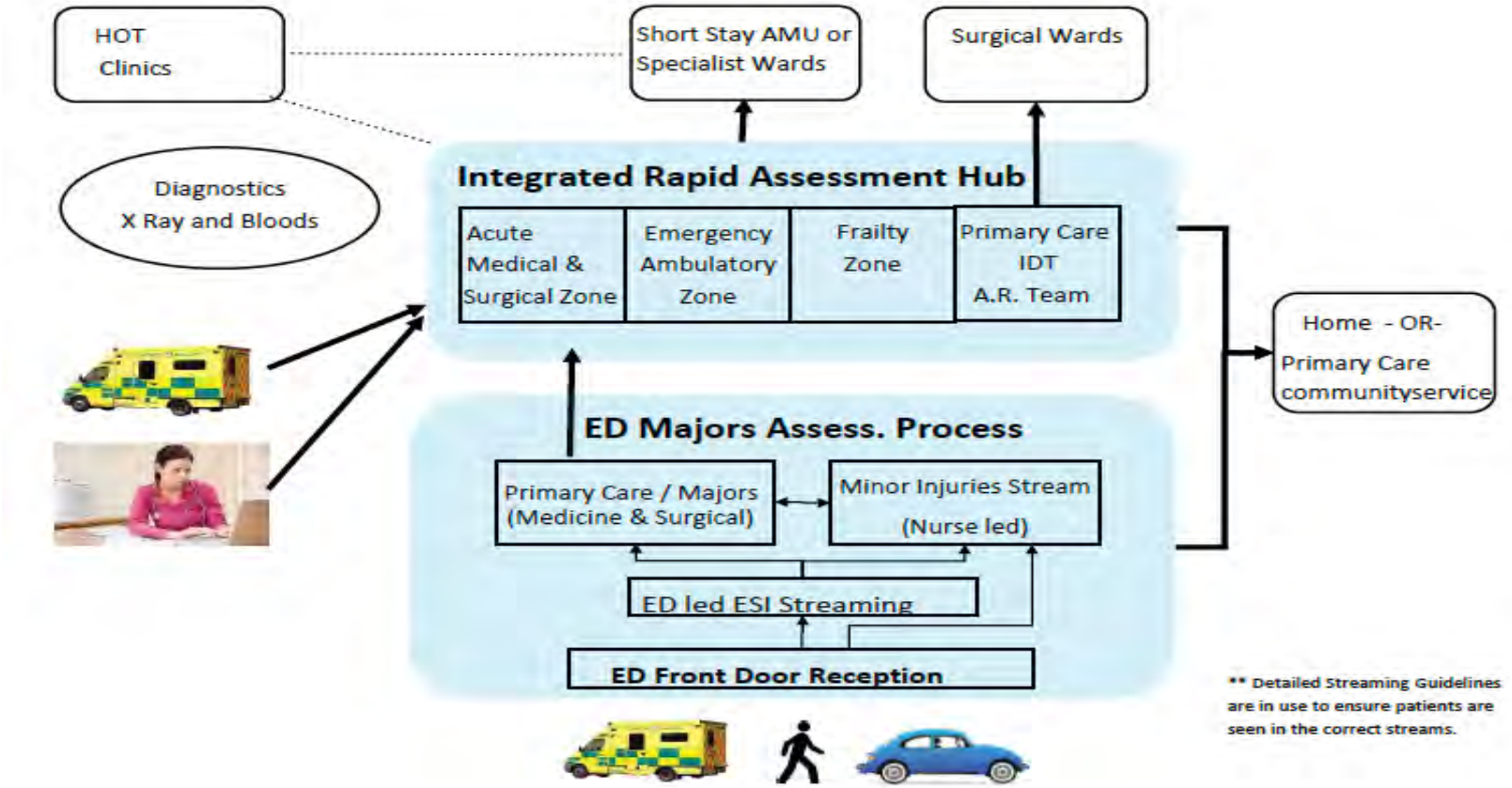
Source: K&M STP submission; 2016

EKHUFT agreed current model

The diagram below represents the agreed EKHUFT model. However the approach remains inconsistent due to variation in:

- Activity volume and capacity in the ED, AMU and in-patient wards
- Availability of medical and nursing staff to provide frailty , ambulatory and hot clinics
- Availability and presence of primary care and community services

This results in poor flow through ED and AMU which causes a break down in the desired model.

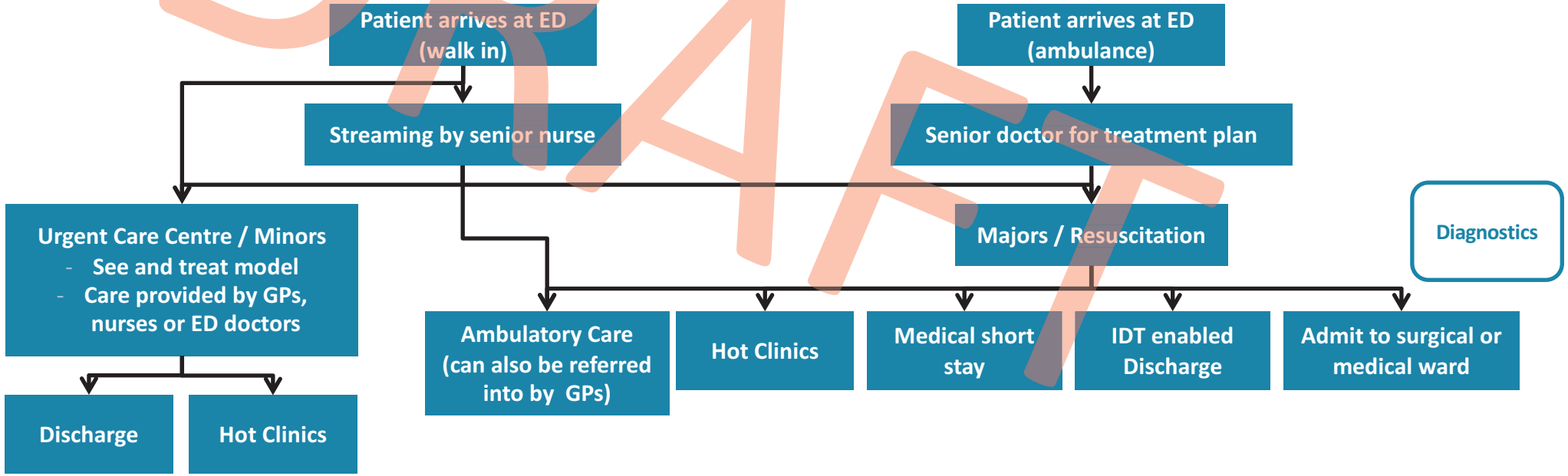


SOURCE: EKHUFT

Darent Valley agreed current model

The diagram below summarises the flow of patients through the emergency department at Darent Valley Hospital, DGT. However, the ability to deliver this consistently is impacted by:

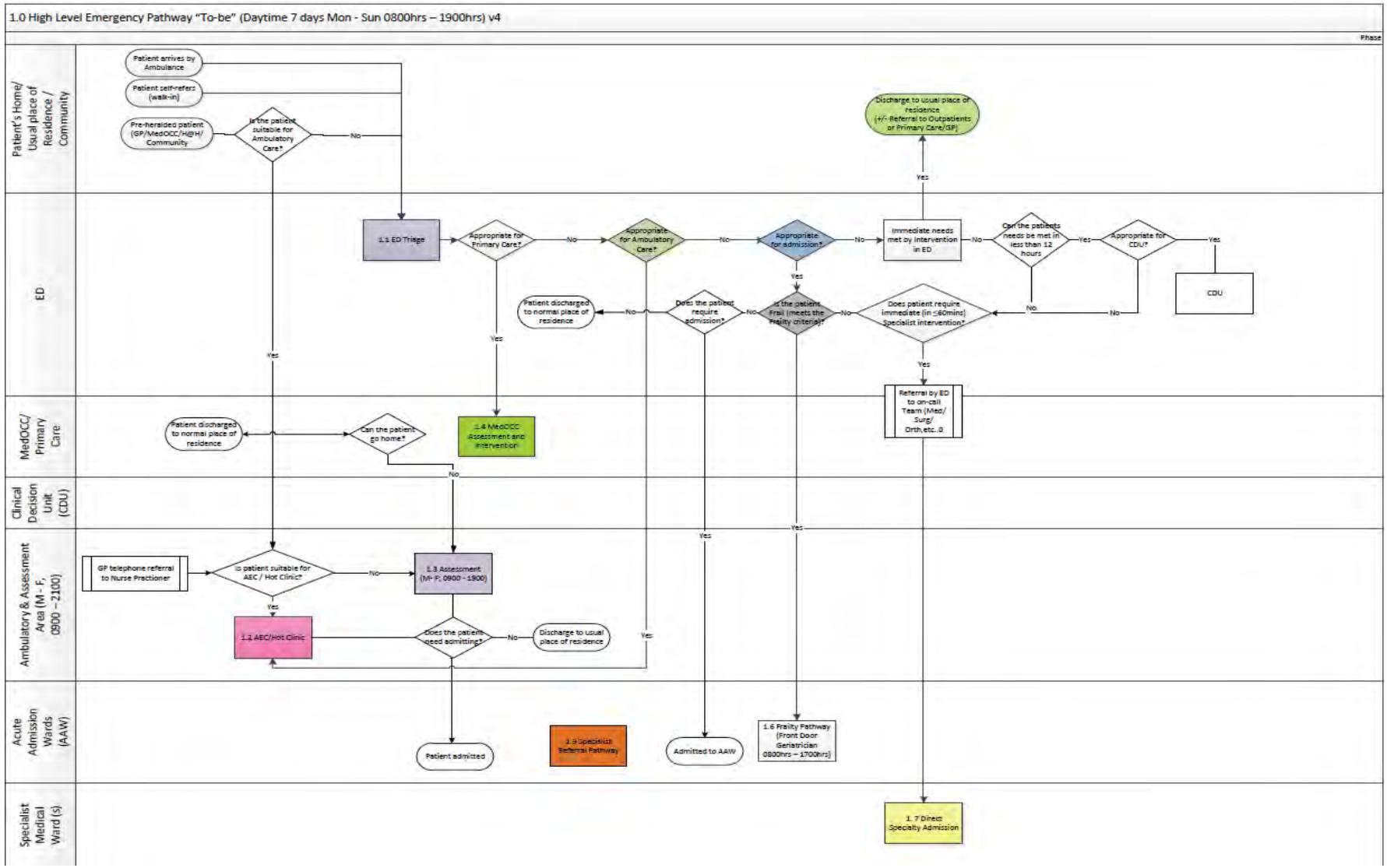
- Volume of ambulances / majors arriving within an hour
- Capacity in Emergency Department (number of bays in majors and resus)
- Capacity in wards (beds) for patients to be admitted to the appropriate ward
- Availability, presence and capacity of services working across the whole system



Source: D&G

Medway Maritime Hospital agreed current model

The diagram below represents the agreed MMH model.



SOURCE: MMH

Maidstone and Tunbridge Wells agreed current model

MTW's Acute Medical Units

At present, referrals to MTW's Acute Medical Units come from several paths:

- GPs directly to AMU SpR – or out of hours via on call SpR
- From the wards after discharge
- From outpatient clinic
- From the Medical take
- Direct from ED (pts being 'pulled directly' by AAU staff)
- Scheduled biologic infusions

The following patient pathways exist:

- Pleural Effusions
- Low risk UGIB (Needs some confirmation and tweaking)
- Cellulitis
- Blood Transfusions
- Abdominal Paracentesis
- Acute Headache
- PE

Key principle - All patients are ambulatory until proven otherwise

SOURCE: MTE provider

Service delivery model today – patient story: Frailty

Douglas is a 74 year old gentleman. He lives with his devoted wife in their family home. He has recently taken to his bed finding little energy or interest to participate in activity. His walking has become erratic and unsteady. His GP has called in a few times recently for injuries from falls.

What can happen now to some patients:

- Douglas has seen his GP who is very keen that he attends the Falls clinic. Douglas is less keen.
- Whilst being helped out of bed on Friday Douglas falls as his legs give way. His wife dials 111; following assessment a paramedic crew brings him into the Emergency Care Centre (ECC). Douglas arrives at 11am, and waits for a Nurse and junior doctor review.
- As his time approaches 4 hours, he is placed in a bed on the Clinical Decisions Unit; he is 74 years old, so is admitted under the General physician on-call, not the Consultant geriatrician.
- The Consultant Physician on-call happens to be a Specialist Respiratory physician and he is called to see a patient who requires a chest drain. This takes him away from his ward round. He returns to review Douglas at 4pm. No clear cause for the fall is found and Douglas is deemed to be medically fit for discharge.
- He is referred to the Integrated Discharge Team (IDT) at 5pm. Following assessment, they attempt a bed transfer. As Douglas has laid in bed all day, it is deemed unsafe; he is admitted into the hospital to the Frailty ward and seen by the Consultant over the weekend.
- By Monday (Day 3), Douglas is delirious. Later the ward pharmacist discovers Douglas has been taking Diazepam for years but this has been omitted from his drug chart since day of admission. Part of the delirium is attributed to sudden benzodiazepine withdrawal.
- Sadly, his delirious state worsens and results in a further in-hospital fall on Day 5.
- By Day 7, it is clear that Douglas' delirium is unlikely to settle quickly. His level of mobility cannot be supported in his own home with care provision to support his wife. Therefore, he is referred to a community step-down bed for a prolonged period of rehabilitation.

SOURCE: EKHUFT

Contents

What is the proposed service delivery model for the future?: Summary

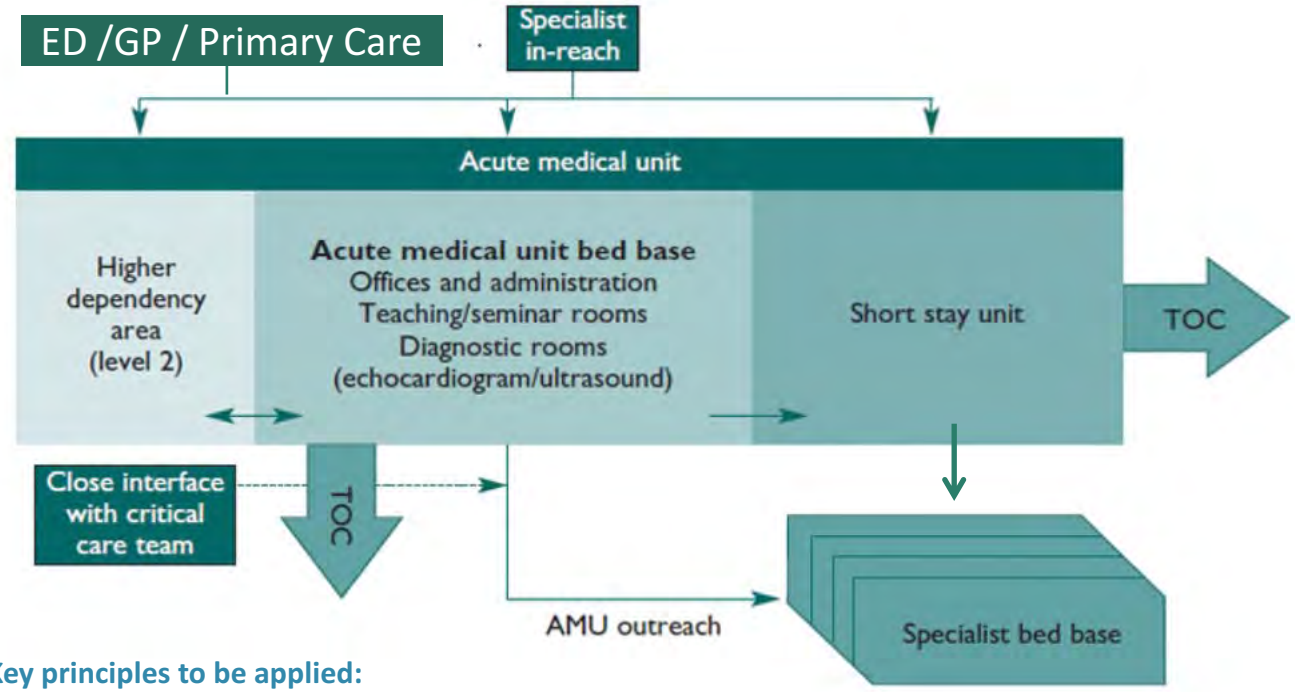
1. Who is the population being served?
2. What are the issues in the case for change which need to be addressed?
3. What is the service delivery model today?
4. **What is the proposed service delivery model for the future?**
5. What are the co-dependencies and building blocks?
6. What engagement has been undertaken?

- There will be interventions along the pathway to improve outcomes. The Local Care workstream is developing detailed models of care to avoid emergency admissions to hospital and support rapid discharge. The focus of this pack is on the in-hospital pathway.
- Streaming to a fully functioning acute medical unit will be key to reducing acute admissions. Timely and appropriate discharge from A&E can also be supported by other schemes such as occurs in the voluntary sector Take Home & Settle service in East Sussex.
- The clinical model will also focus on reducing non-elective length of stay. This service model will incorporate the NHS England pathway for people with dementia, based on NICE guidelines. The Rapid Assessment Interface and Discharge (RAID) & Integrated Psychological Medicine Service (IPMS) models will be used for people with poor mental health.
- Trusts will increasingly need to deliver 7-day services in acute medicine to allow timely access to a senior specialist medical opinion (ST4 and above). This will enable the new service delivery model to meet the standards set out in the case for change

The following slides collate an evidence base to support the issue outlined here

Proposed service model

The term Acute medical Unit (AMU) is defined in an RCP report as '**a dedicated facility within a hospital that acts as a focus for Acute medical care for patients that have presented as medical emergencies to hospitals.'** The report provides a detailed description of the rationale and requirements for an AMU but allows for local design. The structure of an AMU is schematically represented below and ideally an AMU should be co-located with other acute and emergency services as part of an emergency floor incorporating the ethos of Emergency Ambulatory Care. Strong clinical (medical and Nursing) and operational leadership is essential for an AMU to function successfully.



- There should be seamless care between the community and hospital for patients.
- Some of the ways to deliver this could include
- easy and rapid communication channels between professionals (especially between GPs and specialists)
- ready access to the summary care record as a minimum
- provision of discharge summaries within 24 hours of discharge to GPs and other relevant third party providers[1]

Key principles to be applied:

- Assessment of acutely ill patients by competent clinical decision makers supported by appropriate levels of diagnostic support
- All areas follow the ethos of treating patients in an ambulatory model unless deemed otherwise by exclusion criteria
- Nominated medical, nursing and operational leads are in place working in the department on a regular basis
- Integration and collaboration of key acute services e.g. E.D., critical care, AMU and key support services e.g. pharmacy and therapies
- Consistency of quality medical care 24 hours a day, 7 days a week
- Specialist medical in-reach when required in a timely way 7/7
- Dedicated, multidisciplinary health, therapy and social care teams based in the unit

[1] Paragraph 11.6 from NHS Standard Contract 2015/16: Service Conditions. NHS England

Priorities within Acute Hospitals; Interim Management and Support

Streaming to a fully functioning acute medical unit will be key to reducing acute admissions. An example of this may be the following:

	Pathway	Clinical requirements
Referral	• Patients are referred to the acute medical unit (AMU) by their GP or via the emergency department	• All referrals to Acute Medical Unit (AMU) must be made with on-call team involvement and reviewed by the medical team and discussed with a consultant
Assessment	• In the assessment area patients are seen by the multi-disciplinary team. Initial investigations are conducted prior to a decision being made to observe, admit or discharge home • Get patients on the right pathway by managing patients in 'flow streams'	• Real-time senior review process on the AMU: incoming patients are seen by senior decision maker (ST4 and above) within 4 hours of arriving between 8am and 8pm seven days a week and by a middle grade beyond 8pm • Establish "protected streaming" – create separate streams for minors and majors, with dedicated staff, processes and coordination • All patients on the AMU should receive twice daily consultant reviews 7 days/week by the acute medicine team or relevant in-patient specialty. • AMU has rapid access to senior specialist review • The AMU team has access to patients notes including contact numbers for GP and named nurse coordinator • Priority access to diagnostics to facilitate decision making and care planning • Patients on specialist wards should receive daily consultants review 7/7

Observe, admit or discharge home	• Patients may be assessed, diagnosed and treated in one of three areas:
	  • Ambulatory area - discharge within 24 hours
	  • Short stay area - discharge within 48 hours
	  • Referred to specialist team e.g. frailty , cardiology etc.
	  • NB: patients currently may be assessed in A&E due to lack of capacity in the AMU
	• Patients are then transferred to the relevant ward or sent home
		• Nurses should undertake intentional rounding or equivalent patient checks every two hours or proportionate to clinical need.
		• All patients admitted acutely to be continually assessed using the National Early Warning System (EWS). In addition, consultant involvement for patients considered 'high risk' should be within 1 hour
		• Access to all support services essential for patient discharge must be available seven days per week (Pharmacy, Social Services, Physiotherapy, and Occupational Therapy) between 8am and 10pm
		• A structured process to be in place for the medical handover of patients twice a day. These arrangements to also be in place for the handover of patients at each change of responsible consultant/medical team. Changes in treatment plans are to be communicated to nursing and therapy staff as soon as possible if they are not involved in the handover discussions
		• Minimise in-day bed swings by maximising morning discharges – set targets to maximise discharges by a locally agreed „check-out" time

Source: The Society for Acute Medicine (2011), Workforce planning considerations for acute medicine; Carnall Farrar, clinical standards audit (2016); Priorities within Acute Hospitals, Interim Management and Support (2012)

Service delivery model – patient story: Frailty

Douglas is a 74 year old gentleman. He lives with his devoted wife in their family home. He has recently taken to his bed finding little energy or interest to participate in activity. His walking has become erratic and unsteady. His GP has called in a few times recently for injuries from falls.

What might happen in the future:

- Douglas is taken to the Acute Medical Unit (AMU) after he falls.
- He is assessed as being frail by the clinical streaming Nurse who communicates this to the team on AMU. In spite of his age, he is placed under the care of the On-call Geriatrician due his frailty needs. This triggers an urgent IDT review and an immediate Medications reconciliation.
- The IDT recognise that Douglas is at risk for frequent falls through deconditioning and balance issues. They discuss the provision of equipment to support safe living within a micro-environment. They also arrange an immediate twice daily package of care to facilitate a safe discharge. The IDT provide Douglas' wife with details of carer support to prevent carer burden.
- During the medications reconciliation, the Pharmacist notices that Douglas was previously on Diazepam and ensures that this is correctly prescribed. The need for Diazepam is reviewed and a withdrawal regimen is agreed with the GP after Douglas has returned home.
- Douglas is seen by the Frailty Consultant at 10am. A comprehensive geriatric assessment is performed. Medication changes are made. An assessment of mood is done and it is agreed that Douglas' apathy is probably related to depression for which he is happy to accept treatment. In addition, advanced care planning is discussed. Douglas does not wish to be resuscitated and this is documented on the agreed form. He expresses a wish for future treatment to be carried out in his own home. This is communicated to the GP via the discharge notification.
- With all the equipment in place and the carers to arrive for their first visit at 4pm, Douglas is discharged home safely with his wife at 2pm.

SOURCE: EKHUFT

Enablers

Changes to the out of hospital pathway	• Support for self management • Patient activation • Social prescribing • Care closer to home
Information flow and digital developments	• Patient access digital record • Clinical decision making • Appropriate information governance to enable information sharing between organisations
Clinical leadership	• Role model behaviour • Deliver consistently • Hold peers to account • Work within team
Engagement with the local population and people who use services	• Empower people who use services with informed choice • Make use of behavioural economics
Transformation of workforce	• Deliver the transformed model of care, including changes in skills, competencies, roles, numbers, settings and environments • Contribute to skill mix optimisation • Development of common continuous improvement methodology • Streamline admin processes, make use of electronic tools

Aspirations for care in Kent and Medway (across all services)

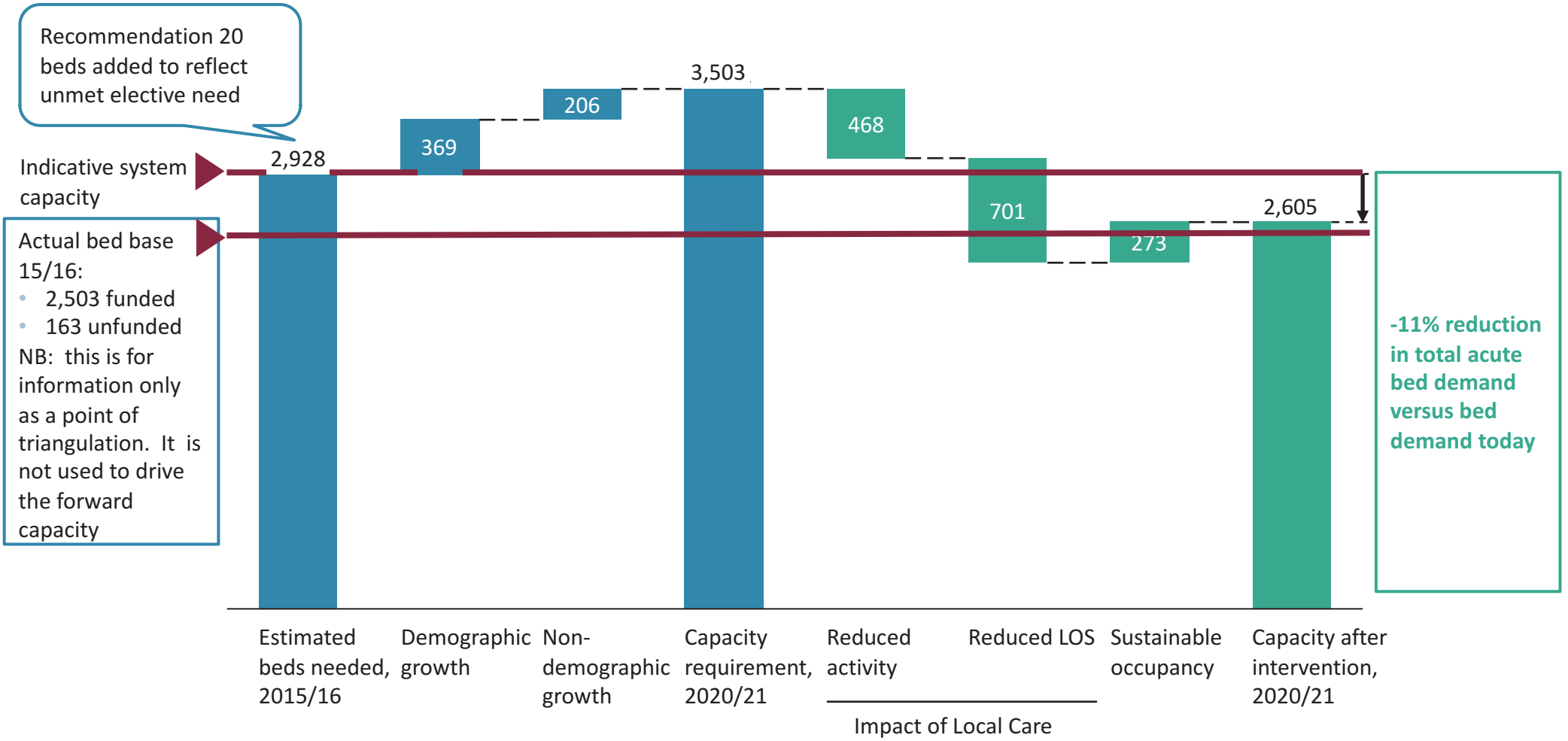
It is the aspiration that patients in Kent and Medway:

1. Are supported to self-care where appropriate
2. Have easy access to advice when needed in person and using technology;
3. Can access care through most appropriate pathway
4. Are rapidly triaged to the most appropriate provider
5. Consistently receive care which is in line with best practice
6. Optimise experience and outcomes 7 days a week

Source: K&M Clinical Board, 2017

The ambition for reducing LOS and bed occupancy in 20/21 across K&M shows an opportunity for a reduction in bed numbers

Acute bed requirements to support elective and non-elective activity



Note: Assumed occupancy rates: DGT: 99%, MTW: 94%, MFT: 99%, EKHUFT: 91%. 'Sustainable occupancy' lever estimates the impact of reducing acute bed occupancy levels to 85% across the Kent and Medway system.

SOURCE: Provider activity returns, 2015/16; KCC, ONS, GLA and East Sussex County Council population forecasts; MAR data; NHS Right Care; Carnall Farrar analysis

This pack focuses on the 'in-hospital' element of the full service delivery model

1 Prevention

- Enlisting public services, employers and the public to support health and wellbeing

2 Local care

- A new model of care closer to home for integrated primary, acute, community, mental health and social care

3 Hospital care

- Optimal capacity and quality of specialised, general acute, community and mental health beds

4 Mental Health

- Bringing parity of esteem, integrating physical and mental health services, and supporting people to live fuller lives

This pack will focus on the clinical model that has been developed to optimise the non-elective pathway underpinned by a service delivery model for an acute medical unit

There will be interventions along the pathway to improve outcomes

1. Avoid admissions
2. Reduce time spent in a bed
3. Optimise the discharge process
4. Facilitate re-ablement and return to independence

Focus of this pack

In hospital

- Behaviour change, "removing barriers of permission"
- Rapid assessment by senior decision maker (ST4+)
- Streaming to medical assessment unit
- A&E process improvements to enable going home early
- Access to hot / ambulatory clinics

- Shared Ownership of place of care for patient
- Discharge to assess
- Generic workforce

- Daily MDT discharge meeting including community and care coordinators, nursing and medical team
- Advance care planning
- Pharmacy services support
- Optimise the discharge process

- Enhanced transport offer

Focus on key groups such as frail elderly, dementia and mental health

Local care focus

Out of hospital

- Single point of access
- Ensure consistency across care models at point of crises
- Integrated care planning
- Greater interaction with voluntary sector including contracting and coordination
- Focus on integrated care
- Better interface with specialist advice
- Enhanced residential and nursing home support

- Shift attitude and behavior of workforce toward risk management to avoid admission

- Rapid access to packages of care when needed
- Pull rather than push

- Use of a single care record
- Access to patient record
- Better use of telemedicine and tele care to manage people out of hospital

At home

- Support carers
- Shift therapy workforce to out of hospital
- 2hr rapid response over all community (via single point of access)
- Access to specialist opinion

- Ensure home environment meets anticipated needs on discharge at the point of admission

- Support carers to reable
- Shift therapy workforce to out of hospital
- Night sitting
- Support individual decision making

The SAFER is a practical tool to reduce delays for patients in adult inpatient wards, this should be used to agree a set of internal professional standards

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

SORCE: The SAFER Patient Flow Bundle, NHS Improvement (2016)

Local care: key elements of the complex elderly care model

Supporting people to be healthy and independent

1 Care and support planning with care navigation and case management

Care navigators and case managers integrate health and social care service delivery, and work much more collaboratively with a wide range of community care colleagues in order to coordinate the care required for their patients

2 Self-care and management

Support people and their carers to improve and maintain hea… …llbeing by building knowledge and changing behaviours through proactive… …ngagement

3 Healthy living environment

Work to ensure a healthy living enviro… …ng-term health & wellbeing e.g. falls prevention, housing improv… …ns

Coordinated care for people who need it

4 Integrated health and social care into or coordinated close to the home

Patient centered, co… …plinary care services, wrapped around GP practices and communit… …are to patients who have care plans assigned dependent on their n…

5 Single point of access

…d by the patient, the GP, community services and acute staff to support …th their care by gaining more efficient, coordinated access to services

6 Rapid R…

The ability within an MDT to respond rapidly to complex patients who are experiencing a health or social care need that left unattended would result in a possible hospital admission

… planning and …blement

A pro-active, anticipatory service designed to target those patients who are medically optimised for discharge, no longer requiring an inpatient bed, but still needing some level of care to prevent their health from deteriorating

Supporting services

8 Access to expert opinion and timely access to diagnostics

The ability for primary care professionals to access a specialist opinion in the community setting and where appropriate, a specialist triage for diagnostics. Access to diagnostic services and the ability to ensure diagnostic results are full and timely will reduce the need for multiple outpatient appointments

The Local Care workstream is developing detailed models of care to avoid emergency admissions to hospital and support rapid discharge. The focus of this pack is on the in-hospital pathway.

Source: K&M STP Local Care workstream, Carnall Farrar

Timely and appropriate discharge from A&E can also be supported by other schemes such as occurs in the voluntary sector Take Home & Settle service in East Sussex

About the service

This service enables older people who have attended Accident and Emergency, at the Conquest Hospital Hastings or the Eastbourne District General Hospital, to go home rather than be admitted to hospital.
It serves older residents of East Susssex with an emphasis on those who live alone or who are carers. It helps to facilitate a safe discharge from hospital, accompany patients home and ensures they are safely settled in.

How the service works

The service provides support to clients discharged from hospital by offering a broad range of services including:

- Taking them home from hospital and settling them in, making sure that they are comfortable
- Carrying out a risk assessment for their safety
- Obtaining any immediate shopping they may need
- Making a cup of tea and preparing a snack if required
- Light housekeeping including tidying and changing bed linen
- Installing/positioning any equipment from hospital
- Assisting in the management of medications
- Helping with simple form filling
- Supporting self care/confidence building
- Sign posting to other services

Who can use the service?

This free service is for residents of East Sussex who are aged 55 and over, especially those who live alone, are carers or have had a fall.

SOURCE http://www.ageuk.org.uk/east Sussex/services-we-provide/take-home-and-settle/

Chronic obstructive pulmonary disorder HOT clinics will aid admission avoidance for patients who cannot wait for an urgent respiratory clinic appointment

Chronic obstructive pulmonary disorder (COPD) HOT clinics are rapid access clinics that helps people with COPD avoid hospital admission

- Patients that risk coming to accident and emergency department because their condition has suddenly worsened can be referred by a GP to be seen by a specialist in Acute Medicine or Respiratory on the same day or next day.
- Some Trusts currently offer this service but there is scope for this to be extended across all Kent and Medway Trusts.

The following pathways are available for a patient presenting with the primary diagnosis of COPD exacerbation:

Patient presentation following review by GP / specialist respiratory nurse practitioner	Care pathway
1) Acute patient making contact with ambulance service	→ Emergency patient is transferred to ED → AMU
2) Patient experiencing unsuccessful treatment and is on the verge of admission	→ Patient is referred to the AMU
3) Patient cannot wait for an urgent respiratory clinic appointment but are not needing immediate specialist management	→ Patient is referred to respiratory HOT Clinic (within 2-3 days)
4) The patient is stable, socially supported, there is no confusion and no chest pain	→ Home management is considered

The model of HOT clinics can be extended to a wider range of specialties such as cardiology for heart failure or chest pain, gastroenterology, endocrine and renal . These urgent clinic slots can be used to enhance earlier discharge of medical patients as it provides a means to review to monitor progress and response to treatment

SOURCE: University of Leicester AEC pathways

Extensive research has shown that Comprehensive Geriatric Assessment (CGA) in increases independence and reduces mortality

Comprehensive geriatric assessment (CGA) may reduce short-term mortality, increase the chances of living at home at 1 year and improve physical and cognitive function.

The Single Assessment Process (SAP) sets out the four levels of assessment:

1. Contact assessment	This is the basic information about an individual and what they are seeking help with and is used routinely in all interactions for an older person who might seek help from a doctor, apply for Meals-on-Wheels Service, or request a hearing aid, for example.
2. Overview assessment	This is a broad but simple assessment across all the domains of comprehensive assessment but of a much lighter touch. The purpose is to identify whether there is or is not a problem. This is commonly incorporated into an assessment when anything more than the most basic health or social care provision is to be provided. This overview assessment identifies individual areas where more detailed and specialist assessments are necessary.
3. Specialist (in depth) assessment	This then is the in depth assessment which usually requires a diagnostic process and treatment planning by a clinician trained to deal with that particular aspect, e.g. a physiotherapist or audiology technician or geriatrician.
4. Comprehensive assessment	This can be understood as an in depth assessment across all domains, and can be adapted to the specific purpose and usually requires a trained multidisciplinary team.

Overall, for every 100 patients undergoing CGA, three more will be alive and in their own homes compared with usual care

SOURCE: http://www.bgs.org.uk/good-practice-guides/resources/goodpractice/gpgcgassessment
Comprehensive geriatric assessment for older hospital patients. Ellis G[1], Langhorne P.2005

The service model will incorporate the NHS England pathway for people with dementia, based on NICE guidelines

PREVENTING WELL	DIAGNOSING WELL	SUPPORTING WELL	LIVING WELL	DYING WELL
Risk of people developing dementia is minimised	Timely accurate diagnosis, care plan, and review within first year	Access to safe high quality health & social care for people with dementia and carers	People with dementia can live normally in safe and accepting communities	People living with dementia die with dignity in the place of their choosing
"I was given information about reducing my personal risk of getting dementia"	"I was diagnosed in a timely way" "I am able to make decisions and know what to do to help myself and who else can help"	"I am treated with dignity & respect" "I get treatment and support, which are best for my dementia and my life"	"I know that those around me and looking after me are supported" "I feel included as part of society"	"I am confident my end of life wishes will be respected" "I can expect a good death"
STANDARDS:	STANDARDS:	STANDARDS:	STANDARDS:	STANDARDS:
Prevention(1) Risk Reduction(5) Health Information(4) Supporting research(5)	Diagnosis(1)(5) Memory Assessment(1)(2) Concerns Discussed(3) Investigation (4) Provide Information(4) Integrated & Advanced Care Planning (1)(2)(3)(5)	Choice(2)(3)(4). BPSD(6)(2) Liaison(2). Advocates(3) Housing (3) Hospital Treatments(4) Technology(5) Health & Social Services (5) Hard to Reach Groups(3)(5)	Integrated Services(1)(3)(5) Supporting Carers(2)(4)(5) Carers Respite(2). Co-ordinated Care(1)(5) Promote independence(1)(4) Relationships(3). Leisure(3) Safe Communities(3)(5)	Palliative care and pain(1)(2) End of Life(4) Preferred Place of Death(5)

References: (1) NICE Guideline. (2) NICE Quality Standard 2010. (3) NICE Quality Standard 2013. (4) NICE Pathway. (5) Organisation for Economic Co-operation and Development (OECD) Dementia Pathway. (6) BPSD – Behavioural and Psychological Symptoms of dementia.

RESEARCHING WELL

- Research and innovation through patient and carer involvement, monitoring best-practice and using new technologies to influence change.
- Building a co-ordinated research strategy, utilising Academic & Health Science Networks, the research and pharmaceutical industries.

INTEGRATING WELL

- Work with Association of Directors of Adult Social Services, Local Government Association, Alzheimer's Society, Department of Health and Public Health England on co-commissioning strategies to provide an integrated service ensuring a seamless and integrated approach to the provision of care.

COMMISSIONING WELL

- Develop person-centred commissioning guidance based on NICE guidelines, standards, and outcomes based evidence and best-practice.
- Agree minimum standard service specifications for agreed interventions, set business plans, mandate and map and allocate resources.

TRAINING WELL

- Develop a training programme for all staff that work with people with dementia, whether in hospital, General Practice, care home or in the community.
- Develop training and awareness across communities and the wider public using Dementia Friends, Dementia Friendly Hospitals/Communities/Homes.

MONITORING WELL

- Develop metrics to set & achieve a national standard for Dementia services, identifying data sources and set 'profiled' ambitions for each.
- Use the Intensive Support Team to provide 'deep-dive' support and assistance for Commissioners to reduce variance and improve transformation.

SOURCE: The well pathway for dementia – NHS England, 2016

The K&M local care model specifies that each dementia patient* would have a a dedicated case manager who integrate their multidisciplinary care and support

Tier 3 Case Management

Case Management is for older people with very complex needs (e.g. end of life care needs, older people with dementia, older people with 3 or more LTCs) who require intensive support to ensure they stay out of hospital as much as possible. A dedicated case manager will be involved in their annual care and support planning and provide more intensive support of condition management, integration of services, adherence to the care plan and more supportive social prescribing. Access will also be available to additional services through the single point of access including rapid response services as appropriate.

*** An elderly patient with dementia would constitute a Tier 3 patient**

SOURCE: The K&M local care toolkit 2017

Liaison mental health services in the hospital will aim to increase the detection, recognition and early treatment of impaired mental wellbeing and mental disorder

What are acute liaison services?

An acute liaison service is designed to provide services for:

- people in acute settings (inpatient or outpatient) who have, or are at risk of, mental disorder
- people presenting at A&E with urgent mental health care needs
- people being treated in acute settings with co-morbid physical disorders such as long-term conditions (LTCs) and mental disorder
- people being treated in acute hospital settings for physical disorders caused by alcohol or substance misuse and people whose physical health care is causing mental health problems

Liaison mental health services aims to:

- reduce excess morbidity and mortality associated with co-morbid mental and physical disorder
- reduce excess lengths of stay in acute settings associated with co-morbid mental and physical disorder
- reduce risk of harm to the individual and others in the acute hospital by adequate risk assessment and management
- reduce overall costs of care by reducing time spent in A&E departments and general hospital beds

There is currently no single, uniform model for liaison services across the country and their effectiveness varies greatly

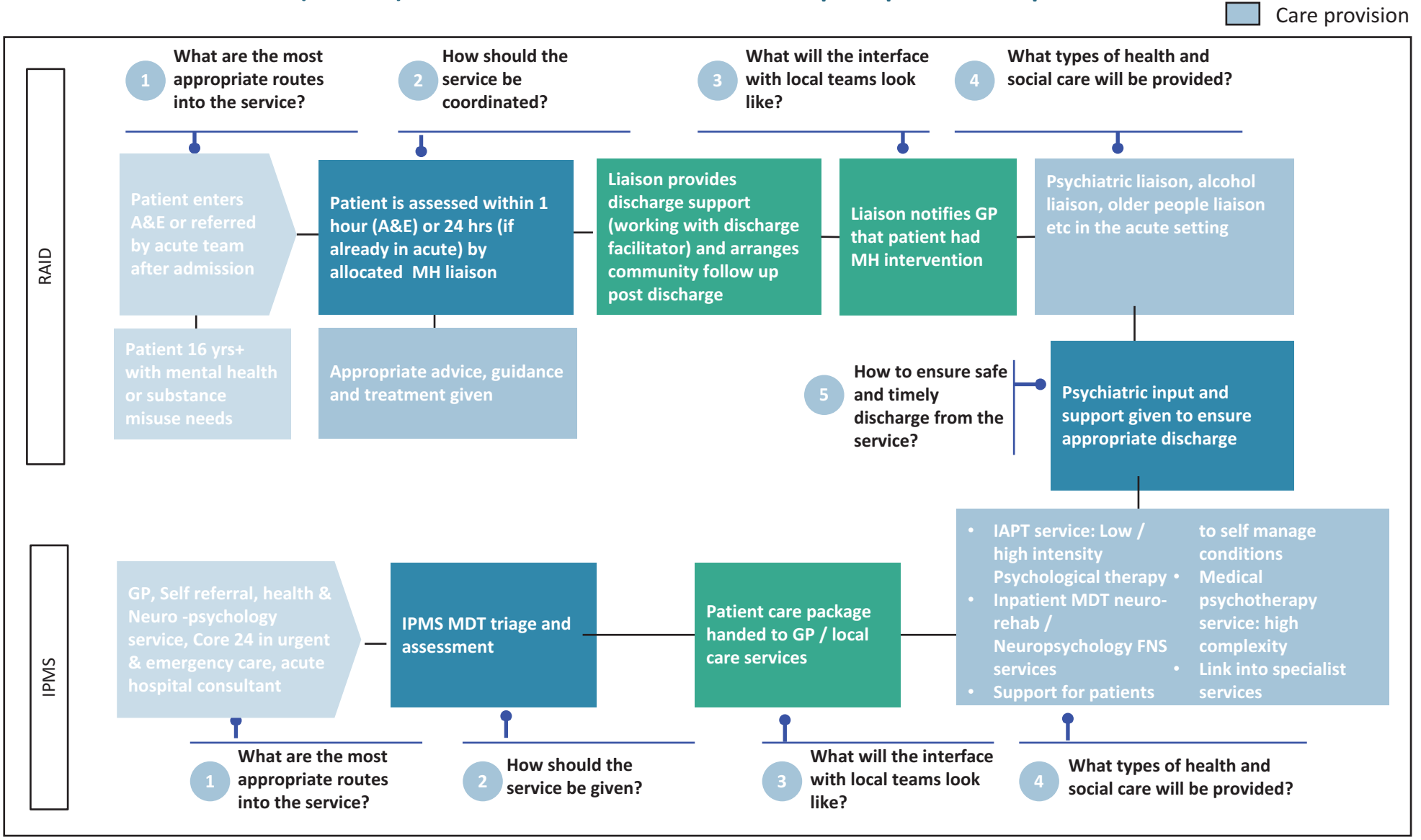
What will a good liaison service look like?

The core service will be based on the following principles:

- A 24/7 liaison psychiatry service in medical assessment units and inpatient wards
- staff members sole (or main) responsibility is to the acute liaison team
- the team includes adequate skill mix
- the team has strong links with specialist mental health services and good general knowledge of local resources
- there is clear and explicit responsibility for all patients in the acute hospital setting
- here is one set of integrated multi-professional healthcare notes
- consultant medical staff are fully integrated.

SOURCE: https://www.rcpsych.ac.uk/pdf/JCP-MH%20liaison%20(march%202012).pdf

The Rapid Assessment Interface and Discharge (RAID) & Integrated Psychological Medicine Service (IPMS) models will be used for people with poor mental health



Trusts will increasingly need to deliver 7-day services in acute medicine to allow timely access to a senior medical opinion (ST4 and above)

"Most importantly, we need to ensure that anywhere that displays a red and white sign is a place that will **provide access** to the very **best care** for the most seriously ill and injured patients, **24 hours a day and 7 days a week**."[1]

"… the vision of a future hospital in which all patients receive **safe, high-quality care** coordinated to meet their clinical and support needs across **7 days**."[2]

"**Seven-day services** in hospital: acutely ill patients in hospital will have the same access to medical care on Saturdays, Sundays and bank holidays as on a week day. Services will be organised so that **consultant review**, **clinical staff**, and **diagnostic and support services** are readily available on a 7-day basis."[2]

"The medical workforce will need to adapt to ensure it can meet demographic pressures, and deliver continuity of care, 7-day services, and integration of hospital and community healthcare in a sustainable fashion."[2]

"The presence of **senior clinicians seven days a week** will be important for ensuring the **best decisions** are taken, reassuring patients and families and making best use of NHS resources."[1]

"The study clearly showed that in obstetrics, paediatrics, intensive care and acute medicine the level of activity is the same throughout the 24- hour period and therefore the **cover required** should be the same **24 hours a day, 7 days a week**."[3]

"Medical support for all hospital inpatients: the remit and capacity of medical teams will extend to adult inpatients with medical problems across the hospital, including those on 'non-medical' wards such as surgical patients. There will be 'buddy' arrangements between consultant physician teams and designated surgical wards to ensure reliable access to a **consultant physician opinion 7 days a week**."[2]

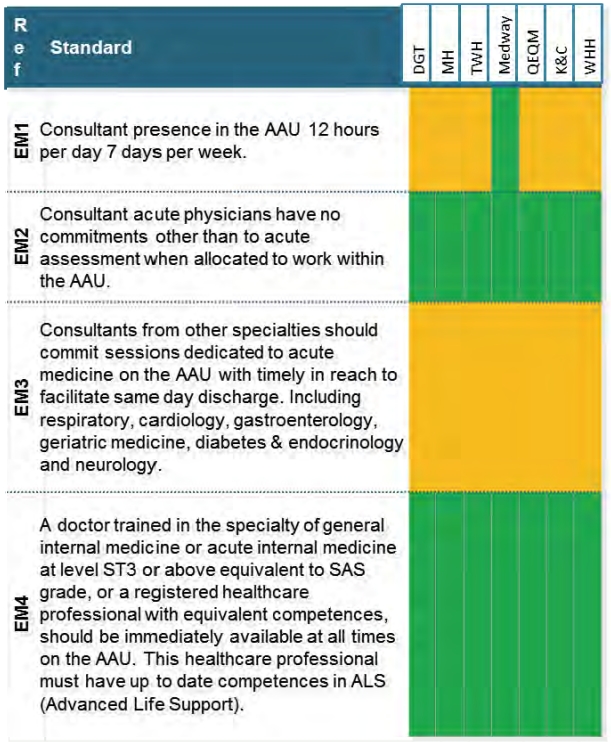
"There will be a **consultant presence** on wards over **7 days**, with ward care prioritised in medical job plans."[2]

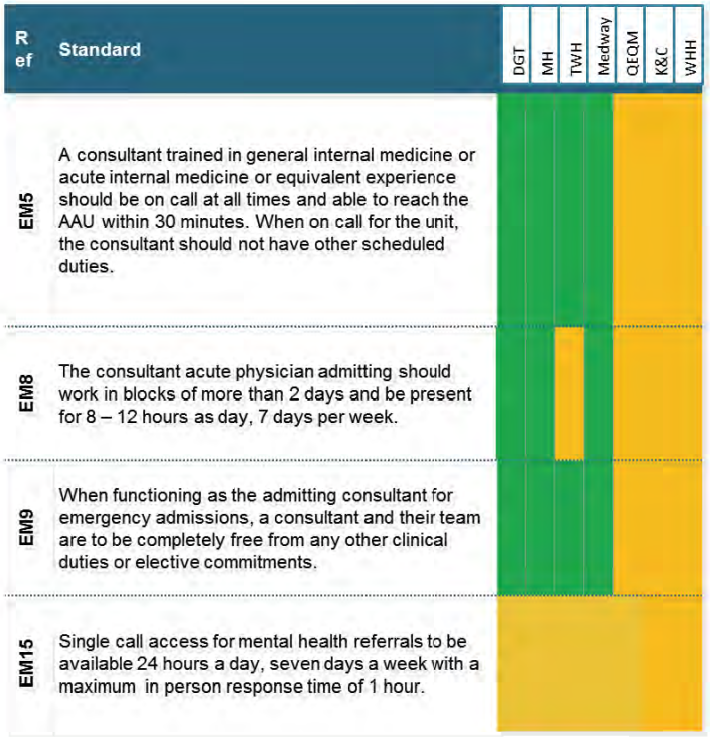
"…aims to develop a **new model of care** that delivers safe, high-quality care for patients **across 7 days**."[2]

[1] Transforming urgent and emergency care services in England: Urgent and Emergency Care Review, 2013, NHS England
[2] Future Hospital: Caring for medical patients, September 2013, Royal College of Physicians

This will enable the new service delivery model to meet the standards set out in the case for change

- A Kent and Medway-wide clinical standards audit has been undertaken as part of the Case for Change
- It highlighted several areas where the current services are not meeting the national recommendation/target
- The new service delivery model has been designed with the expectation that all standards will be met by all Trusts 7 days a week





Source: Trust data, Carnall Farrar, clinical standards audit (2016)

Evidence for the reduction of non-elective activity

	Source	Study	Impact
Comprehensive review of integrated care	Damery et al (2016)	50 reviews were included. Interventions focused on case management, chronic care model, discharge management, complex interventions, multidisciplinary teams and self-management	Reduced NEL admissions by 15–50%; A&E use by 30–40%
	Systematic review Richardson (2016); Richardson & Dorling (2014)	A meta-analysis of 43 studies drawn from Cochrane Review and other systematic sources of studies with well characterized end point of impact on hospitalization.	Median impact of studies is a 19% reduction in emergency admission
	Systematic review NAO (2013)	26% of patients attending a major A&E department were then admitted to hospital in 2012-13. Approximately one-fifth of admissions are for known conditions which could be managed effectively by primary, community or social care and could be avoided.	1/5 NEL admissions are avoidable
Care Coordination and Planning	Case study Sonola et al (2013)	• Torbay, Devon. The Torbay Community Trust established 5 integrated health and social care teams organised in localities aligned with GPs • Daily occupied beds fell from 750 to 502 in 10 years	Emergency bed day use among > 65s is the lowest in the region
	Systematic review Goodwin et al. (2012)	Wales, Carmarthenshire, Cardiff and Gwynedd. co-ordinate care for people with multiple chronic illness. By employing a 'shared care' model of working between primary, secondary and social care. Overall cost reduction of £2m	16.5-27% reduction in NEL admissions for patients with long term conditions
	Case study Richardson et al. (2016) LGA	The Northumberland Frail Elderly Pathway achieved significant impact in terms of emergency admissions reductions between April 2011 and July 2013, with an expected 36% decrease in emergency admissions as compared to a business-as- usual scenario.	Reduced NEL admissions by 36%

Evidence for the reduction of non-elective activity

	Source	Study	Impact
Multi-disciplinary teams	Systematic review Holland et al (2005)	Systematic review of Multi disciplinary teams (MDTs) found a positive impact with hospitalisations reduced by 15-30%. In Northumberland: patients reviewed by a MDT showed a 36% decrease in emergency admissions	Reduced NEL admissions by 15-36%
	Systematic review Damery et al (2016)	MDT were generally effective when used for patients with single conditions, 25% reduction in emergency admission for a COPD MDT with formal links to primary care, through 26% for teams that included specialist heart failure expertise, to 31% for teams that included pharmacists as collaborators	25-31% reduction in admission rates for target conditions; Significantly reduced A&E use
Rapid Response	Rapid review Woodward and Proctor (2016)	Rapid review of rapid response services found that a significant amount of users were able to be treated in their own homes, avoiding a substantial amount of emergency admissions	80-95% of cases referred to the rapid response service avoided an emergency admission
Self-management	Systematic review Damery et al (2016)	Structured self-management interventions demonstrated a 43% reduction in the relative risk of COPD-related admission	Reduced NEL admissions by 43%
	Systematic review Purdy (2010)	Self-management effective in reducing unplanned admissions for patients with COPD and asthma	Reduced NEL admissions by 35-50%
Falls Prevention	Better Care Fund Report (2014)	Falls prevention services in Greenwich, including balance classes and home modifications, reduced 57% of falls admissions	Reduced NEL falls admissions by 57%

Evidence for reduction of non-elective length of stay

	Source	Study	Impact
Discharge support and planning and reablement	Systematic reivew Shepperd, S et al. (2010)	A systematic review of 21 randomised controlled trials evidenced that hospital length of stay (LoS) and readmissions to hospital were significantly reduced for patients allocated to discharge planning (mean difference length of stay −0.91, 95% CI −1.55 to −0.27, 10 trials; readmission rates RR 0.85, 95% CI 0.74– 0.97, 11 trials)	Reduced average LoS by 1 day
	Systematic review Damery et al (2016)	Pooled results from the early supported discharge meta-analysis suggested a mean LoS reduction of 7.7 days, rising to 28 days for the most severely impaired patients compared to 4 days for moderately impaired patients.	Average reduction of 7.7 days
	Case studies National Audit Office (2010)	Newcastle: Early supported discharge (ESD) decreased costs for health and personal care for stroke survivors within the ESD service in the 6/12 after stroke was £7,155 per patient, compared with £7,480 per patient receiving conventional care Scunthorpe: over three years this significantly reduced LOS from 10,397 to 4,947, with cost savings based on £270 per day, this equates to savings of £1,471,500.	50 - 60% reduction in LoS
	Case study Kapur et al (2016)	A pilot of early supported discharge for fractured neck of femur patients reduced length of stay dramatically from an average of 22.9 days to 8.8 days	Reduced average LoS by 60%
Care Coordination and Planning in conjunction with MDTs	Case studies Sonola et al (2013) Goodwin et al. (2012)	**Torbay, Devon**: Torbay Community Trust established 5 integrated health and social care teams organized in localities aligned with GPs . Daily occupied beds fell from 750 in 1998/99 to 502 in 2009/10; emergency bed day use among > 65s is the lowest in the region reduced DTOCs; increased home care provision	Reducing bed days for emergency admissions by 15-30% for target cohort

Evidence for the reduction of avoidable admissions

	Source	Study	Impact
Avoidable admissions	Reducing avoidable hospital based care: re-thinking out of hospital clinical pathways (2016)	An independent clinical review to provide advice and recommendations on how pathways could be re-designed to achieve the goal of improved acute and chronic disease management in the community, thereby moving more care out of the hospital setting.	Reduced NEL admissions by 15-36%
	Integrated respiratory action network for patients with COPD, Terri (2016)	This Future Hospital Programme case study describes how a team from The Royal Wolverhampton NHS Trust established a respiratory action network for patients with chronic obstructive pulmonary disease (COPD). A key reccomendation was the development of respiratory HOT clinics for admission avoidance can help to stem the growth of admissions	A total of 359 patients were seen in the HOT clinic from July 2014 until the end of June 2015. The admission rate for patients seen in the clinic is 5-9% within the same financial year; whereas admission rates for 'scientifically similar' respiratory not seen in the HOT clinic is around 19%.

Contents

What are the co-dependencies and building blocks?: Summary

1. Who is the population being served?`
2. What are the issues in the case for change which need to be addressed?
3. What is the service delivery model today?
4. What is the proposed service delivery model for the future?
5. **What are the co-dependencies and building blocks?**
6. What engagement has been undertaken?

- The models in the Keogh report and RCP 'The Future Hospital' have been used as a basis for developing building blocks of services.
- The South East Clinical Senate has undertaken work to understand the co-dependencies between services and these have been used to further describe the Keogh models.
- The models are Major Emergency Centre with specialist services, Emergency Centre, Emergency Medical Centre and Urgent Care Centre.

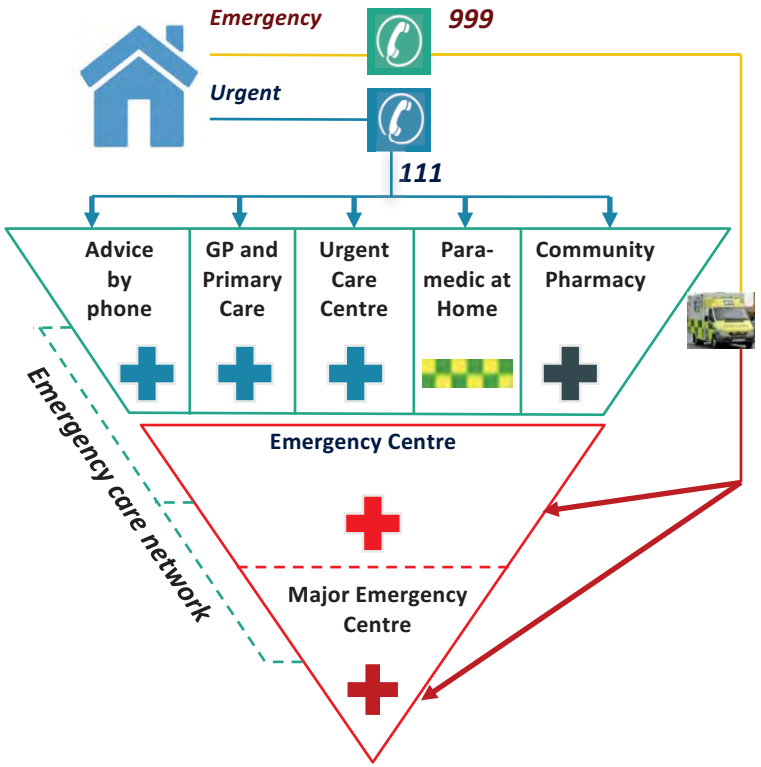
The following slides collate an evidence base to support the issue outlined here

Summary of building blocks of services

- The South East clinical senate has developed a list of co-dependencies between different services for urgent care
- The Keogh models have been used extensively locally to review and agree potential interdependencies
- The Royal College of Physicians ‘ The Future Hospital’
- Carnall Farrar have worked across a number of different health economies to define interdependencies and delivery models
- These three pieces of work have been used to develop proposed building blocks of services for acute care:
    1. Major emergency centre (with specialist services)
    2. Emergency centre
    3. Medical emergency centre
- These building blocks can be co-located or can be located on separate sites. The hurdle and evaluation criteria are used to determine how many of each are required and where they might be located.

The Keogh work in 2014 proposed a network of urgent care

- Major Emergency Centres (MECs) have a concentration of specialist expertise and services which are likely to fall within the remit of specialist commissioning. They provide support and coordination to a whole network for patients with specialist emergency care needs, and work in partnership with the other system components to ensure that patients are able to access specialist care in a timely way.
- An MEC includes specialist facilities that receive patients from Emergency Centres, or directly from an ambulance which has bypassed an Emergency Centre. Such facilities should include two or more specialist services such as major trauma, heart attack, critical care or stroke
- Emergency Departments that are integral to MECs will provide consultant presence over extended hours, immediate access to enhanced diagnostics, such as CT and MRI scanning and interventional radiology, and a wider range of facilities, as a result of the increased capabilities of the hospital in which they are located.



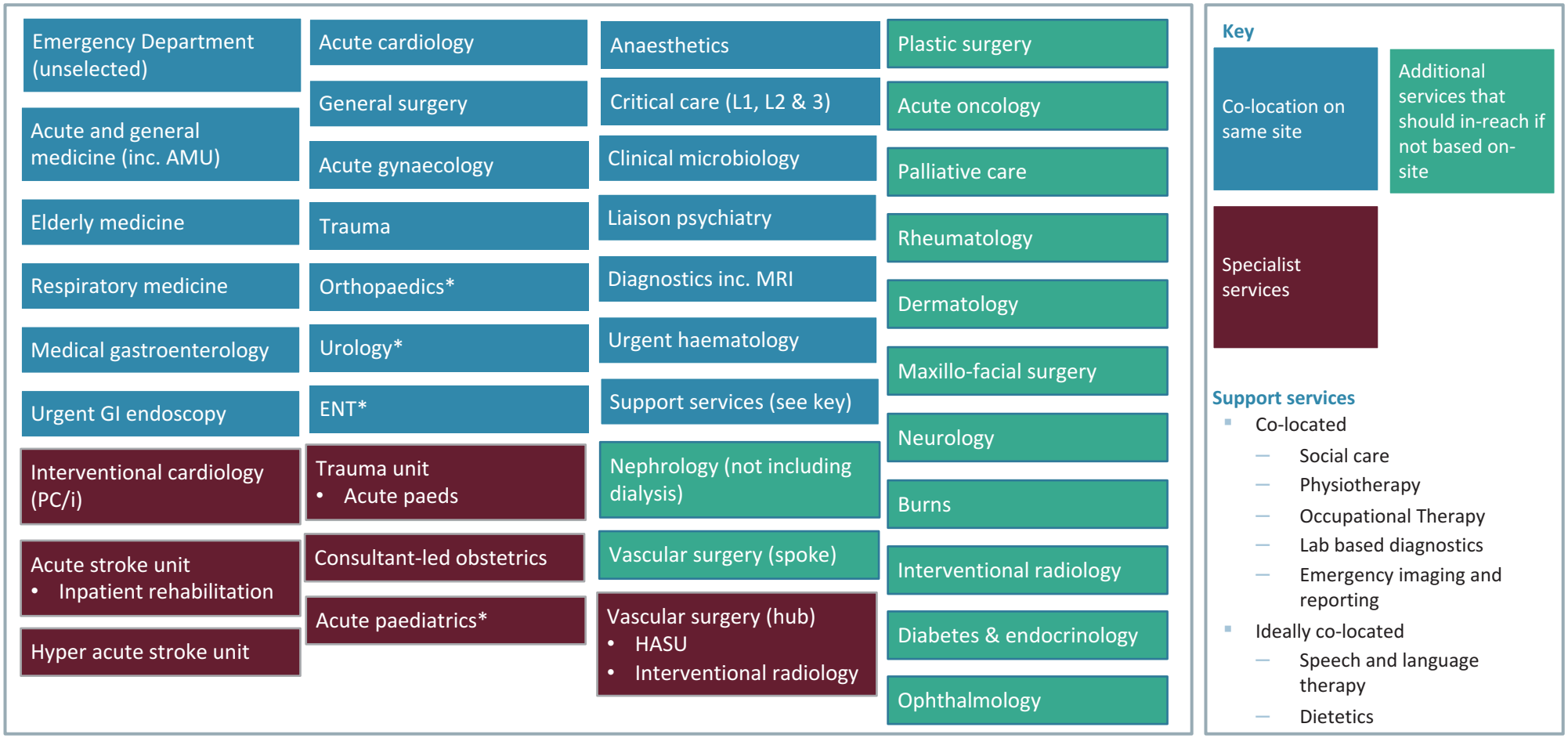
Source: Sir Bruce Keogh, Transforming Urgent and Emergency care services in England, End of Phase 1 Report, 2014

From the Keogh work, six different types of centres are proposed

	What	Services offered
Major trauma centre	▪ Specialised centres co-locating tertiary/complex services on a 24x7 basis ▪ Serving population of at least 2 -3million	▪ Neurosurgery, Cardiothoracic surgery ▪ Full range of emergency surgery and acute medicine ▪ Full range of support services, ITU etc
Major Emergency Centre with specialist services	▪ Larger units, capable of assessing and initiating treatment for all patients and providing a range of specialist hyper-acute services ▪ Serving population of ~ 1-1.5m	▪ Hyperacute cardiac, stroke , vascular services ▪ Trauma unit ▪ Level 3 ICU ▪ Moving towards 24x7 consultant delivered A&E, emergency surgery, acute medicine, inpatient paeds ▪ Full obstetrics and level 3 NICU
Emergency Centre	▪ Larger units, capable of assessing and initiating treatment for the overwhelming majority of patients but without all hyper-acute services ▪ Serving population of ~ 500-700K	▪ Moving towards 24x7 consultant delivered A&E, emergency surgery, acute medicine ▪ Level 3 ICU ▪ Inpatient Paeds and obstetrics with level 2/3 NICU
Medical Emergency Centre	▪ Assessing and initiating treatment for majority of patients ▪ Acute medical inpatient care with intensive care/HDU back up ▪ Serving population of ~ 250-300K	▪ Consultant led A&E ▪ Acute medicine and critical care/HDU ▪ Access to surgical opinion via network ▪ Possibly paeds assessment unit and possibly midwife-led obstetrics
Integrated care hub with emergency care	▪ Assessing and initiating treatment for large proportion of patients ▪ Integrated outpatient, primary, community and social care hub ▪ Serving population of ~ 100-250K	▪ GP-led urgent care incorporating out of hours GP services ▪ Step up/step down beds possibly with 48 hour assessment unit ▪ Outpatients and diagnostics ▪ Possibly midwife-led obstetrics
Urgent care centre	▪ Immediate urgent care ▪ Integrated outpatient, primary, community and social care hub ▪ Serving population of ~ 50-100K	▪ As above but no beds

Source: Sir Bruce Keogh, Transforming Urgent and Emergency care services in England, End of Phase 1 Report, 2014

1. Major emergency centre (with specialist services)

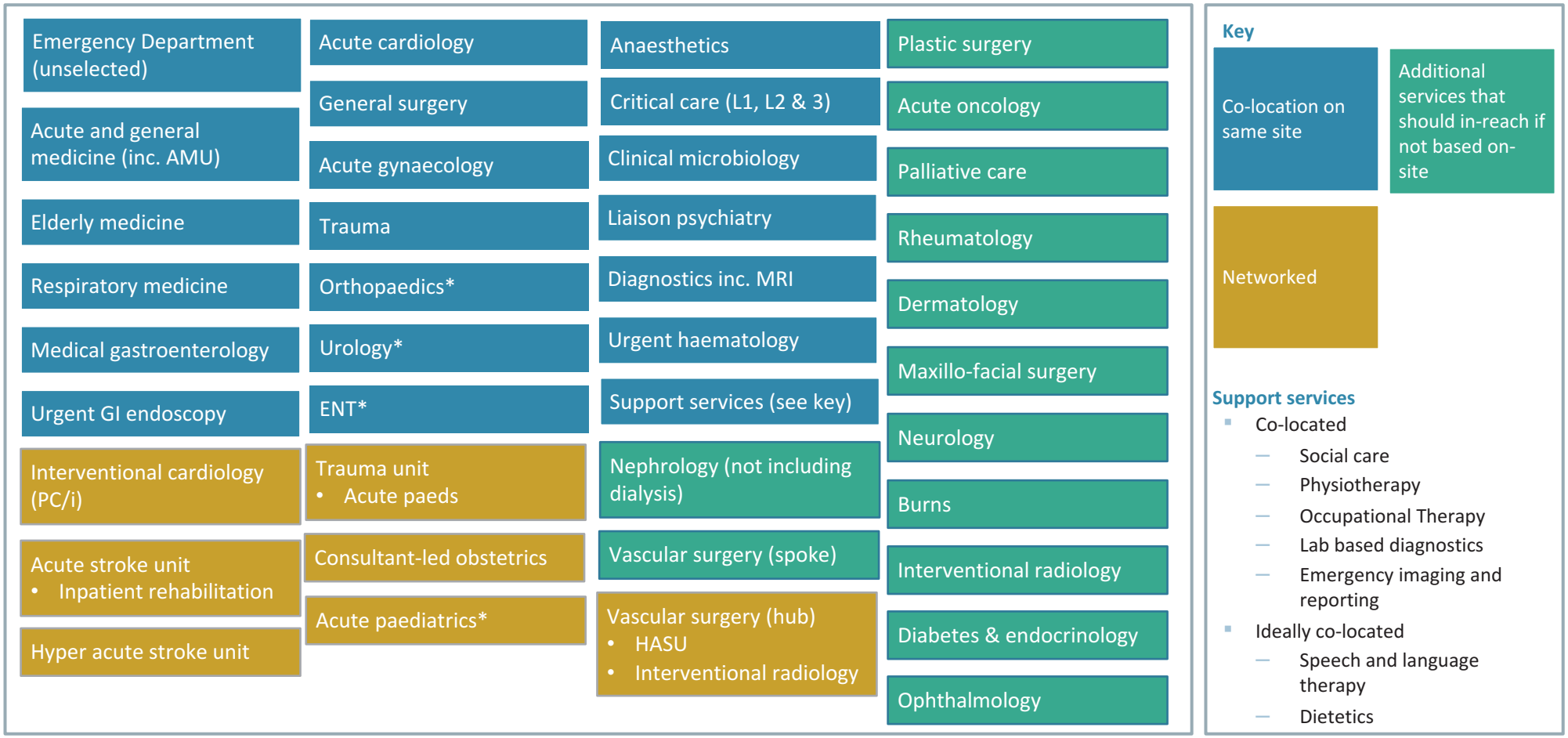


Source: [The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review December 2014], Carnall Farrar analysis

- In-reach may be sufficient depending on ED pathways (required for a trauma unit)

*Non-specialised paediatrics and paediatric surgery

2. Emergency centre

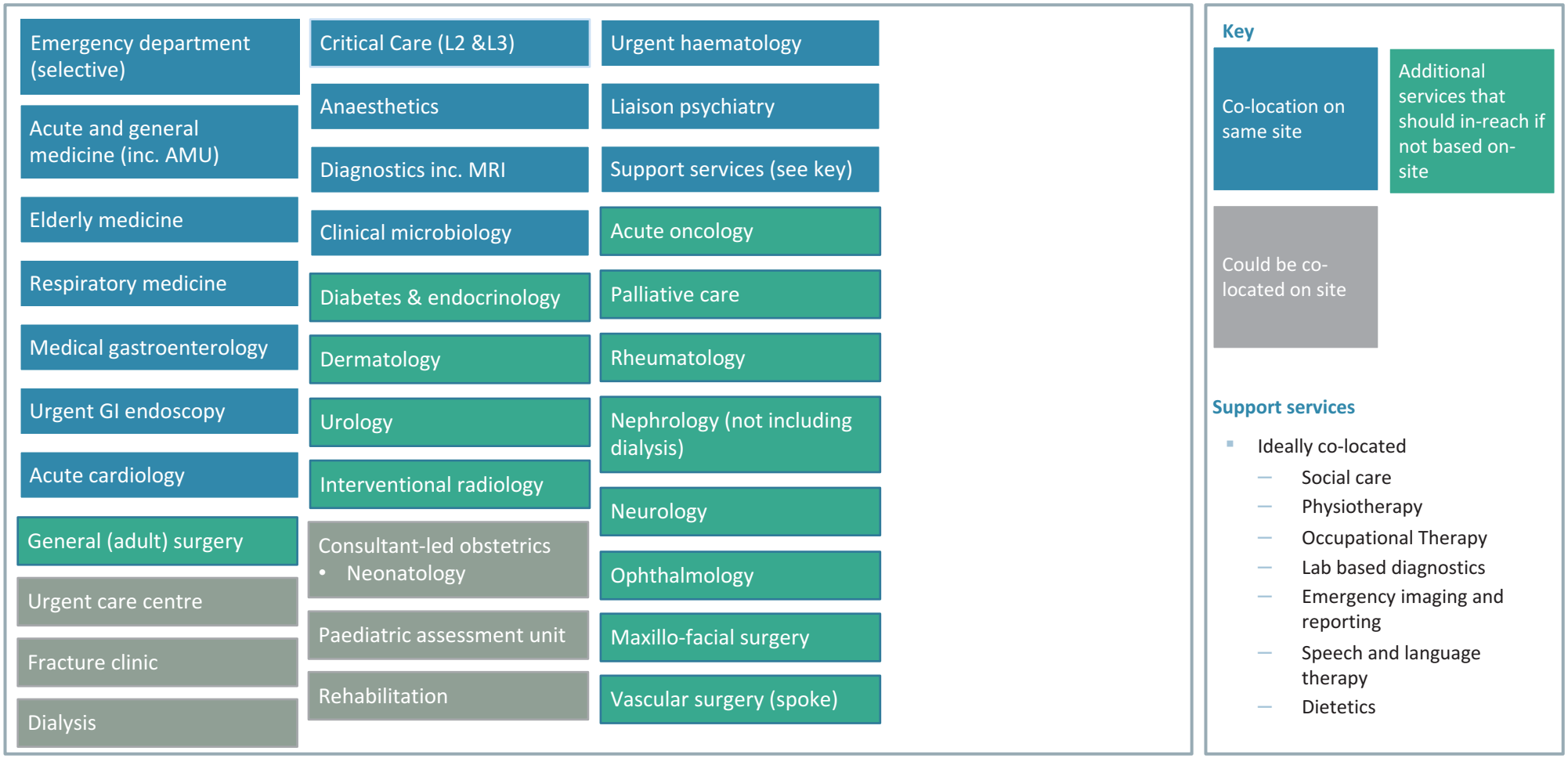


Source: [The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review December 2014], Carnall Farrar analysis

- In-reach may be sufficient depending on ED pathways (required for a trauma unit)

*Non-specialised paediatrics and paediatric surgery

3. Medical emergency centre



Source: [The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review December 2014], Carnall Farrar analysis

There are critical interdependencies for these building blocks

The work carried out by the south east coast clinical senate will govern co-dependencies when considering options for future acute service change

- It is proposed that the co-dependencies work carried out by the South East Coast Clinical Senate will be used to assess any impact of future acute services change
- The work undertaken by the SECCS provides generic advice about what services needed to be provided in the same hospital (either based there, or inreaching), and what could be provided on a networked basis
- The dependencies of eleven major acute hospital services were reviewed and the dependencies on a wide range of acute hospital based services assessed

CO-DEPENDENCIES DEFINITIONS: COLOUR KEY	
The colour describes the dependency of the service in the row, on the support service in the column. Note that both the Purple and Red dependencies describe column services that should not require the patient to move hospitals	
PURPLE	
Service should be co-located (based) in same hospital	
RED	
Service should come to patient (patient transfer not appropriate), but could be provided by visiting/inreach from another site (either physically, or via telemedicine links) if not based in the same hospital	
2	Within 2 hours
4	Within 4 hours
24	Within 24 hours
	Not specified
AMBER	
Ideally on same site but could alternatively be networked via robust emergency and elective referral and transfer protocols	
GREEN	
Does not need to be on same site. Appropriate arrangements are in place to obtain specialist opinion or care	

This resulted in a grid for identifying core groupings of services and the requirements for co-dependent service provision, as described in the rating scale

Source: South East Coast Clinical Senate (2014) The Clinical Co-Dependencies of Acute Hospital Services – A Clinical Senate Review

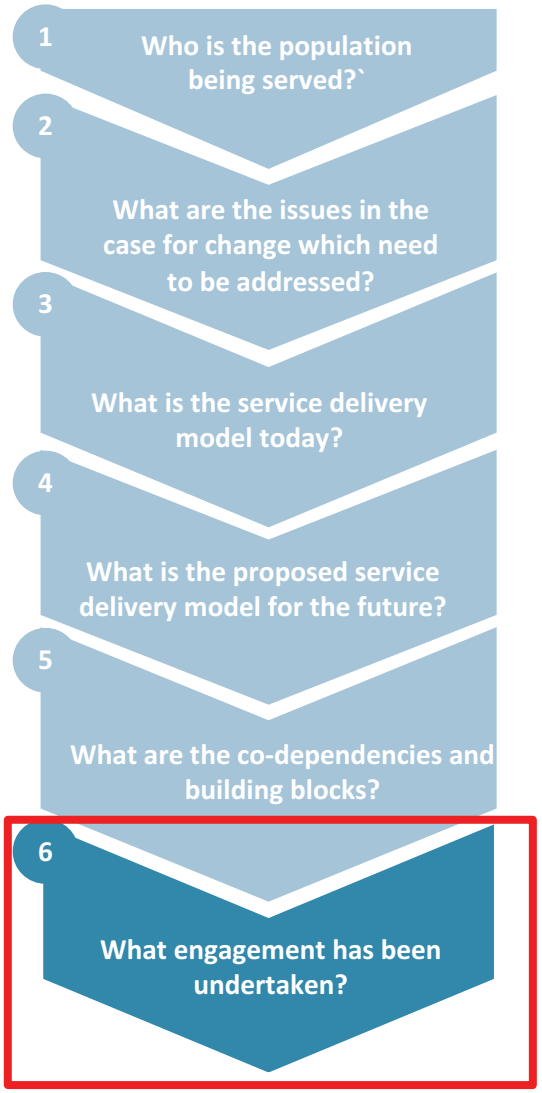
These interdependencies are outlined below

		COLUMN TITLES: Clinical specialties and functions supporting the 11 major acute services in the rows																																																			
	ROW TITLES: The 11 major acute services whose dependencies on the specialties and functions in the columns is being described.	A&E /Emergency Medicine	Acute and General Medicine	Elderly Medicine	Respiratory Medicine (including bronchoscopy)	Medical Gastroenterology	Urgent GI Endoscopy (upper & lower)	Diabetes and Endocrinology	Rheumatology	Ophthalmology	Dermatology	Gynaecology	General Surgery (upper GI and lower GI)	Trauma	Orthopaedics	Urology	ENT	Maxillo-facial Surgery	Hub Vascular Surgery	Spoke Vascular Surgery	Neurosurgery	Plastic Surgery	Burns	Critical Care (adult)	Critical Care (paediatric)	General Anaesthetics	Acute Cardiology	Thoracic Surgery	Cardiac Surgery	Hyper-acute Stroke Unit	Acute Stroke Unit	Nephrology (not including dialysis)	Inpatient Dialysis	Acute Oncology	Palliative Care	Neurology	Acute Paediatrics (non-specialised paediatrics and paediatric surgery)	Neonatology	X-ray and Diagnostic Ultrasound	CT Scan	MRI Scan	Cardiac MRI	Nuclear Medicine	Interventional Radiology (including neuro-IR)	Clinical Microbiology/ Infection Service	Laboratory microbiology	Urgent Diagnostic Haematology and Biochemistry	Acute Inpatient Rehabilitation	Occupational Therapy	Physiotherapy	Speech and Language	Dietetics	Acute Mental Health Services
1	A&E (Emergency Medicine). Acute unselected take (including acute surgical patients)	X					2									2	2																																				
2	Acute Medical Take		X				2	24	24		24		4			12																		24		24																	
3	Acute (Adult) Surgical Take												X														4								24									4	4								4
4	Adult Critical Care (Intensive Care)											24	2	2		24	2							X											4									2	2								
5A	Major Trauma Centre																																																				4
5B	Trauma Unit																																											4									4
6A	Vascular Surgery (Hub)																		X																																		
6B	Vascular Surgery (spoke)																			X																																	
7A	Cardiology: Non-interventional																															24																					4
7B	Cardiology: Interventional - primary PCI for STEMI																															24																					4
7C	Cardiology: Interventional - PCI (non-STEMI) and devices																															24																					4
7D	Cardiology: Interventional - structural heart disease (including TAVI, MitraClips)																												4			24																					4
7E	Cardiac Surgery																																																				4
8A	Hyper-Acute Stroke Unit																													X		24																					
8B	Acute Stroke Unit						4																								X	24																					
9	Renal Services inpatient Hub					24		24	24		24					24																X		24	24	24																	4
10	Consultant led Obstetric Services		4		4	4		4				2	2			2				2		24					4					4				4								4	4					24			4
11	Acute (non-specialised) Paediatrics and Paediatric surgery																																				X								4								

Source: South East Coast Clinical Senate (2014) The Clinical Co-Dependencies of Acute Hospital Services – A Clinical Senate Review

Contents

What engagement has been undertaken?: Summary



- Over the last 2 years EKHUFT has engaged with key stakeholders internally and externally through a series of EKHUFT and East Kent Strategy Board events.
- West Kent have recently commenced engagement

The following slides collate an evidence base to support the issue outlined here

Engagement to date

Over the last 2 years EKHUFT has engaged with key stakeholders internally and externally.

- Engagement commenced in 2014 with attendance at individual CCG groups so ideas could be exchanged between EKHFT clinicians and GPs around emerging issues and solutions
- Representatives of the executive team with relevant clinicians have met regularly with each CCG team to share any emerging thinking and gain feedback
- The EKHUFT case for change has been shared with GP members of CCGs and their responses incorporated

Key engagement events have been tabled on the next slide.

Engagement events to date (1/3)

Date	Type of engagement	Stakeholder group engaged	Description
January 2015 – current date	• Strategic meetings	Divisional and Medical Directors and heads of Nursing	• To keep them informed and gain feedback on every component of the strategy programme and latterly the STP
January 2015 – current date	• Open staff forums	All staff	• To keep them informed and gain feedback on every component of the strategy programme and latterly the STP
January 2015 – current date	• Staff forums for administration staff	All administration staff	• To keep them informed and gain feedback on every component of the strategy programme and latterly the STP
Spring 2015	• Focus Groups facilitated by Health Watch – 7 events in Thanet, Herne Bay, Canterbury, Ashford, New Romney and Folkestone and Tenterden. • Information shared in school book bags and at universities and train stations. Feedback forms given out and returned	Public. Over 1000 people contributed their thoughts some representing organisations	• To share the case for change
July 2015; Sept 2015; Dec 2015; July 2016; Nov 2016	• Clinical Forums for between 100 and 209 consultants and GPS at each event	Trust Consultants GPs CCG representatives	• To bring together the attendees to discuss the way forward in achieving an acute health system that is clinically and financially sustainable
January 2016	• Individual meetings with clinical leads • Sessions at the Quality and Innovation Hubs on al 5 EKHUFT sites	Consultants All staff	• To get feedback from staff about the evaluation criteria for option development

Engagement events to date (2/3)

Date	Type of engagement	Stakeholder group engaged	Description
Jan – Dec 2016	• Clinical engagement working groups	Consultants , GPs, nurses & AHP	• Clinical engagement in developing improvements in clinical pathways and promoting integration
4th February 2016	• EKSB engagement event • East Kent Clinical Forum • Monthly meetings	All health and social care organisations medical directors and clinical chairs	• Clinical input and approval of work done so far; discuss and develop the service area across east Kent
March 2016	• 3 day strategic event to identified innovative ways of working nationally and internationally, gain feedback and commitment to develop new pathways and ways of working	Divisional Clinical and management teams	• Identify new ways of working
7th April 2016	• EKSB engagement event • East Kent Patient & Public Engagement Group (PPEG) • Monthly meetings	Public and representatives of individual groups	• Share Care for Change and gain feedback
April – June 2016	• EK STP Task and Finish groups to identify current practice and issues and identify solutions for future clinical pathway planning across the health economy	EKHUFT Consultants and clinicians, GPs and CCG leads	• Design patient pathways for emergency care, planned care, Long term conditions (including frailty), paediatrics and maternity
April to June 2016	• EKSB engagement event • 6 Task & Finish Groups: 1. LTC & Frailty: 4 sessions 2. Planned and Specialist Care: 3 sessions 3. Maternity: 3 sessions 4. Paediatrics: 4 sessions 5. Emergency & Urgent Care: 4 sessions 6. Mental Health: 2 sessions	Acute Care Consultants, Primary Care, Social Care and Community Health representatives	• Work stream sessions to build a shared vision for service areas in east Kent as well as share good practice from other areas

Engagement events to date (3/3)

Date	Type of engagement	Stakeholder group engaged	Description
July 2016	• EKSB engagement event • 4 Final Workshops for all Task & Finish groups: 1. LTC & Frailty 2. Planned and Specialist Care 3. Maternity & Paediatrics 4. Mental Health	Acute Care Consultants, Primary Care, Social Care and Community Health representatives	• Share information about work done so far; discuss and refine the case for change and start to describe ambition for the service area across east Kent
27th July 2016	• EKSB engagement event • Presentation session	To all council leaders and Chief Executives	• To discuss the progress so far and future plans across east Kent
10th September 2015 – current date	• EKSB engagement event • Monthly meetings	All organisation CEO's, medical directors, accountable officers and clinical chairs (including KCC and NHSE)	• Develop strategy for the services area across east Kent
5th Sept 2016	• EKSB engagement event • Evaluation Criteria half day workshop	All organisation CEO's, medical directors, accountable officers and clinical chairs (including KCC and NHSE)	• To discuss the proposed evaluation criteria and evaluation process
15th Sept 2016	• EKSB engagement event • Discussion with MP • London based meeting		
Autumn 2016	• EKSB engagement event • 6 Focus groups facilitated by EKSB and supported by 'Curved Thinking'	Members of the Public and public groups	• To share the case for change

Elective orthopaedics

Service delivery model

28 February 2017
Updated 13 June 2017

Introduction and purpose of service delivery model template

- A number of services have been prioritised as for early consideration by the K&M hospital care working group. This pack forms one of a series service delivery model templates for the priority services.
- The aim of this pack is to consider the key issues the service is facing within the hospital context, its current in-hospital model of care and aspirational future model among other relevant context.
- The pack follows the structure of:
  - A summary slide outlining key information from each section; then
  - Each section, with a summary slide up front followed by evidence slides
- The pack has been created with expert input from across Kent & Medway, and has been developed by the K&M Hospital care workstream before being signed off by the Clinical Board.

Note: The Acute care template includes paediatrics

This document has been updated to incorporate feedback from the SE Clinical Senate

Comment classification	Comment	Next steps
Can be incorporated into model easily	• The list of support services listed in the 'Key' box (would be more appropriately included within the main list of lo-located services.	• Comment incorporated, no next steps
	• There is no mention of population level or cohort-specific interventions to reduce the dev. of joint pathology	• Comment incorporated, no next steps
	• There is a risk of losing staff from separating elective from non-elective orthopaedics and trauma, training considerations from this split must also be considered	• Comment incorporated, no next steps
	• Extended scope practitioners (ESPs) should do more than triage and initial triage type assessments,	• Comment incorporated, no next steps
	• The recommendations from the national report, should be adopted.	• Comment incorporated, no next steps
Requires further work pre-PCBC	• There should be more emphasis and description of the pain management service and pathway.	• Task and finish group to discuss *
	• Further development of the MDT combined clinics as to whether this is the most efficient way to use the various professionals mentioned in the model	• Task and finish group to discuss *
	• Given the variability in procedure rates across surgeries and CCGs, there should be some analysis of the reasons	• Task and finish group to discuss *
	• The pathways in to surgery should be more fully described, including the role of shared decision making	• Task and finish group to discuss *
	• The range of procedures intended for cold centres is not provided.	• Task and finish group to discuss *
	• The intended size or activity of the proposed elective orthopaedic centres was not described. This would no doubt impact on their efficiency and cost-effectiveness (examples given state over 3000 joint operations p/y)	• Task and finish group to discuss *
	• The criteria for determining low risk patients suitable for a cold surgical site should be outlined	• Task and finish group to discuss *
	• The model needs to describe the pathway for post-operative care, for patients not able to get directly home	• Task and finish group to discuss *
	• The balance between planned inpatient vs outpatient physiotherapy should be mapped.	• Task and finish group to discuss *
	• The pathway for patients who deteriorate needs to take into account some specific issues and be built into model	• Task and finish group to discuss *
	• There are major issues with separating the orthopaedic workforce on multiple sites, these needs to be addressed	• Workforce stream developing response
	• The modelling would benefit from mapping the impact of demographic trends on length of stay	• Awaiting technical group review
	• An alternative approach to a cold centre is to have ring fenced elective orthopaedic beds in the acute hospital, it is also not clear whether the model for K&M was to be purely for stand-alone elective centre	• Will be addressed in hurdle stage
	• There should be agreement as to the minimum number of procedures undertaken per consultant per year.	• Will be addressed in hurdle stage
Requires further work post-PCBC	• The model should aspire to address the recommendation for rehabilitation post-surgery in the GIRFT report	• To develop further as part of model implementation

***It is proposed that a 'task and finish group' comprised of 3-4 senior clinicians from across the trusts is convened to develop the models further with respect to these comments. It is proposed that they meet up to 3 times in June - July 2017**

The STP outlined the aspiration for Hospital Care model which prevents ill health, intervenes earlier and delivers excellent, integrated care closer to home

Care Transformation workstreams

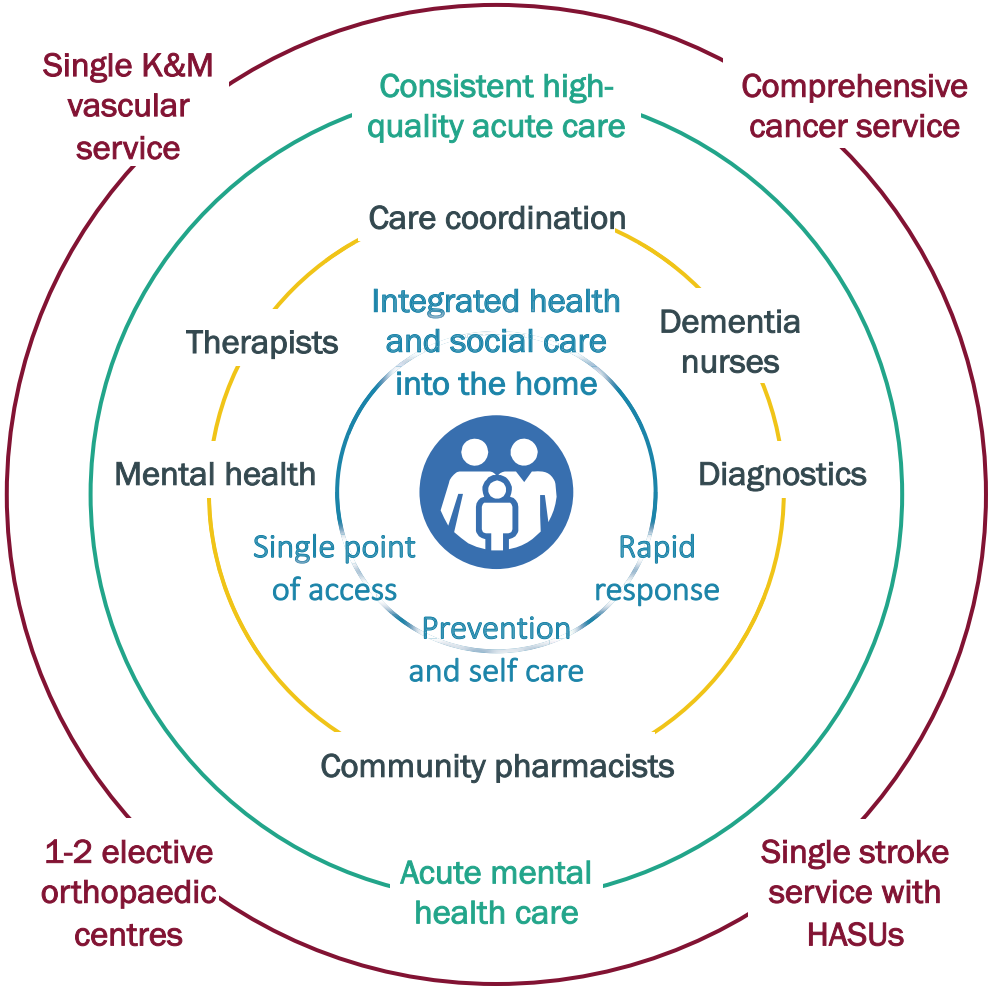
Prevention — Enlisting public services, employers and the public to support health and wellbeing

Local Care — A new model of care closer to home for integrated primary, acute, community, mental health and social care

Hospital Care — **Optimal capacity and quality of specialised, general acute, community and mental health beds**

Mental Health — Bringing parity of esteem, integrating physical and mental health services, and supporting people to live fuller lives

Kent and Medway Future Care Model



Source: K&M STP

The focus of this template will be on Hospital Care

Summary contents

1. Who is the population being served?
2. What are the issues in the case for change which need to be addressed?
3. What is the service delivery model today?
4. What is the proposed service delivery model for the future?
5. What are the co-dependencies and building blocks?
6. What engagement has been undertaken?

- There are 7,921 elective orthopaedic inpatient and 13,331 elective orthopaedic day case procedures undertaken in hospitals in K&M (plus 2,110 IP and 425 DC in private hospitals under choose & book).
- The majority of the people having these procedures are older (with most procedures in the 64-69 age band).
- K&M acute providers outsource approximately 2000 elective orthopaedic procedures each year
- There are an additional 6,000 patients waiting for elective orthopaedic procedures across K&M.
- Referral levels for elective procedures vary between CCGs and between practices.
- Some hospital waiting lists for planned care are long and growing. The number of cancellations on the day of the operation are increasing. This is partly due to increasing pressures from emergency admissions which cause “crowding out” of planned care.
- Right care analysis shows a potential significant opportunity in musculo-skeletal elective procedures across the patient pathway (£8m compared to peers).
- NB RightCare defines MSK as including back and neck pain, osteoarthritis and rheumatoid arthritis.
- Further analysis suggests there may be a £6m (22 bed) opportunity in reducing elective length of stay in orthopaedics across K&M.

- All sites in K&M deliver a mixture of elective and non elective orthopaedic services with the exception of Kent & Canterbury Hospital which does not undertake any non elective activity and Maidstone General Hospital which does not undertake any non elective orthopaedic surgery.
- Dartford & Gravesham NHS Trust have split the majority of the elective and non-elective orthopaedics across their sites, with the majority of elective orthopaedics taking place at Queen Mary’s Hospital in Sidcup.

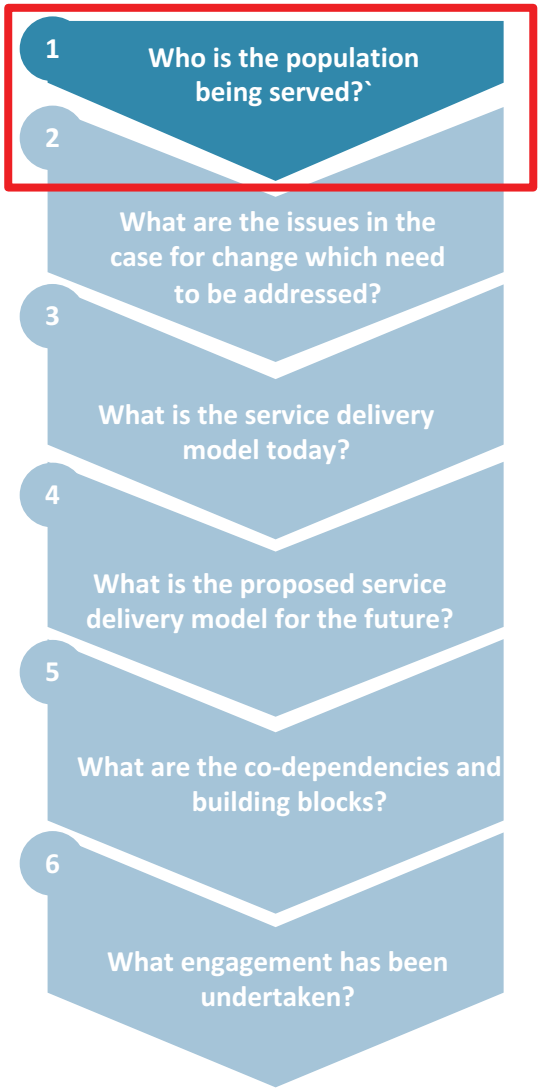
- The proposed model is set within the context of the wider transformation programme which is underpinned by a focus on prevention and self care and the benefit of a community-led MSK pathway which is part of the local care work stream.
- The elective orthopaedic model of care is based on a set of principles including standardised approach, use of multi-disciplinary teams, one-stop services, senior support and better use of IT. It is very important to Get it Right First Time. This will lead to improvements in quality and productivity.
- The proposed inpatient pathway will include greater use of multi-disciplinary teams, consultant feedback, earlier discharge planning and ring-fenced elective beds.
- Consolidating elective orthopaedic surgery onto fewer sites will lead to an improvement in outcomes and separating elective and emergency work will improve efficiency and have an impact on the prevention of infection.
- The future model will also optimise an integrated MSK pathway and integrated provision.

- The critical co-dependencies for orthopaedic elective work are anaesthetics and access to emergency diagnostics .The level of complexity of the procedures that can be undertaken is determined by access to Level 2 critical care facilities on site..

- Over the last 2 years EKHUFT has engaged with key stakeholders internally and externally through a series of EKHUFT and East Kent Strategy Board events.
- West Kent have not carried out engagement to date

Contents

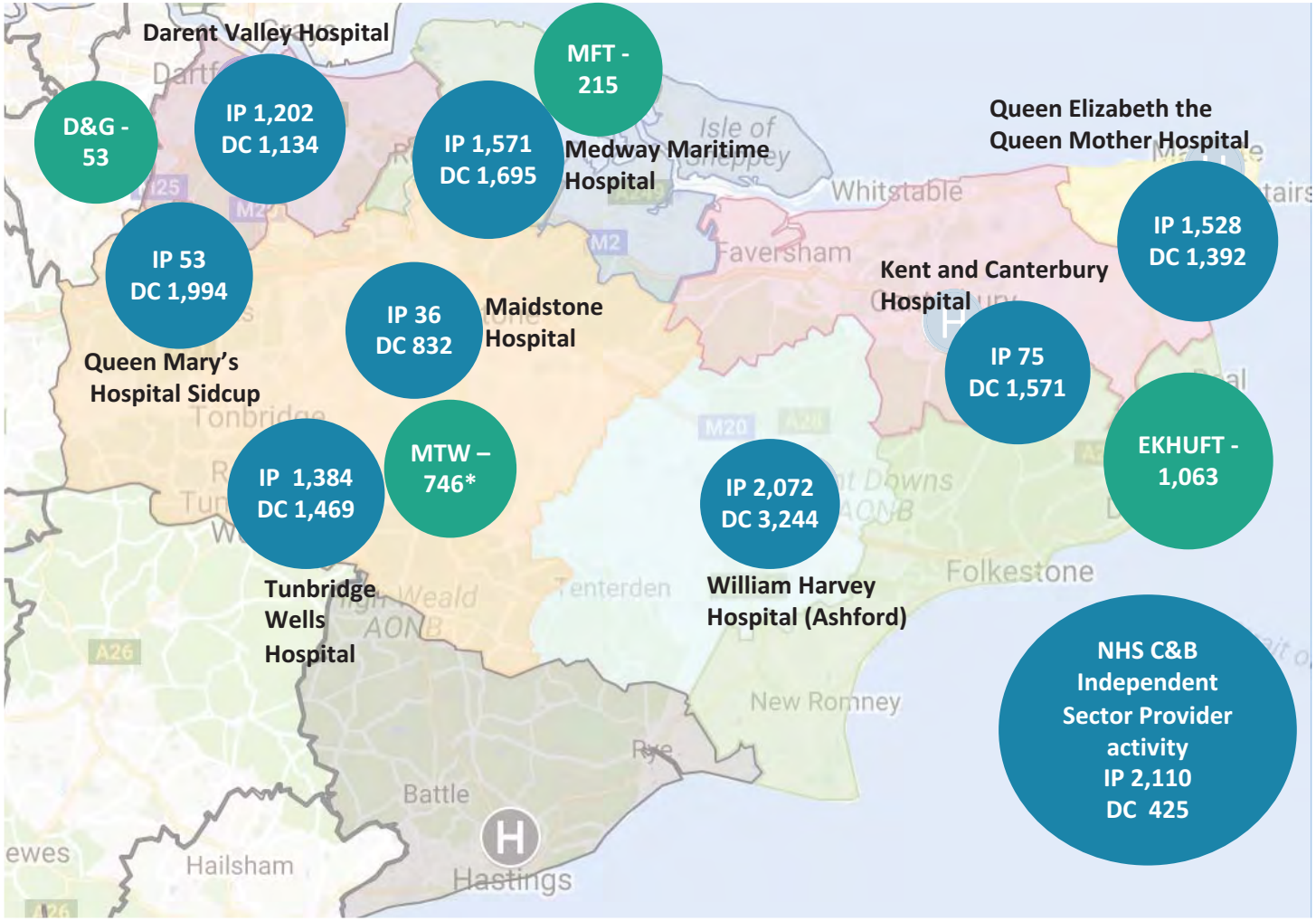
Who is the population being served: summary



- There are 7,921 elective orthopaedic inpatient and 13,331 elective orthopaedic day case procedures undertaken in hospitals in K&M (plus 2,110 IP and 425 DC in private hospitals under choose & book).
- The majority of the people having these procedures are older (with most procedures in the 64-69 age band).
- K&M acute providers outsource approximately 2000 elective orthopaedic procedures each year
- There are an additional 6,000 patients waiting for elective orthopaedic procedures across K&M.

The following slides collate an evidence base to support the issue outlined here

Elective orthopaedics is provided across all the acute hospitals in K&M



Based on clinical discussion, a set of assumptions were agreed for the split between complex / non complex elective orthopaedic cases. This is assumed as 85% / 15% for the purposes of activity and bed modelling in K&M

*MTW outsourced activity comes from TWH only

Note: MFT outsourced 132 in patient and 83 day cases 15/16 ,MTW outsourced 342 in patient and 404 day cases and EKHUFT outsourced 1,063 cases which are not included here

Note: DVH: Darent Valley Hospital and Queen Mary's Hospital Sidcup; MTW: The Tunbridge Wells Hospital (RWFTW),The Maidstone Hospital (RWF03), The Horder Centre , Bmi – the, Somerfield Hospital , Nuffield Health, Tunbridge Wells Hospital, Spire Tunbridge Wells Hospital and Unknown; **MFT:** Kent Institute Of Medicine & Surgery and Medway Maritime Hospital

Note: Day case include some non-elective activity

Source: Provider data returns, Elective orthopedics activity, FY2015-16

For the purposes of this review the following are included as elective orthopaedic conditions/procedures:

Elbow surgery

- Elbow surgery is carried out for trauma, osteoarthritis, rheumatoid arthritis and soft tissue injuries

Foot and ankle surgery

- Foot surgery on patients that suffer from arthritis, congenital or other abnormalities or have suffered some form of trauma

Hand and wrist surgery

- Including trauma, osteoarthritis and rheumatoid arthritis, carpal tunnel decompression and Dupuytren's contracture

Hip replacements

- Total hip arthroplasty

Knee replacements

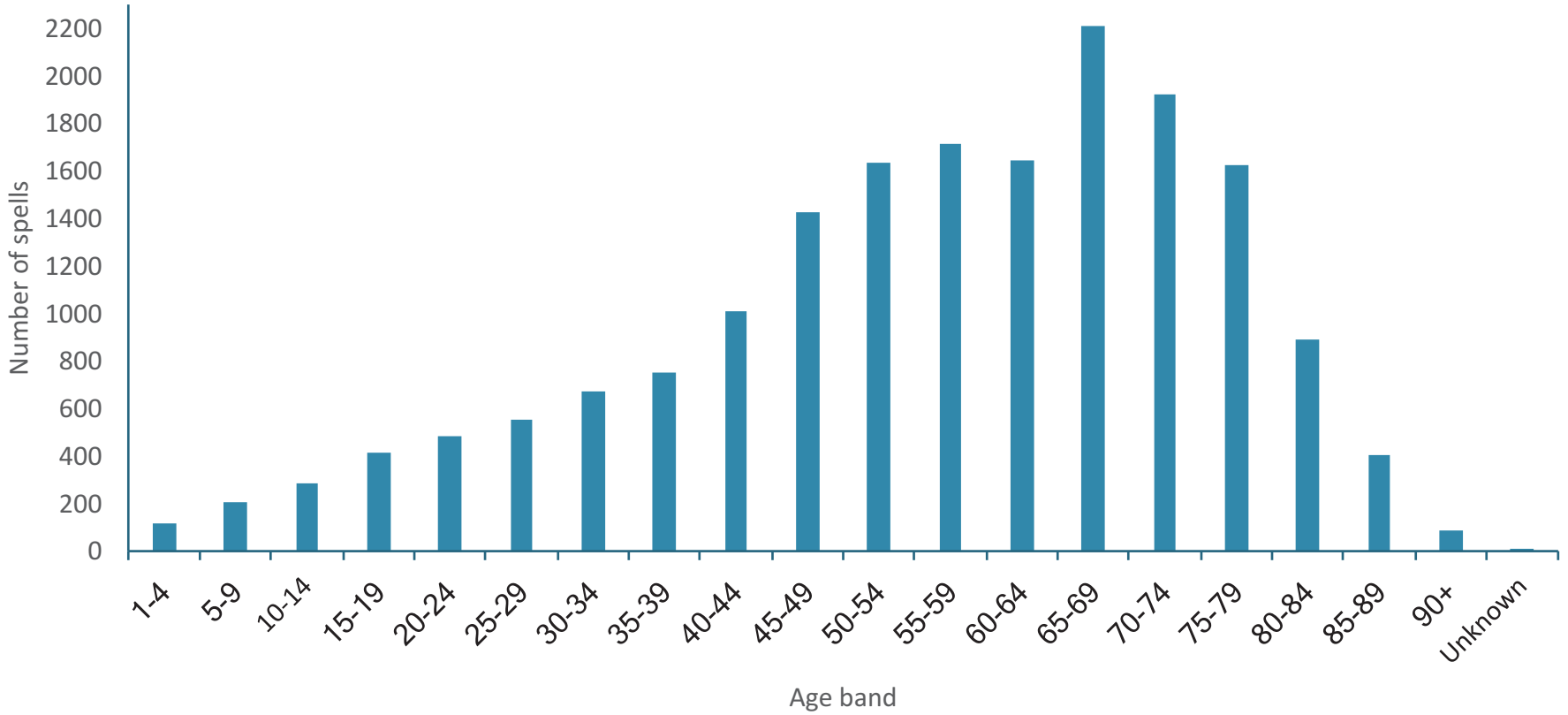
- Total knee arthroplasty

Shoulder replacements

- Shoulder replacements are carried out to treat conditions like osteoarthritis, rheumatoid arthritis or trauma

Number of elective orthopaedic spells by age across all acute sites in K&M per year

Number of spells for 7 K&M acute site, split by age



- The greatest number of spells was across the 65-69 age band (2214 spells)
- The smallest number of spells was in the 1-4 (114 spells) and 90+ age bands (88 spells)

Source: Provided by MTW trust for all K&M elective orth data – January 2017

NOTE: An integrated impact assessment will be undertaken to establish the impact of a new clinical model on particular demographics / cohorts based on their specific needs e.g. the elderly, and the outputs of this will be used to develop mitigations in order to minimise any adverse impact.

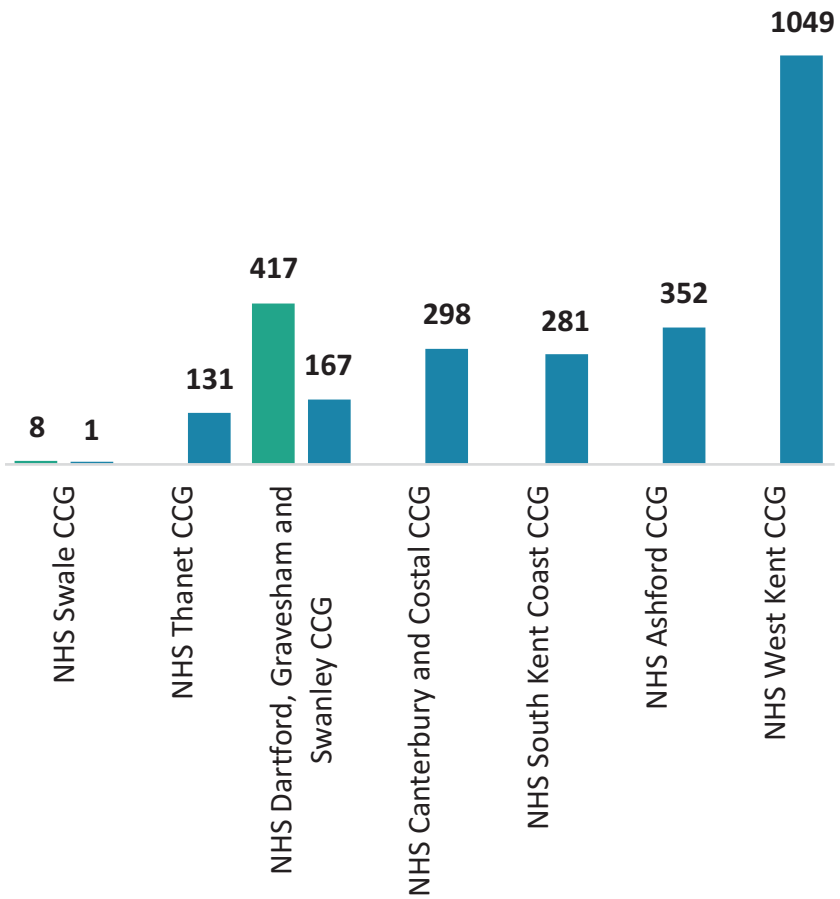
K&M acute providers outsource over 2,000 elective orthopaedic procedures each year

Provider	2015/16	2016/17 M7 YTD
D&G	53	75
MFT	215	211
MTW	746	738
EKHUFT	1,063	549
TOTALS	2,142	1,573

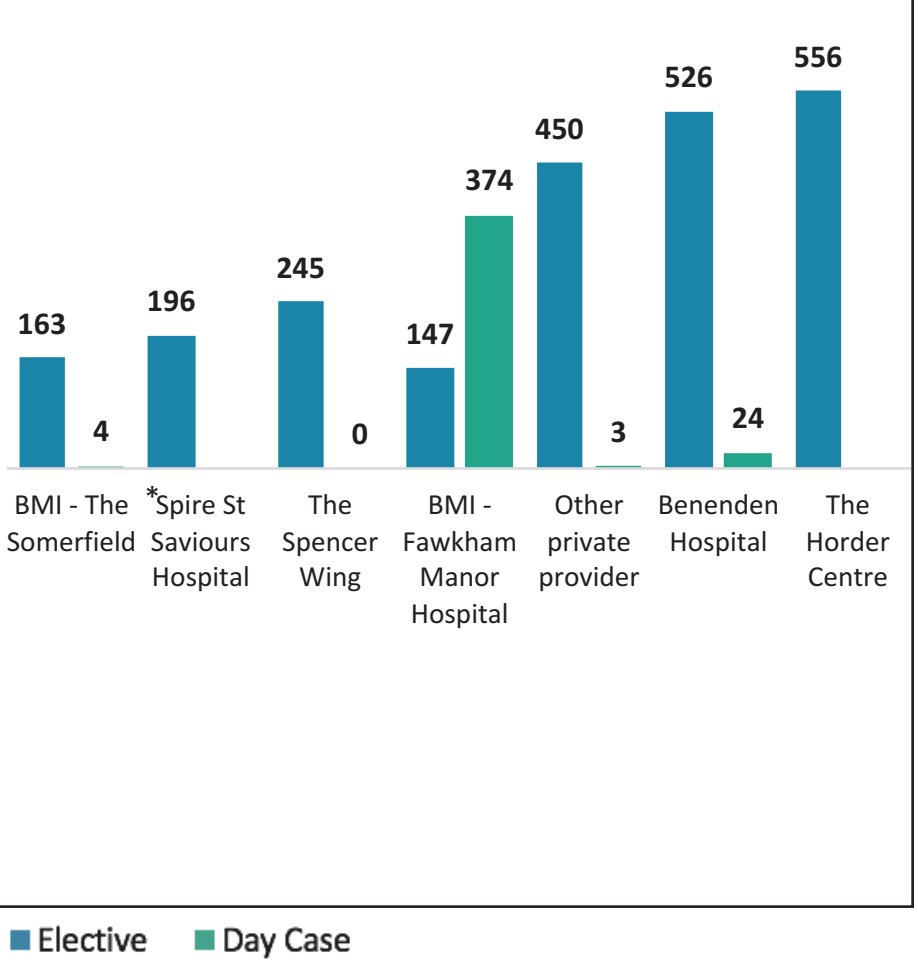
Source: EKHUFT data, Dr foster data for MTW, MFT trust data, D&G trust data

2,704 elective orthopaedic cases were delivered through Choose and Book by Independent Sector Providers, totalling over £7.8m

Elective orthopaedic procedures delivered by private providers by CCG



Elective orthopaedic procedures by private provider

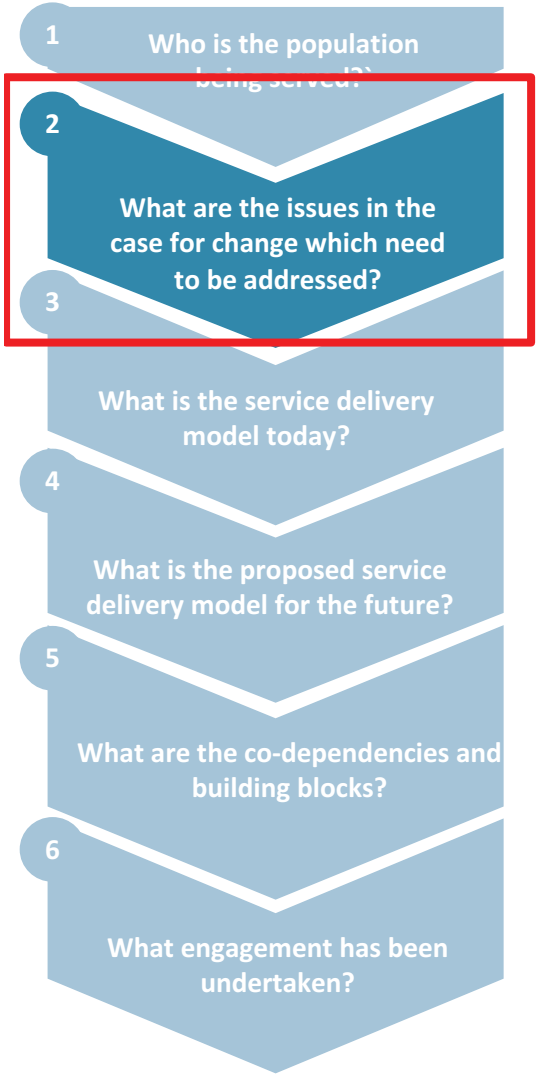


*Please note, Spire is now closed

Source: SLAM data; Carnall Farrar analysis 2017

Contents

What are the issues in the case for change which need to be addressed?: Summary



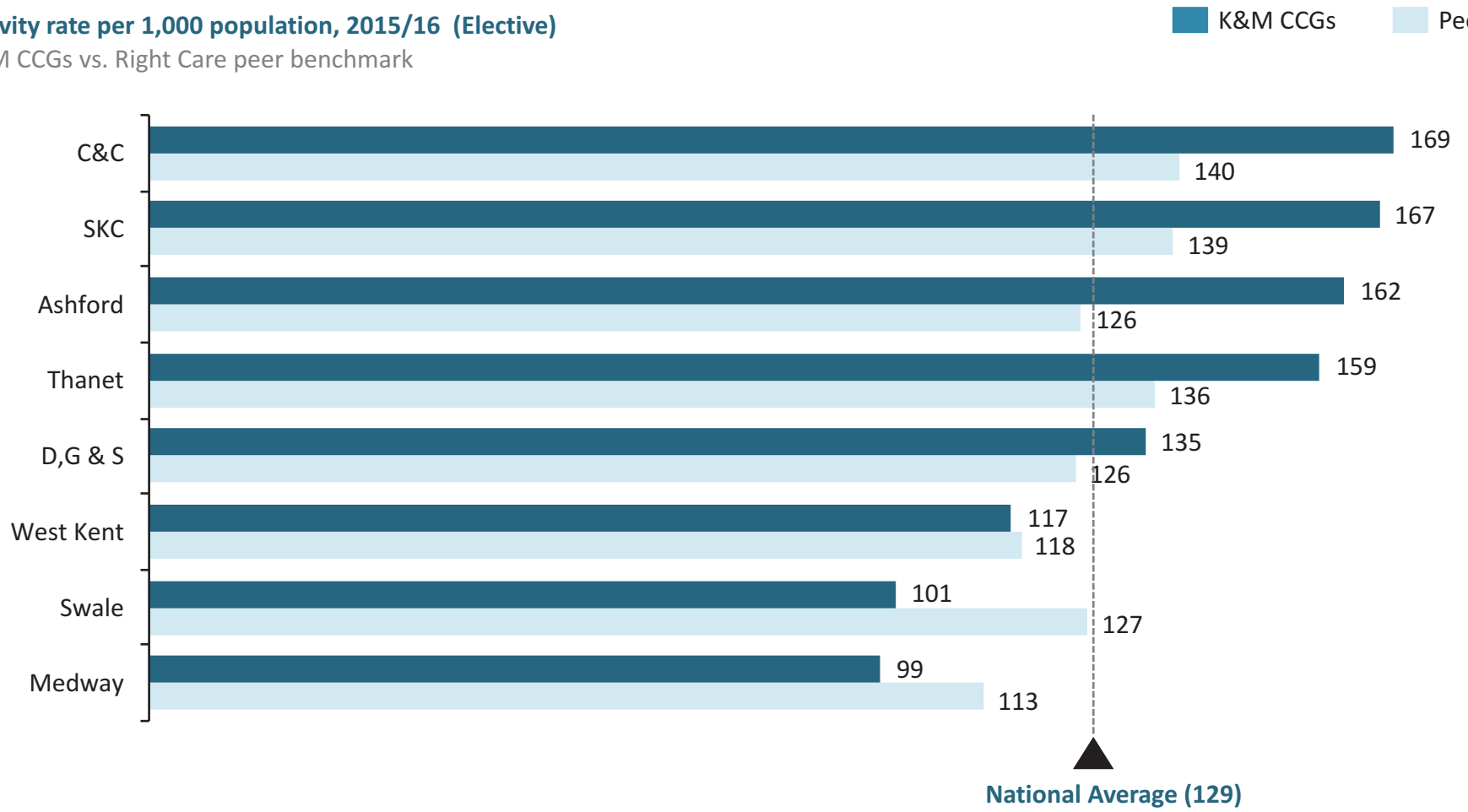
- Referral levels for elective procedures vary between CCGs and between practices.
- Some hospital waiting lists for planned care are long and growing. The number of cancellations on the day of the operation are increasing. This is largely due to increasing pressures from emergency admissions which cause “crowding out” of planned care.
- Right care analysis shows a potential significant opportunity in musculo-skeletal elective procedures across the patient pathway (£8m compared to peers).
- Further analysis suggests there may be a £6m (22 bed) opportunity in reducing elective length of stay in orthopaedics across K&M.

The following slides collate an evidence base to support the issue outlined here

Levels of referrals to elective and outpatient services are higher in many CCGs in K&M than peer benchmarks and the national average

Activity rate per 1,000 population, 2015/16 (Elective)

K&M CCGs vs. Right Care peer benchmark



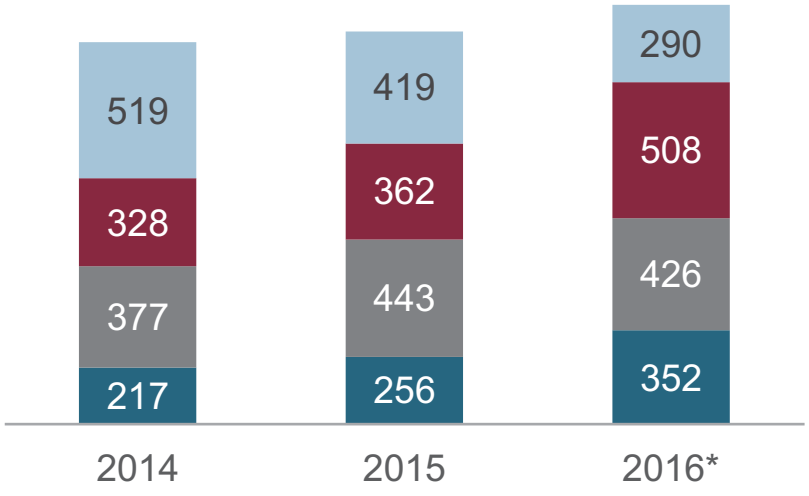
Notes: 1 Peer benchmark calculated as top quartile of activity rates of 10 closest CCG peers identified for each K&M CCG by NHS Right Care

Source: MAR data; NHS Right Care peers; Carnall Farrar analysis

The number of last minute elective cancellations are rising, as is the number of patients not treated within 28 days of cancellation

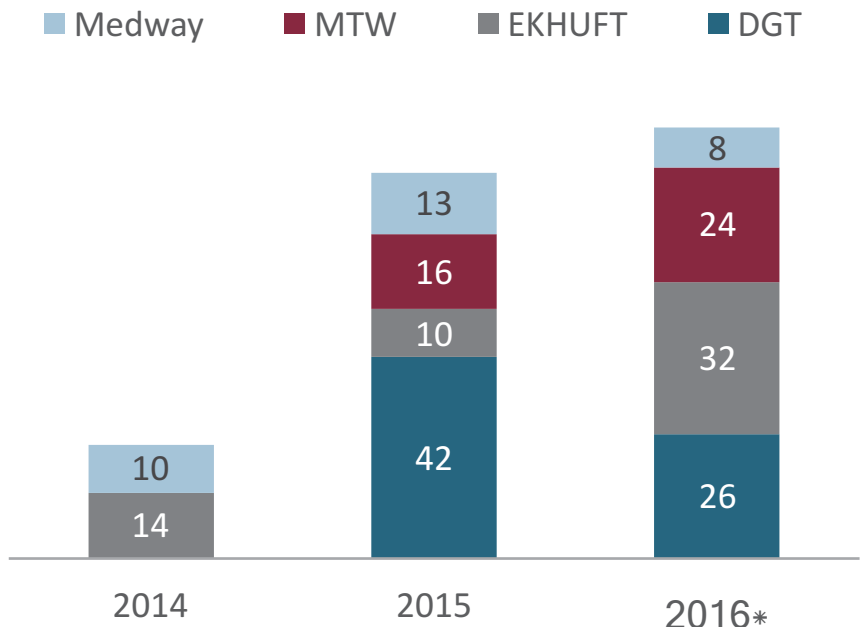
Number of last minute elective operations cancelled for non clinical reasons

High is worse



Number of patients not treated within 28 days of last minute elective cancellation

High is worse



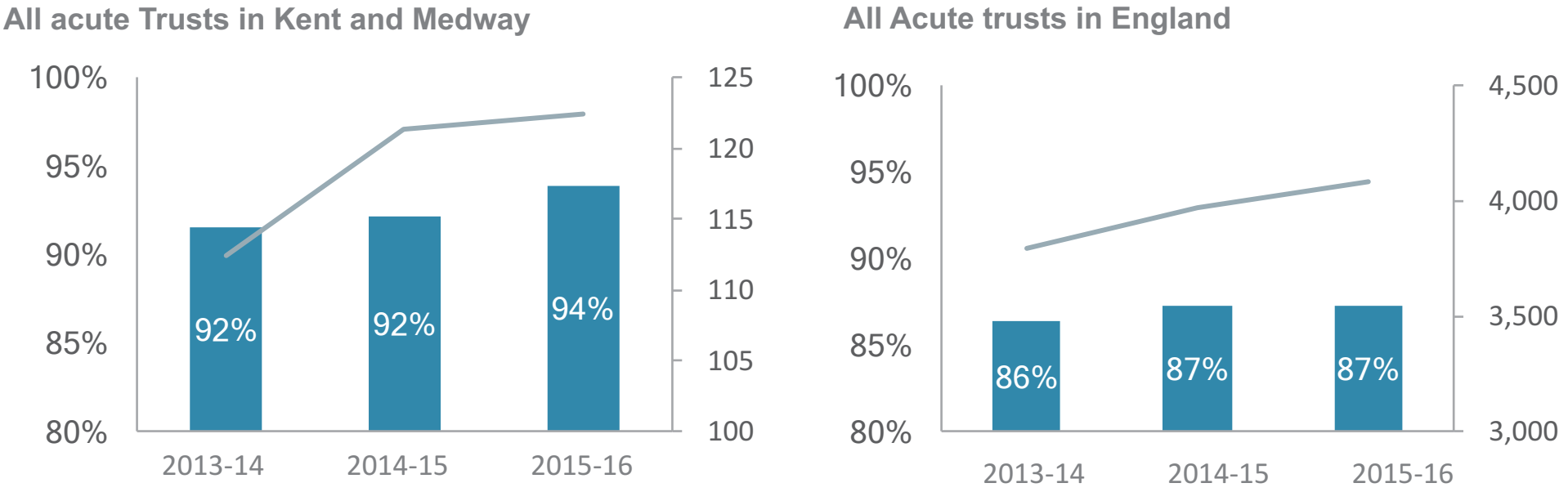
- The number of last minute elective cancellations were **77% higher in Q2 2016** than in the **same quarter of 2014**.
- **Furthermore, the number of patients not** treated within 28 days of cancellation was **122% higher.**

Notes: 2016 is a projection based on data for Q1 and Q2

Source: NHS England, Cancelled Elective Operations (quarterly) data; Carnall Farrar analysis

Increasing pressures from emergency admissions are "crowding out" planned care: bed occupancy has risen over the last 2 years

Average overnight bed occupancy (%) and emergency admissions (k)



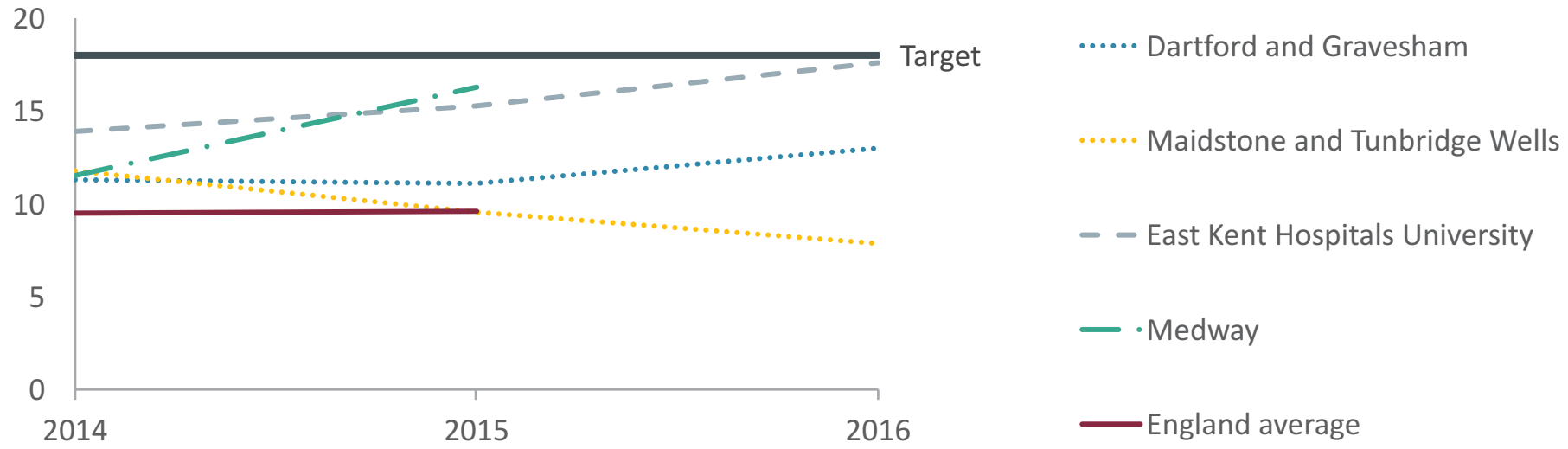
- Between 2013 and 2015, **emergency admissions rose by 8.9%** as across the four acute providers, **and bed occupancy rose by 2.2%.**
- On **average bed occupancy** was **94%** in 2015, compared to **87% nationally.**
- The **average bed occupancy** rate in England **grew** at a **slower rate** over the same period.

Note: The overnight bed occupancy rate is defined as the average daily number of beds occupied overnight that are under the care of consultants as a proportion of all available beds

Source: NHS England, quarterly data from FY2013-14 to FY 2015-16; Carnall Farrar analysis

Beds crowding out services partly explains increasing waiting times

Average total waiting times
weeks

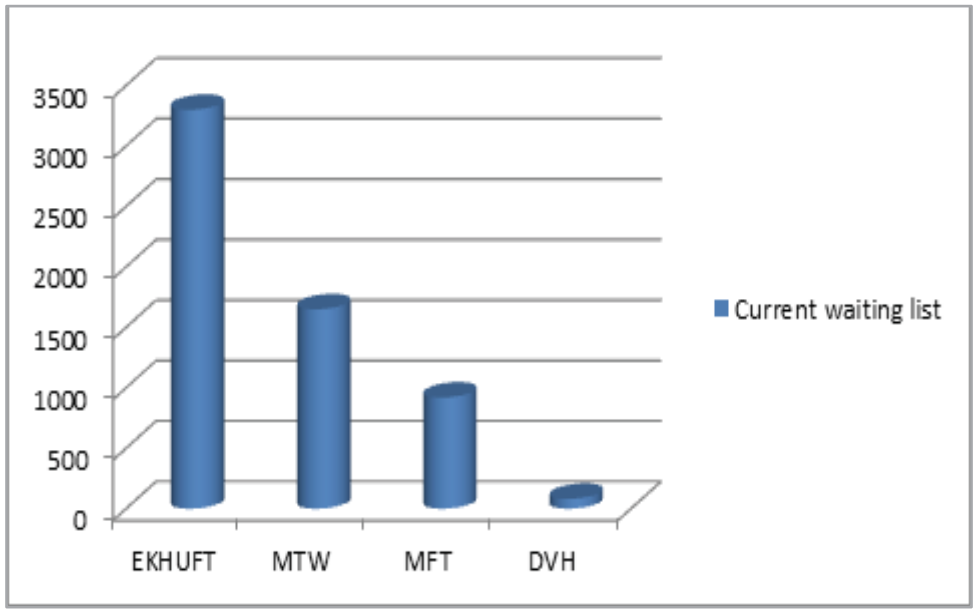


- In 2015 average **referral to treatment waiting times** for admitted patients were **3.5 weeks longer** in Kent and Medway than the national average.
- With the exception of MTW, **waiting times have risen** in all trusts.
- In **EKUHFT**, average waiting times have risen by **4 weeks (or 30%) over four years.**

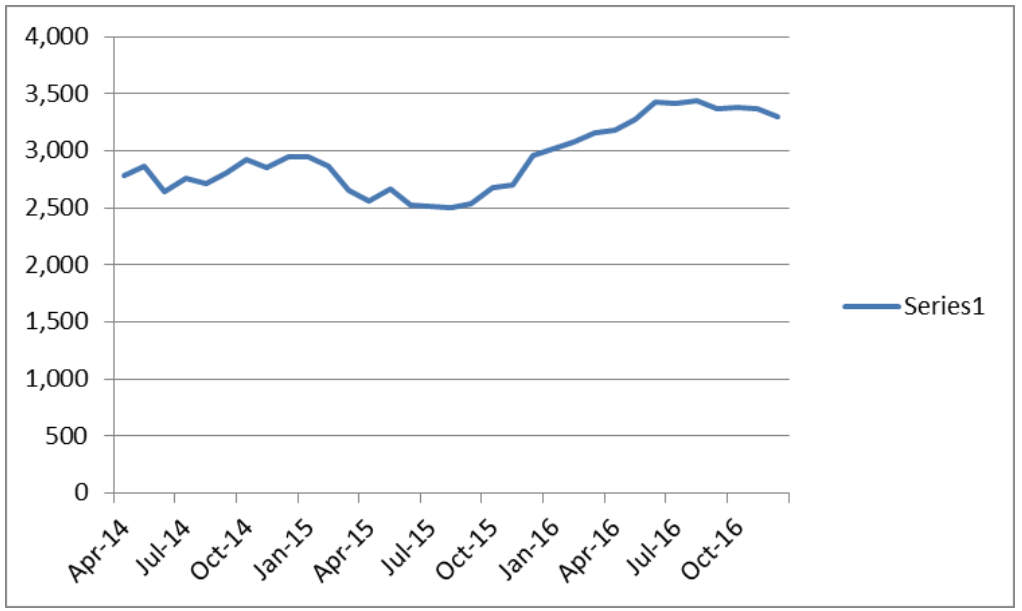
Note: there is no 2016 data for England and Medway NHS Foundation Trust
Source: Consultant-led Referral to Treatment Waiting Time Data NHS England, Provider based, September 2014, 2015, 2016

Elective orthopaedic waiting list numbers are high and climbing

Current waiting list profiles for K&M providers



EKHUFT waiting list growth

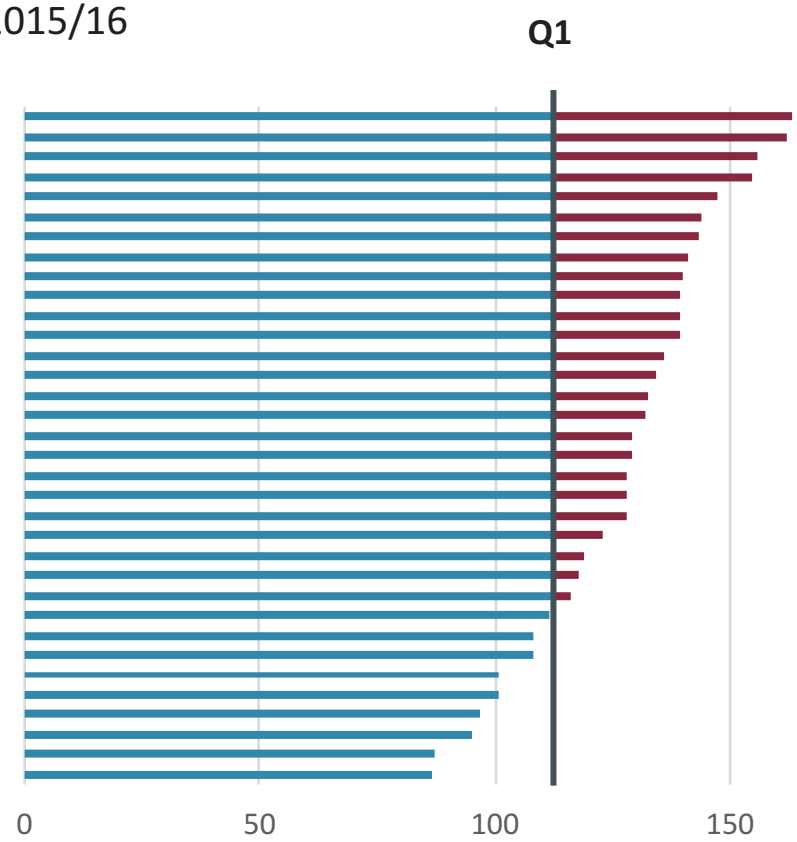


- EKHUFT waiting list has grown by circa 500 (20%) since 2014
- Across Kent and Medway there are approximately 6,000 patients waiting for orthopaedic procedures.

Note: there is no 2016 data for England and Medway NHS Foundation Trust
SOURCE: Consultant-led Referral to Treatment Waiting Time Data NHS England, Provider based, September 2014, 2015, 2016

GP variation analysis was carried out for each CCG within Kent and Medway highlighting an opportunity to reduce activity rates

Elective admissions and daycases per 1,000 population, 2015/16



Opportunity to top quartile: 15%

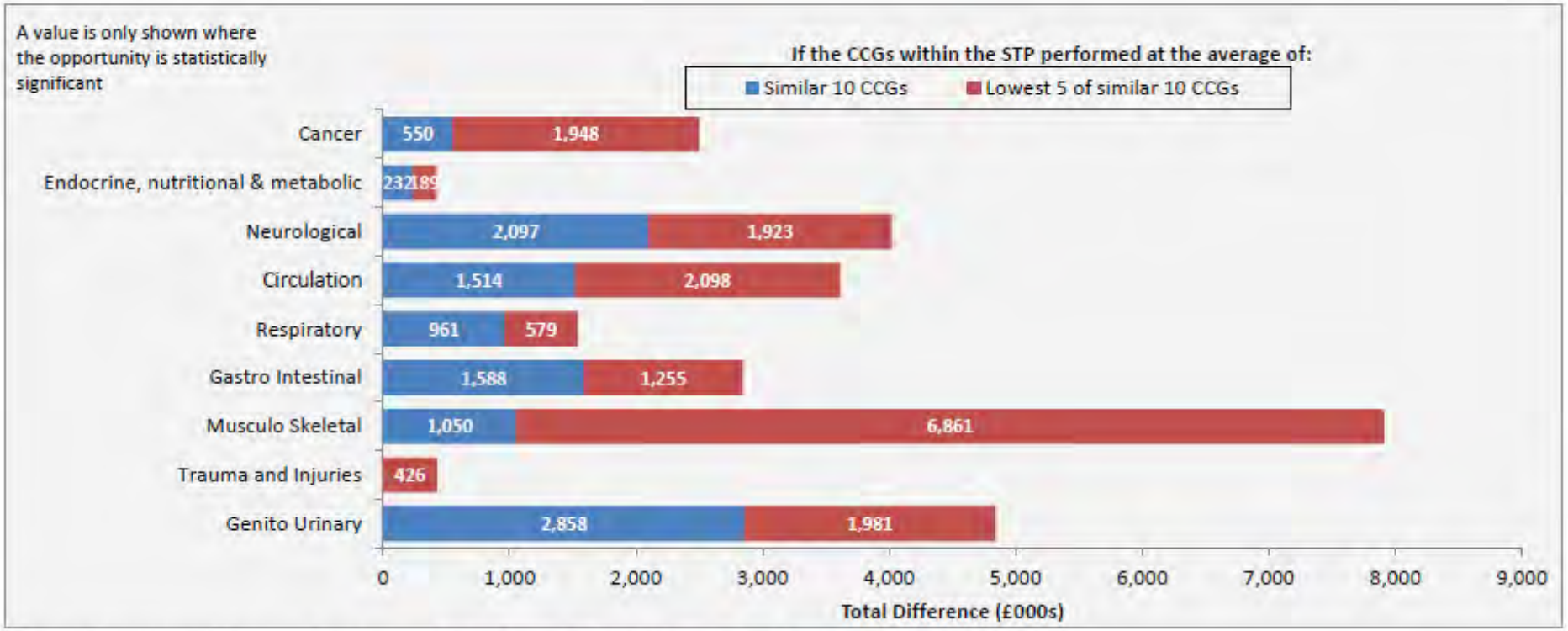
Methodology

- SLAM data returns from each of the Kent and Medway CCGs were used to calculate activity rates (per 1,000 people), split by POD and GP practice
- The top quartile performances for each CCG and POD were calculated
- The chart on the left shows rates of elective admissions and daycases in a single CCG, with each bar representing a single GP practice
- The identified opportunity of 15% could be realised if activity at practices with activity rates above the top quartile could be reduced to match top quartile performance

Local care are creating a similar analysis but at the segment level, to account for local demographic variation

Source: CCG SLAM data (2015/16), Carnall Farrar analysis

Right care analysis shows a potential significant opportunity in musculo-skeletal elective procedures*



The spend data presented above uses Secondary User Services Extract Mart (SUS SEM) and is from financial year 2015/16.

The calculations in this slide are based on expenditure on admissions for any primary diagnoses that fall under the listed co nditions (based on Programme Budgeting classifications which are in turn based on the World Health Organisation's International Classification of Diseases). This only includes expenditure on admissions covered by the mandatory payment by results tariff and includes NHS England Direct Commissioning expenditure.

CCGs can explore this expenditure in more detail using the Commissioning for Value Focus Packs. For example, Neurological expenditure contains Chronic Pain, and the focus pack breaks this down by different types of Pain. CCGs should consider whether these admissions should be considered alongside other programmes e.g. CVD, Gastrointestinal, Musculoskeletal problems

Source: Right Care, Commissioning for Value: where to look pack, December 2016, pg 12.

- This assumes a standard case mix which might not be the case in K&M given the large number of patients seen by non-NHS providers.
- RightCare defines MSK as back and neck pain, osteoarthritis and rheumatoid arthritis.

Improvement opportunities on the MSK pathway: NHS RightCare*

Improvement opportunities

NHS RightCare

This table presents opportunities for quality improvement and spend differences for a range of programme areas. These are based on comparing the CCGs within Kent & Medway STP to the best / lowest 5 CCGs. A quantified unit is only shown when the opportunity is statistically significant.

Disease Area	Spend	£000	Quality	No. of patients, life-years, referrals, etc.
Mental Health Problems (dementia)			• Mortality with dementia, 65+	136
			• % dementia deaths in usual place of residence (65+)	116
			• % short stay emergency admissions aged 65+ with dementia	1,176
			• % new dementa diagnosis with blood test	164
			• Dementia diagnosis rate (65+)	1,592
			• Rate of emergency admissions aged 65+ with dementia	630
			• % of dementia patients with care reviewed	292
Musculoskeletal System Problems (Excludes Trauma)	• Spend on elective and day-case admissions	7,912	• MSK - Rate of bed days	6,278
	• Spend on non-elective admissions	455	• % osteoporosis patients 50-74 treated with Bone Sparing Agent	33
	• Spend on primary care prescribing	717	• % patients 75+ years with fragility fracture treated with BSA	44
	• Spend on admissions relating to fractures where a fall occurred	639	• Hip replacement, EQ-5D Index, average health gain	161
			• Knee replacement, EQ-5D Index, average health gain	205
			• Hip replacement emergency readmissions 28 days	34
			• Hip fractures in people aged 65+	148
			• Hip fractures in people aged 65-79	21
			• Hip fractures in people aged 80+	95
			• % fractured femur patients returning home within 28 days	172
			• Hip fracture emergency readmissions 28 days	14
Neurological System Problems	• Spend on elective and day-case admissions	4,021	• Neurological - Rate of bed days	12,313
	• Spend on non-elective admissions	3,744	• Emergency admission rate for children with epilepsy aged 0–17 years	87
	• Spend on primary care prescribing	6,688	• Patients with epilepsy on drug treatment and convulsion free, 18+	588

Note: 'Spend on admissions relating to fractures where a fall occurred' is a sub-set of Trauma and Injuries non-elective spend and is not included in the spend for overall MSK non-elective admissions. This indicator as well as 'Rates of hip fractures', 'Emergency readmissions to hospital within 28 days for patients: hip fractures' and '% patients returning to usual place of residence following hospital treatment for fractured femur' appear in the quality section of the improvement opportunities table for both Trauma & Injuries and MSK table. This is due to it being in the Trauma & Injury pathway as well as the Osteoporosis pathway. Opportunities for these five indicators have only contributed to the headline; 'Spend', 'Outcomes' (and hence 'Spend and Outcomes') for MSK only.

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Source: RightCare, Commissioning for Value: where to look pack, December 2016, pg 20

NOTE: RightCare classifies MSK as back and neck pain, osteoarthritis and rheumatoid arthritis.

A length of stay analysis was carried out to provide a view on the potential bed day opportunity in elective orthopaedics

1. Identify specialties in scope

- In-scope specialties are those with a surgical pathway (T&O, General Surgery, Urology, Gynecology, ENT, Colorectal Surgery, Vascular Surgery, Breast Surgery)
- These specialties account for 73% of total elective beddays

2. Identify opportunity for patients with LoS of 3 days

- For patients with 3 day LoS, the assumption is that there is a moderate opportunity to further reduce LoS
- A 1 day LoS reduction is applied to 50% of these patients within each in-scope specialty

3. Identify opportunity for patients with LoS between 3 and 10 days

- For patients with a LoS of between 3 and 10 days, there could be a significant opportunity to reduce LoS
- All spells with a LoS of between 3 and 10 days are reduced to 3 days, within in-scope specialties

4. Identify opportunity for patients with 10 day and over LoS

- For patients with long LoS (10 days and over), there may be a further opportunity to reduce LoS
- 50% of spells with a LoS of 10 days and over are reduced to 10 days

Elective beddays

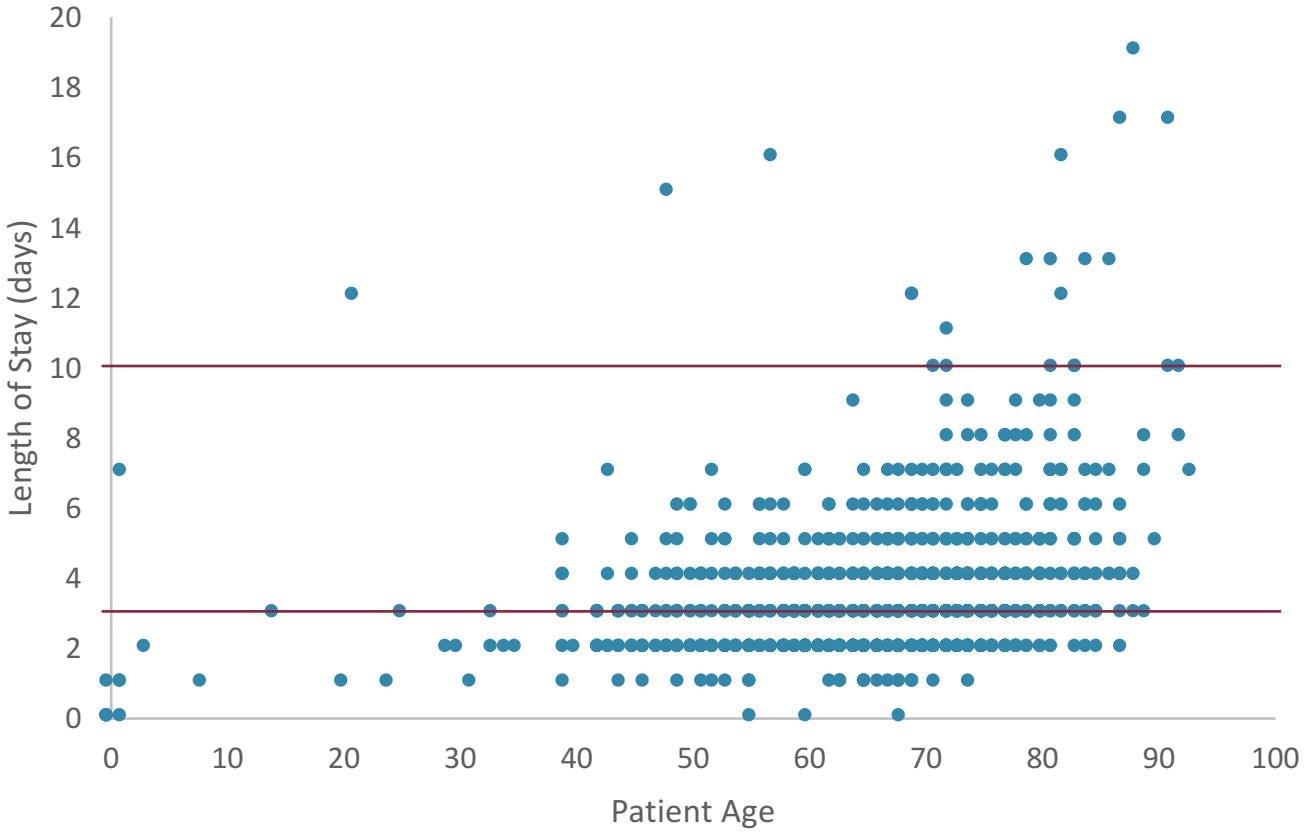
Code	Specialty	DVH	Maidstone	Tunbridge Wells	Medway	WH Ashford	QEQM	K&C	Total
110	Orthopaedics (elective only)	1,377	25	1,049	877	1,791	1,702	2	**6,822**

Source: Carnall Farrar analysis

NOTE: A review of the LOS assumptions (including applicability for particular patient cohorts) is being undertaken by the clinical Board as recommended by the Technical group in May 2017

Patient data shows a 23% opportunity to reduce variation in length of stay in Major Hip Procedures for Non-Trauma, Category 1, without CC

Length of stay for elective major hip procedures for non-trauma, category 1, without CC
(HRG code: HB12C)

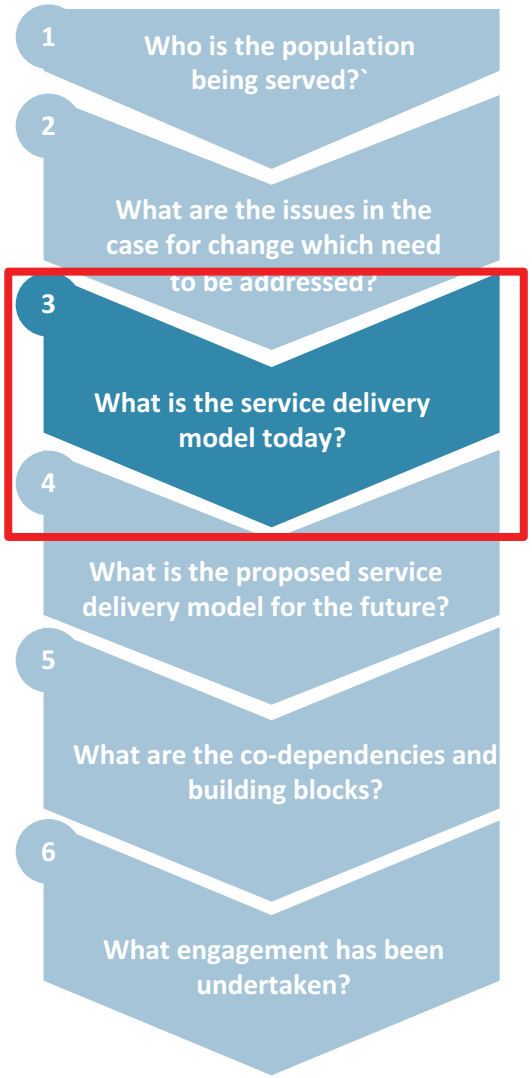


- There is only a slight correlation between patient age and length of stay (r-square = 0.09)
- Hence variation in length of stay is not driven by age
- A 23% bed day reduction saving could be made if length of stay was kept to a maximum of 3 days or less

Source: Provider data returns (2015/16), Carnall Farrar analysis

Contents

What is the service delivery model today?: Summary



- All sites in K&M deliver a mixture of elective and non elective orthopaedic services with the exception of Kent & Canterbury Hospital which does not undertake any non elective activity and Maidstone General Hospital which does not undertake any non elective orthopaedic surgery.
- Dartford & Gravesham NHS Trust have split the majority of the elective and non-elective orthopaedics across their sites, with the majority of elective orthopaedics taking place at Queen Mary's Hospital in Sidcup.

The following slides collate an evidence base to support the issue outlined here

Elective orthopaedics: What is the service delivery model today?

MDT clinic	• Not in place across K&M
Preoperative assessment	• Undertaken separately to first out-patient appointment • Flags patients who are at risk of increased length of stay • Joint school approach in place in some parts of K&M
Re-check prior to surgery	• Not undertaken consistently across K&M
Short-notice reserve list	• In place however not always utilised consistently across K&M
Consultant-level feedback	• Partially in place through audit programmes and clinical forums • Formal team working and agreed case volumes per list, including peer review, is not in place across K&M
Effective planning for discharge	• Often not considered until after surgery
Enhanced recovery	• Not undertaken consistently across K&M
Ring-fenced elective beds	• In place in K&M providers but coming under increasing pressure due to emergency workload. • D&G has geographically separated elective and non-elective activity.
Theatre utilisation	• In place however need to review the use of extended working days and routine weekend working across K&M.

Source: local analysis

Patient story – Orthopaedics, Joint Replacement

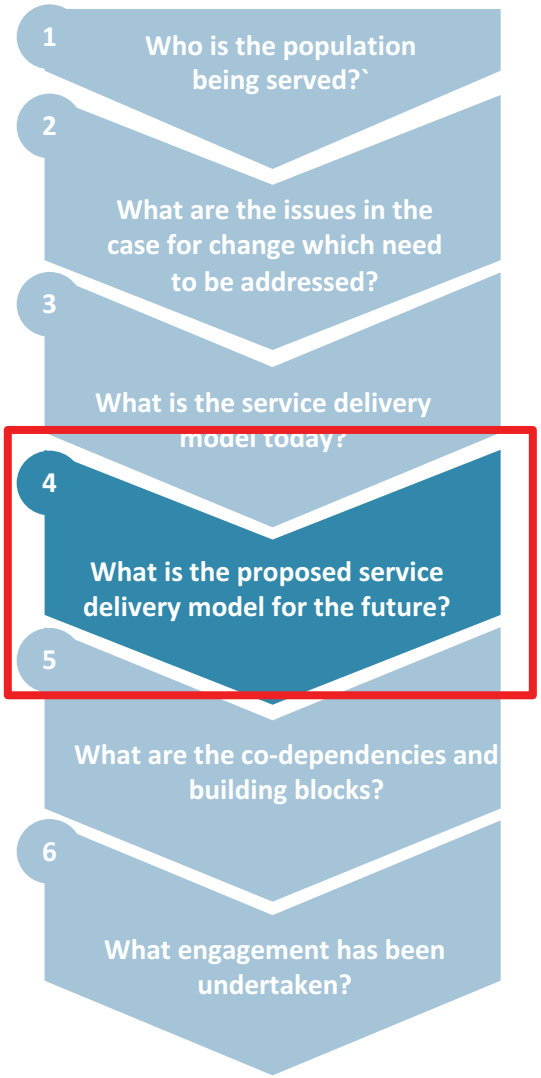
Mary is a 73 year old widow who lives alone in her own home. Mary experiences severe hip pain which is exacerbated when she tries to carry out normal activities of daily living. She struggles to climb the stairs and finds it difficult to get in and out of the bath. She has been under the care of her GP who has helped Mary manage the pain. Mary has in the past received a programme of conservative treatment (physiotherapy). Her GP now refers her to the hospital, to be seen by an orthopaedic surgeon.

What can happen now for some people:

- Mary attends the clinic and once the decision to place her on the waiting list is made, she is sent a letter inviting her to attend pre assessment
- Mary attends the pre- assessment clinic (PAC) and sees a surgeon and pre assessment nurse, who confirms that she is fit for surgery. Any further tests are undertaken at this point .e.g. MRSA screening;
- Mary is sent a letter with a date to come in for surgery.
- Mary also attends the Joint School for hip replacements prior to surgery.
- The day before admission, Mary is contacted by one of the admin team to inform her that her operation has been cancelled due to the increased number of emergency patients, impacting on bed availability. Whilst Mary will not be categorised as on the day hospital cancellation, Mary will not be treated within the 18 week referral to treatment national access standard. Mary is anxious as she had psychologically prepared herself for the operation and her son who lives and works in London had made arrangements to help care for his Mum.
- When Mary is given a new date of admission she is allocated a bed and her hip replacement is successfully carried out
- Mary is nursed on a ward which also houses some other non orthopaedic patients (medical / surgical outliers)
- Mary is seen and mobilised by the physiotherapist on the first day after her operation
- As Mary was operated on Friday, Mary does not benefit from the full mobilisation programme due to insufficient provision over the weekend. This means that her length of stay (LoS) is slightly longer than the average

Contents

What is the proposed service delivery model for the future?: Summary



- The proposed model is set within the context of the wider transformation programme which is underpinned by a focus on prevention and self care and the benefit of a community-led MSK pathway.
- The elective orthopaedic model of care is based on a set of principles including standardised approach, use of multi-disciplinary teams, one-stop services, senior support and better use of IT. It is very important to Get it Right First Time. This will lead to improvements in quality and productivity.
- The proposed inpatient pathway will include greater use of multi-disciplinary teams, consultant feedback, earlier discharge planning and ring-fenced elective beds.
- Consolidating elective orthopaedic surgery onto fewer sites will lead to an improvement in outcomes and separating elective and emergency work will improve efficiency and have in impact on the prevention of infection.
- The future model will also optimise an integrated MSK pathway and integrated provision.

The following slides collate an evidence base to support the issue outlined here

Aspirations for care in Kent and Medway (across all services)

It is the aspiration that patients in Kent and Medway:

1. Are supported to self-care where appropriate
2. Have easy access to advice when needed in person and using technology;
3. Can access care through most appropriate pathway
4. Are rapidly triaged to the most appropriate provider
5. Consistently receive care which is in line with best practice
6. Have access to services provided on all 7 days a week

Source: K&M Clinical Board, 2017

In order to fulfil those aspirations, opportunities across the full patient pathway are being reviewed

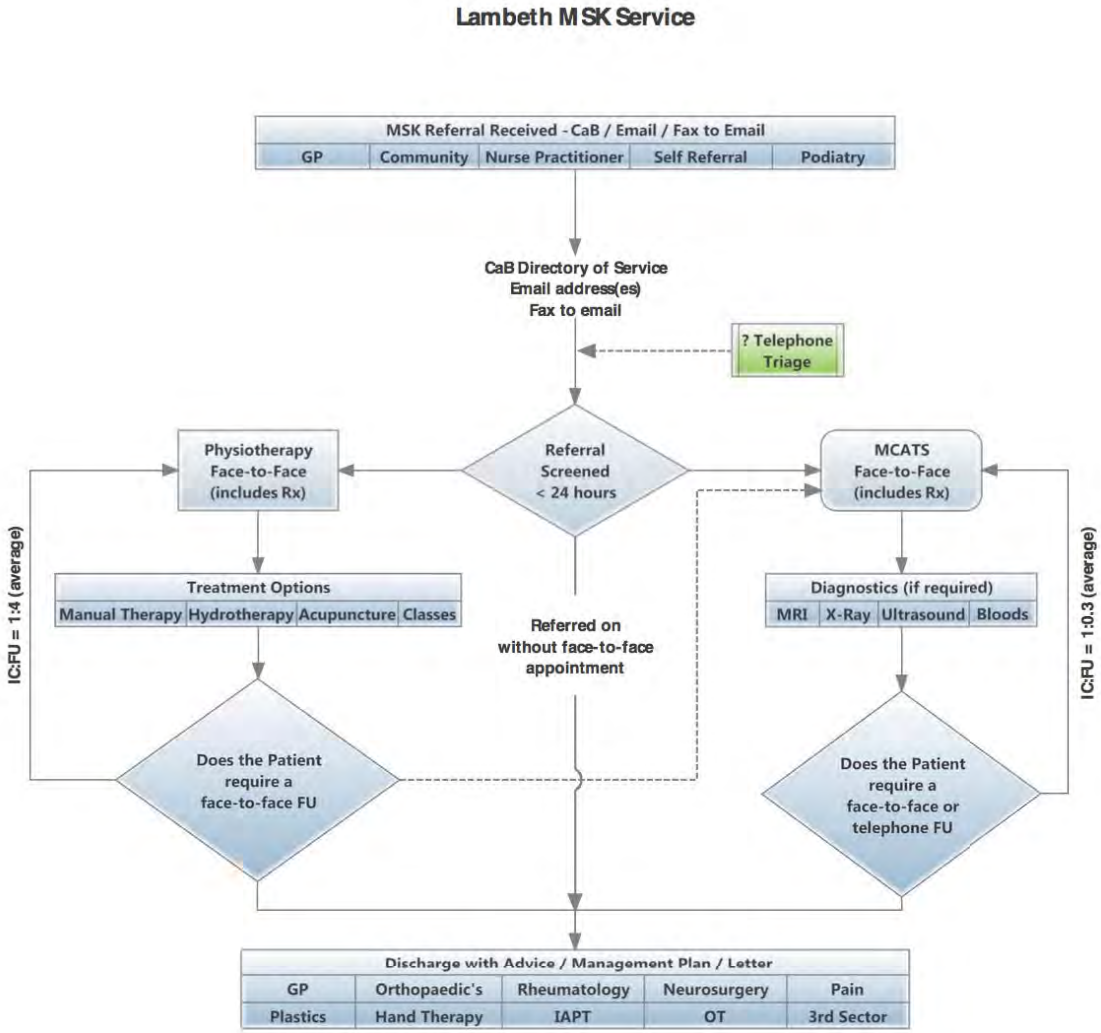
		Key enablers
1	**Deliver prevention interventions at scale**	• Excellent self help resources including maintaining a healthy weight and lifestyle • Investment in falls service to reduce falls and fractured hips • Shared information between health professional • Rapid access to therapies • Access to diagnostic services & more specialist opinion when required
2	**Optimise elective pathway as part of MSK provision**	• Referral management through single point of access • Most appropriate first point of contact through clinical triage (MDT for complex patients) • Onward referral to acute care only when appropriate – increased use of the CAS triage service* • Extension of the range of injections performed in community settings** • Diagnostic protocols to ensure efficient use
3	**Optimise outpatient pathway**	• Efficient pre assessment activities, online if appropriate • Pre operative therapy to support faster mobilisation • Post operative therapy to speed recovery and maximise outcome • Secured beds to avoid cancellation of operations
4	**Reduce avoidable elective inpatient length of stay**	• Enhanced recovery approaches for orthopaedic patients to shorten LOS • Estimated date of discharge confirmed prior to surgery • Multi disciplinary assessments if required • Home aids identified if required • Proactive care for older people undergoing surgery service (POPS)

The main focus of this pack is inpatient elective orthopaedics

*Note: Orthopaedic assessment (CAS) service clinics are already successfully employed in Medway - https://www.medwaycommunityhealthcare.nhs.uk/our-services/orthopaedic-assessment/

**Note: CAS do all peripheral joints but there could be the possibility to extend to SIJ and coccyx

The MSK pathway emphasises the amount of activity which takes place outside the acute hospital



Source: Lambeth Integrated MSK service team

The *Getting it Right First Time* report makes a number of recommendations for optimising orthopaedic pathways*, which will be adopted in the model

Area	Recommendation
Pre-operative	**Recommendation 1:** All total hip replacement (THR) and total knee replacement (TKR) patients should receive a multidisciplinary assessment pre-operatively to determine achievable goals of rehabilitation.
	Recommendation 2: For THR and TKR patients, pre-operative care should include: education, post operative protocol, identifying patients at risk of a poor functional outcome and organisation of rehabilitation equipment at home.
Inpatient rehabilitation	**Recommendation 3:** Properly funded and designed seven day services to ensure consistent quality of care in terms of intensity and frequency of rehabilitation across the whole week.
	Recommendation 4: There should be changes to the culture and layout of wards to ensure all staff are involved in encouraging patients' mobility and independence, providing opportunities for them to get active.
Community / outpatient rehabilitation	**Recommendation 9:** All THR and TKR patients should have follow up with a specialist physiotherapist within three weeks post discharge to assess post operative progress. The majority will not require routine post operative rehabilitation.
	Recommendation 10: Community physiotherapy services should divert resources away from joint rehabilitation to focus more on hip fracture patients.

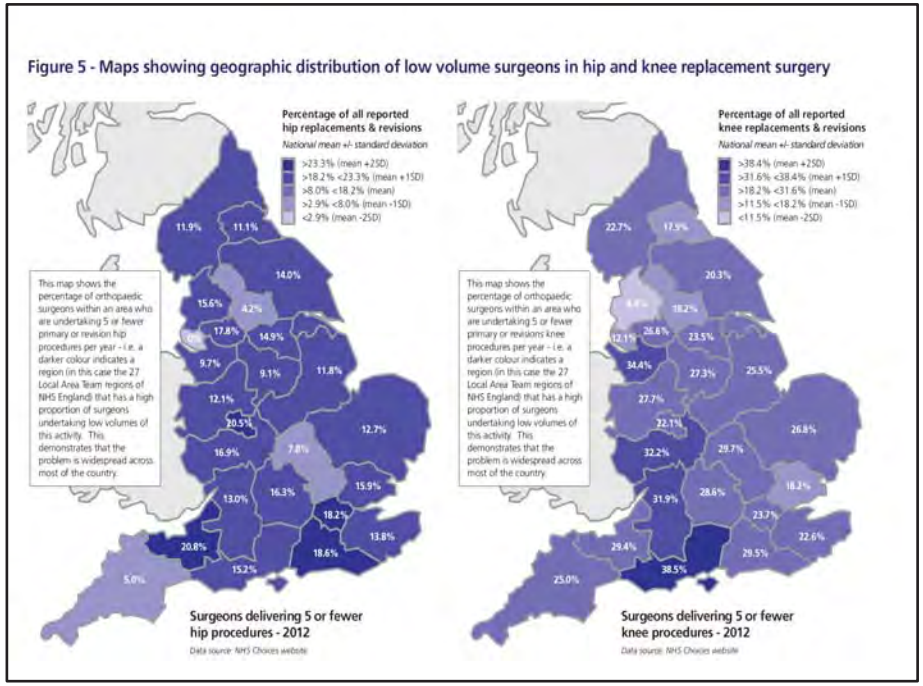
Source: Getting It Right First Time, A national review of adult elective orthopaedic services in England, March 2015

* Recommendations 5-8 relate to trauma and have been removed as not relevant.

Consolidating onto fewer sites would improve clinical outcomes and increase productivity

- Greater volumes enable more productive use of theatres
- This makes it easier for clinicians to undertake surgery above minimum volumes reducing complications and the need for revisions
- It is easier to ring fence orthopaedic beds leading to reduced infection, shorter length of stay and fewer cancellations
- There is earlier access to rehabilitation and specialist support services during the acute phase
- Evidence suggests that surgeons should be undertaking a minimum of 35 primary hip arthroplasty per year and a minimum of 20 knee replacements
- The effectiveness and efficiency of large elective orthopaedic centres, such as that provided to us in the papers (and which performs over 3000 joint operations per year for a catchment population of 1.5 million, with a team of 28 orthopaedic consultants) is well demonstrated
- There were almost 8,000 elective orthopaedic procedures performed across K&M in 2015/16
- Taking average splits of the activity would result in:
  - ~4,000 procedures per site if there were 2 sites in K&M
  - ~2,600 procedures per site if there were 3 sites in K&M
- In East Kent, there are c2,850 ojint ops which, taking into account population growth, private work and reconstruction the total number of procedures is c3000

Figure 5 - Maps showing geographic distribution of low volume surgeons in hip and knee replacement surgery



Source: Getting it Right First Time, British Orthopaedic Association, 2015; Clinical Senate Feedback (2017); Provider data returns 2015/16; HES data 2015

Monitor identified nine key interventions in improving productivity

- Monitor has identified nine key interventions that improved productivity.
- Of these, five released the greatest potential gain:

1. Stratifying patients by risk and creating low-complexity pathways for lower-risk patients
2. Extending clinical roles to enable lower-grade staff to undertake routine tasks in theatre or outpatients usually performed by consultants
3. Increasing throughput in theatres by explicitly measuring, communicating and managing the number of procedures per theatre session
4. Implementing enhanced and rapid recovery practices to reduce length of stay
5. Providing virtual follow-up for uncomplicated patients.

- A single set of supporting conditions helps to improve productivity: standardised pathways and protocols, effective performance management systems and visible leaders accountable for continuous improvement from board to ward.
- The Carter review recommended the development of a "model NHS hospital" to help providers aspire to best practice across all areas of productivity. An output of this has been the development of the model hospital portal, which allows organisations to access a wide set of standardised data and benchmarking analysis in one place.

"If every NHS provider followed the good operational practices adopted by the highest performers at each stage of their elective ophthalmology and orthopaedic care pathways, they could save 13% to 20% of today's spending on planned care in these two specialties"

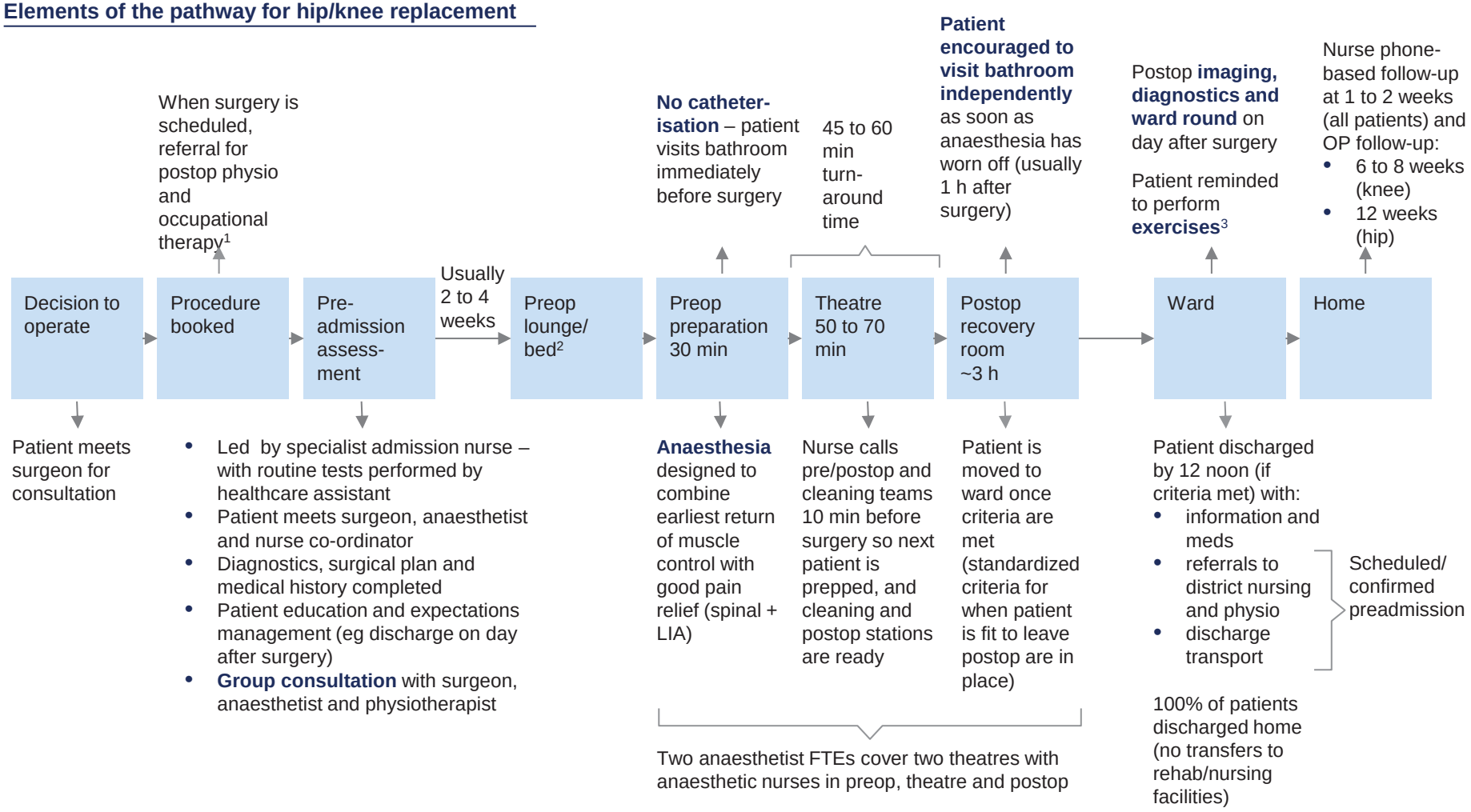
SOURCE: Helping NHS providers improve productivity in elective care October 2015
Implementing the Recommendations of Lord Carter's Review of Operational Efficiency October 2016

Based on this evidence, we have developed a new inpatient service delivery model

MDT clinic	• Identify frail patients to follow proactive care for older people undergoing surgery (POPS) pathway • Combined clinic with consultant, extended scope physio, GPwSI allows in clinic triage to most appropriate clinician • Greater co-working between community staff, primary care and consultants – orthopaedic qualified nurses play a key role • Lower average staff cost per appointment • Spinal injections • Focus on MSK pathway
Preoperative assessment	• Conducted at first outpatient appointment; if patient found not fit then plan reviewed same day • Greater use of self-assessment to support, which patients can complete from home • Ensure social circumstances support the treatment plan, pre-booking of rehab/post-op package of care prior to admission • Flags patients at risk of long length of stay
Re-check prior to surgery	• Contact at 48-72 hours before day of surgery to reduce late cancellation • Ensure patient is well and still wants surgery
Short-notice reserve list	• Ensures effective use of theatre capacity by filling gaps caused by late cancellation
Consultant-level feedback	• Transparency of list utilisation, case volumes per list • Peer challenge • Team working to increase available capacity by reducing cancelled sessions due to leave
Effective planning for discharge	• Discharge planning at preoperative assessment • Referral to discharge services earlier in the process (i.e. before admission) • Access to community support services
Enhanced recovery	• Consistent application of Enhanced Recovery Pathway (ERP) pathways • Clear expectations of predicted length of stay for patient
Ring-fenced elective beds	• Reduction in wasted theatre time • Reduction in infection risk for elective cases
Theatre utilisation	• Scheduling of theatre cases to optimise utilisation • Ensure critical equipment is scheduled to maintain the order and running of the list

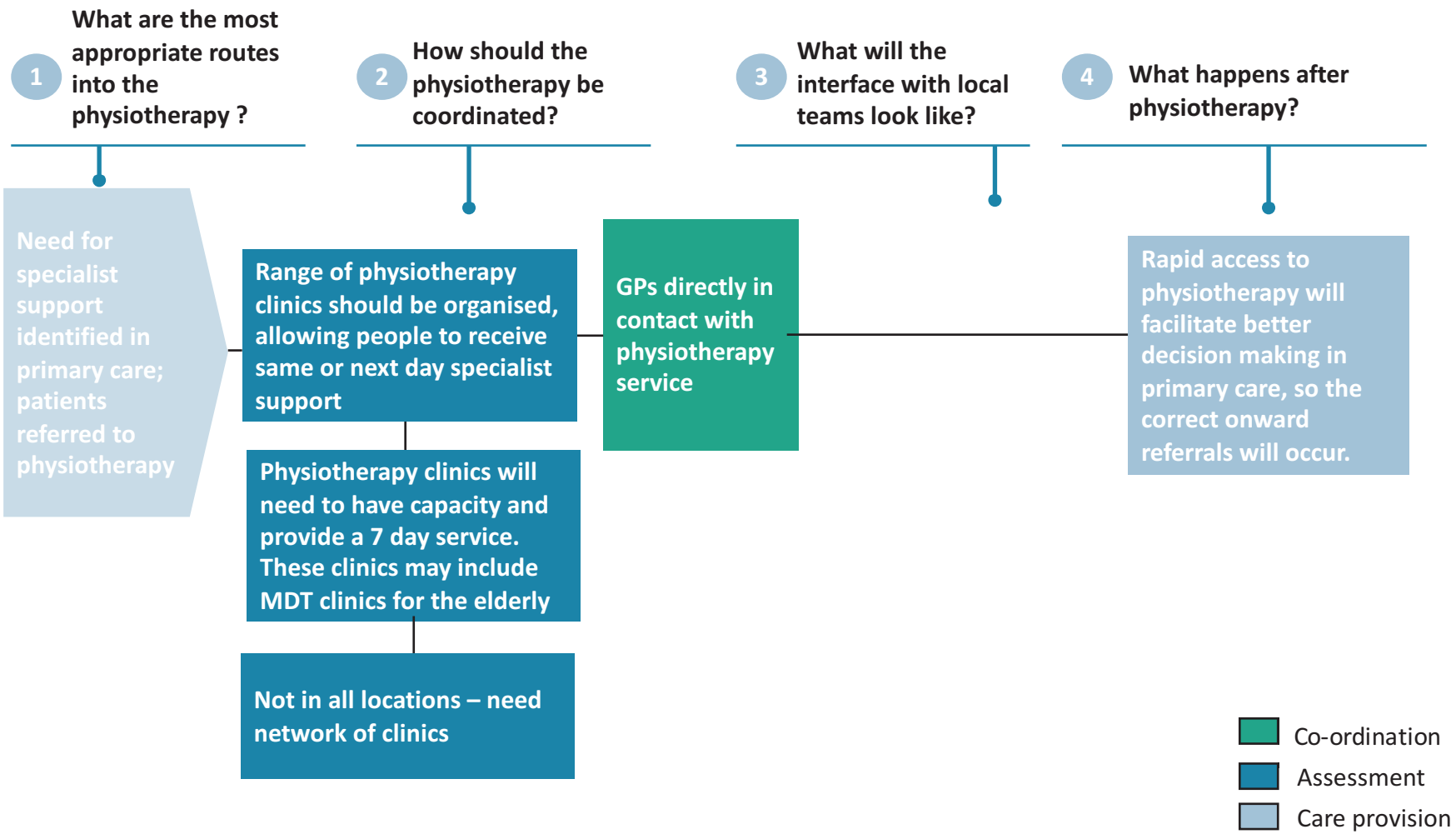
Transforming the patient pathway can improve outcomes and efficiency as shown by Capio Movement's approach to optimising the joint replacement pathway

Elements of the pathway for hip/knee replacement



Source: Helping NHS providers improve productivity in elective care - .gov.uk

The patient pathway needs to be supported by direct access to post-op physiotherapy



Source: Carnall Farrar Analysis, Devon Success Regime 2016

A small number of patients will require in-patient post-operative care

- Aspects of the Burke in-patient rehabilitation programme can be applied to ensure that these patients can return to their home as soon as possible:

- **3 hours of therapy, 5 days per week**
- **Access to a physician**
- **Rehabilitation nursing seven days a week**

Individual's needs should be addressed by:

- Providing rehabilitation through an interdisciplinary approach that emphasises communication, collaboration and cooperation
- Lessening limitations of activities by focusing on the individual's capabilities and utilising compensatory strategies and devices
- Providing the highest quality, patient focused rehabilitation
- Removing or lessening restrictions to participation in life situations to the extent possible
- Providing counseling to the individual and family and/or caregiver on alternative possibilities for life participation when necessary
- Preparing the individual, family and/or caregiver to make the transition to the next stage of the rehabilitation process

SOURCE: https://www.burke.org/inpatient/programs/orthopedic

Patient activation should be incorporated into all future delivery models

'Patient activation' is a widely recognised concept. It describes the knowledge, skills and confidence a person has in managing their own health and health care

Concept

Patients with low levels of activation:

- Are less likely to play an active role in staying healthy
- Are less likely to seek help when they need it
- Are less likely to follow a doctor's advice and manage their health when they are no longer being treated
- Have a lack of confidence and their experience of failing to manage their health often means that they prefer not to think about it

Activation as a healthcare tool

- Knowing a patients level of activation provides an indicator of whether case management, care navigation or a less intensive level of care is needed for the patient
- Case management, care navigation and support navigation can also facilitate increased levels of activation in patients:
  - Intervening to increase activation can improve a patient's engagement and health outcomes and is an important factor in helping patients to manage their health
  - Improvements in patient activation scores have been seen for up 18 months following intervention

Impact

- Highly activated patients are more likely to adopt healthy behavior, to have better clinical outcomes and lower rates of hospitalisation, and to report higher levels of satisfaction with services. More highly activated patients will also play a role in decisions about their healthcare, such as refusing treatment.
- Patients with low activation levels are more likely to attend accident and emergency departments, to be hospitalised or to be re-admitted to hospital after being discharged. It is likely to lead to higher health care costs

Source: The King's Fund, 2014

There are a number of things to consider with regards to the workforce when reconfiguring acute services

- There is a risk of losing staff from reconfiguring any services, including that of geographically separating elective from non-elective orthopaedics and trauma.
- Steps will need to be taken to minimise such risk, including rotation of staff to ensure maintenance of skills and interests.
- Training considerations are paramount if elective work is separated from non-elective acute hospital based work.
- Trainees must continue to get their required wide range of experience and training they need, regardless of the location of the service.
- Extended scope practitioners (ESPs) should do more than triage and initial triage type assessments, and should participate across the patient pathway, such as following up patients and managing patients post-discharge.
- They need to maintain their skills in treatment and the discharge process if they are not going to deskill, and also to maintain their job satisfaction. They should also be a resource for others within a physiotherapy department, providing support and education to others.

Evidence also suggests increased volume and specialisation can improve outcomes in specialist surgery; this strengthens the case for consolidating activity onto fewer sites

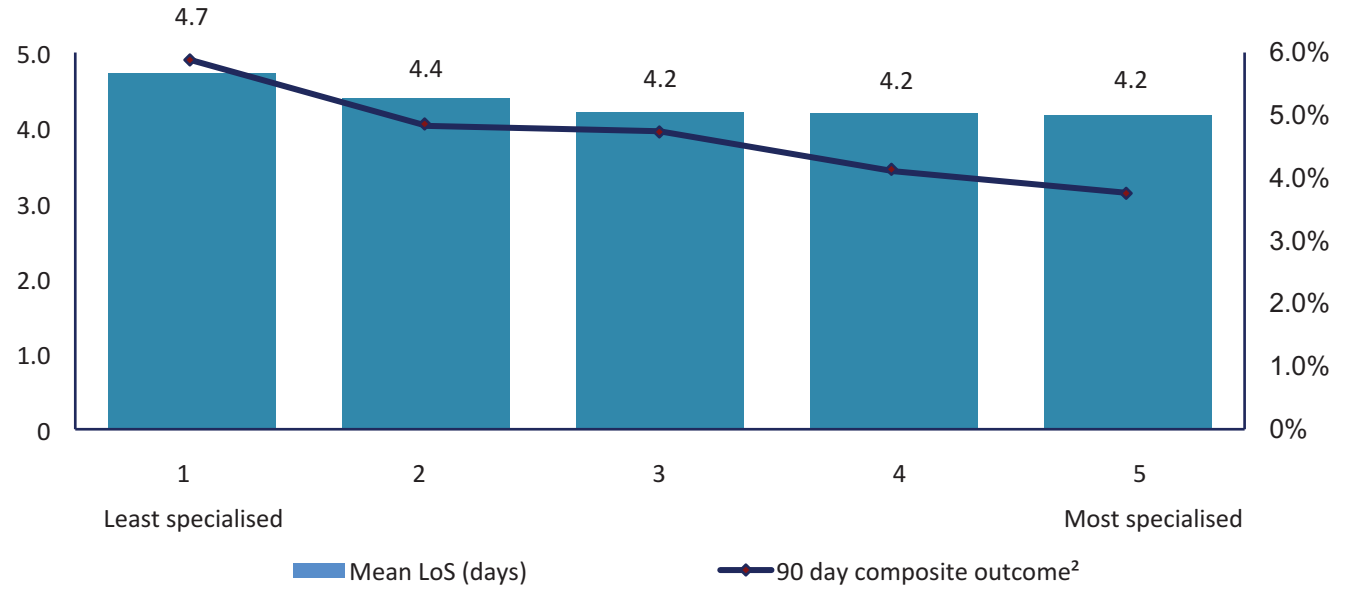
A review of >100 studies found strong evidence for a volume/outcomes relationship in specialist surgery

		Positive volume/outcome relationship found, %				
	Specialty	Overall	Mortality	LOS	Complication rate	No. of studies
Hospital volume[1]	All specialties	74	76	79	62	127
Surgeon volume[1]	All specialties	74	71	78	81	58

[1] Significant difference found between retrospective and prospective studies for hospital volume/outcomes relationship; difference not found in surgeon volume/outcomes nor in surgeon specialisation/outcomes. Percentage of patients who experienced one or more of: 90-day mortality; post-op infection; post-op haemorrhage; DVT; pulmonary embolism; MI

In orthopaedics, increased specialisation improves outcomes and reduces length of stay

Length of stay and patient outcomes following total hip or knee replacements for 3,818 US hospitals, stratified into quintiles by degree of specialisation



Source: British Journal of Surgery, A systematic review of the impact of volume of surgery and specialisation on patient outcomes, 2007; 94; 145–161

Separating emergency and elective work and addressing theatre start-time issues can also deliver efficiency savings

1 Situation

- Over 30 theatres in operation
- Previous initiatives looking at theatre utilisation focused on lean methodologies – promising longer term solutions rather than "quick fixes"
- The standard for good theatre utilisation stands at 85%; Oxford Radcliffe set their target at 90% for planned elective lists, from a low starting point of 74%

2 Approach

- The hospital approached their improvement challenge by focusing on the following elements of theatre utilisation
  - Starting on time
  - Improving turnaround time between cases
  - Finishing on time
  - Booking lists appropriately
  - Separating emergency and elective workloads
  - Effective pre-operative assessment
  - Reminder service to reduce patient DNAs
- Each theatre has a weekly "storyboard" displaying total activity, performance (positive and negative), minutes of operating time, top 10, overall utilisation
- By focusing on starting time, the team felt that this would lead to better utilisation of the list overall, and also deliver a reduction on overruns. Set at target of 50% of all lists starting on time (or within 5 minutes) and 90% of lists to start within 15 mins

3 Impact

- Reduction in lists starting late from ~75% to 55-60% , and increase in utilisation of planned lists from 74% to 77% within first 6 months
- Reduction in the number of cancelations due to the patient being unfit for surgery reduced across the specialties (2.1% to 1.8%)
- Standardised booking process
- Reminder service to reduce DNAs
- Pre-operative assessments

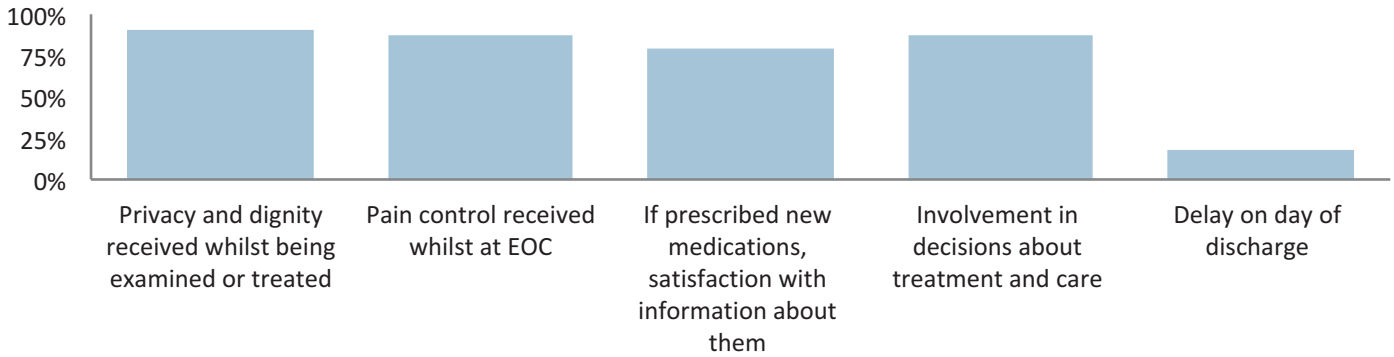
4 Critical Success Factors

- A whole system perspective to improving utilisation
- Iterative approach focusing on one element at a time
- Clinical buy-in across the setting

SOURCE: Oxford Radcliffe Hospitals NHS Trust, http://www.oxfordradcliffe.nhs.uk/aboutus/trustboard/tbdocs08/september/theatreutilisation080918.pdf

South West London Elective Orthopaedic Centre is a good example of a dedicated elective centre

Background	• SWLEOC provides a centre of excellence for 1.5 million people in South West London • Largest state-of-the-art treatment centre for orthopaedic surgery in the UK • Purpose built
Model	• SWLEOC utilises the latest techniques and technology to provide high quality care, minimising infection and supporting patients return to normal in the shortest and safest way[1] • Innovations such as new wound catheter technique allows faster mobilisation, recovery and reduced length of stay for patients[1] • The Centre is run through a partnership model across the four local acute trusts[1] • The trusts provide a team of 28 consultant orthopaedic surgeons who deliver care in collaboration with the Centre's multidisciplinary teams that allow streamlining patient pathways[1] • Stand alone unit on Epsom Hospital site with 'ring-fenced' theatres, beds and staff for planned orthopaedic surgery[4]
Outcomes	• LOS for knee replacement around 4.78 days, compared to a London average of 8.05 days[2] • Consistently achieves operational targets, including length of stay and minimal infection rates3 as well as high inpatient satisfaction scores (below) • 97% of patients would be likely to recommend SWLEOC wards to friends and family if they needed similar care or treatment[3] • Over 95% theatre utilisation in 2008/2009[4] • Surplus of £0.5m on a £27m turnover (1.8%)[4] • Performs over 3000 joint operations a year



1 The Trust Special Administrator draft report (2006)
2 Kingston Hospital Annual Report (2010-11)
3 EOC newsletter (2013)
4 EOC annual report (2009)

Clinical evidence on elective

	Source	Study	Impact
Integrated elective pathway	Systematic review Briggs (2015)	Bradford: Between 2011-2013, the Bradford Teaching Hospitals NHS Foundation Trust ESD pathway saved the Trust a total of 2,698 orthopaedic bed days, equating to an estimated cost saving of more than £600,000. Readmission rates fell from 10-12% to 5-6%.* Other outcomes included a reduction in risk of falls, and standard measures evidenced clinical improvements of between 25-50%	Reduced readmission rates from 10-12% to 5-6%
	Systematic review Monitor (Oct 2015)	Monitor's review of orthopaedics and ophthalmology case studies concludes that: • Good practice including specialisation and extended roles within team, optimised scheduling and management, supporting surgical teams to use theatres efficiently can lead to increased number of patients per hour, reduced postop infection, increased theatre utilisation and reduced cost of theatre and staff • Standardisation of ward care and enhanced recovery, proactive management of infections and readmissions can reduce number of days/ time in hospital postop	Improved efficiency Reduced readmission and postop appointments
Referral Management System	Systematic review Imison (2010) Evans E (2009)	Torfaen, Wales: implemented RMS involving weekly practice-level referral review meetings, and six-weekly cluster meetings including consultant feedback was found to have the following impact in 1 year; a 30 per cent reduction in referrals to hospital, with patients being directed to community alternatives instead. However, there was little evidence of a beneficial effect of relocation of specialists to primary care, or joint primary/secondary care management of patients on outpatient referrals	

*NOTE: This relates to all orthopaedic admissions including falls. MTW currently has an ESD service so any improvement gain may have already been reaised within MTW.

Clinical evidence on elective

	Source	Study	Impact
Standardisation of elective procedures	Systematic review Briggs (2015)	Clinical advantages of having dedicated (ring-fenced) orthopaedic units are well known (reduced infection, shorter length of stay). Physiotherapists who carry out a detailed pre-operative assessment believe this to be a key contributing factor to a shorter length of stay	Reduction in LOS
	Systematic review Monitor (Oct 2015)	Compared to the NHS, the international sites tended to have shorter lengths of stay for joint replacement: average length of stay was around 3.5 days; at some centres it was under 2 days. The average NHS length of stay for hip and knee replacements was 5 days in 2013/14. Achieving shorter lengths of stay through rapid recovery requires complementary efforts across the patient pathway, from preparing patients and setting their expectations before admission, to processes during surgery (including choice of anaesthesia) and postoperative mobilisation and therapy.	Potential of achieving 30-70% reduction in LoS
Rehabilitation and reablement	Systematic review Briggs (2015)	Services that integrate their acute and community rehabilitation services are able to provide continuity of care, and are associated with shorter length of stay. Current evidence demonstrates that early, intense and frequent rehabilitation: • Decreases length of stay and post operative complications and costs. • Increases function and quality of life. • Reduces the rate of falls.	Reduced length of stay Improved outcomes
	Systematic review Monitor (Oct 2015)	In Sweden, the rapid recovery model followed by Capio results in around 75% of hip and knee replacement patients being discharged on the day after surgery (from 3%). Inpatient average length of stay reduced from 6.8 days in 2010 to 2.9 days in H2 2014	55% reduction in LoS

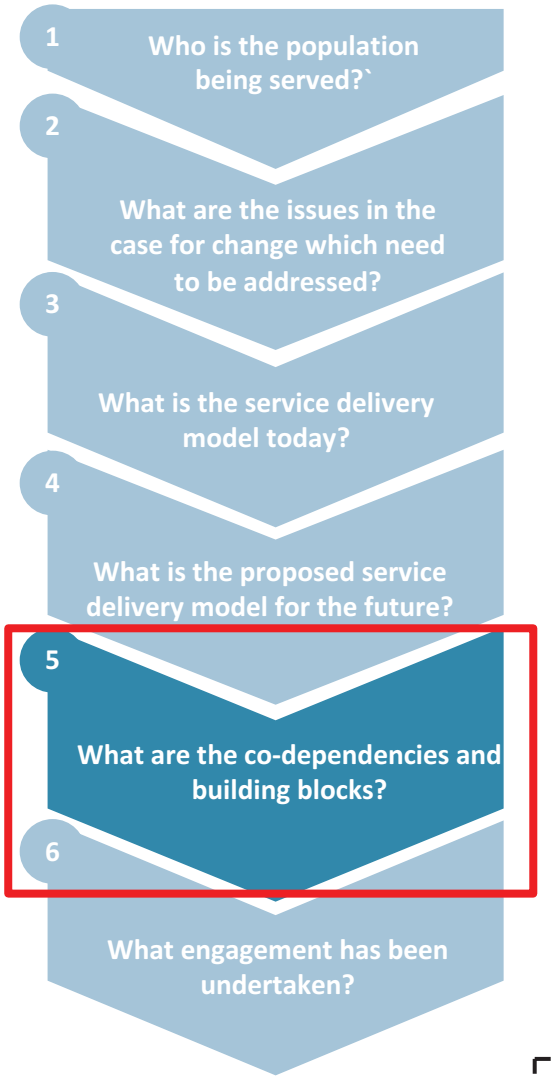
The proposed service delivery model evidence base

	Case study	Source/Publication	Date	Key Points
1	South West London Elective Orthopaedic Centre (SWLEOC, Epsom Hospital)	University of Oxford	2009	• NHS Treatment Centre providing regional elective orthopaedic surgery. • 5 laminar flow theatres* and 71 beds undertaking circa 5,300 procedures per year 6 days per week. • Consultant and nurse delivered – no HO/SHO presence other than for training. • Managed through a partnership board of the four partner Trusts
2	Royal National Orthopaedic Hospital	Getting it right first time approach	June 2015	• Consolidated orthopaedic practice • Team working • Standardisation of care and prosthesis • Low mortality and infection rates
3	Helping NHS Providers Improve Productivity in Elective Care	Monitor	2016	• 9 identified good practices • Standardised pathways • Enhanced and rapid recovery • Skill mix • Virtual follow up

*NOTE: There is emerging evidence that the use of laminar flow theatres does not improve infection rates
(SOURCE: Does laminar airflow make a difference to the infection rates for THR/TKR: a study using the National Joint Registry and local surgical site infection data for two hospitals with and without laminar airflow; Singh, Reddy, Shrivastava 2016)

Contents

What are the co-dependencies and building blocks?: Summary



- The critical co-dependencies for orthopaedic elective work are anaesthetics and access to emergency diagnostics .The level of complexity of the procedures that can be undertaken is determined by access to Level 2 critical care facilities on site.

The following slides collate an evidence base to support the issue outlined here

Elective centre co-dependencies

Co-location on same site

- Non-complex inpatient surgery (85%)
- Non-complex day case surgery (99%)
- Outpatient services
- Anaesthetics
- Simple diagnostics
- Physiotheraphy
- Occupational Therapy
- Emergency imaging and reporting

Networked services

- Specialised emergency surgical opinion
- Acute medical opinion and assessment
- Acute medical intervention
- Critical care
- Lab based diagnostics
- Dietetics
- Specialist imaging
- Interventional radiology
- Stroke services
- Interventional cardiology
- Speech and language therapy

***The presence of L2 critical care will mean a more complex case mix can be seen.**

Source: Carnall Farrar analysis based on collected clinical opinion

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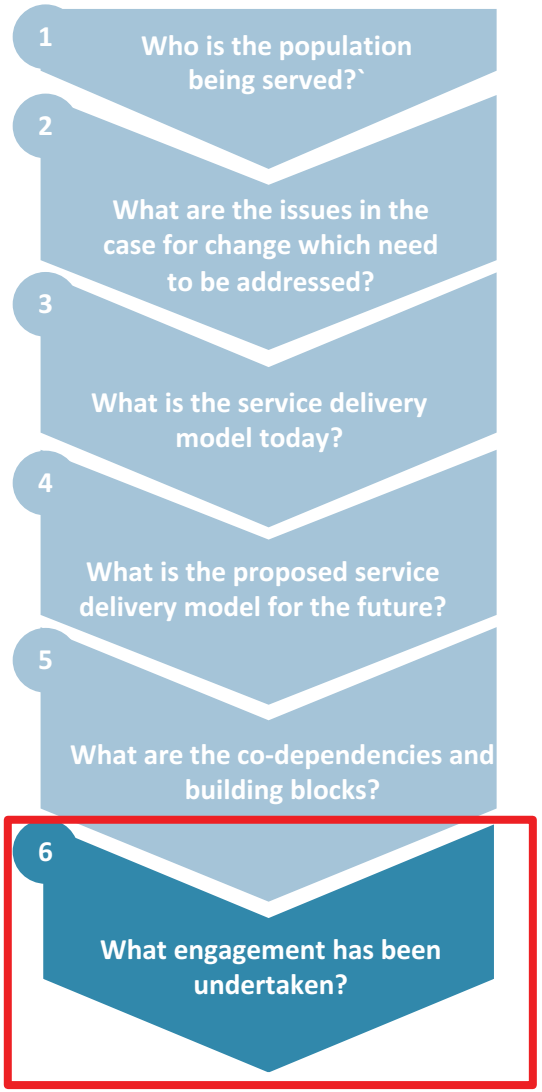
What engagement has been undertaken?: Summary



- Over the last 2 years EKHUFT has engaged with key stakeholders internally and externally through a series of EKHUFT and East Kent Strategy Board events.
- West Kent have not carried out engagement to date

The following slides collate an evidence base to support the issue outlined here

Engagement events to date (1/3)

Date	Type of engagement	Stakeholder group engaged	Description
January 2015 – current date	• Strategic meetings	Divisional and Medical Directors and heads of Nursing	• To keep them informed and gain feedback on every component of the strategy programme and latterly the STP
January 2015 – current date	• Open staff forums	All staff	• To keep them informed and gain feedback on every component of the strategy programme and latterly the STP
January 2015 – current date	• Staff forums for administration staff	All administration staff	• To keep them informed and gain feedback on every component of the strategy programme and latterly the STP
Spring 2015	• Focus Groups facilitated by Health Watch – 7 events in Thanet, Herne Bay, Canterbury, Ashford, New Romney and Folkestone and Tenterden. • Information shared in school book bags and at universities and train stations. Feedback forms given out and returned	Public. Over 1000 people contributed their thoughts some representing organisations	• To share the case for change
July 2015; Sept 2015; Dec 2015; July 2016; Nov 2016	• Clinical Forums for between 100 and 209 consultants and GPS at each event	Trust Consultants GPs CCG representatives	• To bring together the attendees to discuss the way forward in achieving an acute health system that is clinically and financially sustainable
January 2016	• Individual meetings with clinical leads • Sessions at the Quality and Innovation Hubs on al 5 EKHUFT sites	Consultants All staff	• To get feedback from staff about the evaluation criteria for option development

Engagement events to date (2/3)

Date	Type of engagement	Stakeholder group engaged	Description
Jan – Dec 2016	• Clinical engagement working groups	Consultants , GPs, nurses & AHP	• Clinical engagement in developing improvements in clinical pathways and promoting integration
4th February 2016	• EKSB engagement event • East Kent Clinical Forum • Monthly meetings	All health and social care organisations medical directors and clinical chairs	• Clinical input and approval of work done so far; discuss and develop the service area across east Kent
March 2016	• 3 day strategic event to identified innovative ways of working nationally and internationally, gain feedback and commitment to develop new pathways and ways of working	Divisional Clinical and management teams	• Identify new ways of working
7th April 2016	• EKSB engagement event • East Kent Patient & Public Engagement Group (PPEG) • Monthly meetings	Public and representatives of individual groups	• Share Care for Change and gain feedback
April – June 2016	• EK STP Task and Finish groups to identify current practice and issues and identify solutions for future clinical pathway planning across the health economy	EKHUFT Consultants and clinicians, GPs and CCG leads	• Design patient pathways for emergency care, planned care, Long term conditions (including frailty), paediatrics and maternity
April to June 2016	• EKSB engagement event • 6 Task & Finish Groups: 1. LTC & Frailty: 4 sessions 2. Planned and Specialist Care: 3 sessions 3. Maternity: 3 sessions 4. Paediatrics: 4 sessions 5. Emergency & Urgent Care: 4 sessions 6. Mental Health: 2 sessions	Acute Care Consultants, Primary Care, Social Care and Community Health representatives	• Work stream sessions to build a shared vision for service areas in east Kent as well as share good practice from other areas

Engagement events to date (3/3)

Date	Type of engagement	Stakeholder group engaged	Description
July 2016	• EKSB engagement event • 4 Final Workshops for all Task & Finish groups: 1. LTC & Frailty 2. Planned and Specialist Care 3. Maternity & Paediatrics 4. Mental Health	Acute Care Consultants, Primary Care, Social Care and Community Health representatives	• Share information about work done so far; discuss and refine the case for change and start to describe ambition for the service area across east Kent
27th July 2016	• EKSB engagement event • Presentation session	To all council leaders and Chief Executives	• To discuss the progress so far and future plans across east Kent
10th September 2015 – current date	• EKSB engagement event • Monthly meetings	All organisation CEO's, medical directors, accountable officers and clinical chairs (including KCC and NHSE)	• Develop strategy for the services area across east Kent
5th Sept 2016	• EKSB engagement event • Evaluation Criteria half day workshop	All organisation CEO's, medical directors, accountable officers and clinical chairs (including KCC and NHSE)	• To discuss the proposed evaluation criteria and evaluation process
15th Sept 2016	• EKSB engagement event • Discussion with MP • London based meeting		
Autumn 2016	• EKSB engagement event • 6 Focus groups facilitated by EKSB and supported by 'Curved Thinking'	Members of the Public and public groups	• To share the case for change

Contents

Improving productivity: what works?

Intermountain: Hip replacement

- In 1986, Intermountain launched an effort to measure and reduce practice-level variation.
- Pathway redesign, shifting focus from the clinicians to the processes underlying specific treatments, resulted in cost of total hip replacement falling from $12,000 to $8,000 between 1987 and 1989.

Intermountain: Acute respiratory distress syndrome

- Adaptations on the standard pathway were recorded as variances.
- The pathway was periodically adapted to reflect the realities of care more accurately.
- Consequently, clinicians were able to follow the standard guidelines more closely.
- Total cost of care for those most seriously ill dropped by 25%.

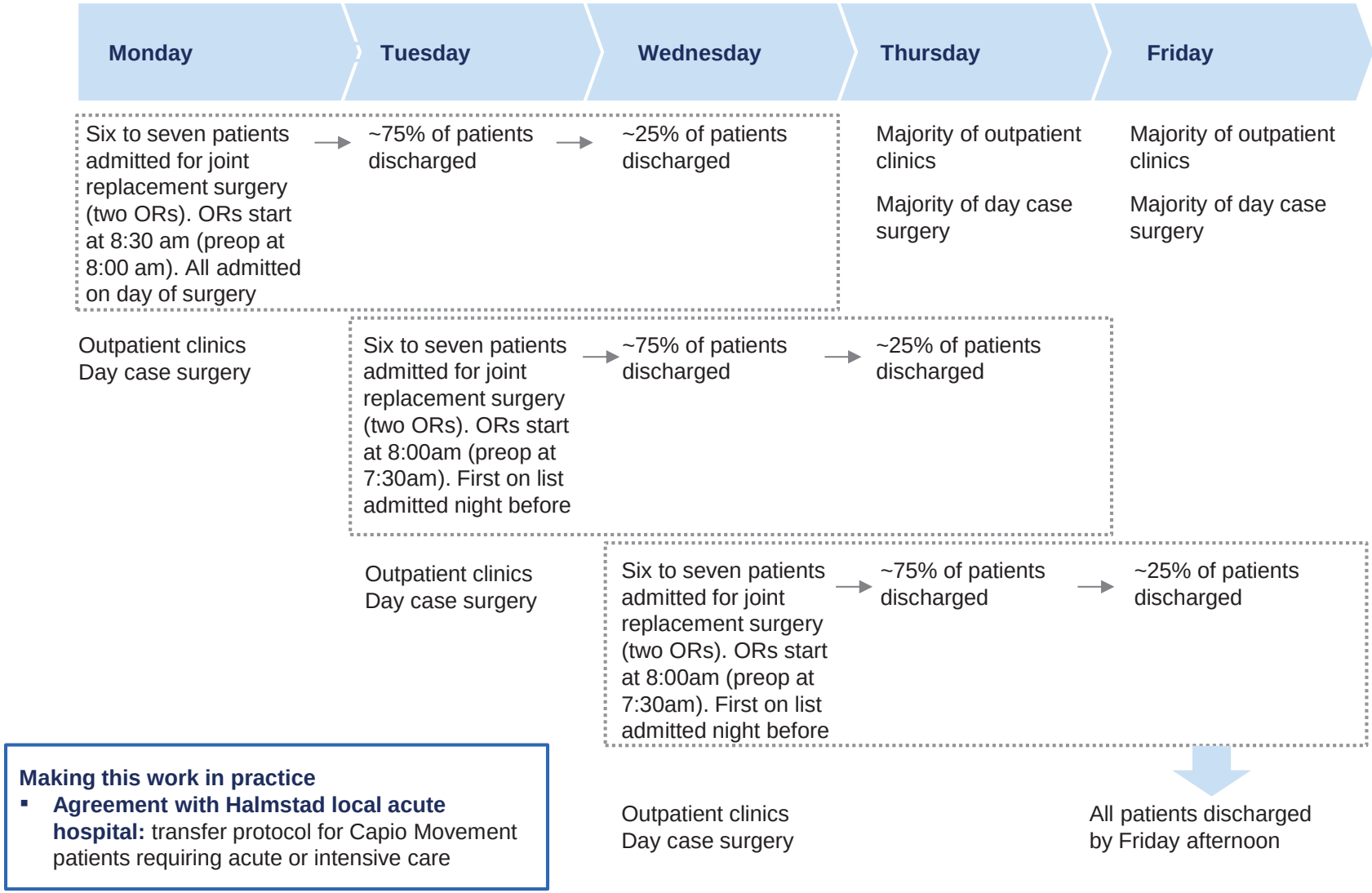
Source: Brent C. James and Lucy A. Savitz (1986). "How Intermountain Trimmed Health Care Costs Through Robust Quality Improvement Efforts." Health Affairs published online, May 19, 2011; Intermountain: Acute respiratory distress syndrome - adaptations of the pathway / https://intermountainhealthcare.org/research/areas-of-research/clinical-research/center-humanizing-critical-care/publications/

Gate Elective Centre, North East London

Business Model	• Provides day care, elective surgery and diagnostic procedures • Specialties include orthopaedics, urology, gynaecology and general surgery • Also houses the Trust's sports injuries clinic and fracture clinic • Integrated with main hospital staff and high-dependency facilities
Clinical Model	• Case-selective only by patient complexity (up to ASA3) • Surgeons doing elective lists are not on-call • Performs the majority of elective surgery at Newham University Hospital, increasing capacity for emergency surgery – Separating elective and emergency rotas enhances expertise, improves quality of patient care and has a positive impact on the prevention of infection – Centre meets clinician recommendation of larger teams of 8-12 specialists working together across all Trust hospitals
Outcomes	• Lean and timely management of services – Diagnosis, pre-assessment and booking on the same day – Patients arrive 'just in time' for their scheduled surgery • Performs 99% of Newham's elective surgery • Majority of patients in single rooms: 12 day-case beds, 23 short-stay (1-2 day) beds, 30 long-stay (>2 day beds) • Newham's elective surgery cancellation rate is just 0.36% (<0.8% national target)

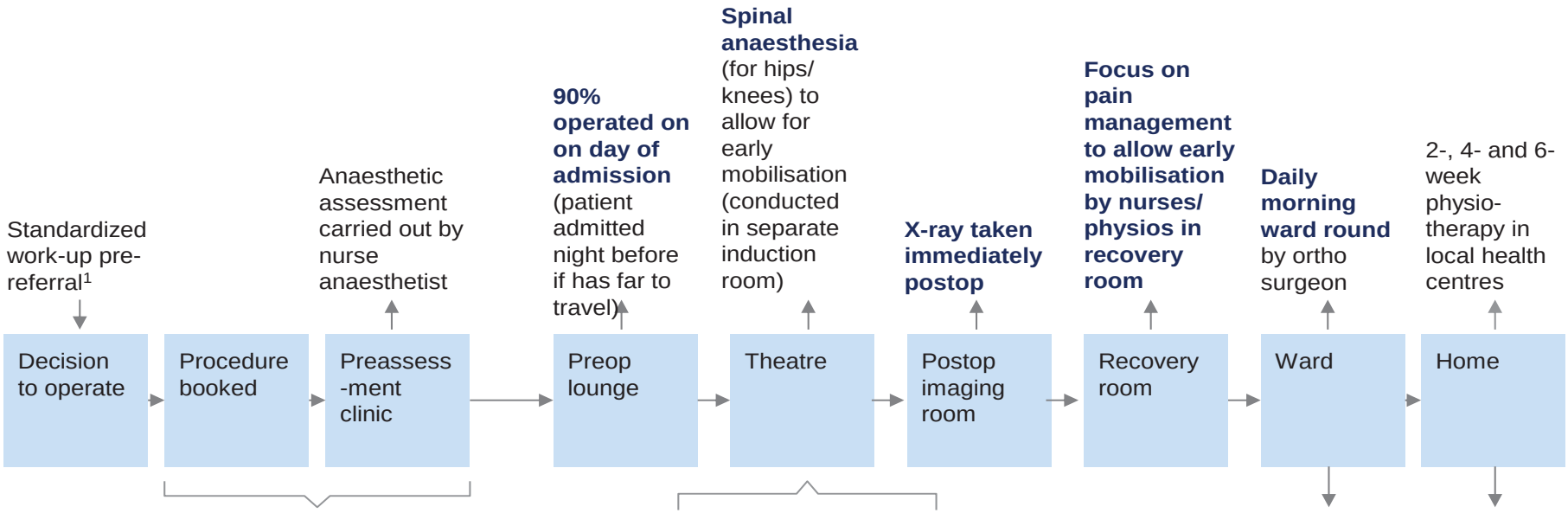
Source: Gate Elective Centre, North East London , Clinical Model:http://www.nelondontreatmentcentre.nhs.uk/

Capio Movement's approach to theatre management



Source: Monitor (Oct 2015). "Improving productivity in elective care". Appendix B International Case Studies – Capio.

Coxa's approach to optimising the joint replacement pathway



PROM, patient reported outcome measure.
[1] For patients referred from local catchment population; referral pathway for other patients varies.
[2] Calculated as actual time (when patient is in theatre) plus turnaround time (15 min) as % of planned theatre time.

Source: Monitor (Oct 2015). "Improving productivity in elective care". Appendix B. International Case Studies - Coxa Hospital for Joint Replacement.

The Stroke Programme Board have agreed the following hurdle criteria

Is the potential configuration option clinically sustainable?	• Does it deliver key quality standards? • Does it address any co-dependencies? • Will the workforce be available to deliver it? • Will there be sufficient throughput or catchment population to maintain skills and deliver services cost effectively?
Is the potential configuration option implementable?	• Will the option deliver financial and clinical sustainability within a medium-term timeframe by 20/21? This statement is based upon a system wide view
Is the potential configuration option a strategic fit?	• Does it implement the outcome of other recent consultations or designation processes?
Is the potential configuration option accessible?	• Can the population access services within a window of 120 minutes from call to needle?[1]
Is the potential configuration option financially sustainable?	• Must not increase the 'do nothing' financial baseline *(given the need for capital investment at any resulting sites which is of similar quantum, noting more at PFI sites, this will be considered in detail at evaluation stage)*

1) Using 95% accessing services within 60 mins (peak) as a proxy)

A set of hurdle criteria for urgent care and elective orthopaedics have been agreed by the Clinical Board and Finance Group

Is the potential configuration option clinically sustainable?	• Does it deliver key quality standards? • Does it address any co-dependencies? • Will the workforce be available to deliver it? • Will there be sufficient throughput or catchment population to maintain skills and deliver services cost effective?
Is the potential configuration option implementable?	• Will the option deliver financial and clinical sustainability within a medium-term timeframe by 20/21? This statement is based upon a system wide view, this may mean that some organisations have a net negative financial impact as well as some have a net positive impact.
Is the potential configuration option accessible?	• Is the maximum travel time (by car) an average of one hour or less?
Is the potential configuration option a strategic fit?	• Does it implement the outcome of other recent consultations or designation processes?
Is the potential configuration option financially sustainable?	• Must not increase the 'do nothing' financial baseline

Kent and Medway Stroke Delivery Model

February 2017

Introduction and purpose of service delivery model template

- A number of services have been prioritised as for early consideration by the K&M hospital care working group. This pack forms one of a series service delivery model templates for the priority services.
- The aim of this pack is to consider the key issues the service is facing within the hospital context, its current in-hospital model of care and aspirational future model among other relevant context.
- The pack follows the structure of:
  - A summary slide outlining key information from each section; then
  - Each section, with a summary slide up front followed by evidence slides
- The pack has been created with expert input from across Kent & Medway, and has been developed by the K&M Hospital care workstream before being signed off by the Clinical Board.
- The Acute medical care template focuses on the model for acute medicine in the acute hospital with future medical models using the assumptions made by local care about preventing acute hospital admission and facilitating appropriate timely discharge.

The STP outlined the aspiration for Hospital Care model which prevents ill health, intervenes earlier and delivers excellent, integrated care closer to home

Care Transformation workstreams

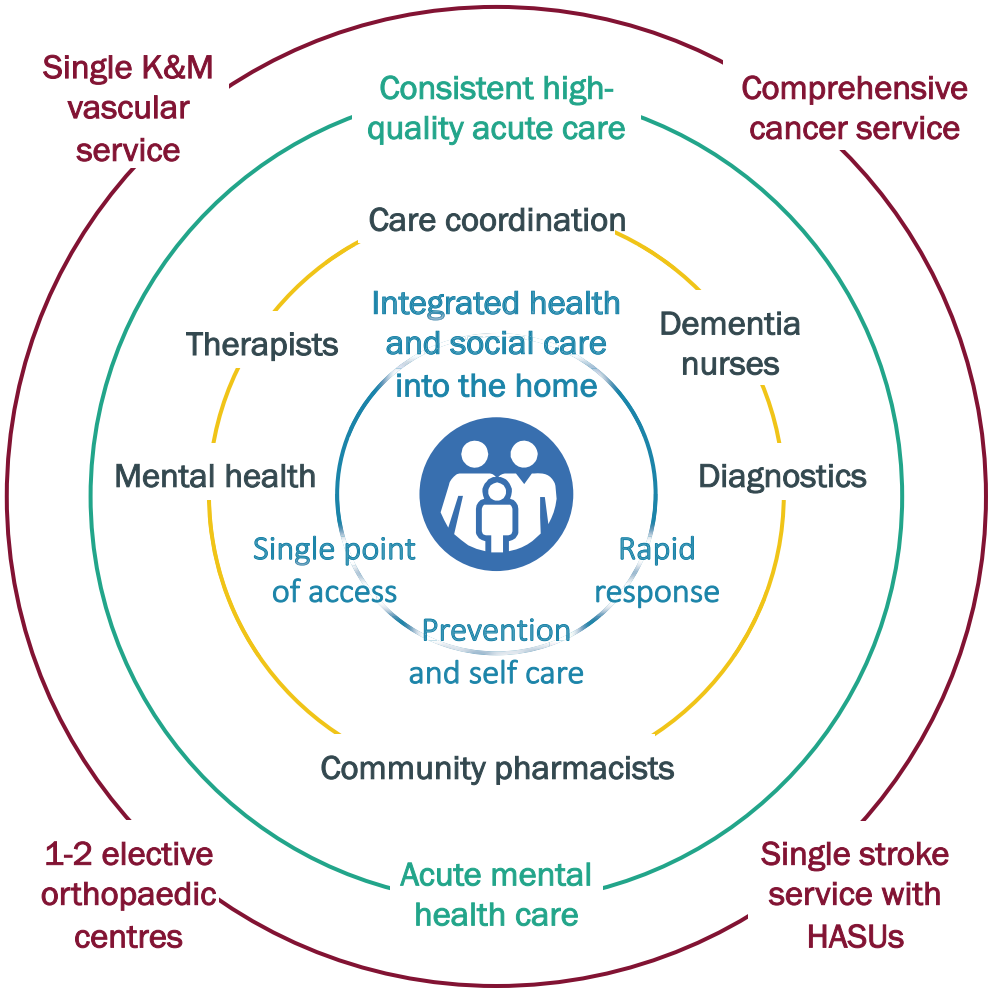
Prevention
Enlisting public services, employers and the public to support health and wellbeing

Local Care
A new model of care closer to home for integrated primary, acute, community, mental health and social care

Hospital Care
Optimal capacity and quality of specialised, general acute, community and mental health beds

Mental Health
Bringing parity of esteem, integrating physical and mental health services, and supporting people to live fuller lives

Kent and Medway Future Care Model



Source: K&M STP

The focus of this template will be on Hospital Care

Summary contents

1. Who is the population being served?
2. What are the issues in the case for change which need to be addressed?
3. What is the service delivery model today?
4. What is the proposed service delivery model for the future?
5. What are the co-dependencies and building blocks?
6. What are the minimum thresholds for staff in clinical standards?
7. Engagement – to date and required

- 2,487 patients (FY 15/16)
- Services currently provided at all 7 acute hospitals

- Only half of all patients admitted within 4 hours and performance is below national average
- All 7 hospitals only provide 5 day stroke consultant face to face cover; none provide 7 day consultant ward rounds, less than 50% of patients receive thrombolysis within 60 mins
- Patient volumes are too small to deliver clinical sustainability/ Performance against SSNAP is variable and inconsistent

- 7 combined HASU/ASU stroke units across Kent & Medway
- Patients receive their Hyper-acute, acute and acute rehabilitation in these units
- Patients are then discharged without further rehab, discharged back to their home with a community rehabilitation package or to a new home such as a residential care home that is suitable for their needs/ Rehab pathways are variable across K&M

- Consolidation onto fewer sites; 3 sites is the optimum when measured against the agreed critical criteria.
- Deliver a combined HASU and ASU service on each of the 3 sites
- Develop robust early supported discharge and rehabilitation services

- A&E /Emergency Medicine
- Acute and General Medicine
- Elderly Medicine
- Respiratory Medicine
- Critical Care (adult)
- General Anaesthetics
- Acute Cardiology
- X-ray and Diagnostic Ultrasound
- CT Scan
- Acute Mental Health Services
- Therapy; SLT/OT and Physiotherapy
- Physiotherapy
- Urgent GI Endoscopy[1]
- MRI Scan[1]
- Acute Inpatient Rehabilitation[2]
- HASU requirements; 24/7 consultant availability with minimum 6 trained thrombolysis physicians on rota and consultant led ward round 7 days a week, 2.9 WTE Nurse (80:20 registered unregistered per bed ,Per 5 beds; 1 Physiotherapist, 0.68 Occupational Therapist, 0.34 S&L therapist, 0.20 Clinical Psychologist, 0.15 Dietician [3]
- HASU Volume requirements; >500 and < 1500 confirmed stroke patients

- Over the last 2 years EKHUFT has engaged with key stakeholders internally and externally through a series of EKHUFT and East Kent Strategy Board events.
- West Kent have not carried out engagement to date

1

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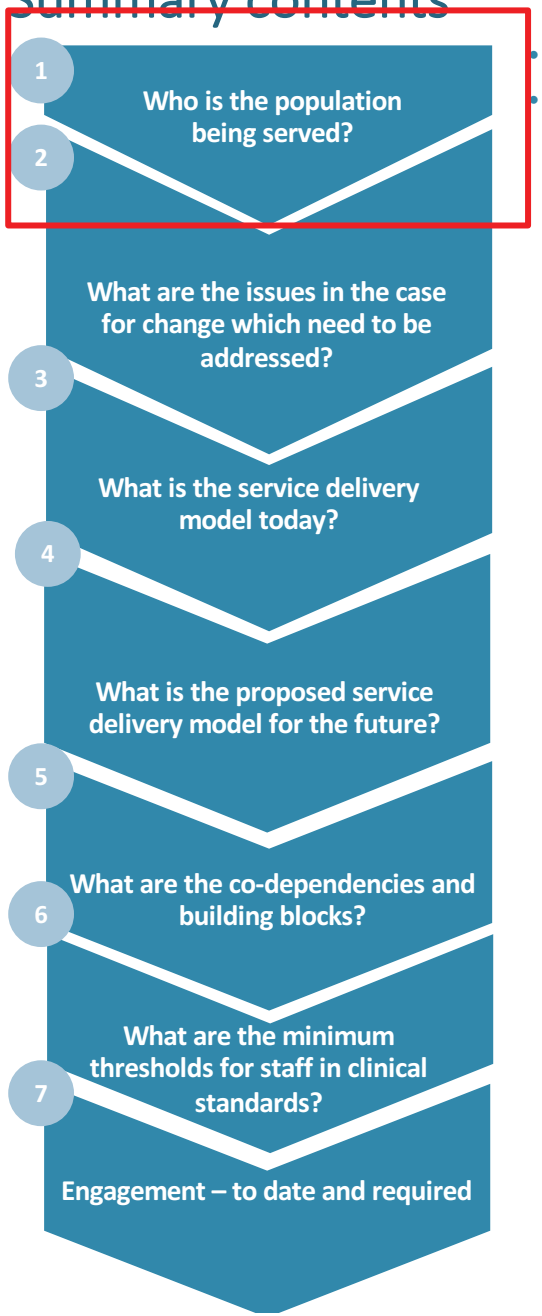
Summary contents



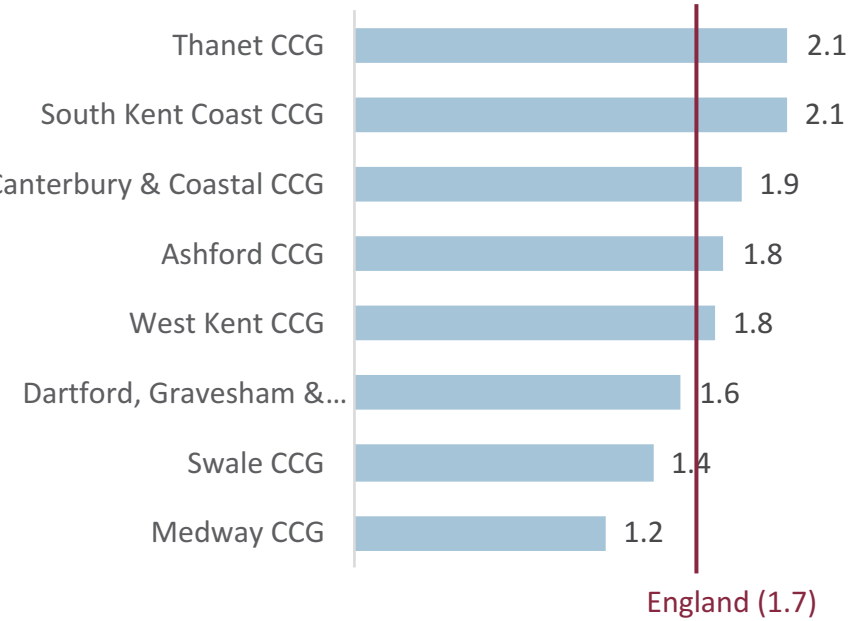
- 2,487 patients (FY 15/16)
- Services currently provided at all 7 acute hospitals

Background

- The total Kent and Medway population is 1.81 million
- On average, prevalence is 1.7% for stroke & 2% for Atrial fibrillation for the Kent & Medway population
- Prevalence varies across CCG and reflects population demographics
- "At risk" groups include:
  - patients with hypertension, atrial fibrillation and diabetes
  - black ethnic populations
  - elderly

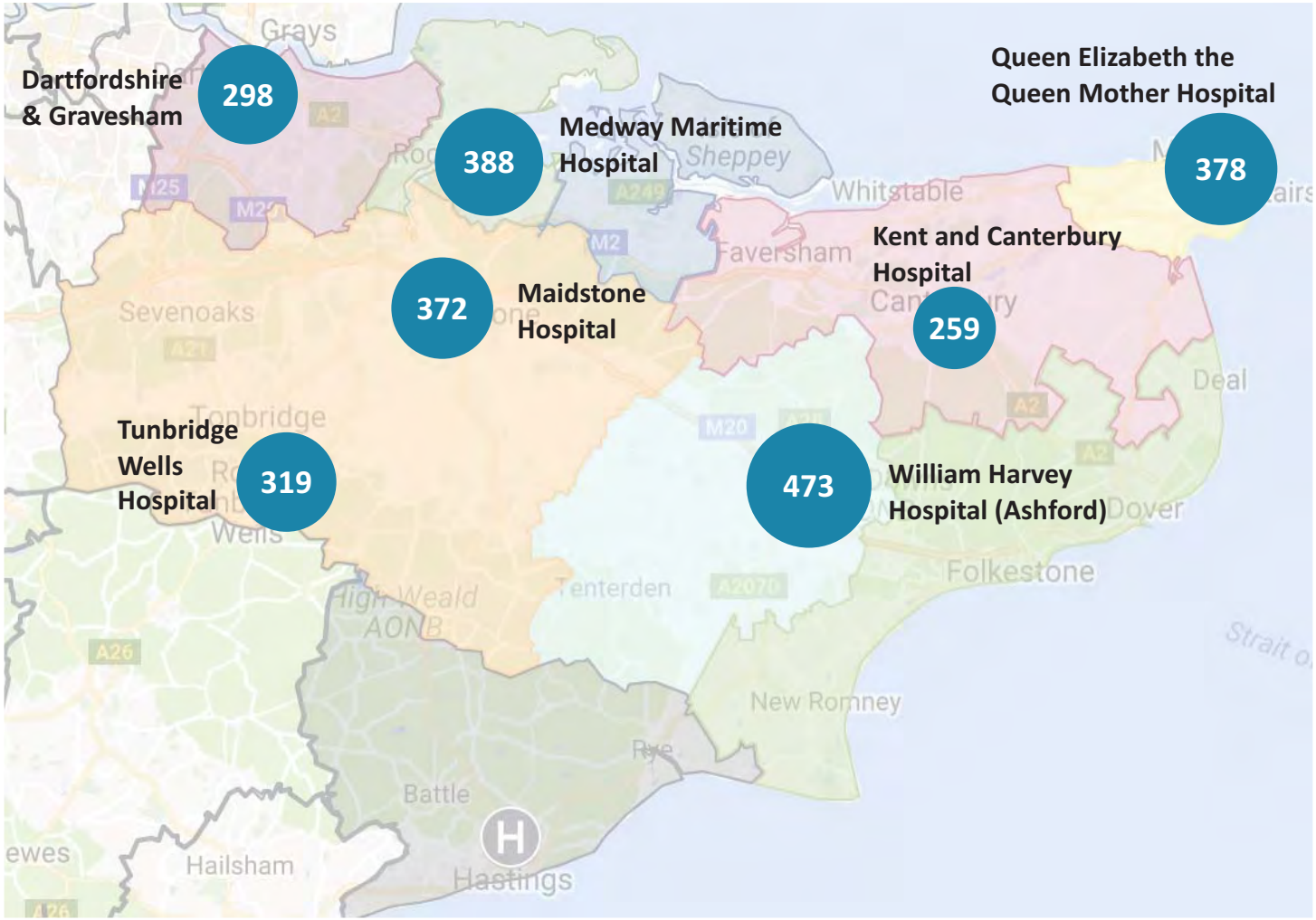
Stroke prevalence, %

Atrial fibrillation prevalence, %



* SSNAP Apr 2015 – Mar 2016 ** CCG Stroke Profiles Public Health England 2014. **QOF 2015/16)**

Who is the population being served?



- At present, stroke is delivered at all 7 acute sites.
- Patients flow into K&M from east Sussex and South London

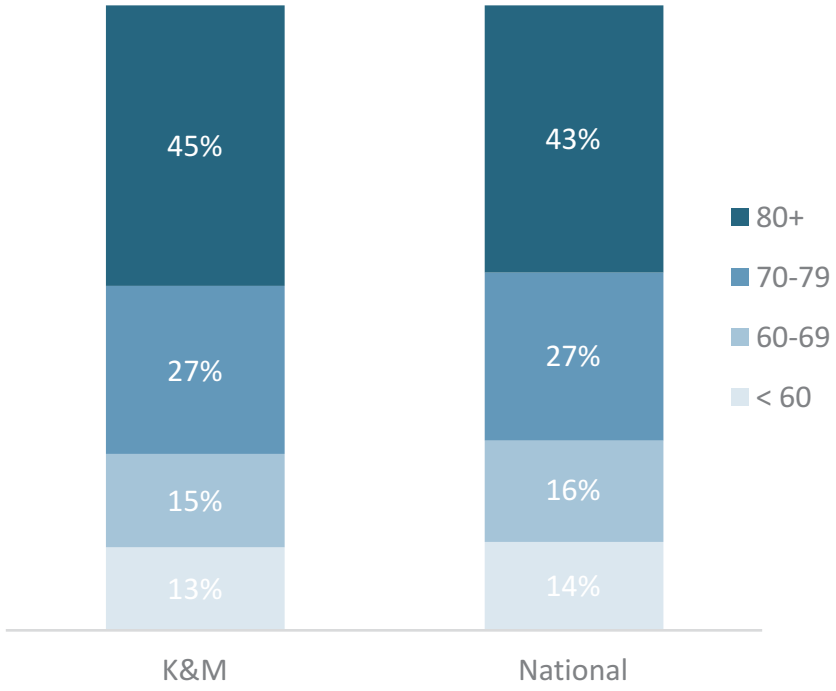
Notes 70 patients per year from South London (into DVH)
65 patients per year form East Sussex
72 hour cohort refers to the processes of care in the first 72 hours of stroke, beyond which patients enter into post-acute stroke care processes

Source: SSNAP clinical audit Apr 15– Mar 16

Stroke incidence

- There are approximately 2,500 confirmed stroke patients per annum treated in the 7 acute hospitals.*
- Public health analysis identifies that based on the current preventative measures and pattern of stroke incidence locally and nationally this figure will not significantly change over the next 10 years, including projected population growth across Kent and Medway.
- Incidence increases with age – although the overall profile is very similar to England

Stroke incidence by age bucket*, %



Stroke activity by site

Site	2012/13	2013/14	2014/15	YoY growth
Darent Valley Hospital	343[1]	324	337	4%
Medway Maritime Hospital	368	417	393	-6%
Maidstone Hospital	294	321	320	0%
Tunbridge Wells Hospital	375[2]	325	298	-8%
William Harvey Hospital	440	473	477	1%
Kent & Canterbury Hospital	292	366	380	4%
Queen Elizabeth the Queen Mother Hospital	319	346	354	2%
Total K&M	**2,431**	**2,572**	**2,559**	-1%

Notes: [1] 70 patients per year from Bexley, South London (into DVH)
[2] 65 patients per year form East Sussex

Source: *SSNAP clinical audit, Apr 2015 – Mar 2016

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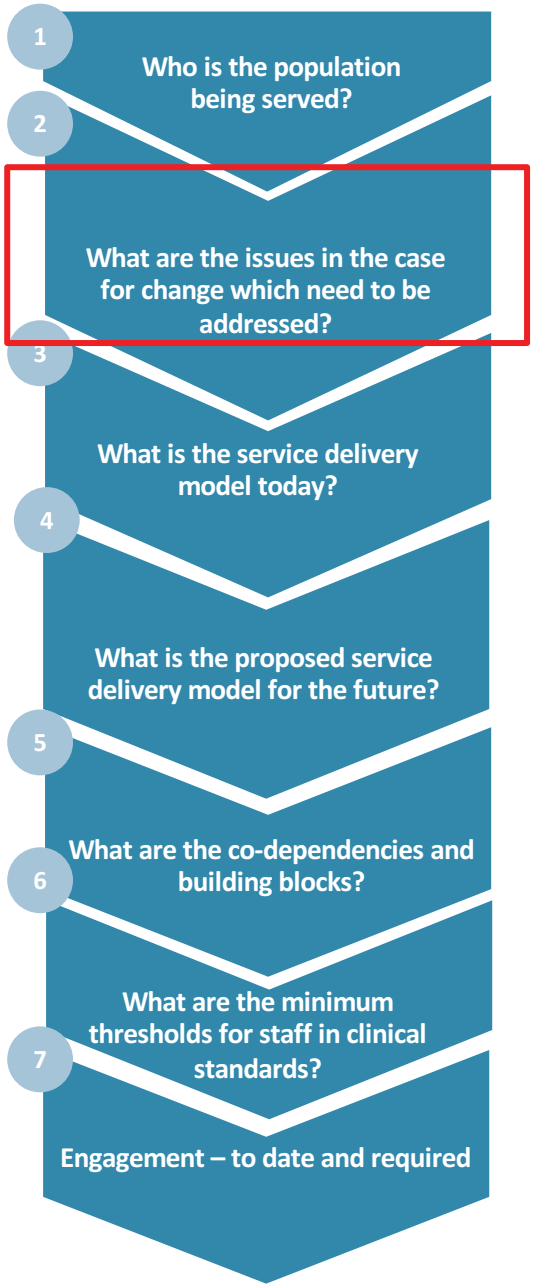

- Only half of all patients admitted within 4 hours and performance is below national average
- All 7 hospitals only provide 5 day stroke consultant face to face cover; none provide 7 day consultant ward rounds, less than 50% of patients receive thrombolysis within 60 mins
- Patient volumes are too small to deliver clinical sustainability/ Performance against SSNAP is variable and inconsistent

2

What are the issues in the case for change which need to be addressed?

1 Delays in direct admission and limited availability of 7 day services

- Generally < 50% of all patients are being admitted within 4 hours and performance is below national average
- Significant workforce gaps across the services therefore 7 day stroke consultant ward rounds not available across any of the hospitals currently
- 7 day therapy service not consistently available across all units

2 Difficult to access to treatment within the recommended timeframes

- In most hospitals, less than 50% of patients receive thrombolysis within 60 mins and are below the national average
- Fewer patients receive speech and language therapy communication assessment within 72hrs of clock start
- Very limited 7 day therapy assessments undertaken

3 Patient volumes are too small to deliver clinical sustainability

- Recommended patient volumes fall between 500 and 1,500 confirmed stroke admissions per year but patient volumes in each acute hospital are below the 500* patient threshold
- No hospital is achieving patient volumes recommended for clinical sustainability

Source: SSNAP clinical audit Apr 15– Nov 16, K&M Case for Change – Stroke * 2016 RCP standards

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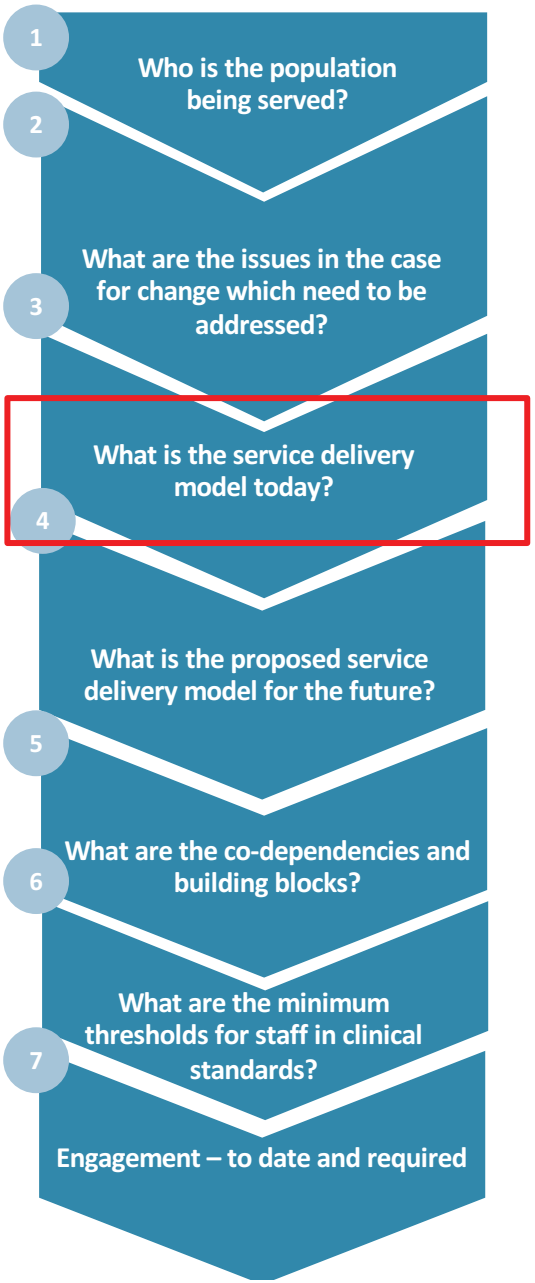
Summary contents



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- Patients receive their Hyper-acute, acute and acute rehabilitation in these units
- Patients are then discharged without further rehab, discharged back to their home with a community rehabilitation package or to a new home such as a residential care home that is suitable for their needs/ Rehab pathways are variable across K&M

What is the current service position?

Below national average | Equivalent to national average | Above national average

Aims	National recommendation/Target	D&G	MFT	MH	TWH	WHH	KCH	QEQM	National
Rapid and accurate diagnosis	Imaging within one hour of admission	50%	50%	55%	56%	61%	59%	69%	48%
Direct admission	Patients admitted directly onto a specialist stroke unit within four hours	41%	43%	56%	41%	53%	51%	60%	58%
	Patients stay in the stroke unit for 90% of the inpatient episode	84%	79%	87%	67%	84%	88%	85%	84%
Immediate access to treatment	Thrombolysis within 60 mins	42%	16%	43%	59%	60%	38%	48%	59%
	Speech and language therapy communication assessment within 72 hours of clock start	22%	67%	35%	39%	24%	26%	37%	39%
Specialist centres with sufficient numbers of patients and expert staff	Assess patients by specialist stroke consultant and within 24 hours.	62%	55%	61%	73%	81%	86%	91%	79%
	Assess patients by stroke trained nurse and therapist within 24 hours.	91%	87%	91%	88%	87%	91%	89%	88%
Multidisciplinary teams	MDT assessment, to include specialist physicians, nurses , therapists. A wider group of specialist is increasingly advised including clinical psychology, dietetics.	Partial	Partial	Partial	Partial	N [1]	N [1]	N [1]	
24 hour access, 7 days a week	7 day stroke consultant ward rounds*	N	N	N	N				
	OOH access to consultant assessment for thrombolysis*	Y	Y	Y	Y	Y	Y	Y	
	7 day stroke trained nurse and therapist cover	Partial	Partial	N	N	N [3]	N [3]	N [3]	
Patient volumes that deliver clinical sustainability	> 500 and <1500 confirmed stroke admissions	N	N	N	N	N	N	N	
SSNAP performance Q1 2016 (Apr-Jun)	Target: A	D	D	B	D	C	D	C	

Notes: [1] Only available 5 days a week
[2] OOH rota is networked across 3 sites with the use of telemedicine; rota is fragile given combined contribution to HCOOP rota simultaneously
[3] Do not meet national guidelines

Source: K&M Case for Change stroke, South East Coast Clinical and Quality standards for stroke, SSNAP audit (April 2015-Mar 2016)

3

What is the current service model for stroke rehabilitation?

East Kent:

- Assessment for a patients rehabilitation needs and the start of their rehabilitation begins as soon as a patient arrives into the Stroke Unit (joint HASU/ASU) until they are discharged. This team is made up of physiotherapists, occupational therapists, speech therapists, and nursing and medical staff.
- The options for patients once discharged from the Stroke Units are:
  - Discharged home with no further requirement for rehabilitation
  - Discharged and referred into ESD (Early Supported Discharge / with beds at Westview in Tenterden and Broad Meadow in Folkestone)
  - Discharged and referred into the East Kent Community Stroke Team
  - Discharged and referred into specialist Neuro-Rehabiltation service at K&CH
  - Discharged and referred for further in-patient rehabilitation at a Community Hospital (To be confirmed)

DGT:

- Rehabilitation starts from day one, with a plan for treatment such as methods of feeding, communication and other aspects of care, drawn up by the rehabilitation team. This team is made up of physiotherapists, occupational therapists, speech therapists, and nursing and medical staff.
- The options for patients once discharged from the Stroke Units are:
  - Discharged home with no further requirement for rehabilitation
  - Discharged and referred into ESD (Early Supported Discharge)
  - Discharged and referred into the Gravesend community neuro-rehabilitation service
  - Transferred to the Sapphire Unit for inpatient rehabilitation at Gravesend Community Hospital

3

What is the current service model for stroke rehabilitation?

MTW:

- Assessment for a patients rehabilitation needs and the start of their rehabilitation begins as soon as a patient arrives into the Stroke Unit (Joint HASU/ASU)
- Patients continue to receive rehabilitation until they are discharged from the Stroke Unit.
- Both stroke units combine HASU/ASU and inpatient rehabilitation (ie all inpatient rehabilitation occurs within the Acute Trust).
- The options for patients once discharged from the Stroke Units are:
  - Discharged home/placement with no further requirement for rehabilitation
  - Discharged and referred into ESD (Early Supported Discharge) – West Kent only
  - Discharged and referred to community neurorehab team

MFT:

- **TBC**

What are the service delivery models: Evidence base

	Source/Publication	Date	Key Points
1	K&M Stroke Review Literature review by K&M Public Health teams	2015	• Hyperacute stroke units are clinically effective • Some evidence of cost effectiveness
2	National stroke Strategy	2007	Recovery significantly influenced by; • Seeing a stroke Consultant within 24 hours; • Having a brain scan within 24 hours of admission; • Being seen by a stroke trained nurse & one therapist within 72 hours of admission; • Being admitted to a dedicated stroke unit • A nutritional assessment & swallowing assessment within 72 hours; • Being given antiplatelet therapy within 72 hours; • Receiving adequate food and fluids for the first 72 hour.

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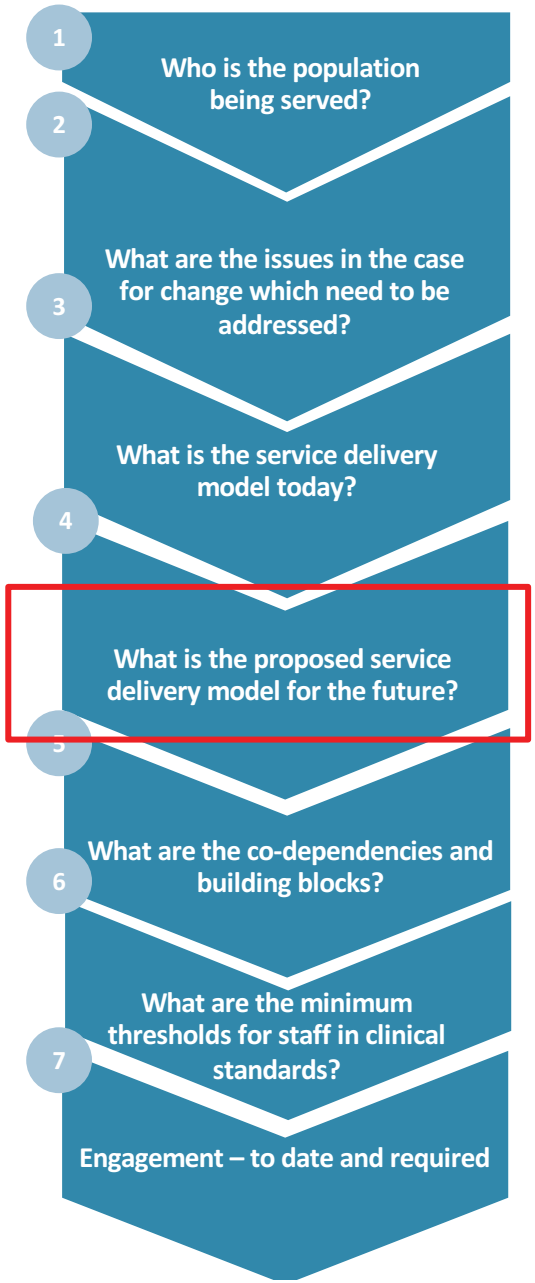

- Consolidation onto fewer sites; 3 sites is the optimum when measured against the agreed critical criteria.
- Deliver a combined HASU and ASU service on each of the 3 sites
- Develop robust early supported discharge and rehabilitation services

What is the proposed model for the future?

TODAY

- All seven units deliver acute Stroke Care
- The units operate combined HASU/ASU models although the specific beds are not always identifiable
- 7 day medical ward rounds only operate in TWH, not always consultant led (on a 1:3 rota)
- Consultant assessment is available in all units over the weekends via telemedicine rotas
- 7 day therapy only available in MFT
- No unit meets the recommended workforce across any profession

FUTURE

- 7 day specialist consultant led stroke service available (able to respond to twice daily ward rounds requirement Autumn 2017)
- Consolidate onto 3 sites; that meet the critical criteria inc travel times
- Combined HASU and ASU units
- Direct access from ambulance transfers to the service ? Stroke assessment unit
- Early Supported Discharge available for min 50% of pts
- Improved rehabilitation services available.
- Development of a centre able to deliver thrombectomy on one of the three sites to provide across K&M
- Co-located with critical co-dependencies that improve patient outcomes and support staff

Source: Kent & Medway Review of Stroke Services (2015 /2016).

What are the implications of not meeting the standards: Patient outcomes

Not delivering the standards does not provide the ability for **a step change** in outcomes.

It minimises the opportunity to potentially improve mortality, length of stay and functional ability.

There is no opportunity to reduce the nature and level of complications ie associated infections/complications such as pneumonia

No opportunity to address the clearly evidenced risks associated with low nursing levels on patient mortality

- London review showed a 17% reduction in 30 day mortality

Reduction in Length of stay

- 7 % reduction in patient length of stay (London Review)

- **Clinical senate advised that compliance with the standards delivers an improvement in;
  - 6 and 12 month modified Rankin scale outcomes (useful as it breaks down disability in to easily understood and captured outcomes).
  - The percentage of stroke patients returning home
  - Reducing the percentage of patients being discharged to a residential / nursing home;
  - Increasing the percentage of patients having their 6 and 12 monthly reviews
  - Increasing the percentage of patients returning to work
- Patients and carers outcomes relating to quality of life scores (although not currently being collected at a national level) such as Euro-QOL, SF-36, the Stroke Impact Scale, and the Stroke Carer Burden Scale

Source: Impact of centralising acute stroke services in English metropolitan areas on mortality and length of hospital stay: difference-in-differences analysis (*BMJ* 2014;349:g4757)

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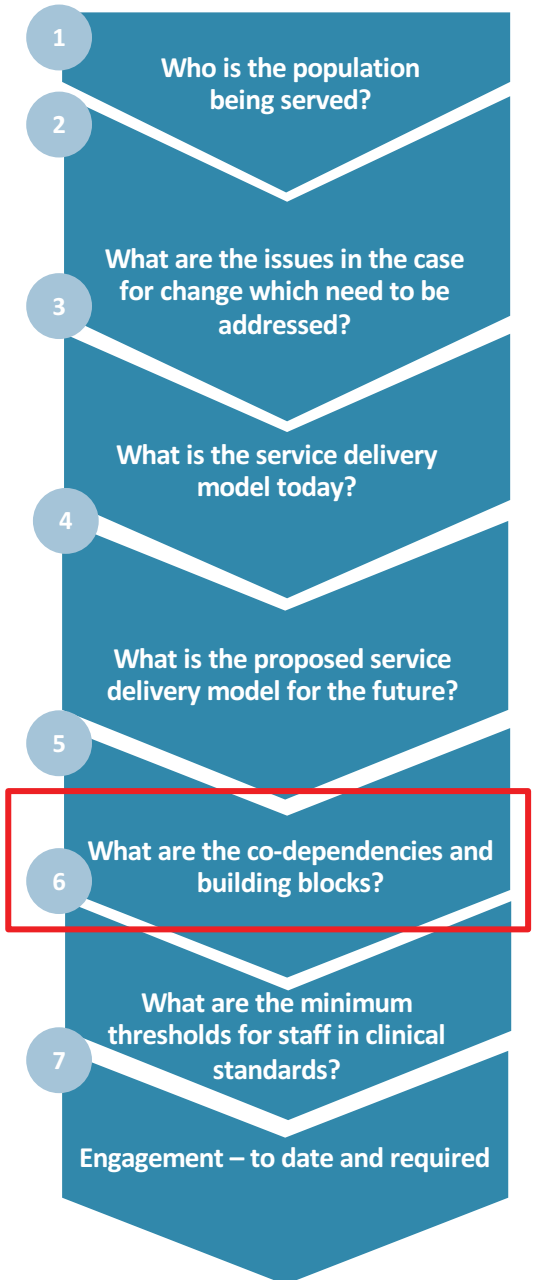
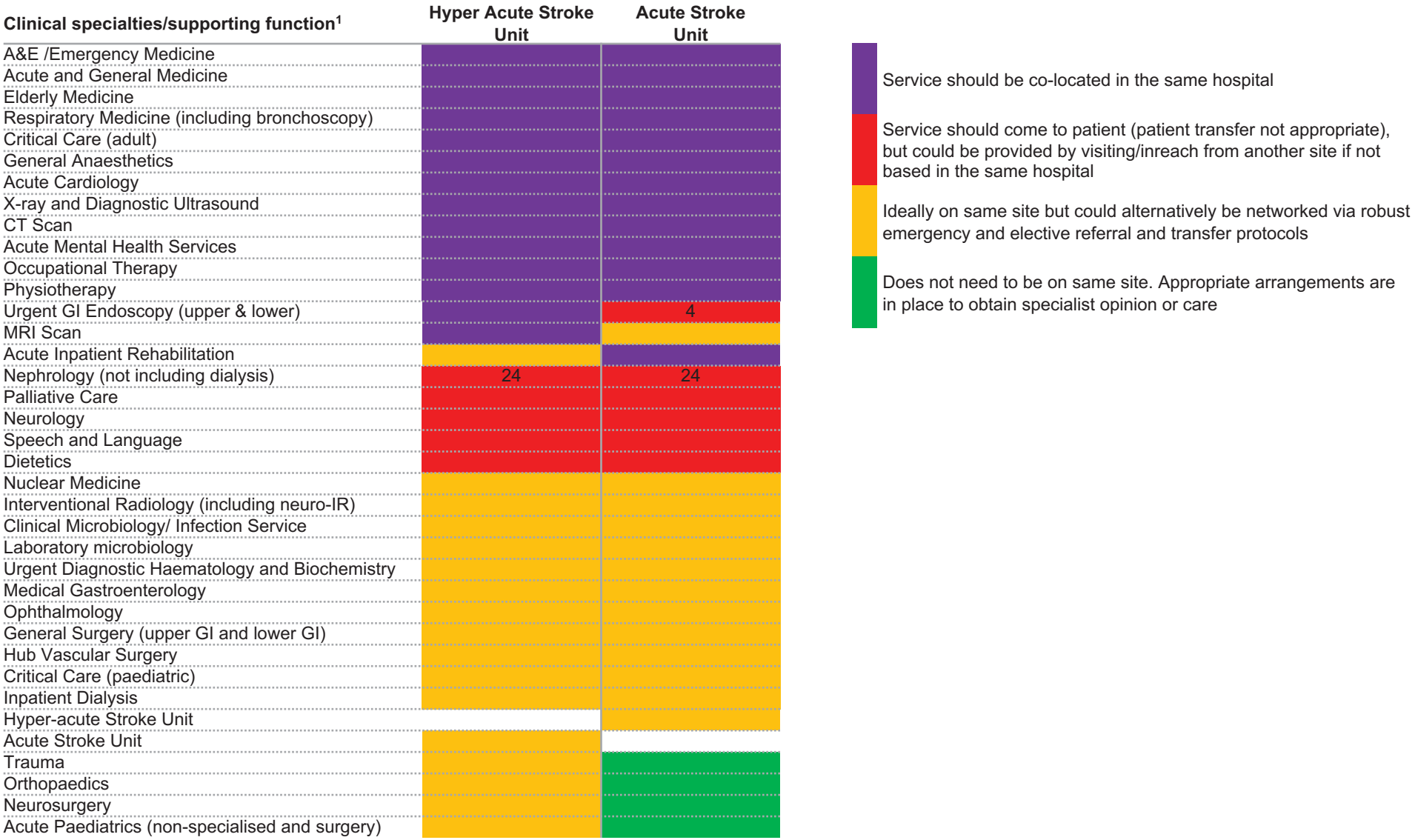


- A&E /Emergency Medicine
- Acute and General Medicine
- Elderly Medicine
- Respiratory Medicine
- Critical Care (adult)
- General Anaesthetics
- Acute Cardiology
- X-ray and Diagnostic Ultrasound
- CT Scan
- Acute Mental Health Services
- Therapy; SLT/OT and Physiotherapy
- Physiotherapy
- Urgent GI Endoscopy[1]
- MRI Scan[1]
- Acute Inpatient Rehabilitation[2]

What are the critical interdependencies?



Notes: [1] Services marked as 'does not need to be on the same site' for both HASU and ASU have been excluded from this table

Source: The Clinical Co-Dependencies of Acute Hospital Services: Clinical co-dependecy grid, South East Coast

5

What are the other critical interdependencies and enablers?

Other dependencies

- Rehabilitation services including community beds, residential/nursing care homes.
- Early supported Discharge services
- Ambulance services
- Patient transport services
- Social Services

Enablers

- IT
- Communication
- Workforce
- Public transport

Local questions for consideration

Question	Comment
Speech and language	• View at STP workstream that this requires co-location – in reach is not adequate(this differs form the senate recommendations)
Does a HASU need to be co-located with a Trauma unit	• Suggestion from CEOs and AOs re co-location with existing trauma unit; STP workstream questioned this but did agree to being on a 24hr ED with full diagnostics and medical cover • Impact on trauma unit EDs is a concern • Clinical advice is that there is clear evidence of benefit and potential of harm • Pts, re delays in diagnosis/staff, need to move, communicate across sites/financial due to transfers of trauma pts/education/ambulance risk re choice of conveyance destination
Ability of a hospital to take on a HASU?ASU	• To be worked through in the detailed site options including application of bed numbers and staffing availability

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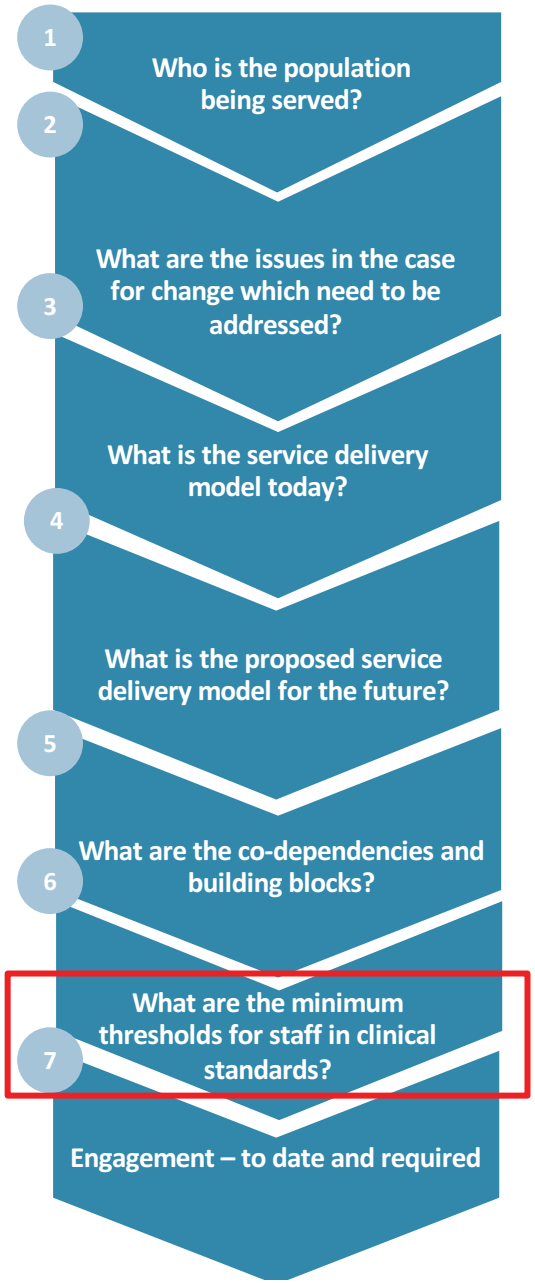
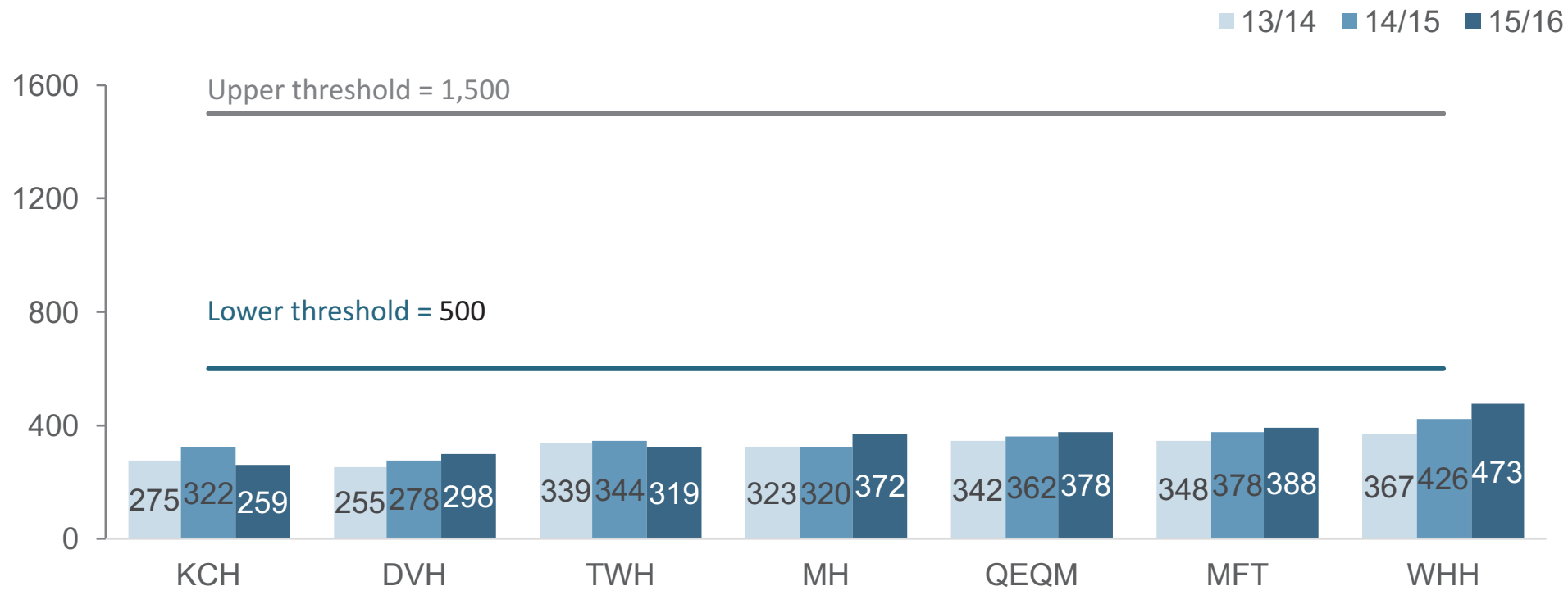


- HASU requirements; 24/7 consultant availability with minimum 6 trained thrombolysis physicians on rota and consultant led ward round 7 days a week, 2.9 WTE Nurse (80:20 registered unregistered per bed ,Per 5 beds; 1 Physiotherapist, 0.68 Occupational Therapist, 0.34 S&L therapist, 0.20 Clinical Psychologist, 0.15 Dietician [3]
- HASU Volume requirements; >500 and < 1500 confirmed stroke patients

What are the minimum thresholds for volume in clinical standards?



- At present, stroke is delivered at 7 acute sites.
- Volume thresholds suggest a requirement for 2-4 sites.
- Further work done suggests a need for 3 sites to meet all critical criteria.

Notes a65 patients per year form East Sussex
b70 patients per year from South London (into DVH)
72 hour cohort refers to the processes of care in the first 72 hours of stroke, beyond which patients enter into post-acute stroke care processes

Source: SSNAP clinical audit Apr 15– Mar 16, K&M Case for Change – Stroke, QOF 2014

6

What are the minimum thresholds for staff in clinical standards?

	Threshold/ Requirement	DVH 23	MH 26	TW 10	Medway 25	QEQM 24	K&C 24	WHH 24	Total gap Jun 2016*
1	Min 6 stroke consultant rota* May require more to manage a units volume of activty	x	x	x	x	x	x	x	29.5
2	2.9 nurses per bed (80/20)	x	x	x	x	x	x	x	65.18/24.37*
3	1.0 wte physio per 5 beds	x	x	x	x	x	x	x	8.75
4	0.68 per 5 beds Occupational therapist	x	x	x	x	x	x	x	11.49
5	0.34 per 5 beds SLT	x	x	x	x	x	x	x	9.89
6	0.15 Dietician								n/k
7	0.20 Clinical Psychologist								n/k

Notes: We don't have a complete data set for therapies or untrained nurses
Detail on dietician and clinical psychologist not collected
** just noted the total gap, this is iterative and staff move and are appointed, so would need to be looked at again in detail when geographic options are worked up in detail

Source: 'As Is/Future State' workforce assessment; updated June 2016

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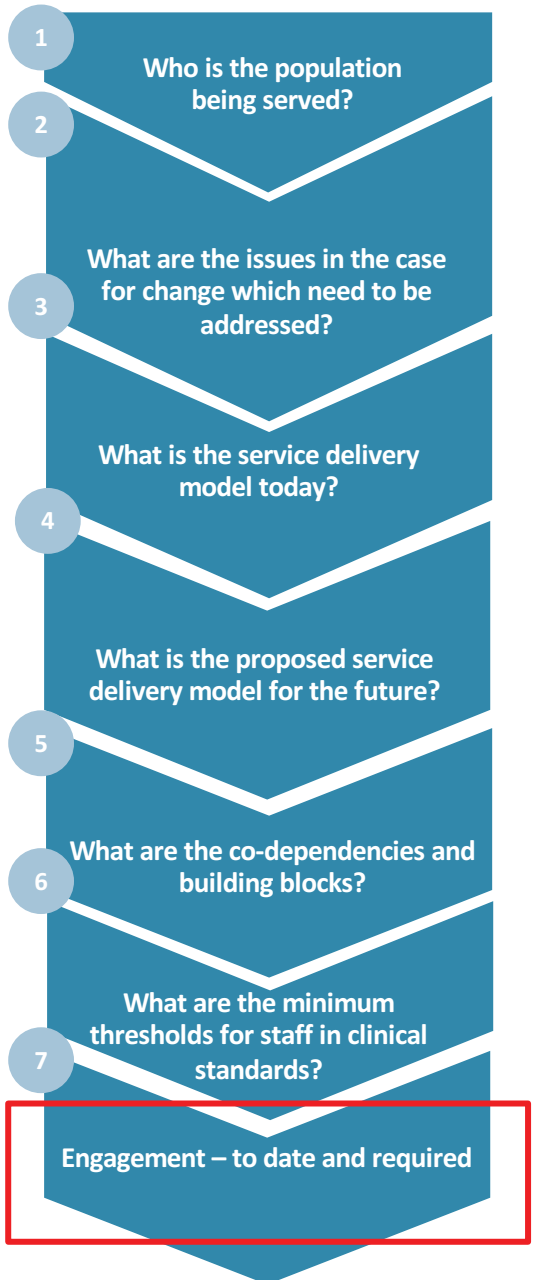


- Over the last 2 years EKHUFT has engaged with key stakeholders internally and externally through a series of EKHUFT and East Kent Strategy Board events.
- West Kent have not carried out engagement to date

Engagement

Over the last 2 years there has been a Kent & Medway review of stroke.

- There was a governance structure created with a Programme Board and Clinical Reference Group (CRG)
- Public and clinical engagement events took place throughout the process, with key engagement events have been tabled on the next slide.

Engagement events to date (January 2017) (Page 1 of 2)

DATE	EVENT	ATTENDEES	PURPOSE
June to Sept 2015	10 Listening Events across K&M Focus groups with the stroke asscition and Hard to Reach groups		To develop the Case for Change and inform decision making criteria
Nov and Dec 2015	3 Deliberative Events: "People's Panels" - 2 in Maidstone and 1 in Ashford	Members of the public	Pre-consultation engagement to work through review process, discuss priority indicators and test the emerging options
Nov 2015	K&M Review 1st Clinical Engagement Event: Presentation by Professor Tony Rudd, National Clinical Lead for Stroke	All staff connected with all 7 stroke units (Therapists, Consultants, Nursing staff, SALT etc)	Progress of the K&M Stroke Review, clinical models and service delivery options. To inform the options appriasal process
Sept to Oct 2016	4 Public Deliberative Listening Events held in conjunction with Health Watch and the Stroek Assocaiation – coordinated by the K&M Stroke Review Process - Sandwich; Ashford; Maidstone; Gillingham	People who have had a stroke, their carers and members of the public	To share the case for change, discuss the on-going review proces, the emerging findings and invite feedback and challenge
Feb to April 2016	3 Direct Engagement Events: 1 x Minority Ethnic Forum in Medway 2 x Asian population in Gravesham	Members of the public, targeted non English speaking communities	To share the case for change, discuss the on-going review process and invite feedback and challenge
April 15 to Sept 2015 March to Sept 16	Presented to CCG Clinical Forums	GPs CCG representatives	To bring together the attendees to discuss the way forward in achieving a stroke service that is clinically and financially sustainable
11.2.16	EK Strategy Board	EK Clinical Chairs, AO's, Provider CEOs, Healthwatch	To update and align to the EK strategy

Engagement events to date (January 2017) (Page 2 of 2)

DATE	EVENT	ATTENDEES	PURPOSE
July, Sept 15, Jan and March 2016	- K&M Commissioning Assembly	K&M CCG Clinical Chairs and AOs, KCC, Specialist Commissioning	To review the Case for Change and inform options appraisal and advise on modelling
April 2015 to Nov 2016	K&M Stroke Review Programme Board - Quarterly meeting - - Also presented 7 times to K&M Joint Health Overview & Scrutiny Committee (JHOSC) Sept 15 to Nov 2016 - Presented to individual HOSC/HASC April and July/Aug 15	Clinical and patient representatives including: Stroke Clinical Lead for Kent, Surrey & Sussex, NHS England, Clinical Experts, CCG representatives, Stroke Association, Health watch ,South East Coast Ambulance Service and Engagement Leads	Agree what actions need to be taken for the review to be successful
Oct 2015 to Nov 2016	K&M Review Clinical Reference Group (CRG) - Monthly meeting	Clinical and operational representatives from all acute hospitals and providers; links to Programme Board	Provides clinical scrutiny to the review process and actions undertaken
March 2016	K&M Programme Board Challenge Session	Clinical and patient representatives including: Stroke Clinical Lead for Kent, Surrey & Sussex, NHS England, Clinical Experts, CCG representatives, Stroke Association, South East Coast Ambulance Service and Engagement Leads JHOSC members	To review progress of the options appriasal and confirm areas of challenge, further detailed modelling and agree non viable options in relation to the criteria
Oct 2014 to June 2016 May 2015, Nov 15 and January 16 Early 2015 ?Jan to April	EKHUFT Organisation of Stroke Services Meetings - Quarterly development and strategy meetings - MTW Stroke Improvement Board - MTW public engagement events	Staff from all 3 stroke units in East Kent; South East Coast Ambulance; Kent Community Health Foundation Trust MTW Stroke leads and executive team Patients and members of the public	Develop the stroke service in east Kent and align to service reviews To advise and align the K&M Review with the MTW Stroke improvement programme To discuss and develop solutions to stroke performance across MTW
Oct 2016 Feb 2017	East Kent Clinical Engagement Stroke Service Away Day Events	Staff from the 3 Stroke Units in east Kent; along with K&M guests and speakers	To continue with strong staff engagement and involvement in the review process and outcomes

Trust Board meeting - June 2017

Maidstone and Tunbridge Wells NHS Trust

6-17	Summary report from the Audit and Governance Committee, 24/05/17	Committee Chair (Non-Executive Director)

The Audit and Governance Committee met on 24th May 2017. A verbal update on the meeting was given at the Trust Board held later on that same day, but this written report has been submitted for completeness.

1. **The key matters considered at the 'main' meeting were as follows:**
   - The final draft Annual Report and Annual Accounts for 2016/17 (including the Governance Statement) was reviewed, and the Committee agreed to recommend that these be approved by the Trust Board, subject to the minor amendments that were discussed at the meeting. Trust Board Members will be aware that these were duly approved on 24/05/17
   - The Audit Findings Report ('Report to those charged with governance') from the External Auditors was reviewed and no significant issues were raised. It was agreed that a review of the "Discrepancies in Inventory Values" item identified within the Audit Findings Report be scheduled for the next Audit and Governance Committee meeting in August 2017.
   - The 2016/17 Draft Management Representation Letter was reviewed, and it was agreed to recommend that this be approved by the Trust Board (and it was, on 24/05/17)

2. **The Committee agreed that (in addition to any actions noted above):**
   N/A
3. **The issues that need to be drawn to the attention of the Board are as follows:**
   N/A

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

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

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

Trust Board meeting – June 2017

NHS
Maidstone and Tunbridge Wells NHS Trust

6-18 Summary report from the Workforce Committee, 01/06/17 — Committee Chair (Non-Executive Director)

The Workforce Committee met on 1st June 2017. The key matters considered at the meeting were as follows:

Staff Engagement

The Committee received a report containing the Staff Survey Action plan for the Trust and also details around plans for Listening into action. The NHS National Staff Survey clearly defined areas for improvement for the Trust which the Workforce Committee in March 2017 examined. Work has already started with some of those areas and will be communicated Trust wide about progress to date. Demonstration that "We Asked and We Listened" is imperative to the organisation. AS part of the action plan, Listening into Action (LiA) is being deployed in the organisation. LiA is a tool that has been successfully used in many NHS Trusts successfully and continuously. It is a fundamental shift in how we work at the Trust by putting staff who know the most at the centre of change. It gives teams permission to make change and reduce bureaucracy and importantly is about bringing together a range of clinical and medical staff who know what the issues are and to work together to resolve them. LiA is a top priority for the Trust and the Executive Team and will be managed by Jim Lusby (Deputy Chief Executive). The Workforce Committee requested that the Committee and Trust Board be kept regularly informed of progress with the LiA initiative.

Nurse Recruitment Plan

The Workforce Committee were provided with a report detailing the changes made to the Trust Nurse Recruitment & Retention Group, an update on the nurse recruitment plan including the recruitment initiatives for the next 12 months, and discussions with local education providers and nurse trainees. The Committee noted the work that was being done and also highlighted the importance of continuing to monitor workforce migration issues as a result of Brexit. The Committee requested that an update be provided to the September 2017 Workforce Committee.

Education, Learning & Development

The Director of Medical Education presented the Committee with an updated against the detailed action plan in relation to the 2016 GMC Survey and an update of progress with the following areas:

- GMC Survey: The 2017 GMC survey closed on 10th May and the results are expected in early July. 99.4% of Trainees responded.
- Health Education Kent, Surrey and Sussex (HEKSS) Programme Quality Review Visits: HEKSS visit will take place on 6th June 2017 to look at Medicine on both sites, O&G, T&O and General Surgery. Pharmacy visit took place on 11th April 2017. Feedback was generally good, with one immediate concern raised which was addressed within the week.
- New Post Opportunities
- Physicians Associates

An update was provided to the Committee in relation to the deployment of apprenticeships in the Trust and work to mitigate the impact of the levy. The Committee requested that the Finance Committee be kept informed monthly of progress.

The Committee received a detailed report of compliance against each of the 25 Statutory and Mandatory Training subjects and also a report on the learning and development activity for last year for non-medical staff. The Committee noted the level of overall training compliance & amount of activity that had taken place last year, including the growth in take-up of e-learning by staff.

Medical Staffing

The Workforce Committee received the second quarterly Guardian for Safe Working Report from Dr Matt Milner (Guardian for Safe Working). The Report is enclosed at Appendix 1 (as the Terms and Conditions of Service for the new Junior Doctors contract require this to be submitted to the Trust Board each quarter).

The Committee also received an update on progress with implementing the 2016 Junior Doctor Contract.

E-Rostering System Deployment Update

The report provided an update on the deployment for the replacement rostering system. The Committee were informed that the pilot stage went well and migration of the temporary staffing component (BankStaff) had now taken place. A short pause in unit deployment was underway to resolve outstanding issues on the BankStaff deployment and to complete process-mapping and configuration of additional specialist pay elements for complex rostering areas.

Employee Relations Activity 2016/17

A detailed report was presented to the Workforce Committee. A new employee relations tracker is being developed. The Workforce Committee acknowledged the sustained performance that the HR team have produced and the volume of activity undertaken.

Workforce Information

The Committee received a detailed report on Trust turnover, the new Workforce Performance Dashboard, and supporting commentary. The Committee commended the approach taken with the new Dashboard and requested that the visible approach be explored for the Trust Performance Dashboard. Furthermore that the Board continue to closely monitor the turnover rate within the Trust.

AOB

The Committee noted that it was the last Workforce Committee for the Director of Workforce and thanked him for his work during his 9.5 years' service. The Director of Workforce thanked the Committee for their kind words and took the opportunity to thank his direct reports, the wider HR team and the Director of Medical Education and his team for their support during the time he has worked for the organisation. The Director of Workforce highlighted that the Trust was lucky to have such a dedicated team and that it had been an absolute pleasure to work with them, and the Trust, over the last 9.5 years.

1. In addition to the actions noted above, the Committee agreed that:

- A regular update needs to be provided to the Trust Board from the Deputy Chief Executive on progress with Listening into Action

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

- N/A

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

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

Maidstone and Tunbridge Wells NHS
NHS Trust

WORKFORCE COMMITTEE – June 2017

09/06/17	**GUARDIAN FOR SAFE WORKING REPORT**	**MATT MILNER, GUARDIAN FOR SAFE WORKING**

Summary / Key points

Report covers the period January – March 2017 (4th Quarter)

- Total of 29 Exception reports received in the period. The majority from within Medicine teams.
- All reports related to working more hours that set out in work schedules.
- Two reports related to inadequate senior support.
- Discussions have been held with Clinical Director, General Manager and Director of Operation (Urgent Care) regarding the issues raised in the reports from junior doctors in Medicine.
- A Twilight shift has been introduced to help improve working hours issues.
- Assistance from Surgical teams has helped improve workload on escalation wards.
- No fines incurred from these reports.
- Bank usage is £758,237.01 for the quarter
- Agency usage is £2,101,342.17 for the quarter

Which Committees have reviewed the information prior to Workforce Committee submission?
None

Reason for receipt at the Workforce Committee (decision, discussion, information, assurance etc.) [1]
- Information
- 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

Reporting Period: Jan – March 2017

Introduction:

This is the second report from the Guardian of Safe Working and outlines the period January to March 2017. Out of all the doctors in training, only 66 are currently contracted to work on the 2016 TCS and therefore eligible to raise an exception report. These are from obstetrics & gynaecology ST3 and above and F1 doctors across specialties.

In total 29 exception reports were received by the Guardian for the period. All related to working more than the hours set out in work schedules. Two of the reports also referred to inadequate senior support.

Report:

From the last report the main area of concern raised was the use of escalation beds across the trust and the associated allocation of work generated from the escalation. It appears that the majority of the additional work load has been taken by the Gastroenterology teams as they run the majority of the on-call takes. This is reflective in the fact that their F1s have generated 11 exception reports relating to this issue.

This increase in workload is compounded by the fact that on the escalation wards such as ASSU and the Wells Suite the F1's are covering jobs such as taking routine blood tests. It has been fed back to me, in light of an action from my previous report, that juniors from Surgical teams are assisting on escalation wards which has helped to improve matters.

Of the 29 reports received 22 were from juniors working within Medicine. These related to extra hours worked and one concern of supervision

7 reports have been received relating to workload of F1's on Acute Medicine take at weekends. I have discussed this with the Clinical Director and General Manager for Acute Medicine who have introduced a new twilight shift slot on the rota; this should ease the workload of the F1's on take.

The final area of concern is the supervision of F1's on the Respiratory Team at Maidstone Hospital. As previously discussed the issue is of inadequate supervision of F1's on John Day Ward with a number of complex respiratory patients under their care. They are currently 1 registrar short in the area.

The matter has been discussed at length with Dr Hussain, Dr Thom and Laurence Maiden and concluded that the respiratory registrar needs to be more supportive to his juniors. I have asked Dr Hussain to discuss this with the registrar, as he is his educational supervisor. I have also asked Dr Hussain to be more accessible by telephone to his juniors when he is not on the ward. The consensus is that a third registrar is required on the Respiratory Team and I have assurance from the Director of Operations for Urgent Care that this will happen.

Interviews are due to take place in April for 3 respiratory registrars, of which hopefully, one will fill the vacant slot on John Day Ward. Of note also is that 11 Clinical Fellows posts in Medicine have been offered and only 5 of the doctors have taken up a post.

A meeting was held with the Clinical Directors, General Managers and Director of Operations for Urgent Care to discuss all the above issues and the actions described have been put in place.

With regard to expenditure on bank staff for the period January – March 2017 was £758,237.01. Agency use was £2,101,342.17.

The Trust currently has 13 WTE vacancies across the specialities at training grade.

High level data:

Number of doctors in training (total):	327 (inc 31 in GP surgeries)
Number of doctors in training on 2016 TCS (total):	66

a) Exception reports (with regard to working hours)

Exception reports by department: Jan – March 2017				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Stroke	3	2	5	0
General Surgery	0	1	1	0
Gastroenterology	0	11	11	0
Respiratory	0	4	4	0
Acute Medicine	0	5	5	0
Gynae	0	6	6	0
Total	**3**	**29**	**32**	**0**

Exception reports by grade: Jan – March 2017				
Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	3	23	26	0
Obs & Gynae ST3+	0	6	6	0
Total	**3**	**29**	**32**	**0**

Exception reports (response time)				
Grade	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
F1	2	8	13	0
Obs & Gynae ST3+	0	6	0	0
Total	**2**	**14**	**13**	**0**

b) Diary card exercises

Hours monitoring exercises (for doctors on 2002 TCS only)						
Specialty	**Grade**	**Rostered hours**	**Monitored hours**	**Banding**	**WTR compliant (Y/N)**	**Percentage Return**
Accident & Emergency	FY2	40	41.55	No supplement	Y	40%
Accident & Emergency TWH	FY2	40	41.39	No supplement	Y	31%
Accident & Emergency Maid	ST3+	41.39	41.39	1A	Y	20%

Accident & Emergency TWH	ST3+	45.12	46.03	1A	Y	18%
General Surgery	CST/JCF	45	36.40	1A	Y	31%
General Surgery	ST	47.25	47.25	1A	Y	11%
Haematology	FY2/CMT/ ST	46.19	41.59	1B	Y	77%
Obstetrics & Gynaecology	FY2/GPV TS/ST	46.56	48.04	1B	N	60%
Obstetrics & Gynaecology	ST	47.08	47.08	1A	Y	12%
ENT	FY2/GP	47.48	No returns	1A	Y	0%
Paediatrics	FY2/GP/S T1-3	46.51	45.53	1A	Y	69%
Paediatrics	ST3+	47.03	46.55	1A	Y	18%
Trauma & Orthopaedics TWH	FY2	44.00	45.44	1A	Y	17%
Trauma & Orthopaedics	ST3+	40.32	40.47	1B	Y	9%
Anaesthetics TWH	CST	47.33	46.25	1A	Y	40%
Anaesthetics Maid	ST3+	47.54	48.19	1A	N	25%
Anaesthetics TWH	ST3+	47.54	47.45	1A	Y	22%
General Medicine Maid	FY2/GP	46.32	48.44	1B	N	32%
General Medicine TWH	FY2/GP	46.27	48.29	2B	N	83%

c) Work Schedule reviews Jan – March 2017

Work Schedule reviews by Grade	
F1	0
Obs & Gynae ST3+	0
Total	**0**

d) Locum bookings

Staff Bank: Jan – March 2017

The tables below give detail of the shifts/hours/costs of bank cover used by specialty and also by grade of doctor.

Specialty	Number of shifts worked	Number of hours worked	Cost of Bank Cover £
Accident and Emergency	1060	4761.86	£298,081.85
General Medicine / Acute Medicine	155	1236.01	£62,276.63
Anaesthetics	305	2788.75	£152,592.50
Cardiology	3	12	£600.00
Cytology	10	62	£7,080.20
ENT	71	975.67	£50,918.80
General Surgery	178	1700.75	£70,832.59
Haematology/Oncology	51	442.25	£22,112.50
Neurology	1	24	£1,300.00
Obstetrics and Gynaecology	81	749	£38,812.50
Oncology Consultants	4	32	£1,600.00
Opthalmology	44	311.29	£18,120.69
Trauma & Orthopaedics	39	415.75	£21,483.50
Paediatrics	23	241.75	£12,425.25
Total	**2025**	**13753.08**	**£758,237.01**

Grade of Doctor	Number of shifts worked	Number of hours worked	Cost of Bank Cover
F1	54	453.25	£12,888.75
F2/ST1/ST2/CT1/CT2/CT3 (SHO LEVEL)	721	4080.68	£197,527.79
ST3+, Specialty Doctor (Registrar Level)	956	6545.11	£363,484.70
Consultant	294	2674.04	£184,335.77
TOTALS	**2025**	**13753.08**	**£758,237.01**

Agency Jan – March 2017

As shown above for bank staff usage, these tables given detail of agency staff used to provide cover.

Specialty	Number of shifts worked	Number of hours worked	Cost of Agency Cover
Accident and Emergency	923	6673	£430,490.04
General Medicine / Acute Medicine	1160	9430	£693,038.05
Anaesthetics	48	456	£34,875.89
Cytology	0	0	0
General Surgery	199	1730.5	£89,762.56

GU Medicine	44	426.75	£44,038.88
Histopathology	0	0	0
Obstetrics and Gynaecology	85	741	£47,308.63
Oncology	65	120	£12,907.91
Ophthalmology	157	1247.5	£104,491.74
Trauma & Orthopaedics	780	7287.75	£475,724.53
Paediatrics	32	322	£23,526.09
Radiology	96	921.5	£110,951.06
Urology	64	515.5	£34,226.79
Total	**3653**	**29871.5**	**£2,101,342.17**

Grade of Doctor	**Number of shifts worked**	**Number of hours worked**	**Cost of Agency Cover**
F1	14.00	113.50	£4,123.18
F2/ST1/ST2/CT1/CT2/CT3 (SHO LEVEL)	1157.00	8782.75	£444,109.13
ST3+, Specialty Doctor (Registrar Level)	1852.00	15962.00	£1,093,532.06
Consultant	630.00	5013.25	£559,577.80
TOTALS	**3653.00**	**29871.50**	**£2,101,342.17**

e) Vacancies WTE

Vacancies by month						
Specialty	Grade	Jan 17	Feb 17	March 17	Total gaps (average)	Comments
General Medicine	ST1-2			2	2	
General Medicine	ST3+	1	1	1	1	Same vacancy running through January/March
General Surgery	FY1	1	1		1	Same vacancy running through January/February
General Surgery	ST3+			2	2	
Ophthalmology	ST3+			1	1	
Paediatrics	ST4+	1	1		1	Same vacancy running through January/February
Trauma & Orthopaedics	FY2	1			1	
Trauma & Orthopaedics	ST1	1	1		1	Same vacancy running through January/February

Obstetrics & Gynaecology	ST1	2	2	2	2	Same vacancy running through January/March
Obstetrics & Gynaecology	ST3+	1	1	1	1	Same vacancy running through January/March
				Total Vacancies	**13**	

f) Fines Jan – March 2017

There were no fines for the period.

Conclusion:

In conclusion, the main area of concern across the trust, as with previous report is the level of work being undertaken by the medicine trainees on both sites. The Clinical Director, Director of Operations and General Manager for Medicine and myself, as Guardian are aware of these issues and we hope to see an improvement in this area at my next report subsequent to the rota changes that are being made, the addition of 5 extra Clinical Fellow posts and sharing of work load on the escalation wards.

Trust Board meeting – June 2017

NHS Maidstone and Tunbridge Wells NHS Trust

6-19	Summary report from the Patient Experience Committee, 13/06/17	Committee Chair (Non-Executive Director)

The Patient Experience Committee (PEC) met on 13th June 2017.

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

- A report on the numbers of and reasons for patient bed transfers in the period October to December 2016 was noted in response to a concern raised about this issue by a Junior Doctor who attended the Committee meeting in September 2016
- An update report on the performance & usage of the Trust's translation service was noted
- A Stroke Exception Report was received and it was agreed that the Committee should receive 6-monthly reports on the performance of the Trust's Stroke Services with effect December 2017 (this was previously a standing agenda item for the Committee)
- The Trust's Head of Compliance and Fire attended the meeting and reported on the policy and process for fire drills within the Trust
- A presentation was given on Chaplaincy Services and the Trust's Chaplains expressed a desire to provide further feedback to the Committee on developments with its services
- An update on Complaints & PALS contacts was received, including a review of the Complaints & PALS Annual Report 2017 (which incorporated a review of the complaints and concerns received by the Trust; a review of performance in responding to complaints and a summary of the learning & action taken in response to complaints received in 16/17)
- A report on Healthwatch activity was noted
- The draft Quality Accounts 2016/17 were reviewed, prior to their submission to Trust Board, which included a review of performance against Patient Experience priorities for 2016/17, and notification of the 2017/18 Patient Experience priorities
- An update on progress against the Patient Led Assessments of the Care Environment (PLACE) Action Plan was given
- A report from the 'Patient and their Medicines Working Group' was presented by the Trust's Deputy Chief Pharmacist (co-chair of the Group)
- Notification of recent/planned service changes was received, including an update on the opening of the new Frailty Unit at Maidstone Hospital
- The new Head of Quality from the West Kent Clinical Commissioning Group (WKCCG) attended the meeting and reported on her role and liaison with the Trust. It was agreed that key parties from the CCG and the Trust should liaise to agree the content of a more targeted and detailed standing report from the CCG to the Committee (with effect September 2017), incorporating outputs from MTW/WKCCG governance review meetings
- A report on Communications activity was noted
- Summary findings from NHS Inpatient Survey 2016 were reviewed, prior to consideration by Trust Board, along with summary proposed actions in response to the findings. It was noted that there were 9 questions in which the Trust had scored lower than in the previous year, but that the Trust's lowest score was higher than the region-wide average
- Latest findings from the local patient survey (including Friends and Family) were reported. It was noted that overall patient satisfaction rates remained stable
- An update was received on the work of the Patient Information and Leaflets Group (PILG)
- A report from the Quality Committee meetings on 15/03/17, 10/04/17 & 03/05/17 was noted
- The Junior Doctor who was scheduled to attend the meeting was ultimately unable to do so, but it was reported that the Trust's Head of Therapies was keen for a junior Allied Health Professional to attend the next PEC meeting in September 2017
- A report from the Patient Representative Working Group was received.

2. In addition to the actions noted above, the Committee agreed that:

- A further update would be provided on the funding status for the pilot of the SWAN initiative and the progress with the existing pilot (of the door/bed magnet and Ward board magnets)
- Liaise should occur with the Communications Team to ensure that PEC Patient Representatives are included in the circulations for the Chief Executive's weekly update, the Governance Gazette and the e-bulletin for stakeholders

- A report on the numbers of complaints resulting in litigation in 2016/17 and their outcome should be formulated and circulated
- The process for implementation of the Friends and Family Test should be confirmed (i.e. who the Test is circulated to and in what circumstances)

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

- N/A

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

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

Trust Board Meeting – June 2017

NHS Maidstone and Tunbridge Wells NHS Trust

6-20 Summary report from Quality C'ttee, 14/06/17 Committee Chair (Non-Exec. Director)

The Quality Committee has met once since the last Board meeting, on 14th June (a 'deep dive').

1. **The key matters considered at the meeting were as follows:**
   - A review of progress with **actions agreed from previous meetings**, which included consideration of whether any of the recent reports from the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) warranted review at a Quality Committee 'deep dive'. The Medical Director confirmed that, having reviewed the Trust's assessments against the recommendations in recent NCEPOD reports, he did not recommend any being reviewed. However, the Medical Director did propose that a review of compliance with the Mental Capacity Act 2005 be scheduled. It was therefore agreed to provisionally schedule this review at the Quality Committee 'deep dive' meeting in August 2017
   - The Clinical Director for Specialist Medicine & Therapies; Associate Director of Nursing, Urgent Care; General Manager for Specialist Medicine & Therapies; General Manager for Acute and Emergency; and Interim Head of Performance & Delivery for Urgent Care attended for a **review of the Trust's plans for developing Acute Frailty Units**. It was noted that at the time of the meeting, the Unit at Maidstone Hospital (the "Chaucer Acute Frailty Unit") was in its second week of operation, whilst the area for a Unit at Tunbridge Wells Hospital was not yet defined, but plans were being developed, and it was hoped that Unit would be operational by Sept. 2017. It was also noted that the next steps were to prove the concept worked, and then monitor and refine the Unit at Maidstone. The hours the Unit was operational would also be expanded. It was highlighted that the Unit was not intended to be 'gold standard', as achieving this would have prevented the Unit being opened so soon, and it was considered better to open the Unit sooner rather than wait. The initiative was commended and it was agreed that a written update on the Units should be submitted to the 'main' Quality Committee in July
   - The Clinical Director for Women's and Sexual Health attended for a **detailed update on the working relationships within Obstetrics and Gynaecology**, as a follow-up to an item at the October 2016 meeting. Assurance was given that good progress had been made with the issues, specifically in terms of communication, transparency in Job Planning, and staff behaviours. It was acknowledged there was further work to do. The Committee considered whether a further update was necessary, but it was agreed that although the findings from the next GMC Doctors in Training survey were expected to be challenging, this was not warranted. It was however highlighted that the Clinical Director was welcome to report any issues, or seek further support, from the Committee as required.
   - The Consultant in Palliative Medicine, End of Life Care Clinical Nurse Specialist, and Lead Nurse for Palliative Care & Associated Services also attended, for a **follow-up review of End of Life Care**, which related to a review held at the Committee in August 2016. The Trust's results from the latest National Care of the Dying Audit for Hospitals (NCDAH) were presented, which demonstrated improvement from the previous (2015) Audit. The item also included the findings from the Trust's own survey of bereaved carers, and it was noted that this had generally been positive, although a desire had been expressed to improve on the negative aspects when the findings had been presented to the Trust's Nursing Education and Learning Forum (NELF). Other developments being implemented by the End of Life Care Team were also reported, which included the AMBER Care Bundle (which focused on patients with an uncertain recovery, and for which the Trust had been selected as a pilot site); and the Care Plan Management System (CPMS), which was an IT platform that enabled information to be shared between NHS and other external agencies
   - The Medical Director then gave an update on the **actions being taken in response to the Trust's higher than expected mortality rates**. The report noted that one of the newly-appointed Deputy Medical Directors would now take the lead on mortality-related issues, although overall responsibility would be retained by the Medical Director. The action being taken was noted, but it was agreed to schedule the submission of a written report on

mortality at the 'main' Quality Committee, via a standing agenda item. It was also agreed to schedule a further review of the issue at the Quality Committee 'deep dive' in October 2017

- It was noted that the **August 2017 'deep dive' meeting** would involve reviews of progress with implementing 7-day services, and compliance with the Mental Capacity Act 2005; whilst the **October 2016 'deep dive' meeting** would involve further reviews of the actions to reduce Length of Stay; and the actions being taken in response to the Trust's higher than expected Hospital Standardised Mortality Ratio (HSMR)

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

- The Trust Secretary should arrange for the presentation for the "Review of the Trust's plans for developing Acute Frailty Units" item at the Quality Committee 'deep dive' meeting on 14/06/17 to be appended to the minutes, when these were circulated

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

- N/A

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

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

Trust Board Meeting – June 2017

NHS Maidstone and Tunbridge Wells NHS Trust

6-21 Summary of the Trust Management Executive (TME) meeting, 21/06 Dep. Chief Exec.

The TME met on 21st June. It was a non-standard meeting, to enable a presentation to be given on the **lessons learned from another acute Trust's exit from Special Measures**. A number of standing items were therefore not considered, but the key items that were covered were as follows:

- In the **safety moment**, the Chief Nurse highlighted the work taking place to mark the safety theme for the month, Adult Safeguarding
- The **revised Risk Management Policy and Procedure** was approved (it is intended that this be submitted to the Trust Board, for ratification, in July)
- The **performance for month 2** was discussed, which included recent Serious Incidents, the A&E 4-hour waiting time target, Referral to Treatment (RTT) performance (where it was noted that the waiting list backlog had now plateaued), 62-day Cancer waiting time target performance, and the month 2 financial position. The latter included the outcome of the recent Financial Special Measures Review Meeting with NHS Improvement, and noted that the next Review Meeting had been set for 17th July. The need to improve the 'RAG' ratings of Cost Improvement Plan (CIP) schemes by that date was emphasised. It was also noted that the Trust was in week 5 of the 6-week intensive improvement to improve patient flow, and it was agreed to receive a report on the themes/learning arising from this at the July TME meeting
- The latest **infection prevention and control** position was reported, which noted that 5 cases of Clostridium difficile had been seen in month 2. Some recent non-compliance with the Trust's 'bare below the elbows' Policy was also reported, and it was agreed to liaise with the Communications Team to ensure that staff were informed of the continued need to comply
- The **winter and operational resilience plans** were reviewed, and it was noted that the next 'Rapid Improvement Week' was scheduled for w/c 17/07/17. The need to promote this among all staff groups was acknowledged
- An update on the **"Listening into Action"** programme was given, & those present were asked to promote the completion of a 'pulse' survey, so the programme's impact could be measured
- The latest position on the **national 7 day service programme** was reported, which included the positive feedback from the Challenge Day held with the National Team on 19th May.
- The draft **Quality Accounts 2016/17** were reviewed, prior to their submission (for approval) to the Trust Board. The provisional outcome of the **External Audit of the Quality Accounts** 2016/17 was also verbally reported.
- The key findings from the **2016 national NHS inpatient survey** were reported, and it was agreed that the Chief Nurse would undertake further investigation to try and identify the underlying cause/s of the Trust's performance on the "Did you have confidence and trust in the doctors treating you?" question
- An update on the **Kent and Medway Sustainability and Transformation Plan (STP)** was given, which included the progress with the productivity workstream
- The summary report from the **Trust Clinical Governance Committee** was received, as was an update on the **implementation of the replacement PAS+**, which noted a potential 'go live' date of 8th October 2017 (subject to successful User Acceptance Testing, and pending approval by the PAS Programme Board, Informatics Steering Group and TME)
- An update was received on the recent **Clinical Operations & Delivery Committee** meetings
- The TME approved an amendment to its **Terms of Reference** to reflect the addition of the new Deputy Medical Director and Associate Medical Director positions to the membership
- The Chief Nurse reported on the forthcoming steps being taken to recruit **overseas Nurses**

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

Trust Board Meeting – June 2017

NHS Maidstone and Tunbridge Wells NHS Trust

6-22 Summary report from Finance C'ttee, 26/06 Committee Chair (Non-Exec. Director)

The Finance Committee met on 26th June 2017.

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

- The actions from previous meetings were reviewed, and the fact that there were no due 'open' actions was commended
- Updated Terms of Reference were considered. These were due their annual review, but as had been reported to the May Trust Board meeting, the review had reflected the Committee's (and Board's) desire to extend the Committee's role. The proposed amendments were duly agreed, subject to 2 changes (the inclusion of some Lord Carter-related duties, and the amendment of the proposed additional "purpose" from "…to provide the Trust Board with…An objective assessment of non-quality performance-related issues" to "…to provide the Trust Board with…An objective assessment of performance-related issues affecting the Trust's financial position"). The agreed Terms of Reference, with the proposed amendments shown as 'tracked' (including the 2 changes above), are enclosed in Appendix 1, for approval
- Under the "Safety Moment", the Trust Secretary reported that June's theme was Safeguarding Adults
- The month 2 performance, including that on the Cost Improvement Plan (CIP), was discussed in detail. The Chief Operating Officer was present, and able to provide detailed responses to activity-related queries
- The monthly update on the Workforce Transformation programme was noted
- A report on the options being considered in relation to the PFI contract at Tunbridge Wells Hospital was discussed, and it was agreed to schedule a further update in December 2017
- The usual monthly update on the Lord Carter efficiency review was considered, and the progress made was commended
- The Business Case to reconfigure Theatre capacity at Tunbridge Wells Hospital was reviewed, and the Committee agreed to recommend that the Trust Board approve the Case (which has been submitted to the Board as a separate Attachment, for approval)
- The approach to the Trust's Reference Costs submission was approved (this is one of the Committee's stated duties)
- The usual monthly report on breaches of the external cap on the Agency staff pay rate was reviewed, as was a report on the recent findings from relevant Internal Audit reviews (such reports are received every 6 months)
- A discussion was held on what information the Committee should receive to fulfil its new performance-related purpose/duties (subject to the Trust Board's approval),and it was agreed that the Deputy Chief Executive and Chief Operating Officer should arrange for this to be considered among the Executive Team before submitting a proposal to the Committee
- A brief written update report on the Apprenticeship Levy was received, and it was agreed that quarterly updates should be scheduled for the future

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

- The Director of Finance should arrange for details of expenditure relating to the Kent and Medway Sustainability and Transformation Plan (STP) to be reported to the Committee
- The Deputy Director of Finance (Financial Performance) should arrange for the revenue relating to High Cost Drugs to be reported separately within the "Run Rate Analysis" table within future monthly financial performance reports to the Finance Committee

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

- Revised Terms of Reference were agreed, and are enclosed (in Appendix 1) for approval

Which Committees have reviewed the information prior to Board submission?

- N/A

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

1. Information and assurance
2. To approve the revised Terms of Reference for the Finance Committee (Appendix 1)

Appendix 1: Proposed revised Terms of Reference

FINANCE AND PERFORMANCE COMMITTEE

Terms of Reference

NHS Maidstone and Tunbridge Wells NHS Trust

1. Purpose

The Trust Board has established the Committee to provide the Trust Board with:

- Assurance on the effectiveness of financial management, treasury management, investment and capital expenditure and financial governance
- An objective assessment of the financial position and standing of the Trust
- An objective assessment of performance-related issues affecting the Trust's financial position
- Advice and recommendations on all key issues of financial management and financial performance
- Assurance on Information Technology performance (and business continuity)
- ~~Advice and recommendations on all aspects of informatics, including Information Technology and telecommunications~~

2. Membership

Membership of the Committee is as follows:

- The Committee Chair - a Non-Executive Director appointed by the Trust Board
- The Committee Vice-Chair - a Non-Executive Director appointed by the Trust Board
- The Director of Finance
- ~~The Medical Director~~
- The Chief Operating Officer[~~1~~]
- The Chief Executive[~~1~~2]
- The Deputy Chief Executive [1]

Members are expected to attend all relevant meetings.

3. Quorum

The Committee shall be quorate when one Non-Executive Director and two Members of the Executive Team~~Directors~~ are present. If a member of the Executive Team~~the Director of Finance~~ cannot attend a meeting, they should aim to send a~~ir~~ representative in their place~~will attend~~.

For the purposes of being quorate, any Non-Executive Director (including the Chair~~man~~ of the Trust Board) may be present; and any 2 Members of the Executive Team~~other Executive Director~~ may be present (including any of those not listed in the Membership)~~in place of the Medical Director, should the latter be unable to attend the meeting~~.

4. Attendance

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

The Committee Chair may also invite others to attend, as required, to cover certain agenda items, and/or ensure the Committee meets its Purpose and complies with its Duties ~~the objectives of the Committee~~.

5. Frequency of meetings

The Committee shall generally meet each month, but the Committee Chair may schedule additional meetings, as required (or cancel any scheduled meetings)~~.~~

[~~1~~] ~~N.B. Either the Chief Operating Officer, Chief Executive or Deputy Chief Executive should aim to be present at each meeting. This does not affect the quorum requirement listed above.~~

[2] N.B. Either the ~~Chief Operating Officer,~~ Chief Executive or Deputy Chief Executive should aim to be present at each meeting. This does not affect the quorum requirements listed above.

6. Duties

The Committee has the following duties:

Financial Management

- Review financial plans and strategies and ensure they are consistent with the Trust's overall vision and strategic goals
- Ensure a comprehensive budgetary control framework is in place and operating effectively
- Monitor financial performance against plan, and ensure corrective action is taken where appropriate
- Develop and monitor key financial performance indicators, and advise the Trust Board on action required to improve performance / address risks. ~~Indicators will include:~~
  - ~~Risk rating and associated financial ratios;~~
  - ~~Other financial ratios;~~
  - ~~Service Line profitability;~~
  - ~~Efficiency and productivity measures;~~
  - ~~Benchmarking information;~~
- Review and monitor~~assess~~ the Trust's ~~Efficiency Savings Plan (formerly~~ Cost Improvement ~~Plan~~Programme (CIP)
- Obtain assurance that all ~~Efficiency Savings Plan~~CIP schemes~~initiatives~~ and B~~b~~usiness C~~c~~ases have been subject to a Quality Impact Assessment, and to liaise with the Quality Committee, as appropriate, to ensure the robustness of the process
- Monitors the delivery of the recommendations of the 'Lord Carter report' ("Operational productivity and performance in English NHS acute hospitals: Unwarranted variations")
- Ensure the Trust is actively engaged and addresses all productivity opportunities presented as part of national initiatives

Treasury Management

- Review any significant (in the judgement of the Director of Finance) proposed changes to ~~Approve~~ the Trust's ~~detailed~~ treasury management policies, processes and controls
- Approve external funding and borrowing arrangements, including approval of working capital facilities and capital investment loan applications (within the Committee's delegated authority), or to review ~~of~~ such applications, and make a recommendation to the Trust Board ~~if~~ the value exceeds the Committee's delegated authority)
- ~~Approve relevant benchmarks for measuring performance e.g. Better Payment Practice Code (BPPC)~~
- Ensure proper safeguards are in place for security of the Trust's funds by ensuring approved bank mandates are in place for all accounts, which are updated regularly for changes in signatories and authority levels;
- Monitor compliance with treasury management policies and procedures
- ~~Specify and review detailed treasury reporting requirements~~
- Review the Trust's cash flow and balance sheet ~~of the Trust~~, to ensur~~e~~ing effective cash management plans are in place

Capital Expenditure and Investment

- Review the Trust's capital plan ensuring its alignment to strategic priorities
- Review and assess the financial implications of the PFI contract for Tunbridge Wells Hospital, including any options for re-financing
- Review B~~b~~usiness C~~c~~ases for capital and service development above the threshold set-out in the Reservation of Powers and Scheme of Delegation, ~~for capital and service development~~ and make a recommendation to ~~advise~~ the Trust Board regarding the approval of such Cases~~on the financial implications of the proposals~~
- Receive assurance on the effectiveness of the Trust's~~Regularly review investment criteria, and the~~ investment appraisal and approval process

Financial Governance, Reporting, Systems and Function

- Review and assess the arrangements for financial governance
- ~~Review and agree financial policies~~
- ~~Ensure financial reporting to Trust Board meets the requirements of the Board~~

- Review and assess the effectiveness of financial information systems, and ~~agree and~~ monitor development plans, including the development of Service Line Reporting
- Review and assess the capacity and effectiveness of the finance function and ensure development plans are in place to meet the current and future requirements of the Trust ~~(including the requirements of Foundation Trust status)~~
- Assess the organisational awareness and adherence to financial management disciplines and controls and promote congruence between quality patient care and the achievement of financial objectives.
- Review and approve the Trust's approach to its Reference Cost submission/s

Procurement

- To monitor performance against the Trust's Procurement Strategy and Procurement Transformation Plan

Performance

- To monitor and review non-quality performance-related issues, particularly in relation to the key patient access targets
- To escalate performance-related issues to the Trust Board in the event of any concerns

Informatics (including Information Technology)

- Review informatics strategies and plans and ensure they are consistent with the Trust's overall vision and strategic goals
- Review plans and proposals for major development and investment in Information Technology, and advise the Trust Board accordingly, paying particular attention to the financial implications and risks of the proposals

Assurance and Risk

- Assure itself on (i) the identification of principal risks associated with the financial performance and financial management of the Trust, and Information Technology, (ii) the effective management of those risks and (iii) the escalation to the Trust Board of matters of significance

7. Parent Committees and reporting procedure

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

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

8. Sub-Committees and reporting procedure

The Finance Committee has no standing sub-committees, but may establish fixed-term working groups, as required, to support the Committee in meeting the Purpose and/or D~~d~~uties listed in these Terms of Reference.

9. Emergency powers and urgent decisions

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

10. Administration

The minutes of the Committee will be formally recorded and presented to the following meeting for agreement and the review of actions.

The Trust Secretary will ensure that each committee is given appropriate administrative support and will liaise with the Committee Chair on:

- The Committee's Forward Programme, setting out the dates of key meetings & agenda items
- The meeting agenda
- The meeting minutes and the action log

11. Review of Terms of Reference and monitoring compliance

The Terms of Reference of the Committee will be reviewed and agreed by the Finance Committee at least annually, and then formally approved by the Trust Board.

History

- Terms of Reference agreed by Finance Committee, May 2013
- Terms of Reference reviewed and agreed by Finance Committee, May 2014 (with a minor additional to duties agreed at the June 2014 Finance Committee)
- Terms of Reference approved by Trust Board, July 2014
- Terms of Reference (revised) agreed by Finance Committee, June 2015
- Terms of Reference (revised) approved by Trust Board, July 2015
- Terms of Reference (minor revision) agreed by Finance Committee, September 2015
- Terms of Reference (minor revision) approved by Trust Board, September 2015
- Terms of Reference (reviewed and revised) agreed by Finance Committee, June 2016
- Terms of Reference (revised) approved by Trust Board, June 2016
- Terms of Reference (reviewed and revised) agreed by Finance Committee, June 2017

Trust Board meeting – June 2017

NHS Maidstone and Tunbridge Wells NHS Trust

6-16	Finance Committee, 26/06/17 (Business Case to reconfigure Theatre capacity at Tun. Wells Hospital)	Chair of Finance Committee / Chief Operating Officer

The unprecedented demand in non-elective activity has resulted in significant elective patient cancellations, long waits for procedures, failure of the Referral to Treatment (RTT) target and failure of the 4 hour Emergency Department (ED) standard.

To mitigate some of this in 2016/17 the Trust spent £4.7m outsourcing 1,150 elective orthopaedic procedures to the independent sector. For 2017/18 the Trauma and Orthopaedics directorate had committed in budget setting to spending £5.7M

Under the new Aligned Incentive Contract the Trust will not receive any additional payment for over performance & there are no Sustainability and Transformation Fund (STF) incentives for achieving RTT in 17/18. This means the benefits in sending work to the independent sector are minimal and it is therefore incumbent on the Orthopaedic Directorate to manage its own activity within MTW.

The objectives of the enclosed Business Case are to:
1. Stop outsourcing elective orthopaedic activity
2. Ensure ring-fenced beds for elective orthopaedic activity at TWH
3. Improve training opportunities for junior doctors (Red flag from GMC)
4. Release theatre capacity to allow other service changes for CEPOD and planned trauma
5. Improve theatre productivity by opening a dedicated admissions lounge at Tunbridge Wells Hospital

The Trust's Reservation of Powers and Scheme of Delegation (2.6) stipulate that "Acquisition, disposal or change of use of land and/or buildings, involving capital expenditure in excess of £1,000,000" is a function reserved for decision by the Trust Board. The enclosed Business Case has therefore been submitted for consideration by the Finance Committee on 26th June 2017, before the Trust Board is asked to approve the Case. The outcome of the Finance Committee's consideration will be reported to the Trust Board as part of the summary report from that Committee (which will be issued after the meeting).

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

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

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

Maidstone and Tunbridge Wells NHS Trust

BUSINESS CASE

Title: ***Reconfigure Theatre capacity at TWH - to increase orthopaedic activity, reduce outsourcing and re-open theatre six at TWH and increase CEPOD/ Planned Trauma capacity to reduce surgical non elective LOS***

Issue date/Version number	20th June 2016 v8
ID reference	
Division	Planned Care
Directorate	Orthopaedics, Critical Care, Surgery and Gynaecology
Department/Site	TWH
Author	Julia McGinley & Jane Rademaker
Clinical lead/Project Manager	Assistant Medical Director

Approved by	**Name**	**Signatur**	**Date**
General Manager	Daniel Gaughan		
Finance manager	Oliver Cuthbert		
Clinical Directors	James Nicholl, Greg Lawton, Danny Lawes, Carol Jones, Mark Cynk		
Executive sponsor	Angela Gallagher		
Division Board	Jane Rademaker		
Supported by	**Name**	**Signatur**	**Date**
Director Estates & Facilities	Jeanette Rooke		
Director of Informatics	Donna Jarrett		
Deputy Chief Operating Officer	Angela Gallagher		
EME Services Manager	Michael Chalklin		
HR Business Partner	Angie Collison/Lucy O'Neil		

Version history

Version	Issue date	Brief Summary of Change	Owner
V4	31/3/17	To DOO-PC for review	JMcG
V5	10/4/17	Submitted with SO and AG for consideration	JR
V6	21/4/17	Edits in *blue italics* following comments from DDofF (governance)	JMcG
V7	25/4/17	Edited preferred option and added anaesthetic needs	JMcG
V8	20/6/17	Added in narrative and finances relating to SSU admissions lounge	JR/OC

Maidstone and Tunbridge Wells NHS Trust

Business Case Summary

Strategic background context and need

The unprecedented demand in non-elective activity caused Maidstone and Tunbridge Wells (MTW) NHS Trust to almost cease all elective activity on the Tunbridge Wells Hospital (TWH) site both in 15/16 and 16/17. Although MOU was opened in December 2016 the high demand for non-elective work has resulted in significant elective patient cancellations, long waits for procedures, failure of the RTT target and failure of the 4 hour ED standard.

To mitigate some of this in 2016/17 the Trust spent £4.7M outsourcing 1,150 elective orthopaedic procedures to the independent sector. For 2017/18 MTW had initially committed in budget setting to spending £5.678M on undertaking the same level of activity to ensure backlogs reduced. However, under the new Aligned Incentive Contract (AIC) Trust will not get any additional payment for over performance and there are no STF incentives for achieving RTT in 17/18. This means the benefits in sending work to the independent sector are minimal and it is therefore incumbent on the Orthopaedic Directorate to manage its own activity within MTW.

In order to achieve part of its 2017/18 CIP the Planned Care Division plans to undertake theatre reconfiguration at TWH to support the cessation of Orthopaedic outsourcing and improve non elective theatre capacity to further reduce LOS and enhance flow. This involves the following

- Re-open theatre six at TWH – by moving the existing Orthopaedic sessions from theatre three to theatre six thus providing 13 additional theatre sessions per 5 week month, supported by 10 ring fenced beds on Ward 30 and realigned consultant job plans.
- Maidstone Orthopaedic Unit will remain open with 10 sessions a week with 12 ring fenced beds
- Establish an admissions lounge within Short Stay unit at TWH to improve theatre productivity for all specialities
- Reallocate the vacated sessions in theatre three as
    - 5 x extra CEPOD sessions – 3 allocated to Surgery and 2 allocated to Gynae
    - 5 x Planned trauma sessions - which will enable theatre eight to be dedicated to inpatient trauma which in turn will also reduce LOS
    - These changes will give T&O a total of 3 theatres dedicated for Elective and 1.5 theatres for trauma as well as increased CEPOD sessions for Surgery and Gynae at TWH.

These plans will be accommodated by changes in surgeon's job plans, additional consultant anaesthetists and improved bed management to ensure ring fenced beds.

In addition Planned care Division is committed to improve existing theatre utilisation building on the work currently being led by the Head of Performance and Delivery. This will include establishing SSU as the admissions area for all elective patients and moving procedures from day case to outpatients to free up capacity.

All of these actions combined will allow the previously outsourced work to be brought back in house. The cost of these changes is less than the cost of outsourcing the work and therefore will produce a CIP of £2.11million.

These plans fit with all the Trust's strategic aims:

- To become a truly patient and customer centred organisation - "It's about really understanding the needs of our patients, caring for them in the right environment and getting the best outcomes for them"
- To deliver services that are viable and sustainable - "We can do this by making MTW the first name that comes to mind when patients choose their care, no matter where they live or if it is highly specialised or routine treatment"
- To take the system leadership role to deliver integrated care in our locality - "We want to work with our patients to meet more of their care needs in hospital, in the community or at home"
- To operate at high levels of quality and efficiency to generate long-term financial sustainability - "Making the very best use of our budgets to continue to provide the very best care for every patient we see"

Objectives -

1. Stop outsourcing elective orthopaedic activity by increasing orthopaedic activity within the Trust
2. Reconfigure theatre sessions to provide additional capacity on the TWH site for Orthopaedics and CEPOD.
3. Provide continuity of care for MTW patients by ensuring they are seen onsite within NHS facilities.
4. Ensure 10 ring fenced beds at TWH for elective orthopaedic capacity
5. Maintain reputation locally for orthopaedic and non-elective surgery work to retain staff
6. Improve theatre productivity for all specialities through the establishment of an admissions lounge at TWH
7. Improve training opportunities for junior doctors
8. Reduce LOS for non-elective surgery and trauma.
9. Achieve performance standards for RTT and A&E

The preferred option.

The preferred option is number two: to reopen theatre six as a dedicated orthopaedic operating theatre, continue with MOU and reconfigure vacated theatre three sessions to increase CEPOD and trauma capacity.

- Re-open theatre six at TWH

  In the five week theatre rota, 37 orthopaedic theatre sessions will be moved out of the non-orthopaedic theatre three at TWH into theatre six. This equates to between 25 and 30 sessions in a normal calendar month.

The theatre timetable has 50 sessions (5 weeks of 2 sessions a day for 5 days) and there will therefore be capacity of 13 sessions per five week month in theatre six to move some of the outsourced work from the independent sector back to TWH. The rest will be accommodated by improving theatre utilisation of existing sessions. An improvement in planned trauma capacity will ensure elective cases are not cancelled to accommodate more urgent trauma work.

- Maidstone Orthopaedic Unit will remain open with 10 sessions a week with 12 ring fenced beds
- Establish an admissions lounge within Short Stay unit at TWH
- Reallocate the vacated sessions in theatre three as
    - 5 x extra CEPOD sessions – 3 allocated to Surgery and 2 allocated to Gynae (hot lap choles, ambulatory procedures e.g abscesses and surgical miscarriage management).
    - 5 x Planned trauma sessions (specialist and trauma waiting at home) - which will enable theatre eight to be dedicated to inpatient trauma which in turn will also reduce LOS
    - 13 elective lists currently in theatre therefore Surgery, ENT, Ophthalmology would be absorbed elsewhere into existing sessions including moving activity to Maidstone

This option will require the following:

- Staff costs - £1,301,539 (annual cost)
    - 4 x band 5 scrub nurses
    - 2 x band 2 theatre runners
    - 1 band 3 Porter
    - 4 x consultant anaesthetists (costs based on locum rates)
    - 1 x radiologist band 5
    - 2 x pharmacists (1 x band 8a + 1 x band 4)
    - 1 x health records staff to pull and prep notes (0.50WTE band 2)
    - 1 x band 3 CAU booker
    - 1.45 x band 5 trained nurse for SSSU
    - 1.45 x band 2 CSW for SSSU
    - 1.38 x band 2 receptionist for SSSU
- Equipment - £462,026. This money is mainly identified and available in the Trust's Capital plan for 2017/18.

Junior doctors training will be considerably improved with an increase in training opportunities in theatre which will also contribute to improved responses on future GMC surveys.

Orthopaedic consultant job plans are being reviewed at the same time to ensure all sessions are covered and

those with capacity can take on additional work. *(more details in preferred option)* The 5 sessions being allocated to Surgery and Gynaecology for CEPOD will also be covered by changes to existing job plans / rotas.

There is no spare capacity in Anaesthetic Consultant job plans and therefore additional staff will be needed. This case includes the costs of 4 consultant anaesthetists, broadly two to cover theatre three and six and two to ensure consultant anaesthetic cover in theatre seven and eight. The latter has historically not been covered and would improve utilisation of these sessions thus avoiding the need to cancel elective work when experiencing peaks in non- elective surgical demand.

It should be noted that this option does not include extra sessions at weekends which could be provided longer term to offer capacity to the CCG to reduce the wider outsourcing demand across West Kent.

Main risks associated with the investment

Main risks;

- Inability to recruit theatre and anaesthetic staff to reconfigure theatres in TWH by end of July (costs assume staffed at agency rates for full year)
- If beds are not ring fenced activity will be significantly impacted
- Inability to deliver theatre utilisation improvements
- Inability to deliver project by July 2017 which will have an impact on the Trust's capacity plan for the year.
- This plan is a substantial part of the Division's £14M CIP for 2017/18; failure to deliver will result in a significant shortfall.

Financial impact of the preferred option – full year effect – include VAT unless recoverable

Summary of financial impact		**Sum(£)**	**Funding source**	**Sum(£)**
CAPITAL COSTS	Estates	Nil	Identified in the Trust capital plan	£410,000 (further £52,000 to be requested)
	IT	Nil	Outsourcing funding identified in directorate revenue budget	£5,779,884
	Equipment	£462,000		
Total Capital cost of project		£462,000	**FYE recurrent saving**	**£2,170,012**
REVENUE COSTS	Pay	£1,301,539	Note – these are the costs for a full year. There is £358k of agency/locum costs built into the costings for theatre staff and anaesthetists, therefore any substantive recruitment will lead to greater savings. There will be a non-recurrent cost of £356k in 17/18 to outsource patients that will breach the 52wk RTT target. An estimate of 15 cases per month from April to September has been included in the costs. The revenue costs of setting up	
Non-pay		£735,985		
Depreciation and PDC		£103,725		
Recurrent cost of MOU		£1,468,625		
Total Revenue cost per annum		£3,609,872		

		theatre 6 are anticipated to start in October. Considering the above the anticipated savings in year 1 are £2.7m

The Business Case

1. Strategic context

National – Ongoing pressure on A&E services across the country are mirrored locally, and escalation into elective beds has become a regular occurrence.

Local – The Trust orthopaedic elective capacity it provided on both sites. The Tunbridge Wells site is experiencing greater pressure on beds and services than the Maidstone site, and orthopaedic beds there are regularly escalated into.

In December 2016 an orthopaedic theatre and 12 beds were moved from the TWH site to the old Maidstone Orthopaedic Unit (MOU). This has maintained a planned level of routine less complex activity in the order of 245 cases in the first 3 months. However, despite this, the Trust continued to send predominantly minor cases to the independent sector. As this initiative has allowed the Trust to maintain some activity and reduce elective cancellations on the previous year, it is proposed that this unit remains open, until a long term plan for elective Orthopaedics emerges as part of wider STP plans.

The new Aligned Incentives Contract places more of a commitment to joint working between the Trust and WK CCG. This means that over-performance in one service can be offset by under-performance in another. However if activity over-performs at the Trust level, the Trust will not receive any additional funding from WK CCG. The principle is to drive activity down and reduce below the plan value. There is therefore no capacity to generate additional income by increasing performance in individual specialties to reduce backlogs to meet RTT performance including outsourcing. In addition there is no STF funds allocation for achieving the RTT standard for 17/18 however it is expected that organisations will continue to reduce waiting times.

Lack of capacity in theatres at TWH for non-elective surgery has increased meaning that patients often have to wait to have their surgery. This increases their LOS and has resulted in a lack of beds which has resulted in elective patients being cancelled to ensure non-elective surgical patients are operated on. Analysis has also shown that in order to accommodate the planned trauma work as well as inpatient trauma the Trust needs to provide 1.5 full day operating per day Monday to Friday without negatively impacting on the Orthopaedic elective capacity.

2. Objective(s) and case for change of the proposed investment

1. Stop outsourcing elective orthopaedic activity and increase capacity on site

    - Current situation, the trust has outsourced 1,150 patients at a cost of £4.7M.
    - Problems/risks of this are that patients are not always treated on the MTW sites; they are sent to the independent sector for treatment or treated out of hours at TWH. The costs of this are significantly more than the costs of undertaking the work on site. Under the new AIC the Trust will not receive any additional money for treating more patients.
    - The gap is due to a lack of dedicated orthopaedic theatres, ring-fenced beds and appropriately skilled staff.
    - The expected benefits of the change: £2.17m cost improvement, improved patient experience, provide continuity of care for MTW patients by ensuring they are seen onsite within NHS facilities, more certainty for patients planning their operation, maintained reputation locally for orthopaedic work, better retention of staff.

2. Ensure ring fenced beds at TWH for elective orthopaedic capacity

    - Current situation, in the last 11 months 3,708 bed days of medical patients were outlying into orthopaedic beds at TWH.
    - Problems/risks of this are that orthopaedic patients are cancelled and their surgery rebooked at the independent sector or not booked in the first place due to the significant risk of cancellation. 100 reportable patients despite having been previously cancelled had their surgery cancelled at the very last minute when they had already been admitted to TWH. Additionally the Trust cannot achieve its RTT trajectory nor reduce its waiting list backlog.
    - The gap is due to a lack of dedicated orthopaedic ring-fenced beds.
    - The expected benefits of the change: Significant CIP, improved patient experience, provide continuity of care for MTW patients by ensuring they are seen onsite within NHS facilities, more certainty for patients planning their operation, maintain reputation locally for orthopaedic work, achievement of RTT trajectory, reduction in cancelled ops.

3. Improve training opportunities for junior doctors (current Red Flag from GMC)

    - Current situation, the GMC has placed a red flag against the training provision for orthopaedic junior doctors at MTW. This mainly relates to a reduction in HSTs elective training opportunities due to capacity issues.
    - Problems/risks of this are that there is a threat to training provision, meaning the best junior doctors are not encouraged to apply here. Ultimately the risk is that, like East Kent, training places will be removed from the Trust.
    - The gap is due to a lack of regular consistent orthopaedic operating sessions offering a diverse range of procedures for juniors to watch and assist with. This is currently complicated by the high % of ortho-geriatric patients which means the doctor's caseload is heavy in this type of case and light on general orthopaedic experience.
    - The expected benefits of the change: Improved junior doctor morale, removal of GMC red flag, Specialty Trainees given preference over non-training grades with regard to operating lists.

4. Releases theatre capacity to allow other service changes for CEPOD and planned trauma

    - Current situation, there are only 3 afternoon sessions a month free in the current theatre schedule at TWH
    - Problems/risks of this are that there are no additional sessions to allow peaks in surgical throughput in other specialities.
    - The gap is due to theatre schedule booked to capacity.
    - The expected benefits of the change: Increased capacity for CEPOD i.e.2 sessions per week for gynae and 3 additional sessions per week for surgery, which can be filled easily within their existing resources.

5. Establish an admissions lounge within Short Stay unit at TWH to improve theatre productivity for all specialities
    - Creates a facility where patients can be admitted and prepared for theatre prior to bed allocation. Close liaison between the admissions lounge nurse, theatre co-ordinators and site practitioners allows for full utilisation of the theatres and optimisation of bed capacity in the knowledge that beds will become available later in the day.
    - Patient admissions to the lounge are staggered in accordance to the theatre lists to avoid overcrowding and preserve privacy and dignity for patients.
    - During May's rapid improvement week the Admissions Lounge was implemented and the concept tested of using the holding bay in theatres for patients prepared for surgery and changed in theatre gowns as the SSSU was escalated.
    - Patients were admitted and held in the SSSU reception area. They were reviewed by the nursing staff, operating surgeon and the anaesthetist via the single consulting rooms using an orderly system. When theatres were ready for the patient, they were prepared in the patient changing rooms and escorted via the middle corridor to the holding bay in order to preserve privacy and dignity. The holding bay was split into male and female waiting areas and the patients were checked into theatre from here.
    - The Admissions Lounge facilitated improved theatre utilisation for ENT, Gynae , Trauma and General Surgical patients as follows

        - Session utilisation improved from 88.4% to 88.8%
        - Significant delays of 30 mins or more decreased from 52% to 50%. The lowest it's been since Oct 2016.
        - Significant delays of 60 mins or more decreased from 11% to 9%. The lowest it's been since Oct 2016.
        - Session overruns decreased from 84.7% to 84.3%.

3. Constraints and dependencies

Although this plan is predominantly about changes to theatres it is critically dependent on the ability of the Trust to change hearts and minds to deliver changes to beds and bookings, to ensure that Orthopaedic elective beds at TWH are ring-fenced and Recovery 2 is not used for escalation. *(Further details of plans in preferred option)*

Recruitment in critical care is a significant constraint. It is likely that both theatre staff and anaesthetic staff will be difficult to recruit and innovative and possibly time consuming recruitment strategies will need to be deployed.

4. Short list of options

Option 1 Title: The do nothing option

Description – continue adhoc outsourcing of elective activity, theatre six remains closed and MOU continues

Key activity and financial assumptions – This option is now not viable, the Aligned Incentives Contract does not make provision for outsourcing of work and the Trust will not be paid for any outsourcing above 2016/17 numbers. An option that the Division might have considered, namely that 1150 cases per annum will be outsourced to approximately 6 organisations at a cost of approximately £5.7M pa is therefore no longer possible. In addition the capacity for non-elective surgery and planned trauma would remain unchanged and would result in longer LOS and increased risk of elective cancellations with peaks in demand.

Non-financial risk associated with the option – Red flag to junior doctors training by GMC, organisational risk to Trust of not offering elective surgery on site, untenable plan

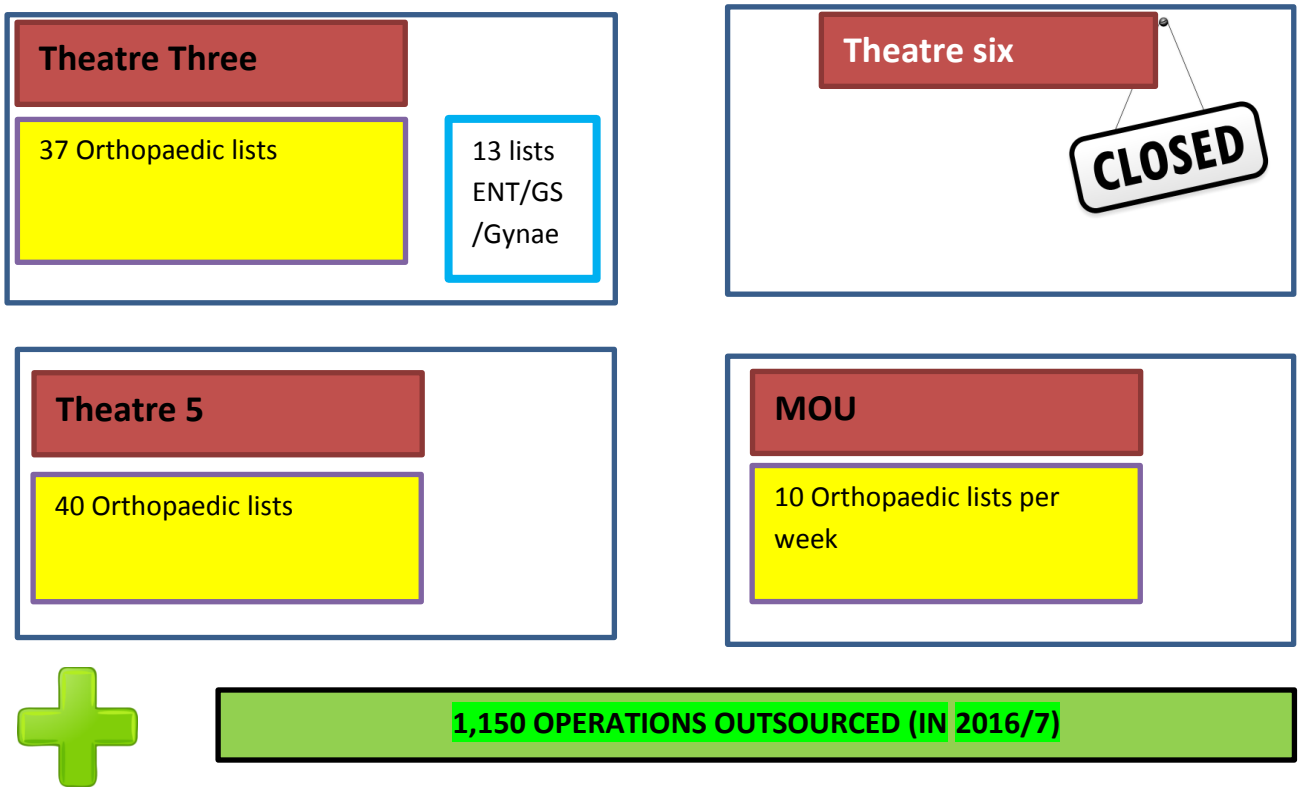
Non-financial benefits associated with the option – allows non-elective activity to continue to use orthopaedic beds

Option 2 : Reconfigure theatre capacity at TWH

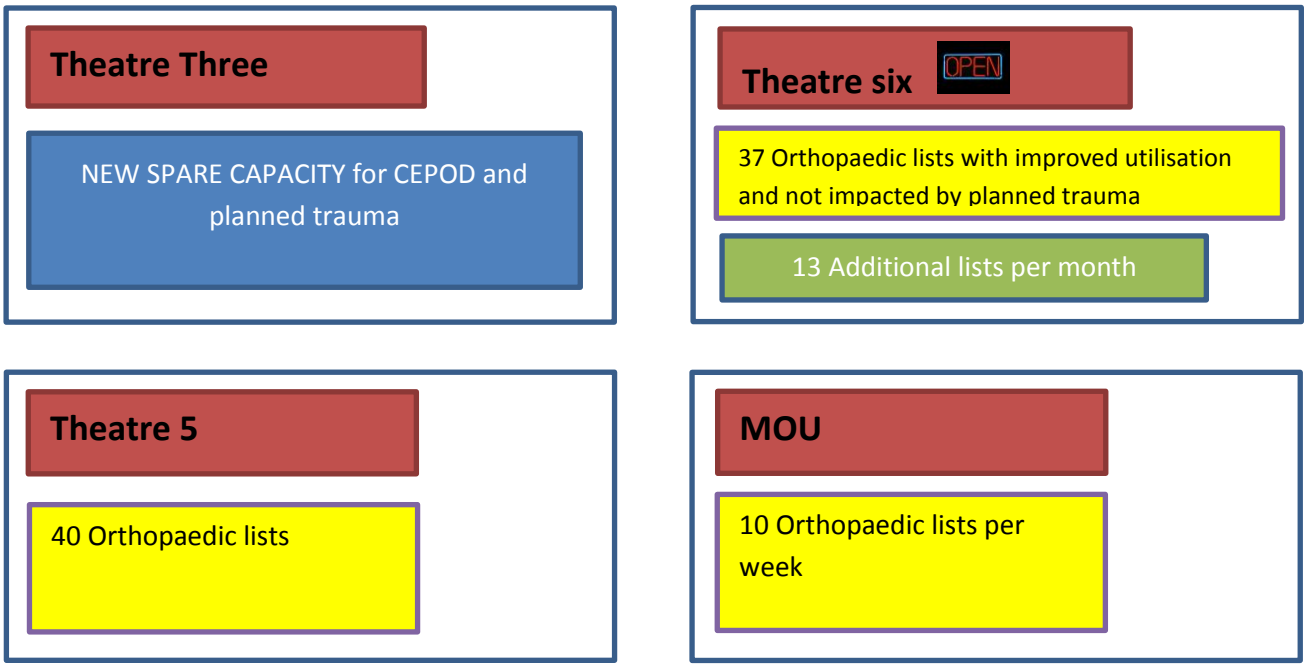
Summary:

1. Reopen, recommission and reconfigure theatre six
    - Use theatre six to provide 13 additional elective orthopaedic sessions per five week month to undertake 390 additional operations pa
    - Move 37 sessions per month from theatre three to theatre six, creating capacity for other specialties in theatre three.
2. Improve theatre utilisation and move day case procedures to outpatient to create capacity for 760 cases pa.
3. Establish an admissions lounge within Short Stay unit at TWH to improve theatre productivity for all specialities
4. Continue MOU – 10 sessions per week
5. Reconfigure Theatre 3 sessions to provide 5 extra CEPOD sessions and 5 planned trauma sessions
6. 13 lists in Theatre 3 would be absorbed elsewhere into existing sessions including moving activity to Maidstone

Current situation and monthly sessions (based on five week theatre schedule)



Proposed plan



Detailed theatre timetable is shown in Appendix one, in summary the following theatre sessions will move:

CURRENT THEATRE TIMETABLE FOR THEATRE 3							TOTAL
Week	Orthopaedics	ENT	Eyes	Urol	Surgery	Total per week	Remaining in theatre 3
1	7	1	0	0	2	11	4
2	8	1	1	0	0	10	2
3	4	3	0	0	1	9	5
4	9	0	0	1	0	10	1
5	9	0	0	1	0	10	1
TOTAL	**37**	**5**	**1**	**2**	**3**	**50**	**13**

This will create the following vacant theatre sessions in Theatre six which will be run by Orthopaedics.

- Monday am – Week 1 and 3
- Monday pm – Week 1 and 3
- Tuesday am – Week 3
- Wednesday am – Week 2, 3, 4 and 5
- Wednesday pm – Week 1, 2 and 3
- Friday pm – Week 3

NB - These are the vacant sessions to be filled by job plan changes to Orthopaedic Consultants and an increase in Anaesthetic Consultants, the existing 37 sessions that will be moved will continue as now.

Theatre utilisation

A review of MOU activity is also being undertaken to assess the level of TW patients who are operated on at Maidstone, to ensure that in the future patients are treated as close as home as possible and this facility is maximised .

The case mix of activity which has been outsourced in 2016/17 are small cases which will be scheduled at the beginning and end of theatre lists, by planning this well we will undertake 2 additional cases per day (across the speciality) removing another 760 patients from the waiting list. These additional cases will be achieved by improving efficiency of moving patients to and from theatre and improving turnaround times (TAT). This work will be overseen by the Theatre, Endoscopy and Cath Lab Utilisation Board who report monthly to the Access Performance Steering Board, their remit is to improve theatre productivity across both sites, and in all specialities, against an agreed programme and trajectory to specific timescales.

Specifically they work:

- To ensure patient quality standards are maintained or improved via the programme of work.
- To monitor the work of the Theatre, Endoscopy and Cath Lab Utilisation Board against their delivery plan.
- To ensure the Theatre, Endoscopy and Cath Lab Utilisation Cost Improvement Plan for 2016/7 & 2017/8 is met and to recommend mitigating measures if slippage occurs.
- To monitor the Key Performance Indicators for each of the programmes.
- To review and mitigate highlighted risks to the programme delivery.
- To review and/or initiate new projects related to increasing theatre utilisation.
- To act as a decision making board where projects require Director/Consultant Input.
- Review the flow of elective work – ensure the plans indicated in business planning are undertaken.
- To monitor start and finish times.
- To monitor DNA and cancellations and ensure a reduction across the Trust.
- To monitor Theatre utilisation and ensure improvements across the Trust.
- To monitor Theatre WHO checklist and ensure quality improvements across the Trust
- To monitor mortality rate and Never events and ensure reduction across the Trust
- To ensure action is taken to improve quality and utilisation of theatres across both sites.
- To ensure any highlighted or potential risks are report and addressed to the relevant Divisional Director and CD.
- Chair or Deputy Chair to give regular updates and assurance to the Access Performance Steering Board.

Current theatre utilisation

	Jan-17	Feb-17	Rolling 12 Months
Case Volume —	63	78	2233
Session Utilisation (with TAT) —	87.7%	87.8%	85.3%
Session Utilisation (without TAT) —	73.4%	74.7%	74.5%
On Time Starts (within 10 mins) —	15%	0%	10.2%
Significant Delay > 30 mins —	60%	90%	47.8%
Significant Delay > 60 mins —	35%	30%	14.2%
On Time Finishes (within 10 mins) —	20%	25%	16.6%
Significant UnderRun (> 30mins) —	40%	40%	46.5%
Significant UnderRun (> 60mins) —	25%	15%	28.7%
Significant OverRun (>30 mins) —	5%	20%	14.0%
Cases per Session —	1.63	1.84	1.89
(TAT) Patient Out to Case Start (minutes) —	30.3	23.5	18.87
On day Cancellation % —	25.0%	9.3%	9.9%
On day Cancellations —	21	8	218
Hospital	20	6	184
Patient	0	1	20
DNA	1	1	14
Session Util Exc Overruns (with TAT)	83.8%	85.5%	82.7%
Session Util Exc Overruns (without TAT)	69.4%	72.4%	72.0%
% Surgical Time (Cut to close)	42.3%	41.0%	42.5%

T&O RTT activity and trajectory

In order to deliver improved RTT performance in T&O need to provide enough capacity to match current demand i.e. 105 cases per week plus reduce its backlog. Given the amount of cancellations across the last 2 years the backlog is now in excess of 800 patients therefore the backlog reduction is proposed to be completed across 2 years i.e. reduction by 400 per year

Ring fencing orthopaedic beds at Tunbridge Wells

A substantial risk to this project is the possibility of escalation of NE patients into elective orthopaedic beds. A review of capacity and demand has shown the need for 17 beds for orthopaedics across the trust in an average week. 12 beds are allocated in the MOU and 10 beds are being established in Ward 30 at TWH to create the Tunbridge Wells Orthopaedic Ward. These beds provide sufficient capacity for peaks and troughs in elective throughput. It should also be noted that 60% of the waiting list is day cases and this activity can continue with little interruption from non elective cases. Additionally improved booking processed will ensure that beds are not free to allow emergency admissions access and a ring fencing policy with heightened escalation will allow us to treat orthopaedic patients with the same priority as cancer patients. These actions; dedicated ward, escalation policy, improved booking, priority patient status will ensure that we move toward the mindset that orthopaedic patients are not cancelled.

Impact on other surgical directorates

These changes have been agreed with the individual directorates who are managing this by a combination of moving sessions to Maidstone and moving work from Day Case to Out Patients to free up surgeons to undertake more sessions on the TWH site. Any reductions to job plans will be captured as part of the relevant Directorate CIP schemes put forward for 17/18.

CEPOD/trauma changes

Non elective utilisation is currently showing high performance, utilisation has been 124% on average for the past 3 months. However despite this improvements to CEPOD and trauma capacity are needed as significant volumes of patients have delays to surgery as there is no free capacity to add additional cases on to lists and therefore patients wait in beds or at home for surgery.

An audit of trauma between 1st April 2015 and 29th April 2016 showed 2536 patients requiring surgery. Analysis revealed demand as follows:

	Demand in mins per day	Theatre capacity in mins per day	Gap
Weekend	650	480	170
Weekday	**800**	660	140

Based on this analysis a requirement of **800** minutes per day for trauma was calculated, this means on average 2.3 hours of additional theatre time are required. To cope with peaks and troughs in activity an additional session per week day is needed to help manage demand and so reduce the number of cancelled cases that occur.

The situation has not improved since 2015/16, during an audit undertaken in a four week period in Feb/March 2017, on average 13 (range 6-20) people are on the trauma board that aren't listed for theatre each day, this includes fractured neck of femur patients who are delayed beyond the treatment target time of day of/next day after admission. Patients are routinely managed on additional lists and by utilising elective lists which are under booked due to the lack of beds.

Current length of stay for orthopaedic non elective patients is 11.08 day (Q4 2016/17), we aim to reduce this to 10.05 days.

Improving trauma capacity and thereby delays will create a better service for the trauma patients, reduce their length of stay, reduce mortality and allow elective capacity to occur without interruption. This is a unique opportunity to improve both elective and trauma throughput at the same time.

Orthopaedic Medical Staff

In order to achieve this plan there is a need to review the job plans of each Orthopaedic Consultant. This work will start in May in order for the changes to be delivered in July 2017. The revised theatre

timetable will be matched to consultant job plans, with the aim of increasing their work broadly by one session each per week.

One consultant is due to retire this summer and rather than replace him with a similar job plan a new locum will be appointed on a 12 month fixed term contract with the sole aim of providing cover to other consultants for annual leave, particularly operating on patients requiring hip or knee replacements. This will enable the directorate to move beyond a 38 week capacity plan.

Additional the middle grade structure is being reviewed to allow the appointment of Clinical Fellows who are post CST (Core Surgical Training) so that they can undertake procedures.

Consultant Anaesthetists

Consultant Anaesthetists are currently working to full capacity. In a full time consultant job plan we can expect that they will do 6.25 PAs of clinical time. 2 additional consultants are therefore required for the additional 13 sessions which will be undertaken in theatre six.

In theatre seven and eight where the majority of emergency work will be undertaken, with the current staffing levels a Consultant and staff grade or registrar would work side by side with the Consultant moving from one theatre to the other. Clearly this way of managing patients and lists results in delays at the beginning and between cases. This can also mean that on occasions a registrar is managing some of the sickest patients, i.e. an emergency laparotomy, without direct supervision; this is a clinical risk. In order to provide consultant led cover for these theatres the equivalent of 2 additional consultants are needed too.

Total anaesthetic requirements are therefore 4 additional Consultant Anaesthetists.

Establish an admissions lounge within Short Stay unit at TWH

During May's rapid improvement week the Admissions Lounge was implemented and the concept tested of using the holding bay in theatres for patients prepared for surgery and changed in theatre gowns as the SSSU was escalated. Patients were admitted and held in the SSSU reception area. They were reviewed by the nursing staff, operating surgeon and the anaesthetist via the single consulting rooms using an orderly system. When theatres were ready for the patient, they were prepared in the patient changing rooms and escorted via the middle corridor to the holding bay in order to preserve privacy and dignity. The holding bay was split into male and female waiting areas and the patients were checked into theatre from here.

The Admissions Lounge facilitated improved theatre utilisation for ENT, Gynae , Trauma and General Surgical patients as follows

- Session utilisation improved from 88.4% to 88.8%
- Significant delays of 30 mins or more decreased from 52% to 50%. The lowest it's been since Oct 2016.
- Significant delays of 60 mins or more decreased from 11% to 9%. The lowest it's been since Oct 2016.
- Session overruns decreased from 84.7% to 84.3%.

Therefore the pilot highlighted the benefits of putting in place an admissions lounge model substantively on this site. However the pilot revealed that his will require the recruitment of a separate nursing team to facilitate the Admissions Lounge process to enable this to continue despite escalation of SSSU. Once in place permanently this will assist in improving theatre productivity.

Option 3 Extend facilities at Maidstone

Description – either extend MOU or use an existing theatre on the Maidstone site to provide an additional theatre for 12 months of the year

Key activity and financial assumptions – 1150 cases per annum to be moved from outsourcing to onsite activity approximately 115 per month , capital and revenue costs have not been finalised however capital costs are substantial circa £5M plus and would take a long time to put into place unless a drop in theatre was considered.

Non-financial risk associated with the option –There is no laminar flow in theatre 4 at Maidstone, additionally the theatre facility is not fit for purpose and there is a need for a strategic review. Increasing theatre capacity for orthopaedics on the Maidstone site is not currently part of the strategic plan for the health economy. However, changes with the STP might make this a viable alternative in a few years and discussions are currently ongoing surrounding a Kent wide plan for elective Orthopaedics.

Non-financial benefits associated with the option – Less reliance on our ability to ring fence beds at TWH improved continuity of care, organisational reputation maintained, improved training opportunities for junior doctors, improved opportunity for surgical skills, LOS reduction and reduced risk of infection

4a. Summary of non-monetary benefits and risks of each option

Non - monetary benefits and risks of each option -		
Option	**Benefits and risks**	**Option benefit and risk score and/or rank**
Option 1 **Do nothing**	Benefits – minimal benefits to trust, endless capacity in independent sector to accommodate additional work Risks - £5.7M budget required to fund outsourcing requirements, organisational reputation risk, no longer viable with AIC in place.	Rank 3
Option 2 **Reconfigure theatres at TWH including opening theatre six , reallocating Theatre 3 and continuing MOU**	Benefits – a £2.17M FYE CIP, patients treated on site, can be delivered in a short timescale, supports RTT trajectory. Reduced LOS for non-elective surgery and improved theatre capacity for CEPOD, planned trauma and elective orthopaedics Risks – inability to risk fence beds at TWH, staff recruitment delays, theatre utilisation not improved	Rank 1
Option 3 **Extend Maidstone facilities**	Benefits – Orthopaedic beds can be ring fenced as on non-emergency site, likely to produce a CIP Risks – Cannot be delivered quickly, not currently part of strategic plan, substantial capital commitment	Rank 2

4b. Summary of information on each option

Category	Option 1	Option 2	Option 3
Capital costs *(One off upfront costs)*	Nil	£462,000	Substantial
A) Annual revenue income	Nil under AIC		
B) Annual costs/ expenses (pay and non-pay)	£5,779,000	£3,610,000	Not known
C) Annual savings (pay and non-pay)	Nil	£5,779,000	Not known
Net annual benefit = (A –B + C)	-£5,779,000	£2,170,000	Not known
Benefits *(non-financial)* score *and or rank of option* **and Risks** score *and or rank of option*	Rank 3, no longer a viable option with AIC	Rank 1	Rank 2, due to capital costs and lead in time
Summary of option (Preferred / discounted/ deferred)	Discounted	*Preferred*	Deferred

4c. Directorate decision on which option is preferred and why

Option 2 is the preferred option as it:

- Delivers substantial CIP for 2017/18 of £2.17 million
- Supports RTT trajectory
- Is consistent with aligned incentives contract
- Improves trauma capacity
- Commits the directorate to deliver improved theatre utilisation
- Maintains activity during the working day and within the Trust
- Supports job planning changes for Consultant Orthopaedic Surgeons and Anaesthetists
- Improves opportunities for junior doctor surgical experience
- Improves theatre productivity
- Improves patient flow and quality of care
- Reduces capital commitment compared to new build on the Maidstone site
- Ensures activity is minimised during the winter months
- Ensure ring fenced beds at TWH for elective activity
- Fits with the Trust and CCGs strategic plan
- Can be delivered in July 2017

5. Commercial considerations (preferred option)

5.a. Services and/or assets required

Orthopaedic equipment was moved from theatre six to the reopened MOU in December 2016. There is therefore a need to re-equip theatre six to allow orthopaedic surgery to be undertaken. Equipment required is outlined in Appendix two.

5.b. Procurement route

Formal quotes have already been received and procurement can proceed rapidly once approval is received. Equipment has a likely lead time of up to 12 weeks, so promote approval is needed to ensure theatre six can open at the end of June 2017.

5.c. Activity and service level agreement (SLA) implications / Commissioner involvement and input.

Under the AIC we do not need to agree changes to the contract with the Commissioners as the same volume of work will be completed internally and quicker than before. Any reduction in orthopaedic backlog would need either other areas over performing against RTT standard to be reduced to enable budget to be transferred to Orthopaedics to cover extra activity or further discussions would be needed with CCG if this was not enough.

5.d. Workforce impact of preferred option

Staff type & band	Current staffing (WTE)	Change (WTE)	The resulting staffing (WTE)
Theatre staff (includes porter)	109.97	+7.29	117.26
Consultant Anaesthetist staff	34.19	+4.00	38.19
Radiographer x Band 5	66.97	+1.00	67.97
Pharmacist x Band 8a and Band 4	123.16	+2.00	125.16
Medical Record resource x band 2	103.26	+0.50	103.76
CAU x Band 3	25.35	+1.00	26.35
Admissions trained nurse	16.03	+1.45	17.48
Admissions CSW	7.15	+1.45	8.60
Admissions receptionist	1.15	+1.38	2.53

5.e. Public

The preferred option provides patients particularly from Maidstone more choice as to which site to have their major orthopaedic procedures than previously, as before MOU opened, all inpatients had to be admitted to Tunbridge Wells, unless they were outsourced.

6. Financial impact of the preferred option –
Full year effect – include VAT unless recoverable

Breakdown of financial impacts	Yr 1 (M4-12) £'000	Yr 2 £'000	Yr 3 £'000	Yr 4 £'000	Yr 5 £'000
See appendix three					
Summarise the activity and income assumptions relating to the preferred option					
Depreciation for the additional theatre 6 capital purchases is based on a useful asset life of 5 years					

Funding source/ body		
Identified in the Trust capital equipment programme	£410,000 £52,000 additional capital bid to be submitted	
Identified in directorate revenue budget	£5,779,884	
Other *(specify)*		

7. Quality Impact Assessment (preferred option)

Quality Impact Assessment	*The Management Case*
Clinical Effectiveness	
Have clinicians been involved in the service redesign? If yes, list who. Clinical Director, James Nichol; all other T&O consultants attending the Directorate meeting in March , and via various emails plus discussion at Planned Care Divisional Board also in March	
Has any appropriate evidence been used in the redesign? (e.g. NICE guidance)	
Following GIRFT guidance on ring fencing elective orthopaedics	
Are relevant Clinical Outcome Measures already being monitored by the Directorate? If yes, list. If no, specify additional outcome measures where appropriate.	
• LOS • SSI • Theatre efficiency through Theatre Utilisation Board • Friends and Family survey • RTT • PROMS data collected on all THRs and TKRs • NJR data submitted monitors surgical outcome (national database)	
Are there any risks to clinical effectiveness? If yes, list. • Lack of beds on the TWH site • Cancellation of surgery due to lack of theatre equipment and implant availability	
Have the risks been mitigated? • Lists to be managed to ensure equipment availability • Orthopaedic ring fenced policy to be reinforced between July and Dec	
Have the risks been added to the departmental risk register and a review date set? Not to date. This will be actioned shortly	
Are there any benefits to clinical effectiveness? If yes, list • Better patient flow • Reduced length of stay • Positive impact on RTT • Reduced reliance on outsourced capacity	
Patient Safety	
Has the impact of the change been considered in relation to:	
Infection Prevention and Control?	Y
Safeguarding vulnerable adults/ children?	Y
Current quality indicators?	Y
Quality Account priorities?	Y
CQUINS?	Y
Are there any risks to patient safety? If yes, list • Risk of infection in the event of risk fenced beds being breached due to winter pressures	
Have the risks been mitigated? • Policy re consultant on site reviews all patients on the ward to be put in place • Trust policy states T&O ring fenced beds will not be breached. • Formal escalation policy required and de-escalation SOP required (deep clean)	
Have the risks been added to the departmental risk register and a review date set? Not to date. This will be actioned shortly	

Are there any benefits to patient safety? If yes, list.
• Formal ring fencing will reduce SSI risk as per GIRFT • Dedicated theatre team will improve theatre efficiency and patient safety
Patient experience
Has the impact of the redesign on patients/ carers/ members of the public been assessed? If no, identify why not.
The impact has not been assessed due to the fast pace of the plan. However, the plan is to recommission a previous service which was well known and popular with both staff and patients.
Has the impact of the change been considered in relation to: • Promoting self-care for people with long-term conditions? – Yes no impact • Tackling health inequalities? - Yes no impact
Does the redesign lead to improvements in the care pathway? If yes, identify
Yes, it improves the number of patients through the pathway
Are there any risks to the patient experience? If yes, list
No
Have the risks been mitigated?
NA
Have the risks been added to the departmental risk register and a review date set?
NA
Are there any benefits to the patient experience? If yes, list
• More certainty regarding procedure dates • Lower risk of cancellation on the day due to lack of beds • Improved wait times for surgery • Surgery in theatre with dedicated laminar flow and orthopaedic trained nursing staff • Improved theatre capacity for trauma and CEPOD reducing LOS and speeding up access to emergency surgery
Equality & Diversity
Has the impact of redesign been subject to an Equality Impact Assessment?
Yes
Are any of the 9 protected characteristics likely to be negatively impacted? (If so, please attach the Equality Impact Assessment)
No
Has any negative impact been added to the departmental risk register and a review date set?
NA
Service
What is the overall impact on service quality? – please tick one box

Improves quality	X	Maintains quality		Reduces quality	

Clinical lead comments:
Case is fully supported by all the CD's in Planned care and has been discussed at the Divisional Board. It also has full support from Women's and Children's Division

8. Project management arrangements - outline

Timetable

Milestone	Date
Divisional board approval	March 2017
TME Approval	April 2017
Staff recruitment – at least 12 weeks	April to June 2017
Equipment purchase	April to June 2017
Finance committee	June 2017
Trust Board	June 2017
Planned opening date	October 2017

Business assurance and benefits realisation arrangements

Benefit	Baseline value	Target Value	Measure	Timing	Responsibility
Improved theatre utilisation	Less than 75%	90%	% of used theatre capacity	Monthly	HOPD
RTT trajectory achieved	70%	92%	Weekly activity and waiting list management	Weekly	General Manager T&O and HOPD
Reduction in out sourcing of activity	Currently 96 cases per month	Zero	Activity	Monthly	General Manager T&O and HOPD
Achievement of CIP		£3.678M pa	Budget monitoring	Weekly	General Manager T&O, HOPD and Director of Operations
Theatre reconfiguration mobilisation group		Theatre reconfiguration completed and in place July 2017	Progress against implementation plan	Weekly	General Manager T&O, HOPD and Director of Operations

Risk Management and Contingency plans

See separate file

9. Arrangements for post project evaluation (PPE)

The following template will be used after the project is completed, to assess issues and lessons learned with the planning for the investment and to what extent the expected benefits were achieved.

Complete the following section now

Name of Division/Directorate – Planned care
Evaluation manager – Beverley Williams, HOPD
Project Title & Reference - Reconfigure capacity at TWH - to increase orthopaedic activity, reduce outsourcing and re-open theatre six at TWH and increase CEPOD/ Planned Trauma capacity to reduce surgical non elective LOS

Total Cost - £3,610,000 (Full year costs)
Start date – April 2017
Completion date – 3/7/17
Post project evaluation Due Date – October 2017

Complete this section by PPE due date

Section 1 INTRODUCTION

Background (a brief description of the project and its objectives)
Please give details of commencement of scheme, when staff were appointed and when full capacity was achieved.

SECTION 2: PROJECT PROCESS EVALUATION

Project documentation issues
Project execution issues
Project governance issues
Project funding issues
Human resource issues
Information issues
What worked well in developing case?
What could be improved in developing a case?
Summary of recommendations for developing a case

SECTION 3: ACHEIVEMENT OF OBJECTIVES

Did this Investment meet objectives?
Objective 1
Objective 2
Objective 3 How were they achieved?

SECTION 4: BENEFITS

Benefits planned in original Business Case (See benefits profile – attached below)
Benefit 1
Benefit 2
Benefit 3
Actual Outcome
(Please comment on variances or delays etc.)
How were benefits and outcomes evidenced? Please give details of such.

SECTION 5: VALUE FOR MONEY

What methodology was used to assess quality, funding and affordability and value for money of service provided? What were the conclusions?

SECTION 6: RECOMMENDATIONS AND LESSONS LEARNED

What problems were encountered during implementation of the project, and how where such resolved? What was learned, how has this been disseminated, and to whom? Please provide supporting evidence.

10. Appendices

Appendix one Current and proposed theatre plan

Appendix two Equipment costs

Appendix three Budget and expenditure for preferred option

Appendix four Risk register summary

CURRENT SESSIONS

FORWARD PLANNING(as at Feb17) - USE OF TWH3 TWH5 & TWH6

Tunbridge Wells	MONDAY			TUESDAY		WEDNESDAY			THURSDAY			FRIDAY	
THEATRES	**am(8:30-12:30)**	**pm (13:30-17:30)**	**Eve**	**am(8:30-12:30)**	**pm (13:30-17:30)**	**am(8:30-12:30)**	**pm (13:30-17:30)**	**Eve**	**am(8:30-12:30)**	**pm (13:30-17:30)**	**Eve**	**am(8:30-12:30)**	**pm (13:30-17:30)**
WEEK 1	**1st MONDAY**			**1st TUESDAY**		**1st WEDNESDAY**			**1st THURSDAY**			**1st FRIDAY**	
Theatre 1	DATTA(ENT Paeds)	VO(ENT)		LLOYD R (ENT)	DATTA (ENT)	HAMANN (ENT)	CHEANG (ENT)		LLOYD R (ENT)	DATTA (ENT)		**DANI (BREAST)**	**DANI (BREAST)**
Theatre 2	**BAILEY C (LGI)**	**LAWES D (LGI)**		CHAPPATTE (W&C)	CHAPPATTE (W&C)	SLACK (W&C)	SLACK (W&C)		TYRRELL (VASCULAR)	TYRRELL (VASCULAR)		BOYLE (UGI)	BOYLE (UGI)
Theatre 3	CHEANG (ENT)	ABDULAAL/HASAN(UGI) (ACUTE)		SLATER G (T&O)	SLATER G(T&O)	NICHOLL (T&O)			FORDER (T&O)	T&O TEAM(T&O)	T&O TEAM(T&O)	NICHOLL (T&O)	NICHOLL (T&O)
Theatre 4	NAZIA (W&C)	MOTH (W&C)		MOTH (W&C)	MOTH (W&C)	HENDERSON (UROL)	SHOTTON (ENT)		WILCOX (W&C)	FLINT (W&C)		PEROVIC (W&C)	PEROVIC(W&C)
Theatre 5	KATCHBURIAN (T&O)	KATCHBURIAN (T&O)		RITCHIE (T&O)	RITCHIE (T&O)	VELAYUDHAM (T&O)	VELAYUDHAM (T&O)		ROSE (T&O)	ROSE (T&O)		AYODELE(T&O) Paeds	AYODELE T&O (Paeds)
Theatre 6	CLOSED	CLOSED		CLOSED	CLOSED	CLOSED	CLOSED		CLOSED	CLOSED		CLOSED	CLOSED
WEEK 2	**2nd MONDAY**			**2nd TUESDAY**		**2nd WEDNESDAY**			**2nd THURSDAY**			**2nd FRIDAY**	
Theatre 1	HAMANN (ENT)	HAMANN (ENT)		VO (ENT)	SHOTTON 2PM (ENT)	MASKELL (ENT)	MASKELL (ENT)		SHOTTON (ENT)	CHEANG (ENT)		LLOYD R (ENT)	LLOYD R (ENT)
Theatre 2	DATTA (ENT)	DATTA (ENT)		CHAPPATTE (W&C)	CHAPPATTE (W&C)	SLACK (W&C)	SLACK (W&C)		DONOHUE (UROL)	PRIVATE		CONNELL (W&C)	CONNELL (W&C)
Theatre 3	AYODELE (T&O)	AYODELE (T&O)		BENSON (T&O)	BENSON (T&O)	ROWSON (EYES)			FORDER (T&O)	FORDER (T&O)		NICHOLL (T&O)	NICHOLL (T&O)
Theatre 4	**BAILEY C (LGI)**	ABDULAAL/HASAN(UGI) (ACUTE)		MOTH (W&C)	MATTHEWS (W&C)	CYNK (UROL)	SHOTTON (ENT)		KOVOOR (W&C)	KOVOOR (W&C)		**CHALMERS/COX (BREAST)**	**CHALMERS/COX (BREAST)**
Theatre 5	GIBB (T&O)	GIBB(T&O)		RITCHIE (T&O)	RITCHIE (T&O)	RAVIKUMAR (T&O)	RAVIKUMAR (T&O)		ROSE (T&O)	ROSE (T&O)		JAHNICH(T&O)	JAHNICH (T&O)
Theatre 6	CLOSED	CLOSED		CLOSED	CLOSED	CLOSED	CLOSED		CLOSED	CLOSED		CLOSED	CLOSED
WEEK 3	**3rd MONDAY**			**3rd TUESDAY**		**3rd WEDNESDAY**			**3rd THURSDAY**			**3rd FRIDAY**	
Theatre 1	SHOTTON (ENT)	HAMANN (ENT)		LLOYD R (ENT)	DATTA (ENT)	MASKELL (ENT)	SHOTTON (ENT)		SHOTTON (ENT)	LLOYD R (ENT)		LLOYD R (ENT)	CHEANG (ENT)
Theatre 2	**BAILEY C (LGI)**	**LAWES (LGI)**		CHAPPATTE (W&C)	CHAPPATTE (W&C)	SLACK (W&C)	SLACK (W&C)		TYRRELL (VASCULAR)	TYRRELL (VASCULAR)		DATTA (W&C)	DATTA (W&C)
Theatre 3	CHEANG (ENT)	CHEANG (ENT)		UGI TEAM	BENSON (T&O)	VO (ENT)			T&O TEAM	T&O TEAM	T&O TEAM(T&O)	NICHOLL (T&O)	DATTA (ENT)
Theatre 4	CONNELL (W&C)	CONNELL (W&C)		KOVOOR (W&C)	KOVOOR(W&C)	HENDERSON (UROL)	MASKELL (ENT)		DATTA (W&C)	FLINT (W&C)		**CHALMERS/COX (BREAST)**	**CHALMERS/COX (BREAST)**
Theatre 5	KATCHBURIAN (T&O)	KATCHBURIAN (T&O)		BOWMAN (T&O)	BOWMAN (T&O)	BENSON (T&O)	BENSON (T&O)		FORDER (T&O)	FORDER (T&O)		DAVID (T&O)	DAVID (T&O)
Theatre 6	CLOSED	CLOSED		CLOSED	CLOSED	CLOSED	CLOSED		CLOSED	CLOSED		CLOSED	CLOSED

WEEK 4	**4th MONDAY**			**4th TUESDAY**		**4th WEDNESDAY**			**4th THURSDAY**			**4th FRIDAY**	
Theatre 1	HAMANN (ENT)	HAMANN (ENT)		LLOYD R (ENT)	SHOTTON 2PM (ENT)	MASKELL (ENT)	ABDULAAL/HASAN (UGI) (ACUTE)		LLOYD R (ENT)	VO (ENT)		LLOYD R (ENT)	CHEANG (ENT)
Theatre 2	**BAILEY C (LGI)**	ABDULAAL/HASAN (UGI (ACUTE)		CHAPPATTE (W&C)	CHAPPATTE (W&C)	SLACK (W&C)	SLACK (W&C)		DONOHUE (UROL)	PRIVATE		CONNELL (W&C)	CONNELL (W&C)
Theatre 3	AYODELE (T&O)	AYODELE (T&O)		BENSON (T&O)	BENSON (T&O)	CYNK (UROL)	SHETTY (T&O)		FORDER (T&O)	FORDER (T&O)		NICHOLL (T&O)	NICHOLL (T&O)
Theatre 4	**BREAST TEAM**	PRIVATE		HENDERSON (W&C)	MATTHEWS (W&C)	ROWSON (EYES)	SHOTTON (ENT)		KOVOOR (W&C)	KOVOOR (W&C)		**DEVALIA (BREAST)**	**DEVALIA (BREAST)**
Theatre 5	GIBB (T&O)	GIBB (T&O)		RITCHIE (T&O)	RITCHIE (T&O)	VELAYUDHAM (T&O)	VELAYUDHAM (T&O)		ROSE (T&O)	ROSE (T&O)		JAHNICH (T&O)	JAHNICH (T&O)
Theatre 6	CLOSED	CLOSED		CLOSED	CLOSED	CLOSED	CLOSED		CLOSED	CLOSED		CLOSED	CLOSED
WEEK 5	**5th MONDAY**			**5th TUESDAY**		**5th WEDNESDAY**			**5th THURSDAY**			**5th FRIDAY**	
Theatre 1	CHEANG (ENT)	MASKELL (ENT)		LLOYD R (ENT)	CHEANG (ENT)	HAMANN (ENT)	ABDULAAL/HASAN (UGI) (ACUTE)		LLOYD R (ENT)	VO (ENT)		LLOYD (ENT)	CHEANG (ENT)
Theatre 2	**BAILEY C (LGI)**	ABDULAAL/ HASAN (ACUTE) (UGI)		CHAPPATTE (W&C)	CHAPPATTE (W&C)	SLACK (W&C)	SLACK (W&C)		DONOHUE (UROL)	PRIVATE		CONNELL (W&C)	CONNELL (W&C)
Theatre 3	AYODELE (T&O)	AYODELE (T&O)		BENSON (T&O)	BENSON (T&O)	HENDERSON (UROL)	SHETTY (T&O)		FORDER (T&O)	FORDER (T&O)		NICHOLL (T&O)	NICHOLL (T&O)
Theatre 4	**BREAST TEAM**	PRIVATE		HENDERSON (W&C)	GYNAE TEAM(W&C)	DATTA (ENT)	SHOTTON (ENT)		BAJRACHARYA (W&C)	BAJRACHARYA (W&C)		**DANI (BREAST)**	**DANI (BREAST)**
Theatre 5	GIBB (T&O)	GIBB (T&O)		RITCHIE (T&O)	RITCHIE (T&O)	VELAYUDHAM (T&O)	VELAYUDHAM (T&O)		ROSE (T&O)	ROSE (T&O)		AYODELE(T&O) Paeds*	AYODELE (T&O) (Paeds)*
Theatre 6	CLOSED	CLOSED		CLOSED	CLOSED	CLOSED	CLOSED		CLOSED	CLOSED		CLOSED	CLOSED

PROPOSED CHANGES FOR ORTHOPAEDIC ELECTIVES – NOTE CEPOD / PLANNED TRAUMA WILL TAKE PLACE IN VACANT SESSIONS IN THEATRE 3

WEEK ONE													
TWH3	CHEANG (ENT)	ABDULAAL/HASAN(UGI) (ACUTE)											
TWH5	KATCHBURIAN (T&O)	KATCHBURIAN (T&O)		RITCHIE (T&O)	RITCHIE (T&O)	VELAYUDHAM (T&O)	VELAYUDHAM (T&O)		ROSE (T&O)	ROSE (T&O)		AYODELE(T&O) Paeds	AYODELE T&O (Paeds)
TWH6	VACANT FOR ORTHO	VACANT FOR ORTHO		SLATER G (T&O)	SLATER G(T&O)	NICHOLL (T&O)	VACANT FOR ORTHO		FORDER (T&O)	T&O TEAM(T&O)	T&O TEAM(T&O)	NICHOLL (T&O)	NICHOLL (T&O)
WEEK TWO													
TWH3						ROWSON (EYES)							
TWH5	GIBB (T&O)	GIBB(T&O)		RITCHIE (T&O)	RITCHIE (T&O)	RAVIKUMAR (T&O)	RAVIKUMAR (T&O)		ROSE (T&O)	ROSE (T&O)		JAHNICH(T&O)	JAHNICH (T&O)
TWH6	AYODELE (T&O)	AYODELE (T&O)		BENSON (T&O)	BENSON (T&O)	VACANT FOR ORTHO	VACANT FOR ORTHO		FORDER (T&O)	FORDER (T&O)		NICHOLL (T&O)	NICHOLL (T&O)
WEEK THREE													
TWH3	CHEANG (ENT)	CHEANG (ENT)		UGI TEAM		VO (ENT)							DATTA (ENT)
TWH5	KATCHBURIAN (T&O)	KATCHBURIAN (T&O)		BOWMAN (T&O)	BOWMAN (T&O)	BENSON (T&O)	BENSON (T&O)		FORDER (T&O)	FORDER (T&O)		DAVID (T&O)	DAVID (T&O)
TWH6	VACANT FOR ORTHO	VACANT FOR ORTHO		VACANT FOR ORTHO	BENSON (T&O)	VACANT FOR ORTHO	VACANT FOR ORTHO		T&O TEAM	T&O TEAM	T&O TEAM(T&O)	NICHOLL (T&O)	
WEEK FOUR													
TWH3						CYNK (UROL)							
TWH5	GIBB (T&O)	GIBB (T&O)		RITCHIE (T&O)	RITCHIE (T&O)	VELAYUDHAM (T&O)	VELAYUDHAM (T&O)		ROSE (T&O)	ROSE (T&O)		JAHNICH (T&O)	JAHNICH (T&O)
TWH6	AYODELE (T&O)	AYODELE (T&O)		BENSON (T&O)	BENSON (T&O)	VACANT FOR ORTHO	SHETTY (T&O)		FORDER (T&O)	FORDER (T&O)		NICHOLL (T&O)	NICHOLL (T&O)
WEEK FIVE													
TWH3						HENDERSON (UROL)							
TWH5	GIBB (T&O)	GIBB (T&O)		RITCHIE (T&O)	RITCHIE (T&O)	VELAYUDHAM (T&O)	VELAYUDHAM (T&O)		ROSE (T&O)	ROSE (T&O)		AYODELE(T&O) Paeds*	AYODELE (T&O) (Paeds)*
TWH6	AYODELE (T&O)	AYODELE (T&O)		BENSON (T&O)	BENSON (T&O)	VACANT FOR ORTHO	SHETTY (T&O)		FORDER (T&O)	FORDER (T&O)		NICHOLL (T&O)	NICHOLL (T&O)

Appendix Two

Theatre equipment requirements and associated costs:

THEATRE EQUIPMENT		COST		COST + VAT
Tendon harvester x 4	£	4,923	£	5,908
Electrosurgical generator	£	7,500	£	9,000
Trauma CAD	£	12,000	£	14,400
Shoulder positioner	£	6,223	£	7,468
T30 operating table	£	27,236	£	32,683
ACL sets	£	45,000	£	54,000
Theatre CAD	£	12,000	£	14,400
Stryker arm board	£	3,510	£	4,212
ACL tendon harvester x 4	£	2,911	£	3,493
Other theatre instrumentation	£	150,146	£	180,175
Image Intensifier	*£*	*100,000*	*£*	*120,000*
Total	*£*	*371,449*	*£*	*445,739*
including contingency	£	13,572.45	£	16,287
GRAND TOTAL	**£**	**385,021**	£	462,026

Appendix 3

Phased costs and savings for 42week operating	Year 1 (2017/18) Finances £													Year 2 £	Year 3 £	Year 4 £	Year 5 £	WTE					
	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	TOTAL	TOTAL	TOTAL	TOTAL	TOTAL	M7	M8	M9	M10	M11	M12
Pay																							
Theatre staff							14,914	14,914	14,914	14,914	14,914	14,914	**89,482**	**178,963**	**178,963**	**178,963**	**178,963**	6.51	6.51	6.51	6.51	6.51	6.51
Theatre staff costed at agency							8,202	8,202	8,202	8,202	8,202	8,202	**49,215**	**98,430**	**98,430**	**98,430**	**98,430**	0.00	0.00	0.00	0.00	0.00	0.00
Anaesthetist staff							39,380	39,380	39,380	39,380	39,380	39,380	**236,277**	**472,555**	**472,555**	**472,555**	**472,555**	4.00	4.00	4.00	4.00	4.00	4.00
Anaesthetic staff costed at locum rates							21,659	21,659	21,659	21,659	21,659	21,659	**129,953**	**259,905**	**259,905**	**259,905**	**259,905**	0.00	0.00	0.00	0.00	0.00	0.00
Surgeon assistant							0	0	0	0	0	0	**0**	**0**	**0**	**0**	**0**	0.00	0.00	0.00	0.00	0.00	0.00
Ward Staff							0	0	0	0	0	0	**0**	**0**	**0**	**0**	**0**	0.00	0.00	0.00	0.00	0.00	0.00
Therapies							0	0	0	0	0	0	**0**	**0**	**0**	**0**	**0**	0.00	0.00	0.00	0.00	0.00	0.00
Radiology							2,635	2,635	2,635	2,635	2,635	2,635	**15,812**	**31,625**	**31,625**	**31,625**	**31,625**	1.00	1.00	1.00	1.00	1.00	1.00
Pharmacy							6,906	6,906	6,906	6,906	6,906	6,906	**41,437**	**82,875**	**82,875**	**82,875**	**82,875**	2.00	2.00	2.00	2.00	2.00	2.00
Pharmacy staff costed at agency rate							0	0	0	0	0	0	**0**	**0**	**0**	**0**	**0**	0.00	0.00	0.00	0.00	0.00	0.00
Cleaning							945	945	945	945	945	945	**5,671**	**11,341**	**11,341**	**11,341**	**11,341**	0.10	0.10	0.10	0.10	0.10	0.10
Portering							2,586	2,586	2,586	2,586	2,586	2,586	**15,515**	**31,030**	**31,030**	**31,030**	**31,030**	0.77	0.77	0.77	0.77	0.77	0.77
CAU staffing - band 3							1,844	1,844	1,844	1,844	1,844	1,844	**11,067**	**22,133**	**22,133**	**22,133**	**22,133**	1.00	1.00	1.00	1.00	1.00	1.00
Health records resource							827	827	827	827	827	827	**4,963**	**9,927**	**9,927**	**9,927**	**9,927**	0.50	0.50	0.50	0.50	0.50	0.50
MOU pay costs	108,226	108,226	108,226	108,226	108,226	108,226	108,226	108,226	108,226	108,226	108,226	108,226	**1,298,713**	**1,298,713**	**1,298,713**	**1,298,713**	**1,298,713**						
Admissions Team																							
Band 5 Trained Nurse							3,827	3,827	3,827	3,827	3,827	3,827	**22,960**	**45,919**	**45,919**	**45,919**	**45,919**	1.45	1.45	1.45	1.45	1.45	1.45
Band 2 CSW							2,428	2,428	2,428	2,428	2,428	2,428	**14,570**	**29,140**	**29,140**	**29,140**	**29,140**	1.45	1.45	1.45	1.45	1.45	1.45
Band 2 Receptionist							2,308	2,308	2,308	2,308	2,308	2,308	**13,848**	**27,696**	**27,696**	**27,696**	**27,696**	1.38	1.38	1.38	1.38	1.38	1.38
Total Pay	108,226	108,226	108,226	108,226	108,226	108,226	216,688	216,688	216,688	216,688	216,688	216,688	**1,949,482**	**2,600,252**	**2,600,252**	**2,600,252**	**2,600,252**	20.17	20.17	20.17	20.17	20.17	20.17
Non Pay																							
Energy							6,250	6,250	6,250	6,250	6,250	6,250	**37,500**	**56,250**	**56,250**	**56,250**	**56,250**						
Prostheses / Consumables							74,750	74,750	74,750	74,750	74,750	74,750	**448,500**	**672,750**	**672,750**	**672,750**	**672,750**						
Ward running costs - catering/meal recharges							776	776	776	776	776	776	**4,657**	**6,985**	**6,985**	**6,985**	**6,985**						
Outsourcing for provision for breach patients	58,965	58,965	58,965	58,965	58,965	58,965							**353,789**										
MOU non-pay costs	10,832	10,832	10,832	10,832	10,832	10,832	10,832	10,832	10,832	10,832	10,832	10,832	**129,989**	**129,989**	**129,989**	**129,989**	**129,989**						
Total Non Pay	69,797	69,797	69,797	69,797	69,797	69,797	92,609	92,609	92,609	92,609	92,609	92,609	**974,435**	**865,974**	**865,974**	**865,974**	**865,974**						
Capital Charges - Depreciation and PDC																							
IT				0	0	0	0	0	0	0	0	0	**0**										
Estates				0	0	0	0	0	0	0	0	0	**0**										
Theatres - Furniture and Fittings				0	0	0	0	0	0	0	0	0	**0**										
Theatres - Equipment				8,913	8,913	8,913	8,913	8,913	8,913	8,913	8,913	8,913	**80,219**	**103,725**	**100,491**	**97,256**	**94,022**						
MOU depreciation	3,425	3,425	3,425	3,425	3,425	3,425	3,425	3,425	3,425	3,425	3,425	3,425	**41,100**	**39,922**	**38,744**	**37,565**	**36,387**						
Total Capital Charges	3,425	3,425	3,425	12,338	12,338	12,338	12,338	12,338	12,338	12,338	12,338	12,338	**121,319**	**143,647**	**139,234**	**134,822**	**130,410**						
Total Additional Costs	181,448	181,448	181,448	190,362	190,362	190,362	321,634	321,634	321,634	321,634	321,634	321,634	**3,045,237**	**3,609,872**	**3,605,460**	**3,601,048**	**3,596,635**	20.17	20.17	20.17	20.17	20.17	20.17
Activity and outsourcing reduction																							
2017/18 budgeted outsourcing total	481,657	481,657	481,657	481,657	481,657	481,657	481,657	481,657	481,657	481,657	481,657	481,657	**5,779,884**	**5,779,884**	**5,779,884**	**5,779,884**	**5,779,884**						
Total Cost reduction per Annum	481,657	481,657	481,657	481,657	481,657	481,657	481,657	481,657	481,657	481,657	481,657	481,657	**5,779,884**	**5,779,884**	**5,779,884**	**5,779,884**	**5,779,884**	0.00	0.00	0.00	0.00	0.00	0.00
Total Surplus (+) / Deficit (-) £	300,209	300,209	300,209	291,295	291,295	291,295	160,023	160,023	160,023	160,023	160,023	160,023	**2,734,647**	**2,170,012**	**2,174,424**	**2,178,836**	**2,183,249**	20.17	20.17	20.17	20.17	20.17	20.17

Appendix 4

Project Risk and Issue Register

Project Title	Reopening of theatre six
Project Lead	Jane Rademaker
Executive Sponsor	Anglea Gallagher

Risk Scores	
Low	4
Moderate	0
High	3
Extreme	0
MAX	16

Risk Scores	
Low	4
Moderate	0
High	3
Extreme	0
MAX	9

Risk (not yet occurred)	Date risk applies	Impact should risk occur	Likelihood of risk happening	Risk Score	Priority rating / overall risk assessment	Mitigating actions	Risk to be escalated to the CIP Board?	Date risk notified or amended	Mitigated Impact 1-5	Mitigated Likelihood 1-5	Mitigated Risk Score	Mitigated Priority Rating
Description of the identified risk: please include risks identified in Project Overview		1 - Negligible, 2 - Minor, 3 - Moderate, 4 - Major/Severe, 5 - Catastrophic	1 - Highly unlikely, 2 - Unlikely, 3 - Possible, 4 - Likely, 5 - Certain		(1 - Very Low 5 - Top)	Actions to be taken/being taken						
Cancellation of surgery due to lack of theatre equipment and implant availability	1st July 2017	4	3	12	Low risk	Forward planning of theatre list, close communication between theatre lead and booking staff, movement of equipment between site	No	21-Apr-17	2	2	4	Low risk
Risk of infection in the event of risk fenced beds being breached due to winter pressures	1st July 2017	3	3	9	Low risk	Adherence to infection control policies	No	21-Apr-17	2	2	4	Low risk
Inability to recruit theatre and anaesthetic staff	1st July 2017	2	4	8	Low risk	Rolling adverts, special recruitment events, overseas recruitment	No	21-Apr-17	3	3	9	Low risk
If beds are not ring fenced activity will cease	1st July 2017	4	4	16	High risk	Agreed process and escalation policy, improved booking, treat ortho with same priority as cancer patients	No	21-Apr-17	3	3	9	Low risk
Inability to deliver theatre utilisation project	1st July 2017	4	4	16	High risk	xxxx	No	21-Apr-17	3	3	9	Low risk
Inability to deliver project by July 2017 which will have an impact on the Trust's capacity plan for the year.	1st July 2017	3	3	9	Low risk	Exec approval to proceed in principle to allow plans to be developed, single focus project manager	No	21-Apr-17	3	2	6	Low risk
This plan is a substantial part of the Division's £14M CIP for 2017/18, failure to deliver will result in a significant shortfall.	1st July 2017	4	4	16	High risk	Above actions will mitigate risk, CIP monitored weekly	No	21-Apr-17	3	3	9	Low risk

Maidstone and Tunbridge Wells NHS Trust

Phased costs and savings for 42week operating	Year 1 (2017/18) Finances £													Year 2 £	Year 3 £	Year 4 £	Year 5 £	WTE											
	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	TOTAL	TOTAL	TOTAL	TOTAL	TOTAL	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Pay																													
Theatre staff							14,914	14,914	14,914	14,914	14,914	14,914	**89,482**	**178,963**	**178,963**	**178,963**	**178,963**							6.51	6.51	6.51	6.51	6.51	6.51
Theatre staff costed at agency							8,202	8,202	8,202	8,202	8,202	8,202	**49,215**	**98,430**	**98,430**	**98,430**	**98,430**							0.00	0.00	0.00	0.00	0.00	0.00
Anaesthetist staff							39,380	39,380	39,380	39,380	39,380	39,380	**236,277**	**472,555**	**472,555**	**472,555**	**472,555**							4.00	4.00	4.00	4.00	4.00	4.00
Anaesthetic staff costed at locum rates							21,659	21,659	21,659	21,659	21,659	21,659	**129,953**	**259,905**	**259,905**	**259,905**	**259,905**							0.00	0.00	0.00	0.00	0.00	0.00
Surgeon assistant							0	0	0	0	0	0	**0**	**0**	**0**	**0**	**0**							0.00	0.00	0.00	0.00	0.00	0.00
Ward Staff							0	0	0	0	0	0	**0**	**0**	**0**	**0**	**0**							0.00	0.00	0.00	0.00	0.00	0.00
Therapies							0	0	0	0	0	0	**0**	**0**	**0**	**0**	**0**							0.00	0.00	0.00	0.00	0.00	0.00
Radiology							2,635	2,635	2,635	2,635	2,635	2,635	**15,812**	**31,625**	**31,625**	**31,625**	**31,625**							1.00	1.00	1.00	1.00	1.00	1.00
Pharmacy							6,906	6,906	6,906	6,906	6,906	6,906	**41,437**	**82,875**	**82,875**	**82,875**	**82,875**							2.00	2.00	2.00	2.00	2.00	2.00
Pharmacy staff costed at agency rate							0	0	0	0	0	0	**0**	**0**	**0**	**0**	**0**							0.00	0.00	0.00	0.00	0.00	0.00
Cleaning							945	945	945	945	945	945	**5,671**	**11,341**	**11,341**	**11,341**	**11,341**							0.10	0.10	0.10	0.10	0.10	0.10
Portering							2,586	2,586	2,586	2,586	2,586	2,586	**15,515**	**31,030**	**31,030**	**31,030**	**31,030**							0.77	0.77	0.77	0.77	0.77	0.77
CAU staffing - band 3							1,844	1,844	1,844	1,844	1,844	1,844	**11,067**	**22,133**	**22,133**	**22,133**	**22,133**							1.00	1.00	1.00	1.00	1.00	1.00
Health records resource							827	827	827	827	827	827	**4,963**	**9,927**	**9,927**	**9,927**	**9,927**							0.50	0.50	0.50	0.50	0.50	0.50
MOU pay costs	108,226	108,226	108,226	108,226	108,226	108,226	108,226	108,226	108,226	108,226	108,226	108,226	**1,298,713**	**1,298,713**	**1,298,713**	**1,298,713**	**1,298,713**												
Admissions Team																													
Band 5 Trained Nurse							3,827	3,827	3,827	3,827	3,827	3,827	**22,960**	**45,919**	**45,919**	**45,919**	**45,919**							1.45	1.45	1.45	1.45	1.45	1.45
Band 2 CSW							2,428	2,428	2,428	2,428	2,428	2,428	**14,570**	**29,140**	**29,140**	**29,140**	**29,140**							1.45	1.45	1.45	1.45	1.45	1.45
Band 2 Receptionist							2,308	2,308	2,308	2,308	2,308	2,308	**13,848**	**27,696**	**27,696**	**27,696**	**27,696**							1.38	1.38	1.38	1.38	1.38	1.38
Total Pay	108,226	108,226	108,226	108,226	108,226	108,226	216,688	216,688	216,688	216,688	216,688	216,688	**1,949,482**	**2,600,252**	**2,600,252**	**2,600,252**	**2,600,252**							20.17	20.17	20.17	20.17	20.17	20.17
Non Pay																													
Energy							6,250	6,250	6,250	6,250	6,250	6,250	**37,500**	**56,250**	**56,250**	**56,250**	**56,250**												
Prostheses / Consumables							74,750	74,750	74,750	74,750	74,750	74,750	**448,500**	**672,750**	**672,750**	**672,750**	**672,750**												
Ward running costs - catering/meal recharges							776	776	776	776	776	776	**4,657**	**6,985**	**6,985**	**6,985**	**6,985**												
Outsourcing for provision for breach patients	58,965	58,965	58,965	58,965	58,965	58,965							**353,789**																
MOU non-pay costs	10,832	10,832	10,832	10,832	10,832	10,832	10,832	10,832	10,832	10,832	10,832	10,832	**129,989**	**129,989**	**129,989**	**129,989**	**129,989**												
Total Non Pay	69,797	69,797	69,797	69,797	69,797	69,797	92,609	92,609	92,609	92,609	92,609	92,609	**974,435**	**865,974**	**865,974**	**865,974**	**865,974**												
Capital Charges - Depreciation and PDC																													
IT				0	0	0	0	0	0	0	0	0	**0**																
Estates				0	0	0	0	0	0	0	0	0	**0**																
Theatres - Furniture and Fittings				0	0	0	0	0	0	0	0	0	**0**																
Theatres - Equipment				8,913	8,913	8,913	8,913	8,913	8,913	8,913	8,913	8,913	**80,219**	**103,725**	**100,491**	**97,256**	**94,022**												
MOU depreciation	3,425	3,425	3,425	3,425	3,425	3,425	3,425	3,425	3,425	3,425	3,425	3,425	**41,100**	**39,922**	**38,744**	**37,565**	**36,387**												
Total Capital Charges	3,425	3,425	3,425	12,338	12,338	12,338	12,338	12,338	12,338	12,338	12,338	12,338	**121,319**	**143,647**	**139,234**	**134,822**	**130,410**												
Total Additional Costs	181,448	181,448	181,448	190,362	190,362	190,362	321,634	321,634	321,634	321,634	321,634	321,634	**3,045,237**	**3,609,872**	**3,605,460**	**3,601,048**	**3,596,635**	0.00	0.00	0.00	0.00	0.00	0.00	20.17	20.17	20.17	20.17	20.17	20.17
Activity and outsourcing reduction																													
2017/18 budgeted outsourcing total	481,657	481,657	481,657	481,657	481,657	481,657	481,657	481,657	481,657	481,657	481,657	481,657	**5,779,884**	**5,779,884**	**5,779,884**	**5,779,884**	**5,779,884**												
Total Cost reduction per Annum	481,657	481,657	481,657	481,657	481,657	481,657	481,657	481,657	481,657	481,657	481,657	481,657	**5,779,884**	**5,779,884**	**5,779,884**	**5,779,884**	**5,779,884**	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total Surplus (+) / Deficit (-) £	300,209	300,209	300,209	291,295	291,295	291,295	160,023	160,023	160,023	160,023	160,023	160,023	**2,734,647**	**2,170,012**	**2,174,424**	**2,178,836**	**2,183,249**	0.00	0.00	0.00	0.00	0.00	0.00	20.17	20.17	20.17	20.17	20.17	20.17