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

NHS Maidstone and Tunbridge Wells NHS Trust

10am – c.12.30pm WEDNESDAY 18TH OCTOBER 2017

PENTECOST/SOUTH ROOMS, THE ACADEMIC CENTRE, MAIDSTONE HOSPITAL

A G E N D A – 'PART 1'

Ref.	Item	Lead presenter	Attachment
10-1	To receive apologies for absence	Chair of the Trust Board	Verbal
10-2	To declare interests relevant to agenda items	Chair of the Trust Board	Verbal
10-3	Minutes of the 'Part 1' meeting of 7th September 2017	Chair of the Trust Board	1
10-4	To note progress with previous actions	Chair of the Trust Board	2
10-5	Safety moment	Chief Nurse	Verbal
10-6	Chair's report	Chair of the Trust Board	3
10-7	Chief Executive's report	Acting Chief Executive	4 (to follow)
	Presentation from a Clinical Directorate		
10-8	Acute & Emergency	Clinical Director / General Manager / Lead Matron	Presentation
10-9	Integrated Performance Report for September 2017	Acting Chief Executive	
	▪ Effectiveness / Responsiveness	Chief Operating Officer	
	▪ Safe / Effectiveness / Caring	Chief Nurse	
	▪ Safe / Effectiveness (incl. mortality)	Medical Director	5
	▪ Safe (infection control)	Dir. of Infect. Prev. & Control	
	▪ Well-Led (finance)	Director of Finance	
	▪ Well-Led (workforce)	Acting Chief Executive	
	Quality items		
10-10	Update on the anticipated inspection by the CQC	Chief Nurse	6
10-11	Planned and actual ward staffing for Aug and Sept 2017	Chief Nurse	7
10-12	Review of clinical outcomes	Medical Director	8
10-13	Quarterly mortality data (incl. Policy for Undertaking Mortality Case Record Reviews)	Medical Director	9
	Planning and strategy		
10-14	Update on the Kent & Medway Sustainability and Transformation Partnership (STP)	Acting Chief Executive	Verbal
10-15	To approve the Trust's strategy	Acting Chief Executive	10 (to follow)
10-16	Update on the 2017/18 Winter & Operational Resilience Plan	Chief Operating Officer	11
	Assurance and policy		
10-17	Self-assessment against the Well Led Framework	Chief Nurse	12 (to follow)
10-18	Ratification of revised Policy and Procedure for the production, approval and ratification of Trust-wide Policies and Procedures ("Policy for Policies")	Trust Secretary	13
	Reports from Trust Board sub-committees (and the Trust Management Executive)		
10-19	Quality Committee, 11/09/17 & 13/09/17	Committee Chair	14
10-20	Audit and Governance Committee, 27/09/17 (incl. the Annual Audit Letter for 2016/17)	Committee Chair	15
10-21	Patient Experience Committee, 05/10/17	Committee Chair	16
10-22	Trust Management Executive (TME), 20/09/17 & 11/10/17	Committee Chair	17 (to follow)
10-23	Finance and Performance Committee, 25/09/17 &16/10/17	Committee Chair	18 & 19 (to follow)
10-24	Charitable Funds Committee, 16/10/17	Committee Chair	Verbal
	Other matters		
10-25	Proposed amendment to the Terms of Reference of Trust Board sub-committees	Trust Secretary	20
10-26	Board members' hospital visits	Trust Secretary	21
10-27	**To consider any other business**		
10-28	**To receive any questions from members of the public**		
10-29	To approve the motion (to enable the Trust Board to convene its 'Part 2' meeting) that in pursuance of Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest	Chair of the Trust Board	Verbal
	Date of next meeting: 29th November 2017, 10am, Education Centre, Tunbridge Wells Hospital		

David Highton, Chair of the Trust Board

MINUTES OF THE TRUST BOARD MEETING ('PART 1') HELD ON THURSDAY 7TH SEPTEMBER 2017, 10A.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)
	Angela Gallagher	Chief Operating Officer	(AG)
	Tim Livett	Non-Executive Director (apart from items 9-12 to 9-17 & 9-22 to 9-24)	(TL)
	Peter Maskell	Medical Director	(PM)
	Claire O'Brien	Interim Chief Nurse	(COB)
	Steve Orpin	Director of Finance	(SO)
In attendance:	Nazeya Hussain	Associate Non-Executive Director	(NH)
	Jim Lusby	Deputy Chief Executive	(JL)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Kevin Rowan	Trust Secretary	(KR)
	Lisa Brereton	General Manager - Surgery, Urology & Gynae Oncology (for item 9-9)	(LB)
	Daniel Lawes	Clinical Director - Surgery, Urology & Gynae Oncology (for item 9-9)	(DL)
	Rob Parsons	Risk and Compliance Manager (for items 9-18 and 9-19)	(RP)
Observing:	Annemieke Koper	Staff Side representative (apart from items 9-1 to 9-5)	(AKo)
	Darren Yates	Head of Communications	(DY)
	Karen Thompson	Care Quality Commission (apart from item 9-21)	(KT)
	Andy Cachaldora	Philips	(AC)
	Mark Cohen	Cymbio (Capita Healthcare Decisions)	(MCo)
	Trevor Cook	Member of the public (apart from items 9-15 to 9-17 and 9-22 to 9-24)	(TC)

[N.B. The order of the items reflects the order listed on the agenda, which differed from the order in which the items were considered at the meeting]

9-1 To receive apologies for absence

Apologies were received from Sarah Dunnett (SDu), Non-Executive Director; and Alex King (AK), Non-Executive Director. It was also noted that Maureen Choong (MC), Associate Non-Executive Director, would not be in attendance.

DH welcomed NH to her first Trust Board meeting.

9-2 To declare interests relevant to agenda items

No interests were declared.

9-3 Minutes of the 'Part 1' meeting of 19th July 2017

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

9-4 To note progress with previous actions

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

- **7-11 ("Arrange for an assessment of the feasibility of establishing a 'finder fee' arrangement for staff who introduce individuals who were subsequently appointed to vacant Nursing positions")**. DH queried whether a more detailed update would be available at the October 2017 Trust Board meeting. COB confirmed this would be the case.
- **7-11 ("Consider appointing Non-Executive Director 'champions' for Safeguarding Adults and Children")**. DH noted that an update would be provided during item 9-6.

9-5 Safety moment

COB noted that the theme for September was deteriorating patients & made the following points:

- The focus of the month thus far had been on identifying patients who may be deteriorating and escalating the situation appropriately, to ensure such patients were treated in a timely manner. As part of this, the use of the Situation, Background, Assessment, Recommendation (SBAR) tool was being promoted. The SBAR process helped staff succinctly assemble the key facts about a patient, to aid communication with medical staff
- The second week focused on Sepsis, and included Sepsis awareness day on 13/09/17. Staff would be visibly promoting the use of the Sepsis screening tool, as although the Trust performed reasonably well on this, there was room for improvement
- Acute Kidney Injury (AKI) would also be subject to focus during the month

PM referred to the latter point, and added that the treatment for AKI and Sepsis was straightforward and evidence-based, but the difficulty was in recognising patients for whom such treatment was appropriate.

9-6 Chairman's report

DH reported the following updates in relating to Non-Executive Director (NED) positions:

- Kevin Tallett had resigned with effect from 31/07/17, and the Trust Board's appreciation of KT's contribution should be recognised and formally noted
- KT had been the Vice Chair of the Trust Board and Senior Independent Director, and both roles would now pass to SDu, subject to no objections being raised from the Trust Board. SDu would therefore become the Vice Chair of the Remuneration and Appointments Committee, by virtue of being Vice Chair of the Trust Board
- AK had agreed to adopt the role of 'Freedom to Speak Up Guardian' for the interim period
- Steve Phoenix would start as a NED from 01/12/17, and would become the NED Emergency Preparedness, Resilience and Response (EPRR) lead for the Trust. DH would however fulfil the EPRR role until 01/12/17
- MC and NH had been appointed as Associate NEDs. The roles of NH and MC, with respect to the committees they would attend, were yet to be finalised, and further details on this would be followed up at the October Trust Board meeting
- TL would become the Non-Executive Lead for Procurement
- From 01/12/17, there would therefore be 6 NED positions, comprising 3 males and 3 females
- At the last Trust Board meeting it was agreed to consider whether there should be NED Safeguarding lead/s. As such roles were not nationally required, and as DH did not want to appoint NEDs to token positions, MC would meet COB to consider whether such a role would add value. The outcome of that meeting would be reported to the October Trust Board meeting

DH then reported that Simon Hart, the new Director of Workforce, was due to commence in post on 01/12/17, but Simon had agreed to make himself available to the Trust's Human Resources team in advance of this date.

Finally, DH noted that TL, JL, PM, SO and himself had recently attended the latest Financial Special Measures (FSM) review meeting with NHS Improvement (NHSI). DH reported that it had been a positive meeting, but no decision had yet been made regarding the Trust's FSM status. DH added that it was however hoped that the Trust would not have to attend a further review meeting, following the 3 that had been held in the past 3 months. DH thanked SO and the rest of the Executive Team for the improvements that had been made, and also noted that PM's assurance that the financial measures taken by the Trust had not compromised patient care had been significant. DH emphasised that this was an important stance for the Trust Board to take.

9-7 Chief Executive's report

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

- Many changes had been made over the summer, and the 'acid test' was approaching in relation to the winter period. The Trust had applied its influence to the issues it could affect,

and had demonstrated a willingness to try new things and 'go the extra mile'. The Trust should therefore feel proud of what it had achieved

- When the data was considered, the Trust should be severely struggling. Although there were problems, this was not the case, and even elective activity, which was sometimes sacrificed to accommodate non-elective activity, had increased. Thanks should therefore go to AG and her team, and all frontline staff
- In terms of the content of Attachment 3, it was important to note the response to the anonymous concerns that had been raised. In addition, when considering the Patient-Led Assessments of the Care Environment (PLACE) findings, the fabric of the Trust's buildings was generally good. This was not the case for Maidstone Hospital (MH) 10 years ago, so significant progress had been made. Disability access was an important feature and the Trust had a common sense approach to this
- The Chaucer Acute Frailty Unit (CAFU) was functioning well, and doing what it could to improve patient flow, by assisting patients to leave hospital sooner. The Virtual Fracture Clinic was also continuing to develop
- The Kent and Sussex Hospital Fund Darts League had made a significant donation, for which they should be thanked

9-8 Update on the 'Listening into Action' programme

JL referred to the report that had been circulated and made the following points:

- Having emerged from the last winter period, and having spoken to staff, the conclusion was reached that staff were the Trust's greatest asset but the Trust had been unable to realise the full potential, and therefore needed to do things differently. A decision was therefore made to engage Listening into Action (LiA) circa March 2017
- The first step in the programme was to undertake a LiA 'Pulse' survey, which was the most comprehensive staff survey the Trust had undertaken. A leadership audit of 120 of the most senior people in the Trust was also carried out, and both provided a detailed suite of information about the Trust
- The surveys did not reveal any major surprises, as most of the issues raised had already been recognised. The most common theme was workforce, but there was also a theme regarding the need to pool collective efforts and work together. There were also some comments about the need for respect and for different professions to work together in a respectful way, which would be very important as LiA entered the next stage
- The "Trust-wide results based on 1368 responses - July 2017" page gave an overall summary
- Notwithstanding the fact that no there had been major surprises, there had been some surprise regarding the strength of feeling in some areas, particularly within the Maternity service. In response, JL and others had met immediately with the Maternity senior leadership team to discuss the findings. The meeting, and discussion, had been positive and insightful, and the emphasis had been on improving the situation
- 'Crowd fixing' events would now commence, to enable staff to voice any frustrations, and allow them to implement solutions
- The 'listening' phase was therefore now moving into the 'action' phase
- Two LiA teams had been invited to present at the Trust's Annual General Meeting, which was scheduled for later that afternoon
- The "CQC 5 domain triangulated results" slide showed the links with the Care Quality Commission's (CQC) areas of interest
- LiA had to be at the centre of the efforts to improve the Trust's culture and this needed to be a priority. It was therefore proposed to discuss the LiA survey findings in greater depth at the next Trust Board 'Away Day', as well as consider how the Board should begin to enable staff to take ownership, speak up when they needed to, and be empowered to make changes where required

SO referred to the leadership audit, and commented that it would be interesting to see how staff viewed the leadership, as some initial triangulation had revealed that staff were not as positive about the leadership as the leadership audit had shown. JL welcomed the comment, and acknowledged there was a discord between staff and management in some areas e.g. in the understanding of the Trust's Strategy. JL added that there was therefore a need for further insight.

NH asked how frequent the survey was carried out, and emphasised the need to remove systematic barriers, ensure that action was taken in response to the survey, and communicate such action. JL concurred, and recounted the details of a recent meeting he had had with Junior Doctors at Tunbridge Wells Hospital (TWH), at which those present had been positive about the recent changes made to improve patient flow, but asked why such changes had not been widely communicated and/or celebrated. JL also confirmed that the frequency of surveys was for the Trust to determine, but the next survey as part of the LiA process would be in 6 months' time.

DH remarked that in his experience it was challenging for an organisation under pressure to not centralise and disempower staff, rather than engage and empower them, to avoid a small cadre of individuals telling others what to do. DH added that the FSM work had shown some positive signs of this, but this needed to be maintained and continued. DH also agreed with NH's point regarding the importance of making changes and communicating these, to enable a cycle of improvement to be introduced. JL agreed and noted that the LiA survey findings had been shared with all staff.

Presentation from a Clinical Directorate

9-9 Surgery

DH welcomed DL and LB to the meeting. LB then gave a presentation highlighting the following:

- The Directorate included Lower Gastrointestinal (GI) Surgery, Upper GI Surgery, Breast, Gynae-Oncology & Urology, and was managed by DL, LB, and Sally Batley (Lead Matron), supported by 2 Assistant General Managers
- The Governance Lead was Mr Hasan, whilst Mr Okaro, Mr Wright, Ms Chalmers, Mr Cynk, and Mr Attard-Montalto were the Clinical Leads
- The Directorate included Ward 10, Ward 11, the Surgical Assessment Unit (SAU), and Short Stay Surgical Unit (SSSU) at TWH; and Cornwallis Ward, Peale Ward, and the Maidstone Short Stay Surgical Unit (MSSU) at MH
- The Medical establishment included Consultants (20 WTE for Surgery and 4.91 WTE for Urology), Associate Specialists (6 WTE for Surgery and 1 WTE for Urology) Specialty and Associate Specialist (SAS) Seniors (17 WTE for Surgery and WTE 5 for Urology); Core Trainees (3 WTE for Surgery and 2 WTE for Urology); SAS Juniors (10 in total) and Foundation Year (FY) 1s (18 in total)
- The Nursing establishment included 7 WTE Band 7 staff, 14 WTE Band 6 staff, 99.54 Band 5 staff, 60.27 Clinical Support Workers (CSWs) and 7.84 WTE Ward Clerks
- Financial performance for 2017/18 included planned revenue of £41.5m and budgeted expenditure of £17.8m, which equated to an expected contribution of £23.7m. At month 4 income was adverse by £0.3m; expenditure was adverse by £0.4m (which related to Nursing Agency and slippage against the Cost Improvement Programme (CIP)
- Performance on the Referral To Treatment (RTT) and Cancer waiting time targets had been challenging

DL then reported the following points

- The Directorate was fantastic, but has some risks/challenges. A key risk related to the recruitment of Junior Doctors, where current vacancies included 2 Urology Specialist Registrars (SpRs), 2 Surgery SpRs, and 6 Surgical Junior Clinical Fellows (JCFs). 2 Upper GI Consultants were also leaving, which would lead to a loss of capacity
- The current (clinical negligence) litigation relating to Upper GI was a problem, and the previous problems with the service had led to a disenfranchised unit
- There were also difficulties in recruiting quality emergency Consultants, whilst the volume of patients was also testing
- Urology was a 3-site delivered service, which included major elective activity at Medway Maritime Hospital, and there were 6 Consultants to deliver the Consultant of the Week (COW), but only 5 substantive Consultants (a shortfall of 1) service. The speciality had been very close to losing its allocation of FY 1 Medical trainees due to lack of supervision
- The Nurse vacancy rate was also a concern, & there was a high level of Agency expenditure
- However, despite these challenges, there were opportunities and planned improvements. These included reconfiguration of services, in accordance with the Sustainability and

Transformation Partnership (STP); reshaping and reviewing the Upper GI Service; and reviewing the model of emergency services
- The LiA Breast service group was making good progress in relation to the annual follow-up programme for Mammography. Similarly, the LiA Urology group was making improvements to the prostate pathway
- A revised SAS (Middle Grade) rota was being developed, and GI proformas were being reviewed. The Colorectal pathway was also being completely reviewed, and there was potential for a One Stop Fresh Rectal Bleed (FRB) clinic

DH referred to the recruitment issues, and asked whether any of the Junior Doctor vacancies were for posts funded by the Deanery (i.e. Health Education Kent, Surrey and Sussex (HEKSS)). DL confirmed there were some such posts, but added that only one of the recent issues relating to the FY1 vacancies was foreseeable. LB noted that work was underway to try to make the Trust a more attractive employer.

DH then commented that attracting good applicants to Fellow posts relied on the reputation of the Consultant to whom they would be a Fellow. DL agreed this was important in part, and was not something currently able to be offered. LB added that this was expected to improve via the aforementioned review of the SAS rota.

GD stated that he regarded the situation in the Upper GI service as an opportunity. DL agreed, but stated that some direction was needed from the Trust. JL noted that PM and JL had, opportunistically, commenced discussions with Guy's and St Thomas' NHS Foundation Trust about how both Trusts could work more closely on GI services. JL added that there were also opportunities for pelvic floor surgery.

JL then opined that ‘lowering the bar’ must be a constant consideration when faced with recruitment challenges, and therefore encouraged DL to ensure that employees recruited with any concerns received appropriate supervision. The point was acknowledged. A discussion was then held regarding the recent appointment of a particular doctor, and DH suggested that PM liaise with DL outside of the meeting to discuss further.

DH thanked DL and LB for their presentation.

9-10 Review of the Board Assurance Framework 2017/18

KR referred to the circulated report and drew attention to the following points:
- This was the second time the Trust Board had received the populated Board Assurance Framework (BAF) in 2017/18, but the first time the status of objective 6 had featured, following the approval of that objective at the July 2017 Trust Board meeting
- The status and confidence reported by the relevant Executive Lead reflected the risks to the achievement of the objectives, which should not be a surprise to Trust Board Members
- The prompts for the Board to consider are listed on page 1
- Appendix 1 contained a summary of the Risk Register, and of red-rated risks in particular. The risks described should also not be a surprise, as the issues were discussed and reported regularly at the Trust Board, its sub-committees, and the Trust Management Executive (TME)

DH remarked that the Trust had reached the half-year point with all objectives still able to be achieved, but was pleased with the ‘green’ rating for the mortality-related objective, noting that a more detailed discussion on mortality was scheduled for the October 2017 Trust Board meeting.

TL commented that an ‘amber’ was reasonable for objectives 5 and 6, but there was a degree of challenge for both, so further assurance was required on these. DH agreed & asked when the next BAF update was due. KR confirmed this was November 2017. GD pointed out that the Finance and Performance Committee would be able to obtain more detailed assurance before then.

9-11 Integrated Performance Report for July 2017

DH referred to the circulated report and noted that as the meeting had been scheduled at the mid-point between the July and October Board meetings, there were several areas where the

performance for August was now known. GD agreed, and highlighted that the 'acid test' was how the Trust had performed with emergency care, which impacted on a wide range of indicators.

Effectiveness / Responsiveness (incl. DTOCs)

AG then highlighted the following points:

- There had been 2 improved months of A&E 4-hour waiting time target performance. The Trust had exceeded the trajectory agreed with NHSI in July (93.3%) and August (93.31%), despite continuing to see more patients and greater pressure on non-elective demand
- The Elderly Frail Unit had seen a huge positive impact. There had also been increased and changed rotas within Medicine, a continued focus on Length of Stay (LOS) and the application of the SAFER bundle. The improvement in LOS in July had continued into August. There had been particular improvement for patients awaiting packages of care
- None of the initiatives that had been implemented would be stopped
- The Winter plan was being finalised & was scheduled for submission to the Board in October
- Delayed Transfers of Care (DTOCs) had improved slightly in August
- The Trust continued to under-perform against the agreed trajectory for the 62-day Cancer waiting time target. There had been some slight improvement, but the main development was in treating patients who had exceeded their 62-day wait. The backlog now only included 58 patients, which compared favourably to the same point in 2016/17. There were however still some difficulties with patients referred from Tertiary centres

GD asked for more details on the latter point. AG clarified that the issue related to patients being referred to the Trust as a Tertiary centre & not to referrals from the Trust to other Tertiary centres.

AG then highlighted that RTT 18 week target performance was also showing some positive signs, and although there was more to do, there had been good engagement with clinical teams.

NH then referred to the "62 Day Performance - All Patients" table on page 5 of 27, and the significant variance in performance on the pathways i.e. 90% for "Breast" and 33.3% for "Sarcoma", and stated that she would welcome a conversation with AG outside of the meeting, to understand the situation in more detail. AG stated she was happy to oblige NH's request, but noted that the differences reflected the complexity of the pathway.

Safe / Effectiveness / Caring (including infection control)

COB then reported the following points:

- The falls rate had reduced overall and was below the plan. This was positive, but further improvement would be sought
- There had been 6 falls-related Serious Incidents (SIs) in July. Some of the key issues discussed at the bespoke falls SI Panel had been included on page 7. There had been only 1 falls-related SI for August. The reasons for the reduction were not known, but it was possible that some of the changes that had been made had had a positive effect
- Friends and Family Test (FFT) positive response scores were above the national benchmark for inpatients and A&E, but Maternity remained below the national benchmark. This was felt to be related to 'survey fatigue' among mothers, but other Trusts had managed to overcome this, so the Trust needed to do so too.
- Response rates for the FFT had improved but were still below target
- The Complaints response target had not been achieved for July, but the corporate teams were working closely with Directorates
- There had been 5 single sex accommodation breaches for July, as 4 female patients were in a bay with a male patient for a very short period of time. No privacy and dignity issues arose however, and the situation was resolved very quickly

SM then reported that there had been 3 cases of Clostridium difficile for July, with no cases of MRSA bacteraemia; and added that the level of MRSA screening remained very high.

Well-Led (finance)

SO then highlighted the following points:

- There was an adverse variance to plan in July of £1.2m, which included non-receipt of Sustainability and Transformation Fund (STF) monies. There were 2 elements to the STF in 2018/19: financial performance and performance on the A&E 4-hour waiting time target. As the former had not been met, the aforementioned positive performance on the latter had not therefore resulted in a financial benefit
- In light of the CIP performance being steadier than that originally planned, a request had been made to NHSI to re-submit the Trust's plan for 2017/18. Until this was accepted, the Trust was obliged to report its performance against the submitted plan
- NHSI had however confirmed that the Trust could claim back all STF monies for Quarter 1
- The cumulative deficit for 2017/18 was £5.4m, which was far lower than at this point in the year in 2016/17
- Temporary staffing usage remained higher than planned
- The cash position remained in accordance with the Trust's intended position. The latest Finance and Performance Committee meeting had discussed the option of removing the pass-through costs associated with the Trust hosting the STP. STP colleagues had subsequently agreed that the Trust would now invoice for these costs in advance, to ensure the Trust's cash position was not adversely affected by being the STP's host
- NHSI had only agreed to 1 of the 2 funding requests for replacement Linear Accelerators (LinAcs) that the Trust had submitted. The installation of the replacement LinAc funded from 2016/17 was however underway at present
- £600k of capital funding had been awarded for GP streaming, and the majority of this would be focused at TWH

Well-led (workforce)

JL then reported the following points:

- The performance was self-explanatory, but it was clear that staff were concerned about Ward staffing levels. Staff tended to be particularly concerned about the impact of temporary staffing
- Much work was taking place, and the incoming Director of Workforce was visiting the Trust regularly prior to his start date, and was therefore starting to take a lead role in some areas, particularly in relation to temporary staffing. A review of the rates of pay for Bank staff was also being undertaken, via the Executive Team
- A new Consultant in Respiratory Medicine had started in post, which was a positive step forward, as there had been previous difficulties in recruiting to a Consultant-level post

DH referred to the review of rates of pay for Bank staff, and queried when an update could be expected. JL agreed this could be provided at the October 2017 Trust Board meeting.

Action: Provide an update to the October 2017 Trust Board meeting on the review of the rates of pay for Bank staff (Deputy Chief Executive, October 2017)

Safe / Effectiveness (incl. Mortality)

PM then reported the following points:

- There was no further update of the Trust's Summary Hospital-level Mortality Indicator (SHMI) (which was 1.0878), which included data for patients who died up to 30 days after discharge
- The most recent data for the Trust's Hospital Standardised Mortality Ratio (HSMR) was 103.8 for a 12-month rolling period, which reflected the fact that the sharp increase that occurred in March 2016 was no longer included in the 12-month position
- The monthly HSMR, for May, was 91.5. The average HSMR position was 100
- All 3 of these reported mortality indicators needed to be considered to get a comprehensive view, but given the latest data PM had rated the mortality-related objective within the BAF as 'green', as had been noted under item 9-10
- An article by Professor Jarman in the most recent edition of the Mail on Sunday had identified the Trust as one of 24 that he regarded as having mortality concerns. Professor Jarman had however used his own measure of mortality to identify the 24 Trusts, which differed from the 10 Trusts that NHS Digital recognised as having such concerns. Professor Jarman's article had also referenced old data, so PM was not concerned with the assertions therein
- There had been good progress with the "Policy for Undertaking Mortality Case Record Reviews", which was scheduled to be ratified at the September 2017 Policy Ratification

Committee (PRC) meeting. The policy would then be submitted to the October 2017 Trust Board meeting, for information
- The level of completed Mortality Reviews had reduced in August, but PM suspected this was due to summer holidays, and therefore an increase was expected

Quality Items

9-12 Update on the anticipated inspection by the CQC

COB referred to the circulated report and drew attention to the following points:
- A Provider Information Request (PIR) had been issued in July, with a 3-week deadline for completion. This had involved considerable work, but COB was satisfied with the submission
- The CQC had simultaneously published their "Insight" document for the Trust, and the Trust was responding to the issues that had raised
- A CQC Project Group had been established, and an 'issues log' created, to try and address the issues most in need of attention
- The communication plan was important, given the staff's potential anxiety about the inspection. GD's weekly email had been used, and a "Take 5, Talk 5" initiative had been launched, to raise the profile and awareness of certain issues. A CQC website had also been established, where key documents (including the Key Lines of Enquiry) had been uploaded. Staff had been encouraged to review the website, and a letter to all staff would be included as part of the September payslips that staff received
- The Trust had recently met with representatives from the CQC. The CQC could visit the Trust at any time, but there would be an announced inspection in December 2017. The exact date would be set soon, but the focus would be on the Well-Led domain, for which the Trust was found lacking at the last inspection. A self-assessment relating to this was being undertaken at present, and NHSI had offered support to the Trust regarding this

SO then referred to the LiA report discussed under item 9-8, and asked if the issues raised via the LiA pulse survey had been used to populate the aforementioned 'issues log'. COB replied that this had not been done, but could be. JL pointed out that this was understandable as thousands of comments had been made in the survey, and the information had not yet been widely circulated.

9-13 The outcome of the investigations into the recent alleged assaults at the Trust

COB referred to the circulated report and drew attention to the following points:
- The definition of an adult at risk of harm had changed, which may account for the increased allegations of abuse
- The incidents had been included only in summary form, to maintain anonymity
- There was a correlation between the allegations and patients' cognitive impairment, and this had led to a review of how enhanced care arrangements were applied. It was recognised that there was a need to focus on the organisation of care for individual patients, and to escalate any issues involving patients with cognitive impairment
- There had been a 'deep dive' review into the Endoscopy-related allegations. The consent process was important in such cases, as often clinicians adopted a softer approach to this for Endoscopy procedures. However, such procedures could be very uncomfortable for patients with a strong gag reflex. There were strong sentiments among those making the allegations, and the descriptions of the SIs included feelings of being violated
- The conclusion from the investigations was that it was important to consider the cases together, to be assured that there was no aspect of practice that needed to be addressed
- No significant issues had been identified

DH asked how any future issues would be escalated to the Board. COB noted that the SI Panel reported to the Trust Clinical Governance Committee which reported its work to the Quality Committee.

9-14 Annual Report from the Director of Infection Prevention and Control (including Trust Board annual refresher training)

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

- This was SM's tenth Annual Report, although the Report reflected the work of the whole Infection Prevention and Control Team
- A significant amount of work had been undertaken during the year, and the process was now a 'well-oiled machine'
- The year saw an increase in Clostridium difficile cases, but only 1 MRSA bacteraemia case
- The Link Nurse network was very strong, and included an annual conference, which was scheduled for w/c 11/09/17
- The Infection Prevention and Control Team was very pleased to receive the Innovation Team of the Year award at the 2016 Trust Staff Star awards. SM had also been invited to present at the Federation of Infection Societies/Hospital Infection Society conference in November 2016
- The Trust Board annual refresher training was primarily focused on section 5. This included details of the Trust's corporate history, which was important given the changes in Trust Board Members since the Clostridium difficile scandal in 2006 (only GD and SM now remained)
- The Trust had declared compliance against the Hygiene Code every year since 2009. The compliance criteria and evidence held were referenced in the Report, although a large amount of evidence was held by the Team, so the Report therefore only provided a summary
- Assurance was obtained via the Infection Prevention and Control Committee, the Trust Clinical Governance Committee and the Quality Committee
- There was focus on 2 key national priorities: antimicrobial resistance and healthcare associated gram negative bloodstream infections. The Trust had a range of measures in place to respond to these, which included working with partner agencies (as there were health economy-wide gram negative infection targets in place)
- Root Cause Analysis continued to be undertaken on every Clostridium difficile infection. This considered whether there were any lapses in care, and whether a case was avoidable. Eight of the cases in 2016/17 were potentially avoidable. There was also 1 episode of cross-infection, which related to the door-opening mechanism of a side room within John Day Ward
- The Trust had a large programme of screening for infections. This was not limited to MRSA as Glycopeptide resistant Enterococci screening was also carried out on all Haematology patients
- The Trust had one case of Candida auris, which had been imported from another hospital. The response to the case was led by Public Health England
- A comprehensive training programme was in place, which including handbooks for Agency and other temporary staff. There was also a strong clinical audit programme

DH commended the comprehensive nature of the report & invited questions. None were received.

9-15 Planned and actual ward staffing for June and July 2017

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

- The report contained 2 months data, which would also be the case for the report to be submitted to the October 2017 Trust Board meeting
- The Trust's Care Hours Per Patient Day (CHPPD) performance was within the range recommended via the Lord Carter efficiency programme. CPPH tended to be higher at TWH, due to the largely single room nature of that site
- Some areas had been rated as 'amber' and 'red', which reflected the need for additional staff in response to clinical activity (although some of these ratings reflected an inability to fill shifts)
- The format of the report was set externally and did not account for Wards that had vacancies, which for many Wards were significantly high

SO referred to the "Overall RAG Status" and noted that Ward 20 was the only area to be rated as 'amber' in June and July. SO added that the same reason had been given in the "Comments" section for both months, and asked whether further work regarding that Ward's establishment was warranted. COB confirmed that the Ward's establishment had been reviewed, and the area was currently subject to focus, as a range of challenges were affecting the Ward.

JL remarked that there was a perception that John Day Ward was not quite functioning effectively, and asked what level of assurance could be given regarding that Ward (which had an "Overall RAG Status" of 'green'). COB acknowledged the faced by that Ward, which included a new Ward

Manager, and a relatively junior team, but pointed out that the 'planned and actual' staffing system was not intended to identify every issue affecting a Ward.

Planning and strategy

9-16 Update on the Kent & Medway Sustainability and Transformation Partnership (STP)

GD reported the following points:

- Progress was being made in relation to the major areas of work, including productivity and shared services (which was being led by SO)
- The major focus of the last few weeks was the local care agenda, with the aim of ensuring the level of care provided in people's homes increased
- Two workshops been held (one for East Kent and one for West Kent) regarding potential Accountable Care Organisations (ACOs)
- The future of Stroke services would be affected by the reconfiguration of services in East Kent. However, GD did not want the Trust's plans for Stroke to be delayed by the East Kent situation

DH referred to the latter point, and asked what the likely date was for a public consultation on the future of Stroke services. GD replied that this would take place in spring 2018.

9-17 To discuss the Trust's strategy

DH invited JL to give a presentation, noting this was a precursor to a report and further discussion at the October 2017 Board meeting. JL then gave a presentation highlighting the following points:

- The Trust would soon be commencing detailed discussions with Dartford and Gravesham NHS Trust (DGT) and Medway NHS Foundation Trust (MFT) regarding closer working
- The Trust should be confident about the future, given its recent history and context, which included the opening of TWH in 2011 and associated service reconfigurations
- The Trust had had a consistent Strategy during the last 10 years, which was based on having Centres of Excellence, integration and partnership. This Strategy was reaffirmed in the Integrated Business Plan (IBP) in 2014 and further tested through detailed 'bottom up' discussions during 2015/16 (which led to the development of the "Time to Change" document)
- The Trust's strategic objective remained the achievement of clinical and financial sustainability, and JL did not propose any major revision to this, or to the focus areas and values, building on the work that had been undertaken previously
- The PRIDE values were also well established and JL did not propose any major changes
- A number of Centres of Excellence already existed. The Trust was a Regional Cancer Centre, and had well-established Women's & Children's, Head and Neck (including Ophthalmology), Trauma and emergency surgery, and elective surgery services
- Opportunities also existed for future Centres of Excellence, for elective Orthopaedics (of which the Maidstone Orthopaedic Unit (MOU) was a first step); Stroke care; and Care of the Elderly
- The Trust had not demonstrated any desire regarding acquisition or organisational change, but had strong relationships and strategic alignment with commissioners and other providers. Such relationships were evident from the progress made regarding the Home First initiative, whilst the Aligned Incentives Contract (AIC) provided a framework to support the Trust's strategic ambition. The Trust was also developing relationships with providers in primary care
- The Trust's Strategy was in accordance with the "Five Year Forward View" and the development of new models of care, including the development of ACOs
- The Trust's approach to improvement needed to focus on LiA as well as maximise the opportunities presented by the Lord Carter, Model Hospital, 'Getting It Right First Time' (GIRFT) programmes, and the AIC
- The next steps included progressing with STP discussions through the Medway, North and West Kent Delivery Board, to ensure there was alignment with the Trust's Strategy. There was also a need for a further level of detail beyond the high-level messages i.e. at Divisional, Directorate and Specialty level, to enable the Strategy to resonate with Wards and the Board
- An annual review of the Strategy was proposed, based on staff feedback via LiA
- There was also a need for further engagement with HealthWatch and key patient groups
- The Strategy would be submitted to the Trust Board in October 2017, for approval

Questions were invited. None were received.

Assurance and policy

9-18 Health & Safety Annual Report, 2016/17 (incl. agreement of the 2017/18 programme and annual refresher training on Health & Safety, Fire safety, and Moving & Handling)

DH welcomed RP to the meeting. AG then introduced the item, and invited RP to draw attention to any key issues. RP duly referred to the circulated report and highlighted the following points:

- There had been an increase in incident rates, and an increase in Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) incidents. This combination indicated that there were minor incidents and near misses going unreported. However there appeared to be a 3-yearly drop in incident rates.
- The 37 RIDDOR incidents showed an increase in all categories. Fractures involving visitors was a theme, and as a result, an objective had been set to ensure that slips, trips and falls incidents involving visitors would be investigated by the Patient Safety Team
- 94% of incidents could be listed under the main categories (listed on page 10), and there was an objective to raise the awareness and reduce incident rates in certain areas
- Moving and handling incidents had increased, which likely reflected a period where the Trust did not have a Moving and Handling Coordinator. More work was planned regarding this
- Violence and abuse was the largest category of specific injury area, but this was a decrease from the previous year. Sharps injuries were the second highest category, but again there had been a reduction, which was likely related to the work that had taken place to prevent such injuries. It was acknowledged that there was more work to be done however
- The objectives from 2016/17 had largely been met
- Sections 7.1 and 7.2 focused on Health and Safety Executive (HSE) inspections and investigations, whilst section 8 noted that there had been some notable NHS prosecutions. The key issue from these was management failings, including not undertaking risk assessments and failing to learn from previous incidents
- Section 10 included the objectives for 2017/18

DH noted that eye splash incidents were covered under “Sharps”, and queried whether this was appropriate. AG confirmed this approach had been agreed with the Health and Safety Committee.

SO then remarked that he and DH had recently attended the Trust’s mandatory training day, noted that no Moving and Handling session had been included, and queried whether this need to be reconsidered, given the RP’s earlier comments. AG noted that the current post-holder was retiring, and such training was therefore likely to be reconsidered in the future.

TL noted that the HSE focused on workplace stress, & asked whether any measures were in place regarding this. AG confirmed this had been discussed, and the need to ensure that staff recorded if any sickness absence they had involved work-related stress had been acknowledged, even though some staff were reluctant to report this. AG added that there was however a comprehensive stress risk assessment in place, and there was a focus on raising awareness.

RP then referred to Appendix A and highlighted that the key change was the increased levels of prosecutions and penalties for Health & Safety breaches. RP added that the Appendix contained the annual refresher training on Health & Safety, Moving & Handling, and Fire safety and the latter made reference to the Grenfell Tower fire. RP confirmed that the Trust had submitted the information returns it had been required to make in response to this

The Trust Board agreed the Health and Safety programme for 2017/18 and delegated the management of the programme to the Health and Safety Committee.

9-19 Ratification of revised Risk Management Policy and Procedure

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

- The previous equivalent document was overdue its review, but this was deliberately deferred until RP had started in post, to provide RP with an opportunity to inform the policy’s content

- A revised policy and procedure was issued for widespread consultation in May 2017, which included a discussion at the Audit and Governance Committee. Previous discussions held at that Committee (most notably a discussion on risk appetite held in May 2016) had also informed the content of the policy. The content had further been informed by the findings of the annual Internal Audit reviews of the Trust's risk management and assurance framework
- The key focus of the revised policy was the application of the risk grading matrix when prioritising risks, and not referring to terminology, such as "Board-level" risks, which had no basis in formal methodology
- The policy was then approved by the TME in June 2017. Policies would usually be ratified at the PRC, but given the importance of the Risk management framework to a range of other policies and processes, the policy had been submitted for ratification to the Trust Board
- The Trust's risk management arrangements had been subject to some critique by the CQC during their previous inspection in 2014. Whilst the focus of that critique was primarily on the effective identification and management of individual risks, the Risk Management policy played a part in this, and the ratification and subsequent publication of the revised policy was therefore a key step in supplementing the improvements in practice that had been made since the previous inspection. No policy implemented itself however, so RP would continue to reinforce the expected behaviour among staff, supported by KR and the Executive Team

GD noted that the policy contained a range of responsibilities and asked how these would be monitored. KR replied that the duties described were primarily those undertaken by key individuals as part of their routine activities. GD acknowledged the point, but proposed that Internal Audit be asked to undertake a review of this aspect. KR agreed to liaise with SO to arrange this.

Action: Liaise, to arrange for Internal Audit to undertake a review of the revised Risk Management Policy and Procedure, particularly in relation to the implementation of the "Duties" section (Trust Secretary / Director of Finance, September 2017 onwards)

DH then asked about the role of the Trust Board in reviewing the Risk Register. KR noted that the Board received the BAF and the BAF reports contained the key headlines from the Risk Register, as had been the case with Attachment 5. KR added that more detailed reports of the Risk Register were submitted to the Audit and Governance Committee and TME.

The revised Risk Management Policy and Procedure was ratified as circulated.

9-20 Approval of Emergency Preparedness, Resilience and Response (EPRR) Core Standards self-assessment

AG referred to the circulated report and noted that the Trust has assessed itself against the 45 Core standards and was fully compliant with 45. AG also noted that a 'deep dive' self-assessment into governance had also revealed the Trust was fully compliant.

GD added that he spoke regularly with the Head of Emergency Planning & Response and the Trust was regarded as being a 'leading light' on EPRR in the region. JL added that the national lead for EPRR also held this view. DH noted that he had also met with the Head of Emergency Planning & Response, as part of his aforementioned temporary role as the NED lead for EPRR.

The Emergency Preparedness, Resilience and Response (EPRR) Core Standards self-assessment was approved as circulated.

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

9-21 Finance and Performance C'ttee, 21/08/17 (incl. quarterly progress update on Procurement Transformation Plan and approval of "Uncommitted Single Currency Interim Revenue Support Facility Agreement")

TL referred to the report that had been circulated and drew attention to the following points:

- Monthly financial performance had been considered, including the CIP
- Non-financial performance had also been discussed
- The quarterly progress update on Procurement Transformation Plan was noted, and the improvements in process were acknowledged, as was the need to focus more on delivery

- A proposal to proceed with a diagnostic/scoping exercise for the establishment of a wholly-owned Trust subsidiary was considered, and supported, but SO had been asked to explore whether this could be funded via the STP
- The proposal to submit a request for an "Uncommitted single currency interim revenue support facility agreement") was considered, and the Committee agreed to recommend that the Trust Board approve the request

SO referred to the latter point, and reported that the Department of Health had now confirmed that the interest rate applicable to the Agreement would be 3.5%, rather than the more punitive 6%, on the basis that although the Trust was still in FSM, it had a plan in place.

SO also referred to the diagnostic/scoping exercise for the establishment of a wholly-owned Trust subsidiary and noted that GD, as Senior Responsible Officer (SRO) for the STP, was supportive of the request for funding.

DH then referred to the discussion held under item 9-11 regarding the receipt of STF payments for Quarter 1 of 2017/18, and asked when such payments would be received. SO replied that he could not be certain, but in 2016/17, such payments were received near to Christmas. SO added that the Interim Revenue Support Facility Agreement request was intended to be a bridge from now to the point at which that payment was received.

The request for an Uncommitted Single Currency Interim Revenue Support Facility Agreement was approved as circulated. Specifically, the Trust Board resolved that:

- The terms of, and the transactions contemplated by, the Finance Documents to which Maidstone and Tunbridge Wells NHS Trust was a party (i.e. the "Uncommitted single currency interim revenue support facility agreement") be approved
- The Finance Documents to which Maidstone and Tunbridge Wells NHS Trust was a party (i.e. the "Uncommitted single currency interim revenue support facility agreement") be executed
- The Director of Finance be authorised, on behalf of the Trust Board, to execute the Finance Documents to which Maidstone and Tunbridge Wells NHS Trust was a party (i.e. the "Uncommitted single currency interim revenue support facility agreement")
- The Director of Finance be authorised, on behalf of the Trust Board, to sign and/or despatch all documents and notices (including, if relevant, any Utilisation Request) to be signed and/or despatched by it under or in connection with the Finance Documents to which Maidstone and Tunbridge Wells NHS Trust was a party (i.e. the "Uncommitted single currency interim revenue support facility agreement")
- Confirming the Trust's undertaking to comply with the Additional Terms and Conditions listed within Schedule 8 of the "Uncommitted single currency interim revenue support facility agreement"

9-22 To consider any other business

No other business was raised.

9-23 To receive any questions from members of the public

No questions were posed.

9-24 To approve the motion that in pursuance of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public now be excluded from the meeting by reason of the confidential nature of the business to be transacted

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

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10-4 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]
7-11 (July 17)	Arrange for an assessment of the feasibility of establishing a 'finder fee' arrangement for staff who introduce individuals who were subsequently appointed to vacant Nursing positions	Chief Nurse	July 2017 onwards	The issue has been discussed at the Recruitment & Retention group and an outline paper has been prepared for Executive Team discussion and consideration. The Executive Team agreed to the principle, but asked that further work be undertaken on the specific details. A verbal update on the latest position will be given at the Trust Board on 17/10/17
7-11 (July 17)	Consider appointing Non-Executive Director 'champions' for Safeguarding Adults and Children	Chair of the Trust Board	July 2017 onwards	The matter was discussed during a recent meeting between the Chief Nurse and one of the Associate Non-Executive Directors, but is still under consideration. A further meeting is scheduled for the coming weeks, and a recommendation will be made following that.
9-11 (Sep 17)	Provide an update to the October 2017 Trust Board meeting on the review of the rates of pay for Bank staff	Deputy Chief Executive	October 2017	A report has been scheduled to be considered at the Executive Team on 17/10/17

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
9-19 (Sep 17)	Liaise, to arrange for Internal Audit to undertake a review of the revised Risk Management Policy and Procedure, particularly in relation to the implementation of the "Duties" section	Trust Secretary / Director of Finance	September 2017 onwards	Internal Audit have been asked to include this aspect within the next annual "Assurance Framework and Risk Management" review. The scoping of that review will take place shortly and the detailed coverage will be discussed further during that stage.

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

Actions not yet due (and still 'open')

Ref.	Action	Person responsible	Original timescale	Progress
7-14 (July 17)	Arrange for details of the length of the Trust's backlog maintenance programme to be included in future Estates and Facilities Annual Reports	Chief Operating Officer	July 2018	The Director of Estates and Facilities has been notified of the request, and been asked to ensure the information is included in the 2017/18 Annual Report, which is scheduled to be considered by the Trust Board in July 2018

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NHS Maidstone and Tunbridge Wells NHS Trust

10-6 Chair's report **Chair of the Trust Board**

Chief Executive Post

Following a recruitment process earlier in the summer, Ministerial approval for the appointment of Glenn Douglas as Chief Executive of the Kent and Medway Sustainability and Transformation Partnership (STP) was given on September 18, and Glenn resigned from the role of CEO and Accountable Officer in order to take up the new role. As MTW is the host organisation for the STP, the Trust will continue to be Glenn's legal employer.
Glenn led the Trust as our CEO for the last 10 years. He joined the Trust at its lowest ebb and has led it on a journey of improvement. The delivery of the new hospital in Tunbridge Wells and associated reconfiguration of services stand as evidence of the outstanding contribution he has made to healthcare in West Kent and beyond. He has been the Senior Responsible Officer (SRO) for the STP since 2016 and will now be able to concentrate on that important role on a full time basis. The Trust should wish him every success because the STP is absolutely key to the partnerships which will help shape and deliver the Trust's own future strategy.

In accordance with the prior approval of the Remuneration and Appointment Committee, Jim Lusby became the Accountable Officer and Acting CEO of the Trust with effect from September 19. Jim has been Deputy CEO of the Trust since April 2015 and has already made a significant contribution, especially sharing the workload with Glenn since he took up the STP SRO role on a part time secondment basis.

Non-Executive Director Membership of Board Committees

The Chairs, Vice-Chairs and other formal members of the Board sub-committees have now been updated, following the recent NED and Associate NED appointments. I can therefore confirm the following arrangements for each Trust Board sub-committee (subject to the Trust Board's approval of a proposal (which comes as separate item/report at the October 2017 Board meeting) to allow Associate NEDs to become formal members of most of the Trust-Board sub-committees):

- Audit and Governance Committee – Chair: Alex King; Vice-Chair: Steve Phoenix (from 01/12/17); Members: Sarah Dunnett and Tim Livett; Invited attendees: Maureen Choong and Nazeya Hussain
- Charitable Funds Committee – Chair: Tim Livett; Vice-Chair: Sarah Dunnett
- Finance and Performance Committee – Chair: Tim Livett; Vice-Chair: Sarah Dunnett
- Quality Committee – Chair: Sarah Dunnett; Vice-Chair: Steve Phoenix (from 01/12/17); Member: Maureen Choong
- Remuneration and Appointments Committee – Chair: David Highton; Vice-Chair: Sarah Dunnett (which follows Sarah also being the Vice-Chair of the Trust Board, as was reported at the Board meeting on 07/09/17)
- Patient Experience Committee – Chair: Maureen Choong; Vice-Chair: Alex King
- Workforce Committee – Chair: Steve Phoenix (from 01/12/17); Vice-Chair: Nazeya Hussain

The above changes do not however alter the current principle that all NEDs and Associate NEDs are welcome to attend any meeting of any Trust Board sub-committee, should they wish to do so. The Executive members of each sub-committee are also unaffected by the changes, so these remain as currently constituted within the respective Terms of Reference."

Board evaluation

It is generally regarded as good practice for Boards to undertake regular evaluation, and the last evaluation of the Trust Board took place in spring 2016 (the Board discussed the findings in May 2016). A further evaluation was therefore due in spring 2017, but this was deferred in light of the departure of the previous Chair (in February 2017) and my arrival (in May 2017). There have since been a number of changes in Trust Board Members that have contributed to an evaluation not being undertaken. The latest development in this regard is the publication of the revised Well Led

Framework for NHS provider, and the requirement that NHS Trusts undertake development reviews against that Framework (the Trust's own self-assessment will be considered at the October 2017 Board meeting via a separate item/report). Therefore given this, plus the arrival of 2 new Trust Board Members (a Non-Executive Director and the Director of Workforce) on 01/12/17, and the announced Care Quality Commission (CQC) inspection, also in December, I have concluded that there would be no benefit in undertaking a separate Trust Board evaluation at the present time. I therefore propose that such an evaluation be scheduled for mid-2018. Trust Board Members are invited to comment.

Other items

I attended an NHS Providers private dinner with Simon Stevens, CEO of NHS England, in September. The discussion included the difficulties in recruiting workforce and the evolving role of STPs and Accountable Care Partnerships, and also focused on planning for Winter (on our Board agenda today). It was very clear from the discussion that the year on year growth in non-elective admissions which our Trust has seen this financial year is atypical, with the growth across England generally being at a much lower level than we have experienced.

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

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10-7 Chief Executive's report — Chief Executive

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

1. I would like to echo the Chairman's comments with regard to Glenn Douglas. He has given outstanding service to this Trust and it is very good news that he will continue to provide leadership to the NHS across Kent and Medway.

2. During my first month as Acting Chief Executive I have enjoyed getting out into as many different parts of the Trust as possible. I have been to most wards and many other clinical and non-clinical areas in both hospitals during the last few weeks but there are still a fair few to do. I am also taking the advice of one of our ED consultants and have started using the departments as my "front door" into the organisation – entering and leaving the hospitals through A&E.

   We are also continuing to embed the principles of Listening into Action (LiA) at MTW. This is an organic process that will spread through MTW as more of our staff are empowered to make the changes they want to see.

3. We have experienced some very busy days in the first weeks of October in terms of emergency activity. These spikes have come a few weeks earlier than we expected and would have liked and I want to acknowledge the effort that our clinical and non-clinical teams are making to keep our patients safe and well. We have already had to make some of the difficult judgements that are involved in keeping patients safe.

   Being realistic i don't expect this winter to be any less demanding than the previous three, which have been gruelling for MTW as they have for acute Trusts across the NHS. I do believe, however, that we are better prepared each year as we readjust to the new reality of steadily increasing emergency demand.

   We are deep in discussion with our partner agencies about the way in which the whole care system needs to work better together and we are working hard with them to ensure that we have the capacity we need. The full implementation of our Home First approach will be crucial.

   At the same time, we need to be doing everything we can internally to support good flow through our hospitals. We have proved that we can make progress on this front. We are now three months into an intensive focus on that flow. The frailty model in Maidstone is working well and our non-elective length of stay across the Trust has fallen in the last three months in a way that it hasn't for three years. We have been on, or above, our planned A&E trajectory throughout the last three months - excellent performance with a direct impact on patient experience. I have thanked our staff for their efforts and we remain focused on the delivery of high standards of care in the coming months with the development of a strong winter plan.

4. The results of the National Emergency Department Survey are, at the time of writing my report, due to be published on 17th October. I can say that many of our patients reported having a positive experience, and while there are always things we can learn from, there are also many positive messages that we can share with our staff. I would urge you to read the many comments our patients have shared with us through the survey.

5. The Care Quality Commission has held a number of focus groups for our staff in the build-up to our unannounced inspection(s). I have voiced my appreciation to all those who have taken the time to attend – feedback from the CQC team is that they have been very pleased with attendance to date.

6. Hundreds of staff have already had their flu vaccinations as part of a drive to protect our workforce and patients this winter. All frontline staff have a professional responsibility to be immunised against common serious communicable diseases and, in doing so, reduce the risk of spreading flu to patients, colleagues and family members.

7. Health commissioners from the eight clinical commissioning groups in Kent and Medway are preparing for a formal public consultation on stroke services early in 2018, following detailed engagement and consideration of a wide number of options. The Stroke Programme Board, which is leading the review of acute stroke services, is currently looking at a number of possible models and expect to make an announcement on the list of options it will consult on early in the new year. The shortlist is likely to include a number of options, each involving three specialist hyper acute stroke centres at existing acute hospitals.

8. We have continued to raise the profile of quality and safety at MTW through our Take Five Talk Five initiative. Since our last board meeting, our clinical and non clinical staff have been encouraged to discuss a wide range of issues, many of which are based on recent patient experience.

9. Congratulations to Sarah Gregson, consultant midwife, who has been shortlisted as one of five finalists for the prestigious Foundation of Nursing Studies Sue Pembrey Award 2017 for reducing the number of vulnerable infants requiring intensive post-natal care.

10. The clinical achievements of our Lung Cancer CNS Team are to be showcased at the International World Lung Conference in Japan. This is an enormous achievement not only for the team but for the Kent Oncology Centre and MTW as a whole.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

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

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10-9	**Integrated Performance Report, September 2017**	**Chief Executive / Members of the Executive Team**

The enclosed report includes:

- The 'story of the month' for September 2017 (including Emergency Performance (4 hour standard); Delayed Transfers of Care (DTOCs); Cancer 62 day First Definitive Treatment) and Referral to Treatment (RTT)
- A Quality and Safety Report
- 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?

- Finance & Performance Committee (in part)

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

Review and discussion

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

The 'story of the month' for September 2017

1. 4 hour emergency standard

Performance for the Trust for September (calendar) fell marginally to 90.0% (including MIU), achieving the Trust recovery plan of 89.8%. 1617 came in at 87.1%. This year, we are required to achieve +90% per quarter and 95% in March 2018 and the improvement plan is based on achieving this target.

- A&E Attendances remain higher than last year but the activity is returning to the previous expected levels rather than the continuous growth that we have seen over the last 18 months.
- Non-Elective Activity (excluding Maternity) however remains considerably above plan and was 25.2% higher than plan for September at 4,141 discharges, and 10.1% higher than September last year.
- There were 1125 bed-days lost (5.3% of occupied bed-days) due to delayed transfers of care which although slightly higher than for August is generally an improving position.
- Non-elective LOS was 7.08 days for September discharges after spiking at 8.68 in Jan. Average occupied bed days rose slightly to 710 in September.

The intensive focus on managing capacity and flow remains in place with daily oversight at senior management and clinical level on the front door pathways and especially on reducing length of stay on the wards. The urgent care division are working collaboratively with system partners to address and change longstanding issues affecting patient transfers and discharges. The most effective changes to date have been

- Increasing the level of senior doctor cover in the ED at specific times of the day.
- Additional doctors working in the AMU
- Twice daily board rounds on AMUs
- Frail Elderly Unit at Maidstone
- Focus on SAFER across all wards.
- Weekly review of the KPI dashboard to monitor improvements
- Daily breach analysis & RCA reviews as appropriate.

2. Delayed Transfers of Care

Following the downward trend in the percentage of delayed transfers of care, this increased slightly in September to 5.3% but remains an improved position. The number of bed days lost increased from 961 in August to 1125 in September. We have experienced a greater focus from external partners on the exit routes from the hospital and have now rolled out Pathway 1 & 2 of the Home First initiative in full and the Frail Elderly unit at Maidstone operating effectively. Plans for the TWH Frailty Unit are in development but with limiting factors of staffing and capacity being a key risk. .

Row Labels	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	Jun-17	Jul-17	Aug-17	Sep-17
A : Awaiting Assessment	17	15	10	5	7	3	8	1	6	25	15	7	5	5	12	20	22	32	14	14	13	11	7	2	2
B : Awaiting Public Funding	8	7	3	1			1	1	1	8	12	25	21	5	3	6		4	3	1	3	3	3	2	
C : Awaiting Further Non-Acute NHS C	30	20	6	3	8	15	18	17	13	11	10	8	10	14	6	23	8	13	16	17	21	27	11	8	21
Di : Awaiting Residential Home	26	22	16	21	15	15	27	32	20	37	21	33	43	34	19	21	30	24	35	21	8	16	16	23	32
Dii : Awaiting Nursing Home	52	56	40	73	53	80	73	58	67	65	67	69	83	69	63	112	78	77	76	57	70	94	53	63	42
E : Awaiting Care Package	17	32	26	43	28	36	36	28	24	39	41	41	76	58	51	89	49	30	38	35	39	43	27	27	32
F : Awaiting Community Adaptations	1	13	9	8	14	5	13	8	7	12	4	6	10	8	5	7	9	10	13	6	8	7	15	8	5
G : Patient or Family Choice	43	26	22	31	12	12	22	13	9	19	19	10	16	20	16	14	9	19	28	6	10	8	10	13	14
H : Disputes	3	1	1		1				3	1	1				1			1	1	1	1	2		1	
I : Housing	1	13	12	9	3	5	1			5	5	2	3	2	4	8	3	5	4	3	3	5	6	8	2
Grand Total	198	205	145	194	141	171	199	158	150	222	195	201	267	215	180	300	208	215	228	161	176	216	148	155	150
Trust delayed transfers of care	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%	6.1%	5.4%	4.5%	5.3%

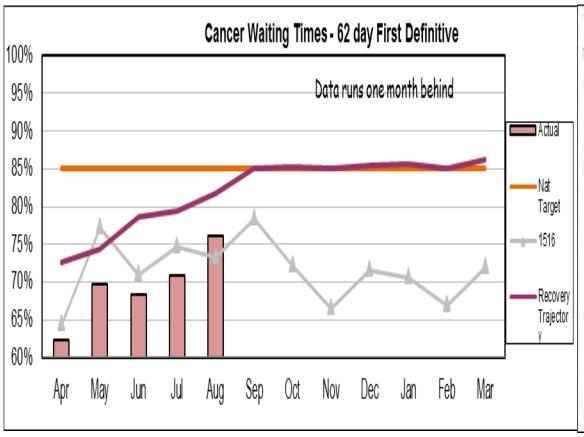
- The number of patients being funded through the CCG commercial bed fund in private nursing homes continued to reduce in month with approximately 15 on the caseload, the majority of these are elderly patients with orthopaedic issues who are waiting healing in order to regain function. This has significantly decreased in month due to patients coming to the end of their stay
- Additional social care support has been allocated to the Maidstone Frailty Unit which commenced in August.
- Enablement capacity has been sufficient to meet the demand throughout the month.
- CHS (an external agency to locate and facilitate discharge to nursing homes and private POC within 5 days for privately funded patients) exceeded target in September, placing 30 patients against a target of 20
- Senior staff from the integrated discharge team 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.
- Homelessness issues have risen during the month, with several older patients becoming homeless on admission. Care Navigator involved in supporting these clients. There have also been several younger patients who have needed housing support

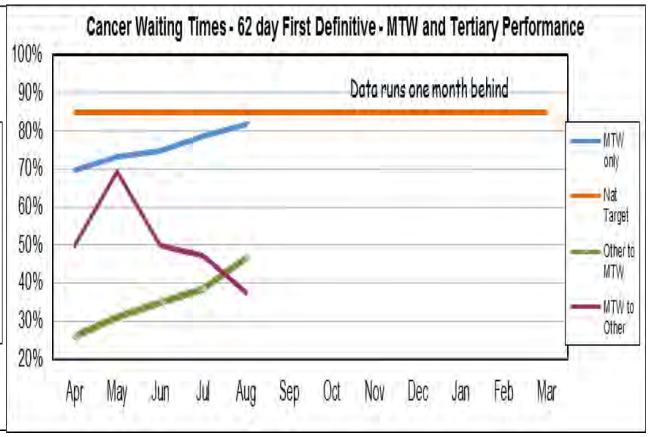
3. Cancer 62 Day First Definitive Treatment

The 62 day performance in August has improved significantly (+5.1%) compared to the previous month. The delivery plan remains focused both on patients in the 40 -62 day category and those who have already breached to bring them in for treatment sooner to help reduce the backlog. The total number of breached patients was lower than in July and the treatments were higher in August than in July. 117.0 treatments were completed in August. Looking forward on the PTL for September the performance overall is a slight decrease on August but has largely matched the performance for MTW only patients.

The key improvement initiative for the cancer services is the daily huddle where the focus is on the next event for individual patients (outpatient appt, test, result review, date for treatment) that is needed to pull them through the pathway, with any delays or blocks being actioned on the same day.

In addition, straight to test triage clinics are now well established for colorectal and lung referrals. This is reducing the overall length of pathways for these patients and has significantly improved the performance of lower GI.





62 Day Performance - All			
Tumour	Total	Brch	%
Breast	22	0.0	100
Lung	10.5	3.0	71.4
Haemat.	4.5	2.5	44.4
Upper GI	11.5	3.0	75.9
Lower GI	22.5	3.0	86.7
Skin	0	0.0	0.0
Gynae	12	3.5	70.8
Urology	26	9.5	63.5
Head & Nk	5.5	2.0	63.6
Sarcoma	0	0.0	0.0
Brain/CNS	0.5	0.5	0.0
Other	2	1.0	50
Total	117	28.0	76.1

62 Day Performance - MTW			
Tumour	Total	Brch	%
Breast	22	0.0	100
Lung	6	1.0	83.3
Haemat.	4	2.0	50.0
Upper GI	9	1.0	88.9
Lower GI	21	2.0	90.5
Skin	0	0.0	0.0
Gynae	10	3.0	70.0
Urology	23	8.0	65.2
Head & Nk	2	0.0	100
Sarcoma	0	0.0	0.0
Brain/CNS	0	0.0	0.0
Other	2	1.0	50
Total	99	18.0	81.8

In August, Urology has contributed the largest number of breaches overall. Gynaecology contributed the second highest number of breaches.

MTW only patient performance in percentage terms continues to improve month on month.

Breaches for lower GI, Lung and Head & Neck in absolute numbers have reduced compared to the previous month

4. Referral To Treatment – 18 weeks

September performance shows the Trust continues to forecast non-compliance with the Incomplete RTT standards at an aggregate level – 84.6%. Our trajectory requires us to achieve 92% by the end of November 2017. The limiting factor remains access to elective capacity at TWH and the Planned Care Division are reviewing the bed and theatre configuration across both sites to

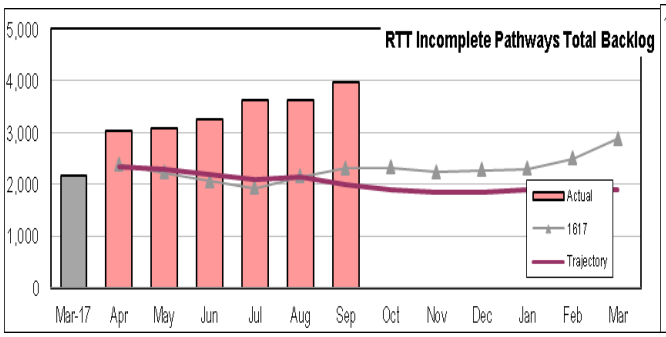
maximise available capacity. There are also 2 medical specialties where consultant capacity is a limiting factor.

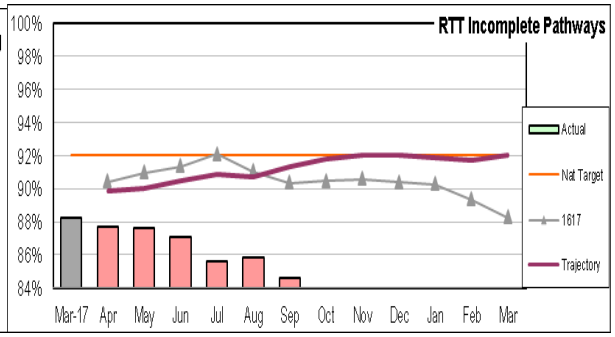
The Trust continues to be non-compliant at a speciality level for a number of specialties but T&O, Gynae, and Cardiology present the most risk of underperforming against the November deadline, all of which are being carefully monitored against action plans put in place to reduce their longest waiters. All these specialities are trying to continue to reduce their backlogs by maximising available capacity across both sites and focusing capacity on booking patients within the backlog to all available sessions, including Saturdays.

	Sep-17	Sep-17 Trajectory	Variance from trajectory
RTT Backlog Incomplete	3,967	2,000	-1967
RTT Waiting List	25,741	23,132	-2609
RTT Incomplete performance %	84.6%	91.35%	-6.75

Operational teams are focused on their recovery plans to increase elective activity and we are holding 2 RTT summits with the specialties in September.
There were 161 operations cancelled on the day of which 59 were reportable.

- Improve overall theatre utilisation to increases levels of elective activity. The Trust has commissioned a productivity company – FourEyes to support us with this work.
- Implement remedial actions to specialties furthest from trajectory - T&O, Gynaecology, and Cardiology. In place.
- Continue weekly PTL/RTT performance monitoring to maintain overall performance.



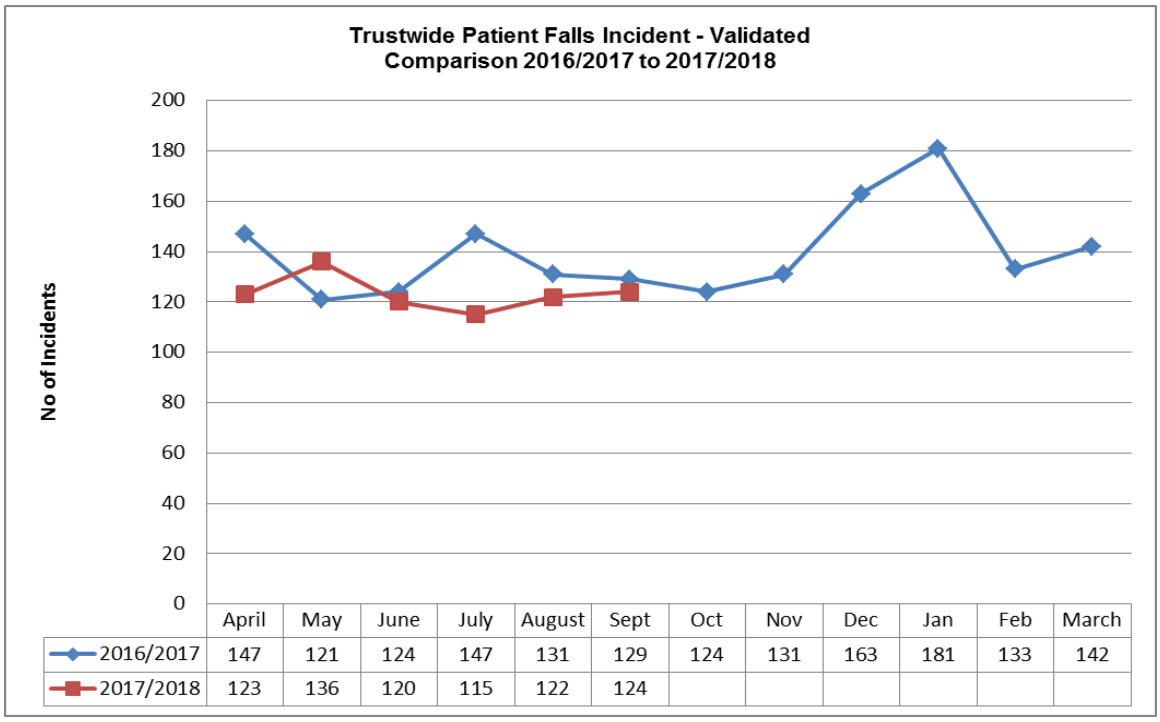


Quality and Safety

Patient falls incidents

There were 124 patient falls reported for September and a rate of 5.87 per 1000 bed days. This is slightly up compared to the same month last year, however the rate YTD is 5.7 against a limit 6.0.

3 falls were declared as Serious Incidents (SI) in September. This makes a total of 19 SIs year to date compared to 13 this time last year.



	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
2016/2017	147	121	124	147	131	129	124	131	163	181	133	142
2017/2018	123	136	120	115	122	124						

Learning identified through recent investigation of serious incidents relating to falls includes the following actions:

- Falls prevention care plan reviewed when patients condition changes (improve, deteriorate or on transfer).
- Assessment for enhanced care where appropriate in the management of patient at high risk of falls.
- Increase frequency of monitoring/ comfort checks of patient at risk of falls who has a decline in cognition.

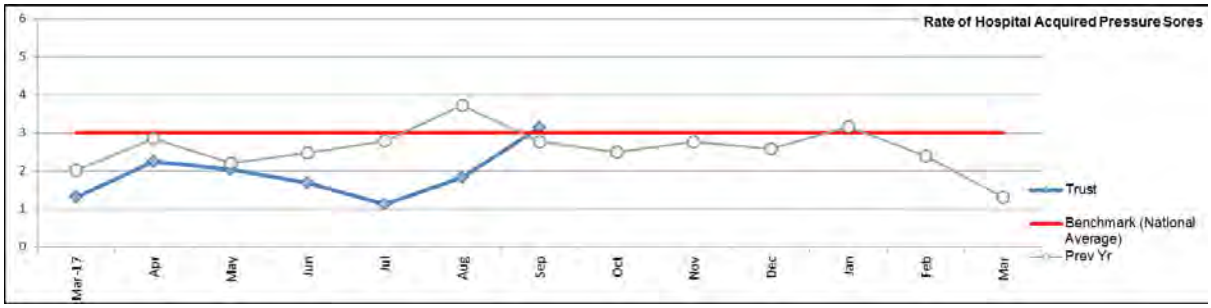
Friends and Family test

The response rates to the Friends and Family test have continued to remain largely stable, however there has been a reduction in the ED responses for the month with a total response rate of 5.2% which is below the Trust target of 15%. This was due, in part, to issues with order and supply of cards.
Positive response scores remain at or above the national average. The drop in positive scores in maternity earlier in the year means that YTD is 93.55 which is below the target of 95%

The FFT group continues to meet regularly to review the project pathways, data analysis and to maintain a raised awareness of the Friends and Family question. There is a continued focus to embed the process of collecting feedback into daily routines and sharing good practice. This has been demonstrated through the development of an AE Case study.

Pressure Ulcers:
There has been an increase in pressure ulcer incidents in September, with 17 being reported in September giving a rate of 3.0 against a limit of 3.0. Of these 1 was a Category 3 and 1 Category 4. These are currently under investigation.

There is a trend for increases in August/September (graph) however a number of actions are in progress including review of care guides, mattress availability, heel protector availability and review of continence products specifically pads.



Complaints

There were 39 new complaints reported for September, which equates to a rate of 1.84 new complaints per 1,000 occupied bed days.

44.4% of the complaints have been responded within target for September compared to a target of 75%.

The Central Complaints Team (CCT) is now fully staffed (as of 18th September) so are now better placed to support the directorates. Ongoing actions include weekly CCT review of all responses approaching deadlines, regular meetings with directorate links to monitor and support progress.

Critical Care is the only directorate to achieve the 75% compliance target.

Financial commentary

- The Trusts surplus including STF was £4.8m in September which was £3.7m favourable to plan, due to, £1.5m STF over-performance in month due to quarterly delivering of the financial control target, £2.1m release of reserves, £1m increased assumption around contract price increase, £0.7m depreciation benefit, partly offset by £1.3m slippage against the original plan CIP phasing and adverse variances against budget.
- The Trust's net surplus (including technical adjustments) in September is £4.8m against a planned surplus of £1m, therefore £3.7m favourable to plan. The Trusts year to date net deficit (including technical adjustments) is £1.1m, achieving the plan.
- The Trust's YTD deficit excluding STF is £5m which is achieving the plan.
- In September the Trust operated with an EBITDA surplus of £6.6m, £3m favourable to plan.
- The key variances in the month are as follows:
  - Total income was £2.6m favourable in the month; Clinical Income excluding HCDs was £1.1m favourable in September which included £1m increased assumption around contract price increase and the release of £0.4m challenge provision therefore a normalised adverse variance of £0.3m. The key adverse variances in September were Elective & Day Cases (£0.6m) and Out Patient Activity (£0.5m) offset by favourable variances within non elective £1.2m.The position included a £1.1m benefit relating to the aligned incentive contract (£2.2m positive YTD). STF was £1.5m adverse in September, other operating income was £0.5m favourable due to £1m STP income offsetting additional costs partly offset by adverse variances relating to Private Patient income (£0.3m) and Education and Training Income (£0.1m).
  - Pay was £0.4m favourable in the month due to the release of £1.7m contingency reserve. Medical Staffing costs were the highest this financial year partly due to consultant arrears of pay

(£50k) and continued high locum and agency usage within Emergency and Acute Directorate. The directorates medical spend is split 42% locum / agency compared to the Trust average of 19%. Nursing costs increased between months by £0.65m, £0.25m due to a five week month, £0.2m release of 2016/17 accrual in August, £0.1m catch-up in invoices and there has been a further increase in the use of non-framework agency's which now is at 20%. Scientific and Technical staff spend increased by £19k between months mainly within Pharmacy due to an increase in agency costs covering vacant posts. Support staff costs within Estates and Facilities increased by £56k between months to cover vacancies and high level of sickness.

  - Non Pay was breakeven in September, £1m adverse relating to pass through costs for STP, Clinical Supplies £0.3m adverse (mainly due to unidentified CIP) partly offset by £0.3m favourable variance relating to reduction of outsourcing costs. The position in September included an estimate for the rates rebate consistent with previous years (£0.7m) an increase of £0.1m due to charges from NHS property services being higher than previously estimated and a £0.1m catch-up in energy invoices.

- The CIP performance in September delivered efficiencies of £1.9m which was £1.3m adverse to the phasing of the original plan, £4.1m adverse year to date. The adverse CIP position is the primary driver behind the pressure on the Trust's financial performance. The Trust has a risk adjusted CIP forecast of £23.3m, £8.4m adverse to plan.
- The Trust held £2.2m of cash at the end of September which is in line with the plan (£2.4m). 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 for resolution. It has also been agreed to switch to invoicing the STP budget in advance, rather than retrospectively.
- The Trust is forecasting to deliver the pre STF deficit of £4.5m, however the Trust needs to deliver the full value of its CIP programme and take additional action of £8.6m to deliver the control total. Please see the Financial Forecast 2017/18 paper which provides further analysis.

Workforce commentary

As at the end of September 2017, the Trust employed 4992.80 whole time equivalent substantive staff, a 3.01 WTE reduction from the previous month. Temporary staffing remains higher than planned, but with a large shift from agency to bank than expected.

Sickness absence in the month (August) increased marginally to 3.41% but remains below target for the Trust as a whole. Effective sickness absence management remains a key area of focus for the HR and operational management teams, particularly targeting outlying areas.

Statutory and mandatory training compliance has increased to 88.82% from the previous month, and remains above the target percentage.

Turnover has remained higher than target in September at 11.79%, despite a slight reduction from a peak of 12.16% in August. HR Business Partners continue to work closely with divisional operational management teams in order to address areas which have a high turnover.

Appraisal compliance for July, following the end of the Trust's designated appraisal window in June, stands at 86.47%, a 2.53% increase from the previous month.

TRUST PERFORMANCE DASHBOARD **Position as at:** **30 September 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)	9.12	4.7	14.4	11.7	-2.7	-	11.5	10.3	
1-02	Number of cases C.Difficile (Hospital)	2	1	19	15	-4	-	27	27	
1-03	Number of cases MRSA (Hospital)	0	0	0	0	0	0	0	0	
1-04	Elective MRSA Screening	98.0%	99.0%	98.0%	99.0%	1.0%	1.0%	98.0%	99.0%	
1-05	% Non-Elective MRSA Screening	97.0%	97.0%	97.0%	97.0%	0.0%	2.0%	95.0%	97.0%	
1-06	**Rate of Hospital Pressure Ulcers	2.78	3.14	2.80	2.01	- 0.79	- 1.00	*3.01*	2.24	3.00
1-07	***Rate of Total Patient Falls	5.43	5.87	5.79	5.70	- 0.09	- 0.30	*6.00*	5.56	
1-08	***Rate of Total Patient Falls Maidstone	4.88	5.76	5.18	5.05	- 0.13			4.76	
1-09	***Rate of Total Patient Falls TWells	5.82	5.93	6.24	6.13	- 0.11			6.13	
1-10	Falls - SIs in month	4	3	14	19	5				
1-11	Number of Never Events	0	0	1	0	-1	0	*0*	0	
1-12	Total No of SIs Open with MTW	30	58			28				
1-13	Number of New SIs in month	6	15	55	77	22	17			
1-14	***Serious Incidents rate	0.27	0.71	0.42	0.60	0.18	0.54	*0.0584 - 0.6978*	0.60	*0.0584 - 0.6978*
1-15	Rate of Patient Safety Incidents - harmful	0.48	1.31	0.62	1.20	0.58	- 0.03	*0 - 1.23*	1.20	*0 - 1.23*
1-16	Number of CAS Alerts Overdue	0	1			1	1	*0*		
1-17	VTE Risk Assessment	95.3%	95.2%	95.3%	96.3%	1.0%	1.3%	95.0%	96.3%	95.0%
1-18	Safety Thermometer % of Harm Free Care	95.8%	97.1%	96.4%	97.2%	0.8%	2.2%	95.0%		93.4%
1-19	Safety Thermometer % of New Harms	4.21%	2.88%	3.33%	2.71%	-0.61%	-0.3%	*3.00%*	2.71%	
1-20	C-Section Rate (non-elective)	12.9%	13.7%	13.9%	14.2%	0.27%	-0.8%	*15.0%*	14.2%	

	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	1.0717	0.0	0.1	Band 2	Band 2	1.0
2-02	Standardised Mortality HSMR	Prev Yr: Apr 15 to Mar 16		107.0	104.6	- 2.4	4.6	Lower confidence limit		100.0
2-03	Crude Mortality	1.0%	0.9%	1.2%	1.1%	0.0%		to be <100		
2-04	****Readmissions <30 days: Emergency	11.5%	13.1%	11.6%	12.4%	0.8%	-1.2%	*13.6%*	12.4%	14.1%
2-05	****Readmissions <30 days: All	11.0%	12.6%	10.8%	11.8%	1.0%	-2.8%	*14.7%*	11.8%	14.7%
2-06	Average LOS Elective	3.12	3.43	3.24	3.49	0.26	0.29	*3.20*	3.49	
2-07	Average LOS Non-Elective	7.81	7.08	7.58	7.27	- 0.31	0.47	*6.80*	7.27	
2-08	******FollowUp : New Ratio	1.55	1.54	1.59	1.56	- 0.03	0.04	*1.52*	1.56	
2-09	Day Case Rates	86.5%	83.5%	84.9%	86.2%	1.3%	6.2%	80.0%	86.2%	82.2%
2-10	Primary Referrals	10,021	8,359	59,742	54,573	-8.7%	-4.5%	119,266	109,586	
2-11	Cons to Cons Referrals	5,594	3,977	30,773	26,415	-14.2%	-11.4%	58,644	53,043	
2-12	First OP Activity	17,331	15,372	100,015	93,490	-6.5%	-6.8%	201,705	187,734	
2-13	Subsequent OP Activity	31,566	27,713	187,608	175,165	-6.6%	-5.8%	383,906	351,743	
2-14	Elective IP Activity	625	658	4,105	3,441	-16.2%	-23.7%	8,303	6,910	
2-15	Elective DC Activity	3,620	3,270	22,772	21,211	-6.9%	-5.9%	43,602	42,593	
2-16	**Non-Elective Activity	4,423	4,763	25,651	28,347	10.5%	19.6%	46,435	56,539	
2-17	A&E Attendances (Inc Clinics. Calendar Mth)	14,096	14,292	85,076	86,047	1.1%	1.3%	168,161	169,162	
2-18	Oncology Fractions	5,966	5,369	35,968	34,507	-4.1%	-8.1%	75,273	69,014	
2-19	No of Births (Mothers Delivered)	560	531	3,050	3,028	-0.7%	1.3%	5,977	6,056	
2-20	% Mothers initiating breastfeeding	80.8%	82.8%	82.8%	81.4%	-1.4%	3.4%	78.0%	81.4%	
2-21	% Stillbirths Rate	0.4%	0.55%	0.53%	0.36%	*-0.2%*	*-0.1%*	*0.47%*	0.36%	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	5	5	5	0	5	
3-02	*****Rate of New Complaints	0.82	1.84	1.69	1.84	0.2	0.53	*1.318-3.92*	1.80	
3-03	% complaints responded to within target	57.7%	44.4%	74.3%	60.2%	-14.1%	-14.8%	75.0%	60.2%	
3-04	****Staff Friends & Family (FFT) % rec care	82.7%	76.0%	82.7%	76.0%	-6.6%	-3.0%	79.0%	76.0%	
3-05	*****IP Friends & Family (FFT) % Positive	92.7%	95.5%	95.3%	95.7%	0.4%	0.7%	95.0%	95.7%	95.8%
3-06	A&E Friends & Family (FFT) % Positive	89.3%	91.1%	90.6%	91.6%	1.0%	4.6%	87.0%	91.6%	85.5%
3-07	Maternity Combined FFT % Positive	94.2%	96.3%	94.0%	93.5%	-0.5%	-1.5%	95.0%	93.5%	95.6%
3-08	OP Friends & Family (FFT) % Positive	83.4%	84.8%	82.6%	84.3%	1.8%			84.3%	

* 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"** ** NE Activity Includes Maternity

	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	89.4%	89.99%	89.6%	90.5%	1.0%	0.5%	90.1%	90.1%	85.4%
4-02	Emergency A&E >12hr to Admission	0	-	0	0	0	0	*0*	0	
4-03	Ambulance Handover Delays >30mins	New	519	New	2,496					
4-04	Ambulance Handover Delays >60mins	New	65	New	224					
4-05	RTT Incomplete Admitted Backlog	1,029	2315	1,029	2315	1,286	983	1,259	1259	
4-06	RTT Incomplete Non-Admitted Backlog	516	1654	516	1654	1,138	986	631	631	
4-07	RTT Incomplete Pathway	90.4%	84.6%	90.4%	84.6%	-5.8%	-5.8%	92%	92.0%	
4-08	RTT 52 Week Waiters	0	0	0	4	4	4	*0*	4	
4-09	RTT Incomplete Total Backlog	2,309	3968	2,309	3968	1,659	1,968	1,890	1890	
4-10	% Diagnostics Tests WTimes <6wks	99.70%	99.8%	99.7%	99.8%	0.1%	0.8%	99.0%	99.0%	
4-11	*Cancer WTimes - Indicators achieved	3	4	2	4	2	- 5	9	9	
4-12	*Cancer two week wait	93.3%	91.5%	91.4%	92.5%	1.1%	-0.5%	93.0%	93.0%	
4-13	*Cancer two week wait-Breast Symptoms	90.0%	82.8%	86.6%	84.9%	-1.7%	-8.1%	93.0%	93.0%	
4-14	*Cancer 31 day wait - First Treatment	96.8%	97.2%	96.5%	96.3%	-0.3%	0.3%	96.0%	96.0%	
4-15	*Cancer 62 day wait - First Definitive	73.3%	76.1%	71.9%	73.7%	1.8%	-2.7%	85.0%	85.0%	
4-16	*Cancer 62 day wait - First Definitive - MTW	76.5%	81.8%	76.5%	81.8%	5.3%		85.0%		
4-17	*Cancer 104 Day wait Accountable	4.5	5.0	46.5	39.0	-7.5	39.0	*0*	39.0	
4-18	*Cancer 62 Day Backlog with Diagnosis	74	54	74	54	-20				
4-19	*Cancer 62 Day Backlog with Diagnosis - MTW	51	41	51	41	-10				
4-20	Delayed Transfers of Care	7.2%	5.3%	6.3%	5.5%	-0.7%	2.0%	3.5%	5.5%	
4-21	% TIA with high risk treated <24hrs	66.7%	81.0%	78.0%	67.3%	-10.7%	7.3%	60%	67.3%	
4-22	*******% spending 90% time on Stroke Ward	84.3%	94.8%	85.9%	91.1%	5.2%	11.1%	80%	91.1%	
4-23	*******Stroke:% to Stroke Unit <4hrs	50.9%	66.2%	49.7%	59.4%	9.8%	-0.6%	60.0%	60.0%	
4-24	*******Stroke: % scanned <1hr of arrival	50.0%	75.8%	53.5%	64.6%	11.1%	16.6%	48.0%	64.6%	
4-25	*******Stroke:% assessed by Cons <24hrs	55.6%	80.3%	62.2%	77.7%	15.5%	-2.3%	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	3	2	6	15	9	15	*0*	15	

RTT Incomplete Pathway Monthly Plan is Trust Recovery Trajectory

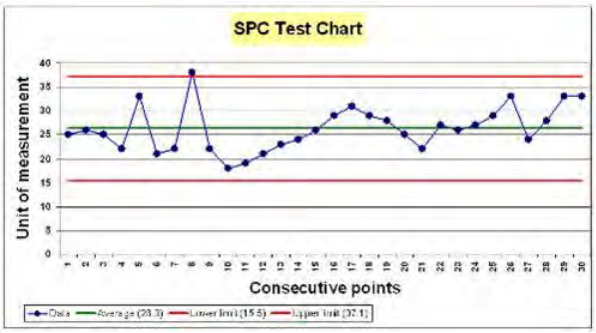
**CWT run one mth behind, YTD is Quarter to date, Monthly Plan for 62 Day Wait First Definitive is Trust Recovery Trajectory*

**** 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	41,319	38,933	211,770	221,542	4.6%	2.3%	436,643	443,179	
5-02	EBITDA	8,175	6,633	4,977	13,524	171.7%	-6.2%	38,055	37,105	
5-03	Surplus (Deficit) against B/E Duty	5,405	4,753	(11,403)	(1,077)			6,673	6,673	
5-04	CIP Savings	1,510	1,920	9,081	9,238	1.7%	-31.0%	31,721	31,721	
5-05	Cash Balance	5,618	2,227	5,618	2,227	-60.4%	-5%	1,000	1,000	
5-06	Capital Expenditure	329	287	1,489	883	-40.7%	-88.5%	*16,948*	15,700	
5-07	Establishment WTE	5,737.2	5,599.0	5,737.2	5,599.0	-2.4%	0.0%	5,599.0	5,599.0	
5-08	Contracted WTE	5,165.0	4,992.8	5,165.0	4,992.8	-3.3%	-2.3%	5,112.5	5,112.5	
5-09	Vacancies WTE	572.3	606.2	572.3	606.2	5.9%	24.6%	486.5	486.5	
5-11	Vacancy Rate (%)	10.0%	10.8%	10.0%	10.8%	0.9%	2.1%	8.7%	8.7%	
5-12	Substantive Staff Used	4,992.0	4,849.3	4,992.0	4,849.3	-2.9%	-5.1%	5,112.5	5,112.5	
5-13	Bank Staff Used	362.1	448.1	362.1	448.1	23.8%	34.4%	333	333.3	
5-14	Agency Staff Used	226.7	164.3	226.7	164.3	-27.5%	7.2%	153.2	153.2	
5-15	Overtime Used	57.3	51.3	57.3	51.3	-10.4%				
5-16	Worked WTE	5,638.1	5,513.1	5,638.1	5,513.1		-1.5%	5,599.0	5,599.0	
5-17	Nurse Agency Spend	(420)	(736)	(4,570)	(3,427)	-25.0%				
5-18	Medical Locum & Agency Spend	(1,199)	(1,313)	(7,922)	(7,208)	-9.0%				
5-19	Temp costs & overtime as % of total pay bill	14.2%	17.6%	16.2%	14.8%	-1.3%				
5-20	Staff Turnover Rate	10.3%	11.8%		11.7%	1.4%	1.2%	*10.5%*	11.7%	11.05%
5-21	Sickness Absence	3.8%	3.4%		3.3%	-0.4%	0.0%	*3.3%*	3.3%	4.3%
5-22	Statutory and Mandatory Training	88.1%	88.8%		87.8%	0.8%	2.8%	85.0%	87.8%	
5-23	Appraisal Completeness	72.2%	86.5%		86.5%	14.3%	-3.5%	90.0%	90.0%	
5-24	Overall Safe staffing fill rate	97.3%	98.8%	99.7%	98.5%	-1.2%		93.5%	98.5%	
5-25	****Staff FFT % recommended work	60.2%	51%	60.2%	51%	-9.3%	-11.1%	62.0%	51%	
5-26	***Staff Friends & Family -Number Responses	98	701	98	701	603				
5-27	*****IP Resp Rate Recmd to Friends & Family	22.1%	22.1%	23.5%	24.0%	0.4%	-1.0%	25.0%	25.0%	25.7%
5-28	A&E Resp Rate Recmd to Friends & Family	15.6%	5.2%	14.2%	15.8%	1.6%	0.8%	15.0%	15.8%	12.7%
5-29	Mat Resp Rate Recmd to Friends & Family	22.4%	21.5%	22.2%	29.9%	7.7%	4.9%	25.0%	29.9%	24.0%

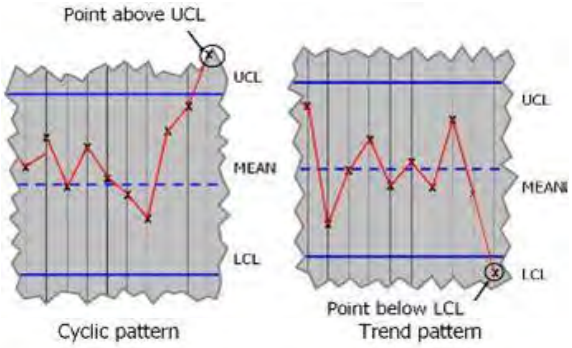
Explanation of Statistical Process Control (SPC) Charts

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:

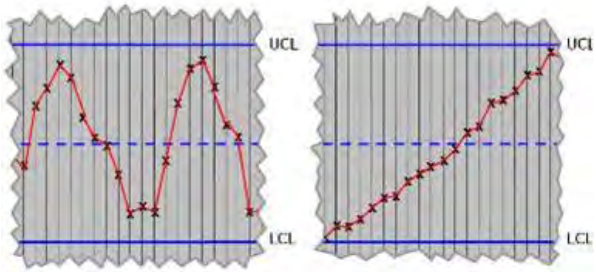


SPC is a type of charting that shows the variation that exists in the systems that are being measured. When interpreting SPC charts there are 4 rules that help to identify what the system is doing. If one of the rules has been broken, this means that 'special cause ' variation is present in the system. 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.

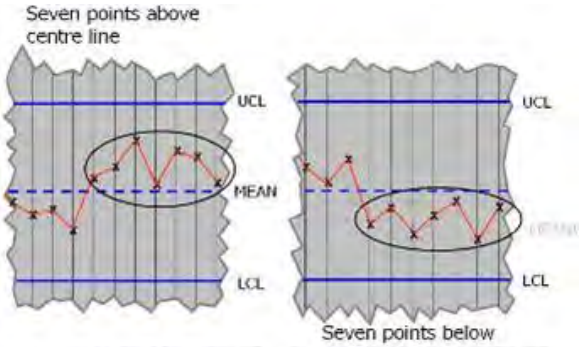


Rule 2: Any unusual pattern or trends within the control limits. The most obvious example of a cyclical pattern is seasonality but we also see it when looking at daily discharges where the weekends have low numbers. To qualify as a trend there must be at least 6 points in a row. This is one of the key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

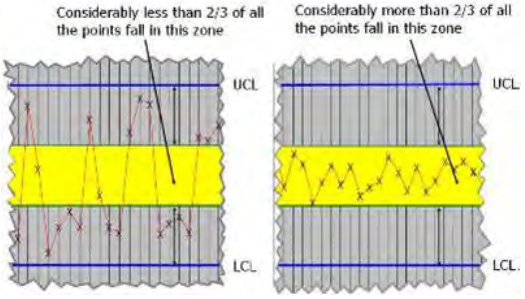


Rules 1 and 2 are the main reason for displaying SPC charts on our performance reports as it makes abnormally high or low values and trends immediately obvious. However there are two other rules that are also used to interpret the graphs.

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.

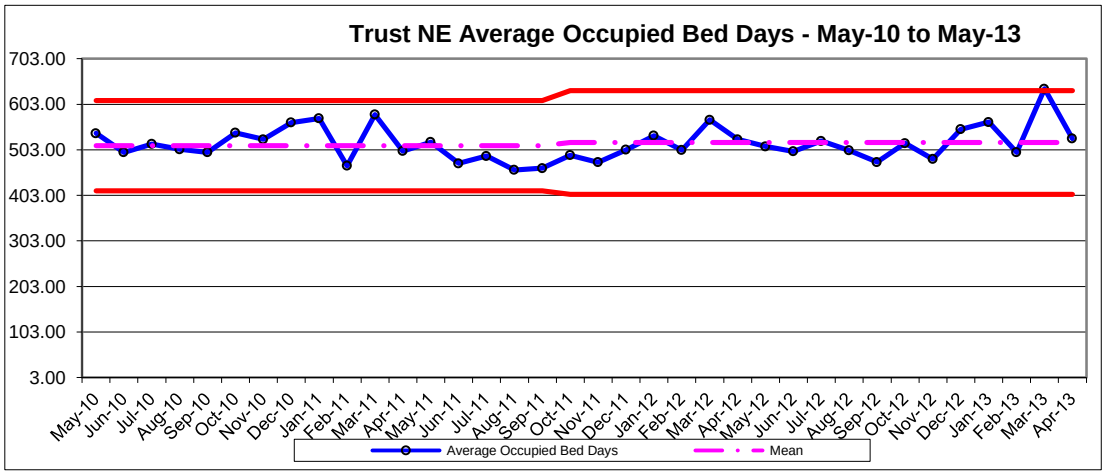


Rule 4: The number of points within the middle third of the region between the control limits differs markedly from two -thirds of the total number of points. This gives an indication of how stable a process is. If controlled variation (common cause) is displayed in the SPC chart, the process is stable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

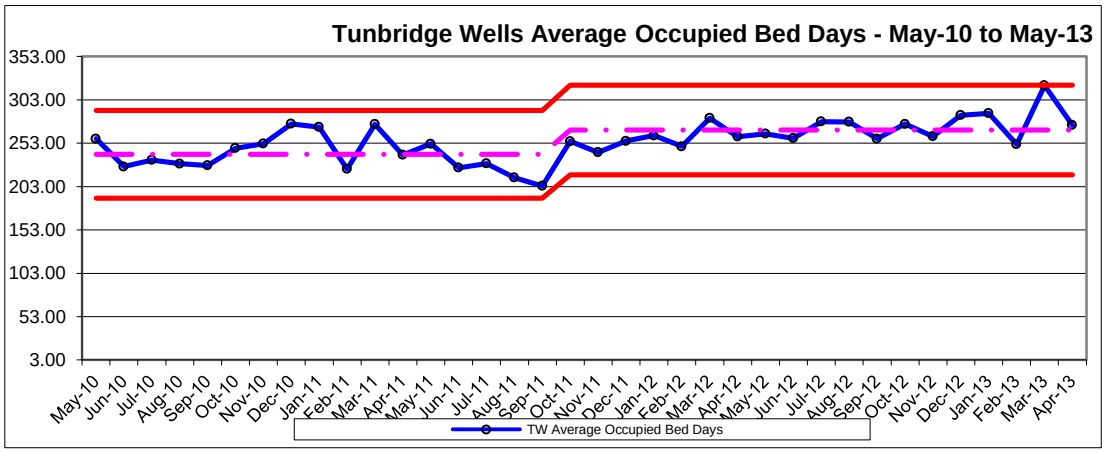


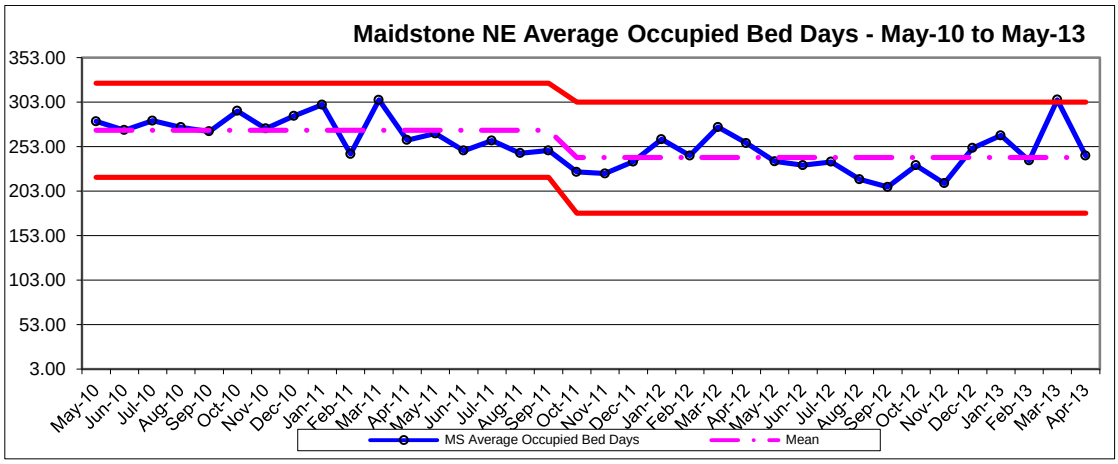
Changes to Control Lines

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:

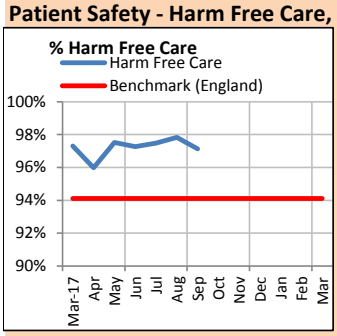


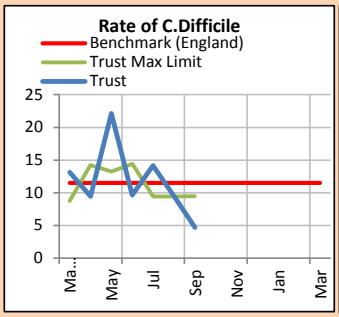


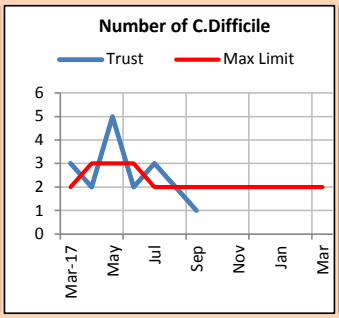
So in the examples given we have calculated a mean and control limits based on the data for May 2010 to September 2011 and then calculated them based on the period October 2011 to April 2013. The lines are all a result of the SPC calculations, only the date of the change is decided by the Information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

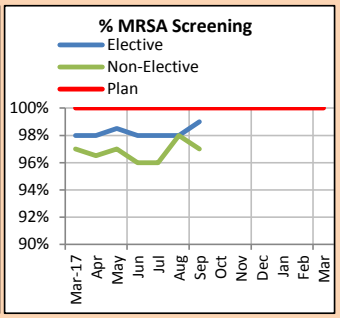
INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

Patient Safety - Harm Free Care, Infection Control

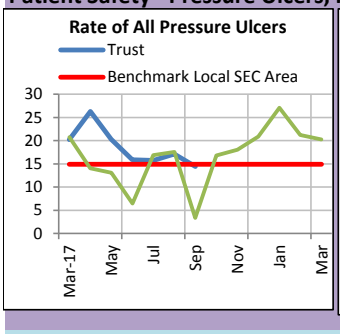


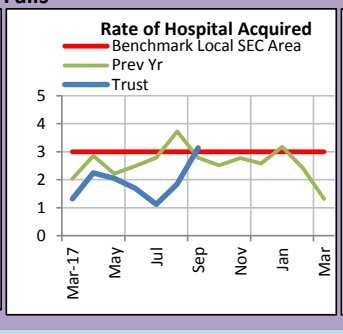


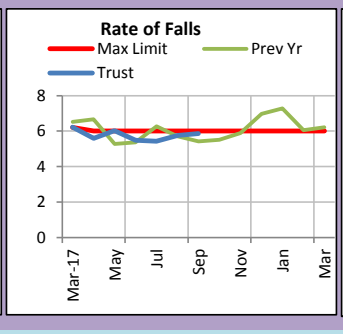


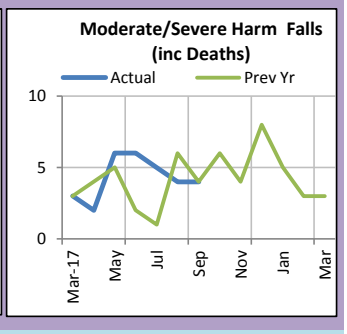


Patient Safety - Pressure Ulcers, Falls

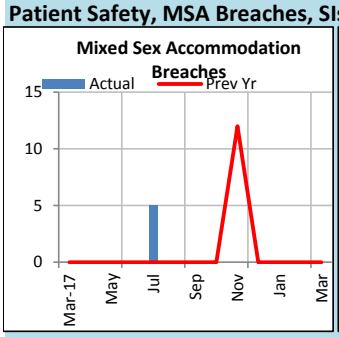


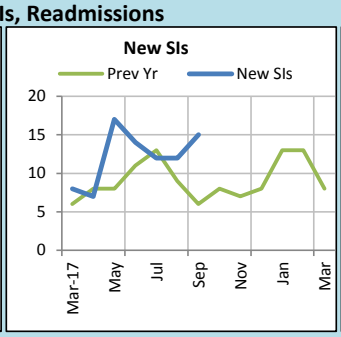


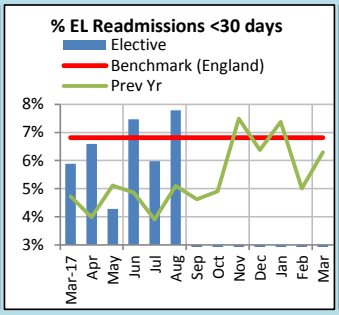


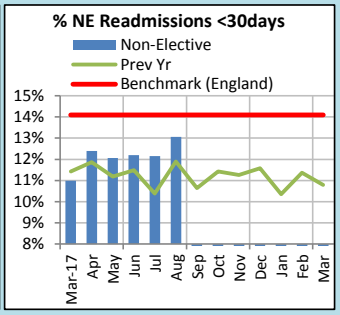


Patient Safety, MSA Breaches, SIs, Readmissions

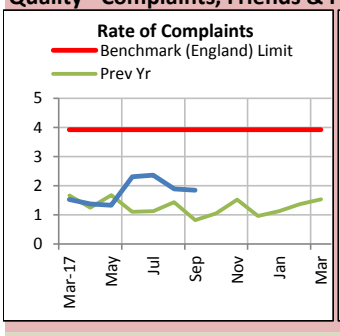


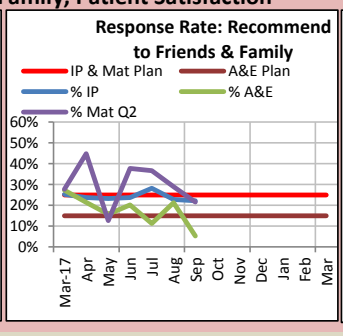


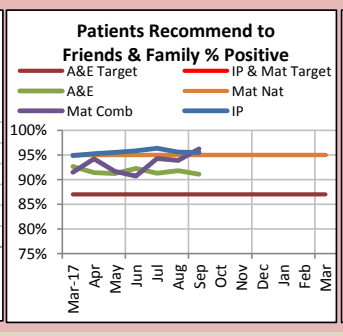


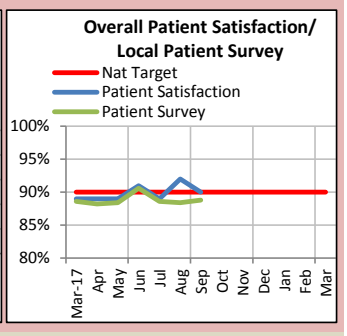


Quality - Complaints, Friends & Family, Patient Satisfaction

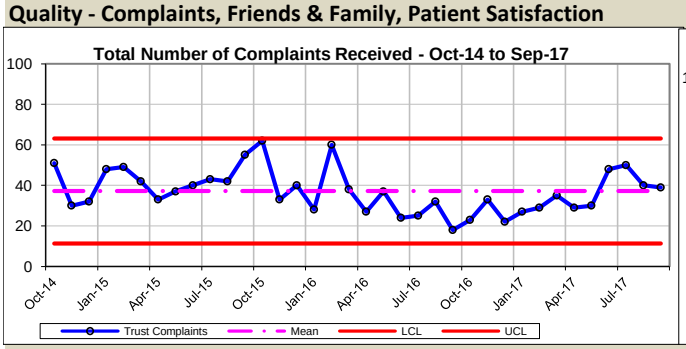


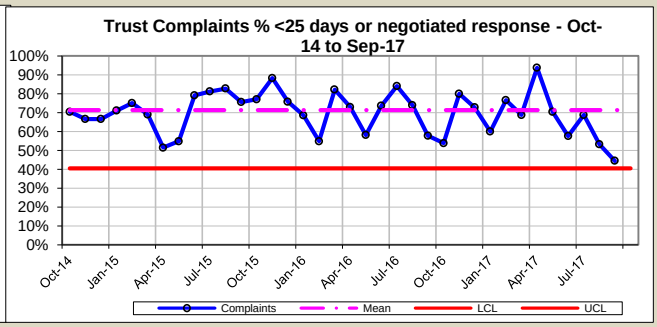




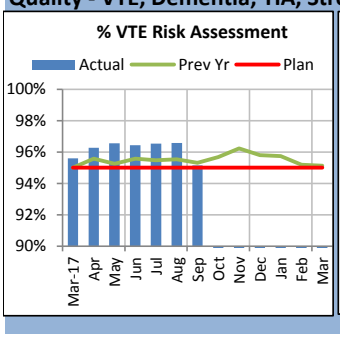


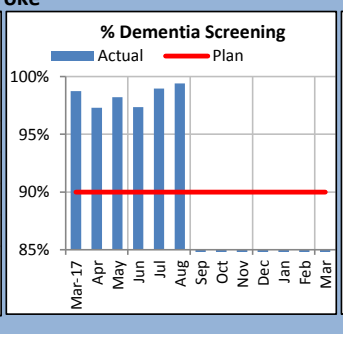
Quality - Complaints, Friends & Family, Patient Satisfaction

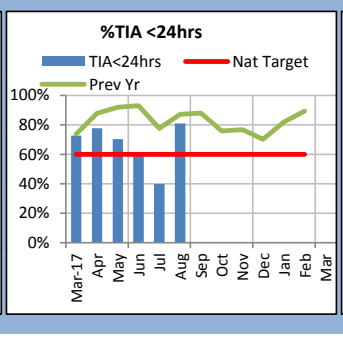


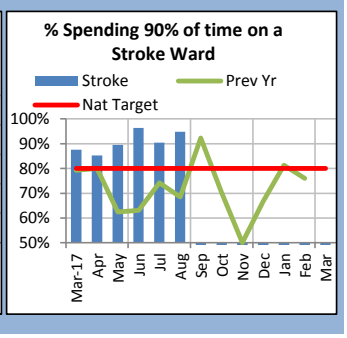


Quality - VTE, Dementia, TIA, Stroke



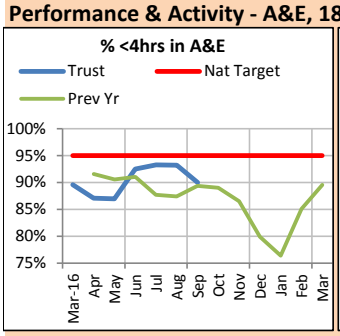


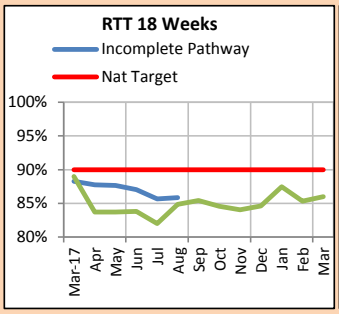


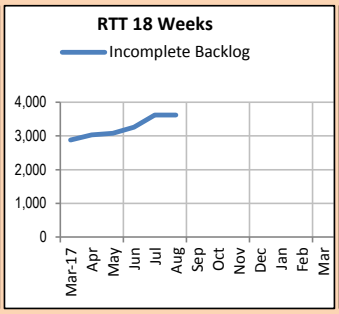


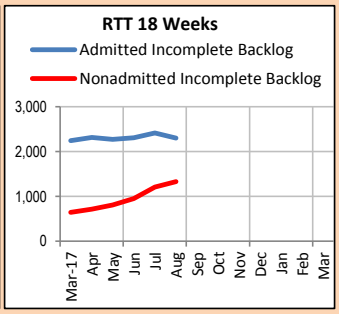
INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

Performance & Activity - A&E, 18 Weeks

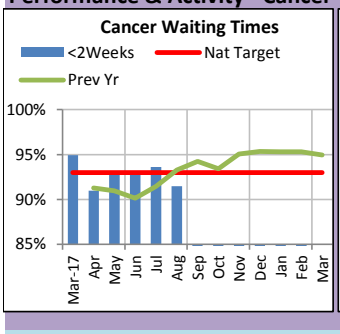


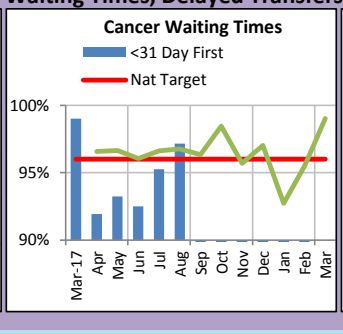


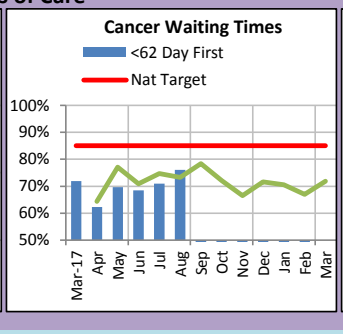


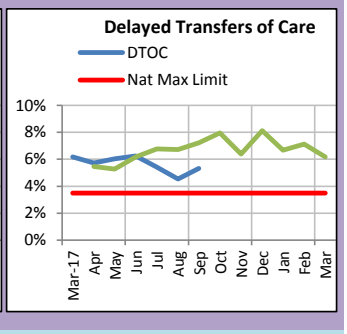


Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care

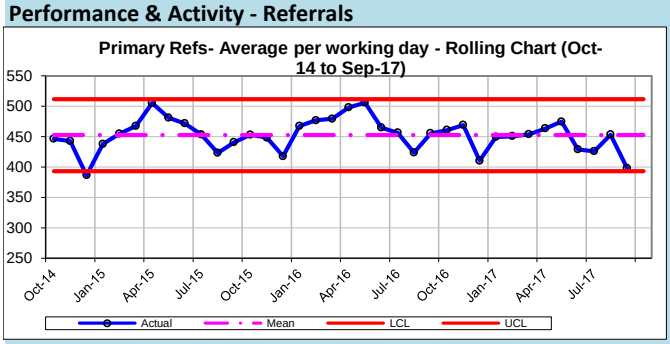


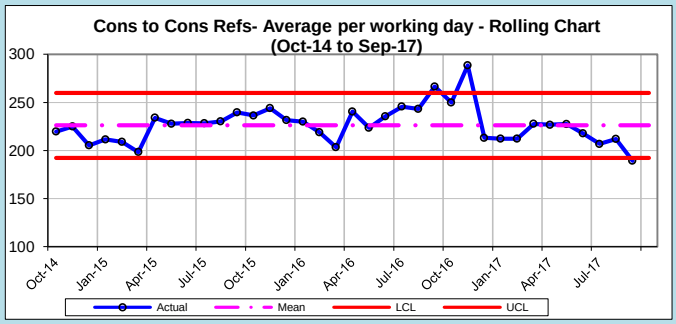




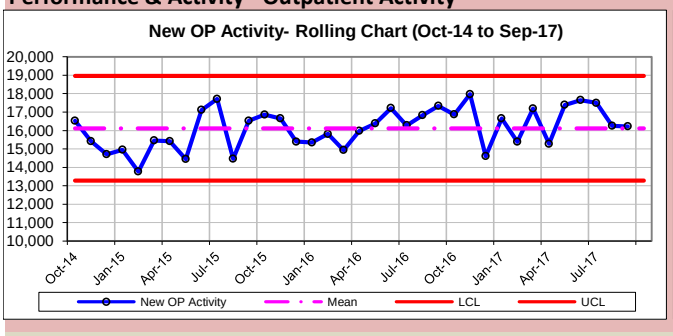


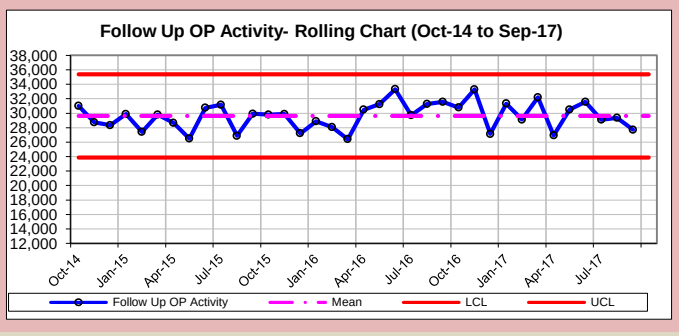
Performance & Activity - Referrals



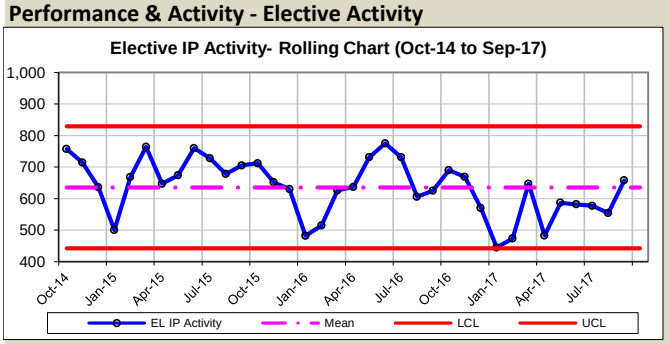


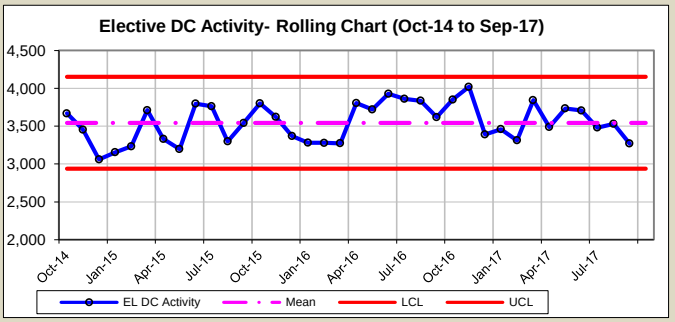
Performance & Activity - Outpatient Activity



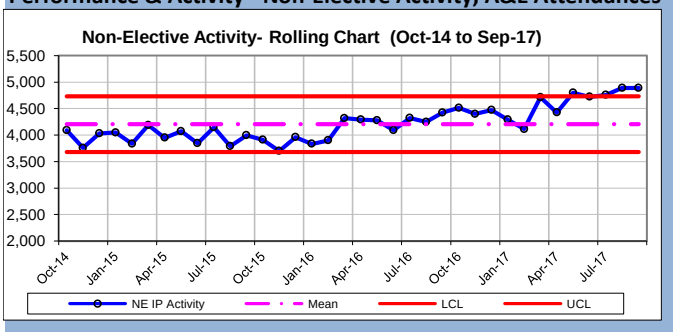


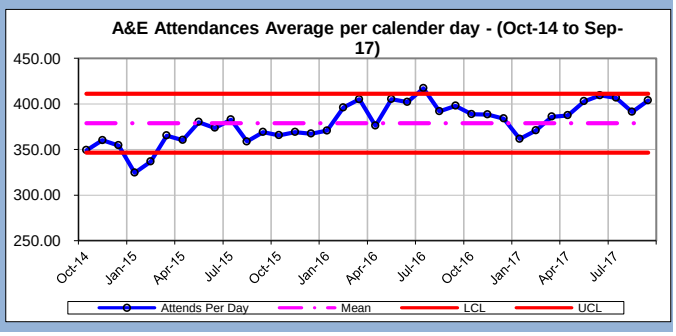
Performance & Activity - Elective Activity





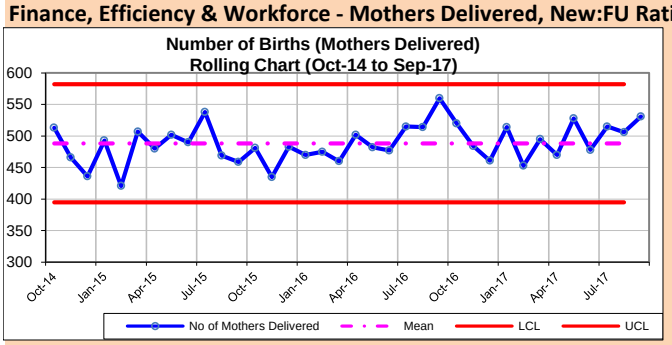
Performance & Activity - Non-Elective Activity, A&E Attendances

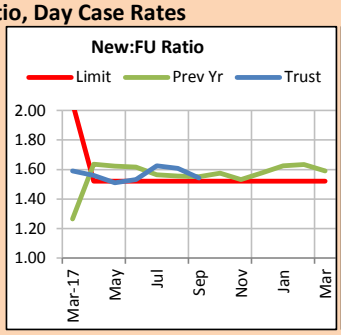


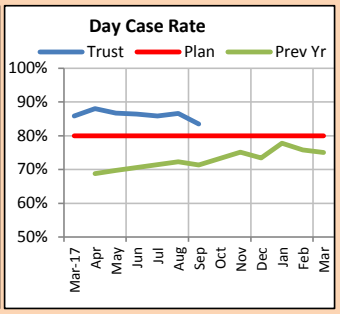


INTEGRATED PERFORMANCE REPORT ANALYSIS - FINANCE, EFFICIENCY & WORKFORCE

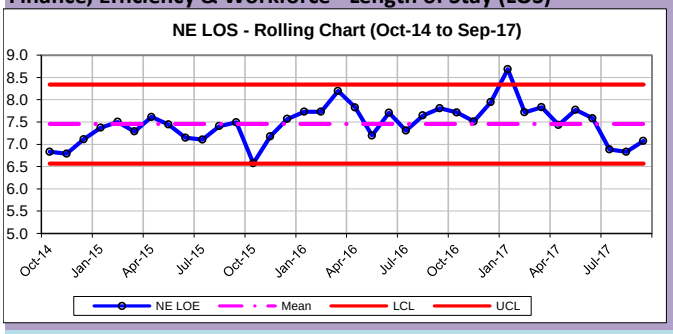
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates

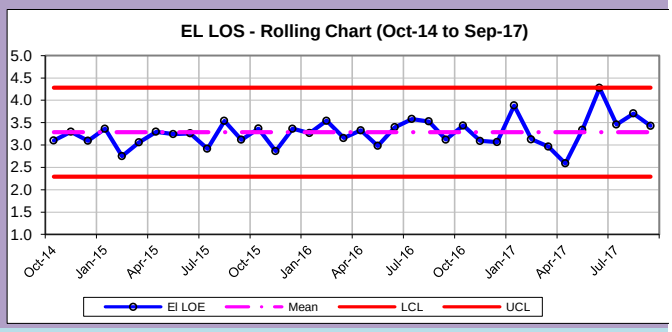




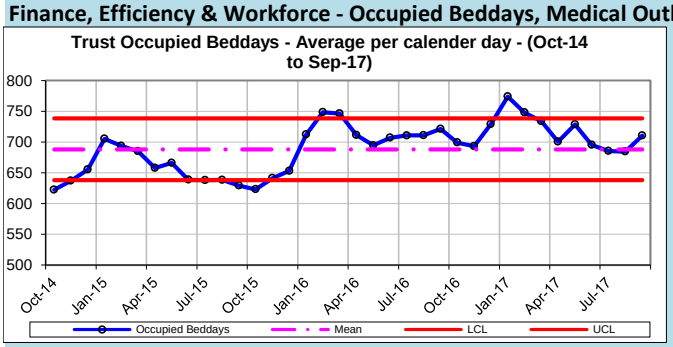


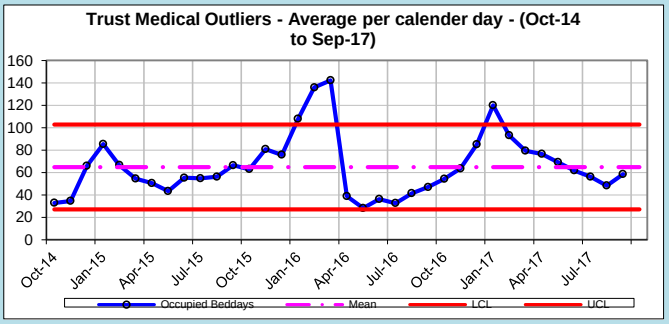
Finance, Efficiency & Workforce - Length of Stay (LOS)



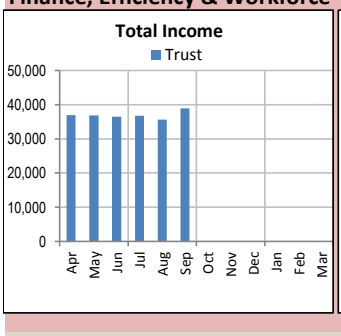


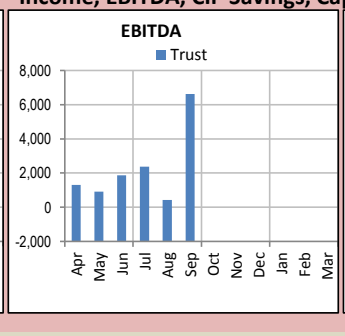
Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

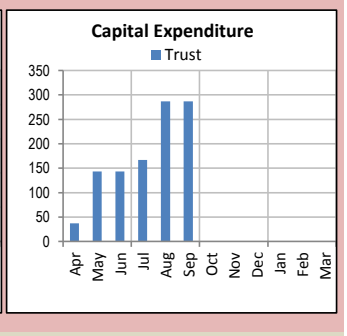




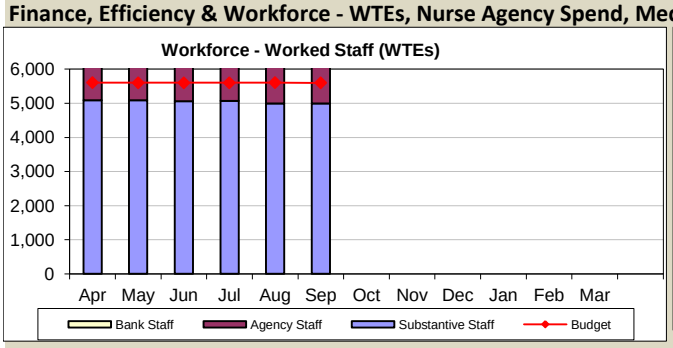
Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure

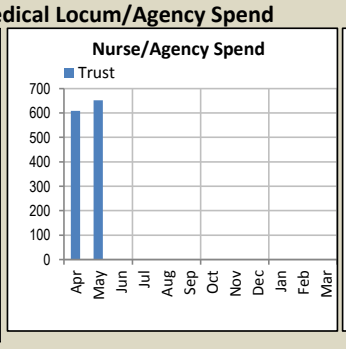


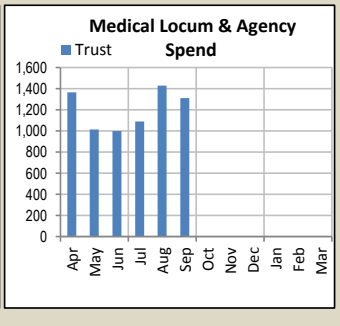




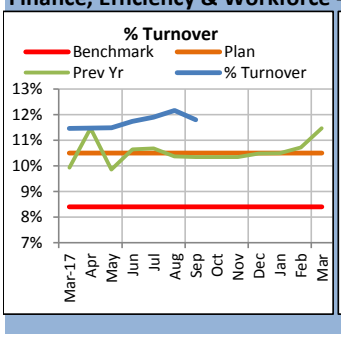
Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend

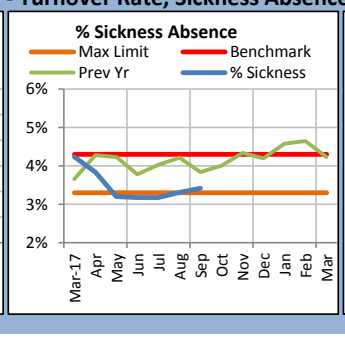


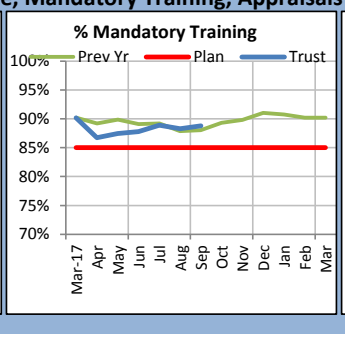


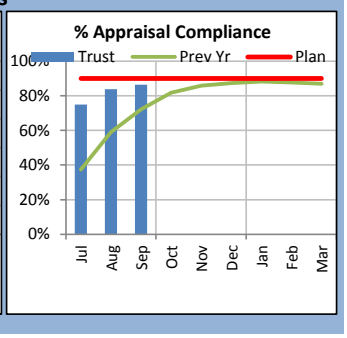


Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals









Maidstone and Tunbridge Wells NHS Trust

Trust Board Finance Pack

Month 6
2017/18

Content

Maidstone and Tunbridge Wells NHS Trust

Trust Board Finance Pack for September 2017

mtw

1.Executive Summary

Maidstone and Tunbridge Wells NHS

1a. Executive Summary September 2017

Key Variances £m

	September	YTD		Headlines
Total Surplus (+) / Deficit (-)	3.7	0.0	Favourable	The Trusts surplus including STF was £4.8m in September which was £3.7m favourable to plan, due to, £1.5m STF overperformance in month due to quarterly delivering of the financial control target, £2.1m release of reserves, £1m increased assumption around contract price increase , £0.7m depreciation benefit, partly offset by £1.3m slippage against CIP and adverse variances against budget.
Clinical Income	1.1	(0.0)	Favourable	Clinical Income excluding HCDs was £1.1m favourable in September which included £1m increased assumption around contract price increase and the release of £0.4m challenge provision therefore a normalised adverse variance of £0.3m. The key adverse variances in September were Elective & Day Cases (£0.6m) and Out Patient Activity (£0.5m) offset by favourable variances within non elective £1.2m.The position included a £1.1m benefit relating to the aligned incentive contract (£2.2m positive YTD).
Other Operating Income	0.5	3.9	Favourable	Other Operating Income £0.5m favourable in the month, £1m favourable relating to STP costs (offset by additional costs), partly offset by adverse variance within Private Patient Income (£0.3m) and Education Training income (£0.1m).
Pay	0.4	0.3	Favourable	Pay was £0.4m favourable in the month due to the release of £1.7m contingency reserve. Medical Staffing costs were the highest this financial year partly due to consultant arrears of pay (£50k) and continued high locum and agency usage within Emergency and Acute Directorate. The directorates medical spend is split 42% locum / agency compared to the Trust average of 19%. Nursing costs increased between months by £0.65m, £0.25m due to a five week month, £0.2m release of 2016/17 accrual in August, £0.1m catch-up in invoices and there has been a further increase in the use of non framework agency's which now is at 20%. Scientific and Technical staff spend increased by £19k between months mainly within Pharmacy due to an increase in agency costs covering vacant posts. Support staff costs within Estates and Facilities increased by £56k between months to cover vacancies and high level of sickness.
Non Pay	0.0	(6.3)	Adverse	Non Pay was breakeven in September , £1m adverse relating to pass through costs for STP, Clinical Supplies £0.3m adverse (mainly due to unidentified CIP) partly offset by £0.3m favourable variance relating to reduction of outsourcing costs. The position in September included an estimate for the rates rebate consistent with previous years. (£0.7m) An increase of £0.1m due to charges from NHS property services being higher than previously estimated and a £0.1m catch-up in energy invoices.
Elective IP and DC	(0.6)	(4.2)	Adverse	Elective and Day Case activity is adverse to plan in month by £0.6m in month and £4.2m year to date.
Sustainability and Transformation Fund	1.5	0	Favourable	The Trust has fully achieved STF Income.
CIP / FRP	(1.3)	(4.1)	Adverse	The Trust achieved £1.9m savings in September which was the same as August however this was £1.3m adverse to plan. The Trust has delivered £9.2m savings YTD and is £4.1m adverse to plan.

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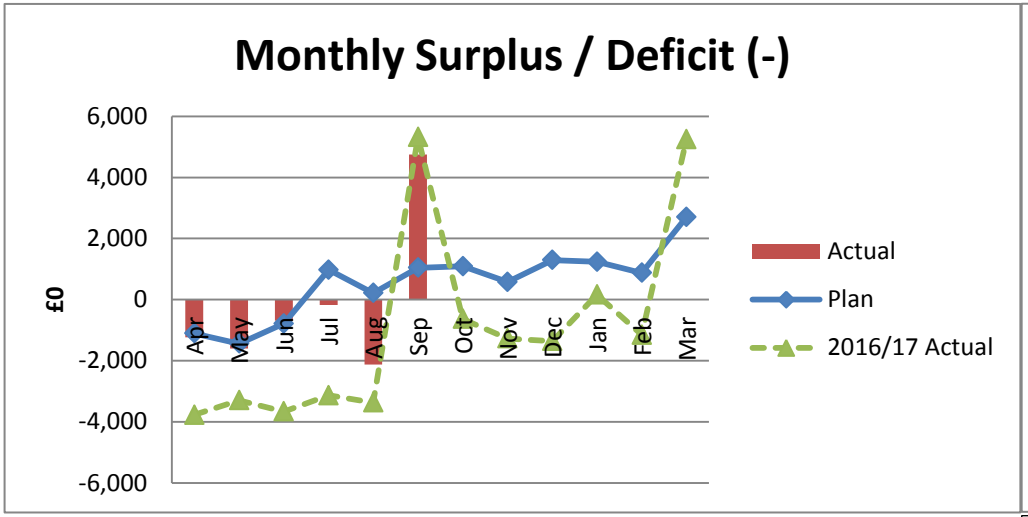
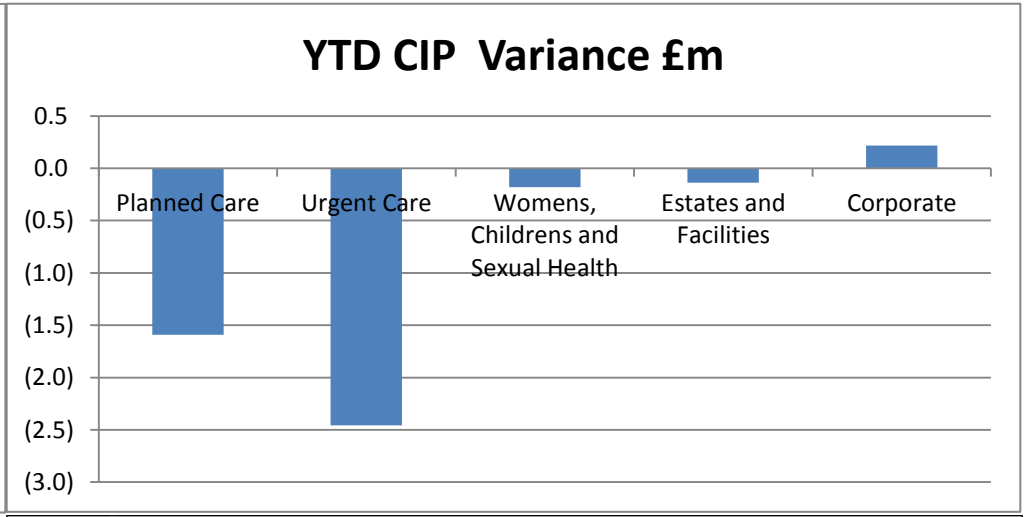
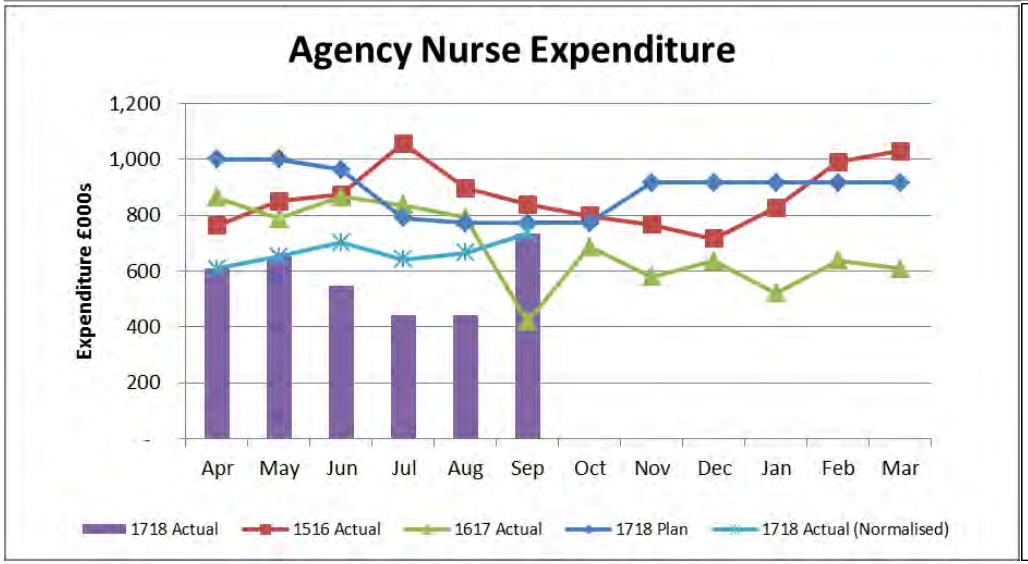
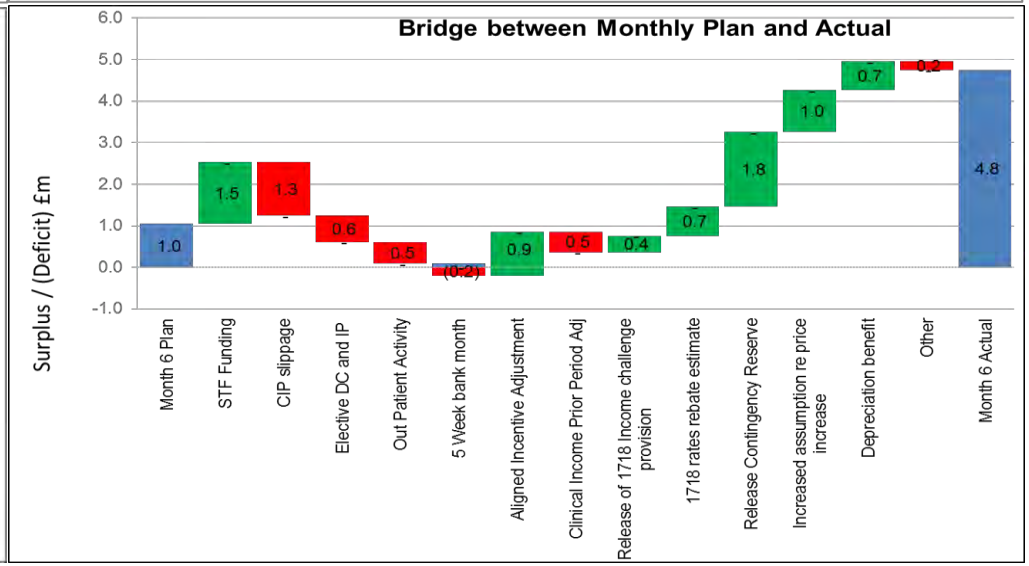
Maidstone and Tunbridge Wells NHS Trust

1b. Executive Summary KPI's September 2017









2.Income and Expenditure

Maidstone and Tunbridge Wells NHS Trust

2a. Income & Expenditure

Income & Expenditure September 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	29.3	28.2	1.1	170.4	170.4	(0.0)	329.0	339.7	(10.7)
	High Cost Drugs	3.3	3.7	(0.5)	21.5	20.4	1.2	51.7	42.2	9.5
	Total Clinical Income	**32.6**	**32.0**	**0.6**	**191.9**	**190.8**	**1.1**	**380.7**	**381.9**	**(1.2)**
	STF	2.2	0.7	1.5	3.9	3.9	0.0	11.2	11.2	0
	Other Operating Income	4.1	3.6	0.5	25.7	21.8	3.9	51.1	43.6	7.5
	Total Revenue	38.9	36.3	2.6	221.5	216.5	5.1	443.0	436.6	6.3
Expenditure										
	Substantive	(17.8)	(17.8)	0.0	(107.3)	(108.4)	1.1	(216.1)	(215.3)	(0.8)
	Bank	(1.3)	(0.5)	(0.9)	(6.1)	(3.3)	(2.8)	(12.9)	(6.1)	(6.8)
	Locum	(1.3)	(0.8)	(0.5)	(7.2)	(5.3)	(1.9)	(15.2)	(10.2)	(4.9)
	Agency	(1.0)	(1.0)	(0.0)	(4.7)	(6.8)	2.1	(9.9)	(13.4)	3.5
	Pay Reserves	1.5	(0.2)	1.7	0.4	(1.4)	1.9	9.0	(2.9)	11.9
	Total Pay	(20.0)	(20.3)	0.4	(124.8)	(125.2)	0.3	(245.2)	(247.9)	2.8
	Drugs & Medical Gases	(4.1)	(4.2)	0.2	(26.5)	(25.6)	(0.9)	(53.2)	(50.9)	(2.3)
	Blood	(0.2)	(0.2)	0.0	(1.3)	(1.2)	(0.1)	(2.5)	(2.5)	(0.1)
	Supplies & Services - Clinical	(2.2)	(1.9)	(0.3)	(15.6)	(12.6)	(3.0)	(30.6)	(23.7)	(7.0)
	Supplies & Services - General	(0.5)	(0.4)	(0.1)	(2.8)	(2.6)	(0.2)	(5.5)	(5.1)	(0.4)
	Services from Other NHS Bodies	(0.7)	(0.6)	(0.1)	(4.1)	(3.8)	(0.3)	(8.0)	(7.6)	(0.4)
	Purchase of Healthcare from Non-NHS	(0.3)	(0.6)	0.3	(2.1)	(4.4)	2.3	(4.2)	(7.9)	3.7
	Clinical Negligence	(1.7)	(1.7)	(0.0)	(10.3)	(10.3)	(0.0)	(20.6)	(20.6)	(0.0)
	Establishment	(0.3)	(0.3)	(0.0)	(1.7)	(1.9)	0.1	(3.5)	(3.7)	0.2
	Premises	(1.5)	(1.8)	0.3	(11.0)	(10.9)	(0.1)	(22.5)	(21.5)	(1.0)
	Transport	(0.1)	(0.1)	0.0	(0.6)	(0.7)	0.1	(1.4)	(1.4)	0.0
	Other Non-Pay Costs	(1.1)	(0.4)	(0.7)	(7.4)	(2.4)	(5.0)	(14.4)	(4.9)	(9.5)
	Non-Pay Reserves	0.3	(0.1)	0.4	0.2	(0.4)	0.6	5.7	(0.9)	6.6
	Total Non Pay	(12.3)	(12.4)	0.0	(83.2)	(76.9)	(6.3)	(160.7)	(150.6)	(10.0)
	Total Expenditure	(32.3)	(32.7)	0.4	(208.0)	(202.0)	(6.0)	(405.8)	(398.6)	(7.3)
EBITDA	**EBITDA**	6.6	3.6	3.0	13.5	14.4	(0.9)	37.1	38.1	(0.9)
		0.0	*0.0*	*0.0*	*6.1%*	*6.7%*	*-17.6%*	*8.4%*	*8.7%*	*-15%*
Other Finance Costs										
	Depreciation	(0.6)	(1.2)	0.7	(6.6)	(7.2)	0.6	(14.1)	(14.8)	0.7
	Interest	(0.1)	(0.1)	0.0	(0.6)	(0.6)	0.0	(1.3)	(1.3)	0.0
	Dividend	(0.1)	(0.1)	0.0	(0.7)	(0.7)	0.0	(1.4)	(1.5)	0.0
	PFI and Impairments	(1.1)	(1.2)	0.0	(6.9)	(6.9)	0.0	(14.8)	(14.9)	0.0
	Total Finance Costs	(1.9)	(2.6)	0.7	(14.8)	(15.5)	0.7	(31.6)	(32.4)	0.8
Net Surplus / Deficit (-)	**Net Surplus / Deficit (-)**	4.7	1.0	3.7	(1.3)	(1.1)	(0.2)	5.5	5.7	(0.2)
Technical Adjustments	**Technical Adjustments**	0.0	0.0	0.0	0.2	(0.0)	0.2	1.2	1.0	0.2
Surplus/ Deficit (-) to B/E Duty	**Surplus/ Deficit (-) to B/E Duty Incl STF**	4.8	1.0	3.7	(1.1)	(1.1)	0.0	6.7	6.7	0.0
	Surplus/ Deficit (-) to B/E Duty Excl STF	2.5	0.3	2.2	(5.0)	(5.0)	0.0	(4.5)	(4.5)	0.0

Commentary

The Trusts surplus including STF was £4.8m in September which was £3.7m favourable to plan, due to, £1.5m STF overperformance in month due to quarterly delivering of the financial control target, £2.1m release of reserves, £1m increased assumption around contract price increase, £0.7m depreciation benefit, partly offset by £1.3m slippage against CIP and adverse variances against budget.

The Financial plan for September included £2m unidentified CIP, this was split £0.1m income, £1m pay and £0.9m nonpay.

The Trust's normalised pre STF run rate in September was a deficit of £1.9m which was £0.1m higher than August.

The September Financial position included £2.1m release of contingency, £1m increased assumption around contract price increase, £0.7m depreciation benefit, £0.4m release of 2017/18 income challenge provision and £0.7m rates rebate consistent with previous financial years accounting.

Clinical Income excluding HCDs was £1.1m favourable in September which included £1m increased assumption around contract price increase and the release of £0.4m challenge provision therefore a normalised adverse variance of £0.3m. The key adverse variances in September were Elective & Day Cases (£0.6m) and Out Patient Activity (£0.5m) offset by favourable variances within non elective £1.2m.The position included a £1.1m benefit relating to the aligned incentive contract (£2.2m positive YTD).

STF income £1.5m favourable in September due to the quarterly delivery of the financial control target.

Other Operating Income £0.5m favourable in the month, £1m favourable relating to STP costs (offset by additional costs), partly offset by adverse variance within Private Patient Income (£0.3m) and Education Training income (£0.1m).

Pay was £0.4m favourable in the month due to the release of £1.7m contingency reserve. Medical Staffing costs were the highest this financial year partly due to consultant arrears of pay (£50k) and continued high locum and agency usage within Emergency and Acute Directorate. The directorates medical spend is split 42% locum / agency compared to the Trust average of 19%. Nursing costs increased between months by £0.65m, £0.25m due to a five week month, £0.2m release of 2016/17 accrual in August, £0.1m catch-up in invoices and there has been a further increase in the use of non framework agency's which now is at 20%. Scientific and Technical staff spend increased by £19k between months mainly within Pharmacy due to an increase in agency costs covering vacant posts. Support staff costs within Estates and Facilities increased by £56k between months to cover vacancies and high level of sickness.

Non Pay was breakeven in September , £1m adverse relating to pass through costs for STP, Clinical Supplies £0.3m adverse (mainly due to unidentified CIP) partly offset by £0.3m favourable variance relating to reduction of outsourcing costs. The position in September included an estimate for the rates rebate consistent with previous years. (£0.7m) An increase of £0.1m due to charges from NHS property services being higher than previously estimated and a £0.1m catch-up in energy invoices.

Contingency reserves, the September position includes the full release of contingency reserves.

3. Expenditure Analysis

Maidstone and Tunbridge Wells NHS Trust

3a. Run Rate Analysis

Analysis of 13 Monthly Performance (£m's)

		Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Change between Months
Revenue	Clinical Income	31.4	27.9	28.0	27.5	26.9	26.4	28.7	31.9	31.8	32.3	32.1	31.2	32.6	1.4
	STF	2.7	0.9	0.7	0.6	(0.0)	0.0	0.8	0.4	0.4	0.6	0.3	0.0	2.2	2.2
	High Cost Drugs	3.5	3.5	3.4	4.4	3.7	3.3	3.6	(0.1)	(0.0)	0.0	0.0	0.0	0.0	(0.0)
	Other Operating Income	1.0	3.2	3.2	3.3	4.5	3.9	8.4	4.7	4.6	3.5	4.3	4.5	4.1	(0.4)
	Total Revenue	**38.6**	**35.4**	**35.3**	**35.7**	**35.1**	**33.5**	**41.5**	**37.0**	**36.8**	**36.5**	**36.7**	**35.7**	**38.9**	**3.3**
Expenditure	Substantive	(18.1)	(18.0)	(18.1)	(18.1)	(17.6)	(17.8)	(17.3)	(17.9)	(18.0)	(18.1)	(17.8)	(17.7)	(17.8)	(0.0)
	Bank	(0.8)	(0.8)	(0.8)	(1.0)	(1.1)	(0.8)	(1.0)	(0.9)	(0.9)	(0.9)	(1.1)	(0.9)	(1.3)	(0.4)
	Locum	(0.8)	(0.9)	(0.5)	(1.9)	(1.1)	(0.9)	(1.6)	(1.4)	(1.0)	(1.0)	(1.1)	(1.4)	(1.3)	0.1
	Agency	(1.2)	(1.4)	(1.6)	(0.1)	(0.8)	(0.9)	(1.0)	(0.8)	(0.8)	(0.8)	(0.5)	(0.6)	(1.0)	(0.4)
	Pay Reserves	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(0.2)	(0.2)	(0.2)	(0.2)	(0.1)	1.5	1.5
	Total Pay	(20.9)	(21.1)	(20.9)	(21.1)	(20.5)	(20.5)	(20.8)	(21.3)	(21.0)	(21.1)	(20.8)	(20.8)	(20.0)	0.8
Non-Pay	Drugs & Medical Gases	(4.5)	(3.9)	(4.8)	(4.6)	(4.2)	(4.0)	(5.1)	(4.2)	(4.6)	(4.6)	(4.2)	(4.8)	(4.1)	0.8
	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)	(2.6)	(2.8)	(2.7)	(2.5)	(3.1)	(2.6)	(2.8)	(2.7)	(2.7)	(2.7)	(2.2)	0.5
	Supplies & Services - General	(0.4)	(0.5)	(0.5)	(0.5)	(0.4)	(0.4)	(0.6)	(0.4)	(0.5)	(0.5)	(0.5)	(0.3)	(0.5)	(0.2)
	Services from Other NHS Bodies	(0.7)	(0.7)	(0.6)	(0.7)	(0.6)	(0.7)	(0.5)	(0.8)	(0.7)	(0.6)	(0.7)	(0.7)	(0.7)	(0.0)
	Purchase of Healthcare from Non-NHS	(0.6)	(0.8)	(0.7)	(0.7)	(0.8)	(0.5)	(0.5)	(0.5)	(0.5)	(0.2)	(0.3)	(0.3)	(0.3)	(0.0)
	Clinical Negligence	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	0.0
	Establishment	(0.4)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.2)	(0.3)	(0.1)
	Premises	(1.2)	(1.7)	(1.4)	(1.8)	(1.8)	(1.7)	(1.7)	(2.0)	(2.3)	(1.6)	(1.7)	(1.9)	(1.5)	0.4
	Transport	(0.2)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	0.0
	Other Non-Pay Costs	(0.3)	(0.3)	(0.9)	(0.9)	(1.2)	(0.7)	(0.5)	(1.5)	(1.1)	(0.7)	(1.4)	(1.6)	(1.1)	0.4
	Non-Pay Reserves	0.4	0.0	0.0	0.0	0.0	0.0	1.3	(0.1)	(0.1)	(0.1)	0.2	0.0	0.3	0.3
	Total Non Pay	(12.3)	(12.9)	(13.6)	(14.1)	(13.8)	(12.7)	(12.9)	(14.4)	(14.9)	(13.5)	(13.6)	(14.4)	(12.3)	2.1
	Total Expenditure	(33.1)	(34.0)	(34.5)	(35.2)	(34.3)	(33.2)	(33.7)	(35.7)	(35.9)	(34.6)	(34.3)	(35.2)	(32.3)	2.9
EBITDA	EBITDA	5.5	1.4	0.9	0.6	0.8	0.3	7.8	1.3	0.9	1.9	2.4	0.4	6.6	6.2
		14%	*4%*	*2%*	*2%*	*2%*	*1%*	*19%*	*4%*	*2%*	*5%*	*6%*	*1%*	*17%*	
Other Finance Costs	Depreciation	(1.4)	(1.4)	(1.4)	(0.8)	0.8	(1.0)	(1.2)	(1.2)	(1.2)	(1.2)	(1.2)	(1.2)	(0.6)	0.7
	Interest	(0.1)	(0.1)	(0.1)	(0.1)	(0.0)	(0.2)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	0.0
	Dividend	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	0.7	0.1	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.0)
	PFI and Impairments	(1.1)	(1.1)	(1.1)	(1.2)	(1.1)	(42.3)	(1.2)	(1.2)	(1.2)	(1.2)	(1.2)	(1.1)	(1.1)	0.0
		(2.9)	**(2.9)**	**(2.9)**	**(2.4)**	**(0.7)**	**(42.7)**	**(2.4)**	**(2.6)**	**(2.5)**	**(2.6)**	**(2.6)**	**(2.6)**	**(1.9)**	**0.7**
Net Surplus / Deficit (-)	Net Surplus / Deficit (-)	2.6	(1.5)	(2.0)	(1.8)	0.1	(42.4)	5.4	(1.3)	(1.6)	(0.7)	(0.2)	(2.2)	4.7	6.9
Technical Adjustments	Technical Adjustments	0.1	0.1	0.1	(0.0)	0.1	40.3	(0.1)	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Surplus/ Deficit (-) to B/E Duty Incl STF	Surplus/ Deficit (-) to B/E Duty	2.7	(1.4)	(1.9)	(1.9)	0.3	(2.0)	5.3	(1.2)	(1.6)	(0.7)	(0.2)	(2.1)	4.8	6.9
Surplus/ Deficit (-) to B/E Duty Excl STF	Surplus/ Deficit (-) to B/E Duty	(0.0)	(2.3)	(2.6)	(2.5)	0.3	(2.0)	4.5	(1.6)	(2.0)	(1.3)	(0.4)	(2.1)	2.5	4.6

4. Cost Improvement Programme

Maidstone and Tunbridge Wells NHS Trust

4a. Current Month Savings by Directorate

	Current Month		
	Actual	*Original Plan*	*Variance*
	£m	£m	£m
Cancer and Haematology	0.1	0.2	(0.0)
Critical Care	0.1	0.2	(0.1)
Diagnostics	0.1	0.2	(0.1)
Head and Neck	0.0	0.1	(0.1)
Surgery	0.1	0.2	(0.1)
Trauma and Orthopaedics	0.5	0.6	(0.1)
Patient Admin	0.0	0.0	(0.0)
Private Patients Unit	0.0	0.0	(0.0)
Total Planned Care	**0.9**	**1.5**	**(0.6)**
Urgent Care	**0.4**	**0.8**	**(0.4)**
Womens, Childrens and Sexual Health	**0.2**	**0.4**	**(0.2)**
Estates and Facilities	**0.2**	**0.3**	**(0.1)**
Corporate	**0.1**	**0.2**	**(0.0)**
Total	**1.9**	**3.2**	**(1.3)**

Comment

The Trust achieved £1.9m savings in September which is consistent with the last two months however this was £1.3m adverse to plan. The plan includes £2m unidentified savings phased from July.

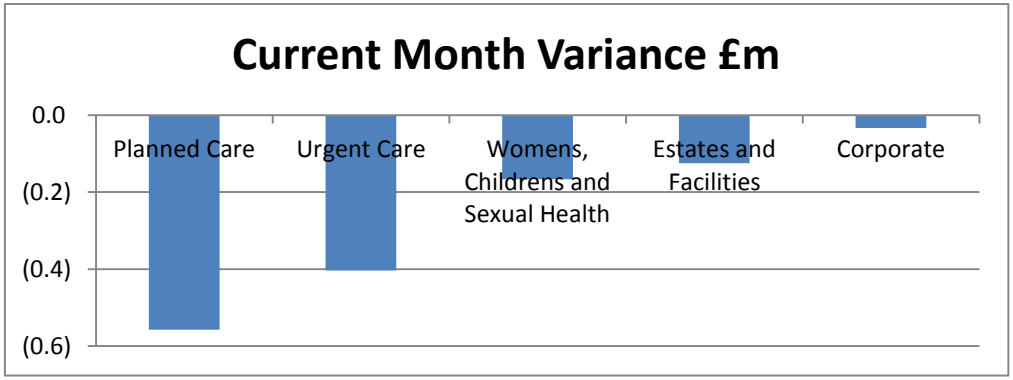
The plan value is based upon the Trusts submitted plan to NHSI in December 16 and March 17. The Trust has a 'live' plan for monitoring the actuals and phasing of the CIP programme. Based upon the 'live plan the savings achieved in September were £1.4m below plan.

Planned Care: £0.6m adverse compared to original CIP planned phasing and £0.4m adverse in September when compared to the 'live' plan. The main directorates adverse to plan (Live) Diagnostics (£143k) which relates to £100k unidentified savings and procurement savings (£30k) and Surgery Directorate (£123k) mainly due to unidentified savings (£70k) slippage relating to pay schemes (job planning and WLI reduction).

Urgent Care: £0.4m adverse compared to the original plan, when compared to the 'live' plan the directorate are £0.6m adverse in the month which is mainly due to £0.3m unidentified savings and slippage in closing 2 ward (£0.3m).

Womens, Childrens and Sexual Health: £0.2m adverse compared to the original plan and the 'live' plan, the slippage relates to unidentified savings.

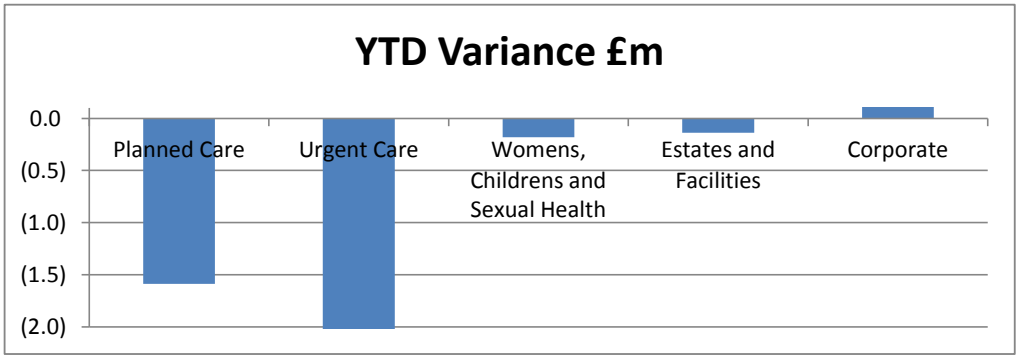
Estates and Facilities: £0.1m adverse to the original and £0.2m adverse to the 'live' plan. The main slippage relates to EPC energy business case (£70k per month) and rental income (£50k).



Maidstone and Tunbridge Wells NHS Trust

4b. Year to Date savings by Directorate

	YTD		
	Actual	*Original Plan*	*Variance*
	£m	£m	£m
Cancer and Haematology	0.7	0.8	(0.1)
Critical Care	0.4	0.9	(0.6)
Diagnostics	0.4	0.9	(0.5)
Head and Neck	0.3	0.4	(0.1)
Surgery	0.4	0.7	(0.3)
Trauma and Orthopaedics	2.6	2.6	(0.0)
Patient Admin	0.0	0.0	0.0
Private Patients Unit	0.0	0.1	(0.0)
Total Planned Care	**4.9**	**6.5**	**(1.6)**
Urgent Care	**1.4**	**3.9**	**(2.5)**
Womens, Childrens and Sexual Health	**1.1**	**1.3**	**(0.2)**
Estates and Facilities	**0.8**	**0.9**	**(0.1)**
Corporate	**1.0**	**0.8**	**0.2**
Total	**9.2**	**13.4**	**(4.1)**



Comment

The Trust has achieved £9.2m savings YTD which is £4.1m 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 £4.9m below plan.

Planned Care: £1.6m adverse compared to original CIP planned phasing, £2.1m slippage YTD when compared to the 'live' plan. The main directorate adverse to plan is Diagnostics (£640k adverse) which is due to £320k unidentified, procurement 10% savings target (£216k) and £50k delay in implementation of the new MLS contract. Surgery Directorate (£460k) adverse which is due to unidentified savings (£212k), deep dive review (£70k) and medical pay savings (£100k) relating to job planning and WLI savings.

Urgent Care: £2.5m adverse compared to the original plan, when compared to the 'live' plan the directorate are £1.9m adverse YTD. This is due to £0.3m unidentified savings, delay in closing wards (£0.7m), slippage in procurement savings (£0.3m) and slippage in pharmacy savings (£0.1m).

Womens, Childrens and Sexual Health: £0.2m adverse compared to the original plan, when compared to the 'live' plan the directorate are £0.6m adverse YTD. The YTD adverse variance (£0.6m) is due to unidentified savings.

Corporate: Corporate directorates are £0.2m favourable to the original plan and are £0.1m favourable to the 'live' plan. The main slippage relating to the live plan relates to HR (£60k) due to the savings plans associated with restricting advertising (£50k) no longer being explored.

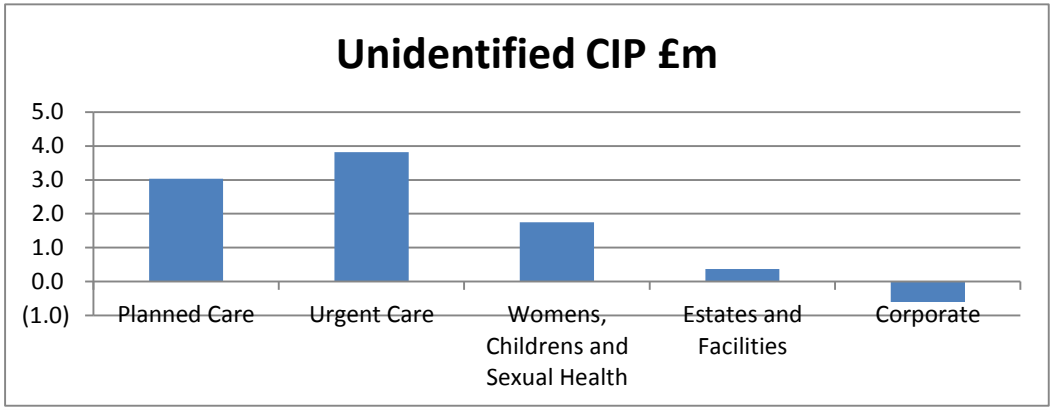
Maidstone and Tunbridge Wells NHS Trust

4c. Forecast savings by Directorate

Directorate Performance

	Forecast Savings			
	Risk Adjusted Forecast	*Unidentified (Risk Adjusted)*	*Plan*	*% Unidentified*
	£m	£m	£m	
Cancer and Haematology	1.9	0.1	2.0	4%
Critical Care	1.5	0.7	2.2	30%
Diagnostics	0.9	1.2	2.2	56%
Head and Neck	0.7	0.3	1.0	29%
Surgery	1.0	0.8	1.8	43%
Trauma and Orthopaedics	5.2	(0.1)	5.1	-1%
Patient Admin	0.1	0.0	0.1	44%
Private Patients Unit	0.1	0.0	0.2	22%
Total Planned Care	**11.4**	**3.0**	**14.5**	**21%**
Urgent Care	**5.1**	**3.8**	**8.9**	**43%**
Womens, Childrens and Sexual Health	**1.9**	**1.8**	**3.7**	**48%**
Estates and Facilities	**2.5**	**0.4**	**2.9**	**13%**
Corporate	**2.5**	**(0.6)**	**1.9**	**-32%**
Total	**23.3**	**8.4**	**31.7**	26%

Savings as per 7th September



The Trust has a £31.7m CIP plan for 2017/18 and has identified £26.4m (non risk adjusted) , £5.3m unidentified. The current forecasted risk adjusted identified savings is £23.3m, a shortfall of £8.4m.

Planned Care Division have identified £13.1m savings which is risk adjusted to deliver £11.4m. The division has £3m risk adjusted shortfall (21%).

Urgent Care Division have identified £6.4m savings which is risk adjusted to deliver £5.1m. The division has £3.8m risk adjusted shortfall (43%).

W&CH Division have identified £2m savings which is risk adjusted to deliver £1.9m. The division has £1.8m risk adjusted shortfall (50%).

mtw

5. Balance Sheet

Maidstone and Tunbridge Wells NHS Trust

5a. Balance Sheet

September 2017

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

	September			August	Full year	
£m's	**Reported**	**Plan**	**Variance**	**Reported**	**Plan**	**Forecast**
Property, Plant and Equipment (Fixed Assets)	274.7	277.7	(3.0)	275.5	282.1	287.1
Intangibles	2.7	2.8	(0.1)	2.8	2.1	2.5
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	1.5
Total Non-Current Assets	**278.9**	**281.7**	**(2.8)**	**279.8**	**285.4**	**291.1**
Current Assets						
Inventory (Stock)	7.6	8.3	(0.7)	7.1	8.3	7.9
Receivables (Debtors) - NHS	42.6	36.2	6.4	39.5	21.0	33.8
Receivables (Debtors) - Non-NHS	14.8	9.5	5.3	15.9	9.5	11.2
Cash	2.2	2.4	(0.2)	5.6	1.0	1.0
Assets Held For Sale	0.7	0.0	0.7	1.7	0.0	0.0
Total Current Assets	**67.9**	**56.4**	**11.5**	**69.9**	**39.8**	**53.9**
Current Liabilities						
Payables (Creditors) - NHS	(5.4)	(5.4)	(0.0)	(4.7)	(4.5)	(4.5)
Payables (Creditors) - Non-NHS	(67.6)	(40.1)	(27.5)	(69.4)	(13.6)	(46.9)
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)	(5.0)
Provisions for Liabilities and Charges	(1.8)	(1.2)	(0.6)	(1.8)	(1.3)	(2.0)
Total Current Liabilities	**(82.0)**	**(53.9)**	**(28.1)**	**(83.1)**	**(44.0)**	**(77.5)**
Net Current Assets	(14.1)	2.5	(16.6)	(13.2)	(4.2)	(23.6)
Finance Lease - Non- Current	(195.5)	(197.7)	2.3	(195.9)	(192.7)	(192.7)
Capital Loan - (interest Bearing Borrowings)	(11.2)	(11.2)	0.0	(12.3)	(10.2)	(10.2)
Interim Revolving Working Capital Facility	(30.7)	(29.0)	(1.7)	(29.0)	(16.1)	(16.1)
Provisions for Liabilities and Charges	(1.1)	(0.6)	(0.6)	(1.2)	(0.4)	(1.0)
Total Assets Employed	**26.2**	**45.6**	**(19.4)**	**28.1**	**61.8**	**47.6**
Financed By						
Capital & Reserves						
Public dividend capital	(205.0)	205.0	(409.9)	(205.0)	(208.6)	(207.3)
Revaluation reserve	(30.3)	30.3	(60.6)	(30.3)	(36.2)	(36.2)
Retained Earnings Reserve	209.0	(189.7)	398.7	207.2	182.9	195.9
Total Capital & Reserves	**(26.2)**	**45.6**	**(71.8)**	**(28.1)**	**(61.8)**	**(47.6)**

Commentary:
The balance sheet is £19.4m or 43% less than plan, primarily due to variations in current assets and current liabilities. Key movements to August are in working capital where Total Current Liabilities is 52.1% 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.

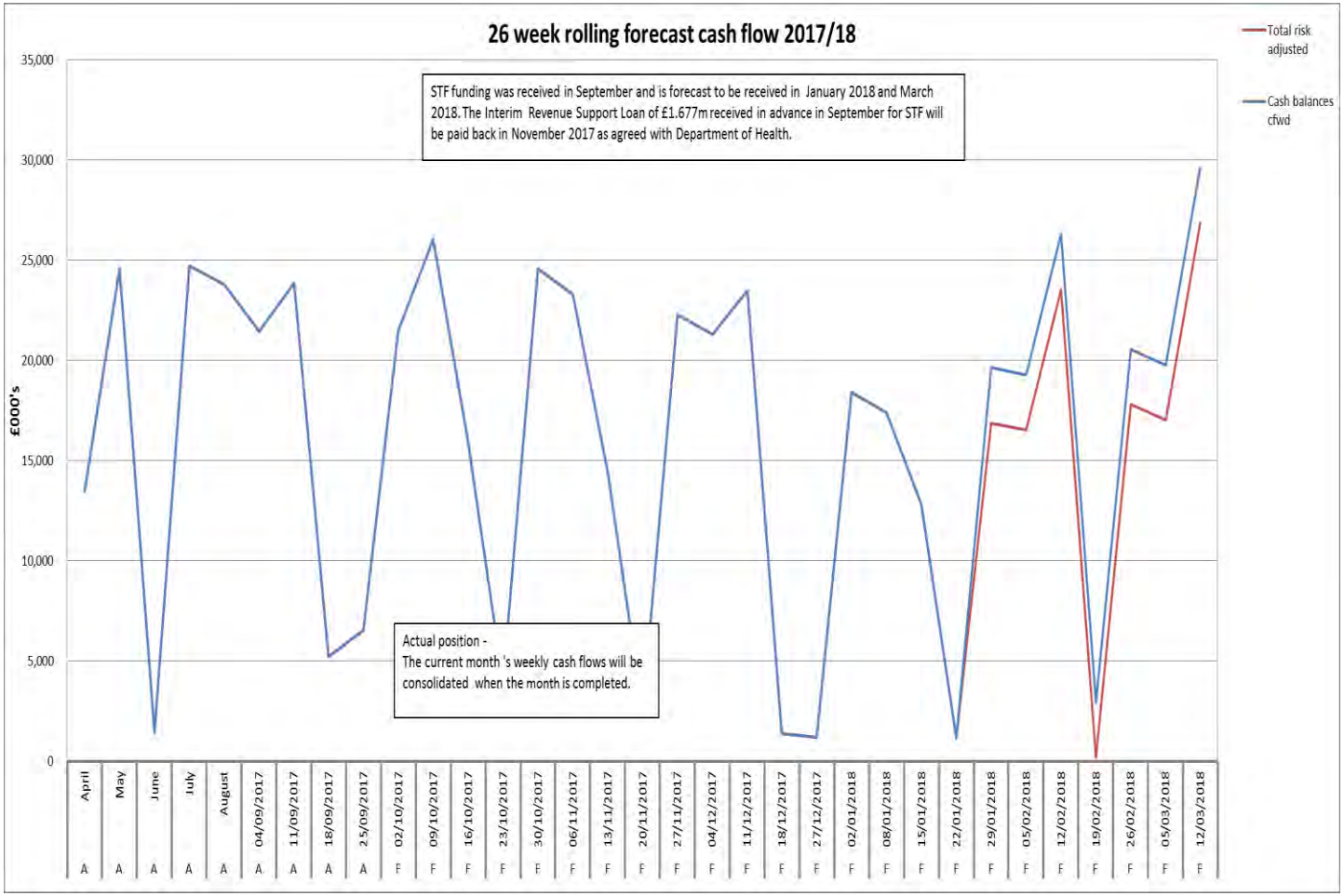
Non-Current Assets (PPE) - The value of PPE has decreased from the August position as assets are depreciated. The in-year capital programme has been prioritised and the majority of business cases have been approved.

Current Assets - Inventory has increased from the reported August position by £0.5m primarily due to Pharmacy stock. Inventory reduction is a cash management strategy. NHS Receivables have increased by £3.0m compared to the August reported position, being above the plan value by £6.4m. Of the £42.6m balance, £16.5m relates to invoiced debt of which £8.3m is aged debt over 90 days. Debt over 90 days has increased by £0.7m compared with the August reported position. The remaining £23.3m relates to Block income raised in advance (£21.7m) for cash flow purposes and 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 decreased compared with the August reported position by £1m, and is above plan by £5.3m. Included within this balance is trade invoiced debt of £2.5m which has decreased by £1.2m compared to August and private patient invoiced debt of £0.3m.

Current Liabilities - NHS payables have increased from the August reported position by £0.7m. Non-NHS trade payables has decreased since August by £1.80m and remain significantly above the plan of £40.1m.

Of the £74.1m creditor balances, £20.6m relates to invoices, £26.1m 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 £26.4m relates to accruals, including TAX, NI, Superannuation, PDC .

5b. | Cash Flow



Commentary

The blue line shows the Trust's cash position from the start of April, after receiving 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 Quarters 2 and 3, along with £0.5m asset sales forecast for receipt in January 2018 . If this income is not received these will be mitigated by proposed strategies.

The other risk adjusted item relates to a capital loan of £0.5m which is mitigated by reducing the capital spend.
The cash flow is based on the Income and Expenditure plan along with working capital adjustments.

The Trust is currently up to date with agency and pharmacy supplier payments,.

6. Capital

Maidstone and Tunbridge Wells NHS Trust

6a. Capital Programme

Capital Projects/Schemes

	Year to Date			Annual		
	Actual	*Plan*	*Variance*	*Plan*	*Forecast*	*Variance*
	£000	£000	£000	£000	£000	£m
Estates	303	7,023	6,720	8,873	6,268	2,605
ICT	743	1,110	367	1,664	1,664	0
Equipment	192	1,704	1,512	5,909	4,015	1,894
PFI Lifecycle (IFRIC 12)	268	268	0	502	502	0
Donated Assets	0	250	250	450	450	0
Total	**1,506**	**10,355**	**8,849**	**17,398**	**12,899**	**4,499**
Less donated assets	0	-250	-250	-450	-450	0
Asset Sales (net book value)	-994	0	994	-1,727	-1,727	0
Contingency Against Non-Disposal	0	0	0	0	0	0
Adjusted Total	**512**	**10,105**	**9,593**	**15,221**	**10,722**	**4,499**

The Trust approved an initial Capital Plan of £17.4m, made up by Capital resources of £14.8m depreciation; the Net Book Value of £1.7m for the planned 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.

Build work on Linac 1 bunker at Maidstone started in mid May, the Linac machine was delivered onsite on 29th July, commissioning the equipment will start ready for clinical use by Dec17. The Trust requested additional PDC funding for the next 2 Linacs, however, only 1 Linac has been approved for 17/18 (£1.7m). The equipment will be put into storage until ready for delivery to the Trust in 18/19.

The Trust has been awarded £645k for GP A&E Streaming works, as additional PDC. The net impact of these 2 changes to Plan is a revised FOT of £16.1m, prior to donations and asset disposals.

The donated equipment is mainly made up of the remaining Cardiology legacies.

The Trust disposed of the Hillcroft property for £1.04m gross receipts generating a small profit on sale of c.£20k.

The proposed Salix loan of £4m has been reduced to £750k, due to a revision in the work required. The first phase of this has been approved by Salix (£241k) and NHSI are agreeing CRL cover with the Department of Health.

The Plan may require revision in year to respond to any forecast underspend in depreciation (which would support the Income & Expenditure position) which would need to be matched by a reduction in the planned capital spend. In addition any shortfall in the value of disposals would result in a reduction in available resource.

Trust Board meeting – October 2017

Maidstone and Tunbridge Wells NHS Trust

10-9	**Integrated Performance Report, September 2017**	**Chief Executive / Members of the Executive Team**

The enclosed report includes:

- The 'story of the month' for September 2017 (including Emergency Performance (4 hour standard); Delayed Transfers of Care (DTOCs); Cancer 62 day First Definitive Treatment) and Referral to Treatment (RTT)
- A Quality and Safety Report
- A financial commentary (to follow)
- 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 (to follow)

Which Committees have reviewed the information prior to Board submission?

- Finance & Performance Committee (in part)

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

Review and discussion

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

The 'story of the month' for September 2017

1. 4 hour emergency standard

Performance for the Trust for September (calendar) fell marginally to 90.0% (including MIU), achieving the Trust recovery plan of 89.8%. 1617 came in at 87.1%. This year, we are required to achieve +90% per quarter and 95% in March 2018 and the improvement plan is based on achieving this target.

- A&E Attendances remain higher than last year but the activity is returning to the previous expected levels rather than the continuous growth that we have seen over the last 18 months.
- Non-Elective Activity (excluding Maternity) however remains considerably above plan and was 25.2% higher than plan for September at 4,141 discharges, and 10.1% higher than September last year.
- There were 1125 bed-days lost (5.3% of occupied bed-days) due to delayed transfers of care which although slightly higher than for August is generally an improving position.
- Non-elective LOS was 7.08 days for September discharges after spiking at 8.68 in Jan. Average occupied bed days rose slightly to 710 in September.

The intensive focus on managing capacity and flow remains in place with daily oversight at senior management and clinical level on the front door pathways and especially on reducing length of stay on the wards. The urgent care division are working collaboratively with system partners to address and change longstanding issues affecting patient transfers and discharges. The most effective changes to date have been

- Increasing the level of senior doctor cover in the ED at specific times of the day.
- Additional doctors working in the AMU
- Twice daily board rounds on AMUs
- Frail Elderly Unit at Maidstone
- Focus on SAFER across all wards.
- Weekly review of the KPI dashboard to monitor improvements
- Daily breach analysis & RCA reviews as appropriate.

2. Delayed Transfers of Care

Following the downward trend in the percentage of delayed transfers of care, this increased slightly in September to 5.3% but remains an improved position. The number of bed days lost increased from 961 in August to 1125 in September. We have experienced a greater focus from external partners on the exit routes from the hospital and have now rolled out Pathway 1 & 2 of the Home First initiative in full and the Frail Elderly unit at Maidstone operating effectively. Plans for the TWH Frailty Unit are in development but with limiting factors of staffing and capacity being a key risk. .

Row Labels	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	Jun-17	Jul-17	Aug-17	Sep-17
A : Awaiting Assessment	17	15	10	5	7	3	8	1	6	25	15	7	5	5	12	20	22	32	14	14	13	11	7	2	2
B : Awaiting Public Funding	8	7	3	1			1	1	1	8	12	25	21	5	3	6		4	3	1	3	3	3	2	
C : Awaiting Further Non-Acute NHS C	30	20	6	3	8	15	18	17	13	11	10	8	10	14	6	23	8	13	16	17	21	27	11	8	21
Di : Awaiting Residential Home	26	22	16	21	15	15	27	32	20	37	21	33	43	34	19	21	30	24	35	21	8	16	16	23	32
Dii : Awaiting Nursing Home	52	56	40	73	53	80	73	58	67	65	67	69	83	69	63	112	78	77	76	57	70	94	53	63	42
E : Awaiting Care Package	17	32	26	43	28	36	36	28	24	39	41	41	76	58	51	89	49	30	38	35	39	43	27	27	32
F : Awaiting Community Adaptations	1	13	9	8	14	5	13	8	7	12	4	6	10	8	5	7	9	10	13	6	8	7	15	8	5
G : Patient or Family Choice	43	26	22	31	12	12	22	13	9	19	19	10	16	20	16	14	9	19	28	6	10	8	10	13	14
H : Disputes	3	1	1		1				3	1	1				1			1	1	1	1	2		1	
I : Housing	1	13	12	9	3	5	1			5	5	2	3	2	4	8	3	5	4	3	3	5	6	8	2
Grand Total	198	205	145	194	141	171	199	158	150	222	195	201	267	215	180	300	208	215	228	161	176	216	148	155	150
Trust delayed transfers of care	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%	6.1%	5.4%	4.5%	5.3%

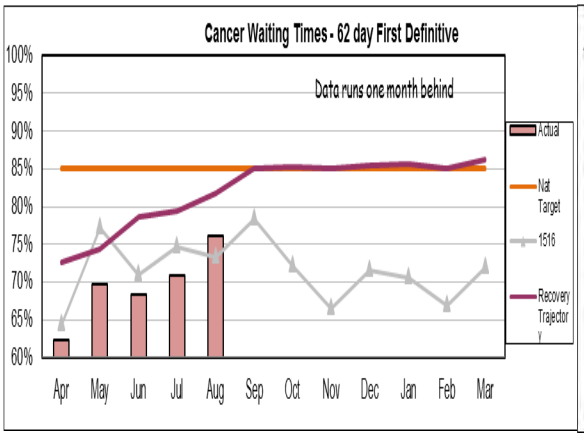
- The number of patients being funded through the CCG commercial bed fund in private nursing homes continued to reduce in month with approximately 15 on the caseload, the majority of these are elderly patients with orthopaedic issues who are waiting healing in order to regain function. This has significantly decreased in month due to patients coming to the end of their stay
- Additional social care support has been allocated to the Maidstone Frailty Unit which commenced in August.
- Enablement capacity has been sufficient to meet the demand throughout the month.
- CHS (an external agency to locate and facilitate discharge to nursing homes and private POC within 5 days for privately funded patients) exceeded target in September, placing 30 patients against a target of 20
- Senior staff from the integrated discharge team 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.
- Homelessness issues have risen during the month, with several older patients becoming homeless on admission. Care Navigator involved in supporting these clients. There have also been several younger patients who have needed housing support

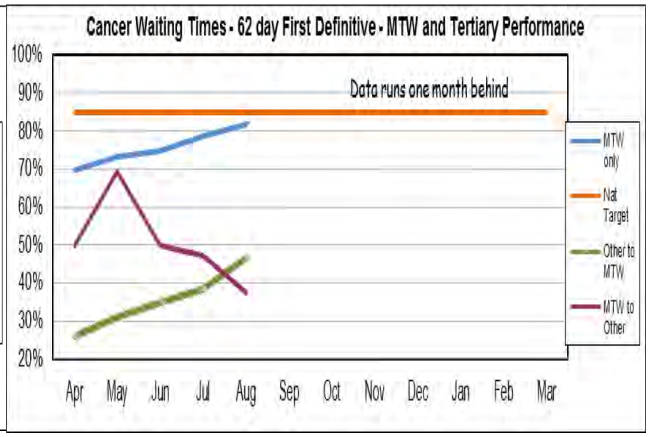
3. Cancer 62 Day First Definitive Treatment

The 62 day performance in August has improved significantly (+5.1%) compared to the previous month. The delivery plan remains focused both on patients in the 40 -62 day category and those who have already breached to bring them in for treatment sooner to help reduce the backlog. The total number of breached patients was lower than in July and the treatments were higher in August than in July. 117.0 treatments were completed in August. Looking forward on the PTL for September the performance overall is a slight decrease on August but has largely matched the performance for MTW only patients.

The key improvement initiative for the cancer services is the daily huddle where the focus is on the next event for individual patients (outpatient appt, test, result review, date for treatment) that is needed to pull them through the pathway, with any delays or blocks being actioned on the same day.

In addition, straight to test triage clinics are now well established for colorectal and lung referrals. This is reducing the overall length of pathways for these patients and has significantly improved the performance of lower GI.





62 Day Performance - All			
Tumour	Total	Brch	%
Breast	22	0.0	100
Lung	10.5	3.0	71.4
Haemat.	4.5	2.5	44.4
Upper GI	11.5	3.0	75.9
Lower GI	22.5	3.0	86.7
Skin	0	0.0	0.0
Gynae	12	3.5	70.8
Urology	26	9.5	63.5
Head & Nk	5.5	2.0	63.6
Sarcoma	0	0.0	0.0
Brain/CNS	0.5	0.5	0.0
Other	2	1.0	50
Total	117	28.0	76.1

62 Day Performance - MTW			
Tumour	Total	Brch	%
Breast	22	0.0	100
Lung	6	1.0	83.3
Haemat.	4	2.0	50.0
Upper GI	9	1.0	88.9
Lower GI	21	2.0	90.5
Skin	0	0.0	0.0
Gynae	10	3.0	70.0
Urology	23	8.0	65.2
Head & Nk	2	0.0	100
Sarcoma	0	0.0	0.0
Brain/CNS	0	0.0	0.0
Other	2	1.0	50
Total	99	18.0	81.8

In August, Urology has contributed the largest number of breaches overall. Gynaecology contributed the second highest number of breaches.

MTW only patient performance in percentage terms continues to improve month on month.

Breaches for lower GI, Lung and Head & Neck in absolute numbers have reduced compared to the previous month

4. Referral To Treatment – 18 weeks

September performance shows the Trust continues to forecast non-compliance with the Incomplete RTT standards at an aggregate level – 84.6%. Our trajectory requires us to achieve 92% by the end of November 2017. The limiting factor remains access to elective capacity at TWH and the Planned Care Division are reviewing the bed and theatre configuration across both sites to

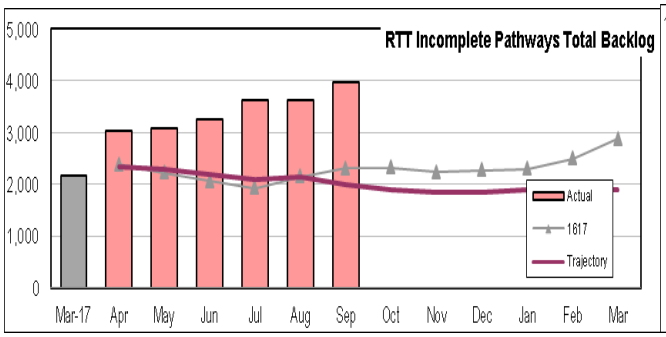
maximise available capacity. There are also 2 medical specialties where consultant capacity is a limiting factor.

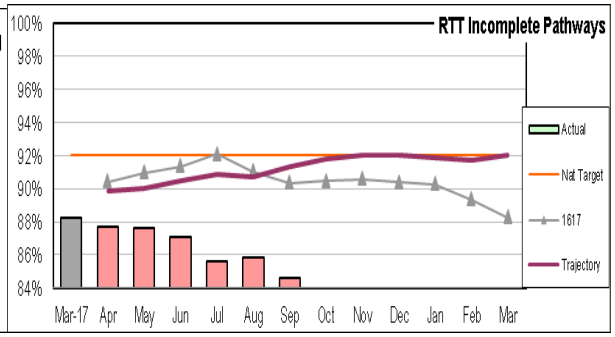
The Trust continues to be non-compliant at a speciality level for a number of specialties but T&O, Gynae, and Cardiology present the most risk of underperforming against the November deadline, all of which are being carefully monitored against action plans put in place to reduce their longest waiters. All these specialities are trying to continue to reduce their backlogs by maximising available capacity across both sites and focusing capacity on booking patients within the backlog to all available sessions, including Saturdays.

	Sep-17	Sep-17 Trajectory	Variance from trajectory
RTT Backlog Incomplete	3,967	2,000	-1967
RTT Waiting List	25,741	23,132	-2609
RTT Incomplete performance %	84.6%	91.35%	-6.75

Operational teams are focused on their recovery plans to increase elective activity and we are holding 2 RTT summits with the specialties in September.
There were 161 operations cancelled on the day of which 59 were reportable.

- Improve overall theatre utilisation to increases levels of elective activity. The Trust has commissioned a productivity company – FourEyes to support us with this work.
- Implement remedial actions to specialties furthest from trajectory - T&O, Gynaecology, and Cardiology. In place.
- Continue weekly PTL/RTT performance monitoring to maintain overall performance.



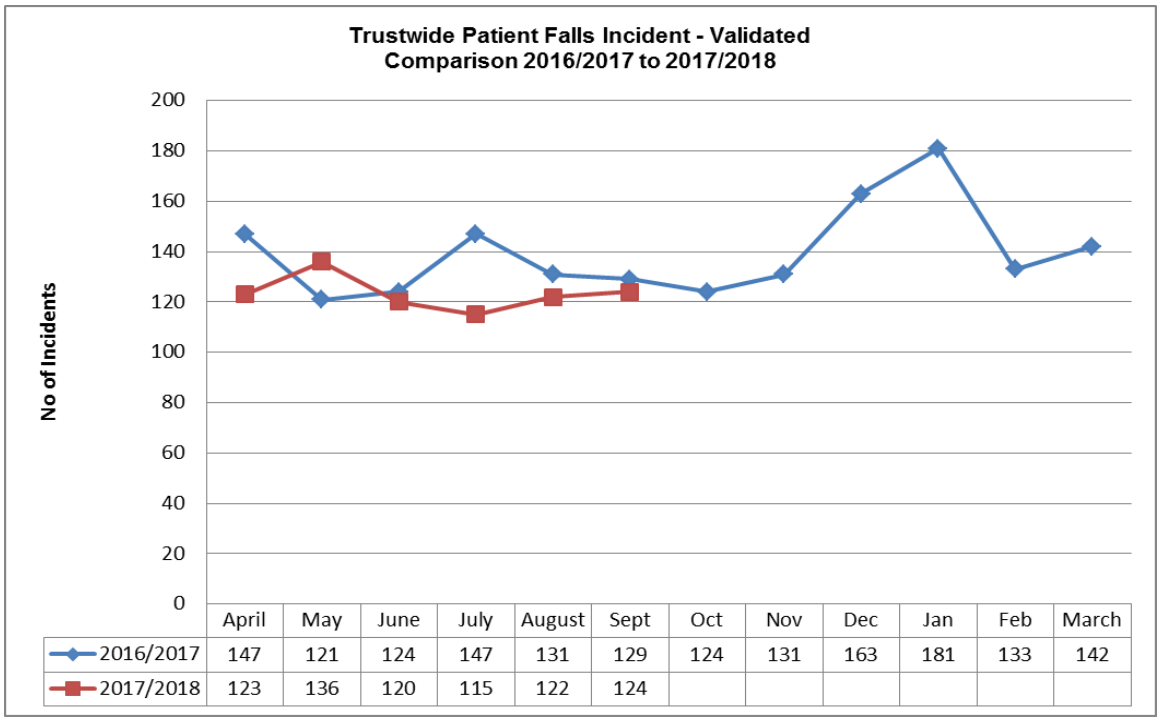


Quality and Safety

Patient falls incidents

There were 124 patient falls reported for September and a rate of 5.87 per 1000 bed days. This is slightly up compared to the same month last year, however the rate YTD is 5.7 against a limit 6.0.

3 falls were declared as Serious Incidents (SI) in September. This makes a total of 19 SIs year to date compared to 13 this time last year.



	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
2016/2017	147	121	124	147	131	129	124	131	163	181	133	142
2017/2018	123	136	120	115	122	124						

Learning identified through recent investigation of serious incidents relating to falls includes the following actions:

- Falls prevention care plan reviewed when patients condition changes (improve, deteriorate or on transfer).
- Assessment for enhanced care where appropriate in the management of patient at high risk of falls.
- Increase frequency of monitoring/ comfort checks of patient at risk of falls who has a decline in cognition.

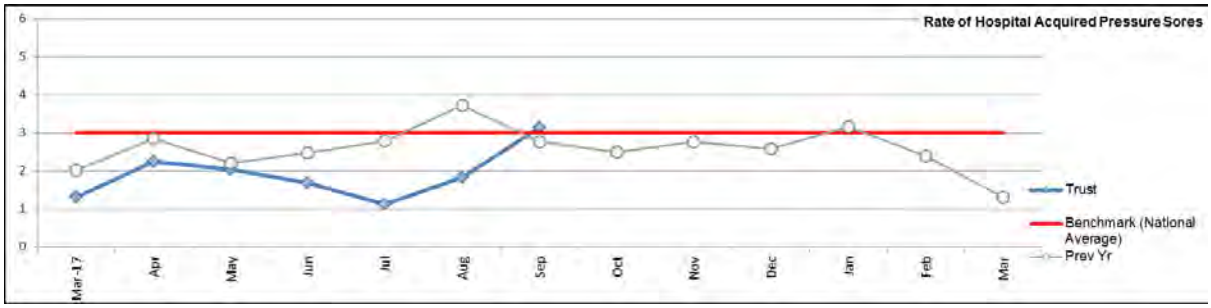
Friends and Family test

The response rates to the Friends and Family test have continued to remain largely stable, however there has been a reduction in the ED responses for the month with a total response rate of 5.2% which is below the Trust target of 15%. This was due, in part, to issues with order and supply of cards.
Positive response scores remain at or above the national average. The drop in positive scores in maternity earlier in the year means that YTD is 93.55 which is below the target of 95%

The FFT group continues to meet regularly to review the project pathways, data analysis and to maintain a raised awareness of the Friends and Family question. There is a continued focus to embed the process of collecting feedback into daily routines and sharing good practice. This has been demonstrated through the development of an AE Case study.

Pressure Ulcers:
There has been an increase in pressure ulcer incidents in September, with 17 being reported in September giving a rate of 3.0 against a limit of 3.0. Of these 1 was a Category 3 and 1 Category 4. These are currently under investigation.

There is a trend for increases in August/September (graph) however a number of actions are in progress including review of care guides, mattress availability, heel protector availability and review of continence products specifically pads.



Complaints

There were 39 new complaints reported for September, which equates to a rate of 1.84 new complaints per 1,000 occupied bed days.

44.4% of the complaints have been responded within target for September compared to a target of 75%.

The Central Complaints Team (CCT) is now fully staffed (as of 18th September) so are now better placed to support the directorates. Ongoing actions include weekly CCT review of all responses approaching deadlines, regular meetings with directorate links to monitor and support progress.

Critical Care is the only directorate to achieve the 75% compliance target.

Financial commentary

To follow.

Workforce commentary

As at the end of September 2017, the Trust employed 4992.80 whole time equivalent substantive staff, a 3.01 WTE reduction from the previous month. Temporary staffing remains higher than planned, but with a large shift from agency to bank than expected.

Sickness absence in the month (August) increased marginally to 3.41% but remains below target for the Trust as a whole. Effective sickness absence management remains a key area of focus for the HR and operational management teams, particularly targeting outlying areas.

Statutory and mandatory training compliance has increased to 88.82% from the previous month, and remains above the target percentage.

Turnover has remained higher than target in September at 11.79%, despite a slight reduction from a peak of 12.16% in August. HR Business Partners continue to work closely with divisional operational management teams in order to address areas which have a high turnover.

Appraisal compliance for July, following the end of the Trust's designated appraisal window in June, stands at 86.47%, a 2.53% increase from the previous month.

Board Finance Pack

To follow.

TRUST PERFORMANCE DASHBOARD **Position as at:** **30 September 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)	9.12	4.7	14.4	11.7	-2.7	-	11.5	10.3	
'1-02	Number of cases C.Difficile (Hospital)	2	1	19	15	-4	-	27	27	
'1-03	Number of cases MRSA (Hospital)	0	0	0	0	0	0	0	0	
'1-04	Elective MRSA Screening	98.0%	99.0%	98.0%	99.0%	1.0%	1.0%	98.0%	99.0%	
'1-05	% Non-Elective MRSA Screening	97.0%	97.0%	97.0%	97.0%	0.0%	2.0%	95.0%	97.0%	
'1-06	**Rate of Hospital Pressure Ulcers	2.78	3.14	2.80	2.01	- 0.79	- 1.00	*3.01*	2.24	3.00
'1-07	***Rate of Total Patient Falls	5.43	5.87	5.79	5.70	- 0.09	- 0.30	*6.00*	5.56	
'1-08	***Rate of Total Patient Falls Maidstone	4.88	5.76	5.18	5.05	- 0.13			4.76	
'1-09	***Rate of Total Patient Falls TWells	5.82	5.93	6.24	6.13	- 0.11			6.13	
'1-10	Falls - SIs in month	4	3	14	19	5				
'1-11	Number of Never Events	0	0	1	0	-1	0	*0*	0	
'1-12	Total No of SIs Open with MTW	30	58			28				
'1-13	Number of New SIs in month	6	15	55	77	22	17			
'1-14	***Serious Incidents rate	0.27	0.71	0.42	0.60	0.18	0.54	*0.0584 - 0.6978*	0.60	*0.0584 - 0.6978*
'1-15	Rate of Patient Safety Incidents - harmful	0.48	1.31	0.62	1.20	0.58	- 0.03	*0 - 1.23*	1.20	*0 - 1.23*
'1-16	Number of CAS Alerts Overdue	0	1			1	1	*0*		
'1-17	VTE Risk Assessment	95.3%	94.7%	95.3%	96.0%	0.7%	1.0%	95.0%	96.0%	95.0%
'1-18	Safety Thermometer % of Harm Free Care	95.8%	97.1%	96.4%	97.2%	0.8%	2.2%	95.0%		93.4%
'1-19	Safety Thermometer % of New Harms	4.21%	2.88%	3.33%	2.71%	-0.61%	-0.3%	*3.00%*	2.71%	
'1-20	C-Section Rate (non-elective)	12.9%	13.7%	13.9%	14.2%	0.27%	-0.8%	*15.0%*	14.2%	

	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	1.0717	0.0	0.1	Band 2	Band 2	1.0
2-02	Standardised Mortality HSMR	Prev Yr: Apr 15 to Mar 16		107.0	104.6	- 2.4	4.6	Lower confidence limit		100.0
2-03	Crude Mortality	1.0%	0.9%	1.2%	1.1%	0.0%		to be <100		
2-04	****Readmissions <30 days: Emergency	11.5%	13.1%	11.6%	12.4%	0.8%	-1.2%	*13.6%*	12.4%	14.1%
2-05	****Readmissions <30 days: All	11.0%	12.6%	10.8%	11.8%	1.0%	-2.8%	*14.7%*	11.8%	14.7%
2-06	Average LOS Elective	3.12	3.43	3.24	3.49	0.26	0.29	*3.20*	3.49	
2-07	Average LOS Non-Elective	7.81	7.08	7.58	7.27	- 0.31	0.47	*6.80*	7.27	
2-08	******FollowUp : New Ratio	1.55	1.54	1.59	1.56	- 0.03	0.04	*1.52*	1.56	
2-09	Day Case Rates	86.5%	83.5%	84.9%	86.2%	1.3%	6.2%	80.0%	86.2%	82.2%
2-10	Primary Referrals	10,021	8,359	59,742	54,573	-8.7%	-4.5%	119,266	109,586	
2-11	Cons to Cons Referrals	5,594	3,977	30,773	26,415	-14.2%	-11.4%	58,644	53,043	
2-12	First OP Activity	17,331	15,372	100,015	93,490	-6.5%	-6.8%	201,705	187,734	
2-13	Subsequent OP Activity	31,566	27,713	187,608	175,165	-6.6%	-5.8%	383,906	351,743	
2-14	Elective IP Activity	625	658	4,105	3,441	-16.2%	-23.7%	8,303	6,910	
2-15	Elective DC Activity	3,620	3,270	22,772	21,211	-6.9%	-5.9%	43,602	42,593	
2-16	**Non-Elective Activity	4,423	4,763	25,651	28,347	10.5%	19.6%	46,435	56,539	
2-17	A&E Attendances (Inc Clinics. Calendar Mth)	14,096	14,292	85,076	86,047	1.1%	1.3%	168,161	169,162	
2-18	Oncology Fractions	5,966	5,369	35,968	34,507	-4.1%	-8.1%	75,273	69,014	
2-19	No of Births (Mothers Delivered)	560	531	3,050	3,028	-0.7%	1.3%	5,977	6,056	
2-20	% Mothers initiating breastfeeding	80.8%	82.8%	82.8%	81.4%	-1.4%	3.4%	78.0%	81.4%	
2-21	% Stillbirths Rate	0.4%	0.55%	0.53%	0.36%	*-0.2%*	*-0.1%*	*0.47%*	0.36%	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	5	5	5	0	5	
3-02	*****Rate of New Complaints	0.82	1.84	1.69	1.84	0.2	0.53	*1.318-3.92*	1.80	
3-03	% complaints responded to within target	57.7%	44.4%	74.3%	60.2%	-14.1%	-14.8%	75.0%	60.2%	
3-04	****Staff Friends & Family (FFT) % rec care	82.7%	76.0%	82.7%	76.0%	-6.6%	-3.0%	79.0%	76.0%	
3-05	*****IP Friends & Family (FFT) % Positive	92.7%	95.5%	95.3%	95.7%	0.4%	0.7%	95.0%	95.7%	95.8%
3-06	A&E Friends & Family (FFT) % Positive	89.3%	91.1%	90.6%	91.6%	1.0%	4.6%	87.0%	91.6%	85.5%
3-07	Maternity Combined FFT % Positive	94.2%	96.3%	94.0%	93.5%	-0.5%	-1.5%	95.0%	93.5%	95.6%
3-08	OP Friends & Family (FFT) % Positive	83.4%	84.8%	82.6%	84.3%	1.8%			84.3%	

* 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"* ** NE Activity Includes Maternity

	Responsiveness	Latest Month Prev Yr	Latest Month Curr Yr	Year/Quarter to Date Plan	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	89.4%	89.99%	89.8%	89.6%	90.5%	1.0%	0.5%	90.1%	90.1%	85.4%
4-02	Emergency A&E >12hr to Admission	0	-	0	0	0	0	0	*0*	0	
4-03	Ambulance Handover Delays >30mins	New	519	0	New	2,496					
4-04	Ambulance Handover Delays >60mins	New	65	0	New	224					
4-05	RTT Incomplete Admitted Backlog	1,029	2315	1,332	1,029	2315	1,286	983	1,259	1259	
4-06	RTT Incomplete Non-Admitted Backlog	516	1654	668	516	1654	1,138	986	631	631	
4-07	RTT Incomplete Pathway	90.4%	84.6%	90.7%	90.4%	84.6%	-5.8%	-5.8%	92%	92.0%	
4-08	RTT 52 Week Waiters	0	0	-	0	4	4	4	*0*	4	
4-09	RTT Incomplete Total Backlog	2,309	3968	2,000	2,309	3968	1,659	1,968	1,890	1890	
4-10	% Diagnostics Tests WTimes <6wks	99.70%	99.0%	99.0%	99.7%	99.0%	-0.7%	0.0%	99.0%	99.0%	
4-11	*Cancer WTimes - Indicators achieved	3	4		2	4	2	- 5	9	9	
4-12	*Cancer two week wait	93.3%	91.5%		91.4%	92.5%	1.1%	-0.5%	93.0%	93.0%	
4-13	*Cancer two week wait-Breast Symptoms	90.0%	82.8%		86.6%	84.9%	-1.7%	-8.1%	93.0%	93.0%	
4-14	*Cancer 31 day wait - First Treatment	96.8%	97.2%		96.5%	96.3%	-0.3%	0.3%	96.0%	96.0%	
4-15	*Cancer 62 day wait - First Definitive	73.3%	76.1%	79.5%	71.9%	73.7%	1.8%	-2.7%	85.0%	85.0%	
4-16	*Cancer 62 day wait - First Definitive - MTW	76.5%	81.8%	79.5%	76.5%	81.8%	5.3%		85.0%		
4-17	*Cancer 104 Day wait Accountable	4.5	5.0		46.5	39.0	-7.5	39.0	*0*	39.0	
4-18	*Cancer 62 Day Backlog with Diagnosis	74	54		74	54	-20				
4-19	*Cancer 62 Day Backlog with Diagnosis - MTW	51	41		51	41	-10				
4-20	Delayed Transfers of Care	7.2%	5.3%		6.3%	5.5%	-0.7%	2.0%	3.5%	5.5%	
4-21	% TIA with high risk treated <24hrs	66.7%	81.0%		78.0%	67.3%	-10.7%	7.3%	60%	67.3%	
4-22	*******% spending 90% time on Stroke Ward	84.3%	94.8%		85.9%	91.1%	5.2%	11.1%	80%	91.1%	
4-23	*******Stroke:% to Stroke Unit <4hrs	50.9%	66.2%	60.0%	49.7%	59.4%	9.8%	-0.6%	60.0%	60.0%	
4-24	*******Stroke: % scanned <1hr of arrival	50.0%	75.8%	48.0%	53.5%	64.6%	11.1%	16.6%	48.0%	64.6%	
4-25	*******Stroke:% assessed by Cons <24hrs	55.6%	80.3%	80.0%	62.2%	77.7%	15.5%	-2.3%	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	3	2		6	15	9	15	*0*	15	

RTT Incomplete Pathway Monthly Plan is Trust Recovery Trajectory

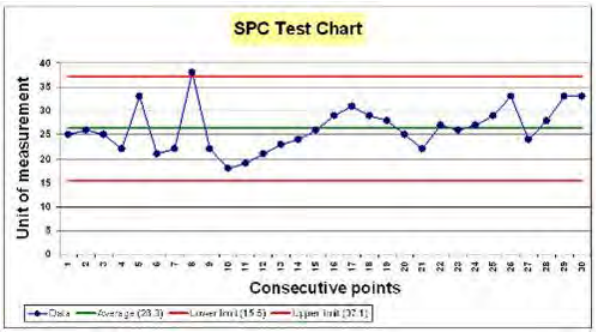
**CWT run one mth behind, YTD is Quarter to date, Monthly Plan for 62 Day Wait First Definitive is Trust Recovery Trajectory*

**** 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 Plan	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	34,109	35,658	35,526	170,452	182,610	7.1%	1.4%	436,643	443,179	
5-02	EBITDA	(491)	428	2,816	(3,198)	6,891	-315.5%	-36.0%	38,055	37,071	
5-03	Surplus (Deficit) against B/E Duty	(3,282)	(2,126)	214	(16,808)	(5,830)			6,673	6,673	
5-04	CIP Savings	1,471	1,912	3,205	7,571	7,309	-3.5%	-28.2%	31,721	31,721	
5-05	Cash Balance	3,964	5,594	5,631	3,964	5,594	41.1%	-1%	1,000	1,000	
5-06	Capital Expenditure	286	287	2,050	1,160	883	-23.9%	-88.5%	*16,948*	15,700	
5-07	Establishment WTE	5,713.5	5,603.2	5,603.2	5,713.5	5,603.2	-1.9%	0.0%	5,603.2	5,603.2	
5-08	Contracted WTE	5,165.0	4,995.8	5,116.7	5,165.0	4,995.8	-3.3%	-2.4%	5,116.7	5,116.7	
5-09	Vacancies WTE	548.5	607.4	486.5	548.5	607.4	10.7%	24.8%	486.5	486.5	
5-11	Vacancy Rate (%)	9.6%	10.8%	8.7%	9.6%	10.8%	1.2%	2.2%	8.7%	8.7%	
5-12	Substantive Staff Used	4,990.6	4,868.6	5,114.4	4,990.6	4,868.6	-2.4%	-4.8%	5,114.4	5,114.4	
5-13	Bank Staff Used	410.2	456.6	333.3	410.2	456.6	11.3%	37.0%	333	333.3	
5-14	Agency Staff Used	242.8	134.8	155.5	242.8	134.8	-44.5%	-13.3%	155.5	155.5	
5-15	Overtime Used	58.5	46.6	0.0	58.5	46.6	-20.3%				
5-16	Worked WTE	5,702.1	5,506.6	5,603.2	5,702.1	5,506.6		-1.7%	5,603.2	5,603.2	
5-17	Nurse Agency Spend	(793)	(444)	(773)	(4,150)	(2,692)	-35.1%				
5-18	Medical Locum & Agency Spend	(1,297)	(1,428)	(919)	(6,723)	(5,895)	-12.3%				
5-19	Temp costs & overtime as % of total pay bill	16.3%	15.0%		16.5%	14.2%	-2.3%				
5-20	Staff Turnover Rate	10.3%	11.8%	11.8%		11.7%	1.4%	1.2%	*10.5%*	11.7%	11.05%
5-21	Sickness Absence	3.8%	3.4%	4.5%		3.3%	-0.4%	0.0%	*3.3%*	3.3%	4.3%
5-22	Statutory and Mandatory Training	88.1%	88.8%			87.8%	0.8%	2.8%	85.0%	87.8%	
5-23	Appraisal Completeness	72.2%	86.5%			86.5%	14.3%	-3.5%	90.0%	90.0%	
5-24	Overall Safe staffing fill rate	97.3%	98.8%		99.7%	98.5%	-1.2%		93.5%	98.5%	
5-25	****Staff FFT % recommended work	60.2%	51%	59.0%	60.2%	51%	-9.3%	-11.1%	62.0%	51%	
5-26	***Staff Friends & Family -Number Responses	98	701		98	701	603				
5-27	*****IP Resp Rate Recmd to Friends & Family	22.1%	22.1%	15.0%	23.5%	24.0%	0.4%	-1.0%	25.0%	25.0%	25.7%
5-28	A&E Resp Rate Recmd to Friends & Family	15.6%	5.2%	5.0%	14.2%	15.8%	1.6%	0.8%	15.0%	15.8%	12.7%
5-29	Mat Resp Rate Recmd to Friends & Family	22.4%	21.5%	15.0%	22.2%	29.9%	7.7%	4.9%	25.0%	29.9%	24.0%

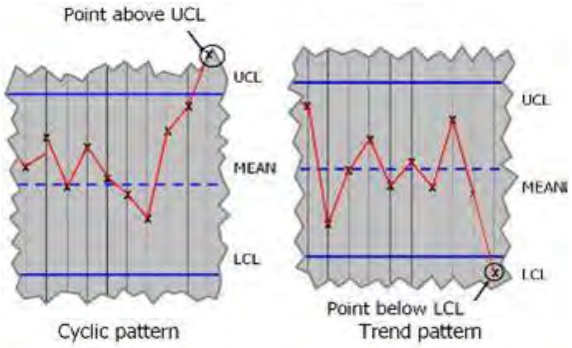
Explanation of Statistical Process Control (SPC) Charts

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:

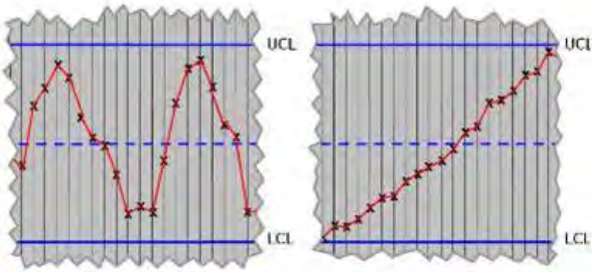


SPC is a type of charting that shows the variation that exists in the systems that are being measured. When interpreting SPC charts there are 4 rules that help to identify what the system is doing. If one of the rules has been broken, this means that 'special cause ' variation is present in the system. 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.

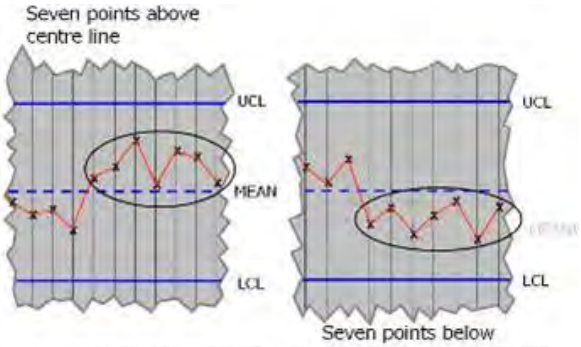


Rule 2: Any unusual pattern or trends within the control limits. The most obvious example of a cyclical pattern is seasonality but we also see it when looking at daily discharges where the weekends have low numbers. To qualify as a trend there must be at least 6 points in a row. This is one of the key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

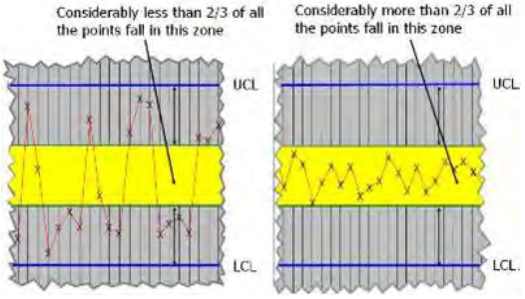


Rules 1 and 2 are the main reason for displaying SPC charts on our performance reports as it makes abnormally high or low values and trends immediately obvious. However there are two other rules that are also used to interpret the graphs.

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.

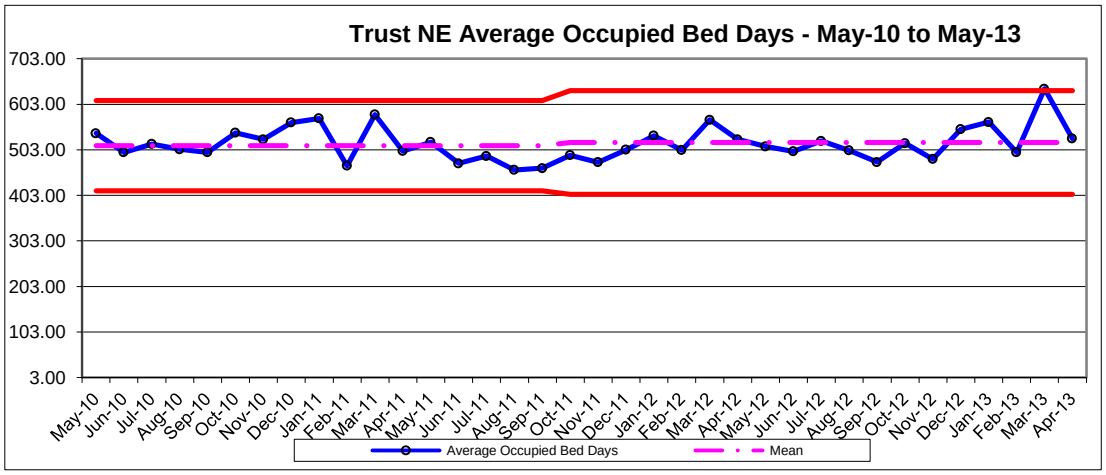


Rule 4: The number of points within the middle third of the region between the control limits differs markedly from two -thirds of the total number of points. This gives an indication of how stable a process is. If controlled variation (common cause) is displayed in the SPC chart, the process is stable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

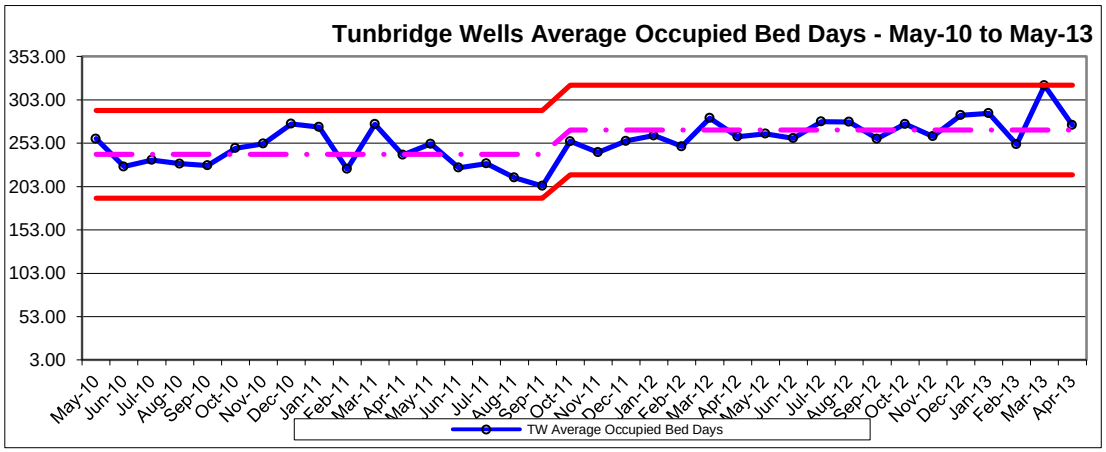


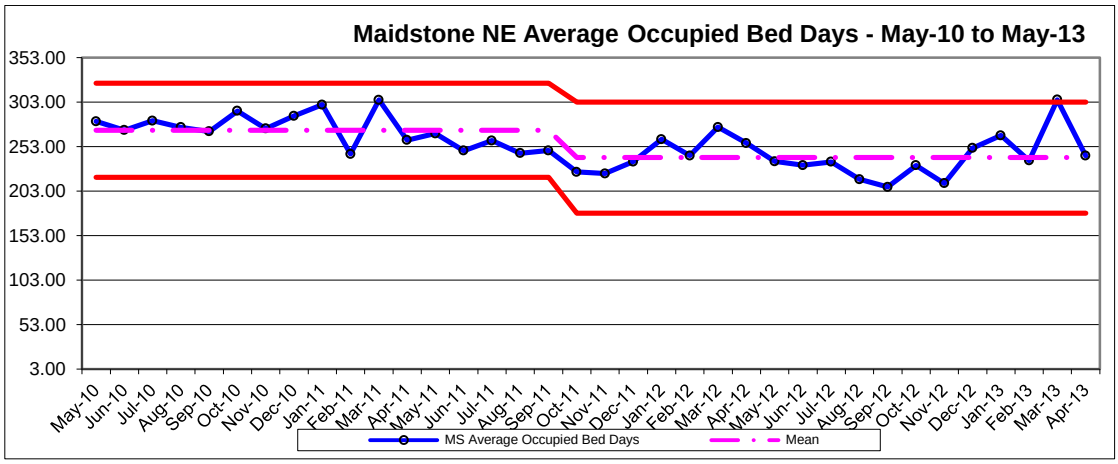
Changes to Control Lines

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:

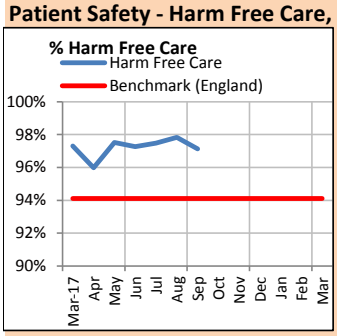


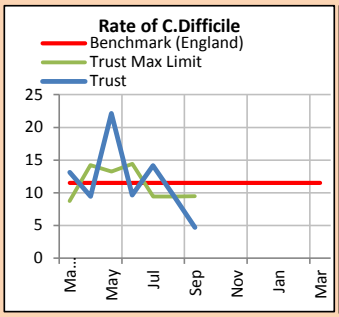


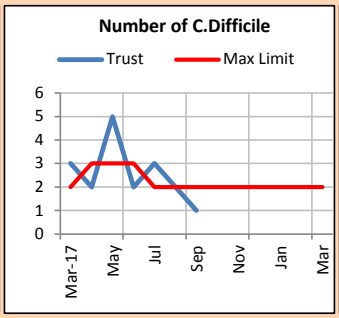
So in the examples given we have calculated a mean and control limits based on the data for May 2010 to September 2011 and then calculated them based on the period October 2011 to April 2013. The lines are all a result of the SPC calculations, only the date of the change is decided by the Information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

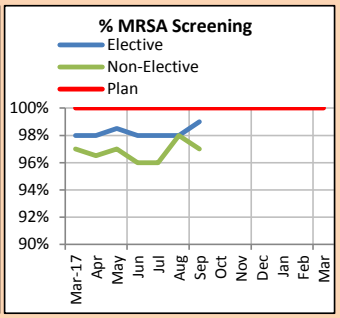
INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

Patient Safety - Harm Free Care, Infection Control

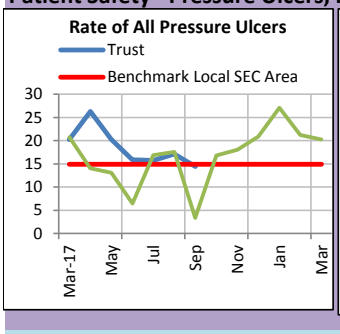


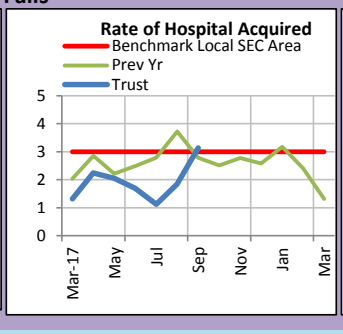


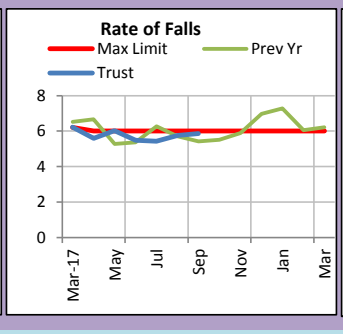


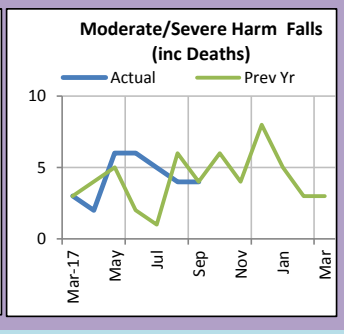


Patient Safety - Pressure Ulcers, Falls

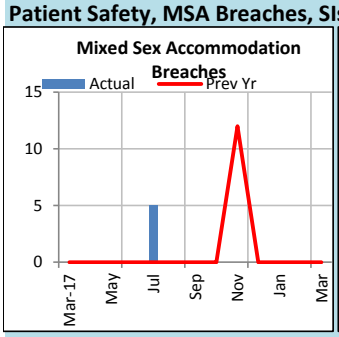


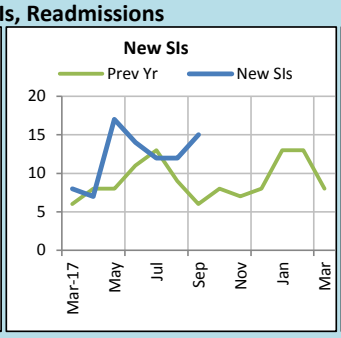


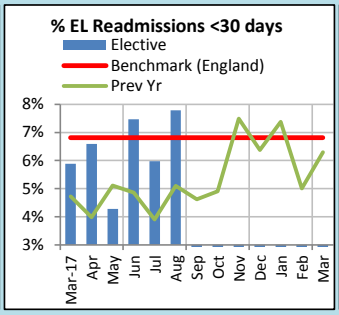


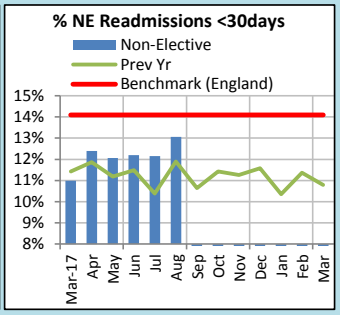


Patient Safety, MSA Breaches, SIs, Readmissions

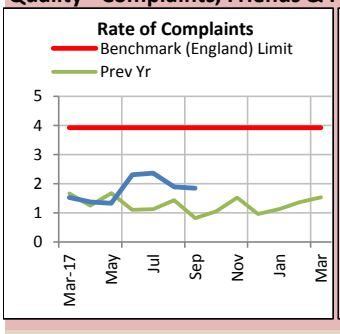


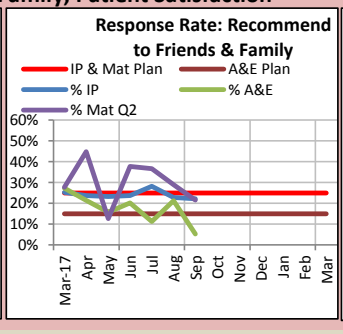


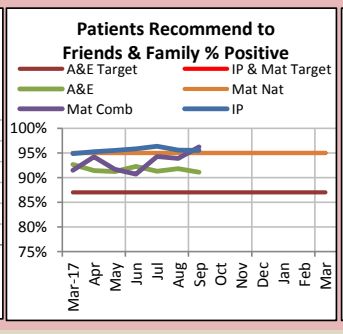


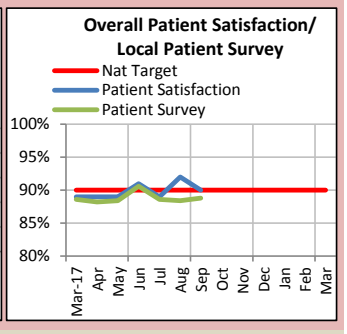


Quality - Complaints, Friends & Family, Patient Satisfaction

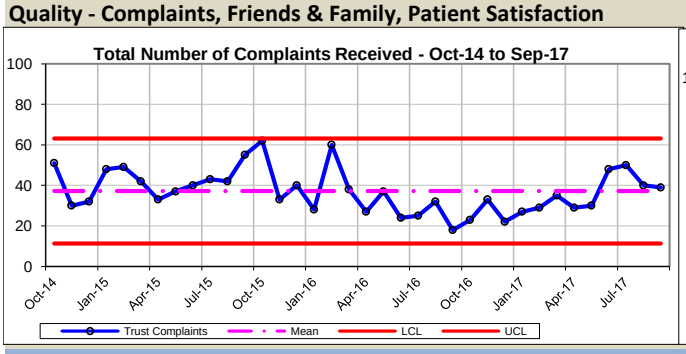


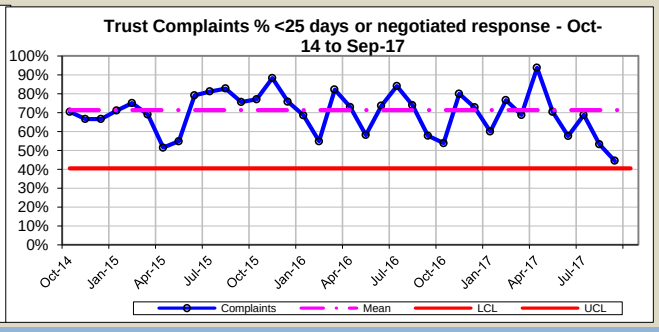




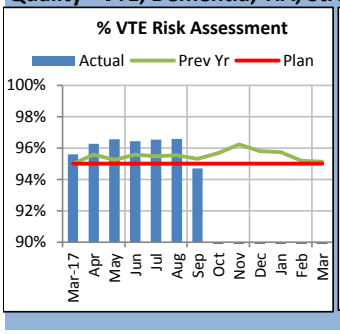


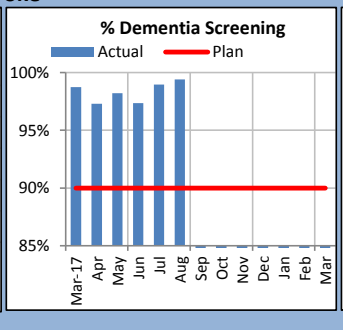
Quality - Complaints, Friends & Family, Patient Satisfaction

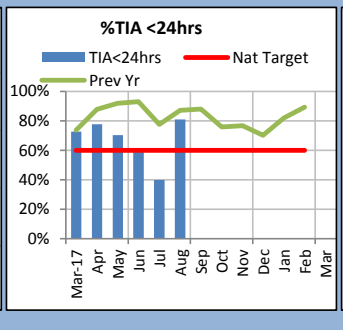


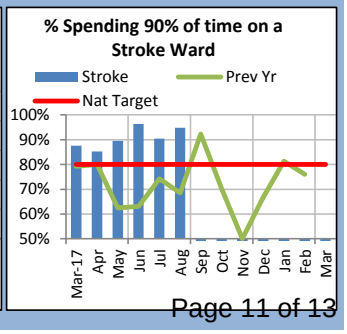


Quality - VTE, Dementia, TIA, Stroke



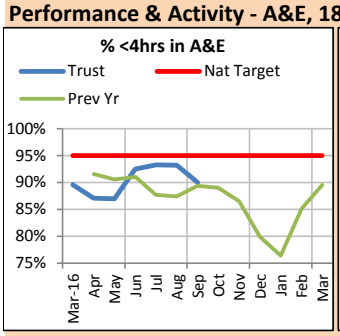


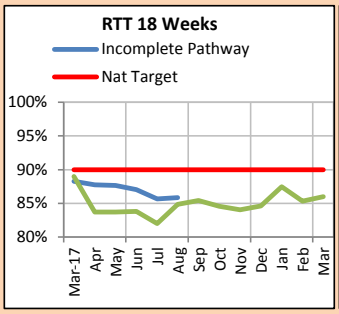


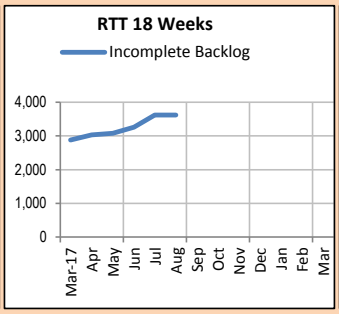


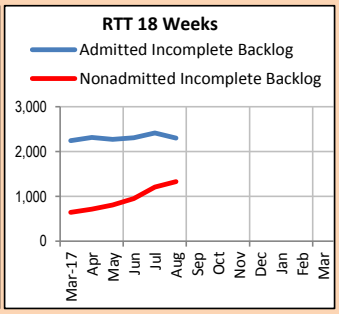
INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

Performance & Activity - A&E, 18 Weeks

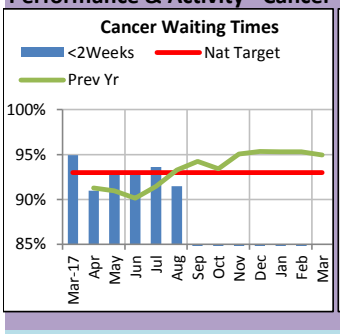


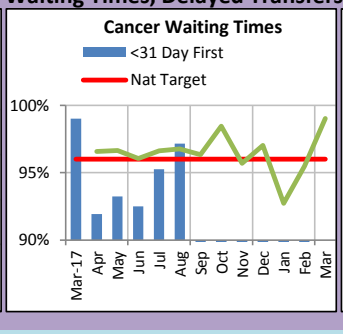


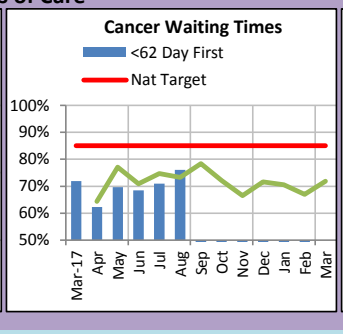


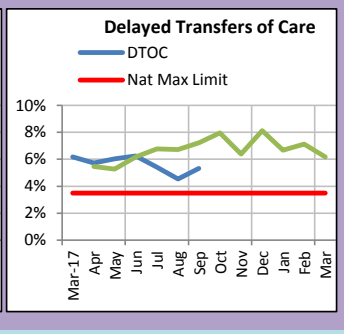


Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care

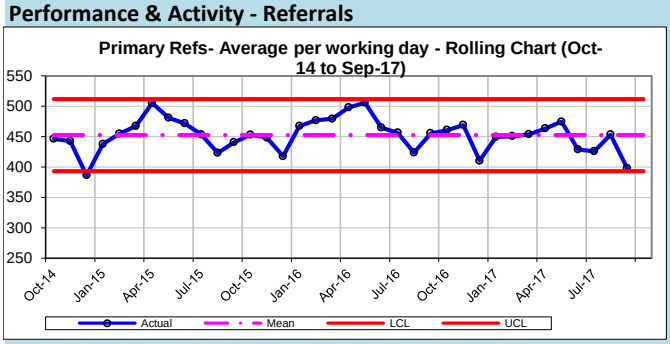


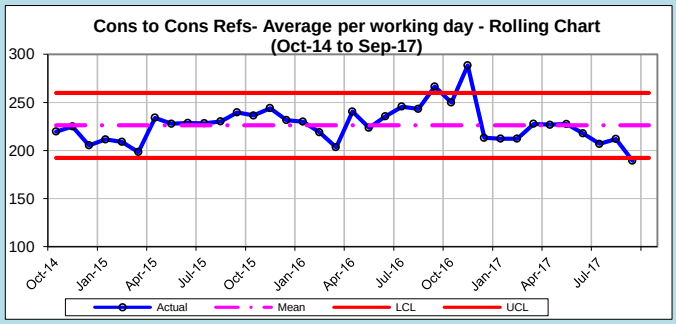




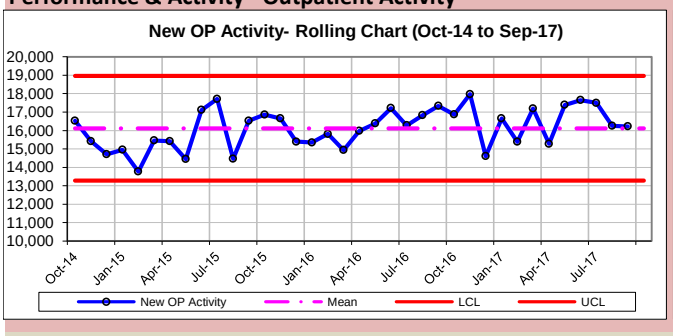


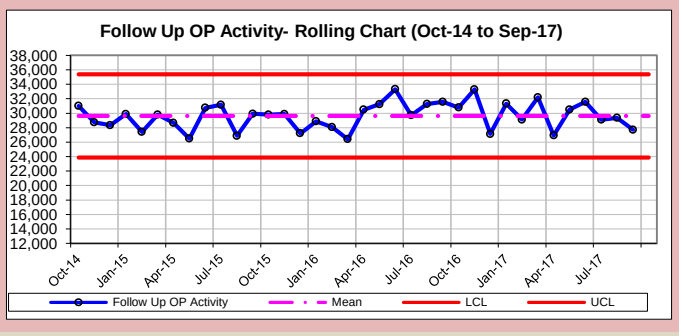
Performance & Activity - Referrals



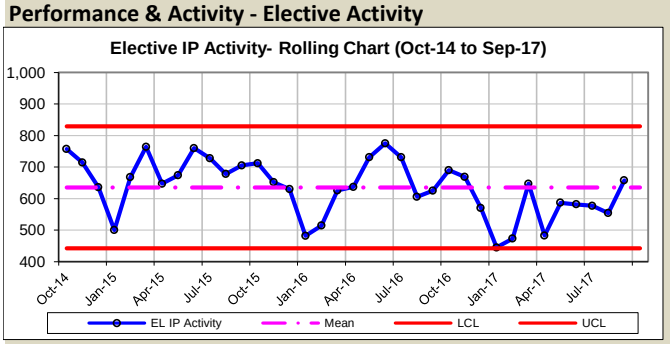


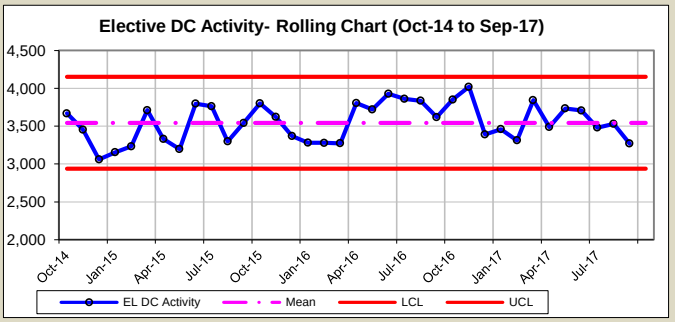
Performance & Activity - Outpatient Activity



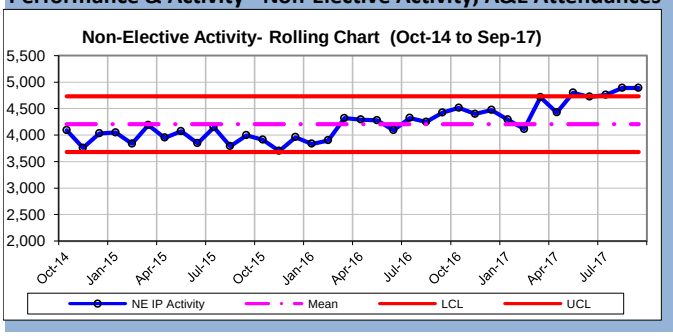


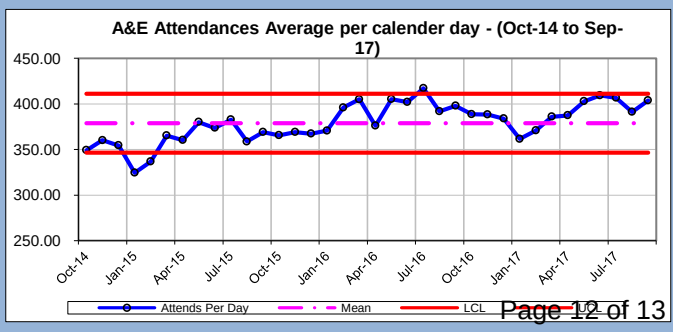
Performance & Activity - Elective Activity





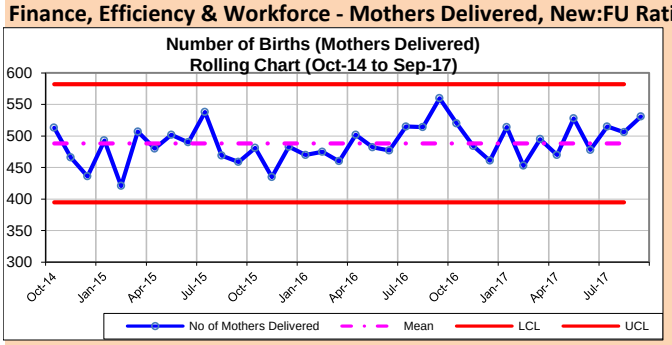
Performance & Activity - Non-Elective Activity, A&E Attendances

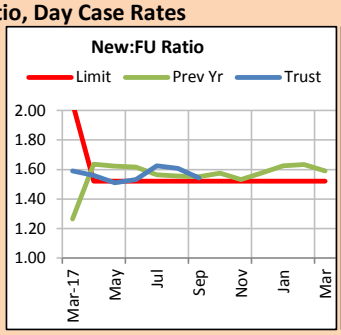


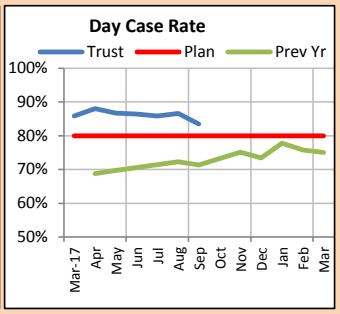


INTEGRATED PERFORMANCE REPORT ANALYSIS - FINANCE, EFFICIENCY & WORKFORCE

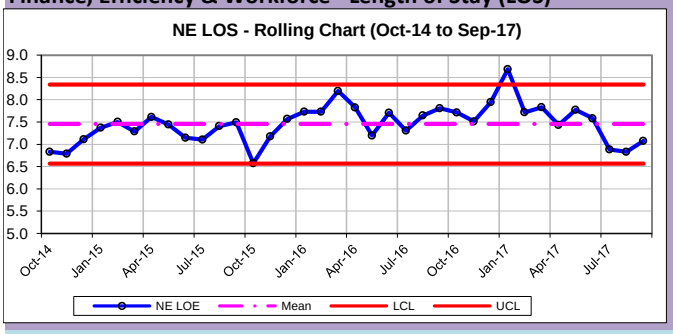
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates

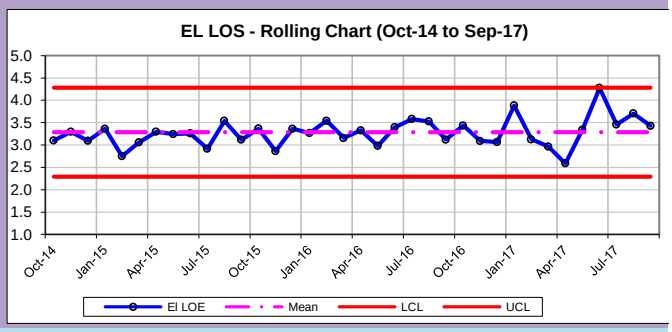




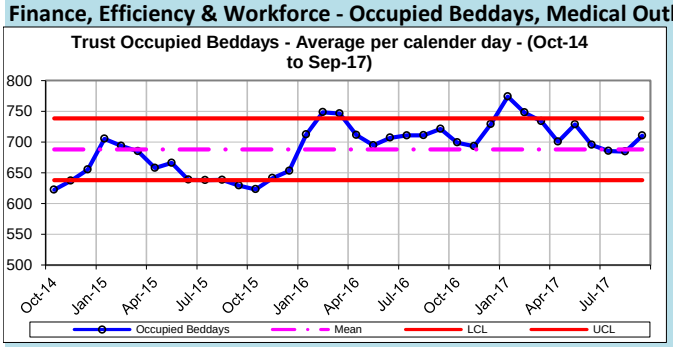


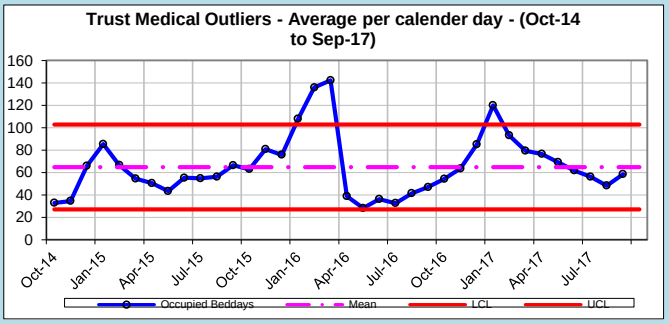
Finance, Efficiency & Workforce - Length of Stay (LOS)



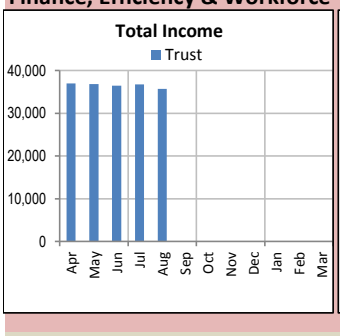


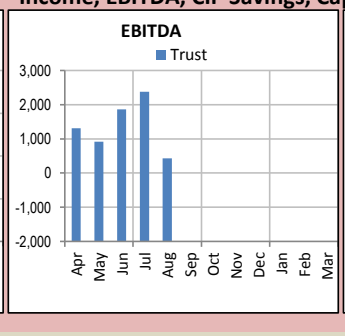
Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

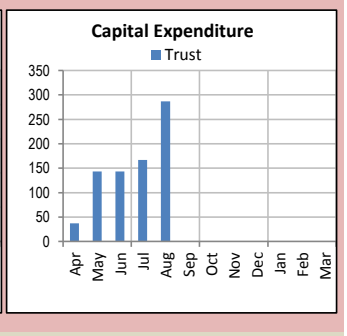




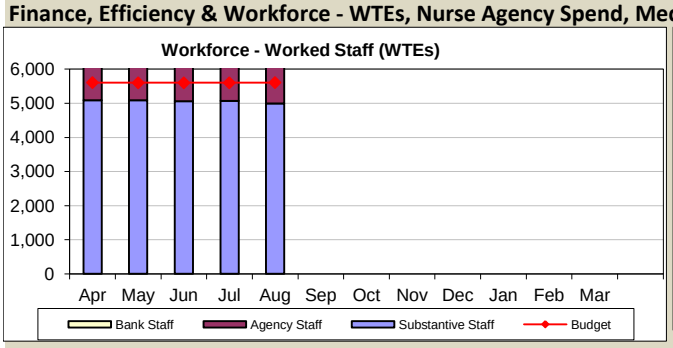
Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure

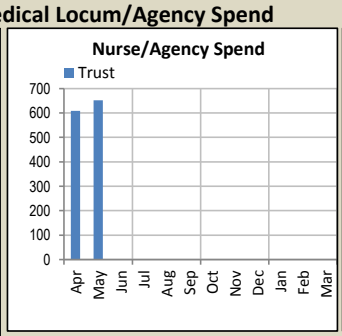


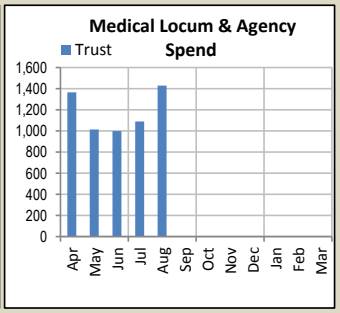




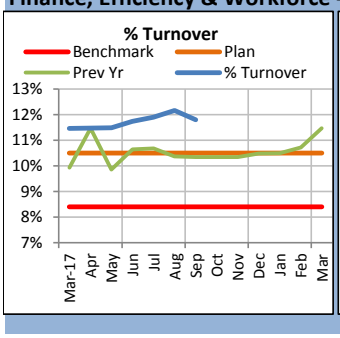
Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend

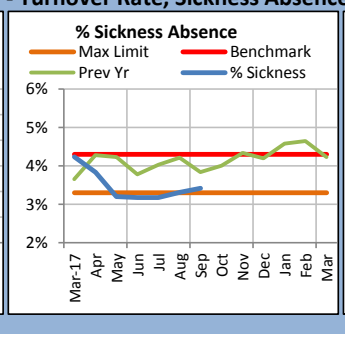


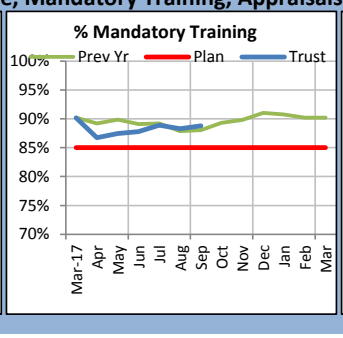


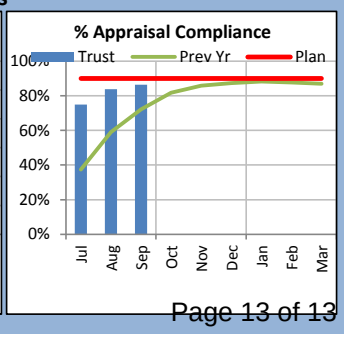


Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals









Trust Board meeting – October 2017

Maidstone and Tunbridge Wells NHS Trust

10-10 Update on the anticipated inspection by the CQC **Chief Nurse**

Summary / Key points

The purpose of this report is to provide the Trust Board with a further update on the anticipated unannounced and announced inspection by the CQC.

The central project team continues to manage the overarching project plan and remains on schedule with Phase 1 completed and Phases 2– 4 running co currently. Activities for preparation to the mapped key objectives and activities within the 6 Phase model of delivery have included:

- **PHASE 1** - **Provider Information Request (PIR) Data Collection/Submission** - Completed on schedule and submitted 14th August 2017.

- **PHASE 2A** - **Replies to Phase 1 Data Submission** – The project plan continues to record this as an ongoing action however, requests from the CQC following the submission of the PIR have ceased at this time. Good communication has been maintained with the CQC and responses were dealt with in a timely manner during this phase.

- **PHASE 2B** - **Preparation for Unannounced CQC Visit** –. The CQC hub room has been established. The cascade information and hospitality plan designed for the arrival of inspectors has been agreed and shared.

  The internal mock inspections have continued with dates mapped out for the remainder of the year. In addition, the CQC requested support in arranging focus groups to provide opportunities for them to meet with staff in the organisation. These took place on the 4th and 6th October 2017at both the Tunbridge Wells and Maidstone Hospital sites respectively. These groups consisted of 7 sessions throughout each day with an open invitation for all staff groups to attend specific group sessions. There were no immediate concerns raised on the day by the CQC inspectors.

- **PHASE 2C** – **Communication** – The CQC have been provided with a welcome guide; "Your Guide to Maidstone and Tunbridge Wells NHS Trust" in advance of both the unannounced and announced inspection to welcome them to the Trust and to provide some guidance on infection control expectations, site locations and key contacts.

  Staff have also been provided with a handbook; "Staff Guide: preparing for CQC Inspections". A letter of communication regarding the CQC was also distributed with September's payslips. The Board Handbook has been shared for comments and is currently being amended to reflect these additional recommendations. Informal CQC "drop in" sessions are now diarised throughout October, November and December. A presentation has been developed and shared widely as well as being presented at local meetings by the nominated directorate leads. The Take 5 Talk 5 campaign is now well established in the Friday CEO Newsletter. This continues to raise awareness of key focus areas and is an ongoing reminder of the 5 Key Lines of Enquiry (KLOEs).

- **PHASE 2D** – **Project Group** - The Daily CQC huddle is now fully embedded into practice providing a daily process for monitoring the risks and issues log. The CQC project group meets weekly with a standing agenda and provides a forum for escalation of any risks / issues requiring the nominated directorate lead to progress outside of the huddle. The Quality Improvement tracker and action plan has been revised to provide a robust form of monitoring, evaluation and assurances against actions in progress with review against "Must do's", "Should do's" and the addition of "New do's".

- **PHASE 3** - **Well Led Domain Self-Assessment** (in preparation for Announced Visit) – A Trust self-assessment has been undertaken and submitted for review by NHSI

- **PHASE 4** - **Announced Visit** – This has now been confirmed for 12th and 13th December 2017. In addition to the above progress, provisional room bookings are in place and hospitality plans are being progressed. Next steps will include interview scheduling and preparation.

- **PHASE 5** - **Post Inspection** – Not due
- **PHASE 6** - **Wrap up/Handover/BAU** – Not due

The aspiration and intention of this project plan remains as before; to ensure that MTW can transition from a 'Requires Improvement' status to one of 'Good' but most importantly to ensure that we continue to strive to improve the standard of care that we provide to our patients and improve work processes which will benefit our staff in the way they deliver this care. The project plan will establish a new way of monitoring progress and achievements against the quality improvement plan with the continuation of the CQC project group post inspection to embed CQC management into our business as usual and align the Trusts ongoing preparedness to the CQCs new strategy.

Which Committees have reviewed the information prior to Board submission?

- n/a

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

For Information

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

Trust Board meeting – October 2017

NHS Maidstone and Tunbridge Wells NHS Trust

10-11 Planned and actual ward staffing for August and September 2017 Chief Nurse

Summary / Key points

The attached paper shows the planned v actual nursing staffing as uploaded to UNIFY for the months of August and September 2017. This data is also published via the NHS Choices website and the Trust website as directed by NHS England and the National Quality Board.

Care Hours Per Patient Day

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

The Carter report indicated a range for CHPPD between 6.3 and 15.48. The median was 9.13.
Overall CHPPD have remained stable over the last two months with 8.1 for Maidstone and 9.4 for Tunbridge Wells Hospital in August, decreasing slightly to 9.2 in September. Overall the CHPPD remains within the national average range.

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 August were Maidstone Stroke Unit, Whatman and Ward 10, and for July Maidstone Stroke Unit, Chaucer, Ward 11 and Ward 20.

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.

A number of wards have a variation in RN/CSW ratios either due to lack of available bank/agency staff, or as an accepted risk based on acuity and dependency. These areas include John Day, wards 10 and 21.

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.

Crowborough Birth Centre had a reduced Registered Midwifery fill rate at night during August due to sickness within the team. This was mitigated with the use of 1st and 2nd on-call system from the community midwifery team.

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 Tunbridge Wells Hospital 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
	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

Reason for receipt at the Board. Assurance

August'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	91.6%	107.3%	99.2%	141.9%	739	34.1%	100.0%	3	0		18 patients requiring enhanced supervision over night during the month.	132,329	133,199	(870)
MAIDSTONE	Cornwallis	102.2%	95.2%	98.9%	104.3%	490	30.8%	92.9%	1	0			72,057	75,721	(3,664)
MAIDSTONE	Coronary Care Unit (CCU)	93.5%	80.6%	100.0%	N/A	183	84.2%	93.8%	1	0		CSW Fill rate an accepted risk, as unit co-located on Culpepper.	103,281	109,088	(5,807)
MAIDSTONE	Culpepper	100.0%	95.2%	100.0%	96.8%	363	81.1%	96.7%	2	1					
MAIDSTONE	John Day	80.3%	143.0%	95.5%	100.0%	911	25.3%	100.0%	3	0		RN:CSW ratio an accepted risk. Increased CSW to ensure sufficient staff on duty to meet fundamental care needs.	127,486	127,951	(465)
MAIDSTONE	Intensive Treatment Unit (ITU)	94.8%	N/A	91.9%	N/A	201	0.0%	0.0%	0	0			174,246	166,751	7,495
MAIDSTONE	Pye Oliver	87.5%	89.7%	96.8%	97.8%	849	43.5%	86.7%	8	1		Day fill rate an accepted risk, as unable to fill gaps in rota with temporary staff.	100,557	107,839	(7,282)
MAIDSTONE	Chaucer	90.9%	99.2%	100.0%	109.7%	401	38.3%	95.7%	5	0			106,207	108,841	(2,634)
MAIDSTONE	Lord North	92.3%	112.9%	95.7%	90.3%	546	11.1%	100.0%	2	0		Increased CSW on 4 shifts to support day ward attenders.	101,914	90,737	11,177
MAIDSTONE	Mercer	111.3%	95.2%	100.0%	103.2%	485	55.6%	85.0%	5	0			101,227	106,350	(5,123)
MAIDSTONE	Edith Cavell (MOU)	97.8%	95.3%	102.2%	100.0%	690	67.9%	100.0%	1	0			69,859	61,904	7,955
MAIDSTONE	Urgent Medical Ambulatory Unit (UMAU)	75.9%	94.8%	132.3%	196.8%	517	9.0%	100.0%	1	0		Escalated at night throughout the month.	94,435	122,791	(28,356)
TWH	Stroke/W22	83.3%	94.2%	94.2%	101.1%	686	117.6%	85.0%	5	1		Day RN fill rate an accepted risk, as unable to fill gaps in rota with temporary staff.	158,182	140,507	17,675
TWH	Coronary Care Unit (CCU)	91.2%	85.7%	93.5%	N/A	212	61.0%	100.0%	1	0		CSW fill rate an accepted risk	61,501	62,715	(1,214)
TWH	Gynaecology/ Ward 33	98.3%	97.0%	100.0%	100.0%	401	24.8%	96.9%	1	0			74,602	66,516	8,086
TWH	Intensive Treatment Unit (ITU)	103.6%	96.8%	102.4%	61.3%	237	0.0%	0.0%	0	0		CSW fill rate an accepted risk, as reduced acuity levels throughout the month.	179,243	183,235	(3,992)
TWH	Medical Assessment Unit	92.5%	95.2%	114.8%	103.2%	914	33.5%	93.2%	9	0		Ambulatory bay escalated over night.	162,759	167,646	(4,887)
TWH	SAU	96.8%	93.5%	100.0%	96.8%	253			2	0			54,119	59,862	(5,743)
TWH	Ward 32	91.4%	90.3%	95.7%	105.6%	764	46.2%	94.4%	5	1			122,764	141,105	(18,341)
TWH	Ward 10	91.5%	91.9%	77.4%	159.7%	902	20.3%	100.0%	4	0		12 nights of enhanced care needs. All cases assessed and reviewed by Matron.	112,453	107,317	5,136
TWH	Ward 11	95.4%	116.1%	100.0%	125.8%	879	12.1%	91.7%	2	0		Increased dependency, with 4 tracheostomy patients (1 from 12th, 2 from 17th, 4 from 27th).	110,018	100,963	9,055
TWH	Ward 12	92.1%	94.4%	98.9%	98.4%	769	19.6%	100.0%	9	0			119,228	115,109	4,119
TWH	Ward 20	91.4%	100.8%	98.9%	100.0%	1136	43.8%	85.7%	10	0			106,506	102,237	4,269
TWH	Ward 21	93.0%	103.2%	85.2%	129.0%	851	20.0%	92.9%	10	1		RN:CSW ratio shift an accepted risk as unable to fill with temporary RN overnight. Additional CSW utilised to ensure fundamental care needs were met.	129,022	127,203	1,819
TWH	Ward 2	91.9%	103.2%	97.8%	108.1%	782	31.6%	77.8%	9	0			124,028	114,149	9,879
TWH	Ward 30	95.7%	80.9%	96.8%	122.6%	861	17.6%	100.0%	8	1			108,041	118,376	(10,335)
TWH	Ward 31	89.8%	91.9%	96.8%	96.8%	884	10.8%	75.0%	7	4			129,736	129,448	288
Crowborough	Birth Centre	106.5%	71.0%	57.4%	96.8%				0	0		RM fill rate at night an accepted risk, due to vacancy, planned and unplanned absence. Mitigated with on-call system.	85,997	66,732	19,265
TWH	Ante-Natal	100.0%	90.3%	100.0%	93.5%	231	28.9%	93.9%	0	0					
TWH	Delivery Suite	97.8%	96.8%	94.6%	88.7%	241			0	0			615,757	624,378	(8,621)
TWH	Post-Natal	98.0%	67.7%	97.6%	62.1%	590			0	0					
TWH	Gynae Triage	96.8%	93.5%	100.0%	87.1%				0	0			11,974	16,969	(4,995)
TWH	Hedgehog	99.5%	48.4%	99.4%	87.1%	453	0.0%	0.0%	0	0		Reduced fill rate for unregistered/CSW staff an considered action as unit had reduced numbers of children during the month.	197,856	174,621	23,235
MAIDSTONE	Birth Centre	100.0%	96.8%	100.0%	96.8%				0	0			63,527	57,392	6,135
TWH	Neonatal Unit	103.2%	87.1%	103.2%	83.9%	408			0	0			167,377	171,371	(3,994)
MAIDSTONE	MSSU	100.0%	91.7%	100.0%	N/A				0	0			40,769	38,461	2,308
MAIDSTONE	Peale	128.0%	57.4%	100.0%	100.0%	382	26.2%	93.8%	0	0			70,239	68,556	1,683
TWH	SSSU	100.0%	100.0%	98.4%	100.0%				2	0		Fill rate reflects available staff for funded short stay surgical beds. Additional staff utilised to cover escalation capacity at night.	60,469	76,875	(16,406)
MAIDSTONE	Whatman	100.0%	116.0%	100.0%	135.5%	899	78.6%	90.9%	5	0		Additional CSW required for enhanced supervision for 25 nights.	90,070	77,355	12,716
MAIDSTONE	A&E	96.4%	82.3%	98.5%	90.3%		4.3%	90.1%	0	0			205,144	190,152	14,992
TWH	A&E	96.5%	84.9%	97.4%	93.5%		37.6%	92.1%	4	0			205,144	190,152	14,992
												Total Establishment Wards	**4,750,123**	**4,700,570**	**49,553**
												Additional Capacity beds	39,307	33,836	5,471
												Other associated nursing costs	2,384,990	2,359,746	25,244
												Total	7,174,420	7,094,151	80,269

RAG Key

Under fill

Over fill

September'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	89.3%	100.8%	99.2%	128.6%	564	29.4%	100.0%	2	1		Enhanced care needs at night. Reviewed by Matron.	132,329	132,752	(423)
MAIDSTONE	Cornwallis	108.9%	90.0%	98.9%	104.8%	452	0.0%	0.0%	1	0			72,057	84,213	(12,156)
MAIDSTONE	Coronary Care Unit (CCU)	96.7%	80.0%	100.0%	N/A	170	0.0%	0.0%	0	0		CSW fill rate an accepted risk. Unit co-located on Culpepper and staff cross cover as required during each shift.	106,475	109,386	(2,911)
MAIDSTONE	Culpepper	100.0%	98.3%	100.0%	110.0%	363	80.0%	100.0%	4	0					
MAIDSTONE	John Day	86.1%	130.0%	106.7%	93.4%	895	51.6%	93.8%	3	1		RN: CSW ratio an accepted risk due to inability to fill with temporary RN staff.	127,486	144,080	(16,594)
MAIDSTONE	Intensive Treatment Unit (ITU)	89.5%	N/A	89.5%	N/A	190	41.3%	90.3%	0	0		Reduced fill rated accepted as unit had decreased dependency. Cover provided to outreach and TWH where appropriate.	174,246	160,595	13,651
MAIDSTONE	Pye Oliver	94.0%	90.7%	100.0%	100.0%	802	0.0%	0.0%	9	2			100,557	109,768	(9,211)
MAIDSTONE	Chaucer	90.4%	98.3%	101.7%	143.6%	359	39.7%	92.6%	1	0		Enhanced care needs over 14 nights. Reviewed by Matron.	109,535	112,372	(2,837)
MAIDSTONE	Lord North	94.0%	120.0%	100.0%	100.0%	570	16.8%	95.0%	2	0		Additional CSW to cover ward day attenders.	101,913	104,789	(2,876)
MAIDSTONE	Mercer	110.0%	101.7%	97.8%	110.0%	762	55.9%	100.0%	8	2			101,227	110,535	(9,308)
MAIDSTONE	Edith Cavell (MOU)	98.9%	89.0%	98.9%	96.7%	636	44.0%	100.0%	0	1		CSW fill rate an accepted risk.	72,020	70,099	1,921
MAIDSTONE	Urgent Medical Ambulatory Unit (UMAU)	84.4%	85.6%	136.7%	190.0%	496	42.9%	66.7%	1	0		Day fill rate an accepted risk. Priority given to cover escalation beds at night.	94,435	139,985	(45,550)
TWH	Stroke/W22	93.9%	96.0%	94.7%	96.7%	660	15.2%	97.7%	8	1			163,074	157,685	5,389
TWH	Coronary Care Unit (CCU)	96.0%	90.6%	98.9%	N/A	205	90.9%	80.0%	0	0			61,501	67,363	(5,862)
TWH	Gynaecology/ Ward 33	97.4%	98.5%	100.0%	100.0%	383	94.5%	100.0%	0	0			74,602	75,750	(1,148)
TWH	Intensive Treatment Unit (ITU)	91.9%	98.3%	114.7%	107.8%	229	27.5%	89.5%	0	0		3 nights of additional capacity/dependency.	179,243	179,815	(572)
TWH	Medical Assessment Unit	91.9%	98.3%	114.7%	107.8%	1026	0.0%	0.0%	7	0		Additional capacity beds.	162,759	198,859	(36,100)
TWH	SAU	95.6%	100.0%	100.0%	100.0%	284	46.6%	92.7%	0	0			54,118	62,370	(8,252)
TWH	Ward 32	95.0%	94.4%	97.8%	110.8%	802	0.0%	0.0%	3	0			122,764	142,863	(20,099)
TWH	Ward 10	90.8%	101.7%	74.2%	151.7%	845	44.2%	95.7%	0	0		RN:CSW ration shift due to inability to cover RN shifts with temporary staff at night. No adverse impacted noted on nurse sensitive indicators (PU & falls)	112,453	116,726	(4,273)
TWH	Ward 11	97.2%	130.1%	96.0%	159.7%	878	12.5%	100.0%	3	0		Additional CSWs to support the observation of 4 'new' tracheostomy patients. 14 nights of enhanced care requirements at night.	110,018	131,868	(21,850)
TWH	Ward 12	90.6%	98.3%	98.9%	99.2%	795	13.6%	100.0%	7	1			122,915	119,249	3,666
TWH	Ward 20	95.6%	109.2%	95.6%	151.7%	1041	26.7%	95.7%	15	0		Enhanced care needs at night throughout month to cover combination of high risk falls and cognitive impairment.	106,507	121,266	(14,759)
TWH	Ward 21	94.4%	98.9%	82.7%	140.0%	862	29.6%	75.0%	6	0		Increased CSW on 20 nights to cover shortfall in RN. CSW utilised to support fundamental care delivery.	133,012	125,324	7,688
TWH	Ward 2	92.5%	98.7%	102.2%	139.2%	792	32.5%	92.0%	9	2		3 patient requiring enhanced care for 20 nights.	124,028	127,964	(3,936)
TWH	Ward 30	94.5%	88.4%	96.5%	107.7%	875	55.9%	89.5%	6	0		CSW fill rate an accepted risk.	108,041	124,217	(16,176)
TWH	Ward 31	89.4%	84.4%	98.3%	97.8%	858	23.3%	96.4%	8	4		Reduced fill rate due to no availability of temporary staff.	129,736	139,109	(9,373)
Crowborough	Birth Centre	100.0%	100.0%	98.3%	100.0%				0	0			85,997	69,640	16,357
TWH	Ante-Natal	100.0%	93.3%	93.3%	83.3%	291	21.5%	96.3%	0	0		Reduced CSW fill rate on post-natal an accepted risk. All three areas work as a single unit, with staff following women through pathway of care.	615,756	664,213	(48,457)
TWH	Delivery Suite	101.5%	93.3%	90.7%	90.0%	228			0	0					
TWH	Post-Natal	97.9%	74.1%	98.3%	95.1%	624			0	0					
TWH	Gynae Triage	100.0%	86.7%	95.0%	93.3%				0	0			11,974	14,283	(2,309)
TWH	Hedgehog	96.7%	56.7%	95.3%	80.0%	484	15.0%	92.2%	0	0		Reduced un-registered (includes play therapy) an accepted risk, with priority been given to maximising cover at night.	197,856	179,188	18,668
MAIDSTONE	Birth Centre	100.0%	100.0%	100.0%	100.0%				0	0			63,527	56,330	7,197
TWH	Neonatal Unit	107.7%	100.0%	103.9%	66.7%	408			0	0		CSW fill rate at night an accepted risk.	167,377	182,670	(15,293)
MAIDSTONE	MSSU	104.1%	74.5%	104.8%	N/A				0	0		CSW fill rate an accepted risk.	40,769	40,421	348
MAIDSTONE	Peale	113.3%	76.5%	100.0%	100.0%	367	17.5%	100.0%	0	0		RN:CSW ratio shift to ensure appropriate levels headcount. Skill mix shift due, in part, 'natural adjustment' from skill mix review.	70,239	73,258	(3,019)
TWH	SSSU	100.0%	100.0%	100.0%	100.0%				2	0		Fill rate reflects available staff for funded short stay surgical beds. Additional staff utilised to cover escalation capacity at night.	60,469	114,178	(53,709)
MAIDSTONE	Whatman	110.8%	100.0%	106.7%	106.7%	840	48.1%	84.6%	9	2			90,070	116,167	(26,097)
MAIDSTONE	A&E	99.2%	88.3%	98.6%	86.7%		1.3%	96.6%	1	0		CSW fill rate an accepted risk due to inability to fill with temporary staff.	205,143	210,502	(5,359)
TWH	A&E	96.4%	82.2%	101.2%	93.3%		8.8%	90.3%	4	0			205,143	210,502	(5,359)
												Total Establishment Wards	**4,771,371**	**5,100,354**	**(328,983)**
												Additional Capacity beds	39,307	33,400	5,907
												Other associated nursing costs	2,285,115	2,625,188	(340,073)
												Total	7,095,793	7,758,942	(663,149)

RAG Key

Under fill

Over fill

Trust Board meeting – October 2017

NHS Maidstone and Tunbridge Wells NHS Trust

10-12 Review of Clinical Outcomes — Medical Director

Summary / Key points

Enclosed is the annual report on clinical outcomes prepared for the Quality Committee. The purpose of the report is to provide assurance over the quality of care provided by the Trust using any available clinical outcomes data and to notify the committee if there any areas of concern or variation to our peers or national benchmarks. In this instance, assurance would be provided over the actions being taken to reduce and adverse variation.

Following review by the Quality Committee on 13/09/17, the Medical Director was tasked with liaising "with each Clinical Director to develop a rolling programme of Directorate-based clinical outcome reporting, and to submit a proposal to the 'main' Quality Committee in November 2017.

Which Committees have reviewed the information prior to Board submission?

- Quality Committee, 13/09/17

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

Information, assurance and discussion

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

1. Introduction

A report on Clinical Outcomes has been prepared for the Quality Committee annually since September 2014, following a deep dive and subsequent review of the data presented. The purpose of the report is to provide assurance over the quality of care provided by the Trust using any available clinical outcomes data and to notify the committee if there any areas of concern or variation to our peers or national benchmarks. In this instance, assurance would be provided over the actions being taken to reduce and adverse variation.

Generally NHS data collection and reporting focusses heavily on process measurement e.g. measuring waiting times and quantifying activity, as such there is less data about true clinical outcomes, than might be expected. Any such data is often the result of specific clinical audits or programmes of work.

There are various measures that are often discussed in terms of clinical outcomes that are out of scope for this particular report. These include Length of Stay and Readmission rates as well as indicators of harm to patients e.g. falls and pressure ulcers. These have been excluded along with Mortality on the basis that these are extensively monitored and discussed in various other reports that are made available to the Board and its committees.

This report should be seen as a starting point, as the new Medical Director and the Clinical Directors, supported by the corporate teams, will look to build a portfolio of information to better inform the Trust Board and its stakeholders of the clinical outcomes of the care the Trust delivers to its patients in future.

2. Sources of Clinical Outcomes Data

Below is a list of the known sources of clinical outcome data at this time. As explained, work is ongoing to build on this with the Clinical Directors and the Clinical Audit team.

- Trauma Audit and Research Network (TARN) - Thoracic & abdominal injuries, Orthopaedic injuries and Head & spinal injuries
- National Hip Fracture Database (NHFD) – Hip Fracture
- Enhancing Quality (EQ) - Heart Failure
- National Joint Registry
- SSNAP - Stroke
- Patient Reported Outcomes (PROMs): Orthopaedics - Groin Hernia, Hips, Knees and Varicose Veins
- Myocardial Ischaemia National Audit Project (MINAP)
- Society for Acute Medicine Benchmarking Audit (SAMBA)
- Dr Foster - various e.g. Stroke
- National NELA - Emergency Laparotomies

Where data has been made available at the time of producing this report, this has been summarised in the following sections

3. Patient reported Outcome Measures (PROMs)

The ‘Provisional’ Quarterly Patient Reported Outcome Measures (PROMs) for England - April 2016 to March 2017 were released in August 2017. PROMs assess the quality of care delivered to NHS patients from the patient perspective. Currently covering four clinical procedures, PROMs calculate the health gains after surgical treatment using pre- and post-operative surveys.

The four procedures are:

- hip replacements

- knee replacements
- groin hernia
- varicose veins

PROMs have been collected by all providers of NHS-funded care since April 2009.

PROMs measure a patient's health status or health-related quality of life at a single point in time, and are collected through short, self-completed questionnaires. This health status information is collected before and after a procedure and provides an indication of the outcomes or quality of care delivered to NHS patients.

3.1. PROMS Methodologies

3.1.1. Scoring

All four procedures - groin hernia, knee replacement, hip replacement and varicose vein - have scores for the EQ-5D™ Index and EQ VAS. Hip replacement, knee replacement and varicose vein procedures each have their own condition-specific measure, which combine into a single score a patient's answers to a number of health questions of particular relevance to their procedure.

3.1.2. EQ 5D™ Index

The EQ-5D™ Index collates responses given in 5 broad areas (mobility, self-care, usual activities, pain/discomfort, and anxiety/depression) and combines them into a single value. The EQ-5D™ Index was developed by the EuroQol Group. EQ-5D™ is a trademark of the EuroQol Group.

3.1.3. EQ Visual Analogue Scale (EQ VAS)

EQ VAS is a simple and easily understood 'thermometer'-style measure based on a patient's self-scored general health on the day that they completed their questionnaire, but which provides an indication of their health that is not necessarily associated with the condition for which they underwent surgery and which may have been influenced by factors other than healthcare. The EQ VAS was developed by the EuroQol Group.

3.1.4. Oxford Hip Score (OHS)

The OHS contains 12 questions on activities of daily living that assess function and residual pain in patients undergoing total hip replacement surgery. The OHS was designed, developed and validated by workers within public health and at the University of Oxford.

3.1.5. Oxford Knee Score (OKS)

The OKS contains 12 questions on activities of daily living that assess function and residual pain in patients undergoing total knee replacement surgery. The OKS was designed, developed and validated by workers within public health and at the University of Oxford.

3.1.6. Aberdeen Varicose Vein Questionnaire (AVVQ)

The AVVQ allows patients to self-assess the severity of their varicose veins via a 13-item measure covering all aspects of their varicose veins including physical symptoms such as pain, ankle oedema, ulcers, the effect on daily activities, and cosmetic issues.

Figure 1: 2015/16 Overview of PROMS (final)

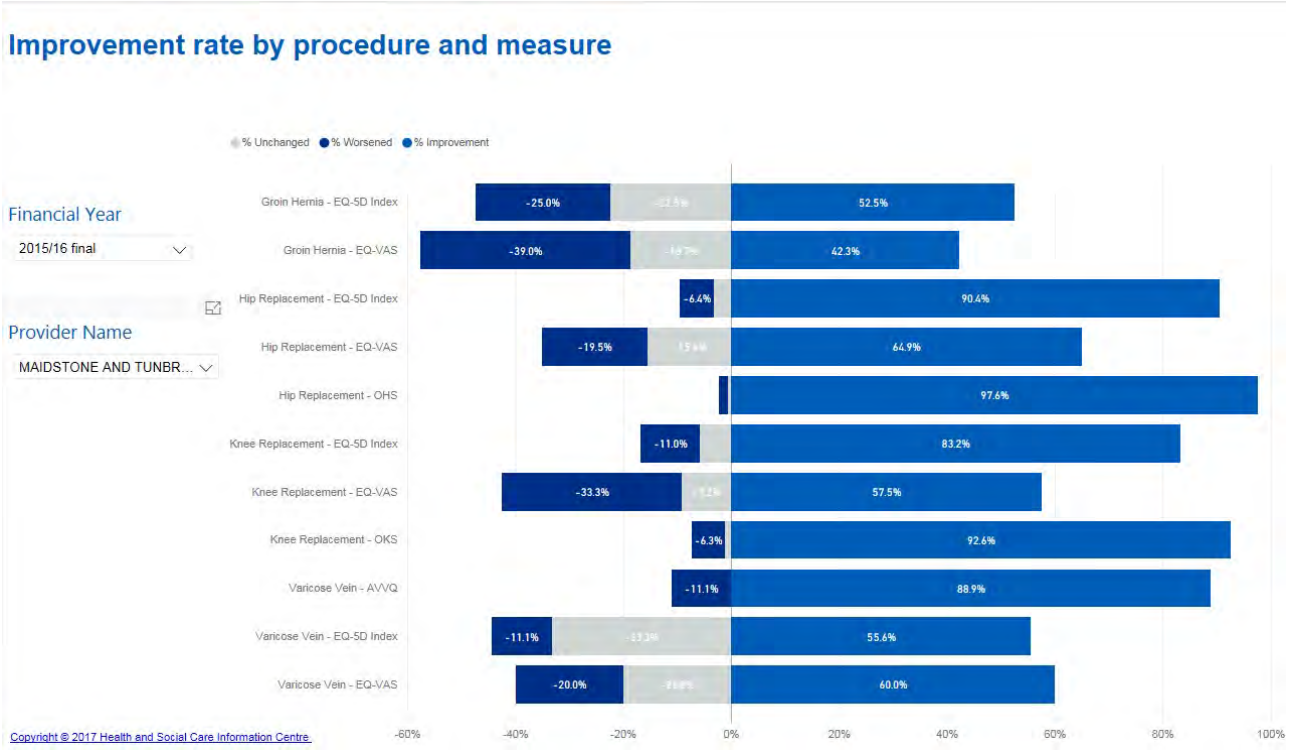
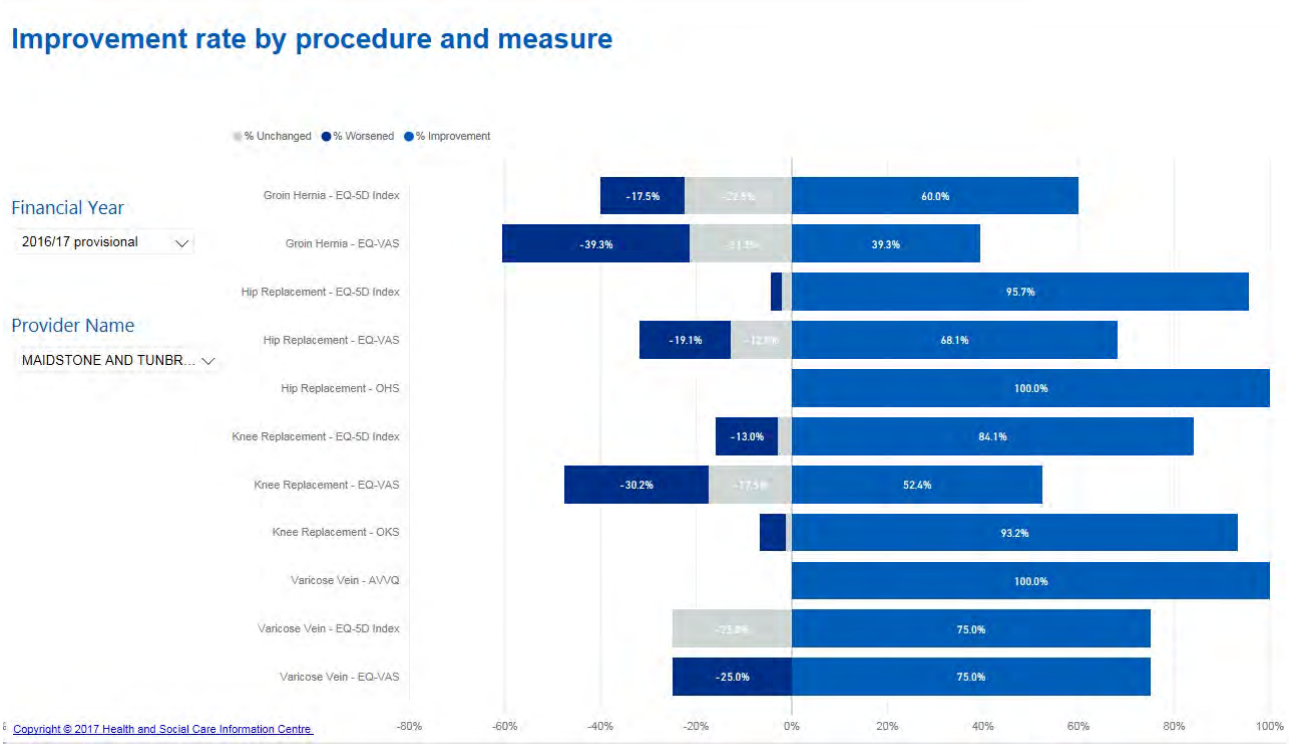


Figure 2: 2016/17 Overview of PROMS (provisional)



3.2. Summary of results

Results from the last two years (2015/16 and 2016/17) are shown above. The results for Groin Hernia surgery show an improvement for one measure (EQ-5D index) and a deterioration for the EQ-VAS score. All measures have improved for the Hip replacement patients, with 100% of patients reporting improvement following surgery for the Oxford Hip Score measure and 95.7% for the EQ-5D Index measure and 68.1% for the EQ-VAS respectively. The results for knee replacements are also positive, with two of the three measures showing an improvement from

2015/16 to 2016/17. The EQ-5D Index changed from 83.2% to 84.1% and the Oxford Knee Score increased to 93.2% from 92.6%. The EQ-VAS score dropped from 57.5% to 52.4%, but with a reduction in patients reporting a worsened outcome, the difference is in this case is an increase in those reporting no change following surgery. Both measures for Varicose Veins showed and improved position with 75% of patients reporting an improved outcome following surgery.

4. National Hip Fracture Database (NHFD)

The details of patients over 60 years old admitted with a hip fracture are input onto the National Hip Fracture Database. There is a Best Practice Tariff payment of £1,350 if all the following criteria are met:

- Time to surgery within 36 hours
- Assessed by a geriatrician within 72 hours of admission
- Pre-op AMTS
- Bone protection medication
- Specialist falls assessment
- Nutritional assessment during the admission
- Delirium assessment using the 4AT screening tool during the admission
- Assessed by a physiotherapist the day of or day following surgery

An annual report is published in September/October which enables the Trust to review data from the previous year and compare the results with all other participating hospitals. The database produces 'live' charts for ongoing monitoring. The following pages show a 12 month snapshot for each of these charts.

Figure 3: Best Practice

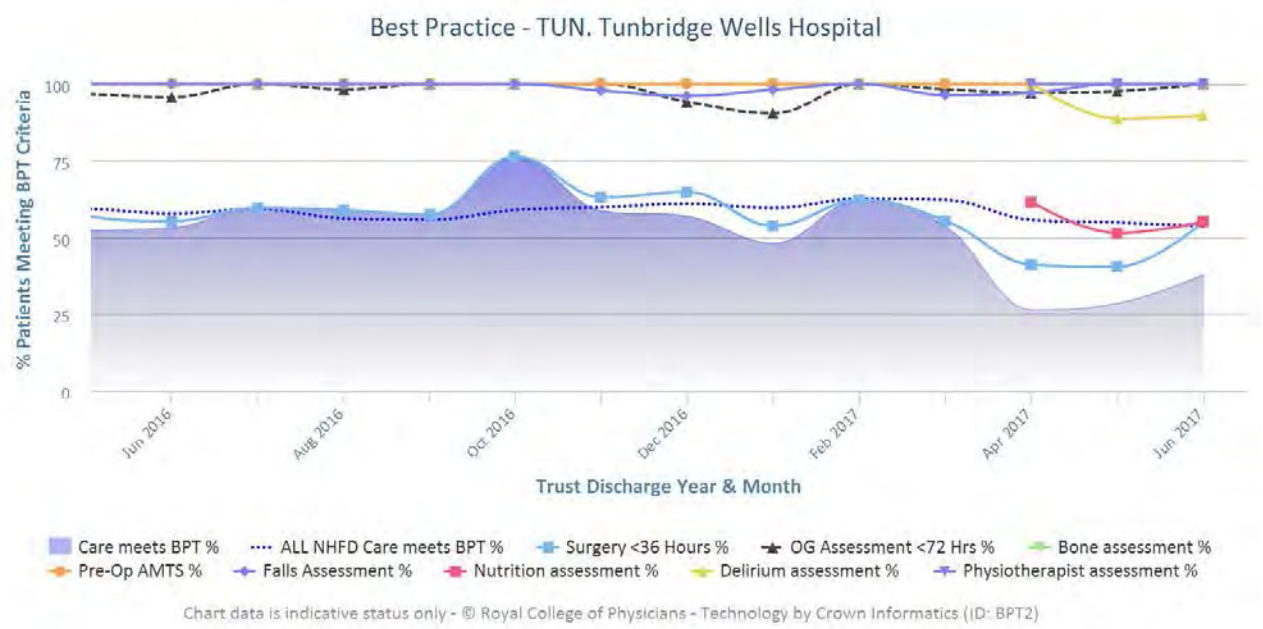


Figure 4: Overall Performance

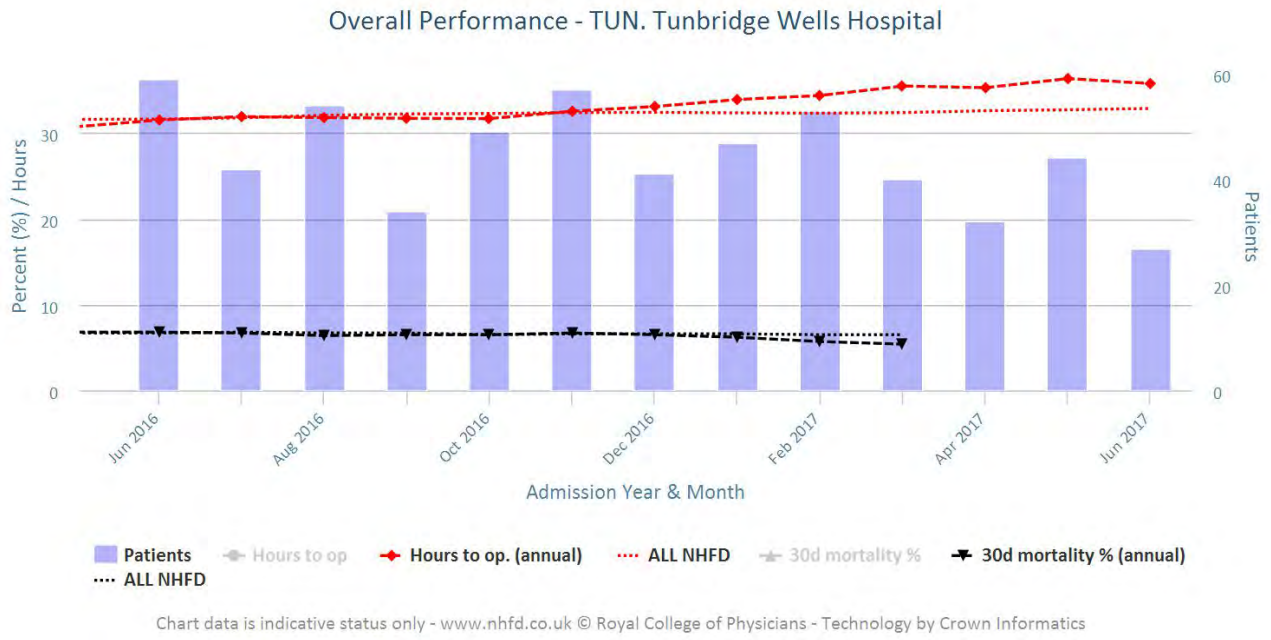


Figure 4 shows a negative variance to the national benchmark in hours to operation, whereas the 30 day mortality shows positive position in comparison to the benchmark. The opening of Theatre 6 will improve the time to surgery metric moving forwards.

Figure 5: Surgery

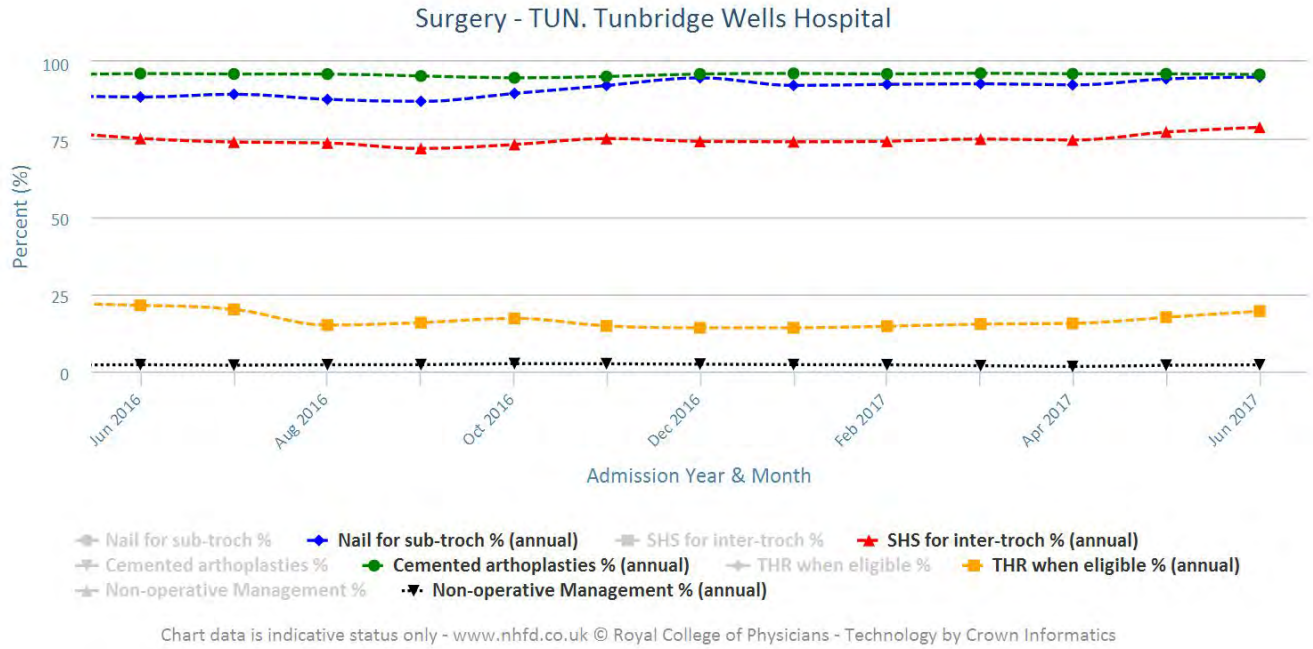


Figure 5 shows that all measure are largely unchanged.

Figure 6: Anaesthesia

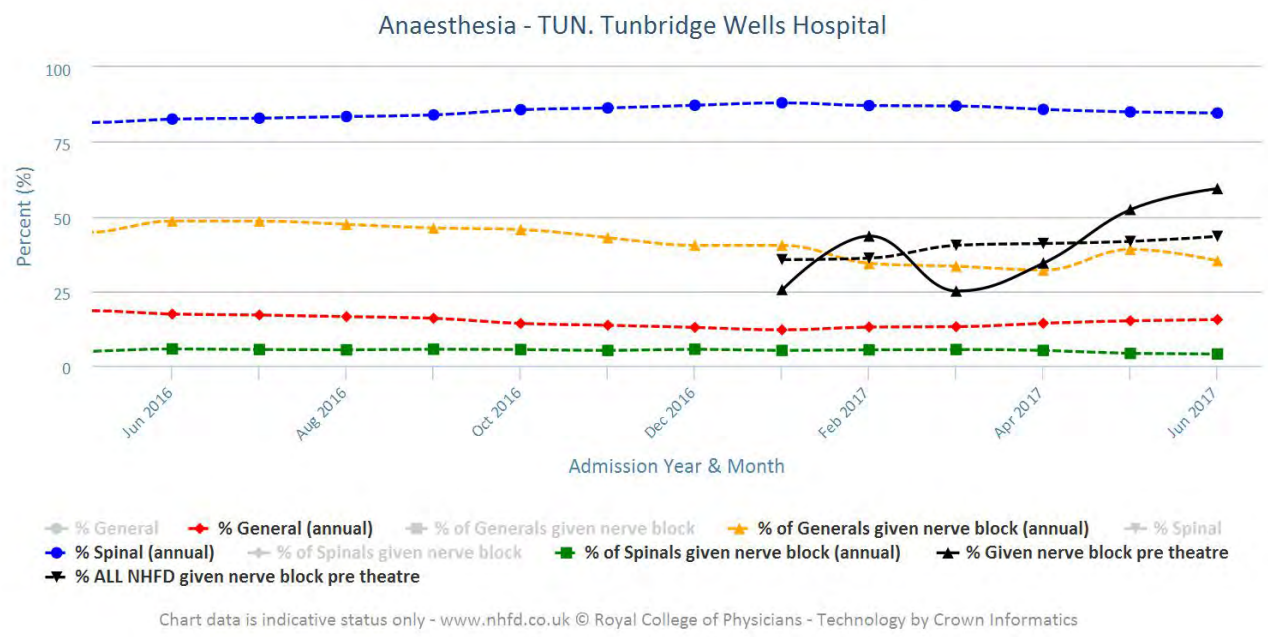


Figure 6 demonstrated that the Trust is giving a higher percentage of patient nerve block pre-theatre than the national benchmark.

Figure 7: Length of Stay

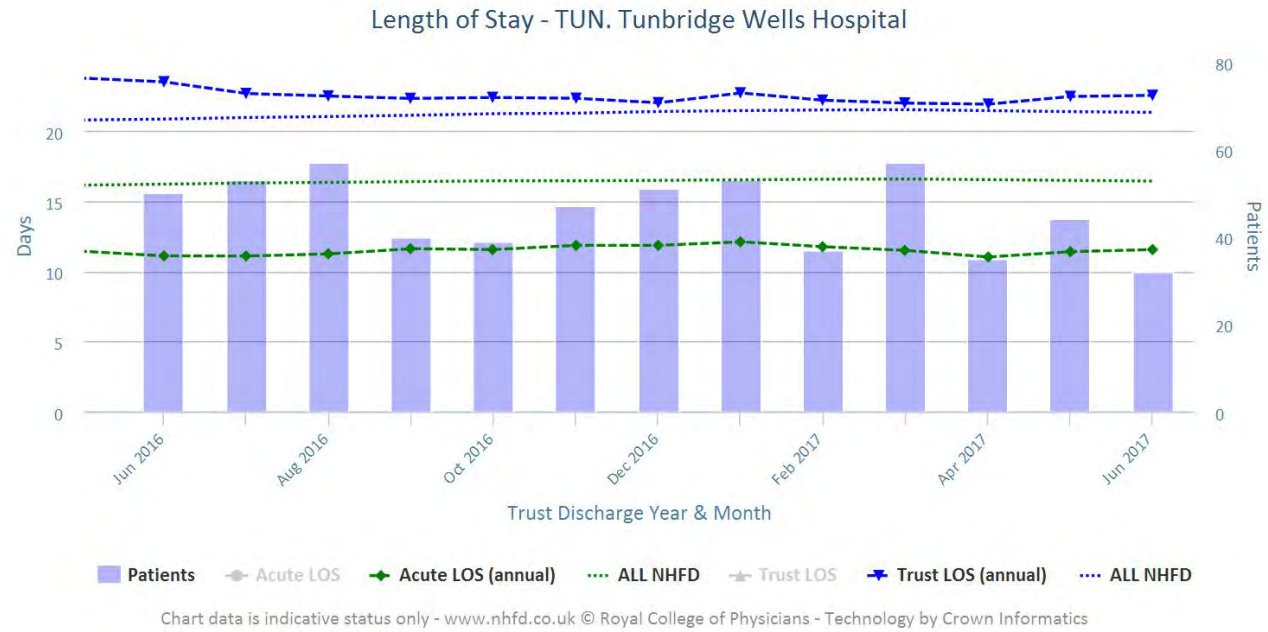


Figure 7 shows that the Trust has a lower LOS than the benchmark for acute patients, whereas as the general LOS for the Trust is slightly above the national benchmark.

Figure 8: Patient Safety

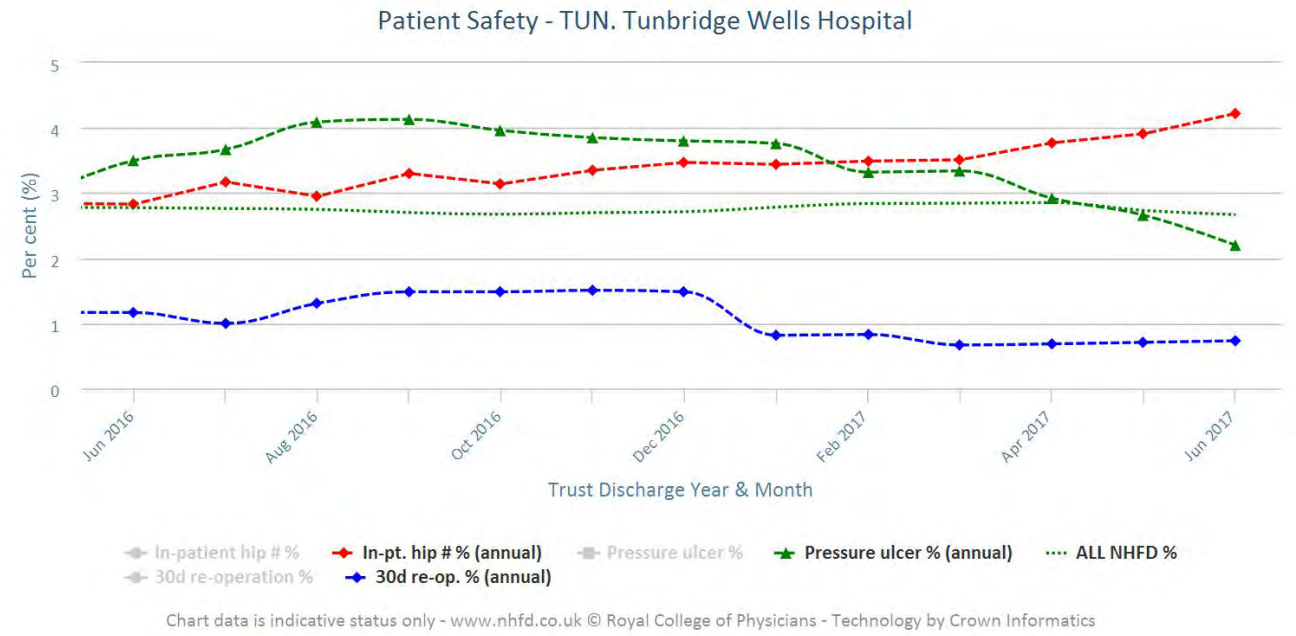


Figure 8 shows that the Trust has a lower pressure ulcer % than the national benchmark. The 30 day Reoperation Rate remains low, whereas the Inpatient Fractures percentage shows an increase.

5. Trauma Audit and Research Network (TARN)

Patients must meet the following criteria to be submitted:

- Have experienced a Trauma
- Length of stay >72 hours
- Trauma patients treated in ITU regardless of LOS
- Trauma patients who die in the hospital including ED
- Patients transferred in or out for further specialist care of repatriation
- Meet the injury severity criteria

There are three reports produced annually:

1. Orthopaedic Injury Report
2. Thoracic and abdominal Injury Report
3. Head and Spinal Injury Report

The table below shows the number of submissions from Maidstone and Tunbridge Wells NHS Trust together with the number of expected submissions as a percentage. This is compared to other Trusts in the region. Maidstone and Tunbridge Wells NHS Trust is the busiest of all the local Trauma Units and achieved the best submission rate for 2016/17.

Case Ascertainment & Accreditation

If case ascertainment is low then the analysis in the rest of the report may not be reflective of true practice.

	01 April 2016 to 31 March 2017				01 April 2015 to 31 March 2016			
Trust / Hospital	N	E	C (%)	A (%)	N	E	C (%)	A (%)
Dartford & Gravesham NHS Trust	**145**	**219**	**66.2**	**79.8**	**116**	**219**	**53**	**90.4**
East Kent Hospitals University NHS Trust	**284**	**629**	**45.1**	**99.1**	**688**	**629**	**100+**	**98.6**
William Harvey Hospital	178	363	49	99	371	363	100+	99.0
Kent & Canterbury Hospital	8	26	30.5	100	46	26	100+	93.8
Queen Elizabeth Queen Mother Hospital	98	239	40.9	99	271	239	100+	98.9
Guy's and St Thomas' NHS Foundation Trust	**194**	**291**	**66.7**	**70.4**	**190**	**291**	**65.4**	**87.3**
King's College Hospital NHS Foundation Trust	**1412**	**1473 - 1547**	**91.3 - 95.8**	**94.9**	**1363**	**1473 - 1547**	**88.1 - 92.5**	**93.9**
King's College Hospital	1191	1144 - 1199	99.3 - 100+	95	1194	1144 - 1199	99.6 - 100+	94.2
Princess Royal University Hospital Orpington	221	329	67.2	94	169	329	51.4	92.2
Lewisham and Greenwich NHS Trust	**448**	**404 - 472**	**94.9 - 100+**	**94.3**	**296**	**404 - 472**	**62.7 - 73.3**	**90.4**
University Hospital Lewisham	201	161 - 188	100+	95	162	161 - 188	86.2 - 100+	93.9
Queen Elizabeth Hospital London	247	243 - 284	87 - 100+	94	134	243 - 284	47.2 - 55.2	86.2
Maidstone and Tunbridge Wells NHS Trust	**544**	**520**	**100+**	**97.0**	**495**	**520**	**95.2**	**96.3**
Maidstone General Hospital	67	91	73.6	96	84	91	92.3	95.6
Tunbridge Wells Hospital	477	429	100+	97	411	429	95.9	96.5
Medway NHS Foundation Trust	**286**	**360 - 420**	**68.1 - 79.4**	**95.6**	**298**	**360 - 420**	**71 - 82.8**	**95.0**

N The number of approved submissions for the period
E The expected number of submissions for the period (from HES / HIPE / PEDW)
C The case ascertainment % for the period
A The accrediation % for the period

5.1. Summary of Clinical Report Orthopaedic Injuries July 2017

5.1.1. Tunbridge Wells Hospital

The Trauma Audit & Research Network

EXECUTIVE SUMMARY

Based on comparison between 15-16 and 16-17 core measures

Improvements are shown in GREEN, no change in AMBER and deteriorations in RED. These are the areas you may want to review.

Data quality and rate of survival	Meets target	Compared to previous year
Case Ascertainment is 100+%, this is *above* the target of 80%. This represents *no change* compared to previous year.		
Data Accreditation is 97.2%, this is *above* the target of 95%. This represents *no change* compared to previous year.		
The rate of survival is as expected **Ws is 0.18**. 95% confidence intervals are **-1.55 to 1.91**		

2016-17 CORE section	Compared to national average	Compared to previous year
3% of ISS > 15 patients were seen by a Consultant within 5 minutes of arrival, this is *below* the national average of 44% and has *remained at the same level* compared to previous year.		
25% of NICE criteria patients had a **CT within 30 minutes**, this is *below* the national average of 53% and has *increased by 25%* compared to previous year. *100% of the patients that had a CT within 30 minutes arrived between the hours of 08:00 - 20:00.*		
11 days median length of stay for ISS > 15 patients, this is *above* the national average of 9 days. This represents *an increase of 5%* compared to previous year.		
Rehabilitation prescription was completed for **11%** of patients with ISS >8, this is *below* the national average of 62%. This has *remained at the same level* compared to previous year.		
2016-17 THEMED section: Patients with orthopaedic injuries		
0% of BOAST4 patients received Surgical Stabilisation within the target of 24 hours, this is *below* the national average of 56%. This represents *a decrease of 50%* compared to previous year.		
100% of BOAST4 patients received Soft Tissue Coverage within the target of 72 hours, this is *above* the national average of 39%. This represents *an increase of 100%* compared to previous year.		

Patients meeting the BOAST 4 injury criteria - stabilisation and cover

The measures reported here reflect not only data recorded at this hospital but also others, where the patient was referred from or transferred to.

Patients with open fractures of the tibia, graded as Gustilo IIIB or IIIC are eligible for the BOAST 4 standard.

BOAST 4 compliance

Date range	Total	Stabilisation			Soft tissue cover			BOAST 4 compliant	
		Median hours to operation	Within 24 hours n	Within 24 hours %	Median hours to operation	Within 72 hours n	Within 72 hours %	n	%
01 April 2016 to 31 March 2017	1	33.5	0	0.0	33.5	1	100.0	0	0.0
01 April 2015 to 31 March 2016	2	23.8	1	50.0	324.8	0	0.0	0	0.0

5.1.2. Maidstone Hospital

EXECUTIVE SUMMARY

Based on comparison between 15-16 and 16-17 core measures

Improvements are shown in GREEN, no change in AMBER and deteriorations in RED. These are the areas you may want to review.

Data quality and rate of survival	Meets target	Compared to previous year
Case Ascertainment is 73.6%, this is ***below*** the target of 80%. This represents ***a decrease of 18%*** compared to previous year.		
Data Accreditation is 95.7%, this is ***within 1% of*** the target of 95%. This represents ***no change*** compared to previous year.		
The rate of survival is as expected **Ws is -0.21. 95% confidence intervals are -5.04 to 4.61**		

2016-17 CORE section	Compared to national average	Compared to previous year
9% of ISS > 15 patients were seen by a Consultant within 5 minutes of arrival, this is ***below*** the national average of 44% and has ***increased by 9%*** compared to previous year.		
0% of NICE criteria patients had a **CT within 30 minutes**, this is ***below*** the national average of 53% and has ***remained at the same level*** compared to previous year.		
6 days median length of stay for ISS > 15 patients, this is ***below*** the national average of 9 days. This represents ***a decrease of 2%*** compared to previous year.		
Rehabilitation prescription was completed for **0%** of patients with ISS >8, this is ***below*** the national average of 62%. This has ***remained at the same level*** compared to previous year.		
2016-17 THEMED section: Patients with orthopaedic injuries		
% of BOAST4 patients received Surgical Stabilisation within the target of 24 hours, this is the national average of %. This represents compared to previous year.		
% of BOAST4 patients received Soft Tissue Coverage within the target of 72 hours, this is the national average of %. This represents compared to previous year.		

5.2. Summary of Clinical Report Thoracic and Abdominal Injuries March 2017

5.2.1. Tunbridge Wells Hospital

Executive Summary

- Case Ascertainment is expressed as a range 86.2 – 100+%, this is above the target of 80%
  This represents no change compared to previous year
- Data Accreditation is 97.5, this is above the target of 95%
  This represents no change to the previous year
- The rate of survival is as expected
  Ws is 0.36. 95% confidence intervals are -1.31 – 1.91

2015 – 16 CORE section
Patients with Thoracic Injuries

- In 2016 97.9% Isolated Thoracic Injuries with AIS 3+ seen by a Consultant in the Emergency Department compared to 83.3% in 2015
- In 2016 100% Non- Isolated Thoracic Injuries with AIS 3+ seen by a Consultant in the Emergency Department compared to 83.3% in 2015
- In 2016 median time to CT or MRI scan for Isolated Thoracic Injuries was 2.7 hours compared to 2.4 hours in 2015
- In 2016 median time to CT or MRI scan for Non-Isolated Thoracic Injuries was 1.6 hours compared to 2.5 hours in 2015

AIS stands for Abbreviated Injury Scale based on a single score for each injury

Patients with Abdominal Injuries
None of the patients admitted with AIS 3+ abdominal injuries were seen by a Consultant general surgeon in ED for 2015 or 2016. Only one patient each year had an operation, both carried out by Consultant Surgeons with a Consultant Anaesthetist.

Patients in Shock

- In 2016 the number of Consultants performing the initial operation on shocked patients was 87.5% compared to 71.4% in 2015
- In 2016 the number of Consultant Anaesthetists performing the initial operation on shocked patients was 62.5% compared to 78.6% in 2015

5.2.2. Maidstone Hospital

The number of patients with Thoracic or Abdominal Injuries treated at Maidstone is low as most of them would be transferred to Tunbridge Wells

5.3. Summary of Clinical Report Head and Spinal Injuries December 2016

5.3.1. Tunbridge Wells Hospital

2015 – 16 CORE section

- In 2016 17.5% of all AIS 3+ head injuries were transferred out compared to 15.4% in 2015
- In 2016 the median arrival time to CT from arrival in ED was 1.5 hours. This is an improvement from 2015 when the median arrival time to CT from arrival was 2.4 hours.
- In 2016 97.6% of patients with spinal injuries were seen by a Consultant in ED compared to 89.4% in 2015
- In 2016 100% of patients with spinal cord injuries were seen by a Consultant in ED compared to 86.7% in 2015

5.3.2. Maidstone Hospital

- In 2016 58.3% of all AIS 3+ head injuries were transferred out compared to 40.0% in 2015. This includes those transferred to Tunbridge Wells Hospital
- In 2016 the median arrival time to CT from arrival in ED was 3.7 hours. Compared to 2015 when the median arrival time to CT from arrival was 2.2 hours.
- In 2016 100% of patients with spinal injuries were seen by a Consultant in ED compared to 94.1% in 2015
- In 2016 100% of patients with spinal cord injuries were seen by a Consultant in ED, this was the same in 2015

6. Myocardial Ischaemia National Audit Project (Minap) - Annual Report 2015/16 Summary

Inclusion Criteria: MINAP covers all ACS of Type 1 (i.e. spontaneous) myocardial infarction, related to ischaemia due to a primary coronary event such as plaque erosion or rupture, fissuring, or dissection.

Included in analyses are patients with specific discharge diagnoses of:

- Myocardial infarction (ST elevation)
- Myocardial infarction (non ST elevation)
- Any patient that had ST elevation at any point in their journey regardless of their discharge diagnosis

Care of nSTEMI	Maidstone	Tunbridge Wells	Maidstone	Tunbridge Wells	Maidstone	Tunbridge Wells	National Average
	2013/14	2013/14	2014/15	2014/15	2015/16	2015/16	2015/16
Proportion of nSTEMI patients seen by a cardiologist %	97.4	97.7	99.2	96.6	93.7	96.0	96.0
Proportion of nSTEMI patients admitted to cardiac unit or ward %	41.4	49.7	31.7	58.8	37.0	59.2	57.5
Number of all nSTEMI patients	116	177	120	119	127	174	51326
Proportion of nSTEMI patients who had angiography during admission %	68.7	75.4	70.0	73.0	77.1	80.4	84.0
Number of all nSTEMI patients eligible for angiography	115	171	120	111	122	163	42773

Ideally patients with non-ST elevation myocardial infarction should be managed in a cardiac ward and be assessed by a cardiologist. In 2016, 57.5% of patients with nSTEMI were admitted to a cardiac ward compared with 49% in 2011; 96% were seen by a cardiologist in 2016 compared with 90% in 2011 and, of those eligible, 86% received an angiogram in 2016 compared with 68% in 2011.

In accordance with clinical guidelines, patients with nSTEMI at moderate to high risk should undergo angiography, with a view to PCI, within 72 hours of admission to hospital. The delay from admission to angiography for nSTEMI has not improved. For those admitted directly to hospitals that are capable of providing on-site angiography, 17.5% received an angiogram within 24 hours; 53% within 72 hours; 66.3% within 96 hours. In 2010/11 the equivalent figures were 21% within 24 hours, 55% within 72 hours and 67% within 96 hours. Centres have an opportunity to provide more timely treatment, which may lead to shorter lengths of stay, reducing the burden on the health system.

Recognising the need to improve this aspect of care, NHS England has introduced a Best Practice Tariff for angiography for those with nSTEMI in the 2016/17 financial year. Participating hospitals will receive a higher reimbursement for services where at least 60% of all nSTEMI patients receive angiography within 72 hours.

6.1. Best Practice Tariff

NHS England and NHS Improvement have introduced a best practice tariff to encourage timely delivery of coronary angiography for people with nSTEMI, within 72 hours of admission. Hospitals and trusts will use their MINAP data to determine the delay to coronary angiography and supply this information to commissioners within the Clinical Commissioning Groups (CCGs) to guide payment of hospital trusts for this procedure, based on performance.

6.2. Discharge medications

NICE clinical guideline CG1728 recommends that all patients who have had acute MI should be offered the following drugs providing there are no contraindications.

- Angiotensin converting enzyme (ACE) inhibitors
- Dual antiplatelet therapy (aspirin & a second antiplatelet agent such as ticagrelor or a thienopyridine inhibitors, e.g. clopidogrel or prasugrel)
- Beta-blockers
- Statins
- Aldosterone antagonists (in those with evidence of systolic heart failure)
- Angiotensin receptor blockers (ARB) (not normally in combination with ACE inhibitors)

Secondary Medication	Maidstone	Tunbridge Wells	Maidstone	Tunbridge Wells	Maidstone	Tunbridge Wells	National Average
	2013/14	2013/14	2014/15	2014/15	2015/16	2015/16	2015/16
Proportion of patients who received all secondary medication for which they were eligible %	56.1	56.4	50.9	68.8	56.2	83.2	90.5
Number of patients eligible	109	167	106	125	105	167	63,544

Minap Forum modification: Updating the Discharge Drug box on the Minap Form from for Maidstone from YES/NO to replicate the NICOR Web Portal, and introducing ACS Patient Discharge Drug Checklist labels to be used by clinical staff, it is hoped to see Maidstone figures for 2016/17 improve.

6.3. Median length of stay (LOS) for patients with nSTEMI and STEMI

Analysis and reporting of length of stay is only for patients with a direct admission, i.e. those patients that did not have a transfer during their episode. Patients who experience transfer

between hospitals during their management are likely to have overall lengths of stay that are far greater.

The following is calculated for patients who either self-presented or were directly admitted via emergency service; it also includes patients who died in hospital.

LOS	Maidstone	Tunbridge Wells	Maidstone	Tunbridge Wells
	2014/15	2014/15	2015/16	2015/16
LOS nSTEMI	6	3	7	4
LOS STEMI	6	3.5	5	5
LOS all patients	6	3	6	4

Increase in LOS 2015/16 due to bed escalation, and Recovery Ward (TW) used for Short Surgical Assessment, therefore increase in capacity.

7. Sentinel Stroke National Audit Programme (SSNAP)

The Sentinel Stroke National Audit Programme (SSNAP) is the single source of stroke data in England, Wales and Northern Ireland. There are three main components of SSNAP, the clinical audit, acute organisational audit, and post-acute organisational audit. For the purpose of this summary, MTW's most recent results from the clinical audit (December 2016 – March 2017), will be discussed and compared with the national averages. Every patient admitted under the trust's stroke pathway and consequently diagnosed with a stroke is added to our SSNAP database enabling the trust to have a clear picture regarding our current performance in stroke services.

The SSNAP results are released every four months and are broken down into ten domains, each with multiple indicators, which are all given a grade rating (A-E). Each site also receives an overall grade rating. For the time period mentioned above Maidstone gained an overall grade rating of 'A', which was the highest rating given to an acute hospital in Kent. Tunbridge Wells Hospital gained an overall 'C' rating. The ten domains within the SSNAP audit and the trust's consequent performance within these are as follows;

7.1. Scanning

Maidstone's rating increased to an A, TWH maintained a B (0.1% away from achieving an A). Both sites are better than the national average for the percentage of patients scanned within 1 hour from clock start and the median time to scanner. Both sites are slightly below the national average for the percentage of patients scanned within 12 hours from clock start. A contributing factor to this may be delayed referrals from other teams to the stroke team, often for patients with atypical presentations of stroke. In order to try and improve this, the Stroke Lead Nurse is currently giving regular training for all staff of the A&E and AMU departments regarding early recognition of strokes.

7.2. Stroke Unit

Maidstone maintained a C rating whilst TWH maintained its D. Maidstone is higher than the national average for all areas within this domain, these include: the percentage of patients admitted to a stroke unit within 4 hours; median time for the patient to be admitted to a stroke unit and the percentage of patients who pass the 80/90 recommendation that 80% of stroke patients spend 90% of their inpatient episode on a stroke unit. TWH is lower than the national average in all of these areas, the main contributory factor to this is believed to have been the recent bed pressures throughout the trust. Ways in which we have tried to improve this is aiming to identify patients for discharge at the morning board round and encouraging the team to make all necessary arrangements the day before discharge. The trust also has a ring-fence bed policy meaning that both stroke units aim to keep one bed vacant at all times for emergency stroke admissions.

7.3. Thrombolysis

Maidstone maintained a C rating whilst TWH improved to a B. At present, both sites thrombolyse more patients than the percentage listed as the national average. Maidstone is below the national average for the percentage of patients who are thrombolysed within 1 hour and the median time from clock start to administration of thrombolysis, meanwhile TWH is above the national average. It is unclear whether this is also due to delayed referrals from other teams within the trust.

7.4. Specialist assessments

Maidstone improved to a B grade rating and TWH maintained a C. Both teams are below the national average for the percentage of patients who see a stroke consultant within 24 hrs. At Maidstone there is not currently any stroke consultant cover at the weekends and there is one longstanding stroke consultant vacancy at TWH, both of which will have contributed heavily to this result. TWH are also below the national average for the percentage of patients seen by a stroke nurse within 24 hours however both sites have a median time from clock start to stroke nurse assessment that is higher than the national average. Similar results are found for the percentage of patients who are given a swallow screen within 4 hours.

7.5. Occupational Therapy

MGH maintained an A rating and exceeds the national average in all areas of this domain. TWH dropped to a B from an A grade and is slightly lower than the national average for most areas. This is most likely due to staffing issues within the TWH occupational therapy team who at present have one band 5 vacancy.

7.6. Physiotherapy

Both sites maintained their A rating and all areas either match or exceed the national averages.

7.7. Speech and Language Therapy

MGH maintained an A rating whilst TWH improved from a B to an A. For both sites most areas significantly exceed the national average apart from the median number of minutes of speech and language therapy received per day, which is slightly lower than the national average at both Maidstone and TWH. At present the speech and language therapy teams do not have enough members of staff to achieve a 7 day service which will have contributed significantly to this result.

7.8. MDT Working

At both sites the proportion of patients who have seen each therapy department within 72 hours is higher than the national average however some of the median times from clock start to therapist assessment are lower than the national average. Occupational therapy and physiotherapy have a 6 day service and, as mentioned above, speech and language therapy have a 5 day service. This means that patients who are admitted on a Friday afternoon and over the weekend will have extended time between clock start and initial therapist assessment. The percentage of patients who have rehabilitation goals set within 5 days is higher than the national average at both sites.

7.9. Standards by Discharge

Maidstone improved to a C and TWH maintained a D rating. Both sites are significantly lower than the national average for the percentage of patients who have a continence assessment completed within 3 weeks of admission however it should be noted that both teams have doubled their percentage from the previous results. This has likely remained an ongoing problem due to the current nursing vacancy rate on both stroke units. The Stroke Clinical Nurse Specialist has recently given continence training to the occupational therapy teams (and physiotherapy at Maidstone) in order for them to assist with this as much as possible. Mood and cognitive screening completion is higher than the national average at Maidstone and lower than the national average at TWH. In terms of nutritional screening it is TWH that is higher than the national average. There are definitely improvements to be made in this domain. The Stroke Lead Nurse and Stroke Clinical Nurse Specialist have started to complete 7 day reviews of the medical notes and stroke pathways in order to identify and patients who have outstanding assessments waiting to be completed.

7.10. Discharge Processes

Maidstone maintained a B rating whilst TWH dropped to a C. Both sites are higher than national average for the percentage of patients referred to an early supported discharge team and for anticoagulating patients in atrial fibrillation. Both teams are lower than the national average for ensuring that there is a plan made for discharge between both health and social care and that the patient has a named contact upon discharge. The named contact is usually given on the discharge summary within the stroke passport. The junior doctors at both sites are to be reminded on rotation and at regular intervals by all senior nurses on the stroke units that the stroke passport needs to be added.

8. National Joint Registry (NJR)

For the most recent NJR report, which covers surgical data up to 31/12/15, hospitals are listed which have a revision rate of their primary hips and knees which is more than 3 standard deviations above their expected number for their case mix.
Nationally 30 hospitals have higher than expected revision rates of their TKRs and 44 for their THRs. Looking at all primary hips done since 2003, Maidstone Hospital was one of the outliers. For operations done since 2011, when all joint replacements were done at The Tunbridge Wells Hospital, we are not outliers for hips or knees.

The quality of our data was audited in 2016 and, out of 750 procedures, only 6 forms were either missed or had incorrect data for the reporting period, the percentage error therefore being 0.8%.

The patient consent rate, that is patients agreeing for their data to be recorded on the NJR, has been 98% annually since the Tunbridge Wells hospital opened. The NJR target for consent rate is 95%.

9. Enhancing Quality (EQ)

The EQ Programme provides the opportunity to benchmark the Trust against our local peers for the treatment of patients with long term conditions such as Heart Failure and COPD. It also provides benchmarking data for elements of Urgent and Emergency Care e.g. Deteriorating Patient and Emergency Laparotomy as well as Fractured Neck of Femur. The data available covers mortality, readmissions, LOS as well as adherence to various pathway measures ('Care Bundle Measures'). Generally, the Trust compares well to the local peer group for the majority of the measures reported. There are three areas where the Trust is an outlier that requires further investigation at this point:

1. Heart Failure mortality: After falling between 2011 and 2013, mortality has risen to 18%.
2. Deteriorating Patient Critical care rate: lowest for sepsis (outlying)
3. Deteriorating Patient Critical care rate: low for AKI (outlying)

The latest full report has been provided as an appendix to this report (Appendix 2).

10. Dr Foster Stroke Summary Report

A full report has been supplied by Dr Foster (see Appendix 1) as in previous versions of this annual report, focussing specifically on Stroke. In summary, it can be demonstrated that the Trust were outliers for Stroke in April 14 to Mar 15. However, it can now be seen that there has been an overall decrease in this trend, with the Trust now showing an overall improved Stroke position for two consecutive years. The expected rate however consistently remains below the observed rate and whilst this continues to remain parallel will have the effect of creating a stable trend for the relative risk, however should the expected rate or observed rate change independently of each other, then a depth of coding review would be recommended. The Trust will continue to monitor this.

Overall, the length of stay data shows that LoS remains stable however is generally higher than similar peers. The readmission rate has remained stable for 7-21 day readmissions compared to

peers however MTW has a high 28 days readmission rate compared to peers of similar size and further investigation may be useful in understanding why the trust is presenting differently to its local peers. These areas will be followed up and analysed in greater detail in conjunction with the service.

The SHMI data also reflects an improving picture with the overall SHMI for Stroke mortality, whilst remaining ‘as expected’ for the period Jan 16 to Dec 16.The overall the picture looks much improved with definite improvements in mortality rates (despite increased crude rate), comorbidity and depth of coding. Readmission rate with 28 days remains high and is probably worth exploring further at some point.

11. Summary and recommendations

This report provides an overview of the various sources of clinical outcomes data available to the Trust at this point. As described these reports are often the result of annual audits, rather than forming part of an ongoing programme of work focussing on clinical effectiveness and patient outcomes, although there are some exceptions.

In order to ensure the focus on clinical effectiveness is maintained throughout the year, the following recommendations / actions are proposed:

1. Set up meetings with the Clinical Directors (CDs) to confirm the source and availability of all current / known outcomes data and reports in their area.
2. Create a calendar of the data collection and publication dates for these reports.
3. Set up a process with the CDs, so that when each report is published, it is assesses within the relevant directorate and an action plan is produced to respond to any recommendations.
4. Ensure a summary of the report, along with an accompanying action plan, is produced and summited to the Quality Committee (or as designated sub-group) for assurance.
5. Liaise with other Trusts across the STP to investigate what reporting they undertake in this area and explore opportunities for local benchmarking.
6. Work with the Medical Director and CDs to see what KPIs can be used to allow ongoing monitoring of clinical outcomes, with a view to creating an early warning trigger tool or reporting dashboard.

Subject to agreement of the above recommendations from the Quality Committee, it is proposed that these actions form part of a programme of work which is overseen by the Medical Director, with reports being made available on a more regular basis. This annual report to the Quality Committee will then become an overview of the programme, summarising the work undertaken over the year and highlighting the main achievements and outstanding areas of work.

Appendix 1.

MORTALITY SUMMARY REPORT OF STROKE ANALYSIS

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Report Date	24th August 2017
Classification	**CONFIDENTIAL**
Healthcare Intelligence Specialist	Penny Booysen
Contact details	m: 07500 797825 e: penny.booysen@drfoster.com
Prepared by	Penny Booysen

BACKGROUND

Following on from the alert raised by the Royal College of Physicians on the 25th May 2016, the following analysis was conducted to review the findings and explore any improvements/changes since that period. The intention of the report will be to present intelligence with potential recommendations for further investigation. This report should be used as an adjunct to supplement other pieces of work completed within the Trust and not used in isolation.

METHODOLOGY

Using routinely collected hospital administrative data derived from Hospital Episode Statistics (HES) and Summary Hospital-level Mortality Indicator (SHMI) and analysed in Healthcare Intelligence Portal and mortality comparator, in-hospital mortality was examined for all inpatient Stroke admissions to Maidstone and Tunbridge Wells NHS Trust (MTW) for the time period June 16 to May 17, which includes the latest HES data available.

Risk adjustment is derived from risk models based on the last 10 years of national HES data up to and including February 2017 (unless otherwise stated). This is the most recent benchmark period available.

Statistical significance is determined using 95% confidence intervals unless otherwise stated.

**The methodology used by the Royal College of Physicians in the report differs from the Dr Foster methodology in a number of areas however; certain themes, trends and patterns can be explored.*

REVIEW OF DATA FOR STROKE DATA

- The funnel plot (fig1.0) shows that MTW sits within both the 95% confidence intervals for that time period and the 99.8% control limits. There are 10 Trusts nationally which sit outside the 95% confidence interval.

FIG.1.0: NATIONAL PEER COMPARISON FOR STROKE DIAGNOSIS JUNE 16 TO MAY 17

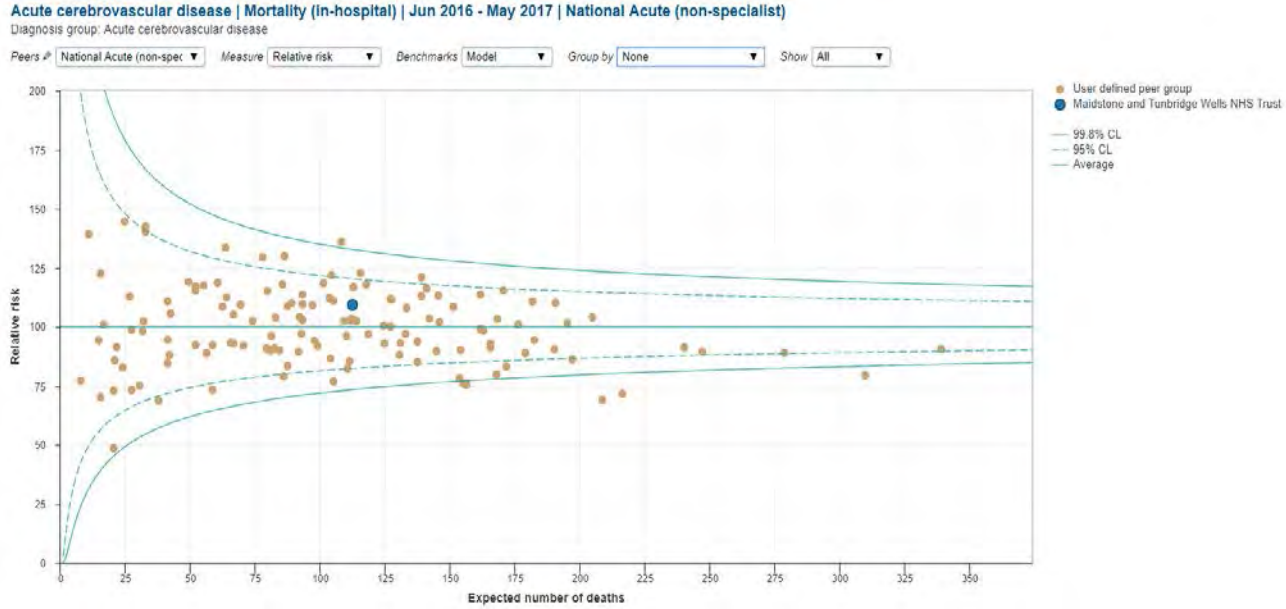
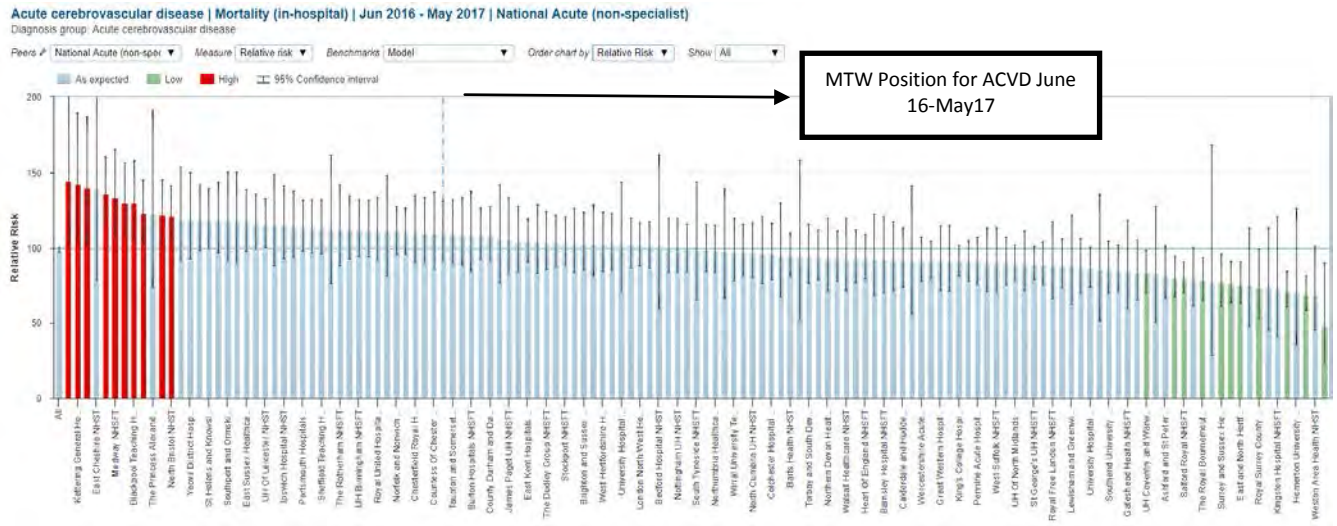


FIG.2.0: NATIONAL PEER COMPARISON FOR STROKE DIAGNOSIS JUNE 16 – MAY 17



- Fig.3.0 below shows that the crude mortality rate has increased from increased from 15.36% in April 15 – Feb 16 to 17.3% in June 16 – May 17. This is a 1.94% increase. Nationally the variance shows a 0.22% decrease and within the South East Coast Peer group, there is a 0.4% decrease. The Stroke SMR for MTW has also increased from 91.37 to 109.2 but remains statistically 'as expected'. The overall number of deaths between each year analysed has increased from 100 to 123.

FIG.3.0: TABLE OF OVERALL FIGURES YEAR COMPARISONS

	MTW	Peers	National
June 16 – May 17			
Crude mortality rate	17.3%	16.5%	16.00%
SMR	109.2	95.4	98.3
Number of deaths	123	1270	14072
Number of expected deaths	112.6	1331.5	14315.1
Apr 15 - Feb 16			
Crude mortality rate	15.36%	16.89%	16.22%
Crude variance	3.46%	0.10%	0.43%
SMR	91.37	98.15	96.96
Number of deaths	100	719	13214
Number of expected deaths	109.44	732.54	13628.87

- The rolling 12 months graph (fig.4.0) shows each point on the graph plotted with 12 months data to show a true trend. It can be seen in fig.4.0 that the trend in June 16 to May 17 has a downward trajectory.
- Fig. 5.0 shows that in March 17 a change in practice either pathway management or coding/recording of data has led to a reversal of the observed and expected crude rate %. This has been maintained now for 6 data points available.
- The 5 year rolling trend for Stroke relative risk shows an erratic trend.

FIG.4.0: ROLLING 12 MONTH STROKE SMR JUNE 16 TO MAY 17

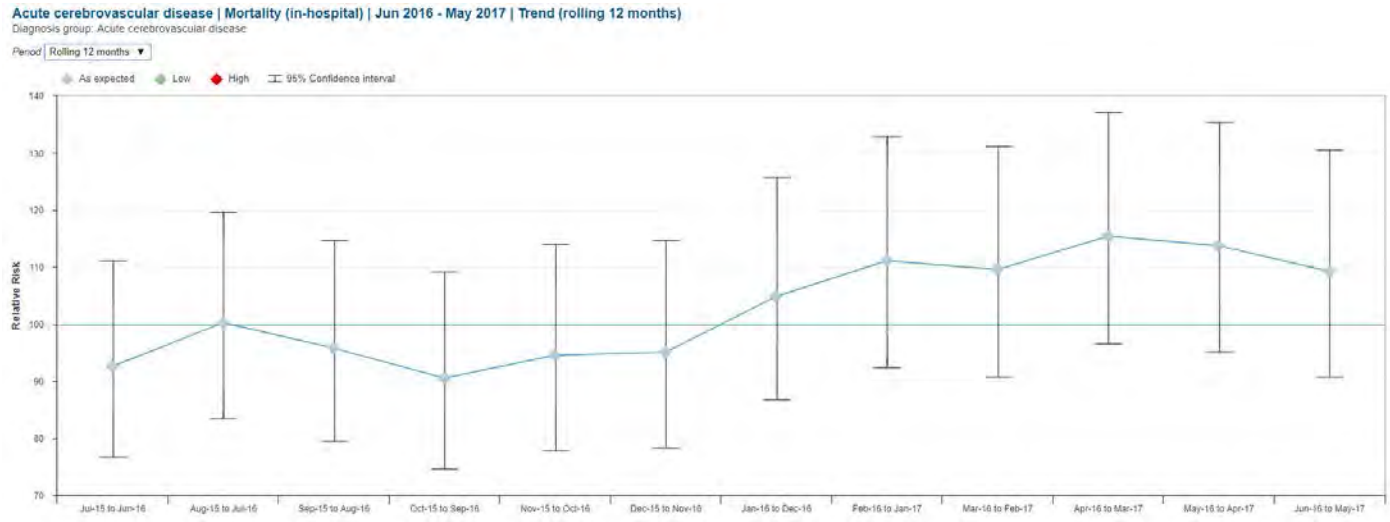


FIG.4.0: 5 YEAR ROLLING 12-MONTH STROKE SMR JUNE 16 TO MAY 17

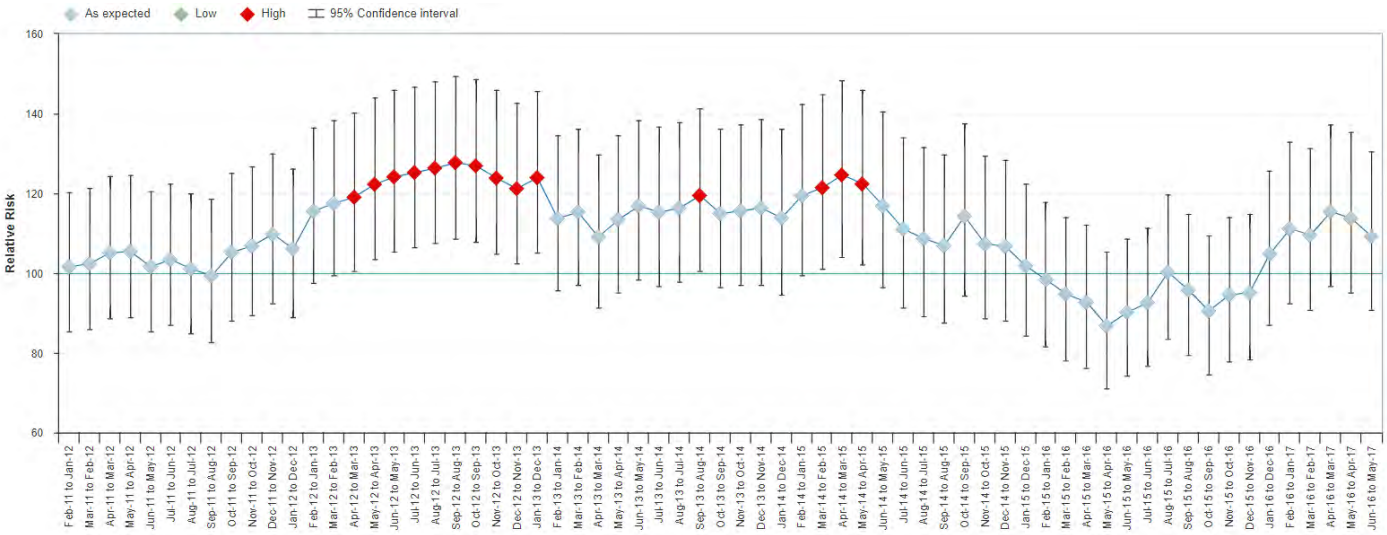
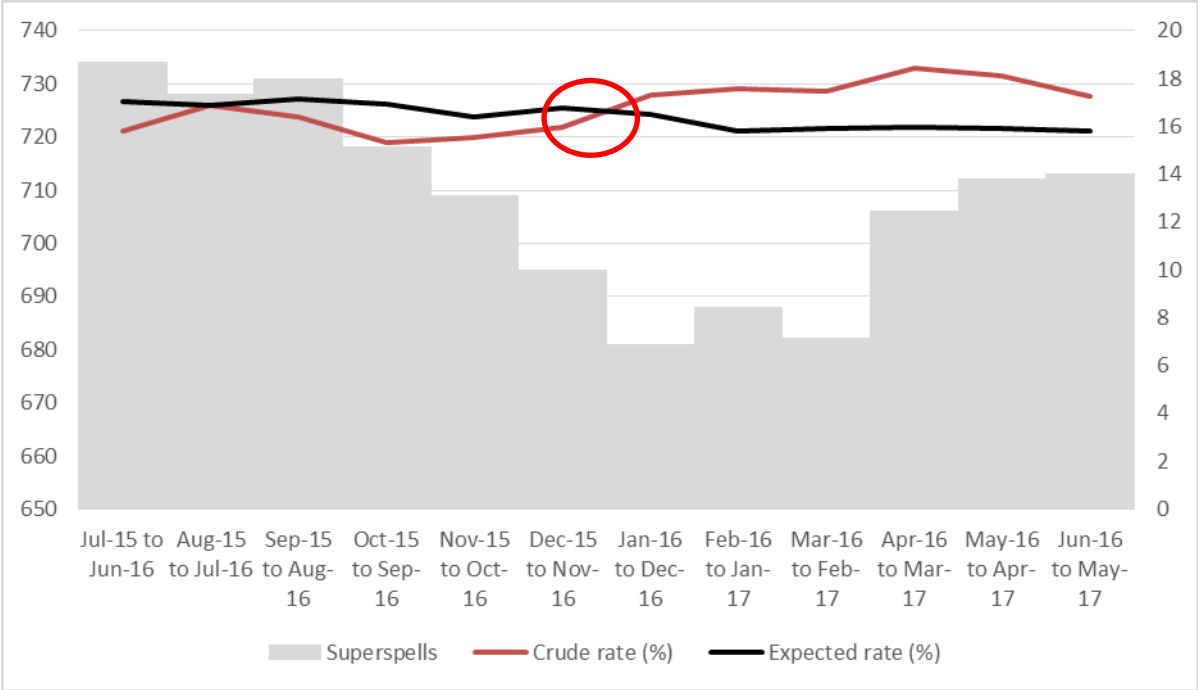


FIG.5.0: CRUDE MORTALITY RATES JUNE 16 TO MAY 17



*The Length of Stay (fig.6.0) analysis and readmission figures (fig.8.0) aid in triangulating not only the number of patients that died but overall quality.

- MTW has an average LOS of 18 days compared to an expected LOS of 15.5 days. Regionally this is the second highest average LOS compared with the 4th highest expected LOS. Suggested that either there is a delay in discharging these patients or that patients at MTW are presenting (either through data capture or actual) as less complex than neighbouring trusts.
- The readmissions data show that readmissions 7-21 days are in line with the Peer average however 28 day readmissions are higher for the Trust compared to similar sized trusts

FIG.6.0: MEAN LENGTH OF STAY ANALYSIS JUNE 16 TO MAY 17

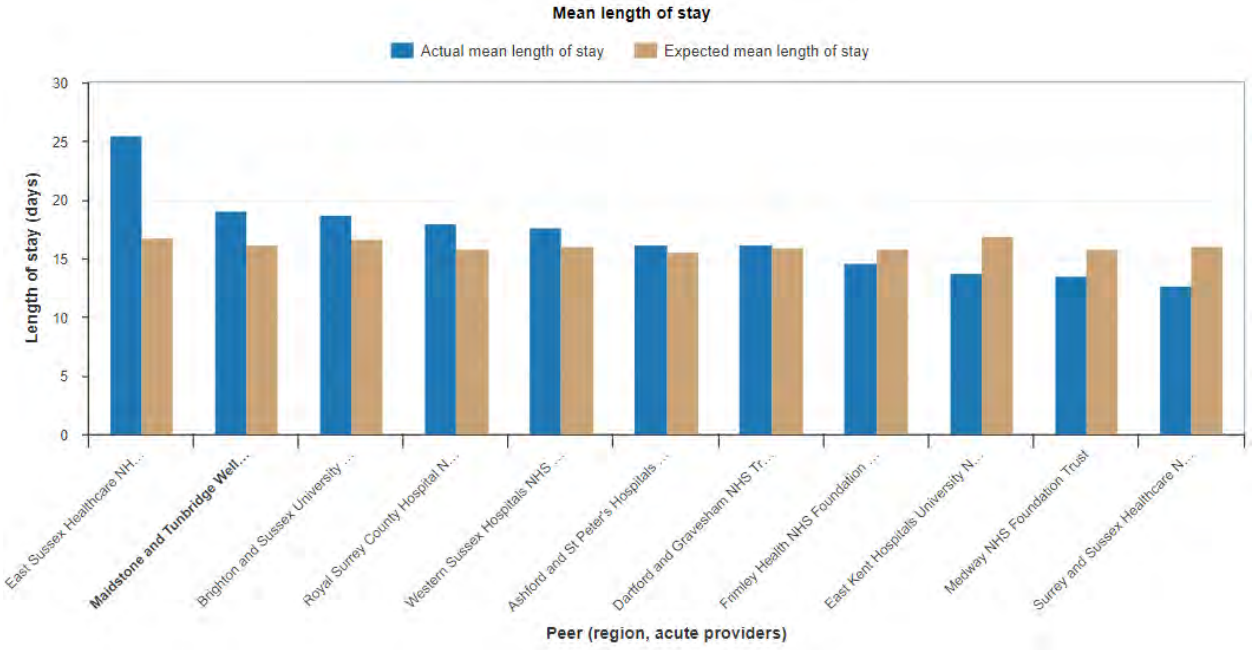


FIG.7.0: EXCESS BED DAYS FOR ACVD SPELLS COMPARED TO REGIONAL ACUTE PEERS JUNE 16 TO MAY17

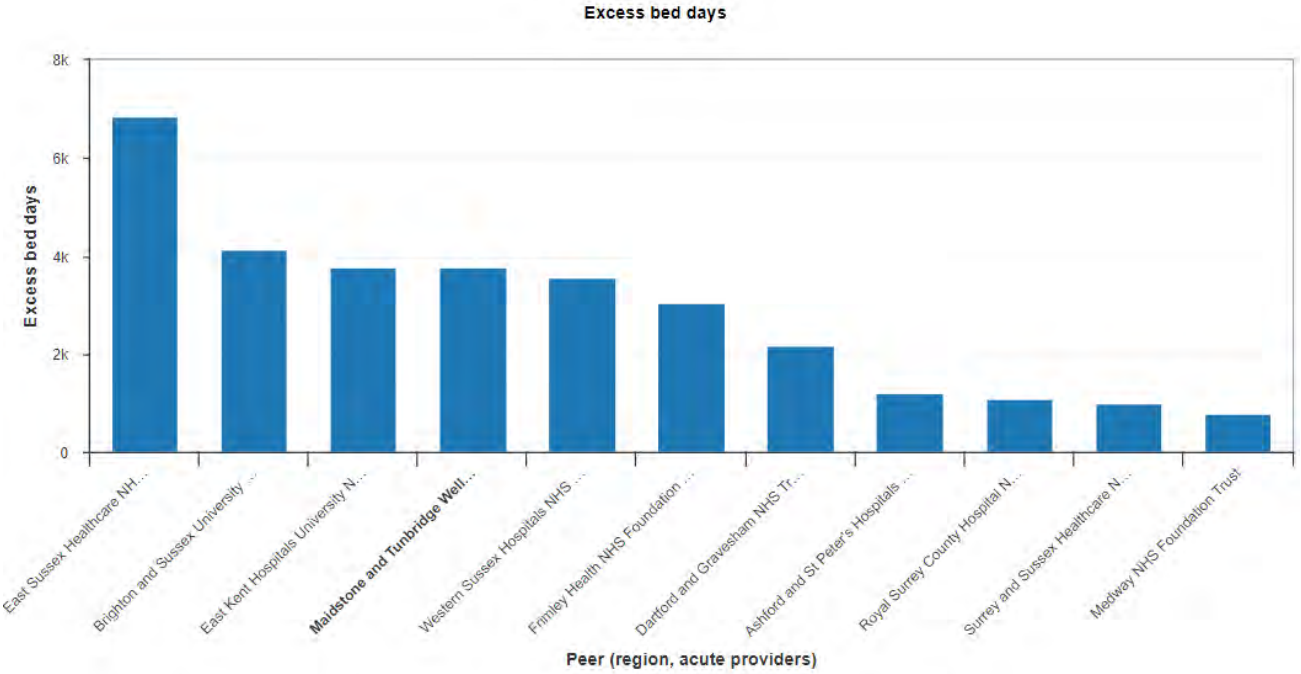
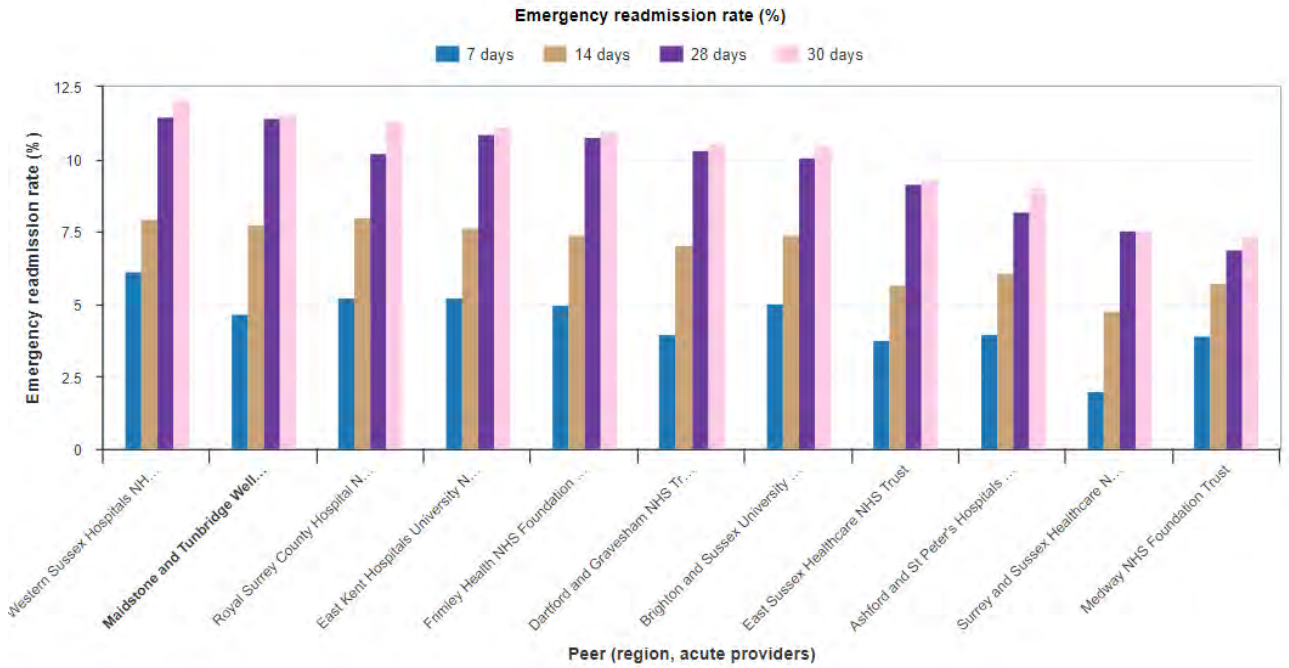


FIG.8.0: READMISSIONS RATE WITHIN 30 DAYS MARCH 16 TO FEBRUARY 17 (LATEST AVAILABLE DATA)



Case-Mix Analysis for Stroke

- The case-mix profile of three coefficients that are included in Dr Foster methodology show that MTW has a higher number of patients who died from a primary diagnosis of Stroke, aged over 75+, compared to the National average.
- The co-morbidity scoring profile shows that MTW has a high number of comorbidities recorded in comparison to its peers in the higher scores, 10+. This implies that the recording of comorbidities at MTW is in line with the trends of its peers for that time-period and possibly shows a more complex presentation.
- The social deprivation coefficients show that MTW has a high number of patients that presented with a Deprivation score of Q1&Q2: Least deprived and below average compared to its peers.

FIG.9.0: AGE PROFILE

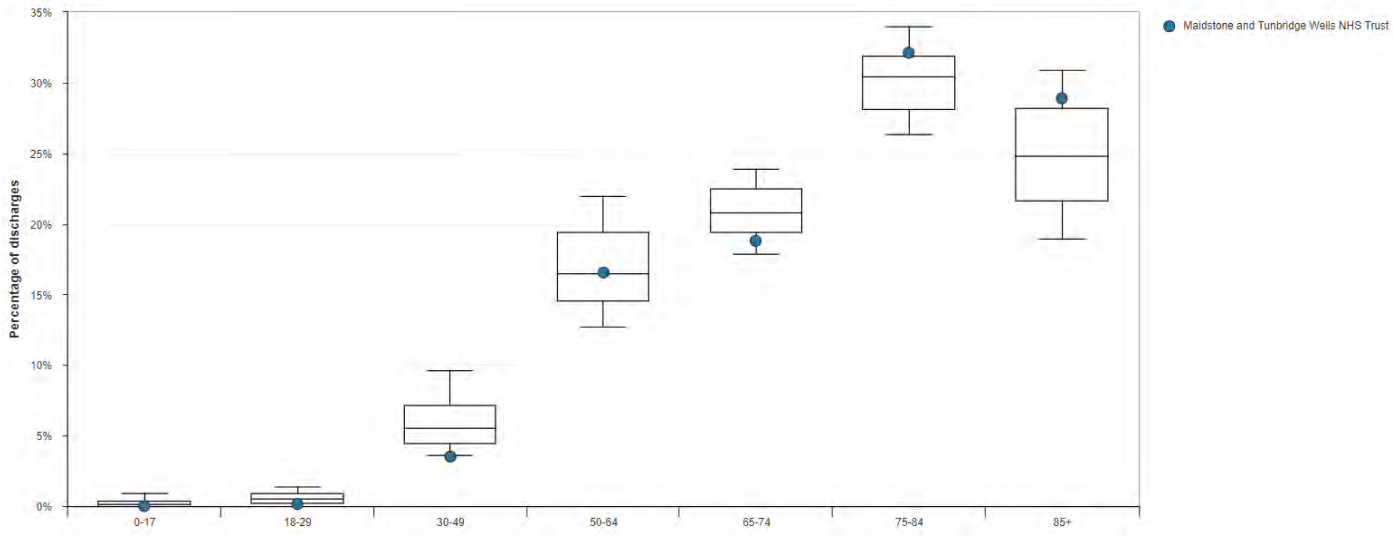


FIG.10.0: COMORBIDITY SCORE PROFILE

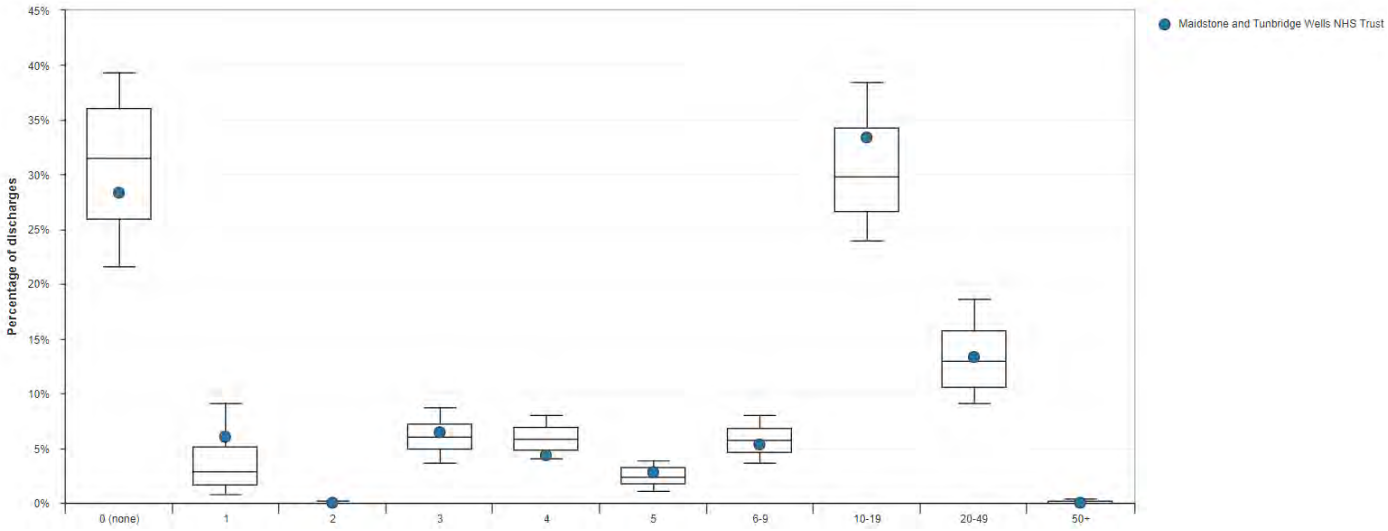
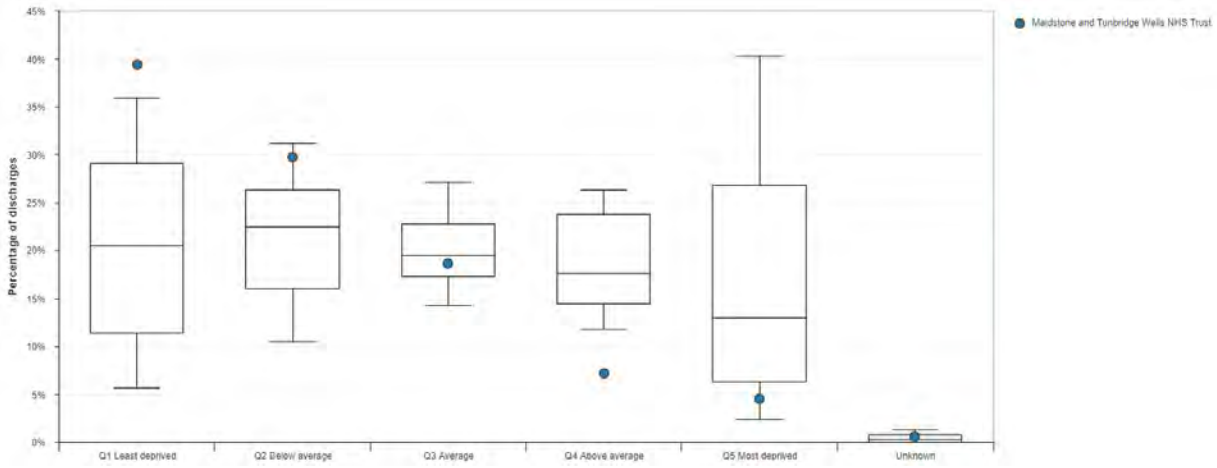


FIG.11.0: DEPRIVATION PROFILE



SHMI Data

- In the SHMI data for the period Jan 16 to Dec 16, it can be seen that MTW remained within the 95% confidence intervals for Stroke. (Fig.13.)
- If Stroke were analysed by crude rates for where a patient died, neither patients in-hospital nor post-discharge deaths were considered statistically significant with an overall rate of In-patients of 17.34% compared to National average of 14.48% and Post-discharge (within 30 days) showing a crude rate of 2.52% against a peer rate of 2.35%. (Fig.14.0)
- Stroke split by in-hospital deaths against Post-discharge deaths shows that neither is statistically significant for the time period Jan 16 – Dec 16.
- The latest SHMI data period available is Jan 16 – Dec 16 and this reflects the improving picture we have seen in SMR for stroke.

FIG.12.0: SHMI BY PROVIDER FOR STROKE ADMISSIONS JAN 16 – DEC 16

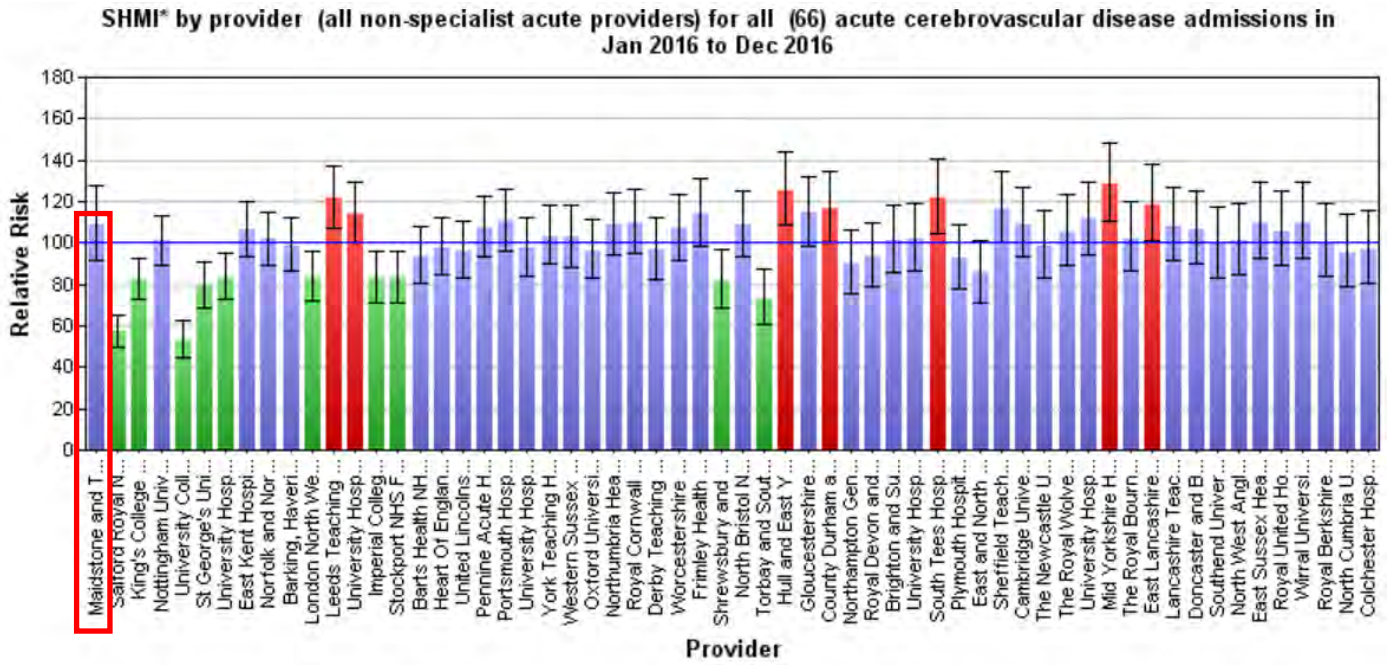


FIG.13.0: MORTALITY (CRUDE) RATE BY WHERE A PATIENT DIED VS SOUTH COAST PEERS JUNE 16 TO MAY 17

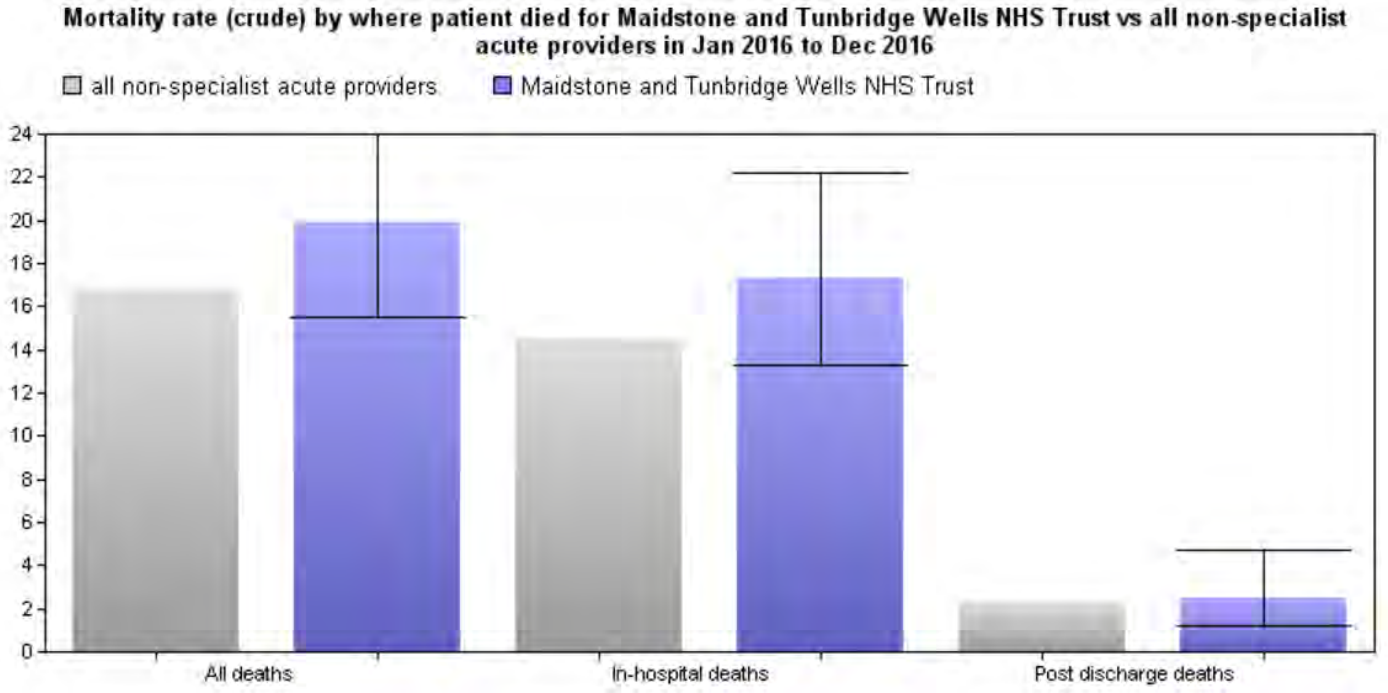
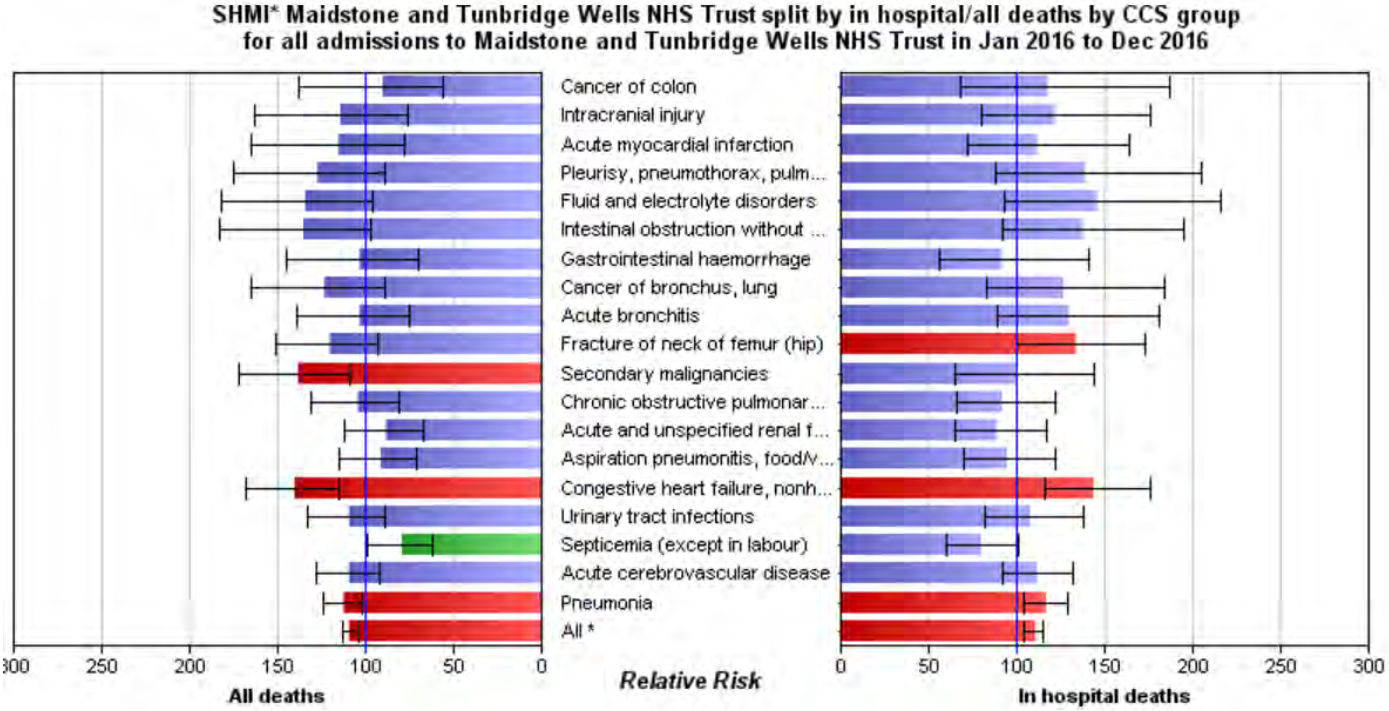


FIG.14.0: SHMI SPLIT BY HOSPITAL/ALL DEATHS BY CCS GROUP JUNE 16 MAY 17



Summary

Overall it can be demonstrated that MTW were outliers for Stroke in April 14 to Mar 15. However, it can now be seen that there has been an overall decrease in this trend, with the Trust now showing an overall improved Stroke position for two consecutive years. The expected rate however consistently remains below the observed rate and whilst this continues to remain parallel will have the effect of creating a stable trend for the relative risk, however should the expected rate or observed rate change independently of each other than a depth of coding review would be recommended.

Overall, the length of stay data shows that LoS remains stable however is generally higher than similar peers. The readmission rate has remained stable for 7-21 day readmissions compared to peers however MTW has a high 28 days readmission rate compared to peers of similar size and further investigation may be useful in understanding why the trust is presenting differently to its local peers.

The case-mix analysis shows that MTW differs from its' peers in that the Trust has a higher proportion of elderly patients and potentially they are more complex in their presentation, however the deprivation classification shows that patients are also mainly from the least deprived categories

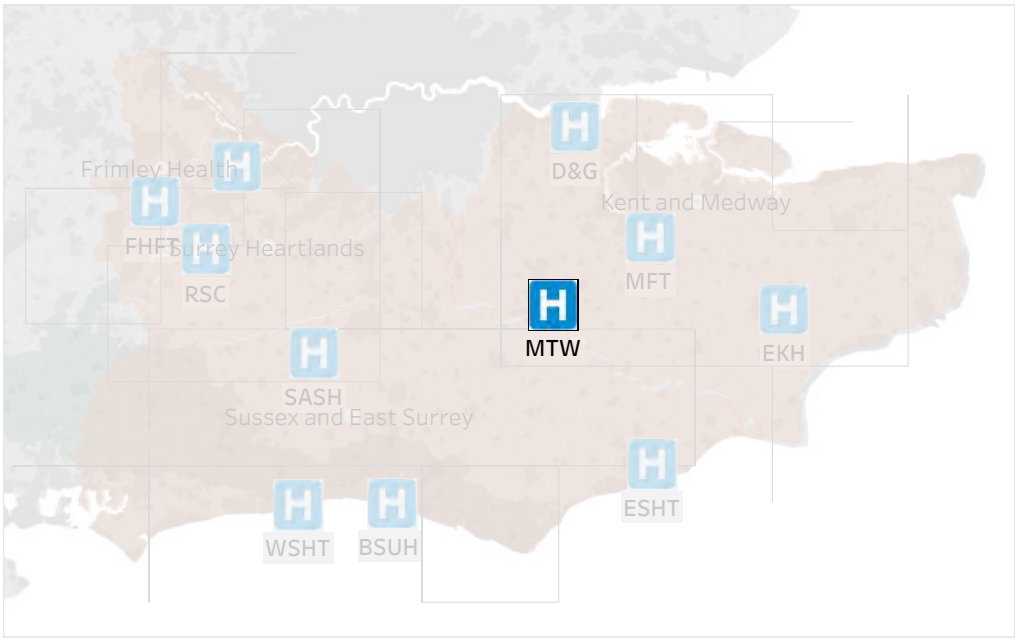
The SHMI data also reflects an improving picture with the overall SHMI for Stroke mortality, whilst remaining 'as expected' for the period Jan 16 to Dec 16.

Cardiovascular

Acute Heart Failure

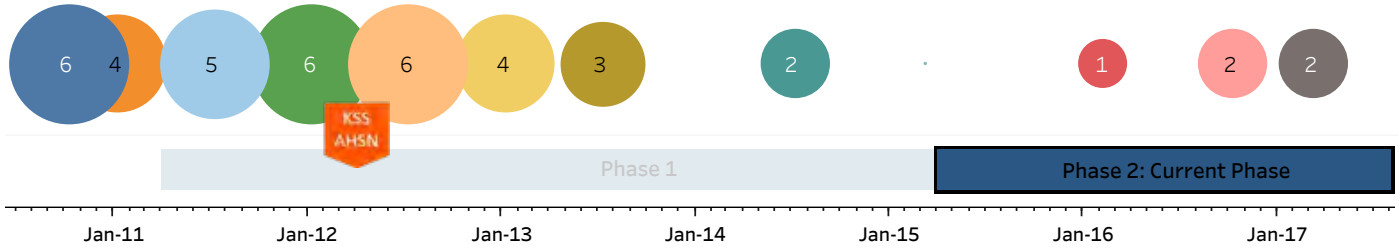
Select Organisation Level

Trust



The Acute Heart Failure Pathway

Heart Failure has been a regional priority since 2011. The Acute Heart Failure measures were revised in April 2015, to align to the National Heart Failure Audit and support greater compliance with NICE guidelines and quality standards.
Organisation-level (acute) attendance to KSS Collaboratives are shown in the bubbles on the pathway timeline below.



Care Bundle Measures - this pathway is a KSS Care Bundle. When performed consistently and fully, care bundles have been clinically proven to improve patient outcomes.
Organisation uptake rates are shown below for each measure against the KSS average. These are averaged over the phase selected in the timeline above.

MTW
KSS

Measure	Description	Uptake Rate
ACEI or ARB at Discharge for Left Ventricular Systolic Dysfunction..	If tests indicate a patient's left side of the heart is not functioning as it should (LVSD), ACEI/ARB are drugs that help improve the condition	98% 95%
Heart failure management plan	Patients should receive a personalised management plan, shared with them, their carer and their GP	100% 96%
Beta Blocker at Discharge for Left Ventricular Systolic Dysfunction	If tests indicate a patient's left side of the heart is not functioning as it should (LVSD), Beta Blockers are drugs that help improve the conditio	93% 95%
Echocardiography	Echo (or other gold standard test, including MRI, Nuclear scan, Angiogram and CT scan) recorded within 12 months of admission	100% 89%
Specialist input	Patients with heart failure should be supported by a multi-disciplinary heart failure team	95% 87%
Referral to heart failure specialist follow up	Patients should receive a clinical assessment by a multidisciplinary heart failure team within 2 weeks of discharge	91% 83%

Acute Heart Failure Admissions across Kent Surrey and Sussex

Admissions data are taken from HES and are presented as a percentage of total trust admissions and plotted against total trust admissions.

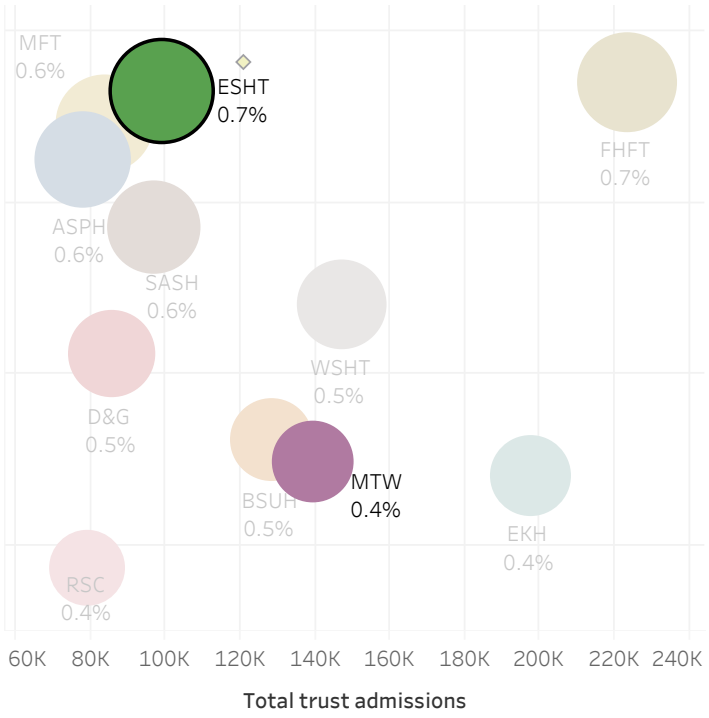
KSS Summary

The rate of HF admissions has not varied greatly since 2011 (as a proportion total trust admissions). However, the number of admissions over the KSS region has increased by 45% (in line with the national average).

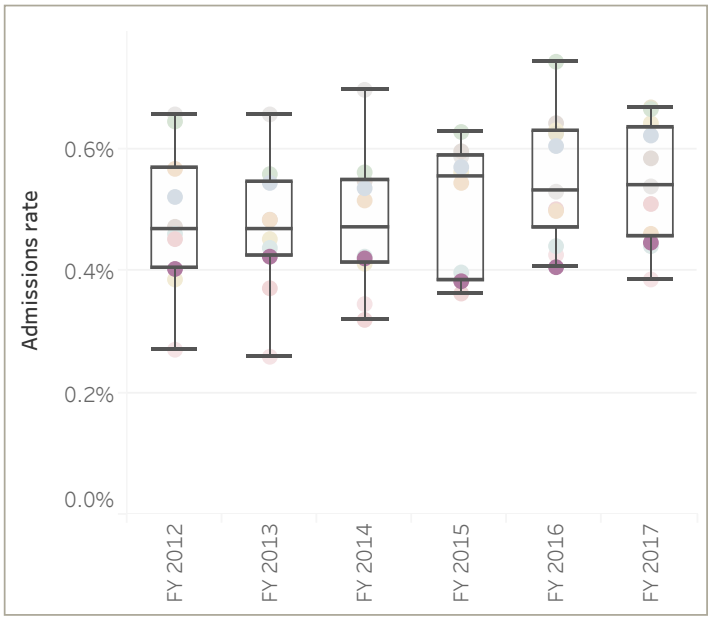
Trust Summary

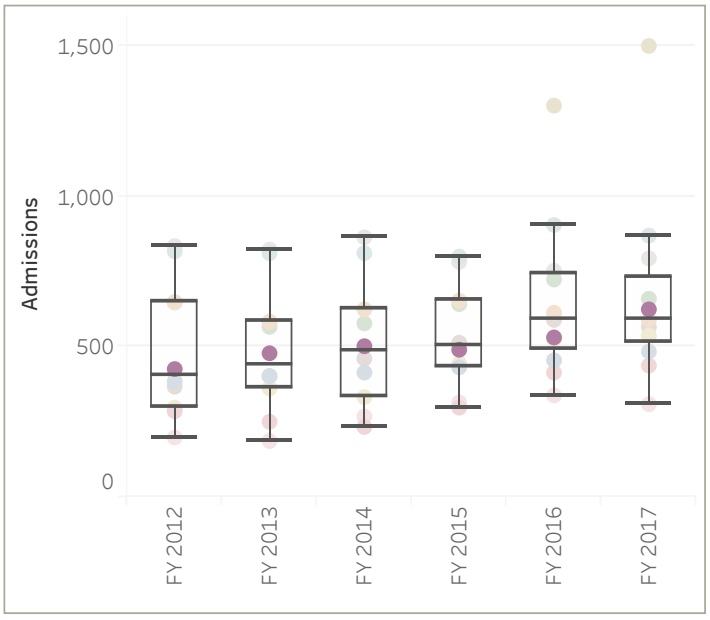
MTW	MTW admissions have risen in line with the regional average.

Date Range
2016 Q1 to 2017 Q1



Admissions Trends: the box plots show the average admission rate / admissions over time (central horizonatal line) along with interquartile range and outliers. This gives a representation of the skew and the spread of the data.





ACS Performance

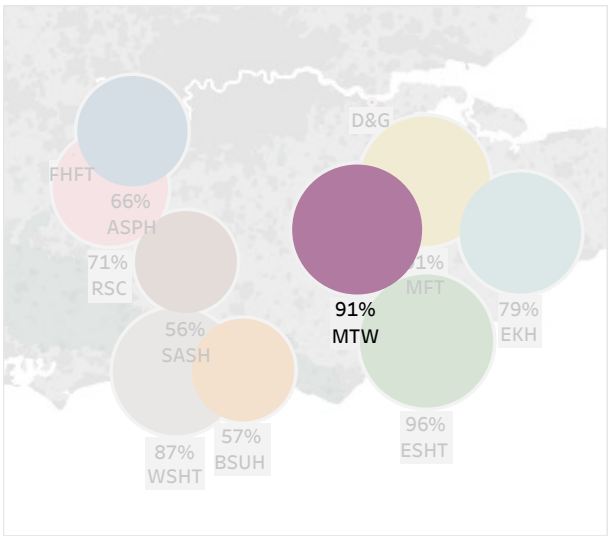
The pathway provides most benefits when each of these measures is regarded collectively as a "Care Bundle". Care Bundles, when performed consistently and fully, have been clinically proven to improve patient outcomes.
The **ACS performance score** measures the percentage of patients who receive the full care bundle (equal to 0 if any measure is incomplete).

KSS Summary

Heart Failure ACS levelled over the period of pathway revision and has increased in the last year.

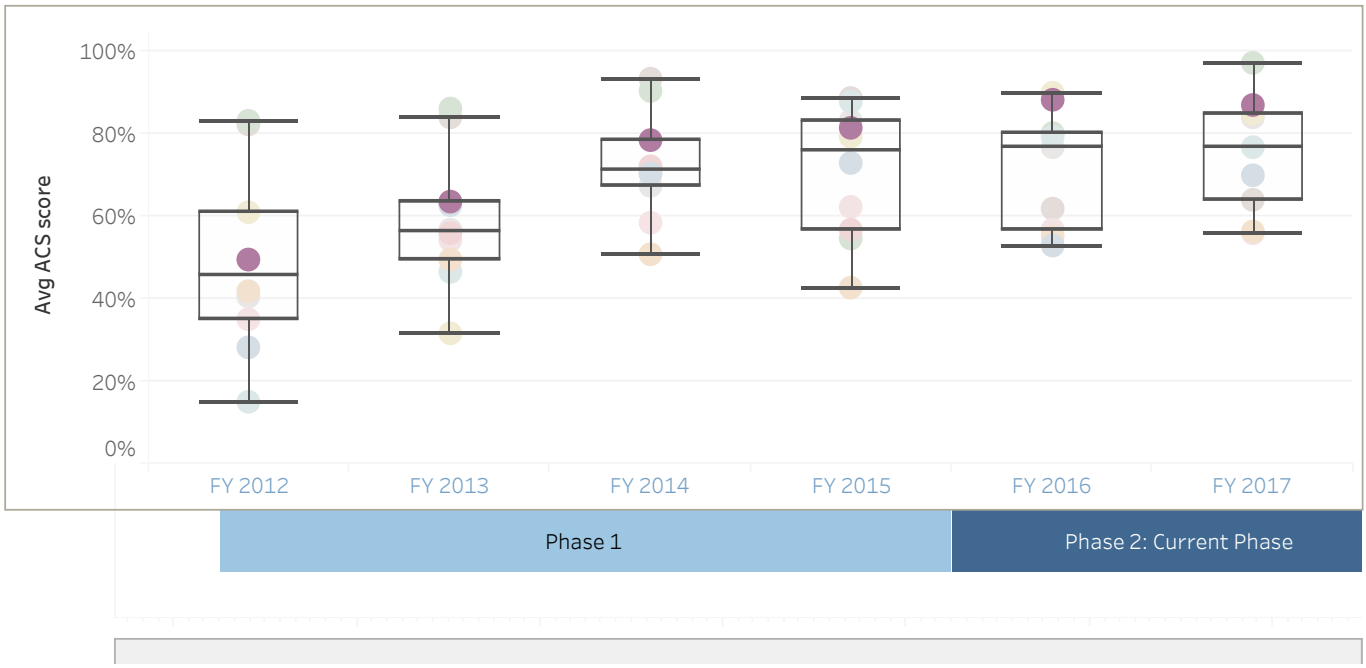
Trust Summary

MTW	Throughout the course of the programme performance has increased and has typically been above average.



Map Date Range
July 2015 to July 2016

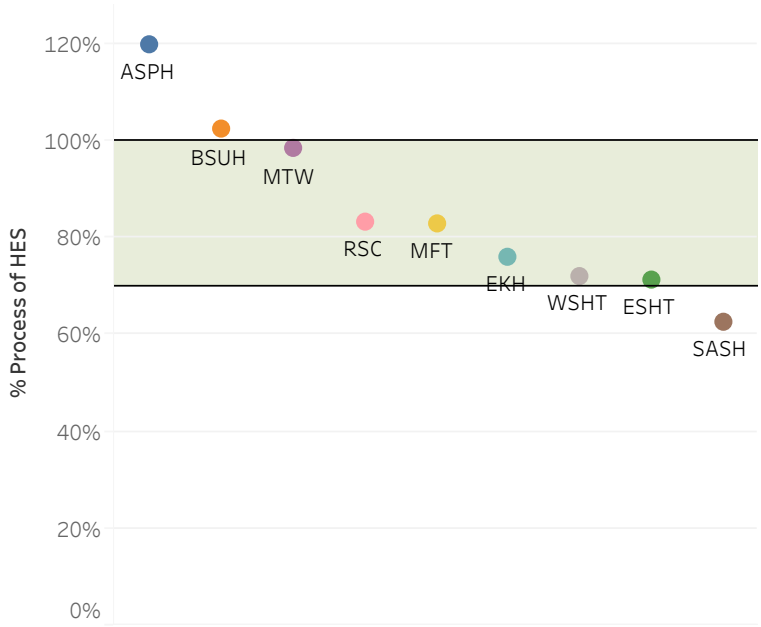
Performance Trend: the box plot shows the average ACS score over time (central horizonatal line) along with interquartile range and outliers. This gives a representation of the skew and the spread of the data.



Data Quality the key DQ indicator is the **case ascertainment rate** is calculated as the patients recorded as part of the process measures data set as a percentage of HES recorded patients. Variation in the DQ score is indicative of under-recording of process measures or differences in definition of patient diagnosis via coding.

Data Quality Scoring

The comparison is only available from April 2015.
In line with NHS guidance on best practice tariffs*, trusts with a data quality indicator of below 70% are flagged as having a large proportion of missing data leading to unreliable trend analysis for process scores. Trusts with indicator above 100% are flagged as having atypical coding methods.



Improving Data Quality further scoring for programme-specific data quality is currently under-development.

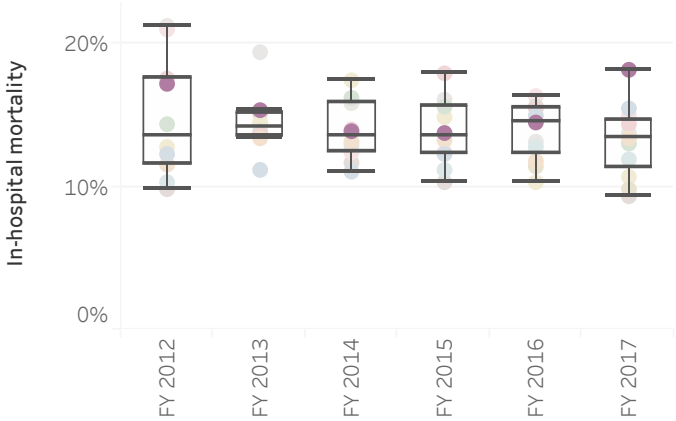
* https://improvement.nhs.uk/uploads/documents/Annex_F_guidance_on_best_pratice_tariffs.pdf
Page 5 & pages 30-32

In Hospital Mortality Rate has been derived from HES data and is calculated as the number of deaths over admissions with diagnosis codes for the pathway (code lists are available from KSS AHSN).

KSS Summary

Analysis

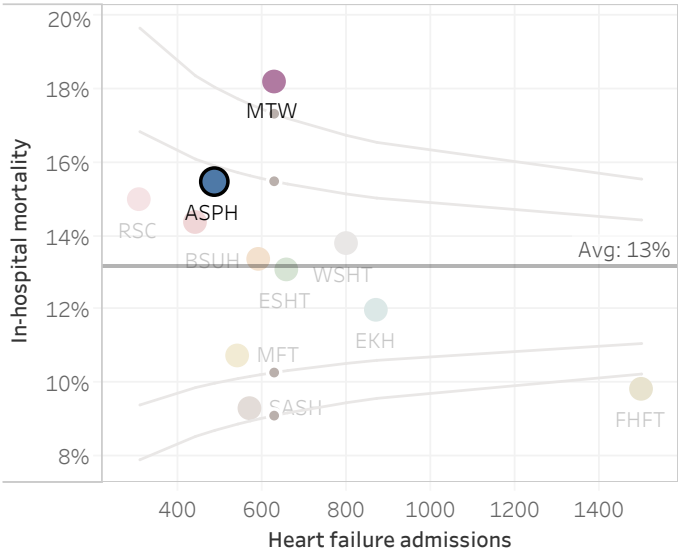
Mortality is seen to decrease over the 6 years of the programme from 15% to 13%. Variation in mortality rat has reduced, with the exception on MTW in the last reported year.



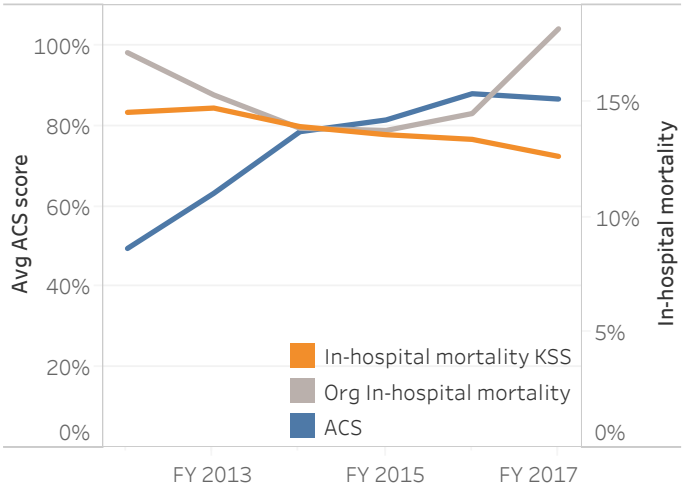
Trust Insight

MTW	After falling between 2011 and 2012, the mortality rate has risen to 17%.

Funnel Plot Date Range
January 2016 to January 2017



Exploring the Wider Context below the outcome trend at trust and regional level are plotted alongside the trust ACS. Other aspects of trust performance which are outlying are flagged below the chart.



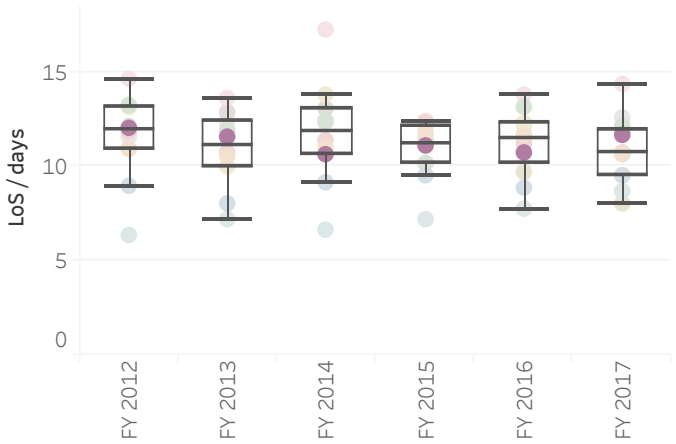
Trust	Context
MTW	Counter trend, Likewise trend in mortality, readmissions
	Likewise trend in mortality, readmissions

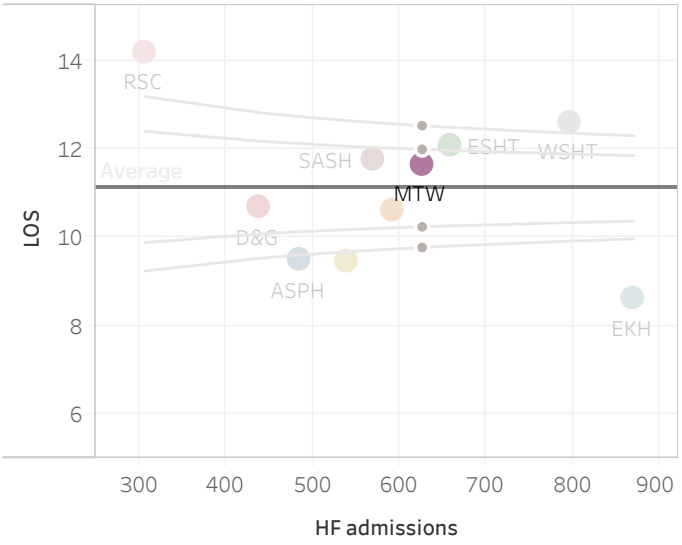
Length of Stay (LoS) has been derived from HES data and is calculated as the total bed days over admissions with diagnosis codes for the pathway (code lists are available from KSS AHSN)

KSS Summary

Analysis

Average length of stay of HF patients has on average remained consistent since 2011. Length of stay is typically highly dispersed.

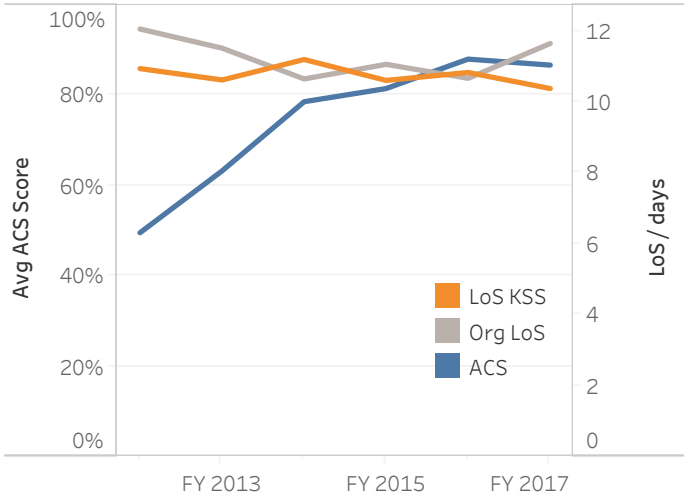




Trust Insight

MTW	Length of stay increased between 2015 and 2016.

Exploring the Wider Context below the outcome trend at trust and regional level are plotted alongside the trust ACS. Other aspects of trust performance which are outlying are flagged below the chart.



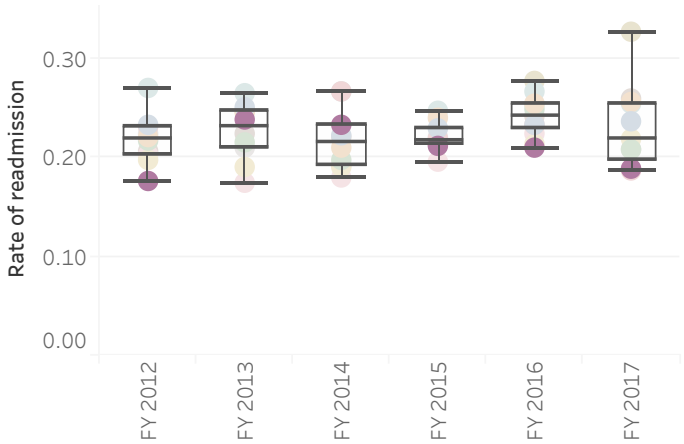
Trust	Context
MTW	Counter trend, Likewise trend in mortality, readmissions Likewise trend in mortality, readmissions

30 day readmission rates have been derived from HES data and are calculated as the no. of readmissions divided by the number of live discharges

KSS Summary

Analysis

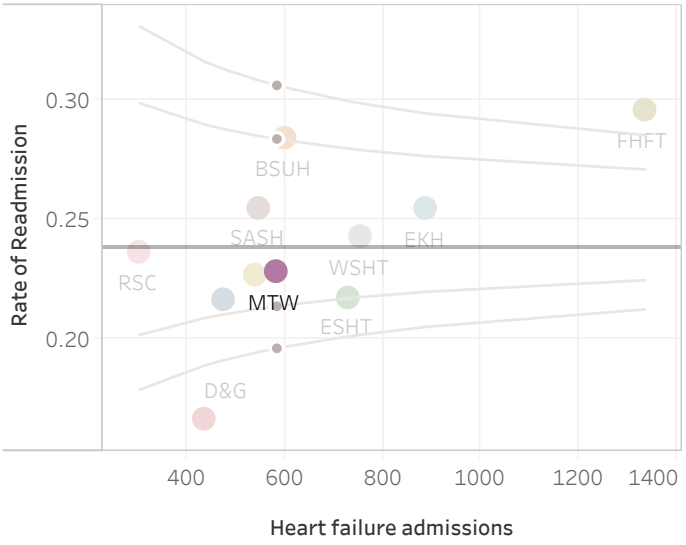
Readmission rates for KSS HF patients have not varied greatly over the last 6 years. The variation over different trusts has been stable and typically within the regional control limits.



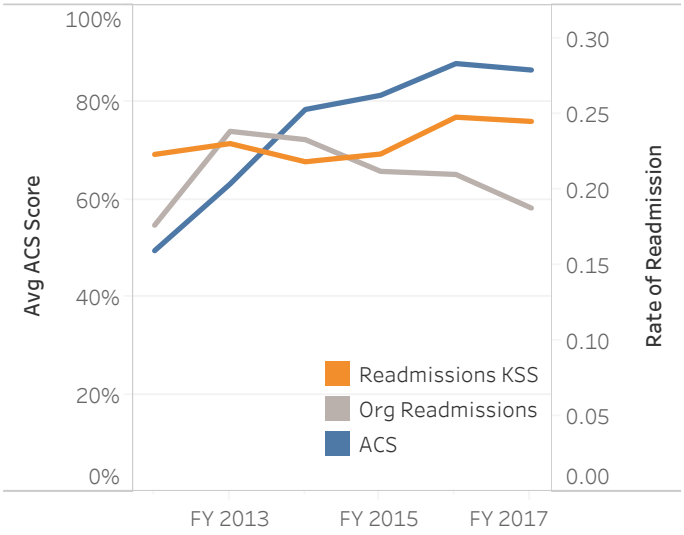
Trust Insight

MTW	Readmission rate has decreased by nearly 6% over the 6 years with significant variation between 2013 and 2014.

Funnel Plot Date Range
09/08/2015 00:00:00 to 01/07/2016 00:00:00



Exploring the Wider Context below the outcome trend at trust and regional level are plotted alongside the trust ACS. Other aspects of trust performance which are outlying are flagged below the chart.



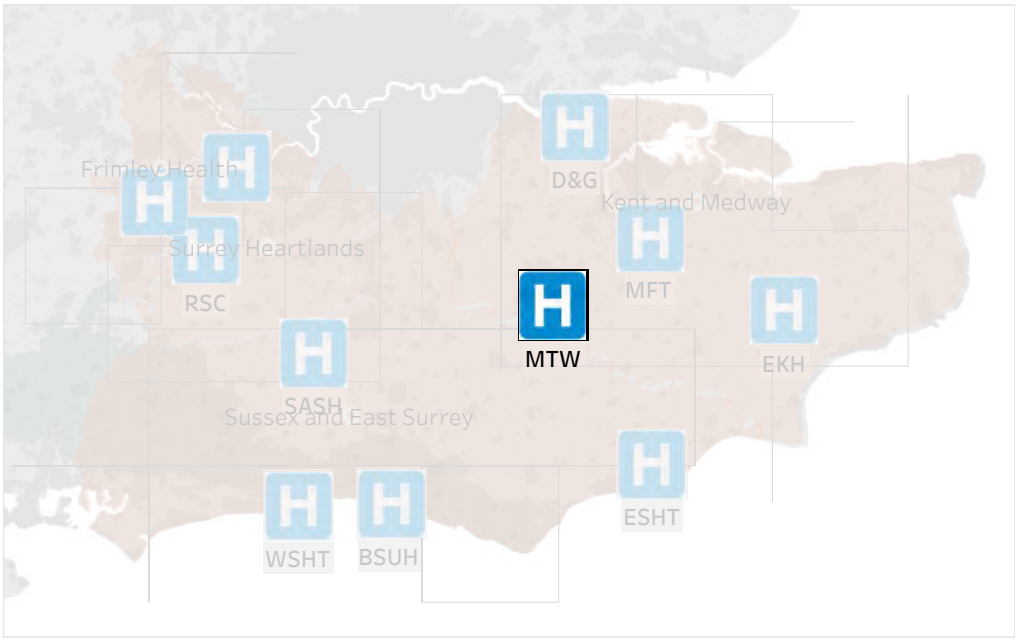
Trust	Context
MTW	Counter trend, Likewise trend in mortality, readmissions
	Likewise trend in mortality, readmissions

Respiratory

COPD

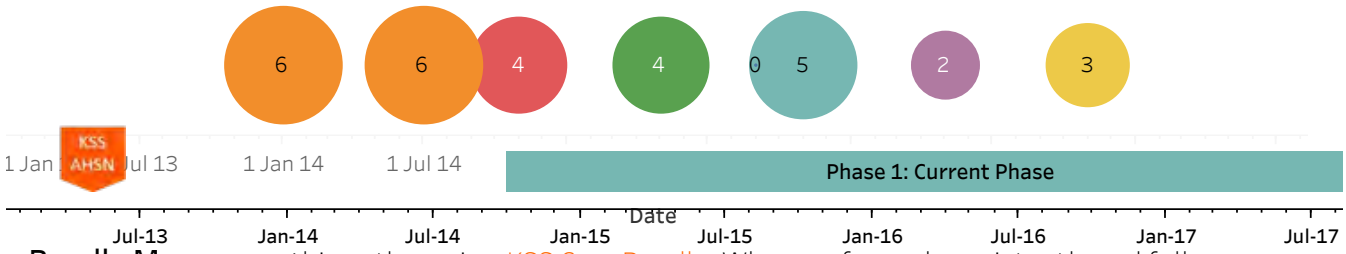
Select Organisation Level

Trust



The COPD Pathway

The Chronic Obstructive Pulmonary Disorder (COPD) pathway has been running since October 2014.
Organisation-level (acute) attendance to KSS Collaboratives are shown in the bubbles on the pathway timeline below.



Care Bundle Measures - this pathway is a KSS Care Bundle. When performed consistently and fully, care bundles have been clinically proven to improve patient outcomes. Organisation specific uptake rates are shown below for each measure, against the KSS average.
Organisation specific uptake rates are shown below for each measure against the KSS average.
These are averaged over the phase selected in the timeline above.

Measure	Description	Uptake Rate
Appropriate follow up post discharge arranged	Follow-up of patients is associated with a reduced risk of readmission.	95%
Inhaler technique assessed with the patient prior to discharge	Correct use of inhalers is associated with improved outcomes, including a reduction in risk of exacerbations and hospital admission.	85%
Patient assessed for suitability for enrolment into a pulmonary rehabilitation ..	Pulmonary rehabilitation forms an important part of the long term management of stable COPD.	87%
Provision of written information on discharge	Self-management plans are associated with improved well-being and reduced risk of hospitalisation. Self-management plans are associated with improved well-bei..	93%
Smoking status assessed and offered referral to stop smoking services if a curren..	It is clinically effective and congruent with the bundles aim of reducing risk of death and hospital readmission to include a clear focus on smoking cessation.	95%
		0.0 0.5 1.0

COPD Admissions across Kent Surrey and Sussex

Admissions data are taken from HES and are presented as a percentage of total trust admissions and plotted against total trust admissions.

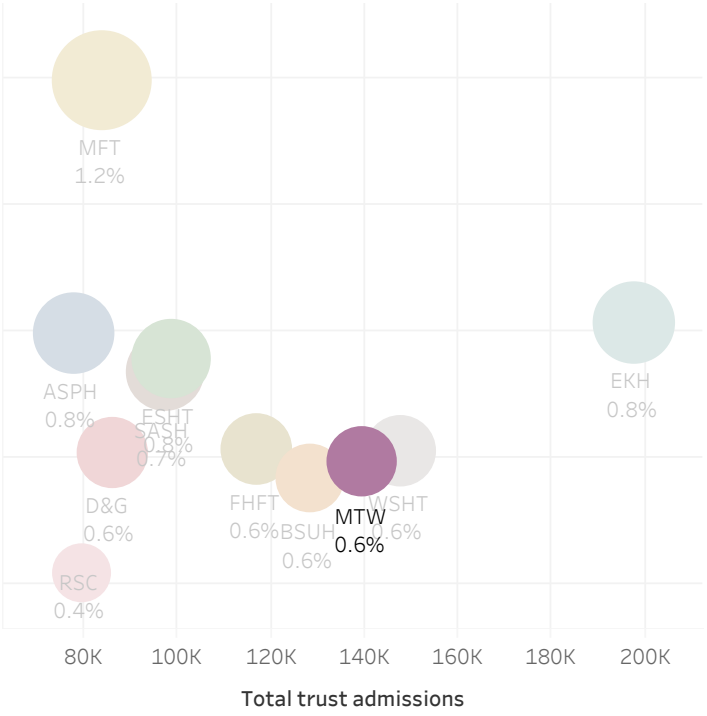
KSS Summary

COPD admissions and admission rates for the region have been relatively stable over the last 6 years. This trend was matched at the naitonal level until 2015/16, where a slight declining trend in admissions is noted.

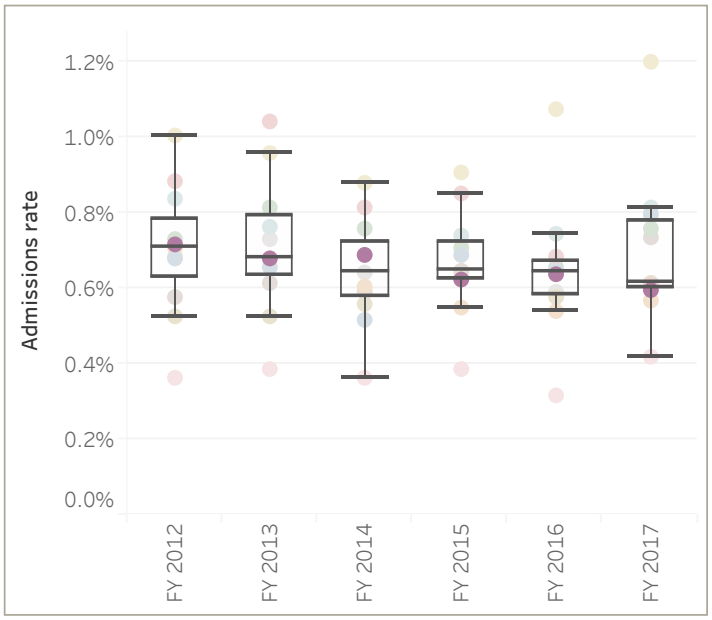
Trust Summary

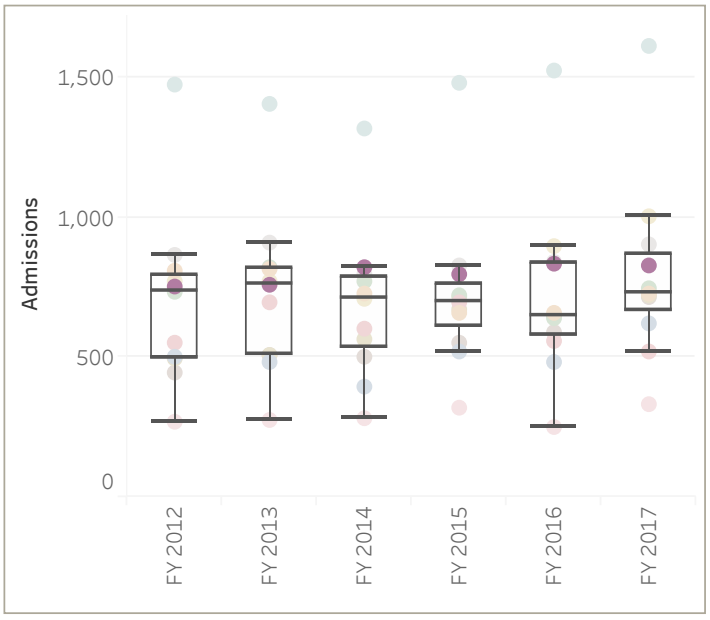
MTW Null

Date Range
January 2016 to January 2017



Admissions Trends: the box plots show the average admission rate / admissions over time (central horizonatal line) along with interquartile range and outliers. This gives a representation of the skew and the spread of the data.





ACS Performance

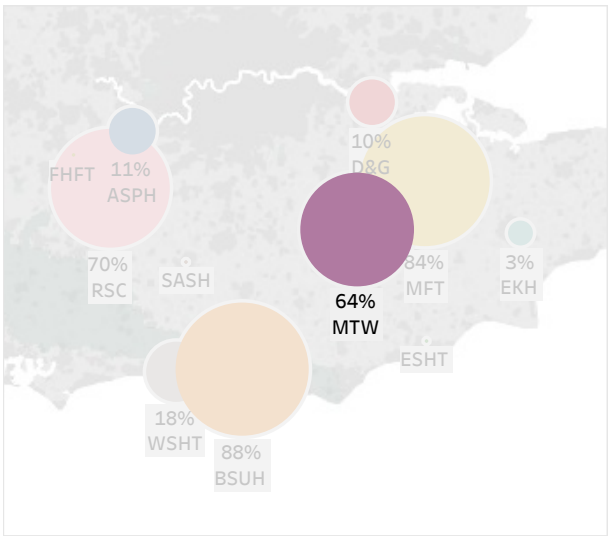
The pathway provides most benefits when each of these measures is regarded collectively as a “Care Bundle”. Care Bundles, when performed consistently and fully, have been clinically proven to improve patient outcomes.
The **ACS performance score** measures the percentage of patients who receive the full care bundle (equal to 0 if any measure is incomplete).

KSS Summary

ACS performance varies widely across participating trusts. For the reported period trusts clearly fall into high or low performing. ACS has increased over the course of the progra..

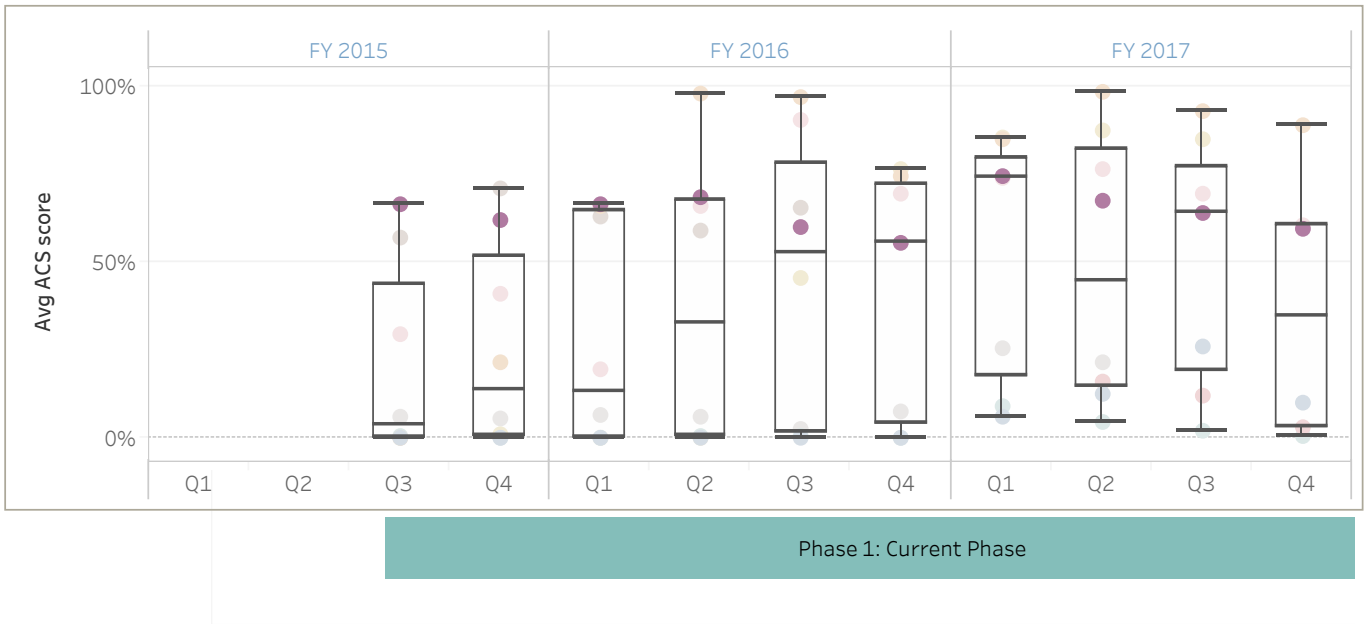
Trust Summary

MTW	Null



Map Date Range
December 2015 to January 2017

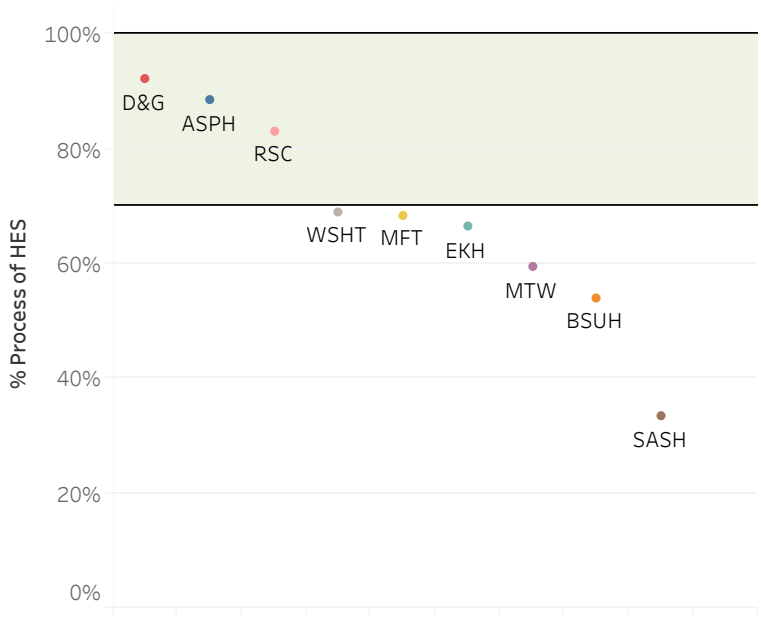
Performance Trend: the box plot shows the average ACS score over time (central horizonatal line) along with interquartile range and outliers. This gives a representation of the skew and the spread of the data.



Data Quality the key DQ indicator is calculated as the patients recorded as part of the process measures data set as a percentage of HES recorded patients. Variation in the DQ score is indicative of under-recording of process measures or differences in definition of patient diagnosis via coding.

Data Quality Scoring

The comparison is shown as an average over the duration of the pathway (since October 2014).
In line with NHS guidance on best practice tariffs*, trusts with a data quality indicator of below 70% are flagged as having a large proportion of missing data leading to unreliable trend analysis for process scores. Trusts with indicator above 100% are flagged as having atypical coding methods.



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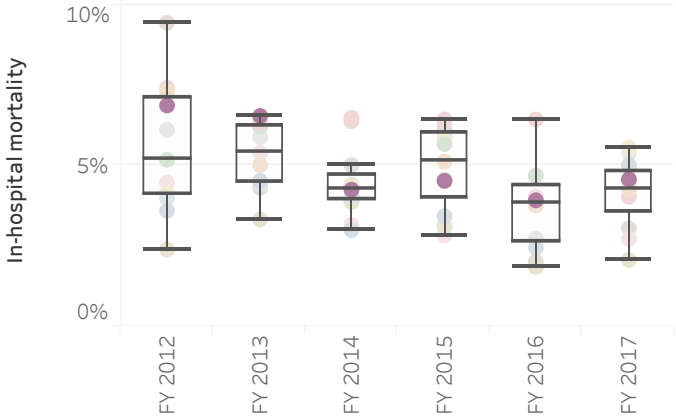
Page 5 & pages 30-32

In Hospital Mortality Rate has been derived from HES data and is calculated as the number of deaths over admissions with diagnosis codes for the pathway (code lists are available from KSS AHSN).

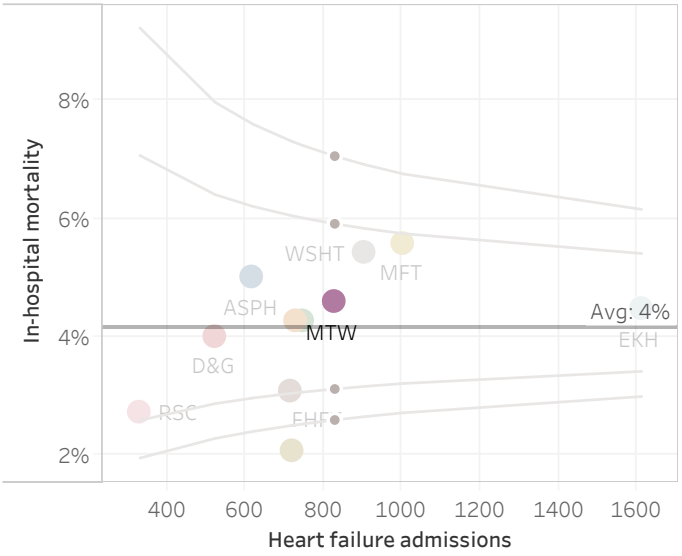
KSS Summary

Analysis

In-hospital mortality rates for COPD are low (compared other AHSN supported pathways), and have been falling over programme period.



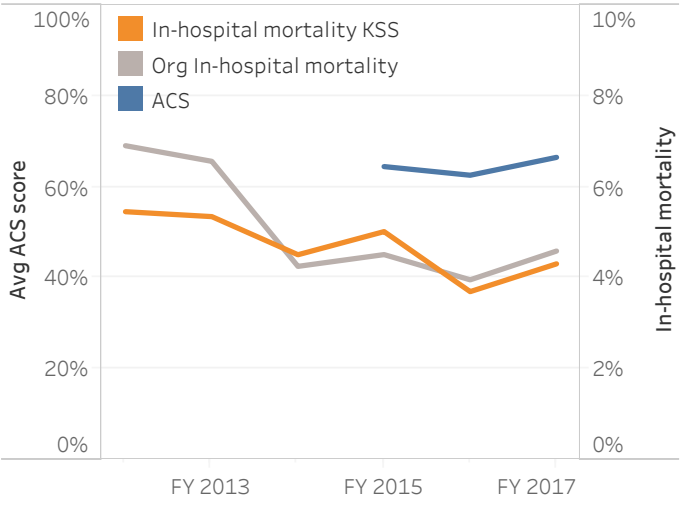
Funnel Plot Date Range
February 2016 to January 2017



Trust Insight

MTW Null

Exploring the Wider Context below the outcome trend at trust and regional level are plotted alongside the trust ACS. Other aspects of trust performance which are outlying are flagged below the chart.



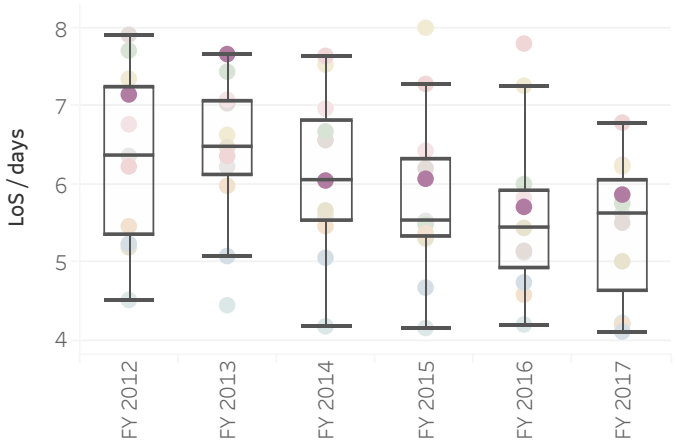
Trust	Context
MTW	Counter trend, Likewise trend in mortality, readmissions
	Likewise trend in mortality, readmissions

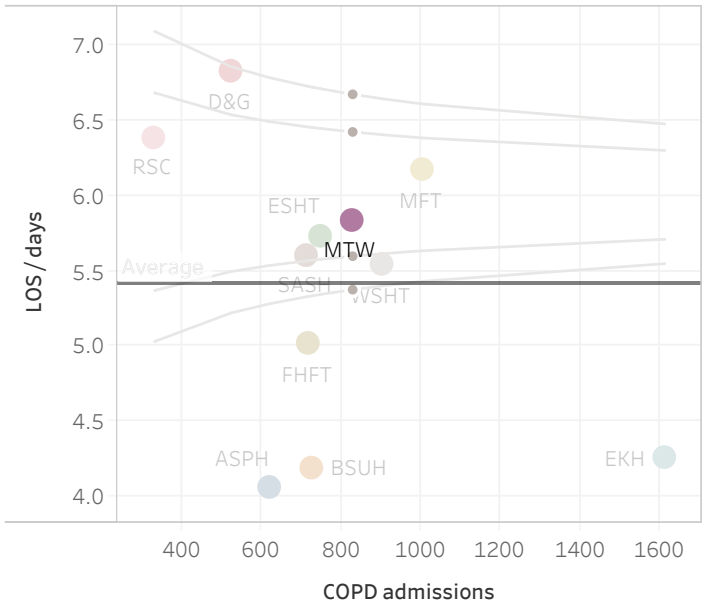
Length of Stay (LoS) has been derived from HES data and is calculated as the total bed days over admissions with diagnosis codes for the pathway (code lists are available from KSS AHSN)

KSS Summary

Analysis

For trusts who have performed above the KSS average, mean length of stay has fallen by 1.5 days since 2011. No trend is observed overall for trusts performing below the regional average for ACS. Across KSS, average length of stay was 1.05 days shorter tha

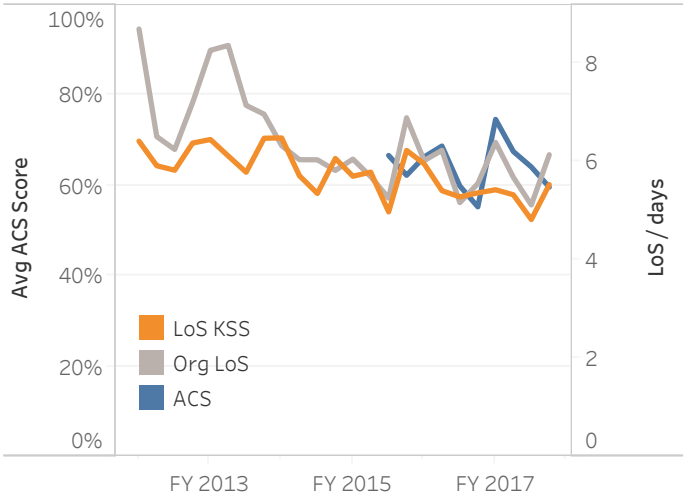




Trust Insight

MTW	Null

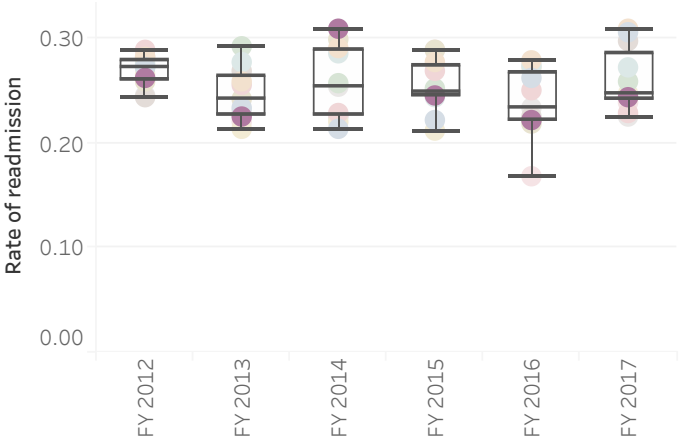
Exploring the Wider Context below the outcome trend at trust and regional level are plotted alongside the trust ACS. Other aspects of trust performance which are outlying are flagged below the chart.



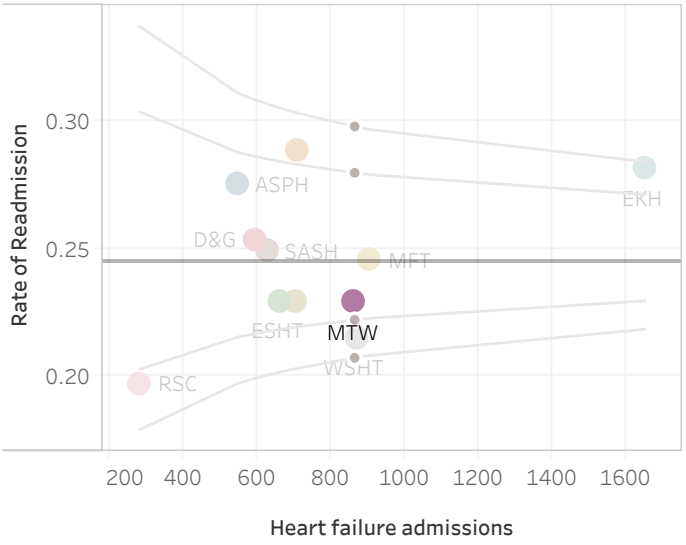
Trust	Context
MTW	Counter trend, Likewise trend in mortality, readmissions
	Likewise trend in mortality, readmissions

30 day readmission rates have been derived from HES data and are calculated as the no. of readmissions divided by the number of live discharges

KSS Summary

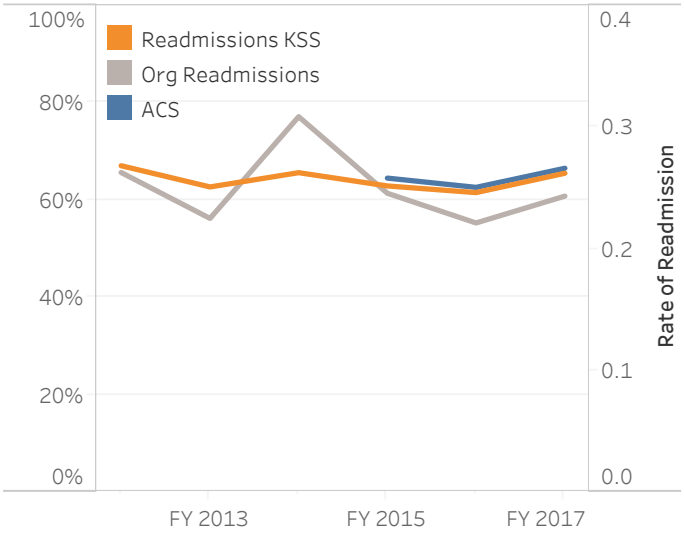


Funnel Plot Date Range
09/08/2015 00:00:00 to 01/07/2016 00:00:00



Exploring the Wider Context below the outcome trend at trust and regional level are plotted alongside the trust ACS. Other aspects of trust performance which are outlying are flagged below the chart.

Trust Insight



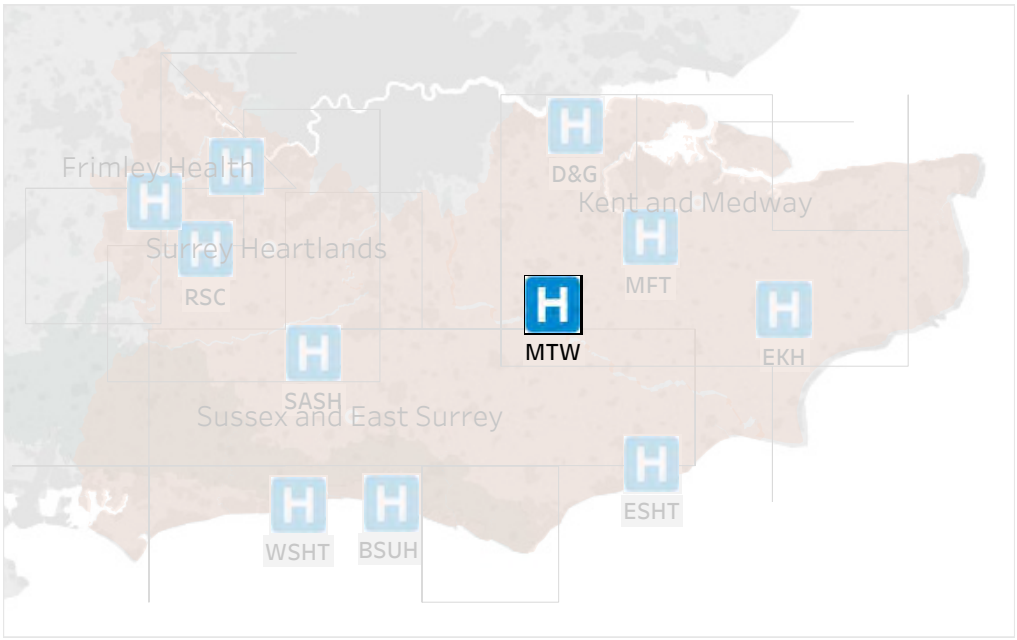
Trust	Context
MTW	Counter trend, Likewise trend in mortality, readmissions
	Likewise trend in mortality, readmissions

Urgent and Emergency Care

The Deteriorating Patient

Select Organisation Level

Trust



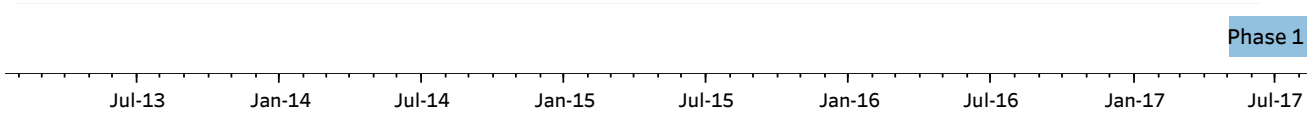
The Deteriorating Patient

KSS AHSN has recently merged its AKI and Sepsis work streams into the Deteriorating Patient work stream. The deteriorating patient is one of the new national Patient Safety Collaborative priorities.

Focus will be on deterioration across all care settings with the aim of improving recognition, escalation and management of the patient. At the same time we will strive to improve communication and safety netting to ensure increased safety across the healthcare system.

We recently launched our Breakthrough Series and as such have formed a Clinical Reference Group to help us deliver the programme. The work with AKI and Sepsis will continue to be supported.

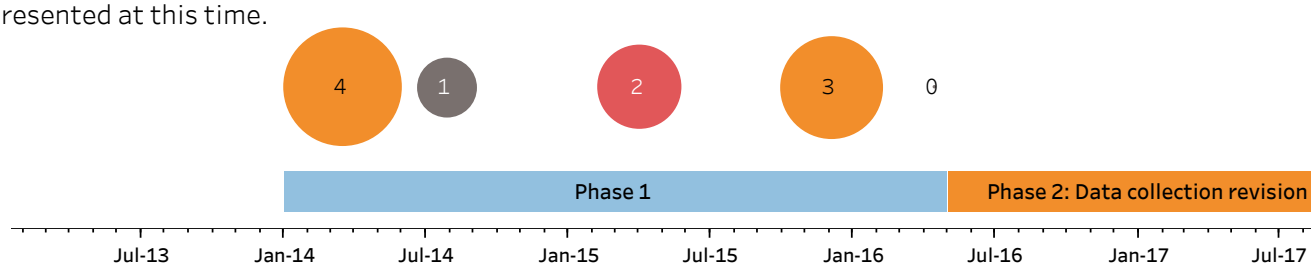
Organisation-level (acute) attendance to KSS Collaboratives are shown in the bubbles on the pathway timeline below.



Acute Kidney Injury

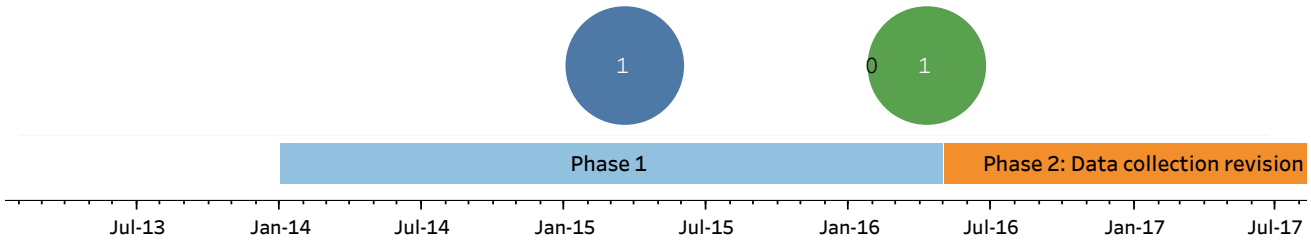
The principal aims of the AKI programme are 1. Improve recognition of AKI 2. Improve early management of patients with AKI 3. Improve knowledge in all staff groups.

Data collection against the pathway measures was interrupted when the Clarity data recording contract ended. A new partnership is planned with the UKRR with 3 trusts currently collecting process data with an aim of piloting new data linkages before the new model is rolled out across the region. Bundle uptake is not presented at this time.



Sepsis

We are working with providers to ensure rapid delivery of the Sepsis Six, a set of basic interventions that can double a patients chances of survival if delivered within an hour of diagnosis. The sepsis CQUIN underpinning intervention set was launched in 2015.



Incidence of AKI and Sepsis across Kent Surrey and Sussex

New diagnoses (both in-hospital and at point of admission) of AKI and Sepsis are counted at trust level from HES and are presented as a percentage of total trust adr

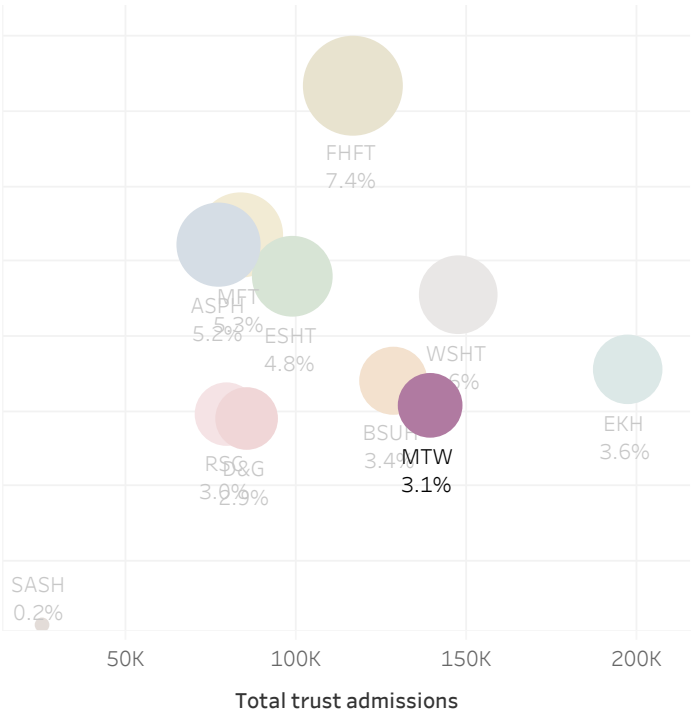
KSS Summary

There is a high incidence of AKI and sepsis in trusts across KSS. There has been an upward trend of recorded cases of both AKI and sepsis. This is expected to be an artefact of changes in recording practice, though it is noted that it is widely accepted that these conditions are still significantly under-recorded. Work is ongoing with NHS trusts to improve coding of sepsis from medical records.

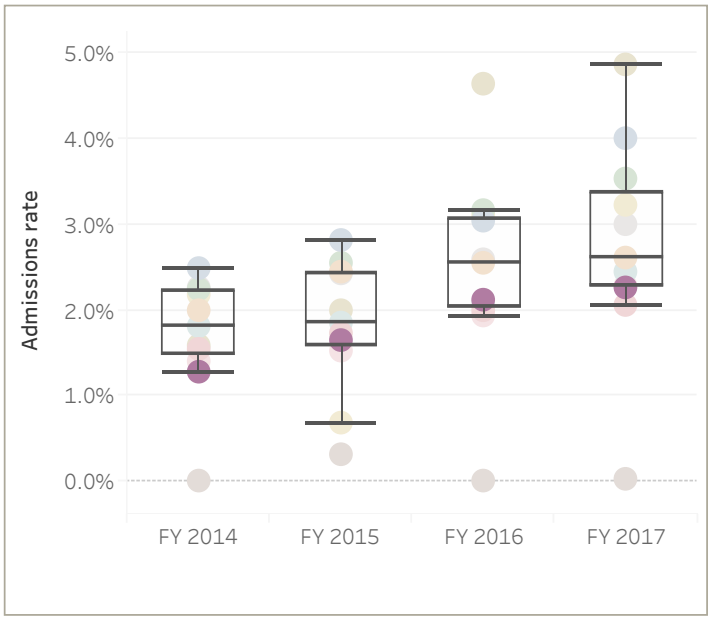
Trust Summary

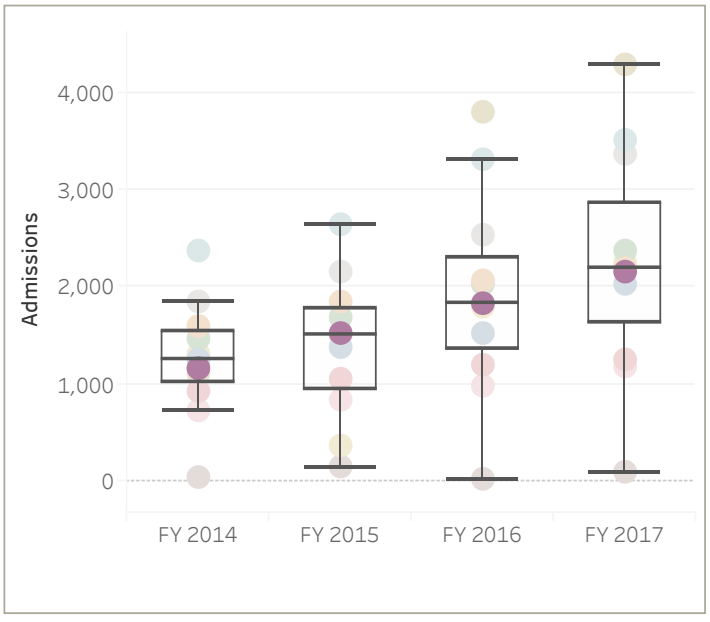
MFT	There was a significant drop in MFT admissions in 2015
SASH	AKI and HES not currently recorded in HES

Date range
January 2016 to January 2017



Admissions Trends: the box plots show the average admission rate / admissions over time (central horizonatal line) along with interquartile range and outliers. This gives a representation of the skew and the spread of the data.



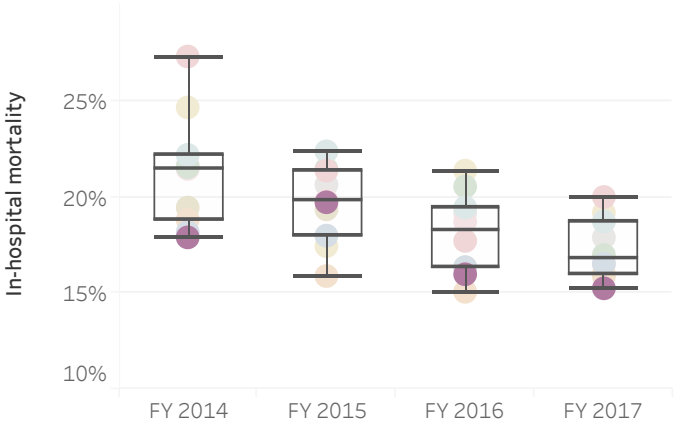


In Hospital Mortality Rate has been derived from HES data and is calculated as the number of deaths over admissions with diagnosis codes for the pathway (code lists are available from KSS AHSN).

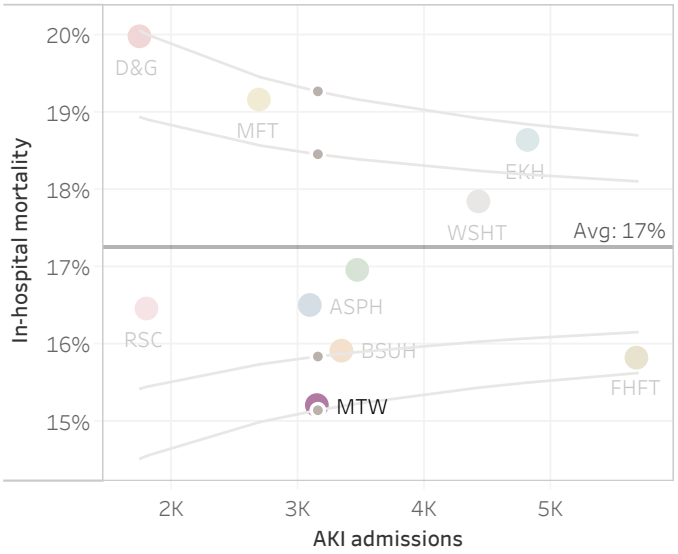
KSS Summary

AKI and Sepsis mortality have fallen over the course of the AHSN pathways. There is also a significant decreases in variation of mortality between trusts for AKI.

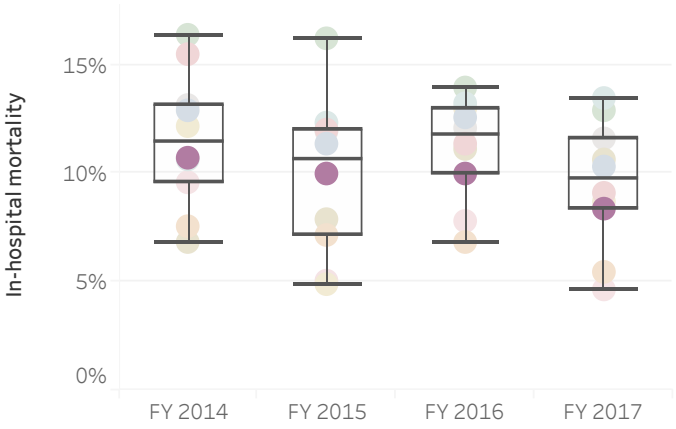
AKI In Hospital Mortality

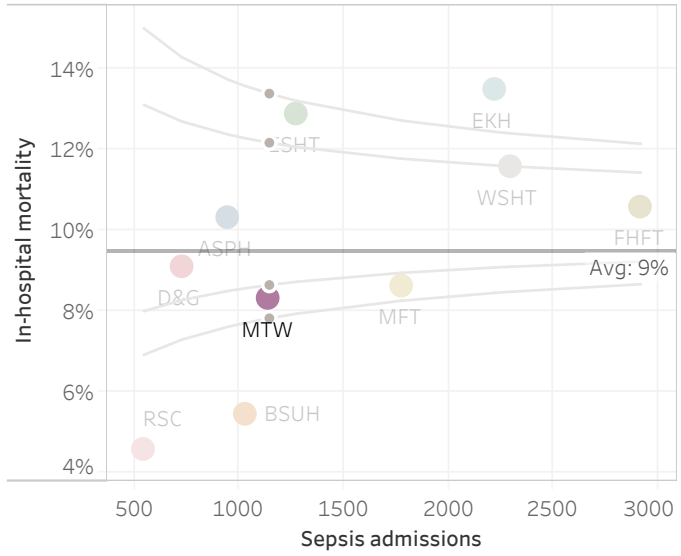


Funnel Plot Date Range
FY 2016 Q4 to FY 2017 Q4



Sepsis In Hospital Mortality





Trust Insight

EKH	Sepsis mortality has risen over the reported period

Length of Stay (LoS) has been derived from HES data and is calculated as the total bed days over admissions with diagnosis codes for the pathway (code lists are available from KSS AHSN)

KSS Summary

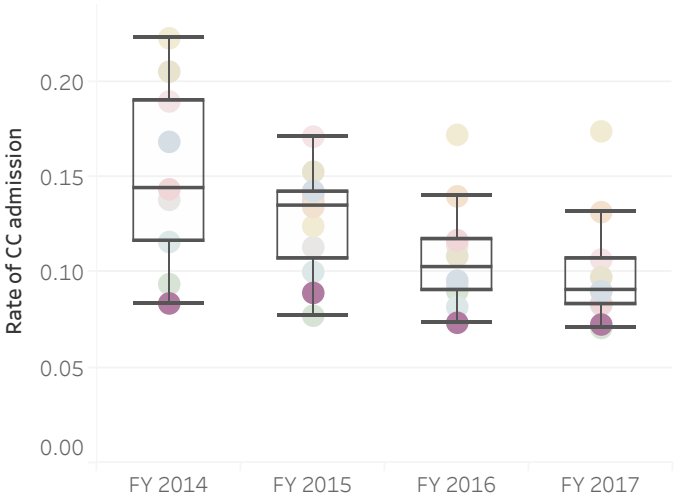
Measure to be revise to include only patients who have completed stay (to counter trend of decreasing mortality)..

Critical Care Admission rate have been derived from HES data and are calculated as the no. of readmissions divided by the number of live discharges

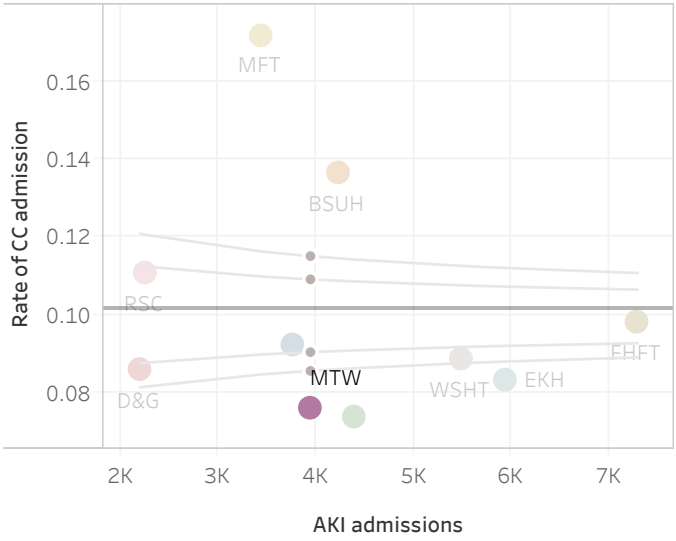
KSS Summary

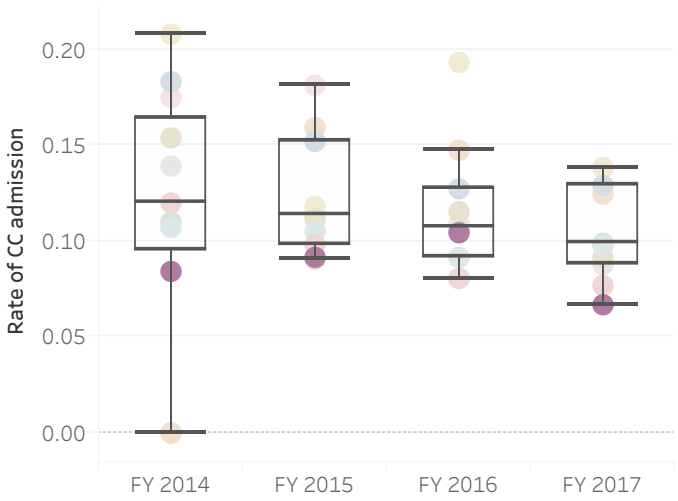
AKI and Sepsis critical care rates have fallen over the course of the AHSN pathways. There is also a significant decreases in variation of mortality between trusts for both pathways.

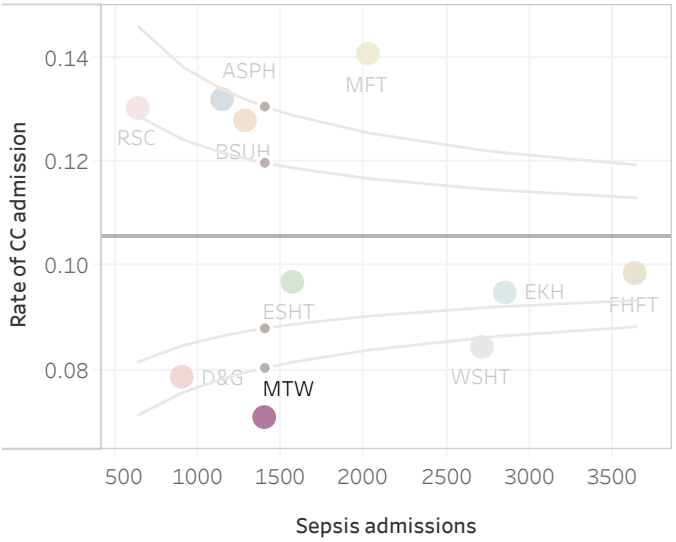
AKI Critical Care Admissions



Funnel Plot Date Range
01/01/2016 00:00:00 to 01/01/2017 00:00:00







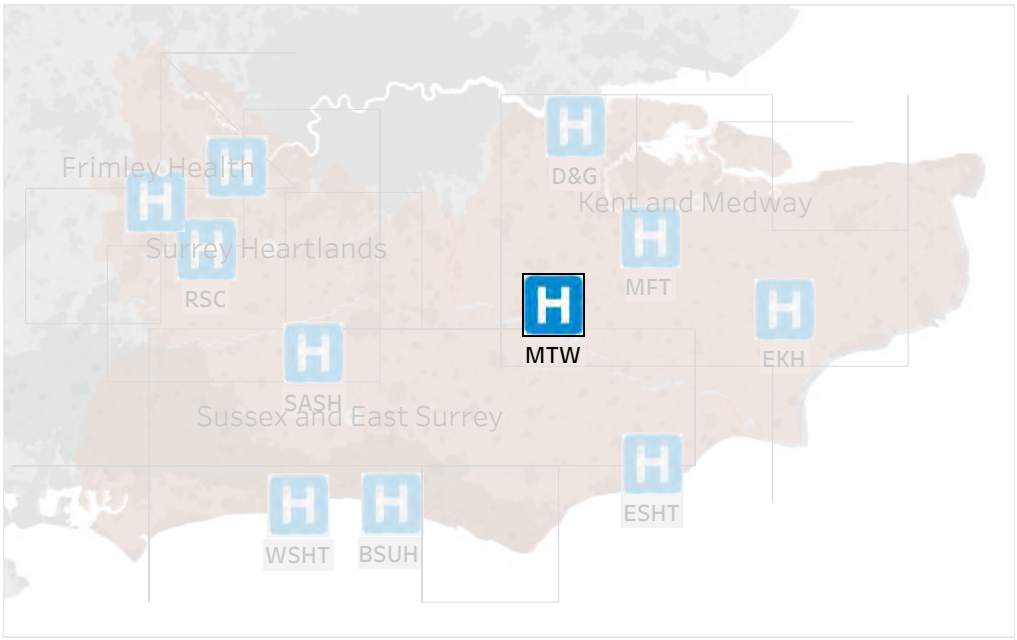
Trust Insight

BSUH	Critical care admissions were recorded as zero in 2014 for both AKI and sepsis
MFT	Critical care admissions are above average for AKI
SASH	SASH have been included from the plots below due to limited recording for AKI and spesis diagnoses (see admissions page).

Urgent and Emergency Care

Emergency Laparotomy Collaborative

Select Organisation Level
Trust

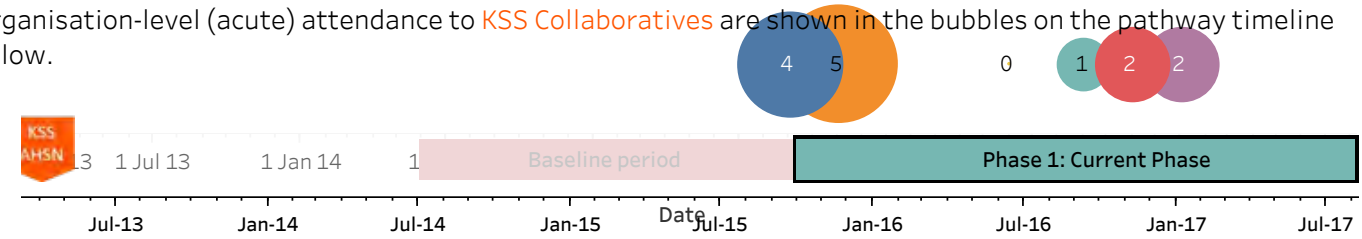


The Emergency Laparotomy Pathway

The Emergency Laparotomy Collaborative (ELC) is led by KSS AHSN and with a grant from the Health Foundation.

The importance of EL has been recognised following evidence of a high incidence of death, and a wide variation in the provision of care and mortality, for patients undergoing EL in hospitals across England and Wales [NELA].

Organisation-level (acute) attendance to KSS Collaboratives are shown in the bubbles on the pathway timeline below.



Care Bundle Measures - this pathway is a KSS Care Bundle. When performed consistently and fully, care bundles have been clinically proven to improve patient outcomes. Organisation specific uptake rates are shown below for each measure, against the KSS average.

Uptake of all measures has improved in the current phase in comparison to the baseline period, particularly and particularly the timeliness of surgery measure.

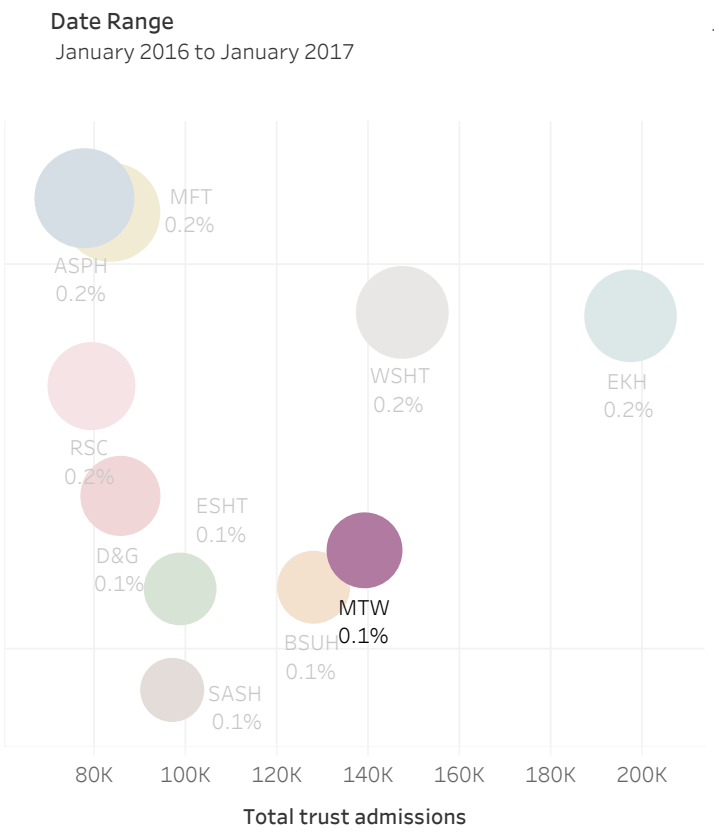
Measure	Description		Uptake Rate
Blood Lactate	All patients should be assessed in a timely manner and further measurements taken when clinically indicated	KSS	78%
		Org	82%
Consultant or Post-CCT Surgeon and Anaesthetі..	The highest risk cases should receive the highest level of care including having a senior surgeon and anaesthetist pr..	KSS	85%
		Org	78%
Critical Care for All Patients	Emergency surgical patients should receive priority to higher levels of post-operative care ahead of elective patie..	KSS	74%
		Org	92%
Goal Directed Fluid Therapy (GDFT)	A Cardiac Output Monitor should be available and should be used for emergency laparotomy cases	KSS	64%
		Org	87%
Timeliness of Surgery	Emergency theatre access should match patient need and prioritisation of access given to emergency surgical patien..	KSS	68%
		Org	60%
Timely Antibiotics	Emergency surgery patients should receive antibiotics to minimise the risk of infection	KSS	57%
		Org	59%

Emergency Laparotomy Admissions across Kent Surrey and Sussex

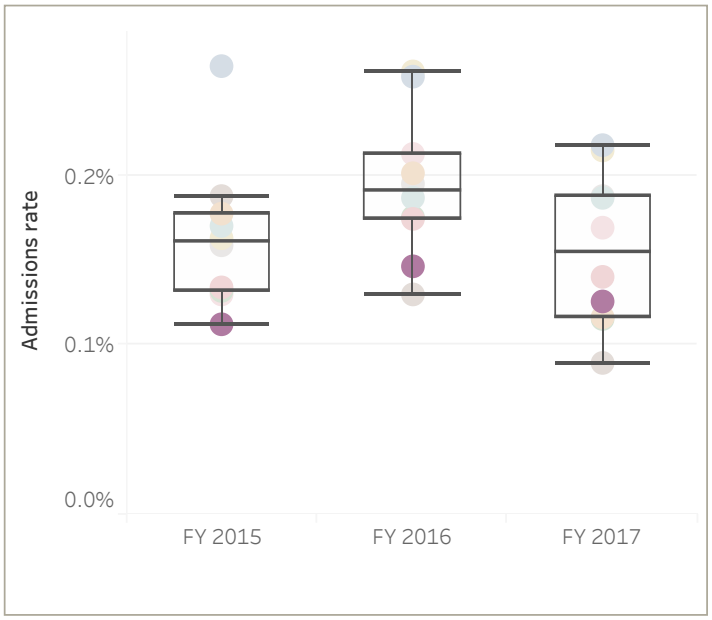
Admissions data are taken from NELA extracts and are presented as a percentage of total trust admissions and plotted against total trust admissions (taken from HES).

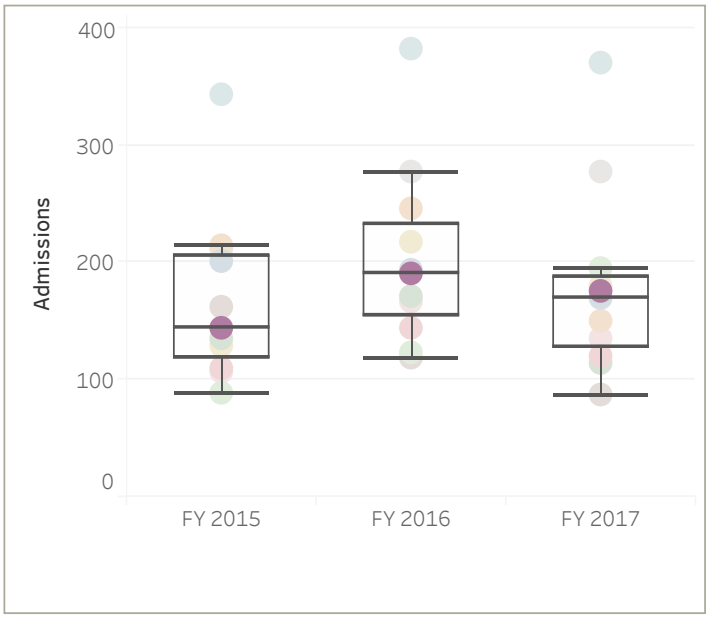
KSS Summary

Trust Summary



Admissions Trends: the box plots show the average admission rate / admissions over time (central horizonatal line) along with interquartile range and outliers. This gives a representation of the skew and the spread of the data.





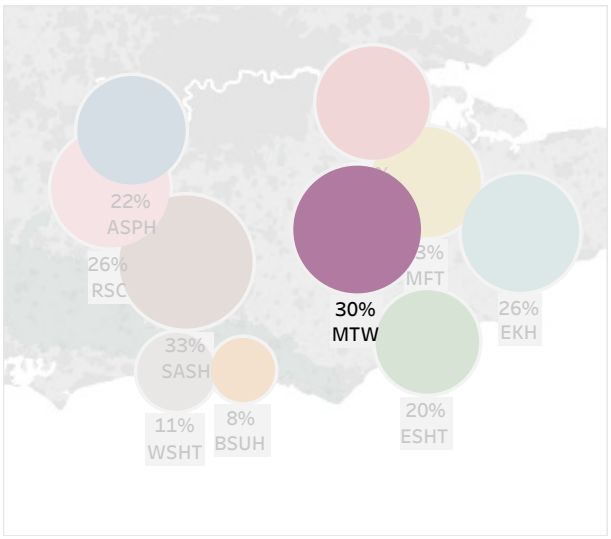
ACS Performance

The pathway provides most benefits when each of these measures is regarded collectively as a "Care Bundle". Care Bundles, when performed consistently and fully, have been clinically proven to improve patient outcomes.

The **ACS performance score** measures the percentage of patients who receive the full care bundle (equal to 0 if any measure is incomplete).

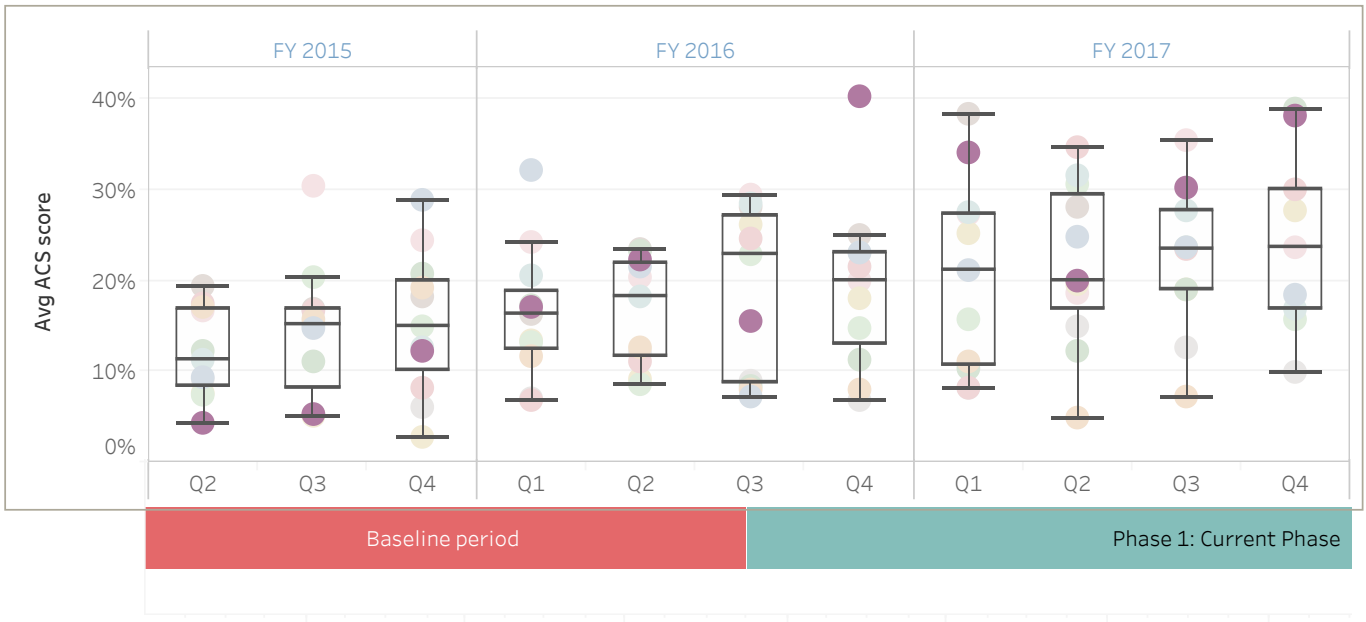
KSS Summary

Trust Summary



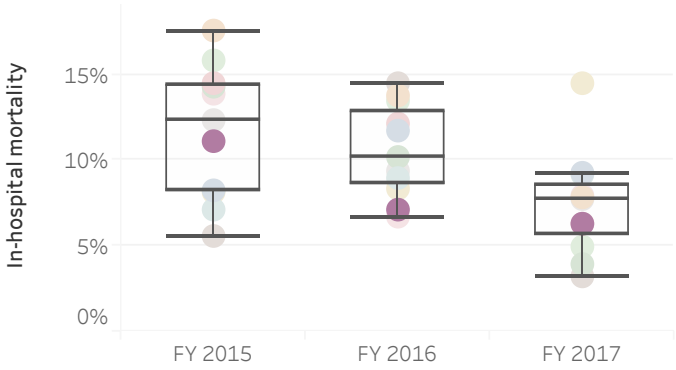
Map Date Range
January 2016 to January 2017

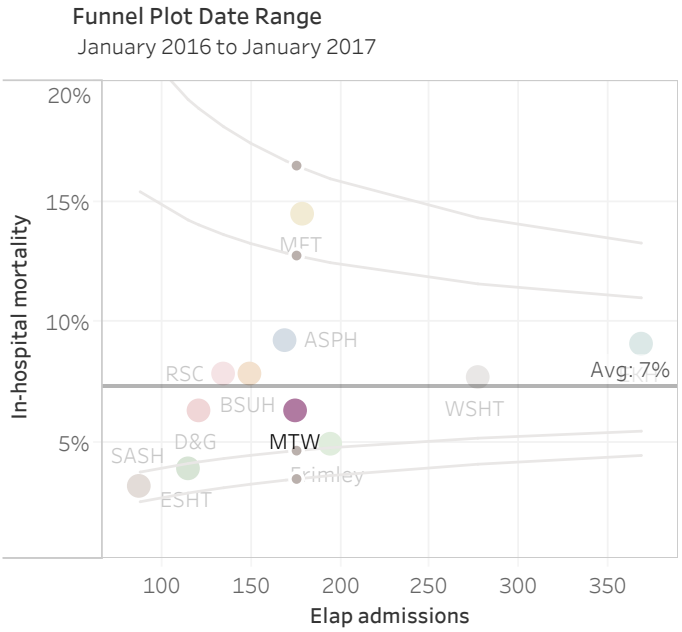
Performance Trend: the box plot shows the average ACS score over time (central horizonatal line) along with interquartile range and outliers. This gives a representation of the skew and the spread of the data.



In Hospital 30 Day Crude Mortality Rate

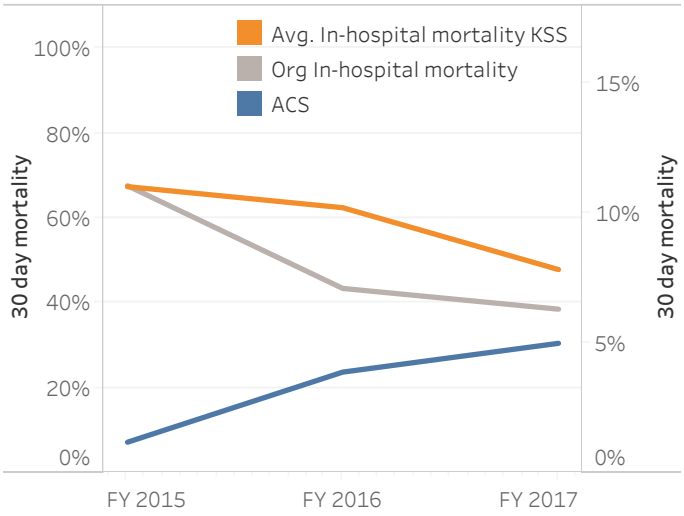
Due to expansive list of ICD-10 and OPCS codes used for ELap, HES data can not be used reliably to assess outcomes. All outcome data presented here has been submitte..





Trust Insight

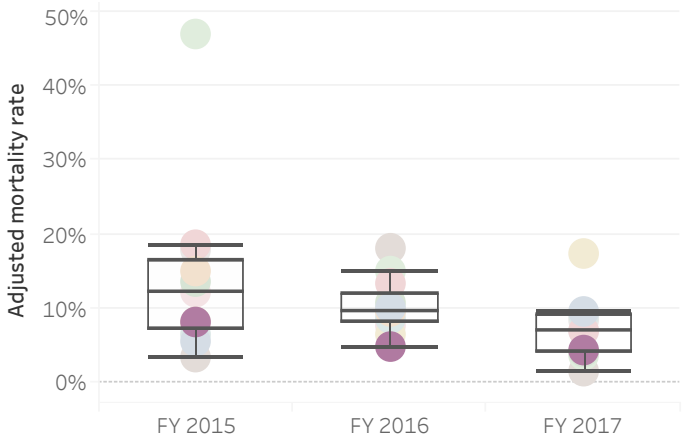
Exploring the Wider Context below the outcome trend at trust and regional level are plotted alongside the trust ACS. Other aspects of trust performance which are outlying are flagged below the chart.



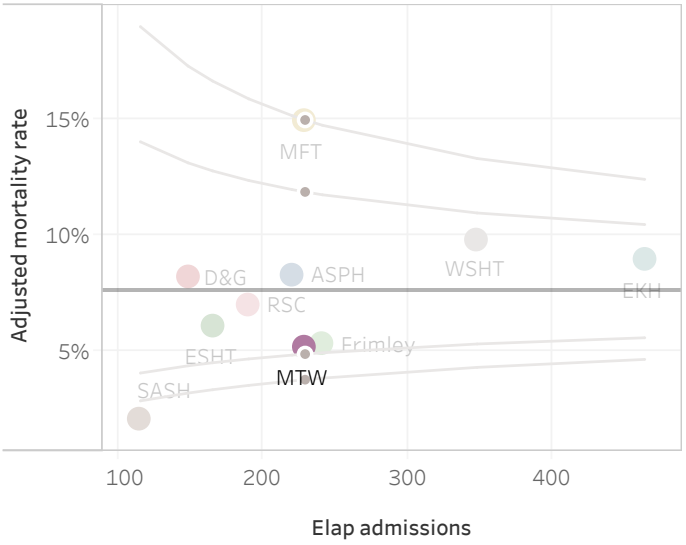
PreOp Risk Adjusted Mortality Rate

Due to expansive list of ICD-10 and OPCS codes used for ELap, HES data can not be used reliably to assess outcomes. All outcome data presented here has been submitted by t..

KSS Summary

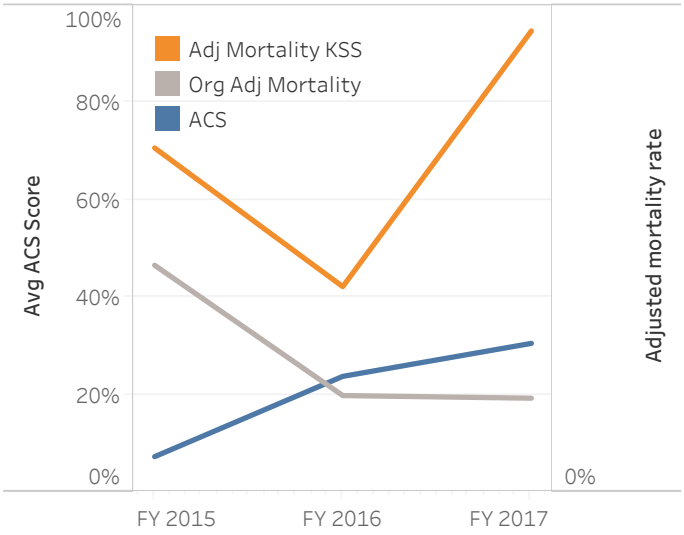


Funnel Plot Date Range
01/01/2016 00:00:00 to 01/01/2017 00:00:00



Exploring the Wider Context below the outcome trend at trust and regional level are plotted alongside the trust ACS. Other aspects of trust performance which are outlying are flagged below the chart.

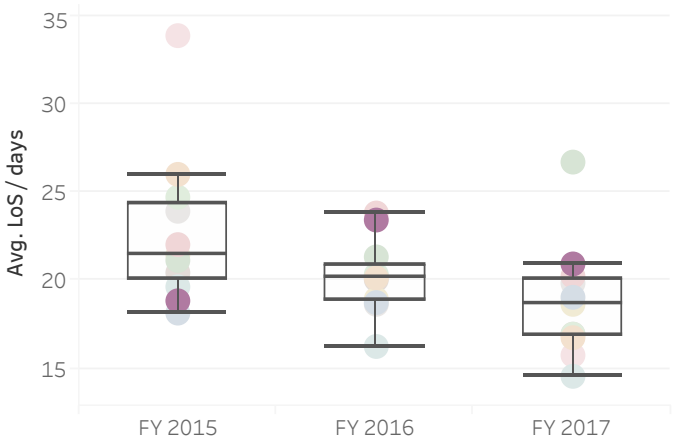
Trust Insight

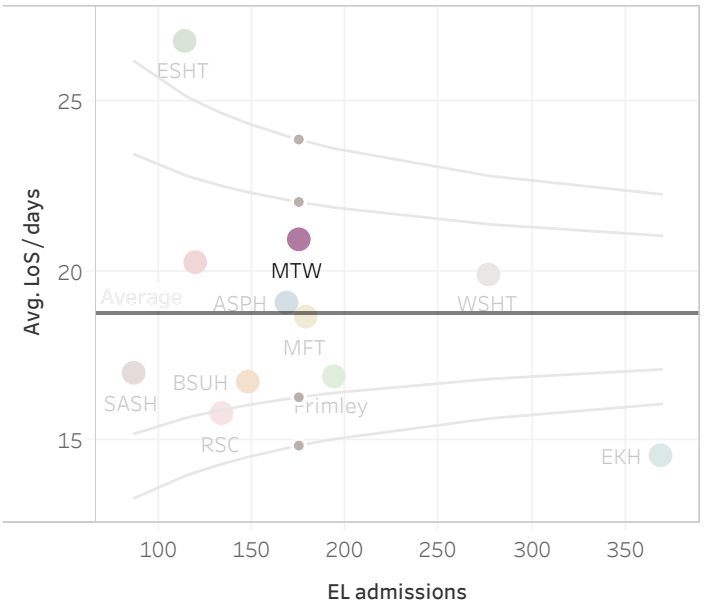


Length of Stay (LoS) has been derived from HES data and is calculated as the total bed days over admissions with diagnosis codes for the pathway (code lists are available from KSS AHSN) ..

KSS Summary

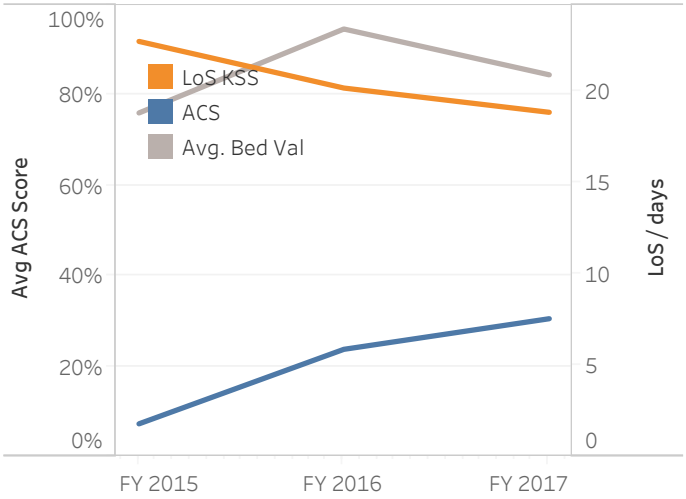
Note LoS will be revised to include only patients who have completed stay (to counter trend of decreasing mortality)





Exploring the Wider Context below the outcome trend at trust and regional level are plotted alongside the trust ACS. Other aspects of trust performance which are outlying are flagged below the chart.

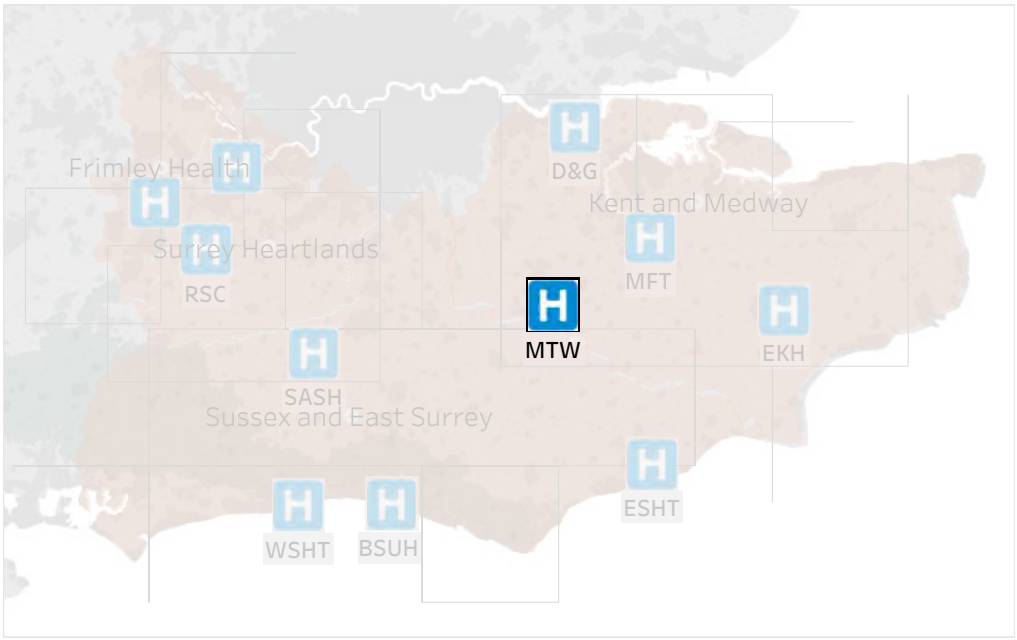
Trust Insight



Care of Older People

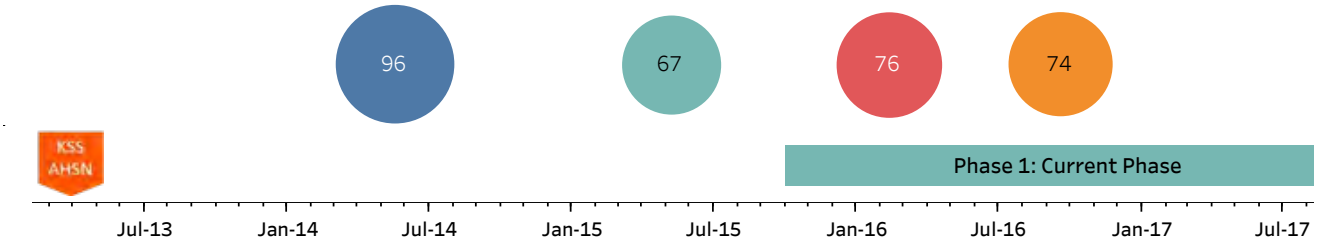
Fracture Neck of Femur (#NOF)

Select Organisation Level
Trust



The Fractured Neck of Femur Pathway

The Fractured Neck of Femur (#NOF) pathway went live in October 2015. Measures have been selected in line with BGS and NICE guidelines and are designed to ensure the patient recovers and quickly and as fully as possible.
Organisation-level (acute) attendance to KSS Collaboratives are shown in the bubbles on the pathway timeline below.



Care Bundle Measures - this pathway is a KSS Care Bundle. When performed consistently and fully, care bundles have been clinically proven to improve patient outcomes.
Organisation specific uptake rates are shown below for each measure against the KSS average.
These are averaged over the phase selected in the timeline above.

Measure	Description	Uptake Rate
4AT @ 4-7 days Post-Operative	Was the 4AT score measured between 4-7 days post-operatively?	41%
4AT @ 24-36 hrs Post-Operative	Was the 4AT score measured between 24-36 hours post-operatively?	50%
Dynamic Pain Score	Was the patients dynamic pain score measured during initial assessment using a validated scale?	47%
Initial Physiotherapy Goals Set	Were initial physiotherapy goals set within 24 hours?	68%
IV Paracetamol	Was Intravenous paracetamol given?	62%
Patient Able to Stand Day One	Was the patient able to stand on day one post operatively?	67%
Post-Operative Pain Measured	Was post operative pain measured reviewed and documented daily for the first week?	68%
Pre-operative Nerve Block	Did the patient have a Fascio-iliaca compartment block, or femoral nerve block, pre operatively?	27%
Pre-Operative NHFS	Was the Nottingham Hip Fracture Score recorded pre-operatively?	49%
		0% 50% 100%

Fractured Neck of Femur Admissions across Kent Surrey and Sussex

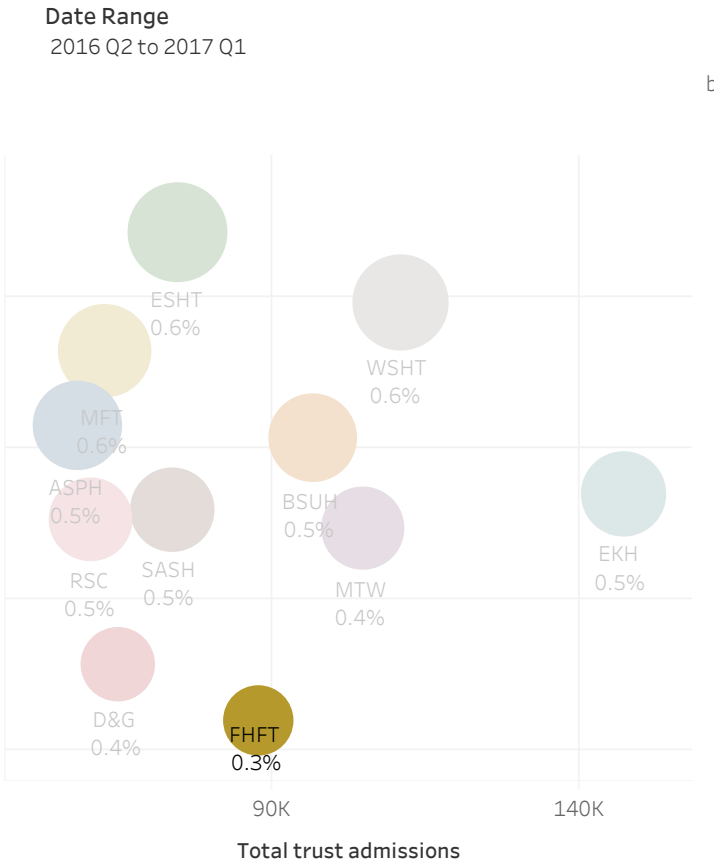
Admissions data are taken from HES and are presented as a percentage of total trust admissions and plotted against total trust admissions.

KSS Summary

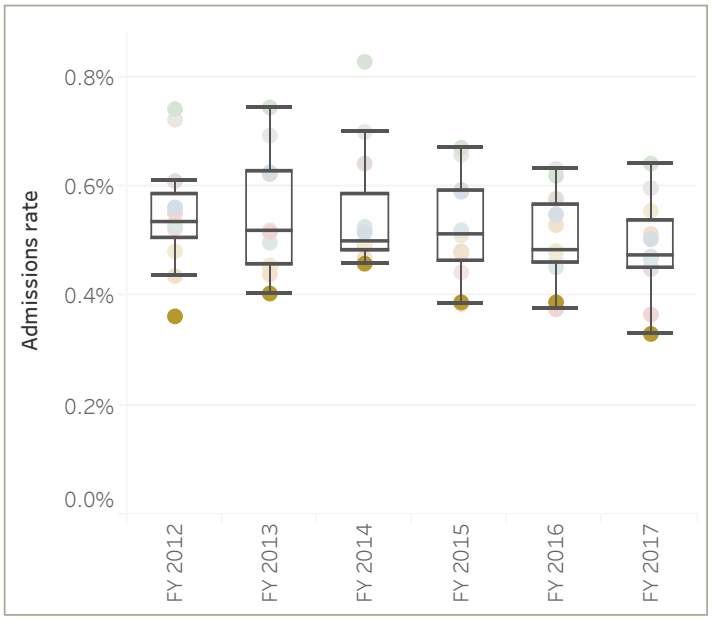
KSS #NOF admission rate has shown a slight downward trend since 2011. Actual admissions have risen since 2011 but have been relatively stable since 2014.

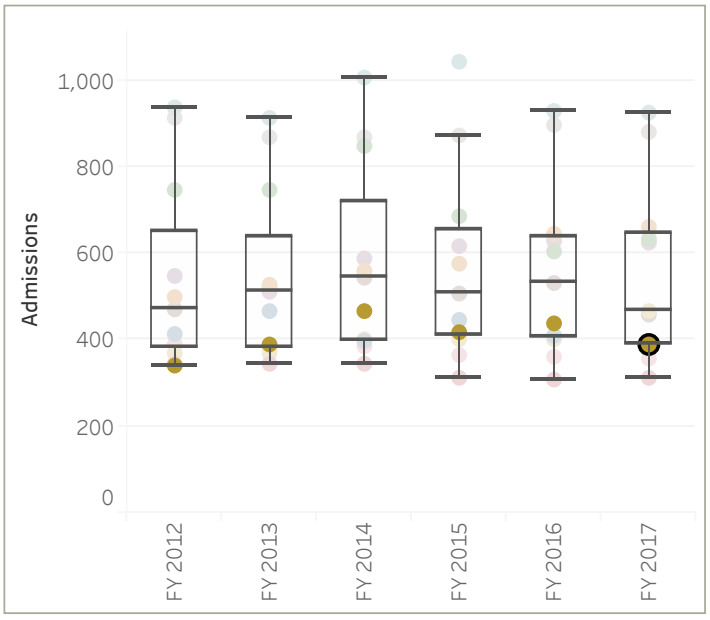
Trust Summary

ASPH	There has been little variation in admissions since 2011 (typically just over 100 per year)
BSUH	Admissions rose above the regional average i 2015
D&G	Number of admissions has been stable since 2011 (typically just under 100 per year)
EKH	Admissions per year average at 240 #NOF patients
ESHT	After a peak in #NOF admissions in 2013 ther has since been a notable decline



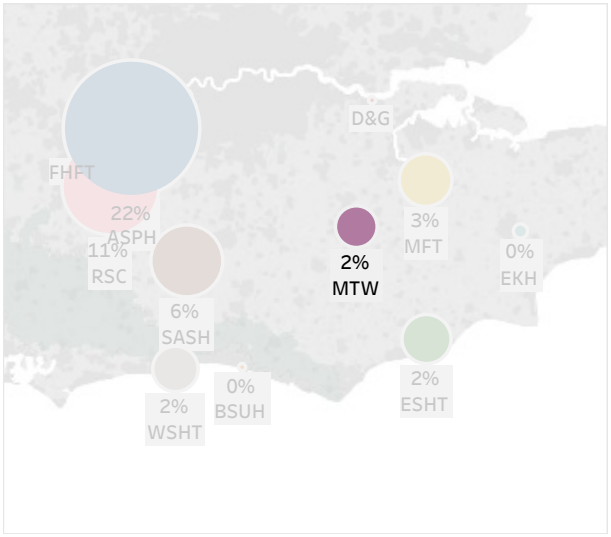
Admissions Trends: the box plots show the average admission rate / admissions over time (central horizonatal line) along with interquartile range and outliers. This gives a representation of the skew and the spread of the data.





ACS Performance The pathway provides most benefits when each of these measures is regarded collectively as a "Care Bundle". Care Bundles, when performed consistently and fully, have been clinically proven to improve patient outcomes.
The **ACS performance score** measures the percentage of patients who receive the full care bundle (equal to 0 if any measure is incomplete).

KSS Summary

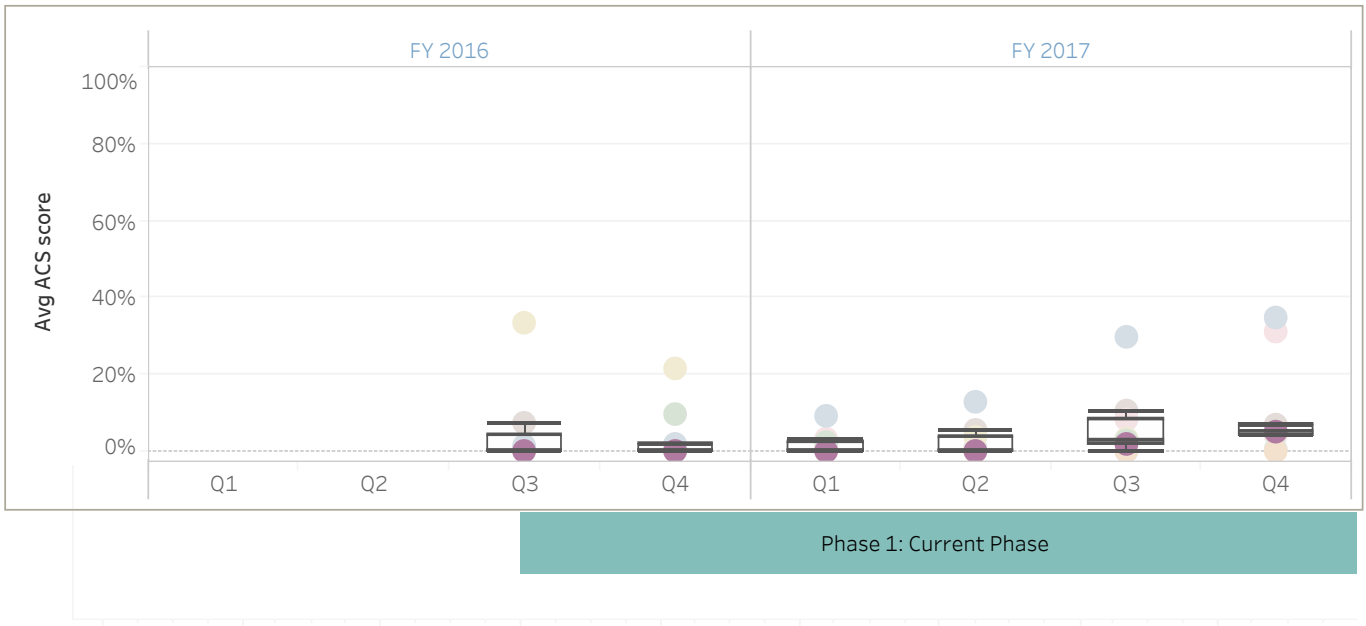


Map Date Range
FY 16 to FY 17
and Null values

Trust Summary

ASPH	Null
BSUH	Null
D&G	Null
EKH	Null
ESHT	Null

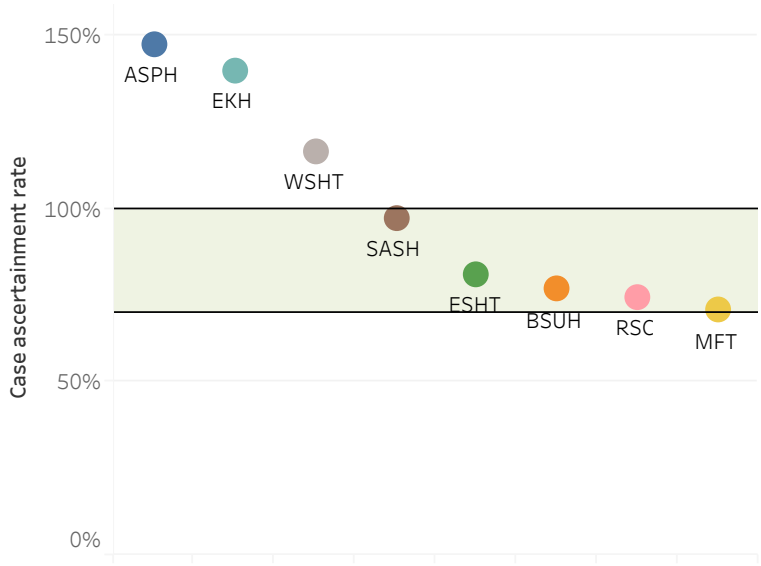
Performance Trend: the box plot shows the average ACS score over time (central horizonatal line) along with interquartile range and outliers. This gives a representation of the skew and the spread of the data.



Data Quality the key DQ indicator is the **case ascertainment rate** and is calculated as the patients recorded as part of the process measures data set as a percentage of HES recorded patients. Variation in the DQ score is indicative of under-recording of process measures or differences in definition of patient diagnosis via coding.

Data Quality Scoring

The comparison is shown as an average over the duration of the pathway (since October 2015).
In line with NHS guidance on best practice tariffs*, trusts with a data quality indicator of below 70% are flagged as having a large proportion of missing data leading to unreliable trend analysis for process scores. Trusts with indicator above 100% are flagged as having atypical coding methods.



Comments the proportion of trusts with a case ascertainment rate above the acceptable range is notably greater than other trusts.

Improving Data Quality further scoring for programme-specific data quality is currently under-development.

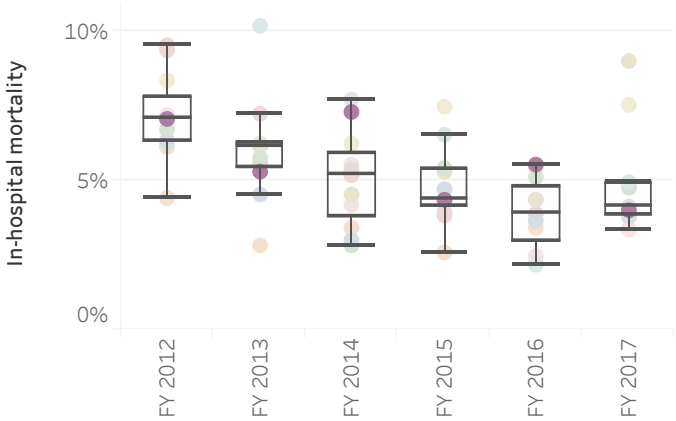
* https://improvement.nhs.uk/uploads/documents/Annex_F_guidance_on_best_pratice_tariffs.pdf
Page 5 & pages 30-32

In Hospital Mortality Rate has been derived from HES data and is calculated as the number of deaths over admissions with diagnosis codes for the pathway (code lists are available from KSS AHSN).

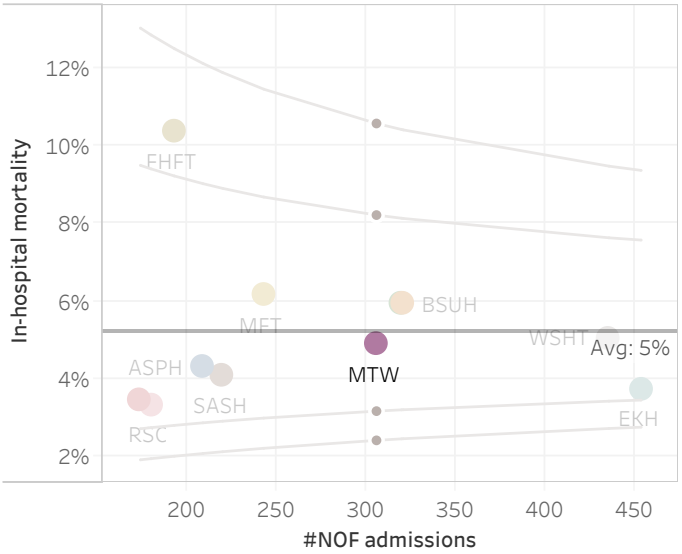
KSS Summary

Analysis

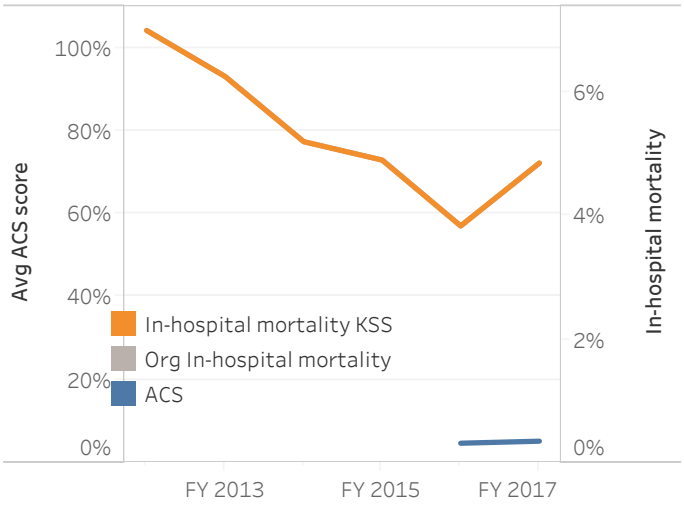
Average mortality for the KSS region has fallen by 3% since 2011. Variation in mortality between KSS trusts has reduced since the #NOF pathway began



Funnel Plot Date Range
FY 17 to FY 17



Exploring the Wider Context below the outcome trend at trust and regional level are plotted alongside the trust ACS. Other aspects of trust performance which are outlying are flagged below the chart.



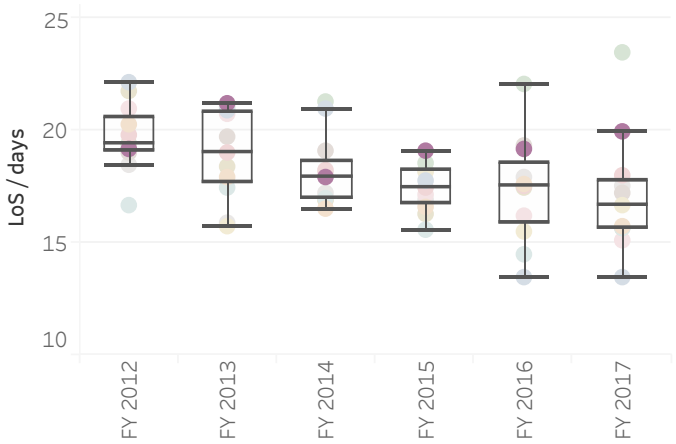
Trust Insight

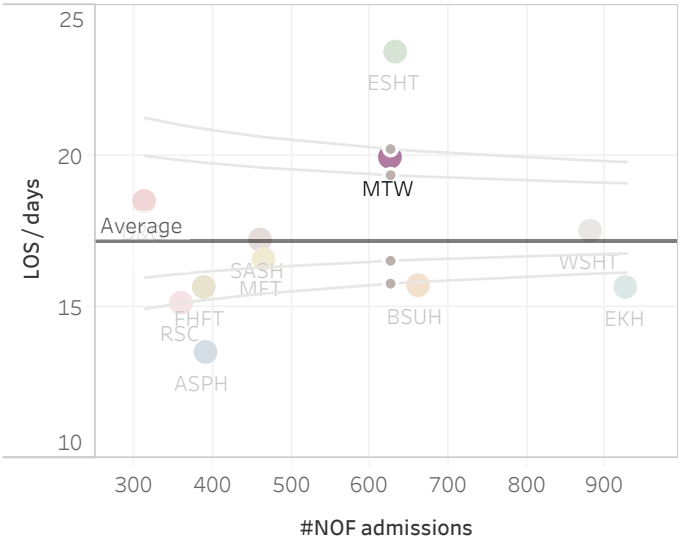
ASPH	For the last quarter of the 16/17 FY, mortality ha been high for the region at 6%
BSUH	Since 2015 mortality has risen steeply to 6%
D&G	Mortality was 10% in 2011 but has since fallen t be below the regional average
EKH	Mortality has fallen significantly since 2011 and was the lowest in the region for the last quarter of the 16/17 FY
ESHT	Since 2015 mortality has risen to 6%

Length of Stay (LoS) has been derived from HES data and is calculated as the total bed days over admissions with diagnosis codes for the pathway (code lists are available from KSS AHSN)

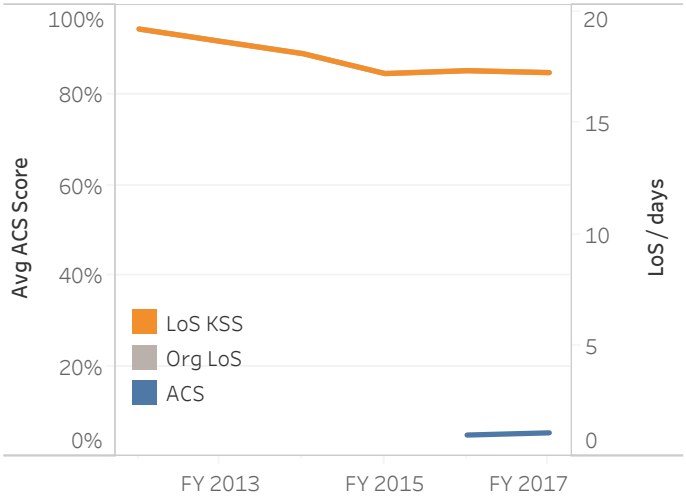
KSS Summary

Measure to be revise to include only patients who have completed stay (to counter trend of decreasing mortality)





Exploring the Wider Context below the outcome trend at trust and regional level are plotted alongside the trust ACS. Other aspects of trust performance which are outlying are flagged below the chart.



Trust Insight

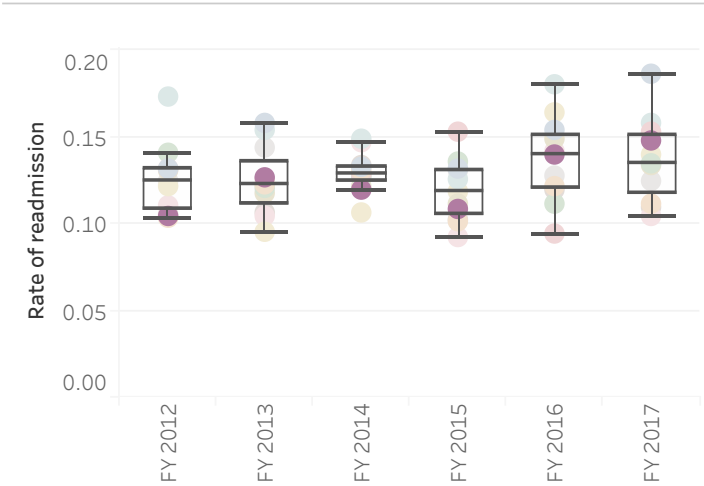
ASPH	Length of stay has dropped from 22 days in 2011 to 13 days in 2016
BSUH	Length of stay has fallen since the beginning of the reporting period but has been variable since 2014
D&G	Length of stay has been variable
EKH	Length of stay has been continuously below the regional average
ESHT	Length of stay has risen from 19 days in 2014 to 23 days in 2016
MFT	Length of stay has been variable

30 day readmission rates have been derived from HES data and are calculated as the no. of readmissions divided by the number of live discharges

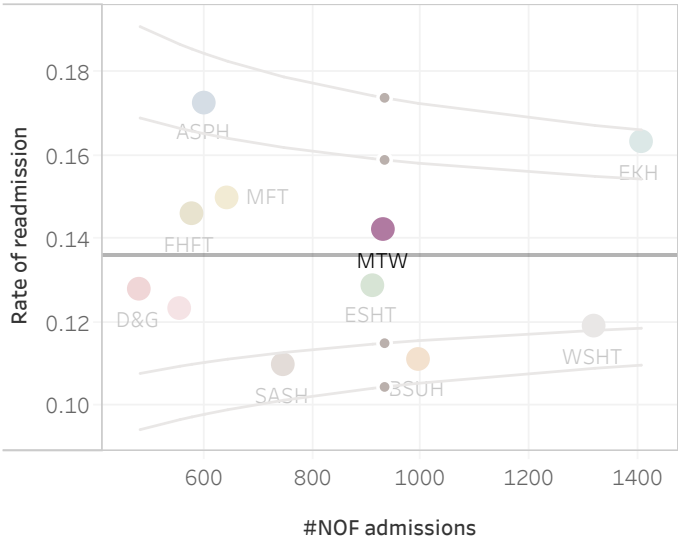
KSS Summary

Analysis

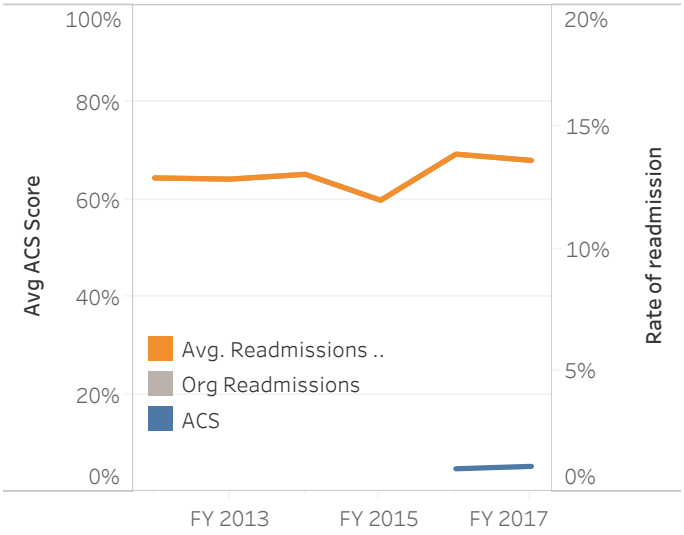
Null



Funnel Plot Date Range
FY 16 to FY 17



Exploring the Wider Context below the outcome trend at trust and regional level are plotted alongside the trust ACS. Other aspects of trust performance which are outlying are flagged below the chart.



Trust Insight

ASPH	Readmission rate increased from 14% in 2014 to 18% in 2017, this is a significant increase compared to the regional trend
BSUH	The BSUH rate has been variable but typically below average
D&G	The D&G rate has been variable but close to the average
EKH	The EKH rate has fallen over the last few years but has been consistently above the regional average
ESHT	Readmission rate has been variable

Trust Board meeting – October 2017

NHS Maidstone and Tunbridge Wells NHS Trust

10-13	Quarterly mortality data (inc. Policy for Undertaking Mortality Case Record Reviews)	Medical Director

Summary / Key points

This report is submitted in line with guidance from the National Quality Board, March 2017. This stipulates that Trusts are required to collect and publish on a quarterly basis specified information on deaths. This should be through a paper and an agenda item to a public board meeting in each quarter to set out the Trust's policy and approach (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 is based upon the Trust's most recent data, published by Dr Foster for the period of July 2016 – June 2017.

Which Committees have reviewed the information prior to Board submission?

▪

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

Information, assurance and discussion

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

Mortality Surveillance Report

1. Hospital Standardised Mortality Ratio (HSMR)

The HSMR is a calculation used to monitor death rates in a trust. The HSMR is based on a subset of diagnoses which give rise to around 80% of in-hospital deaths. HSMRs are based on the routinely collected administrative data often known as Hospital Episode Statistics (HES), Secondary Uses Service Data (SUS) or Commissioning Datasets (CDS).

Measuring hospital performance is complex. Dr Foster understands that complexity and is clear that HSMRs should not be used in isolation, but rather considered with a basket of other indicators that give a well-rounded view of hospital quality and activity.

a. HSMR Current Performance

The standard HSMR calculation uses a 12 month rolling view of our performance. The latest results of this are shown below in Fig. 1. The 12 months July 2016 to June 2017 show our HSMR to be 104.6, which is an improved position from 106.2 reported last month.

Figure 1. Rolling 12 Month view

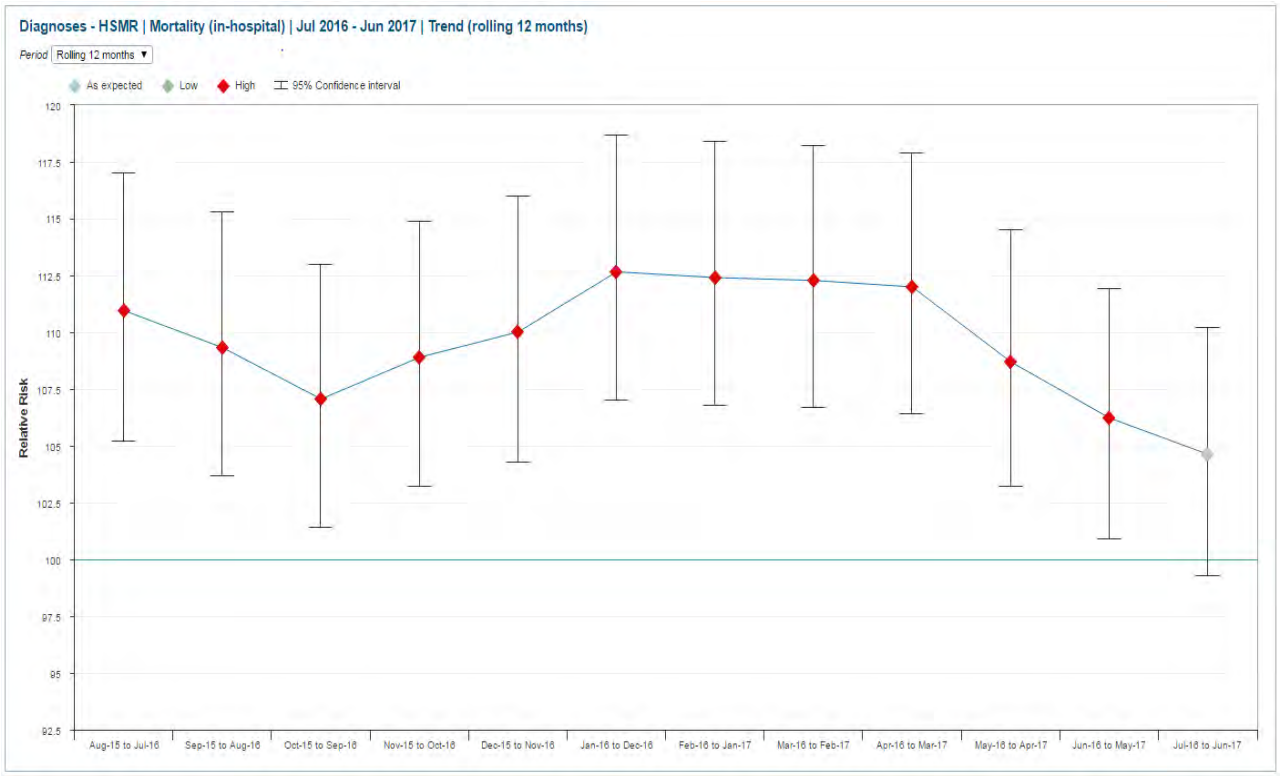
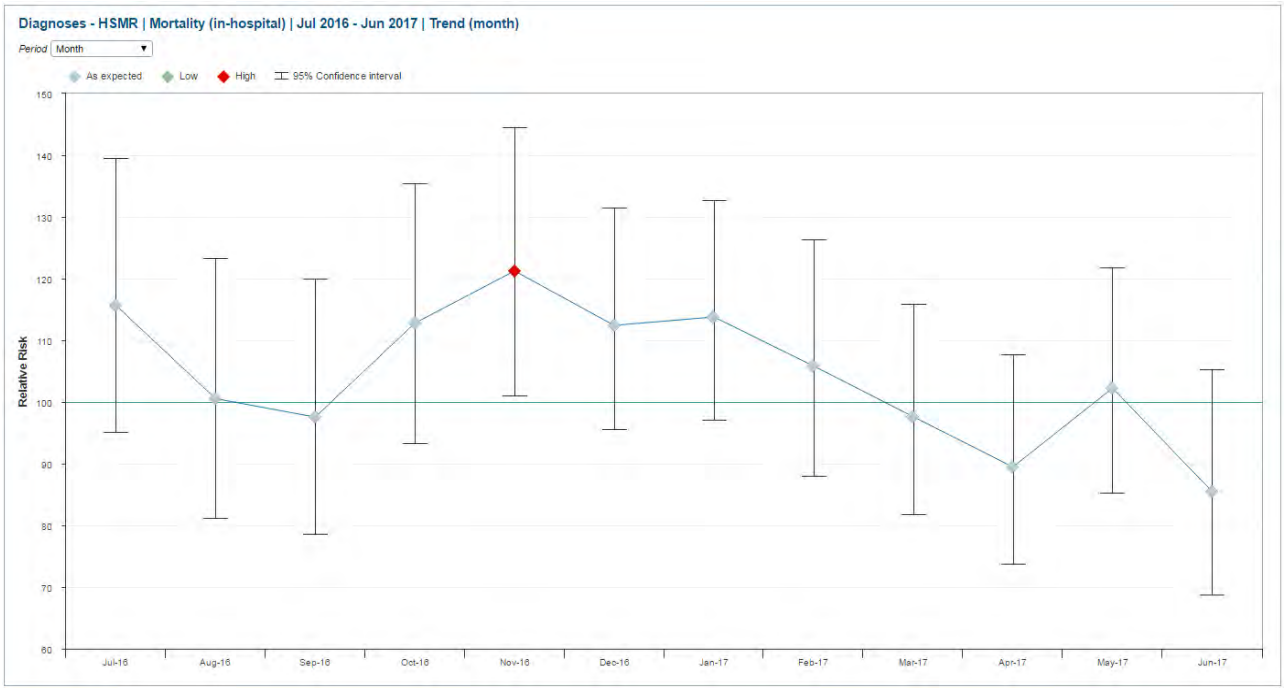


Figure 2. Presents a monthly view of our HSMR performance, which also demonstrates a reduction from November 2016. The latest month should be viewed with caution as this often shows a false position due to the lag in coding activity. Despite the increase in May this still demonstrates an acceptable position in line with Dr Foster standards.

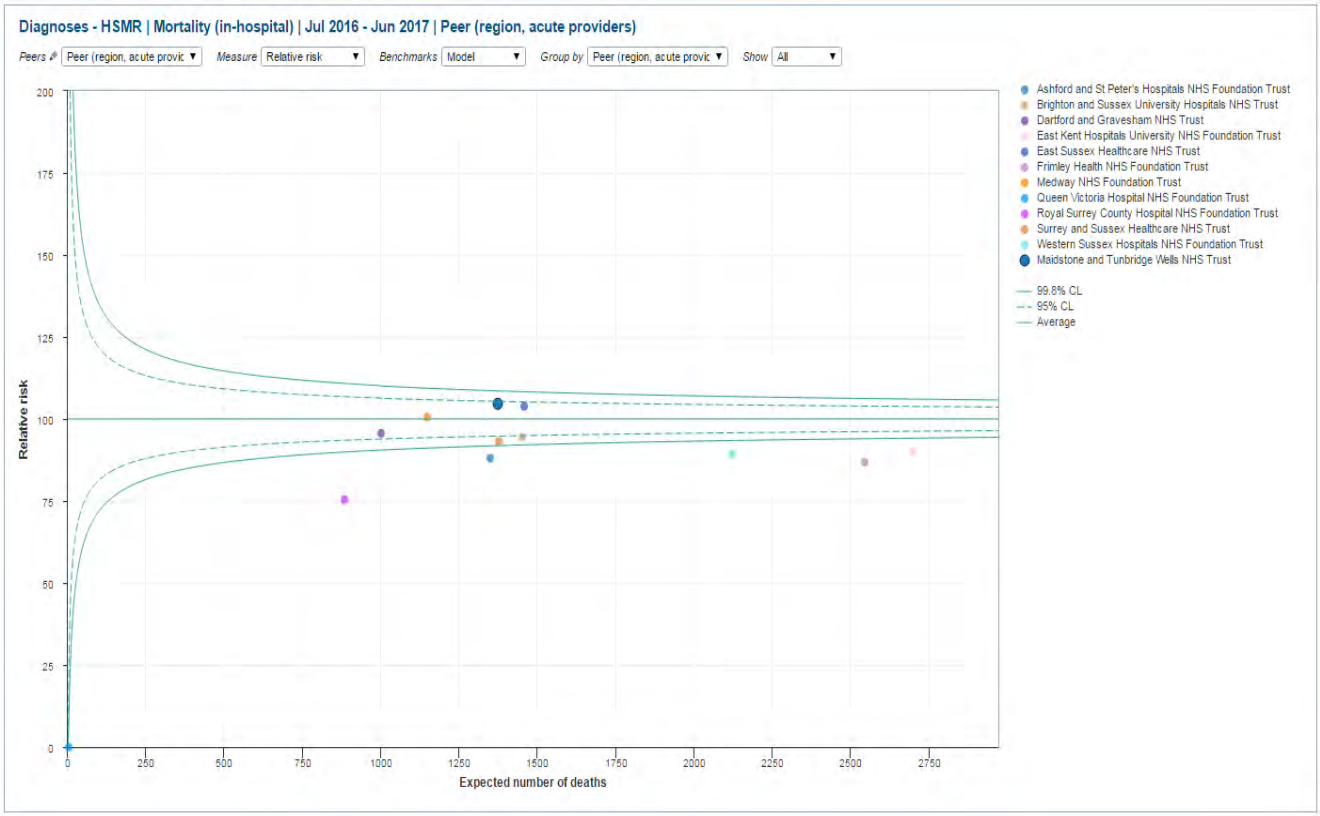
Figure 2. Monthly view



b. Benchmarking

Dr Foster also enables us to benchmark our performance against our peers. There are various peer groups available e.g. GIRFT and Carter groups, but our local acute peers have been selected below in Fig. 3. This demonstrates the Trust to be an outlier against this group, with only East Sussex having a worse position for this period.

Figure 3. Benchmarking against our regional acute peers



Understanding and Improving upon a high HSMR

Guidance from Dr Foster has been instrumental in directing the work of the Mortality Surveillance Group (MSG). In line with this progress has been made, and continues in regard to:-

- *Coding*- poor depth of coding can affect HSMR and it is recommended that coders and clinicians work more closely together.

Expected Deaths- Comorbidities

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 1438 deaths recorded in the period July 2016 to June 2017, 281 had no comorbidities recorded (19.5%).

Figure 4. Deaths with a Charlson score of zero recorded by age

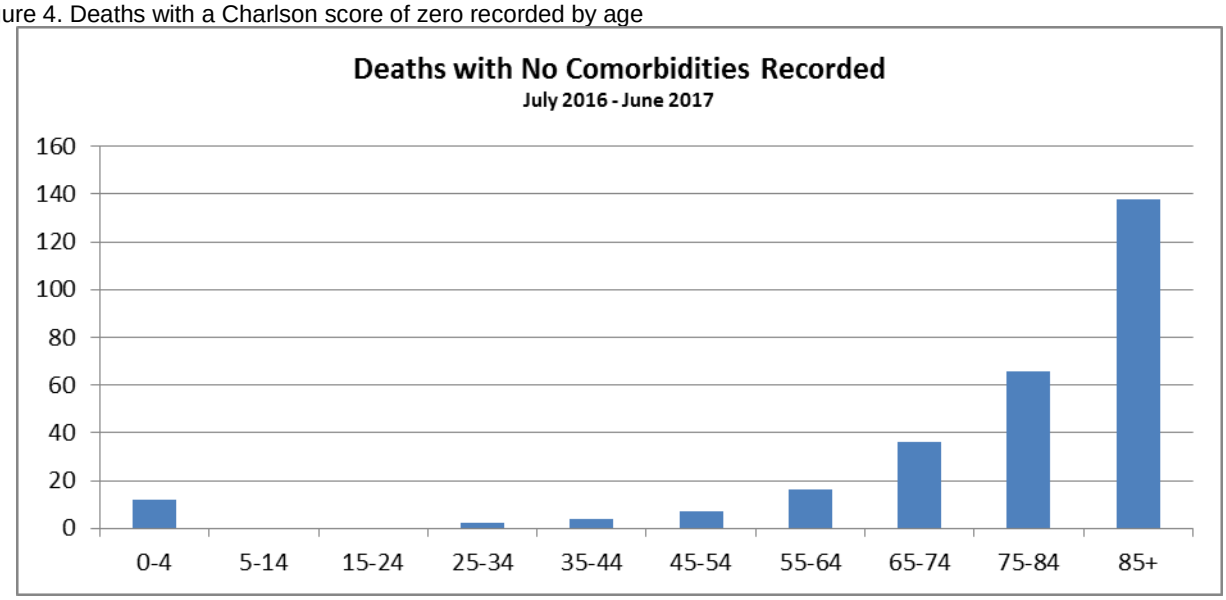
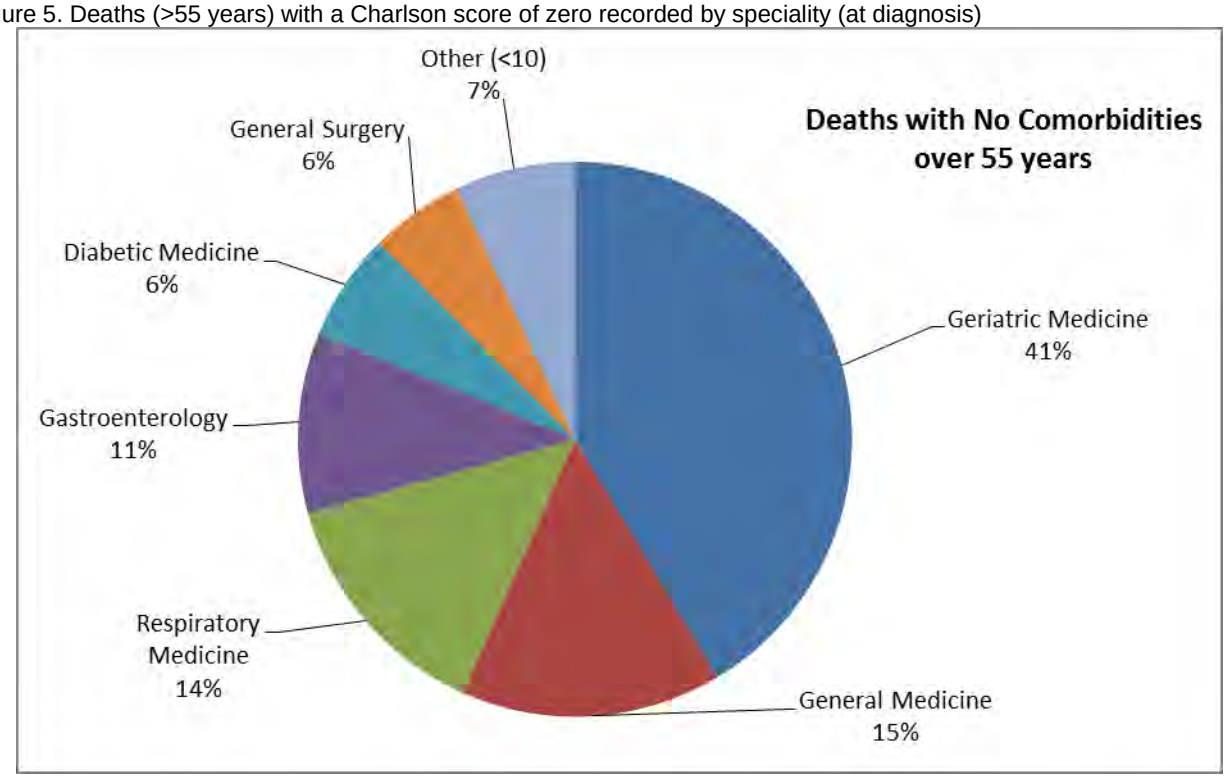


Figure 5. Deaths (>55 years) with a Charlson score of zero recorded by speciality (at diagnosis)

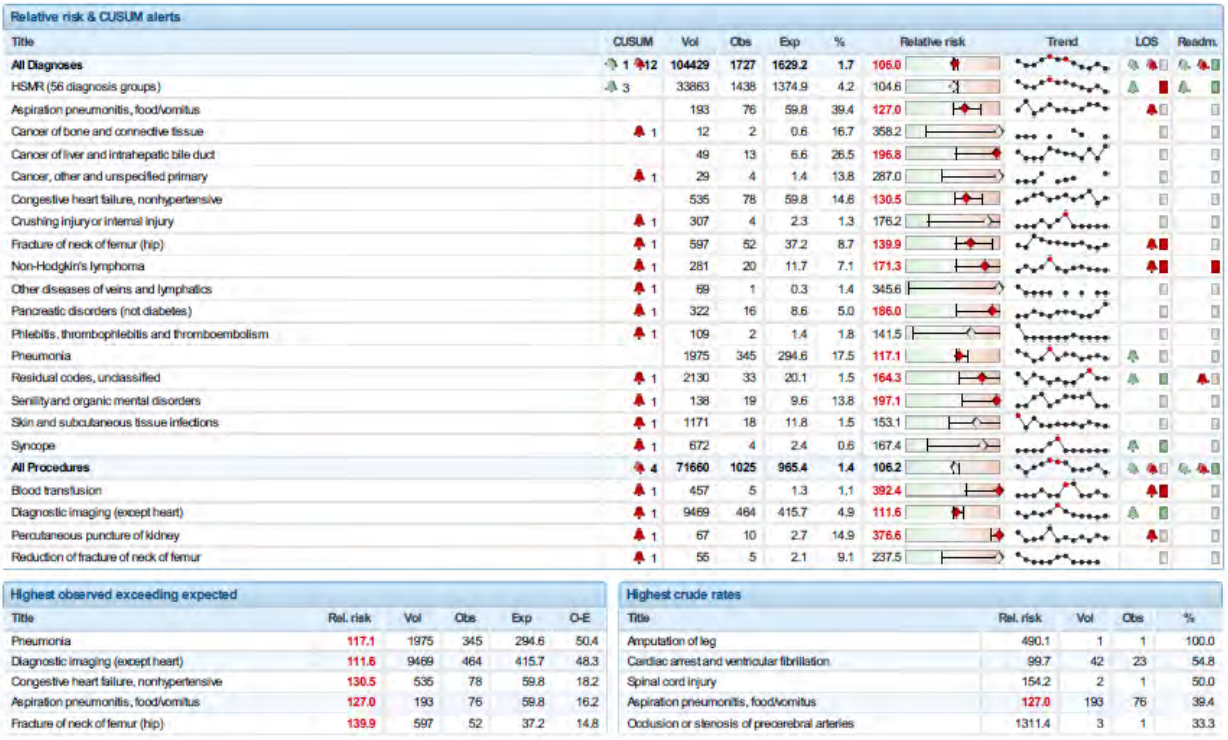


Targeted work with General Medicine and Geriatric Medicine will now be undertaken with the support of the coding team to further understand this cohort of patients and to address this possible underreporting of comorbidities to ensure the 'expected' deaths assigned to the Trust is accurate.

- Process- at this point, consider is there a potential issue with quality of care.

The Dr Foster report has consistently identified four 'red flags' (fig.6) – 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 a 'Deep Dive' into Orthopaedics and a review of Pneumonia and Non-Hodgkin's lymphoma has been undertaken.

Figure 6. Dr Foster CUSUM alerts



Relative risk & CUSUM alerts

Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend	LOS	Readm.
All Diagnoses	1 12	104429	1727	1629.2	1.7	106.0			
HSMR (56 diagnosis groups)	3	33863	1438	1374.9	4.2	104.6			
Aspiration pneumonitis, food/vomitus		193	76	59.8	39.4	127.0			
Cancer of bone and connective tissue	1	12	2	0.6	16.7	358.2			
Cancer of liver and intrahepatic bile duct		49	13	6.6	26.5	196.8			
Cancer, other and unspecified primary	1	29	4	1.4	13.8	287.0			
Congestive heart failure, nonhypertensive		535	78	59.8	14.6	130.5			
Crushing injury or internal injury	1	307	4	2.3	1.3	176.2			
Fracture of neck of femur (hip)	1	597	52	37.2	8.7	139.9			
Non-Hodgkin's lymphoma	1	281	20	11.7	7.1	171.3			
Other diseases of veins and lymphatics	1	69	1	0.3	1.4	345.6			
Pancreatic disorders (not diabetes)	1	322	16	8.6	5.0	186.0			
Phlebitis, thrombophlebitis and thromboembolism	1	109	2	1.4	1.8	141.5			
Pneumonia		1975	345	294.6	17.5	117.1			
Residual codes, unclassified	1	2130	33	20.1	1.5	164.3			
Senility and organic mental disorders	1	138	19	9.6	13.8	197.1			
Skin and subcutaneous tissue infections	1	1171	18	11.8	1.5	153.1			
Syncope	1	672	4	2.4	0.6	167.4			
All Procedures	4	71660	1025	965.4	1.4	106.2			
Blood transfusion	1	457	5	1.3	1.1	392.4			
Diagnostic imaging (except heart)	1	9469	464	415.7	4.9	111.6			
Percutaneous puncture of kidney	1	67	10	2.7	14.9	376.6			
Reduction of fracture of neck of femur	1	55	5	2.1	9.1	237.5			

Highest observed exceeding expected

Title	Rel. risk	Vol	Obs	Exp	O-E
Pneumonia	117.1	1975	345	294.6	50.4
Diagnostic imaging (except heart)	111.6	9469	464	415.7	48.3
Congestive heart failure, nonhypertensive	130.5	535	78	59.8	18.2
Aspiration pneumonitis, food/vomitus	127.0	193	76	59.8	16.2
Fracture of neck of femur (hip)	139.9	597	52	37.2	14.8

Highest crude rates

Title	Rel. risk	Vol	Obs	%
Amputation of leg	490.1	1	1	100.0
Cardiac arrest and ventricular fibrillation	99.7	42	23	54.8
Spinal cord injury	154.2	2	1	50.0
Aspiration pneumonitis, food/vomitus	127.0	193	76	39.4
Occlusion or stenosis of precerebral arteries	1311.4	3	1	33.3

The findings for Pneumonia and Non-Hodgkin's lymphoma are expected in November, however an incidental finding of these investigations has identified further work that needs to be undertaken in regard to the completion of the 'medical certificate of death'. An update on guidance for Junior Doctors and the instigation of our revised Mortality review process are perceived as instrumental in improving standards prior to submission to the Coroner.

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	48	41	67	86	93	116	135	146	153	130	109	1176
%age completed reviews	**30.6%**	**30.4%**	**30.6%**	**50.8%**	**71.1%**	**76.9%**	**74.8%**	**84.9%**	**71.6%**	**76.1%**	**79.3%**	**66.1%**	**62.4%**
No of Completed Reviews within agreed timescale	19	6	17	17	17	28	48	42	54	73	79	50	450
%age completed review within agreed timescale	**11%**	**4%**	**13%**	**13%**	**14%**	**23%**	**31%**	**26%**	**26%**	**36%**	**48%**	**30%**	**24%**
Unavoidable deaths, No Suboptimal Care	44	44	31	59	72	79	98	113	121	131	117	99	1008
Unavoidable Death, Suboptimal care	5	3	6	5	10	11	12	11	12	16	8	5	104
Suboptimal care, possible Serious Incident	1	1	1	1	2	1	3	1	3	3	2	3	22
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	2	3	8	9	3	3	2	38
%age Unavoidable deaths, No Suboptimal Care	**85%**	**92%**	**76%**	**88%**	**84%**	**85%**	**84%**	**84%**	**83%**	**86%**	**90%**	**91%**	**86%**
%age Unavoidable Death, Suboptimal care	**10%**	**6%**	**15%**	**7%**	**12%**	**12%**	**10%**	**8%**	**8%**	**10%**	**6%**	**5%**	**9%**
%age Suboptimal care, possible Serious Incident	**2%**	**2%**	**2%**	**1%**	**2%**	**1%**	**3%**	**1%**	**2%**	**2%**	**2%**	**3%**	**2%**
%age Suboptimal care, a Serious Incident	**0%**	**0%**	**0%**	**1%**	**0%**	**0%**	**0%**	**1%**	**1%**	**0%**	**0%**	**0%**	**0%**

- **(Apr – Aug 17)**

Trust	Apr-17	May-17	Jun-17	Jul-17	Aug-17	YTD
No of Deaths	151	167	130	129	143	720
No of Completed Reviews	92	73	52	33	16	266
%age completed reviews	**60.9%**	**43.7%**	**40.0%**	**25.6%**	**11.2%**	**36.9%**
No of Completed Reviews within agreed timescale	47	39	38	24	9	157
%age completed review within agreed timescale	**31%**	**23%**	**29%**	**19%**	**6%**	**22%**
Unavoidable deaths, No Suboptimal Care	78	60	46	28	15	227
Unavoidable Death, Suboptimal care	12	12	5	1	1	31
Suboptimal care, possible Serious Incident	1	0	0	2	0	3
Suboptimal care, a Serious Incident	0	1	0	0	0	1
Unknown Classification	1	0	1	2	0	4
%age Unavoidable deaths, No Suboptimal Care	**85%**	**82%**	**88%**	**85%**	**94%**	**85%**
%age Unavoidable Death, Suboptimal care	**13%**	**16%**	**10%**	**3%**	**6%**	**12%**
%age Suboptimal care, possible Serious Incident	**1%**	**0%**	**0%**	**6%**	**0%**	**1%**
%age Suboptimal care, a Serious Incident	**0%**	**1%**	**0%**	**0%**	**0%**	**0%**

The percentage of mortality reviews completed still demonstrates significant time delays, with multifactorial reasons, such as access to notes, rostering of staff to undertake reviews, administrative processes etc. The revised Mortality review process is envisaged to increase time efficiency with improved completion rates as a result.

Learning from Deaths Project Working Group.
The project group has been operational since May 2017 and set up in response to the National agenda for learning from deaths. The objectives of the group are:-

National Objectives

- The appointment of one Non-Executive Director and one Executive Director to take responsibility for the Mortality agenda.
- The adaptation of existing Clinical Governance processes to accommodate the revised requirements for the review and reporting of deaths.
- The production of a Policy (Appendix 2) for undertaking case record reviews, aligned with the Structured Judgement Review (SJR) methodology (Royal College of Physicians – 2016). This must be published by September 2017.
- Implementation of the Structured Judgement Review methodology (above).
- A review of the skills and training required to support this agenda.
- A review of the arrangements for engaging with families and carers of bereaved families *(note, further National guidance is being developed in this area)*
- Quarterly collection and publication of specified information on deaths, from April 2017, via a paper and agenda item on the Trust's Public Board agenda.
- A summary of these data in the June 2018 Quality Accounts, including an assessment of the impact of the actions that the Trust has taken as a result of the information that has been collected.

In addition the Trust has identified the following local objectives:-

- Reducing the number of deaths with suboptimal care.
- Clarifying the role of the MSG in the extraction and dissemination of learning from this process.
- Understanding the role of the Informatics Team in monitoring and supporting this process.
- Reducing the observed rates of mortality, in line with expected rates, by specialty.
- Developing the process for the inclusion of 'services with alerts/alarms', via MSG who will instigate an audit if an area is flagged twice and a deep dive if the audit demonstrates any concerns.
- Understanding our mortality data better, facilitated by closer working with the Dr Foster Team.
- Collaborative working with neighbouring Trusts/STP Colleagues via the CoP process (Communities of Practice).
- Developing the service we provide to families and carers.
- Learning from our deaths, supported by the Learning Lessons Task and Finish Group.

Recent achievements include the publication of the Trust's policy and procedure for 'Undertaking Mortality Case Record Reviews, (including Structured Judgement Reviews) which has been ratified and published on both the Trust intranet and internet. This outlines the new approach for mortality reviews with those identified as being of concern now being further reviewed with the Royal College of Physicians methodology.

In addition 3 of our Consultants have undertaken the national training in early October with one more due to attend in November. These consultants are now accredited to train further colleagues thereby ensuring that the Trust has a resource of independent experts suitably qualified to undertake the Structured Judgement review process.

National Quality Board Dashboard- July- September 2017.
The Trust's method of Mortality reviews currently codes into 4 categories 0-3 as above. The New Dashboard attached as an appendix (Appendix 1) however codes in categories of 1-6. The revised Mortality review process, which commenced on the 2nd October, will align these figures going forwards.

Next Steps:-

- Rollout of new Mortality process and work with the Directorates to embed this new process.
- 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 are considered for part 2
- Work with neighbouring hospital Trusts to investigate the potential to develop an online mortality review process to improve efficiency and data extraction for reports/reviews etc.
- Revise processes to meet the requirements issues by the National Quality Board in March 2017
    - Publish new Dashboard (NQB) June 2017 and present at Trust Board (quarterly)- achieved
    - Publish Mortality Strategy, Policy and new Mortality Review process- September 2017- achieved
    - Learning from Mortality reviews to be presented to Board- December 2017
- Joint learning event with Kent Community Health Foundation Trust – 'Making families Count'. This event has been supported by NHS England and gives first-hand accounts from families about the death of their loved ones and the lessons learnt from these. This conference is due to take place on the 3rd November in the Maidstone Academic Centre
- Revision of the bereavement leaflets to include the morality review process
- Introduction of information leaflets for staff and patients/carers/families on the Duty of Candour process
- Summary of coding provided to the Mortality reviewer so that any discrepancy can be promptly addressed and rectified.

Maidstone & Tunbridge Wells NHS Trust: Learning from Deaths Dashboard - August 2017-18

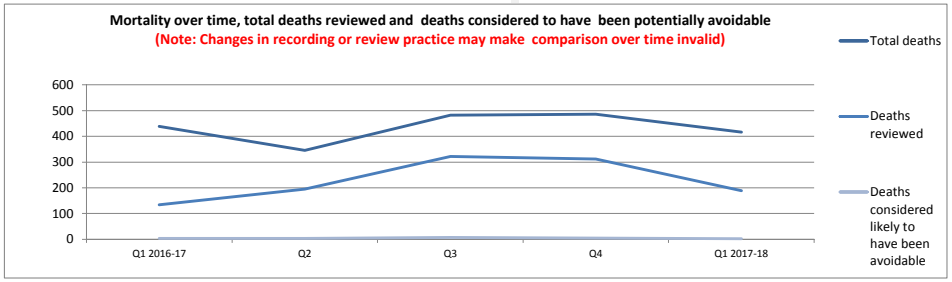
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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
138	123	16	30	0	2
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
261	416	46	189	2	2
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
677	1752	235	963	4	17

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



Total Deaths Reviewed by RCP Methodology Score

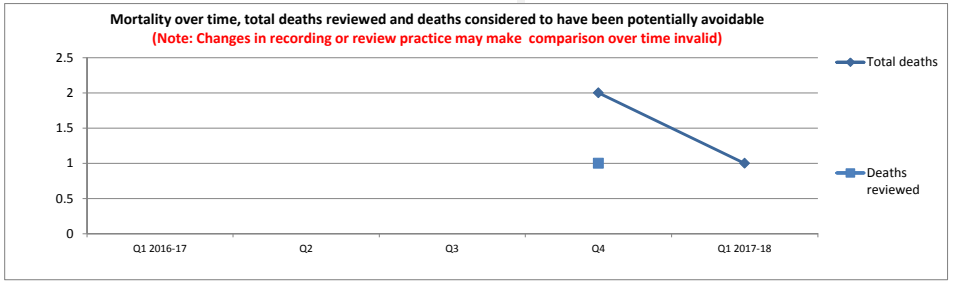
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	1	6.3%	This Month	15	93.8%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	2	4.3%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	2.2%	This Quarter (QTD)	43	93.5%
This Year (YTD)	0	0.0%	This Year (YTD)	1	0.4%	This Year (YTD)	3	1.3%	This Year (YTD)	0	0.0%	This Year (YTD)	20	8.5%	This Year (YTD)	211	89.8%

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	1	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1	2	0	1	0	0

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



Appendix 2

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Undertaking Mortality Case Record Reviews (including Structured Judgement Reviews) policy and procedure

Target audience:	All Trust clinical staff
Main author:	Associate Director of Quality Governance **Contact details:** 01622 226101
Other contributors:	Deputy Medical Director/Assistant Director of Business Intelligence/Head of Delivery Development
Executive lead:	Medical Director
Directorate:	Governance & Quality
Specialty:	Governance
Supersedes:	N/A
Approved by:	Trust Clinical Governance Committee, 14th September 2017
Ratified by:	Policy Ratification Committee, 14th September 2017
Review date:	September 2020

Maidstone and Tunbridge Wells NHS Trust

Document history

Requirement for document:	This policy has been drafted in response to new National guidance on Learning from Deaths, as outlined in the external cross references below.
Cross references (external):	1. Learning, candour and accountability - A review of the way NHS trusts review and investigate the deaths of patients in England, Care Quality Commission, December 2016. www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf 2. National Guidance on Learning from Deaths, National Quality Board, March 2017. www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf 3. Using the structured judgement review method Data collection form Supported by: Commissioned by: National Mortality Case Record Review Programme (England version). Royal College of Physicians (RCP), 2017. www.rcplondon.ac.uk/sites/default/files/media/Documents/NMCRR%20clinical%20governance%20guide_1.pdf?token=AS-qWBcA 4. Letter dated 22.02.17 from Dr Kathy McLean and Professor Sir Mike Richards to all Medical Directors, setting out the requirements for Trusts in respect of the implementation of the new Learning From Deaths Guidance. The letter provides an initial indication of what the commitments mean for Trusts and Foundation Trusts, including new requirements that will come into effect from April 2017. https://minhalexander.files.wordpress.com/2016/09/cqc-nhsi-letter-to-trusts-17022204-learning-from-deaths.pdf 5. Kent Child Death Review process www.proceduresonline.com/kentandmedway/chapters/p_unexpect_death.html 6. Learning Disability Mortality review process (LeDeR) www.bristol.ac.uk/sps/leder/
Associated documents (internal):	• Being Open/Duty of Candour Policy and Procedure [RWF-OPPPCS-NC-CG2] • Quality Accounts (available via Trust Intranet) • Quality Strategy (currently in draft – on Q-Pulse, under revision) • Serious Incidents (SI) Policy and Procedure [RWF-OPPPCS-NC-CG23] • Incident Management Policy and Procedure [RWF-OPPPCS-NC-CG22] • Doctor's Handbook (available via Trust Intranet)

Keywords:	Mortality	SJR	Case record reviews
	Structured Judgement Review		

Version control:		
Issue:	**Description of changes:**	**Date:**
1.0	New policy in response to national requirements.	September 2017

Maidstone and Tunbridge Wells NHS Trust

Policy statement for

Undertaking Mortality Case Record Reviews

This policy explains how the new Structured Judgement Review (SJR) process will be implemented within Maidstone and Tunbridge Wells NHS Trust (MTW). The policy will advise staff on how to undertake a mortality case record review, which documentation to use, in which circumstances an SJR is required and how the new process relates to previous systems and processes adopted by the Trust.

The new process is nationally prescribed and must be followed. The policy will explain how the new process links to revised mortality reporting, escalation of concerns and dissemination of learning.

In scope are all inpatients and Emergency Department (ED) patients who die whilst in the Trust's care, and patients who die within 30 days of discharge.

Undertaking Mortality Case Record Reviews

1.0 Introduction and scope

1.1 Introduction

The process for undertaking mortality reviews has been changed within the NHS to align with a new system called the Structured Judgement Review (SJR) process.

All Trusts and Foundation Trusts are required to implement the revised guidance which replaces all previous systems and processes.

Structured Judgement Review blends traditional, clinical-judgement based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. The result is a relatively short but rich set of information about each case in a form that can also be aggregated to produce knowledge about clinical services and systems of care. Section 5 (Procedure) explains how the new system will operate.

In order to provide the benefits to patient care that are commensurate with the effort put into case note review, review methods need to be standardised, yet not rigid, and usable across services, teams and specialties.

1.2 What does the policy intend to achieve?

For many people death under the care of the NHS is an inevitable outcome and they experience excellent care from the NHS in the months or years leading up to their death. However some patients experience poor quality provision resulting from multiple contributory factors, which often include poor leadership and system-wide failures. When mistake happen, providers working with their partners need to do more to understand the causes.

The purpose of reviews and investigations of deaths for which problems in care might have contributed is to learn in order to prevent recurrence. Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon.

It is incumbent upon the Trust to have a clear policy for engagement with bereaved families and carers, including giving them the opportunity to raise questions or share concerns in relation to the quality of care received by their loved one. Thrust staff should make it a priority to work closely with bereaved families and carers and ensure that that a consistent level of timely, meaningful and compassionate support and engagement is delivered ad assured at every stage, from notification of the death to completion of an investigation report and sharing any lessons learned and actions taken.

The objective of the review method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about the hospital systems where care goes well, and to identify points where there may be gaps, problems or difficulties with the delivery of care. In order to answer these questions, there is a need to look at: the whole range of care provided to an individual; holistic care approaches and the nuances of case management; and the outcomes of interventions.

The Care Quality Commission (CQC) state three key reasons why a Trust may decide to investigate the care provided before a patient's death. These are:

- **Learning**: To improve and change the way that care is provided.
- **Candour**: To support sharing information with others, including families.
- **Accountability**: If failures are found.

Through this policy, the Trust will support the development of enhanced skills and provide training to support this agenda. This will ensure that staff reporting deaths have the appropriate skills through specialist training to review and investigate deaths to a high standard.

1.3 Which staff does this policy apply to?

This policy applies to all clinical staff when conducting a mortality review structured judgement review (SJR). This process is primarily led by medical staff, with the support of all relevant members of the Multi-Disciplinary Team (MDT).

1.4 Which patients does this policy apply to?

This policy applies to all patients who have been cared for by Maidstone and Tunbridge Wells NHS Trust. In addition the following patients will also adhere to the previously prescribed investigatory processes (see Cross references and Appendix 6) for:

- Paediatrics – the Child Death Review process
- Maternal Deaths, Still births and infant deaths - the MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) review process
- Learning Disabilities – the LeDeR process

2.0 Definitions / glossary

Abbreviation	Definition
CQC	Care Quality Commission
DoC	Duty of Candour. NHS providers are required to comply with the duty of candour, meaning providers must be open and transparent with service users about their care and treatment, including when it goes wrong
Dr Foster	Dr Foster works across health economies to monitor and benchmark performance – nationally and globally – against key indicators of quality and efficiency, drawing on multiple datasets in innovative and pioneering ways.
EPR	Executive Performance Review. A monthly performance review of each Division in the Trust, Chaired by the Chief Executive or nominated Executive Director, conducted against the Trust's Performance Framework
Infokiosk	Maidstone and Tunbridge Wells database where performance dashboards can be accessed
KPIs	Key Performance Indicators

Abbreviation	Definition
MDT	Multi-Disciplinary Team. Multi-disciplinary teams are made up of a variety of expert healthcare professionals who have specialised knowledge and training in specific areas. The teams meet regularly to discuss individual cases and to plan the best course of treatment for the patient. MDTs improve communication and decision making, waiting times and patient care
MSG	Mortality Surveillance Group. A group of senior Clinicians and Managers that meets monthly, chaired by the Deputy Medical Director to support the Trust in providing assurance that all hospital associated deaths are proactively monitored, reviewed, reported and where necessary, investigated, with learning disseminated and actions implemented to improve outcomes
MTW	Maidstone and Tunbridge Wells NHS Trust
RCP	Royal College of Physicians
SI	Serious Incident. An incident requiring investigation, as described in the National Framework for Reporting and Learning from Serious Incident
SJR	Structured Judgement Review. Trained reviewers assess the healthcare record in a critical manner and comment on specific phases of clinical care using the new Royal College of Physicians process and recording form for completing mortality reviews, upon which this policy is based
TCGC	Trust Clinical Governance Committee
The Trust	Maidstone and Tunbridge Wells NHS Trust
TME	Trust Management Executive. The senior management committee within the Trust.

3.0 Duties

3.1 Executive and management responsibilities

- **Duties of the Trust Board**
  Authority and responsibility for governance and for establishing, supporting and evaluating the Trust's mortality process rests with the Trust Board. The Trust Board remains the primary point of assurance on mortality.

  The Board has the following responsibilities:

  - Ensuring a Lead Non-Executive and Executive Director are assigned.
  - From April 2017, Trusts have been 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 with publication of the data and learning points. This data should include the total number of the Trust's in-patient deaths (including Emergency Department deaths for acute Trusts) and those deaths that the Trust has subjected to case record review. Of these deaths subjected to review, Trusts will need to provide estimates of how many deaths were judged more likely than not to have been due to problems in care. This data must be presented via the mortality dashboard **(Appendix 4)**.
  - The Board, with support from the Lead Non-Executive and Executive Director must ensure that the organisation:
    - Pays particular attention to the care of patients with learning disabilities or mental health needs.
    - Ensures a robust system for identifying deaths requiring review.
    - Has an effective methodology for case record reviews and that these are carried out to a high quality.
    - Ensures that mortality reporting (reviews, investigations and learning) is regularly provided to the Board.
    - Ensures that learning from reviews is acted upon to change organisational practice and improve care.
    - Ensures that learning from deaths is reported in the annual Quality Accounts.
    - Shares learning across the organisation and with other services where the learning could be useful.
    - Ensure that there is a sufficient number of staff with the right skills to review and investigate deaths in a timely manner.
    - Offer timely, compassionate and meaningful engagement with bereaved families and carers in all stages of the process.
    - Instigates independent investigations where appropriate.
    - Works with commissioners to review and improve processes and approach.

- **The Lead Non-Executive Director** is required to take oversight of the process.

3.2 Executive accountabilities

- **The Chief Executive,** as Accountable Officer, carries overall responsibility for the quality and standards of care delivered by the Trust. The Chief Executive is therefore responsible for ensuring that systems are in place and functioning effectively in respect of the mortality agenda. The Chief Executive is also required to sign the Annual Quality Accounts, in which the specified information on deaths is required to be summarised.
- **The Medical Director** is ultimately accountable for the implementation of the Trust wide mortality review process and monitoring of mortality data received by the Trust. The Medical Director is also ultimately responsible for ensuring clinical effectiveness across the organisation and for ensuring that staff adhere to this policy. The Medical Director is also responsible for ensuring that monthly mortality review meetings are held and that corporately, lessons learned and all actions are implemented.
- **The Chief Nurse** is the CQC Nominated Individual within the Trust. The Chief Nurses' responsibility is respect of mortality reviews is to ensure that all activities relating to mortality comply with CQC regulations.
- **The Deputy Medical Director (Planned Care)** is responsible for chairing the Mortality Surveillance Group and ensuring that all mortality alerts and concerns are addressed appropriately. The Deputy Medical Director (Planned Care) also reports on mortality outcomes to the Quality Committee and the Trust Management Executive.

3.3 Management responsibilities

- **The Associate Director for Quality Governance** is responsible for the production of this policy (the author) and for ensuring that the appropriate governance arrangements exist to safeguard the quality of the systems and processes that contribute to the care of patients. The Associate Director for Quality Governance is also responsible for the mortality review process within the Trust and for embedding a culture of organisational learning from mortality reviews.
- **The Associate Director of Business Intelligence** is responsible for production, supply, interpretation and alerting of all data relevant to the mortality agenda. The Associate Director of Business Intelligence is also the point of liaison between the Trust and the Dr Foster data provider, undertaking a two-way challenge of the data and assurance of interpretation and understanding any data anomalies. The Assistant Director of Business Intelligence is also responsible for the provision to data to the Divisions/Directorates and the Trust's monthly Executive Performance Review (EPR) process.

- **The Divisional Management Teams** are responsible for ensuring that all specialties review all deaths occurring under their care and discuss the findings from mortality reviews as part of the Directorate clinical governance process. The Divisional Management Teams are also responsible for the timely completion of all SJRs and ensuring that these are submitted to the Trust's Clinical Governance Administrator as per the Trust's key performance indicators (KPIs) which are aligned to the Trust's EPR process. Divisional Managers should ensure that they have key staff in place and they are fully trained to undertake their roles. The Divisional Management Teams also have responsibility to adequately address and escalate any concerns raised by bereaved families and/or carers (see section 5 – Procedure).

3.4 Operational staff

- **The Directorate/Speciality Mortality Leads** are responsible for the development and delivery of the Trust-wide mortality review process within their specialties by ensuring that all reviews are completed in line with the standards described in this Policy and Procedure and any areas identified for improvement are addressed. They are also responsible for monitoring their mortality data which is available through the Trust's InfoKiosk and through the specialty reports from Dr Foster, taking action as appropriate. Mortality Leads will also report their Directorate reviews to the Mortality Surveillance Group (MSG) on a monthly basis, providing feedback on learning which has arisen from mortality reviews. The Directorate Mortality Leads are also responsible for the proactive escalation of any mortality review that reveals a potential Serious Incident (SI). Directorate Mortality Leads are already in post.
- **The Consultant Staff** are responsible for:
  - completing mortality reviews within their specialty as appropriate. The review should be conducted by clinicians who were not directly involved in the patient's care.
  - ensuring that mortality reviews provide an accurate record of care containing clear and relevant documentation.
  - ensuring that any reviews that they have been nominated to undertake by the MSG are completed and reported back within the specified timescale to the MSG. Involvement in mortality reviews allows for Consultants to reflect upon their own and their teams' practice.
  - ensuring that SJRs are carried out in line with this Policy to safeguard any learning that has been determined and to also oversee prompt implementation of that learning.
  - Ensuring that relatives and/or carers of all patients who have died in their care are notified of the Trust's responsibility to undertake a mortality review under its Duty of Candour (DoC) requirements should a failure in care be identified in the review process. The Consultant Lead for the SJR will liaise with the family/carers under the Trust's DoC process. Please refer to the Trust's Duty of Candour Policy (RWF-OPPPCS-NC-CG2) for further information.

- **Nurses, Allied Health Professionals and other clinical staff.** All healthcare professionals are required to be involved in SJRs as part of their clinical practice. This involvement could range from simply being aware of the outcome of such reviews which may affect their area of practice, to full involvement in the production of data and implementation of recommendations.
- **Junior Doctors** are responsible for
  - completing the death certificate accurately
  - Completion of the Preliminary Screening Form (Appendix 4)
  - Completion of the discharge summary to notify the patient's General Practitioner (GP) of the patient's death.
- **The Bereavement Team** are responsible for helping families and carers through the practical aspects following the death of a loved one such as:
  - arranging completion of all documentation, including medical certificates;
  - the collection of personal belongings;
  - post mortem advice and counselling;
  - deaths referred to the coroner;
  - emotional support,
  - collection of the doctor's Medical Certificate of Cause of Death and information about registering a death at the Registrar's Office;
  - advising the family/carer of the Trust's responsibility, under its Duty of Candour requirements, to undertake a mortality review of all patients who have died.
  - If no failures in care are identified, advising the family/carer of this outcome. The Bereavement Team will be advised of this outcome by the Clinical Governance Administrator.

  The Bereavement Team are also responsible for acting as a conduit to escalate information (in line with the procedure outlined in section 5 of this document) regarding bereaved families and/or carers who are have concerns about the care and/or treatment of the deceased patient.

3.5 Trust committees

- **The Quality Committee:** The Quality Committee will receive a mortality update.
- **Trust Management Executive (TME)** is the senior management committee within the Trust. Its purpose is to:
  - Receive and where appropriate, discuss the monthly Mortality dashboard and any ensuing actions.
  - Receive the report from the Trust Clinical Governance Committee and where appropriate, discuss and review any key actions relating to mortality.
- **Trust Clinical Governance Committee (TCGC)** is the committee which aggregates and monitors all clinical governance activity within the Trust. Its purpose is to monitor and support clinical governance activity and performance and to monitor quality standards including compliance with national standards and regulations. As such it will:
  - Review the Trust's mortality dashboard and ensure that action is being managed via the Mortality Surveillance Group
  - Review any identified risks and exception reports, make recommendations for actions and escalate where appropriate

- **Mortality Surveillance Group (MSG)** is responsible for supporting the Trust in:
  - providing assurance that all hospital associated deaths are proactively monitored, reviewed, reported and where necessary, investigated, lessons learned and actions implemented to improve outcomes.
  - acting as the principal source of advice and expertise to the Trust on mortality.
  - providing updates on the status of completed investigations, latest mortality data and any areas of concern arising to the Trust Clinical Governance Committee.

4.0 Training / competency requirements

National Training on SJRs has been arranged for Trust's Clinical representatives. These Clinical Representatives have been nominated by the Medical Director and are from a cross-section of clinical disciplines within the organisation. A Trust-wide rollout programme is being devised to cascade this training which will take place in October 2017. The clinicians who attend the National training programme will, in turn, train a team of Trust-level trainers who will act as a resource to roll out the Trust-wide training programme. The training will be co-ordinated by the Learning and Development Team. Ongoing training and support will be provided via the Divisions and Directorates once the rollout programme has been completed. The Training Programme will be available from the end of October 2017, via the Learning and Development Department.

Department name	**Contact telephone number**
Learning and Development	Ext: 24215 (Maidstone Hospital)

5.0 Procedure

5.1 Procedure overview:

There are two stages to the review process.

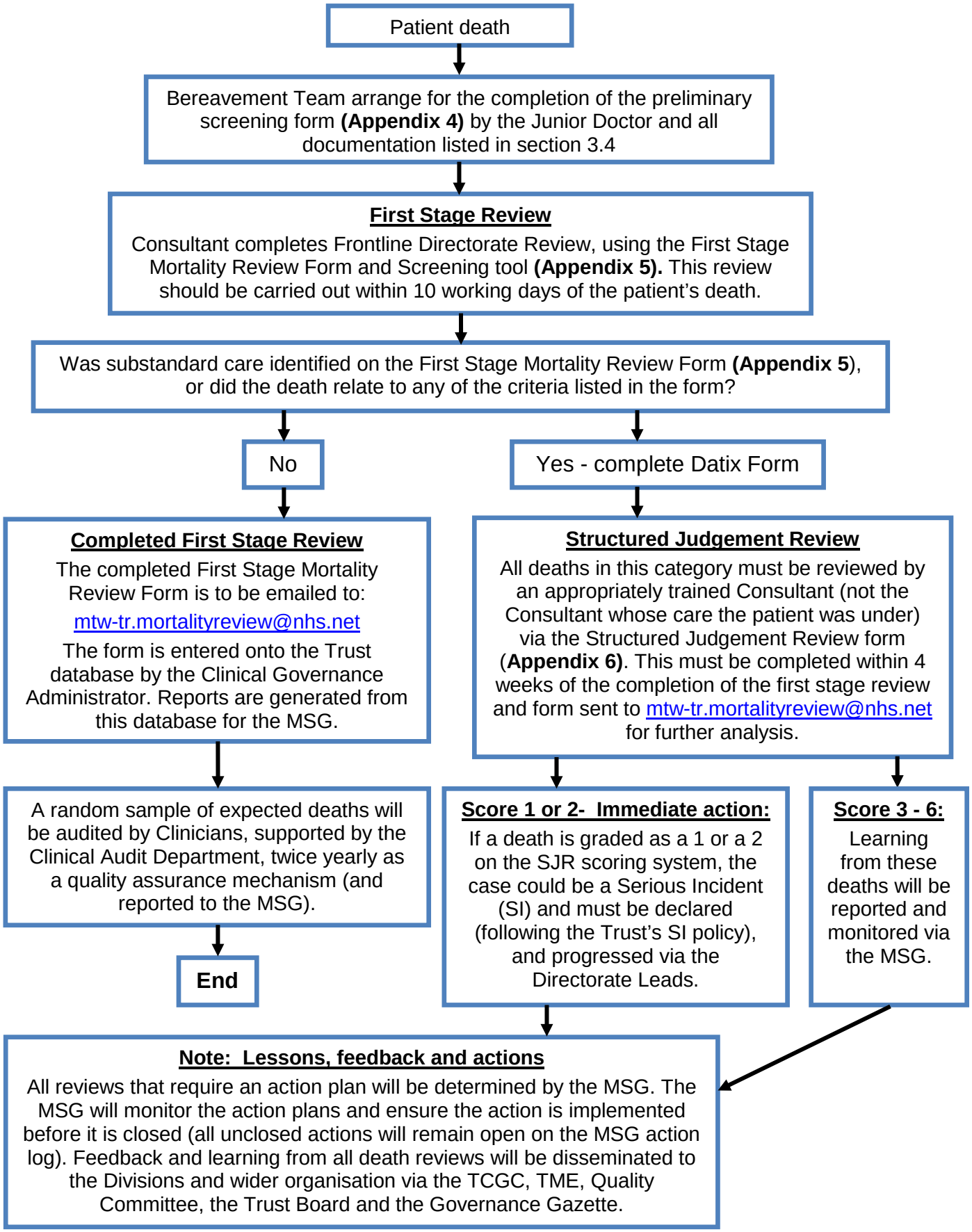
- Stage 1 (the frontline review)
- Stage 2, (the structured judgement review).

The flowchart below outlines the stages in the review process. In scope are all inpatients, ED patients and patients who die within 30 days of discharge. Patients in the following category should proceed straight to an SJR:

- All patients with learning disabilities of diagnosis of mental illness, unexpected deaths from a simple intervention e.g. elective surgical procedures
- Deaths in a service with an alert raised which when reviewed would provide learning
- Deaths to support learning and improvement.
- In line with existing national process, all deaths in patients who have a diagnosis of a learning disability must be notified to the LeDer system, by the person who completes the death certificate, in Bristol (web address: http://www.bristol.ac.uk/sps/leder/) – 0300-777-4774, and also to the West Kent CCG Quality Team on 01732 375273.

On the following page is a flowchart which explains the mortality review process.

5.2 Mortality review procedure



5.3 First-stage review:

The first stage is mainly the domain of what might be called 'front line' reviewers; Consultants who undertake reviews within their own services or Directorates, sometimes as mortality and morbidity (M&M) reviews, sometimes as a part of a team looking at the care of groups of cases. The majority of reviews are completed at this point. The first-stage review will be informed by the Preliminary Screening Form (**Appendix 4)** when the death certificate is completed in the Bereavement Office.

In March 2017 the Department of Health issued 'National Guidance on Learning from Deaths' which mandates that if certain criteria are present, NHS organisations must undertake a case record review of a patient's care, with a view to developing an understanding of themes relating to mortality, in order to drive quality improvement work. The mandatory criteria, indicating case record review is necessary, are present in the form (**Appendix 5).** This form should be used as explained in section 5.2.

If 'YES' is selected in any of the criteria fields, this will trigger a full SJR review and the procedure outlined in the flowchart in section 5.2 of this policy document must be followed.

The data provided on the form will be used to help the Trust develop an understanding of themes relating to mortality, in order to drive quality improvement work.

At the end of the form will be used to help the Trust develop an understanding of themes relating to mortality, in order to drive quality improvement work.

At the end of the form, the reviewer is asked to check if they have selected "yes" to any of the mandatory criteria. In these instances, the Directorate or Specialty Mortality Lead must be informed and this will trigger a case note review. Please refer to the flowchart in section 5.2.

5.4 Second-Stage Review:

A second-stage review is undertaken where care problems have been identified by a first-stage reviewer or a positive response has been given to any of the criteria boxes on the form in **Appendix 5** (where an answer of 'YES' has been given). This second stage review is undertaken within the auspices of the Trust's Clinical Governance process and it uses the same review methodology as the stage 1 process, but with the additional option of judging the potential avoidability of a death where sub-optimal care has been identified.

Second-stage reviews are undertaken using the structured judgement method by those trained in this method. This form is the Royal College of Physicians' recommended tool for conducting SJRs and against which, all national training is being given. This form can be found at **Appendix 6.** It is a process of validation of the first reviewer's concerns. If the second-stage reviewer broadly agrees with the first-stage review (with poor or very poor overall scores and/or where actual harm or harms are judged to have occurred), the MSG may decide on an additional assessment of the level of the potential avoidability of the patient's death.

Judging the level of the avoidability of a death involves a complex assessment. The narrative allows for themes to be developed that act as a focus for the next improvement steps. This approach also has the benefit of enabling individuals to learn from, and recognise, the cases where care has gone well. The judgement is framed by a six-point scale (where 6= Definitely not avoidable; and 1 = Definitely avoidable). In addition, the second-stage reviewer supports the score choice with an explicit judgement comment justifying why the score decision was made.

Making an overall summary judgement on whether a death was avoidable (at least to some extent) is often a challenging process that goes beyond judging safety and quality, by also taking into account comorbidities and estimated life expectancy. Nevertheless, experience in some hospitals suggests that a combination of an 'avoidability' score and an explicit judgement statement may enhance the information provided in this second-stage assessment. The avoidability scale is found in **Appendix 6** on the last page together with an avoidability of death judgement comment. A score of 1 or 2 on the scale would indicate 'cause for concern'. As set out in the flowchart in section 5.2, this may result in a formal SI investigation.

APPENDIX 1

Process requirements

1.0 Implementation and awareness

- Once ratified the Policy Ratification Committee (PRC) Chair will email this policy/procedural document to the Corporate Governance Assistant (CGA) who will activate it on the Trust approved document management database on the intranet, under 'Policies & guidelines'.
- A monthly publications table is produced by the CGA which is published on the Trust intranet under 'Policies & guidelines'; notification of the posting is included on the intranet "News Feed" and in the Chief Executive's newsletter.
- On reading of the news feed notification all managers should ensure that their staff members are aware of the new publications.

2.0 Monitoring compliance with this document

Compliance with this document will be monitored as follows:

- Review of KPIs of completed mortality reviews via the Trust's Executive Performance Review process and the Mortality Surveillance Group.
- Monitoring of the proportion of the number of cases referred for a full Structured Judgement Review via the Trust's Executive Performance Review process and the Mortality Surveillance Group.
- The monitoring of the quality and standard of the completed of the forms via the MSG review process.
- A six monthly audit cycle of a random sample of expected deaths that do not progress to a full SJR review.

3.0 Review

This policy and procedure and all its appendices will be reviewed at a minimum of once every 3 years, following the procedure set out in the 'Principles of Production, Approval and Implementation of Trust Wide Policies and Procedures' [RWF-OPPPCS-NC-CG25].

If, before the document reaches its review date, changes in legislation or practice occur which require extensive or potentially contentious amendments to be made, a full review, approval and ratification must be undertaken.

If minor amendments are required to the policy and procedure between reviews these do not require consultation and further approval and ratification. Minor amendments include changes to job titles, contact details, ward names etc.; they are 'non-contentious'. For a full explanation please see the 'Principles of Production, Approval and Implementation of Trust Wide Policies and Procedures' [RWF-OPPPCS-NC-CG25]. The amended document can be emailed to the CGA for activation on the Trust approved document management database on the intranet, under 'Policies & guidelines'. Similarly, amendments to the appendices between reviews do not need to undergo consultation, approval and ratification.

4.0 Archiving

The Trust approved document management database on the intranet, under 'Policies & guidelines', retains all superseded files in an archive directory in order to maintain document history.

Maidstone and Tunbridge Wells NHS Trust

APPENDIX 2

CONSULTATION ON: Undertaking Mortality Case Record Reviews (including Structured Judgement Reviews) Policy and Procedure

Consultation process – Use this form to ensure your consultation has been adequate for the purpose.

Please return comments to: Associate Director, Quality and Governance

By date: 4th September 2017

Job title:	Date sent dd/mm/yy	Date reply received	Modification suggested? Y/N	Modification made? Y/N
The following staff MUST be included in ALL consultations:				
Corporate Governance Assistant	17/08/2017	17/08/2017	Y	Y
Chief Pharmacist and Formulary Pharmacist	22/08/2017	Nil	N	N
Head of Staff Engagement and Equality	22/08/2017	23/8/2017	N	N/A
Health Records Manager	22/08/2017	Nil	N	N
Complaints & PALS Manager	22/08/2017	05/09/2017	Y	Y
All individuals listed on the front page of this document	22/08/2017	Nil	N	N
All members of the approving committee: Trust Clinical Governance Committee	22/08/2017	Nil	N	N
Other individuals the author believes should be consulted:				
All members of the Mortality Surveillance Group	22/08/2017	Nil	N	N
Executive Directors	22/08/2017	Nil	N	N
Clinical Directors	22/08/2017	Nil	N	N
Deputy Medical Directors	22/08/2017	Nil	N	N
Director of Medical Education	22/08/2017	Nil	N	N
Heads of Services	22/08/2017	Nil	N	N
DDOs/HoNs	22/08/2017	Nil	N	N
GMs	22/08/2017	Nil	N	N
Matron (Surgery & Urology)	22/08/2017	23/08/17	Y	Y

Maidstone and Tunbridge Wells NHS Trust

APPENDIX 3

Equality impact assessment

This policy includes everyone protected by the Equality Act 2010. People who share protected characteristics will not receive less favourable treatment on the grounds of their age, disability, gender, gender identity, marital or civil partnership status, maternity or pregnancy status, race, religion or sexual orientation. The completion of the following table is therefore mandatory and should be undertaken as part of the policy development and approval process. **Please note that completion is mandatory for all policy and procedure development exercises.**

Title of policy or practice	Undertaking Mortality Case Record Reviews (including Structured Judgement Reviews) Policy and Procedure
What are the aims of the policy or practice?	To advise all clinical and managerial staff on the revised National procedural requirements for undertaking mortality reviews.
Is there any evidence that some groups are affected differently and what is/are the evidence sources?	The National process identifies the following vulnerable patient groups as being required for inclusion to ensure that any potential adverse impact of their death is investigated appropriately: *Patients with Learning disability *Patients with a mental health diagnosis Evidence source – Learning From Deaths NQB March 2017.
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	Is there an adverse impact or potential discrimination (yes/no). If yes give details.
Gender identity	No
People of different ages	No
People of different ethnic groups	No
People of different religions and beliefs	No
People who do not speak English as a first language (but excluding Trust staff)	No
People who have a physical or mental disability or care for people with disabilities	No
People who are pregnant or on maternity leave	No
Sexual orientation (LGB)	No
Marriage and civil partnership	No
Gender reassignment	No
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	N/A
When will you monitor and review your EqIA?	Alongside this policy/procedure when it is reviewed.
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix 3 of this policy/procedure on the Trust approved document management database on the intranet, under 'Trust policies, procedures and leaflets'.

FURTHER APPENDICES

The following appendices are published as related links to the main policy /procedure on the Trust approved document management database on the intranet, under 'Policies & guidelines':

No.	Title	Unique ID	Title and unique id of policy that the appendix is primarily linked to
4	Preliminary screening form	RWF-GQU-GOV-FOR-2	This policy
5	First-stage mortality review form and screening tool	RWF-GQU-GOV-FOR-3	This policy
6	Structured Judgement Review form	RWF-GQU-GOV-FOR-4	This policy

NHS
Maidstone and Tunbridge Wells NHS Trust

Preliminary screening form

Demographics label

Who was the Consultant responsible for the patient during last admission (at time of death)?

Dr / Mr / Miss / Ms / Prof ……..

Has this case been referred to the Coroner? Yes / No

Did this patient have a history of learning disabilities? Yes / No

Did this patient have a history of mental health issues? Yes / No

Have the family/carers raised any concerns about care during the last admission? Yes / No

To your knowledge or those of the medical / surgical / nursing teams caring for this patient were there any issues with the care this patient received during their admission?

Cause of death has been certified as:

1a

1b

1c

2

Was the cause of death discussed with the patient's Consultant (or a designated Dr on part 2 of the rota) before the certificate was completed? Yes / No

Any other comments to inform the mortality review?

NHS
Maidstone and Tunbridge Wells NHS Trust

First stage mortality review form and screening tool

NAME	
DOB	
NHS NUMBER	

In March 2017 the Department of Health issued 'National Guidance on Learning from Deaths' which mandates that certain criteria are present, NHS organisations must undertake a case record review of a patients care, with a view to develop an understanding of themes relating to mortality, in order to drive quality improvement work.

The mandatory criteria indicating case record review is necessary are present in the fields below. Please use this form as explained in section 5 of the Trust's 'Undertaking Mortality Case Record Reviews (SJR) Policy and Procedure'.

If 'YES' is selected in any field, this will trigger a full SJR review and the procedure outlined in the flowchart in section 5.2 of the Policy document must be followed.

SPECIALTY	
CONSULTANT undertaking review	
CONSULTANT responsible for care	

Cause of death (death certificate completed as):

1a	
1b	
1c	
2	

Criteria for Case Record Review	Yes	No
1. Was the death unexpected? There will be some patients with frailty and multiple comorbidities in whom death was not considered to be unexpected by the clinical team - these do not require case record review unless other concerns are present.	☐	☐
2. If the death was expected, was there an absence of end of life care planning or DNACPR form?	☐	☐
3. Are you concerned that any problems in healthcare occurred? A problem in healthcare is defined as 'any point where the patient's healthcare fell below an acceptable standard and led to harm' e.g. Avoidable healthcare associated infection, avoidable acquired pressure ulcer, failure to respond in a timely manner to deterioration etc.	☐	☐
4. Have you any concerns that this death was avoidable? Even if you have slight concerns that this death was avoidable, you should refer for Structured Judgement Review	☐	☐

NHS
Maidstone and Tunbridge Wells NHS Trust

Criteria for Case Record Review	Yes	No
5. Is this case subject to an investigation (internal or external)? i.e. when an incident with moderate harm or above has been reported on Datix	☐	☐
6. Did the family/carers have significant concern regarding the quality of care provision in hospital? i.e. cases in which the family/carers have made a complaint	☐	☐
7. Was the patient admitted for an elective procedure?	☐	☐
8. Was this death reported to the coroner? (Including if the patient died whilst sectioned under the Mental Health Act). Excluding when reporting industrial diseases	☐	☐
9. Did this patient have a learning disability?	☐	☐
10.Was a safeguarding concern raised?	☐	☐
11.Did this patient have a recognised mental health condition?	☐	☐
For Structured Judgement Review? (If yes to any of the above then a review is required) You may wish to put this case forward for an SJR for another reason. If so please expand here:	☐	☐
If a Structured Judgement Review is not required are there any aspects of excellent care or compliments received you wish to highlight?		
Any further comments to aid senior review?		

The data you have provided will be used to help the Trust develop an understanding of theme relating to mortality, in order to drive quality improvement work.

CHECK: If you have selected "Yes" to any of the mandatory criteria above, your specialty's Mortality Lead will be informed and this will trigger a Structured Judgement Review.

Please send completed forms to mtw-tr.mortalityreview@nhs.net

Maidstone and Tunbridge Wells NHS Trust

National Mortality Case Record Review Programme
Structured Judgement Review Form:

Please enter the following:

Age at death (years):

Gender:

First part of the patient's postcode (e.g. ME15):

Day of admission/attendance:

Time of arrival:

Day of death:

Time of death:

Number of days between attendance and death:

Month cluster during which the patient died:
Jan/Feb/Mar *Apr/May/Jun* *Jul/Aug/Sept* *Oct/Nov/Dec*

Specialty team at time of death:

Specific location of death:

Type of admission: Elective/Non-Elective:

The certified cause of death (if known):

1a

1b

1c

2

Guidance for reviewers

1. Did the patient have a learning disability?

   - No indication of a learning disability.
     Action: proceed with this review.
   - Yes – clear or possible indications from the case records of a learning disability.

     Action: Please ensure that this case was referred to the LeDeR team in Bristol (web address: http://www.bristol.ac.uk/sps/leder/) – 0300 777 4774, and also to the West Kent CCG Quality Team on 01732 375273 when the Death Certificate was completed. Make arrangements in regard to who is undertaking the review.

2. Did the patient have a diagnosed mental health condition?

   - No indication of a mental health condition.
     Action: proceed with this review.
   - Yes – clear or possible indications from the case records of a severe mental health issue.
     Action: after your review, please refer the case to the Mortality Surveillance Group.

3. Is the patient 18 or older?

   - Yes the patient is 18 years or older.
     Action: proceed with this review.
   - No – the patient is under 18 years old.

     Action: the Kent Child Death procedures must be followed.

     - Form A to be completed on line as soon as possible after confirmation of a child death using the following link – this will notify the Child Death Review Team – https://www.ges-online.com/Kent/eCDOP/Live/Public
     - For any concerns/queries - contact the Child Death team on **03000 41 71 25** or email cdop@kent.gov.uk
     - Kent Procedures http://www.proceduresonline.com/kentandmedway/chapters/p_unexpect_death.html
     - Ensure that the Named Doctor for Child Death and the Named Nurse Safeguarding Children are informed.

Maidstone and Tunbridge Wells NHS Trust

Structured case note review data collection

Phase of care: **Admission and initial management (approximately the first 24 hours)**

Please record your explicit judgements about the quality of care the patient received and whether this was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = Very poor care 2 = Poor care 3 = Adequate care 4 = Good care 5 = Excellent care

Please circle only one score.

Maidstone and Tunbridge Wells NHS Trust

Phase of care: **Ongoing care**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = Very poor care 2 = Poor care 3 = Adequate care 4 = Good care 5 = Excellent care

Please circle only one score.

Using the structured judgement review method: Data collection form

Phase of care: **Care during a procedure (excluding IV cannulation)**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = Very poor care 2 = Poor care 3 = Adequate care 4 = Good care 5 = Excellent care

Please circle only one score.

Using the structured judgement review method: Data collection form

Phase of care: **Perioperative care**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = Very poor care 2 = Poor care 3 = Adequate care 4 = Good care 5 = Excellent care

Please circle only one score.

Using the structured judgement review method: Data collection form

Maidstone and Tunbridge Wells NHS Trust

Phase of care: **End-of-life care**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = Very poor care 2 = Poor care 3 = Adequate care 4 = Good care 5 = Excellent care

Please circle only one score.

Maidstone and Tunbridge Wells NHS Trust

Phase of care: **Overall assessment**

Please record your explicit judgements about the quality of care the patient received overall and whether it was in accordance with current good practice (for example, your professional standards). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = Very poor care 2 = Poor care 3 = Adequate care 4 = Good care 5 = Excellent care

Please circle only one score.

Please rate the quality of the patient healthcare record

1 = Very poor 2 = Poor 3 = Adequate 4 = Good 5 = Excellent

Please circle only one score.

Maidstone and Tunbridge Wells NHS Trust

Assessment of problems in healthcare

In this section, the reviewer is asked to comment on whether one or more specific types of problem(s) were identified and, if so, to indicate whether any led to harm.

Were there any problems with the care of the patient? (Please tick)

No ☐ (proceed to next page) **Yes** ☐ (please continue below)

If you did identify problems, please identify which problem type(s) from the selection below and indicate whether it led to any harm. Please tick all that relate to the case.

Problem types

1 **Problem in assessment, investigation or diagnosis** *(including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls)* **Yes** ☐
Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

2 **Problem with medication / IV fluids / electrolytes / oxygen** *(other than anaesthetic)* **Yes** ☐
Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

3 **Problem related to treatment and management plan** *(including prevention of pressure ulcers, falls, VTE)* **Yes** ☐
Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

4 **Problem with infection management Yes** ☐
Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

5 **Problem related to operation / invasive procedure** *(other than infection control)* **Yes** ☐
Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

6 **Problem in clinical monitoring** *(including failure to plan, to undertake, or to recognise and respond to changes* **Yes** ☐
Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

7 **Problem in resuscitation following a cardiac or respiratory arrest** *(including cardiopulmonary resuscitation (CPR))* **Yes** ☐
Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

8 **Problem of any other type not fitting the categories above - Yes** ☐
Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

Adapted from Hogan H, Zipfel R, Neuberger J, Hutchings A, Darzi A, Black N. Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis. BMJ 2015;351:h3239. DOI: 10.1136/bmj.h3239

Avoidability of death judgement score

We are interested in your view on the avoidability of death in this case. Please choose from the following scale.

Score 1 Definitely avoidable

Score 2 Strong evidence of avoidability

Score 3 Probably avoidable (more than 50:50)

Score 4 Possibly avoidable but not very likely (less than 50:50)

Score 5 Slight evidence of avoidability

Score 6 No evidence of avoidability

Please explain your reasons for your judgement of the level of avoidability of death in this case, including anything particular that you have identified.

Please send completed forms to mtw-tr.mortalityreview@nhs.net

Trust Board meeting – October 2017

Maidstone and Tunbridge Wells NHS Trust

10-15 To approve the Trust's strategy — Acting Chief Executive

Summary / Key points

Enclosed is the Trust's strategy for approval.

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive (presentation), 11/10/17

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

For 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

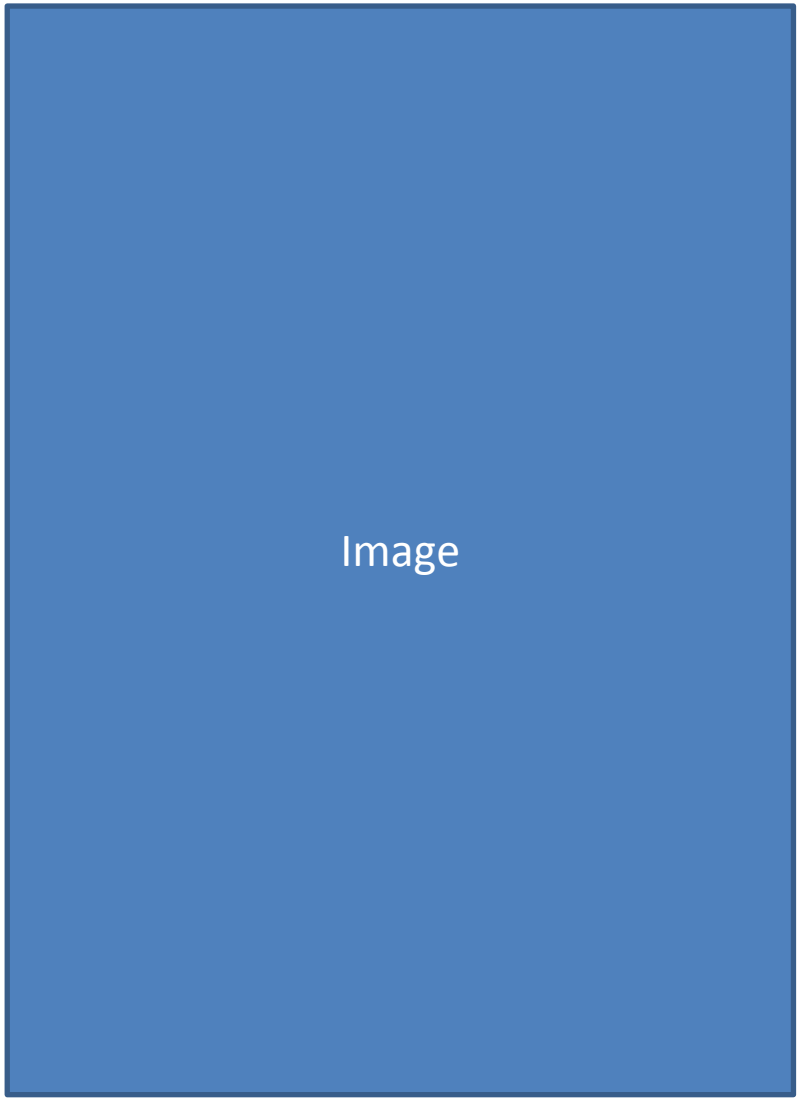
<<Background Graphic>>
All on slides

<<Trust Logo>>

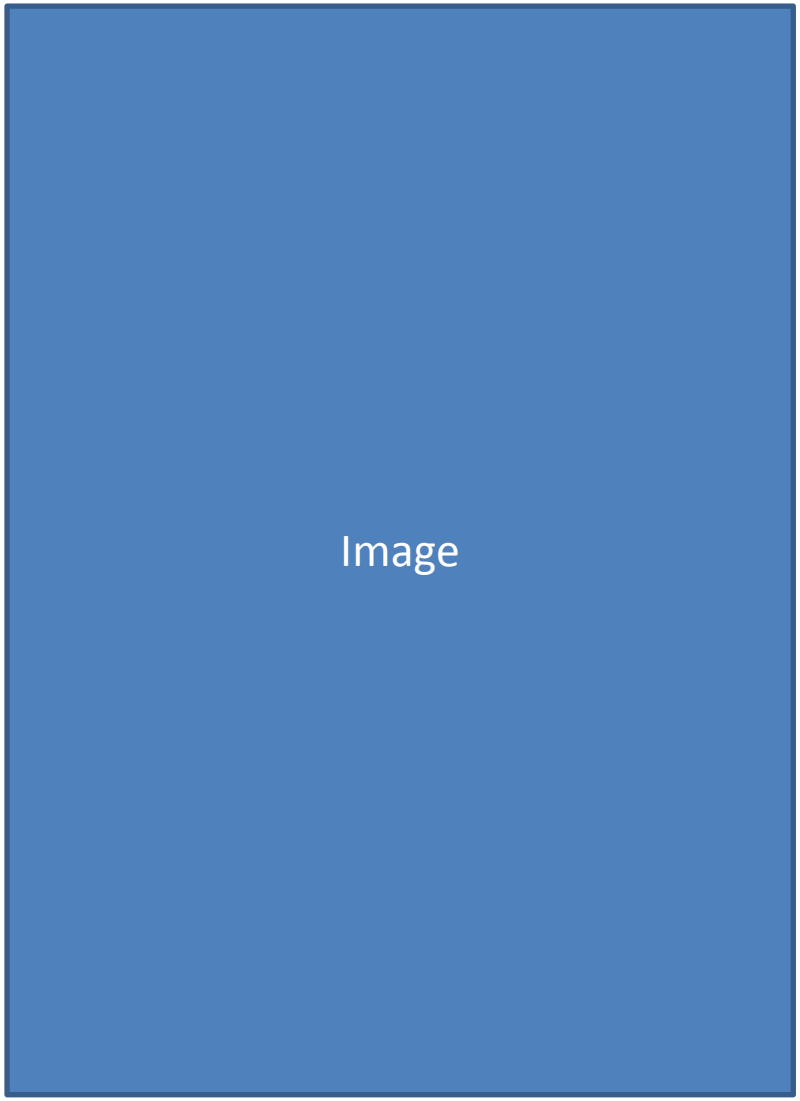
MTW Trust Strategy

2016-2021

"Caring, Sustainable and Improvement Driven"



To be improvement driven and responsive to the needs of our patients and staff, delivering compassionate, sustainable services for our community and making our trust a great place to work



Forward

Introductory words from Chairman and Chief Executive

Xxxxxxxxxxxxxxxxxxxxxx

xxxxxxxxxxxx

Signatures, name and role

Our Trust - MTW

Maidstone and Tunbridge Wells NHS Trust is a large acute hospital trust in the south east of England. It provides a full range of general hospital services to around 590,000 people living in West Kent and East Sussex. The trust also provides some aspects of specialist care to a wider population.

The trust employs a team of over 5000 staff . It operates from two main sites but also delivers services at Canterbury and Crowborough hospitals and outpatient provision at several community locations. It has over 800,000 patient visits a year, 130,000 of these coming through our Emergency Care Centres which are accessible on the main sites. Maidstone Hospital has approximately 350 beds and Tunbridge Wells Hospital approximately 450 beds.

Tunbridge Wells hospital is a Private Finance Initiative (PFI) hospital, providing mainly single bedded, ensuite accommodation for inpatients in a modern, state of the art environment. It is a designated Trauma Unit, undertakes the trust's emergency surgery and is the main site for Women and Children and Orthopaedic services.

Tunbridge Wells Hospital

Maidstone Hospital

Maidstone hospital benefits from its central county location. It hosts the Kent Oncology Centre providing specialist cancer services to around 2 million people across Kent and East Sussex, the 4th largest oncology service in the country. The trust offers PET CT services in a new, dedicated building and has a rolling programme to upgrade its Linear Accelerator radiotherapy machines.

The Maidstone site also has a state of the art birthing centre, a new £3million dedicated ward for respiratory services and an impressive academic centre with a 200 seat auditorium. With the academic centre at Tunbridge Wells, and its full resuscitation simulation suite, the trust is able to offer excellent clinical training for its junior doctors, staff and others. The trust also has a growing research capability.

Overview of Our Strategy

Our strategy was developed based on feedback from staff, patients and partner organisations.

"To be improvement driven and responsive to the needs of our patients and staff, delivering compassionate, sustainable services for our community and making our trust a great place to work"

Vision

By being more responsive and focused on improvement, MTW can fulfil its potential and be the high performing organisation its patients and staff deserve. Our aim is to be a trust where patients choose to be treated and people aspire to work.

The health system is changing around MTW due to the increasing pressure on health and social services and the need for sustainability. MTW must be ready to adapt to meet local and regional health needs. This will involve further supporting community based services and collaborating more closely with neighbouring secondary care trusts and other health providers.

Strategic objectives

The trust has identified three key strategic objectives in order to achieve its vision and become a high performing organisation:

To be recognised as a 'Caring Organisation'

As a **Caring Organisation** MTW aspires to not only care about its patients and their carers but to value and support its staff in their roles. Well supported staff are better placed to provide patients with the care they need. We will also look to work more closely with NHS and social care colleagues and the local community to ensure the safety, care and well being of our population.

To provide 'Sustainable Services'

For MTW to have **Sustainable Services** it must achieve financial balance and provide clinically viable services, ideally 7 days a week. Delivering sustainability will require a review of the way some clinical and non clinical services are configured, not only within the trust but also in partnership with others. We will also need to continue our work to reduce unnecessary costs to the organisation and to deliver services as efficiently as possible.

To be 'Improvement Driven' across all areas

To become an **Improvement Driven** and high performing organisation MTW will need to more fully embrace clinically led change and make improvement an everyday activity. This will involve actively engaging staff in the running of their services and supporting them with their developments. Timely improvement will be helped by the trust having a clear improvement plan each year and increased capability to deliver effective change.

Overview of Our Strategy

Our Values

Our staff worked together to develop our values. They define, as a trust, who we are, what we believe and how we will work as a team to fulfil our vision and meet our strategic objectives.

Patient first

We:

- put the patient first and at the centre of what we do
- ensure patient safety is our top priority
- are courteous and friendly
- keep patients and families informed
- ask people how they are
- offer help to those who need it

Respect

We:

- respect and value our patients, visitors and each other
- are open, honest and polite
- act with discretion
- seek the input of others and respect their opinion
- contribute to meetings and discussions
- take time to explain our views
- are one team, we collaborate and help

Innovation

We:

- take every opportunity to improve service delivery
- share ideas for improvement
- reviews the way things are done
- embrace change
- look out for good ideas used elsewhere
- share our successes
- identify better approaches and implement them

Delivery

We:

- aim to deliver high standards of quality and efficiency in everything we do
- work hard to meet objectives and targets
- keep our promises
- follow agreed policy and good practice
- manage time efficiently
- identify ways to reduce costs
- do not tolerate poor performance

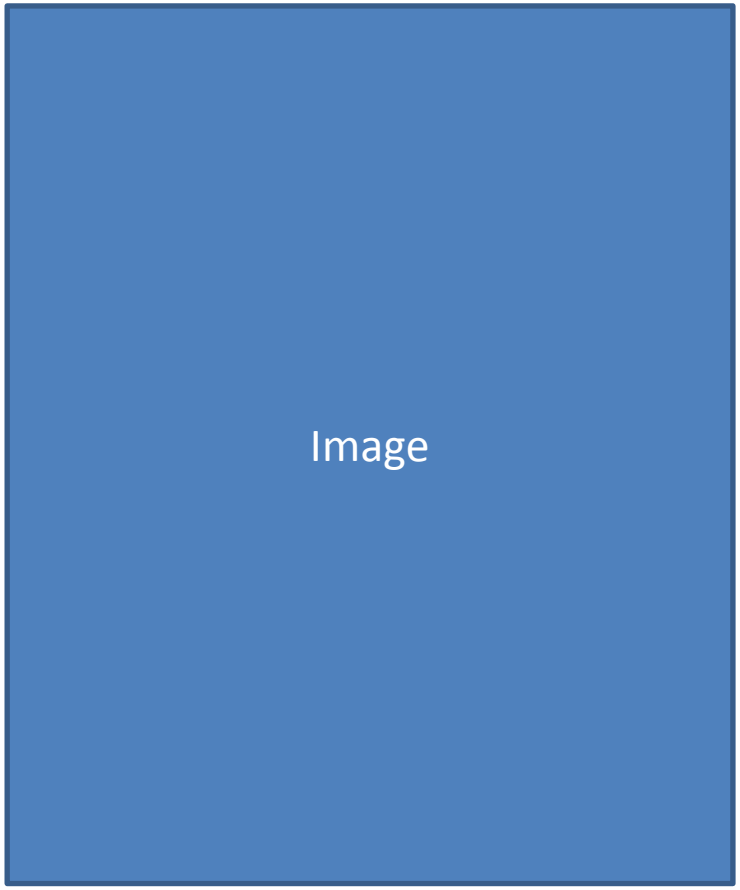
Excellence

We:

- take every opportunity to enhance our reputation and aim for excellence
- always do our best and encourage others to do the same
- challenge cynicism and rumour
- act positively to feedback
- adopt high standards of conduct and integrity
- undertake training to develop and improve
- share good news

Vision	**To be improvement driven and responsive to the needs of our patients and staff, delivering compassionate, sustainable services for our community and making our trust a great place to work**		
Strategic Objectives	**Caring Organisation**	**Sustainable Services**	**Improvement Driven**
Focus Areas	**1. Our patients and their carers** High quality care is pivotal to our vision and needs to be at the centre of what we do at MTW. It must remain the greatest motivation for our staff. **2. Our staff** Ensure staff feel supported in their roles with their efforts appreciated. There will be a continued zero tolerance of bullying and respect demonstrated for colleagues at all levels. **3. Our partners and community** Work closely with NHS and social care colleagues as well as our local community to maximise quality of care and address health inequalities.	**4. Configuration of our Services** Work to enhance local care and ensure acute services at the hospitals are run as effectively as possible in partnership with neighbouring acute providers. **5. Productivity of our services** Continue work to maximise the flow of patients through our hospitals and ensure key facilities such as theatres, outpatients and imaging are used to best effect. **6. Cost of delivering our services** Continue to identify ways in which costs to the organisation can be minimised through working with MTW and wider NHS colleagues and using benchmarking.	**7. Engaging & empowering our staff** Actively strengthen staff engagement in the running of the trust and provide ways in which staff can more easily make improvements to their services. **8. One team with one plan** Provide a clear annual plan and priorities for the trust, aligned with the strategy, so staff can pull in the same direction from across the organisation as a team and be clear about the most important improvements to be achieved. **9. Our clinical leadership** Drive up clinical engagement across the organisation at all levels to ensure we are delivering the most successful improvements for our patients and staff.
Values	**Patient First**	**Respect**	**Innovation**	**Delivery**	**Excellence**

Caring Organisation



Focus Area 1 – Our patients and their carers

The quality of patient care directly impacts outcomes for patients. Delivering high quality and trusted services for our patients and carers is pivotal in our vision; it is at the centre of what we do at MTW; and it is the greatest motivation for our staff. 'Patient First' is one of our trust's core values.

We have continued to make strong progress at MTW improving standards of care in recent years. Despite notable growth in attendances, admissions and length of stay we have managed to maintain or enhance key patient safety areas, but we know we can improve further.

Improving the care of our patients will in part be driven by our annually set quality improvement priorities. They represent the views of our stakeholders and patient groups, and going forwards will incorporate our staff survey responses, which demonstrate our staff's commitment to enhancing patient care.

Our patients, our staff and our community…..

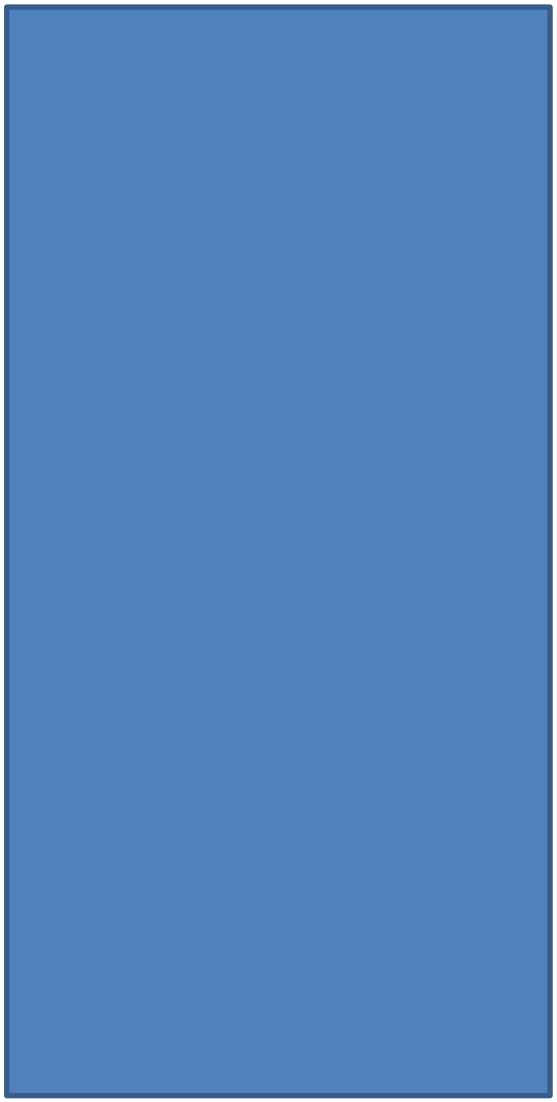
Caring Organisation

Focus Area 2 – Our Staff

Our staff are the trust's greatest asset and their day to day dedication to providing the highest possible patient care is recognised and valued. As a trust we must collectively continue to ensure that our staff have a safe and respectful working environment where issues and concerns are addressed promptly.

Hospital environments can be challenging, especially when the service comes under pressure or when events do not go according to plan. Providing support for our staff at such times and ensuring as a trust we have a learning rather than blame culture, are essential to providing high quality care. Staff must always feel able to report incidents and raise concerns without worry.

Every member of staff has an important and valued role to play in the smooth running of the hospital and the care we deliver. We are focused on improving communications and a sense of team within and across the two hospitals, and ensuring our core value 'Respect' is present at all times.



Focus Area 3 – Our community and partners

As a trust we are focused on providing the most effective and safe care that we can for our local population. To maximise patients' care we are seeking to innovate and work more collaboratively with our patients; local health partners; social care; local councils; and charitable support organisations.

This level of collaborative working will be key to ensuring the success of wider health system reforms driven by the Kent and Medway Sustainability and Transformation Plan. As a trust we are prepared to take the lead on system changes where appropriate and we are focused on working with partners to ensure equality of service provision.

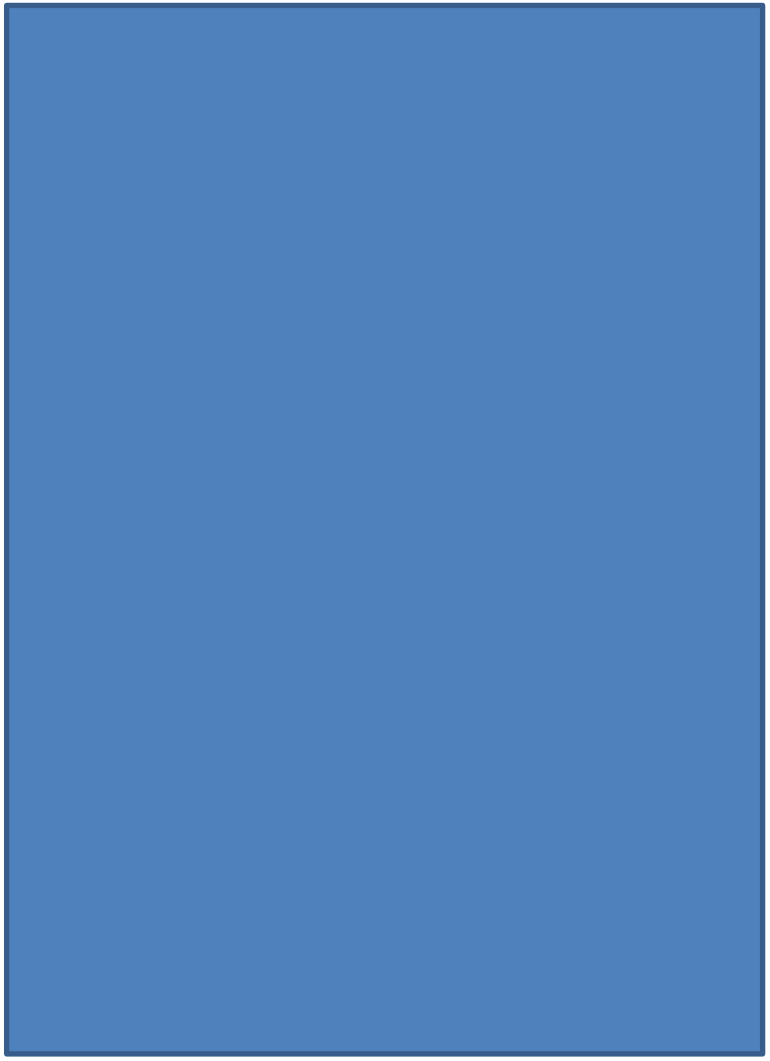
Our patients, our staff and our community…..

Focus Area 4 – Configuration of our services

A trust and health system priority will be ensuring acute hospital services are available for the acutely sick and those requiring hospital based elective care. This will require a much enhanced level of care outside the hospital. MTW recognises the role it will need to play in supporting this development, as can be seen in the redesign of West Kent's Emergency and Urgent Care pathways.

The trust has already consolidated several services across its two sites moving towards a Major Emergency Centre at Tunbridge Wells and Medical Emergency Centre at Maidstone. The projected increase in demand for acute non elective services , due to the aging population and local population growth, will require the trust to maintain an A&E service at both sites. We will continue to strengthen the Cancer Centre at Maidstone Hospital and seek to improve cancer services across the region.

Key to the trust's future service configuration strategy will be the location of the Hyper Acute Stroke Services (HASUs) in Kent. Stroke services in the county are being consolidated to significantly enhance care for all patients. MTW is fully supportive of hosting a HASU in the trust. The trust also needs to work through a permanent solution for maintaining elective care throughout the year and ensuring a consistent level of non elective services 7 days a week in the face of national staff shortages.



Configuration, productivity and cost….

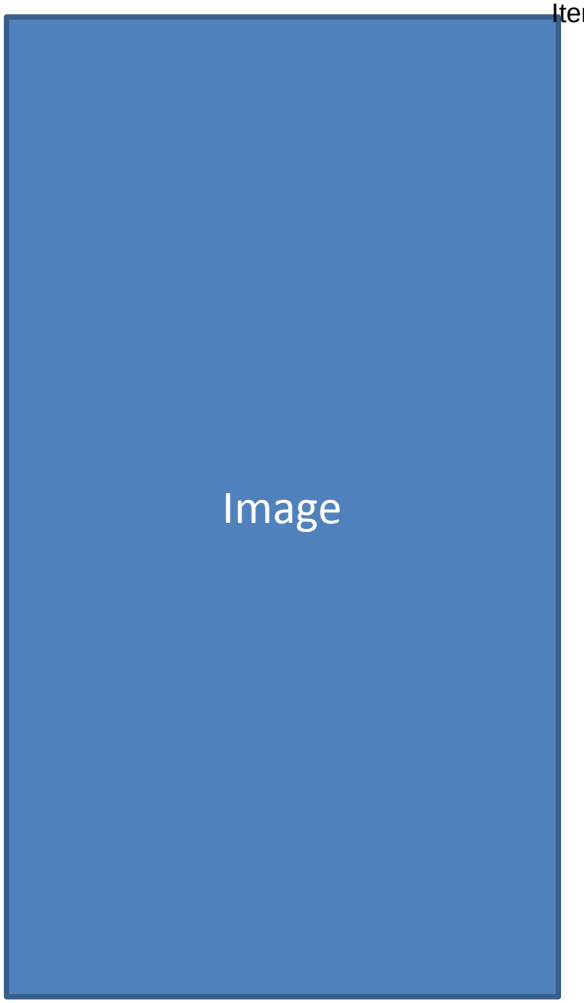
Sustainable Services

Focus Area 5 – Productivity of our services

The trust has ongoing initiatives to maximise the productivity of its services and these will continue as well as being broadened to include working with our health partners through the Kent and Medway Sustainability and Transformation Plan.

Key to the trust's overall efficiency is its ability to maintain patient flow through the hospitals, from admission to discharge. Improvements have been made but more is required, both in the hospital and more widely in the local health and social care systems, to cope with increasing pressures.

Further work around the use of our theatres; rethinking the way outpatient services are run; and understanding how to meet the increasing need for imaging and endoscopies with finite resources are challenges for most NHS trusts including MTW. Innovative on the ground thinking and the use of technology will be key to answering some of these challenges as well as looking at the skills required to do some work.



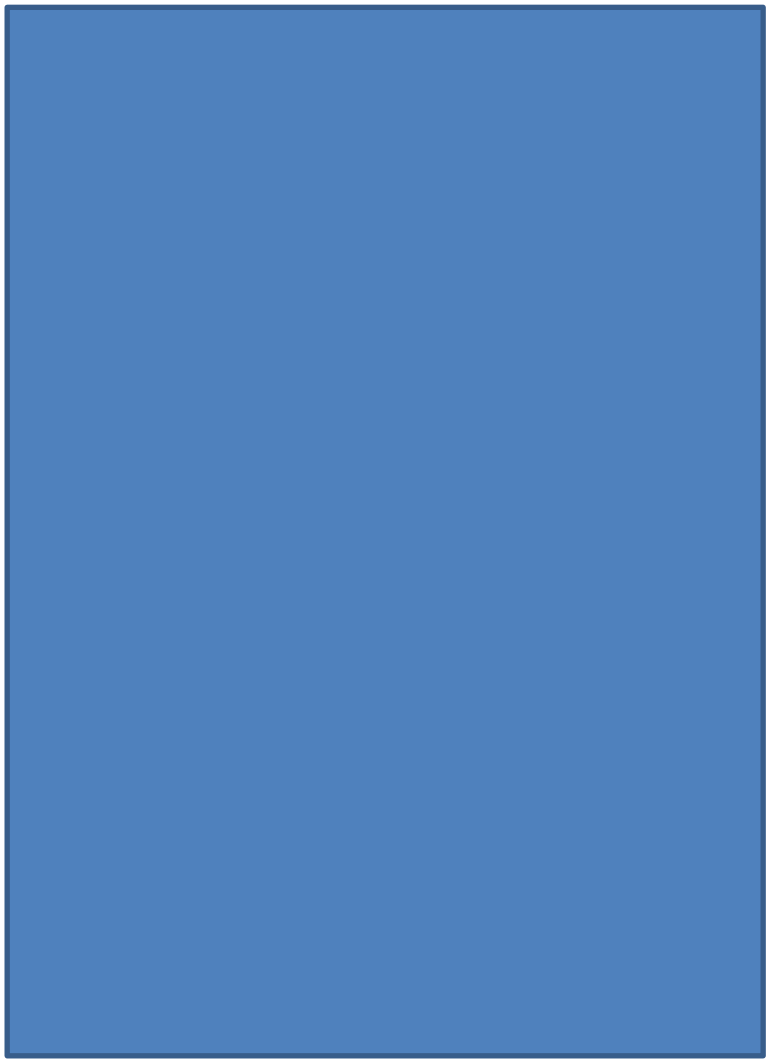
Configuration, productivity and cost….

Focus Area 6 – Cost of delivering our services

Much work has been undertaken in the trust to deepen our understanding of the costs we incur delivering services and how we can avoid unnecessary costs. This will continue with the support of centrally provided benchmarking information provided through the Carter Review and the Model Hospital work MTW is helping to pioneer nationally.

A key area of focus is to reduce the trust's spend on agency and locum positions. Our first priority has to be making MTW a great place to work , thus helping to maximise retention. Our staff will also then be our greatest advertisement for recruiting the best . Ensuring bank staff arrangements are maximised and having processes to quickly fill gaps are also key.

The Kent and Medway Sustainability and Transformation Plan is providing a focus on achieving economies regionally, through the possible consolidation of clinical and non clinical support services between trusts; reviewing procurement arrangements with partners; and the use of estates. The trust is playing an active part in this work and will continue to do so.



Improvement Driven

Focus Area 7 – Engaging and empowering our staff

For the trust to be a high performing organisation in the face of today's challenges, and those in the years ahead, it will need to further engage its staff and better empower them to deliver improvements in services. The best and most innovative ideas for effective change invariably reside with our frontline staff. A significant force for excellence, one of our core values, will come from energising patient centred and staff driven change.

As part of a broader engagement strategy to drive up staff satisfaction levels, it will be important to strengthen the communication channels and tools we use in the trust to help ensure all staff feel an important part of organisation.

Staff driven change will be further empowered through a recognised improvement function within the trust. This will be key in maintaining a focus on the tomorrow as well as today. It will advocate effective change processes to overcome the sometimes silo thinking. As well as giving support it will also provide a clear framework within which improvements can be made by staff in a timely fashion.

Improvement should be an everyday focus from ward to board. Success should be championed and failures accepted, with learning and without judgement.

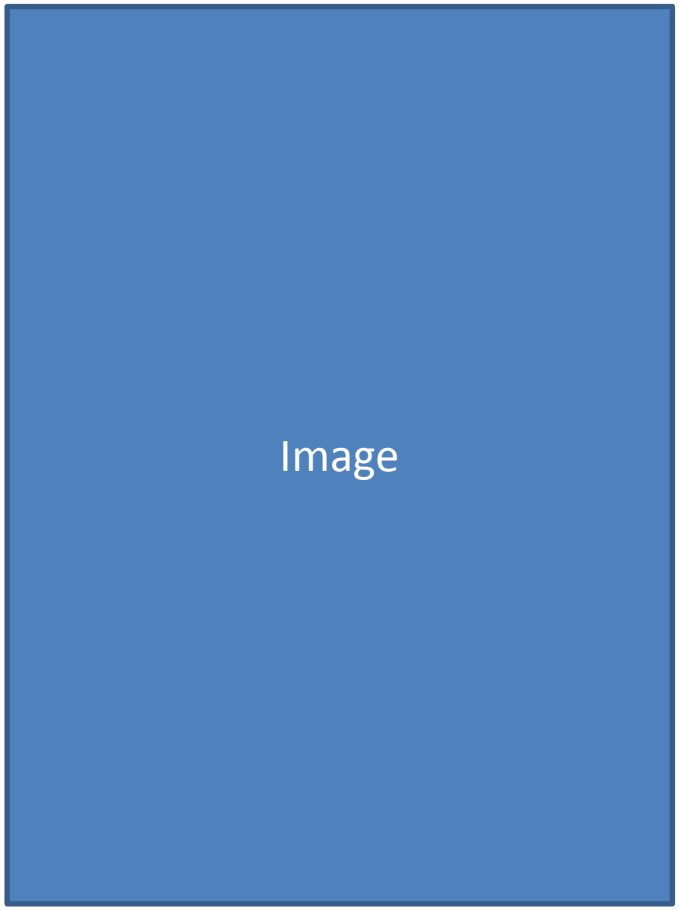
Engage, empower, plan and lead….

Improvement Driven

Focus Area 8 – One team with one plan

There are endless opportunities for improvement in any NHS trust delivering multiple services to thousands of patients every day. However, MTW has a finite number of staff and a set annual budget. It is therefore important for the trust to understand its priorities through working with its staff and patients, and be able to articulate these in the form of trust annual objectives aligned with the trust's strategy.

The annual objectives will help guide yearly divisional level business plans. In turn these will feed the trust's annual improvement plan to be implemented by teams from across the trust, sponsored by the Executive team and supported by the central improvement function. It is anticipated a shared annual improvement plan will also strengthen interdepartmental and cross site working.



Focus Area 9 – Increasing our clinical leadership

Leadership is key in any challenging and complex environments. Increasing leadership capacity at all levels, particularly amongst our clinicians, will be key to driving forwards effective improvements and navigating the coming years at the trust.

The increased presence of clinical leaders in the running of the trust will help ensure that patient or wider improvements are well thought through and implemented to best effect given the overall challenges we face. One such area will be in the use of information technology to ensure, for example, that requirements are prioritised and solutions are designed to best support the needs of our staff and their patients.

Engage, empower, plan and lead….

Trust Board meeting – October 2017

NHS Maidstone and Tunbridge Wells NHS Trust

10-16	Update on the 2017/18 Winter & Operational Resilience Plan	Chief Operating Officer

Summary / Key points

1. Executive Summary

- Winter 2016/17 was very challenging and although the plan that we had in place minimised risk to patients, it did not enable us to meet our performance standards.
- We have a clear process for planning for winter 2017/18
- We continue to have a range of initiatives funded through the operational resilience set-up at WKCCG.

2. Introduction

MTW aims to deliver accessible and high quality services throughout the year and winter is a nationally recognised pressure point that requires additional planning to sustain services and maintain resilience. The aim of our winter plan is to ensure our internal processes and systems are fit for purpose and organised to meet the anticipated level of demand safely.

The system-wide plan is overseen by the A.E Delivery Board (AEDB) and our outputs from our internal preparation have fed into the overall plan. This report confirms the resilience plans concerning the unique operational pressures of the winter period. As previously reported the objectives, governance and delivery structure to manage our clinical services safely and effectively over the winter period has been in place for a number of months.

The planning process included the assessment of likely demand over the winter period based on historical modelling compared to available bed capacity and then how through planned service improvements in operational flow, the additional pressure will be managed. This process identified a likely growth in demand with increased activity of between 5-7%, resulting in pressure on our available bed capacity.

There have been some significant developments at MTW aimed at managing patient flow more effectively, with the intention of reducing the overall number of admissions and reducing the overall length of stay for patients who are admitted.

We have seen some improvement in the health and social community capacity over the last year, largely through the “Hilton Partners” who support enablement packages for patients eligible for home care. However given the increase in demand among the frail elderly there are still significant risks of high demand and major impact on our ability to maintain patient flow with prolonged escalation into elective beds and day surgery units on both sites.

Changes introduced or continued in 2017 include:

- SAFER BUNDLE implementation which underpins improvements in length of stay and patient flow.
- Ambulatory and Acute Assessment model for all non-elective patients (in progress with more to achieve)
- Surgical Assessment Unit remaining within the catheter lab space at TWH.
- Flow co-ordinator post in ED
- Changes to the ED consultant rotas
- Implementation of Pathway 1 & 2 of Home First
- Further expansion of the Integrated Discharge Team
- Implementation of the Frailty Unit at Maidstone.

The winter resilience plan is developed in conjunction with the escalation policy which outlines the specific interventions required to manage the inevitable surges in demand that occur.

This report outlines the resilience plans put forward by each division which in turn will be underpinned by the Trust Escalation Policy. There is continued discussion within the Urgent Care Division regarding the most effective configuration of beds and escalation plans and these will be completed by the end of October.

Delayed transfers of care have reduced over the last year with a corresponding reduction in non-elective length of stay, but bed occupancy has remained high, non-elective demand is higher than previous years and there are significant staffing shortfalls across most clinical teams. .

The level of confidence of being able to manage such an increased demand without significant escalation, and impact on elective work relies on being able to secure clinical operational change, particularly on the TWH site. As the delivery of the current plans are implemented over the next 2 months, along with understanding how the health community plans will help reduce demand and discharge MFFD patients, the level of confidence can grow. The NHS expectation is for the Trust to achieve a 90% performance on the 4 hour Ed standard over the winter period, and also secure the Cancer 62day standard.

It is vital that there is full engagement, understanding and support from clinical & non-clinical services in the management of patients through these challenging periods. Through our divisional structure this engagement is being secured, concerning the winter plans. A significant risk this year is the possible effect of any flu outbreak on staffing levels which are already challenged and the further growth in patient numbers. It is planned to achieve a 70% plus of all staff receiving the improved flu inoculation will help mitigate this risk.

The attached report demonstrates the progress made within each of the divisions against the work streams which make up the winter plan and managed through the Winter Resilience Steering Group.

The report was subject to detailed discussion at the TME meeting on 11/10/17 (part 2) and further discussions have been had since then.

Which Committees have reviewed the information prior to Board submission?
Trust Management Executive, 11/10/17

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

For Information

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

Winter Planning and Resilience (Operational Resilience)

1. Introduction

The aim of the plan is to :

a. To ensure that there are plans in place to manage the modelled increased activity scenarios and likely impact on bed capacity.
b. Adopt and implement evidence based best practice, to reduce the number of non-elective medical admissions by a combination of the extended use of ambulatory care pathways, the establishment of an acute frailty service on both sites and reduced MFFD patients and to ensure internal processes and systems are fit for purpose and resilient to meet the anticipated level of demand,
c. Maintain and optimise patient flow through the hospitals to provide safe emergency and elective care.
d. To ensure that all support services have plans to meet the demand scenarios concerning increased activity throughout the hospital
e. To ensure that there is appropriate, safe escalation plans in place which reduce the risk of medical outliers and negative impact on elective activity in surgery especially when escalation occurs in the theatre recovery areas.

2. Current planning assumptions :

Activity and bed modelling scenarios covering the forthcoming winter, have been assessed and indicate:

a. Emergency admissions are currently running at an 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.

- 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.

- ii. For TW, it's currently 525-575 a week, up from 450-500 in late 2015. This could rise to 575-625 if the trend continues

If the non-elective activity trends continue, then winter admissions could be 5-10% higher than they are now. This could also be compounded by the usual 10% increase in NE LoS which results in a greater bed capacity required.

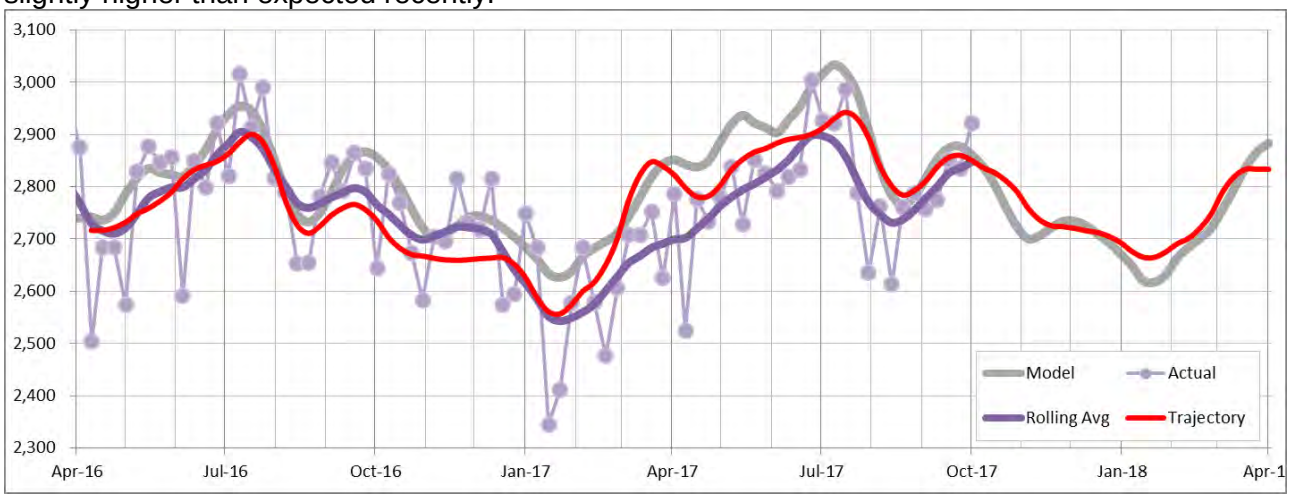
b. Non-elective LoS (excluding zero) has been fairly constant at 7.0 days for the last 2 years, with a tendency to rise by half a day or so in the depths of winter. This effect is usually only seen in Jan & Feb

c. Delayed transfers of care Delayed transfers of care have seen a small reduction over the last year although not yet achieved the limit of 3.5%. The numbers of patients who are medically fit for discharge but remain in acute beds, also remain high and these plus high bed occupancy levels (currently at 97%) which all affect our ability to manage our available capacity With increased demand in winter adds additional pressure in managing patient flow which often results in growing numbers of medical outliers.

d. A&E Attendances

This has been consistently a few percent below model since April, but the two seem to be gradually converging again. This is likely due to the model correcting itself downwards as the unusually high attendances in the first half of last year drop out of the calculation. The model

constantly re-calibrates based on the last 12 month's activity, which is why it has been predicting slightly higher than expected recently.

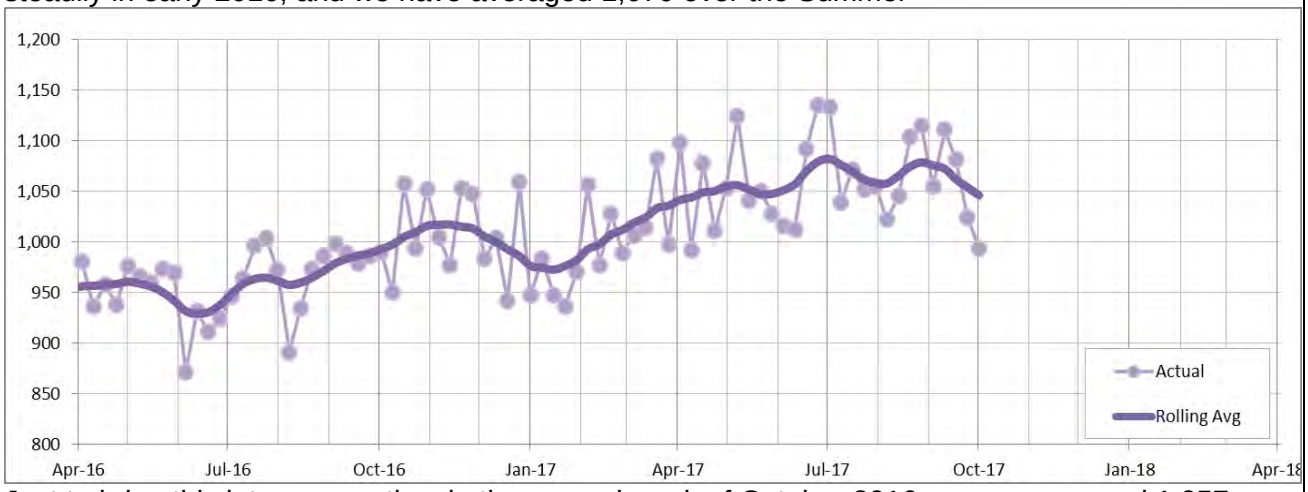


For the first half of the year, our headline A&E Attendance is 1.1% up on last year, but most of that is in the Minor Injury Units which are 5.4% up on last year.
In 1718 YTD has type 1 attendances 0.4% up on last year. This compares to growth of around 1.9% over the past 12 years. Given that 1617 was unusually high, a drop would not have been unusual.

The most likely scenario therefore is to expect a winter with similar (within a few percent) attendance volumes to last year.

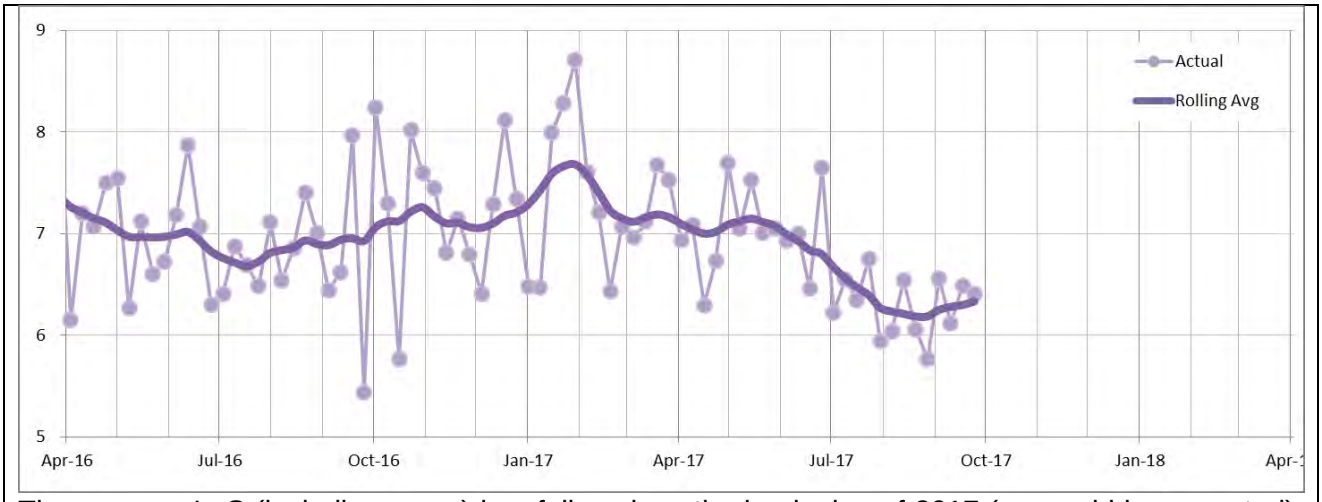
Non Elective Admissions

These have inflated considerably over the past couple of years. 1314, 1415 and 1516 all saw typical weekly NE admissions holding fairly steady in the 900 to 950 range, but that started to climb steadily in early 2016, and we have averaged 1,070 over the Summer



Just to bring this into perspective, in the second week of October 2016, we saw a record 1,057 admissions – but over the past few months, 1,057 would represent a fairly quiet week.
The introduction of Ambulatory and Elderly Frailty pathways will inevitably cause an increase in NE activity, because of a small but significant cohort of patients who are now being recorded and treated as inpatients instead of being dealt with in A&E.

It is worth noting that the percentage of Zero LoS non-electives has increased steadily from 26% in Jan-16 to 35% over the Summer which is the expected outcome from our ambulatory and frailty pathways.



The average LoS (including zeros) has fallen since the beginning of 2017 (as would be expected), but more significantly, the non-zero LoS has also fallen, averaging 6.4 over the Summer, compared to 6.9 for the equivalent period last year

Bed Modelling

Initial analysis indicates that despite an improvement in LOS over the summer months, there will be a shortfall in beds over winter for non-elective admissions. The analysis is based on the actual patients in beds each day this year to date (April to September – Summer) and last year for Winter (December 16 to Feb 17). The data, which is currently being validated across the specialties also assumes that we will have a very similar level of activity (normal level of growth) and LOS this winter as last winter.

A number of initiatives are being proposed by both Urgent and Planned care to mitigate any shortfall that the initial analysis has shown. Therefore a more detailed bed analysis of requirements per site for NEL and elective will be available by end October which takes account of these proposals.

3. Operational Winter resilience plans by Divisions

3.1 Urgent care

- Ambulatory Emergency Care (AEC) and Acute Frailty Service (AFS**)**

Ambulatory care pathways are being introduced in 3 phases during the year with 36 pathways in place by October 2017 across both sites. The ultimate goal is to implement advanced streaming at the front door, so that all patients are ambulatory by default unless the clinical presentation requires a different clinical pathway.

The tables outlined from page 7 offers a summary of what has been achieved to date and what is planned over the forthcoming weeks in preparation for winter within the urgent care division. Each of the divisions has detailed plans to oversee the delivery of each initiative.

The Acute Frailty Unit opened at Maidstone Hospital on 06/06/2017 as a 5 day unit and will open on the Tunbridge Wells site in late October. The planned impact of the Acute Frailty Unit is based on empirical evidence that 50-60% of patients attending the hospital who meet the Bournemouth Criteria are appropriate for the frailty service. This criteria may be widened to include patients meeting the Rockwood Criteria by end October. The service will deliver reduced admission rates and reduction in LOS.

- Medically Fit For Discharge (MFFD)

From February 2017, the Trust has 'cohorted' patients considered medically fit for discharge (MFFD) on to 2 designated wards (58 beds) with a clear approach to discharge management. However, the number of MFFD patients exceeds this capacity by an average of 60 patients. The Trust is exploring a number of options within the Health Community to reduce this number. These include the expansion of the Home First Programme and getting system wide agreement for the procurement of Pathway 3 beds. The Business case has been developed and discussion with the Home first board is making progress.

3.1 Planned benefit

The successful implementation of Ambulatory Emergency Care (AEC) and Acute Frailty Service (AFS) will reduce the demand for inpatient beds and especially for those requiring a long length of stay. However, even with full benefit realisation of these initiates there is still a bed shortfall particularly on the TWH site.

3.2 Additional initiatives

The additional plans in the table below will help patient flow and help counteract the bed shortfall.

Initiative	Explanation of what it involves	The likely benefit
1. *Extending hours of Discharge Lounge at TW to close at 20.00hr*	*Staff consultation underway. Looking at staffing requirements and cost but expecting to be able to do this without additional resources by staggering start/finish times.*	*More patients will be able to be transferred to the Discharge Lounge later in the afternoon which frees up beds on the wards to support better flow.*
2. *Reducing OP clinics over the weeks of 18th Dec, 27th Dec and 2nd Jan and allocating consultants and Regs to wards for additional ward rounds.*	*This has been agreed by Site Leads. Clinics being cancelled.*	*Improved discharge profile on the key weeks leading up to and after the Xmas/New year period to support flow and safety*
3. *Consultants to provide their leave requests for the 3 week period from 18th Dec to 5th Jan to be submitted by October*	*Asking consultants to comply with this request (officially only need to give 6 weeks' notice)*	*Will allow us to roster senior decision makers to each ward as described in point 2.*
4. *'Outlier' medical team to support winter resilience. Supported by both site leads and CD and management team.*	*Suggested team consisting of:* *1 consultant* *1 reg/ staff grade* *2 Juniors* *1 senior nurse* *1 pharmacist*	*Better continuity in reviewing the patients by the same team would improve flow by reducing the LOS of the medical outliers*
5. *Senior nurse to be seconded to support the medical Post Take Ward Round each morning in ED/AMU*	*CSP has agreed to a 6/12 secondment to undertake this role, starting from 1st November*	*Improved patient flow and reduction in Stranded Patients*
6. ED improvement -is 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	Improve timeliness of 1st clinical assessment Breach report circulated to all specialties highlighting breach reasons on a daily basis Review of handover delays Improvement in real time tracking	Improved reaction time to patients needed specialist review within E.D
7. *Implementation of the front-door GP streaming model,*	*A&E departments are then free to treat for the most urgent patients. This includes the estates changes to support this pathway following a successful capital bid*	*The timely review of the most urgent patient within E.D. by diverting patients away from minors .*
8. Improving flow- Embedding of SAFER and implementing a review process of the stranded patients	Review of wards against new CUR (Clinical Utilisation Review) data identifying themes/ action plans for stranded patients. A key to improving this is the process to identify stranded patients which can now occur through	Secure appropriate but well planned patient discharges in a timely way

	the Clinical Utilisation Review (CUR) software initiative . The Stranded Patient metric is be implemented, putting a focus on all patients with a LOS of 7 days and over 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	
9. Go Green for Winter	*Red and green days will be introduced as a visual management system to improve flow and identify where patients are delayed. A Red Day is a day of no added value to the patient. A Green day is a day of value to the patient where a patient receives active medical treatment or diagnostics on the day that they have been requested. These will be monitored on a daily basis through the site meetings*	*To ensure that patients are identified and then receive timely treatment to reduce their LOS*
10. Implementation of Home First in Full (pathways 1 & 2 already in place)	*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.*	*Ability to move 30 MFFD patients from acute beds into a community setting awaiting further assessment of their future needs. This wil generate physical bed capacity within the acute hospital setting*
11. The escalation and de-escalation policy been reviewed	These reflect the changes in bed availability this year compared to last year and ensure that the escalation ladder reflects the operational objectives, needs and priorities of the organisation. To also ensure that that agreed policies such as patient 'ward boarding' are understood and implemented Current available escalation capacity is Foster Clark at Maidstone, however, the use of this ward for transferred elective work from TWH would mean that Paele ward could close and then be available for escalation for non elective	A comprehensive plan / policy which educates the organisation as to how, where and when escalation can take place. Also what it means to staff in terms of additional actions required

	activity if required, recognising that patients (possibly MFFD) would need to move between sites	
12. Workforce – reduce the risk of Flu outbreaks affecting both staffing and patients	*–to secure 70% + inoculation rates amongst our staff and encourage risk patients to have their injections*	*Reduced risk of high staff sickness rates over the acute winter period*

4.0 Planned care Winter and resilience plans

Capacity plans indicate that Maidstone site will be able to continue all elective work as normal. In addition, it should also provide the Division opportunities to move as many sessions as possible from Tunbridge Wells Hospital (TWH) to MH to protect activity, including MOU being fully utilised 10 sessions per week by moving more surgeons and equipment.

The Division developed 2 scenarios for winter 2017-18 whilst further analysis was being undertaken and it is now very clear that **PLAN B** will be the winter plan in operation this year.

The main impact to Planned care, occurred last year on the TWH site. As the bed modelling indicates a shortfall of Urgent care beds, there is a significant risk to elective activity on the TWH site.

Planned care winter plan focuses on

a. Further refine ambulatory care pathways
b. Improve the flow between Trauma Inpatients @ TWH and Edith Cavell Rehabilitation ward
c. Introduce “Ticket Home” to improve discharge.
d. Open Theatre 3 by November, which will further increase capacity for NEL surgery and Trauma. This will reduce the delays for patients waiting for emergency surgery, which in turn will reduce the LOS for these cases and so reduce the demand for beds that Planned care will need for emergency patients.
e. Confirming feasibility of moving Gynaecology or ENT elective activity from TWH to Maidstone over the winter period 23rd Dec- 19th Feb and possibly to the 31st March

4.1 Divisional Elective Activity plan between 23rd Dec and 19th Feb

The last two years has shown that TWH comes under significant pressure over the winter period, however the pressures on the elective pathways, particularly the cancer pathways remain.

An assessment will be made at the end of October as to determine if
the non-elective demand is being managed and the improvements to the unplanned care pathways have been successfully implemented. If they have, escalation into Theatre Recovery 1 or 2 will not be needed routinely. The plan will then be to have 6 theatres open – 3 used for emergency work, the other 3 allocated one each to Gynae, T&O and ENT as these have the largest RTT backlogs (Plan A)

However, if non elective demand at the trust continues to rise and the initiatives identified are unable to cope, plan B will be implemented as SSSU will remain fully escalated and escalation into Recovery 1 or 2 is likely . This would result in only 4 theatres being open – 3 used for emergency work and the remaining one allocated to ENT, Gynaecology, and Ortho for cancer work or 52 week breaches. This will mean very little or no elective activity will take place. Due to this risk, a further assessment is underway to identify the feasibility of moving all of gynaecology or ENT elective activity from TWH to Maidstone over the winter period 23rd Dec- 19th Feb and

possibly to the 31st March

Both plans assume that elective work at Maidstone Hospital will be unaffected and includes keeping MOU ring-fenced from escalation. In plan A, if implemented alongside moving as much activity to Maidstone will enable the Trust to maintain its RTT performance achieved by December. However, if plan B has to be implemented then experience from the last two years would indicate our waiting list backlog would rise by around 500 patients and we could see a 2-3% drop in our overall performance, that is why the assessment of moving all of Gynaecology patients to Maidstone is underway

Initiative / Plan Planned care	Explanation of what it involves	The likely benefit
1. Maintaining elective activity at Maidstone	• All Theatre lists will run as normal in Main theatres, EMU and MSSU – except lists cancelled due to AL • MOU will be run 10 sessions per week and will not feature as part of escalation – this will involve elective Orthopaedic lists being moved in addition to those currently allocated to MOU to ensure it is fully utilised and maximum elective activity is maintained	Ensure elective activity will continue at Maidstone at normal levels and so help maintain cancer performance
2. Moving elective activity from TW to MH	*As many lists as possible will be moved across to Maidstone. Consultants are being asked to provide advance notice of leave now rather than 6 weeks ahead to ensure this is planned well in advance in order to protect as much elective activity as possible* *Plan for moving as much of gynaecology and ENT elective activity from TWH to Maidstone over the winter period to be examined and implemented if feasible*	*To maximise as much elective activity as possible to sustain the RTT position as achieved at the end of Dec throughout jan / Feb rather than worsen by 500 patients as has occurred in the last 2 years through cancellations*
3. Escalation plan for MH involving surgery	Up to 6 IP beds will be offered towards winter escalation for Urgent care to use as part of the wider Escalation plan	To provide medical bed space without impacting on surgical activity to support A&E performance as part of escalation plan
4. Implementation of either Plan A or B (between 23rd Dec and 19th Feb) at Tunbridge Wells for	*1. **Plan A -** If SSSU is able to be de-escalated by 9 beds and it is unlikely that the site needs to use Recovery 1 or 2 for escalation then 6*	*Ensure elective activity can continue at TWH for those specialities with the highest RTT backlogs to maintain*

	elective care based on progress of Urgent care schemes – final decision to be taken at end of October	*theatres open – 3 used for emergency work, the other 3 allocated one each to Gynae, T&O and ENT as these have the largest RTT backlogs assuming both recoveries have not been escalated into. TW Orthopaedic Unit would be reduced from 11 to 5 elective ring-fenced beds* 2. ***Plan B** - If SSSU remains fully escalated and it is likely that the site needs to use Recovery 1 or 2 for escalation then only 4 theatres will be open – 3 used for emergency work and the remaining one allocated to ENT, Gynae, Ortho for cancer work or 52 week breaches. TW Orthopaedic Unit would be reallocated in full to NEL beds* *In both options above SSU will also be staffed to operate an admissions lounge process which again will help flow of any elective activity that does take place.*	*position as at start of winter (i.e. does not worsen) as well as maintain cancer performance.* *This also increases capacity for NEL patients especially for surgery by ensuring extra emergency theatre is in place, thus reducing pre-operative LOS*
	5. *Ambulatory care pathways for I&D and orthopaedic cellulitis/sepsis*	*Develop ambulatory pathways so they are agreed, documented and circulated to the appropriate staff.* *Explore other possible ambulatory pathways for implementation.*	*These pathways will assist in reducing surgical admissions and length of stay.*
	6. *Cancelled operating lists between 23rd Dec and 19th Feb*	• *Surgeons who have their lists cancelled in a planned way will be asked to undertake clinics instead to ensure activity and waiting times are reduced here.* • *Those who still have their lists cancelled on the day will be asked to support the emergency teams in undertaking ward rounds, operating etc.* • *In some areas it may be possible to allocate more surgeons / anaesthetist annual leave during this period than normal, as long as services are covered.*	*As above but focus more towards maintain OPD activity and reducing waiting times here*
	7. *Increasing elective*	*In run up to December extra*	*Improve RTT position*

activity before 23rd Dec across both sites	*activity at weekends and ensuring all existing sessions are fully utilised within theatres will be pushed as much as possible to mitigate any loss of activity in Q4.*	*and reduce waiting times before head into Winter as part of plan to return to 92% aggregate by end of November*
8. Implement a Non-elective Matron for TWH only from 1 November – 31 March 2018	*Matron to support all surgical specialities to optimise patients and assist with the stranded patients on a daily basis*	*Optimise discharges within surgery and assist with the push/pull of patients from A&E*
9. Critical care capacity to meet peaks in demand within the Trust and within the local network.	Escalation for physical Critical Care Capacity and patient dependency occurs on both the Tunbridge Wells and Maidstone sites during peak demand periods. Whilst Maidstone ICU is currently staffed for a dependency of 7, 14 physical bed spaces are available within the ICU to admit patients. At Tunbridge Wells Hospital the ICU is currently staffed for a dependency of 7 although there are 9 physical bed spaces and with the colocation of Non Elective Recovery provides the use of a maximum 2 further bed spaces, an ICU bedside workstation is in place to facilitate this. Both Intensive Care Units submit twice daily updates to the National NHS Directory of Services (DOS) online Critical Care bed capacity system and daily to the Emergency Bed Service. At TWH there are 3 extra wte posts to help facilitate escalation into Recovery by providing a good core staff base to enable a critical care "staff bank" to function and cover when we need to escalate.	All escalation is dependent on a suitably trained workforce and staff are utilised flexibly across site on a daily basis to accommodate patient need. This may be supported by the Critical Care Outreach Service if required
Diagnostics and Clinical Support		
10. 7 day pharmacy service will be provided	The main challenge concerns staffing levels , however these are currently being improved prior to winter	Allow improved discharge arrangements over the weekend
11. Outsource CT Scan capacity	This will be for routine tests in run up to winter to ensure internal capacity free for NEL patients	To ensure 6 week diagnostic target maintained throughout winter for

		CT
12. Increased phlebotomy service	To increase staffing x 1 per day on both sites	To ensure capacity increased to meet demand and assist in improving flow for NEL patients
13. Increase mortuary capacity	To increase mortuary capacity internally and by working with partner organisations	To increase mortuary capacity by 100 for the winter period to cope with potential increase in demand

5.0 Women's and children – winter plans

Initiative	Action	Benefit
1. Maintain elective activity RTT performance	• *Continue with waiting list sessions* • *Move DC and IP gynaecology to Maidstone (as theatre capacity allows)* • *Ensure compliance with ambulatory pathways*	• *Ensure elective activity will continue to maintain RTT performance*
2. Preserving elective activity – linked with implementation of either Plan A or B as part of Planned Care initiatives outlined in section 4.0	• *As per planned care*	• *As per planned care*
3. Cancel operating lists between 23rd Dec and 19th Feb	• *Surgeons who have their lists cancelled in a planned way will be asked to undertake clinics instead to ensure activity and waiting times are reduced here.* • *Those who still have their lists cancelled on the day will be asked to support the emergency obstetric teams in undertaking ward rounds, operating etc.* • *In run up to December extra activity at weekends and ensuring all existing sessions are fully utilised within theatres will be pushed as much as possible to mitigate any loss of activity in Q4.*	• *As above but focus more towards maintain OPD activity and reducing waiting times here* • *Improve RTT position and reduce waiting times before head into Winter as part of plan to return to 92% aggregate by end of November*

4. Emergency gynaecology	• *To extend the opening hours of EGAU to 7 pm dependant on staffing availability when in OPAL 3/4?.*	• *Help to manage the flow of these patients when the trust is experiencing high demand*
5. Emergency Paediatrics	• 5 escalation beds on Hedgehog ward will be escalated from Nov 1st. There is an escalation policy in place . • Once Hedgehog is full then further escalation occurs in Woodlands dependant on staffing.	• To manage peaks in demands
6. Maternity flows	• *Upgrade discharge lounge on post-natal ward to encourage early vacated beds* • *Increase ward clerk hours on delivery suite 1400-2000hrs to ensure no patient flow delays due to paperwork* • *Follow escalation policy on Q pulse* • *This includes network divert on a case by case basis if needed- depends on everyone else's status*	

6.0 Estates and Facilities management – winter plans

Initiative / Plan	Explanation of what it involves	The likely benefit
1. Internal Facilities Staff bank	Increase staff bank pool across Facilities. Employees can work multi/cross disciplinary. Better bank provision reduces need for overtime and agency. Recruitment and retention remains a challenge in FM.	Savings. Multi skilled workforce. Improved morale/lower stress at buy times. Quicker response to shortages.
2. Non Emergency Patient transport	*Provision of self managed discharge and transfer service.*	*Better patient experience. Faster patient discharges and moves.*
3. Catering - emergency food provision	Additional stock of frozen meals to be held in case of inclement weather/delivery failures	Ensure continuity of catering provision to staff and patients.
4. Inter-departmental management working and	Management provision takes responsibility across the full range of Hotel Services. I.e. Zone managers now support catering and portering as well as	Increased management input across services and better resilience through winter when staffing comes

support incl daily/weekly duty manager and supervisor.	domestics. Daily nominated lead for default ‘goes 'to' lead, to avoid confusion.	under pressure and weather can impede staff attendance.
4 x 4 driver training	General Transport drivers to receive 4 x 4 training	Readily available driver pool for driving 4 x 4 vehicles in inclement weather. Keep staff coming to work and maintain discharges of patients etc.
Winter Snow and Ice Procedure	The purpose of this document is to identify who is responsible for managing, implementing and carrying out the various aspects of maintaining the roads and pathways for the safe passage of patients, visitors and staff during periods of forecasted or unpredicted inclement weather i.e. frost, icy conditions and snow	Ensure safe access in and around the sites.

7.0 Engagement Plans

A winter planning table top exercise with representatives from across the health community is planned for the end of october. This will use different scenarios to test the resilience of local plans.

Confirmation of the plans is occurring though the divisions via the divisional meetings and clinical operations and delivery meetings.

Staff Flu inoculation campaign, will begin in October to secure high rates of protection amongst our staff

Planning meetings with health and social care, including ambulance services to share and understand each organisations plans, particularly around escalation.

8.0 Financial Planning.

An appraisal of how much the current winter plans will cost, against the £800k winter funding, is underway. This will identify what financial risk there is , particularly concerning the implementation of the full escalation plans if required . Additional patient transport needs , winter staff transport and staff welfare etc is also be identified as a financial risk but may not be required unless we experience prolong cold weather.

9.0 Risks.

The risk log identifies the key risks and mitigating actions.

No.	Risk Title	Risk Description	Impact	Response/ mitigating Actions
1a	**Significant rise in non-elective activity**	Non-elective activity continues to rise at both E.D's leading to increased numbers of admissions (assuming same admission ratio continues) beyond the model .	• Poor patient experience • increased pressure on staffing and other resources, • reduced quality of care , reduced elective capacity and • added pressure to constitutional targets.	Four key elements to the mitigation action plan: 1. To increase ambulatory work - fully utilising new facility 2. Move planned activity from TWH to Maidstone to generate capacity 3. Using SAFER, improve the inpatient LOS and comprehensively deliver the known best practice across the specialties. 4. Robust directorate plans to be in place, prior to winter.
1b		Increase in more complex, elderly patients. LOS could rise in the future resulting in poor flow of patients through the hospitals	• beds not available in a timely way to absorb the numbers requiring admission . • Overcrowding in the Emergency Department	Delivery of the acute elderly frailty units is proven to help in reduce LOS and impact on MFFD numbers. Focusing on full adherence to safer principles and growth of the HOME to Assess programme (home first)
1c		Insufficient physical beds and trolleys to cope with increased demand and escalated areas To ensure that the order for beds/trolleys have accounted for normal escalated areas	unable to open all escalation areas, with increased pressure in E.D	Accurate needs assessment through EME, undertaken. 20 beds to be leased.
	Staffing vacancies (medical nursing and therapies)	a. There are currently high numbers of nursing and consultant vacancies in key areas. In addition there are a number of junior Dr rota gaps, shortages in AHP & Scientific / Technical staff in particular areas.	All of which cause pressure on the normal operational flow of patients without the additional pressure experienced during winter months. In addition cover arrangements through bank and agency can be very expensive and add to the financial risk.	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 trust-wide approach to payments for temporary staff is being developed to increase the number of MTW staff available to work bank shifts.

No.	Risk Title	Risk Description	Impact	Response/ mitigating Actions
2a		b. insufficient to open escalation areas	Unable to open all necessary beds, use of bank and agency staff to cover shifts with increased cost. NB their availability also variable during winter periods	A clear Temporary Staffing Policy, which supports the need for additional staff particularly during the winter period, is being developed Ongoing recruitment process to increase number of permanent staff and reduce reliance on bank and agency staff
3a	**Financial implications of delivery**	The costs of implementing the winter plans and if full escalation is required, this will cost more than the £800K winter allocation	Added financial pressure to the Trust	develop comprehensive list of likely and possible costs and to prioritise any costed initiatives
3c		reduced PP income due to escalation and need to use greater numbers of PP beds than planned	adding financial pressure to the overall financial position	a. Securing a robust escalation plan agreed with all parties as to use of areas to manage the increased flow. - NB recognised that the risk to remaining PP income will remain through winter B. Improve the LOS of our patients and comprehensively deliver the known best practice across the specialties
5a	**Failure to achieve A&E, standards**	standards are already under pressure	poor patient experience , increased pressure on E.D. staff, reduce quality of care .	Four key elements to the mitigation action plan: 1. To increase ambulatory work - fully utilising new facility 2. Move planned activity from TWH to Maidstone to generate capacity 3. Improve the LOS of our patients and comprehensively deliver the known best practice across the specialties 4. robust directorate plans to be in place, prior to winter
	Failure of Ambulatory care and Acute frailty services Best Practice Pathways to deliver on plan	The benefits of moving patients through the hospital more rapidly reducing the pressure on beds will not be achieved	additional bed capacity required to cope with additional winter pressure	clinically led group set up to secure implementation at TWH initially on the AMU

No.	Risk Title	Risk Description	Impact	Response/ mitigating Actions
6a	**Unable to undertake planned elective activity due to unplanned escalation with non-achievement of RTT and Cancer standards**	More planned care cancelled across the sites due to escalation into planned care beds and theatre recovery	patients waiting longer for vital panned treatment , reduced RTT performance	Comprehensive delivery of the Planned care winter plan with maximising the opportunity to move work to Maidstone
7a	**Patient safety and deterioration patient experience-**	patients waiting within areas not designed to hold beds / trolleys (on-designated assessment or in-patient areas)	Difficulty to maintain appropriate monitoring of patientns. Inability to see emergency patients arriving by ambulance quickly (within 15 mins) increased numbers of complaints	use of boarding policy - patients on wards, recovery area 2 and ED corridors within the escalation policy and a 4 hour maximum stay indicator
8a	**Insufficient support within health community and social services for :** **a. Home first pathway 3 business case - 30 beds**	pathway 3 business case for 30 beds submitted to help to deuced MFFD numbers of patient within acute hospital beds required for increased winter demand	patients in hospital beds who should be discharged resulting reduced bed capacity for acute medical admissions required for winter	AEDB in place to manage system / improvements across the health and social care system
10a	**Adverse Winter weather**	a. cold / ice/ snow causes likelihood of increased numbers of patients needing E.D attention and admission b. difficulty with staff getting into workplace	b. clinical areas short of staff which may then need to close compounding the bed pressures	a. to secure access to 4WD vehicles to support staff travel b. accommodation where necessary c. ensure local access on site is safe for staff and patients
11a	**Flu pandemic**	significant increased number of staff become ill with flue , unable to work resulting in risk to patient care with depleted staff numbers particularly affecting clinical environments. Increased incidence of flu in southern hemispheres.	clinical areas short of staff which may then need to close compounding the bed pressures	need to achieved 70% plus in vaccination programme . Inoculation campaign initiated in October
12a	**Capacity if a major incident happens in a state of full escalation**	this is very unlikely but the trust does need to understand what action would be needed and if access on such occasion with the independent sector hospital is practicable	added pressure of admissions to very busy hospital environments possibly leading to patients being cared for outside normal ward environments	assessment of feasibility / cost of pre arranged use of Independent hospitals to free up capacity to treat major incident casualties?

No.	Risk Title	Risk Description	Impact	Response/ mitigating Actions
13a	**Pathology service**	capacity becomes limited due to breakdown of machinery during period of high demand in winter	delay on pathology results may need to outsource whilst machine repaired . Check current contingency plans	contingency plans in place to secure timely test results
14a	**Mortuary services**	insufficient capacity to meet increased demand on this service	patients without suitable environments to be in, awaiting burial / cremation	modelling identified the need for capacity for 100 additional bodies ,contingency plans for 100 additional capacity identified
15a	**Radiology services**	winter capacity risk identified	delay on radiology test and / or results leading to delay in decision making and patient flow	additional capacity sourced locally for planned work, so that emergency capacity available.
16a	**Pharmacy service**	staffing risk as well as equipment / IT breakdown risk	delay on pharmacy drug advise at ward level and or dispensing, leading to delay in patient flow and discharge	prioritised contingency plans required to secure timely dispensing service to secure timely discharge of patients

Trust Board meeting – October 2017

NHS Maidstone and Tunbridge Wells NHS Trust

10-17	**Developmental review of leadership and governance using the Well-Led Framework – Self-assessment**	**Chief Nurse**

The Trust has been asked by NHS Improvement (NHSI) to undertake a self-assessment review of leadership and governance using the latest NHS Well-Led Framework. NHSI have offered to provide support to the Trust in undertaking a review using the Framework, & has asked the Trust to undertake a self-assessment in the first instance.

Background:

- In May 2014, Monitor published its "Well-led framework for governance reviews: guidance for NHS foundation trusts". This was related to the expectation, within Monitor's Code of Governance, that Foundation Trusts (FTs) carry out an external review of their governance every 3 years (the Framework was considered to help with that assessment). The document did not however apply to NHS Trusts (as the Code of Governance did not apply)
- Robert Francis' second report into the failings at Mid Staffordshire NHS FT subsequently led to major changes in the Care Quality Commission's (CQC) regulatory regime, and to Monitor's and the NHS Trust Development Authority's routine oversight of providers and assessment of aspirant FTs. The 3 bodies committed to developing an aligned Framework for making judgements about how well led NHS providers were.
- An updated "Well-led framework for governance reviews: guidance for NHS foundation trusts" was then issued by Monitor in April 2015. The document again did not strictly apply to NHS Trusts, however the NHS Trust Development Authority stated it would pilot a new process for undertaking well-led reviews with a small number of NHS Trusts. Monitor also confirmed its intention to use the well-led framework as the basis of its assessment of aspirant FTs from that point
- In June 2017, NHSI published "Developmental reviews of leadership and governance using the well-led framework: guidance for NHS trusts and NHS foundation trusts". This replaced the April 2015 Framework, and applies to both NHS Trusts and FTs
- The Trust has not undertaken a review against previous versions of the Well-Led Framework, but (as with all NHS Trusts) is now strongly encouraged to carry out developmental reviews or equivalent activities approximately every 3 years

The Framework is structured around 8 Key Lines of Enquiry (KLOEs), as follows:

1 Is there the **leadership capacity and capability** to deliver high quality, sustainable care?	2 Is there a clear **vision** and credible **strategy** to deliver high quality, sustainable care to people, and robust plans to deliver?	3 Is there a **culture** of high quality, sustainable care?
4 Are there clear responsibilities, **roles** and systems of accountability to support good governance and management?	**Are services well led?**	5 Are there clear and effective processes for managing **risks**, issues and **performance**?
6 Is appropriate and accurate **information** being effectively processed, challenged and acted on?	7 Are the **people** who use services, the public, **staff** and **external partners engaged** and involved to support high quality sustainable services?	8 Are there robust systems and processes for **learning**, continuous **improvement** and **innovation**?

The enclosed document provides the first draft self-assessment, which was sent to NHSI on 29/09/17. The format used has been adapted from NHSI's "Developmental reviews of leadership and governance using the well-led framework: guidance for NHS trusts and NHS foundation trusts" document.

The Trust's compliance with the KLOEs will adapt and developed, and therefore the assessment is dynamic, and subject to change. However, the Trust Board is asked to review the self-assessment, and either agree with the conclusions reached (and associated actions) or propose and agree alternative conclusions.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

To review the self-assessment, and either agree with the conclusions reached (and associated actions) or propose and agree alternative conclusions.

[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

Developmental review of leadership and governance using the well-led framework – Self-assessment

NHS Maidstone and Tunbridge Wells NHS Trust

Key Line of Enquiry (KLOE) 1: Is there the leadership capacity and capability to deliver high quality, sustainable care?		
CQC inspection teams' prompts for assessment of this KLOE	**Positive assurance / evidence**	**Negative assurance/areas for improvement, with additional action/s to be taken (with Lead individual)**
Do leaders have the skills, knowledge, experience and integrity that they need – both when they are appointed and on an ongoing basis? (W1.1)	▪ The Chair of the Trust Board took up post in May 2017, but has a vast amount of senior experience, including as a Chief Executive of NHS acute Trusts (Chelsea and Westminster Hospital NHS Trust and the Oxford Radcliffe Hospitals NHS Trust) and with many years senior experience in the private sector ▪ The Acting Chief Executive has been Deputy Chief Executive since April 2015, and before joining the Trust was a Portfolio Director at the NHS Trust Development Authority (TDA), with responsibility for oversight of NHS Trusts in the South East. He has also previously held senior positions in South East London Strategic Health Authority, King's Health Partners and in central government. ▪ The Director of Finance has been in post since April 2014, and joined from a neighbouring acute NHS Trust, where he had been Deputy Director of Finance (which included a 12-month spell as Director of Finance). ▪ The Medical Director and Chief Nurse both commenced in February 2017; the former was an experienced Medical Director, having fulfilled that role at Kent Community Health NHS Foundation Trust (FT); while providing care in at Maidstone and Tunbridge Wells NHS Trust as a Consultant Physician for more than 10 years. The Chief Nurse also knew the Trust well, having previously served it as a Deputy Chief Nurse ▪ The Chief Operating Officer has been a stable figure at the Trust, having joined in 2004 and undertaking a variety of senior nursing and management roles, including as Deputy Chief Operating Officer and the 18-week programme director. She became Chief Operating Officer in October 2011 ▪ The Director of Infection Prevention and Control has been in post since 2007 (November), and is very well-regarded both regionally and nationally. She had previously been the Consultant in Communicable Disease Control (CCDC) at the Kent Health Protection Unit. ▪ The Trust's Director of Workforce left in the summer of 2017, but a replacement (who is currently the Director of Human Resources and Organisational Development at Oxleas NHS FT) has been appointed and starts in post on 01/12/17 ▪ The 2 most long-standing NEDs are very experienced, having both previously been the Chair of the Board at another local NHS Trust ▪ The Trust engages executive recruitment companies when appointing members of	▪ The substantive Chief Executive post is currently vacant ▪ There is currently 1 vacancy for a NED **Action: Recruit to the current vacant Chief Executive and NED positions (Chair of the Trust Board)**

Key Line of Enquiry (KLOE) 1: Is there the leadership capacity and capability to deliver high quality, sustainable care?		
CQC inspection teams' prompts for assessment of this KLOE	**Positive assurance / evidence**	**Negative assurance/areas for improvement, with additional action/s to be taken (with Lead individual)**
	the Executive Team, to ensure the strongest possible pool of candidates applies ▪ External advisors were also engaged to recruit to a vacant Non-Executive Director (NED) position in 2017, which led to a very strong field of applicants. The resulting appointee is currently Director of Finance of the Wellcome Trust, and had previously been Finance Director of Virgin Atlantic ▪ A further NED starts in post on 01/12/17. The individual has a 37-year management career in healthcare, predominantly in the NHS (including as the Chief Executive of NHS West Kent between 2006 and 2011) ▪ Two very experienced Associate NEDs were appointed in the summer of 2017, to strengthen the pool of Non-Executives and aid NED succession planning. ▪ An induction programme is in place for members of the Executive Team and NEDs ▪ A Code of Conduct is in place for the Trust Board (as part of the "Gifts, hospitality, sponsorship and interests policy and procedure"), which promotes the Nolan Committee's 7 principles of public life ▪ The Trust has a robust process (within its Standing Orders) for complying with The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which requires that Directors (or equivalent) of health service bodies be "fit and proper persons" ▪ The Listening into Action (LiA) Leadership Audit saw a good response (121 respondents within the Trust) and leaders "self-assessed" themselves and the Trust's leadership culture positively in 11 out of 20 questions ▪ In addition to their experience, many Trust Board Members have developed their skills through training and other methods such as action learning sets and mentoring/coaching	
Do leaders understand the challenges to quality and sustainability and can they identify the actions needed to address them? (W1.2)	▪ The Trust Board takes an honest view of the Trust's challenges, and has acknowledged these consistently in its formal documentation, including the Trust's Annual Governance Statements, Board Assurance Framework (BAF), Annual Reports, and forward planning submissions ▪ There are many examples of the Trust Board and its sub-committees holding members of the Executive Team to account (for example in relation to the previously high Hospital Standardised Mortality Ratio (HSMR)) ▪ In addition to their involvement in the Trust Board and sub-committee, NEDs chair steering groups and lead 'deep dive' reviews into areas of concern. For example, the Chair of the Quality Committee also chairs the Workforce Transformation Steering Group and Quality Impact Assessment (QIA) 'deep dives' will be led by NED ▪ The Trust Board meets each month (apart from in August) and receives a range of	▪ Many of the NED Members of the Trust Board are new in post, and require intensive focus to reach the same level of understanding as more longstanding NED colleagues **Action: Complete the induction programmes for the newly-appointed NEDs (Trust Secretary / Chair of the Trust Board)** **Action: Organise a further Trust Board 'Away Day' to assist the newly-appointed NEDs to reach the**

Key Line of Enquiry (KLOE) 1: Is there the leadership capacity and capability to deliver high quality, sustainable care?		
CQC inspection teams' prompts for assessment of this KLOE	**Positive assurance / evidence**	**Negative assurance/areas for improvement, with additional action/s to be taken (with Lead individual)**
	information to enable a broad picture of the Trust's performance, including any areas of concern, to be identified and discussed ▪ Trust Board 'Away Days' are held (usually twice per year) which usually focus on the Trust's future strategy and sustainability ▪ A Committee structure is in place below the Trust Board for specific issues to be considered in more detail, and enable assurance and/or requests for action/support to be escalated to the appropriate level of authority ▪ The Committee structure is dynamic, with changes being made in response to needs, as identified. For example, the Finance Committee has recently extended the scope of its remit to include non-quality performance-related matters (and duly been renamed as the Finance and Performance Committee)	**same level of understanding (with regards to the Trust's future sustainability) as their more longstanding NED colleagues (Trust Secretary / Chair of the Trust Board)**
Are leaders visible and approachable? (W1.3)	▪ Trust Board Members are encouraged to visit departments and reports detailing the visits made are submitted to the Trust Board each quarter ▪ Details of Trust Board Members and their portfolios of responsibility are available on the Trust Intranet ▪ The Trust has recently adopted the LiA initiative and a launch event was held in July 2017. LiA is led by the Acting Chief Executive, and supported by senior staff from across the Trust. Some positive progress is being made	▪ The results from the LiA leadership audit reported that staff wanted greater visibility of senior leaders in the Trust and improved communications and engagement. **Action: To increase the visibility of Trust Board Members (Acting Chief Executive)**
Are there clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership, and is there a leadership strategy or development programme, which includes succession planning? (W1.4)	▪ In September 2015 the Trust Board approved a 5 Year Workforce Strategy, "Shaping Our Future Together, 2015-2020". The Strategy defines the ambition to construct an organisation where people deliver excellence each day and feel engaged, enabled and empowered to work for the Trust. The Strategy has 6 interrelated workforce priorities: Recruitment & Retention; Temporary Staffing; Culture; Health & Wellbeing; Integrated Education; and Equality & Diversity. 6 programmes of work have been identified to deliver the above priorities ▪ The Workforce Strategy incorporates Leadership and Talent Management. A senior talent review was completed in August 2016 to highlight areas of strengths and gaps for succession in the Senior Management structure. ▪ Succession planning and talent management within the Divisions is managed through the appraisal process. Through these processes gaps were identified in development for Band 5 staff to transition into Band 6 and 7 supervisor/manager posts. In addition, a competency set based on the Healthcare Leadership Model was developed, along with an in-house leadership programme ▪ Staff at Band 6/7 and above are funded for accredited programmes with HEI to support transition into Senior Leadership positions. Heads of Service are supported to apply for scholarships to assist them in Director-level posts e.g. Florence	▪ The Trust lacks a current leadership and talent management strategy which incorporates the emerging apprenticeship framework pathways. **Action: To develop a leadership and talent management strategy, separate to and in support of, the Workforce Strategy and incorporating the emerging apprenticeship framework pathways (Director of Workforce)**

Key Line of Enquiry (KLOE) 1: Is there the leadership capacity and capability to deliver high quality, sustainable care?		
CQC inspection teams' prompts for assessment of this KLOE	**Positive assurance / evidence**	**Negative assurance/areas for improvement, with additional action/s to be taken (with Lead individual)**
	Nightingale Leadership Scholarships. ▪ The Trust also works with the NHS Leadership Academy to utilise their courses at the appropriate level. Staff participating in leadership programmes in the last 12 months / full financial year include: o 17 in-house Leadership and Management o 3 CIPD Business Leadership Development o 2 Florence Nightingale Leadership Scholarships o 5 MBA Healthcare Leadership and Management o 2 MSc Health and Management o 1 Mary Seacole Leadership Course o 53 Middle Manager Bootcamp o 5 ILM Leadership and Management Certificates o 1 The Kent MBA ▪ The leadership development needs of Clinical Directors has been recently discussed (within the Clinical Directors' Committee and Executive Team meetings), and an external company (Ashridge Executive Education) has been engaged to undertake a diagnostic review, and make recommendations ▪ Two very experienced Associate NEDs were appointed in the summer of 2017, to strengthen the pool of Non-Executives and aid NED succession planning ▪ The Trust's management structure has evolved considerably in recent times. The most notable recent developments have been the introduction of 3 clinical Divisions, and the establishment of posts associated with the management and oversight of such Divisions. This has included creating Divisional Directors of Operations, Divisional Associate Directors of Nursing, Deputy Medical Directors (aligned to each Division), and an Associate Medical Director for Operations ▪ The Medical Director is the Executive lead for Equality and Diversity	

Key Line of Enquiry (KLOE) 2: Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?		
CQC inspection teams' prompts for assessment of this KLOE	**Positive assurance / evidence**	**Negative assurance/areas for improvement, with additional action/s to be taken (with Lead individual)**
Is there a clear vision and a set of values, with quality and sustainability as the top priorities? (W2.1)	▪ The Trust Board has discussed the Trust's future strategy regularly in the past, within formal Trust Board meetings and Trust Board 'Away Days'. It is currently scheduled to be asked to approve a revised Trust Strategy at its meeting in October 2017;	▪ Following Trust Board approval the awareness of the Strategy will be promoted among staff

Key Line of Enquiry (KLOE) 2: Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?		
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Is there a robust realistic strategy for achieving the priorities and delivering good quality, sustainable care? (W2.2) Have the vision, values and strategy been developed using a structured planning process in collaboration with staff, people who use services, and external partners? (W2.3) Do staff know and understand what the vision, values and strategy are, and their role in achieving them? (W2.4)	provisional conversation about the revised strategy was had at the September 2017 Trust Board meeting ▪ The Strategy has been informed by a range of internal and external liaison and engagement ▪ The Trust's quality priorities are described within the annual Quality Accounts, which are approved by the Trust Board ▪ The Trust Board approved the key objectives to feature within the BAF in April 2017 ▪ In September 2015 the Trust Board approved a 5 Year Workforce Strategy, "Shaping Our Future Together, 2015-2020" ▪ The Trust's has the following long-established values: o P – Patient. First We always put the patient first and at the centre of what we do o R – Respect. We respect and value our patients, visitors and each other o I – Innovate. We take every opportunity to improve service delivery o D – Delivery. We aim to deliver high standards of quality and efficiency in everything we do o E – Excellence. We take every opportunity to enhance our reputation and aim for excellence ▪ The PRIDE mnemonic features widely across the Trust, and is the name of the Trust's staff magazine. The vision and PRIDE values are also incorporated into the online induction for all staff, and have also been promoted specifically over time. For example, "Living our Values" workshops were started in autumn 2015, and ran in 2016. These were led by the Director of Workforce and Communications, Chief Nurse and Medical Director, and operated by the Learning & Development Team, and aimed to enable participants to interact, learn from each other and focus on how we achieve the Trust's future vision together. Some "I'm taking 'PRIDE' in providing safe care" badges were also issued to staff to promote the application of the values during daily activities ▪ The results of the 2016 National NHS staff survey show that the Trust performs above the acute Trust national average for staff stating that "Care of patients / service users is my organisation's top priority". The Trust is also rated as 'average' for "overall staff engagement" ▪ 66% of staff stated that they understood how their role contributes to the wider organisational vision in the LiA 'pulse' survey	**Action: Active engagement with staff in the refreshing and implementation of the Trust's strategy (Acting Chief Executive)** **Action : the Trust is currently undertaking a review of current processes of methodology for quality improvement (acting Chief Executive)**
Is the strategy aligned to local plans in the wider health and	▪ The Trust is fortunate that many of its Executive Team lead on Kent and Medway Sustainability and Transformation Partnership (STP) related work, which enable the	Not Applicable

Key Line of Enquiry (KLOE) 2: Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?		
CQC inspection teams' prompts for assessment of this KLOE	**Positive assurance / evidence**	**Negative assurance/areas for improvement, with additional action/s to be taken (with Lead individual)**
social care economy, and how have services been planned to meet the needs of the relevant population? (W2.5)	Trust to be at the forefront of local plans in the wider health and social care economy. Specifically: o The Trust's former Chief Executive is the Chief Executive for the STP o The Medical Director was until recently the co-Chair of the STP Clinical Board, and remains an active member o The Acting Chief Executive is the Chair of a Joint Clinical Strategy Group (with Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust) o The Director of Finance is the SRO for the STP Productivity workstream ▪ The Trust's Strategy outlines a direction of travel, highlighting particular areas on which to focus. Its implementation, largely through specific initiatives, business planning and improvement work is overseen by the Directorate management structure and the Project Management Office (PMO)	
Is progress against delivery of the strategy and local plans monitored and reviewed and is there evidence to show this? (W2.6)	▪ The Trust Board has discussed the future strategy of the Trust regularly in the past, within formal Trust Board meetings and Trust Board 'Away Days'. It is currently scheduled to be asked to approve a revised Trust Strategy at its meeting in October 2017. ▪ The Trust's quality priorities are described with the annual Quality Accounts, which are approved by the Trust Board. Update reports on the priorities are reported to the Trust Management Executive (TME) and 'main' Quality Committee ▪ The Trust Board approved the key objectives to feature within the BAF in April and July 2017, and BAF update reports are submitted to the TME, Audit and Governance Committee, Finance and Performance Committee (for the financial objectives only), and Trust Board	▪ Regular updates on implementation of the Strategy to be submitted to the Trust Board **Action: Provide reports on the implementation of the Strategy to the Trust Board (Acting Chief Executive)**

Key Line of Enquiry (KLOE) 3: Is there a culture of high quality, sustainable care?		
CQC inspection teams' prompts for assessment of this KLOE	**Positive assurance / evidence**	**Negative assurance/areas for improvement, with additional action/s to be taken (with Lead individual)**
Do staff feel supported, respected and valued? (W3.1) Is the culture centred on the needs and experience of people who use services? (W3.2)	▪ The results of the 2016 National NHS staff survey show that the Trust is… o in the "Highest (best) 20%" for "% appraised in last 12 months" o rated as "Above (better than) average" for "Quality of appraisals" o rated as 'average' for "overall staff engagement" o Rated "Above (better than) average" for "% agreeing that their role makes a difference to patients / service users"	▪ The results of the 2016 National NHS staff survey show that the Trust is rated as "Below (worse than) average" for "Support from immediate managers", "Staff satisfaction with resourcing and support" and "Staff

Key Line of Enquiry (KLOE) 3: Is there a culture of high quality, sustainable care?		
CQC inspection teams' prompts for assessment of this KLOE	**Positive assurance / evidence**	**Negative assurance/areas for improvement, with additional action/s to be taken (with Lead individual)**
Do staff feel positive and proud to work in the organisation? (W3.3)	o Rated as "Highest (best) 20%" for "Effective use of patient / service user feedback" o Rated as "Above (better than) average" for "Staff recommendation of the trust as a place to work or receive treatment" o Rated as "Average" for "Staff motivation at work" ▪ The results of the initial LiA 'pulse' survey show that: o 57% of staff feel happy and supported working in their team/department/service; o 44% feel valued for the contribution they make and the work they do o 37% responded that the organisation supports them to develop and grow in their role o 62% of staff consider that the Trust is providing high quality services to its patients / service users o 54% felt that quality and safety of patient care is the Trust's highest priority o 55% of staff would recommend the Trust to family and friend ▪ Feedback from the LiA organisers is that, while appearing low, these scores compare favourably with most Trusts at this stage in the LiA process. ▪ The Trust celebrates staff achievements via the PRIDE Staff magazine; Employee and Team of the Month Awards; Annual staff star awards; the Chief Executive's weekly newsletter; and the Chief Executive's report to each Trust Board meeting ▪ A range of methods are employed to identify and respond to the needs of patients and carers. These include an active local patient survey programme, the Friends and Family Test (FFT), the Patient Experience Committee, and local user groups (such as the Critical Care Users Forum and Endoscopy Users Group)	satisfaction with the quality of work and care they are able to deliver". However, an action plan has been developed in response to the survey findings (which has been reported to the Workforce Committee), and the work is closely linked to the LiA initiative ▪ The results of the initial LiA 'pulse' survey show only 31% felt that the Trust's organisational structures and processes support them and enable them to do their job well. An action plan therefore needs to be developed to respond to the issues raised via the Listening into Action pulse survey and leadership audit **Action: Develop an action plan to respond to the issues raised via the Listening into Action pulse survey and leadership audit (Acting Chief Executive)**
Is action taken to address behaviour and performance that is inconsistent with the vison and values, regardless of seniority? (W3.4)	▪ The Trust has the expected range of Human Resources policies and procedures to address situations that warrant a more formal response such as a Performance Management (Capability) Policy and Procedure, a Disciplinary Policy and Procedure, and a Bullying and Harassment policy and procedure ▪ High ranking staff have felt the experience of being performance / behaviour managed	▪ The Trust's revised Consultant Job Planning policy will introduce a consistency panel as part of the process **Action: Implement the revised Consultant Job Planning policy, once ratified (Medical Director)**
Does the culture encourage, openness and honesty at all levels within the organisation, including with people who use services, in response to incidents? Do leaders and staff	▪ The Trust has a "Speak Out Safely (SOS) Policy and Procedure" (formerly Whistle Blowing ▪ The Trust Board receives a 6-monthly update on the issues reported by the anonymous reporting process, and the action taken as a result. The issues raised via anonymous reporting, and the Trust's responses, are also posted on the Intranet site. ▪ The Anonymous reporting database has captured 29 anonymous reports / incidents of whistleblowing from staff in the past 12 months ▪ The Trust was rated as "Good" in the national "Learning from Mistakes" League which	▪ The "Speak Out Safely (SOS) Policy and Procedure" does not currently incorporate the Trust anonymous reporting scheme **Action: Update the "Speak Out Safely (SOS) Policy and Procedure" to incorporate the system of anonymous reporting (Chief Nurse /**

Key Line of Enquiry (KLOE) 3: Is there a culture of high quality, sustainable care?		
CQC inspection teams' prompts for assessment of this KLOE	**Positive assurance / evidence**	**Negative assurance/areas for improvement, with additional action/s to be taken (with Lead individual)**
understand the importance of staff being able to raise concerns without fear of retribution, and is appropriate learning and action taken as a result of concerns raised? (W3.5)	was published in March 2016 ▪ The results of the 2016 National NHS staff survey show that the Trust is… o Rated as "Above (better than) average" for "Fairness and effectiveness of procedures for reporting errors, near misses and incidents" and "Staff confidence and security in reporting unsafe clinical practice" o Rated as "Average" for "% reporting errors, near misses or incidents witnessed in last month"	**Director of Workforce)**
Are there mechanisms for providing all staff at every level with the development they need, including high quality appraisal and career development conversations? (W3.6)	▪ The Trust has Policies and Procedures for Non-Medical Staff Appraisal; and for the Appraisal and Revalidation of Medical Staff ▪ The Trust Board receives an Annual Report from the Responsible Officer (the Medical Director) in relation to Medical Appraisal and revalidation, which enables the Board to approve the relevant Statement of Compliance confirming that the Trust, as a designated body, is in compliance with the regulations governing appraisal and revalidation ▪ Appraisal rates are monitored routinely, and are included in the monthly Performance Dashboard reviewed by the TME and Trust Board ▪ The results of the 2016 National NHS staff survey show that the Trust is… o Rated as "Highest (best) 20%" for "% appraised in last 12 months" and for "% believing the organisation provides equal opportunities for career progression / promotion" o Rated as "Above (better than) average" for "Quality of appraisals"	▪ The results of the initial LiA 'pulse' survey show that 37% of staff feel that the organisation supports them to develop and grow in their role **Action: Develop an action plan to respond to the issues raised via the Listening into Action pulse survey and leadership audit (Acting Chief Executive)**
Is there a strong emphasis on safety and well-being of staff? (W3.7)	▪ A range of "Staying Healthy – Feeling Good" activities have been established, led by the Trust's Head of Staff Engagement and Equality. These activities include a Walking Club at Maidstone Hospital; Creative Writing classes; mindfulness classes, acupuncture, and relaxation classes ▪ The Trust is promoting the national "Stoptober" 28-day stop smoking challenge among staff (and patients) ▪ The Trust has a strong Occupational Health service ▪ The Trust has an appointed Guardian of Safe Working Hours to ensure that the safety provisions of the new Terms and Conditions of service for Junior Doctors are working correctly and reported to Trust Board (reports are submitted each quarter, via the Workforce Committee). The Guardian also raises exception reports, attends Junior Doctor meetings and has a direct line to the Medical Director for theresolution of exception reports	▪ The results of the 2016 National NHS staff survey show that the Trust is rated as "Lowest (worst) 20%" for "Org and mgmt interest in and action on health and wellbeing". However, an action plan has been developed in response to the survey findings (which has been reported to the Workforce Committee), and the work is closely linked to the LiA
Are equality and diversity promoted within and beyond the organisation?	▪ The Trust is committed to the equality agenda and continues to support the delivery of the Workforce Strategy, 2015-2010. The strategy demonstrates a commitment to	▪ The results of the 2016 National NHS staff survey show that the Trust is

Key Line of Enquiry (KLOE) 3: Is there a culture of high quality, sustainable care?		
CQC inspection teams' prompts for assessment of this KLOE	**Positive assurance / evidence**	**Negative assurance/areas for improvement, with additional action/s to be taken (with Lead individual)**
Do all staff, including those with particular protected characteristics under the Equality Act, feel they are treated equitably? (W3.8)	creating a culture that promotes equality & embraces diversity in all its functions as both an employer and a service provider. The Trust's aim is to provide a safe environment, free from discrimination, and a place where all individuals are valued, treated fairly and accepted for who they are without exception. ▪ The Trust is in the first year of a new approach to embedding and mainstreaming equality into everything it does, which is spearheaded by a dedicated Staff Engagement and Equality lead. ▪ In June 2016, the Trust implemented a new translation service, providing a one stop shop for all translation requirements. Provision includes written translation, face to face language translation, British Sign Language (BSL), Deaf/Blind services and telephone interpreting. Telephone interpreting is available 24 hours a day, 7 days a week, 365 days a year. Requests for face to face and BSL interpreting may be made both in-an-out-of-hours through an online portal. ▪ A Cultural Diversity network was set up in late 2016 with the purposes of ensuring that the Trust continually improves equality in the provision of healthcare, other services and employment. It will ensure the Trust complies with equality, non-discrimination and human rights law & raise awareness of cultural diversity in the workplace through events, diversity days & initiatives. The Network will act as a forum for staff of different cultures to come together, share experiences and find support for the issues that affect them. ▪ A survey in 2016, created in collaboration with Great Ormond Street Hospital, assessed how members of the Trust's Lesbian, Gay, Bisexual and Transgender (LGBT) community are treated at the Trust and the results will be used as a basis for creating an inclusive environment for its LGBT community as patients and staff within the organisation. The Trust works with Stonewall, a charity which supports people from the LGBT communities, and is pleased to be a Diversity Champion. The programme is an excellent framework for creating a workplace that enables LGBT staff to reach their potential. ▪ The Disability Confident Scheme, launched by the Government in July 2016, replaced the Positive about Disability "Two Ticks" scheme. The Trust has achieved Level 2 – Disability Confident Employer status, demonstrating that it actively seeks out and hires skilled disabled people helping to positively change attitudes, behaviours and cultures. ▪ The results of the 2016 National NHS staff survey show that the Trust is rated as "Highest (best) 20%" for "% believing the organisation provides equal opportunities for career progression / promotion" ▪ Addressing health inequalities is a particular focus of the Sustainability and	rated as "Above (worse than) average" for "% experiencing discrimination at work in last 12 months". However, an action plan has been developed in response to the survey findings (which has been reported to the Workforce Committee), and the work is closely linked to the LiA initiative

Key Line of Enquiry (KLOE) 3: Is there a culture of high quality, sustainable care?		
CQC inspection teams' prompts for assessment of this KLOE	**Positive assurance / evidence**	**Negative assurance/areas for improvement, with additional action/s to be taken (with Lead individual)**
	Transformation Plan in Kent and Medway. The Case for Change for Kent and Medway identifies areas experiencing health inequalities and a consultancy has been employed to specifically understand access to services for all parts of the population and the potential impact on health.	
Are there co-operative, supportive and appreciative relationships among staff? Do staff and teams work collaboratively, share responsibility and resolve conflict quickly and constructively? (W3.9)	▪ The results of the 2016 National NHS staff survey show that the Trust is rated as "Average" for o "Staff motivation at work" o "% appraised in last 12 months" and o "% believing the organisation provides equal opportunities for career progression / promotion" ▪ The results of the initial LiA 'pulse' survey show that 57% of staff feel happy and supported working in their team / department / service	▪ The results of the 2016 National NHS staff survey show that the Trust was rated "Below (worse than) average" for "Staff satisfaction with level of responsibility and involvement", and "Effective team working". However, an action plan has been developed in response to the survey findings (which has been reported to the Workforce Committee), and the work is closely linked to the LiA initiative ▪ The results of the LiA 'pulse' survey show that only 22% of the staff who answered feel that day to day issues and frustrations that get in the way are quickly identified and resolved **Action: Develop an action plan to respond to the issues raised via the Listening into Action pulse survey and leadership audit (Acting Chief Executive)**

Key Line of Enquiry (KLOE) 4: Are there clear responsibilities, roles and systems of accountability to support good governance and management?		
CQC inspection teams' prompts for assessment of this KLOE	**Positive assurance / evidence**	**Negative assurance/areas for improvement, with additional action/s to be taken (with Lead individual)**
Are there effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable	▪ There is a clear organisational structure which sets out responsibility for delivering quality, operational and financial performance. ▪ There are clear processes for planning and budgeting of all income and expenditure ▪ There is timely reporting of any issues or concerns raised by both Internal / External	Not Applicable

Key Line of Enquiry (KLOE) 4: Are there clear responsibilities, roles and systems of accountability to support good governance and management?		
CQC inspection teams' prompts for assessment of this KLOE	**Positive assurance / evidence**	**Negative assurance/areas for improvement, with additional action/s to be taken (with Lead individual)**
services? Are these regularly reviewed and improved? (W4.1)	Audit and implementation of controls in response. ▪ The organisational committee structure demonstrates reporting from sub-committees to the Trust Board. These sub committees include those associated with patient safety and quality, finance and operational performance	
Do all levels of governance and management function effectively and interact with each other appropriately? (W4.2)	▪ The Trust Board assesses its effectiveness, and that of its sub-committees, via a range of methods. The Terms of Reference of the Board and its sub-committees are reviewed annually, to ensure the role and function of each reflects the Board's wishes. Formal self-evaluations were undertaken in 2016/17 by the Trust Board, Audit and Governance Committee, Finance Committee, and Quality Committee, with the findings discussed at those meetings (in May 2016, August 2016, December 2016 and January 2017 respectively) ▪ The governance framework involves each clinical Division being subject to an Executive Performance Review (EPR) meeting, to discuss their key issues in relation to Quality, Workforce, Finance, and Performance. The "Top 5 Divisional Risks and Emerging Risks" are also considered, as are any "Items for Escalation to Executive Team". A Performance Review action log is maintained to ensure agreed actions are monitored	
Are staff at all levels clear about their roles and do they understand what they are accountable for and to whom? (W4.3)	• All Trust Job Descriptions and set out expectations of staff in all roles within the Trust in terms of what individuals are accountable for and to whom they are accountable • The Trust's Strategy (Time to Change) includes the Trust's vision, values and strategic objectives and focus areas – ensuring quality care, creating sustainability (rebalancing services, maximising efficiency and minimising costs) and building an improvement capability. Within each focus area a number of strategies are then discussed. • Both of these documents support staff in understanding their organisational key quality, operational and finance priorities • All appraisals for doctors have a Personal Development Plan (PDP) which is monitored • The Trust generally achieves very high levels of staff appraisal completeness (this was at 83.9% for month 5 of 2017/18)	Not Applicable
Are arrangements with partners and third-party providers governed and managed effectively to encourage appropriate	▪ The Trust has well established working relationships with a number of external partners ▪ The Trust engages with its public via the Patient Experience Committee. This is a formal sub-committee of the Board, which meets quarterly. The Committee's purpose includes capturing the patient/public perception of the Trust's services, and	

Key Line of Enquiry (KLOE) 4: Are there clear responsibilities, roles and systems of accountability to support good governance and management?		
CQC inspection teams' prompts for assessment of this KLOE	**Positive assurance / evidence**	**Negative assurance/areas for improvement, with additional action/s to be taken (with Lead individual)**
interaction and promote coordinated, person-centred care? (W4.4)	monitoring any aspect of patient experience, on behalf of the Board, as required. Its first stated duty is "To positively promote the Trust's partnership with its patients and public", and its membership includes representatives from the public, patient/carer support groups, Healthwatch Kent, the local Independent Health Complaints Advocacy service, and the Leagues of Friends. The Committee's Terms of Reference also reflect its role as the primary forum by which the Trust involves/consults with its patients/public on the planning of the provision of services, proposals for changes in the way services are provided, and significant decisions affecting the operation of services. ▪ The Kent Oncology Centre actively engages with the West Kent Locality Group run by the patient representatives. ▪ The Trust is actively involved with clinical leads and representation in the newly formed Kent & Medway Cancer Alliance whose core membership includes patient representatives. ▪ The Trust is fortunate that many of its Executive Team lead on Kent and Medway Sustainability and Transformation Partnership (STP) related work, which enable the Trust to be at the forefront of local plans in the wider health and social care economy. Specifically: o The Trust's former Chief Executive is the Chief Executive for the STP o The Medical Director was until recently the co-Chair of the STP Clinical Board, and remains an active member o The Acting Chief Executive is the Chair of a Joint Clinical Strategy Group (with Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust)	

Key Line of Enquiry (KLOE) 5: Are there clear and effective processes for managing risks, issues and performance?		
CQC inspection teams' prompts for assessment of this KLOE	**Positive assurance / evidence**	**Negative assurance/areas for improvement, with additional action/s to be taken (with Lead individual)**
Are there comprehensive assurance systems, and are performance issues escalated appropriately through clear structures and processes? Are these regularly reviewed	▪ The Trust Board meets in public every month (with the exception of August). The agenda for Board meetings is mainly focussed around the key aspects of operational performance; quality; planning and strategy; assurance and policy; and reports from its sub-committees. A 12-month rolling forward programme of agenda items is actively managed to ensure the Board receives the information, and considers the matters it requires to perform its duties efficiently and effectively	Not Applicable

Key Line of Enquiry (KLOE) 5: Are there clear and effective processes for managing risks, issues and performance?		
CQC inspection teams' prompts for assessment of this KLOE	**Positive assurance / evidence**	**Negative assurance/areas for improvement, with additional action/s to be taken (with Lead individual)**
and improved? (W5.1) Are there processes to manage current and future performance? Are these regularly reviewed and improved? (W5.2)	▪ A key tenet of the information the Board receives at each meeting in public is an Integrated Performance Report, which contains up-to-date details of performance across a range of indicators, including those within NHSI's Single Oversight Framework for NHS providers. The Board also hears 'patient stories', which provide invaluable first-hand experience of being a patient of the Trust; as well as presentations from its Clinical Directors, General Managers and Matrons. ▪ Information reviewed at the Trust Board and its sub-committees are supplemented by Trust Board Members' visits of Wards and Departments (which are reported to the Board 4 times during the year). ▪ The Trust Board operates with the following sub-committees, to support the delivery of its duties: o The Audit and Governance Committee o The Charitable Funds Committee o The Finance and Performance Committee o The Patient Experience Committee o The Quality Committee o The Remuneration and Appointments Committee o The Workforce Committee ▪ Although not a Board sub-committee, the TME is the senior management committee within the Trust. Its purpose is to oversee and direct: the effective operational management of the Trust, including achievement of standards, targets and other obligations; the delivery of safe, high quality, patient-centred care; the development of Trust strategy, culture and policy; and the identification, mitigation and escalation of assurance and risk issues. The TME meets monthly, and is chaired by the Acting Chief Executive ▪ The Trust Board receives a written summary report from each meeting of its main sub-committees (and the TME) in a timely manner, supplemented by a verbal report from each sub-committee Chair, which highlights the main subjects discussed, and draws attention to any matters requiring the Board's consideration and/or action ▪ The Board assesses its effectiveness, and that of its sub-committees, via a range of methods. The Terms of Reference of the Board and its sub-committees are reviewed annually, to ensure the role and function of each reflects the Board's wishes. Formal self-evaluations were undertaken in 2016/17 by the Trust Board, Audit and Governance Committee, Finance Committee, and Quality Committee, with the findings discussed at those meetings (in May 2016, August 2016, December 2016 and January 2017 respectively) ▪ The Trust's Quality Governance arrangements are managed via the Trust Clinical	

Key Line of Enquiry (KLOE) 5: Are there clear and effective processes for managing risks, issues and performance?		
CQC inspection teams' prompts for assessment of this KLOE	**Positive assurance / evidence**	**Negative assurance/areas for improvement, with additional action/s to be taken (with Lead individual)**
	Governance Committee (and its sub-committees); and via a number of associated systems and processes. The Quality Committee then aims to seek and obtain assurance on the effectiveness of these structures, systems and processes. The Quality Committee is chaired by a NED and meets monthly. On alternate months, the Committee meets in the form of a 'deep dive', with a reduced membership, to enable a small number of subjects to be scrutinised in greater detail.	
Is there a systematic programme of clinical and internal audit to monitor quality, operational, and financial processes, and systems to identify where action should be taken? (W5.3)	▪ Clinical audit is supported by a central team, within the Clinical Governance Department, and is primarily overseen by the Trust Clinical Governance Committee ▪ The Audit and Governance Committee approves the Internal Audit plan for the year and receives details of the findings from each of the Internal Audit reviews that are undertaken. Summary reports of relevant Internal Audit reviews are also submitted to the TME and Quality Committee during the year. Reviews with a 'Limited assurance' are considered at the Audit and Governance Committee, and actions to address the weaknesses identified in controls are monitored via follow-up reviews	▪ The need to strengthen the oversight of clinical audit, via the establishment of a Clinical Audit Overview Committee **Action: Proceed with plans to the establish a Clinical Audit Overview Committee (Chief Nurse)**
Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions? Is there alignment between the recorded risks and what staff say is 'on their worry list'? (W5.4) Are potential risks taken into account when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities? (W5.5)	▪ Risks are identified, analysed and controlled in accordance with the Trust's Risk Management Policy. The Trust has a BAF and a Risk Register. The BAF is the document through which the Trust Board is apprised of the principal risks to the Trust meeting its objectives, and to the controls in place to manage those risks. In addition to the Trust Board, the BAF and Risk Register are reviewed at the Audit and Governance Committee and TME, whilst the financial aspects of both are reviewed at the Finance Committee. ▪ As is the case every year, the BAF and Risk Register are subject to an Internal Audit review. The review for 2016/17, gave a "Reasonable Assurance" conclusion, and the report's "key findings" included the statements that "The Board Assurance Framework and Risk Management processes have been subject to regular review by the Trust, including at the Trust Board, Audit and Governance Committee and the Trust Management Executive", "Clear processes are in place within the Trust to support the identification and management of risks" and "A robust reporting structure to the Trust Board is in place". ▪ The Trust has in place a range of systems to prevent, deter, manage and mitigate risks and measure the associated outcomes, and in addition to the Trust's Risk Management Policy, a full range of risk management policies and guidance is made available to staff. This includes the procedures for incident reporting, managing complaints, risk assessment, investigation of incidents, health and safety, and 'being open' to staff and patients (to support the statutory Duty of Candour). Additional advice on good practice can be obtained from a range of professional and specialist staff. The remit of the Trust's Governance Department includes clinical risk	Not Applicable

Key Line of Enquiry (KLOE) 5: Are there clear and effective processes for managing risks, issues and performance?		
CQC inspection teams' prompts for assessment of this KLOE	**Positive assurance / evidence**	**Negative assurance/areas for improvement, with additional action/s to be taken (with Lead individual)**
	management; clinical governance; clinical audit; complaints; PALS; staff health and safety; medico-legal service and claims handling; research and development; and the management of all clinical and non-clinical incident reporting. In addition, Directorates and sub-specialities have identified clinical governance and risk leads. There is a forum for clinical governance and risk management within each Directorate and within the majority of clinical subspecialties ▪ In addition, a number of specific risk-related roles are held by Trust Board Members. The Chief Nurse is the Senior Information Risk Owner (SIRO); the Medical Director is the Caldicott Guardian and the Responsible Officer (for Medical Revalidation); whilst the Chief Operating Officer is the Board Level Director (with fire safety responsibility), the Accountable Emergency Officer for Emergency Preparedness, Resilience & Response (EPRR), and the Security Management Director ▪ Trust staff are involved in risk management processes in a variety of ways, including raising any concerns they may have (anonymously, if they so wish); being aware of their responsibility to report and act upon any incidents that occur; being involved in risk assessments; and attending regular training updates. In-house support and advice on risk management and mitigation is available. This includes specific advice relating to patient safety, health and safety, finance, and information governance etc. Certain types of risk are also addressed via the engagement of external expertise. For example, the risk of fraud is managed and deterred via the appointment of a Local Counter Fraud Specialist (LCFS) and the Trust engages a Dangerous Goods Safety Advisor (DGSA) to advise on the safe management of healthcare waste. ▪ The Trust's annual operational and resilience plan takes into account fluctuations in clinical demand and activity. The plan is developed via an internal Operational Resilience Group which is chaired by the Chief Operating Officer. An external group also brings together the operational leads from Kent Community Health NHS Foundation Trust, South East Coast Ambulance Service NHS Foundation Trust, Kent County Council and West Kent Clinical Commissioning Group. The plan focuses on 9 workstreams: Ambulatory Emergency Care; Acute Frailty Service; Emergency Department improvement; Workforce; Improving flow; Improving Patient Discharge; Activity and Demand (assessment and planning); Sustainability; and Rapid Improvement weeks ▪ The Trust has a range of emergency response plans, including a Heatwave Plan and Major Incident Plan	
When considering developments to services or efficiency changes, how is the	▪ QIAs are undertaken for all proposed Cost Improvement Programme (CIP) schemes. Proposals to strengthen the QIA process were discussed and agreed at the 'main' Quality Committee in September 2017	Not Applicable

Key Line of Enquiry (KLOE) 5: Are there clear and effective processes for managing risks, issues and performance?		
CQC inspection teams' prompts for assessment of this KLOE	**Positive assurance / evidence**	**Negative assurance/areas for improvement, with additional action/s to be taken (with Lead individual)**
impact on quality and sustainability assessed and monitored? Are there examples of where financial pressures have compromised care? (W5.6)	▪ Since the Trust was placed in Financial Special Measures (FSM) in 2016, a standing item has featured on each 'main' Quality Committee, to enable the Chief Nurse and Medical Director to raise any "Quality matters arising from the plans to exit FSM", including any issues arising from QIAs. This item will include an overview of QIAs	

Key Line of Enquiry (KLOE) 6: Is appropriate and accurate information being effectively processed, challenged and acted on?		
CQC inspection teams' prompts for assessment of this KLOE	**Positive assurance / evidence**	**Negative assurance/areas for improvement, with additional action/s to be taken (with Lead individual)**
Is there a holistic understanding of performance, which sufficiently covers and integrates people's views with information on quality, operations and finances? Is information used to measure for improvement, not just assurance? (W6.1)	▪ A key tenet of the information the Board receives at each meeting in public is an Integrated Performance Report, which contains up-to-date details of performance across a range of indicators, including those within NHSI's Single Oversight Framework for NHS providers. The Board also hears 'patient stories', which provide invaluable first-hand experience of being a patient of the Trust; as well as presentations from its Clinical Directors, General Managers and Matrons. ▪ Information reviewed at the Trust Board and its sub-committees are supplemented by Trust Board Members' visits of Wards and Departments (which are reported to the Board 4 times during the year).	Not Applicable
Do quality and sustainability both receive sufficient coverage in relevant meetings at all levels? Do all staff have sufficient access to information, and challenge it appropriately? (W6.2)	▪ The agenda for Board meetings is mainly focussed around the key aspects of operational performance; quality; planning and strategy; assurance and policy; and reports from its sub-committees. A 12-month rolling forward programme of agenda items is actively managed to ensure the Board receives the information, and considers the matters it requires to perform its duties efficiently and effectively ▪ The Trust Board also however has 7 sub-committees, to support the delivery of its duties, and ensure an appropriate balance is struck between quality and sustainability ▪ Staff are welcome to observe Trust Board meetings, and staff take this opportunity regularly ▪ A wide range of information is available via the Trust Intranet, including the Trust's full suite of policies and procedures ▪ Open Staff Meetings are held regularly. The meetings are held simultaneously for staff at Maidstone and Tunbridge Wells Hospital and two members of the Executive Team are available at each. The presentations and questions (plus responses) raised at each meeting are available via the Trust's Intranet. Representatives from every	Not Applicable

Key Line of Enquiry (KLOE) 6: Is appropriate and accurate information being effectively processed, challenged and acted on?		
CQC inspection teams' prompts for assessment of this KLOE	**Positive assurance / evidence**	**Negative assurance/areas for improvement, with additional action/s to be taken (with Lead individual)**
	team or department are encouraged to attend, and questions can be submitted prior to the meeting if staff are unable to attend ▪ The weekly Chief Executive's all-users email bulletin highlights key issues of note	
Are there clear and robust service performance measures, which are reported and monitored? (W6.3)	▪ The Trust Board approved the key objectives to feature within the BAF in April 2017, and BAF update reports are submitted to the TME, Audit and Governance Committee, Finance and Performance Committee (for the financial objectives only), and Trust Board ▪ The Trust has developed a strengthened Performance Management framework, that puts clarity for responsibility and accountability at the heart of the approach ▪ The framework involves each clinical Division being subject to an Executive Performance Review (EPR) meeting, to discuss their key issues in relation to Quality, Workforce, Finance, and Performance. The "Top 5 Divisional Risks and Emerging Risks" are also considered, as are any "Items for Escalation to Executive Team". A Performance Review action log is maintained to ensure agreed actions are monitored	Not Applicable
Are there effective arrangements to ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant? What action is taken when issues are identified? (W6.4)	▪ The following processes are in place to assure the quality and accuracy of elective waiting time data (and to manage the risks to such quality and accuracy): o The Trust has a "Patient Access to Treatment Policy and Procedure", which encompasses Standard Operational Procedures for waiting list management at all stages of a referral to treatment pathway. The Policy also states the responsibilities of key staff, including those for auditing data quality. The Policy is also currently being reviewed to ensure it is aligned with the Trust's new Patient Administration System (PAS) o The Trust also has an "Information Lifecycle Management Policy and Procedure", which describes the Trust's general approach to data quality, including the role of the Data Quality Steering Group o There is a weekly validation process involving operational, management and information leads, to assure the quality of local and national waiting times reporting/data ▪ Compliance with the above Policies and processes is audited annually by Internal Audit (TIAA Ltd), as part of their review of "Data Quality of Key Performance Indicators" ▪ Appropriate remedial action is taken when issues are identified (for example in response to the recommendations' from Internal Audit reviews)	▪ Further work is underway to improve and strengthen data quality, overseen by the Chief Operating Officer **Action: Continue with the intended work to improve and strengthen data quality (Chief Operating Officer)**

Key Line of Enquiry (KLOE) 6: Is appropriate and accurate information being effectively processed, challenged and acted on?		
CQC inspection teams' prompts for assessment of this KLOE	**Positive assurance / evidence**	**Negative assurance/areas for improvement, with additional action/s to be taken (with Lead individual)**
Are information technology systems used effectively to monitor and improve the quality of care? (W6.5)	▪ The Trust has an IT Strategy, called "INSPIRE" ("delivering *I*ntegrated systems to *S*upport our *P*atients *I*n *RE*al time). This sets out how the Trust can maximise the benefit from the investment already made and exploit it further to enable staff to care for patients in a more responsive, safer way and support the wider Trust's clinical strategy and business plans. Supported by a number of strategic and technical principles, a 5 year roadmap was developed that will see the Trust achieve a fully integrated electronic patient record available to clinicians in the Trust, patients and commissioners ▪ Work on INSPIRE-related projects is progressing, and a are overseen by the Informatics Steering Group (a sub-committee of TME which is chaired by the Acting Chief Executive). Progress reports on the IT strategy (and other related matters) are submitted to the Finance and Performance Committee every 6 months ▪ A programme of IT-related Internal Audit is in place, and the output of this is reported to the Audit and Governance Committee	▪ An independent assessment of the robustness of the Trust's systems, strategy and capability has been commissioned. This is due to report in October 2017. **Action: Respond to the independent assessment of the robustness of the Trust's IT systems, strategy and capability, once completed (Acting Chief Executive)**
Are there effective arrangements to ensure that data or notifications are submitted to external bodies as required? (W6.6)	▪ A range of staff are responsible for data and/or notifications are submitted to the relevant external agencies, including: o National Reporting and Learning System (NRLS) – The Patient Safety Lead o RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) incidents – The Trust Health & Safety Advisor o Data breaches to the Information Commissioner's Office – The Head of Information Governance o Notifications to the Care Quality Commission (CQC) required under the Health and Social Care Act 2008 – The Associate Director, Quality Governance o Data returns to NHS Digital - the Associate Director of Business Intelligence	Not Applicable
Are there robust arrangements (including appropriate internal and external validation), to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards? Are lessons learned when there are data security breaches? (W6.7)	▪ The Trust Board considers an annual update report from the SIRO (a role undertaken by the Chief Nurse), which includes approval of the annual Information Governance Toolkit submission ▪ The Trust has achieved Level 2 compliance against the requirements of the Information Governance Toolkit (for 2016/17), which covers Confidentiality and Data Protection Assurance; Information Security Assurance; Clinical Information Assurance; Secondary Use Assurance; and Corporate Information Assurance ▪ Within the "Confidentiality and Data Protection Assurance" section of the Toolkit, the Trust achieved Level 2 compliance for 8 of the 9 Requirements, but achieved Level 3 compliance for the Requirement that "The Information Governance agenda is supported by adequate confidentiality and data protection skills, knowledge and experience which meet the organisation's assessed needs" ▪ Within the "Information Security Assurance" section of the Toolkit, the Trust achieved	Not Applicable

Key Line of Enquiry (KLOE) 6: Is appropriate and accurate information being effectively processed, challenged and acted on?		
CQC inspection teams' prompts for assessment of this KLOE	**Positive assurance / evidence**	**Negative assurance/areas for improvement, with additional action/s to be taken (with Lead individual)**
	Level 2 compliance for 14 of the 15 Requirements, but achieved Level 3 compliance for the Requirement that "There are documented information security incident / event reporting and management procedures that are accessible to all staff" ▪ The management of data security breaches are overseen by the Trust's Head of Information Governance, and lessons to be learned are considered by the Information Governance Committee	

Key Line of Enquiry (KLOE) 7: Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?		
CQC inspection teams' prompts for assessment of this KLOE	**Positive assurance / evidence**	**Negative assurance/areas for improvement, with additional action/s to be taken (with Lead individual)**
Are people's views and experiences gathered and acted on to shape and improve the services and culture? Does this include people in a range of equality groups? (W7.1) Are people who use services, those close to them and their representatives actively engaged and involved in decision-making to shape services and culture? Does this include people in a range of equality groups? (W7.2)	▪ The Patient Experience Committee is one of the Trust Board's sub-committees. The Committee aims to capture the patient and public perception of the services delivered by the Trust, and monitor any aspect of patient experience, on behalf of the Trust Board (or at the request of any Board sub-committee or other relevant Trust committee), as required. ▪ The Committee is chaired by a NED, and meets quarterly, and in addition to Trust staff, its membership includes representatives from the Trust's catchment area, Healthwatch Kent, and from Leagues of Friends of Maidstone and Tunbridge Wells Hospitals ▪ The Trust undertakes local patient surveys, which include the Friends and Family Test (FFT). Details reports on the former are reported to each Patient Experience Committee meeting, whilst the headline messages from the FFT feature of the Trust's monthly Performance Dashboard which is reviewed at the TME and Trust Board ▪ The Kent Oncology Centre actively engages with the West Kent Locality Group run by Patient Representatives ▪ The Trust is actively involved with clinical leads and representation in the newly formed Kent & Medway Cancer Alliance whose core membership includes Patient Representatives ▪ There is an Acute/Emergency Medicine monthly public engagement event 'Meet the Matron' at TWH, focussing mainly towards local groups with learning disabilities. These commenced following the outcome of a complaint investigation. ▪ Healthwatch was involved in the "proof of concept" of Home First Pathway ▪ Addressing health inequalities is a particular focus of the Sustainability and Transformation Plan in Kent and Medway.	Not Applicable

Key Line of Enquiry (KLOE) 7: Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?		
CQC inspection teams' prompts for assessment of this KLOE	**Positive assurance / evidence**	**Negative assurance/areas for improvement, with additional action/s to be taken (with Lead individual)**
Are staff actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture? Does this include those with a protected equality characteristic? (W7.3)	▪ Open Staff Meetings are held regularly. The meetings are held simultaneously for staff at Maidstone and Tunbridge Wells Hospital and two members of the Executive Team are available at each. The presentations and questions (plus responses) raised at each meeting are available via the Trust's Intranet. Representatives from every team or department are encouraged to attend, and questions can be submitted prior to the meeting if staff are unable to attend ▪ The Trust has recently adopted the LiA initiative and a launch event was held in July 2017. LiA is led by the Acting Chief Executive, and supported by senior staff from across the Trust. Some positive progress is being made ▪ The results of the initial LiA 'pulse' survey show that 41% of staff feel that the organisational culture encourages them to contribute to changes that effect their team / department / service and the same percentage feel that managers and leaders seek their views about how the Trust can improve its services ▪ A series of Listening into Action Crowd Fixing events were held in September 2017, which aimed to bring staff together to turn their collective thoughts towards finding quick and lasting fixes to key frustrations. ▪ To address Junior Doctors concern regards engagement level, meetings with Divisional Senior Managers have resulted in regular 'walk the floor' events with JMS representatives/Executives ▪ A Staff Engagement Group has been established, with cross-Division membership to co-design engagement process/regularly review	Not Applicable
Are there positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs? (W7.4)	▪ The Trust has a mature relationship with West Kent Clinical Commissioning Group (CCG), and in the Trust has moved from a 'Payment by Results' contract to an Aligned Incentives Contract (AIC) for the next 2 years (2017/18 and 2018/19). This contract is designed to deliver efficient and robust patient pathways across the local health economy ▪ Although the Trust remains in FSM, it has been supported in its endeavours to exit the FSM regime by NHSI. This support, has enabled the Trust to improve its financial position, and strengthened its ability to provide sustainable services ▪ The Medical Director meets regularly with the Medical Directors of all of the Trusts in Kent ▪ West Kent alliance meetings could be mentioned	Not Applicable
Is there transparency and openness with all stakeholders about	▪ The Trust has regular open and honest discussions about its performance with West Kent CCG, NHSI and the CQC, and any issues of concern are considered via the appropriate internal processes	Not Applicable

Key Line of Enquiry (KLOE) 7: Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?		
CQC inspection teams' prompts for assessment of this KLOE	**Positive assurance / evidence**	**Negative assurance/areas for improvement, with additional action/s to be taken (with Lead individual)**
performance? (W7.5)		

Key Line of Enquiry (KLOE) 8: Are there robust systems and processes for learning, continuous improvement and innovation?		
CQC inspection teams' prompts for assessment of this KLOE	**Positive assurance / evidence**	**Negative assurance/areas for improvement, with additional action/s to be taken (with Lead individual)**
In what ways do leaders and staff strive for continuous learning, improvement and innovation? Does this include participating in appropriate research projects and recognised accreditation schemes? (W8.1)	▪ The Trust was rated as "Good" in the national "Learning from Mistakes" League which was published in March 2016 ▪ The Trust has recently adopted the LiA initiative and a launch event was held in July 2017. LiA is led by the Acting Chief Executive, and supported by senior staff from across the Trust. Some positive progress is being made ▪ The Trust has a dedicated PMO function, who provide support to staff to improve the efficiency of their service ▪ The IIP committee works in partnership with NHS Innovations for South East England (NISE) and aims to encourage/capture innovation and service improvements from all areas of work/activity ▪ Other processes used to capture innovation include staff being encouraged to put forward suggestions via the PMO, and a new joint CCG programme on the AIC removes income loss as a barrier to innovation ▪ In May 2017 the Trust's Estates team were shortlisted into the top three for the Delivering Innovation Award by the Hospital Estates and Facilities Management Association (HEFMA)	Not Applicable
Are there standardised improvement tools and methods, and do staff have the skills to use them? (W8.2)	▪ The Trust has a dedicated PMO function, who provide support to staff to improve the efficiency of their service. The PMO utilises and promote a range of best practice tools and methods	▪ An external consultant has been commissioned to feed back on the way in which the Trust organises itself in its improvement activities and advise on the identification and application of a single methodology for improvement in the Trust **Action: Respond to the findings of the external review aiming to design a single approach to improvement work (Acting Chief Executive)**
How effective is participation in and learning from internal	▪ The Trust participates in, and learns from a range of external review processes, including peer review and external accreditation schemes. For example, the Trust's	Not Applicable

Key Line of Enquiry (KLOE) 8: Are there robust systems and processes for learning, continuous improvement and innovation?		
CQC inspection teams' prompts for assessment of this KLOE	**Positive assurance / evidence**	**Negative assurance/areas for improvement, with additional action/s to be taken (with Lead individual)**
and external reviews, including those related to mortality or the death of a person using the service? Is learning shared effectively and used to make improvements? (W8.3)	Pathology laboratory is assessed by the United Kingdom Accreditation Service (UKAS) which is the sole accreditation body recognised by government to assess, against internationally agreed standards (ISO 15189). All the Trust's laboratories have been assessed for ISO 15189 and have been recommended for accreditation. All laboratories have retained the previous accreditation standard Clinical Pathology Accreditation (CPA). All Pathology departments also take part in the National External Quality Assessment schemes. ▪ Kent Oncology Centre participates in the CHKS accreditation scheme. The latest inspection report stated that "The Kent Oncology Centre remains an outstanding centre and it is recommended that they continue to be in receipt of their ISO certification." ▪ The Trust has developed "Policy for Undertaking Mortality Case Record Reviews (SJRs)", based on national guidance	
Do all staff regularly take time out to work together to resolve problems and to review individual and team objectives, processes and performance? Does this lead to improvements and innovation? (W8.4)	▪ The Trust's committee and clinical governance structure promotes this approach. Clinical Governance ½ day meetings are held each month in each Directorate. Joint Directorate meetings have been held when required, to share learning and promote improved practice across Directorates	▪ An external consultant has been commissioned to do a piece of work on the development and design of a single approach to improvement work across the Trust **Action: Respond to the findings of the external review aiming to design a single approach to improvement work (Acting Chief Executive)**
Are there systems in place to support improvement and innovation work including objectives and rewards for staff, data systems, and processes for evaluating and sharing the results of improvement work? (W8.5)	▪ The Trust has recently adopted the LiA initiative and a launch event was held in July 2017. LiA is led by the Acting Chief Executive, and supported by senior staff from across the Trust. Some positive progress is being made ▪ The Trust celebrates innovative successes via the PRIDE Staff magazine; Annual staff star awards innovation section; Annual Quality Improvement Projects (QIP) Awards Day; the Chief Executive's weekly newsletter	▪ An external consultant has been commissioned to do a piece of work on the development and design of a single approach to improvement work across the Trust **Action: Respond to the findings of the external review aiming to design a single approach to improvement work (Acting Chief Executive)**

Trust Board meeting – October 2017

NHS Maidstone and Tunbridge Wells NHS Trust

10-18	**Ratification of revised Policy And Procedure for the production, approval and ratification of Trust-wide policies and procedures**	**Trust Secretary**

A revised approach to the approval and ratification of Trust-wide policies was approved by the Trust Board in May 2014 (having been first agreed at the TME in April 2014). The approach established the Policy Ratification Committee (PRC), which started to meet in July 2014, and has met regularly since. The PRC is a sub-committee of TME, and summary reports of the PRC's activity are submitted to the TME after each PRC meeting.

The policy associated with the revised process ("Principles of Production, Approval and Implementation of Trust Wide Policies and Procedures") was not amended at the time, but has now been reviewed and revised, to reflect the process that is currently applied. The revised policy has also been informed by the PRC's 3+ years of operation, and the consideration of the various policy-related issues that have arisen during that time.

The revised policy was circulated widely in July 2017 and approved by the Trust Management Executive on 20th September. This was followed by a review of the policy by the Policy Ratification Committee on 13th October, which resulted in the recommendation that the Trust Board ratifies the policy. The Trust Board is therefore invited to consider the policy for formal ratification.

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive, 20/09/17
- Policy Ratification Committee, 13/10/17

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

For ratification

[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

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Policy and procedure for the production, approval and ratification of Trust-wide policies and procedures ("Policy for Policies")

Target Audience:	All Trust staff involved in the production and/or review of Trust-wide policies and procedures
Author:	Kevin Rowan, Trust Secretary **Contact details:** Ext. 28698
Other contributors:	Corporate Governance Assistant Assistant Trust Secretary Members of the Policy Ratification Committee (PRC)
Executive lead:	Chief Executive
Directorate:	Corporate
Specialty:	Corporate
Supersedes:	Principles of Production, Approval and Implementation of Trust Wide Policies and Procedures [Version 5.0: March 2013] Principles of Production, Approval and Implementation of Trust Wide Policies and Procedures [Version 5.1: June 2017]
Approved by:	Trust Management Executive (TME), 20th September 2017
Recommended for ratification by:	Policy Ratification Committee, 2nd October 2017
Ratified by:	The Trust Board, 18th October 2017
Review date:	October 2021

Maidstone and Tunbridge Wells NHS Trust

Document history

Requirement for document:	• To comply with national recommendation for good practice • To ensure a clear and robust approach and system is in place for the production, approval and ratification of Trust-wide policies and procedures
Cross references (external):	1. The Freedom of Information Act 2000
Associated documents (internal):	• Standing Orders [RWF-OPPCS-NC-TM23] • Publication Scheme available at www.mtw.nhs.uk/freedom-of-information/publication-scheme/ • Terms of Reference of the Policy Ratification Committee (PRC) [available from the Trust Secretary's office] • Policy Ratification Committee (PRC) pre-submission checklist [available from the Assistant Trust Secretary]

Keywords:	Policy	Ratification	PRC
	Approval	Trust-wide	Procedure
	Policy for Policies	Policy Policy	Author
	Policy Ratification Committee	Consultation	

Version control:		
Issue:	**Description of changes:**	**Date:**
1.0	First iteration of policy	August 2005
2.0	Split procedure from policy document	October 2006
3.0	Combined policy and procedure and reformatted	January 2009
3.1	Amended Consultation Table, compliance monitoring committee, and consistent wording on ratification in the policy statement.	July 2009
3.2	Amendment to monitoring	December 2009
4.0	Complete review	August 2011
5.0	Complete review	March 2013
5.1	Review date extended to December 2017 from March 2016 by PRC Chair's action; no other amendments	June 2017
6.0	Complete revision of policy, to reflect the revised ratification process approved by the Trust Board in May 2014 including: ▪ Clearer definitions (of "Policy", "Trust-wide" etc.) ▪ The exclusion of clinical guidance documents from the policy ▪ Clarity regarding the various steps in the process (including "approval" and "ratification") ▪ The existence and functioning of the Policy	November 2017

Version control:		
Issue:	**Description of changes:**	**Date:**
	Ratification Committee (PRC) ▪ Clarification that a Review date is not an expiry date (and that a policy and procedure does not become automatically unfit for purpose solely because its Review date has passed) ▪ The processes for considering amendments and/or withdrawals ▪ All Trust-wide policies and procedures being ratified for 4 years (unless a shorter period is required)	

Maidstone and Tunbridge Wells NHS Trust

Policy statement for

The production, approval and ratification of Trust-wide policies and procedures

Policies are statements of corporate intent that explicitly state responsibilities and accountabilities, and contain details which relevant Trust employees are expected to adhere to, as part of their terms of employment. Trust-wide policies are those that cover the method of working across more than one Directorate.

All NHS organisations need a robust process to ensure the policies and procedures they expect their staff to follow:

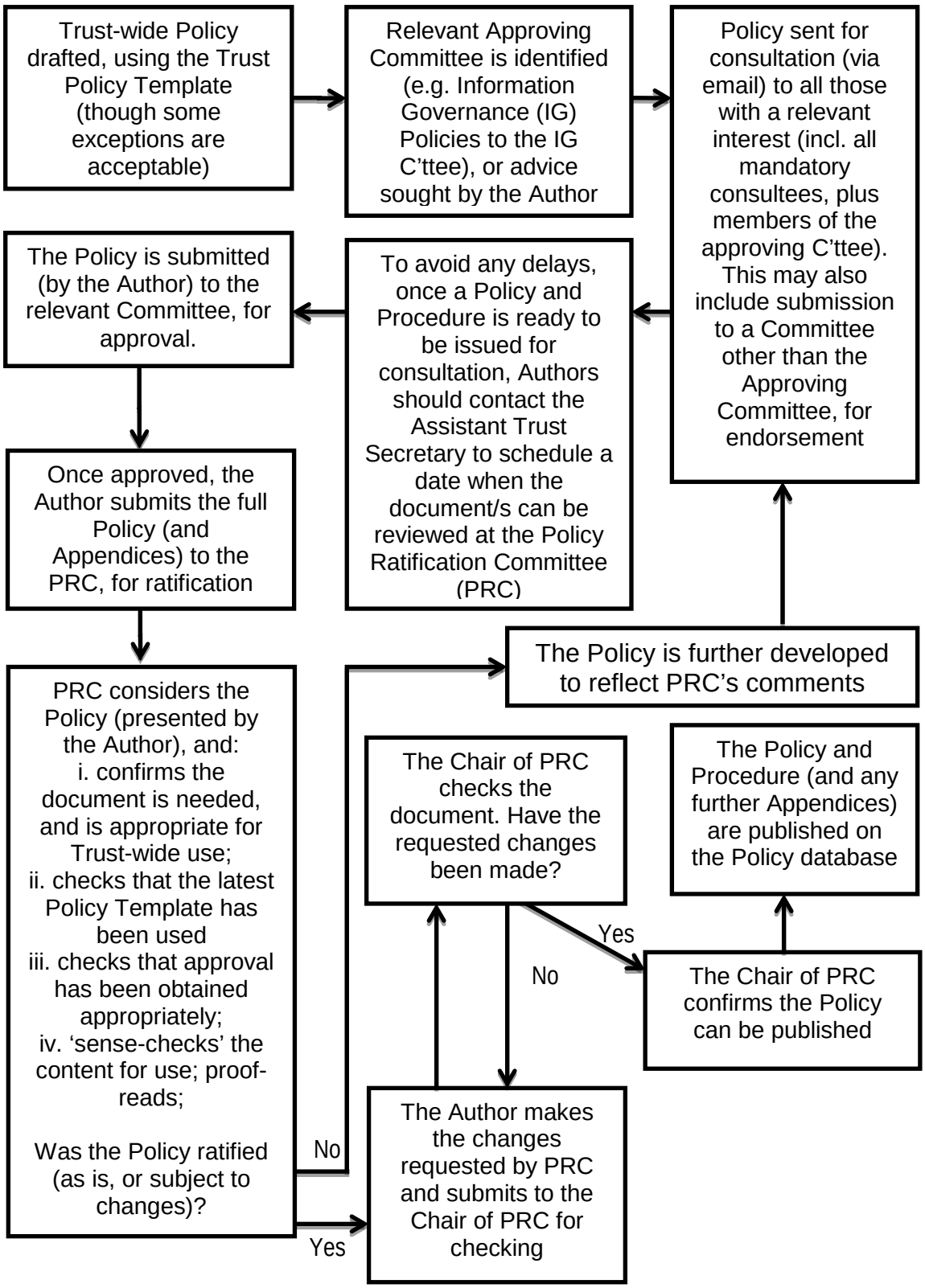
- Are developed with due rigour;
- take account of appropriate external guidance and internal opinion;
- are well-written; and
- meet the needs of staff and the organisation

This policy describes the Trust's approach to ensuring that Trust-wide policies and procedures are produced to the required standard, and properly approved and ratified, to enable the documents to be issued for use.

Maidstone and Tunbridge Wells NHS Trust

Procedure for the production, approval and ratification of Trust-wide policies and procedures

Overview of procedure to be followed
(Refer to the policy and procedure for the full details and requirements of each step)



1.0 Introduction and scope

Policies and procedures are reference documents to assist/support staff in their day to day work by making clear what the Trust expects staff to do in a given situation. As such they need to be well-written and make sense to the most junior member of staff to whom the policy and procedure applies. All NHS organisations therefore need a robust process to ensure the policies and procedures they expect their staff to follow:

- are developed with due rigour;
- take account of appropriate external guidance and internal opinion;
- are well-written; and
- meet the needs of staff and the organisation

This policy describes the Trust's approach to ensuring that Trust-wide policies and procedures are produced to the required standard, and then approved and ratified, to enable the documents to be issued for use by the relevant staff.

This policy and procedure applies to all Directorates and locations within the Trust. However, this policy does not apply to the following documents:

- Local policies (i.e. those that are not "Trust-wide"). These should be produced and approved and/or ratified in accordance with local procedures
- Corporate Strategy documents. These will differ in format, according to their content, but any Strategy affecting the whole Trust should be ratified by the Trust Board (having been subject to appropriate consultation beforehand).
- Clinical Guidance documents. A separate process is in place. For advice refer to the Trust Intranet and/or Governance Team/Associate Director, Quality Governance.
- Trust-wide Plans. These can take many forms, but they are usually a description of a series of time-limited steps that will be taken to achieve a particular aim. Plans may or may not be required to be formally approved but this should be considered by the person with overall responsibility for implementing the Plan.

Documents may have different titles, which may be influenced by convention, external requirements, local considerations or previous precedent. It is therefore the intent, and not the title, that should determine whether this policy and procedure applies to a particular document, taking into account the definitions in section 2.0. In this context, documents that 'look and feel' like Trust-wide policies and procedures should not be labelled as 'Plans' or 'Strategies' to avoid having to comply with this policy and procedure.

Principles

This policy and procedure has been developed in accordance with the following principles:

- The Trust will only produce, approve, ratify and apply the Trust-wide policies and procedures that are genuinely regarded as being required to enable the Trust to effectively fulfil its functions and duties
- Trust-wide policies and procedures are matters for the Trust 'Executive'. Therefore, although it may be appropriate to include Non-Executive Directors

(and the Committees on which they sit) as part of the consultation on a particular policy, the default position is that policies and procedures will be approved by Executive-led committees (unless expressly agreed otherwise by the Trust Board or one of its sub-committees).

- All Trust-wide policies and procedures are to be ratified for 4 years unless a shorter period is required. Regardless of this, all policies and procedures should be revised within that 4-year period to reflect changes as and when they arise
- Policies should not exceed their Review date
- Once ratified, non-material changes to a Trust-wide policy and procedure can be made without seeking re-approval and re-ratification
- All Trust-wide policies and procedures should have a Target Audience identified in recognition that not all Trust-wide policies are of relevance to all Trust staff
- All Trust-wide policies and procedures should be well-written (including ensuring appropriate grammar, format and style), be clear to follow, and contain as much information as is required to provide the appropriate support to its Target Audience
- All Trust-wide policies will be available to the public, on request (in accordance with the requirements of the Freedom of Information Act 2000 and the Trust's associated Publication Scheme)

2.0 Definitions / glossary

Approval:	Official agreement by an appropriate Committee that any resource implications associated with implementation of the policy have been properly considered, and that the content of a policy and procedure: • meets the required standards • is fit for purpose, and • is suitable to be submitted for ratification. Approval is the penultimate step before a policy and procedure is issued for use. Approval can only be given by the appropriate formal Trust Committee.
Author:	The employee that drafts the policy and procedure (and subsequent updates/revisions) in accordance with the requirements of this policy and procedure. Staff will be designated as the author of a policy and procedure according to the role they are employed to perform.
Clinical guidance:	Any document designed to guide clinical practice. This includes clinical guidelines, integrated care pathways, clinical protocols, resource manuals etc. Such documents are recommendations of good practice, which are expected to be applied to all cases, but which permit exceptions, based on the judgement of the practitioner. Clinical guidance documents allow individuals to use their professional judgement and

	decision making skills. They are flexible and act as a support and guide, and are not prescriptive. Such documents are excluded from this policy and procedure.
Consultee:	A person or Group who has been sent a policy and procedure, prior to it being submitted for approval, to enable that person or Group to comment and/or propose amendments.
Endorsement:	The provision of formal support to a policy and procedure (and thereby acknowledgement that the content is fit for purpose and ready for approval), by a Group/Committee, prior to its approval. Endorsement can be provided by more than one Group/Committee, if relevant. Endorsement is not compulsory, but Authors and/or Approving Committees may wish to seek endorsement to support the process of Approval.
Executive Lead:	The most senior employee responsible for the content of a policy and procedure (and for ensuring the policies under their specific areas of responsibility have been developed in accordance with this policy and procedure). Executive Leads must be a Member of the Executive Team (if in doubt, please clarify with the Trust Secretary or refer to the Trust's Standing Orders). Executive Leads will be allocated policies and procedures according to the areas/subjects within their area of responsibility/portfolio. Advice and clarification on this can also be obtained from the Trust Secretary.
Local Policy (and Procedure):	A policy (and procedure) that does not meet the definition of being "Trust-wide" i.e. which covers the method of working within a single Directorate (and the staff therein).
Mandatory consultee:	A person identified by the PRC as needing to be included in the consultation of all Trust-wide policies (or all Trust-wide policies covering a particular subject). The list of mandatory consultees is contained within the Policy Template.
Material change:	A change to an existing Trust-wide policy and procedure that fundamentally affects what staff are expected to do under that policy. Examples of material changes include: ▪ Changes that have resource implications that cannot be applied in a straightforward manner ▪ Changes that may be contentious and/or require debate ▪ Changes that result in the Target Audience regarding the changed policy as different to the existing policy
Non-material change:	A change to an existing Trust-wide policy and procedure that does not fundamentally affect what staff are expected to do under that policy. Non-material changes should not be contentious and/or require debate. Examples of non-material changes include: ▪ Changes to the names of jobs, roles, contact details,

	Committees, clinical areas, locations ▪ Corrections to typographical errors, formatting etc. ▪ Minor changes to policy-related documentation (such as requests for small amounts of additional information on forms)
Other contributors:	Individuals who are closely involved in the production and/or review of a policy and procedure but who are not the author. Such persons will be listed on the front cover of each Trust-wide policy and procedure.
Plan:	Plans can take many forms, but they are usually a description of a series of time-limited steps that will be taken to achieve a particular aim. Such documents are excluded from this policy and procedure.
Policy:	A statement of corporate intent explicitly stating responsibility and accountability, and containing details which relevant Trust employees are expected to adhere to, as part of their terms of employment. Some documents may involve a mixture of 'policy' and 'guidance'. The determination of whether a document should be considered a "Policy" therefore depends on the extent of that mix i.e. if the substance of the document is mostly concerned with content that employees are expected to adhere to, the document should be regarded as a policy. If the substance of the document is mostly concerned with recommendations of good practice, the document should be regarded as guidance.
Policy Template:	A Word document that describes the format, style and layout that Trust-wide policies and procedures should use. The Policy Template is set by the Policy Ratification Committee (PRC) - see Appendix 5.
PRC:	Policy Ratification Committee. The Committee authorised to ratify policies for use in the Trust. PRC members are a pool of committed staff from clinical and non-clinical departments who have responded to invitations to be involved in PRC. PRC members are deliberately not representing their department or area of work, nor are they experts in the subject matter covered by most policies, but they do have an enquiring mind, a keen eye for detail, 'common sense', and a desire to improve the quality of the Trust's processes.
Procedure:	A standardised method of performing a task/s. A procedure related to a policy defines the specific course of action relevant employees are expected to follow.
Q-Pulse:	The database used to upload Trust-wide policies and procedures (along with other documents).

Ratification:	Final authorisation for use within the Trust. Ratification can only be given by the final Committee that considers the document. In the vast majority of cases this would be the PRC, but some policies would be ratified by the Trust Board. Ratification consists of: • checking that the policy and procedure has been subject to an appropriate consultation and approval process; • 'sense-checking' the policy and procedure, to assess whether it makes sense, flows well, is internally consistent etc.; • checking the policy and procedure complies with the format, style and layout requirements of the latest Policy Template; and • proof-reading the policy and procedure for errors
Review:	The process of examining the content of a policy to determine whether it is required; fit for purpose; and well-written.
Review date:	The date by which a Trust-wide policy and procedure is required to be fully reviewed, and, if appropriate, the revised version uploaded. A Review date is not however an expiry date, and a policy and procedure does not become automatically unfit for purpose solely because its Review date has passed.
Strategy:	A document outlining a long-term goal/s (with details of how the goal is intended to be achieved). Such documents are excluded from this policy and procedure.
Trust-wide Policy:	A policy that covers the method of working across more than one Directorate.
Uploading:	Placing a document on the Trust-wide database, to enable it to be accessed by Trust staff.

3.0 Duties

Trust Board:	Responsible for ensuring the Trust has a robust approach to ensuring the policies and procedures staff are expected to follow have been: developed with due rigour; take account of appropriate external guidance and internal opinion; are well-written; and meet the needs of staff and the Trust .This responsibility will be met by ratifying this policy (and seeking assurance on compliance, as required).
Chief Executive:	Responsible for ensuring there are sufficient resources in place to implement this policy and procedure.
Policy Ratification Committee	• Responsible for ratifying Trust-wide policies and procedures in accordance with this policy and procedure • Be the arbiter of any decisions relating to the approval

(PRC):	and/or ratification of Trust-wide policies and procedures • Agreeing the Policy Template applicable to Trust-wide policies and procedures
Trust Management Executive (TME):	Overseeing the process described in this policy and procedure, via monitoring the work of its sub-committee, the PRC.
Approving Committee:	Responsible for ensuring that the content of policies and procedures they approve have been properly considered, that the content matches the best practice in relation to the subject matter of the policy, and that the policy and procedure is suitable for ratification.
Executive Lead:	• Ensuring the policies and procedures under their specific areas of responsibility have been developed in accordance with this policy and procedure • Ensuring that an author is appointed to each policy and procedure under their specific areas of responsibility (and re-appointing if an author leaves or moves role)
Author:	Responsible for ensuring their policies and procedures are produced, consulted, approved and ratified in accordance with this policy and procedure. This includes any subsequent revisions.
Trust Secretary:	• Responsible for implementing this policy and procedure • Chairing the PRC, and ensuring it complies with its Terms of Reference • Providing advice on the implementation of this policy and procedure
Assistant Trust Secretary:	• Scheduling of the policies to be reviewed at the PRC. • Ensuring that authors complete a PRC pre-submission checklist
Corporate Governance Assistant:	• Administering the Trust-wide policy database (Q-Pulse) • Publishing policy documents on the Trust-wide policy database (Q-Pulse) • Issuing reminders to authors in relation to Review dates • Providing advice on the implementation of this policy and procedure • Undertaking a 'pre-PRC' review of policies and procedures, to determine whether they meet the requirements of this policy and procedure and/or the latest Policy Template • Providing reports to the PRC, as required

4.0 Training / competency requirements

No training/competency requirements at this time. However, advice and guidance is available from the Trust Secretary, Ext. 28698. In addition, a series of “Frequently Asked Questions” (FAQs) have been developed in relation to policy ratification (see Appendix 4).

5.0 Procedure

Refer to the flow diagram on page 6 for an overview of the standard process. The specific steps required are as follows:

5.1 Identifying and confirming the need for a Trust-wide policy and procedure

5.1.1 New policy content

The Trust should only produce, approve, ratify and apply the Trust-wide policies and procedures that are genuinely regarded as being required to enable the Trust to effectively fulfil its functions and duties.

The need for a new Trust-wide policy and procedure may be identified via a number of different sources, such as a requirement from external agencies, incidents, complaints or other events; Internal Audit reviews; in-house or external assessment etc.

However, before concluding that a completely new policy is required, a search of existing policies and procedures should be undertaken, via Q-Pulse, and consideration should be given as to whether it is feasible to extend the scope of an existing policy and procedure to incorporate the new content.

If it is considered feasible to extend the scope, liaison should occur with the author of the existing policy and procedure, and agreement should be reached as to who the author of the revised/extended policy and procedure should be. That person will be responsible for ensuring the revised/extended policy and procedure complies with this policy and procedure.

If it is not considered feasible to extend the scope of an existing policy and procedure, a new policy and procedure should be proposed to be produced. However, before that document is drafted, the proposed Executive Lead should be identified and approached, to obtain their confirmation that they believe a completely new policy and procedure is required. This confirmation should be obtained in writing (email confirmation will suffice).

5.1.2 Existing policies and procedures

The Trust should only produce, approve, ratify and apply the Trust-wide policies and procedures that are genuinely regarded as being required to enable the Trust to effectively fulfil its functions and duties. There should therefore be a regular assessment of whether existing policies and procedures are still required, as it is possible that the rationale for the policy being produced has changed and/or

ended. This assessment can occur at any time, but will be formally required (by authors) 6-months before the Review date of each existing Trust-wide policy and procedure.

If a policy and procedure is assessed as no longer being required, it should be withdrawn from publication and archived (see section 5.11.1).

If a policy is assessed as still being required, it should be reviewed in accordance with section 5.8.

5.2 Drafting a new policy and procedure / reviewing and revising an existing policy and procedure

5.2.1 New policies and procedures

The author should firstly download the latest Policy Template [RWF-OP-DocTemp-Policy1] from the Q-Pulse database. The author should then draft the policy and procedure using the Policy Template, and follow the guidance therein (including that for format, style, and layout). The Chair of the PRC may defer policies and procedures not using the latest Policy Template from being reviewed at the PRC. There may however be exceptions to using the Policy Template (see section 5.2.3).

5.2.2 Existing policies and procedures

The author should firstly download the latest Policy Template [RWF-OP-DocTemp-Policy1] from the Q-Pulse database. The author should then critically review the content of the existing policy and procedure and amend/update as required. The revised policy and procedure will need to adhere to the latest Policy Template, and should therefore follow the guidance therein (including that for format, style and layout). The Chair of the PRC may defer policies and procedures not using the latest Policy Template from being reviewed at the PRC. There may however be exceptions to using the Policy Template (see section 5.2.3).

5.2.3 Exceptions to using the Policy Template

Some policies and procedures may be exempt from adhering to the Policy Template. These may be policies that are required and/or expected to be produced in a specific format and/or style, perhaps because they are national, or local, ‘model’ policies, or because they have been agreed in conjunction with several external agencies.

In such circumstances, prior to drafting a new policy, or revising an existing policy (that has not already been authorised to be exempt from using the Policy Template), the author should email the Chair of the PRC requesting an exemption from using the Policy Template, and explaining the reasons for the exemption. The request will be assessed and if an exemption is considered to be warranted, the author will be authorised to add a sentence to the cover page of the policy and procedure stating that “This policy and procedure has been confirmed to be exempt from strictly adhering to the Trust’s Policy Template”. However, the policy will still need to

include certain elements of the Policy Template, to enable it to be recognised as a policy of Maidstone and Tunbridge Wells NHS Trust. These elements are as follows:

- Cover page
- “Document history”, “Keywords” and “Version control”
- “Summary”
- Table of contents
- Appendices 1-3

If the request for an exemption is rejected, the author will need to draft and/or revise the policy and procedure using the latest Policy Template.

5.2.4 Appendices

The decision as to whether a document should be included as an Appendix to a policy and procedure, or just be listed as a ‘cross reference’ depends on the author’s expectations regarding that document.

If the document is not required or expected to be read by the target audience, and is merely listed in case they wish to, for example, find out more about the rationale and/or background to the policy and procedure, this should be listed as a cross reference.

If the document is expected to be read and understood by the policy and procedure’s target audience, the document should be included as an appendix.

If an appendix is a format that is unable to be included as a separate document (such as a web-based form), consideration should be given to having an appendix that shows the original appendix as a ‘screen shot’, and signposts readers to the location of the appendix (i.e. a website/URL, with a hyperlink if suitable).

If an appendix is produced externally (i.e. published by a body other than the Trust), it may still meet the above criteria for being included as an appendix, although it is accepted that revisions to the document might not be possible.

5.3 Consultation

Consulting with the key individuals and groups who have an interest in a policy and procedure is important. It enables the content to be critiqued by those who have detailed knowledge of the subject matter, as well as enabling the document/s to be ‘sense checked’ by those who have not been directly involved in their production.

5.3.1 Scheduling at the Policy Ratification Committee (PRC)

To avoid any delays, once a policy and procedure is ready to be issued for consultation, authors should contact the Assistant Trust Secretary (x26411) to schedule a date when the document/s can be reviewed at the PRC. The dates of PRC are listed on the Intranet.

5.3.2 Consultation period

The default period for consultation is 4 weeks. This recognises that those asked to review and comment on a policy and procedure will likely have to accommodate this whilst performing their own duties. This period also takes account of any potential Annual (or other) Leave such individuals may have.

There may however be occasions when a reduced consultation period is required. This would usually be expected to apply if a policy was required to be produced and/or revised by a specified deadline (such as, for example, a forthcoming external assessment or inspection). In addition, it is acceptable to apply a reduced consultation period for policies that are reviewed annually, on the basis that staff will have had an opportunity to comment on the document within the past year.

A consultation period should not however be less than 2 weeks, and the author should ensure, before submitting the policy and procedure for approval, that the Approving Committee is content to consider approving in the context of a reduced consultation period.

Consultation periods less than 2 weeks can only be authorised by the Executive Lead for the relevant policy and procedure, and such authorisation should be confirmed in writing to the author. The author should also ensure, before submitting the policy for approval, that the Approving Committee is content to consider approving in the context of a further reduced consultation period. The aforementioned authorisation will be sought by the PRC when it reviews the policy and procedure, and absence of such authorisation is likely to result in PRC deferring the policy and procedure, to enable a longer period of consultation to occur.

It may also be beneficial to consult in stages, to allow those with a more direct interest in the policy and procedure (and who are more likely to propose amendments that will be accepted) to be consulted first, before issuing the policy and procedure to a larger number of consultees.

5.3.3 Consultees

Appendix 2 of the Policy Template contains the list of persons who have been identified as mandatory consultees. This list may change, at the behest of the PRC, and therefore authors should consult the latest version of the Policy Template prior to any consultation.

In addition to the mandatory consultees, authors should include the following within the consultation:

- All members of the Approving Committee
- All persons and/or Groups who, by the nature of their role/duties, could reasonably be expected to have a specific interest in the policy. This involves a judgement by the author, but it is an important consideration, as excluding a person and/or Group who has a specific interest is likely to result in PRC deferring the

Policy for further development, and the author being required to re-consult.

It may also be appropriate to include external parties in a consultation (for example, other NHS Trusts) if the policy and procedure is likely to have a significant effect on that party's practice.

5.3.4 Response to consultation

When issuing a policy and procedure for consultation, authors are providing consultees with the opportunity to review, comment, and propose amendments. Consultees are under no obligation to respond to this offer, but if they choose not to do so, any subsequent critique is likely to be dismissed (unless the content identified as unsafe and/or not fit for purpose – see section 5.11.2).

Authors are expected to give due consideration to any comments and/or proposed amendments arising from the consultation. However, they are not obliged to make the proposed amendments if they disagree. Any contentious issues arising from the consultation are however expected to be resolved, by the author, before the policy and procedure is submitted for approval.

A record of the consultation should be kept by the author and this should be documented within the relevant mandated appendix (authors should refer to the latest Policy Template).

5.4 Endorsement

Policies and procedures need only be submitted to one Committee for approval, but certain policies and procedures may be of interest to more than one Committee. If the author or the Chair of that Committee regards the Committee's interest as sufficiently important, the policy and procedure may be formally submitted to that Committee, to obtain the Committee's support. This support will be considered to be "endorsement", and if obtained, should be recorded on the front cover of the policy and procedure. Endorsement can be provided by more than one Group/Committee, if relevant.

The version of the policy and procedure submitted for endorsement should be the post-consultation version i.e. the consultation should have ended, and any comments/proposed amendments should have been considered before the document/s are submitted.

It is up to the endorsing Committee to determine whether it wishes to receive the full policy and procedure document (plus all Appendices) when considering whether the policy and procedure should be endorsed. Certain Committees may, for example, only wish to receive a synopsis of the policy, outlining the key content and perhaps any changes made to the previous version. There is no standard format for this synopsis, and this can therefore be set by the endorsing Committee.

5.5 Approval

Policies and procedures submitted for approval should be the post-consultation version i.e. the consultation should have ended, and any

comments/proposed amendments should have been considered before the document/s are submitted.

5.5.1 Approving Committee

The Approving Committee should be a formal Committee of the Trust, and should be the Committee with the most relevant role in relation to the content of the policy and procedure.

For most policies, the Approving Committee should be obvious, but if authors are uncertain, advice can be sought from the Chair of the PRC. The precedent set by previous, similar, policies may also be useful. The following list should be considered as a guide only, for illustrative purposes.

Type of policy	**Approving Committee**
Human Resources	The Joint Consultative Forum
Clinical operational	Clinical Operations and Delivery Committee
Information Governance	Information Governance Committee
Health and Safety, Fire, Estates and Facilities	Health & Safety Committee
Infection Control	Infection Prevention and Control Committee
Policies which: • Set the overall framework of major clinical or corporate governance matters (e.g. Risk Management Policy and Procedure, Policy and procedure for the production, approval and ratification of Trust-wide policies and procedures etc.) • Have significant implications in relation to widespread changes of practice among staff • Have significant resource implications • Are likely to be contentious	Trust Management Executive

5.5.2 Approval by a Trust Board sub-committee

In accordance with the Principles listed in section 1.0, policies would not ordinarily be expected to be approved at a Trust Board sub-committee. However, any Trust Board sub-committee may

undertake the role of an Approving Committee if the Trust Board or sub-committee formally confirms that it wishes to undertake this role.

5.5.3 The documents to be considered for approval

For new policies, the policy document and any new appendices must be reviewed in full by the Approving Committee, as part of the formal agenda and reports for the meeting.

For existing policies that have been reviewed, it is the responsibility of the Approving Committee to determine whether it wishes to receive the full policy and procedure document (plus all Appendices) when considering whether the policy and procedure should be approved. Certain Committees may, for example, only wish to receive a synopsis of the policy, outlining the key content and perhaps any changes made to the previous version. However, in approving a document, the Approving Committee is officially agreeing that any resource implications associated with implementation of the policy have been properly considered, and that the content of a policy and procedure:

- meets the required standards
- is fit for purpose, and
- is suitable to be submitted for ratification

By not considering the documents in full, the Approving Committee therefore risks approving documents that are not well-written and contain (for example) consistency errors. The Chairs of Approving Committees are therefore expected to bear this in mind when considering the documents they require to be submitted.

5.5.4 Recording approval

Approval should be recorded in the minutes of the Approving Committee meeting at which the policy and procedure was considered.

5.5.5 Approval of sub-standard documents

If the PRC considers that an Approving Committee is repeatedly approving policies and procedures that are sub-standard i.e. that are poorly-written, not complying with this policy and procedure, and/or not adhering to the Policy Template, the Chair of PRC will contact the Chair of the Approving Committee to make this known, and request that the Approving Committee consider whether the processes it applies when approving policies and procedures is sufficiently robust to enable the Approving Committee to fulfil its duties under this policy and procedure.

5.6 Ratification

Ratification is the authorisation for the use of a policy and procedure within the Trust. Ratification can only be given by the final committee that considers the document. In the vast majority of cases this would be the PRC, but some policies would be ratified by the Trust Board (see section 5.6.5).

5.6.1 The documents to be considered for ratification

The documents submitted to PRC should include:

- The full version of the main policy and procedure document
- The full version of any further Appendices that have that policy and procedure as their primary policy (see section 5.10)

5.6.2 The ratification process

Before a policy and procedure can be reviewed at PRC, the author should liaise with the Assistant Trust Secretary and complete a PRC pre-submission checklist, to confirm that all necessary steps have been taken.

Policies and procedures are reviewed in detail at the PRC, and therefore someone who is familiar with the content needs to attend PRC when their policy and procedure is being reviewed, to respond to any queries/proposed amendments. This is expected to be the author, but if they are unavailable, they may send a representative who is able to speak on their behalf.

Ratification consists of the following aspects:

- Checking that the policy and procedure has been subject to an appropriate consultation and approval process
- 'Sense-checking' the policy and procedure, to assess whether it makes sense, flows well, is internally consistent etc.
- Checking the policy and procedure complies with the format, style and layout requirements of the latest Policy Template (or that an exemption has been obtained in the correct manner – see section 5.2.3)
- Proof-reading the policy and procedure for errors

The PRC may propose amendments to the policy and procedure. Authors are expected to consider proposed amendments, but are not obliged to accept them. Any objections should be raised by the author at the PRC meeting and debated, to enable a conclusion to be reached. However, if the PRC believes that the amendment is essential to ensuring that the policy and procedure is fit for purpose, it may insist that such amendments are made before the policy and procedure is ratified. This position should be made clear within the PRC meeting. Any disputes will be considered according to the principles within section 5.6.5.

5.6.3 Outcome of the ratification process

At the end of the review by the PRC, the policy and procedure will either be ratified (as submitted, or subject to changes) or deferred for further development. This latter option will be chosen if the PRC believes that the policy and procedure is not fit for purpose and/or is not substantially compliant with this policy and procedure.

If ratified, the author will be asked to make any changes that have been agreed, and submit the final version of the policy and

procedure (including any further Appendices) to the Chair of the PRC. All amendments must be made within 3 months of the date of review by the PRC, or the policy and procedure would require re-submission to PRC. Discretion may however be applied by the Chair of the PRC, to take account of any extenuating circumstances for missing this 3-month deadline.

If authors have chosen not to make certain changes proposed by PRC, this should be explained. The Chair of the PRC will then check that the requested changes have been made, or whether the rationale for not making any changes had been provided (and is credible), and if this is the case, will confirm the documents can be uploaded (at which point the Corporate Governance Assistant will be asked to publish them on the policy database).

If the Chair of the PRC concludes, after checking, that the changes requested by PRC have not been made, and a rationale for this has not been provided, the author will be notified, asked to make the changes requested by PRC, and submit to the Chair of the PRC again, for checking. The Chair will then check that the requested changes have been made, and if this is the case, will confirm the documents can be uploaded (at which point the Corporate Governance Assistant will be asked to publish them on the Policy database).

If the policy and procedure is deferred for further development, the author will need to amend the document/s to reflect PRC's comments, and then follow the processes described earlier for consultation, approval and ratification.

Any disputes will be considered according to the principles within section 5.6.5.

5.6.4 Recording the ratification decision

The ratification decision should be recorded in the minutes of the PRC meeting at which the policy and procedure was considered.

5.6.5 Resolution of disputes

If an author fundamentally disagrees with an amendment proposed by the PRC, PRC will determine, by a majority verdict, whether it regards the amendment as essential to ensuring that the policy and procedure is fit for purpose. If this is confirmed, the author will be invited to reconsider their position. If the author maintains their position, the policy and procedure will be unable to be ratified at that PRC meeting, and should therefore be deferred, pending further discussion.

The author should then discuss the proposed amendment with the Executive Lead for the policy and procedure. The Chair of the PRC should also provide the Executive Lead with the rationale for the PRC's view. The Executive Lead should be asked to confirm whether they support the author's view or the view of the PRC. The Executive Lead's decision will then be followed (and the policy and procedure re-scheduled for a PRC meeting, to enable formal

ratification, reflecting the decision made), unless the Chair of the PRC feels that a further discussion, with the Chief Executive, is required. In this case, the Chair of the PRC will arrange for a meeting between the Chief Executive, the Executive Lead and themselves, to consider the matter. The decision of the Chief Executive will be final. The policy and procedure should then be re-scheduled for a PRC meeting, to enable formal ratification, reflecting the Chief Executive's decision.

5.6.6 Policies ratified by the Trust Board

Certain policies may be required and/or desired to be ratified by the Trust Board, because of an external requirement to do so, or because the Executive Lead and/or Approving Committee regards the policy as important enough to warrant this. It would be inappropriate for PRC to consider such policies after the Trust Board (as the most senior forum in the Trust) had ratified them. Such policies and procedures would therefore be expected to be ratified at the Trust Board having first been reviewed and "Recommended for ratification" by the PRC. Such policies and procedures would still be required to be approved by the appropriate Committee.

5.7 Publication

Trust-wide policies and procedure will be uploaded to the Trust's policy database, which is accessible via the Trust's Intranet, to ensure that they are available to all relevant staff.

Staff will be notified of any newly- uploaded policies and procedure via the "Policy & guideline updates" page on the Intranet.

Hard copy versions of Trust-wide policies and procedures should not be circulated, as there can be no guarantee that the hard copy is the latest version to be uploaded.

The Trust does not currently publish its Trust-wide policies and procedures on its public website. However, in the interests of openness and accountability, staff are permitted to share uploaded versions of Trust-wide policies and procedures with any external party, including patients and staff from other Trusts.

5.8 Review of policies

5.8.1 Review dates

All Trust-wide policies and procedures will be ratified for 4 years, unless a shorter period (1, 2, or 3 years) is required by an external agency, the author, or the Approving Committee.

Policies should not exceed their Review date. To ensure this, the Corporate Governance Assistant will issue reminder emails to authors at the following points:

1. 6 months before the Review date. The email will first ask for confirmation as to whether the policy is still needed. If the policy and procedure is still required, the email will remind the author of the steps involved in reviewing, approving and ratifying the

document/s, and request that the process commences. If the policy and procedure is no longer required, the process described in section 5.11.1 should be followed.

2. 3 months before the Review date. This email is only required if the reply to the 6-month prompt (see step 1. above) confirms the policy and procedure is still required. The email should again remind the author of the steps involved in reviewing, approving and ratifying the document/s, and request that the process commence if this is not already the case. The email will also state that if the author does not believe that the process will be completed by the Review date, the Approving Committee should be asked to request a short extension to the Review date. This extension can be for a maximum of 6 months, to allow the policy and procedure to be reviewed, consulted, approved and ratified. This request can be made via email, or via formal discussion at one of the Committee's meetings. The email or minutes of the relevant meeting will therefore need to be provided to the Corporate Governance Assistant. The email will also state that if there is no clear plan to enable the revised policy to be uploaded by any extended Review date, the policy and procedure may be withdrawn from publication when that Review date is reached. The author will therefore be asked to reply to the email, confirming their intended course of action.
3. At the Review date. This email is only likely to be required if there has been no clear indication of a plan for reviewing the policy and procedure. The email will state that the policy and procedure will be withdrawn from publication 2 weeks from the date of the email. The author will therefore be asked to reply to the email as soon as possible confirming their intended course of action. If the author does not want the policy to be withdrawn, the Approving Committee will need to request a short extension to the Review date. This extension can be for a maximum of 6 months, to allow the policy and procedure to be reviewed, consulted, approved and ratified. This request can be done via email, or via formal discussion at one of the Committee's meetings. The email or minutes of the relevant meeting will therefore need to be provided to the Corporate Governance Assistant. The email will also state that, at the end of the extension, if there is still no clear plan to enable the revised policy and procedure to be uploaded the policy and procedure will be withdrawn from publication when the extended Review date is reached. See section 5.11.3.

5.8.2 Mandatory detailed reviews

Each Trust-wide policy and procedure should be subject to a detailed review, consultation, approval and ratification at least once every 4 years. The full process should be applied even if the author believes that the existing policy and procedure requires no or few changes. The application of this periodic detailed review will ensure

that the author's view is subject to appropriate challenge (thereby protecting the Trust against over-reliance on an individual's views) and validated.

5.8.3 Light-touch reviews

For Trust-wide policies and procedure that have been allocated a Review date of 1, 2 or 3 years, if the author reviews the document and confirms (in writing, to the Chair of the PRC) that no non-material changes are required, the Review date can be extended to the next period (i.e. another 1 or 2 years) without the document/s requiring to be re-approved or re-ratified.

For policies with a 1-year Review date, this process can occur up to 3 times (i.e. at year 1, year 2, and year 3). At year 4, a Mandatory detailed review (see section 5.8.2) would be required.

For policies with a 2- and 3-year Review date, this process can only occur once (i.e. at years 2 and 3 respectively). At year 4, a Mandatory detailed review (see section 5.8.2) would be required.

5.9 Changes to existing policies and procedures

5.9.1 Non-material changes

Non-material changes to existing policies and procedures can be made any time these are identified as being needed. Ordinarily, the author would be expected to identify the need for such changes, but there may be occasions when others identify this need (in which case this should be brought to attention of the author).

If the need for non-material changes is identified, the author should email the Chair of the PRC giving details of the change/s required. If the Chair of the PRC agrees that the change is non-material, they will email the Corporate Governance Assistant to formally request that the change be made. The author will then be authorised to make the change/s, update the 'Version control' table, and email this to the Corporate Governance Assistant who will then check, and upload the updated document/s.

Requests for amendments from individuals who are not the named author will not be accepted unless the author or the Executive Lead has confirmed the amendment can be made, in writing (via an email to the Corporate Governance Assistant).

5.9.2 Material changes

Material changes to policies and procedures can only be made with the approval of the relevant Approving Committee. In such circumstances, the author should arrange for the Approving Committee to consider, and approve, the proposed changes, and if approval is granted, confirmation should be provided, in writing, to the Chair of the PRC.

All material changes to policies and procedures are then required to be re-ratified at PRC (but the PRC will only be required to ratify the sections of the policy and procedure that have changed).

5.10 Policy Appendices

All Appendices to policies and procedures should be numbered sequentially, and must be referred to within the body of the policy and procedure, including appropriate text. Appendices 1 to 3 are standard and should be incorporated within the main policy document. All subsequent Appendices should be listed within the policy document (in accordance with the latest Policy Template), but should be uploaded as separate documents.

Whether the relevant content of a policy and procedure should be incorporated within the main policy document or treated as an appendix will depend on the nature of the policy and procedure, and it is therefore acknowledged that a 'one size fits all' approach is not appropriate. The author should however adopt the approach they believe would result in the best understanding by the Target Audience, and result in the best 'flow' of the main policy document. The PRC may override the views of the author and/or Approving Committee if the PRC feels that the understanding of the Target Audience would be impaired by the submitted approach.

Each separate appendix document can be an appendix to more than one policy and procedure. However, each appendix should be primarily linked to only one policy and procedure. This primary policy and procedure should be identified in the list of "Further Appendices" that appears at the end of each main policy document.

Appendices are to be treated in the same way as the primary policy and procedure to which they are linked i.e. such Appendices should be reviewed, revised, consulted on, approved, and ratified at the same time as their primary policy and procedure. The same process for applying changes (as stated in section 5.9) also applies to Appendices.

Appendices are not required to conform to specific template requirements, but must be in Arial font and must include the following:

1. The Trust logo in the header
2. The Trust footer (i.e. that used for main policy and procedure documents)
3. The Trust disclaimer (i.e. that used for main policy and procedure documents)

Appendices that are linked to policies and procedures being reviewed and revised, but which are not the Appendices' primary policy and procedure, are not required to be included in that review process. Such Appendices are therefore not required to be submitted for review by the PRC when the policy and procedure is considered for ratification.

If an appendix is an externally-produced document (i.e. published by a body other than the Trust), its place within the policy and procedure should be approved, and ratified, although it is accepted that revisions to the document might not be possible. In such circumstances, authors would be expected to relay any identified errors to the body who publishes the document, but it is accepted that the Trust may not be able to influence the correction of such errors.

5.11 Withdrawing Trust-wide policies and procedures from use

5.11.1 Policies no longer required

If an existing policy and procedure is no longer considered to be required, it can be archived. For this to happen, the Chair of the Approving Committee for the current policy and procedure will need to confirm that the document/s is no longer required. This can be done via email (from the Chair to the author, Chair of the PRC and Corporate Governance Assistant), or via formal discussion at one of the Committee's meetings. If the latter route is chosen, the minutes of the relevant meeting will need to be provided to the Chair of the PRC or Corporate Governance Assistant.

On receipt of the confirmation, the Corporate Governance Assistant will archive the policy and procedure.

If the Approving Committee no longer exists, the most appropriate alternative Committee should be asked to provide the relevant confirmation, via either of the methods listed above. If there is no appropriate alternative committee, the Executive Lead for the current policy should be asked to provide the relevant confirmation, via email (to the Chair of the PRC and Corporate Governance Assistant).

5.11.2 Policies identified as unsafe and/or not fit for purpose

If an existing, uploaded, policy and procedure is identified by any member of Trust staff (including the policy author) as being unsafe and/or not fit for purpose, that member of staff should email the Chair of the PRC as soon as possible, explaining the rationale. The Chair of the PRC will consider the matter as soon as possible (which may involve liaison with the author) and if there is felt to be any credence to the claim, will ask the Corporate Governance Assistant to withdraw the policy and procedure from the Policy database. The Chair of the PRC will then ask the author to liaise with the person raising the concerns and change the policy and procedure to address such concerns (or just change the policy if it was the author that made the request). The process described in section 5.9 should then be followed.

When a policy and procedure is withdrawn in such circumstances, it should be replaced (on the Policy database) with a notice explaining that the policy has been withdrawn for a temporary period, and advising staff which staff member and/or department they can contact for advice until the policy and procedure is amended and re-uploaded.

5.11.3 Policies with no clear intention to be reviewed

As noted in section 5.8.1, a policy and procedure may be withdrawn from publication when its Review date is reached, and there has been no clear indication of a plan for reviewing the policy and procedure. Such circumstances are exceptional, and the author and Executive Lead for the policy and procedure should do all they could

to prevent it being withdrawn. However, if the Chair of the PRC does not receive satisfactory assurances, they will ask the Corporate Governance Assistant to withdraw and archive the policy and procedure.

5.11.4 Documents that no longer wish to be regarded as Trust-wide policies

There may be occasions when a document that has previously been considered to be a Trust-wide policy and procedure is still required, but which is no longer considered appropriate to be regarded as such. This may be because of changes to the emphasis of the document, or the way the document is perceived. It may also be related to the fact that the document is, or acts like, an operational plan. The key consideration should be whether the content of the document/s is sufficiently different from the definition of a "Trust-wide policy" to warrant it being excluded from the policy ratification process.

In such circumstances, the Executive Lead for the document should confirm that they are content for the document to be removed from being regarded as a Trust-wide policy. The Approving Committee should also be asked to formally approve the proposal. It should be made clear to both that if the proposal proceeded, the document could, if desired, remain uploaded to the Trust-wide policy database (Q-Pulse), but it would no longer be subject to the monitoring process applied to Trust-wide policies. In this regard, the author would not be reminded of the document review date, or pursued to ensure this review occurs. The document would also not be obliged to adhere to the Trust's Policy Template.

If the author and/or Executive Lead wants the document/s to remain uploaded to the Trust-wide policy database, this is possible, but the author should ensure that the documents are not also uploaded to other locations (such as the Intranet or shared folders that can be accessed by the target audience). This will avoid the risk of alternative versions of the document being accessed. If the author wishes to promote the awareness of the documents by making reference to these on, for example, a dedicated Intranet page, the page should just contain hyperlinks to the documents that are uploaded to the Trust-wide policy database.

5.12 Authors leaving the Trust

If an author leaves the Trust, the responsibility for the policies and procedures they authored will be transferred to their successor. A list of policies and procedures under the original author's name can be generated, to share with the new appointee, by the Corporate Governance Assistant, on request. Please note that the Corporate Governance Assistant cannot update the Trust policies database to reflect the new author's name unless they are informed of the new appointment.

Where no successor is appointed, or where there is a gap between an individual leaving and their successor starting in post, responsibility will

transfer to the original author's line manager. In the event of a dispute, the Executive Lead will appoint an author.

5.13 Policies without procedures

Some Trust-wide documents consist of policy but no accompanying procedures. Such documents should not therefore include "procedures" in their title. The format of the document should also be amended to remove any references to "procedures". Although this would technically constitute an exception to the Policy Template (see section 5.2.3) (which assumes that there would be "procedures", and includes a section for this), the front cover of such policies is not required to state that "This policy and procedure has been confirmed to be exempt from strictly adhering to the Trust's Policy Template".

5.14 Exceptions to this policy and procedure

This policy and procedure aims to cover all circumstances relating to the production, consultation, approval and ratification of Trust-wide policies and procedures. It is however recognised that there may be some circumstances that warrant exceptional arrangements. In the event of such circumstances arising, which necessitate a request to deviate from this policy and procedure, such requests should be made, in writing, to the Chair of the PRC for their consideration, and potential authorisation. Any authorised exceptions should be reported to the next available meeting of the PRC, and then reported to the TME.

Maidstone and Tunbridge Wells NHS Trust

APPENDIX 1

Process requirements

1.0 Implementation and awareness

- Once ratified the Policy Ratification Committee (PRC) Chair will email this policy and procedure to the Corporate Governance Assistant (CGA) who will activate it on the Trust approved document management database on the intranet, under 'Policies & Q-Pulse'.
- A monthly publications table is produced by the CGA which is uploaded on the Trust intranet under 'Policies & Q-Pulse'; notification of the posting is included on the intranet "News Feed" and in the Chief Executive's newsletter.
- On reading of the news feed notification all managers should ensure that their staff members are aware of the new publications.
- This policy and procedure will also be subject to an all-users email, to draw attention to the documents and ensure the expectations are made clear to the Target Audience

2.0 Monitoring compliance with this document

- A summary report of the output from each Policy Ratification Committee (PRC) will be submitted to the TME at the earliest opportunity
- The PRC will receive regular reports on the review status of each Trust-wide policy and procedure, and agree any action to be taken (including escalating issues to the relevant Executive Lead or TME)

3.0 Review

This policy and procedure and all its appendices will be reviewed at a minimum of once every 4 years, following the procedure set out in this policy [RWF-OPPPCS-NC-CG25].

If, before the document reaches its Review date, changes in legislation or practice occur which require material changes to be made, a full review, approval and ratification must be undertaken. Refer to the content of this policy for further details.

If non-material changes are required to the policy and procedure between reviews these do not require consultation and further approval and ratification. Refer to the content of this policy for further details.

4.0 Archiving

The Trust approved document management database on the intranet, under 'Policies & Q-Pulse', retains all superseded files in an archive directory in order to maintain document history.

Maidstone and Tunbridge Wells NHS Trust

APPENDIX 2

CONSULTATION ON: Policy and procedure for the production, approval and ratification of Trust-wide policies and procedures ("Policy for Policies")

Consultation process – Use this form to ensure your consultation has been adequate for the purpose.

Please return comments to: Trust Secretary, kevinrowan@nhs.net

By date: 31st July 2017

Job title:	**Date sent dd/mm/yy**	**Date reply received**	**Modification suggested? Y/N**	**Modification made? Y/N**
The following staff MUST be included in ALL consultations:				
Corporate Governance Assistant ruthdickens@nhs.net	06/06/17 27/06/17 10/07/17	12/06/17	Y	Y
Chief Pharmacist and Formulary Pharmacist mildred.johnson@nhs.net	10/07/17			
Formulary Pharmacist amanda.lepage@nhs.net	N/A			
Staff-Side Chair annemieke.koper@nhs.net	10/07/17			
Complaints & PALS Manager angelasavage@nhs.net	27/06/17 10/07/17			
Emergency Planning Team Epo.mtw@nhs.net	10/07/17			
Head of Staff Engagement and Equality jo.petch@nhs.net	10/07/17			
Health Records Manager di.peach@nhs.net	10/07/17			
All Members of the Policy Ratification Committee (PRC)	27/06/17 10/07/17	27/06/17 13/07/17	Y Y	Y Y
All members of the approving committee: (Trust Management Executive)	10/07/17			
Other individuals the author believes should be consulted:				
Assistant Trust Secretary	06/06/17 27/06/17 10/07/17	07/06/17	Y	Y
The following staff have given consent for their personal names to be included in this policy and its appendices:				
Ruth Dickens, Mildred Johnson, Amanda LePage, Annemieke Koper, Jo Garrity (was Petch), Di Peach, Kevin Rowan, Angela Savage, Claire Barnett				

Maidstone and Tunbridge Wells NHS Trust

APPENDIX 3

Equality impact assessment

This policy includes everyone protected by the Equality Act 2010. People who share protected characteristics will not receive less favourable treatment on the grounds of their age, disability, gender, gender identity, marital or civil partnership status, maternity or pregnancy status, race, religion or sexual orientation. The completion of the following table is therefore mandatory and should be undertaken as part of the policy development and approval process. **Please note that completion is mandatory for all policy and procedure development exercises.**

Title of policy or practice	Policy and procedure for the production, approval and ratification of Trust-wide policies and procedures ("Policy for Policies")
What are the aims of the policy or practice?	To ensure the policies and procedures Trust staff are expected to follow have been: developed with due rigour; take account of appropriate external guidance and internal opinion; are well-written; and meet the needs of staff and the organisation
Is there any evidence that some groups are affected differently and what is/are the evidence sources?	No
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	Is there an adverse impact or potential discrimination (yes/no). No If yes give details.
Gender identity	No
People of different ages	No
People of different ethnic groups	No
People of different religions and beliefs	No
People who do not speak English as a first language (but excluding Trust staff)	No
People who have a physical or mental disability or care for people with disabilities	No
People who are pregnant or on maternity leave	No
Sexual orientation (LGB)	No
Marriage and civil partnership	No
Gender reassignment	No
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	N/A
When will you monitor and review your EqIA?	Alongside this policy/procedure when it is reviewed.
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix 3 of this policy/procedure on the Trust approved document management database on the intranet, under " Policies & guidelines"

FURTHER APPENDICES

The following Appendices are uploaded as related links to the main policy/procedure on the Trust Policy database on the intranet, under “Policies & guidelines”:

No.	Title	Unique ID	Title and unique id of policy that the appendix is primarily linked to
4	Policy Ratification - Frequently Asked Questions (FAQs)	TBC	This policy
5	Policy Template	RWF-OP-DocTemp-Policy1	This policy

Policy Ratification - Frequently Asked Questions (FAQs)

NHS Maidstone and Tunbridge Wells NHS Trust

Q: What is a policy?
A: A policy is a statement of corporate intent that contains details which relevant Trust employees are expected to adhere to, as part of their terms of employment

Q: What is a procedure?
A: A procedure is a standardised method of performing a task/s. A procedure related to a policy defines the specific course of action employees are expected to follow

Q: What is the Policy Ratification Committee (PRC)?
A: The Policy Ratification Committee (PRC) is a committee which has been given the authority (by the Trust Board) to ratify all Trust-wide policies ('ratifying' a policy means giving final authorisation for the policy to be used within the Trust)

Q: What documents are considered at the PRC?
A: The PRC considers Trust-wide policies and any associated documents. Such associated documents would include the procedure related to the policy (these are usually included within a single 'policy and procedure' document; and any Appendices)

Q: What is a "Trust-wide" policy?
A: A policy that covers the method of working across more than one Directorate. If a policy is solely concerned with the working within a single Directorate, and does not have implications beyond that Directorate, it would not be considered to be "Trust-wide".

Q: Are clinical guidance documents considered at the PRC?
A: No. Clinical guidance documents (i.e. any document designed to guide clinical practice. This includes clinical guidelines, integrated care pathways, clinical protocols, resource manuals etc.) are excluded from the revised process. Details of the process for ratifying clinical guidance documents can be found on the "Policies & guidelines" page of the Intranet. The Associate Director, Quality Governance can also be approached for advice.

Q: Are all Trust-wide policies required to be submitted to the PRC for ratification?
A: Yes. Other committees can 'approve' policies, but only the PRC can 'ratify' Trust-wide policies (apart from a few exceptions, which are ratified by the Trust Board). Ratification is required for a policy to be published on the Policy database (Q-Pulse).

Q: Do Authors need to attend PRC?
A: Yes. Policies are reviewed in detail at PRC, and therefore someone who is familiar with the content of the policy needs to attend to respond to any queries / proposed amendments.

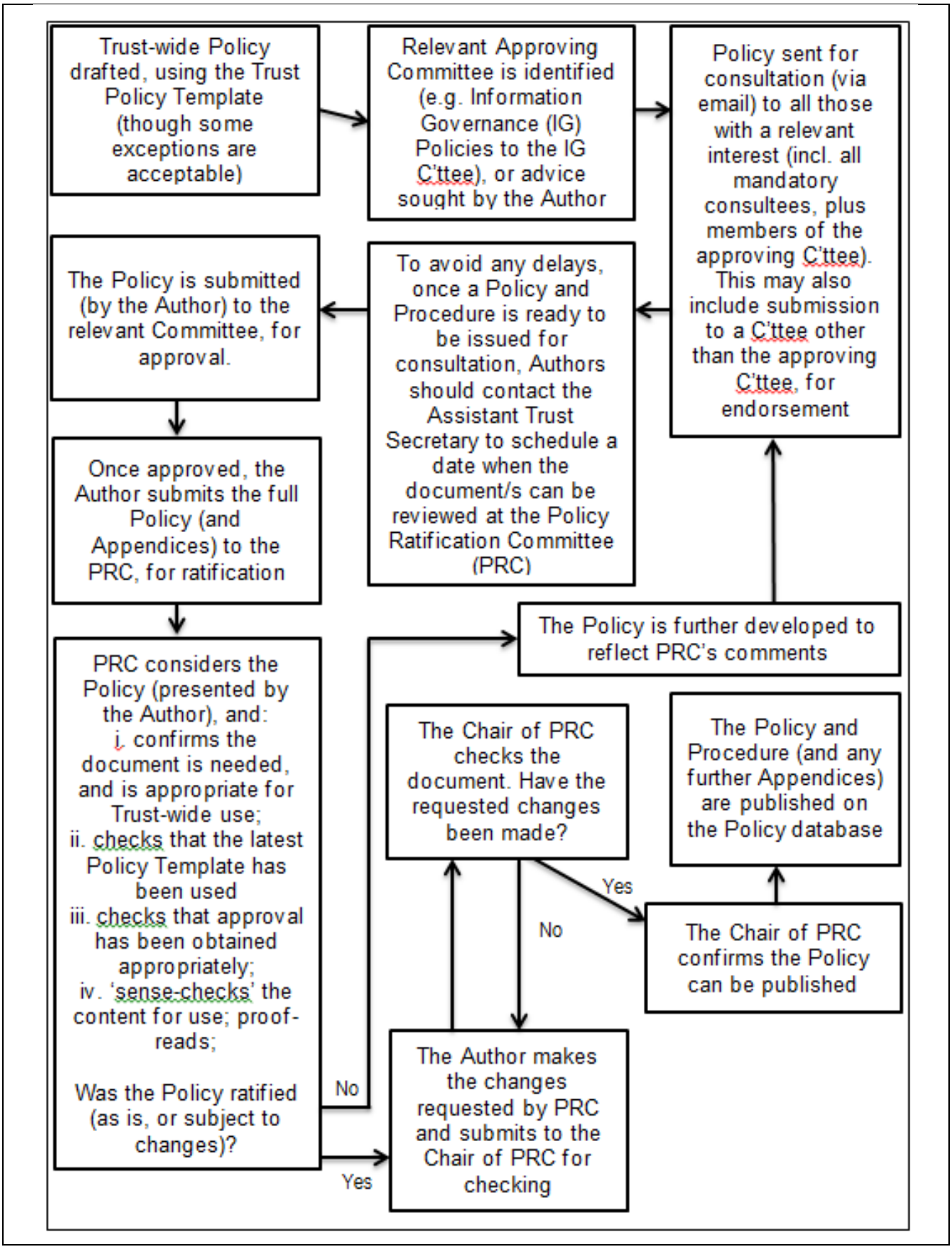
Q: Who are the members of PRC?
A: PRC members are a pool of committed staff from clinical and non-clinical departments who have responded to invitations to be involved in PRC. PRC members are deliberately not representing their department or area of work, nor are they experts in the subject matter covered by most policies, but they do have an enquiring mind, a keen eye for detail, 'common sense', and a desire to improve the quality of the Trust's processes.

Q: How often does the PRC meet?
A: PRC meetings are held monthly, and the dates are publicised via the Intranet (see http://mtwintranet/policies/). If there is a need to ratify a policy in between scheduled meeting dates, extraordinary meetings can be scheduled, at the discretion of the Chair of PRC.

Q: Where does PRC meet?
A: Most PRC meetings are held at Maidstone Hospital. However, at least 2 meetings each year are held at Tunbridge Wells Hospital. It is also possible for video-conference meetings to be arranged, should this be necessary.

Q: Which Committee oversees the work of the PRC?
A: The PRC is a sub-committee of the Trust Management Executive (TME), which is chaired by the Deputy Chief Executive (and meets monthly). A summary report of the outcome of each PRC meeting is received at each meeting of the TME.

Q: What process needs to be followed before a policy is ratified?
A: The diagram below gives an overview of the process (but refer to the Policy and procedure for the production, approval and ratification of Trust-wide policies and procedures ("Policy for Policies") [RWF-OPPPCS-NC-CG25] for the full details and requirements of each step)


Trust-wide Policy drafted, using the Trust Policy Template (though some exceptions are acceptable)
Relevant Approving Committee is identified (e.g. Information Governance (IG) Policies to the IG C'ttee), or advice sought by the Author
Policy sent for consultation (via email) to all those with a relevant interest (incl. all mandatory consultees, plus members of the approving C'ttee). This may also include submission to a C'ttee other than the approving C'ttee, for endorsement
The Policy is submitted (by the Author) to the relevant Committee, for approval.
To avoid any delays, once a Policy and Procedure is ready to be issued for consultation, Authors should contact the Assistant Trust Secretary to schedule a date when the document/s can be reviewed at the Policy Ratification Committee (PRC)
Once approved, the Author submits the full Policy (and Appendices) to the PRC, for ratification
The Policy is further developed to reflect PRC's comments
PRC considers the Policy (presented by the Author), and:
i. confirms the document is needed, and is appropriate for Trust-wide use;
ii. checks that the latest Policy Template has been used
iii. checks that approval has been obtained appropriately;
iv. 'sense-checks' the content for use; proof-reads;
Was the Policy ratified (as is, or subject to changes)?
No
Yes
The Chair of PRC checks the document. Have the requested changes been made?
Yes
No
The Policy and Procedure (and any further Appendices) are published on the Policy database
The Chair of PRC confirms the Policy can be published
The Author makes the changes requested by PRC and submits to the Chair of PRC for checking

Q: What is 'approval'?
A: Approval is official agreement by an appropriate Committee that the content of a policy meets the required standards, is fit for purpose, and is suitable to be submitted for ratification.

Q: What is 'endorsement'?
A: Endorsement is provision of support to a policy (and thereby acknowledgement that the content is fit for purpose and ready for approval), by a Group/Committee, prior to its approval. Endorsement can be provided by more than one Group/Committee, if relevant.

Q: My policy has been approved. How do I get to the PRC?
A: Email the Assistant Trust Secretary (Claire Barnett, claire.barnett2@nhs.net), who will allocate you a slot on one of the future meetings. It is preferable to make contact during the consultation process, rather than wait until your policy has been approved, to avoid any delays.

Q: Is a policy that has been approved guaranteed to be reviewed at the next available PRC meeting?
A: Every effort will be made to add approved policies to the agenda of the next PRC meeting. However, there is a limit to the number of policies that can be reviewed in a meeting (though as noted above, it is possible to hold extraordinary meetings). Therefore early notice of the timing of a policy review should be given to the Assistant Trust Secretary, to enable policies to be scheduled in timely manner. If a policy is not able to be reviewed at the next PRC meeting, the Assistant Trust Secretary will discuss this with the policy author.

Q: I'm presenting a policy for review at PRC. What can I expect at the meeting?
A: The steps involved are as follows:

- Each review takes approximately.30 minutes. You will be allocated a time slot for you to attend the meeting (these times are estimated, so you may have to wait a short time).
- Policies and procedures are reference documents to support staff who are not experts in the subject matter. They therefore need to be well-written, and make sense to the most junior member of staff to which the policy applies. PRC members will have read the document before the PRC meeting, and will have a number of comments/proposed amendments.
- When your slot is reached, you may be asked to give an introduction to the policy, for example to explain its 'journey' to PRC (including the changes made since the previous version, the reason why the policy is required (if it is a new policy) etc.
- The policy will then be reviewed in the meeting in detail, page by page. Comments will range from typographical errors (which you will just be expected to correct) to more significant matters. Minor corrections will not be discussed in the meeting, but issues that may be discussed include:
  - Whether the requirements of the latest Policy Template have been met
  - Whether the content reads well, and makes sense (or whether it should be worded differently)
  - Whether any flowcharts in the document 'flow' well, and are clear to understand (particularly in relation to choices to be made by staff)
  - Whether consistent language/terminology is used throughout the document
  - Whether certain content conflicts with other content in the same policy

- Whether all the external cross references listed are truly relevant
- Whether all Associated documents have been listed
- Whether all the appropriate personnel have been included in the policy consultation
- Whether the document has been correctly approved
- Whether the "Executive lead" is appropriate (Executive Leads must be a Member of the Executive Team)

Q: What if I disagree with an amendment proposed at PRC?

A: The vast majority of amendments proposed at PRC will be non-contentious. However, if you feel strongly that a proposed amendment is without merit, the point can be debated at PRC, and a consensus will be reached. If a proposed amendment represents a lone opinion of a PRC member, the point will be considered in this context, and a decision will be made on the merits of the point. If a point remains in dispute, the policy and procedure contains a dispute resolution process, which will be applied.

Q: What are the common themes arising from the policies that PRC has reviewed?

A: Some of the commonly-made issues that arise when PRC reviews policies are as follows:

- Consultations may not have included all of the mandatory consultees
- The responsibility for carrying out key tasks is not clear
- The duties of key staff involved in implementing the policy may be omitted
- Flowcharts may not flow properly (e.g. there may be multiple exit points from a box without a clear indication of which route to follow; there may be important steps missing)
- There is poor grammar (e.g. misuse of apostrophes, spelling errors)
- The legal name of the Trust ("Maidstone and Tunbridge Wells NHS Trust") is often mis-represented as "Maidstone & Tunbridge Wells NHS Trust". Any "&" in the Trust's name should therefore be amended to "and"
- Abbreviations and/or acronyms are not spelt out in full at the point of first use
- A 4-year review is acceptable (rather than annual or 2-year)
- Paragraph and/or page numbering is incorrect
- Key terms and/or abbreviations are not included in the "Definitions/glossary" section
- Tables that span more than 1 page often do not have the "Repeat Header Rows" option selected (which means the title of each column may not be clear)
- Terminology is inconsistent throughout the document
- Unofficial language is used (e.g. "Medical notes" or "case notes" instead of "Healthcare records"; "Middle grade" rather than "Specialty and Associate Specialist")
- Colloquial language is used (e.g. 'pull the notes', 'chase a response', 'big issue', 'ups and downs' etc.)
- The correct names of departments, job titles and/or committees are not used (e.g. "A&E" rather than "the Emergency Department")
- Mis-numbering of paragraphs, sections or internal references (e.g. "See Appendix 7" when this should be "See Appendix 8")
- Formatting errors are present (e.g. bullets are mis-aligned)
- Relevant documents are not included in the "Cross references" and/or "Associated documents" sections
- For the Equality Impact Assessment (Appendix 3), Authors often state a series of "No" response, when many policies do in fact reflect differences based on certain characteristics. It is therefore more accurate to state "Yes – refer to policy" rather

than “No”

- “Biennial” or “biannual” must be used, as this can be confusing. These should be replaced with “every 2 years” (biennial) or “twice yearly” (biannual)
- The consultation table (Appendix 2) is often not completed
- Additional appendices (i.e. beyond the standard Appendices 1-3) may not be created as separate/stand-alone files (this is required)
- Capital letters and/or italics and/or coloured text are inappropriately used for emphasis
- Documents may be written in non-standard fonts (which should be Arial, 12 point)
- Thresholds may omit certain scenarios (e.g. a policy may describe what should occur for patients aged 18 to 24, and over 25, but omit those who are aged 25)
- ‘Weak’ language may be used in relation to what staff are expected to do (e.g. using “should” instead of “must”)
- Using old versions of the Trust’s logo
- Not using bullets to make large sections of text easier to read and/or follow
- Just ‘copying and pasting’ text from external guidance without adapting/tailoring this to the Trust’s circumstances / needs
- Knowledge of certain processes may be assumed, and therefore not adequately explained
- Policies containing unrealistic requirements for which the resource implications may not have been properly considered (N.B. This should come under the remit of the Approving Committee)
- Documents that are expected to be referred to and/or used by a policy’s target audience (i.e. as part of the policy and procedure) not being included as Appendices
- Internet hyperlinks may not be correctly listed (and therefore do not work)
- Appendices that are expected to be filed within patient’s healthcare records not being sent to the Heath Records Department for review
- Separate ‘Standard Operating Procedures’ being used to describe key aspects of a procedure that should more usefully be included within the main policy document
- Monitoring and/or reporting arrangements being incorrectly described (e.g. referring to reports being submitted to the Trust Board or other senior committees that are not in fact submitted)
- Policy exclusions not being adequately described
- Advice on policy exclusions not being appropriately signposted (e.g. noting that a policy does not include certain situations, but failing to include a reference as to how to obtain advice on those excluded situations)

Q: The policy I’m presenting is largely unchanged from the previous policy. Will the PRC take this into account?

A: No. When PRC reviews a policy, it needs to make sure that the policy reads well and makes sense when considered in its entirety. It is also possible that errors were overlooked when the policy was previously ratified. This is particularly true for policies that were ratified before July 2014 (when PRC was established), but may also apply to Polices previously ratified by PRC. Therefore PRC will review all policies in detail, disregarding whether the changes from the previous policy are minor or substantial.

Q: What are the possible outcomes from PRC?

A: Policies reviewed at PRC are either “Ratified as submitted”; “Ratified subject to amendment” or “Deferred for further development and re-submission”. The vast majority of policies reviewed so far have been “Ratified subject to amendment”.

Q: What happens next?

A: If a policy is "Ratified as submitted", it will be uploaded to Q-Pulse at the earliest opportunity. This outcome is unlikely however, as there will almost certainly be some changes required, even if minor. For this "Ratified subject to amendment" scenario, policy authors are required to make the agreed amendments, and then email the revised document/s to the Chair of PRC, confirming that the changes have been made. Following a check to validate this, the Chair of PRC will then authorise the documents to be uploaded to Q-Pulse. Authors will receive an email confirmation once this has been done. If a policy is "Deferred for further development and re-submission", this is because there are significant concerns that the policy is not fit for purpose in its current state. Authors will therefore need to reflect on the comments made at PRC, and, most likely make significant revisions. It is also likely that the revised policy will need to be subject to further consultation and approval.

Q: I'm interested in joining PRC. Can I?

A: Yes, PRC is always happy to accept new members. In addition to having an interest in how the Trust functions; an enquiring mind; a keen eye for detail; and a desire to improve the quality of the Trust's processes, PRC members need to be able to commit to attend PRC meetings (these are held monthly, and last for circa 2.5 hours); and be committed to reading and critiquing policy documents. Given the time commitment, the support of your line manager is important. If, having considered the above you are still interested, obtain the support of your line manager. If all is OK, email the Chair of PRC (Kevin Rowan, Trust Secretary, kevinrowan@nhs.net) to confirm you would like to be involved. If you would like to have an informal chat with the Chair before deciding whether you would like to join, please contact Kevin on x28698.

Maidstone and Tunbridge Wells NHS Trust

TEMPLATE FOR TRUST-WIDE POLICIES AND PROCEDURES

Insert document title here (Arial font, bold, size 20)

Target audience:	Insert staff groups for whom this document is intended (e.g. 'all Trust staff', 'all Trust clinical staff'
Author:	Insert job title and contact details **Contact details: Ext.**
Other contributors:	Insert job title [optional]
Executive Lead:	Insert job title of the appropriate member of the Executive Team
Directorate:	Insert directorate under which the author sits
Specialty:	Insert specialty under which the author sits
Supersedes:	List all existing documents superseded by this document
Approved by:	List committee and date where the document was approved
Ratified by:	Policy Ratification Committee, DD^{xx} MMMMMMM YYYY
Review date:	Insert date of next review (a maximum of 4 years)

N.B. The text in green is guidance which should be followed and then deleted from the template (unless it refers to optional content which the author wishes to include).

The text in red is guidance which should be followed and over-typed/replaced with the relevant content/text (and then the text colour should be changed to black).

The text in black should be left unchanged. The font size has been set to enable appropriate accessibility and should not be amended.

Maidstone and Tunbridge Wells NHS Trust

Document history

Requirement for document: (Why is this document necessary?)	e.g. • Trust strategies/other policies • legislation • standards • external recommendations • audit
Cross references (external): (List all external best practice documents supporting this document)	1. Please use numbered bullet points 2. These should then be used for cross referencing within the policy and procedure text.
Associated documents (internal): (List all internal documents associated with this document)	• Please use un-numbered bullet points

Keywords: (Search terms to assist staff in finding this document on Q-Pulse)	Keyword	Keyword	Keyword
	Keyword	Keyword	Keyword
	Keyword	Keyword	Keyword

Version control: Details of approved versions		
Issue:	**Description of changes:** This needs to be brief, but able to accurately describe the major changes. For major changes, text such as "Complete overhaul of previous policy and procedure" should be used. For new policies, explain why it has been introduced	**Date:**
Issue number	Description of changes	Date

Maidstone and Tunbridge Wells NHS Trust

Summary for

Insert document title here

Insert policy summary here

A policy summary should be a brief declaration of what the policy is intending to do, including the situation/s and staff to which it applies. The summary should be 1-2 paragraphs maximum.

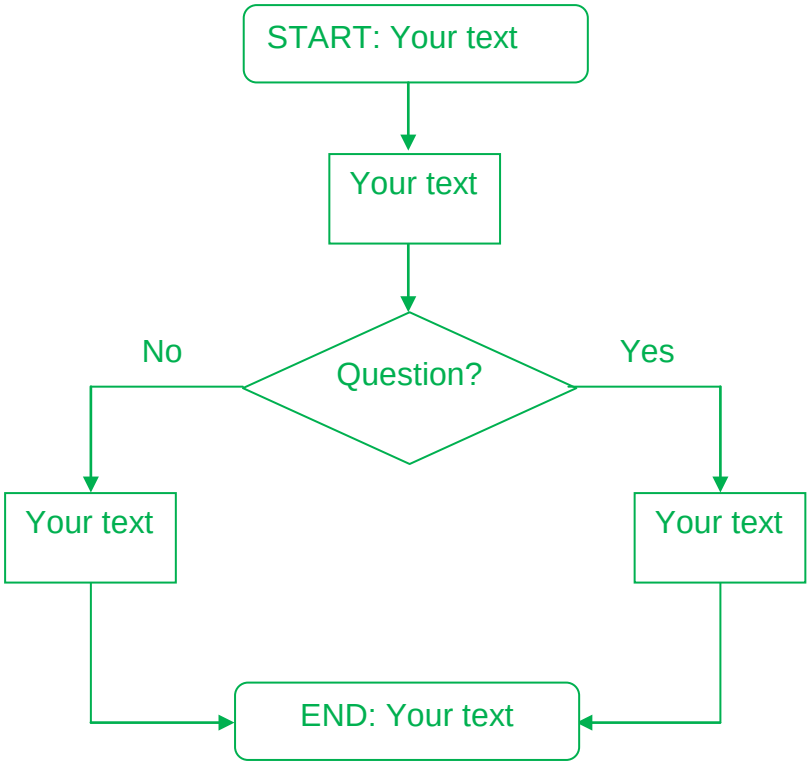
Contents

N.B. The table of contents below is designed to update using the headings that have been used in the policy. Do not therefore amend the text in the Table of contents – just right-click the mouse and choose the "Update Field" option once the content of the document is finalised

Flowchart / diagram of procedure to be followed [optional]

Flowcharts are optional but can be inserted within this section if they will help staff understand and follow required procedures. Alternatively, flowcharts / diagrams can be inserted at the relevant place/s in the procedure or added as appendices.

A simple flowchart is shown below; this demonstrates good flowchart design. Authors are not obliged but may choose to base their own flowcharts on this. The key aspect is that the flowchart 'flows', when worked through.



1.0 Introduction, purpose and scope [compulsory]

Why is the document needed?

What does the document hope to achieve?

Which staff and situations does the document apply to?

Which staff and situations are excluded from the document? (i.e. which may otherwise be considered to apply, from the title of the document). The document should ~~however~~ indicate who staff should contact for advice on any exclusions.

2.0 Definitions/glossary [compulsory]

Insert the definitions/explanation of key terms/acronyms that are used in the policy and procedural document here**.**

These should be listed in alphabetical order, using the following format:

Term	Definition
Term	Definition

It is not acceptable to state "There are no definitions".

3.0 Duties [compulsory]

For staff in implementing the policy and procedure

Please use the following format:

Person/Group	Duties
Heading (e.g. job title, staff group, committee name)	• Description of key duties/actions to be undertaken (listed as bullets if more than one duty is given)
Heading (e.g. job title, staff group, committee name)	• Description of key duties/actions to be undertaken (listed as bullets if more than one duty is given)

Those listed should be ordered by seniority, starting with the most senior (which may the Trust Board, if applicable), and ending with "All staff", or "All other relevant staff".

4.0 Training/competency requirements [compulsory]

Details of information, instructions and training required to implement the policy and procedure**.**

If there are no training/competency requirements please state "No training/competency requirements at this time. However, advice and guidance is available from XXXXX":

Department name Contact telephone number

5.0 Additional sections [optional]

Please detail the procedure itself in numbered sections from this point onwards; if your policy has no supporting procedures please use this and any additional sections required to present any further supporting information.

Tables [optional]

You may choose to use tables to present certain information. If your table won't fit on one page please ensure you use the 'Repeat Header Rows' function (which can be found on the "Layout" tab in Word when you are editing a table). The following table template has this feature 'switched on' if you wish to adapt it for your use:

Column 1	Column 2	Column 3

When writing the content of the document, please take note of the following common pitfalls:

- Consultations may not have included all of the mandatory consultees
- The responsibility for carrying out key tasks is not clear
- The duties of key staff involved in implementing the policy may be omitted
- Flowcharts may not flow properly (e.g. there may be multiple exit points from a box without a clear indication of which route to follow; there may be important steps missing)
- There is poor grammar (e.g. misuse of apostrophes, spelling errors)
- The legal name of the Trust ("Maidstone and Tunbridge Wells NHS Trust") is often mis-represented as "Maidstone & Tunbridge Wells NHS Trust". Any "&" in the Trust's name should therefore be amended to "and"
- Abbreviations and/or acronyms are not spelt out in full at the point of first use
- A 4-year review is acceptable (rather than annual or 2-year)
- Paragraph and/or page numbering is incorrect
- Key terms and/or abbreviations are not included in the "Definitions/glossary" section
- Tables that span more than 1 page often do not have the "Repeat Header Rows" option selected (which means the title of each column may not be clear)
- Terminology is inconsistent throughout the document
- Unofficial language is used (e.g. "Medical notes" or "case notes" instead of "Healthcare records"; "Middle grade" rather than "Specialty and Associate Specialist")
- Colloquial language is used (e.g. 'pull the notes', 'chase a response', 'big issue', 'ups and downs' etc.)
- The correct names of departments, job titles and/or committees are not used (e.g. "A&E" rather than "the Emergency Department")
- Mis-numbering of paragraphs, sections or internal references (e.g. "See Appendix 7" when this should be "See Appendix 8")
- Formatting errors are present (e.g. bullets are mis-aligned)
- Relevant documents are not included in the "Cross references" and/or "Associated documents" sections
- For the Equality Impact Assessment (Appendix 3), Authors often state a series of "No" response, when many policies do in fact reflect differences based on certain characteristics. It is therefore more accurate to state "Yes – refer to policy" rather than "No"
- "Biennial" or "biannual" must be used, as this can be confusing. These should be replaced with "every 2 years" (biennial) or "twice yearly" (biannual)
- The consultation table (Appendix 2) is often not completed
- Additional appendices (i.e. beyond the standard Appendices 1-3) may not be created as separate/stand-alone files (this is required)
- Capital letters and/or italics and/or coloured text are inappropriately used for emphasis
- Documents may be written in non-standard fonts (which should be Arial, 12 point)
- Thresholds may omit certain scenarios (e.g. a policy may describe what should occur for patients aged 18 to 24, and over 25, but omit those who are aged 25)
- 'Weak' language may be used in relation to what staff are expected to do (e.g. using "should" instead of "must")

- Using old versions of the Trust's logo
- Not using bullets to make large sections of text easier to read and/or follow
- Just 'copying and pasting' text from external guidance without adapting/tailoring this to the Trust's circumstances / needs
- Knowledge of certain processes may be assumed, and therefore not adequately explained
- Policies containing unrealistic requirements for which the resource implications may not have been properly considered (N.B. This should come under the remit of the Approving Committee)
- Documents that are expected to be referred to and/or used by a policy's target audience (i.e. as part of the policy and procedure) not being included as Appendices
- Internet hyperlinks may not be correctly listed (and therefore do not work)
- Appendices that are expected to be filed within patient's healthcare records not being sent to the Heath Records Department for review
- Separate 'Standard Operating Procedures' being used to describe key aspects of a procedure that should more usefully be included within the main policy document
- Monitoring and/or reporting arrangements being incorrectly described (e.g. referring to reports being submitted to the Trust Board or other senior committees that are not in fact submitted)
- Policy exclusions not being adequately described
- Advice on policy exclusions not being appropriately signposted (e.g. noting that a policy does not include certain situations, but failing to include a reference as to how to obtain advice on those excluded situations);l

Maidstone and Tunbridge Wells NHS Trust

APPENDIX 1
[Compulsory]

Process requirements

1.0 Implementation and awareness

- Once ratified, the Chair of the Policy Ratification Committee (PRC) will email this policy/procedural document to the Corporate Governance Assistant (CGA) who will upload it to the Trust Policy database on the intranet, under "Policies & guidelines".
- A monthly publications table is produced by the CGA which is published on the Trust intranet under "Policies & guidelines". Notification of the posting is included on the intranet "News Feed" and in the Chief Executive's newsletter.
- On reading of the news feed notification all managers should ensure that their staff members are aware of the new publications.
- Add bullet pointed details of any further plans for implementing this document or bringing it to the attention of relevant staff.

2.0 Monitoring compliance with this document

- Insert details of how the implementation of this policy and procedure will be monitored and/or audited **[compulsory].**
- State details of all monitoring committees and groups.
- Please note that monitoring described here may be expected to be completed by inspectors from external agencies. Do not record monitoring which realistically cannot be completed.
- If no structured monitoring is completed the author should, as a minimum, record any ad-hoc monitoring.

3.0 Review

This policy and procedure and all its appendices will be reviewed at a minimum of once every 1/2/3/4 years.

If changes in legislation or practice occur before the document reaches its review date, which require extensive or potentially contentious amendments to be made, a full review, approval and ratification must be undertaken. If non-material amendments are required to the document between reviews these do not require consultation and further approval and ratification. Such amendments include changes to job titles, contact details, ward names etc.; they are 'non-contentious'. For a full explanation please see the "Policy and procedure for the production, approval and ratification of Trust-wide policies and procedures ("Policy for Policies") [RWF-OPPPCS-NC-CG25].

4.0 Archiving

The Trust approved document management database on the intranet, under '"Policies & guidelines", retains all superseded files in an archive directory in order to maintain document history.

Maidstone and Tunbridge Wells NHS Trust

APPENDIX 2
[Compulsory]

CONSULTATION ON: Insert title of document

Consultation process – Use this form to ensure your consultation has been adequate for the purpose.

Please return comments to: Insert title of author and email address

By date: Insert date

Job title: *List staff to be included in the consultation.*	**Date sent dd/mm/yy**	**Date reply received**	**Modification suggested? Y/N**	**Modification made? Y/N**
The following staff must be included in all consultations:				
Corporate Governance Assistant ruthdickens@nhs.net				
Chief Pharmacist and Formulary Pharmacist (if prescribing or medicine is included in the document) mildred.johnson@nhs.net				
Formulary Pharmacist (if the document includes antibiotic use) amanda.lepage@nhs.net				
Staff-Side Chair (if Workforce/HR issues are included in the document) annemieke.koper@nhs.net				
Complaints & PALS Manager (if the document makes any reference to the Trust's Complaints and/or PALS service) angelasavage@nhs.net				
Emergency Planning Team (a vast majority of Policies have some form of Emergency Planning aspect, even if this is only minor) Epo.mtw@nhs.net				
Head of Staff Engagement and Equality (Equality & Diversity agenda must be considered within all Policies) jo.petch@nhs.net				
Health Records Manager (if the document contains any mention of patient record keeping and documentation) di.peach@nhs.net				
All individuals listed on the front page				
All members of the approving committee (state the committee). To obtain a mailing list for the members of the approving committee please contact the committee's administrator. Trust committees and their Chairs are described in the following document: Trust Committee and Governance Structure Chart [RWF-OWP-APP2]				
Other individuals the author believes should be consulted				
The following staff have given consent for their names to be included in this policy and its appendices: Ruth Dickens, Mildred Johnson, Amanda LePage, Annemieke Koper, Jo Garrity (was Petch), Di Peach, Angela Savage				

Maidstone and Tunbridge Wells NHS Trust

APPENDIX 3
[Compulsory]

Equality impact assessment

This policy includes everyone protected by the Equality Act 2010. People who share protected characteristics will not receive less favourable treatment on the grounds of their age, disability, gender, gender identity, marital or civil partnership status, maternity or pregnancy status, race, religion or sexual orientation. The completion of the following table is therefore mandatory and should be undertaken as part of the policy development, approval and ratification process.

Title of document	Title of document
What are the aims of the policy?	The aims of the policy
Is there any evidence that some groups are affected differently and what is/are the evidence sources?	Respond
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	**Is there an adverse impact or potential discrimination (yes/no). If yes give details.**
Gender identity	Yes or No. If yes give details.
People of different ages	Yes or No. If yes give details.
People of different ethnic groups	Yes or No. If yes give details.
People of different religions and beliefs	Yes or No. If yes give details.
People who do not speak English as a first language (but excluding Trust staff)	Yes or No. If yes give details.
People who have a physical or mental disability or care for people with disabilities	Yes or No. If yes give details.
People who are pregnant or on maternity leave	Yes or No. If yes give details.
Sexual orientation (LGB)	Yes or No. If yes give details.
Marriage and civil partnership	Yes or No. If yes give details.
Gender reassignment	Yes or No. If yes give details.
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	A negative response is allowed provided a rationale is provided
When will you monitor and review your EqIA?	Alongside this document when it is reviewed.
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix 3 of this document

Authors often state a series of “No” response, when many policies do in fact reflect differences based on certain characteristics. It is therefore more accurate to state “Yes – refer to policy” rather than “No”.

Maidstone and Tunbridge Wells NHS Trust

FURTHER APPENDICES

The following appendices are published as related links to the main policy/procedure on the Trust approved document management database on the intranet, under 'Policies & Q-Pulse':

No.	Title	Unique ID	Title and unique id of policy that the appendix is primarily linked to
4	Title of appendix	Unique ID	If the appendix is primarily linked to this policy, state "This policy"
5	Title of appendix	Unique ID	If the appendix is primarily linked to this policy, state "This policy"
6	Title of appendix	Unique ID	If the appendix is primarily linked to this policy, state "This policy"

Trust Board Meeting – October 2017

NHS Maidstone and Tunbridge Wells NHS Trust

10-19	Summary report from Quality Committee, 11/09/17 & 13/09/17	Committee Chair (Non-Executive Director)

The Quality Committee has met twice since the last Board meeting, on 11th September (a Quality Committee 'deep dive' meeting) and 13th September (a 'main' meeting).

1. The key matters considered at the 'deep dive' meeting on 11th Sept. were as follows:

- The **progress with actions** from previous meetings was noted included a discussion of the inclusion of each Clinical Directorate's overall mortality rate/s in the reports from the Trust Clinical Governance Committee to the 'main' Quality Committee. The point was made that including Directorate mortality data in reports to the Trust Clinical Governance Committee may cause issues to be considered prematurely, given the work of the Mortality Surveillance Group. Following assurance that Directorates had demonstrated increased ownership of their mortality data, it was agreed to close the action
- One of the main areas of focus was a **review of progress with implementing 7-day services**, led by the Medical Director. It was noted that variable progress had been made on 7-day services across the country, but good progress had been made at the Trust, which was now regarded as performing well in comparison with others (albeit within a lagging tranche of comparator Trusts). The meeting heard that the overall March 2020 goal was to implement 7-day services in hospital to 100% of the population (via 4 priority clinical standards in all relevant specialities, with progress also made on the other 6 standards), so that patients received the same standards of care, 7 days a week. Before that, the March 2017 goal was to implement 4 clinical priority standards, in all relevant specialties, to 25% of the population, which are:
  1. Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable Consultant as soon as possible, but at the latest within 14 hours of admission
  2. Standard 5: Hospital inpatients must have scheduled 7-day access to diagnostic services such as X-Ray, Ultrasound, CT, MRI, Echocardiography, Endoscopy, Bronchoscopy and Pathology. Consultant-directed diagnostic tests and completed reporting to be available 7 days a week: within 1 hour for critical patients, within 12 hours for urgent patients, and within 24 hours for non-urgent patients
  3. Standard 6: Hospital inpatients must have timely 24 hour access, 7 days a week, to Consultant-directed interventions that met the relevant speciality guidelines, either on-site or thorough formally agreed networked arrangements with clear protocols, such as: Critical Care, Interventional Radiology, Interventional endoscopy & Emergency general surgery
  4. Standard 8: a) All patients on the Acute Medical Unit, Acute Surgical Assessment Unit, and Intensive Therapy Unit & other high dependency areas to be seen & reviewed by a Consultant twice daily (including all acutely ill patients directly transferred and others who deteriorate); & b) Once transferred from the acute area of the hospital to a general Ward patients should be reviewed during a Consultant-delivered Ward round at least once every 24 hours, 7 days a week, unless it had been determined that this would not affect the patient's care pathway
- It was heard that a baseline assessment/organisational stocktake was undertaken in November 2016, and regular in-house audits would be done, with the next audit scheduled for October 2017. It was also noted that a Steering Group had been established, and there had been engagement with all of the leads for internal processes and publications, including the leads for Strategy, Operations and Quality Accounts. A Trust-wide Challenge Day (with the National Leads present) had also been held on 19/05/17
- The Medical Director confirmed that he expected compliance with the requirements, but a query was raised as to whether quarterly reports on the subject be submitted to the Trust Board. It was instead agreed that the summary report from the Quality Committee to the Board should contain detailed information about progress with implementing the 7-day programme, and the Board should be asked if it wished to receive any further reports. It was

also agreed to include the presentation given at the Quality Committee 'deep dive' meeting in the summary report, so this is enclosed in Appendix 1.

- The other main item was a **review of compliance with the Mental Capacity Act (MCA) 2005**, for which the Deputy Chief Nurse attended (the Safeguarding Matron was invited, but was unable to attend). It was noted that compliance with the MCA had been challenging across the country, and The Law Commission had recommended that Deprivation of Liberty Safeguards (DoLS) be replaced with "Liberty Protection Safeguards" and that a new MCA Code of Practice be written, using updated case law. However, this required further discussion and debate in the House of Commons, so this change was not expected soon.
- The Trust appointed a Matron for Safeguarding Adults, and since 2008, the Trust had developed an Assessment of Capacity form and Best Interest guidance & form. An MCA / DoLS Policy & Procedure had also been developed, along with tools for practitioners to use.
- The Standards used in the most recent MCA audit were that 1) All adults with evidence of disturbance of mind or brain, where a decision regarding serious medical intervention or change in residence, should have their potential lack of capacity acknowledged and documented; and 2) All adults with evidence of disturbance of mind or brain where a decision regarding serious medical intervention or change in residence, should have their capacity assessed using the correct 4 stage process. The outcome of the audit was 73% compliance with aspect 1) (which compared to 61% in a 2014 audit) and 10% compliance with aspect 2) (which was also 10% in the 2014 audit). The more detailed findings revealed further unsatisfactory performance
- A number of areas of good practice were reported, but it was noted that the areas requiring improvement included: not completing mental capacity assessments in a timely manner for interventions (admission to hospital, nasogastric tube, chemical restraint etc.); lack of documenting the process of the MCA assessment; lack of consistency in applying for DoLS in cases where they should be (Stroke units, elderly care Wards, A&E etc.); IMCA referrals not being completed or copied to the Matron for Safeguarding Adults; DNACPR forms being poorly completed and without adherence to MCA; there being no clinical MCA/DoLS lead in the Trust; family meetings being held when they clearly should be Best Interest Meetings; clinicians deciding what was in the person's Best Interests prior to holding Best Interest meetings or discussions; DoLS authorisations not being copied to the Matron for Safeguarding Adults; practitioners holding the belief that a DoLS gave them the permission to restrain a patient; and ion-recognition of chemical restraint and thence non-adherence to the MCA/DoLS policy
- The multi-factorial nature of the reasons for non-compliance was acknowledged, but it was concluded that the situation was affected by a combination of education and culture. It was therefore agreed that the Deputy Chief Nurse should develop a proposal/case for improving the Trust's compliance with the Mental Capacity Act 2005, for discussion/approval at the Trust Management Executive (TME)
- The Committee however agreed that in the meantime, it would give, in principle, the support that had been requested of it i.e. for the appointment of MCA/DoLS Clinical Champions from medical and surgical cohort (ideally at least one per site); for the appointment of MCA/DoLS Champions from other disciplines (e.g. AHPs, Security, Pharmacy); that support and encouragement be strengthened from Clinical Directors; and that help in maximising any opportunities for administrative support especially in relation to DoLS be provided. It was also agreed to provisionally schedule a follow-up review of compliance with the Mental Capacity Act 2005 at the Quality Committee 'deep dive' meeting in February 2018.

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

- As part of the discussion of the items for scrutiny at future 'Deep Dive' meetings, it was agreed that the Medical Director and Chief Nurse should Liaise to consider whether (or not) a "Review of Maternity services" was appropriate for a future 'deep dive' meeting; and that the Trust Secretary should arrange for the action plan in response to the findings from the 'Listening into Action' pulse survey in Maternity services to be submitted to a future Quality Committee 'deep dive' meeting

3. The issues from the meeting that need to be drawn to the attention of the Board are as follows:

- The Trust Board should determine whether it wishes to receive a progress report on the implementation of the 7 day services programme, or whether it is content for the matter to be continued to be monitored via other forums (including the TME, which receives a monthly written progress report)
- Under any other business, the Medical Director reported his plans to learn lessons from previous events, and it was agreed that the Trust Secretary should snd Schedule a "Review of lessons learned" for the Quality Committee 'deep dive' meeting in December 2017

4. The key matters considered at the 'main' meeting on 13th September were as follows:

- The **progress with actions** from previous meetings was noted
- The Chief Nurse & Medical Director reported on the **quality matters arising from the plans to exit Financial Special Measures (FSM)**, which included proposals to strengthen the Quality Impact Assessment (QIA) process, which the Committee approved
- The Chief Operating Officer reported on the **work being undertaken to reduce Length of Stay**, which included a discussion of the barriers to implementing Home First Pathway 3
- A report of recent **Trust Clinical Governance Committee** meetings was discussed, and each **Directorate then highlighted their key issues**, which included the following:
  - Specialist Medicine & Therapies reported that the number of open incidents had been rated as a red risk on the Risk Register, although there had been a marked reduction in the number open, due to focused work
  - Acute and Emergency reported that Nursing vacancies continued to be a concern, with 30% vacancy rate at the Emergency Department at Tunbridge Wells Hospital (TWH), but the Directorate was seeking to introduce new roles and new ways of working. The number of falls occurring at the Acute Medical Unit (AMU) at TWH was also noted as a concern, so focused work would follow. It was however reported that the Symphony A&E IT system upgrade had gone well
  - Surgery reported the latest challenges regarding the recruitment of Specialty and Associate Specialist (SAS) staff, but noted that Nursing recruitment had improved
  - Head and Neck reported that work was taking place with community services to develop community teams for long term ocular disease. It was also noted that the IT server capacity concern that occurred in July had been resolved, following a server migration
  - Trauma & Orthopaedics reported the latest position regarding the elective pathway, which included the fact that a booking clerk had now been assigned to undertake scheduling at the Maidstone Orthopaedic Unit (MOU). It was also reported that Nurse staffing remained a red-rated risk, but the methods that had been used to promote learning from incidents were intended to be adapted in other areas
  - Critical Care reported that staffing was also a concern, particularly in retaining Theatre staff during the winter period, when Theatre recovery areas were likely to be used for inpatient escalation. It was also noted that the Directorate had some junior doctor gaps, following the allocation from Health Education Kent, Surrey and Sussex (HEKSS)
  - Cancer & Haematology reported that the Directorate's number one concern was the number of Consultant Haematologist vacancies, and it was noted that the situation meant that the sustainability of a service for treating rarer Cancer tumours was challenging
  - Diagnostics & Pharmacy reported that staffing in Pharmacy had been a major problem, with a 25% vacancy rate, but the service was expected to be fully staffed by the end of September. It was also noted that the Trust's current non-compliance with the Medicines and Healthcare products Regulatory Agency (MHRA) requirements regarding the traceability of blood and blood products would continue until the 'Boodhound 2' IT system was implemented, and although this not scheduled until January 2018, it was hoped this could be brought forward to before Christmas 2017
  - Women's & Sexual Health reported that Level 3 Safeguarding training compliance was not as it should be, but improvement was expected by December. It was also noted that the Directorate was working closely with iwantgreatcare to try to improve its position with regards to the Friends and Family Test (FFT)
  - Paediatrics reported that the gaps in covering the Paediatric rota continued, and August had been a very challenging month. It was also reported that a new risk had arisen

relating to children with mental issues, following an attempted suicide by a child. This had led to the removal of all silver nitrate sticks from Wards, and the identification of a room that could be allocated to children with suicidal tendencies. A pathway for responding to such situations was also being developed.

- The Committee received a **Mortality Update report** which reported the latest position on Hospital Standardised Mortality Ratio and the Mortality Reviews undertaken by Directorates
- A **review of clinical outcomes** report was discussed, ahead of the same report being submitted to the Board (this has been submitted to the October 2017 Board meeting), and it was agreed that the Medical Director should liaise with each Clinical Director to develop a rolling programme of Directorate-based clinical outcome reporting, and submit a proposal to the 'main' Quality Committee in November 2017
- A mid-year **update on the implementation of Quality Accounts priorities 2017/18** was reported by the Associate Director, Quality Governance
- The latest **Serious Incidents** were reported, and the **recent findings from relevant Internal Audit reviews** were noted

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

- In response to the staffing issues raised by several Directorates, it was agreed that the incoming Director of Workforce should be asked to undertake a review of issues affecting staff turnover, and submit a report to the Workforce Committee, for consideration
- The Associate Director, Quality Governance should ensure that the use of arrows indicating an increase (↑), decline (↓), or unchanged (↔) position (as utilised to report the Diagnostics & Pharmacy Directorate's "Staff Mandatory training compliance" within the summary report from the Trust Clinical Governance Committee) was promoted within the Directorate template report to the Trust Clinical Governance Committee
- The Associate Director, Quality Governance should provide an explanation for the 80% "YTD" (2016/17) performance on the percentage of completed mortality reviews for Children's services that was reported within the "Mortality update" report submitted to the 'main' Quality Committee in September 2017 (in the context of 100% compliance being reported for each of the 4 relevant months)

6. The issues from the meeting 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

Appendix 1: Slides from the “Review of progress with implementing 7-day services” item at the Quality Committee ‘deep dive’ meeting on 11/09/17

Maidstone and Tunbridge Wells NHS
NHS Trust

7 Day Services

Reducing Unwarranted Variation

A Focus on the 4 Priority Standards

A Report to the Quality Committee

Deep Dive – August 2017

Government Mandate to England 2016/17

Pledge

"That patients receive a truly seven-day health service, with the services people need being offered in hospitals at the weekend and people able to access a GP at evenings and weekends".

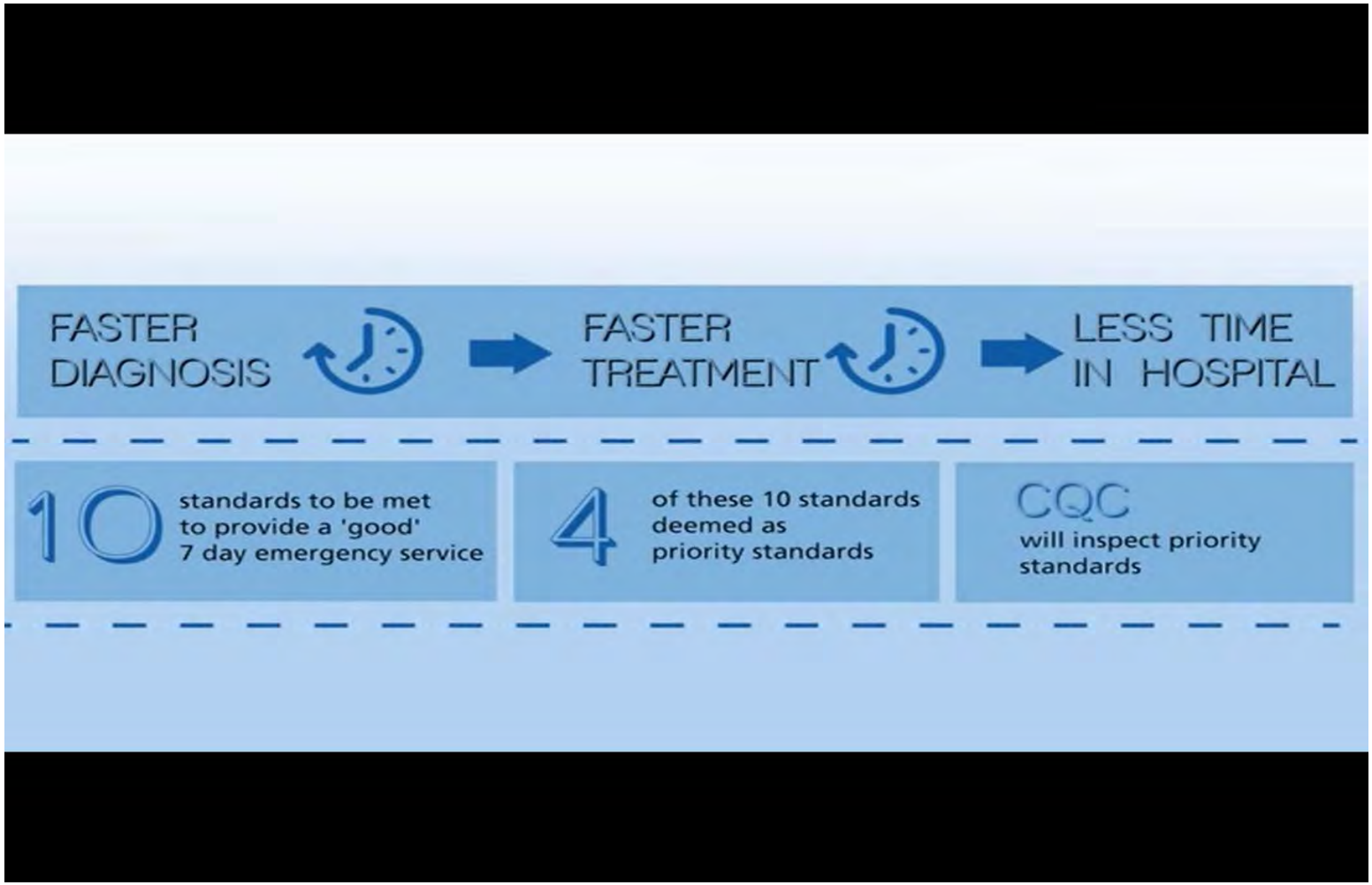
Overall March 2020 Goal

Roll out of seven-day services in hospital to 100% of the population (four priority clinical standards in all relevant specialities, with progress also made on the other six standards), so that patients receive the same standards of care, seven days a week

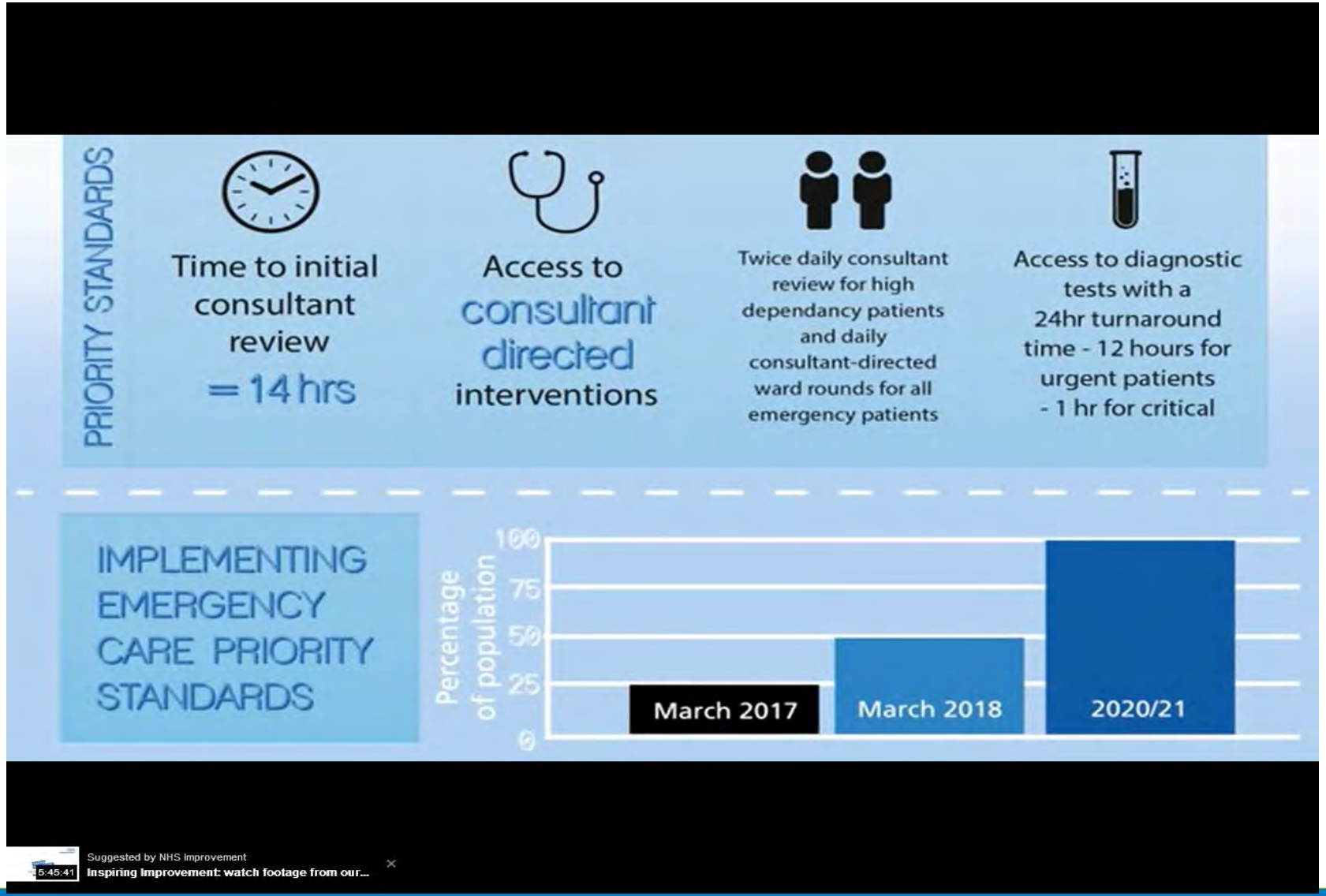
March 2017 Goal

Rollout of four clinical priority standards in all relevant specialties to 25% of population.

7DS Programme Aims



The 4 Priority Standards



The 10 Clinical Standards

1: Patient Experience

2: Time to First Consultant Review - *Priority Standard*

3: Multidisciplinary Team Review

4: Shift Handovers

5: Diagnostics - *Priority Standard*

6: Consultant-Directed Interventions - *Priority Standard*

7: Mental Health

8: Ongoing Review - *Priority Standard*

9: Transfer to Community, Primary and Social Care

10: Quality Improvement

4 Priority Standards

Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours of admission.

Standard 5: Hospital inpatients must have scheduled 7-day access to diagnostic services such as x-ray, ultrasound, CT, MRI, echocardiography, endoscopy, bronchoscopy and pathology. Consultant directed diagnostic tests and completed reporting will be available 7-days a week :

- Within 1 hour for critical patients
- Within 12 hours for urgent patients
- Within 24 hours for non-urgent patients

Standard 6: Hospital inpatients must have timely 24-hour access, 7-days a week, to consultant-directed interventions that meet the relevant speciality guidelines, either on-site or thorough formally agreed networked arrangements with clear protocols such as:

- Critical care
- Interventional radiology
- Interventional endoscopy
- Emergency general surgery

4 Priority Standards

Standard 8

A) All patients on the Acute Medical Unit (AMU), Acute Surgical Assessment Unit (ASU), and Intensive Therapy Unit (ITU) and other high dependency areas are seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate)

B) Once transferred from the acute area of the hospital to a general ward patients should be reviewed during a consultant-delivered ward round at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

Baseline Assessment:

Organisational Stocktake - *Commenced November 2016*

Key questions:

* Who is currently (or has been) involved in this programme?
* What is the current level of organisational understanding/awareness/engagement?
* Is there a programme plan?
* Who are our key players?
* What are our gaps against the standards?
* What data do we have on variation?
* What have the previous National surveys shown us?
* What organisational importance does the Programme have?

Creation of a critical path *(see next slide)*

Establishment of a Steering Group (Medical Director Led)

(Internal: Medical Director, Lead Manager, PMO Lead, Clinical Audit Lead, Business Intelligence Lead)
(External: NHS Improvement Lead, CCG Lead)

Maidstone and Tunbridge Wells NHS
NHS Trust

Review of Existing Data:

Aim: To present compelling data that means something locally to engage clinicians and managers

* **Overview of National Programme's requirements**
* **Simplify the standards and explain them**
* **National findings and statistics (mortality and variation)**
* **Local data (Dr Foster mortality) and variation data by day of week**
  * ED attendances, NE admissions, discharges, conversion rates, readmissions relative risk of death by day of admission and discharge
* **Summary of National survey results from last 2 surveys**
* **List out the 'to do' list and requirements of the key clinical and managerial staff**
* **Review the requirements of the forthcoming National survey**

Engaging Internal Stakeholders for clinical leadership and planning

Aim: Demystify programme, remove the 'fear' barrier and bring everyone up to speed with the requirements:

Staff and Groups presented to:

- Trust Medical Executive
- All General Managers
- Clinical Directors' meeting
- All Divisional Boards
- Clinical Commissioning Group

Communications

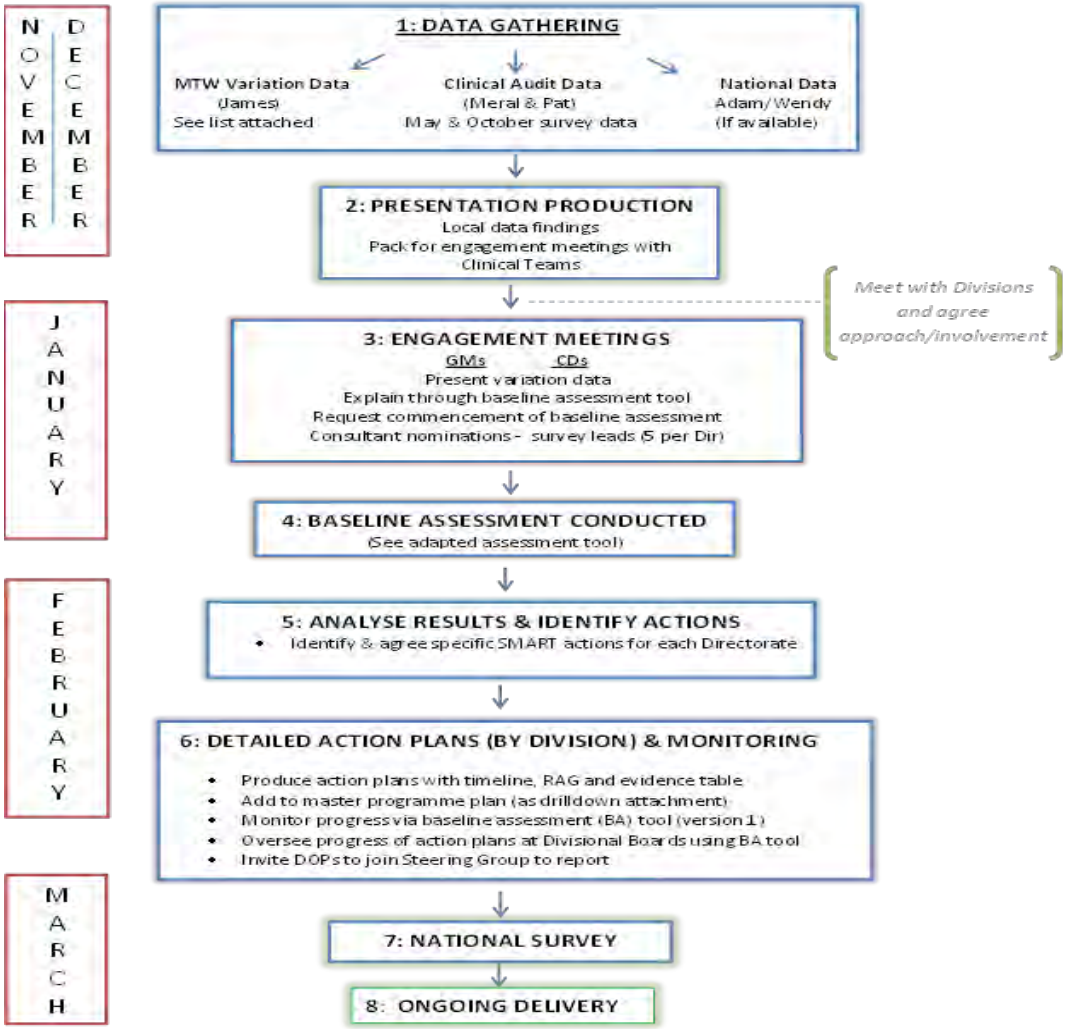
- **Communications plan**
- **Internal 7DS intranet resource site**
- **Linking of 7DS to all relevant internal groups and processes**
  (Clinical Groups inc Mortality, LOS etc, and managerial groups Divisional and Directorate Boards, Trust Medical Executive, Clinical Directors Meeting, Executive Performance Review Meetings)
- **Engagement with all leads for internal processes and publications**
  (STP and Strategy Lead, Operational Plan Lead, Quality Account Lead etc)
- **Induction of all Clinical Leads by Medical Director and Lead Manager, and development of our Trust-wide Clinical Lead**
- **Engagement of and close working with National Team Leaders**
- **Presenter at an NHSI/E national webinar as an example of good practice – twice!**
- **Inclusion of Divisional Directors in Steering Group to report on progress**
- **Making 7DS part of 'Business as Usual'**

Critical Path:

Maidstone and Tunbridge Wells NHS
NHS Trust

7 DAY SERVICES

CRITICAL PATHWAY FOR STOCKTAKE/BASELINE ASSESSMENT
NOV 2016 – MAR 2017



Key Stages in Process

- ❑ **Clinical Lead nominated for each Directorate**
- ❑ **Appointment of a Trust-wide Clinical Lead**
- ❑ **Baseline assessment tool completion – for stocktake against standards**
- ❑ **Production of detailed template for each service, measuring current service model and gaps**
- ❑ **Challenge Day (with National Leads present) – templates presented and discussed**
- ❑ **Directorate level action plans and categorisation - produced after Challenge Day**
- ❑ **Programme plan and trajectory updated with action plan detail**
- ❑ **Steering Group Monitoring of actions *(with National Team involvement)***
- ❑ **National Survey requirements & learning – 6 monthly surveys - *(ongoing)***

(Items in red font are attached as part of this deep dive report)

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Wide Challenge Day With National Team – 19.05.17

- **Whole Day Event**
- **4 Priority Standards were focus**
- **Panel:** Medical Director (Chair), 4 x National Leads, Trust 7DS Clinical Lead, Lead Manager, PMO Lead
- **Delegates:** CDs, 7DS Clinical Leads, DOPs, ADNs, Matrons, GMs, AGMs
- **Programme:** Split into 3 Divisions
  Presentation of service position template by CD
  2 way challenge – panel and delegates
  Confirmation of compliance status and identification of gaps and actions required
- **Outputs:** Report on compliance status and actions required
  Classification of Directorates into 3 groups (compliant, small confirmation actions, non-compliant)
  Production of 'at a glance' compliance table
  Detailed action plans for non-compliant group
  Some small audits for confirmation group
  Evidence production for compliant group
  Ongoing monitoring at Steering Group

Maidstone and Tunbridge Wells NHS
NHS Trust

'At a Glance' Compliance Table

(Hard copy attached to report)

7 DAY SERVICES PROGRAMME
AT A GLANCE COMPLIANCE TABLE @ 19.05.17
(Please see individual Directorate templates for detail)

Division/ Service/ Category	Standard 2				Standard 8			Standard 5			Standard 6								
	14 hrs	1 hrs	6 hrs	NEWS	Twice Daily	Once Daily	Medically Active	1 hr Critical	12 hrs Urgent	24 hr / Routine	Critical Care	IR	Int. Endo	Emerg Surg	Emerg Renal	Urg Radiother	Stroke Thromb.	PPCI	Pacing Temp/ Perm
Urgent Care (A)	✓	X	X	✓	X	X	X				✓	N/A	✓	N/A	N/A	N/A	✓	✓	✓
Urology (A)	X	X	X	✓	✓ (via ICU)	✓	X				✓	*X	N/A	✓	N/A	N/A	N/A	N/A	N/A
Surgery (A)	X	X	X	✓	✓ (via ICU)	X	✓				✓	N/A	N/A	✓	N/A	N/A	N/A	N/A	N/A
T&O (A)	X	X	X	✓	✓ (via ICU)	X	X				✓	✓	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Women's (C)	X	✓	X	✓	✓ (via ICU)	✓	✓				✓	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Paeds (B)	✓	✓	✓	✓	✓ (via ICU)	✓	✓				✓	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
ICU (C)	✓	✓	*X	✓	✓	✓	✓				✓	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Head & Neck (C)	X	N/A	N/A	✓	✓ (via ICU)	X	X				✓	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Haem/Onc (C)	X	X	X	✓	✓ (via ICU)	✓	✓				✓	N/A	N/A	N/A	N/A	✓	N/A	N/A	N/A
CT (B)								✓	✓	✓									
Ultrasound (B)								✓	✓	✓									
MRI (B)								✓	✓	✓									
Microbiology (B)								✓	✓	✓									
Endoscopy (A)								X	X	X									
Echocardiogram(B)								✓	✓	✓									
Note:			* 6pm - 8pm only - to audit un-planned adms									*Audit hrs for OOH Only							

KEY TO INPUT INTENSITY REQUIRED

Category	Position Statement
A	High intensity actions with 7DS Team support to action plans
B	Compliant - No actions required - evidence only (some additional notes to read from Panel)
C	Low intensity actions or small confirmation audits required

Maidstone and Tunbridge Wells NHS
NHS Trust

Maintenance & Next Steps

- **Aim to move to BAU monitoring** **(eventually via monthly Exec Performance Review process)**
- **Monthly Steering Group to move into a 'monitoring' role, with emphasis on Divisions to drive delivery of action plans via Divisional Boards**
- **Monthly reports to:**

  Trust Management Executive

  CCG Performance and Quality Review

- **Quarterly Steering Group Meetings with our National Lead members**
- **Commence work on remaining 6 Clinical Standards (Autumn 2017)**

Trust Board meeting – October 2017

NHS Maidstone and Tunbridge Wells NHS Trust

10-20	Summary report from Audit and Governance Committee, 27/09/17 (incl. the Annual Audit Letter for 2016/17)	Committee Chair (Non-Executive Director)

The Audit and Governance Committee met on 27th September 2017.

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

- Under the Safety Moment, the Trust Secretary reported that the month's theme was the deteriorating patient and outlined the various work streams ongoing throughout the month
- A review of the Board Assurance Framework (BAF) and Trust Risk Register for 2017/18 was undertaken (this was the same report submitted to the Board in September) and there was discussion about the basis for the confidence ratings given for the achievement of Objectives 3, 4 and 5
- An update on progress with the Internal Audit plan for 2017/18 (incl. progress with actions from previous Internal Audit reviews) was reported. The list of recent Internal Audit reviews is shown below (in section 2).
- The status of outstanding ICT audit recommendations was noted, including the fact that 32 of the 36 actions due had been completed
- A Counter Fraud update was reviewed, which included the findings of a recent NHS Protect "Focussed Assessment" on 'Prevent and Deter' and 'Hold to Account' activity. A 'green' assessment rating had been given for 'Prevent and Deter' and a 'red' rating for 'Hold to Account'. The reasons for this latter rating, which centred around the Trust's use of the "First" case management system, were discussed in detail and it was agreed that the Local Counter Fraud Specialist should submit a follow-up report to the next meeting in response to the findings of the Assessment, to include actions taken, dates of actions and steps taken to prevent recurrence of identified issues. It was noted that, with effect from the next meeting, Steffan Wilkinson would take over as the Trust's new Counter Fraud Specialist
- A 'Progress and emerging issues report (including the External Audit Letter for 2016/17)' was received from External Audit. No matters of significance were reported. The Annual Audit Letter is enclosed in Appendix 1.
- The losses & compensations data for Quarter 1 was reviewed, which showed a reduced value from Quarter 1 in 2016/17. It was agreed to circulate the previously compiled comparative data on "compensations under Ombudsman Advice" to Committee members
- The latest single tender waivers data was reviewed, which showed a very similar value and volume to that of the first Quarter of the prior year. The impact on the Trust's procurement processes of its hosting of the Sustainability and Transformation Partnership (STP) at local level was discussed, and it was reported that it had been agreed that STP single tender and quote waivers would be reported as a subset of total activity with effect from Quarter 2. Following discussion of the level of expenditure currently covered by Purchase Orders, it was agreed to ensure that the latest annual review of the Procurement Strategy identified the areas/items outside of the current total covered by Purchase Orders
- A report detailing gifts, hospitality and sponsorship declared in the period 28/04/17 to 18/09/16 was considered. This showed a pro rata decrease in the volume of declarations to that of the previous reporting period. It was agreed to re-order the table of declarations to group disclosures by recipient name, rather than by descending order of value (to more easily enable identification of trends)
- The preliminary findings of the reconciliation between the Association of the British Pharmaceutical Industry (ABPI) disclosures for 2016 and the disclosures received by the Trust for the same period were reviewed. It was agreed to identify individuals to whom reminders were issued as part of the reconciliation process for both the 2015 and 2016 ABPI disclosure database
- The findings of the "Local Proactive Review" of the Trust's Gifts, Hospitality, Sponsorship and Interests Policy and Procedure, which had identified no anomalies, were noted
- The draft revised "Conflicts of Interest Policy and Procedure", which was based on NHS England's model policy, was considered and it was reported that this would be presented

for Trust Board ratification in due course. There was discussion about the Trust's policy on the receipt of patient bequests by staff, and it was agreed to ask the incoming Director of Workforce for an opinion on the Trust's ability and commitment to prevent the acceptance by Trust staff of bequests from deceased patients

- The Director of Finance provided a verbal summary of the latest financial issues, and confirmed that the Trust remained in Financial Special Measures and was awaiting a letter from NHS Improvement following its last checkpoint meeting on 30th August 2017
- A status review of the "Discrepancies in Inventory Values" item identified within the Audit Findings Report 2016/17 was noted. As the Chief Pharmacist was unable to attend for this item (as had been intended), it was agreed to defer more detailed consideration to the next meeting and to invite the Chief Pharmacist to present the item
- A report on provisional changes to authorisation levels to the Trust's Standing Financial Instructions (SFIs)/Scheme of Delegation following Glenn Douglas' appointment as Chief Executive of the STP and Jim Lusby's appointment as Acting Chief Executive for the Trust was noted. It was reported that any other required updates would be considered as part of the forthcoming annual review of the SFIs and Standing Orders. Wider discussion ensued on the governance (and cash) implications for the Trust of the current STP hosting arrangements. It was agreed to submit a report to the 'Part 2' Trust Board meeting in October 2017 identifying proposals regarding temporary/interim arrangements for the hosting of the STP, and to obtain the endorsement of the Chief Executive of the STP for the report.

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

- "Data Quality of Key Performance Indicators" (which received a "Reasonable Assurance" conclusion)
- "Follow Up Review of Pharmacy" (which received a "Reasonable Assurance" conclusion)
- "Audiology Stock Management Follow Up" (which received a "Reasonable Assurance" conclusion)

3. The Committee was also notified of the following "Urgent" priority outstanding actions from Internal Audit reviews:

- Health Records (2 outstanding actions)

4. The Committee agreed that (in addition to any actions noted above):

- None

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

- As a result of the review of the Board Assurance Framework, it was agreed to highlight within its summary report to the Trust Board, the Committee's concerns about the achievement of Objective 4 of the Board Assurance Framework (to deliver the control total for 2017/18) by the year-end

Which Committees have reviewed the information prior to Board submission?

- N/A

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

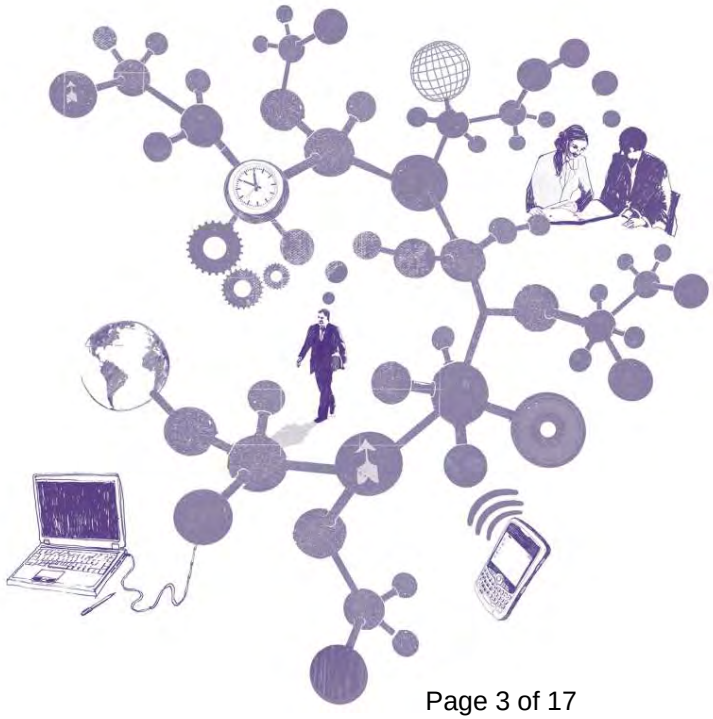
- Information and assurance
- To receive the Annual Audit Letter for 2016/17

[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 Annual Audit Letter for Maidstone and Tunbridge Wells NHS Trust

Year ended 31 March 2017

28 July 2017



Darren Wells
Engagement Lead
T 01293 554 120
E darren.j.wells@uk.gt.com

Matt Dean
Engagement Manager
T 020 7728 3181
E matthew.dean@uk.gt.com

Keith Mungadzi
In-Charge Accountant
T 020 7728 2393
E keith.mungadzi@uk.gt.com

Contents

Executive summary

Purpose of this letter

Our Annual Audit Letter (Letter) summarises the key findings arising from the work that we have carried out at Maidstone and Tunbridge Wells NHS Trust (the Trust) for the year ended 31 March 2017.

This Letter is intended to provide a commentary on the results of our work to the Trust and its external stakeholders, and to highlight issues that we wish to draw to the attention of the public. In preparing this letter, we have followed the National Audit Office (NAO)'s Code of Audit Practice and Auditor Guidance Note (AGN) 07 – 'Auditor Reporting'.

We reported the detailed findings from our audit work to the Trust's Audit Committee as those charged with governance in our Audit Findings Report on 24 May 2017.

Our responsibilities

We have carried out our audit in accordance with the NAO's Code of Audit Practice, which reflects the requirements of the Local Audit and Accountability Act 2014 (the Act). Our key responsibilities are to:

- give an opinion on the Trust's financial statements (section two)
- assess the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (the value for money conclusion) (section three).

In our audit of the Trust's financial statements, we comply with International Standards on Auditing (UK and Ireland) (ISAs) and other guidance issued by the NAO.

Our work

Financial statements opinion

We gave an unqualified opinion on the Trust's financial statements on 31 May 2017.

Value for money conclusion

We were satisfied that the Trust put in place proper arrangements to ensure economy, efficiency and effectiveness in its use of resources except for your arrangements to plan finances effectively to support the sustainable delivery of strategic priorities. The reasons for this 'except for' reporting were:

- You have a cumulative reported deficit of £47.48 million as at 31 March 2017. This increased from last year's cumulative deficit by £10.9 million, the 2016/17 reported outturn. Trusts are expected to plan to break even over a rolling three year cycle, achieving this within the political and operational environment in which they have to operate;
- You have agreed a deficit plan of £4.5 million (prior to any Sustainability and Transformation Funding) for 2017/18 , which will require in addition to strong budgetary control, the delivery of £31.7 million CIPs. You achieved 76% of your £32.1 million cost improvement programme in 2016/17. You have continued to improve your systems to support CIP delivery, but the CIP requirement for 2017/18 is challenging. At the start of the financial year you have identified £18.9m risk adjusted CIPs;
- Your future financial plans anticipate returning to in year break even in 2018/19 and cumulative breakeven by 2020/21.
- You have been placed in a 'Financial Special Measures' regime by your regulator.

We therefore qualified our value for money conclusion in our report on the financial statements on 31 May 2017.

Consolidation template
We also reported on the consistency of the consolidation schedules submitted to the Department of Health with the audited financial statements. We concluded that these were consistent

Use of statutory powers
We referred a matter to the Secretary of State, as required by section 30 of the Act, on 17 May 2017 to highlight that the breach of the Trust's statutory duty to achieve a breakeven position over a rolling three year period.

Certificate
We certify we have completed the audit of the accounts of Maidstone and Tunbridge Wells NHS Trust in accordance with the requirements of the Code of Audit Practice.

Quality Accounts
We completed a review of the Trust's Quality Account and issued our report on 29 June 2017. We concluded the Quality Account and the indicators we reviewed were prepared in line with the Regulations and guidance.

Working with the Trust

During the year we have delivered a number of successful outcomes with you:

- An efficient audit – we delivered an efficient audit with you in May, delivering the vast majority of our work well before the deadline, releasing your finance team for other work.
- Understanding your operational health – through the value for money conclusion we provided you with assurance on your operational effectiveness.
- Providing assurance over data quality – we provided assurance over two key indicators and highlighted the need to ensure VTE forms are completed clearly for all future assessments.
- Sharing our insight – we provided regular audit committee updates covering best practice. We also shared our thought leadership reports.
- Annual Report review – we reviewed your Annual Report from the prior year, highlighting both areas of strength and areas for improvement over the coming years as well.
- Providing training – we provided your teams with training on financial accounts and annual reporting.

We would like to record our appreciation for the assistance and co-operation provided to us during our audit by the Trust's staff.

Grant Thornton UK LLP
July 2017

Audit of the accounts

Our audit approach

Materiality

In our audit of the Trust's financial statements, we use the concept of materiality to determine the nature, timing and extent of our work, and in evaluating the results of our work. We define materiality as the size of the misstatement in the financial statements that would lead a reasonably knowledgeable person to change or influence their economic decisions.

We determined materiality for our audit of the Trust's accounts to be £8,157,000, which is 1.75% of the Trust's gross operating costs. We used this benchmark as in our view, users of the Trust's financial statements are most interested in where it has spent the income it made in the year.

We also set a lower level of specific materiality for cash of £500,000, but no other specific materiality levels were set.

We set a lower threshold of £250,000, above which we reported errors to the Audit Committee in our Audit Findings Report.

The scope of our audit

Our audit involves obtaining enough evidence about the amounts and disclosures in the financial statements to give reasonable assurance that they are free from material misstatement, whether caused by fraud or error. This includes assessing whether:

- the Trust's accounting policies are appropriate, have been consistently applied and adequately disclosed;
- significant accounting estimates made by management are reasonable; and
- the overall presentation of the financial statements gives a true and fair view.

We also read the remainder of the Annual Report to check it is consistent with our understanding of the Trust and with the accounts included in the Annual Report, on which we gave our opinion.

We carry out our audit in line with ISAs (UK and Ireland) and the NAO Code of Audit Practice. We believe the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Our audit approach was based on a thorough understanding of the Trust's business and is risk based.

We identified key risks and set out overleaf the work we performed in response to these risks and the results of this work.

Audit of the accounts

These are the risks which had the greatest impact on our overall strategy and where we focused more of our work.

Risks identified in our audit plan	How we responded to the risk	Findings and conclusions
The revenue cycles include fraudulent transactions Under ISA (UK and Ireland) 240 there is a presumed risk that revenue may be misstated due to the improper recognition of revenue. For this Trust, we have concluded that the greatest risk of material misstatement relates to the occurrence of healthcare income, including income from the Sustainability and Transformation Fund, and existence of receivables.	As part of our audit work we completed the following: • documentation of our understanding of the Trust's processes and controls over revenue recognition; • review and testing of revenue recognition policies; • testing of material revenue streams; • risk based testing of revenue journals posted during the year; • cut off testing of revenue received during the year from both healthcare contracts and non-healthcare revenue; and • review of revenue recognition in respect of Sustainability and Transformation Fund income for Quarter 4	Our audit work did not identify any issues in respect of revenue recognition.
Management override of controls Under ISA (UK and Ireland) 240 there is a non-rebuttable presumed risk that the risk of management over-ride of controls is present in all entities. .	As part of our audit work we completed; • review of accounting estimates, judgments and decisions made by management; • review of journal entry processes and selection of journal entries for testing back to supporting documentation; • review of unusual significant transactions.	We identified one journal which had been posted and authorised by mistake by the same member of staff. We tested the journal and found it was valid. We also identified one journal which was not in balance when posted to the system. This was due to a system error and the Trust correctly processed an entry to balance the General Ledger for this transaction. No other issues were identified from the work performed on journals. We did not identify or were made aware of, any unusual significant transactions.

Audit of the accounts

These are the risks which had the greatest impact on our overall strategy and where we focused more of our work.

Risks identified in our audit plan	How we responded to the risk	Findings and conclusions
Property, Plant and Equipment Revaluation measurement not correct	We completed the following work in relation to this risk • a walkthrough of the Trust's processes and controls over this area to gain an understanding of these. • a review of management's processes and assumptions around the calculation of the estimate. • a review of the competence, expertise and objectivity of the experts used by management when preparing the calculation. • a review of the instructions issued to the valuation experts and the scope of their work. • we discussed with the valuer the basis on which the valuation has been performed, as well as challenging the key assumptions applied. • we reviewed and tested the data provided to the valuer for the revaluation to ensure it is robust and consistent with our understanding. • performed detailed testing of the revaluations performed during the year to ensure these have been correctly accounted for by the Trust. • evaluated the assumptions applied by management to those assets which have not been revalued during the year to determine the validity of their assessment that the valuation of these assets have not moved materially during the course of the year.	PPE was an area we discussed with management. The Trust reconsidered national guidance issued in late 2015/16 to its approach for valuing assets. Key changes to the valuation approach include; valuing the Tunbridge Wells site (as a PFI build) excluding VAT; applying modern rebuild concept to the Maidstone site to incorporate likely design solutions in any reprovision – for example, reducing the footprint by building higher and reducing landscaping; and reconsidering the size and value of car parking and office space accommodation. Management reported this approach to the Audit and Governance Committee in February. We considered the Trust's approach carefully and concluded it is within accepted valuation practices.

Audit of the accounts

Audit opinion

We gave an unqualified opinion on the Trust's financial statements on 31 May 2017, in advance of the national deadline.

The Trust made the accounts available for audit in line with the national timetable for submission, and provided a good set of working papers to support them. The finance team responded promptly and efficiently to our queries during the course of the audit.

Issues arising from the audit of the accounts

We reported the key issues from our audit to the Trust's Audit Committee on 24 May 2017.

In addition to the key audit risks reported above, we identified the following issues/adjustments throughout our audit that we have asked the Trust's management to address for the next financial year:

- In respect of Journals, all members of staff should be made aware of the procedures around journals to make sure that there is a clear separation of duties between the journal poster and the journal authoriser.
- And for stock, the Trust should ensure that all returns of stock are processed on the JAC system in a timely manner to ensure the stock shown on the system is a true reflection of the stock physically held by the Trust.

Annual Governance Statement and Annual Report

We are also required to review the Trust's Annual Governance Statement and Annual Report. It provided these on a timely basis with the draft accounts with supporting evidence.

Other statutory duties

We are also required to refer certain matters to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014. On 17 May 2017 we reported to the Secretary of State that you agreed a £4.2 million deficit budget with NHS England for 2016/17. You did not meet this target and you delivered a deficit of £10.8 million for the year ended 31 March 2017. This was a breach of the Trust's Statutory Duty to achieve a breakeven position over a rolling three year period

Value for Money conclusion

Background

We carried out our review in accordance with the NAO Code of Audit Practice, following the guidance issued by the NAO in November 2016 which specified the criterion for auditors to evaluate:

In all significant respects, the audited body takes properly informed decisions and deploys resources to achieve planned and sustainable outcomes for taxpayers and local people.

Key findings

Our first step in carrying out our work was to perform a risk assessment and identify the key risks where we concentrated our work.

The key risks we identified and the work we performed are set out in the tables on the following pages.

We focused our work on the significant risks that we identified in the Trust's arrangements. In arriving at our conclusion, our main considerations were:

- You have a cumulative reported deficit of £47.48 million as at 31 March 2017. This increased from last year's cumulative deficit by £10.9 million deficit, the 2016/17 reported outturn. Trusts are expected to plan to break even over a rolling three year cycle, achieving this within the political and operational environment in which they have to operate;
- You have agreed a deficit plan of £4.5 million for 2017/18, which will require in addition to strong budgetary control, the delivery of £31.7 million CIPs. You achieved 76% of your £32.1 million cost improvement programme in 2016/17. You have continued to improve your systems to support CIP delivery, but the CIP requirement for 2017/18 is challenging. At the start of the financial year you have identified £18.9m risk adjusted CIPS;
- Your future financial plans anticipate returning to in year break even in 2018/19 and cumulative breakeven by 2020/21.
- The Trust was placed in a 'Financial Special Measures' in August 2016 by NHS Improvement.

Overall VfM conclusion

We are satisfied that, in all significant respects, except for the matter of the Trust's financial position, the Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2017.

Key findings

We set out below our key findings against the significant risks we identified through our initial risk assessment and further risks identified through our ongoing review of documents.

Significant risk	Work to address	Findings and conclusions
Financial Position In 2015/16, the Trust made a deficit of £23.4m, compared to the initial budgeted outturn of a £14.1m deficit, delivering cost improvement savings of £20.8m, against a target of £21.5m. For 2016/17, the Trust initially budgeted for a deficit of £22.9 million. At Month 8, the Trust was showing a deficit of £17.4m, which was £0.3m ahead of the planned position at that stage of the year. Projecting the current position to year end, the Trust is forecasting the delivery of a year end deficit of £12.8m, which when combined with mitigating actions of £16.7m and £4.2m of Sustainability and Transformation Funding leads to the Trust's being on course to delivering a surplus of £4.2m, which is £0.5m behind the £4.7m planned surplus.	We considered the Trust's arrangements for putting together and agreeing its budget, including identification of savings plans; and its arrangements for monitoring and managing delivery of its budget and savings plans for 2016/17, including the impact on service delivery.	Trusts are expected to plan to break even over a rolling three year cycle, achieving this within the political and operational environment in which they have to operate. The operating environment is complex; demand for the Trust's elective and emergency services is increasing, with the latter reimbursed at marginal rate of 30% putting pressure on capacity and the opportunity to deliver all elective activity; a national position of workforce shortages for key disciplines which are met by expensive agency staff; a high quality threshold demanded by the public and enforced by regulators and constrained financial resources within the health economy. The latter inevitably requires each year ever increasing cash releasing efficiency savings along with strong budgetary control to deliver an agreed plan. Not unsurprisingly, many trusts are struggling to achieve the break even duty and recently as part of a transitional pathway to returning to a balanced position, NHS Improvement has agreed individual control totals for trusts. The Trust delivered a retained deficit of £10.9m for the year ended 31 March 2017, which is better than the planned deficit position agreed with NHS Improvement when the Trust entered Financial Special Measures in August 2016. The 2016-17 deficit brings the Trust's cumulative deficit to £47.480m, almost all of which has occurred over the past four years. The Trust delivered over £24.6m of Cost Improvement Plans (CIPs) during the year, which compares well to its delivery of CIPs in 2015/16 (£20.8m) but is significantly short (76% delivery) of its target of £32.1m. The majority of this variance was due to the performance of the Urgent Care Department, who were £5.8m adrift of the Plan. Of the £24.6m of CIPs delivered, 90%, (£22.0m) is recurrent. This compares favourably to 76% recurrent savings in 2015/16 and is indicative of strengthened arrangements to identify and deliver sustainable CIPs. Looking ahead, the Trust is forecasting the delivery of a deficit of £4.5m (prior to any Sustainability and Transformation Funding) in 2017-18. However, achievement of this position depends on continued strong budgetary control and delivering CIPs of £31.7m, which equates to 8% of the total spend which the Trust is able to influence. To date, the Trust has been able to identify £24.4m of CIPs, which when risk-adjusted, reduces to £18.9m, leaving a gap of £12.8m to be identified during the course of the year. However should the Trust be able to achieve its plans in 2017-18, it is well placed to return to breakeven in 2018-19. In respect of the CIPs already identified, almost all of the £18.9m is from recurrent schemes which will have the potential to deliver sustainable change within the Trust over the coming years. Each area of the Trust has been set a CIP target to achieve and where areas have already delivered their portion of the savings, they are being encouraged to look further to support other areas which are finding it more challenging to identify their elements of the CIPs.

Significant risk	Work to address	Findings and conclusions (continued)
Financial Position In 2015/16, the Trust made a deficit of £23.4m, compared to the initial budgeted outturn of a £14.1m deficit, delivering cost improvement savings of £20.8m, against a target of £21.5m. For 2016/17, the Trust initially budgeted for a deficit of £22.9 million. At Month 8, the Trust was showing a deficit of £17.4m, which was £0.3m ahead of the planned position at that stage of the year. Projecting the current position to year end, the Trust is forecasting the delivery of a year end deficit of £12.8m, which when combined with mitigating actions of £16.7m and £4.2m of Sustainability and Transformation Funding leads to the Trust's being on course to delivering a surplus of £4.2m, which is £0.5m behind the £4.7m planned surplus.	We considered the Trust's arrangements for putting together and agreeing its budget, including identification of savings plans; and its arrangements for monitoring and managing delivery of its budget and savings plans for 2016/17, including the impact on service delivery.	Due to the scale of the CIPs which need to be identified, the Trust has made changes to its governance arrangements to help provide the support required in this area. There are now fortnightly CIP meetings chaired by the Deputy Director of Finance where all budget holders are required to provide updates on the progress of schemes identified, along with how they plan to deliver any CIPs unidentified to date. This helps ensure that there is overall monitoring and review in place of the Trust's progress against the target and the likelihood of delivering the CIPs in full. To provide assurance over these revised procedures, we have undertaken a review of the detailed plans in one of the Trust's Cost Centres, which has included a review of the specific procedures to identify CIPs in that Cost Centre and the level of monitoring and review undertaken to ensure any deviations from plan are dealt with appropriately. It is clear that these plans are very detailed, setting out individual milestones and timelines for individual tasks within the overall CIP plan, along with who is responsible for the delivery of these tasks. These are monitored as part of the arrangements mentioned above, and are recorded on a electronic package to allow seamless updates and reviews to take place. We have considered the 'Deep Dives' which have been undertaken in the 10 areas flagged by Carter as areas where the Trust was an outlier and considered the level of challenge and review undertaken as part of these. From our review it is clear that the Trust is committed to at the very least getting to the average position set out by Carter, and is looking to potentially going beyond where possible. In summary, it is clear that the Trust has made great strides in recent months, certainly since being placed within Financial Special Measures which is testament to all the staff involved. However the Trust is being asked to deliver a level of CIP which it has never been asked to before, and no-one should underestimate the challenge this poses. Whilst it is clear the Trust has made a very good start in delivering these savings, identifying the remaining £12.8m is going to be a key ingredient to successfully achieving its annual financial plan. Based on the above, we are satisfied that the Trust's arrangements and the financial outcomes as a indicator of the effectiveness of those arrangements does not warrant an 'adverse' conclusion.

Significant risk	Work to address	Findings and conclusions
Liquidity During 2015/16, the Trust took out a working capital loan of £16.9m to support its cash position. The Trust has mid term liquidity problems and recognises that if no action is taken, it will eventually run out of cash. It has cash support in 2016/17 of £12.1m, which is anticipated to enable it to sufficiently manage its cash position.	We updated our understanding of the Trust's cash position and reviewed the Trust's financial plans for 2017-18 to see whether further cash support is going to be needed.	At year end, the Trust held a cash balance of £1.4m, which was a slight increase from the balance held at 31 March 2016. However this position was supported by a uncommitted term loan of £2.458m from the Department of Health. Since year end the Trust has repaid this loan in full following the receipt of some further Sustainability and Transformation Fund funding and the negotiated early receipt of income from its main commissioners. Looking ahead, the Trust is better placed than it was twelve months ago as it currently does not envisage the need to make use of any borrowing during the course of the year. However this is subject to the delivery of the CIP target which otherwise may have an impact on this plan. We have reviewed the Trust's cash flow forecast and whilst there are some risks to this, the Trust has potential mitigations in place to cover these, such as extending payment terms, along with use of the short-term Department of Health facility, which remains in place. The Trust has appropriate arrangements to manage its cash position over the short term.
Quality and Safety An inspection by the Care Quality Commission in February 2015 rated the Trust as requiring significant improvement overall, with particular areas of weakness being: - The Trust was assessed as not being 'well-led'	We have considered the Trust's progress against the action plan agreed to address the findings of the CQC inspection, and have considered any further findings from the CQC. We have also reviewed the Cost Improvement Savings plans to ensure that where appropriate, clinical engagement has been sought and a Quality Impact Assessment has been properly considered.	During the course of 2016-17, management reported to the Trust Board that all actions within its Quality Improvement Plan, which was put in place to deal with the issues raised by the Care Quality Commission (CQC) had been completed. Following this, the Trust has implemented a Plan to provide continual internal assurance in respect of the CQC standards. A key element of this is monthly 'CQC-style' inspections of different directorates, both announced and unannounced, to identify areas of concern against expected quality standards and practices. The findings from these inspections are communicated via the Quality Committee to highlight both areas of good practice along with areas where improvement is needed. As part of our work on the Trust's CIP plans, we have confirmed for a sample, that where plans have a potential impact on the level of patient care received, a full Quality Impact Assessment is submitted. These Assessments have to be signed off by the Chief Nurse and the Medical Director before the plans can be implemented which helps to ensure financial pressures do not impact on the quality of care delivered. The Trust anticipates that CQC is not due to re-inspect until Autumn 2017. In the absence of a formal report from CQC and based on our commentary above, there is no current impact on the value for money conclusion.

Quality Accounts

The Quality Account

The Quality Account is an annual report to the public from an NHS Trust about the quality of services it delivers. It allows Trust Boards and staff to show their commitment to continuous improvement of service quality, and to explain progress to the public.

Scope of work

We carry out an independent assurance engagement on the Trust's Quality Account, following Department of Health (DH) guidance. We give an opinion as to whether we have found anything from our work which leads us to believe that:

- the Quality Account is not prepared in line with set DH criteria;
- the Quality Account is not consistent with other documents, as specified in the DH guidance; and
- the two indicators in the Quality Account where we have carried out testing are not compiled in line with DH regulations and do not meet expected dimensions of data quality.

Quality Account Indicator testing

We tested the following indicators:

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

For each indicator tested, we considered the processes used by the Trust to collect data for the indicator. We checked that the indicator presented in the Quality Account reconciled to underlying Trust data. We then tested a sample of cases included in the indicator to check the accuracy, completeness, timeliness, validity, relevance and reliability of the data, and whether the calculation of the indicator was in accordance with the defined indicator definition.

Key messages

- We confirmed that the Quality Account had been prepared in line with the requirements of the Regulations.
- We confirmed that the Quality Account was consistent with the sources specified in the DH Guidance.
- We confirmed that the commentary on indicators in the Quality Account was consistent with the reported outcomes.
- Based on the results of our procedures, nothing came to our attention that caused us to believe that the indicators we tested were not reasonably stated in all material respects.

Conclusion

As a result of this we issued an unqualified conclusion on the Trust's Quality Account on 30 June 2017.

Appendix A: Reports issued and fees

We confirm below our final fees charged for the audit and provision of non-audit services.

Fees

	Planned 2016/17 Fees £	Actual 2016/17 fees £	Actual 2015/16 fees £
Statutory audit	75,069	75,069	75,069
Charitable fund	2,000	2,000	3,150
Total fees (excluding VAT)	**77,069**	**77,069**	**78,219**

The variance on the Charitable Fund is due to a full audit being required in 2015/16, whereas an independent examination was only required this year.

Reports issued

Report	Date issued
Audit Plan	2 February 2017
Audit Findings Report	24 May 2017
Annual Audit Letter	28 July 2017

Fees for other services

Service	Fees £
Audit related services	
Assurance on your quality report	10,000

Non- audit services

- For the purposes of our audit we have made enquiries of all Grant Thornton UK LLP teams providing services to the Trust. The table above summarises all non-audit services which were identified.

- We have considered whether non-audit services might be perceived as a threat to our independence as the Trust's auditor and have ensured that appropriate safeguards are put in place.

The above non-audit services are consistent with the Trust's policy on the allotment of non-audit work to your auditor.

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Trust Board meeting – October 2017

NHS Maidstone and Tunbridge Wells NHS Trust

10-21	Summary report from the Patient Experience Committee, 05/10/17	Committee Chair (Non-Executive Director)

The Patient Experience Committee (PEC) met on 5th October 2017. Unfortunately the meeting was not quorate as a Non-Executive Director was not present, but it was agreed to continue regardless.

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

- An update report on the performance & usage of the Trust's translation service was noted & it was agreed to schedule an annual update report on the service for the first PEC meeting following the annual contract review meeting in 2018 (i.e. starting September 2018)
- A presentation was given by the Head of Strategy on the Trust's Strategy and the Listening into Action (LiA) programme. Following consideration of its content, it was agreed to schedule an update on the LiA programme for the PEC meeting in March 2018 and a presentation/update on the Kent & Medway Stroke Care Review for the meeting in December. It was additionally agreed to circulate the following material to the Committee:
  - a copy of the presentation on the Trust Strategy and LiA
  - the hyperlink to further information on the Kent & Medway Stroke Care Review
  - the list of 10 clinical initiatives for change currently in progress under the LiA programme
  - details of the outcome of the LiA "Pass it On" events in November 2017
  - the draft electronic version of the Strategy leaflet due to be received w/c 09/10/17
- An update on Complaints & PALS contacts was received and it was agreed to incorporate details of the number of complaints referred to the Parliamentary and Health Service Ombudsman (PHSO) in future reports to the PEC; and to include brief details of the reasons for complaints being upheld, partially upheld or not upheld
- A report on Healthwatch Kent's activity was noted and it was agreed to request that Healthwatch provide further context for the statements within their report to PEC that: "Healthwatch is not currently involved in any Strategy development" and "Healthwatch is not involved in any service change within the Trust", to clarify if these were neutral or negative statements
- An update was given on progress against the Quality Accounts priorities for 2017/18
- The Patient Led Assessments of the Care Environment (PLACE) Annual Review report was considered and it was agreed that the Head of Communications should consider (in liaison with Healthwatch and the Deputy Chief Nurse) the options for promoting the role of patient/public representatives with a view to potential recruitment
- Notification of recent/planned service changes was received, which included an update on the roll out of the new Allscripts Patient Administration System (PAS) in October
- The offer by the West Kent Clinical Commissioning Group representative on the PEC to arrange a presentation to the Committee (provisionally in December 2017) on the CCG's commissioning intentions/plans was accepted
- The usual update report on communications activity was noted
- An update on the arrangements for the forthcoming Care Quality Commission inspection of the Trust was given
- The findings from and Trust response to the Cancer Patient Experience Survey 2016 were reported by the Lead Cancer Matron, which included the action plan formulated to address those questions where the Trust's performance had declined compared to the previous year and was also below the national average. It was noted that the Trust had received an average rating of 8.8 from respondents asked to rate their care on a scale of 0 to 10
- Latest findings from the local patient survey (including the Friends and Family Test) were reported. It was agreed to check the notification process of Quality Assurance Rounds to patient/public representatives and ensure that all relevant parties were included; to review the programming of Quality Assurance Rounds to explore if it was possible to avoid scheduling rounds at both main MTW sites on the same day; and to ensure that the outcome of Quality Assurance Rounds was routinely reported to the Committee
- An update was received on the work of the Patient Information and Leaflets Group (PILG)
- A report from the Quality Committee meetings on 14/06/17 & 05/07/17 was noted

- Unfortunately, the 2 Junior Doctors who were scheduled to be present at the meeting did not attend on the day
- A report from the Patient Representative Working Group was received.

2. In addition to the actions noted above, the Committee agreed:

- To ensure the "Findings from the Local Patient Survey" report for the meeting of the PEC in March 2018 included an update on the current review of the wording in the Local Inpatient survey (which had been asked to reflect the same wording used in the National Surveys)
- For the comment received from Committee members about the unstable toilet seat in the ladies' toilets in the reception of TWH to be reported to Estates and Facilities
- That an update be sought on progress with the provision of credit/debit card payment facilities for car parking at Maidstone Hospital, & to clarify the issues raised re enforcement of parking penalty notices under the new car parking provider/contractor at that hospital
- To convey to the Estates and Facilities Department the request by the League of Friends (MH) for a change machine in the foyer of Maidstone Hospital
- To schedule an update on the arrangements for managing Overseas Visitors for a future meeting of the Committee
- To convey the request of the PEC for the Chair of the Trust Board to attend the next meeting of the Committee.

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 – October 2017

Maidstone and Tunbridge Wells NHS Trust

10-22	Summary of the Trust Management Executive (TME) meetings, 20/09 & 11/10	Acting Chief Exec.

The TME met on 20th September. The key items that were covered were as follows:

- The meeting acknowledged **Glenn Douglas' departure** and expressed thanks to Glenn during his time as Chief Executive
- The **safety moment** noted the work to mark the month's theme, the deteriorating patient
- Some proposed amendments to the **TME's Terms of Reference** were approved ((to add the Trust Cancer Committee as a sub-committee; to require the Terms of Reference of TME's sub-committees to be approved by TME; and to require the sub-committees to undertake an annual review of their Terms of Reference). The approved Terms of Reference are enclosed in Appendix 1, for the Trust Board's information
- An **Options appraisal for the future of Radiotherapy** was discussed, and it was agreed that the Clinical Director for Cancer, Haematology & Radiology should ensure that representatives from NHS Specialist Commissioning and Kent and Medway Clinical Commissioning Groups were involved in any more formal discussions
- A request to appoint 2 **replacement Consultants** (Consultant Obstetrician and Gynaecologist and a Consultant Physician with an interest in Gastroenterology) was approved
- The revised **Policy and Procedure for the production, approval and ratification of Trust-wide Policies and Procedures** was approved, ahead of the Board being asked to ratify the document at its October 2017 meeting
- An update was the **implementation of the replacement PAS+** was given, and TME formally approved the PAS Programme Board's decision to proceed with the Allscripts PAS 'go live' as scheduled (with the caveat that a further series of 'go or no go' decisions would need to be taken (outside of the TME) in the weeks leading to 08/10/17)
- A presentation on the **Trust's strategy** was given (this was similar to the presentation given at the September 2017 Trust Board)
- An update on the **forthcoming Care Quality Commission (CQC) inspection** was given
- The Medical Director initiated a discussion on the revised **Job Planning for Senior Medical Staff Policy and Procedure**, and support was provided to proceed with finalising the Policy, despite some objections being raised by the Joint Medical Consultative Committee (JMCC)
- The **performance for month 5** was discussed, which included an update on the implementation of the **Operational Resilience plan** and the latest **infection prevention and control** position
- The **key issues from the Divisions** were reported, which included the common challenges relating to capacity and staffing (including in Therapies). It was also noted that the Symphony A&E IT system upgrade had been implemented successfully, and a 'light touch' programme with a company called Four Eyes Insight had commenced to focus on Theatre productivity.
- The **key issues from recent Clinical Directors' Committee** and **Executive Team meetings** were reported. The latter included a written report being submitted for the first time
- Updates were given on **"Listening into Action"** and the **national 7 day service programme**
- A report on the **Business planning process for 2018/19** was received
- An update on the **Kent and Medway STP** was given, which noted the developments regarding potential 'cluster'-based Pathology Networks
- The summary report from the **Trust Clinical Governance Committee** was reviewed, and the **recently-approved business cases** were noted
- The **Board Assurance Framework** (BAF) for 2017/18 **& Trust Risk Register** was reviewed, as was an update report on recent **Internal Audit reviews** and any outstanding actions
- Update reports were received from the recent meetings of some of the **TME's sub-committees** (Clinical Operations & Delivery Committee, Health & Safety Committee, Policy Ratification Committee, MTW Programme Committee, Information Governance Committee and the Nursing, Midwifery and AHP Committee)

The TME also met twice on 11/10/17. The first meeting held was not a 'normal' meeting, as it

utilised the presentational format which has been adopted twice each year for the past few years, and all Trust Board Members were invited to the meeting. The focus of the presentations, which were at Divisional-level (rather than Directorate-level) for the first time was current delivery against the plans for 2017/18. The presentations were circulated by email to all Trust Board Members on 13/10/17. A proposed Trust Strategy was also endorsed, ahead of this being considered by the Trust Board, and a letter from the Care Quality Commission's Chief Inspector of Hospitals on Safety and quality of emergency care was also discussed.

The second meeting held on 11/10/17 was a 'normal' meeting (although this was far shorter than usual). The key items that were covered were as follows:

- A request to appoint a **replacement Consultant Geriatrician** was approved, as was a request for a **retire and return application for a Consultant Microbiologist**
- A revised **Information Governance Management Framework** was ratified, and revised Terms of Reference for the **Information Governance Committee** were approved. A **general Information Governance update** was also provided by the Chief Nurse (the Trust's Senior Information Risk Owner (SIRO)
- Updates were given on the latest position with **the implementation of the replacement PAS**; and the development of plans for the **configuration of services at Tunbridge Wells Hospital**
- The Director of Operations, Planned Care reported the latest position on the **planned Theatre configuration at Tunbridge Wells Hospital**
- The Chief Nurse reported the latest details on the **forthcoming CQC inspection**
- A written update on the implementation of the **Operational Resilience plan** was discussed (a separate report has been submitted to the October 2017 Trust Board)
- The usual monthly update on the **national 7 day service programme** was received
- The **Annual Review of the Procurement Strategy** was received, prior the Review being considered at the Finance and Performance Committee on 16/10/17

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

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

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

Appendix 1: Updated Terms of Reference for the TME

TRUST MANAGEMENT EXECUTIVE (TME)

TERMS OF REFERENCE

NHS Maidstone and Tunbridge Wells NHS Trust

1. Purpose

1.1. The Trust Management Executive (TME) is the senior management committee within the Trust. Its purpose is to oversee and direct:
- 1.1.1 The effective operational management of the Trust, including achievement of standards, targets and other obligations
- 1.1.2 The delivery of safe, high quality, patient-centred care
- 1.1.3 The development of Trust strategy, culture and policy
- 1.1.4 The identification, mitigation and escalation of assurance and risk issues

2. Membership

2.1. The membership of the TME is as follows:
- 2.1.1. Deputy Chief Executive (Chair)
- 2.1.2. Chief Executive (Vice-Chair)
- 2.1.3. Medical Director
- 2.1.4. Chief Nurse
- 2.1.5. Director of Finance
- 2.1.6. Chief Operating Officer
- 2.1.7. Director of Workforce
- 2.1.8. Clinical Directors (x 10)
- 2.1.9. Director of Infection Prevention Control (if not already represented under 2.1.8)
- 2.1.10. Chief Pharmacist
- 2.1.11. Trust Lead Cancer Clinician
- 2.1.12. Director of Operations, Planned Care
- 2.1.13. Director of Operations, Urgent Care
- 2.1.14. Associate Director of Operations, Women's, Paediatrics and Sexual Health
- 2.1.15. Deputy Medical Directors (x3)
- 2.1.16. Associate Medical Directors (if not already represented under another role)

2.2. Members should send appropriate deputies, when they are unable to attend in person

3. Attendance and quorum

3.1. Others may attend by the invitation of the Chair for specific agenda items.

3.2. Meetings will be quorate when attended by no less than 8 members which includes a minimum of 3 Executive Directors (2.1.1 to 2.1.7 above, one of whom will Chair the meeting), 4 Clinical Directors, and 1 Director of Operations or Associate Director of Operations.

4. Frequency of meetings

4.1. Meetings will be generally held monthly, usually on the third Wednesday of the month.

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

4.3. The Trust Secretary will ensure that appropriate secretarial support is provided. This will include agreement of the agenda with the Chair, collation of reports, taking meeting minutes and keeping a record of agreed actions.

5. Sub-committees and reporting procedure

5.1. The following sub-committees report to the TME through their respective Chairs or representatives following each of their meetings. The frequency of reporting will depend on the frequency of each sub-committee meeting:
- 5.1.1. Capital Programme Meetings (x 3 - for Estates, IT and Equipment)
- 5.1.2. Clinical Directors' Committee

5.1.3. Clinical Operations & Delivery Committee
5.1.4. Health & Safety Committee
5.1.5. Information Governance Committee
5.1.6. Informatics Steering Group
5.1.7. MTW Programme Committee
5.1.8. Nursing, Midwifery and AHP Committee
5.1.9. PLACE Action Group
5.1.10. Policy Ratification Committee
5.1.11. Private Patient Committee
5.1.12. Procurement Strategy Committee
5.1.13. Sustainable Development & Environment Committee
5.1.14. Trust Cancer Committee
5.1.15. Trust Clinical Governance Committee

The Terms of Reference of TME sub-committees are required to be approved by the TME, having first been agreed by the sub-committee. Sub-committee Terms of Reference should also be subject to an annual review (although approval should be sought within the year for any significant proposed amendments)

6. Parent Committee and reporting procedure

6.1 The TME has no parent committee, but will provide a summary report on its activities/decisions to the Trust Board (and to appropriate Board sub-committees where required/requested)

7. Duties

Strategy and plans

7.1 Develop and agree proposals for submission to the Trust Board on the Trust's strategy, vision, aims, objectives and values
7.2 Discuss proposals for submission to the Trust Board and/or Finance and Performance Committee on the Trust's annual plan/s, including the revenue and capital budgets / plans.
7.3 Oversee the implementation of the annual plan/s

Finance

7.4 Oversee the annual planning process, including budget setting, to ensure that financial plans are cohesive and deliverable and appropriately reflect (i) agreed service developments, (ii) activity projections, (iii) contract agreements and (iv) resourcing plans
7.5 To monitor monthly financial performance and forecasts (including capital) to aim to ensure that the Trust's annual financial plan is delivered

Performance

7.6 Review the Trust's overall performance, including review of the Trust Performance Dashboard
7.7 Agree actions and responsibilities in relation to key performance issues escalated from Executive Performance Review (EPR) meetings with Divisions

Risk management and internal control

7.8 Ensure that robust risk management policies and processes are in place
7.9 Ensure that all key risk issues are identified and recorded
7.10 Oversee the management of the highest-rated risks
7.11 To escalate any risks of corporate significance or seriousness to the Trust Board, for consideration and/or action
7.12 To review and endorse the Trust's Annual Governance Statement, prior to this being considered at the Audit and Governance Committee and Trust Board

Quality

7.13 Review compliance with the national "fundamental standards", and agree and monitor action plans to address weaknesses in compliance or assurance

7.14 Oversee the effective delivery of safe, high quality, patient-centred care through monitoring integrated performance reports and progress with Quality Accounts priorities, agreeing remedial actions where issues are identified, and monitoring implementation of such actions

7.15 The items in 7.13 and 7.14 will mainly be achieved through reporting from the Trust Clinical Governance Committee, although specific items may be brought directly to the TME with the agreement of the respective Chairs.

IT and Information Governance

7.16 Oversee the resolution of any IT-related operational issues. This will mainly be achieved through exception reporting from the Informatics Steering Group, although specific items may be brought directly to the TME with the agreement of the respective Chairs.

7.17 Review and endorse the draft Information Governance Toolkit year-end return for submission to the Trust Board

7.18 Oversee the implementation of effective arrangements for information governance. This will mainly be achieved through exception reporting from the Information Governance Committee, although specific items may be brought directly to the TME with the agreement of the respective Chairs.

Estates

7.19 Oversee strategic estates issues and ensure that the requirements of clinical services, and the need for the effective use of resources, are delivered through the investment in, and utilisation of, the Trust's buildings and sites. This will mainly be achieved through reporting from the MTW Programme Committee, although specific items may be brought directly to the TME with the agreement of the respective Chairs.

Workforce

7.20 Review and endorse workforce planning proposals to ensure that workforce projections meet current and future service delivery requirements

7.21 Monitor compliance with key workforce metrics, and ensure that effective actions are being taken to meet Trust targets

7.22 Review the annual national (and local) staff satisfaction surveys and agree actions and approaches to further improve levels of satisfaction and motivation and address any issues identified

Business cases

7.23 To note Business Cases approved by the Executive Team and/or the Investment Appraisal Group (IAG)

7.24 To review Business Cases (prior to such Cases being considered for approval by the relevant forum) that, in the judgement of the Chair of TME, involve significant operational impact, and support / make recommendations as required

7.25 To review and approve requests for replacement Consultant posts

8. Emergency powers and urgent decisions

8.1 The powers and authority of the TME may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted at least 2 Executive Director members (2.1.1 to 2.1.7 above) and 1 Clinical Director. The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the TME, for noting.

8.2 If the Chair agrees, a decision on an item can be made via 'virtual' means. In such circumstances, all TME members will be emailed the details of the proposed decision, and offered the opportunity to object, by a given date (this should be at least 2 working days from the date of issue of the email). If no objections are received, the proposal will be considered to be approved. If objections are received, the Chair will determine whether to a) defer the decision to a formal meeting (to enable discussion to occur) or b) overrule the objection/s. If the latter is determined, an explanation will be provided to the next formal meeting.

9. Review

9.1 The TME will review (and approve) its Terms of Reference at least annually

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History

- Agreed by the Trust Management Executive, 22/01/14
- Approved by Trust Board, January 2014
- Amendments agreed by the Trust Management Executive, 23/04/14
- Approved by Trust Board, May 2014
- Amended following decision by Trust Board, November 2014 that the Trust Management Executive should no longer be a sub-committee of the Trust Board
- Amendments approved by the Trust Management Executive, 15/04/15 (annual review)
- Approval of addition of "Procurement Strategy Committee" as a formal sub-committee, November 2015
- Amendments approved by the Trust Management Executive, 17/02/16 (addition of several sub-committees, and refining of described processes to match actual practices)
- Amendments approved by the Trust Management Executive, 16/11/16 (to reflect new Divisional structure and changes to TME's functioning)
- Amendment approved by the Trust Management Executive, 18/01/17 (to change the role in reviewing Business Cases)
- Amendment approved by the Trust Management Executive, 21/06/17 (to add the new Deputy Medical Director and Associate Medical Director positions to the membership)
- Amendments approved by the Trust Management Executive, 20/09/17 (to add the Trust Cancer Committee as a sub-committee; to require the Terms of Reference of sub-committees to be approved by TME; and to require the sub-committees to undertake an annual review of their Terms of Reference)

Trust Board Meeting – October 2017

NHS Maidstone and Tunbridge Wells NHS Trust

10-23	Summary report from Finance and Performance Committee, 25/09/17	Committee Chair (Non-Exec. Director)

The Finance and Performance Committee met on 25th September 2017.

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

- The actions from previous meetings were reviewed, which included an action for the Chief Operating Officer to clarify the operational issues challenging Trauma & Orthopaedics (T&O) performance in the light of apparently low activity levels at Maidstone Hospital. At the meeting, it was clarified that there were a number of issues affecting T&O, which included operational capacity, and variable availability of Orthopaedic Surgeons (due to annual leave, on-call duties and specialist activity). AG added that all such issues would be discussed at a T&O Risk Summit being held later in September. It was however noted that outsourcing of capacity was likely to need to be considered, given the current situation. It was therefore agreed that the issue should be drawn to the Board's attention, as there was potential for the situation to worsen before it improved. It was also agreed that an update on the current issues affecting the T&O Directorate should be included within the monthly "Non-financial performance" reports submitted to the Committee
- Under the "Safety Moment", the Trust Secretary reported that September's theme was the deteriorating patient
- The month 5 financial performance, including that on the Cost Improvement Programme (CIP), was discussed in detail. This included a discussion of the key risks, including to the cash position. The practicalities regarding the approval of a revised 2017/18 plan prior to this being submitted to NHS Improvement (should this circumstance arise) were also discussed
- The month 5 non-finance, non-quality, related performance was discussed, and the Chief Operating Officer reported the latest position in relation to the A&E 4-hour, 62-day Cancer waiting time and Referral to Treatment (RTT) waiting time targets
- The Committee reviewed the timeline for the Trust's 2018/19 planning process
- A further report on the NHS Improvement Use of Resources Assessment Framework was received (the Trust would be one of the first to be subject to the formal assessment process, following the pilots that had recently taken place in some areas). The Trust's performance on the potential metrics to be used in the Assessment were reviewed (although the metrics to be used were not yet known)
- The usual monthly update on the Lord Carter efficiency review was received
- The financial aspects of the Board Assurance Framework and Risk Register were noted
- A quarterly update on the Apprenticeship Levy was provided, and the usual monthly report on breaches of the external cap on the Agency staff pay rate was noted
- The Committee was notified of the recent uses of the Trust Seal

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

- The Director of Finance should submit an update report to the October 2017 Committee meeting on progress with STP Corporate services consolidation (to include progress with reviewing the feasibility of using external catalogue management for Trust procurement)

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

- The Committee was concerned at the situation in the Trauma & Orthopaedics Directorate (see section 1 above for further details)

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

Trust Board Meeting – October 2017

NHS Maidstone and Tunbridge Wells NHS Trust

10-23	Summary report from Finance and Performance Committee, 16/10/17	Committee Chair (Non-Exec. Director)

The Finance and Performance Committee met on 16th October 2017.

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

- The actions from previous meetings were reviewed
- Under the "Safety Moment", the Trust Secretary reported that October's theme was Saying Sorry - our Duty of Candour"
- The month 6 financial performance, including that on the Cost Improvement Programme (CIP), was discussed in detail.
- The month 6 non-finance, non-quality, related performance was discussed, and the Chief Operating Officer reported the latest position in relation to the A&E 4-hour, 62-day Cancer waiting time and Referral to Treatment (RTT) waiting time targets. The report also contained a section on Trauma & Orthopaedics (this was an action from the September meeting)
- A quarterly update on Service tender submissions was noted
- The usual monthly update on the Lord Carter efficiency review was received, and it was agreed that the outcome of the Medical locum-related discussions of the forthcoming 'Deep Dive' meetings should be included in the next update report to the Committee
- A quarterly update on Service Line Reporting (SLR) was discussed, and it was agreed that the Deputy Director of Finance (Financial Performance) should submit a report showing the Divisional SLR position of "Turnover" against contribution (rather than against "Profit/(Loss)"), for inclusion as an Appendix to the minutes of the meeting
- An Annual Review of the Procurement Strategy was considered
- A report on progress with STP Corporate services consolidation (which included progress with reviewing the feasibility of using external catalogue management for Trust procurement) was considered
- The Committee was notified that the Trust would now not be subject to the first wave of "Use of Resources" Assessments
- The Head of Midwifery and Women's Health attended for a further review of the financial performance of the Crowborough Birth Centre (a previous review had taken place in March 2017). The Committee supported the continuation of the service, despite the adverse variance against the financial forecast of the original Business Case, but agreed that performance should be closely monitored (but via 'business as usual' means rather than via the Committee)
- A quarterly analysis of Consultancy use was received
- The usual monthly report on breaches of the external cap on the Agency staff pay rate was received, and a query was raised as to which areas were involved in the engagement of staff listed in the "Nonframework" "A&C Shifts" column of the "TRUST PERFORMANCE" table within the report
- The Committee was notified of the recent uses of the Trust Seal
- The Committee acknowledged the Finance Department being awarded the Healthcare Financial Management Association Kent, Surrey, Sussex "Finance Team of The Year", and Richard Sykes (Head of Financial Management) being awarded the "Outstanding contribution" award

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

- The Director of Finance should undertake further scenario planning, for consideration by the Executive Team, to determine how many Nursing staff currently engaged via Agencies would need to be engaged by the Staff Bank in order to make an increase in the Bank pay rate economically viable
- The Trust Secretary should liaise with the Director of Finance to agree the order in which the 3 Clinical Divisions should be invited to the Finance and Performance Committee for a review of their CIP delivery, and then schedule the reviews
- The Trust Secretary and Chief Executive should review the calendar of Committee meetings scheduled to take place before the Care Quality Commission inspection, to consider whether

it was feasible to have a ‘meeting free week’, to enable additional support to be provided to front-line staff

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

- None

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

Trust Board meeting – October 2017

NHS Maidstone and Tunbridge Wells NHS Trust

10-25	**Proposed amendment to the Terms of Reference of Trust Board sub-committees**	**Trust Secretary**

In the summer of 2017, 2 Associate Non-Executive Directors (NEDs) were appointed to the Trust Board. Although an Associate NED has served on the Trust Board within the past few years, the expectations regarding the input and time commitment of the previous post-holder had been different to that of a NED, in that they were not expected (or required) to attend any meetings other than those of the Trust Board (i.e. they were not expected to attend any Board sub-committee meetings).

The 2 new Associate NEDs have however been appointed on very similar terms and conditions to a NED, and such Associate NEDs are expected to attend Trust Board and certain sub-committee meetings (and contribute fully). Chairs and NEDs of NHS Trust Boards hold a statutory office under the National Health Service Act 2006, and their appointment and tenure of office are governed by the "NHS Trusts (Membership and Procedure) Regulations 1990". Their appointments are made by NHS Improvement, using powers delegated by the Secretary of State for Health. Chairs and NEDs have full voting rights as members of the Board. However these Regulations do not apply to the appointment and tenure of office of Associate NEDs. These roles do not therefore have full voting rights on the Trust Board, and their attendance at Trust Board meetings is recorded using the convention applied to other non-voting Trust Board Members.

The status of Associate NEDs with regards to Trust Board meetings cannot therefore be changed. However, this is not the case for some of the Trust Board sub-committees. Therefore, to ensure that the maximum benefit is obtained from the appointment of the Associate NEDs, the Trust Board is asked to approve a proposal to amend the Terms of Reference of the Quality Committee, Charitable Funds Committee, Finance and Performance Committee, Patient Experience Committee, and Workforce Committee, to include Associate NEDs in the formal membership (as opposed to them being regarded as "attendees"). This will enable Associate NEDs to be appointed as the Chair or Vice-Chair of such Committees, and enable them to count towards the quorum requirements for the meetings at which they are present.

The same arrangement cannot however be applied to the Audit and Governance Committee or Remuneration and Appointments Committee, as the membership of these Committees are (like the Trust Board), governed externally. Associate NEDs will therefore be invited attendees to these meetings, but be unable to be appointed as the Chair or Vice-Chair, or count towards the quorum requirements.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

To approve a proposal to amend the Terms of Reference of the Quality Committee, Charitable Funds Committee, Finance and Performance Committee, Patient Experience Committee, and Workforce Committee, to include Associate NEDs in the formal membership of each

[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 – October 2017

Maidstone and Tunbridge Wells NHS Trust

10-26 Trust Board Members' hospital visits (13/07/17 to 09/10/17) Trust Secretary

"Board to Ward" visits, safety 'walkarounds' etc. are regarded as key governance tools[1] available to Board members. Such activity can aid understanding of the care and treatment provided by the Trust; and provide assurance to supplement the written and verbal information received at the Board and/or its sub-committees.

This quarterly report therefore provides details of the hospital visits reported as being undertaken by Trust Board Members between 13th July and 9th October 2017.

The report includes Ward/Department visits; and related activity, but does not claim to be a comprehensive record of such activity, as some Trust Board Members (most notably the Chief Executive, Chief Operating Officer, Chief Nurse, Medical Director, and Director of Infection Prevention and Control), visit Wards and other patient areas regularly, as part of their day-to-day responsibility for service delivery and the quality of care. It is not intended to capture all such routine visits within this report.

In addition, Trust Board Members may have undertaken visits but not registered these with the Trust Management office and/or Programme Management Office (PMO), who oversee the new framework (see below) (Board Members are therefore encouraged to register all such visits).

The report is primarily for information, and to encourage Trust Board Members to continue to undertake visits. Board Members are also invited to share any particular observations from their visits at the Board meeting.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information, to encourage Board members to continue to undertake visits

[1] See "The Intelligent Board 2010: Patient Experience" and "The Health NHS Board 2013"

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

Hospital visits undertaken by Board members, 13th July and 9th October 2017

Trust Board Member	Areas registered as being visited (MH: Maidstone Hospital; TWH: Tunbridge Wells Hospital)	Formal feedback provided?
Acting Chief Executive (JL)	▪ Wards 21 & 22 (TWH) ▪ John Day Ward (MH) ▪ Cornwallis Ward (MH) ▪ Stroke Unit, (MH) ▪ Wards 20 & 32 (TWH)	-
Chief Nurse (CO'B)	▪ Neo-natal, Hedgehog Ward (TWH) ▪ Short Stay Surgical Unit (TWH) ▪ Ward 20 (TWH) ▪ Chaucer Acute Frailty Unit (MH) ▪ Maternity (TWH): Post-natal; Delivery; Ante-natal clinics	-
Chief Operating Officer (AG)	▪ Theatres ▪ Whatman Ward (MH) ▪ Mercer Ward (MH) ▪ A&E ▪ Acute Medical Unit (TWH) ▪ Maidstone Orthopaedic Unit ▪ Ophthalmology (MH) ▪ Chaucer Acute Frailty Unit (MH) ▪ Edith Cavell Unit (MH) ▪ Chaplains ▪ Volunteers ▪ Pharmacy (MH, TWH) ▪ Reception (TWH)	-
Director of Finance (SO)	▪ John Day Ward (MH)	-
Medical Director (PM)	Chaucer, Acute Frailty Unit (MH) Physiotherapy (TWH) Neonatal (TWH) Short Stay Surgery (TWH) Surgical Assessment Unit (TWH) Acute Medical Unit (TWH) Acute Stroke Unit (TWH) Ward 22 (TWH)	-
Chair of Trust Board (DH)	Acute Medical Unit (TWH) Maidstone Orthopaedic Unit Chaucer, Acute Frailty Unit (MH) Discharge Lounge (MH) New doctors' induction	-
Non-Executive Director (SDu)	A&E (TWH) Radiology (TWH)	-
Associate Non-Executive Director (MC)	*Induction visits to be arranged*	
Associate Non-Executive Director (NH)	Site tour TWH *Further induction visits to be arranged*	
Non-Executive Director (AK)	-	-
Non-Executive Director (TL)	*Induction visits to be arranged*	-